Meeting of the Board of Directors
HELD IN PUBLIC
Friday 7 July 2017 at Liverpool Women's Hospital at 1000
Board Room

Item no. 2017/	Title of item	Objectives/desired outcome	Process	Item presenter	Time	CQC Fundamental Standard
	Thank you				1000 (5mins)	
181	Apologies for absence & Declarations of interest	Receive apologies	Verbal	Chair	1005 (05mins)	-
182	Meeting guidance notes	To receive the meeting attendees' guidance notes	Written guidance	Chair		R17 – Good Governance
183	Patient Story	To receive feedback from patients quality of care	Presentation and video	Kim Clarke, Genetics Counsellor	1010 (20mins)	R9 Person centre care
184	Hewitt Patient Story – update from the patient story received by the Board on 5 May 2017	To receive assurance from actions to address concerns raised.	Written	Director of Operations	1030 (10mins)	R12 & R17 – Safe care and treatment & Good Governance
185	Minutes of the previous meeting held on 2 June 2017	Confirm as an accurate record the minutes of the previous meetings	Written	Chair	1040 (5mins)	R17 – Good Governance
186	Action Log and matters arising	Provide an update in respect of on-going and outstanding items to ensure progress	Written/verbal	Chair		R17 – Good Governance
187	Chair's announcements	Announce items of significance not elsewhere on the agenda	Verbal	Chair	1045 (10mins)	R17 – Good Governance
188	Chief Executive Report	Report key developments and announce items of significance not elsewhere	written	Chief Executive	1055 (10mins)	R17 – Good Governance

Item no. 2017/	Title of item	Objectives/desired outcome	Process	Item presenter	Time	CQC Fundamental Standard
BOARD ASSURANCE						
189	Chair's Report from the Finance Performance and Business Development Committee	Receive assurance and any escalated risks	Written	Committee Chair	1105 (15mins)	R17 – Good Governance
190	Chair's Report from Putting People First Committee	Receive assurance and any escalated risks	Written	Committee Chair		R17 – Good Governance
191	Chairs Report from the Charitable Funds Committee & Terms of Reference	Receive assurance and any escalated risks	Written	Committee Chair		R17 – Good Governance
192	Serious Incident Report: Quarter 2	Assurance regarding reporting and learning	Written	Medical Director	1120 (10mins)	R12 & R17 – Safe care and treatment & Good Governance
193	National Strategy for Maternity Care - Update Report	To note the current status	Written	Director of Nursing and Midwifery	1130 (10mins)	R12, R18 & R17 – Safe care and treatment, Staffing & Good Governance
194	Infection Prevention and Control Annual Report 2016/17	To assure the committee the IPC team have met their requirements and have actions in place where these have not been met	Written	Tim Neal, DIPC	1140 (15mins) **1200 attendance**	R12, R18 & R17 – Safe care and treatment, Staffing & Good Governance
TRUST PERFORMANCE						
195	Bi-Annual Nursing and Midwifery Staffing Report	Review assurance on safe staffing levels for nursing and midwifery	Written	Director of Nursing and Midwifery	1155 (5mins)	R12 & 18 – Safe care and treatment & Staffing
196	Safer Nurse/Midwife Staffing Monthly Report	The Board is asked to note the content of the report and be assured appropriate information is being provided to meet the national and local	Written	Director of Nursing and Midwifery	1200 (10mins)	R18 - Staffing

Item no. 2017/	Title of item	Objectives/desired outcome	Process	Item presenter	Time	CQC Fundamental Standard
		requirements.				
197	i. Performance Report period 2, 2017/18 ii. Cancer 62 Day – Rapid	Review the latest Trust performance report and receive assurance	Written	Director of Operations	1210 (15mins)	R12&18: Safe R17 – Good Governance
198	Finance Report period 2, 2017/18	To note the current status of the Trusts financial position	Written	Director of Finance	1225 (10mins)	R17 – Good Governance
TRUST STRATEGY						
199	Fit for Future Generations Update	To brief the Board on progress and risks	Verbal	Chief Executive	1235 (5mins)	All
BOARD GOVERNANCE						
200	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair		R17 – Good Governance
HOUSEKEEPING						
201	Any other business & Review of meeting	Consider any urgent items of other business	Verbal	Chair	1240 End	-

Date, time and place of next meeting Friday 1 September 2017

Meeting to end at 1240

1240 - 1250	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	2017/184

MEETING	**Board of Directors**	
PAPER/REPORT TITLE:	Hewitt Patient Story Update	
DATE OF MEETING:	7 July 2017	
ACTION REQUIRED	**For Assurance**	
EXECUTIVE DIRECTOR:	Jeff Johnston, Director of Operations	
AUTHOR(S):	Neil Rogers, Interim Managing Director, Hewitt Fertility Centre	
LINK TO STRATEGIC OBJECTIVES:	1. To develop a well led, capable motivated and entrepreneurial workforce 2. To be ambitious and efficient and make best use of available resources 3. To deliver safe services 5. To deliver the best possible experience for patients and staff	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Safe:*** ***Efficient:*** ***Experience:*** *Poorly delivered positive experience for those engaging with our services*	***Effective:*** *Inability to deliver the best clinical outcomes for patients* ***Well Led:***
WHICH CQC KLOE FUNDAMENTAL STANDARD/S DOES THIS REPORT RELATE TO?	***Safe:*** *1.3 Safe- Reg 15 Premises and Equipmemt* ***Caring***: *2.1 Caring - Reg 9 Person Centred Care* ***Responsive:*** *3.1 Responsive - Reg 16 Receiving and acting on complaints*	***Effective:*** *4.0 EFFECTIVE - ALL - Reg 11, 14, 19* ***Well Led:*** *5.2 Well Led - Reg 17 Good Governance*
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT (e.g.: NHS Improvement Compliance/E&D/NHS Constitution)	*Operational Plan*	
FREEDOM OF INFORMATION STATUS (FOIA):	1. 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	
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	To note the actions taken to address the issues following Patient Story at Trust Board 5th May 2017.	
	Committee name	Finance Performance and Business Development Committee Hewitt Executive Committee

	Date of meeting/s	26/06/2017
	Marketing plan considered by FPBD. Full report considered by Hewitt Executive Committee.	

Hewitt Fertility Centre – Update on Concerns Outlined in Patient Story

Executive Summary

1. Situation

At Trust Board on 5th May, a patient who had previously made a complaint about her experience of the fertility service attended to present her Patient Story. Andrew Drakeley, Clinical Director, and Chris Malone, Matron, were present to provide any clinical input that was required, to comment on behalf of the service, and to be able to take the learning back to the wider team.

The patient, who had undergone private treatment and had experience of the HFC from December 2015 through to early 2017, was complimentary about the clinical care she had received from the team, about the counselling support, and the availability of the Patient Forum. However, she raised a number of concerns about more general aspects of her experience, summarised below:

i) Provision of statistics with regard to the likely success rates from IVF treatment, particularly in the over 40 age group.

ii) More information with regard to the evidence base of additional tests (specifically pre-genetic screening and endometrial scratch) that are not part of the standard IVF pathway, given that she had become aware of these informally via the Patient Forum rather than a more formalised route as part of consultations.

iii) Time taken to get through to the nurse telephone helpline.

iv) Lack of and sometimes conflicting information.

v) Limited opportunities to discuss the drugs that were prescribed to stimulate ovulation.

vi) Long waits to be seen on the day of clinic visits, specifically for scans and acupuncture.

There were three further concerns outlined in the patient's original complaint that were not covered as part of her Patient story, and it is assumed that the explanations given for these concerns as part of the complaint response were satisfactory in addressing them. Again, they link very much to the themes of effective channels of communication and provision of appropriate information:

vii) Repetition of tests

viii) Requirements to undergo viral screening

ix) Clarity on invoices issued.

2. Background

The vast majority of feedback from couples using the Hewitt Fertility Centre across the two sites is positive. Given the volume of activity undertaken and the nature of the service coupled with high patient expectations, the number of formal and informal complaints is surprisingly low. There were a number of complaints in Quarter 4 of 2016-17 with regard to the Embryoglue (expired media) incident in December 2016, which has been viewed as special cause. Other than that, complainants are typically seeking a refund or additional treatment, either because they are self-funding or because they have reached the end of their entitlement to NHS funded care. The HFC Executive members are therefore very grateful to this patient for raising her concerns in such a detailed and clear way.

Whilst this particular patient was treated on a self pay basis, and some of the discussion at Trust Board following the patient's departure concerned the improvements that were being made to the private patient pathway, it remains the view of the HFC Executive that we will strive to ensure superlative levels of service to enhance the experience of all of our patients across the two sites. We believe that a positive spin off of this will be that private patient numbers do increase, particularly as NHS commissioning potentially further restricts what is available in the future, but the intention is not to implement differentiation in such a way that a poorer offering than the current one is available to NHS patients.

3. Action

Concerns i), ii) and v) are relatively straightforward to address, and are covered via the action plan (Appendix A.) Concern vi) will be addressed via the HFC's overall Business Plan, which will cover the alignment of capacity to meet demand and the ability to flex up and down, workforce and succession planning, and the removal of single points of failure.

Concerns iii), iv) and v) are, on further investigation, issues that have not been addressed to a satisfactory level, leading to the experience described by this patient. There are some quite fundamental issues with regard to operational systems and processes, the technical capabilities of the phone system and routing / queuing functionality, staff roles and responsibilities, and wider culture, that need to be resolved to make improvements in this area. **The Action Plan at Appendix A describes the steps to be taken.**

4. Recommendation

i) There are regular Patient Forums and Information evenings. It is proposed that, on a rotational basis, a member of the HFC Executive attends these sessions, to hear at first hand any patient concerns or suggestions for improvements to the service, to enable rapid feedback and, where appropriate, implementation of remedial action or suggestions for improvement.

ii) That the Managing Director reviews all complaints (formal and informal) to establish any wider learning or trends, so that these can be incorporated to improve the service. Consideration of "goldfish bowls" for the rare occasions where patients may be particularly dissatisfied.

iii) Summary of patient feedback (good and bad) to be provided as part of the HFC Staff Newsletter, with facilitated discussions about improvement as part of quarterly meetings for the whole department.

iv) That the specific work being undertaken with regard to the private patient pathway is re-energised, to incorporate the issues raised by this patient, and is shared with the Patient Forum.

v) That patient feedback questionnaires / surveys are incorporated in to business as usual, to provide insight from the patient's / partner's perspective.

vi) That the general points above and the in the detailed action plan are endorsed, with monitoring of the plan via the HFC Executive, with a report back to as part of the regularly reporting of HFC progress.

Appendix A – Action to Improve Patient Experience, Hewitt Fertility Centre:

This Action plan addresses the following areas, following a Patient Story presented to Trust Board on 5th May 2017:

i) Provision of statistics / success rates

ii) Provision of information with regard to tests that aren't part of the standard pathway.

iii) Responsiveness of the service for patients phoning in

iv) Conflicting information

v) Limited opportunities for discussion.

Theme	Issue	Action	Who	Deadline
Statistics	Lack of information about different treatments and effectiveness. Current data collection is technical in its focus and geared towards HFEA submission, as opposed to being useful and presented in a clear way for patients and staff. HFC has a long record of very good success rates and should celebrate this, rather than being perceived to be withholding its data.	Provision of the most basic, easy to understand information updated monthly on the website with clear explanations of terminology. Hyperlinks on website to the relevant paged of the HFEA and the most recent validated, bench marked information Review of all data available via engaging a medical statistician on a project basis. Setting up of appropriate queries and statistical process control charts so that this can be run monthly and made available to staff, supported by teaching sessions about what the data means and the trends over time. These can then be laminated and made available to inform patient consultations.	Managing Director / Scientific Director Managing Director/ Scientific Director Scientific Director / Clinical Director / Nurse Consultant	End July 2017 End July 2017 End Dec 2017
Non standard tests	A great deal of mis-information with regard to the benefits of additional tests and investigations within	Provision of a fact sheet for private patients, explaining what is available as part of a standard pathway. This should also explain non-standard tests that are available, and the evidence base / indication for them,	Clinical Director / Nurse Consultant	End Aug 2017

	IVF is available on line to patients, and is potentially marketed for financial reasons by private providers. The HFC is keen to take an ethical stance on this, as it is one of the points that differentiates it from competitors. The view is that even on a self pay basis, HFC should only offer services where there is demonstrable benefit to the patient, based on their own individual clinical circumstances.	so that patients can make an informed decision. Provision of a fact sheet for NHS patients, explaining what is funded as part of an NHS commissioned cycle, and what is not funded. A position to be established with commissioners with regard to whether NHS patients are able to access non-standard tests, where these are clinically recommended as of benefit to the patient and improving the chance of a successful outcome, on a self pay top-up basis.	Managing Director Managing Director	End Aug 2017 End Oct 2017
Phone response	Data and patient feedback with regard to lengthy delays to get through to the correct person by telephone. Whilst this predominantly concerns the nurse helpline in terms of volume, there are also known to be problems with regard to the incorrect routing of calls. Over time, this will diminish the patient's experience and could lead to other centres having a competitive advantage over HFC.	Provision of further detailed information about call volumes and the number of calls abandoned by time of day and day of week. Provision of FAQs via the HFC website, with the intention of reducing call volume and having an alternative to direct patients towards if the nurse help line is busy. Clarification with regard to the technical capabilities of the phone system with regard to the number of options available to segment callers to the correct destination, to be able to have an engaged tone or play music, and to provide a position in the queue (meeting with Vodaphone to clarify what is available at no	IT Project Team Managing Director IT Project Team / Managing Director	End June 2017 Mid July 2017 End July 2017

		additional cost.)		
		Deployment of staff to cover the nurse help line to match the workload data, with consideration of x2 HCAs to be able to run a second triage line at busy times (eg early Monday morning) in addition to the two trained nurse deployed to do the call-backs	Matron	End August 2017
		Set target time for a nurse to call the patient back that is agreed with the patient, with an explanation given to the patient that this will appear as a withheld number.	Matron	End August 2017
		Agree budget for an assigned IT Project Manager for the implementation period, if additional functionality with regard to routing / queuing / messaging is available, and launch task & finish group to oversee changes to ensure no risk to business as usual and KPIs to monitor the solution against.	Managing Director	End July 2017
		Monthly monitoring of data against the Nov ’16 – May ’17 baseline, via HFC Executive, following implementation of changes.	Managing Director	End Sept 2017
		Pilot the use of email or web based forms for specific scenarios (eg pregnancy results and to confirm surge in advance of planning a frozen embryo transfer) to reduce the need for phone calls; however this would require careful implementation and real time monitoring, with information	Matron / Nurse Consultant	End Sept 2017

		governance issues worked through, and could not detract from the ability of staff to be available to answer the phones.		
Conflicting information / opportunities for discussion	A theme from complaints, and one mentioned in the Patient Story to Trust Board, is that different staff involved in the fertility pathway can give conflicting information and that consultations can appear rushed. This can be because the patient's chances of success change over time as treatment progresses and new information emerges, because they have not properly understood what can be very complex and technical details, and because they can be emotionally distressed and not able to take in all the facts. Whilst the provision of information leaflets is helpful, they cannot be expected to be an exact fit for every individual patient in every clinical scenario.	Embed a culture, in face to face discussions, of "any more questions", "anything not clear", "anything you don't understand" to reduce the patient's impression that consultations are rushed, and to provide opportunites for clarification. Encourage patients to bring their partner or a friend / relative to consultations, to provide more opportunity to ask questions and for the information to have been conveyed effectively. Embed the principles of "Copying Letters to Patients" (Department of Health 2003) within HFC, such that the patient is copied in on all correspondence that is sent to their GP. This is a further opportunity to put across the clinical position and treatment plan in simple, non-technical terms that will reinforce the patient's understanding, and act as a prompt for the patient to ask if they are unclear. Ensure that the typing queue is held at no longer than 5 days, to ensure the benefits realisation from the "copying Letters to Patients" initiative.	HFC Executive HFC Executive Managing Director Business Manager	End July 2017 End August 2017 End Sept 2017 End Sept 2017

Board of Directors

Minutes of the meeting of the Board of Directors
held public on Friday 2 June 2017 at 1000 hrs
in the Boardroom, Liverpool Women's Hospital, Crown Street

PRESENT	
Mr Robert Clarke	Chair
Mrs Kathryn Thomson	Chief Executive
Mr Ian Haythornthwaite	Non-Executive Director/Vice Chair
Mrs Vanessa Harris	Director of Finance & Deputy Chief Executive
Mr Tony Okotie	Non-Executive Director/SID
Mr Ian Knight	Non-Executive Director
Dr Susan Milner	Non-Executive Director
Ms Jo Moore	Non-Executive Director
Mr David Astley	Non-Executive Director
Mrs Michelle Turner	Director of Workforce & Marketing
Dr Andrew Loughney	Medical Director
Mr Jeff Johnston	Director of Operations
Dr Doug Charlton	Director of Nursing & Midwifery
Mrs Jenny Hannon	Acting Director of Finance

IN ATTENDANCE	
Mr Colin Reid	Trust Secretary
Greg Hope	Head of Governance

APOLOGIES	
Mr Phil Huggon	Non-Executive Director

Thank You

The Director of Operations introduced the IT team (comprising of: David Walliker; Michael Lawler; Rhianne Lawton; Dennis Estacio; Alex Lester; Peter Dickens; Matt Smith; David Pasko; Steve Chokr and David Cordon) who had been invited to the Board to receive a team thank you for going above and beyond at the time of the NHS cyber-attack. He explained that the team was able to keep the Trust safe and some brave decisions had to be made which protected the Trust. The Director of Operations advised that in keeping the Trust safe and the local economy safe this ultimately meant that patients were kept safe and came to no harm.

The Chair advised that a thank you had also been made on behalf of the Board to Janet Parker, Financial Controller, for her exceptional work surrounding the audit of the Trust's financial systems as part of the external audit of the Trust's Annual Accounts.

149 **Apologies** – as above.

Declaration of Interests – None

150 Meeting guidance notes

The Board received the meeting attendees' guidance notes.

151 Board Visibility Feedback

The Chair reported on the Board visibility activity that took place earlier in the day and advised that prior to each Board meeting, Board members would go out in small groups and spend some time with staff and patients, listening carefully to their views. The findings of these sessions would be reported back to the Board as a whole and any concerns would be addressed. The Board noted that this activity would provide them with real time assurance and understanding of the views of staff.

152 Patient Story

The Chair welcomed the patient to the Board and asked the Director of Nursing and Midwifery to introduce the item.

Director of Nursing and Midwifery introduced the patient and asked her to speak to the Board on the experiences she had had at the Trust. Attending with the patient was Chris Mcghee, Head of Nursing and operations for Gynaecology and Theatres.

The patient explained that her story began 3 years ago, when she had her first child 5 years ago. The patient explained the services she had used at the Trust and the exceptional care she had received from each, praising highly all staff she had encountered from senior clinicians to the lady that provided tea. She explained in detail the treatment she had received in Gynaecology OPD, Ward, emergency room, theatres, maternity and Maternity Theatre and blossom buddies, over the period of three years which cumulated in the birth of Daniel her son by caesarean section.

The Chair thanked the patient for her story and asked for comments and questions. The Director of Nursing and Midwifery advised that this was a fantastic patient story that showed the positive side of the Trust's work in the provision of care to patients. The Chief Executive supported the comment and felt that this type of story shows fantastic work practiced across the services and said that it was important that the Trust learn from the experiences so we can get it right for all service users. The Chief Executive asked that the excellent patient experience and care arising from this story is fed back to all the services and celebrated.

The Chair thanked the patient for attending and eloquently explaining to the Board the quality of care she had received.

The Patient and Chris Mcghee left the meeting.

153 Minutes of previous meeting held on Friday 5 May and 19 May 2017

The minutes of the meeting held on 5 May and 19 May 2017 were approved.

154 Matters arising and action log.

The Board noted that all actions were either complete, on the agenda or to be reported at a future meeting.

The Chief Executive referred to the retirement of Dame Lorna Muirhead as Lord Lieutenant of Cheshire and Merseyside and advised that there was to be a special service of farewell for Dame Muirhead at Liverpool Cathedral on Wednesday 13 September 2017 and an invitation had been received that had been extended to all members of the Trust's staff if they wished to attend. The Chief Executive asked that if anyone wished to attend would they contact the Trust Secretary.

155 Chair's Announcements

The Chair made the following announcements:

Volunteers Week: The Chair advised that there would be a thank you afternoon tea for the Trust volunteers in the Blair Bell atrium. He explained this was an annual event to celebrate with the volunteers the fantastic work they do for the Trust and was part of the celebratory volunteers' week.

The Board noted the Chair's verbal update.

156 Chief Executive's report

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

Cyber-Attack: the Chief Executive referred the Board to the thank you that was given earlier to the IT Team for going above and beyond in dealing with the issues arising from the NHS wide cyber-attack. She also thanked all staff and the executive team for managing the potential impact of the cyber-attack, which resulted in none of the Trust's systems being affected by the virus and more importantly that the quality of care to the Trust patients had not been compromised over the period. The Chair commented on the quick actions of the staff and in particular that of the Chief Information Officer and Director of Operations, whose decisions the Board fully supported and endorsed.

The Board noted that a 'lessons learned' report would be submitted to the Finance, Performance and Business Development Committee in due course, recognising the need for the Board to have visibility on potential threats to the operation of the Trust, its patients and staff.

The Board noted the Report from the Chief Executive.

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

Jo Moore, Chair of FPBD updated the Board on the work of the Committee at its meeting on 22 May 2017 referring in particular to the following:

- Performance Report: The Committee received month 1, 2017/18 performance Dashboard in the new format agreed by the Board last month. The Committee was satisfied that the report provided it with the level of assurance it needed to assess the performance of the Trust within its area of responsibility. The Committee had noted that for month 1 the Committee's indicators remained strong and that there was ongoing work with the CCG regarding CQUIN's to agree key deliverables in 2017/18.
- Financial position & CIP: The Committee received month 1 2017/18 and noted that at Month 1 the Trust was slightly better than plan with an actual deficit of £0.550m against a plan of £0.554m. The Committee received an update on the CIP, noting that in the first month there was slippage in delivery and this was being addressed. The Committee received assurance that all Quality Impact Assessments and Environmental Impact Assessments had been signed off by the Medical Director and Director of Nursing and Midwifery with the exception on one that required additional work.
- Board Assurance Framework (BAF): The Committee had reviewed the BAF risks it was responsible for on behalf of the Board and agreed that there would be no amendments. These were included in the BAF paper later in the meeting.

Referring to the escalation report on the performance measures, the Director of Operations advised that the Trust was slightly behind plan in Gynaecology due to reduced capacity arising from the estate work being undertaken. He explained that once the work had been concluded and the service fully operational the Trust would be able to recover the position and deliver against plan.

The Board noted the content of the FPBD Chair's Report.

158 Chair's Report from the Governance and Clinical Assurance Committee (GACA)

Susan Milner, Chair of GACA updated the Board on the work of the Committee at its meeting on 15 May 2017 referring in particular to the following:

- Medicines Management Update and Assurance: Susan Milner reported on the concerns the Committee had in obtaining the relevant assurances from Pharmacy in relation to CQC Fundamental Standards and self-medication administration. She advised that although a paper had been issued to the Committee meeting on self-medication it was not supported by the attendance of the Chief Pharmacist or her Deputy. Susan Milner further advised that the paper on the CQC Fundamental Standards had not been received and reported that the Medical Director had agreed to take lead on this matter on behalf of the Committee and would report back to the Committee at its July meeting.
- Serious Incident Update Report and Organisational Patient Safety Report: Susan Milner reported on the length of time action plans were taking to complete noting that this had also been identified as a concern by the Board. She advised that there was recognition that some actions had been poorly thought through and as a consequence it had not been possible to close some of them out. The Medical Director provided an example of action plans that had not been closed due the poor drafting of the action. The Director of Nursing and Midwifery advised that all new SI action plans were now required to be quality assessed by himself and the Medical Director before being discussed at the senate's.
- Safety, Effectiveness & Experience Report Q4: Susan Milner advised that there had been some discussion on whether the Board should, through GACA, receive a quality report that would be presented by the Director of Nursing and Midwifery. The Director of Nursing and Midwifery advised that there was still discussions to be had on the content of such a report recognising that the Board received performance of quality indicators through the Performance Report and exception reporting through the Committee Chairs Report. The Chief Executive felt that it would be appropriate for the Director of Nursing and Midwifery to present an example of a quality report to GACA to review and if appropriate recommend such a report for the Board. In considering whether it was appropriate to recommend a quality report, GACA should seek to address whether such a report would add value to Board discussions and understanding.
- GACA Performance Indicators: The Chair referred to the new GACA performance indicators and the comment regarding "Intensive Care Transfers Out" and asked for further clarification on why there was a discussion on the target with an aim to set the target at zero. The matter was discussed and in particular it was noted that the indicator related to "seriously ill women" who should have been transferred to an acute trust but who had remained at the Trust. The Medical Director advised that historically the Trust had always had a target of 8; however it was his view that the real target for this indicator was zero to reflect the best possible outcome for patients. The Board noted that this would be discussed further at GACA in July 2017.

The Chair referring to the actions required by the Board sought the Board view on the proposals.

The Board:

- *noted that the Quality Strategy 2017-20 would be taken at agenda item 2017/162 for approval;*
- *noted the approval of the Quality Report 2016/17, approved by the Board at its meeting on 19 May 2017;*
- *noted that the Committee had approved, on behalf of the Board the Adult Mortality Strategy and Perinatal Mortality Strategies;*
- *approved of the GACA BAF Risks, risk scores and appetite statement for discussion under agenda item 2017/166; and*
- *received the GACA Annual Report 2016/17 attached.*

The Chair thanked Susan Milner for her report which was noted.

159 Chair's Report from the Audit Committee meeting held 19 May 2017

Ian Knight referred the Board to the work of the Audit Committee held on 19 May 2017 and in particular drew the Board attention to the minutes of the Board meeting of same day when he made a verbal report to the Board. The Board noted the work of the Committee in its recommendation to the Board for the approval of the Trust Annual Report and Accounts 2016/17.

160 Performance Report Period 1 2017/18

The Director of Operations presented the new Performance Report for period 1 2017/18 and explained that the Report sets out those top 20 indicators agreed by the Board and advised that all other indicators specific to the Board committees had been issued to the Board members and placed on the intranet in a separate document for ease of access.

Referring to the dashboard, the Director of Operations reported that the Trust was monitoring the indicator 62 day wait for first treatment from urgent GP Referral for suspected cancer given its current underperformance. He explained that this was not a mandated national indicator however it had been agreed to continue its reporting to the Board as it lends itself to supporting the mandatory national targets.

Tony Okotie referring to the sickness absence indicator advised that the Putting People First (PPF) Committee was actively challenging the non-delivery of the target. He advised that such indicators should be reviewed against the same time in previous years to see whether a trend existed, and PPF would be considering this. The Director of Workforce and Marketing advised that the Trust performance in this area was not out of kilter with the acute sector and went on to explain the process by which sickness absence was monitored and managed in the Trust and the process for getting staff back to work on a planned pathway. She referred in particular to those off work due to stress related sickness, which was not necessarily work related.

The Board noted that the report and indicators had been discussed at FPBD and PPF and that no exception reporting had been made by the Chair of each committee other than those discussed.

161 Financial Report & Dashboard Period 1 2017/18

The Director of Finance presented the Finance Report and financial dashboard for month 1, 2017/18 and reported that at Month 1 the Trust is slightly better than plan with an actual deficit of £0.550m against a plan of £0.554m and the Trust delivered a "Use of Resources" Rating of 3 in month which was equivalent to plan. The Director of Finance advised that there was no requirement to draw down cash from the loan facility in month.

The Director of Finance reported that the main risk to delivery of the year end control total was the Trust's ability to deliver the agreed CIP. She explained that this risk had been identified in the Board Assurance Framework as one of the key significant risk to the financial viability of the Trust, reporting that if the Trust was to miss the control total then it would not receive sustainability and transformation funding; resulting in a larger deficit than planned. The Director of Finance reported that, similar to a lot of trusts, delivery year on year of CIP was becoming increasingly difficult to achieve and it was imperative that the Board keep a grip on CIP so that there would be no surprises. She suggested that for quarter 1, the Board receive a comprehensive report on CIP delivery which would include a forecast for the year.

David Astley referring to the pressure on staff to deliver the financial plan commented on whether this had a bearing on work place stress and consequential sickness absenteeism. He felt that delivery of the financial plan required strong and challenging messages to staff regarding the viability of the Trust. Referring to recent press coverage on waiting times David Astley asked whether there was a concern regarding the delivery of the waiting time indicator that the Board needed to be aware of. In response the Director of Operations advised that the Trust continued to deliver against waiting times

indicators as previously explained. He noted that there was an indication that NHSI would be making cancer waiting times harder to deliver in the future, which would put additional national pressures on delivery. It was his view that the Trust would be able to deliver against future mandated targets, although there would be pressure should one or more of providers within the pathway were not able to deliver.

Ian Haythornthwaite referring to the discussion on CIP felt that it was important that the right words were used when communicating the 'need' to deliver CIP. He felt that using the term challenging gives opportunity for managers to feel they only have to do their best. It was important that they were held to account in delivery and that delivery was a "got to" or "must do". The Director of Finance supported the comment and reasserted her comment earlier that the CIP needed to be delivered not only in year but also recurrently and recognised the need to understand what CIP requirements would be for 2018/19 and onwards.

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

162 Quality Strategy 2017-20

The Medical Director presented the Trust Quality Strategy 2017-20 and reported on the three main goals contained within it. He advised that the strategy had been reviewed by GACA and was recommended to the Board for approval.

David Astley asked whether delivery of the Strategy required additional resourcing to that already within the Trust. In response the Medical Director advised that delivery of the Strategy had been assessed on a cost neutral.

The Medical Director gave his thanks to the Governance team who were all involved in the development of the Strategy.

The Board, following recommendation from the Governance and Clinical Assurance Committee (GACA), approved the Quality Strategy 2017-20, noting that performance would be reviewed by GACA on behalf of the Board.

163 Fit for Future Generations Update

The Director of Workforce and Marketing explained to the Board the communications that had been or were being developed for staff, patients and members of the public. She reported that all staff had received briefing on the fit for future generations that had been included in the Chief Executives report and explained the work around social media and the new website. The Board noted the increased communication activity but felt that more could be done when entering the hospital so that patients and service users could read and see what was happening and why. The Director of Workforce and Marketing advised that she would look at improving communication via bill boards for service users whilst accessing the Trust.

164 Operational Plan 2016/17 & Corporate Objectives 2016-17 close out report

The Board received and approved the Operational Plan 2016/17 & Corporate Objectives 2016-17 close out report.

The Director of Workforce and Marketing referred to the operational plan 2016/17 and acknowledged Jayne Parr, Digital Communications Officer, for putting together the messages on a page.

165 Corporate Governance Statement

The Board received the corporate governance statements and the evidence of compliance against the statements and following discussion approved the declarations contained in the paper for publication

on the trust web-site.

166 i) Board Assurance Framework

The Head of Governance joined the meeting to present the new Board Assurance Framework 2017/18 and reported on the main change in process for 2017/18. He advised that he would be assuming operational responsibility for the BAF reporting to the Director of Nursing and Midwifery who would have Executive responsibility.

The Head of Governance advised that meetings would be arranged with the Executive Directors in advance of each sub-committee meeting to ensure correlation and ownership of the risks and that for future reporting to the Board, the Board would receive a quarterly update. The update would outline any proposed amendments from sub-committees in relation to the risk description, risk scores, progress with actions and any associated risks within the corporate risk register; with evidence for any proposed change. The Head of Governance advised that the quarterly paper would include reports from Corporate Risk Committee.

Referring to the risk 'Ineffective understanding and learning following significant events' under the 'Safe' CQC Domain the Board noted the target risk score for the year was '6' against a current risk score of '12' and noted the challenge around delivery of the target score by the end of the financial year, however recognised the significant amount of work being done to address learning across the Trust from serious incidents.

The Board noted that risks relating "Strategic Objective: To participate in high quality research and to deliver the most effective outcomes" would be reflective of the Trust's delivery of its Research and Development Strategy following the strategies review which would be discussed in committee and approved by the Board in the autumn 2017.

The Chair sought the Board approval of the recommendations in set out in the Report.

The Board:

a. Approved the closure of the 2016/17 Board Assurance Framework;
b. Approved the Board Assurance Framework for 2017/18; and
c. Agreed that the proposals for future Board Assurance Framework papers to the Board would provide sufficient assurance.

ii) Risk Appetite

The risk appetite statement was reviewed by the Board, noting that each committee had reviewed the risk appetite levels relating to their areas of responsibility.

The Chair challenged whether the appetite level for the strategic objective "To be ambitious and efficient and make the best use of available resources" was correct. He felt that the Trust appetite was more 'high' than 'moderate' given the definitions provided in the table. This was discussed and it was agreed that the appetite level for the strategic objective should be split on the basis that for the financial management element, the appetite level was 'moderate' but in relation to strategy the appetite level was 'high'.

The Board approved the recommendations of the Board committees regarding risk appetite and risk tolerance levels for 2017-18 subject to the amendment to the tolerance level for the strategic objective "To be ambitious and efficient and make the best use of available resources" which would be split on the basis that for financial management the appetite level was 'moderate' but in relation to strategy the appetite level was 'high'

167 Review of risk impacts of items discussed

The Board noted the risks had been discussed during the meeting.

- Triangulation of Board visibility visits
- Risk of CIP non delivery on control totals and STF

168 Any other business & Review of meeting

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

Date and time of next meeting

7 July 2017

Agenda Item 2017/186

Liverpool Women's NHS Foundation Trust

TRUST BOARD
July 2017 Action Plan

Meeting date	Minute Reference	Action	Responsibility	Target Dates	Status
4 Nov 2016	2016/278	Director of Nursing and Midwifery to provide an update to the board on progress made against the action plan regarding the implementation of the National Maternity Review in February 2017.	Director of Nursing and Midwifery	7 July 2017	*3 March 2017 Update: An update presentation was be provided to the Board on 3 February 2017 with a formal paper presented to the Board at the 7 July 2017 meeting following the visit from Baroness Cumberlege.* See agenda item 2017/193, 7 July 2017
5 May 2017	2017/113	The Director of Operations to develop an action plan to address the concerns identified in the patient story (Fertility) and bring back to the Board for assurance that actions were being taken.	Director of Operations	7 July 2017	See agenda item 2017/184, 7 July 2017

		Agenda Item	**2017/188**
MEETING	**Board of Directors**		
PAPER/REPORT TITLE:	**Chief Executives Report**		
DATE OF MEETING:	7 July 2017		
ACTION REQUIRED	**For Assurance**		
EXECUTIVE DIRECTOR:	Kathy Thomson, Chief Executive		
AUTHOR(S):			
LINK TO STRATEGIC OBJECTIVES:	**All**		
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***ALL*** ***Safe:*** ***Efficient:*** ***Experience:***		***Effective:*** ***Well Led:***
WHICH CQC KLOE FUNDAMENTAL STANDARD/S DOES THIS REPORT RELATE TO?	***Safe:*** ***Caring:*** ***Responsive:***		***Effective:*** ***Well Led:*** *5.2 Well Led - Reg 17 Good Governance*
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT (e.g.: NHS Improvement Compliance/E&D/NHS Constitution)	NHSI Compliance		
FREEDOM OF INFORMATION STATUS (FOIA):	1. 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		
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	***Board is asked to note the Report***		
PREVIOUSLY CONSIDERED BY:	**Committee name**	Not Applicable	
	Agenda Ref.		
	Date of meeting		
	Summary of Outcome	Not Applicable	

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

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

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

Kathy Thomson.
Chief Executive.

SECTION A - INTERNAL

Inpatient redesign project - Gynaecology Ward redevelopment: The inpatient redesign is now in its final phase of refurbishment and is already starting to look like a fantastic environment for both patients and staff who work on the ward. The ward is due to open on the 17th July, 2017 and will also provide a more efficient use of space. Staff in Gynaecology have done an outstanding job in continuing to keep patients safe and provide excellent care and patient experience in the temporary ward accommodation.

Outpatients – Patient flow and self-check in system: the new centralised outpatient check-in opened on the 19th June 2017. Not only providing an excellent new environment for patients to wait but introducing use of new technology for patients to self-check-in. This has enabled the Trust in removing 8 reception areas in the Trust which will improve patient experience and efficiency. In the first two days 73% and 77% of patients used the self-check-in facility. A phone app will be introduced in the near future that will be linked to the self-check-in system so patients can check in by phone and be called to clinic using the app. Included as part of the re-design of the centralised waiting area is a coffee shop for access by all service users.

CQC Mock Inspection: A Care Quality Commission mock inspection was planned and undertaken on 21st & 22nd June 2017 involving a variety of staff from across the organisation. The inspection was facilitated by the external CQC consult Suzanne Rostrum. Teams visited a number of clinical areas including the community to test the organisations readiness for a full regulatory inspection.

The feedback from both days was received by the Director of Operations and Director of Nursing & Midwifery. Overall the inspection teams found many positive areas of good practice which was shared with the staff at the time, more importantly the inspection teams did not report any major concerns following their visits.

Work will continue over the next few months supporting staff to ensure the organisation is complying with all the necessary requirements to result in a positive outcome.

Volunteers: It was National Volunteer's Week from 1June to 7 June and to celebrate the fantastic work of our volunteers the Trust hosted a High Tea afternoon on Friday 2nd June. Over 40 volunteers came, including volunteers from the Newborn Appeal and the League of Friends. The Board attended the event and served sandwiches and tea and coffee to the volunteers as a thank you for their support. The attached newsletter provides further details of the event.

Charity Event: Liverpool Women's Charity held an event for our volunteer knitters on 8th June as part of National Volunteers Week. We were delighted to welcome almost 100 ladies who support the Newborn Appeal to thank them and tell them a bit more about the charity's work. One volunteer said "Knitting at home can be quite isolating

and it was lovely to be able to meet and chat to fellow knitters. I have to say that the input from the Fundraising and Neonatal staff was very informative and it makes such a difference to know that we can all do something to help." We also received approximately £3,000 in donations of knitted items that are to sold on the weekly stall.

Introduction of Yellow Patient Alert Bands: To reduce the risk of items being unintentionally retained or overlooked, a new system is being introduced. A yellow identification band will be placed onto the patient's arm/leg alongside their patient identification band, when an item is intentionally retained to be removed post operatively. This is a simple and effective way of alerting all staff that a patient has AN INTENTIONAL item (pack or swab) inserted into a cavity.

Winning Team: A massive congratulations to John Foley and his team for picking up best waste Management Initiative at the Excellence in Recycling and Waste Management Awards. John and the team attended the awards with Sharpsmart in London on 18th May and were delighted to walk away with the top prize. Congratulations and well done to all involved.

SECTION B – LOCAL

New providers for community health services in south Sefton: From 1 June, Mersey Care NHS Foundation Trust and North West Boroughs Healthcare NHS Foundation Trust (previously 5 Boroughs Partnership) will be the new providers of community services across south Sefton. Building on the current work to improve the health and wellbeing of local people, the services transferring from Liverpool Community Health NHS Trust include the provision of blood testing, community matrons, district nursing, treatment rooms, foot care, intermediate care, adult diabetes and adult dietetics, IV therapy and community respiratory care.

North West Boroughs Healthcare will deliver a number of services including blood testing, community equipment – in partnership with Sefton Council – and Litherland Walk-in Centre. This is in addition to the borough's children's community health services which transferred to North West Boroughs Healthcare in April.
Mersey Care will deliver all other adult community health services within South Sefton.

Referral routes and contact details will remain the same and, aside from logos changing on appointment letters and buildings, people using the services should not see any changes. Staff from the current services will transfer to Mersey Care and North West Boroughs Healthcare. Arrangements are being made for a stakeholder event which will take place on 21 June. This will be an opportunity to continue conversations about how we work together to further develop services. Further details and invitations will be sent out in due course.

Update on Sefton and Liverpool CCGs working together: Clinical commissioning groups in Sefton and Liverpool are pausing their plan to merge the three organisations. NHS South Sefton CCG, NHS Southport and Formby CCG and NHS Liverpool CCG have made the decision so they can spend more time considering the implications of a merger for their patients, staff and partners. The three CCGs were required by NHS England to submit their formal merger application by July 2017, ahead of any agreed organisational change from April 2018. Governing body members have instead agreed to delay submitting their application and revisit their proposal in a year's time.

It is anticipated that the additional time created by a pause will allow the CCGs to concentrate their efforts in two areas. Firstly, in ensuring the CCGs continued focus is on improving financial and health service performance for the distinct populations they serve in line with their individual statutory duties, whilst secondly, developing a more considered and robust business case that clearly demonstrates the benefits of merging to their GP practice members, local residents and other key partners. Membership of the North Mersey Local Delivery System (LDS) means the CCGs will continue to work together on system wide programmes that benefit and affect the populations they serve. Good progress and pace has already been made, without the upheaval that organisational or structural change would bring to the CCGs at this present time.

A revised timetable will be developed over the year ahead focusing on how the CCGs might begin to reassess the feasibility and viability of their merger plans.

Bringing Liverpool's Hospital services together - Consultation on proposed changes to orthopaedic and ENT services: A public consultation has launched proposals for a single orthopaedics service for Liverpool's hospitals. Under proposals, orthopaedics specialists at Aintree University Hospital NHS Foundation Trust and the Royal Liverpool & Broadgreen University Hospitals NHS Trust would join together to become a single team, working across all three hospital sites. This would also mean some changes for Ear, Nose and Throat (ENT) care. This proposal is part of the wider Healthy Liverpool vision.

SECTION C – NATIONAL

Royal College of Obstetricians and Gynaecologists - Each Baby Counts Inquiry and Report: The Trust has been a keen supporter of the Each Baby Counts initiative from its outset. Our multidisciplinary teams have worked hard with governance leads to make sure that everything is done to prevent harm coming to babies born in the hospital whenever this is possible. The four key findings of the report are that: (1) All low-risk women are assessed on admission in labour to see what foetal monitoring is needed - a risk assessment is done in every case so that a plan can be made for fetal monitoring that is most suitable to the clinical needs and to the wishes of the woman, (2) Staff get annual training on interpreting baby heart-rate traces (CTGs) - regular training sessions are delivered in CTG interpretation on the delivery suite and a computerise CTG teaching system called K2 is also used in the Trust, to ensure that all staff are competent in this important area of practice. An annual update is the minimum that our staff achieve, many have a more frequent update, (3) A senior member of staff must maintain oversight of the activity on the delivery suite - leadership on the delivery suite is provided by senior midwives and obstetricians jointly and the anaesthetic leadership in the area is also strong. Our operational plan includes a target for achieving 24/7 cover on the delivery suite from consultant obstetricians and anaesthetists in coming years, with the expansion already underway, and (4) All trusts and health boards should inform the parents of any local review taking place and invite them to contribute - parents, family and carers have been placed at the centre of all investigations when a baby has died before or shortly after its birth. The Trust also applies Duty of Candour rigorously to all cases in which there has been an injury to a baby and follow-up is always offered so that any concerns can be addressed. We agree with the concept that Every Baby Counts and we remain committed to seeking new ways to improve outcomes for all of the patients we look after.

Care Quality Commission: The Care Quality Commission (CQC) has published its response to its consultation for how it will regulate NHS foundation trusts and trusts. Alongside this the updated provider guidance and assessment frameworks for health care services has also been published along with further details about the timetable for the roll-out and implementation of the new approach.

In addition, the CQC has today launched a further consultation on how it will regulate the other sectors within its remit along with additional proposals that apply to all regulated sectors and encompass how the CQC will register, monitor, inspect and rate new models of care and large or complex providers; how the CQC aims to encourage improved quality of care in local areas and how the fit and proper person requirement will be applied.

The briefing attached from NHS Providers summarises the key conclusions following the consultation and highlights next steps that service providers will need to be aware of. The briefing also summarises the proposals contained in the new consultation, which is due to close on 8 August 2017.

NHSI launches training programme to upskill managers: A three-year programme to upskill NHS managers in order to help them tackle growing demand for services has been launched by NHSI. The new national Demand and Capacity Trainer Programme has been designed as a free resource to upskill and support local NHS staff so that they are better prepared to master demand and capacity planning, as well as improve patient outcomes by reducing waiting

times. Sponsored by NHS Improvement (NHSI) and NHS England, the scheme aims to help upskill 300-400 local managers and ease pressure by equipping leaders with all the tools to improve efficiency in their trusts.

NHS Providers chairs and chief executives meeting: The presentations from the NHS Providers chairs and chief executives meeting held 20 June 2017 are available in the links below:
Delivering the key 5YFV next steps priorities – mental health and emergency care
Sir Robert Naylor and the estates review
Strategic and policy update and dialogue

Attachment:

- Volunteer Brief Special Edition – June 2017
- NHS Providers Briefing - CQC Next phase consultation response and follow-up consultation 12 June 2017

Volunteer Brief Special Edition

June 2017

Issue 011

Volunteer's do not get paid, not because they are worthless but because they are priceless!

Liverpool Women's

VOLUNTEER'S WEEK 1-7 JUNE

It was National Volunteer's Week 1-7 June. To celebrate the fantastic work of our volunteers we hosted a High Tea afternoon on Friday 2nd June.

My team and I decorated the atrium with bunting and covered tables with white cloths and laid out fine bone china tea sets courtesy of league of friends. I have to say, I've never seen the atrium look so nice and passes by stopped to admire and give compliments.

Over 40 volunteers came, including volunteers from the Newborn Appeal and the League of Friends.

They all each received a thank you card from the Chair and CEO, and a gift.

We gave our volunteers pots of Begonia's lovingly handcrafted by the 'V' team as a special thank you.

We presented long service awards and Kathryn Thomson, CEO draw the free to enter raffle. Robert Clarke, Chair, presented this months and May's Volunteer of the Month (see pg.2 and our FB page).

But I think what helped make it more special was the support given by the Trust Board, they came out in force to wait on the volunteers, serving them tea, coffee, juice and sandwiches. They sat and ate their lunch with them, chatting and showing an interest in what the volunteers do.

Michelle Turner, Director of HR and Operations sent a message to say:

"*Just a quick note to say thank you so much on behalf of the Board for organising the Volunteers Event last Friday. It was a lovely event and a great joy and privilege for the Board members to be there and spend some time with our wonderful volunteers. These things don't just happen by magic though, so please say thank you to everyone who worked with you to make it such a great event.*"

Volunteers have fed back saying how much they enjoyed themselves and how it made them feel valued. We are delighted to hear the event had the desired outcome and we agree with Robert Clarke, Chair, when he said in his thank you speech that we should do things like this for the volunteers more often. So here I am planning something for you all for Christmas!!

Take a look at the pictures taken on the day on page 3 & our FB page!

Special thanks to G4S, LOF, Newborn Appeal, Laura and Jaye for helping create such a fantastic event.

Gina

Inside this issue:

Volunteer of the Year 2016/7

Award presented to Annalyn at the Dedicated to Excellence Awards evening in April 17

Special belated congratulations to **Annlyn Taylor** (nee Lim) for being this years Volunteer of the Year. The judges had a tough decision choosing only one person to win out of the 11 entries.

Annalyn's winning entry:

Annalyn hadn't been volunteering for long on Meet and Greet when she was nominated for Summer Volunteer of the Season. She'd made a wonderful impression on all the staff in the volunteer's office and volunteers on Meet and Greet in a very short time. She is a joyous person, who can help brighten up everyone's mood. She has a lovely smile, she is kind, caring and she is epitomises what working in the health care sector is

Volunteer of the Month for May and June

May 2017 Volunteer of the Month is **Kevin Lavelle**

Kevin has been a volunteer at the Trust for 8 years, during this time he has helped Dave and staff in the post room deliver and collect mail to ground floor departments. He was nominated by fellow volunteer, Michael, for doing his job very well and for being on time. Kevin is a lovely chap, always smiling and pleasant, it's an honour to have him volunteer for us.

June 2017 Volunteer of the Month is **Patrice O'Malley**

Patrice has volunteered on Gynaecology Ward for over 7 years, and helped May and Helen with the library service until they retired a couple of years ago. She now manages the library service every Wednesday as well as continuing to help and support patients and staff on Gynae. She was nominated by Paula, a volunteer, for always smiling and for being like a breath of fresh air to both staff and patients. She has a cracking sense of humour and makes us all laugh!

Condolences

We are deeply saddened to announce the unexpected death of one our cherished volunteer gardeners, ***Richard Stringer.*** *He past away on Friday 2nd June at home. We will announce the funeral arrangements as soon as we know the details.*

Our thoughts are with his family and friends at this time.

High Tea afternoon photo gallery

We're on the web
www.lwh.org.uk

Liverpool Women's

Volunteer Service
Liverpool Women's NHS Foundation Trust
Crown Street
Liverpool
L8 7SS

Phone: 0151 702 4368
Mobile: 07757057918
Email: volunteers@lwh.nhs.uk

If you or someone you know is interested in becoming a volunteer, please contact the 'V' Team on 0151 702 4368 or e-mail: volunteers@lwh.nhs.uk

Long Service Awards

Congratulations to the following volunteers on achieving a Long Service Award:

June McKie	**10 Years**
Carole Byrne	**5 Years**
Jonathan Harrison	**5 Years**
Barry Lunt	**5 Years**
Christine McKendrick	**5 Years**
Karen Moore	**5 Years**
Marian Wheelan	**5 Years**

Fantastic achievement and dedication everyone, thank you so much for all your help over the years and long may you continue to volunteer with us!!

Gina, Laura and Jaye
The 'V' Team

Those that didn't attend the High Tea afternoon, we have your certificates and lapel star badges in the office, please pick them up when you're next on duty.

"Every year we celebrate those who achieve milestones in volunteering at the hospital.

We are immensely grateful for their generosity and commitment to volunteering with us. They have given their time freely for many years which is testament to their dedication and reliability and we sincerely hope they continue to enjoy their volunteering with us for many more years to come!

Thank you"

Kathryn Thomson, Chief Executive

and

Doug Charlton, Director of Nursing and Midwifery.

Thank you

Hi Gina, Laura and Jaye

Thank you all for a lovely treat on Friday, the lunch was very nice and the service was fantastic. I have planted the plant in a suitable pot and will take good care of it.

Thank you again for inviting us all to the Volunteer lunch.

Cheers
Anne Headey

"Lots of volunteers have been telling me how much they enjoyed themselves at the lunch last Friday. The room was set up lovely and it helped create a lovely atmosphere. We had a really nice chap sit and talk to us on our table!

I liked us all getting together and meeting each other.

Thank you, it made me feel appreciated and valued."

Paula Talbot

The nice chap Paula is referring to is Tony Okete, Non Exec.

12 June 2017

CQC NEXT PHASE CONSULTATION RESPONSE AND FOLLOW-UP CONSULTATION – ON THE DAY BRIEFING

Today the Care Quality Commission (CQC) has published its response to its recent consultation on its next phase for regulating NHS trusts. NHS Providers submitted a response to the consultation, which was informed by feedback from members and can be found on our website. This briefing summarises the conclusions following the consultation and highlights next steps of relevance to trusts.

Alongside this, a further consultation has been published today which sets out proposals for how the CQC will regulate the other sectors within its remit, but also how it will look to adapt its regulatory approach in response to the emergence of new care models and carry out its role in relation to the fit and proper person requirements. If you have any questions about this briefing or would like to feed into our response to the new consultation, please contact Cristina Sarb, Policy Advisor (Regulation) or Cassandra Cameron, Policy Advisor (Quality).

WHAT HAS BEEN PUBLISHED TODAY?

- The CQC's response to its next phase of regulation consultation
- Updated guidance on how the CQC monitors, inspects and regulates NHS trusts
- Updated assessment frameworks for health care services
- The CQC's second next phase consultation seeking views on:
  - how it will regulates primary medical services and adult social care services
  - how it will monitor, inspect and rate new models of care and large or complex providers
  - how it uses its role to encourage improvements in quality of care in local areas
  - how it will carry out its role in relation to the fit and proper person requirement

OUTCOME OF NEXT PHASE OF REGULATION CONSULTATION

The consultation set out the CQC's approach for regulating NHS trusts going forward and covered all of the elements of the new model including monitoring, inspecting and rating. The main feedback and CQC's response to this feedback is finalised below. An independent analysis of the consultation responses by OPM is also available.

Monitoring: CQC Insight

Feedback: The CQC insight model increase administrative requirements on trusts and asked for reassurance that duplication would be avoided and that existing data would be used as much as possible. The need for transparency and clarity about the data sources and weighting given and how it would work particularly for mental health services was stressed.

CQC's response: The content of CQC Insight will initially focus on existing data collections that are available nationally. CQC will share information with NHS Improvement and discussing with other national partners how to further align or reduce the cost of information collections. It will pilot each Insight product with providers before releasing them to ensure they are clear in terms of the data used, how it is analysed and how it will be shared with

others. Once ready, Insight products will be shared with providers and CQC will be asking for feedback to continuously improve them.

Relationship management

Feedback: Respondents to the consultation called for a clearer, more formal and consistent approach to relationship management and also for the CQC to work more closely with local partners.

CQC's response: Relationship management meetings with providers will be quarterly, with an improved structure and format. The relationship owner will develop an understanding of the organisation and CQC will aim to avoid changing this as much as possible. Relationship management meetings will inform the CQC's regulatory planning.

Provider information requests (PIR)

Feedback: Respondents requested further information about the information to be collected, the timing of PIRs within the new annual process and the IT systems providers will need to use to submit the PIR. Concerns were also raised about the potential for PIR data to be outdated by the time of inspection or duplication with data already submitted to other national bodies.

CQC's response: CQC has now published the new PIR template. Providers will receive their first new PIR between June 2017 and autumn 2018. The PIR marks the start of the annual inspection cycle – with targeted inspections expected within the following six months. Thereafter they will be requested approximately once a year. The intention is to move all provider information collections to the new system by April 2018.

Inspections

Well-led inspection at trust level

The main issues raised in the consultation were relating to the challenge of assessing well-led at trust level in a consistent way, particularly across large providers with different types of services. It was also raised that well-led inspections could be too frequent, could increase administration or duplicate work by NHS Improvement. The CQC will ensure the new approach is evaluated and refined during roll-out, including by further assessing the appropriate frequency and approach to future inspections of well-led at trust level.

Core service inspections

Respondents to the consultation sought clarification about how the CQC will select core services to inspect and what role providers may have in influencing that and also how the regulator will ensure that the scope of inspections will be appropriate to the provider size. The selection of core services will be guided by its frequency principles. **Every year the CQC will inspect all core services rated inadequate; half of those rated requires improvement; a third that are rated good; and a fifth that are rated outstanding.**

In some cases, the CQC will consider giving short notice periods for trusts where it would be logistically challenging for an inspection to be unannounced. However, the default will remain unannounced core service inspections.

Use of accreditation schemes

The CQC will only use an accreditation scheme to reduce its inspection activity in a particular core service if it meets key quality standards and has adequate uptake among NHS providers. This will be considered under the well-led and effective key questions but the absence of accreditation would not limit a rating.

Rating

Feedback: Respondents stressed the importance of transparency, clarity and communication of ratings and how aggregation of ratings takes account of complex providers, services that span different geographical locations or that comprise services of different sizes. The issue of if and how the new use of resources rating will be aggregated was also raised.

CQC's response: The CQC will continue to rate NHS trusts at provider level during 2017/18 based on their assessment of the well-led key question and use aggregation principles and professional judgement of inspection teams to rate the other four key questions. The intention is to rely more greatly on professional judgement in agreeing trust-level ratings for trusts that combine different types of health and care services. The accompanying provider guidance for NHS trusts explains how professional judgement might be used.

Implementation timeframe for the new approach

The consultation document sets out the following timetable for rolling out the new approach:

- **Begin using the new assessment framework and approach from the second half of June 2017 and first new PIRs to be sent out at that point.**
- **First regulatory planning meetings** will take place **from August, the first next phase inspections** will take place **between September and November 2017 and the first next phase ratings and inspection reports** will be **published in early 2018.**
- The minimum inspection activity for an individual provider will be one core service and assessment of the well-led key question (at provider level).
- After the CQC's internal regulatory planning meeting, trusts will be informed of timing of the well-led inspection.
- The CQC is intending to **send PIRs to around a third of NHS trusts by the end of December 2017** and ensure all **NHS trusts receive a new PIR by autumn 2018.** The early trusts will be identified on a risk basis and/or those that have not been inspected in the previous 12 months.
- The CQC is expecting that the new approach will be **fully embedded by spring 2019.**
- Both the initial planning and the final review meetings will be chaired by either CQC's Chief Inspector of Hospitals or a Deputy Chief Inspector to ensure consistency.
- The CQC will retain flexibility to carry out a focused, responsive inspection if concerns arise during the year. **Although it will inspect trusts approximately once a year, this will not be at the same time each year.**
- Following an inspection, the CQC will publish a shorter and more focused inspection report, together with an evidence appendix. These will be quality-assured and factually checked by the provider. After that it will hold an internal final review meeting to ratify the ratings and publish the report.

Revised guidance, assessment framework and PIR template

Alongside the consultation response, the CQC has also published a suite of supporting materials which members will wish to familiarise themselves with, which includes:

- The updated assessment framework for healthcare services, including a version showing changes from the previous frameworks
- The revised provider guidance, which includes the new PIR template

CQC'S SECOND NEXT PHASE CONSULTATION

The CQC has also published a second 'next phase' consultation today which includes proposals that apply to all regulated sectors and encompass how CQC will register, monitor, inspect and rate new models of care and large or complex providers; how CQC aims to encourage improved quality of care in local areas; and the fit and proper person requirement will be applied in this context. These proposals are summarised below.

Part 1: Regulating in a complex, changing landscape

1.1 Clarifying how we define providers and improving the structure of registration

CQC proposes to adapt its current approach to registration to better align with the accountability of organisations for the care they provide, and to better adapt to changing models of care. The proposed changes seek to:

- properly informs the public about ownership of providers, what services are provided, to whom and where;
- clarify who is required to register to improve accountability and responsibility for quality improvement;
- accommodate large and complex organisations to enable a more targeted and responsive regulatory approach;
- restructure registration to build CQC's understanding of services offered, and make it easier to register new organisational forms and innovative types of services.

Key points on changing registration:

- All current providers will remain registered.
- Any related organisations, such as parent companies, will also be registered and appear on the register.
- Where a service changes owners, or a legal entity changes for an existing owner, the regulatory history stays with a service including rating s and enforcement action, including the information available on the CQC website.
- By linking up providers to parent companies, CQC seeks to target regulatory action and recommendations at the appropriate leadership level to enact change and establish the correct accountability for improvement.
- Inspections will be enabled at relevant parent company headquarters where appropriate.
- Reporting on inspections will more explicitly draw links between local services, providers and any overarching leadership entities.
- The CQC register will use information that providers submit in their statement of purpose so that the register available to the public will include information about what type of services are provided, who the service is for, what type of setting it is provided in, where the service can be found and where relevant, how much care is provided.
- The new approach will have implications for the fees scheme, although the CQC does not propose to change the proportion of costs recovered from fees (90%) from providers in 2017/18.

Defining accountability for quality of care:

CQC intends to only 'show interest' in those parts of an organisation that exert significant influence over the quality and safety of services. Criteria for when an entity has responsibility for quality, and so should be registered, include:

- Manages and delivers assurance and auditing systems or processes that assess, monitor and drive improvement in the quality and safety of the delivery of regulated activity and to which entities delivering that activity are accountable.
- Has the right to require providers of regulated activity to submit consolidated annual budgets in advance for approval.

- Has the right of veto such that entities providing regulated activity will only be entitled to carry on their business in accordance with financial plans that have been signed off.
- Directly develops and enforces common policies on matters such as staffing levels, clinical policy, governance, health and safety, pay levels and procuring supplies that must be adhered to by entities providing regulated activity.
- Has the right to make employment decisions concerning people who work in, seeking to work in, run or join the board of an organisation delivering a regulated activity.

Timetable for implementation:

April 2017 to March 2018	Develop, plan and assess the impact of the proposed changes.
April 2018 to March 2019	Start live testing, continue to engage with stakeholders and begin phased implementation.
April 2019 to March 2021	Continue phased implementation and engagement with stakeholders.

1.2 Monitoring and inspecting new and complex providers

In response to increasing number of providers operating across multiple sectors, and new and complex models of care emerging including accountable care organisations and systems, CQC's proposes to use a more 'intelligence-driven' approach to better monitor and inspect 'complex providers', defined as:

> Organisations that deliver services across more than one sector. For example, NHS trusts that provide GP services or care homes, independent community health providers that deliver NHS 111 services, or 'new models' and 'accountable care organisations (ACOs)', such as fully integrated multi-specialty community providers (MCPs) and integrated primary and acute care systems (PACS).

To achieve this, CQC proposes to:

- Identify a single CQC relationship-holder for each complex provider, who will work alongside named leads for each type of service to coordinate regulatory activity for that provider based on combined information about all services provided.
- Align the collection of information from providers and combine monitoring information to inform a single regulatory plan, reviewed annually by CQC, and reduce the number of information requests of providers.
- Coordinate scheduled inspection activity for a complex provider within a defined period, except for any focused inspections in response to concerns about quality in individual services.
- Assessing the 'well-led' domain will encompass leadership and governance across all registered services across the sectors and partnership working, and in any future provider-level assessments in other sectors
- As the legal arrangements underpinning ACS do not change, the regulatory approach will continue to treatment as individual providers. However, the CQC will still seek to test the coordinated approach to planning and inspection scheduling with a small number of accountable care organisations and systems in 2017/18.

Timetable for implementation

April 2017 to March 2018:	• test a coordinated approach to monitoring, inspecting, rating and reporting on health and social care services in a sample of areas, with a focus on evolving ACOs and ACSs • identify relationship holders and introduce joint regulatory planning meetings and joint inspections for existing complex providers

	• begin using provider information collections to identify complex providers and links between services.
April 2018 to March 2019:	• continue using provider information collections to identify complex providers and links between services • test approach with independent health and social care led organisations, alongside live testing of provider-level registration • test approach to provider-level assessment and, if appropriate, ratings for complex providers • agree approach to regulating ACOs and groups of organisations in ACSs.

1.3 Provider-level assessment and rating

CQC will assess the quality of care at 'provider level', meaning:

> The highest level at which CQC register any organisation that delivers more than one service. This would include the board level of an NHS trust or independent sector provider, or the management level of a GP federation or care home group.

Summary of proposed changes:

Subject to the outcome of proposed changes to registration, CQC proposes:

- to continue to rate NHS trusts at provider level in 2017/18 for all five key questions based on assessment of the well-led key question, and aggregation and professional judgement to rate the other four key questions.
- there will be a new provider-level assessment for NHS trusts, corporate providers of health and social care services, large-scale general practices and other complex providers.
- For provider-level assessment for all sectors, CQC sets out a range of possible approaches including:

Option	Assessment framework	New or existing framework?	Ratings	Assessment or aggregation?
1	Provider level assessment	New	One provider rating	Assessment
2	Provider well-led	Existing	One well-led rating	Assessment
3	Provider five key questions	New	Five key questions and overall ratings	Assessment, with aggregation for overall rating
4	Provider well-led	Existing	Five key questions and overall ratings	Assessment for well-led/aggregation and professional judgement

- Assessment will still be made at trust level for well-led and reflected in the trust level rating.
- The provider-level assessment approach will be developed in parallel to the approach to assessing use of resources, which is in pilot phase and will be consulted on later in 2017.

April 2017 to March 2018:	• Consultation on more detailed proposal, informed by the current consultation (Winter 2017/18) • Development of operational approach (Spring 2018).

April 2018 to March 2019:	• Pilot assessments alongside live testing of registration approach • Publish final assessment approach • Begin provider-level assessment in line with registration timetable.

1.4 Encouraging improvements in the quality of care in a place

Recognising that people's experiences of care are affected by how well services work together and that quality can be influenced by factors that are outside a provider's direct control, CQC aims to develop an approach to encouraging improvement, innovation and sustainability in the 'quality of care in a place', meaning:

> The quality of health and social care services within a geographical area and their collective impact on people's experiences and outcomes. For example, the quality of care provided within local clinical commissioning group or local authority commissioning areas, within sustainability and transformation plan areas, or nationally in England.

CQC proposes to:

- use monitoring and inspections of individual providers to assess how well services are working together and to understand the impact on people's experiences of care, by:
  - develop CQC Insight at provider level to include information about quality in local areas and, where relevant, about the quality of a provider's different services
  - use cross-sector risk and planning and scheduling arrangements to identify, share and follow up information about quality in a place
  - develop inspection prompts for hospital, primary medical care and adult social care services that enable CQC to assess the interactions between providers and the impact on people using services
  - report findings about local partnership working and integration in provider inspection reports to highlight cross-system issues
  - develop CQC Insight products to provide a view of quality across national, STP and local commissioning area footprints
  - share information with national partners, local commissioners and other stakeholders, including Quality Surveillance Groups, to help them identify priorities for improvement and agree where further monitoring, inspection or other activity may be required.
- use insight about quality in a place to better understand the context in which providers are working and develop a framework to assess quality across a local system, with a focus on leadership, governance and collaboration between providers and commissioners across sectors.
- undertake a small number of targeted reviews that look at how health and social care work together and identify improvements that build on previous local area pilot reviews by CQC.

Timetable:

April 2017 to March 2018:	• publish findings from reviews in Cornwall and the London Borough of Sutton (Summer 2017) • develop and test prompts to assess integration as part of service-level inspections • continue to develop and test area data profiles • carry out targeted reviews in a small number of areas, as requested by the Secretary of State
April 2018 to March 2019	• continue to developing approach to sharing insight and agreeing action with national and local partners and agree a programme of reviews using section 48 powers, as required

Part 2: Next phase of regulation for medical services and social care

This section sets out CQC's intended direction of travel for adapting regulation for primary medical services and social care in line with ambitions of the GP Five Year Forward View, and the changing landscape of provision for primary and social care including multispecialty community providers and GP federations.

The proposals for primary care and social car include annual online provider self-report submissions on quality, development of CQC insight, targeted re-inspection and modified ratings approach. Where an adult social care service is provided alongside hospital or primary care services within a complex provider, CQC will monitor quality and plan a coordinated inspection schedule as set out in Part 1. Consultation questions in this section will be of interest to members working in multispecialty care provider arrangements.

Part 3: Fit and Proper Persons requirement

This section sets out proposed changes to the way CQC will carry out its role in relation to the fit and proper persons requirement (Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).

Key proposals include changing the way CQC will share with providers any information of concern from a third party about the fitness of a director, specifically:

- Ask providers to assess all the information CQC receive concerning their directors and require them to detail the steps they have taken to assure themselves of the fitness of the director.
- Ask the person providing the information for their consent to do this, and protect their anonymity if necessary.
- Inform the director to whom the case refers, but will not ask for their consent and will not disclose the identity of the person who provided the information.
- Indicate what type of response will be needed from a provider in response to a concern, including assurance that:
  - they have used a fair and proportionate process to establish the primary facts of any matter giving rise to a concern about the director (the investigation stage)
  - having ascertained the primary facts, they have assessed whether the facts establish that the director falls within any of the categories in Regulation 5(3) (the assessment stage)
- If CQC is either concerned that the provider has not applied appropriate checks, or applied appropriate checks but not made a reasonable assessment about fitness of the director, further regulatory activity will be undertaken.

Guidance has also been provided in Annex A of the consultation to assist in interpreting and implementing the regulation in respect of what constitutes 'serious misconduct and serious mismanagement', which we encourage all members to consult.

NHS PROVIDERS VIEW

Responding to the Care Quality Commission's response and the launch of the second phase of consultation, Amber Davenport head of policy for NHS Providers, said:

"These proposals are a vital step in ensuring that the system of regulation for trusts is fit for the future. Trusts are positive about the direction of travel set out and the move to a more risk-based and proportionate regulatory model.

"We welcome the steps taken by the CQC to provide clarity about how and when it will begin to implement the changes which will see the next phase of inspections begin in September 2017.

"However our own findings suggest that the level of burden on trusts from regulation is still too high and the CQC must work with others to align activity and reduce duplication. We therefore urge the CQC to monitor this as it implements the new regulatory regime. We look forward to continuing our work with the CQC on this and facilitating engagement with the provider sector.

"The new regime must be able to respond to the changing way in which we deliver health and social care. Success will depend on having the right level of training for its inspection teams and the resources in place to deliver the right level of inspection activity as set out in the response.

"We therefore welcome the second consultation which seeks views on how the CQC inspects and rates providers that combine a complex mix of services and those involved in new models of care. The CQC must carefully consider each of the options about how it will approach ratings at provider level in the future. Lastly we welcome the CQC reviewing its approach to the fit and proper test and would encourage it to seek feedback from providers about how effectively the test has performed to date."

Contact: Cristina Sarb, Policy Advisor (Regulation) cristina.sarb@nhsproviders.org

Liverpool Women's NHS Foundation Trust

Board of Directors
Committee Chair's report of Finance, Performance and Business Development Committee meeting held 26 June 2017

1. **Was the quorate met?** Yes

2. **Agenda items covered**
   - ~ Month 2 2017/18 Performance Review: The Committee received month 2 2017/18 Performance Dashboard. The Committee noted increased pressure nationally to meet and exceed cancer targets. A briefing paper detailing action to be taken and target achievability to be presented to Trust Board in July, agenda item 2017/196ii. The Committee noted that for month 2, 2017/18 the FPBD indicators remained strong and there was continuing work with the CCG with regard to CQUIN's to agree key deliverables in 2017/18.
   - ~ Month 2 2017/18 Finance Review: The Committee received month 2 2017/18 and noted that at month 2 the Trust was slightly better than plan with an actual deficit of £0.581m against a plan of £0.595m.
   - ~ Cost Improvement Programme (CIP) Update: The Committee received a CIP Tracker Report, noting progress at month 2 and a forward look to month 12. CIP under delivery was noted at month 2. The largest risks to programme delivery were noted as the LCL pathology contract and the Soft Facilities Management contract. Further contract discussions would be held with LCL with an aim to resolve the issues before steps are taken to tender the service.
   - ~ Electronic Patient Record (EPR) Programme Update: The Committee received an update on progress made with EPR programme implementation. The Committee noted the remit and membership of the EPR Implementation Board and the Digital Sub-committee. The Committee will receive a monthly update report going forward.
   - ~ Cyber Attack Executive Review: The Committee received a debrief paper, noting lessons learnt from the cyber-attack incident of Friday 12 May. The Committee were assured that appropriate action had been taken to manage the incident and protect Trust services which led to minimal impact on clinical services.
   - ~ Hewitt Centre Update: The Committee noted that the Hewitt Centre achieved month 2 finance position however continued focus is required to deliver the full year plan. The Committee noted the marketing programme in place to increase demand for services.
     The committee were informed that the Hewitt Centre had achieved accredited provider status for Access fertility, offering financial packages for patients seeking private care. The partnership has been well received and is already producing positive interest and increasing private patient activity.
   - ~ The Committee noted that the Emergency Planning Resilience & Response Committee has reviewed fire evacuation processes and equipment as a result of the recent national coverage. The Committee considered potential risks associated to public safety and the associated financial risks.

3. **Board Assurance Framework (BAF) risks reviewed**
   - ~ Board Assurance Framework (BAF): the Committee reviewed the BAF risks it is responsible for on behalf of the Board and agreed that there would be no amendments.

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4. Escalation report to the Board on FPBD Performance Measures
   ~ Performance target: 62 day wait for first treatment from urgent GP referral for suspected cancer, escalation report to be considered by the Board, July 2017.

5. Issues to highlight to Board
   ~ No items to report.

6. Action required by Board
   ~ To receive the Chairs Report.

Jo Moore, Chair of FPBD

Liverpool Women's NHS Foundation Trust

Board of Directors

Committee Chair's report of Putting People First Committee meeting held 23 June 2017

1. Was the quorate met? No

2. Agenda items covered

- Review of HR BAF Risks
- Staff Experience Story – Finance
- Theatres Service Workforce Assurance Review
- Corporate Service Workforce Assurance Review
- Director of Workforce Report
  (includes Apprenticeship Programme Update and Fit for Future Generations Update on Workforce implications and CIP Schemes)
- Workforce KPI Dashboard Report
- Clinical Excellence Awards 2016
- Analysis of Disciplinary, Grievance & Dignity at Work Cases in 2016
- Workforce Planning, Succession Planning, Retirement Intentions and Singleton Posts
- Bi-annual Safe Staffing Review
- Putting People First Strategy annual review
- Audit of the 2014-17 Nursing & Midwifery Strategy
- Workforce Race Equality Standard (WRES) Update
- Policies approved
  - Recruitment & Selection Policy
  - Volunteer Policy
  - Secondary Employment Policy
  - Attendance Management Policy
  - Grievance Policy
  - Overpayments, Underpayment & Incorrect Payments Policy
  - Study Leave Policy
  - Work Experience Policy

- Sub Committee Chair Reports
  - Education Governance
  - Nursing & Midwifery Board
  - Partnership Forum

3. Risk Register risks reviewed Yes

4. Issues to highlight to Board of Directors

- Shortage of junior doctors - The Committee felt that the national shortage of junior doctors is becoming an increasing risk to the Trust, with significant gaps in rotas, and requires escalation to the Board of Directors for further consideration.

- Theatres Service Workforce Assurance Review – The Committee noted a positive improvement with PDR/training compliance, budgetary control and agency usage within the Theatres workforce. The management team continue to manage a level of risk effectively.

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- Corporate Service Workforce – The Committee noted the increased pressures within the corporate service areas. The Committee requested feedback from the Chief Information Officer with regards to action taken in response to feedback via the Annual Staff Survey. The Committee advised that the Board should consider current shared functions, risks associated and direction of travel as part of the Board Development session in August 2017.

- Workforce Planning, Succession Planning, Retirement Intentions and Singleton Posts – The Committee noted the detailed review into workforce risks. The Committee requested a follow up assurance and mitigation report to address those identified risks, with a particular focus on the introduction of new and expanded roles.

- The Committee noted a successful Maternity Open Day held in June which recruited 25 wte midwives, 6 wte of which are experienced Band 6 midwives.

- Clinical Excellence Awards 2016 – The Committee were assured that the CEA round in 2016 was effectively administered with no identifiable bias or inequity.

- The Committee were assured by the content of the Safe Staffing Review, noting that nurse/midwife staffing levels are safe and appropriate. The Committee noted the risk to headroom allocation within workforce budgets.

- Putting People First Strategy – The Committee noted progress delivered against the PPF Strategy.

- The Committee were advised that the audit of the Nursing & Midwifery Strategy 2014-17 demonstrated reasonable progress in ensuring that the actions outlined in the strategy have been implemented. A new iteration of the Nursing & Midwifery Strategy would be developed this year.

5. Risk Register recommendations

Corporate Risk 1909 - Supply of junior doctors in relation to industrial action was reviewed and proposed that this risk is closed.

6. Key Performance Indicators

Sickness remained high and above target in month (5.17% Trustwide) particularly in maternity (8.22%). The committee were assured that robust management of absence was in place in accordance with the policy and welcomed the increased focus on proactive interventions such as stress resilience training, mindfulness, early referral to occupational health for stress, musculo-skeletal and planned surgery and the mandatory leadership modules for managers.

7. Action required by Board of Directors

1) To approve the closure of Corporate Risk 1909 as outlined above.

2) Escalate risks associated to national junior doctor shortage for Board of Director discussion.

AUTHOR NAME: Tony Okotie

DATE: 23 JUNE 2017

Liverpool Women's NHS Foundation Trust

Board of Directors

Committee Chair's report of Charitable Funds Committee held on 22 June 2017

1. Was the quorate met? Yes

2. Agenda items covered

- Charitable Funds Strategy, Annual Operational Plan 2017/18 & Fundraising Report
- Volunteer Strategy Achievements Paper
- Applications for approval
- Financial Position & Investment Reports 2016/17
- Terms of Reference

3. Risk Register risks reviewed Yes

4. Issues to highlight to Board of Directors

- Annual Operational Fundraising Plan in place with clear objectives for 2017/18
- Strategy discussion focused on a potential fundraising campaign and the resources required to develop and support such a campaign
- Update received on the achievements of the Volunteer Service in the last 12 months and the objectives for the coming year as described in the Volunteer Strategy
- Applications approved
    - Fundraisers salary costs
    - Oncology Fellow research post (gynae oncology)
    - Purchase of Plasmajet Generator for use in ovarian and vulval surgery
- The Committee received the Charitable Funds Income & Expenditure for the year 2016/17 and total funds position as at 31 March 2017, including a summary of investment performance.
- Terms of Reference approved and recommended for Board approval

5. Risk Register recommendations

- Ensure that risk register reflects the risk associated with organisational future and potential impact on public confidence with respect to fundraising and charitable donations.

6. Action required by Board of Directors

- To schedule a Board discussion around future Charity Strategy including identification of risk and mitigation
- To approve the updated Terms of Reference

AUTHOR NAME: Phil Huggon

DATE: 22 JUNE 2017

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Liverpool Women's NHS Foundation Trust

CHARITABLE FUNDS COMMITTEE
TERMS OF REFERENCE

Constitution:	The Board hereby resolves to establish a Committee of the Board of Directors to be known as the Charitable Funds Committee (the Committee)
Duties:	The Committee's responsibilities fall broadly into the following areas: **Charitable Legislation** a. To ensure funds are managed in accordance with the latest legislation and regulations pertaining to charities. **Income & Expenditure** b. To review the fund's performance and ensure all expenditure is in line with the charitable objectives of the fund. **Fundraising** c. To oversee fundraising activities and approve all plans for the expenditure of the fund. d. To receive a periodical and annual fundraising reports. **Investment Management** e. To oversee the performance of the fund managers, compare with peer groups and periodically review the fund management function. **Reports** f. To receive periodical and annual reports regarding fundraising. g. To review and approve Trust Annual Report & Accounts. **Strategy** h. To set the strategy regarding Charitable Funds
Membership:	The Committee membership shall consist of the following: • A Chairman who shall be a Non-executive director • One other Non-Executive Director • Director of Workforce and Marketing • Director of Nursing and Midwifery • Deputy Director of Finance (or nominated deputy) • Financial Accountant 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

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	constitute presence in person at the meeting and count towards the quorum. The Board of Directors will appoint a Non-Executive Director as Chair of the Committee. Should the Chair be absent from a meeting of the Committee, the Committee may appoint a Chair of the meeting from amongst the Non-Executive Directors present.
Quorum:	A quorum shall be three members which must include one Non-executive director.
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 non-executive Chairman shall normally attend meetings. Other Board members shall also have right of attendance subject to invitation by the Chairman of the Committee. The Fundraiser to attend as required at request of the Committee. Other 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 on a bi-annually basis. 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.

Accountability and reporting arrangements:	The Committee is authorised by the Board to obtain independent professional advice or to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary. This includes seeking the advice of specialists from within and outside the NHS as appropriate. The minutes of the Charitable Funds Committee shall be formally recorded and key issues summarised and submitted routinely for the board.
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 Charitable Funds Committee Subcommittee:	22 June 2017
Approved by Board of Directors	
Review date:	June 2018
Document owner:	Colin Reid, Trust Secretary Email: Colin.reid@lwh.nhs.uk Tel: 0151 702 4033

		Agenda Item	**2017/192**
MEETING	**Board of Directors**		
PAPER/REPORT TITLE:	**Serious Incident Report: Quarter 2**		
DATE OF MEETING:	7 July 2017		
ACTION REQUIRED	For Assurance		
EXECUTIVE DIRECTOR:	Andrew Loughney, Medical Director		
AUTHOR(S):	Andrew Loughney and the Governance Team		
LINK TO STRATEGIC OBJECTIVES:	3. To deliver safe services 4. To participate in high quality research in order to deliver the most effective outcomes 5. To deliver the best possible experience for patients and staff		
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Safe:*** *Ineffective understanding and learning following significant events* ***Efficient:*** *Inability to deliver the best clinical outcomes for patients* ***Experience:***	***Effective:*** *Inability to deliver the best clinical outcomes for patients* ***Well Led:***	
WHICH CQC KLOE FUNDAMENTAL STANDARD/S DOES THIS REPORT RELATE TO?	***Safe:*** *1.5 Safe - Reg 20 Duty of Candour* ***Caring****:* ***Responsive:*** *3.1 Responsive - Reg 16 Receiving and acting on complaints*	***Effective:*** ***Well Led:*** *5.2 Well Led - Reg 17 Good Governance*	
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	*NHSI Compliance*		
FREEDOM OF INFORMATION STATUS (FOIA):	1. 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		
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	a) Confirm that in the Committee's view serious incidents are currently being identified and appropriately managed *b)* Provide an opinion as to whether the Committee feels able to assure the Board that there is clear evidence of serious incident investigations making a difference and leading to improvement		
PREVIOUSLY CONSIDERED BY:	**Committee name**	Governance and Clinical Assurance Committee Updated data have been included in this report	
	Date of meeting	15 May 2017	

1. Introduction and summary

The agreed definition of a Serious Incident, both nationally and in the Trust Policy, is: “An accident or incident when a patient, member of staff, or member of the public suffers serious injury, major permanent harm or unexpected death, (or the risk of death or injury), on hospital, other health service premises or other premises where health care is provided and where actions of health service staff are likely to cause significant public / media concern”.

The Trust follows NHS England’s guidance in reporting Serious Incidents and carrying out investigations. This includes uploading all Serious Incidents onto StEIS (Strategic Executive Information System) for external review. Both our local commissioners and our regulators are informed of the Trust’s Serious Incidents and monitor the outcomes.

Internally, Serious Incidents are managed operationally through the Safety Senate and through the Governance and Clinical Assurance Committee.

In many cases it is immediately clear that a serious incident has occurred. If it is not clear whether an incident fulfils the definition of a Serious Incident, the Trust engages in open and honest discussions to agree the appropriate and proportionate response. Both NHS England and our local commissioners recognise that the best position is for us to discuss openly, to investigate proportionately and to let the investigation decide. It is nationally accepted that organisations that report more incidents usually have a better and more effective safety culture.

The report includes serious incident reports completed during the last quarter in addition to recommendations made, lessons learnt and learning shared following root cause analyses. The paper thereby provides an overview of the current status with respect to Serious Incidents in the Trust and seeks to provide sufficient information for the Board’s assurance.

2. New Serious Incidents

In the second quarter of the year, there were seven Serious Incidents declared. Details are embedded in the following table:

SI Ref.	Ulysses Ref	Incident Identification Date	Dept	Steis Date	Summary	Draft Report Due from Division	Date Report Due to CCG
2017-9821	48122	10/04/2017	Maternity	12/04/2017	Retained foreign object post-procedure  SBAR - 48122.docx (Never Event)	27/06/2017	11/07/2017
2017-10333	48007	18/04/2017	Gynaecology	19/04/2017	Failure to diagnose ectopic pregnancy  SBAR W1529550.docx	30/07/2017	14/07/2017
2017-13016	48596	19/05/2017	Neonatal Unit	19/05/2017	Unexpected potentially avoidable injury  SBAR 2017_13016.docx	31/07/2017	14/08/2017
2017-13199	48712	22/05/2017	Maternity	22/05/2017	Medication incident meeting SI Criteria  SBAR.docx	01/08/2017	15/08/2017

2017-13234	48876	22/05/2017	Gynaecology	22/05/2017	Incident indicating existing risk likely to result in significant harm  SBAR W0630108 48876 - updated.doc	02/08/2017	16/08/2017
2017-13440	48917/ 48903/ 48904	22/05/2017	Gynaecology	22/05/2017	Unexpected potentially avoidable death  SBAR 48903 W1457513 (2).docx	02/08/2017	16/08/2017
2017/15940	49506	20/06/2017	Maternity	23/6/2017	Unexpected / potentially avoidable injury causing serious harm  SBAR 49506.docx	04/09/2017	18/09/2017

3. Serious Incidents submitted to the CCG

In the second quarter of the year, six Serious Incident reports were submitted to the CCG, details of which are embedded in the table below:

SI Ref.	Ulysses Ref	Incident Identification Date	Dept	Steis Date	Final Report & Action Plan	Extension Required	Date Report Submitted	Submitted to CCG in initial timescale?
2016-28177	45217	28/10/2016	Neonatal	28/10/2016	 SI Report and Action Plan FINAL.pdf	Yes complex investigation extension agreed	04/04/2017	No

2016-32371	45969	12/12/2016	Maternity	14/12/2016	Final report.pdf	Yes	28/04/2017	Yes
2017-1387 (Never Event)	46466	12/01/2017	Gynaecology	16/01/2017	SI Report and Action Plan FINAL 2017_138	Yes	12/04/2017	Yes
2017-2184	46545	19/01/2017	Maternity	19/01/2017	Final Report .pdf	No	19/04/2017	Yes
SI 2017-1240	46408	10/01/2017	Maternity	13/01/2017	Concise Investigation Report	Yes	17/05/2017	Yes
SI 2017- 3809	46876	05/02/2017	Maternity	7/2/2017	Draft report Final 5 6 17.pdf	Yes Delay of one day caused by mislaid notes	06/06/2017	No

A new system of notes holding and tracking has now been introduced for all cases in which a Serious Incident is called. This includes the electronic uploading of the casenotes, which can be used by members of staff writing statements.

4. Overdue implementation of Serious Incident actions

The following two actions from serious incidents are currently beyond their expected completion date and are being monitored by commissioners for immediate response. A verbal update will be provided to the Board at the time of presentation of this paper.

SI Ref.	Recommendation	Department	Action Description	Progress Narrative	Operational Lead	Management Lead	Root Cause?	Target Date
2016/28164	Process and advice for follow-up phone calls, and escalation if necessary, requires a review.	Gynae	Review follow-up call advice to ensure it include scope for escalation to a consultant	Deadline extended by Governance Team to end July 2017 due to many changes in the senior managers within Gynae nursing leadership. The process has been reviewed and Gillian Walker (Matron) and Chris Webster (Cancer Lead Nurse) are in the final stages of process review and this will be presented to Gynae Division for review / ratification in July	Matron for Gynaecology	Head of Nursing for Gynaecology	No	Apr-17
2016/28164	Patient information and advice given at discharge is general to gynaecology but should include information specifically related to bowel surgery	Gynae	Review discharge information to ensure it includes information specifically related to bowel surgery	Deadline extended by Governance Team to end July 2017 due to many changes in the senior managers within Gynae nursing leadership. Ward Manager Debi Rice leading now since the loss of M Herod. Working with leads at Liverpool Royal hospital to standardise the advice re risk related to bowel surgery to ensure a standardised approach	Ward Manager	Head of Nursing for Gynaecology	No	Apr-17

5. Context

There were twelve Serious Incidents (after de-escalations) in the Trust in the first two quarters of 2016 compared to thirteen in the first two quarters of 2016. The following table shows the trend in Serious Incidents in the Trust the last six quarters:

2015-16	Q4	11
2016-17	Q1	7
2016-17	Q2	5
2016-17	Q3	13
2016-17	Q4	4
2017-18	Q1	6
2017-18	Q2	7

The Trust's **incident reporting** rates have improved significantly in the last year. The latest NHS Improvement NRLS report (published 22 March 2017) shows a focus on the reporting of low and moderate harm. The speed of reporting is also significantly better than the specialist acute trusts despite the higher numbers. Incident Reporting has been included as a key theme on the 2017-20 Quality Strategy.

The sub-committee of the Board with responsibility for Clinical Governance, GACA , has included **Serious Incidents** as a standing agenda item for 2017-18 and has also commissioned deep dives into emerging incident themes.

There is now a greater focus on **immediate actions** following Never Events and Serious Incidents. Wherever appropriate, **PDSA cycles** will be made to enable small scale changes to happen prior to the full investigation being completed.

A focus on the production of **SMART Action Plans** relevant to the Serious Incident being investigated is paying dividends, with evidence of improved safety and learning now coming from this important clinical governance activity. The number of outstanding actions has been reduced significantly.

One of the outcome measures in the Quality Strategy is to achieve a zero level of **Never Events**. The Trust is now proactively auditing against the associated best practice guidance for Never Events and is also monitoring all near misses. Never Events are now a standing agenda at the Trust Safety Senate with themes from across the country scheduled to be discussed as well as local incidents. The Trust Board have overseen the response to recent Never Events and a Never Events Framework is being introduced to aid prevention.

Embedded learning from complaints and incident reporting is on the Clinical Audit Forward Plan for 2017-18. This is not only to confirm that actions in response to incidents and complaints are still in place but also to check that actions have been effective in managing the risks identified.

Excellence Reporting has been introduced at the Trust to encourage sharing of good practice. It is known that we can learn as much from what we do well as when mistakes are made.

Staff and stakeholder engagement events linked to the Quality Strategy will continue so that we can share our planned priorities, target hard-to-reach groups of staff and share good practice. Staff will be key in informing 'how' we deliver our improvement priorities.

6. Conclusion

On 2nd June 2017 a Serious Incidents update was presented to the Board of Directors to provide interim assurance following the occurrence of a small cluster of Serious Incidents in the Trust. The present paper reverts to the scheduled quarterly reporting programme. The Board is asked to confirm that in their view, serious incidents are currently being identified and managed in a timely and appropriate manner.

	Agenda Item	**2017/193**
MEETING	**Board of Directors**	
PAPER/REPORT TITLE:	**National Strategy for Maternity Care - Better Births Community Midwifery Re-design - Update**	
DATE OF MEETING:	7 July 2017	
ACTION REQUIRED	**For Assurance**	
EXECUTIVE DIRECTOR:	Doug Charlton, Director of Nursing and Midwifery	
AUTHOR(S):	Jenny Butters, Acting Deputy Head of Midwifery Fiona Bryant, Acting head of Midwifery	
LINK TO STRATEGIC OBJECTIVES:	4. To participate in high quality research in order to deliver the most effective outcomes 2. To be ambitious and efficient and make best use of available resources	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Safe:*** ***Efficient:*** ***Experience:***	***Effective:*** ***Well Led:*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust*
WHICH CQC KLOE FUNDAMENTAL STANDARD/S DOES THIS REPORT RELATE TO?	***Safe:*** *1.1 Safe - Reg12 Safe care and treatment* ***Caring****:* *2.1 Caring - Reg 9 Person Centred Care* ***Responsive:*** *3.1 Responsive - Reg 16 Receiving and acting on complaints*	***Effective:*** ***Well Led:***
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT (e.g.: NHS Improvement Compliance/E&D/NHS Constitution)	**Operational Plan**	
FREEDOM OF INFORMATION STATUS (FOIA):	1. 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	
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	***To receive the report and note progress***	
PREVIOUSLY CONSIDERED BY:	**Committee name**	Not Applicable Or type here if not on list:

	Date of meeting	

Executive Summary

In February 2016 Better Births set out the Five Year Forward View for NHS maternity services in England. Better Births recognised that delivering such a vision could only be delivered through locally led transformation, suitably supported at national and regional levels. Better Births is the steer for how maternity services should look in the future. The vision is for organisations to work together across Mersey and Cheshire within Local Maternity Systems to implement improvements in services and reduce variation.

Plans to implement the vision in Better Births will include delivery of the following, with the aim and focus of Improving choice and personalisation of maternity services, so that:

- All pregnant women have a personalised care plans.
- All women are able to make choices about their maternity care, during pregnancy, birth and during the postnatal period
- Most women receive continuity of the person caring for them during pregnancy, during birth and thorough the postnatal period
- More women are able to give birth in midwifery settings including home

Liverpool Women's Hospital is a part of the pioneer, early adopter sites for Better Births. This has enabled the service to review, where care is currently being delivered in line with both the local and national agenda. The focus of the service is to move away from traditional split hospital and community based services, to a community and family centred approach, with the introduction of the community redesign

1.0 Introduction

1.1 The purpose of this paper is to provide an update to the Board of Directors about the progress of the redesign of the community midwifery service provided by Liverpool Women's NHS FT.

2.0 A Case for Change

2.1 The community redesign aims to ensure services meet the needs of women and families we serve, providing high quality, safe and effective care. The recommendations from ***Better Births: improving outcomes of maternity services in England*** (NHS England 2016), the report of the National Maternity Review is a key driver in shaping the service going forward.

Other drivers include:

- NHS 5 year forward plan
- CQC recommendations following inspection in 2015
- Current NICE guidance
- Cheshire and Merseyside Women's and Children's Partnership (Vanguard)
- Healthy Liverpool Programme
- Future Generations – Liverpool Women's Hospital
- Early Adopter site status.

2.2 In responding to the recommendations of the National review the community redesign will focus on the following areas:

- Identification of hubs in suitable locations where services can be delivered from including ultrasound imaging, obstetric clinics, antenatal education and other support services such as smoking cessation and other public health message support.
- Increasing the number of community births including homebirth and exploring freestanding birth centres.
- Equitable access to an enhanced midwifery service providing support for vulnerable women experiencing complex health social factors such as perinatal mental health issues, substance misuse and child protection service input.
- Consistency of breast-feeding support across the areas.
- Offering contemporary antenatal education provision tailored to meet the needs of the women and families.

- Examination of the New born provided in a timely manner in the most appropriate setting
- To provide a model of continuity of carer within smaller teams promoting normality in pregnancy and birth whilst also coordinating care for women with additional risk factors.
- Improvement in the Information Technology provision available to community midwives and support workers.
- To reduce variation in the current service provision.

2.3 It is acknowledged the redesign has to take place within the constraints of the current financial position.

2.4 This paper will recommend where possible improvements of quality and choice is delivered through new ways of working and restructuring of existing resources.

3.0 Engagement

3.1 Partnership working is vital to the success of the project, significant work has already been undertaken to engage staff and patients regarding the future changes to the service. Communication will be maintained with key frontline staff and stakeholders throughout the redesign to strengthen the success of the project. Key stakeholders include:

- The Board of Directors
- Clinical director and consultant team
- Senior midwifery team
- Community team
- Outpatient services
- Inpatient maternity service
- Imaging team
- Safeguarding team
- Perinatal mental health team
- Communications team
- Infant feeding support team
- Vanguard and Pioneer team
- Parent education team
- Administrative support team.

3.4 Links have been established with the Clinical Commissioning Groups for Liverpool, Sefton and Knowsley.

4.0 Current Model of Community Midwifery Service

4.1 The service is divided into four teams of Midwives and Maternity Support Workers led by a team leader.

Budgeted establishment:

- 60 x WTE Midwives (Band 6)
- 11.2 Maternity Support Workers (MSW - Band 3)
- 4 team leaders (Senior Midwives – Band 7)

4.2 The existing traditional model offering named midwife care and support during the antenatal and postnatal period including on call provision for women requesting homebirth and those who unexpectedly deliver at home (unplanned home birth).

4.3 The total numbers of bookings across the service is in excess of 10,000 per year (LWH Information Reporting System 2017). At booking the care of women is triaged and booked either into in the high risk antenatal clinic or community venues dependent on risk identified. Recent figures demonstrate a split of 6466 women booked in community venues and 3736 women booked in antenatal clinics located in Crown Street and Aintree.

4.4 <u>Enhanced midwifery team</u>

This team consists of a public health /advanced midwife plus 5.6 WTE Midwives (Band 6) and one externally funded (Sefton CCG) advanced Midwife (Band 7).

4.5 The remit of this team is to provide care to the most vulnerable women. This is enabled by a smaller case load which facilitates home visiting and networking with other services such as safeguarding and perinatal mental health support.

4.6 <u>Home birth</u>

In 2015/16 the planned home birth rate was less than 1 % of the total births. The actual home birth rate was X equating to Y number of deliveries.

5.0 Estates and settings

5.1 Care is currently delivered in a variety of settings including, 17 Children's Centres, 72 General Practitioner practices, health centre environments and women's homes.

6.0 Proposed New Model and progress to date

6.1 Community Hubs

6.1.2 The National Maternity Review (2016) states:-

> *Community hubs should be established where Maternity Services particularly ante and postnatally, are provided alongside other family – orientated health and social services provided by statutory and voluntary agencies'.*

6.1.3 To offer high quality care centred on woman, it is planned to integrate most antenatal clinic bookings into community care. This would require an increase in capacity to book a further 3736 women in community hubs.

6.1.4 Current provision has been reviewed and a number of venues have been identified as potential for future development.

6.2 The venues identified so far are:

6.2.1 St Chads in Kirkby L32 – a robust service is currently in place including, midwifery and consultant obstetrician clinic, imaging and antenatal education provision alongside other community services such as GP's. A meeting is due to take place at the end of June with Knowsley CCG to discuss the possibility of expansion in this building to increase the number of women who can be offered care here. There is currently early discussion relating to the future the possibility of offering community birth here in a freestanding birth room.

6.2.2 Speke Children's centre in L24 - is established as a hub after Liverpool Women's NHS FT investing considerable funding into the building to improve the environment. The service provided includes midwifery and obstetric clinic, imaging, new-born hearing screening and health visitor services. A perinatal mental health support clinic is planned to start in the autumn 2017.

6.2.3 Partnership working with the co-located Children's Centre facilitates many activities for women and families to engage with promoting health and wellbeing and preparation for parenting. Although this is valued by the women and staff who use the facility, the estate is limited and an ongoing review is required to ensure suitability for the future.

6.2.4 Yew Tree L14- is a health centre currently provides midwifery and consultant obstetrician clinics with imaging already in place. The possibility expanding this service is currently being explored with the centre manager.

6.2.5 May Logan Centre for wellbeing L20 –This centre is already established and valued by service users offering midwifery care and imaging supported by the health and wellbeing services provided by the centre. The gap in service provision is a consultant obstetric clinic support. Capacity is also an issue however, the centre manager is confident funding will be available from the CCG to support creation of additional rooms for use by Liverpool Women's Community Midwifery Service.

6.2.6 Liverpool Women's Hospital Crown Street Site – Space will become available for a community hub in Crown Street antenatal clinic with the reconfiguration of the bookings undertaken in the high risk clinic. An example would be that a woman from Widnes who chooses to book at LWH for care could be booked at Speke hub rather than Crown street site. Some of the women booked who have more complex health and social factors will be booked in the hubs and case loaded appropriately whilst having rapid access to consultant obstetric support via referral pathways.

6.2.7 Aintree Hospital site - currently in use for obstetric clinic, imaging and obstetric day unit, this area is being reviewed to ascertain whether services should remain or transfer to St Chads in Kirkby.

4.3 Following a meeting with the Liverpool CCG and Liverpool Council greater partnership working has enabled a review of current and possible future availability of estates within the area which should be cost neutral for health and social care use.

5.0 Reorganisation of Current Midwifery Resources

5.1 Teams – to promote the visibility and accessibility to Midwifery Services the current model of four teams will change and be reconfigured into three teams. This new reconfiguration will align with a model of providing care across three geographical area of Liverpool, Sefton and parts of Knowsley namely Kirkby.

5.2 The planning to realign the current Midwifery resource into three teams from the current four has been completed. These new teams will be further sub divide into smaller teams (4 – 6 midwives as per the recommendations to enable continuity of carer). The new team structure is due to go live in September 2017. Redesign of the current high-risk antenatal clinic model will release Midwives to be redeployed to the community setting and thus increase team numbers. Leadership will be provided by three team leaders. The enhanced midwifery team is being reviewed to ensure its provision is equitable to all women who book for care with LWH FT who have complex health and social factors. This team will be enhanced by the appointment of a senior Midwife (Band 7) Perinatal Mental Health Specialist Midwife due to commence in post in September 2017.

5.3 With additional funding from NHS England the specialist perinatal support team will provide additional clinics in the hubs increasing support for women nearer home; it is envisaged these services will be embedded late 2017. A scoping exercise was undertaken to identify specific groups of women such as the very young and women who require interpretation services to ensure continuity of care for such a diverse group has been considered in the new model of care.

5.4 A job planning exercise is being undertaken to clearly identify resource need meets resource availability which together with reduced travel due to hub working, less duplication of documentation with efficient IT facilities will further enhance the efficiency of the service

6.0 Antenatal Education

6.1 The project aims to bring consistency to the content and delivery of antenatal education, encompassing the whole pregnancy journey including birth and early postnatal period. The current service is being scoped, a new job description formulated and appointment of a bespoke team to provide the education package.

7.0 Homebirth

7.1 The current model of offering women the choice to birth at home relies on Community Midwives undertaking an on call service alongside their normal day duties.

7.2 A proposed homebirth team model offers Midwives the opportunity to work in a different way providing care to women who opt for homebirth. To facilitate continuity of care and carer, the caseloads are small but amount of on call per

midwife is high therefore, when considering this option these factors have to be borne in mind to ensure sustainability of the team.

7.3 In recent years many strategies have been deployed in an effort to increase the homebirth rates. However, the rate has only marginally increased and an alternative to the current strategies is to consider implementation of an early labour assessment at home service. This service would need to be tailored to those women considered suitable bearing in mind any considered clinical risks. This service would enable women to stay at home longer in early labour, reduce repeated admissions in the latent phase of labour and possibly increase the home birth rate. The consultant midwife is pursuing this option looking at both clinical and financial implications.

8.0 Personalised Maternity Care Budgets (PMCB)

8.1 As a national early adopter site, LWH has been asked to undertake a pilot offering women the opportunity to make choices regarding their care using a notional budget. The aim is to recruiting 1800 women on the standard pathway over 2 years. The PMCB commenced in December 2016 and to date over a 100 women recruited to the pilot so far.

8.2 As part of the pilot women are offered a menu of choices over and above the routine schedule of care such as hypnobirthing or extra post-natal feeding support visits, a notional budget is in place and when evaluating the pilot the choices made by women will be costed to determine if current maternity tariffs can support the additional choices offered to women.

8.3 The Pioneer is also considering the recommendation of a single point of access for women to support the implementation of PMCB's, as an early adopter site information regarding our current method of early access for women who book into the LWH maternity service has been provided to the Pioneer team.

8.4 A focus Group for women who are part of the pilot is being organised for late July in LWH and it is anticipated that there will be representation from NHS England. Further details will be circulated when there is further information available.

9.0 Conclusion

9.1 The project is progressing well and within agreed timescales.

9.2 The Board are asked to note good progress.

	Agenda Item	**2017/194**

MEETING	**Board of Directors**	
PAPER/REPORT TITLE:	**Infection Prevention & Control Annual Report 2016-2017**	
DATE OF MEETING:	7 July 2017	
ACTION REQUIRED	**For Assurance**	
EXECUTIVE DIRECTOR:	Dr Tim Neal, Director of Infection Prevention & Control	
AUTHOR(S):	Dr Tim Neal, Director of Infection Prevention & Control	
LINK TO STRATEGIC OBJECTIVES:	3. To deliver safe services 4. To participate in high quality research in order to deliver the most effective outcomes 5. To deliver the best possible experience for patients and staff	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Safe:*** *Inability to achieve and maintain regulatory compliance, performance and assurance* ***Efficient:*** ***Experience:*** *Poorly delivered positive experience for those engaging with our services*	***Effective:*** *Inability to deliver the best clinical outcomes for patients* ***Well Led:***
WHICH CQC KLOE FUNDAMENTAL STANDARD/S DOES THIS REPORT RELATE TO?	***Safe:*** *1.1 Safe - Reg12 Safe care and treatment* ***Caring****:* ***Responsive:***	***Effective:*** ***Well Led:*** *5.2 Well Led - Reg 17 Good Governance*
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT (e.g.: NHS Improvement Compliance/E&D/NHS Constitution)	*NHSI Compliance*	
FREEDOM OF INFORMATION STATUS (FOIA):	1. 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	
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	***To approve the Infection Prevention and Control Annual Report for 2016/17.***	
PREVIOUSLY CONSIDERED BY:	**Committee name**	Governance and Clinical Assurance Committee

	Date of meeting	15 May 2017

Report

Liverpool Women's NHS Foundation Trust

Infection Prevention & Control Annual Report 2016-2017

Dr Tim Neal, Director of Infection Prevention & Control

Contents Page

TABLE OF ABBREVIATIONS

CCG	Clinical Commissioning Group
CPE	Carbapenamase-Producing Entrobacteriaeceae
CQC	Care Quality Commission
DIPC	Director of Infection Prevention and Control
DNM	Director of Nursing Midwifery
HCA	Health Care Act
HCAI	Health Care Associated Infection
PHE	Public Health England
IPC	Infection Prevention & Control
IPCC	Infection Prevention and Control Committee
IPCN	Infection Prevention and Control Nurse
IPCT	Infection Prevention & Control Team
IPS	Infection Prevention Society
LWFT	Liverpool Women's NHS Foundation Trust
MRSA & MSSA	Meticillin Resistant (Sensitive) Staphylococcus Aureus
NLMS	National Learning Management System
NUMIS	Nursing & Midwifery System
OLM	Oracle Learning Management System
RLBUHT	Royal Liverpool and Broadgreen University Hospital Trust
SS	Safety Senate
SSI	Surgical Site Infection
TNA	Training Needs Analysis
TVN	Tissue Viability Nurse

1 Summary of Key Achievements and Main Findings

1.1 Key Achievements 2016/17

The Trust was compliant with the prescribed MRSA bacteraemia target

The Trust was compliant with the prescribed MSSA bacteraemia target

The Trust was compliant with the prescribed C*.difficile* target

The IPCT has extended SSI surveillance

Increased audit has improved cannula care

Compliance with CPE screening has improved

All IPC audits are now reported through NUMIS

1.2 Main Findings

1.2.1 Education

The IPCT has provided 59 other general training sessions in 2016-17 (Including, the use of standard precautions, ANTT and Audit/NUMIS training)

1.2.2 Guidelines

The Trust Infection Control Policy has been reviewed in line with new Trust Policy Process.

1.2.3 Environmental and Clinical Practice Audits

140 (100%) environmental and 356 (96%) Clinical Practice Audits have been completed in accordance with the Trust plan.

1.2.4 MRSA

46 adult patients were identified in the Trust with MRSA, 36 were identified by pre-emptive screening. 4 MRSA infections were identified. 5 neonates were identified with MRSA colonization with no evidence of local transmission

1.2.5 C. difficile

There have been no *C.difficile* infections in 2016-17

1.2.6 Bacteraemia

There have been no MRSA bacteraemias reported in 2016-17

There have been no MSSA bacteraemias 2016-17.

14 neonates had significant Gram-negative sepsis (8 congenital) and 5 neonates had significant Gram-positive infections (4 congenital).

There were 24 E.*coli* bacteraemias in 2016-17 (12 neonates and 12 adults). There is no nationally set target for this infection, although baseline data are being collected.

There were no glycopeptide resistant enterococcal bacteremias in 2016-17

1.2.7 Surgical Site Infection Surveillance

1.7% of elective caesarean sections resulted in a SSI and 2.3% of Emergency Caesarean sections resulted in a SSI.

3.3% of open abdominal surgery resulted in a SSI and 0.3% of Laparoscopic abdominal surgery resulted in a SSI

2 Infection Prevention & Control Team Members

During 2016 - 17 the Infection Prevention and Control Team (IPCT) has been supported by a seconded Midwife, and a seconded nurse.

Miss K Boyd
Infection Prevention & Control Analyst (part time 0.80 WTE - 30 hours/week Infection Prevention and Control Analyst, 0.20 WTE - 7.5 hours/week Policy Officer for the Governance Team)
Mrs D Fahy
Infection Prevention & Control Nurse - (0.60 WTE – 22.50 hours/week)
Dr T J Neal
Consultant Microbiologist – Infection Control Doctor and Director of Infection Prevention and Control (DIPC) (2 sessions / week worked on LWFT site)
Mrs Anne-Marie Roberts
Secondment Link Midwife (0.40 WTE - 16 hours)
Mrs Julie Burns
Seconded Link Nurse (0.40 WTE - 16 hours)

The IPCT is represented at the following Trust Committees:

Safety Senate	Monthly
Clinical Supplies Meeting	Monthly
Infection Prevention & Control	Bi-Monthly
Medicines Management	Bi-Monthly
Nursing and Midwifery Board	Monthly
Water Safety Meetings	Twice yearly
PLACE	Ad-hoc
Building Planning	Ad-hoc

The Team is managed by the Deputy Director of Nursing and Midwifery the budget is managed by the IPCN
There are no Trust costs associated with the infection prevention and control doctor and DIPC.

3 Role of the Infection Prevention & Control Team

The following roles are undertaken by the IPC Team:-

- Education
- Surveillance of hospital infection
    - Surgical Site data collection
    - National bacteraemia data reporting
    - PHE data reporting

- Investigation and control of outbreaks
- Development, Implementation and monitoring of Infection Prevention and Control policies
- Audit
- Assessment of new items of equipment
- Assessment and input into service development and buildings / estate works
- Patient care/ incident reviews

Infection prevention and control advice is available from the Infection Prevention & Control Team and 'on-call' via the DIPC or duty microbiologist at RLBUHT.

4 Infection Prevention and Control Committee

The IPC Committee meets bi-monthly and is chaired by the Director of Nursing and Midwifery. The Committee receives regular reports on infection prevention and control activities from clinical and non-clinical Divisions/departments.

The IPCT report quarterly to IPCC and the DIPC reports quarterly to SS which also receives minutes of the IPCC meetings. The Governance and Clinical Assurance committee (GACA) receives minutes from SS. The Trust Board also receives an annual presentation and report from the DIPC.

Trust IPC issues, processes and surveillance data are relayed to the public via Infection Prevention and Control posters, patient information leaflets, the Trust website (copy of this report) a notice board in the main reception which is updated on a monthly basis and departmental notice boards in ward areas.

Throughout the year many changes in practice have been initiated, facilitated, supported or mandated through the work of the IPCT and IPCC. Some of these are on a large scale, such as input of the IPCT into large capital projects undertaken by the Trust (see section 9.2) however many appear smaller and take place in the clinical areas as a consequence of audit, observations and recommendations. These interventions equally contribute to the provision of clean and safe care in the organisation. The IPCT examined its effectiveness throughout the year. The following detail some of the changes facilitated throughout the year.

- The Infection Prevention and Control team have increased CPE screening auditing across the Trust
- Expanded wound surveillance to include perineal infections.
- Cannula audits are completed fortnightly
- The IPCT have identified that ANTT training is required more frequently this has been agreed at IPCC and ANTT training is being delivered in relevant departments.
- Pool audits are completed fortnightly
- A more formal post discharge surveillance has been established via Meditech, Community midwives and MAU

Although there is progress in some areas, in others significant actions are not addressed in a timely manner

The IPCT has failed to make progress on one ‘non-compliance’ from the Health care act:-

- Provision of surveillance software

5 External Bodies

5.1 Health Care Act & Care Quality Commission

The Health Care Act was published in October 2006 and revised in January 2008 and January 2011 as the Health and Social Care Act. This code of practice sets out the criteria by which managers of NHS organisations are to ensure that patients are cared for in a clean environment where the risk of HCAI is kept as low as possible.

The Health Care Act action plan is a standing item on the IPCC agenda which monitors progress. There is one outstanding standard of the HCA with which the Trust is not fully compliant; (detailed in Appendix A). This relates to surveillance software which is awaiting the implementation of suitable software at the provider laboratory with hope of acquisition by LWFT following this.

6 Education

6.1 Mandatory training and Induction:

Mandatory training in Infection Prevention and Control is a requirement for all Trust staff including clinical, non-clinical staff and contractors. The IPCT update the training package annually and ensure that it reflects best practice, national recommendations and issues identified as non-compliant in the previous year. All staff receive training in infection prevention and control every three years either by face to face or electronic learning and a Hand Hygiene Assessment. The electronic package is incorporated into the NLMS and linked to OLM. Seven face to face mandatory sessions have been delivered in 2016-17

Training continues to be provided by the IPCT for medical staff which includes consultants, trainees and ad-hoc mandatory training for corporate services. Five formal teaching sessions have been delivered by the DIPC throughout 2016-17

Although the majority of mandatory training is delivered by the IPCT team a number of Link Staff also provide training including hand hygiene within their areas.

6.2 Link Staff

The IP&C link staff meetings are held bi-monthly and Professional Development Days held twice yearly. The programme is organised to reflect current initiatives, implementation of new guidance and reinforcement of any non-compliance relating to IPC. Attendance by link staff at the first development day was 45% and 50% of link staff attended the second Professional Development Day. Link staff meetings and professional development days are included in the TNA provision for Link Staff.

6.3 FFP3 Face Fit testing

The IPCT have face fit tested those staff required to wear FFP3 masks following a risk assessment. 9 face fit testing sessions have taken place in 2016-2017.

7 Guidelines/Policies

No new IPC Policies have been required. The existing IPC policy and SOP's have been reviewed in line with Trust policy

- Infection Prevention and Control Policy V6
- MRSA Policy V1
- Clostridium difficile Policy V1
- Diarrhoea SOP V1
- Effective Hand Hygiene SOP V1
- Influenza SOP V1
- Isolation Barrier Nursing SOP V1
- Linen SOP V1
- Personal Protective Equipment SOP V1
- Use and Disposal of Sharps SOP V1
- Wound Infection SOP V1
- Norovirus SOP V1
- Aseptic Non Touch Technique SOP V1
- Urinary Catheterisation and Ongoing Care SOP V1
- Peripheral Cannulation and Ongoing Care SOP V1
- Carbapenemase-Producing Entrobacteriaceae SOP V1
- Management of Blood Bourne Viruses SOP V1
- Management of Hepatitis A and E SOP V1
- Management of Inpatients with Viral Infections SOP V1
- Management of Pulmonary Tuberculosis SOP V1
- Management of Known Suspected or at Risk Patients with CJD or other Human Transmissible Spongiform Encephalopathies SOP V1

8 Audits

8.1 ICNA Trust audit programme

The IPCT continue to use the IPS audit tools originally devised in 2004. The audit programme for the year is established and agreed by the IPCC. All areas are audited annually (low risk areas) or twice yearly (high risk areas) by the IPCT. Clinical practice audits (PPE, Sharps and Hand Hygiene) are completed with a minimum frequency of twice yearly by ward/clinical staff. 5 moments of hand hygiene audits are completed by ward/clinical staff monthly.

The IPS Clinical Practice audits, Saving Lives Audits and monthly 5 moment's audits are entered onto the NUMIS system allowing real-time oversight of results and compliance by local managers. A total of 124 Clinical Practice audits and 232 Hand Hygiene audits have been carried out by department staff and have been reviewed by the IPCT

Environmental audits using the IPS audit tools are carried out unannounced by the IP&C Practitioners and where possible accompanied by a member of departmental staff. A total of 140 Environmental scheduled audits (Including general environment, linen, waste and Kitchen) over 26 clinical areas have been carried out by the IPCT. Individual department

scores, main themes of non-compliance and areas of improvement are recorded and available on NUMIS.

The audit scores (mean and range) are outlined below:

Audit	Mean Score (%)	Range (%)
Ward Environment	90%	78 -100
Ward Kitchen	96%	88 -100
Linen	96%	80 -100
Departmental Waste	99%	94 -100
Patient Equipment	97%	85 -100
Hand Hygiene	95%	91 - 100
Personal Protective Equipment	98%	93 - 100
Sharps safety	94%	80 - 100
Monthly 5 moments	98%	38 - 100

The Community Midwives continue to input a combined self-assessment clinical practice audit of sharps, PPE and hand hygiene twice yearly onto NUMIS. Actions have been discussed with Matron, Team Leaders and the IPCT.

The Trust audit process is on target with the planned timetable.

8.2 Peripheral cannula audits

As outlined in last year's annual report the IPCT continue to audit the ongoing care of cannulae in both Maternity and Gynaecology. The IPC have audited on a fortnightly basis. Scores have ranged from 33 - 100% with a mean score of 91%, insufficient documentation on the VIIAD chart remains an area of concern.

8.3 Mattress audits

Mattress audits are completed in all areas in the Trust. The audit examines cleanliness and mattress integrity. Results are reported through the Divisional Report to IPCC. The audits are forwarded to IP&C Team but local areas have ownership for replacement and condemning of any mattress not fit for purpose. There is a system in place for the provision and storage of replacement mattresses across the Trust. The most recent audit identified a number of mattresses in MAU which require replacing.

8.4 Birthing Pool Audits

Pool audits have been completed on a fortnightly basis by IPCT. Both MLU and Delivery Suite achieved 100% compliance with the cleanliness of the pool at the time of audit. Areas of non-compliance relate to the documentation of the daily cleaning of the pools and before and after patient use. IPCT continue to notify Ward Managers, Matrons and Link staff of audit results.

9 Other Issues

9.1 Water Safety

The water safety group has met in line with its terms of reference. The Trust has recently appointed an Authorising Engineer (water) to support the Water Safety Group, the group will review the Trust Water Safety Plan. Water testing for Pseudomonas aeruginosa in augmented care areas has been performed in accordance with national guidance and

results have been compliant with expected standards. There have been no cases of infection with *Pseudomonas aeruginosa* in the current year.

9.2 Building Projects & Design Developments

Meetings between Estates, Facilities & IPCT have continued. The team remain reliant on the Estates Department and the Divisions alerting and involving the Team in impending projects via the Infection Prevention and Control Committee meetings.

2016-17 projects requiring IPC Team involvement included:

- HSSU / Linen Refurbishment
- Gynae Ward Refurbishment
- Gynae Outpatients Refurbishment

9.3 Waste Contract

The new waste stream / bag system was installed in LWFT in May 2016

10 Surveillance of Infection

Hospital infection (or possible infection) is monitored in the majority of the hospital by 'Alert Organism Surveillance' this involves scrutiny of laboratory reports for organisms associated with a cross infection risk e.g. MRSA, *Clostridium difficile* etc.

On the Neonatal Unit, which houses most of the long-stay patients, surveillance is undertaken by both 'Alert Organism' and by prospective routine weekly surveillance of designated samples. The IPCT examines results of these samples and action points are in place for the Unit based on these results.

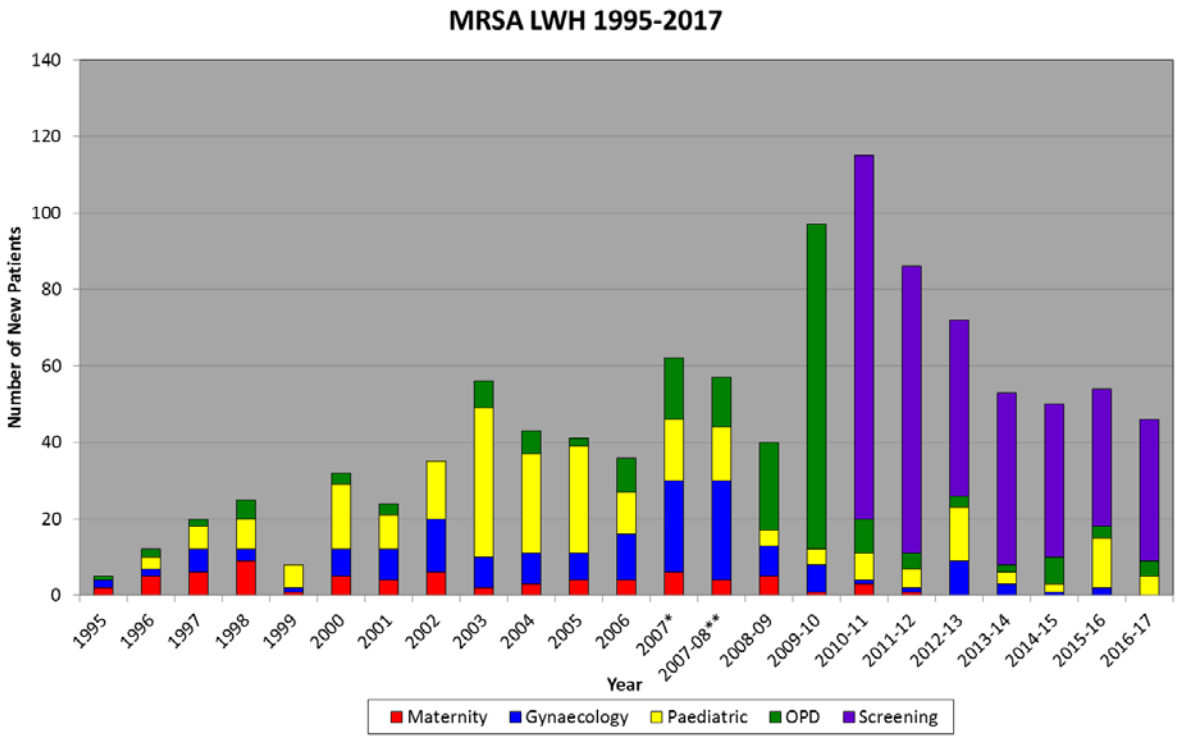
Surveillance of bacteraemias (blood stream infections) for both national mandatory and in house schemes is also undertaken.

The surveillance system for surgical site infections, restarted in 2014 by the IPCT has been extended this year.

10.1 Alert Organism Surveillance

10.1.1 MRSA

The total number of patients identified carrying Methicillin Resistant *Staphylococcus aureus* (MRSA) in the Trust during the year 2016-17 was 46, primarily identified from screening samples. The charts below show the number of new patients identified with MRSA per year for the period 1995 – 2017.



As outlined in previous Annual Reports the Government have established targets for screening such that all elective admissions and all eligible emergency admissions to hospital should be screened for carriage of MRSA prior to, or on, admission. The IPCT have an MRSA screening policy as part of the infection prevention and control policy which outlines actions for patients found to be positive on screening. During 2016-17 the criteria for screening patients for MRSA was modified following consultation with the IPCC and a formal risk assessment, patients attending for day case and ambulatory surgery were excluded from the screening programme.

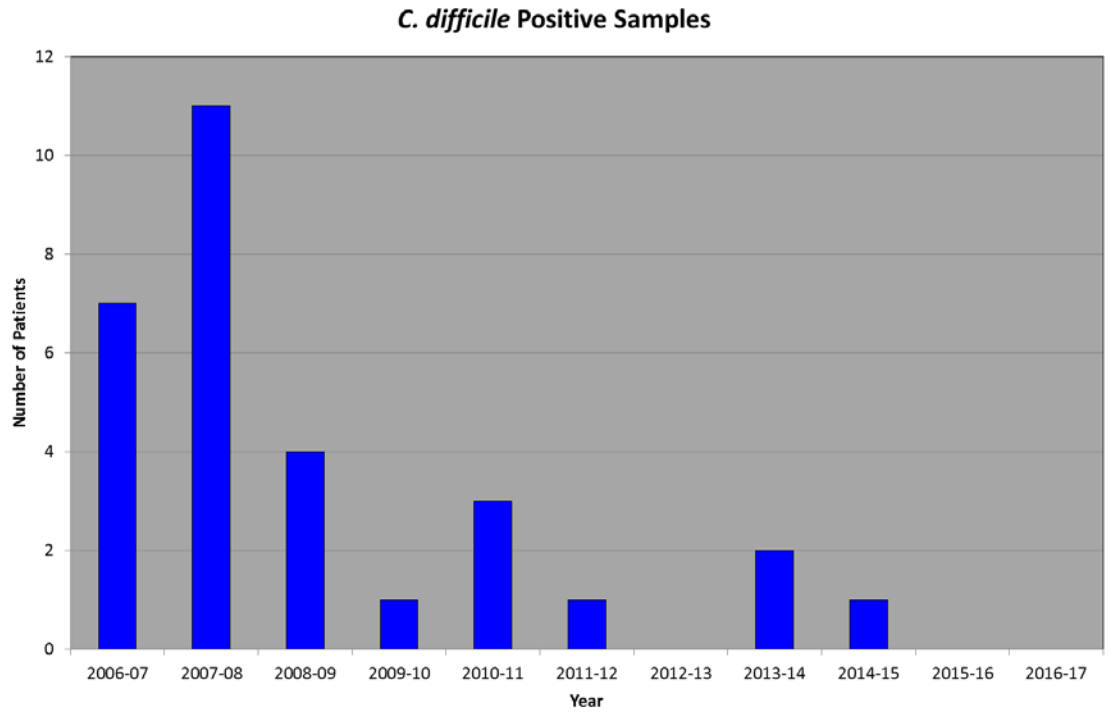
In the period April 2016 to March 2017 6473 adult patients were screened for MRSA carriage. 41 (0.6%) were positive.

Four patients were identified with MRSA wound infections (3 Maternity, 1 Gynaecology) all these infections were identified in clinic after discharge from the hospital.
There were no clusters or other epidemiological linking of adult patients with MRSA infections. There was no evidence of spread of MRSA amongst adult patients in the Trust.
There were no MRSA bacteraemias in adult or neonatal patients in the reported year.

During the period of this report 5 babies were identified with MRSA. There was no identified epidemiological link between the 5 babies and no evidence of spread on the neonatal unit.

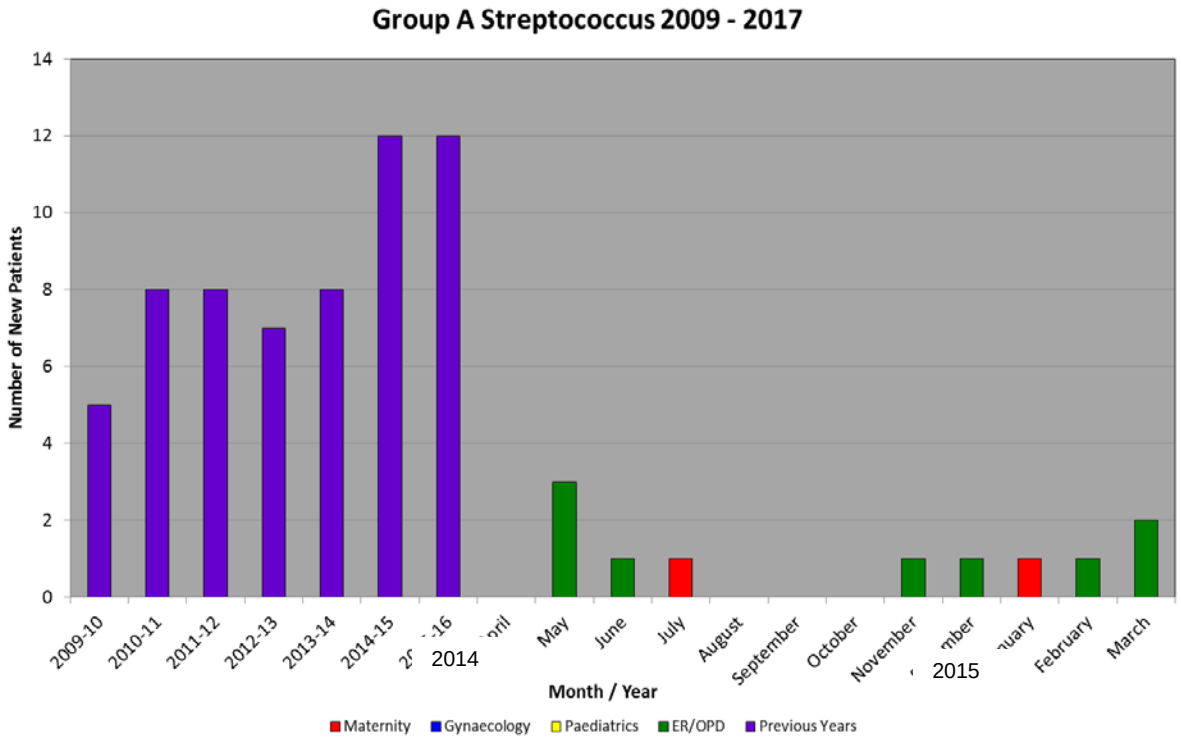
10.1.2 Clostridium difficile

C*lostridium difficile* is the commonest cause of healthcare acquired diarrhoea in the UK. Mandatory reporting of this disease commenced in January 2004 and includes all patients over 2 years old. Historically the number of cases at LWFT has been small (see chart below). During the period April 2016 to March 2017 there were no patients identified with *C.difficile* infection in the Trust.
The prescribed trajectory for this disease for the Trust in 2016-17 was one.



10.1.3 Group A Streptococcus

In the period April 2016 to March 2017, 11 patients were identified with Group A streptococcus as detailed below.



Two of the 11 patients with Group A streptococcal infection were maternity patients, one of whom (January) presented with invasive disease (iGAS). There was no link between the cases. Six patients presented to the emergency room with genital tract infection and the remainder were Gynaecology outpatients. There was no identified transmission of Group A streptococci in the Trust.

10.1.4 Glycopeptide Resistant Enterococcus(GRE)

There were no GRE bacteraemia's reported.

10.1.5 Carbapenemase Producing Enterobacteriaceae

The screening for multidrug - resistant organisms was incorporated into National Guidance and in 2014 LWH commenced screening patients in high risk groups for Carbapenemase producing enterobacteriaceae (CPE). In June 2016 the screening process was extended. All patients who have been an inpatient in any other hospital within the preceeding 12 months require screening. Meditech facilitates the risk assessment. CPE screening compliance is audited weekly by the IPCT
Overall compliance 88%

Month	Screening Compliance
Apr 16- June 16	93%
July 16– Sept 16	89%
Oct 16 – Dec 16	87%
Jan 17 – Mar 17	82 %

The main theme of non-compliance identified has been missed screens on patients who are direct transfers from another hospital. This issue have been addressed with Ward Managers, IPCT Link staff and clinical staff in the relevant areas.

Three patients with CPE carriage have been cared for at LWFT, all 3 were initially identified at neighbouring Trusts.

10.1.6 Routine Neonatal Surveillance

Nearly all infection on the neonatal unit is, by definition, hospital acquired although a small proportion is maternally derived and difficult to prevent. Routine weekly colonization surveillance has continued this year on the neonatal unit. Results are shown in Appendix B

As colonisation is a precursor to invasive infection the purpose of this form of surveillance is to give an early warning of the presence of resistant or aggressive organisms and to ensure current empirical antimicrobial therapy remains appropriate. Action points are embedded in the neonatal unit and IPC policies linked to thresholds of colonisation numbers to limit spread of resistant or difficult to treat organisms.
As well as resistant or aggressive organisms focus has remained on both *Pseudomonas spp*. and *Staphylococcus aureus* as potential serious pathogens. The median number of babies colonized with pseudomonas each week was 1, and with *S.aureus* was 5, both figures unchanged from 2015-16.

1.1 Bacteraemia Surveillance

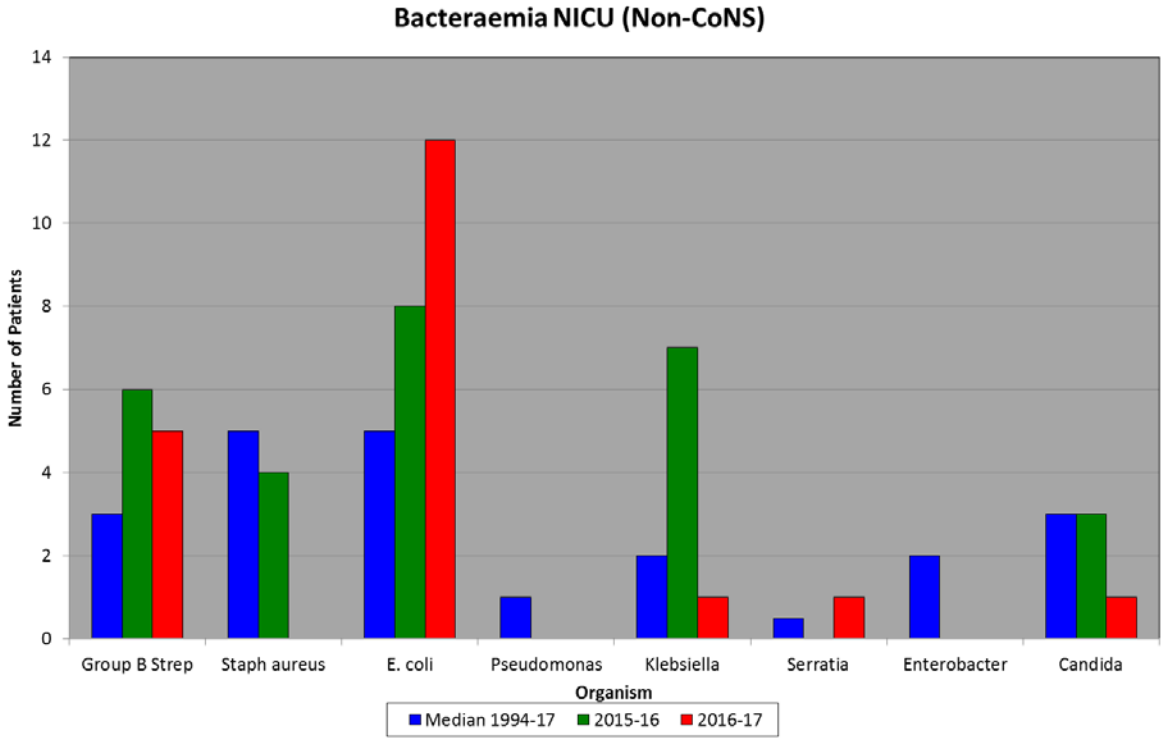
1.1.1 Neonatal Bacteraemia

As always the commonest organism responsible for neonatal sepsis was, the common skin organism, coagulase-negative staphylococcus (CoNS). In the period April 2016 – March 2017 14 babies (15 in 2015-16 and 9 in 2014-15) had infections with Gram-negative organisms, 8 of these infections (all *E coli)* occurred in the first 5 days of life and were congenitally acquired, one *Serratia marcescens* occurred on day 5 and most probably represented a late presentation of congenital infection. The remaining 5 Gram-negative infections occurred after 5 days (1 *Klebsiella sp* and 4 *E.coli*)

There were 5 episodes of infection with significant Gram-positive pathogens; 4 cases were congenitally acquired Group B streptococcus. The remaining case was a late-onset Group B streptococcal infection.

There was one baby in 2016-17 who developed invasive infection with Candida

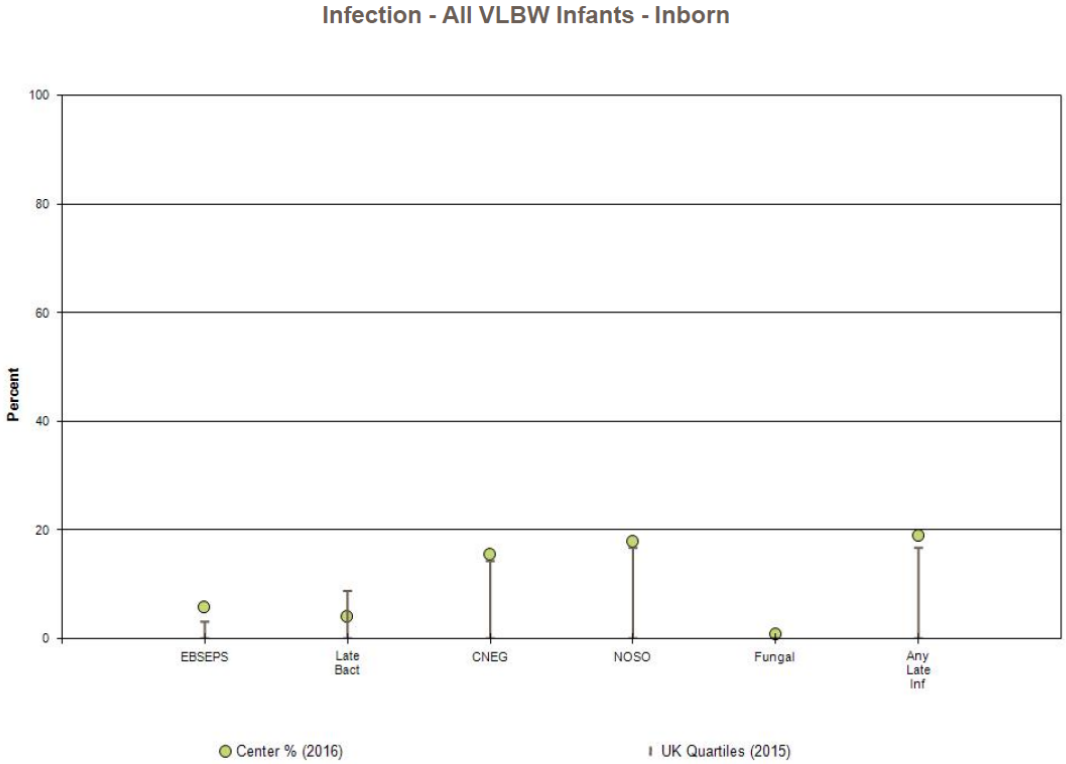
All non-coagulase-negative staphylococcal sepsis on the unit is subject to a review to determine the focus of infection, precipitating causes and the appropriateness of care.
The bar chart below describes the pattern of 'definite-pathogen' neonatal bacteraemia in the current year in comparison to last year and the median value for each organism for preceding years. Although there is considerable variability in the figures from year to year (probably reflecting the complex of pathogen host relationship in this group). The apparent increase in both *S.aureus* and *Klebsiella sp.* Infections noted last year has not been sustained. There have been no *P. aeruginosa* bacteraemias in the last 5 reported years.



12 babies this year had congenital infection (13 in 2015-16, 9 in 2014-15 and 7 in 2013-14) As outlined in last year's work plan review of congenital infections was an identified objective of the IPCT. These reviews have taken place and currently data generated from

the reviews is being analysed with the support of the local PHE epidemiologist to identify trends or actionable interventions.

The Neonatal Unit continues to monitor standardised infection rates. The most recent results (2015, data not finalised) of the benchmarking exercise against other units in the Vermont Oxford network demonstrates that once again infection rates at LWH are at the high end of the expected range.



1.1.2 Mandatory Bacteraemia Surveillance

The IPCT has continued to submit infection data to the national mandatory bacteraemia surveillance scheme. National data are collected on *S. aureus*, (MSSA and MRSA) and *E.coli* bacteraemia.

There have been no MRSA or MSSA bacteraemia cases in adult or neonatal patients in the period April 2016 to March 2017.

E.coli bacteraemia has also been made mandatorily notifiable although targets have not yet been established. In 2016 – 17 the Trust reported 12 *E.coli* bacteraemias in neonates (8 categorised as congenital). In the same period there were 12 *E.coli* bacteraemias in adult patients (10 in 2015-16). The IPCT expect clinical areas to undertake an RCA of all significant bacteraemias to establish any elements of sub-optimal care.

In addition to the mandatory surveillance the IPCT has been collecting clinical data on bacteraemic adults in the Trust; 35 patients were identified with positive blood cultures from 354 cultures submitted (10%). 12 (34% of positives, 3% of total) of these were contaminated with skin organisms. Of 23 significant bacteraemias one was considered to be possibly healthcare associated. Details are provided in Appendix C

10.2 Surgical Site Surveillance

Surgical Site Infection (SSI) is one of the most common healthcare associated infections, estimated to account for 15% of HCAI. National surveillance for abdominal hysterectomy suggests an SSI incidence of 1.5%. There is no national data for caesarean sections

however studies report rates between 2% & 20% with the highest incidence being in emergency sections.

Surgical site wound surveillance in both Maternity and Gynaecology was re-established in 2014/15 to include all abdominal procedures and groin node dissections. In April 2016 wound surveillance extended to include perineal surgical site infections. Data has been collected by a member of the IPCT/TVN using a standard surveillance sheet. Surveillance includes the inpatient period for all patients and the post discharge period until the 30th day.

10.2.1 Maternity

Wound infections are assigned by the time of operation rather than the time infection is recognised i.e. an infection identified in November from surgery in October will be recorded in October's figures.

In the 12 month period April 2016 – March 2017) 2,439 Caesarean Sections were undertaken (1161 elective, 1278 emergency). 69 patients with potential SSI were reviewed with 50 fulfilling the criteria for SSI. Of the 50 infections, 20 were in elective and 30 in emergency cases (1.7 % and 2.3% respectively).

Perineal Surgical Site Infections – 1,343 episiotomies were undertaken, 45 SSI have been identified (3.4%).

10.2.2 Gynaecology

2,141 abdominal procedures were undertaken in the 12-month period in Gynaecology / Gynae oncology with 483 procedures being open and 1658 being laparoscopic. The IPCT/TVN reviewed 44 patients with potential infections. 42 SSI were identified, 16 in open and 6 in the laparoscopic category (3.3% and 0.3% respectively).

The remaining 19 infections were identified in patients undergoing groin or vulval procedures.

As a number of wound infections are diagnosed post discharge, the numbers actually seen by the IPCT are limited at the inpatient period. Some patients who develop infection post discharge will be captured via community notes (although these often take several weeks to return to the Trust) and patients who represent to the Trust. A more formal process of post-discharge surveillance has been established including additional information on Meditech for MAU post-natal attendees and for community midwife patient discharges.

11 Outbreaks of Infection

There have been no major hospital-wide of infection during the period of this report.

12 Health & Wellbeing

The Trust Health & Wellbeing Department report monthly to the IPCC including vaccination updates. Staff have historically been screened for TB, Hepatitis B and Rubella immunity. Guidance on measles, chicken pox, HIV and hepatitis C have been incorporated for all 'new starters' and a catch up exercise is in place for staff already employed. The IPCC supports the Health & Wellbeing Team in ensuring that workers in designated areas have appropriate vaccinations and immunity.

13 Infection Control Team Work Plan

13.1 Infection Control Team Work Plan 2016 - 17

Work Plan	Completion Date	Comments
Training • Continue all Trust mandatory & induction training • Continue to support link staff personal development		Section 6
Audit • Continue with ICNA/IPS Audit Programme • Continue Saving Lives audits including cannulation • Continue monitoring of pool cleaning		Section 8
Surveillance • Continue 'Alert Organism' surveillance focused on resistant pathogens • Continue to monitor cases mandatorily reportable infections • Expand wound surveillance for surgical site infection to include:- - Perineal surgical site infections • Implement actions identified through RCA of bacteremia's and C.difficile infections:- • Commence RCA of congenital infections	April 2016	Section 10 Commenced April 2016 Commenced Oct 2016
Health Act • Review compliance and evidence		Appendix A
NICE • Review compliance and evidence for QS 61 • Review Compliance and evidence for QS 113	April 2016	Baseline assessment performed and partial compliance – awaiting ICNET Complete and Compliant

13.2 Infection Control Team Work Plan 2017 - 18

Work Plan	Completion Date	Comments
Training • Continue all Trust mandatory & induction training • Continue to support link staff personal development		
Audit • Continue with ICNA/IPS Audit Programme • Continue Saving Lives audits including cannulation • Continue monitoring of pool cleaning		
Surveillance • Continue 'Alert Organism' surveillance focused on resistant pathogens • Continue to monitor cases mandatorily reportable infections • Continue wound surveillance for surgical site infection including perineal surgical site infections • Undertake a comprehensive review surgical site infections where figures indicate a rising incidence • Implement actions identified through RCA of bacteremia's and C.difficile infections • Continue to work with external agencies to understand if congenital infection rate rising and any preventable factors • Work with the CCG to deliver their target of 10% reduction in E.coli sepsis.		
Health Act & NICE • Review compliance and evidence • Review and ensure Trust maintains its compliance with current NICE guidance relating to infection, infection control, sepsis and antimicrobial stewardship.		

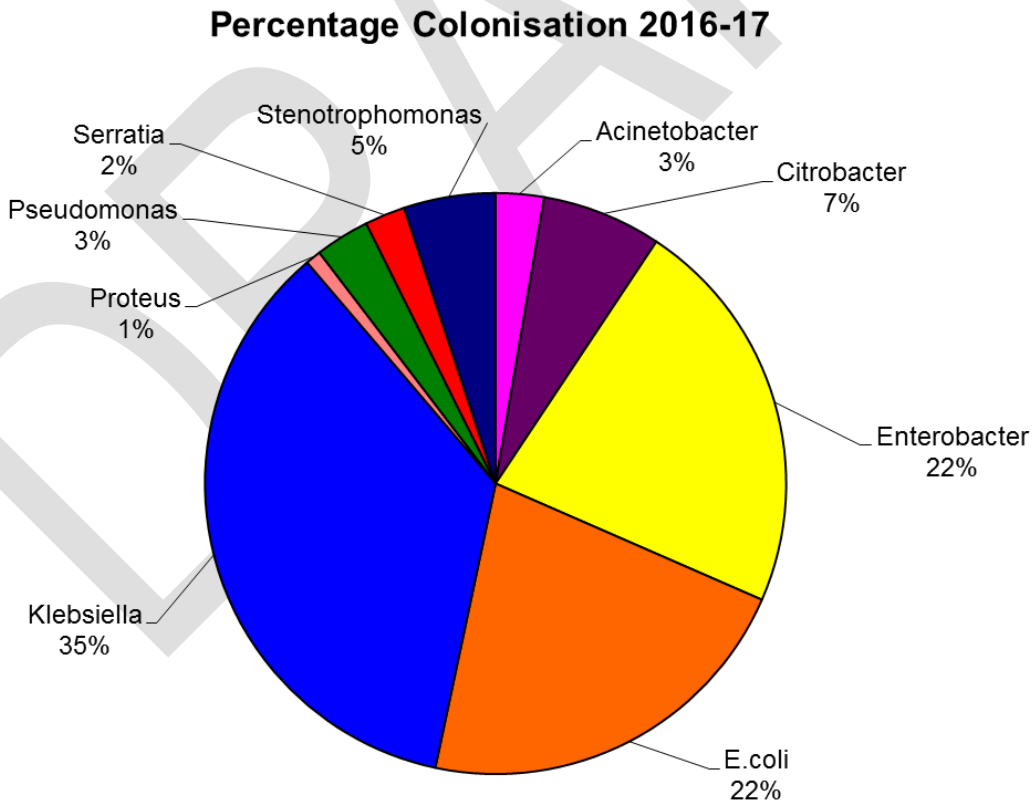
14 Appendices

14.1 Appendix A - Summary of Health Care Act Partial Non-Compliance

Criterion	Additional Quality Elements	Baseline Assurance Jan 17	Update Apr 17	Responsibility	RAG
1.8 An infection prevention and control infrastructure should encompass: In acute healthcare settings for example, an ICT consisting of appropriate mix of both nursing and consultant medical expertise (with specialist training in infection control) and appropriate administrative and analytical support, including adequate information technology. The DIPC is a key member of the ICT		Awaiting implementation at Host Laboratory site prior to implementation at LWFT	Awaiting implementation at Host Laboratory site prior to implementation at LWFT	Director of Nursing / Midwifery / Director of Infection Prevention and Control	Amber

14.2 Appendix B - Neonatal Colonisation Surveillance

	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012-13	2013/14	2014/15	2015-16	2016-17
Acinetobacter	1	1	1	1	2	1	3	3	6	3	3
Citrobacter	3	3	2	4	2	6	6	4	3	4	7
Enterobacter	19	15	12	16	15	21	21	17	14	17	22
E.coli	23	26	29	30	30	23	20	30	27	21	22
Klebsiella	29	34	32	33	31	38	32	34	39	41	35
Proteus	4	1	3	2	4	0	3	1	1	1	1
Pseudomonas	16	14	18	10	9	6	11	5	4	3	3
Serratia	3	4	1	3	4	2	2	2	1	3	2
Stenotrophomonas	2	2	2	1	3	3	2	4	4	7	5



14.3 Appendix C - Adult Bacteraemia Surveillance 2016 - 17

35 Positive blood cultures

12 Coagulase-negative staphylococcus or other contaminant.

23 Pathogens

Directorate	Organism	Potentially Hospital Associated	Likely Source
G*ynaecology*	E.coli	No*	Necrotic fibroid
	E.coli	No*	Pelvic abscess
	E.coli	No*	UTI
	E.coli	No*	UTI
	Raoultella planticola	No	Pelvic malignancy
Maternity	*E.coli*	No*	Peripartum
	E.coli	No	Retained products
	E.coli	No*	UTI
	E.coli	No*	Peripartum
	E.coli	No*	UTI
	E.coli	No*	UTI
	E.coli	Yes	Peripartum
	E.coli	Awaiting review	Peripartum
	Bacteroides	No	Retained products
	Group B streptococcus	No	Chorioamnionitis
	Group B streptococcus	No	Peripartum
	Group B streptococcus	No*	Peripartum
	Group B streptococcus	No*	Peripartum
	Group B streptococcus	No	Chorioamnionitis
	Group B streptococcus	No	Peripartum
	Group B streptococcus	Awaiting review	Peripartum
	Group B streptococcus	Awaiting review	Peripartum
	Group A streptococcus	No*	Peripartum

*Community Acquired

		Agenda Item	**2017/195**
MEETING	**Board of Directors**		
PAPER/REPORT TITLE:	**Bi-Annual Nursing & Midwifery Staffing Report June 2017**		
DATE OF MEETING:	7 July 2017		
ACTION REQUIRED	**For Assurance**		
EXECUTIVE DIRECTOR:	Doug Charlton, Director of Nursing and Midwifery		
AUTHOR(S):	Doug Charlton, Director of Nursing & Midwifery		
LINK TO STRATEGIC OBJECTIVES:	1. To develop a well led, capable motivated and entrepreneurial workforce 5. To deliver the best possible experience for patients and staff		
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Safe:*** ***Efficient:*** ***Experience:***	***Effective:*** ***Well Led:*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust*	
WHICH CQC KLOE FUNDAMENTAL STANDARD/S DOES THIS REPORT RELATE TO?	***Safe:*** *1.4 Safe - Reg 18 Staffing* ***Caring****:* ***Responsive:***	***Effective:*** ***Well Led:***	
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT (e.g.: NHS Improvement Compliance/E&D/NHS Constitution)			
FREEDOM OF INFORMATION STATUS (FOIA):	1. 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		
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	1. Accept the report as assurance of safe nurse/midwife staffing levels 2. Note the content of the mid-year report and the assurances provided staffing levels are safe and appropriate 3. Note the risk of the headroom allocation within workforce budgets and agree to ongoing monitoring through the operational performance metrics and subsequent workforce reviews.		

PREVIOUSLY CONSIDERED BY:	Committee name	Not Applicable
	Date of meeting	

Executive Summary

Following the Francis report, the National Quality Board (NQB) published guidance that set out the expectations of commissioners and providers for safe nursing and midwifery staffing, in order to deliver high quality care and the best possible outcomes for patients. This was followed by the NICE guidance Safe staffing for nursing in adult inpatient wards in acute hospital (July 2014) and Safe midwifery staffing for maternity settings (Feb 2015). NICE recommended their guidance is read alongside that of the NQB guidance.

In June 2015 the Chief Nursing Officer for England confirmed that there would be changes to the safe staffing agenda for all care settings going forward. She emphasised the importance of the NQB expectations and NICE guidance but explained safe staffing would now be led by NHS Improvement who would work closely with NICE, CQC and Sir Robert Francis, to ensure there is no compromise on staffing and its impact on patient safety.

The Lord Carter Review (2016) highlights the importance of ensuring that workforce and financial plans are consistent in order to optimise delivery of clinical quality and use of resources. The review described a new nursing workforce metric to be used (Care Hours per Patient Day (CHPPD) along with a model hospital dashboard.

LWH reports the following in line with the NQB recommendations:

- 6 monthly Trust Board report re: Bi Annual Nursing & Midwifery Staffing Review
- Board level report detailing planned and actual staffing for the previous month.
- Monthly report published on the Trust's website, and uploaded onto NHS Choices website
- Nursing/Midwifery staffing levels each shift (planned and actual) displayed at ward level

This report outlines the changes taken place in the last six months to assure appropriate safe staffing levels:

- The changes required on Mat Base to bring it back to an appropriate level of safe staffing
- Maternity Staffing ratio currently stands at 1:30 within a nationally accepted level
- The increase in theatre staffing following the internal review and increased capacity
- Additional Advanced Nurse Practitioners in Gynaecology Emergency Department (GED)
- Neonatal staffing remains close the nationally recognised BAPM standards
- Proposed alteration to the supervisory status for Ward managers
- Incentive of £50 per shift for additional Midwifery Bank shift for three months on 1st floor

1.0 Introduction and summary

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

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

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

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

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

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

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

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

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

4.0 Fill rates

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

5.0 Summary of Outcomes from Bi annual review

5.1 Gynaecology Services

5.2 Staff turnover within the Division remains at 15% against a Trust target of 10%; the Division will be undertaking further work to determine whether there are any specific themes or trends associated with this pattern.

5.3 Actual staffing levels (fill *rates – planned v actual*) are monitored by each shift. Where fill rates are below 100% an assessment is made of the patient acuity and bed occupancy to ensure safe and effective care can be delivered. During the review period staffing ratios have not exceeded the recommended 1:8.

5.4 A review of theatre activity and productivity was undertaken within the gynaecology service. The project resulted in an increase in 3 theatre sessions per week. This resultant increase in capacity has required an increase in staff requirements of an additional 3.2 WTE. These posts have been fully funded and are in the recruitment process. Recruitment to vacancies within theatres remains problematic and the Division is working alongside HR to consider alternative ways of recruitment. In the interim safe staffing levels are maintained by staff working additional hours and by the use of bank and agency staff.

5.5 Within the Gynaecology Emergency Department (GED) a serious incident was reported last year and escalated to StEIS and investigated in accordance with national requirements. Following the investigation a full review of the departmental requirements was undertaken and this included consideration of the medical staffing model and options for service delivery. Whilst this model has yet to be fully approved there is recognition that additional investment in the nursing model may be required. GED staffing needs a deep review which is planned for later this year and will be undertaken by the new Head of Nursing and Matron.

5.6 The shortage of junior doctors means more patients are breaching the 4 hours target, although still within limits the pressure is increasing. The service created and trained 3 Advanced Nurse Practitioners (ANP) to facilitate treatment decisions to support junior doctors. Currently these staff posts have not been backfilled so whilst some of the pressure on the Junior Doctors has reduced, this has been at the cost of the nursing hours. The Clinical Director and the Head of Nursing are working to resolve this issue by investigating how the medical budget can support these roles; this will enable backfill of the nursing posts.

5.7 In addition, succession planning for the ANP roles is required, but, without investment in the training of more nurses into Advanced Nurse Practitioners the service will remain vulnerable to staff losses. There is staff within the Division suitable and willing to undertake career development.

5.8 GED activity is increasing year on year, the demands on the service are not evenly spread throughout the 24 hours period, and approximately 60% of all attendees to the department come between 3pm and 11pm. A recent analysis of the activity demonstrated a double peak for demand at 5-6pm and 9-10pm in the evening, investment in a mini-shift for nurses to work 5-10pm would reduce risks, reduce 4 hours breaches, reduce waiting times and improve patient experience. The Head of Nursing is currently investigating the resource implication for this change in. practice

5.9 A new leadership model with greater emphasis on visible clinical leadership is being introduced across gynaecology; an additional matron post has been created to improve nursing leadership across the division.

5.10 Gynaecology Division is heavily dependent on specialist nursing roles, nurse Colopscopists / Hysteroscopists / Consultant Nurses and Advance Nurse Practitioners. There is a planned review of all these roles to evaluate the potential expansion and the creation of succession plan to train the next generation of Nurse Specialists.

6.0 Maternity Services

6.1 Birth-rate Plus® (BRP) recommendations a ratio for midwifery staffing of 1:28. Current activity and staffing levels within our service indicate a ratio of 1:30

Midwife to Birth Ratio					
Dec 16	**Jan17**	**Feb17**	**Mar 17**	**Apr 17**	**May 17**
1:27	1:27	1:29	1:28	1:29	1:30

6.2 Staff pressures have been noted on Maternity Base through the recent months. This was exacerbated by the reduction in the number of staff allocated to the clinical area per shift by the previous acting Head of Midwifery. This has now been rectified and work is on-going to provide support to ensure sufficient staff resource is made available for the acuity and volume of patients moving through this area.

6.3 The monitoring of Quality Metrics within maternity service including the measurement of 1:1 care in labour, are reported and monitored through the Board Performance Framework to triangulate care delivery with staff allocation.

7.0 Neonatal Services.

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

7.2 In June 2016 there were identified pressures on staffing levels associated with an unprecedented number of staff taking maternity leave. Many of those staff have now returned or are in the process of returning over the next few months (currently 9 staff on maternity leave), the number of additional shifts required to support the reduction in staff numbers has reduced as the staff return to duty return and new staff gain their competencies. Since January 2017 the unit has only been closed on 10 out of 302 shifts due to staffing (last minute sickness), there has been no further cots closures reported due to staffing issues.

7.3 Additional contract negotiations enabled the additional recruitment of 16.6 WTE registered staff that commenced in post through October and November. However due to a number of unexpected staff leavers the establishment remains just below the whole time equivalent (WTE) required for the commissioned BAPM staffing at 80% occupancy (- 9 WTE) This will be addressed during the next recruitment for Band 5 staff which commenced June 2017.

8.0 Genetics

8.1 There continues to be a significant increase in referrals into the service over the last 2 years in particular with issues relating to BRCA gene alterations. This is under constant review to understand potential implications for service. The workforce profile of the Genetic Counsellors team indicates 40% of the workforce is able to retire in the next 3 years. Due to training requirements to undertake this role and portfolio requirements for registration, proactive recruitment, and a succession plan is in development to prevent the predicted skills and knowledge deficit.

8.2 **Ageing Workforce and a national shortage of Experienced and Qualified GCs** – All new vacancies are reviewed in line with the needs of the service and as a nationally accredited training centre we will continue to take funded STP (Medical) trainees annually. Alongside

this, substantive posts at band 6 are offered until registration with the Genetic Counsellor Registration Board is achieved. The training requirement is significant but planned and deliverable, providing replacement of senior staff with appropriately experienced individuals. Succession planning is accommodated within the current team.

9.0 Hewitt Fertility Centre (HFC)

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

10.0 Quality & Safety

10.1 In addition to the collection of data relating to acuity and dependency of patients and associated staffing levels, a review of triggers which may raise concern is undertaken on a more regular basis.

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

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

11.0 Supervisory Ward Managers

11.1 In line with the Francis Inquiry recommendations all ward managers continue in their supervisory status. However, to ensure there is greater visibility of ward managers a change to the fulltime status of ward managers is being proposed. All ward managers will retain

supernumerary status on three of their working days and the remaining two days will be utilised working with staff to ensure senior nursing/midwifery presence on the floors. This provides an opportunity for the ward managers to fully appreciate the workloads and challenges their staff face. It also provides time to work with individual members of staff and students to ensure direct observation of the quality of care delivered.

12.0 E Roster

12.1 The Trust is currently rolling out an electronic roster system in all clinical areas. This will help ensure efficient and productive rotas are produced in line with the Lord Carter review recommendations. Currently, there are a small number of clinical areas still needing to be placed on to the e-roster system, namely Genetics Service and the Hewitt Centre. It is anticipated these services will be added to the electronic roster system later in the year.

13.0 Temporary Staffing (Bank)

13.1 Due to the recent review of Midwifery numbers across the 1st floor and the identification there will be limited midwives to ensure adequate staffing through the summer months the trust took direct action. The executive agreed and put in place a three month incentive plan to attract our own staff to work additional bank shifts to cover where vacancies had arisen through short term sickness, annual leave or maternity leave. All Midwives willing to work an additional bank shift across the 1st floor is being offered an incentive of an additional £50 per shift.

14.0 Headroom

14.1 The current headroom uplift across the organisation is 18.9%. This is lower than peers and lower than existing recommended workforce tools, (see table below).

14.2 There is a concern this lower level of additional uplift is insufficient to support the continued demands for staff to achieve their training requirements and to cover the amount of maternity leave in this female dominated profession.

14.3 In light of emerging mandatory training requirements for midwives and nurses through national guidance and local contracting, further Training Needs Analysis reviews will be conducted and reported through the bi-annual workforce reviews to provide ongoing assurance staff are equipped with the right skills to deliver safe and effective clinical services.

14.4 The headroom uplift will be kept under review to ensure it is at the correct level to support all clinical activities.

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

15.0 Recruitment and Retention

15.1 Nursing and Midwifery recruitment and retention is part of the overall trust people strategy. There is currently a limited availability of quality candidates applying for post at the trust and therefore it is anticipated work will need to be carried out by the Divisions to consider how they will manage the existing challenges to both recruitment of appropriate nursing and midwifery staff. Divisions also need to consider the how to retain the highly skilled workforce in post. Following the recent Brexit vote to leave the European Union the Nursing and Midwifery Council (NMC) has seen a major reduction of 96% in European nurses applying for registration. This reduction will have a major impact on the available pool of nurses from which to recruit. Midwifery is not similarly affected by this change as most midwives are trained here in the British Isles. However, the source of high quality Midwife applicants is not guaranteed. Liverpool Women's Hospital attracts many newly qualified Midwives who need to consolidate their practice before moving on to other units. This has the effect of adding extra responsibility to the more experienced Midwives to ensure further learning is achieved and to provide advice and training to their more junior colleagues. It is important provide the right environment and incentives to retain these midwives and build a talent pool of experience from which to draw for the most senior roles in the trust.

16.0 Conclusion

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

17.0 **Recommendations**

17.1 Putting People First Committee is requested to:

- Accept the report as assurance of safe nurse/midwife staffing levels
- Note the content of the mid-year report and the assurances provided that nurse/midwife staffing levels are safe and appropriate
- Note the risk of the headroom allocation within workforce budgets and agree to ongoing monitoring through the operational performance metrics and subsequent workforce reviews.

Appendix A

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

CHPDD= Total number of registered and unregistered staff hours
Number of occupied beds at 23:59hrs

	Registered Midwives/Nurses				Care Staff				Overall			
	Jan-17	Feb-17	Mar-17	Apr-17	Jan-17	Feb-17	Mar-17	Apr-17	Jan-17	Feb-17	Mar-17	Apr-17
Gynaecology Ward	3.9	4.5	4.4	5.2	2.6	2.7	2.6	2.8	6.5	7.2	7.0	8.1
Delivery & Induction Suites	29.0	27.3	26.8	30.9	5.1	4.2	4.5	5.6	34.1	31.5	31.3	36.5
Maternity Base	3.6	4.2	3.9	4.2	2.0	2.3	2.1	2.2	5.6	6.5	6.0	6.4
MLU & Jeffcoate	31.2	29.7	31.4	35.9	5.4	5.7	5.7	6.5	36.7	35.4	37.0	42.4
Neonates (All)	10.8	11.5	10.4	9.6	0.7	0.8	0.8	0.5	11.5	12.3	11.2	10.1

Appendix B

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

Safer Staffing Fill Rate - Gynaecology					
		Day		Night	
	Ward name	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
Dec-16	Gynae Ward 1	100.0%	111.1%	98.4%	103.0%
	Gynae Ward 2	93.3%	90.0%	98.8%	96.8%
	Gynae Total	95.8%	98.8%	98.6%	99.9%
Jan-17	Gynae Ward	97.7%	99.9%	100.0%	106.6%
Feb-17	Gynae Ward	96.6%	97.2%	95.8%	95.9%
Mar-17	Gynae Ward	98.4%	95.0%	100.0%	100.0%
Apr-17	Gynae Ward	100.0%	83.3%	99.0%	96.5%
May-17	Gynae Ward	100.7%	100.0%	100.0%	100.0%

Safer Staffing Fill Rate - Maternity					
		Day		Night	
	Ward name	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
Dec-16	Induction&Delivery Suites	87.0%	123.0%	85.0%	84.0%
	Maternity Base	93.0%	85.0%	87.0%	96.0%
	MLU & Jeffcoate	77.0%	50.0%	78.0%	52.0%
	Maternity Total	86.2%	85.7%	83.8%	80.2%
Jan-17	Induction&Delivery Suites	88.2%	106.5%	89.0%	93.4%
	Maternity Base	86.7%	83.2%	84.3%	94.6%
	MLU & Jeffcoate	90.9%	93.5%	88.7%	93.5%
	Maternity Total	88.3%	90.3%	87.8%	94.0%
Feb-17	Induction&Delivery Suites	87.2%	114.3%	91.4%	67.9%
	Maternity Base	98.5%	84.3%	98.8%	73.2%
	MLU & Jeffcoate	80.4%	100.0%	90.3%	96.4%
	Maternity Total	88.5%	93.8%	92.8%	74.1%
Mar-17	Induction&Delivery Suites	85.4%	111.3%	91.4%	79.6%
	Maternity Base	97.7%	78.7%	100.0%	92.5%
	MLU & Jeffcoate	84.4%	93.5%	88.7%	93.5%
	Maternity Total	88.2%	88.7%	92.7%	87.1%
Apr-17	Induction&Delivery Suites	89.6%	108.7%	93.3%	89.7%
	Maternity Base	95.1%	80.0%	98.3%	88.9%
	MLU & Jeffcoate	87.2%	96.7%	89.4%	96.7%
	Maternity Total	90.4%	90.0%	93.6%	90.3%
May-17	Induction&Delivery Suites	85.7%	121.0%	90.5%	83.9%
	Maternity Base	95.4%	84.5%	98.9%	67.7%
	MLU & Jeffcoate	83.9%	96.8%	80.1%	96.8%
	Maternity Total	87.6%	95.2%	90.1%	77.4%

Safer Staffing Fill Rate - Neonatal Care					
		Day		Night	
	Ward name	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
Dec-16	Neonatal Care	103.8%	51.6%	99.8%	51.6%
Jan-17	Neonatal Care	106.5%	66.1%	106.0%	50.0%
Feb-17	Neonatal Care	104.5%	73.2%	105.4%	48.2%
Mar-17	Neonatal Care	104.4%	74.2%	105.4%	51.6%
Apr-17	Neonatal Care	105.4%	55.0%	107.3%	41.7%
May-17	Neonatal Care	109.7%	56.5%	109.9%	38.7%

Achievements against National Quality Board Expectations

Expectation	What does this mean in practice?	LWH Position – June 2017
1. Boards take full responsibility for the quality of care provided to patients, and as a key determinant to quality, take full collective responsibility for nursing, midwifery and care staffing capacity and capability.	Includes all aspects of board reporting and monitoring of establishments, actual and day to day staffing levels Emphasis on hours monitoring included as part of the NICE guidance and the requirements for uploading information to NHS Choices	In place – Monthly Board report which includes NHS Choices monthly submission. Visible on Trust Website and 6 monthly staffing establishment reports presented to Trust Board each year.
2. Processes are in place to enable staffing establishments to be met on a Shift to Shift basis.	Executive team should ensure that policies and systems are in place, such as eRostering and escalation policies.	In place – daily monitoring through staffing meetings within Divisions and Trust wide. eRostering in place for all in patient areas. Escalation policies in place for use of temporary staffing solutions with Head of Nursing/Midwifery.
3. Evidence based tools are used to inform nursing, midwifery and care staffing capacity and capability.	Use of proven methodologies and triangulation with professional judgement for setting staff levels	In place – Benchmarking, Safer Nursing Care Tool, NICE guidance and professional judgement utilized as part of the 6 monthly staffing reviews.

4. Clinical and managerial leaders foster a culture of professionalism and responsiveness where staff feel able to raise concerns	Encourages working in well-functioning teams supported by appropriate infrastructure and support model. Requires an open culture to report shortfall. Staff side organizations have a role.	In place – incidents received, monitored and themed monthly. Staff encouraged to report via Ulysses system any concerns relating to staffing

Expectation	**What does this mean in practice?**	**LWH Position – June 2017**
5. A multi-professional approach is taken when setting nursing, midwifery and care staffing establishments	Heads of Nursing/Midwifery lead the process of reviewing staffing requirements and ensure that: There is a process in place which actively involves Matrons, Ward Managers and team leaders. They work closely with Finance, Workforce (HR) and Operations. Recognising interdependencies between staffing and other aspects of the organization's functions.	In place – Deputy Director of Nursing monitors safe staffing. All requests for additional staffing are reviewed by the entire Executive team every Thursday.

6. Nurses, midwives and care staff have sufficient time to fulfil responsibilities that are additional to their direct caring duties	Recommendation on adequate Headroom (no percentages stipulated) Recommendations on supervisory time for ward leaders (no time stipulated)	In place – headroom included in all budgeted staffing levels for wards at 18.9% exclusive of Maternity Leave. Supervisory ward leader model is in place trust wide. Currently under review to establish great visibility of Ward Managers.
7. Boards receive monthly updates on workforce information, staffing capacity and capability is discussed at Public Board meeting at least every 6 months on the basis of full nursing and midwifery establishment review.	Monthly workforce reports go to board detailing actual staffing levels against establishment for the Previous month – highlighting hotspot areas. 6 monthly establishment reviews to go to open board for discussion and debate	In place – Board report presented monthly

Expectation	**What does this mean in practice?**	**LWH Position – June 2017**
8. NHS providers clearly display information about the nurses, midwives and care staff present on each ward, clinical setting, department or service on each shift.	Display information of staff present by shifts clearly and visibly for patients.	In place – Every ward displays staffing.

9. Providers of NHS services take an active role in securing staff in line with their workforce requirements	Robust recruitment and retention plans need to be in place within the organization. Organizations to work with LETB and others to inform commissioning intensions and future workforce	In place – LWH fully engaged with workforce planning cycle at both local and regional level.
10. Commissioners should seek assurance that providers have sufficient nursing and care staffing capacity and capability to deliver the outcomes and quality standards.	Transparent communication and review with Commissioners about any issues relating to safety and staffing levels. Impact Assessments.	In place- LWH maintain constant assessment and review with Commissioners about any issues relating to safety and staffing levels. Processes are in place to ensure the Medical / Nurse Director review of any Cost Improvement Programmes, ensuring that they are robustly assessed for impact on quality via Quality Impact Assessments.

		Agenda Item	**2017/196**
MEETING	**Board of Directors**		
PAPER/REPORT TITLE:	**Safer Nurse/Midwife Staffing Monthly Report**		
DATE OF MEETING:	7 July 2017		
ACTION REQUIRED	**For Assurance**		
EXECUTIVE DIRECTOR:	Doug Charlton, Director of Nursing and Midwifery		
AUTHOR(S):			
LINK TO STRATEGIC OBJECTIVES:	3. To deliver safe services 5. To deliver the best possible experience for patients and staff		
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Safe:*** ***Efficient:*** ***Experience:***	***Effective:*** ***Well Led:*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust*	
WHICH CQC KLOE FUNDAMENTAL STANDARD/S DOES THIS REPORT RELATE TO?	***Safe:*** *1.4 Safe - Reg 18 Staffing* ***Caring***: ***Responsive:***	***Effective:*** ***Well Led:***	
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT (e.g.: NHS Improvement Compliance/E&D/NHS Constitution)			
FREEDOM OF INFORMATION STATUS (FOIA):	1. 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		
RECOMMENDATION: **(eg: The Board/Committee is asked to:-….)**	The Board is asked to note: • The content of the report and be assured appropriate information is being provided to meet the national and local requirements. • The information on safe staffing and the impact on quality of care. • The organisation has the appropriate number of nursing & midwifery staffing to manage the current clinical		

	workload as assessed by the Director of Nursing & Midwifery	
PREVIOUSLY CONSIDERED BY:	**Committee name**	Not Applicable
	Date of meeting	

Executive Summary

Following a requirement from the NHS Chief Nursing Officer England and the Care Quality Commission, from June 2014 all hospitals are required to publish information about the number of nursing and midwifery staff working on each ward, together with the percentage of shifts meeting safe staffing guidelines. This initiative is part of the NHS response to the Francis report which called for greater openness and transparency in the health service.

This paper launches a new style of Nursing/Midwifery safer staffing report for the organisation. Information contained within the report is currently available but, in a number of reports and this report brings all the relevant information together.

The report offers the Board assurance around the appropriate safe staffing levels and an opportunity for the Director of Nursing & Midwifery to highlight areas of concern using the nursing/midwifery quality indicators as a marker of safe care.

The report demonstrates safe Nurse/Midwife staffing levels on our in- patient wards and assures we have systems in place to manage the demand for Nursing/Midwifery staff.

1.0 Purpose

1.1 To provide the Trust Board with assurance with regard to the management of safe Nursing and Midwifery staffing levels for the month of May 2017.

1.2 To provide context for the Trust Board on the UNIFY safe staffing submission for the month of May 2017.

1.3 To provide assurance of the constant review of Nursing and Midwifery resource using Healthroster.

2.0 Context

2.1 The expectation is the Board 'take full responsibility for the care provided to patients and, as a key determinant of quality, take full and collective responsibility for Nursing/Midwifery care capacity and capability'.

2..2 Monthly nurse staffing updates are submitted to NHS England and the Trust Board with the following information:

1. The number of staff on duty the previous month compared to planned staffing levels.
2. The reasons for any gaps, highlighting those wards where this is a consistent feature and impacts on the quality of care, to include actions being taken to address issues.
3. The impact on key quality and safety measures.

3.0 Background

3.1 Liverpool Women's NHS Foundation Trust is committed to ensuring that levels of nursing staff, which include Registered Nurses (RNs), Registered Midwives (RMs) and Health Care Assistants (HCAs), match the acuity and dependency needs of patients within clinical ward areas in the hospital. This includes an appropriate level of skill mix of nursing and midwifery staff to provide safe and effective care.

3.2 Staffing levels are viewed alongside reported outcome measures, patient acuity (Delivery Suite), and 'Registered Nurse/Midwife to patient ratios', percentage skill mix, and the number of staff per shift required providing safe and effective patient care.

3.3 Care Hours per Patient Day (CHPPD) is an additional parameter introduced by the regulator NHSi to manage the safe level of care provided to all inpatients. This measure uses patient count on each ward at midnight (23.59hrs). CHPPD is calculated using the actual hours worked (split by registered nurses/midwives and healthcare support workers) divided by the number of patients at midnight (for April data by ward please see Appendix 1).

3.4 Staff fill rate information appears on the NHS Choices website www.nhschoices.net. Fill rate data from 1st – 31st May 2017 for Liverpool Women's NHS Foundation Trust was uploaded and submitted on UNIFY, the online collection system used for collating, sharing and reporting NHS and social care data. Patients and the public are able to see how hospitals are performing on this indicator on the NHS Choices website.

3.4 Summary of Staffing Parameters

Standard	Patient Safety is delivered through consistent, appropriate staffing levels for the service					
Ward	**RN/RM**		**Non-Registered**			
	Fill Rate Day%	Fill Rate Night %	Fill Rate Day%	Fill Rate Night %	CHHPD	Red Flags
Delivery & Induction Suite	85.69	90.54	120.97	83.87	26.82	11
Mat Base	95.37	98.92	84.52	67.73	5.94	1
MLU & Jeffcote	83.87	80.11	96.77	96.77	40.36	0
NICU	109.68	109.88	56.45	38.71	10.5	0
Gynae Ward	100.70	100.00	100.00	100.00	6.98	0

Nurse Sensitive Indicators								
Ward	CDT	MRSA	Falls Harm(N)	Falls No Harm(N)	HAPU grade 1&2	HAPU grade 3&4	Drug Admin error	New Complaints
Delivery & Induction Suite							1	
Mat Base				1				1
MLU & Jeffcote							1	
NICU							8	
Gynae Ward	1*						1	

- Patient admitted with infection

4.0 Fill rate indicator return

4.1 The 'actual' number of staffing hours planned is taken directly from our Nurse/Midwife roster system (Allocate). On occasions when there is a deficit in 'planned' hours versus 'actual' hours, and additional staff are required, staff are reallocated to ensure safe staffing levels across the clinical service.

4.2 Appendix 1 details a summary of fill rates 'actual' versus 'planned'. The average fill rate was 95.92 %for registered staff and 89.87 % for care staff during the day and 97.65 % for registered staff and 74.66 % for care staff during the night.

4.3 On the day and night shifts, no clinical areas reported below 90% fill rates for qualified Nurses/Midwives. One clinical area reported above 100% fill rate for Registered Staff (Neonatal) on day shift. Delivery Suite reported above 100% for non-registered staff on night shift.

Day		**Night**	
Average fill rate	Average fill rate	Average fill rate	Average fill rate

registered Nurses /Midwives	Care Staff	registered Nurses/Midwives	Care Staff
95.92%	**89.87%**	**97.65%**	**74.66%**

5.0 'Real Time' management of staffing levels to mitigate risk

5.1 Safe staffing levels are reviewed and managed three times daily. At the daily 09.00am huddle meeting, the Director of Nursing or Deputy Director of Nursing in conjunction with Heads of Nursing/ Midwifery, Matrons, and other senior staff review all registered and unregistered workforce numbers by service. Consideration is given to bed capacity, patient acuity and operational activity within the hospital which may impact on safe staffing. Actions are agreed to ensure all areas are made safe. Matrons and Heads of Nursing/Midwifery review staffing levels again at 13.00 and 17.00 or at other times as decided appropriate to ensure levels remain safe.

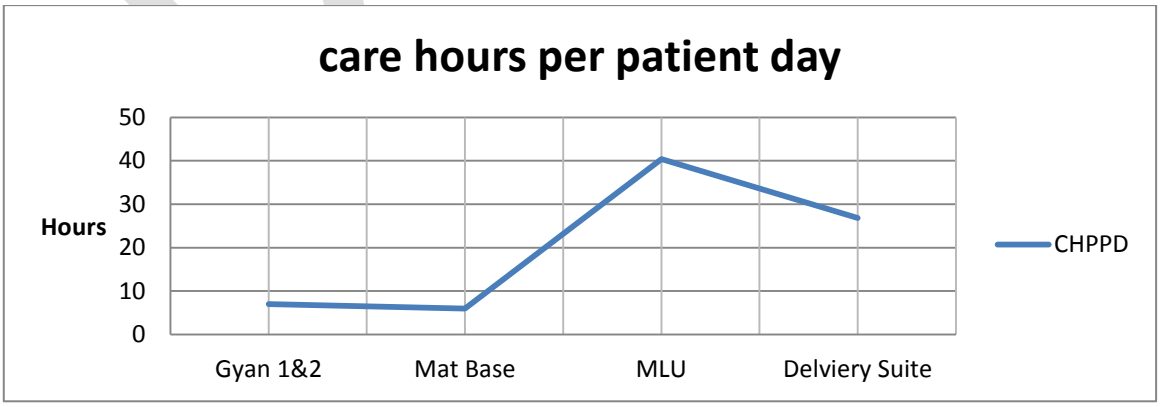
6.0 Reported Incidents of Reduced Staffing (Ulysses Reports)

	Initial Red Shifts				
Wards	Early	Late	Night	Number of shifts where staffing initially fell below agreed levels	% of shifts where staffing fell below agreed levels and triggered a red rating

6.1 Staff are encouraged to report any incident they believe may affect safe patient care using the Ulysses system. During May no reports were submitted relating to staffing. The reports are reviewed by the corporate governance team and referred to the appropriate Head of Nursing/Midwifery for review.

7.0 Care Hours per Patient Day (CHPPD)

7.1 Care hours per patient day is calculated using the patient count on each ward at midnight (23.59hrs). CHPPD is calculated taking the actual hours worked (split by registered nurses/midwives and healthcare support workers) divided by the number of patients at midnight. The graph below shows the average individual care hours per patient for each clinical area. Midwifery led unit have the most care hours (40.36) and the Maternity Base have the least (5.94).



7.2 The average number of hours of Registered Nurse/Midwife time spent with patients was calculated at 9.2 hours and 2.0 hours for care staff. This provides an overall average of 11.2 hours of care per patient day.

	CHPPD
Registered Nurse/Midwife	**9.2**
Care Staff	**2.0**
Overall hours	**11.2**

7.3 The total care hours per patient day is one of the metrics used on a daily basis by the Senior Nursing/Midwifery Team to monitor the level of nursing hours required to deliver care on our inpatient wards.

7.4 The data from CHPPD indicates the total amount of care hours delivered to patients over the last four months has remained similar. Each ward maintained a high level of care delivery when comparing the total registered nurses hours available.

7.5 The table below shows the CHPPD hours for each in patient ward over the last four months and indicates the level of need remained stable overall. There is a slight decrease in hours of care delivered in February compared to January.

Ward Name	Feb17	Mar 17	Apr 17	May 17
Gynae 1&2	7.2	7.0	8.1	6.98
Mat Base	6.5	6.0	6.4	5.94
MLU	35.4	37.0	42.4	40.36
Delivery Suite	31.5	31.3	36.5	26.82
Total CHPPD	**12.5**	**11.7**	**12.25**	**11.19**

8.0 Nurse Sensitive Indicators

8.1 Nurse sensitive indicators are monitored and reviewed against the safe staffing numbers to identify if the level of staffing on the clinic areas has affected the quality patient care.

8.2 There were 11 reported incidents against the Nursing staffing indicators for May. All incidents related to drug administration errors none resulting in patient harm.

8.3 There was 1 new complaint reported against Mat Base which is currently being investigated.

9.0 Patient Acuity

9.1 The acuity of patients is dependent on their care requirements. The most recognised and therefore widely used tool for general patient care is the Association of United Kingdom University Hospitals (AUKUH) Safer Nursing Care Tool. An evidence based tool which enables nurses to assess patient acuity and dependency, incorporating a staffing multiplier to ensure nursing establishments reflect patient needs in acuity / dependency terms. This tool is currently being implemented in our Gynaecology Wards 1 & 2.

9.2 Maternity uses the Department of Health and Royal College of Midwives validated tool Birthrate Plus® which, is currently the only midwifery specific, national tool which gives the intelligence and insights needed to be able to model midwifery numbers, skill mix and deployment and to inform decision making about safe and sustainable services.

9.3 The NICE guidelines on Safe Staffing emphasise the need to ensure adequate resources to meet the needs of woman, but assessing that need is a complex task. Midwives and support staff know how fast paced the workload can be. Admissions 24/7 from labour ward and triage and daily from antenatal clinics, quick turnaround of patients with many discharged in the first 24 hours. Add to this the increase in the number of baby observations, high risk post-natal

and antenatal women, paperwork, answering problems on the phone and it becomes obvious that staff are working flat out to keep providing high quality and increasingly intensive care.

9.4 Post-natal care is often referred to as the 'Cinderella service' and staff are no strangers to multi-tasking; It's not uncommon to do a post-natal check, answer the door bell on the way to get medication from the drug cupboard, pop your head round the door to answer a bell and let a patient know you'll be in shortly to assist with breast feeding, advise a patient you'll have her documentation completed for discharge in the next hour etc. and take a bite of a sandwich and a quick drink on the way past the nursing station and that's just 15 minutes of the 12 hour shift. We can all relate to the scenario, but although we have the standard of one to one care for labour, there is no documented standard to measure how much care we should give our antenatal and postnatal inpatients to meet their differing physical and emotional needs and how many staff do we need to do this effectively.

9.5 In response to demand from many units, Birthrate Plus® developed a ward acuity tool to proactively assess the clinical needs of the women on the ward and match them against the staff available. The tool is an excel spreadsheet; data is inputted at the beginning of a shift for the expected activity. The data collection covers all women in the ward, classified according to their clinical and social needs. Antenatal women are classified by clinical indicators. Further data is collected to record women or babies who may have extra needs. For each category an agreed amount of staff time is allocated. Thus the excel sheet calculates the staff hours needed based upon the client need and compares them with the staff hours available on that shift.

9.6 Development of the ward acuity tool was undertaken with contribution from 3 maternity units in North Wales and further testing in a number of units in England, including 6 hospitals in the North West of which Liverpool Women's was one.

9.7 There is a growing demand for both the Intrapartum and Ward based tools, as Trusts see the value of capturing real time evidence of clinical activity, presented with helpful graphs and analysis.

9.8 Currently Liverpool Women's Hospital has the original version of Birthrate-plus acuity tool for labour ward. We are currently in discussion with Birthrate plus to potentially purchase an upgrade for our labour ward and for our anta-natal post-natal ward (Mat Base). Future reports, should the trust purchase the system will provide detailed data on staffing related to acuity and dependency. This is in line with Lord Carter's recommendations.

10.0 Temporary Staff Utilisation

10.1 Temporary staff utilisation and all requests for temporary staff (Bank) (Nursing and Midwifery) are monitored daily by the Heads of Nursing/Midwifery. Bank staffing is reviewed at the Safety Huddle each morning at 9.00 am to ensure effective utilisation. Depending on acuity and capacity of the ward areas bank staff may be cancelled at the 9.00am huddle to ensure the most effective use of additional resources.

10.2 Monitoring the request for temporary staff in this way serves two purposes:

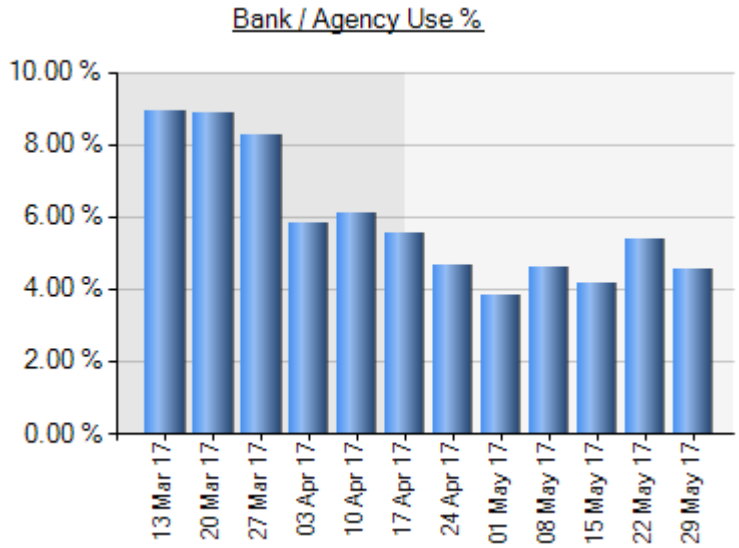
a) The system in place allows for the most appropriate use of temporary bank staff across the organisation and provides a positive challenge mechanism for all requests.

b) The process allows for an overview of the total number of temporary staff (bank) used in different clinical ward areas and provides a monitoring mechanism for the delivery of safe quality care.

11.0 Bank Usage Inpatient Wards (month ending May)

11.1 The utilisation of bank staff across all inpatient wards is monitored using the Healthroster system. The bar chart below graphically represents total usage of temporary (Bank) staff on inpatient wards month ending May (this is cumulative data captured from roster performance reports).

11.2 A key performance indicator (KPI) of less than 6% bank usage (bank shifts compared to total shifts assigned) was set to coincide with the NHS England agency cap. The percentage continues to fluctuate and remains below the agreed 6% target.

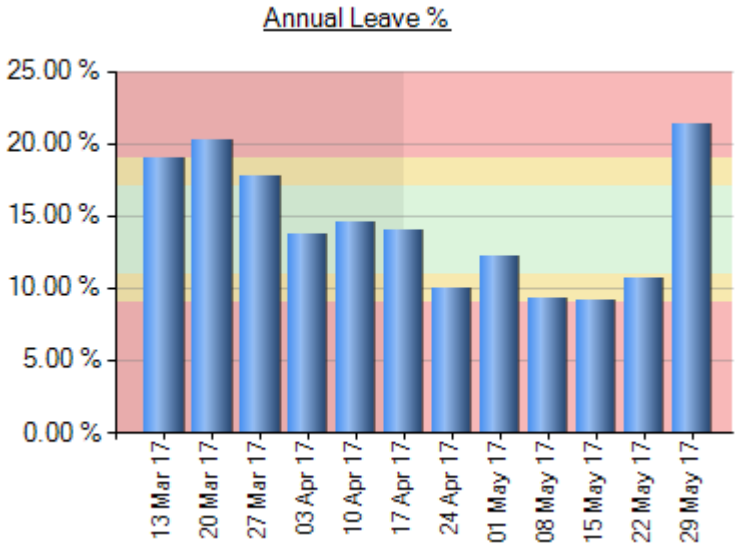


11.3 Temporary staff usage across the inpatient wards fluctuates depending on Nurse/Midwife vacancies and the need to provide additional support.

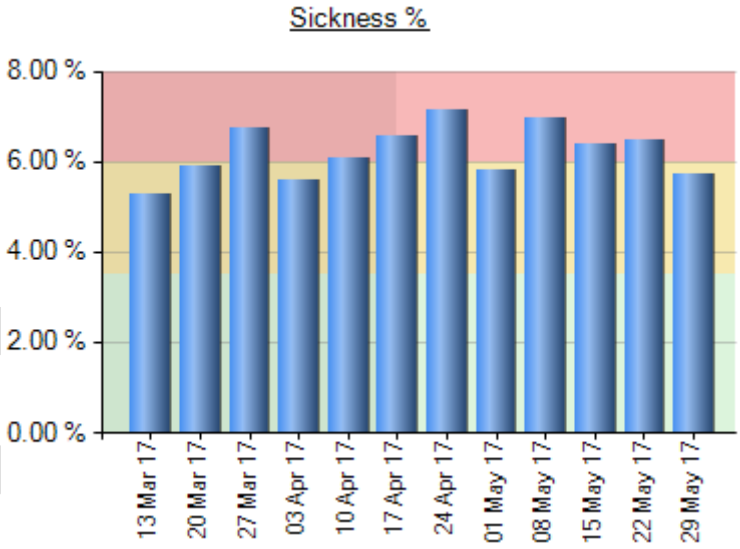
12.0 Managing Staff Resource

12.1 Annual leave taken during May spans the set tolerances of 10% -18%. These tolerance levels ensure all staff are allocated leave appropriately and an even distribution of staff are available throughout the year.

12.2 Heads of Nursing/Midwifery are aware of the need to remind staff to request and take annual leave. This will be monitored closely over the next couple of months to ensure sufficient staff take annual leave in a more consistent way by year end.



12.3 Sick leave reported in May was above the set parameter of less than 3.5%. Heads of Nursing/Midwifery ensure all individuals reporting back from sick leave undergo a sickness review. Sickness levels are being closely monitored to provide support to all staff.



13.0 Conclusion

The Board is asked to note:

- The development of this new report which provides assurance against both staffing levels and nurse sensitive indicators.
- Provides the opportunity for the Director of Nursing & Midwifery to assure the Board with clear evidence of staffing levels triangulate against measure of harm.
- The content of the report and be assured appropriate information is being provided to meet the national and local requirements.
- The information on safe staffing and the impact on quality of care.

Liverpool Women's NHS Foundation Trust

Appendix 1

Updated tables

Fill rate data - summary
May 2017

Day				Night				Average fill rate data- Day		Average fill rate data- Night	
Registered nurses/ midwives		Care staff		Registered nurses/ midwives		Care staff		Registered nurses/ midwives	Care staff	Registered nurses/ midwives	Care staff
Planned (hrs)	Actual (hrs)	Planned (hrs)	Actual (hrs)	Planned (hrs)	Actual (hrs)	Planned (hrs)	Actual (hrs)	95.9%	89.9%	97.7%	74.7%
17756	17031	4427.5	3979	16640.5	16249.5	4266.5	3185.4				

Care Hours per Patient Day
February 2017

Total Patients at Midnight/Month	CHPPD Registered staff	CHPPD Unregistered staff	Average CHPPD (all staff)
3613	9.2	2.0	11.2

Agenda Item	2017/197 i

MEETING	**Board of Directors**	
PAPER/REPORT TITLE:	Performance Dashboard Month 2	
DATE OF MEETING:	July 2017	
ACTION REQUIRED	**For Assurance**	
EXECUTIVE DIRECTOR:	Jeff Johnston, Director of Operations	
AUTHOR(S):	Jeff Johnston, Director of Operations	
LINK TO STRATEGIC OBJECTIVES:	**1. To develop a well led, capable motivated and entrepreneurial workforce** **2. To be ambitious and efficient and make best use of available resources** **5. To deliver the best possible experience for patients and staff** **3. To deliver safe services**	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Safe:*** *Ineffective understanding and learning following significant events* ***Efficient:*** *Inability to deliver the best clinical outcomes for patients* ***Experience:*** *Poorly delivered positive experience for those engaging with our services*	***Effective:*** *Inability to deliver the best clinical outcomes for patients* ***Well Led:*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust*
WHICH CQC KLOE FUNDAMENTAL STANDARD/S DOES THIS REPORT RELATE TO?	***Safe:*** *1.1 Safe - Reg12 Safe care and treatment* ***Caring***: ***Responsive:***	***Effective:*** ***Well Led:*** *5.2 Safe - Reg 17 Good Governance*
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT (e.g.: NHS Improvement Compliance/E&D/NHS Constitution)	**NHS Improvement compliance**	
FREEDOM OF INFORMATION STATUS (FOIA):	1. 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	

RECOMMENDATION: *(eg: The Board/Committee is asked to:-….)*	The Board note the content of the report	
PREVIOUSLY CONSIDERED BY:	**Committee name**	
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	Noted

1. Introduction

The Trust Board performance dashboard is attached in appendix 1 below.

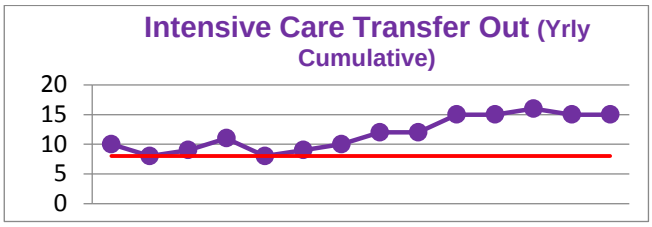
2. Performance

The two indicators to highlight to the Board are as follows:-

2.1 Safe Services – Intensive Care Transfer Out

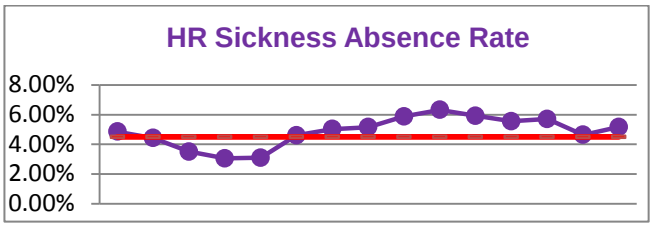
All patients transferred out of the hospital for intensive care are review by the Trust HDU Group and consideration given to the care given. The actual number in the indicator is the cumulative rolling for a year which equates to 15 patients. In May a patient was transferred and the patients' case has been reviewed by the High Dependency Group.

The patient was an Obstetric patient post C-section who returned to theatre for wound debridement. She was admitted to HDU whilst awaiting bed at ITU at the Royal. The patient was transferred over to RLUH at 03.00hrs when bed available and review considered this to be appropriate care.



Intensive Care Transfer Out (Yrly Cumulative)	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
Actual		10	8	9	11	8	9	10	12	12	15	15	16	15	15
Target		8	8	8	8	8	8	8	8	8	8	8	8	8	8

2.2 Workforce – Sickness



HR Sickness Absence Rate	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
Actual	4.86%	4.42%	3.51%	3.05%	3.09%	4.61%	5.03%	5.16%	5.88%	6.32%	5.92%	5.56%	5.71%	4.64%	5.17%
Target	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%

The in month sickness figure increased by 0.53% from 4.64% in month one to 5.17% in month two. This is currently 1.67% above the Trust target figure of 3.5%, and therefore rated as red.

There was increased sickness absence in all three of the largest clinical services (Gynaecology, Maternity & Neonates)

There are currently eight services rated as green, four are rated as amber and six are rated as red (Imaging, Integrated Admin, Maternity, Neonates, Pharmacy and Transport).

The proportion of overall sickness absence that is accounted for by long term sickness absence has fallen. In month one the short/long term split was 15%/85% while in month two it was 38%/62%.

In terms of diagnoses, anxiety/stress/depression, and other known causes, remained the top two most common diagnosis. The third most common was gastrointestinal problems.

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

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

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

The operations team are currently undertaking an audit of return to work interviews.

The HR department are currently working on a series of 'lunch and learn' training sessions which will be open to all managers. These are being developed as 'bite-size' learning sessions that will cover a range of different subjects, including a number of sessions on different aspects of attendance management.

2.3.2 All Cancers: 62 day wait for first treatment from urgent GP referral for suspect cancer (before re- allocation)

This indicator is no longer a national measure but is deemed to be a good measure for the overall performance of cancer waiting times in partnership with other Trusts. It demonstrates the compliance against the 62 target no matter where the patient received treatment in the pathway ie, local hospital, cancer centre, oncology centre.

Although as a Trust we are compliant with cancer indicators nationally less than 50% of Trusts are compliant. Therefore, in attempt to improve overall cancer waiting times NHSI have a plan to deliver a national recovery of the 62 day target by September and are supporting this with transformation monies.

Part of this plan is to identify quick wins to reduce the number of avoidable breaches LWH (plus 4 other trusts in the region) have been identified as having a small number of breaches that would help the overall regional compliance if they were reduced.

The team are working with the regional cancer alliance and have developed an action plan to reduce the number of breaches by improving patient flow and ensuring the right patients are referred to the cancer centre. An additional paper is included in the agenda for the board to consider this new approach to the cancer target.

New breach allocation rules go live in September that reduce the number of days for a Trust to refer to another Trust from 42 to 38 days. The new rules also stipulate that regardless of when the patient is referred to the receiving Trust they have 24 days to provide definitive treatment. The Trust has been shadowing the new guidance and has concluded that it would not have any significant impact on current performance.

3. Emerging concerns

In terms of emerging concerns from last month a full report was received in terms of serious untoward incidents (SUI's) and the actions being taken to June's Trust Board. The SUI indicator reported to GACA has captured the number of new SUI's.

In respect to gynaecology activity for May has seen an improved performance against plan as predicted last month.

4 Conclusion

The Trust is achieving its National access and A & E targets however an increased focus is required in terms of the national drive to improve Cancer 62 day targets.

5 Recommendation

The Board note the content of the report

Agenda Item No:	
Meeting:	Trust Board
Date:	June 2017
Title:	Performance Dashboard - Month 2 - May 2017
Report to be considered in Public or Private?	Public
Where else has this report been considered and when?	FPBD, PPF, GACA
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

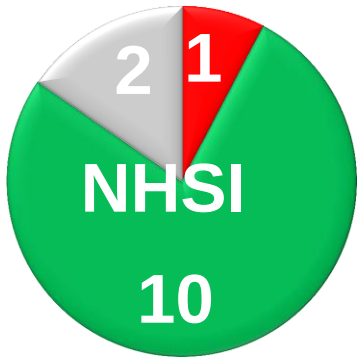
2. Issues for consideration

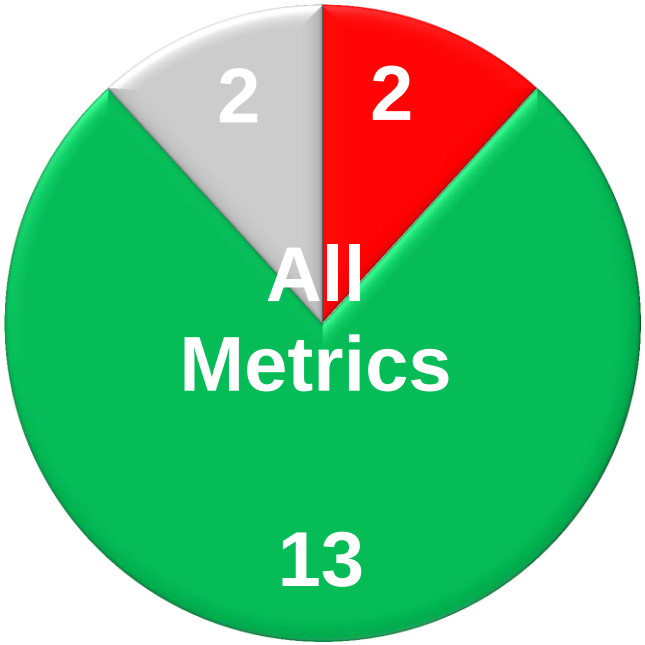
3. Conclusion

4. Recommendation/s

Liverpool Women's NHS Foundation Trust

Performance Report for Trust Board — Month 2 - May 2017





* HR Sickness is shown in both NHSI and Quality Schedule but only recorded once in the All Metrics pie chart. Also only showing once in the Workforce chart.

Liverpool Women's NHS Foundation Trust

NHS Improvement 2017/18 Month 2 - May 2017

To be EFFICIENT and make the best use of available resources

Indicator Name	Ref	Owner of KPI	Target	Apr-17	May-17	Jun-17	Qtr1	Jul-17	Aug-17	Sep-17	Qtr2	Oct-17	Nov-17	Dec-17	Qtr3	Jan-18	Feb-18	Mar-18	Qtr4
Financial Sustainability Risk Rating: Overall Score	KPI087	Jenny Hannon	3	3	3														

To deliver SAFER services

Indicator Name	Ref	Owner of KPI	Target	Apr-17	May-17	Jun-17	Qtr1	Jul-17	Aug-17	Sep-17	Qtr2	Oct-17	Nov-17	Dec-17	Qtr3	Jan-18	Feb-18	Mar-18	Qtr4
Infection Control: Clostridium Difficile	KPI104 (EAS5)		1	0	0														
Infection Control: MRSA	KPI105 (EAS4)		0	0	0														
Never Events	KPI181		0	1	0														
NHSE / NHSI Safety Alerts Outstanding	KPI193		0	0	0														
Infection Control: Clostridium Difficile - infection rate	KPI320		TBC	0	0														
Mortality Rates: Hospital Standardised Mortality Rates (HSMR) - weekend	KPI321		TBC	not available	not available														
Mortality Rates: Hospital Standardised Mortality Rates (HSMR) - weekday	KPI321		TBC	not available	not available														
Mortality Rates: Summary Hospital Mortality Indicator	KPI322		TBC	0	0														

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

Indicator Name	Ref	Owner of KPI	Target	Apr-17	May-17	Jun-17	Qtr1	Jul-17	Aug-17	Sep-17	Qtr2	Oct-17	Nov-17	Dec-17	Qtr3	Jan-18	Feb-18	Mar-18	Qtr4
HR: Sickness Absence Rate	KPI101	Susan Westbury	4.5%	4.64%	5.17%														

To deliver the best possible EXPERIENCE for patients and staff

Indicator Name	Ref	Owner of KPI	Target	Apr-17	May-17	Jun-17	Qtr1	Jul-17	Aug-17	Sep-17	Qtr2	Oct-17	Nov-17	Dec-17	Qtr3	Jan-18	Feb-18	Mar-18	Qtr4
Maximum time of 18 weeks from point of referral to treatment in aggregate - Incompletes	KPI003 (EB3)	Chris McGhee	92%	94.55%	95.31%														
All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (After Re-allocation)	KPI030 (EB12)	Chris McGhee	85%	89.47%	86.36%														
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**)	KPI031 (EB12)	Chris McGhee	>= 85%	77.27%	76.00%														
All Cancers: 62 day wait for first treatement from NHS Cancer Screening Service referral - Numbers (if > 5, the target applies)	KPI033 (EB13)	Chris McGhee	< 5	0	1														
All Cancers: 62 day wait for first treatement from NHS Cancer Screening Service referral - Percentage	KPI034 (EB14)	Chris McGhee	>= 90%	No Pts Applicable	100%														
Complaints: Number Received	KPI038	Kevin Robinson	<= 15	10	7														

Liverpool Women's NHS Foundation Trust

LWH Quality Schedule 2017/18 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 2017/18	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
HR: Sickness Absence Rate	KPI_26			<= 4.5%	4.64%	5.17%										

To deliver the best possible EXPERIENCE for patients and staff

Indicator Name	Ref	Frequency	Owner of KPI	Target 2017/18	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
18 Week RTT: Incomplete Pathway > 52 Weeks	KPI002 EBS4)			0	0	0										
A&E: Total Time Spent in A&E 95th percentile	KPI012 (KPI_62)	Monthly	Sharon Owens	<= 240	235	231										
Friends & Family Test (Upper quartile will recommend)	KPI089	Monthly		>= 75%	97.5%	98.5%										

Liverpool Women's NHS Foundation Trust

LWH Corporate 2017/18 Month 2 - May 2017

To deliver the most EFFECTIVE outcomes															
Indicator Name	**Ref**	**Owner of KPI**	**Target**	**Apr-17**	**May-17**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**
Intensive Care Transfers Out (Cumulative)	**KPI107**		**8 per year (Rolling year)**	**15**	**15**										

Liverpool Women's NHS Foundation Trust

Dedicated to you

Cancer 62 Day – Rapid Recovery

20/06/17

1. Introduction

Following the publication of the *Next Steps on the Five Year Forward View* document, cancer transformation funding (letter appendix 1) has been reviewed to ensure that there is sufficient focus on meeting the 62 day standard nationally as well as on leading longer-term transformation in outcomes. NHSE have outlined their plan to move from under 50% of Trusts meeting the standard (at the start of 2017) to over 70% by July, and full national compliance by September. To do this they have produced '62 day cancer standard: Operating model and support for recovery' (appendix 2). In the North West Region, they identified four Trusts that have less than ten excess breaches per quarter and Liverpool Womens has been identified as one of those Trusts.

The recovery is being led jointly by NHS-E& NHS-E Regional Directors and the Cheshire and Merseyside Cancer Alliance.

2. Current Position

In 2016-17, the Trust is recorded in Open Exeter (cancer database) as responsible for 155 treatments (either here or subsequently treated at Clatterbridge). Of these, 22.5 breached 62 days for treatment (Open Exeter automatically allocates 0.5 between Trusts), which left us with an annual performance of 85.48% treated within target (seven months and two quarters achieved over 85%).

Once the regionally agreed reallocation policy was applied, our position became 153 treated in total, of which 20 breached 62-days, giving an annual performance of 86.89% treated within target (seven months and all four quarters achieved over 85%). (Full breakdown of 2016-17 pre & post reallocation performance is in appendix 3)

In April-17, the Open Exeter reported position was 100% achieved, with a post reallocation position 87.5% (variance due to Open Exeter's rules on pathways involving three of more Trusts). May-17 will not be reported in Open Exeter until after it closes on July 3rd, but our post reallocation is currently reported as 85.71% (this is worst case scenario and can improve once all diagnosis are completed and Open Exeter closes).

The delays in the current pathway can be summarised as follows:-

- Delays in access and reporting for CT Scans – this is due to capacity issues in the local provider Trusts
- Delays in reporting histology results; the local pathology provider has capacity issues which results in delays in turnaround times for results.
- Late referrals from other Trusts, plus late referrals from LWH onto Clatterbridge oncology.
- Delays in diagnostic pathway due to limited urgent capacity.

3. Next Steps

NHS-E & NHS-I issued '10 High Impact Actions', against which each Trust was assessed by a member of Alliance (interview outcome appendix 4). From this six actions have been agreed, each with an operational action plan to support delivery:

1) Reduce average 1st appointment time to 8 days (currently 10.85 in May-17) – Phased reduction in C&B polling & manual referral dates planed over next five week

2) To embed the new Root Cause Analysis form, which will include Clinical review and Cross Trust review for late referrals (April RCA appendix 7) – Now completed
3) Undertake a review of inpatient diagnostic capacity and the processes involved – The capacity concern for Hysteroscopy (Inpatient & Ambulatory), is being addressed via the move to five day theatre schedule, due to start on 19th June
4) To explore the possibility of changing how we Triage our Two week referrals, redirecting some to a Straight to Test pathway –Having piloted within other Tumour types, this is acknowledged as a longer term piece of work and would not affect our ability to improve performance by September, but could be a could long term goal to ensure we continue to achieve.
5) Undertake Patient Pathway Review – Re-Map out our pathways, with times for each pathway event, to identify optimal pathway. This will allow us to then see what elements of the pathways are not working (to aid RCA), but to also allow to predict earlier potential bottlenecks or breach patients. The cancer pathways were last mapped in April-14, and this is being refreshed as part of wider gynaecology pathway review.
6) Identify the minimum standard required for referral to LWH as the specialist centre and agree this with the Gynaecology Cancer Network Group (CNG) – The clinical chair for Specialist MDT has completed referral pro-forma, it has been circulated across the region and is due to be ratified at the next CNG. We have started to receive referrals with the new pro-forma
7) Support the Cancer Alliance in supporting CT capacity, delayed Histopathology results and late referrals and also manage them through Trust contractual relationships.

These actions are currently being developed into an action plan with timelines and responsibilities for submission to Cancer alliance and monitoring via the Executive team and Finance Performance and Business Development as part of the performance framework.

4. Conclusion

To consistently achieve the national 62 day cancer target on a monthly basis the Trust needs to reduce breaches to a maximum of 1.5 per month. The aim would be to improve that position further to improve outcomes and patient experience. This will be achievable by improving our current pathway and significant improvement of the external factors (CT Scans, pathology) that is recognised as a longer term solution.

5. Recommendation

The Trust Board note the content of this report and the actions included.

Appendices

1. Letter to DCO DID CA Leads 0.5.pdf	2. North region - 62 Day recovery Operat	3. 62-day 201617 Performance.xlsx	4. 62 Day Recovery Plan Visits - Liverpool .

	Agenda Item	**2017/198**

MEETING	**Board of Directors**	
PAPER/REPORT TITLE:	Finance Report Month 2 2017/18	
DATE OF MEETING:	7 July 2017	
ACTION REQUIRED	**For Assurance**	
EXECUTIVE DIRECTOR:	Vanessa Harris, Director of Finance	
AUTHOR(S):	Jenny Hannon - Deputy Director of Finance	
LINK TO STRATEGIC OBJECTIVES:	2. To be ambitious and efficient and make best use of available resources 3. To deliver safe services	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Safe:*** ***Efficient:*** *The Trust is not financially sustainable beyond the current financial year* *Failure to deliver the annual financial plan* ***Experience:***	***Effective:*** ***Well Led:***
WHICH CQC KLOE FUNDAMENTAL STANDARD/S DOES THIS REPORT RELATE TO?	***Safe:*** *1.0 SAFE - ALL - Reg 12, 13, 15, 18 20* ***Caring****:* ***Responsive:***	***Effective:*** ***Well Led:***
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT (e.g.: NHS Improvement Compliance/E&D/NHS Constitution)	*NHSI Compliance* *Operational Plan*	
FREEDOM OF INFORMATION STATUS (FOIA):	1. 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	
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	To note the Month 2 2017/18 financial position.	
PREVIOUSLY CONSIDERED BY:	**Committee name**	Finance Performance and Business Development Committee
	Date of meeting	26 June 2017

Executive Summary

1. Executive Summary

The 2017/18 budget was approved at Trust Board in April 2017. This set out a control total deficit of £4m for the year after receipt of £3.2m Sustainability and Transformation Funding (STF). The control total includes £1m of agreed investment in the costs of the clinical case for change identified in the 2017/18 operational plan.

The financial plan delivers a score of 3 in 'finance and use of resources' category within the Single Oversight Framework.

At Month 2 the Trust is slightly better than plan with an actual deficit of £0.581m against a plan of £0.595m.

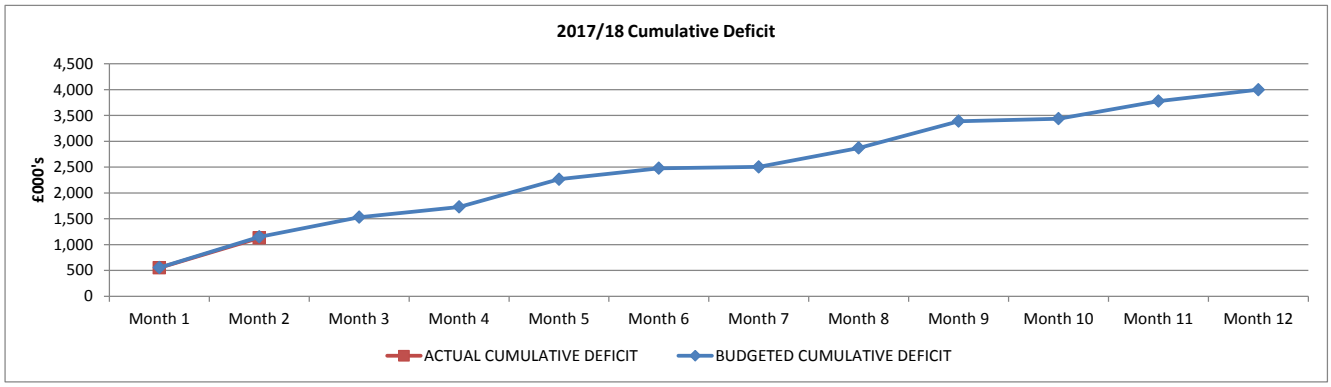
The Trust delivered a Use of Resources Rating of 3 in month which is equivalent to plan.

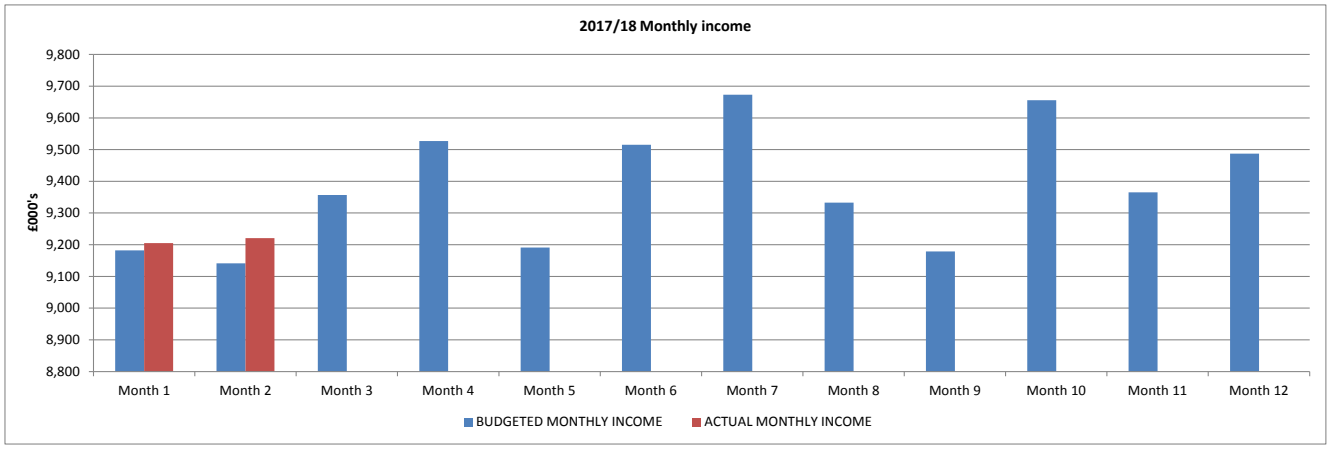
The monthly financial submission to NHSI is consistent with the contents of this report.

Report

2. Month 1 2016/17 Summary Financial Position

The 2017/18 deficit is profiled below. Despite a large proportion of income being under block contract with the Trust's main commissioners, there remains an element of payment by result (PbR) in the income plan. Within the financial plan the block is profiled to reflect expected activity levels in each month. CIP is profiled based on expected delivery across the financial year.





At Month 2 income exceeded plan by £0.08m. This is predominantly neonatal transport income which continues to be received whilst the service is delivered by the Trust. Total income from the block arrangement continues to be adequate for overall levels of activity.

Pay expenditure was again slightly under budget, predominantly in agency staffing. Non-pay expenditure exceeded budget by £0.107m largely as a result of neonatal transport costs and some known slippage in CIP. Mitigating actions in relation to CIP slippage are in place, however as identified in the 2017/18 operational plan CIP delivery remains a key risk to the financial position.

3. Service overview

There are no material issues to bring to the Board's attention at Month 2.

Maternity services were marginally over budget overall in month, this reflects the costs of the increased deliveries against plan. Cumulatively maternity services are slightly better than budget.

Gynaecology and theatres together were overall just slightly behind budget at Month 2. Activity in both general gynaecology and oncology was ahead of plan in month.

Neonates were on plan overall. The additional income to deliver the neonatal transport service is offset by the associated costs.

Hewitt Fertility Centre budget was on plan at Month 2. The service continues to be monitored at Finance, Performance and Business Development Committee.

At Month 2 there are no areas giving rise to a change in forecast outturn from budget. This will be reviewed again at Month 3.

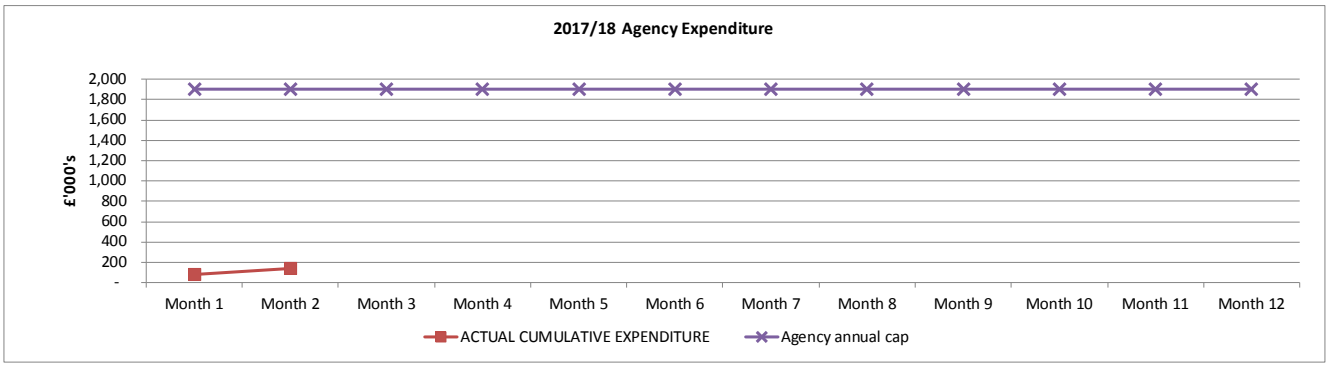
4. Month 2 CIP Delivery

The Trust has an annual CIP requirement of £3.7m for 2017/18. Month 2 cumulative delivery was £0.412m against a £0.524m target.

Scheme performance and recurrent delivery in both this and future financial years remains focus of the Trust's Turnaround and Transformation Committee. As at Month 2 £0.7m of the £3.7m full year target is deemed at risk, however plans are place to mitigate and recover this in year. Detailed updates will be presented on a monthly basis to Finance, Performance and Business Development Committee.

5. Agency Spend

The annual agency cap set by NHSI for the Trust is £1.9m. In Month 2 the Trust incurred £0.061m of agency expenditure and plans to remain within the cap for the financial year.



6. Cash and borrowings

The Trust has an operational cash borrowing requirement of £4.0m for 2017/18. The Trust continues to submit 13 week cash flow statements each month to DH, there was no requirement for a cash drawdown in Month 2.

The table below summarises the Distressed Funding borrowings to date which total £12.6m. By the end of the financial year, without any capital expenditure in relation to the clinical case requirements, the Trust will have drawn down £16.6m

Financial Year	Drawdown	Interest rate
2015/16	£5.6m	3.5%
2016/17	£7.0m	1.5%
2017/18*	£4.0m	1.5%
Total	**£16.6m**	

*planned

The Trust also has an ITFF loan of £5.5m from previous years which is being repaid at the principle sum of £0.6m per annum.

7. BAF Risk

There are no changes proposed in relation to the Board Assurance Framework.

8. Conclusion & Recommendation

The Board are asked to note the Month 2 financial position.

Appendix 1 – Board pack

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

FINANCE REPORT: M2

YEAR ENDING 31 MARCH 2018

Contents

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
NHS IMPROVEMENT RATIOS: M2
YEAR ENDING 31 MARCH 2018

USE OF RESOURCES RISK RATING	YEAR TO DATE Budget	YEAR TO DATE Actual	YEAR Budget	YEAR FOT
CAPITAL SERVICING CAPACITY (CSC)				
(a) EBITDA + Interest Receivable	(93)	(104)	2,342	2,342
(b) PDC + Interest Payable + Loans Repaid	320	295	2,532	2,532
CSC Ratio = (a) / (b)	**(0.29)**	**(0.35)**	**0.93**	**0.93**
NHSI CSC SCORE	**4**	**4**	**4**	**4**
Ratio Score 1 = > 2.5 2 = 1.75 - 2.5 3 = 1.25 - 1.75 4 = < 1.25				
LIQUIDITY				
(a) Cash for Liquidity Purposes	(3,330)	(1,820)	(2,598)	(2,596)
(b) Expenditure	18,419	18,533	110,276	110,276
(c) Daily Expenditure	307	309	306	306
Liquidity Ratio = (a) / (c)	**(10.8)**	**(5.9)**	**(8.5)**	**(8.5)**
NHSI LIQUIDITY SCORE	**3**	**2**	**3**	**3**
Ratio Score 1 = > 0 2 = (7) - 0 3 = (14) - (7) 4 = < (14)				
I&E MARGIN				
Deficit (Adjusted for donations and asset disposals)	1,150	1,129	3,997	3,994
Total Income	(18,324)	(18,426)	(112,608)	(112,608)
I&E Margin	**-6.27%**	**-6.13%**	**-3.55%**	**-3.55%**
NHSI I&E MARGIN SCORE	**4**	**4**	**4**	**4**
Ratio Score 1 = > 1% 2 = 1 - 0% 3 = 0 - (-1%) 4 < (-1%)				
I&E MARGIN VARIANCE FROM PLAN				
I&E Margin (Actual)		-6.13%		-3.55%
I&E Margin (Plan)		-6.27%		-3.55%
I&E Variance Margin	**0.00%**	**0.15%**	**0.00%**	**0.00%**
NHSI I&E MARGIN VARIANCE SCORE	**1**	**1**	**1**	**1**
Ratio Score 1 = 0% 2 = (1) - 0% 3 = (2) - (1)% 4 = < (2)%				
AGENCY SPEND				
YTD Providers Cap	321	321	1,924	1,924
YTD Agency Expenditure	211	139	1,299	1,299
	-34.10%	**-56.72%**	**-32.46%**	**-32.46%**
NHSI AGENCY SPEND SCORE	**1**	**1**	**1**	**1**
Ratio Score 1 = < 0% 2 = 0% - 25% 3 = 25% - 50% 4 = > 50%				
Overall Use of Resources Risk Rating	**3**	**3**	**3**	**3**

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

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

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
INCOME & EXPENDITURE: M2
YEAR ENDING 31 MARCH 2018

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	(8,545)	(8,603)	58	(17,131)	(17,158)	27	(102,883)	(102,883)	0
Non-Clinical Income	(597)	(618)	21	(1,193)	(1,269)	75	(9,725)	(9,725)	0
Total Income	**(9,142)**	**(9,221)**	**80**	**(18,324)**	**(18,426)**	**102**	**(112,608)**	**(112,608)**	**0**
Expenditure									
Pay Costs	5,676	5,650	26	11,352	11,305	47	67,853	67,853	0
Non-Pay Costs	2,222	2,329	(107)	4,445	4,608	(163)	26,695	26,695	0
CNST	1,311	1,311	0	2,621	2,621	0	15,728	15,728	0
Total Expenditure	**9,209**	**9,290**	**(81)**	**18,419**	**18,534**	**(115)**	**110,276**	**110,276**	**0**
EBITDA	**68**	**69**	**(2)**	**95**	**108**	**(13)**	**(2,332)**	**(2,332)**	**0**
Technical Items									
Depreciation	368	366	2	737	731	6	4,419	4,419	0
Interest Payable	36	24	12	72	47	25	432	432	0
Interest Receivable	(1)	(2)	2	(2)	(3)	2	(10)	(10)	0
PDC Dividend	124	124	0	248	248	0	1,488	1,488	0
Profit / Loss on Disposal	0	0	0	0	0	0	0	0	0
Total Technical Items	**527**	**511**	**16**	**1,055**	**1,023**	**32**	**6,329**	**6,329**	**0**
(Surplus) / Deficit	**595**	**581**	**15**	**1,150**	**1,130**	**19**	**3,997**	**3,997**	**0**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 3
EXPENDITURE: M2
YEAR ENDING 31 MARCH 2018

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	341	353	(12)	681	696	(14)	4,085	4,085	0
Medical	1,248	1,238	9	2,495	2,474	21	15,078	15,078	0
Nursing & Midwifery	2,530	2,526	4	5,060	5,051	9	30,109	30,109	0
Healthcare Assistants	416	413	3	832	821	10	4,924	4,924	0
Other Clinical	546	536	10	1,093	1,075	18	6,554	6,554	0
Admin Support	141	157	(16)	281	316	(34)	1,679	1,679	0
Corporate Services	349	366	(17)	699	732	(34)	4,125	4,125	0
Agency & Locum	106	61	45	211	139	73	1,299	1,299	0
Total Pay Costs	**5,676**	**5,650**	**26**	**11,352**	**11,305**	**47**	**67,853**	**67,853**	**0**
Non Pay Costs									
Clinical Suppplies	708	718	(10)	1,416	1,429	(14)	8,521	8,521	0
Non-Clinical Supplies	773	914	(142)	1,545	1,753	(208)	9,498	9,498	0
CNST	1,311	1,311	0	2,621	2,621	0	15,728	15,728	0
Premises & IT Costs	420	434	(14)	841	871	(30)	4,978	4,978	0
Service Contracts	322	263	59	644	555	89	3,697	3,697	0
Total Non-Pay Costs	**3,533**	**3,640**	**(107)**	**7,066**	**7,229**	**(163)**	**42,423**	**42,423**	**0**
Total Expenditure	**9,209**	**9,290**	**(81)**	**18,419**	**18,534**	**(115)**	**110,276**	**110,276**	**0**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
BUDGET ANALYSIS: M2
YEAR ENDING 31 MARCH 2018

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	(3,666)	(3,681)	14	(7,357)	(7,403)	45	(45,612)	(45,612)	0
Expenditure	1,712	1,747	(35)	3,423	3,458	(35)	20,501	20,501	0
Total Maternity	**(1,954)**	**(1,934)**	**(21)**	**(3,934)**	**(3,945)**	**10**	**(25,110)**	**(25,110)**	**0**
Gynaecology									
Income	(2,066)	(2,081)	14	(4,174)	(4,053)	(122)	(25,621)	(25,621)	0
Expenditure	859	862	(2)	1,718	1,744	(26)	10,309	10,309	0
Total Gynaecology	**(1,207)**	**(1,219)**	**12**	**(2,456)**	**(2,309)**	**(148)**	**(15,312)**	**(15,312)**	**0**
Theatres									
Income	(42)	(40)	(1)	(83)	(81)	(2)	(499)	(499)	0
Expenditure	640	661	(21)	1,280	1,283	(3)	7,679	7,679	0
Total Theatres	**598**	**621**	**(23)**	**1,197**	**1,202**	**(6)**	**7,180**	**7,180**	**0**
Neonatal									
Income	(1,354)	(1,418)	64	(2,708)	(2,845)	137	(16,249)	(16,249)	0
Expenditure	945	1,008	(63)	1,890	1,964	(74)	11,341	11,341	0
Total Neonatal	**(409)**	**(411)**	**1**	**(818)**	**(881)**	**63**	**(4,908)**	**(4,908)**	**0**
Hewitt Centre									
Income	(800)	(810)	10	(1,488)	(1,611)	123	(9,971)	(9,971)	0
Expenditure	623	630	(7)	1,245	1,263	(18)	7,471	7,471	0
Total Hewitt Centre	**(177)**	**(180)**	**2**	**(243)**	**(348)**	**105**	**(2,501)**	**(2,501)**	**0**
Genetics									
Income	(600)	(632)	31	(1,201)	(1,160)	(41)	(7,204)	(7,204)	0
Expenditure	478	415	63	956	802	154	5,739	5,739	0
Total Genetics	**(122)**	**(216)**	**94**	**(244)**	**(358)**	**113**	**(1,465)**	**(1,465)**	**0**
Clinical Support									
Income	(25)	(32)	7	(51)	(64)	14	(295)	(295)	0
Expenditure	777	790	(13)	1,554	1,574	(20)	9,098	9,098	0
Total Clinical Support & CNST	**752**	**758**	**(6)**	**1,503**	**1,510**	**(7)**	**8,803**	**8,803**	**0**
Corporate & Trust Technical Items									
Income	(588)	(528)	(60)	(1,261)	(1,210)	(51)	(7,158)	(7,158)	0
Expenditure	3,703	3,689	14	7,407	7,469	(62)	44,467	44,467	0
Total Corporate	**3,115**	**3,161**	**(45)**	**6,146**	**6,258**	**(112)**	**37,310**	**37,310**	**0**
(Surplus) / Deficit	**595**	**581**	**15**	**1,150**	**1,130**	**19**	**3,997**	**3,997**	**0**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 5
BALANCE SHEET: M2
YEAR ENDING 31 MARCH 2018

BALANCE SHEET £'000	YEAR TO DATE Opening	M2 Actual	Movement
Non Current Assets	**72,688**	**72,929**	241
Current Assets			
Cash	4,897	7,512	2,615
Debtors	8,201	8,898	697
Inventories	366	366	0
Total Current Assets	**13,464**	**16,776**	**3,312**
Liabilities			
Creditors due < 1 year	(10,577)	(15,321)	(4,744)
Creditors due > 1 year	(1,717)	(1,712)	5
Loans	(17,175)	(17,175)	0
Provisions	(3,011)	(2,955)	56
Total Liabilities	**(32,480)**	**(37,163)**	(4,683)
TOTAL ASSETS EMPLOYED	**53,672**	**52,542**	**(1,130)**
Taxpayers Equity			
PDC	37,420	37,420	0
Revaluation Reserve	12,233	12,233	0
Retained Earnings	4,019	2,889	(1,130)
TOTAL TAXPAYERS EQUITY	**53,672**	**52,542**	**(1,130)**