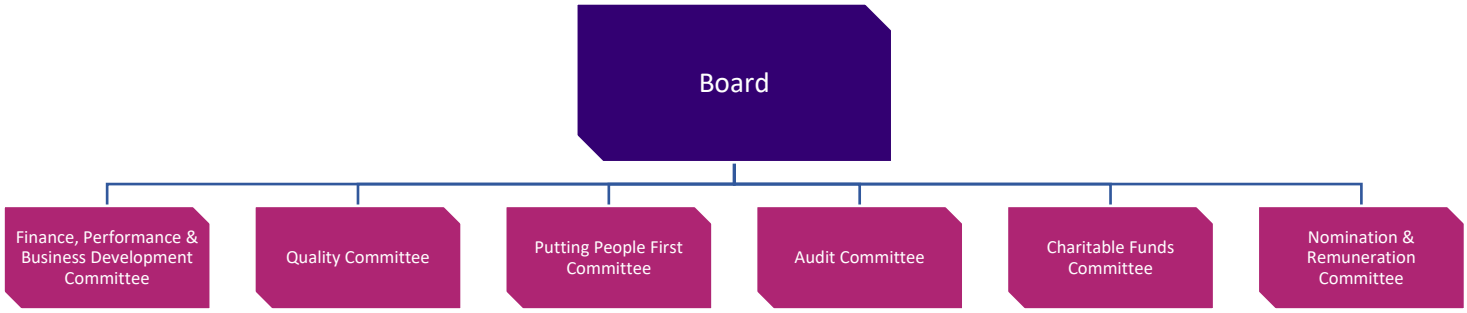
Liverpool Women's NHS Foundation Trust

Trust Board

1 September 2022, 10.00am
Boardroom, LWH & Virtual, via Teams



Liverpool Women's NHS Foundation Trust

Trust Board

Location	Boardroom & Virtual via Teams
Date	1 September 2022
Time	10.00am

Item no. 22/23/	Title of item	Objectives/desired outcome	Process	Item presenter	Time
PRELIMINARY BUSINESS					
088	Introduction, Apologies & Declaration of Interest	Receive apologies & declarations of interest	Verbal	Chair	1000 (5 mins)
089	Meeting Guidance Notes	To receive the meeting attendees' guidance notes	Written	Chair	
090	Minutes of the previous meeting held on 7 July 2022	Confirm as an accurate record the minutes of the previous meeting	Written	Chair	
091	Action Log and matters arising	Provide an update in respect of on-going and outstanding items to ensure progress	Written	Chair	
092	Service Outline – Liverpool Neonatal Partnership	To receive service outline	Presentation	Medical Director	1005 (15 mins)
093	Patient Story	To receive a patient story	Presentation	Chief Nurse & Midwife	1020 (15 mins)
094	Chair's announcements	Announce items of significance not found elsewhere on the agenda	Verbal	Chair	1035 (5 mins)
095	Chief Executive Report	Report key developments and announce items of significance not found elsewhere on the agenda	Written	Chief Executive	1040 (5 mins)
MATERNITY					
096a	Maternity Incentive Scheme (CNST) Year 4 – Scheme Update	To receive	Written	Chief Nurse & Midwife	1045 (10 mins)
096b	Digital.Maternity	To approve	Written	Chief Information Officer	1055 (10 mins)
QUALITY & OPERATIONAL PERFORMANCE					
097a	Chair's Report from the Quality Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	1105 (70 mins)
097b	Quality & Operational Performance Report	For assurance – To note the latest performance measures	Written	Chief Operating Officer	

097c	Neonatal Mortality Review Update	To receive	Written	Medical Director	
097d	Quality Improvement Update	To receive	Presentation	Chief Nurse & Midwife	
097e	Women's Health Strategy for England	To receive	Presentation	Chief Nurse & Midwife	
097f	Safeguarding Annual Report	To approve and to be updated on Board responsibilities	Written / Presentation	Chief Nurse & Midwife	
097g	Whistleblowing / Freedom to Speak up Annual Report 2021/22	For assurance and approval	Written	Chief People Officer	
BREAK – 10 mins					
Board Thank You – 5 mins					
PEOPLE					
098a	Chair's Report from the Putting People First Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	1230 (20 mins)
098b	Workforce Performance Report	For assurance – To note the latest performance measures	Written	Chief People Officer	
098c	WRES and WDES Report 2022	For assurance and approval	Written	Chief People Officer	
FINANCE & FINANCIAL PERFORMANCE					
099a	Chair's Report from the Finance, Performance and Business Development Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	1250 (20 mins)
099b	Chair's Report from the Audit Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	
099c	Finance Performance Review Month 4 2022/23	To receive	Written	Chief Finance Officer	
BOARD GOVERNANCE					
100a	Board Assurance Framework	For assurance	Written	Trust Secretary	1310 (5 mins)
100b	Well-Led Action Plan	For approval	Written	Trust Secretary	1315 (15 mins)
CONSENT AGENDA (all items 'to note' unless stated otherwise) *All these items have been read by Board members and the minutes will reflect recommendations, unless an item has been requested to come off the consent agenda for debate; in this instance, any such items will be made clear at the start of the meeting.*					
101	R&D Annual Report	For assurance	Written	Medical Director	Consent
102	Corporate Governance Manual – 2022 Update	For approval	Written	Trust Secretary	

CONCLUDING BUSINESS					
103	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair	1330 (5 mins)
104	Chair's Log	Identify any Chair's Logs	Verbal	Chair	
105	Any other business & Review of meeting	Consider any urgent items of other business	Verbal	Chair	
106	Jargon Buster	For reference	Written	Chair	

Date of Next Meeting: 3 November 2022

1335 - 1345	*Questions raised by members of the public*	To respond to members of the public on matters of clarification and understanding.	Verbal	Chair

Liverpool Women's NHS Foundation Trust

Meeting attendees' guidance

Under the direction and guidance of the Chair, all members are responsible for ensuring that the meeting achieves its duties and runs effectively and smoothly.

Before the meeting

- Consider the most appropriate format for your meeting i.e. physical, virtual or hybrid. There are advantages and disadvantages to each format, and some lend themselves to particular meetings better than others. Please seek guidance from the Corporate Governance Team if you are unsure.

General considerations:

- Submit any reports scheduled for consideration at least 8 days before the meeting to the meeting administrator. Remember to try and answer the 'so what' question and avoid unnecessary description. It is also important to ensure that items/papers being taken to the meeting are clear and provide a proposal/recommendation to reduce unnecessary discussion time at the meeting.
- Ensure your apologies are sent if you are unable to attend and *arrange for a suitable deputy to attend in your absence
- Prepare for the meeting in good time by reviewing all reports
- Notify the Chair in advance of the meeting if you wish to raise a matter of any other business

*some members may send a nominated representative who is sufficiently senior and has the authority to make decisions. Refer to the terms of reference for the committee/subcommittee to check whether this is permitted.

Virtual / Hybrid Meetings via Microsoft Teams and other digital platforms

- For the Chair / Administrators:
  - Ensure that there is a clear agenda with breaks scheduled if necessary
  - Make sure you have a list of all those due to attend the meeting and when they will arrive and leave.
  - Have a paper copy of the agenda to hand, particularly if you are having to host/control the call and refer to the rest of the meeting pack online.
  - If you are the host or leader for the call, open the call 10-15 minutes before the start time to allow everyone to join in an orderly way, in case there are any issues.
  - At the start of the call, welcome everyone and run a roll call/introduction - or ask the meeting administrator to do this. This allows everyone to be aware of who is present.
  - Be clear at the beginning about how long you expect the meeting to last and how you would like participants to communicate with you if they need to leave the meeting at any point before the end.

- General Participants
  - Arrive in good time to set up your laptop/tablet for the virtual meeting
  - Switch mobile phone to silent
  - Mute your screen unless you need to speak to prevent background noise
  - Only the Chair and the person(s) presenting the paper should be unmuted
  - Remember to unmute when you wish to speak

- Use headphones if preferred
- Use multi electronic devices to support teams.
- You might find using both mobile and laptops is useful. One for Microsoft teams and one for viewing papers

At the meeting

General Considerations:

- For the Chair:
  - The chair will assume that all members come prepared to discuss agenda items having read through supporting papers, this obviates the need for leads to take up valuable time presenting their papers.
  - The chair will allow a free ranging debate and steer discussions to keep members on track whilst at the same time not being seen to overly influence the outcome of the debate.
  - The chair will provide a brief summary following presentation and discussion of the paper, confirming any key risks and / or assurances identified and whether there are any matters for the Chair's log.
  - The chair will question leads when reports have not been submitted within the Trust's standard template or within the required timeframe.
  - Ensure that correct people are in the room to 'form the meeting' with other attendees invited to attend only when presenting their item.

- General Participants:
  - Focus on the meeting at hand and not the next activity
  - Actively and constructively participate in the discussion
  - Think about what you want to say before you speak; explain your ideas clearly and concisely and summarise if necessary
  - Make sure your contributions are relevant and appropriate
  - Respect the contributions of other members of the group and do not speak across others
  - Ensure you understand the decisions, actions, ideas and issues agreed and to whom responsibility for them is allocated
  - Do not use the meeting to highlight issues that are not on the agenda that you have not briefed the chair as AoB prior to the meeting
  - Re-group promptly after any breaks
  - Take account of the Chair's health, safety and fire announcements (fire exits, fire alarm testing, etc)
  - Consent agenda items, taken as read by members and the minutes will reflect recommendations from the paper. Comments can still be made on the papers if required but should be flagged to the Chair at the beginning of the meeting.

Virtual / Hybrid Meetings via Microsoft Teams and other digital platforms

- For the Chair:
  - Make sure everyone has had a chance to speak, by checking at the end of each item if anyone has any final points. If someone has not said anything you might ask them by name, to ensure they have not dropped off the call or assist them if they have not had a chance to speak. In hybrid meetings, it can be useful to ask the 'virtual' participants to speak first.

  - Remember to thank anyone who has presented to the meeting and indicate that they can leave the meeting. It can be easy to forget this if you can't see them.

- General Participants:
  - Show conversation: open this at start of the meeting.
    - This function should be used to communicate with the Chair and flag if you wish to make comment
  - Screen sharing
    - If you wish to share a live document from your desktop click on share and identify which open document you would like others to view

Attendance

Members are expected to attend at least 75% of all meetings held each year

After the meeting

- Follow up on actions as soon as practicably possible
- Inform colleagues appropriately of the issues discussed

Standards & Obligations

1. All documentation will be prepared using the standard Trust templates. A named person will oversee the administrative arrangements for each meeting
2. Agenda and reports will be issued 7 days before the meeting
3. An action schedule will be prepared and circulated to all members 5 days after the meeting
4. The draft minutes will be available at the next meeting
5. Chair and members are also responsible for the committee/ subcommittee's compliance with relevant legislation and Trust policies
6. It is essential that meetings are chaired with an open and engaging ethos, where challenge is respectful but welcomed
7. Where consensus on key decisions and actions cannot be reached this should be noted in the minutes, indicating clearly the positions of members agreeing and disagreeing – the minute should be sufficiently recorded for audit purposes should there need to be a requirement to review the minutes at any point in the future, thereby safeguarding organisational memory of key decisions
8. Committee members have a collective duty of candour to be open and honest both in their discussions and contributions and in proactively at the start of any meeting declaring any known or perceived conflicts of interest to the chair of the committee
9. Where a member of the committee perceives another member of the committee to have a conflict of interest, this should be discussed with the chair prior to the meeting
10. Where a member of the committee perceives that the chair of the committee has a conflict of interest this should be discussed with the Trust Secretary
11. Where a member(s) of a committee has repeatedly raised a concern via AoB and subsequently as an agenda item, but without their concerns being adequately addressed the member(s) should give consideration to employing the Whistle Blowing Policy
12. Where a member(s) of a committee has exhausted all possible routes to resolve their concerns consideration should be given (which is included in the Whistle Blowing Policy) to contact the Senior Independent Director to discuss any high-level residual concerns. Given the authority of the SID it would be inappropriate to escalate a non-risk assessed issue or a risk assessed issue with a score of less than 15

13. Towards the end of the meeting, agendas should carry a standing item that requires members to collectively identify new risks to the organisation – it is the responsibility of the chair of the committee to ensure, follow agreement from the committee members, these risks are documented on the relevant risk register and scored appropriately

Speak well of NHS services and the organisation you work for and speak up when you have Concerns

Page 129 Handbook to the NHS Constitution 26th March 2013

Liverpool Women's
NHS Foundation Trust

Board of Directors

Minutes of the meeting of the Board of Directors held in the Boardroom and Virtually via Teams at 09.00am on 7 July 2022

PRESENT

Robert Clarke	Chair
Kathryn Thomson	Chief Executive
Eva Horgan	Chief Finance Officer
Gary Price	Chief Operating Officer
Louise Martin	Non-Executive Director
Dr Susan Milner	Non-Executive Director / SID
Tracy Ellery	Non-Executive Director / Vice-Chair
Gloria Hyatt MBE	Non-Executive Director
Zia Chaudhry MBE	Non-Executive Director
Tony Okotie	Non-Executive Director
Jackie Bird MBE	Non-Executive Director
Dr Lynn Greenhalgh	Medical Director
Marie Forshaw	Chief Nurse & Midwife
Michelle Turner	Chief People Officer / Deputy Chief Executive

IN ATTENDANCE

Matt Connor	Chief Information Officer
Yana Richens	Director of Midwifery (until item 075a)
Jennifer Huyton	Head of Strategy and Transformation (item 075c only)
Michelle Rushby	Head of Audit, Effectiveness and Patient Experience (item 070 only)
Gillian Walker	Patient Experience Matron (items 070 only)
Carl Griffiths	Named Nurse for Safeguarding Adults / MCA & DoLS Lead (item 071 only)
Angela Winstanley	Maternity Quality and Safety Matron (items 074a and 074b only)
Alison Murray	Interim Head of Midwifery (items 074a and 074b only)
Dr Kat Pavlidi	Guardian of Safe Working Hours (item 075e only)
Tony Okotie	Member of the public
Lesley Mahmood	Member of the public
Felicity Dowling	Member of the public
Peter Norris	Public Governor
Mark Grimshaw	Trust Secretary (minutes)

APOLOGIES:

Sarah Walker	Non-Executive Director
Prof. Louise Kenny CBE	Non-Executive Director
Dianne Brown	Interim Associate Director

Core members	**Aug 21**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul 22**
Robert Clarke - Chair		✓		✓	✓	✓	✓	✓	✓	✓	✓	✓
Kathryn Thomson - Chief Executive		✓		✓	✓	✓	✓	✓	✓	✓	✓	✓

Dr Susan Milner - Non-Executive Director / SID		✓		✓	✓	✓	✓	✓	✓	✓	NM	
Tracy Ellery - Non-Executive Director / Vice-Chair		✓		A	✓	✓	✓	✓	✓	✓	✓	✓
Louise Martin - Non-Executive Director		✓		✓	✓	✓	✓	✓	✓	✓	✓	✓
Tony Okotie - Non-Executive Director		✓		✓	A	✓	✓	✓	✓	✓	A	NM
Prof Louise Kenny - Non-Executive Director		A		✓	A	✓	A	A	A	✓	✓	A
Eva Horgan – Chief Finance Officer	Non-member			✓	✓	✓	✓	✓	✓	✓	✓	✓
Marie Forshaw – Chief Nurse & Midwife		✓		✓	✓	✓	✓	✓	✓	A	✓	✓
Gary Price - Chief Operating Officer		✓		✓	✓	✓	✓	✓	✓	✓	✓	✓
Michelle Turner - Chief People Officer		✓		✓	✓	A	✓	✓	✓	A	✓	✓
Dr Lynn Greenhalgh - Medical Director		✓		✓	✓	✓	✓	A	A	✓	✓	✓
Zia Chaudhry – Non-Executive Director	Non-member				✓	✓	✓	✓	✓	✓	✓	✓
Gloria Hyatt – Non-Executive Director	Non-member				✓	✓	✓	✓	✓	✓	✓	✓
Sarah Walker – Non-Executive Director	Non-member				✓	✓	✓	✓	✓	A	✓	A
Jackie Bird – Non-Executive Director	Non-member								✓	A	✓	✓

22/23/	
069	**Introduction, Apologies & Declaration of Interest** The Chair welcomed everyone to the meeting. Jackie Bird noted that since the previous meeting, she had been appointed as an external advisor for Trinity St James Cancer Institute in Dublin and as Deputy Lieutenant for Derbyshire. It was noted that the Register of Interests would be updated accordingly. Apologies were noted as above. No items proposed to be removed from the consent agenda.
070	**Meeting guidance notes** The Board received the meeting attendees' guidance notes.
071	**Minutes of the previous meetings held on 5 May 2022** The minutes of the Board of Directors meeting held on 5 May 2022 were agreed as a true and accurate record.
072	**Action Log and matters arising** The Board reviewed the Action Log and agreed the updated deadlines for those actions that had risks identified.
073	**Service Outline – Patient Experience Matron** The Board received an update on the progress made since the Patient Experience Matron (PEM) had been appointed in December 2021. It was explained that the PEM provided clinical leadership and

	understanding to the Patient Experience Team and clinical and professional support to all staff. The PEM was responsible for motivating staff to believe that patient experience matters. Work had been undertaken to develop key relationships with organisations such as the Merseyside Deaf Society, the Brain Charity, Merseyside Police and local faith-based community centres. The Chief People Officer sought clarification on how areas of focus were identified and whether there was an underpinning strategy or plan directing the engagement work being undertaken. The Head of Audit, Effectiveness and Patient Experience reported that the Trust's quality governance system (Ulysses) was being utilised to identify key projects but there was acknowledgement that the triangulation with other sources of intelligence could be strengthened. The Board stated that the progress to date was promising and an important step in the right direction in better engaging with patients and stakeholders. It was asserted that further work was required to provide greater direction to engagement efforts (underpinned by an intelligence driven strategy) and in ensuring that information gathered from engagement was being utilised by services to drive improvement. The service outline was noted. *Michelle Rushby and Gillian Walker left the meeting*
074	Patient Story The Named Nurse for Safeguarding Adults presented a story of a patient who had been diagnosed with blood injury injection phobia which manifested with exposure to anything medically related. This had been extended to a diagnosis of Tokophobia, a pathological fear of pregnancy, leading to avoidance of childbirth. The patient commenced IVF treatment with the Hewitt Centre in February 2020 culminating in booking for antenatal care in April 2021. Because of their complexity, they received Consultant led antenatal care, with the support of the Enhanced Midwifery Service and was also referred to both the Peri-Natal Mental Health Service and the Safeguarding Team, for specialist support. A reasonable adjustment risk assessment was completed by the enhanced midwife and a behaviour support plan was agreed following discussion with the patient, Consultant Midwife, Consultant Obstetrician, and the Safeguarding team. The patient's baby was delivered by C-Section in November 2021, and they had noted how they had felt listened to and cared for throughout their experience. The Chief People Officer queried whether the level of support described for this patient was available for unplanned care. The Named Nurse for Safeguarding Adults confirmed that training had been made available across the organisation but acknowledged that there continued to be a challenge with identifying 'invisible' disabilities. Work was underway to improve the sharing of the information with primary care colleagues to strengthen the identification of additional needs. The anticipated implementation of the Meditech Expanse system would support this, and the Chief Information Officer noted that all providers in the Cheshire and Merseyside system had signed up to a shared case record programme. The Chief Operating Officer queried if the Covid-19 pandemic had impacted the Trust's ability to provide reasonable adjustments to patients. The Named Nurse for Safeguarding Adults reported that an audit had been undertaken and this had found that all patients requiring a reasonable adjustment during the pandemic had them in place. The Chief Executive noted that she had never seen a complaint against the Safeguarding Team and stated that lessons could be learned from the approaches undertaken and shared with the wider organisation. The Chief Nurse & Midwife confirmed that the patient story would be shared with the Divisional Teams.

	The Board noted the patient story and thanked the patient for taking the time to record their story and their permission for it to be shared with the Board. *Carl Griffiths left the meeting*
075	**Chair's announcements** The Chair reported that NHS Cheshire and Merseyside had entered its first day as a statutory organisation on 1 July 2022. The milestone meant that Cheshire and Merseyside became one of 42 Integrated Care Systems (ICS) in the country, which were now on a legal footing. It also signalled the closure of all nine Clinical Commissioning Groups (CCG) in Cheshire and Merseyside. It was noted that the Trust would need to change its ways of working and that the implications were currently being considered and would report to the Board in due course. There were expectations about how the Trust would demonstrate commitment to partnerships, collaborative working and work to reduce health inequalities. The Chief Operating Officer placed his thanks on record for the Clinical Commissioning Group teams that had interacted and supported the Trust in recent years. The Chair noted the Council of Governors Meeting would take place on 28 July, looking at the Year-end and Annual Report, and the recent Staff Survey. The Board noted the Chair's update.
076	**Chief Executive's report** The Chief Executive presented the report which detailed local, regional and national developments. The following key points were highlighted: • The Trust's Dedicated to Excellence Awards took place on Thursday 30 June 2022 at St George's Hall. It was noted that it had been great to see everyone there after the previous two years events being either cancelled or recorded due to the COVID-19 pandemic. Congratulations were extended to all the winners and nominees. • The Children Growing Up in Liverpool (C-GULL) study would be launched at a Trust event on the 6 September 2022. The Trust would be supporting the study and the target was to recruit 70% of all first-time mothers into the study. **Action: To provide an overview of the C-GULL study to a future Board meeting** • A recent amendment to the Abortion Act was highlighted. The implications for the Trust would be considered through the appropriate governance routes. • The fact that 91% of Liverpool University's research had been rated as world leading or internationally excellent was noted as being positive for the Trust and its research interests. The Board of Directors: • noted the Chief Executive update. *Alison Murray and Angela Winstanley joined the meeting*
077a	**Ockenden Final Report Self-Assessment** The Board received an update regarding the completion of a gap analysis undertaken as a requirement of the Ockenden Final Report. The self-assessment gap analysis indicated that for the 15 Essential Actions, the Trust could demonstrate compliance with 53 of the 92 sub-sections, 25 of which were amber, three of which were red. The 11 sub-sections not self-assessed were for national action. The Quality Committee had reviewed the gap analysis ahead of submission to the Local Maternity and Neonatal System (LMNS) on 30 June 2022. The Committee had also noted how the how the actions within the final Ockenden Report would be monitored and overseen with assurance reports into Safety & Effectiveness Sub-Committee, to Quality Committee and onward to the Trust Board.

	Non-Executive Director, Zia Chaudhry, queried whether the Trust was awaiting the outcome of the East Kent Maternity Service Review before progressing with identified actions. The Chief Nurse & Midwife explained that the Trust was working to progress actions that were within its control and would await further guidance regarding aspects that had a national focus. The Board of Directors: • noted the assurances provided in the report.
077b	Maternity Incentive Scheme (CNST) Year 4 – Scheme Update The Maternity Quality and Safety Matron outlined the scheme requirements for compliance required to achieve all ten safety actions and their associated standards for the Maternity Incentive Scheme Year 4 and the Trust's status against this. The 'pause' in reporting, in place since early 2022, had now been lifted, with updated reporting deadlines provided. It was noted that specific information was required to be noted by the Board. This related to the following: • Safety Action 6 – Saving Babies Lives Care Bundle V2 (Appendix A) • Safety Action 4 – Obstetric Workforce Review and associated action plan (Appendix B) • Safety Action 9 - Perinatal Surveillance Dashboard Update (Appendix C) The Chief Operating Officer highlighted the following areas of potential risk to compliance: • There was a current vacancy for the Maternity Voices Partnership (MVP) Chair. Interviews for a new Chair had been arranged. • There was a challenge of ensuring that 90% of each maternity staff group attended multi-professional education and training (MPET). A particular issue relating to junior doctor rotation patterns which was being mitigated through including the training during the induction process. This challenge had been escalated to NHS Resolution. Non-Executive Director, Louise Martin, referred to the Perinatal Surveillance Dashboard and noted that current MPET compliance was low across staff groups. The Interim Head of Midwifery explained that the Trust was on a trajectory for compliance by January 2023 and the rate of compliance would be 84% by the end of July 2022. The Chief People Officer noted that human factors training was being implemented across the Trust and suggested that the Putting People First Committee receive additional information regarding the Trust's approach to the 'Civility Saves Lives' agenda. Chair's Log: For the Putting People First Committee to receive additional information regarding the Trust's approach to the 'Civility Saves Lives' agenda The Chair queried whether the outcome from the One to One Midwives review had been made available. The Chief Executive noted that the report had yet to be published but the issue had been escalated to the LMNS. The Board of Directors: • Received the current position in relation to CNST Year 4 • Noted the specific updates in relation to: o Saving Babies Lives Care Bundle V2 o Obstetric Workforce Review and associated action plan o Perinatal Surveillance Dashboard Update *Alison Murray, Angela Winstanley and Yana Richens left the meeting*
078a	Chair's Reports from the Quality Committee The Board considered the Chair's Reports from the Quality Committee meetings held on 23 May and 27 June 2022.

	In terms of issues to escalate it was noted a general theme regarding training compliance was identified through several of the agenda items and included areas such as fit mask testing and safeguarding level 3 training. A presentation had been received outlining the quality impacts of the recovery and restoration work post pandemic. Whilst the Committee was assured by the grip demonstrated by the Operations Team (and improvements in several areas), there was a concern expressed that key waiting time / access metrics continued to deteriorate. Actions to improve the position were outlined and it was expected that the position would plateau in Q3 2022/23. A recommendation was made to ensure that this issue was visible on the BAF going forward. The Board of Directors: • Received and noted the Chair's Report from the Quality Committee meetings held on 23 May and 27 June 2022.
078b	Quality & Operational Performance Report The Board considered the Quality and Operational Performance Report. The Chief Operating Officer noted that whilst eliminating the number of patients waiting over 52 weeks for treatment continued to be challenging, progress had been made in relation to other access targets. The Trust was utilising 'getting it right first time' (GIRFT) data and other benchmarking information to help identify further improvements. The performance against the two-week cancer target had improved during May and June and there had also been better performance in relation to the 4-hour A&E target during the reporting period. Non-Executive Director, Louise Martin, noted that there were thirteen open Serious Incidents and queried if delays in closing the reviews was resulting in missed learning opportunities. The Chief Nurse & Midwife confirmed that 72-hour reviews were held for each serious incident, and these identified immediate actions that needed to be taken. Thirty staff had also recently undertaken root cause analysis training which would help to support the serious incident process. The Board of Directors: • Received and noted the Quality & Operational Performance Report.
078c	Standalone Site - Update on Quality and Safety Risks It was noted that a paper was presented to the Trust Board in March 2022 detailing the primary risks which arise because of the Trust's isolated position and current configuration of services across Liverpool. An update was received on progress made towards reducing risks where possible, as well as the ongoing impact of those risks. Progress included: • Increased partnership working with Liverpool University Hospitals NHS FT (LUHFT) and Liverpool Heart and Chest Hospital NHS FT (LHCH) • Establishment of new diagnostic imaging services on site • Progress towards delivering further imaging services as well as physiological testing services on the Crown Street site. The Chief Finance Officer reminded the Board that a number of the mitigations either implemented or planned were inefficient and were contributing to the Trust not being financially sustainable in the long-term. A review of all serious incidents to date over the last five years was underway, to identity incidents where the current configuration of services was either a root cause or a contributory factor. This review would be completed in July 2022 and the outcome would be reported to the Trust Board. Action: To receive review of all serious incidents to date over the last five years identifying incidents where the current configuration of services was either a root cause or a contributory factor

	Attention was drawn to the fact that the Cheshire and Merseyside Integrated Care System (C&M ICS) had commissioned an independent review of acute and specialist care in Liverpool. The review was requested by NHS England/Improvement in recognition of the complex health and care system in Liverpool, with seven acute and specialist provider trusts, all of which provide good care but were challenged by service duplication, variation in quality and outcomes and experiences of care. The Trust was participating in the review and updates would be provided to the Board. The Chair remarked on the importance of the Board remaining cognisant of the on-going risks and the efficacy of the mitigations being implemented. There was acknowledgement that once all mitigations were implemented, there would still remain an unacceptable level of clinical risk due to the isolated nature of the Crown Street site. This had an ongoing impact on the demands on and workload of clinicians, both based at the Trust and at other locations, as well as quality, risk to outcomes and both patient and staff experience. In turn this presented a significant risk to the Trust's recruitment and retention of staff. The Board of Directors noted: • the recent progress that has been made in relation to further reducing risk on the Liverpool Women's site. • the risks that remain and key data in relation to the impacts of the standalone status of the Trust
078d	Integrated Governance Assurance Report Quarter 4 The Board received the Integrated Governance Assurance report which covered Quarter 4 of 2021/22. The report was part of the regular reporting schedule of the Trust to ensure that there was oversight and assurance monitoring of Integrated Governance across the Trust. It was noted that the report did not reflect the associated risks in relation to the Trust's Future Generations Strategy. Work was on-going between governance, patient experience, finance & transformation & strategy which would support further additions to future reports throughout 2022/23 and beyond. Non-Executive Director, Louise Martin drew attention to the telephony contact issues as a key risk identified for improvement. It was queried what action was being taken to improve patient experience in this area. The Chief People Officer confirmed that a task and finish group had been established to explore solutions. The main issue related to a lack of clinical staff available to answer calls at both the Gynaecology Emergency Department and the Maternity Assessment Unit. Alternative models e.g., those utilised by ambulance services and the 111 service were being considered. The Chief Executive queried whether issues relating to patient experience should be given additional prominence in future reports. It was noted that the Deputy Chief Nurse & Midwife would be taking operational accountability for this area, and this would support enhanced reporting through the governance framework. The Board of Directors noted the contents of the reports and the assurances provided. *Kat Pavlidi joined the meeting*
078e	Guardian of Safe Working Hours (Junior Doctors) Q4 / Annual Report The Guardian of Safe Working presented the report and noted the following key issues for escalation: • That there were an increasing number of rota gaps and whilst these were covered mostly in advance of the shift occurring, they were increasing burnout rates. The need to cover rota gaps was also impacting on protected training time. • In line with a national trend, the number of exception reports submitted had decreased. The Guardian of Safe Working was working to explain the importance of submitting exception reports and raising awareness.

	• The Junior Doctor mess improvements / move had yet to be finalised. With regards to the increasing number of rota gaps, the Medical Director added that the Trust was asking junior doctors to provide cover rather than utilising locum or agency doctors. Whilst this was beneficial for quality and safety purposes, it did pose the risk of burnout and missed training opportunities. The Deputy Medical Director was exploring more sustainable workforce solutions. Non-Executive Director, Louise Martin, sought assurance that the Trust's services were safe considering the issues raised. The Guardian of Safe Working stated that there was no evidence of unsafe practice identified in the exception reports received. There was agreement that the Putting People First Committee should explore the junior doctor experience in more detail, receiving a staff story to support this aim. Chair's Log: Putting People First Committee to explore the junior doctor experience in more detail, receiving a staff story to support this aim. The Board queried if there an expected completion date for the junior doctor mess move. The Chief Operating Officer confirmed that costings had been received and it would most likely be completed during Quarter three 2022/23. The Board of Directors noted the contents of the reports and the assurances provided. *Kat Pavlidi left the meeting*

078f	Learning from Deaths Quarter 4 2021/22
	The Board received the report which presented the mortality data for quarter four and the learning from deaths information for quarter three.
	
	In Quarter four there were the following deaths:
	• Adult deaths – 0 (4 for 2021/22)
	• Direct Maternal Deaths – 0 (0 for 2021/22)
	• Stillbirths 9 (rate 5.0/1000)
	  ○ 2021/22 Stillbirths (excluding TOP) 4.9/1000 total births
	  ○ 2021/22 Stillbirths (incl. TOP) 7.1/1000 total births
	• Neonatal deaths 8 inborn (rate 4.4/1000 inborn births) + 0 deaths from postnatal transfers (2021/22- 3.6/1000 deliveries (inborn)
	
	It was noted that a Serious Incident investigation was conducted for a woman who died in Q2 2021/22. She had undergone debulking surgery for ovarian cancer and died eight days later following a sudden deterioration due to an acute gastric dilatation and intra-abdominal haemorrhage. This was a rare complication of surgery but could also be related to other aetiologies. Learning from the review included that not being co-located with acute services contributed towards the decision making around requesting CT scans for patients on the Crown Street site. There had been one non-direct maternal death during the reporting period that was currently being reviewed.
	
	The provisional ONS data demonstrated that for the first time since 2014 national stillbirth rates had shown a year-on-year increase. Local and national stillbirth data was being analysed and a report would be provided to the September 2022 Board.
	
	The Board of Directors noted:
	• The number of deaths in our care
	• The number of deaths subject to case record review
	• The number of deaths investigated under the Serious Incident framework

	• The number of deaths that were reviewed/investigated and as a result considered due to problems in care • themes and issues identified from review and investigation and the actions taken in response, actions planned and an assessment of the impact of actions taken • That the monitoring and review of the stillbirth rate continues by the Family Health board, with a thematic review to be conducted with Q4 data and learning. Issues identified at the reviews and recommendations made were to be tracked through the Maternity Clinical Meeting • That the monitoring and review of the neonatal mortality rate continued with an external review of mortality for extremely preterm infants to be available in Q2 2022-23.
	Board Thank you The Chief Operating Officer introduced representatives from the Community Midwifery Team noting the work that been undertaken to improve the Trust's Carbon Monoxide monitoring compliance. The Medical Director introduced Hannah Newby and Katie Best from the Hewitt Centre, noting that the Knutsford Centre had recently achieved a positive inspection report from the regulator. The Chief Nurse & Midwife noted thanks to the Interim Head of Midwifery during her time covering the substantive post.
079a	Chair's Report from the Putting People First Committee The Board considered the Chair's Report from the Putting People First Committee meeting held on 16 May 2022. The Committee received a Trust wide deep dive into mandatory training compliance which detailed key findings and options to improve compliance. The Committee had been assured by the review undertaken and approved of the suggested recommendations. It was noted that the options should be selected by the divisions / departments as best fit for their teams. The Committee noted the potential risks of continued rota issues and gaps on the medical workforce. It was agreed that only partial assurance could be noted from the Director of Medical Education Annual report as although the rota gap risk was currently being mitigated it was unlikely to be sustainable. The Board of Directors: • Received and noted the Chair's Report from the Putting People First Committee meetings held on 16 May 2022.
079b	Workforce Performance Report The Board received the Workforce Performance Report. The Chief People Officer noted that there were signs of improvement in the sickness absence rate and that this should have a positive impact on the mandatory training compliance rate as staffing pressures reduce. Divisions had been requested to ensure that in recovering the mandatory training compliance rate that highest risk areas were being prioritised to mitigate potential risks to patient safety. The Board of Directors: • Noted the Workforce Report.
079c	'Big Conversation' Feedback The Chief People Officer provided an overview of the first 'Big Conversation' event which took place at the Trust over a 24-hour period on 15 June 2022. It was explained that for a number of years the Trust had hosted quarterly Listening events, face to face in the Blair Bell Lecture Theatre where staff

	were required to book a place in advance. During the Covid-19 pandemic this was adapted to a virtual listening event, utilising MS teams. Due to challenges with engagement, a decision was taken to host a 24 hour 'Big conversation' from 8am on 15 June until 8am, on 16 June 2022. This involved volunteers from Executive team, Non-Executive Directors, Senior Leaders and the Workforce team to visit different teams / departments throughout the 24-hour period and also the hosting of specific staffing group listening events in the Blair Bell. In addition, the Chief Executive had bookable meetings during this period for staff who wished to engage directly. The model of engagement had worked well and a significant amount of feedback from staff had been received. Some of the emerging themes reaffirmed known issues although there were some issues raised that had not been expected. Non-Executive Director, Zia Chaudhry noted surprise that a lack of kindness had been identified as a theme. The Chief People Officer commented that whilst this was not consistent across the organisation, the lack of kindness articulated related more to intra-team issues rather than between management and direct reports. The intelligence gathered had been separated into divisional and team comments, which had been shared with Divisional Boards and Senior Leadership Teams at the end of June. Managers were expected to develop divisional You Said / We Did processes to check what had been heard with staff and ensure any actions/interventions were right before they are implemented. The You Said / We Did documents would be updated and communicated to divisional staff monthly, so staff remained informed about progress with plans. The Chair remarked that implementing a robust and effective feedback loop was vital and would help to build trust for further engagement activity. It was noted that a further 'Big Conversation' session was scheduled for September 2022. The Board of Directors noted the contents of the reports and the assurances provided.
080a	Chair's Reports from the Finance, Performance and Business Development Committee The Board considered the Chair's Reports from the Finance, Performance and Business Development Committee meetings held on 23 May and 27 June 2022. The Committee Chair, Louise Martin, stated that whilst the Committee was providing robust oversight on the Trust's financial position, equal prominence was being afforded to operational performance issues. The Committee had received positive assurance regarding progress on the digital agenda and had been informed that GROW 2.0 had been implemented into the K2 digital maternity system. This reduced a known risk and was the first time such an implementation had been successfully achieved. The Board of Directors: • Received and noted the Chair's Report from the Finance, Performance and Business Development Committee meetings held on 23 May and 27 June 2022.
080b	Chair's Reports from the Charitable Funds Committee The Board considered the Chair's Reports from the Charitable Funds Committee meeting held on 20 June 2022. The Committee Chair, Tracy Ellery, remarked that the timing of the Committee (being only a few days after the year-end meetings) had resulted in several reports and actions being delayed. It was likely that the year-end process for 2022/23 would be in June 2023 and therefore, the scheduling of meetings would be reviewed as a lesson learned. The Committee had received a draft fundraising forward plan and agreed that it required further consultation, most likely through a Board development session.

	A discussion had been held regarding a potential requirement for a scheme of delegation for the direction / reallocation of noncash goods donated to the Charity. This would be considered as part of the Corporate Governance Manual review process. The Board of Directors: • Received and noted the Chair's Report from the Charitable Funds Committee meetings held on 20 June 2022.
080c	Finance Performance Review Month 2 2022/23 The Chief Finance Officer presented the Month 2 2022/23 finance performance report which detailed the Trust's financial position as of 31 May 2022. It was noted that the paper had been prepared in advance of the final 2022/23 financial plan being agreed. The expectation was that the financial position for M3 would be reported against the revised plan (agreed at Board and system level). There had been financial pressures in each of the Divisions for 2022/23 to date. The principal driver was agency costs and a 'deep dive' had been scheduled with each Division to understand issues and to agree an improvement trajectory. At M2 the CIP plan was behind schedule with £292k of CIP achieved against a £471k target. Capital spend to M2 was £828k underspent due to the Trust awaiting revised plan submissions in June and the outcome of bids for additional funding before committing to some asset replacement schemes. The underlying financial position remained unsustainable with the Trust reliant on £1.6m of non-recurrent mitigation for the year-to-date. The Financial Recovery Board was continuing to meet in 2022/23 and would undertake several pieces of work to understand the drivers for the underlying deficit, movement in expenditure and opportunities to improve the financial position. The Chair noted that the 2022/23 CIP target was the highest it had been in recent years and queried whether additional monitoring was in place. It was confirmed that the Financial Recover Board was monitoring progress with oversight provided by the Finance, Performance and Business Development Committee. Regular meetings were also being held with Divisional managers and finance business partners. The Medical Director noted that a significant amount of medical agency usage was linked to Waiting List Initiatives to support Elective Recovery Fund (ERF) delivery. Non-Executive Director, Tracy Ellery, stated that there was a dynamic tension between costs (financial and workforce related) for delivering ERF performance and the amount of funding that was likely to be received. The Chief Executive queried if the Trust had profiled agency usage against agreed establishment levels. Chair's Log: For the Finance, Performance and Business Development Committee to receive a profile of agency usage against agreed establishment levels. The Board of Directors: • Noted and received the Month 2 2022/23 Finance Performance Review
081	Board Assurance Framework The Board of Directors received the Board Assurance Framework. The Trust Secretary explained that there were no significant updates proposed for the BAF with Quarter 2 scores proposed to be agreed at the September 2022 Board meeting. At the Quality Committee in June 2022, a discussion was held regarding the Trust's position in relation to performance against key access targets. There was agreement that this was a key risk to the Trust

	achieving its strategic aims and it therefore needed to be reflected on the BAF. An action was taken to articulate this as a 'strategic threat'. The outputs of this will be reported to the September 2022 Board. The Board of Directors: • Reviewed the BAF Risks *The following items were considered as part of the consent agenda*
082	Director of Infection Prevention and Control Annual Report 2021/22 & IPC BAF The Board of Directors: • noted the content of the annual report and approved: o Publishing to the Trust website; and o The work plan for 2022-23. • took assurance that the Trust is taking all actions reasonably practicable to ensure it was working to meet its responsibilities for Infection Prevention and Control in relation to Covid-19.
083	Annual Health & Safety Report 2021/22 The Board of Directors noted the assurances provided within the Annual Health & Safety Report 2021/22
084	Review of risk impacts of items discussed The Chair identified the following risk items: Risks: • Ensuring that lessons learned from safeguarding regarding 'invisible disabilities' are communicated across the organisation – supporting the ICS aim of equality of access. • The residual and on-going risks relating to the Trust's isolated site • Ensuring that lessons are learned from the indirect maternal death • The Trust's financial position and long-term sustainability
085	Chair's Log The following Chair's Logs were noted: • For the Putting People First Committee to receive additional information regarding the Trust's approach to the 'Civility Saves Lives' agenda • Putting People First Committee to explore the junior doctor experience in more detail, receiving a staff story to support this aim. • For the Finance, Performance and Business Development Committee to receive a profile of agency usage against agreed establishment levels.
086	Any other business & Review of meeting The Chair and the rest of the Board noted thanks to Tony Okotie whose term of office as a Non-Executive Director came to an end on 30 June 2022. It was noted that Tony had provided a significant amount of support to a developing Board at the beginning of his time with the Trust, provided effective challenge throughout and given invaluable expertise in many areas. The Chief Executive thanked Marie Forshaw who was retiring from her position as Chief Nurse & Midwife at the end of August 2022. It was noted that Marie had made significant progress on the quality agenda and would be hugely missed by all her colleagues. Review of meeting No comments noted.
087	Jargon Buster Noted.

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Action Log

Trust Board - Public
1 September 2022

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
7 July 2022	22/23/078c	Standalone Site - Update on Quality and Safety Risks	To receive review of all serious incidents to date over the last five years identifying incidents where the current configuration of services was either a root cause or a contributory factor	Medical Director	Nov 22	On track	
7 July 2022	22/23/076	Chief Executive's report	To provide an overview of the C-GULL study to a future Board meeting	Medical Director	Nov 22	On track	
5 May 2022	22/23/043	Service Outline – Still Births	For the Board to receive a cohesive and overarching plan to move towards achieving the national target for still birth rates	Medical Director	September 2022	Off track	Report now scheduled for September 2022 Quality Committee with onward reporting to the Board
7 April 2022	22/23/009e	Bi-annual staffing paper, July-December 2021 (Q2 & Q3)	To include mandatory training compliance trajectories in future bi-annual staffing papers.	Chief Nurse & Midwife	Nov 22	On track	
7 April 2022	22/23/009c	Learning from Deaths Quarter 3, 2021/22	For the Board to receive a report on the Trust's stillbirth rate	Medical Director	~~July 22~~ September 2022	Proposed to be closed	See action 22/23/043
7 April 2022	22/23/009a	Quality & Operational Performance Report	To explore the impact on the patient experience due to the closure of the MLU.	Chief Nurse & Midwife	July 22	On track	Verbal Update to be provided

2 December 2021	21/22/118	Patient Story	For the Board to receive an overview of the work being undertaken by the Patient Experience Matron in April 2022.	Chief Nurse & Midwife	July 22	Complete	Received in July 2022
4 November 2021	21/22/86c	Cheshire & Merseyside Women's Health & Maternity Services Programme Update	For the April 2022 Board to receive an update on the work undertaken by the Women's Health & Maternity Services Programme to reduce health inequalities.	Chief Operating Officer	~~July 22~~ September 2022	On track	See item 093d

Chair's Log

Received / Delegated	Meeting Date	Issue and Lead Officer	Receiving / Delegating Body	Action Deadline	RAG Open/Closed	Comments / Update
Delegated	07.07.2022	To receive a profile of agency usage against agreed establishment levels. Lead Officer: CFO	FPBD	Sept 2022	On track	
Delegated	07.07.2022	To explore the junior doctor experience in more detail, receiving a staff story to support this aim. Lead Officer: CPO	PPF	Nov 2022	On track	
Delegated	07.07.2022	To receive additional information regarding the Trust's approach to the 'Civility Saves Lives' agenda Lead Officer: CPO	PPF	Sept 2022	On track	
Delegated	05.05.2022	To reflect on the impact and efficacy of the previous interventions to improve staff experience. Lead Officer: CPO	PPF	July 2022	Closed	Workshop held on staff survey and 'big conversation'
Delegated	05.05.2022	To receive benchmarking information on mandatory training compliance.	PPF	~~July 2022~~	Risks identified	Not received in July 2022 – will be incorporated into work to

		Lead Officer: CPO		September 2022		update reporting mechanisms for each Committee
Delegated	05.05.2022	To retain oversight of the improvements the Trust makes in relation to patient access and experience for the deaf community. Lead Officer: CN&M	Quality	Sept 2022	On track	
Received	24.03.22	To receive a proposed method of assessing the maturity of Divisional Governance arrangements to support the Audit Committee in undertaking reviews. Lead Officer: TS	Audit	~~July 2022~~ September 2022	Closed	See item 096b
Delegated	03.02.22	To review the development of a business case for an expanded endometriosis service. Lead Officer: CFO	FPBD	October 2022	On track	To be progressed through the Divisional Operational Planning process with an update provided to the FPBD Committee as part of the six month review of progress.

LNP Board update - August 2022

Progress, Challenges, Forward Look

NHS
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National Neonatal Drivers

- Neonatal GIRFT (2022)
- LWH External Mortality Review – Manchester – NWODN (2022)
- BAPM revised standards (2021)
- Ockendon review (2021)
- LNP Peer Review (2020)
- LWH External Mortality Review – Birmingham (2020)

FINDINGS, CONCLUSIONS AND ESSENTIAL ACTIONS FROM THE INDEPENDENT REVIEW OF MATERNITY SERVICES at The Shrewsbury and Telford Hospital NHS Trust

Progress
Clinical service

SAFE EFFECTIVE RESPONSIVE CARING WELL LED

Collaborative working with AHCH HDU and PICU – daily ward rounds by neonatal team

Agreed criteria with radiology for babies having ward-based imaging
Portable nano-XR machine on loan to 1C to facilitate

Psychologist has started to attend ward rounds and support parents in 1C
Parent ward-based information App developed
Tissue Viability Audit – consecutive 2 months 100% score by 1C Nurses

Practice educators providing education across both sites
Monthly Risk, and Clinical Quality and Guidelines meetings established

Memorandum of Understanding (MOU) *revised April* 2022
Services Level Agreement (SLA) December 2021, revised May 2022

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Progress
Development and Strategy


WORKFORCE


GOVERNANCE


ESTATE


IT

Specialised commissioning funding agreed → enabling nurse recruitment

Revised Medical Workforce Business Case gaining support
Supportive statements from
Specialised commissioning, BAPM President and Neonatal GIRFT Chair

Governance structures ratified by both Trust Boards
Automated data collection for all neonates across AHCH

Enabling Building works commenced

Stakeholder events repeated

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Challenges
Clinical Service

Need increased medical neonatology cover at AHCH
Deteriorating baby escalation pathway

Implementing infant security system at AHCH
Newborn Screening compliance AHCH wards outside 1c

Mitigating risk of multiple EPR systems (Viewpoint/ K2→ Badger / Meditech/ paper)

Capacity management across 9 1c surgical cots/PICU/NICU/surgical wards/network

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Challenges
Development and Strategy


WORKFORCE


GOVERNANCE


ESTATE


IT

Recruitment and training of adequate numbers of nurses
approx. 2-year lead time; planned opening July 2024
Allied Health Professional support plans need review after GIRFT recommendations

Developing integrated service plans and pathways eg Radiology / Pathology / microbiology/ ID
IT system interoperability strategy
New Build delays
Increasing cost pressures
High risk babies continue to experience multiple transfers between sites

Neonatal Critical Care Review and expected re-configuration of maternity/neonatal services
NWNODN vision following the neonatal critical care review to allow us to design services that meet the requirements for Cheshire and Mersey.

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Forward Look
Clinical Service

Extend medical neonatology hours at AHCH
Augment HDU care on 1C by July 2023 – recommended nursing ratios
Develop clear care pathways with AHCH specialty services
Support Trust-wide Newborn screening programme at AHCH

Enact plans to reduce mortality/improve outcomes for extreme preterm infants
Continue to harmonise guidelines and policies: one service / 2 sites

FiCare accreditation at AHCH
Parent condition-specific information
Improve the collection and use of parent feedback across the LNP

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Forward look
Development and Strategy


WORKFORCE


GOVERNANCE


ESTATE


IT

Focus on Nurse recruitment and training

Continued analysis of new and upcoming recommendations and reports
ensure appropriate staffing and operational capability to safely open July 2024

More stakeholder events to ensure communication of plans and developments across the LNP
Comms plan implementation…. watch out for Jen Deeney on The One Show!
Continued engagement with Charity

Collaboration with BLISS who have agreed to join the LNP Board

Neolook/screen-2-screen and patient monitoring systems development
Workflow mapping and clinical scenario simulation
IT clinical systems interoperability work

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Liverpool Women's
NHS Foundation Trust

CEO Report

Trust Board
September 2022

Executive Summary:

In this briefing for the Board I aim to summarise recent and relevant information which relates to:

- Firstly, in **Section A**, news and developments within the Trust itself that is not already reported elsewhere.
- Secondly, in **Section B**, news and developments within the immediate health and social care economy.
- Thirdly, in **Section C**, other news and developments within the wider national health and social care economy, including regulatory developments.

Further information is available on request on any of the topics covered by the report.

Section A - *Internal*

Hewitt Fertility Centre - UKAS technical assessment

At the end of June 2022, The Hewitt Fertility received its United Kingdom Accreditation Service (UKAS) technical assessment. There were only four minor findings which was an excellent result and testament of a real team effort across the service.

The quality assessment undertaken in August over two days with two assessors purely focused on quality management processes for Andrology. Only 15 findings were found against the standard. All were minor findings for continuous improvement and the assessor recommended continued accreditation once agreed actions are closed mid-September.

With 8 years of maintaining accreditation, Liverpool Women's runs the longest standing UKAS accredited Diagnostic Andrology service in the UK. Well done to all involved.

Maternal Medicine Network Clinical Lead

After interviews held in June 2022, Mark Clement-Jones Consultant Obstetrician at Liverpool Women's has been offered and accepted the post of the Maternal Medicine Network Clinical Lead. Very well done to Mark who I am sure will be a success in the role.

Thank you for Liverpool Women's from Archbishop Beck Catholic College

The Trust engages in a range of Widening Participation projects with the objective of engaging and involving the community in the work of the hospital, and providing opportunities of education, training and employment. The following thank you was received from the Head of Sixth Form at Archbishop Beck Catholic College –

"Just a note to say a massive thank you on behalf of the students and staff at Archbishop Beck Catholic College for the amazing careers support and fantastic work experience opportunities you have provided us with.

We have considered the Women's Hospital our most important partner for many years now. We are fully aware of the time and effort that you and the amazing staff at the hospital put into the various events that take place, and the commitment of the various departments to support work experience.

Student feedback is always incredibly positive with many young people gaining opportunities on the back of the experiences provided by you and the team. I would estimate that over the years several hundred students have benefited from such experiences.

The NHS careers event last Friday was absolutely brilliant. We have received positive parental feedback as well as enthusiastic feedback from students in attendance. This event gets better every time we attend.

None of this would be possible without the hard work and support of yourself Anne [Bridson - Learning & Development Facilitator]. On behalf of us all in college, have a great summer and we look forward to seeing you soon".

Section A - *Internal*

Congratulations to our Employee & Team of the Month colleagues

May's Team of the Month went to Gynae Emergency Department who are dedicated, resilient, helpful, knowledgeable, strong team workers and supportive of each other.

Employee of the month Tracy Ward, Information Analysist for her hard work delivering more efficient and effective processes that have improved the working day for lots of her colleagues. Well done all.

June Team of the Month went to Imaging who have worked tirelessly to ensure our patients get the ultrasound scans they need at the right time.

Employee of the month Sumayo Ibraahim, Staff Nurse Gynaecology Unit for being a passionate nurse who goes above and beyond for her patients, students and her colleagues.

July's Team of the Month went to our Physio Team who continue to work hard to increase the awareness of pelvic health both at LWH and in the community offering a high standard of care being at the forefront of what they do.

Employee of the Month for July was Michaela Sparke-Kvisth, Staff Nurse , Gynaecology Emergency Department for her hardwork, dedication and promoting of leadership to deliver the best possible experience for patients and staff

Section B - *Local*

Liverpool University Hospital given keys to new Royal Liverpool University Hospital ahead of opening

Liverpool University Hospitals NHS Foundation Trust (LUHFT) has confirmed that the long-awaited move to the new Royal Liverpool University Hospital will begin on 28 September 2022.

It comes after a critical milestone in the project was reached as the Trust took partial possession of the building from construction partners Laing O'Rourke on 11 July. This is an important step forward which allows the Trust to start the final phase of work to prepare for moving patients and staff across to the new hospital.

The Trust will begin its 24-day move plan that will see staff, patients and services move across to the new building in a phased approach, with the move complete by 21 October 2022.

Positive CQC results for the North West Ambulance Service (NWAS)

The CQC conducted a focused inspection in April, looking at the trust's emergency and urgent response and 999 and 111 call centres. It was part of overall inspections looking at the broader health and social care system within Lancashire and South Cumbria, Cheshire and Merseyside to understand how services respond to the challenges we face as individual providers.

Although this was not a 'ratings' inspection, the summary of the findings was positive overall, with some recommendations for learning and improvement going forward. The assessment took place against a backdrop of increased pressure on the health service; however, inspectors said that NWAS took action to manage an increase in demand by increasing the number of 999 call handlers and by securing aid from the volunteer ambulance service and the military. Also commended was their work with healthcare partners to reduce the number of patients taken to emergency departments and to improve handover delays.

Among the other findings, inspectors noted the care and compassion shown by the NWAS ambulance crews and call handlers to patients.

Section B - *Local*

Government to set up strategic futures panel to support growth and lead Liverpool to bright future

Levelling Up Secretary Greg Clark announced on 19 August 2022 that he will set up a strategic advisory panel to develop a long-term plan to guide Liverpool City Council out of the current government intervention and help shape the future of the city, alongside confirming he is “minded to” expand the intervention in the council, in response to the latest report from commissioners.

The Liverpool Strategic Futures Advisory Panel will work closely with the City Mayor Joanne Anderson and her Cabinet, and also with the commissioners, to help the council make the right decisions and to develop a plan to give long term confidence in the future of the city, beyond the current temporary intervention. The panel will have a particular focus on driving growth in skills, jobs and opportunities for the city.

The Panel will be chaired by Steve Rotheram, metro Mayor of Liverpool City Region. He will be joined by two of the most experienced people in city leadership, Sir Howard Bernstein, Chief Executive of the City of Manchester from 1999 to 2017, and Baroness Judith Blake, Leader of Leeds City Council from 2015 to 2021. The Panel will be asked to nominate an experienced business leader to join them.

Using their expertise and knowledge, the Panel will work closely with Mayor Joanne Anderson and her Cabinet, members, and wider partners, as well as with the commissioners to support the council to make the right decisions and employ its resources to bring long-term confidence and meet the ambitions of the people of Liverpool.

Section C - *National*

Regulatory Update

NHS England

The Health and Care Act formally brought together NHS England (NHSE) and NHS Improvement into a single organisation. This is intended to remove legal and bureaucratic barriers, provide unified national leadership and to bring commissioner and provider oversight closer together. NHSE is currently developing its new operating model with the intention of transforming its ways of working, culture, and behaviours to suit the new statutory framework and expectations of systems.

NHSE's system oversight framework (SOF) was recently brought up to date to coincide with the launch of ICSs. The new framework aligns with legislative changes and revised NHS priorities for 2022/23, and provides clarity on the respective roles and accountabilities of NHS England, ICBs, trusts and local partnerships.

Care Quality Commission

The Health and Care Act introduced new powers for CQC to assess and oversee ICSs, as well as local authorities (LAs) in relation to their duties under the Care Act. In response to this, and in line with the strategy it published in 2021, the regulator has been developing a new single assessment framework, which will apply equally to its regulation of providers, ICSs and LAs. The familiar five key questions that CQC has been using as the cornerstone of its assessments will remain, underpinned by new "quality statements" and new evidence categories.

A new approach to scoring and rating is intended to provide greater transparency and a more detailed picture of quality. CQC aims to make information more accessible to providers and take a smarter, more targeted and light-touch approach to inspection.

The regulator has recently published additional information on its website to explain its new approach to regulation.

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Trust Board

COVER SHEET

Agenda Item (Ref)	22/23/96a	Date 01.09.2022
Report Title	Maternity Incentive Scheme (CNST) Year 4 – Scheme Update	
Prepared by	*Angela Winstanley – Maternity Quality & Safety Matron* *Gary Price - COO*	
Presented by	*Gary Price – COO*	
Key Issues / Messages	This report outlines the scheme requirements for compliance required to achieve all ten safety actions and their associated standards for the Maternity Incentive Scheme Year 4 and the Trust's current status against this. Detailed Trust Board Minutes must be made available specifically in response to the Midwifery Staffing Paper and Board Level discussion must be reflected and documented to ensure the following is included: - "Evidence, documented in Board minutes, of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations" OR - "Where Trusts are not compliant with a funded establishment based on BirthRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls" Specific information is required to be highlighted for the Trust Board in relation to the following: - Perinatal Quality Safety Dashboard.	
Action required	Approve ☐	Receive ☒	Note ☐	Take Assurance ☐
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	For Decisions - in line with Risk Appetite Statement – Y			
	The Trust Board is asked to: • ***Receive the current position in relation to CNST Year 4*** ○ ***Receive the Paper for Perinatal Quality Surveillance Dashboard (July Data)*** ○ ***Receive the ATAIN and TC Audit for Q1 22-23*** ○ ***Receive the Paper for Maternity Staffing***			
Supporting Executive:	*Gary Price Chief Operating Officer*			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☐

Strategic Objective(s)

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

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

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Quality Committee	Monthly	DoN&M	Monthly updates to be provides to the Committee and where required, issues will be escalated to the Board for formal noting and assurance.
Divisional CNST Oversight Committee	Twice Monthly	COO	Twice monthly progress updates from scheme safety action leads.
Family Health Divisional Board	Monthly	Clinical Director for Family Health	Monthly updates to be provided to the FHDB and where required, issues for non compliance to be escalated and resolved.

EXECUTIVE SUMMARY

This report outlines the scheme requirements for compliance required to achieve all ten safety actions and their associated standards for the Maternity Incentive Scheme Year 4 and the Trust's current status against this.

Specific information is required to be highlighted for the September 2022 Trust Board meeting and these include:

- Receive the Paper for Perinatal Quality Surveillance Dashboard (July Data)
- Receive the Paper concerning TC/ATAIN Audit Q1 2022-2023
- Receive the Paper for Maternity Staffing.

This paper will also be received and noted at the September 2022 Quality Committee, with discussions relating to enhancement of information contained within the report and further detailed analysis of any risks identified that may pose a risk to achieving full compliance. Particularly these discussions, centred around the expected trajectory of multi-disciplinary training (MPMET – Multi-Professional Mandatory Emergency Training) compliance requirements within Safety action 8. Further detailed information pertaining to MPMET training compliance data and anticipated trajectory can be found in the Perinatal Quality Surveillance Dashboard paper.

Areas within this months paper, highlighted in GREEN, are new scheme requirements, published in the May CNST 2022 update.

MAIN REPORT

Introduction.

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

As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund. As in year three, the scheme incentivises ten maternity safety actions.

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

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

December 2021.

In order to be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution by 12 noon on 30 June 2022. However, it should be noted there was an imposed submission deferral issued on the 23rd December 2021. The Family Health Senior Leadership team have agreed to continue as is and maintain progress as a means of preparedness and the Executive Team have supported this approach.

May 2022.

In May 2022, NHS Resolution introduced a re-launch of the scheme, after the scheme pause, with the publication of full up to date guidance, with a new submission date of the Board Declaration form by **Thursday 5th January 2023.**

Conditions of the scheme.

The Quality Committee and ultimately, the Trust Board must also be aware of the conditions of the scheme, some have been added and are detailed in the May 2022 update. 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 maternity safety actions by the Head of Midwifery and Clinical Director for Maternity Services (May 2022)

- The Board declaration form must be signed and dated by the Trust's **Chief Executive Officer** (CEO) to confirm that:

  - The Trust Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required safety actions' sub-requirements as set out in the safety actions and technical guidance document.

  - There are no reports covering either this year (2021/22) or 2022/23 that relate to the provision of maternity services that may subsequently provide conflicting information to our declaration (e.g. Care Quality Commission (CQC) inspection report, Healthcare Safety Investigation Branch (HSIB) investigation reports etc.). All such reports should be brought to the MIS team's attention before 5th January 2023.

The Board must give their permission to the CEO to sign the Board declaration form prior to submission to NHS Resolution. Trust Board declaration form must be signed by the Trust's CEO. If the form is signed by another Trust member this will not be considered.

- In addition, The CEO of the Trust will ensure that the Accountable Officer (AO) for their Clinical Commissioning Group/Integrated Care System (CCG/ICB) is apprised of the MIS safety actions' evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the evidence to be submitted to NHS Resolution

  Note: CCG functions will be subsumed into integrated care systems, with CCGs ceasing to exist as statutory organisations by July 2022.

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

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

- NHS Resolution will continue to investigate any concerns raised about a Trust's performance either during or after the confirmation of the maternity incentive scheme results. Trusts will be asked to consider their previous MIS submission and reconfirm if they deem themselves to be compliant. If a Trust re-confirm compliance with all of the ten safety actions then the evidence submitted to Trust Board will be requested by NHS Resolution for review. If the Trust is found to be non-compliant (self-declared non-compliant or declared non-compliant by NHS Resolution), it will be required to repay any funding received and asked to review previous years' MIS submissions.

- NHS Resolution will publish the outcomes of the maternity incentive scheme verification process, Trust by Trust, for each year of the scheme (updated on the NHS Resolution Website).

Scheme Safety Actions

The table below outlines the ten safety actions for Year four of the scheme.

- **Safety action 1**: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
- **Safety action 2**: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?
- **Safety action 3**: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?
- **Safety action 4**: Can you demonstrate an effective system of clinical workforce planning to the required standard?
- **Safety action 5**: Can you demonstrate an effective system of midwifery workforce planning to the required standard?
- **Safety action 6**: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?
- **Safety action 7**: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?
- **Safety action 8**: Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4? In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4?
- **Safety action 9**: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?
- **Safety action 10**: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) scheme for 2021/22?

Family Health Division Scheme Management and Leadership.

- In the interests of the ability to share and collate evidence for scheme stakeholders, the Information Team have developed a Microsoft Teams Channel. This will consist of each Safety action spreadsheet being held centrally with action owners given the ability to update and upload actions and evidence as the scheme progresses throughout the coming year. This will have oversight by the FHD Division Management Team and CNST Oversight Committee.

- Every action has been nominated a lead, with associated actions being given to action owners. Action Leads and owners will be responsible for ensuring their progress, challenges and completions are presented and overseen by the FHD CNST Oversight Committee. This meeting, now twice monthly, is chaired by the Chief Nurse and Midwife will provide assurance to the FHD Board, with assurance to Quality Committee and Trust Board from the associated assurance paper.

Current Position for Year 4 against the updated May 2022 scheme update – August 2022

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

Safety Action Point	Description	Issue / Update for consideration	Status RAG
SA.1	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard? Leads: Ae Wei Tang – Obstetrics Rebecca Kettle – Neonates Sarah Howard – Midwifery	All eligible births and deaths, from 6th May 2022 must meet the following conditions: A. i) 100% all deaths have been reported to MBRRACE within the seven working day timeframe with 100% of deaths having surveillance completed within one month to date from 6th May 2022. 37 Cases reported to MBRRACE – 100% Compliance. ii) 95% of all deaths of babies, suitable for PMRT Review, will have had their case started within TWO MONTHS of the deaths from 6th May 2022. 28 cases eligible reported to MBRRACE have had reviews started – 100% Compliance. B. 50% of deaths of all babies who are born and die within the Trust, from 6th May 2022. All reports are either in: - Draft format within four months - Fully published within six months. On track for completion. C. 95% of families have been informed and offered involvement in the review of their care and that of their baby. 100% Compliance D. Quarterly reports submitted to Trust Board from 6th May 2022. 100% Compliant Q3 21/22 Learning from Deaths Report. - Submitted to QC Feb 21 - Submitted to Board May 2022 Q4 21/22 Learning from Deaths Report - Submitted to QC May 2022 - Submitted to Board July 2022	
SA.2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard? Leads:	New requirement for a digital maternity to align with trust digital strategy -the Digital Strategy has been developed and is to be presented at Trust Board in September 2022 (Tabled for Trust Board and in agenda). MSDS data for July 2022 data will be submitted in September 2022. Data quality reports from NHDS Digital relating to the CNST standards are reviewed	

	Richard Strover & Hayley McCabe	monthly and the Trust is current compliant against all requirements based on May 2022 data.	
SA.3	Can you demonstrate that you have transitional care services to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme? Leads: Anna Paweletz– Neonates Sarah Kildare – Neonates Paula Nelson – Neonates Sarah Howard – Maternity	A) Pathways of care into TC jointly agreed – Completed B) Pathways of care into TC are audited quarterly and shared with Neonatal Safety Champion, LMNS, Commissioner and ICS Quality Surveillance – Ongoing C) Data recording process (electronic/paper based) capturing all term babies admitted to NICU – Completed using BadgerNet. D) Data recording process for capturing all TC activity has been embedded – Completed - using BadgerNet E) Commissioner returns are available to be shared on request from LMNS/ODN and ICS – Returnable on request. F) Quarterly review of all babies admitted to NICU and shared with BLSC, LMNS and ICS Quality Surveillance Meeting – Ongoing - LWH hold weekly reviews with quarterly reporting G) Action Plan from TC and ATAIN audit agreed with Mat, Neo and Board Level Safety Champion – Completed and Ongoing. H) Progress with ATAIN action plan shared with Mat, Neo, Board Level Safety Champion and the LMNS and ICS Quality Surveillance Meeting – Completed January 2022. All workstreams completed or on track for completion. All Transitional Care and ATAIN audits are on track, Q4 21-22 Audits and Q1 22-23 have been submitted to the FHD Safety Champions. The Q1 22-23 report can be found in the appendices to this paper for noting	
SA.4	Can demonstrate an effective system of clinical workforce planning to the required standard? Leads: Alice Bird – Obstetrics Christopher Dewhurst – Neonates Neonatal Nursing – Jen Deeney Anaesthetic Workforce – Rakesh Parikh	Obstetric Workforce – Paper submitted to Trust Board in December 2020, outlining the current obstetric position as outlined in the RCOG Workforce document. Update paper required as per May 2022 requirements was submitted to Trust Board in July 2022 and outlined the ongoing obstetric workforce review and associated action plan. Anaesthetic Medical Workforce – Complete. Workforce review submitted to Quality Committee April 2022. Neonatal Nursing Workforce – Complete – Workforce review submitted to Trust Board April 2022. Board Mins to reflect requirements within scheme guidance. Neonatal Medical Workforce – Complete – Workforce review submitted to Trust Board April 2022. Board Mins to reflect requirements within scheme guidance.	

SA.5	Can demonstrate an effective system of midwifery workforce planning to the required standard? Leads: Alison Murray – Interim Head of Midwifery	Full Birth-rate Plus and Maternity Staffing paper received at Trust Board in February 2022. Trust Board paper covered all aspects of the evidential requirements. A further detailed midwifery staffing analysis is in **Trust Board agenda for September 2022**, with detailed Trust Board Minutes being made available to the MIS scheme leads and Head Of Midwifery, that confirm the following: - Trust Boards must provide evidence of funded establishment being compliant with the outcomes of BirthRate+… and/if (MIS, 2022) - Trust Boards are not compliant with a funded establishment based on BirthRate+, Trust Board minutes must show the agreed plan, including timescales for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls. An added requirement in the May 2022 guidance, is the plan to address the findings of the full audit or tabletop exercise of BirthRate+, where deficits in staffing levels have been identified, must be shared with local commissioners (MIS, 2022)	
SA.6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives Care Bundle Version 2? Leads: Alice Bird – Obstetrics Angela Winstanley – Midwifery	Trust Board level consideration of how the organisation is complying with the SBLCBV2 and evidence that the quarterly care bundle surveys have been submitted to Trust Board. - SBLCBV2 Quarterly Care Bundle survey (Appendix 1) submitted to Trust Board in June 2022. An identified risk of the lack of compliance to the CO screening in pregnancy programme at 36 weeks has been rectified. In the May 2022 scheme update, Trusts will be required to evidence an average of 80% compliance across any four consecutive month period in the MIS scheme timeframe (August 2021 – December 2022). This is achievable and data compliance is being monitored closely the Head of Information, COO, Chief Nurse and Midwife and CNST Assurance meeting. - February 87.55% - March 82.85% - April 81.75% - May 80.5% A previously identified risk with this safety action was the implementation of a formal risk assessment of fetal growth restriction at the 20-week anomaly USS. The MIS requires compliance of 80% of completed risk assessment. The Clinical Lead for Maternity escalated the difficulties within this action and requested clarification from the National Safety Champion, Matthew Jolly. The DoF and Clinical Lead for Maternity have now received clarification of the Clarification notes that the risk assessment is the completion of a uterine artery doppler (UAD) US in those women deemed high risk at booking. The Digital MW and the Quality & Safety Matrons with the Clinical Lead for Maternity are currently undertaking this audit.	

SA.7	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services? Leads: Gill Diskin – Midwifery Alison Murray – Midwifery Vacant – MVP Chair.	A new MVP Chair has been successfully recruited and will start in role on 01.09.2022. Plan within the FHDB are being aligned to ensure that all MIS requirements are achieved. Upon her commencement, an invitiation to the FHD Maternity Risk Meeting will be extended to her. The Chief Nurse and Midwife has contacted the LMS Lead to request assurance in relation to the MVP work plan and strategy. Assurance has been provided to the Chief Nurse and Midwife that the continue collaborative work between LWH and the MVP will support this strategy.	
SA.8	Can you evidence that at least 90% of each maternity unit staff group attendance an 'in-house' multi-professional maternity emergencies training session within the last year. Leads: Alison Murray – Midwifery Jonathon Hurst – Neonatal	There is a formal maternity training plan which incorporates all the requirements of the Core Competency Framework in accordance with this safety action. This has been tabled and approved by the FHDB and acknowledgment given to recognise the staffing shortages during COVID have disrupted progress. We are endeavouring to meet full compliance prior to the new submission date of 6th January 2023 with the acknowledgment that staffing, and sickness absence are risk to the 90% compliance target. Full further detail and analysis of current compliance data can be found in the Perinatal Quality Surveillance Dashboard Paper. A full and detailed analysis of current training compliance rates and trajectories can be found in the Perinatal Dashboard Paper in the appendix to this paper.	
SA.9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on Maternity and neonatal safety and quality issues? Leads: Rachel McFarland – Obs Safety Champion Angela Winstanley – Midwifery Safety Champion Fauzia Paize – Neonatal Safety Champion.	There are robust processes in place feeding perinatal safety information into the Trust Board and Quality Committee monthly via the Perinatal Clinical Quality Dashboard. The scheme relaunch in May 2022 provides updated timescales within this safety action. Maternity Continuity of Carer and its implementation plan, specifically prioritising those service users most likely to experience poor outcomes, 75% BAME, and 10% of deprived neighbourhoods. Board Level oversight and discussion of the CoC plan must be evidenced. The Board received a full paper in June 2022, this followed on from the Non-Executive Board Level Safety Champion meeting on 31st May 2022 with the DONM, Dep HOM and COC Leads where the CoC plan was discussed in-depth the specific details. All Board Level and Frontline Safety Champion exercises continued throughout the scheme pause.	
SA.10	Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early	All cases required have been reported to HSIB. All families have had information on HSIB and Early Notification/NHSR Scheme All Duty of Candour duties undertaken.	

	Notification (EN) scheme? Leads: Incoming Maternity and Neonatal Governance Managers. Interim Lead: Angela Winstanley	Information pertaining to HSIB reporting is included in the Perinatal Quality Surveillance Paper as well as the Trust Board Performance Report. A full breakdown of all activity pertaining to HSIB, Duty of Candour will be presented to QC and Trust Board in December 2022.	

Conclusion

The Trust Board is asked to note the current position in relation to CNST Year 4 and our current positive position, along with the associated papers found within the appendix.

It is asked that the Trust Board takes note of the associated risks to the scheme compliance as detailed within the narrative of this paper specifically the MDT training requirements outlined in the perinatal quality surveillance dashboard.

Appendix

1) Perinatal Quality Dashboard Paper August 2022 (July 2022 Data)
2) Q1 2022-2023 ATAIN and Transitional Care Audit.
3) Midwifery Staffing Paper.

Maternity Perinatal Quality Surveillance Model: August 2022 (July 22 Data)

CQC MATERNITY RATINGS LAST REPORT – 22/04/2020	Overall	Safe	Effective	Caring	Well Led	Responsive
	Good	Good	Good	Good	Good	Outstanding

Staff Survey Results:	Update Date	Results
Proportion of midwives responding with agree/strongly agree on whether they would recommend LWH as a place to work or receive treatment (reported annually).	Report 2020.	**41%**
Proportion of Specialty Trainees in Obstetrics responding with 'excellent or good' on how they would rate the quality of clinical supervision out of hours (reported annually)	Report 2020	**41.3%**

Midwifery Red Flag:

There was a total of 50 red flags closed in July within Maternity. A further increase from previous months reporting.
The most reported red flag incident, this month related to delay in the provision of ongoing induction of labour process.

- 25 incidents - delay in ongoing process of induction >4 hours
- 7 Incidents - delay >30 mins between presentation and triage
- 9 Incidents - Reported as shortfall in staffing and skill mix.

All staff are encouraged to recognise and report midwifery red flags using the Ulysses System and the maternity managers strive to close incidents in a timely fashion.

Midwifery Red flags are monitored two hourly by the Midwifery 104 Bleep holder, with Data and governance oversight maintained through the Divisional Maternity Governance and Risk Committee.

The Head of Midwifery provides a detailed narrative of midwifery red flags within the Bi-annual Midwifery Safe Staffing Paper, scheduled for Trust Board September 2022.

Red Flag Incidents Closed.	February	March	April	May	June	July
1:1 Support Not Provided During Established Labour	1	3	0	2	1	2
Acuity/ Capacity	1	1	0	0	0	0
Delay >2 Hours Between Admission and Induction	3	19	0	4	4	1
Delay in ongoing process of induction >4 hours	6	28	0	10	17	25
Delay >30 Mins Between Presentation and Triage	0	0	1	0	0	7
Delay in Transfer - Antenatal or Postnatal	1	5	0	0	2	2
Delay or Cancellation of Activity	0	1	0	2	2	2
Inability to Provide Epidural	0	1	0	0	2	2
Medication error – drug not given	0	1	0	0	1	0
Shortfall in Staffing	0	1	0	1	3	4
Staffing Problem – Levels and Skill Mix	0	10	3	1	3	4
Wait for more than 60 mins for sutures post delivery	0	1	1	2	1	1
Incorrect classification as Midwifery Red Flag	0	3	0	0	1	10
Total	**12**	**75**	**5**	**22**	**37**	**50**

Midwifery Red Flag Actions Taken:	- Insufficient Midwifery Staffing on Divisional Risk Register, extreme risk Number 1705, HOM Lead. - Weekly and Daily Roster Oversight Management by HOM, Matrons and Managers. - Exec Led E-Roster Challenge sessions. - Proactive management of staff sickness and RTW - Use of Escalation and Divert Policy where required, including use of non-clinical registrants - NHSP and Agency use – with incentiviced scheme developed and agreed by Senior Leadership Team. - Medical Review, DOC/apologies and Escalation of delay to Senior Obstetrician and 104 Bleep Holder. - Ongoing recruitment and retention programme. - Compliance to Birth Rate Plus Report (Jan 2022) - 46 WTE Midwives anticipated to commence in post in October 2022. In August live reporting will be enacted with the introduction of the Birth rate Plus Acuity App – where red flags are reported instantly and captured in conjunction with the acuity of the areas at that point. 1:1 Care in Labour remains above >98% and all individual cases reviewed to ensure no adverse outcomes and presented at the Maternity Risk Committee. The most common red flag reported (a locally developed red flag) in Maternity services are a delay in Induction of Labour until it is safe to proceed to do so to ensure 1:1 care labour provision is preserved.
MVP Feedback.	MVP Chair Interviews completed on 12th July 2022, LWH was represented on interview panel by Richard Haines Consultant Obstetrician and Alison Murray DHOM. Recruitment to MVP Chair successful and applicant has accepted her offer and commences in post 1st September 2022.
HSIB Referral Details:	The Family Health Division referred ONE any case to HSIB in the month of July. . This case identified the following good practices and issues: - MLU closed and pool on DS out of use, this led to not being able to offer the women the birth of her choice which led to poor patient experience. - Rise in baseline/fetal tachycardia acted upon correctly and CTG commenced. - Prompt recognition of a pathological CTG and a breech presentation resulted in rapid decision for Category 1 caesarean section. Newborn infant requiring therapeutic hypothermia treatment (cooling) after spontaneous vaginal birth with a subsequent normal MRI. 72 Hour review has completed with presentation and review at Trust Weekly Harm Meeting – No escalation to SUI required and case will be subject to full external HSIB investigation
Maternity Serious Safety Incidents	The Family Health Division reported one serious incident to STEISS/CCG in July 2022: Serious Incident where a patient required transfer to RLUH for ITU Care. Escalated to SUI due to lack of onsite specialist acute services and service user requiring transfer to ITU. After a deep dive within the division of outstanding SUI actions, the Maternity Governance Team are working on outstanding SUI actions and collating evidence to support assurance that actions can be closed.
Perinatal Mortality.	Number of Neonatal Perinatal Deaths in July 2022**: 6** Number of Stillbirth Perinatal Deaths in July 2022**: 3** All perinatal deaths in July 2022 have been reported to MBRRACE and will be subject to a full MDT review with an external panel

<table>
<tr><td></td><td>member. Details and actions plans of every death are detailed in the Regional Quarterly Mortality Report presented by the Deputy Medical Director at Quality Committee and Trust Board. The full annual stillbirth report for 2022-2023, which encompasses a thematic analysis of stillbirth deaths is included in the Trust Board Agenda for September 2022.</td></tr>
<tr><td>Ockenden</td><td>On the 29th April 2022, the Family Health Division received formal feedback from NHSe and NHSi who informed the Trust of full compliance against the seven immediate and essential actions published in the emerging findings from 1ST report.
The QC, in June 2022 received an update on the GAP analysis against the 15 IEAS as published in the second and final Ockenden report.
The Family Health Division Senior Leadership Team are reviewing this GAP analysis, with a particular focus on those areas deemed as non-compliant.</td></tr>
<tr><td>FHD Risk Register.</td><td>Maternity currently holds 36 Risks within the Trust Risk register:
Risk Register is a standing agenda item at the Maternity Risk Meeting, where risks and new risks are considered and discussed.
Closed risks agreed and overdue reviews of risk highlighted.
Maternity Division are proactively working through outstanding risk register actions and seeking evidential assurance of those actions completed.
<table>
<tr><th>Risk Rating</th><th>Total</th></tr>
<tr><td>Extreme (Red)</td><td>7</td></tr>
<tr><td>High (Amber)</td><td>24</td></tr>
<tr><td>Moderate (Yellow)</td><td>4</td></tr>
<tr><td>Low (Green)</td><td>1</td></tr>
<tr><td>Total</td><td>36</td></tr>
</table></td></tr>
<tr><td>Maternity Incentive Scheme Progress Year 4.</td><td>Progress against the Year 4 Maternity Incentive Scheme (CNST):

PMRT – Full details of the Trusts progress against the standards in this element are detailed in the quarterly learning from deaths report prepared by the Deputy Medical Director. All deaths have been reported as per the scheme guidance. 2022-2023 Annual SB report on Trust Board Agenda for September 2022.
MSDS – No reported problems. Requirement for maternity digital strategy – linking to trust wide digital strategy. Currently in draft format – shared with Senior Leadership team, for Divisional Sign off with ratification through Digital Hospital Committee, QC and Trust Board.
ATAIN – Trust Board have received the ATAIN Action Plan, and this has been shared with the LMNS. Divisional Leads have been updated, named Cons Obstetrician and Midwife planned to take ownership of obstetric and midwifery requirements. Quarterly ATAIN and TC Reviews continue, sighted by FHDB and Safety Champions.
Clinical Workforce – Action complete with all evidence collated for assurance of completion.
Midwifery Workforce – Detailed staffing paper against Birth Rate Plus Report of 2021 has been sighted at Trust Board, further staffing paper at Trust Board in September 2022.
SBLCBv2 – All workstreams currently on track for completion. CO Screening requirements met. Full SBLCBV2 Audits underway. FGR Audit underway.
MVP – Continued close working relationship with MVP and MVP/LWH Strategy under development. MVP Chair recruitment completed.
Mandatory MPMET and Neonatal Resus Training – MPMET Training session reinstated in face-to-face capacity. Target of 90% of all staff groups to attend by scheme end. See further details below in MPMET Training Compliance section.
Safety Champions – Safety Issues continue to be escalated. BLSC sighted on Perinatal Clinical dashboard and submitted monthly.
HSIB and NHSR Notifications – No issues identified. All HSIB and D.O.C duties completed to date.
</td></tr>
</table>

	A detailed paper is sighted at both Quality Committee and Trust Board where compliance with the MIS scheme is discussed and noted.
Family Health Safety Champions.	Q1 2022-2023 Further Safety Champion activity was sighted at Quality Committee on 25.07.2022. Safety Champion walkarounds and meetings are diarised and planned for the remainder of 2022. The FHD Safety Champions have responded to a request from the NWC Regional Team to supply data for a regional Shoulder Dystocia Audit. In collaboration with the Digital MWs, the Maternity Safety Champion completed a data set collation with a return of this data made on 29.07.2022. LWH data identified a good culture of shoulder dystocia reporting, with 100% of shoulder dystocia's reported to the Trust Ulysses system. We await the result of the regional audit, due to be presented at the Safety SIG in September 2022 and will be reviewed by the FHD upon receipt.

Maternity MPMET Training Compliance – July 2022

(Red Figures denote trajectory based on booking so far)

CNST SA8	Staff Group	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22
SA 8b. MPMET	Midwives	13%	19%	22%	38%	61%	76%	78%	83%	89%	91%
	Maternity HCA	10%	19%	21%	30%	49%	69%	75%	75%	76%	78%
	Cons Obstetrician	6%	10%	46%	62%	71%	71%	71%			
	Trainee Obstetrician	9%	20%	51%	64%	91%	97%	97%			
	Cons Anaesthetist	6%	13%	26%	26%	26%	37%	37%			
	Trainee Anaesthetist	11%	44%	44%	11%	33%	55%	55%			
SA 8c. Fetal Surveillance	Midwives	2%	7%	19%	28%	53%	72%	78%	82%	88%	
	Cons Obstetrician	2%	10%	20%	35%	60%	63%	74%			
	Trainee Obstetrician	0%	13%	39%	63%	67%	80%	83%			
SA 8d. NLS	Midwives	13%	19%	22%	39%	62%	76%	78%	83%	89%	91%
	Cons Neonatologist	94%	94%	94%	94%	100%	100%	100%			
	Trainee Neonatologist	95%	95%	100%	100%	100%	100%	100%			
	ANNPs	62%	85%	88%	88%	88%	86%	93%			
	Neonatal Nurses	80%	84%	89%	89%	89%	89%	96%			

Family Health Division Training Narrative – July 2022

Maternity Training Needs Analysis: Liverpool Women's NHS trust (LWHT) is committed to the vision of the National Maternity Review Better Births Report to become safer, more personalized care with women and families receiving high quality care. Robust education and training are key components of providing safe care and contribute to creating a supportive learning environment where all staff are able to learn from incidents and concerns to continuously improve the care we are providing to women, families and babies. The LWH Maternity training needs analysis (TNA) has been developed and identifies the training required to underpin our commitment. It includes the training required to meet the Core Competency Framework for maternity staff. To support this, LWHT maternity has successfully bid for Health Education England funding for safety training. Following publication of the CNST MIS Year 4 in August 2021, the TNA was reviewed and revised further to ensure compliance to CNST Safety Action 8. Updates in relation to the Midwifery Preceptorship programme and have also been included in v1.1 of this document to reflect current practices.

The LWH Maternity TNA has been shared and ratified with the Local Maternity System Lead Midwife for Quality & Safety, ratified, and agreed and is currently being utilised as a template for other maternity providers within the region as a benchmarking tool. All managers, clinical leads and rota co-ordinators have been contacted and have ensured that staff are booked onto applicable course sessions that are planned and diarised. To note, Anaesthetic trainees are a small cohort of staff (average number 12) who complete a short three-month rotation to Obstetric Anaesthesia at LWH and therefore the compliance figure fluctuates dramatically for this group at the rotation times through the year. The Maternity Education Team have developed an excellent relationship with the rota coordinators who ensures that all obstetric consultant and trainees attend a MPMET session during their placement to achieve compliance. ** Midwifery and neonatal nurse compliance data is based on the one year in house update and does not include and reflect those clinicians who have at reg course and therefore this would supersede annual update. This will require manual verification later. This data has been sighted at the Trust Resuscitation Committee. Fetal Surveillance Training days commenced in January 2022 to include all elements of the Saving Babies Lives Care Bundle, in addition to the fetal monitoring training requirements. An increased number of courses have been arranged from March 2022, with an increased capacity for attendance. A trajectory is in place to ensure that we meet this requirement. Fetal Surveillance Training prior to January had been completed to a compliance rate of 90%.

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Perinatal Dashboard

The infographic below is designed to align with the requirements as set out in the implementing-a-revised-perinatal-quality-surveillance-model.pdf (england.nhs.uk) and highlights some of the key KPIs monitored throughout the family health division. The Division now have a newly developed maternity dashboard (can be accessed clicking on the link below). The Family Health Division along with the Clinical Director and Head of Midwifery

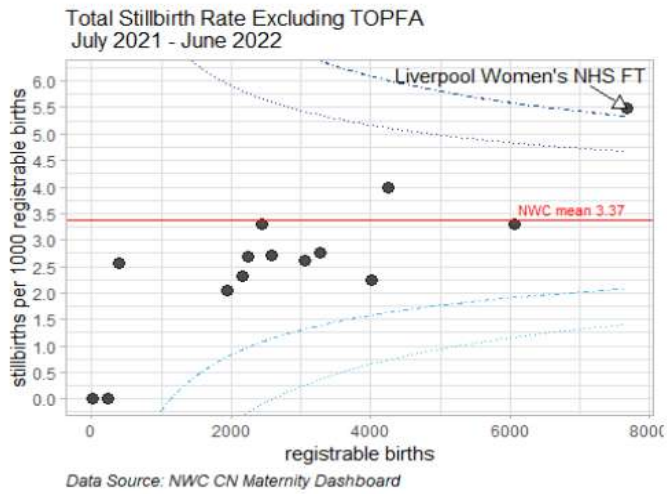
Maternity Clinical Dashboard New - Power BI

	Metric	Standard/ National Standard	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
Perinatal	1:1 Care in Established Labour	100% CNST 95% CCG	99.60%	99.30%	99.20%	98.60%	99.60%	99.40%	98.10%	98.30%	98.90%	96.50%	98.97%	99.20%	99.10%	98.59%
	Stillbirth Number >24 weeks (Adjusted)	Actual Number	2	7	3	1	2	5	2	5	0	5	1	4	2	3
	Stillbirth Adjusted % per 1,000 Birth			10.12%	2.94%	1.47%	4.57%	7.51%	3.21%	6.07%	0%	6.75%	1.70%	6.13%	3.28%	4.70%
	Apgar <7 @ 5 Minutes (>37wks)	<1.6%	0.80%	0.60%	1.30%	0.80%	0.50%	1.15%	1.28%	0.51%	0.59%	1.15%	0.37%	1.19%	0.74%	1.06%
	Term Admission to NICU	<6%	3.54%	4.01%	4.91%	5.10%	4.52%	7.69%	5.46%	5.90%	5.70%	6.70%	2.95%	7.30%	4.24%	5.48%
	Women in reciept of CoC	100%	15.35%	14.49%	16.67%	19.91%	17.85%	20.52%	20.52%	18.7%	25.20%	16.90%	18.50%	21.68%	20.21%	16.01%
	BAME in recipet of CoC	100%	29.41%	31.63%	39.81%	47.96%	39.60%	41.58%	37.89%	37.20%	59.46%	37.70%	41.90%	51.85%	48.11%	36.00%
	Social Depravation of CoC	No standard	18.18%	19.89%	24.21%	26.40%	22.26%	24.78%	23.62%	21.70%	28.90%	23.30%	22.10%	25.87%	26.57%	19.10%
	Provision of Epidural in Labour	No standard	15.1%	20.3%	19.4%	20.3%	22.82%	17.78%	16.78%	18.97%	18.70%	19.20%	19.35%	19.10%	18.30%	20.85%
	Obstetric Haemorrhage >1.5 recieving blood transfusion	<2.7%	4.28%	7.41%	12%	28.57%	27.27%	4.26%	11.11%	3.70%	23.30%	17.39%	3.70%	8.70%	9.52%	25.93%
	Coroner Reg 28 Made to Trust	Actual Number	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Workforce	HSIB Reports Returned	Actual Number	1	0	0	1	1	1	0	1	0	0	1	1	2	4
	Supernamary Shift Leader	100% CNST	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Midwifery Sickness	% of Workforce	10.13%	12.28%	12.17%	14.11%	13.31%	12.63%	15.26%	16.37%	11.45%	9.64%	9.69%	9.65%	9.68%	11%
	Midwife to Birth Ratio (in Post)	>1.30	30	31	31	32	30	29	30	30	30	30	28	31	29	30
	Midwifery Vacancy	% of Workforce	2.40%	1.40%	4.40%	3.30%	5.32%	8.72%	7.84%	2.46%	2.00%	4.10%	13.2%*	13.20%	17%	53.1 WTE
Feedback	Rostered Cons Hrs on DS	Actual Number	91	91	91	91	91	91	91	91	91	91	106.5**	106.5	106.5	106.5
	Number of Formal Complaints	Actual Number	2	2	1	2	3	2	2	2	0	2	3	2	5	4
	Number of Maternity Incidents over 30 days	Actual Number	188	261	89	161	376	97	119	121	120	234	221	273	204	256
	Number of PALS/PALS +	Actual Number	74	66	67	46	52	44	32	44	42	31	27	26	40	44

Northwest Coast Regional Dashboard – Outlier Queries and Responses

On 13th July 2022, a request was made from a NWC Regional Group to the LWH Board Level Safety Champion, and the Family Health Division was to provide a response to our outlier position for total stillbirth rate (adjusted) (Table 1) and StEIS reporting (Table 2).

Total Stillbirth Rate Excluding TOPFA



Reportable StEIS Incidents

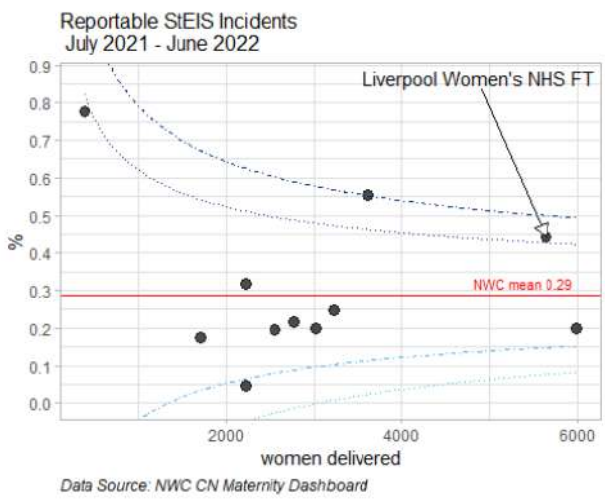


Table 1 and Table 2: North West Coast Outlier Dashboard: June 2022.

The Clinical Director and the FHD Safety Champions, reviewed our position and offered the following response to the outlier positions queries (email returned on 29.07.2022):

Total Stillbirth Rate.

"Liverpool Women's are aware of the increasing adjusted stillbirth rate noted on the NWC dashboard, as well as our own in-house maternity dashboard. In response to this and to understand the rising trends and identify any these, a thematic review is planned in September 2022, which will include a secondary review of PMRT Reports and case analysis pertinent to those births in 2021-2022. This thematic review will be led by the Clinical Director, Consultant Lead for Fetal Mortality and the Quality & Safety Matron. This will be presented to Trust Board and identify any areas for improvement and/or service change, that can be utilised in our Maternity Transformation project, with feedback to our wider regional colleagues via Safety SIG and the LMNS"

StEIS Reporting.

"Liverpool Women's are aware of the increased number of StEIS referrals. In the last 12 months there has been a change in the process of review of clinical incidents. With the introduction of a weekly harm meeting for Senior and Board Level Safety Champion oversight of all cases, including Maternity cases. The weekly harm meeting is chaired by the Medical Director, Chief Nurse & Midwife and Associate Director of Governance. There has been an added scrutiny of cases where women and families care may have been affected by the risk of LWH being a standalone site, where we are without access to onsite acute services. In order to review the impact of this risk on maternity cases and service overall, all cases where transfer to an acute trust are to undergo a full SUI

investigation. LWH Trust Board and Quality Committee have requested from the Board Level and Divisional Safety Champions, a review and analysis of reported StEIS incidents from the last five years to identify any themes and trends. This work will be completed in collaboration with the Governance Team. Areas for improvement, lessons learnt will be identified, shared with appropriate action plans and divisional learning disseminated and supported through the Maternity Transformation Project"

Conclusion

The Family Health Division asks the Trust Board to note this paper as assurance that perinatal quality safety is a key priority within the division and its compliance against the implementation of a perinatal quality dashboard and framework. The data that supports this paper is monitored at the Family Health Divisional Board and includes review of all WE SEE KPIs, as developed within the Maternity Power BI dashboard.

Further to this a review of the Cheshire & Merseyside Variance and Outliers status is undertaken by the Clinical Lead for Maternity at the FHDB, and outlier comments supplied to the LMNS from the Clinical Director for Obstetrics

Liverpool Women's NHS Foundation Trust

Combined report for

Review of Term and Late Preterm Admissions to the Neonatal Unit

ATAIN 2022-23

and

Transitional Care admissions audit

TC audit 2022-23

Quarter 1, April – June 2022

ANNP Paula Nelson

ANNP Sarah Brownrigg

Dr Helen Sacre

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Dr Anna Paweletz

Overview

1. Review of Term and Late Preterm Admissions to the Neonatal Unit ATAIN
   1.1. Term admission
   1.2. Late Preterm admissions
   1.3. Conclusions
2. Transitional Care admissions Audit
   2.1. Background
   2.2. Aims & Objectives
   2.3. Methodology
   2.4. Audit standards and criteria
   2.5. Results
   2.6. Conclusion
3. Summary
4. Actions

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

Purpose

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

Categorisation and Review

The review team classifies each admission to NICU as follows:

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

1.1. TERM ADMISSIONS

(Previous quarter shown for comparison)

	Total term livebirths	Term admissions	Appropriate but avoidable (of Term admissions)	Inappropriate (of Term admissions)	Total potentially avoidable (of Term admissions)
Q4 2021-22	1620	87 (5.4%)	5 (5.7%)	0	5 (5.7%)
Q1 2022-23	1666	89 (5.3%)	6 (6.7%)	2 (2.2%)	8 (9.0%)

The most common reason for Term admissions to NICU were Respiratory distress (n=25) and Fetal anomaly (n=14). Other reasons included Hypoglycaemia, failed pulse oximetry, Feeding problems, low cord pH, HIE/Seizures, Jaundice and suspected sepsis.

There were 6 Term admissions to the NICU that were deemed appropriate but avoidable:

- Social admissions as baby going to foster care/safeguarding concerns (3)
- Baby delivered with mother in standing position where baby fell to floor (1)
- Baby dropped whilst held by mother (in one case mother asleep and the other mother had seizure (2)

There were 2 Term admissions to the NICU that were deemed to be inappropriate:

- Baby admitted with respiratory distress where no respiratory support was required
- Baby admitted with respiratory distress where no respiratory support was required, and baby was also given IV fluids with no clear indication

There were no term admissions in this quarter due to lack of transitional care (TC) capacity or staffing problems.

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

(Previous quarter shown for comparison)

	Total late preterm livebirths	Late preterm admissions	Appropriate but avoidable	Inappropriate	Total potentially avoidable
Q4 2021-22	110	46 (42%)	8 (17%)	0	8 (17%)
Q1 2022-23	112	45 (40.2%)	5 (8.9 %)	0	5 (11.1%)

The most common reason for late preterm admission to NICU remains Respiratory distress (n=17), followed by Hypoglycaemia (n=5) and Fetal anomalies (n=5). Other reasons included Jaundice, Hypothermia, HIE/ Seizures and suspected sepsis.

There were 5 Late-preterm admissions to the NICU that were deemed appropriate but avoidable:

- No TC cot available (3). One baby was initially classified as inappropriate but on review and for consistency was deemed appropriate but avoidable as the admission was due to TC bed unavailability.
- Social admission where mother wished to be discharged home (1)
- Admission as part of process of neonatal transfer (1)

1.3. CONCLUSIONS

The overall proportion of term livebirths admitted to the neonatal unit in this quarter was 5.3% similar to previous quarters. There is a steady and sustained decrease in proportion of potentially avoidable admissions in the Late preterm population and a small increase in Term population (6.7% vs 5.7% in Q4 2021/22).

Appropriate but avoidable admissions:

1. Term admissions (n=6 (6.7%))

   Amongst Term admissions there was a small increase in appropriate but avoidable admissions. The most identified problems leading to potentially avoidable admissions in Q1 2022/23 remain admissions related to 'social issues' in babies destined for foster care (where separation of mothers and babies is not an issue). In this quarter there was no admissions related to maternal request for CS. There was a total of three admissions of babies after a fall. One baby was delivered whilst mother was standing up, two babies sustained a fall from mother's hospital beds. There were no term admissions in this quarter due to lack of transitional care (TC) capacity or staffing problems.

2. Late Preterm admissions (n=5 (8.9%))

   The late preterm admission rate remained similar to the previous quarter. The proportion of appropriate but avoidable late preterm admissions has fallen from 17% to 8.9%. Three babies were admitted to NICU as no TC cot was available- this finding did however not correlate with the findings from the TC audit (see section TC bed availability). One baby was admitted for social reasons, a further as part of the neonatal transfer process.

Inappropriate admissions

1. Term admissions (n=2 (2.2%))

   Two Term babies were admitted inappropriately to NICU. Both babies were admitted for respiratory distress, but respiratory support was not needed. One of the two babies additionally received intravenous fluids with no clear indication.

2. Late Preterm admissions

   Amongst this group there was no inappropriately admitted to NICU.

2. Transitional Care Admissions Audit

2.1. BACKGROUND / RATIONALE

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

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

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

2.2. AIMS & OBJECTIVES

The aim of this audit is to assess compliance with the Transitional Care (TC) Admission Criteria of LWH (2021 – version 11– NICU 34) between 01.04.2022 and 30.06.2022.

2.3. METHODOLOGY

All admissions to the Transitional care unit between 01.04.22 and 30.06.22 were assessed. A BadgerNet search was performed to identify these babies.

Inclusion and exclusion criteria:

Babies that have received at least one day of transitional care, in line with BAPM 2011, HRG definitions, and LWH Transitional Care Guideline. Babies who were still an inpatient on TC on 30/6/22 were excluded from this audit.

Details regarding the date of birth, gestation, birth weight, gender, date of admission to TC, reason for admission to TC (In line with TC guideline on Badger). Where the baby was admitted from, if the baby was admitted from NICU if this was due to no TC availability and whether they were discharged to community team.

2.4. AUDIT STANDARDS AND CRITERIA

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

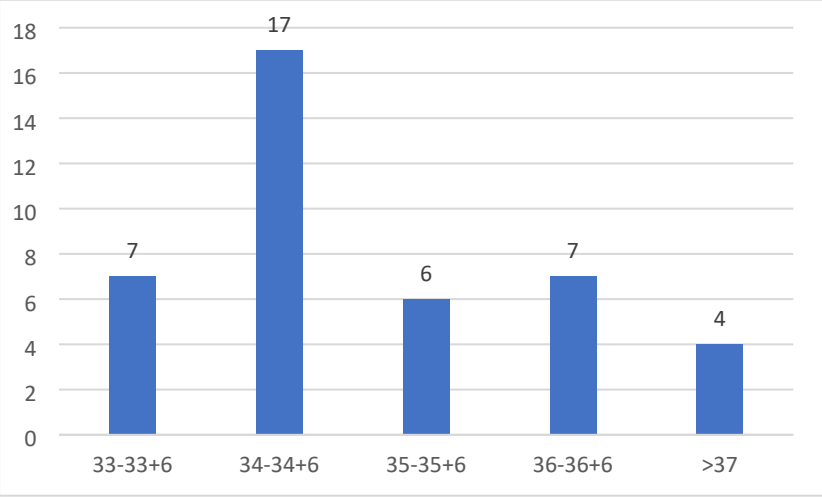
- Babies 34- 35 weeks gestation as per current TC guideline. To comply with CNST requirements (safety section 3), babies born between 34 and 36+6 weeks gestation who neither had surgery nor were transferred during any admission were included
- Birth weight below 1.8kg
- Admission following joint review from 'Small Babies Pathway (2020)' for TC admission (Babies < 2.5kg and < 35 weeks gestation at birth)
- Admission for nasogastric tube feeding
- Babies >33 weeks gestation who have been stable for 72 hours from Neonatal Unit and using an apnoea mattress or stable for at least 24 hours off any form of respiratory support
- Other – Specify (Consultant decision, maternal input needed)
- Other topics reviewed (no pre-audit standards set - Benchmarking):
  - Number of special care or normal care days where supplemental oxygen was not delivered in babies between 34 and 36+6 weeks gestation (CNST requirement, safety section 3). This was evaluated for infants initially admitted to NICU.
  - Place admitted from (including TC bed unavailability)
  - Referral to Liverpool Women's Hospital Neonatal Community Outreach team.

2.5. RESULTS

Between 01.04.2022 and 30.06.2022, there were 41 babies who met the inclusion criteria.

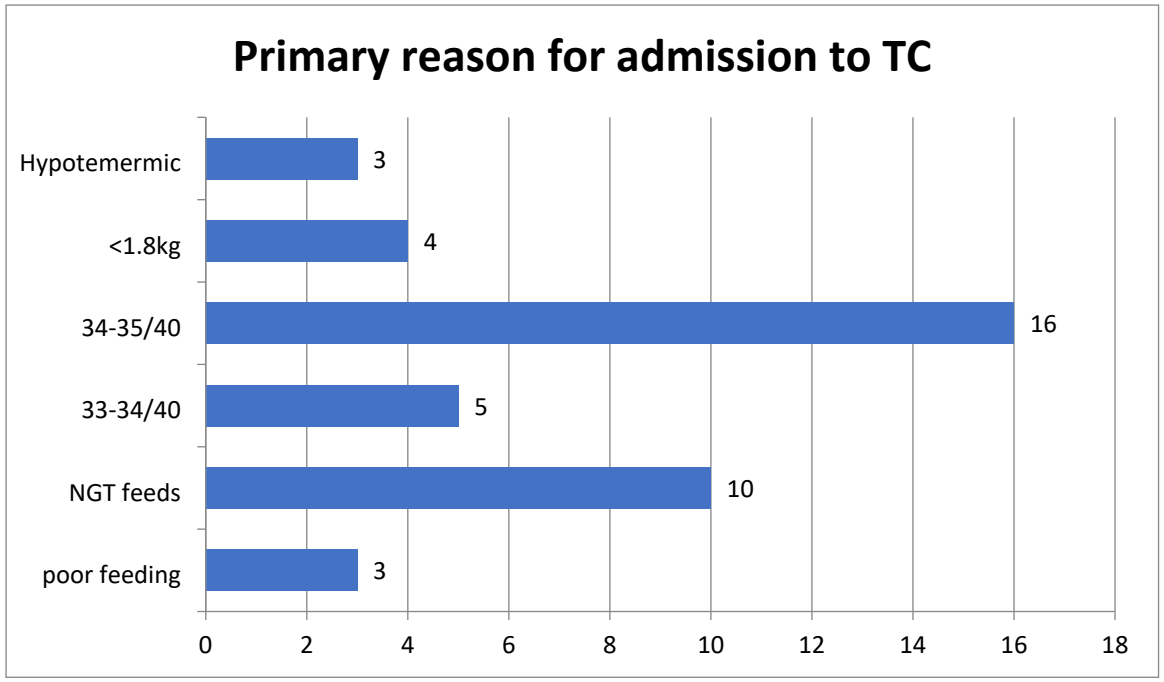
- Average occupancy of the TC unit during this period was 51.2%
- Average weight 2308g (range 1530g -4100g)
- Gestation range 33+2 to 40 +3
- 18 male infants, 23 female infants
- Length of stay on TC ranged from 7hrs to 14 days. The average stay was 5.9 days. The average age at TC admission was 2.1 days with a range from day 1-14.

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



Details of gestations of babies admitted to TC

Primary reason for TC admission



Details per gestation:

33-33+6 (n = 7)

- All admitted via NICU (None admitted to NICU due to lack of TC bed)
- All admitted due to gestational age for Nasogastric tube feeding and thermoregulation
- 2 were <1.8kg

34-34+6 (n= 16)

- 2 admitted from NICU (None admitted to NICU due to lack of TC bed)
- 14 admitted from theatre/ward due to gestation for feeding support
- 1 was <1.8kg

35-35+5 (n = 6)

- admitted for NGT feeding
- 1 admitted hypothermic

36-36+6 (n= 8)

- 4 admitted for NGT feeds
- 2 admitted hypothermic
- 1 admitted due to BW <1.8kg
- 1 admitted with poor feeding

>37 (n= 4)

- All admitted due to poor feeding

Benchmarking:

No babies this quarter were identified to have been admitted to NICU for special care or normal care days who could have been cared for in TC setting (34-36+6/40). All babies at this gestation admitted to NICU were either receiving respiratory support or IV fluids.

Place babies were admitted from:

A large proportion of babies were admitted via NICU (n=19), all for valid reasons (not focused on in this audit), none due to TC unavailability. All remaining admissions were from Delivery Suite (n=11) and Postnatal Ward (n=11) and all except 1 identified with the first day of life to be admitted to TC.

TC bed unavailability

No babies this quarter were documented as being admitted to NICU due to no TC beds.

Babies referred to neonatal community outreach team-Benchmarking

21 babies were eligible for local community follow up. All of whom were referred to the neonatal community outreach team. The remaining babies were either out of the community outreach catchment area or had a discharge weight of >2.3kg

2.6. CONCLUSIONS

This audit demonstrates that transitional care is a busy and active part of the neonatal care provided at Liverpool Women's Hospital. It prevents unnecessary separation of mother and baby and reduces admission to the neonatal unit. It can be seen from the data above that the transitional care service supports the recommendations outlined in the CNST action plan (standard 3), and its use is in line with the unit guidelines on the whole.

It is important to note that there may be some overlap between the reasons for admission to TC, e.g. 'babies 34 - 35 weeks gestation' and 'babies below 1.8Kg', though for the purpose of this audit, the primary reason documented on Badger was used.

In quarter 1, between 01.04.22 and 30.06.22 a total of 41 babies were admitted to TC which is an increase from 38 in the preceding quarter which had been an increase from 26 babies in its preceding quarter. The occupancy was an average of 51.2%. There were more girls than boys in this time period (23 girls and 18 boys). The length of stay averaged at 5.9 days compared 8.9 days in the previous quarter. All admissions met TC criteria. A large proportion of babies were admitted via NICU (19 babies), all other admissions came from DS and PNW.

All babies meeting TC criteria were cared for in the TC setting. All babies admitted to NICU were receiving some degree of acute support such as respiratory support or IV fluids or Jaundice at exchange transfusion level.

When assessing the primary reason for admission, babies fulfilling the criteria for the small baby pathway were identified first. The pathway exists in paper form only and is not clearly referenced in the Badger documentation. It is therefore difficult to establish on the basis of data extracted through Badger, whether the babies were admitted due to being identified on the pathway. The remainder of primary reason for admission was documented regardless of small baby pathway criteria. 21 babies were admitted on gestation criteria, 10 babies for NGT feeding, 4 were <1.8kg, 3 were admitted due to poor feeding and 3 due to hypothermia.

21 out of 41 babies were eligible for community neonatal outreach support in the Liverpool area, all were reviewed regularly at home after discharge. This demonstrates that a robust referral process to the community team is in place, ensuring adequate support for families post discharge.

Documentation issues raised in the last report persist. The small baby pathway exists in paper form and is therefore not readily available through Badger. Documentation as to whether an eligible baby remained on NICU due to lack of TC beds was not evident this quarter although staff report there were cases. As this was not documented it could not be included in this audit. The primary reason for TC admission was not consistently documented.

3. SUMMARY

ATAIN

The ATAIN report demonstrates a stable number of avoidable term admissions and a reduction in avoidable Late Preterm admissions compared to Q4 2021/22. The most commonly identified reason for admission remains 'social issues' in babies. Three babies sustaining falls requiring admission to NICU (one during delivery, two from maternal beds). ATAIN identified three Late Preterm babies were admitted to NICU due to lack of TC beds. This did not match the data collected from the TC audit (see section TC bed availability). There were two inappropriate admissions of Term infants to NICU.

TC audit

TC activity is steadily increasing over the past 3 quarters. The length of stay has reduced from 8.9 to 5.9 days in Q1 2022/23. All admissions met TC criteria and a large proportion of babies was admitted via NICU. The majority of babies were late preterm and admitted via the Small Baby Pathway. Alle eligible infants were followed up appropriately by community outreach team following discharge. Documentation issues persist. The Small Baby Pathway is used in paper format and not on Badger. Documentation as to whether an eligible baby remained on NICU due to lack of TC beds was not evident this quarter although staff report there were cases. As this was not documented it could not be included in this audit. The TC audit did not identify Babies who were not admitted to TC due to a lack of availability in this quarter. This represents a contradictory finding to the ATAIN data and indicates the need for a more robust documentation.

TC bed availability

ATAIN identified 3 Late preterm babies who were classified as appropriate but avoidable NICU admissions due to perceived TC bed unavailability. Interestingly the TC audit did not identify babies, who could not be admitted to TC for the same reason.

On further review:

1. Baby (34+2 weeks gestation) was initially admitted to NICU with hypoglycaemia and subsequently required intravenous fluids. Whilst a TC bed was not available at the time, admission to NICU for intravenous fluids was appropriate.
2. Baby (34+4 weeks gestation) was admitted to NICU for social reasons with the plan to go to a Foster Home. This baby did not fulfil TC admission criteria.

3. Baby (34+4 weeks gestation) was admitted to NICU with low blood sugars. Admission blood sugar in normal range. Baby was found to be quiet, with a mildly raised lactate and SBR and discussed with the Neonatal Consultant, who decided for admission to NICU for observations. It is not clear from the documentation whether a TC bed was available.

In summary one Late preterm baby in Quarter 1 2022/23 was admitted to NICU due to possible TC bed unavailability.

The issues around TC bed availability and discrepancy around its documentation highlight the need to continue to cross reference information obtained from the TC audit and ATAIN. From Q2 2022/23 we will cross reference TC bed availability as recorded on Badger.

4. ACTIONS

TC audit

1. Dissemination of these audit findings to the wider neonatal team – Neonatal MDT and presenting in Neonatal Clinical Governance Day as well as Maternity, Neonatal and Board level safety champions, LMNS and ICS quality surveillance.
2. The TC documentation audit has completed data collection- and is currently in the process of writing the report. The findings will be presented in Neonatal Clinical Governance when available (Emily Hoyle/ Paula Nelson)
3. Data on the Small Baby Pathway will start to be collected separately from Q2 2022/23.
4. Improve documentation of TC bed availability and eligibility on NICU admission.
5. A designated Consultant (Anna Paweletz) and Lead ANNP (Paula Nelson) are now in post. They will complete quarterly audit and reports as per CNST requirements.
6. Improved/expanded facilities are required to enable LWH to offer equivalent facilities to TC parents as NICU parents currently receive. The TC ward has been moved to a more suitable area within the postnatal ward and there are plans in place to renovate the area and bring it in line with NICU standards for parents.

ATAIN

ATAIN Action	Narrative	Owner	Target date	Evidence required	Status
Education and training around prevention and management of hypothermia/hypoglycaemia	Include a presentation (monthly) delivered by ANNP at regular Fetal Surveillance sessions	Fiona Chandler/ Sarah Brownrigg	September 2022	1. Presentation 2. Records of sessions/attendance	Regular education session delivered by ANNP initiated as part of fetal surveillance study days. Teaching session delivered and planned. Attendance not provided. - 15/6/22 - 28/6/22 - 12/7/22 - 27/7/22 - 21/9/22 ATAIN 2020.pptx
Start midwives undertaking eLFH ATAIN module	One-off, nationally approved online training	Emma Pimblett	September 2022	Download of numbers of midwives completing online module	eLFH ATAIN module as per 10.06.22 is 55%- pending further update
Education/training (around CTG interpretation, risk assessment, escalation process when signs of concern)	To be included in Fetal Surveillance sessions	Ange Winstanley/ Fiona Chandler/ Kate Alldred	June 2023	1. Presentation 2. Records of sessions/attendance	Local risk assessment and esc; Fetal Surveillance Day introduction an; fetal surveillance study day; Fetal Surveillance & SVBLCBv2 Study

Education around recognition and management of respiratory distress	Lesson of the week (LOTW) reminder	Sarah Brownrigg	September 2022	LOTW shared (date & content)	
Management of mothers delivering in a standing position	Ongoing incident review	Laura Thorpe	September 2022	To share feedback and lessons from incident review	
Infants sustaining falls from maternal beds on postnatal ward	Multi agency safe sleep policy to be updated (escalated to local safeguarding board)	Joan McDonald /Alison Murray	September 2022	To update Safe Sleeping policy	
Review of TC capacity	To identify reasons for non-availability of TC cots	Paula Nelson/ Anna Paweletz	Sept 2022	Audit of TC occupancy and activity (ongoing quarterly audit)	Cross reference TC audit and ATAIN data with TC bed status (BaderNet)

CNST May 2022

Safety action 3 Standards

- a- Jointly approved pathway of care TC pathway - ***In place***.
- b- pathway fully implemented and audited on quarterly basis. - ***Quarterly combined TC and ATAIN findings are shared appropriately.***
- c- a electronic data recording process for all babies admitted to NICU- ***In place (BadgerNet).***
- d – data recording process in place to monitor existing TC capacity and captures babies between 34+0 and 36+6 weeks gestation who neither had surgery, nor were transferred during any admission, t monitor the number of special care and normal care days where supplemental oxygen was not delivered. – ***In place (TC audit)***
- e- Commissioner return for HRG activity are available to be shared with ODN, LMNS and commissioners.
- f- reviews of babies admitted to NICU continue on a quarterly basis and are shared with the Board Level Safety Champion. Reviews should include all neonatal unit transfers and admissions regardless of their length of stay and /or admission to BadgerNet- ***all admissions to NICU, regardless of length of stay, are recorded on BadgerNet. TC bed availability and infants requiring nasogastric tube feeding recorded in TC audit. Findings shared appropriately.***
- g- Action plan agreed
- h- progress with revised ATAIN action plan- ***shared.***

Appendix 3

EXECUTIVE SUMMARY

The Maternity Staffing paper is provided to the Board of Directors and outlines the requirements of the Maternity Incentive Scheme (MIS) Year 4, Safety Action 5 (SA5). The report sets out the Liverpool Women's NHS Foundation Trust (LWH) position in the context of midwifery staffing. This report covers the six-month period from January 2022 to June 2022 as is required for MIS.

MIS Year 4, SA5 requires that Trusts demonstrate an effective system of midwifery workforce planning. The recognised evidence-based tool within Maternity Services is Birth Rate Plus (BR+).

A Birth Rate Plus audit was completed in 2021, with the final report received in the Trust in January 2022. The

The report highlights the following areas for discussion and noting (January 2022-June 2022).

- Budgeted establishment equates to 354.92wte which is 5.33wte above the BR+ recommendations
- Budgeted posts are inclusive of 23% headroom, which is an increase from the previous 21.4% in maternity and a reflection of the additional specialist training requirements of midwives
- Vacancy rate is 54.92wte in June 2022. Gross unavailability rate (including mat leave and sickness absence) equates to 90.94wte.
- Total recruitment in progress is 67.65wte demonstrating a healthy recruitment campaign and is above actual vacancy rate
- Sickness absence rate is 9.68% in June 2022 which is a reduced position from January 2022 where it was 16.7%. This demonstrates improved rigor in management of sickness absence in line with policy
- Turnover is under Trust threshold (13%) at 12% in June 2022
- Midwife:Birth ratio in June 2022 is 1:29, against a national recommendation of 1:28. The Trust position will improve as vacancies are filled and will fall below the national recommendation
- 164 red flags noted in six months. Majority of the red flags relate to Induction of Labour and Staffing (levels and skill mix). Maternity leadership team are aware of all incidents reported, with oversight and scrutiny
- Supernumerary shift co-ordinator on labour ward is maintained at 100% for past six months
- 1:1 care in labour achieved a compliance rate of 98.1-99.6% in the reporting period, against a standard of 100%.

It is recommended that the Board accepts the information in this paper as assurance that there are robust systems and processes in place that fulfil the requirements of MIS Year 4, SA5.

1.0 Introduction

The Maternity Incentive Scheme (MIS) Year 4 Safety Action 5, 16092021-MaternityIncentiveSchemeYEAR4-Revised-timeframe-October-2021-updated.pdf (resolution.nhs.uk) requires that trusts demonstrate an effective system of midwifery workforce planning.

In response to the National Maternity Transformation agenda, the Local Maternity System commissioned a workforce analysis for Cheshire and Merseyside Maternity Services. The regional emerging clinical picture from local intelligence and clinical dashboards including midwife to birth ratio and vacancy, suggested that whilst births were reducing, complexity and staffing requirements to align to national safety standards were increasing. On review of Liverpool Women's Hospital (LWH) data there has been an increase in complexity at booking and an increase in unscheduled attendances to the Maternity Assessment Unit. The demographic of the population within the greater Liverpool area has seen significant challenges in relation to social deprivation, safeguarding and an ever-increasing public health demand which has increased the requirements for midwifery staffing.

2.0 Birth Rate Plus

Birth Rate Plus (BR+) is a recognised tool for workforce planning and strategic decision-making. It is based upon an understanding of the total midwifery time required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour. Whilst birth outcomes are not influenced by staff numbers alone, applying a recognised and well-used tool is crucial for determining the number of midwives and support staff required to ensure each woman receives one-to-one care in labour. Cheshire and Mersey Local Maternity Neonatal Systems (LMNS) commissioned the BR+ assessment for all maternity units within the LMNS as part of the Ockenden review.

Included in the assessment is the staffing required for antenatal, intrapartum, and postnatal inpatient and outpatient services, including community births. Birth Rate + calculates the clinical establishment based on agreed standards of care and includes the midwifery management and specialist roles required to manage maternity services. Adjustment of clinical staffing between midwives and maternity support workers (Band 3) is included. The recommendation is to provide total care to women and their babies on 24 hours, 7 days a week basis, inclusive of the local percentage for annual, sick & study leave allowance and for travel in community. 23% uplift has been calculated to enable this.

3.0 Maternity Staffing Establishments

Birth Rate Plus audit commenced in LWH in Summer 2021 and annual activity was based on 7488 births (April 2020-March 2021). The report published in January 2022 recommended a workforce establishment of 349.59wte inclusive of 90:10 skill mix (90% midwives and 10% maternity support worker).

LWH midwifery and MSW budgeted posts for financial year 2022/23 equates to 354.92wte which is 5.33wte above the BR+ audit recommendation. Budgeted posts are inclusive of 23% headroom for training, annual leave etc. Rationale for going above the BR+ recommendation relates to the increase in the number of births during calendar year 2021, being 7854 an increase of 366.

Table 1 highlights midwifery and maternity support worker (MSW- Band 3) funded establishment 2022-23 inclusive of a headroom factor of 23%, with additional support staff posts excluded from the BR+ ratio.

Table 1 - 2022/23 Funded Establishment	2022/23 Budget	BR+ Recommendation at 23%	Variance to Budget
Total Clinical Staff	285.50	273.36	12.14
Contribution from Specialist Midwives	5.00	8.31	3.31
Total Direct Care Giving Midwives	290.50	281.67	8.83
Non-Direct Care Giving (Non-Clinical)	31.15	33.27	2.12
Total Registered Midwives	321.6	314.94	6.71
MSW's Included in BR+ (CoC, Community & Mat Ward)	33.27	34.65	1.38
Total MSW's	33.27	34.65	1.38
Total Posts Included in BR+ Ratio	**354.92**	**349.59**	**5.33**
Support Staff Excluded from BR+ Ratio	37.24		
Other Non-BR+ Roles	26.44		
	63.68		
Total Establishment	418.60	349.59	

Table 1- funded establishment

Table 2 reflects actual WTE in post in June 2022 compared to the BR+ recommendation and is split between midwifery and maternity support worker (Band 3) staff.

Table 2 - 2022/23 Contracted Establishment at M3	2022/23 In Post	BR+ Recommendation at 23%	Variance to Budget
Total Clinical Staff	198.10	273.36	-75.26
Contribution from Specialist Midwives	3.60	8.31	-4.71
Total Direct Care Giving Midwives	201.70	281.67	-79.97
Non-Direct Care Giving (Non-Clinical)	30.16	33.27	-3.11
Total Registered Midwives	231.86	314.94	-83.08
MSW's Included in BR+ (CoC, Community & Mat Ward)	26.79	34.65	-7.86
Total MSW's	26.79	34.65	-7.86
Total Posts Included in BR+ Ratio	258.65	349.59	-90.94
Support Staff Excluded from BR+ Ratio	28.69		
Other Non-BR+ Roles	16.76		
	45.45		
Total Establishment	304.10	349.59	

Table 2 – comparison of staff in post and BR+ recommendations

Table 3 demonstrates a breakdown of Midwifery and MSW (Band 3) vacancies shown in WTE at month 3 (June) 2022/23.

True vacancy rate	54.92
Maternity leave	14.36
Sickness absence	21.66
Gross unavailability rate	90.94

Table 3 – gross unavailability breakdown

4.0 Recruitment

As highlighted below (Table 4) recruitment activity reflects a breakdown of midwifery and MSW (Band 3) shown in WTE reflects a position of those currently in the recruitment process, recruited staff pending start date and total recruitment in progress.

Recruitment in progress	2.8
Recruited staff with start date agreed in M7	52.01
Recruited qualified staff tentative start date M9	4.84
Internationally recruited staff tentative start date in M10	8.00
Total recruitment in progress	67.65

Table 4: Recruitment overview

Maternity has seen in the past 2 years a change in the demographic of its midwifery and support worker age profiles, bringing an increase in retire and return requests; there have been 44 retirement requests since January 2020 of which 22 colleagues requested a flexible retire and return arrangement which has resulted in a reduction in overall contracted hours. The service also has ongoing maternity leave, projected at 10 WTE on a rolling basis. The workforce profile is reviewed monthly by the senior midwifery team with support from the HR Business Partner, specifically, meetings take place with Matrons and the Deputy Head of Midwifery, along with Finance (bi-weekly) to review ongoing workforce pressures and the rolling recruitment plan. This will result in 12.73wte over establishment of the midwifery staffing budget. Approval to over recruit taking into consideration the 3.0 WTE monthly midwifery attrition rate, was granted by the Trust Executive Team in April 2022.

Following the retirement of the previous Consultant Midwife in April 2022 the newly appointed Director of Midwifery and newly appointed Head of Midwifery will be considering key roles in the midwifery leadership structure along with developing a professional midwifery advocate strategy for LWH.

5.0 Maternity Staffing (Planned versus Actual)

Maternity has a process for daily review of planned versus actual staffing, this information is fed into the twice daily staffing huddles. In addition, staffing is reported

Trustwide in the daily virtual huddle (Bronze command) which consists of senior managers and the manager on call. LWH procure the services of NHS Professionals to fill bank shifts and if required agency shifts, to support temporary staffing shortfalls. Weekly meetings have been held between NHS Professionals, Deputy COO and Deputy Head of Midwifery to monitor bank fill rates and to ensure consistent and safe staffing levels.

One of the main service priorities is to maintain safe midwifery staffing levels. Maternity staffing and acuity are assessed on a 4hrly basis by the Maternity Bleep Holder (Matron) and should staffing fall by the numbers of midwives to provide safe care, the Maternity Escalation Guideline (v3.3) is followed. This includes the redeployment of staff which is facilitated through adherence to the Maternity Escalation Guideline, to review maternity staffing and acuity on a 4 hourly basis. Midwives and MSW undertake a rotational training programme, allowing midwives to rotate between all clinical areas, ensuring a workforce that are skilled to work across all clinical areas of the maternity service. The Maternity Bleep holder consistently reviews staffing with the aim of redeploying non- direct care givers to address spikes in clinical activity to maintain a safe clinical staffing ratio.

6.0 Sickness absence

Sickness absence continues to present as a challenge in the maternity service standing at 9.68% in June 2022 which is reduced from 16.7% in January 2022 as seen in Table 5. The division has been above the Trust threshold of 4.50% since the start of the Covid-19 pandemic, with the split of absence weighted towards long term cases at 69% in June 22. The service reviews their sickness cases (short and long term) on a weekly basis and any long-term cases are managed in accordance with the Trust Attendance Management policy.

In terms of long-term sickness, there is a downward trend of active cases with regular monitoring taking place jointly between HR and members of the maternity leadership team. For all absences, Occupational Health are fully engaged (as required) and support information for the C&M Resilience Hub is regularly accessed/part of welfare conversations.

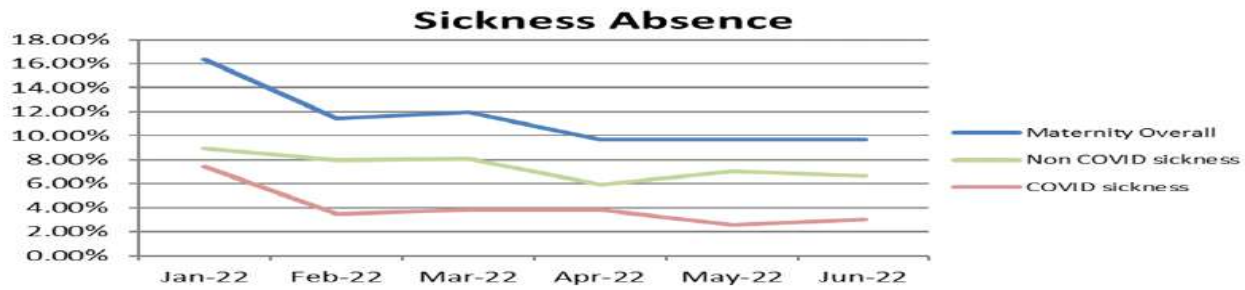


Table 5 – Sickness absence rates

7.0 Turnover

Staff turnover within the first six months of 2022 exceeded the trust threshold of 13% this has reduced to 12% in June 2022 (Table 6). Maternity has seen a gradual increase in staff turnover which reflects the national picture. The division have reviewed all leavers in the last 6 months and determined that attrition is mainly due to staff relocating to be closer to home and family due to the Covid-19 pandemic. Early retirement requests have been received reflecting burnout and the pandemic as reasons to retire early. In the reporting period, LWH has attracted and successfully recruited previously employed midwives back into the organisation within the same job role.

Table 6 – Turnover

8.0 Midwife to Birth Ratio

National recommendations suggest a 1:28 midwife to birth ratio, this ratio is monitored monthly through the maternity dashboard and published externally as part of our Strategic Clinical Network (SCN) dashboard.

At present the maternity services is reporting a ratio of 1:29(June 22 position, Table 7) which is reflective of midwifery turnover and current vacancy. Work is ongoing within NHSE to review maternity staffing and how 'safe' is demonstrated. Early indications have highlighted that Trust Boards should use Birth rate plus, and not the 1:28 midwife to birth ratio. We await NHSE final recommendations.

Midwife to Birth					
Jan 22	**Feb 22**	**March 22**	**April 22**	**May 22**	**June 22**
1:24	**1:24**	**1:24**	**1:28**	**1:31**	**1:29**

Table 7 - midwife to birth ratio

9.0 Midwifery Red Flags

A midwifery red flag event is a warning sign and an early indicator that midwifery staffing ratios maybe incorrect at that given time. If a midwifery red flag event occurs, the midwife in charge of the service should be notified. The midwife in charge (Maternity Bleep Holder) should determine whether midwifery staffing is the cause and take appropriate action, which may include redeployment of staffing to meet acuity or appropriate skill mix, as per Maternity Escalation Policy.

Midwifery red flags are listed in Appendix 2 (main body bi-annual staffing report).

Table 8 highlights the number of midwifery red flags reported by month with Table 9 highlighting the reasons for reporting red flags. It is noted and recognised that 3 highest recorded red flags are related to delay in ongoing process of induction of labour >4 hours (62), delay >2 hours between admission and induction of labour (31) and staffing problems – levels and skill mix (21).

To always ensure patient safety all women waiting for a bed on delivery suite or for an available midwife to provide 1:1 care in labour receive care as per Induction of Labour Guidelines (v9.1). 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 as 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 who are scheduled to come in the following day to identify and pre-empt and areas of challenge. All red flags are reviewed in Maternity Clinical Risk meeting.

Midwifery Red Flags reported					
Jan 22	**Feb 22**	**March22**	**April 22**	**May 22**	**June 22**
13	**12**	**75**	**5**	**22**	**37**

Table 8 – Red flag numbers by month

Red Flag Incidents Closed.	January	February	March	April	May	June
1:1 Support Not Provided During Established Labour	0	1	3	0	2	1
Acuity/ Capacity	0	1	1	0	0	0
Delay >2 Hours Between Admission and Induction	0	3	19	0	4	4
Delay in ongoing process of induction >4 hours	1	6	28	0	10	17
Delay >30 Mins Between Presentation and Triage	2	0	0	1	0	0
Delay in Transfer - Antenatal or Postnatal	1	1	5	0	0	2
Delay or Cancellation of Activity	4	0	1	0	2	2
Inability to Provide Epidural	0	0	1	0	0	2
Medication error – drug not given	0	0	1	0	0	1
Shortfall in Staffing	1	0	1	0	1	3
Staffing Problem – Levels and Skill Mix	4	0	10	3	1	3
Wait for more than 60 mins for sutures post delivery	0	0	1	1	2	1
Incorrect classification as Midwifery Red Flag	0	0	3	0	0	1
Total	**13**	**12**	**75**	**5**	**22**	**37**

Table 9 – Red flag themes

January 2022 reflects multiple incidents relating to the delay in women presenting to the Maternity Assessment Unit and being triaged by a midwife and triage. From February onwards reporting of breaches in triage are recorded as individual incidents.

A monthly midwifery 'Red Flag Report' is tabled at Maternity Risk and Clinical meeting, monitoring themes and trends of red flags in the previous month. The report is compiled from data derived from the live reporting system, completed by the maternity bleep holder. Any themes or actions required are escalated to the senior midwifery team, maternity safety champions, and to the Family Health Divisional Board. Between Jan-June 2022, maternity identified 164 red flag incidents demonstrating a positive reporting culture. A Maternity Assessment Unit multi-professional working group is in place to identify and implement actions to improve performance and consequently reduce the incidences of red flags reported, utilising a Quality Improvement (QI) methodology.

10.0 Supernumerary Shift Coordinator on Labour Ward

Within LWH Labour Ward, supernumerary shift leader compliance is consistently maintained at 100% as listed (Table 10). This role is pivotal in providing oversight into all birth activity within the Labour Ward, Maternity Assessment Unit and Maternity Base Ward, and provides a helicopter view of all staffing/workforce requirements as well as birth activity. During night-time hours the Labour Ward shift co-ordinator carries the maternity bleep (104) for maternity services. The Labour Ward shift co-ordinator is rostered independently from the core midwifery staffing and this is evidenced in e-roster with a distinct marker against the shift coordinator indicating supernumerary status.

Supernumerary Shift Coordinator					
Jan 22	**Feb 22**	**March 22**	**April 22**	**May 22**	**June 22**
100%	**100%**	**100%**	**100%**	**100%**	**100%**

Table 10 – Supernumerary status

11.0 1:1 Care in Labour

NICE (2021) guidance supports one to one care in established labour, as one of the indicators of effective midwifery workforce planning. LWH has consistently across intrapartum areas of Midwifery Led Unit (MLU) and Labour Ward (consultant high risk care), achieved a compliance rate between 98.1% and 99.6% in this reporting period.

1:1 Care in Established Labour					
Jan 22	**Feb 22**	**March 22**	**April 22**	**May 22**	**June 22**
99.3%	**98.6%**	**98.6%**	**99.6%**	**99.4%**	**98.1%**

Table 11 – 1:1 care in labour

MIS (Year 4), Safety Action 5 requires organisations to produce an action plan when compliance is less than 100%. As part of the review of the non-compliance to this required standard, each case where 1:1 care is not achieved has been reviewed to ensure no adverse clinical outcomes have occurred. The common themes identified for non-compliance include midwifery sickness, vacancies and the nature of maternity services which may include precipitate labour or presentation of a woman about to birth imminently.

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

Actions being taken over next 6 months:

- DOM and HOM in partnership with the midwifery leadership will review the midwifery structure on commencement in roles
- Creating a midwifery staffing contingency plan to support times of staff shortages in line with business continuity that releases supporting roles in the division onto the clinical floor
- 47 newly qualified midwives commencing with plans being created for onboarding and pastoral support
- Telephone triage – a QI project within maternity will be planned to enable prioritisation of telephone calls being responded to in a timely manner
- Birth Rate Plus app will be purchased and implemented from August 2022 to monitor acuity, staffing and red flags. This will be a digital solution to the current paper process that allows the senior leadership team in Maternity service to view a live dashboard of key indicators of safety and staffing. This app will be used in MLU and Delivery Suite (for intrapartum areas i.e., labour and birth). The app is not suitable for use in antenatal and postnatal care
- Maternity leadership team will be reviewing the role of the ACPs to determine where best to utilise the skills of the ACPs who are currently in training. This will be undertaken in conjunction with staff members

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	**22/23/96b**		**Date: 01/09/2022**	
Report Title	**Digital.Maternity**			
Prepared by	***Matt Connor, Chief Information Officer***			
Presented by	***Matt Connor, Chief Information Officer***			
Key Issues / Messages	**This is the annual report on Digital activities during 2021-2022. The report is intended to provide the Trust Board with assurance that overall digital delivery and performance was effective and aligned to the Trust's corporate objectives.**			
Action required	**Approve ☒**	**Receive ☐**	**Note ☐**	**Take Assurance ☐**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	***To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it***	***For the intelligence of the Board / Committee without in-depth discussion required***	***To assure the Board / Committee that effective systems of control are in place***
	Funding Source (If applicable): N/A			
	For Decisions - in line with Risk Appetite Statement – ***If no – please outline the reasons for deviation.***			
	The Board is asked to review the strategy and take assurance that the strategy has been developed collaboratively across the Trust and represents the strategic direction for digital requirements within Maternity.			
Supporting Executive:	Matt Connor, Chief Information Officer			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

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

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Family Health Divisional Board, 10 / 08 / 22 - Approved			

EXECUTIVE SUMMARY

This report is intended to inform the Board on the Trusts digital maternity strategy for the next 3 years.

The aim of the strategy is to ensure that Liverpool Women's Hospital has the best Maternity digital capabilities to provide safe and effective care and maximise collaboration with our women and partners. It provides a more detailed insight into how digital developments across the Trust are aligned to and underpinning the Maternity services, what the key deliverables are, how they will be delivered and governed. The strategy is linked to the What Good Looks Like Framework, Digital.Generations, the over-arching Trust Digital Strategy and the Trust's corporate objectives. Since Digital.Generations the digital landscape at LWH has changed significantly with the implementation of K2 in January 2021 along with upgrades to other Maternity systems such as Viewpoint and GROW.

The 4 themes identified in Digital Generations are continued with this strategy, focussing on our identity, fundamentals, innovation and excellence. 7 workstreams have been identified to deliver the aim, which will span multiple existing and new projects across the Trust. The strategy articulates 20 initiatives which will provide significant benefits to both women we care for and the Maternity, and wider workforce at LWH and across the region. There is a strong focus on ensuring that women and staff have access to the right information in the right place and through improved integration we share data safely and effectively with our partners across the region.

To develop the strategy a working group consisting of representatives from across staff groups and across divisions was set up. Once the aims and deliverables were clear the strategy was circulated widely among the group, and further afield before being considered and approved by the Family Health Divisional Board. The strategy will be a living document and reviewed annually through both Family Health Divisional Board and Digital Hospital Sub-Committee. The deliverables within the strategy will be overseen and monitored through the Maternity Transformation Board to ensure a digital first approach underpins and drives transformation within Maternity

Recommendation

The Board is asked to review and approve the strategy, taking assurance that the deliverables outlined are supported by the Maternity service and in line with the corporate objective to provide our hospital with the best digital capabilities and embed a digital first culture.

Liverpool Women's
NHS Foundation Trust

Digital.Maternity

Liverpool Women's Digital Maternity Strategy 2022-2025

Maternity & Digital Services

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

Introduction:
Delivering Digital.Maternity

Welcome to Digital.Maternity a strategy that sets out the digital direction for Liverpool Women's over the next 3 years. The three year timescale is required to achieve the ambitions set out and considering the rapidly changing digital landscape in Maternity care. As part of Digital.Generations we have seen a positive cultural change in the adoption and engagement with Digital and this strategy will build on this. We acknowledge that things change quickly in both Digital and Maternity landscape and therefore are committed to reviewing this Maternity Digital strategy on an annual basis to ensure its aims and values align to local, regional and national priorities.

The aim of this strategy is to ensure that Liverpool Women's Hospital has the best Maternity digital capabilities to provide safe and effective care and maximise collaboration with our women and partners.

By delivering this, we will ensure we are aligned to both our local Digital.Generations and Future Generations strategies, regional and national strategies and place Maternity women, their families and staff at the centre of what we do.

Digital.Maternity will achieve this aim by:

- Ensuring we place our women at the heart of our digital journey through clinically led , digitally driven change with support from our digital team
- Equipping and supporting our Maternity clinical team with the training and equipment to use our digital systems in the correct and most effective way with a focus on promoting good quality assessments and data
- Harnessing new technologies that build on existing digital systems and processes.
- Providing our women and staff with the right information at the right time, streamlining our systems through better integration both locally and regionally.

Working Together

Working in partnership is essential and we will further strengthen our work and partnership with our Cheshire & Merseyside(C&M) Health Care Partnership (HCP) , Local Maternity System (LMS), Liverpool ‘place’ and the Maternity Voices Partnership (MVP). We will continue to build on existing relationships with our key suppliers of Digital Technology and engage at a national level to deliver change in line with recommendations set out in the Maternity Transformation Programme, Ockendon report and other national maternity policies.

Our Themes

This strategy will deliver on the four key themes linked to those set out in Digital.Generations:

- Digital.Identity: empower our women and staff through better digital capabilities
- Digital.Fundamentals: deliver brilliant digital standards and a better experience for our staff
- Digital.Excellence: better integrate our local systems and improve our digital links with the Integrated Care Partnership (ICP), LMS and C&M organisations
- Digital.Innovations: we will use innovative maternity focused technology and data to improve our processes and experience for women and staff.

Where are we now?

Our Maternity Service

Liverpool Women's is a Trust specialising in the health of women and their babies. Our maternity multi disciplinary team cares for women and their babies from conception, to birth,& postnatally. Midwives supported by obstetricians and our neonatal team provide around the clock care for premature and new born babies needing specialist care. We are the recognised specialist provider for high risk maternity care in Cheshire and Mersey region including fetal medicine, maternal medicine and the highest level of maternity care. We deliver around 8000 babies a year both within the Hospital and in the community and care for over 1200 babies on our neonatal unit.

Digital.Generations

Digital.Generations, our over-arching digital strategy launched in 2020 outlines how as a Trust we will deliver patient focussed digital change across the organisation. This strategy looks to further build on the aims and workstreams of Digital.Generations both celebrating the significant achievements already delivered and identifying key objectives that have emerged since its inception. We will also ensure that the aims of this strategy align with our Trust strategy Future Generations, Trust values and aims. Although this strategy focusses primarily on Maternity services, the strategy cuts across the whole hospital and all digital change affects all staff and women receiving care at our Hospital.

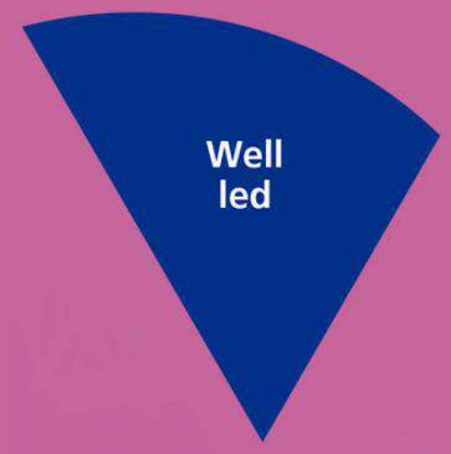
What Good Looks Like (WGLL)

WGLL, published by NHSX following the significant digital change after the Covid-19 pandemic draws on local learning, building on established good practice to provide clear guidance to digitise, connect and transform services safely and securely. This will improve the outcomes, experience and safety of our citizens.

We will use this to benchmark our current Maternity digital maturity and ensure our aims and objectives are aligned to the framework.

Where are we now?

What Good Looks Like



As a specialist women's hospital, we are proud to have a dedicated Maternity digital team. Our two Digital Midwives provide expert guidance, support and training for our Maternity workforce. Our associate Chief Clinical Informaion Officer (CCIO) for Family Health provides digital and medical expertise. Associate CCIOs for Gynaecology and Clinical Support Services and Digital Nurses ensure that we have a collaborative approach to a woman's digital pathway throughout the whole pregnancy. The clinical digital maternity team work as part of the wider digital team, providing a cohesive approach to digital systems

We implemented a full Maternity Electronic Patient Record (EPR) in January 2021 covering a woman's journey from booking through to discharge from Maternity. This is delivering significant benefits to both women and staff at LWH. Highlights include: Personal Health Record for all women receiving care at Liverpool Women's; Remote access for all staff to complete maternity record; Enhanced audit & reporting (fully audit-able in real time); Better data protection (more secure, more transparent); Safer (documentation legible and accessible); Information is documented once and used multiple times.

As a cyber essentials + site we provide a secure and highly available service for our clinical staff. We have upgraded our network, Wi-Fi and VPN connection within the previous 12 months to ensure a robust and reliable infrastructure. Through our robust clinical digital team we have clinical safety officers overseeing our digital developments and placing clinical safety at the heart of our digital systems. Having undertaken multiple significant clinical system deployments in the previous 18 months we have an experienced clinical and digital teams in place to safely enhance our digital capabilities.

Where are we now?

What Good Looks Like

Our switch to a full Maternity EPR has only been enabled through supporting our staff to embrace change. Our Digital Midwives provide continuous support and training for our clinical staff and are supported through provision of the tools to work remotely and flexibly. Our midwives work remotely through a secure VPN connection, where connectivity is an issue our Maternity EPR allows offline working. Through implementing VDI and enhancing our single sign on functionality we have improved access to systems where possible.

Our focus is always on the women receiving care at LWH. Our women can access their online maternity personal health record from when they inform us of their pregnancy via self-referral in the online portal, and we have already started work to better share the right information at the right time with other healthcare providers to ensure that our women experience safe and effective transfer of care between organisations.

We have been the first Trust to successfully integrate the Perinatal Institute GROW 2.0 charts into a Maternity EPR, ensuring that staff and women are able to easily access GROW charts and ultimately improve the care we can provide. We offer women choice through remote consultations and with telemedicine we have been able to provide consultations in neighbouring Trusts for women requiring ICU care not available on our Hospital site.

We are committed to utilising available data to improve care and drive decision planning within the organisation. With the availability of all aspects of a woman's Maternity care available for analysis and interrogation our digital dashboards initiative is providing better insight in to the care we deliver. We are committed to improving information sharing across the region, working with partners to make the right data available at the right time for the women we care for.

Where do we want to be?

What outcomes do we want to achieve?

As the largest and only specialist women's hospital, we want to be a leader in providing staff and women with the best digital capabilities to facilitate the best care possible. We have already achieved several elements of Digital. Generations, significantly delivering a Maternity EPR and a digital patient held record for every woman receiving Maternity care at LWH.

We will now focus on optimising system access and functionality to support. Local system integration should cover all of our main systems and the right information should be in the right place at the right time. Where direct system is not possible, we want to explore innovative options to move data where it needs to be. We want to ensure that on implementation of our Trust-wide EPR, that our Maternity system works side by side with a single point of access and contextual links to other key systems. Integration with our Neonatal system is fundamental and this must be seamless, so clinical staff can feel confident and assured that information can be entered once and shared where required.

We want to integrate regionally with our ICP and LMS, promoting data sharing between providers in a safe and concise manner. We want to help shape the platform and content of aggregated data that should be shared across the LMS to ensure that we, and all Maternity providers, feel assured in utilising this data to improve care and effectively benchmark care. We want to continue in the development of our Maternity Services Dataset content and ensure data is of good quality to support decision making.

We want to ensure our staff are working in the most efficient way possible across all of our clinical systems. Systems should be optimised to support clinical processes. Staff should have the right equipment with the best possible access to our live systems. We want to support our staff in joining this digital journey, providing training and support over multiple platforms to ensure our offer equitable for all staff.

Our Themes

The themes outlined in Digital.Generations still reflect the requirements of our Digital service and capability and can be aligned to this strategy. These are: Digital.Identity; Digital.Fundamentals; Digital.Excellence; Digital.Innovations

Digital.Identity

Digital.Fundamentals

Digital.Innovation

Digital.Excellence

Improve women's access to their Personal Health Record	Right device, right place, right time	Automation & efficiency	System wide integration
Equitable digital access to our services for women	One system, one login	Intelligent data	Enhanced, concise, structured data sharing
Embedding Digital Leadership	Trust wide EPR	Use of artificial intelligence	Aligned local, regional & national reporting
Digital training & engagement	Data completeness & Data quality	GROW chart integration	Digital dashboards
Staff support	One single pregnancy record	Telemedicine	Web based Maternity EPR

How Do We Get There?

The aims of this strategy will be delivered through collaboration between clinical digital staff across the Trust. To fully deliver the aims the strategy will cross several existing and future workstreams. The high level programmes are below our principles we will follow and our specific deliverables we aim to complete, linked to national drivers and the WGLL framework.

NHS Technology Funds

We were successful in our bids to both the Digital Maternity Unified Transformation Fund and the Unified Tech Fund, both of which have and will contribute to delivering the aims of the strategy.

Regional Collaboration

We will not be able to meet the objectives of this strategy without working with our partners across Cheshire & Merseyside.

Trust-wide EPR Implementation

We have committed to upgrading our current PAS system MEDITECH Magic to MEDITECH Expanse with the programme progressing well and implementation scheduled during 22/23. The implementation of a modern EPR facilitates enhanced integration between our main clinical systems and contextual launches between systems. The digital maternity team are central to the success of the programme and delivering a truly streamlined digital experience for our staff and women.

Maternity Digital Optimisation

We will continually optimise our systems, ensuring that we facilitate the safest and most efficient processes through our digital systems.

Maternity EPR Upgrade

Following our Trust-wide EPR implementation we will focus on upgrading our Maternity EPR to a cloud based version facilitating better connectivity and experience for our staff.

The Power of Data & Digital Dashboard

Our clinical digital team working with our BI team will further develop our reporting from our Maternity and related systems.

Staff Engagement

Our clinical digital team working to provide the best support for our Maternity staff. We want to have digital leaders and champions across the Maternity workforce promoting a digital first approach.

Our Digital Principles

In line with our Trust strategy we will deliver this strategy according to our digital principles and trust values

Our clinical digital and digital staff will work to these principles in delivering the aims of the strategy

Principle	Objective	Trust Values
Alignment	Clear **alignment** to regional Maternity drivers, the national Maternity Transformation Plan, Ockenden, CNST guidance and other national policy	Ambition & Learn
Simplify	Make our Maternity systems **simple** and easy to navigate with a single point of access to a woman's complete clinical record	Engage & Learn
Digitally Responsible	Ensure we bring our whole workforce on the journey to improve our digital capabilities for staff and women. We are all **digitally responsible**!	Engage, Learn Care & Respect
'With' and not 'To'	Ensure that digital change is **clinically led** and **digitally delivered**. Work closely with out clinical and operational staff to deliver systems and processes that they need.	Engage, Learn & Respect
Right Technology	Ensure our staff have the **right device** that is connected and right for the environment they deliver care in whether this be on a delivery suite or a woman's home	Engage & Care
Not so technical	Focus on **simplifying** our systems and processes. Reduce the number of clinical systems and ensure data is available in the right system at the right time	Engage & Respect
Digital Innovators	We will utilise and enhance our digital Maternity team, engaging as many staff on the ground to maximise the number **digital champions** across the service	Engage, Ambition & Learn
Listen & Learn	We will **listen** to our women and **learn** from our previous experiences in implementing Maternity systems and digital development through Covid-19	Ambition, Engage, Learn & Care
One-team	Our clinical digital and digital team will work hand in hand as a **single service** delivering safe and seamless change and innovation	Engage, Care & Respect

Digital.Identity

Programme	Initiative	How	Measuring Success	When	WGLL Framework
Regional Collaboration	Improve women's access to their Personal Health Record	We will work closely with our Maternity Voice Partnership to listen and learn from the experiences of our women and their interactions with their digital notes.	Reports are available monitoring access to the Personal Health Record	2023/2024	Empower citizens - Ensure that people can access and contribute to their health and care data
Maternity Digital Optimisation	Equitable digital access to our services for women	Working with our Patient Experience team and Cultural Liaison Midwife, we will focus on ensuring the digitally deprived and those with language or social barriers have the opportunity to access their digital notes to support their care.	Reports split by ethnicity, language and deprivation index will allow daily monitoring. Actions undertaken to improve adoption	2023/24	Empower citizens - Have a clear digital inclusion strategy, incorporating initiatives to ensure digitally disempowered communities are better able to access and take advantage of digital opportunities
Staff Engagement	Embedding Digital Leadership	Our digital clinical team is well established. We will focus on embedding digital leadership across our organisation, with all of our leaders reinforcing a digital first approach.	Staff engagement	2023/24	Create and encourage a digital first approach and share innovative improvement ideas from frontline health and care staff
Staff Engagement	Digital training & engagement	We will as outlined in this strategy undergo significant digital transformation. We will bring our staff on this journey with us providing bespoke training across multiple platforms. We will cater for our staff, providing opportunities based on our staffs needs.	Staff satisfaction and data quality monitoring	2022/23	Support your staff to work flexibly, remotely, and across multiple wards or sites
Staff Engagement	Staff Support	As a 24 hour service Maternity staff need round the clock digital support. Through our helpdesk provision we will extend this to provide 24 hour internal support for our Maternity EPR.	24 hour support available	2023/24	Support People - Provide access to digital support services 24 hours per day, resulting in high first-time fixes

Digital.Fundamentals

Programme	Initiative	How	Measuring Success	When	WGLL Framework
NHS Technology Funds	Right device, right place, right time	As part of the technology funds, we have successfully procured a range of hardware to support our clinical staff. Community staff will have new mobile phones, new computers on wheels in clinical areas and K2 portals will provide better connectivity and efficiency. Our network and Wi-Fi will be upgraded to ensure a robust and secure infrastructure.	Device usage and staff satisfaction	2022/23	Ensure smart foundations - Ensure staff have access to the technology and devices that best support their roles
Trust wide EPR Implementation	Trust wide EPR	We will implement MEDITECH Expanse to fully digitise all aspects of patient care. Through this we will reduce the number of clinical systems in use for our staff.	MEDITECH Expanse go live	2022/23	Ensure smart foundations - Extend the use and scope of your electronic care record systems to all services, ensuring greater clinical functionality and links to diagnostic systems and electronic prescribing and medicines administration (EPMA)
Trust wide EPR Implementation	One system, one login	With MEDIECTH Expanse we will deliver contextual links to our main clinical systems. Staff will be able to open one system, enter a patient's details once and access all information across multiple systems. With all systems active directory authenticated, our single sign on functionality enhanced and VDI solution available staff will be able to move seamlessly between systems and devices.	MEDITECH Expanse go live, Single Sign & VDI	2022/23	Ensure smart foundations - Maintain a central, organisation-wide, real-time electronic care record system
The Power of Data & Digital Dashboards	Data completeness & Data quality	We will provide enhanced data completeness and quality reporting to provide assurance on our data quality across Maternity. Through development of live reports, leaders will be able to view in real-time the completeness and quality of documentation in every woman's care record.	Dashboards available and highlighting improvements	2023/24	Healthy Populations -Use data to inform care planning and decision making in your organisation
Maternity Digital Optimisation	One single pregnancy Maternity record	We will focus on better integrating documentation across a whole pregnancy. Information from pre and early pregnancy will be easily available within our Maternity EPR, our Trust wide EPR will hold summary information relating to antenatal, intrapartum and postnatal care.	Integrated systems	2022/23	Support people - Support your staff to work flexibly, remotely, and across multiple wards or sites

Digital.Innovations

Programme	Initiative	How	Measuring Success	When	WGLL Framework
The Power of Data & Digital Dashboards	Automation & efficiency	We will utilise Robotic Process Automation to replace repetitive manual tasks, with a focus on helping clinical staff. We have already implemented a process for estimated delivery dates. New processes including automatic incident logging will see better data completeness and improved efficiency.	Implementation of RPA processes	2023/24	Improve care - Provide decision support and other tools to help clinicians follow best practice and eliminate unwarranted variation across the entire care pathway
The Power of Data & Digital Dashboards	Intelligent data	With our Maternity EPR every piece of data is available for analysis. We will ensure this is used innovatively to provide in depth analysis in an easy to understand format for clinical and operational teams.	Dashboard development	2023/24	Improve Care - Use data and digital solutions to redesign care pathways across organisational boundaries to give patients the right care in the most appropriate setting
The Power of Data & Digital Dashboards	Use of artificial intelligence	We will explore the use of artificial intelligence to better predict our demand for Maternity services. Using data from across a woman's pathway, we will develop a tool to predict a woman's EDD based on their clinical history.	Development of AI tool and report	2024/25	Support People - Create and encourage a digital first approach and share innovative improvement ideas from frontline health and care staff
NHS Technology Funds	GROW chart integration	We will integrate the Perinatal Institute GROW 2.0 chart in to our maternity EPR K2 to ensure this is available at all times to both women and clinicians.	Successful integration and availability	2022/23	Empower citizens - Ensure that citizens have access to care plans, test results, medications, history, correspondence, appointment management, screening alerts and tools
Regional Collaboration	Telemedicine	We will build on the success of our telemedicine project and facilitate remote consultations for pregnant women receiving care across our region.	Further rollout of telemedicine	2024/25	Improve care - Provide remote consultations, monitoring and care services, promoting patient choice and sustainability

Digital.Excellence

Programme	Initiative	How	Measuring Success	When	WGLL Framework
Maternity Digital Optimisation	System wide integration	We will integrate our systems to ensure data is recorded once and used multiple times. MEDITECH Expanse and K2 will have referral and birth interfaces. We will improve our imaging, neonatal, fetal medicine, and pathology interfaces with our Maternity EPR. All Maternity data will be shared in near real-time with primary care and our Cheshire & Merseyside shared record.	Interfaces made live	2023/24	Provide front-line staff with the information they need to do their job safely and efficiently at the point of care, for example Integrated Care System (ICS) shared care record
Regional Collaboration	Enhanced, concise, structured data sharing	We will work with our partners across Cheshire & Merseyside to facilitate both aggregated and patient level data sharing to support both patient care, service planning and improve performance.	Improved data sharing	2023/24	Healthy populations - Contribute data and resources to the ICS-wide population health management platform and use this intelligence to inform local care planning
The Power of Data & Digital Dashboards	Aligned local, regional & national reporting	We will work to ensure that our information reporting locally, regionally and nationally provides a single version of the truth. Whilst requirements and aggregation will vary, the underlying data source will be consistent and reliable.	Aligned dashboards	2023/24	Healthy populations - Use data to inform care planning and decision making in your organisation
NHS Technology Funds	Digital dashboards	We will provide our clinical teams with access to real time digital dashboards which incorporate data from relevant clinical systems, improving patient flow and care.	Digital whiteboards available across Maternity wards	2023/24	Support people - Provide front-line staff with the information they need to do their job safely and efficiently at the point of care, for example ICS shared care record
Maternity EPR Upgrade	Web based Maternity EPR	We will upgrade our Maternity EPR to provide a web based system, meeting the requirements of the Digital Maternity Record Standard.	Upgrade of K2	2023/24	Ensure smart foundations - Maintain a central, organisation-wide, real-time electronic care record system

Delivering Digital.Maternity

Delivering Digital.Maternity will be a Trust-wide process and will only be achievable with effective governance, engagement with staff across our Trust and collaboration with our HCP, LMS and C&M Trusts.

Digital Leadership & Engagement-

We will provide consistent and effective digital leadership for all staff to deliver this strategy. We will learn from our Maternity EPR implementation and changes through Covid-19. We will engage with all staff groups across the Trust to promote ownership of digital changes across all staff and settings. Our maternity digital champions and leaders will ensure that digital leadership and promotion is sustainable and adopted across the workforce.

Partnership Working

Our links with our HCP and LMS will be vital in our success. Through a shared vision and collaborative working we can deliver our objectives and create sustainable change. Through working closely with peer organisations across Cheshire & Merseyside we will keep women at the heart of this strategy and shared care pathways.

Benchmarking

Complete and accurate data will be key to monitoring the effectiveness of this strategy. There is a wealth of Maternity benchmarking data across multiple platforms. The National Maternity Dashboard, NMPA audits and regional initiatives, such as the Northwest Coast Clinical Network Dashboard. All provide an insight into how we compare against our peers. Through triangulating local and national data, we can monitor our progress in both capturing data effectively, and ultimately, improve the care that we provide for our women and pregnant people.

Governance

The Family Health Division, through the monthly board meetings and regular updates at Digital Hospital Sub-committee (DHSC), will oversee the implementation and progress of this strategy. DHSC will report in to the Finance, Performance & Business Development Committee providing board level oversight of the strategy. For the significant programmes of work, separate project boards will be required to provide assurance on the implementation of these. We will undertake all system implementations and developments in line with the clinical safety standards as set out by the Digital Technology and Assessment Criteria. The Maternity Transformation Board will have oversight of the key deliverables and ensure these are implemented

Quality Committee Chair's Highlight Report to Trust Board
25 July 2022

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• The Committee noted issues relating to the functionality of the Sepsis Delivery Group and Sepsis reporting highlighted by the Safety and Effectiveness Sub-Committee. It noted the action to address attendance and shared learning by the Sub-Committee to improve the position. • The Committee raised concerns in relation to the following metrics within the performance report, a raised volume of cancelled operations, and worsening response times to complaints. • A presentation was received providing an overview of the maternity transformation programme and the workstreams and governance structure underpinning the programme. Whilst the Committee was assured by the programme methodology and timelines, there was a concern expressed that the volume of workstreams and objectives could derail progress. It was agreed that appropriate priority setting would be key to successful delivery. • The CQC Insight Tool intelligence indicated that the overall performance for the Trust was declining. The Committee expressed concern in relation to this position ahead of future independent inspections. It was noted that the soon to be launched Ward Accreditation process would strengthen the evidence. Consideration towards conducting a deepdive would also be discussed by the Executive Lead.	• Noted that the following reviews had been commissioned to review out of hours surgical work, the gynaecology emergency care pathway and a task and finish working group had been initiated to review access issues to the emergency department. • Received the key findings from the NWODN review to benchmark LWH Neonatal Unit against St Mary's Hospital (SMH). The review was designed to look beyond clinical care alone and focused on patient populations, case-mix, workforce and organisation of care delivery, cause of death, and timing and governance around the review of deaths. The Committee noted no clear causative factor identified through the process of this review for the elevated mortality rates at LWH however there had been multifactorial areas of improvement identified by both the Birmingham and NWODN reviews. Plans are in place to implement as many gains as possible in delivery of care to babies, many of which have already been enacted. • The Committee requested strengthened narrative within the Maternity Incentive Scheme update to provide assurances to the Board.
Positive Assurances to Provide Identify in brackets should the assurance provide evidence against the CQC Key Questions – SAFE | EFFECTIVE | CARING | RESPONSIVE | WELL LED	**Decisions Made**
• Noted that performance for the 52-week wait target had been maintained and plateaued. The Committee considered the stretch target to achieve the metric by 2023 as opposed to the national timeline of 2025 and asked the operational team to consider the impact on the wider health system. (RESPONSIVE) • The Committee was assured by the Future Generations update noting that the Committee would receive a monthly update in relation to delivery of the FG Programme alongside the FPBD Committee. (RESPONSIVE) • The Committee received the monthly serious incident report noting that the governance team had established a review group for SI action plans with divisions to improve the evidence that lessons had been learned as requested by the Committee in June 2022. (RESPONSIVE/ WELL LED) • The Committee received the Integrated Governance Report for Q1 2022/23 noting triangulation of key risks for the Trust.	

• The Committee received the Complaints Annual Report and the NICE Annual Report. (ALL) • The Committee received a progress update from the LocSSIPs Implementation Group Q1 2022/23. Background information would be added to the next iteration of the report to inform the new members of the Committee. (SAFE) • The Committee noted safety issues sighted by the Maternity Safety Champions and ongoing action to effectively disseminate information. (SAFE)	

Summary of BAF Review Discussion (Board Committee level only)

- The Committee reviewed the Quality related BAF risks. No changes to risks scores were recommended. No risks closed on the BAF for Quality Committee.

Comments on Effectiveness of the Meeting / Application of QI Methodology

- Appropriate discussion time dedicated to identified reports
- Difficulties to conduct the meeting due to Trust internet connection issues.

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
68.	Board Assurance Framework	Assurance	75.	Mortality review Update	Information
69.	Sub-committee Chair Reports	Assurance	76.	Maternity Incentive Scheme (CNST) Year 4 – Scheme Update July 2022	Information
70.	Quality Performance Report Month 3, 2022/23	Assurance	77.	Family Health Divisional Safety Champions – Q1 22-23 Report	Assurance
71.	Future Generations Update	Information	78.	Complaints Annual Report	Assurance
72.	Serious Incidents & Learning Report (monthly update)	Assurance	79.	NICE Annual Report	Information
73.	Integrated Governance Assurance Report Quarter 1	Assurance	80.	Progress of the LocSSIPs Implementation Group Q1 2022/23	Assurance
74.	CQC Insight Tool	Assurance			

3. 2022 / 23 Attendance Matrix

Core members	April	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Tony Okotie	✓	✓	✓	**NM**								
Susan Milner	✓	**A**	**NM**									
Louise Kenny	**A**	✓	✓	A								
Sarah Walker, Chair	**NM**	✓	✓	A								

Gloria Hyatt	**NM**	✓	✓	✓								
Jackie Bird	**NM**	✓	✓	✓								
Marie Forshaw	✓	✓	✓	✓								
Gary Price	✓	✓	✓	✓								
Lynn Greenhalgh	✓	✓	✓	✓								
Eva Horgan	✓	✓	✓	✓								
Michelle Turner	✓	✓	✓	✓								
Nashaba Ellahi	✓	✓	✓	A								
Philip Bartley	✓	✓	✓	A								

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	**22/23/97b**		**Date: 01/09/2022**	
Report Title	**Quality & Operational Performance Report**			
Prepared by	***Gary Price, Chief Operating Officer, Dr Lynn Greenhalgh, Medical Director and Dianne Brown, Chief Nurse & Midwife***			
Presented by	***Gary Price, Chief Operating Officer***			
Key Issues / Messages	***For assurance – To note the latest performance measures***			
Action required	**Approve ☐**	**Receive ☐**	**Note ☐**	**Take Assurance ☒**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	***To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it***	***For the intelligence of the Board / Committee without in-depth discussion required***	***To assure the Board / Committee that effective systems of control are in place***
	Funding Source (If applicable): N/A			
	For Decisions - in line with Risk Appetite Statement – If no – please outline the reasons for deviation.			
	The Board is asked to note the assurances within the Month 4 Quality and Operational Performance Report.			
Supporting Executive:	***Gary Price, Chief Operating Officer***			

Equality Impact Assessment *(if there is an impact on E,D & I, an Equality Impact Assessment **MUST** accompany the report)*			
Strategy ☐	Policy ☐	Service Change ☐	Not Applicable ☒
Strategic Objective(s)			
To develop a well led, capable, motivated and entrepreneurial ***workforce***	☐	To participate in high quality research and to deliver the most ***effective*** Outcomes	☒
To be ambitious and ***efficient*** and make the best use of available resource	☒	To deliver the best possible ***experience*** for patients and staff	☒
To deliver ***safe*** services	☒		
Link to the Board Assurance Framework (BAF) / Corporate Risk Register (CRR)			
Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks*		Comment:	

5.2 Failure to fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership	
Link to the Corporate Risk Register (CRR) – CR Number: N/A	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Finance, Performance and Business Development Committee	August 22	COO	Circulated via email
Quality Committee	July 22	COO	The Committee noted the report.

Liverpool Women's
NHS Foundation Trust

Trust Board Performance Report

This report has been produced to provide an exception position against the Trust's key performance standards. This page is designed to help readers interpret the report and understand the process for KPI selection and review.

Report Layout:

WE SEE Summary - this provides a breakdown of the number of KPIs that are meeting / failing targets for the most recent month of reported data.

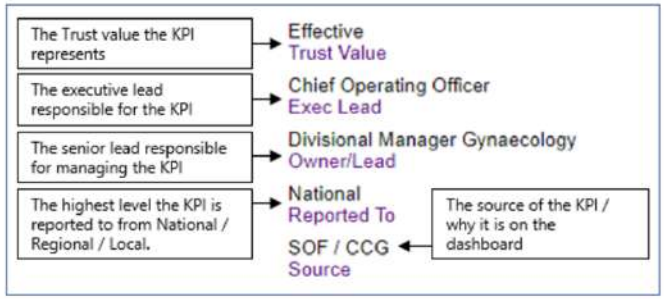
Cover Sheets - these provide an overview of performance with over arching narrative for each of the WE SEE values. In addition a selection of KPIs will be selected for a more in depth review. These are selected based on whether the KPI meets one or more of the following criteria:
•Outside of a control limit, having previously been within control limits
•A consecutive deterioration of performance over a quarter, which is not insignificant
•A significant drop in performance over the space of a month
•A consecutive improvement in performance over a quarter, which is not insignificant
•A significant increase in performance over the space of a month
•KPIs, that following specific analysis require review, or where a change in measurement or data production require escalation

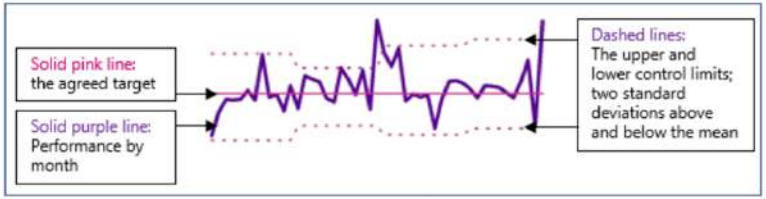
Data Sheets - these provide detailed information for each specific KPI measured. This includes data values for the previous 13 months, a sparkline included performance dating back to April 2018 where available. The sparkline graph includes the performance, target and control limits for the specific KPI. Within the data table the arrows represent whether performance has increased, decreased or remained the same. The colour coding is based on the target type as to whether this movement is positive or negative. All arrows apply to the performance and not other data items. In addition the target, target type, executive lead, operational / clinical owner / lead, source (why are we leasuring the KPI) and data quality kite mark (1 least confidence to 5 highest confidence). Narrative submitted by the KPI owner for the most recent month is included if provided.

Data Health Check - highlights where KPIs have denominators outside of control limits along with a summary of the data quality kite mark scores for each KPI.

KPI Lineage - shows for each committee / meeting that KPI is included within the performance dashboard

How to interpret the report:





Control limits are set using statistical process control. The standard deviation for each indicator is calculated based on the previous two financial years data unless recalculation is required due to service changes. the upper and lower control limits are two standard deviations above and below the mean performance level. Where appropriate data points will be removed and control limits recalculated if reasons for adverse performance are known and accepted.

Performance is reported one or two months in arrears depending on submission deadlines. The reporting month is highlighted against each specific KPI.

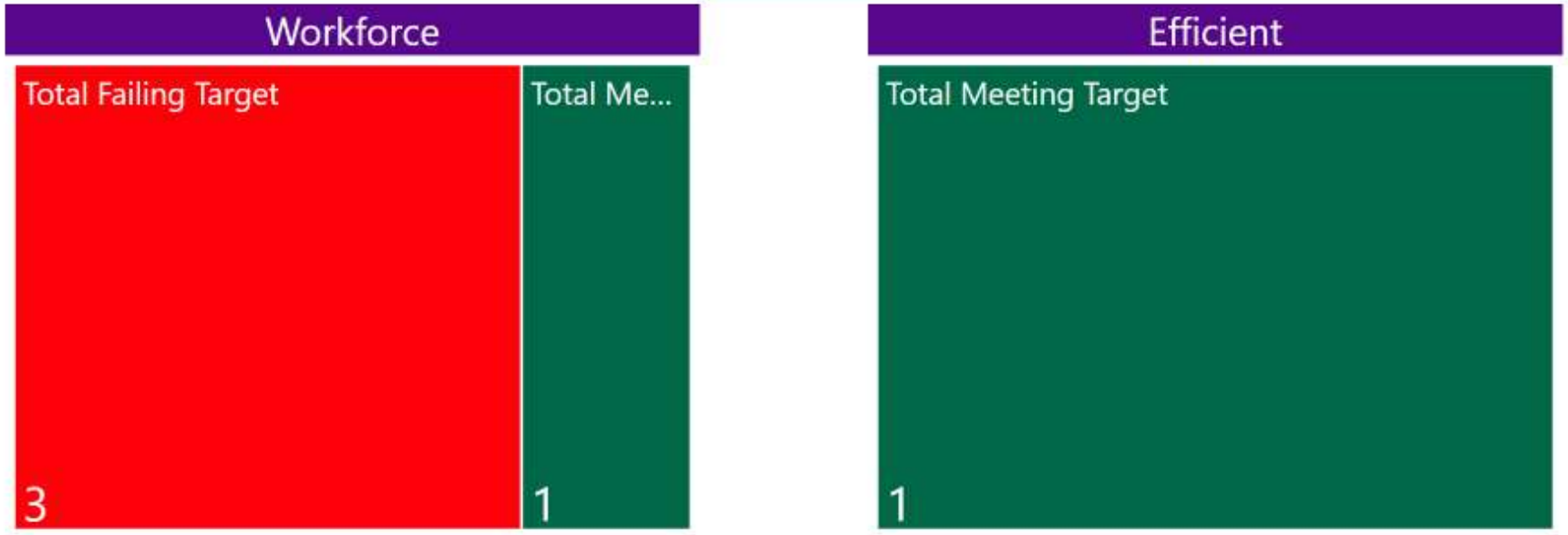
NHS
Liverpool Women's
NHS Foundation Trust

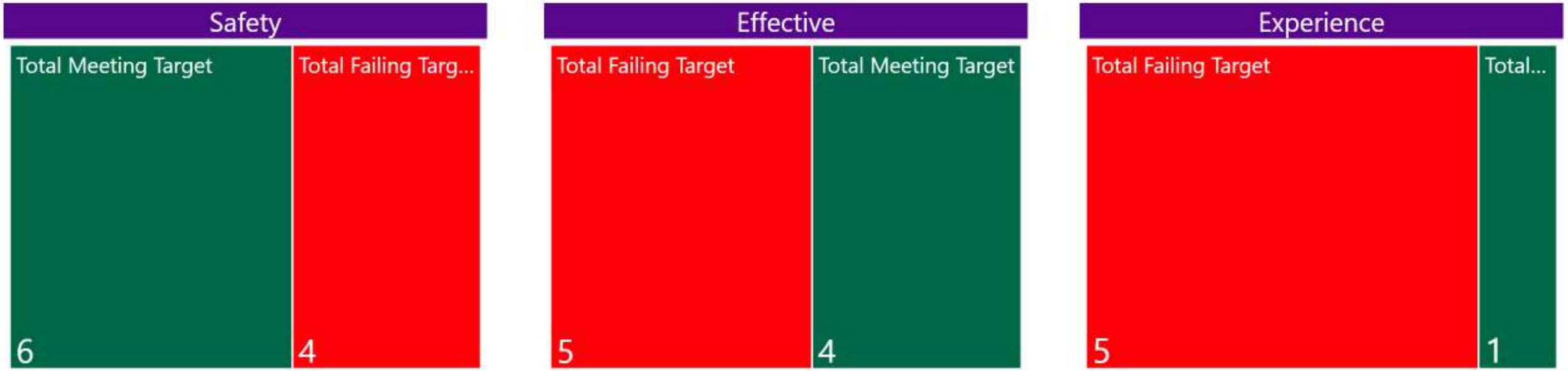
Trust Board

Performance Report

August 2022

WE SEE Summary





July 2022 – Maternity Facts

NHS Liverpool Women's NHS Foundation Trust

Thank you to all our families for choosing Liverpool Women's : Welcome to the world our July 2022 Babies.

645 Babies Born

217 Inductions of labour

10 Home Births

Girls 316

329 Boys

1339 Visits to Maternity Assessment Unit

2 Breech Births

Spontaneous Vaginal Births 290

14 Sets of Twins

13 Women recruited to research studies

110 Elective C - Sections

159 Emergency C - Sections

Have you had a July 2022 Baby? Why not send a picture to our Twitter or Facebook account. We'd love to hear from you. @LiverpoolWomens

Births on MLU 67

Instrumental Births 86

Women Booked For Care 734

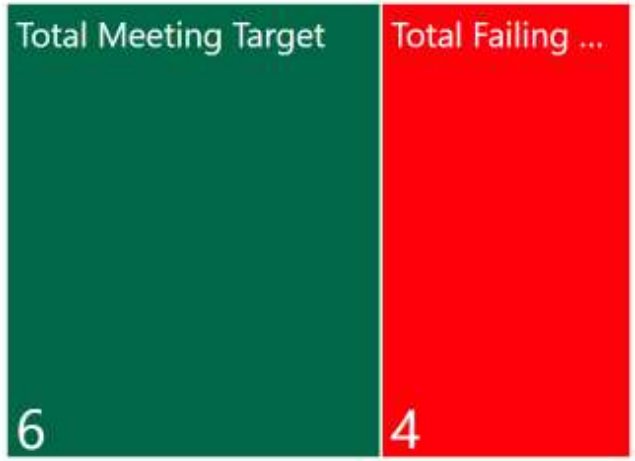
23 Pool Births

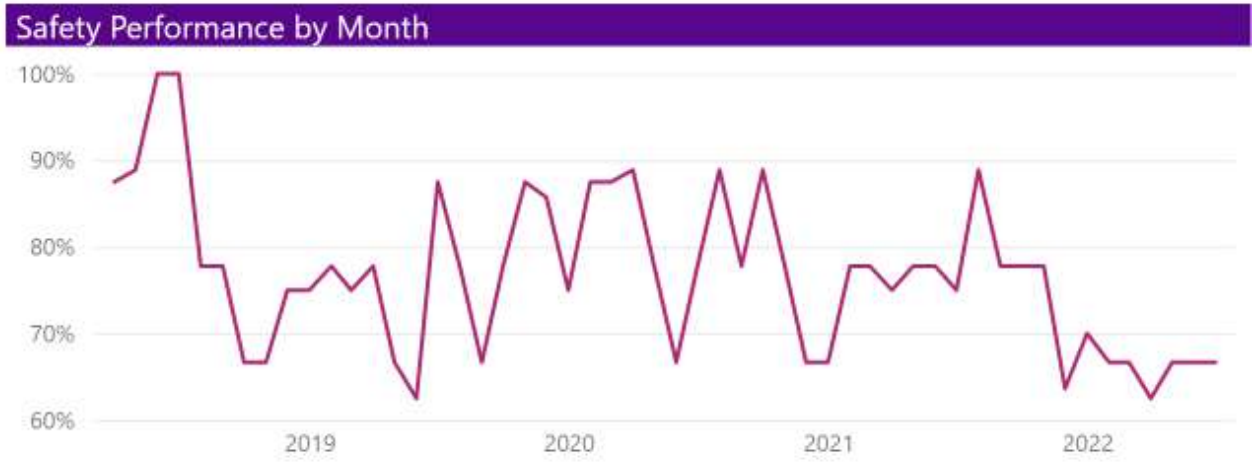
Heaviest Baby 11lb 9oz
Lightest Baby 1lb 4oz

Liverpool Pride 30th July: 18 Births.

Our busiest day: 16th July: 30 Births.

To deliver **Safe** services





Positive Developments

Serious Untoward Incidents - There are no overdue SI actions.
VTE – A VTE Lead has been appointed and prioritising VTE risk assessments to aid planned improvement trajectory to above threshold by the end of Quarter 2.

Areas of Challenge

The use of multiple systems to document assessments continues to be a challenge and the clinical team are fully engaged in MEDITECH Expanse programme to provide a more streamlined process for nursing and medical staff.

KPI	July 2021	August 2021	September 2021	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022	April 2022	May 2022	June 2022	July 2022
Serious Untoward Incidents: Open	8 →	5 ↓	9 ↑	9 →	13 ↑	16 ↑	19 ↑	19 →	17 ↓	14 ↓	13 ↓	14 ↑	18 ↑
Venous Thromboembolism (VTE)	84.58% ↓	88.55% ↑	87.96% ↓	90.64% ↑	86.25% ↓	86.39% ↑	84.16% ↓	85.86% ↑	86.38% ↑	89.11% ↑	89.5% ↑	87.26% ↓	89.11% ↑

These KPIs have been highlighted for the current reporting month based on the criteria highlighted in the report guidance

To deliver Safe Services – Serious Incidents

Overview

There was one SI in June 2022 making a total of three SI's reported for the year to date for 2022/23. Comparations to previous years are shown below.

Year Comparison

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	Total
2016-17	1	2	4	2	2	2	5	3	5	3	1	0	30
2017-18	2	4	1	0	0	1	2	4	1	0	5	0	20
2018-19	1	1	1	0	3	2	1	5	0	0	1	2	17
2019-20	2	4	0	0	3	1	1	2	2	0	0	0	13
2020-21	2	2	2	3	2	2	1	3	2	3	2	1	25
2021-22	0	2	3	0	1	4	1	4	3	4	3	3	28
2022-23	0	2	1										2

The number of Serious Incidents which occur in any given year can vary considerably as shown above for LWH data only. Due to SI data from Trusts not being published we are not able to benchmark this area. It is important to note that LWH has a clear process for the identification and investigation of SIs and has an open and honest approach to this.

To deliver Safe Services – Serious Incidents

June 2022 Serious Incidents

Service	StEIS Ref.	Reported in Line with Policy	Summary
Gynae	2022 - 12423	No	The patient underwent robotic assisted total hysterectomy, bilateral salpingo-oophorectomy, biopsy peritoneum right pelvis. After completion of surgery noted that there was faecal contamination in the uterine manipulator, further investigation revealed that there was an injury in the rectum and posterior vaginal wall which appeared to be related to the Mc-Cartney tube used for uterine manipulation. This was identified and senior consultant colleague and colorectal consultant surgeon were contacted, who helped with repair of the injury and undertook the necessary additional procedures. **Immediate Action Taken:** Statement to be requested from the Operating Surgeon Duty of Candour letter has been sent to the patient Report to MHRA, MHRA would normally in turn report to manufacturer **Immediate Lesson Learnt:** Governance Safety Lead reviewed the notes; the nature of the injury was unusual. Extreme vigilance and attention to details by the operating consultant only led to suspicion and correct diagnosis at the time. Management was exemplary.

To deliver Safe Services – Serious Incidents

HSIB Cases Reported and NHSR Early Notification Scheme

During June 2022 there were 2 cases which met the HSIB criteria and have been reported to HSIB.

	Jan	Feb	Mar	April	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Total
2019	0	3	1	0	3	1	2	0	0	0	1	2	13
2020	1	3 (1 rejected)	1 (rejected)	0	0	0	4 (3 rejected)	0	0	2	3 (2 rejected)	0	14
2021	1	1	2	0	2	0	1	0	3	1	3	1	7
2022	2	1	3	2	0	2							10 to date

The main themes of the incidents reported is in relation to; cooled babies, there have been small numbers of neonatal death and Hypoxic Ischaemic Encephalopathy (HIE):

Duty of Candour
There was one serious incidents reported in June 2022 and Duty Of Candour was 100% compliant.

Overdue Actions for reported Sis
At the time of writing this report there are no actions from Serious Incidents which are overdue.

Dissemination of learning from serious incidents

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

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

What next

The Governance Team have established a review group for serious incident action plans whereby the divisions are required to provide assurance that learning from incidents has been embedded in to culture and practice where necessary. The governance team are in the process of reviewing

To deliver Safe services - Safer Staffing

July 2022					
WARD	Fill Rate Day % RN/RM *	Fill Rate Day % Care staff **	Fill Rate Night % RN/RM *	Fill Rate Night % Care staff **	Supporting narrative (RN/RM = *; Care staff = **)
Gynae Ward	79.03%	73.12%	120.97%	93.55%	*July staffing fill rate is reflective of the current RN vacancy position alongside short and long-term sickness, further challenged with maternity leave, however safe staffing has been maintained by the ability to flexibly rotate RNs across the division. Due to the low bed occupancy of 34% in HDU the team were able to support ward inpatient care. The fill rate of 120.97% RN on nights reflects senior RN cover rotating between GED and inpatient area. The Allocate e-roster did not allow managers to reflect inter-divisional staff moves therefore those staff moves were missed from fill rates, this has now been resolved.
Induction & Delivery Suites	87.59%	83.87%	92.31%	100.00%	*Safe staffing required the Maternity bleep holder to redeploy RM to maintain clinical safety and prioritise 1:1 care in labour, which included the intermittent closure of MLU, and on occasions redeployment of staff from the Mat Base. Vacant shifts are requested to be filled with bank and agency as required. The obstetric unit was required to divert women on one occasion in month (for a period of 4hrs) due to staffing levels and acuity.
Maternity & Jeffcoate	72.35%	85.09%	77.88%	88.07%	*All vacant shifts requested to be filled with bank and agency as required. The Maternity bleep holder redeployed staff to maintain clinical safety to areas of high acuity and to ensure appropriate discharge flow to release capacity and ensure safe care maintained across maternity services.
MLU	61.29%	41.94%	73.39%	54.84%	*/**Due to internal escalation, there were 12 episodes of closure of MLU- and the staffing fill rate is reflective of the deployment of staff on these occasions to Delivery Suite to consolidate activity through one area for both RM and Care Staff.
Neonates (ExTC)	101.02%	96.77%	103.40%	79.03%	*/**Acuity and activity continue to run high within the NICU. Safe staffing was maintained and adjusted to meet the needs of acuity.
Transitional Care	54.84%	103.23%	93.55%	41.94%	**Activity remains consistent within TC with safe staffing maintained.

To deliver Safe services - Safer Staffing

Gynaecology: July Fill Rate

Fill-rate – July staffing fill rate is reflective of the current RN vacancy position alongside short and long- term sickness. The fill rate position is further challenged with maternity leave, however safe staffing has been maintained by the ability to flexibly rotate RNs across the division. Due to the low bed occupancy of 34% in HDU the team were able to support ward inpatient care. The fill rate of 120.97% RN on nights reflects senior RN cover rotating between GED and inpatient area. The Allocate e-roster did not allow managers to reflect inter-divisional staff moves therefore those staff moves were missed from fill rates, this has now been resolved.

All outstanding shifts are out on NHSP and to agency where necessary. Oversight of staffing continues twice daily where consideration is given to re-deploying staff to maintain safe care across all areas.

Attendance/ Absence – – sickness is reported as 6.53% in July with 33.4% STS and 66.26% LT. Return to work interviews managed as per policy. Maternity leave is at 3.61%.

Vacancies – Vacancy position is 8.43 WTE RNs with 3.61WTE awaiting start dates and 4.83WTE out to recruitment.

Red Flags – No staffing red flags recorded, 1 red flag reported related to medicines administration specifically due to antifungal IV therapy being prescribed and not available in the Trust. This was later obtained from another hospital.

Bed Occupancy – 61% for inpatient ward

CHPPD – 8.1

Neonates: July Fill Rate

Fill-rate – Occupancy and acuity throughout July has remained high, seeing occupancy of over 80% in all areas other than transitional care. To ensure safer staffing to meet the acuity needs there has been an increase in the use of bank staff. The escalation policy has been used and the department have worked closely with maternity colleagues to ensure where possible all transfers or refusals are appropriate.

Attendance/Absence - July saw a spike in covid absence of 3.82%, pushing overall sickness up from the previous month of 4.99% to 8.28%. 66% of sickness was short term and 34% was long term and being managed within policy. Turnover has reduced to just over 6%, well below the trust average of 13%. July saw 12.67 wte on maternity leave.

Vacancies - There are some vacancies at band 4, 5 and 6, there are none at band 7. Band 6 vacancies are out to advert. Band 4 and 5 vacancies are within Transitional care are also out to advert. The Band 5 vacancies within NICU – 6 wte are on hold as we are recruiting 25 wte nurses to Liverpool Neonatal Partnership in September that will need placements within NICU. These six band 5 posts will be recruited to later this year to ensure the gap does not widen.

Red Flags – There were no red flags

Bed Occupancy – Unit occupancy has run at 93.7% over July. This has seen an increase in IC to 80.1%, HD running at 86.1% and low dependency continuing to exceed capacity at 106.5%. We have seen a sustained increase in activity over the last 4 months. At all times safer staffing has been maintained and we are working with the team to look at how we can improve flow and efficiency within the unit to support this increased activity.

To deliver Safe services - Safer Staffing

Maternity: July Fill Rate

Fill-rate – Maternity continues to report levels of sickness above the trust target of 4.5%, within its midwifery and support staff group. Bank and agency usage continues due to sickness rates and to cover vacancy gaps. Maternity has been required to close MLU during this reporting period, to allow a consolidation of midwifery staffing to one clinical area. Clinical activity and staff rostered to MLU have been reallocated across the first floor of Maternity Services, to maintain safe midwifery care. Maternity undertakes a 4-hourly activity /acuity review, which allows senior midwifery staff to maintain safety by rotating staff to the areas of highest clinical need. Midwifery managers have been rostered into clinical rota gaps to support safe staffing during this period while enacting Business Continuity Plans.

Attendance/Absence – Maternity sickness is reported at 11.25% which is a combination of clinical, non-clinical and administration staff. This is an increase from the previous month at 9.68% and equated to 24.88wte. Maternity sickness has a higher rate of LT sickness than ST sickness (35%STS versus 65%LTS). Ward managers/matrons have individual sickness reviews, and maternity are planning return to work programmes with all LT employees to facilitate appropriate returns to work. A comprehensive sickness review programme overseen by the HRBP and Deputy HOM continues on a weekly basis and this oversight has supported the resolution of, and overall reduction in active LTS. Meetings with staff who are absent due to Long COVID have occurred following the change in legislation when they will return to contractual entitlements of occupational sick pay.

Vacancies – Current vacancy rate of 53.10 WTE for midwifery staff; this is an increase following new staffing establishments and increased headroom after BirthRate Plus report agreed and supported by Trust Board. Maternity maintains an active recruitment plan with a rolling NHS jobs advert for the B6 post; the service has also welcomed new individuals to the HOM and DOM posts at the beginning of July. There has been a commitment to over recruit for midwives and from this, conditional offers have been made to Band 5 midwives to commence as they receive PIN numbers in autumn - with extensive onboarding activities continued over the summer months to welcome 45.09wte. Maternity is currently implementing an International Recruitment programme as part of the Northwest Collaboration with 8 overseas educated midwives, however the lead trust for the collaborative have informed providers that there is an expected delay of the anticipated summer arrival date, and therefore arrival has been projected for early 2023.

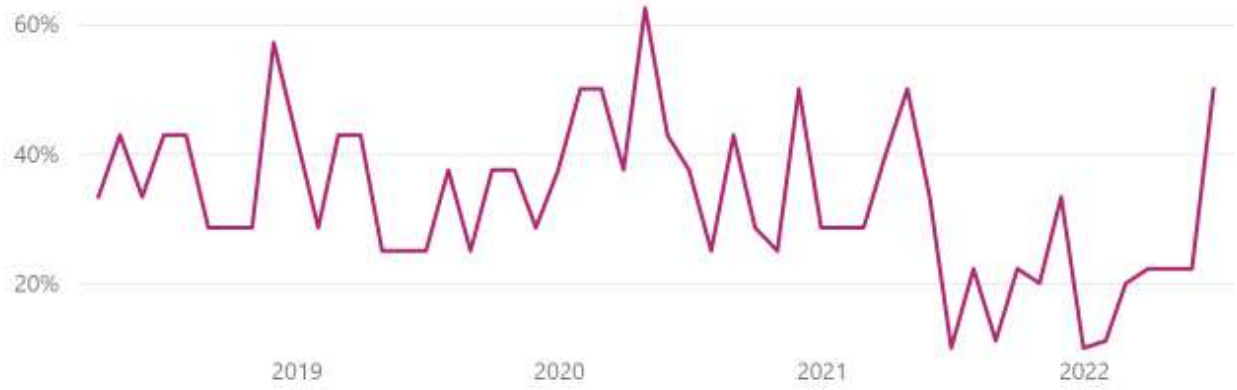
Red flags – Maternity have a positive reporting culture for red flags, with monthly oversight reports at the Maternity Risk and Clinical Meeting (MRC). These are also reported by the 104 Maternity bleep holder 4hrly as part of the bleep recording. In August live reporting will be enacted with the introduction of the Birth rate Plus Acuity App – where red flags are reported instantly and captured in conjunction with the acuity of the areas at that point. 1:1 Care in labour remains above 99% and all individual cases reviewed to ensure no adverse outcomes and presented at the MRC. The most common red flag reported in Maternity services is a delay in Induction of Labour for >4hours. This is due to ensuring the provision of a midwife to provide 1:1 care.

Bed Occupancy – Maternity continues to experience high levels of clinical activity and referrals from other units as a tertiary provider including in utero transfers. Following the appointment of a Deputy Divisional Manager, Maternity Capacity and Demand work is now being undertaken. Intermittent closure of the MLU due to staffing concerns has reduced the overall Intrapartum capacity and our low-risk offer, however our homebirth service has been maintained to facilitate choice for women.

To deliver the most **E**ffective outcomes

Total Failing Target
5

Total Meeting Target
4



Positive Developments

In line with the national recovery ask the Trust has no 104 week breeches and is on target to eliminate 78 week waiting patients by March 2023
In July the Trust has recovered the urgent 2 week wait position and also achieved the 31 day target for the first time since the start of the pandemic

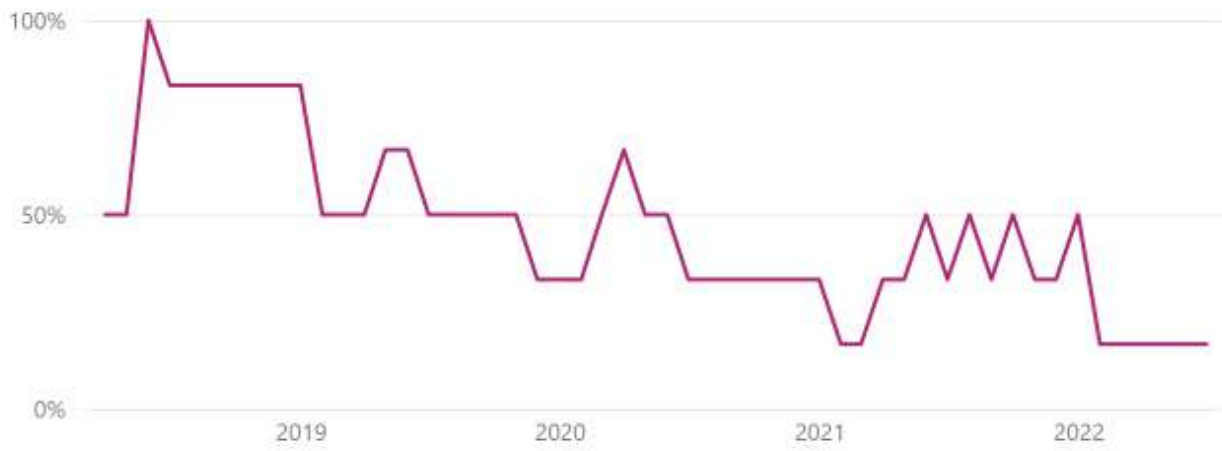
Areas of Challenge

The national ask for the 52 week position is for patients waiting this long to be eliminated by March 2025. The Trust has set itself a stretch target to achieve by Q3 2023/24. The detailed plan and schemes to achieve this has been sent to FPBD committee. August has seen a plateau in the rise of patients waiting in this cohort which is a positive sign.
The 62 day position remains a challenge. The patients that breech this target are often complex and related to challenges around off site diagnostics.

KPI	July 2021	August 2021	September 2021	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022	April 2022	May 2022	June 2022	July 2022
18 Week RTT: Incomplete Pathway > 104 Weeks	1	1	3	1	0	0	1	1	0	0	0	0	0
18 Week RTT: Incomplete Pathway > 52 Weeks	209	244	256	288	294	354	406	479	544	816	1145	1571	
18 Week RTT: Incomplete Pathway > 78 Weeks	4	12	39	21	3	3	11	12	12	26	29	33	35
All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (After Re-allocation)	16.13%	16.22%	6.06%	18.18%	44.83%	54.55%	34.78%	47.06%	18.75%	26.92%	29.17%	12.5%	10.53%
Cancer: 104 Day Breaches	1	3	5	3	3	3	2	2	2	4	2	4	5
Cancer: 2 Week Wait	95.32%	96.42%	96.06%	95.33%	97.04%	95.31%	76.65%	81.91%	67.87%	11.9%	52.71%	88.47%	93.29%
Cancer: 28 Day Faster Diagnosis	61.24%	71.12%	49.12%	64.14%	60.5%	59.93%	54.1%	57.91%	61.07%	55.1%	60.06%	58.63%	60.26%
Cancer: 31 Days from Diagnosis to 1st Definitive Treatment	64.52%	68.97%	54.05%	56.76%	86.67%	93.1%	84.62%	84.380%	95.65%	85.71%	84%	88.46%	96.3%
Overall size of Elective Waiting List	11782	11877	12389	12458	12736	13017	13481	13945	14461	15027	15553	16206	

These KPIs have been highlighted for the current reporting month based on the criteria highlighted in the report guidance

To deliver the best possible **E**xperience for patients and staff



Positive Developments

Diagnostics continues to improve with non-obstetric ultrasound performance driving the improvements. Cystometry continues to be a challenge and a mitigating action plan is being developed to improve performance in this area.

Areas of Challenge

A&E performance has been affected by sickness rates within the team. A review of current processes is due in September to streamline the pathway through GED.

KPI	July 2021	August 2021	September 2021	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022	April 2022	May 2022	June 2022	July 2022
A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge	95.95% ↓	96.06% ↑	97.43% ↑	96.58% ↓	98.64% ↑	95.36% ↓	97.02% ↑	94.11% ↓	89.73% ↓	90.94% ↑	92.38% ↑	91.55% ↓	89.2% ↓
Diagnostic Tests: 6 Week Wait	90.95% ↑	82.73% ↓	69.65% ↓	85.81% ↑	87.25% ↑	90.13% ↑	83.08% ↓	94.39% ↑	88.32% ↓	71.08% ↓	77.74% ↑	89.47% ↑	90% ↑

These KPIs have been highlighted for the current reporting month. In depth detail and narrative is included in the reporting pack

Neonatal Deaths per 1000 live Births

Target: **(Blank)**

Attribute	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
Performance Value	↑ 1.5	→ 1.5	→ 1.5	↑ 3	↑ 4.6	↓ 1.6	↓ 0	↑ 1.8	↓ 1.7	→ 1.7	↑ 3.1	↓ 1.6	↑ 4.7

DQKM

Safety
Trust Value

Medical Director
Exec Lead

Clinical Director Family Health
Owner/Lead

Local
Reported To

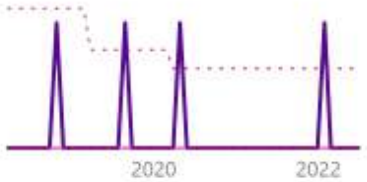
Trust
Source

Never Events

Target: **0**

Attribute	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
Performance Value	→ 0	→ 0	→ 0	→ 0	→ 0	→ 0	→ 0	↑ 1	↓ 0	→ 0	→ 0	→ 0	→ 0

DQKM



Safety
Trust Value

Medical Director
Exec Lead

Head of Governance
Owner/Lead

National
Reported To

Trust
Source

NHSE / NHSI Safety Alerts Outstanding

Target: **0**

Attribute	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
Performance Value	→ 0	→ 0	→ 0	→ 0	→ 0	→ 0	→ 0	→ 0	→ 0	→ 0	→ 0	→ 0	→ 0

DQKM

Safety
Trust Value

Director of Nursing & Midwifery
Exec Lead

Head of Governance
Owner/Lead

TBC
Reported To

TBC
Source

Venous Thromboembolism (VTE)

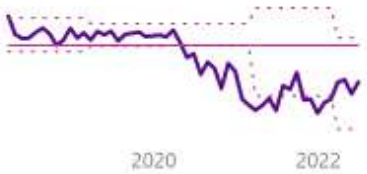
Target: **>= 95%**

Attribute	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
% Performance	↓ 84.58%	↑ 88.55%	↓ 87.96%	↑ 90.64%	↓ 86.25%	↑ 86.39%	↓ 84.16%	↑ 85.86%	↑ 86.38%	↑ 89.11%	↑ 89.5%	↓ 87.26%	↑ 89.11%
Denominator	↓ 1167	↑ 1127	↓ 1138	↑ 1111	↓ 1098	↑ 1029	↓ 1111	↑ 1011	↑ 1109	↑ 1047	↑ 1114	↓ 1052	↑ 1111
Numerator	↓ 987	↑ 998	↓ 1001	↑ 1007	↓ 947	↑ 889	↓ 935	↑ 868	↑ 958	↑ 933	↑ 997	↓ 918	↑ 990

DQKM

May 2022

The divisional actions taken is starting to demonstrate an improvement in VTE performance, however it is acknowledged this remains under threshold. The division anticipate this will improve further by the end of Q2. A VTE Lead is now established in role and prioritising VTE assessments move across to PENS to aid completion.



Safety
Trust Value

Medical Director
Exec Lead

Deputy Medical Director
Owner/Lead

National
Reported To

SOF / CCG
Source

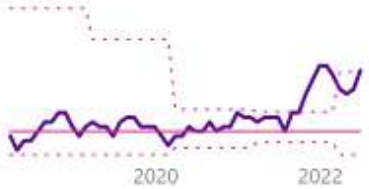
Serious Untoward Incidents: Open

Target: <5

Attribute	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
Performance Value	→ 8	↓ 5	↑ 9	→ 9	↑ 13	↑ 16	↑ 19	→ 19	↓ 17	↓ 14	↓ 13	↑ 14	↑ 18

DQKM

July 2022 There had been a spike in SI's reported in July 2022. The reduced number of Investigating officers (IOs) has impacted the ability for timely investigation. This has since been rectified as further IO's trained. Weekly cross-divisional governance meetings provide oversight and monitoring. Following the increase seen, 1 SI de-escalated, 2 are finalised. No SI's are overdue.



Safety
Trust Value

Director of Nursing & Midwifery
Exec Lead

Head of Governance
Owner/Lead

TBC
Reported To

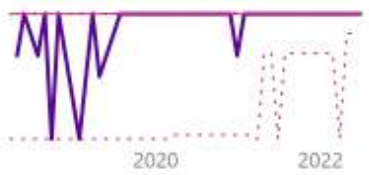
TBC
Source

Serious Untoward Incidents: Number of SUI's reported to CCG within agreed timescales

Target: 1

Attribute	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
% Performance		↑ 100%	→ 100%	→ 100%	→ 100%	→ 100%	→ 100%	→ 100%	→ 100%		↑ 100%	→ 100%	→ 100%
Denominator	0	↑ 1	→ 4	→ 1	→ 4	→ 3	→ 4	→ 2	→ 3	0	↑ 2	→ 1	→ 6
Numerator	0	↑ 1	→ 4	→ 1	→ 4	→ 3	→ 4	→ 2	→ 3	0	↑ 2	→ 1	→ 6

DQKM



Safety
Trust Value

Director of Nursing & Midwifery
Exec Lead

Head of Governance
Owner/Lead

TBC
Reported To

TBC
Source

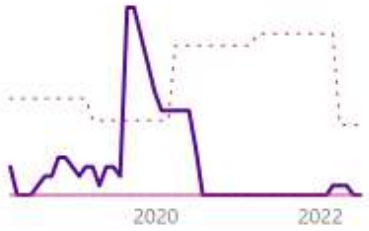
Serious Untoward Incidents: Number of SUI's with actions outstanding

Target: 0

Attribute	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
Performance Value	→ 0	→ 0	→ 0	→ 0	→ 0	→ 0	→ 0	→ 0	↑ 1	→ 1	→ 1	↓ 0	→ 0

DQKM

May 2022 This has now been submitted to the CCG on 10 June 2022 and is no longer overdue.



Safety
Trust Value

Director of Nursing & Midwifery
Exec Lead

Head of Governance
Owner/Lead

TBC
Reported To

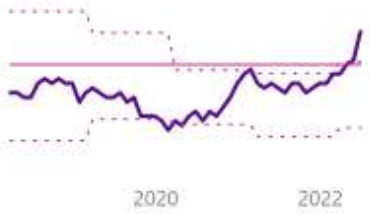
TBC
Source

Serious Untoward Incidents: New (Rolling per year)

Target: 24 /year

Attribute	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
Performance Value	↓ 19	↓ 18	↑ 20	→ 20	↓ 18	↑ 19	↑ 20	→ 20	↑ 22	→ 22	↑ 24	↑ 25	↑ 31

DQKM



Safety
Trust Value

Director of Nursing & Midwifery
Exec Lead

Head of Governance
Owner/Lead

TBC
Reported To

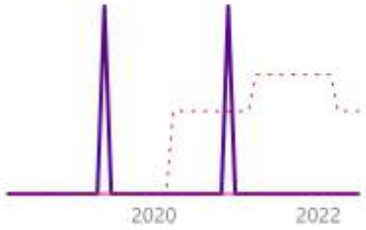
TBC
Source

Infection Control: MRSA

Target: **0**

Attribute	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
Performance Value	→ 0	→ 0	→ 0	→ 0	→ 0	→ 0	→ 0	→ 0	→ 0	→ 0	→ 0	→ 0	→ 0

DQKM



Safety
Trust Value

Director of Nursing & Midwifery
Exec Lead

Infection Control Lead
Owner/Lead

National
Reported To

SOF / CCG
Source

Infection Control: Clostridium Difficile

Target: **1**

Attribute	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
Performance Value	→ 0	→ 0	→ 0	→ 0	→ 0	→ 0	→ 0	→ 0	→ 0	→ 0	→ 0	→ 0	→ 0

DQKM

Safety
Trust Value

Director of Nursing & Midwifery
Exec Lead

Infection Control Lead
Owner/Lead

National
Reported To

SOF / CCG
Source

Flu Vaccine Uptake Trustwide

Target: **>=100%**

Attribute	Dec-21	Jan-22
% Performance	↑ 57.06%	↑ 57.06%
Denominator	↑ 1933	↑ 1971
Numerator	↑ 1103	↑ 1135

DQKM

Safety
Trust Value

Chief People Officer
Exec Lead

Deputy Director of Workforce
Owner/Lead

National
Reported To

External
Source

18 Week RTT: Incomplete Pathway > 52 Weeks

Target: 0

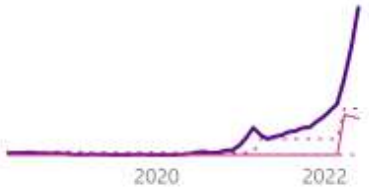
Attribute	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Performance Value	↑ 194	↑ 209	↑ 244	↑ 256	↑ 288	↑ 294	↑ 354	↑ 406	↑ 479	↑ 544	↑ 816	↑ 1145	↑ 1571
Target Value	↑ 0	↑ 0	↑ 0	↑ 0	↑ 0	↑ 0	↑ 0	↑ 0	↑ 0	↑ 0	↑ 430	↑ 410	↑ 390

April 2022 There continues to be significant delays for patients waiting for surgery. there are also increasing numbers of patients who are waiting over 52 weeks for their first out-patient appointment.

Patients are currently dated for surgery based on clinical priority. The position is monitored via Access Board and PTL and currently sits on the divisional risk register.

The Division continues to carefully monitor waiting times and clinic utilisation. WLIs are staffed as often as possible.

DQKM



Effective
Trust Value

Chief Operating Officer
Exec Lead

Deputy Chief Operating Officer
Owner/Lead

National
Reported To

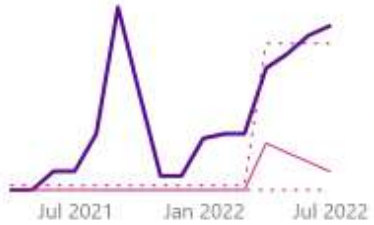
SOF / CCG
Source

18 Week RTT: Incomplete Pathway > 78 Weeks

Target: 0

Attribute	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
Performance Value	→ 4	↑ 12	↑ 39	↓ 21	↓ 3	→ 3	↑ 11	↑ 12	→ 12	↑ 26	↑ 29	↑ 33	↑ 35
Target Value	→ 0	↑ 0	↑ 0	↓ 0	↓ 0	→ 0	↑ 0	↑ 0	→ 0	↑ 10	↑ 8	↑ 6	↑ 4

DQKM



Effective
Trust Value

Chief Operating Officer
Exec Lead

Deputy Chief Operating Officer
Owner/Lead

National
Reported To

SOF / CCG
Source

18 Week RTT: Incomplete Pathway > 104 Weeks

Target: 0

Attribute	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
Performance Value	↑ 1	→ 1	↑ 3	↓ 1	↓ 0	→ 0	↑ 1	→ 1	↓ 0	→ 0	→ 0	→ 0	→ 0
Target Value	↑ 0	→ 0	↑ 0	↓ 0	↓ 0	→ 0	↑ 0	→ 0	↓ 0	→ 0	→ 0	→ 0	→ 0

DQKM

Effective
Trust Value

Chief Operating Officer
Exec Lead

Deputy Chief Operating Officer
Owner/Lead

National
Reported To

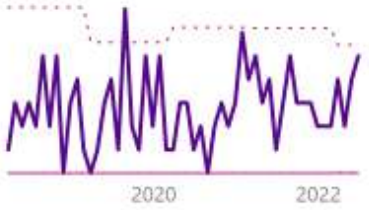
SOF / CCG
Source

Cancer: 104 Day Breaches

Target: 0

Attribute	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
Performance Value	↓ 1	↑ 3	↑ 5	↓ 3	→ 3	→ 3	↓ 2	→ 2	→ 2	↑ 4	↓ 2	↑ 4	↑ 5

DQKM



Effective
Trust Value

Chief Operating Officer
Exec Lead

Divisional Manager Gynaecology
Owner/Lead

National
Reported To

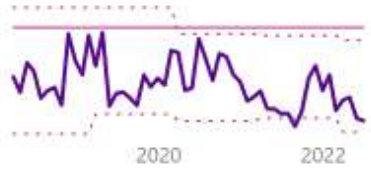
External
Source

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

Target: >=85%

Attribute	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
% Performance	16.13%	16.22%	6.06%	18.18%	44.83%	54.55%	34.78%	47.06%	18.75%	26.92%	29.17%	12.5%	10.53%
Denominator	15.5	18.5	16.5	16.5	14.5	11	11.5	8.5	16	13	12	12	9.5
Numerator	2.5	3	1	3	6.5	6	4	4	3	3.5	3.5	1.5	1

DQKM



Effective
Trust Value

Chief Operating Officer
Exec Lead

Divisional Manager Gynaecology
Owner/Lead

National
Reported To

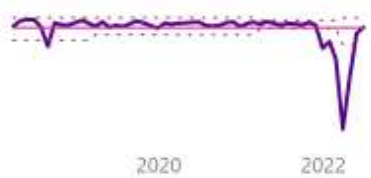
CCG
Source

Cancer: 2 Week Wait

Target: >= 75%

Attribute	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
% Performance	95.32%	96.42%	96.06%	95.33%	97.04%	95.31%	76.65%	81.91%	67.87%	11.9%	52.71%	88.47%	93.29%
Denominator	299	279	279	300	338	277	257	293	305	294	425	295	313
Numerator	285	269	268	286	328	264	197	240	207	35	224	261	292

DQKM



Effective
Trust Value

Chief Operating Officer
Exec Lead

Divisional Manager Gynaecology
Owner/Lead

National
Reported To

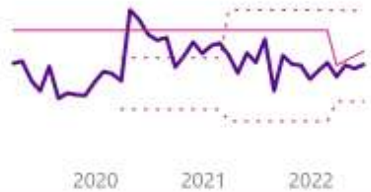
CCG
Source

Cancer: 28 Day Faster Diagnosis

Target: >= 75%

Attribute	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
% Performance	61.24%	71.12%	49.12%	64.14%	60.5%	59.93%	54.1%	57.91%	61.07%	55.1%	60.06%	58.63%	60.26%
Denominator	307	232	397	290	362	287	305	297	298	314	328	307	307
Numerator	188	165	195	186	219	172	165	172	182	173	197	180	185
Target %	75%	75%	75%	75%	75%	75%	75%	75%	75%	60%	62%	64%	66%

DQKM



Effective
Trust Value

Chief Operating Officer
Exec Lead

Divisional Manager Gynaecology
Owner/Lead

National
Reported To

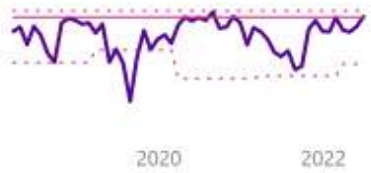
SOF / CCG
Source

Cancer: 31 Days from Diagnosis to 1st Definitive Treatment

Target: >=96%

Attribute	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
% Performance	64.52%	68.97%	54.05%	56.76%	86.67%	93.1%	84.62%	84.380%	95.65%	85.71%	84%	88.46%	96.3%
Denominator	31	29	37	37	30	29	26	32	23	21	25	26	27
Numerator	20	20	20	21	26	27	22	27	22	18	21	23	26

DQKM



Effective
Trust Value

Chief Operating Officer
Exec Lead

Divisional Manager Gynaecology
Owner/Lead

National
Reported To

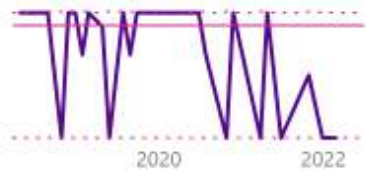
CCG
Source

Cancer: 62 Day Screening Referrals (Percentage)

Target: >=90%

Attribute	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
% Performance	→ 0%				↑ 50%		→ 0%		→ 0%				
Denominator	→ 0.5	0	0	0	↑ 2	0	→ 1	0	→ 1	0	0	0	0
Numerator	→ 0	0	0	0	↑ 1	0	→ 0	0	→ 0	0	0	0	0

DQKM



Effective
Trust Value

Chief Operating Officer
Exec Lead

Divisional Manager Gynaecology
Owner/Lead

National
Reported To

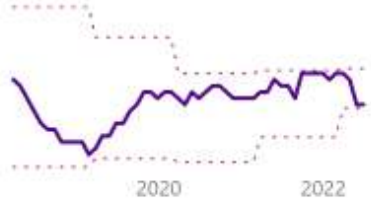
CCG
Source

Intensive Care Transfers Out (Rolling 12 Months)

Target: (Blank)

Attribute	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
Performance Value	↓ 13	→ 13	↓ 11	↑ 15	→ 15	→ 15	→ 15	↓ 14	↑ 15	→ 15	↓ 14	↓ 10	→ 10

DQKM



Effective
Trust Value

Medical Director
Exec Lead

Deputy Medical Director
Owner/Lead

Local
Reported To

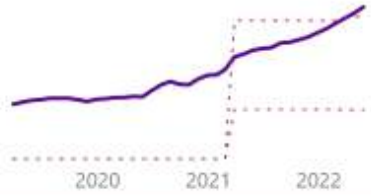
Trust
Source

Overall size of Elective Waiting List

Target: (Blank)

Attribute	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Performance Value	↑ 11609	↑ 11782	↑ 11877	↑ 12389	↑ 12458	↑ 12736	↑ 13017	↑ 13481	↑ 13945	↑ 14461	↑ 15027	↑ 15553	↑ 16206

DQKM



Effective
Trust Value

Chief Operating Officer
Exec Lead

Divisional Manager Clinical Sup...
Owner/Lead

National
Reported To

SOF
Source

Proportion of patient activity with an ethnicity code

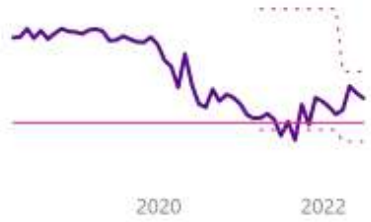
Target: >=96%

Attribute	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
% Performance	↓ 95.59%	↑ 96.03%	↓ 95.45%	↑ 96.58%	↓ 95.94%	↑ 96.8%	↓ 96.68%	↓ 96.49%	↓ 96.27%	↑ 96.41%	↑ 97.16%	↓ 96.94%	↓ 96.79%
Denominator	↓ 15200	↑ 14120	↓ 15339	↑ 14525	↓ 15273	↑ 13116	↓ 14184	↓ 13606	↓ 15244	↑ 13938	↑ 15695	↓ 14553	↓ 14374
Numerator	↓ 14529	↑ 13560	↓ 14641	↑ 14028	↓ 14653	↑ 12696	↓ 13713	↓ 13128	↓ 14675	↑ 13438	↑ 15250	↓ 14108	↓ 13912

DQKM

February 2022

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



Effective
Trust Value

Chief Operating Officer
Exec Lead

Divisional Manager Gynaecology
Owner/Lead

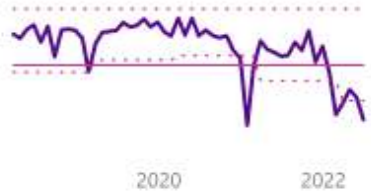
National
Reported To

SOF
Source

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

Target: >= 95%

Attribute	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
% Performance	95.95%	96.06%	97.43%	96.58%	98.64%	95.36%	97.02%	94.11%	89.73%	90.94%	92.38%	91.55%	89.2%
Denominator	1036	989	971	1052	883	969	1039	1086	1139	1038	1129	1112	1194
Numerator	994	950	946	1016	871	924	1008	1022	1022	944	1043	1018	1065



Experience
Trust Value

Chief Operating Officer
Exec Lead

Divisional Manager Gynaecology
Owner/Lead

National
Reported To

CCG
Source

DQKM

June 2022

The gynaecology division has reached 91.6% against a target of 95% for this KPI in June 2022.

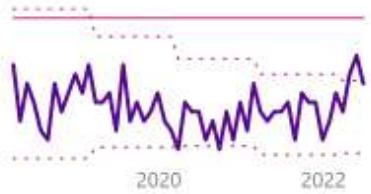
GED performance has continued to be affected by sickness within the clinical team and junior doctor team which has impacted on the number of breaches.

The gynaecology divisional team are in the process of conducting a review of systems and processes in GED to allow for streamlining of patients and pathways. This commenced in June 2022.

Complaints: Number Received

Target: <= 15

Attribute	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
Performance Value	5	6	2	7	6	6	2	4	7	5	9	11	8



Experience
Trust Value

Director of Nursing & Midwifery
Exec Lead

Head of Audit, Effectiveness an...
Owner/Lead

Local
Reported To

Trust
Source

DQKM

August 2021

The number of complaints received by the Gynaecology division was 5 in August 2021. An increase from 3 in July.

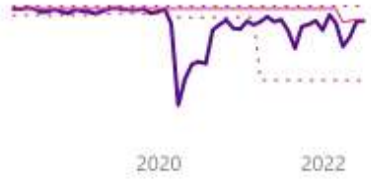
This KPI has been flagged due to the increased number of complaints received in comparison to the previous 2 years performance but it is still well within the target range (n=15).

The reason for the increase in complaints received has predominantly been due to increased waiting times and the cancellation of appointments which has often been due to clinician sickness/isolation.

Diagnostic Tests: 6 Week Wait

Target: >= 99%

Attribute	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
% Performance	90.95%	82.73%	69.65%	85.81%	87.25%	90.13%	83.08%	94.39%	88.32%	71.08%	77.74%	89.47%	90%
Denominator	652	695	794	747	737	628	733	713	796	816	867	731	780
Numerator	593	575	553	641	643	566	609	673	703	580	674	654	702
Target %	99%	99%	99%	99%	99%	99%	99%	99%	99%	89%	90%	91%	91%



Experience
Trust Value

Chief Operating Officer
Exec Lead

Divisional Manager Clinical Sup...
Owner/Lead

National
Reported To

CCG
Source

DQKM

Overall performance for DM01 in July was 90.00% with 702/780 diagnostic tests completed within 6 weeks. This represents a 5% increase on June's position. Positive performance was seen in DEXA, which saw all patients within the 6-week target. Non-obstetric ultrasound performed well at 95% and Cystometry continues to hamper the DM01 performance with 58% tests (n= 63/111) completed within target. Gynaecology divisional management have been tasked with creating a mitigating action plan for cystometry, which is scheduled to be presented at the next Access Recovery Board (29/08/22).

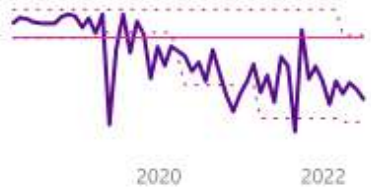
Friends & Family Test: A&E % positive

Target: **95%**

Attribute	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
% Performance	90.91%	88.89%	75%	96.67%	86.21%	88.89%	85.71%	80.77%	85.71%	83.08%	85.37%	84%	81.91%
Denominator	33	27	36	30	29	36	35	26	28	65	82	75	94
Numerator	30	24	27	29	25	32	30	21	24	54	70	63	77

DQKM

July 2022 — 82% positive feedback from patients attending A%E the division will review displeased comments to ensure we can add to you said we did to make improvements



Experience
Trust Value

Director of Nursing & Midwifery
Exec Lead

Head of Nursing Gynaecology
Owner/Lead

National
Reported To

External
Source

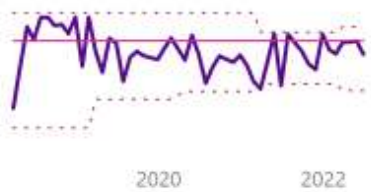
Friends & Family Test: In-patient/Daycase % positive

Target: **0.95**

Attribute	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
% Performance	85.45%	96.4%	94.53%	92.79%	90%	88.89%	96.4%	93.07%	92.23%	94.74%	94.74%	94.95%	92.16%
Denominator	110	111	128	111	130	108	111	101	103	114	95	99	102
Numerator	94	107	121	103	117	96	107	94	95	108	90	94	94

DQKM

July 2022 — 92% patients responded positively, the importance of Feedback as to how we are doing is encouraged both in the day case and the inpatient area and we continue to deliver excellent care



Experience
Trust Value

Director of Nursing & Midwifery
Exec Lead

Head of Nursing Gynaecology
Owner/Lead

National
Reported To

External
Source

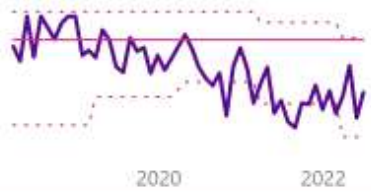
Friends & Family Test: Maternity % positive

Target: **95%**

Attribute	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
% Performance	82.03%	77.5%	76.28%	81.52%	81.2%	85.27%	80.14%	84.09%	79.28%	83%	89.47%	78.33%	83.76%
Denominator	128	160	156	184	133	129	146	132	111	100	95	120	117
Numerator	105	124	119	150	108	110	117	111	88	83	85	94	98

DQKM

July 2022 — Limited number of service user feedback received. To discuss strategies for improvement at Maternity Voices Partnership meetings.



Experience
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Director of Nursing & Midwifery
Exec Lead

Head of Midwifery
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National
Reported To

External
Source

KPI Lineage

Metric Description	WE SEE	Board	FPBD	Quality	PPF	Family Health Division	CSS Division	Gynaecology Division	Maternity Clinical	Neonates Clinical (MDT)
18 Week RTT: Incomplete Pathway > 52 Weeks	Effective	Y	Y	Y						
A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge	Experience	Y	Y	Y				Y		
All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (After Re-allocation)	Effective	Y	Y	Y				Y		
Cancer: 104 Day Breaches	Effective	Y	Y	Y				Y		
Cancer: 2 Week Wait	Effective	Y	Y	Y				Y		
Cancer: 28 Day Faster Diagnosis	Effective	Y	Y	Y			Y	Y		
Cancer: 31 Days from Diagnosis to 1st Definitive Treatment	Effective	Y	Y	Y				Y		
Cancer: 62 Day Screening Referrals (Percentage)	Effective	Y	Y	Y				Y		
Clinical Mandatory Training Compliance	Workforce	Y		Y	Y					
Complaints: Number Received	Experience	Y		Y						
Diagnostic Tests: 6 Week Wait	Experience	Y	Y	Y				Y		
Financial Sustainability Risk Rating: Overall Score	Efficient	Y	Y							
Flu Vaccine Uptake Trustwide	Safety	Y	R	Y	Y					
Friends & Family Test: A&E % positive	Experience	Y		Y				Y		
Friends & Family Test: In-patient/Daycase % positive	Experience	Y		Y				Y		

KPI Lineage

Metric Description	WE SEE	Board	FPBD	Quality	PPF	Family Health Division	CSS Division	Gynaecology Division	Maternity Clinical	Neonates Clinical (MDT)
Friends & Family Test: Maternity % positive	Experience	Y		Y					Y	
Infection Control: Clostridium Difficile	Safety	Y		Y						
Infection Control: MRSA	Safety	Y		Y						
Intensive Care Transfers Out (Rolling 12 Month)	Effective	Y		Y						
Mandatory Training Compliance	Workforce	Y		Y	Y					
Neonatal Deaths per 1000 live Births	Safety	Y				Y				Y
Never Events	Safety	Y		Y						
NHSE / NHSI Safety Alerts Outstanding	Safety	Y		Y					Y	
Overall size of Elective Waiting List	Effective	Y					Y	Y		
Proportion of patient activity with an ethnicity code	Effective	Y	Y					Y		
Serious Untoward Incidents: Number of SUI's reported to CCG within agreed timescale	Safety	Y		Y			Y			
Serious Untoward Incidents: Number of SUI's with actions outstanding	Safety	Y		Y			Y	Y		
Serious Untoward Incindents: New	Safety	Y					Y	Y		
Serious Untoward Incindents: Open	Safety	Y		Y						
Sickness	Workforce	Y		Y	Y					
Turnover	Workforce	Y			Y					
Venous Thromboembolism (VTE)	Safety	Y		Y						

Planned Preventative maintenance

PPM Description	Responsibility	Accountable	Contractors	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
FIRE															
Fire Alarm Testing (W, 3M)	Estates/Contractor	Estates Manager	Tailored Fire	1	1	1	1	1	1	1	1	1	1	1	1
Fire Doors (M)	Estates	Estates Manager		1	1	1	1	1	1	1	1	1	1	1	1
Fire Damper Inspection & Test (12M)	Contractor		VSS/Swegon												
Fire Fighting Equipment (12m)	Contractor		Tailored Fire											12	
Dry Risers (12M)	Contractor		Tailored Fire											12	
Fire Hydrants (12M)	Contractor		Tailored Fire											12	
Emergency Light test (,M,12M)	Estates	Estates Manager		1	1	1	1	1	1	1	1	1	1	1	1
WATER															
Water Treatment (M) (heating and cooling)	Contractor		Aquaserv	1	1	1	1	1	1	1	1	1	1	1	1
Water Tank Cleaning (12M)	Contractor		Aquaserv												12
Water Sampling (M)	Contractor		Aquaserv	1	1	1	1	1	1	1	1	1	1	1	1
Water Safety PPMs	Estates	Estates Manager	Estates	1	1	1	1	1	1	1	1	1	1	1	1
SECURITY															
Access Control System (3M)	Contractor		Clarion	3			3			3			3		
CCTV (3M)	Contractor		HESIS	3			3			3			3		
Intruder Alarm (6M)	Contractor		Clarion	6						6					
Baby Tagging System (3M)	Contractor		X-Tag	3			3			3			3		
LIFTS															
Passengers & Goods Lift (M, 12M)	Contractor		Rubax lifts	1	1	1	1	1	1	1	1	1	1	1	1
Ladder & Access Platforms (6M)	Contractor	Estates Manager			6						6				
ELECTRICAL															
Commercial Dishwashers (6M)	Contractor		JLA	6						6					
Commercial Washing Machine Dryers (6M)	Contractor		JLA	6						6					
Electric Boilers (12M)	Contractor		JLA	12											
Kitchen Equipment (6M)	Contractor		JLA	6						6					
Portable Appliances Testing (12M)	Estates/Contractor	Estates Manager	OCS									12			
Food Trolleys (6M)	Contractor		Socomel	6						6					
Weighing Equipment (3M)	Contractor		Accurate weight	3			3			3			3		
Fixed Appliance Testing (12M)	Contractor		Parr Group	12											
Bed Pan Washers service (6M)	Contractor		Dekomed	6						6					
Bed Pan Washers Testing (3M)	Contractor		Dekomed	3			3			3			3		
Nurse Calling System (3M)	Contractor		Austco	3			3			3			3		
External Light Cleaning (12M)	Estates	Estates Manager					12								
Internal Light Cleaning (12M)	Estates	Estates Manager					12								
Lightning Protection (12 M)	Contractor		PTSG											12	
Generator Testing (W, M,6M,12M)	Estates/Contractor	Estates Manager	Ingrams	1	1	1	1	1	1	1	1	1	1	1	1
Trend Building Management System (M)	Contractor		BTS	1	1	1	1	1	1	1	1	1	1	1	1
LV Distribution System (12M)	Estates	Estates Manager		12											
HV Distribution System (12M)	Contractor		Ipsum	12											
Refridgeration (6M) Catering/Domestic	Contractor		Effective Air	6						6					
MEDICAL GASES															
Medical Gases (3M)	Contractor		Medi-teknique	3			3			3			3		
HVAC (Heating, ventilation and air conditioning															
Boiler Burners (6M)	Contractor		Equans					6						6	
Pressure Units (6M)	Contractor		Equans	6						6					

Planned Preventative maintenance

PPM Description	Responsibility	Accountable	Contractors	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Main Chiller Unit (6)	Contractor		Equans			6									
Air conditions (6M)	Contractor		Effective Air	6						6					
Ventilation System(6M) (AHU)	Estates	Estates Manager		6						6					
NICU Chillers Unit (3M)	Contractor		Carrier	3			3			3			3		
Ceiling Grills Extract Fans (6M)	Estates	Estates Manager		6						6					
OTHER															
Car Park Pay & Display (6M)	Contractor		Newpark	6						6					
Grass Cutting and Grounds Maintenance	Contractor		Rice lane landsca	1	1	1	1	1	1	1	1	1	1	1	1
Windows maintenance (12M)	Estates/Contractor	Estates Manager	Fenestral								12				

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	***22/23/97c***		**Date: 01/09/2022**	
Report Title	**Neonatal Mortality Review Update**			
Prepared by	***Rebecca Kettle, Neonatologist***			
Presented by	***Rebecca Kettle, Neonatologist***			
Key Issues / Messages	**This report outlines the Trust response to the St Mary's review undertaken into neonatal mortality.**			
Action required	**Approve ☐**	**Receive ☒**	**Note ☐**	**Take Assurance ☐**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	***To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it***	***For the intelligence of the Board / Committee without in-depth discussion required***	***To assure the Board / Committee that effective systems of control are in place***
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – Y/N ***If no – please outline the reasons for deviation.***			
	The Board is asked to receive the report.			
Supporting Executive:	***Dr Lynn Greenhalgh, Medical Director***			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

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

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Quality Committee	**July 2022**	**Medical Director**	**The Committee noted no clear causative factor identified through the process of this review for the elevated mortality rates at**

			LWH however there had been multifactorial areas of improvement identified by both the Birmingham and NWODN reviews. Plans are in place to implement as many gains as possible in delivery of care to babies, many of which have already been enacted. The Committee requested that a detailed action plan be developed and for this to report to the Board.

EXECUTIVE SUMMARY

BACKGROUND

In 2020 NWODN published a preterm mortality report for the period 2015-2018; this benchmarking report identified LWH as a network outlier for preterm mortality specifically for babies born <27 weeks gestation. In response to this finding an independent review, requested by LWH, was completed by Birmingham Women's Hospital. This review focused on clinical case reviews of the most preterm group of babies. The Birmingham review identified differences in clinical practice but did not identify a reason for the increased mortality rates. Following the review, it was evident the preterm mortality rates remained high at LWH in 2019 / 2020, both on regional and national benchmarking. Therefore, a further review was commissioned within the NWODN, at the request of LWH, to benchmark against St Mary's Hospital (SMH), the other surgical NICU in the region, which benchmarks favourably nationally.

METHODOLOGY

The NWODN review was designed to look beyond clinical care alone. The review also focused on patient populations, case-mix, workforce and organisation of care delivery, cause of death, and timing and governance around the review of deaths.

The review panel included an independent chair, NWNODN GM clinical lead, NWNODN governance nurse, SMH consultant and specialist nurse, with monthly steering groups including NWNODN C+M clinical lead, and LWH review team. Data was obtained from the Badgernet database. The service review included a site visit and discussions with the leadership team. Clinical reviews were supported by access to Badgernet EPR, PMRT reports, SI reports, guidelines and policies. Case selection was consciously biased towards the more extreme preterm babies and focused on cases with potential to affect outcome including reviews of sepsis, NEC, birth OOH and babies with transfers to AHCH (surgical babies). Babies with congenital anomalies with higher probability of mortality were excluded.

KEY FINDINGS

POPULATION AND CASE MIX

- No apparent difference in deprivation quintiles between LWH and SMH populations
- Ethnicity analysis was compromised by missing data in the EPR. There was a greater variation of ethnic groups in the SMH population compared to LWH
- Babies with severe congenital abnormalities were similar between the units and were not shown to have an apparent influence on overall mortality rates
- A notably greater number of in utero transfers in LWH compared to SMH, but further analysis of this was beyond the scope of this review
- There were no differences in gender, gestational range, multiplicity, time of day of birth or death between LWH and SMH
- LWH has a higher, almost double, mortality rate in the <27 week group, most notable in the 24 week group compared to SMH
- SMH has a higher number late neonatal deaths >28 days compared to LWH with the majority dying in the 8-28 day period. In the early neonatal period LWH had a higher proportion dying <24 hours of age.
- Hypothermia in preterm babies has been associated with increased mortality. LWH benchmarked favourably nationally, and against SMH in achieving normothermia on admission

In conclusion, there were no major differences identified in the population demographics and case-mix of admissions to both units, except for a greater number of IUTs to LWH when compared to SMH.

SERVICE PROVISION

- Key difference between services: LWH is not co-located with paediatric surgical services or other paediatric sub-specialities.
- There were key differences in some essential clinical support services available to the LWH team out of working hours, influenced by the setting within a maternity hospital rather than co-located with paediatric services. Gaps in these services may well influence clinical decision making. Of note radiology services are not on site out of hours, and pathology and blood bank services are not on site.
- Lack of co-location of services increases the need for postnatal transfers.
- Both LWH and SMH are designated surgical NICUs. Both meet the BAPM minimum activity for VLBW (very low birthweight) babies and intensive care days with similar rates of surgical activity.
- Whilst LWH is BAPM compliant for direct clinical nurse staffing, provision of quality nursing time in education and training, breastfeeding, safeguarding and bereavement is limited and should be enhanced, as per the DOH toolkit and GIRFT Neonatology workforce recommendation.
- Medical workforce is compliant at tier 1 and 2 level. During the review period a 24/7 onsite consultant presence was identified as a clear gap at LWH. SMH had this whereas LWH did not.
- Senior nurse leadership: SMH have several matrons who report to a lead nurse, who then reports to a HoN. At LWH a single matron reports directly to the HoN.
- Leadership within each organisation was comparable at consultant level. LWH were noted to have an extensive ANNP team with a leadership structure to support management and development.
- SMH have more dedicated consultant time allocated to governance and dedicated senior nurse time for governance work. LWH had a non-nurse governance facilitator vacancy at the time of the review. Consultant time for PMRT is equitable across both organisations.
- LWH follow the national PMRT process with an external neonatologist present at the majority of reviews, although the external representatives are from a small group within the same locality.

CLINICAL REVIEW FINDINGS

Themes identified through the case reviews included:

- <u>Service provision</u>:
    - Many areas of good practice were identified especially in early optimisation and end of life care
    - No 24/7 resident consultant presence at the time of the review period. Although there was notable timely consultant response and comprehensive input when requested, there were examples of suboptimal decision making when the consultant was not contacted.
    - Radiology provision: there were delays in initial x rays with consequent delay in recognition and management of clinical signs in some instances. There were also examples of high thresholds for requesting OOH radiology services

- Excellent CRUSS and echocardiography skills to assess haemodynamics and direct cardiovascular support within consultant team
- Blood bank: there were delays in obtaining type specific blood due to non-colocation

- Clinical care
  - Evidence of excellent early optimisation, prioritising and achieving good levels of delayed cord clamping (DCC) and thermoregulation in the extremely preterm group
  - Excellent resuscitation and stabilisation practices in delivery room
  - Early onset sepsis management- antibiotic administration timings were acceptable, although the review team noted some cases of discontinuing antibiotics despite significant risk factors
  - Late onset sepsis management: the review team questioned the initial choice of antibiotics in the LWH guideline. They felt there was evidence of delayed escalation in antibiotics and delayed recognition of signs of sepsis on some occasions, which the review team felt to have contributed to death in some cases.
  - Central Lines: use of femoral lines continues at LWH but has reduced in frequency following the Birmingham review. There were still episodes of ischaemic complications in this review cohort
  - Pain management: highly prioritised at LWH. Frequent and concurrent use of morphine and midazolam, with escalation of dosing regimen not obviously correlating to the scoring tool used to monitor pain and sedation control in neonates.
  - Respiratory management: good examples of appropriate ventilation strategies including national recommendation for volume guarantee ventilation as standard, HFOV where necessary, and considered echocardiography guided use of nitric oxide.
  - Use of chin straps is an unusual practice and will be reviewed
  - Sodium bicarbonate use: evidence that due consideration on this has been given following the Birmingham review however use still appears generous.
  - Review Team noted the desire for a robust simulation training program where lessons learnt from incidents and mortalities can be supported, however allocated time and availability have impacted on the success of this.

- PMRT assessment
  - 12 /26 cases were found to have additional learning by the review team. The areas of additional learning are supported by the themes which have been mentioned above with sepsis management, radiology provision, delayed blood products recurrently identified.
  - LWH is compliant with National recommendations for neonatal mortality reviews and best practice in including external representation, but they do not have access to notes and are dependent upon what is presented as part of the PMRT. This is a nationwide issue.
  - Lessons learnt from local review have clearly translated into changes in process within LWH.

There has been no clear causative factor identified through the process of this review for the elevated mortality rates at LWH however there have been multifactorial areas of improvement identified in both the Birmingham and NWODN reviews. Plans are in place to implement as many gains as possible in delivery of care to babies, many of which have already been enacted.

The full report has been shared with the Board as a supporting document.

Action Plan								
	Issue	**Action**	**Lead**	**Operational Manager**	**Operational Lead**	**RAG**	**Completion date**	**Update**
SERVICE PROVISION	Non co-location of the NICU with paediatric surgery/sub-speciality	• Record on Risk register • Develop functional clinical care pathways with relevant paediatric sub-specialities • Ensure SLAs are in place with relevant paediatric sub-specialities • Ensure SLAs are in place with AHPs • Further development of AHP Teams	JD ABR / JM / RK/JV JV JV JD/RK/JD	Vicky Clarke	JMH/JD/JM/ABR		March 2023 March 2023 March 2023 March 2023 Dec 2024	
SERVICE PROVISION	Radiology services not currently meeting the expected standards.	• Record on risk register • Review of current provision • Audit OOH response time with off-site radiography • CSS to agree a maximal response time • Explore provision of 24/7 radiology cover	JD / ABR / JMH JD/JV/EG/LLP/JMH JMH / EG/LLP EG/LLP Trust SMT	Ellen Gerrad Vicky Clarke	Lowri Lloyd Preston /Jen Vose		October 2022 March 2023 December 2023 March 2023 March 2023	
SERVICE PROVISION	Lack of on-site pathology service and blood bank. Delays in processing transfusion and timeliness of sample processessing.	• Record on risk register • Trust are building on-site blood bank facility • Quality improvement work: timing of samples and clear identification of LWH samples for AHCH lab • Audit blood result turn around time after QI work • QI project on time taken for blood transfusion	JD / ABR / JMH LWH Corporate BP / RH RH RH	Ellen Gerrad Vicky Clarke	Jen Vose/Jill Harrison		October 2022 September 2023 March 2023 March 2023 March 2023	

SERVICE PROVISION	Surgical neonatal care not co-located with tertiary neonatal services. Babies having multiple transfers to ensure appropriate care	• LNP NICU services on AHCH site being developed ahead of new build • To reduce the number of transfers required. • FiCare implementation and accreditation across LNP to help improve family experience	JD / ABR / JM/RK/JV JD/ABR/RK/JV EH	Vicky Clarke	LNP SLT		January 2025 September 2023	
CLINICAL CARE	Late Onset Sepsis antibiotic policy not in line with national neonatal guidance.	• Audit time to antibiotics from decision to treat (<1 hour) • Neonatal infection guideline updated in line with NICE guidance • Education to implement new infection guideline	ABR / EW ABR / TN / AH ID team/ AR ABR	JMH	ABR		March 2023 March 2023 April 2022	V5 Infection Guideline with flow charts Jan 2
CLINICAL CARE	The use of femoral arterial and venous lines and how they are monitored within guidelines.	• Femoral line audit to be discussed at consultant away day • All femoral lines injuries to be reported through Ulysses for monitoring	NS FP / VW	JMH	NS		June 2022 Ongoing	Femoral Arterial Line Audit report 4 1 2020
CLINICAL CARE	Education around diagnosis and treatment of metabolic acidosis and blood gas management	• Dedicated metabolic acidosis teaching at ANNP away day • Junior Dr teaching sessions. Presentation added to My-Pediatrics App • Metabolic acidosis guideline to be produced	ABR ABR ABR	JMH/JD/RK	JMH/JD/RK		October 2023 August 2023 May 2022	V4 Management of metabolic Acidosis in
CLINICAL CARE	Use of morphine and midazolam is not always in line with national guidance.	• Undertake a review of local sedation guidance and ensure the use of morphine and midazolam is in line with national guidance. • Audit compliance with neonatal pain and sedation guideline	JMH/RK/ABR BP / FP	JMH/RK	JV		March 2023 September 2023	

		• Review pain and sedation guideline with MDT including nursing, medical and pharmacy team	FP / JMH/ SON				January 2023	
CLINICAL CARE	Recording of unplanned extubation (UE)	• Ensure unit has mechanism for identifying cases of unplanned extubation and continue quality improvement • Safety message of the week: all UE to be reported to Ulysees • QI project on reducing UE	RK / JH RK/JK LH / RK	JMH/RK	JV		September 2022 October 2022 April 2023	
WORKFORCE	Very lean senior neonatal nursing team, with potential gaps in oversight.	• Deputy HON appointed • Increasing Matron complement to support education and governance • Matron to be appointed for the LNP AHCH site in addition to LWH Matron • Review of senior cover on nights	JD JD/SON JD/SON JD/SON	Vicky Clarke	JD		June 2022 Apr 23 Apr 23 Dec 22	
WORKFORCE	Difficulty in maintaining medical BAPM standards across a non- co-located service	• Review medical staffing to ensure latest BAPM standards are met across both LNP sites. • Review the vulnerabilities of the service due to non-colocation • LWH 24/7 on site consultant presence • Future staffing model for LNP to maintain 24/7 middle grade / ANNP presence at LWH, with on call consultant at AHCH	JMH/ RK/ ABR LNP SMT	Vicky Clarke	JMH/ABR/RK		January 2024 January 2022 December 2024	Regarding the medical staffing.docx (support from GIRFT chair)
WORKFORCE	Reduced numbers of quality roles within nursing to	• 2 Band 7 nurse educators appointed	JD	Vicky Clarke	JD		June 2022	

	support bedside nursing	• 0.8WTE Band 7 Governance nurse lead • 2 Lead ANNPs in QI oversight roles • Bid will be put forward to NCCR for funding to increase quality role support across the LNP	JD JD JD				June 2022 July 2022 Jan 23	
WORKFORCE	Lack of AHPs within the LNP	• 1 WTE psychologist, 1 Dietician and 0.8WTE physio appointed across LNP • Discuss with commissioners regarding funding for an additional pharmacist for LNP across 2 sites, SALT, occupational therapy and neuro-physiotherapy provision	JD JD	LNP SMT	JD		July 2022 January 2024	
GOVERNANCE	Lack of senor nurse leadership within the governance structures	• Governance structures should be reviewed to understand the benefit of senior nursing/ANNP input • Band 7 governance nurse lead • Band 6 governance secondment • 4 ANNPs in core mortality review group • Appointment of Governance and education Matron to support governance team	JD JD RK JD/SON JD/SON	Vicky Clarke	JD		December 22 June 2022 June 2022 January 2022 April 2023	
GOVERNANCE	Presence of the education team within the governance structures.	• Review governance terms of reference to ensure education teams are included. • Education team to join monthly risk meeting, PMRT meeting, integrated governance meeting • QI ANNPs and education team to co-ordinate educational activities on the unit	JD / RK JK/SON	JMH/RK/JD	JMH/RK/JD		September 2022 October 2022	

		• Simulation programme to be structured allowing for integration with learning from governance activities	EC / DE / SP / SK SO / SP / SK				December 2022 April 2023	
GOVERNANCE	Lack of truly external review: reviewer is not always truly external as they have trained or worked closely with the hospital that they are reviewing yet works in an equivalent setting.	• Discuss with wider NWNODN regarding external support for PMRT • Use LMNS network to gain a greater range of external representatives • Discuss with national PMRT team regarding a national network of external representatives for greater variety and range of opinion	RK RK RK	Lynn Greenhalgh	JMH		December 2022 August 2022 December 2022	
NETWORK	Mortality data should continue to be monitored at network level allowing comparison between similar activity units annually.	• NWNODN dashboard to be reviewed quarterly • NWNODN to highlight if LWH continues to be an outlier for mortality • MBRRACE report to be reviewed annually and response provided by LWH	HM / LWL / NS HM / LWL/ NS RK	Lynn Greenhalgh	Rebecca Kettle		Ongoing June 2023 Ongoing	

Trust Board

COVER SHEET

Agenda Item (Ref)	*2022/23/97f*		**Date: 01/09/2022**	
Report Title	Safeguarding Annual Report 2021/22			
Prepared by	***Mandy McDonough, Associate Director of Nursing and Midwifery for Safeguarding***			
Presented by	***Matthew O'Neill, Safeguarding Assurance and Governance Lead***			
Key Issues / Messages	***The Safeguarding Annual Report for Children, Young People and Adults is to provide an overview of Safeguarding activity within the Trust for the period 1st April 2021 to the 31st March 2022 and to assure our Board of Directors that the Trust has effective systems and processes in place to safeguard patients who access services provided by Liverpool Women's NHS Foundation Trust.***			
Action required	Approve ☒	Receive ☐	Note ☐	Take Assurance ☒
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – Y *If no – please outline the reasons for deviation.*			
	For the Board to receive and approve the Annual Safeguarding Report 2021/22			
Supporting Executive:	***Marie Forshaw, Chief Nurse & Midwife***			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 5.2 Failure to fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership	Comment:
Link to the Corporate Risk Register (CRR) – CR Number:	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Quality Committee	June 2022	Associate Director of Nursing and Midwifery for Safeguarding	The Committee noted the report and recommended it for approval to the Board.

EXECUTIVE SUMMARY

The Safeguarding Annual Report for Children, Young People and Adults provides an overview of Safeguarding activity within the Trust for the period 1st April 2021 to the 31st March 2022. The intention of the report is to assure our Board of Directors that the Trust has effective systems and processes in place to safeguard those most vulnerable to abuse who access services provided by Liverpool Women's NHS Foundation Trust.

Safeguarding remains a fundamental component of all care within the Trust and we have again this year responded effectively and efficiently to the challenges of safeguarding both our patients and our staff in what has a challenging year.

The Trust Safeguarding Sub-committee (TSSC) and Safeguarding Operational Group (SOG) continue to provide the Board of Directors, Clinical Commissioning Group (CCG) and External Safeguarding Boards with assurance of our ability to respond effectively and demonstrate accountability, for all aspects of Safeguarding Children, Young People and Adults.

The report will outline the progress against the 2020/21 priorities and set out the key priorities for the coming 12 months. These are central to supporting core safeguarding activities and demonstrate the organisations compliance with Section 11 of the Children Act (2004) and the Care Act (2014).

Recommendation

For the Board to receive and approve the Annual Safeguarding Report 2020/21.

Attached at Appendix A is a reminder of the Board Responsibilities for Safeguarding Arrangements.

REPORT

Liverpool Women's
NHS Foundation Trust

The Annual Report for Safeguarding Children, Young People and Adults

2021/22

Amanda McDonough
Associate Director of Nursing and Midwifery for Safeguarding

Contents

Introduction

Maintaining a culture that supports children, young people and adults to live a life free from abuse and neglect, which enables them to retain independence, wellbeing, dignity and choice is a key priority of Liverpool Women's NHS Foundation Trust.

This aspiration requires robust governance and assurance processes to support an ever-evolving Safeguarding Strategy; that reflects the need for effective leadership and engagement in recognising and responding to allegations of harm and abuse, responses that are in line with multi-agency procedures and using learning to improve services for our patients.

Prior to this year, the Trust have produced the annual report using an ‘end of year’ methodology to provide assurance that Liverpool Women's NHS Foundation Trust is statutory compliant with the relevant legislation and national/local guidance.

However, to support a more responsive, quality driven and timely approach to emerging themes and trends, this year has seen the introduction of a methodology designed to harness data that monitors progression and provides assurances to the Trust on a quarterly basis.

Using qualitative and quantitative data with analysis, the quarterly reports show progression against our internal priorities and facilitate the prompt identification of potential areas for improvement as well as commentary on compliance; thereby increasing quality and performance deliverables.

Despite this reporting period (2021/22) continuing to present challenges, in addition to those encountered in the previous year, this Annual Report will demonstrate that through continued

resilience, adaptability and resourcefulness, Safeguarding continues to be quality focused and a fundamental component of all care provided within Liverpool Women's NHS Foundation Trust, that is firmly embedded within the core duties of the organisation.

Statutory Framework and National Policy Drivers

To carry out safeguarding duties, it is vital to understand the local and national safeguarding policies. The government regularly revisit safeguarding legislation and policy to strengthen procedures and make guidance as clear as possible.

To appropriately safeguard children, the Trust is mandated by statute to have the appropriate systems and processes in place to comply with Section 11 of the Children Act (2004), which outlines the requirement for clear lines of accountability for the provision of services that safeguard and promote the well-being of children. *Working Together to Safeguard Children* (2018) establishes a clear legal framework for all statutory agencies to maintain the rights of those with care and support needs who are at risk of harm, abuse or neglect.

Similarly, the Care Act (2014), requires Liverpool Women's to demonstrate compliance with the following regulations:

1. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)
2. Care Quality Commission (Registration) Regulations 2009 (Part 4)

The regulations below relate to Safeguarding and must be considered in how the Trust assures itself that there are effective and robust safeguarding processes and practices in place:

1. Regulation 9: Person-centred care
2. Regulation 10: Dignity and respect
3. Regulation 11: Need for consent
4. Regulation 12: Safe care and treatment
5. Regulation 13: Safeguarding service users from abuse and improper treatment

Again, this year Liverpool Women's NHS Foundation Trust remains fully aligned to the regulatory requirements but also takes into consideration the revised NHS England published

guidance to all NHS organisations on their responsibilities to safeguard children and adults at risk.

The *'Framework for Safeguarding Vulnerable People in the Reformed NHS (2019)'* clearly outlines the statutory duties that all NHS bodies must safeguard and promote the welfare of children and adults, with a particular emphasis placed on the provision of greater assurance to the Board of Directors and external partners, that those at the greatest risk of abuse, regardless of age, continue to be protected within our services.

There is a clear distinction between Providers' responsibilities to deliver safe and high-quality care and Commissioners' responsibilities to assure themselves of the safety and effectiveness of the services they have commissioned.

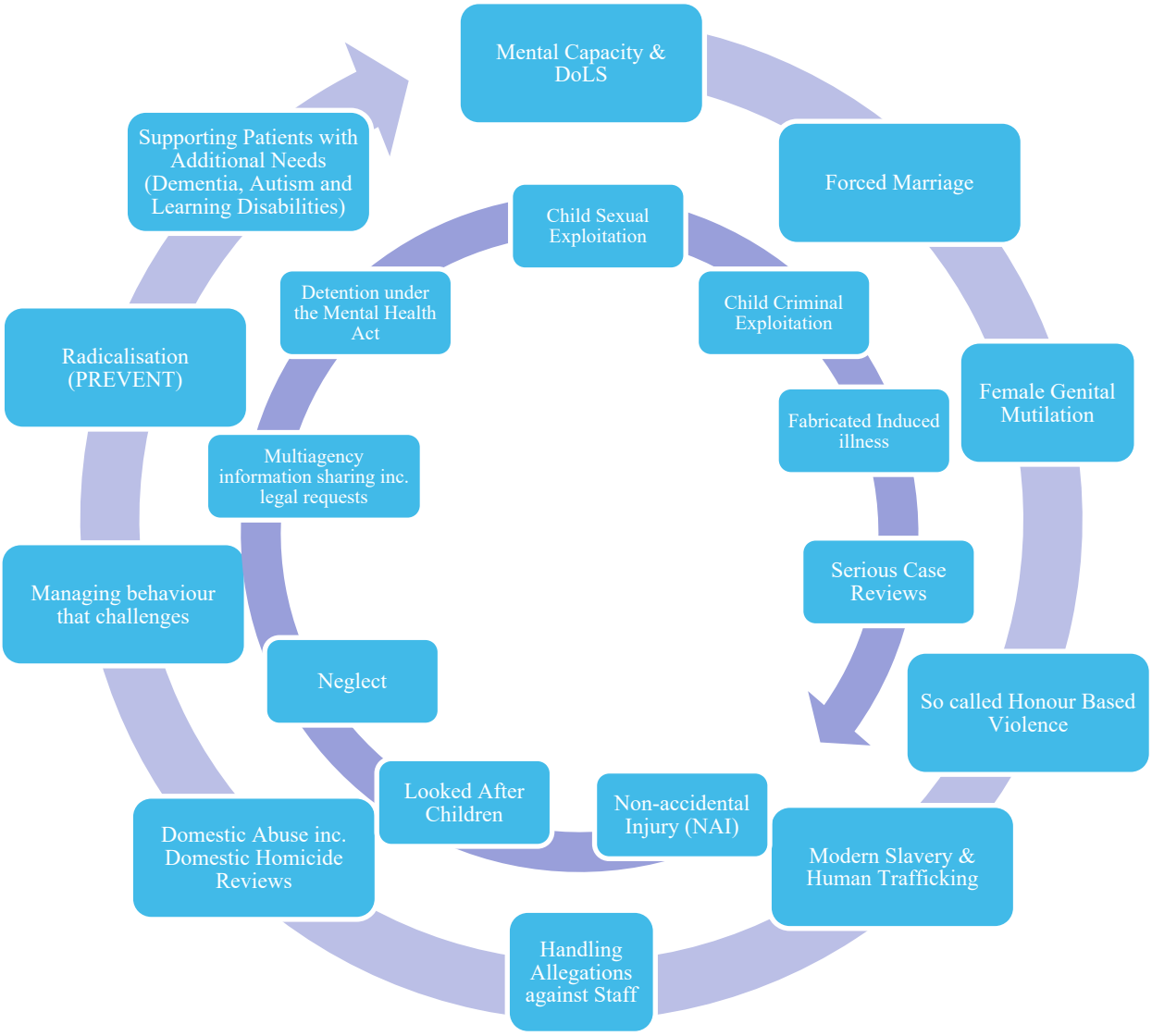
Our Commissioners and Regulators have a role to actively monitor the performance and quality of our service, with the responsibility to intervene if there is a decline in the quality of the service we deliver, or they suspect a breach of our standards.

In partnership with NHS England the Clinical Commissioning Groups (CCG), the Safeguarding Boards, our partner statutory agencies (below) and other provider organisations, Liverpool Women's continue to work in partnership to ensure that we protect the health and well-being and the rights of those identified as vulnerable.

Supporting that activity, the Safeguarding Team is an established, fully integrated, multi professional service, comprising of Senior Health and Social Care Professionals with extensive experience in Midwifery, A&E, Critical Care, Elderly and Social Care.

The relevant skill mix and experience across the many safeguarding subspecialities, ensures that the Team can act both strategically and operationally in preventing and investigating potential abuse.

The following reflects our scope of Service:



Maintaining the function and quality of all aspects of safeguarding practice across the Trust is essential, with a particular focus on the appropriate Safeguarding arrangements to ensure effective strategic safeguarding leadership is in place.

The Associate Director of Nursing and Midwifery for Safeguarding (ADN), Amanda McDonough with executive leadership from the Director of Nursing and Midwifery, Marie Forshaw, ensures safeguarding expertise and clinical/strategic safeguarding leadership is in place and available Trust wide.

As outlined in the *Intercollegiate Safeguarding Competencies for Adults (2018)* and *Children (2019)* all NHS providers must identify a Named Doctor and a Named Nurse for Safeguarding Children and Young People, a Named Professional for Adults and a Named Midwife, (if the organisation provides maternity services); to provide leadership, expert advice and support to Trust employees and promote good practice within their organisation as per Children Act (1989/2004) and the Care Act (2014).

From April 2021 - March 2022 the Liverpool Women's Named Professionals were;

- Named Nurse & Midwife for Children – Amanda McDonough
- Named Doctor for Safeguarding Children –Dr Emily Hoyle
- Named Doctor for Safeguarding Adults – Dr Gillian Fowler
- Specialist Nurse & Midwife for Children and Adults / Named Nurse LAC – Maria Clegg
- Named Nurse for Safeguarding Adults – Carl Griffiths
- Trust Prevent Lead – Matt O'Neill

Summary of Current Position

Throughout the reporting period for 2021/22, despite the challenges post pandemic and subsequent recovery brought about, progress has been made with the safeguarding children, young people and adult's work plans. This has ensured that the Trust has remained compliant with its overall objective to:

Ensure that Liverpool Women's NHS Foundation Trust safeguarding arrangements are statutory compliant with appropriate legislation and national/local guidance in respect of those identified as at risk

Below are the key objectives identified as priorities in the 2021/22 Annual Report, with the key objectives for 2022/23 summarised at the end of this report.

No.	Objective	RAG	Progress
1	Develop a standalone Strategy for Supporting Patients with Additional Needs with an embedded operational work plan		This strategy was ratified in December 2021.
2	Progress the arrangements for patients, detained under the Mental Health Act 1983 with a view as to providing further assurance that the Trust are meeting its statutory obligations		Negotiations for a Service Level Agreement progressed throughout the year culminating in a provisional agreement for Mental Health Law Administration support in May 2022.
3	Engage with EPR developers to enhance the system(s) functionalities around safeguarding to better assist staff		Safeguarding have been working closely with K2 and Meditech Expanse projects to ensure safeguarding processes are clear and supportive.
4	Source further NHSE/I Safeguarding Supervision Training for Liverpool Women's staff and further develop our Supervision processes		Further opportunities for training were identified and shared with the relevant leads. Monitoring access to Safeguarding Supervision and its effectiveness continues.
5	As part of the Liverpool Multi-Agency-Risk-Assessment-Conference (MARAC) Steering Group, implement any changes required to Liverpool Women's processes and policy for Domestic Abuse		This work is ongoing and as such the Domestic Abuse Policy and any practices are reviewed annually to reflect any legislative changes. ** *see below for update from Steering Group***

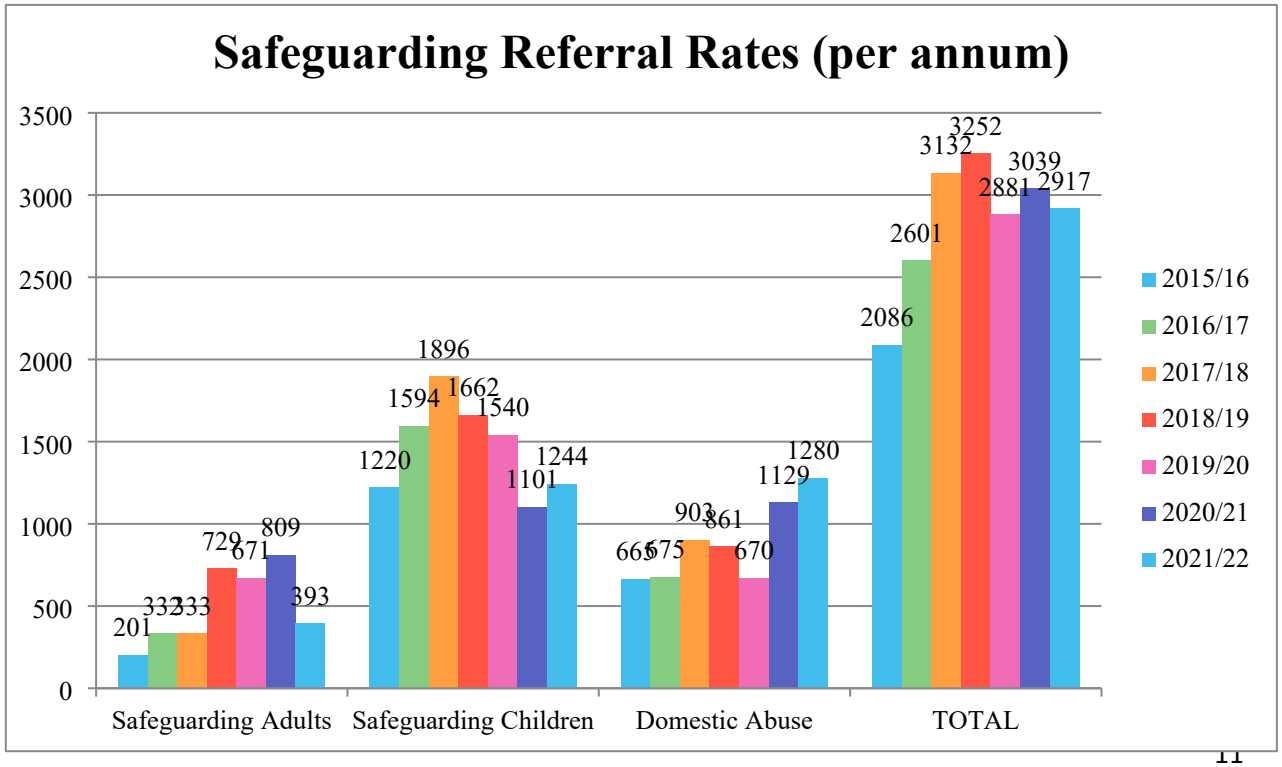
**Liverpool Multi-Agency-Risk-Assessment-Conference (MARAC) has one of the highest volume of cases in the country. Issues of volume versus quality and resource implications for the City are an increasing concern as are the number of Domestic Homicides that were known to services.

The Liverpool MARAC Steering Group strives to address these concerns and are undertaking a MARAC Review with the aim of actioning change to develop the MARAC process and its function.

Liverpool Women's Hospital NHS Foundation Trust's Associate Director of Nursing and Midwifery for Safeguarding, Amanda McDonough, was requested by Liverpool Citysafe to review MARAC processes. The review which will consider the coordination of Liverpool MARAC and associated processes to improve safety and support for the highest risk victims of domestic abuse in the city.

Once completed, the recommendations from the review will be provided to Liverpool City Council which will inform any necessary changes required.**

Safeguarding Performance Overview



Overall, 2021/22 saw a decrease in safeguarding referrals received by the service when compared to 2020/21, decreasing by 122.

Across the subspecialities, a significant reduction was noted in those referrals catagorised as Safeguarding Adults. Following the identification of possible data inaccuracies in last year's Annual report, an internal quality assurance review was completed to accurately identify the principal category of referral e.g. whilst the adult is a victim of Female Genital Mutilation, it is the unborn that is at risk of abuse.

It is reasonable to believe that this data cleansing exercise is a contributory factor in the reduction of Safeguarding Adult referrals and the subsequent increase in both Child and Domestic Abuse referrals.

Integrated Safeguarding Quality Assurance Report

To further enhance the established assurance processes it was agreed, in Q3 2020/21 to develop an integrated quality assurance report that would provide both qualitative and quantitative data.

On a quarterly basis, the report contains a breakdown of activity specific to Safeguarding Adults, Children and Domestic Abuse as well as progression against our internal priorities and facilitate the prompt identification of potential areas for improvement.

In addition, the report also presents performance against mandatory training compliance, findings from completed unannounced inspections and operational process testing.

Whilst the findings detailed in the respective quarterly reports are a 'snapshot' of activity and comparisons can only be made to the previous quarter, there are still some valid assurances that can be drawn from the findings. The following is a synopsis of each quarter within 2021/22 (please see appendices for the full reports).

Quarter 1 2021/22

It should be noted that whilst the restrictions introduced to mitigate the impact of the pandemic started to ease in this quarter, the Trust continued to face significant challenges presented by reduced staffing numbers, the introduction of the Continuity of Care model in Q4 2020/21 and the embedding of a new electronic patient information system (K2) in the Maternity Department.

That said, based on the referral to Safeguarding activity and the subsequent progression to further enquiries; Trust staff continued to be competent at recognising and appropriately reporting safeguarding concerns.

This was seen in the conversion rate for safeguarding referrals, where the majority of child referrals made to the Local Authority progressed to having Child in Need or Child Protection Plans being in place prior to birth and more than double the number of patients being identified as having had FGM, subsequently progressing to completed FGM assessments.

Furthermore, the consistent increase in invites to Conference for Child Protection cases, seen over the previous two years continued in this quarter increasing resulting in the highest monthly activity, where Child Protection Plans were in place at birth in 5 years.

Whilst sitting outside of the scope of safeguarding, the absence of referrals to the Early Help pilot was noted in this quarter. Following discussion at both the Safeguarding Operational Group (SOG) and Trust Safeguarding Sub-committee (TSSC), it was agreed to further promote the pilot service and referral pathway to midwifery staff.

In addition, it was noted that the number of MARAC/IDVA referrals more than doubled since the last quarter which may be related to additional training sessions given to frontline practitioners.

This increase in referrals was, in part attributed to the confidence amongst staff when recognising abuse and competence in the use of tools designed to safeguard those most vulnerable, so improving access to timely support, which was noted via the unannounced safeguarding inspections.

Quarter 2 2021/22

This quarter continued to see the significant challenges presented by reduced staffing numbers and high levels of activity, particularly in the Maternity Division identified in the previous quarter.

That said, based on the number of Safeguarding referrals received and subsequent progression to further enquiries; Trust staff continued to be competent at recognising and appropriately reporting concerns with the support of the Safeguarding Team who act as a conduit between clinical staff and outside agencies ensuring relevant intelligence or information is available.

With the majority of all child referrals made to the Local Authority progressing to a single assessment, continuing from the previous quarter, this demonstrated the effectiveness of the quality assurance process, completed by the Safeguarding Team clarifying the threshold had been met for a referral to the Local Authority.

This was also demonstrated in the Domestic Abuse Risk Assessments quality audit, which highlighted that in almost all the assessments reviewed, despite the threshold for referral to MARAC not being met, the application of professional judgement, by the Safeguarding Team resulted in an appropriate referral to MARAC.

Furthermore, demonstrating the importance the Trust places on providing information as part of Multiagency working, this quarter saw the Safeguarding Team process almost two thirds more information requests from external agencies to inform ongoing enquiries compared to the previous quarter.

Due to ongoing operational pressures a decision was made to temporarily replace face to face, Level 3 Safeguarding Children training specifically for midwifery staff to an adapted online competency assessment module. In response, to provide assurance and monitor any potential reduction in awareness the number of unannounced inspections completed per quarter was increased with a view to provide a greater understanding of the workforce knowledge and confidence.

This quarter also noted that referrals into the Liverpool Early Help pilot project, commenced in the previous year and quality assured by Safeguarding on behalf of the Maternity Department were minimal in this quarter and the previous. Therefore, it was agreed at the Safeguarding Operation Group (SOG) to promote the Early Help referral pathway.

Finally, following publication of the first Integrated Safeguarding Quality Assurance Report and the positive feedback received from Divisions and Departments, it was agreed that any recommendations identified within the report would be included in the Safeguarding Operation Group (SOG) Action Plan and progress would be monitored by the Trust Safeguarding Sub-Committee (TSSC).

Quarter 3 2021/22

With the continued challenges presented by reduced staffing numbers and high levels of activity, particularly in the Maternity Division continuing, this quarter saw a further increase in child referrals made to the Local Authority progressing to a single assessment, providing continued assurance safeguarding procedures remain robust and effective.

Whilst this quarter saw a slight decrease in adult referrals, when compared to the previous quarter, the increase by a quarter of domestic abuse referrals by a quarter identified the benefits of the ongoing quality assurance process completed by the safeguarding Team in clarifying the primary category of abuse.

This also led to an increase of a third in domestic abuse risk assessments being completed by nursing and midwifery staff, outside of the safeguarding team and more than double the number of cases whereby a plan of care was required prior to delivery where domestic abuse was the primary concern.

Despite these pressures and a significant increase in Child Protection Conference invites received in this quarter, Trust staff were able to attend in almost all cases, evidencing the ongoing commitment and prioritization placed by the Trust on multiagency working.

It was acknowledged that the reason for those case conferences not attended was as a consequence of the move to the Continuity of Care Model in Maternity and the work patterns for community midwifery teams restricting their ability to attend meetings at short notice.

Due changes within the agreed processes for Liverpool Local Authority and Liverpool Women's Early Help (EHAT) 2020-21 pilot project, the Safeguarding Team would no longer be required to provide a quality assurance check for all Pre-Early Help referrals identified by Trust staff. In light of this, it was agreed that the responsibility for promoting and monitoring EHAT engagement identified in the previous quarter would be held by the relevant Divisions.

Furthermore, an increase in the completion of reasonable adjustment risk assessments across both Maternity and Gynaecology noted in the previous quarter continued. This provided further

assurance that the Trust remains committed to promoting the rights of those with additional needs that meet the definition of having a disability, as described in the Equality Act 2010.

Unfortunately, notable delays in the receipt of Local Authority plans for an unborn, prior to delivery (36 weeks gestation) became a cause for concern, prompting a significant increase in activity by the Safeguarding Team attempting to contact allocated social workers to secure a robust plan.

Ultimately, due to the significant level of risk identified with not having a plan in place prior to delivery and the amount of resource allocated by the Safeguarding Team resulted in escalation to the Designated Nurses (CCG).

Finally, whilst the findings from unannounced inspection findings were positive overall, there was limited awareness of Gillick competency regarding the consent process for patients under 16 yrs. of age noted.

It was agreed this concern would be included in the Safeguarding Operational Group Action Plan, with a view to agree a way forward to improve awareness.

Quarter 4 2021/22

Whilst this quarter saw a decrease in all safeguarding referrals (11%), the continued improvements, over all three previous quarters in child referrals being accepted for further enquiries by the Local Authority demonstrated the robust nature of current safeguarding processes across the Trust.

Furthermore, a 50% increase in the number of domestic abuse risk assessments completed by frontline practitioners, combined with double the number of women requiring a plan of care to support delivery because of high-risk domestic abuse since Q1 2021/22 further evidenced the ongoing work of the safeguarding team in promoting domestic abuse as a key factor of risk in a family setting.

When this was combined with more than double the number of Safeguarding Children Strategy meetings being attended by midwifery staff and the number of Sudden Unexpected Death in Infants (SUDI) notifications received in this quarter equating to the total number received in 2020; in a climate of limited resources and operational pressures, this further exemplified how committed to both collaborative working and protecting those most vulnerable to abuse Trust staff are.

This quarter saw a 50% reduction in high-risk Police notifications received in comparison to the first quarter of 2021/22 and the notable delay in receiving Local Authority plans to support delivery, identified in the previous quarter continued throughout this quarter with factors such as limited resources within the Local Authority and remote working being identified as contributory factors.

It was noted from unannounced inspections that the decrease in awareness of Gillick Competency identified in the previous quarter had significantly improved, increasing from 30% to 70% in this quarter. This demonstrated an effective response to concerns raised in the previous quarter Operational Group.

Over the year, the Integrated Safeguarding Quality Assurance Report framework has provided not only a comprehensive understanding of Safeguarding activity but also assurance that despite the ongoing difficulties in achieving Safeguarding mandatory training compliance,

Safeguarding remains a fundamental component of all care within the Trust in what has been a particularly challenging year.

The framework not only provides an earlier opportunity for a focused response to emerging themes but also enables frontline staff and managers to be fully appraised of activity across the Trust, which in turn improves their cognizance of how the Trust safeguards those most vulnerable to abuse.

Supporting Patients with Additional Needs

This year saw the Trust launch its three-year strategy to become an exemplar site for the care of patients with additional needs, including those with dementia, learning and or physical disabilities and autism.

The strategy brings together the dementia, autism, learning and disability workstreams, in place since 2015 into one coherent document that details how we will implement relevant national strategies, respond to the profile of our local population and work with our patients, carers, staff and partners to deliver high quality, person-centred care for people with additional needs and their carers/families.

The strategy has three key strategic objectives to improve care for people living with for dementia, learning and or physical disabilities and autism:

1. The rights of those with additional needs are respected and protected

2. People with additional needs, their families and carers are involved in the process of planning and decision making; thereby empowering them to be true partners in the care they receive.

3. A comprehensive education and training framework is provided to empower teams to deliver the best possible care.

To promote engagement, a forum of service users with additional needs who have accessed and received care provided by Liverpool Women's was established to provide constructive challenge and scrutiny of the strategy.

The forum also provides advice and guidance on the delivery of both the strategy and any supporting policies or tools introduced to improve care, as well as an insight on the skills, behaviours and attitudes needed by our workforce to meet the needs of both patients and their carers/families.

To track progress, performance is reported quarterly and annually to the Equality, Diversity and Inclusivity Committee and shared externally as part of the Quality Assurance report.

For our patients with additional needs, this strategy provides the framework that ensures patients feel respected as individuals, their opinions valued, and opportunities provided, along with those interested in their welfare to be fully engaged in their healthcare needs being met.

They will experience being cared for by those who have an appreciation of their individual needs, which in turn will create not only a positive experience for all but achieve the best possible outcome for both the patient and their relatives.

This year also saw the continued involvement of the Safeguarding Team supporting both the Gynaecology Division and Maternity Department in implementing both the Mental Capacity Act, reasonable adjustments to support admission and the development of behaviour management support plans for those will exceptionally complex additional needs.

Whilst the numbers, when compared to those patients without additional needs were small totalling 13, these cases required extensive co-ordination and collaborative working with external care providers, anaesthetics, various clinical staff as well as the patient and those interested in their welfare.

It should be acknowledged that in each of these cases the feedback received from both the patient, relatives and or carers was positive, demonstrating the investment the Trust has made in embedding the principles of both the Equality Act 2010 and the Mental Capacity Act 2005.

Supporting the Trust

Continuing to lead on the Trust response to the COVID pandemic, commenced in 2019 and responding to the emergence of the new Omicron variant, the Safeguarding Team with the support of the Divisions and Departments have continued to successfully co-ordinate and deliver the COVID staff vaccination programme.

This Trust wide campaign ensured all those employed by the Trust received the appropriate vaccination thereby ensuring the Trust were able to prepare for any potential surges in NHS hospitalisation rates, seen in the previous year and move to much lower levels of staff absence.

Following the de-escalation of the Major Incident on the 24th of November 2022, the Restoration and Recovery Oversight Group was commissioned by the Trusts Chief Operating Officer to oversee a co-ordinated response to future major incidents.

Consequently, concerns relating to security management within the Trust were identified, principally centred around Trust environmental failings, a deficit in staff awareness, poor management of security systems and service level agreements/contracts, and inadequate governance processes.

In response, a Security Management Workplan (SMW) was agreed and to support the delivery of the workplan, the Associate Director of Nursing and Midwifery for Safeguarding agreed to a 12-month secondment, to Operations of the Trust Safeguarding Service Manager, utilising the experience gained through acting as the Trust Prevent Lead.

With the appropriate controls in place and on a temporary basis, the Safeguarding Team have, agreed to take on the responsibilities of the Trust Safeguarding Service Manager; ensuring close monitoring to prevent any potential risk to service delivery.

Safeguarding Governance

Risk

Risk 2302

In September 2019, the Hospital Safeguarding Board agreed that as the Trust had not achieved the internal and commissioning training compliance targets for an extended period the Safeguarding Service completed a risk assessment. The group agreed with the score of 10 (2*5), as well as the controls in place and the risk was added to the Risk Register (Service Level).

Risk controls continued to be facilitated and tested to ensure the risk was managed appropriately however, despite an increase, the Safeguarding Level 3 compliance rates never achieved internal or commissioning targets in 2021/22. In Quarter 1, Safeguarding Level 1 (Children and Adults) training achieved the 90% compliance threshold however did not maintain that target for all 2021/22.

Additional controls were added in 2021/22, for example Safeguarding Level 3 compliance was agreed to be embedded within the divisional performance reports as well as weekly sessions being provided by the Safeguarding Service.

The training delivery for Level 3 was amended to blended learning and specific lists of non-compliant staff were sent to divisional leads to manage.

Performance

Clinical Commissioning Group (CCG) Key Performance Indicator (KPI) Reports

For 2021/22 Liverpool Clinical Commissioning Group (LCCG) provided an overall limited assurance rating to the Trust Safeguarding Service. Like 2020/21 the only area of limited

compliance was the adult and children safeguarding training. All other areas of Safeguarding again achieved significant assurance.

LCCG acknowledged and were satisfied that the Trust Safeguarding Team had a detailed recovery action plan and trajectory in place that had oversight from the Director of Nursing and Midwifery, that training programmes have continued to be reviewed and staff training compliance is reported to Quality Committee via the Trust Safeguarding Subcommittee (TSSC).

LWH	Q1 (2021/22) Assurance rating			Q2 (2021/22) Assurance rating			Q3 (2021/22) Assurance rating			Q4 (2021/22) Assurance rating		
Training			↔			↔			↔			↔
Local Authority Children			↔			↔			↔			↔
Local Authority Adults			↔			↔			↔			↔
MCA / DoLS			↔			↔			↔			↔
Commissioning Standards			↔			↔			↔			↔

Section 11 Audit

As per 2020/21 this approach is no longer in operation and Liverpool Women's NHS Foundation Trust have not been required to provide assurance around this process.

Policies

Although it is Trust policy is to ensure 3 yearly reviews of all policies and guidelines the Safeguarding Team review all Safeguarding policies every 12 months. This is to ensure all the policies are compliant and accurate following the regular changes in national guidance and legislation. The main change for 2020/21 was to the Supporting Patients with Additional Needs policy which was redeveloped into a full overarching strategy.

Audits

Forward Plan No.	Title	Auditor / Audit Supervisor	Summary / Findings
2021-008	Trust compliance with the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS)	Carl Griffiths Matt O'Neill	Within the audit it was noted that there was a 42% increase in admissions when compared to 2020/21, where 96 individuals were identified as having been admitted to the Trust, with a relevant cognitive impairment who had serious medical treatment. This can be attributed to the gradual easing of COVID-19 pandemic restrictions and the subsequent increase in primary care attendances and referrals to specialist services. This is the second year; full assurance has been noted and may indicate a potential improvement in the confidence of clinicians when implementing the Act, there was evidence of full compliance with both local policy and statutory guidance.

2021/019	Trust compliance against Domestic Abuse Procedures	Jayne Reid/ Matt O'Neill	The biggest success of this audit was the full (100%) compliance in cases being referred to the Safeguarding Team when a disclosure of domestic abuse has been made, or there is known domestic abuse concerns. In all cases an appropriate response was provided to patients when a disclosure of domestic abuse was made. Large majority of audit findings are positive and demonstrates staff members understanding of domestic abuse and application of appropriate responses is robust and effective. One area that requires further assessing was little or no evidence of Consultants completing mandatory routine enquiry documented.
2021/020	Trust compliance against Safeguarding Children procedures	Maria Clegg Matt O'Neill	Effective multi-agency working is evidenced within the audit findings, including staff making appropriate referrals in respect of Safeguarding concerns identified and involvement in multi-agency planning in respect of Children (including Unborn). There is clearly a need to escalate concerns regarding delays in Social Work planning. There was evidence of difficulties experienced when implementing plans, especially in respect of the supervision of mothers and babies following birth whilst an inpatient. This was identified as being due to external factors, namely provision from other agencies. In all cases reviewed the actions for LWH within the plans had been initiated and completed ensuring effective multiagency working and the safe discharge of children from LWH. This audit provides assurance of compliance with trust policy and the indicators included.

Assurance

Safeguarding Inspections (Unannounced)

As previously discussed, this year saw the introduction of the Integrated Safeguarding Quality Assurance Report, which in its methodology included the findings from Safeguarding Inspections.

Prior to the introduction of the report, Unannounced Safeguarding Inspections had been utilised as a tool, on an annual basis to:

- To assess and evaluate a true reflection of frontline staff knowledge and competency in respect to safeguarding procedures
- To identify any gaps (or patterns) relevant to safeguarding processes and procedures.
- To use the findings to inform/review the current Safeguarding Training Strategy
- To share the findings to demonstrate local training effectiveness and assurance.

The inspection methodology centres on interviewing frontline staff, asking specific and scenario-based questions designed to assess both general and specific themes pertinent to safeguarding as a speciality.

Areas for Inspection		
Family Health	**Nursing**	**CSS**
Neonatal Unit	Gynae Ward	Theatres
Delivery Suite	Bedford Clinic	Genetics
Maternity Ward (Matbase)	Hewitt Fertility Centre	
Community Midwifery	Emergency Room	
Maternity Assessment Unit	Gynae Outpatients	
Maternity Led Unit		
Antenatal Clinic		

The inspection questionnaires are individualised for the areas to ensure the questions are representative of the individual needs of each specialty i.e., Neonates versus Bedford Suite.

Formulating the methodology for the Integrated Safeguarding Quality Assurance Report, it was agreed to include Unannounced Inspections as a quality measure to ascertain any

potential impact in areas of reduced mandatory training compliance as well as provide an opportunity to identify of areas of concern and allow a prompt intervention.

Initially, the frequency of areas inspected on a quarterly basis was limited to 5 of the 13, with a view to assess every area at least twice over the year. However, this was increased in Quarter 2 to 6 areas.

Moving forward, whilst both the Integrated Safeguarding Quality Assurance Report and Unannounced Inspections required resource investment by the Safeguarding Team, it is the intention in 2022-23 to assess every area on a quarterly basis as a means of providing additional assurance to the Trust Board and external regulators.

Over this year, despite the ongoing challenges of improving compliance with Safeguarding Training, the findings on a quarterly basis continued to identify a reassuring level of compliance with Trust safeguarding policies and procedures as well confidence when responding to safeguarding concerns.

This, in turn has been used to provide assurance to both the Board and external partners that the reduction in mandatory training compliance has not impacted on the Trusts ability to safeguard those most vulnerable to abuse.

That said, the inspections have identified aspects of safeguarding practice that required a targeted approach to raise awareness. For example, in Quarter 3 the questionnaire was amended to assess the understanding of the requirements for caring for the child in an adult setting. This included both recognition of the child, ability to consent and the role parental responsibility has.

The findings of this led to several actions designed to improve awareness of consent in children under 16 yrs. of age and the role parental responsibility has in a care setting. Subsequently, in Quarter 4, following the actions being completed a marked increase in awareness was noted.

Within this reporting period, TSSC has focused on the monitoring of progress against the training compliance and the recovery plan. We have also completed a review of the Terms of Reference in which the body of work encompassed within the TSSC was clarified ensuring the following items are continually discussed and monitored.

Safeguarding Operational Group (SOG)

Through the representation of all divisions at a matron level, the primary purpose of the Group is to ensure that safeguarding remains a Trust wide priority. This is achieved through the monitoring of compliance against legislation and national/local guidance, disseminating lessons learnt from risks and external reviews and detailed workplans designed to deliver identified objectives, in a timely manner.

Whilst improving training compliance, through identifying and overcoming barriers to progression has been a key priority, the group have continued to act as a conduit between frontline practitioners and the Trust Safeguarding Sub-Committee providing a clear mechanism to disseminate and escalate concerns that impact on the Trusts ability to safeguard those most vulnerable to abuse.

The Group have utilised the Safeguarding Quarterly report, in particular the unannounced inspection findings to identify areas that require further support to improve as well as the identification and sharing of good practice.

Safeguarding Training

At the end of the reporting period for 2021/22, the Trusts compliance levels for Safeguarding training are:

Competency	CCG Compliance Threshold (%)	Compliance as of April 2022 (%)
Safeguarding Adults Level 1	90%	**89.6%**
Safeguarding Adults Level 2	90%	**77%**
Safeguarding Adults Level 3	90%	**80.2%**
Safeguarding Adults Level 4	90%	**100%**
Safeguarding Children Level 1	90%	**87.8%**
Safeguarding Children Level 2	90%	**75.8%**
Safeguarding Children Level 3	90%	**76.4%**
Safeguarding Children Level 4	90%	**100%**
Children In Care Level 1	90%	**87.8%**
Children In Care Level 2	90%	**75.8%**
Children In Care Level 3	90%	**76.4%**
Children In Care Level 4	90%	**100%**
Executive Board Training	90%	**78.6%**
Prevent (Basic Awareness)	90%	**83.2%**
Prevent (WRAP)	90%	**91.1%**
MCA & DoLS (Advanced) *	90%	**86.5%**
Child Exploitation Awareness	90%	**83.2%**
Child Exploitation Targeted	90%	**97.3%**
Domestic Abuse	90%	**83.2%**

**MCA/DoLS Level 2 training; as no programme was available locally/nationally, Liverpool Women's created a bespoke training module which was launched early 2020 to all staff via ESR. Compliance was reset to zero.*

Recovery Plan to Improve Training Compliance

Throughout 2021/22, compliance against certain levels of mandatory Safeguarding Training was not achieved.

As a means of improving compliance, the Safeguarding Team continued the externally agreed blended learning approach for Level 3 Training that was introduced in 2019-20 in response to the COVID restrictions. These sessions were increased from 25 to 57 (40 for Children and 17 for Adults), which was an increase when compared to the previous year of 128%.

To support improvement, Safeguarding has regularly cleansed non-compliance data, individual staff lists have been sent monthly to relevant managers and Heads of Service, identifying both current non-compliance and those due to become non-compliant and the Safeguarding Team have targeted staff individually, to ensure their attendance at booked sessions. It is hoped that this combined with the continued promotion of non-compliance via the Safeguarding Operational Group (SOG) and progress being monitored via the Trust Safeguarding Subcommittee (TSSC) will provide a mechanism for improvement in compliance.

Despite compliance not being achieved, the findings from the Integrated Safeguarding Quality Assurance Report in every quarter have continued to demonstrate those providing care adhere to Trust safeguarding policies and procedures and are confident when responding to safeguarding concerns, within the scope of their roles.

As previously reported, due to the lack of regulatory compliance, Risk 2302 was raised with controls embedded to provide assurance; alongside actions to support the clinical divisions to increase compliance.

Key Objectives for 2022/23

2021/22 has been another busy year of activity and scrutiny. The Trust has continued to successfully demonstrate that the robust mechanisms required to safeguard children, young people and adults from abuse, remain in place.

However, Safeguarding continually evolves and the complexities around decision making increases when taking into account newly recognised forms of harm and abuse. As such structures and process need to continually develop in response which means as ever, we need to be ahead of the challenges and ready for any changes we may face.

Therefore, aside from further embedding of existing overall process, the following key areas / objectives for improvement have been identified in the priorities for 2022/23:

2022/23 Priorities:

No.	Objective	RAG
1	Working closely with our commissioners and the Domestic Abuse Steering Group, implement and embed the recommendations and subsequent changes to practice following the ADN's review of Liverpool Multi-Agency-Risk-Assessment-Conference (MARAC).	
2	To prepare the necessary infrastructure, policies, procedures, workforce development and legal literacy necessary to implement the Liberty Protection Safeguards in 2023/24.	
3	To achieve CQC the compliance of 90% for all safeguarding training.	
4	Support the Trust with the sharing of resources to redevelop the security strategy.	
5	To assist the Trust Digital Team in delivering a safe and effective electronic patient record to further improve the documentation and communication to support patients who suffer harm/abuse.	
6	Embed the updated Safeguarding Accountability and Assurance Framework (Due to in July 2022)	
7	Self-assess the Safeguarding Service/Trust against updated Safeguarding Accountability and Assurance Framework (expected in July 2022)	

Conclusion

As the Trust moves on from the challenges of adapting to the pandemic, its aftermath and responding to the unprecedented Major Incident of November 2021; this Annual Report demonstrates that the Trust continues to ensure its statutory duties to effectively safeguard both the patients and staff that use our services are maintained, regardless of the presenting challenge.

Reflecting the 'new landscape' the structure of this Annual Report differs from previous years in order to provide an overview of both the journey through the year and reflect the quality of the work completed by the Safeguarding Service.

The successes evident in the report would not have been possible without the professionalism and resolve of the Safeguarding Team and all Trust staff who strive to ensure 'Safeguarding is Everyone's Business'.

More importantly the commitment of the Trust Board and Senior Leadership Team in articulating this vision has remained pivotal to success and this was acknowledged through the Chief Executive's Outstanding Contribution Award to the Associate Director of Nursing and Midwifery for Safeguarding and the Safeguarding Team

Overall, the Trust is again in a strong position moving into the coming year. The Safeguarding Team and I look forward to further strengthening the existing arrangements in place and supporting the safeguarding agenda and the Trust on its journey to become 'Outstanding' as rated by the Care Quality Commission.

Mandy McDonough
Associate Director of Nursing and Midwifery for Safeguarding

Appendix A

Liverpool Women's
NHS Foundation Trust

Safeguarding Arrangements within Liverpool Women's Hospital NHS Foundation Trust

Mandy McDonough
Associate Director of Nursing and Midwifery for Safeguarding

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

Legislative Framework

- Crime and Disorder Act 1998
- Children's Act 1989, 2004
- Domestic Violence, Crime and Victims Act 2004
- Female Genital Mutilation Act 2003
- Mental Capacity Act (MCA) 2005 – Amended 2019
- Convention on the Rights of Persons with Disabilities 2006
- Mental Health Act 2007
- Deprivation of Liberty Safeguard (DoLS) 2009
- Care Act 2014
- Children and Families Act 2014
- Prevent Duty 2015
- Serious Crime Act 2015
- Modern Slavery Act 2015
- Domestic Abuse Act 2021

Expectations

- Safeguarding responsibilities form part of the statutory functions for all providers of NHS-funded care settings and NHS commissioning organisations

- The 2022 *Safeguarding Accountability and Assurance Framework (SAAF)* clearly sets out the safeguarding roles and responsibilities of all individuals working in those organisations

- The framework outlines the minimum standards required and guidance for the development of effective local safeguarding practice and arrangements in line with the underlying legal duties

- Therefore, as an Executive Board you must be assured of effective arrangements in order to appropriately discharge your legal duty

Board Responsibilities

As a Board you must be able to demonstrate:

- Strong leadership (Executive Accountable Officer)
- Allocation of the ‘Safeguarding Champion’ role to a Non-Executive Director (NED) Board member
- Strong commitment to external partners and the legislative requirements
- Effective co-ordination and robust Quality Assurance of Trust Safeguarding arrangements

Board Responsibilities

- Board members should have core competencies in Safeguarding

- Awareness of safe recruitment practices and Trust arrangements for dealing with allegations against staff

- Have an understanding of the statutory role including partnership arrangements, risks and performance indicators, the appropriate safeguarding policies and procedures that support local multi agency arrangements and staff's roles and responsibilities including the provision of:
    - Safeguarding Lead for Children and Adults
    - Named Doctor Safeguarding Children and Adults
    - Named Nurse for Safeguarding Children (including LAC)
    - Named Midwife for Safeguarding Children
    - Named Nurse for Safeguarding Adults (including a Mental Capacity Act (MCA) Lead

Are you assured?

- Assurance to the Board of Directors through an Annual Report for Safeguarding Children, Adults and Children in Care; and the Trust Safeguarding Strategy

- Received the quarterly update Quality and Performance Report which has been presented at the Quality Committee (Unannounced Inspections and Audit within the Report)

- Received the Chair's Reports (via Quality Committee) from the Trust Safeguarding Sub Committee (TSSC) and Safeguarding Operational Group (SOG)

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	***22/23/97g***		**Date: 01/09/2022**	
Report Title	**Whistleblowing/ Freedom to Speak up Annual Report 2021/22**			
Prepared by	***Kevin Robinson, Freedom to Speak Up Guardian***			
Presented by	***Kevin Robinson, Freedom to Speak Up Guardian***			
Key Issues / Messages	***This is the annual report completed by the Freedom To Speak Up Guardian to provide the committee with assurance regarding Whistleblowing. It includes details of those issues that have been formally raised with the Trust and how they have been dealt with.***			
Action required	**Approve ☐**	**Receive ☐**	**Note ☐**	**Take Assurance ☒**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	***To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it***	***For the intelligence of the Board / Committee without in-depth discussion required***	***To assure the Board / Committee that effective systems of control are in place***
	Funding Source (If applicable): N/A			
	For Decisions - in line with Risk Appetite Statement – N/A ***If no – please outline the reasons for deviation.***			
	The Board is asked to accept the assurance provided by this report and endorse the further actions proposed.			
Supporting Executive:	***Michelle Turner, Chief People Officer***			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 1.2 Failure to recruit and retain key clinical staff	Comment:
Link to the Corporate Risk Register (CRR) – CR Number:	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Audit Committee	**July 22**	**CPO**	**It was noted that improvements had been made during the year to raise the profile of the Freedom to Speak Up Guardians. This**

			continued to be tracked via the staff survey and pulse surveys.

EXECUTIVE SUMMARY

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

MAIN REPORT

INTRODUCTION

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

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

ISSUES FOR CONSIDERATION

1.1. Trust Policy

The Trust's policy has been reviewed and updated. The staff side were consulted as part of this process and they were happy with the content and form of the policy. Further review will be undertaken in the next 12 months to expand the "Speak Up" message to include the message that positive improvements/suggestions can be raised at any time via "speak Up" principles, not just what something is failing.

1.2. Assurance: Annual Staff Survey Results

The National NHS Staff Survey includes three questions that relate to issues around raising concerns.

The table below shows the Trust's results from the previous surveys, together with comparisons against the national comparator (in our case Acute Specialist Trusts) and the Trust's previous results. some of the question numbers have changed and there are a couple of new ones:

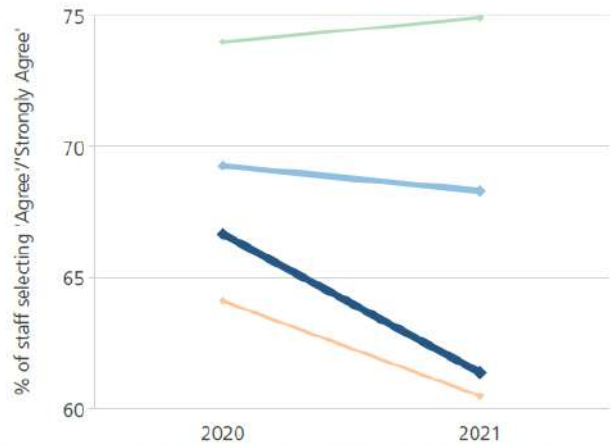
Q17a
I would feel secure raising concerns about unsafe clinical practice

	2017	2018	2019	2020	2021
Best	79.7%	79.8%	78.2%	80.0%	82.2%
Your org	68.8%	68.9%	73.2%	70.3%	75.5%
Average	71.8%	73.0%	73.9%	75.4%	78.5%
Worst	66.0%	68.9%	71.4%	70.3%	73.7%
Responses	862	857	821	790	779

Q17b
I am confident that my organisation would address my concern

	2017	2018	2019	2020	2021
Best	72.1%	77.2%	76.3%	74.0%	75.1%
Your org	60.7%	59.8%	64.0%	63.2%	64.3%
Average	63.2%	64.8%	65.6%	65.7%	66.8%
Worst	54.0%	57.9%	61.3%	62.6%	62.7%
Responses	860	857	816	786	776

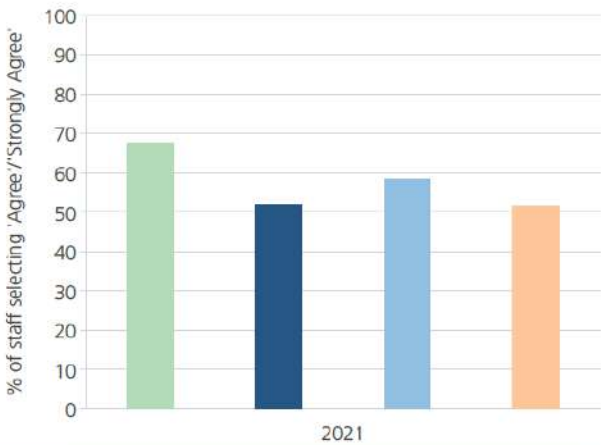
Q21e
I feel safe to speak up about anything that concerns me in this organisation



	2020	2021
Best	74.0%	74.9%
Your org	66.7%	61.4%
Average	69.3%	68.3%
Worst	64.1%	60.5%
Responses	791	777

Q21f
If I spoke up about something that concerned me I am confident my organisation would address my concern

No trend data are shown as this is a new question



	2021
Best	67.4%
Your org	51.8%
Average	58.4%
Worst	51.7%
Responses	778

Source: raw data for 2021 NHS Staff Survey supplied by Quality Health

These figures show an increase in the staff feeling secure about raising concerns about unsafe clinical practice, with the highest score in the last 5 years. The gap between the organisation and the national average has closed over the year. Confidence in the organisation addressing the concern has bounced back following a small dip last year and is again showing the highest score in the past 5 years.

The question "I feel safe to speak up about anything that concerns me in this organisation" has seen a decrease of just over 5%. Although the national picture has seen also seen a decrease in the score from this question, it is more pronounced in the organisation. A new question for 2021 "if I spoke up about something that concerned me I am confident my organisation would address my concerns" also scored poorly for the trust.

Work instigated by the Trust Freedom to Speak up Guardians, that had already commenced during 2021-22, should help us to understand these scores in more detail and address some of the underlying issues affecting these scores.

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

One cased was formally raised with the Trust during the period April 2021 to March 2022:

- It was an anonymous concern raised in August with regards to staffing concerns and patient safety. This was reviewed by the Assistant Director of Nursing & Midwifery and a written response was sent to the CQC.

1.3. Freedom to Speak Up Guardian (F2SUG)

The chart below demonstrates the Guardian contacts per Quarter and the main themes; this recording is in line with National Guardian requirements and reported externally**.**

	Total number of concerns raised	Concerns where staff wanted to remain Anonymous	Concerns with element of Patient Safety/quality	Concerns with element of Bullying and Harassment	Concerns where concerns about detriment	Comments
Q1 2021/22	14	0	3	5	0	Increase of 3 from 2020/21
Q2 2021/22	12	1	2	9	0	Decrease of 2 from 2020/21
Q3 2021/22	11	0	0	7	0	Decrease of 23 from 2020/21 (this

						followed a 26 increase 19/20)
Q4 2021/22	7	0	0	7	0	Decrease of 6 from 2020/21

In the last 12 months a total of **44** contacts were made to the Freedom to Speak up Guardian (F2SUG) requesting support to raise concerns or where staff want to speak to someone in a safe space to discuss work related issues. This is decrease of 39**%** (28) contacts recorded in the previous 12 months. This is after a large increase of 112% the year 2019/20. Concerns throughout the year were raised from a wide variety of staff, with concerns raised by staff of all grades and from all services and teams have spoken to the Freedom to Speak up Guardians. The trend data would seem to indicate that staff continue feel confident to raise concerns by identifying themselves to the Guardian, although there is still some element of apprehension to share their identity any further, with a small number wishing to keep their details confidential at all stages.

At the beginning of Q3 the second Guardian role was successfully filled and have the full complement of guardians again. Dr Srinivasarao Babarao (Shri) is a Consultant Neonatologist and it is hoped that as a medical staff member it will open up another avenue for any medical colleges who prefer to discuss their concerns with a peer. Shri has already forged strong links with the junior Doctors by taking over the main delivery of their induction sessions and is providing a voice for the Guardians and speaking up at medical/clinical meetings.

During 2021/22, the new online national Freedom to Speak Up training program was released that is available for anyone who works in healthcare. Developed in association with Health Education England, the training is spit into 3 modules:

- **"Speak Up"**

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

- **"Listen Up"**

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

- **"Follow Up"**

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

In Q4 2021/22 the "Speak Up" module was launched and classified as essential training for all workers. It is hoped that by continuing to increase the awareness of the speak up program, more staff will feel confident in speaking up.

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

Concerns continue to be raised where staff members advise they have raised issues with their line managers etc. and they either do not seem to have acted or taken action which is felt to be inconsistent and unfair. It is hoped that 2 training provisions being made available during 2022/23 will help with these issues. Firstly, the second "Listen Up" training will be launched in early 2022/23 which is aimed at managers to help them address concerns when the are raised by members of staff. Secondly, the launch of the Fair and Just training for managers in 2022/23 is aimed at giving the managers the skills to review and act on issues by using the fair and just principles.

Concerns raised throughout the year relating to the uncertainty around the COVID-19 Pandemic and the constant changes that this brought about have decreased significantly as the organisation firstly learnt to live with the restrictions and as it gradually moves away from these.

Periodically throughout the year there continues to cases where the root cause seems to be an issue with how change is managed and implemented. Many changes in leadership across the Trust has meant priorities and ways of working have been changed and this has made staff feel unstable in their role. On occasion how this has been implemented meant staff felt frustrated and concerned about the impact of these on patients and themselves. As part of the leadership courses being undertaken the Freedom to Speak Up module includes advice and guidance on change management and the impact this has on the concerns of staff.

Induction and training activities have continued to be undertaken during this year in both virtual, recorded and face to face formats where possible.

Feedback to the Guardians is collected at the end of an episode of raising concerns with staff feedback being wholly positive. There has been 1 piece of negative feedback this year related to the support offered by the Guardians. This related to difficulties in meeting with the person raising a concern in an environment they felt was confidential

enough. To address this the Guardian ended up meeting the staff member away from the Trust site.

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

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

The F2SUG's continue to monitor training, policies and processes undertaken by the Guardians to ensure any national changes are implemented where apprpriate. F2SUG continue to have a presence on all inductions and leadership courses within the Trust.

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

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

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

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

Our Board and senior leadership team will support this vision by:

- Actively championing Speaking Up
- Providing timely and easy access to the Senior Independent Director when requested
- Ensuring all methods of raising concerns are promoted seeking innovative ways to make speaking up accessible to all staff at all times
- Raising the profile and visible leadership of Freedom to Speak Up
- Modelling the behaviours to promote a positive culture in the organisation
- Providing the time and resources required to deliver an effective Freedom to Speak Up function
- Seeking assurance from Guardians across a range of indicators about the underlying culture in relation to speaking up across the Trust

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

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

1.5. Freedom to Speak up survey

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

The most recent Survey conducted in December 2021 showed:

Positive responses compared to the June 2021 survey:

- **83%** of respondents are aware we have Freedom to Speak up Guardians within the Trust – Up from 77%
- **73%** are aware of the role of the guardians and why they are there for them – up from 64%
- **62 %** said F2SU information is NOT visible enough - Down from 75%
- **60%** saying they haven't seen any information displayed across the Trust in the last week. – Down from 81%

As part of the survey, respondents are asked to provide additional comments or thoughts on the freedom to speak up at Liverpool Women's. These comments are key to shape our communication strategy over the next 12 months.

The comments show we need to continue to promote the service and benefits of the guardian service and we would like to see a continued upward trajectory in the awareness and visibility of the service. We are doing this by planning to attend team and divisional meetings to continue with the messaging started during 2021.

New desktop links have been created, along with updates to the Intranet site and creation of videos to promote the benefits of speaking up.

1.6. Actions completed from 2021/22 report

The following items which were listed as action for the coming year on the 2021/22 report have been completed:

- *Launch new promotional campaign with a stronger visual identify across the trust to help with the visibility of the service provided*
- *Embed the national training modules across the trust and encourage all staff to complete to their relevant job level. This will add to the work that is done at induction and other awareness activity. -*
- *Conduct a refreshed Freedom to Speak Up review tool review for 2021 with the Board and work on any associated actions that result from this.*
- *Launch the Freedom to Speak up Strategy*
- *Conduct review of the Freedom to Speak up Guardian structure to support the future plans and strategy.*
- *Support the Leadership and Management Programme by providing specific Freedom to speak up workshops to identified future leaders. This will focus on how concerns are received by managers and the expected actions they are required to take.*
- *Work with HR colleagues on analysis of the any 2020 Staff Survey's to identify pockets of concern and prioritise these areas for contact and support.*
- *Explore how to enable the Freedom to Speak Up data to be triangulated with other data through the Trust's Integrated Governance report*

1.7. Actions for the Coming Year Ahead

The following actions are the priorities for the year ahead

- Development of a Bi-annual Divisional Reports to raise the profile of speaking up at Divisional level.
- Ensure feedback and findings gathered from speaking up cases feed into wider Trust governance reports
- Ensure the Trust Policy on Speaking up reflects the latest best practice National Speaking up Policy Guidance
- Development of closer links with other staff support services such as Mental Health First Aiders and Dignity at Work Advisors, staff disability network, Staff BAME group
- Develop ways to celebrate speaking up across the Trust and externally
- Development of a minimum Data set for reports to Board and PPF which will provide assurance about the Speaking up arrangements in the Trust
- Development of a feedback mechanism to allow learning, improvement, and development of the F2SUG service
- Development with HR leads a system to review impact of speaking up on workforce
- Continue to engage with staff, to be visible within the Trust, support training for staff and managers around Speaking up.

- Continue to support the Fair and Just Culture work program within the Trust and embed its principles into all aspects of Trust business. - Ongoing
- Continue to work with Reginal and National Guardians to improve communication and standards of working and reporting of Concerns Raised. Ongoing
- Continue to Work with the Divisional Leads to identify any trends and themes in concerns raised.

CONCLUSION

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

The report also provides information on the commitment the Trust is making to ensure all staff, managers, senior managers and Directors are provided with the knowledge and skills to make best use of the speak up philosophy.

It also provides assurance that any concerns that have been raised have been dealt with appropriately.

RECOMMENDATION(S)

The Board is asked to accept the assurance provided by this report and endorse the further actions proposed.

Putting People First (PPF) Committee Chair's Highlight Report to Trust Board
18 July 2022

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Reported that the mandatory training target had continued to not be met. Detailed compliance audits in specific areas were planned and the authority to cancel mandatory training had now been reserved for Heads of Nursing / Midwifery. The Trust continued to undertake a risk-based approach to prioritising training to support patient safety. • Noted there had been a significant investment into additional theatre staff. Whilst this was positive, it was asserted that there was a need to remain cognisant of the potential clinical risk of introducing a significant number of new staff. It was confirmed that lessons had been learned from the onboarding experience of new midwives joining the organisation. For a period, the new theatre staff would also be supernumerary whilst they complete their induction and orientation. • An overall theme related to the risk of burnout for junior doctors. The Deputy Medical Director was exploring more sustainable workforce solutions. The Chief Nurse & Midwife requested that senior nurses be represented in the working group. The Committee agreed to review the medical workforce position and attendant risks in six months' time.	• It was noted that corporate services did not have formal KPIs to measure their contribution to the wider Trust. This, along with more formalised feedback mechanisms, are being explored. • There was an acknowledgement that junior doctors were more likely to have different expectations regarding work/balance compared to previous generations. It was therefore important that the Trust recognised this and could create workforce models that enabled a greater degree of flexibility. The Committee received an update on the Trust-wide work that was being undertaken to explore how to provide increased flexible working arrangements for staff.
Positive Assurances to Provide Identify in brackets should the assurance provide evidence against the CQC Key Questions – SAFE | EFFECTIVE | CARING | RESPONSIVE | WELL LED	**Decisions Made**
• The Committee received an overview of the first 'Big Conversation' event which took place at the Trust over a 24-hour period on 15 June 2022. The Committee agreed that the event had been successful and should be replicated in the future. (WELL LED) • The Committee received an overview of the rollout of Multidisciplinary Trust Wide human factors training which was anticipated to commence from October 2022 over a 6-month period following completion of nationally developed e-learning as a pre-requisite. This had been designed to coincide with the anticipated go live launch of the final Patient Safety Incident Response Framework (PSIRF). (SAFE / EFFECTIVE / WELL LED) • Low levels of employee issues noted. In total there had been four disciplinary incidents and four grievances reported during 2021/22. Whilst the small numbers made it challenging to identify any meaningful patterns or trends from the data, there was no evidence to suggest that a disproportionate number of BAME or disabled staff were involved in the process. (CARING / WELL LED) • Positive developments from the most recent Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) data were noted. However, it was acknowledged that a significant amount of work remained to ensure that the Trust was representative of the population that it serves. (WELL LED)	• The Committee ratified several HR policies.
Summary of BAF Review Discussion	

(Board Committee level only)
• The Committee reviewed the PPF aligned BAF risks. No changes to risks scores were recommended. No risks closed. • Stated that the on-going challenges relating to mandatory training could be better reflected in BAF risk 1.2 and this would be developed.
Comments on Effectiveness of the Meeting / Application of QI Methodology
• Timely • Robust discussion

2. Summary Agenda

No.	Agenda Item	Purpose	Rating	No.	Agenda Item	Purpose	Rating
28.	Board Assurance Framework (BAF): Workforce related risks	Assurance		35.	Trust Wide Human Factors Training and Patient Safety Preparation	Assurance	
29.	Chief People Officer Report	Information		36.	Analysis of Disciplinary, Grievance & DAW Cases for 2021/22	Assurance	
30.	Workforce KPI Dashboard Report	Assurance		37.	Equality, Diversity, and Inclusion including WRES/WDES/Gender Pay Gap	Assurance	
31.	Big Conversation – June 2022	Assurance		38.	Retention & Flexible Working Update	Assurance	
32.	Corporate Services Workforce Assurance	Assurance		16.	Policies for Approval	Approval	
33.	Theatre Workforce Update	Assurance		17.	Sub Committee Chair Reports	Assurance	
34	Medical Workforce Assurance	Information					
12.	Mandatory Training Deep dive	Assurance					

3. 2022 / 23 Attendance Matrix

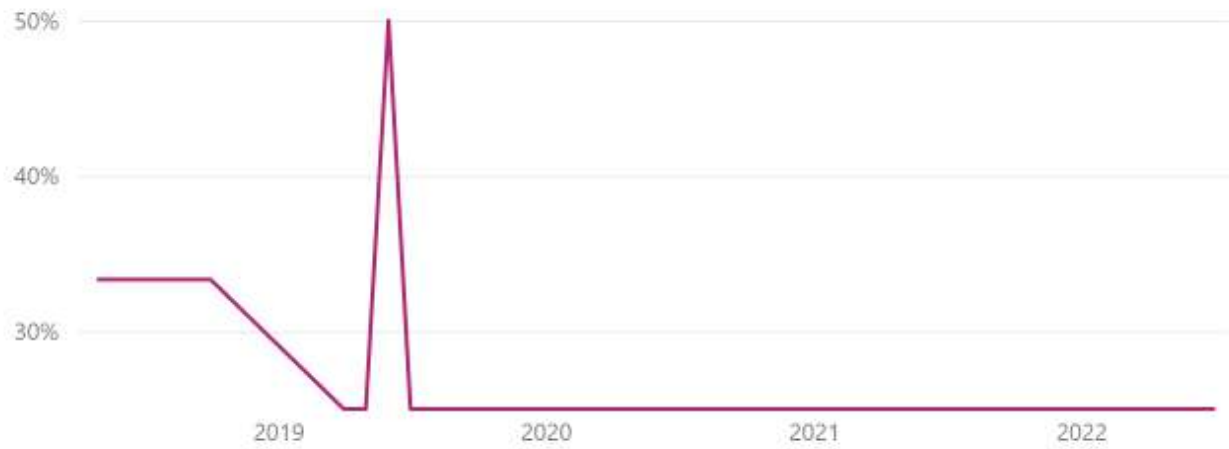
Core members	May	Jun	Sep	Jan	Mar
Susan Milner	✓	NM			
Gloria Hyatt	✓	✓			
Louise Martin	✓	✓			
Zia Chaudhry	✓	✓			
Michelle Turner	✓	✓			
Marie Forshaw	✓	✓			
Gary Price	✓	✓			
Claire Deegan	A	✓			
Liz Collins	✓	✓			
Dyan Dickins	✓	✓			
Present (✓) Apologies (A) Representative (R) Nonattendance (NA) Non-Member (NM) *Non-quorate meetings highlighted in greyscale*					

Liverpool Women's
NHS Foundation Trust

Trust Board

Workforce Performance Report
September 2022

To develop a well led, capable, motivated and entrepreneurial **W**orkforce



Positive Developments

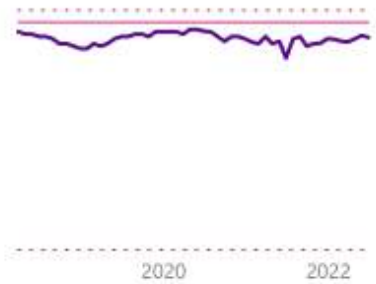
Areas of Challenge

KPI	July 2021	August 2021	September 2021	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022	April 2022	May 2022	June 2022	July 2022
Clinical Mandatory Training Compliance	81.88% ↑	81.17% ↓	81.91% ↑	80.35% ↓	79.21% ↓	78.26% ↓	68.06% ↓	79.22% ↑	78.15% ↓	75.62% ↓	76% ↑	76.99% ↑	77.49% ↑
Mandatory Training Compliance	80% ↓	88% ↑	89% ↑	85% ↓	86% ↑	86.23% ↑	88.17% ↑	87.82% ↓	87.11% ↓	86.76% ↓	88.01% ↑	89.44% ↑	88.64% ↓
Sickness Absence Rate	7.67% ↑	7.99% ↑	8.35% ↑	8.03% ↓	7.93% ↓	10.26% ↑	10.99% ↑	7.64% ↓	9.18% ↑	7.57% ↓	6.6% ↓	6.63% ↑	7.77% ↑
Turnover Rate	11% ↑	11% →	11% →	13% ↑	12% ↓	12% →	13% ↑	13% →	13% →	13% →	13% →	12% ↓	12% →

Mandatory Training Compliance

>= 95%

KPI095T



Workforce
Trust Value

Chief People Officer
Exec Lead

Deputy Director of Workforce
Owner/Lead

Local
Reported To

Trust
Source

Attribute	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
% Performance	80%	88%	89%	85%	86%	86.23%	88.17%	87.82%	87.11%	86.76%	88.01%	89.44%	88.64%
Numerator	0.8	0.88	0.89	0.85	0.86	0.86	0.88	0.88	0.87	0.87	0.88	0.89	0.89

DQKM

The overall Trust mandatory training compliance fell by 0.80%, from 89.44% in month three, to 88.64% in month four. This is now 6.36% under the Trust's target rate of 95% and rated as amber. Across the largest clinical areas, compliance increased by 0.78% in Gynaecology, but fell by 0.87% in Maternity, and by 0.90% in Neonates. At divisional level, compliance fell across all divisions, by 0.09% in the Gynae Division, by 0.82% in Family Health, by 1.41% in Clinical Support Services, and by 1.58% in the Corporate Division.

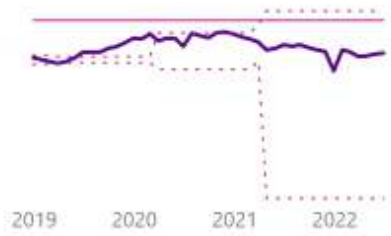
The HR and L&D teams continue to provide support, information, and training to managers across the Trust. Trajectories to underpin a sustained increase in compliance have been developed and are monitored by the Divisional Management Teams. Auto-enrolment has now been rolled out to ensure more accurate reporting and to make it easier for staff to access e-learning modules. There have been a number of technical issues with the new mandatory training courses were launched at the beginning of July, but compliance with these will not be included in any reported figures until three months after the problems have been addressed (to allow staff time to complete these courses).

While every effort is being made to improve and maintain compliance rates, it is difficult to accurately predict when the target figure of 95% will be achieved, particularly in light of the continuing covid 19 global pandemic and the pressures it has created both operationally and in terms of staffing. Nevertheless, every endeavour continues to be made to bring the figure within Trust target through effective collaboration between line managers, Human Resources and Learning & Development.

Clinical Mandatory Training Compliance

>= 95%

KPI378T



Workforce
Trust Value

Chief People Officer
Exec Lead

Deputy Director of Workforce
Owner/Lead

Local
Reported To

Trust
Source

Attribute	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
% Performance	81.88%	81.17%	81.91%	80.35%	79.21%	78.26%	68.06%	79.22%	78.15%	75.62%	76%	76.99%	77.49%

DQKM

July 2022

The overall Trust clinical mandatory training compliance increased by 0.50% from 76.99% in month three. to 77.49% in month four. This is now 17.51% under the Trust's target rate of 95% and rated as red. Across the largest clinical areas, compliance increased by 0.41% in Gynaecology, and by 3.48% in Neonates, but fell by 1.26% in Maternity. At the divisional level, compliance increased by 0.11% in the Gynaecology Division, by 0.12% in Family Health, and 1.60% Clinical Support Services, but fell by 1.67% in in the Corporate Division.

The HR and L&D teams continue to provide support, information, and training to managers across the Trust. Trajectories to underpin a sustained increase in compliance have been developed and are monitored by the Divisional Management Teams. Auto-enrolment has now been rolled out to ensure more accurate reporting and to make it easier for staff to access e-learning modules.

While every effort is being made to improve and maintain compliance rates, it is difficult to accurately predict when the target figure of 95% will be achieved, particularly in light of the continuing covid 19 global pandemic and the pressures it has created both operationally and in terms of staffing. High sickness levels will also be having an impact. Nevertheless, every endeavour continues to be made to bring the figure within Trust target through effective collaboration between line managers, Human Resources and Learning & Development.

Sickness Absence Rate

Target: <= 4.5%

Attribute	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
% Performance	↑ 7.67%	↑ 7.99%	↑ 8.35%	↓ 8.03%	↓ 7.93%	↑ 10.26%	↑ 10.99%	↓ 7.64%	↑ 9.18%	↓ 7.57%	↓ 6.6%	↑ 6.63%	↑ 7.77%

Workforce
Trust Value

Chief People Officer
Exec Lead

Deputy Director of Workforce
Owner/Lead

National TBC
Reported To

SOF / CCG / Trust
Source

DQKM

July 2022

The single month sickness absence figure increased by 1.14%, from 6.63% in month three, to 7.77% in month four. This is therefore now 3.27% above the Trust's target figure of 4.50% and is rated as red.

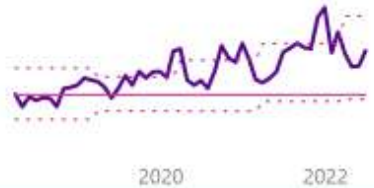
In the largest clinical areas, sickness increased by 0.62% in Gynaecology, by 1.57% in Maternity, and by 3.29% in Neonates. At divisional level, sickness increased by 0.68% in the Gynae Division, by 2.19% in Family Health and by 1.16% in Clinical Support Services, but fell by 0.18% in the Corporate Division.

As in previous months, the proportions of short term/long term sickness varied across the divisions: in the Gynae Division, short term sickness accounted for 41.36% of the overall total, and in Family Health it accounted for 44.37% of the total, while in Clinical Support Services it was only 34.24% and in the Corporate Division, it actually accounted for 74.14% of the total.

In terms of diagnosis, the top three most common again remained the same, but with the order changing, so that cold/cough/flu remained the most prevalent diagnoses, followed by gastrointestinal problems, and then anxiety/stress/depression. The figure for sickness specifically resulting from covid 19 again continued to rise, increasing by 0.50%, from 2.04% in month three, to 2.54% in month four.

The HR Department are continuing to provide support for managers in managing sickness absence and in supporting staff. This includes providing a full range of information and data, training, and regular meetings with local and divisional managers. A range of measures are in place specifically to address the situation with regards to covid 19. Plans are now being developed for a further covid booster vaccination programme in September to run alongside the annual flu vaccination campaign. A lot of work has also been done in pulling together and communicating to staff a whole range of health & wellbeing advice and support, through both the Cheshire and Merseyside Resilience Hub, and local initiatives such as the Wellbeing Conversations. Following the findings of a study showing the effects of trauma and PTSD amongst clinical staff, the Trust has now employed a psychologist to set up a service to support staff across the Trust.

Efforts to reduce sickness absence are on-going, but it is difficult to accurately predict when the target figure of 4.50% will be achieved, particularly in light of the continuing covid 19 global pandemic and the pressures it has created, both operationally and in terms of staffing. Nevertheless, every endeavour continues to be made to bring the figure within Trust target through effective collaboration between line managers, Human Resources and Occupational Health.



Turnover Rate

Target: <= 13%

Attribute	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
% Performance	↑ 11%	→ 11%	→ 11%	↑ 13%	↓ 12%	→ 12%	↑ 13%	→ 13%	→ 13%	→ 13%	→ 13%	↓ 12%	→ 12%
Numerator	↑ 0.11	→ 0.11	→ 0.11	↑ 0.13	↓ 0.12	→ 0.12	↑ 0.13	→ 0.13	→ 0.13	→ 0.13	→ 0.13	↓ 0.12	→ 0.12

Workforce
Trust Value

Chief People Officer
Exec Lead

Deputy Director of Workforce
Owner/Lead

National TBC
Reported To

SOF
Source

DQKM

May 2022

There has been an incremental rise in turnover the last 12 months to reach the current rolling rate of 13%.

Areas exceeding the target include Finance (19%), Gynaecology (19%) Imaging (34%) Integrated Admin (15%) Integrated Governance (16%) Maternity (14%) Operational Support Services (17%) Pharmacy (21%) and physiotherapy (24%)

A number of the departments with high turnover rates have active improvement plans in place and are receiving support from the OD/HR team to improve staff engagement. These include Imaging, Pharmacy and Integrated Admin. Turnover % are higher in departments such as Physiotherapy with a headcount of only 5.

Actions taken centrally to support retention and understand reasons for leaving include

- Revised Exit Interview Process: In order to encourage more leavers to take up the offer of an exit interview, invites are automatically being sent to have an exit interview with a member of the HR Team
- Stay conversations: These have been piloted by the Retention Lead Midwife within maternity who is delivering training to N&M managers to undertake these conversations in their areas
- Career Conversations: These are now embedded as part of the PDR process and N&M staff from an ethnically diverse background are having additional focused career conversations
- Flexible working project: Work life balance is being analysed as a reason for leaving, trials of different rostering patterns are currently being explored in response to staff feedback from the flexible working survey and 1-1 conversations
- Big Conversation: Divisional and Trust wide actions to respond to staff feedback about why they wouldn't recommend Liverpool Women's as a place to work.

During the peak of covid, there was an increase in staff choosing to retire within N&M, this trend now appears to have ceased. National Drivers including the Annual and Lifetime Allowance restrictions within the NHS Pension Scheme pose a risk of staff choosing to retire early and this is affecting more staff, not only high earners. LWH continues to face high competition from other Trusts and the private sector for employees in administrative and entry level roles, and this has only increased since covid restrictions have been released. We have resumed our widening participation and careers promotion activities and the Lead Nurse for HCA Development is promoting our HCA roles at a Liverpool wide careers fair this month.

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	***22/23/098c***	**Date: 01/09/2022**
Report Title	**WRES and WDES Report 2022**	
Prepared by	Rachel Cowley, Head of Culture and Staff Experience	
Presented by	**Michelle Turner, Chief People Officer**	
Key Issues / Messages	We are statutorily required to report to Board, however Board are asked to recognise that these are one set of metric measuring a wider inclusion activities. This paper: • Demonstrates the Trusts current position in relation to the ED&I strategic ambitions outlined within the Trust Strategy • presents the annual data pertaining to the Workforce Race Equality Standard (WRES) and the Workforce Disability Standard (WDES) • Sets out the actions planned in the next 12 months to further strengthen the ED&I position National metrics reported for WRES and WDES where LWH has seen a decrease in position from previous year include: • Likelihood of racially minoritized applicants being appointed from interview. • Likelihood of racially minoritized staff entering formal disciplinary process. • Likelihood of disabled candidate being appointed from interview. • Likelihood of entering formal capability process. • Number of staff experiencing harassment, bullying or abuse from staff. The National and regional comparison data will not be available until later in the year, however the executive summary and detailed analysis outlines how we have reported in comparison to our results from the previous year.	

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

	Actions to be developed into action tracker with target dates for achievement. Progress with actions to be monitored at the Equality, Diversity and Inclusion Committee
Supporting Executive:	**Michelle Turner, Chief People Officer**

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

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

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome

EXECUTIVE SUMMARY

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

The WRES and WDES data is collated as of 31st March 2022 for all data with the exception of data taken from the 2021 National Staff Survey. We are statutorily required to report to Board, however Board are asked to recognise that these are one set of metric measuring a wider inclusion activities.

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

The National and regional comparison data will not be available until later I the year, we are able to compare to our own results from the previous year, noted below and in more detail in section 2 of the report.

The WRES data is measured against the following metrics:

- Band distribution of clinical and non-clinical staff – minor improvement in position from previous year.
- Board member and non-Executive Director data – improvement in position from previous year.
- Likelihood of being appointed from interview – decrease in position from previous year.
- Likelihood of entering formal disciplinary process – minor decrease in position from previous year however same number of white staff also entering formal process.
- Number of staff experiencing harassment, bullying or abuse from staff – improvement in position from previous year.
- Equal opportunities for career progression – improvement in position from previous year.

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

The WDES data is measured against the following metrics:

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

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

Section 2 of this paper provides more details of these results and section 3 of this paper outlines the actions proposed in response. These actions will be drafted into an action tracker, with lead person and

timeframe identified, the progress will be monitored at the Equality, Diversity and Inclusion Committee meetings.

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

This report is required to be approved by the Trust Board as compliant and authorised by the Trust Board for the Head of Culture and Staff Experience to publish the report on the Trust website to fulfil the National requirements for WRES and WDES.

MAIN REPORT

1. Define the issue

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

The WRES and WDES data is collated as of 31st March 2022 for all data with the exception of data taken from the 2021 National Staff Survey.

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

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

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

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

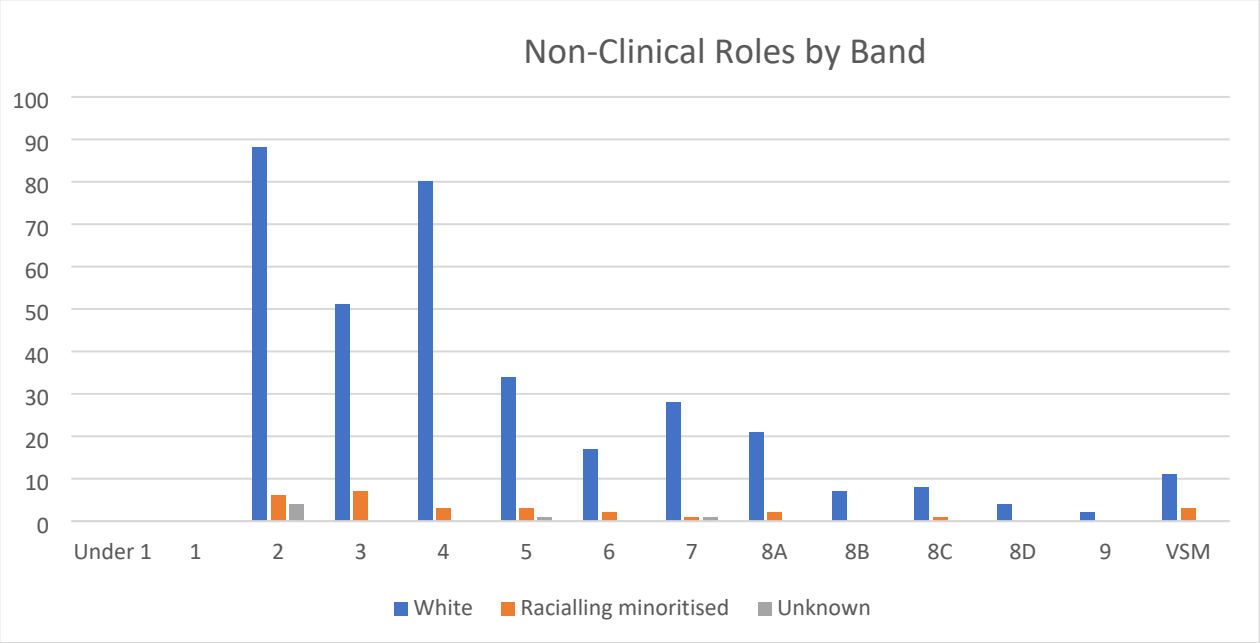
Other achievements for ED&I have been outlined within the Annual ED&I report which is saved on the Trust Website.

2. Key Findings

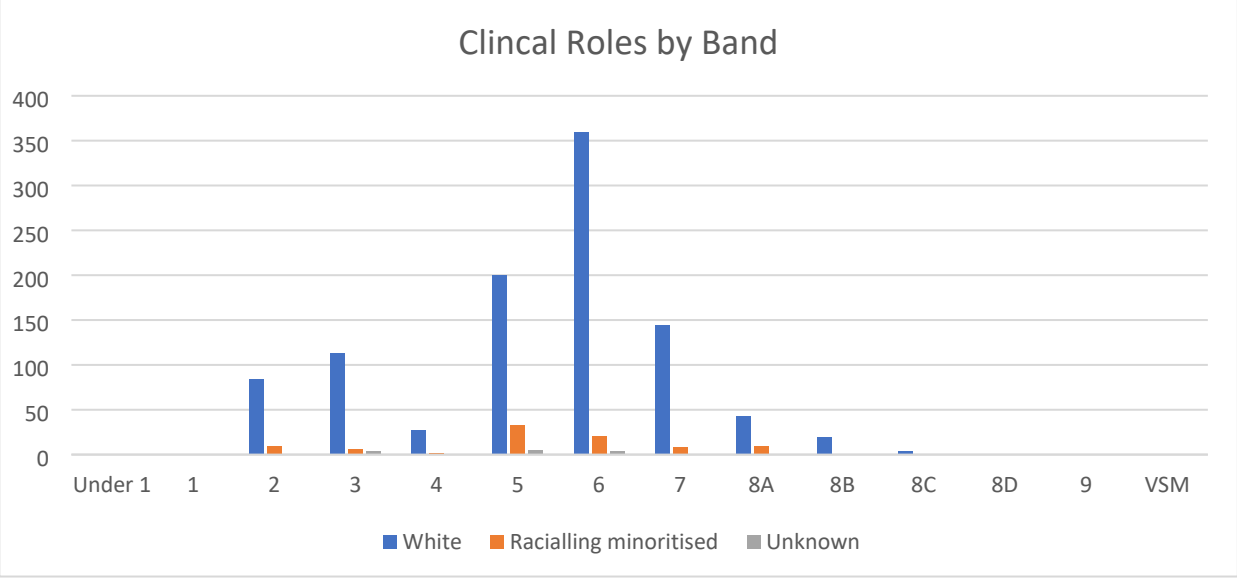
2.1 WRES data 2022

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

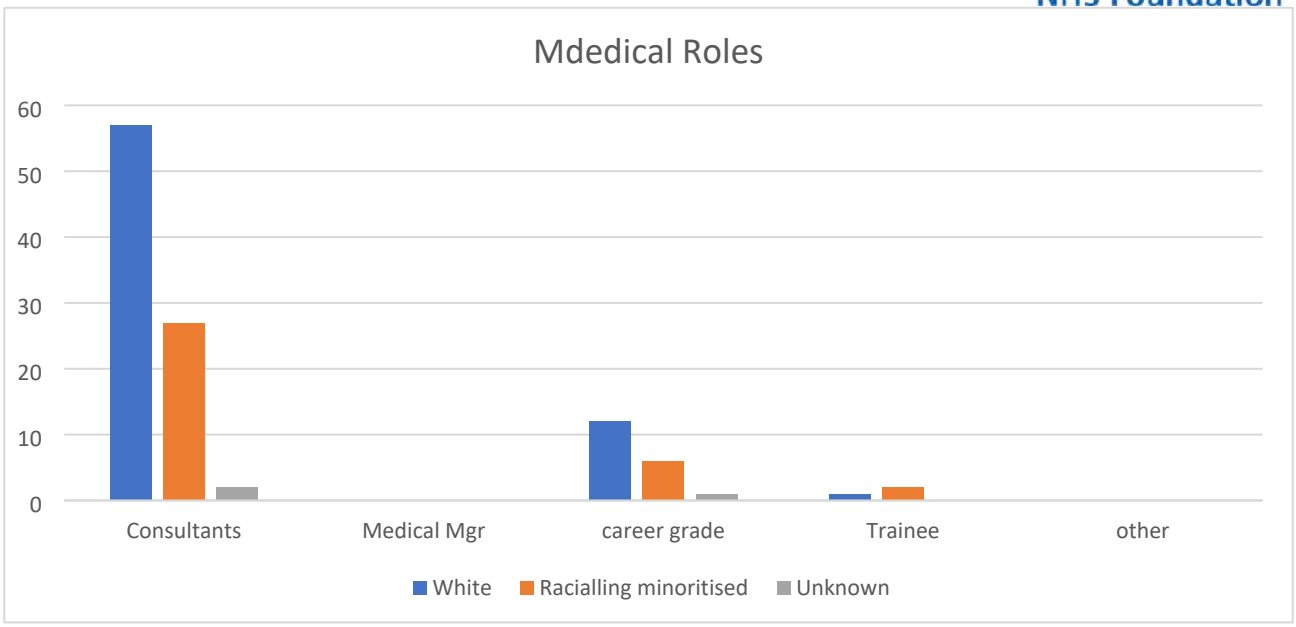
Band distribution has not changed with the majority of racially minoritized staff holding clinical Band 5 and Band 6 posts. The highest banded clinical role (excluding medics) has improved, there is now 1 individual at Band 8D and 9 staff at band 8A, previously there was only 1 individual at Band 8B.



The highest banded non-clinical role has also improved, there are 3 staff at VSM level declaring racially minoritized background, 1 individual at band 8C and 2 staff at Band 8A, previously this had been only 1 individual at Band 8A since 2019.



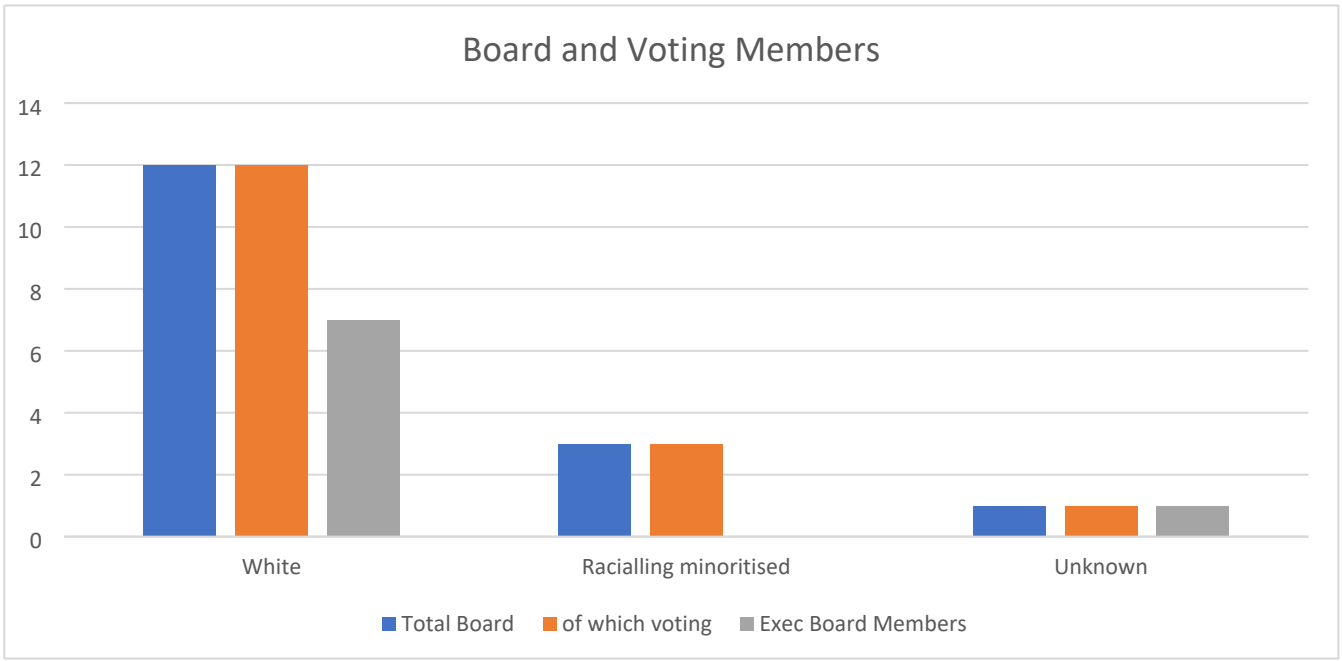
Medical staff figures remain relatively static, 35 staff disclosed racially minoritized background on ESR in 2022 (34 in both 2020 and 2021).



There are 21 staff from Agenda for Change pay scales who have not disclosed on ethnicity within ESR and 3 staff from medical grades who have not disclosed their race within ESR.

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

Board member and non-Executive Director data for racially minoritized staff has increased to 3 individuals which is a positive progression from previous years where there was only 1 individual from a racially minoritized background in a non-Executive Director role. There is 1 individual who has not disclosed ethnicity within ESR.



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

Relative likelihood of being appointed from interview if an applicant is of racially minoritized background has reduced from 52.70% to 46.15% in 2022. This remains a higher likelihood than for white candidates being appointed following shortlisting, however with a staffing population of only 9.54% being from racially minoritized background it is clear this is below the local reported average for the Riverside and means we are not representative of our local population.

The rolling headcount, within year (1 April 2021 – 31 March 2022) there were 14 staff from racially minoritized background who left the organisation (9%) compared to 172 white staff (12%). This indicated there is a clear need for LWH to focus on how we engage with our local community and attract local population, particularly from racially minoritized backgrounds, to apply to work within our organisation.

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

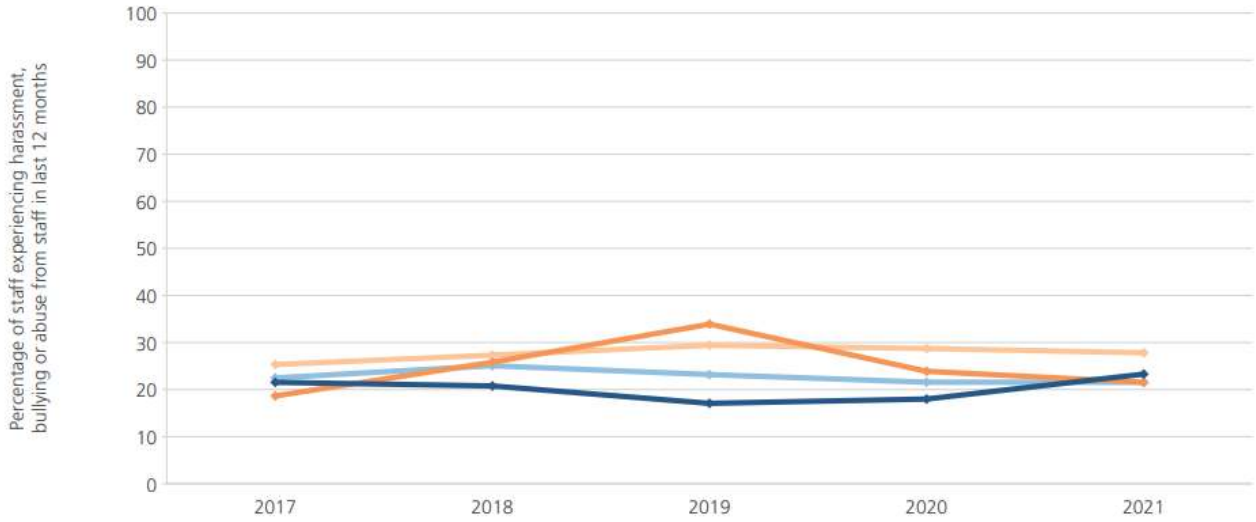
In 2021/22 there was 1 individual from a racially minoritized background entering the formal disciplinary process, this is comparative with the number of white staff also entering the formal disciplinary process during the same period.

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

It is positive to see the continued reduction in the number of staff from a racially minoritized background stating they have experienced harassment, bullying or abuse from staff, this has reduced from 33.9% (2019) to 23.9% (2020) and currently reports at 21.5% (2021), compared to their white colleagues where reporting is 23.3% (2021).

Survey Coordination Centre

2021 NHS Staff Survey Results > WRES > **Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months**



	2017	2018	2019	2020	2021
White: Your org	21.5%	20.8%	17.1%	18.0%	23.3%
BME: Your org	18.6%	25.8%	33.9%	23.9%	21.5%
White: Average	22.5%	25.1%	23.2%	21.6%	21.5%
BME: Average	25.3%	27.3%	29.4%	28.7%	27.8%
White: Responses	794	780	744	706	700
BME: Responses	59	62	59	67	65

Average calculated as the median for the benchmark group

Positively LWH reports a better experience for racially minoritized staff than the average for our staff survey comparator group (27.8%), and LWH ranked as the 4th best NHS organisation for racially minoritized staff for this indicator in the National WRES report for the 2020 submissions. These data comparisons demonstrate that whilst it is positive that LWH continues to report a reduction in this year's data there is still more work to be progressed in this indicator as 21.5% remains a high percentage reporting bullying, harassment or abuse.

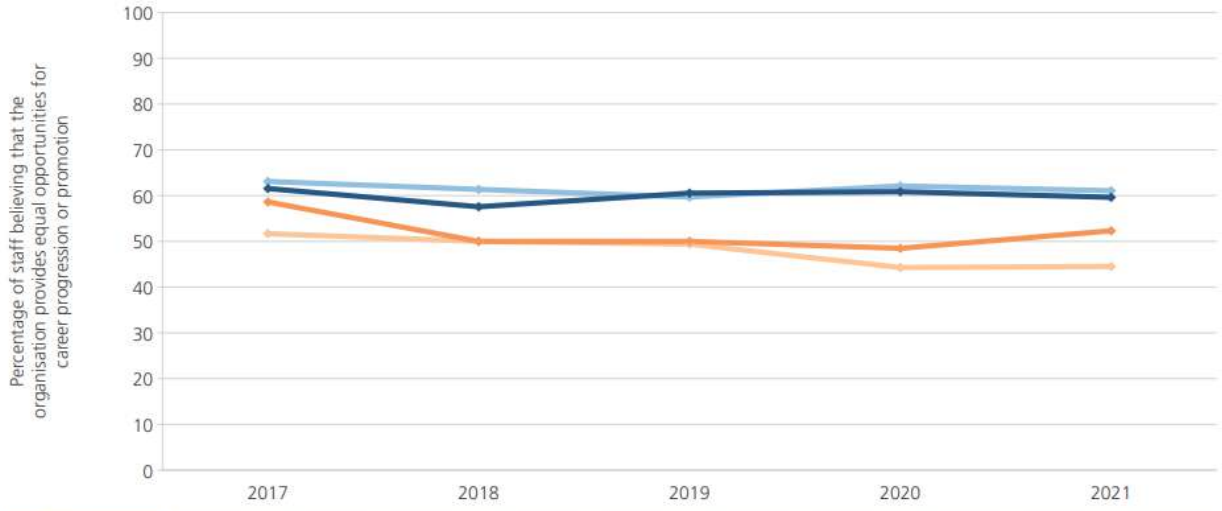
LWH scored as the top NHS organisation in 2020 with the lowest score for *percentage of staff experiencing harassment, bullying or abuse from patients / service users, relatives or the public.* LWH reports a statistically significant negative increase in this indicator for the experience from racially minoritized staff increasing from 8.8% in 2020 to 16.7% in 2021, this also increased for white colleagues from 16.9% to 18.4%. This data indicates there is a need for work within this area to ensure a safe environment for all our staff.

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

There has been an increase in the number of racially minoritized staff believing the Trust provides equal opportunities for career progression, from 48.5% (2020) to 52.3% (2021) compared to 59.6% of white staff this year.

Survey Coordination Centre

2021 NHS Staff Survey Results > WRES > **Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion**



	2017	2018	2019	2020	2021
White: Your org	61.5%	57.6%	60.5%	60.9%	59.6%
BME: Your org	58.6%	50.0%	50.0%	48.5%	52.3%
White: Average	63.1%	61.4%	59.7%	62.1%	61.1%
BME: Average	51.7%	50.0%	49.4%	44.3%	44.5%
White: Responses	788	780	745	705	701
BME: Responses	58	64	58	66	65

Average calculated as the median for the benchmark group

LWH reports lower than the national position for racially minoritized staff reporting there are equal opportunities for career progression in the National WRES report for the 2020 submissions, which reports a national average of 69.2% of racially minoritized background staff believe their trust provides equal opportunities for staff. The national report ranked LWH as 7th best NHS organisation from the 2020 data, this demonstrates an opportunity for LWH to continue to improve in this indicator.

2.2 WDES Data 2022

2.2.1 Band distribution - minor improvement in position from previous year.

There are 248 staff from Agenda for Change pay scales who have not disclosed disability status on ESR (status unknown), which is in improvement from 2021 where there were 285 non-disclosures. The number of staff from Medical grades who have not disclosed on ESR remains static at 20.

In terms of band distribution, there are 4 disabled staff above band 8a in non-clinical roles (previously was 2), and 1 disabled staff above band 8a in clinical roles. There are no staff disclosing a disability in medical roles.

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

In terms of recruitment, non-disabled candidates are 1.70 times more likely to be appointed from shortlisting stage than disabled candidates compared to previous year where non-disabled candidates were 1.41 times more likely to be appointed. *A figure below 1.00 indicates that disabled staff are more likely than non-disabled staff to be appointed from shortlisting, which is positive that the 2022 figure is below 1.00.* The figure for appointment of candidates with a disability has increased from 12 to 20.

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

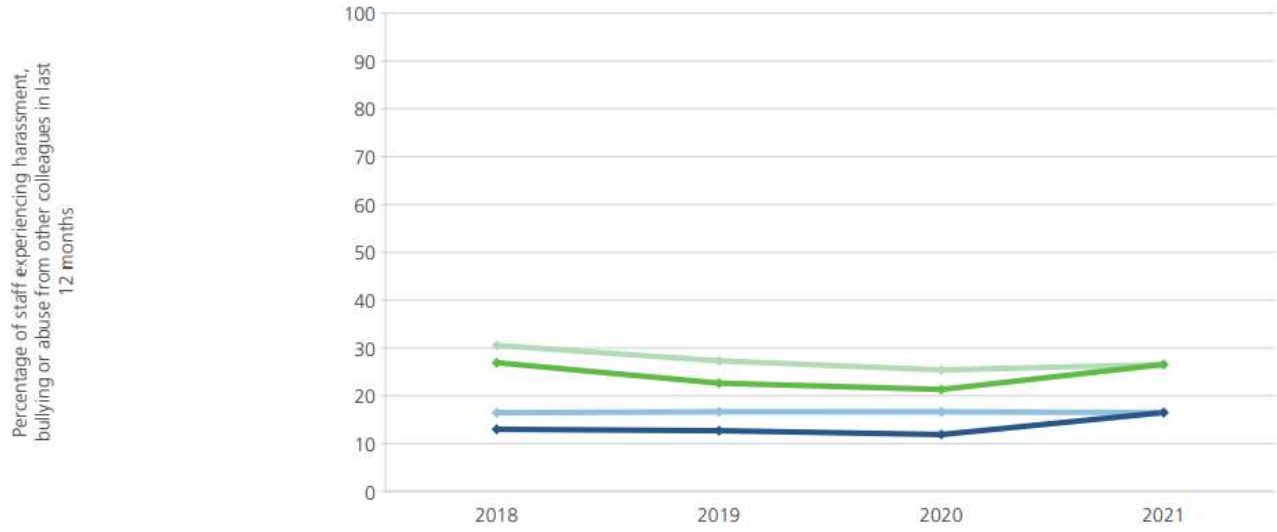
None of the staff entering formal capability process were declared on ESR as having a disability which is a reduction from previous year, which was 1 individual in 2021.

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

It is concerning that the number of disabled staff reporting they have experienced bullying, harassment or abuse in the workplace has statistically significantly increased to 26.5% (increased from 21.3% in 2020) compared to non-disabled colleagues (16.5% in 2021 for non-disabled).

Survey Coordination Centre

2021 NHS Staff Survey Results > WDES > Percentage of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months



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

Average calculated as the median for the benchmark group

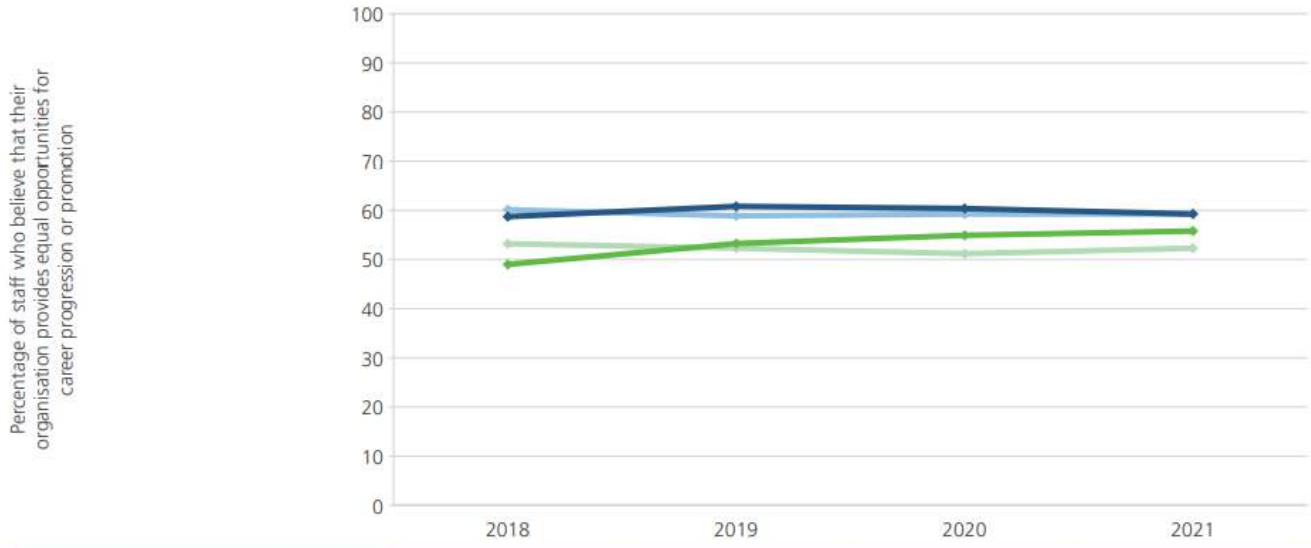
Although there was a statistically significant increase in the number of disabled staff stated they would report bullying, harassment or abuse with 61.7% (55.8% in 2020) compared to 50.6% staff without a disability.

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

Positively for the third year LWH has seen an increase in the staff with a disability reporting that the Trust provides equal opportunities for career progression. This is reported at 55.8% (54.98% in 2020), however this remains lower than non-disabled staff (59.3%).

Survey Coordination Centre

2021 NHS Staff Survey Results > WDES > Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion



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

Average calculated as the median for the benchmark group

3. Solutions / Actions

Planned actions over the next 12 months which go some way to address concerns raised in WRES and WDES 2022 data, as well as strengthen the overall ED&I agenda. Some of these are continued or expanded actions from 2021 due to a resourcing gap for 7 months in 2021/22 to fully complete the work intentioned within year, however a supporting resource has now been identified in progressing with the following actions for 2022/3:

- Data cleanse campaign to be concluded by January 2023 for improvement of disclosure on ESR for all protected characteristics, with a focus on education on what is classed as a disability and long-term condition
- Embed reciprocal mentoring and coaching opportunities for disabled and racially minoritized staff
- Externally provided Inclusive leadership development for the Board and Senior Leaders, with a view to commence a race and culture review
- Implement a focused programme jointly with the Freedom to Speak Up Guardians to support staff from protected characteristic groups to feel safe in raising concerns and to
- Embed career conversations for disabled and racially minoritized staff, with a focus on developmental opportunities being considered for ruing-fencing
- Ringfenced places on Liverpool Women's new Leadership Development Programme for staff from a racially minoritized background
- Continue to strengthen links with diverse community groups, working in partnership to improve positive relationship for staff and patients, as well as improved access for patient care
- Extension of e-learning package to design and deliver specific ED&I training and education to all staff – improved knowledge will result in benefits for better staff and patient experience

- Exploration of how the Trust attracts local population to work at Liverpool Women's, utilising widening participation programmes and alternative ways to advertise and promote our job opportunities
- Development of more diverse recruitment and selection processes, which includes:
  - Recruitment and selection training for members of inclusion staff networks, to ensure sufficiently skilled interview panel members from diverse backgrounds can support recruitment decisions
  - ED&I panel representative to clarify with appointing manager rationale if staff with disclosed disabilities and ethnicity are not chosen for appointment Recommendations

4. Recommendations

This paper has been considered by PPF committee and comments taken into consideration in relation to LWH's actions in response to the national metrics reported.

It is recommended that the actions are transferred into an action tracker document, with clearly outlined leads and deadline dates for each action. Progress with the WRES and WDES action tracker will be monitored at the Equality, Diversity, and Inclusion Committee meetings.

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

This report is required to be approved by the Trust Board as compliant and authorised by the Trust Board for the Head of Culture and Staff Experience to publish the report on the Trust website to fulfil the National requirements for WRES and WDES.

Finance, Performance & Business Development Chair's Highlight Report to Trust Board
25 July 2022

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway

• The following key matters from M3 financial performance report noted:
  ○ At month 3 the Trust is reporting against the revised plan of a £0.526m surplus for the year.
  ○ Agency spend across the Trust is above plan YTD, driven principally by staffing needs recognised in the 2022/23 plan but not yet recruited to permanently and cover for sickness absence. This will be an area of close monitoring throughout the Trust to ensure that the additional investment in staff costs quickly translates into permanent staff.
  ○ Fuel costs: Invoices for energy costs to month 3 have now been received and rates are lower than previously accrued resulting in a £71k underspend year to date (after funding a cost pressure into 2022/23). This remains an area of volatility and risk to the Trust and there is an expectation that rates will continue to fluctuate. Finance and estates teams are working closely to monitor developments.
  ○ Performance against the Better Payment Practice Code has fallen in M3 to 85% by value. Performance by volume of transactions is marginally improved at 77%. The finance team has formed a task and finish group, working closely with colleagues in procurement and operations, to move it to the 95% target.
  ○ Elective Recovery Fund (ERF): There remains uncertainty both about the overall level of ERF and also how this will be distributed to providers.
• The 52 week wait position remains the biggest challenge in terms of recovery which would be reflected on the Trust BAF update.
• Risks were highlighted in relation to non-compliant Fire Door Checks within the Planned Preventative Maintenance schedule. It was confirmed that the Fire workplan is on the risk register. The Committee escalated the matter to the COO and requested an update at the next meeting.
	• The Committee remitted an action for the NED Board Committee Chairs and Executive Leads to meet for a joint piece of work across the Committees to agree a schedule of risks and agree priorities between spending, safety and workforce.
	• The target for out of hours Emergency Gynaecology Surgery is currently under review and will mirror the Cheshire and Mersey Gynaecology GIRFT best practice whereby an accepted range will also be set. Similarly at the end of July the Trust commences a 12-month theatre improvement QI programme whereby out of hours surgical pathways will be under review alongside in hours provision. It is anticipated that this would deliver a series of continued improvements.
	• The Committee agreed that assurances of positive executive partnership and system working should be articulated within reports.
	• Progress maintained with the EPR Programme however the build and business change activities remain challenging. The Meditech 120-day review has been received and this has concurred with the areas of delay identified by the programme team. The NHS Digital External Programme Review has commenced and is expected to conclude during August 2022. This will provide valuable lessons learnt.
	• A refresh of the Community Diagnostic Centre business case is planned, which will take account of the changes to the project plan and funding mechanism which have taken place since the original submission of the case. The updated case will be brought to this Committee for review and Board for approval.
	• The Trust is adopting the Health Financial Management Association (HFMA) self-assessment tool to support their work on maintaining financial sustainability while delivering safe and effective patient care. This has been requested by the region but is also good practice.

Positive Assurances to Provide Identify in brackets should the assurance provide evidence against the CQC Key Questions – SAFE | EFFECTIVE | CARING | RESPONSIVE | WELL LED	**Decisions Made**
• At M3 the CIP plan is ahead of schedule. A number of recurrent schemes are due to commence in quarter 2. These will be monitored in detail within Divisions and through the Finance Recovery Board. The Committee requested quarterly oversight of CIP	• Agreed to receive more detailed CIP updates on a quarterly basis.

(an increase from bi-annual) to maintain a tight grip of controls and for assurance. (WELL LED)

- The aged debtor balance is improved in M3 following payment of outstanding balances. The deferred income balance is now significantly higher than the start of the year as it includes advance payments for 2022/23 and 2023/24 estimated neonatal costs. This is part of the system support of the Trust's cash balances. (WELL LED)
- An elective recovery programme has been established and the Trust has zero 104 week waiters in line with the national recovery asks and also has a small number of over 78 week patients at this stage in line with the national ask for their elimination by March 2023. The Trust has set itself a stretch target to eliminate 52 week waits in half the time of the national ask for March 2025, to September 2023. A revalidation exercise of waiting lists would be repeated (ALL)
- Successful go-live of the electronic GROW charts and the phased approach for full adoption. The Digital Maternity team will focus on the remaining optimisation changes.
- The Committee noted the Information Governance (IG) and the successful Data Security Protection Toolkit (DSPT) submission. MIAA had reviewed the DSPT submission and provided overall substantial assurance.
- Noted continued progress in delivering Future Generations Programme specifically within development of programme governance; staff engagement; and model of care development. It was noted that monthly reports would be presented to both this Committee and the Quality Committee regarding delivery of relevant parts of the Future Generations Programme, in line with the current, more intensive phase of the programme. (ALL)
- The Committee received an updated action plan strengthening the Trust's approach to preventing modern slavery. An updated statement will be reported to the Committee in December 2022. (WELL LED)

- Approved the Future Generations Steering Group Terms of Reference and requested a 6-monthly review.
- Approved the minor amendment to the Crown Street Enhancements Programme Board Terms of Reference.
- Approved the amended Community Diagnostic Centre Oversight Group Terms of Reference.

Summary of BAF Review Discussion (Board Committee level only)

- The Committee reviewed the Finance related BAF risks. No changes to risks scores were recommended. No risks closed on the BAF for FPBD Committee.

Comments on Effectiveness of the Meeting / Application of QI Methodology

- Sufficient time provided to discuss matters thoroughly
- Good contributions and challenge throughout the meeting.

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
2					

64.	Review of BAF risks: FPBD related risks	Assurance	**69.**	Crown Street Enhancements Programme	Information
65.	Finance Performance Report Month 3 2022/23	Assurance	**70.**	Community Diagnostic Centre Update	Information
66.	Operational Performance Report Month 3 2022/23	Assurance	**71.**	HFMA Improving Financial Sustainability Checklist	Information
67.	Digital Services Update	Assurance	**72.**	Modern Slavery Act update	Information
68.	Future Generations Programme Update	Information	**73.**	Sub-Committee Chairs Reports	Assurance

3. 2022 / 23 Attendance Matrix

Core members	Apr	May	Jun	Jul	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Louise Martin	✓	A	✓	✓							
Tracy Ellery	✓	✓	✓	✓							
Tony Okotie	✓	✓	NM								
Sarah Walker	✓	✓	✓	A							
Eva Horgan	✓	✓	✓	✓							
Kathryn Thomson	✓	✓	A	✓							
Gary Price	✓	✓	✓	✓							
Marie Forshaw	✓	✓	✓	✓							

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

Audit Committee Chair's Highlight Report to Trust Board

21 July 2022

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• The Committee noted a concern regarding the on-going need to defer action deadlines, particularly where there was a single point of ownership / failure. It was asserted that a reliance on single individuals to close out actions demonstrated a weakness in internal control. It was noted that the Trust had had made significant recent investments to strengthen operational management capacity and it was expected that this would reduce the risk of single points of failure. There was also agreement that recommendations should be assigned to job roles and not named individuals. • The Committee noted a higher-than-expected number of tender waivers. It was explained that the Trust did have low thresholds for tender requirements and that, on occasion, the Trust received PDC capital later in the year which impacted the ability to plan effectively. It was acknowledged however, that there were opportunities to improve the aspects within the Trust's control.	• The Committee noted and received the Insight Update. The Chair queried how pertinent issues could be highlighted to respective Committee Chairs. The Trust Secretary noted that it was current practice to circulate the Insight Updates to all Board members. There would be an opportunity to incorporate relevant items into the 'regulatory' updates received by each of the Committees. • It was noted that there was a need to consider how the Freedom to Speak Up NED champion role would function as it had now been separated from the Senior Independent Director function. • The Committee was informed that an External Inspections and Accreditations Policy had recently been approved. The Committee requested to see evidence of a Register of External Inspections and Accreditations at the October 2022 meeting and asked the Executive Team to progress this.
Positive Assurances to Provide	**Decisions Made**

• Two internal audit reports were received:
  ○ Data Security and Protection Toolkit (Substantial assurance level)
  ○ Quality Improvement Process – Control Design (Briefing Note Report: no assurance level)
• The Committee was informed that an audit into the Trust's Health and Safety arrangements had also completed, and no high-risk recommendations had been made.
• The MIAA Audit Manager reported that for the 40 recommendations reviewed, evidence of full completion had been provided for 37 which represented a positive position for the Trust.
• It was noted that improvements had been made during the year to raise the profile of the Freedom to Speak Up Guardians. This continued to be tracked via the staff survey and pulse surveys
	• The Committee reviewed an updated Corporate Governance Manual and recommended approval to the Board.

Comments on Effectiveness of the Meeting / Application of QI Methodology	
• The Committee Chair noted that it would be germane to review whether the intervals between Audit Committees was at its most optimum.	

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
023	Follow up of Internal Audit and External Audit Recommendations	To receive and review an update of actions taken.	028	External Inspections and Accreditations Update	To receive update
024	MIAA Internal Audit Reports a) Internal Audit Progress Report b) Follow Up of Audit Recommendations Report c) Anti-Fraud Progress Report 2022/23 Insight d) Insight Update	To note the contents and any recommendations from the report.	029	Corporate Governance Manual review	To receive and note amendments to the Corporate Governance Manual
025	External Auditor Update	To receive update	030	Chairs reports of the Board Committees a) Finance, Performance and Business Development Committee b) Quality Committee c) Putting People First Committee d) Charitable Funds Committee	Review of Chair's Reports for overarching assurance.
026	Waivers Q4 Full Year 2020/21 and Q1 Financial Year 2021/22	The Committee is asked to note the Register of Waivers and receive assurance that contracts requiring a waiver are managed appropriately within the Trust's SFI's	031	Board Assurance Framework (BAF)	To receive assurance on the process being undertaken to assess assurances regarding the Strategic Risks impacting on the Trust's strategic objectives
027	Whistleblowing / Freedom to Speak up Annual Report	The committee is asked to accept the assurance provided by this report			

3. 2022 / 23 Attendance Matrix

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

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

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	**22/23/99c**		**Date: 01/09/2022**	
Report Title	**Finance Performance Review Month 4 2022/23**			
Prepared by	***Claire Scott, Head of Strategic Finance*** ***Eva Horgan, Chief Finance Officer***			
Presented by	**Eva Horgan, Chief Finance Officer**			
Key Issues / Messages	***To receive the Month 4 financial position.***			
Action required	**Approve ☐**	**Receive ☒**	**Note ☐**	**Take Assurance ☐**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	***To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it***	***For the intelligence of the Board / Committee without in-depth discussion required***	***To assure the Board / Committee that effective systems of control are in place***
	Funding Source (If applicable): N/A			
	For Decisions - in line with Risk Appetite Statement – ***If no – please outline the reasons for deviation.***			
	The Board is asked to receive the Month 4 Financial Position.			
Supporting Executive:	***Eva Horgan, Chief Finance Officer***			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 4.1 Failure to ensure our services are financially sustainable in the long term	Comment:

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

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
FPBD Members (by email)	**23/08/2022**	**Eva Horgan, CFO**	**N/A**

EXECUTIVE SUMMARY

At Month 4, the Trust is reporting a £0.497m surplus. This is £53k ahead of plan but is supported by £4m of non recurrent items. The forecast outturn for the year remains consistent with the plan, at £0.526m surplus, although there are risks to this being delivered.

To date elective recovery fund (ERF) income for 2022/23 has been accrued to plan but there is some risk to this.

The cost improvement programme (CIP) is marginally ahead of plan at £1.253m at Month 4, although with some reliance on non-recurrent programmes.

Capital spend is behind trajectory but plans are in place to fully utilise the allocation.

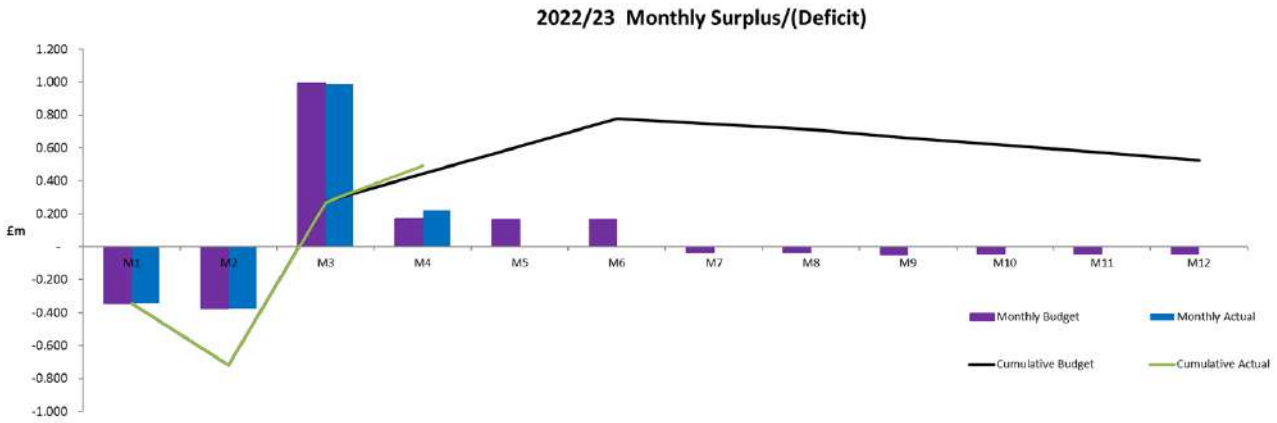
Cash levels are below plan but well above minimum levels as set out in the Treasury Management policy.

	Plan (Revised)	Actual	Variance	RAG	*R*	*A*	*G*
Surplus/(Deficit) YTD	£0.4m	£0.5m	£0.1m	↑	*>10% off plan*	*Plan*	*Plan or better*
I&E Forecast	£0.5m	£0.5m	£0.0m	↔	*>10% off plan*	*Plan*	*Plan or better*
NHS I/E Rating	3	3	0	↔	*4*	*3*	*2+*
Cash	£11.2m	£7.6m	-£3.6m	↓	*<£1m*	*£1m-£4.5m*	*£4.5m+*
Total CIP Achievement	£1.3m	£1.3m	£0.0m	↑	*>10% off plan*	*Plan*	*Plan or better*
Recurrent CIP Achievement	£1.1m	£0.9m	-£0.2m	↑	*>10% off plan*	*Plan*	*Plan or better*
Elective Recovery Fund (net)	£0.7m	£1.0m	£0.4m	↓	*>10% off plan*	*Plan*	*Plan or better*
Non-Recurrent Items YTD	£2.1m	£4.0m	£1.9m	↓	*>£0*		*<£0*
Capital Spend YTD	£4.9m	£2.9m	-£2.0m				

MAIN REPORT

1. Summary Financial Position

At Month 4 the Trust is reporting a £0.497m surplus which is £53k ahead of the £0.444m plan. This reflects the final plan of a £0.526m surplus for the year. The graph below shows the in-month position against the plan.



2. Divisional Summary Overview

The plan for 2022/23 included £7.7m of funded pressures identified during 2021/22. Financial management and adherence to budgets is key in 2022/23.

Family Health: The division is overspent by £268k YTD, primarily in relation to agency midwives.

Gynaecology: The division is overspent by £652k YTD, principally on medical pay.

Clinical Support Services: The division is marginally overspent (£11k YTD). Overspends on nursing and ODPs in theatres are offset by anaesthetic vacancies.

Agency: Agency spend across the Trust is £810k above plan YTD, driven principally by staffing needs recognised in the 2022/23 plan but not yet recruited to permanently, and cover for sickness absence. This will be an area of close monitoring throughout the Trust to ensure that the additional investment in staff costs quickly translates into permanent staff. The agency cap will return from September which the Trust is highly likely to breach without further corrective action.

Fuel costs: There remains significant risk and volatility in relation to fuel costs. The YTD position is now an underspend but this is expected to worsen later in the year.

Financial Recovery Board: The FRB continues to meet. In July the meeting focussed on a CIP deep dive, analysis of procurement data and opportunities, and the Waiting List Initiative process.

3. Community Diagnostic Centre

Activity levels are projected to be lower than originally planned. This is due to

- Late starting of respiratory and physiology testing (driven by additional safety and quality checks and QIA sign off).
- Delay in the build works for MRI. More detail is contained in the Crown Street Enhancements paper. This is in relation to the MRI supplier's turnkey works not any delay from the building contractor.
- Inability to undertake non-obstetric ultrasound and X-Ray as planned due to staffing shortages.

This will be partly offset by the mobile CT undertaking more activity than initially planned, and being kept for longer.

There is some risk of clawback of funds, although there will also be some underspend. This is being kept under close review.

4. Elective Recovery Fund

Under the local ERF calculation for Month 4 (a regional/national calculation not having been shared), the Trust is now behind plan by £188k on in year ERF. This is not reflected in the position pending confirmation on treatment from the regional and national teams.

5. CIP

At Month 4 the CIP plan is marginally ahead of plan with £1,253k of CIP achieved against a £1,251k target. This includes non-recurrent CIP of £341k.

Divisions are clear that CIP plans either need to be delivered or mitigations need to be put in place. Additional ideas, particularly around non-core income, are currently being worked up.

Note that there are additional planned non recurrent adjustments in the plan (e.g. vacancy factor). These are reported as efficiencies but do not form part of the core CIP programme.

6. COVID-19

The Trust's covid related spend at Month 4 is £115k. These costs are falling significantly month on month as the infection control and security costs reduce. Work is also underway to reduce other premises costs including storage hire. However with increased rates and measures being taken on site, there is a risk that costs could increase.

7. Cash and Borrowings

The cash balance at the end of Month 4 is £7.6m, an increase of £1.2m from Month 3. This is still within the Trust's planning limits but does reflect the benefit of advanced payments agreed. Cash levels are under close scrutiny and the ICB has stated that it will commit to supporting trusts in need of cash support.

8. Capital Expenditure

The main development projects are progressing without significant variance to plan from a capital perspective.

The most significant areas of underspend to date relate to medical equipment. Divisions have been given a deadline to order items (unless there is a specific reason they need to be purchased later in the year). Any unspent capital will be reallocated.

9. Balance Sheet

The aged debtor balance is fairly steady in Month 4. The deferred income balance is now significantly higher than the start of the year as it includes an advance payment. This is part of the system support of the Trust's cash balances. Capital creditors have reduced significantly as year end invoices are issued and settled.

Performance against the Better Payment Practice Code has improved slightly to 86% by value. Performance by volume of transactions has remained steady at 77%.

10. BAF Risk

There are no proposed changes to the BAF score.

11. Conclusion & Recommendation

The Board is asked to receive the Month 4 position.

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

FINANCE REPORT: M4

YEAR ENDING 31 MARCH 2023

NHS
Liverpool Women's
NHS Foundation Trust

Contents

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 1
NHS IMPROVEMENT RATIOS: M04
YEAR ENDING 31 MARCH 2023

USE OF RESOURCES RISK RATING	YEAR TO DATE Actual
CAPITAL SERVICING CAPACITY (CSC)	
(a) EBITDA + Interest Receivable	3,365
(b) PDC + Interest Payable + Loans Repaid	835
CSC Ratio = (a) / (b)	**4.03**
NHSI CSC SCORE	**1**
Ratio Score 1 = > 2.5 2 = 1.75 - 2.5 3 = 1.25 - 1.75 4 = < 1.25	
LIQUIDITY	
(a) Cash for Liquidity Purposes	(14,535)
(b) Expenditure	44,288
(c) Daily Expenditure	363
Liquidity Ratio = (a) / (c)	**(40.0)**
NHSI LIQUIDITY SCORE	**4**
Ratio Score 1 = > 0 2 = (7) - 0 3 = (14) - (7) 4 = < (14)	
I&E MARGIN	
Deficit (Adjusted for donations and asset disposals)	(509)
Total Income	(47,623)
I&E Margin	**1.1%**
NHSI I&E MARGIN SCORE	**1**
Ratio Score 1 = > 1% 2 = 1 - 0% 3 = 0 - (-1%) 4 < (-1%)	
I&E MARGIN VARIANCE FROM PLAN	
I&E Margin (Actual)	1.10%
I&E Margin (Plan)	0.90%
I&E Variance Margin	**0.20%**
NHSI I&E MARGIN VARIANCE SCORE	**1**
Ratio Score 1 = > 0% 2 = (1) - 0% 3 = (2) - (1)% 4 = < (2)%	
Note: NHSI assume the score of the I&E Margin variance from Plan is a 1 for the whole year	
AGENCY SPEND	
YTD Providers Cap	596
YTD Agency Expenditure	1,079
	81%
NHSI AGENCY SPEND SCORE	**4**
Ratio Score 1 = < 0% 2 = 0% - 25% 3 = 25% - 50% 4 = > 50%	
Overall Use of Resources Risk Rating	**3**

Note: scoring a 4 on any of the metrics will lead to a financial override score of 3.

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 2
INCOME & EXPENDITURE: M4
YEAR ENDING 31 MARCH 2023

INCOME & EXPENDITURE £'000	Month 4 Budget	Actual	Variance	YTD Budget	Actual	Variance
Income						
Clinical Income	(11,254)	(11,225)	(29)	(44,822)	(45,302)	480
Non-Clinical Income	(623)	(599)	(24)	(2,420)	(2,321)	(100)
Total Income	**(11,877)**	**(11,824)**	**(53)**	**(47,242)**	**(47,623)**	**380**
Expenditure						
Pay Costs	6,623	7,180	(557)	26,523	28,288	(1,766)
Non-Pay Costs	2,757	1,907	850	10,812	8,853	1,960
CNST	1,637	1,787	(150)	6,547	7,147	(600)
Total Expenditure	**11,017**	**10,874**	**143**	**43,882**	**44,288**	**(406)**
EBITDA	**(861)**	**(950)**	**90**	**(3,361)**	**(3,335)**	**(26)**
Technical Items						
Depreciation	483	508	(26)	2,085	2,033	52
Interest Payable	2	3	(0)	10	10	(1)
Interest Receivable	(1)	(8)	7	(4)	(30)	26
PDC Dividend	207	228	(21)	826	825	1
Profit/Loss on Disposal or Transfer Absorption	0	0	0	0	0	0
Total Technical Items	**691**	**731**	**(40)**	**2,916**	**2,838**	**79**
(Surplus) / Deficit	**(170)**	**(219)**	**49**	**(444)**	**(497)**	**53**

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Liverpool Women's
NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST **2a**
INCOME & EXPENDITURE HOSTED SERVICES: M4
YEAR ENDING 31 MARCH 2023

INCOME & EXPENDITURE £'000	Month 4 Budget	 Actual	 Variance	YTD Budget	 Actual	 Variance
Income						
Clinical Income	(115)	(232)	117	(458)	(1,071)	613
Non-Clinical Income	0	0	0	0	20	(20)
Total Income	**(115)**	**(232)**	**117**	**(458)**	**(1,052)**	**594**
Expenditure						
Pay Costs	0	89	(89)	0	377	(377)
Non-Pay Costs	115	142	(28)	458	675	(217)
Total Expenditure	**115**	**231**	**(117)**	**458**	**1,052**	**(594)**
(Surplus) / Deficit	**0**	**(0)**	**0**	**0**	**0**	**(0)**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 3
ELECTIVE RECOVERY FUND ESTIMATE: M4
YEAR ENDING 31 MARCH 2023

	Costed Activity £000	Costed Activity £000	Costed Activity £000	Costed Activity Variance	ERF Actual	ERF Plan £000	Variance £000
Month 1	1,626	1,634	1,859	95	206	165	41
Month 2	1,806	1,813	2,053	240	206	165	41
Month 3	1,748	1,761	1,618	114	21	165	-144
Month 4	1,798	1,621	1,621	114	39	165	-126
Total Income	**5,181**	**5,208**	**5,530**	**449**	**472**	**660**	**-188**
Adjustment back to plan					188	0	188
PY ERF Improvement					373	0	373
Total Variance					**1,033**	**660**	**374**

NHS
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LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 4
EXPENDITURE: M4
YEAR ENDING 31 MARCH 2023

EXPENDITURE £'000	MONTH Budget	 Actual	 Variance	YEAR TO DATE Budget	 Actual	 Variance
Pay Costs						
Board, Execs & Senior Managers	424	488	(64)	1,644	1,722	(77)
Medical	1,695	1,904	(209)	6,930	7,573	(644)
Nursing & Midwifery	2,800	2,960	(161)	11,133	11,628	(495)
Healthcare Assistants	460	499	(39)	1,841	1,872	(31)
Other Clinical	502	421	81	2,008	1,722	285
Admin Support	672	679	(6)	2,689	2,692	(3)
Agency & Locum	70	229	(160)	278	1,079	(801)
Total Pay Costs	**6,623**	**7,180**	**(557)**	**26,523**	**28,288**	**(1,766)**
Non Pay Costs						
Clinical Suppplies	705	788	(83)	2,828	3,047	(219)
Non-Clinical Supplies	165	(870)	1,034	642	(917)	1,559
CNST	1,637	1,787	(150)	6,547	7,147	(600)
Premises & IT Costs	1,004	1,118	(115)	4,050	3,380	670
Service Contracts	884	871	14	3,293	3,343	(50)
Total Non-Pay Costs	**4,394**	**3,694**	**700**	**17,359**	**15,999**	**1,360**
Total Expenditure	**11,017**	**10,874**	**143**	**43,882**	**44,288**	**(406)**

Note that the values above exclude £1,052k in relation to hosted services.

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 5
COVID EXPENDITURE: M4
YEAR ENDING 31 MARCH 2023

EXPENDITURE £'000	MONTH Budget	MONTH Actual	MONTH Variance	YEAR TO DATE Budget	YEAR TO DATE Actual	YEAR TO DATE Variance
Pay Costs						
Board, Execs & Senior Managers	3	12	(9)	12	14	(1)
Medical	0	0	0	0	(0)	0
Nursing & Midwifery	12	0	12	48	0	47
Healthcare Assistants	0	(0)	0	0	16	(16)
Other Clinical	0	0	0	0	(0)	0
Admin Support	0	7	(7)	0	45	(45)
Agency & Locum	0	0	0	0	0	0
Total Pay Costs	**15**	**19**	**(4)**	**60**	**74**	**(15)**
Non Pay Costs						
Clinical Suppplies	0	10	(10)	0	18	(18)
Non-Clinical Supplies	11	0	11	44	0	44
CNST	0	0	0	0	0	0
Premises & IT Costs	0	(38)	38	0	35	(35)
Service Contracts	0	(12)	12	0	(12)	12
Total Non-Pay Costs	**11**	**(40)**	**51**	**44**	**41**	**3**
Total Expenditure	**26**	**(22)**	**48**	**104**	**115**	**(11)**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 6
BUDGET ANALYSIS: M2
YEAR ENDING 31 MARCH 2023

INCOME & EXPENDITURE £'000	MONTH Budget	MONTH Actual	MONTH Variance	YEAR TO DATE Budget	YEAR TO DATE Actual	YEAR TO DATE Variance
Maternity						
Income	(4,156)	(4,166)	10	(16,049)	(16,264)	215
Expenditure	2,212	2,211	1	8,824	9,015	(191)
Total Maternity	**(1,944)**	**(1,955)**	**10**	**(7,225)**	**(7,250)**	**24**
Neonatal						
Income	(1,757)	(1,772)	15	(6,813)	(6,770)	(43)
Expenditure	1,284	1,400	(116)	5,136	5,385	(249)
Total Neonatal	**(473)**	**(372)**	**(101)**	**(1,677)**	**(1,385)**	**(293)**
Division of Family Health - Total	**(2,418)**	**(2,327)**	**(91)**	**(8,903)**	**(8,634)**	**(268)**
Gynaecology						
Income	(2,021)	(2,018)	(3)	(7,790)	(7,736)	(54)
Expenditure	1,384	1,323	60	5,157	5,337	(179)
Total Gynaecology	**(637)**	**(694)**	**57**	**(2,632)**	**(2,399)**	**(233)**
Hewitt Centre						
Income	(751)	(718)	(33)	(2,952)	(2,894)	(58)
Expenditure	711	768	(58)	2,842	3,204	(361)
Total Hewitt Centre	**(40)**	**50**	**(91)**	**(110)**	**310**	**(420)**
Division of Gynaecology - Total	**(677)**	**(644)**	**(33)**	**(2,742)**	**(2,090)**	**(652)**
Theatres						
Income	0	0	0	0	0	0
Expenditure	917	901	16	3,668	3,658	10
Total Theatres	**917**	**901**	**16**	**3,668**	**3,658**	**10**
Genetics						
Income	(13)	(10)	(3)	(51)	(20)	(30)
Expenditure	128	98	30	635	493	141
Total Genetics	**115**	**88**	**27**	**584**	**473**	**111**
Other Clinical Support						
Income	(362)	(359)	(3)	(1,402)	(1,384)	(18)
Expenditure	578	593	(14)	2,201	2,316	(114)
Total Clinical Support	**216**	**234**	**(18)**	**799**	**932**	**(133)**
Division of Clinical Support - Total	**1,249**	**1,223**	**25**	**5,051**	**5,062**	**(11)**
Corporate & Trust Technical Items						
Income	(2,932)	(3,014)	82	(12,644)	(13,606)	962
Expenditure	4,608	4,542	66	18,793	18,771	23
Total Corporate	**1,676**	**1,528**	**148**	**6,149**	**5,164**	**985**
(Surplus) / Deficit	**(170)**	**(220)**	**50**	**(444)**	**(497)**	**53**
Of which is hosted;						
Income	(115)	(232)	117	(458)	(1,052)	594
Expenditure	115	231	(117)	458	1,052	(594)
Total Corporate	**0**	**(0)**	**0**	**0**	**0**	**(0)**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 7
CIP: M4
YEAR ENDING 31 MARCH 2023

	Month 4			YTD		
Scheme	**Target**	**Actual**	**Variance**	**Target**	**Actual**	**Variance**
Procurement and Non Pay	145	119	-26	578	458	-120
Estates utilisation	34	32	-2	137	69	-68
Staffing and skill mix	41	41	0	164	164	0
Medicines Management	3	3	0	10	10	0
Service Developments	0	0	0	0	0	0
Theatre Efficiency	30	0	-30	122	0	-122
Technology Driven Efficiencies	6	6	0	23	10	-13
Income	61	91	30	216	542	326
Other Savings Plans	0	0	0	0	0	0
Total	**320**	**292**	**-28**	**1,251**	**1,253**	**3**

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LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 8
BALANCE SHEET: M04
YEAR ENDING 31 MARCH 2023

BALANCE SHEET £'000	YEAR TO DATE Opening	 M04 Actual	 Movement
Non Current Assets	101,380	102,209	829
Current Assets			
Cash	11,192	7,557	(3,635)
Debtors	5,929	7,848	1,919
Inventories	523	606	83
Total Current Assets	**17,644**	**16,011**	**(1,633)**
Liabilities			
Creditors due < 1 year - Capital Payables	(4,849)	(1,594)	3,255
Creditors due < 1 year - Trade Payables	(18,362)	(19,040)	(678)
Creditors due < 1 year - Deferred Income	(4,157)	(7,359)	(3,202)
Creditors due > 1 year - Deferred Income	(1,561)	(1,550)	11
Loans	(1,525)	(1,525)	0
Loans - IFRS16 leases	(49)	(40)	9
Provisions	(3,889)	(1,983)	1,906
Total Liabilities	**(34,392)**	**(33,091)**	**1,301**
TOTAL ASSETS EMPLOYED	**84,632**	**85,129**	**497**
Taxpayers Equity			
PDC	70,713	70,713	0
Revaluation Reserve	12,749	12,749	0
Retained Earnings	1,170	1,667	497
TOTAL TAXPAYERS EQUITY	**84,632**	**85,129**	**497**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 9
CASHFLOW STATEMENT: M04
YEAR ENDING 31 MARCH 2023

CASHFLOW STATEMENT £'000	Actual
Cash flows from operating activities	1,302
Depreciation and amortisation	2,033
Impairments and reversals	0
Income recognised in respect of capital donations (cash and non-cash)	0
Movement in working capital	(842)
Net cash generated from / (used in) operations	**2,493**
Interest received	28
Purchase of property, plant and equipment and intangible assets	(6,156)
Proceeds from sales of property, plant and equipment and intangible assets	0
Net cash generated from/(used in) investing activities	**(6,128)**
PDC Capital Programme Funding - received	0
PDC COVID-19 Capital Funding - received	0
Loans from Department of Health Capital - repaid	0
Loans from Department of Health Revenue - received	0
Loans from Department of Health Revenue - 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	**(3,635)**
Cash and cash equivalents at start of period	11,192
Cash and cash equivalents at end of period	**7,557**

LOANS SUMMARY £'000	Loan Principal Drawndown	Loan Principal Repaid	Loan Principal Outstanding
Loans from Department of Health - Capital (ITFF) - 2.0% Interest Rate	5,500	(3,975)	1,525
Loans from Department of Health - Capital (Neonatal) - 2.54% Interest Rate	14,572	(14,572)	0
Loans from Department of Health - Revenue - 1.50% Interest Rate	14,612	(14,612)	0
Total	**34,684**	**(33,159)**	**1,525**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST **10**
CAPITAL EXPENDITURE: M04
YEAR ENDING 31 MARCH 2023

CAPITAL EXPENDITURE £'000	Year to Date Plan	Actual	Variance
Estates	218	29	189
Capital Projects	2,685	2,431	254
IM&T	406	393	13
Medical Equipment	1,557	47	1,510
	4,866	**2,900**	**1,966**

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*22/23/100a*		**Date: 01/09/2022**	
Report Title	**Board Assurance Framework**			
Prepared by	*Mark Grimshaw, Trust Secretary*			
Presented by	*Mark Grimshaw, Trust Secretary*			
Key Issues / Messages	*The report outlines any updates relating to the Board Assurance Framework and any key areas for consideration for the Board.*			
Action required	**Approve ☐**	**Receive ☐**	**Note ☐**	**Take Assurance ☒**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable): N/A			
	For Decisions - in line with Risk Appetite Statement – Y *If no – please outline the reasons for deviation.*			
	The Board requested to review the BAF risks and agree their contents and actions.			
Supporting Executive:	*Mark Grimshaw, Trust Secretary*			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 5.2 Failure to fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership	Comment:
Link to the Corporate Risk Register (CRR) – CR Number: N/A	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome

BAF discussed at FPBD, Putting People First and Quality Committees since previous version presented to Board in July 2022.

EXECUTIVE SUMMARY

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

The BAF items are aligned to the Board's assurance committees, and since the last Board meeting these were reviewed and discussed during the July 2022 meetings.

MAIN REPORT

Introduction

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

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

Process for reviewing BAF areas during the meeting

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

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

Changes to BAF

This report outlines proposed scores for Quarter 2 2022/23 for each respective BAF risk. There have also been several housekeeping amendments and updates made to actions. These are shown utilising track changes throughout.

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

1.1 Failure to be recognised as one of the most inclusive organisations in the NHS with Zero discrimination for staff and patients (zero complaints from patients, zero investigations)

- No proposed change to BAF score for Quarter 2 – (likelihood 3 x consequence 4). Demonstrable progress has been made in this area and therefore it is proposed that the target for this risk in 2022/23 remains at '8'.
- No proposed changes to the BAF title
- Narrative has been updated
- Controls, Assurances and Gaps in control / assurance have been tidied and actions updated
- No changes to the strategic threats

1.2 Failure to recruit & maintain a highly skilled & engaged workforce

- No proposed change to BAF score for Quarter 2 – (likelihood 4 x consequence 5). It is proposed that the target score set at '15' remains appropriate.
- Controls, Assurances and Gaps in control / assurance have been tidied and actions updated

2.1 Failure to progress our plans to build a new hospital co-located with an adult acute site

- No proposed change to BAF score for Quarter 2 – (likelihood 4 x consequence 4). Demonstrable progress has been made in terms of securing buy-in from key partners and regulators and therefore it is proposed that the target for this risk in 2022/23 remain at '10'. There do, however, remain significant risks to progressing this strategic aim.
- No proposed changes to the BAF title
- Narrative has been updated
- Controls, Assurances and Gaps in control / assurance have been tidied and actions updated

2.2 Failure to develop our model of care to keep pace with developments and respond to a changing environment

- No proposed change to BAF score for Quarter 2 – (likelihood 4 x consequence 4). It is likely that mitigations will be place for this risk during 2022/23 (new EPR system), effective Divisional Planning but it is unclear at the current time when the benefits for these will be realised. It is for this reason that the proposed target for 2022/23 is a '12'.
- No proposed changes to the BAF title, narrative or strategic threat descriptor
- Controls, Assurances and Gaps in control / assurance have been tidied and actions updated

2.3: Failure to implement all feasible mitigations to ensure services delivered from the Crown Street site are as safe as possible, developing our facilities for the benefit of our patients as well as those across the system

- No proposed change to BAF score for Quarter 2 – (likelihood 4 x consequence 5). There are several actions in train that should support the Trust in reducing this likelihood score down to 3 once they are completed and moved into the 'controls' column. The target for 2022/23 has therefore been set at 15 (3x5).
- No proposed amendments to the BAF title, strategic threat descriptor
- Narrative updated
- Controls, Assurances and Gaps in control / assurance have been tidied and actions updated.
- There has been a request from NHSI colleagues to ensure that the following aspects are sufficiently covered –
    - Lack of ITU
    - Transfusion service
    - Lack of diagnostics
    - Lack of acute specialities
    - Progress on Clinical pathway established and plans for further implementation
- This BAF risk has been reviewed and updated to incorporate these elements

2.4: Major and sustained failure of essential IT systems due to a cyber attack

- No proposed change to BAF score for Quarter 2 – (likelihood 4 x consequence 5).
- Controls, Assurances and Gaps in control / assurance have been tidied and actions updated.

3.1: Failure to deliver an excellent patient and family experience to all our service users

- No proposed change to BAF score for Quarter 2 – (likelihood 3 x consequence 4). However, a new strategic threat has been added following discussion at the Quality and FPBD Committees – 'Lack of clinical capacity and resources i.e. workforce, estate etc. to treat patients in a timely manner resulting in delays in treatment and deterioration in Trust Performance standards' – The Board may wish to reflect on whether this impacts the score rating sufficiently to warrant an amendment.
- Supporting narrative updated to reference waiting time pressures.
- Controls, Assurances and Gaps in control / assurance have been tidied and actions updated.

BAF Risk 4.1: Failure to ensure our services are financially sustainable in the long term

- No proposed change to BAF score for Quarter 2 – (likelihood 5 x consequence 4). There remains a high degree of uncertainty around the financial landscape and whilst there are strong internal controls in place, the external environment means that it seems unlikely that a target lower than '16' can be set for 2022/23.
- No proposed amendments to the BAF title
- Controls, Assurances and Gaps in control / assurance have been tidied and actions updated.

BAF Risk 4.2: Failure to expand our existing partnerships, building on learning and partnership working throughout the COVID-19 pandemic, playing a key role in establishing any ICP or ICS

- No proposed change to BAF score for Quarter 2 – (likelihood 2 x consequence 4). There remains a high degree of uncertainty around the partnership landscape and the FPBD Committee has responded by receiving strengthened assurance of the effectiveness of the Trust's partnership arrangements.
- No proposed amendments to the BAF title or supporting narrative
- Controls, Assurances and Gaps in control / assurance have been tidied and actions updated.

5.1: Failure to progress our research strategy and foster innovation within the Trust

- No proposed change to BAF score for Quarter 2– (likelihood 2 x consequence 4). Significant progress was made throughout 2021/22 and appointments joining the Trust should further strengthen this. It is expected that the score for this risk can be scored at '4' for the third quarter of 2022/23 and therefore it suggested to maintain a target score of '4' for 2022/23.
- Controls, Assurances and Gaps in control / assurance have been tidied and actions updated.

5.2: Failure to fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership

- No proposed change to BAF score for Quarter 2 – (likelihood 3 x consequence 4). There is evidence of improvement and strengthened controls heading into 2022/23 (ward accreditation programme, agreed QI Framework etc) that if implemented effectively should provide assurance to reduce the score to '8'. It is therefore suggested to maintain this as the target for 2022/23.
- No proposed amendments to the BAF title, strategic threat descriptor
- Controls, Assurances and Gaps in control / assurance have been tidied and actions updated.

New Risks or Strategic Threats

There is one new strategic threat proposed for BAF risk 3.1 – Lack of clinical capacity and resources i.e. workforce, estate etc. to treat patients in a timely manner resulting in delays in treatment and deterioration in Trust Performance standards. This has been added following a recommendation from both the Quality Committee and FPBD Committee – rationale as follows:

Following the operational pressures faced as a result of the COVID pandemic, a large number of patients had their treatment and appointments delayed as a result of changes to clinical capacity. This has led to an increasing number of patients waiting beyond 52 weeks to receive their treatment. Continued rises in referrals from Primary Care and an increasing backlog of patients to be seen has led to delays in care and deterioration of Trust performance in relation to national Referral to Treatment (RTT) standards.

Closed Risks or Strategic Threats

Since the report was last circulated and discussed at the Board, no risks closed on the BAF.

Conclusions

Board members are asked to comment on the current content and where required make further recommendation for change and agree the current BAF risks.

Recommendation

The Board requested to review the BAF risks and agree their contents and actions.

NHS
Liverpool Women's
NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK 2022/2023

Trust Board – September 2022

Board Assurance Framework Key

Risk Rating Matrix (Likelihood x Consequence)					
Consequence	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic	5 Moderate	10 High	15 Extreme	20 Extreme	25 Extreme
4 Major	4 Moderate	8 High	12 High	16 Extreme	20 Extreme
3 Moderate	3 Low	6 Moderate	9 High	12 High	15 Extreme
2 Minor	2 Low	4 Moderate	6 Moderate	8 High	10 High
1 Negligible	1 Low	2 Low	3 Low	4 Moderate	5 Moderate

1 - 3	Low risk
4 - 6	Moderate risk
8 - 12	High risk
15 - 25	Extreme risk

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

Key to lead Committee Assurance Ratings	
	Green = Positive assurance: the Committee is satisfied that there is reliable evidence of the appropriateness of the current risk treatment strategy in addressing the threat or opportunity - no gaps in assurance or control AND current exposure risk rating = target OR - gaps in control and assurance are being addressed
	Amber = Inconclusive assurance: the Committee is not satisfied that there is sufficient evidence to be able to make a judgement as to the appropriateness of the current risk treatment strategy
	Red = Negative assurance: the Committee is not satisfied that there is sufficient reliable evidence that the current risk treatment strategy is appropriate to the nature and/or scale of the threat or opportunity

This approach informs the agenda and regular management information received by the relevant lead committees, to enable them to make informed judgements as to the level of assurance that they can take and which can then be provided to the Board in relation to each BAF Risk and also to identify any further action required to improve the management of those risks.

Board Assurance Framework: Legend	
Strategic Priority	The 2021/25 strategic priority that the BAF risk has been aligned to.
BAF Risk:	The title of the strategic risk that threatens the achievement of the aligned strategic priority
Rationale for Current Risk Score:	This narrative is updated on a quarterly basis and provides a summary of the information that has supported the assessment of the BAF risk.
Strategic Threat:	What might cause the BAF risks to materialise
Provider Licence Compliance:	NHS Improvement provider licence conditions that align to the BAF risk providing assurance on compliance.
Controls:	The measures in place to reduce the risk likelihood or risk consequence and assist secure delivery of the strategic priority.
Assurances:	The measures in place to provide confirmation that the controls are working effectively in supporting the mitigation of the risk.
Gaps in Controls / Assurance:	Areas that require attention to ensure that systems and processes are in place to mitigate the BAF risk Areas where there is limited or no assurance that processes and procedures are in place to support the mitigation of the BAF risk.
Required Action:	Actions required to close the gap in control/ assurance
Lead:	The person responsible for completing the required action.
Implemented By:	Deadline for completing the required action.
Monitoring:	The forum that will monitor completion of the required action.
Progress:	A RAG rated assessment of how much progress has been made on the completion of the required action.

Risk Descriptors

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	Negligible	Minor	Moderate	Major	Catastrophic
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long- term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on many patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day)	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days)	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff

			Low staff morale Poor staff attendance for mandatory/key training	Loss of key staff Very low staff morale No staff attending mandatory/ key training	No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10– 25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million

Service/business interruption **Environmental impact**	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Likelihood score (L)

What is the likelihood of the consequence occurring?
The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

Board Assurance Framework Dashboard 2022/2023

SA	BAF Risk	Committee	Lead	May 2022	Q2	Q3	Q4	Q 2 Q movement	2022/23Target
SA1 Workforce	1.1 Failure to be recognised as one of the most inclusive organisations in the NHS with Zero discrimination for staff and patients (zero complaints from patients, zero investigations)	PPF	CPO	12 (I3 x c4)	12 (I3 x c4)			⟷	8 (I2 x c4)
	1.2 Failure to recruit and retain key clinical staff	PPF	CPO	20 (I5 x c4)	20 (I5 x c4)			⟷	16 (I4 x c4)
SA2 Safe	2.1 Failure to progress our plans to build a new hospital co-located with an adult acute site	FPBD	CFO	15 (I3 x c5)	15 (I3 x c5)			⟷	10 (I2 x c5)
	2.2 Failure to develop our model of care to keep pace with developments and respond to a changing environment	FPBD	COO	16 (I4 x c4)	16 (I4 x c4)			⟷	12 (I3 x c4)
	2.3 Failure to implement all feasible mitigations to ensure services delivered from the Crown Street site are as safe as possible, developing our facilities for the benefit of our patients as well as those across the system	Quality	COO	20 (I4 x c5)	20 (I4 x c5)			⟷	15 (I3 x c5)
	2.4 Major and sustained failure of essential IT systems due to a cyber attack	FPBD	CIO	20 (I4 x c5)	20 (I4 x c5)			⟷	15 (I2 x c5)
SA3 Experience	3.1 Failure to deliver an excellent patient and family experience to all our service users	Quality	CNM	12 (I3 x c4)	12 (I3 x c4)			⟷	12 (I3 x c4)
SA4 Efficient	4.1 Failure to ensure our services are financially sustainable in the long term	FPBD	CFO	20 (I5 x c4	20 (I5 x c4			⟷	16 (I4 x c4)
	4.2 Failure to expand our existing partnerships, building on learning and partnership working throughout the COVID-19 pandemic, playing a key role in establishing any ICP or ICS	FPBD	MD	8 (I2 x c4)	8 (I2 x c4)			⟷	8 (I2 x c4)
SA5 Effective	5.1 Failure to progress our research strategy and foster innovation within the Trust	Quality	MD	8 (I2 x c4)	8 (I2 x c4)			⟷	4 (I1 x c4)
	5.2 Failure to fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership	Quality	CNM	12 (I3 x c4)	12 (I3 x c4)			⟷	8 (I2 x c4)

BAF HEAT MAP


Consequence
Likelihood
1
Rare
2 Unlikely
3
Possible
4
Likely
5
Almost certain
5 Catastrophic
4 Major
3 Moderate
2 Minor
1 Negligible
2.1
2.4
2.3
4.2
5.1
1.1
3.1
5.2
2.2
1.2
4.1

Strategic Objective	SA1: To develop a well led, capable, motivated and entrepreneurial WORKFORCE
Committee:	Putting People First Committee
Risk Appetite:	Moderate

Principal risks (BAF)	Risk Score
1.1 Failure to be recognised as the most inclusive organisation in the NHS with Zero discrimination for staff and patients (zero complaints from patients, zero investigations)	12 (3 x 4)
1.2 Failure to recruit & maintain a highly skilled & engaged workforce	20 (4 x 5)

Risk and Controls Summary

To outline changes to risk scores, new risks or closed risks.

2087 - No change in risk score since last review. Last reviewed 09/03/2022

2323 - No change in risk score since last review. Last reviewed 08/03/2022

1704 – No change in risk score since last review. Last reviewed 11/02/2022.

2491 – No change in risk score since last review. Last reviewed 08/03/2022

Ref	Corporate Risk Register / High Scoring (15+) Risks	Risk Score
2443	Inability to recruit specialised allied health professions in a timely manner	16
1705	Insufficient midwifery staffing levels as recognised by birth rate place plus.	20
2424	Unable to meet safe staffing levels in line with BAPM requirements	15
2087 **(CRR)**	Uncertainty about provision of a safe Maternity service able to give more effective interventions with 24/7 Consultant presence on Delivery suite and sufficient consultant cover for 10 elective caesarean lists per week and high-level MAU cover.	16
2323 **(CRR)**	The Trust is currently non-compliant with standards 2,5,6 of the seven-day service standards (due to insufficient consultant numbers)	15
1704 **(CCR)**	Effective management systems are not in place or sufficient to ensure all employees complete and keep up to date with their mandatory training requirements.	12
2491 (CRR)	Noncompliance with mandated level of fit mask testers qualification, accreditation, and competency	15

BAF Risk 1.1: Failure to be recognised as one of the most inclusive organisation in the NHS with zero discrimination for staff and patients (zero complaints from patients, zero investigations)	**Lead Director:** CPO **Op Lead:** Deputy Director of Workforce	**Review Date: August 2022**

Strategic Priority: SA1: To develop a well led, capable, motivated and entrepreneurial workforce

Lead Committee: Putting People First

Provider Licence Compliance link(s):

N/A

SCORE:

May 2022	Q2	Q3	Q4	Q 2 Q movement	2022/23 Target
12 (3 x 4)	12 (3 x 4)			⟷	8 (2 x 4)

Rationale for current risk score:

The Trust has several strong controls in place against this risk and can demonstrate effective performance in comparison with other NHS trusts. During 2021/22, for the first time, the Trust benchmarked within the top 50 inclusive places to work. However, this is an ambitious aim within the Trust's 2021-25 strategy and will require significant cultural change to achieve together with a continued and unrelenting focus. The Trust can also make progress on the mechanisms that it has in place to hear the views and voices from its diverse staffing and patient communities and ensure that these voices have an impact on service improvement and development.~~The Trust has several strong controls in place against this risk and can demonstrate effective performance in comparison with other NHS trusts. During 2021/22, for the first time, the Trust benchmarked within the top 50 inclusive places to work. However, this is an ambitious aim within the Trust's 2021-25 strategy and will require significant cultural change to achieve together with a continued and unrelenting focus. The Trust can also make progress on the mechanisms that it has in place to hear the views and voices from its diverse staffing and patient communities and ensure that these voices have an impact on service improvement and development. Whilst there is evidence that the Trust has responded well to challenge that the pandemic has posed to the Trust in terms of patient and staff inequalities, this will continue to be a challenge during 2022/23.~~

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Unable to create a workforce representative of the community we serve	Monitoring of applications for employment within the Trust throughout the recruitment & selection process over a 12-month period via TRAC reporting	Monitored by the EDI Lead and reported through the ED&I Action Plan	To ensure that there are robust processes in place to target advertising, work shadowing opportunities, pre-application training and offering career advice **(Action 1.1 / 1)** To simplify the EIA process **(Action 1.1 / 2)** To further widen opportunities for the local community to join the LWH workforce **(Action 1.1 / 3)** To continue to develop more diverse recruitment and selection processes **(Action 1.1 / 4)** Enhance availability and quality of training across all protected characteristics including disability and inter-sectionality (Action 1.1 / 5) Establishment and Declaration and Embedding of LWH as an Anti-Racist Organisation (Action 1.1 / 6) Development of ED&I Strategy (Action 1.1 / 7)	
	Links with community leaders established to improve under-representation	PPF Strategy and action plan – monitored by PPF Committee		
	Annual review of all employee relation casework to determine if staff are reporting any form of discrimination and to ensure that process is fairly/consistently applied across all staff groups (benchmark against local and national data, where possible)	WRES and WDES submissions		
	All HR policies have up to date equality impact assessments at the point of review, in line with the policy schedule	Policy schedule is currently on track with EIA's being requested as required		
	HR policies reviewed in line with fair and just culture	Policy review process reported to PPF		
	WDES and WRES action plan delivery in line with timescales presented from NHS England	WDES and WRES Action Plan submissions		
	Demographic tracking for training access	In place and monitored by Head of L&D OD		
	Establishment of staff inclusion Networks and work in collaboration with local Trusts to promote staff networks and LGBTQ Network to be launched in 2022.	Progress reported to PPF Committee		
	Reciprocal Mentorship Scheme developed	Feedback through Executive Team		
	Extension of e-learning package to design and deliver specific EDI training and education to all LWH staff	PPF Committee		
	Education and celebration of the key EDI events: Black History Month, Disability History Month, LGBT+ History Month and key faith observance days/festival	Staff Communications		
	Utilising widening participation programmes and alternative ways to advertise and promote our job opportunities to attract local population to work at LWH.	PPF Committee		
	Staff from diverse backgrounds having career conversations with manager	Review of appraisal process – PPF and feedback from staff inclusion networks		

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
1.1 / 1	Robust targeting of job adverts – engagement in health and careers fairs with local community groups for example Pakistani Centre, Al Ghazali Centre	Head of Culture, Inclusion, Wellbeing and Engagement	~~September 2022~~February 2023 (ongoing)	E&D Sub-Committee	Wellbeing Coach and Assistant Psychologist vacancies will be targeted via Universities with specific focus on racially minoritised communities. Review piece with Patient Experience to identify and prioritise communities within which to target entry level roles. HCA and admin roles- specific careers event in Toxteth (small numbers of roles).
1.1 / 2	Review of the current Equality Impact Assessment (EIA) process, simplification of document and sufficient guidance and education on how to complete, ensuring this is a meaningful form that is completed at the beginning stages of every project/transformation/CIP/Procedure Due to absence within a key post this has not progressed however bank resource has now been secured and this piece of work will be completed by September 22	Head of Culture, Inclusion, Wellbeing and Engagement	September 2022	E&D Sub-Committee	New process and policy developed and tested with stakeholders. New paperwork highlights actions and risks to feed into ED&I Committee
1.1 / 3	Establishment of mentoring scheme for 14/15 year olds in the L8 area to encourage them into the midwifery pathway	Head of Culture, Inclusion, Wellbeing and Engagement	September 2022	E&D Sub-Committee	

	1.1 / 4	Exploration and implementation of more diverse recruitment and selection processes including diverse interview panels and alternative recruitment methods Diverse interview panels have commenced but are yet to be consistently applied to all senior roles. Employees with protected characteristics have been invited to take part in national training to participate in recruitment processes in other NHS Trusts.	Head of Culture, Inclusion, Wellbeing and Engagement	September 2022	E&D Sub-Committee		
	1.1 / 5	Enhance availability and quality of training across all protected characteristics including disability and inter-sectionality	Head of Culture, Inclusion, Wellbeing and Engagement	December 2022	E&D Sub-Committee	Enhanced training for senior leaders developed, additional baseline training in development, additional training around neurodiversity etc required.	
	1.1 / 6	Establishment and Declaration and Embedding of LWH as an Anti-Racist Organisation	Head of Culture, Inclusion, Wellbeing and Engagement	February 2022	E&D Sub-Committee	To be determined via the PPF Development Session in October 22.	
	1.1 / 7	Development of ED&I Strategy	Head of Culture, Inclusion, Wellbeing and Engagement	December 2022	E&D Sub-Committee		

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Unable to effectively engage with our patient and staff groups to understand further the needs of individuals with protected characteristics and respond proactively to identified needs	Patient information leaflets are up to date and accessible for all protected groups. Patient leaflets are on the website that can translate this information into various languages/ fonts and read aloud versions.	Annual audit of patient leaflets to ensure accessibility and usability	Need to create template for patient story capture and response at Divisional level and process to ensure consistent approach is sustainable over time **(Action 1.1 / 4**). To provide assurance regarding Patient Information Leaflet audit to PIEG on an annual basis (**Action 1.1 / 5**) Local ownership of FFT results to enable improvements to be created and implemented at a local level **(Action 1.1 / 6)**	
	Utilisation of the Health Inequalities data within power BI to lead work between the Patient Experience Team and the Cultural Liaison Midwife to target areas of disparity.	Updates from these associated actions are presented and updated through the Patient Involvement and Experience Subcommittee.		
	Engagement with local groups lead by the Patient Experience Matron to listen to the concerns and required adjustments and improvements desired. These include the local Muslim mosque and Merseyside Deaf society	Updates from these interactions, and any associated actions are presented and updated through the Patient Involvement and Experience Subcommittee.		
	FFT Data now included EDI monitoring to allow experience reviews to be compared between groups with and without a protected characteristic	Data is presented at Patient Involvement and Experience Subcommittee.		
	Enhanced communication and patient experience for people with disabilities coming for care at the Trust as part of Reasonable Adjustment activities	Personalised Maternity Care Budgets/ Maternity Early Adopter and Pioneer site – LMS Cheshire and Mersey Patients with learning difficulties, mental health or autism spectrum are allowed relatives to stay with them throughout their stay. Pro-active admissions for these groups with preadmission and discharge planning Admission procedures and assessments e.g. MUST /VTE/ FALLS / risk assessment Maternity Pre-operative assessments Development of a Supporting Patients with Additional Needs Strategy		
	Barriers removed to access/health inequalities to maternity services for all with specific focus to migrant and asylum-seeking women	Barriers identified and measures put in place to remove e.g. Presence of representatives from MRANG in the antenatal clinic to support asylum seekers		

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
1.1 / 4	To create template for patient story capture and response at Divisional level and process to ensure consistent approach is sustainable over time	Head of Audit, Effectiveness and Patient Experience	July 2022	Patient Involvement & Experience Sub-Committee	
1.1 / 5	To provide assurance regarding Patient Information Leaflet audit to PIEG on an annual basis	Head of Audit, Effectiveness and Patient Experience	September 2022	Patient Involvement & Experience Sub-Committee	
1.1 / 6	Local ownership of FFT results to enable improvements to be created and implemented at a local level	Head of Audit, Effectiveness and Patient Experience	September 2022	Patient Involvement & Experience Sub-Committee	

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
COVID-19 impact further increasing health inequalities for staff and patients	Move to recovery of pre-covid activity levels whilst adhering to all covid restrictions and requirements	Corporate BAU largely maintained despite remote working. Regular Covid-19 response reports to the Public Board EPRR Meetings continued Weekly monitoring of vaccine uptake in staff Weekly monitoring of swabbing of in patients	Levels of Asymptomatic staff testing remain lower than desired	
	Hybrid working where appropriate			
	Eased rules for mask wearing in non-clinical spaces providing 1m distancing can be observed			
	Adherence to national guidance in respect of isolation periods for covid positive staff			
	Clear criteria as to elements of activity and types of patients the Trust can assist with			
	Asymptomatic testing twice weekly for staff			
	Staff 'booster' vaccination and flu plan for 22/23 in place			
	Visiting restrictions			
	Patient testing			

	Gap Reference	Required Action	Lead	Implement By	Monitoring	Status	
	1.1 / 7	Close working with Cheshire and Mersey procurement via Covid Supply Response (CSR)	Head of Procurement	On-going	EPPR		

BAF Risk 1.2: Failure to recruit & maintain a highly skilled & engaged workforce

Lead Director: CPO
Op Lead: Deputy Director of Workforce

Review Date: August 22

Strategic Priority: SA1: To develop a well led, capable, motivated and entrepreneurial workforce

Lead Committee: Putting People First

Provider Licence Compliance link:

N/A

SCORE:

May 2022	Q2	Q3	Q4	Q 2 Q movement	2022/23 Target
20 (4 x 5)	20 (4 x 5)			⟷	16 (4x4)

Rationale for current risk score:

The Trust has acute and chronic staffing challenges in several areas and a sickness absence rate which has been consistently above target. Staff engagement scores are below the average for peer organisations as measured by the Annual Staff Survey. Maternity staffing issues are acute and have been exacerbated by absence linked to the Covid pandemic and low morale. The Trust has seen an increase in turnover associated with staff opting to leave the service or take retirement. There are significant challenges associated with specialist obstetric anaesthesia recruitment and theatre staffing. Other impacting factors include insufficient numbers of doctors in training, national shortage of nurses & midwives, the clinical risk associated with an isolated site impacting on the recruitment & retention of senior specialist medical staff, the impact of pension tax changes, the ongoing pandemic challenges and the associated recovery of elective activity.

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance (*Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust.	Appraisal policy, paperwork and systems for delivery and recording are in place for medical and non-medical staff.	Monthly KPI's for controls.	Quality of appraisals requires further improvement and monitoring **(Action 1.2 / 1)** Further evidence required that robust plans are being reviewed regularly at Divisional Board level **(Action 1.2 / 2)** Mandatory Training Compliance is currently not at required levels **(Action 1.2/3)**	
	LWH 'People Promise' to launch in 2022 – bringing together key strands of people strategy including behavioural framework	PPF		
	Behavioural framework developed in partnership with staff in 2021	PFF Committee, In the Loop, Great Place to Work Group		
	Great Place to Work Group Launched as a cross section of staff committed to improving staff experience and a source of two way communication	Great Place to work minutes to PPF		
	Consultant revalidation process.	Outcomes reported to PPF and the Board		
	Reward and recognition processes linked to values.	Monthly KPI's for controls.		
	Pay progression linked to mandatory training compliance	Monthly KPI's for controls.		
	Targeted OD intervention for areas in need to support.	PPF Committee		
	New Leadership Programme and Talent Management framework in place.	Leadership & Talent Strategy		
	Programme of health and wellbeing initiatives including launch of LWH Staff Support Service, recruitment of LWH Psychologist and Wellbeing Coaches	Reported to PPF Committee		
	All new starters complete mandatory PDR training as part of corporate induction ensuring awareness of responsibilities.	Monthly KPI's for controls.		
	Workforce planning processes in place to deliver safe staffing.	Divisional Board and Divisional Performance Reviews		
	Shared decision making with JLNC and Partnership Forum.	Chair's Report to PPF Committee		
	Putting People First Strategy	Progress reported to PPF Committee		
	Guardian of Safe Working.	Report form Guardian of Safe Working		
	PDR training programme in place and PDR window for band 7 and above in N&M commenced in 2021	Monthly KPI's for controls.		
	Two Freedom to Speak Up Guardians (including representation from a diverse and clinical background)	Bi-annual Speak Up Guardian Reports.		
	Whistle Blowing Policy	Annual Report to PPF and Audit Committee		
	Regular Local Staff Surveys	Quarterly internal staff survey (In the Loop)		
	Quarterly Trust wide listening events- Big Conversation~~Regular Listening Events~~	Reports and feedback from Big Conversation into the Board and Divisional Boards~~Listening events increased to bi-monthly~~		
	Divisional oversight of Mandatory training	Trajectories monitored via Divisional Boards		
	Mandatory training quarterly validation	Assurance that MT competencies are assigned correctly via sign off from practice educators and Heads of Nursing		

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
1.2 / 1	To review indicators showing direction of travel for the quality of appraisals	Deputy Director of Workforce	~~September~~ November 2022	PPF Committee	Audit to PPF November
1.2 / 2	To receive assurance that Divisional Boards are effectively reviewing and updating workforce plans	Deputy Director of Workforce	September 2022	PPF Committee	
1.2 / 3	To receive assurance that mandatory training compliance is increasing	Deputy Director of Workforce	November 2022	PPF Committee	Audit to PPF November

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance (*Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
The Covid-19 pandemic &	Staff working from home where appropriate, use of virtual meetings and enhanced IT provision	PPF Committee	None noted.	

associated elective recovery has the ongoing potential to impact staff morale, wellbeing and retention	Refreshed staff absence process and monitoring with increased flexibility Regular staff communications Listening Event for staff completed to consider what further action the Trust could take to ensure staff are protected as much as possible. Specific sessions held for staff with protected characteristics. Risk Assessments undertaken for shielding & vulnerable staff	Feedback from staff side				
	Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
	N/A					
Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*		Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*		Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Insufficient numbers of clinical staff resulting in a lack of capability to deliver safe care and effective outcomes.	Annually agreed funding contract with HEE		PPF Committee, HEN Visit		Further utilisation of the rota management system. E-Rostering System not fully utilised **(Action 1.2 / 3)** Requirement for assurance that workforce plans are reviewing regularly at Divisional Board level **(Action 1.2 / 4)** Requirement to respond effectively to Ockenden recommendations regarding staffing **(Action 1.2 / 5)** Clinical risks associated with isolated site impact upon recruitment & retention of specialist medical staff **(Action 1.2 / 6)**	
	Regional Training Programme Directors manage the junior doctor rotation programme and highlight shortages to the Lead Employer.		Lead Employer notifies the Trust of Gaps in local rotations, giving the Trust autonomy to recruit at a local level into these gaps			
	Effective electronic rota management system for AFC staff implemented with doctors implemented by early 2022		PPF Committee			
	Director of medical Education (DME) to ensure training requirements are met, reporting to the Trust Medical Director and externally to HEN		Quarterly reporting by Guardian of Safe Working, GMC Survey			
	Guardian of Safe Working Hours appointed in 2016 under new Junior Doctor Contract.		Quarterly reporting by Guardian of Safe Working.			
	Acting down policy and process in place to cover junior doctor gaps		Quarterly reporting by Guardian of Safe Working.			
	National Revalidation process ensuring competent staff.		Revalidation report to PPF Committee			
	Shared decision making and review of risk with JLNC.		Chair's Report to PPF Committee			
	Succession Planning and Talent Programmes		PPF Committee			
	NHSE/I leadership programme to reduce sickness		PPF Committee			
	Shared appointments with other providers		PPF Committee			
	Secured operating time at the LUH		PPF Committee			
	Increased consultant recruitment with incentives Neonatal Partnership		PPF Committee			
	Maternity introduction of ACP Midwives		PPF Committee			
	Work underway to ensure that the number of staff without a Covid-19 vaccine is minimised		PPF Committee			
	Flexible working programme		PPF Committee			
	Bi-annual safe staffing reports		PPF Committee and Board			
	Birth rate Plus Report		Board			
	NHSP utilisation for bank staff					
	Preceptorship for nursing and midwifery staff					
	Strategic Medical Workforce group established for short and medium term workforce planning		Chair's report into PPF			
	Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
	1.2 / 3	E-rostering system for doctors - Allocate is implemented for O&G and work commenced for other specialties Roll out of the e-rostering system Allocate for Neonatal and Anaesthetics is ongoing. Project resource has been identified to progress and this work will be completed by Autumn 22	Deputy Director of Workforce	~~November~~November 2022	PPF Committee	
	1.2 / 4	To provide evidence that robust workforce plans are being reviewed regularly at Divisional Board	Deputy Director of Workforce	September 2022	PPF Committee	
	1.2 / 5	Respond to Ockenden recommendations relating staffing	Deputy Director of Workforce	September 2022	PPF Committee	
	1.2 / 6	To ensure that staffing issues are included and noted as a key risk in discussions regarding the single site risk.	CPO	On-going	Board	

Strategic Objective	SA2: To deliver SAFE services
Committee:	Quality Committee & Finance, Performance & Business Development Committee
Risk Appetite:	Low

Principal risks (BAF)	Risk Score
2.1 Failure to progress our plans to build a new hospital co-located with an adult acute site	15 (3 x 5)
2.2 Failure to develop our model of care to keep pace with developments and respond to a changing environment	12 (3 x 4)
2.3 Failure to implement all feasible mitigations to ensure services delivered from the Crown Street site are as safe as possible, developing our facilities for the benefit of our patients as well as those across the system	20 (4 x 5)
2.4 Major and sustained failure of essential IT systems due to a cyber attack	20 (4 x 5)

Risk and Controls Summary

To outline changes to risk scores, new risks or closed risks.

2084 - No change in risk score since last review. Last reviewed 08/11/21

2085 - No change in risk score since last review. Last reviewed 15/09/2021

2086 - No change in risk score since last review. Last reviewed 07/12/21

2296 – Risk moved from 16 to 9 - Discussed as part of the 24/7 transfusion project - machine is still under contract extension

2321 - No change in risk score since last review. Last reviewed 09/03/2022

2469 – No change in risk score since last review. Last reviewed 13/01/2022

2470 – No change in risk score since last review. Last reviewed 09/03/2022

Ref	Corporate Risk Register / High Level (15+) Risks	Risk Score
1961	Risk to patient safety, including risk of misdiagnosis, inaccurate reporting of imaging findings, and lack of evidence that imaging has been performed on PACS.	16
2397	Following a recent serious incident, there is a risk that patients will not be informed of abnormal imaging results from LWH or external organisations when the results are received at the Trust	16
2341	There is a risk that during the Covid-19 pandemic, adult patients who suffer a cardiac arrest will receive suboptimal resuscitation	16
2386	Risk of personal and sensitive information being compromised or being misused	15
2316	Risk of women needing to access emergency care with pregnancy complications and not being able to access advice or care at the point needed. Impact on the safety of patients, (physical/psychological harm)	16
2446	A number of patients who had been waiting for Gynaecology surgery (P4) and had pre-operative scans that were missed / not reviewed in time, subsequently had escalation of diagnosis and further management plan.	16
2084 **(CRR)**	Uncertainty of adequacy of 24/7 access to specialist input to support changing patient profiles and needs, new guidance and the Chief Medical Officer's recommendation of the specialist multidisciplinary team approach to treatment planning and co-ordination, including pre-operative, surgical and up to level 3 post-operative care for improved patient safety and improved outcomes.	6
2085 **(CRR)**	Uncertainty around access to dedicated diagnostic capacity and physiological measurement needed to support needs of a changing patient demographics and an increase in complex multiple comorbidities and meeting the pre-operative assessment standards of the AAGBI and the RCoA, to assess patients' clinical risk and plan for additional requirements for their safety and provide an optimal experience.	12
2086 **(CRR)**	Uncertainty about provision of adequate on-site Blood bank stocking all major blood products necessary to support the needs of the Maternity service.	9
2296 **(CRR)**	The LWH laboratory autoview analyser (the machine used to process Blood Group and Save samples on site) will no longer be supported as of 1st March 2020. This machine cannot continue to be used after this date.	9
2321 **(CRR)**	Due to the Trust not being located next to or with acute services, it is unable to meet the National Recommendations for Maternal Medicine	15
2469 **(CRR)**	Allocation of resources to carry out water safety checks and maintenance has failed to achieve required targets despite prioritising this work and reducing resources for other tasks	9
2470 **(CRR)**	Water cold water temperatures in the new NICU build are being recorded as 2% higher than hospital cold water temperatures.	9

BAF Risk 2.1: Failure to progress our plans to build a new hospital co-located with an adult acute site

Lead Director: CFO
Op Lead: Head of Transformation & Strategy

Review Date: August 2022

Strategic Priority: SA2: To deliver SAFE services

Lead Committee: Finance, Performance & Business Development Committee

Provider Licence Compliance link:

Integrated Care Condition

SCORE:

May 2022	Q2	Q3	Q4	Q 2 Q movement	2022/23 Target
15 (3 x 5)	15 (3 x 5)			⟷	10 (2 x 5)

Rationale for current risk score:

The Trust's services being located on an isolated site away from adult acute services, remains the most significant risk to the organisation. The Trust can demonstrate strong controls in relation to developing the clinical evidence base for the move and has achieved buy in from all significant stakeholders for the case for change. There remains howeve no clear route to capital funding, and no clear direction from the C&M ICS regarding a way forward.~~The Trust's services being located on an isolated site away from an acute centre, remains the most significant risk to the organisation. The Trust can demonstrate strong controls in relation to developing the clinical evidence base for the move and has achieved buy in from significant stakeholders. There remains however, a lack of system support outside of the C&M region to secure the capital case.~~

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Inability to effectively communicate the case for change with regulators and key partners and receive buy-in to move project forward.	Continuing dialogue with regulators	CEO and Chair maintaining on-going dialogue Support for Expression of Interest submitted 9th September 2021 from C&M. Trust has shared EOI with C&M partners, positive support received Regional and national NHSE leaders have visited the Trust and been briefed about the case for change, including Amanda Doyle, Jackie Dunkley-Bent, Ruth May, Lesley Regan CFO has met with national Director of Capital, Chris Jackson	Lack of system support outside of Cheshire and Mersey to secure the capital case Formation of ICB creating delays and repetition in programme H&CP submissions for capital bids not successful despite system agreement of clinical case No clear route to capital funding Business case refresh is led by Trust rather than commissioners as with previous case Public consultation required Transfer of commissioning arrangements from CCGs to ICS New ICS in place from 1 July 2022 with new stakeholders to understand the case~~Potential change in ICS Board in April 2022~~ Requirement for commissioners to agree process to manage non-compliance with service specifications and standards where no further provider action can be taken. Case for change and counterfactual case to be presented to HOSCs Lobby systems and MPs for active support External review/testing of counterfactual case - ongoing External review/testing of refreshed case for change, following completion of FGCAG work/business case refresh - ongoing	
	Future Generations Strategy Update	Available on the Trust website Future Generations Strategy has been included within refreshed overall corporate strategy and is a key supporting strategy within Trust strategic framework Future Generations Clinical Advisory Group has been reconstituted		
	Business case refresh	Refresh of business case is underway, informed by work of FGCAG. Work includes review of compliance against new clinical standards, counterfactual case refresh, future model of care, updated of clinical case for change (taking account of changes at LWH, in system and health and care landscape over last 5 years)		
	Active management with all commissioners	Good meetings with CCG via Clinical Quality and Performance Group (CQPG) Relationships with key ICS stakeholders established Escalation of risks of isolated site to system level The Trust is working closely with Liverpool CCG to plan pre-consultation engagement, engagement with HOSCs and draft consultation timeline. Meetings held with CIC, Spec Comm, Cancer Alliance Steering Group and Programme Board, Adult CCN and LMS and have received unambiguous support for the case for change from all stakeholder groups. Meeting held with specialised commissioners to discuss management of non-compliance with standards, where no further action can be taken by the Trust to mitigate non-compliance. Case for Change and Counterfactual Case presented to Shadow ICB in June 2022. Current LWH risk presented to ICB in August 2022. LWH MD is maintaining contact with ICB MD regarding level of clinical risk.		
	~~Future Generations project group established with the Trust~~	~~Reports to the FPBD~~		
	Future Generations Steering Group established	FG Steering Group established to provide strategic direction and oversight of the FG Programme. Terms of Reference approved by FPBD July 22. Multiple underpinning workstreams/subgroups also established, each led by Executive Directors.		
	External validation of case for change	Output from Clinical Summit report (2019 and 2022)		

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
2.1/1	Management of Future Generations Programme through Project Management Office, with oversight and strategic direction provided by the FG Steering Group~~Management of Future Generations Strategy through Project Management Office~~	Associate Director of Strategy~~Head of Strategy and Transformation~~	August 2021 - ongoing~~August 2021 - ongoing~~	Board	

	2.1/2	Business case refresh – completion of options appraisal and refreshed model of care for future of women's and neonatal services	Associate Director of Strategy~~Head of Strategy and Transformation~~	November 2022~~October 2022~~	Board		
	2.1/3	Business case refresh – refreshed estates modelling and schedule of accommodation for new build	Associate Director of Strategy~~Head of Strategy and Transformation~~	December 2022~~October 2022~~	Board		
	2.1/4	External validation of case for change and counterfactual case COMPLETE – REFERENCED IN SOURCES OF ASSURANCE	Medical Director~~Medical Director~~	April 2022~~April 2022~~	Board		
	2.1/5	Commence public consultation (external control of this action by commissioners and NHSE/I)	Head of Communications and Marketing~~Head of Communications and Marketing~~	December 2022~~December 2022~~	Board		
	2.1/6	Development and completion of business case (OBC, FBC stages) through New Hospitals Building Programme approach (external control of this by NHSE/I)	Associate Director of Strategy~~Head of Strategy and Transformation~~	March 2024~~March 2024~~	Board		
	2.2 / 7	Lobby systems and MPs for active support	Head of Communications and Marketing~~Head of Communications and Marketing~~	September 2022 - Ongoing~~September 2022~~	Board		
	2.2 / 8	Build relationships with key ICS personnel	Medical Director~~Medical Director~~	September 2022~~September 2022~~	Board		
	2.2 / 9	Meetings with key partners to share case for change and counterfactual case and request explicit support COMPLETE – REFERENCED IN SOURCES OF ASSURANCE	Medical Director, Associate Director of Strategy~~Medical Director, Head of Strategy and Transformation~~	April 2022~~April 2022~~	Board		
	2.2 / 10	Request re-prioritisation of C&M capital schemes	Chief Finance Officer~~Chief Finance Officer~~	April 2022 - Ongoing~~April 2022~~	Board		
	2.2 / 11	Meeting with specialised commissioners to discuss management of non-compliance with standards, where no further action can be taken by the Trust to mitigate non-compliance. COMPLETE – REFERENCED IN SOURCES OF ASSURANCE	Medical Director, Chief Finance Officer~~Medical Director, Chief Finance Officer~~	April 2022~~April 2022~~	Board		
	2.2 / 12	Presentation of case for change and counterfactual case at HOSC	Medical Director, Associate Director of Strategy~~Medical Director, Head of Strategy and Transformation~~	January 2023~~June/July 2022~~	Board		

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Inability to effectively communicate the case for change with the local community and receive buy-in to move project forward.	Future Generations Strategy Update	Available on the Trust website Future Generations Strategy has been included within refreshed overall corporate strategy and is a key supporting strategy within Trust strategic framework Future Generations Clinical Advisory Group has been reconstituted	Further communication required of strategy and Future Generations position within strategy with local community, patients and public	
	Pre-consultation Business Case and public consultation	Trust refresh of Strategic Outline Case is underway, informed by work of the FG CAG. Much of this information can be used by commissioners to complete a PCBC ready to inform public consultation. Stage 1 Assurance meeting has been held with NHS England and commissioners to carry out strategic sense check and agree governance and process	Public consultation required – this must be led by commissioners No clear agreement at present regarding commissioners vs provider responsibility for completion of PCBC	
	Discussion of case for change with patients, public and local community	Refreshed case for change and counterfactual case will need to be shared with public, patients and the local community. Case for change and counterfactual case have already been validated by partners and independent clinical senate.	Lobby systems and MPs for active support Case for change and counterfactual case not yet shared with public Engagement with local community required regarding case for change and counterfactual case	
	Comms and Engagement Activities	The Trust is working closely with Liverpool CCG to plan pre-consultation engagement, and draft consultation timeline. Currently reviewing outcomes of previous engagement exercises and updating publicly available information.	Further work required to engage women and their families in option appraisal process and model of care development	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
2.1 / 13	Promotion of Trust Strategy and FG Strategy as part of overall Strategy Comms and Engagement plans	Head of Communications and Marketing	April 2022 – Nov 2022~~April 2022 – Sept 2022~~	Board	
2.1 / 14	Stage 1 Assurance meeting to take place with NHSE COMPLETE – REFERENCED IN SOURCES OF ASSURANCE	Chief Finance Officer	April 2022~~April 2022~~	Board	
2.1 / 15	Agreement of responsibility for production of pre-consultation business case with commissioners	Chief Finance Officer	September 2022~~August 2022~~	Board	

	2.1 / 16	Public consultation regarding options to address case for change (external control of this action by commissioners)	Chief Finance Officer	May 2023~~December 2022~~	Board		
	2.1 / 17	Present case for change and counterfactual case at public Board meeting	Medical Director	December 2022~~June/July 2022~~	Board		
	2.1 / 18	Comms and engagement campaign and public engagement activities to support consultation, options appraisal, model of care development	Head of Communications and Marketing	July 2022 - ongoing~~July 2022~~	Board		

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Failure to secure capital funding to progress our plans to build a new hospital co-located with an adult acute site	Submission of Expression of Interest to New Hospital Building Programme	Expression of interest submitted September 2021 Support for Expression of Interest submitted 9th September 2021 from C&M. Trust has shared EOI with C&M partners, positive support received	Lack of system support outside of Cheshire and Mersey to secure the capital case WHH scheme prioritised in C&M – request re-prioritisation LWH scheme 6th priority across North West Funding option not yet agreed	
	~~Engagement with Liverpool City Council re alternate source of funding~~	~~Previous application for funding submitted and agreed 2019~~ ~~New ongoing engagement to refresh request and model funding options~~		
	Engagement with regional and national teams regarding capital funding options	Regular meetings between CFO and regional teams to discuss capital funding options Engagement with LUHFT CEO to discuss capital funding options		

2.1/ 19	Approval of EOI (external control of this by NHSE/I)	Chief Finance Officer	Date unknown, outside of LWH control~~September 2022~~	Board		
~~2.2 / 20~~	~~Engagement with LCC to develop and potentially agree alternate capital funding source~~	~~Chief Finance Officer~~	~~April – July 2022~~	~~Board~~		

BAF Risk 2.2: Failure to develop our model of care to keep pace with developments and respond to a changing environment

Lead Director: COO
Op Lead: Deputy COO

Review Date: August 22

Strategic Priority: SA2: To deliver SAFE services

Lead Committee: Finance, Performance & Business Development Committee

Provider Licence Compliance link:

SCORE:

May 2022	Q2	Q3	Q4	Q 2 Q movement	2022/23 Target
16 (4 x 4)	16 (4 x 4)			⟷	12 (3x4)

Rationale for current risk score:

The lack of an EPR (and as a corollary, having in place a disparate number of systems), remains a significant risk to the organisation because information is spread across disparate systems leading to information being incomplete, hard to find in a timely manner and a potential for inaccuracies due to manual transfer of information. However, there is evidence of pro-active mitigating controls and progress being made in the procurement and subsequent implementation of an integrated Meditech EPR system. The Trust can demonstrate evidence of being open and responsive to change in service development and delivery, but further work can be done to strengthen the approach to horizon scanning and longer term, strategic planning at a Divisional level.

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
The Trust's current clinical records system (paper and Electronic) are sub-optimal.	Approved Digital Generations Strategy	Quarterly risk assessments completed FPBD Committee overview and scrutiny Digital Hospital Committee oversight Approved EPR Business case which define clear direction and preferred solution. EPR programme board chaired by MD Independent lessons learnt Positive review MIAA Critical Application Audit (rolling programme across trust systems) Reporting into Audit Committee and Digital Hospital Group	Multiple Clinical Systems issues remain **(Action 2.2 / 2)** Ability of clinical staff to engage with the system development due to time and financial impact **(Actions 2.2 / 1, 2.2 / 3, 2.2 / 4)** Optimisations to K2 system and refinements which are required **(Action 2.2 / 5)** Not all Trust using LHCRE for patient information exchange **(Action 2.2 / 6)**	
	Approved Meditech Expanse Business Case			
	Maintenance of present system			
	Development of individual / service solutions e.g. PENs (Gynaecology) and Staff training			
	Incident reporting			
	Tactical solutions including the implementation of K2 Athena system			
	Exchange/LHCRE enables for patent information sharing			
	Virtual Desktop technology to aid staff working flexibly.			
	Additional network resilience for LUHFT supplied systems (K2/PENS/CRIS) to reduce risk of unplanned systems downtime			
	PACS upgrade removes a separate login for that system, reducing multiple systems issues.			
	Task and Finish group established to ensure that clinical investigation undertaken at external trusts have been actioned accordingly.	Safety and Effectiveness Sub-Committee		
	Appropriate task and finish groups established as required by Safety and Effectiveness sub-committee	Safety and Effectiveness Sub-Committee		
	Digital clinical leadership business case developed	Digital Hospital Sub-Committee		
	Optimisations to K2 system and refinements implemented	Digital Hospital Sub-Committee		
	Ongoing review of systems and mitigations quarterly	FPBD & QC		

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
2.2 / 1	Develop staff communication plan for new system	CIO	December 2022	Digital Hospital Committee oversight	
2.2 / 2	Ongoing review of systems and mitigations quarterly (report to FPBD & QC) – MOVED TO CONTROL	CIO	February 2022	FPBD and Quality Committees	
2.2 / 3	Issue appropriate communication to all staff in relation to digital development by multiple means and forms	CIO	November 2022	Digital Hospital Committee oversight	
2.2 / 4	~~Develop a business case for appropriate digital training capabilities for the Trust CLOSE - funding not required. Utilise existing e-learning platform~~	~~CIO~~	~~April 2022~~	~~Digital Hospital Committee oversight~~	
2.2 / 5	~~Implement required system optimisations as identified by Maternity and other Trust stakeholders~~	~~CIO~~	~~April 2022~~	~~Digital Hospital Committee oversight~~	
2.2 / 6	~~Task and Finish group to explore mitigations and identify new solutions to ensure the results of clinical investigations are reviewed and actioned. Ensuring documentation of this process can be provided~~ ~~Added to controls~~	~~CIO~~	~~April 2022~~	~~Digital Hospital Committee oversight~~	

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Clinical service strategies	Operational 'Plans on a page' for Divisions – incorporates horizon scanning section	Divisional Board meetings	To improve horizon scanning processes to constantly review and update plans on a page **(Action 2.2 / 7)** To understand commissioning priorities emerging from developing ICS **(Action 2.2 / 7)**	
	Operational planning process	Operational plans and budgets		
	Availability of data on service trends and demographics	Divisional Boards		
	Workforce plans	Divisional Boards		

that do not sufficiently anticipate evolving healthcare needs of the local population and/or reduce health inequalities					To ensure that Divisions are fully utilising data to understand changing service demands **(Action 2.2 / 8)** To ensure that workforce plans are informed by trends and data led intelligence. **(Action 2.2 / 9)**	
	Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
	2.2 / 7	Use of effective horizon scanning at Divisional Boards to review and update 'plans on a page' – to include emerging intelligence around commissioning priorities from developing ICS – ADDED TO CONTROLS	Deputy COO	July 2022	Executive Team	
	2.2 / 8	To ensure that Divisions are fully utilising data to understand changing service demands	Deputy COO	September 2022	Executive Team	
	2.2 / 9	To ensure that workforce plans are informed by trends and data led intelligence.	Deputy COO	September 2022	Executive Team	

BAF Risk 2.3: Failure to implement all feasible mitigations to ensure services delivered from the Crown Street site are as safe as possible, developing our facilities for the benefit of our patients as well as those across the system

Lead Director: Chief Operating Officer
Op Lead: Head of Strategy & Transformation

Review Date: August 2022

Strategic Priority: SA2: To deliver SAFE services

Lead Committee: Quality Committee

Provider Licence Compliance link:

N/A

SCORE:

May 2022	Q2	Q3	Q4	Q 2 Q movement	2022/23 Target
20 (4 x 5)	20 (4 x 5)			⟷	15 (3 x 5)

Rationale for current risk score:

The Trust's services being located on an isolated site away from an acute centre, remains the most significant risk to the organisation and to patient safety. Good progress is being made on mitigating measures to make the Crown Street site safer with a number of significant capital projects either completed, underway or planned. It should be acknowledged that the impact of this risk cannot be fully mitigated whilst the Trust operates on an isolated site, and that following the implementation of the actions outlined below, the Trust does not believe that any further mitigation is possible. This view was recently confirmed by an independent review undertaken by the Northern England Clinical Senate, in February 2022.

~~The Trust's services being located on an isolated site away from an acute centre, remains the most significant risk to the organisation and to patient safety. Good progress is being made on mitigating measures to make the Crown Street site safer with a number of significant capital projects either completed, underway or planned. It should be acknowledged that the impact of this risk cannot be fully mitigated whilst the Trust operates on an isolated site.~~

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Location, size, layout and accessibility of current services do not provide for sustainable integrated care or safe and high-quality service provision.	Programme for a partnership in relation to Neonates with AHCH has been established.	Neonatal partnership updates provided to the Board	Transfers are often subject to delay due to the Trust being considered a 'place of safety'. Transfer of adults requires accompanying clinical staff, which can lead to staffing pressures on the ward. **(Action 2.3/2)** Onsite and partnership mitigations cannot fully address the clinical risk - this can only be achieved through co-location. Arrangements not formally agreed and underpinned by detailed SLA. **(Action 2.3/3)** Lack of 24/7 transfusion laboratory on site leads to delay in patients receiving transfusion. **(Action 2.3/4, 2.3/5)** Emerging clinical standard leading to potential loss of services and increase in difficulty in relation to recruitment of consultants. Twilight cover to be in place from April 2022 (Maternity) and January 2022 (Neonates). There remains an on-going challenge in relation to Anaesthetics recruitment. **(Action 2.3/6)** Financial and workforce constraints for delivery of additional facilities on site. **(Action 2.3 / 1)** Construction works not yet complete to accommodate new FMU, colposcopy suite, CT & MR Imaging suites – due to complete December 2022 **(Action 2.3/8)** 24/7 transfusion laboratory not yet established – aim for completion September 2022 **(Action 2.3/4)** Colposcopy decant not yet complete – aim for completion June 2022 **(Action 2.3/9)** Full CDC Services not yet implemented **(Action 2.3 / 10)** Signed SLA with LUHFT required **(Action 2.3 /3)**	
	£15m capital investment in neonatal estate to address infection risk	IPC Reports		
	Transfer arrangements well established for neonates	Transfers out monitored by Partnership		
	Transfer arrangements for adults	Transfers out monitored at HDU Group		
	Formal partnership and board established with Liverpool Universities Hospitals with respect to: -Diagnostics -Medical and surgical expertise -Intensive care facilities -Theatre access at Liverpool Universities Hospitals for women with Gynae cancers -Provision of maternity expertise at LUHFT sites -Provision of Gynaecology expertise at LUHFT sites -Placenta accreta service, including specialist imaging and supervision of review from Sheffield Teaching Hospitals NHS FT	Partnership activity to report through to FPBD and Board on a quarterly basis		
	Blood product provision by motorised vehicle from nearby facility, with revised protocols in place to prioritise transport of blood products.	Serious incidents, should they occur are tracked and reported through the governance framework,		
	Investments in additional staffing inc. towards 24/7 cover - Maternity	Staff Staffing levels reports to board		
	Investments in additional staffing inc. towards 24/7 cover - Anaesthetics joint anaesthetic appointments with LUHFT	Staff Staffing levels reports to board		
	Investments in additional staffing inc. towards 24/7 cover – Gynaecology, including additional investment in ANP roles within GED	Staff Staffing levels reports to board		
	Investments in additional staffing inc. towards 24/7 cover - Neonates	Staff Staffing levels reports to board		
	Enhanced resuscitation training provision - Paediatric	Training compliance rates reported to PPF Committee		
	LWH appointed at C&M Maternal Medicine Centre	LWH working as part of NW Maternal Medicine Network		
	Enhanced resuscitation training provision - Adult	Training compliance rates reported to PPF Committee		
	Crown Street Enhancements Programme Board established to oversee: -Construction work required to accommodate new FMU, colposcopy suite, CT & MR Imaging suites (ongoing) -Implementation of Robotic Assisted Surgery (complete) -Implementation of 24/7 transfusion laboratory on site (ongoing) -Decant into and new ways of working within FMU (complete) -Decant into and new ways of working within colposcopy (ongoing)	Crown Street Enhancements Programme progress reviewed monthly at FPBD		
	Community Diagnostic Centre established at Crown Street, to include the following diagnostics with access for LWH patients: -Imaging – CT, MR, X-ray, ultrasound -Physiological – ECHO, ECG, BP monitoring, Spiro, FeNO, Sleep studies Mannitol -Phlebotomy -Pathology	Community Diagnostic Centre Oversight Group reviews progress on a fortnightly basis. Progress also reported to and monitored by regional CDC Programme Board. Mobile CT and respiratory testing operational.		
	Divisional Operational Plans completed	Divisional Boards		
	Use of telemedicine to facilitate consultations both at Crown Street and other sites	Divisional Boards		
	Historic controls still in place include: -Use of cell salvage& ROTEM	Quality Committee		

	-Innovative use of bedside clotting analysis and fibrinogen concentrates -Early order of blood products (high wastage) -Out of hours transfusion lab provided off-site by LCL Outreach midwife post -AN & Gynae outpatient service at Aintree Hospital -Gynaecology Tier 2 rota providing cover for LWH and Liverpool Place -Expanded role of anaesthetists to cover HDU patients and provide pain service -Additional pain service provided by Walton Centre, with psychologist input -Uoskilling of HDU staff -Joint clinics -SLAs in place for clinical support services from LUHFT -Ambulance transfer of patients for urgent imaging or other diagnostics not currently provided on site -Planned pre-op diagnostics provided off-site by LUHFT -Appointment of resus officers, upgrading of resus trolleys and provision of automated defibrillator trolleys -Existing informal links with partner organisations -ANP roles -Transfer of patients for urgent imaging and critical care -Theatre slots at LUHFT with access to colorectal surgeons -Purchase of sentinel node biopsy and 3D laparoscopic kit -ACHD Partnership ~~-Expanded role of anaesthetists to cover HDU patients~~ ~~-Existing informal links with partner organisations~~ ~~-ANP roles~~ ~~-Transfer of patients for urgent imaging and critical care~~ ~~-Theatre slots at LUHFT~~ ~~-ACHD Partnership~~				
	Progress being made in relation to building relationships with LUFT - Task and finish groups established, reporting into the Partnership Board with LUHFT setting out arrangements for partnership working across all four LWH and LUHFT sites	Partnership Board meetings and involvement in wider Estates Strategy Mapping of requirements from and interdependencies with LUHFT across all Trust specialties			
	Agreed funding for all mitigations on site are included in operational planning	FPBD (monthly oversight reports and detailed budget)			
	A telemedicine pilot has been implemented to provide additional support for pregnant women on ITU at the Royal Liverpool Hospital.	Single Site risk report – provided to July 2022 Board			
	SOP implemented for paediatric resus provision	Safety and Effectiveness Senate – received update in January 2022			

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
2.3 / 1	Agree funding for all mitigations on site are included in operational planning See controls	Deputy Chief Finance Officer	April 2022	FPBD Committee	
2.3 / 2	~~Provision of staffed and dedicated ambulance to facilitate transfer of adult patients to be explored.~~ NOT BEING PURSUED AT PRESENT	~~Deputy Chief Operating Officer~~	~~TBC~~	~~Quality Committee~~	
2.3 / 3	Detailed agreements to form part of SLA with LUHFT, clearly explaining routes of access and expectations of both organisations.	Deputy Chief Finance Officer	~~September~~ December 2022	Partnership Board, TBDG	The sub groups for the partnership have not determined the content of the SLA schedules yet
2.3 / 4	Project to establish 24/7 transfusion laboratory on site at Crown Street	Head of AHPs	~~September~~ March 2023~~2~~	Crown Street Enhancements Programme Board, FPBD	Staffing continues to be an issue that requires resolution
2.3 / 5	Implement remote issue of blood products to minimise delay in transfusion ~~delayed due to issues with external suppliers~~	Head of AHPs	October 2022	Crown Street Enhancements Programme Board, FPBD	Now on track
2.3 / 6	Continue to recruit to secure 24/7 Anaesthetics cover	Clinical Directors	January 2023	TBDG	
2.3 / 7	Clear SOP to be implemented for paediatric resus provision	Deputy Medical Director	January 2022	Quality Committee	
2.3 / 8	Complete construction of colposcopy, ~~CT & MR imaging~~ suites	Head of Strategy and Transformation	~~December~~ July 2022	Crown Street Enhancements Programme Board, FPBD	
	Complete construction of CT imaging suite	Associate Director of Strategy	December 2022	Crown Street Enhancements Programme Board, FPBD	
	Complete construction of MR imaging suite	Associate Director of Strategy	February 2023	Crown Street Enhancements Programme Board, FPBD	
2.3 / 9	Project to manage decant and new ways of working within colposcopy delayed due to delay in build programme	Deputy Divisional Manager for Gynaecology	~~August~~ September 2022	Crown Street Enhancements Programme Board, FPBD	
2.3 / 10	Deliver CDC project plan to establish CDC services: -Imaging – CT, MR, X-ray, ultrasound -Physiological – ECHO, ECG, BP monitoring, Spiro, FeNO, Sleep studies -Phlebotomy~~Pathology~~	~~Head of Strategy and Transformation/~~ Deputy Chief Operating Officer	December 2022	CDC Oversight Group, FPBD	
2.3 / 11	Project to expand use of telemedicine technology	Divisional Manager for Family Health	March 2022	Trust Executive	

BAF Risk 2.4: Major and sustained failure of essential IT systems due to a cyber attack

Lead Director: CIO
Op Lead: CIO

Review Date: April 2021

Strategic Priority: SA2: To deliver SAFE services

Lead Committee: FPBD Committee

Provider Licence Compliance link:

SCORE:

May 2022	Q2	Q3	Q4	Q 2 Q movement	2022/23 Target
20 (4x5)	20 (4x5)			⇔	15 (3x5)

Rationale for current risk score:

The Trust's Digital Services department places cyber security management at the core of operational activities, ensuring it maintains its Cyber Essentials standard. Various controls are implemented that are considered effective and this reduces the likelihood of a cyber-attack impact. However, if a cyber-attack was successful the impact would likely be catastrophic to Trust services, likely rendering digital systems that clinical services are increasingly dependent on, unavailable for a period of time. The Digital Services department continue to strengthen controls through process refinement and the introduction of security technologies. On the basis of this, the impact is considered catastrophic (5). Due to recent world events, the environment risk or likelihood for a cyber-attack has increased from possible (3) to likely (4) due to increased cyber threats from Russia. The NHS has reflected the increased threat through guidance issued to all NHS providers and arm's length bodies during March 2022.

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Ineffective cyber controls and technology, inadequate investment in systems and infrastructure, failure in skills or capacity of staff or service providers, poor end user culture regarding cyber security and IT systems use, inadequate contract management. **Consequence: Reduced quality or safety of services, financial penalties, reduced patient experience, loss of reputation, loss of market share / commissioner contracts.**	Microsoft Windows security and critical patches applied to all Trust servers on all servers\laptops and desktop devices on a monthly basis. Network switches and firewalls have firmware updates as and when required installed. Wifi network firmware patches applied for Controllers and Access points. Mobile end devices patched as and when released by the vendor. Externally managed network service provider to ensure network is a securely managed with underpinning contract. Robust CareCert process to enact advice from NHS Digital regarding imminent threats. Network perimeter controls (Firewall) to protect against unauthorised external intrusion. Robust Information Governance training on information security and cyber security good practice. Regular staff educational communications on types of cyber threats and advice on secure working of Trust IT systems. Additional cybersecurity communications in relation to Covid phishing/ scams, advising diligence. Enhanced VPN solution including increased capacity to secure home working connections into the Trust. Review and updating of information security policies and home working IG guidance to support staff who are remote working. Malware protection identifies and removes known cyber threats and viruses within the Trust's network and at the network boundaries. Cyber Security Monitoring System identifies suspicious network and potential cyber threat behaviour. National CareCert alerts inform of known and imminent cyberthreats and vulnerabilities Mobile device management – providing enhanced security for mobile devices	Cyber Essentials Plus Standards/KPIs IMT Risk Management Meeting Digital Hospital Sub Committee MIAA Cyber Controls Review Cyber Essentials Plus Accreditation Cyber Penetration Test NHS Care Cert Compliance	Lack of Cyber Security strategy **(Action 2.4 / 1)** Lack of Network Access Controls within the physical network **(Action 2.4 / 2)** Effective USB port control **(Action 2.4/ 3)** Lack of visibility of medical devices **(Action 2.4 / 4)**	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
2.4 / 1	Implement a Cyber Security strategy	CIO	August 2022	FPBD	Scheduled for the Board in September 2022
2.4 / 2	Procure and implement Network Access Control (NAC) solution	CIO	Dec 2022	DHSC	
2.4 / 3	Purchase and implement software for USB port control	CIO	September 2022	DHSC	
2.4 / 4	Improve grip, control and governance on medical devices	CIO	October 2022	Medical Devices / DHSC	

Strategic Objective	SA3: To deliver the best possible EXPERIENCE for patients and staff
Committee:	Quality Committee
Risk Appetite:	Low

Principal risks (BAF)	Risk Score
3.1 Failure to deliver an excellent patient and family experience to all our service users	12 (3 x 4)

Ref	Corporate Risk Register / High Level (15+) Risks	Risk Score
2418	Lack of support and appropriate care for patients presenting with mental health conditions	16
2430	Network outlier for pre-term mortality - rate is higher than the national average	16
2427	Covid lockdown between March 2020 and July 2020 and then September 2020 and subsequently December 2020 to March 2021, resulting in prolonged wait for elective surgery for benign gynaecologic procedures	16
2350	Due to the need to reduce patient attendance / stop elective activity and adhere to social distancing as a result of Covid-19 a number of services within Gynaecology have had to cease or changes the way in which they are delivered	15
2304	Failure to achieve 31 day and 62 day national cancer targets, and having monthly 104 day breaches	16
1966 **(CRR)**	Risk of safety incidents occurring when undertaking invasive procedures	12
2088 **(CRR)**	Lack of on-site specialist paediatric care and support services Neonatal surgery provision and Level 3 neonatal intensive care unit and lack of on-site provision for CT & MRI scanning and Blood bank and Transfusion Lab.	12

Risk and Controls Summary

To outline changes to risk scores, new risks or closed risks.

1966 - No change in risk score since last review. Last reviewed 12/01/2022.

2088 - No change in risk score since last review. Last reviewed 09/03/2022

BAF Risk 3.1: Failure to deliver an excellent patient and family experience to all our service users

Lead Director: CN&M
Op Lead: Deputy Director of Nursing & Midwifery

Review Date: August 2022

Strategic Priority: SA3: To deliver the best possible EXPERIENCE for patients and staff

Lead Committee: Quality Committee

Provider Licence Compliance link:

SCORE:

May 2022	Q2	Q3	Q4	Q 2 Q movement	2022/23 Target
12 (3 x 4)	12 (3 x 4)			⟷	12 (3 x 4)

Rationale for current risk score:

~~The Trust has strong evidence in relation to its response to the Covid-19 pandemic and continues to receive positive feedback from significant patient surveys.~~ To improve further, it is imperative that the organisation ensures that it can listen to patient voices and the local community and ensure that services are responsive and can cater to differing needs. The evidence for how effective the organisation is undertaking this can be strengthened from the current position.

The Ockenden Final Report made several comments about the importance of trusts listening effectively to the patient voice and strengthening the Trust's approach to this will be a significant area of priority during 2022/23. Considering the importance of this and the fact that available controls / assurances remain limited in this area, the target score for 2022/23 has been set at '12' to reflect the current reality.

Following the operational pressures faced as a result of the COVID pandemic, a large number of patients had their treatment and appointments delayed as a result of changes to clinical capacity. This has led to an increasing number of patients waiting beyond 52 weeks to receive their treatment. Continued rises in referrals from Primary Care and an increasing backlog of patients to be seen has led to delays in care and deterioration of Trust performance in relation to national Referral to Treatment (RTT) standards

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Unable to adequately listen to patient voices and our local communities	Women, babies and their families experience strategy 2021 - 2026	Patient Involvement & Experience Sub-Committee	External MVP involvement in reviewing complaints processes Lack of assurance patient stories are shared at local divisional level Evidence how the divisions are using this data to influence their service design and improvements	
	PALs and Complaints data	Patient Involvement & Experience Sub-Committee		
	Patient Stories to Board	Board Meeting		
	Friends and Family Test	Patient Involvement & Experience Sub-Committee		
	National Patient Survey	Patient Involvement & Experience Sub-Committee		
	Healthwatch feedback	Patient Involvement & Experience Sub-Committee		
	Social media feedback	Patient Involvement & Experience Sub-Committee		
	Membership feedback	Council of Governors		
	Patient Experience Matron in place to build relationships with local community leaders and mechanisms for hearing feedback on the Trust's services	Reports Patient Involvement and Experience Sub-Committee and attends CoG Comms and Engagement Group		
	Bespoke Patient Surveys	Patient Involvement & Experience Sub-Committee		
	Patient experience Review reports produced by the Divisions and reported to PIESC	Patient Involvement & Experience Sub-Committee		

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
3.1 / 1	MVP to conduct a review of complaints process	Head of Audit, effectiveness, and Patient Experience	October 2022	Patient Involvement & Experience Sub-Committee	We have been waiting for a new chair to be appointed for the MVP since the last chair had stood down. The new chair starts in September so we plan to contact the MVP then to discuss the review of the complaints process.
3.1 / 2	Formal process implemented to track and monitor bespoke surveys requested.	Head of Audit, effectiveness, and Patient Experience	November 2022	Patient Involvement & Experience Sub-Committee	PEX team still developing the process but will be completed by the deadline if the Microsoft side of the process is completed.
3.1 / 3	Development and improvements to the Patient experience Review reports produced by the Divisions and reported to PIESC	Divisional Management Teams	September 2022	Patient Involvement & Experience Sub-Committee	MOVED TO CONTROLS
3.1 / 4	Development of a process to share the board presented patient stories to a wider audience such as divisional board and team meetings.	Patient Experience Matron. Head of Comms. Divisional Management Teams	December 2022	Patient Involvement & Experience Sub-Committee	The PEX matron is currently reviewing how the Stories can be shared with the wider audience.

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Failure to act on the feedback provided by	Failure to act on the feedback provided by patients, carers, and the local communities.	Women, babies and their families experience strategy 2021 - 2026	MVP review needed of complaints actions and themes for improvement presented at PIESC	
	Family Liaison Service	Action plans for complaints and PALS+ cases		
	PALs and Complaints data	Action plans for National surveys		

patients, carers, and the local communities.	Friends and Family Test National Patient Survey Healthwatch feedback	Action Plans for Bespoke Surveys KPI for Displeased comments responses in FFT QI Framework			No formal external process in place to monitor completion of complaint/ PALS+ action plans. Poor performance against Trust KPI for displeased FFT responses Gaps in QI understanding/training that is being addressed by the recently approved QI framework in the 4-year workplan.	
	Gap Reference	**Required Action**	**Lead**	**Implement By**	**Monitoring**	**Status**
	3.1 / 5	MVP to become involved in the review of information presented at PIESC	Head of Audit, Effectiveness and Patient Experience	~~Aug~~ October 2022	Patient Involvement & Experience Sub-Committee	We have been waiting for a new chair to be appointed for the MVP since the last chair had stood down. The new chair starts in September so we plan to contact the MVP.
	3.1 / 6	Creation of formal external process to monitor completion of complaint/ PALS+ action plans	Head of Audit, Effectiveness and Patient Experience	November 2022	Patient Involvement & Experience Sub-Committee	The PEX team are reviewing all action plans and monitoring the completion and chasing up. This is a project that has been assigned to a member of the team. This is external to the Divisions.
	3.1 / 7	Improvement of compliance against Trust KPI relating to displeased comments in FFT	Divisional Management Teams	August 2022	Patient Involvement & Experience Sub-Committee	There are slight improvements on the KPI but this is discussed at each PIESC to ensure that it is being reviewed and Power BI is being updated. We have found that the areas are doing the You said we did out in the areas but not updating the Power BI so not reflective in the KPI.

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance (*Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Lack of clinical capacity and resources i.e. workforce, estate etc. to treat patients in a timely manner resulting in delays in treatment and deterioration in Trust Performance standards	Fortnightly Access Board meetings with Divisional Operational Teams and Information present monitoring key performance	FPBD and Board meetings	Gaps in effective delivery of Access Policy including training of staff associated with RTT pathway management Gaps in Standard Operating Procedures for management of patient pathways Timescales for delivery of key elective recovery programme actions	
	Daily monitoring of performance through Power BI dashboards – daily and weekly updates on key performance metrics	Integrated Performance Report		
	Weekly Patient Tracking List (PTL) meetings with Divisional Operational teams and Patient Access	Access Board		
	Elective Recovery Programme in place with workstreams to improve performance and reduce waits	FPBD Executive Team reporting		
	External validation programme of work reviewing all admitted and non-admitted pathways to ensure RTT guidance being applied correctly	Access Board		
	Review of Medical & Nursing job plans to ensure capacity in place to treat patients in a timely manner	Updates via Divisional Performance Reviews and Hospital Management Meetings		
	Cancer Committee – meets bi-monthly to review Cancer performance and track actions to improve performance	FPBD		
	Theatre Utilisation Group	Updates via Divisional Performance Reviews and Hospital Management Meetings		
	Text reminder service to reduce DNA's and ensure patients still require appointments – facility in place if they wish to change or cancel appointments	Monitoring through Access Board		
	Patient Initiated Follow-Ups – to minimise numbers of patients who no longer require follow up to release capacity	Monitoring through Access Board		
	Locum Consultant in place for Gynaecology to increase clinical capacity	Updates via Divisional Performance Reviews and Hospital Management Meetings		
	Sub-specialisation of Gynaecology and sub-specialty recovery plans in place to monitor actions/risks at a sub specialty level and establish performance trajectories to deliver improvements	Updates via Divisional Performance Reviews and Hospital Management Meetings/Access Board		

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
X.X/ 1	Continue to provide updates to the Board regarding the Elective Recovery Plan through Divisional Performance Reviews and to FPBD on a monthly basis through the Integrated Performance Report	Deputy COO	On-going	Board	
X.X/ 2	Access Policy review and delivery of SOP's via Waiting List Management audit action plan	Patient Access Lead	December 2022	Access Board	

Strategic Objective	SA4: To be ambitious and EFFICIENT and make the best use of available resources
Committee:	Finance, Performance and Business Development Committee
Risk Appetite:	Moderate

Principal risks (BAF)	Risk Score
4.1 Failure to ensure our services are financially sustainable in the long term	20 (5 x 4)
4.2 Failure to expand our existing partnerships, building on learning and partnership working throughout the COVID-19 pandemic, playing a key role in establishing any ICP or ICS	8 (2 x 4)

Ref	Corporate Risk Register / High Level (15+) Risks	Risk Score
None identified to date		

Risk and Controls Summary

To outline changes to risk scores, new risks or closed risks.

BAF Risk 4.1: Failure to ensure our services are financially sustainable in the long term

Lead Director: CFO
Op Lead: Deputy CFO

Review Date: August 22

Strategic Priority: SA4: To be ambitious and EFFICIENT and make the best use of available resources

Lead Committee: Finance, Performance & Business Development Committee

Provider Licence Compliance link:

SCORE:

May 2022	Q2	Q3	Q4	Q 2 Q movement	2022/23 Target
20 (5 x 4)	20 (5 x 4)			⟺	16 (4 x 4)

Rationale for current risk score:

The Trust has a well-defined and evidence backed case that whilst it remains on an isolated site, it is not financially sustainable. This position is worsening each year as the impact of prior capital investment, ongoing and increasing revenue investment in staying safe on site, and other pressures such as CNST premium costs and the costs of implementing Ockenden actions are added into the cost base. The financial regime is becoming more constrained into 2022/23 and beyond, as Cheshire and Merseyside is deemed above target funding and so has had a convergence factor in addition to the efficiency requirement applied.

The Trust has undertaken what it can to manage costs and has robust financial controls in place as externally evidenced to and validated by audit. A Financial Recovery Board is in place to manage the position and the emerging Integrated Care System and region have a clear understanding of the Trust's underlying deficit however due to the overall constraints on the financial position are not able to guarantee that a shortfall in funding will not be in place.

Additional funding may be available e.g. through Ockenden but is unlikely to be sufficient to meet the Trust's requirements. If deficits are in place year on year further cost will be added associated with revenue cash support.

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance (*Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
The Trust is not financially sustainable in the long term	5 Year financial model produced giving early indication of issues	5 Year plan approved (BoD Nov 2014) Long Term Plan Submission Nov 19	Whilst plans are in place, there remains significant on-going uncertainty regarding the financial regime, introduction of Integrated Care Systems and consequent change in commissioning landscape and the impact of changing clinical requirements with resource implications. Model to be refreshed by July 2022. **(Action 4.1 / 1)**	
	Future Generations business case demonstrates the Trust is financially viable long term if the preferred option of co-location with an adult acute site is funded.	Future Generations Clinical Strategy and Business Plan (BoD Nov 15 – refreshed in 2020) Sustainability and Transformation Plan (FPBD, Jul 16) PCBC Approval (FPBD, Oct 16)	Implementation of business case is dependent on decision making external to the Trust (CCG, NHSE/I) National CDEL Issue Lack of capital nationally Time has now elapsed, and business case is in process of being refreshed. This will be a Strategic Outline Case. There remains uncertainty as to where and by who this will be assessed Additional work being undertaken to quantify financial benefits of co-location. **(Action 4.1 / 5)**	
	Early and continuing dialogue with NHSE/I and Cheshire and Merseyside ICS	System top up agreed to achieve breakeven for Half One 2021/22 and also Half Two 2021/22, meaning a breakeven plan is in place for 2021/22	Deficit plan likely in 2022/23. Significant financial challenge across C&M as a whole. Increasing costs (e.g. Ockenden) without income matching this. **(Action 4.1 / 4)**	
	Engagement in place with Cheshire and Mersey Partnership to review system solutions	Submission of Cheshire and Mersey STP capital bid Summer 2018 ranked no1 of schemes Active participation in C&M planning processes Trust Expression of Interest as part of New Hospital Programme has not been prioritised by Cheshire and Merseyside in 2021 but was mentioned as (joint) second priority in feedback.	Position potentially superseded by development of ICS Feedback to both ICS and North West region provided. Expression of Interest not ranked first in C&M. **(Action 4.1 / 5)**	
	Clinical Engagement and support for proposals	Northern Clinical Senate Report supporting preferred option both in 2017 and 2022.		
	Reduction in CNST Premium and achievement of Maternity Incentive Scheme.	Process in place regarding CNST MIS. Prior achievement of MIS. Engagement with NHS Resolution and learning from claims and incidents. Direct engagement with NHS Resolution. Increased resource in Maternity to manage this.	Potential resourcing issues to manage this. Actual premium costs still increasing significantly despite achievement of years two and three of CNST Maternity Incentive Scheme.	
	Reduction in back office overheads costs.	Oversight on costs at FPBD and Board Focus on benchmarking and efficiencies, including joint working where possible.	Requirement for resource in relation to recovery and covid.	
	Development of Community Diagnostic Centre.	Upfront capital and revenue funding provided. Letter of comfort from ICS. Funding agreed for 2022/23 and general commitment to ongoing	Significant revenue implications on an ongoing basis, not directly related to LWH patients. No definitive ongoing revenue funding source in place (although 2022/23 funding agreed). **(Action 4.1 / 8)**	
	Agreed financial plan for 2022/23 with NHSI/E and C&M	FPBD and Board (monthly reports)		

	Gap Reference	Required Action	Lead	Implement By	Monitoring	Status	
	4.1/1	Refresh LTFM	CFO	~~July 2022~~October 2022	FPBD Committee / Board	Propose deferral to October 2022 to allow completion of model. Delayed due to delays in national timetable for planning 2022/23.	
	~~4.1/2~~	~~Agree financial plan for 2022/23 with NHSI/E and C&M See Controls~~	~~CFO~~	~~April 2022~~	~~Board~~		
	~~4.1/3~~	~~Agree required cash support for 2022/23 with NHSI/E and obtain revenue support Complete. Not required due to surplus plan but confirmation received from C&M that cash support would be available if it were required.~~	~~CFO~~	~~May 2022~~	~~FPBD Committee~~		
	~~4.1 /4~~	~~Work with regional team, commissioners and Local Maternity System to ensure staffing costs and pressures, particularly in relation to maternity, Ockenden and revised clinical standards are funded or as much funding as possible is made available Complete. Although direct Ockenden funding was not sufficient to cover budgetary pressures, overall System and other funding was enough to cover all essential cost pressures.~~	~~CFO~~	~~May 2022~~	~~FPBD Committee~~		
	4.1 /5	Work towards strategic outline ~~business~~ case production and approval	CFO	~~July~~ January 2023~~2~~	Board	Proposed deferral to link with LTFM completion	
	4.1 /6	Work with commissioners and ICS on revised financial models including population-based approach and Aligned Incentive and Payment contracts	CFO	March 2023	FPBD Committee		
	4.1 / 7	Ensure financial position well understood by regional team and clearly articulated.	CFO	March 2023	FPBD Committee		
	4.1 / 8	Agree ongoing funding model for Community Diagnostic Centre	CFO	March 2023	FPBD Committee		

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance (*Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Risk that the Trust will not deliver agreed plan or have sufficient cash resources in the 2022/23 financial year	Monthly reporting and monitoring of position including taking corrective action where required. Sign off of budgets by budget holders and managers, and holding to account against those budgets Divisional performance reviews Working within ICS/system to ensure issues understood and Trust secures required amount of available funding.	FPBD Committee Internal Audit- high assurance for all finance related internal audit reports in 2020/21 and 2021/22. External Audit Mitigations being worked up in case of identified risks materialising	Lack of contractual income position due financial framework in place following the Covid-19 pandemic, gap in baseline position and block payment compared to actual activity and cost, risk to CIP and income streams, timing of recovery and uncertainty over future regime. Reliance on Cheshire & Merseyside position and NHS Improvement/England national team to support proposed baseline adjustment for Elective Recovery Funding.	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
4.1/9	Ensure regular reporting in place and corrective action taken where needed	Deputy Director of Finance	April 2023	FPBD Committee	
4.1/10	Ensure full CIP programme in place with relevant QIAs etc Ongoing. QIAs in place before schemes are put in place.	Deputy Director of Finance	April 2022	FPBD Committee	
~~4.1/11~~	~~Agree sufficient cash resource Complete. Not required due to surplus plan but confirmation received from C&M that cash support would be available if it were required.~~	~~CFO~~	~~April 2022~~	~~FPBD Committee~~	
~~4.1/12~~	~~Mitigations to be worked up Complete. Mitigations in place or underway and allowed for in budgets 2022/23~~	~~CFO~~	~~May 2022~~	~~FPBD Committee~~	

BAF Risk 4.2: Failure to expand our existing partnerships, building on learning and partnership working throughout the COVID-19 pandemic, playing a key role in establishing any ICP or ICS

Lead Director: Medical Director
Op Lead: Deputy COO

Review Date: August 22

Strategic Priority: SA4: To be ambitious and EFFICIENT and make the best use of available resources

Lead Committee: Finance, Performance & Business Development Committee

Provider Licence Compliance link:

Integrated Care

SCORE:

May 2022	Q2	Q3	Q4	Q 2 Q movement	2022/23 Target
8 (2 x 4)	8 (2 x 4)			⇔	8 (2 x 4)

Rationale for current risk score:

The Trust has well defined partnerships and relationships with a number of key stakeholders. These have been strengthened and added to during the Covid-19 pandemic response. The regulatory and system landscape remains uncertain, and the Board will be looking for additional clarity on future arrangements (and the Trust's assured role in this) in order to mitigate this risk and work towards the target score and improve the overall assurance rating on the controls.

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Conflicting priorities of clinical services for different providers and/or ineffective governance may lead to ineffective use of resources (clinical, financial, people) amongst ICS partners	Quarterly Partnership Reporting to FPBD and Board in 2022/23	FPBD and Board meetings	Governance arrangements are developing **(Action 4.2 / 1)** Governance arrangements are developing for LMS **(Action 4.2 / 2)**	
	Robust engagement with ICS discussions and developments through CEO and Chair	CEO Report updates to the Board		
	Evidence of cash support for the Trust's 2021/22 breakeven position	Trust budget agreed by the Board		
	Chair of the Maternity Gold Command for Cheshire and Merseyside	Executive Team reporting		
	C&M Maternal Medicine Centre	Chairs reports feed into the Maternity Transformation meetings		
	Neonatal partnership in place with Alder Hey	Regular updates to the Board		
	Partnership Board in place with LUHFT and involvement in wider Estates Plan	Updates provided to the Quality Committee and Board		
	Positive and developing relationship with Merseycare NHS FT	Updates provided to the FPBD Committee		
	LMS Hosting Arrangement	Updates provided to the Board		
	Finance Directors Group	Updates provides to the Executive Team and through the governance structure when appropriate		
	Health care partnership are using existing memorandum of understanding in relation to staff movement between local hospital at time of staffing need.	Agreed at Board		
	LWH have provided assistance to LUFT by taking over LWH non obstetric Ultrasound scanning activity	Mutual aid reported through to the Quality Committee and Board		
	LWH identified as Gynaecology Oncology Hub for Cheshire and Mersey.			
	Theatre sessions provided at LWH for other Trusts such as Colorectal for LUFT			
	Provision of mutual aid to NWAST by supporting staff testing on LWH site for them			
	Provision of Mutual aid to NWAST for staff Covid-19 vaccinations			
	Quarterly Partnership Report	FPBD Committee		

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
4.2 / 1	Continue to provide updates to the Board regarding the development of the ICS, highlighting when decision points are likely	CEO	On-going	Board	
4.2 / 2	Development and embedding of governance arrangements for the LMS (one year review meeting held in April 2022) – agreed to build on SLA previously in place with CCG	COO	August 2022	Board	Draft SLA developed – requires consultation and finalisation with the LMNS

Strategic Objective	SA5: To participate in high quality research in order to deliver the most EFFECTIVE outcomes
Committee:	Quality Committee
Risk Appetite:	High

Principal risks (BAF)	Risk Score
5.1 Failure to progress our research strategy and foster innovation within the Trust	8 (2 x 4)
5.2 Failure to fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership	12 (3 x 4)

Ref	Corporate Risk Register / High Scoring (15+) Risks	Risk Score
2336	There is risk to the Trust, as it is not currently meeting the CQC Regulations and national guidance in relation to the care of children aged 18 and below within the Gynaecology services	15
2232 **(CRR)**	There is a risk that due to a number of causes the Trust is unable to meet the safety requirements related to Blood Transfusion	15
2295 **(CRR)**	Inability to achieve and maintain regulatory compliance, performance and assurance.	8
2329 **(CRR)**	There is a risk to the Trust is not meeting it requirements for the safe and proper management of medicines	12

Risk and Controls Summary

To outline changes to risk scores, new risks or closed risks.

2232 - No change in risk score since last review. Last reviewed 16/02/2022.

2295 - No change in risk score since last review. Last reviewed 13/01/2022

2329 - No change in risk score since last review. Last reviewed 04/03/2022

BAF Risk 5.1: Failure to progress our research strategy and foster innovation within the Trust

Lead Director: MD
Op Lead: Director of Research

Review Date: August 2022

Strategic Priority: SA5: To participate in high quality research in order to deliver the most EFFECTIVE outcomes

Lead Committee: Quality Committee

Provider Licence Compliance link:

N/A

SCORE:

May 2022	Q2	Q3	Q4	Q 2 Q movement	2022/23 Target
8 (2 x 4)	8 (2 x 4)			⇔	4 (1 x 4)

Rationale for current risk score:

The Trust has a well-established and successful research process and has been particularly active in the support provided to the wider system during Covid-19. To strengthen this area and further mitigate this risk, the Trust should look to widen participation in research across the organisation making links explicit with quality improvement activity. There is also an opportunity to further enhance the Trust's research profile in the local system but also nationally and internationally.

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance (*Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
If high quality research staff cannot be engaged and retained, then research activities will not be fulfilled leading to challenges in recruitment and retention of staff, damage to reputation or withdrawal of funding	Excellent support continues to be provided to medical staff in identifying and nurturing talent, ensuring projects suggested by new researchers are feasible and of high quality and establishing mentorship for individuals who wish to have a research component as part of their future career. Nursing, Midwifery and Allied Health Professional Talent pipeline developed to provide further support and development for non-medical workforce in relation to the research agenda. The Trust has now appointed a Director of Midwifery who has a strong research background. She will support and facilitate midwifery research.	The Trust in-house research management infrastructure continues to operate in a robust and efficient manner. Its performance can be demonstrated via various internal and external reporting mechanisms. Monitored via RD&I Subcommittee Implementation of the talent pipeline will be monitored via the RD&I sub committee RD&I sub-committee (also attended by three Professors of Midwifery from the respective local universities)	Ongoing funding will be required to support the talent pipeline **(Action 5.1 / 1)**	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
5.1 / 1	To secure funding to support the talent pipeline	Medical Director	September 2022	Research and Development Sub-Committee	This is now awaiting review at the next Business Case Approval Meeting.

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance (*Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Continued engagement with the City-wide integrated approach to innovation is necessary in order to further promote, develop and innovation ideas from the Trust's workforce.	Engagement with Liverpool Health Partners	Regular innovative ideas are identified and supported, for example Life Start Trolley, Butterfly Pillow, Butterfly Shelf, parenteral nutrition product, speculum for the diagnosis of urogenital atrophy. Such ideas are supported in-house and via outsourced expert help and advice. Regular attendance at RD&I sub-committee by LHP theme leads	Further development of this strategic principle is required to enable the Trust to empower its staff in engaging with a City-wide integrated approach to innovation.	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
5.1 / 2	Continue progress towards university hospital status application	Medical Director	March 2023	Research and Development Sub-Committee	
5.1 / 3	Continue Trust engagement with population health and longitudinal studies / workstreams Update – C-Gull programme scheduled to start in Q1 22/23 – Trust is engaged.	Medical Director	July 2022	Research and Development Sub-Committee	C-GULL programme of work commenced – staff recruited, building work underway, regulatory approval on track. Recruitment of first participant expected in late Autumn 2022.

BAF Risk 5.2: Failure to fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership

Lead Director: CN&M
Op Lead: Assoc. Director of Governance and Quality

Review Date: August 22

Strategic Priority: SA5: To participate in high quality research in order to deliver the most EFFECTIVE outcomes

Lead Committee: Quality Committee

Provider Licence Compliance link:

General Licence Condition 7

SCORE:

July 2021	Q2	Q3	Q4	Q 2 Q movement	2022/23 Target
12 (3 x 4)	12 (3 x 4)			⟷	8 (2 x 4)

Rationale for current risk score:
The Trust has a current rating of 'requires improvement' for well-led from the most recent CQC inspection and received a warning notice regarding medicine management. Good assurance is in place regarding the Trust's response to this (supported by MIAA audit) and the warning notice being withdrawn. Further work required to refine process and to ensure that the Trust always remains 'inspection ready'.

The Trust was subject to an external well-led review and themes relating to effective lesson learning and establishing a quality improvement methodology were identified, mirroring findings from the CQC inspection and feedback from commissioners. Progress has been made in relation to both areas, but this needs to go further to achieve the target score.

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
If the Trust fails to comply with the CQC fundamental standards and if actions arising from the CQC visit are not implemented at sufficient pace then clinical standards may not be met leading to significant patient harm, deterioration in patient outcomes, a failure to maintain a CQC rating of 'good' and a serious reputational risk to the Trust.	CQC Framework to be implemented – to include well-led framework, and the on-going development of the CQC self-assessment process including a review of previous CQC action pans.	Quality Committee Executive Team oversight Divisional Board and performance review meetings Trust Board	Ward Accreditation and CQC Self-Assessment process yet to be implemented **(Action 5.2 / 1)** Number of policies and SOPs out of review date **(Action 5.2 / 2)**	
	Horizon scanning for changes in the CQC's regulatory approach	Quality Committee		
	Planned monthly engagement meetings with CQC	Quality Committee		

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
5.2 / 1	To implement updated Ward Accreditation programme	Deputy Director of Nursing & Midwifery	July 2022	Quality Committee	Programme developed and will be implemented imminently
5.2 / 2	Ensure all policies and procedures are within their review date	Assoc. Director of Quality & Governance	July 2022	Quality Committee	The position had improved but further work required ensure this becomes BAU. New controls – Trust wide QI project on-going re reducing duplication of policies. Additional working group set up outside Polices and procedures group to agree a consistent process for review trust wide.

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Ineffective understanding and learning following significant events and evidencing improved practice and clinical outcomes.	Regular dialogue with regulators Incident reporting and investigation policies and procedures. MDT involvement in safety HR policies in relation to issues relating to professional and personal responsibility Mandatory training in relation to safety and risk Serious Incident Feedback form Serious Incident panels Safety is included as part of executive walk rounds. Risk Management Strategy	CQPG Meetings Reporting of incidents and management of action plans through Safety & Effectiveness Sub-Committee Reflection of risks and Corporate Risk Register and Board Assurance Framework CQC Assessment Annual Quality Account Report Monthly meetings with the divisions and Assoc. Director of Quality & Governance and Dep. Chief Nurse & Midwife to review the risk profile, ensuring we move at pace being able to evidence the work we are doing, including any learning from incidents/events etc Discussions with staff on walk arounds conducted by the Director of Nursing & Midwifery and senior clinical staff.	Lack of testing of action plans following audits to ensure they lead embedded change – will be supported by ward accreditation once in place **(Action 5.2 / 3)** Inconsistent completion and dissemination of actions and improvement plans – signs of improvement but with further work required. **(Action 5.2 / 4)** Lack of consistent between divisional governance meetings (noted in recent well-led report) **(Action 5.2 / 3)**	

		Shared learning page now live on the intranet			Human Factors training compliance and availability **(Action 5.2 / 5)** Root Cause Analysis training compliance and availability **(Action 5.2 / 6)** Monitoring compliance with risk management training **(Action 5.2 / 7)**	
	Link on desktop of computer with a link to lesson learnt section of web page					
	Use of the action planning module is to be embedded across all divisions	The Governance team to use weekly meetings for review actions and ensure shared. Governance team to ensure oversight and reporting of progress				
	Dip sampling of SI's and review of action previous plans that were submitted to CCG's to ensure changes in practice were embedded and successful.	Quality Committee				
	Route Cause Analysis training booked for 3~~0~~5 staff in May and June 2022.					
	Divisions are to bring learning from SI's, incidents and complaints etc to Safety and Effectiveness from September. Also, Divisions required to bring a Divisional Integrated Governance Report to Safety & Effectiveness each month, to feed into the Quarterly IGR for QC. Focus on triangulation to inform divisional priorities and learning opportunities	Safety & Effectiveness Sub-Committee				
	Gap Reference	**Required Action**	**Lead**	**Implement By**	**Monitoring**	**Status**
	5.2 / 3	To ensure that Divisional Governance meetings are consistent and seek evidence of actions / lessons being embedded	Deputy COO	July 2022	Safety & Effectiveness Sub-Committee	Improvements have been made but remains on-going. Additional resource secured for project during September 2022
	5.2 / 4	Develop better reporting from the Ulysses System There is a continuing commitment to improving reporting using Ulysses. A recent development has been the agreement to cross-tabulate incidents and complaints using Ulysses using a formal process.	Head of Governance & Quality	July 2022	Safety & Effectiveness Sub-Committee	
	5.2 / 5	Business case for the provision of Human Factors Training to be developed and submitted to education governance committee	Medical Ed Lead	July 2022	Safety & Effectiveness Sub-Committee	Completed – to be added to controls
	5.2 / 6	Root Cause Analysis training for staff to be reviewed and updated and to recommence via teams	Head of Risk	July 2022	Safety & Effectiveness Sub-Committee	Completed – 3~~2~~0 staff ~~booked on for~~completed this training
	5.2 / 7	Governance team to monitor compliance levels with risk management training and highlight staff who are noncompliance to the Divisions and provide compliance update to Safety and Effectiveness Sub-committee.	Head of Risk	On-going	Safety & Effectiveness Sub-Committee	
	5.2 / 8	Legal polices re claims and learning are being reviewed, revised and will be shared	Head of Governance & Quality	October 2022	Safety & Effectiveness Sub-Committee	

Strategic Threat *(what might cause this to happen)*	**Controls** *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Source of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Controls/Assurance** (*Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	**Overall Assurance Rating**
Ineffective and / or ill-defined quality improvement methodology will result in the Trust missing opportunities to improve the safety, effectiveness and experience of care.	Quality Improvement training materials available on Trust Intranet Quality Improvement projects tracked Quality Account tracking key projects Quality Improvement Framework developed and agreed	Training levels reported to the Quality & Clinical Audit Group Safety & Effectiveness Sub-Committee Annual Quality Account In January and February 2022, a Task and Finish Group commenced to design and a deliver a new a QI SOP and an improvement Process identifier. The process identifier distinguishes the differences between QI projects, daily improvements, service evaluations, research and audit which has previously caused some confusion for staff within LWH. These documents were subsequently approved by Quality Improvement Group (QIG) and Policies and Procedures Group, they have now been disseminated and published trust wide. Effectiveness leads have been asked to ensure teams within their areas are sighted and supported to understand them. In the absence of a corporate QI lead, support is being provided by the Associate Director of Quality & Governance with a QI collaborative on the horizon to drive this agenda forward even further. The Associate Director of Quality & Governance and Trust Risk & Patient Safety Manager have undertaken a data cleansing exercise. This was to ensure the data within Ulysses demonstrates the on-going pieces of work reflect the correct workstream each project should be aligned to with reference to the process improvement identifier. This will further support staff to understand the processes with new reports shared more widely on a weekly basis. This work will be monitored by QIG and Quality Committee moving forwards to ensure improvements are sustained and embedded.	Opportunities to engage individuals in QI training limited, particularly during pandemic Evidence of QI projects being undertaken but not 'formalised'	

Gap Reference	**Required Action**	**Lead**	**Implement By**	**Monitoring**	**Status**
5.2 / 8	Continuous review of the trusts approach to QI to enable the planning of priorities identifying improvements required	Assoc. Director of Governance & Quality	On-going	Quality Committee	Recruitment to a new QI role has commenced
5.2 / 9	Increase levels of QI training	Assoc. Director of Governance & Quality	July 2022	Quality Committee	QI summit to commence in October, refresh of QI with a shared vision to take our QI journey forward.

	5.2 / 10	~~Simplify process to encourage staff to record QI projects within formal framework~~ ~~See update to assurances~~	~~Assoc. Director of Governance & Quality~~	~~June 2022~~	~~Quality Committee~~		
	5.2 / 11	Establish what changes can be made to Ulysses to align the system better with the flow of QI projects.	Assoc. Director of Governance & Quality	~~September~~ February 2023~~2~~	Quality Committee		
	5.2 / 12	To create a platform for completed QI projects to be showcased and shared trust wide.	Assoc. Director of Governance & Quality	~~September~~ February 2023~~2~~	Quality Committee		

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	***22/23/100b***		**Date: 01/09/2022**	
Report Title	**Well-Led Action Plan**			
Prepared by	***Mark Grimshaw, Trust Secretary***			
Presented by	***Mark Grimshaw, Trust Secretary***			
Key Issues / Messages	***The report provides an update on several recently published documents that will have a significant impact on the Trust's governance arrangements. It is also good practice for the Board to undertake an annual review against the NHSI Well-Led Framework (last external review reported in July 2021). It was considered germane to review these issues in the round and produce a composite action plan to help the Trust improve its well-led practice and to also prepare to operate in the updated regulatory landscape.*** ***There are a spectrum of issues ranging from cultural and strategic to more tactical and operational – the Board is therefore asked to provide a view on the appropriateness of the proposed actions and consider where there may be gaps or requirement for further iteration. The Board may wish to consider whether specific aspects would benefit from further development through workshop sessions.***			
Action required	**Approve ☐**	**Receive ☒**	**Note ☐**	**Take Assurance ☐**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	***To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it***	***For the intelligence of the Board / Committee without in-depth discussion required***	***To assure the Board / Committee that effective systems of control are in place***
	Funding Source (If applicable): N/A			
	For Decisions - in line with Risk Appetite Statement – Y ***If no – please outline the reasons for deviation.***			
	The Board requested to receive the well-led action plan and consider where there may be gaps or requirement for further iteration. To consider whether specific aspects would benefit from further development through workshop sessions			
Supporting Executive:	***Mark Grimshaw, Trust Secretary***			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

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

5.2 Failure to fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership	
Link to the Corporate Risk Register (CRR) – CR Number: N/A	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Circulated to the Executive Team for feedback and comment. Also discussed with the Chair.			

EXECUTIVE SUMMARY

The report provides an update on several recently published documents that will have a significant impact on the Trust's governance arrangements. It is also good practice for the Board to undertake an annual review against the NHSI Well-Led Framework (last external review reported in July 2021). It was considered germane to review these issues in the round and produce a composite action plan to help the Trust improve its well-led practice and to also prepare to operate in the updated regulatory landscape.

There are a spectrum of issues ranging from cultural and strategic to more tactical and operational – the Board is therefore asked to provide a view on the appropriateness of the proposed actions and consider where there may be gaps or requirement for further iteration.

MAIN REPORT

Introduction

The Trust undertook a self-assessment against the NHS Improvement/ England Well-Led Framework during January to March 2020. This resulted in an overall view of performance which was agreed by the Board in April 2020.

An external Well-Led review was undertaken by Grant Thornton with a final report was shared with the Trust in June 2021 and with the Board ahead of the July 2021 meeting.

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

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

Grant Thornton also undertook a site visit to several clinical areas during April 2021 and several recommendations also flowed out of this process. These, together with the actions from the external and internal assessment were combined into an overall action plan.

The full action plan was made available to the Board in February 2022. Positive progress had been made against the identified actions with the majority (83% (61 of 73 actions)) noted as being 'blue' (complete with evidence).

Since that point, Grant Thornton have undertaken a desktop based follow up (further detail below).

The Trust is required by the NHS Code of Governance to undertake an external well-led review at least every three to five years. It is also recommended that the Trust undertakes an internal annual review against the well-led framework. In the process of undertaking this annual internal review, it is germane to consider several recently published documents that relate or impact NHS provider governance and ensure that the Trust's well-led aims are aligned with these.

The long-awaited update of the Code of Governance was published for consultation on 27 May 22 (closing date 8 July 22). Alongside this were two further draft guidance documents on good governance and collaboration; and an addendum on the role of foundation trust councils of governors (COG). These documents set out the proposed changes to governance requirements for NHS Foundation Trusts (and Trusts) following the Health and Social Care Act 2022, with the establishment of Integrated Care Boards from 1st July 2022. As expected, there is a significant focus on 'system' within the draft documents.

In addition, the Provider Collaborative[1] that the Trust is a part of is called the Cheshire and Merseyside Acute and Specialist Trusts (CMAST) Provider Collaborative. This structure remains in a 'forming' stage, but work has started to establish the governance arrangements that will underpin its operation. Again, the updated action-plan has attempted to take this into consideration to support the Trust's preparations. This is likely to be an iterative process that will require the action plan to be regularly reviewed and possibly updated as additional detail emerges.

This report provides an overview of these key documents and highlights the most important areas for consideration in the Trust developing its updated well-led action plan. The Action plan itself can be found in Appendix A. An attempt has been made to read across all relevant documentation to reduce duplication of actions.

Previous Well-Led Inspection Action Plan and feedback from Grant Thornton

Grant Thornton provided the following feedback on their desktop follow up of their external well-led review. They issues noted were as follows:

[1] https://www.kingsfund.org.uk/publications/provider-collaboratives

- Its good practice that the Trust brought all of the actions together on one plan – Well-Led actions; clinical visits; internal review etc
- The Trust has made good progress with the actions to address the findings of the Well-Led review and visits to clinical areas.
- Response to actions is well documented – however, there was a need to be clearer that the evidence had been fully validated ahead of showing a 'blue' (complete) action.
- There is the recognition that traction and pace is required with the Trust's approach and implementation of QI
- Work with the Divisions to get their ownership of risk and their accountabilities strongly understood and operationalized required.
- Committees operate well– but just look at what lies beneath to ensure that the escalation routes of those reporting groups are fully established and effective.
- Board performance reports have strengthened and again this is good for the future reporting.

Draft Code of Governance for NHS providers

The current Code of Governance has been in place since 2014. This sets out the governance requirements placed on NHS Foundation Trusts (incorporated within the LHCH Constitution and supporting governance documents within our Corporate Governance Manual), including:

- Board leadership and purpose
- Division of responsibilities
- Composition, succession and evaluation
- Audit, risk and internal control
- Remuneration

This is the first significant update of the code of governance for some time, and for the first time will also apply to NHS Trusts as well as Foundation Trusts.

The full draft Code can be found on the following link: https://www.england.nhs.uk/wp-content/uploads/2022/05/B0439-draft-code-of-governance-for-nhs-provider-trusts.pdf

The table below is not exhaustive but attempts to identify key areas for the Trust to consider. Identified actions have been added to the updated Well-Led Action Plan (Appendix A).

Section	Requirement
Section A: Board leadership and purpose	The success of NHS individual trusts and NHS foundation trusts will increasingly be judged against their contribution to the objectives of the ICS, in addition to their existing duties to deliver safe, effective care, and effective use of resources. Reference is made to collaboration within the ICS and having regard to the Triple Aims[2].
	The board of directors should give particular attention to the trust's role in reducing health inequalities in access, experience and outcomes
	Vision and values should reference the ICP's integrated care strategy and the trust's role within system and place-based partnerships, and provider collaboratives.
	The board of directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the trust's vision, values and strategy, it should seek assurance that management has taken corrective action
	Ensuring performance reports are disaggregated by ethnicity and deprivation where relevant
	The chair should ensure that the board of directors as a whole has a clear understanding of the views of the stakeholders including system partners.
Section B: Division of responsibilities	No issues to note
Section C: Composition, succession and evaluation	Appointment of Executive & Non-Executive Directors - Best practice is that the selection panel for a post should include at least one external assessor from NHS England and/or a representative from a relevant ICB
	Open advertising and advice from NHS England's Non-Executive Talent and Appointments team should generally be used for the appointment of the chair and non-executive directors. If an external recruitment agency is engaged, it should be identified in the annual report alongside a statement about any other connection it has with the trust or individual directors.
	The appointment and removal of the company secretary should be a matter for the whole board
	The board should have published plans for how the board and senior managers will in percentage terms at least match the overall black and minority

[2] https://www.dacbeachcroft.com/en/gb/articles/2021/august/health-and-care-bill-2021-meeting-the-triple-aim-duty/

	composition of its overall workforce, or its local community, whichever is the higher.
	NED significant commitments should be disclosed to the council of governors before appointment, with a broad indication of the time involved, and the council of governors should be informed of subsequent changes.
	Directors on the board of directors and, for foundation trusts, governors on the council of governors should meet the 'fit and proper' persons test described in both the provider licence and CQC regulations
	Trusts should also have a policy for ensuring compliance with the CQC's guidance Regulation 5: Fit and proper persons: directors.
Section D: Audit, risk and internal control	The chair of the board of directors should not be a member and the vice chair or senior independent director should not chair the audit committee
Section E: Remuneration	No issues to note

Draft Addendum to Your statutory duties – reference guide for NHS foundation trust governors

This addendum only applies to a council of governors' statutory role within its own foundation trust's governance. Councils of governors will need to be assured their foundation trust board has considered the consequences of decisions on other partners within their system, and the impact on the public at large.

In terms of CoG requirements:

- **Holding NEDs to account** - recognising Trust performance will be increasingly reliant on contribution to ICS achievement
- **Representing the interests of Trust member and the public** - To support collaboration between organisations and the delivery of better, joined up care, councils of governors are required to form a rounded view of the interests of the 'public at large'. This includes the population of the local system of which the NHS foundation trust is part. No organisation can operate in isolation, and each is dependent on the efforts of others.
- **Approval of Significant transactions** in context of due process including consideration of public at large and ICS.

The document provides example development and communications for Boards and COGs to be considered.

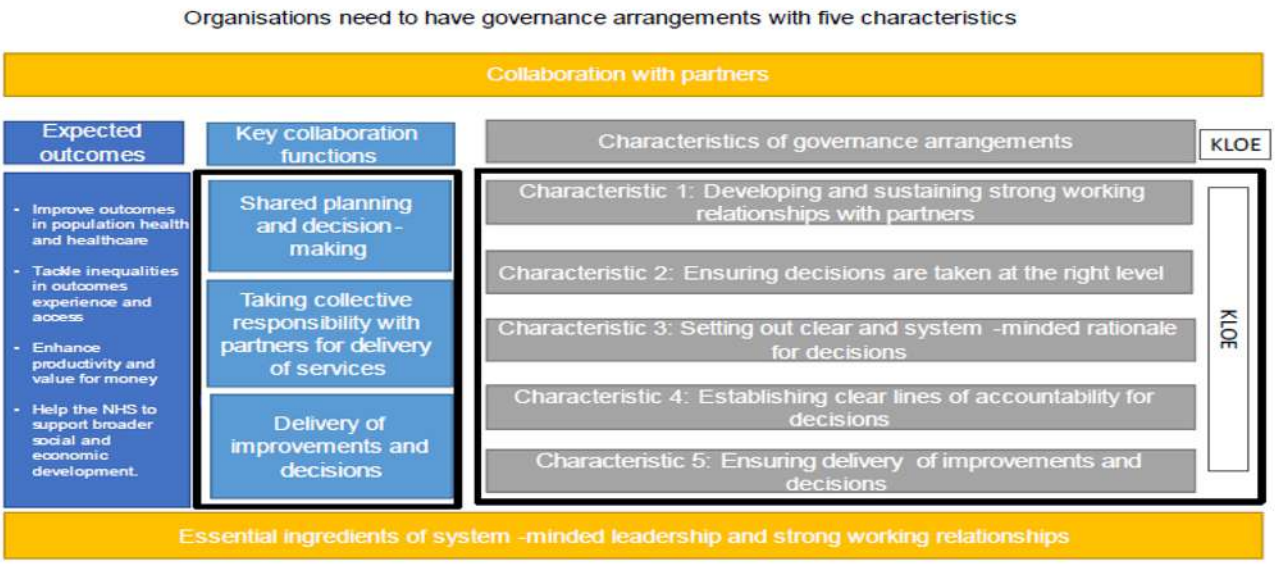
Specific actions have been captured in the Well-Led Action Plan.

Draft guidance on good governance and collaboration

On 27 May 2022 NHS England (NHSE) published its Draft Guidance on good governance and collaboration for consultation. This new guidance sets a clear expectation that providers will collaborate with their system partners in the context of statutory integrated care systems (ICSs).

The guidance can be found on the following link - https://www.england.nhs.uk/wp-content/uploads/2022/05/B0562-draft-guidance-on-good-governance-and-collaboration.pdf

This is a detailed document, and the specific requirements will be captured in the Well-Led Action Plan. The diagram below provides a summary illustration of the requirements:



CMAST / Integrated Care Board (ICB) Governance Documentation

The Chief Executives have been working together for some time to shape CMAST, and there have now been several sessions for Chief Executives and Chairs. CMAST also established several 'Director' groups to bring together peers from each Trust. In May 2022 there was recognition that it would be useful to engage with Governance Directors / company secretaries to support the development of CMAST governance.

The trusts have agreed to pursue a committees-in-common approach (as enabled by the Health and Social Care Act 2022), which it is suggested would in the first instance comprise of the Chief Executives from each of the Trust members each having delegated authority from their Trust Boards to take decisions together at the CMAST Leadership Board. A suggested structure is shown below. The finalised version of the underpinning documents and structures is expected during September 2022.

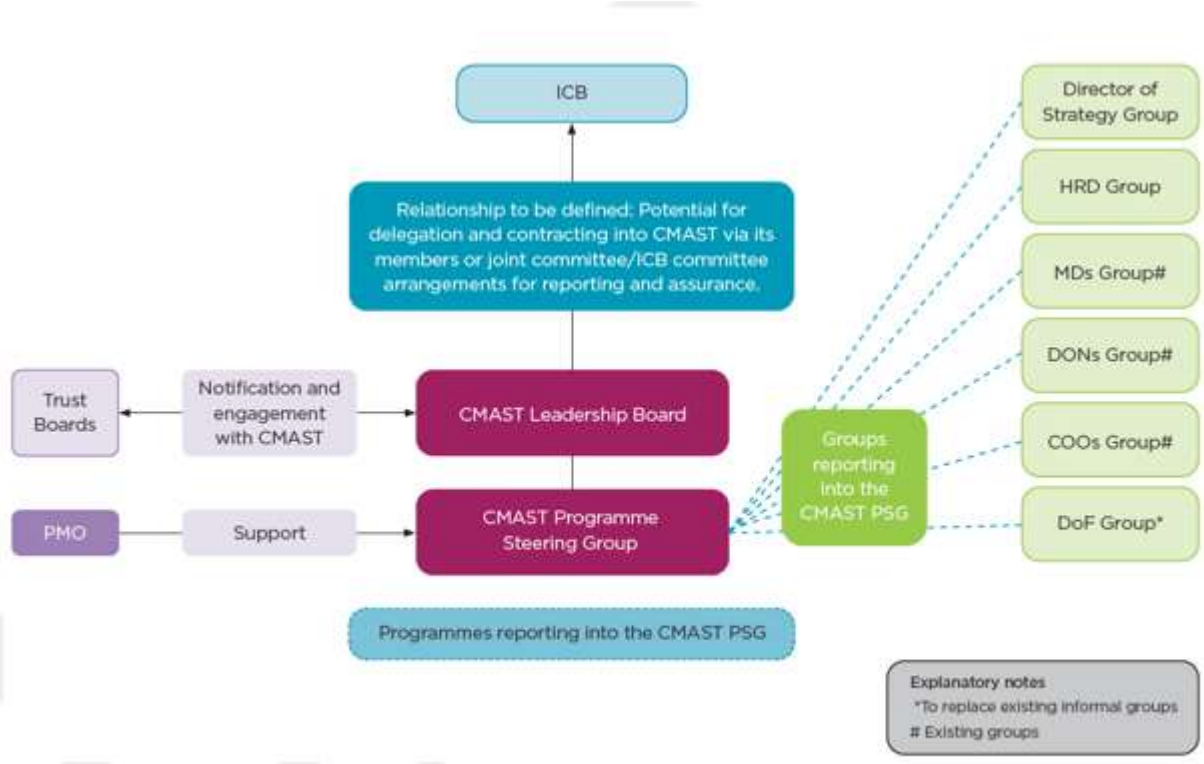


Fig 2: Potential Governance Structure for CMAST

Key actions against this agenda are outlined in the checklist detailed in the section below.

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

The Good Governance Institute has produced the following checklist for Providers in assessing their governance readiness to support their respective ICB:

1. A developed **vision and strategy** that is focused on improving outcomes for local communities and is aligned with the ICB and system partners
2. Clear current arrangements and a future vision for the Trust's **role in the system, place-based partnerships and provider collaboratives**
3. Assessment of the Trust's role and responsibilities in **system oversight and risk frameworks**, incorporated in agreed documents and processes
4. A revised **Board development programme and operation of the Board**, committees and operational structures that reflects the role in the system
5. Initial assessment of the requirements to be a **well-led Board in an ICS**, in line with the CQC's emerging framework for regulation of systems
6. A revised **governance handbook** with appropriate changes made to the constitution, SORD, COI policy etc.

The Good Governance Institute also published the following article - *What does it take to be an outstanding trust board in an ICS?* They assert that for ICSs to thrive, NHS trust boards need to formally evaluate their own readiness to operate in a system.

They suggest that trust boards use the well-led framework for this purpose and highlight the characteristics of trust boards that are, or plan to be, outstanding ICS partners.

https://www.good-governance.org.uk/publications/insights/what-does-it-take-to-be-an-outstanding-trust-board-in-an-ics

These characteristics have been considered when establishing actions in the Well-Led Action Plan.

Recommendation

The Board requested to receive the well-led action plan and consider where there may be gaps or requirement for further iteration. To consider whether specific aspects would benefit from further development through workshop sessions.

Liverpool Women's NHS Foundation Trust

Appendix A

Well-Led Action Plan – Combined

KLOE 1. Is there the leadership capacity and capability to deliver high quality, sustainable care?							
Origin	**Ref.**	**Risk Level**	**Action / Recommendation**	**Timescale**	**Lead**	**Comments**	**Evidence**
GGI	1.1		To explore engagement in joint leadership development programmes with other system partners, and development opportunities across partners.	February 2023	CPO	https://www.cheshireandmerseysidepartnership.co.uk/our-work/workforce/ The Cheshire & Merseyside ICB has a workforce strand and the LWH CEO is the lead for the CMAST element of this. A single leadership framework across C&M is being developed and the Trust will look to participate in this.	
GGI	1.2		Senior leaders commit to system roles and responsibilities with clear reporting back to the Trust	December 2022	CEO	The Trust Executive Team is well embedded in system network roles – further work is required to provide enhanced clarity on the reporting arrangements of this.	

KLOE 2. Is there a clear vision and a credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?								
Origin	**Ref.**	**Risk Level**	**Action / Recommendation**	**Timescale**	**Lead**	Progress	Comments	**Evidence**
External Review	2.1		Milestones and measures to demonstrate achievement should be documented as part of the Leadership and Talent Strategic Framework. Progress should be presented to the PPF Committee.	September 2021 Updated timescale – March 2022	CPO		Progress impacted by Covid 19 resulting in delay to launching leadership programme (now launched) with good engagement. Leadership & Talent Management Framework in place with supporting workplan. PPF have oversight of Leadership & Talent Management Strategy and receive regular updates for assurance purposes against agreed Annual Workplan to allow for identification of progress/slippage – see documents.	LandODFramework.docx LTM Workplan 21 22.xlsx
Updated Code of Governance	2.2		To review the Trust's Strategy to ensure that it clearly articulates how organisational plans integrate with the ICB five-year joint plan and annual capital plan, and other shared plans for delivery of agreed improvements. The strategy should adopt or be aligned with the aims of improving patient experience, improving population health, and improving value.	December 2022	CFO		The Associate Director of Strategy is reviewing the Trust's strategy to review current alignment and opportunities for strengthening.	
Updated Code of Governance	2.3		To ensure that there are credible, SMART plans in place to achieve improvements in population health rather than vague statements of intent.	December 2022	CFO		Once the aims and objectives of the ICB have been made available, the Trust should explore how it can develop its own population health objectives to support this. To be	

							included as part of the 2023/24 strategy development (to begin in November 2022)	
Updated Code of Governance	2.4		To review Trust Vison and Values to ensure that they reference the ICP's integrated care strategy and the Trust's role within system and place-based partnerships, and provider collaboratives.	December 2022	CEO		The Associate Director of Strategy is reviewing the Trust's strategy to review current alignment and opportunities for strengthening.	
KLOE 3. Is there a culture of high quality, sustainable care?								
Origin	**Ref.**	**Risk Level**	**Action / Recommendation**	**Timescale**	**Lead**	Progress	Comments	**Evidence**
External Review	3.1		The NED aligned to the FTSU agenda should access the FTSU training available from the National Guardian's Office to maximise the support offered to the FTSU Guardians	December 2022	CPO		Training provided to previous NED Champion – invitation to be extended to new NED champion	
Updated Code of Governance	3.2		To ensure that there are adequate processes in place for the Board to assess and monitor culture	December 2022	CPO		Regular updates on culture checks are provided to the PPF Committee. Consideration required regarding the most effective way to report this to the Board.	
GGI	3.3		To ensure that there are processes in place to capture examples of when the Trust has decided in the interests of the local community, rather than the organisation and that these are communicated widely	February 2023	CPO		When making decisions, the Trust will need to start considering the impact on the wider community and system – it is proposed that new headings are included in report templates to ensure that this is captured and can be evidenced.	
GGI	3.4		To review leadership programmes to ensure that they include elements relating to system working and collaboration	December 2022	CPO		System working is included within each of the 3 levels of the LWH Leadership programme and participants are also directed to specific system leadership programmes provided by the NW Leadership Academy	
KLOE 4. Are there clear responsibilities, roles and systems of accountability to support good governance and management?								
Origin	**Ref.**	**Risk Level**	**Action / Recommendation**	**Timescale**	**Lead**	**Progress**	**Comments**	**Evidence**
Internal Assessment	4.1	N/A	The level of challenge between Governors and Non-Executive Directors can be strengthened in order for the former to demonstrate discharge of holding to account responsibilities.	September 2022	TS		There has been a planned session with NEDs and Governors to discuss effective challenge and work through case studies. It has been agreed that this would be better suited to a face-to-face meeting which has been limited by COVID-19 IPC restrictions	
Updated Code of Governance	4.2		Appointment of Executive & Non-Executive Directors – To update recruitment policy to include reference that future selection panels for posts include at least one external assessor from NHS England and/or a representative from a relevant ICB	December 2022	Trust Secretary / CPO		Recruitment Policy to be reviewed and amended. No NED recruitment required during 2022/23.	
Updated Code of Governance	4.3		To ensure that plans are in place for how the board and senior managers will in percentage terms at least match the overall black and minority composition of its overall workforce, or its local community, whichever is the higher.	December 2022	CPO		The Trust has clear plans in place (update provided in WRES and WDES report to September 2022 Board).	

Updated Code of Governance	4.4		Council of Governors to be required to sign a Fit and Proper Person declaration on an annual basis.	February 2023	Trust Secretary		New process to be put into place. Discussions taking place across the Liverpool trusts to implement a consistent process.	
Updated Code of Governance	4.5		To review the Trust's comply or explain position regarding the following provision – "The chair of the board of directors should not be a member and the vice chair or senior independent director should not chair the audit committee"	May 2023	Chair / Trust Secretary		This will be reviewed, and decision taken by the time declarations of compliance are required.	
GGI	4.6		Responsibilities for integration and partnerships to be weaved through the portfolios of the senior leadership team and for the Board to actively consider development of capacity through specific roles and teams	February 2023	CEO		This process remains underway and Executive Directors already have existing responsibilities for system working (as evidence by most recent appraisal report)	
GGI	4.7		To review Board committee terms of reference and annual cycle of business in order to incorporate issues related to system working	March 2023	Trust Secretary		To be undertaken as part of the February / March 2022 Board and Committee effectiveness review.	
Internal	4.8		Divisional Governance arrangements to be fully mapped and shows alignment with system-level requirements	November 2022	COO & Trust Secretary		This is being progressed with additional resource being provided to meeting established deadline.	
Internal	4.9		To review the Trust's Constitution to ensure alignment with system aims and objectives – including a review of constituency membership boundaries and strategic partners.	February 2023	Trust Secretary		The Constitution will be reviewed. This may require a working group of governors to be established to support this work.	
Updated Code of Governance	4.10		To develop Fit and Proper Person Policy	September 2022	Trust Secretary		Policy drafted and to be received at the Nomination & Remuneration Committee for review.	
Internal	4.11		To develop and adopt a governance maturity matrix for the Trust's Divisions and for the Audit Committee to monitor progress	March 2023	Trust Secretary		Please see Appendix B.	

KLOE 5. Are there clear and effective processes for managing risks, issues and performance?

Origin	Ref.	Risk Level	Action / Recommendation	Timescale	Lead	Progress	Comments	Evidence
External Review	5.1		The Divisions should ensure that adequate time is timetabled to allow a regular and thorough review of their risk registers.	Updated timescale – March 2023	COO		Improvements have been made to the risk management process through the year and this is demonstrated at the Trust's Corporate Risk Committees. However, an inconsistent approach remains across the Divisions and the Trust Secretary is working with the Assoc. Director of Quality to make further improvements. The outputs of this are scheduled to be reported to the Audit Committee throughout 2022/23 and therefore this action does not yet have sufficient evidence to close out.	N/A
GGI	5.2		Linked to the development of an outward-focused vision and strategy, the board assurance framework to be made more outward-facing and aligned with the major system risks, with evidence that the Trust is	December 2022	Trust Secretary		Once the ICB BAF / risk register has been made available, this will be reviewed alongside the Trust's BAF.	

			playing its part to mitigate risks associated with the wider determinants of health.					
GGI	5.3		The management of issues and performance should routinely consider the external causes and how system partners can be engaged in finding and implementing solutions (i.e. for this to be referenced in performance exception reports and risk controls)	December 2022	COO & CN&M		Performance report in development to include wider metrics and wider determinants.	
Addendum to Council of Governors Statutory Duties	5.4		To provide system level information and intelligence to the Council of Governors to support their duty to hold the Board to account for the Trust's contribution to system aims and objectives.	February 2023	Trust Secretary		To be developed.	
Guidance on collaboration	5.5		To ensure digital and data systems enable system and place-based partnerships, and provider collaboratives to support shared planning and decision-making	February 2023	CIO		NHS Cheshire and Merseyside has a digital workstream with the aims to - Tackling digital exclusion, driving integration of care records and population health management, systems to support transformation including; remote monitoring, digital primary care and digital social care, cyber security and service recovery plans to improve treatment times. The Trust is involved in this work.	
Guidance on collaboration	5.6		To work with partners to deliver financial objectives in line with any system collaboration and financial management agreements	March 2023	CFO		In developing the 2022/23 financial plan, the Trust demonstrated effective system working. This will continue until 2022/23 year-end and beyond.	

KLOE 6. Is appropriate and accurate information being effectively processed, challenged and acted on?

Origin	Ref.	Risk Level	Action / Recommendation	Timescale	Lead	Progress	Comments	Evidence
Updated Code of Governance	6.1		To ensure performance reports are disaggregated by ethnicity and deprivation where relevant	December 2022	COO		Work is progressing on this with updates currently provided to the ED&I sub-committee.	
GGI	6.2		Quality, finance and workforce reports should include metrics related to the wider determinants of health, health inequalities and the role as an anchor institution, with clear actions and recommendations	February 2023	COO/CNM/CFO		Work is progressing to develop the performance reports.	
GGI / Updated Code of Governance	6.3		To receive standing reports on system development and performance	December 2022	CEO / Trust Secretary		Consideration to be given as to whether the CEO Report is the correct place for this information or whether a separate standalone report is required.	
	6.4		To review Board and Committee papers to support authors to identify the impact on the system and how regard has been given to the 'triple aim' duty	November 2022	Trust Secretary		Report templates to be reviewed to ensure that evidence can be recorded.	
Guidance on Collaboration	6.5		To actively build business intelligence capacity with partners to enable a single shared view of local challenges, performance and progress against delivery	February 2023	CIO		See 5.5	

KLOE 7. Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?

Origin	Ref.	Risk Level	Action / Recommendation	Timescale	Lead	Progress	Comments	Evidence
Addendum to Council of Governors Statutory Duties	7.1		To review mechanisms for developing Governor and NED relationships.	December 2022	TS		To be discussed as part of the 21 September training session for governors and NEDs	
GGI	7.2		To produce a plan for developing partnerships and be able to evidence how the Trust is supporting system partners such as primary care and the VCSE through structured programmes of engagement and practical support.	February 2023	TBC		To be considered whether a separate plan is required or whether this requirement should be 'mainstreamed' in existing strategies and plans.	
Addendum to Council of Governors Statutory Duties	7.3		To develop a pan-Liverpool membership group to support governors to form a rounded view of the interests of the 'public at large'	December 2022	Trust Secretary		The first meeting of this group is expected in September 2022.	
KLOE 8. Are there robust systems and processes for learning, continuous improvement and innovation?								
Origin	**Ref.**	**Risk Level**	**Action / Recommendation**	**Timescale**	**Lead**	**Progress**	**Comments**	**Evidence**
External Review	8.1	High	To continue to develop and embed Quality Improvement into Trust day-to-day operations	December 2022	CN&M		This issue remains on-going. QI summit to commence in October 2022, refresh of QI with a shared vision to take our QI journey forward. Recruitment to a new QI role has commenced.	
GGI	8.2		To promote involvement in system research and innovation programmes, as well as networks, and supports staff to take on these roles and responsibilities	December 2022	Medical Director		The Trust is well embedded in system research (see 2021/22 RD&I Annual Report)	
GGI	8.3		Quality improvement methodologies should be used to tackle system issues, with dedicated improvement programmes set up with local partners to improve population health and address health inequalities, and participation in system-wide improvement collaboratives	December 2022	CN&M		To be considered as part of the Trust's QI refresh.	

Liverpool Women's NHS Foundation Trust

Appendix B

Maturity Matrix to support effective governance and meetings at Divisional Level

PROGRESS LEVELS ▶ / KEY ELEMENTS ▼	0 NO ACTION	1 BASIC LEVEL *Principle accepted and commitment to action*	2 EARLY PROGRESS *Early progress in development*	3 FIRM PROGRESS *Progress becomes mainstreamed*	4 RESULTS *Progress becomes mainstreamed*	5 MATURITY *Results systematically achieved over time*	6 EXEMPLAR *Others learning from our consistant achievements*
STRUCTURE	No	Structure developed and agreed. Shared with all staff in divisions/specialty. Roles and responsibilities agreed	Structure across whole divisions discussed at divisions and specialty level, with terms of reference agreed for each standard meeting	Structure shared across all divisions, and structure of other divisions and specialties reviewed and discussed to identify any useful learning points	Annual review of meeting's work confirms positive added value. Structure refined. Task and finish groups set up for one-off projects of work	Structure, with amendments and improvements, has been working for 24 months. Evaluation of structure as remaining fit for purpose two years running	Structure externally recognised as adding value. Other organisations have reviewed the structure as a possible model for their own structure
ENGAGEMENT	No	Attendees for meetings defined and informed. Quorum defined	First three meetings held and quorum maintained. Meeting etiquette discussed and agreed.	No surprise non-attendees from core members at last three meetings. Apologies with reason for no show always given. Substitutes usually attend for planned no shows	At least 75% of core membership have attended last three meetings. Examples of staff-initiated issues being picked up at meetings. Membership reviewed and if needs be developed	Attendance at meetings reviewed for past year and 75% attendance maintained. Refinement to membership based on cycle of business. Engagement by divisions and specialty staff is recognised by external parties as a mark of good practice e.g. ICBs and CQC	The working methods of the divisions/specialty has been used by other organisations to help develop their own approach. The engagement by staff in the governance process has been promoted in a peer review forum as national best practice
RECORDING AND ACTION PLANS	No	Standard format for meeting recording discussed and agreed. This includes adoption of trust templates	Meeting notes and action plans for last three meetings drafted and distributed within five working days	Meeting notes and action plans for last three meetings reviewed at following meeting, with actions initiated against the majority of action points. Commitment to minimise carried over items.	Action plans are reviewed, and examples of tangible improvements have been identified. Meeting records are routinely reported to the next tier up. Meeting recording is characterised as timely and lean by those attending the meetings	Action plans are systematically being met, with evidence of tangible improvements to practice, compliance or meeting targets. The recording of meetings provides reliable evidence of activity for third parties, e.g. internal audit, the CQC, ICB.	Meeting and action plan recording is recognised as being best practice by external parties e.g. commendations from auditors, mentions in CQC reports. Examples of how activity is recorded are used to influence other organisations.
CONTENT AND CYCLE OF BUSINESS	No	Standard agenda agreed, to include consideration of trust template, and first meeting held. Dates organised and advertised for coming three months	Outline annual cycle of business discussed and developed, and shared with next tier up	Annual cycle of business finalised and published with divisions and specialty. Group is "commissioned" by group it reports to.	Annual cycle of business reviewed and updated each meeting. Contributions to cycle of business from work of other specialties and/or divisions, as well as tier above	The BAF relies on the work of meetings to migrate assurance to board level. The content of meetings matches the external compliances the organisation needs to evidence	Other organisations are using the work of the divisions/specialty to provide example templates for their own governance meetings. The cycle of business is commended by external parties such as internal audit, HQIP, CQC
COMMUNICATION	No	Rudimentary communications materials developed and circulated e.g. structure charts, round robin email, posters	Notes and action plans for last three meetings available for staff. Method for cascading news from meetings agreed	Cascading system (Hotspots) successfully used for last three meetings. There are examples of hotspots being populated by examples identified at meetings	Hotspots are routinely populated by issues identified at meetings. Staff feedback about the usefulness of communications is influencing the development of future communications approaches	Feedback from staff is starting to shape elements of the focus of meetings. Leadership of the divisions/specialty is confident that they are routinely informed about the work of colleague divisions and specialties	Communication methods are shared with other organisations or identified through best practice awards. Feedback from other organisations shows that others have found the communications approaches have influenced their own local development

LEVEL OF CHALLENGE	No	The meetings rely on reassurance from managers and staff. Little evidence of challenge in the meeting.	The meetings relies on reassurance from managers and staff. Evidence of challenge in the meeting and requests for further evidence.	Assurance provided with evidence. Assurance is mainly 1st line assurance. Evidence of challenge in the meeting and requests for further evidence.	1st and 2nd line assurance provided. The meeting is showing some evidence of triangulation of differences sources of evidence.	Evidence of 1st and 2nd line assurance and triangulation in the meeting. Challenge leads to definite actions which are followed up with further assurance either in the meeting or at a future date.	Evidence of 1st and 2nd line assurance and triangulation in the meeting. Challenge leads to definite actions which are followed up with further assurance either in the meeting or at a future date and if relevant, utilising 3rd line assurance.
IMPLEMENTING BEST PRACTICE **E.G. NICE GUIDELINES**	No	Knowledge about best practice sits with individuals. Having a structured way to share best practice uniformly is accepted but not developed. The review of new best practice guidelines is often delayed. Clinical guidelines are not routinely updated to reflect best practice until after the clinical guideline has expired	Process in place to ensure new national guidelines come to the attention of divisions and specialties, and that a gap analysis is performed. Process for measuring and monitoring best practice is identified, but not yet implemented systematically. Where best practice is not implemented, this is referenced on the risk register but with limited plans to address gaps	New national best practice is being systematically picked up for adoption by the division/specialty. Evidence of the local situation is collated and evaluated. Multiple examples of best practice being picked up and locally implemented within the last 24 months. Gaps in compliance are routinely captured on the risk register with action plans to close gaps agreed, and implementation monitored	Application of best practice guidelines is systematically monitored and results discussed. Results are shared between specialty and division, and variances with action plans reported upwards. There exists evidence of positive clinical outcomes and experience for patients as a result of the consistent application of national guidelines	Systematic application of best practice locally is routinely reported and learning points shared within and across divisions. The delivery of excellence in care and experience can be consistently demonstrated through ongoing monitoring. There exists evidence that services provided by division/specialty are systematically improving year-on-year	Contribution to the development of national and international standards by being recognised for publishing examples of excellent practice or other peer review recognition. Examples of other organisations learning from this service
CQC REGULATION	No	Division and specialty leadership promote the importance of clinical, quality and regulatory standards more broadly with staff. Staff are aware of CQC quality domains and ratings	Division/specialty has mapped its compliance against all relevant standards and is aware of any gaps. This process has involved staff, and there are dynamic performance measurements in place e.g. ward accreditation. Quality dashboards have been developed at both divisional and specialty level, and these are aligned to the CQC quality domains	Compliance mapping is systematic and kept up to date. Action plans have been developed and implementation progress is being managed. Results and issues are shared within the division/specialty. There are action plans in place to improve performance against any gaps in CQC compliance. Trust-wide rolling programme of ward accreditation and CQC self-assessment is in place	Compliance reviews include an external to the division/specialty component. Evidence of inter-division/specialty sharing of improvement points exists. External recognition being achieved, for example CQC 'Good' rating for service concerned	Inter-division working on standards compliance is achieving consistent results for the trust in broad-theme areas e.g. patient safety and patient experience. Year-on-year consistency or improvements can be demonstrated. Results comparisons with other trusts is used as a spur for adopting better compliance against standards	A CQC rating of "Outstanding" Other organisations learn from the work. The trust benchmarks in the upper decile for standards compliance nationally
RISK MANAGEMENT	No	Staff are aware of the trust's risk management policy and understand key elements of this e.g. risk assessment, risk escalation, etc. This is included within the induction process. New risks are being entered into the risk register and the division/specialty have started to review these.	There exists evidence that risks are being reviewed and calibrated, and action plans agreed. There are examples of appropriate escalation of risks. Risk registers are systematically reviewed at divisional and specialty level, and risk informs quality improvement activity. There are examples of risks being escalated to the corporate risk register. The risk management system is externally tested and recognised, through internal audit	Risk identification is proactive and a key part of annual business planning and quality assurance cycles. SMART action plans are in place for all risks. Division and specialty leadership are fluent in the trust's risk management approach, and understand the trust's risk appetite approach. There are examples of different divisions and specialties collaborating to mitigate risks	No risks overdue for review on the division or speciality risk register. Risks are triangulated between divisions to identify corporate issues. Multiple examples of risk escalation with concomitant actions taken, and of risk score reductions. Divisional and specialty leadership are confident that the risk system is picking up issues they consider important and relevant to better patient care. Staff are aware of the top risks within the division/specialty, and what is being done to mitigate these risks	Internal audit provides positive assurance that risk management is robust and adding value. Staff are involved in peer learning exercises within the trust and externally. There is evidence of consistent risk reduction through the completion of action plans and the lowering of risk scores over the last 24 months. Risk profiling of Cost Improvement Plans (CIPs) shown to be accurate over time	Trust benchmarks within the top decile for achievement of risk management training. Improvements derived from risk management are shared with other organisations and recognised by peers. Contribution by trust to national patient safety learning efforts

PATIENT SAFETY AND MANAGING INCIDENTS	No	Incident reporting is understood by all staff and considered to be valuable. Roles and responsibilities of staff at division and specialty level in relation to incident reporting are clear. There exists evidence of staff reporting incidents of moderate harm and above. A review of incident reports is a standing agenda item at divisional and specialty level clinical governance forums	Evidence of reporting high numbers of no and low harm incidents. With only a few exceptions, incidents are reviewed within policy timescales. Duty of Candour discussions are evidenced. Staff know about 'learning from incidents' events / communications. Serious Incident (SI) investigations are often overdue. Further information requests are frequently received back from commissioners	Quality checking for completion of action plans for incident reports. Feedback is provided to staff on actions arising from incidents. Staff routinely attend patient safety training. Incident reporting is not dominated by one staff group. SI investigations are routinely completed on time, and only occasionally overdue. Further information requests are occasionally received from commissioners. NRLS reporting is in line with the national average	Improvement examples rooted in reported incidents are available. Lessons learnt from incidents are discussed and shared across divisions / specialties. Broader local and national patient safety intelligence is considered. Duty of Candour compliance is tested routinely. No out of date SI investigations exist within the division/specialty. NRLS reporting is in the upper quartile	Staff are systematically involved in peer learning exercises within the trust and externally. Examples of harm reduction are demonstrable. Examples of patient/carer involvement with patient safety initiatives are available within the last 12 months. There are no breaches of internal SI deadlines in the past 24 months. NRLS reporting has been in the upper quartile for the last 12 months	In the upper quartile of NRLS reporters. Examples of harm reduction achievements are externally shared. Staff routinely participate in broader local and national learning around patient safety. Peer recognition exists around patient safety initiatives
PATIENT AND CARER FEEDBACK	No	Staff understand the 'Friends and Family Test', the role of PALS and the local complaints process. The division/specialty has considered these as part of a broader range of potential feedback mechanisms for patient and carer feedback. Complaints are responded to, but response time often falls outside the time period agreed with the complainants	Patient and carer groups within the division/specialty have been identified. Positive and negative patient stories are considered at division/specialty governance meetings. Patient and carer feedback is given the same profile as other elements of quality in division/specialty reporting and discussion. More than 50% of complaints are responded to within the agreed timeframe	Division / specialty complaints and PALS reviews look at content as well as process performance/uptake metrics. There is a consistent approach to advertising feedback mechanisms to patients and carers, and staff are confident to solicit patient and carer involvement in local initiatives e.g. patient forums, surveys, focus groups etc.	There are examples of improvements achieved that were initiated as a result of patient or carer feedback. Broad themes identified from patient and carer feedback are included in division/specialty improvement plans. Feedback concerns are shared across divisions and specialties. When asked, front line staff can recall examples	Improvement plans are systematically checked against, and generated by, patient and carer feedback mechanisms. Improvements in examples of patient experience are demonstrable over the past 24 months. Patient feedback meaningfully contributes to other elements of quality management, e.g. the risk registers	Patient and carer feedback initiatives have been recognised externally. Patient and carer advocates use the work of the division/specialty to suggest improvement mechanisms to other organisations
IMPROVEMENT, IMPLEMENTATION AND LESSONS LEARNED	No	Staff understand that systematic improvement processes are part of business as usual. Division/specialty leadership have considered how to use assurance and other governance mechanisms as the basis for the local improvement plans. The skills for implementing improvement are recognised and form part of overall staff evaluations/recruitment strategies	Quantifiable action plans are part of the approach to compliance and quality management. Success criteria is included within action and improvement plans. Selected staff have received training in improvement techniques. Management forums have time set aside to consider improvement approaches	Regular staff forums have time set aside for sharing improvement work, lessons learnt and changes to practice. Staff understand routes by which they can surface improvement ideas. When ideas have been offered, there is feedback to advise on the adoption or otherwise of such ideas. There are multiple examples of practice changing as a result of improvement plans, and lessons learned. These transcend single divisions/specialties	Staff feedback confirms that improvement work is valued, and recognised as everyday within the division/specialty. Improvements, including CIPs, have a track-record of delivering intended results. Quantifiable dividends from improvement work are identifiable. Several care pathways have developed as a result of specific improvement interventions. Improvement science capacity has been developed locally through training and/or recruitment	There is a consistent track-record of tangible results and multiple examples of learning between divisions and specialties. Improvement initiatives that derive from learning from outside the organisation have been delivered. Future plans are developed on the expectation of continuing improvement work, and this extends beyond financially-related benefits to issues such as improvement to patient experience, harm reduction, etc	External peers have recognised and copied improvement approaches from the division/specialty. Improvement work has been written up and shared at external events or by publication. Other organisations have recognised the contribution of work undertaken by us in their own improvement work
CLINICAL AUDIT	No	Clinical and non-clinical staff recognise the value of clinical audit, and appropriate time has been quantified for involvement in this. The division/specialty has developed an annual plan for supporting clinical audit activity and there is a division/specialty forum established for sharing results and learning points	Specialties have a clinical audit programme which is coordinated by the division, and the division has an overall clinical audit plan as part of its improvement work. The clinical audit plan includes a balance between national and local audits. Clinical audit activity is rooted in areas where risk, or	There is evidence of action being taken to improve clinical practice at ward/team level in response to clinical audit results. Some cross-specialty clinical audits are undertaken, with joint improvement plans in place. The division actively steers clinical audit activity as part of its improvement work	There are quantifiable examples of benefits as a result of clinical audit activity, such as improved compliance, better use of resources, care pathway modification, etc. There are examples of inter-division/specialty learning. There is a tangible connection between clinical audit and other clinical governance mechanisms, for	Quantifiable benefits from the clinical audit plan is systematic over a period of at least 24 months. Where audits are comparative, there is a forum where the results are discussed and benchmarking takes place. Lessons are sought from higher-performers. Clinical audit is used as a dynamic measurement of performance	There are examples where improvements that have used clinical audit have been adopted by others. There is full compliance with all mandatory national audits. Peer-review publications authored by division/specialty staff have used clinical audit, or the

			improvement potential, has been demonstrated		example clinical audit appears as a consistent action plan item within risk registers and SI action plans	to support overall compliance assurance and improvement programmes	equivalent for scientific conference presentations. There have been contributions to the national development of clinical audit, for example by involvement with HQIP
MORTALITY	No	Case note reviews for patients who have died are undertaken on an ad hoc basis. The multidisciplinary team (MDT) is not routinely involved in case note reviews, which is sometimes undertaken by individuals	Case note reviews are standardised and follow agreed best practice. More than 50% of deaths in the division's care are reviewed, and review is usually undertaken by a team rather than an individual	All patient deaths are reviewed by the MDT at a dedicated session. The division receives summary data from the trust which they review with the aim of abstracting issues relevant to the division. Nationally recognised measures are used to measure the quality of care and preventability e.g. Hogan scale, NCEPOD standard	We can identify changes in practice that are routed back to case reviews. There are action plans to pick up issues identified by mortality reviews (reviews from within the division and for the trust overall)	There have been reductions in mortality over the last 24 months	The work on mortality at the trust has influenced care and pathway design in other organisations

Trust Board

COVER SHEET

Agenda Item (Ref)	*22/23/101*		**Date: 01/09/2022**	
Report Title	Research, Development & Innovation Annual Report 2021/2022			
Prepared by	***Louise Hardman, Head of RD&I***			
Presented by	Dr Lynn Greenhalgh, Medical Director			
Key Issues / Messages	*The Annual Health & Safety report is presented for assurance.*			
Action required	Approve ☐	Receive ☐	Note ☐	Take Assurance ☒
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – Y/N *If no – please outline the reasons for deviation.*			
	The Board is asked to note the report for assurance.			
Supporting Executive:	Dr Lynn Greenhalgh, Medical Director			

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

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

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Quality Committee	June 22	Medical Director	The Committee Chair stated that the Annual Report could have been improved through directly referencing the status of achievement against the objectives within the strategy. For the updated Strategy, it was stated that it would be important for it to include 'SMART' objectives that the Committee could track progress against in future annual reports.

EXECUTIVE SUMMARY

Welcome to Liverpool Women's NHS Foundation Trust's Research & Development Annual Report for 2021/22. This provides an opportunity to demonstrate our commitment to continuous, evidence-based research and celebrate our achievements.

Key Themes

The national strategy for research in the NHS remains focused on the clinical and economic imperatives for Trusts to continue to improve their performance in initiating and delivering research. This will accelerate the benefits of research for patients and develop the UK's competitive advantage in the life sciences.

Locally, research activity benefits the Trust's clinical capabilities and deliverables, which means that the Trust can implement evidence-based interventions in a timely manner, thus improving the quality of health care for our patients and enhancing patient choice. Research fosters personal development and attracts high calibre staff. As a result, more of our nursing and midwifery staff than ever before are benefiting professionally from their participation in delivering research. As well as the work of individuals, engagement with Cochrane reviews, NICE, and Clinical Research Networks (CRNs) has positioned the Trust as a national leader in its clinical work-streams.

Summary Report

Key findings from the report can be summarised as follows:

Performance

- A total of 2,330 individuals were recruited to participate in research, including 227 into COVID-19 research studies
- The Trust conducted 123 clinical research studies across all speciality areas, with a further 28 studies in set up at the year end, including 6 industry studies
- Approximately 172 clinical staff contributed directly to research
- Individuals affiliated to the Trust contributed to 148 research publications during the year
- The 2022/23 North West Coast (NWC) CRN baseline funding allocation to the Trust has been matched with the 2021/22 allocation
- Excellent performance at research leadership in all medical speciality areas
- Full contribution to the research component of the Government's COVID-19 strategy

Innovation

- Further programme of work to assess the performance of the new parenteral nutrition product that comprises a specific amino acid formulation concentration.
- In association with Robinson Healthcare, the development of a speculum to assist in the diagnosis of urogenital atrophy for use in both primary and secondary care.
- Development of a tactile sensory array ‘intelligent mattress’ to deliver moving stroking touch to preterm babies in the NICU at velocities and forces that research has shown are optimal

Strategy

- The Trust played a full part in the alignment of research activity across the city during the pandemic and was fully embedded in the integrated “command and control” structures that have continued to evolve
- Continued collaborations with Liverpool Health Partners and Health Education Institutions
- Internal and external consultation in respect of new RD&I strategy
- Development of the Nurse and Midwife talent pipeline plan

Conclusions

Research continues to demonstrate favourable outcomes to the Trust, its staff and its patients. The governance arrangements for research within the Trust are operating well. Good management of research performance has produced measurable results which must be maintained in order to maximise the benefit of external support. The considerable opportunities for strengthening RD&I across the Trust need to be evaluated.

Recommendations

The Board is asked to note the Trust’s Research & Development Annual Report for 2021/22.

Liverpool Women's NHS Foundation Trust

Dedicated to you

Research, Development & Innovation Annual Report 2021/2022

Abbreviations

AHP	Allied Health Professionals
BAME	Black, Asian, and minority ethnic
CCG	Clinical Commissioning Group
CLAHRC	Collaboration for Leadership in Applied Health Research and Care
CRN	Clinical Research Network
DfID	Department for International Development
HEI	Higher Education Institutes
HFC	Hewitt Fertility Centre
HLO	High Level Objective
HTA	Health Technology Assessment
LCR	Liverpool City Region
LHP	Liverpool Health Partners
LMICs	Low and middle income countries
MRC	Medical Research Council
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
NWC CRN	North West Coast Clinical Research Network
PCT	Patent Cooperation Treaty
PDA	Patent ductus Arteriosus
PMDD	Premenstrual dysphoric disorder
PPH	Post-partum haemorrhage
PTSD	Post-traumatic stress disorder
SPARK	Single Point of Access for Research and Knowledge
SPs	Strategic principles
UoL	University of Liverpool
WHO	World Health Organisation

Report

The Trust's vision is to be the recognised leader in healthcare for women, babies and their families. To achieve this vision, the Trust aims to foster a research culture, to support its existing strengths and to explore new directions in its research efforts. Therefore, a Research and Innovation Strategy was produced and approved by the Trust Board in March 2018. The following eight Strategic Principles (SPs) were devised:

(SP1) Research activities will become an integral part of the Trust's clinical activities
(SP2) All of the Trust's clinical staff will contribute to the research agenda and relevant non-clinical staff will support research activity
(SP3) The Trust will support and build upon its present research strengths
(SP4) New areas of research that the Trust supports will link to the healthcare challenges of our local population of women and their newborn babies
(SP5) A contribution to research internationally will be supported, particularly when social and economic disadvantage is linked to poor outcomes
(SP6) The Trust will continue to underpin high quality research by training researchers and managing research infrastructures
(SP7) The Trust will work with local, national and international research partners to achieve its vision and aims
(SP8) Innovation will be encouraged and receive corporate support

The strategy document described the ways in which these eight Strategic Principles were to be pursued in a five-year cycle between 2018 and 2023.

A dashboard of progress against each of these strategic principles has been presented on a regular basis to the Effectiveness Senate, Quality Committee, and also documented within R&D Annual Reports.

A post implementation review of the strategy was undertaken in order to summarise performance against these strategic principles during the first three years of the five-year strategy and reported upon in the 2020/21 R&D Annual Report.

Following a Trust-wide review of its Committee structure, a restructured RD&I Sub-Committee with direct reporting into the Quality Committee was established early in June 2021. The Sub-Committee's remit was to include overseeing the development and implementation of a refreshed research strategy.

During 2021/22 an extensive consultation exercise was undertaken involving members of the RD&I Sub-Committee, the Board of Directors, the Trust Governors, external stakeholders and all Trust employed members of staff. As a result the following guiding principles and aims were agreed:

RD&I Strategy – Plan on a Page

PEOPLE	POTENTIAL	PROJECT	PARTNERS	PLACE
• Provide equitable support for research amongst all staff • Professional development of research delivery staff • Continued support for existing cohort of researchers • Clear leadership for NMAHP research • Development opportunities for NMAHPS • All staff are research able	• Develop an innovation service in collaboration with external partners • Unlock hidden potential of all staff; nuture project development • Create sustainable growth in research & innovation through investment • Promote the implementation of research findings into practice	• Patients in all clinical areas will have access to research relevant to their condition • Increase research activity according to population health needs • Support local, national, international leaders in the development of women and child's health research	• Achieve University hospital status • Continue to develop collaborations with Trusts, Allied Research Collaboration North West Coast, Clinical Research Networks, Health Education Institutes, Liverpool Health Partners etc • Synergise working relationships with the Harris Centre	• Continue to deliver high quality research within existing resources • Streamline RD&I processes to free up capacity for nurturing project development • Patient and public involvement in research design and conduct • Communication of research outputs and good news stories to patients and public • All departments proactively support research

The “plan on a page” will be formulated into a full strategy during the first half of the 2022/23 financial year.

1. Research Activity at Liverpool Women's NHS Foundation Trust during 2021/22

Our commitment to conducting clinical research demonstrates our dedication to improving the quality of care we offer and to making our contribution to wider health improvements. Our healthcare providers stay up to date with new and innovative treatment options and are able to offer the latest medical treatments and techniques to our patients.

This section summaries the research performance of the Trust, the content of which is detailed in section 2. Further detail in respect of the types of projects that are active within each clinical area can be found in Appendix 1.

1.1 Research Activity Summary for 2021/22

As reported in the Trust's Quality Report for 2021/22 we have continued our efforts to contribute to quality National Institute for Health Research (NIHR) studies and to maintain our numbers of participants recruited to NIHR studies (recruitment accruals). We have also continued to focus our efforts on collaborative research with academic partners to ensure the research we conduct is not only of high quality, but is translational, providing clinical benefit for our patients in a timely manner.

In response to the outbreak of SARS-CoV-2 and the subsequent statement by the Department of Health and Social Care, the set-up of all new clinical research projects and the participation of individuals in the majority of active clinical research projects were halted in March 2020. Exception was made to those studies where discontinuing them would have a detrimental effect on the ongoing care of individual participants involved. Following this decision, the Trust prioritised the delivery of COVID-19 research activity, a key element of the Government's overall response to the pandemic.

As the peak incidence of individuals admitted to hospital with COVID-19 reduced significantly in 2021/22, the Trust focused its efforts in restarting contribution to quality NIHR studies whilst balancing the prioritisation of the delivery of COVID-19 research activity.

Despite the challenges faced by the Trust, the number of patients receiving relevant health services provided or sub-contracted by Liverpool Women's NHS Foundation Trust in 2021/22 that were recruited during that period to participate in research approved by a research ethics committee was 2,330 of which, 1,262 were recruited into NIHR portfolio studies and 227 were recruited into COVID-19 research studies.

The Trust was involved in conducting 123 clinical research studies across our speciality areas of maternity, neonates, gynaecology oncology, general gynaecology, reproductive medicine, anaesthetics and genetics during 2021/22. This figure also included 12 COVID-19 related studies that were delivered at the Trust during the year. At the end of 2021/22 a further 28 studies were in set up, including 6 industry studies.

There were approximately 172 clinical staff contributing to research approved by a research ethics committee at the Trust during 2021/22. These staff contributed to research covering a broad spectrum of translational research from basic research at the laboratory bench, through early and late clinical trials, to health systems research about healthcare delivery in the community.

Some members of staff were either funded directly by research income, or the individuals were named on grant applications. Many other members of staff contributed to research within their general job plans. These were named on delegation logs for study activity, for such tasks as the administration of trial medication and performing other interventions including surgery, radiology; collation of questionnaires; dispensing of trial medication; collection and processing of research tissue and blood samples.

Specific examples of the co-operation of clinical staff in helping with research delivery have been:

- An antenatal study investigating the best way to care for women with babies who appear to be bigger than expected and whether labour should be started a little earlier for these women.
- A clinical trial comparing carboprost and oxytocin to determine which is most effective in the first line treatment of post-partum haemorrhage.
- A Hewitt Fertility Centre collaboration with ExamenLab Ltd, Belfast investigating the impact of the quality of sperm on fertilisation, embryo quality, pregnancy and miscarriage.
- Co-operation from obstetric, maternity and theatre staff in the delivery of a research study investigating the physiological and pathological effect of different agents, novel substances and biomarkers on myometrial contractility.
- A trial investigating whether infants born at 30+0 to 32+6 weeks gestation who are given full milk feeds initiated in the first 24 hours after birth reduces the length of hospital stay in comparison to IV fluids with gradual milk feeding.
- An ectopic pregnancy diagnosis study undertaken in the emergency room the aim of which is to develop a metabolomics profile analysis in biofluids to detect an ectopic pregnancy in symptomatic women in early pregnancy.

Our research has contributed to the evidence-base for healthcare practice and delivery, and in the last year individuals affiliated to the Trust contributed to 148 research publications, which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS.

1.2 Contribution to National Institute for Health Research

The Trust does not provide funding for research projects. Trust research is funded by the NIHR, grants (e.g. MRC, HTA and charitable organisations), and industry. All income received is accounted for by the salary costs of the growing research delivery team, research costs and consumables. End of year financial reports are provided to the various funders in order to reconcile funds received against expenditure.

The Trust's annual business planning in collaboration with the North West Coast (NWC) Clinical Research Network (CRN) took place in February 2022. The CRN provides a large proportion of the funding that supports the research function at the Trust. The Trust was informed that the 2022/23 baseline funding allocation would be matched with the 2021/22 allocation.

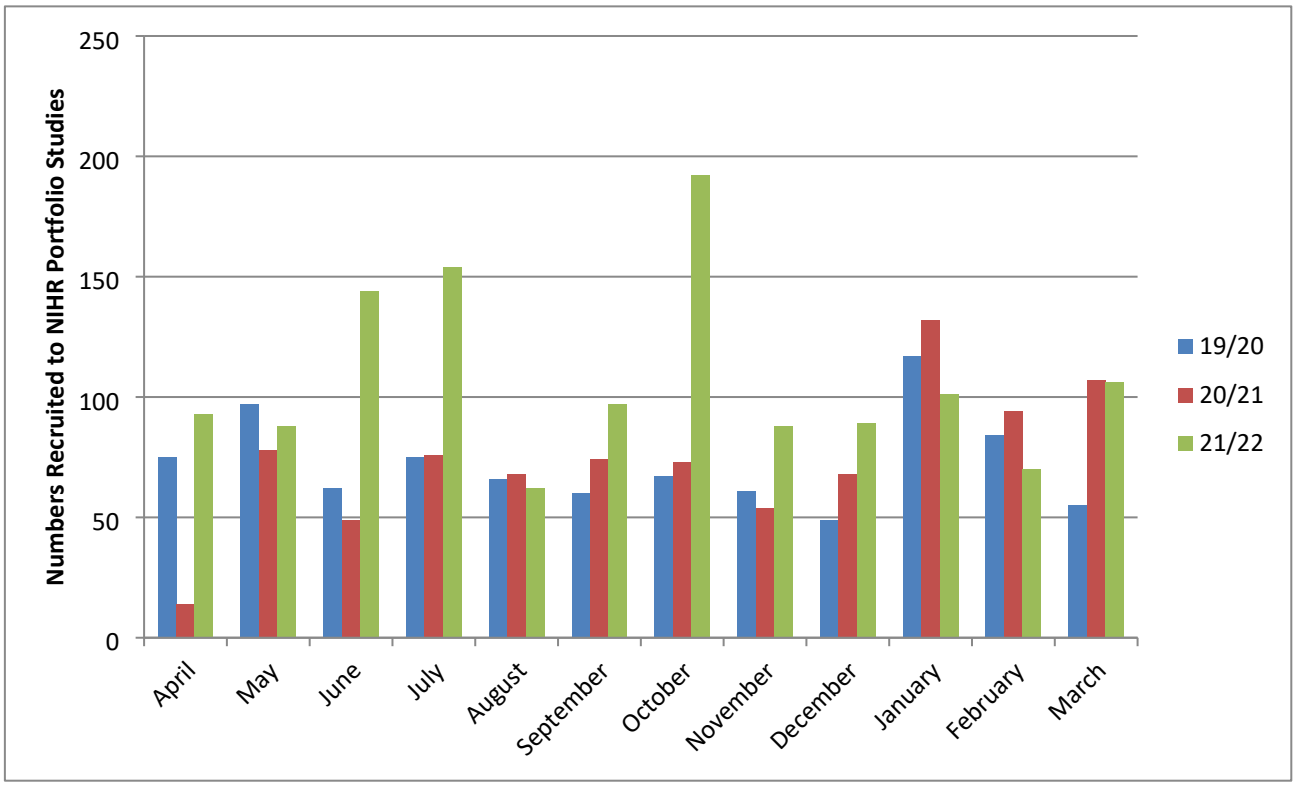
As a government funded initiative, the NIHR CRN has produced a number of high-level objectives against which Trusts are measured. These objectives allow the CRN to track progress and improvements. The RD&I department report performance against these objectives on a monthly basis to the RDI Sub-Committee of the Quality Committee.

Current and historic performance strengthens the Trust's reputation as a high performing research institution. The following sections illustrate the Trust's 2021/22 performance in comparison with the objective metrics set by the Department of Health that apply to this organisation.

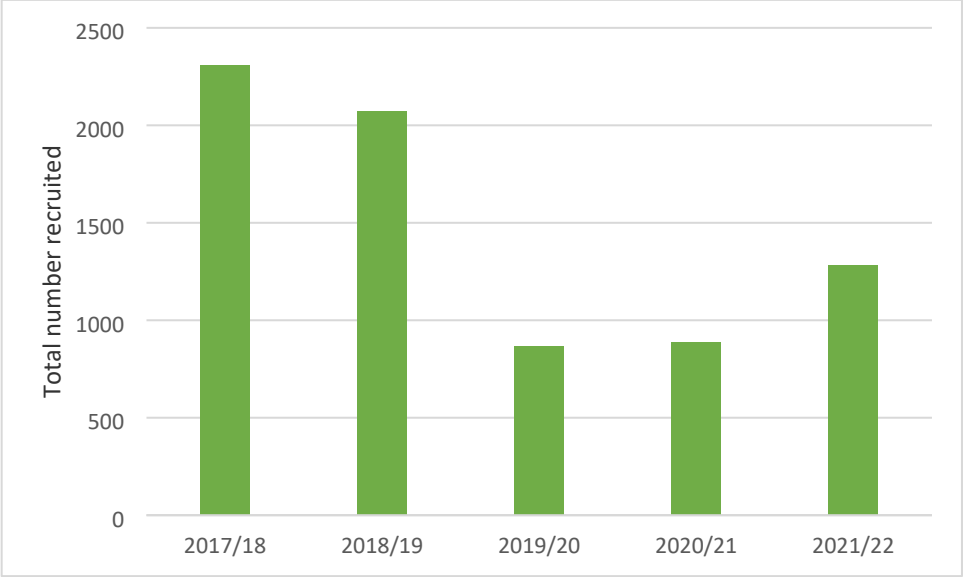
The impact of COVID-19 on the majority of research studies during 2021/22, has been acknowledged by the NIHR and will be taken into account when reviewing the Trust's overall performance for the year.

1.2.1 Number of participants recruited to NIHR research studies

Although during 2021/22 COVID-19 impacted upon the Trust's usual research activity, contribution to COVID related research studies and the proactive efforts to restart non-COVID research resulted in regaining a position comparable with 2019/20. The figure below demonstrates the Trust's overall performance of recruitment of participants to NIHR portfolio research studies during 2021/22, in comparison with 2019/20 and 2020/21.



The following graph shows a comparison with NIHR portfolio research activity from 2017/18 through to 2021/22 which demonstrates continuing good performance in the number of individuals recruited to NIHR portfolio research during 2021/22. The reduction in the overall recruitment number during the last three years can be attributed to the closure of a large interventional trial and the impact of COVID-19. However, during 2021/22 the commencement of a gradual recovery to pre-pandemic levels can be seen.



If there is a national NIHR portfolio study that the Trust is not recruiting to, which meets our clinical areas of expertise, the Trust can be assured that the feasibility, questions of local leadership, equipoise will have been explored and we are confident there is good reason for not being a participating site. However, we remain vigilant in managing our portfolio, continually exploring feasibility of new studies and anticipating and preparing for replacement studies where studies are due to close following completion of recruitment

1.2.2 Managed Research Recovery

The COVID-19 pandemic led the NHS to suspend many routine clinical services and the NIHR to support the Government's research response. The focus from March 2020 to March 2021 had been to support the priority Urgent Public Health COVID-19 studies, which have led to the development of new treatments and vaccines, and generated evidence that has underpinned the response to the pandemic. Whilst research into other conditions continued, it was severely affected by a reduction in capacity and accompanying NHS services.

With the pressures of the pandemic beginning to ease and COVID-19 caseloads falling, work is underway to support the recovery of research into other conditions, and to increase the strength of the UK's research base and life sciences sector. This supports the vision set out by the Department of Health and Social Care in the document Saving and Improving Lives: the future of UK clinical research delivery.

The Department of Health and Social Care asked NIHR to work with research funders and partners across the UK's research system to develop a plan to manage the recovery of those studies that require support during 2021/22. The initial focus will be on studies which could fully recruit and/or close within the year, although some flexibility was allowed where appropriate. The following studies had been identified for the Trust:

Study	Close Date	LWH Target	Recruits to date	Comments
Big Baby	30.06.2022	96	159	To continue to recruit to the RCT arm until end of trial, but stop recruiting to the cohort arm. Will not agree to any trial extension.
WILL	23.07.2023	68	12	Actively recruiting
COPE	01.01.2023	4 per month	36	Extension approved by funder
CERM	31.05.2023	66	10	Actively recruiting
LOCI	31.07.2022	45	16	Actively recruiting

1.2.3 Efficient Study Delivery (1) – New Commercial Studies

Proportion of new commercial contract studies (opening on or after 1st April 2021) achieving or surpassing their recruitment target during their planned recruitment period (Ambition target 80%)

Performance: 100% - one commercial study has closed to recruitment and met target. A further two commercial studies are currently active and six are in set up.

1.2.4 Efficient Study Delivery (2) – Commercial Managed Recovery

Proportion of commercial contract studies in the managed recovery process achieving or surpassing their recruitment target during their planned recruitment period (Ambition target: 80%)

The Trust is not currently recruiting to any of the commercial contract studies within the managed recovery process.

1.2.5 Efficient Study Delivery (3) – Non-Commercial Managed Recovery

Proportion of non-commercial contract studies in the managed recovery process achieving or surpassing their recruitment target during their planned recruitment period (Ambition target: 70%)

The Trust is currently recruiting to 5 studies identified as being part of the managed recovery process. One of these studies has surpassed its recruitment target, the other 4 are currently still actively recruiting. Further detail is contained within section 1.2.7 of this report.

1.2.6 Performance in Initiating and Delivering Clinical Research

Trusts holding NIHR contracts are required to provide and publish, on a quarterly basis, outcomes with regard to performance in initiating and delivering clinical research trials, including commercial trials. The Department of Health use this reporting mechanism to assess the performance of Trusts. Consequences for unsatisfactory performance may result in a proportion of a Trust's Research Capability Funding (RCF) allocation being withheld.

All NHS providers are required to submit information in two specific areas:

- Initiating clinical research
- Delivering commercial contract clinical research to time and target.

The Trust's performance during 2021/22, released by the NIHR Central Commissioning Facility, has been reported as meeting both requirements.

The collection of NHS provider data on initiating and delivering clinical research, is a separate exercise from the ongoing collection of performance data by the NWC CRN against the NIHR HLOs. The overall aim of both exercises is to increase the number of patients participating in research and enhance the nation's attractiveness as a host for research.

1.2.7 COVID-19 Clinical Research

Although the Trust did not provide frontline NHS clinical services for the treatment of COVID-19, during 2021/22 we continued to deliver 12 COVID related studies. A total of 227 participants were recruited to these research studies.

COVID-19 clinical research study activity for 2021/22 is as follows:

Project Short title	**Status as of 31.03.2022**
UKOSS COVID 19 in Pregnancy	Open
RECOVERY - Randomised Evaluation of COVID-19 Therapy	Open
COVID-19 ISARIC/WHO Clinical Characterisation Protocol for Severe Emerging Infections (CCP-UK)	Open
When pandemic and everyday ethics collide: supporting ethical decision-making in maternity care and paediatrics during the Covid-19 pandemic	Closed
SARS-CoV2 viability in the Abdomen or Pelvis and the FEasibility of SURGERY	Closed
ASPIRE-COVID-19 CENTRE: Achieving Safe and Personalised maternity care in response to epidemics - Case studies of eight NHS Trusts in England	Closed
COV-002 (Oxford AZ Vaccine Trial)	Closed
COMCOV II Vaccine Trial	Closed
COV-009 Vaccine Trial Follow-up	Open

Pregnancy and Neonatal Outcomes in COVID-19	In follow up
SINEPOST (SARS-CoV-2 infection in neonates or in pregnancy: outcomes at 18 months	Open
PREG-COV (platform trial to assess safety, reactogenicity and immunogenicity of COVID-19 vaccines in pregnant women in the UK)	Open

In response to a surge in COVID-19 research activity in Liverpool, the Trust became actively involved in supporting the Liverpool School of Tropical Medicine with the delivery of the COV-002 (Astra Zeneca / Oxford) and the COMCOV II vaccine trials. The Trust has continued to provide support for all of the follow up studies resulting from these important trials through 2021/22.

2. Performance at Research Leadership

2.1 Maternity

- A new collaborative world-leading programme of research focused on improving the health and wellbeing of children and their families within the Liverpool City Region (LCR) has been awarded funding from the Wellcome Trust. The 'Children Growing-up in Liverpool (C-GULL)' research study is led by Professor Louise Kenny. The data resource will be used to better understand and improve the lives of LCR children and their families. This will be the first newly established longitudinal birth cohort to be funded in the UK for almost 20 years.

  Currently, Liverpool ranks badly in terms of the highest rates of child mortality and conditions such as asthma, type 2 diabetes, epilepsy and risk factors for poor health such as obesity, poor nutrition and low levels of physical activity. To help develop a better understanding of these issues, researchers will collect information from 10,000 babies and their families, starting in pregnancy and over the first years of life, allowing changes in their health and development to be monitored and recorded over time. The information gathered will provide important evidence for policy, practice and research that will ultimately help improve child health and development in the area.

  Due to COVID-19 the launch of C-GULL was delayed. However, initiation of the programme at Liverpool Women's Hospital is planned for Summer 2022, which will bring together citizens, researchers and clinicians across the Liverpool City Region and wider to make one of the largest family studies in the UK.

- COPE: The Carboprost or Oxytocin Postpartum haemorrhage Effectiveness study. The grant award of approximately £1.8 million in response to a commissioned call by the NIHR HTA, supports a trial which aims to recruit 3,948 women in up to 40 UK hospitals. The study will randomize women following the doctor's decision to give treatment to stop the bleeding caused by PPH. Professor Weeks is the trial lead, with trial management provided by a team from the Clinical Trials Research Centre (CTRC) at the University of Liverpool. Despite the difficulties facing the team during the pandemic, efforts to set up the trial across the UK commenced in the latter half of 2020/21. The first patient was recruited to the trial at LWH in May 2021.

- Dr Andy Sharp was successful in securing a grant award of approximately £250,000 funded by the NIHR Research for Patient Benefit programme. PLANES: Placental Growth Factor Led Management of the Small for Gestational Age Fetus, is a feasibility study which aims to establish whether the management and care given to pregnant women who are carrying a small baby can be improved by the use of a blood test (sFlt-1/PlGF ratio). The test could reveal whether the mother's placenta is working as well as it should. The research is expected to commence April 2022.

- During 2019/20, the Trust was awarded approximately £341,765 by the NIHR Health Technology Assessment programme. The funding will support delivery of the FERN – Intervention or Expectant Management for Early Onset Selective Fetal Growth Restriction in Monochorionic Twin Pregnancy research study. It is anticipated that the clinical research study will commence during Spring 2022.

- Professor Zarko Alfirevic held the post of Associate Pro-Vice Chancellor (Clinical) at the University of Liverpool until the Summer of 2021. Dr Andy Sharp holds the post of CRN NWC Specialty Lead for Reproductive Health and Childbirth. Dr Sharp is also the system lead for Obstetrics and Gynaecology at the University of Liverpool.

- In March 2022, Professor Andrew Weeks was appointed an NIHR Senior Investigator for the period 2022-2026.

- Dr Angharad Care and Dr Kate Navaratnam both hold the position of Clinical Lecturer at the University of Liverpool. These appointments are excellent examples of how both the Trust and the University have supported the career advancement of talented individuals.

- Dr Emma McGoldrick was successful in securing funding as part of the NIHR Research Scholars Programme. The programme is an initiative to develop early career health and care researchers, equipping tomorrow's clinical research leaders with the skills, knowledge and experience needed to become Principal and Chief Investigators of the future.

2.2 Gynaecology

- Professor Hapangama continues with her ground breaking endometrial research supported by specific grant funding awards. She secured grant funding of £197,039 from the Wellbeing of Women, to support ExPeDITe: Ectopic Pregnancy DIagnosis sTudy. The research study aims to develop metabolomic profile analysis in biofluids to detect an ectopic pregnancy in symptomatic women in early pregnancy. If successful, the results of the research could help to improve the way an ectopic pregnancy is diagnosed and reduce the health risks and stress to women.

- Professor Hapangama together with Drs John Kirwan, Sian Taylor, Purushothaman Natarajan and Lucy Dobson have designed a research study to see whether it is possible to develop an acceptable and easy to collect biomarker-based screening test, to identify those with an increased risk of endometrial cancer among women presenting with abnormal post/peri-menopausal bleeding. If successful it could mean many women could have an early test, at their convenience, to rule out endometrial cancer without needing to be referred to hospital, waiting for a scan, or having more invasive tests.

- Dr Nicola Tempest holds the position of NIHR Academic Clinical Lecturer at the University of Liverpool. She continues with her contribution to ground-breaking research, and has been successful in obtaining the following funding awards:

  - *Personalising treatment for women with recurrent implantation failure through characterising regional-specific endometrial abnormalities* - £29,200, Wellbeing of Women
  - *Preliminary study, characterising the region-specific abnormalities in the endometrium of women with recurrent implantation failure* - £29,500, Academy of Medical Sciences Starter Grant

  Dr Tempest also was awarded the "Best Oral Presentation" prize at the RCOG World Congress, 2021 for her work on "*LGR5 expression is seen at a lower level in patients with endometriosis, possibly impacting their fertility*."

- Dr Nicola Tempest (lead author), together with Professor Hapangama et al published their work on the "*Novel microarchitecture of human endometrial glands: implications in endometrial regeneration and pathologies*". The outcomes of their work will change textbooks of the future and will inform reproductive biologists and clinicians to direct their future research to determine disease-specific alterations in glandular anatomy in a variety of endometrial pathological conditions.

2.3 Neonates

- Dr Elaine Neary was successful in securing funding as part of the NIHR Research Scholars Programme to support her research project "Using Novel Echocardiographic Techniques to Facilitate Identification of Preterm Neonates at Risk of Developing Significant Chronic Pulmonary Hypertension".

- Dr Nim Subhedar was successful in securing a place in the NIHR Clinician Researcher Programme. The programme provides funding of £10,000 a year with the aim of supporting established clinicians interested in pursuing and leading their own clinical research.

- Professor Mark Turner is scientific leader of a €140 million pan-European paediatric clinical research network and leads on building interfaces between similar initiatives in Europe, North America and Japan, with clinicians and colleagues in regulators and the Pharmaceutical industry.

- A monthly research meeting has been initiated to in order to offer peer support in the design of research projects and discuss potential recruitment challenges for those studies that are active on the unit. All members of staff who are or who wish to be research champions are encouraged to attend and participate. It is hoped that in the future the meeting expand to accommodate parent involvement in research design.

2.4 Genetics

- Dr Jenny Higgs holds the post of CRN NWC Specialty Lead for Genetics.

- The overall genetics research portfolio is continuing to grow, particularly in respect to rare disease studies. Although the numbers of patients participating in such research studies are small, the time and effort involved in identifying individuals who meet the research study criteria is considerable. Our committed genetics research team have compiled a catalogue of approximately 30 genetic research studies open at the Trust. The catalogue has greatly helped in identifying the type of study each patient would be eligible to take part.

2.5 Hewitt Fertility Centre

Joint Hewitt Fertility Centre and R&D monthly meetings are continuing to take place and have been instrumental in continuing to drive forward the HFC research agenda.

- Mr Andrew Drakeley has been successful in securing funding for the STOP-OHSS (Shaping and Trialling Outpatient Protocols for Ovarian Hyper-Stimulation Syndrome): A feasibility study and randomised controlled trial, with internal pilot, to assess the clinical and cost-effectiveness of earlier active management of OHSS. Dr Drakeley is a co-applicant in this NIHR HTA funded project. The first phase of the trial commenced in the last quarter of 2020/21.

- Mr Andrew Drakeley has also been successful in securing funding for the LOCI Trial: Letrozole or Clomifene, with or without metformin, for ovulation induction in women with polycystic ovary syndrome. Dr Drakeley is a co-applicant in this NIHR HTA funded project. The trial opened to recruitment in the last quarter of 2020/21.

- A collaborative research project between the Trust and ExamenLab Ltd, Belfast commenced recruitment in January 2021. The aim of the research is to study the associations between sperm quality and the impact that this has on fertility diagnosis, fertility treatment, embryo quality, pregnancy and miscarriage. It is hoped that findings can be used to improve infertility treatment or current therapies.

- Andrew Drakeley has been appointed to the role of Honorary Clinical Associate Professor at the University of Liverpool.

2.6 University of Liverpool

- ***Harris Wellbeing Pre-term Birth Centre***

  In collaboration with the Centre for Women's Health Research, the Trust continued to host the Harris Wellbeing Pre-term Birth Centre. The Centre's focus was to develop personalised treatments for all pregnant women who experience or are at risk of preterm birth. The Centre acted as an international hub for research, promoted best clinical practice related to preterm birth, and provided cutting-edge research training for early career researchers committed to preterm birth research. In light of the COVID-19 pandemic an additional no cost extension was approved by Wellbeing of Women and a revised end date of 30/09/2021 was agreed. In January 2022 the Centre's final report was submitted to the Wellbeing of Women detailing the aims, methods, results and conclusions for each of the three work packages agreed within the original application, namely:

- *Work Package 1*: genomic and metabolomic approach to spontaneous preterm birth phenotyping.
- *Work Package 2*: developing more effective tocolytic regimens
- *Work Package 3*: evaluating different preventative strategics by research synthesis

The Harris-Wellbeing Research Centre has now secured small research centre status at the University of Liverpool and as part of this has expanded its remit to include the delivery of women's health research in areas such as growth restriction (A Sharp), twin pregnancy (A Sharp, A Khalil), infection (K Navaratnam), population health (L Kenny) and global health (D Lissauer). A revised Centre strategy is currently being developed in collaboration with key partners under the interim leadership of Professor Mark Turner.

- ***Perinatal Mental Health***

Pauline Slade, Professor of Clinical Psychology at the University of Liverpool continues to lead on a number of ground-breaking psychological research projects, namely:

- *Perinatal Access to Resources and Support: a Feasibility Study with External Pilot (PeARS):* The study, funded by CLAHRC, aimed to check the feasibility of a simple intervention based on three evidence based components to improve uptake of perinatal support for women in neighbourhoods with high deprivation. Outputs to date include four presentations and two papers.

- *Fear of Childbirth: Developing an evidence-based, usable and acceptable tool for UK maternity services (FOCUS*): The project, funded by Liverpool CCG aimed to develop a clear definition of the fear of childbirth construct; evaluate the utility and acceptability of existing measures for fear of childbirth with a UK sample; and, determine and implement where necessary, any requirement for modifications to current measures for fear of childbirth, for use with a UK sample. Outputs to date include three presentations and four papers. Following a successful bid, the team was award further funding from the NIHR Research for Patient Benefit programme.

- *Programme for the prevention of posttraumatic stress disorder in midwifery (POPPY):* The project, funded by Health Education North West, developed and evaluated the feasibility of an educational and supportive package for midwives, aimed at reducing the probability that work-related events are perceived as traumatic, that posttraumatic stress responses develop, and to ensure that access to psychological input for those with clinical PTSD is facilitated. Outputs to date include fourteen presentations and three papers. Following request by the World Health Organisation a case study was submitted and subsequently published in July 2021 – "Programme for Prevention of PTSD in Midwifery (POPPY) World Health Organisation Collaborating Centre - Evidence Based Public Health Nursing, Midwifery and Allied Health Professions into Practice".

- *Psychological health and relationship Experiences After vaginal Childbirth: The effects of experiencing perineal cuts or tears (PEACH):* The aim of this study, funded by the University of Liverpool, was to explore the effects of different degrees of perineal

trauma on women's experiences of childbirth, perineal pain and their psychological and emotional health in the first nine months after they had given birth. Outputs to date include one presentation and two papers. A further two papers are currently being prepared.

- *Preventing Post Traumatic Stress Disorder: the Stress and Wellbeing after Childbirth Study (STRAWB2)":* This definitive trial, funded by the NIHR Research for Patient Benefit programme (£348,363), compared self-help material with usual care for women screened to be at risk of developing Post-Traumatic Stress Disorder (PTSD) after childbirth. The trial successfully recruited to time and target and within budget. Outputs to date include seven presentations and one paper.

- *Post-traumatic stress disorder following childbirth*: A systematic review of clinical effectiveness of psychological interventions, and metasynthesis of barriers and facilitators to uptake of care. Outputs to date include one paper.

- *Coping with the Uncertainties of Childbirth (CUBS):* The feasibility and acceptability of a single-session of Acceptance and Commitment Therapy (ACT) intervention to support women self-reporting fear of childbirth in a first pregnancy. The study has recently been completed and a paper has been published.

- *INDIGO* – the study funded by the Welling of Women and in collaboration with Professor Andrew Weeks sought to better understand the trauma-based experiences that obstetricians and gynaecologists face, and the contributing factors that these experiences have on burnout. The results of the study have been published and are currently being adapted into joint RCOG / RCM guidelines led by Professors Weeks and Slade.

Professor Slade also received the prestigious Monte B Shapiro Award from the British Psychological Society's Division of Clinical Psychology for her contribution to the field of perinatal mental health.

2.8 International Research

- The Centre for Women's Health Research (based at Liverpool Women's Hospital) hosts the **Cochrane Pregnancy and Childbirth Cochrane Centre**. The Cochrane Centre is an independent, international not-for-profit organisation, dedicated to making healthcare readily available worldwide. Pregnancy and Childbirth is one of 53 Cochrane Review Groups and was the first group to be formed. It produces and disseminates systematic reviews of healthcare interventions and promotes the search for evidence in the form of clinical trials and other studies of interventions. Cochrane produces high quality systematic reviews which are published monthly as part of the Cochrane Library. Sub-sets of Cochrane reviews published in the Cochrane Library are also published in the WHO Reproductive Health Library. The Group have also produced a Cochrane Pocketbook which allows doctors, midwives, students and parents to quickly access the best evidence for the care of pregnant women.

- The **Sanyu Research Unit** which was established in 2012, is directed by Professor Andrew Weeks and has a specific remit to improve maternal and newborn health by developing and evaluating innovative, cost-effective technologies and approaches that can be adapted in both high and low resource settings. Due to its co-location at the Trust, it is in the ideal situation to undertake maternal health research here in the UK. This important proof of concept research can be translated into either research studies in Low and Middle Income Countries (LMICs) to provide appropriate context to the clinical setting or translated directly into clinical practice. Some of the activities on-going within Sanyu during 2021/22 are:

  - *MOLI Study* (funded jointly by MRC/Wellcome/DfID: £1,160,007). This mixed methodology trial consists of a cohort study followed by an open label randomized trial comparing oral misoprostol alone with oral misoprostol followed by oxytocin in women induced for hypertension of pregnancy. In January 2020, the study started recruitment within three public hospitals location in Nagpur, India. Due to the COVID-19 pandemic recruitment was suspended for a number of months. However, to date 859 patients have been recruited to the cohort study and 429 to the randomised study.

  - *Fetal Monitoring study – MOLI Sub-Study (1).* This study aims to evaluate the impact of an intra-partum fetal monitoring training programme and quality improvement project in a GMC Hospital, Nagpur using a mixed methods approach. The results of this study and the resultant theory of change developed, will be presented as oral presentations at the RCOG World Congress 2022. Both abstracts will be published in the BJOG, in the top 500 scoring abstracts.

  - *Q-MOLI – MOLI Sub Study (2).* A qualitative study exploring patients' and health care professionals' expectations and experiences of labour induction with misoprostol and oxytocin for hypertension in pregnancy in India. The IOL aspects will be presented at the RCOG World Congress in June 2022 as an oral presentation and the fetal monitoring and mode of birth aspects as a poster. Both abstracts will be published in the BJOG, in the top 500 scoring abstracts.

  - *Baby Saver Tray* (funded by Sir Halley Stewart Trust: £14,000 and Canada Grand Challenges $100,000 CAD). Infant mortality and morbidity in LMICs is a major health problem. Evidence based practice suggests that keeping the mother and baby as close as possible during the immediate post-partum period, which includes delaying cord clamping, will bring benefits for both mother and baby. The Baby Saver Tray (BST) follows on from Professor Weeks' earlier development work on the BASICS trolley at the Trust. A feasibility study to test the device was conducted between August 2020 and February 2021 in Uganda. A number of deliverables were attained, including satisfaction from the women, their attendants and the providers of resuscitation. Recommendations / changes to the design have been taken on board, a local manufacturing unit is being developed in Uganda for mass production. Additional trays are also being produced in Wales for use in Ukraine during the war.

- *The Babygel Study* (funded by European and Developing Countries Clinical Trials Partnership (EDCTP), €5.9m/£5.2m). The principal objective of this study is to determine whether the provision of alcohol-based hand rub (ABHR) to pregnant women for postnatal household use is effective for the prevention of severe illness or death during the first 3 months of life. Over 60 months, pregnant women will be recruited from homes within 72 study villages in Mbale region, Eastern Uganda. To date 2,000 women have been enrolled, the programme of work is due to complete in January 2024.

- *Maternal Self-Assessment Tool* – As the global provision of post-natal care is poor, particularly in Uganda where it has the poorest coverage in the continuum of care, the study will look to optimisation of immediate maternal post-natal care in healthcare facilities through the development and validation of a maternal self-assessment tool for post-natal Ugandan women.

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- Dr Carol Kingdon, Reader in Medical Sociology at the University of Central Lancashire is research active within the area of Midwifery and Maternal Child Health. She has contributed to a global series on optimising caesarean section use published in The Lancet. This research has also informed the new World Health Organisation Guideline recommendations on non-clinical interventions to reduce unnecessary caesarean sections. Other achievements of note during 2021/22 include:

  - *ASPIRE-COVID-19: Achieving safe and personalised maternity care in an epidemic*. Funded by UKRI-COVID-19 Economic and Social Research Council. The aim of this study is to document organisational changes in, responses to, and outcomes of, maternity and neonatal care provision in the context of the COVID-19 pandemic; undertake a case-specific and cross-case analysis of the findings; identify 'best practice' in terms of optimising safe and personalised maternity and neonatal care; create a model of what works in a pandemic, and a toolkit to help organisations to respond rapidly in the context of safe and personalised care

  - *C-Safe: Improving maternal and perinatal outcomes through safe and appropriate caesarean sections in low- and middle-income countries.* Funded by the Medical Research Council Applied Global Health Research Programme (to run from September 2022 to August 2027 - £2,200,00).

  - Presentation in respect of "*Women's, partners' and healthcare providers' views and experiences of assisted vaginal delivery (AVD)"* for the World Health Organisation (WHO) Technical Consultation on Assisted Vaginal Delivery.

- Professor Mark Turner is the scientific leader of CONECT 4 Children, an academic consortium that has been selected to work with a consortium of 10 large pharmaceutical companies on a €140 million, 6 year project to develop a sustainable pan-European research network that integrates research activity in 20 countries, 24 European Reference Networks, 25 clinical specialties, and liaises with networks in 6 other high income countries. He also is also Co-Director (Europe) of the International Neonatal Consortium which has developed global standards for research about medicines in neonates and is using real world data from 300,000 babies to develop a disease progression model for chronic lung disease of prematurity and reference ranges for laboratory values in

neonates. As President of the European Society for Developmental, Perinatal, and Paediatric Pharmacology, he has also hosted the 2021 and 2022 meetings of the society. This work showcases the city's leadership in the development of medicines including the pregnant and lactating women, and for neonates.

3. Innovation

Searching for and applying innovative approaches to delivering healthcare must be an integral part of the way the NHS does business. Doing this consistently and comprehensively will dramatically improve the quality of care and services for patients.

During 2021/22 the Trust has continued to benefit from outsourced expert support from the 2Bio Impact Science team. 2Bio's service model is based on identifying problems and solutions; developing, testing and implementing the solutions and then supporting their adoption and dissemination. In addition, discussions have been held with local Trusts in order to establish collaborative ways of working for the future.

Projects

- Research led by Professor Colin Morgan has led to the development of an idea for a new parenteral nutrition product that comprises a specific amino acid formulation concentration. The research team, together with the R&D Department and a team of expert patent attorneys worked to further protect the IP by formally submitting an international patent allowed the team to publish the preliminary data without other parties using the information for commercial gain whilst additional scientific analysis is undertaken. A programme of further work to examine the changes in gene expression present in arginine supplemented infants <30 weeks' gestation between day 3 and day 10 of postoperatively has commenced. The changes in gene expression will be compared with those seen between day 3 and day 10 in unsupplemented preterm and term infants.

- Following the appointment to the post of Consultant in Sexual and Reproductive Health, Dr Paula Briggs in association with Robinson Healthcare, has developed a speculum to assist in the diagnosis of urogenital atrophy for use in both primary and secondary care. The validation of this objective method of diagnosing urogenital atrophy and assessing response to treatment will facilitate ongoing research in relation to this condition.

- The Trust has entered into preliminary discussions in respect of a collaboration with Liverpool John Moores University. An 'intelligent mattress' has been developed that will deliver the c-tactile afferents preferred forces and velocities of gentle massaging touch that a preterm would have experienced in-utero. A programme of research will be designed aiming to address the question of how to maximise preterm infants' neurodevelopmental outcomes. The hypothesis is that this 'Mattress' device promotes experiences that are conducive to normal development. An application for grant funding to support this programme of work is in development.

4. Summary of Local and National Partnerships

4.1 Health Education Institutions

Although the Trust has a long history of significant collaborations with the University of Liverpool, concerted efforts have been made to develop existing partnerships with other HEIs.

Discussion between researchers at LWH and **Liverpool John Moores University** have continued with the aim of igniting new collaborations/joint working, identifying combined research strengths, exploring important research questions and strengthening existing networks. Some of the early indications of success have been:

- Proposal to develop a tactile sensory array 'intelligent mattress' to deliver moving stroking touch to preterm babies in the NICU at velocities and forces that research has shown is optimal for c-tactile afferents.

- A research study looking at the role of physical activity on metabolic health during pregnancy, specifically trying to understand the role of obesity and health status during pregnancy and whether these are related to habitual physical activity levels.

- Dr Kayleigh Sheen, in collaboration with colleagues at the Trust and the University of Liverpool, has been successful in securing a NIHR Research for Patient Benefit grant to the value of £267,680. The grant will fund a research study the aim of which is to provide an accurate way to identity women who experience fear of childbirth (FOC) during pregnancy in routine maternity care.

Following the appointment of Dr Julie Abayomi as Associate Head of Applied Health & Social Care at **Edge Hill University**, the Trust has been able to further strengthen its research partnership with the institution, for example:

- Dr Abayomi in collaboration with Hazel Billson, Maternal & Women's Health Dietitian (LWH) and Dr Andy Sharp (LWH/UoL) will undertake a study examining dietary intake and weight changes of women with a multiple pregnancy. Funding of £12,158 has been successfully obtained from the British Dietetic Association.

- In January 2021, the University confirmed funding for two PhD studentships; one to research the dietary intake and weight change & physical activity of BAME pregnant women, then comparing observational data to pregnancy outcome data; and the other to evaluate the Mamafit programme with regard to diet, physical activity & perinatal mental health in pregnant/postnatal women. Due to the impact of COVID-19, these projects have been delayed and are due to commence during 2022.

- Dr Abayomi together with Dr Katerina Bambang have submitted a bid to fund a new PhD studentship to research the dietary intake of women attending the multiple miscarriage clinic.

- Jane Rooney's PhD research "negation in the Childbearing Continuum: an in-depth exploration of women's narratives" has completed recruitment and data analysis and is

currently in the writing up phase of the study. She recently presented findings at the International Confederation of Midwifery Congress in June 2021

During 2021/22, Professor Dame Tina Lavender was appointment to the role of Professor of Maternal and Newborn Health, Department of International Public health at the **Liverpool School of Tropical Medicine**. Professor Lavender had previously been appointed as an NIHR Senior Investigator and therefore the Trust now has the privilege of being the appointed as the afflicted Trust. This new working partnership has already demonstrated early success, namely:

- Research Capability Funds, linked to Prof Dame Tina Lavender's Senior Investigator award, has afforded an opportunity for a midwife, Sarah Farrell to be seconded to the Centre for Childbirth, Women's and Newborn Health to conduct a study, titled 'Maternity care experiences of women from minority ethnic groups'. Sarah, who is being mentored by Prof Tina Lavender and Dr Tracey Mills, has written her protocol and is in the process of applying for ethical approval.

4.2 Liverpool Health Partners (LHP)

The overarching aim of Liverpool Health Partners is to bring together leading organisations within the City region in order to develop world-leading research which:

- addresses the needs of the local population
- plays to region's strengths and fulfils its research potential
- establishes an optimal collaborative framework through which LHP partners can work with one another and with other relevant stakeholders to shape and deliver the strategies for LHP's programmes.

In order to achieve these aims and objectives specific programmes and themes have been strategically formulated with key, relevant expertise to positively impact the population, locally and globally.

The positive benefits that have been derived from the partnership are that for the first time there is a possibility of having a City-wide strategic view with interactions from across all organisations, each having an equal share with respect to shaping the vision. The Trust has been actively involved with the Starting Well programme, with Professor Colin Morgan as the Deputy Programme Lead and Carrie Hunt as the Programme Manager. The programme has already been the catalyst for extremely useful dialogue between colleagues with specific specialisms, such as:

- Family integrated care, nutrition and neonatal body composition (nursing PhD fellowship): *Professor Colin Morgan*
- Hugh Greenwood funding - Addressing geographical inequalities in neonatal and infant mortality using linked routine data: *LWH Lead Dr Nim Subhedar*

- Hugh Greenwood funding - MicroRNAs as biomarkers and new molecular targets for the prediction of spontaneous preterm birth - a pilot study*: LWH lead Dr Angharad Care*
- Development of a recurring miscarriage network: the priority focus on the impact on male mental health: *LWH lead Dr Katerina Bambang*
- Hugh Greenwood funding to support PAINT18 (An exploratory study of increased Preterm Arginine INTake on biological pathways affecting immune function in infants requiring early parenteral nutrition) and ASPIRE (An exploratory study of Arginine Supplementation and the Postoperative Immune Response in neonates) studies: *Professor Colin Morgan*
- Continued support for the perinatal mental health research network
- Support the development of a preterm research network

The Neuroscience and Mental Health programme, with the support of Dr Jade Thai has resulted in the following collaborative working:

- Missing Touch 1: Chief Investigator: Prof Mark Turner - collaboration with LJMU Francis McGlone & Laura Mulligan PhD, project sponsor University of Liverpool
- Missing Touch 2: LJMU Francis McGlone & Prof Mark Turner LWH-MRC Development Pathway Funding Scheme Outline application in development submission deadline 8th June 2022
- MRC Partnership BRAINLIFE connected life course biorepository: PI Prof Simon Keller UoL, LWH Clinical co-investigator Mani Chandrasekaran, additional collaborators, LUHFT, Mersey Care, Walton Centre, Alder Hey, application submitted 26th January 2022, value £2.3million, outcome expected June 2022.
- Infant Brain Imaging correlates with Socioeconomic Status (IBISS) study PI Shivaram Avula Alder Hey, LWH co-investigator Andrew Sharp and David Taylor-Robinson UoL.

The response to the COVID-19 pandemic has demonstrated a willingness to pool and manage collective resources. The Strategic One Liverpool Partnership for COVID (STOP COVID), a city-wide framework which aims to support, accelerate and assess research-based innovations within the Liverpool City region has initiated a single approval route for all grant applications for COVID related research, to ensure that the University and NHS partners where applicable have the capacity to undertake research safely. The accompanying Gold / Silver / Bronze research command and control process has provided a structured approach to cross-organisational discussion and decision. This has created an opportunity to learn from the experience, build upon the platform of excellent collaboration and develop improved future ways of working.

4.3 Development of the Nurse, Midwife and Allied Health Professional Research Workforce

It is recognised that healthcare institutions that embrace research can demonstrate better clinical outcomes and therefore it is important that nurses, midwives and AHP's are included in efforts to foster a research culture. Some of the activity during 2021/22, is detailed as follows:

- Gillian Houghton, Consultant Midwife is the lead for a number of research programmes of work at the Trust, including:

    - Principal Investigator for the Optibreech Study – which has involved setting up a Breach Birth Team in preparation for a national RCT
    - Principal Investigator for "ASPIRE-COVID-19: Achieving safe and personalised maternity care in an epidemic".
    - Collaboration with the Department of Psychology at both The University of Liverpool and Liverpool John Moore's University on several fear of childbirth workstreams. A screening tool for tokophobia and interventions to support women with high levels of fear are currently being developed.
    - Working with Liverpool and Lancashire Maternity Voices Partnerships to develop a research tool to explore women's views of information provision and decision making on induction of labour

- Cheryl McNamara, Advanced Nurse Practitioner, Emergency Room - "Can women identify their fertile period during the menstrual cycle?"
- Shani Tatton, Embryology STP – "Development of a traffic light system for retrospective use and as a prognostic tool".
- Olivia Sanys, Andrology STP – "Can the MiOXSYS™ improve the diagnostic accuracy of routine semen analysis at the Hewitt Fertility Centre?"
- Sofya Mahmud, Embryology STP – "Validation of computer-assisted algorithms using Artificial Intelligence (AI) for embryo selection".
- Lowri Underhill, Embryology STP- "Have clinical outcomes improved following changes to vitrification/warming at the Hewitt Fertility Centre?" +
- Bethany Muller, Embryology STP – "Assessment of insemination concentration for conventional in vitro fertilisation".
- Tamanda Timvere-Hartley, Andrology STP – "Introduction and use of Computer Aided Semen Analysis (CASA) in therapeutic semen analysis at the Hewitt Fertility Centre"

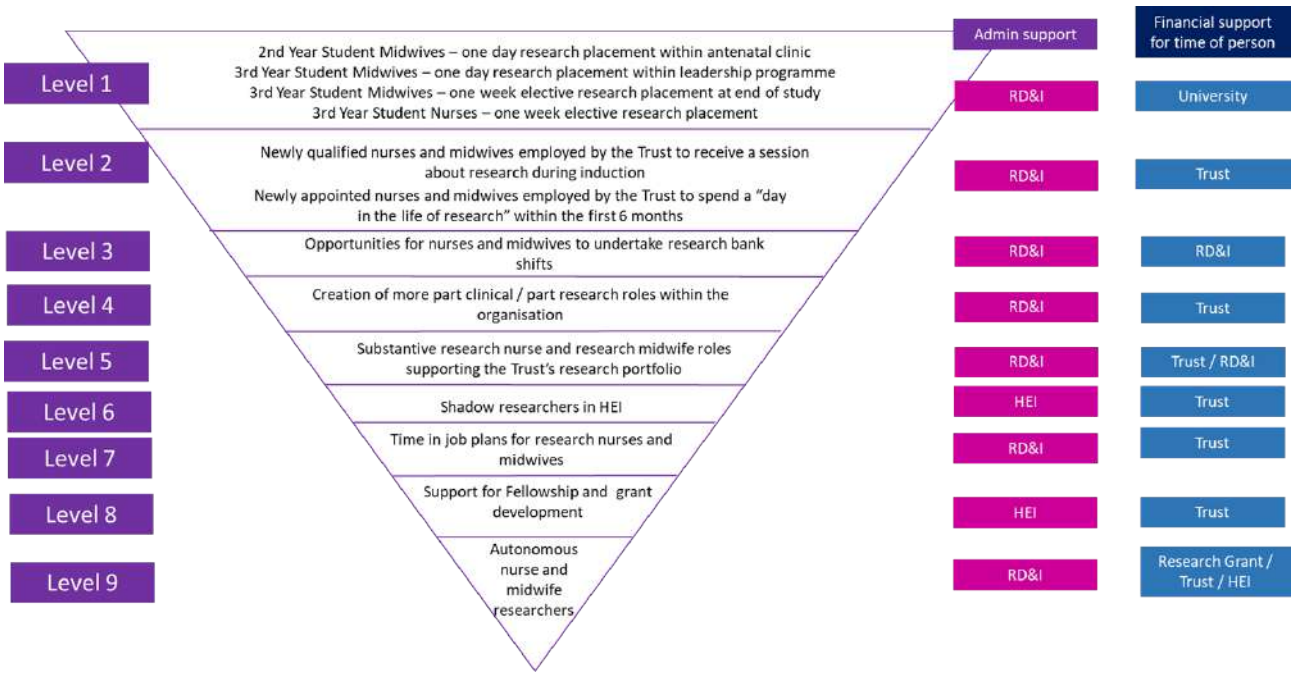
- Jane Wilson, Delivery Suite midwife has embarked on a PhD with LJMU, supported by Professor Andrew Weeks and Dr Gillian Fowler. The aim is to develop a pilot study comparing healing and pain outcomes at 7 days postnatally when the Hegenberger speculum is used, compared with traditional care.

Following their work on the ASPIRE (Achieving Safe and Personalised maternity care In Response to Epidemics) study, the Trust's team of Research Midwives published an article in "The Practising Midwife". As described within the article, their day-to-day role as research midwives working on NIHR portfolio studies, presents limited opportunity to engage with

qualitative research. ASPIRE gave them the chance to refresh their knowledge and learn new skills, and encouraged them to seek more midwifery-led, qualitative projects in the future.

Following suspension during the COVID-19 pandemic, the research and development department has re-commenced making arrangements to host student research midwives and nurses within a dedicated research placement. By sensitising these students to research within their training, it will thus help develop potential researchers of the future.

One of the remits of the RD&I Sub-Committee has been the development of the **"Nurse and Midwife – Talent Pipeline Plan on a Page".**



Its aim is to proactively nurture and support nurses and midwives from when they are students through their formative career years in order to give some individuals the opportunity and desire to become autonomous researchers.

This aspirational plan was ratified by the RD&I Sub-Committee and a business case will be submitted to the Trust for negotiation during 2022/23.

5. Opportunities for Strengthening RD&I Across the Trust

There is scope to strengthen research, development and innovation within each Division by instituting RD&I leads within each clinical area. Regular review of divisional reports by the R&D Sub-Committee and the Quality Committee will ensure oversight of progress within each area.

In order to increase capacity and strengthen the support for the delivery of research across the Trust, continued and increased collaboration with the Harris–Wellbeing Preterm Birth Centre / Centre for Women's Health Research should be encouraged. A number of activities can be successfully and conveniently supported, all to the Trust's benefit, for example:

- Management and coordination of RD&I studies and evaluations led by the Trust, ensuring adherence to research governance and quality assurance requirements
- Management of RD&I data within the Trust and beyond, particularly building upon the work of CIPHA (Combined Intelligence for Population Health Action)

The Trust needs to develop a comprehensive approach to innovation. Effective innovation will need to combine expertise in commercial processes, market assessment, intellectual property, patents etc and integrate with three essential components:

- Identification of clinical needs
- Effect product development
- Deployment of products into clinical practice

At present the Trust provides support for product development by buying in expertise for commercial processes, intellectual property etc, and so there is a need to upgrade this approach, for example:

- Undertaking scoping opportunities within the organisation, with a realistic assessment of likelihood of clinical impact and commercial success
- Identifying the Trust's appetite for novelty, investment, and risk
- Specifying the Trust's preferences for in-house expertise, outsourcing, and collaboration – and then identifying and deploying the resources to meet these requirements

6. Report Conclusions

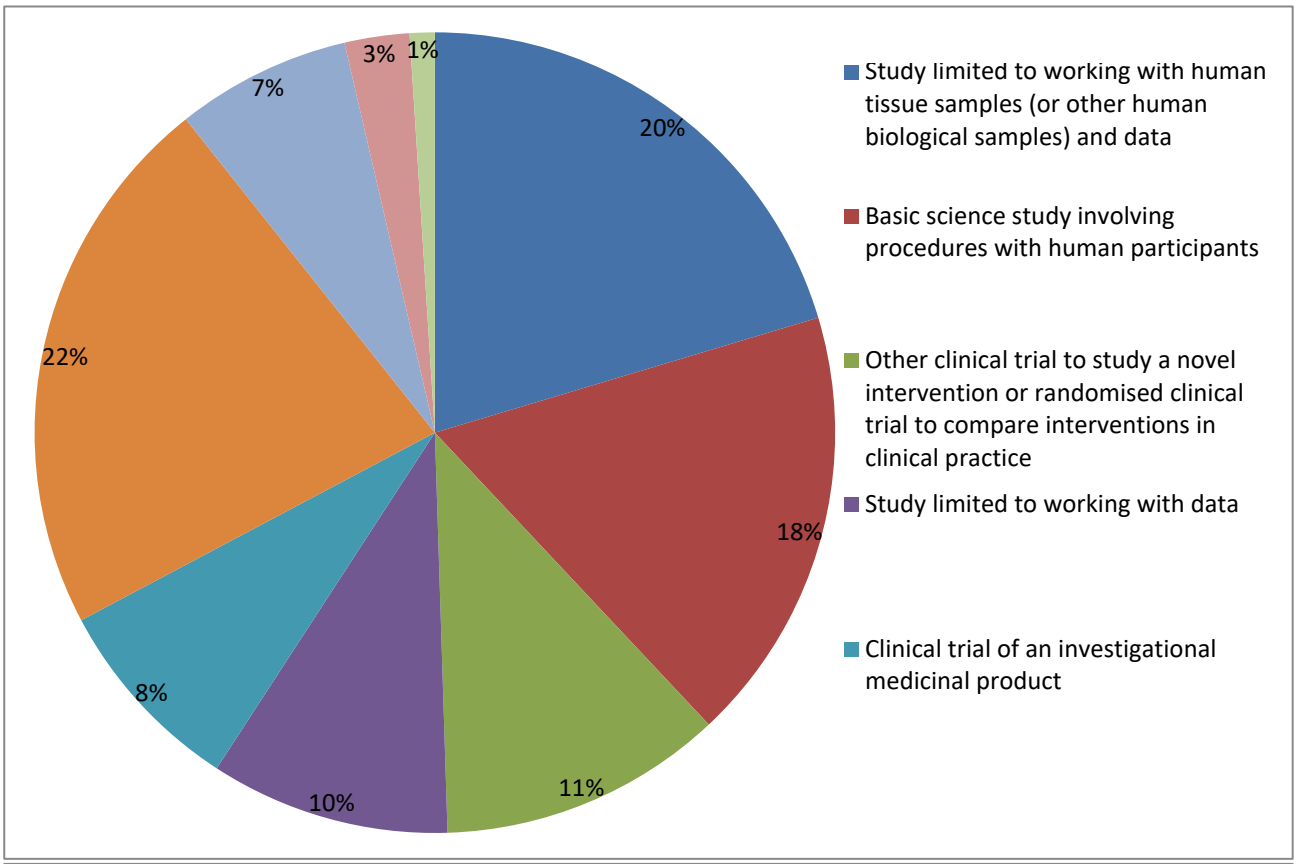
Research continues to demonstrate favourable outcomes to the Trust, its staff and its patients. The governance arrangements for research within the Trust are operating well. Good management of research performance has produced measurable results which must be maintained in order to maximise the benefit of external support. Positive improvements continue to be made in accordance with the overarching Trust research strategy.

External partnerships can be demonstrated as being very helpful in driving forward the Trust's own research agenda. In particular, partnerships with Higher Education Institutes continues to be an effective way to host high quality, high impact research. Therefore, efforts should be made to maintain and increase such collaborations.

Although the implementation of the City-wide joint research service has been at times challenging, by actively engaging and driving forward discussions and decisions, the changes have enabled and strengthened the Trust's ability to deliver and lead research. As evidenced by the City-wide response to the COVID-19 pandemic, lessons can be learned, and experience built upon to improve collaboration and achieve the Trust's own research aims.

APPENDIX 1 – Additional Information

Tables 1 & 2 – Projects active at LWH by study type



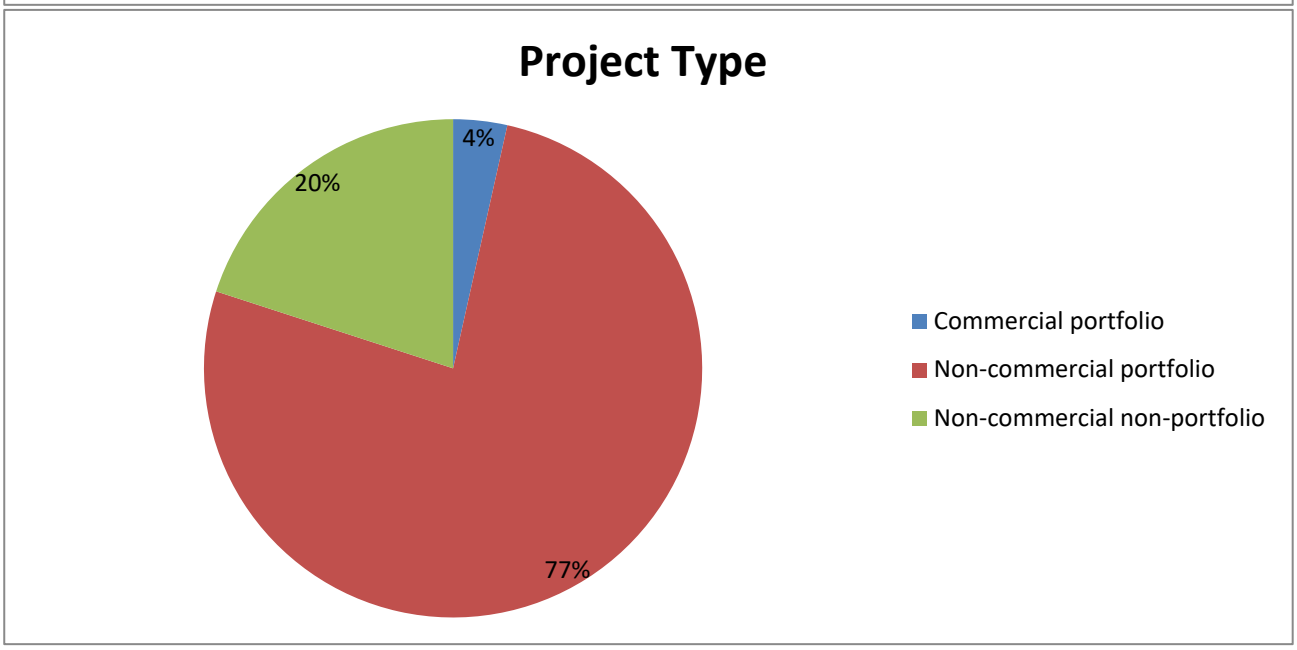
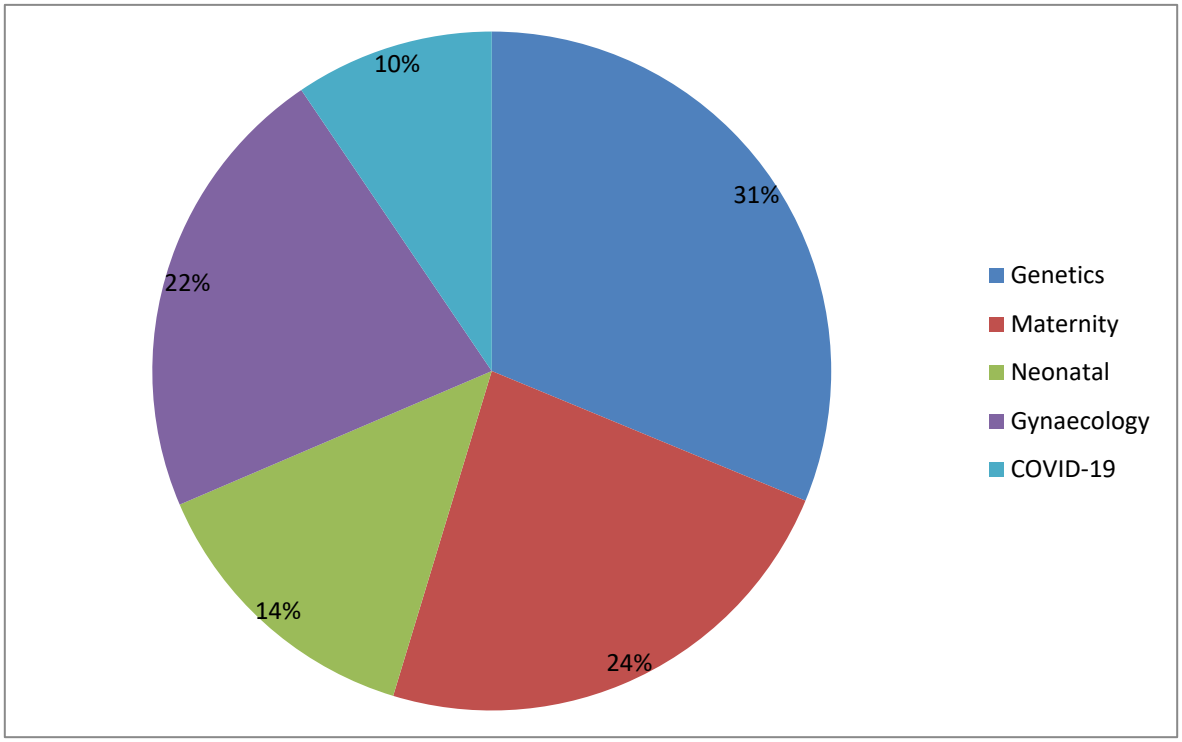


Table 3 – Studies by speciality at LWH



Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	***22/23/102***		**Date: 01/09/2022**	
Report Title	**Corporate Governance Manual – 2022 Update**			
Prepared by	***Mark Grimshaw, Trust Secretary***			
Presented by	***Mark Grimshaw, Trust Secretary***			
Key Issues / Messages	***For the Board to approve the proposed amendments to the Trust's Corporate Governance Manual.***			
Action required	**Approve ☒**	**Receive ☐**	**Note ☐**	**Take Assurance ☐**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	***To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it***	***For the intelligence of the Board / Committee without in-depth discussion required***	***To assure the Board / Committee that effective systems of control are in place***
	Funding Source (If applicable): N/A			
	For Decisions - in line with Risk Appetite Statement – Y ***If no – please outline the reasons for deviation.***			
	The Board is asked to approve the amendments made to the Corporate Governance Manual from July 2021 to date.			
Supporting Executive:	***Mark Grimshaw, Trust Secretary***			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 5.2 Failure to fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership	Comment:
Link to the Corporate Risk Register (CRR) – CR Number: N/A	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome

Liverpool Women's NHS Foundation Trust

Audit Committee – July 2022 – amendments recommended to the Board.

EXECUTIVE SUMMARY

Amendment to the Corporate Governance Manual was last presented and agreed at the Board in September 2021.

A review of the document has been undertaken with input from the Trust Secretary, Finance Team and Head of Procurement.

Amendments to the document are shown utilising track changes.

MAIN REPORT

The following table provides a summary of the amendments that have been made to the Manual since July 2021:

Version control		
Section	**Changes made**	**Date**
Throughout	**Updates post exit from the EU reflected throughout the document**	**July 2022**
4.0	**Approved committee membership and terms of reference added.**	**July 2022**
6.27.11.10.9	**Instances where formal competitive tendering or competitive quotation is not required updated**	**July 2022**

Areas to note

Communication of changes to the Corporate Governance Manual

In line with the procedure for amending the manual, it is incumbent on the Chief Executive and the Trust Secretary to ensure that all directors, governors and Trust staff are made aware of the manual and their responsibilities in respect of it. A key part of this is to ensure that an up-to-date version of the manual will always be available on the Trust's intranet and website.

As noted in last year's update, there is recognition that the Corporate Governance Manual can be an unwieldy document to access and understand. The Procurement Team have developed a 'Procurement Manual' which enables quick access to specific items of information. Please see the 'Supporting Documents' folder for this document (available to Committee members).

The Procurement Team have also committed to providing a brief overview of key issues relating to the SFIs to each Divisional Board and to the corporate areas over the next few months.

Charitable Funds and SFIs

An issue was raised at a recent Charitable Funds Committee relating to the appropriate decision-making route for assets / goods held by the Charity that cannot be utilised and are therefore donated or reappropriated to alternative charities / causes. The specific example discussed related to items donated to the 'little woolens' shop that could not be sold by the Trust and had therefore been donated to the Ukraine appeal. It was suggested that the decisions around such goods should be clarified with additional rules of delegation articulated if required.

There is no current provision relating to this issue in the Scheme of Reservation and Delegation. However, the management of all funds and assets of the Charity are the responsibility of the Corporate Trustee, and this responsibility is currently delegated to the Charitable Funds Committee. For the issue in question, it is suggested that the most appropriate action would be to draft a disclaimer to confirm that any donations that cannot be utilised by the Charity will be disposed of in the most appropriate way i.e., donated to alternative causes if appropriate. This would follow the process that the Trust currently has in place for assets such as equipment and PPE that the Trust cannot use but can still serve an alternative purpose. It was suggested that creating further rules of delegation and decision-making gateways would be unnecessary – a view that the Audit Committee concurred with.

Recommendation

The Board is asked to approve the amendments made to the Corporate Governance Manual from July 2021 to date.

Liverpool Women's
NHS Foundation Trust

This is how we do it ….

Corporate Governance Manual

July 2022~~1~~
V1~~0~~.0

Version control			
Version	**Section**	**Changes made**	**Date**
11.0	**Throughout**	**Updates post exit from the EU reflected throughout the document**	**July 2022**
11.0	**4.0**	**Approved committee membership and terms of reference added.**	**July 2022**
11.0	**6.27.11.10.9**	**Instances where formal competitive tendering or competitive quotation is not required updated**	**July 2022**
10.0	**Throughout**	**Public Contracts Regulations 2015 to the procurement of services and supplies threshold changed to £122,976 rather than £189,330.**	**August 2021**
10.0	**Throughout**	**Removal of references to 'OJEU'**	**August 2021**
10.0	**5.0, Table A**	**TABLE A – Delegated Authority** • **Removal of Head of Estates – replaced where appropriate with Director of Estates** • **19c – removal of references to outdated legislation** • **35a – inclusion of the ability of Executives to nominate a Deputy to enter the Trust into contracts.** • **35c – addition of Divisional Managers as having operational responsibility to nominate officers to oversee and manage contracts on behalf of the Trust** • **35h – removed – duplication with 35g**	**July 2021**
10.0	**Throughout**	**References to 'CONCODE' removed throughout the document.**	**July 2021**
10.0	**4.1**	**Updated Committee Structures**	**July 2021**
10.0	**3.3.4**	**References to Nominations Committee (Executive Directors) and the Remuneration and Terms of Service Committee and replaced by Nomination & Remuneration Committee**	**July 2021**
10.0	**Throughout**	**Alignment with new Corporate branding**	**July 2021**
10.0	**Throughout**	**Change of job titles:** • **Director of Finance changed to Chief Finance Officer**	**July 2021**

		• **Director of Nursing & Midwifery to Chief Nurse & Midwife**	
10.0	**4.0**	**Approved committee membership, Committee Structure and terms of reference added.**	**July 2021**
9.0	**6.15.1.3**	**Reference to Nomination & Remuneration Committee updated to align with updated Nomination & Remuneration Committee Terms of Reference.**	**September 2020**
9.0	**8.0**	**Board Code of Conduct Updated**	**September 2020**
8.0	**6.0 (6.27.1.6.6)**	**Reasons for a single tender action to be reported to the Audit Committee and through the Board of Directors in the Chair's Report.**	
8.0	**6.0 (6.27.1.6.6)**	**All requests to waive tenders to the Audit Committee quarterly and not directly to the Board of Directors**	**July 2020**
8.0	**5.0, Table B**	**OJEU threshold updated from £181,302 to &189,330**	**July 2020**
8.0	**5.0, Table B (4)**	**Provision 'Requisitioning stock and non-stock items / services against a budget, in line with EU procurements thresholds (subject to periodic review) and quotation and tendering procedures set out under Section 6' amended to 'Approving requisitions, authorising invoices and recommending contract awards'.**	**July 2020**
8.0	**5.0, Table A (35, h)**	**Removal of the provision - 'Decide if late tenders should be considered'.**	**July 2020**
8.0	**5.0, Table A (35, a)**	**Provision added – 'Entering into contracts on behalf of the Trust, regardless of value'**	**July 2020**
8.0	**5.0, Table A (35, b)**	**Removal of Head of Estates from Operational Responsibility**	**July 2020**
8.0	**5.0, Table A (30, e)**	**Insertion of '…in line with national requirements' following the 'prompt payment of accounts' section**	**July 2020**
8.0	**5.0, Table A (34, w)**	**Authority to authorise overtime – limited to Clinical Directors and Chief Operating Officer. To encourage preferred option of utilising the Bank rather than overtime.**	**July 2020**
8.0	**5.0, Table A (34, nn)**	**Authorisation of extensions of contract beyond normal retirement age in exceptional circumstances – provision removed.**	**July 2020**
8.0	**5.0, Table A (34, x)**	**Reference 'authorised approvers' in place of budget holders.**	**July 2020**
8.0	**5.0, Table A (34, k)**	**Addition of '…at recruitment stage' to the provision of the granting of additional increments.**	**July 2020**

8.0	**5.0, Table A (34, q)**	**Remove section on 'Authorise car users' – Trust no longer has a car lease scheme.**	**July 2020**
8.0	**5.0, Table A (34, p)**	**Renewal of fixed term contract – role of Vacancy Control Panel stated.**	**July 2020**
8.0	**5.0, Table A (17, l)**	**Reference to 'All corporate posts to be reviewed by the Vacancy Control Panel and all clinical posts by the Executive team' added to operational responsibility.**	**July 2020**
8.0	**5.0, Table A (33, c)**	**Operational responsibility for Informing staff of their duties in respect of patients' property noted as being Head of Governance and Quality rather than Head of Legal Services.**	**July 2020**
8.0	**5.0, Table A (34, i)**	**Removal of line managers from being authorised to book agency staff. In relation to Nursing and Midwifery agency staff, line managers to be replaced with Heads of Nursing / Midwifery.**	**July 2020**
8.0	**5.0, Table A (34, i)**	**Deputy Chief Nurse and Midwife or Matron listed as having operational responsibility for approving bank usage.**	**July 2020**
8.0	**5.0, Table A (17, i)**	**Responsibility to Identify and implement cost improvements and income generation activities in line with the Operational Plan identified as being all budget holders.**	**July 2020**
8.0	**5.0, Table A (throughout)**	**References to 'business plan' removed from budget section and replaced with operational plan.**	**July 2020**
8.0	**5.0, Table A (17, b)**	**Operational responsibility for budget submissions to the Board identified as Deputy Chief Finance Officer (from Chief Finance Officer)**	**July 2020**
8.0	**5.0, Table A (throughout)**	**Removal of reference to Corporate Administration Manager**	**July 2020**
8.0	**5.0, Table A**	**Caldicott Guardian changed from Chief Nurse and Midwife to Medical Director**	**July 2020**
8.0	**5.0, Table A (throughout)**	**Removal of references to Hewitt Centre Managing Director**	**July 2020**
8.0	**Throughout**	**Change of job titles:** • **Director of Operations changed to Chief Operating Officer** • **Director of Workforce & Marketing to Chief People Officer**	**July 2020**
8.0	**4.2**	**Trust Board Terms of Reference added**	**July 2020**
8.0	**4.0**	**Approved committee membership, Committee Structure and terms of reference added.**	**July 2020**

7.0	**4.0**	**Approved committee membership, Committee Structure and terms of reference added.**	**July 2019**
7.0	**5.0, Table A**	**Section 13 - Conflicts of interest definition of decision-making staff in compliance of the Trust's policy 'Managing conflicts of Interest'**	**July 2019**
7.0	**5.0, Table A**	**Section 22 – Gifts and Hospitality- Threshold increased in line with the Trust Policy 'Managing conflict of Interest' from £25 to £50.**	**July 2019**
6.0	**4.0**	**Approved committee membership and terms of reference added.**	**05.07.18**
5.2	**5.0 Table B**	**OJEU threshold has changed and been updated. Threshold value amended from £164,176 (ex VAT) to £181,302 (ex VAT).**	**09.01.2018**
5.1	**4.0**	**Change of name of Governance and Clinical Assurance Committee to the Quality Committee** **Amended Terms of Reference of the Quality Committee and Remuneration and Nominations Committee** **Amended Integrated Structure Charts**	**08.01.2018**
4.1	**4.0**	**Board approved Terms of reference added**	**07.07.17**
	Table B – Delegated Financial Limits	**Threshold value amended from £172,514 ex VAT when in fact it should be £164,176 ex VAT.**	**15.06.17**
4.0	**4.0**	**Board approved Terms of reference added**	**30.01.17**
	5.0	**Table B – Delegated Financial Limits**	**30.01.17**
	6.0	**Amendments to Standing Financial Instructions.**	**30.01.17**
	All	**Changes to names throughout the document, i.e. Trust regulator name, job titles of directors, heads of departments.** **Full reformat required to provide consistency.**	**30.01.17**
3.0	**4.0 Terms of reference**	**Board approved Terms of reference added**	**27.07.15**
	Table A	**Amended job titles of Directors.** **Amended waiving requirements to include delegated authority to authorise the use of a waiver.** **Amended thresholds to reflect the revised EU threshold.**	**27.07.15**
	6.0	**Prudential Borrowing Code removed as is no longer a requirement** **The approval limits for Charitable Expenditure updated.**	**27.07.15**
2.0	**4.0 Terms of reference**	**Board approved Terms of reference added**	**03.10.14**

1.1	**6.12.3 6.13.3.2 Table A Table B**	**Minor amendments approved by Board of Directors in April 2014.**	**05.04.14**

Contents

1. Foreword

1.1. Liverpool Women's NHS Foundation Trust (the Trust) is a public benefit corporation that was established in accordance with the provisions of the National Health Service Act 2006. As a body corporate the Trust has specific powers to contract in its own name and to act as a corporate trustee.

1.2. Corporate governance is the system by which an organisation is directed and controlled, at its most senior levels, in order to achieve its objectives and meet the necessary standards of accountability and probity. Effective corporate governance, along with clinical governance, is essential for a Foundation Trust to achieve its clinical, quality and financial objectives. Fundamental to effective corporate governance is having the means to verify the effectiveness of this direction and control. This is achieved through integrated governance.

1.3. The NHS Act 2006 and subsequent regulations set out the legal framework within which the Foundation Trust operates. The Trust's Constitution sets out who can be members of the Foundation Trust and how it should conduct its business. The Licence is provided by NHS Improvement (the independent regulator of Foundation Trusts) and identifies the conditions of operation. The Accounting Officer Memorandum requires Foundation Trust Boards of Directors to adopt schedules of reservation and delegation of powers and to set out the financial framework within which the organisation operates.

1.4. This corporate governance manual comprises:

- Schedule of matters reserved to the Board of Directors
- Matters delegated by the Board of Directors to its committees
- Scheme of delegation
- Standing Financial Instructions
- Standing Orders for the Board of Directors
- Code of Conduct for the Board of Directors
- Council of Governors' Code of Conduct
- Code of Conduct for NHS Managers
- Standards of Business Conduct for NHS Staff
- Standing Orders for the Council of Governors.

1.5. Compliance with these documents is required of the Foundation Trust, its Executive and Non-Executive Directors, Governors, officers and employees, all of whom are also required to comply with:

- The Trust's Constitution and Provider Licence
- The Accounting Officer Memorandum.

1.6. The Trust must also have agreed its own Standing Orders as a framework for internal governance. Standing Orders for both the Board of Directors and Council of Governors are included in this corporate governance manual.

1.7. All of the above-mentioned documents together provide a regulatory framework for the business conduct of the Foundation Trust.

1.8. The Foundation Trust Board of Directors also has in place Audit, Nomination and Remuneration committees and an established framework for managing risk.

1.9. It is essential that all Directors, Governors, officers and employees know of the existence of these documents and are aware of their responsibilities include within. A copy of this

manual is available on the Trust's website and intranet and has been explicitly brought to the attention of key staff within the organisation and to all staff via the internal communication routes.

1.10. Any queries relating to the contents of these documents should be directed to the Chief Finance Officer, Trust Secretary or myself who will be pleased to provide clarification.

Kathryn Thomson
Chief Executive
July 2022~~1~~

2. Definition and interpretation

2.1. Unless the contrary intention appears or the context otherwise requires, words or expressions contained in this corporate governance manual bear the same meaning as in the NHS Act 2006 and the Constitution. References to legislation include all amendments, replacements, or re-enactments made.

2.2. Headings are for ease of reference only and are not to affect interpretation. Words importing the masculine gender only shall include the feminine gender; words importing the singular shall include the plural and vice-versa.

2.3. In this corporate governance manual, the following definitions apply:

	Definition
The 2012 Act	The Health and Social Care Act 2012
The 2006 Act	The National Health Service Act 2006
The 1977 Act	The National Health Service Act 1977
Accounting Officer	The person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act; they shall be the Officer responsible and accountable for funds entrusted to the Foundation Trust in accordance with the NHS Foundation Trust Accounting Officer Memorandum. They are responsible for ensuring the proper stewardship of public funds and assets. The NHS Act 2006 designates the Chief Executive of the NHS Foundation Trust as the Accounting Officer
Agenda Item	• Board of Directors - an item from a Board member (notice of which has been given) about a matter over which the Board has powers or duties or which affects the services provided by the Foundation Trust • Council of Governors – an item from a Governor or Governors (notice of which has been given) about a matter over which the Council has powers or duties or which affects the services provided by the Foundation Trust
Appointing organisations	Those organisations named in the constitution who are entitled to appoint governors
Authorisation	An authorisation given by NHS Improvement under Section 35 of the 2006 Act
The Board	The Board of Directors of the Foundation Trust as constituted in accordance with the Trust's constitution
Bribery Act	The Bribery Act 2010
Budget	A resource, expressed in financial or workforce terms, proposed by the Board of Directors for the purpose of carrying out, for a specific period, any or all of the functions of the Foundation Trust
Budget holder	The Director or employee with delegated authority to manage finances (income and expenditure) for a specific area of the organisation
The Chair	Is the person appointed by the Council of Governors to lead the Board and ensure it successfully discharges its overall responsibility for the Foundation Trust as a whole. It means the Chair of the Foundation Trust, or, in relation to the

	Definition
	function of presiding at or chairing a meeting where another person is carrying out that role as required by the Constitution, such person
Chief Executive	The chief officer of the Foundation Trust
Committee	A committee or subcommittee created and appointed by the Foundation Trust
Constitution	The constitution of the Foundation Trust as amended from time to time. Describes the type of organisation, its primary purpose, governance arrangements and membership
Contracting and procuring	The systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets
Council of Governors	The Council of Governors of the Foundation Trust as constituted in accordance with the Trust's constitution
Director	A member of the Board of Directors
Chief Finance Officer	The chief finance officer of the Foundation Trust
External auditor	The person appointed to audit the accounts of the Foundation Trust, who is called the auditor in the 2006 Act
Financial year	Successive periods of twelve months beginning with 1 April
Foundation Trust	Liverpool Women's NHS Foundation Trust
Foundation Trust contract	Agreement between the Foundation Trust and Clinical Commissioning Groups and/or others for the provision and commissioning of health services
Funds held on Trust	Those trust funds which the Foundation Trust holds at its date of incorporation, receives on distribution by statutory instrument, or chooses subsequently to accept under powers derived under the 2006 Act. Such funds may or may not be charitable
Governor	An elected or appointed member of the Council of Governors
Legal advisor	A properly qualified person appointed by the Foundation Trust to provide legal advice
Licence	The document issued by the sector regulator setting out the conditions of operation for a Foundation Trust
NHS Improvement (previously known as Monitor)	The independent regulator (NHS Improvement) took over the responsibilities of its predecessors responsibilities from [1 April 2016] NHS Improvement became part of NHS England in July 2022.
Meeting	• Board of Directors – a duly convened meeting of the Board of Directors • Council of Governors - a duly convened meeting of the Council of Governors
Member	A member of the Foundation Trust
Motion	A formal proposition to be discussed and voted on during the course of a meeting
Nominated Officer	An officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions

	Definition
Non commissioner contract	Agreements with non Clinical Commissioning Group t organisations covering the variety of services that the Foundation Trust provides and charges for
Officer	An employee of the Foundation Trust
Partner	In relation to another person, a member of the same household living together as a family unit
Protected property	Property identified in the Licence as being protected. This will generally be property that is required for the purposes of providing the mandatory goods and services and mandatory training and education
Registered medical practitioner	A fully registered person within the meaning of the Medicines Act 1983 who holds a licence to practice under that Act
Registered nurse or midwife	A nurse, midwife or health visitor registered in accordance with the Nurses, Midwives and Health Visitors Act 1997
Secretary	The Secretary appointed under the constitution, the Secretary of the Foundation Trust or any other person appointed to perform the duties of the Secretary, including a joint, assistant or deputy secretary
Standing Financial Instructions	(SFIs) regulate the conduct of the Trust's financial matters
Standing Orders	(SOs) incorporate the Constitution and regulate the business conduct of the Foundation Trust

3. Schedule of matters reserved to the Board of Directors

3.1. General enabling provisions

3.1.1. The Board of Directors may determine any matter it wishes, for which it has authority, in full session within its statutory powers. In accordance with the Code of Conduct and Accountability adopted, the Board explicitly reserves that it shall itself approve or appraise, as appropriate, the following matters detailed in paragraph 3.3 below. All Board members share corporate responsibility for all decisions of the Board and the Board remains accountable for all of its functions, even those delegated to individual committees, subcommittees, directors or officers.

3.2. Duties

It is the Board's duty to:

- Act within statutory financial and other constraints
- Be clear what decisions and information are appropriate to the Board of Directors and draw up Standing Orders, a schedule of decisions reserved to the Board and Standing Financial Instructions to reflect these
- Ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives for the main programmes of action and for performance against programmes to be monitored and senior executives held to account
- Establish performance and quality measures that maintain the effective use of resources and provide value for money;
- Specify its requirements in organising and presenting financial and other information succinctly and efficiently to ensure the Board can fully undertake its responsibilities;
- Establish Audit and Remuneration Committees on the basis of formally agreed terms of reference that set out the membership of the sub-committee, the limit to their powers, and the arrangements for reporting back to the main Board.

3.3. Reserved matters

3.3.1. Standing Orders

Approval of and changes to Board standing orders.

3.3.2. Matters of Governance

- Approval of and changes to the schedule of matters reserved to the Board of Directors
- Approval of and changes to the standing financial instructions
- Suspension of Board standing orders
- Ratify or otherwise instances of failure to comply with standing orders brought to the Chief Executive's attention in accordance with Standing Orders
- Ratification of any urgent decisions taken by the Chair and Chief Executive, in accordance with the standing orders
- Approval of and changes to codes of conduct
- Approval of the Trust's risk assurance framework
- Approval of the Board's scheme of reservation and delegation
- Adoption of the organisational structures, processes and procedures to facilitate the discharge of business by the Foundation Trust and approval of any changes
- Approval of the remit and membership of Board committees, including
- Approval of terms of reference and reporting arrangements of all committees and sub-committees that are established by the Board of Directors
- To confirm the recommendations of committees where they do not have executive powers

- To receive reports from committees including those which the Foundation Trust is required by the National Health Service Act 2006 or other regulation to establish and to take appropriate action thereon
- Audit arrangements
- Clinical audit arrangements
- The annual audit letter
- Annual report (including quality report/accounts) and statutory financial accounts of the Trust
- Annual report and accounts for funds held on trust (charitable funds)
- Approval of arrangements relating to the discharge of the Foundation Trust's responsibilities as a corporate trustee for funds held on trust
- Approval of arrangements relating to the discharge of the Foundation Trust's responsibilities as a bailer for patients' property
- Disciplining Board members or employees who are in breach of statutory requirements or Standing Orders.

3.3.3. Important regulatory matters

- Compliance with the Trust's Licence or any document which replaces it, its constitution, and all statutory and regulatory obligations
- Directors' and officers' declaration of interests and determination of action if required
- Arrangements for dealing with complaints
- Disciplinary procedures for officers of the Trust.

3.3.4. Appointments and dismissals

- Appointment and dismissal of committees (and individual members) that are directly accountable to the Board of Directors excluding the Audit Committee, the Nomination & Remuneration Committee. This does not imply that individual members of all Committees can be dismissed
- Appointment, appraisal, disciplining and dismissal of Executive Directors
- Confirm the appointment of members of any committee of the Foundation Trust as representatives on outside bodies
- Appoint, appraise, discipline and dismiss the Trust Secretary
- Approve proposals received from the Nomination & Remuneration Committee regarding the Chief Executive, Directors and senior employees.

3.3.5. Strategic direction

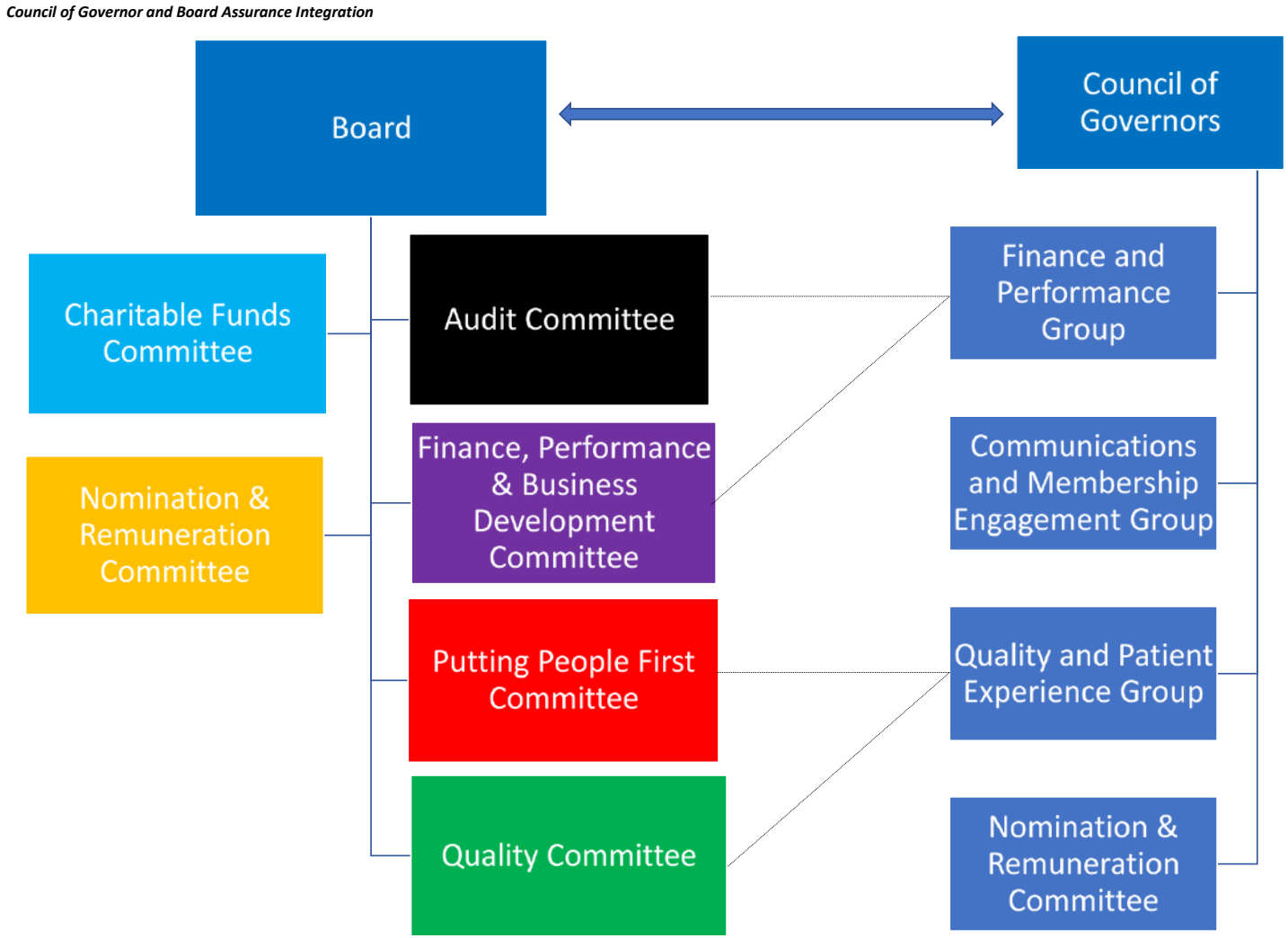
- Strategic aims, direction and objectives of the Foundation Trust
- Financial plans and forecasts
- Approval of the Trust's annual plan, strategic developments and associated business plans
- Approval of annual revenue and capital budgets
- Approval of all Trust strategies to include, but not be limited to the risk management strategy and human resources strategy
- Approval of capital plans including:
    - Proposals for acquisition, disposal or change of use of land and/or buildings
    - Private finance initiative (PFI) proposals
    - Individual contracts, including purchase orders of a capital or revenue nature in accordance with Delegated Financial Limits, Table B, section 2.
- Approve proposals for action on litigation against or on behalf of the Foundation Trust where the likely financial impact is as shown in the Delegated Financial Limits, Table B, section 2 or contentious or likely to lead to extreme adverse publicity, excluding claims covered by the NHS risk pooling schemes.

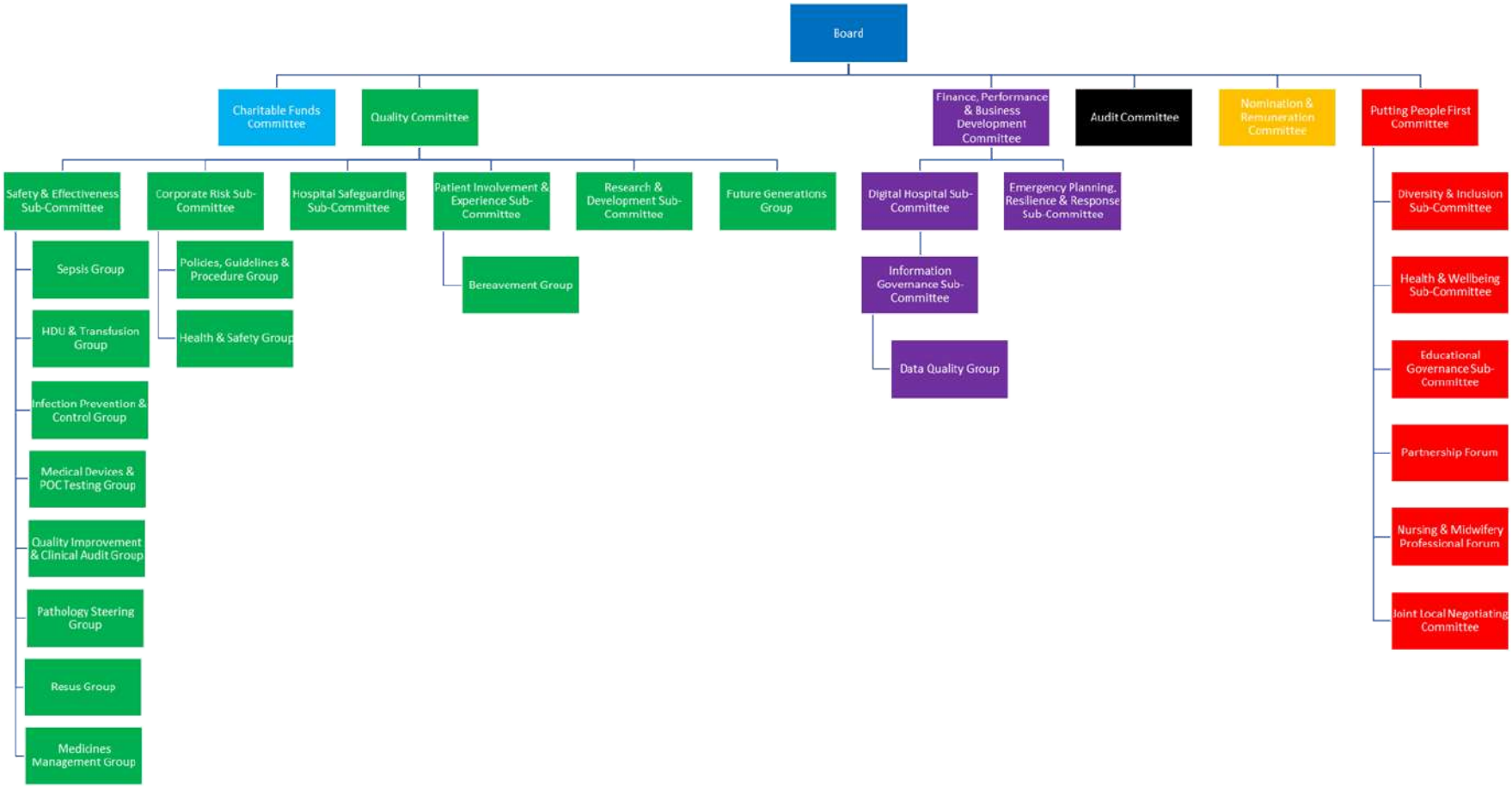
3.3.6. Monitoring performance
Operational and financial performance arrangements at intervals that it shall determine.

3.3.7. Other matters
- Appointment of bankers
- Approve the opening of bank accounts.
- Approve individual compensation payments.

4. Matters delegated by the Board of Directors to its committees

4.1. Committee Structure




Board
Charitable Funds Committee
Quality Committee
Finance, Performance & Business Development Committee
Audit Committee
Nomination & Remuneration Committee
Putting People First Committee
Safety & Effectiveness Sub-Committee
Corporate Risk Sub-Committee
Hospital Safeguarding Sub-Committee
Patient Involvement & Experience Sub-Committee
Research & Development Sub-Committee
Future Generations Group
Digital Hospital Sub-Committee
Emergency Planning, Resilience & Response Sub-Committee
Diversity & Inclusion Sub-Committee
Sepsis Group
Policies, Guidelines & Procedure Group
Bereavement Group
Information Governance Sub-Committee
Health & Wellbeing Sub-Committee
HDU & Transfusion Group
Health & Safety Group
Data Quality Group
Educational Governance Sub-Committee
Infection Prevention & Control Group
Partnership Forum
Medical Devices & POC Testing Group
Nursing & Midwifery Professional Forum
Quality Improvement & Clinical Audit Group
Pathology Steering Group
Joint Local Negotiating Committee
Resus Group
Medicines Management Group

Board Committee Non-Executive Director membership.

For additional members please refer to TORs.

Board Committee	NED Membership
Audit Committee *Membership requirement is not less than 3 Non-Executive Directors*	Chair: Tracy Ellery NED: Zia Chaudhry MBE NED: Jackie Bird MBE Accountable exec: Chief Finance Officer
Finance Performance and Business Development Committee *Membership includes NED Chair and one additional NED* *Additional NED for succession/continuity/ development*	Chair: Louise Martin NED: Sarah Walker NED: Tracy Ellery Accountable exec: Chief Finance Officer
Quality Committee *Membership includes NED Chair and one additional NED* *Additional NED for succession/continuity/ development*	Chair: Sarah Walker NED: Jackie Bird MBE NED: Gloria Hyatt MBE NED: Louise Kenny CBE Accountable exec: Chief Nurse and Midwife & Medical Director
Putting People First Committee *Membership includes NED Chair and one additional NED* *Additional NED for succession/continuity/ development*	Chair: Gloria Hyatt NED: Zia Chaudhry MBE NED: Louise Martin Accountable exec: Chief People Officer
Charitable Funds Committee *Membership includes NED Chair and one additional NED* *Additional NED for succession/continuity/ development*	Chair: Tracy Ellery NED: Louise Martin Accountable exec: Chief Finance Officer
Board Nomination and Remuneration Committee *Membership includes Chair and all NED's*	Chair: Robert Clarke NED: Tracy Ellery Louise Martin Louise Kenny CBE Zia Chaudhry MBE

	Gloria Hyatt MBE Sarah Walker Jackie Bird MBE

4.2. Board of Directors Terms of Reference

BOARD OF DIRECTORS TERMS OF REFERENCE	
Role and Purpose:	The Terms of Reference describe the role and working of the Board of Directors (hereafter referred to as the Board) and are for the guidance of the Board, for the information of the Trust as a whole and serve as the basis of the Terms of Reference for the Board's own Committees. The Trust exists to 'provide goods and services for any purposes related to the provision of services provided to individuals for, or in connection with, the prevention, diagnosis or treatment of illness, and the promotion and protection of public health.' The Trust has a Board which exercises all the powers of the Trust on its behalf, but the Board may delegate any of those powers to a Committee of directors or to the Chief Executive. The Board consists of Executive Directors, one of whom is the Chief Executive, and Non-Executive Directors, one of whom is the Trust Chair. The nominated deputy for the Chief Executive and Trust Chair, upon appointment to a substantive or acting up role, must be formally recorded in the minutes.
Duties:	The Board leads the trust by undertaking four key roles: • setting strategy; • supervising the work of the executive in the delivery of the strategy and through seeking assurance that systems of control are robust and reliable; • setting and leading a positive culture for the Board and the organisation; • giving account and answering to key stakeholders, particularly the Council of Governors. The general duty of the Board of Directors, and of each director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public. Each director also has a duty to avoid conflicts of interest and not to accept benefits from third parties (as well as to declare interests in proposed transactions or arrangements with the Trust). The practice and procedure of the meetings of the Board, and of its committees, are not set out here but are described in the Board's Standing Orders.

GENERAL RESPONSIBILITIES:

The general responsibilities of the Board are:

- to maintain and improve quality of care;
- to work in partnership with service users, carers, local health organisations, local government authorities and others to provide safe, effective, accessible, and well governed services for patients, service users and carers;
- to ensure that the Trust meets its obligations to the population served, its stakeholders and its staff in a way that is wholly consistent with public sector values and probity;
- to ensure relationships are maintained with the Trust's stakeholders, regulators, public, governors, staff and patients, such that the trust can discharge its wider duties;
- to exercise collective responsibility for adding value to the Trust by promoting its success through direction and supervision of its affairs in a cost effective manner;
- to ensure compliance with all applicable law, regulation and statutory guidance.

In fulfilling its duties, the Trust Board will work in a way that makes the best use of the skills of non-executive and executive directors.

LEADERSHIP

The Board provides active leadership to the organisation by:

- ensuring there is a clear vision and strategy for the Trust that is well known and understood by stakeholders and is being implemented within a framework of prudent and effective controls which enable risk to be assessed and managed;
- ensuring the Trust is a good employer by the development of a workforce strategy and its appropriate implementation and operation;
- implementing effective Board and Committee structures and clear lines of reporting and accountability throughout the organisation.

STRATEGY

The Board:

- sets and maintains the Trust's strategic vision, aims and objectives ensuring the necessary financial, physical and human resources are in place for it to meet its objectives;
- determines the nature and extent of the risk it is willing to take in achieving its strategic objectives;

- monitors and reviews management performance to ensure the Trust's objectives are met;
- oversees both the delivery of planned services and the achievement of objectives, monitoring performance to ensure corrective action is taken when required;
- develops and maintains an annual business plan, with due regard to the views of the council of governors, and ensures its delivery as a means of taking forward the strategy of the Trust to meet the expectations and requirements of stakeholders;
- ensures that national policies and strategies are effectively addressed and implemented within the Trust.

CULTURE, ETHICS AND INTEGRITY

The Board:

- is responsible for setting values, ensuring they are widely communicated and adhered to and that the behaviour of the Board is entirely consistent with those values;
- promotes a patient-centred culture of openness, transparency and candour;
- ensures that high standards of corporate governance and personal integrity are maintained in the conduct of foundation trust business.

GOVERNANCE

The Board:

- ensures compliance with relevant principles, systems and standards of good corporate governance and has regard to guidance on good corporate governance and appropriate codes of conduct, accountability and openness applicable to NHS provider organisations;
- ensures that all licence conditions relating to the Trust's governance arrangements are complied with;
- ensures that the Trust has comprehensive governance arrangements in place that guarantee that the resources vested in the Trust are appropriately managed and deployed, that key risks are identified and effectively managed and that the Trust fulfils its accountability requirements;
- ensures that the Trust complies with its governance and assurance obligations in the delivery of clinically effective and safe services taking account of patient and carer experiences and maintaining the dignity of those cared for;
- ensures that all the required returns and disclosures are made to the regulators;

- formulates, implements and reviews standing orders and standing financial instructions as a means of regulating the conduct and transactions of foundation trust business;
- agrees the schedule of matters reserved for decision by the Board of Directors;
- ensures that the statutory duties of the Trust are effectively discharged;
- Acts as corporate trustee for the Trust's charitable funds.

RISK

The Board:

- ensures an effective system of integrated governance, risk management and internal control across the whole of the Trust's clinical and corporate activities;
- ensures that there are sound processes and mechanisms in place to ensure effective user and carer involvement in the development of care plans, the review of quality of services provided and the development of new services;
- ensures there are appropriately constituted appointment and evaluation arrangements for senior positions such as consultant medical staff and those reporting to executive directors.

COMMUNICATION

The Board:

- Ensures an effective communication channel exists between the Trust, its governors, members, staff and the local community.
- Ensures the effective dissemination of information on service strategies and plans and also provides a mechanism for feedback.
- Ensures that those Board proceedings and outcomes that are not confidential are communicated publicly through Board meetings in public and also via the Trust's website.

FINANCIAL AND QUALITY SUCCESS

The Board:

- Ensures that an effective system of finance and quality is embedded within the Trust.
- Ensures that the Trust operates effectively, efficiently and economically.
- Ensures the continuing financial viability of the organisation.
- Ensures the proper management of resources and that financial and quality of service responsibilities are achieved.
- Ensures that the Trust achieves the quality targets and requirements of stakeholders within the available resources.

- Reviews performance, identifying opportunities for improvement and ensuring those opportunities are taken.

RESPONSIBILITIES OF BOARD MEMBERS

All Members of the Board:

- Have joint responsibility for every decision of the Board regardless of their individual skills or status. This does not impact upon the particular responsibilities of the Chief Executive as the Accounting Officer.
- Have a responsibility to constructively challenge during Board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy.

Role of the Trust Chair:

The Trust Chair is the guardian of the Board's decision-making processes and provides general leadership of the Board and the Council of Governors.

- Responsible for leading the Board and for ensuring that it successfully discharges its overall responsibilities for the Trust as a whole.
- Reports to the Board and is responsible for the effective operation of the Board and the Council of Governors.
- Responsible for ensuring that the Board as a whole plays a full part in the development and determination of the Trust's strategy and overall objectives.

Role of the Chief Executive

- The Chief Executive reports to the Trust Chair and to the Board directly. All members of the management structure report either directly or indirectly to the Chief Executive.
- The Chief Executive is responsible to the Board for running the Trust's business and for proposing and developing the Trust's strategy and overall objectives for approval by the Board.
- The Chief Executive is responsible for implementing the decisions of the Board and its Committees, providing information and support to the Board and Council of Governors.

Role of Executive Directors (EDs)

- Share collective responsibility with the Non-Executive Directors as part of a unified Board.
- Shape and deliver the strategy and operational performance in line with the Trust's strategic aims.

Role of Non-Executive Directors (NEDs)

- Bring a range of varied perspectives and experiences to strategy development and decision making.
- Ensure that effective management arrangements and an effective management team are in place.
- Hold the Executive Directors to account for performance of the operational responsibilities.
- Scrutinise the performance of the executive management in meeting agreed goals and objectives, receive adequate information and monitor the reporting of performance. NEDs should satisfy themselves as to the integrity of financial, clinical and other information, and make sure that financial and clinical quality controls, and systems of risk management and governance, are robust and implemented.
- To take an active role in providing advice, support and encouragement to Executive Directors.

Role of the Senior Independent Director (SID)

- Is a Non-Executive Director appointed by the Board in consultation with the Council of Governors to undertake the role. Normally the SID will not be the Vice Trust Chair although this may be the case if the Board deems it necessary.
- Will be available to members of the Foundation Trust and to Governors if they have concerns which, contact through the usual channels of the Trust Chair, Chief Executive, Deputy Chief Executive, Director of Finance and Trust Secretary, has failed to resolve or where it would be inappropriate to use such channels.
- Has a key role in supporting the Trust Chair in leading the Board and acting as a sounding board and source of advice for the Trust Chair. The SID has a role in supporting the Trust Chair in his/her role as Trust Chair of the Council of Governors.

In addition to the duties described here, the SID has the same duties as the other Non-Executive Directors.

Role of the Trust Secretary

The Trust Board shall be supported by the Trust Secretary whose duties in this respect will include:

- agreement of the agenda, for Board and Board committee meetings, with the relevant Chair, in consultation with the Chief Executive;
- collation of reports and papers for Board and committee meetings;
- ensuring that suitable minutes are taken, keeping a record of matters arising and issues to be carried forward;
- ensuring that board procedures are complied with;

	• supporting the Chair in ensuring good information flows within and between the Board, its committees, the Council of Governors and senior management; • advising the Board and Board committees on governance matters; • supporting the chair on matters relating to induction, development and training for directors
Membership:	The composition of the Board shall be: • A Non-Executive Chair • Not more than seven other non-executive Directors • Not more than seven executive Directors including: o The Chief Executive (who is the Accounting Officer) o The Chief Finance Officer o A registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984) o A registered nurse or registered midwife.
Quorum:	Six Directors including not less than three executive Directors (one of whom must be the Chief Executive or another Executive Director nominated by the Chief Executive) and not less than three non-executive Directors (one of whom must be the Chair or the Vice Chair of the Board of Directors) shall form a quorum. An officer in attendance for an executive Director but without formal acting up status may not count towards the quorum. If a Director has been disqualified from participating in a discussion on any matter and/or from voting on any resolution by reason of declaration of a conflict of interest, that Director shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minute of the meeting. The meeting must then proceed to the next business.
Voting:	All questions put to the vote shall, at the discretion of the Chair, be decided by a show of hands save that no resolution of the Board of Directors shall be passed if it is opposed by all of the non-executive Directors present or by all of the executive Directors present. A paper ballot may be used if a majority of the Directors present so request. In case of an equality of votes the Chair shall have a second and casting vote.

	If at least one third of the Board members present so request, the voting on any question may be recorded so as to show how each member present voted or did not vote (except when conducted by paper ballot). If a Board member so requests, her vote shall be recorded by name. In no circumstances may an absent Director vote by proxy. Subject to Standing Order 59, absence is defined as being absent at the time of the vote. An officer who has been appointed formally by the Board to act up for an executive Director during a period of incapacity or temporarily to fill an executive Director vacancy, shall be entitled to exercise the voting rights of the executive Director. An officer attending the Board to represent an executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the executive Director. An officer's status when attending the meeting shall be recorded in the minutes. Where an executive Director post is shared by more than one person: • Each person shall be entitled to attend meetings of the Board • Each of those persons shall be eligible to vote in the case of agreement between them • In the case of disagreement between them no vote should be case • The presence of those persons shall count as one person.
Attendance:	The Board of Directors may agree that Directors can participate in its meetings by telephone, video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting. Directors who are unable to attend a meeting shall notify the Secretary in writing in advance of the meeting in question so that their apologies may be submitted.
Frequency:	Ordinary meetings of the Board shall be held at regular intervals at such times and places as the Board may determine. The Secretary will publish the dates, times and locations of meetings of the Board in advance.
Accountability and reporting arrangements:	The Council of Governors is responsible for holding the Board to account, for example by attending Board meetings in public and meeting with the Trust Chair, Chief Executive and Committee Chairs on the day of Board meetings / Council of Governors' meeting. The agenda and minutes of Board meetings will be shared with the Council of Governors.

	The Trust Chair will be responsible for ensuring the Board of Directors adheres to its Terms of Reference and Annual Work Plan. The Board shall self-assess its performance following each board meeting. A full set of papers comprising the agenda, minutes and associated reports and papers will be sent within the timescale set out in standing orders to all directors and others as agreed with the Chair and Chief Executive from time to time.
Monitoring effectiveness:	The Board will undertake an annual review of its performance against its duties in order to evaluate its achievements.
Review:	These terms of reference will be reviewed at least annually by the Board.
Reviewed by Board of Directors:	*1 April 2022*
Approved by Board of Directors:	*1 April 2022*
Review date:	April 2023
Document owner:	Mark Grimshaw, Trust Secretary Email: mark.grimshaw@lwh.nhs.uk Tel: 0151 702 4033

4.3. Committees of the Board – Terms of Reference

- Audit Committee
- Nomination & Remuneration Committee
- Quality Committee
- Putting People First Committee
- Finance, Performance and Business Development Committee
- Charitable Funds Committee

AUDIT COMMITTEE
TERMS OF REFERENCE

Constitution:	The Committee is established by the Board of Directors and will be known as the Audit Committee (the Committee). The Committee is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference.
Duties:	The Committee is responsible for: **a. Governance, risk management and internal control** The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the Trust's activities (both clinical and non-clinical) that supports the achievements of the Trust's objectives. It will provide an independent and objective view on internal control and probity. In addition, the committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to its financial performance, reviewing significant financial reports and the judgements contained in them. In particular, the Committee will review the adequacy of: • All risk and control related disclosure statements (in particular the Annual Governance Statement and declarations of compliance to external bodies), together with any accompanying Head of Internal Audit opinion, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board • The process of preparing the Trust's returns to NHS Improvement (which returns are approved by the Board's Finance and Performance Committee) • The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements • The policies for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification • The Trust's standing orders, standing financial instructions and scheme of delegation

- The policies and procedures for all work related to fraud and corruption as set out in the Secretary of State directions and as required by the NHS Counter Fraud Authority

- The arrangements by which Trust staff may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. In so doing the Committee's objective should be to ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.

In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

The Committee will undertake an annual training needs assessment for its own members.

b. Internal audit

The Committee will ensure that there is an effective internal audit function established by management that meets mandatory government and Public Sector Internal Auditing Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:

- Consideration of the appointment of the internal audit service, the audit fee and any questions of resignation and dismissal

- Review and approval of the internal audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework

- Reviewing the internal audit programme, considering the major findings of internal audit investigations (and management's response), and ensuring coordination between internal and external auditors

- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation

- Annual review of the effectiveness of internal audit.

c. External audit

The Committee shall review the independence, objectivity and work of the external auditor appointed by the Council of Governors and consider the implications and management's response to this work. This will be achieved by:

- Consideration of the appointment and performance of the external auditor, including making recommendations to the Council of Governors regarding the former

- Discussion and agreement with the external auditor, before the audit commences, of the nature and scope of the audit as set out in the annual audit plan and ensure coordination with internal auditors and with other external auditors

- Discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee

- Reviewing all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Board and any audit work performed outside the annual audit plan, together with the appropriateness of management's response

- Recommending to the Council of Governors the engagement of the external auditor in respect of non-audit work, taking into account relevant ethical guidance regarding the provision of such services

- Annual review of the effectiveness of external audit.

d. Other assurance functions

The Committee will review the findings of other significant assurance functions, both internal and external to the Trust, and consider the implications to the governance of the Trust. These will include, but will not be limited to, reviews and reports by the Department of Health, arms length bodies or regulators/inspectors (e.g. Care Quality Commission, NHS Resolution, etc), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc) or the Local Anti-Fraud Specialist.

In addition the Committee will review the work of other Committees within the Trust, whose work can provide relevant assurance to the Audit Committee's own scope of work. This will particularly include the Quality Committee, Finance, Performance & Business Development Committee and Putting People First Committee, and include a review of an annual report of each of the Committees against their terms of reference. In reviewing the work of the Quality Committee, and issues around clinical risk management, the Audit Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

The Committee will also review all suspensions of standing orders and variation or amendment to standing orders.

	The Audit Committee will report to the Board and to the Council of Governors any matters in respect of which it considers action or improvement is needed. e. Counter fraud The Audit Committee will satisfy itself that the Trust has adequate arrangements in place for countering fraud and will approve the appointment of the Local Anti-Fraud Specialist. The Committee will review the outcomes of counter fraud work. f. Management The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control. The Committee may also request specific reports from individual functions within the organisation (e.g. clinical audit) as they may be appropriate to the overall arrangements. g. Financial reporting The Audit Committee shall monitor the integrity of the Annual financial statements of the Trust. The Audit Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board. The Audit Committee will review the Trust's annual report and financial statements before submission to the Board, focusing particularly on: • The wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee • Changes in, and compliance with, accounting policies and practices • Unadjusted mis-statements in the financial statements • Major judgemental areas, and • Significant adjustments resulting from the audit • Letter of representation • Qualitative aspects of financial reporting.
Membership:	The Committee membership will be appointed by the Board of Directors from amongst its Non-Executive members and will consist of not less than three members.

	Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. The Board of Directors will appoint a Non-Executive Director as Chair of the Committee. Should the Chair be absent from a meeting of the Committee, the Committee may appoint a Chair of the meeting from amongst the Non-Executive Directors present.
Quorum:	A quorum shall be two members.
Voting:	Each member will have one vote with the Chair having a second and casting vote, if required. Should a vote be necessary a decision will be determined by a simple majority.
Attendance:	a. Members Members will be required to attend a minimum of 75% of all meetings. b. Officers The Chief Finance Officer, Deputy Chief Finance Officer, Financial Controller and Deputy Chief Nurse & Midwife shall normally attend meetings. At least once a year the Committee will meet privately with external and internal auditors. The Chief Executive and other executive directors will be invited to attend, particularly when the Committee is discussing areas of risk or operation that are within the responsibility of that director. The Chief Executive will also be required to attend when the Audit Committee discusses the process for assurance that supports the Annual Governance Statement. The Trust Secretary will attend to provide appropriate support to the Chair and Committee members.
Frequency:	Meetings shall be held at least four times per year. The external auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.
Authority:	The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee.

	The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of representatives from partner organisations or other external bodies or organisations with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities.
Accountability and reporting arrangements:	The Audit Committee will be accountable to the Board of Directors. A Chair's Report will be submitted to the next following Board of Directors for assurance. Approved minutes will be made available to all Board members. The Committee will report to the Board annually on its work and performance in the preceding year and, as part of this report, will provide commentary in support of the Annual Governance Statement (AGS), specifically dealing with the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the Trust, the integration of governance arrangements and the appropriateness of the evidence compiled to demonstrate fitness to register with the Care Quality Commission and the robustness of the processes behind the quality accounts. In providing this commentary in support of the AGS the Committee will seek relevant assurance from the Chair of the Board's Quality Committee. Trust standing orders and standing financial instructions apply to the operation of the Audit Committee.
Monitoring effectiveness:	The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements.
Review:	These terms of reference will be reviewed at least annually by the Committee.
Reviewed by Audit Committee:	24 March 2022
Approved by Board of Directors:	1 April 2022
Review date:	March 2023
Document owner:	Mark Grimshaw, Trust Secretary Email: mark.grimshaw@lwh.nhs.uk Tel: 0151 702 4033

NOMINATION & REMUNERATION COMMITTEE
TERMS OF REFERENCE

Constitution:	The Committee is established by the Board of Directors and will be known as the Nomination and Remuneration Committee (the Committee).
Duties:	The Committee is responsible for: a. Overseeing the recruitment and selection process for the posts of Chief Executive[1] and Executive Directors b. Preparing a description of the role and capabilities required for the Chief Executive and Executive Director posts to reflect the balance of skills, knowledge and experience required c. Succession planning Executive appointments taking into account the challenges and opportunities facing the Trust and the skills and expertise required on the Board d. Reviewing the structure, size and composition of the Executive Director composition of the Board of Directors e. Reviewing Executive Directors' performance. f. Determining the remuneration and terms of service of the Chief Executive and the Executive Management Team g. Determining the annual cost of living award for senior managers (excluding those paid under Agenda for Change arrangements) h. Succession planning for Executive Director appointments i. Overseeing agreement of appropriate contractual arrangements relating to the Chief Executive and Executive Management Team j. Scrutinising any termination payments relating to the Chief Executive or the Executive Management Team, ensuring that they have been properly calculated and take account of any relevant guidance k. To be responsible for any disciplinary issue relating to the Chief Executive or member of the Executive Management Team which may result in their dismissal. The Committee will not be responsible for any disciplinary issue which is short of dismissal l. Such other duties as the Board of Directors may delegate.
Membership:	The Committee membership will be appointed by the Board of Directors and will consist of: • Trust Chair • All Non-Executive Directors Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication).

[1] Note that Chief Executive appointments are subject to approval by the Council of Governors

	Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. The Chair of the Board of Directors will be the Chair of the Committee. The Vice Chair of the Board will be the Vice Chair of the Committee from the outset. The Vice Chair will automatically assume the authority of the Chair should the latter be absent.
Quorum:	A quorum shall be three members including the Chair or Vice Chair and at least two Non-Executive Directors.
Voting:	Each member will have one vote with the Chair having a second and casting vote, if required. Should a vote be necessary a decision will be determined by a simple majority.
Attendance:	**a.** Members Members will be required to attend a minimum of 75% of all meetings. **b.** Officers The Chief Executive and Chief People Officer (or equivalent executive lead for the Trust with responsibility for the human resources functions of the Trust) will be in attendance at its meetings, as and when appropriate and necessary. The Trust Secretary will act as Secretary to the Committee.
Frequency:	Meetings shall be held at least once per year or as required to fill Executive Director vacancies. Additional meetings may be arranged from time to time, if required, to support the effective functioning of the Trust.
Authority:	The Committee is authorised by the Board to investigate any activity within its Terms of Reference. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities.
Accountability and reporting arrangements:	The Nomination and Remuneration Committee will be accountable to the Board of Directors. The minutes of the Nomination & Remuneration Committee will be formally recorded and submitted to the Board of Directors. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to it or require executive action. Summary minutes will also be circulated to members of the Audit Committee. The Committee will report to the Board annually on its work and performance in the preceding year.

	Trust standing orders and standing financial instructions apply to the operation of the Remuneration and Nomination Committee.
Monitoring effectiveness:	The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements.
Review:	These terms of reference will be reviewed at least annually by the Committee.
Reviewed by Nominations & Remuneration Committee:	5 May 2022
Approved by Board of Directors:	TBC
Review date:	March 2023
Document owner:	Mark Grimshaw, Trust Secretary Email: mark.grimshaw@lwh.nhs.uk Tel: 0151 702 4033

QUALITY COMMITTEE
TERMS OF REFERENCE

Constitution:	The Committee is established by the Board of Directors and will be known as the Quality Committee (QC) (the Committee).
Duties:	The Committee's responsibilities fall broadly into the following three areas: Strategy and Performance a) Oversee the development and implementation of the Quality Strategy with a clear focus on upholding the tenants of quality (Governance, safety, patient experience and clinical effectiveness). b) Ensure that the Quality Strategy and performance are consistent with the Trust's; Vision and strategic objectives and oversee any initiatives undertaken by the Trust that relates to the development and implementation of the Quality Strategy. c) Review trends in patient safety, experience and outcomes (effectiveness) to provide assurance to the Board on performance and commission 'deep dives' as appropriate. d) To receive assurance that action plans arising from in-patient, out-patient and other care related surveys are being undertaken and make recommendations to the Board as appropriate. e) Oversee the implementation of key national reports and inquiries recommendations and provide assurance to the Board on its delivery. Governance f) Oversee the effectiveness of the clinical systems developed and implemented to ensure they maintain compliance with the Care Quality Commission's Fundamental Standards in relation to Quality, Safety, experience and effectiveness. g) Obtain assurance of the Trust's ongoing compliance with the Care Quality Commission registration. h) Review the controls and assurance against relevant quality risks on the Board Assurance Framework and provide assurance to the Board that risks to the strategic objectives relating to quality and safety are being managed and facilitate the completion of the Annual Governance Statement at year end. i) Obtain assurance that the Trust is compliant with guidance from NICE (through receipt of an Annual Report) and other related bodies. j) Consider external and internal assurance reports and monitor action plans in

	relation to clinical governance resulting from improvement reviews / notices from NHSI, the Care Quality Commission, the Health and Safety Executive and other external assessors. k) Receive the annual clinical audit programme and provide assurance to the Board that clinical audit supports the Trust to provide safe and clinically effective patient care and obtain assurance that there is delivery against agreed annual clinical audit programme. l) Implement and monitor the process for the production of the Trust's year end Quality Report before it is presented to the Trust Audit Committee and Board for formal approval. m) Undertake an annual review of the Quality and Risk Management Strategies to ensure that they reflect all required priorities. n) To have oversight of the Committees performance measures to ensure they are appropriate and provide assurance of compliance and escalate exceptions to Trust Board. o) To review the proposed internal audit plan for all functions areas within the Committees remit e.g. Clinical Audit, Safety, Experience and Effectiveness. p) Review the Trust's Research and Development Strategy and Innovation Strategy prior to their recommendation it to the Board of Directors. q) Approving the terms of reference and memberships of its subordinate committees. Overall r) To approve any matters that, due to time constraints, could not be approved by the Board within the scope of the Committees areas of responsibility. s) Referring relevant matters for consideration to other Board Committees as appropriate. t) Considering relevant matters delegated or referred to it by the Board of Directors or referred by any of the Board Committees. u) Escalating matters as appropriate to the Board of Directors. Assurances will be provided from internal and external sources and will be included in a work plan approved by the Committee at the commencement of each financial year.
Membership:	The Committee membership will be appointed by the Board of Directors and will consist of: • Non-Executive Director (Chair) • Two additional Non-Executive Directors • *Medical Director

	• *Chief Nurse and Midwife • *Chief Finance Officer • *Chief People Officer • *Chief Operating Officer • Deputy Director of Nursing and Midwifery • Associate Director of Quality and Governance *or their nominated representative who will be sufficiently senior and have the authority to make decisions. Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. The Board of Directors will appoint a Non-Executive Director as Chair of the Committee. Should the Chair be absent from a meeting of the Committee, the Committee may appoint a Chair of the meeting from amongst the Non-Executive Directors present.
Quorum:	A quorum shall be three members including two Non-Executive Directors and one Executive Director (one of whom must be either the Medical Director or Director of Nursing and Midwifery or their deputy). The Chair of the Trust may be included in the quorum if present.
Voting:	Each member will have one vote with the Chair having a second and casting vote, if required. Should a vote be necessary a decision will be determined by a simple majority.
Attendance:	a) Members Members will be required to attend a minimum of 75% of all meetings. b) Officers The Trust Secretary shall normally attend meetings. Other executive directors (including the Chief Executive) and officers of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed. Representatives from partner organisations or other external bodies may be invited to attend as appropriate. Such representatives will not have voting rights.
Frequency:	Meetings shall be held monthly. Additional meetings may be arranged from time to time, if required, to support the effective functioning of the Trust.
Authority:	The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of representatives from partner organisations or other external bodies or organisations with relevant

	experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities. The Committee is authorised to approve those policies and procedures for matters within its areas responsibility.
Accountability and reporting arrangements:	The Quality Committee will be accountable to the Board of Directors. A Chair's Report will be submitted to the next following Board of Directors for assurance. Approved minutes will be made available to all Board members. The Committee will report to the Board annually on its work and performance in the preceding year. Trust standing orders and standing financial instructions apply to the operation of the Committee.
Reporting Committees/ Groups	The sub committees/groups listed below are required to submit the following information to the Committee: a) Chairs Report; and b) Annual Report setting out the progress they have made and future developments. The following sub committees/groups will report directly to the Committee: • Safety and Effectiveness Sub-Committee • Patient Involvement & Experience Sub-Committee • Corporate Risk Sub-Committee • Trust Safeguarding Sub-Committee • Research and Development Sub-Committee • Maternity Transformation Board
Monitoring effectiveness:	The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements.
Review:	These terms of reference will be reviewed at least annually by the Committee.
Reviewed by Quality Committee	28 March 2022
Approved by Board of Directors:	1 April 2022
Review date:	March 2023
Document owner:	Mark Grimshaw, Trust Secretary, Email: mark.grimshaw@lwh.nhs.uk Tel: 0151 702 4033

FINANCE, PERFORMANCE AND BUSINESS DEVELOPMENT COMMITTEE TERMS OF REFERENCE

Constitution:	The Board hereby resolves to establish a Committee of the Board to be known as the Finance, Performance and Business Development Committee (the Committee).
Duties:	The Committee will operate under the broad aims of reviewing financial and operational planning, performance and business development. The Committee's responsibilities fall broadly into the following two areas: **Finance and performance** The Committee will: a. Receive and consider the annual financial and operational plans and make recommendations as appropriate to the Board. b. Review progress against key financial and performance targets c. Review on behalf of the Board, financial submissions (as reported in the Financial Performance Report) or others, as agreed by the Board, to NHS Improvement for consistency on financial data provided. d. Review the service line reports for the Trust and advise on service improvements e. Provide oversight of the cost improvement programme f. Oversee external financing & distressed financing requirements g. Oversee the development and implementation of the information management and technology strategy h. Examine specific areas of financial and operational risk and highlight these to the Board as appropriate through the Board Assurance Framework i. To undertake an annual review of the NHS Improvement Enforcement Undertaking. j. To review and receive assurance on the appropriateness of the Trust's Emergency Planning Resilience & Response processes and procedures. **Business planning and development** The Committee will:

	k. Advise the Board and maintain an overview of the strategic business environment within which the Trust is operating and identify strategic business risks and opportunities reporting to the Board on the nature of those risks and opportunities and their effective management l. Advise the Board and maintain an oversight on all major investments, disposals and business developments. m. Advise the Board on all proposals for major capital expenditure over £500,000 n. Develop the Trust's marketing & communications strategy for approval by the Board and oversee implementation of that strategy
Membership:	The Committee membership will be appointed by the Board of Directors and will consist of: • Non-Executive Director (Chair) • Two additional Non-Executive Directors • Chief Executive • Chief Finance Officer • Chief Operations Officer • Chief Nurse and Midwife Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. The Board of Directors will appoint a Non-Executive Director as Chair of the Committee. Should the Chair be absent from a meeting of the Committee, the Committee may appoint a Chair of the meeting from amongst the Non-Executive Directors present.
Quorum:	The quorum for the transaction of business shall be three members including at least two Non-Executive Directors (one of whom must be the Chair or Vice Chair of the Committee), and one Executive Director. The Chair of the Trust may be included in the quorum if present.
Voting:	Each member will have one vote with the Chair having a second and casting vote, if required. Should a vote be necessary a decision will be determined by a simple majority.
Attendance:	**c. Members** Members will be required to attend a minimum of 50% of all meetings. **d. Officers**

	Ordinarily the Deputy Director of Finance and Trust Secretary will attend all meetings. Other executive directors and officers of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed.
Frequency:	Meetings shall be held at least 8 times per year. Additional meetings may be arranged if required, to support the effective functioning of the Trust.
Authority:	The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of representatives from partner organisations or other external bodies or organisations with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities. The Committee is authorised to approve those policies and procedures for matters within its areas responsibility.
Accountability and reporting arrangements:	The Finance, Performance and Business Development Committee will be accountable to the Board of Directors. A Chair's Report will be submitted to the next following Board of Directors for assurance. Approved minutes will be made available to all Board members. The Committee will report to the Board annually on its work and performance in the preceding year. Trust standing orders and standing financial instructions apply to the operation of the Finance, Performance and Business Development Committee.
Reporting Committees and Groups	The sub committees/groups listed below are required to submit the following information to the Committee: a) Chairs Report; and b) an Annual Report setting out the progress they have made and future developments. The following sub committees/groups will report directly to the Committee (see appendix 1): • Emergency Planning Resilience & Response Committee • Digital Hospital Sub-Committee • Crown Street Enhancement Programme Board • Future Generations Project Group

	• Premises Assurance Group • Financial Recovery Board • Community Diagnostic Centre Oversight
Monitoring effectiveness:	The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements.
Review:	These terms of reference will be reviewed at least annually by the Committee.
Reviewed by: Finance, Performance & Business Development Committee	28 March 2022
Approved by: Board of Directors	1 April 2022
Review date:	March 2023
Document owner:	Mark Grimshaw, Trust Secretary Email: mark.grimshaw@lwh.nhs.uk Tel: 0151 702 4033

NHS
Liverpool Women's
NHS Foundation Trust

PUTTING PEOPLE FIRST COMMITTEE
TERMS OF REFERENCE

Constitution:	The Committee is established by the Board of Directors and will be known as the Putting People First Committee (the Committee).
Duties:	The Committee is responsible for: h. Developing and overseeing implementation of the Trust's People Strategy (integrated workforce, wellbeing and organisational development strategy) and plan and providing assurance to the Board of Directors that this is being delivered in line with the annual planning process i. Oversight of the strategic implementation of multi-disciplinary education and training and gaining assurances that the relevant legislative and regulatory requirements are in place (Education Governance Committee) j. Approving, monitoring and reviewing policies, procedures and guidance documents relating to the management of the Trust's workforce k. Monitoring and reviewing workforce key performance indicators to ensure achievement of the Trust's strategic aims and escalate any issues to the Board of Directors l. Reviewing any changes in practice required following any internal enquiries that significantly impact on workforce issues m. Oversight of the strategic implementation and monitoring of staff engagement levels as evidenced by the results of the national and any other staff surveys n. Reviewing and approving partnership agreements with staff side o. Ensuring that the Trust fulfils all legislative and regulatory requirements pertaining to workforce and organisational development issues p. Monitor and evaluate compliance with the public sector equality duty and delivery of equality objectives to improve the experience of staff with protected characteristics q. Approving the terms of reference and membership of its reporting groups and overseeing the work of those groups, receiving reports from them for consideration and action as necessary and routinely receiving the minutes of their meetings r. Receipt and review of relevant risks (including those referred from other Committees or subcommittees) concerned with workforce and organisational development matters as identified through the Board Assurance Framework. Monitor progress made in mitigating

	those risks, identifying any areas where additional assurance is required, escalating to the Board of Directors as required. s. Receiving and considering issues from other Committees when appropriate and taking any necessary action.
Membership:	The Committee membership will be appointed by the Board of Directors and will consist of: • Non-Executive Director (Chair) • 2 other Non-Executive Director • *Chief People Officer • * Chief Nurse & Midwife • *Chief Operating Officer • Staff Side Chair • Medical Staff Committee representative • Senior Finance Manager *or their nominated representative who will be sufficiently senior and have the authority to make decisions. Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. The Board of Directors will appoint a Non-Executive Director as Chair of the Committee. Should the Chair be absent from a meeting of the Committee, the Committee may appoint a Chair of the meeting from amongst the Non-Executive Directors present.
Quorum:	A quorum shall be four members including: • The Chair or at least one other Non-Executive Director • At least one from either Director of Workforce and Marketing or Director of Nursing and Midwifery • Director of Operations or their Deputy • Either Staff Side Chair or Medical Staff Committee representative • The Chair of the Trust may be included in the quorum if present.
Voting:	Each member will have one vote with the Chair having a second and casting vote, if required. Should a vote be necessary a decision will be determined by a simple majority.
Attendance:	**e. Members** Members will be required to attend a minimum of 75% of all meetings. **f. Officers**

	HR & OD Senior Team, Education Governance Chair, and a representative from the Nursing & Midwifery Board shall normally attend meetings. Members may send a nominated representative to attend meetings on their behalf when they are not available, provided they are sufficiently senior and have the authority to make decisions. Other executive directors, officers and staff of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed. Representatives from partner organisations or other external bodies may be invited to attend as appropriate. Such representatives will not have voting rights.
Frequency:	Meetings shall be held at least 10 times per year. Additional meetings may be arranged from time to time, if required, to support the effective functioning of the Trust.
Authority:	The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of representatives from partner organisations or other external bodies or organisations with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities.
Accountability and reporting arrangements:	The Putting People First Committee will be accountable to the Board of Directors. A Chair's Report will be submitted to the subsequent Board of Directors for assurance. Approved minutes will be made available to all Board members upon request. Approved chairs reports will also be circulated to members of the Audit Committee. The Committee will report to the Board annually on its work and performance in the preceding year. Trust standing orders and standing financial instructions apply to the operation of the Putting People First Committee.

Reporting Committees and Groups	The sub committees/groups listed below are required to submit the following information to the Committee: a) Chairs Report; b) an Annual Report setting out the progress they have made and future developments; c) Terms of reference The following sub committees/groups will report directly to the Committee: • Equality, Diversity & Inclusion Committee • Health & Wellbeing Committee • Partnership Forum • Professional Forum of Nurses, Midwives & AHP's • Educational Governance Committee • Joint Local Negotiating Committee
Monitoring effectiveness:	The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements.
Review:	These terms of reference will be reviewed at least annually by the Committee.
Reviewed by Putting People First Committee:	21 March 2022
Approved by Board of Directors:	1 April 2022
Review date:	March 2023
Document owner:	Mark Grimshaw, Trust Secretary Email: mark.grimshaw@lwh.nhs.uk Tel: 0151 702 4033

NHS
Liverpool Women's
NHS Foundation Trust

CHARITABLE FUNDS COMMITTEE
TERMS OF REFERENCE

Constitution:	The Committee has been established to exercise the Foundation Trust's functions as sole corporate trustee of the Liverpool Women's Charity (registered charity number 1048294). The Trust Board is regarded as having responsibility for exercising the functions of the Trustee. The Trust Board delegates these functions to the Committee, within any limits set out in these terms of reference and the sections of the standing financial instructions pertaining to charitable funds.
Duties:	The Committee's responsibilities fall broadly into the following areas: **Compliance** a. Manage the affairs of the Liverpool Women's Charity in accordance with appropriate legislation and ensure statutory compliance with the Charity Commission regulations. b. Ensure systems and processes are in place to receive, account for, deploy and invest charitable funds in accordance with charity law. c. Scrutinise requests for use of charitable funds to ensure that any such use is in accordance with the aims and purposes of any charitable fund or donation and are clinically and ethically appropriate. Committee members will bear in mind due diligence to Charity Commission and Trust guidance regarding the ethical use of funds and acceptance of donations. **Budget, Income & Expenditure** d. Review and approve an Annual Business plan and budget e. Receive and approve periodic income and expenditure statements, ensuring that performance is in line with the Charity's budget and plan. f. Receive and consider the Annual Accounts including the Annual Report from the auditors, before submission to the Board of Directors for approval. **Fundraising** g. Ensure a fundraising strategy is prepared and monitored which complies with Charity Commission guidance and legislation and which includes appropriate communication and marketing plans;

	h. ensure systems and processes are in place to receive, account for, deploy and invest funds raised in accordance with charity law; i. ensure systems, processes and communication are in place around fundraising, staff engagement and funding commitments; j. ensure a cohesive policy around external media and communication; k. encourage a culture of fundraising and raise the profile of the Charity within the Trust and with external partner organisations l. ensure effective communication regarding 'whistleblowing' relating to fundraising, donations or subsequent use of funds. **Investment Management** m. Consider and agree an investment strategy for the safe and secure investment of funds not immediately required for use, taking into account any appropriate ethical considerations. n. Appoint and review external investment advisors and operational fund managers. o. Review the performance of investments on a regular basis (utilising comparator information) with the external investment advisors to ensure the optimum return from surplus funds.
Membership:	The Committee membership shall consist of the following: • A Chairman who shall be a Non-executive director • Two other Non-executive Directors • Chief Finance Officer (or nominated deputy) • Chief People Officer • Chief Nurse & Midwife • Financial Accountant • Head of Fundraising Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. The Board of Directors will appoint a Non-Executive Director as Chair of the Committee. Should the Chair be absent from a meeting of the Committee, the Committee may appoint a Chair of the meeting from amongst the Non-Executive Directors present.
Quorum:	A quorum shall be three members which must include one Executive Director and one Non-Executive Director. The Chair of the Trust may be included in the quorum if present.
Voting:	Each member will have one vote with the Chair having a second and casting vote, if required. Should a vote be necessary a decision will be determined by a simple majority.

Attendance:	**g. Members** Members will be required to attend a minimum of 75% of all meetings. **h. Officers** The non-executive Chairman shall normally attend meetings. Other Board members shall also have right of attendance subject to invitation by the Chairman of the Committee. The Fundraiser to attend as required at request of the Committee. Other officers and staff of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed. Representatives from partner organisations or other external bodies may be invited to attend as appropriate. Such representatives will not have voting rights.
Frequency:	Meetings shall be held on a quarterly basis. Additional meetings may be arranged from time to time, if required, to support the effective functioning of the Trust.
Authority:	The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of representatives from partner organisations or other external bodies or organisations with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities. This includes seeking the advice of specialists from within and outside the NHS as appropriate.
Accountability and reporting arrangements:	The minutes of the Charitable Funds Committee shall be formally recorded and a Chair's Report will be submitted to the subsequent Board of Directors for assurance. Approved minutes will be made available to all Board members upon request.
Reporting Committees/Groups	The Charitable Funds Committee has no reporting committees / groups.
Monitoring effectiveness:	The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements.
Review:	These terms of reference will be reviewed at least annually by the Committee.
Reviewed by: Charitable Funds Committee:	21 March 2022

Approved by: Board of Directors	1 April 2022
Review date:	March 2023
Document owner:	Mark Grimshaw, Trust Secretary Email: mark.grimshaw@lwh.nhs.uk Tel: 0151 702 4033

5. Scheme of delegation (including the NHS Foundation Trust Accounting Officer Memorandum)

5.1 Introduction

5.1.1 Reservation of powers

The Trust's Standing Orders (for its Board of Directors) provide that "Subject to the scheme of reservation and delegation, and such directions as may be given by statute, the independent regulator or the Secretary of State, the Board may make arrangements for the exercise, on behalf of the Foundation Trust, of any of its functions by a committee or subcommittee, or by a Director or an officer of the Trust in each case subject to such restrictions and conditions as the Board things fit." The Code of Accountability also requires that there should be a formal schedule of matters specifically reserved to the Foundation Trust Board of Directors.

The purpose of this document is to detail how the powers are reserved to the Board of Directors, while at the same time delegating to the appropriate level the detailed application of Foundation Trust policies and procedures. The Board of Directors remains accountable for all of its functions, even those delegated to committees, subcommittees, individual directors or officers. A formal structure is in place for monitoring the functions delegated to committees and subcommittees enabling the Board to receive information and to maintain its monitoring role.

5.1.2 Role of the Chief Executive

All powers of the Foundation Trust which have not been retained as reserved by the Board of Directors or delegated to an executive committee or sub-committee shall be exercised on behalf of the Board of Directors by the Chief Executive. The Chief Executive shall prepare a Scheme of Delegation identifying which functions they shall perform personally and which functions have been delegated to other directors and officers for operational responsibility.

All powers delegated by the Chief Executive can be re-assumed by them should the need arise.

5.1.3 Caution over the Use of Delegated Powers

Powers are delegated to directors and officers on the understanding that they would not exercise delegated powers in a manner which in their judgement was likely to be a cause for public concern.

5.1.4 Absence of Directors or Officer to whom Powers have been Delegated

In the absence of a director or officer to whom powers have been delegated those powers shall be exercised by that director or officer's superior unless alternative arrangements have been approved by the Board of Directors. If the Chief Executive is absent powers delegated to them may be exercised by the nominated officer(s) acting in their absence after taking appropriate financial advice, two directors will be required to ratify any decisions within the Chief Executive's thresholds.

Further details about situations where the Accounting Officer is unable to fully discharge their responsibilities are available in the Accounting Officers' Memorandum, sections of which are reproduced below and which is available separately from NHS Improvement.

5.2 Delegation of powers

5.2.1 Delegation to committees

The Board of Directors may determine that certain of its powers shall be exercised by Standing Committees. The composition and terms of reference of such committees shall be that determined by the Board of Directors. The Board of Directors shall determine the reporting requirements in respect of these committees. In accordance with Standing Order

7.18 committees may not delegate executive powers to sub-committees unless expressly authorised by the Board of Directors.

In exercising any delegated power a committee or director must comply with the Foundation Trust's Standing Orders, Standing Financial Instructions and written procedures and with any statutory provisions or requirements. They must not incur expenditure over and above the Foundation Trust's annual budget (excluding the Chief Executive in conjunction with the Chief Finance Officer).

In cases of doubt or difficulty and/or where no policy guidelines exist, decisions should be referred to the Board of Directors.

5.2.2 Delegation to Officers
Standing Orders and Standing Financial Instructions set out in some detail the financial responsibilities of the Chief Executive, the Chief Finance Officer and other directors.

5.2.3 The Accounting Officer Memorandum
The responsibilities of the Accounting Officer are set out in the NHS Foundation Trust Accounting Officer Memorandum[2], relevant sections of which are reproduced below:

Introduction
The National Health Service Act 2006 (the Act) designates the chief executive of an NHS foundation trust as the accounting officer.

The principal purpose of the NHS foundation trust is the provision of goods and services for the purposes of the health service in England. The NHS foundation trust has a general duty to exercise its functions effectively, efficiently and economically.
The Act specifies that the accounting officer has a duty to prepare the accounts in accordance with the Act. An accounting officer has the personal duty of signing the NHS foundation trust's accounts. By virtue of this duty, the accounting officer has the further duty of being a witness before the Public Accounts Committee (PAC) to deal with questions arising from those accounts or, more commonly, from reports made to Parliament by the Comptroller and Auditor General (C&AG) under the National Audit Act 1983.

Associated with these duties are the further responsibilities that are the subject of this memorandum. It is incumbent on the accounting officer to combine these duties with their duties to the board of directors of the NHS foundation trust.
5. It is an important principle that, regardless of the source of the funding, accounting officers are responsible to Parliament for the resources under their control.

General responsibilities
The accounting officer has responsibility for the overall organisation, management and staffing of the NHS foundation trust and for its procedures in financial and other matters. The accounting officer must ensure that:

- there is a high standard of financial management in the NHS foundation trust as a whole
- the NHS foundation trust delivers efficient and economical conduct of its business and safeguards financial propriety and regularity throughout the organisation
- financial considerations are fully taken into account in decisions by the NHS foundation trust.

Specific responsibilities
The essence of the accounting officer's role is a personal responsibility for:

[2] NHS Foundation Trust Accounting Officer Memorandum, NHS Improvement (2015)

- the propriety and regularity of the public finances for which he or she is answerable
- the keeping of proper accounts
- prudent and economical administration in line with the principles set out in *Managing public money*
- the avoidance of waste and extravagance
- the efficient and effective use of all the resources in their charge.

As accounting officer you must:

- personally sign the accounts and, in doing, so accept personal responsibility for ensuring their proper form and content as prescribed by Monitor (now NHSI/E) in accordance with the Act
- comply with the financial requirements of the NHS provider licence
- ensure that proper financial procedures are followed and that accounting records are maintained in a form suited to the requirements of management, as well as in the form prescribed for published accounts (so that they disclose with reasonably accuracy, at any time, the financial position of the NHS foundation trust)
- ensure that the resources for which you are responsible as accounting officer are properly and well managed and safeguarded, with independent and effective checks of cash balances in the hands of any official
- ensure that assets for which you are responsible such as land, buildings or other property, including stores and equipment, are controlled and safeguarded with similar care, and with checks as appropriate
- ensure that any protected property (or interest in) is not disposed of without the consent of Monitor
- ensure that conflicts of interest are avoided, whether in the proceedings of the board of directors, or council of governors or in the actions or advice of the NHS foundation trust's staff, including yourself
- ensure that, in the consideration of policy proposals relating to the expenditure for which you are responsible as accounting officer, all relevant financial considerations, including any issues of propriety, regularity or value for money, are taken into account, and brought to the attention of the board of directors.

An accounting officer should ensure that effective management systems appropriate for the achievement of the NHS foundation trust's objectives, including financial monitoring and control systems, have been put in place. An accounting officer should also ensure that managers at all levels:

- have a clear view of their objectives, and the means to assess and, wherever possible, measure outputs or performance in relation to those objectives
- are assigned well-defined responsibilities for making the best use of resources (both those consumed by their own commands and any made available to organisations or individuals outside the NHS foundation trust), including a critical scrutiny of output and value for money
- have the information (particularly about costs), training and access to the expert advice which they need to exercise their responsibilities effectively.

Accounting officers must make sure that their arrangements for delegation promote good management and that they are supported by the necessary staff with an appropriate balance of skills. Arrangements for internal audit should accord with the objectives, standards and practices set out in the *Public Sector Internal Audit Standards*.

5.2.4 Absence of an accounting officer

An accounting officer should ensure that he or she is generally available for consultation, and that in any temporary period of unavailability due to illness or other cause, or during the normal period of annual leave, there will be a senior officer in the NHS foundation trust who can act on his or her behalf if required.

If it becomes clear to the board of directors that an accounting officer is so incapacitated that he or she will be unable to discharge these responsibilities over a period of four weeks or more, the board of directors should appoint an acting accounting officer, usually the Chief Finance Officer, pending the accounting officer's return. The same applies if, exceptionally, the accounting officer plans an absence of more than four weeks during which he or she cannot be contacted.

The PAC may be expected to postpone a hearing if the relevant accounting officer is temporarily indisposed. Where the accounting officer is unable by reason of incapacity or absence to sign the accounts in time for submission, the NHS foundation trust may submit unsigned copies pending the accounting officer's return. If the accounting officer is unable to sign the accounts in time for printing, the acting accounting officer should sign instead.

5.3 Schedule of Delegated Authority

Delegated matters in respect of decisions which may have a far reaching effect must be reported to the Chief Executive. The **'Delegated to'** authority is in accordance with the Standing Orders and Standing Financial Instructions. The **'Operational Responsibility'** shown below is the lowest level to which authority is delegated.

- Table A - Delegated Authority
- Table B - Delegated Financial Limits

Delegation to lower levels is only permitted with written approval of the Chief Executive who will, before authorising such delegation, consult with other Senior Managers as appropriate.

Table A – Delegated Authority

Delegated matter	Delegated to[3]	Operational responsibility
1. Standing Orders (SOs) and Standing Financial Instructions (SFIs)		
a. Final authority in interpretation of Standing Orders	Chair	Chair
b. Notifying Directors, employees and governors of their responsibilities within the Standing Orders and Standing Financial Instructions and ensuring that they understand the responsibilities	Chief Executive	All Line Managers
c. Responsibility for security of the Foundation Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Standing Financial Instructions and financial procedures	Chief Executive	All Directors and Employees
d. Suspension of Standing Orders	Board of Directors	Board of Directors
e. Review suspension of Standing Orders	Audit Committee	Audit Committee
f. Variation or amendment to Standing Orders	Board of Directors	Audit Committee
g. Emergency powers relating to the authorities retained by the Board of Directors	Chair and Chief Executive with two non-executives	Chair and Chief Executive with two non-executives
h. Disclosure of non-compliance with Standing Orders to the Chief Executive (report to the Board of Directors)	All staff	All staff
i. Disclosure of non-compliance with SFIs to the Chief Finance Officer (report to the Audit Committee)	All staff	All staff
j. Advice on interpretation or application of SFIs and this Scheme of Delegation	Chief Finance Officer	Chief Finance Officer with input from Internal Audit
2. Audit arrangements		
a. Ensure an adequate internal audit service is provided	Audit Committee	Chief Finance Officer
b. To make recommendations to the Council of Governors in respect of the appointment, re-appointment and removal of the external auditor and to approve the remuneration in respect of the external auditor	Audit Committee (for recommendation to the Council of Governors for approval)	Chief Finance Officer
c. Monitor and review the effectiveness of the internal audit function	Audit Committee	Chief Finance Officer
d. Review, appraise and report in accordance with Public Sector Internal Audit Standards (PSIAS) and best practice	Audit Committee	Head of Internal Audit

[3] If the Chief Executive is absent powers delegated to them may be exercised by the nominated officer(s) acting in their absence after taking appropriate financial advice, two directors will be required to ratify any decisions within the Chief Executive's thresholds.

Delegated matter	Delegated to[3]	Operational responsibility
e. Provide an independent and objective view on internal control and probity	Audit Committee	Internal Audit / External Audit
f. Ensure cost-effective audit service(s)	Audit Committee	Chief Finance Officer
g. Implement agreed recommendations	Chief Executive	Relevant Officers
3. Authorisation of Clinical Trials & Research Projects	Chief Executive	Director of Research and Development through the Research and Development committee
4. Authorisation of New Drugs	Chief Executive	Medical Director through the Medicines Management committee
5. Bank Accounts/Cash (including on Trust (Charitable / Non Charitable))		
a. Operation: Managing banking arrangements and operation of bank accounts (Board of Directors approves arrangements)	Chief Finance Officer	Deputy Chief Finance Officer
b. Opening bank accounts as approved by the Board of Directors	Chief Finance Officer	Deputy Chief Finance Officer
c. Authorisation of transfers between bank accounts	Chief Finance Officer	In accordance with bank mandate / internal procedures
d. Approve and apply arrangements for the electronic transfer of funds	Chief Finance Officer	In accordance with bank mandate / internal procedures
e. Authorisation of: • BACS schedules • Automated payment schedules • Manual cheques	Chief Finance Officer	In accordance with bank mandate / internal procedures
f. Investments: • Investment of surplus funds in accordance with Treasury Management Investment Policy • Preparation of investment procedures	Chief Finance Officer Chief Finance Officer	Deputy Chief Finance Officer Deputy Chief Finance Officer
g. Petty Cash	Chief Finance Officer	See Delegated Limits Table B (section 2(a))
6. Capital Investment		
a. Programme: Ensure that there is adequate appraisal and approval process for determining capital expenditure priorities and the effect that each has on Business Plans	Chief Executive	Chief Finance Officer
b. Preparation of Capital Investment Programme	Chief Executive	Chief Finance Officer / Deputy Chief Finance Officer
c. Preparation of a business case for expenditure over £100,000	Chief Executive	Divisional Manager with advice from Chief Finance Officer or Deputy Chief Finance Officer or Divisional Accountant
d. Financial monitoring and reporting on all capital scheme expenditure including variations to contract	Chief Finance Officer	Deputy Chief Finance Officer / Head of Estates
e. Authorisation of capital requisitions	Chief Executive	See Delegated Limits Table B (Section 5)

Delegated matter	Delegated to[3]	Operational responsibility
f. Construction industry tax scheme	Chief Executive	Chief Finance Officer
g. Assessing the requirements for the operation of the construction industry taxation deduction scheme	Chief Finance Officer	Financial Controller
h. Responsible for the management of capital schemes and for ensuring that they are delivered on time and within cost	Chief Executive	Chief Finance Officer and Head of Estates and Facilities
i. Ensure that capital investment is not undertaken without availability of resources to finance all revenue consequences	Chief Executive	Chief Finance Officer
j. Issue procedures to support: • Capital investment • Staged payments	Chief Executive	Chief Finance Officer
k. Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes	Chief Finance Officer	Deputy Chief Finance Officer
l. Issuing the capital scheme project manager with specific authority to commit capital, proceed / accept tenders in accordance with the standing orders and SFIs	Chief Executive	Chief Finance Officer
m. Private Finance: • Demonstrate that the use of private finance represents best value for money and transfers risk to the private sector • Proposal to use PFI must be specifically agreed by the Board of Directors.	Chief Executive Board of Directors	Chief Finance Officer
n. Leases (property and equipment) in accordance Delegated Limits Table B (Section 4)	Chief Executive	Chief Executive or Chief Finance Officer
7. Clinical Audit	Chief Executive	Medical Director
8. Commercial Sponsorship		
Agreement to proposal	Chief Executive	Chief Finance Officer
9. Complaints		
a. Overall responsibility for ensuring that all complaints are dealt with effectively	Chief Executive	Chief Nurse and Midwife
b. Responsibility for ensuring complaints relating to a clinical division are investigated thoroughly	Chief Nurse and Midwife	Chief Operating Officer and Head of Governance & Legal
c. Coordination of the management of medico-legal complaints	Chief Executive	Chief Nurse and Midwife and Head of Governance & Legal
10. Confidential Information		
a. Review of the Trust's compliance with the Caldicott report on protecting patients' confidentiality in the NHS	Chief Executive	Caldicott Guardian (Medical Director)
b. Freedom of Information Act compliance code	Chief Executive	Chief People Officer & Trust Secretary
11. Controlled drugs accountable officer	Medical Director	Head of Pharmacy
12. Data Protection Act		

Delegated matter	Delegated to[3]	Operational responsibility
Review of Trust's compliance	Chief Executive	Chief Information Officer
13. Declaration of Interests		
a. Maintaining a register of interests	Chief Executive	Trust Secretary
b. Declaring relevant and material interests	Board of Directors and Council of Governors	Board of Directors, Council of Governors, Senior Managers, Clinical consultants and all decision-making staff as defined in the Trust policy 'Managing Conflicts of interest'
14. Disposals and Condemnations		
a. Items obsolete, redundant, irreparable or cannot be repaired cost effectively	Chief Finance Officer	(Clinical Director or Divisional Manager or Department Heads) – Approved in accordance with Delegated Limits, Table B Section 8 Head of Procurement or Deputy Chief Finance Officer
b. Develop arrangements for the sale of assets	Chief Finance Officer	(Clinical Director/ Divisional Manager / Department Heads) – Approved in accordance with Delegated Limits Table B Section 8 Head of Procurement or Deputy Chief Finance Officer
c. Disposal of Protected Property (as defined in the Licence	Chief Executive (with authorisation of the Independent Regulator)	Chief Executive
15. Environmental Regulations		
Review of compliance with environmental regulations, for example those relating to clean air and waste disposal	Chief Finance Officer	Head of Estates & Facilities
16. External Borrowing		
a. Advise Board of Directors of the requirements to repay / draw down Public Dividend Capital	Chief Finance Officer	Deputy Chief Finance Officer
b. Approve a list of employees authorised to make short term borrowings for the Trust	Board of Directors	Chief Executive / Chief Finance Officer
c. Application for draw down of Public Dividend Capital, overdrafts and other forms of external borrowing in accordance with approved mandates	Chief Executive	Chief Finance Officer and Deputy Chief Finance Officer
d. Preparation of procedural instructions concerning applications for loans and overdrafts	Chief Finance Officer	Deputy Chief Finance Officer
17. Financial Planning / Budgetary Responsibility		
• **Budget setting**		
a. Submit budgets to the Board of Directors	Chief Finance Officer	Deputy Chief Finance Officer
b. Submit to the Board of Directors financial estimates and forecasts	Chief Finance Officer	Deputy Chief Finance Officer

Delegated matter	Delegated to[3]	Operational responsibility
c. Compile and submit to the Board of Directors an Operational Plan which takes into account financial targets and forecast limits of available resources. The Business Plan will contain: • a statement of the significant assumptions on which the plan is based; • details of major changes in workload, delivery of services or resources required to achieve the plan	Chief Executive	Chief Operating Officer and Chief Finance Officer
• **Budget monitoring**		
d. Devise and maintain systems of budgetary control	Chief Finance Officer	Deputy Chief Finance Officer
e. Delegate budgets to budget holders	Chief Executive	Chief Finance Officer
f. Monitor performance against budget	Chief Finance Officer	Deputy Chief Finance Officer and Divisional Accountants
g. Ensuring adequate training is delivered on an ongoing basis to budget holders to facilitate their management of the allocated budget	Chief Finance Officer	Deputy Chief Finance Officer
h. Submit financial monitoring returns in accordance with NHS Improvement's requirements	Chief Executive	Chief Finance Officer
i. Identify and implement cost improvements and income generation activities in line with the Operational Plan	Chief Executive	All budget holders
j. Preparation of annual accounts	Chief Finance Officer	Deputy Chief Finance Officer / Financial Controller
k. Preparation of annual report	Chief Executive	Trust Secretary
• **Budget responsibilities**		
l. Ensure that: • no overspend or reduction of income that cannot be met from virement is incurred; • approved budget is not used for any other than specified purpose subject to rules of virement; • no permanent employees are appointed without the approval of the Chief Executive other than those provided for within available resources and manpower establishment	Chief Finance Officer	Budget Holders All corporate posts are reviewed by the Vacancy Control Panel and all clinical posts by the Executive team
• **Virement**		
m. It is not possible for any officer to vire from non-recurring budgets to recurring, budgets or from capital to revenue / revenue to capital. Virement between different budget holders requires the agreement of both parties	Chief Executive	Refer To Delegated Limits Table B Section 1

Delegated matter	Delegated to[3]	Operational responsibility
• **Financial procedures and systems**		
n. Maintenance and updating of Trust Financial Procedures	Chief Finance Officer	Deputy Chief Finance Officer
o. Accountability for financial control	Chief Executive / Chief Finance Officer	All budget holders
p. Responsibility for: • Implementing the Trust's financial policies and co-ordinate corrective action • Ensuring that adequate records are maintained to explain the Trust's transactions and financial position. • Providing financial advice to members of the Board of Directors and staff • Maintaining such accounts certificates, records, etc to meet statutory requirements • Designing and maintaining compliance with all financial systems	Chief Finance Officer	Deputy Chief Finance Officer
• **Financial systems Information Management & Technology (IM&T)**		
q. Developing financial systems in line with the Trust's IM&T strategy	Chief Finance Officer	Deputy Chief Finance Officer
r. Implementing new systems to ensure they are developed in a controlled manner and thoroughly tested	Chief Finance Officer	Deputy Chief Finance Officer and Chief Information Officer
s. Seeking third party assurances regarding financial systems operated externally	Chief Finance Officer	Deputy Chief Finance Officer
t. Responsibility for the accuracy and security of computerised financial data	Chief Finance Officer	Deputy Chief Finance Officer
u. Ensure that contracts for computer services for financial applications define responsibility re security, privacy, accuracy, completeness and timeliness of data during processing and storage	Chief Finance Officer	Chief Information Officer
v. Ensure that risks to the Trust from use of IT are identified and considered and that disaster recovery plans are in place	Chief Finance Officer	Chief Information Officer
18. Fire precautions		
Ensure that the Fire Precaution and Prevention policies and procedures are adequate and that fire safety and integrity of the estate is intact	Chief Executive	Head of Estates in conjunction with Head of Resilience, Health and Safety
19. Fixed assets		
a. Maintenance of asset register including asset identification and monitoring	Chief Executive	Deputy Chief Finance Officer in conjunction with Financial Controller
b. Approving procedures for reconciling balances on fixed asset accounts in ledgers against balances on fixed asset registers	Chief Finance Officer	Deputy Chief Finance Officer in conjunction with Financial Controller

Delegated matter	Delegated to[3]	Operational responsibility
c. Ensuring arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with relevant legislation	Chief Finance Officer	Financial Controller in conjunction with Director of Estates
d. Calculate and pay capital charges in accordance with the requirements of the Department of Health / independent regulator	Chief Finance Officer	Deputy Chief Finance Officer
e. Responsibility for security of Trust's assets including notifying discrepancies to the Chief Finance Officer and reporting losses in accordance with Trust procedures	Chief Executive	All staff
20. Fraud (See also 26 & 37)		
a. Monitor and ensure compliance with Secretary of State Directions on fraud and corruption including the appointment of the Local Counter Fraud Specialist	Audit Committee	Local Counter Fraud Specialist
b. Notify NHS Protect and External Audit of all suspected Frauds	Chief Finance Officer	Local Counter Fraud Specialist
21. Funds Held on Trust (Charitable and Non Charitable Funds)		
a. Appropriate management of funds held on trust	Charitable Funds Committee	Chief Finance Officer
b. Maintenance of authorised signatory list of nominated fundholders	Chief Finance Officer	Deputy Chief Finance Officer or Financial Controller
c. Expenditure Limits	Chief Finance Officer	See Delegated Limits Table B Section 7
d. Developing systems for receiving donations	Chief Finance Officer	Deputy Chief Finance Officer
e. Dealing with legacies	Chief Finance Officer	Deputy Chief Finance Officer
f. Fundraising appeals • Preparation and monitoring of budget • Reporting progress and performance against budget	Charitable Funds Committee Chief Finance Officer	Deputy Chief Finance Officer in conjunction with Financial Controller Deputy Chief Finance Officer in conjunction with Financial Controller
g. Operation of Bank Accounts - managing banking arrangements and operation of bank accounts	Chief Finance Officer in conjunction with the Charitable Funds Committee	Deputy Chief Finance Officer
h. Opening bank accounts	Chief Finance Officer in conjunction with Charitable Funds Committee	Deputy Chief Finance Officer
i. Appointing Investment Manager	Charitable Funds Committee	Deputy Chief Finance Officer through Charitable Funds Committee

Delegated matter	Delegated to[3]	Operational responsibility
j. Nominated deposit taker	Charitable Funds Committee	Chief Finance Officer
k. Placing investment transactions.	Chief Finance Officer	Deputy Chief Finance Officer in conjunction with Financial Controller
l. Registration of funds with Charities Commission	Chief Finance Officer	Deputy Chief Finance Officer or Financial Controller
22. Gifts and hospitality		
a. Keeping of gifts and hospitality register	Chief Executive	Trust Secretary
b. Declaration and registration of all individual and collective items in excess of £50.00 per item	Chief Executive	All staff
23. Health and Safety		
Review of all statutory compliance with legislation and Health and Safety requirements including control of Substances Hazardous to Health Regulations	Chief Executive	Chief Nurse and Midwife with Head of Governance & Legal and Head of Resilience, Health & Safety
24. Infectious Diseases and Notifiable Outbreaks	Chief Nurse and Midwife	Director of Infection Prevention & Control
25. Legal Proceedings		
a. Engagement of Trust's Solicitors / Legal Advisors	Chief Executive	Executive Directors
b. Approve and sign all documents which will be necessary in legal proceedings, i.e. executed as a deed	Chief Executive	Executive Directors
c. Sign on behalf of the Trust any agreement or document not requested to be executed as a deed	Chief Executive	Executive Directors
26. Losses, write-offs and special payments		
a. Prepare procedures for recording and accounting for losses and special payments including preparation of a Fraud Response Plan and informing Local Counter Fraud Specialist of frauds	Chief Executive	Chief Finance Officer
b. Setting financial limits	Chief Executive	See Delegated Limits Table B Section 9
b. Losses of cash due to theft, fraud, overpayment and others	Chief Executive	Chief Finance Officer
c. Fruitless payments (including abandoned Capital Schemes)	Chief Executive	Chief Finance Officer
d. Bad debts and claims abandoned	Chief Executive	Chief Finance Officer
e. Damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use due to culpable causes (e.g. fraud, theft, arson)	Chief Executive	Chief Finance Officer
f. Reviewing appropriate requirement for insurance claims	Chief Finance Officer	Deputy Chief Finance Officer
g. Compensation payments by court order	Chief Executive	Chief Executive
h. Clinical negligence, covered by membership of CNST/NHSLA scheme	Chief Executive	Chief Nurse and Midwife

Delegated matter	Delegated to[3]	Operational responsibility
i. Ex-gratia payments • Setting financial limits • Other	Chief Finance Officer Chief Executive	See Delegated Limits Table B Section 9 See Delegated Limits Table B Section 9
j. A register of all losses and special payments should be maintained by the Finance Department and made available for inspection	Chief Finance Officer	Deputy Chief Finance Officer or Financial Controller
k. A report of all losses and special payments should be presented to the Audit committee	Chief Finance Officer	Deputy Chief Finance Officer or Financial Controller
27. Medical		
a. Clinical Governance arrangements	Medical Director	Head of Governance
b. Medical Leadership	Medical Director	Medical Director
c. Programmes of medical education	Medical Director	Medical Director
d. Medical staffing plans	Medical Director	Medical Director
e. Medical Research	Medical Director	Director of Research & Development
28. Medicines inspectorate regulations		
• Review regulations	Chief Executive	Medical Director / Head of Pharmacy
29. Meetings		
a. Calling meetings of the Board of Directors	Chair / Trust Secretary	Chair / Trust Secretary
b. Chair all Board of Director meetings and associated responsibilities	Chair	Chair
30. Non pay expenditure		
a. Maintenance of a list of managers authorised to place requisitions/orders and accept goods in accordance with Delegated Limits Table B Section 4	Chief Executive	Financial Controller in conjunction with Deputy Chief Finance Officer
b. Obtain the best value for money when requisitioning goods / services	Chief Executive	Chief Operating Officer, Clinical Directors, Department Heads and Head of Procurement
c. Non-Pay Expenditure for which no specific budget has been set up and which is not subject to funding under delegated powers of virement (subject to Delegated Limits Table B Section 4)	Chief Executive	Chief Finance Officer
d. Develop systems for the payment of accounts	Chief Finance Officer	Deputy Chief Finance Officer and Financial Controller
e. Prompt payment of accounts in line with national requirements	Chief Finance Officer	Deputy Chief Finance Officer and Financial Controller
f. Financial Limits for budgetary expenditure and ordering / requisitioning goods and services (including invoice authorisation without orders)	Chief Executive	See Delegated Limits Table B Section 4
g. Approve prepayment arrangements	Chief Finance Officer	Chief Finance Officer
31. Nursing		

Delegated matter	Delegated to[3]	Operational responsibility
a. Compliance with statutory and regulatory arrangements relating to professional nursing and midwifery practice	Director of Nursing &Midwifery	Professional nursing and midwifery leads
b. Matters involving individual professional competence of nursing and midwifery staff	Chief Nurse and Midwife	Professional nursing and midwifery leads
c. Compliance with professional training and development of nursing and midwifery staff	Chief Nurse and Midwife	Professional nursing and midwifery leads
d. Quality assurance of nursing and midwifery processes	Chief Nurse and Midwife	Professional nursing and midwifery leads
32. Patient Services Agreements		
a. Negotiation of Foundation Trust Contract and Non Commercial Contracts	Chief Executive	Chief Finance Officer and Chief Operating Officer
b. Quantifying and monitoring out of area treatments	Chief Finance Officer	Director Operations and Deputy Chief Finance Officer
c. Reporting actual and forecast income including payment by results	Chief Finance Officer	Chief Operating Officer and Deputy Chief Finance Officer
d. Costing Foundation Trust Agency Purchase Contracts and Non Commercial Contracts	Chief Finance Officer	Chief Operating Officer and Deputy Chief Finance Officer
e. National Cost Collection Exercise	Chief Finance Officer	Deputy Chief Finance Officer
f. Ad hoc costing relating to changes in activity, developments, business cases and bids for funding	Chief Finance Officer	Chief Operating Officer and Deputy Chief Finance Officer
33. Patients' property (in conjunction with financial advice)		
a. Ensuring patients and guardians are informed about patients' monies and property procedures on admission	Chief Executive	Chief Nurse and Midwife
b. Prepare detailed written instructions for the administration of patients' property	Chief Finance Officer	Deputy Chief Finance Officer or Financial Controller
c. Informing staff of their duties in respect of patients' property	Chief Finance Officer	Divisional Managers, Clinical Managers and Legal Services Manager
d. Issuing property of deceased patients (See SFI 6.25). In accordance with Delegated Limits Table B Section 4	Chief Finance Officer	Deputy Chief Finance Officer or Financial Controller in conjunction with nominated Divisional Lead
34. Human Resources		
a. Develop Human resource policies and strategies for approval by the Board of Directors including training, industrial relations	Chief People Officer	Chief People Officer
b. Nomination of officers to enter into contracts of employment regarding staff, agency staff or consultancy service contracts	Chief People Officer	Divisional Managers or Heads of Departments
c. Ensure that all employees are issued with a contract of employment in a form approved by the Board of Directors and which complies with employment legislation	Chief People Officer	Chief People Officer

Delegated matter	Delegated to[3]	Operational responsibility
• **Staff establishment (including engagement of staff not on the establishment) and re-gradings**		
d. Authority to fill funded post on the establishment with permanent staff	Chief People Officer	Clinical Directors, Divisional Managers or Heads of Departments
e. Additional staff to the agreed establishment with specifically allocated finance	Chief People Officer	Clinical Directors, Divisional Managers or Heads of Departments
f. Additional staff to the agreed establishment without specifically allocated finance	Chief Executive	Chief Finance Officer
g. Self-financing changes to an establishment	Chief People Officer	Human Resources Business Partner and Divisional Accountant
h. Nominate officers to enter into contracts of employment regarding staff, agency staff or non-medical consultancy service contracts	Chief Executive	Chief People Officer
i. Booking of bank staff • Nursing and midwifery • Other	Chief Nurse and Midwife Divisional Manager	Deputy Chief Nurse and Midwife or Matron. Chief Operating Officer
j. Booking of agency staff • Nursing and midwifery • Other	Chief Nurse and Midwife Divisional Manager	Chief Operating Officer, Matron or Heads of Nursing / Midwifery. Chief Operating Officer or Heads of Departments
k. The granting of additional increments at recruitment stage to staff within budget (other than automatic increments)	Chief People Officer	Clinical Directors, Chief Operating Officer or Heads of Departments
l. Re-grading requests / major skill mix changes (all requests shall be dealt with in accordance with Trust procedure)	Chief People Officer	Clinical Directors, Chief Operating Officer or Heads of Departments
m. Waiting list payments (approval of rates of pay and variations to agreed rates)	Chief Executive	Chief Operating Officer, Chief People Officer or Chief Finance Officer
• **Grievance and disciplinary procedures**		
n. Operation of grievance procedure (all grievances cases must be dealt with strictly in accordance with the Grievance Procedure and the advice of the Chief Operating Officer must be sought when the grievance reaches the level of Clinical Director / Divisional Managers / Heads of Department)	Chief People Officer	As per Trust procedure
o. Operation of the disciplinary procedure (excluding Executive Directors)	Chief People Officer	To be applied in accordance with the Trust's Disciplinary Procedure
• **Terms and conditions of employment**		
p. Renewal of fixed term contract	Chief People Officer	Chief Operating Officer on advice from Vacancy Control Panel

Delegated matter	Delegated to[3]	Operational responsibility
q. Authorise mobile phone use / issue	Chief People Officer	Executive Directors, Chief Operating Officer or Heads of Departments
r. Authorisation of payment of removal expenses, excess rent and house purchases (all staff in accordance with Trust policy and as agreed at interview)	Chief People Officer	Executive Directors, Chief Operating Officer or Heads of Departments
• **Pay**		
s. Presentation of proposals to the Board of Directors for the setting of remuneration and conditions of service for those staff not covered by the Nominations committee	Chief Executive	Chief People Officer
t. Authority to complete standing data forms affecting pay, new starters, variations and leavers	Chief People Officer	Clinical Directors, Chief Operating Officer, Heads of Departments or line or departmental managers
u. Authority to complete and authorise staff attendance record / positive reporting forms	Chief People Officer	Clinical Directors, Chief Operating Officer, professional Heads of Service, Heads of Departments or ward or departmental managers
v. Authority to authorise overtime	Chief People Officer	Clinical Directors & Chief Operating Officer
w. Authority to authorise travel and subsistence expenses	Chief People Officer	Executive Directors, Clinical Directors, Chief Operating Officer, Heads of Departments or authorised approvers.
• **Annual and special leave (refer to leave policies)**		
x. Approval of annual leave	Chief People Officer	Departmental Manager (as per Trust policy)
z. Approval of annual leave carry forward (up to maximum of 5 days)	Chief People Officer	Departmental Manager (as per Trust policy)
aa. Approval of annual leave carry forward of 6 to 10 days (to occur in exceptional circumstances only)	Chief People Officer	Executive Directors, Chief Operating Officer, or Heads of Department
bb. Approval of annual leave carry forward in excess of 10 days	Chief People Officer	Executive Directors
cc. Special leave arrangements for personal, domestic and family reasons including compassionate / bereavement leave, parental leave, paternity leave, carers leave and adoption leave (to be applied in accordance with Trust Policy)	Chief People Officer	Line or Departmental Managers
dd. Special Leave for non-domestic / personal / family reasons including jury service and armed services (to be applied in accordance with Trust Policy)	Chief People Officer	Chief Operating Officer or Heads of Departments
ee. Leave without pay (including short-term unpaid leave and career break)	Chief People Officer	Chief Operating Officer, Heads of Departments or line or departmental managers
ff. Medical Staff leave of absence – paid and unpaid	Chief People Officer	Clinical Director with advice from Medical Director

Delegated matter	Delegated to[3]	Operational responsibility
gg. Time off in lieu	Chief People Officer	Divisional Managers or Line Managers
hh. Maternity Leave - paid and unpaid	Chief People Officer	Automatic approval with guidance
• **Sick leave**		
ii. Extension of sick leave on pay	Chief People Officer	Divisional Managers or Human Resources staff, as per Trust policy
jj. Return to work part-time on full pay to assist recovery	Chief People Officer	Deputy Director of Workforce or Divisional Managers
• **Study leave**		
kk. Study leave outside the UK	Chief Executive	Relevant Executive Director
ll. Medical staff study leave (UK): • Consultant • Career Grade • Non Career Grade	 Medical Director Medical Director Post Graduate Tutor	 Clinical Director Clinical Director Clinical Director
mm. All other study leave (UK)	Chief People Officer	Executive Directors, Clinical Directors, Divisional Managers or Department Heads
• **Retirement (including ill-health retirement)**		
nn. Authorisation of return to work in part time capacity under the flexible retirement scheme	Chief People Officer	Divisional Manager
oo. Decision to pursue retirement on the grounds of ill-health following advice from the Occupational Health Department	Chief People Officer	Divisional Manager
• **Redundancy (as approved by Board of Directors)**	Chief Executive	Chief People Officer
35. Quotation, tendering and contracting procedures		
a. Entering into contracts on behalf of the Trust, regardless of value	Chief Executive	Executive Directors or nominated Deputy
b. Best value for money is demonstrated for all services provided under contract or in-house	Chief Executive	Chief Finance Officer, Chief Operating Officer and Head of Procurement
c. Nominate officers to oversee and manage contracts on behalf of the Trust	Chief Executive	Chief Finance Officer, Chief Operating Officer ,Head of Procurement or Divisional Managers
d. Set competitive tender authorisation limits (see Delegated Limits Table B, section 6)	Chief Executive	Chief Finance Officer
e. Maintain a register to show each set of competitive tender invitations despatched	Chief Executive	Financial Controller or Head of Procurement
f. Ensure that appropriate checks are carried out as to the technical and financial capability of the firms invited to tender or quote	Chief Executive	Chief Finance Officer or Head of Procurement
g. Receipt and custody of tenders prior to opening	Chief Executive	Chief Finance Officer or Head of Procurement

Delegated matter	Delegated to[3]	Operational responsibility
i. Waiving the requirement to request tenders (subject to SFI 6.26.11.6, reported to the Audit Committee)	Chief Executive	Chief Executive or Chief Finance Officer
j. Waiving the requirement to request quotes (subject to SFI 6.26.11.6)	Chief Executive / Chief Finance Officer	Chief Executive or Chief Finance Officer
36. Records		
a. Review Trust's compliance with the Retention of Records Act	Chief Executive	Executive Directors
b. Review the Trust's compliance with the Records Management Code of Practice	Chief Executive	Chief Nurse and Midwife, Chief Information Officer, Chief Operating Officer and Heads of Departments
c. Ensuring the form and adequacy of the financial records of all departments	Chief Finance Officer	Deputy Chief Finance Officer
37. Reporting of Incidents to the Police		
a. Where a criminal offence is suspected: • Criminal offence of a violent nature • Arson or theft • Other	Chief Operating Officer	Executive Director on call
b. Where a fraud is involved (reporting to NHS Protect and external audit)	Chief Finance Officer	Local Counter Fraud Specialist in conjunction with Chief Finance Officer
c. Deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption	Chief Finance Officer	Local Counter Fraud Specialist in conjunction with Chief Finance Officer
38. Risk Management		
a. Ensuring the Trust has a Risk Management Strategy and a programme of risk management	Chief Executive	Chief Operating Officer
b. Developing systems for the management of risk	Chief Operating Officer	Head of Governance & Legal
c. Developing incident and accident reporting systems	Chief Operating Officer	Head of Governance & legal
d. Compliance with the reporting of incidents and accidents	Chief Operating Officer	All staff
39. Seal		
a. The keeping of a register of seal and safekeeping of the seal	Chief Executive	Trust Secretary
b. Attestation of seal in accordance with Standing Orders	Chief Executive	Chief Executive and Chief Finance Officer (report to Board of Directors)
c. Property transactions and any other legal requirement for the use of the seal	Chair and Chief Executive	Chair or Non-Executive Director and the Chief Executive or their nominated Executive Director
40. Security Management		
Monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management	Chief Executive	Chief Operating Officer and Local Security Management Specialist

Delegated matter	Delegated to[3]	Operational responsibility
including appointment of the Local Security Management Specialist		
41. Setting of Fees and Charges (Income)		
a. Private Patient, Overseas Visitors, Income Generation and other patient related services	Chief Finance Officer	Deputy Chief Finance Officer and budget holders
b. Non patient care income	Chief Finance Officer	Divisional Managers, Heads of Departments or Divisional Accountants
c. Informing the Chief Finance Officer of monies due to the Trust	Chief Finance Officer	All Staff
d. Recovery of debt	Chief Finance Officer	Deputy Chief Finance Officer
e. Security of cash and other negotiable instruments	Chief Finance Officer	Deputy Chief Finance Officer
42. Stores and Receipt of Goods		
a. Responsibility for systems of control over stores and receipt of goods, issues and returns	Chief Finance Officer	Clinical Directors, Divisional Managers, Heads of Departments or Head of Procurement
b. Stocktaking arrangements	Chief Finance Officer	Clinical Directors / Divisional Managers, Heads of Departments or Head of Procurement
c. Responsibility for controls over pharmaceutical stock	Head of Pharmacy	Head of Pharmacy and Ward Managers
d. Approve system for review of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable items	Chief Finance Officer	Clinical Directors, Divisional Managers, Heads of Departments or Head of Procurement

Table B – Delegated Financial Limits

Delegated matter	Delegated limit	Delegated to[4]
1. Virement		
Authorisation of virement	£100,000 and above	Chief Executive or Chief Finance Officer and reported to Board of Directors
	£50,001 up to £100,000	Chief Finance Officer or Deputy Chief Finance Officer
	Up to £50,000	Divisional Managers, Hewitt Centre Managing Director,, Head of Management Accounts and relevant budget holder, subject to virement signed off by Divisional Accountant
2. Cash and banking		
a. Petty cash disbursements	Up to £50	Petty cash imprest holder
b. Sundry exchequer items	£100 up to £5,000	Deputy Chief Finance Officer or Financial Controller
c. Patient monies	£5,000 and above	Chief Finance Officer or another Executive Director
d. Acceptance of cash transactions	Up to £10,000	Chief Finance Officer, Deputy Chief Finance Officer or Financial Controller
3.Non-establishment pay expenditure		
Nominated officer entering into contracts or agreements with staff not on the establishment:		
a. Where aggregate commitment in any one year (or total commitment) is less than £20,000	Chief Executive	Executive Directors or Divisional Managers
b. Where aggregate commitment in any one year is more than £20,000	Chief Executive	Chief Finance Officer
4. Non-pay expenditure (including invoice authorisation without orders)		
Approving requisitions, authorising invoices and recommending contract awards.	£500,000 and above	Board Approval
	£250,000 up to £500,000	Two Executive Directors – one of which must be the Chief Executive or Chief Finance Officer
	£~~189,330~~122,976 (excluding VAT) up to £250,000	Chief Executive or Chief Finance Officer
	£40,000 up to £~~189,330~~122,976 (excluding VAT)	Executive Director with advice from Deputy Chief Finance Officer and/or Head of Procurement
	£5,000 up to £40,000	Divisional Manager or Head of Department

[4] If the Chief Executive is absent powers delegated to them may be exercised by the nominated officer(s) acting in their absence after taking appropriate financial advice, two directors will be required to ratify any decisions within the Chief Executive's thresholds.

Delegated matter	Delegated limit	Delegated to[4]
	Up to £5,000	Budget holder
5. Capital expenditure		
Requisitioning items / services against capital budget	Over £500,000	Board of Directors (minute approval)
	£250,000 up to £500,000	Chief Executive and Chief Finance Officer
	£25,000 up to £250,000	Chief Finance Officer or Director of Operations
	Up to £25,000	Chief Finance Officer or project sponsor or delegated nominee
6. Quotation, tendering and contract procedures		
a. Quotations: *Obtaining* a minimum of 3 written quotations for goods / services	£5,000 up to £40,000 including VAT	Head of Procurement
b. Competitive tenders: *Obtaining* a minimum of 3 written competitive tenders for goods / services (in compliance with Public Contracts Regulations 2015 where Find a Tender Service value threshold is exceeded~~with EC directives as appropriate~~)	Over £40,000 including VAT	Head of Procurement
c. Waiving requirements for tenders, subject to full compliance with standing orders: Tenders	£40,000 up to £~~189,330~~122,976 (excluding VAT)	The Chief Finance Officer in the first instance. Should the Chief Finance Officer be absent for an extended period of time; or absent when an urgent requirement occurs relating to either service continuity or patient care; any Executive Director will have delegated authority to authorise the use of a waiver
d. Waiving requirements for quotes, subject to full compliance with standing orders: Quotations	£5,000 up to £40,000 including VAT	The Chief Finance Officer in the first instance. Should the Chief Finance Officer be absent for an extended period of time; or absent when an urgent requirement occurs relating to either service continuity or patient care; any Executive Director will have delegated authority to authorise the use of a waiver
7. Funds held on trust		
a. Expenditure authorisation (per request) – General Purpose Fund	£40,001 and above	Chief Nurse and Midwife or Deputy Chief Finance Officer plus Chief Finance Officer plus Charitable Funds Committee
	£20,001 up to £40,000	Chief Nurse and Midwife or Deputy Chief Finance Officer plus Chief Finance Officer
	Up to £20,000	Chief Nurse and Midwife or Deputy Chief Finance Officer

Delegated matter	Delegated limit	Delegated to[4]
b. Expenditure authorisation (per request) – Funds other than the General Purpose Fund	£30,000 and above	Nominated fund holder(s) plus Deputy Chief Finance Officer plus Chief Finance Officer and NED plus Charitable Funds Committee
	£10,001 up to £29,999	Nominated fund holder(s) plus Deputy Chief Finance Officer plus Chief Finance Officer and NED
	Up to £10,000	Nominated fund holder(s) plus Deputy Chief Finance Officer
8. Disposals and condemnations		
With current / estimated purchase price	£5,000 and above	Divisional Manager or Deputy Chief Finance Officer with advice of relevant professional lead where appropriate
	Up to £5,000	Divisional Manager or Head of Department with advice of relevant professional lead where appropriate
9. Losses and special payments		
Losses a. Fruitless payments (including abandoned capital schemes)	£250,000 and above	Board of Directors
	£5,000 up to £250,000	Chief Executive or Chief Finance Officer and reported to Audit Committee
	Up to £5,000	Chief Executive or Chief Finance Officer
b. Losses of cash due to theft, fraud, overpayment and others	£50,000 and above	Board of Directors
c. Bad debts and claims abandoned	£1,000 up to £50,000	Chief Executive or Chief Finance Officer and reported to Audit Committee
	Up to £1,000	Deputy Chief Finance Officer
d. Damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use due to culpable causes (e.g. fraud, theft, arson)	Up to £1,000	Chief Executive or Chief Finance Officer
Special payments	£50,000 and above	Board of Directors
e. Compensation payments by court order	£2,000 up to £50,000	Chief Executive or Chief Finance Officer
	Up to £2,000	Legal Services Manager
f. Ex-gratia payments to patients / staff for loss of personal effects	£50,000 and above	Board of Directors
	£2,000 to £50,000	Chief Executive or Chief Finance Officer
	Up to £2,000	Legal Services Manager
	£50,000 and above	Board of Directors
g. Other ex-gratia payments	Up to £50,000	Chief Executive or Chief Finance Officer
10. Legally binding contracts for clinical service provision or purchase of clinical support services under Foundation Trust contracts		

Delegated matter	Delegated limit	Delegated to[4]
	£1million annual value and above	Chief Executive or Chief Finance Officer or Director Operations
	Up to £1million annual value	Chief Finance Officer or Chief Operating Officer

6 Standing Financial Instructions

6.1 Introduction

6.1.1 The independent regulator sets the Licence for the Foundation Trust that require compliance with the principles of best practice applicable to corporate Governance within the NHS/ Health Sector with any relevant code of proactive ad guidance issued by the independent regulator.

6.1.2 The Code of Conduct and Accountability in the NHS5 requires that each NHS Foundation Trust shall give, and may vary or revoke, Standing Financial Instructions for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. These Standing Financial Instructions (SFIs) are issued in accordance with the Code. They shall have effect as if incorporated in the Standing Orders (SOs) of the Foundation Trust.

6.1.3 These SFIs detail the financial responsibilities, policies and procedures to be adopted by the Foundation Trust. They are designed to ensure that its financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Decisions Reserved to the Board of Directors and the Scheme of Delegation adopted by the Foundation Trust.

6.1.4 These SFIs identify the financial responsibilities which apply to everyone working for the Foundation Trust and its constituent organisations, including Trading Units. They do not provide detailed procedural advice. These statements should therefore be read in conjunction with the detailed departmental and financial procedure notes. The Chief Finance Officer must approve all financial procedures.

6.1.5 Should any difficulties arise regarding the interpretation or application of any of the SFIs, then the advice of the Chief Finance Officer MUST BE SOUGHT BEFORE ACTING. The user of these SFIs should also be familiar with and comply with the provisions of the Foundation Trust's SOs.

FAILURE TO COMPLY WITH STANDING FINANCIAL INSTRUCTIONS AND STANDING ORDERS IS A DISCIPLINARY MATTER, WHICH COULD RESULT IN DISMISSAL.

6.1.6 Overriding Standing Financial Instructions – If for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit Committee for referring action or ratification. All members of the Board of Directors and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Chief Finance Officer as soon as possible.

6.2 Terminology

6.2.1 Unless the contrary intention appears or the context otherwise requires, words or expressions contained in the constitution and these instructions bear the same meaning as in the National Health Service Act 2006. References in the Constitution to legislation include all amendments, replacements, or re-enactments made.

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[5] Code of Conduct, Code of Accountability, Department of Health (1994 & 2004)

6.2.2 Wherever the title Chief Executive, Chief Finance Officer, or other nominated officer is used in these instructions, it shall be deemed to include such other directors or employees who have been duly authorised to represent them. Wherever the term "employee" is used, and where the context permits, it shall be deemed to include employees of third parties contracted to the Foundation Trust when acting on behalf of the Foundation Trust, including nursing and medical staff and consultants practising on the Foundation Trust premises and members of staff of private contractors or trust staff working for private contractors under retention of employment model.

6.3 Responsibilities and Delegation

6.3.1 The Foundation Trust shall at all times remain a going concern as defined by the relevant accounting standards in force. The Board of Directors exercises financial supervision and control by:

(a) Formulating the financial strategy;
(b) Requiring the submission and approval of budgets within overall income;
(c) Defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money) and by ensuring appropriate audit provision; and
(d) Defining specific responsibilities placed on directors and employees as indicated in the Scheme of Delegation document.

6.3.2 The constitution dictates that the Council of Governors may not delegate any of its powers to a committee or sub-committee. The Board of Directors has resolved that certain powers and decisions may only be exercised by the Board of Directors in formal session. These are set out in the “Reservation of Powers to the Board of Directors” document, published within the Scheme of Delegation. The Board of Directors will delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation document adopted by the Foundation Trust.

6.3.3 Within the SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board of Directors and as the Accounting Officer for ensuring that the Board of Directors meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Foundation Trust's activities, is responsible to the Board of Directors for ensuring that its financial obligations and targets are met and has overall responsibility for the Foundation Trust’s system of internal control.

6.3.4 The Chief Executive and Chief Finance Officer will, as far as possible, delegate their detailed responsibilities but they remain accountable for financial control.

6.3.5 It is a duty of the Chief Executive to ensure that existing directors and employees and all new appointees are notified of and understand their responsibilities within these Instructions. All staff shall be responsible for ensuring conformity with the Standing Orders, Standing Financial Instructions and financial procedures of the Foundation Trust.

6.3.6 The Chief Finance Officer is responsible for:

(a) Implementing the Foundation Trust’s financial policies and for co-ordinating any corrective action necessary to further these policies (the SFIs themselves do not provide detailed procedural advice. These statements should therefore be read in conjunction with the detailed departmental and financial procedure notes);
(b) Maintaining an effective system of internal financial control, including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

(c) Ensuring that sufficient records are maintained to show and explain the Foundation Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Foundation Trust at any time and, without prejudice to any other functions of directors and employees to the Foundation Trust, the duties of the Chief Finance Officer include:
(d) The provision of financial advice to other members of the Board of Directors, Council of Governors and employees;
(e) The design, implementation and supervision of systems of internal financial control; and
(f) The preparation and maintenance of such accounts, certificates, estimates, records and financial reports as the Foundation Trust may require for the purpose of carrying out its statutory duties.

6.3.7 All directors and employees, severally and collectively, are responsible for:
(a) The security of the property of the Foundation Trust;
(b) Avoiding loss;
(c) Exercising economy and efficiency in the use of resources; and
(d) Conforming to the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

6.3.8 Any contractor or employee of a contractor who is empowered by the Foundation Trust to commit the Foundation Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

6.3.9 For any and all directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which directors and employees discharge their duties must be to the satisfaction of the Chief Finance Officer.

6.4 Audit

6.4.1 Audit Committee

6.4.1.1 In accordance with Standing Orders, the Board of Directors shall formally establish an Audit Committee with clearly defined terms of reference, which will provide an independent and objective view of internal control by:

(a) Overseeing internal and external audit services;
- Internal audit
  - to monitor and review the effectiveness of the internal audit function
- External audit
  - to assess the external auditor's work and fees on an annual basis to ensure that the work is of sufficiently high standard and that the fees are reasonable
  - to ensure a market testing exercise for the appointment of the external auditor is undertaken at least once every five years
  - to make recommendations to the Council of Governors, in relation to the appointment, re-appointment and removal of the external auditor and to approve the remuneration and terms of engagement of the external auditor
  - to review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process, taking into account relevant UK professional and regulatory requirements.

(b) Reviewing financial and information systems and monitoring the integrity of the financial statements and any formal announcements relating to the Trust's financial performance and reviewing of significant financial reporting judgements;

(c) Reviewing the effective implementation of corporate governance measures to enable the Foundation Trust to implement best practice as set out in appropriate guidance. This will include the Assurance Framework and control related disclosure statements, for example the Statement on Internal Control and supporting assurance processes, together with any accompanying audit statement, prior to endorsement by the Board of Directors
(d) Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (clinical, operational, compliance controls and risk management systems) that support the achievement of the organisation's objectives
(e) Monitoring compliance with Standing Orders and Standing Financial Instructions;
(f) Reviewing schedules of losses and compensations and making recommendations to the Board of Directors.

6.4.1.2 The Board of Directors shall satisfy itself that at least one member of the Audit Committee has recent and relevant financial experience.

6.4.1.3 Where the Audit Committee feels there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the committee wish to raise, the chair of the Audit Committee should raise the matter at a full meeting of the Board of Directors (to the Chief Finance Officer in the first instance).

6.4.1.4 It is the responsibility of the Chief Finance Officer to ensure an adequate internal audit service is provided, and the Audit Committee shall be involved in the selection process when an internal audit service provider is changed.

6.5 Chief Finance Officer

6.5.1 The Chief Finance Officer is responsible for:

(a) Ensuring there are arrangements to review, evaluate and report on the effectiveness of internal control, including the establishment of an effective internal audit function and the coordination of other assurance arrangements;
(b) Ensuring that the internal audit is adequate and meets the NHS mandatory audit standards;
(c) Deciding at what stage to involve the police in cases of fraud, misappropriation, and other irregularities not involving fraud or corruption;
(d) Ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee and the Board of Directors. The report must cover:
    (i) An opinion to support the statement on the effectiveness of internal controls in accordance with current guidance issued by the Department of Health;
    (ii) Major internal financial control weaknesses discovered;
    (iii) Progress on the implementation of internal audit recommendations;
    (iv) Progress against plan over the previous year;
    (v) Strategic audit plan covering the coming three years;
    (vi) A detailed plan for the coming year.

6.5.2 The Chief Finance Officer or designated auditors are entitled without necessarily giving prior notice to require and receive:

(a) Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;
(b) Access at all reasonable times to any land, premises, members of the Board of Directors and Council of Governors or employee of the Foundation Trust;
(c) The production of any cash, stores or other property of the Foundation Trust under a member of the Board of Directors or employee's control; and
(d) Explanations concerning any matter under investigation.

6.6 Role of Internal Audit

6.6.1 The NHS Foundation Trust Accounting Officer Memorandum requires the Foundation Trust to have an internal audit function.

6.6.2 The role of internal audit embraces two key areas:

- The provision of an independent and objective opinion to the Accounting Officer, the Board of Directors and the Audit Committee on the degree to which risk management, control and governance support the achievement of the organisation's agreed objectives
- The provision of an independent and objective consultancy service specifically to help line management improve the organisation's risk management, control and governance arrangements.

6.6.3 Internal Audit will review, appraise and report upon:

(a) The extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;
(b) The adequacy and application of financial and other related management controls;
(c) The suitability of financial and other related management data;
(d) The extent to which the Foundation Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:
    i) fraud and other offences
    ii) waste, extravagance, inefficient administration
    iii) poor value for money or other causes.
(e) Internal Audit shall also independently verify the assurance statements in accordance with guidance from NHS Improvement and the Department of Health.

6.6.4 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Chief Finance Officer must be notified immediately.

6.6.5 The Head of Internal Audit will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chair and Chief Executive of the Foundation Trust.

6.6.6 The Head of Internal Audit shall be accountable to the Audit Committee. The reporting system for internal audit shall be agreed between the Chief Finance Officer, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the Public Sector Internal Auditing Standards (PSIAS). The reporting system shall be reviewed at least every three years. Where, in exceptional circumstances, the use of normal reporting channels is thought to limit the objectivity of the audit, the Head of Internal Audit shall have access to report direct to the Chair or a non-executive member of the Foundation Trust's Audit Committee.

6.6.7 Managers in receipt of audit reports referred to them have a duty to take appropriate remedial action within the agreed timescales specified within the report. The Chief Finance Officer shall identify a formal review process to monitor the extent of compliance with audit recommendations. Where appropriate remedial action has failed to take place within a reasonable period, the matter shall be reported to the Chief Finance Officer.

6.7 External Audit

6.7.1 Duties

6.7.1.1 The Foundation Trust is to have an external auditor and is to provide the external auditor with every facility and all information which they may reasonably require.

6.7.1.2 The external auditor is to carry out their duties in accordance with Schedule 10 of the 2006 Act and in accordance with any directions given by the Independent Regulator on standards, procedures and techniques to be adopted.

6.7.1.3 In auditing the accounts the financial auditor must, by examination of the accounts and otherwise, satisfy themselves that the Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

6.7.1.4 The external auditor will also audit the quality report of the Foundation Trust.

6.7.1.5 The Foundation Trust is required to include an annual governance statement within its annual report and financial accounts which include the quality report. The external auditors have a responsibility to:

- consider the completeness of the disclosures in meeting the relevant requirements; and
- identify any inconsistencies between the disclosures and the information that they are aware of from their work on the financial statements, quality report and other work.

6.7.2 Appointment of External Auditor

6.7.2.1 The external auditor is appointed by the Council of Governors following recommendation from the Audit Committee. 6The Audit Code for NHS Foundation Trusts ("the Audit Code") contains the directions of NHS Improvement with respect of those eligible to be appointed under the National Health Service Act 2006, and with respect to the standards, procedures and techniques to be adopted by the external auditor.

6.7.2.2 A person may only be appointed as the external auditor if they (or in the case of a firm of each of its members) are a member of one or more of the bodies referred to in Schedule 10 of the 2006 Act.

6.7.2.3 The Council of Governors at a general meeting shall appoint or remove the Foundation Trust's external auditor.

6.7.2.4 The Board of Directors may, upon taking the advice of the Audit Committee, resolve that external auditors be appointed to review and publish a report on any other aspect of the Foundation Trust's performance. Approval of the engagement of external auditors on non-audit work will take into account relevant ethical guidance regarding the provision of such services. Any such auditors are to be appointed by the Council of Governors.

6.7.3 Undertaking Work

6.7.3.1 NHS Improvement may require auditors to undertake work on its behalf at the Foundation Trust. In this situation, a tripartite agreement between the Independent Regulator, the auditor and the Foundation Trust will be agreed. This agreement, which will include details of the subsequent work and reporting arrangements, will be in accordance with the principles established in the guidance issued by the Institute if

[6] Audit Code for NHS Foundation Trust, NHS Improvement (2011)

Chartered Accountants in England and Wales in audit 05/03: Reporting to Regulators or Regulated Entities.

6.7.3.2 The auditor may, with the approval of the Council of Governors, provide the Foundation Trust with services which are outside of the scope as defined in the code (additional services). The Foundation Trust shall adopt and implement a policy for considering and approving any additional services to be provided by the auditor.

6.7.4 Liaison with Internal Audit

6.7.4.1 It is expected that the external auditors will liaise with the internal audit function in order to obtain a sufficient understanding of internal audit activities to assist in planning the audit and developing an effective audit approach. The auditors may also wish to place reliance upon certain aspects of the work of internal audit in satisfying their statutory responsibilities as set out in the 2006 Act and the Audit Code. In particular the financial auditor may wish to consider the work of internal audit when undertaking their procedures in relation to the statement on internal control.

6.7.5 Access To Documents

6.7.5.1 The Auditors of the Foundation Trust have a right of access at all reasonable times to every document relating to the Foundation Trust which appears to them necessary for the purpose of their functions under Schedule 10 of the 2006 Act.

6.7.6 Public Interest Report

6.7.6.1 In the event of the External Auditor issuing a Public Interest report the Foundation Trust shall:

- Send the public interest report to the Council of Governors, the Board of Directors and NHS Improvement:
  - At once if it is an immediate report; or
  - Not later than 14 days after conclusion of the audit.
- Forward a report to NHS Improvement within 30 days (or such shorter period as the Independent Regulator may specify) of the report being issued. The report shall include details of the Foundation Trust's response to the issues raised within the Public Interest report.

References in 6.6.5 and 6.6.7 relate equally to internal and external audit.

6.8 Fraud and Bribery

6.8.1 Fraud applies to any person who dishonestly makes a false representation to make a gain for himself or another or dishonestly fails to disclose to another person, information which he is under a legal duty to disclose, or commits fraud by abuse of position, including any offence as defined in the Fraud Act 2006. Bribery applies in the giving (or offering) or receiving (or requesting) a financial or other advantage in connection with the improper performance of a position of trust, or a function that is expected to be performed impartially or in good faith.

6.8.2 The Foundation Trust shall take all necessary steps to counter fraud and bribery affecting NHS funded services in accordance with Clause 47 of the "Foundation Trust Agency Purchase Contract" (FTAPC) including Schedule 11 and in accordance with:

(a) The NHS Fraud and Corruption Manual published by NHS Protect;
(b) The policy statement "Applying Appropriate Sanctions Consistently" published by NHS Protect;
(c) Any other reasonable guidance or advice issued by CFSMS that affects efficiency, systemic and/or procedural matters
(d) The Fraud Act 2006;
(e) The Bribery Act 2010.

The Chief Executive and Chief Finance Officer shall monitor and ensure compliance with the above.

6.8.3 The Foundation Trust shall nominate a suitable, independent person to carry out the duties of the Local Counter Fraud Specialist as specified by the Department of Health Fraud and Corruption Manual and guidance.

6.8.4 The Local Counter Fraud Specialist shall report to the Foundation Trust Chief Finance Officer and shall work with the staff of NHS Protect in accordance with the Department of Health Fraud and Corruption Manual.

6.8.5 All allegations of fraud and bribery will be reported and if necessary investigated by the Local Counter Fraud Specialist. All accountable officers should also be aware of their obligation to pass any referrals onto the Local Counter Fraud Specialist at their earliest convenience.

6.8.6 The Local Counter Fraud Specialist will provide a written plan and report, at least annually, on counter fraud work within the Foundation Trust.

6.9 Security Management

6.9.1 The Foundation Trust shall promote and protect the security of people engaged in activities for the purposes of the health service functions of that body, its property and its information in accordance with the requirements of the 'Foundation Trust Contract', having regard to any other reasonable guidance or advice issued by NHS Protect.

6.9.2 The Foundation Trust shall nominate and appoint a local security management specialist as per the Foundation Trust contract.

6.9.3 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Security Management Director (SMD) and the appointed Local Security Management Specialist (LSMS).

6.10 Allocations/Payment by Results, Business Planning, Budgets, Budgetary Control, and Monitoring

6.10.1 Preparation and approval of Business Plans and Budget

6.10.1.1 The Chief Executive will compile and submit to the Board of Directors an annual plan that takes into account financial targets and forecast limits of available resources. The annual plan will contain:

(a) A statement of the significant assumptions on which the plan is based;
(b) Details of major changes in workload, delivery of services or resources required to achieve the plan.

6.10.1.2 Prior to the start of the financial year the Chief Finance Officer will, on behalf of the Chief Executive, prepare and submit budgets relating to income and expenditure for approval by the Board of Directors. Such budgets will:

(a) Be in accordance with the aims and objectives set out in the annual plan, and the commissioners' local delivery plans;
(b) Accord with workload and workforce plans;
(c) Be produced following discussion with appropriate budget holders;
(d) Be prepared within the limits of available funds;
(e) Identify potential risks;
(f) Be based on reasonable and realistic assumptions; and

6.10.1.3 The Chief Finance Officer shall monitor financial performance against budgets, periodically review it and report to the Board of Directors. Any significant variances should be reported by the Chief Finance Officer to the Board of Directors as soon as they come to light, and the Board of Directors shall be advised of action to be taken in respect of such variances.

6.10.1.4 All budget holders must provide information as required by the Chief Finance Officer to enable budgets to be compiled.

6.10.1.5 All budget holders will sign up to their allocated budgets at the commencement of each financial year.

6.10.1.6 The Chief Finance Officer has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders and budget managers to help them manage successfully.

6.10.2 Budgetary Delegation

6.10.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities, including pooled budget arrangements under Section 31 of the Health Act 1999. This delegation must be in writing and be accompanied by a clear definition of:

(a) The amount of the budget;
(b) The purpose(s) of each budget heading;
(c) Individual and group responsibilities;
(d) Authority to exercise virement (which cannot be from a non-pay heading into a pay heading) (see also sections 6.10.2.2 and 6.10.2.3 below);
(e) Achievement of planned levels of service; and
(f) The provision of regular reports.

6.10.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board of Directors.

6.10.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

6.10.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive as advised by the Chief Finance Officer.

6.10.3 Budgetary Control and Reporting

6.10.3.1 The Chief Finance Officer will devise and maintain systems of budgetary control. These will include:

(a) Regular financial reports to the Board of Directors in a form approved by the Board of Directors containing:
    i) Income and expenditure to date showing trends and forecast year-end position;
    ii) Balance sheet, including movements in working capital;
    iii) Capital project spend and projected outturn against plan;
    iv) Explanations of any material variances from plan/budget;
    v) Details of any corrective action where necessary and the Chief Executive's and/or Chief Finance Officer's view of whether such actions are sufficient to correct the situation;
(b) The issue of timely, accurate and comprehensible advice and financial reports to each budget holder and budget manager, covering the areas for which they are responsible;
(c) Investigation and reporting of variances from financial, and workload budgets;

(d) Monitoring of management action to correct variances;
(e) Arrangements for the authorisation of budget transfers;
(f) Advising the Chief Executive and Board of Directors of the consequences of changes in policy, pay awards and other events and trends affecting budgets and shall advise on the economic and financial impact of future plans and projects; and
(g) Review of the bases and assumptions used to prepare the budgets.

In the performance of these duties the Chief Finance Officer will have access to all budget holders and budget managers on budgetary matters and shall be provided with such financial and statistical information as is necessary.

6.10.3.2 Each budget holder is responsible for ensuring that:
(a) Any planned or known overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Board of Directors;
(b) Officers shall not exceed the budget limit set;
(c) The amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement; and
(d) No permanent employees are appointed without the approval of the Chief Executive or Chief Finance Officer other than those provided for in the budgeted establishment as approved by the Board of Directors.

6.10.3.3 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Annual Business Plan and a balanced budget.

6.10.4 Capital Expenditure

6.10.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure (the particular applications relating to capital are contained in Section 6.18). A project sponsor will be identified who will assume responsibility for the budget relating to the scheme.

6.10.5 Monitoring Returns

6.10.5.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to the requisite monitoring organisation within specified timescales.

6.11 Annual Accounts and Reports

6.11.1 Accounts

6.11.1.1 The Foundation Trust shall keep accounts in such form as NHS Improvement may with the approval of HM Treasury direct. The accounts are to be audited by the Foundation Trust's external auditor. The following documents will be made available to the Comptroller and Auditor General for examination at their request:
- the accounts;
- any records relating to them; and
- any report of the financial auditor on them.

6.11.1.2 The functions of the Foundation Trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer.

6.11.1.3 In preparing its annual accounts, the accounting officer shall cause the Foundation Trust to comply with any directions given by the Independent Regulator with the approval of the Treasury as to:
- the methods and principles according to which the accounts are to be prepared;
- the information to be given in the accounts;

and shall be responsible for the functions of the Foundation Trust as set out in Schedule 10 to the 2006 Act.

6.11.1.4 The annual accounts, any report of the external auditor on them, and the annual report are to be presented to the Council of Governors at a General Meeting. The Accounting Officer shall cause the Foundation Trust to:

- lay a copy of the annual accounts, and any report of the financial auditor on them, before Parliament; and
- once it has done so, send copies of those documents to NHS Improvement.

6.11.1.5 Responsibility for complying with the requirements relating to the form, preparation and presentation of the accounts shall be delegated to the Accounting Officer.

6.11.2 Annual Reports

6.11.2.1 The Foundation Trust is to prepare annual reports and send them to the independent regulator, NHS Improvement. The reports are to give:

- information on any steps taken by the Foundation Trust to secure that (taken as a whole) the actual membership of its public constituencies and of the classes of the staff constituency is representative of those eligible for such membership; and
- any other information NHS Improvement requires.

6.11.2.2 The Foundation Trust is to comply with any decision NHS Improvement makes as to:

- the form of the reports;
- when the reports are to be sent to them;
- the periods to which the reports are to relate.

6.11.2.3 The external auditors of the Foundation Trust have a responsibility to read the information contained within the Annual Report and consider the implications for the audit opinion and/or certificate if there are apparent misstatements or material inconsistencies with the financial statements.

6.11.2.4 Annual Plans

6.11.2.5 The Foundation Trust is to give information as to its forward planning in respect of each financial year to be submitted in accordance with requirements and timescales set by NHS Improvement. The document containing this information is to be prepared by the Directors, and in preparing the document, the Board of Directors must have regard to the views of the Council of Governors. The Annual Plan must be approved by the Board of Directors.

6.11.3 Other Reports

6.11.3.1 The Foundation Trust is required to publish a separate Quality Account each year as required by the NHS Act 2009 and in the terms set out in the NHS (Quality Accounts) Regulations 2010 and any guidance issued by NHS Improvement.

6.11.3.2 The Foundation Trust is also required to provide the following three types of in-year reports:

- regular reports, (quarterly monitoring reports), subject to review;
- Exception reports, which may relate to any in-year issue affecting compliance with the Authorisation, such as performance against core national healthcare targets and standards; and
- Ad hoc reports, following up specific issues identified either in the Annual Plan or in-year.

6.12 Bank and OPG Accounts

6.12.1 General

6.12.1.1 The Chief Finance Officer is responsible for managing the Foundation Trust banking arrangements and for advising the Foundation Trust on the provision of banking services and operation of accounts.

6.12.1.2 The Board of Directors shall approve the banking arrangements.

6.12.2 Bank and OPG Accounts

6.12.2.1 The Chief Finance Officer is responsible for:

(a) Bank accounts including those provided by the Government Banking Service (GBS), and other forms of working capital financing;
(b) Establishing separate bank accounts for the Foundation Trust's non-exchequer funds;
(c) Ensuring payments made from bank accounts do not exceed the amount credited to the account except where arrangements have been made;
(d) Reporting to the Board of Directors all arrangements made with the Foundation Trust's bankers for accounts to be overdrawn (together with the remedial action taken).

6.12.2.2 All accounts should be held in the name of the Foundation Trust. No officer other than the Chief Finance Officer shall open any account in the name of the Foundation Trust or for the purpose of furthering Foundation Trust activities.

6.12.3 Banking Procedures

6.12.3.1 The Chief Finance Officer will prepare detailed instructions on the operation of bank accounts which must include:

(a) The conditions under which each bank is to be operated;
(b) The limit to be applied to any overdraft; and
(c) Those authorised to sign cheques or other orders drawn on the Foundation Trust's accounts.

6.12.3.2 The Chief Finance Officer must advise the Foundation Trust's bankers in writing of the conditions under which each account will be operated.

6.12.3.3 The Chief Finance Officer shall approve security procedures for any cheques issued without a handwritten signature e.g. lithographed. Manually produced cheques shall be signed by the authorised officer(s) in accordance with the bank mandate. All

cheques shall be treated as controlled stationery, in the charge of a duly designated officer controlling their issue.

6.12.3.4 Acceptance of cash will be limited to a maximum of £10,000.

6.12.4 Tendering and Review

6.12.4.1 The Chief Finance Officer will review the banking arrangements of the Foundation Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Foundation Trust's business banking.

6.12.4.2 Competitive tenders should be sought at least every five years. The results of the tendering exercise should be reported to the Board of Directors. This review is not applicable to GBS accounts.

6.13 Income, Fees and Charges and Security of Cash, Cheques and other Negotiable Instruments

6.13.1 Income Systems

6.13.1.1 The Chief Finance Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

6.13.1.2 All such systems shall incorporate, where practicable, in full the principles of internal check and separation of duties.

6.13.1.3 The Chief Finance Officer is also responsible for the prompt banking of all monies received.

6.13.2 Fees and Charges other than Foundation Trust Agency Purchase Contract

6.13.2.1 The Foundation Trust shall follow the Department of Health advice in the NHS Costing Manual in setting prices for non-commercial contracts with NHS organisations other than those covered by the Foundation Trust Agency Purchase Contract and non-NHS organisations.

6.13.2.2 The Chief Finance Officer is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered, the guidance in the Department of Health's [7]'Commercial sponsorship: Ethical standards in the NHS' shall be followed.

6.13.2.3 All employees must inform the Chief Finance Officer promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

6.13.3 Non-NHS Income

6.13.3.1 In accordance with Part 4 of the Health and Social Care Act 2012 the Foundation Trust shall ensure that the income it receives from providing goods and services for the NHS is greater that its income from other sources.

6.13.3.2 Where the Foundation Trust proposed to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of

[7] Commercial sponsorship: Ethical standards for the NHS, Department of Health (2000)

goods and services for the health service, it will seek approval from the Council of Governors.

6.13.4 Debt Recovery

6.13.4.1 The Chief Finance Officer is responsible for the appropriate recovery action on all outstanding debts, including a formal follow up procedure for all debtor accounts.

6.13.4.2 Income not received should be dealt with in accordance with losses procedures (see paragraph 6.21 below).

6.13.4.3 Overpayments should be detected (or preferably prevented) and recovery initiated.

6.13.5 Security of Cash, Cheques and Other Negotiable Instruments

6.13.5.1 The Chief Finance Officer is responsible for:

(a) Approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable (no form of receipt which has not been specifically authorised by the Chief Finance Officer should be issued);

(b) Ordering and securely controlling any such stationery;

(c) The provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

(d) Prescribing systems and procedures for handling cash and negotiable securities on behalf of the Foundation Trust.

6.13.5.2 Official money shall not under any circumstances be used for the encashment of private cheques, nor IOUs.

6.13.5.3 Staff shall be informed in writing on appointment of their responsibilities and duties for the collection, handling or disbursement of cash, cheques etc.

6.13.5.4 All cheques, postal orders, cash or other negotiable instruments shall be banked promptly intact. Disbursements shall not be made from cash received, except under arrangements approved by the Chief Finance Officer.

6.13.5.5 The Foundation Trust will not accept a cash payment for a single transaction which is in excess of the current limit (€15,000 as at October 2010 or sterling equivalent or £10,000, whichever is lower.) This exempts the Trust from the requirement to register under the 2007 Money Laundering Regulations that came into effect on 15 December 2007.

6.13.5.6 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Foundation Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Foundation Trust from responsibility for any loss.

6.13.5.7 Any loss or shortfall of cash, cheques or other negotiable instruments, however occasioned, shall be monitored and recorded within the Finance Department. Any significant trends should be reported to the Chief Finance Officer and internal audit via the incident reporting system. Where there is prima facie evidence of fraud or corruption, this should follow the form of the Foundation Trust's Fraud and Corruption Response Plan and the guidance provided by NHS Protect .

6.13.5.8 Where there is no evidence of fraud or corruption, the loss should be dealt with in line with the Foundation Trust's Losses and Compensations Procedures (see section 6.20 below).

6.14 Foundation Trust Contracts

6.14.1 Provision of Services

6.14.1.1 The Board of Directors shall regularly review and shall at all times maintain and ensure the capacity and capability of the Foundation Trust to provide Commissioner Requested Services in accordance with the Trust's Licence.

6.14.2 Foundation Trust Contract

6.14.2.1 The Chief Executive, as the Accounting Officer, is responsible for ensuring the Foundation Trust enters into suitable Foundation Trust Contracts (FTCs) with CCGs and other commissioners for the provision of NHS services. The Foundation Trust will follow the priorities contained within the schedules of the contract, and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account:

- The standards of service quality expected;
- The relevant national service framework (if any);
- The provision of reliable information on cost and volume of services;
- The Performance Assessment Framework contained within the FT;
- That FTC builds where appropriate on existing partnership arrangements.

6.14.3 A good FTC will result from a dialogue of clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs and inequalities. This will require the Chief Executive to ensure that the Foundation Trust works with all partner agencies involved in both the delivery and the commissioning of the service required.

6.14.4 The Chief Executive, as the Accounting Officer, will need to ensure that regular reports are provided to the Board of Directors detailing actual and forecast income from FTCs. This will include appropriate payment by results performance information.

6.14.5 Non Commissioner Contracts

6.14.5.1 Where the Trust enters into a relationship with another organisation for the supply or receipt of other services – clinical or non-clinical, the responsible executive director should ensure that an appropriate non-commercial contract is present and signed by both parties. This should incorporate:

- A description of the service and indicative activity levels
- The term of the agreement
- The value of the agreement
- The lead officer
- Performance and dispute resolution procedures
- Risk management and clinical governance agreements.

6.14.5.2 Non-commissioner contracts should be reviewed and agreed on an annual basis or as determined by the term of the agreement so as to ensure value for money and to minimise the potential loss of income.

6.15 Terms of Service, Allowances and Payment of Members of the Board of Directors and Employees

6.15.1 Nominations and Remuneration Committee (Executive Directors)

6.15.1.1 In accordance with Standing Orders, the Board of Directors has established a Nominations and Remuneration Committee which is responsible for the appointment of Executive Directors and for agreeing the terms of service of Executive Directors. It has clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

6.15.1.2 The terms of reference for the Nominations and Remuneration Committee (Executive Directors) can be found in this Corporate Governance Manual.

6.15.1.3 The Remuneration and Nomination Committee will be accountable to the Board of Directors. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to it or require executive action.

6.15.1.4 The Board of Directors will approve proposals presented by the Chief Executive for setting of remuneration and conditions of service for those employees not covered by the Committee.

6.15.1.5 Nominations and Remuneration Committee (Non-Executive Directors)

6.15.1.6 In accordance with Standing Orders, the Council of Governors have established a Nominations and Remuneration Committee which is responsible for the appointment and setting the terms of appointment of Non-Executive Directors. It will make recommendations to a general meeting of the Council of Governors on the appointment of Non-Executive Directors. It has clearly defined terms of reference, specifying its area of responsibility, its composition and the arrangements for reporting.

6.15.1.7 The terms of reference of the Nominations and Remuneration Committee (Non-Executive Directors) can be found in this Corporate Governance Manual.

6.15.2 Funded Establishment

6.15.2.1 The workforce plans incorporated within the annual budget will form the funded establishment. The establishment of the Foundation Trust will be identified and monitored by the Chief People Officer under delegation from the Chief Executive.

6.15.2.2 The funded establishment of any department may not be varied without the approval of the Chief Executive or individual nominated within the relevant section of the Scheme of Reservation and Delegation. The Chief Finance Officer is responsible for verifying that funding is available.

6.15.3 Staff Appointments

6.15.3.1 No Executive Director or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

i. Unless authorised to do so by the Chief Executive; and
ii. Within the limit of his approved budget and funded establishment as defined in the Scheme of Reservation and Delegation.

6.15.3.2 The Board of Directors will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc, for employees.

6.15.3.3 Processing of the Payroll

6.15.3.4 The Chief People Officer in conjunction with the Chief Finance Officer is responsible for:

(a) Specifying timetables for submission of properly authorised time records and other notifications;

(b) The final determination of pay and allowances; including verification that the rate of pay and relevant conditions of service are in accordance with current agreements;
(c) Making payment on agreed dates; and
(d) Agreeing method of payment.

6.15.3.5 The Chief People Officer will issue instructions, taking into account the advice of the Chief Finance Officer and provider of payroll services regarding:

a) Verification and documentation of data;
b) The timetable for receipt and preparation of payroll data and the payment of employees and allowances;
c) Maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;
d) Security and confidentiality of payroll information;
e) Checks to be applied to completed payroll before and after payment;
f) Authority to release payroll data under the provisions of the Data Protection Act;
g) Methods of payment available to various categories of employee;
h) Procedures for payment by cheque, bank credit, or cash to employees;
i) Procedures for the recall of cheques and bank credits;
j) Pay advances and their recovery;
k) Maintenance of regular and independent reconciliation of pay control accounts;
l) Separation of duties of preparing records and handling cash; and
m) A system to ensure the recovery from leavers of sums of money and property due by them to the Foundation Trust.

6.15.3.6 Appropriately nominated managers have delegated responsibility for:

(a) Processing a signed copy of the contract/appointment form and such other documentation as may be required immediately upon an employee commencing duty;
(b) Submitting time records, and other notifications in accordance with agreed timetables;
(c) Completing time records and other notifications in accordance with the Chief People Officer's instructions and in the form prescribed by the Chief People Officer; and
(d) Submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's resignation, termination or retirement. Where an employee fails to report for duty in circumstances that suggest they have left without notice, the Chief People Officer must be informed immediately. In circumstances where fraud might be expected this must be reported to the Chief Finance Officer.

6.15.3.7 Regardless of the arrangements for providing the payroll service, the Chief People Officer, in conjunction with the Chief Finance Officer, shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

6.15.4 Contracts of Employment

6.15.4.1 The Board of Directors shall delegate responsibility to a manager for:

(a) Ensuring that all employees are issued with a Contract of Employment in a form approved by the Board of Directors and which complies with employment and Health and Safety legislation; and
(b) Dealing with variations to, or termination of, contracts of employment.

6.16 Non Pay Expenditure

6.16.1 Delegation of Authority

6.16.1.1 The Board of Directors will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

6.16.1.2 The Chief Executive will set out:

(a) The list of managers who are authorised to place requisitions for the supply of goods and services (see Table B Delegated Financial Limits Section 4) which should be updated and reviewed on an ongoing basis and annually by the Finance Department in conjunction with departmental officers;

(b) Where the authorisation system is computerised, the list will be maintained within the computerised system and the 'signature' will be in the form of electronic authorisation in accordance with the access and authority controls maintained within the computerised system; and

(c) The maximum level of each requisition and the system for authorisation above that level.

6.16.1.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

6.16.2 **Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services**

6.16.2.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Foundation Trust with particular reference to the requirements for quotations and tenders detailed in Table B delegated limits of the Scheme of Reservation and Delegation. In so doing, the advice of the Foundation Trust's Procurement Department and advisor on supply shall be sought. Where this advice is not acceptable to the requisitioner, the Chief Finance Officer (and/or the Chief Executive) shall be consulted.

6.16.2.2 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall only commit expenditure within delegated approval limits with the raising of an official Trust Purchase Order (PO). Invoices received by the Trust without an official PO number quoted will be returned unpaid to the supplier.

6.16.2.3 The Chief Finance Officer shall be responsible for the prompt payment of properly authorised accounts and claims in accordance with the Better Payment Practice Code (BPPC). Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

6.16.2.4 The Chief Finance Officer will:

(a) Advise the Board of Directors regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained and, once approved, the thresholds should be incorporated in the Scheme of Reservation and Delegation and regularly reviewed;

(b) Prepare procedural instructions where not already provided in the Scheme of Delegation or procedure notes for budget holders on the obtaining of goods, works and services incorporating the thresholds;

(c) Be responsible for the prompt payment of all properly authorised accounts and claims;

(d) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

i) A list of directors/employees (including specimens of their signatures) authorised to approve or incur expenditure. Where the authorisation system is computerised, the list will be maintained within the

computerised system and the 'signature' will be in the form of electronic authorisation in accordance with the access and authority controls maintained within the computerised system.

ii) Certification that:
- Goods have been duly received, examined and are in accordance with specification and the prices are correct;
- Work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- In the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;
- Where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- The account is arithmetically correct;
- The account is in order for payment.

iii) A timetable and system for submission to the Chief Finance Officer of accounts for payment. Provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department

v) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received (except as below).

6.16.2.5 Prepayments outside of normal commercial arrangements, for example fully comprehensive maintenance contracts and rental insurance, are only permitted where exceptional circumstances apply. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to NPV using the National Loans Fund (NLF) rate);

(b) The appropriate officer in conjunction with the Procurement Department must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Foundation Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;

(c) The Chief Finance Officer will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold);

(d) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and he/she must immediately inform the appropriate Director or Chief Executive if problems are encountered.

6.16.2.6 Official Orders must, where not generated by the Trust's computerised procurement system:

(a) Be consecutively numbered;
(b) Be in a form approved by the Chief Finance Officer;
(c) State the Foundation Trust terms and conditions of trade; and
(d) Only be issued to, and used by, those duly authorised by the Chief Executive.

6.16.2.7 Managers must ensure that they comply fully with the guidance and limits specified by the Chief Finance Officer and that:

(a) All contracts other than for a simple purchase permitted within the Scheme of Delegation or delegated budget, leases, tenancy agreements and other commitments which may result in a liability are notified to the Chief Finance Officer in advance of any commitment being made;

(b) Contracts above specified thresholds are advertised and awarded in accordance with EU and GATT rules on public procurement;

(c) Where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health. Where an officer certifying accounts relies upon other officers to do preliminary checking, he/she shall wherever possible, ensure that those who check delivery or execution of work act independently of those who have placed orders and negotiated prices and terms;

(d) No order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

- Isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars
- Conventional hospitality, such as lunches in the course of working visits

(e) No requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Chief Finance Officer on behalf of the Chief Executive;

(f) All goods, services, or works are ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash or on purchasing cards;

(g) Verbal orders must only be issued very exceptionally – by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order, and clearly marked "Confirmation Order";

(h) Orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(i) Goods are not taken on trial or loan in circumstances that could commit the Foundation Trust to a future uncompetitive purchase;

(j) Changes to the list of directors/employees authorised to certify invoices are notified to the Chief Finance Officer;

(k) Purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Chief Finance Officer;

(l) Petty cash records are maintained in a form as determined by the Chief Finance Officer; and

(m) Orders are not required to be raised for utility bills, NHS recharges and ad hoc services such as private hospital fees. Payments must be authorised in accordance with the delegated limits set for non pay.

6.16.2.8 The Chief Executive and Chief Finance Officer shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within the Capital Investment Manual and any other relevant guidance issued by NHS Improvement. The technical audit of these contracts shall be the responsibility of the relevant Director.

6.16.2.9 Under no circumstances should goods be ordered through the Foundation Trust for personal or private use.

6.16.3 Joint Finance Arrangements with Local Authorities and Voluntary Bodies

6.16.3.1 Payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act shall comply with procedures laid down by the Chief Finance Officer which shall be in accordance with these Acts.

6.17 External Borrowing and Investments

6.17.1 Public Dividend Capital

6.17.1.1 On authorisation as a Foundation Trust, the Public Dividend Capital held immediately prior to authorisation continues to be held on the same conditions.

6.17.1.2 Additional Public Dividend Capital may be made available on such terms the Secretary of State (with the consent of the Treasury) decides.

6.17.1.3 Draw down of Public Dividend Capital should be authorised in accordance with the mandate held by the Department of Health Cash Funding Team, and is subject to approval by the Secretary of State.

6.17.1.4 The Foundation Trust shall be required to pay annually to the Department of Health a dividend on its Public Dividend Capital at a rate to be determined from time to time, by the Secretary of State.

6.17.2 Working Capital Loan Facility

6.17.2.1 The Foundation Trust may be required by NHS Improvement to have a working capital facility. This will be provided by the Trust's banker or other commercial provider if available and cost effective. Such a facility may be of variable term.

6.17.2.2 The Foundation Trust must only draw down against this facility in respect of true working capital needs, and in accordance with the terms and conditions of the facility.

6.17.3 Commercial Borrowing and Investment

6.17.3.1 The Foundation Trust may borrow money from any commercial source for the purposes of or in connection with its functions.

6.17.3.2 The Foundation Trust may invest money (other than money held by it as charitable trustee) for the purposes of or in connection with its functions. Such investment may include forming, or participating in forming, or otherwise acquiring membership of bodies corporate.

6.17.3.3 The Foundation Trust may also give financial assistance (whether by way of loan, guarantee or otherwise) to any person for the purposes of or in connection with its functions.

6.17.4 Investment of Temporary Cash Surpluses

6.17.4.1 Temporary cash surpluses must be held only in such public and private sector investments as authorised by the Board of Directors.

6.17.4.2 The Finance, Performance and Business Development committee is responsible for establishing and monitoring an appropriate investment strategy.

6.17.4.3 The Chief Finance Officer is responsible for advising the Board of Directors on investments and shall report periodically to the Board of Directors concerning the performance of investments held.

6.17.4.4 The Chief Finance Officer will prepare detailed procedural instructions on investment operations and on the records to be maintained. The Foundation Trust's Treasury

Management Policy will include instructions on funding and investing, safe harbour investments, risk management, borrowing, controls, reporting and performance management. It will also incorporate guidance from NHS Improvement as appropriate.

6.18 Capital Investment, Private Financing, Fixed Asset Registers and Security of Assets

6.18.1 Capital Investment

6.18.1.1 The Chief Executive:

(a) Shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;
(b) Is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and
(c) Shall ensure that the capital investment is not undertaken without the availability of resources to finance all revenue consequences, including capital charges.

6.18.1.2 For capital expenditure proposals, the Chief Executive shall ensure (in accordance with the limits outlined in the Scheme of Delegation):

(a) That a business case is produced, setting out:
    i) An option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs; and
    ii) Appropriate project management and control arrangements; and
    iii) The involvement of appropriate Foundation Trust personnel and external agencies; and
(b) That the Chief Finance Officer has certified professionally to the costs and revenue consequences detailed in the business case.

6.18.1.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of the capital investment manual and any other relevant guidance issued by NHS Improvement.

6.18.1.4 The Chief Finance Officer shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme, in accordance with Inland Revenue guidance.

6.18.1.5 The Chief Finance Officer shall issue procedures for the regular reporting of expenditure and commitment against authorised budgets.

6.18.1.6 The approval of a capital programme shall not constitute approval for expenditure on any scheme. The Chief Executive shall issue to the manager responsible for any scheme:

(a) Specific authority to commit expenditure
(b) Authority to proceed to tender
(c) Approval to accept a successful tender.

6.18.1.7 The Chief Executive will issue a scheme of delegation for capital investment management in accordance with the capital investment manual guidance and any other relevant guidance issued by NHS Improvement, and the Foundation Trust's Standing Orders.

6.18.1.8 The Chief Finance Officer shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

6.18.2 Private Finance

6.18.2.1 The Foundation Trust should normally test for PFI when considering a capital procurement. When the Board proposes, or is required, to use finance provided by the private sector, the following should apply:

(a) The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector;
(b) A business case must be referred to NHS Improvement for approval or treated as per current guidelines;
(c) The proposal must be specifically agreed by the Foundation Trust, in the light of such professional advice as should reasonably be sought, in particular with regard to vires;
(d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

6.18.3 Asset Registers

6.18.3.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Chief Finance Officer concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

6.18.3.2 The Foundation Trust shall maintain an asset register recording fixed assets. As a minimum, the minimum data set to be held within these registers shall be as specified in the NHS Foundation Trust Annual Reporting Manual as issued by NHS Improvement.

6.18.3.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder, and be validated by reference to:

(a) Properly authorised and approved agreements, architects' certificates, suppliers' invoices and other documentary evidence in respect of purchases from third parties;
(b) Stores, requisitions and wages records for own materials and labour including appropriate overheads; and
(c) Lease agreements in respect of assets held under a finance lease and capitalised.

6.18.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

6.18.3.5 The Chief Finance Officer shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on the Asset Register.

6.18.3.6 The value of each asset shall be indexed to current values in accordance with methods specified in the NHS Foundation Trust Annual Reporting Manual issued by NHS Improvement.

6.18.3.7 The value of each asset shall be depreciated using methods and rates as specified in the NHS Foundation Trust Annual Reporting Manual issued by NHS Improvement.

6.18.3.8 The Chief Finance Officer shall calculate and pay capital charges as specified by the Department of Health.

6.18.4 Protected Property

6.18.4.1 A register of protected property is required to be maintained in accordance with requirements issued by NHS Improvement. The property referred to in Condition 9(1)

of the Licence, which is to be protected, is limited to land and buildings owned or leased by the Foundation Trust (assets such as equipment, financial assets, cash or intellectual property will not be regarded as protected assets).

6.18.4.2 No protected property may be disposed of (including disposing of part of it or granting an interest in it) without the approval of NHS Improvement.

6.18.4.3 This will be achieved through the annual planning process. The annual plan will include proposed changes in the treatment of assets that are protected and proposed disposals and acquisitions.

6.18.4.4 The Foundation Trust is required to notify relevant bodies of the publication date of their plans to allow them to lodge any objections. Twenty-one days is allowed before the plans are then approved.

6.18.4.5 During the year when the proposed changes are made the Asset Register must be updated accordingly. The relevant bodies should then be notified that an updated Asset Register is available.

6.18.4.6 As required by its Licence the Foundation Trust must make the Asset Register available for inspection by the public. The Foundation Trust may charge a reasonable fee for access to this information.

6.18.5 Security of Assets

6.18.5.1 The overall control of fixed assets is the responsibility of the Chief Executive advised by the Chief Finance Officer. Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Chief Finance Officer. This procedure shall make provision for:

(a) Recording managerial responsibility for each asset;
(b) Identification of additions and disposals;
(c) Identification of all repairs and maintenance expenses;
(d) Physical security of assets;
(e) Periodic verification of the existence of, condition of, and title to, assets recorded;
(f) Identification and reporting of all costs associated with the retention of an asset; and
(g) Reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

6.18.5.2 All significant discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Chief Finance Officer.

6.18.5.3 Whilst each employee has a responsibility for the security of property of the Foundation Trust, it is the responsibility of directors and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board of Directors. Any breach of agreed security practices must be reported in accordance with instructions.

6.18.5.4 Any damage to the Foundation Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by directors and employees in accordance with the procedure for reporting losses.

6.18.5.5 Where practical, assets should be marked as Foundation Trust property.

6.19 Stock, Stores and Receipt of Goods

6.19.1 Stocks are defined as those goods normally utilised in day to day activity, but which at a given point in time have not been used or consumed. There are three broad types of store:

(a) Controlled stores – specific areas designated for the holding and control of goods;
(b) Wards and departments – goods required for immediate usage to support operational services;
(c) Manufactured Items – where goods and consumables are being made or processes are being applied which add to the raw material cost of the goods.

6.19.2 Such stocks should be kept to a minimum and for:

(a) Controlled stores and other significant stores (as determined by the Chief Finance Officer) should be subjected to an annual stock take or perpetual inventory procedures; and
(b) Valued at the lower of cost and net realisable value.

6.19.3 Subject to the responsibility of the Chief Finance Officer for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by him/her to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Chief Finance Officer. The control of any pharmaceutical stocks shall be the responsibility of the Head of Pharmacy. The control of any fuel oil shall be the responsibility of the Head of Estates and Facilities.

6.19.4 The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the designated manager.

6.19.5 Wherever practicable, stocks should be marked as NHS property.

6.19.6 The Chief Finance Officer shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

6.19.7 Stocktaking arrangements shall be agreed with the Chief Finance Officer and there shall be a physical check covering all items in store at least once a year.

6.19.8 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Chief Finance Officer.

6.19.9 The designated manager shall be responsible for a system approved by the Chief Finance Officer for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Chief Finance Officer any evidence of significant overstocking and of any negligence or malpractice (see also 6.20, Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

6.19.10 Receipt of Goods

6.19.10.1 All goods received shall be checked as regards quantity and/or weight and inspected as to quality and specification. A delivery note shall be obtained from the supplier at the time of delivery and shall be signed by the person receiving the goods. Instructions shall be issued to staff covering the procedures to be adopted in those cases where a delivery note is not available.

6.19.10.2 All goods received shall be entered onto an appropriate goods received/stock record (whether a computer or manual system) on the day of receipt. If goods received are unsatisfactory, the records shall be marked accordingly. Further, where the goods

received are found to be unsatisfactory, or short on delivery, they shall only be accepted on the authority of the designated officer and the supplier shall be notified immediately.

6.19.10.3 For goods supplied via the NHS Supply Chain central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note to satisfy themselves that the goods have been received. The Finance Department will make payment on receipt of an invoice. This may also apply for high-level low volume items such as stationery.

6.19.11 Issue of Stocks

6.19.11.1 The issue of stocks shall be supplied by an authorised requisition note and a receipt for the stock issued shall be returned to the designated officer. Where a 'topping up' system is used, a record shall be maintained as approved by the Chief Finance Officer. Regular comparisons shall be made of the quantities issued to wards/departments etc, and explanations recorded of significant variations.

6.19.11.2 All transfers and returns shall be recorded on forms/systems provided for the purpose and approved by the Chief Finance Officer.

6.20 Disposals and Condemnations, Insurance, Losses and Special Payments

6.20.1 Disposals and Condemnations

6.20.1.1 The Chief Finance Officer must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

6.20.1.2 When it is decided to dispose of a Foundation Trust asset, the head of department or authorised deputy will determine and advise the Chief Finance Officer of the estimated market value of the item, taking account of professional advice where appropriate.

6.20.1.3 All unserviceable articles shall be:

(a) Condemned or otherwise disposed of by an employee authorised for that purpose by the Chief Finance Officer;

(b) Recorded by the Condemning Officer in a form approved by the Chief Finance Officer which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Chief Finance Officer.

6.20.1.4 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Chief Finance Officer who will take the appropriate action.

6.21 Losses and Special Payments

6.21.1 The Chief Finance Officer must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments. The Chief Finance Officer must also prepare a fraud response plan that sets out the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it.

6.21.2 Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their directorate manager or head of department, who must immediately inform the Chief Finance Officer who will liaise with the Chief Executive or inform an officer charged with responsibility for responding to concerns involving loss confidentially. This officer will then appropriately inform the Chief Finance Officer who will liaise with the Chief Executive.

6.21.3 Where a criminal offence such as theft or arson is suspected, the Divisional Manager or departmental head must immediately inform the police and obtain a crime number, which should be forwarded to the Chief Finance Officer. In cases of fraud, bribery or corruption, or of anomalies which may indicate fraud, bribery or corruption, the Chief Finance Officer must inform their Local Counter Fraud Officer, who will inform NHS Protect before any action is taken and reach agreement on how the case is to be handled.

6.21.4 The Chief Finance Officer must notify NHS Protect and the external auditor of all frauds.

6.21.5 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Chief Finance Officer must immediately notify:
(a) The Board of Directors, and
(b) The external auditor, and
(c) NHS Protect (through LSMS).

6.21.6 The Board of Directors shall approve the writing-off of all losses and special payments in accordance with the Scheme of Delegation.

6.21.7 The Chief Finance Officer shall be authorised to take any necessary steps to safeguard the Foundation Trust's interests in bankruptcies and company liquidations.

6.21.8 For any loss, the Chief Finance Officer should consider whether any insurance claim can be made.

6.21.9 The Chief Finance Officer shall maintain a Losses and Special Payments Register in which write-off action is recorded.

6.22 Insurance

6.22.1 The Chief Finance Officer shall ensure that insurance arrangements exist in accordance with the risk management programme.

6.23 Compensation Claims

6.23.1 The Foundation Trust is committed to effective and timely investigation and response to any claim which includes allegations of clinical negligence, employee and other compensation claims. The Foundation Trust will follow the requirements and note the recommendations of the Department of Health, and the NHS Litigation Authority (NHSLA), in the management of claims. Where appropriate external insurance has been contracted, this will be within the above mentioned requirements and recommendations. Every member of staff is expected to co-operate fully, as required, in assessment and management of each claim.

6.23.2 The Foundation Trust will seek to reduce the incidence and adverse impact of clinical negligence, employee and other litigation by:

- Adopting prudent risk management strategies including continuous review
- Implementing in full the NHS Complaints Procedure, thus providing an alternative remedy for some potential litigants
- Adopting a systematic approach to claims handling in line with the best current and cost effective practice
- Following guidance issued by the NHSLA relating to clinical negligence
- Achieving compliance with the relevant core Care Quality Commission standards
- Implementing an effective system of clinical governance.

6.23.3 The Chief Nurse and Midwife in association with the Medical Director is responsible for clinical negligence, for managing the claims process and informing the Board of Directors of any major developments on claims related issues.

6.24 Information Technology

6.24.1 Responsibilities and duties of the Chief Finance Officer

6.24.1.1 The Chief Finance Officer, who is responsible for the accuracy and security of the computerised financial data of the Foundation Trust, shall:

(a) Devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Foundation Trust's data, programs and computer hardware for which he/she is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998 (updated 2000) and the Computer Misuse Act 1990;

(b) Ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

(c) Ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

(d) Ensure that adequate controls exist to maintain the security, privacy, accuracy and completeness of financial data sent via transmission networks;

(e) Ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as he/she may consider necessary are being carried out.

6.24.1.2 The Chief Finance Officer shall satisfy themselves that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

6.24.1.3 The Foundation Trust has published and maintains a Freedom of Information (FoI) Publication Scheme as approved by the Information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about our Trust that we make publicly available.

6.24.2 Responsibilities and duties of other Directors and Officers in relation to computer systems of a general application

6.24.2.1 In the case of computer systems which are proposed General Applications (i.e. those applications which a number of NHS organisations wish to sponsor jointly), all responsible directors and employees will send to the Chief Finance Officer:

(a) Details of the outline design of the system;

(b) In the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

6.24.3 Contracts for Computer Services with other health bodies or outside agencies

6.24.3.1 The Chief Finance Officer shall ensure that contracts for computer services for financial applications with another health organisation, or any other agency, shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

6.24.3.2 Where another health organisation, or any other agency, provides a computer service for financial applications, the Chief Finance Officer shall periodically seek assurances that adequate controls are in operation.

6.24.4 Requirement for Computer Systems which have an impact on corporate financial systems

6.24.4.1 Where computer systems have an impact on corporate financial systems, the Chief Finance Officer shall satisfy themselves that:

(a) Systems acquisition, development and maintenance are in line with corporate policies, such as an Information Management and Technology Strategy
(b) Data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;
(c) Chief Finance Officer staff have access to such data; and
(d) Such computer audit reviews as are considered necessary are being carried out.

6.24.5 Risk Assessment

6.24.5.1 The Chief Finance Officer shall ensure that risks to the Trust arising from the use of information technology are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

6.24.5.2 The Foundation Trust shall disclose to NHS Improvement and directly to any third parties, as may be specified by the Secretary of State, information, if any, as specified in the Licence. Other information, as requested, shall be provided to NHS Improvement.

6.24.5.3 The Foundation Trust shall participate in the national programme for information technology, in accordance with any guidance issued by NHS Improvement.

6.25 Patients' Property

6.25.1 The Foundation Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

6.25.2 The Chief Executive is responsible for ensuring that patients, or their guardians as appropriate, are informed before or at admission by

- Notices and information booklets
- Hospital admission documentation and property records
- The oral advice of administrative and nursing staff responsible for admissions

that the Foundation Trust will not accept responsibility or liability for patients' property brought into its premises, unless it is handed in for safe custody and a copy of an official patient's property record is obtained as a receipt.

6.25.3 The Chief Finance Officer must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. The said instructions shall cover the necessary arrangements for withdrawal of cash or disbursement of money held in accounts of patients who are incapable of handling their own financial affairs. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

6.25.4 A patient's property record, in a form determined by the Chief Finance Officer, shall be completed in respect of the following:
(a) Property handed in for safe custody by any patient (or guardian as appropriate); and
(b) Property taken into safe custody, having been found in the possessions of:
- Mentally disordered patients
- Confused and/or disorientated patients
- Unconscious patients
- Patients dying in hospital
- Patients found dead on arrival at hospital (property removed by police).

A record shall be completed in respect of all persons in category (b), including a nil return if no property is taken into safe custody.

6.25.5 The record shall be completed by a member of the hospital staff, in the presence of a second member of staff and the patient (or representative) where practicable. It shall then be signed by both members of staff and by the patient, except where the latter is restricted by physical or mental incapacity. Any alterations shall be validated by signatures as requested for the original entry on the record.

6.25.6 Where Department of Health instructions require the opening of separate accounts for patients' monies (separate from those containing Foundation Trust monies), these shall be opened and operated under arrangements agreed by the Chief Finance Officer.

6.25.7 Patients' income, including pensions and allowances, shall be dealt with in accordance with current Department of Works and Pensions. For long stay patients, the Chief Executive shall ensure that positive action is taken to use their funds effectively and so reduce balances accruing.

6.25.8 Refunds of cash handed in for safe custody will be dealt with in accordance with current Department of Works and Pensions guidance. Property other than cash, which has been handed in for safe custody, shall be returned to the patient as required by the officer who has been responsible for its security. The return shall be receipted by the patient, or guardian as appropriate, and witnessed.

6.25.9 The disposal of property of deceased patients shall be effected by the officer who has been responsible for its security. Such disposal shall be in accordance with written instructions issued by the Chief Finance Officer. In particular, where cash or valuables have been deposited for safe custody, they shall only be released after written authority has been given by the Chief Finance Officer. Such authority shall include details of the lawful kin or other person entitled to the cash and valuables in question.

6.25.10 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

6.25.11 Property handed over for safe custody shall be placed into the care of the appropriate administrative staff. Where there are no administrative staff present, the property shall be placed into the care of the most senior member of nursing staff on duty.

6.25.12 In respect of deceased patients, if there is no will and no lawful next of kin the property vests in the Crown and particulars shall, therefore, be notified to the Treasury Solicitor.

6.25.13 Any funeral expenses necessarily borne by the Foundation Trust are a first charge on a deceased person's estate. Where arrangements for burial or cremation are not made privately, any element of the estate held by the Foundation Trust may be appropriated towards funeral expenses, upon the authorisation of the Chief Finance Officer.

6.25.14 Staff should be informed, on appointment, by the appropriate departmental or senior manager, of their responsibilities and duties for the administration of the property of patients.

6.25.15 Where patients' property or income is received for specific purposes and held for safekeeping, the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing**.**

6.26 Funds held on Trust

6.26.1 General

6.26.1.1 The Foundation Trust has a responsibility as a corporate trustee for the management of funds it holds on trust. The management processes may overlap with those of the organisation of the Foundation Trust. The trustee responsibilities must be discharged separately, and full recognition given to its dual accountabilities, to the Charity Commission for charitable funds held on trust and to the Secretary of State for all funds held on trust.

6.26.1.2 The reserved powers of the Board of Directors and the Scheme of Delegation make clear where decisions where discretion must be exercised are to be taken and by whom.

6.26.1.3 As management processes overlap, most of the sections of these Standing Financial Instructions will apply to the management of funds held on trust.

6.26.1.4 The over-riding principle is that the integrity of each trust must be maintained and statutory and trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

6.26.1.5 Charitable Funds are those gifts, donations and endowments made under the relevant charities legislation and held on trust for purposes relating to the Trust and the objectives of which are for the benefit of the NHS in England. They are administered by the Foundation Trust Board of Directors acting as the Charitable Funds Committee (the trustees).

6.26.1.6 The Chief Finance Officer shall maintain such accounts and records as may be necessary to record and protect all transactions and funds of the Foundation Trust as trustees of non-exchequer funds, including an Investment Register.

6.26.2 Existing Charitable Funds

6.26.2.1 The Chief Finance Officer shall arrange for the administration of all existing funds. A Deed of Establishment must exist for every fund, and detailed codes of procedure shall be produced covering every aspect of the financial management of charitable funds, for the guidance of fund managers. The Deed of Establishment shall identify the restricted nature of certain funds, and it is the responsibility of fund managers, within their delegated authority, and the Charitable Funds Committee, to ensure that funds are utilised in accordance with the terms of the Deed.

6.26.2.2 The Chief Finance Officer shall periodically review the funds in existence, and shall make recommendations to the Charitable Funds Committee regarding the potential for rationalisation of such funds within statutory guidelines.

6.26.2.3 The Chief Finance Officer shall ensure that all funds are currently registered with the Charities Commission in accordance with the Charities Act 1993 or subsequent legislation.

6.26.3 New Charitable Funds

6.26.3.1 The Chief Finance Officer shall recommend the creation of a new fund where funds and/or other assets received for charitable purposes cannot adequately be managed as part of an existing fund. All new funds must be covered by a Deed of Establishment, and must be formally approved by the Charitable Funds Committee.

6.26.3.2 The Deed of Establishment for any new fund shall clearly identify, inter alia, the objects of the new fund, the nominated fund manager, the estimated annual income and, where applicable, the Charitable Funds Committee's power to assign the residue of the fund to another fund contingent upon certain conditions e.g. discharge of original objects.

6.26.4 Sources of New Funds

6.26.4.1 All gifts accepted shall be received and held in the name of the Charity and administered in accordance with the Charity's policy, subject to the terms of specific funds. As the Charity can accept gifts only for all or any purposes relating to the NHS, officers shall, in cases of doubt, consult the Chief Finance Officer before accepting any gift. Advice to the Board of Directors on the financial implications of fund raising activities by outside bodies or organisations shall be given by the Chief Finance Officer.

6.26.4.2 All gifts, donations and proceeds of fund-raising activities which are intended for the Charity's use must be handed immediately to the Chief Finance Officer via the Finance Department to be banked directly to the Charitable Funds Bank Account.

6.26.4.3 In respect of donations, the Chief Finance Officer shall:

(a) Provide guidelines to Officers of the Foundation Trust as to how to proceed when offered funds. These will include:
- The identification of the donors intentions;
- Where possible, the avoidance of creating excessive numbers of funds;
- The avoidance of impossible, undesirable or administratively difficult objects;
- Sources of immediate further advice; and
- Treatment of offers for personal gifts.

(b) Provide secure and appropriate receipting arrangements, which will indicate that donations have been accepted directly into the appropriate fund and that the donor's intentions have been noted and accepted.

6.26.4.4 In respect of Legacies and Bequests, the Chief Finance Officer shall be kept informed of and record all enquiries regarding legacies and bequests. Where required, the Chief Finance Officer shall:

(a) Provide advice covering any approach regarding:
- The wording of wills;
- The receipt of funds/other assets from executors.

(b) After the death of a testator, all correspondence concerning a legacy shall be dealt with on behalf of the Charity by the Chief Finance Officer who alone shall be empowered to give an executor a good discharge;

(c) Where necessary, obtain grant of probate, or make application for grant of letters of administration;

(d) Be empowered to negotiate arrangements regarding the administration of a will with executors and to discharge them from their duty; and

(e) Be directly responsible, in conjunction with the Charitable Funds Committee, for the appropriate treatment of all legacies and bequests.

6.26.4.5 In respect of fund-raising, the final approval for major appeals will be given by the Board of Directors. Final approval for smaller appeals will be given by the Charitable Funds Committee. The Chief Finance Officer shall:

(a) Advise on the financial implications of any proposal for fund-raising activities;
(b) Deal with all arrangements for fund-raising by and/or on behalf of the Charity, and ensure compliance with all statutes and regulations;
(c) Be empowered to liaise with other organisations/persons raising funds for the Charity, and provide them with an adequate discharge;
(d) Be responsible for alerting the Charitable Funds Committee and the Board of Directors to any irregularities regarding the use of the Charity's name or its registration numbers; and
(e) Be responsible for the appropriate treatment of all funds received from this source.

6.26.4.6 In respect of Trading Income (see also NHS Charitable Funds Guidance Chapter 6), the Chief Finance Officer shall:

(a) Be primarily responsible, along with designated fund managers, for any trading undertaken by the Charity; and
(b) Be primarily responsible for the appropriate treatment of all funds received from this source.

6.26.4.7 In respect of Investment Income, the Chief Finance Officer shall be responsible for the appropriate treatment of all dividends, interest and other receipts from this source (see below).

6.26.5 Investment Management

6.26.5.1 The Charitable Funds Committee shall be responsible for all aspects of the management of the investment of charitable funds as delegated under the terms of the approved investment policy. The issues on which the Chief Finance Officer shall be required to provide advice to the Charitable Funds Committee shall include:

(a) The formulation of investment policy which meets statutory requirements (Trustee Investment Act 1961) with regard to income generation and the enhancement of capital value;
(b) The appointment of advisers, brokers and, where appropriate, investment fund managers and:
- The Chief Finance Officer shall recommend the terms of such appointments, and for which
- Written agreements shall be signed by the Chief Executive

(c) Pooling of investment resources and the preparation of a submission to the Charity Commission for them to make a scheme;
(d) The participation by the Charity in common investment funds and the agreement of terms of entry and withdrawal from such funds;
(e) That the use of assets shall be appropriately authorised in writing and charges raised within policy guidelines;
(f) The review of the performance of brokers and fund managers;
(g) The reporting of investment performance.

6.26.5.2 The Chief Finance Officer shall prepare detailed procedural instructions concerning the receiving, recording, investment and accounting for Charitable Funds.

6.26.6 Expenditure from Charitable Funds

6.26.6.1 Expenditure from Charitable Funds shall be managed on a day to day basis by the Financial Accountant and by the Charitable Funds Committee in accordance with delegated limits on behalf of the Corporate Trustee. In so doing, the committee shall be aware of the following:

(a) The objects of various funds and the designated objectives;
(b) The availability of liquid funds within each trust;
(c) The powers of delegation available to commit resources;

(d) The avoidance of the use of exchequer funds to discharge endowment fund liabilities (except where administratively unavoidable), and to ensure that any indebtedness to the Exchequer shall be discharged by trust funds at the earliest possible time;
(e) That funds are to be spent rather than preserved, subject to the wishes of the donor and the needs of the Foundation Trust; and
(f) The definitions of "charitable purposes" as agreed by the Department of Health with the Charity Commission.

6.26.6.2 Delegated authority to incur expenditure which meets the purpose of the funds is set out in the Scheme of Delegations. Exceptions are as follows:
(a) Any staff salaries/wages costs require Charitable Funds Committee approval;
(b) No funds are to be "overdrawn" except in the exceptional circumstance that Charitable Funds Committee approval is granted.

6.26.7 Banking Services

6.26.7.1 The Chief Finance Officer shall advise the Charitable Funds Committee and, with its approval, shall ensure that appropriate banking services are available in respect of administering the Charitable Funds. These bank accounts should permit the separate identification of liquid funds to each trust where this is deemed necessary by the Charity Commission.

6.26.7.2 Asset Management

6.26.7.2.1 Assets in the ownership of or used by the Charitable Fund shall be maintained along with the general estate and inventory of assets of the Foundation Trust. The Chief Finance Officer shall ensure:
(a) That appropriate records of all donated assets owned by the Charitable Fund are maintained, and that all assets, at agreed valuations are brought to account;
(b) That appropriate measures are taken to protect and/or to replace assets. These to include decisions regarding insurance, inventory control, and the reporting of losses;
(c) That donated assets received on trust shall be accounted for appropriately;
(d) That all assets acquired from Charitable Funds which are intended to be retained within the funds are appropriately accounted for.

6.26.8 Reporting

6.26.8.1 The Chief Finance Officer shall ensure that regular reports are made to the Charitable Funds Committee and Board of Directors with regard to, inter alia, the receipt of funds, investments and expenditure.

6.26.8.2 The Chief Finance Officer shall prepare annual accounts in the required manner, which shall be submitted to the Board of Directors within agreed timescales.

6.26.8.3 The Chief Finance Officer shall prepare an annual trustees' report and the required returns to the Charity Commission for adoption by Charitable Funds Committee and subsequently the Board of Directors as Corporate Trustee.

6.26.9 Accounting and Audit

6.26.9.1 The Chief Finance Officer shall maintain all financial records to enable the production of reports as above, and to the satisfaction of internal and external audit.

6.26.9.2 Distribution of investment income to the charitable funds and the recovery of administration costs shall performed on a basis determined by the Chief Finance Officer.

6.26.9.3 The Chief Finance Officer shall ensure that the records, accounts and returns receive adequate scrutiny by internal audit during the year. He/she will liaise with external audit, and provide them with all necessary information.

6.26.9.4 The Charitable Funds Committee and subsequently the Board of Directors shall be advised by the Chief Finance Officer on the outcome of the annual audit.

6.26.10 Taxation and Excise Duty

6.26.10.1 The Chief Finance Officer shall ensure that the Charity's liability to taxation and excise duty is managed appropriately, taking full advantage of available concessions, through the maintenance of appropriate records, the preparation and submission of the required returns and the recovery of deductions at source.

6.27 Tendering, Quotation and Contracting Procedures

6.27.1.1 Duty to comply with Standing Orders and Standing Financial Instructions

6.27.1.1.1 The procedure for making all contracts by or on behalf of the Foundation Trust shall comply with the Trust's Standing Orders and Standing Financial Instructions (except where Suspension of Standing Orders is applied). In particular reference should be made to the Trust Delegated Authorities Table A Section 35 and Table B Section 6 Delegated Financial Limits of this Corporate Governance Manual.

6.27.1.2 EU Directives Governing Public Procurement

6.27.1.2.1 Directives by the Council of the European Union promulgated by the Department of Health (DH) prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these Standing Orders and Standing Financial Instructions. Details of EU thresholds and the differing procedures to be adopted can be obtained from the Supplies Departments (see paragraph 6.27.1.4.1).

6.27.1.2.2 NHS ProCure22 was launched in 2016 as a standardised approach to the procurement of healthcare facilities. It is based upon long term relationships with selected supply chains that have the ability to work with NHS bodies across the whole life cycle of a capital scheme. For further details see the ProCure22 website at www.procure22.nhs.uk

6.27.1.3 Formal Competitive Tendering

6.27.1.3.1 The Foundation Trust shall ensure that competitive tenders are invited for:

- the supply of goods, materials and manufactured articles;
- for the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the Department of Health);
- for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and for disposals.

6.27.1.3.2 Where the Foundation Trust elects to invite tenders for the supply of healthcare these Standing Financial Instructions shall apply as far as they are applicable to the tendering procedure.

6.27.1.3.3 Formal tendering procedures are not required where:

(a) the estimated expenditure or income does not, or is not reasonably expected to, exceed the limit set in the Scheme of Reservation and Delegation; or
(b) the supply is proposed under special arrangements negotiated by the Department of Health in which event the said special arrangements must be complied with; or
(c) regarding disposals as set out in Standing Financial Instruction 'Disposals and Condemnations'.

6.27.1.4 Fair and Adequate Competition

6.27.1.4.1 No company must be given any advantage over its competitors, which might hinder fair competition between prospective contractors or suppliers. In this context see also the section on awarding contracts in the section below containing Standards of Business Conduct for NHS Staff.

6.27.1.4.2 The Foundation Trust shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and in no case less than three firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

6.27.1.5 Items which subsequently breach thresholds after original approval

6.27.1.5.1 Items estimated to be below the limits set in this Standing Financial Instruction for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Chief Executive, and be recorded in an appropriate Foundation Trust record.

6.27.1.6 Waiving of Formal Tendering / Quotation Procedures

6.27.1.6.1 There is no exemption from formal procedures if the total financial value exceeds the threshold. In this instance, and in accordance with the Public Contract Regulations 2015, tendering/quotation procedures cannot be waived.

6.27.1.6.2 Formal tendering procedures may be waived in the following circumstances:

(a) In very exceptional circumstances where the Chief Executive decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures;
(b) Where the requirement is covered by an existing contract;
(c) Where national or other framework agreements are in place and have been approved by the Board of Directors;
(d) Where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;
(e) Where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender;
(f) Where specialist expertise is required and is available from only one source;
(g) When the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;
(h) Where there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;
(i) For the provision of legal advice and services providing that any legal firm or partnership commissioned by the Foundation Trust is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned. The Chief Finance Officer will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work.

6.27.1.6.3 The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

6.27.1.6.4 Competitive tendering cannot be waived for building and engineering construction works and maintenance without Departmental of Health approval.

6.27.1.6.5 Where it is decided that competitive tendering or quotation is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded on the Trust's standard Waiver Request Form. The originating department should submit the completed Waiver Request Form for approval in advance of any requisitioning activity to the Chief Finance Officer / Chief Executive.

6.27.1.6.6 All requests to waive tenders should be reported to the Audit Committee on a quarterly basis.

6.27.1.6.7 Exceptionally a single tender action may be permitted. However it should not be used retrospectively i.e. after a contract has been awarded nor should it be used for administrative convenience or to avoid competition. In all cases the reasons should be documented and reported by the Chief Finance Officer to Audit Committee and through to the Board via the Chair's Report.

6.27.1.7 Competitive Tenders and Quotations

6.27.1.7.1 Wherever practicable, at least three competitive tenders or quotations shall be obtained for the supply of goods or services in accordance with the Trust Delegated Financial Limits Table B Section 6.

6.27.1.7.2 In respect of any formal procurement exercises to be undertaken over the £5,000 threshold, the Head of Procurement's advice must be sought prior to commencement of the exercise. The Head of Procurement will lead any procurement exercises which exceed the ~~EU~~ Find a Tender Service procurement threshold.

6.27.1.8 Contracting / Tendering Procedure

6.27.1.8.1 Invitation to Tender

6.27.1.8.1.1 All invitations to tender on a formal competitive basis shall state the date and time as being the latest time for the receipt of tenders and no tender will be considered for acceptance unless submitted via the Trust's accepted method of receiving completed tender responses. All tenders must be received in this way and no exceptions will be made.

6.27.1.8.1.2 Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable.

6.27.1.8.1.3 Every tender for building or engineering works (except for maintenance work, when Estmancode guidance shall be followed) shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of the Environment (GC/Wks) Standard forms of contract; or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. These documents shall be modified and/or amplified to accord with Department of Health guidance and, in minor respects, to cover special features of individual projects.

6.27.1.8.1.4 Every tender for goods, materials, services (including consultancy services) or disposals shall embody such of the NHS Standard Contract conditions as are applicable. Every tenderer must give a written undertaking not to engage in collusive tendering or other restrictive practice.

6.27.1.8.1.5 Selection and award criterion must always be established in advance of tender selection taking place. Subsequent decisions to vary these criteria will be closely scrutinised before final approval is given. Further to Procurement Policy Note 06/20's application to NHS Trusts from April 2022, a minimum weighting of 10% must be given to Social Value in any tender award criteria.

6.27.1.8.1.6 Before the due date of the tender, the electronic tendering portal will issue an automatic notification to the directors responsible for receiving and the releasing of electronic tenders.

6.27.1.8.2 Receipt and safe custody of tenders

6.27.1.8.2.1 Formal competitive tender documents will be received electronically via the Trust's electronic tendering portal.

6.27.1.8.2.2 The Chief Executive or their nominated representative will be responsible for ensuring a secure system is in place for the safe custody of tenders. Electronic tenders received will be kept 'locked' in a secure electronic tender box within the electronic portal until the tender deadline for receipt of completed tender responses.

6.27.1.8.2.3 The electronic tenders will remained sealed until the electronic seal is removed by the Chief Executive's designated receiving officer. The date and time of receipt of each tender will be recorded on the electronic tender portal along with any tenders that have been received after the tender deadline, which will include details of the date and time the late tender(s) was/were received.

6.27.1.8.2.4 The Chief Executive shall designate a Releasing Officer, not from the originating Department, to release the electronic tenders which have had the seal removed by the receiving officer. Appropriate records will be provided by the electronic portal, as below.

6.27.1.8.2.5 Tenders will be held by the electronic tender portal under electronic seal until the closing date and time have been reached.

6.27.1.8.3 Opening tenders and Register of tenders

6.27.1.8.3.1 The rules relating to the opening of tenders should be read in conjunction with any delegated authority set out in the Trust's Scheme of Delegation.

6.27.1.8.3.2 As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, they shall be opened (i.e. the electronic seal will be removed) at one time in the presence of the Chief Executive or his/her nominated Executive Director together with one other Executive Director who is not from the originating Department (i.e. the department sponsoring or commissioning the tender).

6.27.1.8.3.3 The involvement of Finance Department staff in the preparation of a tender proposal will not preclude the Chief Finance Officer from serving as one of the two Executives to open and release tenders. All Executive Directors are authorised to open and release tenders and for this purpose the Foundation Trust Secretary will count as a Director for the purposes of opening tenders.

6.27.1.8.3.4 Should a tender be procured directly by an Executive Director, that officer should not be present at the opening or releasing of tenders.

6.27.1.8.3.5 The electronic tender portal will provide an extensive audit trail of the time of the tenders being opened and the time they are released to the evaluation team.

6.27.1.8.3.6 No tender shall be amended after it has been received except to correct bona fide errors endorsed as such by the Chief Executive or his nominated Executive Director. Any corrections shall be recorded.

6.27.1.8.3.7 On completion of the opening and releasing arrangements, all accepted tenders will be made available to the issuing department via the electronic tender portal.

6.27.1.8.3.8 Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e. those amended by the tenderer upon their own initiative either orally or in writing after the due time for receipt, but prior to the opening of other tenders, should be dealt with in the same way as late tenders. (See 6.27.1.8.4.2 below).

6.27.1.8.4 Admissibility

6.27.1.8.4.1 In considering which tender to accept, the designated Officers shall have regard to whether value for money will be obtained by the Trust and whether the number of tenders received provides adequate competition. In cases of doubt they shall consult the Chief Executive.

6.27.1.8.4.2 Tenders received after the due time and date may be considered only if the Chief Executive or nominated Executive Director decides that there are exceptional circumstances, e.g. where significant financial, technical or delivery advantages would accrue, and is satisfied that there is no reason to doubt the bona fides of the tenders concerned. The Chief Executive or nominated Executive Director shall decide whether such tenders are admissible and whether re-tendering is desirable. Re-tendering may be limited to those tenders reasonably in the field of consideration in the original competition. If the tender is accepted, the late arrival of the tender should be reported to the Board of Directors at its next meeting.

6.27.1.8.4.3 Incomplete tenders i.e. those from which information necessary for the adjudication of the tender is missing and amended tenders i.e. those amended by the tenderer upon their own initiative either orally or in writing after the due time for receipt should be dealt with in the same way as late tenders under Section 6.26.11.9.4.2 above.

6.27.1.8.4.4 Where examination of tenders reveals errors that would affect the tender figure, the tenderer is to be given details of such errors and afforded the opportunity of confirming or withdrawing their offer.

6.27.1.8.4.5 Necessary discussions with a tenderer of the contents of their tender, in order to elucidate technical points etc, before the award of a contract, need not disqualify the tender.

6.27.1.8.4.6 Formal pre-contract discussions must have the written consent of the Chief Executive and at least two Officers must be present and all details must be confirmed in writing.

6.27.1.8.4.7 If for any reason the designated officers are of the opinion that the tender received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive.

6.27.1.8.4.8 Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Chief Executive or their nominated officer decides that there are exceptional circumstances i.e. despatched in good time but delayed through no fault of the tenderer.

6.27.1.8.4.9 Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the tenders that have been duly opened have not left the custody of the Chief Executive or their nominated officer or if the process of evaluation and adjudication has not started.

6.27.1.8.4.10 While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody by the Chief Executive or their nominated officer.

6.27.1.8.5 Acceptance of formal tenders

6.27.1.8.5.1 Where only one tender is sought and/or received, the Chief Executive and Chief Finance Officer shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Foundation Trust, obtaining an independent assessment if required.

6.27.1.8.5.2 A tender other than the lowest (if payment is to be made by the Trust), or other than the highest (if payment is to be received by the Trust) shall not be accepted unless there are good reasons to the contrary. Such reasons shall be set out in a permanent record and be reported to the Board.

6.27.1.8.5.3 A financial appraisal should be undertaken by the Chief Finance Officer of successful tenderers who bid for contracts in excess of £50,000 and for all contractors bidding for financial services.

6.27.1.8.5.4 All tender documentation should be treated as confidential and should be retained for inspection / audit.

6.27.1.8.5.5 Note, unsuccessful bidders will be debriefed by the Head of Procurement involved, as required.

6.27.1.8.5.6 A contract cannot be concluded until the expiry of a period of at least 10 calendar days with effect from the day following the date on which the contract award decision is sent to the tenderers concerned if fax or electronic means are used; or, if other means of communication are used, before the expiry of a period of either at least 15 calendar days with effect from the day following the date on which the contract award decision is sent to the tenderers and candidates concerned.

6.27.1.8.5.7 Any discussions with a tenderer which are deemed necessary to clarify technical aspects of their tender before the award of a contract will not disqualify the tender (see also 6.27.1.8.4.6 above).

6.27.1.8.5.8 The lowest tender, if payment is to be made by the Foundation Trust, or the highest, if payment is to be received by the Foundation Trust, shall be accepted unless there are good and sufficient reasons to the contrary. Such reasons shall be set out in either the contract file, or other appropriate record.

It is accepted that for professional services such as management consultancy, the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

(a) experience and qualifications of team members;

(b) understanding of client's needs;

(c) feasibility and credibility of proposed approach;

(d) ability to complete the project on time.

Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

6.27.1.8.5.9 No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Foundation Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.

6.27.1.8.5.10 The use of these procedures must demonstrate that the award of the contract was:

(a) not in excess of the going market rate / price current at the time the contract was awarded;

(b) that best value for money was achieved.

6.27.11.9.5.11 All tenders must be treated as confidential and will be retained within the secure electronic tender portal for inspection.

6.27.11.9.6 Tender reports to the Board of Directors

6.27.11.9.6.1 Reports to the Board of Directors will be made for spend above £500,000 to be approved in line with delegated limits.

6.27.11.9.7.1 **Responsibility for maintaining list**

6.27.11.9.7.1.1A manager nominated by the Chief Executive shall on behalf of the Trust maintain lists of approved firms from who tenders and quotations may be invited. These shall be kept under frequent review. The lists shall include all firms who have applied for permission to tender and as to whose technical and financial competence the Foundation Trust is satisfied. All suppliers must be made aware of the Foundation Trust's terms and conditions of contract.

6.27.11.9.7.1.2 **Building and Engineering Construction Works**

(i) Invitations to tender shall be made only to firms included on the approved list of tenderers compiled in accordance with this Instruction or on the separate maintenance lists compiled in accordance with Estmancode guidance (Health Notice HN(78)147).

ii) Firms included on the approved list of tenderers shall ensure that when engaging, training, promoting or dismissing employees or in any conditions of employment, shall not discriminate against any person because of colour, race, ethnic or national origins, religion or sex, and will comply with the provisions of the Equal Pay Act 1970, the Sex Discrimination Act 1975, the Race Relations Act 1976, and the Disabled Persons (Employment) Act 1944 and any amending and/or related legislation.

iii) Firms shall conform at least with the requirements of the Health and Safety at Work Act and any amending and/or other related legislation concerned with the health, safety and welfare of workers and other persons, and to any relevant British Standard Code of Practice issued by the British Standard Institution. Firms must provide to the appropriate manager a copy of its safety policy and evidence of the safety of plant and equipment, when requested.

6.27.11.9.7.1.3 **Financial Standing and Technical Competence of Contractors**

The Chief Finance Officer may make or institute any enquiries they deem appropriate concerning the financial standing and financial suitability of approved contractors. The Director with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical / medical competence.

6.27.11.9.7.1.4 **Exceptions to using approved contractors**

6.27.11.9.7.1.4.1 If in the opinion of the Chief Executive and the Chief Finance Officer or the Director with lead responsibility for clinical governance it is impractical to use a potential contractor from the list of approved firms/individuals (for example where specialist services or skills are required and there are insufficient suitable potential contractors on the list), or where a list for whatever reason has not been prepared, the Chief Executive should ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.

6.27.11.9.7.1.4.2 An appropriate record in the contract file should be made of the reasons for inviting a tender or quote other than from an approved list.

6.27.11.10 **Quotations: Competitive and non-competitive**

6.27.11.10.7 **Quotation Procedures**

6.27.11.10.7.1 Quotations must be obtained in writing as specified in the Delegated Financial Limits Table B Section 6 of this Corporate Governance Manual.

6.27.11.10.7.2 Quotations should be obtained from at least 3 firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Foundation Trust.

6.27.11.10.7.3 Quotations should be in writing unless the Chief Finance Officer or their nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone quotations should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.

6.27.11.10.7.4 Wherever practicable, requests for quotations and quotation responses should be provided via the electronic tendering portal. This electronic tendering portal will allow for all quotations to be received electronically and will record the time and date of receipt.

6.27.11.10.7.5 If quotations are to be received outside of the electronic tendering portal they should be opened by the nominated Receiving Officer.

6.27.11.10.7.6 Where only one quotation is received the Foundation Trust shall, as far as practicable, ensure that the price to be paid is fair and reasonable, obtaining an independent assessment if required.

6.27.11.10.7.7 A quotation other than the lowest (if payment is to be made by the Foundation Trust), or other than the highest (if payment is to be received by the Foundation Trust) shall not be accepted unless there are good reasons to the contrary. Such reasons shall be set out in a permanent record and be reported to the Board.

6.27.11.10.7.8 All quotation documentation should be treated as confidential and should be retained either via the electronic tendering portal of in hard copy format for inspection / audit.

6.27.11.10.8 **Non-Competitive Quotations**

6.27.11.10.8.1 Non-competitive quotations in writing may be obtained in the following circumstances:

(i) the supply of proprietary or other goods of a special character and the rendering of services of a special character, for which it is not, in the opinion of the responsible officer, possible or desirable to obtain competitive quotations;

(ii) the supply of goods or manufactured articles of any kind which are required quickly and are not obtainable under existing contracts;

(iii) miscellaneous services, supplies and disposals;

(iv) where the goods or services are for building and engineering maintenance the responsible works manager must certify that the first two conditions of this SFI (i.e.(i) and (ii) of this SFI) apply.

6.27.11.10.8.2 **Quotations to be within Financial Limits**

6.27.11.10.8.

2.1 No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Foundation Trust and which is not in accordance with Standing Financial Instructions except with the authorisation of either the Chief Executive or Chief Finance Officer.

6.27.11.10.9 Instances where formal competitive tendering or competitive quotation is not required

6.27.11.10.9.1 Where competitive tendering or a competitive quotation is not required the Foundation Trust should adopt one of the following alternatives:

(a) The Foundation Trust shall use the NHS Supply Chain or nominated procurement partner for procurement of all goods and services unless the Chief Executive or nominated officers deem it inappropriate. ~~The decision to use alternative sources must be documented.~~

(b) If the Foundation Trust does not use the NHS Supply Chain - where tenders or quotations are not required, because expenditure is below the levels defined in the Scheme of Reservation and Delegation, the Foundation Trust shall procure goods and services in accordance with procurement procedures approved by the Chief Finance Officer.~~, where a suitable framework agreement exists which does not require further mini competitions~~

6.27.11.11 Private Finance for capital procurement

6.27.11.11.1 The Foundation Trust should normally market-test for PFI (Private Finance Initiative funding) when considering a capital procurement. When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

(a) The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.

(b) Where the sum exceeds delegated limits, a business case must be referred to the independent regulator, NHS Improvement, for approval or treated as per current guidelines.

(c) The proposal must be specifically agreed by the Board of the Foundation Trust.

(d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

6.27.11.12 Compliance requirements for all contracts

6.27.11.12.1 The Board may only enter into contracts on behalf of the Foundation Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

(a) The Foundation Trust's Standing Orders and Standing Financial Instructions;

(b) Public Contracts Regulations 2015~~EU Directives~~ and other statutory provisions;

(c) Any relevant directions including the NHS FREM, Estate code and guidance on the Procurement and Management of Consultants;

(d) Such of the NHS Standard Contract Conditions as are applicable.

(e) Contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance.

(f) Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

(g) In all contracts made by the Foundation Trust, the Board shall endeavour to obtain best value for money by use of all systems in place. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Foundation Trust.

6.27.11.13 Foundation Trust Contracts / Healthcare Services Agreements

6.27.11.13.1 Service agreements with NHS providers for the supply of healthcare services shall be drawn up in accordance with the requirements of the law. A contract with a Foundation Trust, being a Public Benefits Corporation, is a legal document and is enforceable in law.

6.27.11.13.2 The Chief Executive shall nominate officers to commission service agreements with providers of healthcare in line with a commissioning plan approved by the Board of Directors (refer to Scheme of Reservation and Delegation).

6.27.11.14 Disposals (See also Section 6.20 Condemnations and Disposals)

6.27.11.14.1 Competitive Tendering or Quotation procedures shall not apply to the disposal of:

(a) Any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or their nominated officer;

(b) Obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Foundation Trust;

(c) items to be disposed of with an estimated sale value of less than that defined on the Scheme of Delegation, this figure to be reviewed on a periodic basis;

(d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;

(e) land or buildings concerning which DH guidance has been issued but subject to compliance with such guidance.

6.27.11.15 In-house Services

6.27.11.15.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Foundation Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

6.27.11.15.2 In all cases where the Board of Directors determines that in-house services should be subject to competitive tendering the following groups shall be set up:

(a) Specification group, comprising the Chief Executive or nominated officer/s and specialist.

(b) In-house tender group, comprising a nominee of the Chief Executive and technical support.

(c) Evaluation team, comprising normally a specialist officer, a supplies officer and a Chief Finance Officer representative.

6.27.11.15.3 All groups should work independently of each other and individual officers may be a member of more than one group but no member of the in-house tender group may participate in the evaluation of tenders.

6.27.11.15.4 The evaluation team shall make recommendations to the Board of Directors.

6.27.11.15.5 The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Foundation Trust.

6.27.11.16 Applicability of SFIs on Tendering and Contracting to funds held in trust

6.27.11.16.1 These Instructions shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased from the Foundation Trust's trust funds and private resources.

6.27.12 Acceptance of Gifts and Hospitality by Staff

6.27.12.1 The Chief Finance Officer shall ensure that all staff are made aware of the Foundation Trust policy on acceptance of gifts and other benefits in kind by staff. This policy should follow the guidance contained in the [8]Department of Health Standards of Business Conduct for NHS Staff.

6.27.13 Retention of documents

6.27.13.1 **Context**

6.27.13.1.1 All NHS records are public records under the terms of the Public Records Act 1958 section 3 (1) – (2). The Secretary of State for Health and all NHS organisations have a duty under this Act to make arrangements for the safe keeping and eventual disposal of all types of records. In addition, the requirements of the Data Protection Act 1998 and the Freedom of Information Act 2000 must be achieved.

6.27.13.1.2 Accountability

6.27.13.1.2.1 The Chief Executive and senior managers are personally accountable for records management within the organisation. Additionally, the organisation is required to take positive ownership of, and responsibility for, the records legacy of predecessor organisations and /or obsolete services. Under the Public Records Act 1958 all NHS employees are responsibility for any records that they create or use in the course of their duties. Thus any records created by an employee of the NHS are public records and may be subject to both legal and professional obligations.

6.27.13.1.2.2 The Chief Executive shall be responsible for maintaining archives for all documents required to be retained under the direction contained in the [9]Department of Health guidance, Records Management: NHS Code of Practice.

6.27.13.1.3 **Types of Record Covered by The Code of Practice**

6.27.13.1.3.2 The guidelines apply to NHS records of all types (including records of NHS patients treated on behalf of the NHS in the private healthcare sector) regardless of the media on which they are held:

- Patient health records (electronic or paper based)
- Records of private patients seen on NHS premises;
- Accident and emergency, birth and all other registers;
- Theatre registers and minor operations (and other related) registers;
- Administrative records (including e.g. personnel, estates, financial and accounting records, notes associated with complaint handling);
- X-ray and imaging reports, output and other images;

[8]Standards of business conduct for NHS staff (HSG(93)5), NHS Management Executive, 1993
[9]Records Management: NHS Code of Practice, Department of Health 2006 & 2009

- Photographs, slides and other images;
- Microform (i.e. fiche / film)
- Audio and video tapes, cassettes, CD-ROM etc.
- Emails;
- Computerised records;
- Scanned records;
- Text messages (both outgoing from the NHS and incoming responses from the patient).

6.27.13.1.3.3 The documents held in archives shall be capable of retrieval by authorised persons.

6.27.13.1.3.4 Documents held in accordance with the Records Management Code of Practice shall only be destroyed at the express instigation of the Chief Executive, records shall be maintained of documents so destroyed.

6.27.14 Risk Management

6.27.14.1 The Chief Executive shall ensure that the Foundation Trust has a programme of risk management which must be approved Board of Directors and monitored by the Quality committee.

6.27.14.2 The programme of risk management shall include:

(a) A process for identifying and quantifying risks and potential liabilities;
(b) Engendering among all levels of staff a positive attitude towards the control of risk;
(c) Management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;
(d) Contingency plans to offset the impact of adverse events;
(e) Audit arrangements, including internal audit, clinical audit, health and safety review;
(f) Decisions on which risks shall be insured;
(g) Arrangements to review the risk management programme.

6.27.14.3 The existence, integration and evaluation of the above elements will assist in providing a basis to make a statement on the effectiveness of internal control within the Annual Report and Accounts, as required by current guidance.

6.27.15 Insurance arrangements

6.27.15.1 The Board shall decide if the Foundation Trust will insure through the risk pooling schemes administered by the NHS Litigation Authority or self insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

6.27.15.2 Arrangements to be followed by the Board of Directors in agreeing Insurance cover:

(a) Where the Board decides to use the risk pooling schemes administered by the NHS Litigation Authority the Chief Finance Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Chief Finance Officer shall ensure that documented procedures cover these arrangements.
(b) Where the Board decides not to use the risk pooling schemes administered by the NHS Litigation Authority for one or other of the risks covered by the schemes, the Chief Finance Officer shall ensure that the Board is informed of the nature and extent of the risks that are self insured as a result of this decision. The Chief

Finance Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

(c) All the risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the 'deductible'). The Chief Finance Officer should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

6.27.15.3 **Standard Areas for Commercial Insurance Cover**

(a) Foundation Trust's may enter commercial arrangements for insuring motor vehicles owned by the Foundation Trust including insuring third party liability arising from their use;

(b) Where the Foundation Trust is involved with a consortium in a Private Finance Initiative contract and the other consortium members require that commercial insurance arrangements are entered into; and

(c) Where income generation activities take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Foundation Trust for a NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from the Litigation Authority. In any case of doubt concerning a Foundation Trust's powers to enter into commercial insurance arrangements the Finance Director should consult NHS Improvement or the Department of Health as appropriate.

6.27.15.4 Consideration for Other Areas of Insurance Cover

6.27.15.4.1 As a Foundation Trust the Board need to consider the adequacy of insurance cover recognising the Public Benefit Corporation status. Key areas to consider include:

(a) Directors and Officers Liability – Recognising the cover available through the NHSLA, consideration is required to the adequacy of the cover in respect of selling assets, entering into contracts and insolvency indemnity cover

(b) Property Damage – consider the provision for underwriting claims.

(c) Business interruption resulting from property damage-consider the provision to cover for loss of income.

7 Standing Orders for the Board of Directors

These are contained in the Trust Constitution

8. Code of Conduct for the Board of Directors

8.1 Introduction

8.1.1 High standards of corporate and personal conduct are an essential component of public services. As an NHS foundation trust, Liverpool Women's NHS Foundation Trust is required to comply with the principles of best practice applicable to corporate governance in the NHS/health sector and with any relevant code of practice. The purpose of this code is to provide clear guidance on the standards of conduct and behaviour expected of all directors.

8.1.2 This code, with the Trust's Constitution, Corporate Governance Framework and Code of Conduct for Governors forms part of the framework designed to promote the highest possible standards of conduct and behaviour within the foundation trust. The code is intended to operate in conjunction with the principles of the NHS Foundation Trust Code of Governance, the NHS Constitution, requirements set out within the 2006 Health and Social Care Act, and all subsequent amendments, and Regulation 5 of the new Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Fit and Proper Persons: Directors. The code applies at all times when directors are carrying out the business of the foundation trust or representing the foundation trust.

8.2 Principles of public life

8.2.1 All directors are expected to abide by the Nolan principles of: selflessness, integrity, objectivity, accountability, honesty, transparency and leadership:

Selflessness
Holders of public office should act solely in terms of the public interest: they should not do so in order to gain financial or other benefits for themselves, their family or their friends.

Integrity
Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

Objectivity
In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit alone.

Accountability
Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

Openness
Holders of public office should be as open as possible about all the decisions and actions they take: they should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

Honesty
Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

8.3 General principles

8.3.1 Foundation Trust Boards of Directors have a duty to conduct business with probity, to respond to staff, patients and suppliers impartially, to achieve value for money from the public funds with which they are entrusted and to demonstrate high ethical standards of personal conduct. The general duty of the Board of Directors, and of each director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public. The Board of Directors therefore undertakes to set an example in the conduct of its business and to promote the highest corporate standards of conduct. The Board of Directors will lead in ensuring that the provisions of the Constitution, the Standing Orders, Standing Financial Instructions and accompanying Scheme of Delegation conform to best practice and serve to enhance standards of conduct. The Board of Directors expects that this Code will inform and govern the decisions and conduct of all directors.

8.4 Confidentiality & access to information

8.4.1 Directors must comply with the Foundation Trust's confidentiality policies and procedures. Directors must not disclose any confidential information, except in specified lawful circumstances.

8.4.2 Information on decisions made by the Board of Directors and information supporting those decisions should be made available in a way that is understandable. Positive responses should be given to reasonable requests for information and in accordance with the Freedom of Information Act 2000 and other applicable legislation and directors must not seek to prevent a person from gaining access to information to which they are legally entitled.

8.4.3 The Foundation Trust has adopted policies and procedures to protect confidentiality of personal information and to ensure compliance with the Data Protection Act, the Freedom of Information Act and other relevant legislation which will be followed at all times by directors.

8.5 Register of interests

8.5.1 Directors are required to register all relevant interests on the Board of Directors' Register of Interests in accordance with the provisions of the Trust's Constitution. It is the responsibility of each director to update their register entry if their interests change. The register is held by the Trust Secretary. Directors must send notification of any updates to the Trust Secretary and request confirmation that the register has been updated. Failure to register a relevant interest in a timely manner may constitute a breach of this Code.

8.6 Conflicts of interest

8.6.1 Directors have a statutory duty to avoid a situation in which they have (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Foundation Trust. Directors have a further statutory duty not to accept a benefit from a third party by reason of being a director or for doing (or not doing) anything in that capacity.

8.6.2 If a director has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the director must declare the nature and extent of that interest to the Chairman or Trust Secretary. If such a declaration proves to be, or becomes, inaccurate or incomplete, a further declaration must be made. Any such declaration must be made at the earliest opportunity and before the Trust enters into the transaction or arrangement.

8.6.3 The Chairman will advise directors in respect of any conflicts of interest that arise during Board of Directors meetings, including whether the interest is such that the director should withdraw from the meeting for the period of the discussion. In the event of disagreement, it is for the Board of Directors to decide whether a director must withdraw from the meeting. The Trust Secretary will provide advice on any conflicts that arise between meetings.

8.7 Bribery

8.7.1 The Bribery Act 2010 introduces a new, clearer regime for tackling bribery that applies to all businesses (including NHS organisations) based or operating in the UK. It covers all sorts of bribery, the offering and receiving of a bribe, directly or indirectly, whether or not it involves a public official, in the UK or abroad.

8.7.2 The Board of Directors has a responsibility to protect both the Trust and the wider NHS from bribery or corruption. Directors shall at all times comply with the Bribery Act 2010 and with the Trust's policy. Directors will not request or receive a bribe from anybody, nor imply that such an act might be considered. This means not agreeing to receive or accept a financial or other advantage from any source as an incentive or reward to perform improperly the function or activities of the Liverpool Women's NHS Foundation Trust.

8.8 Gifts & hospitality

8.8.1 The Board of Directors will set an example in the use of public funds and the need for good value in incurring public expenditure. The use of the Foundation Trust for hospitality and entertainment, including hospitality at conferences or seminars, will be carefully considered. All expenditure on these items should be capable of justification as reasonable in the light of the general practice in the public sector. The Board of Directors is conscious of the fact that expenditure on hospitality or entertainment is the responsibility of management and is open to be challenged by the internal and external auditors and that ill-considered actions can damage the reputation of the Foundation Trust in the eyes of the community.

8.8.2 The Board of Directors has adopted a policy on gifts and hospitality, within its Standards of Business Conduct, which will be followed at all times by directors. Directors must not accept gifts or hospitality other than in compliance with this policy.

8.9 Whistle-blowing

8.9.1 The Board of Directors acknowledges that staff must have a proper and widely publicised procedure for voicing complaints or concerns about maladministration, malpractice, breaches of this Code and other concerns of an ethical nature. The Trust has adopted a whistle-blowing policy (concerns reporting procedure) that is available for staff.

8.9.2 This policy reflects the provisions of the Public Interest Disclosure Act 1998, which gives protection from dismissal, harassment, fear of reprisal or other detrimental treatment to "workers" (this term means Trust employees, agency or bank staff, the staff of one of our contractors, or volunteers) who wish to report information, which they reasonably believe, is in the patient or public interest. This enables staff to express concerns safely, so that issues are raised at an early stage and in the right way. Directors will understand and fulfil their responsibilities in respect of the Trust's Whistleblowing Policy and the Public Interest Disclosure Act 1998.

8.10 Personal conduct

8.10.1 Directors are expected to conduct themselves in a manner that reflects positively on the Foundation Trust and not to conduct themselves in a manner that could reasonably be regarded as bringing their office or the Foundation Trust into disrepute.

8.10.2 Specifically directors must:

- Act in the best interests of the Foundation Trust and adhere to its Values, expected Behaviours and this Code of Conduct.
- Respect others and treat them with dignity and fairness.
- Seek to ensure that no one is unlawfully discriminated against and promote equal opportunities and social inclusion.
- Be honest and act with integrity and probity.
- Contribute to the workings of the Board of Directors as a Board of Directors member in order for it to fulfil its role and functions.
- Recognise that the Board of Directors is collectively responsible for the exercise of its powers and the performance of the foundation trust
- Raise concerns and provide appropriate challenge regarding the running of the Trust or a proposed action where appropriate.
- Recognise the differing roles of the Chairman, Vice-Chairman, Senior Independent Director, Chief Executive, Executive Directors and Non-Executive Directors.
- Make every effort to attend statutory meetings.
- Adhere to good practice in respect of the conduct of meetings and respect the views of others.
- Take and consider advice on issues where appropriate.
- Acknowledge the responsibility of the Council of Governors to represent the interests of the Foundation Trust's members and partner organisations in the governance and performance of the Foundation Trust and to hold Non-Executive Directors to account for the performance of the Board of Directors, and to have regard to the views of the Council of Governors.
- Not use their position for personal advantage or seek to gain preferential treatment; nor seek improperly to confer an advantage or disadvantage on any other person.
- Accept responsibility for their performance, learning and development.

8.11 Eligibility Criteria

8.11.1 The Trust's Provider Licence requires that the Trust will not appoint as a director any person who is an unfit person, and shall ensure termination is enforced promptly on discovering any director to be an unfit person, except with the approval in writing of Monitor.

8.11.2 The Trust's Constitution also sets the approved criteria, which deem a person to be an unfit person to become or continue as a Director of the Foundation Trust, as follows:

- s/he is a member of the Council of Governors, or a Governor of an NHS body or another NHS Foundation Trust;
- s/he is a member of a Local Involvement Network, its successor organisation, Local Healthwatch, or any of its successor organisations;
- s/he is the spouse, partner, parent or child of a member of the Board of Directors of the Trust;
- s/he is a member of a Local Authority's committee which scrutinises health matters.;
- s/he is a Director or member of a Clinical Commissioning Group with whom the Trust contracts;
- s/he been adjudged bankrupt or her estate has been sequestrated and in either case s/he has not been discharged;

- s/he has made a composition or arrangement with, or granted a Trust deed for, her creditors and has not been discharged in respect of it;
- s/he is the subject to a sex offender order;
- s/he has within the preceding five years been convicted in the British Islands of any offence:
- against a woman or child; or
- any other offence for which a sentence of imprisonment (whether suspended or not) for a period of three months or more (without the option of a fine) was imposed
- s/he is the subject of a disqualification order made under the Company Directors Disqualification Act 1986;
- in the case of a non-executive Director, s/he is no longer a member of one of the public constituencies or an individual exercising functions for a University providing a medical or dental school to a hospital of the Trust;
- s/he is a person whose tenure of office as a Chair or as a member or Director of a health service body has been terminated on the grounds that her appointment is not in the interests of the health service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;
- s/he has within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with a health service body;
- in the case of a non-executive Director s/he has refused without reasonable cause to fulfil any training requirement established by the Board of Directors; or
- s/he has refused to sign and deliver to the Secretary a statement in the form required by the Board of Directors confirming acceptance of the code of conduct for Directors.

8.11.3 In addition, Regulation 5 of the new Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Fit and Proper Persons Directors states that Directors should be of good character, have the required skills, experience and knowledge and as such that their health enables them to fulfil the management function.

8.11.4Furthermore, Directors would be excluded from office if they have been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether lawful or not) in the course of carrying out a regulated activity, or discharging any functions relation to any office or employment with a service provider.

8.11.4 Directors will notify the Trust Secretary immediately if any of the above criteria apply to their personal or professional circumstances.

8.12 Removal of a Director under the Fit and Proper Person Test

8.12.1 In addition to the Trust Disciplinary Rules which apply to all staff there is a requirement for Directors to be Fit and Proper Persons and to meet the Care Quality Commission Fit and Proper Person Test (FPPT) on an ongoing basis under Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

8.12.2 Where a Director fails to meet the FPPT then consideration will be given to removing that person from their role of Director.

8.12.3 Directors should be of good character, have the required skills, experience and knowledge and as such that their health enables them to fulfil the management function. To pass the FPPT none of the criteria of unfitness should apply, which include bankruptcy, sequestration and insolvency, appearing on a barred list and being prohibited from holding Directorships under other laws. Directors should not have been involved or complicit in any serious misconduct, mismanagement of failure of care in carrying on a regulated activity.

8.12.4 An individual can be appointed as a Director with the expectation that they develop specific competence to undertake the role within specified timescales. Failure to do so may result in the FFPT not being met.

8.12.5 Where information is discovered that suggests an individual is not of good character after appointment to a role (e.g. through annual checks or through information provided to, or discovered by, the Trust) then appropriate and timely action will be taken to investigate and rectify the matter. Immediate action will be taken to protect people receiving services from risk or potential risk.

8.12.6 In such cases the Chair or Deputy Chairman may suspend a Non-Executive Director or the Chief Executive where this is deemed appropriate. The Chief Executive may suspend an Executive Director and he/she, will notify the Chair of the reasons for this decision and the Chair shall forthwith call a meeting of the Board Nominations and Remuneration Committee to consider what actions should be taken. All concerns will be investigated quickly and due diligence in all such investigations demonstrated.

8.12.7 For concerns regarding a Non-Executive Director the Council of Governors Nominations and Remuneration Committee, supported by the Chief People Officer or other nominated person, will investigate the concerns and make a recommendation to the Chair and to the Council of Governors on the continued fitness of the Director where concerns are substantiated. Where the Director is deemed not to be a fit and proper person then action, as is proportionate, up to and including the termination of their engagement with immediate effect will be considered.

8.12.8 For concerns regarding an Executive Director or other Director level appointment, then an investigating officer will be appointed by the Chief Executive or Chief People Officer. The Investigating Officer may be an employee or Director of the Trust or may be a person or organisation engaged to undertake this role. They will investigate and present a case to a Director or Chief Executive of the Trust who will determine an outcome to be recommended in the first instance to the Board Nominations and Remuneration Committee and thereafter to the Board of Directors. Proportionate action up to summary dismissal will be taken as appropriate.

8.12.9 Where concerns are substantiated but an individual is retained as a Director, the rationale for this will be recorded and made available to those that need to be aware of this.

8.12.10 Where an individual appointment is terminated because they no longer meet the FPPT then this will be reported to the Regulator and to any appropriate professional body.

8.13 Compliance

8.13.1 All Directors will be required to:

- prior to appointment, and annually thereafter, give an undertaking to abide by the provisions of this Code of Conduct by signing the declaration below.

9. Code of Conduct for the Council of Governors

9.1 Introduction

This Code seeks to outline appropriate conduct for the Council of Governors and addresses both the requirements of office and the personal behaviour of individual Governors. Ideally any sanctions for non-compliance would never need to be applied, however a Code is considered an essential guide for Foundation Trust (FT) Governors. The Code seeks to expand on and complement our NHS Foundation Trust Constitution.

As a member of the Council of Governors sometimes dealing with difficult and confidential issues, Governors are required to act with discretion and care in the performance of their role. They will be required to maintain confidentiality with regard to information gained via their involvement with the Trust.

9.2 Qualifications for Office

Governors must continue to comply with the qualifications required to hold elected office throughout their period of tenure. The Trust Secretary should be advised of any changes in circumstances which disqualify the Governor from continuing in office. An example of this would be joining the Trust as an employee, given that the number of employees sitting on the Trust's elected body is limited.

All Governors will be expected to understand, agree and promote the Trust's Equal Opportunities Policy in every area of their work.

One of the key objectives of the governing body is to promote social inclusion through its activities and as such the development and delivery of initiatives should not prejudice any part of the community on the grounds of age, race, disability, marital status, sexual orientation or religious belief.

9.3 Role of Governors and the Council of Governors

- To hold the Non-Executive Directors (NEDs) individually and collectively to account for the performance of the Board of Directors
- To represent the interests of the members of the Foundation Trust as a whole and the interests of the public, bringing a fair and open-minded view on all issues
- To appoint and, if appropriate, remove the Chair
- To appoint and, if appropriate, remove the other Non-Executive Directors
- To decide the remuneration and allowances and other terms and conditions of office of the Chair and the other NEDs
- To approve the appointment of the Chief Executive
- To appoint and, if appropriate, remove the NHS Foundation Trust's auditor
- To receive the NHS Foundation Trust's annual accounts, any report of the auditor on them, and the annual report
- Put forward views on the Foundation Trust's forward plan and communicate the Trust's plans to members
- To adhere to the seven principles of public life, as defined by the Nolan Committee (further information at www.public-standards.org.uk). The seven principles are:
    - Selflessness
    - Integrity
    - Objectivity
    - Accountability
    - Openness
    - Honesty
    - Leadership
- To actively support and promote the principle of FT and contribute to its success
- To adhere to the Trust's policies and procedures and support its objectives

- To lead the Trust's membership development strategy, including membership recruitment
- To engage and consult with the membership of the Trust
- To encourage members to become future Governors.
- To recognise that their role is a collective one whereby they exercise collective decision making in the meeting room which is recorded in the minutes. Outside the meeting room a Governor has no more rights and privileges than any other member
- To undertake an advisory role to the Board of Directors.

In addition, individual Governors are required to:

- To attend Council of Governor meetings
- To contribute to the workings of the Council, ensuring that it fulfils its role and functions.

It should be noted that the functions allotted to the Council of Governors are not of a managerial nature.

9.4 Confidentiality

In the course of their duties Governors may receive information which is confidential. All Governors are required to respect the sensitivity of the information they are made privy to as a result of their position and to adhere to the Trust's policy in this regard. Information made available to Governors in confidence must remain confidential. Failure to maintain confidentiality may result in removal from the Council of Governors.

9.5 Conflict of Interest

Governors should act with the utmost integrity and objectivity and in the best interests of the Trust in performing their duties. They should not use their position for personal advantage or seek to gain preferential treatment. They should declare any conflicts of interest which may arise and should not vote on any such matters. If in any doubt they should seek advice from the Trust Secretary. It is important that conflicts of interest are addressed and are seen to be actioned in the interests of the trust and all individuals concerned.

Governors must declare any involvement they may have in any organization with which the hospital may be considering entering into a contract.

There is a Register of Interests in which Governors must enter any pecuniary and non-pecuniary interests that might create a conflict of interest. It also records 'nil' returns. Failure to declare interests may result in removal from the Council of Governors.

Please see separate declaration of interests documentation included in the induction pack.

9.6 Council of Governors meetings

Governors have a responsibility to attend meetings of the Council. When this is not possible they should submit an apology to the Trust Secretary in advance of the meeting.

Absence from the Council of Governors meetings without good reason established to the satisfaction of the Council is grounds for disqualification. Absence from three consecutive meetings will result in the member being deemed to have resigned their position unless the grounds for absence are deemed to be satisfactory by the Council of Governors.

Governors are expected to attend for the duration of the meeting.

9.7 Personal Conduct

Governors are required to adhere to the highest standards of conduct in the performance of their duties. In respect of their interaction with others they are required to:

- Adhere to good practice in respect of the conduct of the meetings and respect the views of their fellow members, both elected and appointed.
- Be mindful of conduct which could be deemed to be unfair or discriminatory.
- Treat the Trust's employees and fellow members with respect and in accordance with the trust's policies.
- Recognise that the Council of Governors and the Board of Directors and its management team have a common purpose, ie the success of the trust, and to work together as a team to this end.
- Governors should conduct themselves in such a manner as to reflect positively on the trust. When attending external meetings or any other events at which they are present, it is important for Governors to be ambassadors for the trust.

9.8 Accountability

Governors are accountable to the membership and should demonstrate this by attending members' meetings and other key events which provide opportunities to interface with their electorate in order to best understand their views.

9.9 Training and Development

Training and development are essential for the Council of Governors in respect of the effective performance of their role and Governors will be expected to both contribute to the formulation of a Training Programme for the Council and to actively participate in training events which are arranged for them. Governors may be removed from the Council of Governors if they have refused without reasonable cause to undertake any training which the Council of Governors requires all Governors to undertake.

9.10 Visits to Trust premises

Where the Governors wish to visit the premises of the Trust in a formal capacity as opposed to individuals in a personal capacity, the Council should liaise with the Trust Secretary to make the necessary arrangements. When attending Trust premises in the formal capacity of Governor, Governors must wear their identity badge which clearly indicates that they are a Governor of Liverpool Women's NHS Foundation Trust.

9.11 Non-compliance with the Code of Conduct

Non-compliance with the Code may result in action being taken as follows:

- Where misconduct takes place, the Chair shall be authorized to take such action as may be immediately required, including the exclusion of the person concerned from a meeting.
- Where such misconduct is alleged, it shall be open to the Council of Governors to decide by simple majority of those in attendance, to lay a formal charge of misconduct.
- The individual will be notified in writing of the charge/s, detailing the specific behaviour which is considered to be detrimental to the trust and inviting their response for consideration by the Council within a defined timescale.
- The Governor will be invited to address the Council in person if the matter cannot be resolved satisfactorily through correspondence.
- The Council of Governors will decide by simple majority of those present and voting whether to uphold the charge of conduct detrimental to the trust.
- The Council of Governors may impose such sanctions as shall be deemed appropriate, ranging from the issuing of a written warning as to the member's future conduct, to the removal of the individual from office.
- In order to aid participation by all parties it is imperative that all Governors observe the points of view of others and conduct likely to give offence will not be permitted. The Chair will reserve the right to ask any member of the Council who, in his or her opinion, fails to observe the Code to leave the meeting.

This Code of Conduct does not limit or invalidate the right of the Council of Governors or the trust to act under the constitution.

10. Code of Conduct for NHS Managers[10]

10.1 Introduction

The Code of Conduct for NHS Managers sets out the standards of conduct expected of NHS Managers. It serves two purposes:

- to guide NHS managers and employing health bodies in the work they do and the decisions and choices they have to make
- to reassure the public that these important decisions are being made against a background of professional standards and accountability.

10.2 The Code

10.2.1 As an NHS manager, I will observe the following principles:

- make the care and safety of patients my first concern and act to protect them from risk;
- respect the public, patients, relatives, carers, NHS staff and partners in other agencies;
- be honest and act with integrity;
- accept responsibility for my own work and the proper performance of the people I manage;
- show my commitment to working as a team member by working with all my colleagues in the NHS and the wider community;
- take responsibility for my own learning and development.

10.2.2 This means in particular that I will:

- respect patient confidentiality;
- use the resources available to me in an effective, efficient and timely manner having proper regard to the best interests of the public and patients;
- be guided by the interests of the patients while ensuring a safe working environment;
- act to protect patients from risk by putting into practice appropriate support and disciplinary procedures for staff; and
- seek to ensure that anyone with a genuine concern is treated reasonably and fairly.

10.2.3 I will respect and treat with dignity and fairness, the public, patients, relatives, carers, NHS staff and partners in other agencies. In my capacity as a senior manager within the NHS I will seek to ensure that no one is unlawfully discriminated against because of their religion, belief, race, colour, gender, marital status, disability, sexual orientation, age, social and economic status or national origin. I will also seek to ensure that:

- the public are properly informed and are able to influence services;
- patients are involved in and informed about their own care, their experience is valued, and they are involved in decisions;
- relatives and carers are, with the informed consent of patients, involved in the care of patients;
- partners in other agencies are invited to make their contribution to improving health and health services; and
- NHS staff are:
  - valued as colleagues;
  - properly informed about the management of the NHS;
  - given appropriate opportunities to take part in decision making.

[10] Based on Code of Conduct for NHS Managers published by the Department of Health, 2002 time to time amended.

- given all reasonable protection from harassment and bullying;
- provided with a safe working environment;
- helped to maintain and improve their knowledge and skills and achieve their potential; and
- helped to achieve a reasonable balance between their working and personal lives.

10.2.4 I will be honest and will act with integrity and probity at all times. I will not make, permit or knowingly allow to be made, any untrue or misleading statement relating to my own duties or the functions of my employer.

10.2.5 I will seek to ensure that:

- the best interests of the public and patients/clients are upheld in decision-making and that decisions are not improperly influenced by gifts or inducements;
- NHS resources are protected from fraud, bribery and corruption and that any incident of this kind is reported to the NHS Protect;
- judgements about colleagues (including appraisals and references) are consistent, fair and unbiased and are properly founded; and
- open and learning organisations are created in which concerns about people breaking the Code can be raised without fear.

10.2.6 I will accept responsibility for my own work and the proper performance of the people I manage. I will seek to ensure that those I manage accept that they are responsible for their actions to:

- the public and their representatives by providing a reasonable and reasoned explanation of the use of resources and performance;
- patients, relatives and carers by answering questions and complaints in an open, honest and well researched way and in a manner which provides a full explanation of what has happened, and of what will be done to deal with any poor performance and, where appropriate giving an apology; and
- NHS staff and partners in other agencies by explaining and justifying decisions on the use of resources and give due and proper consideration to suggestions for improving performance, the use of resources and service delivery.

10.2.7 I will support and assist the Accountable Officer of my organisation in his or her responsibility to answer to Parliament, Ministers, the Department of Health and the Independent Regulator of Foundation Trusts in terms of fully and faithfully declaring and explaining the use of resources and the performance of the local NHS in putting national policy into practice and delivering targets.

10.2.8 For the avoidance of doubt, nothing in paragraphs 10.2.3 to 10.2.7 of this Code requires or authorises an NHS manager to whom this Code applies to:

- make, commit or knowingly allow to be made any unlawful disclosure;
- make, permit or knowingly allow to be made any disclosure in breach of his or her duties and obligations to his or her employer, save as permitted by law.

10.2.9 If there is any conflict between the above duties and obligations and this Code, the former shall prevail.

10.2.10 I will show my commitment to working as a team by working to create an environment in which:

- teams of frontline staff are able to work together in the best interests of patients;
- leadership is encouraged and developed at all levels and in all staff groups; and
- the NHS plays its full part in community development.

10.2.11 I will take responsibility for my own learning and development. I will seek to:

- take full advantage of the opportunities provided;
- keep up to date with best practice; and
- share my learning and development with others.

10.2.12 I will also uphold the seven principles of public life as outlined by the Nolan Committee:

- Selflessness – holders of public office should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family or their friends
- Integrity – holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties
- Objectivity – in carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit
- Accountability – holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office
- Openness – holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands
- Honesty – holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest
- Leadership – holders of public office should promote and support these principles by leadership and example

10.3 Implementing the Code

10.3.1 The Code should be seen in a wider context that NHS managers must follow the 'Nolan Principles on Conduct in Public Life' (see paragraph 8.2.11 above), the 'Corporate Governance Codes of Conduct and Accountability', the 'Standards of Business Conduct', the 'Code of Practice on Openness in the NHS' and standards of good employment practice.

10.3.2 In addition many NHS managers come from professional backgrounds and must follow the code of conduct of their own professions as well as this Code.

10.3.3 In order to maintain consistent standards, the Trust will consider suitable measures to ensure that managers who are not their employees but who:

- manage their staff or services; or
- manage units which are primarily providing services to their patients also observe the Code.

10.3.4 It is important to respect both the rights and responsibilities of managers. To help managers to carry out the requirements of the Code, the Trust will provide reasonable learning and development opportunities and seek to establish and maintain an organisational culture that values the role of managers. NHS managers have the right to be:

- treated with respect and not be unlawfully discriminated against for any reason;
- given clear, achievable targets;
- judged consistently and fairly through appraisal;

- given reasonable assistance to maintain and improve their knowledge and skills and achieve their potential through learning and development; and
- reasonably protected from harassment and bullying and helped to achieve a reasonable balance between their working and personal lives.

10.4 Breaching the Code

10.4.1 Alleged breaches of the Code of Conduct will be promptly considered and fairly and reasonably investigated. Individuals must be held to account for their own performance, responsibilities and conduct where employers form a reasonable and genuinely held judgement that the allegations have foundation. Investigators should consider whether there are wider system failures and organisational issues that have contributed to the problems. In order to learn from and prevent future breaches of the Code, it is necessary to look at the wider causes of alleged breaches.

10.4.2 Local employers should decide whether to investigate alleged breaches informally or under the terms of local disciplinary procedures. It is essential however that both forms of investigation should be, and be seen to be, reasonable, fair and impartial. If Chief Executives or Directors are to be investigated, the employing authority should use individuals who are employed elsewhere to conduct the investigation. The NHS Confederation, the Institute of Healthcare Management and the Healthcare Financial Management Association are among the organisations who maintain lists of people who are willing to undertake such a role.

10.5 Application of the Code

10.5.1 The Code codifies and articulates certain important contractual obligations that apply to everyone holding management positions. These include Chief Executives and Directors who as part of their duties are personally accountable for achieving high quality patient care.

10.5.2 The Trust will:

- incorporate the Code into the employment contracts of Chief Executives and Directors and include the Code in the employment contracts of new appointments to that group
- identify any other senior managerial posts, i.e. with levels of responsibility and accountability similar to those of Director-level posts, to which they consider the Code should apply
- include the Code in new employment contracts as appropriate
- incorporate the Code into the employment contracts of existing postholders as appropriate.
- investigate alleged breaches of the Code by those to whom the Code applies promptly and reasonably as at paragraphs four to five
- provide a supportive environment to managers (see paragraph 10.2.5 above).

See also Standards of Business Conduct for NHS Staff, included in this manual

11. Standards of Business Conduct for NHS Staff

11.1 Introduction

11.1.1 These guidelines are based on recommendations by the NHS Management Executive to assist NHS employers and staff in maintaining strict ethical standards in the conduct of NHS business. They cover:

- the standards of conduct expected of all NHS staff where their private interests may conflict with their public duties; and
- the steps which NHS employers should take to safeguard themselves and the NHS against conflict of interest
- Action checklist for NHS Managers -*Part C* (omitted from this extract)
- Short guide for staff - *Part D*
- Ethical Code of the Chartered Institute of Purchasing and Supply (CIPS) (reproduced courtesy of IPS) - *Part E.*

11.1.2 The guidance is in four parts:

- Part A - brief summary of the main provisions of the Bribery Act 2010
- Part B - general policy guidelines
- Part C – Short guide for staff
- Part D - Ethical Code of the Chartered Institute of Purchasing and Supply (CIPS).

Part A

Bribery Act 2010

Bribery is generally defined as an inducement or reward offered, promised or provided to someone to perform their functions or activities improperly in order to gain a personal, commercial, regulatory and/or contractual advantage, on behalf of oneself or another.

The Act repeals the UK's existing anti-corruption legislation – the Public Bodies Corrupt Practices Act 1889, the Prevention of Corruption Acts of 1906 and 1916 and the common law offence of bribery – and provides an updated and extended framework of offences to cover bribery both in the UK and abroad.

Zero Tolerance

Bribery is a criminal offence. Liverpool Women's NHS Foundation Trust does not, and will not, pay bribes or offer improper inducements to anyone for any purpose; nor do we or will we, accept bribes or improper inducements. This approach applies to everyone who works for us, or with us. To use a third party as a conduit to channel bribes to others is a criminal offence. We do not, and will not, engage indirectly in, or otherwise encourage, bribery.

Proactively combatting bribery has clear benefits for this Trust and the wider NHS. It helps prevent:

- adverse damage to or criticism of the organisation's reputation and funding;
- the potential diversion and/or loss of resources from NHS care;
- unforeseen and unbudgeted costs of investigations and/or defence of any legal action; and,
- a negative impact on patient/stakeholder perceptions.

Part B

General policy guidelines

Responsibility of the Trust
The Trust is responsible for ensuring that these guidelines are brought to the attention of all employees; also that machinery is put in place for ensuring that they are effectively implemented.

Responsibility of NHS staff
It is the responsibility of staff to ensure that they are not placed in a position which risks, or appears to risk, conflict between their private interests and their NHS duties. This primary responsibility applies to all NHS staff, i.e. those who commit NHS resources directly (e.g. by the ordering of goods) or those who do so indirectly (e.g. by the prescribing of medicines). A further example would be staff who may have an interest in a private nursing home and who are involved with the discharge of patients to residential facilities.

Guiding principle in conduct of public business
It is a long established principle that public sector bodies, which include the NHS, must be impartial and honest in the conduct of their business, and that their employees should remain beyond suspicion. It is also an offence under the Bribery Act 2010 for an inducement or reward offered, promised or provided to someone to perform their functions or activities improperly in order to gain a personal, commercial, regulatory and/or contractual advantage, on behalf of oneself or another (see Part A).

A breach of the provisions of the Act renders employees liable to prosecution and may also lead to loss of their employment and superannuation rights in the NHS.

NHS staff are expected to:
- ensure that the interest of patients remains paramount at all times;
- be impartial and honest in the conduct of their official business;
- use the public funds entrusted to them to the best advantage of the service, always ensuring value for money.

It is also the responsibility of staff to ensure that they do not:
- abuse their official position for personal gain or to benefit their family or friends;
- seek to advantage or further private business or other interests, in the course of their official duties.

Implementing the guiding principles
Casual gifts
Casual gifts offered by contractors or others, e.g. at Christmas time should be politely but firmly declined.

Any gifts received from or offer of gifts by a contractor or potential contractor must be reported immediately to the Chief Executive. In the context of these instructions contractor means any supplier of goods and/or services to the Trust. Exception may be made only for items of a trivial nature, otherwise staff should decline all offers of gifts.

Articles of low intrinsic value such as diaries or calendars, or small tokens of gratitude from patients or their relatives, need not necessarily be refused. In cases of doubt staff should either consult their line manager or politely decline acceptance.

Hospitality
Modest hospitality provided it is normal and reasonable in the circumstances, e.g. lunches in the course of working visits, may be acceptable, though it should be similar to the scale of hospitality which the NHS as an employer would be likely to offer.

Visits to contractors or potential contractors or to another site to inspect their installations must be made at the Trust's expense and not the contractor's. Exception to this rule may be granted by the Chief Executive where reasonable. Otherwise only minimal hospitality should be accepted from a contractor or potential contractor and an immediate explanation must be given to the Chief Executive if a breach of the rules occurs. As with gifts, unless of a minor nature hospitality and entertainment should be declined.

Staff should decline all other offers of gifts, hospitality or entertainment. If in doubt they should seek advice from their line manager.

Any item/s of gifts and hospitality accepted, which are over the value of £25.00, should be entered into the gifts and hospitality register held in the Chief Executive's office.

Declaration of interests
For conflict of interests please refer to the Trust policy 'Managing Conflicts of interest' which sets out the requirement for staff to disclose any conflict or perceived conflict with the Trust's activities.

All NHS staff should therefore declare such interests to their employer, either on starting employment or on acquisition of the interest, in order that it may be known to and in no way promoted to the detriment of either the employing authority or the patients whom it serves.
One particular area of potential conflict of interest, which may directly affect patients, is when NHS staff hold a self-beneficial interest in private care homes or hostels. While it is for staff to declare such interests to their employing authority, the employing authority has a responsibility to introduce whatever measures it considers necessary to ensure that its interests and those of patients are adequately safeguarded. This may for example take the form of a contractual obligation on staff to declare any such interests. Advice on professional conduct issued by the General Medical Council recommends that when a doctor refers a patient to a private care home or hostel in which he or she has an interest, the patient must be informed of that interest before referral is made.
In determining what needs to be declared, employers and employees will wish to be guided by the policy referred to above and to the following documents that can be found on NHS England's website at https://www.england.nhs.uk/ourwork/coi/.
The Trust will:

- ensure that staff are aware of their responsibility to declare relevant interests
- keep a register of all such interests and make them available for inspection by the public
- develop a local policy, in consultation with staff and local staff interests, for implementing this guidance. This may include the disciplinary action to be taken if an employee fails to declare a relevant interest or is found to have abused his or her official position, or knowledge, for the purpose of self-benefit, or that of family or friends.

Preferential treatment in private transactions
Individual staff must not seek or accept preferential rates or benefits in kind for private transactions carried out with companies with which they have had, or may have, official dealings on behalf of their NHS employer. (This does not apply to concessionary agreements negotiated with companies by NHS management, or by recognised staff interest, on behalf of all staff - for example, NHS staff benefits schemes.)

Contracts
All staff who are in contact with suppliers and contractors (including external consultants), and in particular those who are authorised to sign purchase orders, or place contracts for goods, materials or services, are expected to adhere to professional standards of the kind set out in the Ethical Code of the CIPS, reproduced at Part D.

Favouritism in awarding contracts

Fair and open competition between prospective contractors or suppliers for NHS contracts is a requirement of NHS Standing Orders and of EC Directives on Public Purchasing for Works and Supplies. This means that:

- no private, public or voluntary organisation or company which may bid for NHS business should be given any advantage over its competitors, such as advance notice of NHS requirements. This applies to all potential contractors, whether or not there is a relationship between them and the NHS employer, such as a long-running series of previous contracts
- each new contract should be awarded solely on merit, taking into account the requirements of the NHS and the ability of the contractors to fulfil them.

The Trust will ensure that no special favour is shown to current or former employees or their close relatives or associates in awarding contracts to private or other businesses run by them or employing them in a senior or relevant managerial capacity. Contracts may be awarded to such businesses where they are won in fair competition against other tenders, but scrupulous care must be taken to ensure that the selection process is conducted impartially, and that staff who are known to have a relevant interest play no part in the selection.

Warnings to potential contractors- Trust bribery statement
NHS employers will wish to ensure that all invitations to potential contractors to tender for NHS business include a notice warning tenderers of the consequences of engaging in any corrupt practices involving employees of public bodies.

Liverpool Women's NHS Foundation Trust does not, and will not, pay bribes or offer improper inducements to anyone for any purpose; nor do we or will we, accept bribes or improper inducements. This approach applies to <u>everyone</u> who works for us, or with us. To use a third party as a conduit to channel bribes to others is a criminal offence. We do not, and will not, engage indirectly in, or otherwise encourage, bribery.

Outside employment
NHS employees are advised not to engage in outside employment which may conflict with their NHS work, or be detrimental to it. They are advised to tell the Trust if they think they may be risking a conflict of interest in this area: the Trust will be responsible for judging whether the interests of patients could be harmed, in line with the principles in 'Implementing the guiding principles' above.

Second employments must also be considered carefully. These activities should neither take precedence over an officer's main employment with the Trust nor should engagement in these activities in any way affect an officer's efficient discharge of duties under his or her main employment. Where an officer has reason to believe that this or her second employer has any business dealings whatsoever with the Trust the fact must be reported to the Chief Executive.

For full time staff, the main employment of officers necessarily takes precedence over any other paid or voluntary activities undertaken. Employees should not engage in any second or spare time job which affects in any way their performance or discharge of their duties with this Trust.

Second or spare time jobs are permissible without the need for registration or authorisation where the activity is not with a supplier or contractor to the Trust or not with any other NHS organisation.

Extra jobs, whether regular or occasional, should not be with a supplier to the Trust unless specifically approved by the Chief Executive who will keep a register detailing the personnel, the activity, the employer, and any other such details as deemed desirable.

Details of such situations must be submitted as and when these arise and confirmed on an annual basis.

Particular care must be taken to disclose any employment, even if only on a temporary or supply basis, with another NHS or private health care body.

Private practice
Consultants (and associate specialists) employed under the Consultant Contract are permitted to carry out private practice in NHS hospitals subject to the conditions outlined in the handbook and in accordance with the Code of Conduct for Private Practice

Other grades may undertake private practice or work for outside agencies, providing they do not do so within the time they are contracted to the NHS, and they observe the conditions in the paragraph above. All hospital doctors are entitled to fees for other work outside their NHS contractual duties (paragraph 41 of the TCS of Hospital Medical and Dental staff) e.g. examinations and reports for life insurance purposes. Hospital doctors and dentists in training should not undertake locum work outside their contracts where such work would be in breach of their contracted hours. Career grade medical and dental staff employed by NHS Trusts may agree terms and conditions different from the National Terms and Conditions of Service.

Rewards for Initiative
The Trust will identify potential intellectual property rights (IPR), as and when they arise, so that they can protect and exploit them properly, and thereby ensure that it receives any rewards or benefits (such as royalties) in respect of work commissioned from third parties, or work carried out by their employees in the course of their NHS duties. Most IPR are protected by statute e.g. patents are protected under the Patents Act 1977 and copyright (which includes software programmes) under the Copyright Designs and Patents Act 1988. To achieve this, the Trust will build appropriate specifications and provisions into the contractual arrangements which they enter into *before* the work is commissioned, or begins. They should always seek legal advice if in any doubt in specific cases.

With regard to patents and inventions, in certain defined circumstances the Patents Act gives *employees a right* to obtain some reward for their efforts, and employers should see that this is effected. Other rewards may be given voluntarily to employees who within the course of their employment have produced innovative work of outstanding benefit to the NHS. Similar rewards should be voluntarily applied to other activities such as giving lectures and publishing books and articles.

In the case of collaborative research and evaluative exercises with manufacturers, NHS employers should see that they obtain a fair reward for the input they provide. If such an exercise involves additional work for an NHS employee outside that paid for by the NHS employer under his or her contract of employment, arrangements should be made for some share of any rewards or benefits to be passed on to the employee(s) concerned from the collaborating parties. Care should however be taken that involvement in this type of arrangement with a manufacturer does not influence the purchase of other supplies from that manufacturer.

Commercial sponsorship for attendance at courses and conferences
Acceptance by staff of commercial sponsorship for attendance at relevant conferences and courses is acceptable, but only where the employee seeks permission in advance and the employer is satisfied that acceptance will not compromise purchasing decisions in any way.
On occasions when NHS employers consider it necessary for staff advising on the purchase of equipment to inspect such equipment in operation in other parts of the country (or exceptionally, overseas), employing authorities will themselves want to consider meeting the cost, so as to avoid putting in jeopardy the integrity of subsequent purchasing decisions.

Commercial sponsorship of posts - “linked deals”
Pharmaceutical companies, for example, may offer to sponsor, wholly or partially, a post for the Trust. The Trust will not enter into such arrangements, unless it has been made abundantly clear to the company concerned that the sponsorship will have no effect on purchasing decisions by the Trust.

Where such sponsorship is accepted, monitoring arrangements will be established to ensure that purchasing decisions are not, in fact, being influenced by the sponsorship agreement.

Under no circumstances should employers agree to "linked deals" whereby sponsorship is linked to the purchase of particular products, or to supply from particular sources.

"Commercial in-confidence"
Staff should be particularly careful of using, or making public, internal information of a "commercial in-confidence" nature, *particularly if its disclosure would prejudice the principle of a purchasing system based on fair competition. This principle applies whether private competitors or other NHS providers are concerned,* and whether or not disclosure is prompted by the expectation of personal gain (see the paragraphs above and Part D).

However, NHS employers should be careful about adopting a too restrictive view on this matter. It should certainly not be a cause of excessive secrecy on matters which are not strictly commercial per se. For example, the term "commercial in confidence" should not be taken to include information about service delivery and activity levels, which should be publicly available. Nor should it inhibit the free exchange of data for medical audit purposes, for example, subject to the normal rules governing patient confidentiality and data protection. In all circumstances the overriding consideration must be the best interests of patients.

Disciplinary action
Failure to follow the principles and the guidance in this Code may result in disciplinary action and possibly prosecution under the Bribery Act 2010.

Officers should take action to report as soon as possible any instance where they feel the guidelines have been broken, accidentally or otherwise, by themselves or others. It should be emphasised that the crime occurs when any money, gift or consideration has been offered, requested or received and the recipient then shows favour or partiality to the donor. The recipient should be prepared to, and be able to demonstrate that any gift or hospitality was not received corruptly. Money should never be accepted. Prompt disclosure and registration are important acts to refute the charge of corruption.

Part C

Short guide for staff
Do:
- make sure you understand the guidelines on standards of business conduct, and consult your line managers if you are not sure
- make sure you are not in a position where your private interests and NHS duties may conflict (3)
- declare to your employer any relevant interests. If in doubt, ask yourself:
  - am I, or might I be, in a position where I (or my family/friends) could gain from the connection between my private interests and my employment?
  - do I have access to information which could influence purchasing decisions?
  - could my outside interest be in any way detrimental to the NHS or to patients' interests?
  - do I have any other reasons to think I may be risking a conflict of interest?
  - if still unsure - declare it!
- adhere to the ethical code of the Chartered Institute of Purchasing and Supply if you are involved in any way with the acquisition of goods and services
- seek your employer's permission before taking on outside work, if there is any question of it adversely affecting your NHS duties (special guidance applies to doctors)
- obtain your employer's permission before accepting any commercial sponsorship.

Do not:

- accept any gifts, inducements or inappropriate hospitality
- abuse your past or present official position to obtain preferential rates for private deals
- unfairly advantage one competitor over another or show favouritism in awarding contracts
- misuse or make available official “commercial in confidence” information.

If in doubt seek advice from the Trust Secretary on 0151 702 4033 or if you wish to report any concerns in relation to fraud or corruption contact the Trust’s LCFS on 07800 617 012 , the Fraud and Corruption Reporting Line 0800 028 4060 or www.reportnhsfraud.nhs.uk.

Part D

Chartered Institute of Purchasing and Supply - Ethical Code (Reproduced by kind permission of CIPS)

Introduction
The code set out below was approved by the CIPS Council on 11 March 2009 and is building on CIPS members.

- maintain the highest standard of integrity in all my business relationships
- reject any business practice which might reasonably be deemed improper
- never use my authority or position for my own personal gain
- enhance the proficiency and stature of the profession by acquiring and applying knowledge in the most appropriate way
- foster the highest standards of professional competence amongst those for whom I am responsible
- optimise the use of resources which I have influence over for the benefit of my organisation
- comply with both the letter and the intent of:
  - the law of countries in which I practise
  - agreed contractual obligations
  - CIPS guidance on professional practice
- declare any personal interest that might affect, or be seen by others to affect, my impartiality or decision making
- ensure that the information I give in the course of my work is accurate
- respect the confidentiality of information I receive and never use it for personal gain
- strive for genuine, fair and transparent competition
- not accept inducements or gifts, other than items of small value such as business diaries or calendars
- always declare the offer or acceptance of hospitality and never allow hospitality to influence a business decision
- remain impartial in all business dealing and not be influenced by those with vested interests.

See also Code of Conduct for NHS Managers, included in this manual.

12. Standing Orders of the Council of Governors –

These can be found in the Trust Constitution

13. Procedure for amending the Corporate Governance Manual

13.1 Procedure for Reviewing and Updating

13.1.1 Background

This manual sets out how the Trust operates and regulates itself. This is of vital importance in the public sector where the use of public funds and the performance and conduct of the organisation is under constant scrutiny.

13.1.2 Annual Review

The manual will be reviewed annually. It will be reviewed by the Trust Audit Committee in July. Thereafter it will be presented to the Board of Directors for formal approval and adoption at the next available meeting.

All changes[11] to the manual will be reviewed by the Audit Committee. These changes will be clearly highlighted in the updated Manual which is presented for subsequent adoption to the Board of Directors.

Following adoption, the Chief Executive and the Trust Secretary are responsible for ensuring that all directors, governors and trust staff are made aware of the manual and their responsibilities in respect of it. An up-to-date version of the manual will at all times be available on the Trust's intranet and website.

Where there are proposed changes to the manual that require initial review and approval by the Council of Governors, this will be done prior to consideration by the Audit Committee and the Board of Directors.

Care should be taken to ensure that all changes are consistent with the Trust's Constitution. Any proposed changes to the Constitution must first be approved by the Trust's members and NHS Improvement as per paragraph 23 of the Constitution.

Changes to Standing Financial Instructions, Scheme of Delegation of Board powers and associated section or which have financial implications or impact must always be routed through the Trust's Finance Department, where the Deputy Chief Finance Officer will ensure all financial aspects of the change are given due consideration and approval. These changes must be subsequently approved by the Finance, Performance and Business Development Committee ahead of consideration by the Audit Committee and Board of Directors.

The Trust Secretary will co-ordinate the submission of Corporate Governance Manual changes for approval to the Audit Committee, the Board of Directors and the Council of Governors as required.

13.1.3 Periodic Updating

The manual will be reviewed annually when necessary changes will be made. However it is recognised that changes may need to be made in-year to reflect legislative, constitutional, operational or other requirements i.e. periodic updating.

In such circumstances the same procedures must be followed, in due order, as specified above in respect of the annual review.

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[11] With the exception of minor changes such as an organisational name change which will be reported for noting to the next available Audit Committee

Liverpool Women's
NHS Foundation Trust

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 an normal acute admission ward *or* an inpatient unit specialising in the care of critically ill infants, children, and teenagers
PLACE	Patient-Led	Surveys inviting local people going into hospitals as
	Assessments of the Care Environment	part of a team to assess how the environment supports patient's privacy and dignity, food, cleanliness and general building maintenance
PPI	Patient and Public Involvement	mechanisms that ensure that members of the community --- whether they are service users, patients or those who live nearby – are at the centre of the delivery of health and social care services
PTS	Patient Transport Services	free transport to and from hospital for non-emergency patients who have a medical need

	Primary Care	the first point of contact with the NHS for most people and is delivered by a wide range of independent contractors, including GPs, dentists, pharmacists and optometrists, it also includes NHS walk-in centres and the NHS 111 telephone service

Q

QA	Quality assurance	monitoring and checking outputs to make sure they meet certain standards
QI	Quality improvement	A continuous improvement process focusing on processes and systems
QIA	Quality Impact Assessment	A process within NHS trusts which ensures the quality of service is systematically considered in decision- making on service changes
QUI	Qualities and Outcomes Framework	The system for performance management and payment of GP's in the NHS

R

R&D	Research & Development	work directed towards the innovation, introduction, and improvement of products and processes
RAG	Red, Amber, Green classifications	a system of performance measurement indicating whether something is on or better than target (green), below target but within an acceptable tolerance level (amber), or below target and below an acceptable tolerance level (red)
RGN	Registered General Nurse	a nurse who is fully qualified and is registered with the Nursing and Midwifery Council as fit to practise
RoI	Return on Investment	the benefit to the investor resulting from an investment of some resource. A high RoI means the investment gains compare favourably to investment cost. As a performance measure, RoI is used to evaluate the efficiency of an investment or to compare the efficiency of a number of different investments.
RTT	Referral to Treatment Time	the waiting time between a patient being referred by a GP and receiving treatment

S		
SALT	Speech and Language Therapist	assesses and treats speech, language and communication problems in people of all ages to help them better communicate
SFI	Standing Financial Instructions	Policy used for the regulation of the conduct of an NHS trust in relation to all financial matters
SHMI	Summary Hospital Level Mortality Indicator	reports mortality at trust level across the NHS in England using standard and transparent methodology
SID	Senior independent Director	a non-executive director who sits on the board and plays a key role in supporting the chair; the SID carries out the annual appraisal of the chair, and is available to governors as a source of advice and guidance in circumstances where it would not be appropriate to involve the chair
SIRO	Senior Information Risk Officer	a senior manager who will take overall ownership of the organisation's information risk policy
SITREP	Situation Report	a report compiled to describe the details surrounding a situation, event, or incident
SLA	Service Level Agreement	an agreement of services between service providers and users or commissioners
SoS	Secretary of State	the minister who is accountable to Parliament for delivery of health policy within England, and for the performance of the NHS
SRO	Senior Responsible officer	A leadership role which is accountable for the delivery and outcome of a specific project
STP	Sustainability and Transformation Partnership	Partnerships formed between local councils and NHS services to help plan and run services, and agree system-wide priorities
SUI	Series Untoward Incident / Serious Incident	A serious incident which resulted in one or more of the following: unexpected or avoidable death, a never event, a prevention of organisation's ability to continue to deliver healthcare services, abuse, or loss of confidence in a service
SWOT	Strengths, Weaknesses, Opportunities, Threats	a structured planning method used to evaluate the strengths, weaknesses, opportunities and threats involved in a project or in a business venture
	Secondary Care	NHS health service provided through hospitals and in the community

T		
TTO	To Take Out	medicines to be taken away by patients on discharge

	Tertiary Care	healthcare provided in specialist centres, usually on referral from primary or secondary care professionals

V

VTE	Venous Thromboembolism	a condition where a blood clot forms in a vein. This is most common in a leg vein, where it's known as deep vein thrombosis (DVT). A blood clot in the lungs is called pulmonary embolism (PE)
VfM	Value for Money	used to assess whether or not an organisation has obtained the maximum benefit from the goods and services it both acquires and provides, within the resources available to it

W

WLF	Well Led Framework	a set of indicators that seek to identify how well led an organisation is, also used as a framework for board governance reviews
WRES	Workforce Race Equality Standard	a metric to demonstrate progress against a number of indicators of workforce equality, including a specific indicator to address the low levels of black and minority ethnic (BME) board representation
WTE	Whole-time equivalent	See FTE

Y

YTD	Year to Date	a period, starting from the beginning of the current year, and continuing up to the present day. The year usually starts on 1st April for financial performance indicators