**Meeting of the Board of Directors**
**HELD IN PUBLIC**
**Friday 2 December 2016 at Liverpool Women's Hospital at 10:00a.m.**
**Board Room**

| Item no. | Title of item | Objectives/desired outcome | Process | Item presenter | Time | CQC Fundamental Standard | BAF Risk |
|---|---|---|---|---|---|---|---|
| | Thank you to Staff | | | | 1000 10mins | | |
| 299 | Apologies for absence & Declarations of interest | Receive apologies | Verbal | Chair | | - | - |
| 300 | Meeting guidance notes | To receive the meeting attendees' guidance notes | Written guidance | Chair | | R17 – Good Governance | - |
| 301 | Patient Story | To receive a patient story | Presentation | | 1010 10mins | | |
| 302 | Minutes of the previous meetings held on 4 November 2016 | Confirm as an accurate record the minutes of the previous meetings | Written | Chair | 1020 05mins | R17 – Good Governance | - |
| 303 | 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 | - |
| 304 | Chair's announcements | Announce items of significance not elsewhere on the agenda | Verbal | Chair | 1025 15mins | R17 – Good Governance | All |
| 305 | Chief Executive Report | Report key developments and announce items of significance not elsewhere | Written | Chief Executive | | R17 – Good Governance | All |
| BOARD ASSURANCE | | | | | | | |
| 306 | Chair's Report from the Finance Performance and Business Development Committee | Receive assurance and any escalated risks | Written | Committee Chair | 1040 15mins | R17 – Good Governance | 5a-f |

| Item no. | Title of item | Objectives/desired outcome | Process | Item presenter | Time | CQC Fundamental Standard | BAF Risk |
|---|---|---|---|---|---|---|---|
| 307 | Chair's Report from the Governance and Clinical Assurance Committee | Receive assurance and any escalated risks | Written | Committee Chair | | R17 – Good Governance | 1&3 |
| 308 | Chair's Report from the Putting People First Committee | Receive assurance and any escalated risks | Written | Committee Chair | | R17 – Good Governance | |
| 309 | Chair's Report from the Charitable Funds Committee | Receive assurance and any escalated risks | Written | Committee Chair | | R17 – Good Governance | |
| 310 | Review of Terms of Reference of Board Committees | Approval | Written | Trust Secretary | | R17 – Good Governance | 5a-f, 1&3 |
| 311 | Bi annual staffing Review – Mid Year Update | To Note and receive assurance | Written | Director of Nursing and Midwifery | 1055 5mins | R18 – Safe Staffing | BAF 1&3 |
| TRUST PERFORMANCE | | | | | | | |
| 312 | Performance Report period 7, 2016/17 | Review the latest Trust performance report and receive assurance | Written | Associate Director of Operations | 1100 10mins | R12&18: Safe R17 – Good Governance | 3a |
| 313 | Finance Report period 7, 2016/17 | To note the current status of the Trusts financial position | Written | Director of Finance | 1110 10mins | R17 – Good Governance | 5 |
| TRUST STRATEGY | | | | | | | |
| 314 | Future Generations Update | To brief the Board on progress and risks | Verbal | Chief Executive | 1120 10mins | All | All |
| BOARD GOVERNANCE | | | | | | | |
| 315 | Board Assurance Framework | To review the strategic risks | written | Trust Secretary | | R17 – Good Governance | All |
| 316 | Review of risk impacts of items discussed | Identify any new risk impacts | Verbal | Chair | | R17 – Good Governance | All |

| HOUSEKEEPING | | | | | | | |
|---|---|---|---|---|---|---|---|
| 317 | Any other business & Review of meeting | Consider any urgent items of other business | Verbal | Chair | | - | - |

Date, time and place of next meeting either Friday 6 January 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 |

# Meeting attendees' guidance, May 2013

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

## Before the meeting

- Prepare for the meeting in good time by reviewing all reports
- Submit any reports scheduled for consideration at least 8 days before the meeting to the meeting administrator
- Ensure your apologies are sent if you are unable to attend and *arrange for a suitable deputy to attend in your absence
- Notify the Chair in advance of the meeting if you wish to raise a matter of any other business

*some members may send a nominated representative who is sufficiently senior and has the authority to make decisions. Refer to the terms of reference for the committee/subcommittee to check whether or not this is allowable

## At the meeting

- Arrive in good time to set up your laptop/tablet for the paperless meeting
- Switch to silent mobile phone/blackberry
- Focus on the meeting at hand and not the next activity
- Actively and constructively participate in the discussions
- Think about what you want to say before you speak; explain your ideas clearly and concisely and summarise if necessary
- Make sure your contributions are relevant and appropriate
- Respect the contributions of other members of the group and do not speak across others
- Ensure you understand the decisions, actions, ideas and issues agreed and to whom responsibility for them is allocated
- Do not use the meeting to highlight issues that are not on the agenda that you have not briefed the chair as AoB prior to the meeting
- Re-group promptly after any breaks
- Take account of the Chair's health, safety and fire announcements (fire exits, fire alarm testing, etc)

## Attendance

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

## After the meeting

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

## Standards & Obligations

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

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

Page 129 Handbook to the NHS Constitution 26th March 2013

Board Agenda item 16/302

# Board of Directors

Minutes of the meeting of the Board of Directors
held public on Friday 04 November 2016 at 1015 hrs
in the Boardroom, Liverpool Women's Hospital, Crown Street

PRESENT

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

IN ATTENDANCE

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|---|---|
| Mr Colin Reid | Trust Secretary |
| Mrs Jenny Hannon | Deputy Director of Finance |

APOLOGIES

| | |
|---|---|
| Mrs Kathryn Thomson | Chief Executive |
| Mrs Vanessa Harris | Director of Finance & Deputy Chief Executive |

**Thank You**
Before the meeting opened formally the Board expressed its thanks to:

- Russell Cowell, Information Governance
- Anne Bridson & Sarah Woods, Organisational Development
- Honeysuckle team

270 **Apologies** – as above. The Chair reported that both the Chief Executive and the Director of Finance had been requested to attend a meeting with Liverpool CCG.

**Welcome:** The Chair welcomed members of the public who were observing the Board meeting and advised they would have opportunity to ask questions of the Directors after the meeting.

**Declaration of Interests** – None

271 Meeting guidance notes

The Board noted the meeting guidance notes.

272 Liverpool Health Partners

The Chief Executive introduced Prof Sir Ian Gilmore, Chair at Liverpool Health Partners (LHP) to provide a presentation on the role, aims and vision of LHP. He advised that LHP, the Academic Health Science Centre for the North West Coast, was set up due to the region being known for its fragmentation of healthcare resources. He explained that Liverpool had long been a crucible of innovation and discovery in health care and LHP was the vehicle that would harness the experience so enhancing opportunities to improve health for the region. Prof Sir Ian Gilmore advised that the vision and ultimate goal of LHP was to provide the optimum environment for excellence, achieved through the pooling of resources and expertise from across the Partners, significantly increasing the scale and strengths of quality research and delivering these benefits more rapidly to patients.

Prof Sir Ian Gilmore explained the scope of the work undertaken by LHP in such areas as infection, musculoskeletal, therapeutics and education and the future development of informatics strategy. He went on to explain the work of the trust and its development of its future health strategies and research for the benefit of women and babies within the Liverpool footprint. Prof Sir Ian Gilmore felt that for a cohesive approach across the health providers in Liverpool it was key that the infrastructure of the services was correct, which would include the co-location of services.

In response from a question from the Chair on whether LHP had the necessary resource in order to support health providers in the co-ordination of the fragmented healthcare resource, Prof Sir Ian Gilmore advised that it would be necessary to increase the amount of subscription paid by members of the partnership to increase its capability and capacity.

The Chair, on behalf of the Board thanked Prof Sir Ian Gilmore for his presentation.

273 Archie's Story

Jennifer Deeney, Head of Neonatal Care provided the Board with a patient story that told the story of Archie, who was born at the Trust weighing 4.195kg, with his umbilical cord wrapped twice around his neck. She ran through the story explaining the ups and downs of Archie's condition and the faith the parents had in him pulling through, even when a decision could have been made on whether it was appropriate to carry on with treatment. The Board heard that after all the trial and tribulations of Archie's care, he was now a healthy 2 year old with no effects to his wellbeing.

The Board recognised the impact the care to babies can have on staff and received an update on what is done to help and support staff involved in cases on the neonatal ward, noting that although babies stay for their whole journey on the unit, staff were moved around the unit and therefore were not looking after babies for the whole of the babies journey in the unit. They were also informed that all staff was debriefed and follow up calls made to staff to make sure they had no underlying problems or concerns.

The Chair thanked the Head of Neonatal Care for her powerful presentation which was noted.

274 Minutes of previous meeting held on Friday 7 October 2016

The minutes of the meeting held on 7 October were approved, subject to the amendment to the date of the meeting in the title.

275 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.

276 Chair's Report

The Chair provided a brief verbal report:

Council of Governors Meeting: The Chair advised that the next Council of Governors meeting would be held on 19th November 2016. He recognised that this was a change of date from the original meeting date and asked everyone to attend if they were able to do so.

Annual Member Meeting: The Chair advised that the AMM was held on 11 October 2016. He advised that although well attended there was a need for greater engagement with the public and asked that consideration be given to holding the AMM with a family event next year. The Chair was reminded that the meeting was to coincide with a visit from Dr Denis Mukwege a Congolese gynecologist who was to provide a key note speech on the international day of the girl child but due to unforeseen circumstances he was unable to attend.

Governor Elections: The Chair reported that a public governor had recently resigned her post due to work commitments which made it difficult for her to commit to attending meeting. He explained that there would therefore need to be an election in the Knowsley constituency and this would be raised at the Council of Governors meeting on 19th November.

Butterfly awards: the Chair referred to the Honeysuckle Bereavement Team and congratulated them on winning the "best hospital bereavement service category" at the Butterfly Awards 2016 last month. He also thanked the team for arranging the Service of Remembrance that took place on Thursday 13th October, At the Isla Gladstone Conservatory, which he felt was a fantastic and very moving event for all who attended.

The Board noted the Chair's update report.

277 Chief Executive's report

The Director of Workforce and Marketing presented the Chief Executive Report in her absence.

The Director of Workforce and Marketing referred the Board to the items within the report, in particular drawing the Board attention to the sections:

- One Born Every Minute which was returning to the Trust for the third time.
- Agency Spend and self-certification. The Board noted the requirements of NHSI and agreed that the checklist once completed be reviewed and approved by the FPBD at its meeting on 21 November and distributed to the Board members prior to submission.
- National Whistleblowing Guardian – The Trust was privileged this week to host a visit by the recently appointed National Freedom to Speak Up Guardian, Dr Henrietta Hughes. Dr Hughes spent some time with the lead Director and the Trust's Guardian discussing the Trust's approach to support staff to raise concerns and speak up with confidence.

The Board noted the Chief Executive Report.

278 Implementation of the National Maternity Review at Liverpool Women's

The Director of Nursing and Midwifery introduced Claire Mathews, Interim Head of Midwifery and reminded the Board that it had asked for an update on the Trust's response to drive forward the recommendations of the national maternity review, 'Better Births – National Maternity Services Review' (NMSR) which was published in April 2016 and was led by Baroness Julia Cumberlege.

Interim Head of Midwifery presented the report and advised that the Review sets out what the vision means for the planning, design and safe delivery of maternity services; how women, babies and

families would be able to get the type of care they want; and how staff would be supported to deliver the care.

In response to Susan Milner's comment on the boundaries for community redesign project, the Interim Head of Midwifery advised that there were three CCGs: Liverpool CCG, Sefton CCG and Knowsley CCG and their respective local authority areas of Liverpool, Sefton and Knowsley. Referring to Multi-Disciplinary teams, the Interim Head of Midwifery advised that within the community areas, GPs were linked to and fully aware of the team of midwives within their specific hubs.

The Director of operations reported that As a pioneer site the Trust together with the Vanguard was concentrating on the nominal personalised care budget to make sure that issues arising from the proposals were expressed appropriately.

Referring to the action plan and in particular Action 5.3 - Use of electronic maternity records should be rolled out nationally, to support sharing of data and information between professionals, organisations and with the woman. Commissioners and providers should invest in the right software, equipment and infrastructure to collect data and share information, the Board noted that there would be some compatibility issues relating to the EPR system and Maternity and that funding had been made available in order to design a system that would fit Maternity needs.

The Chair thanked the Interim Head of Midwifery for her report and asked that a further update come back to the Board in February 2017.

The Board:

a) Received the Implementation of the National Maternity Review at Liverpool Women's NHSFT
b) Report;
c) noted the progress made to date;
d) supported the on-going work within vanguard; and
e) confirmed on going reporting requirements from the division to the board.

*Action 16/278: 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.*

279 **Chair's Report from the Finance, Performance and Business Development (FPBD) Committee**

Ian Haythornthwaite presented the Chair's Report from the Finance Performance and Business Development Committee held on 24 October 2016. He advised that there was nothing that needed to be brought to the attention of the Board and that both the Financial and Operational performance would be dealt with under their own agenda items later in the meeting.

The Chair thanked Ian Haythornthwaite for his report which was noted.

280 **Chair's Report from the Audit Committee**

Ian Haythornthwaite reported on the Chair's Report from the Audit Committee held on 24 October 2016.

Ian Haythornthwaite advised that good progress had been made against the Internal Audit plan although there was concern regarding a number of audits that had been deferred by the responsible executive and this would be fed back to the Executive. He reported that the Committee's expectation was that any proposed changes made to the Audit Plan would need to be agreed by the Executive Team prior to seeking Committee agreement including justification on why the proposed change was required.

Referring to the register of Waivers of Standing Orders, Ian Haythornthwaite advised that the number

of waivers had continued to fall from previous reports and explained that the common reason for most waivers was 'sole supplier'. He felt it was important that any future procurement exercise should seek to address the potential future costs from a sole supplier source.

Ian Haythornthwaite advised that as part of the review of review of the External and Internal Audit the Committee agreed to extend the appointment period of the external auditor. As required a recommendation would be made to the Council of Governors on the re-appointment of the External Auditors at the next Council meeting in November.

Ian Knight referred to the delivery of CIP and although recognised this was not the work of the Audit Committee asked for further detail on the reconciliation of over versus under delivery of CIP and over and under delivery of activity. Ian Haythornthwaite advised that it was important that the process against which CIP was identified and approved was robust enough as the Trust moves forward. The Director of Nursing explained the process undertaken in assessing the appropriateness of schemes so that quality and safety was not compromised.

Ian Haythornthwaite concluded his report by notifying the Board that the last Audit Committee meeting was his last as Chair and advised that from 1 January, Ian Knight would take over as Chair of the Committee.

The Chair thanked Ian Haythornthwaite for his report and for chaining the committee over the last five years. He reported that Ian Haythornthwaite would remain on the Audit Committee as a member of the Committee.

281 Quality, Operational Performance report Period 6 2016/17

The Director of Operations presented the Performance Dashboard.

The Director of Operations drew the Board attention to the three areas that continued to underperform: Women given one to one care whilst in established Labour; Maternity Triage; and Women that requested and Epidural, but weren't given one for non-clinical reasons. He reported that each of these performance measures were being addressed and reported through the relevant committees within the governance structure.

The Director of Operations reported on the introduction of daily huddles across all areas within the Trust and advised that having these had resulted in the ability to move available resources into areas of need. He explained that this had shown a greater degree of flexibility in staff and allowed for management of staff appropriately and safely.

The Chair referring to the agency cap asked where the biggest user of agency staff was. In response the Director of Operations reported that Theatre's continued to be the biggest user, explaining that this was a national problem due to the shortages of qualified staff and explained that the matter had been discussed at the FPBD committee to give additional assurances around what the trust was doing to address the problems. David Astley advised that it was important that the Board supported the executives in delivering the action plan recognising that this was a national rather than local problem.

The Board reviewed the Quality and Operational Performance Report and recognised the work being done to address emerging concerns and non-compliant indicators.

282 Financial Report & Dashboard Period 6 2016/17

The Deputy Director of Finance presented the Finance Report and financial dashboard for month 6, 2016/17 and reported that Trust was reporting a monthly deficit of £0.342m against a deficit plan of £0.411 which was a positive variance of £0.069m for the month. Cumulatively the Trust was slightly ahead of plan by £0.039m and achieved a Financial Sustainability Risk Rating (FSRR) of 2 against a

plan of 2. She advised that the Trust was on target to deliver its annual control total of £7m deficit assuming receipt of the full £2.8m Sustainability and Transformation Funding.

The Chair referring to the capital expenditure asked whether a reduction in capital spend put at risk the maintenance and replacement of equipment. In response the Deputy Director of Finance advised that all capital spend is risk assessed to identify any potential current and future needs, with critical items being addressed as they arose.

The Chair thanked the Deputy Director of Finance for her report which was noted.

283 Future Generations

The Chief Executive reported that there had been no change since the last report to the Board when she updated the Board on the NHS Liverpool CCG's options appraisal for women's and neonatal services and pre-consultation engagement exercise.

The Chair thanked the Chief Executive for her update which was noted.

284 Review of risk impacts of items discussed

The Board noted the risks had been discussed during the meeting and the following had been highlighted:

- not meeting the financial control total in year
- staffing and estates
- EPR – issue regarding Community Maternity.

285 Any other business & Review of meeting

None

Conduct of the meeting was excellent with good challenge, scrutiny and assurance.

Date and time of next meeting
2 December 2016

Liverpool Women's NHS Foundation Trust

**16/303**

TRUST BOARD
Action Plan

| Meeting date | Minute Reference | Action | Responsibility | Target Dates | Status |
|---|---|---|---|---|---|
| 4 Nov 2016 | 16/278 | 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 | Action ongoing. |
| 7 Oct 2016 | 16/255 | 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 | March 2017 | The Executive undertook a review of the BAF and following discussion agreed that a number of risks could be re-defined such that there would be a movement of some risks on the BAF to the corporate risk register. The BAF requires additional work to re-define the risks. This will be completed and reviewed by the Board committees and brought back to the Board in March with proposed changes.<br><br>Action ongoing. |

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| **Agenda item no:** | 16/305 |

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| **Meeting:** | Board of Directors |

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|---|---|
| **Date:** | 2 December 2016 |

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|---|---|
| **Title:** | Chief Executive's Report |

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| **Report to be considered in public or private?** | Public |

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

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| **Reference/s:** | N/A |

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| **Resource impact:** | - |

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

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

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

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

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| **Presented by:** | Kathryn Thomson, Chief Executive |

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| **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.**

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## SECTION A - INTERNAL

**Fit for Future Generations - Outpatients Survey:** During the week 28 November – 02 December 2016 members of Liverpool Women's *Fit for Future Generations* Team will be in Outpatients to conduct a short survey with patients. Patients will be asked to share their views about their experience of Outpatients. This piece of work is looking to improve the patient experience in Outpatients.

**St Paul's Eye Unit collaboration:** The latest development of our collaboration with partners saw the Royal Liverpool Hospital's St Paul's Eye Unit move some of its services onto the Liverpool Women's site, from 18th November. St Paul's Eye Unit requires additional theatre capacity to achieve and maintain the 92% Active Pathways Target. There are 4 Day Case Theatres for St Paul's on the Royal Liverpool site that are fully utilised so they will be running 1 theatre per week at Liverpool Women's in theatre space and on Rosemary Ward. All services will be undertaken by Royal Liverpool Hospital staff for their patients and services only.

**Thursday, 17th November 2017 was #WorldPrematurityDay** - thank you to all our amazing families for sending in their Inspirational, Miracle Babies pictures

**LWH launches LifeStart Trolley:** The Trust is the first hospital in the UK to introduce bedside neonatal care for all births – even for babies that need resuscitation. Prior to this new born babies who needed help with breathing straight after birth had to be taken away from their mothers to a large resuscitation unit. The new LifeStart trolley, developed in Liverpool, allows the new born to be looked after at the mother's bedside.

**National Awards:** The Trust has been shortlisted a number of top national awards including Health Service Journal (HSJ) and Royal Collage of Midwives (RCM) Awards.

> At the **HSJ Award** held on Tuesday 23 November the Trust was nominated for two awards in the 'Using Technology to Improve Efficiency' category and the 'Patient Safety Category' (previously reported in the CEO Report 2 September2016). Although not successful it was great to see the Trust staff getting recognition for the work they do.
>
> The Trust would like to congratulate Liverpool CCG who won the 'Clinical Commissioning Group of the year' HSJ award
>
> **Royal Collage of Midwives (RCM) Awards:** The Bereavement Service at the Trust has been recognised for a number of Awards, most recently winning a national Butterfly Award (reported last month). They have also been shortlisted for a RCM and NHS Leadership Award. The team provides support and care to anyone suffering a baby loss.

SECTION B - LOCAL

**Review of Liverpool Women's Services:** Following the pre-consultation engagement events in the summer, the business case to form the formal consultation into the future of Liverpool Women's services is currently going through NHS England's assurance process. Once this process concludes, the Trust, along with Liverpool CCG, will be in a position to share specific options for change. This will be followed by a formal public consultation which is currently being planned to start in January 2017. However, these timescales are dependent on a number of factors before they can be confirmed and staff will be kept up to date on progress over the coming weeks.

**Liverpool Community Health (LCH) NHS Trust:** NHS Improvement announced on 24 November 2016 that Bridgewater Community Healthcare NHS Foundation Trust and Mersey Care NHS Foundation Trust are the named as the preferred providers of Liverpool Community Health (LCH) NHS Trust services from April 2017. Under the proposed change, Bridgewater will run the Trust's Liverpool services as the contract holder in partnership with Liverpool City Council and Liverpool General Practice Provider Organisation, and Mersey Care would run its Sefton services. Bridgewater will also run the community dental contracts currently covered by LCH subject to final agreement. This follows LCH's decision in January 2015 to halt plans to become a Foundation Trust and instead focus on hiring extra nurses and providing better out-of-hospital. The announcement means NHS Improvement, NHS Liverpool CCG, NHS South Sefton CCG, NHS Southport and Formby CCG, Bridgewater and Mersey Care can now complete financial and regulatory checks before the new arrangements are confirmed early next year.

SECTION C – NATIONAL

**Publication of the Cheshire & Merseyside Sustainability and Transformation Plan (STP):** The Cheshire & Merseyside STP is a plan for how health services across the region will develop over the next few years to provide better quality services. The final version and official publication of the Cheshire & Merseyside STP took place last week and is available via the Trust website. The STP includes specific reference to Liverpool Women's with proposed timescales for change. It should be remembered when viewing the document that these are broad plans for the region and extensive engagement activities will be undertaken with all stakeholders when more specific Trust level plans are developed.

16/306

**Board of Directors**

**Committee Chair's report of Finance Performance and Business Development Committee meeting held 21 November 2016**

## 1. Agenda items covered

- Month 7 Finance Report: The Committee was assured that the Trust was still on target to deliver the control total at year end even though there was recognition of variations with the plan (including CIP). The Committee asked for additional financial information that provided a reconciliation of activity, CIP and contingencies.
- Performance dashboard, Month 7: the Committee noted that the Trust continued to deliver against the NHSI performance targets. The Committee noted that GACA were looking at the Target for Maternity Triage which was escalated from FPBD last month. The Committee noted that even though the Trust was finding it difficult to deliver against this target no patients were put at risk.
- Agency Governance – Self certification Checklist: the Committee received a report on the checklist arising from NHSI's letter 'Taking further action to reduce agency spend' and approved on behalf of the Board, as delegated, the checklist presented. The Committee noted that the Trust was in the top 3 performing trusts in achieving agency cap.
- 2017/18 and 2018/19 Operational Plans and Financial Control Totals. The Committee received the financial part of the Operational Plan and control totals for 2017/18 and 2018/19. The Committee noted the key areas that could underperform in 2017/18 which would have a potential impact on delivery of the control total, further noting that non delivery of the control totals would likely place organisations into special measures.
- In-patient redesign: the Committee received paper on the proposed changes to Gynaecology In-patient redesign and the potential CIP savings that the redesign could deliver in 2016/17 and 2017/18. It was noted that the majority of CIP would be delivered in 2017/18.
- Turnaround and Transformation: the Committee received assurance surrounding the approach the Trust was taking in delivery of future activity and CIP that would enable the delivery of the control totals in 2016/17, 2017/18 and 2018/19.
- The Committee received an amended Terms of Reference which was approved. The amendment related to changes in reporting committees to FPBD.

## 2. Board Assurance Framework (BAF) risks reviewed

- The Committee noted the BAF risks and agreed to that risk 5aii – 'To deliver the financial plan beyond 2016/17' is increased from risk score 15 to 20 in view of the increased risk in relation to the achievement of the 2016/17 control total reported during the meeting .

## 3. Issues to highlight to Board

- Amended Terms of Reference. See Board agenda item 310

## 4. BAF recommendations

- The Board to note the change of risk score under 2 above, now contained in the Board assurance Framework at Board agenda item 314

## 5. Action required by Board

- The Board to note that approval of the Agency Governance – Self certification Checklist.

16/307

Board of Directors

Committee Chair's report of Governance and Clinical Assurance Committee meeting held 18 November 2016

1. Agenda items covered

- ~ Infection Prevention and Control Quarterly Report, Q1: The Committee noted the Trust position. The Committee agreed to receive a chairs report from the infection prevention and control committee (IPCC) and the annual report going forward. Any exceptions would be escalated to GACA. The quarterly reports would continue to be considered at IPCC.
- ~ Thematic Review of Serious Incidents: The Committee noted improvements made in numbers of incident reporting across the Trust, and is now reporting in the upper quartile, when previously in the lower. The Trust is meeting NRLS upload standards. The Committee discussed at length themes and actions, learning and sharing.
- ~ Triage and Assessment: The Committee received assurance regarding the breach in triage and assessment and cause factors. Further assurance was given relating to implications, harm and patient experience. An audit would be completed regarding breaches in MAU.
- ~ Neonatal Transport Service – Park and Ride Risk Update: The Committee noted the update and recommended a de-escalation of BAF Risk 1(m) Neonatal Transport Service Risk Register, to 8.
- ~ Quality Strategy Update (including Performance report data): Concerns were raised regarding some objectives of the Quality Strategy in terms of specific clinical outcomes. GACA agreed to receive a formal close down report in March detailing why objectives were being closed. This would then feed into the revised and updated Quality Strategy. [Note: the quality is coming to the end of its three year cycle and requires review by the Board in 2017.]
- ~ Clinical Audit Annual Report 2015/16: The Committee noted the report and the alignment of the audit programme alongside national and strategic objectives.
- ~ Complaints Annual Report 2015/16: The Committee noted plans to enhance further the complaints policy in line with new guidance.
- ~ Patient Surveys: National Cancer Patient Experience Survey: The Committee noted an overview of themes and actions resulting from the national cancer patient experience survey results.
- ~ Quarterly SEE Report Quarter 1 2016/17: The Committee received an overview of the safe, effective and experience senates. The Committee agreed to receive the SEE report on behalf of the Board of Directors as the assurance sub-committee and to escalate by exception.
- ~ Single Oversight Framework: The Committee noted the introduction of the new single oversight framework.
- ~ External Review of Trust risk Management Processes: The Committee recognised improvements and delivery of the risk management strategy. Dr Street, external consultant in Risk & Governance, reported an improved standard of risk management position from level 2 to 3.
- ~ The Committee received an amended Terms of Reference which was approved.

2. Board Assurance Framework (BAF) risks reviewed

- ~ The Committee noted the BAF risks and agreed to recommend a de-escalation to risk 1m, [Ulysses No. 1944] to the Neonatal Transport Service Risk Register from risk score 16 to 8.

## 3. Issues to highlight to Board

- The Board to note the change of risk score under 2 above, now contained in the Board assurance Framework at Board agenda item 314
- The Board to note that the current Quality Strategy led by the Medical Director is in its final year of a three year cycle. The 2017/20 Quality Strategy will be developed in light of concerns raised at GACA (above) and Board development sessions will be put in place in 2017 as the new strategy takes shape.
- The Quarterly SEE Report will not now come to the Board in the future as assurance will be provided by the Committee. The Committee Chair will report any matters in the Chairs Report to the Board on areas of exception that may require additional investigation/review.

## 4. BAF recommendations

- The Board to note the change of risk score under 2 above, now contained in the Board assurance Framework at Board agenda item 314

## 5. Action required by Board

- Approval of the amended Terms of Reference at Board Agenda item 310

16/308

Board of Directors

Committee Chair's report of PPF Committee meeting held 24 November 2016

1. Agenda items covered
   - ~ Staff Story – Consultant Genetics Scientist. Reflections of an employee as they approached the end of their career and enter retirement.
   - ~ Genetics Service Workforce Review – a deep dive into the workforce risks, challenges, mitigation and longer term plans to address those risks. The Committee was assured that the service has control of its workforce planning processes.
   - ~ Half yearly review of Putting People First Strategy – a review of progress against each theme of the PPF Strategy as evidenced by appropriate metrics.
   - ~ IG Mandatory Training – following referral by GACA, a review of issues impacting on compliance and actions in place to drive improved compliance rates.
   - ~ Fit for Future Generations: Financial Sustainability - assurance with respect to the quality and equality impact assessments and other controls in place with respect to CIP and streamlining projects and their impact on the workforce.
   - ~ Workforce KPI Report – for information.
   - ~ Electronic Staff Record Self Service Implementation – Progress report on implementation of self service and assurance that the project was on track and on time.
   - ~ Payroll & Pre Employment Checks Audit – Interim action plan tabled. Received reasonable assurance of controls with respect to payroll and pre-employment and assured that actions & timescales for implementation had been agreed. Final report will be submitted to Audit Committee and the next PPF Committee.
   - ~ Safe Staffing Six Monthly Assurance Report – DoN highlighted the Trust as being an outlier for "headroom" but was assured that this was not a service risk at this point in time. This will be reviewed again in 6 months.
   - ~ Employee Volunteering – presentation given on initial ideas of an employer support scheme. Further work to be undertaken to develop a potential scheme further.
   - ~ Minutes
     - o Partnership Forum
     - o Joint Local Negotiating Committee
     - o Nursing & Midwifery Board
     - o Diversity & Inclusion Committee

2. Board Assurance Framework (BAF) risks reviewed
   - ~ All Committee relevant BAF risks were reviewed.
   - ~ The committee recommended that the BAF Risk relating to junior doctor's industrial action be reduced from 12 to 4 (4x1) in light of the BMA's recent decision.

3. Issues to highlight to Board
   - ~ None

4. Action required by Board
   - ~ To agree the reduction in Risk Score for Industrial Action by Junior Doctors as set out in agenda 314

Chair report provided by:
Tony Okotie
Date: 24 November 2016

16/309

# Board of Directors

## Committee Chair's report of Charitable Funds Committee

## Meeting held 24 November 2016

### 1. Agenda items covered

~ The Committee received a presentation on the proposed way forward for the development of the Charity and fundraising strategy. It agreed that with the current uncertainties regarding future generations that a strategy would be developed once the outcome of the public consultation was known, to be followed by a Board and Committee workshop in April 2017 to discuss a proposed strategy in order to have a final draft strategy for approval in June 2017. The Committee would continue in the meantime to raise the charity's profile and fundraising activities.

~ The Committee noted that the Charity would have its own web page within LWH (Corporate Trustee) website with clear links to the webpage from the Corporate Trustee home page. The Development of the webpage would be in line with that of the Foundation Trust and would go live in or around April 2017.

~ Annual Report and Accounts 2015/16. The Committee received the draft Annual Report and Accounts 2015/16 together with the external audit report. The Committee received an unqualified audit opinion from the external auditor for the financial statements. The Committee agreed that it would be appropriate to recommend the Annual Report and Accounts to the Corporate Trustee for approval, after a number of requested amendments had been made to the "Trustee Annual Report" section. The Annual Report and Accounts will be presented to the LWH board (as the Corporate Trustee) at the Board meeting on 6 January 2017 meeting for approval.

~ The Committee received an impact report noting the number of key fund requests made since the last meeting. Concern was expressed regarding a number of requests for funding and whether they were within the boundaries of the objectives of the Charity and give rise to benefits of patients. The Committee asked for clarification on a number of requests.

~ The Committee noted the financial position and investment report for the first 6 months of the current financial year. The Committee was assured from a presentation by the Investment manager that the Charity's investment portfolio was performing well in the current economic climate.

~ The Committee received an update report on the external and internal fundraising activities and thanked all those who had raised funds for the Charity. The Committee also noted the future fundraising activities that would be promoted over the coming months.

~ A request was made to amend the aim of one of the funds to designate the fund to a singular field of activity rather than two fields of activity. The Committee did not feel it was appropriate to approve the change.

### 2. Board Assurance Framework (BAF) risks reviewed

~ None

### 3. Issues to highlight to Board

~ The Annual Report and Accounts of the Charity will be presented to the Board at the 6 January 2017 meeting for approval.

### 4. BAF recommendations

~ None

### 5. Action required by Board

~ None

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| **Agenda item no:** | 16/310 |

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| **Meeting:** | Trust Board Meeting |

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| **Date:** | 2 December 2016 |

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| **Title:** | Terms of Reference approval |

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| **Report to be considered in public or private?** | Public |

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| **Where else has this report been considered and when?** | |

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| **Reference/s:** | FPBD meeting 21 November 2016<br><br>GACA meeting 16 September 2016 & 18 November 2016 |

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| **Resource impact:** | |

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

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

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

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

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| **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)**:** | |
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| 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 | |

# FINANCE, PERFORMANCE AND BUSINESS DEVELOPMENT COMMITTEE TERMS OF REFERENCE

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| **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.<br><br>The Committee's responsibilities fall broadly into the following two areas:<br><br>**Finance and performance**<br>The Committee will:<br>a. Receive and consider the annual financial and operational plans and make recommendations as appropriate to the Board.<br>b. Review progress against key financial and performance targets<br>c. Act on behalf of the Board to approve Monitor quarterly returns.<br>d. Review the service line reports for the Trust and advise on service improvements<br>e. Provide oversight of the cost improvement programme<br>f. Oversee external financing & distressed financing requirements<br>g. Oversee the development and implementation of the information management and technology strategy<br>h. Examine specific areas of financial and operational risk and highlight these to the Board as appropriate through the Board Assurance Framework<br><br>**Business planning and development**<br>The Committee will:<br>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<br>j. Advise the Board and maintain an oversight on all major investments, disposals and business developments.<br>k. Advise the Board on all proposals for major capital expenditure over £500,000<br>l. Develop the Trust's marketing & communications strategy for approval by the Board and oversee implementation of that strategy |

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| **Membership:** | The Committee membership will be appointed by the Board of Directors and will consist of:<br><br>• Non-Executive Director (Chair)<br>• Two additional Non-Executive Directors<br>• Chief Executive<br>• Director of Finance<br>• Associate Director of Operations<br><br>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.<br><br>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:** | A quorum shall be three members including two Non-Executive Directors (one of whom must be the Chair or Vice Chair of the Committee), and one Executive Director (including the Associate Director of Operations). 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**<br>Members will be required to attend a minimum of 50% of all meetings.<br><br>**b. Officers**<br>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 |

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| | directed to cooperate with any request made by the Committee.<br><br>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.<br><br>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.<br><br>The Committee will report to the Board annually on its work and performance in the preceding year.<br><br>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:<br><br>a) Chairs Report and minutes of meetings; and<br>b) an Annual Report setting out the progress they have made and future developments.<br>The following sub committees/groups will report directly to the Committee:<br><br>Information Governance Committee<br>EPR Programme Board<br>Turnaround and Transformation Committee<br>Emergency Planning Resilience & Response 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. |
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| **Reviewed by Finance, Performance &** | 28 April 2015 v1<br>27 July 2015 v2 |

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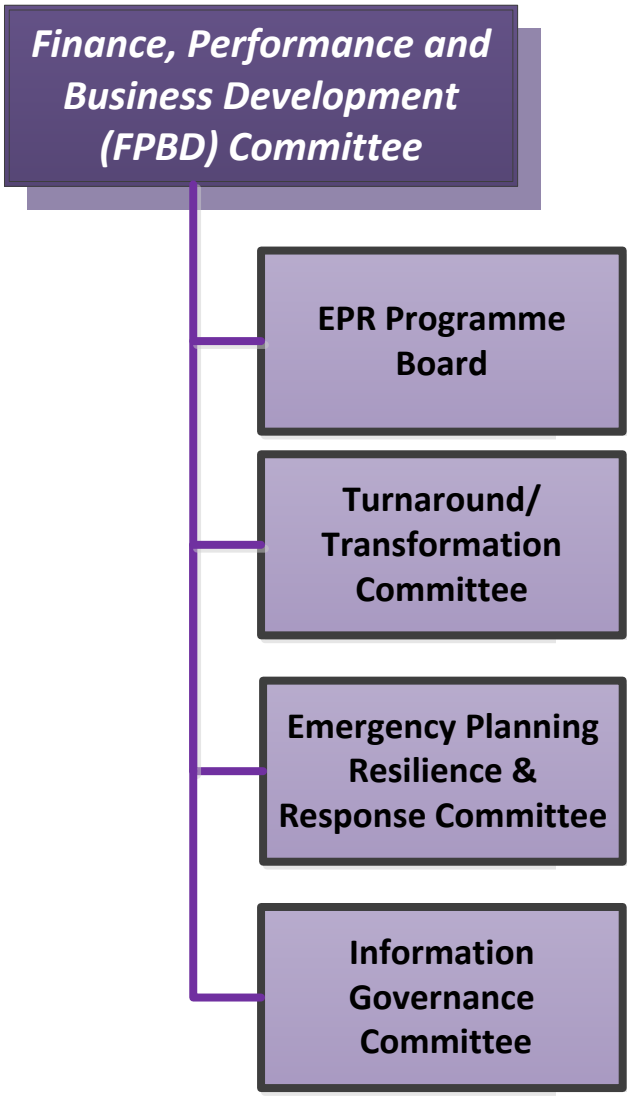
| **Business Development Committee:** | 25 April 2016 v1<br>21 November 2016 v2 |
| **Approved by Board of Directors:** | 5 June 2015 v1<br>4 September 2015 v2 – Ratified<br>1 July 2016 |
| **Review date:** | April 2017 |
| **Document owner:** | Trust Secretary<br>Tel: 0151 702 4033 |



# GOVERNANCE AND CLINICAL ASSURANCE COMMITTEE
# TERMS OF REFERENCE

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| **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:<br><br>• Receiving assurance that the Trust has in place effective integrated governance systems, risk management and quality improvement<br>• Exercising oversight of the systems of governance, risk management and quality improvement and focusing on matters of concern<br>• 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<br>• Seeking assurance that the Trust complies with its own policies and all relevant external regulation and standards of governance and risk management<br>• Oversight, scrutiny and monitoring of progress against the Trust Quality Strategy.<br><br>In particular the Committee will be responsible for:<br><br>a) Reviewing risks included on the Board Assurance Framework that are assigned for its oversight<br>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):<br>• The Trust's Safe Effective Experience Report (SEE)<br>• Exception reports from internal Provider Compliance Assessment against CQC Fundamental Standards and other regulatory frameworks<br>• Patient surveys<br>• The Director of Infection Prevention and Control<br>• Chairs reports and items for escalation of subordinate committees<br>• Review of morbidity and mortality |

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| | • Assurance reports relating to quality improvement initiative eg SU2S, and other QI projects commissioned locally by the Trust and by divisions<br>• Opportunity to review harm free care data which currently is not considered anywhere<br>c) Testing assurances through 'deep dives' as require, including Quality quarterly review of clinical services<br>d) Receiving exception reports in respect of matters of non-compliance with clinical quality, performance and risk management targets and standards<br>e) Reviewing the Trust's draft quality report and recommending it to the Board of Directors<br>f) Receiving assurances in respect of progress against the Trust's quality report<br>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<br>h) Receiving the quarterly Board Statements relating to quality and governance as submitted to Monitor<br>i) Reviewing the Trust's draft Research and Development strategy and recommending it to the Board of Directors<br>j) Receiving assurances in respect of progress against the Trust's Research and Development strategy<br>k) Approval of the Trust's Patient Experience Strategy and recommending it to the Board of Directors<br>l) Receiving assurances in respect of progress against the Trust's Patient Experience Strategy<br>m) Receiving assurances in respect of the Trust's clinical audit function<br>n) Approving the terms of reference and memberships of its subordinate committees<br>o) Considering relevant matters delegated or referred to it by the Board of Directors or referred by any of the Board Committees<br>p) Referring relevant matters for consideration to other Board Committees as appropriate.<br>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:<br><br>• Non-Executive Director (Chair) |

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| | • Two additional Non-Executive Directors (one of whom shall be Vice Chair)<br>• *Medical Director<br>• *Director of Nursing and Midwifery<br>• *Director of Finance<br>• *Director of Workforce and Marketing<br>• *Committee Chairs of the Safe, Experience and Effectiveness Senates<br>• Deputy Director of Nursing and Midwifery<br>*or their nominated representative who will be sufficiently senior and have the authority to make decisions<br><br>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.<br><br>The Board of Directors will appoint a Non-Executive Director as Chair of the Committee 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<br>Members will be required to attend a minimum of 75% of all meetings.<br>b. Officers<br>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. |

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| | 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.<br><br>The Committee is authorised to approve those policies and procedures for matters within its areas responsibility.<br><br>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.<br><br>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.<br><br>Approved minutes will also be circulated to members of the Audit Committee.<br><br>The Committee will report to the Board annually on its work and performance in the preceding year. |

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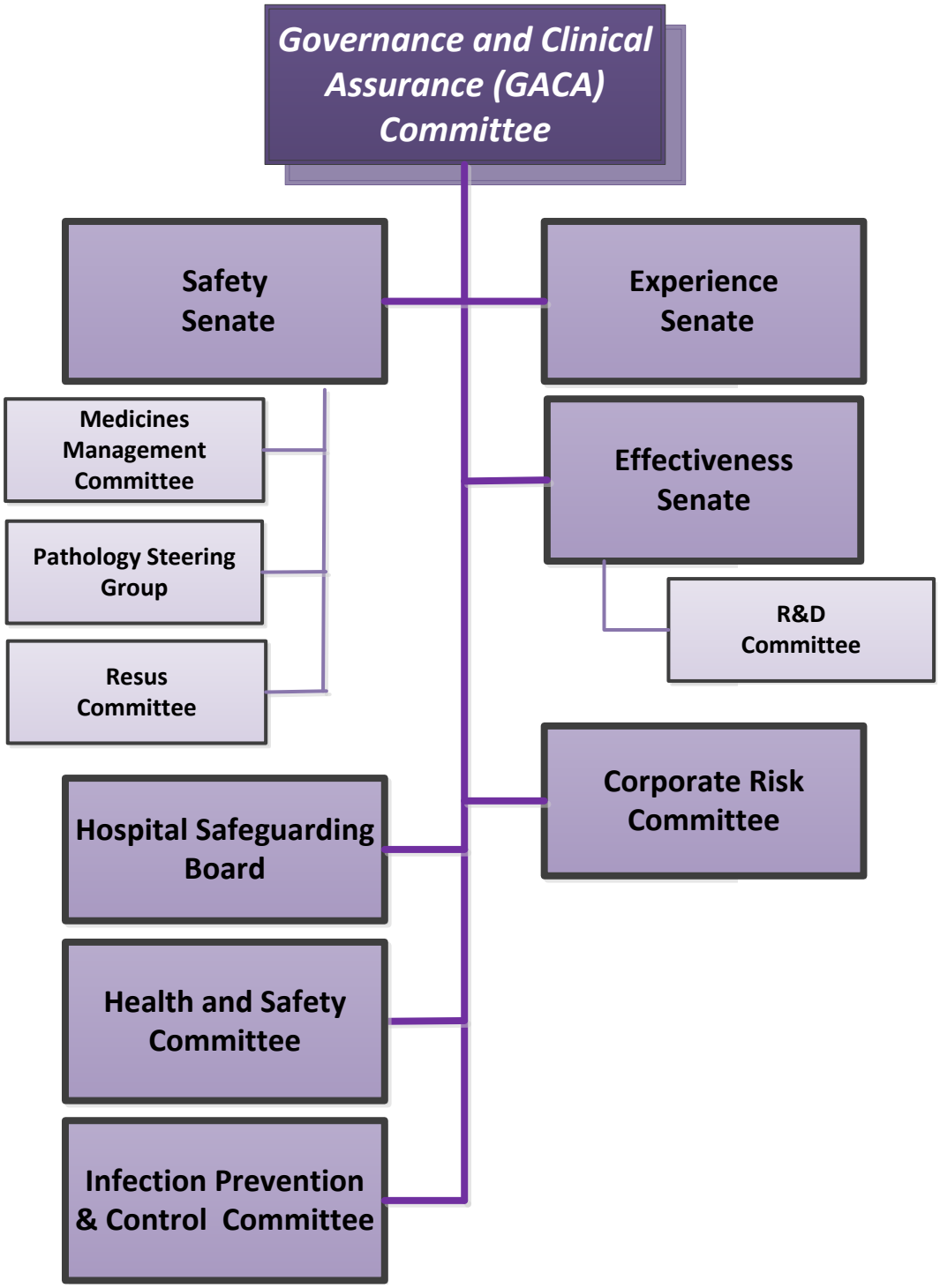
| | Trust standing orders and standing financial instructions apply to the operation of the Governance and Clinical Assurance Committee. |
| Reporting Committees/Groups | The sub committees/groups listed below are required to submit the following information to the Committee:<br><br>a) Chairs Report and minutes of meetings; and<br>b) an Annual Report setting out the progress they have made and future developments.<br><br>The following sub committees/groups will report directly to the Committee:<br>• Safety Senet<br>• Effectiveness Senet<br>• Experience Senet<br>• Corporate Risk Committee<br>• Hospital Safeguarding Board<br>• Health and Safety Committee<br>• 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 Clinical Assurance: | 16 September 2016<br>18 November 2016 |
| Approved by Board of Directors: | |
| Review date: | September 2017 |
| Document owner: | Colin Reid, Trust Secretary ,Email: colin.reid@lwh.nhs.uk<br>Tel: 0151 702 4033 |


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

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| **Agenda item no:** | 16/311 |

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| **Meeting:** | Board of Directors |

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| **Date:** | 2 December 2016 |

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| **Title:** | Bi annual staffing Review – Mid Year Update |

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| **Report to be considered in public or private?** | Public |

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| **Where else has this report been considered and when?** | Putting people First Committee 24.11.2016 |

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| **Reference/s:** | National Quality Board (July 2016) 'Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time'.<br>Francis Report (Feb 2013) 'Inquiry into the failings of Mid Staffordshire NHS Foundation Trust'.<br>DH (2012) ' Hard Truths: the journey to putting patients first'<br>Carter Report (Feb 2015) 'Unwarranted Variation: A review of operational productivity and performance in English NHS acute hospitals'<br>NHSE (2014) 'Five Year Forward View'. |

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| **Resource impact:** | |

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

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| **Which Board Assurance Framework risk/s does this report relate to?** | **BAF 1731** |

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| **Which CQC fundamental standard/s does this report relate to?** | **Regulation 18** |

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| **What action is required at this meeting?** | Note the contents of the paper and assurance in relation to Nursing and Midwifery Staffing levels |

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| **Presented by:** | Dianne Brown Director of Nursing and Midwifery |

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| **Prepared by:** | Dianne Brown – Director of Nursing and Midwifery |

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 | **X** |

| **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 | **X** |
| 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

This paper forms the six monthly review of nursing and midwifery staffing in line with the commitment requested by the National Quality Board (2013, 2016).The paper will provide the Board of Directors with the assurance that there are robust systems and processes in place throughout the year to monitor and manage nursing and midwifery staffing requirements.

Getting the right numbers of nurses and midwives and care staff in place is essential for the delivery of safe and effective patient care. Not only is this desirable but it is also now required for executive nurse directors , on behalf of the Board of Directors to review the nursing and midwifery staffing numbers a minimum of twice a year and to present those at a public Board meeting. Senior leaders have taken ownership of their workforce reviews and utilized evidence based guidelines were applicable to ensure their individual areas achieve standards that promote care that is safe, high quality and puts patients first.

Considerable scrutiny and focus has been on the review of midwifery staffing as would be expected due to the previous reported issues and regulatory concerns. Reassuringly it is apparent that outside of the formal workforce reviews safe and appropriate staffing has become integral to day to day business and is now an essential part of any service redesign, incident review or complaint response across all service areas. There have been no reductions in any nursing and midwifery posts in the period of reporting

### 1.1 Issues for Consideration

Whilst this review was being undertaken and prepared the National Quality Board has issued new guidelines for determining safe staffing levels. The new guidance has been reviewed by the Nursing and Midwifery Board, and a revised assurance report for Trust Board is being developed to ensure that the Board is apprised of triangulated staffing, quality and experience data. It is envisaged that this work will be completed in the form of a dashboard and presented to the Board of Directors within the Performance Metric in December 2016

### 1.2 Methodology used for workforce reviews at Liverpool Women's NHS Foundation Trust

The following evidence based and accredited tools are utilised to assess nursing and midwifery staffing levels. They are not used in isolation and always overlaid with professional judgement.

*Safer Nursing Care Tool (SNCT)* is utilised in adult inpatient areas (Gynaecology Wards) which calculates the care requirements of patients based on their acuity and dependency scores the staffing and acuity measures are modelled twice yearly and are used in part of the ongoing assurance process. Birthrate Plus® and professional judgements are used to determine appropriate midwifery staffing. In addition the Trust has implemented an acuity model of staffing which are reviewed 4 hourly and staffing flexed in accordance to the needs of the women within the maternity services. British Association of Perinatal Medicine (BAPM) standards have been utilised to provide the benchmark for staffing within the Neonatal Unit.

Genetic services and Reproductive Medicine were also reviewed. There are no approved tools for the assessment of safe staffing of these services, however the services provided are predominantly clinic based, and with some procedures and therefore staffing levels were determined in response to the service demand and clinic provision time required.

In the review of ward staffing establishments, the ongoing monitoring of nursing and midwifery quality indicators, patient survey results, friends and family feedback, reported incidents and complaints have all been taken into account to assess whether the nursing and midwifery needs of patients are being met. These are presented within the Safe, Experience and Effective report and demonstrate good compliance.

### 1.3 Requirements of National Reporting in relation to Nursing and Midwifery Workforce Care Contact Time

From May 2016, all trusts should report monthly Care Hours per Patient per day (CHPPD) data to NHS Improvement. This will allow trusts to see how their CHPPD relates to other trusts within a speciality and by ward in order to identify how they can improve their staff deployment and productivity The Trust has been compliant with the requirement to submit this information monthly since May 2016**. (Appendix A)**

### 1.4 Fill rates

There is a requirement for hospitals to publish information about staffing levels on all inpatient wards, including the percentage of shifts meeting their agreed staffing levels. This is reported monthly through to NHSE and updated to the Trust website. (**Appendix B)** Levels of staffing numbers alone do not indicate how safe or unsafe a ward is, however this data is used in conjunction with other metrics and indicators as discussed earlier

## 2. Summary of Outcomes from Bi annual review

### *2.1 Gynaecology Services*

This review has identified an increase in labour turnover within the division which was reported as 15% against a Trust target of 10%; the division will be undertaking further work to determine whether there are any specific themes or trends associated with this pattern.

Actual staffing levels ( *fill rates – planned v actual* ) are monitored by each shift Where fill rates are below 100% assessment is given to acuity of patients and bed occupancy to ensure safe and effective care Staffing ratios have not exceeded the recommended 1:8 during the time period specified. There have been no recommendations from the completion of the SNCT for this period.

A major review of theatre activity and productivity is underway within the service, the 'Four Eyes Project'. Any impact on staffing will be reported within the next staffing review paper. Recruitment to vacancies within theatres remains problematic and the division is working alongside HR to consider alternative ways of recruitment. In the interim safe staffing levels are maintained by staff working additional hours and by the use of bank and agency staff.

Within GED a serious incident was reported, escalated to StEIS and investigated in accordance with national requirements. Following the investigation a full review of the departmental requirements has been undertaken and this included consideration of the medical staffing model and options for service delivery. Whilst this model has yet to be fully approved there is recognition that additional investment in the nursing model may be required.

### *2.2 Maternity Services*

Birth-rate Plus® (BRP) recommendations a ratio for midwifery staffing of 1:28. Current activity and staffing levels within our service indicate a ratio of 1:27.5

Particular staffing pressures have been noted on Maternity Base through the summer months, which were exacerbated by the failure to recruit to vacant posts in a timely manner. This has now been addressed through the senior midwifery teams and a plan in place to monitor. The monitoring of other Quality Metrics within maternity service, including the measurement of 1:1 care in labour, these are reported and monitored through the Board Performance Framework.

### *2.3 Neonatal Services*.

The nurse staffing requirement is based on a nurse to cot ratio .Staffing requirements are directly influenced by the number and acuity of babies and this is reviewed twice daily alongside predicted admissions from the Delivery Suite. There are clear escalation processes in place to support peaks in activity.

In June 2016 there were further identified pressures on staffing levels associated with an unprecedented number of staff going on maternity leave. Due to the specialist nature of the service and the shortage of trained staff nationally it has not been possible to recruit staff to fixed term contracts and therefore the existing pool of staff have taken on additional shifts to meet the shortfall in staffing and maintain safe staffing levels. There have been occasions where additional cots have been closed if staffing levels cannot be achieved. This has been reported through to the Board and approved appropriately.

Additional contract negotiations have enabled the additional recruitment of 16.6 WTE registered staff who have commenced in post through October and November, it is envisaged that once they have completed their induction period in April 2017 the compliance against BAPM standards will increase considerably and this will be reported though the next staffing review update

### *2.4 Genetics*

There has been a significant increase in referrals into the service over the last 2 years in particular with issues relating to BRCA gene alterations. This is currently being reviewed to understand implications for service redesign The workforce profile of the GC team indicates that 40% of the workforce is able to retire in the next 3 years. Due to training requirements to undertake this role and portfolio requirements for registration, proactive recruitment, and a succession plan is in development to prevent the predicted skills and knowledge deficit.

### *2.5 Hewitt Fertility Centre (HFC)*

Benchmarking of this service against other units has not been possible as the service provided at LWH is predominantly nurse based and therefore a different model to those provided elsewhere. As previously stated, clinic activity and professional judgement have therefore been utilised to determine the staffing requirements for this service. The staffing review has identified that 58% of nursing staff are over the age of 50. In order to attract and retain staff, HFC are continuing to develop the role of the Advanced Nurse Practitioner (ANP) within the service and there are currently 3 staff undertaking training.

It has been difficult to establish precise staffing requirements associated with service expansion as activity levels have been variable. There have been initial requests for additional staffing that forms part of ongoing work to understand the operational and projected activity within the HFC.

### 2.6 Quality & Safety

In addition to the collection of data relating to acuity and dependency of patient and staffing levels it is also important to review other triggers that may raise cause for concern on a more regular basis.

Within the Trust staffing levels are displayed within all clinical areas displaying the agreed / planned /staffing levels and actual staffing levels. Escalation processes are in place within all clinical areas and staff can be moved to support where appropriate. Internal bank staff are utilised to backfill shifts due to short or long term absence. Utilisation of internal bank staff provides significant mitigation of the usual risks associated with the use of temporary staff.Within Maternity services the acuity of the labour ward is monitored 4 hourly and staff moved from clinical areas within the specialty to support the increased activity. The clinical area has also introduced a 'Hands on Help' scheme with registered midwives which provide additional assistance, particularly on labour ward, at times of peak activity.

Nursing and Midwifery 'Red Flag' events were identified by NICE as key markers of safety within their staffing recommendations. The Trust has incorporated these into the Trust incident reporting system. Incidents reported can be reviewed against a backdrop of acuity and dependency and the planned and actual staffing levels for the day. Triangulation of data assists in informed decision making relating to staffing and also provides an indicator of stressors within clinical areas..Liverpool Women's Hospital participates in and publishes data relating to NHS Safety Thermometer Classic and Maternity

### 2.7 Supervisory Ward Managers

In line with recommendations all ward managers continue in their supervisory status. In light of the current financial pressures within the Trust this will be reviewed and reported through the next Staffing review

### 2.8 E Roster

The Trust is currently rolling out an electronic roster system in all clinical areas. This will help ensure efficient and productive rotas are produced in line with the NHSI recommendations. It is anticipated that this roll out will be complete in April 2017.

### 2.9 Headroom

Although the current Headroom uplift at the Trust is lower than peers and recommended workforce tools, (see table below) there is evidence to suggest that the current Headroom is meeting the service needs. In light of emerging mandatory training requirements for midwives and nurses through national guidance and local contracting, further TNA reviews will be conducted and reported through the Bi annual workforce reviews to provide ongoing assurance that staff is equipped with the right skills to deliver safe and effective clinical services.

| Local/Recommended Headroom | |
|---|---|
| Liverpool Women's NHS Foundation Trust | 18.9% |
| SNCT – (Shelford Model) in Pt Areas | 22% |
| NHSI – Good Rostering Guidance | 22-25% |
| Royal Liverpool University Trust | 22% |
| AHCH | 23% |
| Wirral University Hospital | 25% |

### 3.0 Conclusion

There are robust systems and process both at a local and Trust level to ensure that Nursing and Midwifery staffing levels are safe and appropriate. It is reassuring that the is a much clearer understanding of the multiple factors that can impact on safe staffing and that there are robust and timely escalation process in place to manage effectively. It is evident that there have been no reductions in whole time equivalents across the nursing and Midwifery workforce in the reporting period, and that all mandatory reporting has been completed

### 4. Recommendations

The Board of Directors is requested to:

- Note the content of the mid-year report and the assurances provided that staffing levels are safe and appropriate
- Acknowledge the continuing work to progress staffing within neonatal services and GED
- Acknowledge the work being undertaken to ensure that NQB guidelines are being incorporated into future local staffing reviews
- Note the risk of the Headroom allocation within workforce budgets and agree to ongoing monitoring through the operational performance metrics and subsequent workforce reviews within Putting people First Committee

## *Appendix A*

The calculation for Care Hours per Patient Day (CHPPD) is provided below;

$$\text{CHPDD} = \frac{\text{Total number of registered and unregistered staff hours}}{\text{Number of occupied beds at 23:59hrs}}$$

| | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 |
|---|---|---|---|---|---|---|
| **Gynaecology** | **2.36** | **2.29** | **2.16** | **2.91** | **2.81** | **2.40** |
| Ward 1 | 1.23 | 1.13 | 1.08 | 1.45 | 1.51 | 1.12 |
| Ward 2 | 1.13 | 1.16 | 1.09 | 1.46 | 1.30 | 1.28 |
| **Maternity** | **37.99** | **37.08** | **20.75** | **22.70** | **23.40** | **21.95** |
| Delivery Suite | 13.11 | 13.03 | 6.58 | 6.47 | 6.91 | 6.46 |
| Induction | 5.70 | 5.04 | 5.28 | 4.89 | 5.42 | 6.44 |
| Jeffcoate | 1.63 | 2.07 | 1.00 | 0.96 | 0.97 | 0.91 |
| Maternity Base | 1.98 | 1.93 | 0.94 | 0.83 | 0.95 | 0.82 |
| MLU | 15.58 | 15.01 | 6.95 | 9.54 | 9.15 | 7.32 |
| **Neonatal Care** | **2.91** | **2.62** | **2.64** | **2.62** | **2.70** | **2.48** |
| Neonatal Care | 2.91 | 2.62 | 2.64 | 2.62 | 2.70 | 2.48 |
| **Grand Total** | **43.26** | **41.99** | **25.55** | **28.22** | **28.91** | **26.82** |

## Appendix B

The table below demonstrates the fill rates for inpatient areas as submitted to NHSE monthly

**Safer Staffing Fill Rate January 2016 to June 2016 - Gynaecology**

| Month | Ward | Day | | Night | |
|---|---|---|---|---|---|
| | | Average Fill Rate **Registered (%)** | Average Fill Rate **Care Staff (%)** | Average Fill Rate **Registered (%)** | Average Fill Rate **Care Staff (%)** |
| Jun-16 | Ward 1 | 100.0% | 95.0% | 100.0% | 100.0% |
| | Ward 2 | 95.5% | 100.0% | 97.6% | 100.0% |
| | Total | **97.1%** | **97.9%** | **98.6%** | **100.0%** |
| May-16 | Ward 1 | 101.6% | 95.3% | 100.0% | 100.0% |
| | Ward 2 | 96.3% | 107.3% | 100.0% | 96.4% |
| | Total | **98.2%** | **102.0%** | **100.0%** | **98.3%** |
| Apr-16 | Ward 1 | 105.0% | 95.0% | 100.0% | 100.0% |
| | Ward 2 | 95.5% | 90.9% | 100.0% | 100.0% |
| | Total | **98.8%** | **92.6%** | **100.0%** | **100.0%** |
| Mar-16 | Ward 1 | 100.0% | 79.6% | 100.0% | 84.6% |
| | Ward 2 | 93.3% | 89.8% | 99.7% | 100.0% |
| | Total | **95.6%** | **85.0%** | **99.8%** | **90.8%** |
| Feb-16 | Ward 1 | 103.4% | 92.7% | 100.0% | 96.7% |
| | Ward 2 | 95.1% | 100.0% | 96.2% | 100.0% |
| | Total | **98.1%** | **96.7%** | **97.8%** | **98.3%** |
| Jan-16 | Ward 1 | 100.0% | 92.9% | 100.0% | 87.1% |
| | Ward 2 | 97.1% | 95.8% | 97.5% | 100.0% |
| | Total | **98.2%** | **94.4%** | **98.6%** | **93.2%** |

## Safer Staffing Fill Rate January 2015 to December 2015 - Maternity

| Month | Ward | Day | | Night | |
|---|---|---|---|---|---|
| | | Average Fill Rate **Registered (%)** | Average Fill Rate **Care Staff (%)** | Average Fill Rate **Registered (%)** | Average Fill Rate **Care Staff (%)** |
| Dec-15 | Delivery Suite | 79.4% | 108.1% | 76.8% | 68.9% |
| | Induction Suite | 161.3% | N/A | 174.2% | N/A |
| | Jeffcoate | 148.4% | 96.8% | 135.5% | 93.6% |
| | Maternity Base | 90.3% | 89.0% | 86.6% | 74.2% |
| | MLU | 74.2% | 100.0% | 81.2% | 96.8% |
| | Total | **86.1%** | **95.3%** | **85.2%** | **77.4%** |
| Nov-15 | Delivery Suite | 82.9% | 108.3% | 81.1% | 82.2% |
| | Induction Suite | 166.7% | N/A | 186.7% | N/A |
| | Jeffcoate | 196.7% | 100.0% | 153.3% | 96.7% |
| | Maternity Base | 92.9% | 83.3% | 89.5% | 68.3% |
| | MLU | 73.3% | 103.3% | 81.7% | 96.7% |
| | Total | **90.0%** | **93.0%** | **89.1%** | **79.3%** |
| Oct-15 | Delivery Suite | 85.6% | 132.8% | 81.7% | 91.2% |
| | Induction Suite | 151.6% | N/A | 145.1% | N/A |
| | Jeffcoate | 167.7% | 100.0% | 132.3% | 91.9% |
| | Maternity Base | 100.0% | 89.7% | 87.4% | 70.6% |
| | MLU | 87.3% | 104.4% | 81.8% | 95.7% |
| | Total | **94.6%** | **102.0%** | **86.9%** | **83.3%** |
| Sep-15 | Delivery Suite | 80.2% | 110.0% | 82.9% | 84.4% |
| | Induction Suite | 146.7% | N/A | 153.3% | N/A |
| | Jeffcoate | 170.0% | 96.7% | 140.0% | 86.7% |
| | Maternity Base | 105.0% | 91.3% | 88.6% | 72.5% |
| | MLU | 83.9% | 106.7% | 72.8% | 83.3% |
| | Total | **92.4%** | **97.8%** | **86.4%** | **79.3%** |
| Aug-15 | Delivery Suite | 78.3% | 124.2% | 74.4% | 73.1% |
| | Induction Suite | 145.2% | N/A | 154.8% | N/A |
| | Jeffcoate | 158.1% | 96.8% | 116.1% | 90.3% |
| | Maternity Base | 104.4% | 89.7% | 89.4% | 77.4% |
| | MLU | 82.3% | 96.8% | 75.8% | 90.3% |
| | Total | **90.5%** | **98.9%** | **82.3%** | **78.9%** |
| Jul-15 | Delivery Suite | 78.3% | 129.0% | 73.6% | 87.1% |
| | Induction Suite | 154.8% | N/A | 151.6% | N/A |
| | Jeffcoate | 161.3% | 100.0% | 112.9% | 87.1% |
| | Maternity Base | 106.6% | 88.4% | 88.5% | 70.2% |
| | MLU | 81.7% | 100.0% | 84.4% | 103.2% |
| | Total | **91.4%** | **100.0%** | **83.1%** | **81.4%** |
| Jun-15 | Delivery Suite | 78.0% | 133.3% | 78.0% | 75.6% |
| | Induction Suite | 133.3% | N/A | 143.3% | N/A |
| | Jeffcoate | 170.0% | 96.7% | 116.7% | 93.3% |
| | Maternity Base | 109.6% | 87.3% | 94.8% | 70.0% |
| | MLU | 83.3% | 100.0% | 82.8% | 106.7% |
| | Total | **91.9%** | **100.0%** | **86.3%** | **78.5%** |
| May-15 | Delivery Suite | 79.8% | 124.2% | 77.4% | 76.3% |
| | Induction Suite | 122.6% | N/A | 119.4% | N/A |
| | Jeffcoate | 154.8% | 100.0% | 132.3% | 87.1% |
| | Maternity Base | 103.6% | 92.9% | 90.8% | 76.6% |
| | MLU | 82.8% | 96.8% | 76.9% | 93.6% |
| | Total | **90.3%** | **101.1%** | **83.7%** | **79.6%** |
| Apr-15 | Delivery Suite | 82.89% | 116.67% | 77.33% | 91.11% |
| | Induction Suite | 129.17% | N/A | 124.00% | N/A |
| | Jeffcoate | 160.00% | 100.00% | 116.67% | 93.33% |
| | Maternity Base | 108.20% | 87.58% | 94.76% | 70.83% |
| | MLU | 71.43% | 96.67% | 66.19% | 100.00% |
| | Total | **90.56%** | **96.34%** | **81.51%** | **83.33%** |
| Mar-15 | Delivery Suite | 78.7% | 111.3% | 78.1% | 86.0% |
| | Induction Suite | 116.1% | N/A | 119.4% | N/A |
| | Jeffcoate | 161.3% | 96.8% | 112.9% | 90.3% |
| | Maternity Base | 91.5% | 75.1% | 91.2% | 74.2% |
| | MLU | 74.2% | 96.8% | 59.4% | 96.8% |
| | Total | **84.9%** | **87.0%** | **79.3%** | **82.4%** |
| Feb-15 | Delivery Suite | 79.0% | 77.4% | 81.4% | 125.0% |
| | Induction Suite | 100.0% | N/A | 100.0% | N/A |
| | Jeffcoate | 164.3% | 107.1% | 114.3% | 103.6% |
| | Maternity Base | 98.8% | 78.9% | 92.3% | 71.9% |
| | MLU | 79.6% | 85.7% | 62.2% | 71.4% |
| | Total | **87.8%** | **81.7%** | **81.2%** | **88.9%** |
| Jan-15 | Delivery Suite | 79.6% | 77.4% | 78.7% | 83.9% |
| | Induction Suite | 112.9% | N/A | 122.6% | N/A |
| | Jeffcoate | 138.7% | 80.6% | 135.5% | 80.6% |
| | Maternity Base | 95.0% | 79.8% | 92.2% | 78.0% |
| | MLU | 77.0% | 93.5% | 64.1% | 100.0% |
| | Total | **86.0%** | **80.5%** | **81.7%** | **82.7%** |

**Neonatal Care - Staffing Rates per Shift - Jan 2016 to June 2016**

| Shift | Day | | Night | |
|---|---|---|---|---|
| StaffGroup / Month | Average Fill Rate Registered (%) | Average Fill Rate Care Staff (%) | Average Fill Rate Registered (%) | Average Fill Rate Care Staff (%) |
| **Jan-16** | **104.0%** | **40.3%** | **105.0%** | **37.1%** |
| **Feb-16** | **103.7%** | **69.0%** | **103.4%** | **70.7%** |
| **Mar-16** | **102.6%** | **50.0%** | **100.2%** | **75.8%** |
| **Apr-16** | **104.0%** | **63.3%** | **102.9%** | **68.3%** |
| **May-16** | **105.0%** | **78.3%** | **101.7%** | **75.0%** |
| **Jun-16** | **105.0%** | **78.3%** | **101.7%** | **75.0%** |

| | |
|---|---|
| **Agenda Item No:** | 16/312 |
| **Meeting:** | Trust Board |
| **Date:** | 2 December 2016 |
| **Title:** | Performance Dashboard - Month 7 - October 2016 |
| **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<br>3. Deliver the best possible experience for patients and staff<br>4. To develop a well led, capable and motivated workforce<br>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<br>Staffing<br>Safety<br>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 7 - October 2016






# Performance Summary - Trust Board - Month 7 - October 2016

## Overview

Of the 33 KPI's RAG rated in the Trust Board Dashboard for October 2016, **22** are rated Green, **8** are rated Red and **2** are rated as Amber. The figure for Choose and Book is not yet available nationally although the data for August 2016 has just been released and is at 18% against a target of >= 6%

The KPI's rated as Red for October 2016 are:

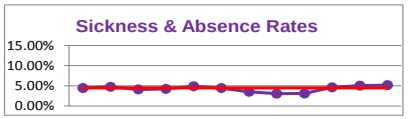
- Sickness & Absence Rate at 5.2% against a target of <= 4.5%
- Nurse Staff Fill Rates at 89% against a target of >= 90%
- Maternity Triage at 88% against a target of >= 95%
- Number of complaints received at 16 against a target of <= 15
- Rate of Epidurals not provided due to non-clinical reasons at 7.5% against a target of <= 5%

The KPIs rated as Amber for October 2016 are:

- Mandatory Training at 93% against a target of >= 95%
- Turnover Rates at 14% against a target of <= 10%

# Performance Summary - Trust Board - Month 7 - October 2016

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




**Sickness & Absence rather 5.16% against target <=4.5%**

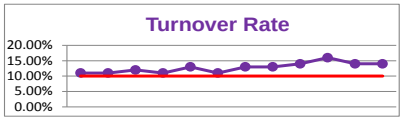
The overall single month sickness figure increased slightly by 0.13% from 5.03% in month six to 5.16% in month seven. This is 1.66% above the Trust target figure of 3.5%, and consequently rated as red. The cumulative figure increased from 4.27% up to 4.39%.

Managers continue to work closely with their HR teams to ensure that individual cases are managed appropriately, that staff are managed on the appropriate stages and that staff are supported in returning to work as soon as is appropriate.

The Human Resources Department provide detailed absence information and advice to support managers in addressing sickness absence. They also provide training to new and existing managers in how to effectively manage sickness absence.

Support for managers is also provided by Occupational Health, particularly in terms of advice for supporting staff off long term in returning to work.

The Human Resources Department are reviewing all sickness absence in order to put together an action plan to target the recent increases in sickness absence




**Turnover Rate 14% against target <=10%**

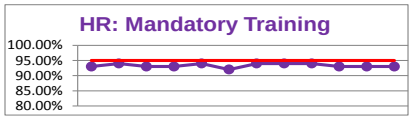
In total, there were 11 leavers in month seven, compared to 13 in month six. Overall, there are currently two areas are under the Trust's target figure of 10% and therefore rated as green. One department is rated as amber and 14 are rated as red.

Actions:

Work is being undertaken with Theatres to formulate a specific recruitment and retention strategy to address the continuing concerns with their level of turnover.

Managers are provided with detailed information on turnover by the Human Resources Department so that they can identify any concerns.

The potential impact of Future Generations will continue to be monitored.




**Mandatory Training 93% against target <=95%**

At service level there were only slight variations of one or two per cent. The exceptions to this were:

Gynaecology compliance increased from 82% in month six to 91% in month seven.

Integrated Governance compliance fell from 97% in month six to 94% in month seven.

Overall, seven areas are currently rated as green, nine as amber, and just one (Trust Offices) is rated as red.

**Actions:**

The Learning & Development and Human Resources teams provide managers at all levels with detailed information regarding mandatory training compliance.

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.

All efforts are on-going to reach the overall mandatory training target of 95%, it is anticipated the target will be reached by the end of quarter three.

All Linear graphs are rolling 12 months

# Performance Summary - Trust Board - Month 7 - October 2016

## To be EFFICIENT and make best use of available resources

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

## To deliver SAFER services

**Safer Staffing Levels at 89% against a target of >= 90%**
Maternity activity can be unpredictable in nature, although we have planned admissions the majority of the women enter the service via the Maternity Assessment Unit and in labour, therefore it is evident at times our activity and complexity of our women can be different to the actual availability of midwifery staffing. To manage this we have a senior midwife bleep holder available to cover the 24 hour period who will coordinate the allocation of staff to the clinical area where there may be increased demand.

The Ward managers ensure the off duty is completed in a timely manner and that the allocation of staff is evenly distributed throughout the working day. We also have a local escalation policy to assist with increased activity or reduced staff.

Staffing and bed occupancy are constantly reviewed by members of the senior midwifery team. Current process for the maternity bleep holder is under review which will offer additional support at times of increased activity. Staffing shift patterns are reviewed and amended where possible to support known pressures.

Although the staffing level dipped below the 90% target, 96% of women received One to One care in the month.

**Caesarean Section Rates**

The Caesarean Section rates are included but haven't been RAG rated as the targets have been reviewed and discussed at GACA in November 2016. Upon agreement of the Board, these will be removed from this report from December 2016.

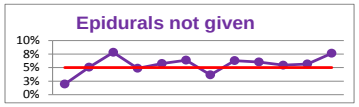
# Performance Summary - Trust Board - Month 7 - October 2016

## To deliver the most EFFECTIVE outcomes

**There are no Red or Amber rated KPIs in this section**

# Performance Summary - Trust Board - Month 7 - October 2016

## To deliver the best possible EXPERIENCE for patients and staff




**Epidurals not given for Non-Clinical reasons 7.56% against a target of <=5%**

172 Women requested an Epidural for their chosen analgesia during the month of October.

18 of these women were in advanced labour and therefore the request for an epidural was unable to be facilitated. It is common for women in the transition period of labour to request further regional analgesia, attempts are made to facilitate this, however if labour events take over this at times this may not be achieved. However all these women were offered care that was safe and had appropriate support by a midwife.

7 women in the month of October did not receive an epidural due to high activity and complexity of other women on the Delivery Suite. These women were being cared for on the Delivery Suite and were given other alternatives and coping strategies

4 women who were originally receiving care in labour on the MLU requested and epidural, however due to bed occupancy, increased and increased acuity on the delivery suite this request was not facilitated. This was also compounded by delays in women being transfers to the postnatal wards in a timely manner

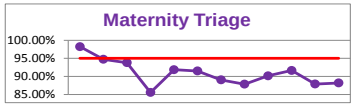
**Actions:**

The ward managers are currently reviewing transfer delays from the Intrapartum areas to the postnatal wards. Breach analysis forms have now been introduced into the Intrapartum areas that will provide exact details of why an epidural could not be provided. This in turn will enable the ward managers to identify any area of concern.

Daily operational huddles have also been introduced to monitor and reduce these issues.

Postnatal area are reviewing the discharge process to ensure any obstacles that potentially delay women going home in a timely manner are being addressed

Expected Date of Discharge is being clearly identified next to all women on the handover board on the postnatal wards to ensure all staff have clear guidance around the expectations for discharging women to the care of the community midwifery team




**Maternity Triage within 30 minutes at 88.24% against a target of >= 95%**

On average the MAU reviews nearly 1000 per month. The organisations aim is to see all women attending the MAU within 30 minutes of arrival; at times this is not always achieved.

Women are categorised in either a red, amber or green, based on clinical presenting history from the initial phone call to the department, so therefore if several women do arrive together the order women are seen is based on clinical need and not only on the time of arrival alone. If a woman is classified as red, she needs to be seen and assessed as a priority, which may delay other women falling outside the set target.

Although members of the medical team are assigned to the MAU, due to other activity across the maternity unit they are required to support other activity, this results in women not being assessment in a timely manner, blocking MAU, delaying movement. At times Junior medical staff will see women but are not able to make decisions and need to seek additional senior opinion .Delays in the flow of women through the rest of the service, can also impact upon MAU.

At times women are also delayed due to lack of available bed on the Maternity base, again this impacts on the ability to effectively move women through the service. Out of hours the Maternity Day Unit women are seen by MAU, the numbers are variable but put additional pressure on the MAU. Also some

# Performance Summary - Trust Board - Month 7 - October 2016

## Emerging Concerns

There are no emerging concerns from October 2016. However the data has just been released for Choose & Book for July and August 2016 and are at 22% and 18% respectively, against a target of <= 6% and therefore needs investigating.

## Conclusion

Overall, for October 2016 the Trust performance remains stable. The KPI's where the Trust has not achieved the target rates are generally the same as has been reported each month in the first half of the year and as such merit greater scrutiny in order to ensure that they are achieved going forward.

## 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 | | | | | |
| HR: Sickness & Absence Rates (Commissioner) | | <= 4.5% | 4.42% | 3.51% | 3.05% | 3.09% | 4.61% | 5.03% | 5.16% | | | | | |
| HR: Annual Appraisal and PDR | | >= 90% | 89.00% | 87.00% | 82.00% | 87.00% | 90.00% | 92.00% | 90.00% | | | | | |
| HR: Completion of Mandatory Training | | >= 95% | 92.00% | 94.00% | 94.00% | 94.00% | 93.00% | 93.00% | 93.00% | | | | | |
| HR: Turnover Rate | | <= 10% | 11.00% | 13.00% | 13.00% | 14.00% | 16.00% | 14.00% | 14.00% | | | | | |

## 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 | | | | | |
| 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 | | | | | |
| 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 | | | | | |
| 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 | | | | | |
| Monitor: Financial Sustainability Risk Rating: Capital Cover | | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 4 | | | | | |
| Monitor: Financial Sustainability Risk Rating: Liquidity | | 2 (1 from Sep 2016) | 2 | 2 | 1 | 1 | 1 | 1 | 4 | | | | | |
| Monitor: Financial Sustainability Risk Rating: I & E Margin | | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 4 | | | | | |
| Monitor: Financial Sustainability Risk Rating: Variance to Plan | | 4 | 4 | 4 | 4 | 3 | 3 | 4 | 1 | | | | | |
| Monitor: Financial Sustainability Risk Rating: Overall Score | | 2 | 1 | 2 | 2 | 2 | 2 | 2 | 3 | | | | | |
| Monitor: Financial Sustainability Risk Rating: Agency Cap | | 0 | 51 | 25 | 57 | 88 | 75 | 68 | 138 | | | | | |

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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total Caesarean Section Rate | | < 23% | 28.29% | 28.41% | 28.00% | 29.59% | 28.57% | 27.76% | 26.35% | | | | | |
| Elective Caesarean Section Rate | | < 10% | 13.00% | 12.61% | 14.17% | 13.57% | 14.42% | 14.40% | 13.93% | | | | | |
| Safer Staffing Levels (Overall - includes Registered and Care Staff) | | <= 90% | 92.78% | 91.92% | 92.60% | 91.70% | 86.86% | 89.50% | 89.14% | | | | | |
| Serious Incidents: Number of Open SI's | | Monitoring Only | 23 | 23 | 20 | 20 | 20 | 19 | 21 | | | | | |
| Serious Incidents: Number of New SI's | | Monitoring Only | 1 | 2 | 4 | 2 | 2 | 2 | 5 | | | | | |
| % of women seen by a midwife within 12 weeks | | >= 90% | 96.82% | 95.44% | 95.70% | 94.88% | 91.78% | 93.28% | 92.38% | | | | | |
| Neonatal Bloodstream Infection Rate | | TBD | 0.11 | 0.00 | 0.00 | 0.36 | 0.00 | 0.00 | 0.00 | | | | | |

## 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% | | | | | |
| Biochemical Pregnancy Rates | | > 30% TBC | 45.94% | 47.62% | 46.21% | 44.70% | 47.13% | 48.63% | 45.58% | | | | | |
| Still Birth Rate (excludes late transfers) | | TBD | 0.00 | 0.01 | 0.01 | 0.01 | 0.00 | 0.00 | 0.00 | | | | | |
| Neonatal Deaths (all live births within 28 days) | | Rate per 1000 TBD | 1.44 | 2.90 | 6.65 | 1.33 | 2.66 | 5.17 | 0.00 | | | | | |
| Returns to Theatre | | <= 0.7% TBC | 0.64% | 1.03% | 0.50% | 0.51% | 0.22% | 0.21% | 0.32% | | | | | |

## 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% | | | | | |
| Number of Complaints received | | <= 15 | 15 | 5 | 13 | 18 | 13 | 19 | 16 | | | | | |
| 18 Week RTT Incompletes (aggregate) | | >= 92% | 95.71% | 95.90% | 93.86% | 95.20% | 94.28% | 92.63% | 92.20% | | | | | |
| Friends & Family Test | | > 75% | 99.26% | 98.47% | 98.60% | 97.52% | 98.37% | 99.11% | 98.51% | | | | | |
| % 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% | | | | | |
| % 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% | | | | | |
| 6 Week Wait Diagnostic Tests | | >= 99% | 98.96% | 97% | 98% | 100% | 97% | 100% | 99.22% | | | | | |
| Last Minute Cancellation for non-clinical reasons | | <= 4% | 4.30% | 6.31% | 5.81% | 5.01% | 4.79% | 4.20% | 2.64% | | | | | |
| Last Minute Cancellation for non-clinical reasons (Not re-admitted within 28 days) | | 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 | | | | | |

Liverpool Women's NHS Foundation Trust

# Safe Staffing Report - October 2016

| 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 1 | 100.0% | 100.0% | 9.7 | 97.3% | 97.2% | | 7.01% | 10% | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 19 | 95% |
| *Narrative* | Sickness is being monitored and managed locally in accordance with the attendance management policy. | | | | | | | | | | | | | | | | | | | | |
| Gynae 2 | 93.9% | 100.0% | 6.6 | 93.4% | 112.9% | | 5.49% | 15% | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 30 | 100% |
| *Narrative* | Sickness is being monitored and managed locally in accordance with the attendance management policy. Staff turnover is high but is conducive to the implementation of the impatient redesign work | | | | | | | | | | | | | | | | | | | | |
| Delivery & Induction Suites | 86.5% | 82.3% | 19.8 | 122.6% | 83.9% | | 1.35% | 11% | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | |
| *Narrative* | | | | | | | | | | | | | | | | | | | | | |
| Mat Base | 83.1% | 78.8% | 4.2 | 81.9% | 88.2% | | 8.27% | 9% | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 7 | 73 | 97% |
| *Narrative* | Fill rates on day and night duty are monitored and reviewed against the ward occupancy and acuity. Midwife to patient ratios have been maintained safely at 1:8/9 . Appropriate staffing levels have improved with the introduction of the daily huddle and the temporary closure of Jeffcoate, as staff are moved to areas of highest demand /acuitiy. | | | | | | | | | | | | | | | | | | | | |
| MLU & Jeffcoate | 76.2% | 88.2% | 15.1 | 76.7% | 82.4% | | 14.50% | 7% | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | |
| *Narrative* | During this month as a result of low occupancy on Jeffcoate has temoporarily closed. Staffing levels are reviewed on a daily basis at the huddle and staff are redeployed to areas with the most need.Sickness is being monitored and managed locally in accordance with the attendance management policy. | | | | | | | | | | | | | | | | | | | | |
| NICU | 99.8% | 100.4% | 11.6 | 78.3% | 68.3% | | 3.72% | 11% | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | None | None |
| *Narrative* | Safe staffing has been achieved throughout the month. The unit will be reviewing the use of registered/unregistered posts and responsibilities within the low dependancy area and rotas will be adjusted accordingly. Turnover is not a cause for concern. (2 leavers who are not retire and returns) | | | | | | | | | | | | | | | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| *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:** | 16/314 |

| | |
|---|---|
| **Meeting:** | Board of Directors |

| | |
|---|---|
| **Date:** | 2 December 2016 |

| | |
|---|---|
| **Title:** | Month 7 2016/17 Finance Report |

| | |
|---|---|
| **Report to be considered in public or private?** | Public |

| | |
|---|---|
| **Where else has this report been considered and when?** | n/a |

| | |
|---|---|
| **Reference/s:** | Operational Plan and Budgets 2016/17 |

| | |
|---|---|
| **Resource impact:** | - |

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

| | |
|---|---|
| **Which Board Assurance Framework risk/s does this report relate to?** | 5a |

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

| | |
|---|---|
| **What action is required at this meeting?** | To note the Month 7 financial position |

| | |
|---|---|
| **Presented by:** | Vanessa Harris - 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 | |

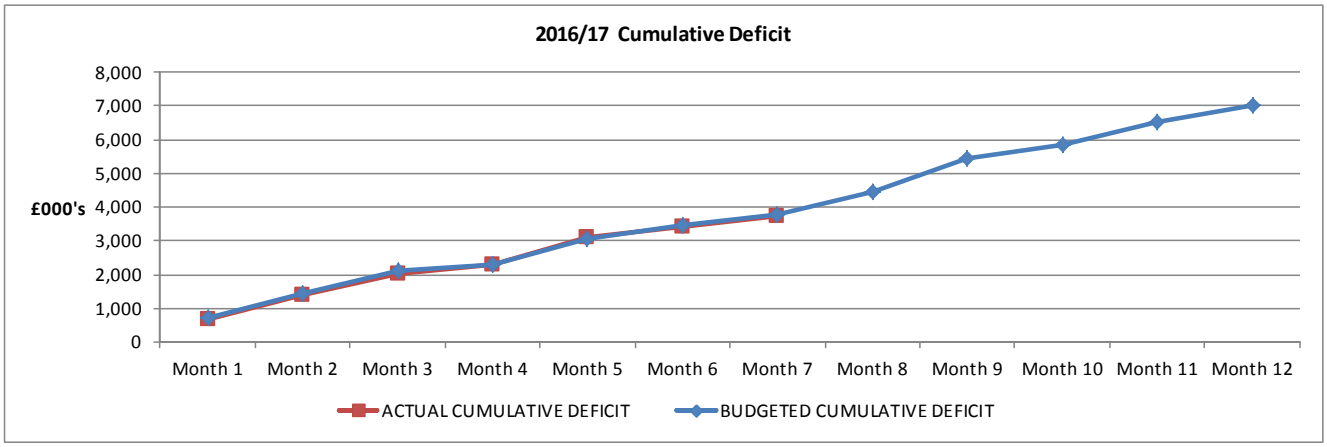
## 1. Executive Summary

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 of 2 and a cash shortfall of £7.7m. This planned position assumes receipt in full of £2.8m Sustainability and Transformation Funding.

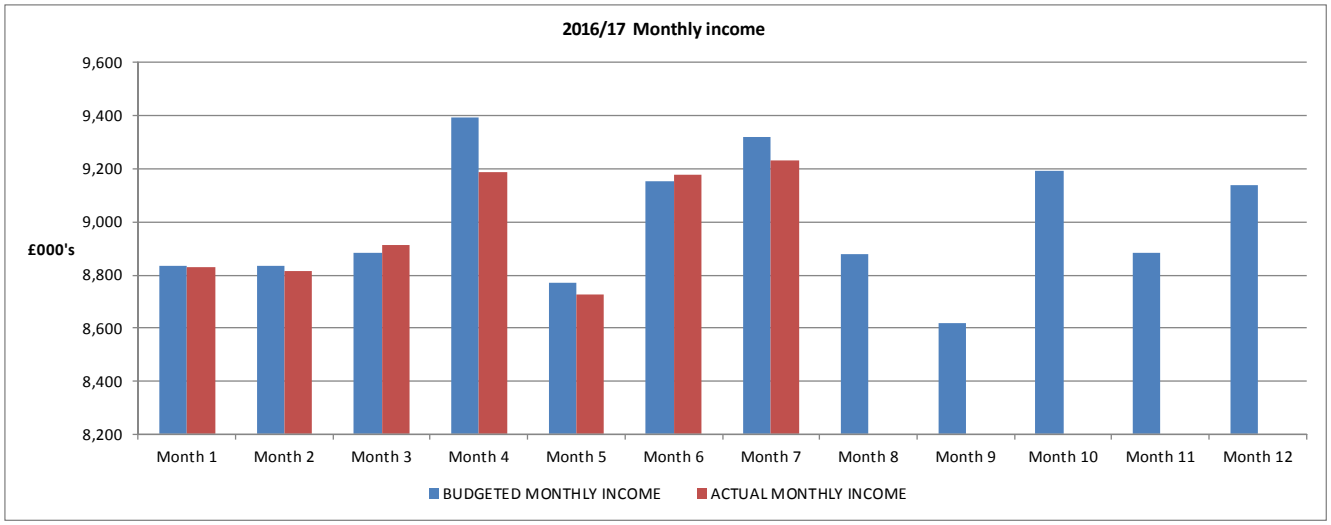
In Month 7 the Trust is reporting a monthly deficit of £0.300m against a deficit plan of £0.283 which is a negative variance of £0.017m for the month. Cumulatively the Trust is ahead of plan by £0.022m.

Following further detailed review in Month 7, the Trust is still forecasting to achieve the overall control total of £7m deficit for the full year, although there are some key areas of over and under-performance within that total and issues to be addressed in order to ensure delivery of the anticipated control total in 2017/18. These are reported in section 3.

## 2. Summary Financial Position




Total income in month was lower than plan, the plan was the second highest planned income target of the year however this profile was established on the basis of previous years activity profiles.




Pay expenditure overall remains below budget predominantly due to vacancies across a number of services including neonates, Hewitt Centre, Catherine Medical and genetics. With the exception of

neonates the vacancies are reflective of controls over staffing in relation to lower than planned levels of activity in those services.

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

Following a mid-year review of the currently paused capital program and current level of cash borrowings, the Trust has been able to report a positive forecast in relation to technical items.

On 1 October 2016 the new Single Oversight Framework regime came into force. The Trust delivers a rating of 3 (with a 4 being the lowest rating) as per the table set out in Appendix 2. The Trust had planned an FSRR of 2 which ranks comparably under the new framework.

## 3. Forecast Year End Position

The Trust is still forecasting it will deliver the £7m control total in year and therefore be able to access the full £2.8m of sustainability funding. However there are a number of service areas which show a significant deterioration in their year end forecast position, these are set out in the table below and explained in the service review in section 4.

The Trust has also identified a number of areas which have either received additional income or are further ahead of forecast than expected, also set out in the table below and explained in section 4.

| *Summary of movement in forecast from M6 to M7* | |
|---|---|
| **Opening forecast outturn (achievement of control total)** | **£7.0m** |
| Hewitt Fertility Centre adverse variance movement (£0.6m to £1.3m) | £0.7m |
| Gynaecology reduction in forecast over-performance from £0.3m to £nil | £0.3m |
| **Deficit (£7m + £1.0m)** | **£8.0m** |
| Additional income received from HEE leading improvement in neonatal forecast from £0.4m adverse to £nil | (£0.4m) |
| Improvement in technical items arising from paused capital program | (£0.2m) |
| Utilisation of previously uncommitted non-pay inflation | (£0.2m) |
| **Closing forecast outturn (achievement of control total)** | **£7.0m** |

The net impact is that the Trust can retain the forecast position, however without unexpected income or committing most of the Trust non pay inflation reserve this would not be possible. This leaves the Trust in a difficult position as it has minimal reserves to manage any further in year variances and also raises concern in respect of the recurrent position for 17/18 planning.

In order to improve this position and reduce the level of risk actions will be required by the Trust including;

- Freeze all discretionary spend
- Freeze/pause any vacancies which are not front line clinical staff

- Further escalate performance management of those areas which are failing to deliver agreed budgets
- Bring forward/accelerate the delivery of cost saving schemes for 17/18

The impact of the actions will be monitored closely to the end of the financial year.

## 4. Service Review

As described above there are a number of areas which require further explanation. Detailed figures can be found in Appendix 1.

**Hewitt Fertility Centre (HFC)**
The financial impact to date is a net £0.558m behind plan with a projected £1.269m full year shortfall. This has worsened from the previously reported £0.573m full year shortfall. The deterioration in the HFC financial position is impacted by three key issues

a) Further deterioration within forecast activity
b) Slippage within the delivery of the recovery plans
c) Non-delivery of the Kings Joint Venture contribution (CIP scheme) and subsequent losses

During November 2016 an offer was received in respect of the sale of the Kings Joint Venture. In summary this offer reimburses the Trust for the value of the Trust's capital investment and allows the Trust to exit the venture at a time when losses are being incurred and expected to worsen.

The Trust's share of the loss so far this financial year is £0.32m (being 50% of the reported total loss of £0.64m year to date). It is expected that the venture will continue to make a loss for the foreseeable future and it is advisable to exit at this point. The cumulative financial position over the three years of the joint venture agreement is effectively breakeven.

The Kings Joint Venture was one of the Trust's 2016/17 CIP schemes with a target of £0.5m contribution. The non-delivery of this £0.5m plus the share of the loss in year impacts delivery of this target by £0.8m. Whilst this is mitigated in 2016/17 (see section 3), the recurrent impact of the non-delivery of £0.5m contribution must be included in the HFC's recovery plans.

HFC recovery is currently being scrutinised by Non Executive Director chaired Hewitt Oversight Board, and additional turnaround support has been pointed towards this area.

**Gynaecology and Theatres**
Activity performance across general gynaecology services was strong during the first half of the financial year. This over performance more than offset the under performance in gynae oncology, overall delivering a positive income position against plan. However, in month 7 total gynaecology income is £0.033m behind plan with levels of general gynaecology income no longer supporting the shortfall in oncology.

Over-performance in gynaecology had previously supported the mitigation of the non-delivery of the theatres efficiency CIP (full year target £0.5m). However based on the latest forecast this is no longer the case.

**Neonatal**
The majority of neonatal income is on block contract and as such is not directly impacted by activity on a month by month basis. During 2016/17 both NHS England and Health Education England (HEE) were approached to support a shortfall in funding for the costs of staffing and staff training to cover the current levels of activity. During November 2016 £0.4m of funding was secured on a non-recurrent basis from HEE.

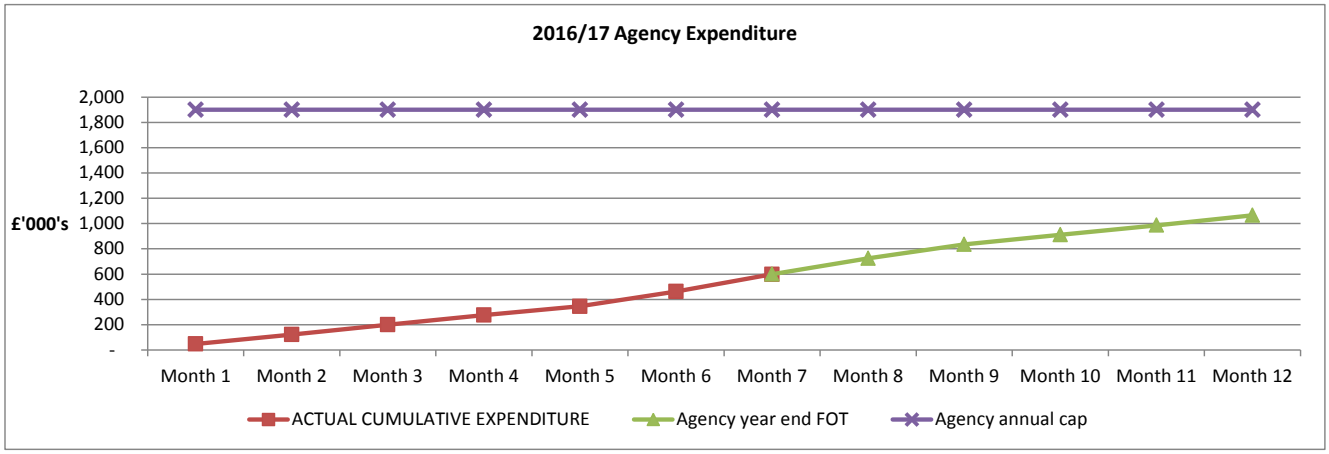
This, along with tight management control, has brought the service back to its financial target for the full year.

**Further Mitigations**

In order to mitigate the above the Trust has utilised £0.6m of the available non-pay inflation contingency of £0.8m. The majority of the remaining mitigation has been achieved by reforecasting technical items (depreciation and interest payable) following the Trust's decision to pause the capital program.

## 5. 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. The Trust is third highest performing in the North region in terms of meeting the agency cap.

## 6. CIP Delivery

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

Under-delivery of the ten identified 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.

## 7. 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 which is now in the process of being repaid at a principle sum of £0.6m per annum.

The £5.6m Interim Revenue Support is due for repayment, in full, in March 2018. This will need to be replaced by longer term, planned support.

The Trust's financial plan for 2016/17 indicated a further requirement for cash of £7.7m. Whilst this request is being finalised centrally the Trust has in place a £2.5m working capital facility at an interest rate of 3.5%. NHS Improvement have been approached with regards to increasing this facility in the short term, and it has been confirmed that the working capital facility can be extended, in advance on

a month by month basis, whilst DH assess the full national cash requirement. This is taken into account when the Trust produces its 13 week cash flow for submission to NHSI and the DH each month.

The Trust has drawn down £2m from the working capital facility as at Month 7. An additional £1m will be required in December 2016. This will amount to £3m in total by the end of Quarter 3 against a full year planned requirement of £7.7m. This positive position has been supported by the paused capital program which at Month 7 was £1.4m against a year to date budget of £3.1m and a full year budget of £4.3m.

The Trust's cash flow requirements are produced on a daily basis. The latest cash flow, which has undergone sensitivity analysis, indicates that the Trust will be within the £7.7m planned figure for the full year.

The cash balance as at the end of Month 7 was £3.6m.

## 8. BAF Risk

As a result of the deterioration in the HFC position and the utilisation of the available mitigation, it is recommended that the BAF risk 5a element in relation to the achievement of the 2016/17 control total should be elevated.

This currently stands at 15 (possible and catastrophic). It is proposed that this be raised to 20 (probable and catastrophic).

## 9. Conclusion & Recommendation

The Board are asked to note the Month 7 financial position and actions to improve the position to the year end.

Appendix 1

# LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

# FINANCE REPORT: M7

# YEAR ENDED 31 MARCH 2017

## Contents

**LIVERPOOL WOMEN'S NHS FOUNDATION TRUST**
**NHS IMPROVEMENT RATIOS: M7**
**YEAR ENDED 31 MARCH 2017**

| 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 | 88 | (84) | (400) | (990) |
| **(b)** PDC + Interest Payable + Loans Repaid | 1,531 | 1,413 | 2,712 | 2,394 |
| **CSC Ratio = (a) / (b)** | **0.06** | **(0.06)** | **(0.15)** | **(0.41)** |
| **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 | (5,200) | (3,927) | (8,924) | (8,924) |
| **(b)** Expenditure | 63,103 | 62,975 | 108,297 | 108,060 |
| **(c)** Daily Expenditure | 300 | 300 | 301 | 300 |
| **Liquidity Ratio = (a) / (c)** | **(17.3)** | **(13.1)** | **(29.7)** | **(29.7)** |
| **NHSI LIQUIDITY SCORE** | **4** | **3** | **4** | **4** |
| **Ratio Score** **1** = > 0 **2** = (7) - 0 **3** = (14) - (7) **4** = < (14) | | | | |
| **I&E MARGIN** | | | | |
| Deficit (Adjusted for donations and asset disposals) | 3,761 | 3,741 | 6,992 | 6,992 |
| Total Income | (62,895) | (62,880) | (107,395) | (106,866) |
| **I&E Margin** | **-5.98%** | **-5.95%** | **-6.51%** | **-6.54%** |
| **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) | | -5.95% | | -6.51% |
| I&E Margin (Plan) | | -5.98% | | -6.51% |
| **I&E Variance Margin** | **0.00%** | **0.03%** | **0.00%** | **0.00%** |
| **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** | 1,122 | 1,122 | 1,924 | 1,924 |
| **YTD Agency Expenditure** | 413 | 594 | 708 | 1,065 |
| | **-63.20%** | **-47.07%** | **-63.20%** | **-44.65%** |
| **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: scoring a 4 on any of the metrics will lead to a financial override score of 3.**
**Note: FOT re-stated to reflect updated Hewitt Centre Kings JV position**

**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.**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
INCOME & EXPENDITURE: M7
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 | (8,737) | (8,667) | (71) | (59,098) | (58,971) | (128) | (100,881) | (100,368) | (514) |
| Non-Clinical Income | (584) | (567) | (17) | (4,087) | (3,910) | (177) | (7,006) | (6,691) | (315) |
| **Total Income** | **(9,321)** | **(9,233)** | **(88)** | **(63,185)** | **(62,880)** | **(305)** | **(107,887)** | **(107,058)** | **(829)** |
| **Expenditure** | | | | | | | | | |
| Pay Costs | 5,613 | 5,607 | 6 | 39,288 | 38,706 | 581 | 67,352 | 66,694 | 658 |
| Non-Pay Costs | 2,250 | 2,246 | 4 | 15,470 | 15,923 | (453) | 26,638 | 27,059 | (421) |
| CNST | 1,192 | 1,192 | 0 | 8,346 | 8,346 | 0 | 14,307 | 14,308 | (1) |
| **Total Expenditure** | **9,055** | **9,045** | **10** | **63,103** | **62,975** | **129** | **108,297** | **108,060** | **237** |
| **EBITDA** | **(266)** | **(188)** | **(78)** | **(82)** | **94** | **(176)** | **410** | **1,002** | **(592)** |
| **Technical Items** | | | | | | | | | |
| Depreciation | 375 | 339 | 36 | 2,625 | 2,549 | 76 | 4,500 | 4,227 | 273 |
| Interest Payable | 35 | 20 | 15 | 245 | 191 | 54 | 420 | 239 | 181 |
| Interest Receivable | (1) | (1) | 0 | (6) | (10) | 4 | (10) | (11) | 1 |
| PDC Dividend | 140 | 131 | 9 | 980 | 917 | 63 | 1,680 | 1,543 | 137 |
| Profit / Loss on Disposal | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total Technical Items** | **549** | **488** | **61** | **3,844** | **3,647** | **198** | **6,590** | **5,998** | **592** |
| **(Surplus) / Deficit** | **283** | **300** | **(17)** | **3,763** | **3,741** | **22** | **7,000** | **7,000** | **0** |

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 3
EXPENDITURE: M7
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 | 351 | (13) | 2,361 | 2,351 | 9 | 4,047 | 4,005 | 42 |
| Medical | 1,271 | 1,244 | 26 | 8,894 | 8,720 | 175 | 15,248 | 14,954 | 293 |
| Nursing & Midwifery | 2,504 | 2,459 | 45 | 17,527 | 17,019 | 508 | 30,047 | 29,424 | 623 |
| Healthcare Assistants | 391 | 392 | (2) | 2,736 | 2,757 | (20) | 4,691 | 4,730 | (39) |
| Other Clinical | 543 | 487 | 56 | 5,350 | 5,106 | 245 | 6,513 | 6,064 | 449 |
| Admin Support | 159 | 160 | (1) | 1,112 | 1,176 | (64) | 1,906 | 2,006 | (100) |
| Corporate Services | 358 | 378 | (20) | 956 | 979 | (23) | 4,299 | 4,444 | (146) |
| Agency & Locum | 50 | 136 | (86) | 350 | 599 | (249) | 600 | 1,065 | (465) |
| **Total Pay Costs** | **5,613** | **5,607** | **6** | **39,288** | **38,706** | **581** | **67,352** | **66,694** | **658** |
| **Non Pay Costs** | | | | | | | | | |
| Clinical Suppplies | 755 | 749 | 6 | 5,156 | 5,223 | (67) | 8,858 | 8,919 | (61) |
| Non-Clinical Supplies | 614 | 649 | (35) | 4,144 | 4,569 | (425) | 7,203 | 7,708 | (506) |
| CNST | 1,192 | 1,192 | 0 | 8,346 | 8,346 | 0 | 14,307 | 14,308 | (1) |
| Premises & IT Costs | 415 | 411 | 4 | 2,907 | 2,901 | 6 | 4,983 | 4,958 | 25 |
| Service Contracts | 466 | 437 | 29 | 3,263 | 3,230 | 33 | 5,594 | 5,473 | 120 |
| **Total Non-Pay Costs** | **3,443** | **3,439** | **4** | **23,816** | **24,268** | **(453)** | **40,945** | **41,367** | **(421)** |
| **Total Expenditure** | **9,055** | **9,045** | **10** | **63,103** | **62,975** | **129** | **108,297** | **108,060** | **237** |

**LIVERPOOL WOMEN'S NHS FOUNDATION TRUST**
**BUDGET ANALYSIS: M7**
**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 | (3,514) | (3,491) | (22) | (23,750) | (24,398) | 648 | (40,771) | (41,645) | 874 |
| Expenditure | 1,698 | 1,703 | (5) | 11,886 | 12,075 | (188) | 20,378 | 20,825 | (447) |
| **Total Maternity** | **(1,816)** | **(1,788)** | **(28)** | **(11,863)** | **(12,323)** | **460** | **(20,393)** | **(20,821)** | **428** |
| **Gynaecology** | | | | | | | | | |
| Income | (2,114) | (2,081) | (33) | (14,165) | (14,527) | 363 | (23,965) | (24,512) | 547 |
| Expenditure | 879 | 959 | (80) | 6,156 | 6,484 | (328) | 10,554 | 11,110 | (557) |
| **Total Gynaecology** | **(1,234)** | **(1,121)** | **(113)** | **(8,009)** | **(8,043)** | **34** | **(13,411)** | **(13,401)** | **(10)** |
| **Theatres** | | | | | | | | | |
| Income | (42) | (42) | (0) | (294) | (293) | (1) | (504) | (501) | (3) |
| Expenditure | 608 | 644 | (36) | 4,257 | 4,533 | (277) | 7,298 | 7,700 | (402) |
| **Total Theatres** | **566** | **603** | **(37)** | **3,963** | **4,241** | **(278)** | **6,794** | **7,199** | **(405)** |
| **Neonatal** | | | | | | | | | |
| Income | (1,409) | (1,360) | (49) | (9,863) | (9,556) | (307) | (16,908) | (16,778) | (130) |
| Expenditure | 997 | 976 | 21 | 6,980 | 6,788 | 193 | 11,967 | 11,815 | 152 |
| **Total Neonatal** | **(411)** | **(384)** | **(28)** | **(2,882)** | **(2,768)** | **(114)** | **(4,941)** | **(4,963)** | **22** |
| **Hewitt Centre** | | | | | | | | | |
| Income | (1,086) | (899) | (187) | (7,024) | (6,081) | (943) | (11,874) | (9,913) | (1,961) |
| Expenditure | 751 | 645 | 105 | 5,125 | 4,741 | 385 | 8,805 | 8,113 | 692 |
| **Total Hewitt Centre** | **(335)** | **(254)** | **(82)** | **(1,898)** | **(1,340)** | **(558)** | **(3,069)** | **(1,799)** | **(1,269)** |
| **Genetics** | | | | | | | | | |
| Income | (596) | (559) | (37) | (4,167) | (3,962) | (205) | (7,143) | (6,746) | (397) |
| Expenditure | 446 | 416 | 31 | 3,125 | 2,992 | 134 | 5,358 | 5,165 | 193 |
| **Total Genetics** | **(150)** | **(143)** | **(7)** | **(1,041)** | **(970)** | **(71)** | **(1,785)** | **(1,581)** | **(204)** |
| **Catharine Medical Centre** | | | | | | | | | |
| Income | (101) | 9 | (110) | (544) | (134) | (410) | (817) | (134) | (683) |
| Expenditure | 80 | 24 | 56 | 392 | 195 | 197 | 557 | 247 | 309 |
| **Total Catharine Medical Centre** | **(22)** | **33** | **(55)** | **(152)** | **61** | **(213)** | **(260)** | **113** | **(374)** |
| **Clinical Support & CNST** | | | | | | | | | |
| Income | (25) | (28) | 3 | (172) | (189) | 18 | (291) | (302) | 10 |
| Expenditure | 733 | 705 | 28 | 5,129 | 5,061 | 68 | 8,793 | 8,621 | 172 |
| **Total Clinical Support & CNST** | **708** | **677** | **31** | **4,957** | **4,871** | **86** | **8,502** | **8,320** | **183** |
| **Corporate** | | | | | | | | | |
| Income | (755) | (783) | 29 | (3,528) | (3,740) | 212 | (6,165) | (6,528) | 363 |
| Expenditure | 3,732 | 3,461 | 271 | 24,217 | 23,753 | 463 | 41,728 | 40,462 | 1,267 |
| **Total Corporate** | **2,978** | **2,677** | **300** | **20,689** | **20,013** | **676** | **35,563** | **33,933** | **1,630** |
| **(Surplus) / Deficit** | **283** | **300** | **(17)** | **3,763** | **3,741** | **22** | **7,000** | **7,000** | **0** |

Note: FOT re-stated to reflect updated Hewitt Centre Kings JV position

# LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
## BALANCE SHEET: M7
## YEAR ENDED 31 MARCH 2017

| BALANCE SHEET £'000 | YEAR TO DATE Opening | M07 Actual | Movement |
|---|---|---|---|
| **Non Current Assets** | **70,529** | **69,330** | (1,199) |
| **Current Assets** | | | |
| Cash | 3,225 | 3,568 | 343 |
| Debtors | 4,302 | 7,388 | 3,086 |
| Inventories | 326 | 333 | 7 |
| **Total Current Assets** | **7,853** | **11,289** | **3,436** |
| **Liabilities** | | | |
| Creditors due < 1 year | (8,056) | (12,556) | (4,500) |
| Creditors due > 1 year | (1,748) | (1,761) | (13) |
| Commercial loan | (10,794) | (12,489) | (1,695) |
| Provisions | (2,392) | (2,162) | 230 |
| **Total Liabilities** | **(22,990)** | **(28,968)** | (5,978) |
| **TOTAL ASSETS EMPLOYED** | **55,392** | **51,651** | **(3,741)** |
| **Taxpayers Equity** | | | |
| PDC | 36,610 | 36,610 | 0 |
| Revaluation Reserve | 10,019 | 10,019 | 0 |
| Retained Earnings | 8,763 | 5,022 | (3,741) |
| **TOTAL TAXPAYERS EQUITY** | **55,392** | **51,651** | **(3,741)** |

## Appendix 1: Board Finance Pack

See above

## Appendix 2 : Single Oversight Framework - Use of Resources Rating

| 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 | 88 | (84) | (400) | (990) |
| **(b)** PDC + Interest Payable + Loans Repaid | 1,531 | 1,413 | 2,712 | 2,394 |
| **CSC Ratio = (a) / (b)** | **0.06** | **(0.06)** | **(0.15)** | **(0.41)** |
| **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 | (5,200) | (3,927) | (8,924) | (8,924) |
| **(b)** Expenditure | 63,103 | 62,975 | 108,297 | 108,060 |
| **(c)** Daily Expenditure | 300 | 300 | 301 | 300 |
| **Liquidity Ratio = (a) / (c)** | **(17.3)** | **(13.1)** | **(29.7)** | **(29.7)** |
| **NHSI LIQUIDITY SCORE** | 4 | 3 | 4 | 4 |
| **Ratio Score** **1** = > 0 **2** = (7) - 0 **3** = (14) - (7) **4** = < (14) | | | | |
| **I&E MARGIN** | | | | |
| Deficit (Adjusted for donations and asset disposals) | 3,761 | 3,741 | 6,992 | 6,992 |
| Total Income | (62,895) | (62,880) | (107,395) | (106,866) |
| **I&E Margin** | **-5.98%** | **-5.95%** | **-6.51%** | **-6.54%** |
| **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) | | -5.95% | | -6.51% |
| I&E Margin (Plan) | | -5.98% | | -6.51% |
| **I&E Variance Margin** | **0.00%** | **0.03%** | **0.00%** | **0.00%** |
| **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** | 1,122 | 1,122 | 1,924 | 1,924 |
| **YTD Agency Expenditure** | 413 | 594 | 708 | 1,065 |
| | **-63.20%** | **-47.07%** | **-63.20%** | **-44.65%** |
| **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.**

| | |
|---|---|
| **Agenda item no:** | 16/315 |

| | |
|---|---|
| **Meeting:** | Board of Directors |

| | |
|---|---|
| **Date:** | 2 December 2016 |

| | |
|---|---|
| **Title:** | Board Assurance Framework |

| | |
|---|---|
| **Report to be considered in public or private?** | Public |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Purpose - what question does this report seek to answer?** | Does the Board Assurance Framework provide assurance that the key risks to strategic aims are being controlled/ mitigated? | | | | | | | |
| **Report For:** | **I**nformation | (✓) | **D**ecision | (✓) | **E**scalation | (✓) | **A**ssurance | (✓) |

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

| | |
|---|---|
| **Reference/s:** | N/A |

| | |
|---|---|
| **Resource impact:** | |

| | |
|---|---|
| **What action is required at this meeting?** | Review of the BAF and consideration of any change proposals. |

| | |
|---|---|
| **Presented by:** | Colin Reid, Trust Secretary |

| | |
|---|---|
| **Prepared by:** | Risk Team |

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 | |
| NHS constitution | | Operational plan | |

| **Which standard/s does this issue relate to:** | |
|---|---|
| Care Quality Commission<br>Hospital Inspection Regime Indicator | All |
| Board Assurance Framework Risk | All |

| **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

The Board Assurance Framework (BAF) is designed to provide the Board with an easily digestible overview of the principal risks relating to the strategic aims of the organisation. It highlights ownership and accountability through identification of the Executive Lead and of the Non-Executive via the associated Board Committee.

The BAF lists alongside each principal risk those associated risks that are being managed at service level or via the Corporate Risk Register. It is for the Board to form a view of their satisfaction with the assurance(s) provided and identify any gaps and actions they consider necessary.

## 2. Key Themes

Since the last meeting of the Board Directors the following sub-Committees of the Board have met and considered the BAF risks for which they are responsible:

Governance & Clinical Assurance Committee: 18 November 2016
The GACA Committee agreed to de-escalate Risk 1944 (1m on the BAF) after receiving a report from the Director of Operations outlining a reduction in the likelihood of occurrence, fewer reported incidents and a refined process. It was agreed that this risk be de-escalated and managed locally on the Neonatal Transport Team's risk register.

Putting People First Committee: 21 November 2016
The PPF Committee agreed to reduce the score of Risk 1909 (4c on the BAF). The Committee were informed that the risk to clinical services caused by industrial action by junior doctors was now lower in view of the reduced likelihood of a full withdrawal of labour. This risk is now scored at 4 rather than 20. There are discussions underway regarding de-escalating this risk off the BAF in the near future.

Finance, Performance & Business Development Committee: 25 November 2016
The Committee agreed that the score for Risk 1663 (5aii on the BAF) be increased in view of the increased likelihood of failure to achieve the 2016/17 control total. Full details of this were reported under agenda item 16/17/104 at FPBD.

Other Issues
The Trust commissioned an independent review of its Risk Management processes in July. This review was intended to complement a similar review conducted in 2015 and to compare current processes with those from 12 months ago. The review was carried out in September and October 2016 and included observations from an external expert along with a random anonymous sample of the views of Executive Directors, Directors, Senior Managers and staff spanning the organisation.

The findings were reported back through the Governance & Clinical Assurance Committee in November. The review confirmed that "risk management is applied consistently and thoroughly across the organisation" and gave an overall assessment of 'Good'. This compares favourably to the assessment 12 months ago of 'Satisfactory'. The report found a restructure of the Governance Team has led to changes to the central reporting of risk at a corporate level that have strengthened strategic overview.

The Board of Directors also considered that some of the risks currently on the BAF could be consolidated and that the definition of the risk is aligned more closely with the Strategic Objectives. Additionally there were a number of risks that remained on the BAF that maybe more appropriately held on the Corporate Risk Register. The Board that a review the BAF risks was undertaken and look to consolidate or remove the risk as appropriate and take to the Board Committees proposed changes for approval. This exercise is currently being undertaken and would be addressed with each Board

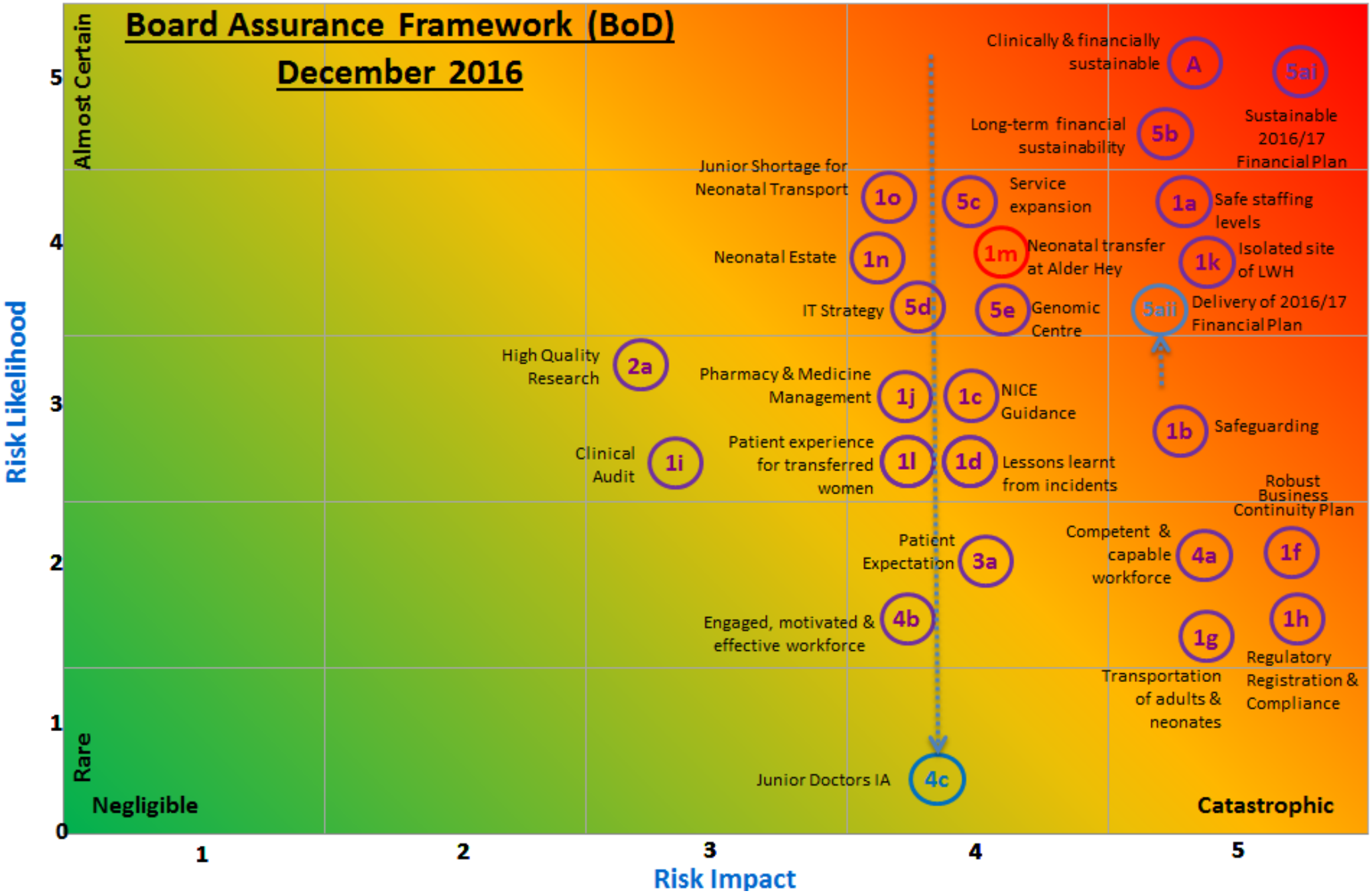
committee in the next round of meetings in January/February in readiness for the BAF to be updated and presented to the Board in March.

## 3. Conclusions and Recommendations

It is recommended that the Board:-

a) Review the BAF risks, their presented risk grading, controls, assurances and related gaps and required actions.
b) Note that Board committees will be asked to review any proposed changes to the Risks applicable with the committee areas of accountability with a view of ensuring only key strategic risks are included on the BAF and that the Corporate Risk Register be used to manage operational risks.
c) Note and communicate any change proposals.

**Appendix 1 – Heat-map of BAF Risks**



## Appendix 2 – Full details of BAF Risks

| SA Ref | Strategic Aim | ID of Sub-Risks | Enablers | Exec Lead (Resp Comm) | Risk Level | | Key Controls/Mitigation Action | Assurance/Evidence | Gaps in Control / Assurance | Action | Date for Completion |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **A** | **Deliver Liverpool Women's Hospital strategic intention effectively and efficiently ensuring sustainable quality services through transitional arrangements** | | | | **Initial** | **Current** | | | | | |
| i | In order to be clinically and financially sustainable the Trust will need to undertake major change over an extended time period (five years).<br>**Risk**: (1) Failure to communicate clearly and effectively during a period of significant changes.<br>(2) Failure to maintain a focus on the operational delivery of services.<br>(3) Failure to attract and retain high calibre clinicians and managers.<br>**Cause**: This level of change will produce a period of uncertainty and then radical change, this will be a significant plan to implement within the Trust capacity.<br>**Effect**: (1) Difficulty in retaining public and staff confidence in Trust services.<br>(2) Activity related to this subject may distract from day-to-day activity and therefore quality of services could reduce.<br>3) Staff choose to seek alternative employment and difficulties recruiting.<br>**Impact**:<br>(1) Reputational damage.<br>(2) Failure to maintain quality standards and CQC compliance.<br>(3) Inability to deliver PPF.<br>**Ulysses Ref:1846** | 1906<br>1962 | Risk Management Strategy | Chief Exec (FPBD) | **5x5 =25** | **5x5= 25** | • Board leadership internally and externally<br>• Executive Oversight<br>• Consistent and cohesive message from Board of Directors<br>• Board approval of strategic options business plan and stakeholder communication and engagement strategy<br>• Appointment of Project Director and Project Clinical Lead.<br>• Establishment of Future Generations Project Board<br>• Project Mandate for governance and risk arrangements.<br>•Communication and Engagement strategy agreed and Head of Communication appointed<br>• Pro-active engagement in Healthy Liverpool Programme.<br>• Regular dialogue with Monitor & CQC and CCG.<br>• Support external consultants(PwC) | • November 2014- Business Plan<br>• December 2014 - Communications Plan<br>• Board & CoG agendas to include monthly project updates.<br>• Staff survey / Pulse survey scores as reflection of staff engagement<br>• Minutes of Future Generations Project Board<br>• Regular dialogue with Monitor & CQC and CCG.<br>• Chair & CEO activity update reports re networking and dialogues with external stakeholders. | Yes | CCG Options Appraisal<br>Public Consultation | July 2016<br>Dec 2016 |

| 1 | 1. To deliver SAFE services<br><br>Risk Appetite - Low | | | | Initial | Current | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | **a)** To ensure appropriate and safe staffing levels are maintained<br>**Risk:** Failure to have operational grip / effective utilisation of resource .<br>**Cause:** 1) insufficient investment in clinical staffing to meet recommended staffing levels associated with Maternity Tariff 2) high sickness absence levels in midwifery workforce<br>**Effect:** Risk to financial viability associated with additional investment in nurse/midwifery staffing. Inadequate numbers of staff available to deliver services<br>**Impact:** Potential risk to patient safety and experience; risk to continuity of service rating; potential breach of CQC licence conditions<br>**Ulysses Ref: 1731.** | 146<br>1709<br>1863<br>1953 | Putting People First Strategy | DONM (GACA) | **5x4 =20** | **5x4= 20** | •Staffing Policies<br>•Escalation Policies<br>•Daily Monitoring Activity and Acuity<br>•Incident Reporting Policy and Process<br>•Bank<br>•Sickness and Absence Policy<br>•Health and Well Being Policy<br>•Unify returns<br>•Monitoring Performance Data<br>• Fill rates | •Annual Staffing Review<br>• Staff Survey & Pulse Survey<br>•KPI's<br>•Patient Survey<br>•Claims Litigation Incident PALS Report<br>• Monthly performance data (sickness)<br>•Nursing and Midwifery Board Minutes 08-04-14, (PPF Committee, 20-06-14, item 14/15/27)<br>• Leadership Programme Proposal (PPF Committee, 20-06-14, item 14/15/16)<br>• Evidence on NHS Choices<br>• CQC inspection report; overall rating for Trust Good | Yes | • Dashboard to be produced and tabled at GACA each month- to include current staffing levels, sickness, maternity, emerging risk and areas of concern.<br>• Staff feed back from Staff survey & Pulse Survey to be considered at PPF, | December, 2016 |
| 1 | **b)** To comply with national standards for the safeguarding of children and adults<br>**Risk:** Failure to ensure effective arrangements with partners to safeguard vulnerable adults and children<br>**Cause:** Lack of direction and control , systems and processes<br>**Effect:** Potential failure to prevent harm; damage to Trust reputation<br>**Impact:** May result in avoidable harm; may result in regulatory action; financial penalty; prosecution .<br>**Ulysses Ref: 1732** | 1895 | Quality Strategy<br><br>Safeguarding Strategy (draft) | DONM (GACA) | **5x3 =15** | **5x3= 15** | •Safeguarding Strategy<br>•Policy<br>•Mandatory Training<br>• KPI's<br>• Partnership/Networking arrangements<br>• Safeguarding Board<br>• Further interim support identified | •Peer review & associated action plan<br>• Audit (associated with Regulation 11)<br>• Contractual KPI's<br>• Annual Safeguarding Report.<br>• External Safeguarding Review report September 2014 and July 2015 | Yes | •Safeguarding dashboard to be tabled to GACA each meeting to highlight progress against key recommendations and risks | December, 2016 |

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| 1 | **c)** To consider and appropriately respond to NICE guidance**Risk:** Failure to comply may result in adverse public reaction, additional cost pressure or resources. Contractual obligation being compromised. **Cause:** Lack of robust, efficient and effective management system for decision Effect: Non-compliance or appropriate administration**Impact:** Contractual failure, loss of revenue or service, breaches of safety and adverse public reaction (complaint).<br>**Ulysses Ref: 1733.** | 1597 | Quality StrategySafeguarding Strategy (draft) | MD (GACA) | **4X3 =12** | **4X3= 12** | • NICE guidance and clinical audit managed by Head of Dept.• Software generates compliance reports• Best Practice Policy• Reports to Clinical Governance Committee | •New External NICE Guidance (June, 2014), (Clinical Governance Committee, 13-06-2014, Item 14/15/83 ... 11-07-2014, Item 14/15/117 … 12 --09-2014, Item, 14/15/133)• Communication-LOTW | Yes | • Quarterly update to GACA-1. NICE guidance in last 1/4. 2. Compliance performance. 3. Non-Compliance rationale and risk. | Decembe r, 2016 |
| 1 | **d)** To ensure lessons are learnt shared, and appropriate change enacted from the reporting and investigation of incidents locally and across the wider NHS Community.<br>**Risk:** Risk of repeat and costly events, regulatory action, service interruption, poor staff and patient experience<br>**Cause**: Poor system and training for reporting, recording, and investigating incidents<br>**Effect:** Compromised safety and learning outcomes<br>**Impact:** Regulatory action, increased cost, poor quality outcomes.<br>**Ulysses Ref: 1734** | 154<br>902<br>1707<br>1597 | Quality Strategy<br><br>Risk Management Strategy | DONM (GACA) | **4X4 =16** | **4X3= 12** | •Clear Policies(incident and SUI) • 10 yr. look back<br>•Mandatory Training<br>•RCA training<br>•Data Base recording and reporting | NRLS<br>•Performance Reports to GACA<br>• Complaints, Litigation, Incidents & PALS (CLIP) Report. (GACA 28-08-2014, Item,14/15/68)<br>•Serious Untoward Incident Report. (GACA 28-08-2014, Item,14/15/69)<br>• RCA training delivered September 2015<br>• NW Quality and Safety Forum member<br>• Quarterly SEE report | Yes | • Gap analysis of current themes. • Evidence/ Assurance that there are no un-escalated incidents. •Formal process for review/assurance to be undertaken by clinical audit | Decembe r, 2016 |
| 1 | **f)** To ensure the Trust has a robust business continuity plan that is understood and operational**Risk:** Failure to ensure the business continuity of the Trust **Cause:** Utilities, or Staff conditions creating major business interruption**Effect:** Limited service provision**Impact:** Compromised safety of service, financial loss.<br>**Ulysses Ref: 1736.** | 1571 | Business Continuity Plan | ADOps (GACA) | **5x4 =20** | **5x2= 10** | • Business Continuity Plan•Major Incident Plan• MRF Recovery Plan• Guidance early warning weather Report• Partnership/Local Authority/ Stakeholder working• Fuel Plan• Staff skills register• HPA plan | • Weather precautions (gritting)• Emergency Generator (monthly testing)• Drought/Flood plans ( external agencies)• Flu/Pandemic plans• Emergency exercise with Partners | None | | |

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| 1 | **g)** Transportation of adults and neonates across the critical care network<br>**Risk:** Patient safety compromised by inadequate arrangements, pathways, protocols, systems and equipment required for the safe transportation of 'critical care' patients<br>**Cause:** Patients in 'critical care' require treatment outside the scope and expertise available at LWH<br>Effect: Vulnerable patients potentially exposed to journey hazards<br>**Impact:** Patient safety and experience could be compromised.<br>**Ulysses Ref: 1737.** | | Risk Management Strategy<br><br>Putting People First Strategy | ADOps (GACA) | **5x4 =20** | **5x2= 10** | Transportation critical care neonates:<br>• Specialised cots for transport<br>• Dedicated specialised trained staff<br>•Policy and procedure for transportation<br>•Cot Bureau - patient allocated specific cot<br><br>Transportation of Adults - critical care:<br>•Critical care network standards<br>•Dedicated trained staff<br>•Transport Policy<br>•Education training/support from networks<br>•Escalation Policy<br>•External KPI's | •Compliance with CRG specification NNTS<br>•External KPI's- reported to NNW and CMNN | | • Seek patient's and clinician's feedback on the handling of transfers | January, 2017 |
| 1 | **h)** Maintaining appropriate Regulatory Registration and Compliance<br>**Risk:** Insufficient robust processes and management systems that provide regulatory compliance performance and assurance.<br>**Cause**: Failure to provide evidence and assurance to regulatory agencies<br>**Effect:** Enforcement action, prosecution, financial penalties, image and reputational damage<br>**Impact:** loss of commissioners/patient confidence in provision of services.<br>**Ulysses Ref: 1739.** | | Business Continuity Plan Risk Management Strategy Putting People First Strategy Quality Strategy | DONM (GACA) | **5x4 =20** | **5x2= 10** | • Monitor meetings<br>• CQC engagement meetings<br>• CQC registration updated to include detention of persons under Mental Health Act. | • CQC inspection report 2015; overall rating good. No restrictions placed on the Trust<br>• Internal inspection conducted in June 2016 to update regulatory knowledge | Yes | Inspection in December 2016 to include Exec, Non-Exec and external input | December, 2016 |
| 1 | **i)** To develop and support a comprehensive Clinical Audit provision<br>**Risk:** Failure to meet Statutory and Mandatory requirements, CPD for Clinicians<br>**Cause:** Lack of robust planning and monitoring, training and support<br>**Effect:** Breach of Statutory targets, failure of Trust to learn from clinical audit results<br>**Impact**: Potential action by CQC, image and reputation damage.<br>**Ulysses Ref: 1738.** | | Risk Management Strategy | MD (GACA) | **4x3 =12** | **3x3= 9** | •Forward Plan• Annual Report•Audits prioritised: Statutory, Mandatory and CPD• Performance KPI's | • Clinical Audit Forward Plan 2014/14- *What are the Trust's plans for clinical audit*? (GACAC 14-06-2014, Item, 14/15/44)•Research and Development Annual Report 2013/14- *What were the issues and achievements during the year*? (GACAC 14-06-2014, Item, 14/15/41)•Internal Audit (Baker Tilly) | Yes | • No evidence/assurances re-outcomes from clinical audit<br>• Evidence required to show 'learning' from clinical audit | December, 2016 |

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| 1 | **j)** Lack of robust systems and processes for the direction and control of Pharmacy and Medicine Management<br>**Risk**: Failure to maintain, update or review policy and guidance in a timely fashion<br>**Cause:** Staff shortages and change in leadership and arrangement with partner organisation<br>**Effect:** Significant amount of policy and guidance is past review date<br>**Impact**: Potential for safety to be compromised, staff not following best practice.<br>**Ulysses Ref: 1740.** | | Risk Management Strategy | ADOps (GACA) | **4x3 =12** | **4x3= 12** | • Training<br>• CPD<br>• Appraisal<br>• Medicines Management Committee | • Medicines Management Report -CQG Comm | Yes | | |
| 1 | **k)** Isolated Site of LWH<br>**Risk:** Location, size, layout and current services do not provide for sustainable integrated care package for quality service provision.<br>**Cause:** Patient, Public and stakeholders expectations and the financial cost of maintaining current facilities is not sustainable<br>**Effect:** The Trust's image and reputation is damaged. Our service offer is less attractive to commissioners<br>**Impact**: Loss of Business and revenue, loss of confidence in the Trust's ability to meet the needs of patients<br>**Ulysses Ref: 1809.** | | Risk Management Strategy | DONM (FPBD) | **5x4 =20** | **5x4= 20** | •Future Generation Project established<br>• Links to Stakeholders & Commissioners<br>• Project Board / Plans<br>• Monitoring of related care & service delivery issues via CGC and GACA. | • Board Papers / Updates Jan2014/ January 2015<br>• Project mandate<br>• Bi-monthly reports to Exec Committee.<br>. | None | | |

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| 1 | l) Patient Experience for Transferred Women **Risk:** Women are transferred out of Liverpool Women's for delivery elsewhere **Cause:** Cot closures, failure of the system to limit post natal transfers in, an increase in the birth rate at LWH, an increase in the number of babies born at extremely preterm gestations and a reduced mortality rate for babies born at those gestations. **Effect:** Women with babies likely to need admission to a Neonatal Unit because of either prematurity or congenital malformation are transferred out as there is no capacity to deliver this at Liverpool Women's due to reduced availability of neonatal cots. **Impact:** Poor patient experience for transferred women, continued growth of the maternity service will not be possible without an expansion of neonatal capacity. **Ulysses Ref: 1936.** | | Risk Management Strategy | ADOps (GACA) | **5x3 =15** | **4x3= 12** | • Raised with NHS England (increased funding for 48 cots)• Amended escalation policy re: out of area babies• Twice daily staffing and capacity reviews to Exec Team• Working with Neonatal network to preserve ITU cots for the sickest babies• Network Cot repatriation Policy in development• Daily Maternal & Neonatal review meetings | • Status Escalation Policy• Letters of escalation to NHS England• Network correspondence• Neonatal network Steering Group meetings• Meetings with NHS England• Incident reports of transfers• Log of transfers and outcomes | Yes | Respond to funding decision from NHS England | Novembe r, 2016 |
| 1 | **n)** Neonatal Estate**Risk:** Inability to safely meet the needs and demands of a changing neonatal service within the confines of the current environment and staffing establishment. **Cause:** Increased intensity, rising demand and over occupancy of Neonatal Unit **Effect:** Shortfall in staffing levels and skill mix to meet British Association of Perinatal Medicine (BAPM) standards, Inability to cohort colonised babies which is good practise without impacting on overall capacity within the unit, Environment does not meet the current requirement for a new unit (Health Building Note 09-03 Neonatal Units DOH 2013) leading to babies being nursed too close together and increasing risk of hospital acquired infection (HAI), lack of sufficient storage facilities for essential high cost equipment which is currently stored on main corridor increasing risk of damage , tampering and infection risk. **Impact**: Moderate to severe harm to patients. **Ulysses Ref: 1928** | | Risk Management Strategy | ADOps (FPBD) | **4x4 =16** | **4x4= 16** | • Raised with NHS England (increased funding for 48 cots)• Amended escalation policy re: out of area babies• Twice daily staffing and capacity reviews to Exec Team• Working with Neonatal network to preserve ITU cots for the sickest babies• Network Cot repatriation Policy in development• Daily Maternal & Neonatal review meetings | • Status Escalation Policy• Letters of escalation to NHS England• Network correspondence• Neonatal network Steering Group meetings• Meetings with NHS England• Incident reports of transfers• Log of transfers and outcomes | Yes | Respond to funding decision from NHS England | Novembe r, 2016 |

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| 1 | **o)** Junior Doctors Shortage on Neonatal Transport<br>**Risk:** Inability to provide a Neonatal Transport service<br>**Cause:** Shortage of junior doctors, skills gaps within junior doctor workforce<br>**Effect:** Gaps in the Neonatal Transport Team rota, inability to provide a neonatal transport service<br>**Impact**: Failure to transfer seriously ill patients, moderate to severe harm to patients.<br>**Ulysses Ref: TBC** | | Risk Management Strategy | ADOps (GACA) | **4x4 =16** | **4x4= 16** | • Training for ANNPs<br>• Assessments of junior doctors against competency framework<br>• Upskilling of existing ST4s<br>• Collaboration on business plan to NHS England for North-West wide solution<br>• Working with Manchester and NHS England on interim plan | • Letters of escalation to NHS England<br>• Correspondence with Manchester<br>• Training records for ANNPs and ST4s<br>• Meetings with NHS England | Yes | Business case submission and decision from NHS England | March, 2017 |

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| | **2. To participate in high quality research and to deliver the most effective outcomes**<br><br>**Risk Appetite - Low** | | | | **Initial** | **Current** | | | | | |
| 2 | **a)** Research adds value, and enhances services and reputation of the Trust<br>**Risk:** Research is not linked to strategic aims<br>**Cause:** Research work plan potentially insular and not connected to quality improvement of service provision<br>**Effect:** Research fails to contribute to the work of LWH<br>**Impact**: The cost of research function fails to yield measurable effective outcomes.<br>**Ulysses Ref: 1741.** | | Risk Management Strategy | MD (GACA) | **4x3 =12** | **3x3= 9** | • Regular reports to Clinical Governance Committee | • R&D Governance Report CGC Nov 2014<br>• BT R+D Internal Audit Report | None | | |

| | **3. To deliver the best possible experience for patients and staff**<br><br>**Risk Appetite - Low** | | | | **Initial** | **Current** | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 3 | **a)** To meet and where possible exceed patient expectations.<br>**Risk:** Failure to effectively engage and learn from patient, internal and external stakeholders to inform service development, corporate aims and annual plan**.**<br>**Cause:** Inadequate system & processes and structure; capacity and capability.<br>**Effect:** Failure to learn & improve the quality of service and experience.<br>**Impact**: Poor quality services leading to loss of income/activity; reputational damage; patient harm; turnover.<br>**Ulysses Ref: 1742.** | | Putting People First Strategy<br><br>Quality Strategy<br><br>Membership Strategy | DNM (GACA) | **4x4 =16** | **4x2= 8** | • Family and Friends Report<br>• Pt Stories to Board • Healthwatch /Stakeholders engagement<br>• Complaints and Compliments Report | •Patient & Staff Surveys• CLIP Report• Pt Stories to Board • Healthwatch /Stakeholders engagement<br>• Annual Complaints Report<br>• SI Report<br>• Performance Monitoring<br>• Nursing & Midwifery Indicators<br>• Compassionate Conversation- (PPFC, 20-06-2014, Item 14/15/14)<br>• Equality and Human Rights Committee minutes - (PPFC, 20-06-2014, Item 14/15/26)<br>• Family & Friends Tests<br>• Safety Thermometer<br>• Patient Engagement Strategy<br>• CQC inspection report; rating good for experience | None | | |

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| **4** | **To develop a well led, capable, motivated and entrepreneurial workforce**<br><br>**Risk Appetite - Moderate** | | | | | | | | | | |
| | **a)** A competent and capable workforce: To support workers to deliver safe care by ensuring that all staff are clear about their role, objectives and performance, and have the opportunity to have their competencies and knowledge regularly updated<br>**Risk**: Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have staff with the capability and capacity to deliver the best care **Cause**: Lack of time, inefficient processes or insufficient prioritisation by managers.<br>**Effect**: Employees not competent or equipped to ensure patient safety and maintenance of the organisational reputation<br>**Impact**: May result in unsafe care to patients, insufficient improvements in quality and breach of CQC conditions of registration resulting in regulatory action.<br>**Ulysses Ref: 1743.** | 1707170 4169014 45 | Putting People First Strategy | DWM (PPF) | **5x2 =10** | **5x2= 10** | •Clear Policies•Metrics(KPI's)• Performance Monitoring•Training Regime•Local OLM reports• Induction •All Staff aware of role and accountabilities | •Monthly Performance Report (Ops Board/Board of Directors)• Internal audit report (PPF and Audit Committee)• Annual Staff Survey (PPF Committee 20-06-14, item 14/15/10)• Health and Well Being Strategy (PPF Committee 20-06-14, item 14/15/11)•Education Governance Committee minutes (PPF Committee 20-06-14, item 14/15/24) | Yes | Deep dive into service 'Right person/ right place / right time tested at Putting People FirstPPF Committee agreed that an in-depth review of Mandatory Training be undertaken in order to provide assurance following concerns re: lack of assurance from KPI report and reported to PPF at next meeting | completed |

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| | **b)** An engaged, motivated and effective workforce: To deliver the Trust's vision of being a leading provider of healthcare to women, babies and their families through a highly engaged, motivated and effective workforce**Risk:** staff are not engaged, motivated and aligned to the vision and values of the Trust resulting in poor patient experience and health outcomes , poor reputation and impact on the Trust's ability to recruit and retain the best.**Cause**: Lack of time, inefficient processes or insufficient priority assigned by management.**Effect:** Trust fails to become the provider and employer of choice for patient, commissioners, and employees **Impact:** impact on Trust's ability to recruit and retain the best, and on the Trust's ability to achieve its strategic vision.**Ulysses Ref: 1744.** | | Putting People First Strategy | DWM (PPF) | **4x4 =16** | **4x2= 8** | • Appraisal policy, paperwork and systems for delivery and recording are in place for medical and non-medical staff• Consultant appraisal linked to Revalidation process• Managers clear about their responsibility to undertake annual appraisals with their team• Pay progression linked to appraisal and mandatory training compliance.• Appraisal guides available for Managers and employees• Monthly reporting at Departmental/ Divisional and organisation wide level via Performance Report.• Targeted intervention for areas identified as under-=performing• Training programme available for managers• All new starters complete mandatory training Inc. PDR training as part of corporate induction ensuring awareness of their responsibilities. • Consultant revalidation requires mandatory training compliance• Extensive mandatory training programme available via classes, online resources and study days• Monitored at Education Governance Committee. | • CQC visit of April 2014 identified improvement in appraisal rates and recorded compliance with 'Supporting workers' - outcome 14.• Pay progression policy recently implemented. Impact of policy will not be evaluated until 2015-16• Increase in managers attending training programme• Annual internal audit of policy by Trust's audit partners. Due to report Q3 2014-15,• Review by Trust's audit partners showed that system and processes used are effective if applied consistently across the Trust.•Compliance with GMC Revalidation requirements• Monthly performance report for June 2014 identifies organisational compliance at 84% for mandatory training. Areas identified requiring intervention Imaging & Maternity. | Yes | Review contract and JD templates to ensure they accurately articulate managers' responsibilities with respect to appraisal and mandatory training compliance for their team members.<br><br>Complete OLM project<br><br>Expedite roll out and promotion of e-learning<br><br>Evaluate impact of pay progression policy.<br><br>Develop project plan to implement Self Service | completed<br><br>completed<br><br>completed<br><br>completed<br><br>Project on plan. Completion 3/17 |
| | **c) To maintain delivery of clinical services Risk:** Insufficient Junior Doctors or disruption to care/the environment in which care is given resulting in harm to patients, damage to organisational reputation and impact upon income and achievement of access targets.<br>**Cause:** Industrial action by Junior Doctors<br>**Effect:** Trust is unable to deliver clinical services.<br>**Impact:** Damage to reputation, income and access targets.<br>**Ulysses Ref: 1909.** | | Putting People First Strategy | DWM (PPF) | **4x3 =12** | **4x1= 4** | • Pro-formas sent to CD's to assess impact of industrial action on clinical activity and to make contingency arrangements.<br>• Pro-forma sent to junior and Trust grade doctors re "intentions".<br>• Lessons learnt from industrial action taken previously<br>• All planned industrial action is now completed (awaiting results of national ballot on 7 July | All CD's and Heads od Service have plans in place (SMT 6/1/16)<br>Pro-forma re service provisison sent to all CD's 5/1/16 for completion.<br>Mitigation Actions for Junior Doctor strike 12-13th February effective (no directly related incidents reported in that period) | Yes | De-briefing to review and note any lessons to be learned from previous action<br><br>Review risk upon result of ballot | completed |

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| **5** | **To be ambitious and efficient and make the best use of available resources**<br><br>**Risk Appetite - Significant** | | | | | | | | | | |
| ai | To deliver the financial plan beyond 2016/17<br>**Risk:** The Trust does not have a financially sustainable plan in 2016/17<br>**Cause:** Tariff insufficiency, commissioner intentions, CNST premiums and liabilities and inability to identify further significant CIPs<br>**Effect:** Requirement for Distressed Financing, Breach of Licence Conditions<br>**Impact:** Regulatory Intervention<br>**Ulysses Ref: TBC** | 1381 | Risk Management Strategy | DOF (FPBD) | **5x5 =25** | **5x5= 25** | • Zero based budget methodology adopted<br>• Voluntary turnaround process adopted to identify robust CIP schemes<br>• FPBD & Board approval of budgets<br>• Sign off of budgets by accountable officers<br>• Monthly reporting to all budget holders with variance analysis<br>• Monthly reporting to FPBD & Trust Board •<br>Monthly reporting to Monitor | • 2016/17 plan approved by Trust Board in April<br>• Performance & Finance Report presented monthly to FPBD<br>• Finance & CIP achievement reported monthly to FPBD, Executive Team and Operational Board<br>• Monthly budget holder meetings<br>• Monthly reports to monitor<br>• Internal audit review of budgetary controls | None | Ongoing review of position | Mar-17 |
| aii | To deliver the financial plan beyond 2016/17<br>**Risk:** The Trust does not deliver the 2016/17 financial plan and control total<br>**Cause:** Lack of operational grip and financial controls<br>**Effect: N**on-delivery of the financial plan and reduction in available cash<br>**Impact:** Further regulatory intervention and special measures<br>**Ulysses Ref: TBC** | 1381 | Risk Management Strategy | DOF (FPBD) | **5x3 =15** | **5x3= 15** | • Zero based budget methodology adopted<br>• Voluntary turnaround process adopted to identify robust CIP schemes<br>• FPBD & Board approval of budgets<br>• Sign off of budgets by accountable officers<br>• Monthly reporting to all budget holders with variance analysis<br>• Monthly reporting to FPBD & Trust Board •<br>Monthly reporting to Monitor | • 2016/17 plan approved by Trust Board in April<br>• Performance & Finance Report presented monthly to FPBD<br>• Finance & CIP achievement reported monthly to FPBD, Executive Team and Operational Board<br>• Monthly budget holder meetings<br>• Monthly reports to monitor<br>• Internal audit review of budgetary controls | None | Ongoing review of position | Mar-17 |
| b | To deliver long term financial sustainability<br>**Risk:** The Trust is not financially sustainable beyond 2016/17<br>**Cause:** Tariff insufficiency, commissioner intentions, CNST premiums and liabilities, non delivery of CIP<br>**Effect:** Lack of financial stability and ability to fund services, insolvency and Trust unable to deliver services<br>**Impact:** Invocation of Monitor sanctions-special measures.<br>**Ulysses Ref: 1986.** | | Risk management Strategy | DOF (FPBD) | **5x5 =25** | **5x5= 25** | • 5 year financial model produced giving early indication of issues<br>• Advisors with relevant experience (PWC) engaged early to review strategic options<br>• Early and continuing dialogue with Monitor<br>• Active engagement with CCG's through the Healthy Liverpool Programme<br>• Final Business Case to Trust Board in Dec 15<br>• Clinical engagement through regular reporting to Trust Management Group | • 5yr plan presented to Board, June, 2014<br>• Business Case, November, 2014 | Yes | Finalisation of shortlist of options and development of preferred option Dec 2016<br>Further discussion with NHSLA following outcome of consultation exercise Sept 2016 | Mar-17 |

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| c | To take forward plans to develop services nationally and internationally<br>**Risk:** Non-delivery of the expected return from expansion investment<br>**Cause:** Demand less than expected<br>**Effect:** Loss of potential revenue<br>**Impact:** Costs could exceed income of the project adding additional pressure to the financial position of the Trust.<br>**Ulysses Ref: 1748.** | | Risk Management Strategy | DOF (FPBD) | **4x4 =16** | **4x4= 16** | • Detailed project plan in place<br>• Experienced manager appointed to lead expansion<br>• Key clinical staff identified to implement plan<br>•Legal agreements completed<br>• Experienced advisors engaged (e.g. Pinsent Mason)<br>•Capital planned for all projects and ITFF funding in place | • Business Case for expansion approved by Trust Board in December 2013<br>• Legal contracts reviewed by FPBD<br>• Quarterly update to FPBD from October 2014 onwards | None | Continuing review of performance | Mar-17 |
| d | Fail to achieve benefits from the IT Strategy**Risk:** Failure to successfully deliver the IM&T Strategy**Cause:** Poor programme management controls**Effect:** Programme running over budget, out of scope, late or non delivery of stated benefits realisation**Impact:** Trust being non compliant with national initiatives, data collection requirements or financial compliance.<br>**Ulysses Ref: 1750.** | **902** | IM&T Strategy | DOF (FPBD) | **4x4 =16** | **4x4= 16** | • IM&T Business case• Capital Reporting Plan in place• Project Management Office in place• Project Plan established• Programme Board in place and meeting regularly• Regular reports to FPBD• Robust business continuity plan in place• Supplier contracts• Replicated data centres• Disaster recovery plans• System Training• Doing IT Right Strategy• IM&T policies• Data Protection Policy• Data Quality Policy• Structured change control in line with ITIL | • IM&T business case approved (TB) • Programme Board in place, minutes available• Quarterly FPBD reports | Yes | New Plan for EDMS and Bed Management to be formulated July 2016.<br>EPR business case to be implemented per project plan | Jul-16 |
| e | To develop a sustainable Genomic Centre<br>**Risk:** Potential loss of service following re-commissioning of genetics nationally - unsuccessful tender service cost<br>**Cause**: Relatively small unit<br>**Effect**: Loss of service and financial contribution of £1.5m per-p.a.<br>**Impact**: Loss of genetics service through failure to engage appropriately in the future model of genetics service provision in Liverpool / North West .<br>**Ulysses Ref: 1749.** | | Risk Management Strategy | DOF (FPBD) | **4x4 =16** | **4x4= 16** | • External Engagement through the Liverpool Health Partners<br>• Genetics strategy group in place<br>• Significant engagement with NHS England through national lead<br>• Successful 100,000 genome bid<br>• Developed MOU to collaborate with LCL to meet service specification | • Successful submission of tender to NHS England 100,000 genome project<br>• MOU with LCL | Yes | • Tender date for genomic hub yet to be confirmed. To be kept under review | TBC by NHS Genomics |