Meeting of the Board of Directors
HELD IN PUBLIC
Friday 7 April 2017 at Liverpool Women's Hospital at 0900
Board Room

Item no. 2017/	Title of item	Objectives/desired outcome	Process	Item presenter	Time	CQC Fundamental Standard	BAF Risk
	Thank you to Staff				0900		
078	Patient Story - Genetics				0910 (20mins)		
079	Apologies for absence & Declarations of interest	Receive apologies	Verbal	Chair	0930 (10mins)	-	-
080	Meeting guidance notes	To receive the meeting attendees' guidance notes	Written guidance	Chair		R17 – Good Governance	-
081	Minutes of the previous meetings held on 3rd March 2017	Confirm as an accurate record the minutes of the previous meetings	Written	Chair		R17 – Good Governance	-
082	Action Log and matters arising	Provide an update in respect of on-going and outstanding items to ensure progress	Written/verbal	Chair		R17 – Good Governance	-
083	Chair's announcements	Announce items of significance not elsewhere on the agenda	Verbal	Chair	0940 (5mins)	R17 – Good Governance	All
084	Chief Executive Report	Report key developments and announce items of significance not elsewhere	written	Deputy Chief Executive	0945 (10mins)	R17 – Good Governance	All
BOARD ASSURANCE							
085	NHS Annual Staff Survey	To note the key findings of the staff survey	Paper/ Presentation	Director of Workforce and Marketing	0955 (30mins)	All	All

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086	Chair's Report from the Governance and Clinical Assurance Committee	Receive assurance and any escalated risks	Written	Committee Chair	1025 (15mins)	R17 – Good Governance	1 & 3
087	Chair's Report from the Audit Committee	Receive assurance and any escalated risks	Written	Committee Chair		R17 – Good Governance	All
088	Chair's Report from the Finance Performance and Business Development Committee	Receive assurance and any escalated risks	Written	Committee Chair		R17 – Good Governance	5 a - f
089	Board Committees Terms of Reference	To Approve	Written	Trust Secretary		R17 – Good Governance	1 & 3 5 a - f
090	Quarterly Serious Incidents Report	Assurance regarding the reporting of SI	Written	Medical Director	1040 (10mins)	R17 – Good Governance R12 – safe care and treatment	1 & 3
091	Mortality Strategies	Assurance regarding the mortality strategies for adult, Stillbirths and Neonatal Deaths	Written	Medical Director	1050 (10mins)	R17 – Good Governance R12 – safe care and treatment	1 & 3
TRUST PERFORMANCE							
092	Performance Report period 11, 2016/17	Review the latest Trust performance report and receive assurance	Written	Director of Operations	1100 (10mins)	R12&18: Safe R17 – Good Governance	3a
093	Finance Report period 11, 2016/17	To note the current status of the Trusts financial position	Written	Director of Finance	1110 (10mins)	R17 – Good Governance	5a-f

Item no. 2017/	Title of item	Objectives/desired outcome	Process	Item presenter	Time	CQC Fundamental Standard	BAF Risk
TRUST STRATEGY							
094	Fit for Future Generations Update	To brief the Board on progress and risks	Verbal	Deputy Chief Executive	1120 (5mins)	All	All
BOARD GOVERNANCE							
095	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair		R17 – Good Governance	All
HOUSEKEEPING							
096	Any other business & Review of meeting	Consider any urgent items of other business	Verbal	Chair	1130 End	-	-

Date, time and place of next meeting Friday 5 May 2017

Meeting to end at 1130

1130-1145 15mins	Questions raised by members of the public observing the meeting on matters raised at the meeting.	To respond to members of the public on matters of clarification and understanding.	Verbal	Chair

Board Agenda item 17/081

Board of Directors

Minutes of the meeting of the Board of Directors
held public on Friday 3 March 2017 at 1015 hrs
in the Boardroom, Liverpool Women's Hospital, Crown Street

PRESENT

Mr Robert Clarke	Chair
Mrs Kathryn Thomson	Chief Executive
Mr Ian Haythornthwaite	Non-Executive Director/Vice Chair
Mr Tony Okotie	Non-Executive Director/SID
Mr Ian Knight	Non-Executive Director
Mr Phil Huggon	Non-Executive Director
Dr Susan Milner	Non-Executive Director
Ms Jo Moore	Non-Executive Director
Mr David Astley	Non-Executive Director
Mrs Michelle Turner	Director of Workforce & Marketing
Dr Andrew Loughney	Medical Director
Mrs Vanessa Harris	Director of Finance
Mrs Dianne Brown	Director of Nursing & Midwifery

IN ATTENDANCE

Mr Colin Reid	Trust Secretary
Mr Greg Hope	Head of Governance (agenda item 054-058)
Mrs Cath Barton	Deputy Director of Operations (agenda item 062)

APOLOGIES

Mr Jeff Johnston	Director of Operations

Thank You

Thank yous were made to the following for their hard work, support and dedication to the Trust:

The Director of Workforce and Marketing introduced Cheryl Farmer. Cheryl is the Trust's Diversity & Inclusion Manager and the Chair of the Trust's Staff Side. After nearly 20 years at the Trust, where she initially started in a scientific role in genetics, Cheryl had decided it's time to try something new and was taking her talents to St Helens & Knowsley Hospitals NHS Trust where she will be continuing her interest in diversity & inclusion, but taking on additional responsibility for patient experience.

The Director of Workforce and Marketing said that we all know that sometimes relationships with trade unions can be difficult. But at Liverpool Women's we have all benefited from Cheryl's pragmatic and realistic approach to employee relations. Cheryl understands what partnership is about. She is as committed to a great patient experience and a great staff experience will always sit down in partnership and try and find a way to an acceptable resolution. Cheryl has decided it is time to hang up her union boots and will be a loss to Unite. On behalf of the Board the Director of Workforce and Marketing thanked Cheryl for her good and wicked humour, her challenge and her

support.

Introducing Ed Williams, Performance Information Developer, the Director of Nursing and Midwifery explained that ED worked across all areas in the Trust providing consistent high quality work. Ed listens and acts on feedback from clinical teams and makes IT and performance real and understanding. Ed is pivotal in delivering all of the national requirements for Nursing and Midwifery staffing reports, CQC compliance and CQUINs and always portrays a can do, helpful and positive attitude.

The Director of Nursing ad Midwifery introduced: Jeanette Jones, Administration Manager; Sandra Wilson, MDT Co-ordinator; and Lesley Brown, Administration Manager and explained that they all work diligently in the background ensuring that patients are seen in the right place by the right clinician. They always act as advocates for patients ensuring the needs of the patients are met and take the responsibilities of their role seriously often going above and beyond ensuring that clinicians have all the information available to them.

The Board expressed their appreciation to all the members of staff.

054 Apologies – as above.

Declaration of Interests – None

055 Meeting guidance notes
The Board noted the meeting guidance notes.

056 Minutes of previous meeting held on Friday 3 February 2017
The minutes of the meeting held on 3 February 2017 were approved, subject to typographical amendments.

057 Matters arising and action log.
The Board noted that all actions were either complete, on the agenda or to be reported at a future meeting. Recognition was given to the date changes to conclude the actions.

Referring to the action on the formulation of the new Performance Report and proposed indicators, Susan Milner was concerned that the timeframe for delivery of the draft report for review by the committees had been pushed back and asked for assurance that the Committees would be in the position of having been able to review the indicators prior to Board. The Chair clarified the timeframes for the new performance report noting that the 2nd June 2017 Board would receive the first performance report (period 1) for 2017/18 with the new indicators; he therefore advised that the Board would need to have sight of the performance framework and draft performance report at the 7th April 2017 meeting for comment and the final version of the 2017/18 performance report at the 5th May 2017 meeting in readiness for the 2 June meeting. The Board noted that the new performance report would include indicators that would be reviewed by the Board committees, and that no one committee would be responsible for the overall although there would be in some cases a crossover of accountability. The Chief Executive advised that there was a substantial amount of work already undertaken and that on the return of the Director of Operations he would be undertaking work to pull together the new performance report, noting that a substantial number of the indicators would be those mandated external to the Trust. She agreed that the Director of Operations would speak with Susan Milner on his return. The Medical Director advised that a lot of the quality indicators that would flow through GACA to Board would be taken from NICE guidance and targets would be set in accordance with the aspirations of the Board, its committees and clinicians.

Susan Milner felt that the Board needed to be robust in the way it set its targets and they should

include trend analysis. Tony Okotie agreed and felt that aspirational targets were fine so long as they were also achievable. He felt that before a decision could be made on the target the Board had to understand what 'good' looked like so that an informed decision could be made. The Director of Nursing and Midwifery advised that it was important that the Board set stretch targets to local indicators and that these would be instigated by the clinicians. She said it was important that the performance report identify clearly what are mandated targets through regulators and the CCG and those that were set by the Trust locally to deliver the safe and quality services to patients. The Board agreed that the revised reporting format be reviewed by the Board and Board committees in the timeframes identified above.

058 Learning from Incidents/ Feedback and Harms

(i) Learning, Candour & Accountability – Gap Analysis

The Director of Nursing and Midwifery reported on the CQC report 'Learning, Candour & Accountability' that was received at the Safety Senate in January. She referred to the gap analysis requested by the Senate which assessed the Trust's position against the key findings and recommendations; the Senate had considered the gap analysis and had agreed a series of actions to be undertaken to become fully compliant. The Director of Nursing and Midwifery referred to the small number of board specific responsibilities that require actions to be taken referring to page 11 of the report which related to the Boards responsibility to have effective governance arrangements to drive quality and learning from the deaths of patients in receipt of care. Ian Knight asked whether the recommendations contained in the paper was new or whether this was already something that the trust was undertaking. The Director of Nursing and Midwifery reported that the paper identified a number of areas for improvement that all trusts should seek to implement surrounding the 5 areas of: involvement of families and carers; identification and reporting; decision to review or investigated; review and investigation; and governance and learning.

The Board considered the gap analysis and commented that where an action had been fully completed that a different colour to the RAG rating be used to show the action had been concluded which would help the Board place additional focus on areas that required addressing. This was in response to a question from Ian Haythornthwaite regarding template letter that had been drawn up under section 1 of the GAP analysis.

Referring to page 10 of the report and the requirement for specialist training on reviews and investigations, Ian Haythornthwaite asked what was meant by protected time and why the Gynaecology safety lead did not currently have protected time allocated. The Medical Director explained that all consultants have protected time to undertake training and therefore it was important that time was allocated appropriately for the Gynaecology safety lead. Once this was done then the rating would turn green. The Medical Director advised that he would seek to understand why no protected time had been allocated to the Gynaecology safety lead for specialist training and make sure that time was made available.

Phil Huggon referring to the number of amber rated recommendations felt that there may be 6 or 7 that make a difference, which could be followed up with an audit. The Director of Nursing and Midwifery referred to the comments earlier and felt that the Board recommendations on page 11 and 12 and those relating to communication with families would have the biggest impact. David Astley agreed with the comment noting that it was imperative that the family was involved in the process from the beginning supporting the need for candour.

Ian Haythornthwaite referring to the recommendation "When boards receive information about deaths, board members often do not interrogate or challenge the data effectively. Most board members have no specific training in this issue or time that is dedicated to focus on it." Asked what was being done to re-provide this training for newer Board members and whether this could be done

at the 7th April 2017 Board given the number of actions currently having to be addressed at that meeting. It was agreed that the timeframe for training would be extended to the 5th May 2017 Board meeting in line with receiving the final Mortality Strategies at the 5th May 2017 meeting.

Regarding assurance the Board:

a) Subject to the comments discussed above, was assured that the gap analysis and the Safety Senate's response to it was correct;

b) Agreed that the action plan adequately addresses the issues identified by the CQC

c) Agreed to deliver the actions identified against the Board specific responsibilities.

Action 2017/58(i): The Medical Director to provide training on mortality at the 5th May 2017 Board meeting.

(ii) Learning from Incidents/ Feedback and Harms Presentation

The Director of Nursing and Midwifery introduced the presentation that would be provided by Greg Hope, Head of Governance and explained that the presentation was to provide assurance to the Board on lessons learned within the trust following incident reporting and was a pre curser to the next two items on the agenda regarding the Never Events reported in Gynaecology and Neonates.

The Head of Governance gave his presentation and highlighted the strong reporting culture in the Trust. He reported on how the Trust identifies safety issues through reactive and proactive, internal and external activities. Referring to the graphs in the presentation the Board recognised that although the trust was a specialist Trust there was a need to report against acute trusts given that a lot of the trust's work related to work done in acute organisations. It was felt this would give clearer comparisons for reporting purposes.

The Head of Governance referred to the process for investigating incidents referring to the Trust's web based system that supports easy to complete (drop-downs); provides instant reference number; and allows email notifications to be auto-generated immediately. The system was flexible and enabled designated staff to see incident details, investigation progress and action plans. The Head of Governance went on to explain that all incidents were assessed by a local manager with multi-disciplinary assessment of seriousness, within strict timescale monitored by Senate. Any incidents requiring further investigation or serious incident investigation would be identified and escalated appropriately. He explained that there was a structured approach to investigations with standard templates, clear deadlines and a reporting structure with a pool of 60 trained local clinicians that could be tapped into together with additional external support from such organisations as LeDeR and Each Baby Counts. The Head of Governance explained how the Trust seeks to embed learning and change through local ownership and dissemination of learning across the services.

The Head of Governance referred to the final slide that provided the responsibilities within the integrated Governance Structure that supported assurance, escalation and de-escalation. Ian Haythornthwaite referring to the way Never Events were presented felt that as they were Never Events they should not have occurred and therefore there was some difficulty understanding how they could happen. The Medical Director advised that there is always a discussion around whether an incident should be treated as a Never Event. He explained that human factors tend to come into play in these circumstances as you can never remove all human elements of risk.

Tony Okotie wondered whether the Board should as part of the new performance report receive an update on serious incidents over the period rather than through the Safety, Experience and Effectiveness report which was reported through GACA and Board on a quarterly basis.

The Chair thanked the Head of Governance for this presentation and asked that the Board move on to the next two agenda items on Never Event Assurances.

(iii) Gynaecology Never Events Assurance

John Kirwan Clinical Director Gynaecology, Chris McGhee, Head of Nursing and Operations and Bill Yoxall, Clinical Director Neonatal Services joined the meeting. The Chair asked that the paper was taken as read and asked John Kirwan to provide the Board with assurances regarding the learning received from the three Never Events in Gynaecology.

John Kirwan gave a brief explanation of the Never events that occurred between July 2015 and January 2017. He put the number of never events in context to the number of procedure the Gynaecology Team had completed in 2015/6 and reported on the recent changes in staffing within Gynaecology with the appointment of Chris McGee as Head of Nursing and Operations and Mr George Botros as the new Gynaecology Safety Lead. John Kirwan advised that changes had been made to Mr Botros clinical work to allow him dedicated time to complete the role of safety lead.

John Kirwan ran through the lessons learned from the three Never Events explaining that all Never Events and Significant incidents were discussed at monthly Gynaecology Divisional meeting, and at the daily Theatre huddle, when all theatre staff on duty are present. He explained that all staff are encouraged to contribute to the improvement of safety in Gynaecology and Theatres.

John Kirwan made a number of observations regarding the learnings from the Never Event and advised that with regards to incident three, a recommendation that before a patient was moved from the operating table, positive affirmations were obtained that the surgeon confirms what operation had been completed, to identify any concerns about the patient or the procedure and that all insertions had been removed; the Anaesthetist confirms that he was happy with patient; and the Scrub Nurse confirms Swab/ needle etc. count was correct and all insertions/ attachments had been removed. John Kirwan in reporting lessons learned and the need for training etc., provided two practical pieces of kit that had been trailed and had been implemented in order to prevent reoccurrence of the events. John Kirwan explained a number of potential innovations within theatres and ideas around pre populated procedure specific electronic checklists and use of 'whiteboards'

The Medical Director referring to the checkout confirmations mentioned above advised that with the ramping up of the WHO checklist for checking in, less emphasis had been placed on checkouts and this required the same degree of management. The Director of Nursing and Midwifery supported the comments and stated that the checkout confirmations needed to be done at the right time. Ian Haythornthwaite referring to the process of check-in and outs asked whether there was a more sophisticated process. John Kirwan advised that there was and referred to the new EPR system. The Director of Nursing and Midwifery advised that there was a system of bar coding items that could be used however the cost of implementation could be prohibitive.

The Chair thanked John Kirwan and Chris McGee for attending the Board.

The Board noted the content of the paper and received assurance that lessons had been learned and shared regarding the adverse incidents reported.

(iv) Neonatal Never Events Assurance

Bill Yoxall, Clinical Director Neonatal Services presented his paper on the Never Event that occurred on 25th November 2016 regarding a lumbar puncture performed on a baby. He explained that the procedure was based on results of a blood test taken earlier that morning and that while the decision to perform the clinical procedure was appropriate, the initial blood sample had been taken from the wrong baby. Bill Yoxall advised that although this event should not have happened, the incident was graded as "Actual effect on patient / service – Low Harm" and "Actual severity of incident – Minor".

Bill Yoxall ran through the investigation findings and reported that the root cause of the event was

that the Phlebotomist incorrectly identified the patient and, therefore, took blood from the wrong baby, mislabelling the sample that was sent to the laboratory. Consequently a number of lessons learned had been identified and implemented. These included the need to review a SOP for ordering, taking and recording of all neonatal blood samples; and improved dissemination of "Identification of Patients Policy". Bill Yoxall went on to explain that a working group had been convened in order to map a process for ordering, collecting and recording blood samples and to develop a SOP for this process. The Phlebotomy service from AHCH would be discontinued from April 2017 and blood samples from babies would only be taken by Trust clinical staff caring for the individual babies in future. The working group would be convened by the end of April 2017 and would be led by the Nurse Consultant /ANNP and the Neonatal Matron. Additional to this, enhanced training and publication around Identification of Patients Policy would be undertaken to be led by the neonatal education team and implemented before the end of April 2017.

Bill Yoxall advised that a further recommendation had been made to investigate the use of barcode scanning for patient identification. This action had been assigned to the Chief Information Officer, who chaired the investigation panel, with a delivery date of 30 June 2017

Referring to the duty of candour and re-assurance, Ian Knight asked whether the family were satisfied with the responses provided. Bill Yoxall reported that the mother was content with the feedback from the investigation and reasons for the event occurring. The Grandmother was not as content.

The Chair asked how the Board could be assured that there was learning across the service from the event. In response Bill Yoxall advised that undertaking the Phlebotomist role within the service had been discussed for a long time and all staff were on board to take on the role as they see the benefit to the babies. The Board recognised that the event arose through human error and supported the decision to undertake the Phlebotomist role within the service reduced the likelihood of re-occurrence. Responding to a question from the Director of Workforce and Marketing, Bill Yoxall advised that the lesson learned had been disseminated throughout the service and also at Alder Hey Children's NHS Foundation Trust.

Tony Okotie asked whether bringing the Phlebotomist role into the service made best use of nurse's time. In response Bill Yoxall advised that from a clinical point of views the decision to move the Phlebotomist service definitely was. He advised that staff were much better at doing the procedure and this improved care to the babies. The Medical Director supported the comment noting that this was unique to neonatal.

The Chair in drawing the discussion to a close felt that the Board had received the necessary assurances that the necessary changes to processes and procedure was being implemented to help prevent the reoccurrence of the event. He recognised that the whole process had been transparent and that the families had been kept fully informed in accordance with the duty of candour. The Chair asked that it be noted that the event was human error and was not a deliberate act.

The Board noted the content of the paper and received assurance that lessons had been learned and shared regarding the adverse incident and that changes had been or would be made to clinical practices.

059 Chair's Report

The Chair made a number of announcements regarding the Council of Governors. He advised that a Board/Governor workshop was to be held on Monday 6 March 2017 to discuss the future CIP programme for 2017/1. The Chair further reported on the current bi elections taking place and explained that one of the two constituencies had been filled.

The Chair announced that this would be the last Board meeting for the Director of Nursing and

Midwifery who was leaving the Trust at the end of the month to join Aintree University Hospitals NHS Foundation Trust at their Director of Nursing. He thanked the Director of Nursing and Midwifery on behalf of the Board for her hard work and support whilst both a staff member of the Trust and as an Executive Director on the Board. The Chair felt that the Director of Nursing and Midwifery was a force for good and always had the patients' wellbeing at the heart of everything she did.

The Board noted the Chair's update report.

060 Chief Executive's report

The Chief Executive presented her Report and highlighted a number of matters contained within it.

The Chief Executive referred to the successor appointment for the post of Director of Nursing and Midwifery; Doug Charlton. Doug would join the Board on 1 April 2017. The Chief Executive reported on the appointment of Julie King, Deputy Director of Nursing and Midwifery who would be supporting Doug.

The Chief Executive asked the Director of Nursing and Midwifery to report on two items that had recently come to light. The Director of Nursing and Midwifery advised that Edge Hill University had signed off a shortened duel registration course with the Trust. The second item related to the Trust receiving a funding award for safeguarding.

The Chief Executive referring to the plans being undertaken in the hospital that provided improvements for patients and reduction in cost over the next year and asked the Director of Nursing and Midwifery to provide an update on the inpatient redesign project for gynaecology and the outpatients – patient flow and self-check in system project. The Director of Nursing and Midwifery reported on the two projects explaining that the inpatient work would ensure that patients were treated at the right time – right place and the outpatient project would ensure the Trust improves the waiting areas supported by better technology. She explained that both projects were great steps forward but that they did not reduce the risks identified in the future generations and PCBC, explaining that they were great for the environment and patient experience but did not reduce clinical risks. The Director of Finance supported the comments and advised that it was important to make improvements with the limited amount of capital available to help make the Trust more efficient than it would be if no improvements were made.

The Board noted the Chief Executive Report.

061 Chair's Report from the Finance Performance and Business Development Committee (FPBD)

Jo Moore, Chair of FPBD presented the Chairs report from the last meeting of the FPBD held on 20 February 2017. She reported that the Committee was assured that the Trust was on target to deliver £6M deficit at year end explaining that the improved forecasted outturn deficit of £0.5m reported last month would be matched by £0.5m of STF incentive funding. Referring to the performance dashboard, Jo Moore reported that the Committee had noted that the Trust continued to deliver against the NHSI performance targets however mandatory training had seen a fall in performance over the period. The Committee recognised that the target set was a stretch target and recognised the importance that all staff received mandatory training. She advised that the Committee was assured that the delivery of the mandatory training performance was high on the agenda of the Putting People First Committee.

Jo Moore reported that the Committee had received a presentation on the Trust's Cost Improvement Programme for 2017/18 and had noted that the Trust must deliver £3.7m of CIP in 2017/18. The Committee had received assurance from the Executive that detailed plans had been worked up to allow 62% of schemes to be transacted however there was a level of concern that detailed plans had not been drawn up for the remaining 38%, to enable 100% to be transacted by the start of the

2017/18 financial year. In response to a question from Phil Huggon regarding delivery of the remaining 38% of the Schemes, Jo Moore advised that the Committee had noted that the delivery would be extremely challenging and that there was risk to delivery, despite the identified mitigations.

Jo Moore advised that the Committee had noted the BAF and agreed that there were not changes for recommendation to the Board.

The Chair thanked Jo Moore for her report which was noted.

062 Quality, Operational Performance report Period 10 2016/17

The Chair welcomed The Deputy Director of Operations to the meeting to present the Performance Report on behalf of the Director of Operation.

The Deputy Director of Operations presented the Performance Report for period 10 and advised on the areas where the Trust was not on target to deliver. She explained that all of the mandatory NHSI indicators were on target; it was those indicators set locally by the Trust that were underperforming.

The Board noted the discussion earlier in the meeting regarding delivery of the mandatory training target which was being reviewed by the Putting People First Committee with the sickness absence and PDR targets.

With regard to maternity triage, the Board noted discussions at previous meetings and whether the indicator and target were the most appropriate to use in the future. The Board recognised that the new performance report which would include mandatory targets set by NHSI; CQINS and contractual targets agreed with the CCG; and local targets set by the Board through discussion at the Board committees and from advice from clinicians. The Chief Executive referring to the maternity triage indicator advised that this was originally set as a local indicator as there was not a national indicator in place around it. She stated that maternity triage indicator had been put in place to support patient waiting times. Referring to the review of the local indicators the Chief Executive advised that it was important that the clinicians were fully engaged in setting them.

The Chair thanked the Deputy Director of Operations for attending the meeting. The Board noted the Performance report and the continuance of the action to bring to the Board at its April 2017 meeting a template performance report for future reporting of agreed metrics, both prescribed and those required locally by the Trust.

063(i) Financial Report & Dashboard Period 10 2016/17

The Director of Finance presented the Finance Report and financial dashboard for month 10, 2016/17 and reported that Trust was reporting a monthly deficit of £0.25m against a deficit plan of £0.39m which was a positive variance of £0.14m for the month. Cumulatively the Trust was slightly ahead of plan by £0.2m.

The Director of Finance referring to the work of the FPBD reported that the Trust was on track to deliver an improved position at year end against budget. David Astley referring to the improved position congratulated the staff on what had been achieved. The Director of Finance was pleased with the position however was concerned that the Trust may not be in the position of delivering 2017/18 control total. She felt that the biggest financial concern was the delivery of the CIP programme and in particular the 38% of the programme that had not yet been fully worked up. The Director of Finance advised that savings for future years would continue to rise and being able to find additional CIP would not be possible without an impact on services.

The Chief Executive advised that the Trust was now at a stage where she needed to consider whether to send an 'Accounting Officer' letter to the Centre in the next few months setting out the key issues

being faced by the Trust, in particular the delays around public consultation impacting on the risks to clinical services and also the public purse particularly as the Trust looked forward to 2018/19 and beyond.

Ian Haythornthwaite advised that as a Board it must decide on whether the Trust was able to deliver its CIP programme; if the Board agrees to it then the Board is accountable to deliver. He felt that the Board had to consider very carefully were it was regarding delivery before deciding on progressing with an 'Accounting Officer' letter to the Centre.

The Chair thanked the Director of Finance for her report which was noted. He advised that at the next meeting the Board would need to decide on whether it could accept the CIP programme for 2017/18.

063(ii) Uncommitted Single Currency Interim Revenue Support Facility Agreement

The Director of Finance presented her report on the requirements for the Trust to enter into new loan arrangements with the Department of Health. She explained the differences between the current working capital facility and the new uncommitted single currency interim revenue support facility (set out in appendix 1) under which all new and existing loans would be converted. The Director of Finance reported that the facility would incur an interest rate of 1.5% against the interest rate for the working capital facility of 3.5%, however should the Trust be unable to meet its control total and was in financial special measures the interest rate would rise to 6%, with a middle ground of 3.5% if the Trust was not meeting control total but was not in financial special measures. The Board discussed the requirement to move from the current working capital facility to the uncommitted single currency interim revenue support facility and noted that without the cash support the Trust would not have sufficient cash to meet its obligations.

The Board:

1. *approved the terms of, and the transactions contemplated by, the generic uncommitted interim revenue support facility set out in appendix 1 of the report;*
2. *approved the arrangements for entering into uncommitted interim revenue support facility as Borrower;*
3. *authorised the Director of Finance to execute uncommitted interim revenue support facility on behalf of the Trust; and*
4. *authorised the Director of Finance, to sign and/or despatch all documents and notices in connection with any future uncommitted interim revenue support facility.*

The Board confirmed that the Trust, as Borrower, would comply with all and any additional terms and conditions that may be requested from time to time in accordance with the arrangements. Compliance would not be unreasonably withheld. Any significant changes to the arrangements would require the additional authorisation of the Chief Executive and Chair.

064 Fit for Future Generations Update

The Chief Executive advised that the Executive team were continuing to work actively with Liverpool CCG, NHS Improvement and NHS England to move the process forward to public consultation.

065 Review of risk impacts of items discussed

The Board noted the risks had been discussed during the meeting and the main issue was the related to:

- Delivery of the CIP programme for 2017/18
- Future Generations clinical risks had not changed with the improvements being made in inpatients and outpatients
- Making sure that learning from incidents was disseminated across the services
- Consideration of the Accountable Officer putting in writing to the Department of Health regarding delays in public consultation and the risk the delays had on both the clinical services

and the public purse.

Any other business & Review of meeting

None.

Conduct of the meeting was very good with good challenge, scrutiny and assurance provided. The Chair felt that there was contribution from all members of the Board.

Date and time of next meeting

7 April 2017

Liverpool Women's NHS Foundation Trust

17/082

TRUST BOARD
April 2017 Action Plan

Meeting date	Minute Reference	Action	Responsibility	Target Dates	Status
3 March 2017	2017/58(i)	The Medical Director to provide training on mortality at the May 2017 Board meeting.	Medical Director	On target	On the Board agenda for May 2017
6 Jan 2017	2017/010	The Director of Operations to bring to the Board at its March meeting a template performance report for future reporting of agreed metrics, both prescribed metrics and those required locally by the Trust.	Director of Operations	Complete	An extension of time is required to bring the template to the Board.
6 Jan 2017	2017/009	The Director of Nursing and Midwifery include in future quarterly SI reports to the Board the matters identified in the discussion and provide a Serious Incidents Quarterly Report to the meeting on 7 April 2017.	Director of Nursing and Midwifery	Complete	
4 Nov 2016	2016/278	Director of Nursing and Midwifery to provide an update to the board on progress made against the action plan regarding the implementation of the National Maternity Review in February 2017.	Director of Nursing and Midwifery	~~February 2017~~ 7 July 2017	3 March 2017 Update: An update presentation was be provided to the Board on 3 February 2017 with a formal paper presented to the Board at the 7 July 2017 meeting following the visit from Baroness Cumberlege Action ongoing.
7 Oct 2016	2016/255	The Executive Team to review the risks identified in the BAF and bring back a proposal on whether the risks can be grouped or consolidated.	Trust Secretary/Executive	~~February 2017~~ (i) 7 April 2017 - complete (ii) 5 May 2017	3 February 2017 update: This action has now been superseded following the findings of the CQC mock inspection reported through GACA. A complete review of the BAF has been commissioned that would take into account not only the consolidation of the risks on the BAF (these have continued to be reviewed by the Committees) but also to consider structural changes to the way the BAF reports and manages the risks and its relationship with the Corporate Risk Register. The

					Executive with the support of the Chair has commissioned an external review of the BAF to make it fit for purpose and accessible by the Board, Board committees and staff. 3 March 2017 Update: a Board workshop on the day of the April Board has been arranged to review the structure of the new BAF and risks following which the final version of the BAF will be circulated prior to being received at the 5 May 2017 meeting, *7th April 2017 Update: Board workshop to discuss BAF following the Private Board on 7 April 2017* Action ongoing.

Agenda item no:	17/084

Meeting:	Board of Directors

Date:	7 April 2017

Title:	Chief Executive's Report

Report to be considered in public or private?	Public

Where else has this report been considered and when?	N/A

Reference/s:	N/A

Resource impact:	-

What is this report for?	**Information**	✓	**Decision**		**Escalation**		**Assurance**	✓

Which Board Assurance Framework risk/s does this report relate to?	**All**

Which CQC fundamental standard/s does this report relate to?	**Reg 17: good Governance**

What action is required at this meeting?	To receive and note the report.

Presented by:	Kathryn Thomson, Chief Executive

Prepared by:	Colin Reid, Trust Secretary

This report covers (tick all that apply):

Strategic objectives:	
To develop a well led, capable motivated and entrepreneurial workforce	✓
To be ambitious and efficient and make best use of available resources	✓
To deliver safe services	✓
To participate in high quality research in order to deliver the most effective outcomes	✓
To deliver the best possible experience for patients and staff	✓

Other:			
Monitor compliance	✓	Equality and diversity	
Operational plan		NHS constitution	

Publication of this report (tick one):	
This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting	✓
This report will not be published under the Trust's Publication Scheme due to exemptions under S21 of the Freedom of Information Act 2000, because the information contained is reasonably accessible by other means	
This report will not be published under the Trust's Publication Scheme due to exemptions under S22 of the Freedom of Information Act 2000, because the information contained is intended for future publication	
This report will not be published under the Trust's Publication Scheme due to exemptions under S41 of the Freedom of Information Act 2000, because such disclosure might constitute a breach of confidence	
This report will not be published under the Trust's Publication Scheme due to exemptions under S43(2) of the Freedom of Information Act 2000, because such disclosure would be likely to prejudice the commercial interests of the Trust	

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

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

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

Kathy Thomson.
Chief Executive.

SECTION A - INTERNAL

Care Quality Commission: The Care Quality Commission (Ann Ford, Regional Director), Simon Regan (Lead Inspector) & Helen Cain (link inspector) met with Kathy Thomson and senior managers on Monday 20th March to discuss recent Never Events and Serious Incidents, plus explore issues raised by an anonymous whistleblower regarding risk reporting and governance HR processes.

Further to the NE & SI, the Trust has produced a multidisciplinary response and action plan, supported with evidence, which was submitted to CQC on Wednesday 29th March as required. Additionally, there is a current 'task & finish' working group specifically looking at the Maternity Assessment Unit's staffing and process models. This work will be shared with CQC upon completion.

Regarding the anonymous concerns raised, CQC were assured that the Trust has a positive and supportive culture of risk reporting, and the 'Board to ward' escalation and feedback is well established and effective. We have commissioned the services of CQC's lead governance & risk specialist inspector to provide further scrutiny and support in terms of risk reporting and management, and governance processes Trust wide.

In response to the HR concerns, the senior business partner conducted an audit of both recent governance team restructures (18 months ago and December 2016), and has found that process was followed in both cases. This information has been provided to CQC. In addition, we have commissioned an internal investigation into the corporate governance team management and culture. This investigation will also be fully shared with CQC as soon as complete.

Medical Genetics: NHS genetic laboratory providers were notified in 2016 that NHS England will tendering their services from April 2017. Genetics laboratory services are expected to be tendered in 11 lots with the North West, incorporating the populations of NW Coast GMC and Greater Manchester GMC, as one lot. Following the re-procurement, there are expected to be fewer (prime) providers than there are lots and over time it is expected that the 'lots' may reduce further to 4 nationally (North, Midlands, South, London).

NHS England is strongly promoting partnership bids and the Liverpool Women's service has been encouraged to work with the Manchester service in order to submit a bid for the North West lot. The team has been advised that a LWFT bid will not be successful.

The procurement exercise will be conducted in in two stages. Stage 1 – April - May 2017 – providers to detail their proposed governance and infrastructure for the future regional service and Stage 2 – June – August 2017 – a full 'Invitation to Tender'.

The Trust has started conversations with Manchester at both Executive level and at service level to ensure that the appropriate deadlines and a successful bid can be achieved.

Dedicated to Excellence: The 2017 Dedicated to Excellence Awards will take place on Thursday, 13th April 2017, at the Marriott Hotel, Liverpool. There are 8 categories this year:

- Dedicated to Innovation and Improvement (clinical)
- Dedicated to Innovation and Improvement (non-clinical)
- Dedicated to Working together (team working and partnerships
- Dedicated to Research
- Dedicated to Patients and their Families
- Dedicated to Patient Safety
- Mentor of the Year
- Learner of the Year

There will also be:

- Employee of the Year
- Team of the Year
- Volunteer of the Year
- Foundation Award

Honeysuckle Team was shortlisted for the RCN award for SANDS Award for Bereavement care at the 7 March Ceremony.

Team of the Season: Neonatal Services won the Trust Team of the Season award and the Trust Executive attended one of their Management Team meetings to give the award. Over the last 12 months they have worked through a number of difficult situations, keeping the patients at the heart, continuing to make an outstanding contribution.

SECTION B – LOCAL

Terrorist attack in London: In order to provide some assurance, the following statement is the local picture in relation to counter-terrorism and the Police's national statement:

Statement from the National Police Prevent Team: *The incident in London appears to be contained, the UK national threat level remains at 'SEVERE': (An attack is highly likely). However, although there is no specific intelligence that would suggest that further attacks are imminent, we would urge all sites to remain vigilant and to report suspicious behaviour.*

Further to this, Merseyside Police have reassured the trust that there has been no reports of any community tensions or hate crime incidents in Liverpool since the attack. The appropriate security measures in place have been checked in relation to the city's infrastructure etc. The Counter Terrorism Security Advisors' are in communication with Local Authority departments including Emergency planning.

The Trust has a Prevent Lead with Safeguarding who attends the regional NHS Prevent Leads Forum and has developed a Local NHS Prevent Leads Group for the Trust's area. This ensures the Trust has strong links with Prevent Leads in Merseyside Police, Liverpool City Council and NHS England.

The Local Authority have requested from internal departments to inform their Prevent Lead of any negative changes in the current circumstances, they have numerous LA community officers (Street Scene/Community Safety Team) out in the city and all businesses have been contacted and briefed. All faith institutions have also been contacted and issued with advice and support. The Police Prevent team are checking all social media information to monitor any concerns and will report any issues to us.

The Trust needs to remain vigilant and understanding what to look for and how to escalate concerns is key to this. All Trust staff have received Prevent basic awareness training and following our Trust TNA; our Workshop

to Raise Awareness of Prevent (WRAP) training for clinical staff is over 60% with a trajectory to reach 90% by year end.

In order to assist with awareness, following the events of this week, the Trust will be creating an update for all staff next week reminding them of their responsibilities and how to report any concerns relating to the Prevent Duty.

For further information and guidance please access https://act.campaign.gov.uk/

Liverpool Health Partners: Attached is an update from Liverpool Health Partners. The Board will note LPH have published a research profile for Liverpool Health Partners. This highlights some of the outstanding contributions all partners bring. If any Board members would like to access a copy of the research profile, there is a copy of this kept in the CEO's office.

SECTION C – NATIONAL

NHS England Mandate 2017-18: 20 March 2017 the Department of Health published its mandate to NHS England for 2017-18. The mandate sets the government's objectives for NHS England, as well as its budget. In doing so, the mandate sets direction for the NHS, and helps ensure the NHS is accountable to parliament and the public. The 2017-18 mandate continues the approach set out in 2016-17's mandate, maintaining the direction set and defining annual deliverables for 2017-18 that will keep health services on track to meeting those longer-term goals.

NHS Litigation Authority: Please find attached a letter from the NHS Litigation Authority regarding the bringing together of three core services under one umbrella organisation with the new name NHS Resolution.

Public Health England: Please find attached the latest edition of the PHE North West Bulletin.

Public Health England

PHE North West Bulletin

Issue 08, April 2017

Protecting and improving the nation's health

Contact us: PHE North West Centre, 5th Floor, 3 Piccadilly Place, London Road, Manchester, M1 3BN

Tel: 0344 225 0562 Email: PHENWBulletin@phe.gov.uk Twitter: @PHE_NorthWest

Welcome

Welcome to our 8th edition of the North West Bulletin.

Well Spring has returned and with it the usual challenges!

As the nights get longer and the days warmer the public health cycle begins again. We are already making plans for this year's Heatwave Plan whilst evaluating the work we have been engaged in during the past winter.

This edition is a chance to look at upcoming events and show how we engage with stakeholders across the public health community to address the many demands we all face.

In this issue

It is also a great opportunity to showcase the work being done by colleagues and partners. If we can't shout about our successes then who can?

We will look at the work of the Cheshire and Merseyside Health Protection Team who won the recent North West Coast Research and Innovation Award for Delivering Research in Collaboration. The edition will also feature the success of PHE's first ever Quality Hub event which allowed colleagues from PHE and beyond to share best practice.

The impact of the North West pilot campaign on AMR is also causing waves nationally. The campaign has proved to have exceeded expectations with high levels of engagement and amplification across the country. We shall look at the next stages for the campaign and also an overview on upcoming Health and Wellbeing work we are engaged with.

The good news should, of course, be shared by us all; as our achievements are only possible thanks to the great partnership work that exists across the North West. This is evidenced by collaboration on issues as diverse as the recent avian flu outbreaks, and our campaign for a tobacco free NHS. These, and other efforts, will be highlighted in this edition.

This edition of the newsletter will also look at the impact of changes taking place outside of our area where we will look at national plans for the Science Hub in Harlow and how they may impact on the North West. We will also feature how the North West continues to be a focus for national events and activities such as the venue for the annual Health Checks Conference.

Health Protection continues to be at the core of our work whether it is screening and immunisation programmes or the day-to-day outbreak meetings we have with colleagues across the North West on issues as diverse as TB, norovirus, cryptosporidium or flu.

We hope you enjoy this edition and, as always, look forward to hearing your comments, feedback and suggestions for future articles.

Susanna Sewell, Centre Operations Manager, PHE North West

Cheshire & Merseyside Health Protection Team scoop award

The team recently won the Delivering Research in Collaboration Award at the North West Coast Research and Innovation Awards 2017. In 2012/13 there was a large outbreak of measles in Merseyside. Rather than concentrate solely on outbreak

control, we in the Cheshire & Merseyside Health Protection Team became more dynamic. Realising opportunities for research, we undertook an unprecedented amount of high quality studies, grasping collaborative opportunities with a wide variety of partners, innovatively using routine data to identify ways of reducing childhood illness. To date we have five peer-reviewed publications relating to this outbreak with another five in print, in draft or submitted. Only one of these projects required additional funding, highlighting the innovative and creative working practices. The results of several of the projects have influenced a variety of both local and national policies. During the outbreak there were 651 confirmed cases of measles, since the outbreak, there has been only one case in Merseyside. Winning another award is acknowledgement for the efforts of the whole team, especially as we are a front line team and not a research Unit.

Pictured – Dr Roberto Vivancos, Regional Epidemiologist, Dr Alex Keenan, Epidemiology and Surveillance Analyst, Dan Hungerford, Dr Sam Ghebrehewet, Head of Health Protection PHE North West – Cheshire & Merseyside

Contributor – Dr Alex Keenan, Epidemiology and Surveillance Analyst

Advice for pregnant women during lambing season

As we approach lambing season it is important to remind pregnant women about the potential risk of coming into contact with livestock animals that are or recently have given birth. Some infections can be passed to humans and if pregnant women become infected, it could harm her and her unborn baby's health.

Although the number of human pregnancies affected by contact with sheep is extremely small, it is important for pregnant women to avoid close contact with sheep and other livestock that have recently given birth.

Animals that have recently given birth may carry germs that can affect pregnant women, such as chlamydiosis, listeriosis, Q fever and toxoplasmosis.

This advice also applies to pregnant women who may be visiting petting farms. To avoid the risk of infection, pregnant women should:

- not help deliver lambs (or calves or kids)
- not milk ewes
- avoid contact with aborted (miscarried) or newborn lambs, and with the afterbirth, birthing fluids or contaminated materials, such as bedding
- avoid handling or washing clothing, boots or any materials that may have come into contact with animals that have recently given birth, their young or afterbirths, potentially contaminated clothing will be safe to handle after being washed on a hot cycle and clothing worn during lambing should be washed separately from other washing
- ensure that contacts or partners who have attended animals giving birth take appropriate health and hygiene precautions. This includes wearing personal protective equipment and clothing and adequate washing to remove any potential contamination

Pregnant women are advised to seek medical advice if they experience fever or influenza-like symptoms, or if they are concerned that they could have acquired infection from a farm environment.

PHE guidance can be found **here** and further information can be found on NHS Choices about **infections in pregnancy** and **pregnancy and lambing**.

Contributor: Janey Kenyon, Specialty Registrar in Public Health, Cumbria and Lancashire Health Protection Team

Screening programmes

In this edition, we continue our look at the screening programmes that are commissioned in our region. This time we will be exploring the Fetal Anomaly Screening Programme, Infectious Diseases in Pregnancy and Newborn and Infant Physical Examination.

Fetal Anomaly Screening Programme

The NHS fetal anomaly screening programme (FASP) is one of the antenatal and newborn NHS population screening programmes. FASP currently offers antenatal screening to all pregnant women in England for the following conditions:

- anencephaly
- open spina bifida
- cleft lip
- diaphragamtaic hernia
- gastrochisis
- exomphalos
- serious cardiac abnormalities
- bilateral renal agenesis
- lethal skeletal dysplasia
- Edwards' syndrome (T18)
- Patau's syndrome (T13)
- Downs Syndrome (T21)

Screening tests for Down's, Edwards' and Patau's syndromes:

The Combined Test

This test is the most effective early screening test for Down's, Edwards' and Patau's syndromes available on the NHS in England. The combined test involves measuring the fluid at the back of the fetus' neck using nuchal translucency, and taking a blood sample. A midwife offers this test to expectant mothers at between 10+0 and 14+1 weeks of their pregnancy.

The Quadruple Blood Test

If a mother presents late for Down's syndrome screening and is between 14+2 and 20+0 weeks of pregnancy, the quadruple blood test is available for screening. A blood sample from the mother determines levels of 4 different biochemical markers that together with maternal age can indicate whether there is a higher risk of Down's syndrome.

If either the combined test or the quadruple blood test returns a higher risk result, the next step is to offer 1 of 2 diagnostic tests: chorionic villus sampling, amniocentesis.

Infectious Diseases in Pregnancy

The infectious diseases in pregnancy screening (IDPS) programme currently screens for:

- HIV

- Hepatitis B
- Syphilis

Midwives should offer and recommend testing to all pregnant women as part of their antenatal care. The woman's decision to accept or decline testing should be noted in the woman's health records. The healthcare professional takes a blood sample from a pregnant woman and send it for testing. Each condition has a clear pathway to care. Healthcare professionals caring for pregnant women should be familiar with these pathways and the timeframe in which to refer patients.

Newborn and Infant Physical Examination

The newborn and infant physical examination screening programme (NIPE) is one of the antenatal and newborn NHS population screening programmes. NIPE screens newborn babies within 72 hours of birth, and then once again between 6 to 8 weeks, the 6 to 8 week screen is necessary as some conditions appear later in a child's development, this is carried out by the GP.

NIPE currently offers newborn screening to babies born in England for:

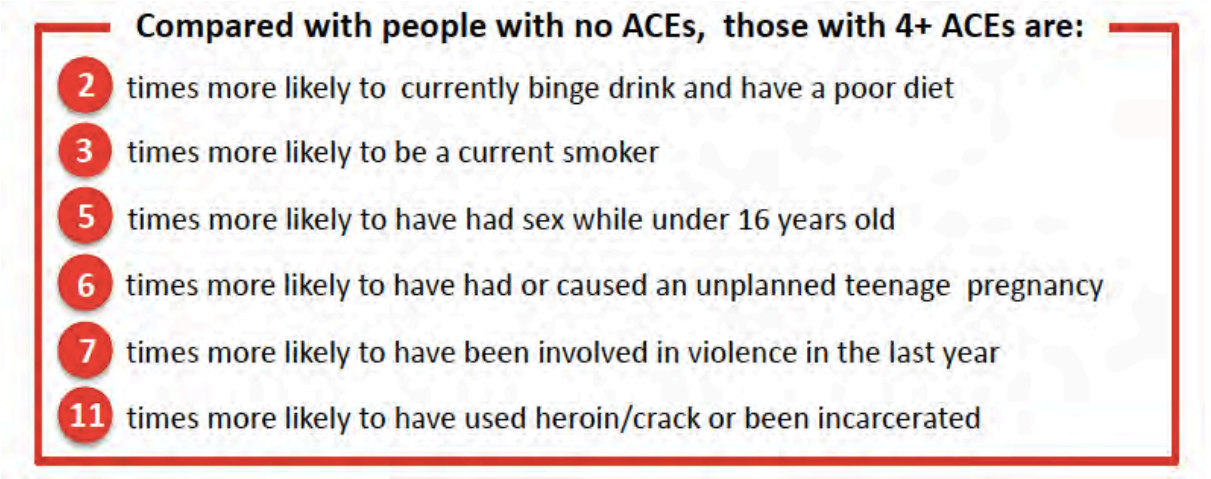
- Congenital heart disease
- Developmental dysplasia of the hip
- Congenital cataracts
- Cryptorchidism (undescended testes)

Contributor – Carol Bailey, Screening and Immunisation Manager

Tackling adverse childhood experiences

In February PHE North West, in partnership with Blackpool and Blackburn with Darwen councils, organised a North West Conference to explore good practice in addressing Adverse Childhood Experiences (ACEs).

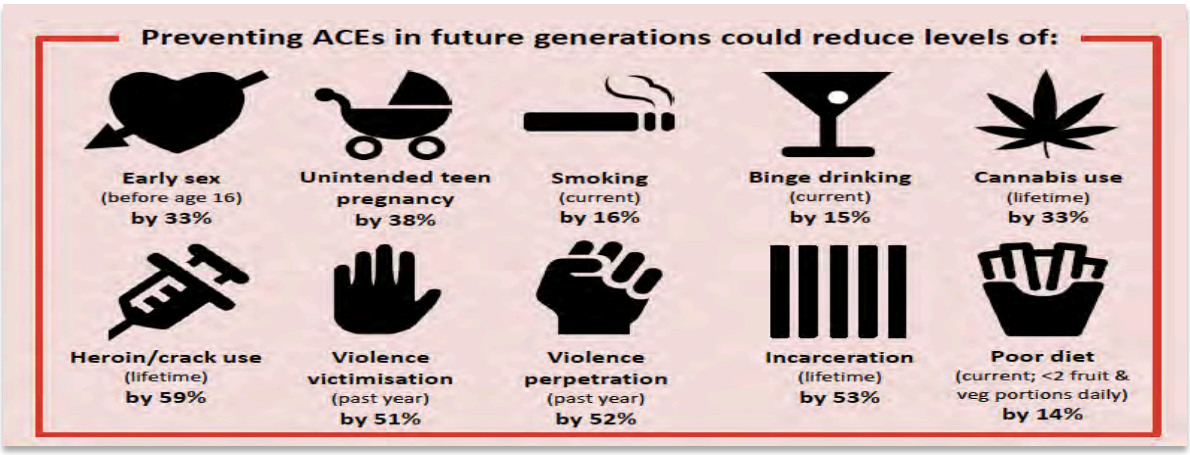
Experiences such as bereavement, parental mental health, parental substance misuse have been proven to have a significant impact on a young person's development and increases their risk of poor health, education outcomes and entering the criminal justice system later in life.



The one-day event was held in the Blackpool Winter Gardens with attendees coming from public health, education, carers, children's services, safeguarding teams, NHS providers and the third sector.

The programme included speakers from PHE, local authority public health teams, academia, police, early intervention programmes, a school, substance misuse services, and the NHS. All present recognised the need to identify young people at risk of experiencing four or more ACEs and providing them with support to either avoid or cope with the experience to reduce the potential harm later.

The day proved to be very thought provoking and encouraged delegates to behave differently when encountering young people experiencing ACEs in future. It was agreed to map current activity, identify gaps, identify where disciplines can work in partnership and there was a desire to repeat the event to monitor progress in twelve months' time.



Contributor - Steve Morton; Health and Wellbeing Manager, PHE North West

AMR campaign in Granada TV region

In February 2017 PHE launched a pilot awareness campaign across the Granada TV region to support national efforts to reduce inappropriate prescriptions for antibiotics.

Running for 8 weeks and ending on 7 April, the campaign features advertising on TV, radio, outdoor, press, digital and social media, in addition to PR.

TV advert

Press example

GP poster

The campaign has been well reported in regional media including pieces on BBC North West, Bay TV, Made in Manchester, That's Manchester, BBC Radio Merseyside and Key 103 FM to name a few. In print articles have appeared in titles for example The Liverpool Echo, The Blackpool Gazette, The Lancashire Telegraph and the Wigan Observer.

BBC North West – Interview with Dr Rob Barnett

Interview with Dr William Welfare

Online the campaign is generating lots of buzz with over 3.45 million impressions and over 880,000 views of our two lead videos.

The campaign page on NHS Choices, which features key campaign messages and our TV ad, has had over 66,000 visits, which illustrates the appetite for further information on this topic.

To date 291,260 leaflets and 19,280 posters have been distributed to 6,455 GPs, pharmacists, health care settings, children's centres and local authorities to raise awareness of antibiotic resistance. In addition, as part of toolkits created for GPs, 4,068 prescription pads have been sent out which provide GPs with a tangible intervention to satisfy patient concerns and help alleviate pressure to prescribe.

Overuse and misuse of antibiotics is creating antibiotic-resistant strains of bacteria against which none of our current antibiotics work. The race is on to develop new antibiotics to kill these resistant strains but, if we don't win that race, we could face a future in which antibiotics no longer work. That could mean a return to the pre-antibiotic age, where people with compromised immune systems may not recover from common infections and deaths in childbirth or from infected wounds or pneumonia were commonplace.

The Granada Region was chosen as the North West (In Q2 in 2016), had the highest levels of antibiotics prescribed, both overall and per head in the UK – with over 1.2 million prescribed equating to 169 items per 1000 residents (15% of the total population in England).

A range of partners from across the North West including local authorities, healthcare providers e.g. pharmacies, GPs, trust and dentists are actively supporting the campaign. Look out for the TV adverts and marketing materials appearing across the North West and join us in the fight to reduce antibiotic resistance.

For more information contact **partnerships@phe.gov.uk**

Contributor – Claire Roach, Communications Manager, Public Health England

A bird's eye view of an outbreak

In late January the Animal and Plant Health Agency (APHA) reported a probable outbreak of H5N8 avian flu A in a flock of pheasants at a farm in Wyre, Lancashire to our Cumbria and Lancashire Health protection team.

As is usual in these cases a local incident control team was convened and the outbreak was confirmed on the 27 January.

This declaration was the first of three sequential outbreaks in the three kilometre protection zone surrounding the first infected flock with the incident control team not stepping down until 17 February whilst our health protection team's operational response continued for a further five days.

During this four week period the team worked closely with the APHA, Clinical Commissioning Group (CCG), and other local partners.

The CCG adopted an existing avian flu Patient Group Directive (PGD) to provide pre and post exposure prophylaxis with antivirals to farm workers and APHA staff.

Meanwhile, in line with national guidelines our health protection team developed systems for active and passive monitoring of people who had been in contact with the infected premises.

From a national perspective the three outbreaks in Lancashire were the 5th, 7th and 8th recorded nationally and as a result APHA staff and contractors were being moved around the country to respond to outbreaks.

In these circumstances it became apparent that APHA workers were likely to exceed the 42 day limit for antiviral treatment and PHE advised that staff working on infected premises should cease work at 32 days and complete 10 days post exposure prophylaxis followed by three days of no treatment before resuming work and antiviral prophylaxis.

This presented a significant operational challenge to APHA and resulted in a rapid review of PHE guidelines. Subsequent to national discussions with PHE and APHA, new interim guidelines for the public health response to outbreaks of H5N8 avian flu A were published on 14th February. These place greater emphasis on use of personal protective equipment and active monitoring for people in contact with an infected premises. The use of antivirals is reserved for post exposure prophylaxis.

Work is now underway to prepare for further H5N8 outbreaks in line with new guidelines.

Contributor - Grainne Nixon, Nurse Consultant, Cumbria and Lancashire Health Protection Team

North West kids get food smart

The national Be Food Smart campaign continues to inspire activity across the North West with events including roadshows, tailored lesson plans and school visits.

At Halton Borough Council's annual 'Crucial Crew' event the council's Health Improvement Team presented a session on healthy eating, focusing on the harmful effects of eating too much sugar, fat and salt through an interactive presentation and sugar quiz.

The children were all given a Be Food Smart pack to take home with many saying they would actively encourage their parents and siblings to cut down on unhealthy foods and snacks.

Pictured - Children from Pewithall Primary School in Runcorn

Contributor – Val Anderton, Halton Council

North West venue for national conference

In February Manchester was the venue for the 2017 national NHS Health Checks Conference.

Pictured - Dr Dawn Harper, GP and media medic, with Health and Wellbeing Director Kevin Fenton and Prof Jamie Waterall, National Health Check Lead

The conference was aimed at those involved with commissioning, providing, evaluating and supporting the NHS Health Check programme and the risk factors it assesses and seeks to change.

The event was opened by GP and media medic Dr Dawn Harper and key speakers included PHE's National Director of Health and Wellbeing Professor Kevin Fenton who gave an overview of the programme's achievements so far.

There was also an update by Professor Jamie Waterall the National Lead for the NHS Health Check programme whilst Halton based GP Dr Matt Kearney; National Clinical Director CVD prevention at NHS England also spoke about the crucial role of prevention.

Among the discussions points was the finding of a review of the emerging evidence on the NHS Health Check, which was published in February. To date, 4.8 million people have had a check.

The NHS Health Check is a health check-up for adults in England aged 40-74. It's designed to spot early signs of stroke, kidney disease, heart disease, type 2 diabetes or dementia.

Contributor – Julie Kinsella-Shenton, Press Officer, Public Health England

Invite to Blood Pressure event

The Halliwell Jones Stadium in Warrington will be the venue for next month's Cheshire and Merseyside's Blood Pressure Stakeholder event.

Entitled Saving Lives: Reducing the pressure – One Year On the event has been organised in partnership with PHE North West and NHS England Cheshire & Merseyside and will take place on Thursday 27 April.

It is open to public health teams, CCGs, clinicians, primary care teams, pharmacists, the voluntary sector and other partners.

It will look at progress made since the launch of the Saving Lives: Reducing the Pressure strategy a year ago and will be an opportunity to share learning and celebrate successes.

The day will include a series of breakout sessions to share learning and raise awareness of what has worked well. There will also be an opportunity to build understanding on how everyone can contribute to the overall blood pressure strategy and improve blood pressure outcomes in Cheshire and Merseyside.

For further information and how to book a place please visit the Champs website at **http://www.champspublichealth.com/events**

Contributor – Tracey Lambert, Champs

Hepatitis refresher training

It is estimated that 40,000 people in the North West are living with hepatitis C with some infected for a long time without symptoms.

Incidents in the North West, as indicated by positive tests in young people remain stable, but have not matched the rate of decline seen in some areas in the UK in recent years.

Those patients most at risk of contracting hepatitis C infection are those who inject drugs or have injected drugs. Sharing of drug injecting equipment remains a significant issue.

They are likely to be at increased risk even if they injected only once or twice in the past. Others include people who had blood transfusions before 1991 or received blood products before 1986 in the UK and people who originate from countries where hepatitis C is endemic, such as some South Asian countries. People from countries where hepatitis C is endemic tend to be at risk if they've had medical or dental treatment with unsterile equipment.

Cases of hepatitis B remain stable in the North West however serious health sequelae associated with chronic hepatitis B infection appear to be increasing this in turn impacts on health services.

The PHE North West Viral Hepatitis Group published a suite of reports in 2016 with a range of recommendations to support commissioners and providers in addressing this major public health issue. The recommendations look at prevention, early diagnosis and treatment. If you would like a copy of these reports please contact me at **Evdokia.Dardamissis@phe.gov.uk**

Finally, I would like to raise awareness of an excellent special training course on hepatitis B and C that is available to healthcare professionals through the Royal College of General Practitioners. Although the certificated part of the course is payable there is an e-learning resource which is free and can be used as a stand-alone learning resource or as a refresher course.
http://elearning.rcgp.org.uk/course/index.php?categoryid=8

Contributor - Dr Evdokia Dardamissis, Cheshire & Merseyside Health Protection Team, PHE North West

Increasing active travel across the North West

Congratulations to our North West partners who have secured Government money to encourage healthier lifestyles through Department for Transport funding.

The Access Fund will support local projects over three years from 2017 - 2020 and form part of a wider government package of more than £300 million to boost walking and cycling.

The money will be used to deliver:

- more safety and awareness training for cyclists
- extra secure cycle storage
- bike repair and maintenance courses

- road safety measures
- mapping information for pedestrian
- real time bus information through smart phone apps or information at bus stops
- increased focus on car sharing clubs

The funding will also target those looking to get back into work because access to transport and the cost of travel often restricts where jobseekers can look for work and their ability to attend interviews. They will also benefit from discount bus travel and bike loans.

The successful bids across the North West were:

- Lancashire County Council and Blackburn with Darwen who submitted a joint bid for East Lancashire to increase connectivity worth £1.94 million
- Blackpool were lead authority for a bid with nine other authorities, partnered by Living Streets, Modeshift and Cycling UK.The £7.5m pot will fund initiatives for promoting and encouraging walking throughout England for three years. As delivery partner for this consortium, Living Streets will work with over one thousand primary schools and 55 post-primary institutions to encourage walking. It will also help people in 55 workplaces to introduce more walking into their everyday

City regions Liverpool and Manchester were also successful in being awarded the Cycling and Walking to work Fund which offers £3.8 million to be invested in the city regions over the next 12 months to connect jobseekers with employment and apprenticeships.

Contributor – Caroline Haltom, Health and Wellbeing Lead, PHE North West

Putting quality at the heart of what we do

Earlier this year a delegation from the North West travelled to York for the first ever North Region Quality Assurance Conference.

This was not just a first for the north but also a first for PHE. The event, which was introduced by Professor Paul Johnstone PHE's North Regional Director, was a chance for PHE staff and stakeholders to showcase their work on quality and innovation.

PHE North West colleagues at the York event

The keynote address was led by the Director of North West-based Advanced Quality Alliance (AQuA) Elizabeth Bradbury, whilst Warrington DsPH Dr Muna Abdel Aziz joined Dr Gunjit Bandesha for an overview of the Cheshire and Merseyside high blood pressure programme “Saving Lives; Reducing the Pressure.” Our Greater Manchester based Research Nurse Kate Harrington also gave an overview of the Empact B study for chronic hepatitis.

The event included some great opportunities to learn and network and highlighted the wealth of talent and teamwork existing across the north and beyond.

As well as hearing from local authority colleagues, attendees were able to share best practice with a range of posters showcasing their innovative work.

Contributor – Jeff Scott, Nurse Consultant, PHE North West

Social Marketing update

My name is Claire Troughton and I am the regional marketing manager for PHE North and I am here to support all NHS and LA colleagues to make use of the national PHE marketing resources to support local priorities.

The last few months have been very busy – we had a very successful New Year One You campaign, Tobacco Health Harms, Sepsis and many of you were still supporting Stay Well this Winter.

We also launched our latest change 4 life campaign: Be Food Smart and have had a large number of roadshows across the region with great engagement with families and support from yourselves.

Partners from across the North West have supported our campaigns in a number of ways, Cheshire East Council for example recently showcased their lifestyle and health advice services offered by 'One You Cheshire East' at an official launch with the help of Paralympic gold medallist Megan Giglia MBE.

Team from Cheshire East Council and Peaks & Plains Housing Trust who engaged with the public in Crewe at the One You Cheshire East launch

Councillor Paul Bates (portfolio holder for health at Cheshire East Council) and Megan Giglia MBE with Megan's Paralympic gold medal

On the 20th March One You launches a new campaign to encourage adults to get more active by walking briskly in daily bursts of ten minutes or more to raise their heart rate and improve their fitness. Search 'Active 10' online to find out more or to download the app.

If you're not already familiar with our campaign resource centre please do check it out as there are a wide range of resources to order, download as well as insight and evaluation data **https://campaignresources.phe.gov.uk/**. As well as free campaign materials for our national campaigns we have a range of resources for you to use at times to suit you locally.

If you have any questions or suggestions please feel free to contact me directly or you can email **partnerships@phe.gov.uk**

Contributor – Claire Troughton, Social Marketing Manager (North), PHE

Planning the future of PHE – Science Hub Programme

PHE faces major challenges with its current facilities due to their age and geographical dispersal. Looking to the future, we need flexible accommodation which can readily facilitate new ways of working and collaboration.

Co-locating key PHE services to Harlow is an important and central factor in helping PHE play its part in bringing down costs across health. It will enable a more effective response to future challenges including, a revolution in microbiology testing with whole genome sequencing, the need to link bio-medical and behavioural science, and rising expectations about what science and government can do to protect the public.

The government has approved £400m of capital, to buy, convert and expand the current Glaxo Smith Kline (GSK) premises in Harlow, Essex maximising the value for the taxpayer.

The location in Harlow offers a unique and excellent opportunity to co-locate and consolidate existing PHE facilities, with the purpose of serving the public in the UK and internationally with the highest level of expertise.

PHE Harlow will provide an outstanding facility focused on protecting and improving the public's health; a ground breaking public health science to improve outcomes for the communities we serve. It will support our wider network of public health facilities and our people working locally, regionally, nationally and internationally. It will also provide a national resource for public health staff.

This national resource will be able to support the centres and regions even better. It will also enable PHE to be one of the leading organisations in the world introducing major technological changes.

The site has the added advantage of a strategic location, being in close proximity to one of the major UK life sciences and bioscience clusters in England's biomedical sector, with major collaborating universities and academic centres.

The relocation of staff is planned from 2021. Our aim is to complete the relocation of staff and have the site fully operational by the end of 2024.

For more information on the Science Hub Programme, visit **http://phenet.phe.gov.uk/Programmes/science-hub/**

For comments, suggestions and feedback, email **phehub@phe.gov.uk**

Contributor – PHE communications

Call to make all North West hospital sites tobacco-free

Hospital sites across the North West are being urged to take steps to become tobacco-free to improve the health of their patients and staff.

In December Public Health England (PHE) Chief Executive Duncan Selbie wrote to every NHS Trust Chief Executive across England as part of the Tobacco Free NHS campaign asking them to implement a ban on smoking by patients, staff and visitors across all hospital buildings and grounds.

Despite declines in smoking prevalence over recent decades, over 18% of adults in the North West still smoke and tobacco use remains the single largest cause of health inequalities and premature death. For every death caused by smoking, approximately 20 smokers are suffering from smoking related disease. Smoking during pregnancy can cause complications during labour and lead to increased risk of miscarriage, premature birth, still birth, low birth-weight and sudden unexpected death in infancy.

In the North West several trusts have led the way with smoking bans in hospital grounds, while many more are working with their local authority public health teams and other partners towards going completely smoke and tobacco-free in the future.

Becoming tobacco-free refers to **NICE Guidance PH48** which sets out recommendations for smokefree NHS buildings and grounds accompanied by access to evidence-based quitting support for all patients who smoke.

Public Health England North West is organising a workshop on 1st June to support Trusts implementing PH48. Details to follow.

For the latest blog on the campaign visit:
https://publichealthmatters.blog.gov.uk/2017/03/17/tobacco-free-nhs-troubleshooting-tips-for-hospitals/

Contributor – Tasneem Choudhri, Health and Wellbeing Manager

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Tel: 0344 225 0562 Email: **PHENWBulletin@phe.gov.uk**

Agenda item no:	2017/085

Meeting:	Trust Board

Date:	7 April 2017

Title:	Staff Survey 2016 Update

Report to be considered in public or private?	Public

Where else has this report been considered and when?	N/A

Reference/s:	None

Resource impact:	None

What is this report for?	**Information**		**Decision**	✓	**Escalation**		**Assurance**	

Which Board Assurance Framework risk/s does this report relate to?	

Which CQC fundamental standard/s does this report relate to?	

What action is required at this meeting?	Approval.

Presented by:	Michelle Turner, Director of Workforce & Marketing

Prepared by:	Rachel London, HR Business Partner

This report covers (tick all that apply):

Strategic objectives:	
To develop a well led, capable motivated and entrepreneurial workforce	✓
To be ambitious and efficient and make best use of available resources	✓
To deliver safe services	✓
To participate in high quality research in order to deliver the most effective outcomes	
To deliver the best possible experience for patients and staff	✓

Other:			
Monitor compliance	✓	Equality and diversity	✓
Operational plan	✓	NHS constitution	✓

Publication of this report (tick one)**:**	
This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting	
This report will not be published under the Trust's Publication Scheme due to exemptions under S21 of the Freedom of Information Act 2000, because the information contained is reasonably accessible by other means	
This report will not be published under the Trust's Publication Scheme due to exemptions under S22 of the Freedom of Information Act 2000, because the information contained is intended for future publication	
This report will not be published under the Trust's Publication Scheme due to exemptions under S41 of the Freedom of Information Act 2000, because such disclosure might constitute a breach of confidence	
This report will not be published under the Trust's Publication Scheme due to exemptions under S43(2) of the Freedom of Information Act 2000, because such disclosure would be likely to prejudice the commercial interests of the Trust	

Introduction

The fourteenth NHS staff survey was carried out between October and November 2016, with the results published in March 2017. The NHS Staff Survey is the national tool to measure levels of engagement and wellbeing amongst NHS Staff.

It remains very encouraging that staff at LWH are happy to provide feedback. Although our response rate of 60% represented a slight decrease from the 64% achieved in 2015, it compares favourably to the national average of 44%. As we survey all our staff, this provides valuable data which the Trust must be seen to act upon.

Overall, there have been minimal changes to the results compared with 2015. There have been no statistically significant areas of improvement and the only area of statistically significant decline was a decrease in staff motivation from 3.98 to 3.87.

It should be noted that LWH is classed as an 'acute specialist Trust' and our scores in the Staff Survey are benchmarked against these Trusts. As our services are akin to those provided in an 'acute' Trust for the majority of our services, average scores for these Trusts are also referenced for the purposes of comparison. Metrics used in the Staff Survey are either a percentage, or a scale score between 1 and 5.

Given the context of year on year cost improvement programmes since 2011 with £8m removed from pay budgets over this 5 year period as part of an overall £26m cost improvement programme, the staff survey results show stability and demonstrate that despite pressures, staff remain proud to work at Liverpool Women's and believe they deliver high quality care.

Our aim is to be a value based, change ready and resilient organisation. The CQC Well Led Domain makes clear that the board has a responsibility to shape an open, transparent and quality- focused culture. During times of strategic change, the links between staff experience and patient outcomes must continue to be reiterated. Development of our staff must continue to be a priority if we are to equip them with the necessary skills for the future.

The staff survey comes at a critical point for the organisation and the Trust's response to it will dictate how well our workforce is able to respond to the challenges ahead. With this in mind, the staff survey should be used as a driver to look critically and transparently at our staff experience and take decisive steps for improvement.

National Context

The national staff survey picture showed a trend for improvement in 26 of the key findings, whilst 3 deteriorated and 3 remained the same. There are therefore reasons for national optimism, particularly when significantly more NHS staff would recommend their Trust as a place to work or have treatment compared to staff in other parts of the public and private sectors.

The RCM 'Caring for You' campaign launched in 2016 highlighted that 48% of midwives feel stressed every day and over 30% feel bullied by managers and colleagues. This compares to 15% of midwives who stated they feel bullied at LWH. As a Trust we have signed up to the campaign and recognise that there are key risks identified which could be applied in other

clinical areas, and if left unresolved could pose a risk to patients and a risk of healthcare professionals leaving the NHS. This highlights the particular challenges and risks around our midwifery workforce, although the staff survey results did not show midwives responding more negatively than other members of the nursing workforce.

Local Context

The staff survey results come in the second year of the 2015-2018 Putting People First strategy. The strategy builds on previous work undertaken to increase staff involvement and engagement and develop the capabilities of our managers.

Our values and behaviours were developed in partnership with staff and remain current and relevant. Whilst behaviours are integrated into our appraisal, induction and recruitment structures, there remains work to do in equipping staff at all levels to challenge behaviours which are not in line with LWH values, and there is more that could be done to consistently communicate expected behaviours through all available communications channels. To kick start this, a board development session focused on how we can better model and communicate our vision, values and expected behaviours will be run in the next quarter, and rolled out to other leaders in the organisation.

Extensive staff engagement and consultation was undertaken in 2015 and the early part of 2016 as part of the Future Generations strategy. Whilst staff do not report feeling anxious about the future of Liverpool Women's, there is a potential for apathy and a feeling of inertia during this current period where there is limited information to communicate. It is vital that staff continue to feel trust in the organisation and its senior leaders during a time of change.

205/2016 saw a higher than average turnover, and there was change in a number of key leadership roles including senior nursing and operational management roles. Turnover for reasons of promotion was particularly high in corporate areas, whilst theatres continued to be the clinical area with highest turnover. It should be highlighted that the operational management team at LWH is comparatively small, and there are risks of channelling a high number of deliverables through a small cohort of individuals. Middle managers have a pivotal role as enablers and are often those staff view as 'senior managers' when they complete the survey. We need to ensure this key group are modelling our values and are valued themselves in order to ensure retention and stability and foster a sense of shared purpose.

Equally important is the role played by our medical leaders. Values based recruitment will continue to be used in selection processes to ensure that our Clinical Directors, Associate Medical Directors and consultants are modelling values and behaviours and fostering multidisciplinary working.

Key Results

The key results and themes from the 2016 staff survey are summarised below.

Appraisals and Development

In line with the themes in previous staff surveys, whilst the quantity of appraisals is high (93%) quality is perceived to be low (2.92 out of a maximum score of 5). The PDR training has recently been revised and training sessions, face to face and e-learning have been provided. The PDR process now includes an opportunity to 'talent map' individuals to more clearly identify future career pathways and aid succession planning. The more pressing issues is ensuring managers devote sufficient time to undertake PDRS effectively and that they are equally distributed throughout the year. Gynaecology are rolling out a programme of 1-1 supervision for nursing and support staff to ensure that every member of clinical staff has protected time with their manager at least bi-monthly. If successful, the programme will be rolled out Trust wide.

Incident Reporting

Whilst the number of staff witnessing potentially harmful incidents has decreased from 26% to 22%, there has been a downward trend in the number of staff reporting incidents from 95% to 90%, on a par with acute Trusts. This should be viewed in the context of NHS England data on incident reporting which place LWH in the top 25% of acute Trusts.

There have also been small declines in staff confidence in reporting incidents and their belief that incident reporting processes are fair.

Whilst these declines are not statistically significant, they highlight that we can still do better in the way we learn from incidents. Much work has been undertaken in the quest of creating a positive 'no blame' culture and it is known that there are areas of good practice for incident reporting such as maternity but other areas of the Trust where a reporting culture is less established. The governance team is undertaking a review of hotspot areas who may need additional support and Trust wide actions will be undertaken such as the re-launch of the policy 'Supporting Staff Involved in Incidents, Complaints and Claims' and ensuring that 'lesson of the week' and other learning from incidents and complaints are fully disseminated to all levels of the organisation by making it a standard item on team meeting agendas for example.

Equality and Diversity

The percentage of staff experiencing discrimination at work (7%) is lower than acute and specialist Trusts and 89% of staff believe the Trust offers equal opportunities for career progression or promotion.

Health and Wellbeing

62% of staff have felt pressure to attend work in the last 3 months despite illness due to pressure from colleagues, manager or themselves, compared to an average of 56% in acute Trusts and 57% in specialist Trusts.

Staffing levels are clearly a potential trigger for this pressure to attend work. The bi-annual safe staffing review process and the introduction of e-roster have both provided an additional level of scrutiny on staffing levels within clinical areas. Headroom was reduced from 21% to 18.9% in 2014 and is anecdotally cited as a source of staffing pressure. This was recently

reviewed by the Director of Nursing & Midwifery and found to be safe and adequate. The investment in 2013 of 25.5 additional midwives was focused on the delivery of 1-1 care in labour and staff on Maternity Ward have expressed on-going concerns regarding staffing levels in this postnatal area. In response to the concerns raised, listening events with the Director of Nursing were undertaken, an external review was done and a detailed action plan completed. Conversely, neonatal have benefited from improved levels of staffing in the last 12 months and this is reflected in their staff survey results. Six monthly staffing reviews are provided for Board assurances for all clinical areas and regular deep dive into workforce related risks for each clinical area are undertaken in the Putting People First Committee.

It should also be noted that similar percentage of staff in corporate areas expressed feeling a pressure to come to work despite illness and that CIP programmes have resulted in a reduction in posts in corporate areas since 2011.

The number of staff feeling ill as a result of work related stress is 33%, compared with 31% in 2015 and 37% in 2014. In acute Trusts the figure is 35%. Whilst recognising that NHS careers can often be viewed as stressful, the Trust needs to ensure that we are taking necessary steps to equip staff to deal with stress. Stress resilience training is offered as part of the leadership programme. The newly re-formed Health and Wellbeing Working Group will review the current provision and make recommendations around any additional measures to be taken.

Staff satisfaction

There has been a statistically significant decline in motivation at work from 3.98 in 2015 to 3.87 in 2016.

67% of staff feel they can contribute towards improvements at work, compared to 70% in acute Trusts and 73% in acute specialist Trusts. In 2015 the figure was 71% and has been identified as a priority area in the last two staff surveys. Amongst nursing and midwifery and HCA staff this figure is significantly lower at around 45%. Work has been undertaken to improve internal communications mechanisms in clinical areas where getting staff together for traditional team meetings can be challenging. Morning ‘huddles’ are an example of where this has worked well. On a corporate level, staff are being asked to contribute to the development of the 2017-20 Quality strategy. In the last 12-24 months, there was wide scale staff engagement with both the clinical case for change as part of Future Generations Strategy, and the Cost Improvement and Turnaround Projects. It is recognised that staff need training on simple Quality Improvement Methodology that they can apply to projects in their own areas and this is now available to all staff.

The number of staff recommending the trust as a place to work or have treatment has declined slightly in 2016 to 3.79 from 3.83 in 2015. However the trend over the last 5 years has been a year on year trend of improvement.

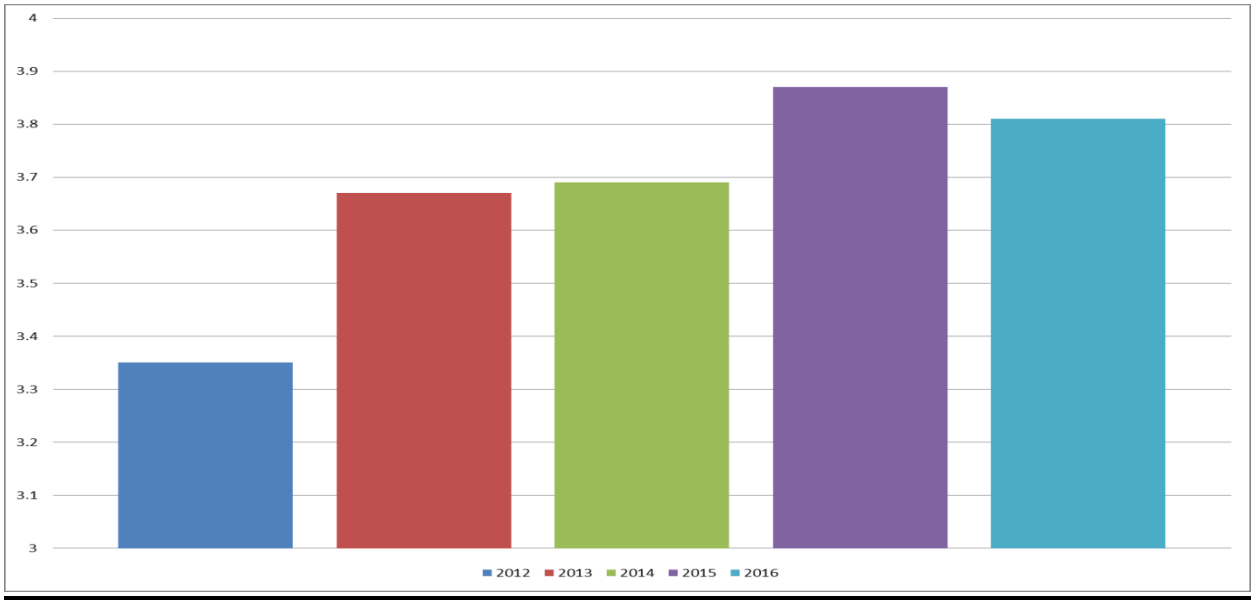


Figure 1- Recommendation by staff of LWH as a place to work or come for treatment

Managers

31% of staff feel communication from senior management is effective. In the best Trust in the NHS the score is 49%.

As a small Trust, the onus is on the board to review and reflect on visibility and communication channels from line managers up to board level.

Staff rated 'support from immediate managers' as 3.74. Financial turnaround has resulted in some 'grip and control' behaviours and a removal of autonomy for decision making from line managers. LWH has always had a 'permission seeking culture' however investment via previous leadership programmes to empower managers to lead their teams is at risk of being diminished. Therefore there must be renewed focus from the executive team and senior management on giving local managers key deliverables, holding to account and supporting them to succeed.

Patient care and experience

The score for 'staff satisfaction with the quality of work and care they are able to deliver' is 3.97 out of a maximum of 5. Acute Trusts have an average score of 3.96. The best score for acute specialist Trusts is 4.31. It is positive that despite perceptions or realties of reduced resources, most staff feel they deliver great care and this score is unchanged from 2015. Trust wide and local communications with staff over the next 12 months will continue to reiterate the question of 'what's getting in the way of great care'.

Harassment and Bullying

The numbers of staff experiencing physical violence from patients is lower than acute and specialist Trusts at 3%, as is the percentage of staff experiencing physical violence from staff at 1%.

It should be noted that no incidents of violence between staff have been reported to the Trust in the last 12 months so this figure may potentially be an anomaly. 24% of staff reported that

they had experienced harassment, bullying or abuse from staff, which although unacceptable, is the same in acute and acute specialist Trusts and this figure has remained static since 2012.

Following an investigation into potentially racist language earlier in the year, a new training session 'Bullying or Banter' was introduced as part of clinical mandatory training which reiterated the Trust values of respect. 2016 also saw the introduction of 6 trained 'Dignity at Work' advisors whose role is to provide impartial support and guidance to staff experiencing difficulties in the workplace.

Staff Engagement Score Results compared to other Trusts

LWH does not compare favourably against other specialist Trusts in the region but is on a par with the acute Trusts of Aintree and the Royal and performs better than Birmingham Women's.

Out of a maximum score of 5

Walton Centre	4.03
Clatterbridge	4.03
Heart and Chest	4.02
St Helen's and Knowsley	3.96
Wigan, Wrightington and Leigh	3.95
Mid Cheshire NHS FT	3.90
Countess of Chester	3.81
Aintree	3.81
Wirral NHS FT	3.78
Liverpool Women's NHS FT	**3.77**
Royal Liverpool and Broadgreen	3.77
Warrington and Halton	3.73
Birmingham Women's	3.72
Alderhey	3.70
Southport and Ormskirk	3.66

Trends by staff group

	Employee Engagement Questions *	2016 Trust Score	Add Prof Scientific and Technical	Additional Clinical Services	Admin and Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered
2a	I look forward to going to work *(reply often and always)*	53%	61%	59%	47%	62%	18%	44%	84%	53%
2b	I am enthusiastic about my job *(reply often and always)*	75%	67%	80%	68%	92%	40%	72%	92%	76%
2c	Time passes quickly when I am working *(reply often and always)*	78%	72%	71%	78%	100%	80%	81%	86%	79%
4a	There are frequent opportunities for me to show initiative in my role *(reply agree and strongly agree)*	70%	67%	69%	66%	62%	55%	75%	86%	71%
4b	I am able to make suggestions to improve the work of my team / department *(reply agree and strongly agree)*	73%	67%	67%	74%	69%	45%	91%	94%	72%
4d	I am able to make improvements happen in my area of work *(reply agree and strongly agree)*	52%	56%	46%	56%	54%	40%	72%	78%	48%
21a	Care of patients / service users is my organisation's top priority *(reply agree and strongly agree)*	77%	72%	83%	78%	67%	82%	88%	81%	73%
21c	I would recommend my organisation as a place to work *(reply agree and strongly agree)*	58%	53%	64%	50%	58%	36%	59%	78%	59%
21d	If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation *(reply agree and strongly agree)*	80%	76%	81%	78%	100%	91%	84%	95%	78%

In line with previous years, nurses and midwives respond consistently more negatively to the survey than Healthcare Assistants, Medical Staff, Administrative Staff, Scientific staff or management. This trend is replicated nationally. Therefore the focus on supporting managers in these areas to develop their leadership skills and enhance engagement at a local level is justified and must be continued.

Trends by directorate

Employee Engagement Questions *		2016 Trust Score	Corporate	Genetics	Gynae	Hewitt	Int. Admin	Maternity	Medical	Neonatal	Surgical
2a	I look forward to going to work *(reply often and always)*	53%	48%	56%	55%	49%	40%	56%	84%	52%	46%
2b	I am enthusiastic about my job *(reply often and always)*	75%	72%	74%	77%	74%	54%	76%	92%	78%	70%
2c	Time passes quickly when I am working *(reply often and always)*	78%	74%	83%	68%	77%	69%	80%	86%	83%	61%
4a	There are frequent opportunities for me to show initiative in my role *(reply agree and strongly agree)*	70%	72%	79%	70%	63%	49%	66%	86%	74%	73%
4b	I am able to make suggestions to improve the work of my team / department *(reply agree and strongly agree)*	73%	73%	86%	67%	89%	56%	69%	94%	66%	72%
4d	I am able to make improvements happen in my area of work *(reply agree and strongly agree)*	52%	62%	67%	54%	54%	31%	45%	78%	41%	45%
21a	Care of patients / service users is my organisation's top priority *(reply agree and strongly agree)*	77%	81%	88%	78%	79%	71%	72%	81%	78%	79%
21c	I would recommend my organisation as a place to work *(reply agree and strongly agree)*	58%	55%	63%	53%	55%	33%	57%	78%	66%	61%
21d	If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation *(reply agree and strongly agree)*	80%	83%	84%	80%	84%	61%	75%	95%	79%	85%

Neonatal responded more positively than other clinical departments to the question of would they recommend the Trust as a place to work at 66% . This recognises the positive changes to culture which have been realised through implementation of a planned strategy for nursing recruitment, investment in additional nursing posts and the leadership provided by the new role of Head of Nursing.

Issues for consideration

Investment in leadership skills of our staff has been a priority for some time. Between 2013 - 2015 significant investment was made in leadership development for band 6 and above staff through both the Patient Team Leader Programme and the Systems and Service Leader Programme. A revised modular leadership programme was launched in September 2016 which offers high quality leadership training at 4 levels. Whilst this offer is available to all staff, it is clear that operational constraints have meant key members of staff have not accessed this training and therefore the programme is now mandatory for these groups.

In order to achievable measurable and continuous improvement in our patient care outcomes, there is a need to equip managers with skills in quality improvement. This process

has started with the appointment of a Quality Improvement Lead, however the Trust needs to consider how it responds to the 'Developing People, Improving Care' document (NHS Improvement, 2015) which highlights the need for every leader to have develop four critical capabilities of systems leadership, quality improvement methodology, inclusive and compassionate leadership and talent management.

Nationally, ten Trusts have come together to form the 'NHS Quest' group with the objective of delivering quality and safety. The next phase is to develop employment practices that identify the Quest Trusts as a 'best place to work'. There is an opportunity to join with the group moving forward which is being considered.

Actions

Some of the practical actions outlined below are not new and have been utilised or attempted previously. To deliver the actions proposed, there must be recognition and support from the board and the executive team, and commitment from operational management to implement the recommendations as part of the systematic and incremental approach we have adopted as part of our People Strategy to secure sustained improvement.

Managers have all been offered a team briefing session on the staff survey results and have been tasked with identifying 3 key actions which they will take forward in their department. Actions from staff survey will be included in managers' objectives and there will be a framework to hold managers accountable for progress via the quarterly performance reviews.

A revised performance report, currently in development, which triangulates workforce metrics such as sickness, staffing levels and turnover with quality and performance indicators such as incidents and complaints, will aid in the ongoing monitoring of workforce engagement and will help to identify hotspot areas.

A large scale 'listening event' will be arranged in quarter 1 to consider the staff survey results and identify Trust wide and team priorities.

Investing in our leaders

- Review attendance at leadership training and make some modules mandatory for some people
- Audit PDRS across the Trust, review objectives and provide support to managers in setting objectives. Instigate the use of team objectives across the Trust.
- Ensure managers are confident to use the talent mapping framework and provide support to ensure succession planning for key roles (eg. Ward Manager).
- Empower managers to manage, ensure training in key skills such as rota management, workforce planning and budgetary management

Effective communication and management support

- Improve the visibility of all managers from executives to middle managers. Avoid perception that managers only visit teams to give negative feedback.
- Walkabouts with executive team members in partnership with the staff side chair

- Increase frequency of communication on the future strategic direction of the Trust, whilst recognising this is challenging given the lack of decisions being taken at an external level.
- Reiterate our objectives and vision and ensure that organisational goals are aligned with the objectives of managers, teams and individuals to achieve shared accountability.
- Implement large and small scale 'listening events' to identify improvement priorities for the next 2 years.

Reward and recognition

- Review our reward and recognition structures
- Ensure that compliments and positive feedback are reported formally in the same way as complaints
- Implement simple schemes such as 'thank you' postcards on every reception desk for patients / staff to write the name of someone who has delivered exemplary service.
- Investigate other ways to recognise teams such as the ward accreditation scheme.

Health and Wellbeing

- Re-invigorate the existing health and wellbeing group to implement the health and wellbeing action plan produced in 2016.
- Assess the success of resilience training and implement further measures around stress management.

Team Working

- Develop understanding of the roles of colleagues in other departments to break down silos (the rotation of shift leaders in maternity is an example of how this will be implemented.)

Learning from incidents and reporting

- Review existing de-briefing and feedback structures to ensure fit for purpose
- Analyse the success of previous initiatives around psychological supervision and re-introduce if applicable

Conclusion

The staff survey results provide a driver and opportunity to re-invigorate our commitment to supporting and developing our staff and ensuring that the objectives set out in the Putting People First Strategy are achieved. Therefore the hence the themes raised in the staff survey should be swiftly and comprehensively addressed with energy from all levels of the organisation.

Recommendations

The board is asked to note the contents of this report and provide support for the actions proposed.

Attachment: Full staff survey results

NHS_staff_survey_2016_REP_full.pdf

Attachment: Example of local feedback report

Maternity feedback key questions.xlsx

2017/086

Board of Directors

Committee Chair's report of Governance and Clinical Assurance Committee meeting held

24 March 2017

1. Was the quorate met? Yes

2. Agenda items covered

- Actions from previous meeting:
  The Committee noted that the Quality Strategy 2017-2020 was being developed and would include the quality indicators that would form part of the performance framework to be seen by the Board in April. The Committee noted that the Strategy would be presented to its meeting in May.

  Medicines Management Update and Assurance: the Committee was concerned regarding the potential delay that may arise in the assurance papers from Pharmacy relating to a specific medicines management response to the CQC Fundamental Standards and; a separate paper on self-medication administration, detailing the current Trust process, plans for the future and identify support required.

- Serious Incident Update Report and deep dive on Failure to act on test results: the committee received assurance that there was evidence of investigations leading to learning, improvement and prevention of recurrence of serious incidents however requested that greater focus on learning should be directed through the Safety Senate. Regarding the Deep Dive the Committee requested that greater emphasis is placed on the follow up of actions and identification of an accountable officer.

- Adult Mortality Strategy (Draft) and Mortality Review Guidance & Perinatal mortality position statement. The Committee noted the perinatal mortality position statement and noted that the final strategies for both Adult and still births and neonatal mortality Strategies would be presented to the Board at the 5 May Board meeting. Prior to this date the Committee members would be provided with a copy of each strategy for comment.

- Care Quality Commission (CQC) Inspection Preparation: the committee noted the preparations are currently under way.

- Urogynaecology Group Action Claims Update: The Committee received Assurance that the claims are being managed appropriately and would be concluded by 2018. As of 1 April 2017 Hill Dickinson had been appointed the as the Trust's legal services provider for claims.

- Safety, Effectiveness & Experience (SEE) Report Quarter 3 2016/17 and the Performance Assurance Report: The Committee reviewed and received assurance on behalf of the Board. There were no exceptional items that needed to be highlighted from the Report.

- Clinical Audit Work Programme 2017-18: The Committee received the clinical audit work plan for 2017-18 which was approved.

- Risk Appetite Statement and Risk Management Strategy: the Committee received and noted the Risk Management Strategy and endorsed the Risk Appetite as low.

- Cycle of Business and Terms of Reference: The Committee made two changes to the terms of reference, the first relating to membership, the Committee agreed to extend the membership to the Head of Governance and also amend the clause relating to the requirement to appoint a vice Chair.

3. Board Assurance Framework (BAF) risks reviewed

   - No Changes

4. Issues to highlight to Board

   Items to be presented to the Board

   - Adult Mortality Strategy (Draft) and Mortality Review Guidance & Perinatal mortality position statement.

   - Serious Incident quarterly Update Report

5. Action required by Board

   Approval of the terms of reference of the committee

17/087

Board of Directors

Committee Chair's report of Audit Committee meeting held 27 March 2017

1. Meeting Quorate: Yes

2. Agenda items covered

~ Follow up of Internal and External Auditors Recommendations: The Committee raised concern regarding the provision of services provided to the Trust by the Royal Liverpool Hospital Trust. The Committee had noted that performance in terms of medical devises had been poor and had been consistent with that provided to pharmacy. The Chair agreed to highlight this concern with the Board. With regard to completion dates the Committee requested that for those identified as completed by 31 March 2017 and 30 April 2017 a report is produced and distributed to the Committee members on the status of the recommendations.

~ Internal Audit Annual Report and Internal Audit Opinion 2016/17 & Internal Audit Progress Report: The Committee noted that there had been no change to the audit opinion from last years and stated that "The organisation has an adequate and effective framework for risk management, governance and internal control. However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective". The Committee noted that there were three outstanding audits and that the outcome of these would not impact on the opinion. The Committee noted that management responses on draft reports (18.8days) had not been delivered against the target (15 days) and assurances had been requested that the executive would make sure that responses are being made in accordance with target dates set.

~ Counter Fraud. The Committee received the counter fraud report as part of the internal audit progress report and noted that Annual Report 2016/2017 will be drafted by RSM Fraud Risk Services and following our internal quality review process, will be issued to the Trust and the new counter fraud provider.

~ Internal audit and Counter Fraud Provider: the Committee was assured that processes were in place to support a clean hand over of work from RSM to the Trust's new internal Auditor MIAA on 1 April 2017. The Chair formally thanked RMS for their support and time as the Trust's internal auditor. The Committee had as part of the meeting reviewed and endorsed the process for the appointment of the internal auditor and counter fraud service.

~ Areas of Judgement in the Annual Accounts: The Committee noted and agreed the approach to the areas of judgement within the 2016/17 annual accounts and recognised that as with last year the audit opinion would most likely include an emphasis of matter given the financial and cash position. The Committee noted that it would be meeting on 19 May 2017 to review the Annual Report and Accounts 2016/17 for recommendation to the Board for approval.

~ Review of Losses and Special Payments. The Committee noted and agreed the write-off of bad debts. The amount related to long standing debts dating as far back as 2005/06 and had been extensively chased for payment and had been deemed not feasible to recover. The Committee was assured that the processes and procedures in place to recover private patient payments were robust.

~ Raising Concerns: The Committee received assurance provided by the Raising Concerns Report and endorsed the actions proposed. The Committee noted that the policy now included a section on the role of the Snr Independent Director and the role of the new Freedom to Speak Up Guardian.

- Clinical Audit Annual Report 2015 -16: The Committee noted the report that had also been reviewed by GACA and the Effectiveness Senate and received assurance on the robust audit processes undertaken by the Trust's clinical audit team.
- Terms of Reference: The Committee agreed the terms of reference for formal approval of the Board.

3. Board Assurance Framework (BAF) risks reviewed

- None

4. Issues to highlight to Board

- Change of Internal Auditor and Counter Fraud service from 1 April 2017
- External Audit – Emphasis of Matter regarding going concern
- Internal Audit Opinion 2016/17: The organisation has an adequate and effective framework for risk management, governance and internal control. However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective.

5. BAF recommendations

- None

6. Action required by Board

- Approval of the Terms of Reference

17/088

Board of Directors

Committee Chair's report of Finance Performance and Business Development Committee meeting held 27 March 2017

1. Meeting Quorate: Yes

2. Agenda items covered

~ Month 11 Finance Report: The Committee was assured that the Trust was still on target to deliver £6M deficit at year end which included the matched by £0.5m of STF incentive funding. The Trust had utilised £3.65m of cash from DH and there is a planned drawdown of £3.34m in Month 12

~ Performance dashboard, Month 11: The Committee noted that the Trust continued to deliver against the NHSI performance targets and CQINs.

~ Performance Framework: the Committee noted that a draft performance framework 2017/18 was being constructed by the Director of Operations and noted that a presentation on the framework would be provided to the Board in April. The Committee recognised that it would receive a number of indicators that related to quality and would be reviewed by GACA however they may also have a financial impact such as CQUINs that would need to be reviewed by the Committee as part of integrated governance.

~ 2017-19 Budget setting: the Committee received and noted the current status of the draft budget 2017-19.

~ EPR: the Committee noted that Phil Huggon, Non-Executive Director and a member of the Committee would also attend the EPR project Group meetings as agreed by the Board

~ The Committee reviewed and agreed its Terms of Reference for formal approval of the Board.

3. Board Assurance Framework (BAF) risks reviewed

~ The Committee noted the BAF and agreed that there were not changes to be made.

4. Issues to highlight to Board

~ To note the challenging CIP programme for 2017/18.

5. BAF recommendations

~ None

6. Action required by Board

~ To approve the terms of reference of the committee.

Agenda item no:	17/089

Meeting:	Trust Board Meeting

Date:	7 April 2017

Title:	Terms of Reference approval

Report to be considered in public or private?	Public

Where else has this report been considered and when?	

Reference/s:	GACA – 24 March 2017 Audit Committee – 27 March 2017 FPBD Committee – 27 March 2017

Resource impact:	

What is this report for?	**Information**		**Decision**	**X**	**Escalation**		**Assurance**	**x**

Which Board Assurance Framework risk/s does this report relate to?	5a-f, 1&3

Which CQC fundamental standard/s does this report relate to?	Well led

What action is required at this meeting?	Board is asked to approve the terms of reference of the following Board Committees: • Audit Committee • Finance Performance and Business Development Committee • Governance and Clinical Assurance Committee

Presented by:	Colin Reid Trust Secretary

Prepared by:	

This report covers (tick all that apply):

Strategic objectives:	
To develop a well led, capable motivated and entrepreneurial workforce	**X**
To be ambitious and efficient and make best use of available resources	**X**
To deliver safe services	**X**
To participate in high quality research in order to deliver the most effective outcomes	
To deliver the best possible experience for patients and staff	**X**

Other:			
Monitor compliance		Equality and diversity	
Operational plan		NHS constitution	

Publication of this report (tick one)**:**	
This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting	**x**
This report will not be published under the Trust's Publication Scheme due to exemptions under S21 of the Freedom of Information Act 2000, because the information contained is reasonably accessible by other means	
This report will not be published under the Trust's Publication Scheme due to exemptions under S22 of the Freedom of Information Act 2000, because the information contained is intended for future publication	
This report will not be published under the Trust's Publication Scheme due to exemptions under S41 of the Freedom of Information Act 2000, because such disclosure might constitute a breach of confidence	
This report will not be published under the Trust's Publication Scheme due to exemptions under S43(2) of the Freedom of Information Act 2000, because such disclosure would be likely to prejudice the commercial interests of the Trust	

AUDIT COMMITTEE
TERMS OF REFERENCE

Constitution:	The Committee is established by the Board of Directors and will be known as the Audit Committee (the Committee). The Committee is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference.
Duties:	The Committee is responsible for: **a. Governance, risk management and internal control** The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the Trust's activities (both clinical and non-clinical) that supports the achievements of the Trust's objectives. It will provide an independent and objective view on internal control and probity. In addition, the committee shall NHS Improvement the integrity of the financial statements of the Trust and any formal announcements relating to its financial performance, reviewing significant financial reports and the judgements contained in them. In particular, the Committee will review the adequacy of: • All risk and control related disclosure statements (in particular the Annual Governance Statement and declarations of compliance to external bodies), together with any accompanying Head of Internal Audit opinion, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board • The process of preparing the Trust's returns to NHS Improvement (which returns are approved by the Board's Finance and Performance Committee) • The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements • The policies for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification • The Trust's standing orders, standing financial instructions and scheme of delegation • The policies and procedures for all work related to fraud and corruption as set out in the Secretary of State directions and as required by the NHS Counter Fraud Security Management Service • The arrangements by which Trust staff may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. In so doing

the Committee's objective should be to ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.

In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

The Committee will undertake an annual training needs assessment for its own members.

b. Internal audit

The Committee will ensure that there is an effective internal audit function established by management that meets mandatory government and Public Sector Internal Auditing Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:

- Consideration of the appointment of the internal audit service, the audit fee and any questions of resignation and dismissal
- Review and approval of the internal audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework
- Reviewing the internal audit programme, considering the major findings of internal audit investigations (and management's response), and ensuring coordination between internal and external auditors
- Ensuring that the internal audit function is adequately resources and has appropriate standing within the organisation
- Annual review of the effectiveness of internal audit.

c. External audit

The Committee shall review the independence, objectivity and work of the external auditor appointed by the Council of Governors and consider the implications and management's response to this work. This will be achieved by:

- Consideration of the appointment and performance of the external auditor, including making recommendations to the Council of Governors regarding the former
- Discussion and agreement with the external auditor, before the audit commences, of the nature and scope of the audit as set out in the annual audit plan and ensure coordination with internal auditors and

with other external auditors

- Discussion with the external auditors of their local evaluation of audit risks and assessment of Trust and associated impact on the audit fee
- Reviewing all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Board and any audit work performed outside the annual audit plan, together with the appropriate of management's response
- Recommending to the Council of Governors the engagement of the external auditor in respect of non-audit work, taking into account relevant ethical guidance regarding the provision of such services
- Annual review of the effectiveness of external audit.

d. Other assurance functions

The Committee will review the findings of other significant assurance functions, both internal and external to the Trust, and consider the implications to the governance of the Trust. These will include, but will not be limited to, reviews and reports by the Department of Health, arms length bodies or regulators/inspectors (e.g. Care Quality Commission, NHS Litigation Authority, etc), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc) or the Local Counter Fraud Specialist.

In addition the Committee will review the work of other Committees within the Trust, whose work can provide relevant assurance to the Audit Committee's own scope of work. This will particularly include the Governance and Clinical Assurance Committee, Finance and Performance Committee and Putting People First Committee, and include a review of an annual report of each of the Committees against their terms of reference. In reviewing the work of the Governance and Clinical Assurance Committee, and issues around clinical risk management, the Audit Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

The Committee will also review all suspensions of standing orders and variation or amendment to standing orders.

The Audit Committee will report to the Board and to the Council of Governors any matters in respect of which it considers action or improvement is needed.

e. Counter fraud

The Audit Committee will satisfy itself that the Trust has adequate arrangements in place for countering fraud and will approve the appointment of the Local Counter Fraud Specialist. The Committee will review the outcomes of counter fraud work.

	f. Management The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control. They may also request specific reports from individual functions within the organisation (e.g. clinical audit) as they may be appropriate to the overall arrangements. **g. Financial reporting** The Audit Committee shall NHS Improvement the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance. The Audit Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board. The Audit Committee will review the Trust's annual report and financial statements before submission to the Board, focusing particularly on: • The wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee • Changes in, and compliance with, accounting policies and practices • Unadjusted mis-statements in the financial statements • Major judgemental areas, and • Significant adjustments resulting from the audit • Letter of representation • Qualitative aspects of financial reporting.
Membership:	The Committee membership will be appointed by the Board of Directors from amongst its Non-Executive members and will consist of not less than three members. Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. The Board of Directors will appoint a Non-Executive Director as Chair of the Committee. Should the Chair be absent from a meeting of the Committee, the Committee may appoint a Chair of the meeting from amongst the Non-Executive Directors present.~~The Audit Committee will appoint one of the members to be Chair and another Vice Chair from the outset. The Vice Chair will automatically assume the authority of the Chair should the letter be absent. The Chair of the Trust shall not be a member of the Committee.~~

Quorum:	A quorum shall be two members.
Voting:	Each member will have one vote with the Chair having a second and casting vote, if required. Should a vote be necessary a decision will be determined by a simple majority.
Attendance:	a. Members Members will be required to attend a minimum of 75% of all meetings. b. Officers The Director of Finance, Deputy Director of Finance, Financial Controller and Deputy Director of Nursing & Midwifery shall normally attend meetings. At least once a year the Committee will meet privately with external and internal auditors. The Chief Executive and other executive directors will be invited to attend, particularly when the Committee is discussing areas of risk or operation that are within the responsibility of that director. The Chief Executive will also be required to attend when the Audit Committee discusses the process for assurance that supports the Annual Governance Statement. The Trust Secretary will attend to provide appropriate support to the Chair and Committee members.
Frequency:	Meetings shall be held at least four times per year. The external auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.
Authority:	The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities.
Accountability and reporting arrangements:	The Audit Committee will be accountable to the Board of Directors. The minutes of Audit Committee meetings will be formally recorded and submitted to the Board of Directors. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to it, or

	require executive action. The Committee will report to the Board annually on its work and performance in the preceding year and, as part of this report, will provide commentary in support of the Annual Governance Statement, specifically dealing with the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the Trust, the integration of governance arrangements and the appropriateness of the evidence compiled to demonstrate fitness to register with the Care Quality Commission and the robustness of the processes behind the quality accounts. In providing this commentary in support of the AGS the Committee will seek relevant assurance from the Chair of the Board's Governance and Clinical Assurance Committee. Trust standing orders and standing financial instructions apply to the operation of the Audit Committee.
Monitoring effectiveness:	The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements.
Review:	These terms of reference will be reviewed at least annually by the Committee.
Reviewed by Audit Committee:	~~21 March 2016~~ 27 March 2017
Approved by Board of Directors:	~~1 July 2016~~ 7 April 2017
Review date:	March 2018~~7~~
Document owner:	Colin Reid, Trust Secretary Email: colin.reid@lwh.nhs.uk Tel: 0151 702 4033

GOVERNANCE AND CLINICAL ASSURANCE COMMITTEE
TERMS OF REFERENCE

Constitution:	The Committee is established by the Board of Directors and will be known as the Governance and Clinical Assurance Committee (GACA) (the Committee).
Duties:	The Committee is responsible for: • Receiving assurance that the Trust has in place effective integrated governance systems, risk management and quality improvement • Exercising oversight of the systems of governance, risk management and quality improvement and focusing on matters of concern • Seeking and providing assurance to the Board that the Trust's systems of governance and risk management are fit for purpose, adequately resourced and effective deployed in order to achieve organisational objectives • Seeking assurance that the Trust complies with its own policies and all relevant external regulation and standards of governance and risk management • Oversight, scrutiny and monitoring of progress against the Trust Quality Strategy. In particular the Committee will be responsible for: a) Reviewing risks included on the Board Assurance Framework that are assigned for its oversight b) Receiving assurances in respect of the Trust's quality performance. These assurances will come from internal and external sources including (but not limited to): • The Trust's Safe Effective Experience Report (SEE) • Exception reports from internal Provider Compliance Assessment against CQC Fundamental Standards and other regulatory frameworks • Patient surveys • The Director of Infection Prevention and Control • Chairs reports and items for escalation of subordinate committees • Review of morbidity and mortality

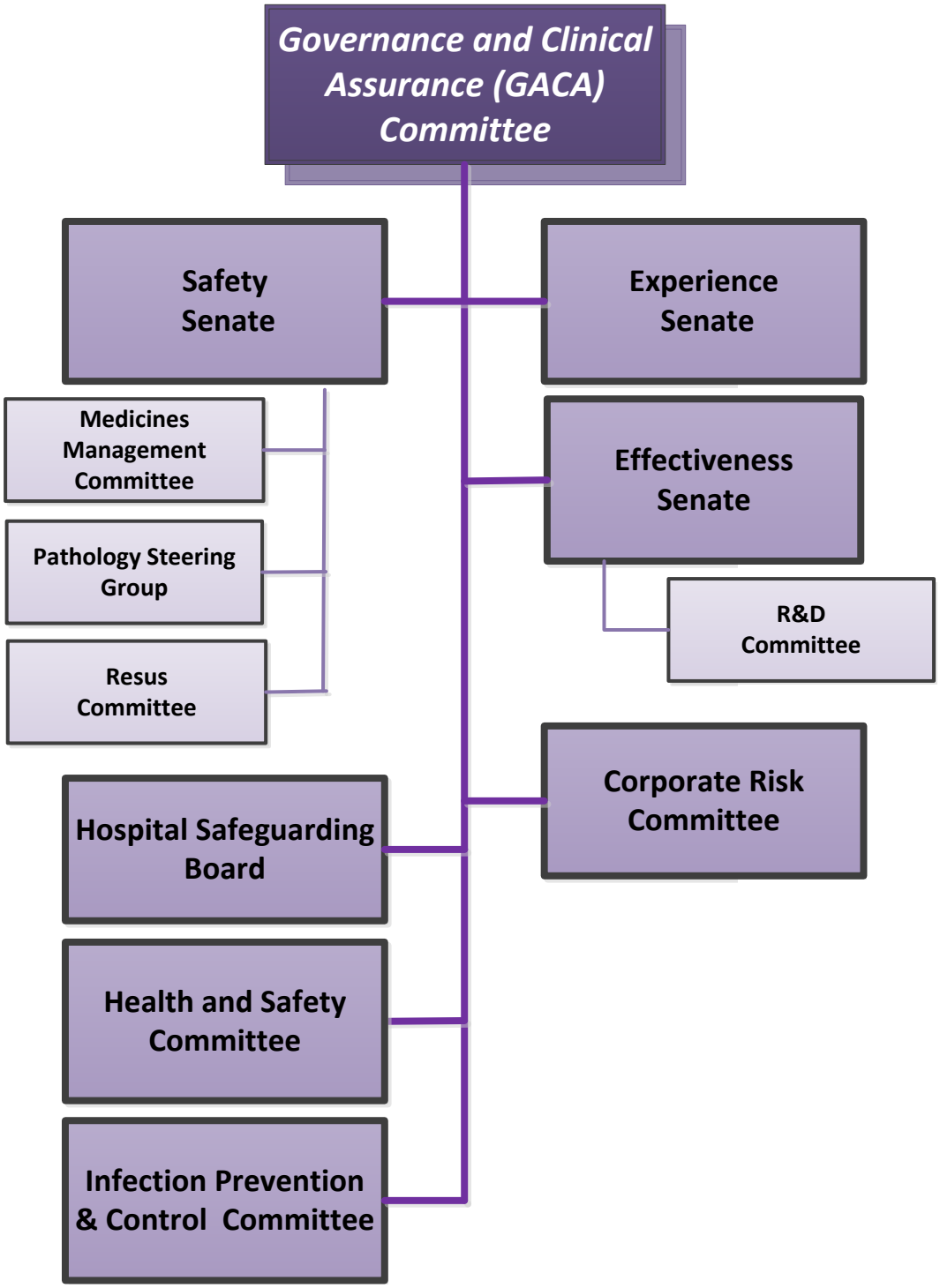
	• Assurance reports relating to quality improvement initiative eg SU2S, and other QI projects commissioned locally by the Trust and by divisions • Opportunity to review harm free care data which currently is not considered anywhere c) Testing assurances through 'deep dives' as require, including Quality quarterly review of clinical services d) Receiving exception reports in respect of matters of non-compliance with clinical quality, performance and risk management targets and standards e) Reviewing the Trust's draft quality report and recommending it to the Board of Directors f) Receiving assurances in respect of progress against the Trust's quality report g) Receiving assurance in respect of the Trust's response to national clinical guidance from external agencies such as the Care Quality Commission, Health and Safety Executive h) Receiving the quarterly Board Statements relating to quality and governance as submitted to Monitor i) Reviewing the Trust's draft Research and Development strategy and recommending it to the Board of Directors j) Receiving assurances in respect of progress against the Trust's Research and Development strategy k) Approval of the Trust's Patient Experience Strategy and recommending it to the Board of Directors l) Receiving assurances in respect of progress against the Trust's Patient Experience Strategy m) Receiving assurances in respect of the Trust's clinical audit function n) Approving the terms of reference and memberships of its subordinate committees o) Considering relevant matters delegated or referred to it by the Board of Directors or referred by any of the Board Committees p) Referring relevant matters for consideration to other Board Committees as appropriate. q) Escalating matters as appropriate to the Board of Directors.
Membership:	The Committee membership will be appointed by the Board of Directors and will consist of:

	• Non-Executive Director (Chair) • Two additional Non-Executive Directors (one of whom shall be Vice Chair) • *Medical Director • *Director of Nursing and Midwifery • *Director of Finance • *Director of Workforce and Marketing • *Committee Chairs of the Safe, Experience and Effectiveness Senates • Deputy Director of Nursing and Midwifery • Head of Governance *or their nominated representative who will be sufficiently senior and have the authority to make decisions Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. The Board of Directors will appoint a Non-Executive Director as Chair of the Committee. Should the Chair be absent from a meeting of the Committee, the Committee may appoint a Chair of the meeting from amongst the Non-Executive Directors present.~~and another Non-Executive member to be Vice Chair from the outset. The Vice Chair will automatically assume the authority of the Chair should the latter be absent.~~
Quorum:	A quorum shall be three members including two Non-Executive Directors and one Executive Director (one of whom must be the Medical Director or the Director of Nursing and Midwifery). The Chair of the Trust may be included in the quorum if present.
Voting:	Each member will have one vote with the Chair having a second and casting vote, if required. Should a vote be necessary a decision will be determined by a simple majority.
Attendance:	a. Members

	Members will be required to attend a minimum of 75% of all meetings. b. Officers The Head of Governance and Trust Secretary shall normally attend meetings. Other executive directors (including the Chief Executive) and officers of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed. Representatives from partner organisations or other external bodies may be invited to attend as appropriate. Such representatives will not have voting rights.
Frequency:	Meetings shall be held bi-monthly, with at least 5 meetings per year. Additional meetings may be arranged from time to time, if required, to support the effective functioning of the Trust.
Authority:	The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It will report directly to the Board of Directors in respect of matters of risk excluding financial and commercial risks which are within the remit of the Finance, Performance and Business Development Committee. The Committee is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee. The Committee is authorised to approve those policies and procedures for matters within its areas responsibility. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities.
Accountability and reporting arrangements:	The Governance and Clinical Assurance Committee will be accountable to the Board of Directors.

	The minutes of the Governance and Clinical Assurance Committee meetings will be formally recorded and submitted to the Board of Directors. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to it, or require executive action. Approved minutes will also be circulated to members of the Audit Committee. The Committee will report to the Board annually on its work and performance in the preceding year. Trust standing orders and standing financial instructions apply to the operation of the Governance and Clinical Assurance Committee.
Reporting Committees/Groups	The sub committees/groups listed below are required to submit the following information to the Committee: a) Chairs Report and minutes of meetings; and b) an Annual Report setting out the progress they have made and future developments. The following sub committees/groups will report directly to the Committee: • Safety Senet • Effectiveness Senet • Experience Senet • Corporate Risk Committee • Hospital Safeguarding Board • Health and Safety Committee • Infection Prevention and Control Committee
Monitoring effectiveness:	The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements.
Review:	These terms of reference will be reviewed at least annually by the Committee.
Reviewed by Governance and	~~16 September 2016~~ ~~18 November 2016~~

Clinical Assurance:	25 March 2017
Approved by Board of Directors:	[7 April 2017]
Review date:	March 2017~~7~~8
Document owner:	Colin Reid, Trust Secretary ,Email: colin.reid@lwh.nhs.uk Tel: 0151 702 4033


Governance and Clinical Assurance (GACA) Committee
Safety Senate
Experience Senate
Medicines Management Committee
Effectiveness Senate
Pathology Steering Group
R&D Committee
Resus Committee
Corporate Risk Committee
Hospital Safeguarding Board
Health and Safety Committee
Infection Prevention & Control Committee

FINANCE, PERFORMANCE AND BUSINESS DEVELOPMENT COMMITTEE TERMS OF REFERENCE

Constitution:	The Board hereby resolves to establish a Committee of the Board to be known as the Finance, Performance and Business Development Committee (the Committee).
Duties:	The Committee will operate under the broad aims of reviewing financial and operational planning, performance and business development. The Committee's responsibilities fall broadly into the following two areas: **Finance and performance** The Committee will: a. Receive and consider the annual financial and operational plans and make recommendations as appropriate to the Board. b. Review progress against key financial and performance targets c. Act on behalf of the Board to approve NHS Improvement quarterly returns. d. Review the service line reports for the Trust and advise on service improvements e. Provide oversight of the cost improvement programme f. Oversee external financing & distressed financing requirements g. Oversee the development and implementation of the information management and technology strategy h. Examine specific areas of financial and operational risk and highlight these to the Board as appropriate through the Board Assurance Framework **Business planning and development** The Committee will: i. Advise the Board and maintain an overview of the strategic business environment within which the Trust is operating and identify strategic business risks and opportunities reporting to the Board on the nature of those risks and opportunities and their effective management j. Advise the Board and maintain an oversight on all major investments, disposals and business developments. k. Advise the Board on all proposals for major capital expenditure over £500,000 l. Develop the Trust's marketing & communications strategy for approval by the Board and oversee implementation of that strategy

Membership:	The Committee membership will be appointed by the Board of Directors and will consist of: • Non-Executive Director (Chair) • Two additional Non-Executive Directors • Chief Executive • Director of Finance • Associate Director of Operations Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. The Board of Directors will appoint a Non-Executive Director as Chair of the Committee. Should the Chair be absent from a meeting of the Committee, the Committee may appoint a Chair of the meeting from amongst the Non-Executive Directors present.~~The Committee will appoint one of the members to be Chair and another Vice Chair from the outset. The Vice Chair will automatically assume the authority of the Chair should the letter be absent.~~
Quorum:	The quorum for the transaction of business shall be three members including at least two Non-Executive Directors (one of whom must be the Chair or Vice Chair of the Committee), and one Executive Director. The Chair of the Trust may be included in the quorum if present.
Voting:	Each member will have one vote with the Chair having a second and casting vote, if required. Should a vote be necessary a decision will be determined by a simple majority.
Attendance:	**a. Members** Members will be required to attend a minimum of 50% of all meetings. **b. Officers** Ordinarily the Deputy Director of Finance will attend all meetings. Other executive directors and officers of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed.
Frequency:	Meetings shall be held at least 5 times per year. Additional meetings

	may be arranged if required, to support the effective functioning of the Trust.
Authority:	The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities.
Accountability and reporting arrangements:	The Finance, Performance and Business Development Committee will be accountable to the Board of Directors. The minutes of Finance, Performance and Business Development Committee meetings will be formally recorded and circulated to the Board of Directors. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to it, or require executive action. The Committee will report to the Board annually on its work and performance in the preceding year. Trust standing orders and standing financial instructions apply to the operation of the Finance, Performance and Business Development Committee.
Reporting Committees and Groups	The sub committees/groups listed below are required to submit the following information to the Committee: a) Chairs Report and minutes of meetings; and b) an Annual Report setting out the progress they have made and future developments. The following sub committees/groups will report directly to the Committee: • Information Governance Committee • EPR Programme Board • Turnaround and Transformation Committee • Emergency Planning Resilience & Response Committee
Monitoring	The Committee will undertake an annual review of its performance

effectiveness:	against its duties in order to evaluate its achievements.
Review:	These terms of reference will be reviewed at least annually by the Committee.
Reviewed by Finance, Performance & Business Development Committee:	~~28 April 2015 v1~~ ~~27 July 2015 v2~~ ~~25 April 2016 v1~~ ~~21 November 2016 v2~~ 27 March 2017
Approved by Board of Directors:	~~5 June 2015 v1~~ ~~4 September 2015 v2 – Ratified~~ ~~1 July 2016~~ 27 March 2017
Review date:	~~April 2017~~March 2017
Document owner:	Colin Reid, Trust Secretary Tel: 0151 702 4033

Agenda item no:	2017/090

Meeting:	Trust Board

Date:	7 April 2017

Title:	Serious Incident Update Report

Report to be considered in public or private?	Public

Where else has this report been considered and when?	Governance & Clinical Assurance Committee – March 2017

Reference/s:	Serious Incident Framework – NHS England Trust Policy for Managing Incidents & Serious Incidents

Resource impact:	--

What is this report for?	**I**nformation	(✓)	**D**ecision	( )	**E**scalation	( )	**A**ssurance	(✓)

Which Board Assurance Framework risk/s does this report relate to?	1d) To ensure lessons are learnt shared, and appropriate change enacted from the reporting and investigation of incidents locally and across the wider NHS Community.

Which CQC fundamental standard/s does this report relate to?	Regulation 16 – Receiving and acting on complaints Regulation 17 – Good governance Regulation 20 – Duty of candour

What action is required at this meeting?	a) Agree to continue to receive updates regarding serious incidents on a quarterly basis. b) Take a position as to whether it feels serious incidents are currently being identified and appropriately managed c) Provide an opinion as to whether the Board is assured that there is clear evidence of serious incident investigations making a difference and leading to improvement

Presented by:	

Prepared by:	Gregory Hope, head of Governance

This report covers (tick all that apply):

Strategic objectives:	
To develop a well led, capable motivated and entrepreneurial workforce	✓

To be ambitious and efficient and make best use of available resources	✓
To deliver safe services	✓
To participate in high quality research in order to deliver the most effective outcomes	✓
To deliver the best possible experience for patients and staff	✓

Other:			
NHS Improvement compliance	✓	Equality and diversity	
NHS constitution		Operational plan	

Publication of this report (tick one)**:**	
This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting	✓
This report will not be published under the Trust's Publication Scheme due to exemptions under S21 of the Freedom of Information Act 2000, because the information contained is reasonably accessible by other means	
This report will not be published under the Trust's Publication Scheme due to exemptions under S22 of the Freedom of Information Act 2000, because the information contained is intended for future publication	
This report will not be published under the Trust's Publication Scheme due to exemptions under S41 of the Freedom of Information Act 2000, because such disclosure might constitute a breach of confidence	
This report will not be published under the Trust's Publication Scheme due to exemptions under S43(2) of the Freedom of Information Act 2000, because such disclosure would be likely to prejudice the commercial interests of the Trust	

1. Introduction and summary

Both Board and GACA received a paper in January detailing how vital it is that there is adequate Board oversight of serious incidents. It was agreed that GACA would take the lead in regards to this on behalf of the Board. In March GACA therefore received details in relation to the current situation regarding serious incidents and were asked to make an assessment regarding assurance.

This paper gives overview details of the information received by GACA and their opinion in regards to assurance.

2. Key Themes

What is a Serious Incident?

The Trust follows NHS England's guidance in reporting serious incidents and carrying out investigations. Both the local commissioners and the regulators are informed of the Trust's serious incidents and monitor the outcomes. Serious incidents are managed operationally through the Safety Senate and through the Governance and Clinical Assurance Committee

.

The agreed definition, both nationally and in the Trust Policy, is that a Serious Incident is:-

"An accident or incident when a patient, member of staff, or member of the public suffers serious injury, major permanent harm or unexpected death, (or the risk of death or injury), on hospital, other health service premises or other premises where health care is provided and where actions of health service staff are likely to cause significant public / media concern".

In many cases it is immediately clear that a serious incident has occurred. It may however be unclear initially. Where it is not clear whether or not an incident fulfils the definition of a serious incident, the Trust aims to engage in open and honest discussions to agree the appropriate and proportionate response. Both NHS England and our local commissioners recognise that the simplest and most defensible position is for us to discuss openly, to investigate proportionately and to let the investigation decide. It is nationally accepted that organisations that report more incidents usually have a better and more effective safety culture.

New Serious Incidents

Since the Committee last met there has been 1 Serious Incident declared.

SI Ref.	Ulysses Ref	Incident Identification Date	Dept	Steis Date	Summary	Draft Report Due from Division	Date Report Due to CCG
2017-3809	46875	05/02/2017	Maternity	07/02/2017	Inpatient Stillbirth - Intrauterine death at 35+4 weeks whilst patient on maternity base ward	24/04/2017	08/05/2017

Serious Incidents submitted to the CCG

Since the Committee last met there were 3 Serious Incident reports submitted to the CCG:

SI Ref.	Ulysses Ref	Incident Identification Date	Dept	Steis Date	Final Report & Action Plan	Extension Required	Date Report Submitted	Submitted to CCG in Timescale?	Investigation Lead
2016-28164	44983	26/10/2016	Gynaecology	28/10/2016	SI 2016_28164.pdf	Yes	17/02/2017	Yes	Sian Taylor
2016-28836	45266	05/11/2016	Gynaecology	07/11/2016	SI 2016_28836.pdf	Yes	15/02/2017	Yes	David Patrick
2016-31119	45712	29/11/2016	Neonatal	01/12/2016	SI 2016_31119.pdf	No	28/02/2017	Yes	Nim Subhedar

Overdue implementation of Serious Incident actions

The following actions from serious incidents are currently beyond their expected completion date and are being monitored by commissioners for immediate response.

SI Ref.	Recommendation	Dept.	Action Description	Progress Narrative	Operational Lead	Management Lead	Root Cause?	Target Date
2016/1835	This Trust develop, document and implement robust processes to ensure ordered investigations, including pre-operative investigations, and externally provided reports are reviewed and acted upon. Such processes should include appropriate recording of clinical review and intended and completed action.	Gynae	2.1 Create procedural documents describing robust processes for the ordering of imaging requests. This should ensure documentary recording of the clinical review and any intended responsive actions	CD feels he can't provide assurance. Trust is sharing issues requiring a commissioning solution at CQPG as a standing agenda item. In the meantime some action is needed by LWH as an interim measure and MD is progressing with the relevant Clinical Directors as a matter of urgency for discussion at April Safety Senate.	Consultant Lead for IT /Clinical Directors	Medical Director	Yes	Sep-16

2016/1835	MDT groups and operating teams ensure and document review and consideration of all relevant pre-surgical investigations	Gynae	3.1 revision of MDT terms of reference 3.2 Revision of MDT Documentation 3.3 Revision of WHO Checklist documentation as necessary (NB.LocSSIPS)	MRI and CT scans are discussed at MDT. X-rays are not. CD of Gynaecology has been asked to review the MDT TOR and documentation as per and to inform the Medical Director of changes made by 14 April. The review of WHO checklist is being discussed at the April SSIPS meeting:	Clinical Director for Gynaecology	Medical Director	Yes	Sep-16
2016/16258	A process for cleansing lists is required to ensure that results are not listed under a clinician that has left the Trust	Gynae	Implement process for cleansing lists clinicians/locations	Lists circulated and item listed for discussion at PSG in April. Main problem by volume lies with Clatterbridge results- they have been contacted and agreed to file outstanding results	Medical Consultant IT	Medical Director	No	Feb-17

2016/16258	Develop SOP for incorrectly assigned results - in particular with regards to feedback to LCL	Gynae	To develop an appropriate SOP for incorrectly assigned results	MD is progressing with the relevant Clinical Directors as a matter of urgency for discussion at April Safety Senate	Consultant Lead for IT	Clinical Director	Yes	Dec-16
2016/25853	Clocks in theatre, recovery and HDU are not always aligned	Gynae	Review clocks to ensure synchronised	Estates and IT are in talks to fit 48 clocks across the trust in a hierarchy prioritised by clinical need	Head of Estates	Director of Nursing & Midwifery	No	Jan-17

3. Conclusion

The Trust works to an agreed national definition of what a Serious Incident is and has policies and guidance in place. Nominated Board members are in place to provide regulatory oversight and there are clear processes in place for GACA and the Safety Senate to own and review Serious Incidents in detail. Beginning to discuss serious incidents in more depth at all GACA meetings with assurance reports to Board on a quarterly basis has strengthened this process.

Although GACA felt there was a robust process in place for identifying, reporting and managing serious incidents they had concerns regarding implementation of actions. The Medical Director gave assurance that the most pressing issue, failure to act on test results, would be progressed via meetings between himself and Clinical Directors.

It is vitally important that the Board is support by GACA to ensure it is well sighted on this issue as it is a requirement placed upon Boards to ensure serious incident investigations are “making a difference and leading to improvement”. Challenging the assurance given to it is a fundamental part of the Board’s role in this regard.

4. Recommendation

The Committee is asked to:-

a) Agree to continue to receive updates regarding serious incidents on a quarterly basis.
b) Take a position as to whether it feels serious incidents are currently being identified and appropriately managed
c) Provide an opinion as to whether the Board is assured that there is clear evidence of serious incident investigations making a difference and leading to improvement

Agenda item no:	17/091

Meeting:	Trust Board Meeting

Date:	7 April 2017

Title:	Mortality Strategies

Report to be considered in public or private?	Public

Where else has this report been considered and when?	

Reference/s:	GACA – 24 March 2017

Resource impact:	

What is this report for?	**Information**		**Decision**	**X**	**Escalation**		**Assurance**	**x**

Which Board Assurance Framework risk/s does this report relate to?	5a-f, 1&3

Which CQC fundamental standard/s does this report relate to?	Reg 17 & 12

What action is required at this meeting?	Board is asked to note: 1. the current status in the development of the Adult Mortality Strategy and the development of the Stillbirths and Neonatal Strategy; and 2. the Perinatal Mortality Position Statement

Presented by:	Andrew Loughney, Medical Director
Prepared by:	

This report covers (tick all that apply):

Strategic objectives:	
To develop a well led, capable motivated and entrepreneurial workforce	**X**
To be ambitious and efficient and make best use of available resources	**X**

To deliver safe services	**X**
To participate in high quality research in order to deliver the most effective outcomes	
To deliver the best possible experience for patients and staff	**X**

Other:			
Monitor compliance		Equality and diversity	
Operational plan		NHS constitution	

Publication of this report (tick one)**:**	
This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting	**x**
This report will not be published under the Trust's Publication Scheme due to exemptions under S21 of the Freedom of Information Act 2000, because the information contained is reasonably accessible by other means	
This report will not be published under the Trust's Publication Scheme due to exemptions under S22 of the Freedom of Information Act 2000, because the information contained is intended for future publication	
This report will not be published under the Trust's Publication Scheme due to exemptions under S41 of the Freedom of Information Act 2000, because such disclosure might constitute a breach of confidence	
This report will not be published under the Trust's Publication Scheme due to exemptions under S43(2) of the Freedom of Information Act 2000, because such disclosure would be likely to prejudice the commercial interests of the Trust	

Included in this document are:

1. The current draft of the Adult Mortality Strategy
2. The Perinatal Mortality Position Statement

The Board has been issued with the above for information and will receive an updated Adult Mortality Strategy and a Stillbirths and Neonatal Strategy at its meeting on 5 May 2017 for approval. In accordance with the action 2017/58(i) a Board development session will be held on the 5 May 2017.

Board is asked to note:

1. the current status in the development of the Adult Mortality Strategy and the development of the Stillbirths and Neonatal Strategy; and
2. the Perinatal Mortality Position Statement

Adult Mortality Strategy

Liverpool Women's NHS Foundation Trust

Version 1.0
March 2017

Contents

1 Introduction

Around 500 000 people die in the UK every year and of these, nearly half die in an NHS hospital.[1] While many of these deaths represent the expected end point of a known disease process, the CQC have recently highlighted the need for NHS Trusts to review the care they provide [2] so that they can learn from their experiences (hence improve the way that they provide care), fulfil their duty of candour and make themselves accountable for any deficiencies or failures that they might have.

The CQC and NHS England[3] recommend that individual NHS trusts should work with their commissioners to review and improve their local approach following the death of people receiving care from their services. Emphasis is given to the need for their Boards to ensure that national guidance is implemented at a local level, so that deaths are identified, screened and investigated when appropriate and that learning from deaths is shared and acted upon. Engagement with families and carers is also prioritorised in these new national recommendations.

Liverpool Women's NHS Foundation Trust recognises that although most of the adult death it encounters is the expected end point of a known disease process, the principles described above are equally valid to its own services. In the Trust's Risk Management Strategy, commitment is given to minimise risk through the systematic embedding of relevant, efficient and effective risk management processes. Since the Trust's core purpose is to provide clinical care, its foremost risks are those that are clinically based and the ultimate clinical risk is that of death. In acknowledgement of that fact, the Board of Directors has approved this Adult Mortality Strategy, which relates to adult disease across the specialties of obstetrics and gynaecology.

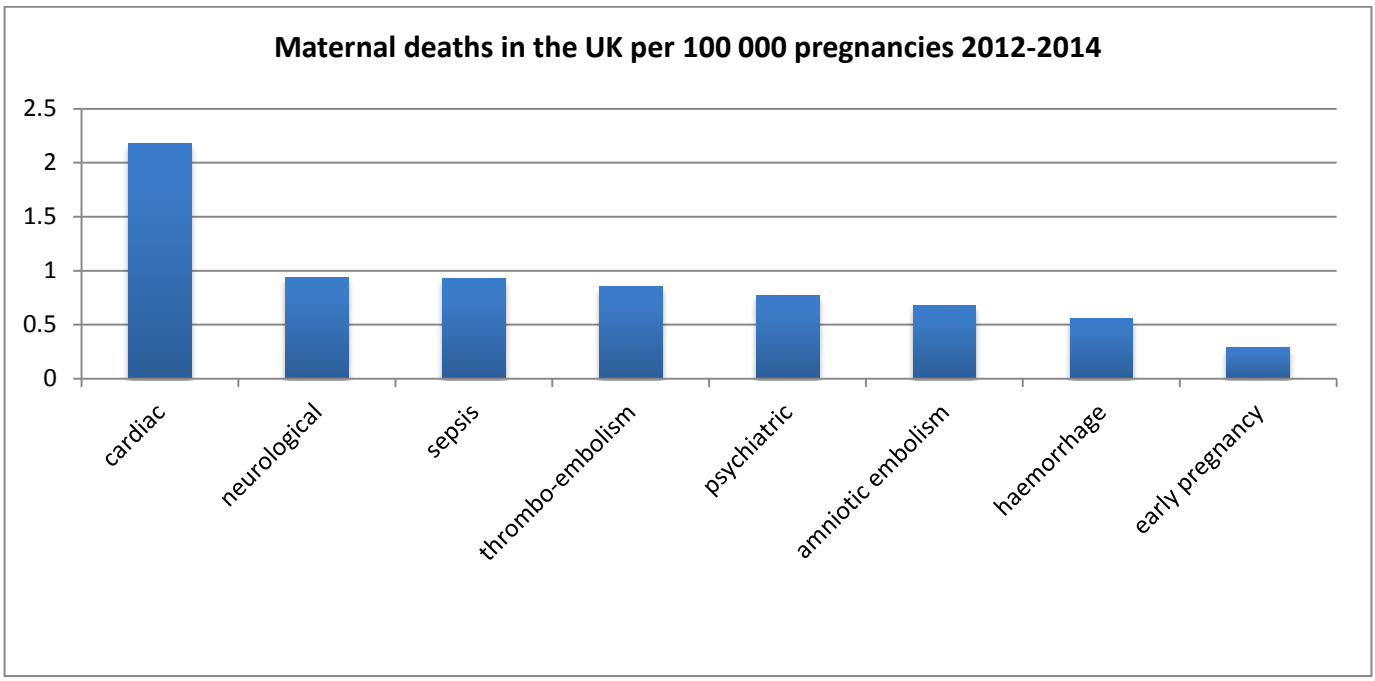
This strategy is relevant and applies to all of the Trust's clinical and managerial staff because the management of adult mortality is a shared responsibility.

2 Causes of Mortality

The causes of adult mortality (and as a surrogate, severe morbidity) are similar between gynaecology and obstetrics. In gynaecological practice, for example, the most common reasons for transferring a patient to an intensive care unit after surgery are:[4, 5]

- recovery from haemorrhage
- treatment of sepsis
- management of pre-existing cardiovascular disease
- recovery from a procedure-related injury
- treatment of thrombo-embolism

For comparison, the profile of maternal death in the UK during or shortly after pregnancy is shown in the chart below.[6]



Common themes emerge that point to the importance of multidisciplinary team working and optimising the management of some specific clinical conditions that are encountered in gynaecological and obstetric practice, including cardiac disease, sepsis, venous thrombo-embolism and haemorrhage. Consequently, the key elements of this strategy apply equally to gynaecology and obstetrics.

3 Aim of the Strategy

The aim of this strategy is to set out the Trust's vision for managing mortality. There are four key elements to be met:

Prevention Our aim is to prevent all avoidable adult mortality in the Trust across the specialties of gynaecology and obstetrics.

Analysis Our aim is to gather detailed intelligence on all individual instances of adult mortality in the Trust, to identify local issues and themes arising from those events, to audit key areas of clinical practice that relate to mortality and to consider all relevant national documents.

Response Our aim is to respond to our analyses by production of SMART Action Plans, including a commitment to seeing those plans through to completion and a commitment to disseminating the intelligence gathered to all relevant clinical and managerial groups. After completion of these action plans we will ensure that full benefit has been achieved by measuring relevant and related clinical outcomes.

Bereavement Our aim is to provide bereaved families with an environment tailored to their needs, to raise awareness of the needs of bereaved people amongst our clinical staff and to comply in full with the Duty of Candour in response to the death of a patient. Bereaved families will form a central part in our investigatory processes when there has been an adult death.

3.1 Prevention

To minimise the risk of adult mortality, the following must be provided:

- adequate numbers of clinical staff with the correct mix of clinical skills
- ready availability of all necessary equipment and facilities
- accessible guidelines for the treatment of clinical conditions associated with adult mortality

Relocation The key long term strategy for the prevention of death is therefore to relocate all of the Trust's acute services to a hospital site that is already providing multidisciplinary acute adult care. This would give immediate access to medical and surgical teams from other specialties, to assist with a full range of acute and sub-acute obstetric, gynaecological and anaesthetic complications. A specialised cardiac arrest team would also then be available and there would be ready access to an on-site blood bank, full imaging and laboratory diagnostic services and a Level 3 Intensive Care Unit. The Board of Directors is committed to pursuing this strategy through

a process of negotiation with local Clinical Commissioning Groups, NHS Improvement and NHS England and through a process of discussion with the public.

Business Plan Since relocation is not an immediately achievable option, the Board of Directors has also put forward a two year Business Plan (2017-2019) that will address each of the Trust's key present clinical weaknesses in turn. This appears as Appendix A at the rear of this document.

Present Resources It is recognised that the full implementation of this Operational Plan will require the support of external regulatory and funding bodies, which is outwith the direct control of the Trust. Therefore, in addition to the measures included in the Operational Plan, the Trust is committed to optimising its strategy for the prevention of death using present resources. Six examples of the most directly relevant preventative measures that have already been implemented using present resources are as follows:

- A Major Haemorrhage Protocol has been developed to optimise the use of available resources and expertise on the Crown Street site. It incorporates bespoke elements, including the use of on-site blood clotting analysis to guide administration of blood products. Training in major haemorrhage management forms part of the Mandatory Training Programme for all clinical staff in the Trust.

- The Sepsis Bundle has been developed in line with national guidance, to ensure that rapid detection of sepsis and the correct medical and nursing response is provided. Training in sepsis management forms part of the Mandatory Training Programme for all clinical staff in the Trust.

- Adult Resuscitation (Basic Life Support) forms part of the Mandatory Training Programme for all clinical staff in the Trust. Since the medical element of the resuscitation team is drawn from available anaesthetists, obstetricians and gynaecologists on-site, all medical staff in the Trust are trained in the use of defibrillators.

- Level 2 HDU Care is provided for gynaecological and obstetric patients on-site, with support being provided to the Trust's nursing and midwifery staff from Consultant Anaesthetists and a Practice Educator based at The Royal Liverpool Hospital.

- Pregnant women with cardiological conditions are cared for throughout their pregnancies by a Consultant Cardiologist and a Consultant Obstetrician in tandem, who run a specialised antenatal clinic for that purpose.

- Case by case selection has allowed an increasing number of our most complex gynaecological cases to be operated upon at The Royal Liverpool Hospital, with access to colorectal and urological surgeons and elective access to an adult Intensive Care Unit.

Clinical Guidelines The maintenance of up to date clinical guidelines that cover our full scope of clinical activity adds to the culture of prevention of adult death in the Trust. In 2016, this was activity identified as one of the key responsibilities of the Effectiveness Leads, who are appointed to each of the Trust's clinical specialties. In February 2017, around 85% of all clinical guidelines in the Trust were ratified and up to date. Our strategy for the prevention of adult death includes the following commitment for the specialties of obstetrics and gynaecology:

- At any one time, at least 95% of all clinical guidelines will be ratified, maintained within their stated review date and available to view on the trust intranet. The 5% of remaining clinical guidelines that fall outside of this target will have an identified reviewer and an identified completion date for ratification.

This commitment will be achieved by August 2017. It will be monitored at Divisional Clinical Meetings, the Effectiveness Senate and ultimately by GACA.

3.2 Analysis

The Trust's strategy for analysis relies upon the following activities:

- gather detailed intelligence on all individual instances of adult mortality in the Trust
- identify local issues arising from each of those events individually
- explore themes that may be emerging from groups of events
- audit key areas of clinical practice that relate to mortality
- consider newly published relevant documents from external bodies

Intelligence-Gathering Process Appendices 2, 3 and 4 are flow charts that illustrate the intelligence-gathering processes that will be followed after expected gynaecological deaths, unexpected gynaecological deaths and all adult deaths in obstetrics. Expected gynaecological deaths are those that arise as the predicted end point of a known disease process. In this Trust, most expected deaths result from gynaecological cancers.

Adult Mortality Audit Sheet From April 2017, whenever there is an adult death in the trust, whether expected or not, an Adult Mortality Audit Sheet will be completed. This will record performance against a predefined set of standards, using the recognised and validated methodology detailed in PRISM studies.[7] In each clinical area, the Clinical Director will provide feedback to clinicians if individual errors or omissions in care have been identified by use of this audit tool. The forms gathered will be passed to the Head of Governance, who will pool the data and identify any emerging Trust-wide themes. These will be highlighted in the Quarterly Mortality Report, from July 2017 onwards.

Root Cause Analysis For unexpected gynaecological deaths and all maternal deaths, either a Level 2 or a Level 3 Root Cause Analysis is performed. One of the main aims of the Root Cause Analysis is to identify case-specific errors and systematic flaws. All Root Cause Analyses are scrutinised by the Head of Governance, who pools data and identifies any emerging Trust-wide themes. These Root Cause Analyses will continue but their lessons and SMART Action Plans will be highlighted in the Quarterly Mortality Report, from July 2017 onwards.

Responding to an adult death by use of the Adult Mortality Audit Sheet or by performing a Root Cause Analysis are forms of reactive risk management. The Trust's strategy is, however, planned to be both reactive and proactive. Proactive elements will include audit in key areas of clinical practice (as is already common practice), use of a newly created Adult Mortality Dashboard and horizon scanning for national documents of relevance to adult mortality.

Clinical Audit Forward Plan With respect to clinical audit, an annual Clinical Audit Forward Plan is presently formulated by the Associate Medical Director for Clinical Governance, after consultation with the Trust's Effectiveness Leads and after discussion with the Trust's Head of Governance. The content of the Clinical Audit Forward Plan is flexible but from April 2017 the Trust commits to the principle that it must include work of relevance to the highest risk areas for adult mortality including:

- haemorrhage
- psychiatric disease
- sepsis
- neurological disease
- venous thromboembolism
- cardiac disease

In each of these areas of audit, the Associate Medical Director for Clinical Governance will allocate a Consultant Lead who will ensure that the audit is completed within the timeframe of annual audit cycle and presented at the corresponding Directorate Clinical Meetings. All audit work performed against the above areas of clinical practice will therefore have been completed, presented and have recommendations made against them by March 2018.

Adult Mortality Dashboard At present, there is no adult mortality specific dashboard available in the Trust, to provide easily accessible data about the clinical outcomes of most relevance to the field. As part of the Trust's Adult Mortality Strategy, The Associate Medical Director for Clinical Governance will work with the Head of Governance and the Clinical Directors of Obstetrics, Gynaecology and Anaesthetics to create such a dashboard. A draft will be presented to the Safety Senate in July 2017 so that its content can be agreed. A functioning dashboard will be in use by September 2017, forming an agenda item for discussion at each Directorate Clinical Meeting in Obstetrics, Gynaecology and Anaesthetics. The Adult Mortality Dashboard will also appear as an integral part of the Quarterly Mortality Review, from September 2017.

Horizon Scanning With respect to horizon scanning for national documents of relevance to adult mortality, the following sources of information are monitored by the Safety Leads in Gynaecology, Maternity and Anaesthetics:

- CQC
- NHSLA
- NICE
- NPEU
- RCOG
- NCEPOD

Documents that are potentially relevant to adult mortality are summarised by the Safety Leads and presented to their respective Directorate Clinical Meetings for minuted discussion. Areas of concern and areas for improvement are then brought to the attention of the Associate Medical Director for Clinical Governance, who will determine whether there is a case for immediate action or a need for inclusion in future Adult Mortality Strategy documents.

Benchmarking The Trust is committed to analysing and comparing its performance in activities relevant to adult mortality through a process of benchmarking. Since the Trust runs specialised services, it is acknowledged that the standard benchmarking tools available to most acute adult trusts in the UK may not provide data that are directly applicable to activities at Liverpool Women's Hospital. A working group will therefore be convened to debate and agree upon the best available benchmarking data. The group will consisting of the Associate Medical Director for Clinical Governance, the Clinical Directors for Obstetrics, Gynaecology and Anaesthetics and the Head of Governance. An agreed Adult Mortality Benchmarking Dataset will feature as part of the Adult Mortality Quarterly Report from October 2017 onwards.

3.3 Response

SMART Action Plans After the analysis of events following an adult death areas of deficiency and opportunities for improvement are presently captured by the production of SMART Action Plans. Similarly, after completion of any clinical audit of relevance to adult death, areas of deficiency and opportunities for improvement are captured by the production of SMART Action Plans.

- specific
- measurable
- agreed
- realistic
- time-based

Each action in a SMART Action Plan has an assigned person responsible for its completion. This may for example be the Safety Lead, the Effectiveness Lead, a senior nurse or midwife or a

manager. Progress against Action Plans is discussed as a routine agenda item at Directorate Clinical Meetings.

The Head of Governance provides oversight and prompts the assigned person responsible if an action is overdue for completion. From April 2017, if a planned action relating to adult mortality has not been completed within one month of its agreed completion date, The Head of Governance will escalate the matter to the Medical Director and the Director of Nursing and Midwifery, who will pursue completion of the action.

When any action in a SMART Action Plan is being closed relating to adult mortality, evidence must be attached to show how the requirements of that action have been met. From May 2017 as an additional measure beyond completion of a SMART Action Plan, the Trust will ensure that full benefit has been achieved by measuring relevant and related clinical outcomes. These outcome measures will be agreed at the Directorate Clinical Meetings and monitored at those same meetings with the assistance of the Head of Governance.

Quarterly Adult Mortality Report

The Head of Governance will produce a Quarterly Adult Mortality Report from July 2017 onwards. As a minimum, this report will contain data about:

- number of adult deaths
- number of women who had an Adult Mortality Audit Sheet completed
- number of woman whose death lead to a Root Cause Analysis
- number of deaths attributable to deficiencies in care
- themes identified from the Adult Mortality Audit Sheets and Root Cause Analyses
- actions being taken
- progress against those actions
- outcome measures identified for on-going scrutiny, beyond completion of action plans

In a broader sense, the Quarterly Adult Mortality Report will contain information relevant to all of the activities outlined in this Adult Mortality Strategy, including activities around prevention, analysis, response and bereavement. The Head of Governance will present the Quarterly Adult

Mortality Report to GACA and The Medical Director will present the Quarterly Adult Mortality Report to the public meeting of the Board of Directors, quarterly, to give assurance. A summary of the Quarterly Mortality Reports will also be used by the Head of Governance to populate the Quality Accounts of the Trust from 2018 onwards.

3.4 Bereavement

The Macmillan Team provides bereavement support to family and carers after the death of an adult in the Trust. The team comprises six clinical nurse specialists (TWE 4.4), all of whom have advanced communications skills training. They draw upon guidelines from the Cheshire and Merseyside Palliative Care Network to underpin their work,[8] in addition to in-house guidelines that are displayed on the Trust Intranet (Policies Procedures and Guidelines > Gynaecology > general Gynaecology > Bereavement Guideline).

The Trust is committed to putting families and/or carers at the centre of the investigatory process in cases of unexpected adult deaths in gynaecology and all adult deaths in maternity. The Lead Investigator or deputy consults with the bereaved family and/or carers to inform them that an investigation is taking place and notes any questions that they would like addressed. On completion of the investigation, the Lead Investigator or deputy feeds back findings to the bereaved family and/or carers and gives them the opportunity to ask further questions. A copy of the investigatory report is provided to the bereaved family and/or carers at this time. A further opportunity is given to the bereaved family and/or carers to meet with the Lead Investigator or deputy at a later date, once they have had time to consider the content of the investigatory report.

4 Learning Disabilities

The Trust recognises that at the present time, there is no agreed approach to the performance of case review after the death of an adult with learning disabilities. The Trust is committed to the production of a Standard Operating Procedure for this circumstance. The work will be lead by the Medical Director and the Head of Adult Safeguarding. It will include a commitment to the use of LeDeR methodology, which is a University of Bristol initiative commissioned by the Healthcare Quality Improvement Partnership on behalf of NHS England.[9] The Standard Operating Procedure will be introduced after discussion at the Effectiveness Senate by the end of August 2017.

5 Duties and Responsibilities

5.1 Individuals

All Staff

It is the responsibility of all staff to minimise the risk of adult mortality and to minimise its impact. To highlight areas for improvement, the Trust's risk management processes may be used. Issues may also be brought directly to the attention of Safety or Effectiveness Leads, Clinical Directors, senior nursing and midwifery staff, Divisional Managers, the Associate Medical Director for Clinical Governance, the Medical Director or the Director of Nursing and Midwifery for consideration, escalation and action.

Medical Director

The Medical Director sponsors the Adult Mortality Strategy and has lead responsibility for its delivery. The Medical Director presents the Quarterly Adult Mortality Report to the public meeting of the Board of Directors for assurance. More generally, the Medical Director has joint responsibility for clinical governance in the Trust and with respect to adult mortality, provides the function of 'patient safety director.'

Non Executive Director

The Non Executive Director who Chairs the meetings of GACA, in conjunction with the Medical Director, takes oversight of the process for reviewing and reporting on adult death in the Trust.

Director of Nursing and Midwifery

The Director of Nursing and Midwifery has joint responsibility for clinical governance, delegated authority for quality improvement and risk management and is the Executive Lead for infection control. The Director of Nursing and Midwifery supports delivery of the Adult Mortality Strategy.

Associate Medical Director for Clinical Governance

The Associate Medical Director for Clinical Governance assists the Medical Director and the Director of Nursing and Midwifery in delivering the commitments made in the Adult Mortality Strategy. The Associate Medical Director for Clinical Governance assists the Medical Director and the Director of Nursing and Midwifery in driving up the quality and consistency of clinical governance activities in the Trust.

Head of Governance

The Head of Governance works with Medical Director, the Director of Nursing and Midwifery and the Associate Medical Director for Clinical Governance, to support delivery of the Adult Mortality Strategy. The Head of Governance produces the Quarterly Adult Mortality Report, presents it to GACA and includes a summary of the Quarterly Adult Mortality Reports in the Trust's Annual Quality Accounts.

Safety Leads

Safety Leads are usually consultants in the trust, but at the joint request of the Medical Director and the Director of Nursing and Midwifery, senior nursing or midwifery staff can also hold these posts. Safety Leads take responsibility in their own clinical areas for a range of clinical governance activities of relevance to the Mortality Strategy, including the promotion of incident reporting, identifying cases requiring Serious Untoward Incident investigations, ensuring completion of action plans after Serious Untoward Incident investigations, disseminating clinical lessons learnt and co-ordinating responses to national reports or initiatives.

Effectiveness Leads

Effectiveness Leads are usually consultants in the trust, but at the joint request of the Medical Director and the Director of Nursing and Midwifery, senior nursing or midwifery staff can also hold the posts. Effectiveness Leads take responsibility in their own clinical areas for a range of clinical governance activities of relevance to the Mortality Strategy, including the maintenance of clinical guidelines, formulation and delivery of clinical audit, benchmarking and horizon scanning.

Senior Managers

Senior managers take a leading role in the management of clinical risks in the Trust, including the management of risks relating to adult mortality. Examples of their responsibilities include escalating clinical risks from the front line, identifying the actions needed to reduce the risk, assigning owners to elements of Action Plans and monitoring mitigating factors.

5.2 Committees and Meetings

Directorate Clinical Meetings

Directorate Clinical Meetings are open to attendance by all medical, nursing and midwifery staff of the relevant directorate. The standing items on their agenda of relevance to the Adult Mortality Strategy include review of the Directorate Risk Register, review of progress against the Clinical Audit Forward Plan, review of the actions detailed in SMART Action Plans after an adult death, review of the actions detailed in SMART Action Plans after a relevant clinical audit, horizon scanning and review of the Quarterly Adult Mortality Report.

Safety Senate

The Safety Senate monitors themes arising from clinical incidents that have been reported in the Trust, including those that have arisen following an adult death. In addition, after a Serious Untoward Incident, although the Directorate Clinical Meetings monitor progress against the SMART Action Plans produced, the Safety Senate provides monthly oversight and escalates unresolved risks to GACA.

Effectiveness Senate

The Effectiveness Senate monitors progress against the Trust's Clinical Audit Forward Plan, which includes audit work in those clinical activities most closely related to the risk of adult mortality. In addition, although the Directorate Clinical Meetings monitor progress against the SMART Action Plans produced after their clinical audits, the Effectiveness Senate provides monthly oversight and escalates unresolved risks to GACA.

Governance and Clinical Assurance Committee

The Governance and Clinical Assurance Committee (GACA) is the sub-committee responsible for providing the Board of Directors with assurance on all aspects of quality of clinical care. GACA therefore oversees clinical governance activity relating to adult mortality. It meets on alternate months and receives, via the Effectiveness Senate and Safety Senate Chairs' Reports, risks relating to adult mortality that have not been resolved at directorate or senate level. In addition, it receives the Quarterly Adult Mortality Report and escalates unresolved risks relating to adult mortality to the Board of Directors. Since the Quarterly Adult Mortality Report is also provided directly to the Board of Directors, which meets monthly, it is accepted that the Board of Directors will occasionally have had sight of an Adult Mortality Quarterly Report before it has been considered by GACA.

Board of Directors

The Board of Directors meets in public on a monthly basis. It has the overarching responsibility for activities relating to adult mortality in the Trust. It therefore receives the Quarterly Adult Mortality Report for direct consideration. It also receives assurance from GACA with respect to the detailed elements of the report, via the Chair of GACA's Report. In addition, the following items of relevance to adult mortality appear on the Board Assurance Framework: (i) the isolated site of Liverpool Women's Hospital, (ii) transport of adults across the critical care network, (iii) development and support of a comprehensive Clinical Audit Forward Plan, (iv) ensuring that lessons are learnt and change enacted from the reporting and investigation of incidents locally and across the NHS and (v) considering response to NICE Guidance**.**

6 Implementation and Monitoring Compliance

An implementation timetable appears as Appendix H to this document. The progress being made against the implementation timetable will be monitored through GACA. Compliance with the commitments made in this strategy document will be monitored via the Quarterly Adult Mortality at GACA and at the Public meeting of the Board of Directors. This strategy will be reviewed and updated annually by the Medical Director.

7 Dissemination and Access to the Document

This strategy will available on the Trust intranet from May 2017. All staff will be notified that the strategy is available on the intranet and will be notified by email is any amendments are made at a later date.

8 Evidence Base

1. Office for National Statistics, Death registrations summary tables – England & Wales for 2015

2. Learning, Candour and Accountability: a review of the way NHS trusts review and investigate the deaths of patients in England (December 2016). Available online at www.cqc.org.uk

3. National Guidance on Learning from Deaths. National Quality Board (2017) Available at www.england.nhs.uk

4. Need for critical care in gynaecology: a population based analysis. Heinonen S et al (2002). Available online at http://ccforum.com/content/6/4/371

5. Knowing the Risk: a review of peri-operative care of surgical patients (2016). Available at: www.ncepod.org.uk

6. Saving Lives, Improving Mothers' Care. (2016) Available at www.npeu.ac.uk/mbrrace-uk

7. Preventable deaths due to problems in care in English acute hospitals: a retrospective case record review study. Hogan H et al (2012) BMJ Qual Saf 21, 737-745.

8. North West Coast Strategic Clinical Network: Standards and Guidelines (2017). Available at www.cmscnsenate.nhs.uk/strategic-clinical-network/our-networks/palliative-and-end-of-life-care/audit-group/standards/

9. Learning Disabilities Mortality Review (LeDeR) Programme (2017) Available at www.bristol.ac.uk/sps/leder

Appendix A: Operational Plan 2017-2019

The features of the service enhancements described in the Operational Plan are as follows:

(a) Full Consultant Obstetrician Cover

Twenty-four hour Delivery Suite presence of a Consultant Obstetrician on seven days per week would reduce medical and surgical complication rates and lead to more effective interventions. Full cover would reduce the risk of adult death in the Trust when set against the following causes:

Cardiac Disease	Sepsis	Thrombosis	Neurological Disease	Psychiatric Deaths	Haemorrhage	Amniotic Embolism	Pre-eclampsia	Early Pregnancy	Anaesthetic Deaths
✓	✓	✓	✓	✗	✓	✓	✓	✗	✗

(b) Full Consultant Anaesthetist Cover

Twenty-four hour presence of a Consultant Anaesthetist on seven days per week would allow for the safer provision of anaesthesia and the most effective response to physiological deterioration across a range of obstetric and gynaecological complications. Full cover would reduce the risk of adult death in the Trust when set against the following causes:

Cardiac Disease	Sepsis	Thrombosis	Neurological Disease	Psychiatric Deaths	Haemorrhage	Amniotic Embolism	Pre-eclampsia	Early Pregnancy	Anaesthetic Deaths
✓	✓	✓	✓	✗	✓	✓	✓	✓	✓

(c) Enhanced Consultant Gynaecologist Cover

The twenty-four hour availability of a Consultant Gynaecologist (who is not otherwise engaged in providing elective gynaecological care) would provide support for the optimal management of a full range of life-threatening gynaecological emergencies. Full cover would reduce the risk of adult death in the Trust when set against the following causes:

Cardiac Disease	Sepsis	Thrombosis	Neurological Disease	Psychiatric Deaths	Haemorrhage	Amniotic Embolism	Pre-eclampsia	Early Pregnancy	Anaesthetic Deaths
✗	✓	✗	✗	✗	✓	✗	✗	✓	✗

(d) Blood Bank On-Site

The provision of a Blood Bank on the Crown Street site, stocking all major blood products (with full technical support) would reduce the risk of adult death in the Trust when set against the following causes:

Cardiac Disease	Sepsis	Thrombosis	Neurological Disease	Psychiatric Deaths	Haemorrhage	Amniotic Embolism	Pre-eclampsia	Early Pregnancy	Anaesthetic Deaths
×	✓	×	×	×	✓	✓	×	✓	×

(e) Enhanced Imaging Capability On-Site

The provision of enhanced imaging capabilities on the Crown Street site, to include CT and MRI scanning facilities (with full technical support) would reduce the risk of adult death in the Trust when set against the following causes:

Cardiac Disease	Sepsis	Thrombosis	Neurological Disease	Psychiatric Deaths	Haemorrhage	Amniotic Embolism	Pre-eclampsia	Early Pregnancy	Anaesthetic Deaths
×	✓	✓	×	×	✓	✓	×	×	×

(f) Enhanced Laboratory Diagnostic Capability On-Site

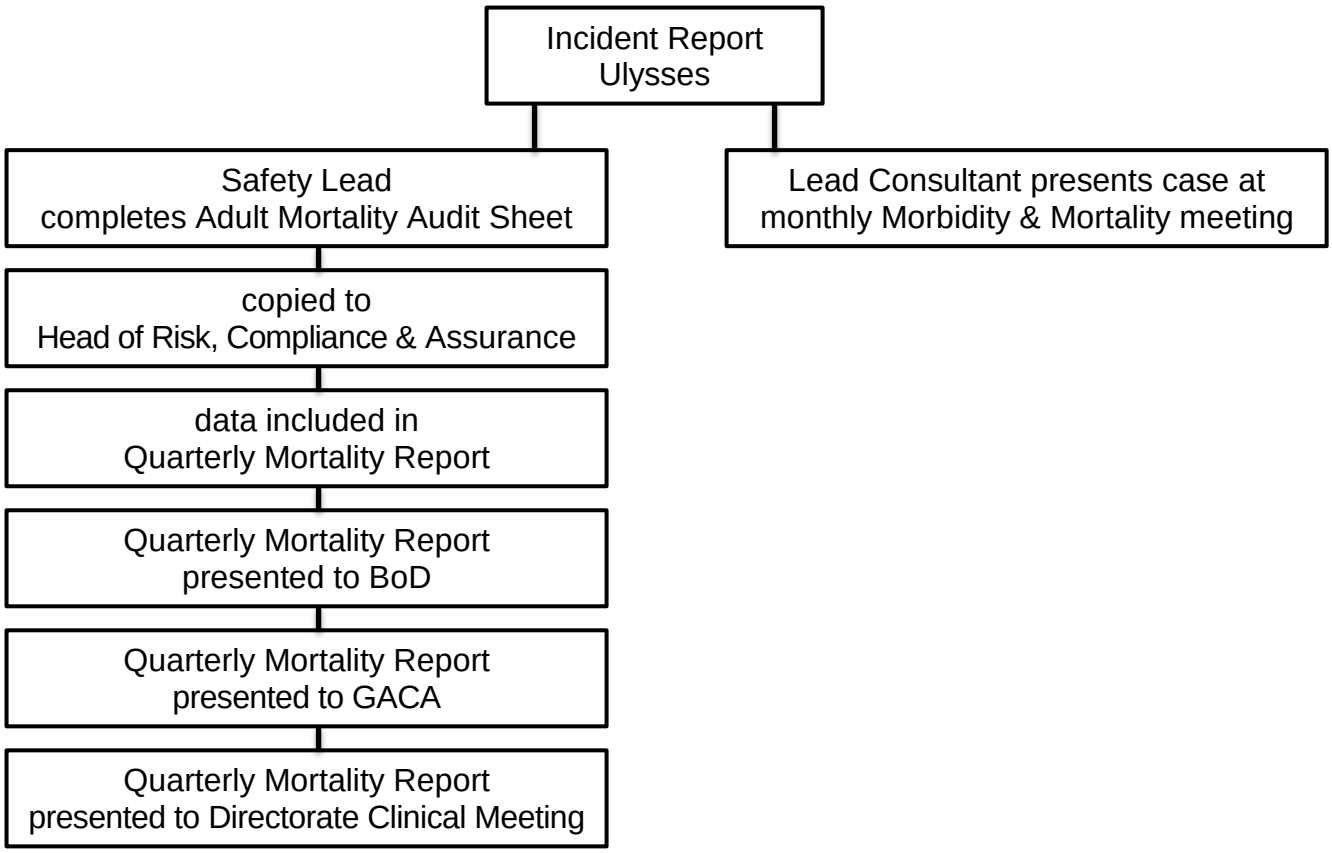
The provision of enhanced laboratory diagnostic capabilities on the Crown Street site, to include rapid processing of FBC, blood clotting, CRP, lactate, UE, LFT and cardiac enzymes (with full technical support) would reduce the risk of adult death in the Trust when set against the following causes:

Cardiac Disease	Sepsis	Thrombosis	Neurological Disease	Psychiatric Deaths	Haemorrhage	Amniotic Embolism	Pre-eclampsia	Early Pregnancy	Anaesthetic Deaths
✓	✓	×	×	×	✓	✓	✓	✓	×

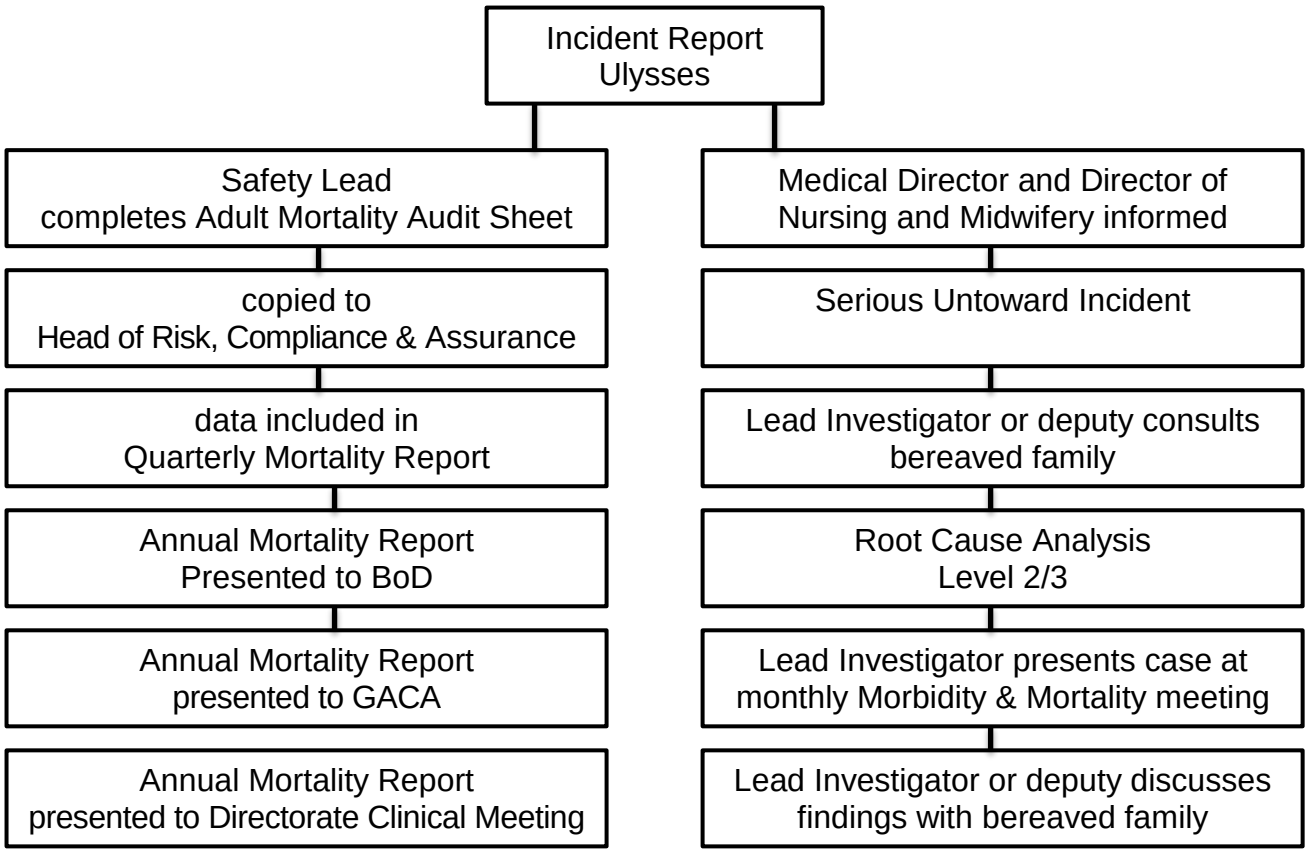
(g) Additional Resources for the Management of Gynaecological Cancers

Death from gynaecological malignancy is the commonest cause of adult mortality in the Trust. To minimise this risk, multidisciplinary working is required together with an increased access to the operating theatres and Intensive Care Unit at The Royal Liverpool Hospital. The Business Plan details the following additional resource requirements: (i) formal SLAs for the services of a colorectal surgeon, a urologist and a radiologist specialising in pelvic disease, (ii) increased time-allocation for Consultant Gynaecologists to attend Pelvic Cancer MDTs and (iii) weekly operating theatre lists at the Royal Liverpool Hospital.

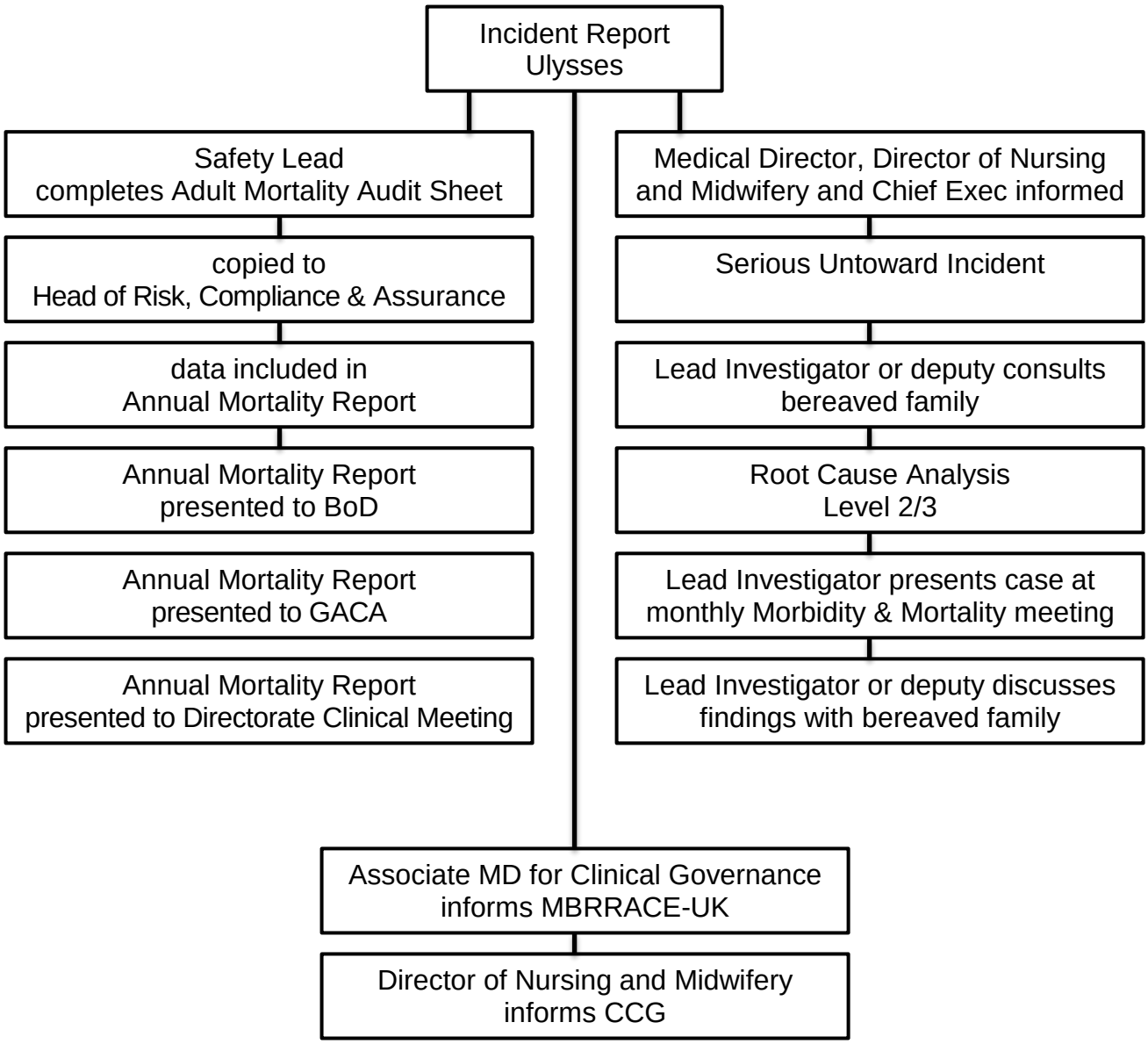
Appendix B: Response to an Expected Gynaecological Death



Appendix C: Response to an Unexpected Gynaecological Death



Appendix D: Response to a Maternal Death



Appendix E: Adult Mortality Audit Sheet

The content of the Adult Mortality Audit Sheet is as follows:

Date and time of admission:
Date and time of death:
Cause of death 1a: disease or condition directly leading to death
Cause of death 1b: other disease or condition if any, leading to 1a
Cause of death 1c: other disease or condition if any, leading to 1b
Cause of death 2: other significant disease or condition contributing indirectly to death
PM performed: Y/N
Documentation of DNAR in case notes: Y/N
Was the patient on an End of Life Care Pathway: Y/N
Did the patient receive any treatment prior to admission:
Was the patient seen in the emergency department prior to admission:
On initial clerking, were the history and examination appropriate: (If not, specify why)
Was the initial differential diagnosis appropriate: (If not, specify why)
Were the initial investigations (if any) appropriate: (If not, specify why)
Was this an unplanned readmission of a previous discharge?
Time of first review:
Number of hours after admission of first review:
Grade of doctor performing first review:
On first review, were the history and examination appropriate: (If not, specify why)
Was the differential diagnosis on first review appropriate: (If not, specify why)
Were the investigations on first review (if any) appropriate: (If not, specify why)
Time of first Consultant review:
Number of hours after admission of first Consultant review:
Was the NEW score recorded appropriately throughout:
Frequency of observations prescribed:
Clinical deterioration recognised:
Appropriate graded response to deterioration:
Clearly documented medical response to deterioration:
Did the deterioration result in cardiac arrest:
Did the patient receive CPR/resuscitation:
Did the separate location of LWH from an adult acute site contribute to the patient's death:
Did the separate location of LWH from an adult acute site reduce the quality of care provided: (If so, please specify)
Should the patient's management have been handled differently: (If so, please specify)
Are there any lessons to be learnt from this case: (If so, please specify)
Hogan scale:
1 definitely not preventable
2 slight evidence of preventability
3 possibly preventable but not very likely, a little less than 50/50
4 probably preventable but not certain, a little more than 50/50
5 strong evidence of preventability
6 definitely preventable
NCEPOD
1 good practice
2 room for improvement – some clinical care could have been better
3 room for improvement – some organisational care could have been better
4 room for improvement – some clinical & organisational care could have been better
5 less than satisfactory – several aspects of care below an acceptable level
How would you rate the overall quality of care provided by the trust: Excellent / Good / Adequate / Poor / Very poor
Please give a brief clinical resume of the patient:

Appendix F: Initial Equality Impact Assessment

Name of policy/ business or strategic plans/CIP programme:	**Adult Mortality Strategy v 1.0**	
Does the proposal, service or document affect one group more or less favourable than another on the basis of:	**No**	**Justification/evidence and data source**
Age	No	No discrimination / inequality identified, the document sets out the Trust's approach and framework for the management of Adult Mortality, ensuring this is systematic and objective and applied without prejudice or favour.
Disability: including learning disability, physical, sensory or mental impairment.	No	
Gender reassignment	No	
Marriage or civil partnership	No	
Pregnancy or maternity	No	
Race	No	
Religion or belief	No	
Sex	No	
Sexual orientation	No	
Human Rights – are there any issues which might affect a person's human rights?	**No**	**Justification/evidence and data source**
Right to life	No	No impact on human rights, the document sets out the Trust's approach and framework for the management of Adult Mortality, ensuring this is systematic and objective and applied without prejudice or favour. The aim being to reduce risks to the organisation, its services and the safety and well-being of patients, visitors, staff and the wider public.
Right to freedom from degrading or humiliating treatment	No	
Right to privacy or family life	No	
Any other of the human rights?	No	

Assessment carried out by: **Alan Clark**

Date:

Signature and Job Title:

Appendix G: Glossary and Abbreviations

Action	A response to control or mitigate a risk
Action Plan	A collection of actions that are specific, measurable, achievable, realistic and targeted.
Board Assurance Framework (BAF)	A matrix setting out the organisation's strategic objectives, the risks to achieving them, the controls in place to manage them and the assurance that is available
BoD	Board of Diorectors
Clinical Audit	A quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit previously stated standards
Corporate Governance	The system by which Boards of Directors direct and control organisations in order to achieve their objectives
CQC	Care Quality Commission
Escalation	Referring an issue to the next appropriate management level for resolution, action, or attention
GACA	Governance and Clinical Assurance Committee
LeDeR	Learning Disabilities Mortality Review Programme
MBRRACE-UK	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK
NHSLA	NHS Litigation Authority
NICE	National Institute for Health and Care Excellence
NPEU	National Perinatal Epidemiology Unit
RCOG	Royal College of Obstetrics and Gynaecology
Risk	The uncertainty of outcome of activity, described as the combination of likelihood and consequence, including perceived importance
Risk Management	The processes of identifying, assessing & judging risks, assigning ownership, taking actions to mitigate & anticipate them, monitoring and reviewing progress
Risk Register	A tool for recording identified risks and monitoring actions and plans against them
Strategy	A document that sets out the corporate approach to a particular area or work activity. This is sometimes described as a policy, particularly outside the NHS

Appendix H: Implementation Timetable

March 2017	Agreement of the Clinical Audit Forward Plan at Safety Senate
March 2017	Discussion of the Adult Mortality Strategy at the Executives' Meeting
March 2017	Discussion of the Adult Mortality Strategy at GACA
April 2017	Commencement of data collection using the Adult Mortality Audit Sheet
April 2017	Presentation of the Adult Mortality Strategy to Public Board of Directors
May 2017	Outcome data requirement following completion of SMART Action Plans
July 2017	Draft Adult Mortality Dashboard presented to Effectiveness Senate
July 2017	Presentation of the first Quarterly Mortality Report to GACA
July 2017	Presentation of the first Quarterly Mortality Report to Board of Directors
August 2017	Learning Disabilities SOP / LeDeR presented to Effectiveness Senate
August 2017	Functioning Learning Disabilities SOP / LeDeR in use
August 2017	Functioning Adult Mortality Dashboard in use
September 2017	Clinical Guidelines 95% commitment met
October 2017	Second quarterly report to include adult mortality benchmarking dataset
March 2018	Clinical Audit Forward Plan content relevant to adult mortality completed
2018	Quarterly Mortality Report summary included in Quality Accounts

1. Background

Two of the major clinical services provided by Liverpool Women's NHS Foundation Trust are its maternity and its neonatal services. It is therefore understandable that key markers of our performance include our rates of stillbirth and neonatal mortality. This paper provides an update on our present position. In particular it details the ways in which expected and unexpected stillbirths and neonatal deaths are investigated.

MBRRACE-UK is a national system for the monitoring and benchmarking performance against stillbirth and neonatal death. At Liverpool Women's NHS Foundation Trust, the stabilised & adjusted extended perinatal (stillbirth plus early neonatal death) mortality rate falls into the MBRRACE-UK banding 'more than 10% higher than the average for the comparator group'. Unfortunately, the MBRRACE-UK report does not reflect the fact that this trust does not actually have a valid comparator group. This is because the trust's casemix is significantly different to our paired hospitals. In particular, we care for a lot more babies with severe cardiac defects than others and this impacts greatly on neonatal mortality in particular.

2. Neonatal Death

The last MBRRACE-UK report was produced in 2016 and it dealt with deaths from 2014. In that year, the trust had 32 neonatal deaths from babies born at Liverpool Women's and nine of these 32 were deaths of babies with severe cardiac congenital defects. If we were to exclude these cases from analysis, our neonatal mortality rate would have been 2.99/1000 which is well below the national median. We have raised this important issue with MBRRACE and they have informed us that they will in future include information in their reports that puts these cardiac deaths into a correct perspective.

Nevertheless, we take each and every event of neonatal death very seriously. MBRRACE suggest that all identified trusts should:

- Check data for case validation and data quality
- Conduct a full review of the care provision for all neonatal deaths
- Identify any local factors which might be responsible for their reported high stabilised and adjusted mortality rate
- Establish whether there are lessons to be learned to improve the quality of care provision.

All of the trust's data are now validated by its lead clinicians, all neonatal deaths undergo case review, local factors responsible for the 'high' mortality rate are identified (see above) and in each case, lessons learnt are sought and disseminated.

Specifically, all neonatal deaths are met with an initial assessment by medical and nursing leads in the department, at which time the following questions are asked:

- Does the death meet the threshold for triggering a SUDI investigation (sudden unexplained death in infancy)?
- Does the death require discussion with HM Coroner?
- Does the death require reporting as a Serious Incident?

If the death is a SUDI a police investigation takes place and this has precedence over all other investigatory work. We ask staff to make a written record of their involvement as soon as possible after the event and this can be converted into a police statement if required. If the coroner decides that a coroner's investigation is required, the baby will normally have a post mortem examination. We are only able to find out the post mortem result with the coroner's permission. Although there are usually no objections, there is often some delay.

If an SI investigation is required, this can progress at a normal pace unless there is a SUDI, which takes precedence. If the coroner's investigation is concurrent with the SI investigation, we can only normally reach a preliminary conclusion prior to the conclusion of the coroner's investigation (the coroner's investigation always takes longer than the maximum amount of time allowed by the CCG for an SI investigation).

In addition to the above, all neonatal deaths are reviewed by a multi-disciplinary panel on the neonatal unit using a standardised tool. (We are aware that the British Association for Perinatal Medicine are in the process of developing a standardised tool for neonatal mortality review and when this is available for use, it is likely that we will use this tool for future reviews.) The aim of these reviews is to agree the cause of death and to try to determine whether there were any deficiencies in care delivery and whether or not these were likely to have had any causal role in the death. Learning points are communicated to the wider team. A CESDI code is also determined at this meeting. These data are all collected prospectively on a spreadsheet and we are committing to using these data for the production of an annual perinatal death report, which will contain formalised action plans around any learning points identified.

Selected individual cases are presented in the bi-annual perinatal mortality meeting. We select cases that will be of interest to both the neonatal and maternity clinicians who are in attendance at those meetings.

A summary of the data collected from our neonatal death reviews is reported to the Cheshire and Mersey neonatal network Clinical Effectiveness Group (CEG), along with any learning points. The trust has several representatives sitting on the CEG. All deaths are also reported to the local Child Death Overview Panel (CDOP) and are discussed there. One of the neonatal Consultants from this trust attends the CDOP to inform this discussion and feed back any relevant points from the discussion.

In terms of benchmarking, the trust has several projects in addition to the MBRRACE-UK report: (i) Vermont Oxford Neonatal network – our VON data collection allow us to benchmark our VLBW and extreme preterm in-hospital mortality against other neonatal units across UK and across the world, with risk adjustment for case mix. This provides reassurance that our mortality rates are within the expected range, (ii) Quality Account – neonatal mortality (death within 28 days of birth) for babies born at LWH (all births and births from booked pregnancies) are compared with national neonatal mortality rates published by the Office for National Statistics, with adjustment for the gestation profile. This provides reassurance that our mortality rates are within the expected range, and (iii) The Neonatal Data Analysis Unit also produces an annual report on in hospital mortality for preterm babies in UK neonatal units. This also provides reassurance that our mortality rates are within the expected range.

3. Stillbirth

The Trust has a well-embedded process to follow which ensures stillbirths are reviewed effectively. The key steps are as follows:

- All stillbirths are recorded locally
- All non-fetal abnormality stillbirths are recorded as an ‘adverse event’ using the Trust Ulysses system
- Intrapartum stillbirths are automatically declared Serious Incidents (SI) and form part of the each Baby Counts review process

- The Clinical Director, Clinical Governance Lead and Head of Midwifery review all other stillbirths and agree whether a Serious Incident (SI) investigation, formal review or MDT review is required for each
- Stillbirths identified as requiring SI investigation or formal review receive a documented report identifying key learning and potential changes in practice
- Any stillbirths meeting the criteria for Each Baby Counts (EBC) are reported nationally and fully reviewed with external input (external panel members are facilitated by the Strategic Clinical Network)
- Cases reported to StEIS and EBC are logged on the Governance shared drive
- EBC cases are reviewed using a standardised proforma and has full involvement from an Obstetrician and Neonatologist with responsibility for review of Perinatal Mortality
- The Clinical Coding department send a monthly update showing all coded stillbirths so that the local list and the external coding data correlate correctly
- By recording all stillbirths locally and correlating that with information from the Clinical Coding department the Trust ensures accurate raw data on stillbirths
- All stillbirths (including those that have undergone SI or formal review) are discussed at a bi-monthly MDT. This is done using a standardised, validated proforma
- Standards of care are graded according to CESDI criteria.

The Trust produces a stillbirth report which collates all the causes & information from the review panels and investigations, benchmarks against other similar Trusts (and itself) and addresses emergent themes with an action plan. By taking this active approach to understanding the key reasons for the stillbirths we encounter, we have identified two key themes linked to stillbirth:

i) detection of small for gestational age fetuses
ii) response to reduced fetal movements.

Local guideline changes have been put in place to tackle these issues and our performance against the standards we have set for ourselves will form part of our audit forward plan for 2016-2017.

With respect to learning from serious incidents. the trust has in place local guidance for serious incident management which is consistent with the framework outlined in line ‘Serious Incident Framework: Supporting learning to prevent recurrence’. As outlined in the ‘Policy for Managing Incidents and Serious Incidents’, the purpose of reporting and investigating incidents is to ensure

that the trust learns and prevents similar incidents from occurring in the future. Following a Serious Incident Investigation, the following actions are taken:

- A full and robust action plan is created and implemented to resolve any issues or requirements identified through the investigation.
- Learning from incidents is widely shared with staff both within the team and across the Trust, via divisional and local meetings.
- A copy of the report is sent to all staff involved. Feedback is offered via educational and midwifery supervision
- Learning from investigations is reported to the CCG.

4. Conclusions

To conclude, the processes for investigating stillbirths and neonatal deaths at the Trust are robust and are tailored to the specific clinical circumstances that arise. A Stillbirth and neonatal Death Strategy is now in production under the lead of the Associate Medical Director for Clinical Governance and will be presented to GACA in April 2017.

Agenda Item No:	2017/092
Meeting:	Trust Board
Date:	March 2017
Title:	Performance Dashboard - Month 11 - February 2017
Report to be considered in Public or Private?	Public
Where else has this report been considered and when?	Performance Group, Trust Management Group, Finance, Operations Board, Finance, Performance and Business Development Board
Reference/s	Quality Strategy, Quality Schedule, CQUINS, Corporate Performance Indicators, Monitor Assurance Framework
Resource impact:	

What is this report for?	**Information**		**Decision**		**Escalation**		**Assurance**	

Which Board Assurance Framework risk(s) does this report relate to?	1. Deliver safe services 3. Deliver the best possible experience for patients and staff 4. To develop a well led, capable and motivated workforce 5 to be ambitious and efficient and make best use of available resources
Which CQC fundamental standard(s) does this report ralet to?	Good Governance Staffing Safety Complaints
What action is required at this meeting?	To Note
Presented by:	Jeff Johnson , Director of Operations
Prepared by:	David Walliker

This report covers (tick all that apply):

Strategic objetives:	
To develop a well led, capable, motivated and entrepreneurial **workforce**	✓
To be ambitious and **efficient** and make best use of available resources	✓
To deliver **safe** services	✓
To participate in high quality research in order to deliver the most **effective** outcomes	✓
to deliver the best possible **experience** for patients and staff	✓

Other:

Monitor Compliance	✓		Equality and diversity	
NHS Constitution			Integrated business plan	

Publication of this report (tick one):

This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting.		
This report will not be published under the Trust's Publication Scheme due to exemptions under S21 of the Freedomn of Information Act 2000, because the information contained is reasonable accessible by other means.		
This report will not be published under the Trust's Publication Scheme due to exemptions under S22 of the Freedomn of Information Act 2000, because the information contained is intended for future publication.		
This report will not be published under the Trust's Publication Scheme due to exemptions under S41 of the Freedomn of Information Act 2000, because such disclosure might constitute a breach of confidence.		
This report will not be published under the Trust's Publication Scheme due to exemptions under S43(2) of the Freedomn of Information Act 2000, because such disclosure would be likely to prejudice the commercial interests of the Trust.		

1. Introduction and summary

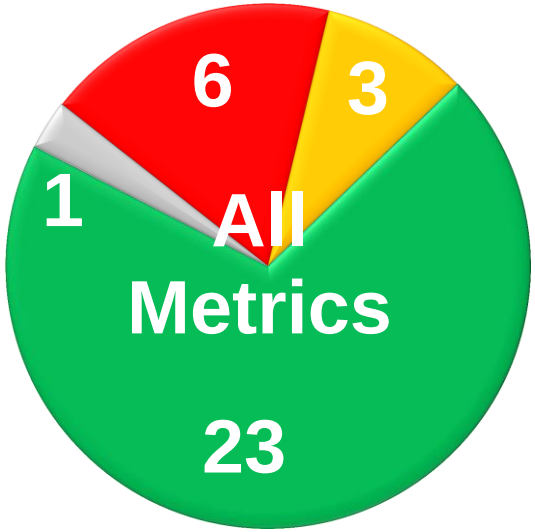
2. Issues for consideration

3. Conclusion

4. Recommendation/s

Liverpool Women's NHS Foundation Trust

Performance Report - Trust Board — Month 11 - February 2017



Performance Summary - Trust Board - Month 11 - February 2017

Overview

Of the 33 KPI's RAG rated in the Trust Board Dashboard for February 2017, 23 are rated Green, 6 are rated Red and 3 are rated as Amber. The figure for Choose and Book is not yet available nationally.

The KPI's rated as Red for February 2017 are:

- 2 x Finance KPI's reported separately via the Finance Report
- HR: Sickness & Absence Rate at 5.56% against a target of <= 4.5%
- 6 Week Wait for Diagnostic Tests at 98.6% against a target of >= 99%
- Maternity Triage within 30 Minutes at 86.16% against a target of >= 95%

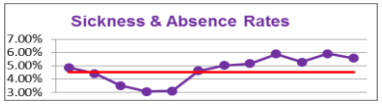
The KPIs rated as Amber for January 2017are:

- HR: Appraisals & PDR at 87**%** against a target of >= 90%
- HR: Mandatory Training at 90**%** against a target of >= 95%
- HR: Staff Turnover Rates at 13**%** against a target of <= 10%

To view the Full TMG/FPBD version of the Performance Dashboard double click the PDF icon to the right.

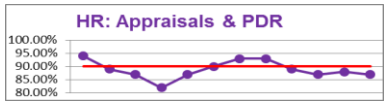
Performance Summary - Trust Board - Month 11 - February 2017

To develop a well led, Capable, Motivated and Entrepreneurial WORKFORCE



HR: Sickness & Absence Levels at 5.56% against a target of <= 4.5%

There are currently twelve services that are now rated as red. Two are rated as amber (Estates & Facilities and Trust Offices) and three are under the Trust's target figure of 3.5% and therefore rated as green (Genetics, Human Resources, and Medical Staff). T
here was a significant shift in the split between short and long term sickness absence. In month ten it was 52%/48%, while in month eleven it was 42%/58%.
In terms of the most prevalent diagnoses across the Trust, there was little change from month ten: gastrointestinal problems swapped with cold/cough/flu to become first and second most common diagnosis respectively, while anxiety/stress/depression remained the third most common.



HR: Appraisals & PDR Rates at 87% against a target of >= 90%

Ten areas are now rated as green against the Trust target figure of 90%.Of those areas that remain uncompliant: **Six** areas are rated as amber – Gynaecology, Human Resources, Maternity, Medical Staff, Surgical Services and Trust Offices.
One area is rated as red – Transport. The continuing high level of sickness absence is likely to have an effect on PDR compliance, particularly in clinical areas.

The L&D and HR teams continue to provide detailed information to managers with regards to PDR compliance in their areas of responsibility. On-going workshops are scheduled for managers and reviewers.

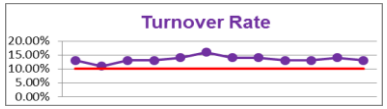
Managers are required to have plans in place to ensure that compliance targets are met and maintained, and these are regularly reviewed and updated.

HR: Mandatory Training Rates at 90% against a target of >= 95%

Eight areas are now rated as green against the Trust target figure of 95%. Of those areas that remain uncompliant: Eight areas are rated as amber – Genetics, Gynaecology, Imaging, Integrated Governance, Maternity, Medical Staff, Surgical Services and Trust Offices.
One area is rated as red – Transport.

The continuing high level of sickness absence is likely to have an effect on mandatory training compliance, particularly in clinical areas where some areas have struggled to release staff to attend training sessions. All ward and department managers are required to have appropriate plans in place to ensure that compliance rates are reached and maintained, and these are reviewed and updated each month.

There have been continuing issues with the unavailability of conflict resolution training. Dates for refresher training have now been arranged and plans are in place to facilitate new full training sessions. Similarly the availability of ILS training has been an issue with a number of recent sessions having to be withdrawn because of the withdrawal of attendees at short notice.



HR: Staff Turnover Rates at 13% against a target of <= 10%

In total, there were 11 leavers in month eleven, down from 18 in month ten.

There are currently four areas under the Trust's target figure of 10% and therefore rated as green (Hewitt Centre, Integrated Admin, Maternity & Trust Offices). No departments are rated as amber, and the remaining thirteen areas are rated as red.
Managers are provided with detailed information on turnover by the Human Resources Department so that they can identify any concerns. An overview of the outcomes of exit interviews is provided to the Putting People First Committee. The potential impact of Future Generations will continue to be monitored.
The turnover figure for the Trust has been consistently above target since September 2015. It is likely that this trend will continue for the foreseeable future although the aim is to bring the figure under target by quarter one in 2017/18.

All Linear graphs are rolling 12 months

Performance Summary - Trust Board - Month 11 - February 2017

To be EFFICIENT and make best use of available resources

Financial Report will be provided separately (3 x Red KPIs)

To deliver SAFER services

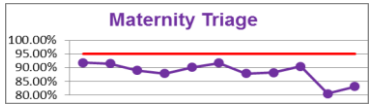
There are no Red or Amber rated KPIs in this section

To deliver the most EFFECTIVE outcomes

There are no Red or Amber rated KPIs in this section

Performance Summary - Trust Board - Month 11 - February 2017

To deliver the best possible EXPERIENCE for patients and staff

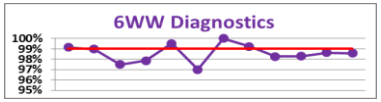


Maternity Triage within 30 minutes at 86.16% against a target of >= 95%

The MAU group are reviewing this KPI and aim to complete the work by end of April 2017.
Following this, the new targets will be introduced and tested in the first quarter. They will also be reconciled with the larger work on Trust wide performance metrics being undertaken by the Director of Ops and the Medical Director., with monthly reporting of the refined KPI following in July 2017.

The MAU task and finish group (chaired by Professor Alfirevic) is currently looking at case mix attending MAU and fine tuning the pathways and prioritisation methodology. This group will also advise on the appropriate targets for triage for the different groups. It is expected that there will be different thresholds depending on:

- Whether telephone triage has already been undertaken
- Urgency of the case (red, amber, green)



6 Week Diagnostic Waits at 98.55% against a target of >= 99%

Due to the ongoing pressures with Consultant Cystometry appointments and the small amount that are scheduled on a weekly basis, this continues to be a pressure within the service.

In the event of any consultant leave, the clinics are closed and therefore the consultant cystometry capacity is reduced. In the month of February 3 sessions were lost equating to 8 cystometry appointments. This accounts for the breaches within the month.

Consultant cystometry requests are being reviewed by the nursing staff to see if they can do the test to avoid delay in appointments.

Additional clinics are being added wherever possible to support consultant cystometry requests.
Due to ongoing planned leave clinics are reduced/cancelled.

Performance Summary - Trust Board - Month 11 - February 2017

Emerging Concerns

There are no emerging concerns from February 2017.

Conclusion

Overall, for February 2017 performance has improved in comparison to January 2017. However, most of the KPI's where the targets have not been attained have been prevalent throughout the year. These include the HR KPIs along with Maternity Triage, Diagnostic Waits. It is anticipated that overall performance will continue to improve when reporting the position for March, although some of the KPI's that the Trust has failed to achieve through the year will continue to be of concern through to the end of the financial year.

Recommendations

It is recommended that the Trust Board receives and reviews the content of the report in relation to the assurance it provides of Trust performance and request any further actions considered necessary.

Liverpool Women's NHS Foundation Trust

LWH - The Board Report 2016/17

Key: TBA = To Be Agreed. TBC = To Be Confirmed, TBD = To Be Determined, ID = In Development

To develop a well led, Capable, Motivated and Entrepreneurial WORKFORCE

Indicator Name	Ref	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Staff Friends & Family Test (PULSE)		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	
HR: Sickness & Absence Rates (Commissioner)		<= 4.5%	4.42%	3.51%	3.05%	3.09%	4.61%	5.03%	5.16%	5.88%	6.32%	5.92%	5.56%	
HR: Annual Appraisal and PDR		>= 90%	89.00%	87.00%	82.00%	87.00%	90.00%	92.00%	90.00%	89.00%	87.00%	88.00%	87.00%	
HR: Completion of Mandatory Training		>= 95%	92.00%	94.00%	94.00%	94.00%	93.00%	93.00%	93.00%	93.00%	92.00%	91.00%	90.00%	
HR: Turnover Rate		<= 10%	11.00%	13.00%	13.00%	14.00%	16.00%	14.00%	14.00%	13.00%	13.00%	14.00%	13.00%	

To be EFFICIENT and make best use of available resources

Indicator Name	Ref	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Planned Surplus/ Deficit (YTD) £'000		Planned Cumulative	£710	£1,434	£2,104	£2,282	£3,069	£3,480	£3,763	£4,460	£5,431	£5,823	£6,529	£7,000
Actual Surplus / Deficit (YTD) £'000		<= Planned	£696	£1,375	£2,027	£2,297	£3,098	£3,440	£3,741	£4,429	£5,373	£5,622	£6,207	
Planned CIP (YTD) £'000		Planned Cumulative	£167	£333	£500	£667	£833	£1,000	£1,167	£1,333	£1,500	£1,667	£1,833	£2,000
Actual CIP (YTD) £'000		>= Planned	£46	£114	£170	£226	£283	£511	£793	£1,075	£1,357	£1,357	£1,357	
Planned Cash Balance (YTD) £'000		Planned Cumulative	£1,189	£1,000	£2,242	£1,001	£1,001	£2,816	£1,001	£1,001	£1,152	£1,000	£1,853	£1,001
Actual Cash Balance (YTD) £'000		>= Planned	£4,913	£4,898	£5,395	£4,517	£4,318	£3,764	£3,568	£3,706	£4,991	£5,713	£10,546	
Planned Capital (YTD) £'000		Planned Cumulative	£119	£436	£1,113	£1,330	£1,597	£3,049	£3,156	£3,474	£3,722	£3,990	£4,098	£4,314
Actual Capital (YTD) £'000		>= Planned	£89	£220	£311	£602	£914	£1,221	£1,380	£1,549	£2,271	£2,383	£2,981	
Monitor: Financial Sustainability Risk Rating: Capital Cover		1	1	1	1	1	1	1	4	4	4	4	4	
Monitor: Financial Sustainability Risk Rating: Liquidity		2 (1 from Sep 2016)	2	2	1	1	1	1	4	4	4	3	4	
Monitor: Financial Sustainability Risk Rating: I & E Margin		1	1	1	1	1	1	1	4	4	4	4	4	
Monitor: Financial Sustainability Risk Rating: Variance to Plan		4	4	4	4	3	3	4	1	1	1	1	1	
Monitor: Financial Sustainability Risk Rating: Overall Score		2	1	2	2	2	2	2	3	3	3	3	3	
Monitor: Financial Sustainability Risk Rating: Agency Cap		0	51	25	57	88	75	68	138	177	136	158	157	

Liverpool Women's NHS Foundation Trust

LWH - The Board Report 2016/17

Key: TBA = To Be Agreed. TBC = To Be Confirmed, TBD = To Be Determined, ID = In Development

To deliver SAFER services

Indicator Name	Ref	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Safer Staffing Levels (Overall - includes Registered and Care Staff)		>= 90%	92.78%	91.92%	92.60%	91.72%	86.86%	89.53%	89.14%	93.55%	89.35%	93.58%	93.07%	
Serious Incidents: Number of Open SI's		Monitoring Only	23	23	20	20	20	14	17	15	16	18	18	
Serious Incidents: Number of New SI's		Monitoring Only	1	2	4	2	2	2	5	3	5	3	1	
% of women seen by a midwife within 12 weeks		>= 90%	96.82%	85.53%	95.70%	94.88%	91.78%	93.28%	92.38%	93.91%	93.38%	91.88%	94.77%	
Neonatal Bloodstream Infection Rate		TBD	1.11	0.00	0.00	1.30	0.36	0.19	0.00	0.00	0.42	0.20	0.64	

To deliver the most EFFECTIVE outcomes

Indicator Name	Ref	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Cancer: Referral to Treating Trust by day 42	EXP_11	100%	50%	50%	50%	100%	None	100%	100%	0%	50%	100%	100%	
Biochemical Pregnancy Rates		> 30% TBC	45.94%	47.62%	46.21%	44.70%	47.13%	48.63%	45.58%	45.13%	54.00%	46.88%	47.19%	
Still Birth Rate (excludes late transfers)		TBD	0.00	0.01	0.01	0.01	0.00	0.00	0.00	0.00	0.00	0.00	0.01	
Neonatal Deaths (all live births within 28 days)		Rate per 1000 TBD	4.35	1.44	2.90	6.65	1.33	2.66	0.00	2.73	2.92	2.74	5.47	
Returns to Theatre		<= 0.7% TBC	0.64%	1.03%	0.50%	0.51%	0.22%	0.21%	0.32%	0.56%	0.74%	1.18%	0.12%	

To deliver the best possible EXPERIENCE for patients and staff

Indicator Name	Ref	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Maternity: Triage within 30 minutes	KPI_35	>= 95%	91.50%	89.05%	87.86%	90.17%	91.66%	87.90%	88.24%	90.49%	80.48%	83.12%	86.16%	
Number of Complaints received		<= 15	15	5	13	18	13	19	16	10	8	11	9	
18 Week RTT Incompletes (aggregate)		>= 92%	95.71%	95.90%	93.86%	95.20%	94.28%	92.63%	92.20%	93.03%	92.86%	92.68%	92.74%	
Friends & Family Test		> 75%	99.26%	98.47%	98.60%	97.52%	98.37%	99.11%	98.51%	97.85%	98.78%	98.04%	100.00%	
% Women that requested and Epidural, but weren't given one for non-clinical reasons		<= 5%	6.37%	3.66%	6.29%	6.04%	5.45%	5.66%	7.56%	7.58%	4.32%	5.92%	4.14%	
% Women given one to one care whilst in established Labour (4cm dilation)		>= 95%	96.86%	96.08%	94.44%	95.74%	95.60%	93.23%	95.97%	99.12%	97.09%	97.50%	98.17%	
6 Week Wait Diagnostic Tests		>= 99%	98.96%	97.47%	97.85%	100%	97.00%	100%	99.22%	98.26%	98.3%	98.6%	98.6%	
Last Minute Cancellation for non-clinical reasons		<= 4%	4.30%	6.31%	5.81%	5.01%	4.79%	4.20%	2.64%	5.28%	4.40%	8.01%	2.65%	
Last Minute Cancellation for non-clinical reasons (Not re-admitted within 28 days)		0	0	0	0	0	0	0	0	0	0	0	0	
Failure to ensure that sufficient appointment slots are available on Choose & Book		< 6%	16.29%	13.23%	3.13%	22.48%	18.47%	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	

Liverpool Women's NHS Foundation Trust

Safe Staffing Report Month 11 - February 2017

Ward	RN/RM			Unqualifed			Staff Availability		Care Delivery		Nurse Sensitive Indicators									Patient Experience	
	Fill Rate Day%	Fill Rate Night%	RN/RM CHPPD	Fill Rate Day%	Fill Rate Night%	Total Workforce CHPPD	Sickness %	Vacancy %	Numis Indicators (N)	Numis indicators achieved (N)	Red Flag Incidents Reported (N)	CDT	MRSA	Falls no harm (n)	Falls Harm (N)	HAPU grade 1&2	HAPU Grade 3&4	Drug Admin Errors	New Complaints	FFT (no of responses)	% Recommend this hospital
Gynae	96.6%	95.8%	4.5	97.2%	95.9%	2.7	1.96%	17%			0	0	0	1	0	0	0	0	0	27	100%
Narrative	17% vacancy. The vacancy factor includes posts that will be transacted as CIP as part of the inpatient redesign project. This will be transacted on 1st April 2017 when the new budgets are in the system. Staffing levels have been reviewed in line with the workforce review and a quality impact assessment under taken. A member of staff assisted a patient to the bathroom. Whilst in the bathroom the patient turned around and lost her balance. This resulted in a bang to the head. The patient was reviewed by a doctor. No injury was sustained. The patient was closely monitored and reviewed again , as a precaution. Red flag incident: a patient attended GYOPD with a support worker. The patient attended the wrong clinic and an error had been made by the doctor when completing the clinic out come sheet. apologies given to the patient and a correct appointment made.																				
Gynae 2																					
Merged with Ward 1																					
Delivery & Induction Suites	87.2%	91.4%	27.3	114.3%	67.9%	4.2	3.13%	9%			0	0	0	0	0	0	0	0	1	N/A	N/A
Narrative	Delivery suite sickness has reduced this month, the ward manager is working closely with HR to ensure all staff are on the appropriate stages within the Sickness and Absence policy. There has been 1 new complaint that has been completed by the ward manager and a brief description added to the weekly brief within delivery suite.																				
Mat Base	98.5%	98.8%	4.2	84.3%	73.2%	2.3	3.60%	12%			0	0	0	0	0	0	0	1	1	10	100%
Narrative	Maternity base sickness has reduced from the previous month all staff are on the appropriate stages within the sickness and absence policy. There has been a reduction in the drug administration errors but this information has been shared with the staff in the area to highlight the common themes within the incident reporting system. There has been 1 new complaint the Matron is currently investigating the issues identified.																				
MLU & Jeffcoate	80.4%	90.3%	29.7	100.0%	96.4%	5.7	4.18%	2%			0	0	0	0	0	0	0	0	0	N/A	N/A
Narrative	MLU has seen a drop in sickness this month as staff on long term sick have returned and short term sickness has reduced, there have been no new complaints and no red flags reported																				
NICU	104.5%	105.4%	11.5	73.2%	48.2%	0.8	5.16%	12%			0	0	0	0	0	0	0	3	0	N/A	N/A
Narrative	During the month of February 2017 the overall occupancy was 76% . There were not breaches in staffing levels as staff continue to work flexibly and work additional shifts to meet the needs of the service. Although sickness rates have reduced they are still above the Trust target and this along with the continued high rate of maternity leave meant that bank usage had increased slightly. Sickness is being managed appropriately with HR support. There is currently an ongoing recruitment process to increase the establishment of Non - Registered staff at Band 3 with interviews planned for April 2017.																				

Key Fill Rate		*<80%*		*80.94.9%*		*95-109.9%*	*>110%*
Key Sickness		*> 4.5%*				*<= 4.5%*	
Key Vacancy		*> 10%*				*<= 10%*	
Key F&FT		*< 95%*				*>= 95%*	

Agenda item no:	2017/093

Meeting:	Trust Board

Date:	7 April 2017

Title:	Month 11 2016/17 Finance Report

Report to be considered in public or private?	Public

Where else has this report been considered and when?	FPBD 27 March 2017

Reference/s:	Operational Plan and Budgets 2016/17 Operational Plan 2017/18 – 2018/19

Resource impact:	-

What is this report for?	**Information**	✓	**Decision**		**Escalation**		**Assurance**	✓

Which Board Assurance Framework risk/s does this report relate to?	5a, 5b

Which CQC fundamental standard/s does this report relate to?	

What action is required at this meeting?	To note the Month 11 financial position

Presented by:	Vanessa Harris - Director of Finance/ Jenny Hannon - Deputy Director of Finance

Prepared by:	Jenny Hannon - Deputy Director of Finance

This report covers (tick all that apply):

Strategic objectives:	
To develop a well led, capable motivated and entrepreneurial workforce	
To be ambitious and efficient and make best use of available resources	✓
To deliver safe services	
To participate in high quality research in order to deliver the most effective outcomes	
To deliver the best possible experience for patients and staff	

Other:			
Monitor compliance	✓	Equality and diversity	
Operational plan	✓	NHS constitution	

Publication of this report (tick one)**:**	
This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting	✓
This report will not be published under the Trust's Publication Scheme due to exemptions under S21 of the Freedom of Information Act 2000, because the information contained is reasonably accessible by other means	
This report will not be published under the Trust's Publication Scheme due to exemptions under S22 of the Freedom of Information Act 2000, because the information contained is intended for future publication	
This report will not be published under the Trust's Publication Scheme due to exemptions under S41 of the Freedom of Information Act 2000, because such disclosure might constitute a breach of confidence	
This report will not be published under the Trust's Publication Scheme due to exemptions under S43(2) of the Freedom of Information Act 2000, because such disclosure would be likely to prejudice the commercial interests of the Trust	

1. Executive Summary

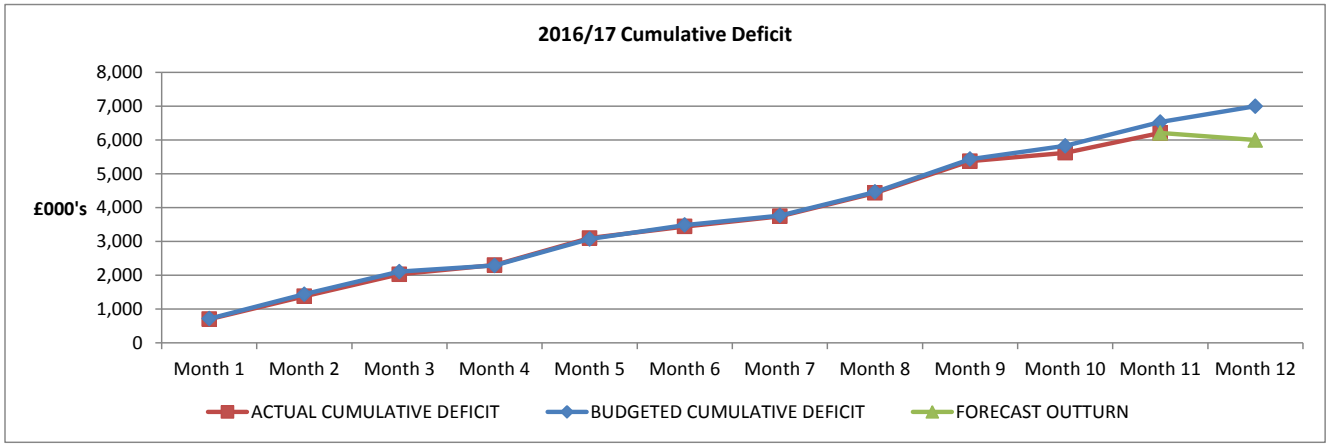
The 2016/17 budget was approved at Trust Board in April 2016. This set out a deficit of £7m for the year (as per the control total set out by NHS Improvement), an FSRR[1] of 2 and a cash shortfall of £7.7m. This planned position assumes receipt in full of £2.8m Sustainability and Transformation Funding (STF).

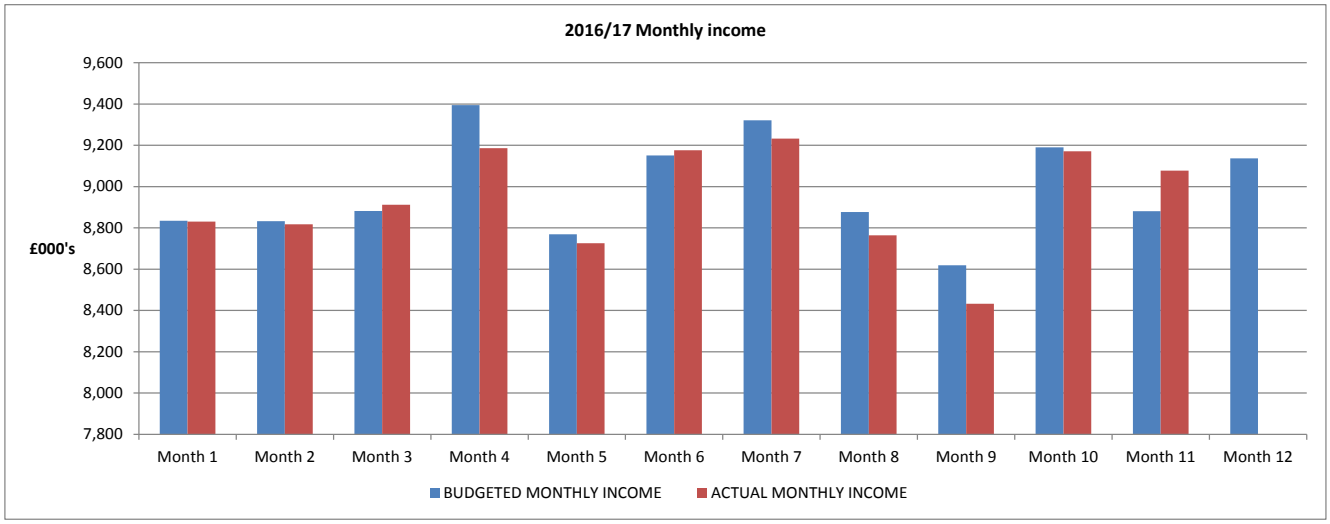
At Month 11 the Trust is reporting a monthly deficit of £0.59m against a deficit plan of £0.71m which is a positive variance of £0.12m for the month. Cumulatively the Trust is ahead of plan by £0.32m on a year to date budget of £6.5m deficit and delivering a Use of Resources Rating of 3 which is equivalent to plan.

The Trust is on track to deliver the overall 2016/17 control total. As previously reported, following detailed review the Trust is reporting a forecast outturn deficit £0.5m better than plan. This improvement will be matched by £0.5m of STF incentive funding centrally. Together this improves the 2016/17 forecast position by £1m compared to plan, which equates to a £6m deficit for the full year.

2. Summary 2016/17 Financial Position

At Month 11 the Trust is reporting a £6.2m deficit against a plan of £6.5m and is forecasting a £6.0m deficit for the year as summarised below. The £6.0m forecast deficit includes £0.5m of STF incentive funding to be recognised in Month 12.





[1] Now replaced by the Use of Resources Rating under the Single Oversight Framework

Month 11 income was ahead of plan by £0.2m. This reflects the benefit of the year end block arrangement with Liverpool, St Helens and Knowsley CCGs as well as neonatal income from Health Education England.

Pay expenditure overall remains below budget predominantly due to vacancies across a number of services including neonates, Hewitt Fertility Centre and genetics.

Non-pay expenditure is forecast to be above plan predominantly due to the non-delivery of CIP in gynaecology/theatres.

3. Service Review

Maternity
Maternity Services remain on track to out-perform budget in 2016/17. Deliveries are the main driver of income out-performance, which is being partly offset by activity-related expenditure.

Gynaecology and Theatres
Gynaecology activity is forecast to be ahead of plan overall, predominantly across general gynaecology. However, high agency costs in theatres and the non delivery of the inpatient CIP in year continue to more than offset this.

Neonates
Neonates is forecast to outperform budget following the receipt of non-recurrent monies from Health Education England and an improvement in the Welsh income position, along with non-recurrent underspend arising from vacancies.

Hewitt Fertility Centre (HFC)
The HFC financial position remains impacted by three key issues

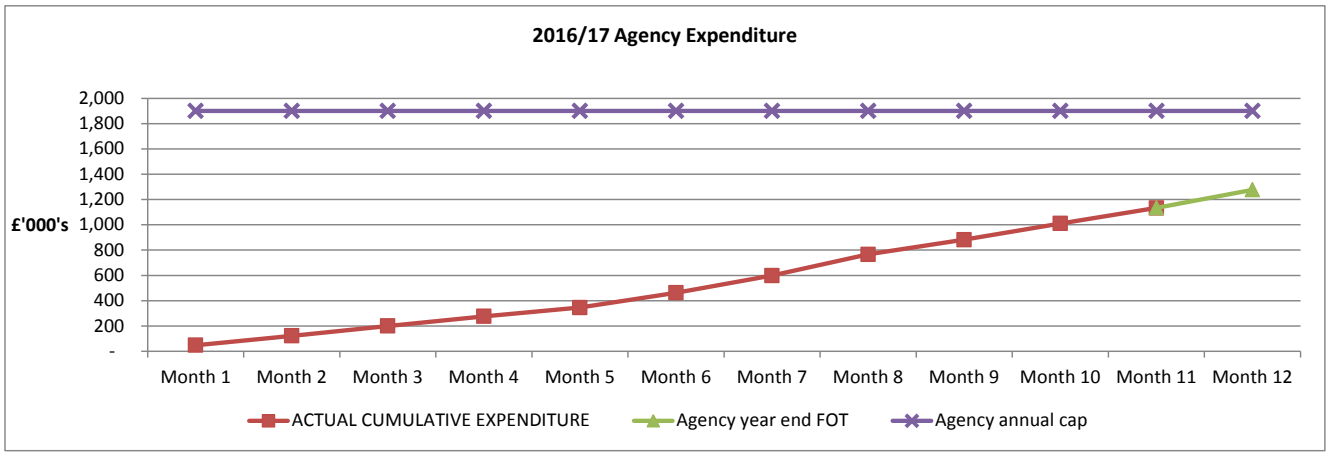
a) Non-delivery of the Kings Joint Venture contribution (CIP scheme) and subsequent losses
b) Deterioration of the North West business
c) Slippage in the delivery of the recovery plans

The financial impact to date is a net £1.1m behind plan with a projected £1.2m full year shortfall. The position includes some mitigations already put in place and takes into account the further loss of planned activity and the share of a loss in relation to the Kings Joint Venture. Focus remains within this area.

Genetics
Genetics income is behind plan year to date as a result of underperformance on the 100,000 genomes contract and decreased lab activity due to staff shortages. However, the majority of the income shortfall is offset by a reduction in pay costs and the service is effectively on plan overall with recovery expected across the 100,000 genome program going forward.

4. Agency Spend

The chart below illustrates the level of agency spend against budget and in terms of the agency cap set for the Trust.



The Trust has supported the agency rules which were introduced last year and is adhering to the actions set out in NHSI's letter of 17 October 2016.

5. CIP Delivery

The Trust has an annual CIP target in 2016/17 of £2m, which represents c2% of the Trust's budgets. This is made up of ten schemes and has been transacted through the ledger as part of budget setting.

Under-delivery across the CIP schemes is £1m for the full year. This arises from two schemes each valued at £0.5m, Hewitt Fertility Centre growth and theatre/inpatient redesign. Non-recurrent mitigations at a Trust level are in place and significant focus has been placed in these two areas to minimise the impact on future years.

A full post implementation review on the 2016/17 schemes will be presented to Finance, Performance and Business Development Committee in April 2017.

6. Cash and borrowings

During 2015/16 the Trust was in receipt of £5.6m Interim Revenue Support from the Department of Health (DH). This is in addition to £5.5m of ITFF capital funds previously drawn down in relation to the Hewitt Fertility expansion and which is now in the process of being repaid at a principle sum of £0.6m per annum.

The Trust's financial plan for 2016/17 indicated a further requirement for cash of £7.7m. The Trust has been utilising a DH working capital facility to manage cash requirements to date. This attracted an interest rate of 3.5%. During January 2017 the Trust was able to convert the working capital facility to an uncommitted loan facility with DH at an improved rate of 1.5%. This rate is available as a result of the Trust being on target to meet the 2016/17 control total.

At Month 11 the Trust has utilised £3.65m of cash from DH. A further drawdown of £3.34m in Month 12 takes the full year borrowings to £6.99m.

The cash balance as at the end of Month 11 was £10.5m, this was significantly higher than plan as a result of CCG's paying Month 12 income in advance and the receipt of PDC funding awarded for 100,000 genomes IT capital.

7. BAF Risk

There are no changes proposed in relation to the BAF risks.

8. Conclusion & Recommendation

The Board are asked to note the Month 11 financial position.

Appendix 1 – Board pack

Board Finance Pack
M11 Linked Pack.xlsx

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

FINANCE REPORT: M11

YEAR ENDED 31 MARCH 2017

Contents

USE OF RESOURCES RISK RATING	YEAR TO DATE Budget	YEAR TO DATE Actual	YEAR Budget	YEAR FOT
CAPITAL SERVICING CAPACITY (CSC)				
(a) EBITDA + Interest Receivable	(478)	(639)	(400)	165
(b) PDC + Interest Payable + Loans Repaid	2,231	2,042	2,712	2,480
CSC Ratio = (a) / (b)	**(0.21)**	**(0.31)**	**(0.15)**	**0.07**
NHSI CSC SCORE	4	4	4	4
Ratio Score **1** = > 2.5 **2** = 1.75 - 2.5 **3** = 1.25 - 1.75 **4** = < 1.25				
LIQUIDITY				
(a) Cash for Liquidity Purposes	(5,408)	(4,527)	(8,924)	(3,041)
(b) Expenditure	99,238	98,941	108,297	107,864
(c) Daily Expenditure	301	300	301	300
Liquidity Ratio = (a) / (c)	**(18.0)**	**(15.1)**	**(29.7)**	**(10.1)**
NHSI LIQUIDITY SCORE	4	4	4	3
Ratio Score **1** = > 0 **2** = (7) - 0 **3** = (14) - (7) **4** = < (14)				
I&E MARGIN				
Deficit (Adjusted for donations and asset disposals)	6,523	6,204	6,992	6,013
Total Income	(98,293)	(98,608)	(107,387)	(108,333)
I&E Margin	**-6.64%**	**-6.29%**	**-6.51%**	**-5.55%**
NHSI I&E MARGIN SCORE	4	4	4	4
Ratio Score **1** = > 1% **2** = 1 - 0% **3** = 0 - (-1%) **4** < (-1%)				
I&E MARGIN VARIANCE FROM PLAN				
I&E Margin (Actual)		-6.29%		-5.55%
I&E Margin (Plan)		-6.64%		-6.51%
I&E Variance Margin	**0.00%**	**0.34%**	**0.00%**	**0.96%**
NHSI I&E MARGIN VARIANCE SCORE	1	1	1	1
Ratio Score **1** = > 0% **2** = (1) - 0% **3** = (2) - (1)% **4** = < (2)%				
AGENCY SPEND				
YTD Providers Cap	1,764	1,764	1,924	1,924
YTD Agency Expenditure	649	1,133	708	1,276
	-63.20%	**-35.76%**	**-63.20%**	**-33.68%**
NHSI AGENCY SPEND SCORE	1	1	1	1
Ratio Score **1** = < 0% **2** = 0% - 25% **3** = 25% - 50% **4** = > 50%				
Overall Use of Resources Risk Rating	3	3	3	3

Note: NHSI assume the score of the I&E Margin variance from Plan is a 1 for the whole year and year to date budget. This is because NHSI recognise the fact that an organisation would not "plan" to have a variance from plan and have not applied a calculated ratio to the budgeted columns of this metric.

Note: scoring a 4 on any of the metrics will lead to a financial override score of 3.

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
INCOME & EXPENDITURE: M11
YEAR ENDED 31 MARCH 2017

INCOME & EXPENDITURE £'000	MONTH Budget	MONTH Actual	MONTH Variance	YEAR TO DATE Budget	YEAR TO DATE Actual	YEAR TO DATE Variance	YEAR Budget	YEAR FOT	YEAR Variance
Income									
Clinical Income	(8,297)	(8,312)	15	(92,329)	(92,255)	(74)	(100,881)	(101,318)	436
Non-Clinical Income	(584)	(765)	181	(6,422)	(6,034)	(388)	(7,006)	(6,696)	(310)
Total Income	**(8,881)**	**(9,077)**	**196**	**(98,751)**	**(98,288)**	**(463)**	**(107,887)**	**(108,013)**	**126**
Expenditure									
Pay Costs	5,613	5,420	192	61,738	60,705	1,033	67,352	66,223	1,129
Non-Pay Costs	2,234	2,532	(298)	24,386	25,122	(736)	26,638	27,334	(696)
CNST	1,192	1,192	0	13,115	13,115	0	14,307	14,307	0
Total Expenditure	**9,039**	**9,144**	**(106)**	**99,238**	**98,941**	**297**	**108,297**	**107,864**	**433**
EBITDA	**157**	**67**	**90**	**487**	**653**	**(166)**	**410**	**(150)**	**559**
Technical Items									
Depreciation	375	312	63	4,125	3,833	292	4,500	4,314	186
Interest Payable	35	77	(42)	385	296	89	420	325	95
Interest Receivable	(1)	(1)	1	(9)	(14)	5	(10)	(16)	6
PDC Dividend	140	131	9	1,540	1,440	100	1,680	1,543	137
Profit / Loss on Disposal	0	0	0	0	0	0	0	0	0
Total Technical Items	**549**	**518**	**31**	**6,041**	**5,554**	**487**	**6,590**	**6,166**	**425**
(Surplus) / Deficit	**707**	**585**	**121**	**6,528**	**6,207**	**321**	**7,000**	**6,016**	**984**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
EXPENDITURE: M11
YEAR ENDED 31 MARCH 2017

EXPENDITURE £'000	MONTH Budget	MONTH Actual	MONTH Variance	YEAR TO DATE Budget	YEAR TO DATE Actual	YEAR TO DATE Variance	YEAR Budget	YEAR FOT	YEAR Variance
Pay Costs									
Board, Execs & Senior Managers	337	320	17	3,710	3,671	39	4,047	4,021	26
Medical	1,271	1,157	114	13,977	13,548	429	15,248	14,747	501
Nursing & Midwifery	2,504	2,405	99	27,543	26,699	844	30,047	29,097	951
Healthcare Assistants	391	382	9	4,300	4,259	41	4,691	4,652	39
Other Clinical	543	515	28	5,970	5,518	452	6,513	6,032	481
Admin Support	162	159	3	1,784	1,817	(33)	1,946	1,983	(37)
Corporate Services	355	361	(6)	3,904	4,060	(157)	4,259	4,415	(156)
Agency & Locum	50	122	(72)	550	1,133	(583)	600	1,276	(676)
Total Pay Costs	**5,613**	**5,420**	**192**	**61,738**	**60,705**	**1,033**	**67,352**	**66,223**	**1,129**
Non Pay Costs									
Clinical Suppplies	737	730	8	8,105	8,126	(21)	8,858	8,862	(4)
Non-Clinical Supplies	615	923	(308)	6,586	7,308	(722)	7,203	7,901	(699)
CNST	1,192	1,192	0	13,115	13,115	0	14,307	14,307	0
Premises & IT Costs	415	417	(2)	4,568	4,552	16	4,983	4,977	7
Service Contracts	466	462	4	5,127	5,136	(9)	5,594	5,594	(0)
Total Non-Pay Costs	**3,426**	**3,724**	**(298)**	**37,501**	**38,237**	**(736)**	**40,945**	**41,641**	**(696)**
Total Expenditure	**9,039**	**9,144**	**(106)**	**99,238**	**98,941**	**297**	**108,297**	**107,864**	**433**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 4
BUDGET ANALYSIS: M11
YEAR ENDED 31 MARCH 2017

INCOME & EXPENDITURE £'000	MONTH Budget	MONTH Actual	MONTH Variance	YEAR TO DATE Budget	YEAR TO DATE Actual	YEAR TO DATE Variance	YEAR Budget	YEAR FOT	YEAR Variance
Maternity									
Income	(3,320)	(3,386)	66	(37,317)	(37,900)	582	(40,771)	(41,431)	660
Expenditure	1,698	1,777	(79)	18,679	19,028	(350)	20,378	20,816	(438)
Total Maternity	**(1,622)**	**(1,609)**	**(13)**	**(18,639)**	**(18,871)**	**233**	**(20,393)**	**(20,615)**	**222**
Gynaecology									
Income	(1,940)	(1,924)	(16)	(21,979)	(22,688)	710	(23,965)	(24,647)	682
Expenditure	879	943	(63)	9,673	10,207	(534)	10,554	11,165	(611)
Total Gynaecology	**(1,061)**	**(982)**	**(79)**	**(12,306)**	**(12,482)**	**176**	**(13,411)**	**(13,482)**	**71**
Theatres									
Income	(42)	(40)	(2)	(462)	(444)	(18)	(504)	(485)	(19)
Expenditure	608	623	(15)	6,689	7,036	(346)	7,298	7,688	(390)
Total Theatres	**566**	**582**	**(16)**	**6,227**	**6,592**	**(365)**	**6,794**	**7,202**	**(409)**
Neonatal									
Income	(1,409)	(1,566)	158	(15,498)	(15,523)	25	(16,908)	(17,021)	113
Expenditure	997	1,030	(33)	10,969	10,824	145	11,967	11,833	134
Total Neonatal	**(412)**	**(536)**	**125**	**(4,529)**	**(4,700)**	**171**	**(4,941)**	**(5,188)**	**247**
Hewitt Centre									
Income	(1,014)	(987)	(27)	(10,784)	(9,189)	(1,596)	(11,874)	(10,071)	(1,803)
Expenditure	733	698	35	8,057	7,520	537	8,805	8,235	570
Total Hewitt Centre	**(281)**	**(289)**	**8**	**(2,727)**	**(1,669)**	**(1,058)**	**(3,069)**	**(1,836)**	**(1,233)**
Genetics									
Income	(596)	(534)	(62)	(6,548)	(6,252)	(296)	(7,143)	(6,812)	(331)
Expenditure	446	441	5	4,911	4,646	265	5,358	5,076	282
Total Genetics	**(150)**	**(93)**	**(57)**	**(1,637)**	**(1,606)**	**(31)**	**(1,785)**	**(1,735)**	**(49)**
Clinical Support									
Income	(24)	(29)	5	(267)	(292)	26	(291)	(316)	25
Expenditure	733	709	23	8,060	7,859	201	8,793	8,568	226
Total Clinical Support	**709**	**680**	**29**	**7,793**	**7,567**	**227**	**8,502**	**8,251**	**251**
Corporate & Trust Technical Items									
Income	(536)	(609)	73	(5,896)	(6,000)	104	(6,432)	(7,230)	798
Expenditure	3,493	3,441	52	38,241	37,376	865	41,735	40,649	1,086
Total Corporate	**2,957**	**2,832**	**125**	**32,345**	**31,376**	**969**	**35,303**	**33,420**	**1,883**
(Surplus) / Deficit	**707**	**585**	**121**	**6,528**	**6,207**	**321**	**7,000**	**6,016**	**984**

BALANCE SHEET £'000	YEAR TO DATE Opening	M11 Actual	Movement
Non Current Assets	**70,529**	**69,313**	(1,216)
Current Assets			
Cash	3,225	10,546	7,321
Debtors	4,302	6,241	1,939
Inventories	326	318	(8)
Total Current Assets	**7,853**	**17,105**	**9,252**
Liabilities			
Creditors due < 1 year	(8,056)	(19,147)	(11,091)
Creditors due > 1 year	(1,748)	(1,720)	28
Loans	(10,794)	(14,139)	(3,345)
Provisions	(2,392)	(2,227)	165
Total Liabilities	**(22,990)**	**(37,233)**	(14,243)
TOTAL ASSETS EMPLOYED	**55,392**	**49,185**	**(6,207)**
Taxpayers Equity			
PDC	36,610	36,610	0
Revaluation Reserve	10,019	10,019	0
Retained Earnings	8,763	2,556	(6,207)
TOTAL TAXPAYERS EQUITY	**55,392**	**49,185**	**(6,207)**