Liverpool Women's
NHS Foundation Trust

Annual Report/Accounts 2009/10

NHS

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paragraph 25(4) of the National Health Service Act 2006

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Liverpool Women's NHS Foundation Trust

Welcome from the Chairman

Welcome to Liverpool Women's 2009/10 Annual Report. Publication of this report is both timely and particularly relevant, as it sets out the Trust's achievements in its fifth year as an NHS foundation trust.

Even with our long experience and many successes as a public benefit corporation, the past year has presented us with just as many challenges as previous years, with significant changes in senior management positions and in a wider context, uncertainty across the service in the lead up to the recent General Election.

Against this background, the Trust's performance and financial results are very impressive. Much of the credit for our achievements must go to our excellent staff for the efforts they have made. It would be wrong however, to overlook the work of the Trust's Council of Governors for the contribution it has made in a variety of ways, including its constructive scrutiny of and support for the way in which the Board has handled some important issues during the year. I firmly believe that this Trust can be proud of its Governors and the level of engagement which takes place.

As with any Annual Report, there are plenty of facts and figures to follow but please do not be put off – it is well worth the read!

Ken Morris

Ken Morris
Chairman

Our Mission

To provide excellent healthcare for women, babies and their families in a safe, friendly and caring environment.

Chief Executive's Introduction

How time flies! It seems incredible that this is the second Annual Report I have brought to you as Chief Executive of Liverpool Women's. 2009/10 was another very busy and successful year for our organisation and the process of producing this report has given me the opportunity to reflect upon exactly how much we have achieved, thanks to our fantastic, dedicated staff.

Liverpool Women's enjoys a very strong reputation as a leader in women's healthcare and it is something that we strive to maintain and improve by ensuring that we get it right consistently for both patients and our staff. During the last year we have focused our efforts on doing this through a number of significant investments and developments:

- The new, extended Hewitt Centre for Reproductive Medicine opened its doors and is a wonderful, leading edge facility
- Our Gynaecology and Patient Services teams have worked together to continue to deliver target access times for our patients
- With support from the King's Fund, we created a new End of Life suite that provides vastly improved facilities for patients and their families
- We developed a highly specialised Laser Fetoscopy service for the first time in Liverpool, which means that patients no longer have to travel to Birmingham or London We invested £150,000 to improve the environment at our Aintree site
- We rolled out our brand and values programme that sums up the essence of what we are about
- We worked with celebrity chef Simon Rimmer to provide a range of fresh, nutritious and delicious dishes for our patients
- We launched the Liverpool-Mulago Partnership to provide mutually beneficial learning opportunities with colleagues in Uganda
- We launched a drop-in service for women who are suffering domestic violence or abuse
- In February the Board approved funding of £1m to begin a refurbishment programme on our maternity ward as part of the 'Big Push' project to redesign our maternity services
- We invested in our 'Step it up Programme' for staff to enhance our communications and behaviours with each other and with our patients and their families

None of our achievements in the last 12 months would have been possible without the commitment of everyone involved in delivering and improving women's services – our staff, our governors, our volunteers and our partner agencies. I would like to offer my heartfelt thanks to each and every one of them for their hard work, flair, creativity, drive and sheer enthusiasm for making Liverpool Women's an organistion that we can all be proud of.

Kathryn Thomson

Kathryn Thomson
Chief Executive

Our Vision

To be the recognised leader in healthcare for women, babies and their families


Liverpool Women's

Our Values –

What Liverpool Women's stands for

- **Specialism:** because our focus is on the health and well being of women, babies and their families
- **Excellence:** because delivering the safest and highest quality of healthcare is our shared goal
- **Compassion:** because the emotional well being of our patients and their families is really important to us
- **Commitment:** because we care and take pride in everything we do
- **Unity:** because we work together and with others in partnership to deliver the best possible care
- **Integrity:** because we listen and show respect, honesty and inclusiveness amongst our patients, their families, our staff and our partners
- **Progress:** because we want to stay at the forefront of patient care

Liverpool Women's NHS Foundation Trust

'official opening of the mulberry suite'

Directors' Report

The Board of Directors is pleased to present its review of the Trust's development and performance during the year 2009/10. In presenting this review the directors have ensured that so far as the directors are aware, there is no relevant audit information of which the auditors are unaware and directors have taken all of the steps that directors ought to have taken in order to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

About the Trust

Liverpool Women's NHS Foundation Trust was founded on 1st April 2005 under the Health and Social Care (Community Standards) Act 2003. Operating in its former guise as Liverpool Women's Hospital NHS Trust, the organisation had been created in 1995, when all services for women and babies in Liverpool came together under one roof in a state of the art building in the heart of Toxteth. In 2000 the Trust took over the Aintree Centre for Women's Health, which provides services to the women of north Liverpool, Sefton and Knowsley and in so doing became the largest women's hospital in Europe.

Each year, the Trust now delivers over 8,000 babies, carries out 10,000 gynaecological procedures and cares for 1,000 preterm infants on our Neonatal Unit.

Our clinical services have, in accordance with our mission, been created and developed in response to the specific needs of local women and their families. We currently manage our services through four Clinical Business Units, each led by a Clinical Director who is a senior consultant and a General Manager who reports to an Executive Director. General Managers, Clinical Directors, Heads of Corporate Departments and the Executive Team sit on the Management Executive Board, which has overall responsibility for the operational management and leadership of the Trust and is accountable to the Board of Directors.

Corporate non-clinical support services are provided by the Finance, Human Resources, Operational Services, Quality and Information Mangement and Technology teams. The hotel services and security functions of the Trust are carried out by contractors working in partnership with us.

Staff are kept informed of strategic and operational developments through the monthly Team Brief which is delivered by the Executive Team in the week following the Board meeting and is then cascaded through each clinical business unit and department.

Our Services

Maternity & Imaging

- Antenatal care – hospital or community based
- Ultrasonography
- Fetal medicine
- Twin clinic
- Home births
- Midwifery led unit
- Delivery suite
- Infant feeding team
- Link clinics for minority ethnic communities
- Smoking cessation midwives
- Parent education
- Public Health
- Radiology

Gynaecology & Surgical Services

- General gynaecology
- Urogynaecology
- Termination of pregnancy
- Gynaecological cancer
- Family planning
- Recurrent miscarriage clinic
- Emergency Room
- Menopause
- Theatres and Anaesthesia
- Physiotherapy

Genetics & Reproductive Medicine

- Clinical Genetics
- Cytogenetics – laboratory based
- Molecular Genetics – laboratory based
- IVF
- ICSI
- Donor insemination
- Sperm recovery
- Freezing of embryos
- Frozen embryo transfer
- Freezing of sperm
- Ovum donation
- Egg freezing
- Sperm bank

Neonatology & Pharmacy

- Neonatal intensive care
- Neonatal high dependency care
- Transitional care (with Maternity)
- Newborn hearing screening
- Newborn eye screening
- Pharmacy

Our Committed Staff – Our Greatest Asset

Our staff are our most valuable asset in delivering services that are safe, effective, efficient and achieve the best possible experience for patients and their families.

As at 31st March 2010, we employed 1,410 staff (1,193.92 whole time equivalents) not including those who work for our external contractors or staff seconded out to other organisations. Staff work within five main areas across the Trust:

35% Maternity and Imaging Clinical Business Unit
20% Gynaecology and Theatres Clinical Business Unit
16% Pharmacy and Neonatology Clinical Business Unit
11% Genetics and Reproductive medicine Clinical Business Unit
15% Corporate support services

Our staff are employed under the following main groups:

Staff group	% of overall workforce
Doctors	5%
Registered Nurses & Midwives	49%
Scientific and technical staff	6%
Additional Clinical Services	18%
Administrative, management and estates staff	22%

The majority of full time staff earn between £15k and £25k annually, with over a third of the workforce earning between £25k and £50k. Less than 1% earn over £100k. 46% of employees hold part-time contracts with the Trust demonstrating our ongoing commitment to supporting where possible flexible working options for staff.

The role of Human Resources and Organisational Development is to ensure staff can deliver the best possible service to women, babies and their families. This is achieved by creating a place to work where staff are treated fairly and equitably, are given an opportunity to grow and develop their skills, are feel recognised and rewarded for the contribution that they make, and engaged in decisions that affect them. This commitment is outlined through the NHS Constitution's four pledges to staff. Significant achievements were made in 2009/10 in the following areas:

Staff pledge 1 – ensure there are clear roles and responsbilities and rewarding jobs for teams and individuals that make a difference to patients

- Support for the recruitment and organisational change involved with Clinical Business Units
- The fifth annual 'Focussing on Excellence' Awards was held with an expanded number of categories and judging critieria, including demonstration of organisational values
- Allocation of a £50 gift voucher for every member of staff in recognition of our Annual Health Check assessment for 2008/09

Staff pledge 2 – provide personal development, access to training and development and line management support to succeed

- The formal launch across all sites of our Bullying and Harassment policy and associated 'buddy' scheme
- Continuing high standards of take up and delivery of vocational training
- Establishment of the Reflective Practice Project supporting staff to be able to work effectively in high pressure roles and environments

Staff pledge 3 – provide opportunities for staff to maintain their health, well-being and safety

- Highest take up of seasonal flu vaccinations of any trust in the North West
- Recruitment to permanent posts of Occupational Health Manager and Occupational Health Nurse
- Completion of Trust wide stress audit

Staff pledge 4 – provide opportunities for staff to engage in decisions that affect them and the services they provide

- Establishment of the Executive Director visibility programme
- Greater levels of partnership working with Trades Union colleagues
- Introduction of the 'Pennies from Heaven' scheme to support the identified organisational charity, the Liverpool-Mulago Partnership

Staff involvement and engagement will be crucial in meeting the key challenge of delivering consistently high quality care within an increasingly challenged financial climate. Part of the Trust's involvement and engagement process has been to communicate widely on specific issues which may be of concern to them as employees. This is done through a range of mechanisms from Team Brief, topic based briefings and staff fora on various sites, Partnership Forum, e-mail and intranet. Topics which have been discussed with staff using the above mechanisms have ranged from:

- Trust-wide operational planning and strategic development sessions
- Financial briefings
- Trust wide governance review
- Launch of the anti bullying and harrassment buddy scheme

How We Performed

Our Key Achievements against our Corporate Aims in 2009/10

We shall deliver clinical excellence in all our services

We have...

- Successfully implemented 98 hour consultant cover on our delivery suite to improve access to senior clinical decision making out of hours
- Increased our home birth rate through the appointment of a consultant midwife for normal birth
- Successfully introduced the Royal College of Obstetricians and Gynaecologists' dashboard for patient safety in maternity services
- Shown significant improvements in neonatal nutrition through changes to parenteral feeding
- Achieved an outstanding Cancer Peer Review report for our gynae-oncology services
- Implemented the Embryology Witnessing System that provides a significantly higher degree of safety when dealing with clinical material in our laboratories
- Reduced twinning rates from 24% to 16% by implementing single embryo transfer
- Developed the EPaQ questionnaire in Urogynaecology to assess patient reported outcomes

We shall deliver strong financial performance across all our services

We have...

- Delivered services within financial plans and ended the year with a financial risk rating of 4 from our regulator Monitor
- Delivered significant capital schemes to time and to budget; including the Catherine Suite, the Mulberry Suite, the new Hewitt Centre and office refurbishments
- Revised and improved our performance and financial reporting through the integrated Performance and Assurance Report

We shall ensure all patients have a positive experience in our care

We have...

- Refurbished parent accommodation in the Neonatal unit
- Developed 'baby link' neonatal CDs, following feedback from bereaved parents
- Delivered outstanding facilities for our patients following significant investment in new and refurbished accommodation
- Developed the Trust's volunteer service to the benefit of a wide range of patients
- Piloted bedside entertainment in Gynaecology and on the Catherine Suite and received very positive patient feedback
- Redesigned our pharmacy with the support of the LEAN process resulting in timely patient discharge and reduced wastage of staff time and medication
- Launched the 'Step it Up' programme to develop customer/patient focus amongst managers and frontline staff
- Developed a range of nutritious menu options for patients in partnership with celebrity chef, Simon Rimmer

We shall be the provider of 1st choice for women and their families

We have...

- Increased consultant obstetrician clinics in the community for women with high risk pregnancies to access care closer to their homes
- Developed and introduced a regional laser fetoscopy service for twin to twin transfusion
- Attracted high levels of non contracted activity in maternity and neonatology due to the Trust's reputation for the effective management of high risk cases
- Developed excellent facilities for women suffering from gynaecological cancer in the last 12 months of life, by creating the Mulberry Suite in partnership with the King's Fund
- Continued to offer access to treatment to over 96% of our patients within 18 weeks of referral
- Received unconditional registration by the Care Quality Commission (CQC) for provision of service and compliance with the 'Hygiene Code'
- Held the first Liverpool Women's Health Evening aimed at raising the profile of our services
- Developed a range of marketing communications: *Health Talk* aimed at GPs, *Generations* aimed at Foundation Trust members, Infection Control posters aimed at patients and visitors and *Celebrating Success* to showcase staff achievements

We shall promote our status as a premier University Teaching Hospital & Centre for Research

We have...

- Commissioned the implementation of the Somerset database to capture clinical data associated with the management of gynaecological cancer
- Strengthened Research & Development through the appointment of R&D leads in each Clinical Business Unit
- Successfully increased the proportion of R&D activity that is funded from outside of the Trust (40% of 114 open research studies)
- Actively contributed to the North West Exemplar Programme and demonstrated excellence in clinical trials performance
- Become the first site in the world to be initiated to the neonatal pharmacokinetic study

We shall deliver our aims with skilled, competent and motivated staff supported by effective leadership

We have...

- Continued to provide ongoing development to Clinical Business Units
- Held a Trust wide clinic summit to respond to the future financial challenges and requirement to improve quality within our services
- Put in place the 'Meet Anna' Programme to support development of management capability in HR processes and procedures
- Supported the redesign of administrative teams to support delivery of clinical pathways
- Reduced sickness and absence rates from 5.53% to 5.18% and provided continued focus on supporting staff back to work through improved access to occupational health services
- Established an Executive Director visibility programme allowing staff to meet and spend members of the executive team in their workplace
- Held the 5th annual *Focussing on Excellence* awards, celebrating success across

Regulatory Ratings

Monitor, the independent regulator of NHS foundation trusts assigns each NHS foundation trust a risk rating for governance, finance and the provision of mandatory goods and services (as defined in their terms of authorisation) on a quarterly basis during the year.

A green risk rating indicates that a foundation trust's governance arrangements comply with its terms of authorisation; an amber risk rating reflects that concerns exist about one or more aspects of governance; and a red risk rating indicates that there are concerns that a trust is, or may be, in significant breach of its terms of authorisation.

Financial risk ratings are allocated using a scorecard which compares key financial metrics consistently across all foundation trusts. The rating reflects the likelihood of a financial breach of an NHS foundation trust's terms of authorisation. A rating of 5 reflects the lowest level of financial risk and a rating of 1, the highest.

A summary of Liverpool Women's performance against the parameters of the ratings for 2009/10 is set out below, including a comparison with 2008/09.

For 2009/10 the Trust took the decision to reduce its planned financial risk rating from 5 to 4 in the light of emerging clinical priorities. The Board of Directors reviewed the target Income and Expenditure margin and decided to reduce it from circa 3% to circa 2%. This allowed the establishment of a Clinical Priorities reserve for the year. This step was well received by the organisation and a multi-disciplinary prioritisation exercise was undertaken to identify key risks and therefore priorities for resources, a proportion of which was subsequently invested in additional nursing staff for the Neonatal Unit.

Liverpool Women's is proud of its ratings record and its ability to develop realistic plans that have been consistently delivered within Monitor's risk framework.

	Annual Plan 2008/09	Quarter 1 2008/09	Quarter 2 2008/09	Quarter 3 2008/09	Quarter 4 2008/09
Financial risk rating	5	5	5	5	5
Governance risk rating	Green	Green	Green	Green	Green
Mandatory services risk rating	Green	Green	Green	Green	Green

	Annual Plan 2009/10	Quarter 1 2009/10	Quarter 2 2009/10	Quarter 3 2009/10	Quarter 4 2009/10
Financial risk rating	4	4	4	4	4
Governance risk rating	Green	Green	Green	Green	Green
Mandatory services risk rating	Green	Green	Green	Green	Green

Key Performance Indicators in 2009/10

Our performance against national targets has remained strong throughout the year. We have sustained low waiting times for all our patients and ensured that over 96% of our patients have been able to access treatment in less than 18 weeks from referral by their GP. All patients referred to us with suspected cancer follow agreed clinical pathways and access appropriate treatment quickly.

Our infection prevention and control processes are robust and we have only had one baby on our Neonatal unit with MRSA (2 bouts) and one gynaecology patient with clostridium difficile during the year. We have been able to declare compliance with all the Standards for Better Health.

Indicator Name	Performance 2008/09	Target 2009/10	Performance 2009/10
Annual Health Check: national priority			
18 week referral to treatment times: admitted (All specialties)*	90.19%	90%	Qtr 1: 92% Qtr 2: 96.23% Qtr 3: 98.01% Qtr 4: 97.49%
18 week referral to treatment times: non-admitted (All specialties)*	95.03%	95%	Qtr 1: 96.3% Qtr 2: 95.71% Qtr 3: 96.51% Qtr 4: 96.11%
18 week referral to treatment times: non-admitted (Gynaecology, Infertility and RMU)*	New for 09/10	95%	Qtr 4: 95.64%
18 week referral to treatment times: non-admitted (Clinical Genetics)*	New for 09/10	95%	Qtr 4: 100%
18 week referral to treatment times: Non-admitted Data completeness	99%	80-120%	96%
18 week referral to treatment times: Admitted Data completeness	99%	80-120%	101%
All Cancers: two week wait.	98.68%	>=93%	95.42%
All Cancers: one month diagnosis to treatment. (1st definitive)	100.00%	>=96%	97.98%
All Cancers: one month diagnosis to treatment (subsequent)	New for 09/10	>=94%	100%
All Cancers: Two month referral to treatment (GP referrals)	97.50%	>=85%	90.95%
All Cancers: Two month referral to treatment (consultant upgrade)	New for 09/10	>=92.40%**	96.25%
All Cancers: Two month referral to treatment (screening referrals)	New for 09/10	>=90%	100%
Engagement in clinical audits	Yes to all	tbc	Annual Survey
Experience of patients	82.455 85.197 79.959 88.563	tbc	Annual Survey
Incidence MRSA bacterium	0	<=4 2	2
Incidence of Clostridium Difficile	1	<=8	1
Infant health and inequalities: Breastfeeding rate	0.72	>=-5%	2.02%
Infant health and inequalities: Smoking rate	-0.54	<=0%	0.56%
Maternity Hospital Episode statistics: data quality indicator	11.028%	<=15%	Method under review
NHS Staff satisfaction	3.471	tbc	Annual Survey
Annual Health Check: existing commitments			
Data quality on ethnic group (April to December)	97.59%	>=85%	97.80%
Delayed transfers of Care	0.00%	<=3.5%	0.00%
Inpatients waiting longer than the 26 week standard	0.027%	<=0.03%	0.00%
Last minute cancellation for non clinical reasons	0.491%	<=0.8%	0.291%
Last minute cancellation for non clinical reasons not readmitted in 28 days	0.00%	<=5%	0.00%
Outpatients waiting longer than the 13 week standard	0.00%	<=0.03%	0.00%
Total time in A&E (% within 4 hours)	99.98%	>=98%	99.98%
Annual Health Check: Core Standards			
Core Standards: Standards for Better Health	2 exceptions	Full compliance	Full compliance

* Trusts will be assessed on having maintained this performance during each quarter of the assessment year (April 2009 to March 2010) and in each of the treatment functions in the fourth quarter of the year.
** This is the only target not yet agreed by the Department of Health. The Trust continues to reflect the most recent national benchmark available via Open Exeter (for January 2010 this stood at 92.40%)

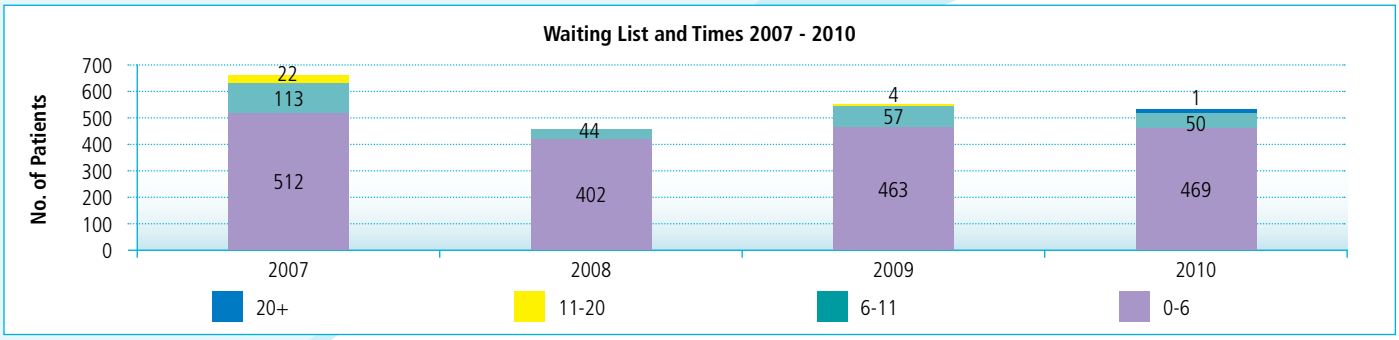
Performance against national targets

• 18 week referral to treatment

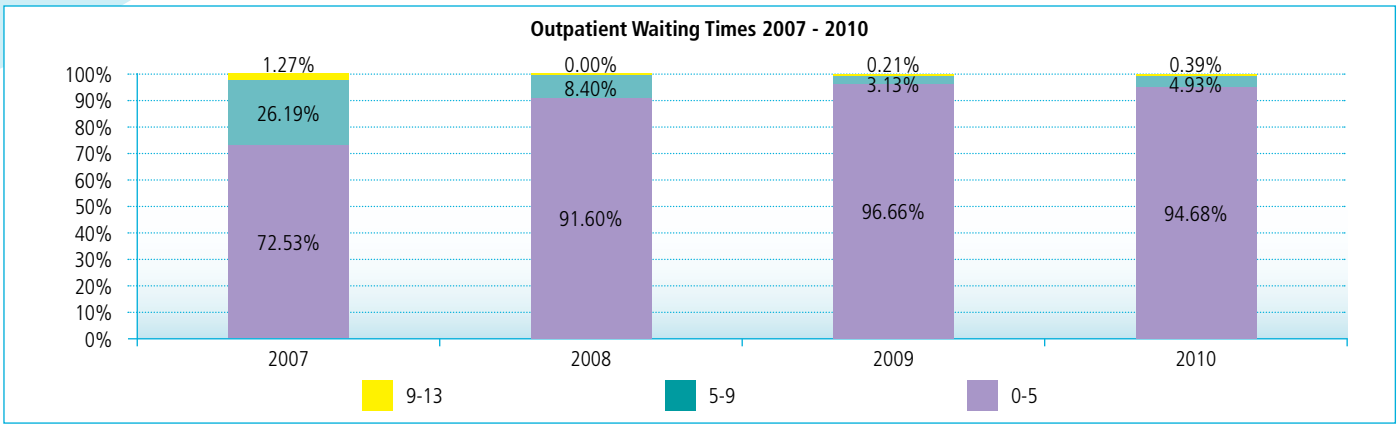
The Trust has continued to ensure that patients are able to access appropriate treatment within 18 weeks of referral, whether their treatment is as an outpatient or an inpatient. During the year we have been able to improve access times for all our patient pathways - Gynaecology, Infertility (including IVF) and Clinical Genetics. We have exceeded national targets for all patient pathways, achieved by continually reviewing how we deliver care and how this can be done more effectively and supporting clinical care with robust administrative processes.

Year	% of pateints requiring surgery treated within 18 weeks	% of patients requiring outpatient treatment and treated within 18 weeks
2008/09	90.70%	95.20%
2009/10	97.49%	96.11%

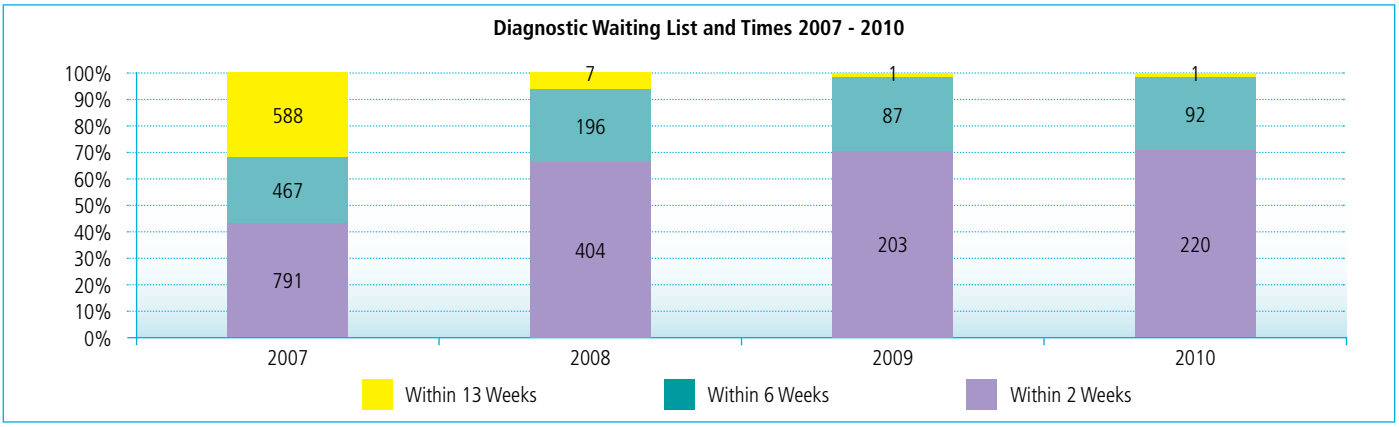
• Waiting Lists and Waiting Times



Over the last year the number of women waiting for surgery has reduced by over 4%. 90% of women wait less than 6 weeks for their surgery compared to 88% in the previous year. We are proud that through the active management of patient pathways we are able to continue to offer prompt access to treatment.



95% of women were offered an outpatient appointment within 5 weeks of referral from their GP.



Despite a difficult year for the Trust in terms of the provision of imaging services we have managed to end the year with waiting times for scanning at 6 weeks or less; the majority of women can access scanning within 2 weeks.

• Cancer Treatments

The Trust is the Gynaecological Cancer Centre for Cheshire and Merseyside and as such treats patients who are referred from anywhere within the region. In particular, the Trust specialises in all ovarian and high risk endometrial surgery. The Trust therefore has to work in collaboration with all referring units and the tertiary centre for the provision of radiotherapy and chemotherapy. As a result of close working, we have been able to continue to offer women rapid access to cancer services and have exceeded all existing and new national targets in this area. The Trust has also been subject to a rigorous peer review against national standards and received an exceptional report.

• MRSA and Clostridium Difficile

The Trust considers the preventation and control of infection a top priority and works hard to ensure that patients are safe within our care. During the last year we have maintained our excellent track record and we have only had one baby with MRSA (two bouts) and one gynaecology patient with clostridium difficile during the year.

Patient Quality Indicators

• Smoke Free NHS

The Trust continues to actively contribute to the Smoke Free Liverpool Campaign. In particular, the Trust is involved in a great deal of collaborative work around smoking in pregnancy.

The Trust works closely with primary care to provide access to smoking cessation services for women during pregnancy. This has proved a significant challenge and we have seen a small rise in the number of women smoking at the time they had their baby. We are continually looking at ways to effect a real change in attitude and behaviours towards smoking. We also offer smoking cessation services and support to our staff.

• Breast feeding

The Trust is proud of the success we have had in encouraging more women to breastfeed. The number of women initiating breastfeeding at birth and who still breastfeed on discharge from hospital continues to improve steadily. We have successfully increased the number of women who themselves have breastfed and have wanted to go on to offer support and encouragement to other women. We have well established peer support for women in some of our most deprived localities.

The Trust has been commissioned by Liverpool Primary Care Trust to further develop peer support programmes which have been shown to be effective in increasing both the initiation and duration of breastfeeding. The service will be operational during 2010.

Progress against Service Developments

• Maternity Services

In 2008/09 Liverpool Women's was successful in attracting significant additional investment from our host PCT for maternity services. 2009/10 was therefore a year of consolidation of these developments. We were also able to continue to work in close collaboration with the PCT to benchmark resources for maternity services and secure further investment for 2010/11 as follows:

- We have increased Consultant Obstetrician cover on our Delivery Suite to 98 hours per week

Following targeted investment from our PCT and in line with national best practice, we have increased consultant cover on delivery suite from 56 to 98 hours per week, improving access to senior clinical decision making. This was operational from Autumn 2009 following consultation and successful recruitment in to additional consultant obstetrician posts.

- The 'Big Push' Project to reconfigure maternity services

Over the last two years, the Trust has reviewed its model of care for maternity services and the associated facilities required to deliver this service. Whilst the final business case will be completed in the summer of 2010, approval has was given in February 2010 for the 1st phase of reconfiguration of inpatient facilities. This area is a priority and responding to the needs of patients and providing a positive patient experience are paramount.

• Hewitt Centre for Reproductive Medicine

The Trust's Reproductive Medicine services continue to go from strength to strength. 2009/10 has been a landmark year for the service. We have seen the lowest waiting times ever for access to IVF. We have expanded the NHS sperm bank benefiting couples requiring donor sperm. We are now able to offer IVF as an option to viral discordant couples and are the only centre in the North of England to do this. We have trialled new hormone tests to be able to better assess a woman's response to fertility drugs. We have also opened our brand new £5m facility on our Crown Street site which offers an exceptional patient environment, state of the art embryology laboratories and a dedicated andrology suite. Other developments over the last year have seen the unit;

- agree with local commissioners that the Hewitt Centre will the semenology centre for Cheshire and Merseyside.
- implement the agreed management for single embryo transfer which has successfully reduced twinning rates in assisted conception from 24% to 16%.

• Development of a Dedicated Private Patient Unit

Liverpool Women's private patient unit opened in May 2009. This gives a choice to patients to have their treatment under the care of experienced consultants and healthcare professionals while remaining within the safety of an NHS setting. The unit provides the majority of gynaecology private work in Liverpool and offers increasing options for cosmetic surgery.

• Gynaecological Cancer Services

Our gynaecological cancer services have been endorsed by very strong peer reviews for both core services and colposcopy services. We have achieved all new national targets and developed an outstanding patient facility in collaboration with the King's Fund. The new facility is named the Mulberry Suite and offers en-suite patient and family accommodation for patients at the end of life, giving much needed privacy at this very difficult time. The suite has been designed with the close involvement of patients and their relatives and was opened in late 2009.

We still have aspirations to bring chemotherapy to the Trust in order to offer women local access. Currently, any woman requiring chemotherapy for the treatment of gynaecological cancer from Merseyside or Cheshire has to travel to Clatterbridge Centre for Oncology on the Wirral.

Now the two hospitals are working together to develop facilities at Crown Street so that chemotherapy can be delivered locally. This would be to the benefit of women from across Merseyside.

• Neonatology

Liverpool Women's is the Level 3 unit for the region and as such offers care to the most complex and poorly of newborn babies. During 2009 the unit has benchmarked its outcomes with those of the international Vermont Oxford Network. This has led to a focus on the management of neonatal infection and the funding to improve benchmarking of neonatal units across the UK.

– Neonatal Infection and Staffing

Following the publication of the most recent Vermont Oxford Network data the Trust increased its focus on the management of neonatal infection. After assessing the contributory factors, the Trust invested an additional £200k in staffing which has seen more specialist nursing staff trained and employed in 2009. Additional capital funding has been approved for 2010 to support the reconfiguration of facilities on the unit. The Trust has also funded a research post to develop benchmarking with other UK units.

- 24/7 Neonatal Transport Service

In conjunction with the Neonatal Network, the Trust has supported the development of a business case for the provision of a 24/7 Neonatal Transport Service for Cheshire and Merseyside. This would mean that babies across the region would be able to access the level of care appropriate to their needs at any time. The business case has been supported and funding approved for 2010/11.

Information Management and Technology

The department of Information Management and Technology (IM&T) has remained commited to providing connectivity and access to all information required by the Trust staff to help them meet the strategic goals of the organisation at the point of care. IM&T has continued to enhance IM&T services at the Trust through business process redesign, innovation, Six Sigma project management and the implementation of cutting-edge technology, whilst engaging clinical users. IM&T's goal has remained to deliver flexible, efficient and reliable IT services, whenever, wherever needed, to ensure the Trust continues to deliver clinical excellence.

• National and International recognition

During the year IM&T has received national and international accolades and achieved the following international standards:

- 2009 British Computer Society IT Industry Awards Finalist (UK)
- ISO 9001: 2008 accreditation in quality
- ISO 27001: 2005 accredition in data security
- ISO 14001: 2004 accreditation in environmental management

• IM&T Key Achievements

In 2009/10, the team:

- Maintained full disaster recovery and business continuity for all clinical and critical information systems
- Maintained 99.9% uptime for all key systems
- Deployed a new storage and tapeless backup solution for the Trust's data
- Developed a data warehouse to gather critical data from all clinical and non-clinical systems and support business intelligence
- Delivered point of care data collection/coding to accurately record clinical information
- Delivered computerised point of care at the patient bedside
- Delivered electronic systems to keep patients entertained and informed whilst receiving services
- Delivered a redesigned patient services function that improves administrative efficiencies and services resulting in a positive patient experience
- Provided remote access to key clinical systems to allow point-of-care delivery of Trust services into the community
- Provided remote access to key clinical and non-clinical systems to improve communication and the working lives of staff
- Maintaining 100% coding completion by the 2nd working day after month end throughout the financial year
- Delivered coding accuracy classified as 'excellent' in the Payment by Results assurance audit

The Trust has complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information guidance.

• Partnership working with Alder Hey Children's NHS Foundation Trust

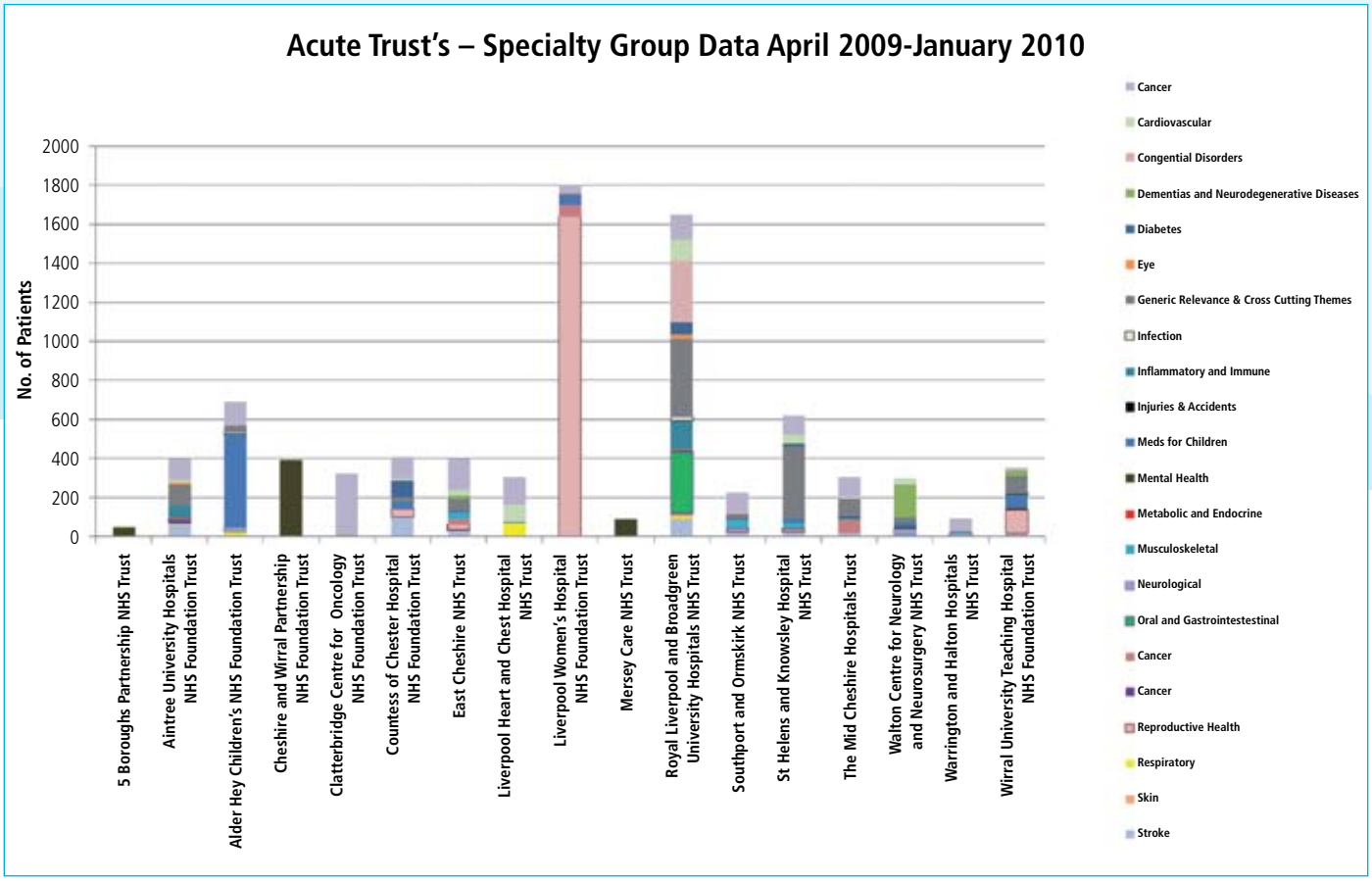
During the year, the Board of Directors agreed to strengthen its arrangements for IM&T provision by pursuing partnership working with Alder Hey. To this end, the two trusts have agreed on the joint appointment of a Chief Information Officer, Assistant Director of Informatics and Clinical Coding Manager and a new IM&T strategy is in development that aligns opportunities for development and resilience across both organisations.

Research & Development

Supporting a broad range of patient-centred, high quality research continues to be a high priority for the Trust. This is reflected by the growing number of studies the Trust is actively involved with that are on the portfolio of the National Institute for Health Research (NIHR). A total of 113 projects are currently active across the Trust with a further 15 in set up. Of these, 53 are on the NIHR research portfolio (40 active studies, 6 studies closed to recruitment/in follow up, and 7 studies in set up). Studies adopted onto this portfolio must meet stringent quality standards including the award of funding via national, peer-review competition. We are pleased to report that an increasing number of studies led by investigators from within Liverpool Women's are being adopted onto the NIHR portfolio. Furthermore, the Trust is engaged with a growing number of successful collaborations, whereby staff are actively recruiting to portfolio studies led from outside the Trust. Indeed, the Trust is a top recruiter to NIHR studies within the region as shown opposite.

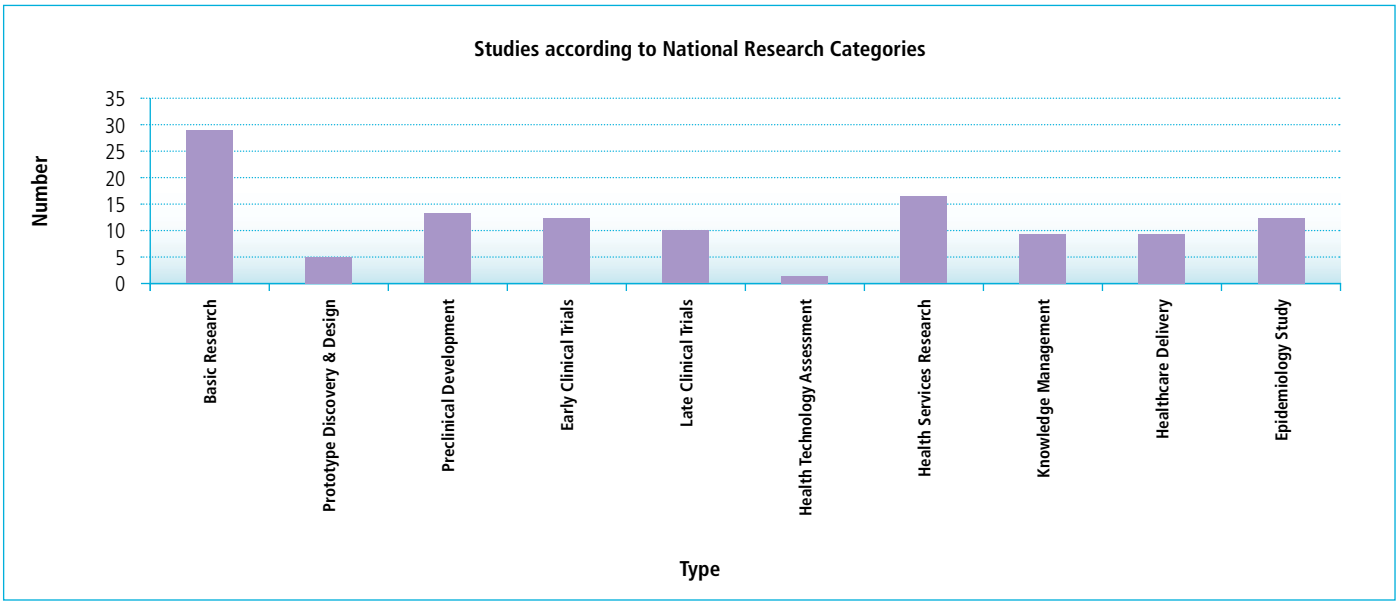
The Trust also continues to address its own patient-centred research agenda. This is facilitated by income from the NIHR, grant applications and collaborations with industry. Priorities for 2009 included greater involvement of service users and the public in shaping the Trust's research portfolio. It is widely accepted that engaging service users in every step of the research process from devising research questions to writing and approving research protocols, makes research topical, relevant and cost effective. In order to achieve this, the Trust has established a Research User Group, which it hopes will get more service users and lay members engaged with research and ultimately improve patient choice and care.

The Trust is committed to conducting a broad spectrum of research in line with national objectives. This covers research conducted within the laboratory, for example, looking at the role of stem cells in endometriosis or natural killer cells in miscarriage, as well as how healthcare is delivered, such as questionnaire studies to evaluate patient experience. A diverse portfolio of research is important for exploring the fundamental aspects of health and disease and the way in which we deliver healthcare. The chart below gives an overview of the types of research currently underway across the Trust.



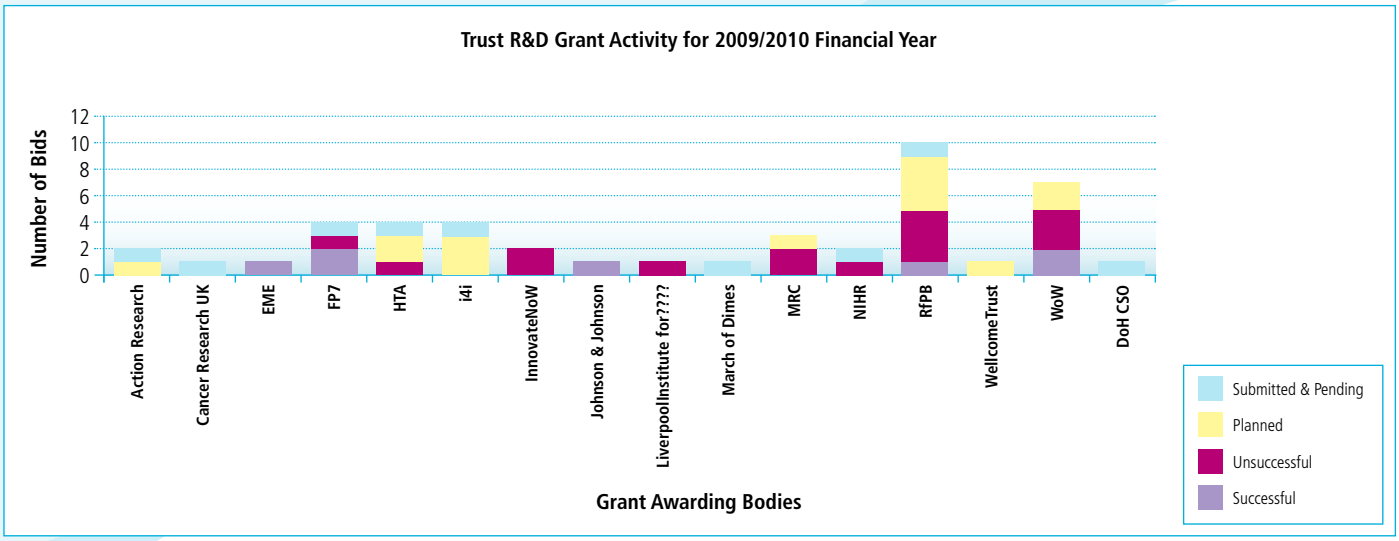
Innovation is a further priority being driven by R&D. The Department works collaboratively with staff who have innovative ideas for improving healthcare delivery. This can include the development of a new device or changes to the way in which services are delivered. Innovation is at the heart of transforming NHS healthcare delivery for the better, and the Trust has a considerable number of staff with innovative ideas. These must continue to be nurtured for the benefit of patients.

The 2009/10 financial year saw 45 grant proposals registered with the Trust's R&D Deparment. Of these, seven were successful at securing grant funding and nine have results pending.

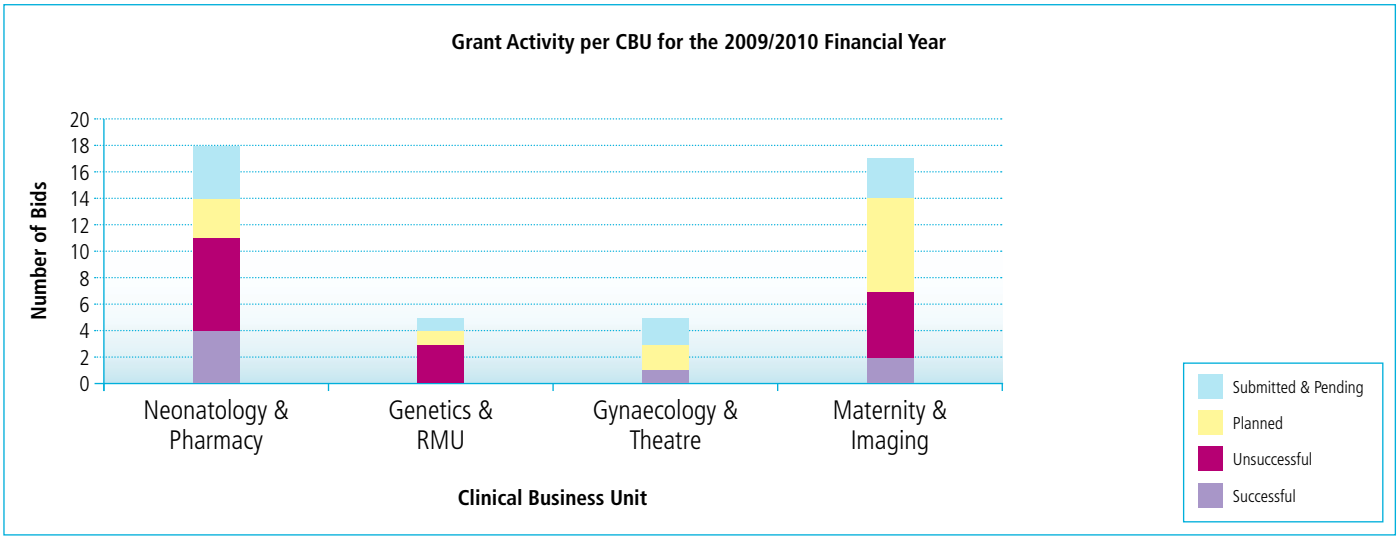


Funding Body	Funding Amount
Wellbeing of Women	£149,247
SANDS	£15,000
Johnson & Johnson	£200,000
Research for Patient Benefit	£218,000
FP7	€5,000,000
FP7	€10,000,000
EME Programme	£1,042,000

Funding has been secured from the Efficacy & Mechanism Evaulation (EME), the European Commission Seventh Framework (FP7), the Research for Patient Benefit (RfPB) and Wellbeing of Women (WoW) programmes. The Trust is tapping into a wide pool of Grant Awarding Bodies, whilst staying at the forefront of the competition by readily embracing newly released grant awards (eg i4i, InnovateNoW, FP7).



Of those unsuccessful with their initial application, three bids from the Maternity & Imaging CBU are due to be submitted to alternative Grant Awarding Bodies in the new financial year.



The Trust is building up good partnerships with other trusts, universities and organisations during the grant application process, including those at local, national, European and international level, in turn raising the Trust's excellent research reputation.

In 2009/10, Trust research was disseminated via publications in scientific peer reviewed journals (79), national press, conferences and symposiums. Research was highligthed in press releases made by the Royal College of Obsterics and Gynaecology, the University of Liverpool and via national media streams.

Sustainability/climate change

Sustainability reporting is being carried out at Liverpool Women's to demonstrate to the Trust's stakeholders that the organisation is more than a 'going concern'. We anticipate in future that patients, staff and other stakeholders will question our sustainability credentials before making a decision to choose the Trust for their care or as an employer.

As a result of our commitment to sustainability the Trust has recruited an dedicated Environmental Manager to review the organisation's overall environmental performance and with a remit to reduce where practicable utility usage and waste arising from our activities.

• Sustainability Strategy

The Trust's sustainability strategy is still in the early stages of development and is to be based in the main on the NHS Sustainable Development Unit's (SDU) Good Corporate Citizenship model. It is intended to assess our baseline as a Trust against the model and review performance against the established criteria on at least a bi-annual basis, with the results reported to the Board. A gap analysis will be carried out after the first model workshop and this will provide areas where the Trust will focus its strategy. We intend to expand our current environmental performance which has seen one department attain the ISO 14001 environmental standard.

• Summary of performance

	Annual usage		Annual cost (£)	
	2008/09	2009/10	2008/09	2009/10
Gas	5776699 Kwh	4702346 Kwh	189,671	129,221
Electricity	5176359 Kwh	5840748 Kwh	676,028	576,249
Water	30829 m3	29434 m3	39,817	49,329
Clinical Waste	238 tonnes	208 tonnes	104,107	113,480
Domestic Waste	465 tonnes	407 tonnes	52,331	59,647

• Governance Processes

A sustainability report will be submitted to the Board of Directors on a bi-annual basis showing both positive and negative aspects and benchmarked impacts. It is expected that the strategy will be ratified by the Board once the initial workshop has taken place. The strategy will then to be translated into policies, standards and procedures with associated targets set.

• Future priorities and targets

- The Trust plans to engage with the Carbon Trust's reducing carbon programme. This is an initiative to reduce, where practicable, our scope 1 carbon and understand and target scope 2 & 3 carbon emissions. We will develop a programme which will demonstrate that if parts or all of the initiatives identified by the Carbon Trust are implemented, this will result in a reduction in our emissions.

- The Trust is developing a sustainable procurement policy in line with NHS Purchasing and Supply Agency (PASA) and Office of Government Commerce (OGC) requirements. We anticipate that as part of the Good Corporate Citizen model a focus will need to take place on our procurement activities. It is intended to engage with the SDU and OGC to develop benchmarks to demonstrate our improvements in these activities.

- In the coming year we will review our environmental policy as a result of the aforementioned initiatives. Part of our organisation has recently attained ISO 14001 as a recognised environmental performance standard. It is intended to widen the scope of this to encompass other departments. However, it is expected to base this on the BS 8855 (Acorn) standard. We anticipate that phase three of the six phase model is to be completed within the next 12 months. Regular reporting to the Trust's Environmental Management Group is to take place on a quarterly basis.

- We plan to carry out adaption risk management reviews to understand how adverse weather-related events could interrupt the provision of services and implement plans to overcome these risks.

Quality Report

Statement on Quality from the Chief Executive

Liverpool Women's NHS Foundation Trust has a well-earned reputation as a centre of excellence at a local, regional and national level. As an NHS organisation that has been awarded and retained NHSLA and CNST level 3 - the highest possible ratings for clinical risk management - Liverpool Women's can demonstrate that it is among the safest hospitals in the country. Our challenge however is to find more ways in which we can prove to our patients and the public that this is consistently true, each and every day. During 2009/10 the Trust made a commitment to a range of national programmes aimed at keeping patient safety at the heart of everything we do and we are in the process of rolling these out across our organisation.

Here at Liverpool Women's the concept of reporting to patients and the public on the quality of our services is not new. The Trust has been publishing a Clinical Annual Report since 2003, a testimony to the commitment of our clinicians to shared learning and continual service improvement. Our reports have developed over time and last year we presented information framed around safety, clinical effectiveness and the patient experience and this has formed the cornerstone of the quality report that follows. As Chief Executive I am confident therefore that the information set out here is accurate and a reasonable reflection of the key issues and priorities that clinical staff have themselves developed over time.

Clear direction from the Board to champion the quality agenda is important, however a quality-driven culture cannot be developed without effective leadership at all levels in the organisation and this is a goal that we continue to pursue.

Kathryn Thomson

Kathryn Thomson
Chief Executive

Priorities for improvement

Looking Back

In its Annual Report for 2008/09 the Trust identified three quality improvement priorities for 2009/10 as follows:

1. To investigate, monitor and reduce infection rates within Neonatology and Gynaecology
2. To influence the national picture on delivery suite staffing levels for both midwives and obstetricians
3. To focus on staff attitude and behaviour in order to deliver improved patient experience and staff satisfaction

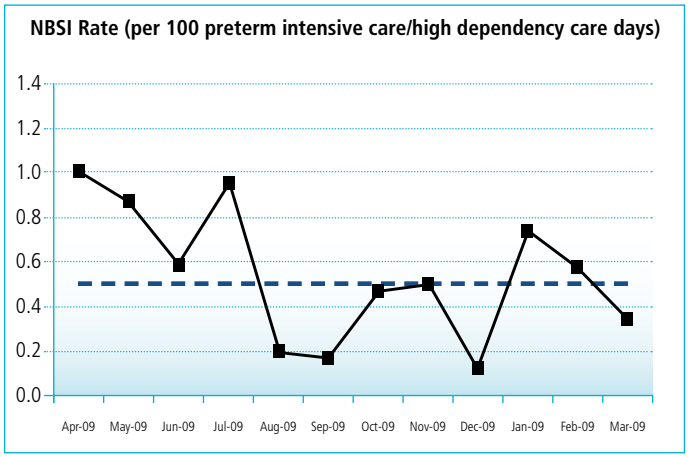
Priority 1 - To investigate, monitor and reduce infection rates within Neonatology and Gynaecology

MRSA and C Difficile

In 2009/10, the Trust had two cases of MRSA bacteraemia and one case of C Difficile, both below the Care Quality Commission targets of three and eight respectively.

Infection rates in newborn babies

Late-onset neonatal bloodstream infections (NBSI) in preterm babies (less than 32 weeks gestation and/or less than 1500g birth weight) occurring after three days of age, is one of the commonest complications of premature birth and is an important cause of preterm illness morbidity and mortality. It is also the major contributor to hospital-acquired infections in this population. It was decided last year that the rate of this particular type of infection would be a good marker of the overall risk of infection on the Neonatal Unit. We set our target at less than 1 episode of infection per 200 days each of our very preterm babies spends on the Neonatal Unit (0.5/100). This target may be revised when appropriate national benchmarks are agreed.



The above graph shows that the rate of NBSI varied between 0.1 and 1.0 in 2009/10. We have implemented the following actions in 2009/10:

- Infection update sessions held as part of nurse protected teaching
- The Infection Quality Project developed and funding secured for a lead nurse
- Development of the '3 Steps' initiative designed to improve infection control practice at the cot-side

Our challenge is to keep the rate of NBSI below the target consistently throughout 2010/11.

Postoperative infections in gynaecology

Our "infection rate" (0.2%) in post operative gynaecological patients is lower than the national standard of four per thousand operations (0.4%) published by CHKS, a nationally recognised organisation which compares the data from similar groups of patients and hospitals.

The Trust has implemented the following initiatives:

1. A prospective wound infection surveillance programme to ascertain objective infection rates for the Trust to allow meaningful comparisons.

2. The implementation of Root Cause Analysis (RCA) for all cases of MRSA, C Difficile and all non-Coagulase negative staphylococcus (CoNs) infections which is a common bacteria on the skin of premature babies.

Looking forward to 2010/11, trends in late onset NBSI, surgical wound infection and hospital acquired infection will remain as key safety quality indicators for the Trust.

Priority 2 - To influence the national picture on delivery suite staffing levels for midwives and obstetricians

The Royal College of Obstetricians and Gynaecologists (RCOG) and the Royal College of Midwives (RCM) recommended in the 'Safer Childbirth' report that there should be 168 hours of consultant cover and one to one midwifery care for delivery suites that deliver more than 6000 babies per year such as at Liverpool Women's. The scientific evidence to support this proposal (in terms of improved clinical outcomes) remains inconclusive. There was no cost benefit analysis in the report to justify the implementation of such a costly change in workforce provision. However, the cost of litigation cases relating to obstetric services is responsible for around 60% of the NHS total. We have estimated the true cost of obstetric damages nationally to be in the region of £850m per annum for the last four years. The cash costs are met by an annual insurance payment from each trust into a Department of Health 'pooling' arrangement administered by the NHS Litigation Authority. In its Annual Report for 2008/09 the Authority suggested that the NHS is not good at investing funds 'up front' in relation to patient safety in order to generate savings to the service in terms of reduced negligence claims – money that could be spent elsewhere. It is important therefore to consider carefully the possible impact of delivery suite staffing on litigation costs to the NHS.

Current status

In 2008/09 Liverpool PCT provided the Trust with funding to enhance consultant obstetric cover for 98 hours per week; this model was implemented in October 2009 but remains short of the ideal described above. During the year the Trust has provided a number of briefings on this subject, including to the Secretary of State for Health, in order to raise the profile of the issue and its consequences for patient safety.

Looking forward to 2010/11, the Trust will continue to Influence the national picture on delivery suite staffing levels for both Midwives and Obstetricians.

Priority 3 - To focus on staff attitude and behaviour in order to deliver improved patient experience and staff satisfaction

Achieving our vision of being the recognised leader for women's healthcare will only happen with the continuous commitment and dedication of our staff.

Positive staff attitude and whether they would recommend their organisation as a good place to work links directly to improved patient experience and clinical outcomes. The focus on standards of behaviour and attitude at work is part of our way of making sure our patients and their families have the best possible experience.

Outcomes from the national staff survey showed that positive staff attitude and overall staff satisfaction need to be improved to deliver better patient experience and clinical outcomes.

A number of actions have been taken to deliver improved levels of positive staff attitude and satisfaction:

- Introduction of the Executive team 'visibility programme' whereby directors spend time in clinical areas and corporate departments across the Trust each month

- Development and delivery of a values based customer care programme for all staff called 'Step it Up' which 87 managers and 259 staff have attended to date

- Introduction of a Reflective Practice Programme for consultants and managers: currently 24 participants are involved in this programme which will be evaluated 2010/11 and may be rolled out further, based on the results of that evaluation

- An increased focus on leadership development including active involvement in the:

  - North West Leadership Academy - with staff involved in Chief Executive, Executive stretch, Aspiring Directors and Clinical leadership programmes
  - Leading Improvement in Patient Safety (LIPS) programme
  - delivery of an introductory leadership development programme Leading an Empowered Organisation (LEO) which 239 staff have now attended
  - leadership modules for 85 nurses and midwives as part of their multi-professional education and training (MPET) allocations
  - other leadership development programmes for 67 other staff Delivery of "Workplace Coaching for Managers" programme in which 19 managers have been involved.

The Trust has begun a process to identify value based behaviours and equip staff with the skills and ability to both show and challenge others who don't show these behaviours.

The above interventions will continue throughout 2010/11 with a focus on delivery of organisational development interventions to show improvement in the staff survey results on the following:

- improve both **quality and quantity** of **Performance Development Reviews** (PDR)

- develop an **engagement** model linking patient experience directly throughout all formal and informal communication and development programmes

- ensure leadership development is directly linked to **leading improvements in patient safety** and continuous improvement of services

- pilot ways of **developing high performing teams**, evaluate this and roll out from results of that evaluation

- work with staff to agree **value based behaviours** that will deliver high quality outcomes for patients and their families

- targeted **line management development** in key skills to support staff effectively, lead improvement and meet the financial challenges of the years ahead

- support staff in developing **skills, experience and confidence in challenging negative behaviours**, to get positive results from holding difficult conversations with colleagues and patients

Additional Quality Indicators

In addition to our three main priorities, we have monitored a series of quality indicators across the domains of Safety, Clinical Effectiveness and Patient Experience as outlined in our Quality Report 2008/09. These are:

Patient Safety

- Low umbilical cord pH – less than 7.00
- Miscarriage following amniocentesis
- Twin live birth rates for all assisted conception treatments
- Medication errors across the Trust

Clinical Effectiveness

- Transfer to Intensive Therapy Unit (ITU) per 1000 maternities
- Stillbirth rate of Trust booked maternities
- Readmission rates to gynaecology
- Haemorrhage and haematoma (blood loss and blood clots) following Gynaecological surgery
- Outcome of In Vitro Fertilisation (IVF) and Intra Cytoplasmic Sperm Injection (ICSI) treatment
- Neonatal mortality rate

Patient Experience

- Rate of epidural for pain relief in labour
- In-patient Survey in Gynaecology

Patient Safety

Low umbilical cord pH – less than 7.00

Cord pH is a proxy measure of a baby's condition immediately after birth; the expectation is that healthy babies who coped with labour well would have a cord pH of more than 7.2. A very low cord pH of less than 7.00 is regarded as clinically significant. The Trust's rate of cord pH below 7.00 was 3.8 in every 1000 maternities in 2008 and 4.05 in 2009. There are as yet no agreed national benchmarks.

Looking forward to 2010/11, data on this quality indicator will continue to be collected and will be complemented with the Incidence of low Apgar scores (of less than 4), in live babies born after 34 weeks gestation and low heart rate (less than 100) in babies born before 34 weeks gestation.

Miscarriage following amniocentesis

Amniocentesis is an antenatal invasive procedure that takes place after 15 weeks gestation. It involves taking a sample of the amniotic fluid which surrounds the baby. Assessment of a baby's genes to exclude conditions such as Down's Syndrome is the common indication for this procedure. The overall miscarriage rate following amniocentesis at the Trust was 0.7% in 2008 and 0.77% in 2009 (2 out of 299 and 261 procedures respectively). The RCOG quotes a procedure related miscarriage risk rate of 0.5% to 1%.

Looking forward to 2010/11, this quality indicator will be improved with the introduction of individual performance indicators for the consultants trained to perform these procedures.

Twin live birth rates for all assisted conception treatments

The incidence of antenatal complications and newborn illnesses associated with multiple pregnancies has led to Human Fertilisation and Embryology Authority (HFEA) guidance which advocates single embryo transfer.

The introduction of single embryo transfer for all women under 35 was implemented at the Trust in April 2009. More than one embryo can be replaced for women over 35, with a history of failed IVF, with poor quality embryos and also as patient choice. The HFEA target for multiple pregnancy rates is 25%, aiming for 20% in 2010/11. The Trust's multiple pregnancy rate for 2009 was 18.9%, already below next year's target.

The challenge for the Unit is to maintain these results without compromising the overall success of treatment.

Looking forward to 2010/11, twin live birth rates for assisted conception treatments will remain as a safety quality indicator for the Trust.

Medication errors across the Trust

Medication errors feature consistently within Adverse Clinical Event (ACE) reports across clinical areas. There were 213 such reports in 2009/10 which is higher than the national average (170) for Acute Trusts reported by National Patient Safety Agency (NPSA). We believe that this higher rate reflects the willingness of our staff to report such incidents, rather than particular safety issues.

Looking forward for 2010/11, the current indicator will continue, as reporting is encouraged and supported. However, we shall focus our attention on a clearer understanding of the multifactorial reasons and circumstances that lead to such events.

Clinical Effectiveness

Transfer to ITU per 1000 maternities

In 2008 the ITU transfer rate was 0.5 per 1000 maternities and 0.63 per 1000 during 2009. This compares favourably with Birmingham Women's Hospital, the only other specialist NHS Trust providing maternity services, whose figure was 0.96 in 2007/08.

Performance Indicator	Source of Data	2008 LWH	2009 LWH	Benchmark
Transfer to ITU	Critical care lead midwife database	0.5 per 1000 maternities	0.63 per 1000 maternities	Birmingham Women's Hospital – 0.96 per 1000 maternities

Looking forward to 2010/11, transfer to ITU per 1000 maternities will continue to be used as a clinical effectiveness quality indicator for the Trust.

Stillbirth rate

In 2008, the stillbirth rate in women who booked at Liverpool Women's was 6.2 per 1000 maternities and 5.5 per 1000 in 2009. Comparable figure from Birmingham Women's Hospital (BWH) is 7.5 for 2007/08.

Performance Indicator	2008 LWH	2009 LWH	Comparable data from BWH from 2007/08
Stillbirth rate from maternities booked at Liverpool Women's	0.62%	0.55%	0.75%

Looking forward to 2010/11, we will continue to monitor stillbirth rates from booked maternities.

Readmission rates of gynaecological patients

Readmission rates in 2009/10 remained below the national average.

Performance Indicator	Source of Data	2008 LWH	2009 LWH	National Average 2009/10
Readmission rates of gynaecological patients	CHKS (a national clinical benchmarking organisation)	2.9%	2.5%	5.8%

Looking forward to 2010/11, readmission rates to gynaecology will be used as a clinical effectiveness quality indicator for the Trust.

Haemorrhage and haematoma (blood loss and blood clots) following gynaecological surgery

The Trust performance is comparable with the national average.

Performance Indicator	Source of Data	2008 LWH	2009 LWH	National Average 2009/10
Haemorrhage and Haematoma rate (blood loss and blood clots) following gynaecological surgery	CHKS	0.6%	0.5%	0.5%

Looking forward to 2010/11, Haemorrhage and haematoma (blood loss and blood clots) following Gynaecological surgery will be monitored regularly at Clinical Business Unit level.

Outcome of In Vitro Fertilisation (IVF) and Intra Cytoplasmic Sperm Injection (ICSI) treatment

HFEA data for pregnancy rates per cycle of treatment are available on an annual basis and benchmarked nationally.

Performance Indicator	LWH 2008 Calendar year	LWH 2009 Calendar year	National Average
Clinical pregnancy rates for treatment by in vitro fertilisation, intra cytoplasmic sperm injection (ICSI) for patients under 35 years per treatment cycle started	31.3%	28.9%	HFEA data Oct 2007-Sept 2008 36.0%

Our data are below the national average, but HFEA national average data include **all** units providing IVF/ICSI (NHS and Private) treatment. Adherence to national guidance regarding single embryo replacement has been variable. Transferring more than one embryo may improve success rates but also increases the risk of multiple pregnancy.

Looking forward to 2010/11, the outcome of IVF/ ICSI treatment will continue to be an important clinical effectiveness quality indicator for the Trust.

Neonatal mortality rate

The Trust delivers babies of mothers booked into the hospital as well as those transferred from other centres, either still pregnant, or in the immediate post partum period. The table below looks at the mortality in all babies delivered and then specifically those "booked" at Liverpool Women's.

	2008 LWH		2009 LWH		
	All births	Booked pregnancies	All births	Booked pregnancies	ONS 2008
Neonatal Mortality rate /1000 live births	7.8	5.3	6.3	3.8	3.2

Source of data - Office for National Statistics (ONS)

The crude neonatal mortality data remain higher than the national average. However, it is at the level expected when adjusted for case mix. Also, the overall figures reflect the population we serve, which include high risk women who chose to have their care at the Trust and also the high deprivation scores in the local population.

Looking forward to 2010/11, the neonatal mortality rate will continue as a clinical effectiveness quality indicator for the Trust.

Patient Experience

- Rate of epidural for pain relief in labour

The present rate is 18.7% and there is a perception this could and should be higher.

Performance Indicator	2008/09 LWH	2009/10 LWH	National Average 2007/08
Epidural rate for pain relief in labours	16.1%	18.7%	22.2%

However, the numbers may reflect patient choice and we shall continue with in-depth analysis of these trends to ensure that this type of analgesia is available at all times to all women who wish to have it.

Looking forward to 2010/11, the rate of epidural pain relief in labour will continue as a Patient Experience quality indicator for the Trust.

In-patient Survey in Gynaecology

The 2007 and 2008 surveys included questions concerning a wide range of patient experiences ranging from communications with clinical staff to quality of food. The latest results showed the Trust to be better than the national average on 40 questions.

Performance Indicator	2008/09 LWH	2009/10 LWH
CQC In patient survey	• Better than national average in 70% • Worse in 8.5%	• Better than national average 50% • Worse in 5%

Looking forward to 2010/11, the in-patient survey in Gynaecology will continue as a Patient Experience quality indicator for the Trust.

Performance against key national priorities and National Core Standards

The Trust's performance across these target areas is set out in the section on Trust achievements on page 14-15 of the report.

Priorities for 2010/11

Looking Forward

In 2010/11 our main priorities will be:

1. To investigate, monitor and reduce infection rates

2. To investigate, monitor and reduce mortality rates

3. To monitor and improve patient experience

1. To investigate, monitor and reduce infection rates

The Trust wishes to concentrate upon infection prevention and control as one of its priorities for 2010/11. This will embrace the main clinical disciplines of Obstetrics (wound infections after caesarean section) Gynaecology (surgical site infection) and Neonatology where late onset neonatal bloodstream infection remains one of our key areas.

MRSA and C Difficile remain national targets. Although the Trust has low infection rates, they will be monitored monthly by specialty and reported to the Clinical Governance Committee.

2. To investigate, monitor and reduce mortality rates

The Trust wishes to concentrate on reducing mortality across the spectrum of our care. Maternal mortality is extremely uncommon but has a devastating consequence. Gynaecological mortality is predominantly related to cancer. Perinatal mortality encompassing the aspects of antenatal and neonatal care will be measured and rigorously compared with appropriate national and international standards. The data will be presented and reported regularly to the Clinical Governance Committee.

3. To monitor and improve patient experience

The Trust wishes to concentrate on patient experience as this is a key component to our service delivery. Several methods for capturing patient experiences currently exist, however the Trust is keen to develop this further, particularly with respect to obtaining real time information on patient experience.

Additional Quality Indicators

In addition to our three main priorities, we shall continue to monitor a series of quality indicators across the domains of Safety, Clinical Effectiveness and Patient Experience. These are:

Patient Safety

We shall continue to monitor twin live birth rates for assisted conception and medication errors and add three new measures. They are:

Incidence of Apgar scores less than 4 in infants born at more than than 34 weeks gestation and heart rate scores less than 100 in infants born less than 34 weeks.

The Trus's Clinical Annual Report for 2008 revealed an apparent increase in the incidence of babies born with either low Apgar scores or cord pH. The cord pH may not be available for all births, particularly births which are difficult either from a maternal or fetal perspective. Therefore, we shall focus on Apgar scores for all live births after 34 weeks and a heart rate of less than 100 at 5 minutes for babies born under 34 weeks. We shall endeavour to obtain national and international comparators for these outcomes.

Post operative Deep Vein Thrombosis / Pulmonary Embolism

The prevention of blood clots after hospital admissions is a one of the new Commissioning for Quality and Innovation (CQUINS) targets for 2010. Obtaining accurate data from patients who may develop this complication after being discharged presents a challenge for the whole NHS. We shall aim to develop robust monitoring systems to provide accurate data for comparison with similar hospitals.

Excessive ovarian response (more than 20 eggs) in an assisted conception cycle

Ovarian hyper stimulation syndrome can be a life threatening event. It is associated with an excessive response to the fertility drugs. More than 20 eggs retrieved in a treatment cycle would be considered excessive.

Clinical Effectiveness

We shall continue to monitor transfer to ITU per 1000 maternities, readmission rates in Gynaecology and the outcome of IVF and ICSI treatment. In addition we shall introduce three new measures of effectiveness, namely:

Blood transfusion rates following vaginal delivery

Post-partum haemorrhage is a significant cause of maternal morbidity. It is more common following caesarean section (both elective and emergency). Correct management can reduce the effect on maternal health. Estimated blood loss is notoriously unreliable. A more effective surrogate would be blood transfusion following delivery which is recorded and benchmarkable.

Brain injury in preterm babies

Brain injury (neurodisability) is an important adverse outcome for survivors of neonatal intensive care. Long term neurodevelopmental outcome data takes several years to become available and is incomplete as we rely on other organisations (hospitals with paediatric departments) to follow up our patients. The most important determinant of neurodisability in the most vulnerable premature babies is evidence of brain injury on ultrasound examination of the brain. Reporting rates of severe intraventricular haemorrhage (IVH, bleeding within the brain) and periventricular leukomalacia (PVL, injury due to a low blood flow or infection/inflammation affecting the brain) is used as a surrogate measure for monitoring adverse neurodevelopmental outcome.

Care indicators for nursing and midwifery

New care indicators will enable nurses and midwives to audit their practice with a focus on seven key aspects of care which directly impact on clinical effectiveness, patient safety and experience. The Trust will develop the following suite of care indicators:

- Medicine prescribing and administration
- Food and nutrition
- Pressure area care
- Pain management
- Falls assessment
- Patient observations
- Infection prevention and control

In addition, the CQUIN care indicators will be developed to complement the above:

- Reduction in hospital acquired pressure ulcers
- End of life, important choices of where to die when the time comes
- Keeping nourished, getting better
- Preventing falls
- Protection from urinary infection

Patient Experience

The development of the Patient Experience and Involvement Strategy will enable engagement with staff, women and their families about their experiences at Liverpool Women's and together develop a plan of action for the future.

We shall continue to monitor the epidural rates in maternity and the in-patient survey in Gynaecology. We shall introduce one additional new measure:

Provision of one to one care in established labour

The National Service Framework for maternity services stipulates that maternity services should develop the capacity for every woman to have a designated midwife to provide care for them when in established labour 100% of the time.

Statements of assurance from the Board of Directors

Information on the review of services

During 2009/10 Liverpool Women's NHS Foundation Trust provided NHS Services in four core specialty areas.

Liverpool Women's has reviewed all the data available to them on the quality of care provided by its clinical business units (CBU) as listed below:

- Gynaecology and Surgical Services
- Maternity Services and Imaging
- Reproductive Medicine and Medical Genetics
- Neonatology and Pharmacy

Each CBU reports to Clinical Governance Committee which is a sub-committee of the Board of Directors. CBU clinical governance leads report at least 5 self selected clinical outcome indicators that are categorised into safety, effectiveness and experience. These indicators are part of the CBU dashboard and form part of the monthly performance and assurance report for the Trust Board. Some of the CBU indicators are bench marked with CHKS national data or other relevant speciality organisations. Data collected has influenced the organisation as identified in the its improvement initiatives for 2010/11.

The Trust recognises that access to clinical information and clinical audit capacity and function is an issue in terms of ensuring data quality and accuracy. Therefore two new posts have been approved, a Director for Clinical Audit has been appointed and the position of Head of Clinical Audit will be advertised by June 2010. This commitment to quality will enable the Trust to deliver a comprehensive clinical audit strategy that will enable efficient and effective audit and data quality going forward.

The income generated by the NHS services reviewed in 2009/10 represents 100% per cent of the total income generated by the provision of NHS services by the Liverpool Women's NHS Foundation Trust for 2009/10.

Participation in Clinical Audits

In 2009/10 LWH staff participated in all five national clinical audits (100%):

- National Comparative Audit of Blood Transfusion
- Audit of the use of Red Cells in neonates and Children (20 cases required to be audited, 20 (100%) cases audited)
- CEMACE Obesity Project
- Elective and Emergency Surgery in the Elderly
- National Neonatal Audit Project

and both national confidential enquiries (100%):

- NCEPOD (National Confidential Enquiry into Patient Outcomes and Death)
- CEMACH (Confidential Enquiry into Maternal and Child Health)

In addition the Trust reported to the following national perinatal epidemiological studies (UKOSS projects):

- H1N1v in Pregnancy
- Extreme Obesity in Pregnancy

In addition, there were 16 local clinical audits in 2009/10. These are summarised below together with the key outcome of each audit.

Obstetrics and Imaging

- Audit of pregnancy outcomes of the antenatal bariatric clinic and audit of reasons for emergency Caesarean section in multiparous women
  - Take measures to promote vaginal birth after caesarean section
- Audit of Haemoglobinopathy screening
  - Add information in the current guidelines about action to be taken if findings abnormal
- Audit of intermittent fetal heart rate auscultation during labour
  - Training to be provided at annual mandatory training for midwives
- Audit of Group B Strep positive results
  - Ensure a supply of group B Strep positive stickers are available in all areas
- Audit of Health Professionals' Knowledge and Attitudes to Domestic Violence
  - Increase visibility of domestic violence team so that staff feel more supported and aware of whom to speak to if they encounter domestic violence

Genetics and Reproductive Medicine

- Audit of Genetics Cancer Referral Form
  - Referral forms to be submitted to Clinical Reference Group for comment in June 2010

- Clinical Genetics Patient Correspondence audit
  - Standardised letters and templates trialled in early 2010

- Genetic Counsellor First Contact audit
  - Research bid submitted to Research for Patient Benefit and INNOVATE North West

Gynaecology and Surgical Services

- Audit of Sacrospinous Fixation
  - Complete data to be entered onto the national database

- Audit of Abdominal Vault Support procedures
  - Patient information leaflet to be produced and consent form to include specific risks

- Audit of Thromboprophylaxis for Hysterectomy
  - New procedure for risk assessment developed

Neonatology and Pharmacy

- Evaluation of the Effectiveness on Educational Intervention on Aseptic Non Touch Technique Competence
  - Educational Intervention Programme to be developed

- Audit of Morphine Use on Neonatal Unit
  - Teaching session for staff and update on pain guidelines

Research & Development

Commitment to research as a driver for improving the quality of care and patient experience

The number of patients receiving NHS services provided or sub-contracted by Liverpool Women's NHS Foundation Trust in 2009/10 recruited during that period to participate in research approved by a research ethics committee was 3,281 of which 2,050 were recruited to NIHR research studies.

This increasing level of participation in clinical research demonstrates Liverpool Women's NHS Foundation Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our primary focus is through recruitment to studies on the National Institute for Health Research (NIHR) research portfolio. We also lead some research projects and aim to be an effective environment for industry studies.

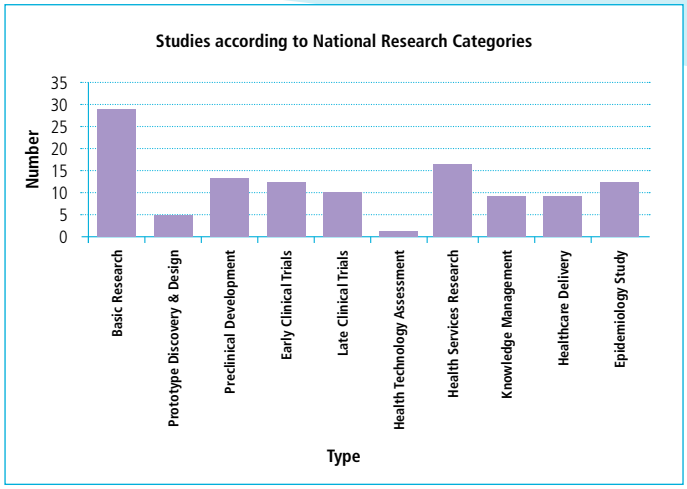
Liverpool Women's NHS Foundation Trust was involved in conducting 137 clinical research studies in 2009/10. Of the studies that were completed during this period, 65% were completed within the agreed time and to the agreed recruitment target. Liverpool Women's NHS Foundation Trust used national systems to manage the studies in proportion to risk.

Of the 56 studies given permission to start in 2009/2010, 80% of the studies processed through the NIHR Coordinated System for gaining NHS Permission (NIHR CSP) were given permission by an authorised person less than 35 days from receipt of a valid complete application. Of the studies (56), 25% were established and managed under national model agreements and 100% of the 23 eligible research projects, which involved external researchers, utilised the NIHR Research Passport system and associated documentation.

In 2009/10 the NIHR supported 46 of the 137 open studies, through its research networks.

In the last three years, 28 publications have resulted from our involvement in NIHR research, helping to improve patient outcomes and experience across the NHS.

The number of studies open at the Trust as at 31st March 2010 (not necessarily NIHR) that fall into each element of the research pipeline is detailed in the chart below.



Information on the use of CQUIN

A proportion of the Liverpool Women's NHS Foundation Trust income in 2009/10 was conditional on achieving quality improvement and innovation goals agreed between the Liverpool Women's NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the CQUIN payment framework.

CQUIN indicators were negotiated and agreed following discussion between Liverpool PCT (as host commissioner) and Liverpool Women's NHS Foundation Trust and reflect key issues in the local health economy. Progress in achieving targets were reviewed monthly and in March 2010, Liverpool PCT confirmed that the full CQUINS payment of 0.5% of contract income would be paid to Liverpool Women's NHS Foundation trust in 2009/10 for performance against its CQUINS targets. Total CQUINS income in 2009/10 amounted to £376,365.

Further details of the agreed goals for 2009/10 and for the following 12 month period are available on request from the Director of Service Development.

Information relating to registration with the CQC and periodic special reviews statement

Liverpool Women's NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is without conditions.

The Care Quality Commission has not taken enforcement action against Liverpool Women's NHS Foundation Trust during 2009/10.

Liverpool Women's NHS Foundation Trust is not subject to periodic review by the Care Quality Commission. The Trust has not participated in any special reviews or investigations by the CQC in the reporting period.

Data Quality

Liverpool Women's Hospital NHS Foundation Trust submitted records during April 2009 and end of January 2010 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which:

Included the patient valid NHS Number was:
- 94.6% for admitted patient care
- 95.2% for Outpatient care; and
- 96.5% for accident and emergency care.

Included the patients valid General Medical Practice was:
- 100% for admitted patient care
- 100% for Outpatient care; and
- 100% for accident and emergency care

Information Governance Toolkit attainment levels

The Liverpool Women's NHS Foundation Trust score for 2009/10 for Information Quality and Records Management assessed using the Information Governance Toolkit was 85.7.

Source

Data Quality scores from SUS Dashboard
IG Toolkit attainment levels from National IG Assessment.

Clinical Coding 2009/10 Audit

The role of the clinical coders is to analyse the patients' clinical record and assign specific codes for the diagnoses, procedures and interventions that take place during the patients' hospital admission. In addition to assigning codes to inpatients admissions codes are also assign to outpatients attendances where a procedure or intervention takes place e.g. cervical smear.

The table below summarises the findings from the 2009/10 independent, targeted external Clinical Coding audit on inpatient activity at Liverpool Women's carried out in October 2009 on data from 1 April to 30 June 2009.

Area audited	Specialty/ Sub- chapter / HRG	% Procedures coded incorrectly		% Diagnoses coded incorrectly		% of episodes changing HRG	% of spells changing HRG
		Primary	Secondary	Primary	Secondary		
Specialty	Obstetrics	2.2	3.0	11.0	9.4	9.0	9.0
Sub- chapter	Digestive system procedures	0.0	2.9	8.6	4.1	0.0	0.0
HRG	Normal Delivery 19 years and over with CC	0.0	0.0	0.0	5.2	6.7	6.7
Overall		0.7	2.2	8.5	6.3	5.5	5.5

As with the two previous audits, the 2009/10 results show that the Trust's clinical coding error rate remains consistently below the national average.

The 2009/10 report states:

'The Trust's performance is good compared to the overall performance of trusts. In 2008/09 although the Trust HRG error rate has increased compared to the previous audits, it remains below the national average and it has and continued to implement the recommendations from our 2008/09 review, indicating a commitment to improving performance. This year the Trust's HRG error rate is 5.5 %. The national average in 2008/09 was 8.1 %. The financial value of the total or gross errors found is £5,066 from an audit sample of £361,045. The net impact of the errors is that the Trust has overcharged its commissioners by £764 or 0.2 % on the sample tested.'

The high levels of coding accuracy as demonstrated in all three Payment by Results Data Assurance Framework audits provide financial assurance to Liverpool Women's and Liverpool PCT, its host commissioner. The audit also shows that the coded data accurately reflects the complexities of care provided by the Trust to its patients.

Our Future Plans

As the Trust enters 2010/11, it is faced with a number of significant challenges. The change of Government and anticipated White Paper (July 2010) signals changes in health policy to which the Trust will be required to respond. The current financial climate and the specific impact of this and changes in tariff, upon our income means that we will have to find different ways of delivering services that are both efficient and effective. The NHS has a continued focus on improving the quality of the services it provides to its patients and the aspirations of Liverpool Women's are fully aligned to this agenda.

In November 2009, the Trust held a clinical summit which brought together managers and clinicians from across the Trust to better understand what Liverpool Women's can do to make sure it continues to be able to meet all its aspirations in the future and continue to put patients at the heart of all that we do. There was strong ongoing support for the collective vision of Liverpool Women's which is to be…

…the recognised leader in healthcare for women, babies and their families

In order to support this vision, our focus will be on patient safety and patient experience as well as clinical outcomes and financial stability. It is recognised that in order to do this we will have to continue to develop our staff to ensure they have the skills and support to respond to the challenges ahead.

The Trust's operational plan for 2010/11 presents further context of the challenges ahead and articulates the focus of the service strategies and developments of our clinical business units and our corporate support departments.

Our Strategies	• To be productive and efficient (P) ~ reduce costs by £15m over 4 years • To grow services (G) ~ increase income from new activity by 1% over 3 years • To deliver high quality outcomes (O) ~ provide evidence of best of class
Our Aims	• To deliver safe services. • To deliver the most effective outcomes. • To deliver the best possible experience for patients and staff. • To develop a well led, capable and motivated workforce. • To be efficient and make best use of available resources.

We recognise that we cannot deliver our aims in isolation of others. The Trust does and will continue to explore appropriate and productive partnerships both within and outside of the NHS to ensure that Liverpool Women's remains a successful provider of healthcare whatever the measure.

Key Drivers and Challenges

Our key drivers and challenges can be summarised into four themes. These themes will continue to shape NHS policy and influence regional and local decision making. It is essential that through the collective intelligence of the Board of Directors, the Council of Governors, clinicians, managers, frontline staff and our patients that we keep abreast of the influence and changes these drivers may bring.

Themes:-
1. Continuous improvement in quality and patient experience
2. Enhanced governance and public scrutiny/accountability
3. Limited resources
4. Capable and skilled workforce

National Drivers

Economic Climate: The economic climate will continue to impact on the resources available to the public sector and specifically to the NHS. The NHS cannot expect any notable increase in funds over the next three years and must plan to deliver services with fewer available resources.

Political Climate: We enter 2010/11 at a time of political change. The new coalition Government has been elected and is due to issue its health White Paper in July 2010. This will undoubtedly mean changes in health policy that the Trust and its partners will be required to understand and respond to. The Board will give due consideration to these changes once the White Paper is published. There is likely to be stability within local government, however, changes to local MPs will require the Trust to build new relationships.

The Operating Framework for 2010/11 and 'From Good to Great': 2010/11 is the last year of the current planning round and therefore focuses on getting services fit for the future and leaner in anticipation of future reductions in funding. Current priorities remain:

improved local access, choice, infection control, cancer care, maternity and neonates. Aligned to the financial framework are the quality framework and the performance framework.

'Good to Great' articulates a vision for the NHS that is focused on a more preventative and people centred service approach. Frontline staff are the key to its delivery; with the developed set of skills and competencies. The plan builds on the work initiated by Lord Darzi and emphasises accelerated quality improvement. Although no set route and promises of no top down reorganisations there is an expectation of partnership working and service redesign.

National Tariff/Payment by Results: In 2010/11 the Trust is significantly affected by changes in the Maternity Tariff, a reduction of over £2m in year. The Trust continues to work with the Payment by Results team from the Department of Health to shape the future funding of maternity services. However, this has to be taken in the context of the overall funding of the NHS. Early indications are that there will not be future increases in maternity tariff.

Private Patient Income Cap: The recent legal ruling on the Private Patient Income Cap means that the Trust will have to review the current arrangements it has in place with North West Fertility for the provision of private assisted conception services. This potentially impacts on all other elements of private patient income that the Trust currently receives

Quality Accounts: There remains a strong national focus on Quality Accounts and transparency of clinical outcomes. This is supported by the Trust and builds on the work we have done for many years within our Clinical Annual Report. However, we can expect significantly more scrutiny of our clinical practice and outcomes from statutory bodies, the media, patients and the public.

Changes to regulation/Establishment of Care Quality Commission: As a result of changes to statutory regulation at a national level, the Trust is required to respond to revised processes and assessment arrangements as they are published. This has introduced a degree of uncertainty during this transitional phase.

Governance: The NHS has seen a number of high profile inquiries that have reported over the last year. The most significant being the investigation into events at Mid Staffordshire NHS Foundation Trust and the subsequent recommendations made through the Francis Report. The Trust must continue to review its own practice against the recommendations made in this report. Additionally, recent publications reflecting on Board effectiveness are a prompt for greater scrutiny on how Boards ensure they are fit for purpose through ongoing development and robust appraisal of Directors.

Regional Drivers

QIPP Programme: Although this is a national agenda, the regional interpretation and application of the programme in the region is strong. Quality, Innovation, Productivity and Prevention are the cornerstones of the NHS North West approach to managing the future challenges of the NHS. This is also translated at a local level and the Trust is planning to fully participate in appropriate aspects of the programme. Our internal aims mirror the aspirations of the QIPP Programme.

Advancing Quality Alliance (AQuA) - the North West Quality Observatory: The aim of AQuA is to develop and promote improvements in quality across the North West through benchmarking, capturing and sharing intelligence and supporting innovation. The development of quality metrics so far has not included services provided by Liverpool Women's although this is expected to be redressed particularly for maternity services. The Trust will be contributing financially to the Alliance, a not for profit organisation, and will work with it to develop links with our services and clinical pathways.

North West Exemplar Programme: The programme aims to raise the profile of the North West as an attractive focus for pharmaceutical and biotechnical industries due to our ability to recruit appropriately and responsively to clinical trials. The Trust has an active R&D profile and is already participating at a high level in this programme.

Commissioning: As commissioning arrangements across NHS North West mature, it is to be expected that the focus is on consistent delivery of services across a wider geographical footprint. This would aim to align access to services across the region and eliminate post code commissioning of services. This will impact on services provided by Liverpool Women's we must remain close to changes in commissioning intentions through better relationships with our PCTs and Specialist Commissioners.

Local Drivers

NHSLA/CNST: The Trust will be re-assessed against both sets of standards during 2010/11 and it is a priority to retain our Level 3 status in both. The co-ordination of evidence to support assessment against the new standards will be significant and will require sufficient time and resources to achieve.

Care Closer to Home: Local PCTs are keen to develop services closer to home and this carries a risk to the services that we currently provide. It is expected that this will lead to a disinvestment in acute services with a greater impact on gynaecology and fertility services than others. Transfer to first line outpatient services has already commenced in Liverpool and other PCTs are pursuing similar service models. The Trust must review its service model in order to be able to respond effectively and maintain safe services.

Demographic Profiles: The Trust has undertaken a considerable amount of work over the last year to better understand changes in our local population. Given our service profile it is of particular interest that the female population (aged 15-44) is anticipated to decrease in the coming years, as is the birthrate within the same population. This intelligence is reflected in the 'Big Push' project Business Case and will have to be considered for other proposed developments and changes to service.

Patient Care

Patient and Public Involvement

The Patient Involvement Committee consists of two of the Trust's governors and five public members, volunteers and Trust representatives. The committee has provided valuable input to the development and ongoing review of progress of the Patient Quality Strategy and associated action plans. An evaluation of the strategy was presented to the Board of Directors, highlighting the achievements and outcome of the objectives set out in the document.

This strategy will be superceded by the Patient Experience and Involvement strategy, which is curerntly in development. This strategy will provide a clear vision of how the Trust will engage with service users and their families to learn from their experiences and to assist in all aspects of Trust business. The Patient Involvement Committee will play a pivotal role in the development and implementation of the strategy.

The Patient Quality Team has engaged in discussions with patients and members of the public to enhance our knowledge of how the Trust as a whole is viewed. This information has been collated through focus groups and direct discussion on a one to one basis. Examples include:

- Patients, visitors and staff views on enhancing the 'smoke free site'
- Quality of food served to patients
- Patients perception of mixed sex accomodation, highlighting the effects that male visitors may have on privacy and dignity

The use of 'comment cards' provides valuable information about patients' experiences highlighting areas of good practice and occasions when the service could have been improved. As a result, a number of changes to practice have been brought about:

- Improved climate control apparatus in waiting areas, which staff can alter accordingly
- Provision of further reading material in waiting areas
- Replacement of communal televisions in ward areas
- Review of system for provision of 'take home' medication to prevent delays
- Provision of warm drinks during the evening
- Food served by nursing staff to monitor comments
- Provision of 'hot plates' to keep meals warm
- Appointment of house keeper to assess quality of food and appropriate delivery of food
- Increased frequency of 'go and see' visits to assess levels of cleanliness and develop action plans where standards fall short of expectation
- Visiting times amended following patient feedback

This information has been disseminated widely throughout the Trust and actions taken as a result displayed on our 'You said, we did' notice boards.

Patient Information

The patient information group have reviewed 25 patient information leaflets during the year. The leaflets have been produced by multidisciplinary teams within the Clinical Business Units. The written information has been processed using a rigorous method for ensuring they are easily understood and contain sufficient information by which patients and their families can make an informed decision about the care they receive.

The findings of a comprehensive audit of the policy provide assurance to the Trust that all existing patient information leaflets have been reviewed within an agreed timescale specified and this information is clearly demonstrated on each document. All leaflets explaining clinical treatments contain information about the associated risks and benefits and any alternative treatment to consider.

Requests for information in other languages and formats such as audio version and large print have been processed on request.

Copies of all leaflets are available on the Trust's intranet, these can be printed on request and in large font format if patients have a sight impairment.

Patient Surveys

National Outpatient Survey

The Care Quality Commission's Outpatient Survey results were published in November 2009. Postal questionnaires were sent to a random sample of 850 patients who attended the Gynaecology Outpatient Clinic. Exclusion criteria included women who had undergone a termination of pregnancy, early pregnancy loss and investigations and treatment within the Hewitt Centre for Reproductive Medicine.

A total of 850 patients who had attended the Gynaecology Outpatient Department in March, April or May 2009 were asked to complete a questionnaire containing 73 questions relating to their visit to the clinic.

Of the 850 patients asked to participate, 835 were eligible to take part, of which 393 returned a completed questionnaire giving a response rate of 47.7%. The average response rate for the 73 participating trusts was 50.1%.

Results

The survey results are presented in the form of 'problem scores'. The problem score shows the percentage of patients for each question, who by their response have indicated that this particular aspect of their care could have been improved. Therefore lower problem scores are better.

This survey was previously undertaken in 2004 and therefore the findings of this year's survey can be compared to those responses.

The Trust scored significantly better on 9 questions:

- Had to wait more than 5 months for an appointment 3%
  Previously 6%
- Appointment not with person told it would be with 19%
  Previously 33%
- Not enough or no information given about condition or treatment 15%
  Previously 22%
- Not told how would find out results of tests 11%
  Previously 22%
- Test results not fully explained or never received 22%
  Previously 30%
- Not fully told purpose of medications 7%
  Previously 16%
- Did not receive copies of all letters sent between hospital doctors and family doctor (GP) 27%
  Previously 76%
- Not given any written or printed information about condition/ treatment but would have liked it 15%
  Previously 28%

The Trust scored significantly worse on five questions:

- Not given name of person that appointment was with, before the appointment 37% (23%)
- Could not find a convenient place to park 28% (10%)
- Other patients could overhear discussions with receptionist 62% (55%)
- Patients unable to get suitable food or drink 8% (14%)
- Not given complete privacy when discussing condition / treatment 10% (6%)

The Picker Institute report indicates that the trust scored significantly better than other Trusts on 35 questions and significantly worse on 2 questions:

- Not fully aware of what would happen during the appointment
- Not given name of person that appointment was with, before the appointment

National Inpatient Survey

The Care Quality Commission Inpatient Survey results were released in February 2010. Postal questionnaires were sent to a random sample of 850 patients who attended the Gynaecology Inpatient Ward.

Of the 850 patients asked to participate, 845 were eligible to take part, of which 408 returned a completed questionnaire giving a response rate of 48%. The average response rate for the 73 participating trusts was 48%

Results

The survey results are presented in the form of problem scores. The problem score shows the percentage of patients for each question, who by their response have indicated that this particular aspect of their care could have been improved. Therefore lower problem scores are better.

This survey was previously undertaken in 2008 and therefore the findings of this year's survey can be compared to those responses.

The Trust scored significantly better on 8 questions:

- **Hospital:** room or ward not very or not at all clean 2%
  Previously 5%
- **Nurses:** did not always get clear answers to questions 20%
  Previously 26%
- **Nurses:** some/none knew enough about condition/treatment 7%
  Previously 13%
- **Care:** did not always get help in getting to the bathroom when needed 16%
  Previously 27%
- **Discharge:** did not receive copies of letters sent to GP 26%
  Previously 80%
- **Overall:** doctors and nurses working together fair or poor 3%
  Previously 6%
- **Overall:** no posters/leaflets seen explaining how to complain about care 32%
  Previously 39%
- **Religious Beliefs:** not always respected by hospital staff 1%
  Previously 7%

The Trust scored significantly worse on 1 question:

- Hospital did not offer a choice of food 22 %
  Previously 15%

The Picker Institute report indicates that the Trust scored significantly better than other trusts on 59 questions and significantly worse on one question. This relates to having a facility for safely storing personal belongings. Secure lockers have subsequently been installed at all bedsides in Gynaecology since the survey took place.

The Gynaecology CBU staff have developed action plans detailing how they will respond to the qualitative and quantitative data generated from the survey reports. The details and progress of this work will be disseminated throughout the organisation with in the quarterly patient experience report.

Complaints

The Trust responds to all complaints with equal seriousness and attention. Complaints are viewed in a positive manner and are a powerful tool for learning lessons and changing practice and procedures when appropriate. By listening to concerns raised by complaints, the Trust is able to continuously reflect on many aspects of the patients' experience and actively respond to any concerns constructively.

Complaints can be made by patients, relatives or visitors, although patient confidentiality is maintained at all times.

In February 2009, the Department of Health published *'Listening, Responding, Improving - A guide to better customer care'*, which provides guidance for complaints management within Health and social care settings. There is a particular focus on the NHS Constitution, which clearly identifies the standards that the public can expect when accessing services.

Listening

The document provides guidance on how organisations gather patients' views and emphasises the importance of ease of access to encourage feedback.

Responding

The document sets out a process:

- Assessing the seriousness of the complaint
  This is dependent upon a number of factors, i.e. the potential effect the experience has had in terms of the impact on service provision and the potential for litigation. The likelihood of recurrence is taken into consideration and categorised in terms of potential risk.
- Responding in the right way every time
  This is based on negotiation between the complainant and the Trust and should involve the development of a personalised plan, which should be realistic in achieving objectives. This will include the offer of an early meeting to discuss the patient's concerns face to face.

Importance is placed upon:
- Addressing the concerns raised as quickly as possible
- Staying in regular contact with whoever has complained to update them on progress
- Keeping to any agreements made and if not, explain why
- Offering support to complainants from internal or external agencies e.g. ICAS (Independent Complaints Advocacy Service)
- Providing mediation when disagreements are difficult to resolve
- Offering a full explanation of events, a conclusion of investigation findings, an apology when appropriate and details of how the Trust will prevent a recurrence
- Advising the complainant of the role of the Health Service Ombudsman when resolution has not been achieved locally

Improving

The document discusses ways in which patient feedback can be used to shape services and improve care. This incorporates the benefits of utilising comments, compliments and complaints to identify what is working well in addition to potential risks and problems.

In the period between April 2009 and March 2010, the Trust received 95 formal complaints, which is a decrease compared to the previous year (109). The main themes, which have emerged during this period were:

- Treatment and care
- Communication
- Facilities
- Attitude of staff

In line with the new legislation, complainants who remained dissatisfied with the Trust's response referred their concerns to the Health Service Ombudsman. During this period six complaints were referred on. To date, although recommendations have been made, the Health Service Ombudsman has not identified the need to investigate the concerns further.

Meetings with complainants

The flexibility afforded to complainants within the new regulations has led to an increase in the number of complainants who have met with Trust staff to resolve thier concerns. 36 of the 95 complainants have attended a meeting at various stages of the complaints management process. Meeting the complainant is an excellent opportunity to learn about the experience in more detail and this interaction is positively encouraged as part of the procedure. Meetings are facilitated by the Patient Quality Team, who provide a transcript of the meeting and when necessary provide any follow up action as a result.

Action taken as a result of complaints this year include:

- Development of a system for checking blood results when patients attend the recurrent miscarriage clinic
- Customer care training across CBU's
- Review of male toilet facilities
- Development of a more robust system for identifying and recording mothers' expressed breast milk when taken to the Neonatal Unit.
- Audit of policy for the sensitive disposal of fetal remains
- Electronically operated chairs to be purchased for patients with limited mobility
- Review of the process for midwifery referral to the assessment unit for postnatal review
- Review of guidance for staff when asked about a baby's gender when born at early gestation
- Development of a bedside handover signature list

Work in progress

- Review of food choices for mothers with specific dietary requirements
- Audit of the provision of one to one care in labour
- Review of the assessment room triage process
- Introduction of ward based pharmacists to prevent delays in patients receiving medication

Developing the Patient Safety Agenda

Liverpool Women's took the decision in November 2009 to sign up to the Leading Improvement in Patient Safety programme (LIPS). The programme is led by the NHS Institute for Innovation Safer Care Team and consists of six modules of learning over a nine month period, for both clinical and managerial teams. The purpose of the programme is to support every member of staff within the Trust to have the passion, confidence and skills to eliminate harm to patient. LIPS will support the organisation by sharing improvement tools that measure patient safety effectively and consistently.

The Trust was successful with its application to join the LIPS programme in December 2009 and the 'Getting Started' team attended the first module in March 2010.

In addition and as part of the Trust's patient safety agenda, the organisation has signed up to the National Patient Safety Campaign, with its emphasis on "no avoidable deaths, no avoidable harm" ensuring safer care remains our top priority and to help us better understand how we as an organisation can continuously improve safety for women, babies and their families.

Infection Control

Liverpool Women's continues to maintain its excellent record and high standards of performance in respect of infection prevention and control.

- There were only 2 cases of MRSA blood infection in the Trust during the year; on neither occasion was the infection considered preventable and this has maintained the Trust's excellent performance against this standard.
- During 2009/10, only 1 patient was identified with clostridium difficile disease at Liverpool Women's Hospital, again review of this case did not suggest a link with care in the hospital.
- The Trust has introduced prospective surveillance of wound infections across the organisation, although in its initial stages results show a comparably low rate of wound infections in the organisation.
- The Trust has recently undergone a Patient Environment Action Team (PEAT) assessment and was once again awarded an 'excellent' rating.

The Trust continues to retain unconditional registration by the Care Quality Commission in relation to Healthcare Acquired Infection. An unannounced inspection in August 2009 resulted in a small number of issues being identified which the Trust took rapid and decisive action to rectify.

Stakeholder Relations

Liverpool Safeguarding Children Board

The Trust continues to build on partnerships with a number of local agencies in particular the Safeguarding Children Boards (LSCB's) within Liverpool, Sefton and Knowsley.

The Trust adheres to its statutory duties under Section 11 of the Children Act 2004 and to the expectations of the Liverpool, Sefton and Knowsley Safeguarding Children Boards in all areas described in its Safeguarding legislation and policy, which adheres to LSCB procedures and is reviewed on an annual basis.

Following the external review commissioned by the Trust to assess our safeguarding arrangements in terms of best practice, supervision, policy, systems, processes and training, the Trust has recently appointed to a new post of Head of Safeguarding Adults and Children. The Head of Safeguarding will lead a team of three expert staff to further strengthen the Trust's integrated systems and processes in respect of safeguarding.

The present named lead midwife for Safeguarding Children and lead doctor together with other key staff continues to attend and contributes to strategy meetings, Safeguarding Children and Vulnerable Adults Protection conferences and reviews, core groups and the development and implementation of Safeguarding Children and Vulnerable Adults Protection Plans.

Through specific targeted training, Trust staff have a sound understanding of risk factors and recognise adults and children in need of support and/or safeguarding; they recognise the needs of parents who may need extra help in bringing up their children and know where to refer for help and the risks of abuse to an unborn child or adult, they make appropriate referrals under Section 17 and Section 47 of the Children Act 1989 and contribute to enquiries from other professionals about a child, adult and their family or carers.

As part of safeguarding children, young people and vulnerable adults, Trust staff provide ongoing promotional and preventative support through proactive work with women, children, families and expectant parents. Initiatives include a multi agency training seminar for practitioners to enable them to actively work with new or young parents and to make them aware of the risks to newborn and young babies. In addition, in January 2010 Liverpool Women's NHS Foundation set up a Domestic Abuse drop in centre to support vulnerable women in Liverpool. The drop-in clinic is held on Monday afternoons between 1-4 pm in Liverpool Women's Antenatal clinic. The centre is only one of a few such centres in the country and although a Trust initiative, will be jointly staffed with volunteers from Kensington Domestic Abuse Service and the expert staff on Domestic Abuse from the Trust. The service has been set up to support any woman in Liverpool who needs support and advice on issues relating to Domestic Abuse.

Hotel Services - Sodexo

The Trust continues to work with Sodexo, delivering cleaning, portering and catering services to the Trust. Partnership working has ensured improvement in the management of cleaning and catering this year. The Trust has once again received "excellent" scores in the recent round of Patient Environment Assessments for both cleaning and catering services. In an ongoing effort to raise standards still further, a new cleaning system is being introduced, providing new equipment and standard operating procedures which will ensure consistency of cleaning practices.

Within the catering service, the Trust and Sodexo have jointly funded an initiative with celebrity chef Simon Rimmer. The new Simon Rimmer designed menus were introduced during the year and have been received exceptionally well by all patients.

With the increasing pressure on NHS finances the Trust will be market testing all these services during 2010/11 to ensure value for money is maintained.

Primary Care Trusts (PCT)

During 2009/10 the Trust has worked collaboratively with its host Primary Care Trust, Liverpool. We have a monthly contracting meeting attended by the host and associate PCTs. We have introduced a joint quality meeting which is held bi-monthly and has focused on the monitoring of CQUINS and shadow quality indicators. In addition, we have undertaken a specific piece of work to review resource requirements for the provision of maternity services. The outputs from this review have influenced further targetted investment in maternity services for 2010/11. During the year our host PCT appointed a new commissioning manager for women's and children's services.

Our host PCT has undertaken an 'any willing provider' tender for the provision of primary care gynaecology services. The Trust has been successful with its application and will commence the provision of services as one of five accredited providers from April 2010.

North West Fertility Ltd

Liverpool Women's and North West Fertility Ltd continue to enjoy a successful working partnership. The year has presented challenges to both service provision and joint working as a result of changes in the economic environment, the legal ruling on the Private Patient Cap for foundation trusts and the commissioning of the new laboratories and refurbished Reproductive Medicine unit. New services have been introduced and the portfolio of services is continually reviewed through the partnership board.

Finance

Performance

The Board of Directors is pleased to report achievement of an excellent financial performance in its fifth year of operation as an NHS Foundation Trust. This is summarised in the key financial measures set out below and detailed in full in the annual accounts on pages 79 to 114.

Measure

Comparative Performance	**2009/10**	2008/9
Earnings before Interest, Tax, Depreciation and Amortisation (EBITDA) (Total Income – (Total Operating Costs – Depreciation)	**£6.8million**	£8.3million
EBITDA Margin (EBITDA/Total Trust Income)	**7.6%**	9.7%
EBITDA Achievement of Plan (EBITDA Actual/EBITDA Plan)	**103%**	131%
Income and Expenditure (I & E) Surplus	**£1.6 million**	£4.5 million
I & E Surplus Margin (I&E Surplus/Total Trust Income)	**2.9%**	5.3%
Return on Assets	**7.3%**	10.6%
Liquidity	**46 days**	66 days
Monitor Risk Rating	**4**	5

The Trust planned to achieve a surplus in 2009/10 of £2.0m and was marginally below this level, achieving a surplus of £1.6m. However the surplus was reduced due to a £1.0m impairment charge relating to a reduction in the value of land and building. The operational surplus excluding impairment would therefore have been £2.6m exceeding the Trust plan. The total impairment of land and buildings amounted to £12.2m, however £11.2m was charged to the revaluation reserve, recognising earlier increases in value. The reduction in land and buildng values are consistent with the current economic conditions and are reflected across many health service organisations.

The strong financial performance was underpinned by the continuation of patient activity levels and the control of expenditure budgets. This has allowed the Trust to invest in clinical areas such as the increasing of staffing levels on the Neonatal unit.

The continued strong financial performance has also allowed the Trust to continue the capital investment it commenced in 2008/09 completing a number of capital schemes.

The Trust anticipates that the financial climate will become increasingly challenging in future and has commenced a strategic review to identify savings for future years, this will continue in 2010/11 to identify schemes for future years.

Private Patient Income

Performance against the Private Patient Cap is set out below:

	09/10	08/09
Total patient related income	**£79,519,000**	£76,117,000
Private patient income	**£212,000**	£116,000
Proportion of private patient income as a percentage	**0.27%**	0.15%
Private Patient Cap	**1.8%**	1.8%

Income from private patients increased during the year as the Trust sucessfully completed the development of the Catherine Suite.

The Trust continues to provide staffing, services and accommodation to North West Fertility Limited a company set up by a number of Consultant Gynaecologists and the Reproductive Medicine Unit's Scientific Director and is remunerated according to the terms of the contract. This income continues to be categorised in the Trust's accounts as "Other Operating Income" consistent with the NHSFT Annual Reporting Manual 2009/10 issued by Monitor. However at the end of 2009/10 following a challenge in the courts and subsequent revision to the Monitor rules relating to the private patient cap, this income will be classified as private patient income and will therefore be included within the private patient cap. This will mean the the Trust would potentially breach the private patient cap. The Trust has identifed a solution and will be implementing the necessary actions during 2010/11.

Prudential Borrowing Limit

The Trust had a prudential borrowing limit of £23.6 million in the year of which £18.6 million related to long term borrowing and £5 million to a working capital facility. The Trust has not borrowed against the limit during the year.

Capital Expenditure

A capital programme of £5.96 million was completed during the year. This was financed from internally generated funds and accumulated cash balances, and related to protected assets.

The financial year 2009/10 saw the completion of construction works associated with the Hewitt Centre expansion which will provide expanded and upgraded laboratory facilities and clinical accommodation. In addition the Trust opened the Catherine Suite during the year which remodelled vacated ward accommodation to provide a centralised facility for delivering services to private patients. The Trust also invested in the Mulberry Suite as part of the King's Fund 'enhancing the healing environment' project, which seeks to improve the environment for care at the end of life.

In addition the Trust was able to maintain traditional areas of investment in improving and upgrading the environment for staff and patients, investment in medical and scientific equipment, and ensuring the most up to date technology possible is available to support the delivery of clinical and non clinical services.

Details of the capital programme are set out below.

	£000	£000
Building Related		
Hewitt Centre and Catherine Suite Development	2,961	
Building Infrastructure and Environment	1,751	4,712
Medical and Scientific Equipment	547	
IM&T Infrastructure	633	
Energy Saving Scheme	72	1,252
Total Capital Expenditure		5,964

Better Payment Practice Code

The code requires that 95% of undisputed invoices relating to trade creditors are paid within 30 days of receipt. Trust performance is recorded below:

	2009/10	2008/09
Value of Invoices paid within 30 days	61%	66%
Number of Invoices paid within 30 days	51%	58%

No interest was paid to suppliers under the late Payments of Commercial Debts Interest Act (1998).

The Trust has signed up as an approved signatory to the code (registration pending) and seeks to support its suppliers in maintaining cashflow by paying within agreed terms. The implementation of a new finance system in 2010/11 is designed to support the Trust in enhancing its performance in this area.

Going concern


WEDECO
Hand Hygiene
The most important way of preventing the spread of infection
DON'T
WALK
PAST
CLEAN
HANDS
ONLY

Going Concern

After making enquiries the directors have a reasonable expectation that Liverpool Women's NHS Foundation Trust has adequate resources to continue in operational existence for the forseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

NHS Foundation Trust Code of Governance

Since its publication by Monitor, the NHS Foundation Trust Code of Governance has been subject to an annual operational assessment within the Trust, which has included a report on the current position in relation to each of the provisions, any actions required and a statement against the principle of 'comply or explain'. The Trust is committed to the prinicples of best practice corporate governance, which has resulted in regular reviews of the effectiveness of the Board and its committee structures by external organisations to provide assurance to our stakeholders that the organisation remains fit for purpose.

Having undertaken an operational assessment of its governance arrangements for 2009/10, the Trust can confirm that it complies with the provisions of the Code with the following exceptions:

Code provision	Explanation
A.3.2 – At least half the board, excluding the chairman, should comprise non-executive directors determined by the board to be independent	The Board comprises an equal number of executive and non-executive directors, including the chairman, with the chairman holding a casting vote under the Trust's constitution
C.2.1 – Executive directors should be… subject to re-appointment at intervals of no more than five years	Executive directors will not be subject to a formal re-appointment process as this would not be in line with NHS terms and conditions; they are however held to account for their performance against agreed objectives by the Chief Executive and the Chief Executive in turn by the Chairman
E.1.4 – The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointment would entail in the event of early termination…They should take a robust line on reducing compensation to reflect departing directors' obligations to mitigate loss	The Board has agreed that the Trust would not move away from NHS terms and conditions and therefore nationally agreed compensation payments including redundancy would apply

Our Board of Directors

The Trust's constitution provides for a Board of Directors which is comprised of six executive and six non-executive directors including the Chairman. All of these roles have been occupied during 2009/10 in accordance with the policy developed by the Trust in support of the constitution. The Trust considers that it operates a balanced, complete and unified Board with particular emphasis on achieving the optimum balance of appropriate skills and experience; this is reviewed whenever any vacancy arises and was rigorously tested in 2009/10 during the process to recruit three new Executive Directors and two new Non Executive Directors.

Since April 2005 non-executive directors have been appointed by the Council of Governors at a general meeting, following a selection process undertaken on behalf of the Council by its Nominations Committee. The Council of Governors has adopted a standard term of office of three years for all non-executive appointments. The Chairman and non-executive directors can also be removed by the Council of Governors through a process which is described in section 13 of the constitution.

Ken Morris – Chairman

Ken Morris commenced with the Trust in August 2005. Following a successful appraisal process, Ken was re-appointed in April 2008 for a further 3 years. Ken has had over 20 years experience of working at Executive and Non Executive Director level in a variety of organisations in the public, private and not-for-profit healthcare sectors. Immediately prior to joining the Trust he was Chair of a successful PCT. His management consultancy experience has been centred around change and improving overall performance in a variety of health and not for profit organisations. He has chaired and been a member of a number of national committees. In 2008/09 Ken was elected to the Board of the national Foundation Trust Network. He is also chair of the Foundation Trust Network in the North West. In May 2009 Ken was approached by NHS North West to support another trust within the patch through a transitional period as interim Chair. The Council of Governors approved a secondment for a period of four months and Ken returned to the Trust on 1st September 2010.

Non-Executive Directors

Hoi Yeung

Hoi Yeung was appointed in March 2005 for a period of 4 years and following his successful appraisal was re-appointed in January 2009 by the Council of Governors for a further 3 years. Hoi is a retired senior chartered accountant who has enjoyed a very successful and varied career with the Littlewoods Group spanning 29 years. He worked his way up through the finance function to the position of Director of group finance and accounting. From this role Hoi brings particular skills in audit, management and financial accounting, treasury management, tax and risk management. In addition, Hoi has a wealth of experience in public and voluntary sectors which included his roles as a Governor of Liverpool Community College, a Trustee of the John Moores Liverpool Exhibition Trust and an observer at the board of the Liverpool

Biennial of Contemporary Art. Hoi is the Chair of the Trust's Audit Committee and a member of the Finance, Performance and Business Development Committee.

Roy Morris CBE, DL

Roy Morris was appointed in February 2005 for a period of 4 years and following his successful appraisal was re-appointed in January 2009 by the Council of Governors for a further 3 years. Roy was formerly the Chief Executive of Rathbone Brothers Plc and Chairman of the Executive Committee, which manages the day to day affairs of the Group. Roy had been with Rathbones, involved in investment management throughout his working career. He was a Partner in Rathbone Bros. & Co and in 1988 he became Managing Director. He was appointed as Group Chief Executive in 1997. He retired as Chairman of the Mersey Partnership in March 2008 but continues to hold a number of non-executive positions with several prominent local businesses. Roy was awarded a CBE in the Queen's Birthday Honours list in June 2008. and will serve as High Sheriff of Merseyside during 2010. Roy is the Chair of the Trust's Finance, Performance and Business Development Committee and is a member of the Charitable Funds Committee.

Ann McCracken

Ann McCracken first joined the Trust as a non-executive Director in December 2001 and served two terms of office under NHS arrangements. Ann was re-appointed in 2006 for a further three years following a successful performance appraisal and approval by the Council of Governors. She has subsequently had her appointment extended for a further two years in order to ensure continuity on the Board. A former journalist, she now works as Head of Communications for O2 in the north. Her other commitments include Mersey Common Purpose's advisory group. Ann is the Trust's Vice Chairman and sits on the Governance and Clinical Assurance, Charitable Funds and Audit Committees. During the year, Ann became acting Chair for the period of Ken Morris' secondment.

David Carbery

David joined the Board in February 2004 after a long career in the Civil Service, working in a variety of government departments including social security. He was also the Regional Operations Manager in charge of the Charity Commission's Liverpool office, dealing with charities in the North West. He is the Senior Independent Director on the Board and chairs the Governance and Clinical Assurance Committee and the Charitable Funds Committee. He is also a member of the Audit Committee. In January 2008 he was reappointed for a further period of three years.

Liz Cross

Joining the Trust as a non executive Director in February 2010, Liz Cross is an experienced executive and non executive director who has worked in community based organizations in the UK and overseas for the past 25 years. Liz is currently Deputy Chair of Blackburne House Group in Liverpool, actively involved in many aspects of its work and development since 1992. She has been an active school Governor in Moss Side since 1988 and is a member of the advisory group for Common Purpose in Manchester. Liz had the first water assisted delivery in a Manchester hospital and raised the funds and secured the commitment to open a birthing pool suite for St Mary's Women and Children's Hospital. Liz owns and runs The Connectives, a successful social business working with private, public and voluntary sector organisations locally, nationally and internationally to improve performance and deliver better economic and social outcomes. Liz sits on the Governance and Clinical Assurance Committee.

Yvonne Rankin

Yvonne joined the Board in July 2006 for a term of three years, bringing with her a successful leadership track record, developed in the service and retail industries having spent 10 years with the Co-operative Group where she was CEO for Specialist Retail businesses. Between 2007 and 2007 Yvonne was CEO of Central and Southern Europe for A.S. Watson (Health and Beauty). In September 2007, Yvonne became CEO of the Thresher group which encompasses the Wine Rack, Thresher, Local and Haddows (Scotland) Retail Brands, with 1650 shops across the UK. She is also a Companion of the Institute of Management. Yvonne resigned from the Trust in October 2009 following a period of ill health.

Independence of Non-Executive Directors

The Board considers all of its current non-executive directors to be independent. All appointments and re-appointments are made by the Council of Governors specifically to meet the requirements set out in Monitor's 'NHS Foundation Trust Code of Governance.'

Kathryn Thomson MCIPD – Chief Executive

Kathryn joined the Trust in September 2008 from the University Hospital of South Manchester NHS Foundation Trust where she was a director for six years. During that time she supported the Trust through a major financial and performance recovery plan and subsequent achievement of foundation trust status. Kathryn has previously held key posts as a director of Operations and Human Resources in a number of Merseyside hospital trusts.

Executive Directors

David Richmond MD FRCOG – Medical Director

David became Medical Director of the Trust in September 1993 following his appointment as a Consultant to central Liverpool in 1990. During that time he has successfully steered the Trust through innumerable changes and developments, including the amalgamation of the previous hospitals into a brand new facility in Toxteth in 1995 and the subsequent merger with the Aintree Centre for Women's Health in 2000. His main interests lie in manpower planning (he currently contributes to local and national manpower working parties) and education and training. He is currently the RCOG Council representative for the north west. David is also Chair of the Trust's Clinical Governance Committee.

David Renouf BSc CPFA – Acting Director of Finance

David joined the NHS in 1984 as a Regional Financial Management Trainee and is a CIPFA qualified accountant. Having spent 18 years within the Portsmouth Health Economy in a variety of senior finance roles he moved to Liverpool Women's in 2003 where as Deputy Director of Finance he helped the Trust achieve foundation status in April 2005. He was Acting Director of Finance between February and September 2009.

Vanessa Harris BSc, ACA, MBA – Director of Finance (from 1st September 2009)

Vanessa joined the Trust in September 2009 as Director of Finance. Vanessa has held a number of senior posts in the health service and the independent sector, including previous Director of Finance posts. Vanessa has experience of leading and managing organisations through periods of change and improving financial performance.

Gail Naylor RCN, RM, MBA – Director of Nursing, Midwifery and Patient Experience (from 29th June 2009)

Gail joined the Trust in June 2009 as Director of Nursing, Midwifery and Patient Experience. She trained as a nurse in 1983 at North Manchester General Hospital and then as a midwife in 1987. She continued to work in a variety of clinical roles at North Manchester General Hospital until 1993, when she moved to Bolton Hospitals NHS Foundation Trust, where she remained until she moved to Liverpool Women's. Gail's background is in leading and managing women and children's services and she has held a variety of senior clinical leadership and managerial roles. Gail is passionate about the impact high quality care can have on women and the wider family unit.

Kim Doherty MA, MCIPD, BA (Hons) – Director of Human Resources (to 31st January 2010)

Kim has been the Director of Human Resources at the Trust since September 2003. She is accountable for the development and implementation of people management strategies which support organisational aims and effectiveness. Kim started her career as a graduate trainee in NHS Human Resources in the West Midlands where she held a number of posts. Prior to joining the Liverpool Women's Hospital NHS Trust she held the post of Head of Human Resources & Planning at Clatterbridge Centre for Oncology NHS Trust. Kim is a member of and has previously held roles within both the Chartered Institute of Personnel and Development and the Association of Healthcare Human Resource Management.

Triona Buckley MSc, BSc (Hons) – Acting Director of Human Resources (1st February to 31st March 2010)

Triona Buckley joined the NHS, as a graduate trainee in 1998. She has worked across the full range of NHS services in primary, secondary and tertiary care on a national, regional and local level, from operational management to Executive Director. Her substantive role is Head of Organisational Development at the Trust. Triona has a strong interest in how shaping and influencing the personal development of others can lead to transformational change within an organisational structure. She has a BSc (Hons) Psychology, MSc in Managing Healthcare Organisations and a Post Graduate Diploma in Leadership Mentoring and Executive Coaching. Her research interests lie in the field of organisational psychology and its application to improve services. Triona is an active mentor as part of the North West Mentorship Scheme for over seven years and has been coaching others since 2007. She is also an active member of the NHS North West Coaching Steering Group. Fundamental to any cultural change is how leaders act and behave at all levels to ensure sustainability of improvements to service, which has been the focus for her work.

Caroline Salden MBA, BA (Hons), Dip M – Director of Service Development

Caroline joined the Trust in April 2004 as its Director of Service Development. She started her NHS career in 1993 as a graduate trainee in the Mersey Region and has undertaken a range of operational and service improvement posts in both mental health and acute services in Cheshire and Merseyside and Trent. Caroline"s interests lie in operational and strategic planning as well as service improvement through people. Caroline's management experience has been supported by the attainment of an MBA (Open University) and a Diploma in Marketing and she has recently completed the North West Leadership Executive Stretch programme.

A register of interests of each member of the Board of Directors is held by Erica Saunders, Trust Secretary which is accessible to the public through the office of the Trust Secretary at the Trust headquarters, Crown Street, Liverpool. No interests were held with related parties.

Board Performance

The Board of Directors has been mindful of the importance of evaluating its effectiveness during the year and to that end has reviewed its performance in the following ways:

- **Board Effectiveness Review** – an in-depth review of the Board and its operation and processes was commissioned from Independent Audit Ltd towards the end of 2008. The resulting action plan was implemented during 2009/10. A key element of this was the third review of the Trust's Board committee structure since gaining foundation trust status, which aimed to ensure that governance corporate arrangements continue to be fit for purpose, to reflect best practice and the move towards implementation of Clinical Business Units. The review resulted in the streamlining of a number of committees and the establishment of two new assurance committees which are aimed at focussing Non-Executive input on principal clinical and business risks.

- **Non-Executive Directors** – the appraisal system for non-executive directors first agreed by the Remuneration Committee of the Council of Governors in April 2006 has continued to operate effectively during the year, providing assurance to the Council with regard to the contribution of individuals to the performance of the organisation as a whole. The Remuneration Committee reviewed the process in 2009/10 and recommended that the Senior Independent Director be appraised by the Vice Chair rather than the Chairman. This change has been put in place for the most recent appraisal round.

- **Executive Directors** – an appraisal system for executive directors, including the Trust Secretary, has been in operation during the year and a report on individuals' performance presented to the Remuneration Committee of the Board.

Board Operation and Decision-making

The Board of Directors operates to clear terms of reference which underpin the Trust's consitution and which are in turn supported by a Corporate Governance Manual that includes detailed Standing Financial Instructions and Standing Orders, a scheme of delegation and schedule of matters reserved for the Board.

It is the role of the Board to set the organisation's strategic direction in the context of an overall operational planning framework It is responsible for all key business decisions but delegates the operationalisation of these to an appropriate committee, Management Executive Board or project board.

Board Meetings and Attendance

The Board of Directors met formally eleven times during 2009/10. Attendance by directors is reported by exception below:

- April 2009 – full attendance
- May 2009 – apologies from Christine Hedley (Interim Director of Nursing & Midwifery, March to June 2009)
- June 2009 – apologies from Yvonne Rankin
- July 2009 – apologies from Yvonne Rankin
- September 2009 – apologies from Yvonne Rankin
- October 2009 – apologies from David Richmond
- November 2009 – full attendance
- December 2009 – full attendance
- January 2010 – apologies from Roy Morris
- February 2010 – full attendance
- March 2010 – apologies from Vanessa Harris and Gail Naylor

Audit Committee

The Audit Committee is chaired by Hoi Yeung; other members are David Carbery and Ann McCracken. The Committee met six times during 2009/10. Members' attendance was as follows:

- Hoi Yeung – full attendance
- David Carbery – full attendance
- Ann McCracken – three meetings (Mrs McCracken temporarily stepped down from the Committee during her tenure as Acting Chair)

The key role of the Committee is to establish the following:

- Assurance Framework is fit for purpose
- Systems for risk management identify and allow for the management of risk
- Organisation has robust governance arrangements
- Organisation has rigourously self-assessed against the Standards for Better Health
- Organisation has robust systems of financial control

The work of the Audit Committee during 2009/10 has been to review the effectiveness of the organisation in the following key areas:

- Internal Control and Risk Management
- Internal Audit
- External Audit
- Financial Reporting

In discharging its duties the Committee meets its responsibilities through self assessment and review, requesting assurances from Trust officers and directing and receiving reports from the auditors and fraud specialists. During the year the Committee have complied with 'good practice' recommended through:

- Agreement and monitoring of an annual work programme.
- Prepared an Annual Report of its activities and reviewed similar reports from other Board Sub-Committees
- Undertaken a review of the performance of internal and external service providers

Nominations Committees

The Trust has established separate Nominations Committees to oversee the appointment of executive and non-executive directors.

- The **Nominations Committee of the Council of Governors** is responsible for the appointment of non-executive directors. It is chaired by Ken Morris; other members are Leanne Bricker, Godfrey Mazhindu and Annette James. During 2009/10 the Committee was responsible for the recruitment of two new non-executive Directors and also considered the re-appointment of Ann McCracken as a non-executive director for a further 12 month period to provide short term continuity on the Board. The recommendations of the committee as to the suitability of preferred candidates were made to the Council of Governors which approved the new appointments for an initial period of three years. It also approved Mrs McCracken's re-appointment.

- The **Nominations Committee of the Board of Directors** is responsible for the appointment of executive directors. It is chaired by Ken Morris; other members are a minimum of three other non-executives and the Chief Executive as appropriate to the post under consideration. The committee met three times during 2009/10 in relation to the appointments of the Director of Finance, Director of Nursing, Midwifery and Patient Experience and the Director of Human Resources. There was full attendance at all meetings held.


NHS

Our Council of Governors

Liverpool Women's
NHS Foundation Trust

The Trust's Council of Governors was established on 1st April 2005 and has operated very effectively since that time.

The Council of Governors has continued to develop its relationship with the Board, in particular its advisory function and its level of involvement and participation in setting Trust strategy. It continues to carry out its functions as set out in the constitution with a pleasing sense of clarity and purpose and understands explicitly that this means that it does not involve itself in operational matters or decisions as these fall within the remit of the Board of Directors. The Council met formally four times during the year; details of individual attendance is contained within appendix 1 to this report.

The Council of Governors is comprised of 33 governors under the leadership of Trust Chairman Ken Morris. Angela Douglas has remained as Deputy Chairman of the Council during the year and also took on the role of 'Lead Governor' formally following discussion and approval by the full Council. All Board members have a standing invitation to attend Council of Governors meetings and the Board of Directors receives a monthly briefing from the Trust Secretary on the work of the Council and its committees as a formal agenda item at each Board meeting. The Council of Governors receives a report from the Chairman after each Board meeting, highlighting the key issues and decisions made. This process ensures that the agendas of the two bodies remain interlinked.

Public and staff members of the Council of Governors are elected by the membership. Elections are held in accordance with the rules appended to the constitution using a single transferable vote system. In 2009, seven public and two staff seats were eligible for election. All but one of the seats were uncontested; there were two candidates for the south Liverpool seat and turnout was 12%. The term of office for all Council members is three years.

During the year the Council has been actively involved in many areas of the Trust's work. Councillors have been co-opted on to a number of committees and working groups covering a variety of areas including patient quality, patient involvement and 'smoke free'. These activities are in addtion to the main areas of Council work which focus on advising the Board on its strategic and operational planning intentions and holding it to account for its performance.

During 2009/10 the Council gave some focus to its own development needs and designed and commissioned a programme from the Office of Public Management which was aimed at meeting the requirements of both new and existing governors. An initial workshop was held in November 2009 and a range of activities are being developed as a consequence, including a joint 'time out' session with the Board of Directors and some more informal development sessions relating to specific issues, for example small group work on the draft Operational Plan for 2010/11. The governors are also developing a 'buddy' system that links up pairs of governors for mutual support.

The formal sub-committees of the Council of Governors have continued to operate during the year:

- The **Membership Strategy Committee** has been proactive in taking forward the Trust's Membership Strategy and was responsible for organising the successful Trust Open Day and Annual Members' meeting held in September 2009. This event was attended by around 700 people and focused on the theme of the Trust's leading edge research portfolio. The Committee also held two roadshows in outlying parts of the patch during the year to showcase the Trust's services, hihglight the role of governors and encourage debate and feedback.

- The **Nominations Committee** was responsible for the appointment of two new non-executive directors, Liz Cross and Pauleen Lane in January 2009. An Executive Recruitment Agency was used to support this work. The recommendation of the Committee to make the appointments was approved by the full Council of Governors at its meeting in January 2010.

- The **Remuneration Committee** has continued its work to review the appraisals of non-executive directors and satisfy the Council of Governors that levels of time commitment and performance are acceptable.

- The **Corporate Social Responsibility Committee** gave its support to the Liverpool-Mulago Partnership an initiative established by Dr Andrew Weeks, one of the Trust's consultant Obstetricians to provide resources and expertise to the Mulago Hospital in Kampala, Uganda. The Mulago Hospital is the largest maternity unit in Africa providing 33,000 deliveries each year. The Board and Council of Governors agreed to match funding from an NHS North West Leadership Academy bursary to enable a formal twinning programme to be set up by the partnership. The Liverpool Mulago Partnership was formally established as a charity in 2009/10 and a programme of exchange visits is underway.

Composition of the Council of Governors

PUBLIC GOVERNORS 18 ELECTED SEATS

Central Liverpool
Morag Day (re-elected 2009)
Betty Stopforth
Maggi Williams
Anees Paracha
Annette James
Dorothy Zack Williams (elected 2009)

North Liverpool
Angela Parker
Barbara Kerr (elected 2009)

South Liverpool
Janine Wooldridge
Mary McDonald (elected 2009)

Sefton
Patricia Jones (re-elected 2009)
Maureen Kelly Geoff McKeating

Knowsley
Ronnie Kehoe
Anne Smith

Rest of England & Wales
Anna Banks
Patricia Jones (elected 2009)
One vacant seat from September 2009

STAFF GOVERNORS 6 ELECTED SEATS
Doctors – Leanne Bricker
Nurses – Dianne Brown
Midwives – Jane Rooney (elected 2009)
Scientists & Technical staff – Angela Douglas
Non-clinical staff – Denise Carter & Catherine O'Keeffe (elected 2009)

PCT GOVERNORS 3 APPOINTED SEATS
Dr Janet Atherton, Director of Public Health, Sefton PCT (resigned September 2009)
Dr Paula Grey, Director of Public Health, Liverpool PCT One vacant seat

LOCAL AUTHORITY GOVERNORS 2 APPOINTED SEATS
Councillor Jane Aston, Knowsley Borough Council
Councillor Marilyn Fielding, Liverpool City Council

UNIVERSITY OF LIVERPOOL 1 APPOINTED SEAT
Professor Susan Wray

COMMUNITY/VOLUNTARY/ OTHER PARTNERSHIP ORGANISATIONS 3 APPOINTED SEATS
Professor Godfrey Mazhindu, Liverpool John Moores University
Margaret Hogan, Down's Syndrome Liverpool
One vacant seat

A register of interests of each member of the Council of Governors is held by the Trust Secretary which is accessible to the public through the office of the Trust Secretary at the Trust headquarters, Crown Street, Liverpool.


NEW BORN
APPEAL OFFICE

Our Membership

It is important to us that membership is relevant to all sections of the greater Liverpool community and we continue to make every effort to reach all groups within our membership constituencies. We seek to ensure that our membership reflects the social and cultural mix of the Liverpool conurbation.

We also need to ensure that our Council of Governors reflects our membership and we aim to address this challenge by encouraging a large, genuine membership from all parts the community served by the Trust.

The membership community of Liverpool Women's NHS Foundation Trust is drawn from our public and staff constituencies which are defined follows:

Constituency type	Sub-constituencies	Rationale and eligibility
Public	• Central Liverpool • North Liverpool • South Liverpool • Knowsley • Sefton • England & Wales Defined by local authority electoral boundaries	60% of our activity is derived from within Liverpool. A further 31% comes from the boroughs of Knowsley and Sefton. The remaining 9% of activity relates to our specialist services and can bring in patients from across the country. Membership is open to any member of the public over the age of 12 who live within any of the local authority areas described.
Staff	• Doctors Nurses • Midwives • Scientists, Technicians & Allied Health Professionals • Administrative, Clerical & Managerial staff • Clinical Support & Ancillary/Maintenance staff	Our staff constituency is defined by those who have a permanent employment contract or who have worked for the trust for at least 12 months. Staff who are employed by contractors to the trust or who are based at the trust but employed by another NHS organisation are also eligible for membership.

Liverpool Women's NHS Foundation Trust

Membership Strategy

The Trust's Membership Strategy is led by a committee of the Council of Governors called the Membership Strategy Committee. This group has been very active during the year and has continued to refine its approach to how the Trust should develop as a membership organisation in the context of our population and the profile of our members.

The Committee is chaired very effectively by Janine Wooldridge, a public governor representing south Liverpool. During 2009/10 the Committee's workplan focused on two key areas, recruitment and engagement. A successful membership recruitment campaign was undertaken during the year focusing on the agreed target groups: younger people and members of black and minority ethnic communities.

The Committee was keen to build on the consistent enthusiasm that the local community and membership has shown for engaging with the Trust via the last three Annual Members' meetings and Open Days. The 2009 event was held on Saturday 12th September and once more proved very successful, with around 700 people coming in to the hospital, creating a warm and family oriented atmosphere. Another particularly successful event was held in Hale Village in January, when around 30 members joined with members of the Council of Governors to discuss women's health issues following interactive talks given by the governors themselves.

The main communication method with members has continued to be via the Trust newspaper which was re-launched during 2009/10 as 'Generations' to better reflect the organisation's brand and values.

The Committee plans to maintain its broad focus during 2010/11 on the principles of the membership strategy set out below.

Building and sustaining a representative membership

Liverpool Women's NHS Foundation Trust primarily serves local residents in Liverpool, Sefton and Knowsley. Our ongoing focus needs to be on continuing to build and engage with the membership community from these areas. Given the socio-economic structure of the local area, an additional challenge is presented by the need to ensure that under-represented populations, such as young people, black and ethnic minority groups and those from more disadvantaged backgrounds, are approached and included.

Public Membership targets

The public section of the membership community should include as diverse a range as possible and be representative of the local area. The following specific cohorts were our focus during 2009/10:

- 16 – 29 year olds: this is almost the most difficult cohort with which to engage and remain in contact as many are extremely mobile. ONS statistics for Liverpool indicate that people of this age comprise approximately 23% of the local population.
- Black and Minority Ethnic Groups: again, according to population data, Asian, Black, Chinese and other ethnic groups make up 5.7% of the local population. Again, we seek to ensure that the public constituency is comprised of a similar percentage.
- Men: whilst the services provided by the Trust are primarily aimed at women, it is critical to ensure that men are also active members of the Foundation Trust community. Therefore, we will seek to attain a balance of 85% women and 15% men.
- Social class: there is a social class correlation with regard to community engagement, which in turn correlates with health disadvantage. This makes it particularly important that we ensure that the Trust membership properly reflects the socio-economic strata of the local area.

Membership Profile

Constituency	Public	Staff	Total
Number at year start (1st April 2009)	7,971	1,287	9,258
Number at year end (31st March 2010)	10,864	1,646	12,510

In terms of our diversity targets we have maintained around 20% of members aged between 16 and 29. The number of members from black and minority ethnic communities increased as a result of the recruitment campaign so that by year end it was 5.4% which is closer to target than previous years (17% of our members have opted not to disclose their ethnicity). Our gender balance has altered slightly with men increasing to 20% of our membership from 16% last year.

Geographically, membership in our public constituencies is broadly reflective of our activity profile, although there has been considerable growth in members residing outside of the main North Mersey area:

- 58% of our members are resident in Liverpool
- 11% of our members are resident in Knowsley
- 13% of our members are resident in Sefton
- 18% of our members are from other parts of England and Wales

In the coming year therefore we will aim to recruit and retain members from our target areas and maintain an overall total of 12,500.

Members can contact governors and directors by the following routes:

In writing care of the Foundation Trust Team, Liverpool Women's NHS Foundation Trust, Crown Street, Liverpool L8 7SS

By telephone on 0800 073 0825 (FREE)

By email at yourviews.LWH@nhs.net

Public Interest Disclosures

Valuing our staff

Valuing the skills, contribution and motivation of our staff is absolutely central to ensuring that the Trust achieves our vision of being the leader in healthcare for women, babies and their families. Our commitment to equality and human rights is part of our approach to valuing staff with appropriate skills and expertise irrespective of their background, disability, gender, age, sexual orientation or religious belief.

Equal opportunities for staff

Part of our commitment to valuing staff is taking action on specific areas where we have identified that improvement in our approach is required. Our focus for 2009/10 was in the area of disability where we targeted recruitment, continuing employment and arranging for appropriate training for those who become disabled and the career development and promotion of disabled employees.

Recruitment of staff with a disability

The Trust is signed up to the 'Two Ticks Symbol' which is a quality symbol providing assurance to individuals with a disability that we welcome applications from all individuals with or without a disability.

In the financial year, 155 applicants (3% of all applications) declared a disability in their application, 37 of this group were shortlisted (3.7% of all shortlisted applications) with one candidate appointed (0.5% of all appointments in the period).

Career development and promotion of staff with a disability

The Staff Survey identified that this was an area which requires further investigation and action to ensure that staff with a disability have the same level of access to career development and promotion.

Reasonable adjustments for staff with a disability

The Trust's policy on the management of sickness absence provides for adjustments to be made to enable employees becoming disabled to remain in the Trust's employment and the Trust's Disability Adviser Midwife is available to provide advice and support in individual cases.

Single Equality Scheme

The Single Equality Scheme for 2007–10 was completed with two outstanding actions which will be resolved following implementation of recommendations from the Physical Access Audit. The coming year will see a revision of the Single Equality Scheme to include the impact of the 2010 Equality Act and ensure that the Trust continues to fulfil its duties and commitments outlined within that.

Recognising and Rewarding Excellence

The Trust held its fifth annual 'Focussing on Excellence' Awards in 2009/10 which are aimed at celebrating and rewarding staff to deliver clinical and non-clinical improvements to achieve excellence for women, babies and their families. This year the number of categories were expanded and the judging criteria included the extent to which teams or individuals demonstrated the Trust values in action. These categories were:

- Excellence in Clinical innovation
- Excellence in Non clinical innovation
- Excellence in Team working
- Excellence in Staff/patient care
- Excellence in Patient experience
- Excellence in Leadership

The overall Foundation Award was presented to the Gynaecology – oncology team for their "Home Away from Home project" working in partnership with The King's Fund and Marie Curie Cancer Care to create a palliative care suite on the hospital site delivering the best possible environment for terminally ill patients and their families.

Health and well-being of the workforce

The staff sickness absence rate within the organisation fell from 5.53% to 5.18% during 2009/10. The focus in the coming year will be to concentrate on the top three reasons for absence across each Clinical Business Unit and provide support and interventions to staff to prevent or reduce the impact of those reasons on overall staff health and well-being. Our target is to have sickness absence rate of no more then 4.5% by 2011.

The Trust is required to include the sickness data reported to the Cabinet Office which for 2009/10 was:

Total Number of fte days lost to sickness	Total number of fte years available	Average number of days sickness absence per full time equivalent
14,418	1,258	11.5

Listening to staff

The national Staff Survey is a core tool for the Trust to engage consistently with staff each year to identify what is important to them and work to address identified issues. The Trust has opted for a full survey for all staff employed by the organisation to be able to feedback their views and perceptions on what it is like to work at Liverpool Women's NHS Foundation Trust.

Major efforts have been made over the last two years to increase the survey response, with a partnership approach with the local full-time staff side representatives to encourage returns.

In both 2008 and 2009 the Trust undertook a full survey, achieving 63% overall returns in 2008 and 54% in 2009. Locally, Clinical Business Units developed action plans arising from the survey results using focus groups with staff to further inform these plans. Pre and post communication of the survey results and of the actions put in place as a result of these were disseminated across the organisation.

Summary of performance – NHS staff survey 2009

Response rates

Some Clinical Business Units improved their response rates, with a significant drop in one Clinical Business Unit which led to an overall response rate reduction from 2008. Analysis of the factors which may have influenced the drop in response rates have identified the following issues:

- significant organisational structural change due to the establishment of Clinical Business Units (CBUs) as a new way of working
- considerable level of managerial change at CBU management level
- lack of confidence of staff in whether staff views would really make a difference

The top 4 ranking scores were:

	Trust (%)	Average (%)
Lower numbers than average of staff suffering work-related injury	10	13
Lower numbers than average of staff working extra hours	62	67
Lower numbers than average of staff experiencing physical violence from patients/relatives	3	4
Lower numbers than average of staff witnessing potentially harmful errors, near misses or incidents	29	34

The bottom 4 ranking scores were:

	Trust (%)	Average (%)
Staff motivation at work	3.67	3.86
Staff job satisfaction	3.41	3.55
Trust commitment to work-life balance	3.33	3.52
Staff recommending Trust as a place to work or receive treatment	3.50	3.89

There were no areas of improvement from 2008

Four key findings deteriorated from 2008

	2008 (%)	2009 (%)
Staff agreeing that they have an interesting job	84	76
Staff using flexible working options	77	70
Support from immediate managers	3.66	3.52
Staff receiving health and safety training	82	73

In addition to the core questionnaire, the Trust included local questions around the visibility of senior managers (Executive team), profile of the partnership forum and bullying in the 2009 survey. The responses to these questions will form the baseline for future year's regarding the impact of the various interventions to tackle some of the issues identified by staff. The responses were:

- Over 20% felt differently about their work following the introduction of the Executive Director visibility programme
- Over 20% saw the partnership forum and staff representation as a means for engagement
- 50% recognised the efforts made by the Trust to address bullying and harassment issues, with 40% feeling that this was beginning to impact positively on behaviours

Future priorities and targets

The key priorities for the Trust for 2010/11 are:

- Specific focus on internal communication within the Trust to improve overall perception of the positive achievements of staff within the Trust on a more regular basis
- Increase the levels and perception of staff involvement in delivering services to women and their families
- Targeted development and support to managers in leadership and management development
- Improving equity of access to learning and development opportunities for staff
- Ensuring all staff have the opportunity to have a Performance Development Review each year which demonstrates the difference they make to patient care
- Improving the Health and Wellbeing of staff across the Trust

Performance management and monitoring of progress against these priorities will be taken through the performance management framework for the Trust.

Our Workforce

The Trust continues to focus on how it respects and values the diversity of staff providing a service that is truly reflective of the backgrounds and cultural and other needs of the populations that we serve. The Single Equality Scheme is the key mechanism to ensure that all aspects of Equality and Human Rights are considered in both the workforce and the services we provide. Progress against the Single Equality Scheme is monitored through the Equality and Diversity Taskforce.

The Executive Director responsible for Equality and Diversity is the Director of Human Resources. All relevant documentation in relation to Equality and Diversity is publically available through the Trust's website http://www.lwh.me.uk

A detailed breakdown of the overall profile of our workforce can be found in the tables below.

Workforce Monitoring Profile Analysis

Ethnicity

The Trust's workforce broadly reflects the local demographics for this area and where the reported ethnicity of staff is predominantly White-British. Asian and Black employees represent less than 5% of the workforce.

Ethnic origin	Total - Population	Total - Membership	Total – Staff
White - British	94.30%	75.72%	88.88%
White - other than British	2.03%	1.47%	3.36%
Mixed ethnicity	1.26%	0.76%	0.84%
Asian	0.73%	1.11%	3.15%
Black	0.73%	1.69%	1.47%
Chinese	0.71%	0.38%	0.14%
Other ethnic group	0.24%	1.51%	0.70%
not stated	0.00%	17.43%	1.47%

The total population used for this sample is that of the five key constituencies that Liverpool Women's serves (North, South and Central Liverpool, Sefton and Knowsley). Based on this data we as a Trust need to focus on how we may seek to increase the representativeness of our Chinese community.

Age

Almost 30% of our staff are over 50 years of age which reflects the significant levels of experience of our staff in delivering a specialised service for women, babies and their families. This is also an issue which will require focus over the forthcoming years to ensure an accelerated level of skill and expertise in members of staff who will not be due to retire in the next 5 to 10 years.

Age Group - Population	Total - Population	Total - Membership	Total – Staff
Under 30	39.51%	17.39%	15.73%
Over 30	26.28%	27.66%	54.90%
Over 50	17.70%	17.27%	28.04%
Over 65	22.05%	15.76%	1.33%

Disability

Fair and equitable support of staff who may have a disability is a key area of focus for the organisation.

Disability	Total
Yes	0.49%
No	21.19%
Not declared	1.68%
Not known*	76.64%
Total	**100.00%**

Currently less then 0.5% of staff are recorded on our Electronic Staff Record system as having a disability, however 15% staff responding to the national staff survey identified themselves as having some form of disability. Understanding the differences between these figures and what the accurate figure is will be a priority issue to focus on for 2010/11. Specific areas of focus for 2009 on the issue of disability are detailed further on in this document.

Gender

Over 90% of our staff are female, which reflects not only of the main groups within the Trust but also the specialist focus on women's services will serve to attract a higher proportion of female staff.

Gender	Total - Population	Total - Membership	Total – Staff
Female	51.79%	79.61%	90.42%
Male	48.21%	19.84%	9.58%
Transgender	Not known	Not collected	Currently not recorded

Focus for the following year will be to understand whether this proportion of female to male is consistent across staff groups and pay bands and take appropriate action where necessary to address any identified issues. It will also be important to gain an understanding of what proportion of our workforce have direct caring responsibilities in order to ensure that working policies and practices can best facilitate these responsbilities.

Sexual orientation

The vast majority of the workforce records do not detail sexual orientation as this has not been systematically captured on appointment until 2008. 25% of staff where the data is recorded identify as heterosexual, with just over 1% identifying as gay or lesbian.

Sexual orientation	Total
Gay	0.07%
Heterosexual	25.17%
Lesbian	0.07%
Declined to disclose	5.59%
Not known*	69.09%

Religious belief

Religious belief	Total
Atheism	2.05%
Buddhism	0.11%
Christianity	18.92%
Hinduism	0.28%
Islam	0.06%
Judaism	0.17%
Other	3.44%
Declined to disclose	9.88%
Not known*	65.09%

The Trust recognises the importance of ensuring that the demographic data currently available through the Electronic Staff Record system requires updating to reflect the broad diversity of the workforce across all groupings. A more comprehensive data system will inform where potential risks for direct or indirect discrimination may occur across all of the equality groupings, especially disability, sexual orientation and religious belief groupings as we have identified gaps within the existing data.

In 2010 we plan to consult with staff as to options regarding the best way forward to capture what many may view as sensitive data and provide appropriate levels of assurance regarding the benefits to staff of having this level of detailed confidential data. Definitive plans on the implementation of manager and employee self-service are not in place currently, but these would provide a clear solution to addressing this issue.

Volunteers

The Volunteer Service has increased its participants from 70 to 120 during 2009/10, with an average of nine Volunteers helping every day. The service continues to grow as more efficient processes are developed; the website is regularly updated to ensure that answers to frequently asked questions are accessible at any time. An online form is used so that people can express their interest in volunteering when it's convenient. We have on average 50 requests per month.

All Volunteers are supported by a full induction programme and training opportunities. The time taken to conduct local and general induction has been reduced from 1 hour for each individual, to only 2 hours for a group of 6 people.

The group session is not only an efficient use of time, but helps Volunteers to get to know each other in a relaxed environment.
New Volunteers are given a Volunteer Buddy for their first shift, helping Volunteers to become more confident in their role, familiar in their surroundings and some even form friendships which develop outside the Trust.

The total number of recorded hours of voluntary work coordinated by the Volunteer Services Manager this year is 5932, an increase of 4770 since 2008/09. This figure is for the Trust's Volunteer Scheme only and excludes the independent organisations, such as League of Friends who run the tea bars.

Throughout the year the volunteers have supported: the Trust's Open Day, Women's Health Evening, Domestic Abuse Drop-in Clinic launch, Christmas Fair, carol singing, patient feedback Camper Van experience, book sales, Macmillan coffee day, New Born appeal raffle, bric-a-brac sale, the Home Office Volunteer Event, Patient Environment Assessment Team Inspection, Liverpool Mulago Partnership fundraising and the Patient Involvement Day.

Volunteers regularly participate in Trust group/meetings, including - Patient Information Groups, Chaplaincy Meetings, Staff Prayer Meeting, and EVOC – Gynaecology Cancer Support Group.

Volunteers assist with the recruitment session for new Volunteers, by providing a brief talk on their own experience. Staff also come along and talk about the role of the Volunteer and give examples of when Volunteers have helped patients.

This year we have had one Volunteer achieve an NVQ Level 2 in Business Administration and 10 Volunteers have been offered places at University to study Midwifery or Nursing. Two Volunteers have been successful at securing jobs as Healthcare Assistants within the Trust, and many have gained employment within the private sector, using the Volunteer Service for a reference.

The Volunteer Service has teamed up with Nextstep who offer support with application forms, interview skills and related activities. Sessions have been set up to help Volunteers who are applying for University, Access Courses and jobs within the NHS.

During November 2009 we conducted a survey on the Volunteer Service and asked Patients, Staff and Volunteers what they thought about the service. We discovered that some patients couldn't identify the Volunteers amongst staff, and Volunteers thought the uniform wasn't practical. We are now in the process of introducing new uniforms for the volunteers. The uniform will be in the Trust's brand colours, will be more practical, and will clearly identify Volunteers to patients and staff by having 'Volunteer' embroidered onto the uniform.

The survey also identified what the patients thought about the Volunteers:

- 85% said they feel better knowing that the Volunteers care enough to give their time to help them
- 45% said Volunteers made their visit to the hospital a more enjoyable experience
- 30% said their mental & emotional health had increased because of Volunteers

The Volunteer Service not only enhances the patient experience, but it contributes towards the well-being of our local community. The Volunteers said that by being given the opportunity to become a Volunteer, we help them to overcome personal barriers; increase confidence, improve social skills, a sense of achievement and a feeling of belonging.

Health and Safety

The Health and Safety department is committed to provide a safe and secure environment for staff, patients and others and delivering a quality service at every level of the organisation.

The work to continually improve health, safety and security performance throughout the Trust has been achieved through systematic review and revision of the Risk Register reducing risks accordingly. This involves carrying out risk assessments; auditing; action planning and ongoing monitoring and review of incidents and trends, ensuring risks are addressed effectively and escalated appropriately.

In an aim to reduce the number of sharps and needle stick injuries throughout the Trust a 'sharps awareness' campaign was developed and a working party was set up with the aim to review, evaluate and implement needle free/safe devices. Over the last 12 months the Trust has trialled, standardised and implemented a significant number of needle free and safe devices which has in turn significantly reduced the number of incidents of this type.

Violence and aggression and Lone workers

The Health and Safety department is also working towards implementing more robust procedures and systems to better protect staff from violence and aggression, especially lone workers. A lone worker protection system has been implemented to help protect staff who work alone in the community. Community midwives/nurses and, genetic counsellors have lone worker devices to summon police assistance if they are subjected to verbal/physical abuse or feel under duress.

Security Management

The Local Security Management Specialist (LSMS) who is also the Health and Safety Manager continues to develop both proactive and reactive initiatives with in the Trust in relation to security management work across a range of areas. The overall objective of the LSMS is to work on behalf of the Trust to deliver an environment that is safe and secure so that the highest standards of clinical care can be made available to patients. The LSMS provides a comprehensive and professional security management service for the Trust working towards the creation of the Trust's pro-security culture.

In line with best practice security principles, the Trust undertook a comprehensive security risk assessment of Trust premises, assets and people. This resulted in an extensive action plan being developed, which continues to be progressed and monitored through the Health and Safety Committee.

Stress Audit

In relation work related stress, a Trust wide stress audit was a carried to ascertain the Trust's performance against the Health and Safety Executive's stress management standards. The aim of the audit was to provide a broad indication on how staff rate the Trust's performance in managing risks associated with work related stress. The report identified Trust and departmental recommendations. This will be used in conjunction with the results of the national staff survey to further improve Trust performance in reducing sickness and absence due to work related stress.

Zero Tolerance and Conflict Resolution

The Health and Safety department is working towards implementing more robust procedures and systems to better protect staff from violence and aggression, especially lone workers. A lone worker business case has been developed and has been submitted to the NHS Security Management Services to apply for funding for lone worker devices to help protect staff who work alone in the community and within the Trust premises from violence and aggression. The funding is due to be released in April 2010. In the interim period the Trust has also implemented a buddy system to ensure that all staff are home safe after their shift has finished.

The Trust has funded six members of staff to complete a "train the trainer" conflict resolution training course. Subsequently, a comprehensive training programme was put in place with the aim to train all frontline staff by the end of March 2009 with all remaining staff being given the opportunity to attend when this is complete. The purpose being to ensure all staff are facilitated with the knowledge and skills to address any situation of conflict they may encounter while working for the Trust.

Counter Fraud Activities

The Trust obtains effective support in this area from the NHS Counter Fraud and Security Management Service with local counter fraud specialists being part of our internal audit service. The Trust's policies are set out in our Standing Financial Instructions and we also operate a 'Raising Concerns' policy via our Senior Independent Director.

Creditors' Payment Policy

It is the policy of the Trust to settle all expenses on a timely basis in the ordinary course of business. It is the Trust's policy to agree appropriate terms and conditions in advance with its suppliers and to make payment in accordance with those terms and conditions, provided the supplier has complied with them.

Working with our partners

The Trust is actively working with a number of local partners to support people from the local area who may be struggling to find employment. 28 people have been supported to gain essential skills and experience by working within the Trust for six month placements as part of the Future Jobs Fund. We also regularly support individuals in short term placements as part of the Ambition Health programme and have an active and successful volunteers programme. Plans for the future are to continue this focus on local jobs for local people and build on the work to date.


Liverpool Women's
Disabled
Parking Only
WARNING

Remuneration Report

The Remuneration Committee of the Board of Directors is chaired by the Trust Chairman (Ken Morris) and comprises all non-executive directors: David Carbery, Hoi Yeung, Roy Morris, Ann McCracken and Liz Cross. This Committee is responsible for determining the remuneration and terms and conditions of the Chief Executive, Executive Directors and Trust Secretary, taking into account the results of the annual appraisal process. The Chairman undertakes the annual appraisal of the Chief Executive; who in turn is responsible for assessing the performance of the Executive Directors and Trust Secretary. The Committee met twice during 2009/10 with three out of four and all four non-executives were in attendance on these occasions.

The Remuneration Committee of the Council of Governors comprises three public, one staff and one appointed members. This Committee is responsible for determining the remuneration of the Chairman and Non Executive Directors, taking into account the results of the annual appraisal process. The Committee met twice during 2009/10 with three out of five and all five members in attendance with the second meeting of the year convened specifically to consider the remuneration for the acting chair. The Trust Chairman is responsible for assessing the performance of the non-executive directors. The Chairman's appraisal is undertaken by the Remuneration Committee in accordance with their policy which has been developed to reflect best practice nationally.

Executive Directors and the Chief Executive are employed on permanent contracts of employment, subject to three months notice on either side.

Rates of pay for all senior managers are based on job size, market intelligence (including published remuneration surveys) and performance and have regard for remuneration of other trust employees whom hold contracts under terms and conditions agreed nationally. Chief Executive and Executive Director remuneration packages comprise annual basic salary and normal NHS pension contributions plus a non-consolidated performance related payment as agreed by the Remuneration Committee of up to 5% of basic salary, based on the Trust's performance in Healthcare Commission ratings and achievement of individual and team objectives.

For non-executive directors comparative data was provided to the Remuneration Committee from other Foundation Trusts, mutual organisations and the private sector. The remuneration and retirement benefits of all directors are set out within notes 3.4 and 3.5 of the annual accounts Accounting policies for pensions and other retirement benefits are set out in note 3.1.

Signed

Kathryn Thomson

Kathryn Thomson
Chief Executive
4th June 2010

Statement as to disclosure to auditors

The directors who were in office as at 4th June 20109 confirm that:

- as far as they are aware there is no relevant audit information of which the auditors are unaware and
- the directors have taken all of the steps that they ought to have taken as directors in order to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

Signed

Kathryn Thomson

Kathryn Thomson
Chief Executive
4th June 2010

Statement of Accounting Officer's responsibilities as the accounting officer of Liverpool Women's NHS Foundation Trust

The National Health Service Act 2006 (The Act) states that the Chief Executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of accounting officers including their responsibility for the propriety and regularity of public finances for which they are answerable and for the keeping of proper accounts are set out in the accounting officers' Memorandum issued by the Independent Regulator of NHS Foundation Trusts ('Monitor').

Under The Act, Monitor has directed the Liverpool Women's NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Liverpool Women's NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts the Accounting Officer is required to comply with the requirements of the NHS foundation trust Financial Reporting Manual and in particular to:

- Observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the NHS foundation trust Financial Reporting Manual have been followed, and disclose and explain any material departures in the financial statements; and
- Prepare the financial statements on a going concern basis

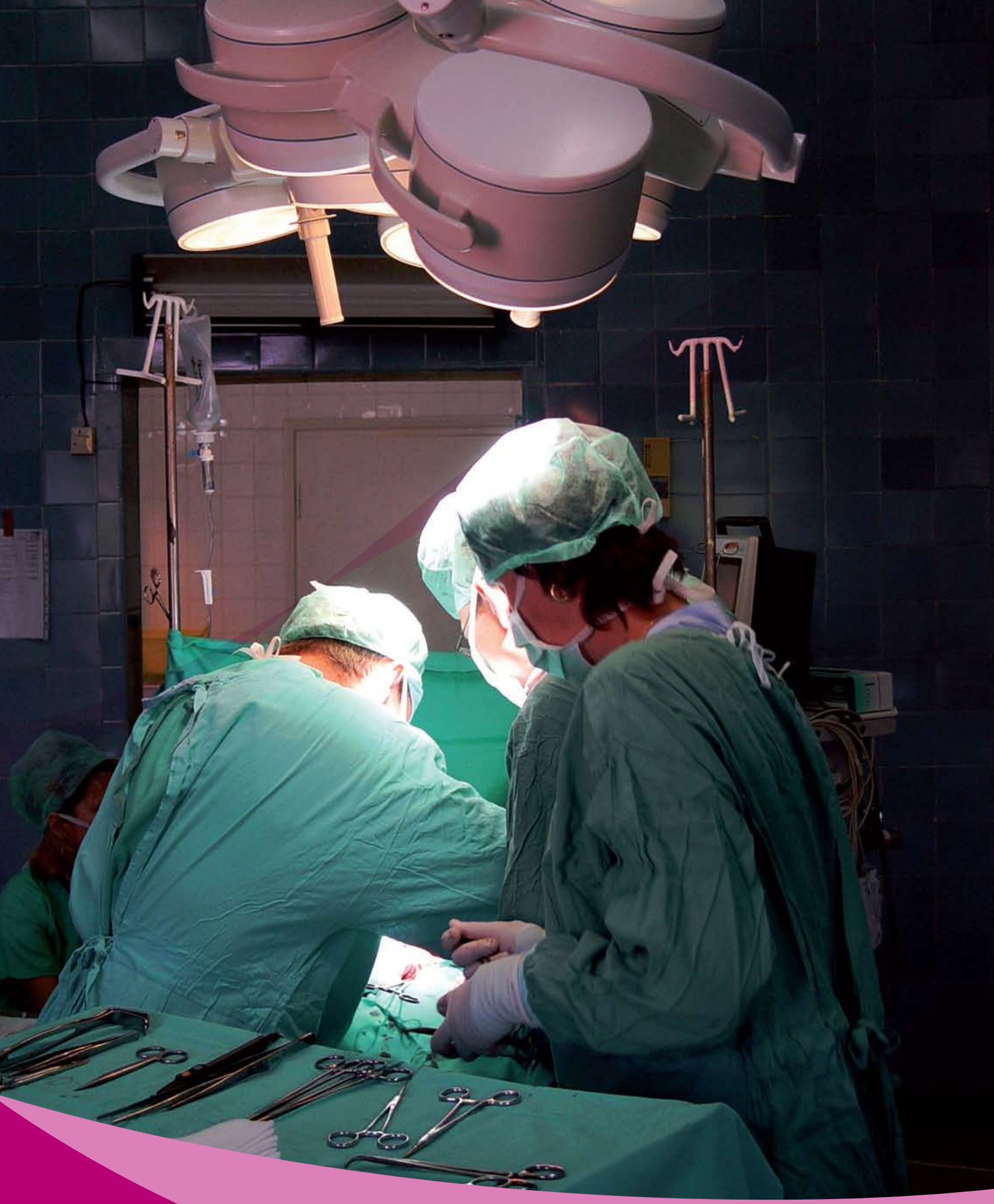
The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The accounting officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief I have properly discharged the responsibilities set out in Monitor's *NHS Foundation Trust Accounting Officer Memorandum*.

Signed

Kathryn Thomson

Kathryn Thomson
Chief Executive
4th June 2010



Statement on Internal Control

Scope of responsibility

As Accounting Officer and Chief Executive, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to:

- identify and prioritise the risks to the achievement of the policies, aims and objectives of Liverpool Women's NHS Foundation Trust;
- evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically

The system of internal control has been in place at Liverpool Women's NHS Foundation Trust for the year ended 31st March 2010 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Trust's Risk Management Strategy sets out the responsibility and role of the Chief Executive in relation to risk management. During the year 2009/10, delegated responsibility operated through the Clinical Governance Committee and via two newly established board assurance committees, to the Board of Directors, which together provide the Trust with a formal structure for addressing risk at the corporate level, embracing strategic risk issues, implementation of the Care Quality Commission's Essential Standards of Quality and Safety, the Board Assurance Framework and key risk performance indicators. The Trust's committee structure is based upon principles of integrated governance and is designed to better support the Trust's operation as an NHS Foundation Trust.

The Trust's Corporate Risk Committee, which is chaired by the Chief Executive and is attended by all Executive Directors, Clinical Business Unit General Managers and Heads of Corporate Departments underpins the corporate arrangements by undertaking the following functions:

- Ensure that appropriate arrangements exist within the Trust for the effective management of risk and that strategies and policies pertaining to the management of risk are effectively implemented.
- Review the Trust's Risk Management Strategy on an annual basis.
- Review corporate and clinical risks as they may impact upon achievement of the Trust's strategic objectives, ensuring appropriate mitigation plans are in place.
- Co-ordinate and prioritise risk management issues across the Trust, using the Trust Framework for the grading of risks, and assign responsibility to appropriate individuals or sub-groups to address these priorities.

- Ensure the maintenance of a comprehensive risk register and the inclusion of prioritised risk issues.
- In conjunction with other Board committees and sub-committees, monitor the risk register and review the progress of action plans to reduce risk, recommending remedial action where appropriate.
- Develop an annual management plan for the control, reduction and removal of significant and priority risk issues and produce a quarterly report to the Board on progress against the plan.
- Produce an annual risk management report for submission to the Board and for circulation across the Trust and to relevant stakeholders.
- Define and develop key indicators capable of showing improvements in the management of risk
- Provide information to the Board to enable it to focus on key prioritized risks, adequacy of controls and action required
- Ensure that standards and procedures relating to risk are embedded throughout the organization
- Monitor compliance with legal, statutory and other regulatory requirements related to risk management

The Trust built upon and developed its Board Assurance Framework during 2009/10, contributing towards the achievement of an overall category 'A' rating defined as "An Assurance Framework has been established which is designed and operating to meet the requirements of the SIC and provide reasonable assurance that there is an effective system of internal control to manage the principal risks identified by the organisation." The Director of Internal Audit Opinion for the year rated the Trust as having 'significant assurance' as did a review of assurances carried out by the Trust's internal auditors.

The NHS Counter Fraud and Security Management Service reported in October 2009 its Compound Indicator Assessment. This assessed the Trust for 2008/09 at Level 2 "Adequate Performance" maintaining the position reported for 2007/08. The Compound Indicator Assessment is used to inform decisions as to the investment in the Counter Fraud Plan which is monitored through the Trust Audit Committee.

Ward, departmental and directorate risk registers have been in place for the full year and continue to be promulgated by robust systems for ensuring effective management of operational risks across all areas of the organisation. Significant work was undertaken during the year on the development of the operational risk register, to ensure that risks are being identified, scored and treated in a consistent and systematic way throughout the Trust.

There is an escalation process whereby risks that cannot be managed locally are reviewed at the appropriate level within the organisation to ensure that reasonable measures are taken. This is a continuous process that assists with the development of an organisation-wide risk-aware culture, sharing of lessons learned and enables risk management decision making to occur as near as practicable to the risk source.

In 2007/08 the Trust was successful in gaining re-accreditation at CNST Level 3 for maternity standards and in securing Level 3 against the more broadly based general NHS Litigation Authority standards which replaced the CNST general scheme. These are the highest possible levels of accreditation for risk management nationally and continued to be in place throughout 2009/10.

Risk management, risk assessment and incident reporting is included in core induction and within the Trust's mandatory training programme. This approach will be continued during 2009/10 with specific emphasis on maintaining the exceptional standards of training required for CNST/NHSLA level 3 across all staff groups.

The risk and control framework

The risk management framework is set out in the Risk Management Strategy and is underpinned by the policies and procedures for risk management, which have been approved by the Board of Directors.

The key elements of the strategy include:

- A statement of the purpose of the strategy document
- A definition of risk management
- The Trust's policy statement and organisational philosophy in relation to risk management as an integral part of our corporate objectives, goals and management systems
- Strategic vision for risk management across the organisation
- Acceptable levels of risk and the levels of delegated authority to act
- Roles, responsibilities and accountabilities
- The risk management process, including risk identification, risk assessment and risk treatment
- Governance structures in place to support risk management, including terms of reference
- Planning, resourcing and prioritisation
- Implementation plan

The Board Assurance Framework, which focuses on identifying the principal risks at corporate level has been embedded within the foundation trust and is regularly reviewed and updated. The Assurance Framework has been reviewed by the Board in full twice during the year and in addition the priority risks identified by the Board have been reported on a monthly basis via the corporate performance and assurance report. The Board Assurance Framework covers the following:

- Corporate objectives and goals
- Identification of the principal risks to the achievement of objectives and goals, mapped to the relevant Standards for Better Health
- Identification and description of mechanisms of internal control in place to manage the risks Identification and description of the review and assurance mechanisms which relate to the effectiveness of the system of internal control
- Records the actions taken by the Trust to address control and assurance gaps, with progress and actual assurances identified through the year, linked to the Trust's risk scoring matrix.

During 2009/10 the Trust had no serious untoward incidents involving data and was re-accredited for ISO 27001 "Information Security Management" a standard which seeks to help establish and maintain an effective information management system. The Director of Nursing Midwifery and Patient Experience continues to lead on information governance issues at Board Level and is supported in this role through the Information Governance sub committee which in turn reports to the Governance and Clinical Assurance Commitee.

In 2008/09 the Trust reviewed its approach to the process for providing assurance in relation to the Healthcare Commission's Standards for Better Health. This was in response to the new approach being taken by the Healthcare Commission in ensuring that the standards are consistently applied throughout the year and embedded across the organisation. On completion of this programme of scrutiny, the Trust was unable to fully satisfy the Board of Directors that the full range of evidence had been in place for the full year against two of the Standards:

C4c - Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that all reusable medical devices are properly decontaminated prior to use and that the risks associated with decontamination facilities and processes are well managed, and

C4d - Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that medicines are handled safely and securely.

Consequently, the Trust declared that it had 'insufficient assurance' in relation to these Standards within its declaration against the Core Standards as part of the Annual Health Check for 2008/09. The Trust has evidence that both aspects of service are fully safe for patients in these areas, however the requisite documentation has not been evidenced for the full reporting period. Action plans were developed to address these deficits and the Trust was able to declare full compliance in December 2009. Stakeholders are actively involved in the consideration of Trust declarations.

In addition, the Trust has in place a range of control mechanisms which support the risk management and assurance agenda:

- Ward, department and directorate risk assessments which are formally updated on an annual basis
- The Ulysses system, a software package for risk management is used to support an integrated risk management system across the Trust and enable direct reporting to the National Patient Safety Agency
- Education and training programmes throughout the organisation
- Policy approval and ratification by appropriate committees of the Board in support of the integrated governance framework
- A timetable of directorate progress reports to the Clinical Governance Committee
- Risk assessment inbuilt within all new projects

As an employer with staff entitled to membership of the NHS pension scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Whilst control measures are in place to monitor compliance with equality, diversity and human Rights legislation, the Trust recognises that to maintain compliance against the Equality Bill that further development is needed. An independent review of the Trust's Single Equality Scheme action plan, infrastructure and governance arrangements has taken place to inform the Equality & Diversity Strategy for the Trust going forward and this is to be reported to the Board in May 2010.

The Foundation Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and Civil Contingency requirements, as based on UKCIP 2009 weather projects to ensure that this organization's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with. The Trust has had Automatic Meter Readings installed on site and is able to provide Scope 1 carbon figures. It has recently engaged with the Carbon Trust on a programme to further reduce its carbon footprint and it is anticipated that one of the outputs of this will be the ability to understand the organisation's Stage 2 & 3 carbon. The Trust falls under the auspices of the Climate Change Levy, however its outputs at this moment do not require it to purchase carbon credits, it is only required to report.

Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

The Trust created a new post of Head of Clinical Effectiveness to lead the delivery and production of the quality report this year and to support the broader quality strategy going forward. The executive lead for the quality agenda across the Trust is the Medical Director, with significant input from the Director of Nursing, Midwifery and Patient Experience, both of whom sit on the Clinical Governance Committee, which monitors CBU outcome data throughout the year. It is through this control mechanism that primary assurance is obtained of the balance and accuracy of the quality data that is presented in the report for 2009/10. The Clinical Governance Committee in turn reports to the Governance and Clinical Assurance Committee which has delegated authority from the Board of Directors to to seek assurance on the effectiveness of clinical quality, clinical practice and governance arrangements and activities within the Trust.

In developing the quality report a standard template was used for completion by leads within Clinical Business Units and departments. In addition to the Medical Director and the Director of Nursing, Midwifery and Patient Experience, senior staff who contributed to the production of the quality report were as follows:

- CBU Clinical Governance Leads
- Data Quality lead
- Director of Clinical Audit
- Director of Research & Development
- Director for Infection, Prevention and Control
- Chief Pharmacist
- Head of Organisational Development
- Head of Clinical Effectiveness
- CBU General Managers
- Clinical Directors
- Director of Corporate Affairs
- Professor of Fetal and Maternal Medicine, Division of Perinatal and Reproductive Medicine, University of Liverpool

Each of these individuals took responsibility either for ensuring that data submitted for their specific area was accurate or for providing an overview of balance and validity for the entire report.

The process for developing the indicators was such that the lead for each area, in consultation with clinical teams, categorised clinical priorities into three domains of safety, effectiveness and experience although priorities interrelate. Data collection was undertaken within each area and checked for source and accuracy through a sign off process. The draft quality report was presented to Clinical Governance Committee, providing members with an opportunity to sense check the indicators and benchmarks where available. The Board of Directors also had an opportunity to discuss the key indicators at its meeting in May 2010 and question the lead clinicians as to the underlying rationale and how each one will be developed.

Quality Report - Review of effectiveness

The indicators set out in the quality report are reviewed on an ongoing basis through the Clinical Governance Committee. A number of the indicators are linked to issues that have been escalated to the Board Assurance Framework and monitored on a monthly basis, for example, Neonatal infection. In addition, more detailed scrutiny of the controls in place has been undertaken by the Governance and Clinical Assurance Committee. The Board has endorsed the approach that all of the indicators set out in the quality report will be subject to quarterly monitoring by the Executive team as part of its routine performance management of Clinical Business Units.

Review of economy, efficiency and effectiveness of the use of resources

As Accounting Officer, I am responsible for ensuring that the organisation has arrangements in place for securing value for money in the use of its resources. To do this I have implemented systems to:

- Set, review and implement strategic and operational objectives
- Engage with patients, members and other stakeholders to ensure key messages about services are received and acted upon
- Monitor and review organisational performance
- Deliver efficiency gains and savings targets

Annually, the Trust produces a service strategy which incorporates a supporting financial plan for approval by the Board of Directors. This informs the annual detailed operational plan and budget which is also approved by the Board. Views of the Trust's 12,000 members are gained through their representatives on the Trust's Council of Governors. In 2009/10 members of the Council of Governors were involved in the development of the Trust's service strategy. The resulting plan informs the Trust's corporate objectives and provides the basis for quarterly performance reviews at directorate level. The Board of Directors monitors performance monthly through the corporate report which provides integrated information on financial performance, achievement of savings targets, contract activity, human resource indicators and key service performance indicators. The newly established Finance, Performance and Business Development Committee of the Board also meets monthly to provide dedicated time to review financial and contract performance in detail prior to Board meetings.

Reports on specific issues relating to economy, efficiency and effectiveness are commissioned by the Audit Committee within the Internal Audit plan and the implementation of recommendations made by Internal Audit is overseen by the Audit Committee. Within the 2009/10 risk based Internal Audit Plan specific resource was utilised to evaluate the effectiveness of committee structures and governance arrangements within the Trust, both at Board level and within the clinical directorates. This review, the third of its kind undertaken by the Trust since gaining authorisation as a foundation trust resulted in a more streamlined cohort of Board committees. It has resulted in ensuring that Non Executive Director input is focussed in the most appropriate areas and taking on Board recommendations arising from national best practice governance reviews, such as the Audit Commission's 'Taking it on Trust' report. Two new Board assurance committees were established from July 2009 – the Governance and Clinical Assurance Committee and the Finance, Performance and Business Development Committee. The Trust's new approach to corporate governance is also a reflection of the creation of Clinincal Business Units and the direct relationship between autonomy and accountability inherent in this model.

During the year the Trust was subject to the national PbR Data Assurance Framework Audit of its clinical coding systems for both Inpatient and Outpatient activity which identified a number of areas of good practice.

Specific management reviews have also been identified by the Board of Directors, Executive Directors and Clinical Business Units as a result of risks to performance identified from the performance management system. These reviews have included:

- An extensive review of imaging services within the Trust resulting in the establishment of a service improvement project
- Continued review of Obstetrics pathways to inform the development of a business case to enhance further the service model for maternity services
- Development of proposals to deliver a Primary Care Gynaecology service
- A review of Pharmacy Services under the lean methodology
- The Trust is also particpating in two reviews across a number of oirganisations in relation to:
  - Pathology (North Mersey Pathology Network Group)
  - North Mersey QUIPP

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework and comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board of Directors and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The process that has been applied in maintaining and reviewing the effectiveness of the system of internal control includes the following elements:

- The Board of Directors provides active leadership of the Trust within a framework of prudent and effective controls that enable risk to be assessed and managed.
- The Audit Committee, as part of an integrated governance structure, is pivotal in advising the Board on the effectiveness of the system of internal control.
- The Committees of the Board are key components by which I am able to assess the effectiveness and assure the Board of risk management generally and clinical risk in particular.
- Internal Audit provides quarterly reports to the Audit Committee and full reports to the Director of Finance and other Trust Officers. The Audit Committee also receives details of actions that remain outstanding following any follow up of previous audit work. The Director of Finance also meets regularly with the Audit Manager.
- Other explicit review and assurance mechanisms include Clinical Business Unit assurance frameworks linked to the Operational Plan and a range of independent assessments against key areas of control, as set out in the Assurance Framework.

Any significant internal control issues would be reported to the Board via the appropriate Committee. There have been no significant internal control issues identified during 2009/10 although the Trust is reviewing in the light of audit reviews its procurement practices to ensure compliance with current and future regulations. All significant risks identified within the Board Assurance Framework have been regularly reviewed in-year by the Board and appropriate control measures put in place.

During the previous year the Trust had cause to review the surgical practices of one of its consultants. This led to the recall of a number of patients in order for the Trust to be satisfied that they had received the quality of care expected for all patients. All of these patients have now been signposted to further treatment or discharged, as appropriate. An independent review of governance arrangements was commissioned by the Trust to determine the lessons that can be learned and identify any areas for further improvement. The outcome of the review was reported to the Board of Directors in January 2010. Whilst it concluded that the Trust's governance arrangements are generally strong and that the issue that triggered the review was not systemic, the Trust has developed an action plan based on the recommendations set out in the report and this will be regularly monitored by the Board of Directors in the coming year. The Trust will also report on progress to its regulators with whom the report has been shared.

Independent assessment has been provided by the NHS Litigation Authority assessors who awarded the Trust Level 3 for general standards in March 2008 and re-accreditation at CNST Level 3 for maternity standards in February 2008.

Liverpool Women's continues to place great emphasis on its control of infection, as evidenced by our track record in this area (there have been only two reportable cases of MRSA this year and one case of Chlostridium difficile). In order to test the Trust's compliance with the standards set out in the Code of Practice for the Prevention and Control of Health Care Associated Infections ('the Hygiene Code'), as set out in the Health Act 2006 the Care Quality Commission carried out an unannounced inspection in August 2009. On inspection no evidence was found that Liverpool Women's Hospital had breached the regulation to protect patients, workers and others from the risks of acquiring a healthcare associated infection. Of the nine measures inspected, no concerns were identified for seven of the measures, however areas for improvement were found in the remaining two. The two areas for improvement were:-

1) Ensuring that the environment for providing healthcare is suitable, clean and well maintained.
2) Using effective arrangements for the appropriate decontamination of instruments and other equipment which are detailed in appropriate policies

An action plan was developed and a Hygiene Action Group was established to oversee the implementation of the Action Plan, which was complete by 1st October 2009. The Trust continues to hold unconditional registration by the Care Quality Commission.

During the year the I receive reports from the Royal Colleges and following Deanery visits. In addition, there are a range of other independent assessments against key areas of control, for example:

- Healthcare Commission's Annual Health Check 2008/09 (reported in October 2009) resulted in ratings of 'excellent' for use of resources and 'good' for quality of services
- Achievement of 'excellent' category in PEAT assessment
- Interim inspection by the Healthcare Commission and the Human Embryology and Fertilisation Authority of the Hewitt Centre for Reproductive Medicine
- A rating of excellent and good from the external clinical coding audit undertaken as part of the Audit Commission's Payment by Results
- Data Assurance Framework in 2009/10 for Inpatient and Outpatient Activity respectively
- The Genetics laboratories were subject to CPA review in December to determine continued compliance with standards. This determined that accreditation was maintained and during quarter 2 of 2009/10 outstanding action points were resolved and in quarter 3 the trust was advised of unconditional accreditation for 4 years.

The Board of Directors is committed to continuous improvement and development of the systems of internal control.

Conclusion

There have been no significant internal control issues identified during 2009/10

Signed

Kathryn Thomson

Kathryn Thomson
Chief Executive
4th June 2010

Appendix 1

Attendance at Council of Governors meetings 2009/10 – Attendance at meetings marked with ✓

	22nd April 2009	15th July 2009	21st October 2009	20th January 2010
Public members				
Anna Banks	✓	✓	✓	✓
Morag Day	✓	✓		✓
Irene Drakeley (until Sept 09)	✓	✓		
Sheila Foley (until Sept 09)	✓			
Annette James	✓		✓	✓
Patricia Jones	✓	✓	✓	
Pat Jones (from Sept 09)			✓	
Ronnie Kehoe	✓	✓	✓	
Maureen Kelly		✓	✓	✓
Barbara Kerr (from Sept 09)			✓	✓
Mary McDonald (from Sept 09)			✓	✓
Brenda McGrath (until Sept 09)				
Geoff McKeating	✓	✓	✓	✓
Anees Paracha				
Angela Parker	✓	✓		
Anne Smith	✓	✓		✓
Betty Stopforth	✓			
Maggi Williams	✓	✓	✓	✓
Deirdre Wood (until Sept 09)	✓	✓		
Janine Wooldridge	✓		✓	✓
Dorothy Zack Williams (from Sept 09)				
Staff Members				
Dorcas Akeju (until Sept 09)				
Leanne Bricker				✓
Dianne Brown		✓		✓
Denise Carter		✓		✓
Angela Douglas	✓	✓		✓
Helen Gavin (until Sept 09)	✓			
Catherine O'Keeffe (from Sept 09)			✓	✓
Jane Rooney (from Sept 09)			✓	✓
Appointed members				
Jayne Aston				
Janet Atherton (until Sept)				
Marilyn Fielding				✓
Paula Grey	✓		✓	✓
Margaret Hogan		✓	✓	
Godfrey Mazhindu	✓			
Susan Wray	✓		✓	

Board of Directors				
Ken Morris	✓		✓	✓
Ann MCracken	✓		✓	✓
Roy Morris				
Hoi Yeung	✓	✓		
David Carbery	✓	✓		✓
Yvonne Rankin (until October 2009)				
Kathryn Thomson	✓	✓	✓	✓
Caroline Salden	✓		✓	✓
David Richmond				✓
Gail Naylor		✓	✓	✓
Kim Doherty		✓	✓	✓
Vanessa Harris (from Sept 2009)			✓	✓
David Renouf (Acting to Sept 09)	✓	✓		
Erica Saunders (Trust Secretary)	✓	✓	✓	✓

Note: The meeting on 15th July 2009 was chaired by Angela Douglas as Deputy Chair, due to Ken Morris' secondment.

Liverpool Women's NHS Foundation Trust Annual Accounts 2009/10

Foreword to the Accounts

These accounts for the year-ended 31st March 2010 have been prepared by the Liverpool Women's NHS Foundation Trust under schedule 7 sections 24 and 25 of the National Health Service Act 2006 in the form which Monitor, the Independent Regulator of NHS Foundation Trusts has, with the approval of the Treasury directed.

Signed

Kathryn Thomson

Kathryn Thomson
Chief Executive
4th June 2010

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31st MARCH 2010

	Note	2009/10 £000	2009/10 £000	2008/09 £000
Operating Income	2.1		89,419	85,590
Operating Expenses	3.1		(86,242)	(79,668)
OPERATING SURPLUS			**3,177**	**5,922**
Finance Costs:				
Finance income	5	58		632
Finance expense – unwinding of discount on provisions		(20)		(20)
PDC Dividends Payable		(1,614)		(1,986)
Net Finance Costs			(1,576)	(1,374)
Surplus from continuing operations			**1,601**	4,548
SURPLUS FOR THE YEAR			**1,601**	4,548
Other comprehensive income				
Revaluation gains/(losses) and impairment losses property, plant and equipment			(11,242)	0
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of on donated assets			(17)	(17)
TOTAL COMPREHENSIVE INCOME AND EXPENSE FOR THE YEAR			**(9,658)**	4,531

Income and operating surpluses are derived from the Foundation Trust's continuing operations.

Note: Allocation of (Losses)/Profits for the year		2009/10 £000	2008/09 £000
(a) Surplus for the year attributable to:			
(i) minority interest, and		0	0
(ii) owners of the parent		1,601	4,548
	TOTAL	**1,601**	4,548
(b) total comprehensive income and expense for the year attributable to:			
(i) minority interest, and		0	0
(ii) owners of the parent		(9,658)	4,531
	TOTAL	**(9,658)**	4,531

STATEMENT OF FINANCIAL POSITION as at 31st MARCH 2010

	Note	2009/10 £000	2008/09 £000
NON CURRENT ASSETS:			
Intangible assets	7.1	121	76
Property, plant and equipment	8.1	48,186)	57,102
Total non-current assets		**48,307**	57,178
CURRENT ASSETS			
Inventories	11	603	662
Trade and other receivables	12	4,927	4,124
Cash and cash equivalents	19	9,366	14,670
Other financial assets	19.3	2,000	1,500
Total current assets		**16,896**	20,956
CURRENT LIABILITIES			
Trade and other payables	14.1	(9,898)	(12,287)
Provisions	17	(89)	(120)
Other liabilities	15	(804)	(683)
Total current liabilities		**(10,791)**	(13,090)
NON-CURRENT LIABILITIES			
Provisions	17	(970)	(1,944)
Total non-current liabilities		**(970)**	(1,944)
TOTAL ASSETS EMPLOYED		**53,442**	63,100
TAXPAYERS' EQUITY			
Public Dividend Capital		35,210	35,210
Revaluation reserve	18	4,307	15,549
Donated Asset Reserve		229	246
Income and expenditure reserve		13,696	12,095
TOTAL TAXPAYERS' EQUITY		**53,442**	63,100

The financial statements were approved by the Board of Directors and authorised for issue on 4th June 2010 and are signed on its behalf by:

Kathryn Thomson

Kathryn Thomson
Chief Executive

STATEMENT OF CHANGES IN TAXPAYERS EQUITY

2009/10	Total £000	Minority Interest £000	Public Dividend Capital £000	Revaluation Reserve £000	Donated Assets Reserve £000	Available for Sale Investment Reserve £000	Other Reserves £000	Merger Reserve £000	Pension Reserve £000	Income and Expenditure Reserve £000
Taxpayers' Equity at 1 April 2009	**63,100**	**0**	**35,210**	**15,549**	**246**	**0**	**0**	**0**	**0**	**12,095**
Surplus for the year	1,601	0	0	0	0	0	0	0	0	1,601
Revaluation gains/(losses) and impairment losses property, plant and equipment	(11,242)	0	0	(11,242)	0	0	0	0	0	0
Reduction in the donated asset reserve in respect of depreciation on, impairment of, and/or disposal of donated assets	(17)	0	0	0	(17)	0	0	0	0	0
Taxpayers' Equity at 31 March 2010	**53,442**	**0**	**35,210**	**4,307**	**229**	**0**	**0**	**0**	**0**	**13,696**

STATEMENT OF CHANGES IN TAXPAYERS EQUITY

2008/09	Total £000	Minority Interest £000	Public Dividend Capital £000	Revaluation Reserve £000	Donated Assets Reserve £000	Available for Sale Investment Reserve £000	Other Reserves £000	Merger Reserve £000	Pension Reserve £000	Income and Expenditure Reserve £000
Taxpayers' Equity at 1 April 2008	**58,692**	**0**	**35,333**	**15,616**	**196**	**0**	**0**	**0**	**0**	**7,547**
Surplus for the year	4,548	0	0	0	0	0	0	0	0	4,548
Reduction in the donated asset reserve in respect of depreciation on, impairment of, and/or disposal of donated assets	(17)	0	0	0	(17)	0	0	0	0	0
PDC repaid	(123)	0	(123)	0	0	0	0	0	0	0
Other transfers between reserves	0	0	0	(67)	67	0	0	0	0	0
Taxpayers' Equity at 31 March 2009	**63,100**	**0**	**35,210**	**15,549**	**246**	**0**	**0**	**0**	**0**	**12,095**

STATEMENT OF CASH FLOWS for the YEAR ENDED 31st MARCH 2010

	Note	2009/10 £000	2008/09 £000
Cash flows from operating activities			
Net cash generated from operations	19.2	**4,014**	10,038
Cash flows from investing activities			
Interest received		61	683
Purchase of financial assets		(500)	(1,500)
Purchase of Property, Plant and Equipment		(6,936)	(7,383)
Sales of Property, Plant and Equipment		17	1
Net cash used in investing activities		**(7,358)**	(8,199)
Cash flows from financing activities			
Public dividend capital repaid		0	(123)
PDC Dividend paid		(1,960)	(1,986)
Net cash used in financing activities		**(1,960)**	(2,109)
(Decrease)/Increase in cash and cash equivalents		**(5,304)**	(270)
Cash and Cash equivalents at 1 April 2009		14,670	14,940
Cash and Cash equivalents at 31 March 2010		**9,366**	14,670

NOTES TO THE ACCOUNTS

1. Accounting policies and other information

Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2009/10 NHS Foundation Trust Annual Reporting Manual issued by Monitor.

The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS foundation trusts.

The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

These accounts have been prepared under the historical cost convention modified to include the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities in accordance with applicable accounting standards

1.1 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the trust is contracts with commissioners in respect of healthcare services.

Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

Where it is reasonably certain that the Trust will receive the income for a treatment or spell once the patient is admitted and treatment begins then the income relating to those spells that are partially completed at the financial period end is apportioned on a pro-rata basis. The apportioned amounts are disclosed as NHS Trade receivables.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Other operating income is recognized when, and to the extent, performance occurs. It is measured at the fair value of the consideration receivable. The main source of this income is from Primary Care Trusts, NHS Foundation Trusts and NHS Trusts. It includes Education and Training income, which arises from the provision of mandatory education and training as set out in the Trust's Terms of Authorisation. This income is recognised as costs are incurred.

Finance income relates to interest receivable which is accrued on a time basis by reference to the principal outstanding and the interest rate applicable.

1.2 Accounting Judgments and key sources of estimation and uncertainty accounting policy

In the application of the Trust's accounting policies management is required to make judgments estimates and assumptions about the carrying amount of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors considered of relevance. Actual results may differ from those estimates and estimates and underlying assumptions are continually reviewed. Revisions to estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of revision and future periods if the revision affects both current and future periods.

The following are the areas that critical judgments have been made in the process of applying accounting policies at the end of the reporting period that have a significant risk of causing a material adjustment to the carrying amount of assets and liabilities within the next financial year.

Asset Valuation and Lives

The value and remaining useful lives of land and buildings have been estimated by DTZ. The valuations are carried out in accordance with the Royal Institute of Chartered Surveyor's Valuation Standards, 6th edition. The valuations were carried out in 2010 as at the valuation date of 31st March 2010 and were applied on that date. Valuations are carried out primarily on the basis of Depreciated Replacement Cost for specialised operational property and Existing Use Value for non-specialised operational property.

The lives of equipment assets are estimated using historical experience of similar equipment lives with reference to national guidance and consideration of the pace of technological change. Operational equipment is carried at current value. Where assets are of low value and/or have short useful economic lives, these are carried at depreciated historical cost as this is not considered to be materially different from fair value.

Software licences are depreciated over the shorter of the term of the licence and the useful economic life.

Impairments of receivables

A provision for the impairment of receivables has been made for specific amounts where there is reasonable uncertainty of obtaining settlement from organisations at 31st March 2010.

Holiday pay accrual

The accrual for outstanding leave has been calculated on a sample basis.

For non medical staff the amount of outstanding annual leave as at 31st March is requested from a representative sample from across the Trust. The accrual is then calculated on a pro-rata basis according to the numbers of staff within the sample compared to the total staff in post in March. The accrual is split between the various staff groups based on the results of the sample.

Pension provisions

Pension provisions relating to former employees, including directors, have been estimated using the life expectancy from the Government's actuarial tables.

Legal claims

Legal claims provisions relate to employer and public liability claims and expected costs are advised by the NHS Litigation Authority.

1.3 Expenditure on Employee Benefits

Short-term Employee Benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs – NHS Pension Scheme
Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. It is not possible for the NHS foundation trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employers pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

1.4 Expenditure on other goods and services
Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.5 Property, Plant and Equipment

Recognition
Property, Plant and Equipment is capitalised where:
- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
- it is expected to be used for more than one financial year; and
- the cost of the item can be measured reliably.

Where a large asset, for example a building, includes a number of components with significantly different asset lives e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Measurement

Valuation
At each reporting period end, the Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount.

If there has been an impairment loss, the asset is written down to its recoverable amount, with the loss charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

Recoverable amount is the higher of fair value less costs to sell and value in use. In assessing value in use the estimated future cash flows are discounted to their present value using a pre-tax discount rate that reflects current market assessments of the time value of money and the risks specific to the asset, for which the estimates of future cash flows have not been adjusted.

An impairment loss is only reversed if there is a subsequent increase in the recoverable amount that can be related objectively to an event occurring after the impairment loss was recognised.

All land and buildings are revalued using professional valuations in accordance with IAS 16 every five years. A three yearly interim valuation is also carried out.

Valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. The last asset valuations were undertaken in 2010 as at the prospective valuation date of 1 April 2010. The revaluation undertaken at that date was accounted for on 31st March 2010.

The valuations are carried out primarily on the basis of depreciated replacement cost for specialised operational property and existing use value for non-specialised operational property. The value of land for existing use purposes is assessed at existing use value. For non-operational properties including surplus land, the valuations are carried out at open market value.

Additional alternative open market value figures have only been supplied for operational assets scheduled for imminent closure and subsequent disposal.

Subsequent expenditure
Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is added to the asset's carrying value. Where subsequent expenditure is simply restoring the asset to the specification assumed by its economic useful life then the expenditure is charged to operating expenses.

Depreciation
Items of Property, Plant and Equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated. Depreciation is applied using the straight line method.

Property, Plant and Equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-balance sheet PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively. As at 31st March 2010 there were no assets classified as 'Held for Sale'.

Revaluation and impairment
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised in operating income.

At the end of each reporting period the Trust's assets' residual value and useful lives are reviewed, and adjusted if appropriate, at each year end date. An asset's carrying amount is written down immediately to its recoverable amount if that carrying amount is greater than the estimated recoverable amount. If there is an indication of an impairment loss the recoverable amount of the asset is estimated to determine whether there has been a loss.

Decreases in asset values and impairments are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

De-recognition
Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met:
- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable i.e.: management are committed to a plan to sell the asset; an active programme has begun to find a buyer and complete the sale; the asset is being actively marketed at a reasonable price; the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated assets
Donated non-current assets are capitalised at their current value on receipt and this value is credited to the donated asset reserve. Donated non-current assets are valued and depreciated as described above for purchased assets.

Gains and losses on revaluations are also taken to the donated asset reserve and, each year, an amount equal to the depreciation charge on the asset is released from the donated asset reserve to the income and expenditure account. Similarly, any impairment on donated assets charged to the income and expenditure account is matched by a transfer from the donated asset reserve. On sale of donated assets, the net book value of the donated asset is transferred from the donated asset reserve to the Income and Expenditure Reserve.

Private Finance Initiative (PFI) transactions
PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-balance sheet' by the Trust. The underlying assets are recognised as Property, Plant and Equipment at their fair value. An equivalent financial liability is recognised in accordance with IAS 39.

The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services. The finance cost is calculated using the effective interest rate for the scheme.

The service charge is recognised in operating expenses and the finance cost is charged to Finance Costs in the Statement of Comprehensive Income.

1.6 Intangible assets

Recognition
Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably. Where internally generated assets are held for service potential, this involves a direct contribution to the delivery of services to the public.

Internally generated intangible assets
Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.
Expenditure on research is not capitalised.
Expenditure on development is capitalised only where all of the following can be demonstrated:
- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development.

None of the Trust's development activity meets the above criteria and costs have been charged to operating expenses.

Software
Software which is integral to the operation of hardware e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset.

Measurement
Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at fair value. Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised in operating income.

Decreases in asset values and impairments are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses. Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

Amortisation
Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

At the end of each reporting period the Trust's assets' residual value and useful lives are reviewed, and adjusted if appropriate, at each year end date. An asset's carrying amount is written down immediately to its recoverable amount if that carrying amount is greater than the estimated recoverable amount. If there is an indication of an impairment loss the recoverable amount of the asset is estimated to determine whether there has been a loss.

The economic life of intangible assets is shown in note 7 to the accounts.

1.7 Government grants

Government grants are grants from Government bodies other than income from primary care trusts or NHS trusts for the provision of services. Grants from the Department of Health, including those for achieving three star status, are accounted for as Government grants as are grants from the Big Lottery Fund. Where the Government grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure the grant is held as deferred income and released to operating income over the life of the asset in a manner consistent with the depreciation charge for that asset.

1.8 Inventories

Inventories are valued at the lower of cost and net realisable value. Cost comprises direct material cost and, where applicable, direct labour costs and those overheads that have been incurred in bringing the inventories to their present location and condition. Cost is calculated using the weighted average method. Net realisable value represents the estimated selling price less all estimated costs to completion and selling costs to be incurred.

1.9 Financial instruments and financial liabilities

Recognition
Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.
All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition
All financial assets are de-recognised when the rights to receive cashflows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.
Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and Measurement
Financial assets are categorised as 'Fair Value through Income and Expenditure', Loans and receivables or 'Available-for-sale financial assets'.

Financial liabilities are classified as 'Fair value through Income and Expenditure' or as 'Other Financial liabilities'.

Financial assets and financial liabilities at 'Fair Value through Income and Expenditure'
Financial assets and financial liabilities at 'fair value through income and expenditure' are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges.

Derivatives which are embedded in other contracts but which are not 'closely-related' to those contracts are separated-out from those contracts and measured in this category. Assets and liabilities in this category are classified as current assets and current liabilities.

The Trust has not entered into any derivatives in the year.

These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the Statement of Comprehensive Income. Subsequent movements in the fair value are recognised as gains or losses in the Statement of Comprehensive Income.

Cash is cash-in-hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours.

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments with are not quoted in an active market. They are included in current assets.

The Trust's loans and receivables comprise: current investments, cash and cash equivalents, NHS debtors, accrued income and 'other receivables'.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Available-for-sale financial assets
Available-for-sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. They are included in long-term assets unless the Trust intends to dispose of them within 12 months of the balance sheet date.

Available-for-sale financial assets are recognised initially at fair value, including transaction costs, and measured subsequently at fair value, with gains or losses recognised in reserves and reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'. When items classified as 'available-for-sale' are sold or impaired, the accumulated fair value adjustments recognised are transferred from reserves and recognised in 'Finance Costs' in the Statement of Comprehensive Income.

Other financial liabilities
All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the balance sheet date, which are classified as non-current liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Determination of fair value
For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from quoted market prices/ independent appraisals/value in use calculation based on estimated future cashflows discounted to their present value.

Impairment of financial assets
At the balance sheet date, the Trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cashflows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced - either directly or through the use of an allowance account/provision for impairment of receivables.

1.10 Leases

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS foundation trust, the asset is recorded as Property, Plant and Equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the inception of the lease, and are de-recognised when the liability is discharged, cancelled or expires. The annual rental is split between the repayment of the liability and a finance cost. The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to Finance Costs in the Statement of Comprehensive Income.

Operating leases
Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Leases of land and buildings
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately. Leased land is treated as an operating lease.

1.11 Provisions

The NHS foundation trust provides for legal or constructive obligations that are of uncertain timing or amount at the year end date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate of 2.2% in real terms.

Clinical negligence costs
The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS foundation trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS foundation trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS foundation trust is disclosed at note 22.2.

Non-clinical risk pooling
The NHS foundation trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme.

Both are risk pooling schemes under which the trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises. The Trust has also taken out "top up" property insurance via a commercial insurer with premiums charged to operating expenses.

1.12 Contingencies

Contingent assets that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control are not recognised as assets, but are disclosed in the accounts where an inflow of economic benefits is probable.

Contingent liabilities are not recognised because the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:
* possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
* present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Contingent liabilities are disclosed in note 26 to the accounts.

1.13 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the forecast cost of capital utilised by the NHS foundation trust, is paid over as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS foundation trust. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for donated assets and cash held with the Office of the Paymaster General. Average relevant net assets are calculated as a simple means of opening and closing relevant net assets.

1.14 Value Added Tax

Most of the activities of the NHS foundation trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable.

Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of non-current assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.15 Corporation Tax

The Trust has determined that it has no corporation tax liability having reviewed "Guidance on the tax treatment of non core health care commercial activities of NHS Foundation Trusts" issued by HM Revenue and Customs supplemented by access to specific specialist advice when necessary.

1.16 Foreign exchange

The currency of the Trust is sterling.
A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.
Where the Trust has assets or liabilities denominated in a foreign currency at the year end date:

- monetary items are translated at the spot exchange rate on 31 March;
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the balance sheet date) are recognised in income or expense in the period in which they arise.
Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

1.17 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS foundation trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's Financial Reporting Manual.

1.18 Losses and special payments policy

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories which govern the way each individual case is handled.

Losses and special payments are charged to the relevant functional headings in the income statement on an accruals basis including losses which would have been made good through insurance cover had Trusts not been bearing their own risks (with insurance premiums then being included as normal operating expenditure). However the note on losses and special payments is compiled directly from the losses and compensations register which is prepared on a cash basis.

1.19 Standards and Interpretations in issue not yet adopted

The following standards have been issued but are not yet effective:
IFRS1 – First-time Adoption of IFRS - Amendment; Additional exemptions for first-time adopters.
IFRS1 – First-time Adoption of IFRS - Amendment; Limited exemption from comparative IFRS7 disclosures for first-time adopters.
IFRS9 – Financial Instruments
IAS24 – Revised IAS24 Related Party Disclosures
The following interpretations are issued but not yet effective:
IFRIC14 – Amendment – Prepayments of a Minimum Funding Requirement
IFRIC19 – Extinguishing Financial Liabilities with Equity Instruments.
With the exception of IFRS9 which has been postponed, these standards and interpretations are expected to be endorsed by the EU during 2010.
None of these standards or interpretations are expected to have a known significant impact on the Trust on adoption.

1.20 First Time Adoption of IFRS

In line with the Government's timetable for the NHS to move its reporting from UK Generally Accepted Accounting Practice (GAAP) to International Reporting Standards (IFRS) these are the first to be produced under IFRS. Details of how the transition to IFRS has affected the reported financial position, financial performance and cash flows are shown in Note 32.

1.21 Going Concern

The Trust adopts the going concern principle in the formulation of its accounts having due regard to forecasts, medium term financial plans and the availability of funding for a period to at least 12 months from the date of signing the financial statements.

1.22 Segmental reporting accounting policy

The Trust has adopted IFRS8 which requires disclosure of information to enable the users of the financial statements to evaluate the nature and financial effects of business activities in which it engages. Where the chief operating decision maker uses information pertaining to "operating segments" to make decisions about allocation of resources and performance assessment; and where there is sufficient and appropriately discreet information available in this respect, disclosure of that information is made in the financial statements.

2 Operating Income

Note 2.1 Operating Income (by classification)	Note	2009/10 £000	2008/09 £000
Income from Activities			
Elective income		10,516	10,122
Non elective income		25,952	22,436
Outpatient income		15,008	15,208
A & E income		1,002	1,017
Other NHS clinical income*		26,829	27,218
Income from activities before private patient income		**79,307**	76,001
Private patient income	2.2	213	116
Total income from activities	2.4	**79,520**	76,117
Other operating income			
Research and development		614	554
Education and Training		4,791	4,635
Transfer from donated asset reserve in respect of deprecation on donated assets		17	17
Other*	2.5	4,460	4,267
Profit on disposal of other unprotected tangible fixed assets		17	0
Total other operating income		**9,899**	9,473
TOTAL OPERATING INCOME		**89,419**	85,590

Income from activities arising from mandatory and non mandatory services	2009/10 £000	2008/09 £000
Income from mandatory services	79,266	75,876
Income from non mandatory services	254	241
Total income arising from activities	79,520	76,117

Note 2.2 Private Patient Income	2009/10 £000	2008/09 £000	Base Year £000
Private patient income	**213**	116	939
Total patient related income	**79,520**	76,117	52,415
Proportion of private patient income (as proportion)	**0.27%**	0.15%	1.80%

Section 44 of the National Health Service Act 2006 requires that the proportion of private patient income to the total patient related income of an NHS Foundation Trust should not exceed its proportion whilst the body was an NHS Trust in 2002/03 (the base year). The Trust was compliant with this requirement in 2009/10.

Following a legal challenge by Unison the Administrative Court delivered on the 9th December 2009 its ruling on the judicial review of Monitor's interpretation of the legislation to limit the proportion of NHS Foundation Trust (NHSFT) income derived from private patient charges (The PP Cap). As a result Monitor issued revised and updated guidance on 10th February 2010 as to how the PP Cap should be operated for accounting periods beginning on or after 1st April 2010.

The revised guidance defines private patient income as income attributable to an NHSFT either directly or indirectly and which has its origin in the provision of goods and services to non NHS patients. For Liverpool Women's income received from North West Fertility Limited under contract for the provision of clinical services will in 2010/11 fall within the scope of private patient income and presents a risk of breaching the PP Cap in 2010/11. The Trust is in discussion with North West Fertility Limited to agree actions to enable compliance with Monitor guidance. Monitor are being closely consulted on actions and timescales proposed.

Note 2.3 Operating lease income	2009/10 £000	2008/09 £000
Operating Lease Income		
Rents recognised as income in the period	**122**	122
TOTAL	**122**	122

Note 2.4 Operating Income (by type)	2009/10 £000	2008/09 £000
Income from activities		
NHS Foundation Trusts	1,017	122
NHS Trusts	832	553
Primary Care Trusts	76,182	70,057
Department of Health – other	0	3,437
NHS Other	1,153	1,081
Non NHS: Private patients	213	116
NHS injury scheme (was RTA)	4	1
Non NHS: Other	119	118
Total income from activities	**79,520**	76,117

Note 2.5 Analysis of Other Operating Income – Other	2009/10 £000	2008/09 £000
Income from activities		
Provision of clinical support services to North West Fertility Limited	2,080	1,800
Local Information Systems monies	284	350
Car parking income	322	329
Catering	155	129
Perinatal Audit	51	250
Property Rentals	112	112
Other	1,456	1,297
Total Other Other Operating Income	**4,460**	4,267

Note 3.1 OPERATING EXPENSES (by type)	2009/10 £000	2008/09 £000
Services from NHS Foundation Trusts	**3,664**	3,521
Services from NHS Trusts	**2,995**	2,912
Services from other NHS Bodies	**282**	148
Purchase of healthcare from non NHS bodies	**32**	100
Employee Expenses – Executive directors	**595**	677
Employee Expenses – Non-executive directors	**95**	110
Employee Expenses – Staff	**52,431**	49,770
Drug costs	**2,566**	2,580
Supplies and services – clinical (excluding drug costs)	**4,088**	3,533
Supplies and services – general	**3,335**	3,215
Establishment	**1,296**	1,145
Research and development	**517**	522
Transport	**103**	88
Premises	**3,139**	2,565
(Decrease)/increase in allowance for impairment in receivables	**(163)**	71
Depreciation on property, plant and equipment	**2,550**	2,299
Amortisation on intangible assets	**8**	53
Impairments of property, plant and equipment	**1,033**	0
Audit fees		
audit services – statutory audit	**67**	37
Other auditors remuneration		
further assurance services	**0**	10
other services	**19**	0
Clinical negligence	**4,518**	2,655
Loss on disposal of other property, plant and equipment	**0**	9
Legal fees	**114**	116
Consultancy	**0**	786
Training, courses and conferences	**190**	258
Patient travel	**7**	6
Car parking and security	**299**	345
Early retirements	**0**	(53)
Hospitality	**0**	50
Insurance	**108**	0
Other services	**0**	730
Losses, ex-gratia and special payments	**88**	0
Other	**2,266**	1,410
TOTAL	**86,242**	79,668

Note 3.2 Arrangements containing an operating lease	2009/10 £000	2008/09 £000
Minimum lease payments	25	55
TOTAL	**25**	55

Note 3.3 Arrangements containing an operating lease other than land and buildings	2009/10 £000	2008/09 £000
Future minimum lease payments due:		
- not later than one year	2	2
- later than one year and not later than five years	22	16
TOTAL	**24**	18

Note 3.4 Salary Entitlements of Senior Managers Name and position held		2009/10 £000		2008/09 £000	
Senior Managers in post as at 31st March 2010					
Kathryn Thomson	Chief Executive with effect from 1st September 2008	**135 - 140**	0	70 - 75	0
David Richmond	Medical Director	**40 - 45**	**170 - 175**	50 - 55	155 - 160
Gail Naylor	Director of Nursing, Midwifery & Patient Experience with effect from 29th June 2009	**65 - 70**	0	-	-
Vanessa Harris	Director of Finance with effect from 1st September 2009	**50 - 55**	0	-	-
Caroline Salden	Director of Service Development	**90 - 95**	0	80 - 85	0
Triona Buckley	Acting Director of Human Resources with effect from 1st February 2010	**10 - 15**	0	-	-
Ken Morris	Chair Excludes secondment 11th May to 31st August 2009	**25 - 30**	0	30 - 35	0
Ann McCracken	Non executive director Acting Chair Between 11th May to 31st August 2009	**15 - 20**	0	10 - 15	0
David Carbery	Non executive director	**10 - 15**	0	10 - 15	0
Roy Morris	Non executive director	**10 - 15**	0	10 - 15	0
Hoi Yeung	Non executive director	**10 - 15**	0	10 - 15	0
Liz Cross	Non executive director with effect from 1st February 2010	**0 - 5**	0	-	-
Senior Managers who have held posts during the financial years 2008/09 and 2009/10					
Gill Core	Director of Nursing Midwifery and Patient Quality Left 22nd Feb 2009	-	-	80 - 85	0
Christine Hedley	Director of Nursing Midwifery and Patient Quality with effect from 26th February 2009 to 27th June 2009	10 - 15	0	5 - 10	0
Kim Doherty	Director of Human Resources Left 31st January 2010	55 - 60	0	45 - 50	0
Susan Lorimer	Acting Chief Executive 1st April 2008 – 31st August 2008 Director of Finance left 1st February 2009	-	-	90 - 95	0
David Renouf	Acting Director of Finance 1st April 2008 - 31st August 2008 1st February 2009 – 31st August 2009	30 - 35	0	45 - 50	0
Yvonne Rankin	Non executive director Left 31st October 2009	5 - 10	0	10 - 15	0

Note 3.5 Pension Entitlements of Executive Directors

		Real increase in pension and related lump sum at age 60 (bands of £2,500) £000	Total accrued pension and related lump sum at age 60 31st March 2010 (bands of £2,500) £000	Real increase in CETV £000	(CETV) at 31st March 2010 £000	Cash Equivalent Transfer value (CETV) at 31st March 2009 £000
Kathryn Thomson	Chief Executive with effect from 1st September 2008	**17.5-20.0**	**172.5-175.0**	113	742	614
David Richmond	Medical Director	**35.0-37.5**	**282.5-285.0**	247	1,709	1,426
Gail Naylor	Director of Nursing, Midwifery & Patient Experience with effect from 29th June 2009				490	Not Appicable
Vanessa Harris	Director of Finance with effect from 1st September 2009				284	Not Appicable
Caroline Salden	Director of Service Development	**10.0-12.5**	**75.0-77.5**	47	266	214
Christine Hedley	Director of Nursing Midwifery and Patient Quality with effect from 26th February 2009 to 27th June 2009. Retired prior to 31st March 2009.	0	0	0	0	0
Kim Doherty	Director of Human Resources Left 31st January 2010	**0.0-2.5**	**50.0-52.5**	13	178	161

The pension information for David Renouf and Triona Buckley has not been disclosed because it is not possible to split the pension entitlements earned between acting as a director and the permanent roles.

Gail Naylor and Vanessa Harris were not employed by the Trust in 2008/09.

As non executive directors do not receive pensionable remuneration there are no entries in respect of pensions for non executive directors.

The Cash Equivalent Transfer Value (CETV) is the actuarially assessed capitalised value of the pension scheme benefits accumulated by a member at a particular point in time. The benefits valued are the member's accumulated benefits and any contingent spouse's pension payable from the scheme. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation contributions paid by the emplyee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Other remuneration report details are included in the annual report on page 48.

Note 3.6 Directors remuneration

	2009/10 £000	2008/09 £000
Remuneration	612	709
Employers Pension Scheme Contribution	78	78
Total	**690**	787
The total number of directors accruing benefits under the NHS Pension Scheme were	**6**	4

Note 4.1 Employee Expenses

	2009/10 £000	2008/09 £000
Salaries and wages	43,818	41,409
Social security costs	3,222	3,216
Pension costs – defined contribution plans	0	0
Employers contributions to NHS Pensions	4,952	4,727
Pensions Cost – other contributions	0	0
Termination benefits	0	0
Agency/contract staff	1,034	1,042
Total	**53,026**	50,394

Note 4.2 Average number of employees (Whole Time Equivalent basis)	2009/10 Total Number	2009/10 Permanent Number	2009/10 Other Number	2008/09 Number
Medical and dental	129	129		128
Administration and estates	270	270		266
Healthcare assistants and other support staff	129	129		156
Nursing, midwifery and health visiting staff	597	597		593
Scientific, therapeutic and technical staff	107	107		106
TOTAL	**1,232**	**1,232**		1,249

Note 4.3 Early retirements due to ill health	2009/10		2008/09	
	Value £000	Number	Value £000	Number
Early retirements on the grounds of ill-health	32	2	198	3

Note 4.4 Pension Costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The Scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. As a consequence it is not possible for the Trust to identify its share of the underlying scheme assets and liabilities. Therefore the scheme is accounted for as a defined contribution scheme and the cost of the scheme is equal to the contributions payable to the scheme in the accounting period.

The NHS pension scheme is subject to a full valuation every four years by the Government Actuary. The latest published valuation relates to the period 1 April 1999 to 31 March 2004 which was published in December 2007 and is available on the Pensions Agency Website: http://www.nhspa.gov.uk/nhspa_site/foi/foi1/Scheme_Valuation_Report/NHSPS_Valuation_report.pdf

The notional deficit of the scheme was £3.3 billion as per the last scheme valuation by the Government Actuary for the period 1 April 1999 to 31 March 2004. The conclusion of the valuation was that the scheme continues to operate on a sound financial basis.

Employer contribution rates are reviewed every four years following the scheme valuation, on advice from the actuary. At the last valuation, it was recommended that employer contribution rates should continue at 14% of pensionable pay. Employees' contributions are on a tiered scale from 5% to 8.5% of their pensionable pay.

Note 5 Finance income	2009/10 £000	2008/09 £000
Interest on loans and receivables	0	0
Interest on available for sale financial assets	0	0
Interest on held-to-maturity financial assets	25	132
Other gains (investment properties)	0	0
Available for sale financial assets and liabilities held at fair value through income and expenditure account		
- fair value gains	0	0
- fair value losses	0	0
Net gains/(losses) on available for sale financial assets through income and expenditure	0	0
Other	**33**	500
Total	**58**	632

Note 6. Impairment losses (Property Plant and Equipment and Intangibles)	2009/10 £000	2008/09 £000
Changes in market price	12,275	0
TOTAL IMPAIRMENTS	12,275	0

Valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. A valuation of the Trust's land and buildings was carried out by DTZ, a firm of professionally qualified surveyors and valuers on 31st March 2010. The Modern Equivalent Asset (MEA) basis of valuation was used to value land and buildings.This resulted in an impairment of £12,275k of which, £11,242k was charged to the revaluation reserve and the balance of £1,033k was charged to operating expenses. Further details in respect of the valuation are shown in the accounting policy note 1.5.

Note 7.1 Intangible assets at the balance sheet date comprise the following: The Trust only holds Software Licences (purchased)	2009/10 £000	2008/09 £000
Gross Cost as at 1st April	383	332
Additions – purchased	53	51
Gross Cost at 31st March	**436**	383
Amortisation as at 1st April	307	254
Provided during year	8	53
Amortisation at 31st March	**315**	307
Net book value:		
Total Purchased at 1st April	76	78
Total Purchased at 31st March	**121**	76

Note 7.2 Intangible assets acquired by government grant

No intangible assets were acquired by government grant

Note 7.3 Economic life of intangible assets	Minimum Life Years	Maximum Life Years
Software licences (purchased)	2	8

Note 8.1 Property, plant and equipment 2009/10

	Total £000	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under Construction £000	Plant & Machinery £000	Information Technology £00	Furniture & Fittings £000
Gross cost at 1 April 2009	**70,513**	**4,365**	**39,677**	**420**	**6,908**	**15,733**	**3,166**	**244**
Additions – purchased	5,909	0	1,373	0	2,927	857	653	99
Additions – donated								
Reclassifications	0	0	7,776	0	(9,381)	829	776	0
Revaluation surpluses	(13,480)	(765)	(12,670)	(45)	0	0	0	0
Gross cost at 31 March 2010	**62,942**	**3,600**	**36,156**	**375**	**454**	**17,419**	**4,595**	**343**
Accumulated depreciation at 1 April 2009	**13,411**	**0**	**541**	**5**	**0**	**11,282**	**1,412**	**171**
Provided during the year	2,550	0	654	5	0	1,292	562	37
Impairments recognised in operating expenses	(1,033)	0	(1,027)	(6)	0	0	0	0
Revaluation surpluses	(172)	0	(168)	(4)	0	0	0	0
Accumulated depreciation at 31 March 2010	**14,756**	**0**	**0**	**0**	**0**	**12,574**	**1,974**	**208**
Net book value								
NBV – Purchased at 1 April 2009	56,856	4,365	38,935	415	6,908	4,411	1,754	68
NBV – Donated at 1 April 2009	246	0	201	0	0	40	0	5
NBV total at 1 April 2009 as restated	**57,102**	**4,365**	**39,136**	**415**	**6,908**	**4,451**	**1,754**	**73**
Net book value								
NBV – Purchased at 31 March 2010	47,957	3,600	35,959	375	454	4,816	2,621	132
NBV – Donated at 31 March 2010	229	0	197	0	0	29	0	3
NBV total at 31 March 2010	**48,186**	**3,600**	**36,156**	**375**	**454**	**4,845**	**2,621**	**135**

Note 8.1 Property, plant and equipment 2008/09

Gross cost at 1 April 2008	**63,045**	**4,365**	**39,078**	**420**	**1,640**	**14,631**	**2,679**	**232**
Additions – purchased	7,480	0	378	0	6,202	657	231	12
Reclassifications	0	0	221	0	(934)	457	256	0
Disposals	(12)	0	0	0	0	(12)	0	0
Gross cost at 31 March 2009	**70,513**	**4,365**	**39,677**	**420**	**6,908**	**15,733**	**3,166**	**244**
Accumulated depreciation at 1 April 2008	**11,114**	**0**	**0**	**0**	**0**	**10,038**	**946**	**130**
Provided during the year	2,299	0	541	5	0	1,246	466	41
Disposals	(2)	0	0	0	0	(2)	0	0
Accumulated depreciation at 31 March 2009	**13,411**	**0**	**541**	**5**	**0**	**11,282**	**1,412**	**171**
Net book value								
NBV – Purchased at 1 April 2008	51,735	4,365	39,958	420	1,640	4,524	1,733	95
NBV – Donated at 1 April 2008	196	0	120	0	0	69	0	7
NBV total at 1 April 2008	**51,931**	**4,365**	**39,078**	**420**	**1,640**	**4,593**	**1,733**	**102**
Net book value								
NBV – Purchased at 31 March 2009	56,856	4,365	38,935	415	6,908	4,411	1,754	68
NBV – Donated at 31 March 2009	246	0	201	0	0	40	0	5
NBV total at 31 March 2009	**57,102**	**4,365**	**39,136**	**415**	**6,908**	**4,451**	**1,754**	**73**

Note 8.2 Analysis of property, plant and equipment 31 March 2010

Net book value	Total £000	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under Construction £000	Plant & Machinery £000	Information Technology £00	Furniture & Fittings £000
NBV – Protected assets at 31 March 2010	40,131	3,600	36,156	375				
NBV – Unprotected assets at 31 March 2010	8,055	0	0	0	454	4,845	2,621	135
Total at 31 March 2010	**48,186**	**3,600**	**36,156**	**375**	**454**	**4,845**	**2,621**	**135**

Note 8.2 Analysis of property, plant and equipment 31 March 2009

Net book value								
NBV – Protected assets at 31 March 2009	43,918	4,365	39,136	415				
NBV – Unprotected assets at 31 March 2009	13,186	0	0	0	6,908	4,451	1,754	73
Total at 31 March 2009	**57,102**	**4,365**	**39,136**	**415**	**6,908**	**4,451**	**1,754**	**73**

Note 8.3 Economic life of property plant and equipment	**Minimum Life Years**	Maximum Life Years
Buildings excluding dwellings	**9**	98
Dwellings	**79**	79
Assets under Construction and POA	**0**	0
Plant & Machinery	**0**	10
Information Technology	**1**	10
Furniture & Fittings	**1**	9

Note 9 Net Book Value of Assets held under finance leases

No tangible assets were held under finance leases during 2008/09 and 2009/10

Note 10 Non current assets for sale and assets and liabilities in disposal groups

No non current assets were held for sale during 2008/09 and 2009/10

No liabilities or assets were held in disposal groups during 2008/09 and 2009/10

Note 11.1 Inventories	**2009/10 £000**	2008/09 £000
Finished goods	603	662
Total Inventories	**603**	662

Note 11.2 Inventories	**2009/10 £000**	2008/09 £000
Inventories recognised in expenses	**5,731**	5,489
Write-down of inventories recognised as an expense	**0**	0
Reversal of any write down of inventories resulting in a reduction of recognised expenses	**0**	0
Total Inventories recognised in expenses	**5,731**	5,489

Note 12.1 Trade receivables and other receivables	Total 31 March 2010 £000	Financial assets 31 March 2010 £000	Non-financial assets 31 March 2010 £000	Total 31 March 2009 £000	Financial assets 31 March 2009 £000	Non-financial assets 31 March 2009 £000
Current						
NHS Receivables	**2,520**	**2,520**	**0**	2,445	2,445	0
Other receivables with related parties	**900**	**900**	**0**	481	481	0
Provision for impaired receivables	**(137)**	**(137)**	**0**	(300)	(300)	0
Prepayments	**734**	**0**	**734**	669	0	669
PFI Prepayments				0	0	0
Prepayments – Capital contributions				0	0	0
Prepayments – Lifecycle replacements				0	0	0
Accrued income				0	0	0
Corporation tax receivable				0	0	0
Finance Lease Receivables				0	0	0
PDC receivable	**346**	**0**	**346**	0	0	0
Other receivables	**564**	**564**	**0**	829	829	0
Total Current Trade and Other Receivables	**4,927**	**3,847**	**1,080**	4,124	3,455	669

The Trust held no non-current trade and other receivables.

Note 12.2 Provision for impairment of receivables	2009/10 £000	2008/09 £000
At 1st April 2009	**300**	231
Increase in provisions	**0**	69
Amounts utilised	**0**	0
Unused amounts reversed	**(163)**	0
At 31st March 2010	**137**	300

Note 12.3 Analysis of impaired receivables	2009/10 £000	2008/09 £000
Ageing of impaired receivables		
Up to three months		
In three to six months		
Over six months	**137**	300
Total	**137**	300
Ageing of non-impaired receivables		
Up to three months	**645**	2,257
In three to six months	**29**	923
Over six months	**2,886**	275
Total	**3,560**	3,455

Impaired receivables have been aged on the basis of invoice date.

Note 12.4 Analysis of finance lease receivables

The Trust held no finance lease receivables

Note 13 Other assets

The Trust held no other assets

Note 14.1 Trade and other payables

	Total 31 March 2010 £000	Financial liabilities 31 March 2010 £000	Non-financial assets 31 March 2010 £000	Total 31 March 2009 £000	Financial liabilities 31 March 2009 £000	Non-financial liabilities 31 March 2009 £000
Current						
Receipts in advance	**0**	0	0	0	0	0
NHS payables	**1,313**	1,313	0	2,552	2,552	0
Amounts due to other related parties	**0**	0	0	105	105	0
Trade payables – capital	**527**	527	0	1,500	1,500	0
Other trade payables	**0**	0		0	0	0
Taxes payable	**1,216**	1,216	0	1,169	1,169	0
Other payables	**3,651**	3,651	0	2,945	2,945	0
Accruals	**3,191**	3,191	0	4,016	4,016	0
PDC payable	**0**	0	0	0	0	0
Reclassified to liabilities held in disposal groups in year	**0**	0	0	0	0	0
TOTAL CURRENT TRADE AND OTHER PAYABLES	**9,898**	9,898	0	12,287	12,287	0

The Trust held no non current trade and other payables

Note 15 Other liabilities

	2009/10 31st March 2010 £000	2008/09 31st March 2009 £000
Current		
Deferred income	**804**	683
Deferred PFI credits	0	0
Deferred Government Grant	0	0
Net Pension Scheme Liability	**0**	0
TOTAL OTHER CURRENT LIABILITIES	**804**	683

The Trust held no non-current liabilities.

Note 16 Prudential Borrowing Limit

The Liverpool Women's NHS Foundation Trust is required to comply and remain within a Prudential Borrowing Limit (PBL). This is made up of two elements:

a) the maximum cumulative amount of long term borrowing, set by reference to five ratio tests set out in Monitor's Prudential Borrowing Code further details of which can be found on the website of Monitor;
b) the amount of any working capital facility approved by Monitor.

The Trust had a prudential borrowing limit (PBL) of £23.6 million (£23.4million in 2008/09) of which £18.6m (£18.4m) related to long-term borrowing and £5m (£5m) to a working capital facility. The Trust has not yet borrowed against this limit and thus the only ratio of relevance is that of the Minimum Dividend Cover. The table below confirms that the Trust was within the approved ratios set by Monitor in its guidance document "Prudential Borrowing Code (PBC) for NHS Foundation Trusts 1 April 2009.

Component of Prudential Borrowing Code	2009/10 Actual Ratio	2009/10 Approved Ratio Tier 1	2008/09 Actual Ratio	2008/09 Approved Ratio
Maximum Debt/Capital Ratio			Not Applicable	25%
Minimum Dividend Cover	**4.2**	**>1x**	4.5	>1x
Minimum Interest Cover	Not Applicable	**>3x**	Not Applicable	>3x
Minimum Debt Service Cover	Not Applicable	**>2x**	Not Applicable	>2x
Maximum Debt Service to Revenue	Not Applicable	**< 2.5%**	Not Applicable	<3%

On 31st March 2010 the Trust had in place an actual working capital facility of £5million.

Note 17.1 Provisions for liabilities and charges

	Current		Non Current	
	31 March 2010 £000	31 March 2009 £000	31 March 2010 £000	31 March 2009 £000
Pensions relating to Other Staff	60	60	808	922
Other Legal Claims	29	60	0	0
Agenda for Change	0	0	0	0
Other	0	0	162	1,022
Total	**89**	**120**	**970**	**1,944**

Note 17.2 Provisions for liabilities and charges

	Total £000	Pensions – other staff £000	Other legal claims £000	Other £000
At 1 April 2009	**2,064**	**982**	**60**	**1,022**
Arising during the year	44	0	44	0
Utilised during the year	(104)	(60)	(44)	0
Reclassified to liabilities in disposal groups in year				
Reversed unused	(965)	(74)	(31)	(860)
Unwinding of discount	20	20	0	0
At 31 March 2010	**1,059**	**868**	**29**	**162**
Expected timing of cashflows:				
- not later than one year	**251**	60	29	162
- later than one year and not later than five years	**240**	240	0	0
- later than five years	**568**	568	0	0
Total	**1,059**	**868**	**29**	**162**

Pensions relating to other staff are for early retirements and reflect actuarial forecasts in respect of the duration of payments.

Other Legal Claims comprises amounts due as a result of third party and employee liability claims. The values are informed by information provided by the NHS Litigation Authority.

£57,934,108 is included within the provisions of the NHS Litigation Authority as at the 31st March 2010 in respect of the clinical negligence liabilities of the Trust (31st March 2009 £60,874,868).

Note 18 Revaluation Reserve

	Total Revaluation Reserve £000	Revaluation Reserve – Intangibles £000	Revaluation Reserve – property, plant and equipment £000
Revaluation reserve at 1 April 2009	**15,549**	**63**	**15,486**
Revaluation gains/(losses) and impairment losses on property plant and equipment	(11,242)	0	(11,242)
Revaluation reserve at 31 March 2010	4,307	63	4,244
Revaluation reserve at 1 April 2008	15,616	63	15,553
Revaluation gains/(losses) and impairment losses on property plant and equipment	0	0	0
Other transfer between reserves	(67)	0	(67)
Revaluation reserve at 31 March 2009	**15,549**	**63**	**15,486**

Third Party Assets

The Trust held no cash or other assets on behalf of patients at 31st March 2010.

Note 19.2 Net cash generated from operations	2009/10 £000	2008/09 £000
Cash flows from operating activities		
Operating surplus	**3,177**	5,922
Non-cash income and expense:		
Depreciation and amortization	**2,558**	2,352
Impairments	**1,033**	0
Transfer from the donated asset reserve	**(17)**	(17)
Increase in Trade and Other Receivables	**(459)**	(360)
Decrease/(Increase) in Inventories	**59**	(171)
(Decrease)/Increase in Trade and other Payables	**(1,416)**	2,530
Increase/(Decrease) in Other Liabilities	**121**	(77)
Decrease in Provisions	**(1,025)**	(141)
Other movements in operating cashflows	**(17)**	0
NET CASH GENERATED FROM/(USED IN) OPERATIONS	**4,014**	10,038

Note 19.3 Other financial assets	2009/10 £000	2008/09 £000
Held to maturity investments	2,000	1,500
Total	**2,000**	1,500
Held to maturity investments includes £2,000k temporary cash surpluses deposited with the National Loans Fund.		

Note 20. Contractual Capital Commitments

At the balance sheet date of 31st March 2010 the Trust had capital commitments of £1,168,425 in respect of property plant and equipment (2008/09 £3,035,474).

Note 21. Contingent (Liabilities)/Assets	2009/10 £000	2008/09 £000
Gross value of contingent liabilities	6	18
Amounts recoverable against liabilities	0	0
Net value of contingent liabilities	6	18
Net value of contingent assets	0	0

Note 22.1. Related Party Transactions

Transactions with related parties are undertaken on a normal commercial basis.

During the year none of the Trust Board members or any party related to them have undertaken any transactions with this Trust.

During the year with the exception of the transaction described below none of the key staff members of the Trust or any party related to them have undertaken any transactions with this Trust.

Senior clinical and scientific managers within the Trust hold directorships and shareholdings in North West Fertility Limited to whom the Trust provides a range of clinical support services. During the year the Trust invoiced £2,094k in respect of those services (2009: £1,799k). At the 31st March 2010 the Trust was owed £557k (2009: £49k)

The Liverpool Women's NHS Foundation Trust is a public interest body authorised by Monitor, the Independent Regulator for NHS Foundation Trusts. It undertakes as part of its ongoing provision of healthcare services in accordance with its terms of authorisation a number of transactions are undertaken with bodies defined as being within the scope of Whole Government Accounts (WGA) including the Department of Health and for other entities that the Department is regarded as the parent department. The total value of the transactions that were undertaken are listed below, together with the names of the individual entities for the most significant of those transactions.

	Income £000	Expenditure £000	Receivables Balance £000	Payables Balance £000
Total Value of transactions with other related parties in 2009/10	**86,026**	**6,580**	**3,453**	**1,421**
Individual entities with Income or expenditure transactions over £1,000k:				
Liverpool PCT	38,493	0	40	2
Western Cheshire PCT	10,922	0	103	0
Sefton PCT	10,165	0	76	0
Knowsley PCT	6,829	0	0	52
North West Strategic Health Authority	4,961	0	61	0
Halton and St. Helens PCT	3,011	0	0	165
Wirral PCT	2,368	0	33	10
Health Commission Wales	1,084	0	0	11
Royal Liverpool and Broadgreen University Hospitals NHS Trust	561	2,830	528	662
Aintree University Hospitals NHS Foundation Trust	171	2,603	4	51
NHS Litigation Authority	0	4,518	0	1
Total Value of transactions with other related parties in 2008/09	**83,469**	**9,329**	**2,509**	**2,557**
Liverpool PCT	33,427	130	37	5
Western Cheshire PCT	13,005	0	281	0
Sefton PCT	9,039	0	501	0
Knowsley PCT	6,175	0	152	0
North West Strategic Health Authority	4,960	18	28	0
Halton and St. Helens PCT	2,757	0	0	28
Warrington PCT	1,073	0	22	0

The Trust is the corporate trustee of the Liverpool Women"s NHS Foundation Charitable Trust and receives grants from the Charity in accordance with its charitable objectives. During the year the Trust received charitable grants from that body amounting to £155k (2009: £233k). At the 31st March 2010 the Trust was owed £11k by the Charity (2009: £15k).

Note 23.1 Financial assets by category

	Total £000	Loans & receivables £000	Assets at fair value through Income & Expenditure Account £000	Held to maturity £000	Available-for-sale £000
Assets as per Statement of Financial Position	3,847	3,847			
Trade and other receivables excluding non financial assets (at 31 March 2010)					
Other investments (at 31 March 2010)					
Other Financial Assets at 31 March 2010	2,000			2,000	
Non current assets held for sale and assets held in disposal group excluding non financial assets (at 31 March 2010)					
Cash and cash equivalents (at 31 March 2010)	9,366	9,366			
Total at 31 March 2010	**15,213**	**13,213**	**0**	**2,000**	**0**
Assets per Statement of Financial Position	3,445	3,445			
Trade and other receivables excluding non financial assets (at 31 March 2009)					
Other investments (at 31 March 2009)					
Other Financial Assets at 31 March 2009	1,500			1,500	
Non current assets held for sale and assets held in disposal group excluding non financial assets (at 31 March 2009)					
Cash and cash equivalents (at 31 March 2009)	14,670	14,670			
Total at 31 March 2009	**19,615**	**18,115**		**1,500**	

Note 23.2 Financial liabilities by category	Total £000	Other financial liabilities £000	Liabilities at fair value through the I &E £000
Liabilities as per Statement of Financial Position			
Trade and other payables excluding non financial assets (31 March 2010)	**9,898**	9,898	
Provisions under contract (at 31 March 2010)	**1,059**	1,059	
Liabilities in disposal groups excluding non-financial assets (at 31 March 2010)			
Total at 31 March 2010	**10,948**	10,948	
Trade and other payables excluding non financial liabilities (31 March 2009)	**12,287**	12,287	
Provisions under contract (at 31 March 2009)	**2,064**	2,064	
Total at 31 March 2009	**14,351**	14,351	

Note 23.3 Fair values of financial assets at 31 March 2010	Book Value £000	Fair value £000
Cash and cash equivalents	9,366	9,366
Total	**9,366**	**9,366**

Note 23.4 Fair values of financial assets at 31 March 2009	Book Value £000	Fair value £000
Cash and cash equivalents	14,670	14,670
Total	**14,670**	**14,670**

Note 23.5 Fair values of financial liabilities at 31 March 2010	Book Value £000	Fair value £000
Provisions under contract	1,059	1,059
Total	**1,059**	**1,059**

Note 23.6 Fair values of financial liabilities at 31 March 2009	Book Value £000	Fair value £000
Provisions under contract	2,064	2,064
Total	**2,064**	**2,064**

Note 23.7 Financial Risk Management

Background

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with primary care trusts and the way those primary care trusts are financed the Trust is not exposed to the degree of financial risk faced by business entities. In addition financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies to which the financial reporting standards mainly apply.

The Trust's treasury management operations are carried out by the finance department of the Trust within parameters agreed by the Trust Board and subject to review by the Trust"s internal auditors.

Liquidity risk

The Liverpool Women's NHS Foundation Trust net operating costs are incurred under legally binding contracts with local Primary Care Trusts (PCTs). The Trust receives regular monthly payments from PCTs based on an agreed contract value with adjustments made for actual services provided. The availability of a working capital facility with the Trust's bankers mitigates the risk arising from potential variations in income arising from delivery of patient care services.

The Trust finances its capital expenditure from internally generated funds or Public Dividend Capital made available by the Department of Health. The Trust is therefore not exposed to significant liquidity risks.

Interest Rate Risk

All of the Trust's financial assets carry nil or fixed rates of interest. The Trust is not exposed to significant interest rate risk.

Foreign Currency Risk

The Trust is principally a domestic organisation and has negligible foreign currency income or expenditure transactions and therefore has low exposure to currency rate fluctuations during any financial year, though not from one year to another.

Price Risk

The contracts from NHS commissioners in respect of healthcare services have a pre-determined price structure which negates the risk of price fluctuation.

Credit Risk

The contracts form NHS commissioners in respect of healthcare services are agreed annually and take into account the commissioners' ability to pay and hence the credit risk is minimal.

Note 24. Losses and Special Payments

NHS Foundation Trusts are required to record cash payments and other adjustments that arise as a result of losses and special payments. These are reported on an accruals basis but excluding provisions for future losses.

In the year 2009/10 the Trust had 382 (2008/09 340) separate losses and special payments, totaling £87,763.91 (2008/09 £119,587).

The bulk of these were in relation to the impairment of receivables. There were no net payments in excess of £100,000 for individual cases of clinical negligence, fraud, personal injury, compensation under legal obligation or fruitless payment cases.

Note 25. First time adoption of IFRS

IFRS 1 grants certain exemptions from the full requirements of IFRS in the transition period. The following exemption has been taken in the consolidated historical financial performance in that the net book values of all items of property, plant and equipment at the date of transition have been treated as deemed cost.

Reconciliation statements are provided below in respect of the movement from:

- Income and expenditure Account to Statement of Comprehensive Income for the year ended 31st March 2009
- Balance Sheet to Statement of Financial Position at 31st March 2009 and 31st March 2008.
- Cashflow statement to Statement of Cash flows for the year ended 31st March 2009.
- A summary of the main changes on the aforementioned statements are as follows:
  - Accrual for Employees' unused annual leave entitlement of £431k at 31st March 2009; and
  - Reclassification of items in the Statement of Comprehensive Income and Statement of Financial Position.

Group Income and Expenditure Account	UK GAAP 31 March 2009 £000	IFRS Adjustments All IAS 1 £000	IFRS Restated 31 March 2009 £000	Statement of Comprehensive Income
INCOME AND EXPENDITURE ACCOUNT				STATEMENT OF COMPREHENSIVE INCOME
Income from activities	76,117	9,473	85,590	Operating Income
Other Operating Income	9,473	(9473)		
Operating expenses	(79,667)	(1)	(79668)	Operating expenses
OPERATING SURPLUS/(DEFICIT)	5,923		5,922	OPERATING SURPLUS/(DEFICIT) FINANCE COSTS
		632	632	Finance Income
			0	Finance expense – financial liabilities
		(20)	(20)	Finance expense – unwinding of the discount on provisions
		(1,986)	(1,986)	PDC Dividends payable
Cost of fundamental reorganization/re-structuring/other Profit/(Loss) on disposal of fixed assets	(9)	9		
SURPLUS/(DEFICIT) BEFORE INTEREST	5,914		(1,374)	NET FINANCE COSTS
			0	Share of profit/(Loss) of Associates/Joint Ventures accounted for using the equity method
Finance Income	632	(632)		
Finance costs – interest expense	0	0		
Other gains/(losses) on financial instru-ments	0	0		
Other finance costs – unwinding of the discount	(20)	20		
Other finance costs – changes in dis-count rate on provisions	0	0		
SURPLUS/(DEFICIT) BEFORE TAXATION AND MINORITY INTEREST	6,526		4,548	
PDC dividends payable	(1,986)	1,986	0	

Group Income and Expenditure Account	UK GAAP 31 March 2009 £000	IFRS Adjustments All IAS 1 £000	IFRS Restated 31 March 2009 £000	Statement of Comprehensive Income
INCOME AND EXPENDITURE ACCOUNT (continued)				**STATEMENT OF COMPREHENSIVE INCOME**
RETAINED SURPLUS FOR THE YEAR	4,540		4,548	Surplus/(Deficit) from continuing operations
			0	Surplus/(Deficit)of discontinued operations and the profit/(loss) on disposal of discontinued operations
		8	4,548	**SURPLUS/(DEFICIT) FOR THE YEAR**
STATEMENT OF RECOGNISED GAINS AND LOSSES				OTHER COMPREHENSIVE INCOME
Surplus/(deficit) for the year before dividend payments	6,526			
			0	Share of comprehensive income from associates
Fixed asset impairment losses	0			
Unrealised surplus/(deficit) on fixed asset revaluations	0		0	Revaluation gains/(losses) and impairment losses on intangible assets
Net gains/(losses) on available for sale investments	0		0	impairment losses property, plant and equipment
			0	Fair value gains/(losses) on Available for sale financial investments
			0	Recycling gains/(losses) on Available for sale financial investments
Increase in the donated asset reserve due to receipt of donated assets	0		0	Increase in the donated asset reserve due to receipt of donated assets
Reduction to the donated asset reserve in respect of depreciation, impairment, and/or disposal of donated assets	(17)		(17)	Reduction to the donated asset reserve in respect of depreciation, impairment, and/or disposal of donated assets
Additions/(reduction) in 'Other reserves'	0		0	Additions/(reduction) in „Other reserves"
Other recognised gains and losses	0		0	Other recognised gains and losses
			0	Actuarial gains/(losses) on defined benefit pension schemes where recognised under UK GAAP
TOTAL RECOGNISED GAINS AND LOSSES FOR THE FINANCIAL YEAR	6,509		4,531	TOTAL COMPREHENSIVE INCOME AND EXPENSE FOR THE YEAR
Prior period adjustments	0		0	Prior period adjustments
TOTAL RECOGNISED GAINS AND LOSSES FOR THE FINANCIAL YEAR	6,509		4,531	TOTAL COMREHENSIVE INCOME AND EXPENSE FOR THE YEAR
Note: Allocation of Profits/(Losses) for the period:				Note: Allocation of Profits/(Losses) for the period:
(a) profit/(loss) for the period attributable to: i) minority interest, and ii) owners of the parent	6,509		4,548	(b) profit/(loss) for the period attributable to: iii) minority interest, and iv) owners of the parent
(c) total comprehensive income for the period attributable to: i) minority interest, and ii) owners of the parent	6,509		4,531	(d) total comprehensive income for the period attributable to: iii) minority interest, and iv) owners of the parent

Group Balance Sheet	UK GAAP 31 March 2009 £000	IFRS Adjust IAS1 £000	IFRS Restated 31 March 2009 £000	IFRS Restated 31 March 2009 £000	Statement of Financial Position
FIXED ASSETS					**NON-CURRENT ASSETS**
Intangible assets	76			76	Intangible assets
Tangible assets	57,102			57,102	Property, plant and equipment Investment property Investments in associates Other investments Trade and other receivables
Investments	0				Other financial assets Tax receivable Other Assets
TOTAL FIXED ASSETS	57,178			57,178	TOTAL NON-CURRENT ASSETS
CURRENT ASSETS					CURRENT ASSETS
Stocks and work-in-progress	662			662	Inventories
Debtors	4,124			4,124	Trade and Other receivables
Investments	1,500			1,500	Other financial assets
				0	Tax receivable
				0	Non-current assets held for sale and assets in disposal groups
Cash at bank and in hand	14,670			14,670	Cash and cash equivalents
TOTAL CURRENT ASSETS	20,956			20,956	TOTAL CURRENT ASSETS
CREDITORS:					CURRENT LIABILITIES
Creditors falling due within one year					
Trade creditors	(10,742)	252		(10,490)	Trade and other payables
Provisions	(120)			(120)	Provisions
Tax payable	(1,797)			(1,797)	Tax payable
Other liabilities	0	(683)		(683)	Other liabilities
TOTAL CURRENT LIABILITIES	(12,659)			(13,090)	TOTAL CURRENT LIABILITIES
NET CURRENT ASSETS/(LIABILITIES)	(8,297)			(7,866)	
TOTAL ASSETS LESS CURRENT LIABILITIES	65,475				
CREDITORS:					NON-CURRENT LIABILITIES
Creditors falling due after more than one year	0			0	Trade and other payables
				0	Borrowings
				0	Other financial liabilities
PROVISIONS FOR LIABILITIES AND CHARGES	(1,944)	120		(1,944)	Provisions
				0	Tax payable
				0	Other liabilities
				(1,944)	TOTAL NON-CURRENT LIABILITIES
TOTAL ASSETS EMPLOYED	63,531	(431)		63,100	NET ASSETS TAXPAYERS' EQUITY
					Minority interest
Public Dividend Capital	35,210			35,210	Public Dividend Capital
Revaluation reserve	15,549			15,549	Revaluation Reserve
Donated asset reserve	246			246	Donated asset reserve

Group Balance Sheet	UK GAAP 31 March 2009 £000	IFRS Adjust IAS1 £000	IFRS Restated 31 March 2009 £000	IFRS Restated 31 March 2009 £000	Statement of Financial Position
FIXED ASSETS (continued)					**NON-CURRENT ASSETS**
Available for sale investments reserve	0			0	Available for sale investments reserve
Other reserves	0			0	Other reserves
				0	Merger reserve
				0	Pension reserve
Income and expenditure reserve	12,526	(431)		12,095	Income and expenditure reserve
TOTAL TAXPAYERS' EQUITY	63,531	(431)		63,100	TOTAL TAXPAYERS' EQUITY
Intangible assets	78			78	Intangible assets
Tangible assets	51,931			51,931	Property, plant and equipment Investment property Investments in associates Other investments Trade and other receivables
Investments	0				Other financial assets Tax receivable
					Other Assets
TOTAL FIXED ASSETS	52,009			52,009	TOTAL NON-CURRENT ASSETS
CURRENT ASSETS					CURRENT ASSETS
Stocks and work-in-progress	491			491	Inventories
Debtors	3,813	(159)		3,654	Trade and Other receivables
Investments	2,500	(2,431)		159	Other financial assets
				0	Tax receivable
				0	Non-current assets held for sale and assets in disposal groups
Cash at bank and in hand	12,440	2,500		14,940	Cash and cash equivalents
TOTAL CURRENT ASSETS	19,244			19,244	TOTAL CURRENT ASSETS
CREDITORS:					CURRENT LIABILITIES
Creditors falling due within one year Trade creditors	(8,477)	321		(8,156)	Trade and other payables
Provisions	(2,185)	1,797		(388)	Provisions
Tax payable	(1,460)	0		(1,460)	Tax payable
Other liabilities	0	(760)		(760)	Other liabilities
TOTAL CURRENT LIABILITIES	(12,122)			(10,764)	TOTAL CURRENT LIABILITIES
NET CURRENT ASSETS/(LIABILITIES)	(9,307)			(8,480)	
TOTAL ASSETS LESS CURRENT LIABILITIES	61,316				
CREDITORS:					NON-CURRENT LIABILITIES
Creditors falling due after more than one year	0			0	Trade and other payables
				0	Borrowings
				0	Other financial liabilities

Group Balance Sheet	UK GAAP 31 March 2009 £000	IFRS Adjust IAS1 £000	IFRS Restated 31 March 2009 £000	IFRS Restated 31 March 2009 £000	Statement of Financial Position
FIXED ASSETS (continued)					**NON-CURRENT ASSETS**
PROVISIONS FOR LIABILITIES AND CHARGES	0	(1,797)		(1,797)	Provisions
				0	Tax payable
				0	Other liabilities
				(1,797)	TOTAL NON-CURRENT LIABILITIES
TOTAL ASSETS EMPLOYED	59,131	(439)		58,692	NET ASSETS
					TAXPAYERS' EQUITY Minority interest
Public Dividend Capital	35,333			35,333	Public Dividend Capital
Revaluation reserve	15,616			15,616	Revaluation Reserve
Donated asset reserve	196			196	Donated asset reserve
Available for sale	0			0	Available for sale investments reserve
Other reserves	0			0	Other reserves
				0	Merger reserve
				0	Pension reserve
Income and expenditure reserve	7,986	(439)		7,547	Income and expenditure reserve
TOTAL TAXPAYERS' EQUITY	59,131	(439)		58,692	TOTAL TAXPAYERS' EQUITY

Cash Flow Statement	UK GAAP 31 March 2009 £000	IFRS Adjust IAS1 £000	IAS 19 £000	IFRS Restated 31 March 2009 £000	Statement of Cash flows
Operating Activities					**Cash flows from operating activities**
Available for sale investments reserve		(9)	8	5,922	Surplus/(Deficit) from continuing operations Surplus/(deficit) of discontinued operations and the gain/(loss) on disposal of discontinued operations
OPERATING SURPLUS/DEFICIT	5,923			5,922	Operating surplus/(deficit) Non-cash income and expense:
Depreciation and amortization	2,352			2,352	Depreciation and amortization
Fixed asset impairments	0				Impairments
Fixed asset reversal of impairments	0				Reversals of impairments
Transfer from the donated asset reserve	(17)			(17)	Transfer from the donated asset reserve Amortisation of government grants Amortisation of PFI credit
(Increase)/decrease in debtors	(360)	510		150	(Increase)/Decrease in Trade and Other Receivables
		(510)		(510)	(increase)/Decrease in Other Assets
(Increase)/decrease in stocks	(171)			(171)	(Increase)/Decrease in Inventories
Increase/(decrease) in creditors	2,452	(259)		2,193	Increase/(Decrease) in Trade and other Payables
		(77)		(77)	Increase/(Decrease) in Other Liabilities
Increase/(decrease) in provisions	(141)	0		(141)	Increase/(Decrease) in Provisions
		337		337	Tax (paid)/received
Other movements				0	Other movements in operating cashflows
				0	Movements in operating cashflow of discontinued operations
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES RETURNS ON INVESTMENTS AND SERVICING OF FINANCE:	10,038			10,038	NET CASH GENERATED FROM/ (USED IN) OPERATIONS Cash flows from investing activities
Interest received	683			683	Interest received
	1,000	(1,000)		0	Purchase of financial assets
					Sales of financial assets
					Purchase of intangible assets
					Sales of intangible assets
		(7,383)		(7,383)	Purchase of Property, Plant and Equipment
Interest paid		1		1	Sales of Property, Plant and Equipment
Interest element of finance lease rental payments					
NET CASH INFLOW/(OUTFLOW) FROM RETURNS ON INVESTMENTS AND SERVICING ON FINANCE	683				Cash flows attributable to investing activities of discontinued operations
				(6.699)	Net cash generated from/(used in) investing activities
TAXATION PAID/RECEIVED CAPITAL EXPENDITURE:					
(Payments) to acquire tangible fixed assets	(7,383)	7,383	0		

Cash Flow Statement	UK GAAP 31 March 2009 £000	IFRS Adjust IAS1 £000	IAS 19 £000	IFRS Restated 31 March 2009 £000	Statement of Cash flows
Operating Activities					**Cash flows from operating activities**
Receipts from sale of tangible fixed assets	1	(1)		0	
(Payments) to acquire intangible fixed assets					
Receipts from sale of intangible fixed assets					
(Payments)/receipts for fixed asset investments					
NEW CASH INFLOW/(OUTFLOW) FROM CAPITAL EXPENDITURE	(7,382)				
DIVIDENDS PAID	(1,986)	1,986		0	
NET CASH INFLOW/(OUTFLOW) FROM MANAGEMENT OF LIQUID					
RESOURCES AND FINANCING	1,353				
MANAGEMENT OF LIQUID RESOURCES:					
(Purchase) of current asset investments Sale of current asset investments	1,000	(1.000)		0	
NET CASH INFLOW/(OUTFLOW) FROM MANAGEMENT OF LIQUID RESOURCES	1,000				
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING	2,353				
TAXATION PAID/RECEIVED CAPITAL EXPENDITURE:					
NEW CASH INFLOW/(OUTFLOW) FROM CAPITAL EXPENDITURE					
DIVIDENDS PAID					
NET CASH INFLOW/(OUTFLOW) FROM MANAGEMENT OF LIQUID RESOURCES AND FINANCING					
MANAGEMENT OF LIQUID RESOURCES: (Purchase) of current asset investments Sale of current asset investments					
NET CASH INFLOW/(OUTFLOW) FROM MANAGEMENT OF LIQUID RESOURCES					
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING FINANCING:					Cash flows from financing activities
New public dividend received					Public dividend capital received
Public dividend capital repaid	(123)			(123)	Public dividend capital repaid
Loans received from Foundation Trust					Loans received
Financing Facility					
Other loans received					
Loans repaid to Foundation Trust					Loans repaid

Cash Flow Statement	UK GAAP 31 March 2009 £000	IFRS Adjust IAS1 £000	IAS 19 £000	IFRS Restated 31 March 2009 £000	Statement of Cash flows
Operating Activities					**Cash flows from operating activities**
Loans repaid to Foundation Trust					Loans repaid
Financing Facility					
Other loans repaid					
Other capital receipts					Cash flows from (used in) other financing activities
					Cash flows attributable to financing activities of discontinued operations
Capital element of finance lease rental payments					Capital element of finance lease rental payments
					Capital element of Private Finance Obligations
					Interest paid
					Interest element of finance lease rental payments
					Interest element of Private Finance Initiative obligations
					Cash from acquisitions/(disposals) of business units and subsidiaries
		(1,986)		(1,986)	PDC Dividend paid
NET CASH INFLOW/(OUTFLOW) FROM FINANCING	2,230			(2,109)	Net cash generated from/(used in) financing activities
INCREASE/(DECREASE) IN CASH				1,230	Increase/(decrease) in cash and cash equivalents
				14,940	Cash and cash equivalents at 1 April 2008
				16,170	Cash and cash equivalents at 1 April 2009

Note 26. Segmental Reporting

The Chief Executive and the Board receive sufficient and appropriate high level information to enable the business to be managed effectively and to monitor and manage the strategic aims of the Trust. Sufficiently detailed information is used by middle and lower management to ensure effective management at an operational level. Neither of these are sufficiently discrete to profile operating segments, as defined by IFRS8, that would enable a user of these financial statements to evaluate the nature and financial effects of the business activities that this Trust undertakes.

The development of Clinical Business Units during 2010 will enable the Trust to provide sufficiently discrete operating segmental reporting information. The first full financial year this will be available is 2011/2012. Investments in IT infrastructure to support the provision of this information and for the Chief Executive and the Board to receive the appropriate level of information to assess performance of the hospital on a Clinical Business Units basis.

The bulk of these were in relation to the impairment of receivables. There were no net payments in excess of £100,000 for individual cases of clinical negligence, fraud, personal injury, compensation under legal obligation or fruitless payment cases.

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

We have audited the financial statements of Liverpool Women's NHS Foundation Trust, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayer's Equity, the Statement of Cash Flows and the related notes.

This report is made solely to the Council of Governors of Liverpool Women's NHS Foundation Trust ("the Trust"), as a body, in accordance with the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to it in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not, in giving our opinion, accept or assume responsibility to anyone other than the Trust and the Trust's Governors, as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of directors and auditors

The Accounting Officer's responsibilities for preparing the financial statements in accordance with directions made by the Independent Regulator of NHS Foundation Trusts ("Monitor") for being satisfied that the financial statements give a true and fair view are set out in the Statement of Accounting Officer's Responsibilities.

Our responsibility is to audit the financial statements and the part of the Directors' Remuneration Report to be audited in accordance with the Audit Code for NHS Foundation Trusts, relevant legal and regulatory requirements and International Standards on Auditing (UK and Ireland).

We report to you our opinion as to whether the financial statements give a true and fair view and are properly prepared in accordance with directions issued under paragraph 25(2) of Schedule 7 of the National Health Service Act 2006 as directed by Monitor. We report whether the part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts.

We read other information contained in the Annual Report and consider whether it is consistent with the audited financial statements. The other information comprises only the Chief Executive's introduction, the Directors' Report, the sections on Finance, NHS Foundation Trust Code of Governance and the Remuneration Report. We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies within the financial statements. Our responsibilities do not extend to any other information.
In addition, we report to you if, in our opinion, the Trust has not kept adequate accounting records, or if we have not received all the information and explanations we require for our audit.

We review whether the Statement on Internal Control reflects compliance with Monitor's guidance issued in the NHS Foundation Trust Financial Reporting Manual. We report if it does not meet the requirements specified by Monitor or if the statement is misleading or inconsistent with other information we are aware of from our audit of the financial statements. We are not required to consider, nor have we considered, whether the Statement on Internal Control covers all risks and controls. We are also not required to form an opinion on the effectiveness of the Trust's corporate governance procedures or its risk and control procedures.

Basis of audit opinion

We conducted our audit in accordance with International Standards on Auditing (UK and Ireland) issued by the Auditing Practices Board. An audit includes examination, on a test basis, of evidence relevant to the amounts and disclosures in the financial statements. It also includes an assessment of the significant estimates and judgements made by the Accounting Officer in the preparation of the financial statements, and of whether the accounting policies are appropriate to the Trust's circumstances, consistently applied and adequately disclosed.

We planned and performed our audit so as to obtain all the information and explanations which we considered necessary in order to provide us with sufficient evidence to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or other irregularity or error. In forming our opinion we also evaluated the overall adequacy of the presentation of information in the financial statements.

Opinion

In our opinion

- the financial statements of Liverpool Women's NHS Foundation Trust's give a true and fair view of the Trust's state of affairs as at 31 March 2010, its income and expenditure, gains and losses and cash flows for the year then ended and have been properly prepared in accordance with directions issued under paragraph 25(2) of Schedule 7 of the National Health Service Act 2006 as directed by Monitor; and
- the part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts.

Certificate

We certify that we have completed the audit of the accounts in accordance with the requirements of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

Baker Tilly UK Audit LLP

Keith Ward (Senior Statutory Auditor)
For and on behalf of BAKER TILLY UK AUDIT LLP, Statutory Auditor
Chartered Accountants
3 Hardman Street
Manchester
M3 3 HF
4th June 2010

Liverpool Women's
NHS Foundation Trust

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NHS