Meeting of the Board of Directors
HELD IN PUBLIC
Friday 3 November 2017
at St Chads Walk-in Centre, Kirkby at 1015hrs

Item no. 2017/	Title of item	Objectives/desired outcome	Process	Item presenter	Time	CQC Domain
289	Apologies for absence & Declarations of interest	Receive apologies	Verbal	Chair	1015 (5mins)	-
290	Meeting guidance notes	To receive the meeting attendees' guidance notes	Written guidance	Chair		Well Led
291	Minutes of the previous meeting held on 6 October 2017	Confirm as an accurate record the minutes of the previous meetings	Written	Chair		Well Led
292	Action Log and matters arising	Provide an update in respect of on-going and outstanding items to ensure progress	Written/verbal	Chair		Well Led
293	Chair's announcements	Announce items of significance not elsewhere on the agenda	Verbal	Chair	1020 (15mins)	Well Led
294	Chief Executive Report	Report key developments and announce items of significance not elsewhere	Verbal	Chief Executive		Well Led
BOARD COMMITTEE ASSURANCE						
295	Chair's Report from the Charitable Funds Committee	Receive assurance and any escalated risks	Written	Committee Chair	1035 (15mins)	Well Led

Item no. 2017/	Title of item	Objectives/desired outcome	Process	Item presenter	Time	CQC Domain
296	Chair's Report from the Finance Performance and Business Development Committee	Receive assurance and any escalated risks	Written	Committee Chair		Well Led
297	Chairs Report from the Audit Committee	Receive assurance and any escalated risks	Written	Committee Chair		Well Led
TO DEVELOP A WELL LED, CAPABLE AND MOTIVATED WORKFORCE; TO DELIVER SAFE SERVICES; TO DELIVER THE BEST POSSIBLE EXPERIENCE FOR OUR PATIENTS AND OUR STAFF						
298	Mortality Quarter 2 Report	To note the content of the report	Written	Medical Director/Associate Medical Director	1050 (10mins)	Caring Well Led
299	Serious Incidents Report	To note the content of the report	Written	Medical Director	1100 (10mins)	Caring Well Led
TRUST PERFORMANCE - TO DELIVER THE MOST EFFECTIVE OUTCOMES; TO BE EFFICIENT AND MAKE BEST USE OF AVAILABLE RESOURCES						
300	Safer Nurse/Midwife Staffing Monthly Report	The Board is asked to note the content of the report	Written	Director of Nursing and Midwifery	1110 (10mins)	Safe Well Led
301	Performance Report period 6, 2017/18	Review the latest Trust performance report and receive assurance	Written	Director of Operations	1120 (10mins)	Safe Well Led
302	Finance Report period 6, 2017/18	To note the current status of the Trusts financial position	Written	Director of Finance	1130 (10mins)	Well Led
TRUST STRATEGY						
303	Fit for Future Generations Update	To brief the Board on progress and risks	Verbal	Chief Executive	1140 (5mins)	All
BOARD GOVERNANCE						
304	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair	1145 (5mins)	Well Led

Item no. 2017/	Title of item	Objectives/desired outcome	Process	Item presenter	Time	CQC Domain
HOUSEKEEPING						
305	Any other business & Review of meeting	Consider any urgent items of other business	Verbal	Chair	1150 End	Well Led

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

Meeting to end at 1150

1150-1205	Questions raised by members of the public observing the meeting on matters raised at the meeting.	To respond to members of the public on matters of clarification and understanding.	Verbal	Chair

Meeting attendees' guidance, May 2013

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

Before the meeting

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

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

At the meeting

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

Attendance

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

After the meeting

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

Standards & Obligations

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

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

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Liverpool Women's NHS Foundation Trust

Board Agenda item 2017/291

Board of Directors

Minutes of the meeting of the Board of Directors
held in public on Friday 6 October 2017 at 1400 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
Dr Andrew Loughney	Medical Director
Mr Jeff Johnston	Director of Operations
Mr Tony Okotie	Non-Executive Director/SID
Mr Ian Knight	Non-Executive Director
Mr David Astley	Non-Executive Director
Ms Jo Moore	Non-Executive Director
Mrs Michelle Turner	Director of Workforce & Marketing
Dr Doug Charlton	Director of Nursing & Midwifery
Mr Phil Huggon	Non-Executive Director
Dr Susan Milner	Non-Executive Director

IN ATTENDANCE

Mr Colin Reid	Trust Secretary

APOLOGIES

2017	**Board Thank You** **Andy Sharp,** Clinical Lecturer. The Medical Director provided the thank you on behalf of the Board to Andy Sharp. Andy gave a presentation on the Trust's data on LPGF informed management of pre-eclampsia on behalf of the Liverpool Women's at the International congress of Hypertension in Pregnancy in Berlin. Andy was also congratulated on being awarded for best presentation at the congress. **Andy Veal,** ST3 Doctor on rotation. The Medical Director provided a thank you to Andy Veal for swift action and strong leadership demonstrated to respond to a patient suffering cardiac arrest. The medical records and statements demonstrate that Andy performed to a standard above what might reasonably have been expected for his level of training as an ST3 in anaesthesia having worked at the Trust for only 8 weeks. He took the team leader role in managing the cardiac arrest and articulated to other members of the team exactly what was going on. **Anaesthetics Team Thank you.** The Medical Director in saying thank you to Andy Veal advised that as with a lot of cases it is a team effort and thanked the Anaesthetics team in their response to the same incident. Helen McNamara was in attendance to receive the thank you.
268	**Apologies** – as above. **Declaration of Interests** – None

269 **Meeting guidance notes**

The Board received the meeting attendees' guidance notes.

270 **Patient Story**

As the patient was unavailable the chair asked that the Board move onto the next item on the agenda Minutes of Previous meeting.

271 **Minutes of previous meeting held on Friday 1 September 2017**

The minutes of the meeting held on 1 September 2017 were approved subject to amendments to typographical errors.

272 **Matters arising and action log.**

The Board noted that the action would be taken at a future meeting.

273 **Chair's Announcements**

The Chair made the following announcements:

Staff Listening Event: The Chair reported on the staff listening event held this morning attended by all the Board. He thanked the Director of Workforce and Marketing and her team for organising the event which had been well received by the Board members and staff. The Director of Workforce and Marketing advised that feedback from the event would be presented to the December Board meeting.

Annual Members Meeting (AMM) and Council of Governors Meeting: The Chair reminded the Board that the Annual Members Meeting would be held on 14 October 2017 and the Council of Governors meeting will be held on 25 October 2017.

Governor Elections: The Chair reported that the recent Governor elections had taken place and would be concluded in time for the announcement of who the new governors are at the AMM.

The Chair reminded the Board that the Service of Remembrance organised by the Honeysuckle team will be held on 11 October 2017.

The Board noted the Chair's verbal update.

270 **Patient Story**

The Trust received a patient story of one person's view of the Chaplaincy at the Women's.

Nina Maryanji provided a presentation of her story and how the chaplaincy, through Farther Peter Morgan, helped and supported her and her family through her journey whilst attending the Hospital for the birth of her baby and afterwards whilst on NICU.

Nina advised that the chaplaincy provides in a few words; a hand to hold; an ear to listen; a heart to love; a mouth for kindness; and peace to feel. She went on to say that the benefits of the Chaplaincy at the hospital were intangible, unquantifiable and qualitative in: emotional wellbeing; independent support; restoration of faith; bring the community of the hospital together; and supporting staff.

The Chair thanked Nina for her wonderful presentation and recognised and was appreciative of the work of the Chaplaincy in supporting both patients and staff. The Chief Executive echoed the comments of the Chair and recognised the massive part the multi-faith chaplaincy plays in all aspects of the Trust's operations and thanked Nina for highlighting not only the work and support of the chaplaincy but also that of the staff in supporting mothers and babies.

274 **Chief Executive's report**

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

The Chief Executive reported on the success of Mersey Care NHS Foundation Trust in its bid to run the community services of Liverpool Community Health (LCH) NHS Trust. The management agreement would transfer to Mersey Care from November 1 from Alder Hey who was the second bidder for the community services and who had been managing the service on a temporary basis with the transaction expected to be complete by 1 April 2018.

The Board noted the Report from the Chief Executive.

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

Jo Moore, Chair of FPBD presented the Chairs Report of the FPBD covering the meeting held on 25 September 2017 and ran through the main items discussed and where assurance was obtained.

Referring to the escalation report on performance measures, Jo Moore reported that as with the previous month Gynaecology was still underperforming planned activity. This was being investigated to identify why there had been such a shift in activity so that it could be brought back in line.

With regard to the issues to be highlighted to the Board, Jo Moore advised that there was recognition that junior doctors' availability was having an impact resulting in increased waiting time for follow up appointments. She reported that the other item related to the development of International business noting that progress was in its early stages of development and would require governance arrangements to be put in place in due course.

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

276 **Chair's Report from the Putting People First Committee (PPF)**

David Astley who Chaired the PPF committee meeting held on 22 September 2017 presented the Chairs Report and highlighted the key areas discussed at the meeting. In particular David Astley reported on the receipt of the Medical Appraisal and Revalidation Annual Report 2016/17 which was approved by the Committee. He advised that the Medical Appraisal and Revalidation Annual Report and the statement of compliance had been submitted to NHS England as part of quality assurance arrangements. David Astley advised that the Committee had recommended that the report be submitted and presented to the Council of Governors to support public engagement with the revalidation process.

Referring to the escalation report on performance measures, David Astley reported that sickness analysis over a 5 year period demonstrated a 60% long term and 40% short term sickness split as a constant pattern year on year. Anecdotal evidence had been received from the Trust's Occupational Health providers advising that the Trust submits more management and self-referrals for mental health issues compared to other local trusts. He advised that there was also evidence that the sickness absence policy was not used consistently across the Trust; consequently a sickness working group had been established to review the sickness and absence policy and audit compliance.

David Astley referred to the issues to be highlighted to Board and advised that the Committee had noted the concerns of the Deputy Chief Information Officer in relation to the working conditions of the office space utilised by the IM&T teams. The Director of Finance advised that there was available space and that moving to the space was very much in the hands of the IT team who had an action to complete digitising paper records which would then free up the space. Referring to the Seven day service the Board noted that that the Trust could not achieve the standard whilst on the Crown Street Site. The Medical Director advised that NHSI were aware of the issues and noted that the Trust would continue with the referral patterns across the city.

David Astley referred to the concerns surrounding the shortage of junior doctors that had also been discussed at the other Board assurance committees and advised that PPF had felt that the shortage was becoming an increasing risk for the Trust coupled with increasing gap in available specialist nursing roles. The Committee had reviewed the corporate risk in relation to a competent and capable workforce (1743) and had agreed the increase of the corporate risk score to 20 and that the Board approve the escalation of corporate risk to the Board Assurance Framework.

The Chair thanked David Astley for his report noting that the discussed under the Board Assurance Framework. The Board noted the issues escalated and the work being undertaken to mitigate them.

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

Susan Milner Chair of GACA presented the Chairs Report of the GACA covering the meeting and workshop held on 18 September 2017 and ran through the main items discussed and where assurance was obtained.

Susan Milner reported that the Committee had undertaken a workshop that was held on the morning of the Committee meeting. She explained that the workshop had been facilitated by MIAA and had addressed the terms of reference of the Committee including its purpose and work plan. Susan Milner advised that the draft report identified a number of recommendations that was to be considered by herself, the Director of Nursing and Midwifery, the Medical Director and the Trust Secretary and that following review a new terms of reference of the Committee would be presented for Board approval.

Susan Milner referred to her report and advised on the issues surrounding the close out of the Francis Report Recommendations action plan. She explained the problems that had been encountered is closing the final action relating to recommendation 244; patient access to and write in own notes, noting that the recommendation would only be delivered once EPR was in place. There was discussion on whether the whole of the action should remain Red given the remaining 4 parts of the recommendation had been closed and following discussion it was agreed to leave the action Red. The Chief Executive suggested that further consideration be given to the close down if the action recognising that it cannot be completed for some time.

Susan Milner referred to the two items that had been presented to the Committee for approval: the Safeguarding Annual Report 2016/17; and the Patient Led Assessment of the Care Environment (PLACE) Assessment 2017. She explained that both had been approved by the Committee and are on the Board agenda for its consideration.

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

280 Safeguarding Annual Report 2016/17

Mandy McDonough, Associate Director of Safeguarding Children and Adults joined the meeting to present the Safeguarding Annual Report 2016/17 for approval having been reviewed by GACA prior to its submission to the Board.

Associate Director of Safeguarding Children and Adults summarised the achievements of the team over the last financial year and ran through an overview of the Trust's compliance with training and training needs. She reported that there was a requirement to update the Safeguarding Strategy to take account of and give evidence to why and what was undertaken by the Safeguarding team. The Chief Executive recognised the work of the Safeguarding team and its leadership in taking the service to an exceptional level. She advised that it was not recognisable [in a positive sense] to what it was some years ago. The Chief Executive noted the positive responses from outside agencies to the work of the Safeguarding team which she had reported previously to the Board. The Associate Director of

Safeguarding Children and Adults advised that the success of the team had been because of the Board's leadership in making sure that the service was successful and thanked the Board on behalf of the team. The Director of Nursing and Midwifery commented that there was a huge amount of work the staff at the Trust do which goes unreported and needs to be celebrated.

Referring to the work now being undertaken at Aintree under an SLA, the Associate Director of Safeguarding Children and Adults advised that they were determined not to allow the work to detract from the work the team did here.

The Director of Finance noted that there had been an increase in referrals, particularly children and asked why this was the case. In response the Associate Director of Safeguarding Children and Adults reported that the policy allows for staff to make referrals and there have, over the period, been a number that were, on reflection not appropriate. She advised that rather than stop clinical staff from making referrals, which may result in missing an appropriate one, the Team works with staff to gain experience on what to look for. She advised that since last year the team has seen a small drop in the number of referrals.

The Chief Executive asked that the Board hold a workshop so that it could see and be part of the success story of the safeguarding team. The Chair thanked the Associate Director of Safeguarding Children and Adults for her attendance and sought the Board approval of the Safeguarding Annual Report 2016/17. The Board approved the Safeguarding Annual Report 2016/17.

Action 280: Trust Secretary to arrange a safeguarding Board workshop on a future Board day.

278 Learning from Mortality Policy

The Medical Director presented the learning from Mortality Policy for approval and referred the Board to the approved Adult Mortality Strategy and Perinatal Mortality Strategy that had been produced in response to national guidance and approved by the Board earlier in the year. The Policy presented today goes further to meet the requirements of National Quality Board in relation to learning from deaths.

The Board approved the Learning from Deaths Policy, which would be amended to take account of Trust formatting requirements. The Board noted that the Policy would be placed on the Trust's external facing website together with each Quarterly Report.

279 Freedom to Speak Up – National Guardian Survey 2017

The Director of Workforce and Marketing presented the Freedom to Speak Up – National Guardian Survey and referred to the findings, key recommendations and the Trust's position against the recommendations. The Board noted the status of the actions recognising that the Trust was actively looking to support the guardian post by adding an additional guardian as reported at the last Board meeting when it received the Speak Up Guardians Annual Report.

The Board confirmed that it was sufficiently assured that the Trust had appropriate arrangements in place to support the role of the Freedom to Speak Up Guardian and actions in place to meet the recommendations of the National Guardian's Report 2017.

281 Patient Led Assessment of the Care Environment (PLACE) Assessment 2017

The Director of Nursing and Midwifery presented the finding of the Patient Led Assessment of the Care Environment (PLACE) Assessment 2017 and advised that the paper had also been presented to GACA as reported earlier in the meeting. He reported that the results were generally good with some positive comments; however the Trust had seen a reduction in results compared to 2016. The Director of Nursing and Midwifery advised that actions have been put in place to address the

comments raised and also noted that the new enhanced environment for patients following the refurbishments of Outpatients and in-patient Gynaecology should reflect favourably in the 2018 results.

The Board received the findings of Patient Led Assessment of the Care Environment (PLACE) Assessment 2017 and the actions put in place to address comments raised during the assessment.

282 Safer Nurse/Midwife Staffing Monthly Report

The Director of Nursing and Midwifery presented the Safer Nurse/Midwife Staffing Monthly Report. He advised that the data presented demonstrated effective use of current Nursing & Midwifery resources for all inpatient clinical areas and that overall fill rates versus planned remain high with the reallocation of nursing and midwifery resources where necessary to maintain safe staffing levels.

The Director of Nursing and Midwifery reported that there were two staffing level incidents reported during August that related to Delivery Suite. He explained that these were due to shortages in planned staff from vacancies and short term sickness; the Levels were managed appropriately using the redistribution of existing nursing and midwifery resources.

Referring to the medication errors in Neonates, the Director of Nursing and Midwifery advised that these errors did not cause actual harm to the patient they were administratively based. Ian Knight asked where it was reported should there be a medication error that causes harm to a patient. The Director of Nursing and Midwifery advised that these were recorded as a serious incident and never events and the Board would see these in quarterly reports to the Board and bi monthly to GACA.

The Board noted the content and recommendations contained in the report.

283 Performance Report Period 5 2017/18

The Director of Operations presented the Performance Report for period 5 2017/18 and reported that the Trust was continuing to deliver all national targets to date.

The Director of Operations referred the Board to the discussions earlier in the meeting regarding actions taken to address sickness absenteeism and also referenced the issues surrounding the achievement of the target for transfers out given the Trust continued to remain on an isolated site.

The Director of Operations reported to the Board the emerging concern and potential threat to the activity of the Trust's fertility service from the Trust's footprint on the Wirral and west Cheshire. He advised that a new private IVF service had been set up on Countess of Chester Hospital site which, although not having the historical evidence of success rates the Trust offered, receive referrals, both NHS and Private, that would ordinarily have come to the Trust. He reported that the Trust may need to go into competition with the new private IVF service in order to mitigate and reduction in activity. The Board discussed the threat the new Private IVF service had on the Trust's planned activity any potential misunderstanding patients may have given the service was located on an NHS hospital site.

The Board noted the Performance Report for period 5 2017/18 report.

284 Financial Report & Dashboard Period 5 2017/18

The Director of Finance presented the Finance Report and financial dashboard for month 5, 2017/18 and reported that at Month 5 the Trust was £0.042m favourable against the planned £2.265m deficit, and was forecasting delivery of the full year control total and the Trust delivered a "Use of Resources" Rating of 3 in month which was equivalent to plan. CIP was slightly ahead of Plan overall, forecasting to deliver £3.7m for the year of which £0.7m was non-recurrent saving.

The Chief Executive referring to the FPBD chair report earlier in the meeting explained her views as

the Trust's Accountable Officer in terms of the private maternity provider who had stopped making payments to the Trust for services. She explained that this matter had been escalated to NHSI given the problem the Trust had had in 2016 in receiving payments from the same organisation. The Chief Executive advised that in the times of having to make savings in services to deliver sustainable services it was vital that the Trust receives these payments in full.

The Chair asked at what stage the Board would receive and review the operational plan 2018/19 and whether the plan would be an update of the second year of the 2017-2019 Operational Plan. It was reported that no guidance had yet been received from NHSI; however there was an assumption that it would take the form of an update. This would be undertaken in Q4.

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

285 Fit for Future Generations Update

The Chief Executive advised that a lot had already been discussed at the last meeting surrounding the Northern England Senate Report which was now in the public domain and presented today to the Board for noting. She asked the Medical Director if he wished to add anything to what had already been said about the Report.

The Medical Director responded and explained the membership of the senate who were eminent in their field of speciality who had been asked to review the process and findings from the Pre Consultation Business Case and provide assurance to NHS England. He advised that the assurance was clinically based only. The Medical Director commented that there had been no decision to move the hospital and that the Senate Report would be used as part of any public consultation that would need to take place before any decision was reached.

The Medical Director summed up the position and advised that the process being undertaken was Liverpool CCG's. They were responsible to NHS England in providing the necessary assurances so that NHS England could allow the CCG to move to the next stage in the process; public consultation.

The Board noted the update.

286 Board Assurance Framework

The Board Assurance Framework was taken as read given that all the Board committees responsible for the risks had undertaken their review and made recommendations. The Chair asked that before the Board discuss the recommendation in the paper that there were no additional comments.

The Chair noted the recommendation of the PPF Committee to escalate the corporate risk relating to Junior Doctors staffing to the Board Assurance Framework risk; To develop a well led, capable, motivated and entrepreneurial workforce. The Board approved the escalation of the risk.

Referring to the Corporate Risk score movements as a result of discussion at PPF, the Director of Workforce and Marketing advised that all avenues were being investigated to mitigate and reduce the risk however the Committee concluded that the national shortage of junior doctors was becoming an increasing risk to the Trust, alongside a gap of specialist nursing roles and agreed to move the corporate risk score to 20 (Likelihood 4 x Impact 5 = risk score of 20). The Board noted the change in risk score.

287 Review of risk impacts of items discussed

The Board noted the risks had been discussed during the meeting including:

i. the risk of the shortage of Junior Doctors and increasing gap in specialist Nursing roles and recruitment
ii. 7 day service

iii. Private Sector competition – fertility

288 **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

The Chair reported that the next meeting of the Board in public would be 3 November 2017

Agenda Item 2017/292

Liverpool Women's NHS Foundation Trust

TRUST BOARD
3 November 2017 Action Plan

Meeting date	Minute Reference	Action	Responsibility	Target Dates	Status
7 July 2017	2017/196:	The Director of Nursing and Midwifery to provide an update report on the implementation of the National Maternity Review to the 1 December 2017 Board meeting.	Director of Nursing and Midwifery	On Target	
6 Oct 2017		The Trust Secretary to make arrangements for a safeguarding Board workshop	Trust Secretary		A Board workshop to be arranged on the day of a future Board meeting.

Liverpool Women's NHS Foundation Trust

Board of Directors

Committee Chair's report of Charitable Funds Committee meeting held
13 October 2017

1. Was the quorate met? Yes

2. Agenda items covered

~ **Fundraising Strategy Review:** The Committee was introduced to Victoria Symes, Director at impact fundraising who has been commissioned to undertake the scoping exercise into the development of a fundraising campaign. The Committee would receive the final scoping exercise in December 2017 and be considered by the Board in January 2018.
~ **Investment Overview:** The Committee received an overview of the investment position against the political and economic background during 2017 from Investec representatives. The Committee reviewed the asset allocation of funds and agreed to reduce the cash reserve fund to 3% and transfer the remainder to the infrastructure fund and property fund. The Committee confirmed that their appetite for investment remains at a medium risk profile.
~ **Financial Position and Investment Reports 2016/17:** The Committee noted the Charitable Funds Income & Expenditure for quarter 1, 2017/18.
~ **Review of Medical Education Fund:** The Committee welcomed Ruben Trozhez, one of the fund holders for the Medical Education Fund to the meeting. Ruben attended to request Committee approval to split the Medical Education Fund into two separate funds. One for Obstetric & Gynaecology research and medical education and the other for Urogynaecology research and medical education. The Committee considered the request, noting that donations have been given to a joint fund and it is the expectation of those donors that the money is used across the specialities. The Committee also considered the historical background to this fund and agreed that it would be extremely difficult to unravel. It was recommended by the Committee that a sub-fund can be created for Urogynaecology if they wish to generate their own fundraising. It was also agreed that a new fund holder should be allocated to the Medical Education Fund representing the obstetric workforce, as currently both fund holders are urogynaecologists.
~ **Fundraising Report:** The Committee received the Fundraising Report detailing current and planned fundraising events. They agreed to share the report with the Board of Directors for information to highlight the significant work undertaken.
~ **Review of Fund Signatories:** Committee noted a rolling process to manage and review fund signatories to ensure that appropriate governance is maintained. They were assured that all information is recorded and available for auditing purposes.

3. Board Assurance Framework (BAF) risks reviewed
None.

4. Escalation report to the Board on Performance Measures
None.

NHS

5. Issues to highlight to Board

~ To note that investments had positively achieved 10% return over a 5 year period. It is anticipated that income generated from investment will decrease during the next 5 years as the political and economic market is becoming increasingly challenging.

6. Action required by Board

~ None

Phil Huggon
Chair of Charitable Funds Committee

Liverpool Women's NHS Foundation Trust

Board of Directors

Committee Chair's report of Finance, Performance and Business Development Committee meeting held 23 October 2017

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

2. **Agenda items covered**
   - **Strategic Outline Case Update:** The Committee was informed that NHS England (NHSE) are still reviewing the additional information and a decision with regard to public consultation is awaited.
   - **Month 6 2017/18 Operational Performance Review:** The Committee received Month 6 2017/18 performance dashboard. It was noted that the Trust had self assessed against a number of the CQUIN targets and RAG rated as red or amber due to the lack of evidence provided. This has been escalated to managers to update immediately to ensure that when information is submitted to the CCG it will be sufficiently robust.
   - **Month 6 2017/18 Finance Performance Review:** The Committee received Month 6 2017/18 finance position and noted that at month 6 the Trust is continuing to forecast delivery of the full year control total. The Committee was informed that new contract negotiations had commenced with Liverpool Clinical Laboratories. Any issues relating to contract negotiations would be promptly escalated to the Director of Operations. The Committee noted and agreed with recommendations from the financial controls audit. The Committee was notified that the maternity provider that had stopped making payments have since agreed to make payments at a discounted rate. The Committee considered the cash borrowing position and agreed to review again at Month 9.
   - **Activity and Financial Performance against the Block Contract:** The Committee was informed that at Month 6 activity performance against block contract is underperforming. The Committee was particularly concerned about activity within gynaecology since the reconfiguration of services. The Committee noted the recovery plans and the additional operational management support required to manage these issues. The position would be reported monthly to the Committee within the financial performance report.
   - **Cost Improvement Programme (CIP) Update:** The Committee received the CIP tracker report.
   - **NHSI Enforcement Undertaking Review:** The Committee noted the position statement and was assured that the Trust had made significant progress against the undertakings to deliver its services on a financially sustainable basis.
   - **Liverpool Women's Health Consultancy Update:** The Committee had received supplementary information since the last meeting as requested. A Memorandum of Understanding was tabled at the meeting for Committee approval. The Committee agreed to review the document and provide comments within 48 hours.
   - **Hewitt Centre Update:** The Committee noted the Interim Managing Director for the Hewitt Centre would remain in position until the end March 2018. The Committee considered the position reached by the Hewitt Centre and agreed to reduce reporting to a quarterly update report.
   - **Electronic Patient Record Update:** The Committee was informed of a deferment of the implementation date from June 2018 to October 2018. Potentially this would mean a combined 'go live' date with the Royal Liverpool Hospital. The Committee was asked to support the appointment of a Programme Director to move forward the strategic management to implement EPR, and to approve the attendance of the Director of Finance at the Programme Board.
   - **Sub Committee Chairs reports received**
     - Turnaround and Transformation Committee
     - Emergency Planning Resilience and Response Committee

NHS

- Information Governance Committee
  The Committee noted the Data Protection Regulations action plan and requested a report to be considered in January 2018.

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. It was considered that scores might be amended in Month 9 upon receiving further financial and performance planning information.

4. Escalation report to the Board on FPBD Performance Measures

~ The Trust is achieving the NHSI targets in relation to those appropriate for FPBD. Although the cancer target before reallocation has breached by 0.38% in month it is not anticipated to carry forward into after reallocation indicator.

5. Issues to highlight to Board

~ Activity and financial performance: The underperformance against the contract in 2017/18 has a potentially significant impact on the Trusts financial position in 2018/19. Further investigation and action is required in this area.

6. Action required by Board

~ None

Jo Moore
Chair of FPBD

Liverpool Women's NHS Foundation Trust

Board of Directors

Committee Chair's report of Audit Committee meeting held 23 October 2017

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

2. **Agenda items covered**
   - ~ Follow up of Internal Audit and External Audit Recommendations: The Committee received an updated position on implementation of outstanding recommendations from 2017/18. The Committee noted that a number of actions had been finalised since the report had been circulated. It was noted that since the last meeting, the two re-opened audits in relation to the BAF and NPSA Alert audits, have both been reviewed and closed as completed. It was clarified that a review process of closed audits is following best practice.
   - ~ Internal Audit Progress Report: The Committee noted the update and the finalised audit reports and recommendations. In particular, the findings of the unannounced quality spot checks on three wards were considered. The Director of Finance informed the Committee on behalf of the Executive Team that they had been disappointed with some of the findings and are arranging further spot checks. The Committee noted the GACA effectiveness review and considered whether a similar exercise should be conducted for the other Board Sub-Committee's.
   - ~ Counter Fraud Progress Report: The Committee noted progress to date. It was highlighted that NHS Protect had requested that an investigation be reopened. The investigation evidence was reviewed and confirmed no case to answer and closed.
   - ~ Appointment of External Auditors Update: The Committee noted the appointment process and the selection of KPMG as external audit providers. The Committee would make a recommendation to the Council of Governors to approve the appointment of KPMG in October 2017.
   - ~ Register of Waivers: The Committee received the register of waivers covering the period quarter 2 2017/18. The Committee was assured by the governance process in place to approve waivers.
   - ~ Review of assurances processes, integrated governance, risk management and internal control arrangements: The internal review demonstrates evidence of effective learning and risk management. The review would support the internal control governance statement submission. The Committee discussed the interpretation of learning and how it can be effectively delivered to every staff group.
   - ~ Review of audit committee effectiveness: The Committee noted the review of committee effectiveness.

3. **Board Assurance Framework (BAF) risks reviewed**
   - ~ Board Assurance Framework (BAF): The Committee received a paper describing the process taken to review the Trust's Board Assurance Framework. Since the implementation of the new framework, one additional risk had been added to the BAF, escalated by the Putting People First Committee. The Committee approved the process and was assured that each Board sub-committee reviews the BAF risks aligned to them.

4. **Escalation report to the Board on Audit Performance Measures**
   - ~ None

5. **Issues to highlight to Board**
   - ~ None

6. **Action required by Board**
   - ~ None

NHS

Liverpool Women's NHS Foundation Trust

Ian Knight
Chair of Audit Committee

NHS

Agenda Item	2017/298

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Mortality Quarter 2 Report**
DATE OF MEETING:	Friday, 03 November 2017
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Andrew Loughney, Medical Director
AUTHOR(S):	Devender Roberts, Associate Medical Director Amanda Cringle Quality Lead
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** 1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☐ 2. To be ambitious and *efficient* and make the best use of available resource ☐ 3. To deliver *safe* services ☒ 4. To participate in high quality research and to deliver the most *effective* Outcomes ☒ 5. To deliver the best possible *experience* for patients and staff ☐
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust* ☐ ***2.*** *The Trust is not financially sustainable beyond the current financial year* ☐ ***3.*** *Failure to deliver the annual financial plan* ☐ ***4.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision* ☐ ***5.*** *Ineffective understanding and learning following significant events* ☒ ***6.*** *Inability to achieve and maintain regulatory compliance, performance and assurance* ☒ ***7.*** *Inability to deliver the best clinical outcomes for patients* ☒ ***8.*** *Poorly delivered positive experience for those engaging with our services* ☐
CQC DOMAIN	***Which Domain?*** ***SAFE-*** *People are protected from abuse and harm* ☐ ***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☐ ***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐ ***RESPONSIVE –*** *the services meet people's needs.* ☐ ***WELL-LED -*** *the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ☒ ***ALL DOMAINS*** ☐

LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution ☐ **2.** Operational Plan ☒ **3.** NHS Compliance ☒	**4.** NHS Constitution ☒ **5.** Equality and Diversity ☐ ***6.*** Other: **Click here to enter text.**
FREEDOM OF INFORMATION (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:** a. Take assurance that there is adequate progress against the requirements laid out by the National Quality Board b. Confirm that the Board are confident there are effective governance arrangements in place to drive quality and learning from the deaths of patients in receipt of care at this trust	
PREVIOUSLY CONSIDERED BY:	**Committee name**	Not Applicable
	Date of meeting	

Executive Summary

The Board have previously been informed that both the National Quality Board and the Care Quality Commission have made clear that trusts should be developing systems and processes to review and learn from the deaths of patients under their care. It is expected that the Board of Directors oversee this work and receive quarterly reports on progress.

This report details how the trust is meeting the requirements laid down externally and provides details of mortality within the Trust during Quarter 2 of 2017-18. It concludes that there is currently evidence available that adequate progress is being made and that mortality rates are within expected ranges. The report outlines the work taking place operationally and being overseen by Effectiveness Senate and GACA.

Report

1. Introduction

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

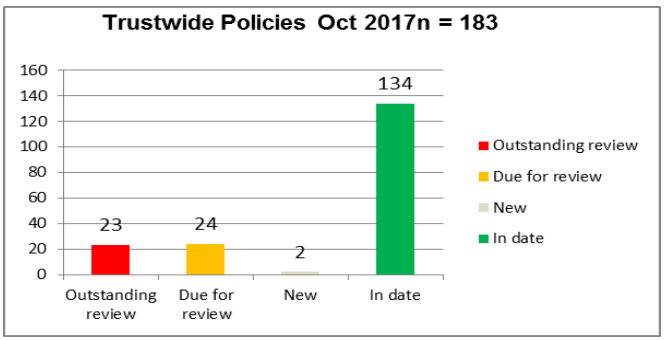
This overview outlines the most recent trust figures and headline findings in regards to mortality. It provides details to the Board of their own accountabilities while setting out the responsibilities of the Governance and Clinical Assurance Committee and Effectiveness Senate to monitor progress regularly and escalate as required; this includes escalation of exceptions from any audit work related to the risk of adult mortality, stillbirth and neonatal death.

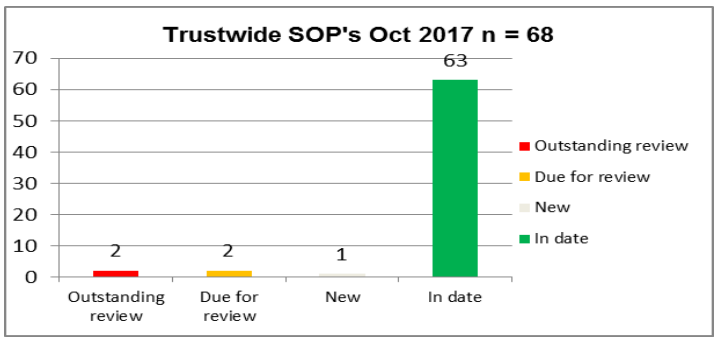
Liverpool Women's NHS Foundation Trust recognises that although most of the adult death it encounters is the expected end point of a known disease process, the principles described above are equally valid to its own services. In the Trust's Risk Management Strategy, commitment is given to minimise risk through the systematic embedding

of relevant, efficient and effective risk management processes. Since the Trust's core purpose is to provide clinical care, its foremost risks are those that are clinically based and the ultimate clinical risk is that of death.

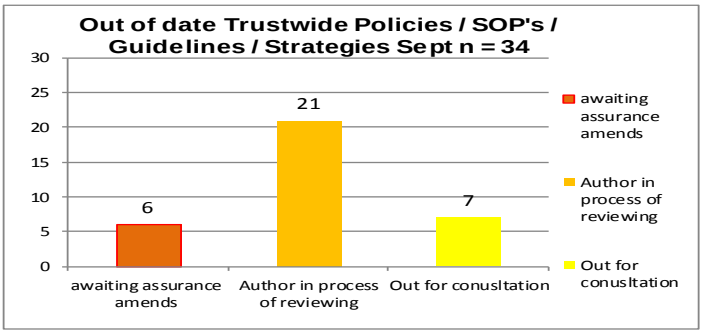
2. Prevention

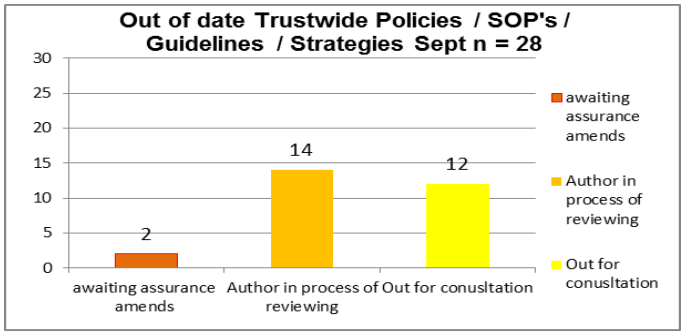
a) There are currently 267 Trust wide Policies / SOP's / Guidelines and Strategies, the below charts identify the current status of each type of document.





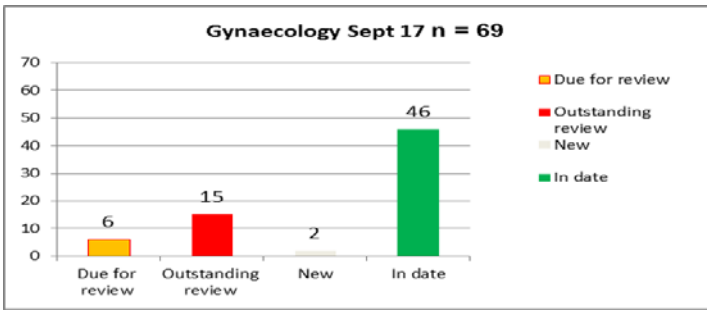
b) There are currently 28 Trust wide Policies, SOP's, Guidelines and Strategies out of date.
Out of the 28 documents 23 are policies; of which 2 are awaiting assurance amendments before final upload and 9 policies are awaiting assurance within the policy group. The residual documents are in process of being reviewed. The remaining 5 out of date documents consist of 2 Guidelines, 2 SOP's, and 1 strategy; 2 of which are awaiting ratification, 2 are being reviewed and a paper is going to the Board regarding one.

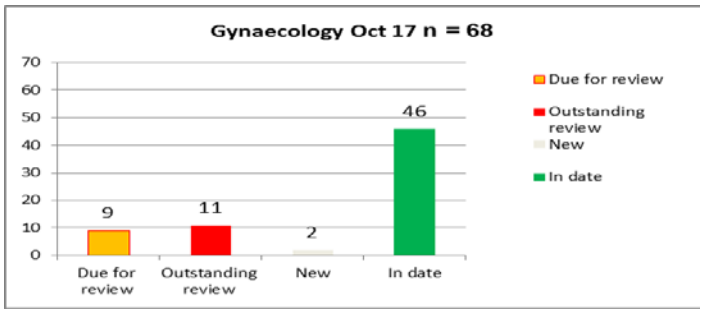




Gynaecology

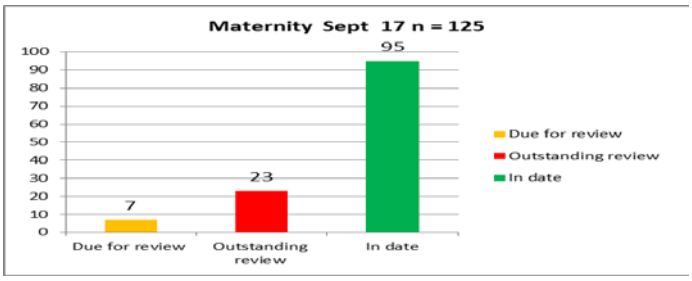
c) Policies / guidelines are currently being monitored via Gynaecology Clinical meeting; there are 11 outstanding reviews, of which 7 are awaiting ratification.

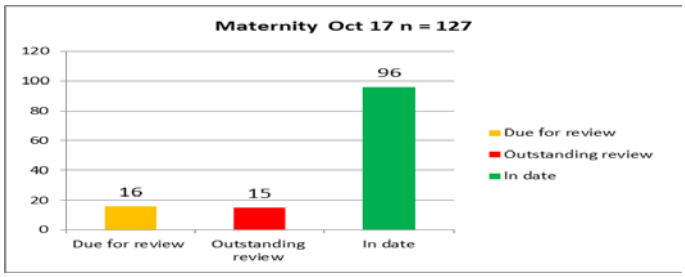




Maternity

d) There are currently 15 outstanding documents for Maternity which have all been allocated for review





3. Analysis

Adult Mortality Incidents 2017-18 Quarter 2

A review of incident data for the period 01/07/2017 to 30/09/2017 shows no recorded Death incidents, either unrelated to or as a result of a Patient Safety Incident (PSI).

No. of Adult Deaths in Period	0
No. with Completed Mortality Audit Form	N/A
No. Needing Root Cause Analysis	N/A

Outcomes from Review of Mortality Audit Forms

Deficiencies in Care	• None identified
Themes from Audit sheets and RCA investigation	• No deaths in period, therefore no themes identified.

Actions Identified from Review of Incidents

No actions determined in this quarter.

Closed Actions – Evidence of Effectiveness

No actions relating to Adult Mortality incidents were closed nor were assessed for effectiveness in this period.

4. Audit

A clinical audit programme should be developed so that specialities are focused on improving performance against standards in a systematic way. The responsibility for agreeing which clinical audit will take place within specific services rests ultimately with Clinical Audit Leads and Clinical Directors (with input from wider clinical colleagues and stakeholders) and should be informed by quality and performance as well as local priorities.

The Annual Audit Programme for 2017 – 18 had been informed by intelligence from a number of different sources including:-

- national audits
- mandatory requirements
- incidents, particularly Serious Untoward Incidents (SUI's)
- themes within claims and complaints
- audits that could not be completed by the end of the previous year
- key quality themes
- Aspects of care which we are keen to re-audit following previous audit activity and improvement work.

The content of the Clinical Audit Forward Plan is flexible from April 2017 the Trust commits to the principle that it must include work of relevance to the highest risk areas for adult mortality including:

- Haemorrhage
- Psychiatric disease
- Sepsis
- Neurological disease
- Venous thromboembolism
- Cardiac Disease

Adult Mortality – Clinical Audit progress October 2017

Topic	Clinical Audit Title/s	Progress
Haemorrhage	• i. Use of O Negative blood	• i. Data collection in progress – report and action plan expected Dec-17.
	• ii. Bedside transfusion (including consent)	• ii. Data collection in progress – report and action plan expected Dec-17.
	• iii. SHOT NCA of TACO prevention	• iii. Data submitted. Awaiting National report.
Psychiatric disease	• Antenatal Perinatal mental health management and outcome at Liverpool Women's Hospital	• Audit due to commence Oct-17 but no proposal received to date.
Sepsis	• i. Audit of the management of pregnant women with asymptomatic bacteraemia at booking visit (Previously titled: "Maternal and Congenital sepsis")	• i. Audit not started.
	• ii. SEPSIS bundle – Maternity	• ii. Data being captured via NUMIS – therefore, no

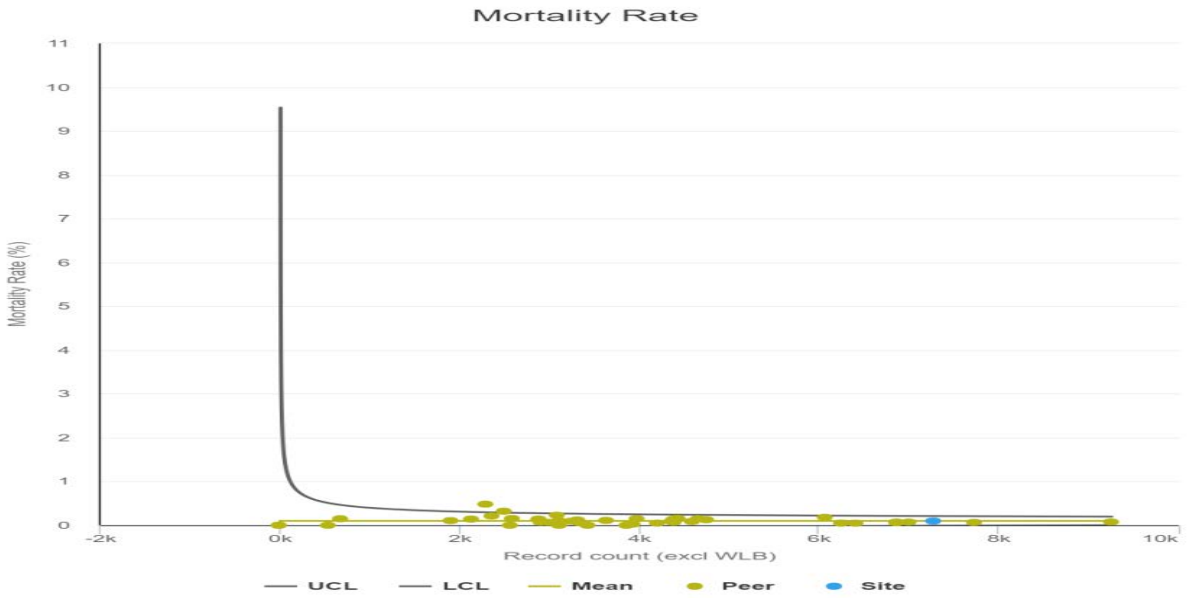
	• iii. Audit of the management of patients with sepsis/compliance to the 1 hour Sepsis Bundle – Gynaecology • Please include the recently concluded audit of caesarean section associated infections (aka Surgical site infection at CS audit) under Sepsis box: All infections related to CS (including sepsis) were examined by the audit	Clinical Audit planned. • iii. NUMIS set up for data entry and reporting but currently issues with system overloading and data extraction – once this is rectified the planned Clinical Audit can be abandoned – Debi Rice & Russell Cowell are liaising to rectify this.
Neurological disease	• Antenatal Perinatal mental health management and outcome at Liverpool Women's Hospital	• Audit due to commence Oct-17 but no proposal received to date.
Venous thromboembolism	• Assess LWH Gynaecology admissions against NICE QS 03 – VTE in Adults; reducing the risk	• Additional audit to be approved at Effectiveness Senate 20.10.17 – audit has taken place prior to registration. Report received but requires quality checking once audit is registered.
Cardiac disease	• EFM prospective re-audit (re-audit)	• Audit postponed until 2018-19 due to an audit only recently being completed; however the re-audit was currently on the forward plan to be undertaken this year. Bode Williams felt that it was too soon to undertake the re-audit and requested this could be postponed until next year, i.e. 2018-19. This was approved by Effectiveness Senate 16th June 2017.

5. Mortality Dashboard

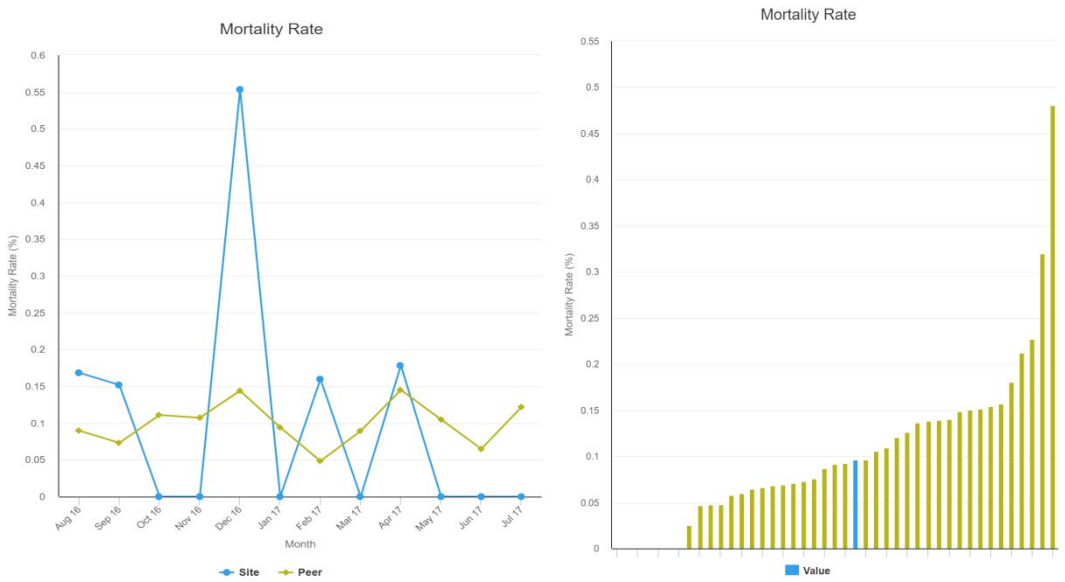
Currently in development awaiting clinical confirmation for what is needed to be compliant with national guidance 'Learning from Deaths' the LeDeR (Learning Disabilities) framework and the trust Mortality Strategies. Completion by end of November 2017.

6. Benchmarking

The data chart below excludes Bedford and Hewitt patients to bring more in line with other Trusts. LWH, represented by the blue dot, lies on the mean line of adult mortality.



The data source is from CHSK national database covering date range available from Aug 16 – Jul 17 to ensure peer data currently available.



For the charts above, peers are based on Gynaecology units of a similar size and type to that of Liverpool Women's Trust. The adult mortality figures for LWH are historically low as the majority of deaths that occur are 'expected' deaths within gynaecology and oncology units. There were three expected oncology deaths in December 2016 and one in February and one in April 2017; there have been none to date. Each death will have a mortality audit review conducted, this is currently under development to be included on the Ulysses system,

this avoids losing any paper documents (current system) and allows for searching, monitoring and auditing of an electronic system.

7. Key Themes

Adult Mortality Quarter 2		
	Maternity	**Gyneacology**
No of Adult Deaths	0	0
No of Mortality Reviews completed	0	0
No of deaths requiring RCA's	0	0
No of deaths due to deficiencies in care	0	0
Mortality Themes	N/A	N/A
Progress v Smart Plans	N/A	N/A
Mortality Outcomes	N/A	N/A
Measures for ongoing scrutiny	N/A	N/A

There are no deaths either within gynaecology or maternity, therefore we cannot provide any mortality themes for analysis.

Adult Gynaecological Deaths – Quarter 1

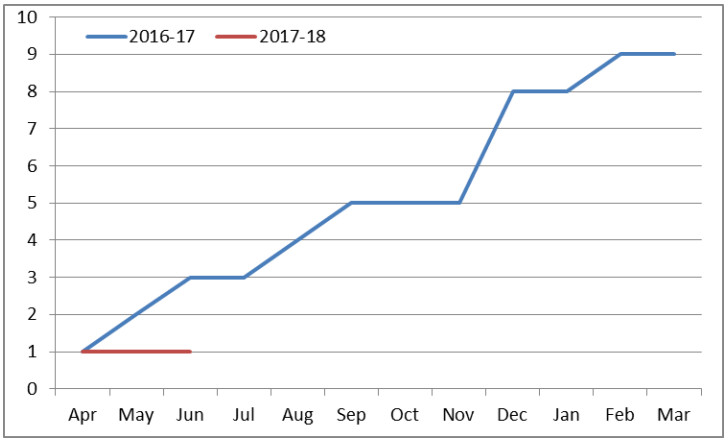


Figure 1: Cumulative Adult Gynaecology Deaths: Apr 2016-Jun 2017

- There was one death in April; out of 93 discharges this represents a rate of 10.8 per 1000 discharges.

- There was one adult gynaecology death in Quarter 1 of 2017-18. This compares to 3 in Quarter 1 of 2016-17.
- There were 12 adult gynaecology deaths in 2016-17, a reduction on the 14 in 2015-16
- The Quarter 1 death was assessed as an expected death.
- All adult gynaecology deaths are discussed at the gynaecology Morbidity & Mortality meeting. As part of this process an adult mortality sheet is completed indicating any potential for improvement in care. Unexpected adult gynaecology deaths trigger a serious incident investigation.

Adult Gynaecological Deaths – Quarter 2
There have been no gynaecological deaths for this period, therefore performance death have produced no chart to depict the zero rate.

8. Horizon Scanning

NICE Guidance:

Nice guidance updates and new guides are presented and assigned owners to review at the monthly Effectiveness Senate, this is then monitored, reviewed and audited through the senate.

A review for the past quarter of NICE guidance and updates has yielding no results in any outstanding or updates to guides in relation to Adult Mortality.

Other Professional Organisations:

Library services provide monthly horizon scanning of any new clinical reports, documents, guidance, and research across a wide range of clinical subject matter for review at the monthly Effectiveness Senate, this is then monitored, reviewed and audited through the senate.

Horizon Scanning Summary for guidance, reports and publications

Subject(s): Adult mortality (Maternity/ Gyneacology)

Period: August – October 2017

Sources: CQC; NCPOD ; NHS Digital, NHS Resolution, Public Health England, RCOG,

CQC – no updates found for the period covered

NCPOD – no updates found for the period covered

NHS Digital:

Summary Hospital-level Mortality Indicator (SHMI) - Deaths associated with hospitalisation, England, April 2016 - March 2017

This publication of the Summary Hospital-level Mortality Indicator (SHMI) relates to discharges in the reporting period April 2016 to March 2017.

NHS Resolution – no updates found for the period covered

Public Health England – no updates found for the period covered

RCOG – no updates found for the period covered

9. Progress / Learning from Deaths

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

- Recovery from haemorrhage
- Treatment of sepsis
- Management of pre-existing cardiovascular disease
- Recovery from a procedure-related injury
- Treatment of thrombo-embolism

Currently there have been no deaths to comment on in which to provide specific learning from death outcomes.

10. Conclusion

There have been no gynaecological or LeDer (Learning disability) deaths within quarter 2 reporting period. Work against the Adult Mortality Strategy is progressing steadily.

11. Recommendations

Mortality dashboard will be completed by the end of November, after there have been further clinical discussions made to finalise the agreed data to be collected, monitored and audited.
The mortality audit toolkit will be available electronically via the Ulysses risk management database, this will allow for the toolkit to be monitored and audited providing additional reassurances for the trust.

It is recommended that the Board:

a. Take assurance that there is adequate progress against the requirements laid out by the National Quality Board
b. Confirm that the Board are confident there are effective governance arrangements in place to drive quality and learning from the deaths of patients in receipt of care at this trust

Agenda Item	**2017/299**

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Serious Incident Report: Quarter 2**
DATE OF MEETING:	Friday, 03 November 2017
ACTION REQUIRED	For Assurance
EXECUTIVE DIRECTOR:	Andrew Loughney, Medical Director
AUTHOR(S):	Governance Team
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** **1.** To develop a well led, capable, motivated and entrepreneurial ***workforce*** ☐ **2.** To be ambitious and ***efficient*** and make the best use of available resource ☐ **3.** To deliver ***safe*** services ☒ **4.** To participate in high quality research and to deliver the most ***effective*** Outcomes ☒ **5.** To deliver the best possible ***experience*** for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust* ☒ ***2.*** *The Trust is not financially sustainable beyond the current financial year* ☐ ***3.*** *Failure to deliver the annual financial plan* ☐ ***4.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision* ☐ ***5.*** *Ineffective understanding and learning following significant events* ☒ ***6.*** *Inability to achieve and maintain regulatory compliance, performance and assurance* ☐ ***7.*** *Inability to deliver the best clinical outcomes for patients* ☒ ***8.*** *Poorly delivered positive experience for those engaging with our services* ☒
CQC DOMAIN	***Which Domain?*** ***SAFE-*** *People are protected from abuse and harm* ☒ ***EFFECTIVE*** *- people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☐ ***CARING*** *- the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐ ***RESPONSIVE –*** *the services meet people's needs.* ☒ ***WELL-LED*** *- the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ☒

	ALL DOMAINS ☐			
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution ☐ **2.** Operational Plan ☒ **3.** NHS Compliance ☒		**4.** NHS Constitution ☒ **5.** Equality and Diversity ☐ ***6.*** Other: **Click here to enter text.**	
FREEDOM OF INFORMATION (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		
	Date of meeting	Monday, 18 September 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 financial year, there was one Serious Incident 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
2017/22885	51336	04/09/2017	Gynaecology	14/09/2017		27/11/2017	07/12/2017

3. Serious Incidents submitted to the CCG

In the second quarter of the financial 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?
2017/9821	48122	10/04/2017	Maternity	12/04/2017	Final Report July 17.pdf	No	14/07/2017	Yes
2017/10333	48007	18/04/2017	Gynaecology	19/04/2017	Final Incident Report 48007.pdf	No	14/07/2017	Yes
2017/13016	48596	19/05/2017	Neonatal	19/05/2017	2016_13016 Report and Action Plan FINAl	No	14/08/2017	Yes
2017/13199	48712	22/05/2017	Maternity	22/05/2017	SI 2017-13199 final report submit.pdf	No	16/08/2017	No – 1 day overdue
2017/13234	48876	22/05/2017	Gynaecology	23/05/2017	SI 2017-13234 Report and Action Pla	No	17/08/2017	No – 1 day overdue

2017/13440	**48917**	**22/05/2017**	**Gynaecology**	**24/05/2017**	2017_13440 SI Report Action FINAL	**Had requested extension but no confirmation/ agreement received from CCG**	**30/08/2017**	**No – 14 days overdue**

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.

SI Ref.	Recommendation	Department	Action Description	Progress Narrative	Operational Lead	Management Lead	Root Cause?	Target Date
2017/3809	Comprehensive information to be included on SBAR	Maternity	SBAR should be reviewed and updated to include a plan for follow up results		Shift Leader	Community Matron	Y	Sept 17
2017/3809	Formal handover tool	Maternity	Develop robust systems for recording handover information for		Mat base Manager	Matron and Clinical Director	Y	Sept 17

			admissions, including follow up and action of results					
2017/13440	Review of GED transfer communication and gestation specific management to include SOP, SBAR & Escalation processes – to be agreed with Gynaecology/Maternity Teams.	Gynaecology	Discussion with GED/Delivery Suite, Doctors/Nurses/ midwives to agree SOP/SBAR and escalation for transfer for patients from GED to MAU/Delivery Suite	SBAR added to PENS, SOP ready for agreement	GED Ward Manager/ MAU War Manager	Head of Midwifery/ Head of Nursing	Y	Sept 17
2017/13440	Medical staff involved in the incident to have educational review meeting and reflection discussion with Educational Supervisor.	Gynaecology	Report to be shared with Medical Director	Awaiting confirmation these discussions have taken place	GED Ward Manager/MAU Ward Manager	Director of Medical Education	N	Sept 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 or so, indeed the latest NRLS report shows the Trust has the highest Incident reporting rate within the Specialist Acute Trust cohort for the reporting period Oct-16 to Mar 17. This is good news when we consider that NRLS recognise that high reporting rates is a feature of organisations with good safety culture. The Harm profile of the reported incidents indicates that work to improve the reporting of Near miss and no harm events has been successful, as the Trust profile is near that of the aggregated profile for the cohort.

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 continues to be used and monitored throughout the Trust.

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

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

Agenda Item	2018/300

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Safer Nurse/Midwife Staffing Monthly Report**
DATE OF MEETING:	Friday, 03 November 2017
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Doug Charlton, Director of Nursing and Midwifery
AUTHOR(S):	Doug Charlton, Director of Nursing and Midwifery
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** 1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☐ 2. To be ambitious and *efficient* and make the best use of available resource ☐ 3. To deliver *safe* services ☒ 4. To participate in high quality research and to deliver the most *effective* Outcomes ☐ 5. To deliver the best possible *experience* for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust* ☒ ***2.*** *The Trust is not financially sustainable beyond the current financial year* ☐ ***3.*** *Failure to deliver the annual financial plan* ☐ ***4.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision* ☐ ***5.*** *Ineffective understanding and learning following significant events* ☐ ***6.*** *Inability to achieve and maintain regulatory compliance, performance and assurance* ☒ ***7.*** *Inability to deliver the best clinical outcomes for patients* ☒ ***8.*** *Poorly delivered positive experience for those engaging with our services* ☒
CQC DOMAIN	***Which Domain?*** ***SAFE-*** *People are protected from abuse and harm* ☐ ***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☒ ***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐ ***RESPONSIVE –*** *the services meet people's needs.* ☐ ***WELL-LED -*** *the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ☒ ***ALL DOMAINS*** ☐

LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution	☐	**4.** NHS Constitution	☐
	2. Operational Plan	☐	**5.** Equality and Diversity	☐
	3. NHS Compliance	☒	***6.*** Other: **NHS England Compliance**	
FREEDOM OF INFORMATION (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 organization has the appropriate number of nursing & midwifery staff on its inpatient wards to manage the current clinical workload as assessed by the Director of Nursing & Midwifery			
PREVIOUSLY CONSIDERED BY:	**Committee name**		***Choose an item.*** Or type here if not on list: ***Click here to enter text.***	
	Date of meeting		***Click here to enter a date.***	

Executive Summary

Data presented in this report demonstrates the effective use of current Nursing & Midwifery resources for all inpatient clinical areas.

Overall fill rates versus planned remain high with the reallocation of nursing and midwifery resources where necessary to maintain safe staffing levels.

Nurse sensitive indicators continue to highlight the good practice of reporting medication errors especially in the neonatal unit. All errors are investigated and appropriate action taken. No error resulted in harm to any patient. Three complaints were received during September relating to the Maternity and Gynaecology services. These complaints were investigated and responded to within the specified timeframe.

Care hours per patient day remain at a sustained level indicating a consistent level of care nursing/midwifery resource to provide care to our patients.

Bank staff usage was high in September but slightly lower than in August. September usage was still above the set KPI of 6%; additional staff have been used to fill gaps in rotas due to vacancies. This should now resolve due to the recent midwifery recruitment drive.

Sickness levels remain above the set 3.5% KPI target abut are slightly better than the previous month and average around 5%. The majority of reported sickness is due to long term sickness leave.

Staffing across the inpatient ward areas for September remained appropriate to deliver safe and effective patient care

Ward Staffing Levels – Nursing and Midwifery
Report

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 September 2017.

1.2 To provide context for the Trust Board on the UNIFY safe staffing submission for the month of September 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 – 30th September 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 – September 2017**				
Ward	RN/RM		Non Registered		
	Fill Rate Day%	Fill Rate Night %	Fill Rate Day%	Fill Rate Night %	Total Workforce CHHPD
Delivery & Induction Suite	88.8	86.7	130.0	86.7	34.7
Mat base	87.9	83.8	81.3	95.6	6.6
MLU & Jeffcoate	90.6	83.7	95.0	86.7	40.3
NICU	113.5	114.6	68.3	48.3	11.4
Gynae Ward	96.2	97.0	80.2	72.2	7.4

Nurse Sensitive Indicators - August 2017									
Ward	**CDT**	**MRSA**	**Falls No Harm (N)**	**Falls Harm (N)**	**HAPU grade 1&2**	**HAPU grade 3&4**	**Drug Admin error**	**New Complaint**	**Red Flags**
Delivery & Induction Suite								**1**	
Mat base							**1**		
MLU & Jeffcoate								**1**	
NICU							**18**		
Gynae Ward								**1**	**1**

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 97.3% for registered staff and 87.9 % for care staff during the day and 96.1 % for registered staff and 79.6 % for care staff during the night.

4.3 On the day and night shifts, two clinical areas (Delivery Suite, Mat Base) reported staffing below 90% fill rates for qualified Nurses/Midwives. MLU reported staffing below 90% on night duty. One clinical area reported above 100% fill rate for Registered Staff (Neonatal) on day and 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
97.3%	**87.9%**	**96.1%**	**79.6%**

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

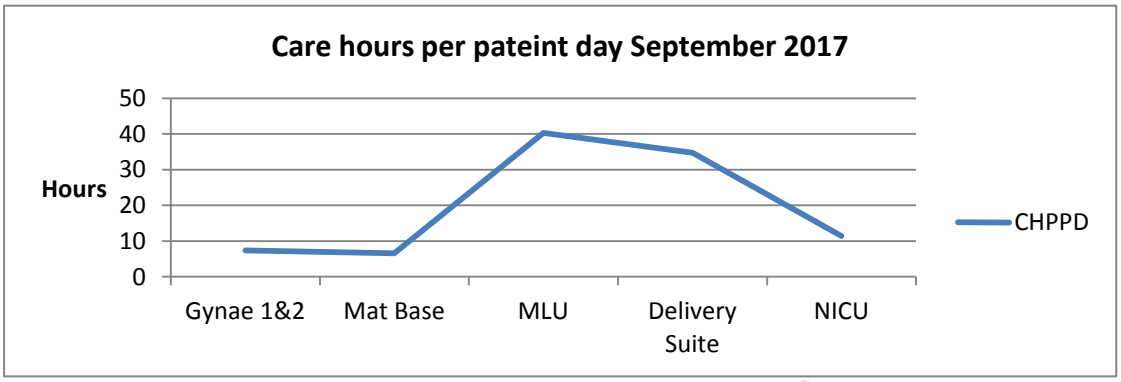
5.1 Safe staffing levels are reviewed and managed three times daily. At the daily 09.00am huddle meeting, the Director of Nursing or Deputy Director of Nursing in conjunction with Heads of Nursing/Midwifery, Matrons, and other senior staff review all registered and unregistered workforce numbers by service. 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 staff appropriately and 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)

6.1 Staff are encouraged to report any incident they believe may affect safe patient care using the Ulysses system. During September no reports was submitted relating to staffing on the inpatient ward areas. Staffing is reviewed by Matrons on a regular basis to ensure all clinical areas are staffed appropriately to support the delivery of safe care.

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. MLU have the most care hours (40.4 hours) and the Maternity Base have the least (6.6 hours). These data have remained consistent over the last eight months.



7.2 This month's average recorded number of hours of Registered Nurse/Midwife time spent with patients was calculated at 10.9 hours and 2.5 hours for care staff. This provides an overall average of 13.4 hours of care per patient day.

	CHPPD
Registered Nurse /Midwife	10.2
Care Staff	2.3
Overall Hours	12.5

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

Ward Name	**Sept17**	**Aug17**	**Jul 17**	**Jun 17**	**May 17**	**Apr 17**	**Mar 17**	**Feb 17**
Gynae 1&2	7.4	9.1	9.9	8.5	7	8.1	7	7.2
Mat Base	6.6	6.3	6	6.4	5.9	6.4	6	6.5
MLU	40.3	36.8	42	38.1	40.4	42.4	37	35.4
Delivery Suite	34.7	32.7	33.1	34.3	26.8	36.5	31.3	31.5
NICU	11.4	13.8	12.6	11.8	10.5	10.1	11.2	12.3
Total CHPPD	**12.5**	**13.4**	**13.1**	**12.5**	**11.2**	**12.3**	**11.7**	**12.5**

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 negatively affected the quality patient care.

8.2 There were 22 reported incidents against the Nursing staffing indicators for September. Of those incidents reported 19 related to medications 1 on Mat base and 18 on the Neonatal Unit.

8.3 There were 2 new complaints reported, one relating to delivery suite and one related to Gynaecology ward.

8.4 All incidents are reviewed by the senior nursing/midwifery team and corrective actions taken where appopriate.

Nurse Sensitive Indicators - August 2017									
Ward	**CDT**	**MRSA**	**Falls No Harm (N)**	**Falls Harm (N)**	**HAPU grade 1&2**	**HAPU grade 3&4**	**Drug Admin error**	**New Complaints**	**Red Flags**
Delivery & Induction Suite	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**
Mat base	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**
MLU & Jeffcoate	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
NICU	**0**	**0**	**0**	**0**	**0**	**0**	**18**	**0**	**0**
Gynae Ward	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**1**

8.5 1 Red Flag was identifed during September. This one red flag was reported on the Gynacology ward and it was a delay of activity.

9.0 Temporary Staff Utilisation

9.1 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.

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

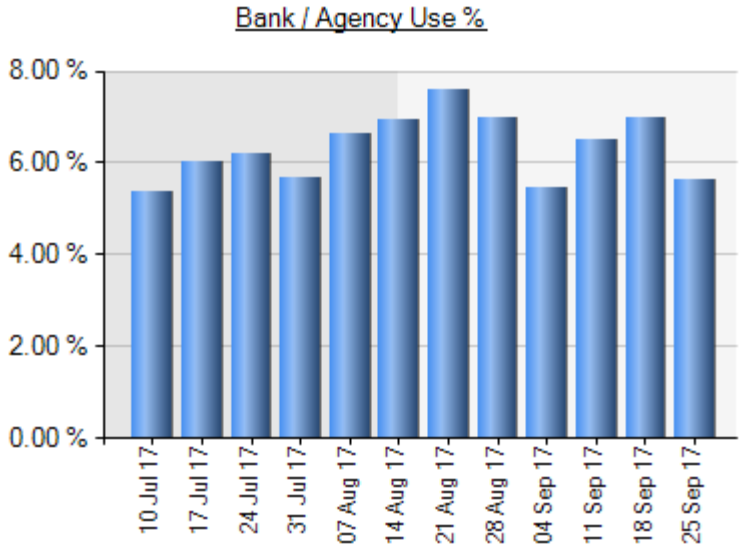
a) The system in place allows for the most appropriate use of temporary bank staff across the organisation and provides a positive challenge mechanism for all requests.

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.

10.0 Bank Usage Inpatient Wards (month ending September)

10.1 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 September (this is cumulative data captured from roster performance reports). No agency staff were used to replace substantive staff.

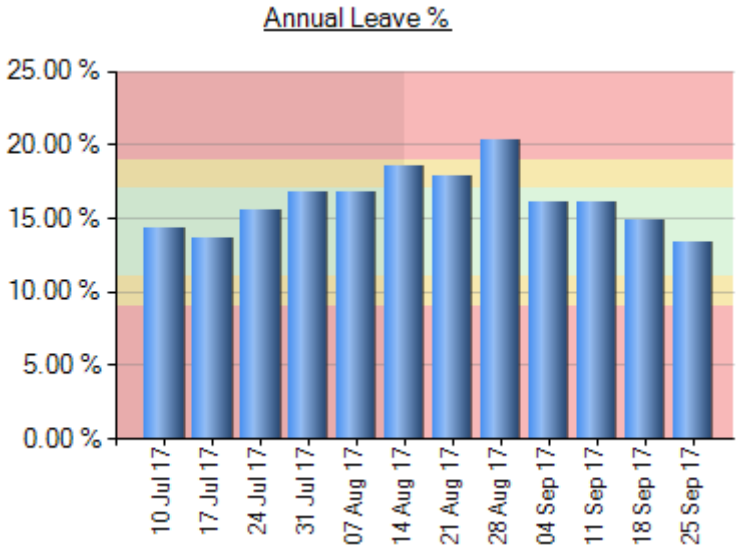
10.2 A key performance indicator (KPI) of less than 6% bank usage (bank shifts compared to total shifts assigned) was set to coincide with the NHS England agency cap. The percentage continues to fluctuate and has risen above the 6% target for September.



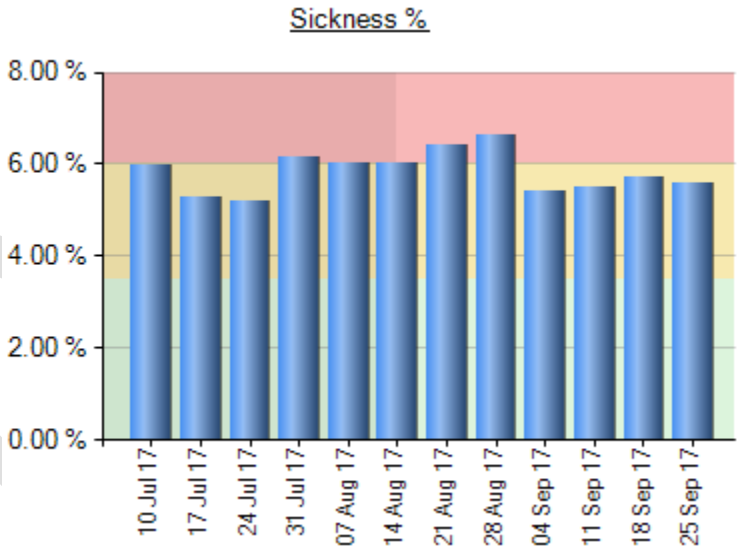
11.0 Managing Staff Resource

11.1 Annual leave taken during September spans the set tolerances of 9% -18%. These tolerance levels ensure all staff are allocated leave appropriately and an even distribution of staff are available throughout the year.

11.2 Heads of Nursing/Midwifery are aware of the need to remind staff to request and take annual leave. This continues to be monitored closely to ensure sufficient staff take annual leave by year end in a consistent manner. The annual leave has remained within the tolerance for September.



11.3 September demonstrated a reduction in the overall sickness levels across the inpatient areas but remained above the set parameter of less than 3.5%. Heads of Nursing/Midwifery ensure all individuals reporting back from sick leave undergo a robust sickness review. Sickness levels are being closely monitored to provide support to all staff.



12.0 Turnover rates

12.1 Turnover rates across the clinical areas have remained static overall for the last two months but with wide variation in different specialities. Turnover rates for the month of September have risen to a high of 14%. All staff that leave the trust are invited to attend an exit interview with the Human Resources department.

12.2 All senior nurse midwife managers are also encouraged to discuss the reasons for leaving the trust with individual members of staff. Where deficits have been identified as the cause of the departure an attempt is made to put these right to prevent other staff leaving.

Turnover rates	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
Hewitt Centre	10.00%	10.00%	10.00%	12.00%	22.00%	25.00%
Genetics	11.00%	8.00%	8.00%	5.00%	4.00%	6.00%
Gynaecology	15.00%	12.00%	12.00%	13.00%	18.00%	17.00%
Theatres	5.00%	36.00%	21.00%	17.00%	21.00%	20.00%
Imaging Services	18.00%	18.00%	6.00%	12.00%	12.00%	13.00%
Maternity Services	6.00%	7.00%	7.00%	7.00%	11.00%	11.00%
Neonatology	7.00%	7.00%	7.00%	6.00%	14.00%	14.00%
Pharmacy	6.00%	6.00%	6.00%	6.00%	12.00%	13.00%
Trust Total	**10.00%**	**10.00%**	**10.00%**	**9.00%**	**14.00%**	**14.00%**

13.0 Professional Registration

13.1 The Director of Nursing & Midwifery monitors all staff professional registrations to ensure all non-medical clinical staff are licensed to practice across the trust. During September two nurses and four midwives failed to revalidate with the Nursing & Midwifery Council. One member of staff is on Maternity leave one on a career break, the other four failured to renew. All other staff remain complaint with the legal requirement to be registered with a professional body.

Professional Registration Lapses	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
Hewitt Centre	0	0	0	0	0	0
Genetics	0	0	0	0	0	0
Gynaecology	0	0	0	1	2	2
Theatres	0	0	0	0	0	0
Imaging Services	0	0	0	0	0	0
Maternity Services	1	0	0	0	1	4
Neonatology	0	1	0	0	0	0
Pharmacy	0	0	0	0	0	0
Trust Total	**1**	**1**	**0**	**1**	**3**	**7**

14.0 Conclusion

14.1 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 organization has the appropriate number of nursing & midwifery staff on its inpatient wards to manage the current clinical workload as assessed by the Director of Nursing & Midwifery

Updated tables

Fill rate data - summary
September 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)				
17583.5	**17117.5**	**4956.5**	**4358.5**	**16267**	**15628.5**	**3726**	**2967**	**97.3%**	**87.9%**	**96.1%**	**79.6%**

Care Hours per Patient Day
February 2017

Cumulative count over the month of patients at 23.59 each day	CHPPD Registered staff	CHPPD Unregistered staff	Average CHPPD (all staff)
3210	**10.2**	**2.3**	**12.5**

Agenda Item	2017/301

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	Performance Dashboard Month 6
DATE OF MEETING:	3 November 2017
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Jeff Johnston, Director of Operations
AUTHOR(S):	Jeff Johnston, Director of Operations
STRATEGIC OBJECTIVES:	***Which Objective(s)?***
	1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☒
	2. To be ambitious and *efficient* and make the best use of available resource ☒
	3. To deliver *safe* services ☒
	4. To participate in high quality research and to deliver the most *effective* Outcomes ☐
	5. To deliver the best possible *experience* for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?***
	1. *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust* ☒
	2. *The Trust is not financially sustainable beyond the current financial year* ☐
	3. *Failure to deliver the annual financial plan* ☐
	4. *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision* ☐
	5. *Ineffective understanding and learning following significant events* ☒
	6. *Inability to achieve and maintain regulatory compliance, performance and assurance* ☒
	7. *Inability to deliver the best clinical outcomes for patients* ☒
	8. *Poorly delivered positive experience for those engaging with our services* ☒
CQC DOMAIN	***Which Domain?***
	SAFE- *People are protected from abuse and harm* ☒
	EFFECTIVE - *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☒
	CARING - *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐
	RESPONSIVE – *the services meet people's needs.* ☐
	WELL-LED - *the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ☒

	ALL DOMAINS ☐	
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution ☐ **2.** Operational Plan ☐ **3.** NHS Compliance ☐	**4.** NHS Constitution ☐ **5.** Equality and Diversity ☐ ***6.*** Other: ***Click here to enter text.***
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**	***Choose an item.*** Or type here if not on list: ***Click here to enter text.***
	Date of meeting	***Click here to enter a date.***

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:-

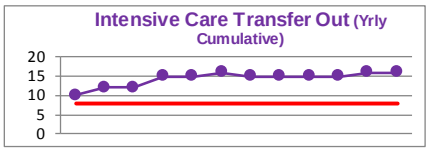
2.1 NHSI Targets – Access Targets including Cancer targets

The Trust is achieving the NHSI access targets. Although the cancer target before reallocation has breached by 0.38% in month it this is not anticipated to carry forward into after reallocation indicator. This is due to a late referral for treatment from another provider.

2.2 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 16 patients, the group consider the transfers to be appropriate.

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



The target is based upon previous year's numbers of transfers and as discussed previously at Board is an historic number for comparison purposes. This demonstrates the increased number of transfers from Crown street site for intensive care at the Royal site. The target should really be zero for this indicator as our services should be co-located with an adult intensive care unit. This is unachievable whilst services are run on the Crown street site.

2.3 Sickness and Absence Rates

Sickness has reached its lowest level all year and is now under target at 3.2% for only the second time this financial year. Close monitoring and full application of sickness policy will be adhered to as winter approaches.

3. Emerging concerns

Both Gynaecology and Maternity are not achieving expected activity levels against the block contract for 2017/18. It is not anticipated that the commissioners will adjust contracts in this year however, there is a risk for 2018/19 as all other local providers are currently over performing their contracts. A full report has been submitted to FPBD with regard to the reasons and the actions that are being undertaken to mitigate the risk. Access targets are being managed appropriately but there are considerable challengers in achieving this target.

4 Conclusion

The Trust is achieving all its National access and A & E targets, although risks have emerged in terms of access targets and now more recently to activity and income for 2018/19. FPBD are monitoring performance and the mitigating actions.

ITU transfers remain a continuing clinical risk that is managed by robust clinical policies and procedures and the experience of clinicians, this particular issue remains a strong focus of our long term strategy. A significant improvement has been made in terms of the sickness rate.

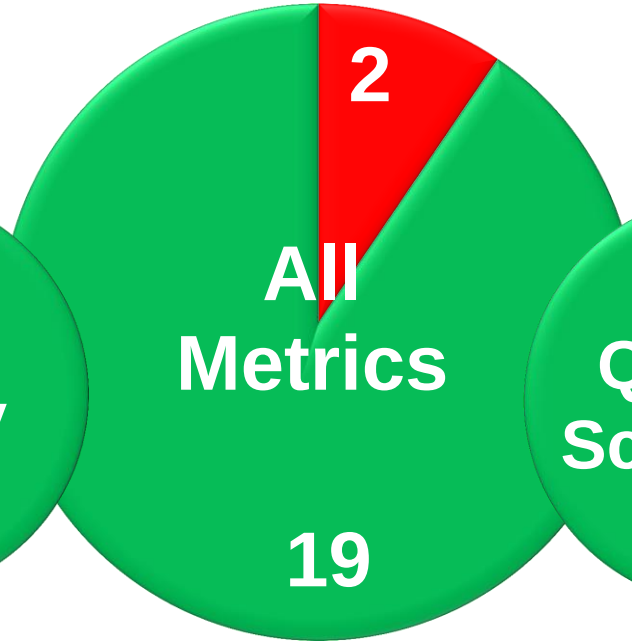
5 Recommendation

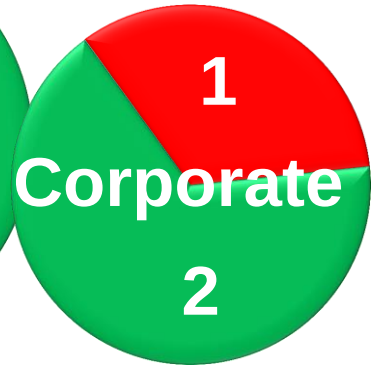
The Board note the content of the report

APPENDIX 1

Liverpool Women's NHS Foundation Trust

Performance Report for Trust Board — Month 6 - September 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 6 - September 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	Finance	3	3	3	3		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	1		0	0	0									
Infection Control: MRSA	KPI105 (EAS4)		0	0	0	0		0	0	0									
Never Events	KPI181	Greg Hope	0	1	0	0		0	0	0									
NHSE / NHSI Safety Alerts Outstanding	KPI193	Greg Hope	0	0	0	0		0	0	0									
Infection Control: Clostridium Difficile - infection rate	KPI320	ICT	TBC	0	0	0		0	0	0									
Mortality Rates: Hospital Standardised Mortality Rates (HSMR) - weekend (1 Month Behind)	KPI321		TBC	0	0	0		0	1	0									
Mortality Rates: Hospital Standardised Mortality Rates (HSMR) - weekday (1 Month behind)	KPI321		TBC	0	0	0		0	0	0									
Mortality Rates: Summary Hospital Mortality Indicator	KPI322		TBC	0	0	0		0	1	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	HR	4.5%	4.64%	5.17%	4.56%		4.05%	4.51%	3.26%									

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%	94.83%	94.90%	94.25%	93.67%	93.45%	93.78%								
All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (**Before re-allocation)** **Provisional Position**	KPI031 (EB12)	Chris Webster	>= 85%	100.00%	85.00%	87.50%	91.38%	85.71%	85.71%	84.62%	85.19%								
All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (**Before re-allocation)** **Final Reported Position**	KPI031 (EB12)	Chris Webster	>= 85%	100.00%	85.00%	76.19%	85.45%	90.91%	95.83%										
All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (**After Re-allocation**) **Provisional Position**	KPI030 (EB12)	Chris Webster	85%	89.47%	86.36%	87.50%	87.50%	85.71%	92.31%	95.65%	92.00%								
All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (**After Re-allocation**) **Final Reported Position**	KPI030 (EB12)	Chris Webster	85%	87.50%	85.00%	88.89%	87.04%	95.24%	*95.83%*										
All Cancers: 62 day wait for first treatement from NHS Cancer Screening Service referral - Numbers (if > 5, the target applies)	KPI033 (EB13)	Chris Webster	< 5	0.0	1.0	0.5	1.5	0.0	0.0	0.5	0.5								
All Cancers: 62 day wait for first treatement from NHS Cancer Screening Service referral - Percentage	KPI034 (EB14)	Chris Webster	>= 90%	No Pts Applicable	100%	100%	100%	No Pts Applicable	No Pts Applicable	100%	100.00%								

Complaints: Number Received	**KPI038**	**Debi Rice**	**<= 15**	**10**	**9**	**5**		**5**	**11**	**9**								

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	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	HR	<= 4.5%	4.64%	5.17%	4.56%	4.05%	4.51%	3.26%						

To deliver the best possible EXPERIENCE for patients and staff

Indicator Name	Ref	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)	Chris McGhee	0	0	0	0	0	0	0						
A&E: Total Time Spent in A&E 95th percentile	KPI012 (KPI_62)	Sharon Owens	<= 240	235	231	220	221	221	210						
Friends & Family Test (Upper quartile will recommend)	KPI089	Ward Manager	>= 75%	97.5%	98.5%	85.2%	96.7%	94.6%	97.2%						

Liverpool Women's NHS Foundation Trust

LWH Quality Strategy 2017/18 LWH Quality Strategy

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	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
Sickness & Absence Rate	KPI101	HR	<= 4.5%	4.64%	5.17%	4.56%	4.05%	4.51%	3.3%						

To deliver SAFER services

Indicator Name	Ref	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
Never Events	KPI181	Greg Hope	0	1	0	0	0	0	0						
Mortality Rates: Summary Hospital Mortality Indicator	KPI322		TBA	0	0	0	0	1	0						

To deliver the best possible EXPERIENCE for patients and staff

Indicator Name	Ref	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
Complaints: Number Received	KPI038	Debi Rice	<= 15	10	9	5	5	11	9						

Liverpool Women's NHS Foundation Trust

LWH Corporate 2017/18 Month 6 - September 2017

To deliver SAFER services															
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**
Deaths (All Live Births within 28 Days) All live births	**KPI168**	**Jill Harrison**	**< 6.1%**	**0.14%**	**0.38%**	**0.28%**	**0.15%**	**0.28%**	**0.29%**						
Deaths (All Live Births within 28 Days) Booked births	**KPI168**	**Jill Harrison**	**< 4.6%**	**0.15%**	**0.26%**	**0.29%**	**0.15%**	**0.28%**	**0.29%**						

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**	**Abraham Ssenoga**	**8 per year (Rolling year)**	**15**	**15**	**15**	**15**	**16**	**16**						

Agenda Item	2017/302

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Month 6 Finance Report**
DATE OF MEETING:	Friday, 03 November 2017
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Vanessa Harris, Director of Finance
AUTHOR(S):	Jenny Hannon, Director of Strategy and Planning
STRATEGIC OBJECTIVES:	***Which Objective(s)?***
	1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☐
	2. To be ambitious and *efficient* and make the best use of available resource ☒
	3. To deliver *safe* services ☐
	4. To participate in high quality research and to deliver the most *effective* Outcomes ☐
	5. To deliver the best possible *experience* for patients and staff ☐
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?***
	1. *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust* ☐
	2. *The Trust is not financially sustainable beyond the current financial year* ☐
	3. *Failure to deliver the annual financial plan* ☒
	4. *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision* ☐
	5. *Ineffective understanding and learning following significant events* ☐
	6. *Inability to achieve and maintain regulatory compliance, performance and assurance* ☐
	7. *Inability to deliver the best clinical outcomes for patients* ☐
	8. *Poorly delivered positive experience for those engaging with our services* ☐
CQC DOMAIN	***Which Domain?***
	SAFE- *People are protected from abuse and harm* ☐
	EFFECTIVE - *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☐
	CARING - *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐
	RESPONSIVE – *the services meet people's needs.* ☐
	WELL-LED - *the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ☒
	ALL DOMAINS ☐

LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution ☐ **2.** Operational Plan ☒ **3.** NHS Compliance ☒	**4.** NHS Constitution ☐ **5.** Equality and Diversity ☐ ***6.*** Other:
FREEDOM OF INFORMATION (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:-….)***	***Note the Month 6 Financial Position and Forecast Outturn***	
PREVIOUSLY CONSIDERED BY:	**Committee name**	Finance, Performance and Business Development Committee
	Date of meeting	23 October 2017

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.

At Month 6 the Trust is £0.019m favourable against the planned £2.477m deficit, and is forecasting delivery of the full year control total.

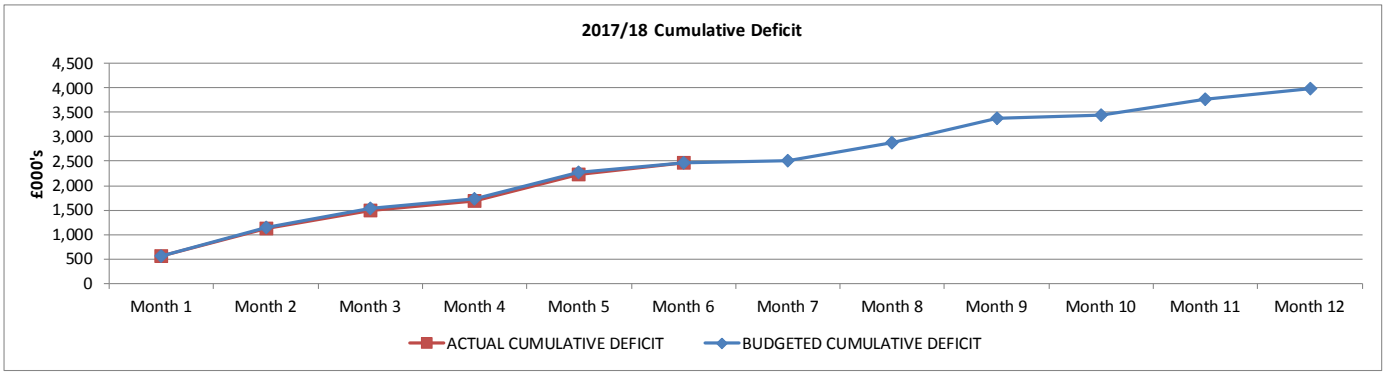
The Trust delivered a finance and use of resources' of 3 in month which is equivalent to plan.

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

Report

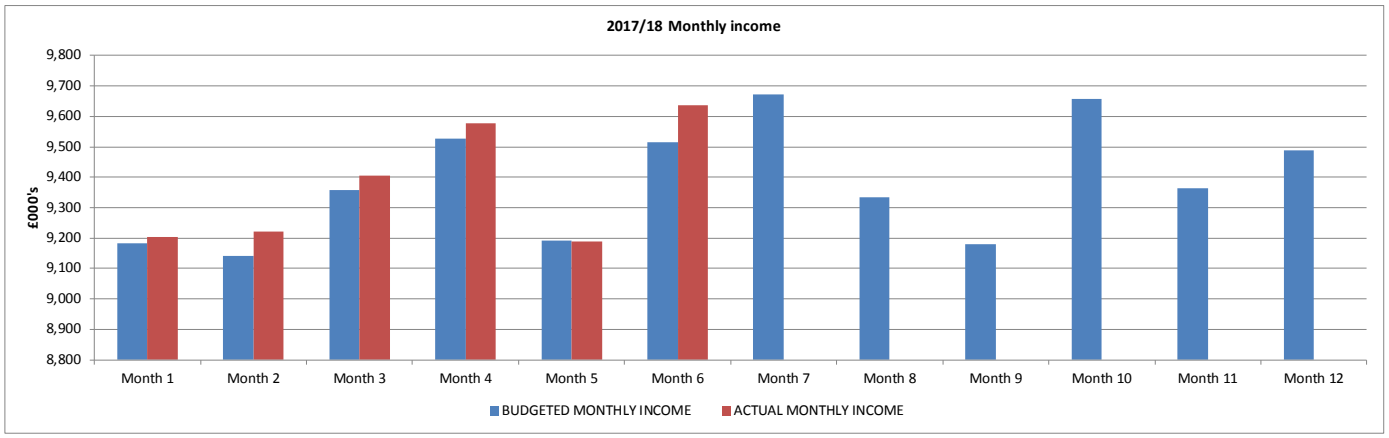
1. Month 6 2017/18 Summary Financial Position

The 2017/18 deficit is profiled below.



The Trust is achieving the planned deficit at Month 6.

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.

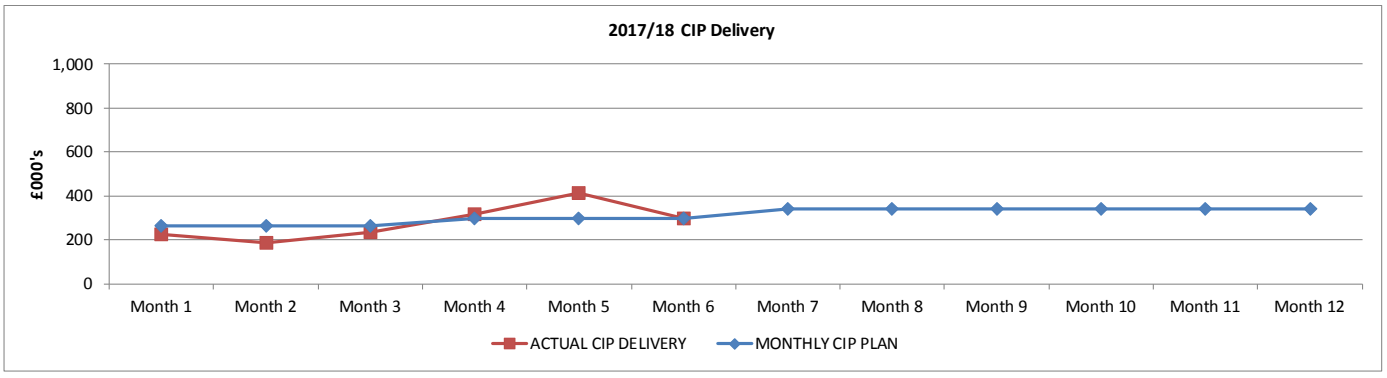


To date, the CCG block payment has been higher than what would have been received under PbR for the level of activity during 2017/18. This has arisen particularly across both Gynaecology and Maternity, with activity levels in each currently below plan. Despite a shortfall in activity, overall income remains ahead of plan due predominantly due to neonatal revenue.

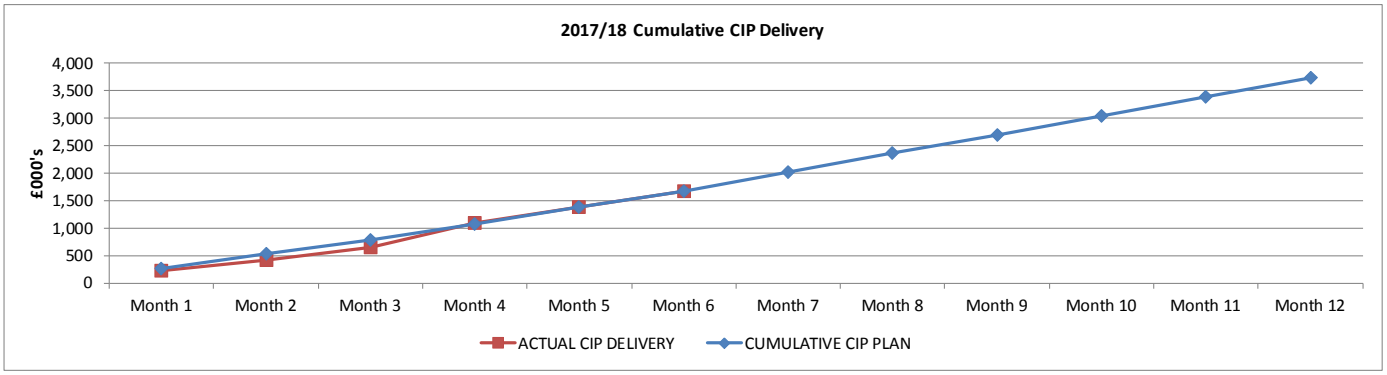
Pay expenditure is expected to slightly exceed plan as a result of the recruitment of additional midwives in year and the costs of delivering neonatal transport service. Non-pay expenditure is also expected to slightly exceed plan partly due to the introduction of new service contracts for clinical support. These variances are covered by the favourable income position.

2. Month 6 CIP Delivery

CIP is profiled based on expected delivery across the financial year. The Trust is forecasting the delivery of the full £3.7m CIP target for 2017/18, with mitigations reflected in the reported position. £0.7m of this full year forecast is currently on a non-recurrent basis.



Actual CIP delivery is £0.297m in month which includes £0.069m of mitigations against the plan.



Scheme performance and recurrent delivery in both 2017/18 and future financial years remains focus of the Trust's Turnaround and Transformation Committee.

3. Service summary overview

As previously reported, the Maternity service is forecasting an overspend on pay - arising from additional recruitment in midwifery in response to concerns raised within the service. Forecast income is also below plan based on current PbR activity.

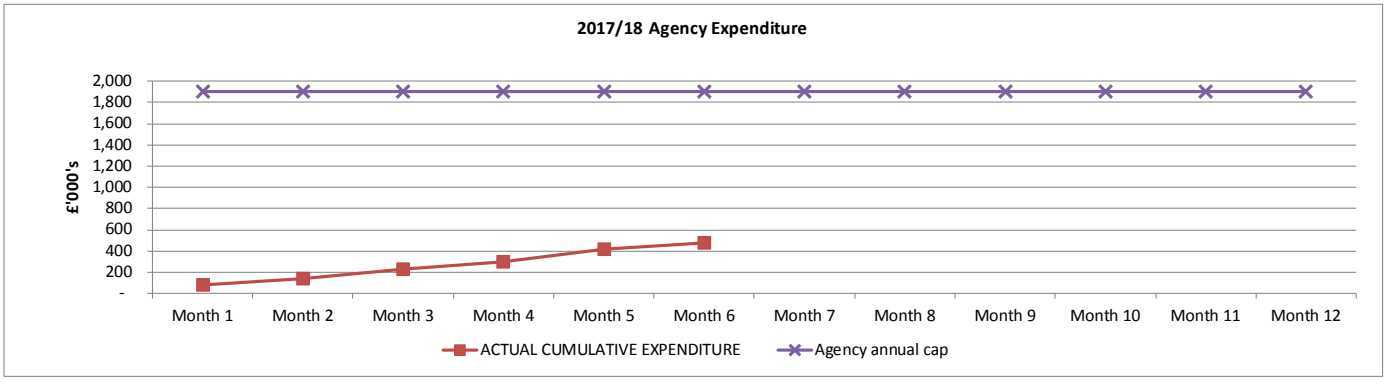
Gynaecology is also forecasting income behind plan as a result of reduced activity.

Neonates continues to benefit from transport income over and above planned levels and from activity across the non-block elements of the contract. Out-performance is expected to continue throughout 2017/18 resulting in a positive variance.

Hewitt Fertility Centre was behind plan in month however remains on target to deliver its current contribution target of £2.5m. Work is ongoing to ensure delivery of a further £0.5m contribution from 2018/19.

4. Agency Spend

The annual agency cap set by NHSI for the Trust is £1.9m. In Month 6 the Trust incurred £0.065m of agency expenditure (cumulative £0.481m) and plans to remain within the cap for the financial year.



5. Cash and borrowings

The Trust identified an operational cash borrowing requirement of £4.0m for 2017/18. This was on the basis of a planned closing cash balance of £1m at the end of 2016/17 as per DH distressed financing cash drawdown requirements.

The Trust made a cash drawdown of £7m in 2016/17 against a planned deficit of £7m. However towards the year end the Trust was able to improve the deficit as follows:

	Month 12 Actual
Planned Deficit (inc £2.8m planned STF)	**£7m**
Non-recurrent improvement in year	(£0.6m)
STF Incentive Funding – position improvement	(£0.6m)
STF Incentive Funding – changes in discount rate	(£0.1m)
STF Incentive Funding - bonus	(£1.0m)
Year-end deficit	**£4.7m**

The related improvement in the opening cash balances means that the Trust does not require the full £4m in year.

2017/18 cash balance in excess of opening plan	£3.9m
Cash repaid to DH in excess of minimum balance allowance	£(2.4m)
Surplus cash carried forward to 2017/18	£1.5m

The Trust continues to forecast prudently, it is currently envisaged that only £2.5m of the planned £4m Distressed Finance will be required in 2017/18.

6. BAF Risk

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

7. Conclusion & Recommendation

The Board are asked to note the Month 6 financial position and the reduced cash requirement for 2017/18.

Appendix 1 – Board pack

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

FINANCE REPORT: M6

YEAR ENDING 31 MARCH 2018

Contents

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
NHS IMPROVEMENT RATIOS: M6
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	685	736	2,341	2,319
(b) PDC + Interest Payable + Loans Repaid	1,266	3,554	2,532	4,742
CSC Ratio = (a) / (b)	**0.54**	**0.21**	**0.92**	**0.49**
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	(2,650)	(6,072)	(2,598)	(3,213)
(b) Expenditure	55,234	55,507	110,277	110,718
(c) Daily Expenditure	307	308	306	308
Liquidity Ratio = (a) / (c)	**(8.6)**	**(19.7)**	**(8.5)**	**(10.4)**
NHSI LIQUIDITY SCORE	3	4	3	3
Ratio Score 1 = > 0 2 = (7) - 0 3 = (14) - (7) 4 = < (14)				
I&E MARGIN				
Deficit (Adjusted for donations and asset disposals)	2,477	2,456	3,998	3,995
Total Income	(55,914)	(56,236)	(112,608)	(113,021)
I&E Margin	**-4.43%**	**-4.37%**	**-3.55%**	**-3.53%**
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)		-4.37%		-3.53%
I&E Margin (Plan)		-4.43%		-3.55%
I&E Variance Margin	**0.00%**	**0.06%**	**0.00%**	**0.02%**
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	962	962	1,924	1,924
YTD Agency Expenditure	648	481	1,301	913
	-32.64%	**-49.96%**	**-32.38%**	**-52.55%**
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: M6
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	(8,812)	(8,904)	92	(52,014)	(52,183)	169	(102,883)	(103,103)	219
Non-Clinical Income	(703)	(733)	31	(3,900)	(4,052)	152	(9,725)	(9,919)	194
Total Income	**(9,514)**	**(9,637)**	**123**	**(55,914)**	**(56,236)**	**321**	**(112,608)**	**(113,021)**	**413**
Expenditure									
Pay Costs	5,636	5,638	(2)	33,851	33,918	(68)	67,503	67,694	(191)
Non-Pay Costs	2,255	2,281	(26)	13,519	13,724	(205)	27,046	27,296	(250)
CNST	1,311	1,311	0	7,864	7,864	0	15,728	15,728	0
Total Expenditure	**9,201**	**9,229**	**(28)**	**55,234**	**55,507**	**(273)**	**110,277**	**110,718**	**(441)**
EBITDA	**(313)**	**(408)**	**95**	**(680)**	**(729)**	**48**	**(2,331)**	**(2,304)**	**(28)**
Technical Items									
Depreciation	366	504	(138)	2,203	2,309	(107)	4,419	4,550	(130)
Interest Payable	36	21	15	216	138	78	432	266	166
Interest Receivable	(1)	(1)	0	(5)	(8)	3	(10)	(15)	5
PDC Dividend	124	120	4	744	749	(5)	1,488	1,502	(14)
Profit / Loss on Disposal	0	0	0	0	(1)	1	0	(1)	1
Total Technical Items	**525**	**644**	**(118)**	**3,158**	**3,187**	**(29)**	**6,329**	**6,302**	**28**
(Surplus) / Deficit	**212**	**236**	**(24)**	**2,477**	**2,458**	**19**	**3,998**	**3,998**	**0**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
EXPENDITURE: M6
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	339	364	(25)	2,040	2,133	(93)	4,085	4,167	(82)
Medical	1,233	1,255	(22)	7,410	7,460	(51)	14,928	14,955	(27)
Nursing & Midwifery	2,513	2,527	(14)	15,105	15,127	(22)	30,009	30,232	(223)
Healthcare Assistants	412	412	(0)	2,489	2,467	22	4,924	4,906	18
Other Clinical	537	512	25	3,226	3,139	87	6,454	6,481	(27)
Admin Support	140	158	(18)	841	948	(107)	1,679	1,873	(195)
Corporate Services	342	345	(3)	2,072	2,162	(89)	4,125	4,166	(41)
Agency & Locum	120	65	55	667	481	186	1,299	913	386
Total Pay Costs	**5,636**	**5,638**	**(2)**	**33,851**	**33,918**	**(68)**	**67,503**	**67,694**	**(191)**
Non Pay Costs									
Clinical Suppplies	717	768	(51)	4,251	4,316	(65)	8,471	8,631	(160)
Non-Clinical Supplies	582	567	15	3,458	3,590	(132)	7,018	7,034	(16)
CNST	1,311	1,311	0	7,864	7,864	0	15,728	15,728	0
Premises & IT Costs	497	475	22	2,643	2,668	(25)	5,268	5,239	28
Service Contracts	459	472	(13)	3,167	3,150	18	6,289	6,391	(102)
Total Non-Pay Costs	**3,566**	**3,592**	**(26)**	**21,383**	**21,588**	**(205)**	**42,774**	**43,024**	**(250)**
Total Expenditure	**9,201**	**9,229**	**(28)**	**55,234**	**55,507**	**(273)**	**110,277**	**110,718**	**(441)**

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	(4,005)	(4,019)	14	(22,828)	(22,749)	(78)	(45,612)	(45,452)	(160)
Expenditure	1,661	1,663	(2)	10,208	10,243	(35)	20,398	20,571	(173)
Total Maternity	**(2,343)**	**(2,355)**	**12**	**(12,619)**	**(12,506)**	**(113)**	**(25,214)**	**(24,882)**	**(332)**
Gynaecology									
Income	(2,254)	(2,363)	109	(12,945)	(12,931)	(14)	(25,742)	(25,667)	(74)
Expenditure	810	861	(52)	5,164	5,151	13	10,317	10,345	(28)
Total Gynaecology	**(1,444)**	**(1,502)**	**57**	**(7,781)**	**(7,781)**	**(1)**	**(15,425)**	**(15,322)**	**(103)**
Theatres									
Income	(42)	(30)	(12)	(249)	(231)	(18)	(499)	(482)	(17)
Expenditure	640	675	(35)	3,840	3,874	(34)	7,679	7,680	(1)
Total Theatres	**598**	**645**	**(47)**	**3,590**	**3,642**	**(52)**	**7,180**	**7,198**	**(18)**
Neonatal									
Income	(1,356)	(1,362)	7	(8,135)	(8,380)	246	(16,249)	(16,694)	445
Expenditure	945	975	(30)	5,671	5,712	(42)	11,341	11,625	(284)
Total Neonatal	**(410)**	**(387)**	**(23)**	**(2,464)**	**(2,668)**	**204**	**(4,908)**	**(5,069)**	**161**
Hewitt Centre									
Income	(903)	(817)	(85)	(4,981)	(5,096)	115	(9,971)	(10,164)	193
Expenditure	623	635	(12)	3,735	3,794	(59)	7,471	7,654	(184)
Total Hewitt Centre	**(280)**	**(183)**	**(97)**	**(1,246)**	**(1,302)**	**56**	**(2,501)**	**(2,510)**	**9**
Genetics									
Income	(600)	(583)	(18)	(3,602)	(3,532)	(70)	(7,204)	(7,065)	(139)
Expenditure	376	422	(46)	2,767	2,521	246	5,535	5,217	318
Total Genetics	**(224)**	**(160)**	**(64)**	**(835)**	**(1,011)**	**176**	**(1,669)**	**(1,848)**	**179**
Clinical Support									
Income	(25)	(31)	6	(151)	(189)	38	(295)	(349)	54
Expenditure	774	773	1	4,608	4,608	0	9,164	9,203	(40)
Total Clinical Support & CNST	**749**	**742**	**7**	**4,457**	**4,419**	**38**	**8,869**	**8,855**	**14**
Corporate & Trust Technical Items									
Income	(331)	(432)	101	(3,023)	(3,125)	103	(7,037)	(7,148)	112
Expenditure	3,898	3,868	30	22,399	22,791	(392)	44,702	44,724	(21)
Total Corporate	**3,567**	**3,435**	**131**	**19,375**	**19,664**	**(290)**	**37,666**	**37,575**	**90**
(Surplus) / Deficit	**212**	**236**	**(24)**	**2,477**	**2,458**	**19**	**3,998**	**3,998**	**0**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 5
BALANCE SHEET: M6
YEAR ENDING 31 MARCH 2018

BALANCE SHEET £'000	YEAR TO DATE Opening	M6 Actual	Movement
Non Current Assets	**72,688**	**73,073**	385
Current Assets			
Cash	4,897	5,511	614
Debtors	8,201	8,896	695
Inventories	366	451	85
Total Current Assets	**13,464**	**14,858**	**1,394**
Liabilities			
Creditors due < 1 year	(10,577)	(17,622)	(7,045)
Creditors due > 1 year	(1,717)	(1,701)	16
Loans	(17,175)	(14,507)	2,668
Provisions	(3,011)	(2,887)	124
Total Liabilities	**(32,480)**	**(36,717)**	(4,237)
TOTAL ASSETS EMPLOYED	**53,672**	**51,214**	**(2,458)**
Taxpayers Equity			
PDC	37,420	37,420	0
Revaluation Reserve	12,233	12,233	0
Retained Earnings	4,019	1,561	(2,458)
TOTAL TAXPAYERS EQUITY	**53,672**	**51,214**	**(2,458)**