Liverpool Women's NHS
NHS Foundation Trust

Annual Report and Accounts for the year ended 31 March 2011

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Welcome from the Chair

I am delighted to welcome you to Liverpool Women's 2010/11 annual report. This is our sixth year as an NHS Foundation Trust and you will see from this report that our mission of providing excellent healthcare for women, babies and their families in a safe, friendly and caring environment continues.

This mission has perhaps been even more challenging in the past year as the economic downturn continues to demand greater efficiencies across the public sector. Our commitment to high quality, safe care has continued unabated, however. I am therefore especially proud that this report so clearly demonstrates that Liverpool Women's continues to be a great place to receive care and a great place to work, evidence of which you will see through the pages that follow and which illustrate that our clinical and financial performance remains strong.

Of significant importance during this year was the election of a new national government in 2010, quickly followed by publication of a White Paper and then the Health and Social Care Bill 2011. The Trust will continue to carefully consider the likely impact and opportunities new legislation will bring, and will strive to ensure that whatever shape or form the NHS takes, everyone who comes to Liverpool Women's has the best experience possible.

Finally, I must convey sincere thanks to the Trust's staff, without whom we would not be the place of excellence we are. Thanks are also conveyed to members of our Council of Governors whose involvement, ideas, comments and challenge keep us firmly focused on what matters most – our patients.

Ken Morris

Ken Morris
Chair

Introduction from the Chief Executive

Our achievements of the past year are no less impressive than the years before, and it gives me great pleasure to present details of these in the third annual report I have brought to you as Liverpool Women's Chief Executive.

2010/11 has been another successful and very busy year. It was also an especially challenging one which saw the need to make efficiencies whilst at the same time developing and improving our services. We managed to achieve both. This is due in no small part to the hard work and commitment of our staff and the passion they share with me, the rest of the Board of Directors, and our Council of Governors, to make Liverpool Women's a special place to be.

Amongst many other things, during the year we:

- Introduced a neonatal transport service 24/7
- Saw the introduction of a service for first trimester screening for Down's Syndrome
- Continued with the refurbishment of our maternity facilities to provide the best possible environment for women and their babies
- Transferred major and intermediate surgery, and some day case surgery, from Aintree Centre for Women's Health to our Crown Street site whilst at the same time refurbishing the outpatient facilities at the Aintree Centre
- Brought chemotherapy services on site for women with gynaecological cancers so they no longer have to travel to Clatterbridge Centre for Oncology on the Wirral
- Launched our patient involvement and engagement strategy
- Developed a micro array service in our medical genetics services, which provides more comprehensive test results for interpretation
- Launched our Single Equality Scheme (2010 - 2014) which was developed in partnership with our local community, staff, patients and their families
- Further strengthened our governance arrangements
- Launched the Kitty Appeal in order to raise charitable funds.

You will find details of even more of our achievements throughout this report.

During the year we also began to address the implications of the forthcoming new health and social care legislation. This will see the application of market-based principles to the provision of health care with the aim of increasing diversity of supply, promoting competition and increasing choice for patients. Liverpool Women's is committed to seizing the opportunities these changes will bring and ensuring its patients benefit from them.

I join the Chair in saying a big thank you to our fantastic, dedicated staff, and to our governors, volunteers and stakeholders, for making Liverpool Women's what it is – a Trust to be proud of.

Kathryn Thomson

Kathryn Thomson
Chief Executive

Our vision, aims and values

Our vision is to be the recognised leader in healthcare for women, babies and their families.

Our aims are:

To develop a well led, capable and motivated workforce

To be efficient and make best use of available resources

To deliver safe services

To deliver the most effective outcomes

To deliver the best possible experience for patients and staff

And _our values_ are:

Caring – we show we care about people

Ambition – we want the best for people

Respect – we value the differences and talents of people

Engaging – we involve people in how we do things

Learn – we learn from people past, present and future

Liverpool Women's is the largest women's hospital in Europe

Directors' report

About Liverpool Women's…

Liverpool Women's NHS Foundation Trust provides a comprehensive range of health care for women and babies from Liverpool and surrounding areas.

It is the largest women's hospital in Europe and has been an NHS Foundation Trust since 1 April 2005. Prior to that it had operated as Liverpool Women's Hospital NHS Trust, created in 1995, when all services for women and babies in Liverpool came together under one roof at Liverpool Women's Hospital in Toxteth, Liverpool.

In 2000 the Trust began operating the Aintree Centre for Women's Health which provides services to women from north Liverpool, Sefton and Knowsley.

Some 67% of the Trust's income comes from contracts with Liverpool, Sefton and Knowsley Primary Care Trusts.

In 2010/2011 we:

- Delivered 8,344 babies
- Undertook gynaecological procedures on 6,145 women
- Cared for 1,185 babies in our neonatal intensive and high dependency care units
- Performed 1,255 cycles of in-vitro fertilisation (IVF).

Our full range of care includes:

Maternity & Imaging

Antenatal care, both hospital and community based

Ultrasound and radiology

Fetal medicine – the care of pregnant women who are ill or whose unborn baby is ill

Maternal medicine

Delivery of babies in our midwife-led unit, delivery suite or at the woman's own home

Infant feeding support

Smoking cessation support

Parent education

Public health advice

Specialist clinics e.g. for teenagers, women with mental health problems, diabetes

Gynaecology & Surgical Services

Full range of general gynaecology

Urogynaecology

Care for women with gynaecological cancer

Termination of pregnancy

Family planning

Recurrent miscarriage clinic

Emergency care

Menopause care

Theatres and anaesthesia

Physiotherapy

Genetics & Reproductive Medicine

Clinical genetics

Laboratory based cytogenetics and molecular genetics

In-vitro fertilisation (IVF)

Vitro fertilisation with Intra-cytoplasmic Sperm Injection (ICSI)

Donor insemination

Sperm recovery

Freezing of embryos, sperm and eggs

Frozen embryo transfer

Ovum (egg) donation

Sperm bank

Neonatology & Pharmacy

Neonatal intensive care

Neonatal high dependency care

Transitional care (run jointly with maternity services)

Newborn hearing screening

Newborn eye screening

Pharmacy services

The Board of Directors are pleased to present a fair review of the Trust's business during the financial year. In doing so the Directors have ensured that so far as they are aware, there is no relevant audit information of which the auditors are unaware and the directors have taken all steps that they 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.

Our annual plan was developed to ensure we delivered the maximum benefit for women, babies and their families from the resources we have available. We recognise that there are always many things we could do and would like to do, and so it is important that we remain focussed on the things we said we would deliver in our annual plan. Here we are pleased to report to in respect of those plans.

Business review

Business review (management commentary / operating and financial review)

In our annual plan for 2010/11 we set out how we intended to achieve our corporate aims as set out on page 16. Our key achievements against these aims is summarised below together with our other service developments during the year. This impressive list of achievements demonstrates how the Trust is using its status as an NHS Foundation Trust to drive up the quality and range of our services whilst achieving efficiencies year-on-year:

Workforce

To develop a well led, capable and motivated workforce

- We developed a new workforce strategy in partnership with our staff, which will be launched in May 2011. This strategy also includes our approach to our corporate social responsibilities
- Strengthened clinical leadership by reviewing and relaunching the role of the matron
- Our appraisal systems were significantly strengthened along with improved focus on mandatory training rates as well as the development of a leadership and management development framework
- We achieved a 1% reduction in sickness absence as planned and continue to support the health and wellbeing of our staff through a range of initiatives
- Held regular engagement events with our staff to discuss key issues and developments
- Continued to support staff training, development and education in all areas

Efficiency

To be efficient and make best use of available resources

- The Trust maintained sound financial control throughout the year and retained a financial risk rating of 4
- The number of women going home within 12 hours of birth was increased from 1% to 20%
- We reconfigured our organisational structure; reducing four clinical business units down to two clinical divisions
- Our cost improvement programme for the year was achieved

Safety

To deliver safe services

- Major and intermediate surgery was transferred from Aintree Centre for Women's Health to our Crown Street site along with day case surgery that does not meet the criteria for the elective day case unit at Aintree
- Testing of our system to minimise the risk of infant abduction was regularly carried out and the system strengthened even further
- A 24/7 neonatal transport service was introduced
- We increased the consultant complement in our neonatal service by introducing a resident evening consultant rota
- MRSA screening for both planned and unplanned patients was implemented
- We implemented a venous thromboembolism assessment and treatment protocol
- A service for first trimester screening for Down's Syndrome was introduced together with an early access antenatal pathway
- Programmes of work were undertaken to improve patient safety in accordance with the national programmes 'Patient Safety First' and 'Leading Improvement in Patient Safety'
- We implemented the majority of the recommendations from the review of governance carried out in 2009 (those outstanding will be implemented during 2011/12)

Effectiveness

To deliver the most effective outcomes

- A business case was agreed with the University of Liverpool to establish the Centre for Women's Health at Liverpool Women's
- We developed effectiveness indicators to report progress in respect of our quality account (see pages 36 - 87 of this report)
- The way in which the Trust monitors gynaecological cancer survival rates was even further improved
- We brought about better outcomes for our patients by changing clinical practice and implementing NICE (National Institute for Health and Clinical Excellence) guidelines. In particular our gynaecological service converted fewer cases to surgery as a result of changes introduced
- We developed a micro array service in our medical genetics service, which provides more comprehensive test results for interpretation
- Our clinical audit function was strengthened by the appointment of a Head of Clinical Audit

Experience

To deliver the best possible experience for patients and staff

- Chemotherapy services were introduced for women with gynaecological cancers, in partnership with Clatterbridge Centre for Oncology NHS Foundation Trust
- A new elective day case service opened at the Aintree Centre for Women's Health
- Introduced a family planning services for patients attending the Bedford clinic
- The outpatient facilities at the Aintree Centre for Women's Health were refurbished providing a bespoke facility to improve our patients' experience of care
- We continued with the refurbishment of our maternity facilities to provide the best possible environment for women and their babies
- A breast feeding peer support service was introduced to improve breast feeding rates
- Our genetic counsellors achieved practice development unit accreditation, putting patients at the heart of this service and providing assurance as to its quality
- Our patient experience and involvement strategy was introduced
- We developed and launched the Single Equality Scheme in partnership with our local community, staff, patients and their families
- We improved communication and information about the Trust by re-launching our website at www.liverpoolwomens.nhs.uk
- Together with our Council of Governors we communicated with our members and invited their views on our services
- We rolled-out the 'productive ward' series which focuses on improving ward processes and environments to help nurses and therapists spend more time on patient care thereby improving safety and efficiency
- We saw improvements in our overall staff survey results

We will build on these achievements throughout 2011/12 and beyond.

Our future plans

Our future plans

Our future plans are detailed in our annual plan for 2011/12 and include:

- Continuing with the refurbishment of our maternity facilities as part of our 'Big Push' project. The project will bring about major improvements to the maternity ward areas by the installation of ensuite bathroom facilities in all rooms and creating more space at each bedside
- Introducing an early access maternity pathway and redesigning our community-based work. This will enable women to be seen at an earlier stage in their pregnancy, closer to where they live. It will also facilitate earlier discharge from hospital for those women wishing to go home soon after delivery as the examination of their new baby will be done in the community
- Redesigning our imaging service to introduce 3D scanning in partnership with Diagnostic Health. Parents-to-be will be able to purchase 3D photographs and DVDs
- Introducing one-to-one midwifery on the Wirral
- Developing near patient ward based pharmacological services
- Evaluating potential alternative models for the provision of our pharmacy service
- Preparing a business case to provide 24 hour dedicated theatre cover in our maternity service
- Streamlining our high dependency unit provision, bringing together the two units into one integrated unit with enhanced care pathways
- Continuing to develop our primary care gynaecology service and look to develop other primary care based services using this model
- Providing more outpatient procedures in outpatient clinic environments as opposed to the operating theatre, and as close to the patients' home as possible
- Improving our emergency access facilities and arrangements
- Embedding the enhanced recovery programme across our gynaecology services to even better manage patients' discharge from hospital
- Redesigning the service we offer for termination of pregnancy
- Making even better use of our gynaecology theatres and operating time
- Migrating our neonatal services to an electronic patient record system (Badger Net)
- Reducing the number of providers we buy pathology services from in order to make efficiency savings
- Upgrading equipment in our genetics laboratories
- Developing new services within our reproductive medicine unit
- Supporting the haematological malignancy diagnostic services for Wirral and Preston through the provision of genetic testing
- Developing pre-implantation genetic screening that will allow embryos to be tested for any genetic defects
- Seeking opportunities to develop private patient services, particularly if the current private patient cap is removed
- Continuing to engage and learn from the communities and people we serve about how we can continuously improve and develop services that are valued, and used

Performance against key targets

Performance against key targets – key performance indicators

Our performance against national targets has remained strong throughout the year. Those we were required to achieve are set out below, together with our actual performance.

Indicator name	Target	Performance 2010/2011
Care Quality Commission: national priority		
18 week referral to treatment times: admitted (all specialties)	90%	97.97%
18 week referral to treatment times: non-admitted (all specialties)	95%	97.57%
18 week referral to treatment times: non-admitted (gynaecology, infertility and reproductive medicine)	95%	97.35%
18 week referral to treatment times: non-admitted (clinical genetics)	95%	99.46%
18 week referral to treatment times: non-admitted data completeness	80 – 120%	105.92%
18 week referral to treatment times: admitted data completeness	80 – 120%	99.67%
All cancers: two week wait	≥ 93%	97.30%
All cancers: one month diagnosis to treatment (first definitive)	≥ 96%	97.99%
All cancers: one month diagnosis to treatment (subsequent surgery)	≥ 94%	98.36%
All cancers: one month diagnosis to treatment (subsequent drug)	≥ 94%	None applicable
[1]All cancers: two month referral to treatment (GP referrals)	≥ 79%	89.96%
[2]All cancers: two month referral to treatment (consultant upgrade)	≥ 93.4%	91.89%
All cancers: two month referral to treatment (screening referrals)	≥ 90%	100%
Experience of patients	To be confirmed	Via annual survey
Incidence of MRSA bacterium	≤ 2	0
Incidence of Clostridium difficile	≤ 7	2
Infant health and inequalities: breastfeeding rate	≥ 5%	-1.92%
Infant health and inequalities: smoking rate	≤ 0%	1.14%
Maternity Hospital Episode statistics: data quality indicator	≤ 15%	Method under review
NHS staff satisfaction	To be confirmed	3.51
Care Quality Commission: existing commitments		
Data quality on ethnic group (April to December 2010)	≥ 85%	98.30%
Delayed transfers of care	≤ 3.5%	0%
Last minute cancellation for non-clinical reasons	≤ 0.8%	0.54%
Last minute cancellation for non-clinical reasons not readmitted in 28 days	≤ 5%	1.72%
Total time in Accident & Emergency (%seen within 4 hours)	≥ 98%	99.91%
Care Quality Commission: core standards		
Core standards for better health	Full compliance	Full compliance

[1]The national target is 85%, however the Trust has a further tolerance of 6% given the specialist nature of referrals received (Department of Health 2009, Monitor 2011)

[2]This target is not confirmed by the Department of Health. The Trust continues to reflect the most recent national benchmark available via OpenExeter (for Q3 2010/11 this stood at 93.4%)

Regulatory ratings

Regulatory ratings

Monitor is the independent regulator of NHS Foundation Trusts. It assigns each Foundation Trust a risk rating for finance and governance.

The financial risk rating is determined by four factors:

- Achievement of financial plan
- Underlying performance
- Financial efficiency
- Liquidity

The governance risk rating is determined by an assessment of eight elements of each

Foundation Trust's governance arrangements:

- Legality of constitution
- Growing a representative membership
- Appropriate Board roles and structure
- Service performance
- Clinical quality and patient safety
- Effective risk and performance management
- Cooperation with NHS bodies and local authorities
- Provision of mandatory services

Our performance over the last two years in respect of these ratings is detailed below:

	Annual plan 2010/11	Q1 2010/11	Q2 2010/11	Q3 2010/11	Q4 2010/11
Financial risk rating	4	4	4	4	4
Governance risk rating	Green	Amber-red	Amber-red	Amber-red	Red

	Annual plan 2009/10	Q1 2009/10	Q2 2009/10	Q3 2009/10	Q4 2009/10
Financial risk rating	4	4	4	4	4
Governance risk rating	Green	Green	Green	Green	Green
[3]Mandatory services risk rating	Green	Green	Green	Green	Green

[3]The mandatory services risk rating related to the services each Foundation Trust must provide as detailed in its terms of authorisation. From 2010/11 this is now included in the governance risk rating

The Trust's governance risk rating for the year was red because of changes to the accounting requirements for private patient income in 2010/11 as issued by Monitor on 10 February 2011. This is explained in further detail on pages 34.

Risk	Rating	Definition
Financial	1	Highest risk, very likely to be in significant breach of authorisation
	2	Risk of significant breach of authorisation
	3	Regulatory concern in one or more components but significant breach of authorisation unlikely
	4	Achieving weighted average of 4 across assessed components and no over-riding rules apply
	5	Lowest risk, achieving weighted average of 5 across assessed components and no over-riding rules apply
Governance	Red	Likely or actual significantly breach of authorisation
	Amber-Red	Breach of authorisation
	Amber-Green	Limited concerns surrounding terms of authorisation
	Green	No material concerns concerning terms of authorisation

Trust staff – our greatest asset

Our people are the most valuable asset we have to deliver services that are safe, effective and efficient and achieve the best possible outcomes and experience for our patients and their families.

As at 31 March 2011 the Trust employed approximately 1,200 staff in a variety of clinical and support roles (1,183.95 whole time equivalents), not including those who work for our external contractors or staff seconded out to other organisations.

Our staff work within five main areas across the [4]Trust:

36% Maternity and imaging
22% Gynaecology and theatres
17% Pharmacy and neonatology
11% Genetics and reproductive medicine
15% Corporate support

[4] Numbers have been rounded hence do not add up to 100%

The numbers of staff employed by group are shown below:

Staff group	Whole time equivalent as at 31 March 2011
Doctors	63.61
Registered nurses and midwives	569.52
Healthcare scientists	34.99
Allied health professionals	10.24
Other clinical services staff	203.9
Other professional, scientific and technical	25.19
Estates and ancillary	8.67
Administrative and management	267.84
Total	**1,183.95**

Of our workforce, 91.3% of staff have identified themselves as white British. Some 7.2% have identified as being from a minority ethnic background, which compares favourably with the figure quoted for the total population of Liverpool (7.7%). Compared with the numbers in our local population, people from Chinese and mixed heritage communities are under-represented amongst the Trust's staff. Encouraging applicants from these specific groups has been identified as an action within our Single Equality Scheme.

Age profile

The age profile of our staff is shown below:

Age band	Number of staff
16-25	7.0%
26-40	33.0%
41-65	58.8%
66-70	1.2%
Total	100%

Religion and belief

The significant majority (67%) of our people's religion or belief is undefined. Feedback received through our Single Equality Scheme consultation process strongly identified the need for positive promotion of minority religions to aid in general understanding of others and generate a greater sense of inclusion for those religions or beliefs.

Sexual orientation and transgender

At present, none of our staff are formally recorded on our electronic record system as lesbian, gay or bisexual. This does not represent the number of lesbian, gay or bisexual staff employed at the Trust, and discussions with staff who identify themselves in this way has revealed their lack of confidence in how such information may be used and whether it may affect future employment opportunities. Positive communication of issues, events and celebrations for this group of Trust staff is a key part of our strategy to encourage all of our people to feel included and valued for the skills, experience and expertise they bring to their roles. Similar issues and actions have been identified for transgender people.

Staff pledges

Our human resources and learning and development team expertly support our staff to deliver the very best services for women, babies and their families. We continue to be focused on creating a great place to work where staff are treated fairly and equitably, are given an opportunity to grow and develop their skills, feel recognised and rewarded for the contribution that they make, and are engaged in decisions that affect them and the services they provide. This commitment is outlined through our achievements in respect of the four NHS constitution pledges to staff:

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

- Ensured our corporate aims are used as the basis of personal objective setting so that staff's personal aims are linked to the organisation's strategic aims
- Put in place plans to move to a two division management structure (down from 4). This was based on staff feedback about reducing bureaucracy and streamlining management
- Involved over 200 staff at all levels and across disciplines, in the development of our revised values and expected behaviours in order to gain a common approach to delivering excellence.

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

- Were the first Trust in the region to gain an 'overall satisfaction' rating from the results of the Trainee General Medical Council/Post Graduate Medical Education and Training Board
- Were externally assessed as 'excellent' by Ofsted, the external regulatory body for general education provision
- Undertook a complete review of our performance development system documentation and process, resulting in an improvement in appraisal rates from 65% in April 2010 to 86.5% in February 2011 (a 21.5% improvement).

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

- Markedly reduced the Trust-wide sickness absence rate from 5.37% for the 12 months to 31 March 2010 to 4.46% for the 12 months to 31 March 2011 through sustained and combined focus on key areas of sickness absence, direct support to management referrals made to our occupational health department and specific focus on early intervention clinic appointments for musculo-skeletal and mental health problems and planned surgery, to reduce long-term absence
- Held three highly participative health and well-being events for staff to promote positive approaches to ensuring they are healthy and fit for work
- Actively promoted update of the flu vaccine to protect staff, their families and patients. Our uptake was one of the highest in the North West at 70%.

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

- Launched our 'Big Chat' engagement events where staff are actively engaged in providing feedback on specific themes every two months throughout the year. Five events were held in 2010/11 covering communication and equality, reward and recognition, innovation and improvement, speaking up for safety and health and well-being
- Held meetings between the Chief Executive and nearly 700 members of staff, either individually or in groups, to discuss how the Trust can rise to the challenge of the next few years. These meetings actively encouraged the involvement of our staff in the Trust's

performance and helped achieve a common awareness on the part of staff in respect of the financial and economic factors affecting the performance of the Trust
- Actively involved staff in a range of improvement programmes such as Leading Improvements in Patient Safety and the Productive ward, giving staff the time, skills and techniques to bring about improvements for patients and themselves.

We remain committed to achieving good communication links with our staff and as well as the approaches outlined above we also issue a monthly Team Brief to all staff members. Team Brief provides staff with information about developments at the Trust, the organisation's performance and outlines any matters of concern to them as employees.

In the course of the year we also consulted our staff in respect of organisational change proposals as part of a programme of work known as 'Rising to the Challenge'. This programme proposed some staff restructuring across the Trust, in respect of which a very detailed process of consultation was undertaken with staff and their representatives, to ensure their views were taken fully into account in respect of decisions likely to affect their interests. As a consequence of the final proposals a number of staff were identified as 'at risk' and formal redeployment procedures instigated. It is considered probable that at the conclusion of this process a number of staff will be made redundant and others redeployed into posts for which an entitlement to pay protection exists.

NHS annual staff survey

The NHS annual 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 issues.

In 2010 we saw a 6% increase in the rate of response to our survey and a summary of the results is shown below:

Summary of performance:

	2009/10		2010/11		Improvement
	Trust	National average	Trust	National average	
Response rate	53%	55%	59%	54%	6% increase

	2009/10		2010/11		Improvement
Top 4 ranking scores	Trust	National average	Trust	National average	
Percentage of staff appraised in last 12 months	65%	76%	85%	79%	20% increase
Percentage of staff appraised with personal development plans in last 12 months	57%	65%	78%	68%	21% increase
Percentage of staff believing the Trust provides equal opportunities for career progression and promotion	89%	91%	95%	92%	6% increase
*Effective team working	*not scored on this scale	*not scored on this scale	3.84	3.75	2009 percentage score also above national average

	2009/10		2010/11		Improvement
Bottom 4 ranking scores	Trust	National average	Trust	National average	
*Staff recommending the Trust as a place to work or receive treatment	3.50	3.89	3.47	3.39	No statistically significant change
Percentage of staff reporting good communication between senior management and staff	25%	32%	20%	35%	5% decrease
*Fairness and effectiveness of incident reporting procedures	3.52	3.51	3.46	3.35	Statistically significant decrease
*Perception of effective action from employer towards violence and harassment	3.50	3.62	3.50	3.67	No change from previous year

*scale summary score

There has been a demonstrable and significant improvement in both the perception of staff in relation to their appraisal and the overall increase in appraisal rates across the Trust, which have been averaging over 80% from September 2010 – a significant improvement from 65% in April 2010. Our focus for the year ahead is to continue to maintain this improvement and ensure that the structure and quality of appraisal is monitored also.

We have consistently scored above the national average for effective team working, an area that we are immensely proud of. Keen to build on these strengths we will be targeting bespoke team development throughout the year to continue to build high performing teams. This is the foundation of our 'One Team, One Goal: Putting People First' Strategy that will be launched during 2011/12.

Our bottom ranking scores have been consistently low, three of which were the only scores that deteriorated further in 2010. The introduction of a revised governance structure across the Trust will provide the opportunity to tackle issues in relation to management and safety. A safety campaign was launched in December 2010 (Speak Out for Safety) which focuses on promoting key safety related policies and specific actions staff can take to address risk related issues. This focus will continue to run throughout 2011/12.

Progress against the above actions and focus areas will be monitored through a revised workforce committee – the Human Resources and Organisational Development Committee – which will be chaired by a Non-Executive Director. The Putting People First: One Team, One Goal Strategy has a clear implementation plan with identified outcome measures across all areas of workforce planning, leadership and management, engagement and communication, health and wellbeing, learning and development and organisational development. We recognise that our people are our greatest asset and that it is only by listening to them and involving them in addressing issues that are important to them, that we will achieve our overall vision of becoming the leading healthcare provider for women, babies and their families.

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. Based on feedback through development of the new Single Equality Scheme we focussed during the year on positively promoting the three protected characteristics of the Scheme within the Trust, to raise awareness of difference and actively demonstrate how difference is valued in staff:

- Disability – our work included raising awareness of the need to collect disability related data from staff and obtaining feedback on why they are reluctant to provide it; a free disability awareness newspaper was introduced which positively promotes the achievements of disabled people, and; we made significant progress in tackling areas of concern raised in relation to services provided to meet the needs of patients with a learning disability
- Religious belief – a weekly equality bulletin was introduced to raise awareness of the various religious celebrations and positively promote practices to celebrate them
- Sexual orientation – we were actively represented in the first Liverpool Pride that took place during the year and engaged with its participants to feed in their views to our Single Equality Scheme. We also positively promoted events aimed at lesbian, gay, bisexual and transgender people through our equality bulletin.

The Trust is signed up to the 'Two Ticks Symbol' which is a quality symbol that provides assurance to individuals with a disability that we welcome applications from all people with or without a disability. We have also revised our pre-employment health screening programme to

take into account changes in legislation relating to health screening as part of the Equality Act 2010. These changes have also been included in mandatory training requirements for all staff.

During the year, the Trust received 1,305 job applications. Twenty-one applicants (1.6%) declared a disability in their application. Seven of this group were shortlisted (0.5% of all shortlisted applications) with 3 candidates appointed (0.22% of all appointments in the period).

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. Our Specialist Disability Advisor is available to provide advice and support in individual cases.

The 2010 NHS staff survey identified that 97% of staff who identify themselves as disabled felt that they had an equal opportunity for pay and career progression (compared to 94% of the non-disabled group), a significant improvement from the previous year.

Recognising and rewarding excellence

We are committed to recognising and rewarding our staff in respect of excellence. The Trust held its sixth annual 'Focussing on Excellence' awards in 2010/11 which celebrate and reward staff who deliver clinical and non-clinical improvements to achieve excellence for women, babies and their families. This year the number of categories were further expanded and we saw the number of entries almost double to 73.

Following feedback from staff in respect of reward and recognition, we were also please to re-launch our Employee of the Month scheme in January 2011.

Equality and diversity

The Trust is committed to positively supporting people with protected equality characteristics as defined by the Equality Act 2010. Our equality objective/s, which will be delivered as a part of the Trust's corporate aims, are:

- To approve a new Single Equality Scheme (SES) for 2010 – 2012 and action plan
- To ensure full implementation of the SES across the Trust through clear monitoring and evaluation
- To establish a performance management process to ensure delivery of the SES and equality related priorities
- To develop policies that promote equality for everyone
- To promote a positive image of anti-discrimination in all the Trust's functions and services.

Our SES and action plan were published during the year and can be found on our website at www.liverpoolwomens.nhs.uk.

An equality governance framework is in place at the Trust. This framework oversees the Trust's compliance with the general Equality Duty introduced as a part of the 2010 Act, monitors implementation of the SES action plan and seeks assurance of compliance.

Our policies and practices covering both staff and patients seek to promote equality and ensure the Trust complies with its general Equality Duty. Our SES details how we do this and includes:

Disability equality

- The appointment of a Specialist Midwife for Disability to provide support for patients and staff across the Trust
- All corporate documents and leaflets are offered in a range of formats and including Braille, audit and large print

Gender equality

- All jobs have been evaluated under the national Agenda for Change job evaluation scheme to ensure that all staff receive equal pay for jobs of equal value
- Implementation of a transgender policy

Race equality

- We have impact assessed how the delivery of services could affect minority groups, identified any potential for adverse differential impact and considered any necessary remedial action. The outcomes of the assessments are published
- The setting up of a range of specialist services included a Link antenatal clinic for women who, for cultural or religious reasons, are unable to see a male consultant or who do not have English as their first language, and a female genital mutilation/multi cultural women advisory group.

These and other initiatives in place and planned at the Trust demonstrate our compliance with the Equality Duty. Further details of our equality and diversity commitment and work can be found at www.liverpoolwomens.nhs.uk.

Sustainability report - environmental matters/climate change

The Trust is committed to minimising any negative impact on the environment. Sustainability reporting is being carried out at Liverpool Women's to demonstrate to our stakeholders that we are more than a 'going concern' and to allow patients, staff and others to review our sustainability credentials as a part of deciding whether or not to come to the Trust for care or employment.

During 2010 the Trust saw an increase in its gas energy consumption, the majority of which was attributable to the very cold winter experienced. And landfill costs increased in line with the Treasury escalator which impacted upon our costs overall in respect of waste disposal. Our staff took part in various initiatives to reduce energy consumption.

Also during the year, the Trust prepared a carbon management plan in conjunction with other Trusts within North Merseyside, and The Carbon Trust. The plan establishes a baseline of Scope 1 and Scope 2 emissions of 4,347 tonnes of CO2. Our target is to reduce this by 23% in the next five years and a team of staff from across the Trust, led by our dedicated Environmental Manager, are working to make this a reality. Progress against this target will be monitored via the Trust's Environmental Forum and reported to the Board of Directors on a bi-annual basis.

We also continue to hold the BS 8555 (Acorn) standard. The Acorn scheme is an officially recognised standard recommended by central government and which offers accredited recognition for organisations evaluating and improving their environmental performance through the phased implementation of an environmental management system.

Summary of performance:

	Annual usage			Annual cost (£)		
	2008/09	2009/10	2010/11	2008/09	2009/10	2010/11
Gas (Kwh)	5776699	4702346	5632074	189,671	129,221	149,701
Electricity (Kwh)	5176359	5840748	6050966	676,028	576,249	514,612
Water (m3)	30829	29434	30822	39,817	49,329	36,545
Clinical waste (tonnes)	238	208	203	104,107	113,480	103,538
Domestic waste (tonnes)	465	407	407	52,331	59,647	59,835

It should be noted that gas prices have risen by approximately 47% in the last year. Our expenditure on gas was exacerbated by very cold weather during December 2010 and January 2011.

Priorities and targets for 2011/12

We have an environmental policy in place which has been ratified by the Trust's Environmental Forum and is scheduled for approval by the Board of Directors in 2011/12. This will then be placed on the Trust's website to ensure compliance with our environmental performance standard.

Automatic meter reading has been installed on all our gas and electricity meters, which enables us to review usage on a half-hourly basis. Future refurbishments and building works will have sub-metering installed to enable us to review usage by area also.

We are working in partnership with the University of Liverpool, Liverpool John Moores University and the Royal Liverpool and Broadgreen University Hospitals NHS Trust to influence and effect the provision of direct public transport services into the area of Liverpool known as the 'knowledge quarter'. The plan is to create an area-wide car share database so that staff working for the four organisations and who use private vehicles to travel to work, can share travel and costs whilst reducing their personal carbon footprint.

Our other travel plan for 2011/12 is to seek wider promotion of our Cyclescheme initiative. This enables our staff to purchase a bicycle in a tax efficient way so they can improve fitness and reduce pollution through cycling to work.

2011/12 will also see a tender exercise in respect of our waste contract. This will focus on reducing the amount of waste which goes to landfill and the use of methods to reduce and recycle waste. Reducing waste is also the focus of the 'Real Nappy' campaign we are involved in together with our local government partners.

This campaign aims to promote the use and benefits of non-disposable nappies as part of an overall education campaign with our patients in respect of reducing waste.

Partnership and consultation – working with our patients, the public, our partners and stakeholders

We remain committed to working in partnership with our patients, their families, the public, Trust staff and stakeholder organisations, and are proud to state below just some of the ways in which we have achieved this during 2010/11:

- *Patient experience and involvement strategy.* In 2010 we produced a patient experience and involvement strategy. This has been developed to clearly set out the methods and processes we use to learn from patients, their families and visitors and to involve them in all aspects of our work. Through a series of face-to-face discussions with individuals and groups of service users, and meetings with key stakeholders and community groups, we developed a strategy which focuses on five themes relating to patients' experience at Liverpool Women's:

  - Give me the right message
  - Know me, involve me
  - Knowing what's what and who's who
  - Feeling safe and 'at ease'
  - Help me help myself

  Based on these five themes we will ask patients about their experiences of Liverpool Women's via surveys, comment cards, complaints and contacts with our Patient Advice and Liaison Service. The focus will be on privacy and dignity, the attitude of staff, cleanliness and hygiene, communication and the quality of food. The strategy has the full support of our Council of Governors.

- *Patient and public involvement.* Development of the patient experience and involvement strategy led to the re-establishment of the

Trust's patient involvement committee. Its membership includes public members of the Trust, volunteers, members of the Trust's Council of Governors and Trust staff. It provides a designated forum for patients and visitors to review, challenge, comment on, monitor and influence all aspects of the Trust's services

- *Recording 'patient stories'.* Using both audio and video, recording patient stories has been a powerful method of relaying the patient experience. The Board of Directors sees or hears a patient story at its formal meeting each month, and at one meeting a patient attended in person to share with the Board her experience of the Trust's maternity services on two occasions

- *Preparation of a quarterly patient experience report.* All patient feedback is incorporated into a patient experience report which is produced every three months. It includes details of complaints received, contacts with our Patient Advice and Liaison Service, comment cards, survey findings, details obtained from feedback websites such as NHS Choices and quotes from letters of appreciation

  The Trust takes very seriously the feedback our patients give to us via these methods. We are committed to listening to patients, hearing what they say and responding to their complaint, concern or comment; we consider all patient feedback to be a positive opportunity to learn from the experience of those who have been in contact with our services, and to improve care as a result

  Actions we have taken as a result of patient feedback include:

  - Organising a remembrance service for families who have lost a baby
  - Handover of care by midwifery staff at the bedside, to ensure that women are actively involved in their plan or care
  - Improved signage for the early pregnancy assessment unit
  - Redesign of treatment rooms in the early pregnancy assessment unit to enable patients to leave the department without having to go through the main waiting area. This is particularly important to patients and those accompanying them, who have received bad news
  - Additional bathroom facilities for visitors, close to clinical areas in both maternity and gynaecology
  - Installation of drinking water facilities in gynaecology out patients
  - A designated member of staff being available each day to ensure women are supported when bathing and feeding their new baby
  - Windowed doors on the Bedford ward covered in opaque film to maintain patient confidentiality
  - Refreshments provided via dispensing machine at main reception

- *Public engagement in respect of service transfer.* During the year we transferred to our Crown Street site the major surgical services we provided at Aintree Centre for Women's Health along with some day-case surgery. This involved a close partnership with local Primary Care Trusts, engaging with the joint Overview and Scrutiny Committee of our partner Local Authorities, and with Liverpool and Sefton Local Involvement Networks. Three public engagement meetings were held to discuss the changes during which patients and the public expressed their concerns about public transport links between Aintree in North Liverpool and the Trust's Crown Street site in city centre Liverpool. As a result plans are in place to work with local public and community transport providers

- *Volunteers.* We were proud to work with approximately 100 volunteers during the year who between them provided 8,825 hours of service to the Trust. Their work included talking to and befriending patients, supporting new mothers with skin to skin contact, stocking up leaflet racks, collecting and

returning equipment and escorting new parents and their baby out of the hospital when they are ready to go home. In addition they supported a wide range of events at the Trust such as our service of remembrance, Christmas carols on the wards and our fundraising activities. We are in no doubt that the contribution of our volunteers adds a great deal to the experience of our patients

- *Safeguarding.* Through membership of the local Safeguarding Children Boards, led by the Local Authorities, the Trust fulfils its statutory duties in respect of The Children Act 2004. The Trust is represented at Knowsley, Liverpool and Sefton Safeguarding Children Boards and contributes to their task and finish sub-groups. The Trust is also represented on the Liverpool Safeguarding Adults Board and Trust representatives regularly attend and contribute to the Multi-Agency Risk Assessment Committees run in Liverpool, Knowsley and Sefton which discuss and safety plan for high risk cases of domestic abuse. We also continue to work closely with our health and social care partners in respect of safeguarding issues

- *Primary Care Trusts.* We have continued to work collaboratively with our host Primary Care Trust, Liverpool, with whom we meet monthly by way of monitoring the contracts we have in place to deliver care they purchase from the Trust, which includes regular scrutiny of our contracts for quality

- *North West Fertility Limited.* The Trust continues to enjoy a successful working partnership with North West Fertility which is based at Liverpool Women's Hospital. However, as in 2009/10, changes in the economy have negatively impacted upon this partnership, as has the legal cap placed on private patient income. In the year ahead we will work with North West Fertility to ensure that we can compete and maintain our market share for both the NHS and private patients

- *Hotel services.* We have continued to work with Sodexo who provide cleaning, portering and catering services to the Trust under contract. During the year the Trust received an 'excellent' score in respect of its Patient Environment Action Team (PEAT) assessment. This covers the quality of the environment in which we care for people, the privacy and dignity they experience and also the quality of the food we serve

- *Equality Performance Improvement Toolkit (EPIT).* This provides an opportunity for the Trust to demonstrate progress on a number of areas relating to the equality agenda. Central to all of these is the level of involvement members of the community we serve have in the design, delivery and evaluation of the services we provide. Our work with local communities was identified as clear evidence of our ongoing commitment to the involvement of members of our community from all backgrounds in the development of our services. Of the five goals within the EPIT submission we demonstrated clear progress by moving from the assessed position of "developing" across all five goals in January 2010, to "achieving" in two and progress within the "developing" category in the remainder, in January 2011. This is significant progress in comparison to other local Trusts. A detailed plan of how we will develop our services further to be assessed as "achieving" across all goals is identified within our Single Equality Scheme

- *Single Equality Scheme (SES).* 2010 saw the development of our new SES for 2010/13. Over 200 local organisations were invited to contribute to the development of our Scheme and more than 80 people did so at an open event in June 2010. This was followed by a series of specifically targeted events with groups who were under-represented at the initial session and included the transgender, lesbian, gay and bisexual communities together with women from under-represented religious backgrounds and people with physical, sensory and mental health disabilities. The feedback

received from these events was incorporated within the SES and progress will be actively monitored on a bi-monthly basis. We will formally feed back to those involved in the original consultation event in respect of progress made during 2011/12 and seek additional input into further improvements that we can continue to make

- *Future Jobs Fund.* This government initiative, implemented through the Department of Work and Pensions, is aimed primarily at people aged between 18 and 24 years of age who have been unemployed for 6 months or longer. Some 25 trainees have been through the scheme at the Trust and we are proud to have provided them with job skills and experience

- *Aim Higher.* The Trust actively participates in the Aim Higher programme encouraging young people from deprived areas to consider the range of roles, education and employment opportunities that may be available for them in the future. Eighty-five students attended a specially designed event in October 2010 as part of this programme, when a wide range of professionals presented on their roles and how they came to them. This included a presentation from our male Consultant Midwife who challenged stereotypes and potential prejudice of the students relating to being a male midwife. All participants at the event were female and we are planning a further event for 2011 aimed at young men

- *Staff consultation.* The views of our people are of great importance to us. In response to feedback from the NHS national staff survey in 2009, which identified that staff did not feel their voice was heard or being acted upon in relation to service changes and matters that affected them, we established a series of engagement events called the Big Chat. Held bi-monthly, the Big Chat highlighted specific themes of importance to staff and sought their views in respect of them. Staff's feedback has informed our future plans and the topics covered to date have been equality and communication, innovation and involvement, safety and the values and related behaviours of the Trust, health and wellbeing, [5]Rising to the Challenge and sustainability and managing within finite resources. Our work in respect of staff engagement will continue to be progressed during 2011/12 and beyond.

Research & Development

Clinical research leads to better treatments for patients. The Trust has had another highly successful year in respect of its research and development (R&D) work, the primary focus of which continued to be activity supported by the National Institute for Health Research (NIHR). The Trust contributes to NIHR research, leads on a number of NIHR projects and works with industry. We are committed to ensuring research continues to benefit our patients and that our research efforts focus on answering pressing questions in respect of the care of women and babies.

The NIHR was established by the Department of Health for the conduct of clinical research across the UK. It is concerned with ensuring the quality of research, its translation into clinical practice and value for money. Over the previous year, the Trust has worked extremely hard to implement NIHR processes, systems and objectives for the benefit of our patients. We are pleased to say that in 2010/11 we continue to be a top NIHR recruiter in the region.

Translational research is the process of taking potential treatments from the laboratory to patients and testing them properly before they are used widely. It often takes 15 – 20 years to test a new treatment properly and so small scale studies are needed to fine tune new treatments before large, definitive studies can be done. No single organisation can meet all the challenges raised by testing new treatments. We can only meet the needs of our patients for new treatments by

[5]Rising to the Challenge is the Trust's programme of organisational change also referred to elsewhere in this report

collaborating with others. Our theme of translational research through collaboration includes work in several clinical areas at all stages of the pathway:

- *Gynaecological Oncology.* The Trust is collaborating with University and NHS partners to develop a clinical hub for cutting-edge oncology research. The Trust has progressed significantly with its oncology research portfolio. During 2010/11 the Trust collaborated on 8 national oncology studies, all adopted onto the NIHR research portfolio

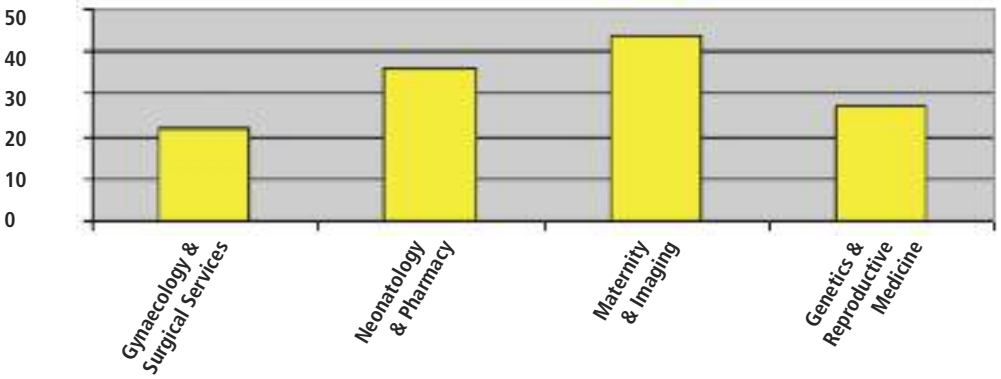
- *Early Pregnancy.* Together with its partner organisations, the Trust leads two research projects that are testing treatments in early pregnancy. The prednisolone trial examines whether prednisolone can improve outcomes in a specific type of recurrent miscarriage. The DOLS (Duration of Luteal Support) study examines whether the success of assisted conception is affected by the duration of progesterone treatment in early IVF pregnancy

- *Maternity Services.* We are currently supporting a number of translational research projects being led by University researchers. These laboratory based studies are designed to answer fundamental questions about the physiology of labour, miscarriage and endometriosis. We also continue to drive forward maternity research in developing regions, endeavouring to make low-cost but effective healthcare interventions for pregnancy and childbirth available to those most at need. This work has been recognised by a recent invitation to become a Collaborating Centre for the World Health Organization in Global Maternal Health

- *Neonatal.* Research in the neonatal unit includes rigorous evaluation of innovative approaches to delivering patient care (the SCAMP trial), evaluation of approaches to patient safety that are recognised across Europe, and contributions to evidence-based policy about the development and use of medicines that are appropriate for newborn babies. The Trust has a unique portfolio of 5 neonatal projects funded by the European Commission. Funding for research obtained through the European Commission is a useful benchmark for research success

- *Genetics.* Our genetics department has always had strong regional and national research collaborations. The department currently collaborates on 12 NIHR projects including a large national study concerning developmental disorders. The overall aim of the study is to develop methods to improve the diagnosis for children with developmental disorders through the application of new genomic methodologies by establishing new analytical methods and a database designed to inform diagnosis and genetic counselling. The department leads on innovative research across cytogenetics, molecular genetics and clinical genetics.

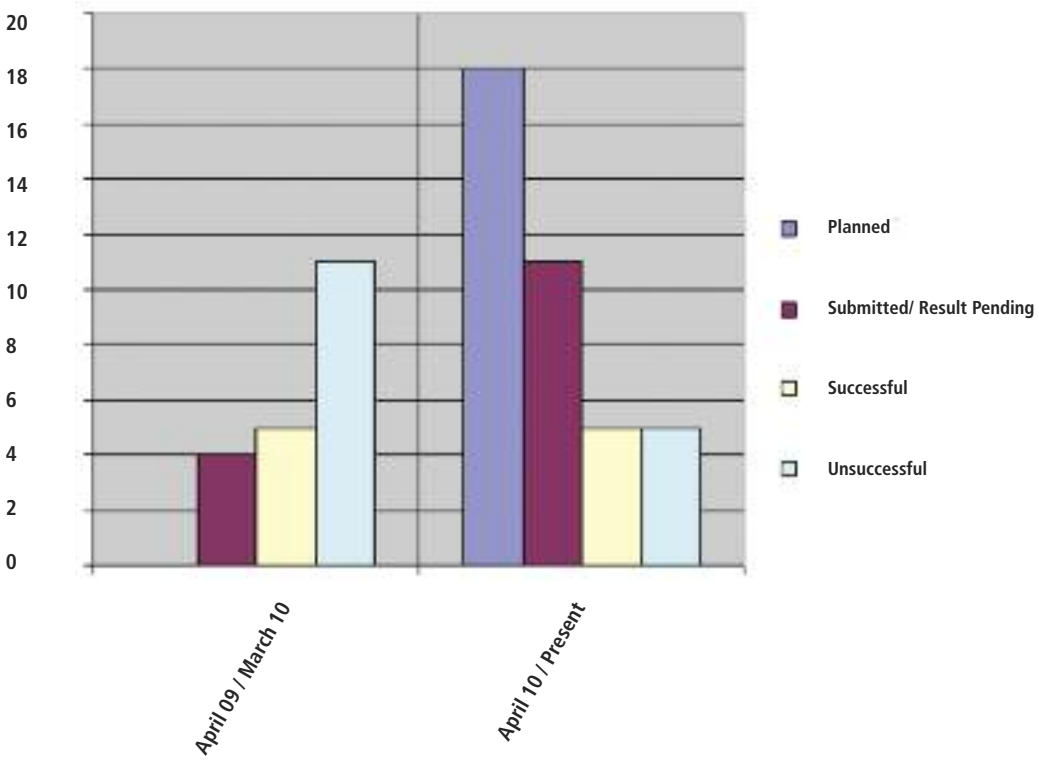
Active research studies in which the Trust is participating, by Clinical Business Unit (CBU), is shown below:



Active Research Studies

We are in a strong position with our academic partners and NIHR infrastructure to become a leading centre of research excellence. To do so we will aim to continue to secure research income and to engage our collaborators and patients. In terms of income, we rely upon service support income provided by the NIHR on the basis of our successful NIHR recruitment, funding from industry partners and funding from public grants. In 2010/11, the Trust R&D Department has seen 5 successful proposals and is awaiting the results of 11 submitted applications from the awarding bodies. Income has been received from The Moulton Charitable Foundation, NIHR Programme Grants in Applied Health Research, NIHR Research for Patient Benefit, Wellbeing of Women, and the European Commission (FP7). Our grant activity during 2010/11 is shown below:

Grant Activity at Liverpool Women's NHS Foundation Trust



In 2010/11, our research findings have been disseminated via 75 publications in peer reviewed scientific journals, in addition to research conferences and symposiums. Our research has also been highlighted in press releases made by the Royal College of Obstetrics and Gynaecology, the University of Liverpool and via national media streams.

Now that the Trust has embedded NIHR processes, metrics and recruitment into its daily research activities we are working to adapt to the changing research landscape. In 2010/2011 and beyond, we will foster research excellence through collaborations. In the first instance, we are working closely with the University of Liverpool and other local NHS Trusts to establish a joint research office, which will provide a one-stop shop for research involving more than one organisation demonstrating our commitment to developing ways to work together for the benefit of our patients.

Information management and technology

Our department of information management and technology (IM&T) has remained committed to improving services by providing Trust staff with access to information and technology and ensuring robust secure systems are in place. This essential infrastructure supports the achievement of the Trust's corporate aims and delivery of

clinical excellence. Some of the progress made during the year has been recognised by the achievement of international standards including:

- BS 25999-2:2007 - standards that establish the process, principles and terminology for business continuity management
- Achievement of 91.6% coding accuracy for primary diagnosis and 99.3% for primary procedures.

Working closely with our clinical staff, the department's plans for 2010/11 included:

- Supporting the development of clinical outcomes measures
- Implementing the first phase of a data warehouse to enable easy access to clinical, operational and management information
- Completing replacement of the Trust's switchboard
- Procuring a replacement electronic patient record
- Moving the Trust's disaster recovery data centre off site to ensure continuity of service provision
- Providing remote access to key clinical systems to allow point-of-care delivery of services in the community
- Providing remote access to systems to improve communication and the working lives of our staff.

The position of the Trust at the end of March 2011

Performance

The Trust ended the year with a surplus of £1m, Monitor Financial Risk Rating (FRR) of 4 and red governance rating. Key elements supporting our financial performance are summarised in the key financial measures set out below and detailed in full in the annual accounts on pages 128 to 168.

Measure

The Trust planned and achieved a surplus of £1m in 2010/11. It made provision for restructuring costs of £2.8m which under the Monitor regime are excluded from calculation of the FRR metrics. The impact of this on the key financial performance metrics is summarised in the table below:

Comparative performance	2010/11 (unadjusted)	2010/11 (adjusted)	2009/10
Earnings before Interest, Tax, Depreciation and Amortisation (EBITDA) (Total income – total operating costs (excluding depreciation)	£4.8million	£7.7million	£6.8million
EBITDA margin (EBITDA/total Trust income)	5.2%	8.3%	7.6%
EBITDA achievement of plan (EBITDA actual/EBITDA plan)	88%	140%	103%
Income and expenditure (I&E) surplus	£1million	£3.8million	£1.6million
I&E surplus margin (I&E surplus/total Trust income)	1.1%	4.2%	2.9%
Return on assets	4.6%	9.9%	7.3%
Liquidity	46 days	46 days	46 days
Monitor FRR	3	4	4

This strong financial performance was underpinned by the continuation of patient activity levels and the control of expenditure budgets.

In response to an increasingly challenging financial climate the Trust has identified savings of £6.4m for 2011/12 and continues a strategic review to identify savings for future years.

Private patient income

Our performance against the private patient cap is set out below:

	2010/11	2009/10
Total patient related income	£84,418,000	£79,519,000
Private patient income	£2,239,000	£212,000
Proportion of private patient income as a percentage	2.65%	0.27%
Private patient cap	1.8%	1.8%

The primary reason for the increase in income from private patients relates to changes to the accounting requirements for private patient income in 2010/11 issued by Monitor on 10 February 2010.

The revised guidance defines private patient income as income attributable to a Foundation Trust either directly or indirectly and which has its origin in the provision of goods and services to non NHS patients. For Liverpool Women's this includes income received from North West Fertility Limited (NWF) under contract for the provision of clinical services, income from the Trust's private patient unit (Catharine Suite) and any income received from overseas patients not covered by bi-lateral agreements.

The Trust advised Monitor at the commencement of the financial year that given the need to renegotiate contract agreements with NWF, it was likely that the Trust would breach the cap in 2010/11. This, together with the receipt of higher income from overseas visitors in respect of the provision of long stay neonatal care for which the Trust has an obligation to recover, has led to the reported breach.

The Trust has in place revised arrangements to minimise the risk of a further breach in 2011/12.

Prudential borrowing limit

The Trust had a prudential borrowing limit of £24m in the year of which £17.5m related to long term borrowing and £6.5m to a working capital facility. The Trust has not borrowed against the limit during the year.

Capital expenditure

The capital programme of £4.4m was completed during the year. This was financed from internally generated funds and accumulated cash balances, and related to protected assets.

The financial year 2010/11 saw the completion of Phase 1 and continuation of Design work for future phases of the 'Big Push' project which aims to enhance the environment in which the Trust provides its maternity services. The Trust also enhanced outpatient accommodation at its Aintree site and facilitated the provision of onsite chemotherapy at its Crown Street site.

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 capital programme expenditure for 2010/11are set out below:

Capital expenditure	£000	£000
Building related - 'Big Push' project to enhance accommodation for maternity services	1,405	
Building related – building infrastructure and environment	1,239	2,644
Medical and scientific equipment	1,392	
Information management and technology infrastructure	385	1,777
Total capital expenditure		4,421

The main trends and factors underlying the development, performance and position of the business of the Trust during the financial year were:

- At the beginning of the year the Trust knew that it was facing some challenges with regard to meeting efficiency targets. As a result, we introduced our programme of organisational change known as 'Rising to the Challenge' and which is referred to elsewhere in this report
- Contracts with the Trust's main commissioners were renewed by the year end ensuring security of Trust funding for the year ahead
- Throughout the year the Trust began moving to a robust model of integrated governance. The Board kept under review the Trust's response to the findings of national inquiries and subsequently worked through a process of assurance regarding the issues and learning points arising from them.

The main trends and factors that are likely to affect the Trust's future development, performance and position are:

- The Trust is moving to a two division management structure which will be a key driver for how services are developed and efficiencies made during 2011/12
- Pressures on the budgets of health care commissioners, 0% financial growth and increased inflationary pressure
- Achievement of our cost improvement plan and savings targets for 2012/13 onwards
- Achievement of Level 3 accreditation in respect of CNST (Clinical Negligence Scheme for Trusts) and NHSLA (NHS Litigation Authority).

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 foreseeable future. For this reason they continue to adopt the going concern basis in preparing the accounts.

Focussing on patient safety, the clinical effectiveness of our services, and patient experience.

Quality report - our commitment to quality

Statement of Quality from the Chief Executive

The Liverpool Women's NHS Foundation Trust Quality Account for 2010/11 is our second Quality Account and therefore the first opportunity to look back at what we have already achieved and forward to what we hope to achieve in the future. There is little doubt that the Liverpool Women's NHS Foundation Trust has a proven record in the provision of high quality services. However, whilst it is easy and tempting to focus on areas of strength, a successful organisation must understand both its strengths and weaknesses and should strive to improve in all areas.

In our pursuit of providing excellence in everything we do, we are again focussing on patient safety, the clinical effectiveness of our services, and patient experience. There is much work in progress and many new initiatives that have been developed in the Trust during the last 12 months. We have worked hard to record accurate and relevant data about our services over a much wider range of outcome indicators and aim to use this information to assure quality and drive improvement.

As Chief Executive I am pleased to see the progress that has been made since the publication of our first Quality Account in 2009/10. This year's publication is the next step on what will be a long and relentless quest to improve services wherever possible. I am confident 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.

On behalf of the Trust Board of Directors and myself, I would like to say a big thank you to staff, patients and our community for a very successful, quality driven and productive year.

Kathryn Thomson

Kathryn Thomson
Chief Executive

Priorities for improvement

At the very heart of what Liverpool Women's NHS Foundation Trust aims to do is quality; we aim to provide care of the highest possible safety and quality. Our quality report, also known as our Quality Account, sets out our approach to making this happen, and details our achievements during the year. It also sets out our quality priorities for 2011/12.

Central to this commitment to quality is our desire to learn from the experiences of our patients and staff, and to improve what we do in the light of those experiences. As such we regularly review, and report through our governance structure, in respect of the things patients have complained about or contacted our Patient Advice and Liaison Service (PALS) about, together with any serious incidents that have occurred. Some of the positive changes we have introduced as a result of patient feedback are highlighted on page 66.

From incidents, complaints, PALS contacts, claims and other feedback that occurred during the year we have also been able to make a number of improvements.

These include the development of:

- A molar pregnancy pathway in partnership with the regional Trophoblastic Centre in Sheffield
- Twelve procedure specific consent forms, enhancing patient information relating to defined benefits, risks and alternatives to the procedure
- Systems to support implementation of 'Patient Group Directive(s)' which allows the prescribing of oxygen Anti-D and a number of family planning drugs.

Our quality report is a review of the quality of services provided to our stakeholders, that is, patients, public, staff, commissioners and partners.

We have listened to and consulted with our stakeholders in order to produce our quality account for 2010/11 which includes plans for 2011/12.

Review of our quality performance in 2010/11

Looking back over the year (2010/11) we have worked hard to implement quality initiatives that have enabled staff to focus on clinical effectiveness, patient safety and patient and staff experience. Throughout the report you will see quality initiatives that focus on providing quality care to patients and their families, where we need to improve care provision and how we will measure improvement in clinical care.

This section of the report looks back at the three identified quality priorities that were set at the beginning of 2010/11 and in addition a series of quality indicators in relation to patient safety, clinical effectiveness and patient experience.

Liverpool Women's identified three quality improvement priorities for 2010/11:

- To investigate, monitor and reduce infection rates
- To investigate, monitor and reduce mortality rates
- To monitor and improve patient experience

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 Account 2009/10.

These were:

Patient Safety

- Post operative deep vein thrombosis (DVT)/Pulmonary Embolism following discharge
- Gynaecology Surgical Site Infections
- Ovarian Hyper Stimulation Syndrome

- Incidence of multiple pregnancy
- Late onset Neonatal bloodstream infections
- APGAR scores < 4 in infants born at more than 34 weeks
- Heart Rate < 100 in infants born at less than 34 weeks
- Delivery Cord PH < 7.00
- Wound infections following Caesarean Section
- Incidence methicillin-resistant staphylococcus aureus (MRSA) Bacterium
- Incidence of Clostridium Difficile
- Medication Errors

Clinical Effectiveness

- Readmission Rates in Gynaecology
- Hospital Standardised Mortality Rate in Gynaecology
- Clinical Pregnancy Rates in in-vitro fertilisation (IVF), Intracytoplasmic sperm injection (ICSI) and frozen embryo transfer (FET) treatments
- Brain Injury in preterm babies (Severe intraventricular haemorrhage and Periventricular Leukomalacia)
- Perinatal Mortality
- Transfer to intensive therapy unit (ITU) per 1000 maternities
- Stillbirth Rate
- Blood Transfusion Rates following Vaginal Delivery
- Hospital Standardised Mortality Rate in Maternity
- Care Indicators for Nursing and Midwifery

Patient Experience

- Patient Experience & Involvement Strategy
- One to one care in established labour 100% of the time
- Rates of epidural pain relief for analgesia in labour

How we monitor our progress

Statistical Process Control (SPC) Charts

As a recommendation of the LIPS VI and LIPS VII programme the Trust has adopted the use of SPC charts to plot and monitor trends in our data. All clinical data is subject to natural variability and recorded results would be expected to change within certain limits from time to time. Simply comparing two points in time is therefore a crude and unhelpful way of using data to assess or improve quality. A more productive way of using this information is to use an analysis of trends in data that occur over time.

SPC charts are used to determine whether a process is in a state of statistical control or not. Natural variations are expected so only exceptional behaviour is highlighted by the use of both upper and lower control limits. These limits identify results that fall outside the expected norm. This allows us to identify a potential cause for concern or may provide evidence of an improvement in care.

The more data that is fed into an SPC chart the better the indication of the process it is looking at. For our Quality Account Indicators in 2010/11 we included data from the previous year to help us get a better understanding of our indicators. This can be identified in the graphs when the mean, upper limit and control limit shift to reflect the change in data.

How to read our SPC charts

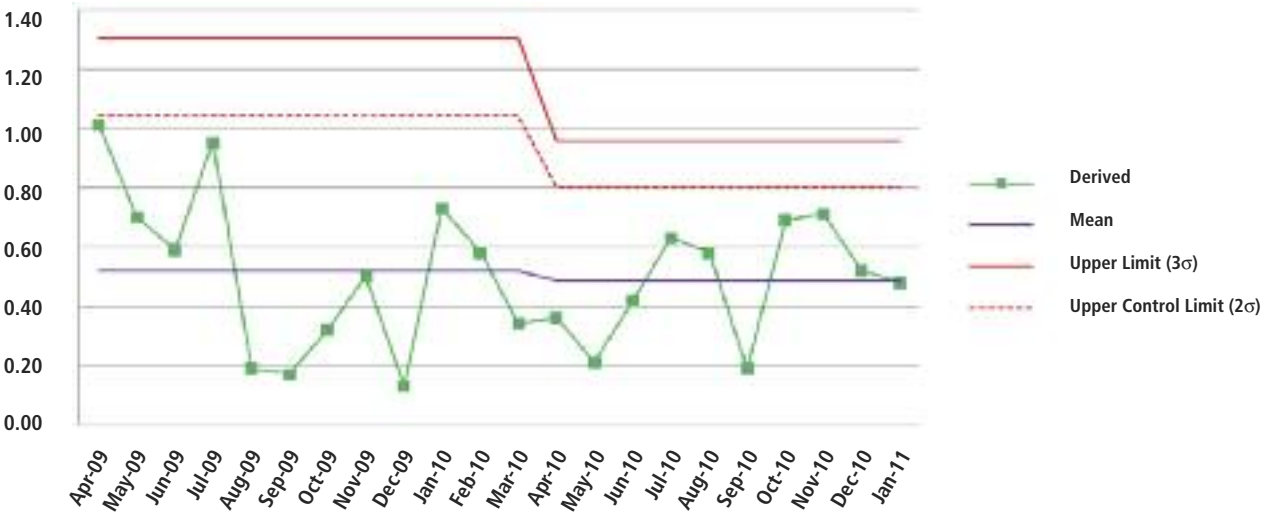
Most of the charts used to present data in this Quality Account are SPC charts. They will all have the same key calculations displayed on them as follows and in the example chart below.

- **Derived data** This shows the derived or calculated value from the data we have collected for the indicator. This is usually a percentage or a rate.

- **Mean** The mean is the average of the derived data. It tells us our average rate across the year.

- **Upper Limit** The upper limit is a key concept of SPC charts. This represents a theoretical breach point that highlights data that is outside of the normal expected variations.

- **Upper Control Limit** The Upper Control Limit is a warning level which tells us the derived value is approaching the upper limit.



Patient safety

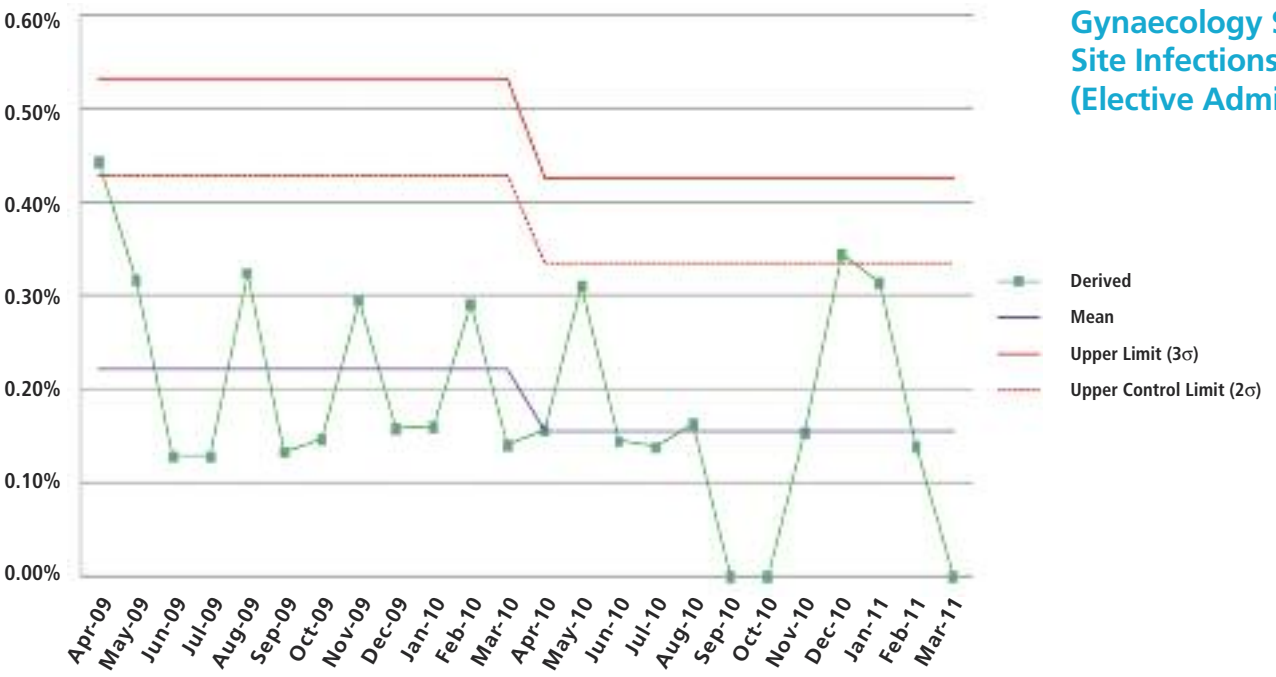
Post Operative DVT/ Pulmonary Embolism after Discharge

Deep vein thrombosis (DVT) is the term used to describe the formation of a thrombus (blood clot) in a deep vein, usually in the legs, which partially or completely obstructs blood flow. Pulmonary embolism is a condition in which one or more emboli, usually arising from a DVT are lodged in and obstruct the pulmonary arterial system. This is the blood vessels that supply the lungs. Obstruction of these vessels is a serious complication and potentially fatal. Both DVT and Pulmonary Embolism are potential complications that occur after surgery.

The National Institute for Clinical Excellence (NICE) (Guideline 92, 2010) gives guidance on 'Reducing the risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) in patients admitted to hospital. As part of our CQUIN scheme for 2010/11 we have been actively monitoring our patient screening rates for VTE but due to the nature of the Trust's services these specific conditions may not develop until our patients have left us. We are working closely with the Primary Care Trust to try and capture this data and have taken it forward as a CQUIN indicator for 2011/12.

Gynaecology Surgical Site Infections

Surgical site infection is one of the commonest causes of post operative morbidity (poor health) and delayed recovery. A reduction in the incidence of infection will have a significant impact on patient recovery. The prevention and treatment of surgical site infections is outlined in NICE Clinical Guidelines (2008). CG74.



Gynaecology Surgical Site Infections (Elective Admissions)

"Prospective data is crucial, and our surgical site infection on elective cases is the most important (and readily quantifiable) measure of the risk of infection within Gynaecology. The figures for the past 18 months show a potential improvement in the infection rate in elective cases, in line with the significant work put into the LIPS programme – development and promotion of the WHO surgical site checklist, initiation of the Enhanced Recovery Programme and employment of a Tissue Viability Nurse."

Dr Robert Macdonald
(Clinical lead for Gynaecology)

Looking forward to 2011/12, surgical site infections in Gynaecology will continue to be a Patient Safety indicator.

Ovarian Hyper Stimulation Syndrome

Ovarian hyper stimulation syndrome (OHSS) is a potentially life threatening condition attributed to an excess of fertility drugs given to a patient as part of her fertility treatment. Most fertility patients are healthy before the start of treatment, so making someone sick should be considered a failure on the part of the clinical team.

Every IVF cycle sets out to stimulate the woman's ovaries in order to obtain a few more eggs than normal with the aim of increasing the chance of a pregnancy. The treatment aim is to do this in a controlled manner.

Some patients are very sensitive to the drugs used and it is the clinician's responsibility to identify those patients and modify treatment accordingly.

Ovarian Hyper Stimulation Syndrome is discussed in NICE Guidelines (2004), 'Fertility: assessment and treatment for people with fertility problems.'

Response to Stimulation (Ovarian Hyper Stimulation Syndrome)

"We decided to choose a numerical figure of 'eggs collected in excess of 20' as 'indicative' of ovarian hyper stimulation as the definition is not universally agreed upon. These data are readily available to us and easy to measure. An excess of 20 eggs would be considered by most IVF units to be too many.

Our unit average is about 10 eggs retrieved per collection. By eyeballing the monthly data, it was clear to us that we were exceeding our pre-determined targets. As a result of this, we have amended the stimulation protocol by reducing the dose of stimulatory drugs used and also altered our practice at egg collection.

We are also auditing the number of women admitted to the gynaecology wards with a suspected diagnosis of ovarian hyper stimulation syndrome requiring clinical management. Nineteen women (out of over 1000 women having egg collections) were admitted to the gynaecology ward for this reason in 2010."

Dr Andrew Drakeley
(Clinical Lead for Reproductive Medicine)

Ovarian Hyper Stimulation Syndrome will continue to be a Patient Safety Indicator looking forward to 2011/12 but measured in a different manner as discussed above.

Incidence of multiple pregnancy

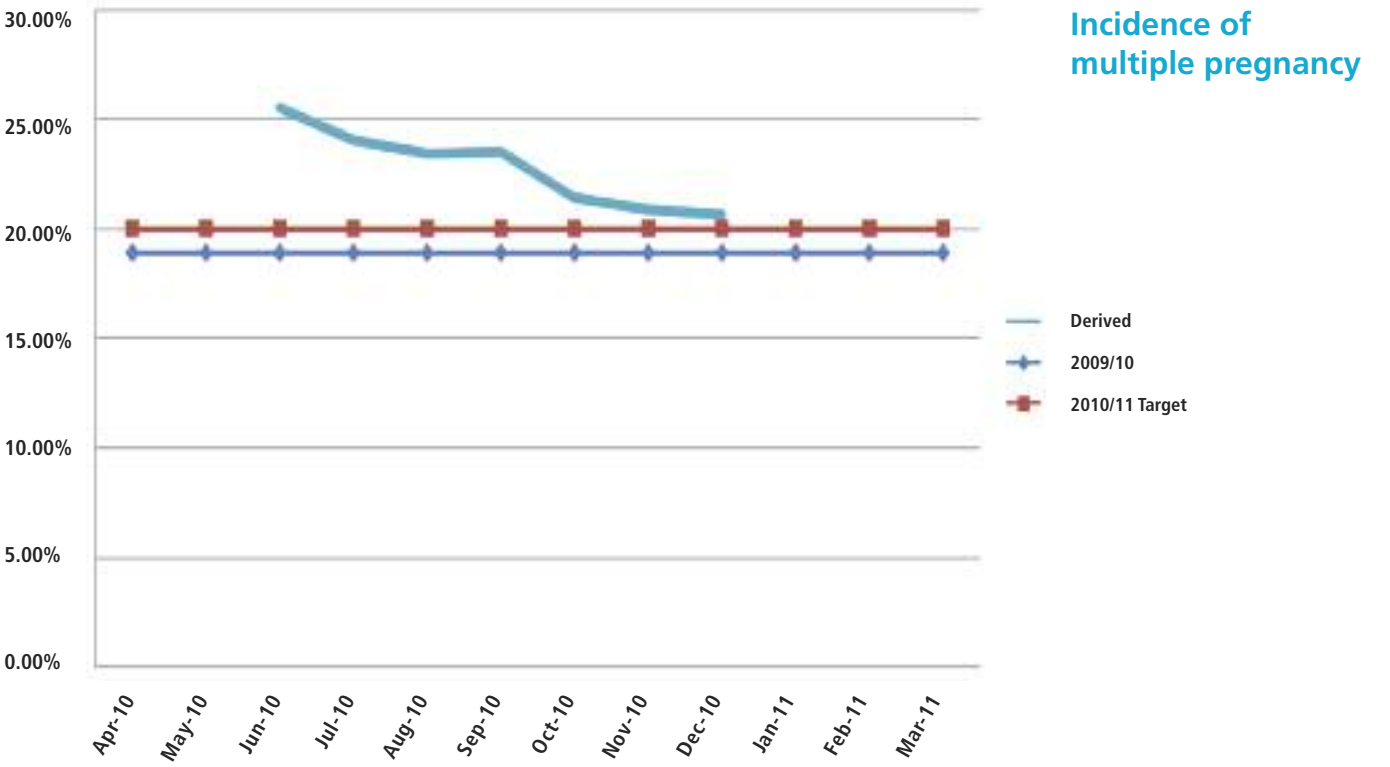
For some couples, twins bring an 'instant complete family' and for childless couples this may be an attractive thought. Once one child is born, the couple subsequently lose entitlement to any more NHS funded fertility treatment.

As a consequence there can be a lot of pressure applied to fertility clinics to replace more than one embryo. However twin pregnancies are much more complicated than a normal singleton pregnancy. In particular there is a higher risk of premature delivery which can lead to developmental problems or even loss of baby.

It is becoming more widely accepted that the increased multiple pregnancy rate associated with fertility treatment is not a good thing and should be lowered.

The fertility regulator the Human Fertilisation Embryology Authority (HFEA) has set an upper limit of 15% multiple pregnancy live birth rate for clinics to achieve in the period April 2011 – March 2012.

NICE (2004), 'Fertility: Assessment and treatment for people with fertility problems,' also covers multiple pregnancy in fertility.



"By assessing the monthly trend as set out in our quality account, it is clear that our elective single embryo transfer policy has only been partially successful.

We have recently decided that for all first IVF/ICSI cycles (NHS funded) for women below the age of 37, we will only allow a single embryo to be transferred for their first treatment cycle (unless there are issues relating to embryo quality which indicate a two-embryo transfer to be appropriate). This is based on analysis of the last 50 sets of twin pregnancies, where all bar 5 were in women under the age of 37. Our health Commissioners may well add this caveat to the access criteria for NHS funded treatment."

Dr Andrew Drakeley
(Clinical Lead for Reproductive Medicine)

Looking forward to 2011/12 Incidence of multiple pregnancy will continue to be used as a Patient Safety indicator for the Trust.

Late Onset Neonatal Bloodstream Infections (NBSI)

Late-onset NBSI in preterm infants has been chosen as a marker of quality because it is a good measure of patient safety in neonates.

Hospital-acquired infections are one of the commonest complications of preterm birth and are an important cause of morbidity and mortality in newborn babies.

NBSI is also one of the national quality markers in neonatal medicine. Appropriate NICE guidelines include 'Infection Control: Prevention of healthcare-associated infections' (2003) and 'Intrapartum Care: Care of healthy women and their babies during childbirth' (2007).

Late Onset Neonatal Bloodstream Infections

"We set a target at less than one bloodstream infection per 200 days each of our very preterm babies spends on the neonatal unit (0.5 per 100 days).

There are no nationally agreed benchmarks in this area of practice. The graph below shows that the NBSI rate varied between 0.19 and 0.71 in 2010/2011. The average rate of NBSI was lower in 2010/11 (0.48) compared with the previous year (0.55)"

Nim Subhedar
(Clinical Governance Lead for Neonates)

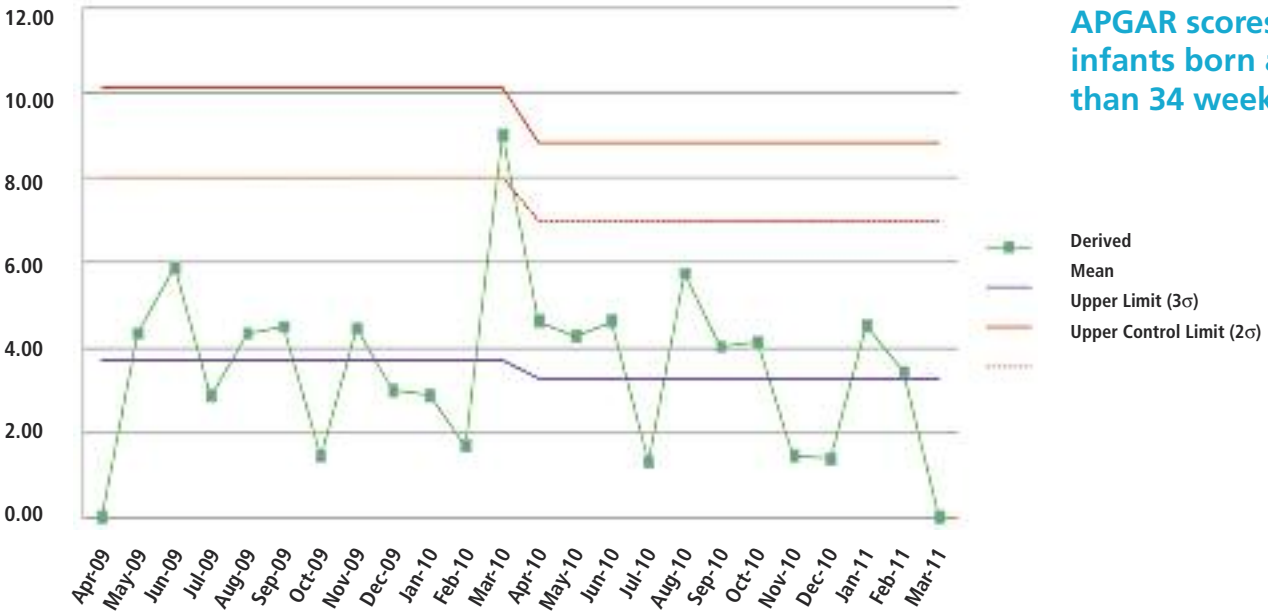
Late onset Neonatal Bloodstream Infections will continue to be used as a Patient Safety Indicator looking forward to 2011/12.

APGAR scores < 4 in infants born at more than 34 weeks

The Apgar score is a measure of a baby's condition at birth.

Although developed as an indicator to aid with resuscitation, a low Apgar score (<4 out of 10) is an indicator that the baby has been born in poor condition and not coped well with the rigours of labour.

All babies born with low Apgars should have the mother's notes reviewed to identify pre-delivery risks missed, or sub-optimal labour care. NICE Guideline – 'Intrapartum Care: Care of healthy women and their babies during childbirth' (2007) covers all aspects of Maternity Care.



"The data shows that our Apgar score, less than 4 at 5 minutes, for infants born after 34 weeks, was 3.29 per 1000 maternities in 2010/11. This is comparable to 3.7 for 2009/10."

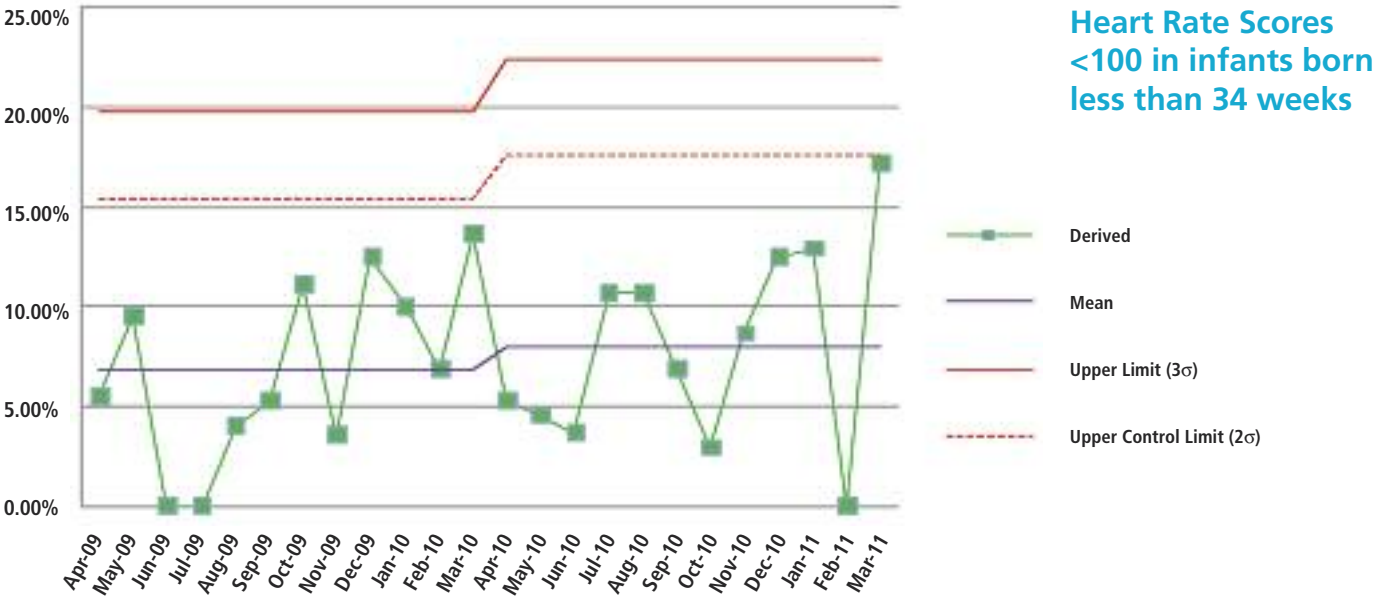
Mark Clement-Jones
(Clinical Lead for Obstetrics)

Looking forward to 2011/12 APGAR scores will continue to be used as an indicator for Patient Safety.

Heart Rate <100 in infants born at less than 34 weeks

For babies born less than 34 weeks gestation, the use of the Apgar score is less useful, due to active measures at birth to resuscitate the infant. For these babies, the most useful indicator of neonatal wellbeing at birth is probably a heart rate greater than 100, at 5 minutes old. Therefore this is the measure used rather than Apgar <4 at 5 minutes for infants born below this gestation.

Again as for Apgar score, it is a measure of the quality of intrapartum care.



Heart Rate Scores <100 in infants born less than 34 weeks

"This is a new quality indicator for 2010/11. In the last year an average of 8.01% of babies less than 34 weeks had a heart rate of less than 100 at 5 minutes. This compares with an average 6.84% in 2009/10.

There were no months when there appeared to be an increased number or trend, beyond normal variation."

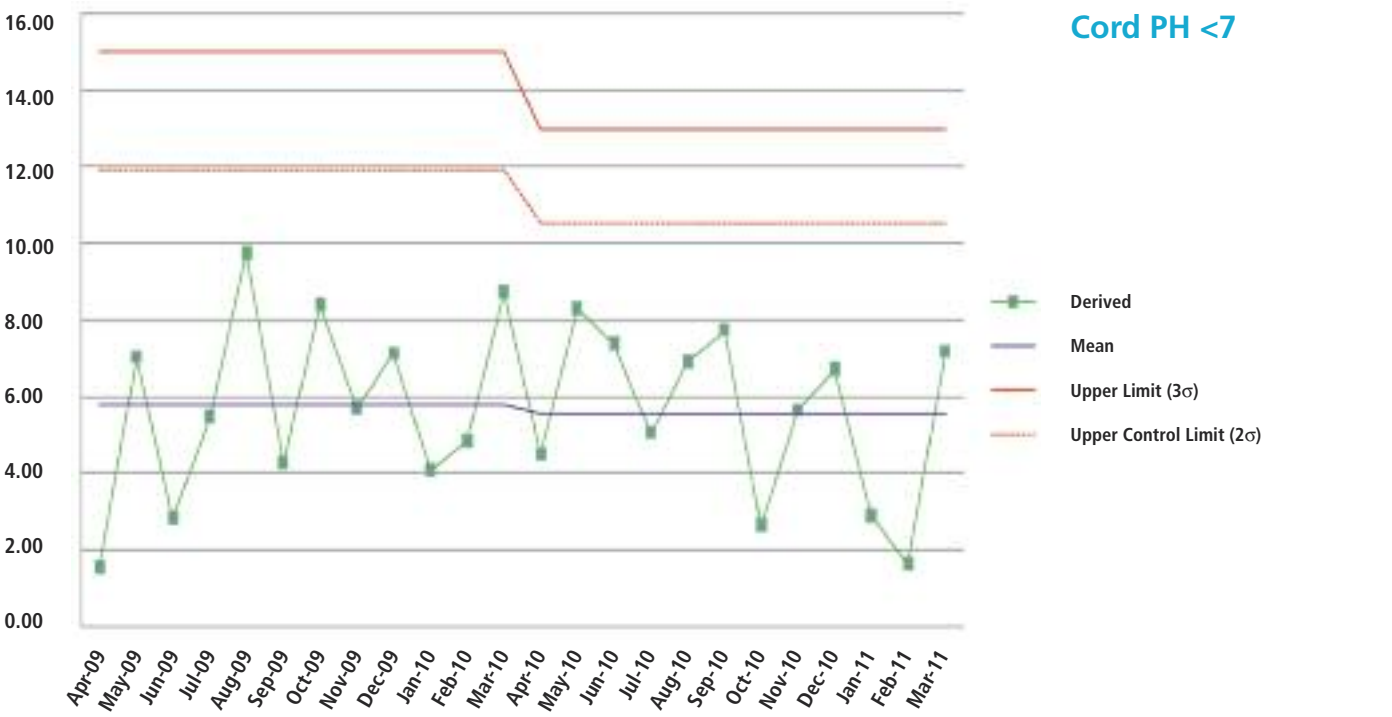
Mark Clement-Jones
(Clinical Lead for Obstetrics)

Looking forward to 2011/12 Heart Rate scores will continue to be used as an indicator for Patient Safety.

Delivery Cord Blood PH < 7

The umbilical cord blood pH analysis is a measure of a baby's condition at birth.

All babies born with low cord blood pH (less than 7.00) should have the mother's notes reviewed to identify pre-delivery risks missed, or sub-optimal labour care. Appropriate NICE guidance includes: 'Intrapartum Care: Care of healthy women and their babies during childbirth' (2007), 'Postnatal Care: Routine postnatal care of women and their babies' (2006) and 'Antenatal Care: Routine care for the healthy pregnant woman' (2008).



"The incidence of cord blood pH <7 was 5.53 per 1000 deliveries, for 2010/11. This compares to 5.8 in 2009/10. In the previous quality account (and annual reports) the incidence was for the calendar year rather than fiscal (2008, 3.8 and 2009, 4.05/1000 maternities).

A change to the denominator has also occurred in 2010/11 because nearly all the babies born on the midwifery led unit no longer have cord blood gas analysis performed.

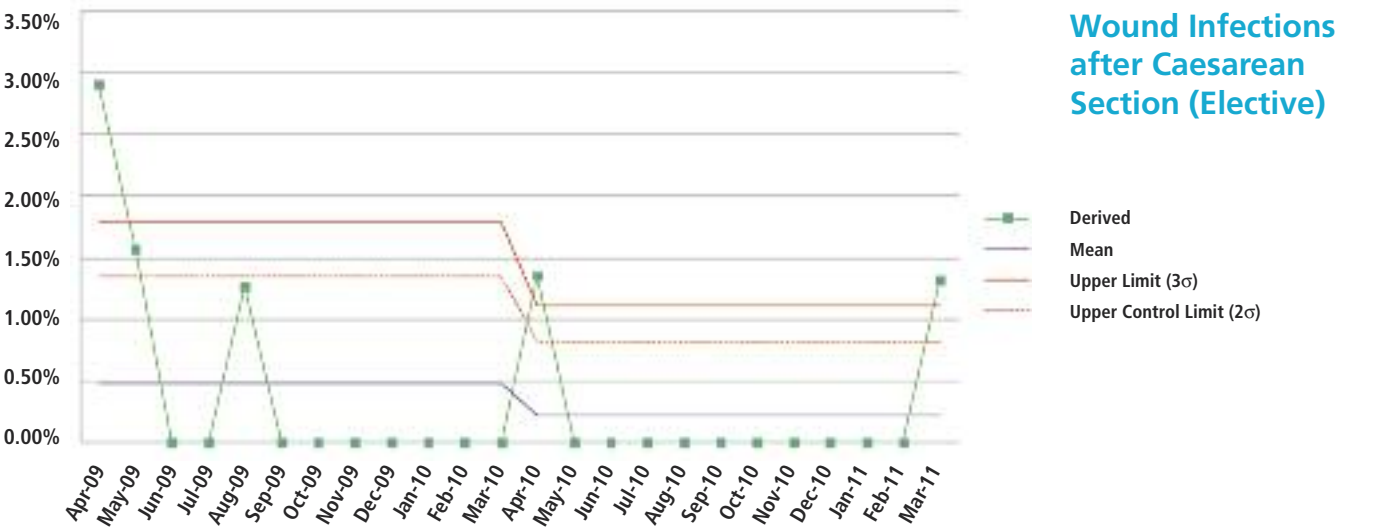
This should reduce the numerator by approximately 6 per year / but the denominator by between 2500 – 3000 (approx. 2.4 – 2/1000 maternities). Babies born in poor condition on the MLU will still be identified using the quality indicator 'low Apgar score at 5 minutes less than 4'."

Mark Clement-Jones
(Clinical lead for Obstetrics)

Looking forward to 2011/12, Cord PH will continue to be used as a Patient Safety indicator.

Wound Infections Following Caesarean Section

Wound infection following caesarean section is a significant complication following delivery, which is potentially avoidable. NICE Guidelines covering this area include 'Caesarean Section' (2004), 'Intrapartum Care: Care of healthy women and their babies during childbirth', 'Surgical Site Infection: Prevention and treatment of surgical site infection' (2008) and 'Postnatal Care: Routine postnatal care of women and their babies' (2006).



"The CBU would like to collect better data on the development of wound infection following abdominal delivery, as it is probably the biggest morbidity following birth. As part of LIPS VI the aim is to reduce infection in the trust by 25%.

Currently data is limited because women go home within 3 – 4 days of delivery, whereas wound infection may only become apparent after 5 – 7 days. Current data is for wound infection diagnosed as in patients, or who return to the Trust (emergency or assessment room)."

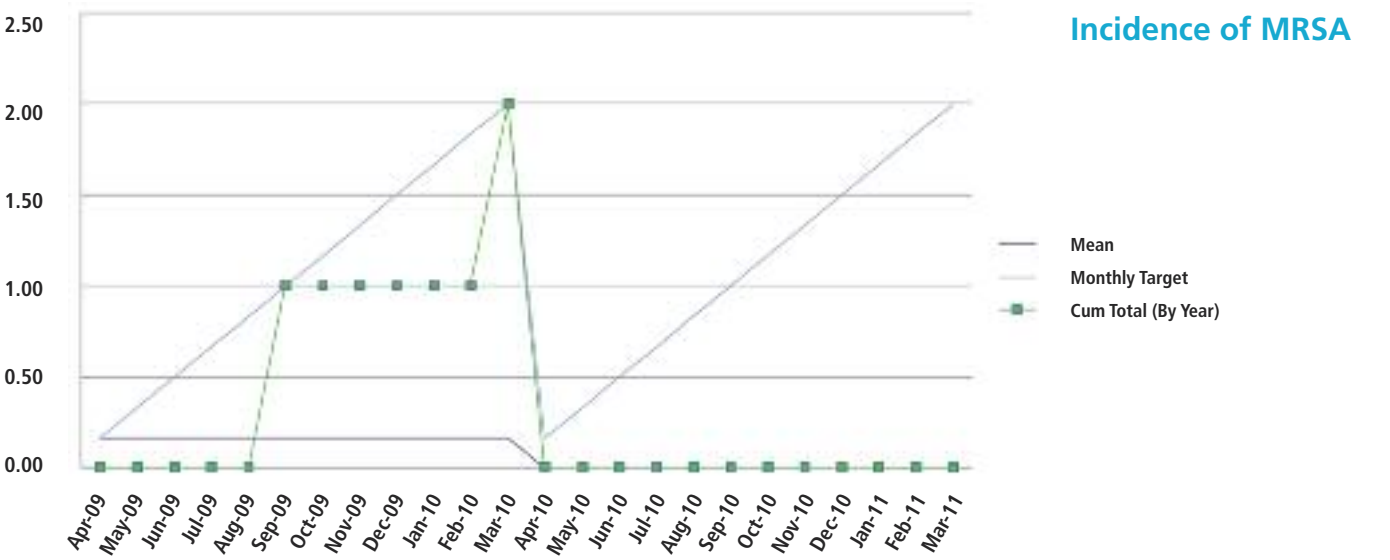
Mark Clement-Jones
(Clinical Lead for Obstetrics)

Looking forward to 2011/12 wound infections following Caesarean Section will continue to be used as a Patient Safety indicator but more accurate data will be collected by Community Midwives after patients have been discharged.

Incidence of MRSA

MRSA is methicillin-resistant Staphylococcus aureus. Staphylococcus aureus is a bacterium (germ) and is often found on the skin or in the nose of healthy people. Most S. aureus infections can be treated with commonly used antibiotics. However, MRSA infections are resistant to an antibiotic called methicillin and also to many other types of antibiotics. Infections with MRSA are usually associated with high fevers and signs of the infection.

As mentioned, most commonly these are infections of the skin and soft tissues (like boils and abscesses). Less commonly, MRSA can cause pneumonia and urine infections.



2009-10 – 2 cases
2010-11 – 0 cases

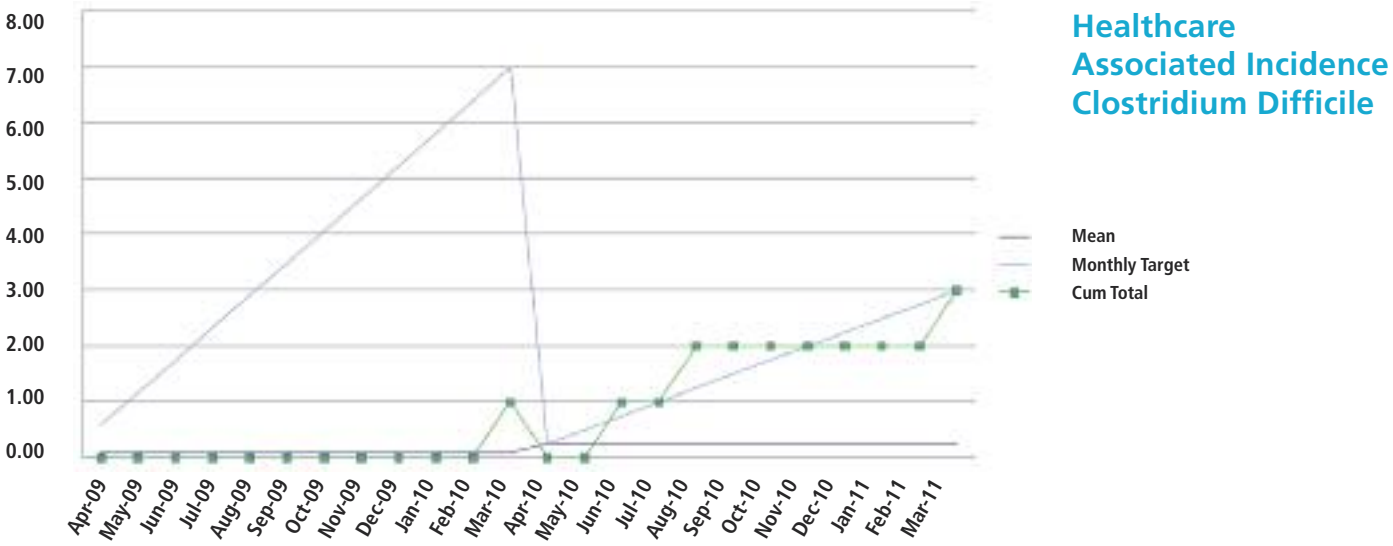
"In 2010/11 the Trust reported zero cases of MRSA bacteraemia, continuing the Trust's excellent performance against this standard."

Dr Tim Neal
(Clinical Lead for Infection Prevention and Control)

Looking forward to 2011/12 incidence of MRSA will continue to be monitored as an indicator of Patient Safety.

Healthcare Associated Incidence Clostridium Difficile

Clostridium difficile (C. difficile) are bacteria that are present naturally in the gut of around two-thirds of children and 3% of adults. C. difficile does not cause any problems in healthy people. However, some antibiotics that are used to treat other health conditions can interfere with the balance of 'good' bacteria in the gut. When this happens, C. difficile bacteria can multiply and produce toxins (poisons), which cause illness such as diarrhoea and fever.



2009-10 – 1 case
2010-11 – 3 cases

"In 2010/11 the Trust reported 3 cases of healthcare associated C.difficile diarrhoea, meeting the agreed target for this infection."

Dr Tim Neal
(Clinical Lead for Infection Prevention and Control)

Looking forward to 2011/12 incidence of C-Difficile will continue to be monitored as an indicator of Patient Safety.

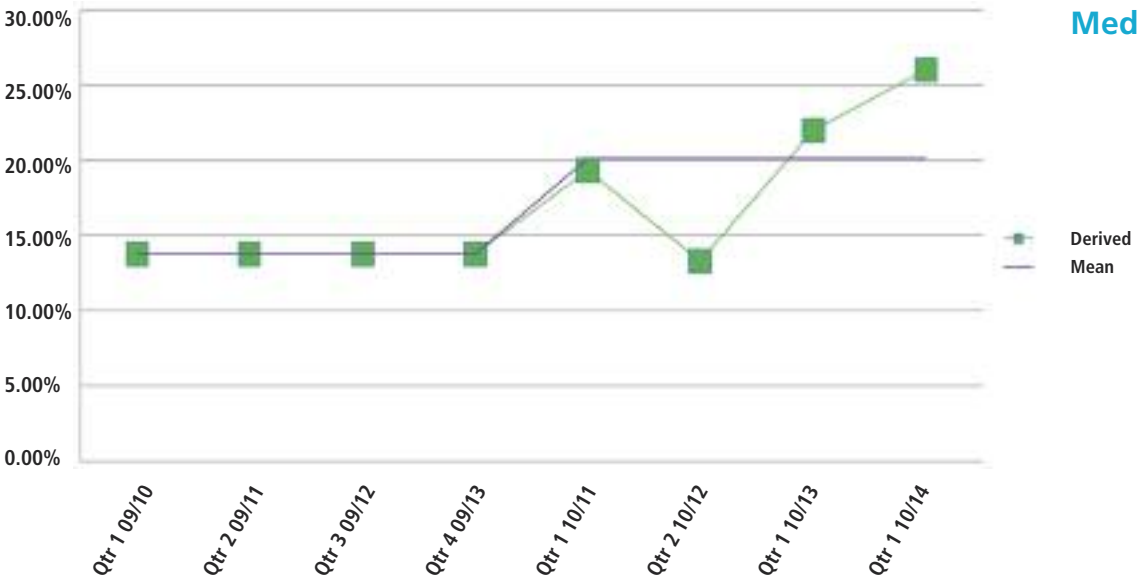
Medication Errors

The data presented here represents medication related incident reports that were downloaded onto the Trust Incident Reporting system each quarter.

Sometimes an incident, (known as an adverse clinical event (ACE) report) is made up of a number of events which contributed to the incident occurring. Pharmacy analyse each medicine incident reported taking this into account.

As a result of this, the number of incidents reported can be contributed to a number events happening when they should not have done, or not happening when they should. As such, each incident can be made up of a number of events.

The number of incidents reported represents the reporting activity only. The rise in medication errors is attributed to the rise in reporting incidents which is encouraged by Liverpool Women's to ensure that we have an open and honest culture where staff feel they can raise concerns and learn from errors.



"High incident reporting is considered good practice as it demonstrates that an organisation is committed to improving its performance by learning from its mistakes. Staff are actively encouraged, with a no blame culture, to report incidents and a drive on medicine incident reporting is taking place.

Despite a poor result in Quarter 2, reporting figures have improved. The main reporters, NICU due to the high risk nature of their work, had a lull in reporting in Q2, but the increase in reporting in Q3 was significant, with a further improvement in Q4."

Eileen Reynolds
(Pharmacy Manager)

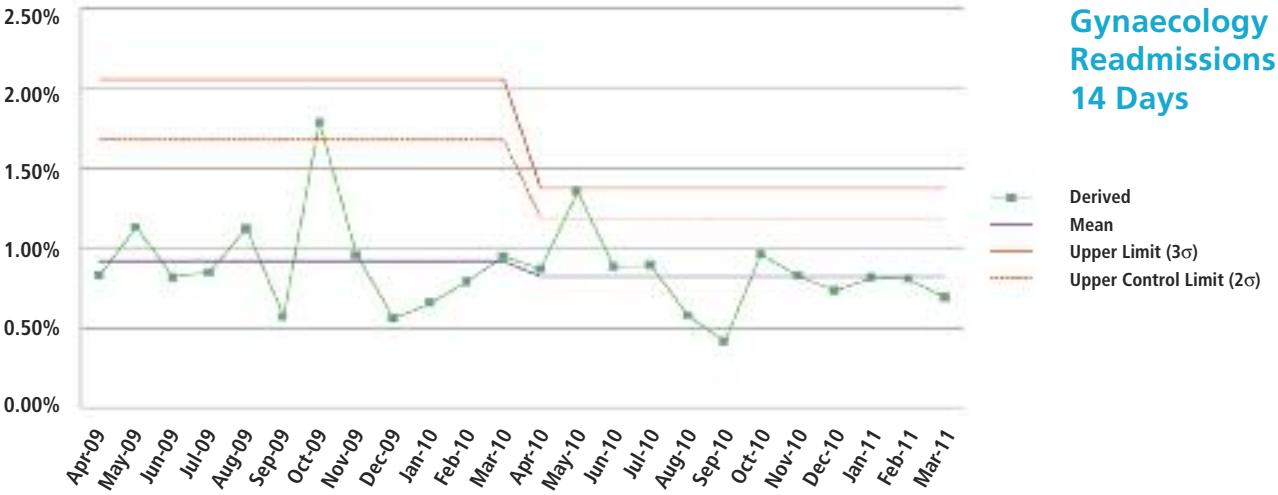
Looking forward to 2011/12 Medication Errors will continue to be monitored as an indicator of Patient Safety.

Clinical Effectiveness

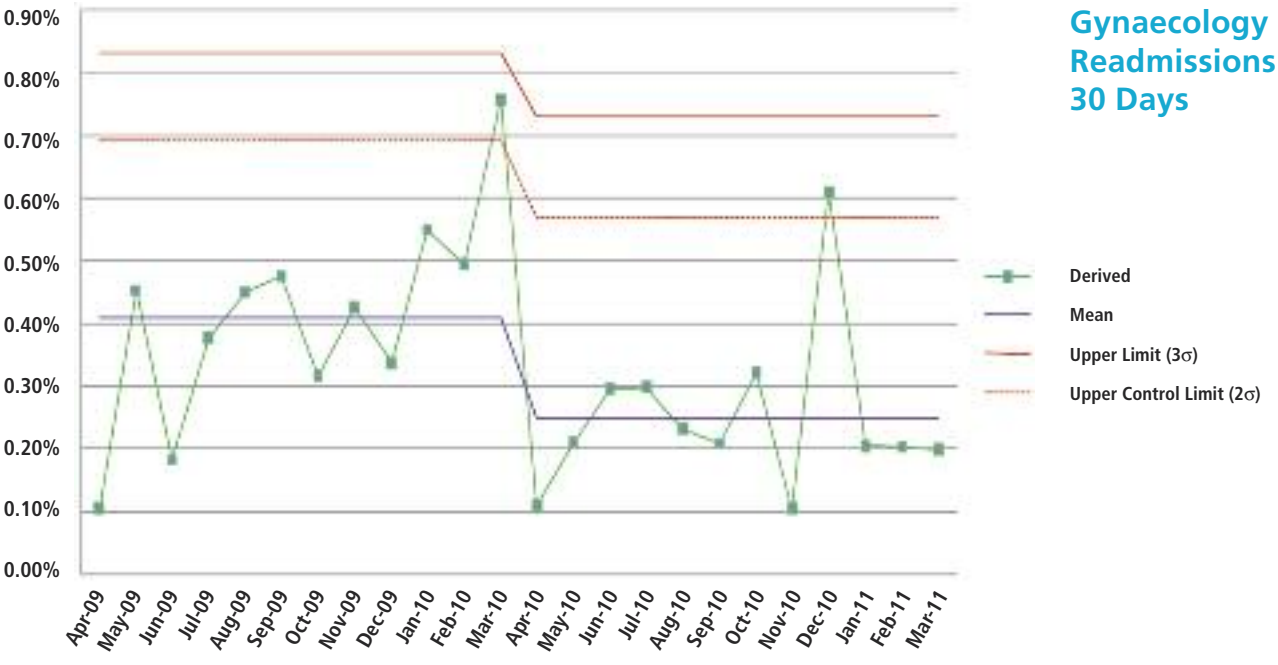
Readmission Rates in Gynaecology

Measurement of readmissions is part of CQUINS and the Enhanced Recovery Programme. CQUINS is a required national process, whilst the Enhanced Recovery Programme, which started in the Liverpool Women's Hospital NHS Foundation Trust in February 2011, is an internally driven programme to improve patients' journey through the hospital, aiming to reduce complications, reduce readmissions and improve patient experience.

Measurement of the readmission rate, both early (14 days) and late (30 days) will be integral to the planned improvements.



Gynaecology Readmissions in 14 Days



Gynaecology Readmissions in 30 Days

"Continued monitoring will enable the hospital to identify whether new developments such as the Enhanced Recovery Programme are improving patient care.

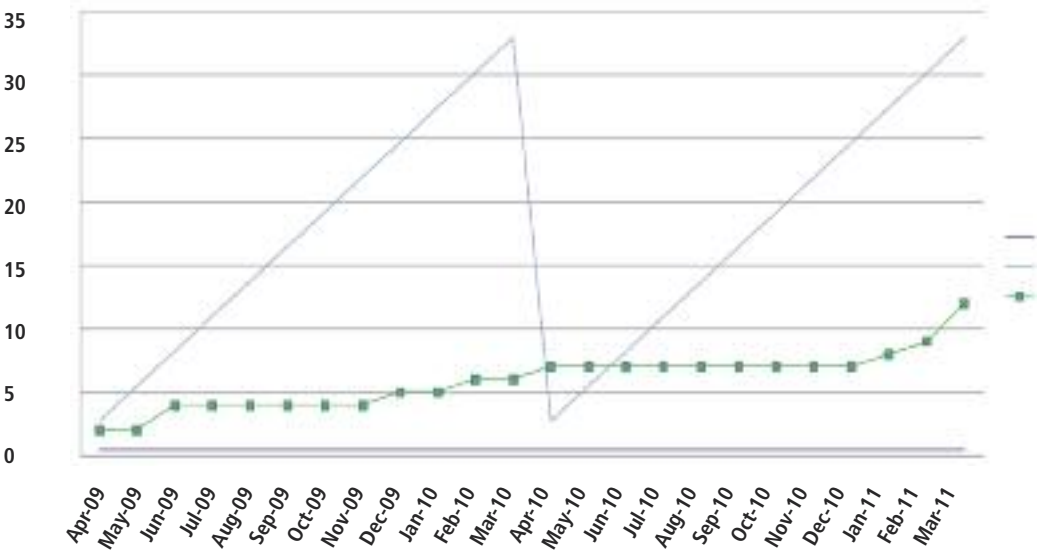
It will also allow the trust to closely monitor and action readmissions, making changes in practice as required not only to improve the patient pathway but reduce financial penalty of not receiving income for readmissions"

Robert Macdonald
(Clinical Lead for Gynaecology)

Looking forward to 2011/12 readmission rates in Gynaecology will continue to be used as an indicator for Clinical Effectiveness.

Mortality Rate in Gynaecology

The mortality rate in gynaecology is a measure of the number of deaths in the hospital population being treated or cared for in this medical specialty.



"Measurement of the mortality rate is crucial in a hospital with major surgery and in particular tertiary referral facilities for Gynaecological Cancer and palliative care facilities.

In this circumstance, a "target" for mortality is likely to be inappropriate, as nearly all deaths are in the palliative care setting, but continued monitoring is essential to allow (as occurred appropriately in 2009) a swift review of cases if and when a sudden rise in the hospital mortality figures occurs."

Robert Macdonald
(Clinical Lead for Gynaecology)

Mortality rate in gynaecology will continue to be used as an indicator for Clinical Effectiveness in 2011/12.

Performance Indicator	LWH 2009	Peer 2009	LWH 2010	Peer 2010
Gynaecology Mortality	0.13%	0.09%	0.04%	0.07%

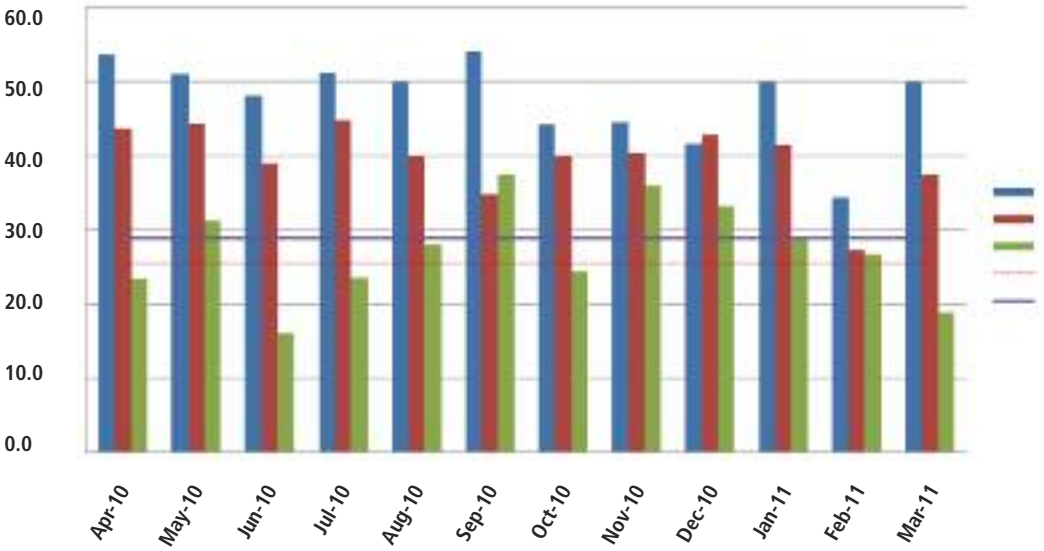
Source: CHKS (National Clinical Benchmarking Organisation)

Clinical Pregnancy Rates in in-vitro fertilisation (IVF), intracytoplasmic sperm injection (ICSI) and frozen embryo transfer (FET) treatments

Every couple embarking on fertility treatment wants to know how likely it is to work. Whilst live birth rates are perhaps more meaningful to lay people and academics, those data are only available a year or so after the event.

What is perhaps more meaningful is clinical pregnancy rate (the incidence of fetal heart(s) on scan) or biochemical pregnancy rate (the incidence of positive pregnancy tests) as these are available as soon as two weeks after treatment and are a more immediate reflection on the performance of the service allowing meaningful reactive management.

The obtainment of a pregnancy is why we are here and why patients come to us. It is therefore fundamental to know how we are performing. NICE guidelines on this issue are found in 'Fertility: Assessment and treatment for people with fertility problems' (2004).



Biochemical Pregnancy Rate for IVF, ICSI & FET

"The achievement of a pregnancy is the rationale for which all couples undergo fertility treatment. It is therefore imperative to know our pregnancy rate. It is pleasing to see above target pregnancy rates throughout the year."

Andrew Drakeley
(Genetics Clinical Lead)

Looking forward to 2011/12 Biochemical Pregnancy rate will be used as an indicator for Clinical Effectiveness.

Brain Injury in preterm babies (Severe intraventricular haemorrhage and Periventricular Leukomalacia)

Perinatal brain injury is assessed in very low birth weight babies using ultrasound examination. Severe periventricular haemorrhage (grade 3 or 4) and periventricular leukomalacia are associated with a high rate of subsequent neurological disability.

We report the rates of these two outcomes in very low birth weight babies who have survived to discharge after birth at Liverpool Women's Hospital (LWH).

We have benchmarked these outcomes with the reported rates across the Vermont Oxford Network (VON), a collaborative network involving over 950 neonatal units across the world.

Severe periventricular haemorrhage

LWH 2009	2.2%
LWH 2010	3.4%
VON 2009 median (interquartile range)	4.5% (0% to 6.1%)

Periventricular leukomalacia

LWH 2009	1.5%
LWH 2010	4.2%
VON 2009 median (interquartile range)	2.4% (0% to 3.6%)

"The rates of severe PVH and PVL in very low birth weight survivors were within the range seen across the VON network in 2009 and remained within the expected range after adjustment for the risk profile of the babies cared for at Liverpool Women's hospital. The raw data show that there has been an increase in the rate of PVL in 2010 to a rate which is above the VON interquartile range for 2009. We have not yet received the risk adjustment for 2010. If the risk adjusted rate is raised, then further investigation will be performed to allow us to understand this."

Bill Yoxall
(Clinical Director of Neonatology and Pharmacy)

Looking forward to 2011/12 Brain Injury in preterm babies will be used as an indicator for Clinical Effectiveness.

Perinatal Mortality

The following table shows the neonatal mortality rate for babies born at Liverpool Women's Hospital between 2008 and 2010

	2008	2009	2010
Live births (Total)	8344	8259	8583
Live births (from booked pregnancies)	8227	8106	8466
Neonatal deaths (total)	65	52	61
Neonatal deaths (from booked pregnancies)	44	31	41
[6]NNMR (Total)	7.8	6.3	7.1
NNMR (booked pregnancies)	5.3	3.8	4.8
[7]UK NNMR 2009	3.1		
LWH gestation corrected NNMR (total)	4.2	4.2	4.7
LWH gestation corrected NNMR (booked pregnancies)	3.6	3.1	3.6

[6]NNMR – = neonatal mortality rate and is expressed as deaths per 1000 live births
[7]Office of National Statistics bulletin, March 2011

NNMR for all babies born at LWH is higher than the published UK rate. Most of this apparent excess is explained by the fact that a significant number of women transfer their care to LWH during pregnancy or labour due to known fetal malformation, pregnancy complications or preterm labour with no local neonatal care availability. These are high risk pregnancies with a high NNMR.

The NNMR for booked pregnancies is still higher than the UK rate. This appears to be due to the high prematurity rates seen in our local population. 1% of babies in UK are born before 31 weeks gestation, compared with 1.8% at LWH. Over 60% of neonatal deaths occur in babies born before 31 weeks gestation. When the mortality rate is corrected for the gestation profile of our population, the NNMR for babies at LWH is comparable with national figures.

Benchmarking with CEMACH

CEMACH is the Confidential Enquiry into Maternal and Child Health. Funded by NICE it aims to improve the health of mothers, babies and children by carrying out confidential enquiries on a nationwide basis and by sharing the findings and recommendations.

It is recognised that there is great variability in the reporting of live births in pregnancies that deliver before 22 weeks. None of these pregnancies are viable, so variation reporting rates will impact on NNMR. To allow for this CEMACH publish an 'adjusted' NNMR for UK, excluding all pregnancies that deliver before 22 weeks.

The UK and LWH Neonatal mortality rates are presented in the following table:

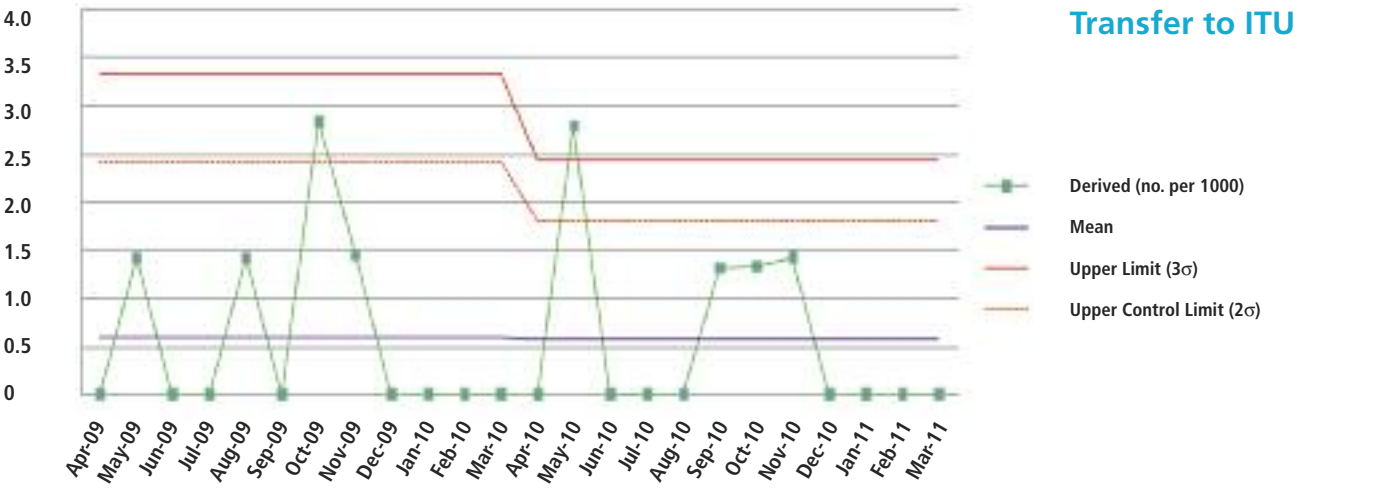
[8]UK 2009 (CEMACH)	2.7
LWH 2010 (all births)	6.2
LWH 2010 (booked pregnancies)	3.9

The NNMR at Liverpool Women's is comparable with published UK NNMR when adjustments are made for births before 22 weeks.

[8]Perinatal Mortality, 2009 CEMACH Trust specific report

Transfer to Intensive Therapy Unit (ITU) per 1000 maternities

The transfer of a woman before or post-delivery to ITU (Intensive Therapy Unit) is an indicator of both the pre-morbid status and/or the development of severe pregnancy associated morbidity. The identification and regular review of all women transferred to ITU is important to monitor the quality of our care for high risk pregnancies and complications. This care is as per NICE guidance 'Intrapartum Care: Care of healthy women and their babies during childbirth' (2007) and 'Postnatal Care: Routine postnatal care of women and their babies' (2006).



"In 2010/11 the mean ITU transfer rate was 0.57 per 1000 compared to 0.59 in 2009/10. This is comparable to other specialist NHS Trusts providing maternity services."

Mark Clement-Jones
(Clinical Lead for Obstetrics)

Transfer to ITU will continue to be used as a Clinical Effectiveness indicator looking forward to 2011/12.

The following table shows the mean ITU Transfer Rate by calendar year:

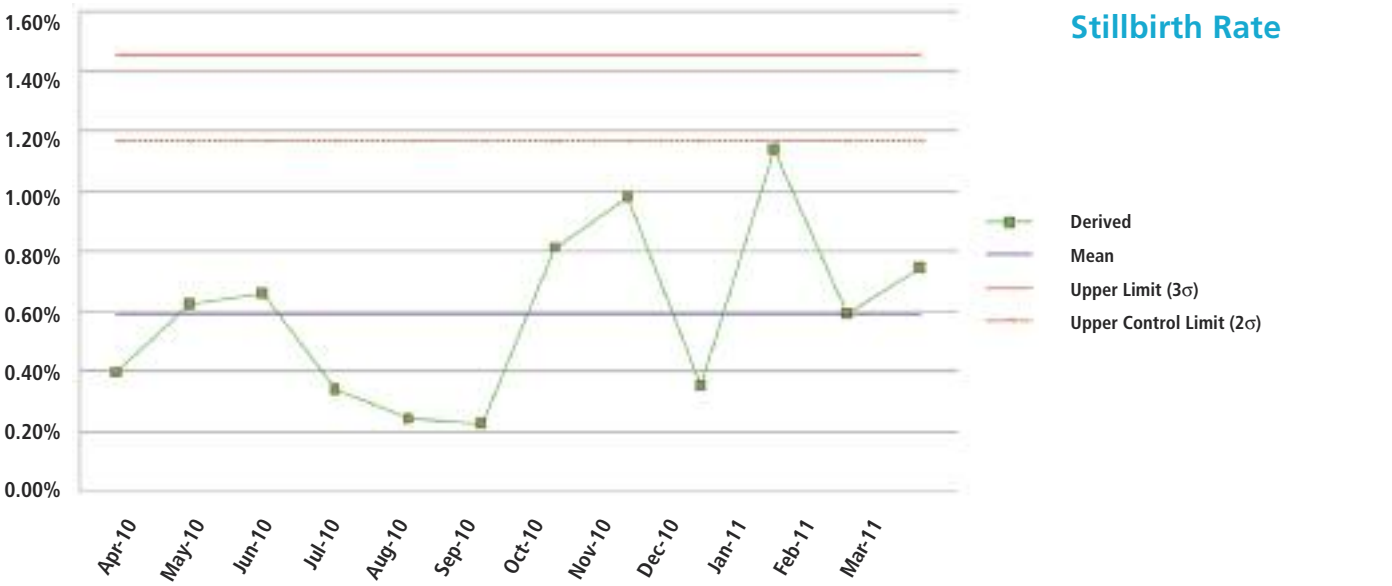
Performance Indicator	LWH 2008	LWH 2009/10	LWH 2010/11	National Average 2007/8
Transfer to ITU	16.1%	18.7%	17.5%	22.2%

Source: Critical Care Lead Midwife Database, Peer Data Birmingham Women's Hospital 2007/8

Stillbirth Rate

Clearly the aim of antenatal and intrapartum care is a healthy mother and healthy baby.

A stillbirth is unfortunately a relatively common (1 in 200) event and we should be constantly aware of our stillbirth rate, and identify trends or spikes in the rate, and investigate when appropriate. Available guidelines for this are covered by NICE in 'Antenatal Care: Routine care for the healthy pregnant woman' (2008) and 'Intrapartum Care: Care of healthy women and their babies during childbirth' (2007).



"The stillbirth rate for the Trust was 6.2 per 1000 maternities in 2008; this was reduced to 5.5 per 1000 in 2009. In 2010/11 the stillbirth rate was 5.9.

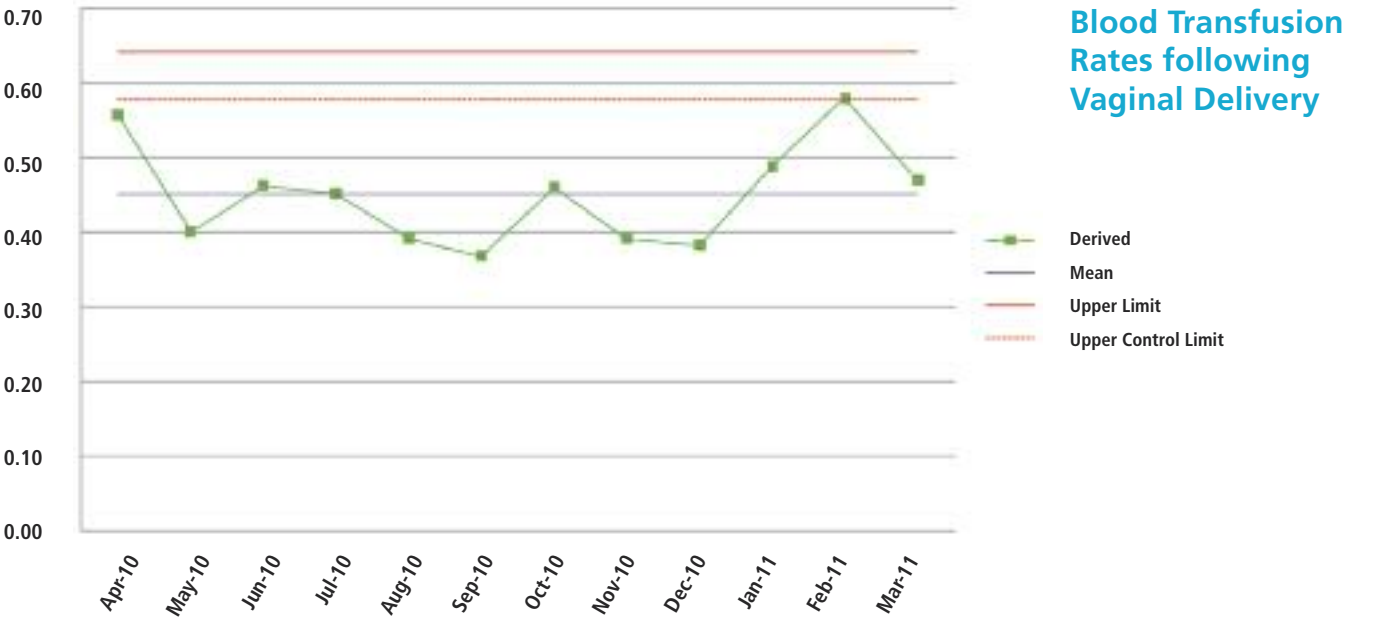
This is within the normal range for natural variation. The trust continues to perform an annual audit of stillbirths, to attempt to identify themes or factors that could influence future pregnancy care, with the aim of reducing the future stillbirth rate."

Mark Clement- Jones
(Clinical Lead for Obstetrics)

Looking forward to 2011/12 Stillbirth rate will continue to be used as an indicator for Clinical Effectiveness.

Blood Transfusion Following Vaginal Delivery

This is a new indicator for 2010/11. Post-partum haemorrhage is a significant cause of maternal morbidity. Correct management can reduce the effect on maternal health. Estimated blood loss is notoriously unreliable. This substitute will hopefully be more effective and be easier to benchmark. NICE Guidelines include 'Intrapartum Care: Care of healthy women and their babies during childbirth' (2007), 'Postnatal Care: Routine postnatal care of women and their babies' (2006) and 'Antenatal Care: Routine care for the healthy pregnant woman' (2008).



Blood Transfusion Rates following Vaginal Delivery

"In 2010/11 the number of units of blood transfused in women having vaginal delivery was 0.45 per 100 women."

Mark Clement-Jones
(Clinical Lead for Obstetrics)

Looking forward to 2011/12 this indicator will be refined to look at all methods of delivery including spontaneous vaginal, assisted vaginal, emergency and elective Caesarean section.

Mortality Rate in Obstetrics

There have been no maternal deaths within Liverpool Women's Hospital in 2010/11 as identified in the table below:

Performance Indicator	LWH 2009	Peer 2009	LWH 2010	Peer 2010
Obstetrics Mortality	0.00%	0.02%	0.00%	0.02%

Source: CHKS (National Clinical Benchmarking Organisation)

Mortality rate in Obstetrics will continue to be used as an indicator for Clinical Effectiveness in 2011/12.

Care Indicators in Nursing and Midwifery

Care indicators enable nurses and midwives to undertake spot-check audits on the quality of care received by patients. By undertaking monthly audits teams can assess quality of care provided and identify areas for improvement.

This provides the Clinical Business Units with monthly assurance that care is being regularly and consistently measured. The following graphs show the compliance of theses care indicators across the year for each Clinical Business Unit, zero compliance was evident when no audit was completed for the month.

Care Indicators for nursing and Midwifery - Gynaecology

"The initiation of measurement of the Nursing Indicators in 2010 was a significant success, allowing the nursing management and the nursing staff themselves to have a clear way to assess day to day nursing of in patients on a prompt and regular basis for the first time.

Since the initiation of the indicators, the improvement in measured care has been significant, since it has identified where the improvements were needed in a very timely fashion".

Diane Brown
(Gynaecology Head of Nursing)

Care Indicators for nursing and Midwifery - Neonates

"The introduction of nursing care indicators has enabled the unit to focus on the important nursing contribution to clinical care of neonatal babies. Compliance is good and reflects the nursing care delivered."

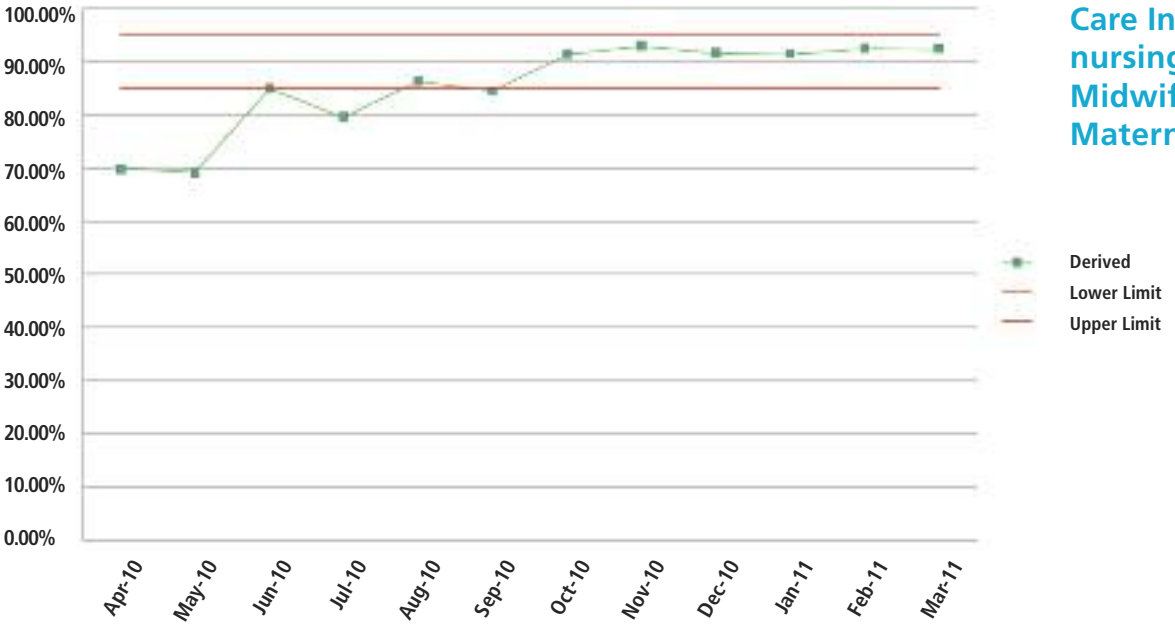
Valerie Irving
(Matron Neonates)

Care Indicators for nursing and Midwifery - Hewitt Centre

"Whilst there is still room for improvement there has been an overall improvement in compliance since introduction of the indicators. The last quarter results have been encouraging although we still have areas that need improvement.

The most difficult area we have chosen to look at is documentation, however we feel that the care indicators are there to ensure that improvements are made and all improvements are a move towards excellent patient care."

Jane Mutch
(Hewitt Centre Matron)



Care Indicators for nursing and Midwifery - Maternity Services

"Within the maternity CBU we have demonstrated huge clinical improvements surrounding maternity care indicators. In areas we feel still require additional support we have embraced new methods of working.

We aim to raise the profile of maternity care indicators within the CBU to all our staff, by newsletters and at local ward meetings, we hope these alternative working patterns will increase the compliance and RAG rating of our indicators. We also feel that we will use the Trust policies of capability, behavioural standards and finally supervision to aid use in our goal of increasing our RAG rating."

Clare Fitzpatrick
(senior midwife)

Patient Experience

Patient Experience and Involvement Strategy

The Trust is committed to achieving its vision and aims and ensuring the best possible experience for all service users and their families. The Patient Experience and Involvement Strategy has been developed to clearly detail the methods and processes used within the organisation to learn from patients, their families and visitors and to involve them in all aspects of Trust business.

Strategy Development

A series of patient and public engagement activities were undertaken to develop the strategy.

The aims were:

- To explore what is important to our patients and their families
- To inform patients how we gather information currently
- To explore how we could improve patient involvement in the future

Exploring what is important to our patients and their families

Activities included face to face discussions with individuals and groups of service users, and meetings with key stakeholders and community groups e.g. Local Involvement Networks (LINk) clinic staff, Young Mother's Group, Young Father's Group representatives, Women with mental health problems, Sisters at a local mosque.

Representatives from specific patient groups, organisations, voluntary and employed staff also provided their views. This information was considered along with that already gathered through existing methods of obtaining feedback e.g. complaints and compliments, Patient Advice and Liaison Service (PALS), comment cards, research findings where patients views were explored and existing patient involvement groups.

The information gathered was analysed using standard qualitative methods. Five themes were identified regarding the needs of service users in relation to patient experience at Liverpool Women's NHS Foundation Trust, as illustrated below:

Gathering patient experience information

The Trust will continue to use traditional methods of collecting feedback from Complaints, PALS, comment cards, national surveys and service evaluations.

'Real time' surveys have been conducted in many areas using specifically designed electronic devices enabling a speedy analysis of the data collected. Patients and visitors, where appropriate, are invited to comment on their experience at the Trust using this innovative resource. Our Patient Quality team will ensure that feedback is collected from all areas within the Trust.

Patient Involvement

Following the development of the Patient Experience and Involvement Strategy, the Patient Involvement Committee has been re - established. Its membership includes members of the public, members of the Trust, Trust governors, volunteers and Trust representatives. The purpose of the committee is to ensure that there is a designated forum for patients & visitors to review, challenge,

influence and monitor all aspects of the Trust's work enabling it to achieve its vision and aims.

The committee will continue to meet every 3 months. The agenda will be developed collaboratively and this will enable both the Trust and committee members to contribute and benefit from the meetings.

The Patient Quality team will continue to meet with local communities in their own settings. This flexible approach to gathering feedback will assist in ensuring that the opportunity to become involved is equitable, particularly for those who are unable to attend meetings at the Trust.

Patient Experience report

All patient feedback received by the Trust is incorporated into a patient experience report, which is published every 3 months. The report includes details of complaints and PALS issues, comment card data, quotes from letters of appreciation, findings of surveys and details obtained from feedback websites such as NHS Choices. It is important that we learn from patients' experiences and from the feedback they provide in terms of what is important to them.

Some actions taken as a result of patient feedback are:

- Organisation of remembrance service for families who have lost their babies
- Handover of care by the midwifery staff at the bedside to ensure that women are actively involved in plan of care.
- Improved signage for the Early Pregnancy Assessment Unit
- Designated member of staff each day to ensure women are supported when bathing their baby and preparing feeds
- Additional bathroom facilities for visitors, close to the clinical areas in both Gynaecology & Maternity Units.
- Drinking water facilities installed in Gynaecology Outpatient's Clinic
- Windowed doors on Bedford ward covered in opaque film to maintain patient privacy.
- Refreshments provided in dispensing machine at main reception, particularly used when cafe and shop are closed.

National Surveys

National surveys of both Gynaecology and Maternity patients were undertaken this year.

Gynaecology survey

842 women were eligible for the survey, of which 422 returned a completed questionnaire, giving a response rate of 50%. The average response nationally being 47%

Nationally, the Trust scored:

- Significantly BETTER than average on 65 questions
- AVERAGE on 22 questions
- Significantly WORSE on 1 question

Some examples are:

- Overall: rating of care was good/excellent 95%.
- Overall: doctors and nurses worked well together 95%.
- Doctors: always had confidence and trust 88%.
- Hospital: room or ward was very/fairly clean 99%.
- Hospital: toilets and bathrooms were very/fairly clean 96%.
- Hospital: hand-wash gels visible and available for patients and visitors to use 93%.
- Care: always enough privacy when being examined or treated 93%.
- Surgery: risks and benefits clearly explained 83%.

The Trust scored significantly worse when patients were asked if they were bothered by sharing sleeping area with opposite sex. The Trust is committed to support the Department of Health's directive to eliminating the sharing of accommodation with members of the opposite sex.

The Trust cares for approximately 25 men per year attending as an inpatient for very short periods of time when attending the Hewitt centre for reproductive medicine. Male patients are always cared for in wards with their own sleeping and bathroom facilities and as such the Trust has not breached its strict policy for delivering same sex accommodation.

The Trust has also provided visitor male and female toilet facilities externally to ward areas in order to ensure visitors do not utilise in ward facilities.

Maternity Survey

A total of 569 patients were sent a questionnaire. 560 patients were eligible for the survey, of which 232 returned a completed questionnaire, giving a response rate of 41.4%. The average response rate was 49.8%.

The findings of the survey indicate that:

- Significantly BETTER than average on 10 questions
- AVERAGE on 55 questions
- Significantly WORSE than average on 11 questions

'Real time' surveys

The use of electronic resources has aided the efficiency of collecting, analysing and presenting patient feedback.

The questionnaires used are developed to address themes identified from other sources of feedback data. All areas will ask patients their views on core questions which include:

- Privacy & dignity
- Cleanliness
- Attitude of staff

All participants are asked if they would recommend the Trust to their family and friends:

Area	Yes, definitely	Yes, probably	No
Gynaecology inpatients (35 patients answered	25 (71.4%)	8 (22.8%)	2 (5.7%
Maternity inpatients (131 patients answered)	94 (71.7%	30 (22.9%)	7 (5%)
Bedford (51 patients answered)	42 (82%)	9 (17.6%)	0
Hewitt Centre (40 patients answered)	33 (82.5%)	4 (10%)	3 (7.5%)
Fetal Medicine Unit (11 patients answered)	10 (91%)	1 (9%)	0
Assessment Unit (77 patients answered)	45 (58%)	20 (26%)	12 (15.5%)
Neonatal (34 patients answered)	30 (88%)	4 (11%)	0

One to one care in established labour 100% of the time

This was originally a maternity indicator for 2010/11. However it was recognised through audit that the figures were not a true representation of the actual activity. The results that were forwarded were demonstrating 1:1 care by a midwife during the second stage of

labour and not during established labour which is the standard.

In view of this, in November 2010, this indicator was removed from the hospital's computerised medical system (Meditech) whilst further work on the understanding of this standard took place. NICE guidance for this includes: 'Intrapartum Care: Care of healthy women and their babies during childbirth' (2007)

Going forward this will be a recognised care indicator for maternity during 2011/12.

Rates of epidural pain relief for analgesia in labour

A working epidural is the most effective form of pain relief in labour and the provision of a 24 hour epidural service may influence a woman's choice of where they would like to give birth.

Performance Indicator	LWH 2008/9	LWH 2009/10	LWH 2010/11	National Average 2007/8
Epidural Rate for Pain Relief in labours	16.1%	18.7%	17.5%	22.2%

"In 2010/11 the epidural rate was 17.5%, which is a decrease on last year (18.7%). There is a suggestion that this might be higher. However the numbers almost certainly reflect patient choice. A more meaningful indicator may be the number of women unable to have the pain relief of their choice. In the future we will capture the data of non-provision of epidurals."

David Patrick (Consultant Anaesthetist and Clinical Governance Lead)

Looking forward to 2011/12 Rates of Epidural Pain Relief for Obstetric Analgesia will be refined to look at the non compliance of pain relief of choice during labour.

Also outlined below are some key quality initiatives that shape the quality agenda here at Liverpool Women's:

Leading Improvement in Patient Safety (LIPS VI and LIPS VII) Programme

Teams of both clinical and administrative staff have participated in national Leading Improvement in Patient Safety (LIPS) programmes with a focus on infection prevention and control, reduction in medication errors and prompt recognition of the deteriorating patient.

The teams undertook a nine month programme consisting of six modules with a focus on patient safety and service improvement. This has enabled Liverpool Women's to improve clinical care through the use of service improvement tools.

A key lesson for the team was the need for timely robust clinical information. In order to improve clinical information systems the Trust recruited a clinical information analyst to work with its clinical governance team. This enabled the introduction of a robust reporting system providing up to date quantitative data presented in a structured and transparent manner. This 'clinical dashboard and workbook' as it has been described has provided clinical staff with access to a user friendly central clinical information system.

Patient Safety First

Patient Safety First has at its heart a vision of an NHS with no avoidable death and or avoidable harm. It is a campaign to make the safety of patients everyone's highest priority.

The Trust has focused on two Patient Safety First interventions:

- Leadership
- Perioperative care.

To ensure a leadership culture at Board level, all Directors and most of our Non Executive Directors have participated in 'walkrounds' and

have taken the executive lead for patient safety programmes of work. This has included monitoring progress and supporting staff to build patient safety and improve knowledge. The Director of Nursing, Midwifery and Patient Experience undertakes regular visibility walkabouts so that she is visible to patients and staff and undertakes a clinical shift every month, she gives feedback to staff on the wards and departments to ensure learning is embedded.

In terms of perioperative care, clinical teams have focused on reducing surgical site infections and improving teamwork and communication with the introduction of the use of the World Health Organisation (WHO) Surgical Safety Checklist within theatre and 'Briefing Huddles' of all relevant theatre staff prior to surgery.

Advancing Quality Alliance (AQuA) Partnership

The Trust has been a member of AQuA since April 2010. A clinical seminar was held with the Chief Executive of AQuA which determined our priorities from a clinical perspective. Liverpool Women's are currently working in partnership with the North West Maternity and Neonatal Steering Group leading on maternity early warning scores. The Head of Clinical Effectiveness has undertaken the role of AQuA Link Associate in order to work with colleagues across the region to share good practice. The Trust will continue as a member of AQuA going forward.

Energising for Excellence in Nursing and Midwifery Care

Energising for Excellence (E4E) in Care is a quality framework for nursing and midwifery that aims to support the delivery of safe and effective care, creating positive patient and staff experiences that builds momentum and sustainability: this is underpinned by 'Social Movement Thinking' principles.

The aims of this initiative are to ensure patients report a positive experience when using healthcare and for nurses and midwives to drive the delivery of high quality care which in turn

improves job satisfaction. This is supported by commissioners (the people who purchase or commission care from the Trust) using quality indicators to drive improvements in safe, efficient and effective care. In addition, it informs Boards in their decision making about nursing, midwifery and patient care.

The majority of quality improvement initiatives that carry financial incentives are delivered by the nursing and midwifery workforce; a good example of this is the Clinical Quality and Innovation (CQUIN).

As the financial challenges continue and further efficiencies are required, nurses and midwives are key to working differently and innovatively whilst continuing to drive improvements in quality and the patient experience. The past twelve months have seen the development of a suite of nursing and midwifery care indicators. Nursing and midwifery care Indicators are evidence based process indicators that allow nurses and midwives to undertake 'spot audits' of care provided to patients. This has been established through nurses and midwives coming together within a task and finish group to share ideas on implementation and find solutions to potential problems. Within four meetings the task and finish group members were able to launch the introduction of their indicators across the organisation.

From April 2010, each clinical business unit (CBU) devised its own set of care indicators relevant to speciality and based on work that had been developed regionally.

The role of the matron has been reviewed and redefined and has been further strengthened. Matrons at Liverpool Women's Hospital are visible in red uniforms, clinically present for a significant part of their role and their primary focus is on ensuring a quality service is consistently delivered to our patients. This year we want to focus on developing the role further through the Organisation Development (OD) strategy, increasing visibility further with posters and an event with the Council of Governors is being planned. The development of Band 7 clinical leaders is critical to ensuring high quality care is consistently delivered and this forms a fundamental element of the OD strategy.

Productive Ward

The Productive Ward project helps staff to look at their ward and the process of care within it.

Productive Ward has been implemented in the following areas: maternity base, midwife led unit, general outpatients, Bedford ward, gynaecology ward, neonatal unit, and the Reproductive Medical Unit (RMU). Below are some examples of good practice that have emerged from the implementation of Productive Ward:

- Each day a member of the support team is identified to undertake parent education. The staff member is identified on the nursing rota and now wears a distinct tabard so that she is easily identifiable. The member of staff ensures that women are shown how to make up artificial feeds if appropriate and how to sterilise equipment. They record all information to provide an audit trail for assurance. The support staff also take student midwives with them to be involved in this quality aspect of care
- The use of the multifunction room on Jeffcoate ward for parent education and examination of the new born. Using an identified room promotes privacy and dignity and keeps the sitting room free for women to use
- Medicine rounds are commencing on the maternity base, a tabard has also been purchased for the midwife responsible for the round to be easily identified and ensure that she is not disturbed during the activity as this has been shown to reduce medication errors
- A shift leader template has been devised with the shift leaders on the ward to improve

handover of care in particular for women with complex social and clinical needs
- Bedside handover takes place at 0715 hours for all women; however we are exploring how we can undertake bedside handover for antenatal women at 1945 hours
- The Hewitt Centre (our reproductive medicine department) improved telephone response times, from 31% of patients getting through first time and 29% of patients trying more than 5 times, to 83% of patients getting through first time and 2% of patients trying more than 5 times
- Reduction of clinical supplies waste on the Neonatal Unit and standardisation of storage areas. In an area that carries so much equipment as the Neonatal Unit this has been a very positive improvement.

This year we will continue to implement all the modules of Productive Ward throughout wards and departments and we will commence productive ward in Delivery Suite.

Lead nurses and midwives within each CBU have undertaken monthly audits of care and provided quarterly progress reports to the Board of Directors. Care indicators are also part of the 2010/11 Trust Quality Account as part of the clinical effectiveness suite of indicators.

Enhanced Recovery Programme

The Enhanced Recovery Programme is an NHS initiative that focuses on the care of patients before, during and after their operation. By encouraging patients to take ownership of their own care it aims to reduce complications, reduce length of stay in hospital, reduce readmission rates and increase patient involvement in clinical decisions. Lengths of stay and re-admission rates have historically been consistently lower than our benchmarking peer Trusts, but it is our ambition to improve these figures further.

This initiative is initially focused on Gynae-oncology patients (patients with gynaecological cancer) but it is planned that we will apply the lessons learnt from our initial work to all gynaecological patients in the coming months.

Liverpool Mulago Partnership

The Liverpool-Mulago partnership is a collaboration between the Liverpool Women's NHS Foundation Trust and the Mulago Hospital in Kampala, Uganda.

The Aims of the partnership are to:

- Improve the health care of women in Uganda
- To provide technical training for Ugandan Hospital staff
- To develop personal skills (practical and life skills) amongst out British staff

This initiative is evidence that we see ourselves as an important healthcare organisation that wishes to benefit the health of women on the international stage as well as here in our local region. A number of our staff have visited the team in Mulago and staff from Uganda have visited Liverpool Women's, and a visiting fellowship has been established which enables one of our junior doctors to spend a year in Uganda on an ongoing basis. Early work has focussed on the Maternity services in Mulago and in particular the establishment of triage systems which have already demonstrated a reduction in maternal deaths.

A small team from the Gynae-oncology department will shortly be visiting Mulago to identify how we may help establish better services for women with cervical and ovarian cancer in Mulago. This work will be carried out in conjunction with a team from the University of British Columbia, Canada.

Our priorities for improvement 2011/12

These priorities have been determined by clinical teams within Liverpool Women's clinical units and have been shared with stakeholders. In 2011/12 our main priorities will be:

1. To investigate, monitor and reduce infection rates (LIPS VI)
    - Wound infection following elective and emergency Caesarean section to be monitored by Community Midwifery team.
    - Surgical Site Infections in Gynaecology
    - Neonatal Bloodstream Infections (NBSI)
    - Methicillin-resistant staphylococcus auereus (MRSA) and methicillin-sensitive staphylococcus aureus (MSSA)
    - Clostridium Difficile

2. To investigate, monitor and reduce mortality rates
    - Neonatal mortality for all live births at LWH early/late
    - Neonatal mortality for all live births from booked pregnancy early/late
    - Perinatal mortality, stillbirth and early neonatal mortality benchmark appropriate

3. To monitor and improve Patient Experience
    - Patient Experience and Involvement Strategy
    - Energising for Excellence in Nursing and Midwifery
    - Urogynaecology Quality of Life Electronic Personal Assessment Questionnaire (EPAQ).

Additional Quality Indicators

In addition to our three main priorities and the indicators already identified as continuing priorities for 2011/12 the following additional indicators will be also be monitored.

Patient Safety

Administration of Medication Errors

One of LIPS VII's primary aims is to reduce medication errors associated with the administration of medicines across the Trust. It is paramount that we aim to reduce harm to our patients, medication errors are a preventable harm. The LIPS VII team are auditing the administration of medicines to identify medication errors and compare the outcomes with previous audits.

The Trust's performance will be measured by identifying a reduction in medication errors year on year. The LIPS VII team will review current polices and guidelines, review staff education and training, identify a tool to quantify errors, standardise the process of administration of medicines and increase reporting of incidents.

Currently all staff are encouraged to report medication errors through the Trust's incident reporting system, 'Safeguard.' The opinion of the CBU is errors are under reported. The LIPS VII team will review current polices and guidelines, review staff education and training, identify a tool to quantify errors, standardise the process of administration of medicines and increase reporting of incidents.

A scoring tool is being devised to quantify medication administration errors, taking into account the type of medicine and other parameters. The pilot tool is being tested currently. A benchmark score will be obtained from previous (last years) ACE reports, with the aim to reduce this score by 5% whilst increasing the reporting rate.

Clinical Effectiveness

Accidental perforation or damage

This is a current internal indicator for gynaecology, collating the number of patients during surgery who experience accidental perforation or damage to an organ or vessel.

This may have been identified during the procedure and repaired, or it may be identified post operatively, requiring the patient to undergo further surgery to repair. As a Trust this indicator is important as it identifies when difficulties or complications during surgery have occurred. This information is then shared with clinical staff and reviewed to identify trends. In some cases it may support the need for additional training and competency. Following discharge all of a patients care is clinically coded.

The specific code for accidental perforation or damage is recorded against the patient episode. This information is then stored within the Trust's main electronic data storage facility (data warehouse), which can be reported on as required. The CBU will report on this indicator monthly. This will be presented by Clinician, as a clinical team, as a Trust and as a comparison against peers. The information will form part of the clinical dashboards as an episode but also as a percentage of procedures performed.

The CBU aims to audit all cases where accidental perforation or damage has occurred to assess for trends. The outcome will be actioned as required.

The CBU is currently developing their clinical dashboard to support clinical outcomes. This will be shared with clinicians to inform them of their own clinical outcomes. Clinicians will be asked to ensure all episodes of accidental perforation or damage which are identified during surgery and repaired to be clearly documented to enable the episode to be coded.

Patient Experience

The Patient Quality team will continue to implement the Patient Experience and Involvement Strategy to staff within all areas of the Trust. This process will include discussions in individual areas before a Trust-wide launch of the strategy in the Spring of 2011. The discussions will underpin the main objective of embedding the strategy throughout the organisation, and stressing the responsibility that each individual staff member has to deliver an excellent patient experience.

Patient Surveys

In addition to the annual patient surveys, required by the Care Quality Commission, we will continue to develop systems for collecting 'real time' patient experience data and having sets of comparable data to assess whether the action planning process is effective in improving patient experience.

We propose to collect data from each clinical area on a monthly basis and this information will form a part of the monthly performance indicators.

Action planning

We have recognised the need to develop a robust system for collating aggregated data for all aspects of patient experience. This will inform each area of the expected standards of care identified in the survey response. It will also act as a performance indicator to measure the effectiveness of the feedback in making improvements.

Patient Involvement

The consultation events held during the development of the strategy provided an invaluable opportunity to develop links with local communities. This work will continue and expand to ensure an equitable opportunity for groups who are currently under represented or

'hard to reach' to become involved in Trust business and share their views with us.

Patient Experience report

The patient experience report will demonstrate the continuing use of service user feedback and the ways in which we liaise with local and wider communities who may consider using, or have already used the range of services provided by the Trust.

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.

The clinical teams and clinical information leads are in the process of identifying quality indicators that support the patient experience strategy.

To sustain the improvement in communication achieved from the introduction of the triage phone system

Our telephone service has shown huge improvements over the last twelve months following the introduction of a new triage process, but it is imperative that this is maintained to improve and maintain good patient communication links.

Maintaining a good communication system is an extremely vital element of the patient experience as well as ensuring patient safety and this is also key to reducing patient complaints. Through phone satisfaction audits, which have been a part of Productive Ward, we intend monitor patient complaints and compliment letters.

Energising for Excellence within Nursing and Midwifery care

As described on page 69, Energising for Excellence (E4E) in Care is a quality framework for nursing and midwifery that aims to support the delivery of safe and effective care, creating positive patient and staff experiences.

The role of the matron and band 7 leaders is pivotal to the success of this framework of governance and clinical care. The clinical teams and clinical information leads are in the process of identifying quality indicators that support energising for excellence within nursing and midwifery care.

Urogynaecology Quality of Life Electronic Personal Assessment Questionnaire (EPAQ)

The CBU want to develop a process to clearly capture Patient Reported Outcome Measures (PROMs). PROMs measure quality from the patients' perspective, they measure the health gain after surgical treatment using pre and post operative questionnaires.

The urogynaecology team have introduced a process to capture PROMs using the Electronic personal Assessment Questionnaire (EPAQ).

PROMs are measures of a patient's health status or health-related quality of life. They are typically short, self-completed questionnaires, which measure these at a single point in time.

Currently two groups of patients are asked to complete an EPAQ.

- All new referrals to urogynaecology
- All women who have undergone prolapse or continence surgery.

Currently the urogynaecology team collect this data using EPAQ. However, the results obtained from EPAQ are not continuously monitored and reviewed, and are not being used to shape our services. Also, not all patients complete the EPAQ but those who do have reported how useful it was in supporting them during their consultation to concentrate on their specific clinical complaint.

This information will be presented monthly to

the urogynae multi-disciplinary team (MDT) by the Clinical information Analyst. The team will review and action changes in practice as required. It is aimed to roll out EPAQ to all urogynaecology patients after every intervention.

The clinical teams and clinical information leads are in the process of identifying quality indicators that support the urogynaecology PROMs.

Statements of assurance from the Board of Directors

Review of Services

During 2010/11 Liverpool Women's NHS Foundation Trust provided NHS services in four core specialty areas.

The Trust 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 five 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 Board of Directors. Some of the CBU indicators are benchmarked with CHKS national data or other relevant specialty organisations. Data collected has influenced the organisation as identified in its improvement initiatives for 2011/12.

The income generated by the NHS services reviewed in 2010/11 represents 100% per cent of the total income generated from the provision of NHS services by Liverpool Women's NHS Foundation Trust for 2010/11.

Clinical Audit

The reports of two national clinical audits relevant to the services provided by Liverpool Women's Hospital (NNAP and Occupational Health Practice in the NHS in England: Round 2 Report) were reviewed in 2010/11, as well as the reports from the Vermont Oxford Network (in which LWH participates) and wider clinical network reports.

Liverpool Women's intends to take the following actions to improve the quality of healthcare provided:

- Ensure that the data and reports from national audits and network reports relevant to the services provided here are considered within and across clinical teams and support services
- Clinical care services are reviewed to provide a position statement against issues identified by national audit and network reports, as appropriate
- Action plans are developed and their implementation monitored in line with local recommendations

Through our involvement in local, regional and national networks we will also continue to support the development of clinical audit practitioners and programmes and to ensure that the value of audit is realised in practice.

In 2011-12, for example, we will be involved in a North West project looking at specific aspects of nursing care. The project involves regular audits and through the use of web-based technologies ensures that the results are available to staff almost immediately.

As there are a number of Trusts involved in the project not only can we review our own audit results very quickly, but the system also allows us to

compare our audit results with other organisations. This is a major initiative for the Trust and we are delighted to be involved as it demonstrates how audit can be embedded at ward or service level and used to provide assurance about specific standards of care.

Participation in Clinical Audits

During 2010-2011, 3 national clinical audits and 2 national confidential enquiries covered NHS services that Liverpool Women's NHS Foundation Trust provides.

We participated in 100% (3 out of the 3) of the national clinical audits and 100% (2 out of 2) of the national confidential enquiries which we were eligible to participate in during 2010/11, as follows:

National Clinical Audits

- Neonatal intensive and special care (NNAP)
- Heavy menstrual bleeding (RCOG National Audit of HMB)
- O negative blood use (National Comparative Audit of Blood Transfusion)

Confidential Enquiries

- National Confidential Enquiry into Patient Outcome and Death (NCEPOD)
- Confidential Enquiry into Maternal and Child Health (CMACE);

The national clinical audits and national confidential enquiries that Liverpool Women's NHS Foundation Trust participated in, and for which data collection was completed or ongoing during 2010-2011, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Audit / Confidential Enquiry	Number of Cases Submitted	Number of cases as a percentage of the number of registered cases required by the terms of the audit / enquiry
NNAP	1198	1198 (all eligible cases) 100%
HMB Audit	Data collection still ongoing	-
O Negative blood use	3	100% (all eligible cases in the month of data collection)
NCEPOD	0	No eligible cases occurred within the reporting year although on-going participation by the Trust
CMACE	126 119	100% (2009 data) 100% (2010 data)

During 2010-2011 Liverpool Women's NHS Foundation Trust undertook a major review of its clinical audit activity to ensure that all of our clinical audit projects provide us with confidence about the standards of care we provide and/or are used to stimulate our quality improvement activities.

For those unfamiliar with what clinical audit actually is, clinical audit involves us looking at aspects of our care to ensure that what we do is in line with particular standards and/or guidelines. Clinical audit is one of the main ways that we review the quality of the care we provide and is particularly useful in identifying areas for improvement or, once we have done an audit and implemented changes, demonstrating that our standards have improved.

All of the specialities within Liverpool Women's undertake clinical audit projects during the year and each clinical speciality has a designated Senior Clinician as the Speciality Clinical Audit Lead. Each service prospectively identifies key clinical audit projects to be undertaken during the forthcoming year, and these may be in relation to national audit projects (such as the heavy menstrual bleeding (HMB) audit in gynaecology and neonatal intensive and special care (NNAP) in neonatal), regional audits or specific audits which have been identified as being important to us at a local level. In addition, we also instigate audit projects in-year, to reflect new guidance or to explore specific aspects of care which merit review.

It should be recognised that some of the clinical audit projects registered in 2010-2011 have yet to be fully completed, and progress on these is being monitored and reviewed by the relevant speciality clinical audit lead. However, the reports of 28 of our 'local' (speciality specific) clinical audits were reviewed by us in 2010-2011. Additional reporting on clinical audit related to our participation in the Clinical Negligence Scheme for Trusts (CNST), which requires provider organisations in the scheme to undertake a major programme of audit throughout the year (51 separate clinical audits in our obstetrics and neonatal departments).

Our Reproductive Medicine Unit is regulated by the Human Fertilization and Embryology Authority (HFEA) which also requires a programme of clinical audit to be in place and the Trust has a significant programme of Trust-wide audits for Infection Control and Medicines Management which report to our Infection Control Committee, Medicines Management Committee and on to Clinical Governance Committee and the Trust Board. In the year 2010-2011 for example, we undertook almost 150 infection control audits within the Trust.

Examples of where clinical audit has influenced / enhanced practice are provided below:

- Within Clinical Genetics: "Genetic Testing For A Predisposition To Bowel Cancer". Based on the findings of this audit undertaken during 2010 and new recently produced guidelines we have changed who we offer direct and indirect gene testing to. We now offer more intensive testing to our highest risk families and less testing to our lower risk families where the audit showed we have a low chance of picking up an abnormality.
- Within Maternity, an audit of all stillbirths has been ongoing since 2004. The audit methodology used involves determining cause-specific reasons for stillbirth as well as a panel assessment of the standard of care relating to each case. This allows identification of key themes which may require action (such as the systems in place to monitor fetal growth) and has resulted in a number of different work streams as a result.
- Within Gynaecology, a Thromboembolic Prophylaxis Audit ensured our clinical practice was in line with NICE guidelines and we have modified patient preoperative assessment and postoperative prescribing rules for anticoagulants. An audit of thermachoice endometrial ablation led to the

revision of hospital guidelines and raised the profile of patient safety across different staff groups working in this area.

- Reproductive medicine have recently completed a six month audit on antibiotic usage following oocyte collection. The audit concluded that no changes in practice were required in relation to oocyte collection and after care of the patient post procedure. However, given the importance of information control and patient experience this is an area of care that will be monitored on a regular basis.
- Within our Neonatal Unit, an audit was undertaken of 50 babies at risk of neonatal hypoglycaemia by virtue of birth weight and gestation. The standards of care and documentation were reviewed and compared with previous audit results from 2005. It was identified that practice had improved in a number of key areas, but that specific actions were required in order to further support the effective management of babies at risk in this area. Since the audit was undertaken we have purchased haemacue blood glucose measurement devices, introduced birth centile charts on labour ward to help identify at risk babies and have developed a NEWS (Neonatal Early Warning Score) chart. The use of the NEWS chart will itself be subject to further review and audit in our 2011-12 audit programme.

In 2011-2012 we intend to take the following actions in relation to clinical audit in order to improve the quality of healthcare provided:

- Ensure that each clinical service has a prioritised programme of clinical audit activity in place
- Where changes in practice have occurred as a result of an earlier audit project, we will look at instigating a re-audit or collect data via other reporting mechanisms to demonstrate that our standards have improved
- Support staff from across a wide range of clinical specialities to undertake audit projects through awareness raising, the provision of education / training events and mentoring opportunities
- Promote robust clinical audit by ensuring that our audit projects are conducted to the highest possible standards
- Further develop standardised reporting of audit findings and monitoring of action plans within and across all of our clinical services
- Report the findings from all audit projects within the clinical speciality and to wider staff groups as well as at external events, as appropriate, to share the knowledge and learning from audit activities/findings and to stimulate improvement.
- Ensure that our clinical audit activity links into wider patient experience, risk management and quality improvement activity
- Develop the profile of clinical audit within the Trust and amongst our patients, membership and wider stakeholders.
- Explore how we can work with other providers to develop clinical audits which reflect the care provided to women and babies across care pathways.

Clinical Research

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

In last year's quality account, we reported our progress with implementing National Institute for Health Research (NIHR) processes and subsequent NIHR recruitment accruals. We continue to focus our efforts on conducting quality NIHR research.

We are also building strong collaborations with academic partners to ensure the research we conduct is not only of high quality, but is translational, providing clinical benefit for our patients.

The number of patients receiving NHS services provided or sub-contracted by Liverpool Women's NHS Foundation Trust in 2010/11 that were recruited during the period 1 April 2010 to 31 January 2011 to participate in research approved by a research ethics committee was 2,137 of which, 1,323 were recruited into NIHR portfolio studies.

Offering our patients the opportunity to participate in clinical research demonstrates our commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our healthcare providers stay abreast of cutting-edge treatment options and are able to offer the latest medical treatments and techniques.

Liverpool Women's was involved in conducting 119 clinical research studies in reproductive medicine, maternity, neonates, gynaecology oncology and genetics during 2010/11.

Clinical research leads to better treatments for patients. At Liverpool Women's we focus our research efforts on answering pressing questions, with an emphasis on translational research. A number of studies being led by Liverpool Women's were completed during 2010/11, the results of which have directly impacted clinical practice. Studies completed during this period which have had a direct bearing on healthcare delivery, recruited 1,242 patients. These studies were concerned with miscarriage, third-stage labour, preterm infants and neonatal care, and have all influenced healthcare delivery in their respective areas for the benefit of patients. Furthermore, we are leading on a number of ongoing studies, including studies adopted onto the NIHR portfolio. These studies will influence healthcare delivery in assisted conception, neonatal nutrition, antimicrobial use in neonates, obesity in pregnancy, and foetal medicine.

There were 72 clinical staff contributing to research approved by a research ethics committee at Liverpool Women's during 2010/11. These staff contributed to research covering a broad spectrum of translational research from basic research at the laboratory bench, through early and late clinical trials, to healthcare delivery in the community.

In terms of contributing to the evidence-base for healthcare practice and delivery, in the last three years, 31 publications have resulted from our involvement in NIHR research, which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS.

Clinical Quality and Innovation (CQUIN)

A proportion of the Trust's income in 2010/11 was conditional upon achieving quality improvement and innovation goals agreed between 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 for 2010/11 were negotiated and agreed following discussion between Liverpool Primary Care Trust (PCT) (as host commissioner) and the Trust and reflect key issues in the local health economy as well as national health issues. The total CQUINS amount for 2010/11 is 1.5% of contract income and progress against the agreed targets is subject to a detailed monthly review.

In February 2011, Liverpool PCT confirmed that £954,000 out of the full CQUINS total of £1,062,000 would be payable to the Trust. A further payment would then be made post 31 March 2011 providing the Trust could demonstrate achievement against any outstanding targets. The Trust is confident that the majority of the £108,000 payment withheld will subsequently be paid.

Further details of the agreed CQUIN targets for 2010/11 and for the following year are available on request from the Director of Nursing,

Midwifery and Patient Experience.

Registration with the Care Quality Commission (CQC)

The Care Quality Commission (CQC) is an independent regulator of health and social care in England. It regulates care provided by NHS, local authority, private and voluntary organisations. It aims to make sure better care is provided for everyone – in hospitals, care homes and their own homes and seeks to protect the interests of people whose rights are restricted under the Mental Health Act.

Liverpool Women's NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is fully compliant. Liverpool Women's NHS Foundation Trust currently does not have any conditions on registration.

The Care Quality Commission has not taken enforcement action against Liverpool Women's NHS Foundation Trust during the 2010/11 reporting period.

Liverpool Women's NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Data Quality

The Liverpool Women's Hospital NHS Foundation Trust submitted records during April 2010 and at the end of December 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's valid NHS number was:

- 97.6% for admitted patient care
- 95.7% for outpatient care; and
- 97.0% for accident and emergency care

which included the patient's valid General Medical Practice was:

- 100% for admitted patient care
- 100% for outpatient care; and
- 100% for accident and emergency care

Information Governance (IG) Toolkit attainment levels

The Liverpool Women's Hospital NHS Foundation Trusts Information Governance Assessment Report overall score for the March 2011 assessment was 60% and was graded not satisfactory.

Liverpool Women's NHS Foundation Trust will be taking the following actions to improve data quality:

- Complete review of data quality processes with a focus on returning errors to the user who created it with the opportunity for re-training where appropriate.
- Development of high level data quality monitoring reports to monitor trends in errors and identify when further action is required.

Clinical Coding

Liverpool Women's NHS Foundation Trust was not subject to the Payment by Results (PbR) clinical coding audit during 2010/11 by the Audit Commission.

The PbR Assurance Framework for 2010/11 stated that only the worst performing 20 percent of Trusts, based on the finding of the previous three years audit work, would be audited during 2010/11. The high levels of coding accuracy, demonstrated in all three PbR Data Assurance Framework audits resulted in Liverpool Women's NHS Foundation Trust being exempt from 2010/11 PbR Clinical Coding Audit.

Clinical Coding Supporting Clinical Risk

During 2009 the clinical coding staff, were involved in a pilot project in conjunction with the clinical risk team for gynaecology.

The gynaecology team developed adverse clinical incident trigger form for completion by coders. Initially five clinical triggers were listed on the form e.g. unexpected admission to the high dependency unit, post operative blood transfusion.

If during analysis of the patient health record for coding purposes, the coder became aware that the patient fulfils the criteria for one of the 5 five triggers he/she would complete a trigger form. The completed forms were forwarded to the Gynaecology risk team for investigation and review.

This proved to be highly successful. The original trigger form was amended to include two further clinical 'triggers' making seven in total and the process was rolled out to incorporate obstetric in-patients.

Stakeholder statements on our quality account (referred to in this report as the quality report)

Statement from Commissioning Primary Care Trust – Liverpool Primary Care Trust

In line with the NHS (Quality Accounts) Regulations, Liverpool PCT is happy to receive the Quality Account for 2010/11 from Liverpool Women's NHS Foundation Trust.

As Director for Service Improvement and Executive Nurse for Liverpool PCT I have reviewed the information contained within the account and verified this against data sources where this is available and can confirm that this is an accurate account of the quality of care in relation to the services provided. I have also reviewed the content of the account and can confirm that the Quality Account complies with the prescribed information, form and content as set out by the Department of Health. I believe that the account represents a fair and balanced view of the 2010-2011 progress that Liverpool Women's NHS Foundation Trust has made against the identified quality standards. The Trust has complied with all contractual obligations and has made progress over the last year with evidence of improvements in key quality and safety measures.

Liverpool Women's NHS Foundation Trust has taken positive steps to engage with patients, staff and stakeholders in developing a comprehensive set of quality priorities and measures for the forthcoming year 2011/12 and I personally applaud their continued commitment to sustainable quality improvements.

Trish Bennett
Director of Service Improvement and Executive Nurse
Liverpool PCT

Commentary from Liverpool Local Involvement Network (LINk)

The comments made here pertain to a draft document that was made available to LINk prior to Quality Account publication. This means that the published document may have already been amended in line with some of the suggestions made here.

Throughout 2010/11, Liverpool Women's NHS Foundation Trust has engaged effectively with Liverpool LINk, met regularly with LINk members and hosted LINk members during an Enter and View visit which examined the quality of services offered by the Trust. The Trust has demonstrated effective involvement of service users, staff and other stakeholders in evaluating the quality of its services by holding consultation events in which LINk members and other stakeholders participated.

Given the clinical/technical nature of the Quality Account, the language used is as plain and accessible to the public as possible and all acronyms are explained. However, it would be good to see a statement in the final version about how to access the document in other formats/languages.

This Quality Account is generally well laid out and the inclusion of a contents page is a helpful aid to finding your way around the document that is not found in all Quality Accounts produced by NHS Trusts.

Liverpool Link is aware that a number of effective consultation and involvement events were undertaken by the Trust and this is reflected in the Quality Account.

Liverpool LINk Quality Accounts Commentaries are restricted in scope to commenting on issues pertaining to individual Quality Accounts. LINk remains engaged with the Trust in order to monitor the progress of the Quality Account and other quality considerations.

Endorsed by Liverpool LINk Core Group May 2011

Commentary from Knowsley LINk

Knowsley LINk is pleased to be able to provide a comment on the Trust's Quality Account for 2010 – 11. This response was completed following the review of a draft copy of the Quality Account and formal presentation to LINk members to provide further information on the content of the Account.

Knowsley LINk has had ongoing discussions with the Trust in particular regarding the local services for the Kirkby community. Knowsley LINk has expressed its disappointment at the Trust's failure to carry out its statutory duty to consult the community regarding the closure of some of the Services at the Aintree Centre for Women's Health. We have, however, been pleased that the Trust has now opened a dialogue with Knowsley LINk to ensure that the most vulnerable people in the community are not disproportionately disadvantaged. We do however congratulate the Trust on its excellent community services in particular the community midwives, who provide an invaluable and greatly treasured service to the women of Kirkby. We were therefore concerned to be informed that community services are not monitored for the purposes of the Quality Account, as we think this would be an excellent opportunity for the Trust to showcase some of its excellence in quality of service.

The Quality Account itself was rather difficult to read, with the typeface being very small and there being a high number of graphs and statistics, which were sometimes difficult to interpret. We would recommend that the Quality Account should include a glossary to make it easier to understand. We would also recommend that the Quality Account should also provide some data to put the statistics into context, for example percentages do not mean much without quantifiable data to substantiate this.

We were disappointed at the lack of focus on patient experience within the Quality Account. For example we note that in the National Gynaecology and Maternity surveys few details are given of the domains in which the Trust scored significantly better or worse than the national average.

We were also concerned at some of the results of the annual staff survey. We were pleased to note that the Trust has now put into place a new strategy to support staff that are experiencing violence and harassment. We would recommend that for the year 2011-12 measures are put in place to gauge staff morale particularly around the proposed changes to the NHS and budget cuts.

We would like to congratulate the Trust on its excellent infection control results and would recommend in the Quality Accounts that they highlight these successes to improve patient confidence.

Knowsley LINk looks forward to building on the work completed so far and providing an ongoing critical friend relationship.

Statement of Directors' responsibilities in respect of the 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) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- The content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2010-11

- The content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2010 to June 2011
  - Papers relating to quality reported to the Board over the period April 2010 to June 2011
  - Feedback from the commissioners dated 02/06/2011
  - Feedback from governors dated 20/04/2011
  - Feedback from Liverpool Local Involvement Network (LINk) dated 27/05/2011 and Knowsley LINk dated 31/05/2011. Sefton LINk have declined to comment on Liverpool Women's Quality Account 2010/11
  - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 dated 12/11/10
  - The national patient survey 2010/11
  - The national staff survey 2010/11
  - The Head of Internal Audit's annual opinion over the Trust's control environment dated 12/04/2011
  - CQC quality and risk profiles dated 31 March 2011.

- The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered

- The performance information reported in the Quality Report is reliable and accurate

- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice

- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitornhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitornhsft.gov.uk/annualreportingmanual)).

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board.

Ken Morris *Kathryn Thomson*

Ken Morris
Chair

Kathryn Thomson
Chief Executive

Independent Auditor's Report to the Council of Governors of Liverpool Women's NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Council of Governors of Liverpool Women's NHS Foundation Trust to perform an independent assurance engagement in respect of the content of Liverpool Women's NHS Foundation Trust's Quality Report for the year ended 31 March 2011 (the "Quality Report").

Scope and subject matter

We read the Quality Report and considered whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual, and considered the implications for our report if we become aware of any material omissions.

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual 2010/11 issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that the content of the Quality Report is not in accordance with the NHS Foundation Trust Annual Reporting Manual or is inconsistent with the documents.

We read the other information contained in the Quality Report and considered whether it is materially inconsistent with:

- Board minutes for the period April 2010 to June 2011;
- Papers reported to the Board over the period April 2010 to June 2011:
  - Liverpool Women's Clinical Quality Strategy, Progress report and next steps - 1 October 2010
  - Patient Experience & Involvement Strategy – 5 November 2010
  - Care indicators Q2 Progress Report – 3 December 2010
  - Patient experience report Q2 (July 2010 – September 2010) - 4 February 2011
  - Liverpool LINk 'enter and view' visit – 4 March 2011
  - Patient experience report Q3 (October 2010 - December 2010) – 6 May 2011

- Feedback from the commissioners dated 2 June 2011
- Feedback from governors dated 20 April 2011
- Feedback from Liverpool Local Involvement Network (LINk) dated 27/05/2011 and Knowsley LINk dated 31/05/2011
- The Trust's Annual Complaints Report (April 2009 to March 2010) published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009
- The National In-patients Survey 2010
- The National NHS staff survey 2010
- The Director of Audit Opinion over the trust's control environment and Annual Report 2010/11
- CQC quality and risk profiles.

We considered the implications for our report if we became aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information.

This report, including the conclusion, has been prepared solely for the Council of Governors of Liverpool Women's NHS Foundation Trust as a body, to assist the Council of Governors in reporting Liverpool Women's NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2011, to enable the Council of Governors

to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the Quality Report. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Liverpool Women's NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- Making enquiries of management;
- Comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- Reading the documents.

A limited assurance engagement is less in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2011, the content of the Quality Report is not in accordance with the NHS Foundation Trust Annual Reporting Manual.

BAKER TILLY UK AUDIT LLP
Chartered Accountants
3 Hardman Street
Manchester
M3 3HF

[Anticipated to be dated 28 June 2011]

Remuneration report

Remuneration report

The remuneration and pension benefits of the Trust's senior employees are shown in the tables on pages 150 and 152 of this report. These senior managers are all Executive and Non-Executive Director of the Board of Directors who served during the financial year 2010/11. This information has been subject to audit.

The Remuneration Committee of the Board of Directors determines the remuneration and terms and conditions of the Chief Executive, executive Board members and the Trust Secretary. They do this based on job evaluation, market intelligence (including published remuneration surveys) and uplifts for inflation, and are guided by national recommendations for senior managers in the NHS. In doing so the Committee has regard to the remuneration of other Trust employees who hold contracts under terms and conditions agreed nationally and locally. Also taken into account are the results of annual appraisal and the overall achievement of the Trust's corporate objectives for the year.

Executive directors' objectives are set at the start of each year and performance is reviewed annually and shared with the Board's Remuneration Committee. The Chair undertakes the Chief Executive's appraisal who in turn appraises Executive Directors and the Trust Secretary. The Chief Executive and Executive Director remuneration packages comprise annual basic salary and normal NHS pension contributions plus a non-consolidated discretionary performance related payment as agreed by the Committee, of up to 5% of basic salary, based on the Trust's performance overall and the achievement of individual and team objectives.

The Chief Executive, Executive Directors and Trust Secretary are employed on permanent contracts of employment, subject to three months notice on either side. Termination payments would be subject to review and approval by the Board of Directors' Remuneration Committee if outside of statutory entitlements.

Membership of the Board's Remuneration Committee comprises the Trust Chair and all Non-Executive Directors. It met on 3 occasions during the year and attendance is detailed in the table below. The Director of Human Resources and Organisational Development acted as Secretary to the Committee and provided advice to it on each occasion. She was not present for any discussion in relation to her own remuneration.

At the Committee's invitation and in accordance with its terms of reference, the Chief Executive also attended part of each of the meetings in an ex-officio capacity.

Non-Executive Director	Remuneration Committee
Ken Morris – Chair	3 out of 3
David Carbery	3 out of 3
Liz Cross	2 out of 3
Pauleen Lane	2 out of 3
Ann McCracken	1 out of 3
Roy Morris	2 out of 3
Kathryn Thomson – Chief Executive	3 out of 3 (ex-officio)
Michelle Turner – Director of Human Resources and Organisational Development	3 out of 3 (ex-officio)
Hoi Yeung	3 of 3

The Remuneration Committee of the Council of Governors determines the remuneration and terms and conditions of the Chair and Non-Executive Directors of the Board. It uses a process of benchmarking based on information from all foundation trusts and from mutual organisations and the private sector, and the results of individual NEDs' annual appraisals.

Objectives are set with the Chair and Non-Executive Directors at the start of each year and performance is reviewed annually and shared with the Council's Remuneration Committee. The Chair is responsible for assessing Non-Executive Directors' performance and undertakes their appraisal. The Senior Independent Director undertakes the Chair's appraisal, with input from members of the Board and Council of Governors.

The Chair and Non-Executive Directors are appointed by the Council of Governors for a fixed term of office.

Membership of the Council's Remuneration Committee comprises three public, one staff and one appointed governor namely Professor Susan Wray (Committee Chair), Morag Day, Angela Douglas, Pat Jones and Tricia Jones. The Committee met once during the year when four of its members were present (apologies were received from Angela Douglas). The Trust Secretary acted as Secretary to the Committee.

Remuneration and retirement benefits (pensions) of all directors are set out within notes 3.4 to 3.6 of the annual accounts. Accounting policies for pensions are set out in notes 1.3 and 4.4.

The audited remuneration and [9]pension benefits of senior managers is disclosed in this report and can be found on pages 150 and 152.

Kathryn Thomson

Kathryn Thomson
Chief Executive
3 June 2011

[9]Note that pension disclosures apply to executives only as Non-Executive Directors do not receive any pensionable remuneration

Board of Directors

Board of Directors

The Board is responsible for determining the Trust's strategy and business plans, budgets, policy determination, audit and monitoring arrangements, regulations and control arrangements, senior appointment and dismissal arrangements and approval of the annual report and accounts. It acts in accordance with the requirements of its Foundation Trust terms of authorisation.

A number of decisions are delegated by the Board to management. These are set out in the Trust's scheme of reservation and delegation to facilitate the efficient operation and success of the organisation.

In accordance with the Trust's constitution, a policy in respect of the Non-Executive Director composition of the Board is in place, as confirmed by the Council of Governors. Overall Board composition is in accordance with the constitution.

In this reporting year, composition of the Board of Directors was:

- Non-Executive Directors – 7, including the Chair
- Executive Directors – 6, including the Chief Executive

In-year changes to the Board of Directors were:

- Mr Jonathan Herod was appointed as Medical Director with effect from 1 October 2010. He is a Consultant Gynaecologist at the Trust and prior to taking up his Medical Directorship was Clinical Director for Gynaecology
- Mr David Richmond held the position of Medical Director until the end of September 2010 and stood down following his appointment as Vice President for Standards at the Royal College of Obstetricians and Gynaecologists.

[10]Non-Executive Director			Executive Directors
Name	**Date of appointment**	**Length of appointment**	
Ken Morris - Chair	April 2008 August 2005	3 years 3 years	Kathryn Thomson – Chief Executive (from September 2008)
David Carbery	February 2011 February 2008 February 2004	1 year 3 years 4 years	Vanessa Harris – Director of Finance (from September 2009)
Liz Cross	February 2010	3 years	Jonathan Herod – Medical Director (from 1 October 2010)
Pauleen Lane	April 2010	3 years	Gail Naylor – Director of Nursing, Midwifery & Patient Experience (from June 2009)
Ann McCracken	April 2010 April 2009 April 2008 December 2005 December 2001	1 year 1 year 1 year 2 years 4 months 4 years	David Richmond – Medical Director (from September 1993 to end September 2010)
Roy Morris	January 2009 February 2005	3 years 4 years	Michelle Turner – Director of Human Resources & Organisational Development (from 6 April 2010)
Hoi Yeung	January 2009 March 2005	3 years 4 years	Caroline Salden – Director of Service Development (from April 2004)

The Council of Governors is responsible for the appointment and removal of Non-Executive Directors.

Non-Executive Director appointments may be terminated if they become ineligible to hold the position during their term of office, details of which are set out in the Trust's constitution.

Based on the criteria cited in the [11]Code of Governance the Board of Directors considers that all of its Non-Executive Directors are independent except for one. Non-Executive Director Roy Morris is not considered to be independent on the basis that he is the local Chair of a firm of solicitors with whom the Trust contracts for legal services. This is a declared interest in the Board of Directors' register of interests.

[10]The Trust was established on 1 April 2005. Non-Executive Directors whose initial appointment was made pre-Foundation Trust status (four year terms of office) were appointed for the unexpired period of their term of office.
[11]The NHS Foundation Trust Code of Governance, Monitor (2010)

Directors' attendances

During 2010/11 the Board of Directors met monthly excepting August. Directors' attendance at meetings during the year, possible and actual, is shown below.

Director	Board of Directors	Audit Committee	Governance and Clinical Assurance Committee	Finance, Performance & Business Development Committee
David Carbery	11 out of 12	4 out of 5	6 out of 6	
Liz Cross	10 out of 12		5 out of 6	
Vanessa Harris	12 out of 12			9 out of 11
Jonathan Herod	4 out of 6			
Pauleen Lane	10 out of 12			6 out of 11
Ann McCracken	10 out of 12	4 out of 5	6 out of 6	
Ken Morris	12 out of 12		5 out of 6	11 out of 11
Roy Morris	10 out of 12			11 out of 11
Gail Naylor	10 out of 12		5 out of 6	
David Richmond	3 out of 6		3 out of 3	
Caroline Salden	11 out of 12		5 out of 6	8 out of 11
Kathryn Thomson	12 out of 12			10 out of 11
Michelle Turner	10 out of 12		4 out of 6	9 out of 10
Hoi Yeung	12 out of 12	5 out of 5		10 out of 11

Pen portraits of the Board

Ken Morris - Chair

Ken Morris commenced with the Trust in August 2005. Following a successful appraisal process, he was reappointed 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 Primary Care Trust. His management consultancy experience has 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 and a member of the Department of Health Foundation Trust Financing Facility. And early in 2011, Ken was appointed as Chair of the Social Value Foundation and of the Audit Committee of the Foundation Trust Network.

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.

David Carbery - Non-Executive Director and Senior Independent Director

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.

David is the Board's Senior Independent Director and chairs the Governance and Clinical Assurance Committee. He is also a member of the Audit Committee. In January 2011 David was appointed by the Council of Governors for a further period of one year.

Liz Cross BSc (Hons), MBA, MBPS, Non-Executive Director

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 organisations 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, Manchester 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, delivering consultancy and projects to improve performance and deliver better economic and social outcomes. As well as chairing the Trust's Charitable Funds Committee, Liz also sits on the Board's Governance and Clinical Assurance Committee.

Vanessa Harris BSc, ACA, MBA - Director of Finance

Vanessa joined the Trust in September 2009 as Director of Finance. She 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.

Jonathan Herod – BSc MBChB (Hons), MRCOG – Medical Director (from 1 October 2010)

Jonathan joined the Board as its Medical Director on 1 October 2010. He is also a Consultant Gynaecological surgeon and Oncologist at the Trust and an Honorary Lecturer at the University of Liverpool.

Jonathan has worked in Liverpool since 2000 having trained in gynaecology oncology at St Bartholomew's and The Royal Marsden hospitals in London. During his time at Liverpool Women's he has carried out many posts, most recently as Clinical Director for Gynaecology immediately prior to his appointment as Medical Director.

He is a member of the Royal College of Obstetricians and Gynaecology, British Gynaecological Cancer Society, an Executive Committee member of the British Society for Colposcopy and Cervical Pathology and of the National Quality Assurance Committee for Cervical Screening.

Pauleen Lane – Non-Executive Director

Pauleen joined the Trust's Board of Directors in April 2010. From 2001 to 2007 she was a member of the North West Development Agency Board with a special interest in urban regeneration and public health.

She has been Deputy Chair of English Partnerships and a Charitable Trustee for Lloyds TSB Foundation and the Theatres Trust. And she currently serves on the Football Licensing Authority and is Deputy Chair of the Infrastructure Planning Commission.

Pauleen lectures part-time in engineering at the University of Manchester and is a local Councillor in Trafford where she has sat on the Health Scrutiny Committee.

She has been a member of the Audit Commission and is also a member of South Manchester and Central Manchester Foundation Trusts. Pauleen sits on the Trust's Finance, Performance and Business Development Committee.

Ann McCracken – Non-Executive Director and Vice Chair

Ann McCracken first joined the Trust as a Non-Executive Director in 2001 and served two terms of office under NHS arrangements. She was subsequently reappointed following successful performance appraisal and approval by the Council of Governors in order to ensure continuity on the Board.

Her final term of office came to an end on 31 March 2011. Prior to joining Liverpool Women's, Ann was a Non-Executive Director at the Royal Liverpool University Hospitals NHS Trust.

A former journalist, Ann's early career saw her working at a number of newspapers and local radio stations and in public relations covering internal communications, media relations, stakeholder engagement, public affairs and corporate social responsibility. She now works as Communications Manager for O2 UK in the North of England.

Ann is involved in a number of charities and not-for-profit organisations including Blackburne House and Common Purpose.

Roy Morris CBE, DL – Non-Executive Director

Roy Morris was appointed in February 2005 for a period of four years and following his successful appraisal, was reappointed in January 2009 by the Council of Governors for a further three years. Roy was formerly the Chief Executive of Rathbone Brothers plc and Chair of the Executive Committee, which manages the day-to-day affairs of the Group. Roy was with Rathbones, involved in investment management, throughout his working career. He was a partner in Rathbone Brothers and Company and in 1988 he became Managing Director and appointed as Group Chief Executive in 1997.

He retired as Chair 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 served as High Sheriff of Merseyside during 2010.
Roy chairs the Trust's Finance, Performance and Business Development Committee and is a member of the Charitable Funds Committee.

Gail Naylor RGN, RM, MBA – Director of Nursing, Midwifery and Patient Experience

Gail joined the Trust in June 2009. 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 until she joined 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, and the health economy.

David Richmond MD, FRCOG – Medical Director (to end September 2010)

David became Medical Director of the Trust in September 1993. He was previously a Consultant to central Liverpool during which time he successfully steered the Trust through numerous 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.

David is an examiner and workforce advisor for the Royal College of Obstetricians and Gynaecologists where is also a member of a number of its committees. In 2010 he became Vice President for Standards at the Royal College and subsequently resigned from his position as the Trust's Medical Director.

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

Caroline joined the Trust in April 2004. 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, Merseyside and Trent. Her interests lie in operational and strategic planning as well as service improvement.

Caroline's management experience has been supported by the attainment of an MBA (Open University) and a Diploma in Marketing. She has recently completed the North West Leadership Executive Stretch programme and is a registered mentor with the North West Mentorship Scheme.

Michelle Turner MCIPD – Director of Human Resources and Organisational Development

Michelle Turner joined the Trust in April 2010. Committed to creating great places to work, Michelle is responsible for ensuring the Trust has a competent, engaged and truly motivated workforce focussed on delivering the best possible patient experience.

A member of the Chartered Institute of Personnel & Development, Michelle has a long and varied NHS career, working in patient-facing roles early in her career and undertaking senior human resources roles more recently.

Hoi Yeung – Non-Executive Director

Hoi Yeung was appointed in March 2005 for a period of 4 years and following his successful appraisal was reappointed 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, task and risk management.

In addition, Hoi has a wealth of experience in the public and voluntary sectors which included his role as a Governor of Liverpool Community

College, a Trustee of the John Moores Liverpool Exhibition Trust and an observer at the Board of Liverpool Biennial of Contemporary Art.

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

The Trust confirms the balance, completeness and appropriateness of the membership of the Board.

Evaluation of the performance of the Board, its committees and individual directors is undertaken in a number of ways:

- The Board continued to review the Trust's governance model during the year and agreed to introduce a model of integrated governance to further support its performance. It began reviewing its own meeting performance at the end of each Board meeting from early in 2011
- This review of its governance model facilitated a review of the overall effectiveness of the Trust's system of internal control. Such review is also conducted on the instruction of its Audit Committee, by internal auditors
- Individual appraisal and performance development planning:

- Non-Executive Directors. The appraisal system for Non-Executive Directors was first agreed by the Remuneration Committee of the Council of Governors. Non-Executive Directors are appraised by the Chair who in turn is appraised by the Senior Independent Director, who takes the views of other Directors and Governors as part of the process. The Senior Independent Director is appraised by the Vice Chair of the Board.
- Executive Directors. Executive Directors are appraised by the Chief Executive and the Chief Executive is appraised by the Chair of the Board. A report on individuals' performance is presented each year to the Remuneration Committee of the Board of Directors

- Preparation of annual reports by key governance committees (received by the Board of Directors).

The Chair's other significant commitments are detailed in the pen portrait shown on page 96 and within the Board of Directors' register of interests. Members of the public can gain access to the Board of Directors' register of interests at www.liverpoolwomens.nhs.uk.

Directors can be contacted by email via details on the Trust's website at www.liverpoolwomens.nhs.uk or via the Trust Secretary, Julie McMorran, at julie.mcmorran@lwh.nhs.uk or on 0151 702 4033.

Audit Committee

During the year, the Chair of the Audit Committee was Non-Executive Director Hoi Yeung. Its other members were Non-Executive Directors David Carbery and Ann McCracken. The attendance of Audit Committee members at its meetings is shown in the table above.

The aim of the Audit Committee is to provide one of the key means by which the Board ensures effective internal control arrangements are in place. In addition, the Committee provides a form of independent check upon the executive arm of the Board.

The Trust's external auditor for the period has been Baker Tilley. It is the Trust's policy to ensure that the external auditor's independence has not been compromised where work outside of Monitor's audit code for NHS Foundation Trusts has been purchased from them. Approval for any work falling into this category would be sought from the Trust's Council of Governors and Audit Committee. No such work was undertaken during the year.

Where the Trust is planning to appoint outside management consultants to undertake work, consideration is given to whether the auditors

can be included in the list of firms to be considered, or whether they should be excluded as the work would potentially compromise their independence as auditors. Consideration is given to factors such as the likely fees for the work, the area in which the work is to be undertaken and whether the auditors are likely to review the area as part of their work.

Through the Chief Executive as the Trust's accounting officer, Directors are responsible for preparing the accounts as presented in this report. The Directors take this opportunity to state so far as they are aware there is no relevant audit information of which the Trust's auditors are unaware. 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.

Nominations Committee

The Trust has two Nominations Committees:

- Nominations Committee of the Council of Governors in respect of Non-Executive Director appointments to the Board. This is chaired by the Trust's Chair, Ken Morris, and the Committee's members during the year were governors Denise Carter, Annette James and Godfrey Mazhindu. Directors' attendance at this Committee is shown below.

  During 2010/11 the Committee met on 3 occasions. At one of its meetings its purpose was to consider the reappointment of Non-Executive Director David Carbery and to confirm arrangements for the appointment of a successor Non-Executive Director to Ann McCracken, whose term of office ended on 31 March 2011. Its subsequent meetings were to conduct the recruitment process and agree a recommended appointment to be presented to the Council of Governors.

- Nominations Committee of the Board of Directors in respect of Executive Director appointments. This is also chaired by the Trust's Chair, Ken Morris, and its members are at least three other Non-Executive Directors plus the Chief Executive (unless the Chief Executive is being appointed). Non-Executive Director membership of this Committee during the year included David Carbery, Liz Cross, Roy Morris and Hoi Yeung. It met once during 2010/11 and Directors' attendance is shown below.

The number of meetings and individual attendance by Directors at Nominations Committees – possible and actual – is shown below:

Director	Nominations Committee of the Council of Governors	Nominations Committee of the Board of Directors
David Carbery		1 out of 1
Liz Cross		1 out of 1
Pauleen Lane		
Ann McCracken		
Ken Morris	3 out of 3	1 out of 1
Roy Morris		1 out of 1
Kathryn Thomson	2 out of 3 (ex-officio)	1 out of 1 (ex-officio)
Michelle Turner		1 out of 1 (ex-officio)
Hoi Yeung		1 out of 1

The Nominations Committee of the Council of Governors oversaw the recruitment of a new Non-Executive Director during the year. It took the following approach:

- A job description and role specification were prepared by the Board of Directors
- An executive search consultancy was appointed to oversee open advertising and long-listing
- Short-listing was undertaken by the Nominations Committee
- Five candidates were interviewed by members of the Nominations Committee together with the Chair of another NHS Foundation Trust who sat as independent assessor. All candidates also met with small groups of Directors, Governors, clinicians, managers and front-line staff as part of the process
- Following a rigorous and transparent process, the Committee agreed to recommend to the Council of Governors that one of the candidates be appointed to the position of Non-Executive Director with effect from 1 May 2011 for a three year term.

Remuneration Committee

Please see remuneration report on page 88.

Code of Governance

The Board of Directors and the Council of Governors of the Trust are committed to the principles of good corporate governance as detailed in the NHS Foundation Trust Code of Governance.

Since publication of the Code by Monitor, the independent regulator of Foundation Trusts, the Trust has undertaken an annual assessment of its position against each of the Code provisions. This assessment states the current position and any actions required together with a statement against the principle of 'comply or explain'.

For the year 2009/10 the Trust can confirm that it complies with the provisions of the Code with the following exceptions:

Code provision	Explanation
A.3.1 – NED independence	One of the Trust's Non-Executive Directors is not considered to be independent as per the Code criteria. This is on the basis that he holds a position in a company with which the Trust contracts. His position and interest in this company is stated in the Board of Directors' register of interests.
C.2.2 - Non-Executive Directors (NEDs), including the Chair, should be appointed by the Council of Governors for specified terms subject to reappointment thereafter at intervals of no more than three years and to the 2006 Act provisions relating to the removal of a director. The Chair should confirm to the governors that, following formal performance evaluation, the performance of the individual proposed for reappointment continues to be effective and to demonstrate commitment to the role.	The Trust's constitution covers terms of office and the arrangements for reappointment of NEDs. A NED appraisal system is operated via the Council of Governors' Remuneration Committee and with reference to its Nominations Committee, which provides for rigorous performance review prior to any proposed reappointment. In-year, [12]four of the Board's NEDs reached the sixth year of their appointment since the Trust was established as a Foundation Trust.
Any term beyond six years (e.g. two three-year terms) for a NED should be subject to particularly rigorous review, and should take into account the need for progressive refreshing of the Board. NEDs may in exceptional circumstances serve longer than six years (e.g. two three-year terms following authorisation of the Trust), but subject to annual reappointment. Serving more than six years could be relevant to the determination of a NED's independence.	Of these, the Council of Governors has extended one of the NEDs for a further period of one year in order to maintain Board stability. Succession planning to this and two other positions will be undertaken during 2011/12. A successor NED has been recruited to one of the vacancies that will occur from 1 April 2011.
E.1.4 - The remuneration committee (of the Board of Directors) should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointment would give rise to in the event of early termination. The aim should be to avoid rewarding poor performance. In an early termination, compensation should be reduced to reflect the departing director's obligation to mitigate loss.	The Board has agreed that the Trust will not move away from NHS terms and conditions and therefore nationally agreed compensation payments including redundancy would apply.

[12]Non-Executive Directors whose initial appointment was made pre-Foundation Trust status (four year terms of office) were appointed for the unexpired period of their term of office

Council of Governors

Council of Governors

The Council of Governors is responsible for fulfilling its statutory duties (of appointing, removing and deciding the terms of office (including remuneration) of the Chair and Non-Executive Directors, approving the appointment of the Chief Executive, appointing or removing the Trust's auditors, receiving the annual report and accounts and auditor's report, and expressing a view on the Board's forward plans) and for ensuring that the interests of the community served by the Trust are appropriately represented.

The Council of Governors meets at least three times per annum, in public.

In the reporting period, composition of the Council of Governors was:

- Public – 18 governors
- Staff – 6 governors
- Partnership – 9 governors

The tables overleaf give the names of those who occupied the position of Governor during the reporting period, how they were appointed or elected and how long their appointments are for. Between April 2010 and March 2011 the Council of Governors met on 4 occasions and attendance by individual Governors at those meetings is indicated in the tables.

Public Governors (elected)	Area	[13]Term of office	From	To	Council of Governors' meetings attended, April 2010 – March 2011
Banks, Anna	Rest of England & Wales	3 years	2008	2011	3 out of 4
Day, Morag	Central Liverpool	3 years	2008	2011	3 out of 4
James, Annette	South Liverpool	3 years	2010	2013	2 out of 4
Jennings, Bethan	Rest of England & Wales	3 years	2010	2013	0 out of 1
Jones, Pat	Sefton	3 years	2009	2012	2 out of 4
Jones, Pat	Rest of England & Wales	3 years	2009	2012	3 out of 4
Kehoe, Ronnie	Knowsley	3 years	2008	2011	4 out of 4
Kelly, Maureen	Sefton	3 years	2008	2011	3 out of 4
Kerr, Barbara	North Liverpool	3 years	2009	2012	4 out of 4
McDonald, Mary	South Liverpool	3 years	2009	2012	4 out of 4
McKeating, Geoff	Sefton	3 years	2008	2011	3 out of 4
Paracha, Anees	Central Liverpool	3 years	2010	2013	1 out of 4
Rodney, Lisa	Central Liverpool	3 years	2010	2013	1 out of 2
Smith, Anne	Knowsley	2 years	2008	2010	2 out of 2
Stopforth, Betty	Central Liverpool	4 years	2007	2011	0 out of 4
Williams, Maggi	Central Liverpool	3 years	2008	2011	4 out of 4
Wooldrige, Janine	South Liverpool	3 years	2007	2010	2 out of 2
Zack-Williams, Dorothy	Central Liverpool	3 years	2009	2012	1 out of 4

[13]Terms of office begin and end at the annual members' meeting, usually held in September of each year

Staff Governors (elected)	Class	Tenure	From	To	Council of Governors' meetings attended, April 2010 – March 2011
Brown, Diane	Nurses	3 years	2008	2011	3 out of 4
Carter, Denise	Clinical and non-clinical support staff	3 years	2008	2011	2 out of 4
Douglas, Angela (Deputy Chair of the Council/Lead Governor)	Scientists, allied health professionals & technicians	3 years	2008	2011	2 out of 4
Drakeley, Andrew	Doctors	3 years	2010	2013	1 out of 1
O'Keeffe, Catherine	Clinical and non-clinical support staff	3 years	2009	2012	3 out of 4
Rooney, Jane	Midwives	3 years	2009	2012	3 out of 4

Partnership Governors (appointed)	Organisation	Council of Governors' meetings attended, April 2010 – March 2011
Ashton, Jane	Knowsley Borough Council	1 out of 4
Gladden, Roz	Liverpool City Council	0 out of 1
Gray, Paula	Liverpool Primary Care Trust	2 out of 4
Hogan, Margaret	Partnership organisation – Downs's Syndrome Liverpool	1 out of 2
Mazhindu, Godfrey	Partnership organisation Liverpool John Moores University	2 out of 4
[14]Spelman, Sue	Partnership organisation – Down's Syndrome Liverpool	1 out of 1
Wray, Susan	University of Liverpool	2 out of 4

[14]Sue Spelman succeeded Margaret Hogan in-year

During the year there were vacancies in respect of the North Liverpool and Knowsley public seats, and two Primary Care Trusts seats.

Governor elections were held during the year in respect of 7 seats that became vacant at the conclusion of the 2010 annual members' meeting. These were in respect of 6 public seats and 1 staff seat. Four of the seats were filled following contested election or uncontested nomination and 3 of the seats were declared vacant.

One by-election was held during the year in respect of the Rest of England and Wales public seat. This seat was filled following a contested election. A re-run of the election held in respect of the staff doctors seat was re-run because of a problem with the original ballot papers. This seat was also filled following a contested election.

All public and staff governors were elected by members in their constituency, by secret ballot (the Electoral Reform Service acted as returning officer).

Partnership governors were appointed by their nominating organisation.

Members of the Board of Directors regularly attend meetings of the Council of Governors in order to understand governors' views and the views of members as the Council conveys on their behalf. The Chief Executive has a standing invitation to attend all meetings of the Council and all Directors receive the Council's papers to review.

Directors' attendance at meetings of the Council of Governors during 2010/2011 is shown below:

Director	Council of Governors' meetings attended, April 2010 to March 2011
David Carbery	4 out of 4
Liz Cross	3 out of 4
Vanessa Harris	1 out of 4
Jonathan Herod	2 out of 2
Pauleen Lane	3 out of 4
Ann McCracken	2 out of 4
Ken Morris (Chair)	4 out of 4
Roy Morris	0 out of 4
Gail Naylor	3 out of 4
David Richmond	2 out of 2
Caroline Salden	4 out of 4
Kathryn Thomson (Chief Executive)	4 out of 4
Michelle Turner	4 out of 4
Hoi Yeung	3 out of 4

The Trust maintains a register of interest for governors which is available at www.liverpoolwomens.nhs.uk

Membership of the Trust is open to any member of the public over the age of 12 years

Our membership

Membership of the Trust is open to any member of the public over the age of 12 years and living in the local authority areas of Central Liverpool, North Liverpool, South Liverpool, Knowsley, Sefton or the rest of England and Wales. Membership is also automatically available to all Trust staff 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 here but employed by another NHS organisation, are also eligible for staff membership.

As at 31 March 2011 the Trust had 12,787 members, broken down as follows:

Public	Number
Central Liverpool	3,334
North Liverpool	1,597
South Liverpool	1,550
Knowsley	1,259
Sefton	1,427
Rest of England & Wales	1,983
Total public membership	**11,150**

Staff	Number
Doctors	166
Nurses	415
Midwives	362
Scientists, technicians and allied healthcare professionals	101
Administrative, clerical, managers, ancillary and other support staff	593
Total staff membership	**1,637**

Our aim is to make membership relevant, interesting and rewarding and to recruit to membership as many people living in our communities as possible. It is important that our membership – and our Council of Governors – reflects the characteristics of the population we serve. During the year our target was to recruit and retain members from our target areas and maintain an overall membership total of 12,500. We have achieved that target.

The Membership Strategy Committee of our Council of Governors, which oversees our membership work, met during the year with a wide range of individuals and groups across the city of Liverpool. Led by Governor Janine Wooldridge until September 2010, and then by governor Mary McDonald, our governors attended a range of community events to encourage membership and promote the work of the Trust and the role of governors. These included a talk at the Women's Institute at Blackburn House, Hope Street Feast Festival, Hale Carnival and Disability Awareness Day 2011 held at Walton Hall Gardens in Warrington.

A number of our members were also involved in developing the Trust's patient experience and involvement strategy (see page 65).

In September 2010 we also held our annual members' meeting and hospital open day. Based on a formula that has been successful for four years, several hundred people came through the hospital's doors to meet with Governors, Directors and Trust staff and learn about the Trust's work. An inspirational story was told at the annual members' meeting itself by one of the Trust's patients and her consultant. It focused on a pioneering technique to improve the chances of successful pregnancy in women who suffer recurrent miscarriage.

Members continue to receive regular communications in the form of a newsletter entitled 'Generations'.

Members can contact governors and directors by:

- Post – Trust Offices, Liverpool Women's NHS Foundation Trust, Crown Street, Liverpool L8 7SS
- Telephone – 0800 073 0825 (free)
- Email – www.lwh.me.uk/Contact_Us

Public interest disclosures

Public interest disclosures

Information to and consultation with employees

The Trust is committed to good information sharing and consultation with its staff. The national staff survey is a core tool for us to engage consistently with staff each year to identify what is important to them and work to address identified issues. The Trust this year opted for a full survey of all staff employed by the organisation to be able to feed back their views and perceptions on what it is like to work at Liverpool Women's. The results of this survey are given on pages 22 to 24.

This year we also consulted in respect of a programme of organisational change known as 'Rising to the Challenge' that will see the preparation of a five year integrated business plan and long term financial model. The programme includes proposals in respect of staff restructuring with streamlined management teams and overall reduction in the requirement for corporate support. 'Rising to the Challenge' was the subject of very detailed formal consultation with our staff and their representatives during the year.

Equal opportunities and disabled employees

A new Single Equality Scheme for 2010 – 2013 was agreed in September 2010 to include the requirements of the 2010 Equality Bill and ensure that the Trust continues to fulfil its duties and commitments outlined within it.

Further details of our operation of the Scheme, and our positive approach to equal opportunities and disabled employees, is given on pages 24 and 26.

Health and safety performance and occupational health

The Trust is committed to providing a healthy, safe environment for staff, patients and others. The Director of Nursing, Midwifery and Patient Experience is the Executive Director with Board level responsibility for health and safety. She acts on behalf of the Chief Executive to ensure the management of health and safety across the Trust is effective by ensuring the relevant policies, systems and processes are in place and carefully monitored; that appropriate advice is available on health and safety matters, and; the importance of health and safety is promoted.

The Trust has a Health and Safety Committee that is attended by staff side representatives in order for consultation to take place in respect of health and safety matters. Reports of the Trust's performance in respect of health and safety issues are monitored by this Committee which reports to the Governance and Clinical Assurance Committee of the Board.

We continue to improve safety in respect of needle stick injuries. Our health and safety staff work closely with our occupational health department to monitor compliance with the Trust's needle stick injury policy, to implement safe devices and procedures and provide training to reduce risks to staff.

All our staff who visit patients in the community are equipped with protection devices. We continue to monitor incidents of violence and aggression and report all security related incidents to the national body NHS Protect. Conflict resolution training is mandatory for all frontline staff and compliance with this and all other health, safety and security related mandatory training is monitored through our governance structure.

Our occupational health department supports the Trust's Health and Wellbeing lead in actively promoting health and wellbeing approaches and initiatives to staff. The department is responsible for monitoring the health of staff, actively promoting health choices and undertaking health screening for prospective employees. Occupational health can also provide expert advice to managers who are responsible for ensuring health surveillance is carried out as determined locally in accordance with relevant legislation, and for liaising with and supporting managers in relation to staff health at work.

Countering fraud and corruption

The Trust engages the services of a registered Local Counter Fraud Specialist and is compliant with the requirements of the Counter Fraud Manual, cooperates with the NHS Counter Fraud and Security Management Service and responds to the national proactive reviews. The Trust's accountable officer for fraud is the Director of Finance.

Our counter fraud policies are set out in our Standing Financial Instructions. We also have in place a whistleblowing policy.

The Trust received a Counter Fraud Qualitative Assessment rating of 2 for 2009/10 (the most recent rating available).

Better Payment Practice Code

The Better Payment Practice Code requires that 95% of undisputed invoices relating to trade creditors are paid within 30 days of receipt. Our performance during the year 2010/11 and 2009/10 is shown below:

Item	2010/11	2009/10
Value of invoices paid within 30 days	64%	61%
Number of invoices paid within 30 days	69%	51%

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

The implementation of a new finance system in 2010/11 has supported the Trust in securing some improvement in its performance and embedding of this system to support further enhancement of performance in this area.

Consultations

The Trust did not undertake any formal public consultations during the year.

As stated previously in this report we did, however, engage with our patients, the local public and the joint Overview and Scrutiny Committee of our partner Local Authorities (Liverpool, Sefton and Knowsley) in respect of the transfer of our major surgical services and some day-case surgery from Aintree Centre for Women's Health to our Crown Street site. In respect of this transfer we also worked closely with local Primary Care Trusts and with Liverpool and Sefton Local Involvement Networks, and took part in three public engagement meetings to discuss the proposed changes.

Patient and public involvement

Please see pages 27 to 30.

Sickness absence data

Sickness absence performance for 2010/11 is shown on page 21.

Cost allocation and charging requirements

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

Details of serious incidents involving data loss or confidentiality breach

During the year there was one serious incident involving data loss. It related to entries on the Trust's patient information system in respect of patients placed in a queue following a clinic attendance, cancellation of an appointment or who did not attend a scheduled appointment. The queue was insufficiently managed and entries were subsequently validated to ensure all patients who required a further appointment had, or would, receive one.

Statement of the Chief Executive's responsibilities

Statement of the Chief Executive's responsibilities

Statement of the Chief Executive's responsibilities as the Accounting Officer of Liverpool Women's NHS Foundation Trust

The NHS Act 2006 states that the Chief Executive is the Accounting Officer of the NHS Foundation Trust. The relevant responsibilities of the Accounting Officer, 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 NHS Foundation Trust Accounting Officer Memorandum issued by the independent regulator of NHS Foundation Trusts (Monitor).

Under the NHS Act 2006, Monitor has directed 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 Annual 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 Annual 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.

Kathryn Thomson

Kathryn Thomson
Chief Executive
3 June 2011

Statement on internal control

Statement on internal control

Scope of responsibility

As Accounting Officer, 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, to 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 in Liverpool Women's NHS Foundation Trust for the year ended 31 March 2011 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. A formal structure is in place to ensure risk is appropriately identified, mitigated, monitored and reported. The Trust's Corporate Risk Committee, chaired by the Chief Executive, coordinates and prioritises all categories of risk management and its principal task is to ensure that appropriate arrangements exist within the Trust so that effective management of risk is implemented and embedded. In fulfilling its role the committee routinely reviews the Trust's risk registers.

The Chief Executive is clearly identified within the risk management strategy as providing leadership and accountability to the organisation for risk management and quality improvement. The Board of Directors receives as a minimum, annual training in risk management. All staff receive basic risk management training through the mandatory training programme; and in addition, specific staff are trained to a higher level in risk management techniques (i.e. root cause analysis investigation training, IOSH (Institution of Occupational Safety and Health) working and managing safely) as identified within the training needs analysis (TNA) process. In addition to the TNA process, the annual staff performance and development review process is used to identify where and if additional, enhanced risk management training is required.

The Trust captures all adverse incidents through a centralised system (ULYSSES, SAFEGUARD). Data from the SAFEGUARD system is utilised to inform trend reports to the Board subcommittes and operational risk and quality committees. In addition, data from complaints and claims is used to inform organisational learning.

The Audit Committee has overarching responsibility for the management of risk systems and processes within the organisation. The Trust's two assurance committees – the Governance and Clinical Assurance Committee and the Finance, Performance and Business Development Committee - monitor the Trust's Board Assurance Framework (BAF) and progress against action plans prepared in respect of risk issues. Both committees report directly to the Board.

The BAF in place at the Trust has been reviewed by its internal auditors. Their review focused on the method by which the Trust produced, refreshed, managed and monitored its BAF and resulted in a Level A definition. Level A is defined as the Trust having a framework in place which is designed and operating to meet the requirements of the Statement on Internal Control and provide reasonable assurance that there is an effective system of internal control to manage the principal risks identified by the organisation.

Developing a risk aware and risk sensitive culture for the Trust is an ongoing aim. This is to enable risk management decisions to occur as near as practicable to the source of the risk and facilitate appropriate escalation of those risks that cannot be dealt with at the local level.

The risk and control framework

The Trust's BAF is the principal mechanism through which the organisation quantifies, prioritises and monitors risk management activity and outcomes. The most significant risks (in-year and on-going) are contained within the Trust's corporate risk register, which is a sub-register of the principal risks within the BAF. The corporate risk register is a dynamic process that changes in response to the changing profile of individual risks contained on the register.

The Trust identifies significant risks to the organisation, through the activities of the risk reporting and working committees which are informed by all the risk management and quality improvement functions operating across the Trust (these are described within the risk management strategy). The Board reviews the risks contained within the corporate risk register and makes informed decisions upon risk treatments and interventions based on the best intelligence available. This approach can result in the Board deciding that no additional risk treatments or interventions are the least worst response to an identified risk. Decisions relating to the organisation's response to individual identified risks are determined by the Trust's risk appetite which is currently risk averse, and therefore favours intervention wherever possible.

During the year the Trust's major risks, as described in the BAF, were those relating to infant abduction, neonatal infection, retention of level three accreditation in respect of NHSLA (NHS Litigation Authority) and CNST (Clinical Negligence Scheme for Trusts), breach of the private patient cap, achievement of the cost improvement programme (CIP), development of an integrated workforce strategy and delivery plan and the need to improve maternity facilities. Future risks are 0% financial growth, increased inflationary pressures and savings targets, potential loss of income from contract changes, achievement of the 2011/12 CIP, external regulatory compliance, achievement of the national target in respect of venous thromboembolism assessment and treatment and implementation of guidance published by the National Institute for Health and Clinical Excellence. These risks have been, and will continue to be, monitored by the Board's assurance committees using the BAF. The committees monitor progress against action plans prepared in respect of risks identified and they will continue to do so.

Patients are involved in the risk management process through a number of initiatives, including the regular telling of a patient story to the Board. In addition the Trust engage in a number of patient and public experience activities which feed into the risk management development process. The Trust considers complaints, litigation and PALS (Patient Advice and Liaison Service) feedback as important indicators into the effectiveness and development needs for the risk management processes. The Board and its relevant committees regularly receive reports detailing this feedback.

The Trust is moving towards a model of integrated governance which is recognised as the best practice model by the Department of Health. This approach to governance is defined by the development and implementation of highly effective systems, processes and behaviours governing quality assurance; operating within a transparent dynamic that encourages challenge. Integrated governance systems include the effective monitoring and continuous performance assessment across key activities including:

- Corporate governance
- Clinical governance
- Risk management
- Financial governance
- Research governance
- Information governance

A revised committee structure has been approved by the Board as a part of its move towards this model, which will be implemented from 1 April 2011. Terms of reference for the majority of Board committees have already been reviewed to ensure that each is clear about its duties and to ensure appropriate memberships. All other Board committee terms of reference will be reviewed early in the 2011/12 year. Refreshed business cycles and action logs are also being prepared for the Board and its committees to ensure timely consideration of issues pertaining to principal risks. During the year 2011/12 a Head of Integrated Governance will be appointed to coordinate the Trust's integrated governance model.

Within the broad governance work-streams there are defined clinical and patient safety performance metrics which are monitored through the Trust's internal control systems (clinical governance) and external assurance(s) accreditation including NHSLA, CNST, Care Quality Commission (CQC), Human fertility and Embryology Authority (HfEA) and the National Patient Safety Agency (NPSA). Evidence in respect of the Trust's compliance with internal controls (patient safety and clinical effectiveness) is maintained through a near-live evidence repository (Performance Accelerator) which is available for evaluation by internal and external managers. The assurance repository is continuously updated and monitored and provides robust in-year (near real-time) assurance in respect of external accreditations of safety and quality.

Within an integrated governance model the Trust operates a principle whereby risks are identified early, and are resolved as close as possible to where the risk originated. The Trust maintains clinical business unit risk registers, which are actively monitored by the senior management within the clinical directorates. Serious risks and/or risks that have remained unresolved for a period of time are escalated to the Trust's corporate risk register for action by senior management. The risk registers described operated as part of a coordinated process within the Trust's BAF and are performance managed by the Board's subcommittees for assurance and exception reporting to the Board.

The Trust actively encourages the reporting of incidents, including serious incidents, through SAFEGUARD, the Trust's online reporting system. During the year the Trust has seen an increase in the reporting and learning from reported incidents, including serious incidents, an outcome which is viewed by the NPSA as an indicator of a positive quality culture within NHS organisations.

Risks to data security are managed and controlled as part of our risk and control framework. The Trust is ISO 27001 certified which brings our information and data security under explicit management control. Our Director of Finance is responsible for information governance, the performance against which is monitored through our Governance and Clinical Assurance Committee.

The Foundation Trust is fully compliant with the requirements of registration with the Care Quality Commission.

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.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The Foundation Trust has undertaken risk assessments and is working with the Carbon Trust to ensure 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 organisation's obligations under the Climate Change Act and the Adaption Reporting requirements are complied with. The Trust engages the services of an emergency prepardness consultant who is responsible for ensuring compliance with these requirements. Policies are in place to deal with a major incident.

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.

Each year the Trust prepares an annual plan and produces a complementary service strategy which incorporates a supporting financial plan approved by the Board of Directors. This informs the annual, detailed operational plan and budget which is also approved by the Board. Efficiency targets are included in this plan. In the year 2010/11 the Trust's Council of Governors were involved in developing our service strategy and a report on the Trust's performance against plans is presented to the Council of Governors at each of its formal meetings.

In the course of this year the Trust initiatiated a programme of work to respond to the current economic climate by preparing itself to continue to be a viable and successful organisation in the future. Our 'Rising to the Challenge' programme will see the preparation of an integrated business plan and long term financial model during the course of 2011/2012 which will set out the Trust's realistic ambitions to 2015/2016.

Reports on specific issues relating to economy, efficiency and effectiveness are commissioned by the Audit Committee through the internal audit plan. Implementation of recommendations is overseen by the Audit Committee.

The Board reviews the financial position of the Trust on a monthly basis via a performance and assurance report. This provides integrated information on financial performance, including the achievement of efficiency targets, and other performance measures. There is a scheme of delegation in place and the key governance committees of the Board are a part of this process, principally the Audit Committee and Finance, Performance and Business Development Committee. The latter meets monthly ahead of

the Board in order to review in detail the financial and contracting performance data included in the performance and assurance 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 stated legal requirements in the NHS Foundation Trust Annual Reporting Manual.

Key controls are in place to prepare and publish a quality report, contained within this annual report. Responsibility for preparing, publishing and delivering the quality report is discharged through the Trust's Medical Director. Each of the Trust's clinical business units (CBU) has a designated clinical governance lead who is a consultant clinician. Clinical governance leads are responsible for operationally managing delivery of the quality report which focuses on patient safety, clinical effectiveness and patient experience, in their CBU. And each CBU's Clinical Director and General Manager are accountable for delivering all aspects of the quality report.

The Trust's Clinical Governance Committee plays a key role in preparing the quality report each year. This committee, chaired by the Trust's Medical Director, provides a forum for discussion and challenge in respect of quality indicators and enables a balanced view to be presented in the published quality report. Led by the Medical Director, a stakeholder event in respect of our draft quality report was held in March 2011 at which patients and representatives of the public, Primary Care Trust quality commissioners, Local Involvement Networks and Local Authority Overview and Scrutiny Committees were invited to comment upon and question our draft report. They have been given a subsequent opportunity to comment on the draft report also. The input of stakeholders adds further to the balanced view presented in the quality report.

A quality performance report and dashboard has been established in order to review and report the quality metrics. This is updated monthly and regularly reviewed by the Trust's Clinical Governance Committee, and is key to delivery of the quality account. Delivery is also supported by the Trust's Director of Clinical Audit, Head of Clinical Audit, Head of Clinical Effectiveness and Clinical Information Lead who between them provide the skills necessary to compile, analyse and audit for accuracy the data which informs the quality metrics.

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, counter fraud specialists and the executive managers within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this annual report and other performance information available to me. My review is also informed by 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, the Audit Committee and the Corporate Risk Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Director of Internal Audit has provided me with a positive opinion on the overall arrangements for gaining assurance through the assurance framework and on the controls reviewed as part of the internal audit work. The assurance framework itself provides me with evidence that the effectiveness of controls that

manage the risks to the organisation achieving its principal objectives has been reviewed.

My review is also informed by reports from the Audit Committee, Governance and Clinical Assurance Committee, Clinical Governance Committee, Corporate Risk Committee, Patient Experience Group, Emergency Planning Group and Infection Control Group. Other relevant assessments to which the Trust responds includes CNST and NHSLA risk management standards, relevant Care Quality Commission reviews, PEAT (Patient Environment Action Team) reviews, national confidential inquiries, reports from the Centre for Maternal and Child Enquiries and Ombudsman's reports. 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 Level 3 of the Clinical Negligence Scheme for maternity standards in February 2008. The Audit Commission provided independent assurance in respect of our coding and costing system during the year through an audit of our reference costs data quality, and also by publication of an audit of our Payment by Results data assurance framework in November 2010.

In reviewing the system of internal control I am aware of the importance of the roles and responsibilities of the following:

- The Board's role is to provide 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 our governance structure, is pivotal in advising the Board on the effectiveness of the system of internal control
- The Governance and Clinical Assurance Committee and the Finance, Performance and Business Development Committee, provide strategic direction and assurance to the Board in respect of risk management
- Internal audit provides regular reports to the Audit Committee and full reports to the Director of Finance and to the executive team. The Audit Committee also receives details of any actions that remain outstanding following the follow-up of previous audit work. The Director of Finance also meets with the audit manager.
- External audit provides an annual audit letter and progress reports through the year.

Any significant internal control issues would be reported to the Board via the Governance and Clinical Assurance Committee, the Finance, Performance and Business Development Committee and the Audit Committee. All significant risks identified within the BAF have been regularly reviewed in-year by the Board and relevant Committee and appropriate control measures put in place.

My review of the system of internal control has led to the introduction of a strengthened model of integrated governance at the Trust which was approved by the Board in December 2010. This model, which will be implemented from April 2011, includes the introduction of a new Human Resources and Organisational Development Committee and a Governance and Clinical Assurance Working Group. The model will significantly strengthen the Trust's system of internal control and provide even greater assurance, risk and quality improvement systems. The Board of Directors is committed to continous improvement and development of the system of internal control.

During the year, specific management reviews were undertaken as a result of risks to performance identified from the performance management system. These included:

- Private patient income cap. Following updated guidance from Monitor on 10 February 2010 the Trust advised Monitor that a breach of the private patient cap was likely in 2010/11 (note 2.2 of the accounts refers). Revised arrangements with North West Fertility were established during 2010/11 which provide the basis for ensuring compliance with the private patient cap in 2011/12. This represents a breach of the Trust's terms of authorisation which resulted in a red governance rating.

- MRSA screening data. Prompted by a review of our reported position at the end of quarter 2, the Trust has revised both its clinical and reporting policies associated with the management of patient screening for MRSA. The Trust's clinical policy was reviewed against best national practice and against advice from the Department of Health. This review resulted in the following amendment to our policy:
  - Refined definition of patients covered by the guidance resulting in inclusion of neonates and high risk obstetrics (both non-elective/emergency) and the exclusion of termination of pregnancy (elective). All changes were implemented from quarter 4.

In respect of reporting against both the elective and non-elective screening targets the Trust has reviewed the classification of patients against elective and non-elective definitions. This has resulted in the following amendment:

- Patients for whom the decision to admit is made in the gynaecology emergency room, and who are subsequently admitted as elective patients, are classified as elective as are their MRSA screens. This change was implemented from quarter 4.

- Timing of submission of cancer data. Monitor highlighted differential data presented in our quarter 3 report submitted to them, and the data available via the Open Exeter system and the Department of Health. Our internal reporting deadlines have been reviewed and will now ensure that data reported to Monitor is reconciled with that submitted through Open Exeter with effect from quarter 4.

- Information governance toolkit. The national information governance toolkit underwent a major change in requirements during 2010/11. As a result of these changes the Trust did not achieve a satisfactory rating in respect of its toolkit assessment in March 2011. We achieved a satisfactory rating in respect of 21 of the 45 standards and plans are in place to achieve 22 of the standards by the end of June 2011, which is the level of attainment required by Monitor for a satisfactory governance rating. A plan to address other standards where a satisfactory assessment was not achieved will be monitored via the Board's Governance and Clinical Assurance Committee throughout 2011/12.

- During the year 2008/09 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 have received the quality of care expected for all patients. All of these patients were signposted to further treatment or discharged, as appropriate. An independent review of governance arrangements was commissioned by the Trust to determine the lessons that could be learned and identify any areas for further improvement. The outcome of this review was considered by the Board of Directors in January 2010 and whilst it concluded that the Trust's governance arrangements are generally strong and that the issue that triggered the review was not systemic, an action plan was developed based on the report's recommendations. This action plan was implemented and monitored by the Trust during 2010/11. An independent review of its implementation was also commissioned and undertaken during the year, to provide robust assurance that all required actions had been satisfactorily completed or were on target for completion. The report of this review was considered by the Board of Directors in April 2011.

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

Conclusion

There have been no significant internal control issues identified during 2010/11 and up to the date of approval of the annual report and accounts.

Kathryn Thomson

Kathryn Thomson
Chief Executive
3 June 2011

Liverpool Women's NHS Foundation Trust Annual Accounts 2010/2011

Financial accounts

Liverpool Women's NHS Foundation Trust
Annual Accounts 2010/2011

Foreword to the accounts

These accounts for the year-ended 31 March 2011 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.

Kathryn Thomson

Kathryn Thomson
Chief Executive
3 June 2011

	Note	2010/11 £000	2010/11 £000	2009/10 £000
Operating income	2.1		92,578	89,419
Operating expenses	3.1		(90,156)	(86,242)
OPERATING SURPLUS			2,422	3,177
Finance costs:				
Finance income	5	48		58
Finance expense – unwinding of discount on provisions		(15)		(20)
PDC Dividends payable		(1,458)		(1,614)
Net finance costs			(1,425)	(1,576)
Surplus from continuing operations			**997**	1,601
SURPLUS FOR THE YEAR			**997**	1,601
Other comprehensive income				
Revaluation gains/(losses) and impairment losses property, plant and equipment			0	(11,242)
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of on donated assets			(16)	(17)
Other recognised gains and losses			(57)	0
TOTAL COMPREHENSIVE INCOME FOR THE YEAR			**924**	(9,658)

Income and operating surpluses are derived from the Foundation Trust's continuing operations.	2010/11 £000	2009/10 £000

Note: Allocation of Profits/(Losses) for the year		
(a) Surplus for the year attributable to:		
(i) owners of the parent	997	1,601
TOTAL	**997**	1,601
(b) total comprehensive income and expense for the year attributable to:		
(i) owners of the parent	924	(9,658)
TOTAL	**924**	(9,658)

	Note	2010/11 £000	2009/10 £000
ASSETS			
Non-current assets:			
Intangible assets	7.1	105	121
Property, plant and equipment	8.1	50,223	48,186
Total non-current assets		**50,328**	**48,307**
Current assets			
Inventories	11.1	396	603
Trade and other receivables	12.1	4,957	4,927
Cash and cash equivalents	19.1	15,459	9,366
Other current financial assets	19.3	1,000	2,000
Total current assets		**21,812**	**16,896**
TOTAL ASSETS		**72,140**	**65,203**
LIABILITIES			
Current liabilities			
Trade and other payables	14.1	(13,454)	(9,898)
Provisions	17	(2,532)	(89)
Other current financial liabilities	15	(1,108)	(804)
Total current liabilities		**(17,094)**	**(10,791)**
Non-current liabilities			
Provisions	17	(680)	(970)
Total non-current liabilities		**(680)**	**(970)**
TOTAL LIABILITIES		**(17,774)**	**(11,761)**
NET ASSETS		**54,366**	**53,442**
TAXPAYERS' EQUITY			
Public Dividend Capital		35,210	35,210
Revaluation reserve	18	4,307	4,307
Donated Asset Reserve		213	229
Income and expenditure reserve		14,636	13,696
TOTAL TAXPAYERS' EQUITY		**54,366**	**53,442**

The financial statements were approved by the Board of Directors and authorised for issue on 3 June 2011 and are signed on its behalf by:

Kathryn Thomson

Kathryn Thomson
Chief Executive

2010/11	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 2010	**53,442**	**0**	**35,210**	**4,307**	**229**	**0**	**0**	**0**	**0**	**13,696**
Surplus for the year	997	0	0	0	0	0	0	0	0	997
Revaluation gains/(losses) and impairment losses property, plant and equipment	0	0	0	0	0	0	0	0	0	0
Other recognised gains and losses	(73)	0	0	0	(16)	0	0	0	0	(57)
Taxpayers' Equity at 31 March 2011	**54,366**	**0**	**35,210**	**4,307**	**213**	**0**	**0**	**0**	**0**	**14,636**

	Note	2010/11 £000	2009/10 £000
Cash flows from operating activities			
Net cash generated from operations	19.2	**10,598**	**4,014**
Cash flows from investing activities			
Interest received		51	61
Purchase/sale of financial assets		1,000	(500)
Purchase of property, plant and equipment		(4,402)	(6,936)
Sales of property, plant and equipment		0	17
Net cash used in investing activities		**(3,351)**	**(7,358)**
Cash flows from financing activities			
Public dividend capital repaid		0	0
PDC dividend paid		(1,154)	(1,960)
Net cash used in financing activities		**(1,154)**	**(1,960)**
Increase/(Decrease) in cash and cash equivalents		**6,093**	**(5,304)**
Cash and Cash equivalents at 1 April		**9,366**	**14,670**
Cash and Cash equivalents at 31 March		**15,459**	**9,366**

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 2010/11 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.

Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.1 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
- Impairments of receivables
- Holiday pay accrual
- Pension provisions
- Legal claims

The critical judgements are addressed in the accounting policies that follow.

1.2 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 recognised 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 from balances held in bank accounts and amounts placed on short term deposit which is accrued on a time basis by reference to the principal outstanding and the interest rate applicable.

1.3 Expenditure on Employee Benefits

Holiday pay accrual

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

For all staff the amount of outstanding annual leave as at 31 March was requested from managers across the whole Trust. The accrual was then calculated on a pro-rata basis according to the numbers of staff within the responses compared to the total staff in post in March.

The accrual for outstanding leave has been calculated on the basis of responses relating to 75% of the workforce. However for Medical staff the response rate was significantly lower than for all other groups (33%). A separate accrual was calculated for this group. Not to have done so would have lead to a significant under accrual for Annual leave entitlement untaken as at 31 March.

Pension provisions

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

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

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 31 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.

Recognition

The capitalisation policy for non-current assets is to capitalise expenditure over £5,000 that results in the creation of non-current assets for individual or grouped assets.

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

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

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 31 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.

Impairment review
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 has 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.

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 31 March 2011 there were no assets classified as 'Held for Sale'.

Revaluation gains and losses
Revaluation gains
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.

Revaluation losses
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'.

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.

Assets in the course of construction
Assets in the course of construction are measured at cost of construction as at the 31 March 2011. Assets are reclassified to the appropriate category when they are brought into use.

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.

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.

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.

Revaluation gains and losses and impairments are treated in the same manner as for property, plant and equipment.

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 measured using the weighted average cost 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 cash flows 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 which 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.

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 2011.

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 Statement of Financial Position 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 cash flows 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 - both directly and also 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, so as to achieve a constant rate of finance over the life of the lease. 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 17.2.

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

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 21 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 Government Banking Services. 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.

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 the Trust not been bearing its own risks (with insurance premiums then being included as normal operating expenditure). The note on losses and special payments is compiled directly from the losses and compensations register which is prepared on an accruals basis.

1.19 Standards an Interpretations in issue not yet adopted
As at the 31 March 2011 the following standards have been issued but are not yet effective:

- IFRS7 – Financial Instruments Disclosure Amendment Transfer of Financial Assets.
- IFRS9 – Financial Instruments Financial Assets and Liabilities
- IAS12 – Income Taxes amendmentsures

IFRS7 and IAS12 are effective from 2012/13 but are not currently adopted by the EU. The timing of the adoption of IFRS9 is uncertain.

The following interpretations are issued but not yet effective:
IFRIC14 – Amendment – Prepayments of a Minimum Funding Requirement
IFRIC19 – Extinguishing Financial Liabilities with Equity Instruments.
Both were published in November 2009 and are effective for 2011/12

None of these standards or interpretations are expected to have a known significant impact on the Trust on adoption.

1.20 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.

1.21 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 thatinformation is made in the financial statements. The chief operating decision maker does not make use of such information within the Trust therefore no additional analysis has been given.

2 Operating Income

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 not compliant with this requirement in 2010/11.

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 10 February 2010 as to how the PP Cap should be operated for accounting periods beginning on or after 1 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 (NWF) under contract for the provision of clinical services; income from the Trust's Private Patient Unit (Catharine Suite) and any income received from overseas patients not covered by bi-lateral agreements falls within the scope of private patient income.

The Trust advised Monitor at the commencement of the financial year that given the need to renegotiate contract agreements with NWF it was likely that the Trust would breach the cap in 2010/11. This together with the receipt of higher income from overseas visitors in respect of the provision of long stay neo-natal care for which the Trust has an obligation to recover has led to the reported breach.

The Trust has in place revised arrangements to minimise the risk of a further breach in 2011/12.

Note 2.1 Operating Income (by classification)	Note	2010/11 £000	2009/10 £000
Income from Activities			
Elective income		9,966	10,516
Non elective income		26,633	25,952
Outpatient income		12,883	15,008
A & E income		1,095	1,002
Other NHS clinical income		31,568	26,829
Income from activities before private patient income		**82,145**	**79,307**
Private patient income	2.2	2,239	213
Other non-protected clinical income		34	0
Total income from activities	2.4	**84,418**	**79,520**
Other operating income			
Research and development		578	614
Education and training		4,887	4,791
Transfer from donated asset reserve in respect of deprecation on donated assets		16	17
Other	2.5	2,679	4,460
Profit on disposal of other unprotected tangible fixed assets		0	17
Total other operating income		**8,160**	**9,899**
TOTAL OPERATING INCOME		**92,578**	**89,419**

Income from activities arising from mandatory and non mandatory services	2010/11 £000	2009/10 £000
Income from mandatory services	82,145	79,266
Income from non mandatory services	2,273	254
Total income arising from activities	**84,418**	**79,520**

Note 2.2 Private Patient Income	2010/11 £000	2009/10 £000	Base Year £000
Private patient income	**2,239**	213	939
Total patient related income	**84,418**	79,520	52,415
Proportion of private patient income (as proportion)	**2.65%**	**0.27%**	1.80%

Note 2.3 Operating lease income	2010/11 £000	2009/10 £000
Operating Lease Income		
Rents recognised as income in the period	**159**	122
TOTAL	**159**	122

Note 2.4 Operating Income (by type)	2010/11 £000	2009/10 £000
Income from activities		
NHS Foundation Trusts	1,387	1,017
NHS Trusts	849	832
Primary Care Trusts	79,590	76,182
Department of Health – other	0	0
NHS Other	318	1,153
Non NHS: Private patients	2,239	213
NHS injury scheme (was RTA)	3	4
Non NHS: Other	32	119
Total income from activities	**84,418**	**79,520**

Note 2.5 Analysis of Other Operating Income – Other	2010/11 £000	2009/10 £000
Provision of clinical support services to North West Fertility Limited		2,080
Local Information Systems monies	281	284
Car parking income	349	322
Catering	127	155
Perinatal Audit	0	51
Property Rentals	110	112
Other	1,812	1,456
Total Other Operating Income	**2,679**	**4,460**

Note 3.1 OPERATING EXPENSES (by type)	2010/11 £000	2009/10 £000
Services from NHS Foundation Trusts	**3,653**	3,664
Services from NHS Trusts	**3,190**	2,995
Services from other NHS Bodies	**451**	282
Purchase of healthcare from non NHS bodies	**3**	32
Employee Expenses – Executive directors	**634**	595
Employee Expenses – Non-executive directors	**128**	95
Employee Expenses – Staff	**57,213**	52,431
Drug costs	**1,958**	2,566
Supplies and services – clinical (excluding drug costs)	**4,130**	4,088
Supplies and services – general	**3,715**	3,335
Establishment	**1,108**	1,296
Research and development	**561**	517
Transport	**105**	103
Premises	**2,761**	3,139
(Decrease)/increase in allowance for impairment in receivables	**150**	(163)
Depreciation on property, plant and equipment	**2,383**	2,550
Amortisation on intangible assets	**18**	8
Impairments of property, plant and equipment	**0**	1,033
Audit fees		
audit services – statutory audit	**63**	67
Other auditors remuneration		
other services	**0**	19
Clinical negligence	**4,898**	4,518
Loss on disposal of other property, plant and equipment	**0**	0
Legal fees	**94**	114
Consultancy	**0**	0
Training, courses and conferences	**408**	190
Patient travel	**7**	7
Car parking and security	**282**	299
Insurance	**112**	108
Losses, ex-gratia and special payments	**91**	88
Other	**2,040**	2,266
TOTAL	**90,156**	**86,242**

Note 3.2 Arrangements containing an operating lease	2010/11 £000	2009/10 £000
Minimum lease payments	131	25
TOTAL	**131**	**25**

Note 3.3 Arrangements containing an operating lease other than land and buildings	2010/11 £000	2009/10 £000
Future minimum lease payments due:	46	2
- not later than one year	56	22
- later than one year and not later than five years		
TOTAL	**104**	**24**

Note 3.4 Salary Entitlements of Senior Managers Name and position held					
Senior Managers in post as at 31 March 2011		**Salary (bands of £5,000 2010/11 £000**	**Other Remuneration (bands of £5,000) 2010/11 £000**	**Salary (bands of £5,000 2009/10 £000**	**Other Remuneration (bands of £5,000) 2009/10 £000**
Kathryn Thomson	Chief Executive	135-140	0	135 -140	0
Jonathan Herod	Medical Director from 1 October 2010	20-25	60-65	0	0
Gail Naylor	Director of Nursing, Midwifery & Patient Experience	90-95	0	65 -70	0
Vanessa Harris	Director of Finance	90-95	0	50 -55	0
Caroline Salden	Director of Service Development	90-95	0	90 -95	0
Michelle Turner	Director of Human Resources with effect from 5 April 2010	80-85	0	0	0
Ken Morris	Chair	40-45	0	25 -30	0
Ann McCracken	Non executive director Acting Chair Termination date 31 March 2011	10-15	0	15 -20	0
David Carbery	Non executive director	10-15	0	10 -15	0
Pauleen Lane	Non executive director with effect from 1 April 2010	0-5	0	0	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	10-15	0	0 -5	0

Salaries reflect posts being held for part of year during 2009/10

Senior Managers who have held posts during the financial year 2010/11

David Richmond	Medical Director from 1 April 2010 to 30 September 2010	15-20	80-85	40-45	170-175

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 31 March 2011 (bands of £2,500) £000	Real increase in CETV £000	(CETV) at 31 March 2011 £000	Cash Equivalent Transfer value (CETV) at 31 March 2010 £000
Kathryn Thomson	Chief Executive	8-10.5	180-182.5	-69	673	742
David Richmond	Medical Director until 30 September 2010	0-2.5	72.5-75	-29	1652	1709
Jonathan Herod	Medical Director with effect from 1 October 2010				605	Not Applicable
Gail Naylor	Director of Nursing, Midwifery & Patient Experience	7.5-10	125-127.5	-34	456	490
Vanessa Harris	Director of Finance	5-7.5	75-77.5	-19	265	284
Caroline Salden	Director of Service Development	2.5-5	75.5-80	-29	297	266
Michelle Turner	Director of Human Resources		115-117.5		415	Not Applicable

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.

Michelle Turner and Jonathan Herod were not employed by the Trust in their executive roles during 2009/10.

Other remuneration report details are included in the annual report on pages 89 and 90.

Note 3.6 Directors remuneration	2010/11 £000	2009/10 £000
Remuneration	796	612
Employers Pension Scheme Contribution	111	78
Total	**907**	**690**
The total number of directors accruing benefits under the NHS Pension Scheme were	**7**	**6**

Note 4.1 Employee Expenses	2010/11 £000	2009/10 £000
Salaries and wages	45,472	43,818
Social security costs	3,330	3,222
Pension costs – defined contribution plans	0	0
Employers contributions to NHS Pensions	5,247	4,952
Pensions Cost – other contributions	0	0
Termination benefits	2,877	0
Agency/contract staff	921	1,034
Total	**57,847**	**53,026**

Note 4.2 Average number of employees (Whole Time Equivalent basis)	2010/11 Total Number	2010/11 Permanent Number	2010/11 Other Number	2009/10 Total Number
Medical and dental	130	130		129
Administration and estates	286	286		270
Healthcare assistants and other support staff	139	139		129
Nursing, midwifery and health visiting staff	619	619		597
Scientific, therapeutic and technical staff	105	105		107
TOTAL	**1,279**	**1,279**		**1,232**

Note 4.3 Early retirements due to ill health	2010/11 Value £000	2010/11 Number	2009/10 Value £000	2009/10 Number
Early retirements on the grounds of ill-health	29	1	32	2

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 4.5 Staff Exit Packages **Exit package cost band**	**Number of compulsory redundancies**	**Number of other departures agreed**	**Total number of exit packages by cost band**
<£10,000	0	2	2
£10,000 - £25,000	0	10	10
£25,001 - £50,000	0	5	5
£50.001 - £100,000	0	2	2
£100,001 - £150,000	0	1	1
Total number of exit packages by type	0	**20**	**20**
Total resource cost £000	0	**661**	**661**

Number of other departures agreed reflects exit packages approved under the terms of MARS (Mutual Agreed Resignation Scheme).

The Trust instigated between the 14 December 2010 and 18 February 2011 a Trust-wide consulation on organisational change proposals the outcome of which was published on the 9 March 2011. As a consequence of the final proposals a number of staff were identified "at risk" and formal redeployment procedures instigated. It is considered probable that at the conclusion of this process a number of staff will be made redundant and others redeployed into posts for which an entitlement to pay protection exists.

As a result the Trust has made provision for these restructuring costs. Note 17.1 refers.

Note 5 Finance income	2010/11 £000	2009/10 £000
Interest on held-to-maturity financial assets	15	25
Other	33	33
TOTAL	**48**	**58**

Note 6. Impairment losses (Property Plant and Equipment and Intangibles)	2010/11 £000	2009/10 £000
Changes in market price	0	12,275
TOTAL IMPAIRMENTS	**0**	**12,275**

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 31 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)	2010/11 £000	2009/10 £000
Gross Cost as at 1 April	436	383
Additions – purchased	14	53
Gross Cost at 31 March	450	436
Amortisation as at 1 April	315	307
Amortisation for the year	30	8
Amortisation at 31 March	345	315
Net book value:		
Total at 1 April	121	76
Total at 31 March	**105**	**121**

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)	1	7

Note 8.1 Property, plant and equipment 2010/11

	Total £000	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & Machinery £000	Information Technology £000	Furniture & Fittings £000
Gross cost at 1 April 2010	**65,180**	**3,600**	**38,384**	**385**	**454**	**17,419**	**4,595**	**343**
Additions – purchased	4,408	0	2,089	0	915	1,313	82	9
Additions – donated								
Reclassifications	0	0	76	0	(156)	80	0	0
Revaluation surpluses								
Gross cost at 31 March 2011	**69,588**	**3,600**	**40,549**	**385**	**1,213**	**18,812**	**4,677**	**352**
Accumulated depreciation at 1 April 2010	**16,994**	**0**	**2,228**	**10**	**0**	**12,574**	**1,974**	**208**
Provided during the year	2,371	0	610	5	0	1,072	638	46
Impairments recognised in operating expenses								
Revaluation surpluses								
Accumulated depreciation at 31 March 2011	**19,365**	**0**	**2,838**	**15**	**0**	**13,646**	**2,612**	**254**
Net book value								
NBV – Purchased at 1 April 2010	47,959	3,600	35,961	375	454	4,818	2,621	132
NBV – Donated at 1 April 2010	227	0	195	0	0	29	0	3
NBV total at 1 April 2010 as restated	**48,186**	**3,600**	**36,156**	**375**	**454**	**4,845**	**2,621**	**135**
Net book value								
NBV – Purchased at 31 March 2011	50,010	3,600	37,498	370	1,213	5,166	2,065	98
NBV – Donated at 31 March 2011	213	0	213	0	0	0	0	0
NBV total at 31 March 2011	**50,223**	**3,600**	**37,711**	**370**	**1,213**	**5,166**	**2,065**	**98**

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 £000	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
Impairments	(11,242)	(765)	(10,442)	(35)	0	0	0	0
Gross cost at 31 March 2010	**65,180**	**3,600**	**38,384**	**385**	**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	(1,033)	(0)	0	0	0	0
Accumulated depreciation at 31 March 2010	**16,994**	**0**	**2,228**	**10**	**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 8.2 Analysis of property, plant and equipment 31 March 2011	Total £000	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & Machinery £000	Information Technology £000	Furniture & Fittings £000
Net book value								
NBV – Protected assets at 31 March 2011	41,468	3,600	37,498	370				
NBV – Unprotected assets at 31 March 2011	**8,842**	**0**	**0**	**0**	**1,213**	**5,166**	**2,065**	**98**
Total at 31 March 2011	**50,010**	**3,600**	**37,498**	**370**	**1,213**	**5,166**	**2,065**	**98**

Note 8.2 Analysis of property, plant and equipment 31 March 2010	Total £000	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & Machinery £000	Information Technology £000	Furniture & Fittings £000
Net book value								
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 8.3 Economic life of property plant and equipment	Minimum Life Years	Maximum Life Years
Buildings excluding dwellings	8	97
Dwellings	78	78
Assets under Construction and POA	0	0
Plant & Machinery	0	10
Information Technology	0	10
Furniture & Fittings	0	8

Note 9 Net Book Value of Assets held under finance leases

No tangible assets were held under finance leases during 2009/10 and 2010/11.

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

No non current assets were held for sale during 2009/10 and 2010/11.

No liabilities or assets were held in disposal groups during 2009/10 and 2010/11.

Note 11.1 Inventories	2010/11 £000	2009/10 £000
Finished goods	396	603
Total Inventories	**396**	**603**

Note 11.2 Inventories recognised in expenses	2010/11 £000	2009/10 £000
Inventories recognised in expenses	6,273	5,371
Total Inventories recognised in expenses	**6,273**	**5,371**

Note 12.1 Trade receivables and other receivables	Total 2010/11 £000	Financial Assets 2010/11 £000	Non-Financial Assets 2010/11 £000	Total 2009/10 £000	Financial Assets 2009/10 £000	Non-Financial Assets 2009/10 £000
Current						
NHS receivables	1,786	1,786	0	2,520	2,520	0
Other receivables with related parties	1,408	1,408	0	900	900	0
Provision for impaired receivables	(287)	(287)	0	(137)	(137)	0
Prepayments	643	0	643	734	0	734
PDC receivable	42	0	42	346	0	346
Other receivables	1,365	1,365	0	564	564	0
Total current trade and other receivables	**4,957**	**4,272**	**685**	**4,927**	**3,847**	**1,080**

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

Note 12.2 Provision for impairment of receivables	2010/11 £000	2009/10 £000
At 1 April 2009	137	300
Increase in provisions	150	0
Amounts utilised	0	0
Unused amounts reversed	0	(163)
At 31 March 2010	**287**	**137**

Note 12.3 Analysis of impaired receivables	2010/11 £000	2009/10 £000
Ageing of impaired receivables		
Up to three months		
In three to six months		
Over six months	287	137
Total	**287**	**137**
Ageing of non-impaired receivables		
Up to three months	3,413	2,886
In three to six months	351	29
Over six months	457	645
Total	**4,221**	**3,560**

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 2010/11 £000	Financial Liabilities 2010/11 £000	Non-Financial Liabilities 2010/11 £000	Total 2009/10 £000	Financial Liabilities 2009/10 £000	Non-Financial Liabilities 2009/10 £000
Current						
NHS payables	4,436	4,436	0	1,313	1,313	0
Trade payables – capital	547	547	0	527	527	0
Taxes payable	1,091	1,091	0	1,216	1,216	0
Other payables	2,672	2,672	0	3,651	3,651	0
Accruals	4,708	4,708	0	3,191	3,191	0
TOTAL CURRENT TRADE AND OTHER PAYABLES	**13,454**	**13,454**	**0**	**9,898**	**9,898**	**0**

The Trust held no non-current trade and other payables

Note 14.2 Ageing of trade and other payables	2010/11 £000	2009/10 £000
Up to three months	12,971	9,336
Three to six months	270	88
Over six months	213	474
Total	**13,454**	**9,898**

Note 15 Other liabilities	2010/11 £000	2009/10 £000
Current		
Deferred income	1,108	804
TOTAL OTHER CURRENT LIABILITIES	**1,108**	**804**

The Trust held no non-current liabilities.

Note 16 Prudential Borrowing Limit

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 **£24million** (£23.6million in 2009/10) of which **£17.5million** (£18.6million) related to long-term borrowing and **£6.5million** (£5million) 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	2010/11 Actual Ratio	2010/11 Approved Ratio Tier 1	2009/10 Actual Ratio	2009/10 Approved Ratio
Minimum Dividend Cover	5.3	>1x	4.2	>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	< 2.5%

On 31 March 2011 the Trust had in place an actual working capital facility of **£6.5million,** which has not been utilised.

Note 17.1 Provisions for liabilities and charges	Current 31 March 2011 £000	Current 31 March 2010 £000	Non-Current 31 March 2011 £000	Non-Current 31 March 2010 £000
Pensions relating to Other Staff	55	60	680	808
Other Legal Claims	39	29	0	0
Other	2,438	0	0	162
Total	**2,532**	**89**	**680**	**970**

Note 17.2 Provisions

	Total £000	Pensions – other staff £000	Other legal claims £000	Other £000
At 1 April 2010	**1,059**	868	29	162
Arising during the year	2,299	0	23	2,276
Change in the discount rate	(79)	(79)	0	0
Utilised during the year	(57)	(57)	0	0
Reversed unused	(25)	(12)	(13)	0
Unwinding of discount	15	15	0	0
At 31 March 2011	**3,212**	**735**	**39**	**2,438**
Expected timing of cashflows:				
- not later than one year	2,532	55	39	2,438
- later than one year and not later than five years	225	225	0	0
- later than five years	455	455	0	0
Total	**3,212**	**735**	**39**	**2,438**

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. Other comprises provision for restructuring costs arising from the outcome of ogansisational change proosals issued on 9 March 2011.

£74,501,528 is included within the provisions of the NHS Litigation Authority as at the 31 March 2011 in respect of the clinical negligence liabilities of the Trust (31st March 2010 £57,934,108).

Note 18 Revaluation Reserve

	Total Revaluation Reserve £000	Revaluation Reserve – Intangibles £000	Revaluation Reserve – property, plant and equipment £000
Revaluation reserve at 1 April 2010	**4,307**	**63**	**4,244**
Revaluation gains/(losses) and impairment losses on property plant and equipment	0	0	0
Revaluation reserve at 31 March 2011	**4,307**	**63**	**4,244**
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**

Note 19.1 Cash and cash equivalents	2010/11 £000	2009/10 £000
At 1 April	9,366	14,670
Net change in year	6,093	(5,304)
At 31 March	15,459	9,366
Broken down into:		
Cash at commercial banks and in hand	549	123
Cash at OPG (Office of Paymaster General)	14,910	9,243
Cash and cash equivalents as in Statement of Financial Position	**15,459**	**9,366**

Third Party Assets

The Trust held no cash or other assets on behalf of patients at 31 March 2011.

Note 19.2 Net cash generated from operations	2010/11 £000	2009/10 £000
Cash flows from operating activities		
Operating surplus	2,422	3,177
Non-cash income and expense:		
Depreciation and amortization	2,401	2,558
Impairments	0	1,033
Transfer from the donated asset reserve	(16)	(17)
Increase in trade and other receivables	(337)	(459)
Decrease/(Increase) in inventories	207	59
(Decrease)/Increase in trade and other payables	3,536	(1,416)
Increase/(Decrease) in other liabilities	304	121
Increase/(Decrease) in provisions	2,081	(1,025)
Other movements in operating cashflows	0	(17)
NET CASH GENERATED FROM/(USED IN) OPERATIONS	**10,598**	**4,014**

Note 19.3 Other financial assets	2010/11 £000	2009/10 £000
Held to maturity investments	1,000	2,000
Total	**1,000**	**2,000**

Held to maturity investments includes £1,000k temporary cash surpluses deposited with Barclays Bank PLC.

Note 20. Contractual Capital Commitments

At the balance sheet date of 31 March 2011 the Trust had capital commitments of £362,000 in respect of property plant and equipment (2010/11 £1,168,425).

Note 21. Contingent (Liabilities)/Assets	2010/11 £000	2009/10 £000
Gross value of contingent liabilities	0	6
Net value of contingent liabilities	**0**	**6**

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 other than Mace and Jones Solicitors (£44,964) with whom a Non-executive director holds the post of Local Chairman of Legal Services.

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 £1,680k in respect of those services (2010: £2,094k). At the 31 March 2011 the Trust was owed £846k (2010: £557k). The Trust purchased clinical supplies from North West Fertility Limited during 2010/11 with a value of £416k.

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 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 2010/11	**81,104**	**10,371**	**842**	**3,934**
Individual entities with income or expenditure transactions over £1,000k:				
Liverpool PCT	38,744	148	644	28
Western Cheshire PCT	13,652	-	-	2,994
Sefton PCT	9,716	-	18	-
Knowsley PCT	6,608	-	-	115
North West Strategic Health Authority	5,465	-	57	-
Halton and St. Helens PCT	2,656	73	-	67
Wirral PCT	2,197	-	-	112
Health Commission Wales	1,373	-	110	28
Royal Liverpool and Broadgreen University Hospitals NHS Trust	528	2.945	13	465
Aintree University Hospitals NHS Foundation Trust	165	2,307	-	125
NHS Litigation Authority		4,898	-	-
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

Note 23.1 Financial assets by category	Total £000	Loans & receivables £000	Held to maturity £000
Assets as per Statement of Financial Position			
Trade and other receivables excluding non- financial assets (at 31 March 2011)	4,272	4,272	
Other Financial Assets	1,000	0	1,000
Cash and cash equivalents	15,459	15,459	
Total at 31 March 2011	**20,731**	**19,731**	**1,000**
Assets per Statement of Financial Position			
Trade and other receivables excluding non financial assets (at 31 March 2010)	3,847	3,847	
Other Financial Assets at 31 March 2010	2,000		2,000
Cash and cash equivalents (at 31 March 2010)	9,366	9,366	
Total at 31 March 2010	**15,213**	**13,213**	**2,000**

Note 23.2 Financial liabilities by category	Total £000	Other financial liabilities £000
Liabilities as per Statement of Financial Position		
Trade and other payables excluding non-financial assets	13,454	13,454
Provisions under contract	3,212	3,212
Liabilities in disposal groups excluding non-financial assets (at 31 March 2011)		
Total at 31 March 2011	**16,666**	**16,666**
Trade and other payables excluding non-financial liabilities	9,898	9,898
Provisions under contract	1,059	1,059
Total at 31 March 2010	**10,957**	**10,957**

Note 23.3 Fair values of financial assets at 31 March 2011	Book Value £000	Fair Value £000
Cash and cash equivalents	15,459	15,459
Total	**15,459**	**15,459**

Note 23.4 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 23.5 Fair values of financial liabilities at 31 March 2011	Book Value £000	Fair Value £000
Provisions under contract	3,212	3,212
Total	**3,212**	**3,212**

Note 23.6 Fair values of financial liabilities at 31 March 2010	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 Board of Directors 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.

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 2010/11 the Trust had 125 (2009/10 382) separate losses and special payments, totaling £93,000 (2009/10 £87,763.91).

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

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 for the year ended 31 March 2011. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union.

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 auditor

As more fully explained in the Accounting Officer's Responsibilities Statement, the Accounting Officer is responsible for preparing the financial statements in accordance with directions made by the Independent Regulator of NHS Foundation Trusts ("Monitor") and for being satisfied that they give a true and fair view. 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).

Scope of the audit of the financial statements

A description of the scope of an audit of financial statements is provided on the APB's website at www.frc.org.uk/apb/scope/private.cfm

A description of the audit scope for the audit of the accounts of an NHS Foundation Trust is given in section 4 of the Audit Code for NHS Foundation Trusts issued by Monitor. www.monitor-nhsft.gov.uk/sites/default/files/publications/Audit%20Code

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the Trust's state of affairs as at 31 March 2011and of its income and expenditure for the year then ended;
- 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;

Opinion on other matters prescribed by Audit Code For NHS Foundation Trusts
In our opinion the information given in the

Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

We have nothing to report in respect of the following matters where applicable law and any directions made by Monitor require us to report to you if, in our opinion:

- the Statement on Internal Control 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
- the auditors are not able to satisfy themselves that the NHS foundation trust has made proper arrangements for securing economy, efficiency and effectiveness.

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.

Keith Ward

Keith Ward ACA (Senior Statutory Auditor)
For and on behalf of BAKER TILLY UK AUDIT LLP, Statutory Auditor
Chartered Accountants
3 Hardman Street
Manchester
M3 3HF

6 June 2011

Annual Report and Accounts 2011

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