Meeting of the Board of Directors
HELD IN PUBLIC
Friday 1 July 2016 at Liverpool Women's Hospital at 1330 - 1540
Board Room

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time	CQC Fundamental Standard	BAF Risk
	Thank you to Staff				1330 10mins		
166	Apologies for absence & Declarations of interest	Receive apologies	Verbal	Chair		-	-
167	Annual Assurance on end of life care – Chris Webster, Macmillan CNS and Lead cancer nurse & Dr Leslie Allsopp palliative care consultant	Receive assurance and any escalated risks	Written/Presentation	Director of Nursing and Midwifery	1340 20mins		
168	Meeting guidance notes	To receive the meeting attendees' guidance notes	Written guidance	Chair		Well Led	-
169	Minutes of the previous meetings held on Friday 3 June 2016	Confirm as an accurate record the minutes of the previous meetings	Written	Chair	1400 10mins	Well Led	-
170	Action Log and matters arising	Provide an update in respect of on-going and outstanding items to ensure progress	Written/verbal	Chair		Well Led	-
171	Chair's announcements	Announce items of significance not elsewhere on the agenda	Verbal	Chair	1410 10mins	-	-
BOARD ASSURANCE							
172	Chief Executive Report	Report key developments and	Verbal	Chief Executive	1420 10mins	Well Led	-

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time	CQC Fundamental Standard	BAF Risk
		announce items of significance not elsewhere					
173	Chair's Report from the Finance Performance and Business Development Committee held on 20 June 2016	Receive assurance and any escalated risks	Verbal/Written	Committee Chair	1440 20mins	Well Led	5a,b,c,d,e
174	Chair's Report from the Putting People First Committee held on 17 June 2016 and annual Report 2015/16	Receive assurance and any escalated risks	Verbal	Committee Chair		Well Led	
175	Board Committee Terms of Reference Review and amendments • Audit Committee • FPBD Committee • PPF Committee	Receive assurance	Written	Trust Secretary		Well Led staffing	
TRUST PERFORMANCE							
176	Performance Report	Review the latest Trust performance report and receive assurance	Written	Associate Director of Operations	1500 10mins	Well Led Staffing	3a
177	Finance Report period 2, 2016/17	To note the current status of the Trusts financial position	Written	Director of Finance	1510 10mins	Well Led	5a,b,c,d,e
TRUST STRATEGY							
178	Future Generations strategy Update	To brief the Board on progress and risks	Verbal	Chief Executive	1520 10mins	Well Led	Strategic aim

BOARD GOVERNANCE							
179	Board Assurance Framework	To review and note the current risks not being able to manage at a service level	Written	Trust Secretary	1530 10mins	Well Led	Strategic aim
180	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair		Well Led	-
HOUSEKEEPING							
181	Any other business	Consider any urgent items of other business	Verbal	Chair		-	-
	Review of meeting	Review the effectiveness of the meeting (achievement of objectives/desired outcomes and management of time)	Verbal	Chair / all		-	-

Date, time and place of next meeting either Friday 5 August 2016 or Friday 2 September 2016

Meeting to end at 1540

1540-1555 15 mins	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

Agenda item no:	16/166

Meeting:	Trust Board Meeting

Date:	1 July 2016

Title:	Annual Report: End of Life Care

Report to be considered in public or private?	Public

Where else has this report been considered and when?	

Reference/s:	The Route to Success: achieving quality in Acute Hospitals. National End of Life Care Programme, July 2010. One Chance to Get it Right, Leadership Alliance for Care of Dying People, June 2014. Care of Dying Adults in the last days of life. NICE (NG31) December 2015.

Resource impact:	

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

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

Which CQC fundamental standard/s does this report relate to?	End of Life Care

What action is required at this meeting?	Board is asked to receive report, provide any advice / feedback in relation to the action plan

Presented by:	Diane Brown: Director of Nursing and Midwifery

Prepared by:	Dr Leslie Allsopp, Chris Webster

This report covers (tick all that apply):

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

Other:			
Monitor compliance		Equality and diversity	
Operational plan		NHS constitution	

Publication of this report (tick one)**:**	
This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting	
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

The National End of Life Care Strategy (London, DH 2008) was produced in recognition that there are specific challenges to providing quality care to patients and family members / carers when death approaches. This was acknowledged as a time when all involved are very vulnerable to distress and need the best possible care and support.

Publication of the Independent Review into the Liverpool Care Pathway (LCP) for the Dying Patient ("More Care, Less Pathway" July 2013) scrutinising care in the last few days of life in acute hospitals, and associated press coverage and public reaction, has been very negative. It was clear that there was no single tool or pathway which ensures best care for all and INDIVIDUALISED care planning is essential for best practice.

The Leadership Alliance for the Care of the Dying Patient (LACDP) published a new approach for caring for people in the last few days and hours of life. This approach focused on the needs and wishes of the dying person and those closest to them, in the planning and delivery of care. The approach, as outlined in One Chance to get it Right centres on 5 key priorities for care. These follow on from the recommendations put forward following the Independent Review of the Liverpool Care Pathway (LCP) for the Dying Patient ("More Care, Less Pathway" 2013).

The 5 priorities of care:

Priority 1
The possibility that a person may die within the coming hours is recognised and communicated clearly, decisions of care are made in accordance with the person's needs and wishes, and these are reviewed and revised regularly.

Priority 2
Sensitive communications take place between staff and the person who is dying and those important to them

Priority 3
The dying person, and those identified to them, are involved in decisions about treatment and care.

Priority 4
The people important to the dying person are listened to and their needs respected.

Priority 5
Care is tailored to the individual and delivered with compassion – with an individual care plan in place.

All of these priorities must be addressed when providing high quality end of life care for patients and these form the basis of the Guidance for End of Life Care for Adults in the Liverpool Women's Hospital.

The importance of delivery of high quality End of Life Care (EOLC) in acute trusts has now been formally recognised by its inclusion as one of eight key areas for inspection for the Care Quality Commission (CQC). End of Life Care Services at the Liverpool Women's Hospital were rated as Good throughout the five domains following the inspection in February 2015. The CQC recommended consideration of the publication of an annual End of Life Care Report following this review.

There is an annual audit of End Of Life Care at the Women's hospital as well as a survey of bereaved relatives asking for their comments in relation to end of life care their loved ones received at the Women's hospital. These help inform of the delivery and quality of end of life care and identify areas for improvement moving forward.

2. Activity Throughout the Year

CQC Inspection in February 2015

As part of the planned inspection regime review of End of Life Care was undertaken. The overall assessment for the service was Green; however the inspectors recommended 2 areas for improvement within care provision.

I. Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR): compliance with DNACPR was considered with the inspection team and was based on the audit results available. This audit reviewed the timely and appropriate recording of decisions within the documentation of the 2 patients involved in the audit. In both instances it was felt that nothing should have been done differently.

II. Advanced Care Planning: since the inspection the Specialist Palliative Care Team (SPCT) have adopted the NHS Advanced Care Planning documentation. This is currently being rolled out across the Trust and is supported by a programme of education relating to its use. The documentation will be in use across the Trust by the end of June 2016.

Audit to assess compliance with Liverpool Women's Hospital Guidance on End of Life Care.

The standards which were assessed as part of this audit were formed on the back of a number of national documents as referenced earlier. The standards include key areas that are essential in providing quality care of the dying and include:

- Recognition of the Dying patient
- Communication of the dying phase with the patient and their relatives and loved ones
- Assessment of the patients' priorities of care and wishes including DNACPR
- Assessment of ongoing physical symptoms at the end of life as well as spiritual and psychological needs
- Anticipatory prescribing of medications at the end of life
- Ongoing assessment of nutritional and hydration needs of the patient
- Care after Death of the patient and their relatives

The audit involved retrospective review of case notes, MEDITECH, individualised end of life care plans and Somerset database for all deaths that occurred on the Gynaecology wards over an 11 month period

The results of the audit have demonstrated areas of good practice which are consistently being delivered for our patients at the end of life. In particular

- All patients had a DNACPR in place and died in their preferred place of death
- The multidisciplinary team regularly assess these patients and the dying phase is being recognised and communicated with patients and their families
- Individualised End of Life Care plans are in use within the Trust
- Anticipatory medications are being prescribed when the patient is recognised as being in the dying phase
- Patients are being assessed frequently throughout their last 24 hours of life

However it did highlight a particular area to focus on

- Assessment and recording of nutritional and hydration needs of our dying patients

Since this audit the team have introduced a communication record that is kept at the front of the case notes where the Health Care Professional (HCP) can record any significant conversations with patients and their relatives. Hydration and Nutrition were highlighted as an area to focus on and since the audit this has been addressed by the AMIGOS sessions which included flashcards as a reminder and prompt. End of Life care at the LWH is audited on an annual basis.

Evaluation of Adult End of Life and Bereavement Care – Results

In order to gain feedback regarding the provision of end of life care at the Liverpool Women's Hospital, a survey was sent to those bereaved relatives who's loved ones died at the Women's Hospital during the period from January 2014 to December 2014. The survey was adapted from the VOICES survey and was sent out to 17 relatives. 10 Surveys were returned providing a response rate 59%. There were 19 questions within the survey and scores of 80% and over were reported for 14 of the returns

Key findings from the survey are provided below:

- Did the person breaking news to you do this in a sensitive and caring manner: 100%
- After your relative's death did staff help and support you in a sensitive manner: 100%
- During your relative's last hospital admission were they treated with dignity and respect: 90%
- Pain relief: 90%
- Were you able to discuss worries and fears: 80% (10% had nothing to discuss)
- Relief of symptoms; 80% (10% not applicable)
- There were no decisions made about the care and treatment of your relative you would not have wanted: 90% (10% said they did not know)
- Did you feel that your relative died in the right place: 80% yes, 20% yes to some extent
- 90% of respondents were present at the time of their relatives death

The survey also identified some areas for improvement as is demonstrated by the results below:

- 50% of respondents indicated they would have liked more information about their relative's condition
- 40% of respondents were not aware of where their relative wished to die
- 50% of respondents felt that their relative had sufficient information to make a decision about the choice of place to die

The findings from the survey will be incorporated into training packages for staff and information for patients and families. The effectiveness of this approach will be evidenced in the results of the survey in the next annual report.

Since this survey the questionnaire has been adapted further to include questions on hydration and nutrition. Contact has also been made with bereaved relatives by phone prior to the survey going out to ensure they were happy to receive the survey. The results of this survey will be reported in the next annual report.

NICE Guidance – Care of the Dying Adults in the last days of life

NICE produced evidenced based guidelines regarding the clinical care of adults who are dying during the last 2-3 days of life in December 2015. It included recommendations on

- Recognising people are in the last few days of life
- Communication and shared decision making
- Clinically assisted hydration
- Anticipatory prescribing and symptom control

The guidance is broken down to 69 recommendations surrounding end of life care. The Trust is 96% compliance with the recommendations. There are 3 recommendations which we are currently non-compliant against –

Provision of individualised care – record individualised care plan discussions and decisions in the dying person's case notes and share the plan with the dying person, those important to them and all member of the multidisciplinary team.

It is evident from the audit that individualised care plans are in use and these care plans on the whole are being discussed verbally with patients and their relatives. However there currently is no process to routinely share the actual documentation relating to the ICP with the patients and families. This is difficult as it is accessed through MEDITECH. In order to address this the team plan to implement comfort round charts that are specific for end of life care patients. These can then be shared with the patient and their relatives.

Managing pain – for a person who is unable to effectively explain that they are in pain e.g. learning disability or dementia, use a validated behavioural pain assessment tool to inform of pain management

At the time of the review the Trust did not use any behavioural tools as part of the assessment of pain. Review of available tools has been undertaken and agreement made to utilise the Abbey Pain Tool to assess patients who have difficulties expressing their pain. The tool will be implemented initially on Gynae Ward 1 and will be accompanied by educational sessions linked to its use.

Symptom Control – consider non pharmacological methods for treating nausea and vomiting in the last days of life.

Nasogastric tubes in the management of intractable nausea and vomiting are often used in end of life care patients. There is currently no access to acupuncture techniques for the management of such symptoms. SPCT is exploring options to deliver this service via the physiotherapy team.

Education

The SPCT at the Liverpool Women's Hospital strive to improve palliative and end of life care for patients and their loved ones at the LWH. A key focus of the team is related to education of HCP's within the Trust. The team have developed an education plan for staff that provides EOLC within the Trust. This includes communication skills, Advanced Care Planning and symptom control guidance.

Key Performance Indicators

PPD – 100% patients who died at the Trust died in their preferred place of death
Use of individualised care plans – 100% patients who died at the Trust had individualised care plans in place for their end of life care
Key workers – all patients known to the SPC team and who received EoL care at the trust had a named key worker
All hcp working on gynae base one have completed training in end of life care and attend regular AMIGOS sessions on the ward led by the Clinical Nurse Specialists

3. Forward Plan

- Ongoing annual review of End of Life Care for adults dying at the Trust
- Annual relatives survey
- Implementation and role out of Advanced Care Planning and documentation within the Trust

- Consider the use of Patient Reported Outcome Measures (PROMs) as part of patients ongoing assessment
- Review of Educational Plan
- Progressing towards the use of EPaCCs (Electronic Palliative Care Coordination system)
- Review of Trust Strategy for Palliative and End of Life Care
- Inclusion in subsequent reports EoL care provision within Neonatal and Maternity Services.

4. Conclusion

Following recommendations from the CQC within their report, appropriate actions have been taken to make improvements where required.

The annual report provides assurance of the delivery of a consistently high standard of service provision. The service have undertaken regular audits of their service , review of experience and review of compliance with NICE recommendations as part of their annual work plan and to provide assurance of the quality and consistency of the care received. Where areas for improvement have been identified plans have been discussed and agreed with the team, and actioned accordingly.

Key achievements include:

- Planned implementation of advanced care planning
- Consistent compliance with Liverpool Women's Hospital Guidance on End of Life Care
- Introduction of a communication record for ACP
- Adaptation of user survey to reflect further standards of care
- Introduction of comfort rounds for EoL care patients that can be shared with patients and their families
- Implementation of the Abbey Pain Tool
- Development of an educational package to assist staff in the sustained delivery of high quality care.
- Development of facilities leaflet for relatives who's loved ones are dying in the Trust

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

Agenda item16/169

Board Agenda item

Board of Directors

Minutes of the meeting of the Board of Directors
held public on Friday 3 June 2016 at 1000 hrs
in the Boardroom, Liverpool Women's Hospital, Crown Street

PRESENT

Mr Robert Clarke	Chair
Mr Ian Haythornthwaite	Non-Executive Director/Vice Chair
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
Mrs Kathryn Thomson	Chief Executive
Mrs Vanessa Harris	Director of Finance
Mrs Michelle Turner	Director of Workforce & Marketing
Dr Andrew Loughney	Medical Director

IN ATTENDANCE

Mr Jeff Johnston	Associate Director of Operations
Allison Edis	Deputy Director of Nursing & Midwifery
Mr Colin Reid	Trust Secretary

APOLOGIES

Mrs Dianne Brown	Director of Nursing & Midwifery
Ms Jo Moore	Non-Executive Director
Mr Phil Huggon	Non-Executive Director

Thank You
Before the meeting opened formally the Board expressed its thanks, and presented flower and employee of the month to: Marie Mace, Reception Desk.

138 **Apologies** – as above

Welcome: The Chair welcome Dr Susan Milner to her first Board meeting advising the Board and observers that he had been appointed by the Council of Governors on 26 May 2016 and that her appointment was effective from 1 June 2016.

Declaration of Interests – None

139 **Meeting guidance notes**
The Board noted the meeting guidance notes.

140 **Freedom to Speak Up Guardian**

Chris McGhee, Service Manager in Genetics provided a presentation on her role as the Trust's

Freedom to Speak Up Guardian. She reported on the development following the Francis Report and freedom to speak up review. She provided an explanation of the difficulties employees have found in in raising concerns, which was not just confined to the NHS and reported on the results of the staff survey which had shown a small percentage reduction in "Staff who feel safe/secure to report a concern" which needed to be addressed.

Chris McGhee explained that getting the right approach to reporting of serious concerns would help to improve patient safety, retain good organisational reputation, lead to financial savings and have an organisation that had an open and transparent culture. She further advised that there were also benefits to staff who would feel supported and have a knock on effect on reduced stress and sickness in the workplace and a reduction staff turnover.

Chris McGhee advised that she had a 4 point plan in developing the role across the Trust that included: Visibility; Accessibility; Reliability; and Communicability and went on to explain how each part of the plan would be implemented.

In concluding her presentation, Chris McGhee advised that she would bring to the Board following review within its committees an Annual Report that would seek to identify and trends or themes.

In response to a question on dealing with vexatious and/or malicious claims, Chris McGhee reported that she would have to deal with all cases in the same way, however she was of no doubt that some concerns may be vexatious or malicious and therefore she had to be mindful of this when dealing with the concern raised. The Board noted that the Senior Independent Director (Tony Okotie) had been identified to support the Freedom to Speak Up Guardian should any concerns arise that needed additional independent support.

The Chief Executive advised that she and her Executive supported the role and recognised the need for staff to have a vehicle to raise concerns; however she felt that it was important the guardian's role did not conflict with the other processes in the Trust that related to such matters as grievances procedures etc. Chris McGhee advised that she was mindful that other policies existed and that she saw her role as a sign post to those policies and procedures should they be the most appropriate direction of travel. Tony Okotie supported the comments and felt that concerns falling under the Freedom to Speak Up Guardian would be those that potentially had a public interest implication.

The Board discussed further the role of Freedom to Speak Up Guardian and its need to support cultural change within the Trust. The Chair, on behalf of the Board, thanked Chris McGhee for her presentation and for taking on the role. He advised that he looked forward to seeing the first annual report in 2017.

141 Minutes of previous meeting held on Friday 6 May and 20 May 2016

The minutes of the meeting held on 6 May 2016 and 20 May 2016 were approved.

142 Matters arising and action log.

Action 16/128: The Associate Director of Operations to report back the board on the financial impact of the junior doctor's strike. The Associate Director of Operations agreed to circulate a note to the Board. Action discharged.

Action 16/134: The Trust Secretary to review with the Director of Nursing and Midwifery and Governance Team the content of the BAF dashboard that provides a heat map of risks that can be easily identified and reviewed together with a short narrative when the risk score on a risk has moved. The Trust Secretary advised that A heat map had been provided to Governance and Clinical Assurance Committee (GACA) to test out whether it provides the right information. He advised that additional

reporting to the Board Committees would be made during June to assess the effectiveness of the changes to the BAF prior to Board on 1 July. Tony Okotie advised that the GACA BAF risks and heat map had been reviewed by GACA at its meeting on 27 May and comment from the meeting was that there needed to be additional narrative on the changes made to the risk so that the Committee could see more clearly the reasons for the change. The Trust Secretary advised that this had been reported back to the team that maintained the BAF on behalf of the Board. Action ongoing

143 Chair's Report

The Chair provided a brief verbal report:

- NHS Improvement Induction day: The Chair advised that he had attended an induction day facilitated by NHS Improvement at which there was considerable discussion surrounding the requirements to develop sustainability and transformational plans. He advised that the discussion concentrated on how major transformations could be made and there was recognition that this could only be done with NHS organisations working together to reduce costs in the system whilst maintaining services.
- NHS Improvement (NHSI) progress meeting: The Chair referred to the NHSI meeting he had attended with the Chief Executive and Director of Finance and reported that NHSI had been overall, very satisfied with the progress the Trust was making in delivering its financial and operation plans.
- Liverpool Echo: The Chair referred to an article in this week's edition of the Liverpool Echo and advised that the interview, which took place a few weeks ago, was requested by the newspaper as a general chat with him in his position as the new chair of the hospital. He explained that he was asked a lot of questions about the future of the hospital and was keen to stress that the Trust was looking for solutions that addressed the problems faced the Trust faced, as well as improving services overall and ensuring that what matters most to the public who use the Trust's services was retained. The Chair reported that whilst the clinicians had done a considerable amount of work, looking at where the Trust's services could best be provided in future, the Trust was fully committed and involved in the current process being led by the Liverpool CCG in exploring all of the possible options that might be available for the services.

The Board noted the Chair's update report.

144 Chief Executive's report

The Chief Executive provided an update to her report contained in the Board papers and reported on the following matters:

- Cheshire and Merseyside (C&M) Sustainability and Transformation Plan (STP): The Chief Executive reported on the current status of the C&MSTP and advised that there were a number of overarching themes that had been agreed within the C&M footprint. The main overarching theme was the recognition that maternity and neonatal services would be the first key line in the STP, as it was accepted that it was the most important service to the public. She reminded the Board that C&M footprint had been broken down to a further 6 areas and each area was required to develop their own STP. The Trust's STP was North Mersey and it was well ahead of the other areas in developing a fully sustainable and transformational plan. The Chief Executive advised that a draft plan for C&M footprint was required to be submitted by 24 June; however as it was a draft plan it was not required to be signed off by the boards of each trust within the footprint. She advised that as soon as she had something that she could share with the Board she would do so. In response to a question from Susan Milner regarding local authority involvement in development of the STP, the Chief executive advised that it had not been perfect given the size of the footprint, however there involvement was improving.
- NHS Workforce Race Equality Standard: The Chief Executive provided an update on the standard and analysis report and advised that the Putting People First (PPF) Committee would oversee any

actions required to improve the Trust's performance with respect to the workforce race equality agenda.

- 18 Weeks Incomplete Pathways: The Chief Executive advised that following the audit committee on 20 May 2016 the Trust had established a process for 2016/17 which would address the overstating of the number of breaches when reporting to NHSI. She explained the process that would be followed in the future. Ian Knight referred to the previous reporting to NHSI and asked it any changes would be made to future reports. The Associate Director of Operations advised that this had been checked with NHSI and that there would be no changes to how the Trust reports to NHSI. He advised that for future Board reporting he would identify in his performance report and changes arising from a reconciliation of the data.
- Trust Charity: The Director of Workforce and Marketing advised the Board that following the merger of the two charities that had been approved by the Board earlier in the year a workshop was being held on 5 July to develop the new merged charities strategy, brand and identity. Tony Okotie advised that, as Chair of the Charitable Funds Committee, he would provide an update to the Board on the outcomes from the workshop.

  Action 144.1: Chair of the Charitable Funds Committee to provide an update to the Board on the outcomes from the Charity workshop to be held on 5 July 2016.

- Liverpool Health Partners – The Chief Executive reported that Liverpool Health partners would be attending the Board in November to provide a presentation on the work of the Partnership.

  Action 144.2: Liverpool Health partners to attend the Board in November to provide a presentation on the work of the Partnership

- Junior Doctor's: The Chief Executive referred to her paper and the current status of the Junior Doctor's dispute regarding the new junior doctor's contract. The Director of Workforce and Marketing reported that NHS organisations had been instructed to continue the suspension of work on preparing for the introduction from 3 August of the contract published on 31 March but to continue with appointment process for Guardians of Safe Working. She advised that the Trust would be interviewing for its Guardian role in mid-June, and junior doctors would be invited to be involved in the appointment process. The PPF Committee would continue to review the progress of contract implementation as appropriate and would review the financial and service impact of the industrial action to date. David Astley asked that the Board continue to receive updates on the implementation of the new contract. The Director of Workforce and Marketing advised that it would, as part of the PPF Committee remit.

  Action 144.3: The Board continue to receive updates on the implementation of the new contract through the PPF Committee.

The Chair thanked the Chief executive for her report. The Board noted the content and verbal update from the Chief Executive.

145 **Chair's Report from the Audit Committee held on 20 May 2016, including Audit Committee Annual Report contained within the Annual Report and Accounts 2016.**

Ian Haythornthwaite provided an update on the work of the Audit Committee for 2015/16 which had been included in the annual report and accounts of the Trust submitted to Monitor at the end of May 2016 and would be submitted to Parliament at the end of June 2016. He advised on the key matters discussed at the Audit Committee meeting held on 20 May 2016 at which the draft Annual report and Accounts 2015/16 was presented, prior to going to board for approval.

Ian Haythornthwaite advised that a key finding from the audit of the Trust Quality report was the 18 week incomplete pathway indicator for 2015/16 which, following the audit of a sample number the auditor had been unable provide assurance that the reported performance data was correct. He advised that this had been discussed earlier in the meeting under the Chief Executive report noting that actions had been taken to address the audit concerns.

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

146 Chair's Report from the Governance and Clinical Assurance (GACA) Committee held on 27 May 2016

Tony Okotie, Chair of GACA Committee, provided a verbal report on the work of the Committee held on 27 May 2016. He advised that the agenda had included a number of areas that required contributions from the Committee including: Quarterly review of compliance CQC Fundamental standards (CQC inspection reports); RSM Internal Audit - Follow Up of Care Quality Commission (CQC) Action Plan; Progress against quality strategy; Clinical Audit Work Programme; National Inpatient Survey; and Quarter 4 SEE report 2015/16. He advised that there was considerable discussion regarding RSM Internal Audit - Follow Up of Care Quality Commission (CQC) Action Plan which requires further actions to identify any gaps in understanding, noting that a number of management actions had been or were in the process of being concluded since the report had been written.

Tony Okotie referred to the progress against the quality strategy and reported that delivery of the 16 objectives identified for delivery in 2015/16, 13 had been completed and 3 remained outstanding with actions in place to address delivery in 2016/17. With regards to the National Inpatient Survey, Tiny Okotie advised that the Trust's score was significantly better than the national average at each stage of care, from admission to discharge. He reported that further improvements had been made throughout the care pathway since the last National Inpatient Survey was conducted and that there were early indications that the Trust was likely to be among the top performers in the country when Trust level results are published in June.

The Chair thanked Tony Okotie for his verbal report which was noted.

147 Bi annual Staffing Assurance Report (NHS England reporting requirement).

The Deputy Director of Nursing presented the Bi annual Staffing Assurance Report reminding the Board of the requirement for the Trust to publish monthly data relating to staffing fill rates against expected staffing levels and reported that the Trust was fully compliant with its submissions. She explained that in addition to the submissions there was a requirement to undertake a bi-annual nursing and midwifery workforce review for sharing with the Board at meetings in public. The Deputy Director of Nursing advised that the report provides assurance to the Board that staffing levels at the Trust during the period had been safe and at appropriate levels to provide the services.

Reference was made to the staffing levels on Neonatal Unit and the review that identified a shortfall in staffing required to deliver direct care to babies. It was noted that in order to retain safe staffing levels and resulted in a closure of 4 ITU cots following a discussion with the Neonatal Network. The Board noted the position regarding the staffing of the Unit and the work being done to address the shortfall with NHS England (NHSE). The Deputy Director of Nursing advised that NHSE had provided additional investment into the service to support the appointment of neonatal nurses, however there remains a shortfall in funding that equates to 8.5 WTE staff. The Director of Finance recognising the funding shortfall felt that it was appropriate for the Trust to escalate the concerns with the Neonatal Network and also with NHSI so that they were aware of the concerns. The Chief Executive advised that the Trust was doing everything it can to support the Neonatal Unit and would not compromise the safety of babies in our care. She felt that if there was a need to reduce the number of cots due to staffing levels this would impact on the number of babies the Unit could admit.

The Board noted that the staffing levels were being discussed at the PPF Committee and also the need to for a higher number of in-take of trainees in September to address the risk.

The Board considered the recommendations in the Report and:

1. noted the challenges and risks described within the report;
2. noted the Trust's compliance with the requirement to publish staffing information monthly and undertake Biannual staffing review;
3. took assurance that staffing levels were safe within Gynaecology and Maternity Services, and that there was mitigation in place to ensure delivery of safe care within Neonatal Services through the enhanced escalation processes; and
4. agreed that the recommendations for increased headroom would be taken into consideration for budget setting for 2017/18.

Item 148 was not submitted.

149 Quality, Operational and Financial Performance reports

i) Quality & Operational Performance Dashboard

The Associate Director of Operations presented the Performance Dashboard and reported that the performance framework had been reviewed and refreshed for 2016/17 and now includes new indicators prescribed by NHSI and commissioners. He advised that the local finance and efficiency indicators had also been reviewed and changed to make them more relevant and the report included all non-compliant indicators in the overall performance framework to ensure the correct level of reporting was achieved.

The Associate Director of Operations advised that overall, the Trust had performed well in April 2016; however, focus, together with robust and practical action plans were required to be put in place in order to prevent a repeat of 2015/16 performance that saw a number of KPI's breaching with little or no improvement over the course of the year. Referring to the non compliant indicators the Associate Director of Operations reported that three indicators had been escalated into board level performance dashboard as they had been non complaint for more than three months and actions taken had not rectified the position. The three indicators were included in the Board report and were also reviewed by GACA to gain more focus and assurance. Of the three indicators, the indicators that the Trust had set itself up to fail related to C Section rates and GACA had agreed to review whether the targets were appropriate.

The Associate Director of Operations advised that an emerging concern was the continued failure to achieve the Epidural and Maternity Triage targets, and the failure to achieve the CQUIN of Cancer 62 Day referral and emphasis is being placed on how these targets can be delivered or if unable to do so whether the targets were appropriate if they related to targets set by the Trust. With regard to the delivery of the 62 cancer referral target, the Associate Director of Operations reported that the Trust was working with the Cancer Network to address delays in referrals from other service providers which result in the Trust's ability to deliver.

The Board reviewed the Quality and Operational Performance Report and recognised the work being done to address the non compliant indicators. The Board noted the changes to the performance framework and the Trust's performance.

150 ii) Financial Report & Dashboard Period 12

The Director of Finance presented the Finance Report and financial dashboard for month 1, 2016/17 and reported that the budget set out a deficit of £7m for the year, 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.

The Director of Finance reported that at month 1 of 2016/17 the Trust was reporting a deficit of £0.696m against a deficit plan of £0.710 which provided a positive variance for month 1 and a Financial Sustainability Risk Rating (FSRR) of 2 against a plan of 2.

The Director of Finance advised on the cash position and reported that the Trust's financial plan for 2016/17 identified a need for a further cash requirement of £7.7m over the year. She advised that whilst the request for full funding of the £7.7m was in the process of being finalised with NHSI and DH, the Trust was relying on the £2.5m working capital facility that was already in place to support the Trust's cash requirement for the first quarter of the financial year. The Director of Finance advised that NHSI had been approached to extend this facility in the short term, and it had been confirmed that the working capital facility could be extended whilst DH assess the full national cash requirement. To preserve its cash position, the Director of Finance advised that the Trust had 'paused' the already limited capital program.

The Director of Finance referred to the need to deliver the annual CIP target of £2m, which represents circa 2% of the Trust's income. The detail of the schemes and related quality impact assessments had been presented to the Finance Performance and Business Development Committee (FPBD) in March 2016. The Director of Finance advised that the Executive had some concern that a number CIP schemes would not be delivered and mitigations for the schemes at risk were currently being worked up by the project leads alongside detailed CIP plans for 2017/18. She advised that the Executive was looking to see if any schemes identified for 2017/18 could be brought forward into the current financial year to offset and shortfall should it materialise. The Associate Director of Operations advised on two of the schemes that were not delivering, Pathology and 4 Eyes and provided an update on actions being taken. The Chair asked that the FPBD be kept appraised of the CIP schemes that are not delivering.

Board noted the current status of the Trust's financial position.

151 Future Generations

The Chief Executive updated the Board on the current position of the NHS Liverpool CCG's options appraisal for women's and neonatal services and reported that the first stage of the NHS England assurance process should be concluded at the end of June, following which there will be a pre consultation period that will take the process into a public consultation in the autumn.

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

152 Corporate Risk Register

The Deputy Director of Nursing presented the Corporate Risk Register update report that provided an overview of 13 risks. She advised that since the last report two risks had been removed from the register and had been archived. The Board reviewed the register commenting on specific risks. The Chair asked that for future reports the any abbreviations are defined appropriately.

The Board noted:
1. the Corporate risk register and the mitigating actions;
2. the continued management of the register via the Corporate Risk Committee; and
3. that further updates would be provided on a bi-monthly basis.

153 Review of risk impacts of items discussed

The Board noted the risks had been discussed and noted during the meeting, in particular the neonatal unit staffing and junior doctors.

154 Any other business

None

155 Review of meeting

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

Date and time of next meeting

Friday 1 July 2016 Boardroom

Liverpool Women's NHS Foundation Trust

Agenda item16/170

TRUST BOARD

Action Plan

Meeting date	Minute Reference	Action	Responsibility	Target Dates	Status
5 May 2016	16/134	The Trust Secretary to review with the Director of Nursing and Midwifery and Governance Team the content of the BAF dashboard that provides a heat map of risks that can be easily identified and reviewed together with a short narrative when the risk score on a risk has moved.	Trust Secretary with the Director of Nursing and Midwifery and Governance Team	1 July 2016	See agenda item 16/179
3 June 2016	16/144	Chair of the Charitable Funds Committee to provide an update to the Board on the outcomes from the Charity workshop to be held on 5 July 2016.	Chair of the Charitable Funds Committee	August/September Board 2016	
3 June 2016	16/144	Liverpool Health partners to attend the Board in November to provide a presentation on the work of the Partnership	Chief Executive/Trust Secretary	November 2016	
3 June 2016	16/144	The Board continue to receive updates on the implementation of the new contract through the PPF Committee.	Director of Workforce and Marketing	As and when	

Agenda 16/171

Chair's Announcements

Agenda item 16/172

Chief Executive Report - Verbal

Agenda item no:	16/174

Meeting:	Trust Board Meeting

Date:	1 July 2016

Title:	Chair's Report - Putting People First Committee

Report to be considered in public or private?	Public

Where else has this report been considered and when?	

Reference/s:	

Resource impact:	

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

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

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

What action is required at this meeting?	Board is asked to note the work f the PPF committee and the minutes of the PPF Committee held on 17 June 2016

Presented by:	Tony Okotie, Chair of the PPF Committee

Prepared by:	

This report covers (tick all that apply):

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

Other:			
Monitor compliance		Equality and diversity	
Operational plan		NHS constitution	

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

Board of Directors

Committee Chair's report of PPF Committee meeting held 17 June 2016

1. **Agenda items covered**

- Staff Story – Theatres – a member of theatre staff presented their story focusing on their decision to leave the Trust in order to progress her theatre career and her experience on returning to the Trust following the Theatre's skill mix and organizational review

- Surgical Services Workforce Review – a deep dive presented by the senior management team of surgical services & theatres into the workforce risks, challenges, mitigation and longer term plans to address those risks

- Neonatal Workforce Review – a deep dive presented by the senior management team into neonatal services workforce risks, which were mainly associated with recruitment of neonatal staff, national shortage of neonatal staff, a high level of maternity leave and funding of this specialist commissioned service. The Committee heard the actions being taken to address the immediate pressures in the system, and the longer term negotiations with NHS England. Remit to GACA deep dive into impact of cot closures on maternity eg transfers/delayed procedures

- Clinical Excellence Awards 2015 – Outcomes report

- Workforce Race Equality Scheme 2015 – national & local outcomes on BME staff experience

- Director of Workforce Report – update on Apprenticeship Levy, Workforce Plan 2016/17, Staff Survey follow up actions

- HR Key Performance Indicators – Committee seeking further assurance that recruitment KPIs are robust and timely, to limit vacancy period

- Bi-Annual Safe Staffing Review – Committee assured of safely staffed services and areas for review as part of budget setting for 2017/18

- 12 Month Report on Disciplinary & Grievance processes – Committee noted reduction in time to investigate issues and length of suspension reducing

- Volunteer Strategy & Workplan

- Internal Communications & Engagement Strategy

- Putting People First Committee Annual Report 2015/16

- Policies approved

- Special Leave Policy
- Supporting Staff Policy
- Induction Policy
- Mandatory Training & Development Policy
- Removal & Related Expenses for Consultant Medical Staff SOP

Board Assurance Framework (BAF) risks reviewed

- All Committee relevant BAF risks were reviewed and no amendments recommended.
- No new risks identified

2. Issues to highlight to Board

- **Workforce Race Equality Schemes –** Committee remitted this national outcomes report to Diversity & Inclusion Committee to identify actions required to improve BME staff experience
- **HR Key Performance Indicators Update:** Turnover has reduced slightly but remains high in corporate services. Further work is underway with corporate teams and via exit interviews to understand impact of Future Generations Strategy and identify required actions.
- **Neonatal Workforce** – Workforce review highlighted the need to continue to influence at specialist commissioner and national level with respect to investment in staffing; also highlighted impact of decisions to reduce cot numbers on maternity transfers
- **Theatres Workforce –** Significant and continuing pressures relating to anaesthetics medical staffing resulting from changes to training at national level and proactive approach being taken by Clinical Director looking to pool resources across organisations to address the shortfalls and make posts more attractive to potential candidates.

3. Action required by Board

Chair report provided by:

Tony Okotie

Date: 21 June 2016

Putting People First Committee

Minutes of a meeting held on Friday 17th June 2016 at 1.00 in the Large Meeting Room, Liverpool Women's Hospital

PRESENT:	Mr Tony Okotie (Chair)	Non-Executive Director
	Mr David Astley	Non-Executive Director
	Mr Ian Knight	Non-Executive Director
	Mrs Michelle Turner	Director of Workforce and Marketing
	Ms Cheryl Farmer	Equality and Human Rights Manager
	Ms Claire Scott	Divisional Accountant
	Ms Cath Barton	General Manager
	Ms Gill Curry	Occupational Health Manager
	Ms Jean Annan	OD Business Partner
	Ms Janet Hinde	Workforce Information Manager
	Ms Gill Diskin	Matron – Maternity
IN ATTENDANCE:	Ms Sacha Keating	Corporate EA – Minutes
	Ms Tracy McNulty	Theatres (for item 16/17/35 & 16/17/36)
	Dr Edwin Djabatey	Consultant Anaesthetist (for item 16/17/35 & 16/17/36)
	Ms Katherine Wright	Head of Communications (for item 16/17/45)
	Ms Alison Eddis	Deputy Director of Nursing & Midwifery
	Ms Susan Milner	Non-Executive Director
	Mr Simon Davies	HR Advisor
	Ms Joanne Topping	Consultant Obstetrician (representing MSC)
	Ms Janet Hinde	Medical Staffing, HR
	Ms Val Irving	Neonates Matron
	Ms Gina Barr	Voluntary Services Manager
16/17/028	**Apologies**	
	Mr Jeff Johnston	Associate Director of Operations
	Mrs Dianne Brown	Director of Nursing & Midwifery
	Ms Liz Adams	Medical Staff Committee Representative
	Dr Ruben Trochez	Education Governance Committee Chair
	Ms Carla Marshall	HR Business Partner
	Ms Susan Westbury	Head of Workforce
	Ms Chris McGhee	Freedom to Speak Up Guardian
	Ms Nicky Maggs	Theatres Manager

16/17/029 **Meeting guidance notes**
Noted.

16/17/030 **Declarations of Interest**
There were no interests declared.

16/17/031 **Minutes of the previous meeting held Friday 15th April 2016**
The meeting approved the minutes of the meeting held on 23rd February 2016 with the following amendment made:-

- 16/17/007 – change of wording from alteration to reduction of current risk score.

16/17/032 **Matters arising and action log**
The action log was reviewed and updated.

16/17/033 Chair's Announcements

The Chair welcomed all new Non-Executive Directors to the meeting & declared the Trust now has a full complement of Board members.

16/17/034 Staff Story - Theatres

Tracy McNulty, Theatres detailed a recent staff story to the committee on behalf of a member of staff who had left the Trust frustrated by a lack of career progression opportunities within Theatres but subsequently returned following a workforce review within the Theatre team. The workforce review had resulted in a better career structure within Theatres. The period of change had been challenging for staff, and had resulted in several employees leaving the organisation. However, , the returning staff member has expressed that there have been some positive improvements since their return & lessons learnt by the Trust to focus on retention of staff & not just recruitment.

Michelle Turned, Director of Workforce & Marketing stated the comments made from the staff member story correlates to feedback received from the latest Staff Survey & reinforced that the theatre workforce review was conducted to ensure the correct skillset was present within the department.

Resolved

The Committee noted & received the Theatre Staff Story.

16/17/035 Surgical Services Workforce Review

Tracy McNulty presented the Surgical Services workforce review on behalf of Nikki Maggs, Theatre Manager focusing on the key workforce risks and challenges.

The Committee acknowledged the challenging year experienced by theatre staff and the management team following the reorganisation which had resulted in a period of increased turnover. However, career progression and work/life balance issues had been addressed by the reorganisation, and it had enabled additional support to out of hours working. The Unit had seen a stabilising of turnover and sickness, and a reduction of its reliance on agency staffing

Dr Edwin Djabatey, Consultant Anaesthetist updated the Committee on the medical workforce issues for surgical services, and referred to the most recent national Medical Census for anaesthetics

Changes to national training, had resulted in pressures within the anaesthetic service and Consultant posts were also increasingly hard to recruit to. The Clinical Director had a clear line of sight on the issues and was working innovatively with other organisations and overseas to attract anaesthetists to the Trust. The Committee noted that the aspiration to pool anaesthetists across the city would go some way to ease the difficulties being experienced in fully staffing rotas currently.

The Committee were assured that workforce risks were identified and understood, with mitigation in place and longer term plans in development.

Claire Scott, Divisional Accountant made an amendment to the section relating to the Research Registrar post, noting that the CIP referred to in the presentation was transacted in 2013/14 and had since been reinstated. .

Resolved

The Committee noted and received the Surgical Services Workforce Review.

16/17/036 Review of HR BAF Risks

Michelle Turner updated the committee that are no new HR risks or removed ones since the last meeting held.

The committee noted that the Junior Doctor risk will be reviewed in July once there has been more clarity around the contract terms.

Resolved

The committee noted & received the HR BAF Risks.

16/17/37 Clinical Excellence Awards Round 2015

Michelle Turner presented the annual CEA Report for the 2015 Awards round. .

It was noted by the committee that a constituted panel have put applicants forward with 8 points awarded out with 2 candidates awarded 2 points for service delivery with a national process guide to follow for this. No issues of concern were identified.

Resolved

The committee noted & received the Clinical Excellence Awards update.

16/17/38 Neonates Workforce Review Paper

Val Irving, Neonates Matron briefed the committee on the Neonatal workforce review stating the main challenge in this area is the recruitment to Neonatal posts. It was noted that there was a national shortfall of over 2000 wte Neonatal Nurses. Liverpool Women's recruited twice a year on qualification and then put candidtes through a robust academic programme with Liverpool John Moores University.

It was noted by the Committee that the challenges centre around staffing and acuity of babies in the unit, meant that the Unit had to flex its capacity. A decision had been taken to reduce from 48 to 44 cots but on occasion this reduced to a a knock on effect to maternity who then experienced an associated increase in women transferred to other units. Or whose planned procedure eg Induction of Labour, may be delayed. The Trust was in ongoing negotiations with NHS England around funding for the neonatal service. The Unit was on twice daily monitoring, with status reports provided to the Executive team to enable early intervention when required.

Cath Barton, General Manager outlined the action agreed with staff to incentivise LW staff to take on additional hours to support the Unit. Agreement had also been given to recruiting over and above the normal intake, given the high number of maternity leavers on the Unit currently. Mrs Barton anticipated the Unit being in a better position with respect to substantive staffing by end of the fourth quarter of the year.

The Chair stated that the Board has had an intense focus on Neonates & the new Non-Executive Directors are also monitoring the area through visits & meetings with staff.

Resolved

The Committee received assurance a daily status report is ensuring Executives are kept ahead of any potential issues & noted the challenges contained in the report are being managed.

Action: The Chair suggested the Governance and Clinical Assurance Committee may want to perform a deep dive into the transfer of women as a piece of work & show the potential wider risks involved. **JJ**

16/17/39 Report of the Director of Workforce & Marketing

A report was circulated as part of the agenda for the Committee to review prior to this meeting highlighting the issues of recent interest or activity, which were not separate agenda items. Michelle Turner particularly highlighted:-

- **Workforce Planning 2016/2017**
  Michelle Turner updated the committee that local & regional work is being done to increase workforce planning & this is being linked into the Sustainable Transformation Programme.

- **Apprenticeship Reforms**
  Michelle Turner stated the anticipated levy would be a real challenge for the Trust with a potential impact of £300,000 in 2017 – work is being done across the Cheshire & Merseyside patch to reduce the impact on organisations.

- **DBS Update**
  Michelle Turner provided assurance to the committee regarding staff DBS checks & that there are now only 3 members of staff who are showing as non-compliant and who would be subject to disciplinary action.

Michelle Turner updated the committee on a visit by the Deanery to the Trust. Verbal feedback had been positive with a written report to be received. It was noted by the committee that issues had been raised regarding Junior Doctors access to education and training which has been impacted due to service delivery requirements.

Resolved
The Committee received and noted the HRD report.

16/17/040 Workforce Race Equality Scheme Baseline Assessment & Draft Action Plan
Ms Cheryl Farmer, Equality and Human Rights Manager briefed the committee on the main items within the national WRES report It was agreed that further work should be undertaken by the Diversity & Inclusion Committee to develop an action plan to respond to the issues identified by the WRES report, and to include the issues relating to access to employment identified by the Committee when it reviewed the workforce profile.

Resolved
The Committee received and noted the report.
Action: Action plan to be brought to next PPF committee to update members on work done to engage BME, disability groups & LGBT community. **CF**

16/17/041 HR Key Performance Indicators
The Committee received the KPIs and noted the slight fall in turnover, with the highest turnover still being in the corporate services. This was felt to be associated with the Future Generation Strategy which had greater implications for those in back office areas but further analysis would be undertaken through exit interviews and with teams to understand and address this issue.

The Chair sought assurance that managers are not holding vacancies for CIP purposes and that the length of time from offer to commencement of post for staff is not encountering any unnecessary delays. The Committee asked for a more detailed breakdown of the recruitment KPIs, identifying time from somebody resigning from their post, to advert, advert to interview, interview to start in post.

Resolved
The Committee noted the HR Key Performance Indicators.

ACTION: To provide the recruitment KPI breakdown as detailed above **CM**

16/17/042 Safe Staffing Review

Allison Eddis, Deputy Director of Nursing & Midwifery briefed the committee on the annual safe staffing review which is a requirement of NHS England to provide assurance to the Board regarding nursing staffing levels & the requirement to record care contact time which was subsequently changed to reflect the Carter review methodology to visually record staff time spent with each patient.

Allison Eddis stated a recommendation was made to increase staff in clinical areas including gynae, fertility & genetic facilities staff – the plan was to reduce gynae beds to release staff & review fertility & genetics to reduce activity. It was noted that work is to be done to convert unregistered to registered posts to include nursing staff – 18.9% headroom with additional space above wte required with Neonates increased to 19.2% to be included in budget for 2017.

It was noted by the committee that assurance from reports that staffing is safe across services with challenges in Neonates that are being addressed via a robust plan.

Allison Eddis informed the committee that occupancy rates figures may reduce as under the Carter review the recording is done at midnight which is not an appropriate time to capture occupancy rates for the Trust.

The Chair suggested requesting the data team to collate date from during the day to assess the difference in figures captured.

It was noted by the committee that maternity track occupancy data every four hours & flex the capacity of the staff accordingly.

Resolved
The Committee received the Safe Staffing Review, noting the changes to reporting procedures.

Actions:

1. Occupancy data & staff hours recordings to be conducted during day time to assess these against the data collected from midnight recordings. **AE**

16/17/043 Discipline & Grievance 12 month Review Report

Simon Davies, HR Advisor, presented the 12 month review of Disciplinary & Grievances. The committee noted that whilst there have been more incidents recorded, there were less formal hearings. The Committee were pleased to note a reduction in the length of investigation time and the length of suspensions.

The Chair suggested the Trust capture GMC & LMC direct referrals and include these numbers into the report in future. .

Resolved
The Committee received & noted the report & progress made.

Action:

1. GMC & LMC data regarding disciplinaries to be built into future reporting to the committee. **SD**

16/17/044 Internal Communications & Engagement Strategy

Katherine Wright, Head of Communications presented the draft Communications & Engagement Strategy.

David Astley stated the importance of ensuring gap between Ward & Board is minimal, ensuring recruitment is top priority and that opportunities are taken to recognise and celebrate success both internally and externally..

Ian Knight, Non-Executive Director stated patients are important group to focus on along with their experience of the Trust as staff drive patient experience which influences public perceptions.

Resolved

The Committee approved the strategy.

16/17/045 Volunteer Strategy 2016/2017 Work Plan

Ms Gina Barr, Voluntary Services Manager briefed the committee on the proposed Volunteer Strategy.

Currently, most volunteers were seeking to gain experience prior to employment or further education but the Trust was keen to expand its volunteer cohort from more diverse groups. This would require a focus on raising awareness of volunteering in the Trust both internally and externally. Social media and a more interactive website were seen as useful tools to support this activity.

The Committee supported the stated aim to recognise & reward the volunteers.

The Chair was assured that the Trust also had a desire to support and increase the number of employees volunteering and a business case would be brought to PPF for consideration later in the year.

Resolved

The Committee approved the Strategy & requested a detailed business case on employee volunteering .

Action:

1. A detailed business case to be brought to the September PPF committee

16/17/046 Putting People First Annual Report

Michelle Turner stated this report reflects 2015/16 activity which will be presented to the June Board of Directors meeting.

Resolved

The Committee approved the report.

16/17/047 Policies for Approval

Simon Davies stated policies are brought to PPF for approval prior to being reported at any other committee & informed the committee that there are three policies which are not for approving at this current time.

The Committee noted that there has been a slight change to the Mandatory Training policy regarding study days.

The committee approved all the policies listed below:

- Special Leave Policy
- Supporting Staff following a work related trauma or serious incident Policy
- Induction Policy
- Mandatory Training Development Policy
- Policy for submission & assessing competency of Doctors
- Removal & related expenses for Consultant Medical Staff SOP

The following policies were deferred at the request of the partnership forum who required further information

- Social Media Policy
- Redeployment Policy
- Organisational Change Policy

Resolved
The Committee ratified the above policies

16/17/048 Draft Minutes of Education Governance Committee on 22nd April 2016

Resolved
The minutes of the above meeting were noted.

16/17/049 Chair Report & Minutes of Nursing & Midwifery Board on 26th April 2016 and Chair Report & Minutes of Nursing & Midwifery Board on 24th May 2016

Resolved
The minutes of the above meetings were noted.

16/17/050 Chair Report & Draft Minutes of Joint Local Negotiating Committee on 20th April 2016

Joanne Topping, Consultant queried whether the policy relating to Supervision of Doctors had been approved by JLNC. .

Resolved
The minutes of the above meetings were noted.

16/17/051 Review of risk impacts of items discussed.
No new risks were identified. No changes to risks were recommended.

Cath Barton advised the Committee that appraisal & mandatory training rates in Neonates may fall in the next few months associated with current staffing pressures and priority being given to service.

16/17/052 Any Other Business
No items raised.

16/17/053 Review of meeting
All items have been covered in a timely manner.

16/17/054 Date, time and place of next meeting
Friday 23rd September 2016 @ 13:00 in Large Meeting Room

Agenda item no:	16/175

Meeting:	Trust Board Meeting

Date:	1 July 2016

Title:	Terms of Reference approval

Report to be considered in public or private?	Public

Where else has this report been considered and when?	

Reference/s:	

Resource impact:	

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

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

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

What action is required at this meeting?	Board is asked to approve the terms of reference of the following Board Committees: • Audit Committee • Finance Performance and Business Development Committee • Putting People First Committee and note that the Terms of Reference of the Governance and Clinical Assurance Committee will be reviewed by the Committee at its next meeting and be presented to the Board for approval at the next following meeting.

Presented by:	Colin Reid Trust Secretary

Prepared by:	

This report covers (tick all that apply):

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

Other:			
Monitor compliance		Equality and diversity	
Operational plan		NHS constitution	

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

AUDIT COMMITTEE
TERMS OF REFERENCE

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

place for the proportionate and independent investigation of such matters and for appropriate follow-up action.

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

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

b. Internal audit

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

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

c. External audit

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

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

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

d. Other assurance functions

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

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

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

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

e. Counter fraud

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

f. Management

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

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

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

FINANCE, PERFORMANCE AND BUSINESS DEVELOPMENT COMMITTEE TERMS OF REFERENCE

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

Membership:	The Committee membership will be appointed by the Board of Directors and will consist of: • Non-Executive Director (Chair) • Two additional Non-Executive Directors • Chief Executive • Director of Finance • Associate Director of Operations Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. The 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** Members will be required to attend a minimum of 50% of all meetings. **b. Officers** Ordinarily the Deputy Director of Finance will attend all meetings. Other executive directors and officers of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed.
Frequency:	Meetings shall be held at least 5 times per year. Additional meetings may be arranged if required, to support the effective functioning of the Trust.
Authority:	The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are

	directed to cooperate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities.
Accountability and reporting arrangements:	The Finance, Performance and Business Development Committee will be accountable to the Board of Directors. The minutes of Finance, Performance and Business Development Committee meetings will be formally recorded and circulated to the Board of Directors. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to it, or require executive action. The Committee will report to the Board annually on its work and performance in the preceding year. Trust standing orders and standing financial instructions apply to the operation of the Finance, Performance and Business Development Committee.
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 Finance, Performance & Business Development Committee:	28 April 2015 v1 27 July 2015 v2 25 April 2016 v1
Approved by Board of Directors:	5 June 2015 v1 4 September 2015 v2 – Ratified 1 July 2016
Review date:	April 2017
Document owner:	Trust Secretary Tel: 0151 702 4033

PUTTING PEOPLE FIRST COMMITTEE
TERMS OF REFERENCE

Constitution:	The Committee is established by the Board of Directors and will be known as the Putting People First Committee (the Committee).
Duties:	The Committee is responsible for: a. Developing and overseeing implementation of the Trust's People Strategy (integrated workforce and organisational development strategy) and plan and providing assurance to the Board of Directors that this is being delivered in line with the annual planning process b. Oversight of the strategic implementation of multi-disciplinary education and training and gaining assurances that the relevant legislative and regulatory requirements are in place (Education Governance Committee) c. Approving, monitoring and reviewing policies, procedures and guidance documents relating to the management of the Trust's workforce d. Monitoring and reviewing workforce key performance indicators to ensure achievement of the Trust's strategic aims and escalate any issues to the Board of Directors e. Reviewing any changes in practice required following any internal enquiries that significantly impact on workforce issues f. Oversight of the strategic implementation and monitoring of staff engagement levels as evidenced by the results of the national and any other staff surveys g. Reviewing and approving partnership agreements with staff side h. Ensuring that the Trust fulfils all legislative and regulatory requirements pertaining to workforce and organisational development issues, including but not limited to equality and diversity i. Approving the terms of reference and membership of its reporting groups and overseeing the work of those groups, receiving reports from them for consideration and action as necessary and routinely receiving the minutes of their meetings j. Receipt and review of relevant risks (including those referred from other Committees or subcommittees) concerned with workforce and organisational development matters as identified through the Board Assurance Framework. Monitor progress made in mitigating those risks, identifying any areas where additional assurance is required, escalating to the Board of Directors as required. k. Receiving and considering issues from other Committees when appropriate and taking any necessary action.

Membership:	The Committee membership will be appointed by the Board of Directors and will consist of • Non-Executive Director (Chair) • 2 other Non-Executive Director • Director of Workforce & Marketing • Director of Nursing & Midwifery • Associate Director of Operations / General Manager • Staff Side Chair • Medical Staff Committee representative • Representative from the Nursing & Midwifery Board • Senior Finance Manager Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum The Board of Directors will appoint a Non-Executive Director as Chair of the Committee 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 four members including: • The Chair or Vice Chair who must be a Non-Executive Director • One Executive Director • Divisional Manager or designated deputy • Staff side Chair or Medical Staff Committee representative
Voting:	Each member will have one vote with the Chair having a second and casting vote, if required. Should a vote be necessary a decision will be determined by a simple majority.
Attendance:	**a. Members** Members will be required to attend a minimum of 75% of all meetings. **b. Officers** HR & OD Business Partners, Health & Wellbeing Manager, Head of Midwifery, Education Governance Chair and representative from the Finance Department shall normally attend meetings. Members may send a nominated representative to attend meetings on their behalf when they are not available, provided they are sufficiently senior and have the authority to make decisions. Other executive directors, officers and staff of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed.

	Representatives from partner organisations or other external bodies may be invited to attend as appropriate. Such representatives will not have voting rights.
Frequency:	Meetings shall be held at least 4 times 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 is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities.
Accountability and reporting arrangements:	The Putting People First Committee will be accountable to the Board of Directors. The minutes of the Putting People First Committee meetings will be formally recorded and submitted to the Board of Directors. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to it, or require executive action. Approved minutes will also be circulated to members of the Audit Committee. The Committee will report to the Board annually on its work and performance in the preceding year. Trust standing orders and standing financial instructions apply to the operation of the Putting People First 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 Putting People First Committee:	15 April 2015
Approved by Board of Directors:	1 July 2016
Review date:	April 2017
Document owner:	Colin Reid, Trust Secretary Email: colin.reid@lwh.nhs.co.uk Tel: 0151 702 4033

Agenda Item No:	16/176
Meeting:	Trust Board
Date:	June 2016
Title:	Performance Dashboard - Month 2 - May 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 3. Deliver the best possible experience for patients and staff 4. To develop a well led, capable and motivated workforce 5 to be ambitious and efficient and make best use of available resources
Which CQC fundamental standard(s) does this report ralet to?	Good Governance Staffing Safety Complaints
What action is required at this meeting?	To Note
Presented by:	Jeff Johnson
Prepared by:	David Walliker

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			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.		
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1. Introduction and summary

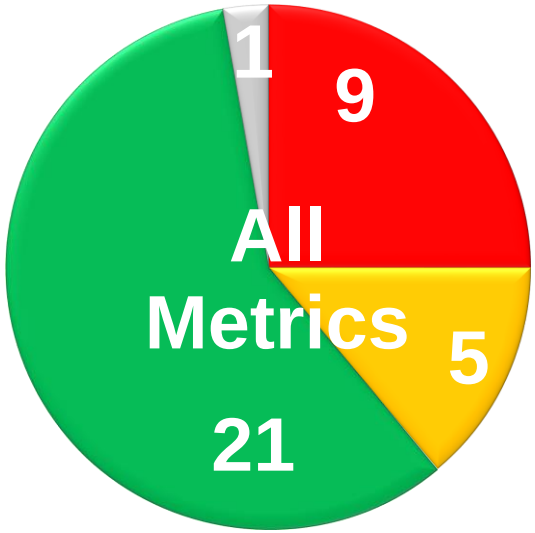
2. Issues for consideration

3. Conclusion

4. Recommendation/s

Liverpool Women's NHS Foundation Trust

Performance Report - Trust Board — Month 2 - May 2016



Performance Summary - Trust Board - Month 2 - May 2016

Overview

Of the 40 KPI's reported in the Trust Board Dashboard for May 2016, 22 are rated Green, 9 are rated Red and 5 are rated as Amber. The Choose & Book figure for May is not yet available nationally via HSCIC.

The KPI's rated as Red are:

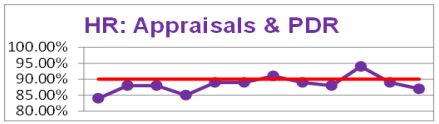
- 3 x Finance reported separately via the Finance Report
- Caesarean Sections: Total Section rates at 28.4% against a target of <= 23%
- Caesarean Sections: Elective Section rates at 13% against a target of <= 10%
- Cancer: Referral onto treating Trust by day 42 at 50% against a target of 100%
- Bloods fated within 4 Hours at 92% against a target of 100% (improved from 89% in April)
- 6 Week Wait for Diagnostic Test at 97.12% against a target of >= 99% (carries financial penalties)
- Maternity Triage within 30 minutes at 89% against a target of >= 95% (breached for 5 consecutive months)

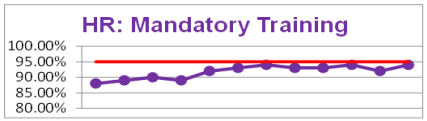
The KPIs rated as Amber are:

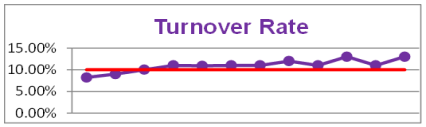
- HR: Appraisals/PDR rate at 87% against a target of >= 90%
- HR: Mandatory Training rate at 94% against a target of >= 95%
- HR: Staff turnover rate at 13% against a target of <= 10%
- TCI Cancellations for Clinical reasons at 2.14% against a target of <= 2%
- Returns to Theatre at 1.03% against a target of 0.7% (3 Obstetric and 6 Gynae cases)

Performance Summary - Trust Board - Month 2 - May 2016

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







Rate of Appraisals/PDR at 87% against a target of >= 90%

Overall, 8 areas are rated as Green, with 6 as amber and 3 rated red. The areas rated red are Genetics at 72%, Neonates at 76% and Medical Staff at 81%. Managers are required to have plans in place to ensure that compliance targets are met and maintained, and these are regularly reviewed and updated. Managers have been advised that a zero tolerance policy will be applied at the end of quarter one, and managers will be held accountable if compliance rates remain below target.

Neonates will be temporarily exempt because of the operational pressures , however all other areas should achieve target by the end of Quarter 1.

Rate of Mandatory Training at 94% against a target of >= 95%

Although still below the target, the rate of compliance has increased from 92% to 94% in May 2016. There are currently 11 areas rated as green and 6 rated as amber. There are no areas rated as red.

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.
Managers have been advised that a zero tolerance policy will be applied at the end of quarter one, and managers will be held accountable if compliance rates remain below target. The only temporary exception will be Neonates because of the operational pressures they are currently experiencing. All remaining areas should achieve compliance by the end of Quarter 1.

Staff Turnover Rates at 13% against a target of <= 10%
There were 14 leavers in month two, compared to 11 in month one, and 27 in month 12.

At service level, there were increases in turnover for:
Finance (wte 27.88) turnover increased from 20% to 28%
Gynaecology (wte 154.89) turnover increased from 12% to 15%

There was also a significant reduction in turnover for Integrated Governance which fell from 27% down to 21%.

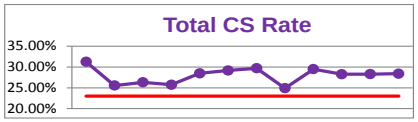
Information from the 2015 NHS Staff Survey, the PULSE survey results and exit interviews will be analysed to help identify any trust wide or local issues that may need to be addressed. The potential impact of future generations will be monitored. It is anticipated that the turnover figure will return to below the Trust's target figure of 10% within the first half of the year.

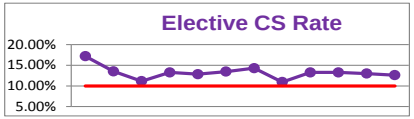
Performance Summary - Trust Board - Month 2 - May 2016

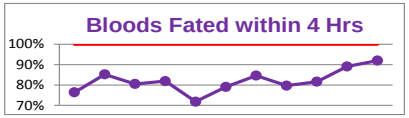
To be EFFICIENT and make best use of available resources

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

To deliver SAFER services







There are 3 KPI's that have consistently been rated as Red that require scrutiny from the Board and these are: -

Caesarean Sections: Total section Rate at 28.4% against a target of <= 23%

and

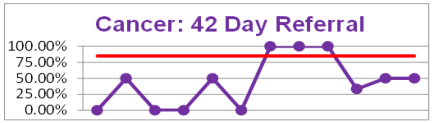
Caesarean Sections: Elective Section Rate at 13% against a target of <= 10%
The Target and rates of Caesarean sections are being reviewed along with benchmarking of rates in other Trusts and within the Cheshire & Merseyside Strategic Clinical Network. This work is intended to inform our target rates and the findings of the review will be presented for clinical review at GACA August 16. In the mean time, the rates will continue to be closely monitored.

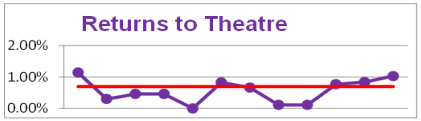
Blood Fating within 4 Hours: at 92% against a target of 100%
Although still not achieving the 100% target rate, performance against this KPI has improved from 89% in April to 92% in May. Work continues in educating and training staff of the importance of fating bloods within the 4 hour window. Performance is expected to demons trate improvement and we are currently exploring options to cover blood transfusion practitioner to help get target back on track, unfortunately we ha ve been unable to secure appropriate staff .

All Linear graphs are rolling 12 months

Performance Summary - Trust Board - Month 2 - May 2016

To deliver the most EFFECTIVE outcomes





Cancer: referral on to treating Trust by day 42 at 50% against target of 100% (1 patient from 2)

1 patient breached the target against a denominator of 2 patients. The patient had a complex pathway and required a number of clinical interventions prior to referral to Clatterbridge. The Root Cause Analysis identified a delay in patient having CT scan (17 days from request) CT scan delays to be escalated to RLUBH if appointments are not offered within 2/52.

Owing to the low numbers and the absence of a tolerance in this measure , it is always at risk of failing due to complex pathways. therefore unable to provide a robust date to achieve target

Returns to Theatre at 1.03% against a target of 0.7% (3 Obstetric and 6 Gynaecology cases)

6 Gynaecology returns – All returns have been reviewed by the Clinical Director.

3 Obstetric returns

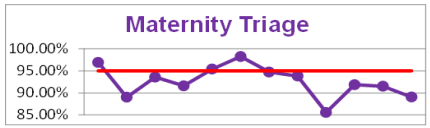
Returns to theatre are currently reviewed on a weekly basis and appropriate escalation takes place when required. This practice will continue in order to identify any returns that require further analysis and investigation.

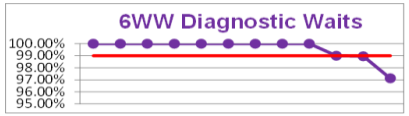
Owing to the clinical nature of this measure, we will occasionally breach as post-operative can be uncertain. The directorates will continue to monitor trends on a monthly basis and carry out RCA's when required

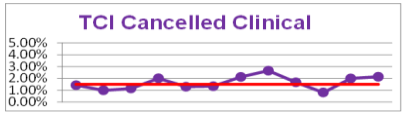
All Linear graphs are rolling 12 months

Performance Summary - Trust Board - Month 2 - May 2016

To deliver the best possible EXPERIENCE for patients and staff







Maternity Triage within 30 Minutes at 89% against a target of >= 95%

The service have failed to achieve the target rate for this KPi for the 5th consecutive month. The reason for failing this target is that staff are not escalating in a timely fashion when potential breaches occur.

The leadership model in this area is to be reviewed and support provided for staff to respond and escalate appropriately. Furthermore, an SBAR will be completed for each breach and a full analysis to be undertaken. With these measures in place, it is expected that the target rate will be achieved in July 2016.

6 Week Wait for Diagnostic Test at 97.12% against a target of >= 99%
The target was breached due to 13 breaches in cystometry. This is due to reduced capacity due to sickness over the past 6 months. There has also been an increase in patients requiring specialist procedures by consultants.

Booking processes also impacted on the performance as patients were not booked in date order due to multiple referral sources.

A capacity and demand review has taken place. New partial booking process has been implemented to manage patient waiting times and ensure patients are booked in wait time order. We are also reviewing consultant request for cystometries to ensure appropriateness.
Date: by Aug 2016

TCI's cancelled for Clinical reasons at 2.14% against a target of <= 2%

A higher number than average cases were cancelled due to patients being unwell following pre-operative assessment. This measure has not been identified as a risk previously.

A proportion of the cancellations for non-clinical reasons were listed as ‘Administration Error’ & ‘Consultant Unavailable’

Administration staff are reviewing how cancellations are recorded to ensure that the data is accurate.

The data has been requested on a weekly basis in order that performance can be reviewed at weekly Gynaecology Activity and Performance meeting

Admission manager to review recording of ‘Administration Error’ & ‘Consultant Unavailable’ to identify areas of improvement.

Root cause of failure of the target has not yet been identified so target date to achieve can not yet be identified.

All Linear graphs are rolling 12 months

Performance Summary - Trust Board - Month 2 - May 2016

Conclusion

Overall, the Trust performance has remained steady in May 2016 with a small decrease in the number of KPIs meeting the target, and an increase the number of KPIs that are now amber. Focus, together with robust and practical action plans being reviewed and discussed at SMT will ensure plans and dates provided to achieve targets are being monitored.

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										
HR: Sickness & Absence Rates (Commissioner)		<= 4.5%	4.42%	3.51%										
HR: Annual Appraisal and PDR		>= 90%	89.00%	87.00%										
HR: Completion of Mandatory Training		>= 95%	92.00%	94.00%										
HR: Turnover Rate		<= 10%	11.00%	13.00%										

To be EFFICIENT and make best use of available resources

Indicator Name	Ref	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Planned Surplus/ Deficit (YTD) £'000		Planned Cumulative	£710	£1,434	£2,104	£2,282	£3,069	£3,480	£3,763	£4,460	£5,431	£5,823	£6,529	£7,000
Actual Surplus / Deficit (YTD) £'000		<= Planned	£696	£1,375										
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	£88	£196										
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										
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										
Monitor: Financial Sustainability Risk Rating: Capital Cover		1	1	1										
Monitor: Financial Sustainability Risk Rating: Liquidity		2 (1 from Sep 2016)	2	2										
Monitor: Financial Sustainability Risk Rating: I & E Margin		1	1	1										
Monitor: Financial Sustainability Risk Rating: Variance to Plan		4	4	4										
Monitor: Financial Sustainability Risk Rating: Overall Score		2	1	2										
Monitor: Financial Sustainability Risk Rating: Agency Cap		0	51	25										

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%										
Elective Caesarean Section Rate		< 10%	13.00%	12.61%										
Blood Transfusion Service: Fating of Bloods within 4 Hours		100%	89.10%	92%										
Safer Staffing Levels (Overall - includes Registered and Care Staff)		<= 90%	92.78%	91.92%										
Serious Incidents: Number of Open SI's		Monitoring Only	22	21										
Serious Incidents: Number of New SI's		Monitoring Only	1	2										
% of women seen by a midwife within 12 weeks		>= 95%	96.82%	95.44%										
Neonatal Bloodstream Infection Rate		TBD	0.45	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%										
Biochemical Pregnancy Rates		> 30% TBC	45.94%	47.62%										
Still Birth Rate (excludes late transfers)		TBD	0.00	0.01										
Neonatal Deaths (all live births within 28 days)		Rate per 1000 TBD	1.44	0.00										
Returns to Theatre		<= 0.7% TBC	0.64%	1.03%										

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%										
Number of Complaints received		<= 15	15	5										
18 Week RTT Incompletes (aggregate)		>= 92%	95.71%	95.90%										
Friends & Family Test		> 75%	99.26%	98.47%										
% Women that requested and Epidural, but weren't given one for non-clinical reasons		<= 5%	6.37%	3.66%										
% Women given one to one care whilst in established Labour (4cm dilation)		>= 95%	96.86%	96.08%										
6 Week Wait Diagnostic Tests		>= 99%	98.96%	97%										
Last Minute Cancellation for non-clinical reasons		TBA	4.30%	6.31%										
Last Minute Cancellation for non-clinical reasons (Not re-admitted within 28 days)		0	0	0										
Failure to ensure that sufficient appointment slots are available on Choose & Book		< 6%	Not Available	Not Available										

Performance and Information Department
Performance Team

Agenda Item No:	
Meeting:	Trust Management Group and Finance, Performance and Business Development Board
Date:	June 2016
Title:	Performance Dashboard - Month 2 - May 2016
Report to be considered in Public or Private?	Public
Where else has this report been considered and when?	N/A
Reference/s	Quality Strategy, Quality Schedule, CQUINS, Corporate Performance Indicators, Monitor Assurance Framework
Resource impact:	

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

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

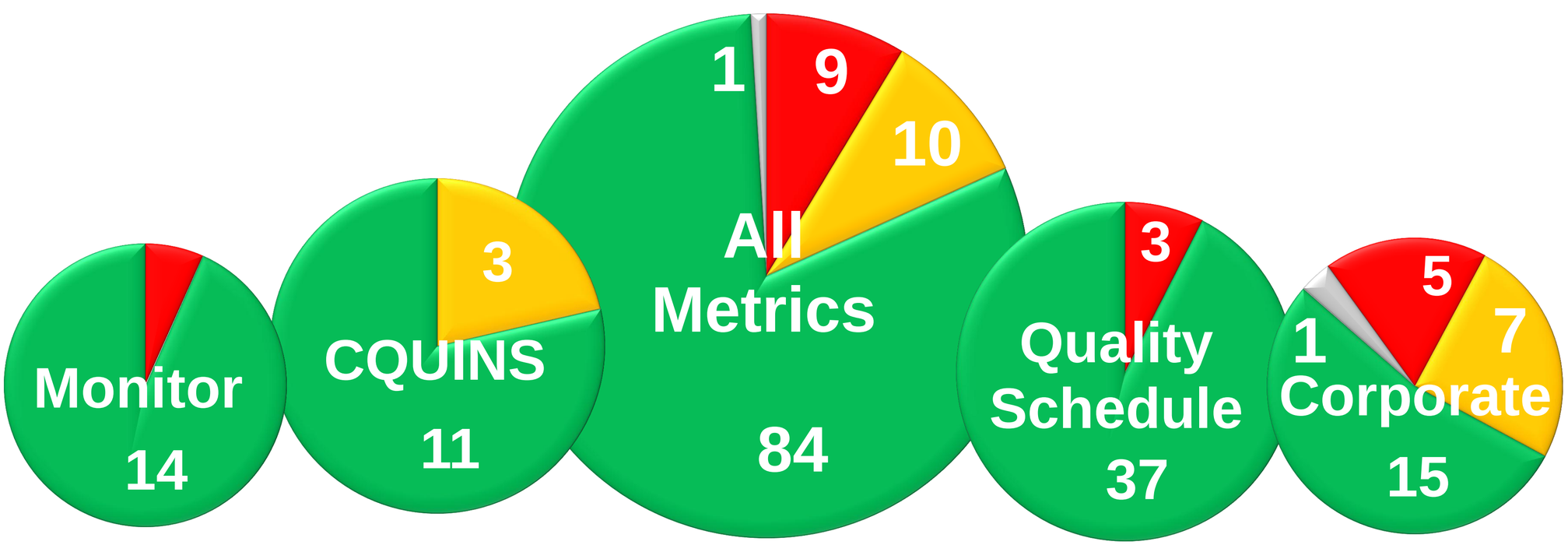
2. Issues for consideration

3. Conclusion

4. Recommendation/s

Liverpool Women's NHS Foundation Trust

Performance Report for TMG and FPBD Board - Month 2 - May 2016



Performance Summary for TMG and FPBD - Month 2 - May 2016

Overview

For May 2016 there were a total of **104** RAG rated KPIs of which, **84 (82%)** have been rated as Green, **9** rated as Red, **10** rated as Amber and **1** where the data is not available nationally. The KPIs rated as Red which are of most concern are:-

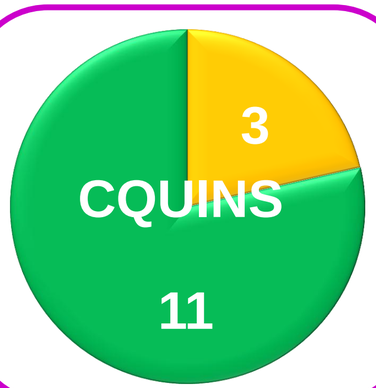
- Maternity Triage at 89% against a target of >= 95% - This is the 5th consecutive month that tthe Trust has faliled to achive this KPI.
- Bambis: Peer support for Breastfeeding contact during stay at 88.5% against a target of >= 90% (never breached before)
- 6 Week Wait for Diagnostic Test at 97.12% against a target of >= 99% - second month of breaching declined from last month.
- Serious Incidents with Actions that remain outstanding - 7 against a target of 0 - one less than last month.

There is concern that the Trust is not compliant with 3 of the agreed CQUINS and these have been rated as Amber.

The rate of Appraisals/PDR, Mandatory Training and Turnover continue to be of concern as they are yet to achieve compliance.

Monitor:

All KPI's for Monitor are compliant apart from the number of shifts above agreed cap that were staffed by agency. However, this has improved significantly form 51 in April to 25 for May.



CQUINS:
Quarter 1 is the period of development and planning of new processes for most of the CQUINS. All CQUINS are progressing towards acheiveing compliance for quarter one. However, concerns have been raised with ragards the following 3 CQUINS:-

Reduction of Antibiotic Use (2 CQUINS)- Processes have not been progressed as far as had been indicated. This has been escalated to Senior Management and it is expected that Pharmacy leads will put in place actions to ensure we will be on track to achieve this CQUIN by the close of the Quarter.

Health & Wellbeing - The Trust must upload information to Unify by the 30th of June in order to comply with the Quarter 1 milestones for this CQUIN howevr key staff members are currently on leave. This will be picked up by director of HR upon her return from leave on the 20th June.

Performance Summary for TMG and FPBD - Month 2 - May 2016

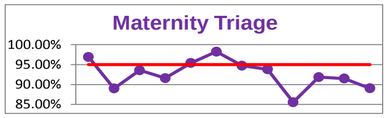
Quality Strategy

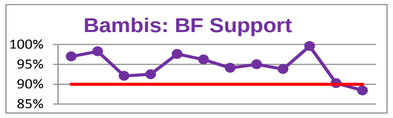
7

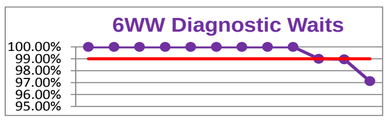
Quality Strategy:

The targets for all Quality Strategy KPI's have been achieved and there are no indications or early warnings of not being able to achieve the targets in the near future.

Performance Summary for TMG and FPBD - Month 2 - May 2016







Quality Strategy:

Maternity Triage within 30 Minutes at 89% against a target of >= 95%

The service have failed to achive the target rate for this KPi for the 5th consecutive month. The reason for failing this target is that staff are not escalating in a timely fashion when potential breaches occur.

The leadership model in this area is to be reviewed and support provided for staff to respond and escalate appropriately. Furthermore, an SBAR will be completed for each breach and a full analysis to be undertaken. With these measures in place, it is expected that the target rate will be ahcieved in July 2016.

Bambis: Support for Breastfeeding - Rate of women contacted during stay at 88.4% against a target of >= 90%

This is the first time that the Trust has failed to achive the target rate for this KPI. The failure has occured due to the removal of the Breast Start peer support service due to a withdrawal of funding and vacancies in the Peer Support Team, with post not being recuited to due to it being fixed term contracts unitl March 2017 and the part time hours remain vacant. The Bambi's team co-ordinator has reviewed the hours worked and the peer support contact time on the post-natal areas and will monitor the activity of the team closely on a day to day basis.

Although the Trust has failed to achiev the target rate forthis KPI, it is of note that the Trust has achieved the target rate for breastfeeding for the second month in a row at 56% for May 2016 .

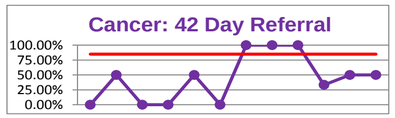
6 Week Wait for Diagnostic Test at 97.12% against a target of >= 99%
The target was breached due to 13 breaches in cystometry. This occurred because of reduced capacity due to sickness absence over the past 6 months. There has also been an increase in patients requiring specialist procedures by consultants.

Booking processes also impacted on the performance as patients were not booked in date order due to multiple referral sources.

A capacity and demand review has taken place. New partial booking process has been implemented to manage patient waiting times and ensure patients are booked in wait time order. We are also reviewing consultant request for cystometries to esure appropriateness.

All Linear graphs are rolling 12 months

Performance Summary for TMG and FPBD - Month 2 - May 2016



Corporate Metrics:
2 Finance KPI's are rated red , the details of which can be found in the Fianance Report

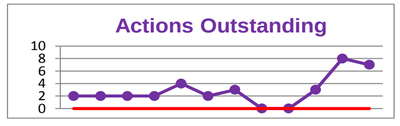
Cancer: referral on to treating Trust by day 42 at 50% against atarget of 100% (1 patient from 2)
1 patient breached the target against a denominator of 2 patients. The patient had a complex pathway and required a number of clinical interventions prior to referral to Clatterbridge. The Root Cause Analysis identified a delay in patient having CT scan (17 days from request) CT scan delays to be escalated to RLUBH if appointments are not offered within 2/52.

Owing to the low numbers and the absence of a tolerance in this measure , it is always at risk of failing due to complex pathways.

Complaints: Response Times at 89% against a target of 100% (1 from 9)
The reason for failure to achieve this target was :-

1. The complaint timescale was not met due to the inability to arrange a suitable meeting date for the complainant. The complainant refused the request to extend. (Imaging)
2. The investigation report was not completed within the agreed timescale
3. Imaging to introduce new processes to ensure that meeting dates are arranged within the agreed timescale
4. Maternity to put processes in place to ensure that investigation reports and responses are complete within the

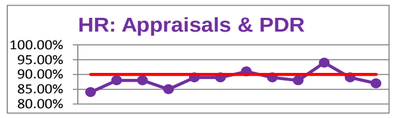
The Head of Patient Experience will inform the divisions of the requirement to achieve these actions. The Head of Patient Experience recommends that a new escalation process is agreed as this is not an isolated occurrence. To enable the divisions to agree the new escalation process, it is expected to achieve the target rate for July 2016.



Serious Incidents with Actions that remain outstanding at 7 agaisnt a target of 0
This is the result of a more robust process being introduced before an action is considered closed. Whereas in the past verbal assurance was taken that an action has been completed the Governance Facilitators now require the submission of supporting evidence. Although the revised process has initially led to a failure against target it has strengthened the assurance that can be taken for completed actions.
The Governance Facilitators are addressing individual actions with the relevant staff members. Actions from Serious Incidents are now a standing agenda item at the Safety Senate with overdue actions identified and addressed. The first meeting in which this was a standing item took place on 13 May.The action plans identified this month are expected to be closed by the end of the month with exception reports in place for each action point.

At the outset of this performance dip it was reported that as staff become accustomed to the new process there may be some fluctuation in performance and that it is expected this would settle and the target be consistently met within 3-6 months. This remains the expectation.

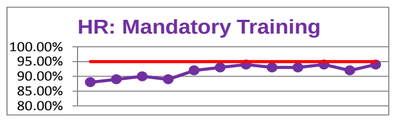
Performance Summary for TMG and FPBD - Month 2 - May 2016



Corporate Metrics continued

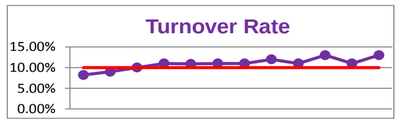
Rate of Appraisals/PDR at 87% against a target of >= 90%
Overall, 8 areas are rated as Green, with 6 as amber and 3 rated red. The areas rated red are Genetics at 72%, Neonates at 76% and Medical Staff at 81%. Managers are required to have plans in place to ensure that compliance targets are met and maintained, and these are regularly reviewed and updated. Managers have been advised that a zero tolerance policy will be applied at the end of quarter one, and managers will be held accountable if compliance rates remain below target.

Neonates will be temporarily exempt because of the operational pressures , however all other areas should achieve target by the end of Quarter 1.



Rate of Mandatory Training at 94% against a target of >= 95%
Although still below the target, the rate of compliance has increased from 92% to 94% inMay 2016. There are currently 11 areas rated as green and 6 rated as amber. There are no areas rated as red.

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. Managers have been advised that a zero tolerance policy will be applied at the end of quarter one, and managers will be held accountable if compliance rates remain below target. The only temporary exception will be Neonates because of the operational pressures they are currently experiencing. All remaining areas should achive compliance by the end of Quarter 1.



Staff Turnover Rates at 13% against a target of <= 10%
There were 14 leavers in month two, compared to 11 in month one, and 27 in month 12.

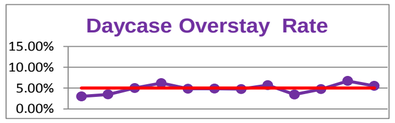
At service level, there were increases in turnover for:
Finance (wte 27.88) turnover increased from 20% to 28%
Gynaecology (wte 154.89) turnover increased from 12% to 15%

There was also a significant reduction in turnover for Integrated Governance which fell from 27% down to 21%.

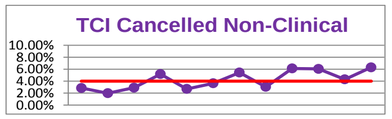
Information from the 2015 NHS Staff Survey, the PULSE survey results and exit interviews will be analysed to help identify any trust wide or local issues that may need to be addressed. The potential impact of future generations will be monitored.It is anticipated that the turnover figure will return to below the Trust's target figure of 10% within the first half of the year.

Performance Summary for TMG and FPBD - Month 2 - May 2016

Corporate Metrics continued



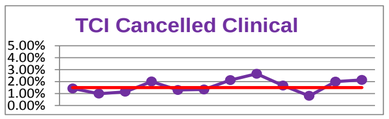
Daycase overstay rate at 5.3% against a target of <= 5%
This has been a rate that fluctuates for some time and the service are planning an in-depth review of the data to see if there is any particular reason why breaches occur some months and not others. The results of this enquiry will be presented in next Performance report for June and at the Quarterly review.



TCI Cancelled for Non-Clinical Reasons at 6.3% against a target of <= 4%

and

TCI Cancelled for Clinical reasons at 2.14% against a target of <= 2%



A higher number than average cases were cancelled due to patients being unwell following pre-operative assessment. This measure has not been identified as a risk previously.

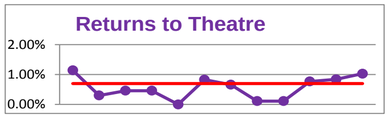
A proportion of the cancellations for non-clinical reasons were listed as ‘Administration Error’ & ‘Consultant Unavailable’

Administration staff are reviewing how cancellations are recorded to ensure that the data is accurate.

The data has been requested on a weekly basis in order that performance can be reviewed at weekly Gynaecology Activity and Performance meeting

Admission manager to review recording of ‘Administration Error’ & ‘Consultant Unavailable’ to identify areas of improvement.

Root cause of failure of the target has not yet been identified so target date to achieve can not yet be identified.



Returns to Theatre at 1.03% against a target of <= 0.7%

6 Gynaecology returns – All returns have been reviewed by the Clinical Director.

3 Obstetric returns

Returns to theatre are currently reviewed on a weekly basis and appropriate escalation takes place when required. This practice will continue in order to identify any returns that require further analysis and investigation.

Owing to the clinical nature of this measure, we will occasionally breach as post-operative can be uncertain. The directorates will continue to monitor trends on a monthly basis and carry out RCA’s when required

Performance Summary for TMG and FPBD - Month 2 - May 2016

Emerging Concerns

Achivevment of Quarter 1 milestones for 3 of the 14 CQUINS is of concern and needs to be escalated in order to ensure that we are compliant by the end of Quarter 1, and that we have all the evidence to hand for submission at the end of July 2016.

Of lesser concern, but worth noting is that the rate of cancelled TCI's for both Clinical and non-clinical reasons are breaching as it may affect the capacity of future lists.

Conclusion

Overall, for May 2016 the Trust has performed well in many areas with improvements seen in the reducton of DNA rates, and the number of women not receiving an Epidural.

It is imperative that focus and support be given in order to ensure achievement of all Quarter 1 milestones for CQUINS.

Recommendations

It is recommended that the FPBD 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 Monitor 2016/17 Month 2 - May 2016

To be EFFICIENT and make the best use of available resources

Indicator Name	Ref	Owner of KPI	Target	Apr-16	May-16	Jun-16	Qtr1	Jul-16	Aug-16	Sep-16	Qtr2	Oct-16	Nov-16	Dec-16	Qtr3	Jan-17	Feb-17	Mar-17	Qtr4
Financial Sustainability Risk Rating: Capital Cover		Jenny Hannon	1	1	1														
Financial Sustainability Risk Rating: Liquidity		Jenny Hannon	2 (1 from Sep 2016)	2	2														
Financial Sustainability Risk Rating: I & E Margin		Jenny Hannon	1	1	1														
Financial Sustainability Risk Rating: Variance to Plan		Jenny Hannon	4	4	4														
Financial Sustainability Risk Rating: Overall Score		Jenny Hannon	2	1	2														
Number of Shifts covered in breach of Agency Cap		Jenny Hannon	0	51	25														

To deliver SAFER services

Indicator Name	Ref	Owner of KPI	Target	Apr-16	May-16	Jun-16	Qtr1	Jul-16	Aug-16	Sep-16	Qtr2	Oct-16	Nov-16	Dec-16	Qtr3	Jan-17	Feb-17	Mar-17	Qtr4
Clostridium (C.) Difficile - meeting the C. Difficile objective	9	Kerry Boyd	0	0	0														

To deliver the most EFFECTIVE outcomes

Indicator Name	Ref	Owner of KPI	Target	Apr-16	May-16	Jun-16	Qtr1	Jul-16	Aug-16	Sep-16	Qtr2	Oct-16	Nov-16	Dec-16	Qtr3	Jan-17	Feb-17	Mar-17	Qtr4
All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (After Re-allocation)	3	Shaun Curran	>= 85%	85.71%	90.00%														
All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (before re-allocation - Not RAG rated - for monitoring purposes only)		Shaun Curran	>= 85%	80.00%	81.82%														
All Cancers: 62 day wait for first treatement from NHS Cancer Screening Service referral - Percentage	4	Shaun Curran	>= 90%	100.00%	None														
All Cancers: 62 day wait for first treatement from NHS Cancer Screening Service referral - Numbers (if > 5, the target applies)	4b	Shaun Curran	< 5	2	0														
All Cancers: 31 day wait for second or subsequent treatment comprising surgery	5	Shaun Curran	>= 94%	100%	100.00%														
All Cancers: 31 day wait for second or subsequent treatment comprising anti cancer drug treatments	6	Shaun Curran	>- 98%	None	None														
All Cancers: 31 day wait from diagnosis to first (definitive) treatment	7	Shaun Curran	>= 96%	100%	100%														
All Cancers: Two week wait from referral to date first seen comprising all urgent referrals (cancer suspected)	8	Shaun Curran	93%	96.63%	96.25%														

To deliver the best possible EXPERIENCE for patients and staff

Indicator Name	Ref	Owner of KPI	Target	Apr-16	May-16	Jun-16	Qtr1	Jul-16	Aug-16	Sep-16	Qtr2	Oct-16	Nov-16	Dec-16	Qtr3	Jan-17	Feb-17	Mar-17	Qtr4
Maximum time of 18 weeks from point of referral to treatment in aggregate - Incompletes	1	Shaun Curran	>= 92%	95.71%	95.90%														
A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge	2	Sharon Owens	>= 95%	99.58%	97.98%														

LWH CQUINS (CCG) 2016/17 Month 2 - May 2016

To deliver SAFER services

Indicator Number	Indicator Name	Owner	% Weighting	£ Weighting	Apr-16	May-16	Jun-16	Target	Qtr1	Jul-16	Aug-16	Sep-16	Target	Qtr2	Oct-16	Nov-16	Dec-16	Target	Qtr3	Jan-17	Feb-17	Mar-17	Target	Qtr4
1.1	Introduction of health and wellbieng initiatives	Gill Curry	0.25% (N)	£162,362	Compliant	Compliant		> 2015 + 5%																
1.2	Healthy food for NHS staff, visitors and patients	Linda Martin	0.25% (N)	£162,362	Compliant	Compliant																		
1.3	Increase uptake of Flu Vaccinations among Staff	Gill Curry	0.25%(N)	£162,362	N/A Seasonal	N/A Seasonal	N/A Seasonal		N/A	N/A Seasonal	N/A Seasonal	N/A Seasonal		N/A							N/A Seasonal	N/A Seasonal		
3.1	Timely identification and treatment for sepsis in emergency departments	Debbie Mennim	0.13% (N)	£81,181	None	None																		
3.2	Timely identification and treatment for sepsis in acute inpatient settings	Debbie Mennim	0.13% (N)	£81,181	None	None																		

To be EFFICIENT and make best use of available resources

Indicator Number	Indicator Name	Owner	% Weighting	£ Weighting	Apr-16	May-16	Jun-16	Target	Qtr1	Jul-16	Aug-16	Sep-16	Target	Qtr2	Oct-16	Nov-16	Dec-16	Target	Qtr3	Jan-17	Feb-17	Mar-17	Target	Qtr4
5	Digital Maturity	David Walliker	0.18% (L)	£116,900	Compliant	Compliant		Compliant																
5.1	Digital Maturity : Named IM&T Lead	David Walliker	0.045%	£29,225	Compliant	Compliant																		
5.2	Digital Maturity: engagementwith iLinks Transformation Programme via CIAG and subgroups	David Walliker	0.045%	£29,225	Compliant	Compliant																		
5.3	Digital Maturity: Undertake Information Sharing Framework indicsator in full	David Walliker	0.045%	£29,225	Compliant	Compliant																		
5.4	Digital Maturity: undertake Shared records guidance and principles indicator.	David Walliker	0.045%	£29,225	Compliant	Compliant																		
7	Screening for Alcohol Use Disorders using AUDIT-C/AUDIT tool	Ruth Stubbs/ Clare Fitzpatrick	0.2% (L)	£129,889	In Progress	Compliant		Compliant					Compliant					Compliant					Compliant	
7a	Staff Departments routinely screening for alcohol use				From	Quarter	2																	
7b	Percentage of patients who have had the alcohol consumption recorded on IT System				From	Quarter	2																	
7c	Percentage of patients who are drinking more than the recommended units per week, have their alcohol intake recorded using the AUDIT-C or AUDIT Tool				From	Quarter	2																	
7d	Percentage of patients receiving a brief intervention				From	Quarter	2																	
7e	Percentage of patients receiveing onward referral to specialist services in line with Liverpool Alcohol Pathway, if appropriate.				From	Quarter	2																	
7f	Percentage of patients with their AUDIT-C or AUDIT outcome recorded on IT system				From	Quarter	2																	
8	Early Health Assessment (EHAT) Framework	Clare Fitzpatrick	0.15% (L)	£97,417	In progress	Compliant		Compliant					Compliant					Compliant					Compliant	

LWH CQUINS (CCG) 2016/17 Month 2 - May 2016

To deliver the most EFFECTIVE outcomes

Indicator Number	Indicator Name	Owner	% Weighting	£ Weighting	Apr-16	May-16	Jun-16	Target	Qtr1	Jul-16	Aug-16	Sep-16	Target	Qtr2	Oct-16	Nov-16	Dec-16	Target	Qtr3	Jan-17	Feb-17	Mar-17	Target	Qtr4
2.1	**Reduction in antibiotic consumption per 1,000 admissions**	Paul Skipper/ Noeline Giblin	0.2% (N)	£129,889	Compliant	Compliant		Compliant																
2.1a	Rate of Antibiotic consumption per 1000 admissions	Paul Skipper/ Noeline Giblin			#DIV/0!	#DIV/0!																		
2.1b	Rate of consumption of Carbapenem per 1000 admissions	Paul Skipper/ Noeline Giblin			#DIV/0!	#DIV/0!																		
2.1c	Rate of consumption of Piperacillintazobactam per 1000 admissions	Paul Skipper/ Noeline Giblin			#DIV/0!	#DIV/0!																		
2.2	Percentage of antibiotic prescriptions reviewed within 72 Hours	Paul Skipper/ Noeline Giblin	0.05% (N)	£32,472	Compliant	Compliant		Compliant																
4.1	Urgent GP (GMP,GDP or Optometrist) referral for suspected cancer to first treatment (62 day classic) **After Reallocation**	Shaun Curran	0.16% (L)	£129,889	85.71%	90.00%		>= 85%					>= 85%					>= 85%				>= 85%	
4.2	Review of long waiters (>104 days)	Shaun Curran	0.16% (L)	£32,472	None	None		100%					100%					100%				100%	

To deliver the best EXPERIENCE

Indicator Number	Indicator Name	Owner	% Weighting	£ Weighting	Apr-16	May-16	Jun-16	Target	Qtr1	Jul-16	Aug-16	Sep-16	Target	Qtr2	Oct-16	Nov-16	Dec-16	Target	Qtr3	Jan-17	Feb-17	Mar-17	Target	Qtr4
9.1	Cancer: Holistic Needs Assessment and Care Planning	Shaun Curran	0.160%	£103,911	Compliant	Compliant		Compliant					Compliant					Compliant					50%	
9.2	Cancer: Teatment Summaries	Shaun Curran	0.160%	£103,911	Compliant	Compliant		Compliant																
6	Learning Disabilities	Carl Griffiths	0.15% (L)	£97,417	Compliant	Compliant		Compliant					Compliant					Compliant					Compliant	

LWH CQUINS (CCG) 2016/17 Month 2 - May 2016

LWH CQUINS (SCom) 2016/2017

To deliver the most EFFECTIVE outcomes

Indicator Number	Indicator Name	Owner	% Weighting	£ Weighting	Apr-16	May-16	Jun-16	Target	Qtr1	Jul-16	Aug-16	Sep-16	Target	Qtr2	Oct-16	Nov-16	Dec-16	Target	Qtr3	Jan-17	Feb-17	Mar-17	Target	Qtr4
SC1	Reduce the number of Term Admissions	Nim Subhedar / Val Irving			TBC	TBC																		

To deliver the best EXPERIENCE

Indicator Number	Indicator Name	Owner	% Weighting	£ Weighting	Apr-16	May-16	Jun-16	Target	Qtr1	Jul-16	Aug-16	Sep-16	Target	Qtr2	Oct-16	Nov-16	Dec-16	Target	Qtr3	Jan-17	Feb-17	Mar-17	Target	Qtr4
SC4	Set up/ expand Community Outreach Project	Bill Yoxhall / Val Irving			TBC	TBC																		

Liverpool Women's NHS Foundation Trust

LWH Quality Strategy 2016/17 Month 2 - May 2016

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

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

There are no indicators in this section

To be EFFICIENT and make best use of available resources

There are no indicators in this section

To deliver SAFER services

Indicator Name	Ref	Owner of KPI	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
Maintain the incidence of multiple pregnancy after fertility treatment		Stephen Troup	<= 10%	5.48%	5.72%										
Reduce number of Surgical Site Infections (Gynaecology)		Kerri Boyd	Report by exception	0	0										
No increase in rate of late-onset (> 72h) bloodstream infection in VLBW (very low birth weight) and or <30 weeks gestation babies		Bill Yoxhall	TBC	0.45	0.00										

To deliver the most EFFECTIVE outcomes

Indicator Name	Ref	Owner of KPI	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
Adjusted Still birth rate i.e. excluding fetal abnormalities (Rate per 1000 births) Reports 1 month behind		Devender Roberts	TBC	0.00	0.01										
Increase biochemical pregnancy rates following infertility treatments [In-vitro fertilisation (IVF), Intracytoplasmic sperm injection (ICSI) and frozen embryo transfer (FET)] by 5% over 5 years.		Stephen Troup	> 30%	45.94%	47.62%										

To deliver the best possible EXPERIENCE for patients and staff

Indicator Name	Ref	Owner of KPI	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
Reduction in number of complaints relating to care (Number received in month)		Viv Smith	<= 3	0	0										
75 % of patients recommend us in the family friends test.		Viv Smith	>= 75%	99.26%	98.47%										

LWH Quality Schedule 2016/17 LWH Quality Schedule

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

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

Indicator Name	CCG Ref	Frequency	Owner of KPI	Target 2016/17	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Fit and Well to Care: Sickness & Absence Rates of All Staff: **Trust Level**	KPI_18	Quarterly	Susan Westbury	<= 4.5%	4.42%	3.51%										
Fit and Well to Care: Sickness & Absence Rates of Clinical Staff: **Trust Level**	KPI_19	Quarterly	Susan Westbury	<= 4.5%	4.42%	3.51%										
Nursing Fill Rate (Safer Staffing): **Trust Level**	KPI_20	Quarterly	Susan Westbury	<= 90%	92.78%	91.92%										
Nursing Fill Rate: Monthly Safer Staffing Reports to be uploaded to Trust Website and accessible via NHS Choices (through upload to Unify2 (NHS England))	WELL_LED	Quarterly	Allison Edis	Compliant: Yes/ No	Yes	Yes										

To be EFFICIENT and make best use of available resources

Indicator Name	Ref	Frequency	Owner of KPI	Target 2016/17	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Outpatients: DNA Rates: New	KPI_07	Monthly	Lesley Brown/ Ann Morris	Monitoring Only	8.61%	7.83%										
Outpatients: DNA Rates: Follow-up	KPI_08	Monthly	Lesley Brown/ Ann Morris	Monitoring Only	10.02%	10.45%										
Outpatients: Cancelled by Hospital Rates: New	KPI_09a	Monthly	Lesley Brown/ Ann Morris	Monitoring Only	8.63%	6.97%										
Outpatients: Cancelled by Hospital Rates: Follow-up	KPI_09b	Monthly	Lesley Brown/ Ann Morris	Monitoring Only	11.99%	9.51%										
Outpatients: Cancelled by Patient Rates: New	KPI_10a	Monthly	Lesley Brown/ Ann Morris	Monitoring Only	13.41%	14.18%										
Outpatients: Cancelled by Patient Rates: Follow-up	KPI_10b	Monthly	Lesley Brown/ Ann Morris	Monitoring Only	15.59%	15.57%										
Discharge Summaries to be electronically constructed, integrated TTO's and contains the recommended minimum data set.	KPI_23	Quarterly		>= 98%	97%	97.93%										
Discharge Summaries to be sent from all ward areas to general practice within 24 hours.	KPI_24	Quarterly		>= 95%	97%	97.93%										
Patients to receive a copy of their Discharge Summary on day of discharge.	KPI_25	Quarterly		>= 95%	97%	97.93%										
A&E correspondence to be sent to General Practice within 24 hours.	KPI_28	Quarterly		>= 95%	100%	100.00%										
Day Case correspondence to be sent to General Practice within 24 hours.	KPI_29	Quarterly		>= 95%	100%	100.00%										
Maternity KPIs submitted via Cheshire and Merseyside Strategic Clinical Network Maternity Dashboard.	KPI_30	Monthly	Ed Williams	Compliant Yes/No	Quarter 2	Yes										

To deliver SAFER services

Indicator Name	Ref	Frequency	Owner of KPI	Target 2016/17	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
VTE (Venous Thromboembolism)	KPI_01	Quarterly	Ruth Stubbs	>= 95%	98.00%	98.37%										
Falls Prevention: Assessments for Falls	KPI_11	Quarterly	Debbie Mennim	>=98%	99.59%	100.00%										
Falls Prevention: Of the patients identified as at risk of falling to have a care plan in place across the whole trust	KPI_12	Quarterly	Debbie Mennim	100%	100%	100.00%										
Malnutrition: Adult in-patients screened for malnutrition on admission using the MUST tool	KPI_15	Quarterly	Debbie Mennim	>= 95%	100%	96.06%										
Malnutrition: Patients with a score of 2 or more to receive an appropriate care plan	KPI_16	Quarterly	Debbie Mennim	100%	100%	100.00%										
Malnutrition: Patients scoring high risk (2 or more) are referred to dietician	KPI_17	Quarterly	Debbie Mennim	100%	100%	100.00%										
Mortality Rates in Gynaecology	KPI_05	Monthly	John Kirwan	Monitoring Only	0	0										
Mortality Rates in Neonates (within 28 days of live birth at LWH or at home under LWH care)	KPI_06	Monthly	Bill Yoxhall	Monitoring Only	1.44	0.00										

LWH Quality Schedule 2016/17 LWH Quality Schedule

To deliver the most EFFECTIVE outcomes

Indicator Name	Ref		Owner of KPI	Target 2016/17	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: Booked with a Midwife by 12 Weeks (+6 days)	KPI_31	Monthly	Jenny Butters	>= 90%	96.82%	95.44%										
Maternity: Breastfeeding Support - Women informed of service	KPI_32	Monthly		>= 90%	100%	100.00%										
Maternity: Breastfeeding Support - Women contacted during stay	KPI_33	Monthly		>= 90%	90.25%	88.42%										
Maternity: Breastfeeding Support - Rate of Women breastfeeding at birth	KPI_34	Monthly		>= 53% TBC	54.12%	56.91%										
Maternity: Skin to Skin contact	KPI_36	Quarterly		>= 75%	89.39%	84.88%										
Maternity: One to One Care in established labour (4cm dilation)	KPI_37	Quarterly		>= 85%	96.86%	96.08%										
Maternity: Women whom requested an Epidural and for non-clinical reasons, didn't receive one	KPI_38	Quarterly		<= 5%	6.37%	3.66%										
Maternity: Women offered a Flu vaccination at Booking	KPI_41	Seasonal	Jenny Butters	>= 75%	Out of Season	Out of Season	Out of Season	Out of Season	Out of Season	Out of Season					Out of Season	Out of Season
Maternity: Women given Vitamin D	KPI_42	Quarterly	Jenny Butters	>= 85%	95.48%	95.22%										
Maternity: women with a BMI of 35 or more at Booking are offered advice from an appropriately trained person on healthy eating and physical activity.	KPI_43	Quarterly	Jenny Butters	>= 90%	95.06%	93.24%										
Smoking - Ascertain smoking status of all patients in Maternity and Gynaecology	KPI_02	Quarterly		>= 95%	100%	100.00%										
Smoking - All smokers will be offered referral to an intensive Stop Smoking Specialist Service which provides at least 4 weeks of treatment	KPI_03	Quarterly		>= 70%	95.06%	96.19%										
Smoking - Offer smoking intervention to all pregnant women who smoke at 12 week booking appointment.	KPI_04	Quarterly	Jenny Butters	>= 95%	95.06%	96.19%										

To deliver the best possible EXPERIENCE for patients and staff

Indicator Name	Ref	Frequency	Owner of KPI	Target 2016/17	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
A&E: Unplanned Reattendances within 7 days (Non-pregnant Rate)	KPI_18	Monthly	Sharon Owens	<= 7%	5.65%	7.62%										
A&E: Left Department without being seen	KPI_19	Monthly	Sharon Owens	<= 5%	2.80%	3.56%										
A&E: Time to Initial Assessment (95th Percentile)	KPI_20	Monthly	Sharon Owens	<= 15	10	14										
A&E: Total Time Spent in A&E 95th percentile	KPI_21	Monthly	Sharon Owens	<= 240	215	232										
A&E: Time to Treatment (Median)	KPI_22	Monthly	Sharon Owens	Monitoring Only	67	74										
A&E: Ambulance Handover Time: None greater than 15 minutes	E.A.S.7a	Monthly	Sharon Owens	0	0	0										
A&E: Ambulance Handover Time: If over 15 minute, none greater than 60 minutes	E.A.S.7b	Monthly	Sharon Owens	0	0	0										
A&E: 12 Hour Trolley Waits	E.B.S.5	Monthly	Sharon Owens	0	0	0										
Operations: No Operation should be cancelled for a 2nd Time	E.B.S.6	Monthly	Nikki Maggs	0	0	0										
Maternity: Triage within 30 minutes	KPI_35	Monthly	Sharon Owens	>= 95%	91.50%	89.05%										
Maternity: Fetal Anomaly Scan undertaken between 18(+0) and 20(+6) Weeks	KPI_39	Monthly	Marianne Hamer	>= 95%	99.57%	94.35%										
Maternity: Fetal Anomaly Re-Scan undertaken by 23(+0) weeks	KPI_40	Monthly	Marianne Hamer	>= 98%	94.00%	0.00%										
6 Week Diagnostic Waits		Monthly	Marianne Hamer/ Shaun Curran	>= 99%	98.96%	97.12%										

LWH Corporate 2016/17 Month 2 - May 2016

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

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Indicator Name	Ref	Owner of KPI	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
HR: Sickness and Absence Rates (Internal)	HR_01	Susan Westbury	< 4.5%	4.42%	3.51%										
HR: Annual Appraisal & PDR	HR_02	Susan Westbury	>= 90%	89.00%	87.00%										
HR: Attendance/ Completion of all Mandatory Training Elements	HR_03	Susan Westbury	>= 95%	92.00%	94.00%										
HR: Professsional Registration Lapses	HR_04	Susan Westbury	0	0	0										
HR: Turnover Rates	HR_05	Susan Westbury	<= 10%	11.00%	13.00%										

To be EFFICIENT and make best use of available resources

Indicator Name	Ref	Owner of KPI	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	FIN_01P	Jenny Hannon	Planned	£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	FIN_01	Jenny Hannon	>= Planned	£696	£1,375	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Variance to Budget (YTD)		Jenny Hannon		£14	£59										
Planned CIP £'000	FIN_02P	Jenny Hannon	Planned	£167	£333	£500	£667	£833	£1,000	£1,167	£1,333	£1,500	£1,667	£1,833	£2,000
Actual CIP £'000	FIN_02	Jenny Hannon	>= Planned	£88	£196	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Planned Agency Spend £'000	FIN_04P	Jenny Hannon	Planned	£50	£100	£150	£200	£250	£300	£350	£400	£450	£500	£550	£600
Actual Agency Spend £'000	FIN_04	Jenny Hannon	<= Planned	£48	£122	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Planned Cash Balance £'000	FIN_03P	Jenny Hannon	Planned	£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 £'000	FIN_03	Jenny Hannon	>= £1000	£4,913	£4,898	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Planned Capital £'000	FIN_04P	Jenny Hannon	Planned	£119	£436	£1,113	£1,330	£1,597	£3,049	£3,156	£3,474	£3,722	£3,990	£4,098	£4,314
Actual Capital £'000	FIN_04	Jenny Hannon	<= Planned	£89	£220	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0

To deliver SAFER services

Indicator Name	Ref	Owner of KPI	Planned	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Newborn blood spot screening: Coverage	SAF_01	Heather Longworth	>= 95%	QTRLY	QTRLY		QTRLY	QTRLY		QTRLY	QTRLY		QTRLY	QTRLY	
Newborn & Infant physical Examination: Coverage	SAF_02	Heather Longworth	>= 95%	QTRLY	QTRLY		QTRLY	QTRLY		QTRLY	QTRLY		QTRLY	QTRLY	
Newborn & Infant physical Examination: Timely assessment	SAF_03	Heather Longworth	>= 95%	QTRLY	QTRLY		QTRLY	QTRLY		QTRLY	QTRLY		QTRLY	QTRLY	
Newborn Hearing screening: Coverage (Reporting 1 QTR behind)	SAF_04	Heather Longworth	>= 95%	QTRLY	QTRLY		QTRLY	QTRLY		QTRLY	QTRLY		QTRLY	QTRLY	
Newborn Hearing screening: Timely assessment (Reporting 1 QTR behind)	SAF_05	Heather Longworth	>= 95%	QTRLY	QTRLY		QTRLY	QTRLY		QTRLY	QTRLY		QTRLY	QTRLY	
Seasonal Flu vaccine uptake (Oct - Jan Only)	SAF_06	Gill Curry	Cumulative >= 75%	Out of Season	Out of Season	Out of Season	Out of Season	Out of Season	Out of Season					Out of Season	Out of Season
Number of Open SI	SAF_07	Gregory Hope	Monitoring Only	22	21	0	0	0	0	0	0	0	0	0	0
Number of New SI	SAF_08	Gregory Hope	Monitoring Only	1	2	0	0	0	0	0	0	0	0	0	0
Number of SI reported to the CCG within 48 - 72 hour requirement	SAF_09	Gregory Hope	100%	100%	100%										
Number of SI with any outstanding actions that have not been completed in the defined time period	SAF_10	Gregory Hope	0	7	7										

LWH Corporate 2016/17 Month 2 - May 2016

To deliver the most EFFECTIVE outcomes															
Indicator Name	**Ref**	**Owner of KPI**	**Target**	**Apr-16**	**Apr-16**	**May-16**	**Jun-16**	**Jul-16**	**Aug-16**	**Sep-16**	**Oct-16**	**Nov-16**	**Dec-16**	**Jan-17**	**Mar-17**
Intensive Care Transfers Out (Cumulative)	EFE_01		8	1	2										
Returns to Theatre	EFE_02		<= 0.7%	0.64%	1.03%										
Daycase overstay rates	EFE_03	Shaun Curran	<= 5%	6.70%	5.53%										
Delayed Transfers of Care (DToC)	EFE_10			0	0										
Rate of Empty Beds at 8am	EFE_11			In Development	In Development										
Rate of discharges before Midday	EFE_12			In Development	In Development										
Rate of Actual Discharges against Planned	EFE_13			To be Agreed	To be Agreed										
Antenatal Infectious disease screening: HIV coverage	EFE_04	Heather Longworth	<= 90%	QTRLY	QTRLY		QTRLY	QTRLY		QTRLY	QTRLY		QTRLY	QTRLY	
Antenatal Infectious disease screening: Hepatitis	EFE_05	Heather Longworth	<= 90%	QTRLY	QTRLY		QTRLY	QTRLY		QTRLY	QTRLY		QTRLY	QTRLY	
Down's Screening Completion of Laboratory request forms	EFE_06	Heather Longworth	>= 95%	QTRLY	QTRLY		QTRLY	QTRLY		QTRLY	QTRLY		QTRLY	QTRLY	
Antenatal sickle cell and thalassaemia screening: Coverage	EFE_07	Heather Longworth	<= 99%	QTRLY	QTRLY		QTRLY	QTRLY		QTRLY	QTRLY		QTRLY	QTRLY	
Antenatal sickle cell and thalassaemia screening: Timeliness	EFE_08	Heather Longworth	<= 50%	QTRLY	QTRLY		QTRLY	QTRLY		QTRLY	QTRLY		QTRLY	QTRLY	
Antenatal sickle cell and thalassaemia screening: FOQ completion	EFE_09	Heather Longworth	<= 95%	QTRLY	QTRLY		QTRLY	QTRLY		QTRLY	QTRLY		QTRLY	QTRLY	
Cancer: 62 Day referral to treatment (Consultant Upgrade) Non urgent suspected cancer referrals) (Cummulative Quarterly)*	EXP_10	Shaun Curran	90%	94%	96%										
Cancer: Referral to Treating Trust by day 42	EXP_11	Shaun Curran	100%	50%	50%										
Cancer: Diagnostic test by Day 14	EXP_12	Shaun Curran	100%	95%	94%										

To deliver the best possible EXPERIENCE for patients and staff														
Indicator Name	**Ref**	**Owner of KPI**	**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**
Complaints: Response Times	EXP_01	Viv Smith	100%	100%	89%										
Complaints: Number received each month	EXP_02	Viv Smith	<= 15 TBA	15	5										
Complaints: Number of Action Plans received each month	EXP_03	Viv Smith	100%	100%	#DIV/0!										
TCI: Cancelled by hospital for clinical reasons	EXP_04	Shaun Curran	<= 1.5% TBC	2.00%	2.14%										
TCI: Cancelled by hospital for non-clinical reasons	EXP_05	Shaun Curran	<= 4% TBC	4.30%	6.31%										
Daycase rates based on management intent	EXP_06	Shaun Curran	> 75%	76.74%	77.27%										
Last Minute Cancellation for non-clinical reasons (Not re-admitted within 28 days)	EXP_07	Nikki Maggs	0	0	0										
Choose & Book: Rate of slots not available	EXP_13	Lesley Brown	<= 6%	Not Available	Not Available										

Agenda item no:	16/177

Meeting:	Board of Directors

Date:	1 July 2016

Title:	Month 2 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 2 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. Summary Financial Position

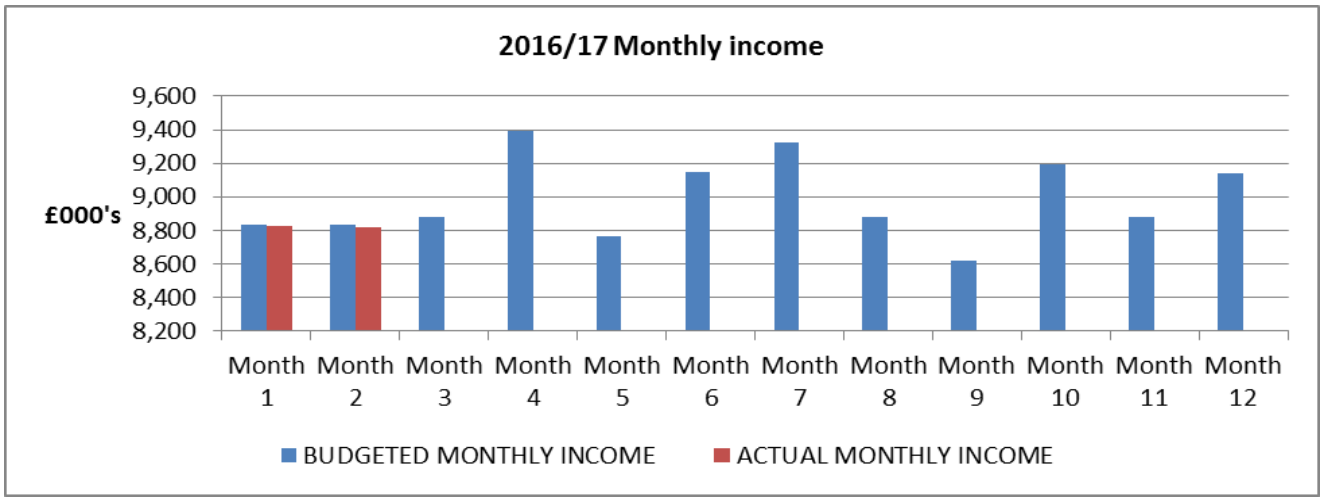
The 2016/17 budget was approved at Trust Board in April 2016. This set out a deficit of £7m for the year (as per the control total set out by NHS Improvement), an FSRR of 2 and a cash shortfall of £7.7m. This planned position assumes receipt in full of £2.8m Sustainability and Transformation Funding.

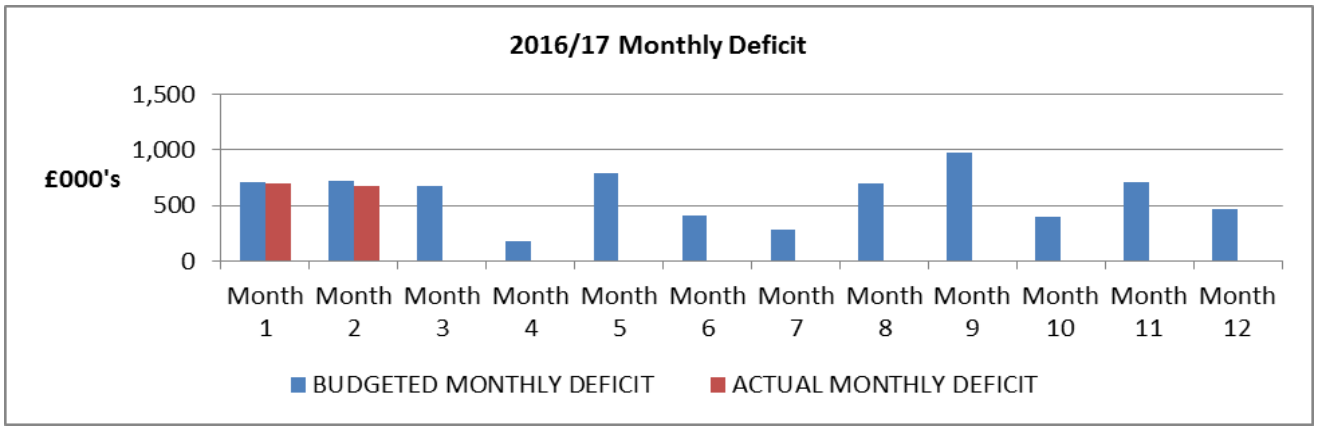
In Month 2 the Trust is reporting a monthly deficit of £0.678m against a deficit plan of £0.724 which is a positive variance of £0.046m for the month. Cumulatively the Trust is ahead of plan by £0.059m. The Trust achieved a Financial Sustainability Risk Rating (FSRR) of 2 against a plan of 2.

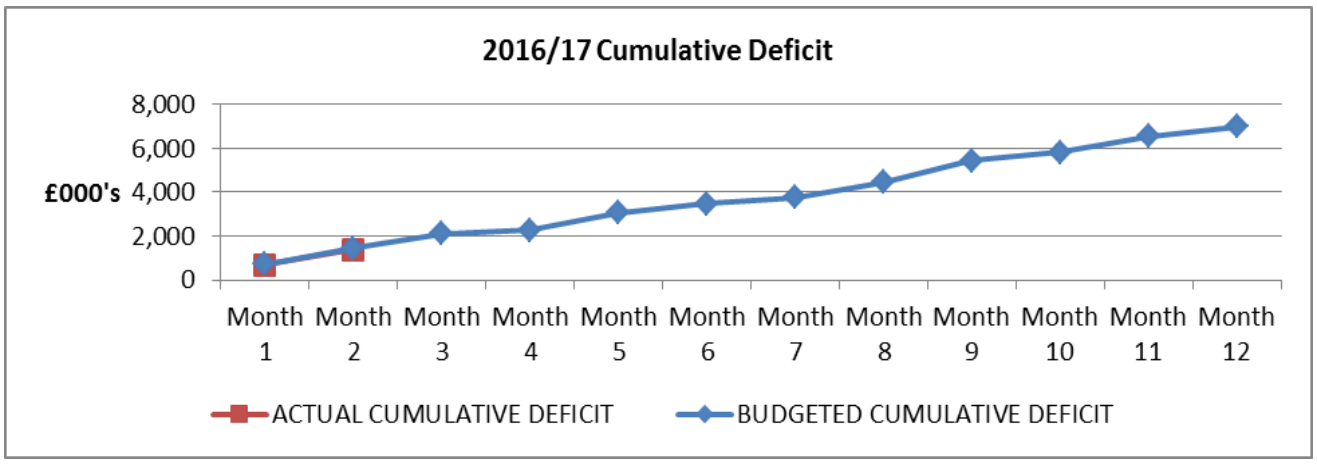
FINANCIAL SUSTAINABILITY RISK RATING	YEAR TO DATE Budget	YEAR TO DATE Actual	YEAR Budget	YEAR FOT
CAPITAL SERVICING CAPACITY (CSC)				
(a) EBITDA + Interest Receivable	(334)	(288)	(400)	(400)
(b) PDC + Interest Payable + Loans Repaid	350	343	2,712	2,712
CSC Ratio = (a) / (b)	**(0.95)**	**(0.84)**	**(0.15)**	**(0.15)**
MONITOR CSC SCORE	1	1	1	1
Ratio Score **4** = 2.5 **3** = 1.75 **2** = 1.25 **1** < 1.25				
LIQUIDITY				
(a) Cash for Liquidity Purposes	(3,862)	(3,944)	(8,924)	(8,924)
(b) Expenditure	18,002	17,939	108,297	108,297
(c) Daily Expenditure	300	299	301	301
Liquidity Ratio = (a) / (c)	**(13)**	**(13)**	**(30)**	**(30)**
MONITOR LIQUIDITY SCORE	2	2	1	1
Ratio Score **4** = 0 **3** = -7 **2** = -14 **1** < -14				
I&E MARGIN				
Deficit	1,434	1,375	7,000	7,000
Total Income	(17,667)	(17,647)	(107,887)	(107,887)
I&E Margin	**-8.12%**	**-7.79%**	**-6.49%**	**-6.49%**
MONITOR I&E MARGIN SCORE	1	1	1	1
Ratio Score **4** = 1% **3** = 0% **2** = -1% **1** < -1%				
I&E MARGIN VARIANCE				
I&E Margin	-8.12%	-7.79%	-6.49%	-6.49%
I&E Variance Margin	**0.83%**	**0.32%**	**0.83%**	**0.00%**
MONITOR I&E MARGIN VARIANCE SCORE	4	4	4	4
Ratio Score **4** = 0% **3** = -1% **2** = -2% **1** < -2%				
Overall Financial Sustainability Risk Rating	2	2	2	2

As in previous years income is profiled across the financial year in line with planned activity as demonstrated below.

The charts below show income against plan as well as the deficit by month and the cumulative deficit. The planned monthly deficit is linked to the income and activity levels which vary month on month throughout the year in line with the demand for services.







The detail behind the financial position is explored further in section 2.

2. Income and expenditure variances

The key components of the Month 2 financial position are outlined below. See appendix 1 for detailed results.

Income
Income was £0.015m behind budget in-month which is broadly in line with the overall budget.

Pay costs
Pay costs are £0.191m below budget in month. This continued underspend is largely attributable to vacancies in nursing posts in neonates, genetics and gynaecology which are expected to be filled during the year.

Vacancies continue to be approved by the executive team on an individual basis.

Non pay costs
Non-pay costs are overspent by £0.137m in month. The majority of this is due to delays in the delivery of CIP which is explored in the next section, however there are some increases in clinical supplies in line with increased activity in maternity.

Without the non-recurrent benefit within the pay costs the Trust would be behind plan at Month 2.

3. CIP Delivery

The Trust has an annual CIP target 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.

A number of the CIP schemes are experiencing some delays in implementation. All schemes, and the related month 2 position, are set out in appendix 2.

Priority is being given to the identification and development of mitigation plans. Non recurrent mitigation has already been identified for the pathology schemes, and further mitigation is being sought for the remaining £0.55m at risk which is arising predominantly from the delay of the theatre review scheme. This mitigation could include the use of part of the £0.8m non-pay inflation budget, however this would leave the Trust exposed if further cost pressures arose.

The Trust recognises that early grip and control of the CIP programme is vital to ensure the overall financial plan is delivered. Therefore the Trust is putting particular focus on CIP at this early stage in the year to develop further mitigation and future schemes, and ensure the CIP programme delivers in 2016/17 and beyond.

The overall forecast outturn is currently being held at £7m deficit on the basis that mitigations will be put in place. This will be reviewed again in detail at the end of Q1 along with a dedicated review of CIP performance to be presented to Finance, Performance and Business Development Committee.

4. Cash and borrowings

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

The £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. 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 will be taken into account when the Trust produces its 13 week cashflow for submission to NHSI and the DH each month.

The cash balance at Month 2 was £4.9m. The Trust has currently paused the already limited capital program to preserve cash.

5. Looking ahead

The Trust has a deficit target of £7m in 2016/17. The delivery of this is dependent on the receipt of £2.8m of Sustainability and Transformational funding and ongoing Distressed Finance cash support from the Department of Health. The Trust must continue to keep a focus on financial and operational grip to ensure that the control total is delivered. Significant efforts will continue into 2016/17 to manage the delivery of the financial plan.

With regards to the longer term plan, Liverpool CCG have accepted the case for change presented in the Trust's Future Generations business case and has engaged a team of professional consultants to expand on this work. This work is now well under way with a review of the Trust's financial position and evaluation of the options arising from the Future Generations work in order to assess the affordability and long term financial sustainability of the options. The outputs from the options appraisal process will directly inform a pre-consultation business case. The options appraisal is planned for completion by end of June 2016, with business case production due by July 2016. This will culminate in public consultation following completion of the relevant governance and assurance processes.

Local trusts are also working together to inform the wider 5 year Sustainability and Transformation Plan (STP) which covers the Cheshire and Mersey footprint, in an attempt to identify ways in which collaboration and wider transformation can address the long term clinical and financial viability issues.

6. Conclusion & Recommendation

The Board are asked to note the Month 2 financial position

Appendices

Appendix 1: Board Finance Pack

Appendix 1

Appendix 2: CIP Delivery

CIP Scheme		Full Year Value £m	Executive Lead	M2 Cum Budget £m	M2 Cum Actual £m	M2 Var £m	Full Year Effect £m	Mitigation identified
1	**Hewitt Centre growth – Kings JV**	**0.500**	VH	0.083	0.083	-	**-**	n/a
2	**FourEyes theatre efficiency project**	**0.500**	JJ	0.083	-	(0.083)	**(0.500)**	No
3	**Counting and coding efficiencies**	**0.250**	VH	0.042	0.042	-	**-**	n/a
4	**Pathology - demand management**	**0.200**	JJ	0.033	-	(0.033)	**-**	Yes non-recurrently
5	**DHC imaging contract cessation**	**0.120**	JJ	0.020	0.020	-	**-**	n/a
6	**Procurement savings**	**0.100**	VH	0.017	0.017	-	**-**	n/a
7	**Genetics growth - BRCA**	**0.100**	JJ	0.017	0.017	-	**-**	n/a
8	**Medical staffing – additional session payments and compensatory rest breaks**	**0.100**	AL	0.017	0.008	(0.009)	**(0.050)**	No
9	**Pathology – Alder hey contract**	**0.070**	JJ	0.012	-	(0.012)	-	Yes non-recurrently
10	**Car Parking**	**0.060**	VH	0.010	0.010	-	-	n/a
Total		**2.000**		**0.333**	**0.196**	**(0.137)**	**(0.550)**	

Some CIP schemes are expected to over-perform (eg counting and coding) however a prudent approach is being taken in not yet recognising this potential over performance in mitigation of the above.

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

FINANCE REPORT: M2

YEAR ENDED 31 MARCH 2017

Contents

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 1
MONITOR SCORE: M2
YEAR ENDED 31 MARCH 2017

FINANCIAL SUSTAINABILITY RISK RATING	YEAR TO DATE Budget	YEAR TO DATE Actual	YEAR Budget	YEAR FOT
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Ratio Score **4** = 0 **3** = -7 **2** = -14 **1** < -14				
I&E MARGIN				
Deficit	1,434	1,375	7,000	7,000
Total Income	(17,667)	(17,647)	(107,887)	(107,887)
I&E Margin	**-8.12%**	**-7.79%**	**-6.49%**	**-6.49%**
MONITOR I&E MARGIN SCORE	**1**	**1**	**1**	**1**
Ratio Score **4** = 1% **3** = 0% **2** = -1% **1** < -1%				
I&E MARGIN VARIANCE				
I&E Margin	-8.12%	-7.79%	-6.49%	-6.49%
I&E Variance Margin	**0.83%**	**0.32%**	**0.83%**	**0.00%**
MONITOR I&E MARGIN VARIANCE SCORE	**4**	**4**	**4**	**4**
Ratio Score **4** = 0% **3** = -1% **2** = -2% **1** < -2%				
Overall Financial Sustainability Risk Rating	**2**	**2**	**2**	**2**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
INCOME & EXPENDITURE: M2
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	(8,249)	(8,190)	(59)	(16,499)	(16,433)	(66)	(100,881)	(100,881)	0
Non-Clinical Income	(584)	(628)	44	(1,168)	(1,214)	46	(7,006)	(7,006)	0
Total Income	**(8,832)**	**(8,817)**	**(15)**	**(17,667)**	**(17,647)**	**(20)**	**(107,887)**	**(107,887)**	**0**
Expenditure									
Pay Costs	5,613	5,421	191	11,225	10,903	322	67,351	67,351	0
Non-Pay Costs	2,202	2,339	(137)	4,393	4,652	(259)	26,639	26,639	0
CNST	1,192	1,192	0	2,385	2,384	0	14,307	14,307	0
Total Expenditure	**9,007**	**8,953**	**54**	**18,002**	**17,939**	**63**	**108,297**	**108,297**	**0**
EBITDA	**174**	**136**	**39**	**335**	**292**	**44**	**410**	**410**	**0**
Technical Items									
Depreciation	375	374	2	750	744	6	4,500	4,500	0
Interest Payable	35	31	4	70	63	7	420	420	0
Interest Receivable	(1)	(2)	1	(2)	(4)	2	(10)	(10)	0
PDC Dividend	140	140	0	280	280	0	1,680	1,680	0
Profit / Loss on Disposal	0	0	0	0	0	0	0	0	0
Total Technical Items	**549**	**543**	**7**	**1,098**	**1,083**	**15**	**6,590**	**6,590**	**0**
(Surplus) / Deficit	**724**	**678**	**46**	**1,434**	**1,375**	**59**	**7,000**	**7,000**	**0**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 3
EXPENDITURE: M2
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	330	7	674	663	11	4,047	4,047	0
Medical	1,271	1,228	43	2,541	2,493	49	15,248	15,248	0
Nursing & Midwifery	2,504	2,370	134	5,008	4,767	241	30,047	30,047	0
Healthcare Assistants	391	384	7	782	779	3	4,691	4,691	0
Other Clinical	543	497	46	1,086	1,001	84	6,512	6,512	0
Admin Support	517	538	(21)	1,034	1,078	(44)	6,205	6,205	0
Corporate Services	0	0	0	0	0	0	0	0	0
Agency & Locum	50	74	(24)	100	122	(22)	600	600	0
Total Pay Costs	**5,613**	**5,421**	**191**	**11,225**	**10,903**	**322**	**67,351**	**67,351**	**0**
Non Pay Costs									
Clinical Suppplies	733	742	(10)	1,460	1,494	(34)	8,858	8,858	0
Non-Clinical Supplies	588	695	(106)	1,170	1,369	(199)	7,204	7,204	0
CNST	1,192	1,192	0	2,385	2,384	0	14,307	14,307	0
Premises & IT Costs	415	407	8	830	826	4	4,983	4,983	0
Service Contracts	466	496	(30)	932	962	(29)	5,594	5,594	0
Total Non-Pay Costs	**3,394**	**3,532**	**(137)**	**6,777**	**7,036**	**(259)**	**40,946**	**40,946**	**0**
Total Expenditure	**9,007**	**8,953**	**54**	**18,002**	**17,939**	**64**	**108,297**	**108,297**	**0**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 4
BUDGET ANALYSIS: M2
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	(3,337)	(3,359)	23	(6,637)	(6,757)	120	(41,192)	(41,192)	0
Expenditure	1,713	1,720	(7)	3,427	3,434	(7)	20,561	20,561	0
Total Maternity	**(1,623)**	**(1,639)**	**16**	**(3,211)**	**(3,323)**	**113**	**(20,631)**	**(20,631)**	**0**
Gynaecology									
Income	(1,961)	(2,125)	164	(3,947)	(4,114)	166	(23,965)	(23,965)	0
Expenditure	921	887	34	1,842	1,804	38	11,054	11,054	0
Total Gynaecology	**(1,040)**	**(1,238)**	**199**	**(2,105)**	**(2,310)**	**205**	**(12,911)**	**(12,911)**	**0**
Neonatal									
Income	(1,408)	(1,342)	(66)	(2,817)	(2,689)	(127)	(16,908)	(16,908)	0
Expenditure	997	958	39	1,994	1,939	55	11,967	11,967	0
Total Neonatal	**(411)**	**(384)**	**(26)**	**(822)**	**(750)**	**(72)**	**(4,941)**	**(4,941)**	**0**
Hewitt Centre									
Income	(965)	(842)	(124)	(1,939)	(1,747)	(193)	(11,874)	(11,874)	0
Expenditure	728	676	53	1,451	1,373	79	8,805	8,805	0
Total Hewitt Centre	**(237)**	**(166)**	**(71)**	**(488)**	**(374)**	**(114)**	**(3,069)**	**(3,069)**	**0**
Genetics									
Income	(595)	(541)	(54)	(1,191)	(1,093)	(98)	(7,143)	(7,143)	0
Expenditure	446	402	44	893	820	73	5,358	5,358	0
Total Genetics	**(149)**	**(138)**	**(10)**	**(298)**	**(274)**	**(25)**	**(1,785)**	**(1,785)**	**0**
Catharine Medical Centre									
Income	(66)	(7)	(60)	(133)	(27)	(106)	(796)	(796)	0
Expenditure	64	24	40	129	56	73	773	773	0
Total Catharine Medical Centre	**(2)**	**18**	**(19)**	**(4)**	**29**	**(33)**	**(23)**	**(23)**	**0**
Theatres									
Income	(42)	(42)	(0)	(84)	(83)	(1)	(504)	(504)	0
Expenditure	566	629	(62)	1,133	1,297	(164)	6,798	6,798	0
Total Theatres	**524**	**587**	**(62)**	**1,049**	**1,214**	**(165)**	**6,294**	**6,294**	**0**
Clinical Support & CNST									
Income	(260)	(304)	43	(521)	(569)	48	(3,123)	(3,123)	0
Expenditure	748	764	(17)	1,356	1,380	(24)	7,441	7,441	0
Total Clinical Support & CNST	**487**	**461**	**27**	**835**	**811**	**24**	**4,318**	**4,318**	**0**
Estates									
Income	(61)	(62)	0	(123)	(127)	4	(738)	(738)	0
Expenditure	429	425	4	857	887	(30)	5,145	5,145	0
Total Estates	**367**	**363**	**4**	**734**	**761**	**(26)**	**4,407**	**4,407**	**0**
Corporate									
Income	(137)	(195)	58	(274)	(441)	167	(1,645)	(1,645)	0
Expenditure	2,943	3,012	(69)	6,018	6,032	(14)	36,985	36,985	0
Total Corporate	**2,805**	**2,816**	**(11)**	**5,744**	**5,591**	**153**	**35,341**	**35,341**	**0**
(Surplus) / Deficit	**724**	**678**	**46**	**1,434**	**1,375**	**59**	**7,000**	**7,000**	**0**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
BALANCE SHEET: M2
YEAR ENDED 31 MARCH 2017

BALANCE SHEET £'000	YEAR TO DATE Opening	Actual	Movement
Non Current Assets	70,529	**70,142**	(387)
Current Assets			
Cash	3,225	4,898	1,673
Debtors	4,302	7,611	3,309
Inventories	326	320	(6)
Total Current Assets	**7,853**	**12,829**	**4,976**
Liabilities			
Creditors due < 1 year	(8,056)	(14,031)	(5,975)
Creditors due > 1 year	(1,748)	(1,779)	(31)
Commercial loan	(10,794)	(10,794)	0
Provisions	(2,392)	(2,351)	41
Total Liabilities	**(22,990)**	**(28,955)**	(5,965)
TOTAL ASSETS EMPLOYED	**55,392**	**54,017**	**(1,375)**
Taxpayers Equity			
PDC	36,610	36,610	0
Revaluation Reserve	10,019	10,019	0
Retained Earnings	8,763	7,388	(1,375)
TOTAL TAXPAYERS EQUITY	**55,392**	**54,017**	**(1,375)**

Agenda item no:	16/179

Meeting:	Board of Directors

Date:	1 July 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 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:

Putting People First Committee: 17 June 2016
The PPF Committee made no changes to the BAF risks for which they are accountable.

However, they did note that it is likely that risk 4c (a risk to clinical services caused by industrial action by junior doctors) is likely to be re-assessed once the results of a ballot of junior doctors are known. The ballot closes on 7 July.

Finance, Performance & Business Development Committee: 20 June 2016
The FPBD Committee made no changes to the BAF risks for which they are accountable.

Other Issues
The actions relating to a number of the BAF risks are in need of a full review. Risk owners have been asked to identify actions that would fill the assurance gaps and that the Risk Team are working with the risk owners to bring the BAF fully up to date.

RSM have been asked to carry out an audit of the Board Assurance Framework and Risk Management escalation processes. The audit will be carried out between 18 and 22 July and will consider:

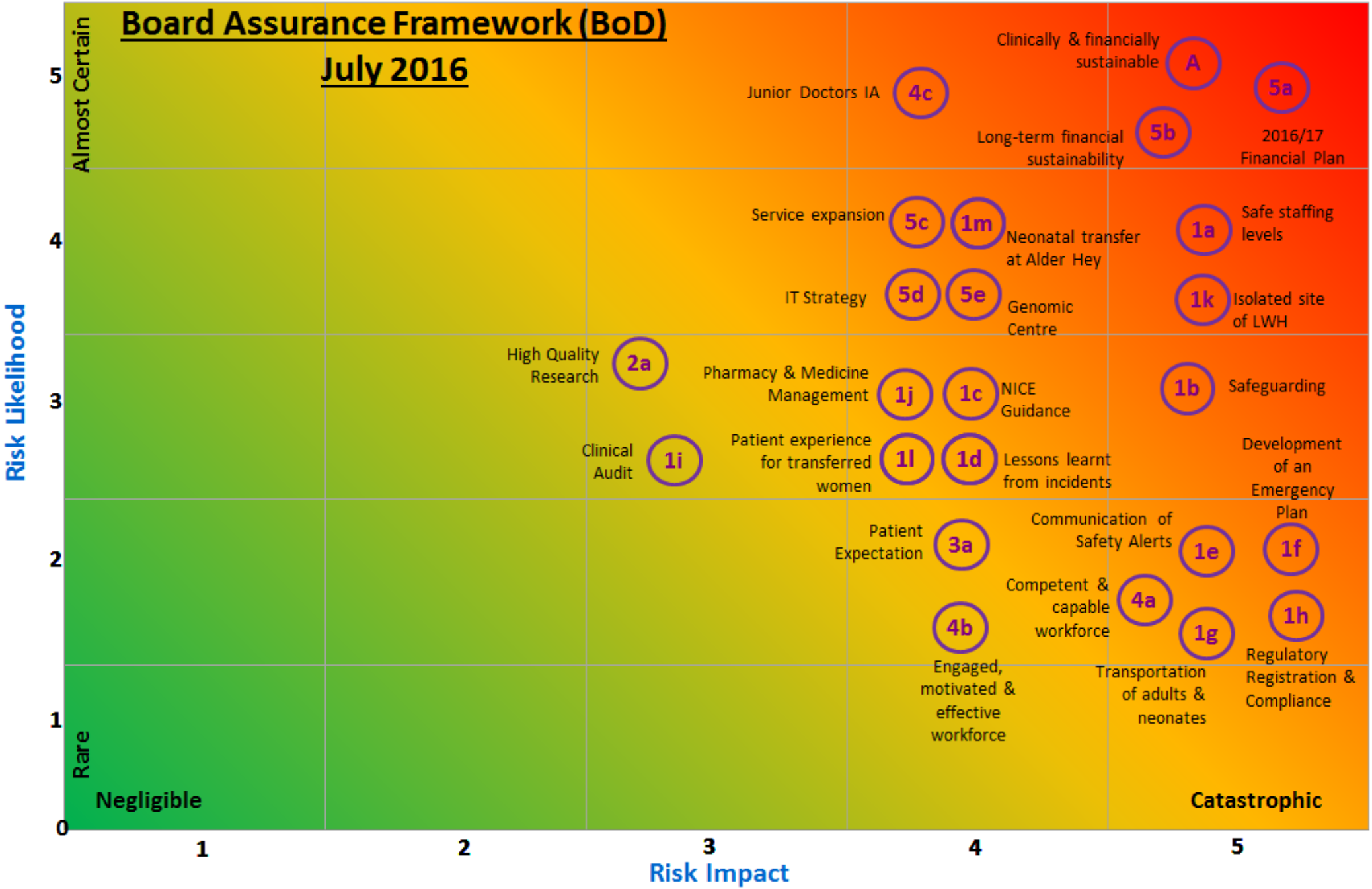
- The process used to score risks and who this is carried out by to ensure there is sufficient review and challenge of scoring. This will include consideration of the assurances received by Divisional Groups in order to decide whether a risk can be managed locally, or if it requires escalation;
- The escalation process for a risk identified by the Divisions whereby it is escalated through the Committee structure and included on the BAF (if appropriate);
- Evidence of ongoing consideration of risk by relevant groups and Committees, including confirming whether risk is a standing agenda item on meeting agendas; and
- The de-escalation process for risks and how this ensures risks are reincorporated in to the relevant risk register with appropriate ownership assigned

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 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	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**					
	In order to be clinically and financially sustainable the Trust will need to undertake major change over an extended time period (five years). **Risk**: (1) Failure to communicate clearly and effectively during a period of significant changes. (2) Failure to maintain a focus on the operational delivery of services. (3) Failure to attract and retain high calibre clinicians and managers. **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. **Effect**: (1) Difficulty in retaining public and staff confidence in Trust services. (2) Activity related to this subject may distract from day-to-day activity and therefore quality of services could reduce. 3) Staff choose to seek alternative employment and difficulties recruiting. **Impact**: (1) Reputational damage. (2) Failure to maintain quality standards and CQC compliance. (3) Inability to deliver PPF. **Ulysses Ref:1846**	1906 1962	Risk Management Strategy	Chief Exec	**5x5=25**	**5x5=25**	• Board leadership internally and externally • Executive Oversight • Consistent and cohesive message from Board of Directors • Board approval of strategic options business plan and stakeholder communication and engagement strategy • Appointment of Project Director and Project Clinical Lead. • Establishment of Future Generations Project Board • Project Mandate for governance and risk arrangements. •Communication and Engagement strategy agreed and Head of Communication appointed • Pro-active engagement in Healthy Liverpool Programme. • Regular dialogue with Monitor & CQC and CCG. • Support external consultants(PwC)	• November 2014- Business Plan • December 2014 - Communications Plan • Board & CoG agendas to include monthly project updates. • Staff survey / Pulse survey scoresas reflection of staff engagement • Minutes of Future Genrations Project Board • Regular dialogue with Monitor & CQC and CCG. • Chair & CEO activity update reports re networking and dialogues with external stakeholders.	Yes	CCG Options Apppraisal Public Consultation	July 2016 Dec 2016

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

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). **Ulysses Ref: 1733.**	1597	Quality Strategy Safeguarding Strategy (draft)	MD	**4X3=12**	**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.	December, 2014
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. **Risk:** Risk of repeat and costly events, regulatory action, service interruption, poor staff and patient experience **Cause**: Poor system and training for reporting, recording, and investigating incidents **Effect:** Compromised safety and learning outcomes **Impact:** Regulatory action, increased cost, poor quality outcomes. **Ulysses Ref: 1734**	1549021 7071597	Quality StrategyRisk Management Strategy	DONM	**4X4=16**	**12**	•Clear Policies(incident and SUI) • 10 yr. look back•Mandatory Training•RCA training•Data Base recording and reporting	NRLS•Performance Reports to GACA• Complaints, Litigation, Incidents & PALS (CLIP) Report. (GACA 28-08-2014, Item,14/15/68)•Serious Untoward Incident Report. (GACA 28-08-2014, Item,14/15/69)• RCA training delivered September 2015• NW Quality and Safety Forum member• 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	December, 2014

1	**e)** To ensure appropriate and robust systems of communication and action are in place to respond to 'safety product or equipment Safety Alerts' **Risk:** Failure to ensure or respond in a timely manner to National Alerts **Cause:** Inadequate systems or processes **Effect:** Failure to communicate and enable actions to prevent harm **Impact:** May result in avoidable harm to patients and results in regulatory action brought by CQC or HSE. **Ulysses Ref: 1735.**	1597 1945 1964 1966	Risk Management Strategy	DONM	**5X3=15**	**10**	•Draft CAS policy •Software system in place •Cascade system in Place •Training • Performance Reports to Clinical Governance Committee	•NPSA Alerts. (Clinical Governance Committee,13-06-2014, Item 14/15/77) •NPSA Alerts- *Early identification of failure to act on Radiological Imaging Reports.* (Clinical Governance Committee,13-06-2014, Item 14/15/78) •CAS Report- (Clinical Governance Committee,13-06-2014, Item 14/15/83 & 11-07-2014, 14/15/07) •NPSA Compliance Update- (Audit Committee, 22-09-2014. Item 14/15/29)	None	• Clinical Audit & Internal audit re Medical devises compliance	
1	**f)** To ensure the development of an Emergency Plan **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. **Ulysses Ref: 1736.**	1571	Business Continuity Plan	ADOps	**5x4=20**	**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		
1	**g)** Transportation of adults and neonates across the critical care network**Risk:** Patient safety compromised by inadequate arrangements, pathways, protocols, systems and equipment required for the safe transportation of 'critical care' patients**Cause:** Patients in 'critical care' require treatment outside the scope and expertise available at LWHEffect: Vulnerable patients potentially exposed to journey hazards**Impact:** Patient safety and experience could be compromised.**Ulysses Ref: 1737.**		Risk Management Strategy Putting People First Strategy	ADOps	**5x4=20**	**10**	Transportation critical care neonates:• Specialised cots for transport• Dedicated specialised trained staff•Policy and procedure for transportation•Cot Bureau - patient allocated specific cotTransportation of Adults - critical care:•Critical care network standards•Dedicated trained staff•Transport Policy•Education training/support from networks•Escalation Policy•External KPI's	•Compliance with CRG specification NNTS•External KPI's- reported to NNW and CMNN		• Seek patient's and clinician's feedback on the handling of transfers	

1	**h)** Maintaining appropriate Regulatory Registration and Compliance/ Building relationships with Regulatory Agencies **Risk:** Insufficient robust processes and management systems that provide regulatory compliance performance and assurance. **Cause**: Failure to provide evidence and assurance to regulatory agencies **Effect:** Enforcement action, prosecution, financial penalties, image and reputational damage Description **Impact:** loss of commissioners/patient confidence in provision of services. **Ulysses Ref: 1739.**		Business Continuity Plan Risk Management Strategy Putting People First Strategy Quality Strategy	DONM	**5x4=20**	**10**	• Monitor meetings • CQC engagement meetings	• Application to revise Trust's registation submitted to CQC. • Until the revised registration application is implemented; any requirement for the application of short term emergency holding powers under section 5 of the Mental Health Act will require the patient to be transferred to an alternative local provider unless this compromises patient safety. • SLA with Mersey Care Trust submitted to CQC, policy approved for administration of Mental Health Act, training actioned for key personnel • CQC inspection report 2015; overall rating good. No restrictions placed on the Trust	Yes	CQC registration to include detention of persons under Mental Health Act.	
1	**i)** To develop and support a comprehensive Clinical Audit provision **Risk:** Failure to meet Statutory and Mandatory requirements, CPD for Clinicians **Cause:** Lack of robust planning and monitoring, training and support **Effect:** Breach of Statutory targets, failure of Trust to learn from clinical audit results **Impact**: Potential action by CQC, image and reputation damage. **Ulysses Ref: 1738.**		Risk Management Strategy	MD	**4x3=12**	**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 • Evidence required to show 'learning' from clinical audit	December, 2014
1	**j)** Lack of robust systems and processes for the direction and control of Pharmacy and Medicine Management**Risk**: Failure to maintain, update or review policy and guidance in a timely fashion **Cause:** Staff shortages and change in leadership and arrangement with partner organisation**Effect:** Significant amount of policy and guidance is past review date**Impact**: Potential for safety to be compromised, staff not following best practice.**Ulysses Ref: 1740.**		Risk Management Strategy	ADOps	**4x3=12**	**12**	• Training• CPD• Appraisal• Medicines Management Committee	• Medicines Management Report - CQG Comm			

1	**k)** Isolated Site of LWH **Risk:** Location, size, layout and current services do not provide for sustainable integrated care package for quality service provision. **Cause:** Patient, Public and stakeholders expectations and the financial cost of maintaining current facilities is not sustainable **Effect:** The Trust's image and reputation is damaged. Our service offer is less attractive to commissioners **Impact**: Loss of Business and revenue, loss of confidence in the Trust's ability to meet the needs of patients **Ulysses Ref: 1809.**		Risk Management Strategy	DONM	**5x4=20**	**20**	•Future Generation Project established • Links to Stakeholders & Commissioners • Project Board / Plans • Monitoring of related care & service delivery issues via CGC and GACA.	• Board Papers / Updates Jan2014/ January 2015 • Project mandate • Bi-monthly reports to Exec Committee. .	No		
1	**l) Isolated Site of LWHRisk:** 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	**5x3=15**	**12**					

1	**m) Neonatal Transfer Team** **Risk:** Patient safety risk arising from lack of capacity to transfer babies whilst the neonatal team are operating a 'Park and Ride' service at Alder Hey **Cause:** Lack of cot capacity to accept urgent transfers of babies requiring surgical care at Alder Hey Hospital requires transport team to remain with babies on this site to provide direct care during treatment and until the baby is stabilised Lack of second transport team to support retrieval/transfer of babies from other units whilst **their** service is in operation **Effect:** Inability to maintain service delivery, no official transfer of care of babies to clinicians at Alder Hey **Impact:** Moderate to severe harm to patients. **Ulysses Ref: 1944**		Risk Management Strategy	ADOps	**4x4=16**	**16**					

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

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

4	**To develop a well led, capable, motivated and entrepreneurial workforce**										
	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**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.**Effect**: Employees not competent or equipped to ensure patient safety and maintenance of the organisational reputation **Impact**: May result in unsafe care to patients, insufficient improvements in quality and breach of CQC conditions of registration resulting in regulatory action.**Ulysses Ref: 1743.**	1707170 4169014 45	Putting People First Strategy	DWM	**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	Nov 2014April 2015

	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	**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.Complete OLM project in accordance with agreed timescalesExpedite roll out and promotion of e-learningEvaluate impact of pay progression policy.Develop project plan to implement Self Service	Nov 2014Dec 2014Dec 2014Mar 2015
	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. **Cause:** Industrial action by Junior Doctors **Effect:** Trust is unable to deliver clinical services. **Impact:** Damage to reputation, income and access targets. **Ulysses Ref: 1909.**		Putting People First Strategy	DWM	**4x3=12**	**4x5=20**	• Pro-formas sent to CD's to assess impact of industrial action on clinical activity and to make contingency arrangements. • Pro-forma sent to junior and Trust grade doctors re "intentions". • Lessons learnt from industrial action taken previously • 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) Pro-forma re service provisison sent to all CD's 5/1/16 for completion. 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 Review risk upon result of ballot	April 2016 July 2016

5	**To be ambitious and efficient and make the best use of available resources**										
a	To deliver the financial plan beyond 2016/17 **Risk:** The Trust does not deliver its financial plan or achieve the planned continuity of services ratio of 3 in 2016/17. **Cause:** Tariff insufficiency, commissioner intentions, CNST premiums and liabilities and inability to deliver further significant CIPs **Effect: N**on-delivery of the financial plan and FSRR and reduction in available cash **Impact:** Regulatory Intervention **Ulysses Ref: 1663.**	1381	Risk Management Strategy	DOF	**5x5=25**	**5x5=25**	• Zero based budget methodology adopted • Voluntary turnaround process adopted to identify robust CIP schemes • FPBD & Board approval of budgets • Sign off of budgets by accountable officers • Monthly reporting to all budget holders with variance analysis • Monthly reporting to FPBD & Trust Board • Monthly reporting to Monitor	• 2016/17 plan approved by Trust Board in April • Performance & Finance Report presented monthly to FPBD • Finance & CIP achievement reported monthly to FPBD, Executive Team and Operational Board • Monthly budget holder meetings • Monthly reports to monitor • Internal audit review of budgetary controls	None	Ongoing review of position	Mar-17
b	To deliver long term financial sustainability **Risk:** The Trust is not financially sustainable beyond 2016/17 **Cause:** Tariff insufficiency, commissioner intentions, CNST premiums and liabilities, non delivery of CIP **Effect:** Lack of financial stability and ability to fund services, insolvency and Trust unable to deliver services **Impact:** Invocation of Monitor sanctions-special measures. **Ulysses Ref: 1986.**		Risk management Strategy	DOF	**5x5=25**	**5x5=25**	• 5 year financial model produced giving early indication of issues • Advisors with relevant experience (PWC) engaged early to review strategic options • Early and continuing dialogue with Monitor • Active engagement with CCG's through the Healthy Liverpool Programme • Final Business Case to Trust Board in Dec 15 • Clinical engagement through regular reporting to Trust Management Group	• 5yr plan presented to Board, June, 2014 • Business Case, November, 2014	Yes	Finalisation of shortlist of options and development of preferred option Dec 2016 Further discussion with NHSLA following outcome of consultation exercise Sept 2016	Mar-17

c	To take forward plans to develop services nationally and internationally **Risk:** Non-delivery of the expected return from expansion investment **Cause:** Demand less than expected **Effect:** Loss of potential revenue **Impact:** Costs could exceed income of the project adding additional pressure to the financial position of the Trust. **Ulysses Ref: 1748.**		Risk Management Strategy	DOF	**4x4=16**	**4x4=16**	• Detailed project plan in place • Experienced manager appointed to lead expansion • Key clinical staff identified to implement plan •Legal agreements completed • Experienced advisors engaged (e.g. Pinsent Mason) •Capital planned for all projects and ITFF funding in place	• Business Case for expansion approved by Trust Board in December 2013 • Legal contracts reviewed by FPBD • 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. **Ulysses Ref: 1750.**	**902**	IM&T Strategy	DOF	**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	None	New Plan for EDMS and Bed Management to be formulated July 2016. EPR business case to be implemented per project plan	Jul-16
e	To develop a sustainable Genomic Centre **Risk:** Potential loss of service following re-commissioning of genetics nationally - unsuccessful tender service cost **Cause**: Relatively small unit **Effect**: Loss of service and financial contribution of £1.5m per-p.a. **Impact**: Loss of genetics service through failure to engage appropriately in the future model of genetics service provision in Liverpool / North West . **Ulysses Ref: 1749.**		Risk Management Strategy	DOF	**4x4=16**	**4x4=16**	• External Engagement through the Liverpool Health Partners • Genetics strategy group in place • Significant engagement with NHS England through national lead • Sucessful 100,000 gemone bid	• Sucessful submission of tender to NHS England 100,000 genome project	Yes	• Tender date for genomic hub yet to be confirmed. To be kept under review	TBC by NHS Genomics