

# Annual Report and Accounts

for the year ended **31 March 2012**



Liverpool Women's **NHS**  
NHS Foundation Trust

  
**Jane Mutch**  
Matron



Liverpool Women's NHS Foundation Trust

**Annual Report and Accounts for the year ended 31 March 2012**

Presented to Parliament pursuant to Schedule 7,  
paragraph 25(4) of the National Health Service Act 2006



# Contents

<b>Introduction from the Chair and Chief Executive</b>	<b>7</b>
<b>Directors' report</b>	<b>9</b>
Business review	10
Our future plans	12
Performance against key targets	14
Regulatory ratings	15
Quality	16
Our most valuable asset - our people	17
Sustainability report	27
Health, safety and security	28
Countering fraud and corruption	29
Going concern	31
One hundred reasons to be proud	32
<b>Quality report</b>	<b>37</b>
Introduction	37
Statement of Quality from the Chief Executive	38
Our Commitment to Quality	40
Focus on Quality	41
Looking back 2011/12 Review of Quality Performance	42
Priorities for improvement 2012/13	77
Statements of assurance from the Board of Directors	80
Stakeholder statements on our quality report	91
Statement of Directors' responsibilities in respect of the Quality Report	96
Independent Auditor's Limited Assurance Report to the Council of Governors of Liverpool Women's NHS Foundation Trust on the Annual Quality Report	98
<b>Remuneration report</b>	<b>101</b>
<b>Board of Directors</b>	<b>104</b>
Directors' meeting attendances	106
Pen portraits of members of the Board	106
Remuneration Committee	114
Code of Governance	114
<b>Council of Governors</b>	<b>116</b>
<b>Our membership</b>	<b>119</b>
<b>Statement of the Chief Executive's responsibilities</b>	<b>121</b>
<b>Annual governance statement</b>	<b>122</b>
<b>Financial accounts</b>	<b>130</b>
Independent auditor's report to the Council of Governors of Liverpool Women's NHS Foundation Trust	164



# Introduction from the Chair and Chief Executive

**It is with great pleasure that we welcome you to this annual report which details the achievements of Liverpool Women's NHS Foundation Trust during 2011/12.**

**Our mission remains to provide excellent healthcare for women, babies and their families in a safe, friendly and caring environment. This report demonstrates how we continue to achieve that mission and strive to continue to improve.**

We are especially pleased to present our '100 reasons to be proud' on pages 32 to 36. This shows just some of our achievements during the year and gives an indication of our total commitment to being the best place for patients to receive care, and for staff to come to fulfil their career ambitions in the NHS. These include:

- Developing a unique model of mental health support for women in the period immediately before and after birth
- Making an additional 20 'mobile' birthing pools available for women who wish to have a water birth at home
- The introduction of a revolutionary new embryo incubator that could increase the chances of success for IVF (in-vitro fertilisation) couples
- Successfully reducing patients' need for post-operative high dependency care, and the length of their hospital stay
- Achieving 'top marks' in patient safety by being awarded the highest level of accreditation for the Clinical Negligence Scheme for Trusts and NHS Litigation Authority scheme, making us only one of 5 Trusts in the country to achieve this position as a national leader in risk management
- Our Neonatal Unit featuring as part of a three-part documentary series which charted the experience many parents have at Liverpool Women's.

We hope you will enjoy reading about our other reasons to be proud as much as we did compiling them.

Chief Executive,  
Kathryn Thomson and  
Chair, Ken Morris





The year has not been without its challenges, however, particularly as the ongoing economic downturn continues to require even greater efficiencies. The Trust has been through a challenging programme of organisational restructuring and delivered an ambitious cost improvement programme. As shown on the pages that follow, we have successfully made the efficiencies required without compromising the quality of care we provide, and we are proud that both our clinical and financial performance remains strong.

During the year the Health and Social Care Bill has also been a key feature of the NHS and we have invested time and energy in considering its likely impact and the opportunities it will provide. As the year ends the Bill has become the Health and Social Care Act; we will ensure that the changes it brings allow us to continue providing the best experience possible to everyone who comes to Liverpool Women's.

We take this opportunity to place on record our thanks to Board members who left during the year. These were Non-Executive Directors Dave Carbery, Roy Morris and Hoi Yeung, all of who brought expertise, insight and challenge to the Board room and whose contributions to developing the Trust are warmly acknowledged. We also welcome new Non-Executive Directors Allan Bickerstaffe, Steve Burnett and Ian Haythornthwaite.

Our final notes are perhaps the most important. The first is a note of thanks to our patients, who allow us to touch their lives during times that may be happy, sad, difficult, frightening. It is a privilege to share in these times and our patients remain our number one reason to be the best.

Our second is a note of thanks to our staff, governors, members, volunteers and fundraisers, who together make Liverpool Women's the fantastic place it is. Each and every day they provide inspiration and unerringly ensure that we stay focused on what matters most of all – our patients.

*Ken Morris*

Ken Morris  
Chair  
28 May 2012

*Kathryn Thomson*

Kathryn Thomson  
Chief Executive  
28 May 2012





# Directors' report

## About Liverpool Women's...

We are Liverpool Women's – the largest women's hospital in Europe providing a comprehensive range of health care for women and babies from Liverpool and surrounding areas.

In 2011/2012, we:

- Delivered 8,396 babies
- Undertook gynaecological procedures on 6,189 women
- Cared for 1,269 babies in our neonatal intensive and high dependence care units
- Performed 1,255 cycles of in-vitro fertilisation (IVF)

Our vision, aims and values are:

### Our Vision

We will be the recognised leader in healthcare for women, babies and their families.

### Our Aims – WE SEE

- To develop a well led, capable and motivated **W**orkforce
- To be **E**fficient and make best use of available resources
  - To deliver **S**afe services
  - To deliver the most **E**ffective outcomes
- To deliver the best possible **E**xperience for patients and staff

### Our Values – we CARE and we LEARN

- **C**aring – we show we care about people
- **A**mbition – we want the best for people
- **R**espect – we value the differences and talents of people
  - **E**ngaging – we involve people in how we do things
- **L**earn – we learn from people past, present and future

We became Liverpool Women's NHS Foundation Trust on 1 April 2005. Prior to this the Trust operated as Liverpool Women's NHS Hospital Trust, created in 1995 when all services for women and babies in Liverpool came together under one roof at Liverpool Women's Hospital on Crown Street in Toxteth, Liverpool, a purpose-built hospital designed for providing care in the twenty-first century. We began operating the Aintree Centre for Women's Health in 2000, which provides care to women from north Liverpool, Sefton and Knowsley.

The Trust has two main contracts for its income which are essential for the Trust's business. These are Liverpool Primary Care Trust and North West Specialist Commissioners. In 2011/12 the Trust received £39.8m and £13.2m respectively from these commissioners. These contracts represent 56.1% of the Trust's total income and 62.4% of the Trust's clinical income.

## Business review

We have a great story to tell in respect of our achievements over the last year, our plans for which were set out in our annual plan 2011/12.

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.

### We will develop a well led, capable and motivated workforce

#### We have...

- Developed the new divisional structures, that is the way our services are organised both clinically and managerially
- Consistently achieved high levels of attendance at mandatory training to ensure that we are putting patient safety at the heart of everything we do
- Achieved high levels of staff having had an annual appraisal or personal development review (PDR)
- Redeveloped the Genetic Laboratory area
- Appointed a new female Paediatric Gynaecologist to provide adolescent services
- Identified a lead for induction and training among the research nurses
- Developed a programme to support sonography training, two students to qualify in April 2012
- Piloted, established and rolled out One Team, One Goal Team coaching programme (5 team coaches trained, 6 teams to date with further 3 teams in development)
- Provided direct organisational development interventions to support the establishment of Clinical Divisional management structure and relevant Clinical Division Board Development
- Received re-accreditation of Investors in People standards

### We will make the most efficient use of available resources

#### We have ....

- Achieved cost improvement targets for 2011/12 and identified further savings by redesigning services for 2012/13
- Reduced length of stay at hospital year on year
- Re-scheduled theatres to operate over four days at reduced cost

- Extended theatre operating time to four hour sessions
- Delivered financial balance
- Submitted grants to all relevant national funding streams to attract resources to research led by the Trust
- Increased the number of Advance Neonatal Nurse Practitioners, delivering an improved BCG service
- Increased activity within the Neonatal Unit, by efficient cot management enabling over performance against non contracted activity
- Increased the number of midwives who can perform examination of the newborn, enabling early discharge where clinically appropriate
- Delivered Data Warehouse and Information Specification Phase 1
- Completed Phase 1 of our new telephone system
- Explored and progressed plans around shared services for relevant support services for our people
- Concluded Rising to the Challenge Administration and Clerical Review

## We will deliver safe services

### We have...

- Consistently achieved National Cancer Targets
- Consistently achieved 18 week referral to treatment times for admitted and non-admitted patients
- Continued to roll out a Microarray Service that provides more comprehensive cyto-genetic test results
- Ensured the Twin Birth Rate from assisted conception has remained within the quality indicator set by the Human Fertilisation and Embryology Authority
- Contributed to a national consultation about the management of risk in neonatal trials involving Neonates
- Retained NHS Litigation Authority and Clinical Negligence Scheme for Trusts Level III accreditation
- Reduced infection rates in the Neonatal Unit

## We will deliver the most effective outcomes

### We have...

- Low levels of patients being admitted following attendance at the Emergency Room
- Implemented Pre-implantation Genetic Testing
- Consistently achieved the Hospital Standardised Mortality Rate
- Introduced BhCG (pregnancy test) machines to detect early pregnancy (point of care testing)
- Introduced a ROTEM machine to provide better information to clinicians concerning patients' blood clotting ability (a ROTEM is a device used in theatre to measure a patient's blood clotting to help manage potential blood clotting problems)
- Reported to the local Cancer Network the first year's information of the Somerset Cancer Registry which provides outcome information which helps to inform and develop cancer services. This was held up by the Network as good practice and our information was considered to be of a high standard
- Implemented a Haematological Malignancy Diagnostic Service (HDMS) to provide a genetic testing service across the Merseyside and Cheshire Cancer Network that now includes the Wirral
- Reduced mortality rates in our babies delivered at 25-26 weeks' gestation
- Improved breast feeding rates in our babies below 29 weeks' gestation
- Delivered ongoing improvement in all equality related issues for both staff and patients as measured through submissions to the National Performance Management Framework
  - Equality Delivery System

## We will deliver the best possible experience for patients

### We have...

- Worked closely with Liverpool, Sefton and Knowsley LiNK (Local Involvement Network) groups in the redesign of the services to be provided from Aintree Centre for Women's Health in 2012/13
- Received re-accreditation for our Clinical Genetics Practice Development Unit
- Become a founder member of Liverpool Health Partners which will work to integrate clinical services and research across the city
- Developed and piloted a prototype trolley for neonatal resuscitation that allows a newborn baby to be cared by next to their mother in the minutes after birth.
- Introduced birthing pools into the community for women want to give birth in water at home
- Opened the first phase of the Big Push building project on the site of the Women's Hospital, giving en-suite facilities to all patients who have their baby with us
- Experienced no delays in the transfer of patients to an Intensive Therapy Unit
- Taken part in a national prime time television programme that showed the experience many parents have of the Neonatal Unit
- Achieved top education provider in the country for General Practitioner/ Vocational Training Scheme placements as measured by the trainees themselves through General Medical Council survey

As in previous years we will strive to build on these achievements.

Some of our plans for 2011/12 have yet to be achieved. They are:

- Development of our Quality Strategy; work commenced in-year to identify priority areas. This work will be integrated in 2012/13 with our service redesign and efficiency programmes
- Development of private patient services; following the passing of the Health and Social Care Bill the Trust will now scope the potential to introduce paid for services to supplement NHS services provided
- Review of pharmacy services; this review commenced in-year and will continue into the first part of 2012/13 focusing on governance and efficiency
- Review of theatres; the review is underway to provide the most efficient and clinically effective service to all planned and emergency patients. The review will be completed by the end of September 2012.

## Our future plans

Our future plans are detailed in our annual plan for 2012/13 and are summarised below:

### Within gynaecology, surgical services, genetics and reproductive medicine...

- Redesign access to day case and outpatient procedures across sites
  - Deliver the medical termination of pregnancy service in an outpatient setting
  - Increase capacity at Aintree Centre for Women's Health
  - Enhance the ambulatory gynaecology service
- Redesign inpatient and outpatient clinical pathways
  - Implement advances in clinical practice (termination of pregnancy) and day case procedures
  - Develop an endometriosis chronic pelvic pain pathway
- Implement next generation sequencing in genetics laboratories
  - Procure the technology

- Implement a 7 day IVF service for NHS and private patients
  - Review all clinical pathways
  - Develop the donor sperm bank
  - Improve communications with patients
- Relocate the clinical genetics service from Alder Hey Hospital to Liverpool Women's Hospital on Crown Street
  - Redesign the service to ensure an optimum service is provided at Crown Street

### **Within maternity, neonates and clinical support services...**

- Develop efficient services that will generate income
  - Renegotiate tariff with commissioners for fetal medicine services
  - Introduce a range of enhanced patient services such as alternative therapies, amenity beds, partner accommodation
- Improve the market share position of the Trust and continue to enhance the reputation of services
  - Remodel fetal medicine accommodation to increase productivity and access for women
  - Develop the vaginal birth after caesarean section (VBAC) service
  - Further develop our partnership work with One2One midwives
- Improve the overall productivity of the division whilst enhancing patient experience
  - Implement redesign projects in community midwifery, midwifery services, maternity theatre and neonatal low dependency teams
  - Reduce extreme pre-term mortality rates/late onset infections
  - Reduce duplication of prescriptions and medication errors
- Implement the imaging strategy to improve function and governance and to promote growth
  - Agree the strategic direction of the service; the use of third party provision
  - Ensure an effective equipment replacement programme is in place
- Continue to improve the estates (buildings) provision to ensure that facilities are fit for purpose
  - Commission phase III of the Big Push project
  - Commission the reconfiguration of neonatal estate project

The principal risks and uncertainties facing the Trust include:

- delivery of our cost improvement programme
- 0% financial growth
- changes in the national funding tariff
- changes in the architecture of the NHS, in particular the introduction of Clinical Commissioning Groups
- the future of genetics service provision, and
- retaining our market share in the face of increasing competition.

The main trends and factors likely to affect the future development, performance and position of the Trust's business are the savings targets we must achieve to remain cost effective; introducing a new business model for our reproductive medicine services; developing a commercial skill set within the Trust in order to fully respond to changes in the market and the provisions in the Health and Social Care Act 2012, and; the maintenance of our Level III accreditation in respect of the Clinical Negligence Scheme for Trusts and the NHS Litigation Authority.

## Performance against key targets

We are proud to report that our performance against national targets has remained strong during the year. Details of the targets we are required to achieve are set out below, together with our actual performance:

Indicator name	Target	Performance 2011/2012
<b>Care Quality Commission: national priority</b>		
18 week referral to treatment times: admitted (all specialties)	90%	97.52%
18 week referral to treatment times: non-admitted (all specialties)	95%	97.15%
18 week referral to treatment times: non-admitted (gynaecology, infertility and reproductive medicine)	95%	96.84%
18 week referral to treatment times: non-admitted (clinical genetics)	95%	99.61%
18 week referral to treatment times: non-admitted data completeness	80 –120%	97.19%
18 week referral to treatment times: admitted data completeness	80 –120%	95.71%
All cancers: two week wait	≥93%	97.54%
All cancers: one month diagnosis to treatment (first definitive)	≥96%	98.54%
All cancers: one month diagnosis to treatment (subsequent surgery)	≥94%	100%
All cancers: one month diagnosis to treatment (subsequent drug)	≥94%	100%
<sup>1</sup> All cancers: two month referral to treatment (GP referrals)	≥79%	91.67%
<sup>2</sup> All cancers: two month referral to treatment (consultant upgrade)	≥94% (to be confirmed)	92.45%
All cancers: two month referral to treatment (screening referrals)	≥90%	88.37%
Experience of patients	To be confirmed	Via annual survey
Incidence of MRSA bacterium	≤2	0
Incidents of Clostridium difficile	≤7	1
Infant health and inequalities: breastfeeding rate (performance should not decrease by 5% or more)	≥-5%	-2.10%
Infant health and inequalities: smoking rate	≤0%	0.68%
Maternity Hospital Episode statistics: data quality indicator	≤15%	Method under review
NHS staff satisfaction (overall staff engagement)	<sup>3</sup> National average 3.77	3.49
<b>Care Quality Commission: existing commitments</b>		
Data quality on ethnic group (April to December 2011)	≥85%	97.08%
Delayed transfers of care	≤3.5%	0%
Last minute cancellation for non-clinical reasons	≤0.8%	0.71%
Last minute cancellation for non-clinical reasons, not readmitted in 28 days	≤5%	1.33%
Total time in Accident & Emergency (%seen within 4 hours)	≥98%	99.82%

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 as at Q3 2011/12 (94%) (<http://transparency.dh.gov.uk/2012/02/24/waiting-times-cancer-q3>)

3 National average of acute specialist Trusts

In respect of the targets we did not achieve, the following remedial action is being taken:

- All cancers (two months referral to treatment consultant upgrade); this indicator does not have a nationally defined target for performance. The Trust has previously benchmarked itself against the most recent national performance data. There were only 2 patient breaches against this indicator in 2011/12
- Smoking rates; the Trust has struggled to impact sustainable improvement in this area of public health promotion. We identify and refer women to the primary care service. The update of the service is limited and the Trust is working more collaboratively with commissioners and service providers to develop a more effective model for smoking cessation
- Our work in respect of the NHS staff survey is outlined on pages 22 - 25.

## Regulatory ratings

Monitor is the independent regulator of NHS Foundation Trusts. When assessing our performance, Monitor uses a risk rating system for financial performance and governance:

- Financial performance – this is based on the achievement of our financial plan, underlying performance, financial efficiency and liquidity. A scale of 1 – 5 is used for each with 5 indicating the lowest risk and 1 the highest
- Governance – this takes into account our service performance, clinical quality and patient safety, risk and performance management arrangements, cooperation with partner organisation, our membership and compliance with the statutory framework. A traffic light system is used to indicate the rating given, based on green, amber-green, amber-red and red where green is the lowest risk and red the highest.

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

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

	Financial risk rating	Governance risk rating	
Annual plan 2011/12	3	Green	
Q1 2011/12	4	Green	
Q2 2011/12	4	Green	
Q3 2011/12	5	Green	
Q4 2011/12	4	Green	

Our governance risk rating for 2010/11 was red because of changes to the accounting requirements for private patient income in 2010/11 as issued by Monitor in February 2011. This was explained in further detail in our 2010/11 annual report.

We confirm that there were no formal interventions from Monitor during the year.



## Quality

Over the course of 2011/12 the Trust reviewed and significantly revised its risk and governance structures. This restructuring entailed integrating a number of posts and functions previously managed separately across a number of departments into a single, centrally managed integrated governance team. This facilitates better coordination of their related and often interdependent activities.

The previously stand-alone functions are now incorporated into an integrated governance model including:

- Clinical audit
- Research and development
- Risk management
- Health and safety
- Infection prevention and control
- Patient experience
- Safeguarding.

This newly formed governance team has played a significant part across the Trust in a number of areas of risk, governance, quality and external assessment. This included providing automated and real-time collation of data across some of the quality report care parameters, to provide an online tool for clinical managers to monitor compliance and act where necessary.

During the year the governance team managed the Trust's reporting and development of Commissioning for Quality and Innovation (CQUIN) metrics. These will continue to be strengthened in 2012/13 so that our clinical teams can further improve patient care, clinical effectiveness and patient safety.

Management of the Monitor Quality Governance Framework had, by the end of the financial year, become a more collective process, engaging more staff and thus sharing greater responsibility. Examples of this enhanced working model are:

- The Trust's Health and Safety Manager now also leads on emergency planning arrangements which was previously outsourced to an external provider
- Our risk management, patient experience and claims teams are improving the way we gather information about incidents, risks, complaints and claims to make sure they are properly 'joined up' and intelligence about them is shared
- The clinical audit team ensures the Trust's clinical audit programme focuses on key risk issues and supports the achievement of our quality priorities. Clinical audit continues to provide assurance on the robustness of many of our clinical and non-clinical systems and provides the data needed to target improvement activity
- During the year our risk management team continued to work with NHS Merseyside (incorporating Liverpool Primary Care Trust) Patient Safety Collaborative to host and participate in root cause analysis training which is an important element of serious incident investigations
- The infection prevention and control team continues to work with our neonatal team to reduce infection and take all practicable steps to minimise the risk of pseudomonas infection on the unit. They have also worked with our Patient Services Manager and domestic services contractor to ensure high standards of cleanliness throughout the hospital. We are confident that this has contributed to the fact we achieved MRSA elective and emergency screening standards and had:
  - No MRSA bacteraemias in the Trust for a second consecutive year
  - No major outbreaks of infection during the year
  - A single episode of infection due to *Clostridium difficile*
- Our safeguarding team continued to provide advice and support to staff across the Trust on all issues concerning safeguarding vulnerable adults and children. The team have seen a sizeable increase in their workload during the year as referrals to social care services from the Trust have almost

doubled. At the start of 2012 our safeguarding training programme was completely revised to ensure compliance with national standards

- In February 2012 the Trust welcomed the Care Quality Commission (CQC) on an unannounced visit. This was a largely successful and positive visit with considerable recognition by the CQC on much of the organisation's practice. However, the CQC registered a 'moderate concern' in respect of CQC Outcome 09 - Management of Medicines. The Trust is working to resolve the deficiencies in practice that the CQC visit highlighted.

The Trust began to develop a Quality Improvement Strategy in December 2011. This will be completed and launched in 2012/13 and will relate to other organisational initiatives through the establishment of a QIPP programme board to oversee and drive quality, effectiveness and cost improvement.

Key to the success of the revised governance structure is the cross-working relationship between the Clinical Governance Committee and the Corporate Risk Committee. In 2011/12 they have continued to establish their profile and influence with evolution of terms of reference and membership. This should enable a more integrated relationship between these two committees in 2012/13 that will further support and strengthen the new governance structure.

## Our most valuable asset - our people

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

As at 31 March 2012 we employed 1,349 staff in a variety of clinical and support roles (1,141.88 whole time equivalents) not including those who work for our external contractors or staff seconded out to other organisations.

Our people work within three main areas across the Trust:

**50%** Maternity, Neonatal and Clinical Support Services Division

**31%** Gynaecology, Anaesthesia & Theatres, Hewitt Centre and Genetics Division

**19%** Corporate Support Services

Staff Group	Whole time equivalent as at 31 March 2012
Registered Nurses and Midwives	561.71
Doctors	61.25
Other clinical services staff	201.55
Healthcare Scientists	33.77
Additional Professional, Scientific and Technical	27.19
Allied Health Professionals	10.79
Administrative and management	237.62
Estates and Ancillary	8.00
<b>Totals</b>	<b>1,141.88</b>

Our Human Resources and Learning & Development teams 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 the four NHS Constitution pledges to staff. Significant achievements were made in 2011/12 in the following areas:

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

- Completed organisational restructure from a four Clinical Business Unit structure to a two Clinical Division structure based on staff feedback around reducing bureaucracy and streamlining management structure
- Establishment and embedding of the Employee of the Month programme which culminates at the Focussing on Excellence awards when the Employee of the Year will be awarded
- Record number of entries (99) – a 20% improvement on the previous year - for the seventh annual Focussing on Excellence awards, celebrating the achievements of our people
- Introduction of a loyalty award for 67 staff currently working in Liverpool Women's who have worked in the NHS for over 25 years

Areas for improvement and continuous focus for 2012/13:

- Continuing focus on ensuring that all staff receive a Personal Development Review that recognises their individual contribution to delivering the organisational aims and provides an opportunity to discuss and agree relevant personal and professional development needs to be addressed over the following year

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

- Liverpool Women's was identified as top nationally for GP trainee placements from the results of Trainee GP/Vocational Training Scheme General Medical Council(GMC) Survey
- Retained Investors in People recognition with 32 key strengths identified within the report and the One team, One Goal: Putting People First strategy identified as an area of best practice
- Targeted individual leadership and management development to provide senior (57) and middle (60) level leaders with consistent foundation skills and experience
- Pro-active support for leaders from under represented backgrounds through joint design and delivery of Liverpool-wide Aspire & Achieve programme
- Revision and re-launch of work experience and outreach programme

Areas for improvement and continuous focus for 2012/13:

- Complete the Putting People First: service and system leader (senior) leadership development programme and continue to roll out the Putting People First: patient team leader (middle) leadership development programme
- Investigate development of a leadership for all programme designed for front-line staff

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

- Achieved one of the highest scores in the country relating to Competent and Capable workforce as part of the NHS Litigation Authority level 3 assessment
- One of top 20 Trusts in the country for level of staff uptake of the flu vaccine (77%)
- Successful introduction and impact of early intervention clinics to support staff with the following conditions – mental health, musculo-skeletal and planned surgery
- Introduction and piloting of hospital site based exercise classes, Zumba continues on a weekly basis with any profit made from staff contributions being donated to the Kitty Appeal

Areas for improvement and continuous focus for 2012/13:

- Attainment of occupational health accreditation with national standards (SEQOSH)
- Development and agreement of Trust-wide health and well-being plan to include and expand services available for staff across all aspects of well being – physical, mental health, social, financial, etc

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

- Extensive Trust wide consultation processes in relation to organisational change (Rising to the Challenge and Administrative and Clerical Review)
- Involvement and testing of operational plans with staff in key focus groups for each of the Divisional Teams
- Pilot, establishment and roll out of One Team, One Goal Team coaching programme
- Increasing visibility of managers and Board members through the Go & See visit programme

Areas for improvement and continuous focus for 2012/13:

- Feedback more effectively on achievements made through organisational change processes and learning from their implementation with staff
- Continue to roll out and expand the One Team One Goal team coaching programme
- Introduce a localised staff engagement measure (pulse survey) to test the level of engagement individual teams have with their team leader, learn from where this works well and take action where necessary where it is not working so well.

During the year the Trust joined forces with ten other NHS Trusts from across the Mersey Region under the Quality, Innovation Productivity and Prevention (QIPP) programme, to develop a shared service for transactional human resources and payroll services. Following a competitive tendering and selection process, the decision was taken to move with Capita due to their experience in setting up and providing integrated business services. It has been projected that the Trusts involved from the start of the shared service will see total savings of around 17%, and will benefit from the efficiencies of bringing together shared expertise from within the NHS and the private sector in developing a modern, 21st century service.

### **Working with our partners in the community**

2011 saw a continued focus on working together with partners in the community and expanding our reach and impact as a local employment provider.

We have now expanded and enhanced our work experience and outreach programme to offer quality placements across the Trust in a wide variety of roles. The re-launch and improvement of the work experience and outreach programme is a central part of our overall plan to address issues relating to:

- under representation across certain professions and groups
- encouraging more students to consider careers particularly in shortage occupations or job roles where our current staff are likely to retire within the near future
- support our local community to raise aspiration and gain valuable work experience for the future as part of our corporate social responsibilities as a major employer within Liverpool.

Our work with partners in relation to focussing on ensuring equity of access and improved overall health outcomes for patients and staff across all nine equality protected characteristics continues to develop and improve services for all. This year saw the introduction of a new performance management framework called the Equality Delivery System which assesses in partnership with stakeholder groups how we are progressing the equality agenda. Feedback from our stakeholder groups was immensely positive. This process has identified further improvements linked to our equality and human rights work plan for 2012-13.

## Valuing our staff

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

## Equal opportunities for staff

Part of our commitment to valuing staff is taking action on specific areas where we have identified that improvement in our approach is required. Our focus area for 2011/12 was based on feedback we sought about capturing data from staff in relation to all nine protected equality characteristics.

By running a series of events highlighting how having information about individual characteristics of staff can ensure:

- potential indirect discrimination is minimised
- effective targeted support services for staff
- proactive measures can be taken to support staff with specific needs

and linking this to a comprehensive data capture campaign called 'Count Me In', we have now made significant progress in improving the data we have across all protected characteristics for all staff. Through proactive communication of the impact this data can have when tackling equality related issues we expect to continue to further increase the capture rate throughout the year.

## Recruitment of staff with a disability

The Trust is signed up to "Two Ticks Symbol" which is a quality symbol providing assurance to individuals with a disability that we welcome applications from all individuals with or without a disability. We have also revised the pre-employment health screening programme to take into account changes in the legislation in relation to health screening as part of the Equality Act 2010. These changes have also been included in mandatory training requirements for all staff.

In 2011-12, 50 applicants (4% of all applications) declared a disability in their application, 14 of this group were shortlisted (4% of all shortlisted applications) with 6 candidate appointed (5% of all appointments in the period). The consistency in progress of candidates through each of the stages is positive although we would look to have a higher percentage of applications from people who have a disability. It may be that people with a disability are choosing not to disclose this at application stage and so we need to ensure that confidence is built with prospective employees that this will not work against them.

## Career development and promotion of staff with a disability

The NHS staff survey has identified that this is not seen as an area for concern by staff who have a disability. However, we know that there is a reluctance to declare a disability through the data capture report and are investigating the launch of a positive promotion campaign of disability roles models from across the Trust and their experiences of working at the Trust.

## Reasonable adjustments for staff with a disability

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



## Single Equality Scheme moving to the Equality Delivery System and Equality objectives

We welcome the move to improving access and the impact of equality on health outcomes that has been introduced as part of the new NHS Equality Delivery System.

We will focus our resources on areas where we and our partners have identified require further improvement to ensure equity of access and improved health outcomes for all. These objectives are in the process of being consulted on and finalised with our partners and will focus on the following themes:

- continuing our work to ensure we collect data across all nine protected characteristics for all of our patients, service users, and our staff
- using this data to monitor access to services and inform where more targeted services may need to be developed
- further refine our consultation and involvement mechanisms to ensure we listen to the views of everyone, particularly from hard to reach or vulnerable groups
- continue to embed equality related issues and topics into leadership development at all levels across the Trust.

## Recognising and Rewarding Excellence

The Trust held its seventh annual “Focussing on Excellence” Awards for 2011/12 which celebrate and reward staff who deliver clinical and non-clinical improvements to achieve excellence for women, babies and their families. This year the categories were expanded to reflect our focus on team based working to deliver enhanced services and also embed the Trust values of CARE (Care, Ambition, Respect, Engage) and Learn.

The Employee of the Month scheme was further enhanced to introduce an Employee of the Year award which was announced at the Focussing on Excellence award ceremony. A loyalty award scheme was also re-introduced for staff who had served the NHS for over 25 years.



The Trust's longest serving staff were celebrated in November 2011. The people in this picture have accumulated over 1342 years service between them!

## Health and well-being of the workforce

The sickness absence rate of staff within the organisation has continued to drop from 4.6% in 2011 to 4.36% cumulative as at March 2012. This has only been achieved through a shared focus on preventing and reducing the impact of sickness absence and improving overall staff health and well-being. Whilst there is scope for further improvement in this area, the investment in our leaders and managers is expected to contribute to the improvement and consistent management of sickness absence.

The introduction of early intervention clinics for stress and anxiety, muscular-skeletal and planned surgery have begun to impact positively by bringing staff back to work within a shorter timeframe.

Our future strategy for the management of sickness will focus on improving return to work times and promoting good attendance through the use of our existing model.

## Listening to staff

Our people are our greatest asset. It is only by truly listening to them and involving them in addressing issues that are important to them that we will achieve our overall vision of becoming one of the leading healthcare providers for women, babies and their families.

As part of the feedback from the NHS staff survey over previous years we have implemented a range of ways of getting the views and involvement of staff in decision making and service planning for the future. These ranged from Trust wide events called "Big Chat" events to explore key themes, to formal Trust wide consultation, and divisional based engagement events in relation to planning for the future and finally team based review and coaching sessions.

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

Our consistent measure of both the involvement of our people and the impact of the changes that are made in partnership with them, is the NHS staff survey. However, we have identified the development and implementation of more localised engagement surveys (or pulse surveys) on a rolling programme as a key priority for 2012/13. These pulse surveys will be able to give us more rapidly available information to act on and to support accelerated improvements.

Major efforts have been made over the last three years to increase the survey response so that we hear the views of as many of our people as possible. This has been possible through a partnership approach with the local full-time staff side representatives to encourage increased returns across all areas. The response rate for 2011 was above average for UK specialist acute Trusts (52%) but a decrease from the 2010 response rate of 59%.

2010/11 was a year of significant organisational change due to two major restructures moving from four Clinical Business Units to two Clinical Divisions and a later Trust wide restructure of our administrative and clerical service. Structural changes of this scale had not happened within the Trust previously and so the impact on staff was significant, particularly in relation to role clarity and perception of feeling valued. Important lessons were learned through the restructure process which has now been incorporated into our approach to leading and implementing organisational change. 2011/12 was a year where we focussed on restructuring our services to ensure we deliver sustainable, high quality, effective and efficient services for women, babies and their families. 2012/13 will be a year of repair and rebuild focussing on how we continue to develop and grow our services in the future.

Clearly experiencing this level of organisational change will have an impact on how staff feel about their roles and the Trust, and as such we did not expect the overall NHS staff survey results to improve dramatically.



Of the 38 key findings within the NHS staff survey 31 key findings have not statistically significantly changed, the remaining 7 key findings deteriorated, which are:

- Effective team working
- Percentage of staff appraised in the last 12 months
- Percentage of staff having well structured appraisals in the last 12 months
- Percentage of staff appraised with a personal development plan in the last 12 months
- Staff job satisfaction
- Staff intention to leave
- Staff recommendation of the Trust as a place to work or receive treatment.

Actions being taken to address these areas of deterioration are clearly identified within our organisational development work plan, as follows:

- Continuing focus on ensuring that all staff receive a Personal Development Review that recognises their individual contribution to delivering the organisational aims and provides an opportunity to discuss and agree relevant personal and professional development needs to be addressed over the following year
- Continued delivery and expansion of the One Team One Goal team coaching programme to increase team effectiveness and engagement levels across staff
- Continued delivery of the leadership and management development programmes for staff at senior and middle levels with the implementation of a specific communications and engagement module, the impact of which will be measured through the local staff engagement (pulse) survey
- Reinvigoration and consistent promotion internally of the achievements and successes of our people such as publication of '100 reasons to be proud of Liverpool Women's', Focussing on Excellence awards, active entry and promotion of excellent practice into external awards.

### Summary of performance:

	2010/11		2011/12		Improvement/ deterioration
	Trust	National average	Trust	National average	
Response rate	59%	54%	57%	52%	2% decrease (5% better than the national average)

Top 4 ranking scores	2010/11		2011/12		Improvement
	Trust	National average	Trust	National average	
Staff experiencing bullying, harassment or abuse in the last 12 months	15%	14%	10%	14%	5% increase in Trust position (4% better than the national average)
Staff suffering work related injury in the last 12 months	14%	13%	9%	13%	5% increase in Trust position (4% better than the national average)
Staff experiencing discrimination at work in the last 12 months	10%	10%	6%	10%	4% increase in Trust position (4% better than the national average)
Staff working extra hours	66%	65%	59%	67%	7% increase in Trust position (8% better than the national average)

Bottom 4 ranking scores	2010/11		2011/12		Deterioration
	Trust	National average	Trust	National average	
Staff able to contribute to improvements at work	63%	66%	55%	66%	8% decrease in Trust position (11% worse than national average)
Staff recommendation of the Trust as a place to work or receive treatment (higher score better)	3.47	3.93	3.34	3.90	0.13 decrease in Trust position (0.56% worse than national average)
Staff intention to leave jobs (lower score better)	2.59	2.46	2.81	2.54	0.22 decrease in Trust position (0.27 worse than national average)
Staff job satisfaction (higher score better)	3.51	3.57	3.34	3.55	0.17 decrease in Trust position (0.21 worse than national average)
Areas of largest deterioration	2010/11		2011/12		Deterioration
	Trust	National average	Trust	National average	
Effective team working (higher score better)	3.83	3.75	3.55	3.73	0.28 decrease in Trust position (0.18 worse than national average)
Staff appraised with personal development plan in last 12 months	78%	68%	65%	70%	13% decrease in Trust position (5% worse than national average)
Staff appraised in last 12 months	85%	79%	73%	81%	12% decrease in Trust position (8% worse than national average)
Staff having well structured appraisals in last 12 months	35%	36%	22%	40%	13% decrease in Trust position (8% worse than national average)

Our previous (2009/10, and 2010/11) bottom four scoring areas which focussed on the areas of risk and safety have seen improvements which are important to consolidate and build on to continue to deliver on our commitment to patient (and staff) safety.

Bottom 4 ranking scores	2009/10		2010/11		Deterioration
	Trust	National average	Trust	National average	
Staff recommending the Trust as a place to work or receive treatment (higher score better)	3.50	3.89	3.47	3.93	0.03 decrease in Trust position (0.46 worse than national average)
Staff reporting good communication between senior management and staff	25%	32%	20%	35%	5% decrease in Trust position (15% worse than national average)
Fairness and effectiveness of incident reporting procedures (higher score better)	3.52	3.51	3.46	3.53	0.06 decrease in Trust position (0.07 worse than national average)
Perception of effective action by employer towards violence and harassment (higher score better)	3.50	3.62	3.50	3.67	No change in Trust position (0.17 worse than national average)

Appraisal (performance development reviews) had been one of our top scoring key findings in the last year. Given the significant impact a high quality appraisal can make in relation to clarity of role and objectives, opportunity for staff to contribute their ideas about improvements at work and to gain feedback around what they do well and how they can continue to improve, and so feel valued, this will be our top priority action to resolve for 2012/13.

2012/13 will be the second year of our four year Putting People First strategy, which has been reviewed and refreshed in the light of the findings of the 2011 staff survey. Our leadership programme continues, rolling out to more junior and emerging leaders in our organisation. The team coaching programme continues with a focus on building high performing teams. The early part of 2012/13 will see us commence a review of our staff communication and engagement process, and we will implement local 'pulse' surveys to enable leaders to respond quickly to staff views.

These key priority areas and our performance against them will be monitored via the Board's Human Resources and Organisational Development Committee.

## Partnership and consultation

Our commitment to working in partnership with our patients, their families, the public, our staff and stakeholder organisations, continues unabated. During 2011/12 we were proud to work with the following:

- Our patients** – at the beginning of each of its meetings, the Board of Directors hears a patient story. This is told via a presentation given by an executive director, an audio recording or by the patient in person. It has proved to be a very powerful method of conveying the experience of our patients of the services we provide. The experience of some of our patients is also captured in the six-monthly report of complaints, litigation, incidents and Patient Advice and Liaison Service contacts, received by the Board of Directors and its Governance and Clinical Assurance Committee, and which is shared with our Council of Governors. We remain totally committed to listening to our patients, hearing what they say and responding to their complaint, concern or comment whilst using what patients tell us as an opportunity both to learn and to improve services

Further details of our work in respect of patient experience and patient involvement, are included in our quality report on pages 71 to 77.

- **Local Involvement Networks** – we continue to work with the Local Involvement Networks in our three main localities of Liverpool, Sefton and Knowsley, to develop services closer to peoples' homes
- **Volunteers** - our volunteers continue to give their time, talent and enthusiasm to supporting what we do. This includes talking to and befriending patients, 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. They also support a wide range of events at the hospital such as our service of remembrance, Christmas carols on the wards and our fundraising activities

Last year our volunteers gave a total of 13,041 hours of their time to helping the patients, relatives and staff at the hospital. We recruited 241 people into volunteer positions and we currently have over 170 active volunteers

We continue to recognise the good work our volunteers do by issuing certificates in respect of the hours they volunteer for, their length of voluntary service, providing written references, and hosting awards for Volunteer of the Season and Volunteer of the Year

- **Hotel services** – this has been the first year of working with our new provider of cleaning and catering services, G4S. A new menu has been introduced and ward hostesses serve food to patients having discussed with them each morning what meals they would like through the day. 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 patients are cared for, their privacy and dignity and also the quality of the food we serve
- **Safeguarding** – we continued to be a member of the local Safeguarding Children Boards, led by the Local Authorities, in order to fulfil our statutory duties in respect of The Children Act 2004. The Trust is represented at the Liverpool, Knowsley and Sefton Safeguarding Children Boards, and on the Liverpool Safeguarding Adults Board. We also continue to work closely with our partners in health and social care on safeguarding issues
- **Primary Care Trusts** – our collaborative working arrangements with our host Primary Care Trust continue. Regular contract monitoring meetings were held in respect of the services they purchase from the Trust, including scrutiny of our contracts in respect of quality
- **North West Fertility Limited** – during the year agreement was reached with North West Fertility Limited, with whom the Trust has enjoyed a successful working partnership, to move to a different business model to provide reproductive medicine services at Liverpool Women's Hospital. Our arrangement with North West Fertility Limited accordingly ceased at the end of the financial year and the services it provided brought in-house to the Trust. These services will continue to be available to both NHS and private patients. North West Fertility Limited is in the process of being wound-up
- **Laing O'Rourke** – our partnership with Laing O'Rourke in respect of capital developments has been a great success during the year. Through building work, significant improvements have been made to the environment in which our maternity patients receive care. The new outlay of our maternity wards means that staff are now based in the ward area and have more contact time with their patients

No formal consultations were carried out during the year. In 2012/13 we anticipate conducting consultation processes in respect of a proposed new model for termination of pregnancy services, and the transfer of clinical genetics onto the site of Liverpool Women's Hospital from Alder Hey Children's Hospital. We also anticipate participating in any qualified provider procurements during the year.

## Research and Development

Our commitment to, and involvement in, clinical research continued throughout the year. Details of our research and development activities can be found in the quality report section of this document on pages 83 to 84.

# Sustainability report

## Environmental matters/climate change

We aim at all times to minimise any negative impact on the environment and to play our part in helping to reduce pollution, climate change and any damage to the natural world. Wherever possible we refine working practises to reduce adverse environmental impact whilst at the same time providing excellent patient care.

Our carbon management plan set out a number of carbon reduction schemes which have been implemented during the year, including:

- Introduction of a new way of monitoring energy and water usage. This is now done via online automatic meter reading software which records and reports our energy consumption
- Replacement of lighting controls in the main corridor of the hospital which equates to a 4% saving on our annual electricity consumption
- Rolling-out of our Remote Access Service (RAS) technology which allows out staff to get access to their switched-off computer when they are off site
- Installation of two energy efficient lifts saving us 7.7 tonnes of CO<sub>2</sub> each year. The lifts are also faster and so are more efficient in respect of waiting and travel time
- Pipework lagging in our plant rooms and energy centre with an estimated saving of 459,441Kwh of energy and 87.3 tonnes of carbon
- Introduction of a 'set back' system in our theatres to reduce the amount of theatre equipment left switched on when not in use
- Our Big Push project, which aims to improve facilities for women and their babies, is being constructed using the Building Research Establishment Environmental Assessment Model (BREEAM) making us a more sustainable Trust.

## Performance

Our performance during 2011/12, and for the two years previous, is summarised below:

	Annual usage			Annual cost (£)		
	2009/10	2010/11	2011/12	2009/10	2010/11	2011/12
Gas (Kwh)	4702346	5632074	5055119	129,221	149,701	165,308.50
Electricity (Kwh)	5840748	6050966	5838426	576,249	514,612	558,011.65
Water (m3)	29434	30822	30040	49,329	36,545	39,229.66
Clinical waste (tonnes)	208	203	209	113,480	103,538	102,686.00
Domestic waste (tonnes)	407	407	299	59,647	59,835	59,760.00

## Travel

We have updated our travel plan to make sure it fits entirely with our future vision of care and best enables our patients and staff to get access to the Trust in the most environmentally friendly way. We will continue to promote the use of means of transport that are alternative to the car.

## Priorities and targets for 2012/13

Our commitment to sustainability will continue throughout 2012/13, for which our key priorities and targets are:

- To run an awareness campaign aimed at motivating our staff to reduce energy and waste. This will be run in conjunction with other organisations across the North Mersey health economy
- Preparation of plans to install a combined heat and power unit, a generator powered by gas but which produces electricity, and the exhaust heat from which is used for heating and hot water. Including the possible replacement of a chiller which we estimate could save in the region of 920 tonnes of carbon each year and achieve payback within just over four years
- Introduction of an offensive waste stream which will divert a high proportion of what is frequently treated as clinical waste to an alternative disposal facility
- Promote wider use of BREEAM in our building projects
- Engage even more with our local communities and encourage the use of the grounds at Liverpool Women's Hospital in Crown Street, as a community resource. This approach has already seen the planting and growing of trees herbs in partnership with Project Seacole and local schools.

## Information management and technology

The department of Information Management and Technology (IM&T) has remained committed to providing connectivity and access to all information required by the Trust staff to help them meet the strategic goals of the organisation at the point of care. IM&T has continued to enhance services at the Trust through business process redesign, innovation and the implementation of cutting-edge technology whilst engaging clinical users.

IM&T's goal has remained to deliver flexible, efficient and reliable IT (information technology) services whenever and wherever needed. The department has been able to deliver new hardware, including the replacement of 200 desktops; standardise workstations and application environments; provide remote access to our key clinical systems to allow point-of-care delivery in the community; enhance mobile and remote working for staff; support the development of clinical information; achieve 100% of clinical episodes coded within two working days of the end of each month; develop the next generation, intelligent information infrastructure (data warehouse) to gather critical data from all clinical and non-clinical systems, support business intelligence and effect performance improvements faster and more efficiently.

The IM&T department itself has maintained the following international standards:

- ISO 27001 accreditation in data security
- ISO 9001 accreditation in quality
- ISO 14001 accreditation in environmental management.

## Health, safety and security

The Trust is committed to providing a safe and secure environment for staff, patients and visitors. The Director of Nursing, Midwifery and Patient Experience is the Executive Director with Board level responsibility for health, safety and security management arrangements across the Trust.

Our health and safety achievements and improvements during the year include our health, safety and security related policies undergoing an extensive programme of review and audit in order to comply with the risk management standards set by the NHS Litigation Authority.

The primary causes for concern during the year related to sharps and bodily fluid exposure, security incidents and lone worker compliance with personal protection devices.

In respect of needle stick injuries, our Health and Safety Committee worked closely with the Trust's occupational health department to improve safety and monitor compliance with the Trust's needle stick injury policy. Training was also provided to staff in respect of reducing the risks of needle stick injury. By 2013 the Trust must be compliant with the European Union Sharps Directive which will involve implementation of needle-free and needle-safe devices Trust-wide.

The Health and Safety Committee continues to monitor incidents of violence and aggression within the Trust and reports all security related incidents and breaches to NHS Protect. Following investigations by the Trust and NHS Protect, an organised gang which targeted the Trust and many others across the country, was convicted of numerous charges of deception and theft. Further initiatives to reduce crime within the Trust have been achieved by sharing local intelligence with the local Crime Stoppers team within Merseyside Police. The Local community support police officer also holds regular crime prevention surgeries in the Trust's main reception area, to offer advice to staff, patients and visitors.

All community-based Trust staff who visit patients in their homes are equipped with lone worker protection devices which enables them to discreetly call for assistance in a potentially aggressive situation. The device enables the swift and accurate location of their whereabouts and movements when an alert is activated. Compliance with staff's use of this system has been monitored closely by our Health and Safety Committee as it was reducing; extensive promotion of the system and increased training has therefore been undertaken to encourage our lone working staff to make full use of the protection devices.

## Countering fraud and corruption

The Trust engages the services of a registered counter fraud specialist and is compliant with the requirements of the counter fraud manual, cooperates with NHS Protect and responds to the national proactive reviews. This work is overseen by the Trust's Audit Committee. During the year the Audit Committee approved the Trust's policy and action plan in respect to the Bribery Act 2010.

Counter fraud policies are set out in the Trust's Standing Financial Instructions. We also have in place a whistleblowing policy. The Trust's accountable officer for fraud is the Director of Finance.

The Trust received a Counter Fraud Qualitative Assessment rating of 2 for 2010/11 (the most recent rating available). This is consistent with the previous year's assessment.

### Serious incidents involving data loss or confidentiality breach

During the year there were no serious incidents involving data loss or confidentiality breach.

### 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 2011/12 and the previous year is shown below:

Better Payment Practice Code	2011/12	2010/11
Value of invoices paid within 30 days	69%	64%
Number of invoices paid within 30 days	57%	69%



During 2011/12 there was an improvement in the value of invoices paid and a slight deterioration in the number of invoices paid, due to the implementation of new financial systems. The Trust is reviewing its systems and process in order to ensure improved performance in 2012/13.

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

### 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.

### The position of the Trust at the end of March 2012

The Trust ended the year with a surplus of £3.4m after all expenditure was accounted for. This represents the continued strong financial performance of the Trust in what is an increasingly challenging environment for health care.

The Trust also achieved an overall financial Financial Risk Rating (FRR) of 4 and a green governance rating, as measured by Monitor. For 2011/12 the Trust had a plan to achieve an FRR of 3. The breakdown of this risk rating and comparison with last year is provided in the table below:

Monitor Risk rating	2011/12	2010/11
Earnings before Interest, Depreciation and Amortisation (EBITDA)	3	3
EBITDA Margin	5	5
Return on Capital employed	5	5
Income and Expenditure Surplus	5	5
Liquidity Ratio	4	4
Overall Monitor Financial risk Rating	4	4

It can therefore be seen that the Trust has maintained its overall risk rating of 4 from the previous financial year.

Full details of the Trust's financial performance in 2011/12 can be found in the annual accounts at pages 130 - 164 of this report.

### Business overview

The Trust has two main contracts for its income which are essential for the Trust's business. These are Liverpool Primary Care Trust and North West Specialist Commissioners. In 2011/12 the Trust received £39.8m and £13.2m respectively from these commissioners. These contracts represent 56.1% of the Trust's total income and 62.4% of the Trust's clinical income.

Like most NHS organisations the key challenge facing the Trust in 2011/12 and in future years is the continued need to deliver efficiency savings. The Trust has a strong record of delivering these efficiencies and has plans in place to deliver £6m savings in 2012/13.

## Private Patient income

Our performance against the private patient cap is set below:

Private Patient Cap	2011/12	2010/11
Total Patient Related Income	£85,058,000	£84,418,000
Private Patient Income	£1,415,000	£2,239,000
Percentage of Private Patient Income of total patient income	1.66%	2.65%
Private Patient cap	1.8%	1.8%

The Trust put in place revised arrangements in order to ensure that the Trust would not breach the Private Patient Cap (PPC) in 2011/12. The Trust breached the PPC in 2010/11 due to changes in the way it was calculated.

The majority of the Trust's private patient income came through its arrangement with North West Fertility (NWF). The Trust worked closely with NWF during 2011/12 to ensure there was no breach in-year.

## Capital

The Trust continues to reinvest in its estate, medical equipment and Information technology for the benefit of patients. Details of capital expenditure for 2011/12 are detailed in the table below:

Capital expenditure	2011/12 £000s
Buildings	1,004
Assets Under Construction	5,284
Plant and Machinery	1,049
Information technology	135
<b>Total</b>	<b>7,472</b>

The Assets Under Construction primarily relate to the 'Big Push' maternity redevelopment; the Centre for Women's Health in collaboration with the University of Liverpool; and on information technology which was not in use by 31 March 2012.

## Going concern

After making enquires, the directors have a reasonable expectation that the 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.

## Prudential Borrowing Limit

The Trust had a prudential borrowing limit of £24.4m in the year of which £17.9m related to long term borrowing and £6.5m to a working capital facility. The Trust has not borrowed against the limit.

## One hundred reasons to be proud

It is with very great pleasure that we present in this section one hundred reasons to be proud of Liverpool Women's during 2011/12:



Members of our clinical genetics team

One hundred reasons to be proud	
Our accreditations, certifications and performance	
1.	Liverpool Women's is one of the top 4 hospitals in the country for patient safety by retaining Level 3 accreditation in our assessments by the NHS Litigation Authority and the Clinical Negligence Scheme for Trusts
2.	Our clinical genetics service was re-accredited as a Practice Development Unit, the only one in the country
3.	Ore reproductive medicine team passed their interim inspection by the Human Fertility and Embryology Authority
4.	Our environmental project team obtained certification from the Carbon Trust for our plans to reduce our carbon footprint by 25%
5.	Liverpool Women's was re-accredited against the Investors in People standards
6.	We have delivered against all national access targets offering timely appointments for all patients; 18 weeks in all specialities, early access to a named midwife, cancer pathways, access to treatment and advice in our specialist accident and emergency department, access to imaging and diagnostics.
7.	Delivered a 6% cost improvement programme and released savings through the significant redesign of services and workforce
8.	Achieved a Monitor Financial Risk Rating of 4 as planned and a green Governance Rating
9.	Improved against a range of clinical indicators including reduced neonatal infection and mortality rates
Our People	
10.	Sue Thompson, Midwife for Teenage Pregnancy, was voted Midwife of the Year by the British Journal of Midwifery
11.	Sue Snowdon, Neonatal Nurse, won the Woman of Learning Award at the Merseyside Woman of the Year
12.	Consultant Obstetrician Andrew Weeks and Consultant Neonatologist Bill Yoxall won 'Best Innovation in Service Redesign' at the Medical Futures Awards for the BASICS Trolley (Bedside Assessment, Stabilisation and Initial Cardio respiratory Support)

13.	Midwives Gill Winder, Kate Almond and Ruth Charters won the WOW Award for Best Health Care Provider
14.	Neonatal nurses Sarah Mayne and Vivienne Carr won the Tommy's & Hologic 'Miracle Unit' Award
15.	Our ward hostesses were finalists at the Patient Experience Network Awards
16.	Triona Buckley won North West Deputy Human Resources Director of the Year
17.	Consultant Gynaecologist Roy Farquharson won the Clinical Science Award for his recurrent miscarriage work at ESHRE the European Society for Human Reproduction and Embryology
18.	We were voted the top Obstetric and Gynaecology educational provider in England by GP Trainees
<b>Our Developments</b>	
19.	Our gynaecology team successfully implemented the Enhanced Recovery Programme; reducing the need for High Dependency Care, improving patient experience and shortening stays in hospital
20.	Our patient services team improved access to health records by introducing a closed library
21.	Our community midwives are able to provide 20 additional birthing pools in the community and offer women early access directly to a named midwife
22.	Our maternity service introduced first trimester Nuchal Translucency scanning for NHS patients
23.	Our reproductive medicine team introduced a revolutionary new embryo incubator and introduced ovarian hormone testing to improve success rates for IVF
24.	Our gynaecology-oncology team brought chemotherapy to Liverpool Women's which is a major step forward for women who are on a cancer pathway
25.	Ann Parry, a neonatal nurse, and our Research and Development team have worked to successfully bring the 'Butterfly Pillow' into commercial production
26.	Our neonatal transport team secured funding for and implemented a 24/7 regional transport service
27.	Our clinical audit team introduced the GREAT DAY for governance, research, education, audit and teaching
28.	Our Anaesthetic teams have introduced ROTEM and cell saver technology to better manage bleeding during surgery and improve clinical outcomes after surgery
29.	Our genetics team have introduced Pre-Implantation Genetic Screening and developed the Haematological Malignancy Diagnostic Service for the Wirral
<b>Our investment in the future</b>	
30.	Made a £10m investment to improve maternity facilities and increase midwife to woman contact time by 20%
31.	£2.2m investment in the Centre for Women's Health Research in partnership with Liverpool University
32.	£500k investment to improve our genetics laboratories and increase efficiency.
33.	Investing in staff support with a new Occupational Health Department
34.	Improving patient experience, privacy and dignity through better patient toilet facilities
35.	Improving facilities for mums with a new breastfeeding room and baby changing rooms
<b>Our investment in staff</b>	
36.	Launch of the Trust's 'Putting People First Strategy'
37.	Ran the first 'Top 50' managers and leaders programme
38.	Hosted 'Big Chat' events throughout the year to broaden staff engagement in key issues
39.	Achieved 'excellent' from the Quality Management annual assessment visit and General Medical Council survey
40.	74 members of staff within bands 1-4 successfully completed a National Vocational Qualification
41.	130 post qualified staff achieved a pass or above within a higher education university module

**Our stars of focussing on excellence (Liverpool Women's annual awards ceremony to recognised and reward the amazing contributions made by our staff)**

42.	Excellence in Clinical Innovation and Improvement awarded to the gynaecology team for the piloting and roll out of the 'Enhanced Recovery Programme' reducing hospital stays and time in high dependency care for cancer patients and all patients undergoing surgery
43.	Excellence in Non Clinical Innovation and Improvement awarded to the Macmillan team for 'Evocalise', an up-lifting scheme that has made sure that women suffering from, recovering from or living with cancer have the self confidence to live their lives to the full by setting up a choir for the women of the EVOC cancer support group
44.	Excellence in Research awarded to Ann Parry and the 'Flight of the Navigator' for developing and successfully bringing to the commercial market a positional aid that benefits the babies in our neonatal unit and now any premature baby in the UK or beyond
45.	One Team: One goal (Team working and partnership) awarded to the Gynaecology Team for 'Can you help us? Yes we can!' which saw the team working in collaboration with Alder Hey to bring children's surgery to Liverpool Women's for the first time. The team made sure that the service was set up safely and quickly so that children could continue to access care without any delays
46.	Making Liverpool Women's a Great Place to work awarded to the Genetic Counsellors for 'Valuing Staff is Value for Money'. The team focus on meeting the needs of their patients by also focussing on the well-being of staff within the team. The development of an evidence based bespoke counselling supervision model which now sets the model for other teams
47.	Making Liverpool Women's a Great Place to Receive Care awarded to our Ward Hostesses for 'A Little but of what you Fancy'. Staff in this new role have transformed meal times at Liverpool Women's. They have taken the choosing, presentation and delivery of hospital food to a whole new level
48.	Learner of the year awarded to Betty Reed from the Safeguarding Team for taking the plunge and dramatically accelerating her own knowledge and skills in her new specialist role to deliver training programmes that are tailored to the individual needs of learners
49.	Volunteer of the year awarded to Terry Kay who has overcome learning difficulties and a lack of self-confidence to become a valuable member of the estates volunteer gardening team. He volunteers enthusiastically in all weather, encourages new members of the team and promotes a positive image of the Trust
50.	The Foundation Award, our overall winner was the Anaesthetic Team for Cell Salvage, 'Saving the bleeding world'. This project places Liverpool Women's at the top of the UK in providing safe high risk obstetric surgery. The project has been showcased worldwide and has inspired other Trusts to follow their example
51.	The Excellent Patient Experience Award awarded to midwife Jayne Hanson and nominated by a patient who wrote "She has been amazing and represents what I believe midwives should be about. She was caring, kind and understanding and I would hope that she could receive some recognition for her passion for her profession, If it was not for her I may have had a mini breakdown and she has done above and beyond her duty"
52.	Award for Outstanding Contribution awarded to Jackie Rotherham, Trust Lead for Perinatal Mental Health and Disabilities. One of the entries particularly stood out for the judges because of the long term contribution this member of staff has made to patients and staff locally, regionally and nationally. This member of staff is not only an ambassador for Liverpool Women's but also is a passionate advocate for women with additional needs due to disability or mental health issues. The judges felt strongly that they wanted to formally celebrate the dedication of this individual and their overall contribution to our patients and our Trust
53.	Employee of the year jointly awarded to Vicky Eaton and Angela Purcell following nominations by patients who felt that they had significantly contributed to make their experience positive. Of Vicky, "she made me feel comfortable and confident whilst in her care. She made a special trip to visit me on the postnatal ward after she had finished her shift." Of Angela, "she gave me exceptional care and support. She helped me while my baby was in special care. Her lovely smiley face popped into the cubicle and she said she will make it her personal mission to help me – she is an angel."

<b>Our Contribution to research</b>	
54.	A growing programme of joint research with Liverpool University concerning cellular/physiological mechanisms in labour
55.	Research into endometriosis and endometrial cancer are delivering pivotal findings in gynaecology research
56.	European commission funded research programme exploring the use and safety of medicines in neonates – ESNEE the European Study of Neonatal Excipient Exposure
57.	Recognition from the National Institute for Health Research (NIHR) Clinical Research Network Coordinating Centre for our submission to the Health Service Journal Awards
58.	Research fellowship from the NIHR to study the use of next generation sequencing in the diagnosis of genetic variations for genetic diagnosis
59.	One of two UK sites undertaking emergency research project in obstetrics. The WOMAN trial is looking at using tranexamic acid to treat women who bleed dangerously after giving birth
60.	A growing portfolio tackling the most pressing health research questions from fetal monitoring, recurrent pregnancy loss, obesity in pregnancy, developmental care of neonates, neonatal medicines and nutrition
<b>Our Volunteers</b>	
61.	We are proud to have 141 active volunteers offering time to the Trust.
62.	Our volunteers have given over 12,000 hours of their time this year
63.	Our volunteers run the Trust patient library service
64.	The Macmillan coffee morning is supported by our volunteers
65.	Our patient involvement events have the support of our volunteers
66.	Our volunteers help facilitate our Patient Environment Action Group and Assessments and our Disability Audit Plan
<b>Our Fundraisers</b>	
67.	This year £20,000 has been donated to the Kitty Appeal to support the provision of our neonatal parental accommodation
68.	Kevin Bellion has raised a massive £15,000 in memory of his partner, Carla, to refurbish a second palliative care room at the hospital which will be called the 'Orchid Suite'
69.	The Liverpool Women's Charity has opened a Just Giving page which has already seen £23,000 raised
70.	John and Andrea Barnes are supporting the refurbishment of the 'viewing room' through a Charity Ball and Auction at Chester Race Course
71.	The family of Margaret Lloyd, particularly her widower Tommy, have raised £30,000 for EVOC the gynaecology cancer support group across Cheshire and Merseyside
<b>Our Partnerships</b>	
72.	With Alder Hey; to bring children's surgery to Liverpool Women's
73.	With the Liverpool-Mulago Partnership; to develop high dependency care in Uganda
74.	With Local Improvement Networks; to develop outpatient and ambulatory gynaecology services at Aintree
75.	With the Women's Alliance; working with maternity units over 5,000 births to influence national agenda
76.	With the NSPCC; to promote their Non Accidental Head Injuries programme in Liverpool
77.	With G4S; to continue to improve domestic, portering and catering services
78.	With local school children; making syringe driver bags with personal messages
79.	Became a founder member of the Liverpool Health Partners which will work to integrate clinical services and research across the city



Being influential in our field	
80.	Consultant Gynaecologist David Richmond was appointed Vice President of the Royal College of Obstetricians and Gynaecologists
81.	Consultant Obstetrician Andrew Weeks was appointed Professor in International Maternal Health by Liverpool University
82.	Consultant Obstetrician Devender Roberts was appointed as North West Regional Advisor for the Royal College of Obstetricians and Gynaecologists
83.	Consultant Neonatologist Nim Subhedar was appointed as lead clinician and Chair of the Cheshire and Merseyside Neonatal Network
84.	Consultant Cytogeneticist Angela Douglas was appointed as regional Scientific Director
85.	Consultant Obstetrician Helen Scholefield was appointed to the Department of Health Specialised Commissioning Transition Team as Chair of the Clinical Reference Group for Specialist Maternity Services
86.	Consultant Gynaecologist Roy Farquharson was appointed onto the Advisory Board of ESHRE the European Society for Human Reproduction and Embryology
87.	The launch of the 'Menarche to Menopause' educational programme for GPs
88.	Liverpool Women's began hosting a monthly General Practitioner educational meeting, 9 meeting gave taken place this year
89.	The launch of 'Medicine for Members' educational sessions held every quarter
90.	The introduction of cardio pulmonary respiration training for local school children
91.	Bringing patients and patient stories to the Board of Directors every month
92.	Providing national commentary on clinical developments including caesarean section guidelines, breast feeding, home birth and the place of birth study
Promoting our services	
93.	The Trust's new website was launched and has now been accessed from over 50 different countries
94.	Launched the 'GP Hub' to promote services to our GP Colleagues
95.	Developed a collaboration with other specialist Trusts in Merseyside 'Stars in specialist health'
96.	Presented at GP educational sessions in St Helens/Knowsley
97.	Held the first 'working in partnership' session with Liverpool GP Consortia
98.	Hosted the three part 'Baby Hospital' series for ITV
99.	Currently filming for a BBC4 documentary in the Hewitt Fertility Centre
100.	Worked with ITN and the NHS Alliance to showcase innovation and technology adoption in genetics; next generation sequencing and micro array





# Quality report

## Introduction

**Welcome to Liverpool Women's NHS Foundation Trusts third Annual Quality Report.**

**Liverpool Women's NHS Foundation Trust Quality Report is a review of the quality of services provided to our stakeholders, that is, patients, public, staff, commissioners and partners. This report has been prepared in consultation with our stakeholders and we are grateful for their comments and input which have helped us to produce our Quality Report for 2011/12 which includes plans for 2012/13.**

Looking back over the past year we have, despite the recognised economic pressures, continued to work hard to maintain our focus on quality, clinical effectiveness, patient safety and both patient and staff experience.

The report refers to a number of quality initiatives focussed on providing quality care to the patients and families that use our services; identifies where we need to improve and how improvement in clinical care will be measured.

Neonatal nurses Vivienne Carr (left) and Sarah Mayne (right) receive the the national 'Miracle Unit' award from Tommy's, a leading baby charity



## Statement of Quality from the Chief Executive

The Liverpool Women's NHS Foundation Trust Quality Report for 2011/12 is our third Quality Report. It gives us the opportunity to look back at what we have already achieved over the past year and forward to what we hope to achieve in the future. We at Liverpool Women's NHS Foundation Trust recognised that it is easy and tempting to focus on areas of strength, but that 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 continue to maintain our focus 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 improve our recording of accurate and relevant data about our services over a broad range of outcome indicators and aim to use this information to assure quality and further drive improvement through the establishment of clinically meaningful metrics.

Last year, I wrote of the 'long and relentless quest to improve services wherever possible', I very much recommitted myself, the Board of Directors and every member of staff in the organisation to delivering that clear and straightforward objective. Whilst this report details a wealth of sophisticated measures and metrics, the purpose is simple:

- Provide assurance and confidence that clinical performance and standards are high
- Identify where further improvement can and will be made

I hope you will find a little time to review this Quality Report – as ever Liverpool Women's Hospital NHS Foundation Trust welcomes feedback – if you have any questions or thoughts about the Quality Report – we would be delighted to hear from you, in the first instance by e-mail at: [Quality.Report@lwh.nhs.uk](mailto:Quality.Report@lwh.nhs.uk).

As Chief Executive, I am pleased to see the progress that has been made since the publication of our last Quality Report for 2010/11. We are particularly proud at achieving our second successive year without any MRSA infection and are pleased to see the ongoing development of rigorous and timely automated data collation processes to inform our monitoring and quality improvement initiatives.

Highlights of our achievements in 2011-12 include:

- The opening of the first phase of the Big Push building project on the site of the Women's Hospital, giving en-suite facilities to all patients who have their baby with us
- Our close work with Liverpool, Sefton and Knowsley LINK (Local Involvement Network) groups in the redesign of the services to be provided from Aintree Centre for Women's Health in 2012/13
- Becoming a founder member of Liverpool Health Partners which will work to integrate clinical services and research across the city
- Our development and piloting of a prototype trolley for neonatal resuscitation that allows a newborn baby to be cared by next to their mother in the minutes after birth.
- We achieved top education provider in the country for General Practitioner/ Vocational Training Scheme placements as measured by the trainees themselves through General Medical Council survey.

The Trust has continued to reinvest in its estate, medical equipment and Information technology for the benefit of patients. Details of capital expenditure for 2011/12 are detailed on page 31 in this report.

This year's publication is the next step in our quest for improvement and includes our priorities for 2012/13 aimed at further improving 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 again like to offer a big thank you to our staff, patients and our community for a very successful, quality driven and productive year.



Kathryn Thomson,  
Chief Executive  
28 May 2012

## Our Commitment to Quality

Last year on page 15 of the Annual Report and Accounts 2010/2011, we stated, in summary of our Safety, Effectiveness and Experience achievements that:

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

And so we did. However the Quality Report is part reflection and part look forward, it is an opportunity to provide plain and simple evidence of improvement in our services over the last year combined with highlighting what we hope to achieve next.

The NHS landscape is changing and our successes in 2011/12 will count for very little unless we constantly strive to do better in 2012/13, 2013/14 and further. As one of only two organisations in the NHS dedicated to the provision of services to Women and their families, we will look to measure our performance against the very best nationally and internationally. We will do this openly, sharing with you results that can give you confidence in the services we provide.

Newborn baby Jay-Lo gets a cuddle from the country's Chief Nursing Officer, Dame Christine Beasley pictured with proud parents Ivor and Natalie



## Focus on Quality

We have continued to shape and influence the quality agenda as one of our key priorities during the year. We have focussed on a number of projects and initiatives to improve the safety and outcomes of clinical services as well as improving the experience of patients. Below are some examples of the work we have been doing.

### Energising for Excellence

Energising for Excellence (E4E) is a national initiative, which defines and demonstrates the contribution of nursing and midwifery to patient experience, outcomes and staff experience. Having undertaken the preparatory work during 2011/12, we launched within the Trust on the 15 March 2012. Over the past months we have been engaging in a number of national E4E events, as well as undertaking local preparation, developing systems to capture data and working with our ward and department teams to define which initiatives and metrics they wish to use for their own areas.

### Enhanced Recovery Programme

The Enhanced recovery Programme is an NHS initiative that focuses on the care of patients before during and after their operation. The programme encourages patients to take ownership of their own care and aims to reduce complications, the length of their stay in hospital and the readmission rate, whilst increasing patient involvement in clinical decisions. Following a successful pilot of enhanced recovery with a cohort of oncology patients, in February 2012, the project team have now implemented enhanced recovery pathways for all elective gynaecology patients.

There are 5 specific pathways in place

1. Urogynaecology
2. Complex gynaecological surgery
3. Laparoscopic gynaecological surgery
4. 24-36hrs intermediate surgery
5. 3-4 days major surgery

The team have also developed a pathway to support gynaecological day surgery.

Feedback from patients is fundamental to any new project and recent ward assessments have reported that patients said:

- "The enhanced recovery pathway was excellent and made me feel involved in my care"
- "It helped me plan for going home, and what to expect"
- "I was able to share with my family the diary and what was going to happen."

### Liverpool - Mulago Partnership

Liverpool Women's has the largest maternity unit in this country, delivering over 8000 babies a year; Mulago Hospital is the largest in Uganda with 30,000 births a year. Through our Liverpool-Mulago partnership set up in 2009, we continue to support the Mulago Hospital in Uganda to improve the care it is able to offer women and babies in Uganda.

Since the partnership was established, doctors, midwives and other people from Liverpool Women's have been spending time in Mulago, sharing their expertise and helping in the training of staff. At the same time, staff from Mulago have travelled to Liverpool to experience how we work and share with our teams the expertise that they have in dealing with conditions now rarely seen in the UK.



With help from our staff, a high dependency unit has now been set up at Mulago. It is not the sort of high tech, well equipped unit we have here but a room cleaned and decorated by Liverpool staff. It has six beds and the basic essentials. Even so, it is already helping to save the lives of women with life threatening conditions such as pre-eclampsia, haemorrhage and ruptured uterus who would rarely lose their lives in our country. There is also an assessment room now so that it can quickly be recognised when a woman has developed dangerous symptoms. There is still much more to be done and Liverpool Women's looks forward to the continuation of this partnership.

Our Medical Director, Jonathan Herod, a gynaecological and oncology surgeon, has recently spent time in Mulago and found there is a huge problem with cervical cancer which is usually diagnosed in its late stages while deaths from gynaecological and obstetric complications are commonplace. He said on his return: "It is a very humbling experience to see how big the gap is between the services we can provide and those in Mulago Hospital. Staff there are treating large numbers of very ill patients with minimal resources."

As part of our ongoing effort, he is hoping we may be able to develop some training opportunities here in Liverpool for the Mulago Oncology team and is collaborating with Canadian doctors from British Columbia to try and develop a gynaecology oncology service in Mulago.

A research centre is also to be set up at Liverpool Women's with the University of Liverpool which will be named after Edith Sanyu; a Mulago patient who unfortunately died after complications that led to the rupture of her uterus and a fatal haemorrhage. The centre will concentrate on improving the care of women like her in developing countries.

## Looking back 2011/12

### Review of Quality Performance

#### Priorities for improvement

Liverpool Women's NHS Foundation Trust aims to provide its users and their families with care of the highest safety and quality. This document sets out our approach to achieving this and includes our look back at the past year (2011-12) and our quality priorities for 2012-13.

Key to our commitment to safety and quality, is our desire to ensure that we learn from the experiences of our patients and staff and from the information they provide improve what we do in future. Intelligence gathered from the complaints made by our patients, the issues they raise with our Patient Advice and Liaison Service (PALS) and that from the reporting of serious incidents and other feedback is reviewed and reported through our governance structure to ensure that we capture learning opportunities and make responsive changes to address the issues and improve the services and patient experience we provide.

Examples of the changes made from this process are included here and in the patient experience review of this report.

In response to a patient comment that they did not receive a breakfast fitting their dietary and care requirements until 10.00 am; we re-launched the "red tray" system with the ward staff and the new catering company that started in April. (The red tray system is a national scheme to ensure patients who need assistance with nutrition receive the help required). We also introduced ward hostesses who are aware of all the patients catering needs in their areas.

When we learned that dentures had been “lost” on the ward we secured a supply of denture pots which are now included in the ‘To Come In’, or ‘TCI’ packs provided to patients at admission; (these contain undergarments, hat, theatre gown and denture pot and a patient property bag). We also introduced the use of a patient property bag to return patients’ property such as their dressing gown, when they return from theatre and this also includes a denture pot.

Changes arising from issues and deficiencies identified in the investigation of serious incidents include:

- Updated guidelines for Intermittent Auscultation (non-continuous listening to the fetal heart beat) and updates to both National and Local Guidance on the requirement for ultrasound hip examination after birth for all cases where the fetus was in the breech position on any occasion after 36 completed weeks gestation.
- Creation of field within Meditech, the Trust’s patient information system, to record breech presentation at any stage beyond 36 completed weeks gestation.
- Audits on efficacy of records management system to identify and ensure the availability of all separate records relevant to IVF appointments.
- Requirement for re-suturing of opened abdominal wounds post surgery to be performed under direct vision of the surgeon performing the task.
- Provision of controlled drugs disposal kits to clinical areas to facilitate appropriate safe disposal of controlled drugs and cessation of inappropriate disposal ‘down the sink’.
- Increase from 50% to 100%, the proportion of Neonatal Consultants trained in the scanning procedure required to diagnose Pericardial/Cardiac Tamponade.

Over 2011/12 we have sought to monitor the same measures and metrics as we scrutinised in 2010/11. We have done this deliberately to aid us in measuring the improvement year on year and to ensure that staff across the organisation become increasingly familiar with how we measure our own success. We have used familiar headings to describe and monitor our quality quest in 2011/12:

## Patient Safety

- Gynaecology Surgical Site Infections
- Ovarian Hyper Stimulation Syndrome
- Incidence of multiple pregnancy
- Late onset Neonatal bloodstream infections
- APGAR scores<sup>4</sup> < 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 for babies born alive after 24 weeks gestation.
- Wound infections following Caesarean Section
- Incidence methicillin-resistant staphylococcus aureus (MRSA) Bacterium,
- Incidence of Clostridium Difficile
- Incidence of methicillin-sensitive staphylococcus aureus (MSSA) Bacterium
- Medication Errors
- Accidental Perforation or Damage

4 The Apgar score is a number arrived at by scoring 5 features (Heart rate, Respiratory effort, Muscle tone, Skin Colour and Response to a catheter in the nostril). Each of these objective signs can receive 0, 1 or 2 points. A score of 10 indicates that the infant is in the best possible condition. An infant with an Apgar score of 0-3 needs immediate resuscitation. The Apgar score is done routinely 60 seconds after the birth of the infant and then is commonly repeated at 5 minutes after birth. In the event of a difficult resuscitation it may be done again at 10, 15 and 20 minutes.



## Clinical Effectiveness




- Readmission Rates in Gynaecology
- Mortality Rate in Gynaecology
- Biochemical 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
- 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

## Review of Performance

Please note that in the following sections the charts presented show the monthly instances for the measure in bars and may have a blue line showing the level of activity and a black line showing the trend in the data. Where possible, two years data is shown with 2010/11 on the left and 2011/12 on the right. Some measures were introduced in 2011/12 and show only the one year's data. Each chart is accompanied with an improvement indicator in accordance with the following key:

		
Improvement in performance against the measure shown over the period.	Performance against the measure shows stable /insignificant change or cannot be judged due to concerns described in associated text	Performance against the measure showed a decline over the period.

## Patient safety

### Surgical Site Infections

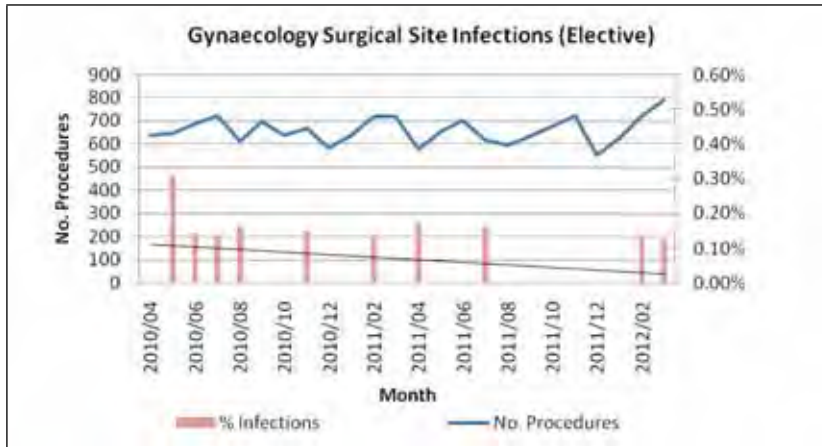
Surgical site infection is one of the commonest causes of post operative morbidity and delayed recovery. A reduction in the incidence of infection will have a significant impact on patient recovery. The prevention and treatment of surgical site infections is outlined in NICE Clinical Guidelines (2008). CG74. The following graph shows the percentage of patients who underwent elective surgical procedures reported with a surgical site infection by month at the Trust.

### Elective Surgical Site Infections

Definition: The number of patients undergoing an elective Gynaecological surgical procedure where an infection has been identified at the surgical site during their inpatient episode. The number is expressed as a percentage of all patients undergoing a Gynaecological surgical procedure.

Data source: Meditech

In the year 2011-12 the Trust encountered 4 elective surgical site infections in 7,866 elective procedures, a rate of 0.05% or approximately 1 per 2000 procedures. The following figure shows these as percentages of the monthly procedures.



**IMPROVEMENT?**

	Procedures	Infections	%
2010-11	7965	7	0.09%
2011-12	7866	4	0.05%

*“Although these figures are retrospective, and are known to underestimate the true infection rate (due to under reporting and patient treatment outside the hospital), the continued fall over several years of a consistently measured assessment of infection is greatly encouraging, and a testament to the effectiveness and hard work that has gone into infection reducing measures, such as hand washing, the WHO surgical checklist, and the No Touch Technique for all invasive interventions.”*

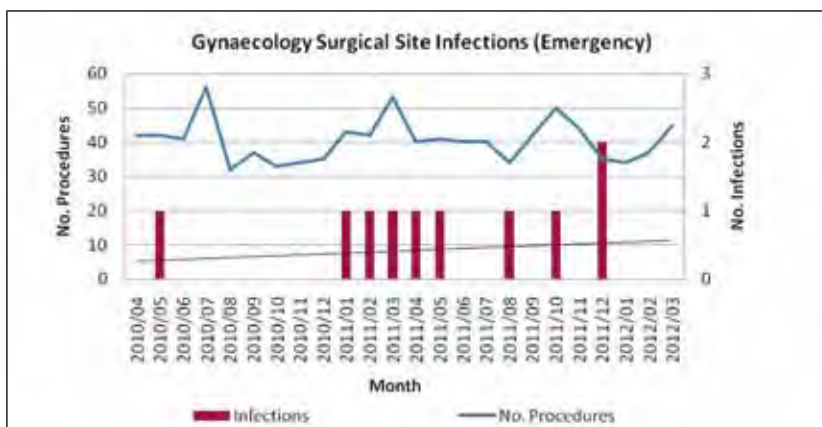
Mr Robert MacDonald, Consultant Gynaecological Oncologist/ Gynaecology Clinical Governance lead.

## Non-Elective Surgical Site Infections

Definition: The number of patients undergoing a non-elective Gynaecological surgical procedure where an infection has been identified at the surgical site during their inpatient episode. The number is expressed as a percentage of all patients undergoing a Gynaecological surgical procedure.

Data source: Meditech

In the year 2011-12, the Trust encountered 6 non-elective surgical site infections in 535 emergency procedures, a rate of 1.12% or approximately 1 in 90 procedures. The following chart shows monthly instances of infection and the monthly number of procedures. The black line is a plot of the trend in the data.



**IMPROVEMENT?**



	Procedures	Infections	%
2010-11	490	4	0.82%
2011-12	482	6	1.24%

*"The lack of fall in infections in emergency operations (in contrast to the success in improvement in elective cases) shows this to be the next area for focus for the hospital."*

Mr Robert MacDonald, Consultant Gynaecological Oncologist/ Gynaecology Clinical Governance lead.

## Ovarian Hyper Stimulation Syndrome - Eggs Collected >20

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.

As explained in the Quality Report for the previous period, from 2010-11 we decided to choose number of eggs collected in excess of 20 as 'indicative' of ovarian hyper stimulation as the definition is not universally agreed upon. More than 20 eggs would be considered by most IVF units to be too many. Our unit average was then about 10 eggs retrieved per collection.

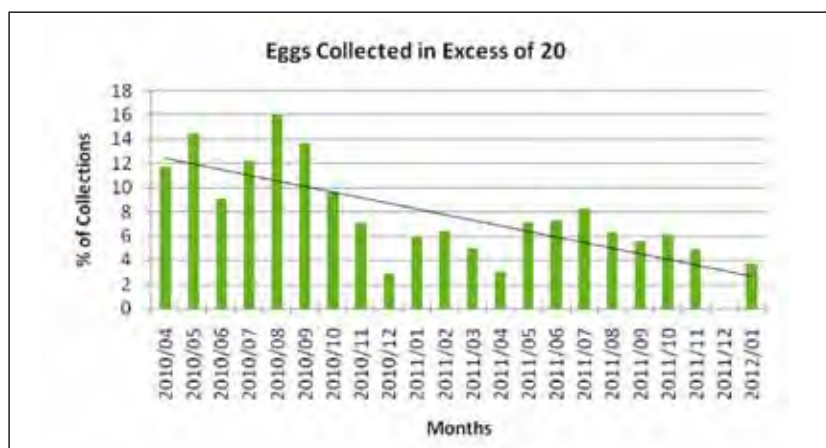
Definition: The number of egg collections where >20 eggs are obtained/the total number of egg collections in period.

Data source: IDEAS, the Reproductive medicine database system.

The following chart shows the continuing downward trend in the proportion of egg collections from which more than 20 eggs were obtained as evidenced in the data available to January 2012.

*"In 2010, we felt that the number of patients having more than twenty eggs collected was too high as this can lead to the potentially fatal condition of ovarian hyperstimulation syndrome (OHSS). We therefore amended our stimulation protocol by reducing the dose of gonadotrophins administered and also introduced a 'mild IVF' stimulation protocol option. We also altered our egg collection policy. As a result, it is pleasing to see a far lower rate of excess egg numbers obtained (4% down from 16%). For 2012, we wish to continue to look at OHSS, but will alter the way we measure this to record the number of patients admitted to the gynaecology ward as a reflection of severity of symptoms. OHSS requiring hospital admission is now a reportable incident to the Human Fertilisation & Embryology Authority (HFEA)."*

Andrew Drakeley, Consultant Gynaecologist/Reproductive Medicine Clinical Governance Lead



**IMPROVEMENT?**

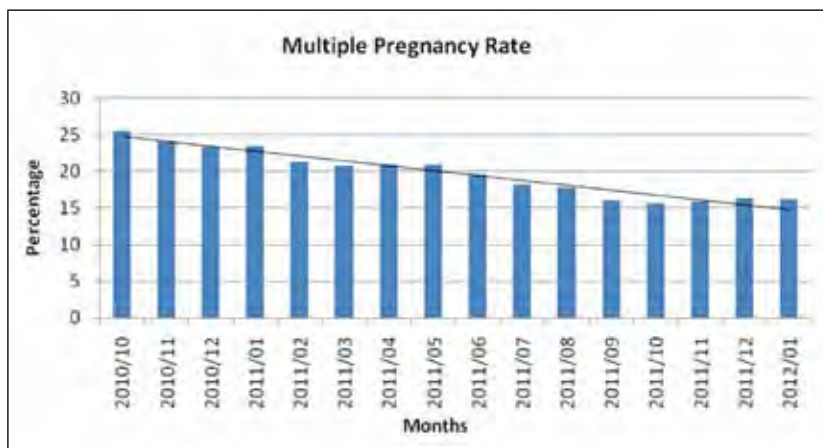
## Multiple Pregnancy Rate

Definition: The multiple pregnancy rates (MPR) are calculated as number twins (and triplets)/number clinical pregnancies x 100. This is one of the Hewitt Fertility Centre's Quality Indicators and is examined on a monthly basis by looking at the MPR for the previous 12 month period. This allows us to assess our performance in relation to the HFEA's targets (please note the HFEA target is multiple birth rate not multiple pregnancy rate).

Data source: IDEAS the Reproductive medicine database.

For some couples, twins bring an 'instant complete family' and for childless couples this may be an attractive thought. In addition, 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 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.



**IMPROVEMENT?**

The above bar chart shows the decreasing proportion of multiple pregnancies over the period October 2010 to January 2012.

*"The fertility regulator, Human Fertilisation & Embryology Authority (HFEA) has mandated that all fertility clinics should be able to demonstrate that they are making every attempt to reduce their multiple birth rates, as this is associated with far higher obstetric & neonatal problems than a singleton pregnancy. Clearly, we are aiming to achieve this without a drop in overall pregnancy rates. Currently, we are aiming for a 15% live twin rate, however from October 2012 this level is set to reduce further to 10%. It is very pleasing to see that following the introduction of a selective embryo transfer policy, our twin rate has fallen month on month towards the 15% mark. The most recent monthly figure at the time of writing was 13.8%. We need to continue to re-examine this policy in order to achieve the new lower rate by the end of 2012. Note that the HFEA targets are 'live' birth rates, whereas we are able to more easily measure ongoing 'clinical' pregnancy rates (heart beat seen on scan). Some twin pregnancies early on ultimately deliver a single baby. To help manage this, the HFEA are introducing an alert system for clinics to pre-warn them that their registered clinical pregnancy rates are falling outside of the accepted national range so that they can react earlier and further amend their embryo transfer policies."*

Andrew Drakeley, Consultant Gynaecologist/Reproductive Medicine Clinical Governance Lead.

## Late Onset Neonatal Blood Stream Infections

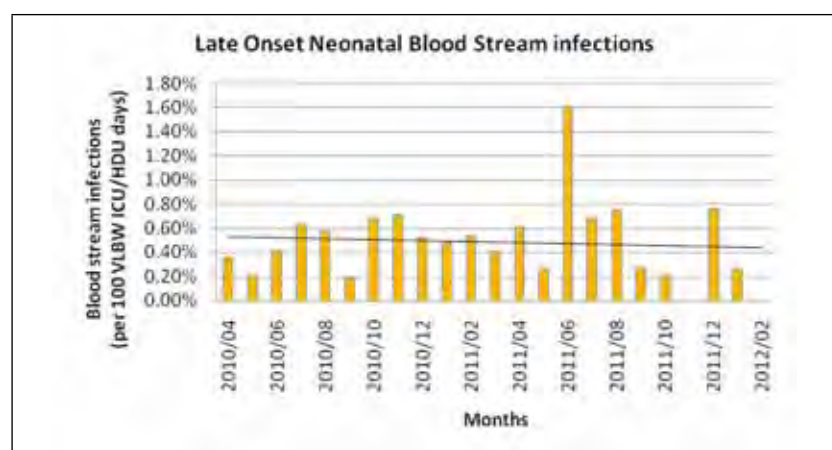
Definition: The number of pre-term babies (<30wks gestation) with late onset (post 72hrs) bloodstream infections per total number of days that very low birth weight (VLBW) babies have spent in either intensive or high dependency care. [Where VLBW means a birth weight below 1500grams]

It should be noted that congenital infections (i.e obtained from the mother) within 3 days and repeated positive blood tests are excluded from the numbers.

Data source: "Badger" the Neonatal database system.

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 a significant cause of morbidity and mortality in newborn babies. NBSI is also one of the national quality markers in neonatal medicine adopted by the NICE Quality Standards and National Neonatal Audit Programme.

The following chart shows the preterm late-onset NBSI rate for 2010-2012. The monthly rate of NBSI varied between 0 and 1.6 infections per 100 ICU/HDU days.



**IMPROVEMENT?**

*"Although there is no nationally agreed benchmark for neonatal infection, we have previously set ourselves a target of maintaining an overall infection rate of below 0.5 infections per 100 ICU/HDU (i.e. one infection per 200 care days). The mean rate during this period was 0.48 and 0.49 infections per 100 ICU/HDU days in very low birth weight babies, in 2010/11 and 2011/12, respectively. The high infection rate in June 2011 related to three cases of methicillin-sensitive Staphylococcus Aureus infection. Despite no specific cause being identified, infection control and prevention practices were reinforced and ongoing infection surveillance has demonstrated a return to low baseline monthly infection rates."*

Nim Subhedar, Consultant Neonatologist/ Neonatal Clinical Governance Lead

N.B. The nature of this measure forces a lag time in establishing monthly data and as a consequence March 2012 data is unavailable at the time of writing.

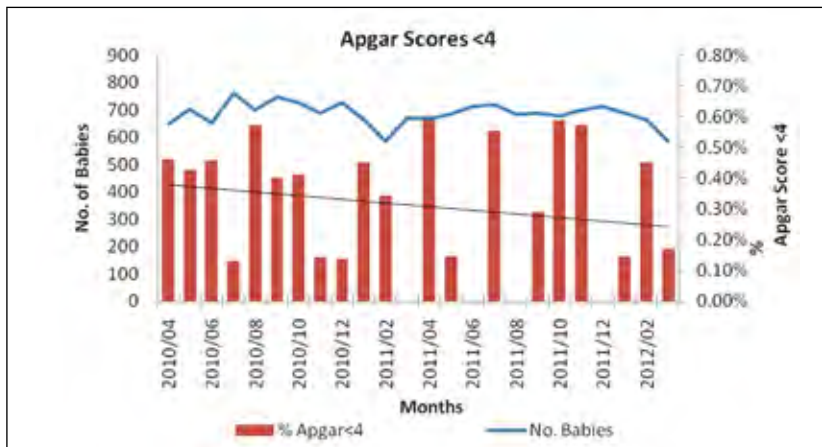
## Apgar Scores <4 (at 5 mins)

Definition: The number of live births after 34 weeks gestation where the Apgar Score at 5 minutes is less than 4. The number is expressed as a percentage of all live babies born after 34 weeks gestation. (Exclusions apply to these calculations where baby has been born before arrival of midwife).



Data source: Meditech

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 mothers 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.



**IMPROVEMENT?**

In the year 2011-12 the Trust reported 24 of 8178 babies with an Apgar score <4, or 2.9 per 1000 babies. This rate is slightly down on the previous period. (3.2 in 2010/11, 3.7 in 2009/10) - Mark Clement-Jones, Consultant Obstetrician.

Statistical Process analysis indicates that the data shows normal variation.

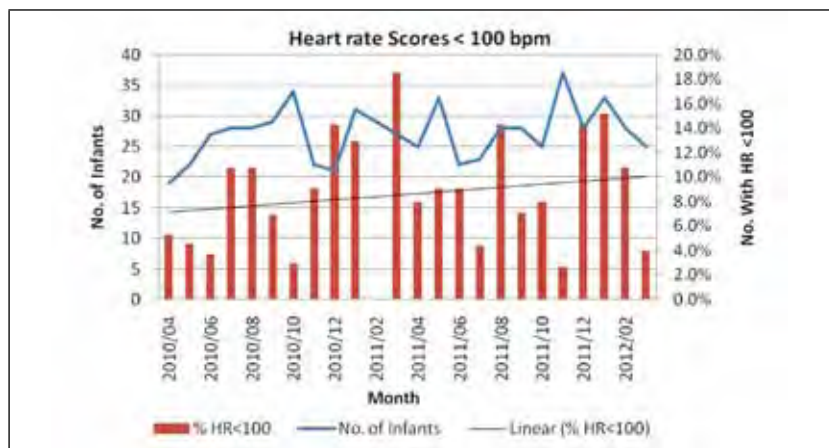
### Baby Heart Rates <100

Definition: The number of live births born before 34 weeks where the baby heart rate is less than 100. The number is expressed as a percentage of all live babies born before 34 weeks. (Exclusions apply to these calculations where baby has been born before arrival of midwife).

Data source: Meditech

*"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. 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. In the Year 2011-12, the Trust reported 30 infants with a heart rate below 100 beats per minute (bpm) in 335 babies born at less than 34 weeks gestation. This equates to a figure of 8.96% and compares with figures of 6.84% in 2009/10 and 8.01% in 2010/11."*

Mark Clement-Jones, Consultant Obstetrician.



IMPROVEMENT?



Statistical Process analysis indicates that the data shows normal variation.

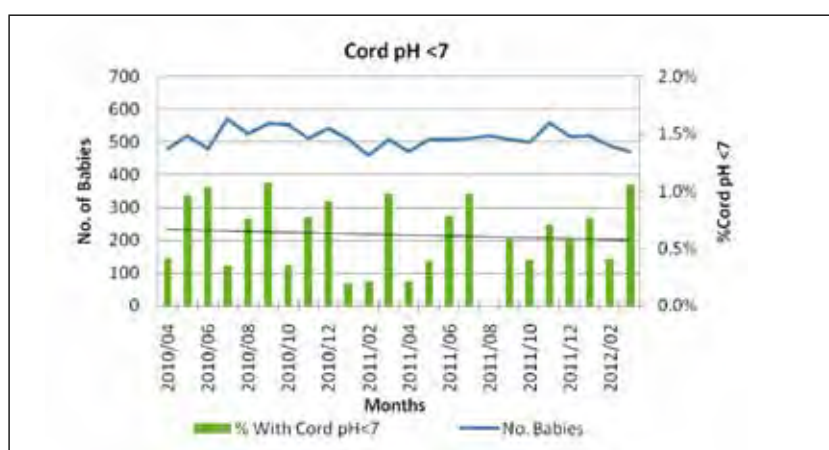
### Delivery Cord pH <7

Definition: The number of live births after 24 weeks gestation with a where the arterial cord pH is recorded as less than 7. The number is expressed as a percentage of all births after 24 weeks with a recorded pH. (Exclusions apply to these calculations where baby has been born before arrival of midwife and for babies born on Midwifery Led Unit).

Data source: Meditech

*"The 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). In the year 2011-12 the Trust reported 35 of 6,085 babies with a cord pH less than 7; an incidence of 5.7 per 1000, this compares with figures of 5.53 for 2010/11 and 5.8 for 2010/11."*

Mark Clement Jones, Consultant Obstetrician.



IMPROVEMENT?



Statistical Process analysis indicates that the data shows normal variation.

### Wound Infections Post Caesarean Section

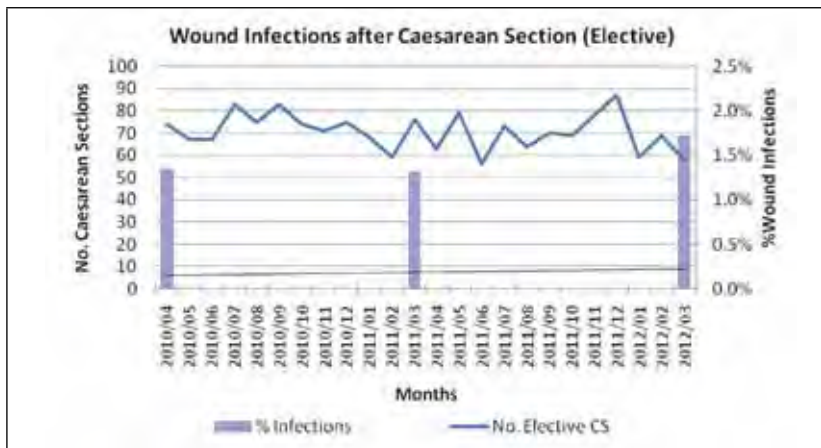
Wound infection following caesarean section is a significant complication following delivery, which is potentially avoidable. NICE Guidelines covering this area include Caesarean Section (2004), Intrapartum Care: Care of healthy women and their babies during childbirth, Surgical Site Infection: Prevention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



## Wound Infections Post Caesarean Section (Elective)

Definition: The number of patients undergoing an elective Caesarean Section who exhibit signs of an infection at the surgical site during their inpatient episode. The number is expressed as a percentage of all patients undergoing an elective Caesarean Section.

Data source: Meditech



**IMPROVEMENT?**



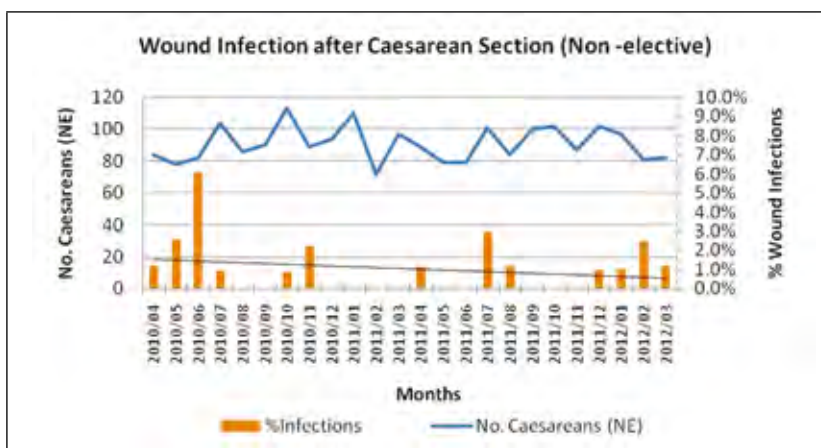
(see commentary)

In the Year 2011-12 the Trust reported a single case of wound infection following an elective caesarean section amongst 825 performed equating to an annual incidence of 0.12%.

## Wound Infections Post Caesarean Section (Non-Elective)

Definition: he number of patients undergoing a non-elective Caesarean Section who exhibit signs of an infection at the surgical site during their inpatient episode. The number is expressed as a percentage of all patients undergoing a non-elective Caesarean Section.

Data source: Meditech



**IMPROVEMENT?**



(see commentary)

In the Year 2011-12 the Trust reported 10 instances of wound infection following Non-elective Caesarean section in a total of 1083 performed. This equates to an incidence of 0.92% or approximately 9 per 1000 non-elective Caesareans.

Although we closely monitor the rate of infection following caesarean-section delivery, our clinical systems allow us to identify only the infections that occur during the period when the patient is under our direct care. We are aware that infections can be contracted during the patient's stay but only become apparent after the patient has been discharged. One of the challenges for us going forward is to work more closely with our partners in the community and diagnostic services to improve measurement and, therefore, reporting.

## Infection Incidence for Methicillin Resistant Staphylococcus Aureus, Clostridium difficile and Methicillin Sensitive Staphylococcus Aureus

### MRSA

Definition: The number of MRSA infections identified by a positive MRSA laboratory test each month. Only cases after 48hrs of admission are counted as hospital acquired rather than community acquired. Repeat positive tests >14 days apart are considered separate infection episodes.

Data source: Microbiology Laboratory Royal Liverpool University Hospital.

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 the antibiotic 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.

### Clostridium difficile

Definition: The number of C. difficile infections identified by a positive Clostridium difficile laboratory test each month in patients over 2 years of age.

Only cases where the Trust is deemed responsible; i.e. where the sample was taken on or after the patients 4th day as an in-patient are counted. Nb. For long stay patients positive results >28 days apart are considered as separate infection episodes.

Data source: Microbiology Laboratory Royal Liverpool University Hospital.

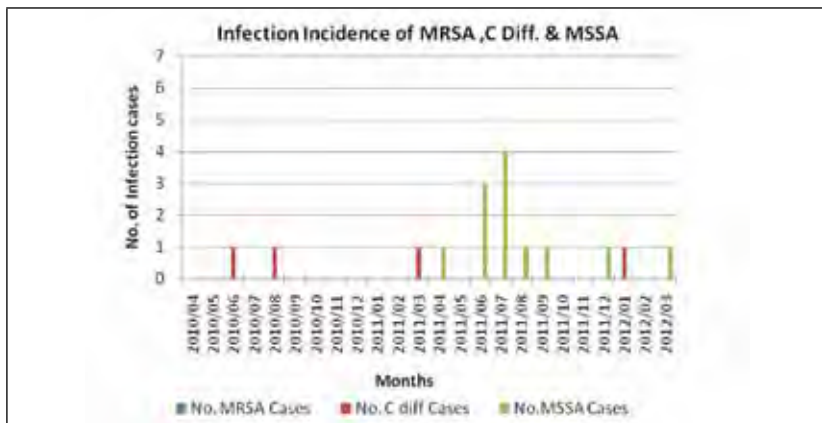
Clostridium difficile (C. difficile) are bacteria that are present naturally in the gut of around two-thirds of children and 3% of adults. C. difficile does not cause any problems in healthy people. However, some antibiotics that are used to treat other health conditions can interfere with the balance 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.

### MSSA

Definition: The number of MSSA infections identified by a positive MSSA laboratory test each month. Only cases after 48hrs of admission are counted as hospital acquired rather than community acquired. Repeat positive tests >14 days apart are considered separate infection episodes.

Data source: Microbiology Laboratory Royal Liverpool University Hospital.

The term MSSA (Methicillin Sensitive Staphylococcus aureus) is used to describe those strains of the Staphylococcus aureus bacterium (germ) that are sensitive (not resistant) to the antibiotic Methicillin. Trusts are now required to collate data on the incidence of infections involving MSSA and the data for 2011-12 is included in the following chart. As the factors which lead to infection with MSSA in adults are identical to those for MRSA the inclusion of MSSA within the National Surveillance data set is expected to demonstrate similar success in reducing infections.



  
**IMPROVEMENT?**

Source: Clinical Coding Data

Infection Instances	MRSA	C.diff	MSSA
2009-10	2	1	Not Collected
2010-11	0	3	Not Collected
2011-12	0	1	12

*"In the year 2011-2012, the Trust reported no instances of MRSA infection, a single case of Clostridium difficile infection and 12 cases of MSSA infection. The Trust takes extremely seriously its duty to prevent infection and provide care in a safe environment. For the second successive year no patients developed MRSA bacteraemia. A single adult patient developed bacteraemia as a consequence of MSSA infection; however this infection was associated with community acquisition and not related to the care delivered in the Trust. The remaining 11 infections with MSSA occurred in patients cared for on the neonatal unit. There was a single patient with C. difficile infection which is a reduced incidence compare to previous years."*

Dr Tim Neal, Consultant Microbiologist/Director for Infection Prevention and Control.

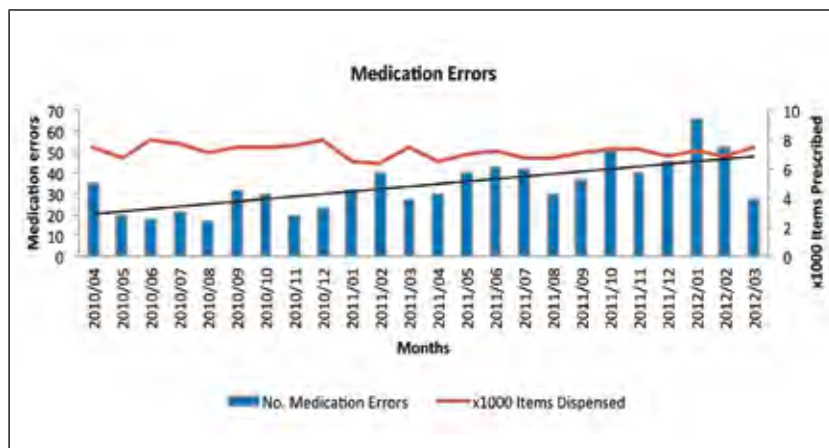
## Medication Errors

Definition: The number of recorded instances where an error has occurred at any point during the administration of medication.

Data source: Ulysses, the Trust's Incident/Risk database system.

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 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 data shows 503 medication errors amongst 84248 items prescribed in the year 2011-12, this equates to an error rate of ~0.6%. This compares to a rate of 0.35% for the previous year. Although the medication error rate appears to be increasing as shown by the trend line on the chart, it is thought that the rise is due to an increase in reporting rather than an increase in errors, this conclusion is consistent with a known shift from 'batch' reporting of some incidents to separate reporting of individual incidents. There has been a drive to encourage staff to report errors as this information is vital for us to identify and analyse the incidents. The more information we have helps us to reduce the risk factors that result in medication errors.



**IMPROVEMENT?**



(see commentary)

*"The pharmacy are currently working with the Risk team on an electronic tool to review medication administration errors so that errors can be effectively risk scored consistently across the Trust. The aim will be to use the concept of this tool to review other medication error types and potentially develop other non medication incidents risk scoring tools."*

Eileen Reynolds, Chief Pharmacist.

## Accidental Perforation or Damage

Definition: The number of patients undergoing a Gynaecological surgical procedure where accidental perforation has been identified and occurred during the surgical procedure. The number is expressed as a percentage of all patients undergoing a Gynaecological surgical procedure.

Data source: Meditech.

Originally an internal measure in Gynaecology, this measure was introduced in the Quality Report for 2011-12. Data is collated on 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. 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 patient's 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 division reports on this indicator monthly, with instances being recorded as episodes and as a percentage of procedures performed.

The Division aims to audit all cases where accidental perforation or damage has occurred to assess for trends and take appropriate action as required.



**IMPROVEMENT?**



(see commentary)

*"The data shows that 71 instances of accidental perforation or damage were recorded by the Trust in the year 2011-12 this equates to an incidence of 0.84% or approximately 1 in 119. The gradual creep upwards of the accidental perforation rate (injury to the patient during surgery) within Gynaecology has coincided with the increasing complexity of the Gynaecological surgery (particularly in Gynaecological Oncology) that has developed over the past 2-3 years. However, this is not to assume the rate is acceptable, and in view of this, a review of cases of accidental injury over the past year by the Gynaecological Oncology consultants is underway, and prospectively, a monthly review of all cases coded as an accidental injury is due to commence in May/June 2012 to ensure any potential recurring problem is not overlooked."*

Mr Robert MacDonald, Consultant Gynaecological Oncologist/Gynaecology Clinical Governance lead.

## Clinical Effectiveness

### Re-admission rates in Gynaecology

Measurement of re-admissions is part of the CQUIN payment framework<sup>5</sup> 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.

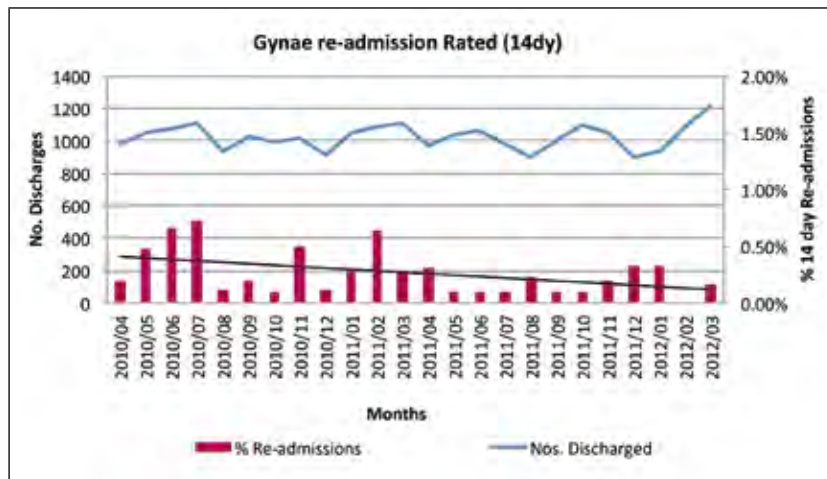
### 14 Days Gynaecological Re-Admissions

**Definition:** The number of hospital admissions where the patient has a recorded discharge from a hospital spell within the last 14 days. The number is expressed as a percentage of all discharges. (Exclusions apply for diagnoses and procedures that conform to the allowed list of exclusions agreed with PCT).

Data source: Meditech.

<sup>5</sup> The CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals.





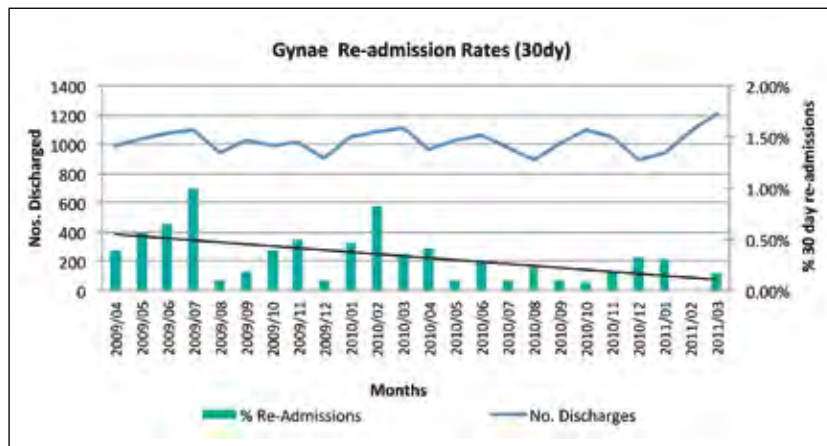
**IMPROVEMENT?**

14-day	Discharges	Readmissions	%
2009-10	12599	45	0.36%
2010-11	12334	45	0.36%
2011-12	12217	20	0.16%

### 30 Day Gynaecological Re-Admissions

Definition: The number of hospital admissions where the patient has a recorded discharge from a hospital spell within the last 30 days. The number is expressed as a percentage of all discharges. (Exclusions apply for diagnoses and procedures that conform to the allowed list of exclusions agreed with PCT).

Data source: Meditech.



**IMPROVEMENT?**

30-Day	Discharges	Readmissions	%
2009-10	12599	73	0.58%
2010-11	12334	59	0.48%
1011-12	12217	23	0.19%

The data for 2011-12 shows that 20 of 12,217 discharged patients were re-admitted within 14 days; an incidence of 0.16% or approximately 1 in 625.

By the 30-day benchmark, 23 of the 12,217 discharged patients had been re-admitted; an incidence of 0.19% or approximately 1 in 526.

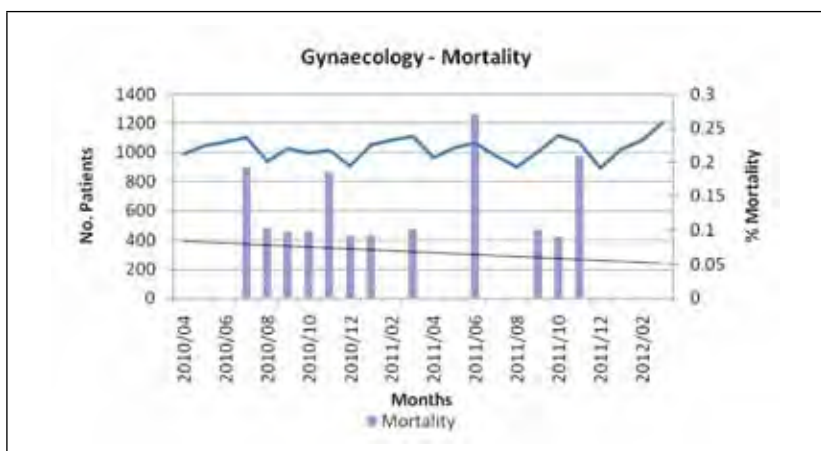
*“The continued fall in readmissions (at 14 and 30 days) is to be welcomed. With the initiation of the Enhanced Recovery Programme<sup>6</sup> (aimed at improving patient outcome but also reducing the length of stay), there was a possible concern that readmissions could rise as a consequence of early discharge. Thankfully, this has not happened, and the long term fall in readmissions has continued.”*

Mr Robert Macdonald, Consultant Gynaecological Oncologist/Gynaecology Clinical Governance lead.

## Mortality Rate in Gynaecology

Definition: The number of instances of death occurring during a Gynaecological episode.

Data source: Meditech.



**IMPROVEMENT?**

In the year the Gynaecology Division reported 8 cases of patient mortality, this equates to an incidence of 0.06% or approximately 1 in 1542.

*“There is no aim or target for the Hospital Standardised Mortality Rate in the Liverpool Women’s. In contrast to most District General hospitals, all the deaths within the Trust usually relate to Gynaecology<sup>7</sup>, are palliative in nature and are of women who are known to be in the terminal phase of their illness. Indeed, it is possible that our mortality rate may well rise over the coming years, as the excellent nursing care provided by the Gynaecology nursing staff (supported by the Gynaecology Macmillan nurses) and the facilities provided in the Mulberry Suite mean that more women actively choose the Women’s Hospital for their end of life care.”*

Mr Robert MacDonald, Consultant Gynaecological Oncologist/Gynaecology Clinical Governance lead.

## Biochemical Pregnancy Rates in in-vitro fertilisation (IVF), intracytoplasmic sperm injection (ICSI) and frozen embryo transfer (FET) treatments.<sup>8</sup>

Definition: This is the most useful and rapidly obtainable marker of how the whole system (drug stimulation, egg quality, lab performance) is working and is defined as the number of positive pregnancy tests per number of embryo transfers for a given time period.

<sup>6</sup> Enhanced Recovery Programme, see Introduction, Enhanced Recovery Programme p

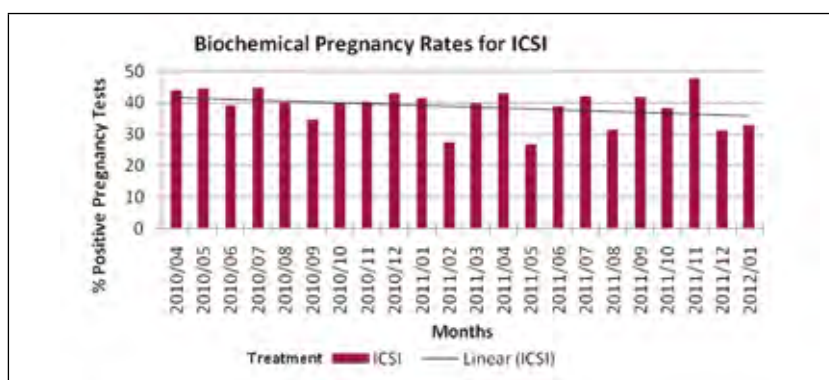
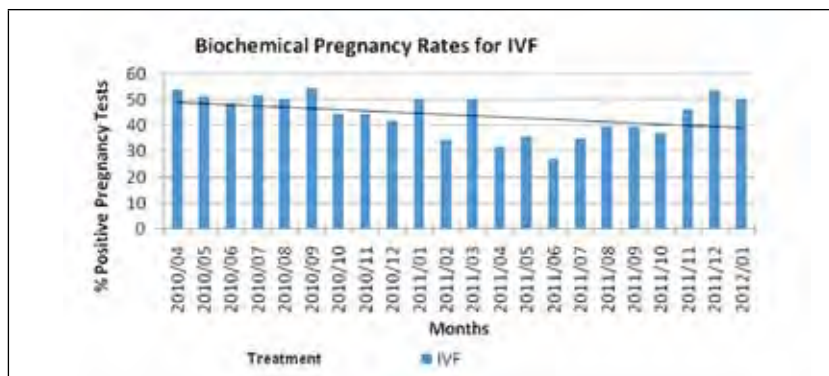
<sup>7</sup> Within this document, we include reporting of the Trusts first case maternal mortality in 15 years.

<sup>8</sup> IVF is a fertility treatment involving bringing egg and sperm together in the laboratory to achieve fertilisation. ICSI is a fertility treatment involving the manual injection of a sperm into an egg to achieve fertilisation. FET is ‘frozen embryo transfer’ a process by which embryos from successful fertilisations are grown briefly then retained in frozen storage for later thawing and transfer to the mother’s womb.



Data source: IDEAS the Reproductive medicine database system.

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 attainment 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 rates over the last two years have been at a respectable 35 to 50%. The biochemical rate is a more immediate reflection of how the laboratory is working. In addition to that, we have had to implement a selective single embryo transfer policy as directed by the Human Fertilisation & Embryology Authority (HFEA). A slight dip was seen in the middle of 2011, but monthly rates have picked up since then after a slight adjustment to the embryo transfer policy."*

Mr Andrew Drakeley, Consultant Gynaecologist/ Reproductive Medicine Clinical Governance Lead.

## Brain Injury in premature babies - Severe Intraventricular Haemorrhage & Periventricular Leukomalacia (PVL)

Cranial ultrasounds should be performed on all Very Low Birth Weight (VLBW) babies with a birth weight <1,501g during their period on the neonatal unit to look for evidence of brain injury (periventricular haemorrhage (PVH) or periventricular leukomalacia (PVL)). The following data are based on all inborn VLBW babies admitted to the neonatal unit. Data is collated and analysed annually and the full calendar year data available are presented in the table below:

	2009		2010		2011	
	No.	%	No.	%	No.	%
Number Scan Not Performed	35		37		22	
Number transferred/did not survive to scan	(25)		(19)		(11)	
Total Scanned	134		117		120	
PeriVentricular Leukomalacia	4	3.0	8	6.8	4	3.3
PVH grade 4	3	2.2	8	6.8	4	3.3
Total with no evidence of serious injury (no PVL, PVH grade<3)	119	88.8	99	84.6	103	85.8

There are a small number of VLBW babies who do not have a cranial ultrasound scan during their period of admission. The majority of these babies are babies who are transferred to other units or do not survive sufficiently long for the scan to be performed.

There has been some variation in the incidence of some types of abnormality across the past 3 years, but the numbers are small and there is no obvious pattern of improvement or deterioration. The proportion of babies who have no evidence of serious injury on their scan is high and appears to be stable across the past 3 years.

## Benchmarking

We benchmark our brain injury data by collaboration in the Vermont Oxford Neonatal (VON) network. The data for 2011 are not yet published.

The VON report for 2010 reports standardised rates of major PVH across 2008 to 2010. Standardised rate of severe PVH at LWH in 2008-2010 was 1 (with a 95% Confidence Limit = 0.77 to 1.23), so is not statistically different for the expected rate given the case mix of babies cared for.

The incidence of PVL across the VON network during 2008 to 2010 was 3.1% (interquartile range 1.1% to 4%). The rate at LWH was 3.3%, within the interquartile range.

## Conclusions

The rates of brain injury seen in VLBW babies cared for at LWH is in keeping with the rate that is seen in other neonatal units and appears to be stable.

## Perinatal Mortality

### Neonatal Mortality

The following table shows the neonatal mortality rate for babies born at Liverpool Women's Hospital between 2009 and 2011.

	2009	2010	2011
Live births (Total)	8,259	8,583	8,430
Live births (from booked pregnancies)	8,106	8,466	8,252
Neonatal deaths (total)	52	61	45
Neonatal deaths (from booked pregnancies)	31	41	29
<b>Neonatal mortality rate (NNMR) expressed as deaths per 1000 live births.</b>			
NNMR (Total)	6.3	7.1	5.3
NNMR (booked pregnancies)	3.8	4.8	3.5
UK NNMR <sup>9</sup>	3.1	4.2	
LWH gestation corrected NNMR (total)	4.2	4.7	3.2
LWH gestation corrected NNMR (booked pregnancies)	3.1	3.6	3.7

Crude 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.

Over 60% of neonatal deaths occur in babies born before 31 weeks gestation. 1% of babies in UK are born before 31 weeks gestation. In our booked population this rate was 1.8% at LWH in 2009 and 2010 but had fallen to 1% in 2011. When the mortality rate is corrected for the gestation profile of our population, the NNMR for babies at LWH is comparable with national figures.

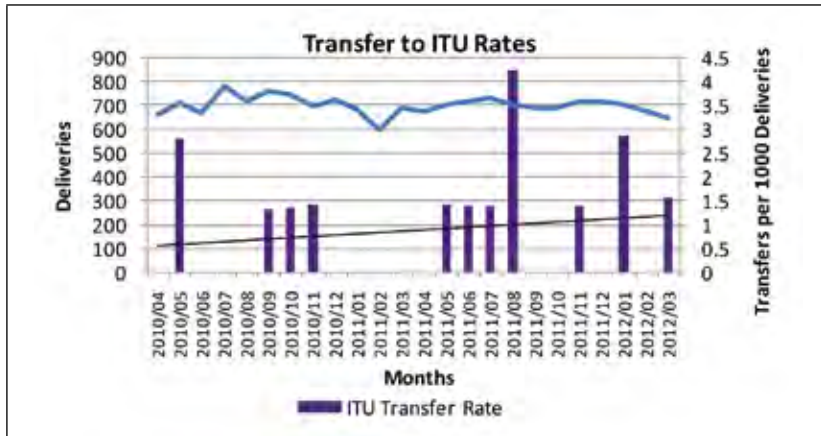
### Transfers to Intensive Therapy Unit (ITU)

Definition: The number of transfers to the Intensive Therapy Unit per 1000 maternities.

Data source(s): Number of ITU Transfers: ITU data team. Maternity data: Meditech.

The transfer of a woman before or post-delivery to ITU is an indicator of both the pre-morbid status (prior state of health) 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).

9 UK NNMR data. The UK figure is published by the Office for National Statistics and is not yet available for 2011.



IMPROVEMENT?



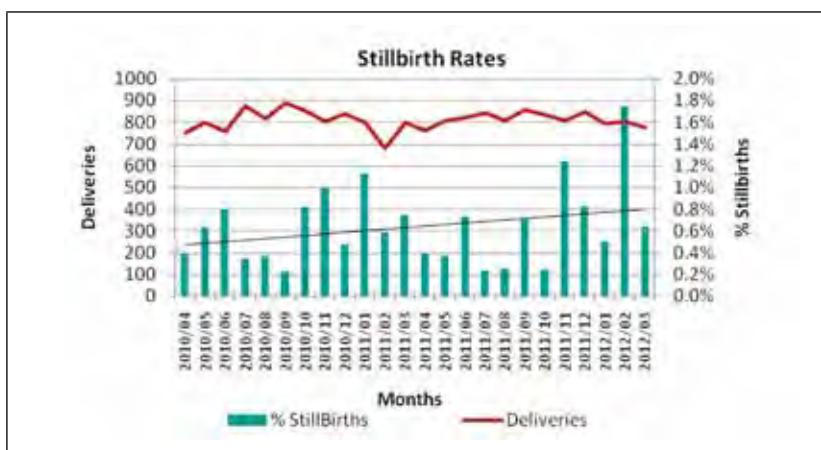
In the year 2011-12 the data shows that the Trust had an annual transfer to ITU rate of 0.12% or 1.2 per 1000.

## Stillbirth rates

Definition: The number of babies born who are classified as stillborn. The number is expressed as a percentage of all births.

Data source: Meditech.

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 still birth 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).



IMPROVEMENT?



(see commentary)

*"In the year 2011-12 the Trust experienced an annual stillbirth rate of 0.66% or an incidence of approximately 1 in 152 births. The rate is up slightly on 0.55 and 0.59; the rates for the last two years."*

Mark Clement-Jones, Consultant Obstetrician.

Statistical Process analysis indicates that the data shows normal variation.

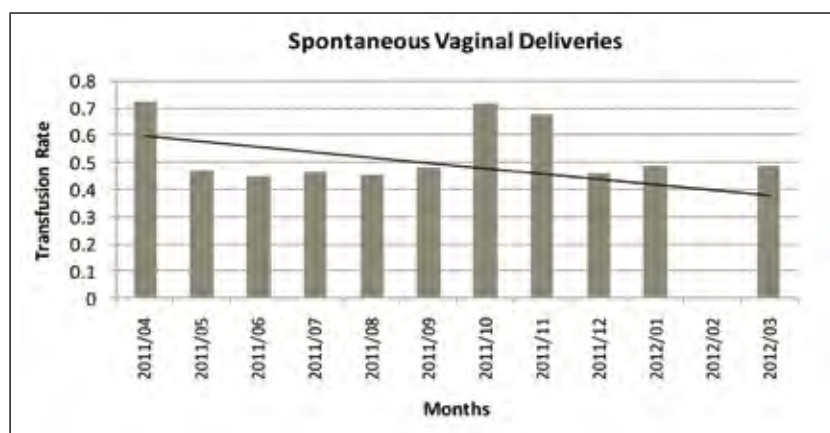
## Transfusions Post Spontaneous Vaginal Delivery

Definition: The number of units transfused per 100 deliveries for patients having a spontaneous vaginal delivery.

Data sources: Transfusion data: Haematology Laboratory. Delivery data: Meditech.

*'Transfusions following Vaginal Delivery' was a new indicator for 2010/11. Upon review at the close of 2010-11 the Trust decided to report the transfusion rates for all modes of delivery, hence the data presented is for the 2011-12 period only. The transfusion rate in the following charts is expressed as a number of transfusions per 100 deliveries.*

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 surrogate measure 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).

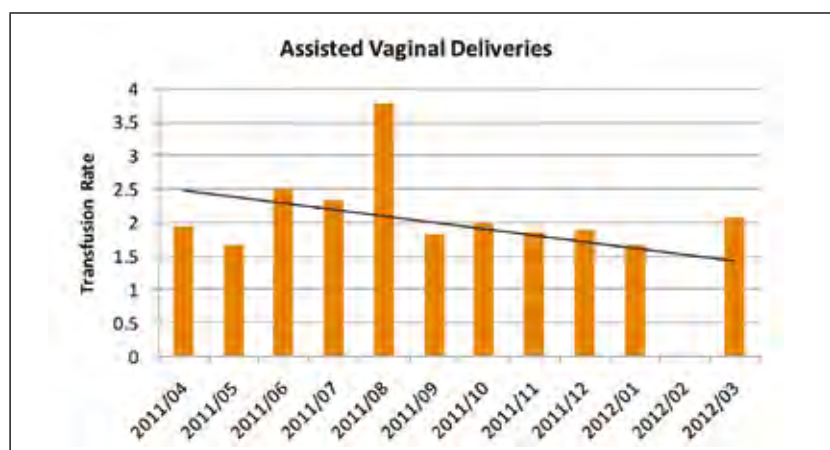


**IMPROVEMENT?**

### Transfusions following Assisted Vaginal Delivery

Definition: The number of units transfused per 100 deliveries for patients having an assisted vaginal delivery.

Data sources: Transfusion data: Haematology Laboratory. Delivery data: Meditech.



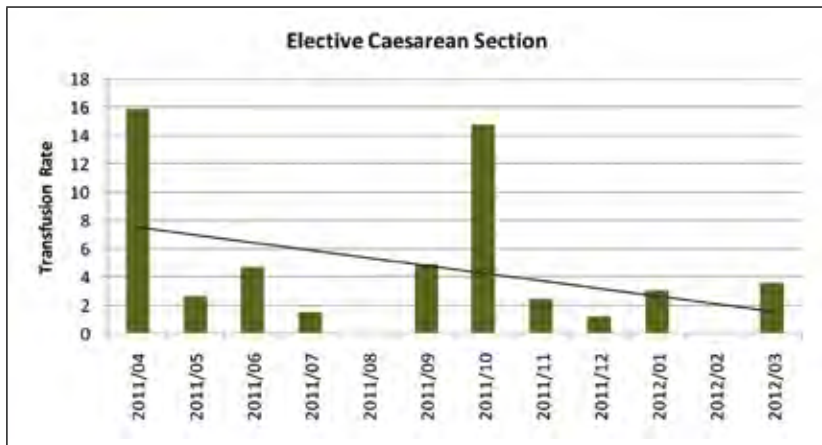
**IMPROVEMENT?**

### Transfusions following Elective Caesarean Section

Definition: The number of units transfused per 100 deliveries for patients having an elective Caesarean Section.



Data sources: Transfusion data: Haematology Laboratory. Delivery data: Meditech

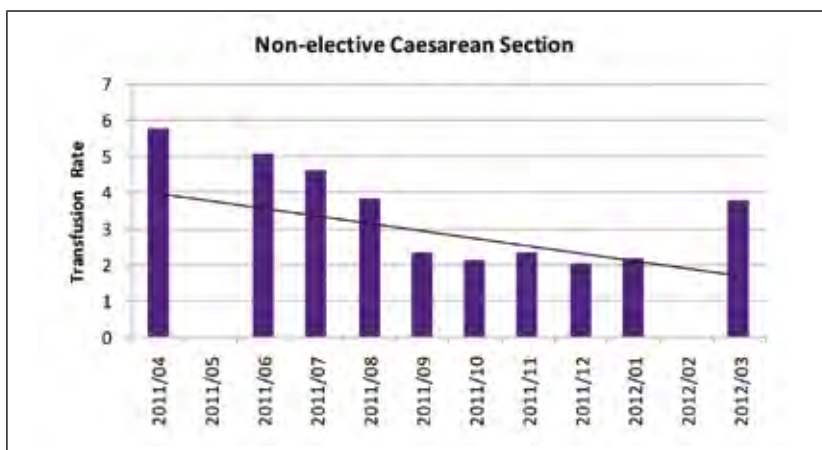


↑  
**IMPROVEMENT?**

Transfusions following Non-Elective (Emergency) Caesarean Section

Definition: The number of units transfused per 100 deliveries for patients having an emergency Caesarean Section.

Data sources: Transfusion data: Haematology Laboratory. Delivery data: Meditech



↑  
**IMPROVEMENT?**

As the trend lines in the above charts show the transfusion rates for each mode of delivery showed a downward trend during 2010-12. In the 2010-11 period the number of units of blood transfused to women having vaginal deliveries was 0.45 per 100 Deliveries. The rates for the 2011-12 data are presented in the table below:

Mode of Delivery	Spontaneous Vaginal	Assisted Vaginal	Elective Caesarean	Non-Elective Caesarean
Transfusion Rate	0.45	1.78	4.19	2.5

The stratification of the original measure for Vaginal births into spontaneous and assisted cohorts and the addition of the caesarean groups makes comparison of this data with that of the previous period impracticable. However, the data will be used as a baseline measure for future analysis. As discussed under 'Clinical Indicator Priorities 2012/13' later in this Report, from 2012-13 these data will be measured and monitored internally, but will not be included in future Quality Reports.

## Mortality Rate in Maternity

Definition: The number of instances of death occurring during a Maternity episode.

Data source: Meditech.



**IMPROVEMENT?**



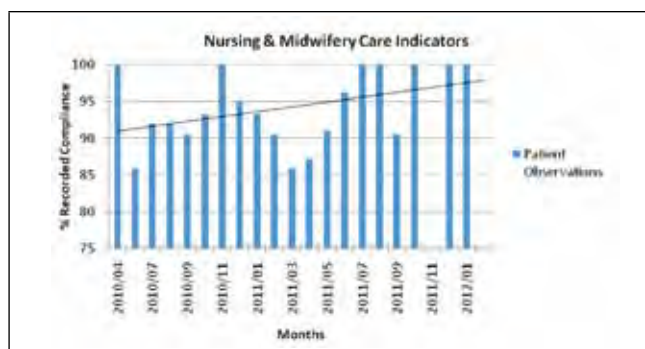
(see commentary)

As the data shows the Trust experienced a single inpatient maternal death in the year 2011-2012; its first in 15 years. This was reported as a serious incident to NHS Merseyside and was subject to root cause analysis investigation.

## Nursing Indicators

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 Divisions with monthly assurance that care is being regularly and consistently measured.

### Gynaecology



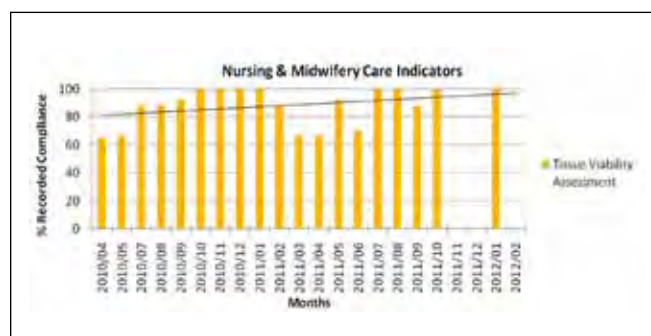
**IMPROVEMENT?**



**IMPROVEMENT?**



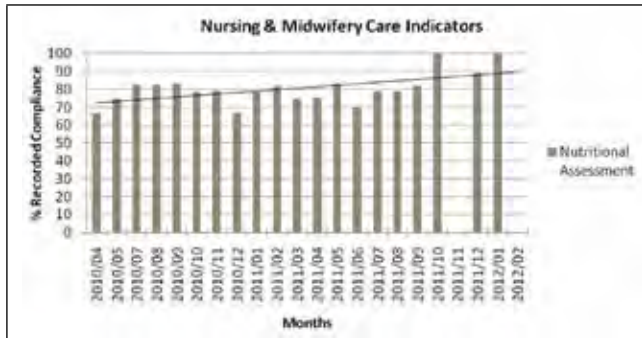
**IMPROVEMENT?**



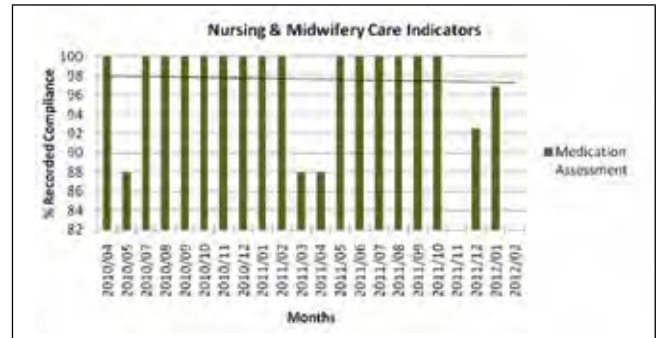
**IMPROVEMENT?**







IMPROVEMENT? ↑



IMPROVEMENT? ↔



IMPROVEMENT? ↑



IMPROVEMENT? ↑

Definition: Audits of a range of basic care indicators in the Gynaecology Specialty calculated as a percentage compliance to defined standards.

Data source: Nurse Matron Gynaecology.

Data for November 2011 is not available; however the average compliance with the requirements of these measures from the available data for the periods April – Oct 2011 and December 2011 – January 2012 is shown in the following table.

Gynaecology Measure	Patient Observation	Pain Management	Assessments					Infection Control	Personal Care
			Falls	Tissue Viability	Nutrition	Medication	VTE		
Average Compliance	96.1%	76.5%	85.5%	89.6%	84.2%	97.5%	91.7%	95.2%	96.7%

*“The measurement of key performance indicators relating to the delivery of nursing care allows the nursing management and the local nursing teams, to take responsibility and ownership where remedial actions are required to improve performance.*

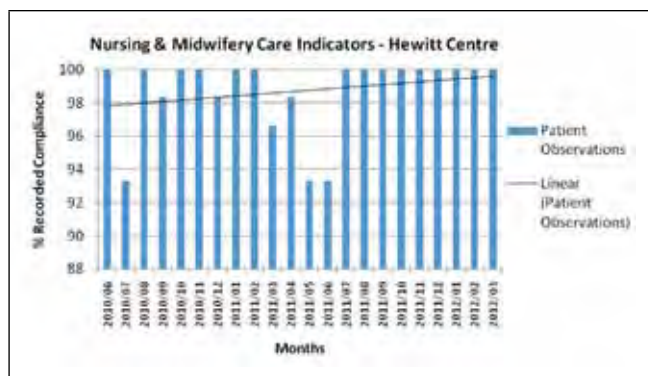
*“There have been significant challenges in relation to admission assessments, and as such a daily and weekly admissions assessment report has now been devised in conjunction with the Governance Team that provides detailed analysis of non compliance and information for action in a timely manner.*

*"Going forward into 2012, we are embracing the Energising for Excellence initiative and have reviewed all of our current nursing indicators to ensure that they are all meaningful and add value to both patient safety and experience."*

*"We have developed an additional set of indicators for theatres, Emergency room and outpatients that will focus more actively on the views and feedback from our patients. They are designed to facilitate both internal and external benchmarking, and it is hoped that they will become a vehicle for real time feedback and engagement with our patient throughout the year."*

Dianne Brown – Head of Nursing.

## Hewitt Centre



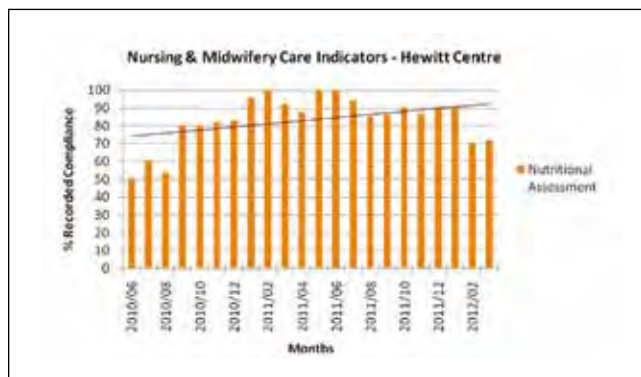
IMPROVEMENT? ↑



IMPROVEMENT? ↓



IMPROVEMENT? ↑



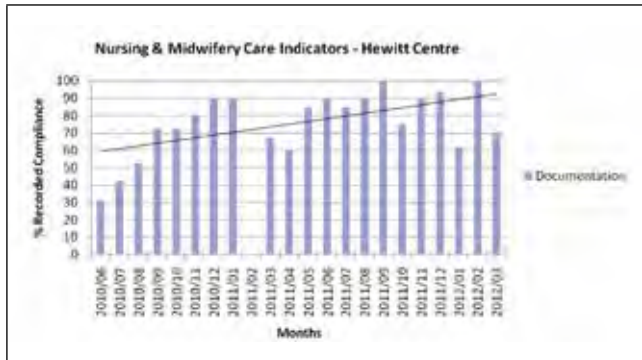
IMPROVEMENT? ↑



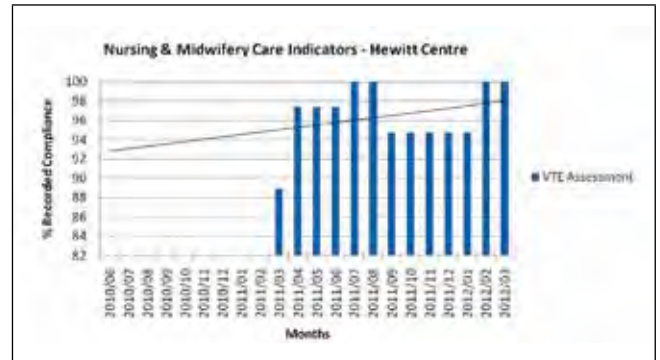
IMPROVEMENT? ↑



IMPROVEMENT? ↑



IMPROVEMENT? ↑



IMPROVEMENT? ↑

Definition: Audits of a range of basic care indicators in the Reproductive Medicine Unit Specialty calculated as percentage compliance to defined standards.

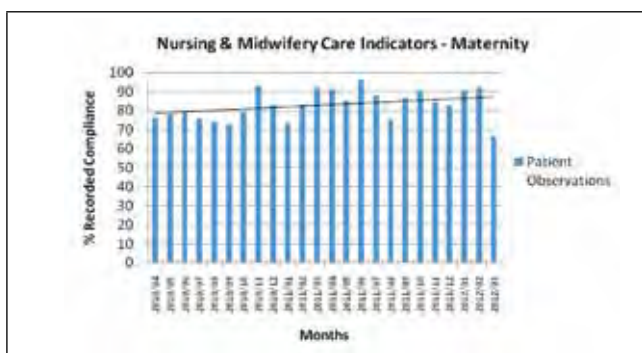
Data source: Nurse Matron Reproductive Medicine Unit.

Hewitt Centre Measure	Patient Observation	Pain Management	Assessments				Infection Control	Documentation
			Falls	Nutrition	Medication	VTE		
Average Compliance	98. %	91. %	96. %	87. %	100%	97. %	99. %	83. %

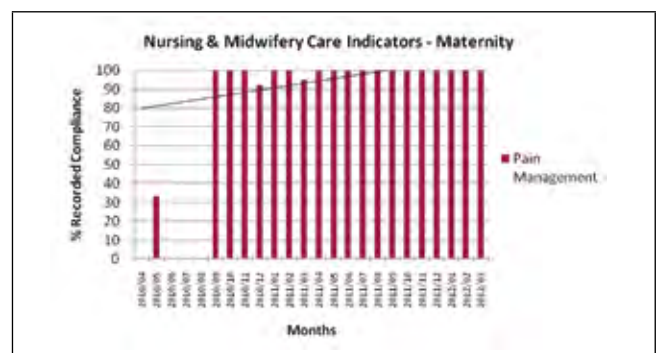
*"The Care Indicators are recorded from patient case notes post oocyte collection. The results are then discussed locally at nursing and departmental meetings. Although these are nursing indicators some require medical action and when there are medical omissions these are discussed at the appropriate executive meeting to be fed back to the medical team by the clinical director. Although there is still room for improvement, there has been an marked increase in compliance since introduction of the indicators, which is extremely encouraging."*

Jane Mutch, Hewitt Centre Matron

## Maternity



IMPROVEMENT? ↑

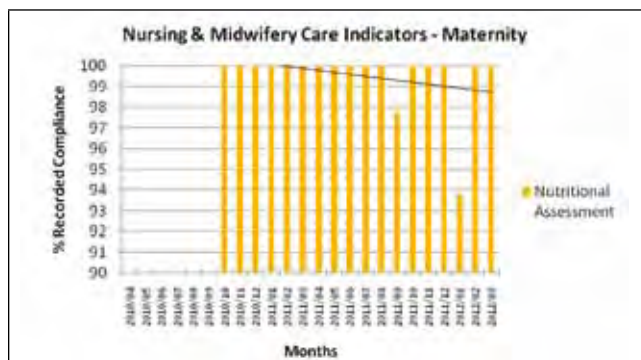


IMPROVEMENT? ↑

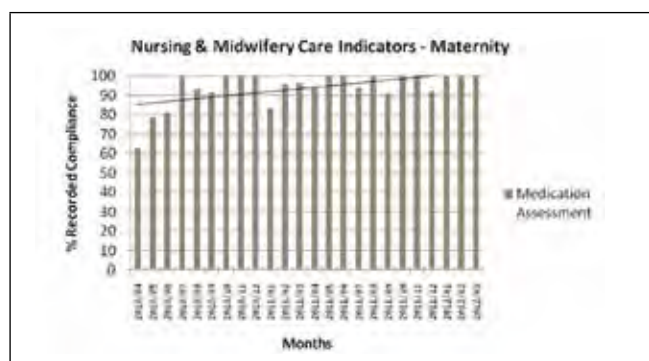




IMPROVEMENT? ➡



IMPROVEMENT? ↓



IMPROVEMENT? ↑



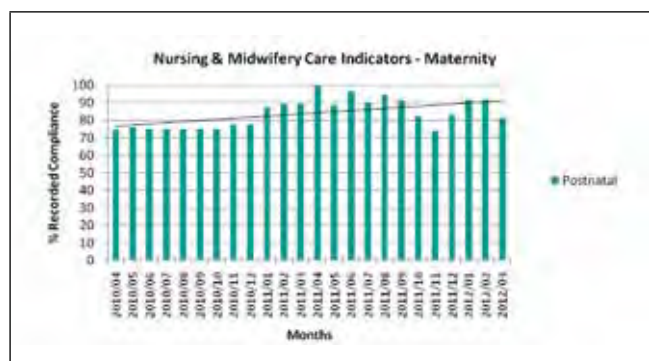
IMPROVEMENT? ↑



IMPROVEMENT? ↓



IMPROVEMENT? ↓



IMPROVEMENT? ↑



IMPROVEMENT? ↑

Definition: Audits of a range of basic care indicators in the Maternity Specialty calculated as percentage compliance to defined standards.

Data source: Nurse Matron Maternity.

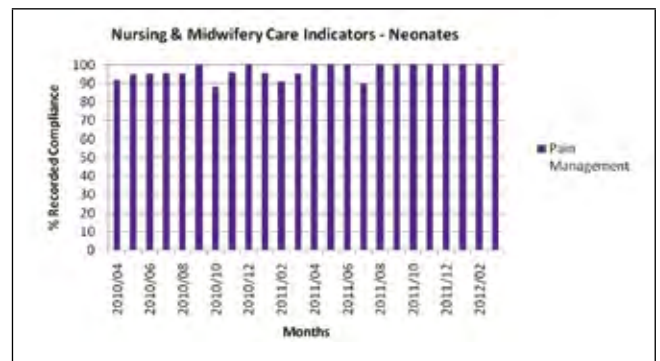
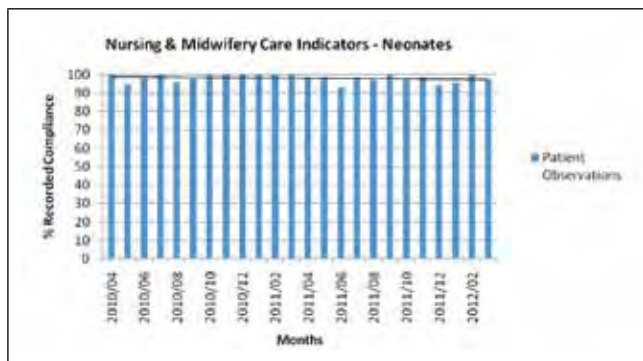
There are gaps in the data available for some of these measures, due to re-establishment of an agreed measure or in a minority of cases missing data. The average compliance from the data available, with the requirements of these measures is shown in the following table.

Maternity Measure	Patient Observation	Pain Management	Wound Surveillance	Assessment			Infection Control	Antenatal	Intrapartum	Postnatal	Personal Care
				Nutrition	Medication	VTE					
Average Compliance	85.8%	100%	97.8%	99.3%	97.6%	84.4%	76.7%	89.4%	88.4%	88.8%	97.9%

*“These midwifery indicators are measured on a monthly basis by senior midwives. The results are then discussed at ward level where improvements in care can be identified and implemented.”*

Cathy Atherton, Head of Midwifery

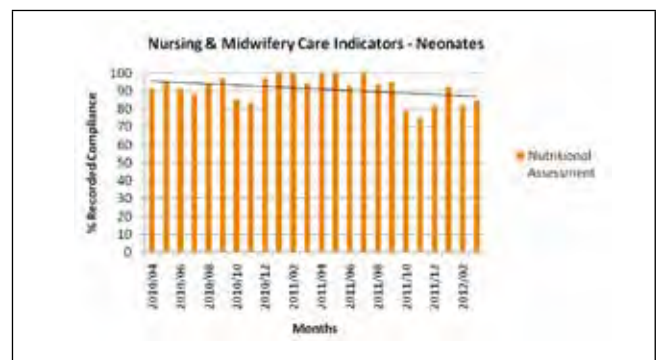
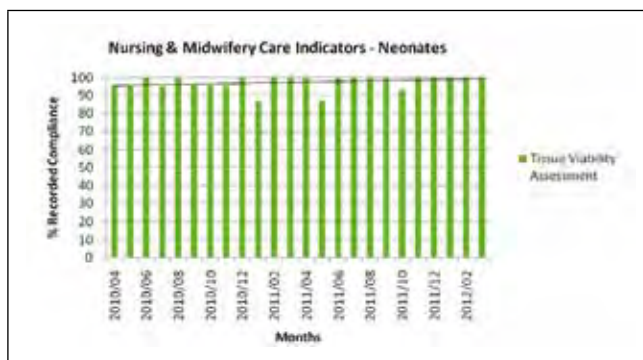
## Neonates



IMPROVEMENT?



IMPROVEMENT?

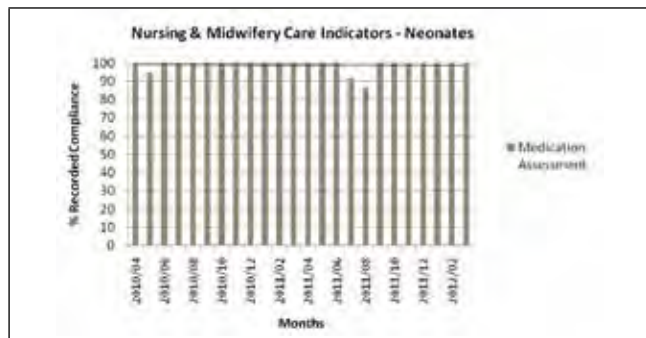


IMPROVEMENT?

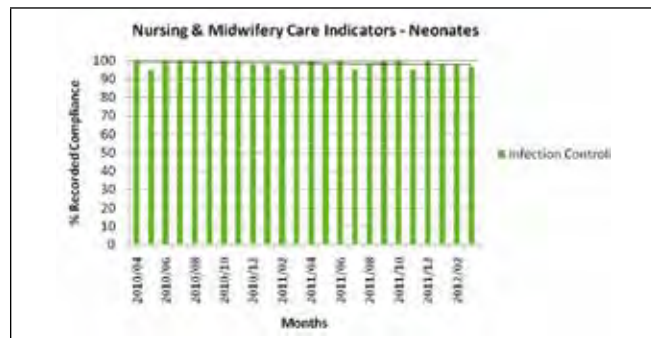


IMPROVEMENT?

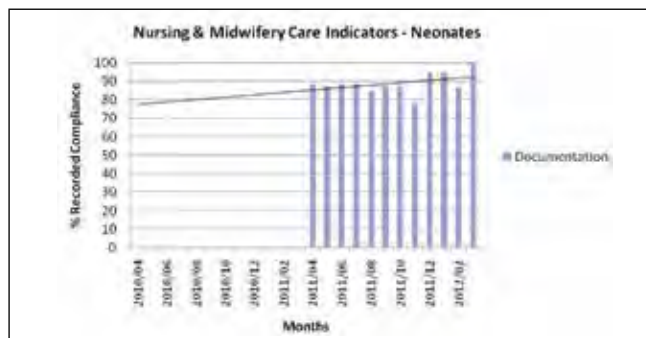




IMPROVEMENT?



IMPROVEMENT?



IMPROVEMENT?



Definition: Audits of a range of basic care indicators in the neonate specialty calculated as percentage compliance to defined standards.

Data source: Specialist Nurse Neonatal Unit.

The average compliance with the requirements of these measures is shown in the following table.

Neonatal Measures	Patient Observations	Pain Management	Assessments			Infection Control	Documentation
			Tissue Viability	Nutrition	Medication		
Average Compliance	97.3%	99.2%	98.3%	89.7%	98.2%	98.2%	88.9%

*"Ten sets of infant records are randomly selected from infants admitted within the current month. The results are discussed at the operational meeting and disseminated to staff through team meetings, as well as being displayed on the notice board in the staff room. Any actions required are carried out within the month and during 2011/12 there was no one factor which gave cause for concern in respect of delivery of nursing care."*

*"Staff have been involved in deciding new factors for the forth coming year in order to improve the nursing care provided to sick term and preterm infants within the neonatal setting."*

Val Irving, Matron for Neonates and Imaging.



## One to One Care in Labour

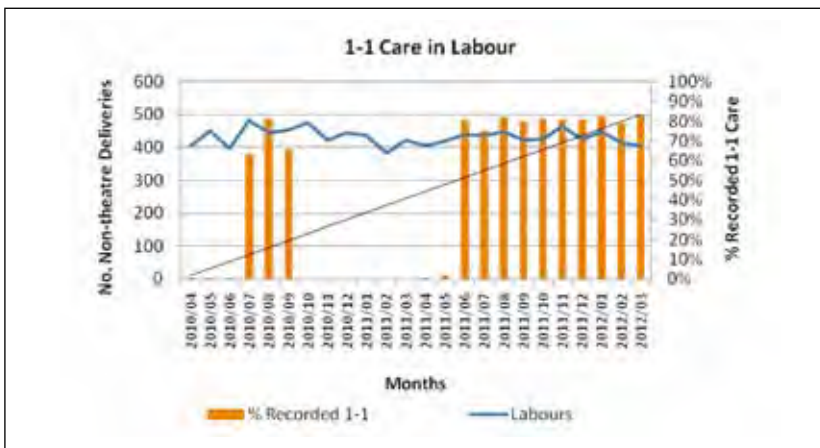
Definition: The number of patients receiving one to one care during labour. The number is expressed as a percentage of all maternity episodes of care. (Exclusions apply for patients with Elective Caesarean Section).

Data source: Meditech.

This measure relates to women in established labour receiving care from an identified, midwife whilst she is in labour.

*"In the year 2011-12, the annual figure for recorded 1-1 care was approximately 68%. As the following chart shows for most of the year the monthly figures were around 80%, with a lack of recording in the early part of the year (due to re-establishment of the definitions) accounting for the lower annual figure. During the time where the monthly figures are shown to be low, the maternity service was further developing the tool used to measure this standard and the data was not collected. Once this was agreed the chart shows an increase in women receiving one to one care in labour."*

Cathy Atherton, Head of Midwifery



**IMPROVEMENT?**

## Patient Experience and Involvement

The Trust is committed to achieving its vision and aims and 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. Our membership strategy, devised by our Council of Governors, similarly seeks to involve our members on helping to shape, develop and improve the services we provide.

### Gathering patient experience information

The Trust has and 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. At the time, there were only 3 devices in use, which were not enough as surveys needed to be completed in all areas. Thus at the moment it is being considered as to what is the best device that can be used and one is currently being tried out in the clinical areas. If this device is found to be suitable, then it is planned to purchase devices for all clinical areas. It is considered vital that when patient experience feedback is gathered it is taken from all areas.

## Patient Involvement

This is an area that is being looked at as it is absolutely crucial that we are able to liaise with all public members about our services and to get their feedback.

Patient Experience plan to work with the Trust Secretary and the Council of Governors to discuss and develop a robust plan for Patient Involvement, this could include independent surveys and the use of a "mystery patient" activity.

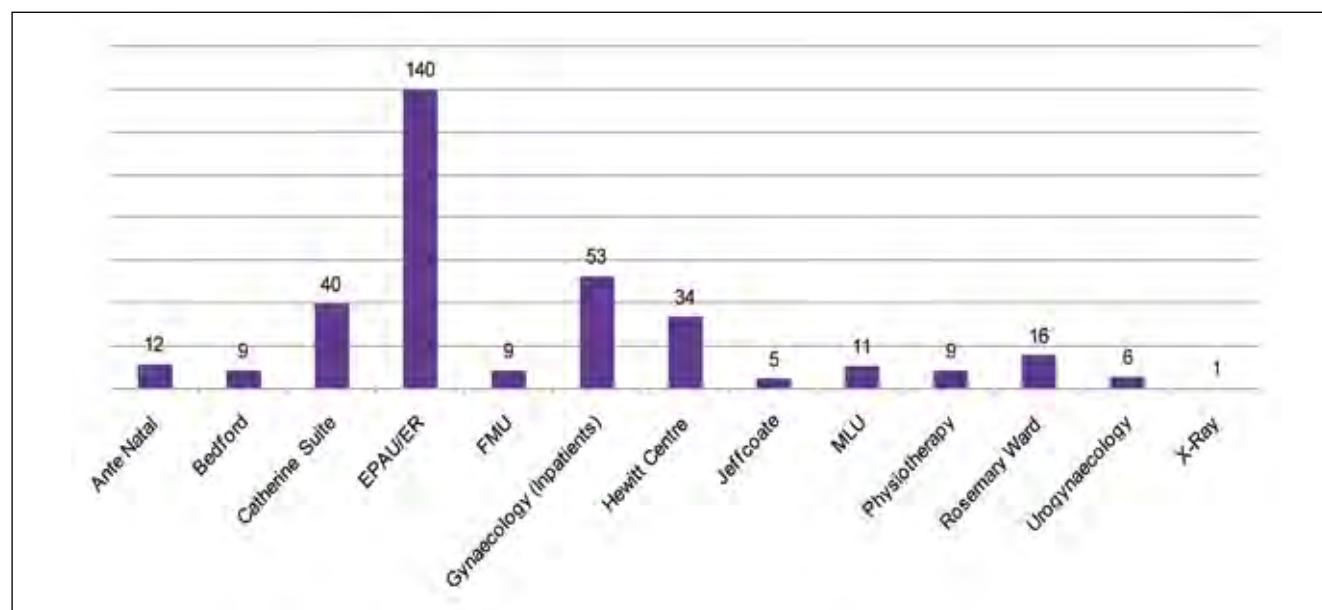
Recently we met with a hard of hearing lady and her sign language interpreter. This was a very interesting meeting as she was able to talk about her journey as a patient from the perspective of a hard of hearing person. Issues raised included the comment that when they press a buzzer to gain access to an area they are not able to hear if staff reply. In response to this feedback and their advice, we are investigating the possibility of making the buzzer light up when staff reply. We are also in the process of reviewing what interpreters are provided as hard of hearing patients may depend upon 'sign' as a standalone language, and this does not equate to a literal translation of the written/spoken word. This may mean they require information usually provided in leaflet form to be translated to sign language.

This is just the first step of looking at ways that we are able to communicate with all our patients regardless of their needs.

## Patient Experience

High on the agenda for all the staff who work at the Trust is to provide a positive patient experience. Sometimes a poor clinical outcome cannot be avoided and may not be the one that the patient wishes for but we can still make their experience of Liverpool Women's a positive one. One of the greatest rewards for staff comes when patients they have cared for through a poor outcome leave the hospital thanking them for their support.

To be able to support a patient and provide them with what they want, we need to know what it is that they want. For this reason we continue to use the comment cards. In quarter 3 we received 345 comment cards from various areas across the Trust as shown below:



The feedback they provided is presented as the total number of all comments made in Q3 of about a certain theme are presented below:

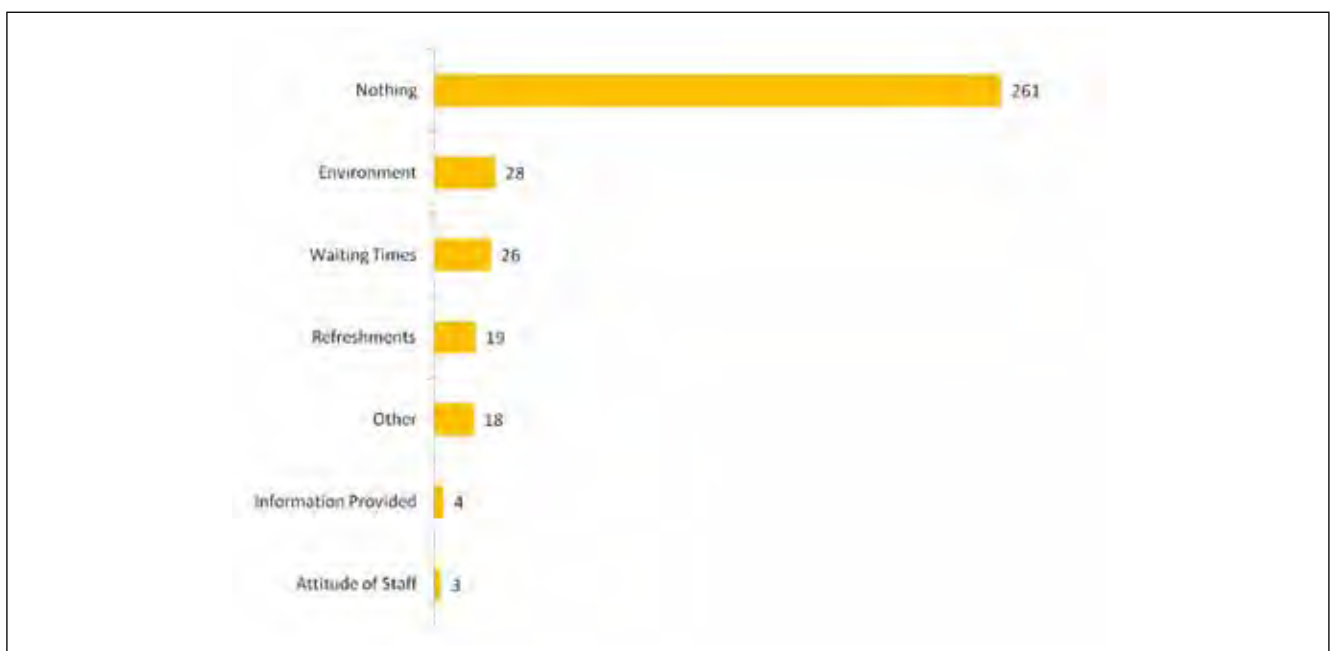
## Overall, What Was Good About Your Care?



The data presented are the total number of all comments made in Q3 about a certain theme. Other topics included:

- Comfortable 6
- Privacy 5
- Food 5
- Quality of Care 3
- Honesty of Staff 3

## What Do We Need to Improve?



An exciting development this year has been the introduction of Patient Stories as told by them. It is very powerful to hear in their words how they have been affected by what has happened to them. The Patient Story was originally introduced to the Trust Board by the Director of Nursing, Midwifery and Patient Experience and has gone on to be introduced at many of the meetings that take place. It is a reminder to everyone what our service is there for and how much impact we can have on a patient. No matter what we are planning and discussing whether it be money, or the building, always at the heart of it is what difference it will make to the patient.

At one Board meeting, the patient herself attended to talk about her experience. It was nerve wracking for the patient but afterwards she said how empowering it was for her and how reassuring to know that staff wanted to hear what she had to say.

Many of the patient stories are used as a teaching tool for the staff so that they can see how what happens to the patient affects them and in some cases using the patient's story has driven through change.

Examples of changes made in response to patient feedback:

Problem	Change
Patient not given her breakfast until 10am	Relaunching of the "red tray" system with the ward staff and the new catering company that started in April. (Red tray system is a national scheme to ensure patients who need assistance with nutrition receive the help required) Introduction of the ward hostesses who are aware of all the patients needs re catering.
Regular medication not given in a timely manner.	Nursing staff ensure the Senior House Officer prescribes medication on Meditech when patient admitted, if not done they escalate to senior staff until the job is complete. The importance of the need for the medication to be prescribed in a timely manner to be highlighted on the care plan
Dentures were "lost" on the ward	A supply of denture pots now kept in "forward wait" in theatre. Denture pots to be included in the TCI packs (contain undergarments, hat, theatre gown and denture pot and patient property bag) To use a patient property bag to return patients property such as dressing gown back from theatre and this will include denture pot.
Patient attends Emergency Room for a scan, is sent down 2 floors to the scan department, then had to make her way back to the ER after receiving bad news	After walking the patient's journey and discussion with the scan department, the scans are now carried out in the ER

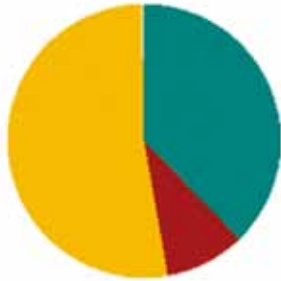
## National Surveys

This year 2 national surveys were carried out, they were for Gynaecology Out-patients and Gynaecology In-patients

## Gynaecology Out-patients

The response rate for Liverpool Women's NHS Foundation Trust was 47% with 399 of 850 eligible patients responding. The average response rate nationally was 49% (74 NHS Trusts).

### How do we compare to other trusts in the 2011 survey?



The survey showed that your Trust is:

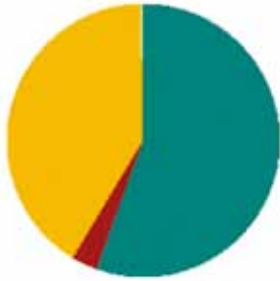
- Significantly **Better** than average on 28 questions
- Significantly **Worse** than average on 7 questions
- The scores were average on 39 questions

## Gynaecology In-patient Results

The response rate for Liverpool Women's NHS Foundation Trust was 51% with 342 of 842 eligible patients responding. The average response rate nationally was 50% (73 NHS Trusts).

Admission types: 84% were planned admissions; 11% admitted urgent

### How do we compare to other trusts?



The survey showed that your Trust is:

- Significantly **Better** than average on 54 questions
- Significantly **Worse** than average on 3 questions
- The scores were average on 40 questions

These reports are encouraging as they indicate that in relation to the out-patient measures, the Trust matched or bettered the national average for 90.5% of the indicators and significantly exceeded the national average for 38% of the measures. In relation to in patient measures the Trust match or bettered the national average for 97% of indicators and significantly exceeded the national average for 56% of the measures. The results also identify the areas where we need to improve to meet and surpass national performance.

The criteria for which the Trust's performance was better than average included:

Hospital:

- Bothered by noise at night from either other patients or staff
- Bothered/feeling threatened by other patients/visitors

Communication Doctors and Nurses:

- Did not always get clear answers to questions Talked in front of patients as if they were not there
- Did not always wash their hands between touching patients & Nurses)
- Some/none knew enough about condition/treatment

## Surgery communication – various elements

Discharge information elements - medication purpose, taking, side effects, danger signs and who to contact if worried

Some of the survey criteria for which the Trust's performance was worse than average are highlighted below with the Trust's draft proposals to address them:

Criterion	Improvement Proposals
Not fully aware what would happen during appointment	<p>Include question on hand held device and survey 25 patients a month to pinpoint problem areas</p> <p>Development of GOPD board displaying indicator information for patients and staff</p> <p>Review patient information provided and map whom provides what, when</p> <p>Admin redesign- Ensure requirements regarding correspondence are communicated to admin teams</p> <p>Devise clinic guidelines/ clinic rules- raise awareness amongst staff of importance of introductions, welcoming script and explanations</p> <p>Information regarding one stop pre op assessment to be reviewed and revised</p> <p>Patient information Review- Represent GOPD Ensure process changes have positive influence</p> <p>Patient Records Committee undertaking work regarding quality of patient correspondence</p>
Not given the name of person appointment would be with	<p>Review of patient clinic correspondence</p> <p>Review of patient information leaflets relating to whom appointment will be with</p>
Patient not told why they had to wait	<p>Ensure clinic guidelines/ clinic rules- include requirement for explaining reasons for delays</p> <p>Include question on hand held device and survey 25 patients a month to pinpoint problem areas</p> <p>Development of GOPD board displaying indicator information for patients and staff</p> <p>Links with admin teams/ reception staff to be further developed</p>
Nobody apologised for the delay when waiting to be seen	<p>Ensure clinic guidelines/ clinic rules- delays encourage staff to apologise for delays</p> <p>Include question on hand held device and survey 25 patients a month to pinpoint problem areas</p> <p>Development of GOPD board displaying indicator information for patients and staff</p>
Other Member of staff did not know enough about medical history	Administrative review and monitoring of clinical information in case sheets timely
Did not receive copies of letters sent between hospital doctors and family doctors	<p>Administrative review action to address</p> <p>Patient records committee reviewing discrepancies in clinical correspondence re demographics/ GPs links with national spine</p>
Clinic delays	<p>Standardised agreement/ guidelines regarding clinic templates to be revised, launched and monitored, deviations to be reported ( including overbooking</p> <p>Clinics known to persistently over run/ long delays to be subjected to deep dive to establish specific remedial action required</p>

## Data Quality

Our performance against national targets is shown on pages 14 - 15 of this report. In respect of the quality of the data used to monitor and manage our performance, the Trust runs weekly Patient Tracing Lists (PTLs) for cancer and episode data within 18 wks (Out-patient/Diagnostic/ Definitive treatment



episodes) and holds weekly PTL meetings with the Divisional leads. The Trust Information Analyst conducts monthly audit of the work of the divisional trackers work to highlight and take action on any errors. The Information Analyst also holds monthly validation meetings with the trackers to discuss in detail in order to verify breaches prior to providing breach analysis reports and releasing data.

Commentary:

The Trust recognises that performance against the 'All cancers: two month diagnosis to treatment (Consultant upgrade)' target is below the benchmark used and is now tracking all Cancer patients and providing weekly assurance to the Divisions through robust PTL monitoring.

In respect of the Infant health and inequalities breastfeeding target; there are two ongoing initiatives that the maternity service is working on:

- An ongoing audit of the breast feeding initiation data on Meditech against that in the case notes to test/provide assurance re data collection
- The maternity service is currently accredited to Baby Friendly Initiative level 2 and is working towards achieving level 3 by the end of 2012 /early 2013.

Performance against Department of Health 2011/12 Operating Framework:

Measure	Target/ Threshold	Performance 2011-12
1. HCAI (MRSA/C. diff inc)	MRSA 1, C. diff 2	MRSA 0, C. diff 1
2. Patient experience survey		See national surveys (p75 - 77)
3. Referral to treatment rates (95th centile)	Admitted<23wk Non-Admitted<18.3wk	Admitted 17.0 Non-admitted 17.3
4. MSA breaches	Cumulative 4	Cumulative 0
5. A&E quality indicators Total time in A&E Time to initial assessment Time to Treatment decision Unplanned re-attendance rate Left without being seen rate	<240 mins <15 mins <60 mins <5% <5%	Median 102, 95th Centile 218, max 239 Median 3, 95th Centile 9, max 29 Median 60, 95th Centile 178, max 391 9.11% 3.04%
6. Ambulance quality	Not Applicable	N/A
7. Cancer 2 week, 62 day waits	>93% , >79%	97.54%, 91.67%
8. Emergency re-admissions		(See p. 55 - 57)

## Priorities for improvement 2012/13

During 2011/12 the organisation underwent a significant period of change in terms of the alignment of staff directly associated with the delivery of Patient Safety, Effectiveness and Experience, integrating these valued staff into a team has been completed. 2012/13 will be the first opportunity for the Governance Team to demonstrate the value and benefit of this significant change. Bringing together for the first time the combined knowledge, experience and talent across the Governance spectrum (Patient Safety, Risk Management, Health and Safety, Clinical Audit and Effectiveness, Research & Development, Information Governance, Infection Prevention & Control, Complaints, Patient Advice and Liaison, Chaplaincy, Bereavement and Volunteer Services) to help the clinical services design, run, maintain safe, effective, patient focused services.

Over the course of the year the Trust will develop a long term commitment to quality which dovetails seamlessly with the other key drivers in any public sector organisation:

- Value for money/customer focus
- Efficiency
- Service development and longevity.

## Quality Improvement Strategy

To further strengthen the quality focus, Liverpool Women's NHS Foundation Trust are engaged in partnership with the Northwest Advancing Quality Alliance (AQuA) to pull all the existing quality work streams together into an overarching Quality Improvement Strategy, which we hope to launch in September 2012.

## Clinical Indicator Priorities for 2012/13

The Trust is mindful of the fact that the quality indicators it has previously committed to and reported through the Annual report remain of value and are worthy of continued monitoring; and of the feedback received from the audience of its earlier Quality Reports indicating that the content was too extensive and detailed.

Therefore, the Trust has decided to retain the priorities previously declared:

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

and to continue to measure and monitor the indicators included in the 2010-11 report, but from the 2012-13 report to include data and commentary on those more pressing indicators itemised below. The current means of measuring and monitoring employed in 2011-12 will be carried forward into the next period and any changes and enhancements made during the period explained and justified in the next report.

The Gynaecology consultants have committed to completing the commenced review of Accidental perforations and damage and to the proposed prospective review and monitoring of cases commencing May-June 2012, but as explained above, this will not be included in the report from 2012/13.

NB. For continuity this report with the exception of 'Rates of epidural pain relief for analgesia in labour' measure, which was abandoned in favour of a CQUIN measure reflecting patient choice in the selection of pain relief, reports on the indicators included in the report for 2010/11.

## Patient Safety

- VTE assessment (Nursing/Midwifery Care indicator) and Post operative deep vein thrombosis/pulmonary embolism following discharge.
- Gynaecology surgical site infections (Note particularly the reference to the "...lack of fall in infections in emergency operations (in contrast to the success in improvement in elective cases..." in performance review section)
- Incidence of Multiple pregnancy
- Apgar scores <4 in infants born at more than 34 weeks gestation
- Delivery Cord pH<7.00
- Incidence of methicillin resistant staphylococcus aureus (MRSA bacterium)
- Incidence of Clostridium difficile
- Medication Errors

Whilst the Gynaecological Oncology consultants are committed to complete the review of cases of accidental injury that is underway, and to prospectively conduct a monthly review of all cases coded as an accidental injury from May/June 2012; the measure will not be amongst the reported measures in the Quality Report for 2012/13.

## Clinical Effectiveness

- Readmission Rates in Gynaecology
- Hospital Standardised Mortality Rate in Gynaecology
- Biochemical 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
- Stillbirth Rate
- Care indicators for Nursing and Midwifery

## Patient Experience

- Commitment to implementation of Patient experience & Involvement Strategy
- One to one care in established labour 100% of the time
- Patients receiving pain relief of choice (NB. This measure replaces the previous measure of Rates of epidural pain relief for analgesia in labour in recognition of patient choice).



Paula Kelly, housekeeper on delivery suite, with a young visitor to our annual member's meeting and open day

# Statements of assurance from the Board of Directors

## Review of services

During 2011-12 Liverpool Women's NHS Foundation Trust provided services in four core specialty areas within its two Clinical Divisions.

Liverpool Women's NHS Foundation Trust has reviewed all the data available to them on the quality of care provided by the services within its Clinical Divisions.

### Gynaecology Division:

- Gynaecology and Surgical Services
- Reproductive Medicine and Medical Genetics

### Maternity Division:

- Maternity Services and imaging
- Neonatal and Pharmacy

Each Clinical Division reports to the Clinical Governance Committee, which is a sub-committee of the Board of Directors. Their Clinical Governance leads report on their self selected clinical outcome indicators categorised into Patient safety, Clinical effectiveness and patient experience.

These indicators are part of the divisional dashboard and form part of the monthly performance and assurance report to the Board of Directors. Some of the indicators are benchmarked with the CHKS<sup>10</sup> national data or other specialty organisations. Data collected has influenced the organisation as identified in its improvement initiatives for 2012-13.

The income generated by the NHS services reviewed represents 100% of the total income generated from the provision of NHS services by Liverpool Women's NHS Foundation Trust for 2011/12.

## Clinical Audit

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 or guidelines. Clinical audit is one of the main ways that we review the quality of the care we provide and is particularly useful for providing assurances about our standards or care, identifying areas for improvement or, once we have done an audit and implemented changes, demonstrating that our standards have improved.

## National Clinical Audit and Confidential Enquiries

During 2011-2012, 4 national clinical audits and 2 national confidential enquiries covered NHS services that Liverpool Women's NHS Foundation Trust provides. During 2011-12 Liverpool Women's NHS Foundation Trust participated in 100% (4 out of the 4) national clinical audits and collected data for 100% (2 out of 2) national confidential enquiries which we were eligible to participate in, as follows:

### National Clinical Audits

- Peri-and Neo-natal
  - Neonatal intensive and special care (NNAP)

<sup>10</sup> CHKS is an independent provider of healthcare benchmarking intelligence and quality improvement services

- Blood transfusion
  - Bedside transfusion (National Comparative Audit of Blood Transfusion)
  - Medical use of blood (National Comparative Audit of Blood Transfusion)
- Long term conditions
  - Heavy menstrual bleeding (RCOG National Audit of HMB)

## Confidential Enquiries

These include:

- National Confidential Enquiry into Patient Outcome and Death (NCEPOD)
- Confidential Enquiry into Maternal and Child Health (CMACE) – note that data collection ongoing, although submission currently suspended at national level due to changes in the process for NCEPOD.

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.

The report of 1 national clinical audit (NNAP) was reviewed by us in 2011/12 (in line with the availability of national reports). The findings from the audit have been reviewed within the Neonatal speciality, presented at our Breakfast Meetings and discussed more widely at Clinical Audit Committee. When compared to other Trusts, the quality of care provided by Liverpool Women's (as audited by the NNAP) was extremely high in a number of core areas. However, in a small number of areas the national audit data suggests that we could be doing better.

We have instigated a programme of additional audit in 2012/13 to provide us with more detailed information as to the quality of care we provide in these areas and have a detailed action plan in place to improve specific areas of care for our mothers and babies.

National Audit	Number Of Cases Included	Number Of Cases As % Of Eligible Cases
Neonatal intensive and special care (NNAP)	1239	This data not yet available to LWH
Bedside transfusion (National Comparative Audit of Blood Transfusion)	60	LWH required to audit 40
Medical use of blood (National Comparative Audit of Blood Transfusion)	11 (phase 1)	11 (Phase1)
Heavy Menstrual Bleeding (HMB) Audit	452	47% (452/960) <sup>11</sup>

Additional Data regarding the HMB audit:

Number of Women Screened in our Gynaecology Outpatient Clinics	2,493
Number of Women Eligible	486
Number of Women Agreeing to Take Part	452

<sup>11</sup> The denominator for the HMB audit is calculated on the number of women eligible to take part as calculated from national hospital activity data. However the methodology employed in Phase 1 of the national HMB audit (1 February 2011 to 31 January 2012) required participating Trusts to identify eligible women when they booked in for their outpatient appointment (against the specific criteria for inclusion set by the national project team) and then for Trusts to offer eligible women the opportunity to participate. We are aware that although we screened 2,493 women and discussed the HMB audit with them personally, given the year long process we may not have identified all eligible women. Additionally, a small number of women opted not to take part. It is worthy of note however, that the Royal College of Obstetricians and Gynaecologists (who are involved in running the HMB audit in conjunction with IPSOS Mori) commended Liverpool Women's on its approach to the HMB audit and its recruitment.



In addition to the national clinical audits and enquiries that LWH participates in, further audit projects are undertaken within the clinical specialties and across the Trust as whole. These may reflect requirements placed on us by our regulators, regional audits or areas of care we have 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.

In 2011-2012, Liverpool Women's NHS Foundation Trust undertook a major review of its clinical audit activity and introduced a new strategy to ensure that our clinical audit programme and individual projects provide us with confidence about the standards of care we provide and/or are used to stimulate quality improvement activities. Each of our clinical specialties has a designated Senior Clinician as the Speciality Clinical Audit Lead and each speciality prospectively identifies key clinical audit projects to be undertaken during the forthcoming year. These may be in relation to national audit projects (such as the heavy menstrual bleeding (HMB) audit and neonatal intensive and special care (NNAP) regional audits (such as Vitamin D) or specific audits which are particularly important to us as they link to our quality priorities. We may also instigate audit projects in areas which we have audited in the past and where action plans have been completed or as a result of a specific concern.

During 2011-12 we have recruited a patient representative onto our clinical audit committee and this has brought significant benefit to the clinical audit process overall. We are currently in the process of developing a range of information for patients and our wider membership about audit projects and outcomes and will be strengthening the role of the patient representative during 2012-13.

In 2011-12 we undertook over 250 audit projects, covering services across the Trust. The largest proportion of our audit activity was in Maternity, although all clinical specialties are involved in clinical audit projects. We have seen an increasing number of non-medical staff undertaking audits and staff at all levels are becoming more involved in audit activities. Our high dependency nursing team, for example, undertake an audit of the management of patients with sepsis and the genetic counselling team have embarked on a major programme of audit, looking at a range of different aspects of their service. Our midwifery teams are all actively involved in audit projects and our audits in maternity cover over 80 different topics.

The reports of over 100 local clinical audits were reviewed by Liverpool Women's in 2011-12 and we intend to take the following organisation wide actions to improve the quality of healthcare provided:

- improve our monitoring of the implementation of action plans linked to audits and provide support to action plan leads
- introduce a quarterly review of progress against delivery of our annual audit programme
- focus a significant proportion of the audit programme in 2012-13 on re-auditing areas where we know that there have been improvement programmes in place
- develop a risk-sensitive audit programme, linking audit to other areas of quality
- provide a wider programme of training to clinical staff to support high quality audit

(Please note that it is not practical to detail the action plan for every local audit project undertaken, rather the information above illustrates how we intend to improve the quality of our audit programme per se, thus ensuring that actions are implemented and embedded and we can demonstrate high quality care in specific areas).

During 2010-11 Liverpool Women's was subject to an external review by the NHS Litigation Authority (NHS LA). The NHS LA set out standards for NHS organisations in general and for providers of maternity care in particular. The standards cover a number of different aspects of care (from care of women in labour, to making sure staff receive appropriate training to medicines management). The aim of the standards is to ensure that organisations manage risk effectively and that we can demonstrate that the policies we have in place are implemented and monitored so as to ensure the highest standards of care. Following the 2 assessments (for the general standards across the Trust and for the maternity service in particular), we were awarded the highest level of accreditation possible – one of very few Trusts in the



country to achieve this. Our approach to audit was also recognised by the Care Quality Commission (the organisation which regulates health and social care in England) who, following on from a recent inspection, specifically commented on how we are using clinical audit to review and improve standards across the hospital and the high profile of audit more generally.

## Clinical Research

The Trust is continually striving to improve the quality of its services and recognises that participation in research is pivotal to this ambition. The Trust also recognises that research is of the utmost importance in achieving cost improvement measures across the organisation. The White Paper Equity and Excellence: Liberating the NHS (DH July 2010) highlights that "Research is even more important when resources are under pressure – it identifies new ways of preventing, diagnosing and treating disease. It is essential if we are to increase the quality and productivity of the NHS and to support growth in the economy".

In 2011/12 we have continued our efforts to contribute to quality National Institute for Health Research (NIHR) studies and to increase subsequent NIHR recruitment accruals. We also continue to focus our efforts on collaborative research with academic partners to ensure the research we conduct is not only of high quality, but is translational, providing clinical benefit for our patients in a timely manner.

The number of patients receiving NHS services provided or sub-contracted by Liverpool Women's NHS Foundation Trust in 2011/12 that were recruited during the period 1 April 2011 to 31 January 2012 to participate in research approved by a research ethics committee was 3,023 of which, 1,916 were recruited into NIHR portfolio studies.

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

Liverpool Women's was involved in conducting 101 clinical research studies across our speciality areas of maternity, neonates, gynaecology oncology, general gynaecology, reproductive medicine and genetics during 2011/12. At the end of 2011/12 a further 12 studies were in set up including 4 industry studies (anaesthesia, neonates, gynaecology and reproductive medicine).

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; moving innovative changes in treatment from the laboratory bench to clinical practice. A number of studies being led by Liverpool Women's were completed during 2011/12, the results of which have directly impacted clinical practice. Studies completed during this period which have had a direct bearing on healthcare delivery, recruited 902 patients. These studies were concerned with blood-clotting in emergency surgery, failure to progress in labour (women with diabetes), blood monitoring in babies, out-patient monitoring in labour, and obesity in pregnancy, and have all influenced healthcare delivery in their respective areas for the benefit of patients. We continue to lead on a number of studies, including studies adopted onto the NIHR portfolio, which will influence healthcare delivery in assisted conception, neonatal nutrition, antimicrobial use in neonates, obesity in pregnancy, and foetal medicine.

There were 71 clinical staff contributing to research approved by a research ethics committee at Liverpool Women's during 2011/12. 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.

Our research has contributed to the evidence-base for healthcare practice and delivery, and in the last year, 87 publications have resulted from our involvement in research (with 21 NIHR publications), which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS.

## Clinical Quality and Innovation (CQUINs)

A proportion of the Liverpool Women's NHS Foundation Trust's income in 2011/12 was conditional on 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 Commissioning for Quality and Innovation payment framework.

The CQUIN indicators were negotiated and agreed following discussions between the Trust and Liverpool Primary Care Trust (LPCT), the host commissioner. These indicators reflect the key issues in the local health economy and National Health issues. Progress against these indicators was reviewed in detail at set intervals throughout the year.

In March 2012, Liverpool Primary Care Trust and North West Specialist Commissioning Trust confirmed that £934,000 out of the full CQUIN total of £1,071,000 would be payable to the Trust. A further payment would then be made post 31 March 2012 providing the Trust could demonstrate achievement against any outstanding targets.

Further details of the agreed CQUIN targets for 2011/12 and for the following 12 months are available on request from the Director of Nursing, Midwifery and Patient Experience. Alternatively, further information can be found at the following web site: [http://www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/\\_openTKFile.php?id=327](http://www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=327)

Chairman Ken Morris (centre) helps to raise awareness of the Sands charity



## About Our CQUIN Measurement Process

Our CQUIN measurement dashboard is a tool that we use for internal monitoring of some of our quality improvement initiatives and whilst we are happy for this information to be published, the fact that this is an internal monitoring means it is important that we provide some explanation of what is being viewed.

Each year the Trust will agree a series of quality improvement targets with the local Primary Care Trust and these will generally be implemented over the course of the following 12 months.

In order to do this we will need to make changes within our organisation and this inevitably takes time. Sometimes the changes we need to make take just a few weeks but others can take us a whole year.

Regardless of the changes we are making and the time it takes to implement them, we will try to monitor the changes straightaway. Many of our measures, therefore, show us apparently under-performing when, in fact, it is simply that we are making the changes within the organisation but they have yet to be fully implemented.

Another aspect of our monitoring system is that occasionally we will make changes in the middle of the year that will inevitably impact on our performance. We may need to implement training programmes for our staff in order to familiarise themselves with new ways of working and, therefore, our activity may be affected whilst we introduce and embed those changes.

Regardless of the changes that are being made, we continue to monitor them as our monitoring system provides an effective method of judging how successful our changes have been.

We can also reach the end of the year and the data or information that informs us of any changes may not yet be available to us at the time and so cannot be published within this report.

A summary of the Trust's performance against CQUIN targets is provided in the following dashboard.



Indicator	Number	Goal	achieve	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Patient Experience		Involved in decisions about treatment/care					48%	35%	29%	34%	91%	26%	100%	100%	100%	
		Hospital staff available to talk about worries/concerns					42%	28%	26%	24%	86%	19%	100%	89%	100%	
		Privacy when discussing condition/treatment					48%	33%	29%	29%	100%	23%	100%	96%	100%	
		Being informed about side effects of medication					44%	5%	7%	13%	88%	13%	100%	85%	92%	
		Being informed who to contact if worried					46%	20%	20%	31%	97%	26%	100%	100%	94%	
Harm Free Nursing	3.1	You skin matters	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	
	3.2.1	Falls - Patients risk assessed for falls (Gynae: Meditech)	>=98%	89%	90%	95%	92%	93%	86%	89%	95%	100%	99%	96%	93%	
	3.2.1	Falls - Patients risk assessed for falls (Maternity: Audit)	>=98%	80%	76%	96%	80%	92%	68%	68%	60%					
	3.2.2	Falls - Patients at risk to have a care plan (Gynae: Meditech)	>=98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
	3.2.2	Falls - Patients at risk to have a care plan (Maternity: Audit)	>=98%	0%	NIL	NIL	NIL	NIL	NIL	NIL	NIL					
	3.2.3	Falls - RCA completed for all falls	100%	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	
	3.3.1	Weight Loss - Patients screened for malnutrition on elective admission	>=95%	100%	100%	100%	100%	100%	100%	100%	61%	80%	96%	95%	87%	83%
	3.3.2	Weight Loss - Patients screened for malnutrition on emergency admission	>=90%	100%	100%	100%	100%	100%	100%	100%	57%	74%	91%	90%	85%	80%
	3.3.3	Weight Loss - Patients at risk to have care plan	100%	NIL	NIL	NIL	NIL	NIL	0%	NIL	33%	66%	52%	71%	89%	59%
	3.3.4	Weight Loss - Patients high risk referred to dietician	100%	NIL	NIL	NIL	NIL	0%	NIL	NIL	58%	66%	67%	86%	72%	73%
	3.4.1	End of Life - Patients are cared for on LCP	100%	NIL	100%	0%	NIL	NIL	NIL	0%	100%	100%				
			>=35%		Redefined measure reporting from December							NIL	NIL	100%	NIL	
	3.4.2	End of Life - Preferred place of care recorded	>=98%	NIL	100%	0%	NIL	NIL	NIL	100%	100%	100%				
	3.4.3	End of Life - Patient has personalised care plan	>=95%		Redefined measure reporting from December								NIL	NIL	100%	NIL
	3.4.4	End of Life - Patient died in preferred place of care	>=98%	NIL	100%	100%	100%	NIL	NIL	100%	100%	100%				
			>=60%	NIL	100%	100%	100%	NIL	NIL	100%	100%	100%				
			>=70%		Redefined measure reporting from December								NIL	NIL	100%	NIL
3.4.5	End of Life - Patient assessed for pain	>=98%	NIL	100%	100%	100%	NIL	NIL	100%	100%	100%					
	End of Life - Pain assessed and controlled	>=80%		Redefined measure reporting from December								NIL	NIL	100%	NIL	
3.4.6	End of Life - Patient pain controlled	>=90%	NIL	100%	100%	100%	NIL	NIL	100%	100%	100%					
	End of Life - Symptoms assessed and controlled	>=80%		Redefined measure reporting from December								NIL	NIL	100%	NIL	
3.4.7	End of life - Patient symptom controlled	>=80%	NIL	100%	100%	100%	NIL	NIL	100%	100%	100%					
	End of Life - Fax sent to GP to support supportive care template	>=80%		Redefined measure reporting from December								NIL	NIL	100%	NIL	

Indicator	Number	Goal	achieve	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	3.5	Fit & Well - Sickness & Absence in nurses & midwives	>=96%	96%	96%	96%	96%	95%	95%						
			>=95.5		Q3 & Q4 Target 95.5 (see spec)				94.0%	94.5%	95.3%	94.5%	95.8%	96.3%	95.6%
	3.6	Nurse led discharge	>= 97%	87%	90%	93%	91%	98%	97%	97%	99%	97%	99%	98%	98%
	3.7	Reduce infections following c-section	<= 10	1	0	0	3	1	0	0	0	1	1	2	1
	3.8.1	Increase in number of pts offered appt at VBAC clinic at 36 weeks	>=95%												
		Increase the number of staff supporting physiological birth	>=95%									78%	80%	82%	69%
	3.8.2	Increase in number of pts offered appt at VBAC clinic at 36 weeks	>=95%												
		Increase in number of pts offered appt to discuss pain relief and choice of birth	>=95%									56%	44%	88%	84%
	3.8.3	Increase normal births as % of total births	>75.8%	77%	77%	79%	77%	78%	75%	75%	76%	73%	76%	78%	78%
	4.1	Identify a Trust Board Executive Champion													
	4.2	Identify a Lead Officer													
	4.3	Submit Public Health Strategy													
	4.4	Staff to complete Brief Advice train the trainer course													
	4.5	BA trained staff to cascade to other staff													
	4.6.1	Brief Advice given to smokers	>= 90%	100%	100%	100%	100%	100%	100%	100%	98%	96%	97%	97%	99%
	4.6.2	Brief Advice given to drug/ alcohol issues	>= 90%	50%	50%	50%	50%	63%	87%	76%	80%	76%	76%	76%	76%
	4.6.3	Brief advice given to patients with BMI 30+	>= 90%	50%	50%	50%	50%	55%	87%	85%	89%	91%	86%	89%	90%
	4.6.4	Communication system identified with GPs to highlight Public health issues													
	4.7	No. patients with smoking status recorded	>=95%	86%	87%	86%	87%	86%	85%	99%	98%	100%	99%	100%	98%
	4.8	Brief Intervention to smoking patients at booking (12 weeks)	>=95%	96%	99%	98%	99%	98%	98%	99%	99%	98%	96%	94%	97%
	4.9	Refer smokers into specialist stop smoking services	>=40%	27%	40%	34%	59%	61%	69%	65%	55%	57%	54%	56%	60%
	4.10	Increase in women at booking offered a CO2 reading - System setup													
		Increase in women at booking offered a CO2 reading - Measurement													
	4.11	Participate in evaluation process coordinated by LPCT													
	4.12	Health Start Training	>=80%												
	4.13	1:1 discussion with women at 12 wks and mothers at birth re: Healthy Start	>=80%												
	4.14	Increase sign up of patients to Health Start Vitamin Scheme	>=95%												
	5a.1	Est. discharge discussion within 24hrs of inpatient admission	>=90%	74%	73%	77%	73%	76%	71%	65%	80%	87%	90%	87%	90%
	5a.2	Discharge summaries to contain CRG dataset	>=98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Brief Interventions											27.7%	78.9%	59.0%	42.5%	44.2%

Indicator	Number	Goal	achieve	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Brief Interventions (continued)	5a.3	Discharge summaries received by GP within 24 hours	>=95%	96%	98%	98%	98%	99%	99%	99%	99%	99%	99%	98%	98%	
	5b	Implementation plan to provide electronic method		Complete												
	5c	Discharge summary given to patient on discharge	>=95%	81%	82%	85%	88%	87%	98%	98%	98%	99%	99%	98%	96%	
	5d	Discharge letter received by GP in 2 weeks	>=98%	100%	99%	99%	95%	97%	97%	98%	98%	100%	97%	93%	98%	
	5e	Discharge of inpatients prescribing	>=98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Optimum Care Package	6.1	Patients assessed for clinical triage assessment within 1/2 hour	>98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
	6.2 A	No Patients completing questionnaire in community services	>=98%	0%	0%	0%	0%	0%	0%	0%	0%	0%	100%	100%	100%	
	6.2 B	Patient offered a choice of pain relief (Yes)	>=98%	0%	0%	0%	0%	0%	0%	0%	0%	0%	88%	91%	100%	
	6.2 C	Patient received pain relief of choice in a timely manner (Yes)	>=98%	0%	0%	0%	0%	0%	0%	0%	0%	0%	100%	83%	85%	
	6.2 D	Patient satisfied pain was managed in labour (As expected or better)	>=98%	0%	0%	0%	0%	0%	0%	0%	0%	0%	86%	93%	100%	
	6.3 A	Reducing LOS - Patient discharged within 12 hours	>16.0%	20%	22%	20%	20%	21%	21%	20%	20%	19%	27%	29%	20%	22%
	6.3 B	Reducing LOS - Patient discharged within 24 hours	>41.7%	42%	46%	43%	43%	42%	45%	43%	43%	40%	51%	47%	41%	44%
	6.4 A	Patient Experience - Number of patients receiving a questionnaire	>=98%	0%	0%	0%	0%	0%	0%	0%	0%	0%	100%	100%	100%	100%
		Patient Experience - Overall rating of hospital food (Good/Very Good)		0%	0%	0%	0%	0%	0%	0%	0%	0%	71%	71%	79%	61%
		Patient Experience - How clean was ward and toilets (Clean or Very Clean)		0%	0%	0%	0%	0%	0%	0%	0%	0%	96%	96%	92%	100%
6.4 B	Patient Experience - Suitability for Breastfeeding (Yes)		0%	0%	0%	0%	0%	0%	0%	0%	0%	100%	100%	100%	100%	
6.4 B	Patient Experience - Response Rate		0%	0%	0%	0%	0%	0%	0%	0%	0%	3%	3%	2%	3%	
6.5 A	Skin to Skin Contact		85%	85%	86%	87%	86%	86%	86%	84%	87%	86%	88%	85%	83%	
6.5 B	Skin to Skin Contact - 1 Hour			48%												
Neonatal optimum care package	1	Benchmark against NICE 2010 Quality Standards		Complete												
	2	Initiation of Common Assessment Framework for all eligible babies (<1500g)	100%	Complete												
	3	Questionnaire on Discharge from Neonatal services								78%		100%	81%			
	4	Increase in very low birth weight babies being breast fed by mother	>=90%	91%	100%	95%	86%	94%	75%	87%	87%	85%	100%	88%	100%	82%
	2	Manage demand of counselling for at risk couples by introducing referral protocol		Complete												



## 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.

Two unannounced visits were made to the Trust during Quarter 4 by the Care Quality Commission. The first, on 7 February 2012, was made by six inspectors including two pharmacists, who reviewed Key CQC Outcomes 01, 04, 07, 09, 14 and 16. The final report of the Commission's compliance review was overwhelmingly positive reporting excellent feedback from patients, their families and staff. A moderate concern was identified in respect of the management of medicines and for which actions were swiftly taken. In particular a planned review of the Trust's pharmacy services and medicines management was expedited and an external review commenced on 20 February 2012.

### Statements from the CQC

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 did not take any enforcement actions against Liverpool Women's NHS Foundation Trust during the 2011-12 reporting period.

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

The Trust is assured that it satisfies the CQC registration requirements through its monitoring of its CQC Quality & Risk Profile (QRP).

## Data Quality

The Liverpool Women's Hospital NHS Foundation Trust submitted records to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data which included the patient valid NHS Number was:

- 94.8% for admitted patient care
- 93.9% for Outpatient care; and
- 91.4% for accident and emergency care

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

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

- Development of Data Quality dashboard at departmental level
- Action plan in place to improve batch tracing processes to improve NHA numbers
- Improved data quality monitoring processes being developed with Booking, Scheduling and Administration service

## Information Governance Toolkit attainment levels

The Liverpool Women's Hospital NHS Foundation Trust's Information Governance Assessment Report score overall score for the March 2012 assessment was 62% and was graded not satisfactory.

Due to turnover in personnel a significant level of evidence was not submitted at this time, but which had been submitted in previous quarters within the year 2011/12. Of the 13 Requirements that were below level 2 in this submission, an internal assessment identified clear evidence to support a level 2 standard for 11 out of the 13 requirements and two which were at risk of not achieving a level 2. This assessment is similar to many other NHS Trusts which have scored an overall level 2 for Information governance.

The Trust is confident that these issues can be resolved by the end of Quarter 1 2012/13 in time for the next submission.

## Clinical Coding

Liverpool Women's NHS Foundation Trust was granted exemption from the Audit Commission's clinical coding audit during 2010/11 due to its demonstration of high levels of accuracy in three previous Payment by Results (PbR) Data Assurance Framework audits. However, in 2011/12 all Acute NHS Trusts were subject to re-audit.

Liverpool Women's NHS Foundation Trust was subject to the Payment by Results clinical coding audit during the period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were as presented below.

### Clinical coding error rates:

- Primary Diagnoses Incorrect 5%
- Secondary Diagnoses Incorrect 7.4%
- Primary Procedures Incorrect 0%
- Secondary Procedures Incorrect 3.2%

The services audited during this period included:

- Locally determined speciality – Obstetrics 100 spells
- Random selection from SUS – 100 spells

The coding accuracy rates are excellent and equate to level 3 in the Information Governance toolkit.

**It is important to note that these results cannot be extrapolated further than the actual sample audited.**

# Stakeholder statements on our quality report

## Statement from Commissioning Primary Care Trust – NHS Merseyside (Liverpool Primary Care Trust)



In line with the NHS (Quality Accounts) Regulations 2011, NHS Merseyside can confirm that we have reviewed the information contained within the account and checked this against data sources where this is available to us as part of existing contract/ performance monitoring discussions and is accurate in relation to the services provided. We have reviewed the content of the account and can confirm that this complies with the prescribed information, form and content as set out by the Department of Health.

As Director for Service Improvement and Executive Nurse for NHS Merseyside I believe that the account represents a fair and balanced view of the 2011/12 progress that Liverpool Women's NHS Foundation Trust has made against the identified quality standards. The Trust has complied with its contractual obligations and has made good progress over the last year with evidence of improvements in key quality & safety measures.

**Trish Bennett**  
Director of Service Improvement & Executive Nurse  
NHS Merseyside

## Commentary from NHS Liverpool Clinical Commissioning Group

NHS Liverpool Clinical Commissioning Group welcomes the opportunity to receive and comment on Liverpool Women's NHS Foundation Trust Quality Accounts for 2011/12.

In preparation for the formal establishment of the CCG in April 2013, NHS Liverpool have led the contractual arrangements over the past year and this account is consistent with reports received and development of priorities for 2012/13.

It is clear to the CCG that Liverpool Women's NHS Foundation Trust has a clear commitment to quality improvement and engagement with patients and staff. Clear progress has been made through the year.

We have established excellent working arrangements between the CCG and the Trust and look forward to developing our relationship further over the coming years as we collaboratively seek to improve health outcomes for the population of Liverpool.

Dr. Nadim Fazlani,  
Chair Liverpool Central Locality,  
NHS Liverpool Clinical  
Commissioning Group

Dr. Simon Bowers,  
Chair Liverpool Matchworks Locality,  
NHS Liverpool Clinical  
Commissioning Group

Ray Guy,  
Chair, Liverpool North Locality,  
NHS Liverpool Clinical  
Commissioning Group

## Commentary from Liverpool Local Involvement Network (LINK)

Liverpool LINK once again welcomes the opportunity to comment on Liverpool Women's NHS Foundation Trust's Quality Account.

We would like to congratulate the Trust on its efforts to meet the very ambitious number of priorities it set itself during 2011/12 and we are particularly pleased to note that there has been steady improvement regarding the majority of these priorities. However, without having access to data from other trust that are comparable with Liverpool Women's, it is hard for the lay person to judge exactly how well the hospital is performing in relative terms. This is a general weakness with quality accounts when dealing with hospitals that are fairly unique in a number of respects, but where in future there are opportunities to give some narrative on benchmarking for a particular priority this would be welcome if included in Quality Accounts.

The use of the Quality Accounts monitoring data by the Trust to inform future actions, as exemplified regarding the lack of a fall in emergency operations leading to a future focus on this issue, show the real value of the Quality Accounts exercise in driving up standards at the Trust.

The Quality Account document is reasonably easy to read and understand, and the graphs are somewhat informative in terms of absolute performance against specified targets. However, the sheer amount of data that needs to be covered by the Quality Account means that it is desirable, if one requires to explore any priority in detail, to be able to ask questions of Trust Officers rather than just relying on the text. So, Liverpool LINK welcomed the opportunity that the Trust afforded for LINK members and the public to engage at an event organised by and at the Trust. We also thank the Trust for its participation in the joint LINK Quality Accounts consultation event held at Knowsley LINK on 23/5/2012. Therefore, Liverpool LINK members have engaged adequately with the Trust to inform this commentary.

In terms on ongoing LINK engagement with the Trust, Liverpool LINK has a member designated to engage with Liverpool Women's NHS Foundation Trust on an ongoing basis and we have started to visit the Trust to gather patient experience with the full cooperation of the Trust and also in cooperation with Knowsley and Sefton LINKs.

We will be interested to monitor progress against the quality priorities chosen for 2012/13 with a particular focus on Patient Experience and Involvement. With this in mind, we will be seeking to instate quarterly meeting with the Trust to receive updates on Quality Accounts and Equality Delivery System progress. The fact that this Quality Account gives Liverpool LINK a firm focus for our ongoing engagement with Liverpool Women's NHS Foundation Trust is one of its major benefits to both patients and the public.

**Reverend Sister Maria Renate, Liverpool LINK**

## Commentary from Knowsley LINK



Knowsley LINK is pleased to be able to provide a commentary in support of the Liverpool Women's NHS Foundation Trust Quality Account for 2011-12. This response was compiled 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. The Quality Account was provided to LINKs in a timely manner and presented in detail during a question and answer session held in May 2012.

Over the past 12 months there has been ongoing involvement between the Trust and LINKs. The Trust has worked with LINKs in supporting the patient experience information stands held regularly by LINKs (Sefton, Liverpool and Knowsley) on the hospital site. Knowsley LINK members have also been part of an ongoing piece of work with the Liverpool Women's Hospital to look at increasing the number of services provided and available within local community settings.

The collaboration work, described within the Quality Account presentation, with Clatterbridge and Alder Hey Children's Hospital was particularly welcomed by LINK members. This is seen as a positive initiative within an NHS environment which increasingly seems to be focused on competition.

LINK members welcomed the focus around medication and the development of a method of reviewing and analysing medication errors to reduce risk. This is an area in which LINKs would be keen to monitor progress over the coming year.

It was felt that the Priorities for Improvement identified for the coming year are both challenging and reflective of the issues Community Members, Service Users and LINK members are keen to see addressed. The decision to retain the priorities monitored in previous years Quality Accounts is welcomed as this will help provide a clear picture of performance moving forward.

The focus on patient experience and the implementation of the Patient Experience and Involvement Strategy is again an area of work which Knowsley LINK is committed to supporting.

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

### Commentary from Sefton LINK



Sefton LINK would like to thank the Trust for their continued partnership work with the LINK over the past 12 months. This response was completed following a review of the draft copy of the Quality Account and from LINK members receiving a presentation. Members also attended a stakeholder event to gain a greater understanding of progress with priorities.

We congratulate the Trust on the work they have undertaken on the ambitious priorities which were set for 2011/12 and on the success of the 'Enhanced Recovery Programme', which is now implemented for all elective gynaecology patients.

Gathering patient experience and learning from those experiences to enhance the quality of services is vital. We are pleased that the Trust will look at patient experience and how the Trust is able to liaise with patients further over the coming year. It would have been useful for more information to have been provided within the account relating to patient experience as we found the information within this section to be lacking. We would like to suggest that the Trust review the patient experience section and provide further details on who will be involved in this work. We would be keen to get involved in this work over the next 12 months and to continue the patient experience stands we hold in partnership with Knowsley and Liverpool LINK at the Trust every month.

Within the patient experience section it would have been useful to highlight the partnership work which the Trust has been undertaking with Local Involvement Networks in improving access to services closer to home for gynaecological services.

We have noted the work of the Trust in reporting medication errors and would welcome an update on this work. We are interested in an update on progress and any actions which are put in place to reduce medication errors.

We appreciate that the Trust is unique in the services it provides and therefore it is hard to provide comparison data but it would be useful for the reader to be informed of this issue.

Little information is provided on the issues raised via the Patient Advice and Liaison (PALS) Service and this would have been useful. We would welcome copies of the reports which the PALS service produce and will progress this issue with the Trust.

The report is easier to read than some but there are a number of abbreviations and initials used throughout the report. Although the glossary is a useful tool and provides us with terminology, abbreviations are not provided and this would be helpful. We felt from reading the document that it was very clinical in its content (a large proportion of the report is dedicated to clinical effectiveness). The document could have included some of the work it has undertaken with the community and work in health promotion and well being.

We look forward to our work with the Trust over the coming 12 months to ensure that local people receive quality services.

Prepared by Sefton LINK

### **Commentary from Liverpool City Council Overview and Scrutiny Committee**

We thank you for the submission of the Quality Accounts for this year, which we formally note as received and reviewed. We particularly note your high standards of commitment to patient safety and experience and the ongoing commitment of your Board to maintain standards.

From the Liverpool Adult Social Care and Health Select Committee

### **Commentary from Knowsley Borough Council Overview and Scrutiny Board**

The Knowsley Overview and Scrutiny Board welcome the opportunity to provide a commentary on the Liverpool Women's NHS Trust Quality Account.

The Board has delegated responsibility for considering Quality Accounts to the Chair of the Overview and Scrutiny Board in consultation with the Lead and Deputy Lead Member for the Wellbeing theme. A meeting was convened on Wednesday 9th May to consider the Quality Account document received by the Liverpool Women's NHS Hospital Trust. The three members spent time considering the document and made a number of observations which have formed the basis of the Board's commentary, as set out below.

We focussed our discussions around three priority areas. Our first was the Trust's Improvement Priorities for 2012-2013 and the achievements highlighted over the previous year. We discussed where we thought work should be commended and whether there were areas where we felt more information may have been useful. Our final observations referred to the layout, style and format of the document, particularly focussing on how the document related to and/or involved the public.

We noted, in the first instance, that we had been given the opportunity to consider some of the Trust's activity at their consultation and engagement event in April prior to receiving a Quality Account. We felt that this enabled us to provide a more detailed assessment of the information contained within the document.

Having considered the Trust's priorities for improvement, we felt they were an accurate reflection of the issues identified in the main body of the report. The achievements section was very detailed and thorough and provided us with a clear understanding of the area being reported on. We thought it was important that the Trust had made the information accessible to the lay person.

In terms of Patient Safety we recognised that there had been a continued fall over several years in elective surgical infections and commend the Trust for their work in this area. We noted that there was a lack of fall in infections in emergency operations and we supported the Trust's decision to focus on this area over the next few years. The Trust's performance in terms of hospital acquired infections was very good and we felt it was important that the Trust takes its duty to prevent infection seriously, particularly in relation to the protecting vulnerable new babies. We thought it was good practice that the Trust monitored Late Onset Neonatal Blood Stream Infections and had set its own target despite there not being any nationally agreed benchmark.



We thought there was a general reduction in re-admission rates which had been helped by the introduction of the Enhanced Recovery Programme. We recognised that stillbirths were common but we would have appreciated some further information on the slight increase in rates over the past two years.

We were particularly pleased to see that the Trust had developed Patient Stories which were becoming an integral part of the meetings that took place across the organisation. We hoped that the Patient Stories will help to support improvements in the future. From the information on the comment cards, we were pleased to see that the reports were positive but we would have liked more information about the results. We also felt from our experience of other Trusts' practices, that there was more that the Trust could do to capture and learn from patient experiences.

We thought the layout and style of the report was very good. The descriptions of each area of work and the analysis of performance were clear, honest and demonstrated that the Trust continually aims for improvement in all elements of its work. We would welcome the opportunity to comment on the Trust's Quality Account next year in order to compare progress against priority outcomes and achievements.

**This commentary has been provided by Councillor Mal Sharp**

(Chair of Overview and Scrutiny Board), Councillor Bob Swann (Lead Member for Wellbeing) and Councillor Kay Moorhead (Deputy Lead Member for Wellbeing) on behalf of Knowsley Overview and Scrutiny Board.

### **Commentary from Sefton Borough Council Overview and Overview and Scrutiny Committee (Health and Social Care)**

The Committee received the draft Quality Report for 2011/12.



Members of local band The Beatelles, performed at our International Women's Day event in March 2012

## 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 2011-12
- 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 2011 to June 2012
  - Papers relating to quality reported to the Board over the period April 2011 to June 2012
  - Feedback from the commissioners dated 28/05/2012
  - Feedback from governors dated 14/04/2012 and 18/04/2012 (Quality event and meeting of Council of Governors respectively)
  - Feedback from Liverpool Local Involvement Network (LiNK) dated 25/05/2012
  - Feedback from Knowsley LiNK dated 29/05/2012
  - Feedback from Sefton LiNK dated 29/05/2012
  - Feedback from Liverpool City Council Adult Social Care and Health Select Committee dated 30/05/2012
  - Feedback from Knowsley Borough Council Overview and Scrutiny Board dated 29/05/2012
  - Feedback from Sefton Borough Council Overview and Scrutiny Committee (Health and Social Care) dated 29/05/2012
  - Feedback from NHS Liverpool Clinical Commissioning Group dated 30/05/2012
  - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 (publication pending)
  - The national patient surveys 2011 dated 13/04/2012
  - The national staff survey 2011
  - The Head of Internal Audit's annual opinion over the Trust's control environment dated March 2012
  - CQC quality and risk profiles dated 02/04/2012.
- 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 <http://www.monitor-nhsft.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](http://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.

Signed:



Ken Morris  
Chair  
28 May 2012



Kathryn Thomson  
Chief Executive  
28 May 2012

# Independent Auditor's Limited Assurance 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 Liverpool Women's NHS Foundation Trust's Quality Report (the 'Quality Report') and specified performance indicators contained therein.

## Scope and subject matter

The indicators in the Quality Report that have been subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- 62 day cancer wait
- Clostridium Difficile

We refer to these national priority indicators collectively as the "specified indicators".

## Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the assessment criteria referred to on page 97 of the Quality Report (the "Criteria"). The Directors are also responsible for their assertion and the conformity of their Criteria with the assessment criteria set out in the NHS Foundation Trust Annual Reporting Manual ("FT ARM") issued by the Independent Regulator of NHS Foundation Trusts ("Monitor"). In particular, the Directors are responsible for the declarations they have made in their Statement of Directors' Responsibilities.

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 Quality Report does not incorporate the matters required to be reported on as specified in Annex 2 to Chapter 7 of the FT ARM;
- The Quality Report is materially inconsistent with the sources specified below; and
- The specified indicators have not been prepared in all material respects in accordance with the Criteria.

We read the Quality Report and consider whether it addresses the content requirements of the FT ARM, and consider the implications for our report if we become aware of any material omissions.

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

- Board minutes for the period April 2011 to March 2012;
- Papers relating to Quality reported to the Board over the period April 2011 to March 2012;
- Feedback from the Commissioners (NHS Merseyside) dated 28/05/2012;
- Feedback from Liverpool Local Involvement Network (LINK) dated 25/05/2012;
- Patient surveys 2011 dated 13/04/2012;
- 2011 NHS staff survey;

- Care Quality Commission quality and risk profiles dated 02/04/2012; and
- The Head of Internal Audit's annual opinion over the trust's control environment dated March 2012.

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

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

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 2012, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. 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 '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:

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- Making enquiries of management;
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- Comparing the content requirements of the FT ARM 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

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the assessment criteria set out in the FT ARM and the Directors' interpretation of the Criteria in the Statement of Directors' Responsibilities on page 96 of the Quality Report.

The nature, form and content required of Quality Reports are determined by Monitor. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators in the Quality Report, which have been determined locally by Liverpool Women's NHS Foundation Trust.

## Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that,

- The Quality Report does not incorporate the matters required to be reported on as specified in annex 2 to Chapter 7 of the FT ARM;
- The Quality Report is materially inconsistent with the sources specified above; and
- the specified indicators have not been prepared in all material respects in accordance with the Criteria.

The logo for PricewaterhouseCoopers, featuring the company name in a stylized, handwritten-style font.

PricewaterhouseCoopers LLP, Chartered Accountants, 101 Barbirolli Square, Lower Mosley Street, Manchester, M2 3PW 29 May 2012

The maintenance and integrity of the Liverpool Women's NHS Foundation Trust's website is the responsibility of the directors; the work carried out by the assurance providers does not involve consideration of these matters and, accordingly, the assurance providers accept no responsibility for any changes that may have occurred to the reported performance indicators or criteria since they were initially presented on the website.



# Remuneration report

**The remuneration and pension benefits of our senior employees are given in the tables on pages 151-154. These senior managers are all Executive and Non-Executive Directors of the Board of Directors who served during the financial year 2011/12.**

The remuneration and terms and conditions of the Trust's Chief Executive, executive Board members and the Trust Secretary are determined by the Remuneration Committee of the Board of Directors. The Committee does this based on job evaluation, market intelligence and inflation together with any guidance drawn from national recommendations for senior managers in the NHS. The results of annual appraisals are also taken into account as is the achievement overall of the Trust's corporate objectives for the year. In determining this group of staff's remuneration the Committee has regard to the remuneration of other Trust employees who hold contracts under terms and conditions agreed nationally and locally.

Executive Directors' objectives are set at the beginning of each financial year, drawn from the Trust's corporate objectives. Performance is formally reviewed annually and shared with the Board's Remuneration Committee. The Chair appraises the Chief Executive who in turn appraises Executive Directors and the Trust Secretary.

The remuneration package of the Chief Executive and Executive Directors comprise annual basis 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. This is based on the Trust's performance overall and the achievement of individual and team objectives.

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.

The mid-point of the banded remuneration of the highest-paid director for the Trust in the financial year 2011/12 was £197,500 (£212,500 in 2010/11 (full year effect)). This was 7.1 times (7.5 times in 2010/11) the median remuneration of the workforce, which was £27,625 (£28,470 in 2010/11). In 2011/12, one employee received remuneration in excess of the highest paid director (0 in 2010/11).

In 2011/12 the average total number of whole time equivalent staff employed at the Trust was 1,230 (1,279 in 2010/11).

Total remuneration includes salary, non consolidated performance-related pay, benefits in kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

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's 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 or the Trust Secretary acted as Secretary to the Committee but neither was present for any discussion in relation to their own remuneration. At the Committee's invitation and in accordance with its terms of reference, the Chief Executive and Director of Human Resources and Organisational Development attended all or part of the meetings and provided advice on each occasion. Neither executive was present for any discussion in relation to their own remuneration.

Non-Executive Director	Remuneration Committee
Ken Morris – Chair	3 out of 3
Allan Bickerstaffe	1 out of 1
Steve Burnett	1 out of 1
David Carbery	2 out of 2
Liz Cross	3 out of 3
Ian Haythornthwaite	1 out of 2
Pauleen Lane	0 out of 3
Roy Morris	0 out of 2
Hoi Yeung	2 out of 2
Kathryn Thomson – Chief Executive	2 out of 3 (ex-officio)
Michelle Turner – Director of Human Resources & Organisational Development	3 out of 3 (ex-officio)
Julie McMorran – Trust Secretary	2 out of 3 (ex-officio)

The remuneration and terms and conditions of the Chair and Non-Executive Directors are determined by the Remuneration Committee of the Council of Governors. It uses a process of benchmarking based on information from all foundation trusts and from mutual organisations and the private sector. The results of individual Non-Executive Directors' annual appraisals are also taken into account.

The Chair and Non-Executive Directors' objectives are set at the beginning of each financial 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 (SID) undertakes the Chair's appraisal, with input from members of the Board and Council of Governors. The Trust was without a SID at the end of 2011/12 as this role was fulfilled by Non-Executive Director David Carbery whose term of office ended in February 2011. The Chair's appraisal was therefore conducted on this occasion by the interim Vice Chair, Non-Executive Director Liz Cross.

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 together with the Council's lead governor. During the year they were Professor Susan Wray (Committee Chair), Morag Day, Angela Douglas, Cathy O'Keeffe, Pat Jones and Pat Jones.

The Committee met twice during the year. However, its first meeting was inquorate and no decisions could be taken. A quorate meeting was subsequently held to ratify the matters discussed. Present at the first meeting were Professor Susan Wray and Morag Day, with apologies received from Angela Douglas, Pat Jones and Pat Jones. At the second meeting, present were Professor Susan Wray, Angela Douglas and Pat Jones (public governor for rest of England and Wales). Apologies were received from other members; Cathy O'Keeffe was not a member of the Committee at the time of its meetings. The Trust Secretary acted as Secretary to the Committee.

Remuneration and retirement benefits (pensions) of all directors are set out within note 4.4 of the annual accounts. Accounting policies for pensions are set out in note 4.3.

The audited remuneration and <sup>12</sup>pension benefits of senior managers is disclosed in this report and can be found at note 4.4 on page 151. This information has been subject to audit.



Kathryn Thomson  
Chief Executive  
28 May 2012

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

# Board of Directors

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

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

As per 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.

During the year, composition of the Board of Directors was:

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

Changes to the Board during the year were:

- Mr Ian Haythornthwaite was appointed as a Non-Executive Director with effect from 1 May 2011 for a period of three years
- The terms of office of Non-Executive Directors Mr David Carbery and Mr Roy Morris came to an end on 31 January 2012
- Mr Allan Bickerstaffe was appointed as a Non-Executive Director with effect from 1 February 2012 for a three year term
- The term of office of Non-Executive Director Mr Hoi Yeung ended on 28 February 2012
- Mr Steve Burnett was appointed as a Non-Executive Director with effect from 1 March 2012 for a three year term.

As a result of these changes there were also changes in respect of who held the Vice Chair and Senior Independent Director roles on the Board. Mr Roy Morris was Vice Chair until he left the Trust on 31 January 2012. Ms Liz Cross was appointed as interim Vice Chair from 1 February 2012 until a formal process was run in respect of the appointment in March 2012. That process duly took place, after which Liz Cross was formally appointed to the Vice Chair role.

Mr David Carbery was the Trust's Senior Independent Director until 31 January 2012. This appointment is made by the Board in conjunction with the Council of Governors. It was therefore agreed with the Council of Governors that the role would fall vacant for a short while from 1 February 2012 and that a process for appointing to it would commence in March 2012 and conclude in April 2012.

The decision to defer appointing to both roles until March 2012 allowed the most recently appointed Non-Executive Directors the opportunity to play a full part in the process. At no time were the balance, completeness and appropriateness of the Board compromised.

Board membership during the year is detailed below:

Non-Executive Directors	<sup>13</sup> Date of appointment	Length of appointment
Ken Morris - Chair	August 2011	3 years
	April 2008	3 years
	August 2005	3 years
Allan Bickerstaffe	February 2012	3 years
Steve Burnett	March 2012	3 years
David Carbery	February 2011	1 year
	February 2008	3 years
	February 2004	4 years
Liz Cross	February 2010	3 years
Ian Haythornthwaite	May 2011	3 years
Pauleen Lane	April 2010	3 years
Roy Morris	January 2009	3 years
	February 2005	4 years
Hoi Yeung	February 2009	3 years
	March 2005	4 years

Executive Director	Date of appointment
Kathryn Thomson – Chief Executive	September 2008
Vanessa Harris – Director of Finance	September 2009
Jonathan Herod – Medical Director	October 2010
Gail Naylor – Director of Nursing, Midwifery & Patient Experience	June 2009
Caroline Salden – Chief Operating Officer	April 2004
Michelle Turner – Director of Human Resources & Organisational Development	April 2010

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

Non-Executive Director appointments may be terminated if individuals 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 set out in the <sup>14</sup>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 holds a position with a local firm of solicitors with whom the Trust contracts for legal services. This is a declared interest in the Board of Directors' register of interests.

<sup>13</sup> 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

<sup>14</sup> The NHS Foundation Trust Code of Governance, Monitor (2010)

## Directors' meeting attendances

During 2011/12 the Board of Directors met monthly excepting August. Directors' attendance at meetings of the Board and its committees held during the year, possible and actual, is shown below:

Director	Board of Directors	Audit Committee	Governance & Clinical Assurance Committee	Human Resources & Organisational Development Committee	Finance, Performance & Business Development Committee
Allan Bickerstaffe	2 of 2				
Steve Burnett	1 of 1	1 of 1			
David Carbery	8 of 9	1 of 1	3 of 5		
Liz Cross	10 of 11			2 of 2	
Vanessa Harris	11 of 11				8 of 9
Ian Haythornthwaite	7 of 11	5 of 5			
Jonathan Herod	9 of 11		4 of 5		
Pauleen Lane	11 of 11	3 of 5			9 of 9
Ken Morris	11 of 11		4 of 5	1 of 2	8 of 9
Roy Morris	9 of 9			1 of 1	7 of 8
Gail Naylor	10 of 11		3 of 5	0 of 2	
Caroline Salden	11 of 11		4 of 5		8 of 9
Kathryn Thomson	11 of 11				7 of 9
Michelle Turner	9 of 11			2 of 2	
Hoi Yeung	9 of 10	5 of 5	4 of 5		7 of 8

## Pen portraits of members 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, and again in July 2011 for a third and final 3 year term of office. 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 on 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 and in 2011 became the Chair of its Audit Committee. He is also Chair of the Foundation Trust Network in the North West, a member of the Department of Health Foundation Trust Financing Facility and Chair of the Social Value Foundation.





### **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 an Executive 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.



### **Steve Burnett – Non-Executive Director**

Steve joined the Board in March 2012. He is a qualified actuary and spent 35 years in the financial services sector during which time he was Chief Executive of two large Merseyside companies, Swiss Life and Royal Liver. In recent years Steve has actively promoted the values of mutuality and is a keen supporter of member engagement in the setting of strategy and the governance of organisations.

Steve has now successfully diverted his attention to new areas and to the public sector in particular, with Liverpool Women's joining the Wales Audit Office and the Homes and Communities Agency as diverse areas where he now has non executive roles.

He now sits on the Trust's Audit Committee, Governance and Clinical Assurance Committee and Charitable Funds Committee.



### **Allan Bickerstaffe – Non-Executive Director**

Allan joined the Board in February 2012 and until the end of March 2012 was employed by Liverpool John Moores University as a Pro Vice Chancellor. In earlier times he also served as University Bursar and Director of Finance.

Allan has spent his entire working life in Liverpool, employed by several large private and public sector organisations, including United Biscuits, Merseyside Passenger Transport Executive, Arriva Limited and Liverpool City Council. He has held roles, past and present, with many voluntary organisations in the area.

Allan also has experience as a Non-Executive Director with a number of private and public sector companies, both regionally and nationally. In June 2011 he ended a five year term of office as a Non Executive Director with the North West Ambulance Service NHS Trust, where he was Chair of the Audit Committee.

By profession Allan is a Chartered Secretary and through work with his professional body has been involved with the development of governance best practice over many years and hopes to utilise this experience in his role with Liverpool Women's. Allan Chairs the Board's Governance and Clinical Assurance Committee and has joined the Human Resources and Organisational Development Committee.

He has three grown up sons, each of whom was born in the Trust's former hospital locations at Oxford Street and Mill Road.



### **David Carbery - Non-Executive Director and Senior Independent Director (to 31 January 2012)**

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 served during the year as the Board's Senior Independent Director, was Chair of its Governance and Clinical Assurance Committee and was also a member of the Audit Committee. His final term of office came to an end in January 2012.



### **Liz Cross BSc (Hons), MBA, MBPS, Non-Executive Director and Vice Chair (Vice Chair from 1 February 2012)**

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, as well as with the voluntary, public and private sector in the UK and overseas for the past 25 years.

Liz is currently 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.

She 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 founded The Connectives – a successful consultancy based value-led business – that works with private, public social enterprises and not for profit organisations, locally, nationally and internationally, to improve performance and deliver better economic and social outcomes. Liz and her team have been lucky enough to work in, and of course, learn and take inspiration from a diverse range of industries including financial services, pharmaceutical, retail, construction, health, housing, education and social justice, developing powerful partnership and projects that delivery break-through sustainable solutions.

Liz chairs the Trust's Human Resources and Organisational Development (Putting People First) Committee and its Charitable Funds Committee. On 1 February 2012 she was appointed as the Board's interim Vice Chair and subsequently appointed to the role substantively.



### **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.



### **Ian Haythornthwaite – Non-Executive Director**

Ian joined the Trust in May 2011 and is a fellow member of the Chartered Institute of Management Accountants, with extensive public sector management experience.

Ian is currently the Chief Finance Officer for BBC North and Future Media. He is based at Media City in Salford which opened in May 2011.

He is responsible for the strategic financial management of the BBC's interests in the North and leading on the sports rights negotiations for the BBC. He is responsible for the financial management of Future Media at the BBC which covers the mobile and internet platforms and the development of the i-player.

Prior to taking up his current role Ian was the Deputy Chief Executive at the North West Development Agency which led on the economic regeneration of the North West of England. Prior to this Ian was the Finance Director and then Pro Vice Chancellor at the University of Central Lancashire. As an Executive Director of the group he was responsible for the regional strategy, business interaction, commercial and intellectual property exploitation and innovation. In addition he was responsible for executive management of the University estate and facilities including all trading and service provision.

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



### **Jonathan Herod - BSc MBChB (Hons), MRCOG - Medical Director**

Jonathan joined the Board as its Medical Director in 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 1999 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. She has been a member of the Audit Commission and is also a member of South Manchester and Central Manchester Foundation Trusts. Pauleen Chairs the Trust's Finance, Performance and Business Development Committee and is a member of its Audit Committee.



### **Roy Morris CBE, DL - Non-Executive Director and Vice Chair (to 31 January 2012)**

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 chaired the Trust's Finance, Performance and Business Development Committee and was a member of the Charitable Funds Committee. He also served as the Trust's Vice Chair up to the end of his term of office in January 2012.



### **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.



### **Caroline Salden MBA, BA (Hons), Dip M – Chief Operating Officer**

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 also 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 focused on delivering the best possible patient experience.

A member of the Chartered Institute of Personnel and 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 (to 28 February 2012)**

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, 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 was the Chair of the Trust's Audit Committee and a member of its Finance, Performance and Business Development Committee. His final term of office came to an end in February 2012.

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

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

- The whole Board reviewed its performance in January 2012. This was led by external facilitators and allowed the Board to consider its strengths and weaknesses, and agree a programme of Board development in the context of the Trust's strategic plans
- At the end of each meeting the Board and each of its committees assesses its performance against the objective of each agenda item
- The Trust's internal auditors undertook a review of the Board's reporting systems, on the instruction of its Audit Committee. The audit indicated significant assurance in respect of the Board's reporting arrangements
- Each Board committee prepares an annual report of its achievements which is formally received by the Board of Directors
- Each Board director undergoes formal appraisal each year during which their performance against agreed objectives is evaluated:
  - As agreed by the Council of Governors, Non-Executive Directors are appraised by the Chair. In turn the Chair is appraised by the <sup>15</sup>Senior Independent Director, who invites the views of other Directors and Governors as a part of the process. <sup>16</sup>The Senior Independent Director is appraised by the Vice Chair
  - Executive Directors are appraised by the Chief Executive and the Chief Executive is appraised by the Chair. A report on individuals' performance is presented each year to the Remuneration Committee of the Board of Directors.

The Chair's other significant commitments are detailed on page 106 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](http://www.liverpoolwomens.nhs.uk).

Directors can be contacted by email via the 'contact' link on the Trust's website at [www.liverpoolwomens.nhs.uk/Contact\\_Us/](http://www.liverpoolwomens.nhs.uk/Contact_Us/) or via the Trust Secretary, Julie McMorran, at [julie.mcmorran@lwh.nhs.uk](mailto:julie.mcmorran@lwh.nhs.uk) or on 0151 702 4033.

<sup>15</sup> For 2011/12 this was conducted by the newly appointed Vice Chair in the absence of a Senior Independent Director

<sup>16</sup> There was no appraisal of the Senior Independent Director during 2011/12 as his term ended part-way through the year



## Audit Committee

Non-Executive Director Hoi Yeung was Chair of the Audit Committee until November 2011 when the role passed to Non-Executive Director Ian Haythornthwaite. During the year the Committee's other members were Non-Executive Directors David Carbery, Pauleen Lane and Steve Burnett. 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 auditors up to late 2011 were Baker Tilley. Following a process of competitive tender, in October 2011 PricewaterhouseCoopers LLP were appointed by our Council of Governors.

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. During the year, PricewaterhouseCoopers LLP (PwC) did undertake non-audit work for the Trust. The first piece of work commenced prior to their appointment as our external auditors, whilst the second piece occurred shortly after appointment (late in 2011/12), but was directly linked to the first. Due diligence was undertaken upon PwC's appointment as our external auditors, and prior to them commencing the second piece of work, to ensure that their independence was not compromised. It would be usual practise for approval for any work falling into this category to be sought from the Trust's Council of Governors and Audit Committee. However, the inextricable link between the first and second pieces of work meant this did not take place in-year, but approval will be sought retrospectively early in 2012/13.

Where the Trust is planning to appoint outside management consultants to undertake work, consideration is given to whether the external 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. The Trust would consider factors such as the likely fees for the work, the area in which it was to be undertaken and whether the auditors were likely to review the same area as a part of their work.

The Trust's internal auditors during the year were Mersey Internal Audit Agency. The Audit Committee agreed an internal audit plan for the year which focused on business critical systems using a risk based approach. The internal audit reports received by the Committee provided assurance in respect of the Trust's governance of both financial and non-financial risks.

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 Committees

The Trust has two Nominations Committees:

- In respect of Non-Executive Director appointments to the Board there is a Nominations Committee of the Council of Governors. This is chaired by the Trust's Chair, Ken Morris, and the Committee's members during the year were governors Denise Carter, Annette James, Pat Jones (lead governor), Gail Mannion and Godfrey Mazhindu. Directors' attendance at this Committee is shown below.

During 2011/12 the Committee met on 3 occasions. At two of its meetings the reappointment of the Trust's Chair was considered and the relevant sections of those meetings were chaired by the Vice Chair of the Board of Directors, Roy Morris. The Committee also considered Non-Executive Director recruitment to three vacancies that would occur during the year.

In accordance with the process agreed by the Council of Governors the Committee also considered the appointment of a new Senior Independent Director to the Board. At the invitation of the Trust's Chair it was joined on that occasion by the Chair of the Council of Governors' Remuneration Committee.

Details of the number of meetings held by the Council of Governors' Nominations Committee, and attendance by eligible Directors, is shown below:

Director	Nominations Committee of the Council of Governors
Ken Morris – Chair	1 – full attendance 1 – partial attendance 1 – for interview only
Roy Morris – Vice Chair (in the Chair for all or part of meeting when reappointment of Chair being considered)	2 out of 2
Kathryn Thomson – Chief Executive	2 out of 3 (ex-officio)

The Committee oversaw the reappointment of the Trust's Chair, and the recruitment of three new Non-Executive Directors during the year. In doing so it took the following approach:

- Reappointment of Chair - the reappointment of the incumbent Chair for a further three year term of office was supported, subject to satisfactory appraisal and interview. In doing so the Committee took into account the provision in Monitor's Code of Governance which states that reappointments beyond six years ought to occur in exceptional circumstances only, be subject to particularly rigorous review and based on annual reappointment (since serving more than six years could be relevant to the NEDs' independence.)

The Chair was formally interviewed by members of the Committee together with an independent assessor, namely the Chair of another Foundation Trust. The interview process focused in particular on assessing his independence. The panel also took into account the fact that NED membership of the Board would change significantly during 2011/12 hence there was a strong rationale for supporting continuity in the Chair. Following the interview process the Committee recommended to the Council of Governors that Ken Morris be reappointed as the Trust's Chair for a third and final three-year term. The Council confirmed this recommendation

- Recruitment of new Non-Executive Directors - three new Non-Executive Directors joined the Board in 2011/12, namely Ian Haythornthwaite, Allan Bickerstaffe and Steve Burnett. They each applied for the same NED vacancy at the end of 2010; however during the recruitment process the Committee considered they had found three exceptional candidates with a broad range of skills that could significantly contribute to the Trust. It therefore took the opportunity to consider the longer term strategy for Non-Executive recruitment and supported the immediate appointment of one of the candidates and the appointment of a further two later in the year 2011/12 when vacancies would occur.

In taking this approach the Committee took fully into account the gender and ethnic diversity of the Board. It acknowledged that the appointment of the second and third candidates would result in a Board of 5 male and 2 female Non-Executive Directors, none of whom are from minority ethnic backgrounds, and agreed that the next recruitment campaign would address the gender and ethnic balance of the Board. It also considered the overall skill mix that would result which would see a strong focus on finance, governance and business.

The recommendations of the Committee were accepted by the Council of Governors who considered fully all of the advantages and disadvantages of the approach. The Council also shared the Committee's confidence that the approach ensured compliance with the requirements of the Trust's constitution and Monitor's Code of Governance for Foundation Trusts.

- Executive Directors are appointed by the Nominations Committee of the Board of Directors. 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). The Committee did not meet during the year as no Executive Director appointments were made.

## Remuneration Committee

Please see remuneration report on pages 101 - 103.

## Code of Governance

The Trust is committed to the principles of good corporate governance as detailed in the NHS Foundation Trust Code of Governance. An annual assessment of the Trust's position against each of the Code provisions is undertaken. This assessment states the current position and any actions required, together with a statement against the principle of 'comply or explain'.

For the year 2010/11 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	<p>One of the Non-Executive Directors who served on the Board during the year 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 for 2011/12</p>
<p>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.</p> <p>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 appointment. Serving more than six years could be relevant to the determination of a NED's independence.</p>	<p>During the year the Trust's Council of Governors reappointed the incumbent Chair for a third and final three year term of office. Ken Morris had already served two three-year terms.</p> <p>In reaching its decision the Council's Nominations Committee took this Code provision fully into account. Its interview of Ken Morris focused in particular on assessing his independence, which the Committee agreed remained intact.</p> <p>Governors were also mindful of the need for some continuity on the Board of Directors given that three new NEDs would join the Board during 2011/12. The terms of office of the NEDs who held the roles of the Board's Vice Chair and Senior Independent Director would end early 2012 hence these roles would fall to new NEDs. Accordingly, the Committee did not consider that a change in Chairmanship at this time was in the best interests of the Trust.</p>
<p>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 department director's obligations to mitigate loss.</p>	<p>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.</p>

# Council of Governors

**Our Council of Governors has a number of statutory duties. These are to appoint, remove and decide 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. The Council also ensures that the interests of the community served by the Trust are appropriately represented.**

The Council of Governors meets at least three times each year, in public. Between April 2011 and March 2012 the Council of Governor met on four occasions.

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. Also shown is attendance by individual Governors at formal meetings of the Council of Governors held during the year.

Public Governors (elected)	Area	<sup>17</sup> Term of office	From	To	Council of Governors' meetings attended, April 2011 – March 2012
<sup>18</sup> Banks, Anna	Rest of England & Wales	3 years	2008	2011	1 of 1
Bedding, Kate	Central Liverpool	3 years	2011	2014	2 of 2
Craven, Andrew	Knowsley	3 years	2011	2014	2 of 2
<sup>19</sup> Croft, Jayne	Knowsley	3 years	2011	2014	0 of 0
Day, Morag	Central Liverpool	3 years	2009	2012	4 of 4
Henry, Felicia	Sefton	3 years	2011	2014	2 of 2
James, Annette	South Liverpool	3 years	2010	2013	4 of 4
Jennings, Bethan	Rest of England & Wales	3 years	2010	2013	1 of 3
Jones, Pat	Sefton	3 years	2009	2012	4 of 4
Jones, Pat	Rest of England & Wales	3 years	2009	2012	3 of 4
Kehoe, Ronnie	Knowsley	3 years	2008	2011	2 of 2
Kelly, Maureen	Sefton	3 years	2011	2014	3 of 4
Kerr, Barbara	North Liverpool	3 years	2009	2012	2 of 4
McDonald, Mary	South Liverpool	3 years	2009	2012	4 of 4
McKeating, Geoff	Sefton	3 years	2008	2011	2 of 2
Moran, Paul	Central Liverpool	3 years	2011	2014	2 of 2
<sup>20</sup> Paracha, Anees	Central Liverpool	3 years	2010	2013	0 of 2

<sup>17</sup> Terms of office begin and end at the annual members' meeting, usually held in September each year

<sup>18</sup> Governorship ended in May 2011 upon resignation

<sup>19</sup> Term commenced March 2012 following by election (seat previously vacant)

<sup>20</sup> Governorship ended in July 2011 for reasons for non-attendance

Public Governors (elected)	Area	<sup>17</sup> Term of office	From	To	Council of Governors' meetings attended, April 2011 – March 2012
Read, Tina	Rest of England & Wales	3 years	2011	2014	2 of 2
Rodney, Lisa	Central Liverpool	3 years	2010	2013	3 of 4
<sup>21</sup> White, Valerie	North Liverpool	3 years	2011	2013	0 of 0
Williams, Maggi	Central Liverpool	3 years	2008	2011	2 of 2
<sup>22</sup> Yadata, Nuhamin	Central Liverpool	1 years	2011	2012	2 of 2
Zack-Williams, Dorothy	Central Liverpool	3 years	2009	2012	3 of 4

Staff Governors (elected)	Class	Term of office	From	To	Council of Governors' meetings attended, April 2011 – March 2012
Brown, Dianne	Nurses	3 years	2008	2011	1 of 2
<sup>23</sup> Carter, Denise	Clinical & non-clinical support staff	3 years	2008	2011	0 of 1
Cooper, Iris	Nurses	3 years	2011	2014	2 of 2
Douglas, Angela	Scientists, allied health professionals & technicians	3 years	2008	2011	1 of 2
Drakeley, Andrew	Doctors	3 years	2010	2013	4 of 4
Graham, Susan	Clinical & non-clinical support staff	3 years	2011	2014	2 of 2
Mannion, Gail	Scientists, allied health professionals & technicians	3 years	2011	2014	2 of 2
<sup>24</sup> Mehigan, Simon	Midwives	1 year	2011	2012	2 of 2
O'Keeffe, Catherine	Clinical & non-clinical support staff	3 years	2009	2012	2 of 4
<sup>25</sup> Rooney, Jane	Midwives	3 years	2009	2012	1 of 1

Partnership Governors (appointed)	Organisation	Council of Governors' meetings attended, April 2011 – March 2012
Gladden, Roz	Liverpool City Council	1 of 4
Gray, Paula	Liverpool Primary Care Trust	4 of 4
Wray, Susan	University of Liverpool	3 of 4
Sue Spelman	Partnership organisation – Down's Syndrome Liverpool	2 of 4
Mazhindu, Godfrey	Partnership organisation – Liverpool John Moores University	3 of 4
<sup>26</sup> Aston, Jayne	Knowsley Borough Council	1 of 4

<sup>21</sup> Term commenced March 2012 following by election (seat previously vacant)

<sup>22</sup> Next highest polling candidate following end of governorship served by Anees Paracha, hence elected until the next annual election (summer 2012)

<sup>23</sup> Governorship ended in June 2011 when she left the employ of the Trust

<sup>24</sup> Elected for the remainder of the term of office initially served by Jane Rooney

<sup>25</sup> Governorship ended in April 2011 when she left the employ of the Trust

<sup>26</sup> Resigned seat in March 2012

During the year there were vacancies in respect of the Knowsley, Sefton, North Liverpool and rest of England and Wales public seats, one staff seat (Scientists, allied health professionals and technicians), two Primary Care Trust seats and one partnership organisation seat.

Elections to the Council were held during the year in respect of 12 seats that became vacant at the conclusion of the 2011 annual members' meeting, or shortly beforehand. There were in respect of 9 public seats and 4 staff seats. Seven of the seats were filled following contested election or uncontested nomination, and 5 of the seats were declared vacant.

Two by-elections were held during the year in respect of the Knowsley, Sefton, North Liverpool and rest of England and Wales public seats, and the staff scientists, allied health professionals and technicians seat. At the first by-election, for the five seats, three were elected to following uncontested nomination (Sefton and rest of England and Wales public seats, and the staff seat). The public seats of Knowsley and North Liverpool were filled following uncontested nomination at the second by-election.

All public and staff governors were elected by members in their constituency, by secret ballot (the Electoral Reform Service acted as returning officer). The exception to this is where governors were elected unopposed as a result of being the sole candidate for an available seat.

Partnership governors were appointed by their nominating organisation.

Excellent working relationships exist between the Council of Governors and the Board of Directors, and indeed between the Council and the wider Trust. Members of the Board of Directors regularly attend meetings of the Council of Governors. They do so in order to understand governors' views and the views of the Trust's members as conveyed by the Council. The Chief Executive has a standing invitation to attend all meetings of the Council. All Directors receive the Council's agenda and reports.

Directors' attendance at meetings of the Council of Governors during 2011/12 is shown below:

Director	Council of Governors' meetings attended, April 2011 to March 2012
Allan Bickerstaffe	0 of 0
Steve Burnett	0 of 0
David Carbery	3 of 4
Liz Cross	3 of 4
Vanessa Harris	3 of 4
Ian Haythornthwaite	1 of 4
Jonathan Herod	3 of 4
Pauleen Lane	2 of 4
Ken Morris - Chair	4 of 4
Roy Morris	1 of 4
Gail Naylor	3 of 4
Caroline Salden	3 of 4
Kathryn Thomson – Chief Executive	3 of 4
Michelle Turner	3 of 4
Hoi Yeung	2 of 4

The Trust maintains a register of interests for governors which is available at [www.liverpoolwomen.nhs.uk](http://www.liverpoolwomen.nhs.uk).



# Our membership

**Membership of Liverpool Women's NHS Foundation Trust is open to any member of the public over the age of 12 years and living in England and Wales. The majority of our members come from the areas where we provide services, that is the local authority areas of Central Liverpool, North Liverpool, South Liverpool, Knowsley and Sefton. However, almost 2,000 of our members come from outside of these areas, the constituency known as Rest of England and Wales.**

Membership is automatically available to all Trust staff who have a permanent contract of employment or who have worked for the Trust for at least 12 months.

As at 31 March 2012 the Trust had 11,845 members:

Public	Number
Central Liverpool	3,115
North Liverpool	1,751
South Liverpool	1,468
Knowsley	1,206
Sefton	1,360
Rest of England & Wales	1,280
Total public membership	10,491

Staff	Number
Doctors	67
Nurses	331
Midwives	337
Scientists, technicians and allied healthcare professionals	137
Administrative, clerical, managers, ancillary and other support staff	491
Total staff membership	1,363

As stated last year, our aim continues to be to make membership relevant, interesting and rewarding. With this firmly in mind, in October 2011 the Council approved a new membership strategy. Developed by the Membership Strategy Committee of our Council of Governors, which is led by Governor Mary McDonald, the strategy sets out the Council's aims for the next three years to 2014. These are to achieve and maintain a representative membership, listen to our members and take their views into account when planning new developments and/or changes to services, encourage our members to stand for election to the Council of Governors, provide an opportunity for our members to learn more about the Trust, and to increase the quality and level of participation in the Trust's democratic structures.

It is important that our membership, and our Council of Governors, reflects the characteristics of the populations we serve. During the year we introduced a revised membership form in order to gather information from our new members that would help us to more accurately determine these characteristics. This information is also being gathered from as many of our existing members as possible.

One of the aims of the strategy was to introduce a Medicine for Members series. Held bi-monthly, these events are open to all members of the Trust who wish to learn more about a particular topic and meet the Trust's experts in that field. Meetings have so far been held on the topics of preparing for pregnancy and continence, with a calendar of further events planned across 2012/13.

In September 2011 we held our annual members' meeting and hospital open day. As in previous years the formula was a huge success and many hundreds of people came through the hospital's doors to meet with Governors, Directors and Trust staff and to learn more about the services we provide. Our Young Women's Midwife Sue Thomson – who during the year was also awarded the honour of national Midwife of the Year - addressed the annual members' meeting together with a young woman who had delivered her baby at the Trust. They spoke about young women's experience of pregnancy and birth and the care the Trust was proud to provide to them and their families.

The Trust marked International Women's Day on 8 March 2012 with a celebratory event open to its members, patients and the public. Well over 150 people attended the event which was officially opened by local radio personality Linda McDermott. Performing on the day were local group The Beatelles, the only all female Beatles tribute band in the UK, and the Liverpool Harmonic Gospel Choir

Our members' newsletter, Generations, continues to be sent regularly to all of our members.

Members can contact Governors and Directors at the Trust by:

- Post – Trust Offices, Liverpool Women's NHS Foundation Trust, Crown Street, Liverpool L8 7SS
- Telephone – 0800 073 0825 (free)
- Email – [communications@lwh.nhs.uk](mailto:communications@lwh.nhs.uk).

# 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 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  
Chief Executive  
28 May 2012

# Annual governance statement

## 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 2012 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 which, as Accounting Officer, I have overall responsibility for. The risk management strategy was reviewed during this reporting period. I have delegated the following responsibilities to my Executive Directors:

- The Director of Nursing, Midwifery and Patient Experience is responsible for implementation and effectiveness of risk management systems, all aspects of risk management and governance including all aspects of health and safety management
- The Medical Director is responsible for all aspects of clinical risk management and clinical governance
- The Director of Finance is responsible for risk management as it relates to the policies, procedures and systems of financial control and management
- The Director of Human Resources and Organisational Development is responsible for workforce risks
- The Chief Operating Officer is responsible for operational and business risks.

The risk management strategy provides a framework for managing risks across the organisation. It provides a clear, structured and systematic approach to the management of risks to ensure that risk assessment is an integral part of clinical, managerial and financial processes at all levels across the organisation.

A committee structure is in place to support the process of integrated governance and is set out in the risk management strategy. This ensures 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 Corporate Risk Committee reports to the Governance and Clinical Assurance Committee of the Board of Directors.

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 known adverse incidents through a centralised system (ULYSSES, SAFEGUARD). Data from the SAFEGUARD system is utilised to inform trend reports to the Board, its Governance and Clinical Assurance Committee and operational risk and quality committees. This reporting process has significantly developed during the year to evolve from the performance management of serious incidents to the performance management of actions and recommendations arising from them. It provides clearer, more transparent intelligence that eliminates the risk of false assurance. It also reports the dates and/or modes of feedback of lessons learned to both staff involved in specific incidents and wider generic feedback.

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 have oversight of progress against action plans prepared in respect of risk issues. Both committees report directly to the Board. The Board itself reviews the BAF twice per annum.

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 Annual Governance Statement 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 the organisation's risks, its risk management activity and outcomes. The most significant risks (in-year and on-going) are contained within the Trust's corporate risk register, which drives a dynamic process that changes in response to the changing profile of individual risks it contains. Significant risks are those rated 15 or above within our clinical divisions and corporate functions. The corporate risk register is regularly reviewed by the Trust's Corporate Risk Committee, chaired by the Chief Executive.

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 outlined in the BAF and makes informed decisions upon risk treatments and interventions based on the best intelligence available. This approach enables the Board to determine its risk appetite and can result in it deciding that no additional risk treatments or interventions are the most appropriate response to an identified risk. Decisions relating to the organisation's response to individual identified risks are therefore determined by the Trust's risk appetite which is currently risk averse, and consequently favours intervention wherever possible.

During the year the Trust's most extreme risks, as described in the BAF, were those relating to 0% financial growth, increased inflationary pressures and savings targets, potential loss of income from contract changes, achievement of the cost improvement programme, achievement of the national target in respect of venous thromboembolism assessment and treatment and the policy approval process. These risks have been, and will continue to be, monitored by the Board's assurance committees using the BAF.

The major risks facing the Trust are 0% financial growth; delivery of our cost improvement programme, changes in the national funding tariff; changes in the architecture of the NHS, in particular the introduction of Clinical Commissioning Groups; the future of genetics service provision; retaining our market share in the face of increasing competition, and; workforce plans to address the ageing workforce and loss of expert knowledge.

The Trust has moved to 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. During the year, the Trust appointed a Head of Integrated Governance to oversee robust and effective implementation of this 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 NHS Litigation Authority (NHLA), Clinical Negligence Scheme for Trusts (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 (HealthAssure) 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.

The quality of performance information used across the Trust is assessed using a multi-layered approach. All patient NHS numbers are checked and validated against national data on a weekly basis, patient level activity data is validated against plan on a monthly basis, including consistency checking across hospital clinical/patient record systems and a central data warehouse, and datasets are verified through two external sources. Our data is then further reviewed to compare against national, contractual and locally agreed data quality measures using comparators provided by CHKS, an independent provider of healthcare benchmarking intelligence, and for validation against national expectations using data provided via SUS (Secondary Uses Service), which is part of the NHS. Summary and data level reports are provided to our clinical divisions following the quality checking process, to allow them to correct any errors and review data entry processes.

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 divisional risk registers, which are actively monitored by the senior management within the clinical and corporate 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 operate 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. A decline in quality would be measured via a triangulation of intelligence from a number of valid sources including incidents,



complaints, contacts with our Patient Advice and Liaison Service, dialogue with patient representative organisations such as Local Involvement Networks, input from our primary care stakeholders and feedback from GPs, alongside clinical performance benchmark data to give a comprehensive and holistic quality map of the Trust.

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.

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 engages 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 Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC). Assurance is obtained on compliance with CQC registration requirements via the monthly Quality and Risk Profile the Commission issues. This is reviewed by members of the executive team and via the Trust's Clinical Governance Committee. The CQC did, however, register a moderate concern about the Trust's compliance with the key CQC outcome relating to medicines management, further details of which are given on pages 128 - 129 of this Statement.

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 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.

## **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/operational plan 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 2011/12 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.

During the course of this year, the Trust undertook a comprehensive review of its administrative and clerical functions. It was driven by a need for significant service improvement and significantly contributed to the Trust's Cost Improvement Programme.

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 and the executive team.

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.

## Annual quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) 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 divisions 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 division. And each division's Clinical Director and Divisional Manager are accountable for delivering all aspects of the quality report.

The Trust's Clinical Governance Committee plays a 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 and Head of Integrated Governance, a stakeholder event in respect of our draft quality report was held in April 2012 at which our stakeholders, including Primary Care Trusts, 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 Integrated Governance and Head of Information for Integrated Governance 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, clinical audit and the executive managers and clinical leads 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, the Governance and Clinical Assurance Committee, the Clinical Governance 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. The Director of Internal Audit has stated that in his opinion, significant assurance can be given that there is a generally sound system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.

My review is also informed by reports from the Audit Committee, Governance and Clinical Assurance Committee, Clinical Governance Committee, Corporate Risk Committee, 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 re-accredited the Trust Level 3 for general standards in May 2011 and re-accreditation at Level 3 of the Clinical Negligence Scheme for maternity standards in June 2011. The Audit Commission provided independent assurance in respect of our coding and costing of inpatient activity during the year through an audit of our inpatient data, as part of the Payment by Results data assurance framework in December 2011.

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
- The Clinical Governance Committee is instrumental in preparing our quality report and monitoring performance against agreed quality indicators
- 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 internal 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.

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

- **Medicines management.** The Care Quality Commission made an unannounced visit to the Trust in February 2012 and reported a moderate concern in respect of compliance with the key CQC outcome 09 – Management of Medicines. Based on the checks undertaken by the Commission’s inspectors and on their discussions with patients and staff on the day, the Commission judged that the Trust had arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines but staff were not always following these so patient’s health was being placed at unnecessary risk. In response the Trust expedited an already planned review of its pharmacy services and swiftly put in place an action plan to address the concerns raised. A report detailing progress in relation to medicines management will be reviewed by the Board’s Governance and Clinical Assurance Committee in July 2012.
- **Information governance toolkit.** The Trust did not achieve a satisfactory rating in respect of its toolkit assessment in March 2012, when its submission was graded as Level 1. This occurred due to turnover in responsible personnel which resulted in significant evidence not being submitted at the time of the assessment, but which had been submitted in previous quarters throughout 2011/12. It is not possible to amend the March 2012 submission, however. Of the 13 standards that were assessed as being below Level 2 in this submission, an internal assessment identified clear evidence to support that 11 of them did reach Level 2 standard, but that insufficient evidence was put forward to demonstrate this. The Trust is confident that these issues can be resolved by the end of June 2012.
- **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. 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 which was implemented and monitored by the Trust during 2010/11 and 2011/12. An independent review of its implementation was also commissioned and undertaken during 2010/11, to provide robust assurance that all required actions had been satisfactorily completed or were on target for completion, and the report of this review was considered by the Board of Directors in April 2011. The Board is scheduled to receive a final report early in 2012/13 confirming that all actions have been satisfactorily completed.
- **Compliance with Human Fertilisation and Embryology Authority registration requirements.** An interim assessment of the Trust’s Reproductive Medicine Unit by the HfEA in 2011 identified some deficiencies in the administrative processes and systems. This related to the registration details the Trust is required to provide in respect of fertility care being undertaken. An action plan was put in place to rapidly address the problem, which plan was monitored weekly by the Executive Team. The HfEA assessment did not place any conditions on the Trust’s Reproductive Medicine Unit at the interim assessment. A full HfEA inspection is due to take place in the Autumn/Winter of 2012.

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 2011/12 and up to the date of approval of the annual report and accounts.



Kathryn Thomson  
Chief Executive  
28 May 2012

# Financial accounts

## Liverpool Women's NHS Foundation Trust Annual Accounts 2011/12

### Foreword to the accounts

These accounts for the year-ended 31 March 2012 have been prepared by the Liverpool Women's NHS Foundation Trust in accordance with paragraphs 24 and 25 of the National Health Service Act 2006 Act 2006 in the form which Monitor, the Independent Regulator of NHS Foundation Trusts has, with the approval of the Treasury directed.



Kathryn Thomson  
Chief Executive  
28 May 2012

Liverpool Women's NHS Foundation Trust is a public benefit corporation domiciled in England. The principal activities of the Trust are to serve the community by the provision of goods and services for the purpose of the health service in England. This includes education and training, research, accommodation and other facilities related to the provision of health care.

Registered address: Crown Street, Liverpool L8 7SS.



**STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2012**

	<b>Note</b>	<b>2011/12 £000</b>	<b>2011/12 £000</b>	<b>2010/11 (Restated) £000</b>
<b>Operating Income</b>	2		94,364	93,730
<b>Operating Expenses</b>	3		(89,488)	(91,324)
<b>OPERATING SURPLUS</b>			<b>4,876</b>	2,406
<b>Finance Costs:</b>				
Finance income	5	49		48
Finance expense – unwinding of discount on provisions	15	(18)		(15)
PDC Dividends payable		(1,480)		(1,458)
<b>Net Finance Costs</b>			(1,449)	(1,425)
<b>Surplus from continuing operations</b>			<b>3,427</b>	981
<b>SURPLUS FOR THE YEAR</b>			<b>3,427</b>	981
<b>Other comprehensive income</b>				
Other recognised gains and losses			0	(57)
<b>TOTAL COMPREHENSIVE INCOME FOR THE YEAR</b>			<b>3,427</b>	924

The previous year's income has been increased by £1,168,000 to reflect the grossing up of salary recharges less the income previously received from the donated asset reserve to equate to the corresponding depreciation charge of £16,000.

The previous year's expenditure on staff costs has been increased by £1,168,000 to reflect the change in policy to gross up salary recharges.

## STATEMENT OF FINANCIAL POSITION as at 31 MARCH 2012

	Note	At 31 March 2012 £000	31 March 2011 (Restated) £000	At 1 April 2010 (Restated) £000
<b>ASSETS</b>				
<b>Non-current assets:</b>				
Intangible assets	7	84	105	121
Property, plant and equipment	8	54,747	50,223	48,186
<b>Total non-current assets</b>		<b>54,831</b>	50,328	48,307
<b>Current Assets</b>				
Inventories	10	223	396	603
Trade and other receivables	11	3,573	4,957	4,927
Cash and cash equivalents	12	14,075	15,459	9,366
Other financial assets		0	1,000	2,000
<b>Total current assets</b>		<b>17,871</b>	21,812	16,896
<b>TOTAL ASSETS</b>		<b>72,702</b>	72,140	65,203
<b>LIABILITIES</b>				
<b>Current liabilities</b>				
Trade and other payables	13	(10,440)	(13,454)	(9,898)
Provisions	15	(2,593)	(2,532)	(89)
Other liabilities	15	(1,123)	(1,108)	(804)
<b>Total current liabilities</b>		<b>(14,156)</b>	(17,094)	(10,791)
<b>Non-current liabilities</b>				
Provisions	15	(753)	(680)	(970)
<b>Total non-current liabilities</b>		<b>(753)</b>	(680)	(970)
<b>TOTAL LIABILITIES</b>		<b>(14,909)</b>	(17,774)	(11,761)
<b>TOTAL ASSETS EMPLOYED</b>		<b>57,793</b>	54,366	53,442
<b>TAXPAYERS' EQUITY</b>				
Public Dividend Capital		35,210	35,210	35,210
Revaluation reserve	16	4,307	4,307	4,307
Income and expenditure reserve		18,276	14,849	13,925
<b>TOTAL TAXPAYERS' EQUITY</b>		<b>57,793</b>	54,366	53,442

The previous years SOFP has been restated to comply with the change in accounting policy regarding the donated asset reserve which has been eliminated and transferred to the income and expenditure reserve.

The financial statements on pages 130 to 164 were approved by the Board of Directors on 25 May 2012 and signed on the Board's behalf by:

Kathryn Thomson  
Chief Executive

**STATEMENT OF CHANGES IN TAXPAYERS' EQUITY**

2011/12	Total	Public Dividend Capital	Revaluation Reserve	Donated Asset Reserve	Income and Expenditure Reserve
	£000	£000	£000	£000	£000
<b>Taxpayers' Equity at 1 April 2011</b>	<b>54,366</b>	<b>35,210</b>	<b>4,307</b>	<b>213</b>	<b>14,636</b>
Prior period adjustment	0	0	0	(213)	213
<b>Taxpayers' Equity at 1 April 2011 - restated</b>	<b>54,366</b>	<b>35,210</b>	<b>4,307</b>	<b>0</b>	<b>14,849</b>
Surplus for the year	3,427	0	0	0	3,427
Taxpayers' Equity at 31 March 2012	57,793	35,210	4,307	0	18,276

**STATEMENT OF CHANGES IN TAXPAYERS' EQUITY**

2010/11	Total	Public Dividend Capital	Revaluation Reserve	Donated Asset Reserve	Income and Expenditure Reserve
	£000	£000	£000	£000	£000
Taxpayers' Equity at 1 April 2010	53,442	35,210	4,307	229	13,696
Prior period adjustment	0	0	0	(229)	229
Taxpayers' Equity at 1 April 2010 - restated	53,442	35,210	4,307	0	13,925
Surplus for the year	981	0	0	0	981
Other recognised gains and losses	(57)	0	0	0	(57)
Taxpayers' Equity at 31 March 2011	54,366	35,210	4,307	0	14,849

The previous and current years SOCITE have been restated to comply with the change in accounting policy regarding the donated asset reserve which has been eliminated and transferred to the income and expenditure reserve.

## STATEMENT OF CASH FLOWS for the YEAR ENDED 31 MARCH 2012

		2011/12	2010/11
	Note	£000	£000
Operating cash surplus generated from operations	<b>SOCI</b>	<b>4,876</b>	2,406
<b>Non-cash income and expense:</b>			
Depreciation and amortisation		2,368	2,401
Impairments		599	0
(Increase)/decrease in Trade and Other Receivables		1,342	(337)
(Increase)/decrease in Inventories		173	207
Increase/(decrease) in Trade and Other Payables		(2,503)	3,661
Increase/(decrease) in Other Liabilities		15	304
Increase/(decrease) in Other Provisions		134	2,081
Tax (paid)/received		0	(125)
<b>Net cash generated from operations</b>		<b>7,004</b>	10,598
<b>Cash flows from investing activities</b>			
Interest received	<b>5</b>	49	51
Sales of financial assets		1,000	1,000
Purchase of Intangible assets		0	(14)
Purchase of Property, Plant and Equipment	<b>8</b>	(7,983)	(4,388)
<b>Net cash used in investing activities</b>		<b>(6,934)</b>	(3,351)
<b>Cash flows from financing activities</b>			
PDC Dividend paid		(1,438)	(1,154)
Cash flows used in other financing activities		(16)	0
<b>Net cash used in financing activities</b>		<b>(1,454)</b>	(1,154)
<b>Increase/(decrease) in cash and cash equivalents</b>		<b>(1,384)</b>	6,093
<b>Cash and Cash equivalents at 1 April</b>		<b>15,459</b>	9,366
<b>Cash and Cash equivalents at 31 March</b>	<b>12</b>	<b>14,075</b>	15,459

## 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 2011/12 NHS Foundation Trust Annual Reporting Manual issued by Monitor.

The accounting policies contained in that manual follow EU endorsed International Financial Reporting Standards (IFRS), and IFRS Interpretation Committee updates (IFRICs) 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 except for the policy in relation to donated assets. All donated assets are now accounted for in the same manner as purchased items of non-current assets for property plant and equipment. This accounting policy change has been applied retrospectively and consequently the 2010/11 results have been restated.

#### 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 and entitlements

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.

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**

#### **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 provisions**

Pension provisions relating to former employees, have been estimated using the life expectancy from the Government's actuarial tables. Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate of 2.2% in real terms (2.8% for employee early departure obligations).

#### **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.

#### **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 56% of the workforce. However for Medical staff the response rate was significantly lower than for all other groups (24%). A separate accrual was calculated for this group. Not to have done so would have led to a significant under accrual for Annual leave entitlement untaken as at 31 March.

## **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 as a desktop/ interim valuation measure. The valuations are carried out in accordance with the Royal Institute of Chartered Surveyor's Valuation Standards, 6th edition. The valuations were re-assessed at March 2012 by DTZ but because of only a small variation to the carrying values of land and buildings no adjustments have been made to the quoted values with the exception of Dwellings where the valuation was adjusted in line with DTZ valuation. An impairment was subsequently charged to the Income and Expenditure statement of the Trust to reflect this. 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, which includes plant and machinery, information technology equipment and furniture and fittings, 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 valued at depreciated cost with an annual review to make sure that such a method reflects current values. 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 assets subsequently are measured at fair value.

Fair value of land and buildings are based on advice received from DTZ professional valuers.

Valuations provided by the professional valuers for land and buildings as at the 31 March 2012 have been reflected in the 2011/12 accounts.

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.

### **Subsequent expenditure**

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably.

Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

### **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.

Assets in the course of construction are not depreciated until the asset is brought into use.

### **Revaluation losses and gains**

Where a revaluation results in an increase in an asset's value, this increase is credited to the revaluation reserve unless it reverses a revaluation loss previously recognised in operating expenses, in which case it will be credited initially to operating income and thereafter to revaluation reserve.

Where a revaluation results in a reduction in an asset's value, the reduction is charged initially to the revaluation reserve to the extent that there is an available balance in respect of that asset, and thereafter it will be charged to operating expenses. Negative revaluation reserve balances for individual assets are not permitted.

### **Impairment review**

At each reporting period end, the Trust checks whether there is any indication that any of its property plant and equipment 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.

### **Impairments**

Impairments that are due to a loss of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of the impairment charged to operating expenses and the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment arising from a loss of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made to from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversal of other impairments are treated as revaluation gains.

### **Assets in the course of construction**

Assets in the course of construction are measured at cost of construction as at the 31 March 2012. 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 property, plant and equipment assets are capitalised at their fair value on receipt. The donation is credited to the income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the donation are to be consumed in a manner specified by the donor, in which case, the donation is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated assets are subsequently accounted for in the same manner as other items of non-current assets for property, plant and equipment.

This accounting policy change has been applied retrospectively and consequently the 2010/11 results have been restated.

Previously donated non-current assets were capitalised at their current value on receipt and this value was credited to the donated asset reserve. Each year an amount equal to the depreciation charge on the asset was released from the donated asset reserve to the income and expenditure account. Gains, losses and impairments on revaluations were also taken to the donated reserve

## **1.6 Intangible assets**

### **Recognition**

Intangible assets are 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.

Expenditure on research and development is not capitalised.

### **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. Fair value is the amount at which an asset may be exchanged in an arm's length transaction. 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.

The economic life of intangible assets is shown in note 9 to the accounts.

## **1.7 Inventories**

Inventories are valued at the lower of cost and net realisable value. 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. No provision is made for obsolete or slow moving items as they are not included within inventory valuations.

## **1.8 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.

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

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.

### **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 against specific debtor amounts where there is reasonable uncertainty of obtaining settlement from organisations concerned as at 31 March 2012.

### **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 Statement of Financial Position date, which are classified as long-term 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 cash flows 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 a provision for impairment of receivables.

## **1.9 Leases**

### **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. Where the Trust acts as the Lessor operating lease income is received for the lease of buildings or land where the risks and rewards of ownership of the leased asset are retained by the Trust.

## **1.10 Provisions**

The NHS foundation trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount at the year-end date for which it is probable that there will be a future outflow of cash or other resources and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources 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, except for early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of 2.8% (2010/11: 2.9%) 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 31.2.

### **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.

## **1.11 Public dividend capital**

Public dividend capital represents taxpayers' equity at the time of the creation of the predecessor NHS trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities, except for donated assets and cash balances held with the Government Banking Services. The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

## **1.12 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 fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

## **1.13 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.

## 1.14 Foreign exchange

The currency of the Trust is sterling. A transaction which is denominated in a foreign currency is translated into sterling at the spot exchange rate on the date of payment/receipt of the transaction. No assets or liabilities are held by the Trust in any other currency than sterling.

## 1.15 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.

## 1.16 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.

## 1.17 Accounting standards and amendments issued but not yet adopted in the accounts

- IFRS 7 Financial Instruments – Transfer of financial assets – Effective date 2012/13, but not yet adopted by the EU.
- IFRS 9 Financial Instruments – Financial Assets and Liabilities – Effective date uncertain, but not yet adopted by the EU.
- IFRS 10 Consolidated Financial Statements - Effective date 2013/14, but not yet adopted by the EU.
- IFRS 11 Joint Arrangements - Effective date 2013/14, but not yet adopted by the EU.
- IFRS 12 Disclosure of Interests in Other Entities - Effective date 2013/14, but not yet adopted by the EU.
- IFRS 13 Fair Value Measurement - Effective date 2013/14, but not yet adopted by the EU.
- IAS 12 Income Taxes amendment - Effective date 2012/13, but not yet adopted by the EU.
- IAS 1 Presentation of financial statements, on other comprehensive income (OCI) - Effective date 2013/14, but not yet adopted by the EU.
- IAS 27 Separate Financial Statements - Effective date 2013/14, but not yet adopted by the EU.
- IAS 28 Associates and joint ventures - Effective date 2013/14, but not yet adopted by the EU.

None of these standards or interpretations are expected to have a significant impact on the accounts for 2011/12 were they applied in that year.

## 1.18 Going Concern

After making enquiries, the directors have a reasonable expectation that Liverpool Women's HNS 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.

## 1.19 Segmental reporting accounting policy

The Trust's core activities fall under the remit of the Chief Operating Decision Maker (CODM), which has been determined to be the Board of Directors. These activities are primarily the provision of NHS healthcare, the income for which is received through contracts with commissioners. The contracts follow the requirements of Payment by Results where applicable and services are paid for on the basis of tariffs for each type of clinical activity. The planned level of activity is agreed with our main commissioners for the year. The Trust's main commissioners are listed in the related party disclosure (see Note 17).

The Trust comprises of two clinical divisions, Maternity and Gynaecology. These divisions have been aggregated into a single operating segment because they have similar economic characteristics, the nature of the services they provide are the same (NHS care), and they have the same customers (the general public from surrounding geographical areas). The majority of the Trust's customers come from the City of Liverpool and surrounding areas. Although the Trust also has contracts to cover patients from further afield including Wales and the Isle of Man. Both divisions have the same regulators (Monitor, the Care Quality Commission and the Department of Health). The overlapping activities and interrelation between the divisions also suggests that aggregation is appropriate. The divisional management teams report to the CODM, and it is the CODM that ultimately makes decisions about the allocation of budgets, capital funding and other financial decisions.

Total assets and liabilities for each segment are not disclosed as they are not reported to the CODM.

## 1.20 Subsidiary - Charitable Funds

The Trust is also the corporate trustee of the Liverpool Women's NHS Foundation Charitable Trust (Registration No. 1048294) and considers this to be a subsidiary of the Trust in accordance with International Accounting Standard (IAS) 27 (revised).

HM Treasury has granted dispensation to the application of IAS 27 (revised) by NHS foundation trusts solely in relation to the consolidation of the charitable funds for 2011/12 and 2012/13, and thereby none of the income, expenditure, assets or liabilities of the charity is included herein. Separate charity accounts are prepared in accordance with the Charities SORP and submitted to the Charity Commissioners. The Trust does not have any other subsidiaries.

## 1.21 Prior Period Adjustments

A prior period adjustment has been made to the statement of changes in taxpayers' equity to eliminate the donated asset reserve as donated assets are now treated the same way as purchased assets. This is in accordance with HM Treasury reporting guidance and the previously published balances have been restated to reflect this. In addition recharges of staff on secondment to other NHS bodies are treated as income and expenditure whereas previously the income was treated as a reduction in expenditure. This change has been made to the 2010/11 final accounts.

## 1.22 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 from 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. In addition temporary cash surpluses may be invested for up to one year with designated "Safe Harbour" investment bodies provided their Standard and Poors short term credit rating is A-1 or above; namely money market deposits. Such rating is monitored on a monthly basis and the investment limited to £1,500,000 with a single, non government investment body.

## **1.23 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 2011/12 the Trust had 14 (2010/11 125) separate losses and special payments, totalling £434,000 (2010/11 £93,000).

The majority of this cost related to voluntary redundancy payments under the MARS protocol.

## Operating Income

### Note 2. Operating Income (by classification)

	2011/12	2010/11 (Restated)
	£000	£000
Elective income	9,547	9,966
Non elective income	26,688	26,633
Outpatient income	13,109	12,883
A & E income	1,047	1,095
Other NHS clinical income*	33,203	31,568
<b>Income from activities before private patient income</b>	<b>83,594</b>	<b>82,145</b>
Private patient income	1,415	2,239
Other non-protected clinical income	49	34
<b>Total income from activities</b>	<b>85,058</b>	<b>84,418</b>
<b>Other operating income</b>		
Research and development	687	578
Education and training	4,831	4,887
Other	3,737	3,847
Profit on disposal of other unprotected tangible fixed assets	51	0
Total other operating income	9,306	9,312
Total operating income	94,364	93,730

	2011/12	2010/11
	£000	£000
Income from activities arising from mandatory and non mandatory services	83,594	82,145
Income from mandatory services	83,594	82,145
<b>Income from non mandatory services</b>	<b>1,464</b>	<b>2,273</b>
<b>Total income arising from activities</b>	<b>85,058</b>	<b>84,418</b>

### Note 2.1 Private Patient Income

	2011/12	2010/11	Base Year
	£000	£000	£000
Private patient income	1,415	2,239	939
Total patient related income	85,058	84,418	52,415
Proportion of private patient income (as proportion)	1.66%	2.65%	1.80%

Section 44 of the 2006 Act requires that the proportion of private patient income to the total patient related income for the Trust should not exceed the proportion whilst the body was an NHS Trust in the base year.

**Note 2.2 Operating lease income**

	<b>2011/12</b>	2010/11
	<b>£000</b>	£000
Operating Lease Income		
Rents recognised as income in the period	<b>153</b>	159

**Note 2.3 Operating Income (by type)**

	<b>2011/12</b>	2010/11
	<b>£000</b>	£000
Income from activities		
NHS Foundation Trusts	998	1,387
NHS Trusts	674	849
Primary Care Trusts	79,641	79,590
Strategic Health Authorities	1,402	0
NHS Other	879	318
Non NHS: Private patients	1,415	2,239
NHS injury scheme (was RTA)	0	3
Non NHS: Other	49	32
<b>Total income from activities</b>	<b>85,058</b>	84,418

**Note 2.4 Analysis of Other Operating Income – Other**

	<b>2011/12</b>	2010/11
	<b>£000</b>	(Restated) £000
Local Information Systems monies	347	281
Car parking income	361	349
Catering	12	127
Property Rentals	153	110
Other	2,864	2,980
<b>Total Other Operating Income - Other</b>	<b>3,737</b>	3,847



**Note 3. Operating Expenses (by type)**

	<b>2011/12</b>	2010/11 (Restated)
	<b>£000</b>	£000
Services from NHS Foundation Trusts	2,241	3,653
Services from NHS Trusts	2,934	3,190
Services from PCTs	61	451
Purchase of healthcare from non NHS bodies	0	3
Employee Expenses – Executive directors	652	634
Employee Expenses – Non-executive directors	137	128
Employee Expenses – Staff	57,028	58,381
Drug costs	2,230	1,958
Supplies and services – clinical (excluding drug costs)	4,485	4,130
Supplies and services – general	3,641	3,715
Establishment	1,292	1,108
Research and development	727	561
Transport	98	105
Premises	2,737	2,761
(Decrease)/increase in allowance for impairment in receivables	915	150
Depreciation on property, plant and equipment	2,347	2,371
Amortisation on intangible assets	21	30
Impairments of property, plant and equipment	599	0
Audit fees		
audit services – statutory audit	52	63
Other auditors remuneration		
internal audit services *	85	0
Clinical negligence	5,374	4,898
Legal fees	82	94
Training, courses and conferences	282	408
Patient travel	10	7
Car parking and security	244	282
Insurance	129	112
Losses, ex-gratia and special payments	4	91
Other **	1,081	2,040
<b>TOTAL</b>	<b>89,488</b>	91,324

\*Internal audit services are provided by the Mersey Internal Audit Agency department of Liverpool Primary Care Trust  
In addition to statutory audit fees £149,000 has been paid to PricewaterhouseCoopers LLP (PWC LLP) for consultancy work.  
The limitation on the External Auditor's (PWC LLP) liability was set at £5m in the 2011/12 engagement letter (N/a in 2010/11).

\*\*Other expenditure in 2011/12 is primarily made up of consultancy costs of £751,000.

**Note 3.1 Arrangements containing an operating lease**

	<b>2011/12</b>	2010/11
	<b>£000</b>	£000
<b>Minimum lease payments</b>	<b>46</b>	131

**Note 3.2 Arrangements containing an operating lease other than land and buildings**

	<b>2011/12</b>	2010/11
	<b>£000</b>	£000
Future minimum lease payments due:		
- not later than one year	30	46
- later than one year and not later than five years	16	58
<b>TOTAL</b>	<b>46</b>	104

**Note 4. Employee Expenses**

	2011/12	2010/11 (Restated)
	£000	£000
Salaries and wages	46,269	46,640
Social security costs	3,261	3,330
Employers contributions to NHS Pensions	4,901	5,247
Termination benefits	699	2,877
Agency/contract staff	2,550	921
<b>Total</b>	<b>57,680</b>	<b>59,015</b>

**Note 4.1 Average number of employees (Whole Time Equivalent basis)**

	2011/12 Total Number	2011/12 Permanent Number	2010/11 Number
Medical and dental	135	135	130
Administration and estates	260	260	286
Healthcare assistants and other support staff	137	137	139
Nursing, midwifery and health visiting staff	593	593	619
Scientific, therapeutic and technical staff	105	105	105
<b>TOTAL</b>	<b>1,230</b>	<b>1,230</b>	<b>1,279</b>

**Note 4.2 Early retirements due to ill health**

	2011/12	2010/11
	Value £000	Value £000
Early retirements on the grounds of ill-health	54	29

**Note 4.3 Pension Costs**

Past and present employees are covered by the provisions of the NHS Pension 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. the scheme is not designed to be run in a way that would enable 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 taken as equal to the contributions payable to the scheme in the accounting period.

The scheme is subject to a full valuation every four years by the Government Actuary and an accounting valuation every year. More information may be found on the Pensions Agency Website: <http://www.nhsbsa.nhs.uk/pensions>  
Employer contributions rates are 14% of pensionable salary with employee contribution rates on a tiered scale from 5% to 8.5% of pensionable pay.

**Note 4.4: Salary Entitlements of Senior Managers**

Name	Position Held	2011/12			2010/11		
		Salary (bands of £5,000)	Performance-related bonuses (bands of £5,000)	Total Salary (bands of £5,000)	Salary (bands of £5,000)	Performance-related bonuses (bands of £5,000)	Total Salary (bands of £5,000)
		£000	£000	£000	£000	£000	£000
Kathryn Thomson	Chief Executive	135-140		135-140	135-140		135-140
Jonathan Herod	Medical Director	160-165	35-40	195-200	70-75	10-15	80-85
Gail Naylor	Director of Nursing, Midwifery & Patient Experience	90-95		90-95	90-95		90-95
Vanessa Harris	Director of Finance	90-95		90-95	90-95		90-95
Caroline Salden	Chief Operating Officer	90-95		90-95	90-95		90-95
Michelle Turner	Director of Human Resources & Organisational Development	85-90		85-90	80-85		80-85
David Richmond	Medical Director to 30 September 2010	0		0	70-75	25-30	95-100
Ken Morris	Chair	40-45		40-45	40-45		40-45
Ann McCracken	Non Executive Director to 31 March 2011	0		0	10-15		10-15
David Carberry	Non Executive Director	10-15		10-15	10-15		10-15
Pauleen Lane	Non Executive Director	10-15		10-15	0-5		0-5
Roy Morris	Non Executive Director to 31 January 2012	10-15		10-15	10-15		10-15
Hoi Yeung	Non Executive Director to 29 February 2012	10-15		10-15	10-15		10-15
Liz Cross	Non Executive Director	10-15		10-15	10-15		10-15
Ian Haythornthwaite	Non Executive Director from 1 May 2011	10-15		10-15	0		0
Allan Bickerstaffe	Non Executive Director from 1 February 2012	5-10		5-10	0		0
Steve Burnett	Non Executive Director from 1 March 2012	5-10		5-10	0		0

The total remuneration and on costs paid to executive directors amounts to £651,882 of which £90,165 is for employers pension contributions to the NHS staff pension scheme.

**Note: Pension Entitlements of Executive Directors**

Name	Position Held	Real increase in pension at age 60 (bands of £2,500)	Real increase in pension lump sum at age 60 (bands of £2,500)	Total accrued pension at age 60 - 31 March 2012 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2012 (bands of £5,000)	Cash equivalent transfer value (CETV) at 31 March 2012	(CETV) at 31 March 2011	Real increase in (CETV) during the 2011/12 year
		£000	£000	£000	£000	£000	£000	£000
<b>PENSION ENTITLEMENTS</b>								
Kathryn Thomson	Chief Executive	0-2.5	0-2.5	45-50	140-145	793	673	99
Jonathan Herod	Medical Director	5-7.5	15-17.5	45-50	140-145	803	605	180
Gail Naylor	Director of Nursing, Midwifery & Patient Experience	0-2.5	0-2.5	30-35	95-100	538	456	68
Vanessa Harris	Director of Finance	0-2.5	0-2.5	20-25	60-65	326	265	53
Caroline Salden	Chief Operating Officer	0-2.5	0-2.5	20-25	60-65	303	237	59
Michelle Turner	Director of Human Resources & Organisational Development	0-2.5	0-2.5	30-35	90-95	500	415	72

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 employee (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.

**Note 4.5 Staff Exit Packages**

The staff exit packages below were identified in 2010/11 from which 18 have been actioned in 2011/12 at a cost to the Trust of £430,000.

No new exit packages were identified in 2011/12.

**Staff Exit Packages 2010/11**

<b>Exit package cost band</b>	<b>Number of compulsory redundancies</b>	<b>Number of other departures agreed</b>	<b>Total cost of exit packages (£000s)</b>
<£10,000		2	11
£10,001 - £25,000		10	179
£25,001 - £50,000		5	211
£50,001 - £100,000		2	125
£100,001 - £150,000		1	135
<b>Total number of exit packages by type</b>		20	
<b>Total resource cost £000</b>			661

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

The Trust instigated between the 14 December 2010 and 18 February 2011 a Trust-wide consultation 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.

**Note 5. Finance income**

	2011/12	2010/11
	£000	£000
Interest on held-to-maturity financial assets	16	15
Other bank interest	33	33
<b>Total</b>	<b>49</b>	<b>48</b>

**Note 6. Impairment losses (Property, plant and equipment and intangibles)**

	2011/12	2010/11
	£000	£000
Changes in market price	145	0
Unforeseen obsolescence	454	0
<b>Total Impairment losses</b>	<b>599</b>	<b>0</b>

The impairment charge for a change in market price is as a result of a professional valuation of owned dwellings by DTZ, professional valuers. The impairment for unforeseen obsolescence resulted in a write down of owned portacabins at the Alder Hey Children's hospital for the clinical genetics service now being brought back to the Crown Street site and for which the portacabin accommodation will not be required,

**Note 7. Intangible assets at the balance sheet date comprise the following:**

	2011/12	2010/11
	£000	£000
<b>The Trust only holds Software Licences (purchased)</b>		
Gross Cost as at 1 April	450	436
Additions – purchased	0	14
Disposals	(77)	0
<b>Gross Cost at 31 March</b>	<b>373</b>	<b>450</b>
Amortisation as at 1 April	345	315
Provided during year	21	30
Disposals	(77)	0
<b>Amortisation at 31 March</b>	<b>289</b>	<b>345</b>
Net book value:		
Total Purchased at 1 April	105	121
<b>Total Purchased at 31 March</b>	<b>84</b>	<b>105</b>



**Note 8. Property, plant and equipment 2011/12**

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under Construction	Plant & Machinery	Information Technology	Furniture & Fittings
	£000	£000	£000	£000	£000	£000	£000	£000
	<b>69,588</b>	<b>3,600</b>	<b>40,549</b>	<b>385</b>	<b>1,213</b>	<b>18,812</b>	<b>4,677</b>	<b>352</b>
Additions – purchased	7,472	0	1,004	0	5,284	1,049	135	0
Reclassifications	0	0	66	0	(481)	5	410	0
Disposals	(2,213)	0	0	0	0	(1,807)	(406)	0
<b>Gross cost at 31 March 2012</b>	<b>74,847</b>	<b>3,600</b>	<b>41,619</b>	<b>385</b>	<b>6,016</b>	<b>18,059</b>	<b>4,816</b>	<b>352</b>
<b>Accumulated depreciation at 1 April 2011</b>	<b>19,365</b>	<b>0</b>	<b>2838</b>	<b>15</b>	<b>0</b>	<b>13646</b>	<b>2612</b>	<b>254</b>
Provided during the year	2,347	0	658	5	0	1,065	589	30
Impairments recognised in operating expenses	599	0	454	145	0	0	0	0
Disposals	(2,211)	0	0	0	0	(1,807)	(404)	0
<b>Accumulated depreciation at 31 March 2012</b>	<b>20,100</b>	<b>0</b>	<b>3,950</b>	<b>165</b>	<b>0</b>	<b>12,904</b>	<b>2,797</b>	<b>284</b>
<b>Net book value at 31 March 2012</b>	<b>54,747</b>	<b>3,600</b>	<b>37,669</b>	<b>220</b>	<b>6,016</b>	<b>5,155</b>	<b>2,019</b>	<b>68</b>
<b>Net Book Value</b>								
NBV - Purchased at 31 March 2012	<b>54,587</b>	3,600	37,509	220	6,016	5,155	2,019	68
NBV - Donated at 31 March 2012	<b>160</b>	0	160	0	0	0	0	0
	<b>54,747</b>	3,600	37,669	220	6,016	5,155	2,019	68

Valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) *Appraisal and Valuation Manual*. An assessment of the value of the Trust's land and buildings was carried out by DTZ, a firm of professionally qualified surveyors and valuers at 31 March 2012. The Modern Equivalent Asset (MEA) basis of valuation was used to value land and buildings.

**Note 8.1 Property, plant and equipment 2010/11**

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under Construction	Plant & Machinery	Information Technology	Furniture & Fittings
	£000	£000	£000	£000	£000	£000	£000	£000
<b>Gross cost at 1 April 2010</b>	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
Reclassifications	0	0	76	0	(156)	80	0	0
<b>Gross cost at 31 March 2011</b>	<b>69,588</b>	<b>3,600</b>	<b>40,549</b>	<b>385</b>	<b>1,213</b>	<b>18,812</b>	<b>4,677</b>	<b>352</b>
<b>Accumulated depreciation at 1 April 2010</b>	<b>16,994</b>	<b>0</b>	<b>2,228</b>	<b>10</b>	<b>0</b>	<b>12,574</b>	<b>1,974</b>	<b>208</b>
Provided during the year	2,371	0	610	5	0	1,072	638	46
<b>Accumulated depreciation at 31 March 2011</b>	<b>19,365</b>	<b>0</b>	<b>2,838</b>	<b>15</b>	<b>0</b>	<b>13,646</b>	<b>2,612</b>	<b>254</b>
<b>Net book value at 31 March 2011</b>	<b>50,223</b>	<b>3,600</b>	<b>37,711</b>	<b>370</b>	<b>1,213</b>	<b>5,166</b>	<b>2,065</b>	<b>98</b>
<b>Net Book Value</b>								
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
	<b>50,223</b>	<b>3,600</b>	<b>37,711</b>	<b>370</b>	<b>1,213</b>	<b>5,166</b>	<b>2,065</b>	<b>98</b>

## Note 9. Economic life of intangible assets

Software licences (purchased)

Minimum Life Years	Maximum Life Years
1	7

## Note 9.1 Economic life of property, plant and equipment

Buildings excluding dwellings

Dwellings

Assets under Construction and POA

Plant & Machinery

Information Technology

Furniture & Fittings

Minimum Life Years	Maximum Life Years
41	75
75	75
0	0
1	10
1	10
1	10

## Note 9.2 Analysis of property, plant and equipment 31 March 2012

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under Construction	Plant & Machinery	Information Technology	Furniture & Fittings
	£000	£000	£000	£000	£000	£000	£000	£000
NBV – Protected assets at 31 March 2012	41,489	3,600	37,669	220	0	0	0	0
NBV – Unprotected assets at 31 March 2012	13,258	0	0	0	6,016	5,155	2,019	68
<b>Total at 31 March 2012</b>	<b>54,747</b>	<b>3,600</b>	<b>37,669</b>	<b>220</b>	<b>6,016</b>	<b>5,155</b>	<b>2,019</b>	<b>68</b>

## Note 9.3 Analysis of property, plant and equipment 31 March 2011

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under Construction	Plant & Machinery	Information Technology	Furniture & Fittings
	£000	£000	£000	£000	£000	£000	£000	£000
NBV – Protected assets at 31 March 2011	41,681	3,600	37,711	370	0	0	0	0
NBV – Unprotected assets at 31 March 2011	8,542	0	0	0	1,213	5,166	2,065	98
<b>Total at 31 March 2011</b>	<b>50,223</b>	<b>3,600</b>	<b>37,711</b>	<b>370</b>	<b>1,213</b>	<b>5,166</b>	<b>2,065</b>	<b>98</b>

## Note 10. Inventories

	2011/12	2010/11
	£000	£000
<b>Finished goods</b>	<b>223</b>	<b>396</b>

## Note 10.1 Inventories recognised in expenses

	2011/12	2010/11
	£000	£000
<b>Inventories recognised in expenses</b>	<b>1,681</b>	<b>6,273</b>

<b>Note 11. Trade receivables and other receivables</b>	<b>Total</b>	<b>Financial assets</b>	<b>Non-financial assets</b>	<b>Total</b>	<b>Financial assets</b>	<b>Non-financial assets</b>
	<b>At 31 March 2012</b>	<b>At 31 March 2012</b>	<b>At 31 March 2012</b>	<b>At 31 March 2011</b>	<b>At 31 March 2011</b>	<b>At 31 March 2011</b>
	<b>£000</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>
NHS Receivables	<b>1,607</b>	<b>1,607</b>	<b>0</b>	1,786	1,786	0
Other receivables with related parties	<b>1,768</b>	<b>1,768</b>	<b>0</b>	1,408	1,408	0
Provision for impaired receivables	<b>(1,178)</b>	<b>(1,178)</b>	<b>0</b>	(287)	(287)	0
Prepayments	<b>527</b>	<b>0</b>	<b>527</b>	643	0	643
PDC receivable	<b>0</b>	<b>0</b>	<b>0</b>	42	0	42
Other receivables	<b>849</b>	<b>849</b>	<b>0</b>	1,365	1,365	0
<b>Total Current Trade and Other Receivables</b>	<b>3,573</b>	<b>3,046</b>	<b>527</b>	4,957	4,272	685

<b>Note 11.1 Provision for impairment of receivables</b>	<b>2011/12</b>	<b>2010/11</b>
	<b>£000</b>	<b>£000</b>
At 1 April 2011	287	137
Increase in provisions	915	150
Amounts utilised	(24)	0
Unused amounts reversed	<b>0</b>	0
<b>At 31 March 2012</b>	<b>1,178</b>	287

<b>Note 11.2 Analysis of impaired receivables</b>	<b>2011/12</b>	<b>2010/11</b>
	<b>£000</b>	<b>£000</b>
<b>Ageing of impaired receivables</b>		
Up to three months	<b>0</b>	0
In three to six months	134	0
Over six months	1,044	287
<b>Total</b>	<b>1,178</b>	287
<b>Ageing of non-impaired receivables</b>		
Up to three months	2,447	3,413
In three to six months	(247)	351
Over six months	846	457
<b>Total</b>	<b>3,046</b>	4,221

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

**Note 12. Cash and cash equivalents**

	2011/12	2010/11
	£000	£000
<b>At 1 April</b>	<b>15,459</b>	9,366
Net change in year	(1,384)	6,093
<b>At 31 March</b>	<b>14,075</b>	15,459
Broken down into:		
Cash at commercial banks and in hand	57	549
<b>Cash with the Government Banking Service</b>	<b>14,018</b>	14,910
<b>Cash and cash equivalents as in Statement of Financial Position</b>	<b>14,075</b>	15,459

	Total	Financial liabilities	Financial liabilities
	At 31 March 2012	At 31 March 2012	At 31 March 2011
	£000	£000	£000
<b>Note 13. Trade and other payables</b>			
<b>Current</b>			
NHS payables	807	807	4,436
Trade payables – capital	36	36	547
Amounts due to other related parties - revenue	552	552	46
Taxes payable	1,105	1,105	1,091
Other payables	2,272	2,272	2,626
Accruals - expenditure	4,366	4,366	4,708
Accruals - capital	1,302	1,302	0
<b>Total current trade and other payables</b>	<b>10,440</b>	<b>10,440</b>	13,454

The Trust did not hold any non-current trade and other payables during the year.

**Ageing of trade and other payables**

	At 31 March 2012	At 31 March 2011
	£000	£000
Up to three months	<b>9,845</b>	12,971
Three to six months	175	270
Over six months	420	213
<b>Total</b>	<b>10,440</b>	<b>13,454</b>

**Note 14. Prudential Borrowing Limit**

The Liverpool Women's NHS Foundation Trust is required to comply and remain within a prudential borrowing limit (PBL).

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 PBL of £24,400,000 (£24,000,000 in 2010/11) of which £17,900,000 (£17,500,000) related to long-term borrowing and £6,500,000 (£6,500,000) 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	2011/12 Actual Ratio	2011/12 Approved Ratio Tier 1	2010/11 Actual Ratio	2010/11 Approved Ratio
Minimum Dividend Cover	<b>5.3</b>	<b>&gt;1x</b>	<b>5.3</b>	<b>&gt;1x</b>
Minimum Interest Cover	Not Applicable	<b>&gt;3x</b>	Not Applicable	<b>&gt;3x</b>
Minimum Debt Service Cover	Not Applicable	<b>&gt;2x</b>	Not Applicable	<b>&gt;2x</b>
Maximum Debt Service to Revenue	Not Applicable	<b>&lt; 2.5%</b>	Not Applicable	<b>&lt; 2.5%</b>

At 31 March 2012 the Trust had in place a working capital facility of £6,500,000.

**Note 15. Provisions for liabilities and charges**

	Current		Non Current	
	<b>31 March 2012</b>	31 March 2011	<b>31 March 2012</b>	31 March 2011
	<b>£000</b>	£000	<b>£000</b>	£000
Pensions relating to other staff	58	55	753	680
Other Legal Claims	39	39	0	0
Other	2,496	2,438	0	0
<b>Total provisions</b>	<b>2,593</b>	2,532	753	680

**Note 15.1 Provisions for liabilities and charges analysis**

	<b>Total</b>	<b>Pensions – other staff</b>	<b>Other legal claims</b>	<b>Other</b>
	£000	£000	£000	£000
<b>At 1 April 2011</b>	<b>3,212</b>	<b>735</b>	<b>39</b>	<b>2,438</b>
Arising during the year	850	128	23	699
Utilised during the year	(560)	(58)	(23)	(479)
Change in the discount rate	(12)	(12)	0	0
Reversed unused	(162)	0	0	(162)
Unwinding of discount	18	18	0	0
<b>At 31 March 2012</b>	<b>3,346</b>	<b>811</b>	<b>39</b>	<b>2,496</b>
<b>Expected timing of cashflows:</b>				
- not later than one year	2,593	58	39	2,496
- later than one year and not later than five years	232	232	0	0
- later than five years	521	521	0	0
<b>Total</b>	<b>3,346</b>	<b>811</b>	<b>39</b>	<b>2,496</b>

Pensions provisions relating to other staff are for early retirements and reflect actuarial forecasts in respect of the duration of payments, the life expectancy of the persons involved and current value of the future stream of payment flows.

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 organisational change proposals and anticipated to be finalised within the next year.

**Note 15.2 Clinical Negligence liabilities**

£80,658,000 as at 31 March 2012 in respect of the clinical negligence liabilities of the Trust is included within the provisions of the NHS Litigation Authority and is not included within the provisions shown above. (31 March 2011 £74,502,000).



**Note 15.3 Other liabilities**

	<b>At 31 March 2012 £000</b>	At 31 March 2011 £000
<b>Current liabilities</b>		
<b>Deferred Income</b>	<b>1,123</b>	1,108

**Note 16 Revaluation reserve balances 2010/11, 2011/12**

	<b>Total Revaluation Reserve £000</b>	<b>Revaluation Reserve – intangibles £000</b>	<b>Revaluation Reserve – property, plant and equipment £000</b>
Revaluation reserve at 1 April 2010	4,307	63	4,244
Revaluation reserve at 31 March 2011	4,307	63	4,244
<b>Revaluation reserve at 31 March 2012</b>	<b>4,307</b>	<b>63</b>	<b>4,244</b>

**Note 17. Related Party Transactions and Balances**

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 (£446) with whom a Non-executive director holds the post of Local Chairman of Legal Services. During the 2011/12 financial year Mace and Jones Solicitors merged with Weightmans Solicitors. The Trust spent £7,094 with Weightmans Solicitors in 2011/12.

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 (NWFL) to whom the Trust provides a range of clinical support services. During the year the Trust invoiced £1,556,000 in respect of those services (2010/11 £1,680,000), and from whom the Trust purchased clinical supplies. The net income due from NWFL at 31 March 2012 was £546,000. This relationship has ceased with effect from 1 April 2012 with services now provided by the Trust.

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	Expenditure	Receivables Balance	Payables Balance
	£000	£000	£000	£000
<b>Total Value of transactions with other related parties in 2011/12</b>	<b>89,484</b>	<b>11,786</b>	<b>1,607</b>	<b>807</b>
<b>Individual entities with Income or expenditure transactions over £1,000,000:</b>				
Liverpool PCT	39,820	109	0	161
North West Specialised Commissioning Team	13,202	0	0	11
Sefton PCT	10,083	0	195	0
Knowsley PCT	6,661	0	0	44
North West Strategic Health Authority	5,634	0	1	0
Halton and St. Helens PCT	2,541	0	0	29
Wirral PCT	2,145	0	62	0
Royal Liverpool and Broadgreen University Hospitals NHS Trust	1,013	3,260	155	241
Aintree University Hospitals NHS Foundation Trust	172	1,499	12	36
NHS Litigation Authority	0	5,374	0	0
<b>Total Value of transactions with other related parties in 2010/11</b>	<b>81,104</b>	<b>10,371</b>	<b>842</b>	<b>3,934</b>
<b>Individual entities with Income or expenditure transactions over £1,000,000:</b>				
Liverpool PCT	39,036	148	644	28
North West Specialised Commissioning Team	12,902	0	0	2,986
Sefton PCT	9,716	0	18	0
Knowsley PCT	6,689	0	0	115
North West Strategic Health Authority	5,830	73	57	0
Halton and St. Helens PCT	2,656	0	0	67
Wirral PCT	2,197	0	0	112
Health Commission Wales	1,373	0	110	28
Royal Liverpool and Broadgreen University Hospitals NHS Trust	952	3,155	13	531
Aintree University Hospitals NHS Foundation Trust	165	2,307	0	125
NHS Litigation Authority	0	4,898	0	0

**Note 18. Contractual Capital Commitments**

At the balance sheet date 31 March 2012 the Trust had capital commitments of £5,490,000 in respect of property plant and equipment (31 March 2011 £362,000 ).

**Note 19. Financial Assets by Category**

	<b>Total</b>	<b>Loans &amp; receivables</b>	<b>Held to maturity</b>
	<b>£000</b>	<b>£000</b>	<b>£000</b>
Assets as per Statement of Financial Position			
NHS, Trade and other receivables excluding non financial assets at 31 March 2012	3,046	3,046	0
Cash and cash equivalents	14,075	14,075	0
<b>Total at 31 March 2012</b>	<b>17,121</b>	<b>17,121</b>	<b>0</b>
Assets as per Statement of Financial Position			
NHS, Trade and other receivables excluding non financial assets at 31 March 2011	4,272	4,272	0
Other Financial Assets	1,000	0	1,000
Cash and cash equivalents at 31 March 2011	15,459	15,459	0
<b>Total at 31 March 2011</b>	<b>20,731</b>	<b>19,731</b>	<b>1,000</b>

**Note 19.1 Financial liabilities by category**

	<b>Total</b>	<b>Other financial liabilities</b>
	<b>£000</b>	<b>£000</b>
<b>Liabilities as per Statement of Financial Position</b>		
Trade and other payables excluding non financial assets at 31 March 2012	<b>10,440</b>	10,440
Provisions under contract	<b>3,346</b>	3,346
<b>Total at 31 March 2012</b>	<b>13,786</b>	13,786
Trade and other payables excluding non financial liabilities 31 March 2011	13,454	13,454
Provisions under contract at 31 March 2011	3,212	3,212
Total at 31 March 2011	16,666	16,666

The book value and fair value of cash and cash equivalents are considered to be the same at £14,075,000 (2010/11 £15,549,000).

# 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 2012 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Cash Flows, the Statement of Changes in Taxpayers' Equity and the related notes. The financial reporting framework that has been applied in their preparation is the NHS Foundation Trust Annual Reporting Manual 2011/12 issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

## Respective responsibilities of directors and auditors

As explained more fully in the Statement of the Chief Executive's Responsibilities, the directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view in accordance with the NHS Foundation Trust Annual Reporting Manual 2011/12. Our responsibility is to audit and express an opinion on the financial statements in accordance with the NHS Act 2006, the Audit Code for NHS Foundation Trusts issued by Monitor and International Standards on Auditing (ISAs) (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

This report, including the opinions, has been prepared for and only for the Council of Governors of Liverpool Women's NHS Foundation Trust in accordance with paragraph 24 of Schedule 7 of the National Health Service Act 2006 and for no other purpose. We do not, in giving these opinions, accept or assume responsibility for any other purpose or to any other person to whom this report is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

## Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the NHS Foundation Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the NHS Foundation Trust; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the Annual Report and Accounts to identify material inconsistencies with the audited financial statements. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

## Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view, in accordance with the NHS Foundation Trust Annual Reporting Manual 2011/12, of the state of the NHS Foundation Trust's affairs as at 31 March 2012 and of its income and expenditure and cash flows for the year then ended; and
- have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2011/12.

## Opinion on other matters prescribed by the Audit Code for NHS Foundation Trusts

In our opinion

- the part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2011/12; and
- the information given in the Directors' 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 the Audit Code for NHS Foundation Trusts requires us to report to you if:

- in our opinion the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2011/12 or is misleading or inconsistent with information of which we are aware from our audit. We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls;
- we have not been able to satisfy ourselves that the NHS Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources; or
- we have qualified our report on any aspects of the Quality Report.

## Certificate

We certify that we have completed the audit of the financial statements in accordance with the requirements of Chapter 5 of Part 2 to the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

**Rachel McIlwraith (Senior Statutory Auditor)**

For and on behalf of PricewaterhouseCoopers LLP

Chartered Accountants and Statutory Auditors

Manchester

29 May 2012

## Notes:

- a) The maintenance and integrity of the Liverpool Women's NHS Foundation Trust website is the responsibility of the directors; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the website.
- b) Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.









Liverpool Women's NHS Foundation Trust  
Crown Street  
Liverpool  
L8 7SS

Telephone: 0151 708 9988  
Fax: 0151 702 4028  
Web: [www.liverpoolwomens.nhs.uk](http://www.liverpoolwomens.nhs.uk)