**Meeting of the Board of Directors**
**HELD IN PUBLIC**
**Friday 1 December 2017 at 1015hrs**
**Liverpool Women's Hospital**
**Board Room**

| Item no.<br><br>2017/ | Title of item | Objectives/desired outcome | Process | Item presenter | Time | CQC Domain |
|---|---|---|---|---|---|---|
| | Thank you | | | | 1010 | |
| 317 | Apologies for absence & Declarations of interest | Receive apologies | Verbal | Chair | 1015 (25mins) | - |
| 318 | Meeting guidance notes | To receive the meeting attendees' guidance notes | Written guidance | Chair | | Well Led |
| 319 | Patient Story | To receive assurance on the provision of end of life care | Presentation | | | Caring |
| 320 | Minutes of the previous meeting held on 3 November 2017 | Confirm as an accurate record the minutes of the previous meetings | Written | Chair | 1040 (05mins) | Well Led |
| 321 | Action Log and matters arising | Provide an update in respect of on-going and outstanding items to ensure progress | Written/verbal | Chair | | Well Led |
| 322 | Chair's announcements | Announce items of significance not elsewhere on the agenda | Verbal | Chair | 1045 (15mins) | Well Led |
| 323 | Chief Executive Report | Report key developments and announce items of significance not elsewhere | Verbal | Chief Executive | | Well Led |

| Item no.<br><br>2017/ | Title of item | Objectives/desired outcome | Process | Item presenter | Time | CQC Domain |
|---|---|---|---|---|---|---|
| BOARD COMMITTEE ASSURANCE | | | | | | |
| 324 | Chair's Report from the Governance and Clinical Assurance Committee (incl. amended Terms of Reference) | Receive assurance and any escalated risks | Written | Committee Chair | 1100 (20mins) | Well Led |
| 325 | Chair's Report from the Putting People First Committee | Receive assurance and any escalated risks | Written | Committee Chair | | Well Led |
| 326 | Chair's Report from the Finance Performance and Business Development 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 | | | | | | |
| 327 | Feedback from October Staff Listening Event | To note the content of the report | Written | Director of Workforce and Marketing | 1120 (10mins) | Caring<br>Well Led |
| 328 | National Maternity Review – update reports on community midwifery and better births | To note the status of the implementation of the review in the trust | Written | Clare Fitzpatrick Head of Midwifery | 1130 (30mins) | Caring<br>Well Led |
| TRUST PERFORMANCE - TO DELIVER THE MOST EFFECTIVE OUTCOMES; TO BE EFFICIENT AND MAKE BEST USE OF AVAILABLE RESOURCES | | | | | | |
| 329 | Safer Nurse/Midwife Staffing Monthly Report | The Board is asked to note the content of the report | Written | Acting Director of Nursing and Midwifery | 1200 (10mins) | Safe<br>Well Led |
| 330 | Performance Report period 7, 2017/18 | Review the latest Trust performance report and receive assurance | Written | Director of Operations | 1210 (10mins) | Safe<br>Well Led |
| 331 | Finance Report period 7, 2017/18 | To note the current status of the Trusts financial position | Written | Director of Finance | 1220 (10mins) | Well Led |
| TRUST STRATEGY | | | | | | |

| Item no.<br><br>2017/ | Title of item | Objectives/desired outcome | Process | Item presenter | Time | CQC Domain |
|---|---|---|---|---|---|---|
| 332 | Fit for Future Generations Update | To brief the Board on progress and risks | Verbal | Chief Executive | 1230 (15mins) | All |
| BOARD GOVERNANCE | | | | | | |
| 333 | Review of risk impacts of items discussed | Identify any new risk impacts | Verbal | Chair | | Well Led |
| HOUSEKEEPING | | | | | | |
| 334 | Any other business<br>& Review of meeting | Consider any urgent items of other business | Verbal | Chair | END 1245 | Well Led |

Date, time and place of next meeting Friday 12 January 2018

## Meeting to end at 1245

| | | | | |
|---|---|---|---|---|
| 1245-1300 | Questions raised by members of the public observing the meeting on matters raised at the meeting. | To respond to members of the public on matters of clarification and understanding. | Verbal | Chair |

# Meeting attendees' guidance, May 2013

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

## Before the meeting

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

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

## At the meeting

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

## Attendance

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

## After the meeting

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

## Standards & Obligations

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

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

Page 129 Handbook to the NHS Constitution 26th March 2013

Board Agenda item 2017/320

# Board of Directors

Minutes of the meeting of the Board of Directors
held in public on Friday 3 November 2017 at 1015 hrs
at St Chads Community Centre, Kirkby.

*PRESENT*

| | |
|---|---|
| Mr Robert Clarke | Chair |
| Mrs Kathryn Thomson | Chief Executive |
| Mr Ian Haythornthwaite | Non-Executive Director/Vice Chair |
| Dr Andrew Loughney | Medical Director |
| Mr Jeff Johnston | Director of Operations |
| Mrs Jenny Hannon | Director of Strategy and Planning |
| 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 |
| Mr Phil Huggon | Non-Executive Director |

*IN ATTENDANCE*

| | |
|---|---|
| Mr Colin Reid | Trust Secretary |
| Dr Devender Roberts | Associate Medical Director (items 295 onwards) |

*APOLOGIES*

| | |
|---|---|
| Dr Susan Milner | Non-Executive Director |
| Dr Doug Charlton | Director of Nursing & Midwifery |
| Mrs Vanessa Harris | Director of Finance & Deputy Chief Executive |
| Mrs Michelle Turner | Director of Workforce & Marketing |

| 2017 | |
|---|---|
| 289 | **Apologies** – as above.<br><br>**Declaration of Interests** – None<br><br>**Welcome:** The Chair opened the meeting and welcomed those present. He reported on the reasons for holding the meeting offsite and advised that following the meeting the Board would be spending some time with the Community Midwives that work out of the centre.<br><br>Referring to the normal process of thanking staff who had gone above and beyond in their individual and team roles reported that these would take place at Crown Street in the afternoon session of the Board. |
| 290 | **Meeting guidance notes**<br>The Board received the meeting attendees' guidance notes. |
| 291 | **Minutes of previous meeting held on Friday 6 October 2017**<br>The minutes of the meeting held on 6 October 2017 were approved subject to amendments to |

typographical errors identified.

292 Matters arising and action log.

The Board noted that the outstanding action regarding the holding of a Safeguarding Board workshop would be arranged for a time in quarter 4 2017/18.

Referring to the minutes the Chair noted that there was an action on the Director of Workforce and Marketing to bring back to the Board the findings of the second staff listening event to the December Board that had not been included in the log. The Trust Secretary noted the discrepancy and reported that the action would be included in the action log for the December meeting.

293 Chair's Announcements

The Chair made the following announcements:

Annual Service of Remembrance: The Chair referred to the service of remembrance organised by the Honeysuckle team held on 11 October 2017 and thanked all staff who attended or participated in the service. The Chief Executive commented that it was fantastic to see so many families attending the service which seems, sadly, to increase year on year. She also thanked the staff who had attended from the different services. Ian Knight advised that he attends the Bereavement Committee, which had recently discussed the numbers attending and was discussing whether it would be appropriate to move the venue. The Medical Director asked that the Bereavement Committee consider how future services were delivered, in particular that they were made more multi-faith rather than predominantly Christian. David Astley felt that the venue was appropriate for the event and felt that if it was to move, it would need to continue to be held in the community in a community setting.

NHS Improvement: The Chair advised that he had received a letter from Baroness Harding, the new Chair of NHSI. In the letter she had made comment that she would like to be invited to the Trust and the Chair advised that he would be inviting her to the Trust.

Annual Members Meeting (AMM): The Chair thanked the staff for giving up their personal time on a Saturday morning to support the Trust at the Annual Members meeting held on 14 October 2017. He felt that the tenor of the meeting was well received by all who attended.

Council of Governors Meeting and Governor Elections: The Chair referred to the Council of Governors meeting held on 25 October and in particular the presentations the Council received on the vision of the Health and Life Sciences Campus and Liverpool Knowledge Quarter which was well received. The Chair referred to the bi-elections for Governors from the Knowsley constituency and the Rest of England and Wales which would be taking place and concluding before the next Council meeting in January 2018.

The Chair thanked Jill Hughes, Lead Community Midwife for helping with the arrangements for the meeting. The Board noted the Chair's verbal update.

294 Chief Executive's report

The Chief Executive provided a verbal report and referring to the thank you that would normally take place before the start of the meeting in public advised that the Estates Team would be receiving the team thank you. She explained that the team had won team of the season award and had donated the award of £500 to the Neonatal charity rather than using it for themselves. The individual awards were being given to Mark Little who had, at his own expense, renovated the rocking horse that was in the Neonatal Unit and a thank you to Helen Scholefield, Obstetrics Consultant who would be retiring from the Trust.

The Chief Executive reported that the Trust had received the Provider Information Request from the

CQC and has been given 3 weeks to complete. She explained that this involved everyone in the Trust and reported that approximately 94-97% was complete. The Chief Executive advised that she had asked the Director of Workforce and Marketing to quality assure the data prior to submission.

The Board noted the Report from the Chief Executive.

295 **Chair's Report from the Charitable Funds Committee (CFC)**

Phil Huggon, Chair of the CFC presented the Chair's report of the committee held on 13 October 2017. He reported on the fundraising strategy review and advised that the Committee would receive the final scoping exercise at its meeting in December 2017 and this would then be considered by the Board in January 2018 together with the Annual Report and Accounts 2016/17 of the Charity.

Phil Huggon referred to the current investment and advised that the Committee had reviewed the asset allocation of funds and agreed to reduce the cash reserve fund and use the cash to increase the infrastructure fund and property fund. He advised that the Committee had confirmed that their appetite for investment remains at medium risk profile.

The Chair thanked Phil Huggon for his report the content of which was noted.

296 **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 23 October 2017 and ran through the main items discussed and where assurance was obtained.

Jo Moore referred to activity performance in gynaecology, theatres and maternity which had seen a downturn in activity. The Committee had noted that recovery plans and additional operational management support were being implemented in order to address the underperformance. Jo Moore noted that this would be discussed later in the meeting under the finance report; however reported that should the underperformance continue this would potentially have an effect on the 2018/19 financial position as the CCG may seek to renegotiate down the Block Contract.

Jo Moore referred to the report it had received on the Electronic Patient Record Update and advised that the Committee was informed of a deferment of the implementation date from June 2018 to October 2018. The Board noted the positon recognising that it would receive an update report at its meeting in December, which would cover amongst other things the key risks to implementation.

The Chief Executive referred to the bullet point in the report on the review of the NHSI Enforcement Undertaking and advised that at the next monthly meeting with NHSI, she would be discussing with NHSI where the Trust was against the enforcement undertaking. She advised that it was her view and that of the Executive that the Trust had complied with the requirements of the undertaking; however the Trust was still in enforcement. The Chief Executive felt that NHSI needed to be challenged so that the next steps could be understood.

The Chair referring to the delivery of CIP noted that although the Trust was on target to deliver its CIP for 2017/18, 2018/19 would be more difficult to achieve and asked what the timetable would be for the Board to understand any gaps in delivery. The Director of Strategy and Planning advised that a planning paper was being drafted that would be presented to FPBD in November and would include: what the 'ask' was; where the Trust was in delivery; and the gaps in delivery of the 'ask'.

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

297 **Chair's Report from the Audit Committee (AC)**

Ian Knight, Chair of the Audit Committee presented the Chairs Report covering the meeting held on 23 October 2017 and ran through the main items discussed and where assurance was obtained.

Ian Knight referred the Board to the updated position on implementation of outstanding Internal Audit and External Audit recommendations from 2017/18. He advised that a number of actions had been finalised since the report had been circulated and that the two re-opened audits, referenced in his last report to the Board, in relation to the BAF and NPSA Alert audits had both been reviewed and closed.

Ian Knight advised that consideration was being given to undertake a full review of the work of the Audit Committee, similar to that undertaken by GACA. This would take place in the new year to coincide with other Board committee reviews.

Referring to the appointment of the External Auditor, Ian Knight confirmed that the Council of Governors had approved the appointment of KPMG as the Trusts External Auditors from the 2017/18 to the 2019/20 financial years; with the option to extend for a further 2 years.

Ian Knight reported that the Committee had received a paper describing the process taken in the review the Trust's Board Assurance Framework and advised that since the implementation of the new framework, one additional risk had been added to the BAF, escalated by the Putting People First Committee. Ian Knight advised that the Committee was assured that each Board sub-committee appropriately reviews the BAF risks aligned to them.

The Board discussed the internal audit progress report and requested that as part of any future reporting the Board receive an understanding of the assurance levels for each finalised audit report.

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

298 Quarter 2 Mortality Report

The Medical Director introduced the Quarter 2 Mortality Report which was focused on adult mortality and asked Devender Roberts, Associate Medical Director to present the report.

The Associate Medical Director advised that the Report outlined the most recent Trust figures and headline findings with regard to mortality and provided a backdrop of the governance responsibilities of the Board and that of its committee and sub committees.

The Associate Medical Director advised that the Trust recognised that although most of the adult death it encounters was an expected end point of a known disease process, the principles surrounding learning from deaths were equally valid to its services. She went on to report that the Trust's Risk Management Strategy provide for a commitment to minimise risk through the systematic embedding of relevant, efficient and effective risk management processes. Since the Trust's core purpose was to provide clinical care, its foremost risks were those that were clinically based and the ultimate clinical risk was that of death.

The Associate Medical Director advised that the report details how the Trust was meeting the requirements laid down externally and provides details of mortality within the Trust during Quarter 2 of 2017-18. She reported that the Report concludes that there was evidence that adequate progress was being made and that mortality rates were within expected ranges. The Associate Medical Director reported that there were no adult deaths in Quarter 2.

Referring to prevention the Associate Medical Director advised on the process for review of the Trust's policies /SOPs/Guidelines and strategies and the work being undertaken to address those that were either outstanding or due for review. The Director of Operations noted the outstanding and due for review policies /SOPs/Guidelines and strategies contained in the graphs and felt that as all documents require a review date, he asked whether the graphs would show that all were in date. In

response the Associate Medical Director advised that this should not be a problem, however there was a huge amount of information that required review and this had to be done by clinicians. She felt however that all should be 100% green by end of Quarter 3.

The Board noted that a Mortality dashboard would be completed by the end of November, after there had been further clinical discussions to finalise the agreed data to be collected, monitored and audited and that a mortality audit toolkit would be available electronically via the Trist's risk management database. This would provide additional reassurances to the Board and the Trust. The Board requested a demonstration of the toolkit to the Board at a future meeting or workshop.

*Action 2017/298: Associate Medical Director to provide the Board with a demonstration of the mortality audit toolkit at a future Board meeting.*

The Board:

a. took assurance that there was adequate progress against the requirements laid out by the National Quality Board; and
b. Confirmed that there were effective governance arrangements in place to drive quality and learning from the deaths of patients in receipt of care at this Trust.

299 Serious Incidents Report - Quarter 2

The Medical Director presented the Serious Incidents Report and reported on a number of typographical errors in the text of the Report. In particular he advised that there had been only one incident reported Quarter 2 2017/18 rather than the seven reported in section 5 of the Report.

The Medical Director reported that in the last 10 days two babies had died on NICU. He confirmed that following sepsis reviews the cause of death indicates pseudomonas. The Trust had looked at the possibility that cross infection had occurred however the two babies had different strains of pseudomonas. Following the findings he felt that there was no additional risk to other babies on the Unit.

The Medical Director reported that the causes of the infections was being investigated with the infection control team reviewing the environment in order to identify the source, this included reviewing infection control practices on the Unit. He went on to report that repeated water tests had been undertaken and included a review of taps, sinks and undertaking laundry off site. Additional to this resuscitaires had also been tested and barrier nursing throughout the unit put in place. The Medical Director advised that these very sad cases would have been more effectively managed within a larger unit and reported that in order to reduce the possible impact of future infections stricter access controls were being put in place on the Unit.

Referring to the number of overdue action plans reported, the Medical Director advised that the action plans were complete however the evidence had not been transposed to the table.

The Medical Director reported on a Never Event that had recently occurred relating to the insertion of intrauterine conceptive device for which the patient had consented to. He advised that on her return from theatre it was found that a different type of intrauterine contraceptive device had been inserted in error; the patient was immediately informed and an apology provided. The patient was informed that there were no contraindications for her and she was happy with the explanation provided and opted to keep the coil fitted. The Medical Director reported that the WHO checklist did not require the inclusion of the specific type of coil recorded on it, this had now been rectified for future checklists. The Medical Director recognised that the incident was a reportable Never Event however in the circumstances the patient had not been harmed and was satisfied with the outcome.

The Medical Director advised that in all three cases the duty of candour had been followed and

recorded in the patient notes.

The Chair thanked the Medical Director for his update of the three additional incidents that had occurred at the Trust. The Board noted the content of the paper presented together with the additional verbal updates relating to the baby deaths on NICU and the Never Event.

300 Safer Nurse/Midwife Staffing Monthly Report

The Chair asked that the paper be taken as read and sought comments. The Chief Executive felt that the paper continued to provide the Board with assurance that the Trust operated at safe staffing levels. She felt that the paper could be extended to include staffing in outpatients and asked that this be explored.

The Chair advised that there were a number of accuracy clarifications and advised he would take these offline. The Board noted the content and recommendations contained in the report.

301 Performance Report Period 6 2017/18

The Director of Operations presented the Performance Report for period 6 2017/18 and reported that the Trust was continuing to deliver all national targets to date; although the cancer target before reallocation had breached by 0.38% in month. He advised that this was not anticipated to carry forward after reallocation indicator and explained that the breach was due to a late referral for treatment from another provider.

The Director of Operations referred to the Sickness and Absent rates and reported that sickness had reached its lowest level all year and was now under target at 3.2% for only the second time this financial year. Close monitoring and full application of sickness policy would need to be adhered to as winter approaches. Tony Okotie asked whether the Director of Operations had the comparable figure for 2016, in response the Director of Operations advised he did not have the figures to hand and would make the figures available after the meeting.

The Associate Medical Director referred to the Intensive Care Transfer Out target set at eight and felt that this should be zero given the safety risks. The Medical Director explained that this had been discussed at length by the Board and although there was agreement that the target should be zero, the fact was that as long the Trust remained on an isolated site away from adult acute services, there would always be a requirement to transfer patients to another provider. It was therefore appropriate to include a target so that the indicator was on the Board's radar.

The Board noted the Performance Report for period 6 2017/18 report.

302 Financial Report & Dashboard Period 6 2017/18

The Director of Strategy and Planning presented the Finance Report and financial dashboard for month 6, 2017/18 and reported that at Month 6 the Trust was £0.019m favourable against the planned £2.477m deficit, and was forecasting delivery of the full year control total. The Trust delivered a "Use of Resources" Rating of 3 in month which was equivalent to plan.

Referring to the underperformance in activity against the block contract, the Director of Strategy and Planning reported that at month 6 the Trust was £1.2m under the block, with an anticipated £2.5m under the block at year end. The Director of Strategy and Planning advised that for this year the income was secure however it was not clear whether the CCG would look to review the block contract and reduce the income in proportion to the reduction in activity for 2018/19.

The Director of Operations advised that an assessment of why the activity in maternity had reduced. He advised that an early indication was that this was not a local issue and that other part of the region and nationally had seen a reduction in maternity activity which may be related to wider

government policy decisions.

The Director of Operations explained the issues of underperformance in Gynaecology inpatients, outpatients and theatres reporting that there were some productivity issues that needed to be addressed and some capacity issues. With regard to inpatients the reduction in activity had manifested itself through junior doctor and consultant gaps and was not sustainable going forward. Referring to Theatres, the Director of Operations advised that theatres needed to be run more efficiently, explaining that the Trust was operating on fewer patients during the standard day whilst the order book was full. Outpatients had seen an increase in the number of DNAs which had impacted on activity. The Director of Operations advised that recovery plans and additional operational management support was being implemented in order to address the underperformance.

The Director of Strategy and Planning reported that the Trust continued to forecast prudently and it was envisaged that only £2.5m of the planned £4m Distressed Finance would be required to drawdown in 2017/18.

The Chair thanked the Director of Strategy and Planning for presenting the Financial Report & Dashboard Period 6 2017/18 report which was noted.

303 Fit for Future Generations Update

The Chief Executive advised NHS Improvement and NHS England at local level had completed their processes and were awaiting a decision on when to proceed. She advised that it was now highly unlikely that the public consultation would take place in November 2017 and that the Trust was hoping that the Liverpool CCG would commence the public consultation in January 2018.

The Board noted the update.

304 Review of risk impacts of items discussed

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

- Activity levels in Gynaecology inpatients and outpatients; theatres and maternity
- Neonatal infection risks reported

305 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 1 December 2017

**Agenda Item 2017/321**

Liverpool Women's NHS Foundation Trust

TRUST BOARD
1 December 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 | | See agenda item 2017/328; 1 December 2017 Board meeting |
| 5 Oct 2017 | 2017/280 | The Trust Secretary to make arrangements for a safeguarding Board workshop | Trust Secretary | | A workshop has been arranged for the afternoon of 23 February 2018 (following the Listening event). |
| 5 Oct 2017 | 2017/273 | The Director of Workforce and Marketing to provide feedback from the listening event to the December Board meeting. | The Director of Workforce and Marketing | | See agenda item 2017/327; 1 December 2017 Board meeting |
| 3 Nov 2017 | 2017/298 | The Associate Medical Director to provide the Board with a demonstration of the mortality audit toolkit at a future Board meeting. | The Associate Medical Director | | A demonstration of the toolkit will be provided on 2 February 2018 Board meeting to coincide with the Q3 Mortality Report. |

2017/322 Chairs Report - Verbal update

2017/323 Chief Executive Report - Verbal update

2017/324: Chair's Report from the Governance and Clinical Assurance Committee

2017/325: Chair's Report from the Putting People First Committee

2017/326: Chair's Report from the Finance Performance and Business Development Committee

To be sent out under separate cover as a suite of Committee Chairs Reports
following the FPBD meeting on Monday 27 November 2017

| Agenda Item | 17/327 |
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| **MEETING** | **Board of Directors** |
| **PAPER/REPORT TITLE:** | **Listening Event – 6th October 2017** |
| **DATE OF MEETING:** | Friday, 01 December 2017 |
| **ACTION REQUIRED** | **For Assurance** |
| **EXECUTIVE DIRECTOR:** | Michelle Turner, Director of Workforce and Marketing |
| **AUTHOR(S):** | Jean Annan, Head of Learning and Development |
| | |
| **STRATEGIC OBJECTIVES:** | ***Which Objective(s)?***<br>1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☒<br>2. To be ambitious and *efficient* and make the best use of available resource ☒<br>3. To deliver *safe* services ☐<br>4. To participate in high quality research and to deliver the most *effective* Outcomes ☐<br>5. To deliver the best possible *experience* for patients and staff ☒ |
| **LINK TO BOARD ASSURANCE FRAMEWORK (BAF):** | ***Which condition(s)?***<br>***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust* ☒<br>***2.*** *The Trust is not financially sustainable beyond the current financial year* ☐<br>***3.*** *Failure to deliver the annual financial plan* ☐<br>***4.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision* ☐<br>***5.*** *Ineffective understanding and learning following significant events* ☐<br>***6.*** *Inability to achieve and maintain regulatory compliance, performance and assurance* ☐<br>***7.*** *Inability to deliver the best clinical outcomes for patients* ☐<br>***8.*** *Poorly delivered positive experience for those engaging with our services* ☐ |
| **CQC DOMAIN** | ***Which Domain?***<br>***SAFE-*** *People are protected from abuse and harm* ☐<br>***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☐<br>***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐<br>***RESPONSIVE –*** *the services meet people's needs.* ☐<br>***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.* ☒<br>***ALL DOMAINS*** ☐ |

| | | |
|---|---|---|
| **LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT** | **1.** Trust Constitution ☐<br>**2.** Operational Plan ☐<br>**3.** NHS Compliance ☐ | **4.** NHS Constitution ☒<br>**5.** Equality and Diversity ☒<br>***6.*** Other: **34T** |
| | | |
| **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<br>• Receive and consider the feedback from the second Listening Event<br>• Endorse the approach and commit to further regular Listening Events with staff<br>• Provide challenge into the organisation and gain assurance that the feedback from staff is being acted upon | |
| **PREVIOUSLY CONSIDERED BY:** | **Committee name** | Or type here if not on list:<br>34T |
| | **Date of meeting** | 34T |
| | | |

**Executive Summary**

Following on from the positive reception of the initial Trust Listening Event in July, a further event was conducted in October. The conversations concentrated on further exploring issues raised at the July event and gave an additional number of people the opportunity to speak. This paper provides an update on the second of the series of listening events that are being held in the Trust and a review of progress to date

In broad terms, the feedback from the second Listening Event was

- Staff again welcomed the time to speak freely away from the workplace with very senior leaders
- Staff appreciated the continued commitment to the listening events
- They enjoyed the opportunity to spend time with colleagues from other areas/disciplines
- They wanted the values and behaviours of the Trust truly modelled by all at every level, and that action be taken where that wasn't the case – they talked about being kind to each other
- Tackling the culture that perpetuates silo working

Board are asked to

- Receive and consider the feedback from the second Listening Event
- Endorse the approach and continue to support regular Listening Events with staff

Provide challenge into the organisation and gain assurance that the feedback from staff is being acted upon

**Report**

1. Background

Following the positive response to the first listening event the Board agreed to commit to a further 3 events before deciding on future engagement fora. This is the second of those events and sought to build on the opportunity for staff to speak to each other and the Senior Team, and to provide an opportunity to gather suggestions and disseminate these across the organisation. Since the first and second events, action has been taken to share widely what has been discussed, providing support and interventions through L&D where appropriate and drawing managers' and individuals' attention to changes that they can work on.

2. Outcomes from Session 2.

The key messages were:

- Both new and returning attendees enjoyed the event
- We should be better at managing and talking about mental health issues
- Communications at all levels could be improved and staff had ideas about how they might address this
- They wanted more and earlier consultation on changes that affected them because they often felt they had valuable knowledge and suggestions they could make
- There were several common themes regarding opportunities to meet up more including huddles, team days and meetings
- They wanted more opportunity to share learning and success with others
- More feedback from complaints as they often had to complete statements but didn't know the outcome
- Tackling the culture that perpetuates silo working

Once again, the event evaluated very well and the greatest positive was that the Board should continue to run these events. Attendance was high. Engagement in conversation was evident throughout the session with a good a mixture of returnees and new attendees of staff.

The success of the previous two sessions has been crucial in developing relationships and conversations across the Trust to improve engagement and system thinking. It has also been invaluable as a springboard to moving forward. The previous events concentrated on giving people a safe place to share concerns or successes, and build relationships. By creating this space that people have enjoyed, the positive energy and engagement will be harnessed to utilise future events as problem solving fora in which solutions to issues will be jointly developed, with clearly identified actions to be undertaken at Trust and local team level.

Table of Actions Update

| **Key Messages** | **Update** |
|---|---|
| Staff welcomed the time to speak freely away from the workplace with very senior leaders | Event 2 completed. Event 3 planned as a problem solving event |
| They enjoyed the opportunity to spend time with colleagues from other areas/disciplines | Solutions identified by staff in the second learning event have been emailed to managers with support offered by L&D as requested.<br><br>Eg: Finance Department Open Day, shadowing, social events, making visiting other departments part of PDR or local induction, "lunch and Learn" as an opportunity to showcase and share successful initiatives, local |

| | |
|---|---|
| | huddles to share news and success |
| They heard about and realised the demands on each other | Systems Thinking workshop now running. Next steps to enrol sufficient members of staff for the language to become common currency |
| They wanted their PDRs to be more meaningful and helpful, with recognition for good work done | PDR workshops very well attended. L&D currently collecting information regarding perception of quality of PDR |
| They wanted to see more Senior Managers out and about in the workplace | Senior Team continue with Walk Arounds |
| They wanted the values and behaviours of the Trust truly modelled by all at every level, and that action be taken where that wasn't the case – they talked about being kind to each other | Workshops to support increased understanding of others continue. Feedback and suggestions circulated to managers |
| They wanted learning from incidents to be constructive, positive and widely shared, driving an 'Always Event' culture rather than a 'Never Event' culture | Human factors training to be delivered to key staff with cascade trainers widening impact. Feedback a critical part of training |
| Tackling the culture that perpetuates silo working | Coffee buddy list available and promoted. Managers informed and asked to support. Shadowing opportunities identified in PDR and local induction, continue with Trust listening events, increase understanding of system thinking |
| Improve handling of mental health issues | 22 mental health first aiders will be trained in January/ February 2018 aiming to have 10% of staff trained by April 2019<br><br>New Occupational Health contract provides increased access to counselling<br><br>Promotion of NHS Employers tool "How are you feeling" which helps managers to discuss mental wellbeing |
| Improve Communication | Use 3rd listening event to identify a range of activities |

3. Summary

There is considerable potential to increase staff engagement and morale through continuing with the listening events and acting on feedback. Elements of staff engagement are made up of ability to influence change in an organisation and motivation. It was clear from discussions immediately following the event and from subsequent ad hoc conversations that people really enjoyed the chance to talk to each other and to senior staff in the Trust, and that other staff had been disappointed that they had not been able to attend. Staff have perceived this as an opportunity to have their voices heard and were beginning to identify ways in which they could address some of the issues themselves. There were a considerable number of practical suggestions particularly related to breaking down silos and barriers. The raised energy levels were evident. It is important to maintain the events and provide ongoing opportunity for staff to continue these conversations whilst at the same time ensuring credibility is protected by feeding back what has happened as a result of these discussions.

As a consequence of this work, it is anticipated that the Trust will over time experience an improvement in all of the elements that make up staff engagement and especially that between staff and senior leaders as this was highlighted as an issue for staff in the Trust last year.

4. Board Actions

The Board is asked to

- Receive and consider the feedback from the second Listening Event
- Endorse the approach and commit to further regular Listening Events with staff
- Provide challenge into the organisation and gain assurance that the feedback from staff is being acted upon

| Agenda Item | 17/328(i) |
|---|---|

| | |
|---|---|
| **MEETING** | **Board of Directors** |
| **PAPER/REPORT TITLE:** | **Better Births Update Report** |
| **DATE OF MEETING:** | Friday, 01 December 2017 |
| **ACTION REQUIRED** | **For Assurance** |
| **EXECUTIVE DIRECTOR:** | Doug Charlton, Director of Nursing and Midwifery |
| **AUTHOR(S):** | Gill Diskin, Matron, Maternity |
| | |
| **STRATEGIC OBJECTIVES:** | ***Which Objective(s)?***<br>1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☒<br>2. To be ambitious and *efficient* and make the best use of available resource ☒<br>3. To deliver *safe* services ☒<br>4. To participate in high quality research and to deliver the most *effective* Outcomes ☐<br>5. To deliver the best possible *experience* for patients and staff ☒ |
| **LINK TO BOARD ASSURANCE FRAMEWORK (BAF):** | ***Which condition(s)?***<br>***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust* ☒<br>***2.*** *The Trust is not financially sustainable beyond the current financial year* ☐<br>***3.*** *Failure to deliver the annual financial plan* ☐<br>***4.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision* ☐<br>***5.*** *Ineffective understanding and learning following significant events* ☐<br>***6.*** *Inability to achieve and maintain regulatory compliance, performance and assurance* ☐<br>***7.*** *Inability to deliver the best clinical outcomes for patients* ☒<br>***8.*** *Poorly delivered positive experience for those engaging with our services* ☐ |
| **CQC DOMAIN** | ***Which Domain?***<br>***SAFE-*** *People are protected from abuse and harm* ☒<br>***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☒<br>***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☒<br>***RESPONSIVE –*** *the services meet people's needs.* ☒<br>***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.* ☒<br>***ALL DOMAINS*** ☒ |

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|---|---|---|---|---|
| **LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT** | **1.** Trust Constitution<br>**2.** Operational Plan<br>**3.** NHS Compliance | ☐<br>☒<br>☒ | **4.** NHS Constitution<br>**5.** Equality and Diversity<br>***6.*** Other: **34T** | ☒<br>☐ |
| | | | | |
| **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 progress to date of the Better Births project arising from the National Maternity Review*** | | | |
| **PREVIOUSLY CONSIDERED BY:** | **Committee name** | | Or type here if not on list:<br>34T | |
| | **Date of meeting** | | 34T | |
| | | | | |

## Executive Summary

The National Maternity Review, commissioned by NHS England, aimed to survey current maternity services in England and make recommendations for improvement for services. The review conducted site visits in England and abroad, held consultations, drop-in sessions and listening events across the country. The review makes seven recommendations, which it hopes will be trialed in four sites between September 2016 and September 2018. The report of the National Maternity Review in England was launched on 22nd February, runs to 124 pages and includes 28 recommendations or actions

Our vision for maternity services across England is for them to become safer, more personalised, kinder, professional and more family friendly; where every woman has access to information to enable her to make decisions about her care; and where she and her baby can access support that is centered on their individual needs and circumstances.

Better births sets out a vision for safe, efficient models of Maternity care: safer care, joined up across disciplines, reflecting women's choices and offering continuity of care along the pathway. Commissioners are asked to work across areas as local Maternity systems (LMS). The aim is to ensure women have equitable access to the services they choose and need, as close to home as possible.

**The review calls for:**

1. **Personalized care** – women should have a personalized care plan and use of a digital maternity tool. They suggest a 'NHS Personal Maternity Care Budget' which would allow women to choose the provider of their care.
2. **Continuity of care** - every woman should have a midwife who follows her through her pregnancy and each team of midwives should have an identified obstetrician.
3. **Safer care** – each board should have a champion for maternity services and teams should routinely collect data on the quality and outcomes of their services. A national standardized investigation process is also needed for when things go wrong.
4. **Better postnatal and perinatal mental health care** – they call for significant investment in perinatal and post-natal mental health services.

5. **Multi-professional working** - multi-professional learning should be a core part of all pre-registration training for midwives and obstetricians and electronic maternity record should be rolled out.

6. **Working across boundaries** - community hubs should be established creating a one-stop shop for women. They also call for clinical networks where professionals, providers and commissioners can come together on a larger geographical area.

7. **A payment system that fairly and adequately compensates providers for delivering high quality care to all women efficiently** - the review acknowledges that different services in different areas have different cost structures and states that the money needs to follows the woman and her baby as far as possible, to ensure women's choices drive the flow of money, whilst supporting organizations to work together.

**Report**

**LWH Self-Assessment against Better Births**

| No | Recommendation | Trust Position | Actions |
|---|---|---|---|
| 1. | **Personalised Care** | Compliant | |
| 2. | **Continuity of care** | Compliant | |
| 3. | **Safer Care** | Complaint | |
| 4. | **Perinatal Mental Health** | Complaint | |
| 5. | **Multi Professional Working** | Compliant – Maternity<br>Non- complaint from IT perspective | Digital maternity hand held notes part of the EPR project estimated time for implementation Jan 2019 |
| 6. | **Working Across Boundaries** | Partial compliance | Full compliance relies on Community Hubs progress ongoing within community redesign phase 2 expected implementation April 2018 |
| 7. | **Payment System** | Non- complaint | Awaiting clarification from a national perspective in relation to maternity tariff payments expected advice from DOH early 2019 |

**Updates on Progress**

Maternity Services have focused their efforts on concentrating on the following initiatives:

**Personlised Care**

Women are given choices throughout the Maternity pathway explaining maternity pioneer and have a booklet explaining the choices at every pregnancy stage. We are offering the following at LWH on this pilot on the grounds of choice in:

- Hypno-birth
- Additional parent education
- Additional support with breast feeding – also in community with support
- Aqua natal sessions
- Additional post-natal visits (which excludes Enhanced midwifery)

We as a maternity pioneer pilot site have had to provide additional training to midwifery staff to enable us to provide the above options to women; the greatest uptake has been from women choosing hypnobirthing as a pioneer option. We have recognized this fact and increased our training with the aim to provide this service to all women who request on booking this option.

**Continuity of Carer**

- All women have a named midwife at the point of booking.
- All women have access to a named consultant
- Non-English speaking women have access to continuity of carer through Link Clinic

**Safer Care**

- Designated each baby counts process
- Board level non-executive safety champion
- Director of Nursing heading safer care for maternity services

**Perinatal Mental Health**

- Designated perinatal mental health senior Midwife
- Strengthened Consultant presence through links with Merseycare
- Nominated Consultant Obstetrician

**Next Steps**

The Division recognises that further work is required to achieve compliance as detailed above. We are confident with the timescales noted above, in achieving full clinical compliance. We will continue to work with corporate services to achieve full Better Births compliance.

Gill Diskin
**November 2017**

| Agenda Item | 17/328(ii) |
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| | | |
|---|---|---|
| **MEETING** | **Board of Directors** | |
| **PAPER/REPORT TITLE:** | Community Midwifery Re-design progress report | |
| **DATE OF MEETING:** | Friday, 01 December 2017 | |
| **ACTION REQUIRED** | **For Assurance** | |
| **EXECUTIVE DIRECTOR:** | Director of Nursing and Midwifery | |
| **AUTHOR(S):** | Clare Fitzpatrick, Acting Associate Director of 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*** | ☒ |

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|---|---|---|---|---|
| **LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT** | **1.** Trust Constitution<br>**2.** Operational Plan<br>**3.** NHS Compliance | ☐<br>☒<br>☒ | **4.** NHS Constitution<br>**5.** Equality and Diversity<br>***6.*** Other: **34T** | ☒<br>☐ |
| | | | | |
| **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 current status of the Community Midwifery re-design Project*** | | | |
| **PREVIOUSLY CONSIDERED BY:** | **Committee name** | | Or type here if not on list:<br>34T | |
| | **Date of meeting** | | 34T | |
| | | | | |

## Executive Summary

This paper is to provide an update to the Board of Directors to the progress of the community redesign project

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

Other significant drivers include:

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

In line with the national and local recommendations the community redesigns focus is around the following:

- Identification of suitable hubs in locations that are accessible for women and where a philosophy that services can be delivered jointly to enhance the woman's experience of the service she receives, that a community ethos establishes an holistic model of care supporting an integrated services that would include ultrasound imaging services, obstetric clinics, antenatal education and other services such as smoking cessation, along with services which support the public health agenda for women, babies and families .
- The current home birth rate is around 1% of the total births, therefore in line with offering women choice around place of birth there is a need to increase the number of community led births, there is also a need to explore the need for a freestanding birth centre.

- Equitable access to an enhanced midwifery service providing support for vulnerable women experiencing complex health social factors such as perinatal mental health issues, substance misuse and child protection service input.
- There is a need to support ongoing breastfeeding and ensure this is equitable and appropriate across the whole service
- Offering contemporary antenatal education provision tailored to meet the needs of the women and families.
- Examination of the New born provided in a timely manner in the most appropriate setting
- To provide a model of continuity of carer within smaller teams promoting normality in pregnancy and birth whilst also coordinating care for women with additional risk factors.
- Improvement in the Information Technology provision available to community midwives and support workers.
- To reduce variation in the current service provision.

**Report**

**Updates on Progress**

- Mapping of women who use the current service including ANC service at LWH site
- Undertaken a review of premises which may be suitable for one of the hubs
- Identified 7 potential hubs- further work to ensure capacity and demand are achievable
- Full ANC consultation to review bookings on site at LWH, current staffing model and proposed staffing model required in ANC
- Service review of ANC, consultant, midwife Led and specialist clinics
- Reviewed the contacts, ensuring that the correct data is collected that the correct number of contacts are being undertaken and that all work that is undertaken is fully remunerated
- A paper has been submitted to look at two options to establish a home birth team, this is currently with the finance department awaiting a cost analysis
- A Antenatal Education review has been undertaken, an alternative is being explored with a move towards a more digital and interactive approach to parent education, this work will also ensure women where English is not there first language are not disadvantaged
- The criteria for the Enhanced Midwifery Team has been reviewed and now expanded to include Teenage pregnancy, women with disabilities and asylum seekers
- The community teams are now aligned with the geographical picture across the city, this has resulted in the reduction of the team leaders from four to three
- Information Technology has been reviewed extensively to improve access in the community setting to ensure information systems are available remotely. A app is being reviewed with the plan to implement shortly
- Link clinic has been improved, bespoke to the needs of the women who use this service, this will focus on antenatal and postnatal case loading to improve outcomes, and experience for this group of women

There is ongoing work across Cheshire and Mersey which is intrinsically linked to the community redesign and is likely to steer some of the ongoing work streams, these include

**Work for 2018 in Cheshire and Mersey:**

- A single point of access for women accessing Maternity services will be developed in 2018. This work will link providers of care ensuring pathways are in place to allow women's choice to be taken into account.
- Information given by midwives about choice of place of birth is being reviewed by the Maternity transformation team.

- Electronic Maternity record. This work is on-going and will improve information for women and midwives to ensure that all evidence and guidance is embedded. Women will have access to notes and providers view notes if women change during the pathway.

**Conclusion**

The community redesign has made some definite progress and the work is ongoing. Confirmation is required from the exec board and CCG as to whether a public consultation is required. Further work will be undertaken around the provision of true community hubs, ensuring the estate is fit for purpose and that local GP's support the transition away from the current GP model of care.

The community staffing modeller is continuing which will continue to support operational delivery of a community based service

| Agenda Item | 2017/329 |
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|---|---|
| **MEETING** | **Board of Directors** |
| **PAPER/REPORT TITLE:** | **Safer Nurse/Midwife Staffing Monthly Report** |
| **DATE OF MEETING:** | Friday, 01 December 2017 |
| **ACTION REQUIRED** | **For Assurance** |
| **EXECUTIVE DIRECTOR:** | Director of Nursing and Midwifery |
| **AUTHOR(S):** | Julie E. King, Acting Director of Nursing and Midwifery |
| | |
| **STRATEGIC OBJECTIVES:** | ***Which Objective(s)?***<br>1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☐<br>2. To be ambitious and *efficient* and make the best use of available resource ☐<br>3. To deliver *safe* services ☒<br>4. To participate in high quality research and to deliver the most *effective* Outcomes ☐<br>5. To deliver the best possible *experience* for patients and staff ☒ |
| **LINK TO BOARD ASSURANCE FRAMEWORK (BAF):** | ***Which condition(s)?***<br>***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust* ☒<br>***2.*** *The Trust is not financially sustainable beyond the current financial year* ☐<br>***3.*** *Failure to deliver the annual financial plan* ☐<br>***4.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision* ☐<br>***5.*** *Ineffective understanding and learning following significant events* ☐<br>***6.*** *Inability to achieve and maintain regulatory compliance, performance and assurance* ☒<br>***7.*** *Inability to deliver the best clinical outcomes for patients* ☒<br>***8.*** *Poorly delivered positive experience for those engaging with our services* ☒ |
| **CQC DOMAIN** | ***Which Domain?***<br>***SAFE-*** *People are protected from abuse and harm* ☐<br>***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☒<br>***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐<br>***RESPONSIVE –*** *the services meet people's needs.* ☐<br>***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.* ☒<br>***ALL DOMAINS*** ☐ |

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|---|---|---|---|---|
| **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:<br>• The content of the report and be assured appropriate information is being provided to meet the national and local requirements.<br>• 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.***<br>Or type here if not on list:<br>***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. There were no complaints related to staffing in November.

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. The Trust has had a successful midwifery recruitment drive, and since the previous staffing report, has an additional 22 staff across AfC bands 5 & 6.

The staffing across the inpatient ward areas for October remained appropriate to deliver safe and effective patient care day and night.

Liverpool Women's NHS Foundation Trust

# 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 October 2017.

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

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

## 2.0 Context

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

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

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

## 3.0 Background

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

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

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

3.4 Staff fill rate information appears on the NHS Choices website www.nhschoices.net. Fill rate data from 1st – 31st October 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 – October 2017 | | | | |
|---|---|---|---|---|---|
| Ward | RN/RM | | Non Registered | | |
| | Fill Rate Day% | Fill Rate Night % | Fill Rate Day% | Fill Rate Night % | Total Workforce CHHPD |
| Delivery & Induction Suite | 91.0 | 89.5 | 143.8 | 80.8 | 38.9 |
| Mat base | 95.2 | 94.5 | 87.7 | 89.3 | 7.1 |
| MLU & Jeffcoate | 94.6 | 83.8 | 103.2 | 109.7 | 44.5 |
| NICU | 107.7 | 111.3 | 93.6 | 56.5 | 11.4 |
| Gynae Ward | 94.0 | 98.8 | 89.3 | 94.7 | 7.6 |

| Nurse Sensitive Indicators - October 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 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 6 |
| Mat base | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 2 | 0 |
| MLU & Jeffcoate | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 2 |
| NICU | 0 | 0 | 0 | 2 | 0 | 0 | 14 | 0 | 0 |
| Gynae Ward | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 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 97.6% for registered staff and 98.7 % for care staff during the day and 97.5 % for registered staff and 83.7 % for care staff during the night.

| Day | | Night | |
|---|---|---|---|
| Average Fill Rate | Average Fill Rate | Average Fill Rate | Average Fill Rate |
| Registered Nurses/Midwives | Care Staff | Registered Nurses/Midwives | Care Staff |
| **97.6%** | **98.7%** | **97.5%** | **83.7%** |

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

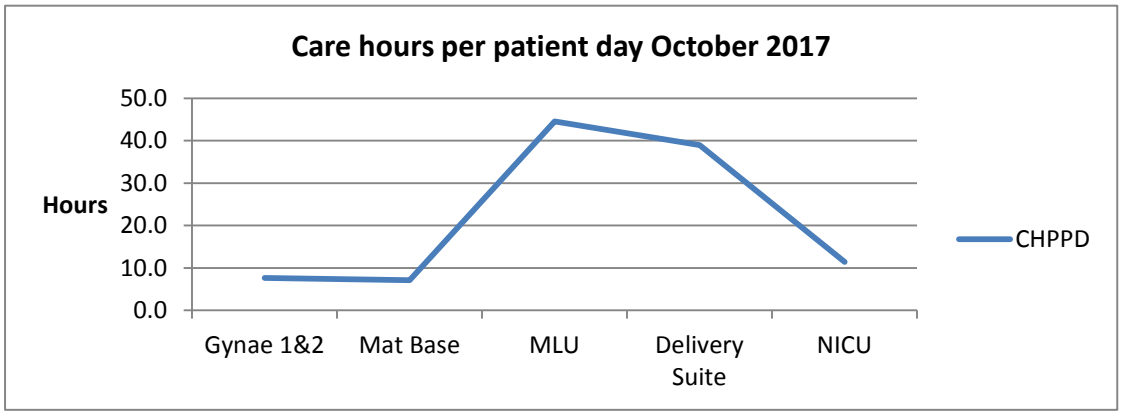
5.1 Safe staffing levels are reviewed and managed three times daily. At the daily 09.00am huddle meeting, the Director of Nursing or Deputy Director of Nursing in conjunction with Heads of Nursing/Midwifery, Matrons, and other senior staff review all registered and unregistered workforce numbers by service. 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 October 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 (44.5 hours) and the Maternity Base have the least (7.1 hours). These data have remained consistent over the last nine 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 | 10.5 |
| Care Staff | 2.6 |
| Overall Hours | 13.0 |

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

| Ward Name | Oct 17 | Sept 17 | Aug 17 | Jul 17 | Jun 17 | May 17 | Apr 17 | Mar 17 | Feb 17 |
|---|---|---|---|---|---|---|---|---|---|
| Gynae 1&2 | 7.6 | 7.4 | 9.1 | 9.9 | 8.5 | 7 | 8.1 | 7 | 7.2 |
| Mat Base | 7.1 | 6.6 | 6.3 | 6 | 6.4 | 5.9 | 6.4 | 6 | 6.5 |
| MLU | 44.5 | 40.3 | 36.8 | 42 | 38.1 | 40.4 | 42.4 | 37 | 35.4 |
| Delivery Suite | 38.9 | 34.7 | 32.7 | 33.1 | 34.3 | 26.8 | 36.5 | 31.3 | 31.5 |
| NICU | 11.4 | 11.4 | 13.8 | 12.6 | 11.8 | 10.5 | 10.1 | 11.2 | 12.3 |
| **Total CHPPD** | **13.0** | **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 no staffing levels complaints reported.

8.3 There were a total of 9 'red flags' in October, all of which are investigated and reviewed in accordance with policy, prevention and learning.

| Nurse Sensitive Indicators - October 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 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 6 |
| Mat base | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 2 | 0 |
| MLU & Jeffcoate | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 2 |
| NICU | 0 | 0 | 0 | 2 | 0 | 0 | 14 | 0 | 0 |
| Gynae Ward | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 |

## 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:

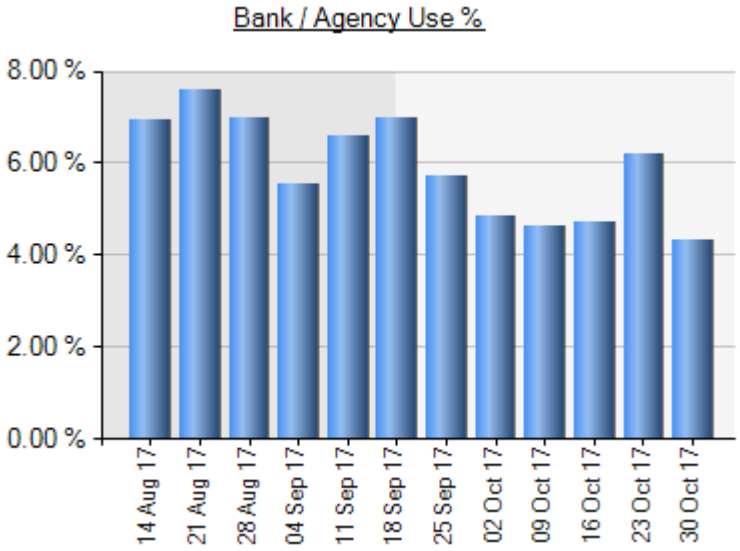
a) The system in place allows for the most appropriate use of temporary bank staff across the organisation and provides a positive challenge mechanism for all requests.

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 October)

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

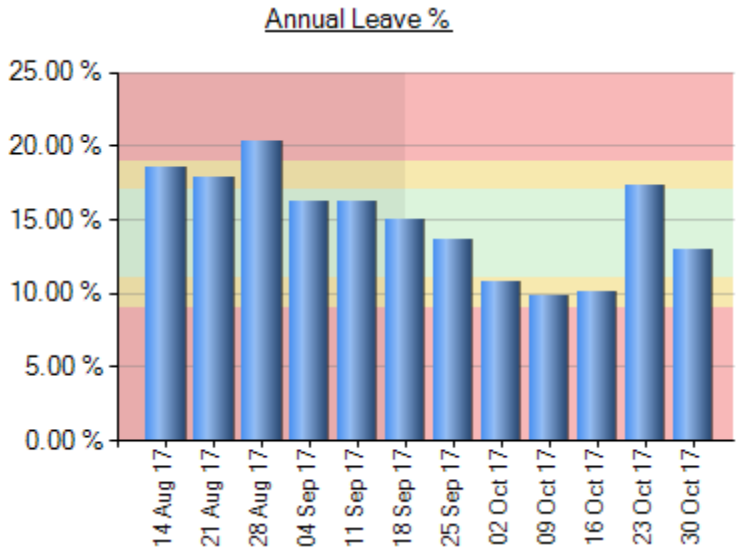
10.2 A key performance indicator (KPI) of less than 6% bank usage (bank shifts compared to total shifts assigned) was set to coincide with the NHS England agency cap. The percentage continues to fluctuate and has risen above the 6% target for October.




## 11.0 Managing Staff Resource

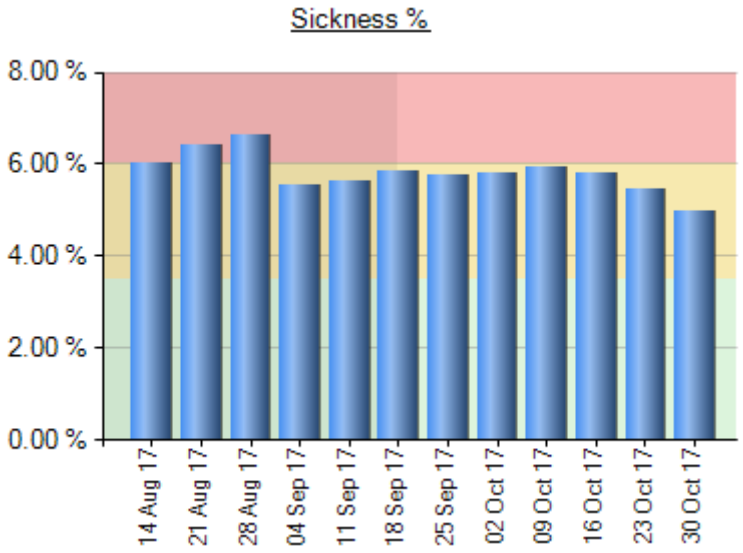
11.1 Annual leave taken during October spans the set tolerances of 10% -18%. These tolerance levels ensure all staff are allocated leave appropriately and an even distribution of staff are available throughout the year.

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 takes annual leave by year end in a consistent manner. The annual leave has remained within the tolerance for October.




11.3 October sickness levels have remained constant from September's levels across inpatient areas and have remained above the set parameter of less than 3.5%. Heads of Nursing/Midwifery ensures 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 October have reduced down to 10%. 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 | Oct -17 |
|---|---|---|---|---|---|---|---|
| Hewitt Centre | 10.00% | 10.00% | 10.00% | 12.00% | 22.00% | 25.00% | 16.00% |
| Genetics | 11.00% | 8.00% | 8.00% | 5.00% | 4.00% | 6.00% | 5.00% |
| Gynaecology | 15.00% | 12.00% | 12.00% | 13.00% | 18.00% | 17.00% | 14.00% |
| Theatres | 5.00% | 36.00% | 21.00% | 17.00% | 21.00% | 20.00% | 12.00% |
| Imaging Services | 18.00% | 18.00% | 6.00% | 12.00% | 12.00% | 13.00% | 13.00% |
| Maternity Services | 6.00% | 7.00% | 7.00% | 7.00% | 11.00% | 11.00% | 8.00% |
| Neonatology | 7.00% | 7.00% | 7.00% | 6.00% | 14.00% | 14.00% | 7.00% |
| Pharmacy | 6.00% | 6.00% | 6.00% | 6.00% | 12.00% | 13.00% | 13.00% |
| **Trust Total** | **10.00%** | **10.00%** | **10.00%** | **9.00%** | **14.00%** | **14.00%** | **10.00%** |

## 13.0 Professional Registration

13.1 The Acting Director of Nursing & Midwifery monitors all staff professional registrations to ensure all non-medical clinical staff are licensed to practice across the trust. During October 2 midwives failed to revalidate with the Nursing & Midwifery Council. 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 | Oct-17 |
|---|---|---|---|---|---|---|---|
| Hewitt Centre | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Genetics | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Gynaecology | 0 | 0 | 0 | 1 | 2 | 2 | 0 |
| Theatres | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Imaging Services | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Maternity Services | 1 | 0 | 0 | 0 | 1 | 4 | 2 |
| Neonatology | 0 | 1 | 0 | 0 | 0 | 0 | 0 |
| Pharmacy | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Trust Total** | **1** | **1** | **0** | **1** | **3** | **7** | **2** |

## 14.0 Conclusion

14.1 The Board is asked to note:

- The content of the report and be assured appropriate information isbeing 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 Acting Director of Nursing & Midwifery.

Liverpool Women's NHS Foundation Trust

Appendix 1

Updated tables

Fill rate data - summary
October 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) | | | | |
| 18181.5 | 17744.5 | 5186.5 | 5121.5 | 16756.5 | 16341.5 | 3864 | 3233 | 97.6% | 98.7% | 97.5% | 83.7% |

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) |
|---|---|---|---|
| 3257 | 10.5 | 2.6 | 13.0 |

| Agenda Item | 2017/329 |
|---|---|

| | |
|---|---|
| **MEETING** | **Board of Directors** |
| **PAPER/REPORT TITLE:** | Performance Dashboard Month 7 |
| **DATE OF MEETING:** | 1 December 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<br>**2.** Operational Plan<br>**3.** NHS Compliance | ☐<br>☐<br>☐ | **4.** NHS Constitution<br>**5.** Equality and Diversity<br>***6.*** Other: **34T** | ☐<br>☐ |
| | | | | |
| **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** | | Or type here if not on list:<br>34T | |
| | **Date of meeting** | | 34T | |
| | | | | |

## 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.

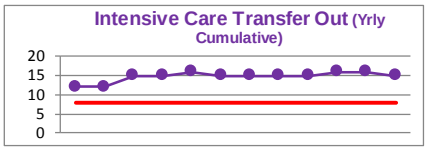
### 2.2 Never Event

There has been one Never Event in the month of October which has been reported to commissioners, safety senate and GACA. There has been a case of a patient receiving a hormone releasing coil rather than a standard coil in the operating theatre. Immediate actions have been taken to ensure that this is not repeated. No harm arose and the patient was informed immediately.

### 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 15 patients, the group consider the transfers to be appropriate.

| Intensive Care Transfer Out (Yrly Cumulative) | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Actual | 12 | 12 | 15 | 15 | 16 | 15 | 15 | 15 | 15 | 16 | 16 | 15 |
| 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 been maintained at 4%. Close monitoring to ensure full application of sickness policy is adhered to.

## 3. Emerging concerns

The activity performance of both Maternity and Gynaecology is a concern and is a feature of the finance report and is being monitored through FPBD.

## 4. Conclusion

The Trust is achieving all its National access and A & E targets. FPBD are monitoring activity and contractual performance and the mitigating actions.

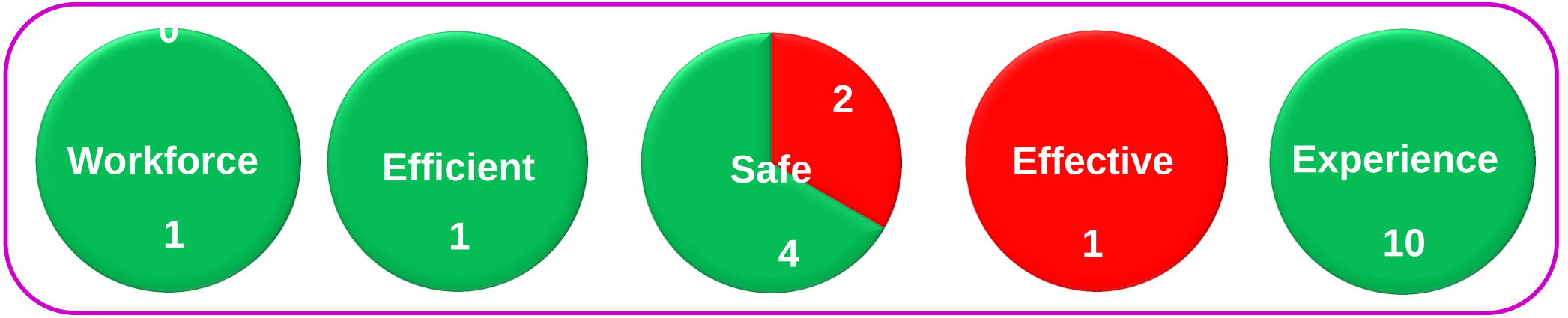
ITU transfers remain a continuing clinical risk that is managed by robust clinical policies and procedures and the experience of clinicians, this particular issue remains a strong focus of our long term strategy. A significant improvement has been made in terms of the sickness rate.

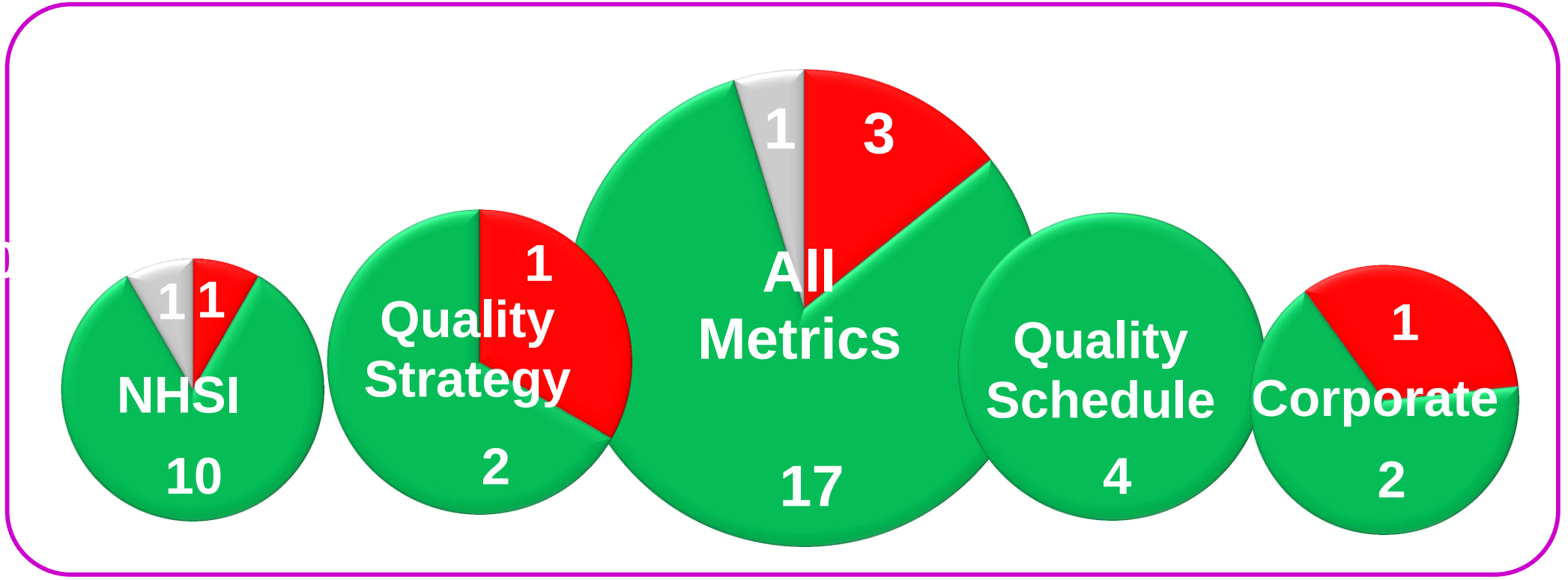
## 5. Recommendation

The Board note the content of the report

Liverpool Women's NHS Foundation Trust

# Performance Report for Trust Board — Month 7 - October 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 7 - October 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 | | 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 | | 0 | | | | | | | |
| Infection Control: MRSA | KPI105 (EAS4) | | 0 | 0 | 0 | 0 | | 0 | 0 | 0 | | 0 | | | | | | | |
| Never Events | KPI181 | Greg Hope | 0 | 1 | 0 | 0 | | 0 | 0 | 0 | | 1 | | | | | | | |
| 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 | | 0 | | | | | | | |
| Mortality Rates: Hospital Standardised Mortality Rates (HSMR) - weekend (1 Month Behind) | KPI321 | | TBC | 0 | 0 | 0 | | 0 | 1 | 0 | | 0 | | | | | | | |
| Mortality Rates: Hospital Standardised Mortality Rates (HSMR) - weekday (1 Month behind) | KPI321 | | TBC | 0 | 0 | 0 | | 0 | 0 | 0 | | 0 | | | | | | | |
| Mortality Rates: Summary Hospital Mortality Indicator | KPI322 | | TBC | 0 | 0 | 0 | | 0 | 1 | 0 | | 0 | | | | | | | |

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

| Indicator Name | Ref | Owner of KPI | Target | Apr-17 | May-17 | Jun-17 | Qtr1 | Jul-17 | Aug-17 | Sep-17 | Qtr2 | Oct-17 | Nov-17 | Dec-17 | Qtr3 | Jan-18 | Feb-18 | Mar-18 | Qtr4 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| HR: Sickness Absence Rate | KPI101 | HR | 4.5% | 4.64% | 5.17% | 4.56% | | 4.05% | 4.51% | 3.26% | | 4.15% | | | | | | | |

## 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% | 94.71% | | | | | | | |
| 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% | 93.33% | | | | | | | |
| 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% | 84.00% | 90.14% | | | | | | | | |
| 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% | 100.00% | | | | | | | |
| 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%* | *95.45%* | 95.52% | | | | | | | | |
| 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 | 0.0 | | | | | | | |
| 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% | No Pts Applicable | | | | | | | |
| Complaints: Number Received | KPI038 | Debi Rice | <= 15 | 10 | 9 | 5 | | 5 | 11 | 9 | | 14 | | | | | | | |

# 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% | 4.15% | | | | | |

**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 | 0 | | | | | |
| A&E: Total Time Spent in A&E 95th percentile | KPI012 (KPI_62) | Sharon Owens | <= 240 | 235 | 231 | 220 | 221 | 221 | 210 | 230 | | | | | |
| Friends & Family Test (Upper quartile will recommend) | KPI089 | Ward Manager | >= 75% | 97.5% | 98.5% | 85.2% | 96.7% | 94.6% | 97.2% | 94.7% | | | | | |

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% | 4.15% | | | | | |

| 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 | 1 | | | | | |
| Mortality Rates: Summary Hospital Mortality Indicator | KPI322 | | TBA | 0 | 0 | 0 | 0 | 1 | 0 | 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 | 14 | | | | | |

Liverpool Women's NHS Foundation Trust

# LWH Corporate 2017/18 Month 7 - October 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% | 0.47% | | | | | |
| 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% | 0.47% | | | | | |

## 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 | 15 | | | | | |

| Agenda Item | 2017/331 |
|---|---|

| | |
|---|---|
| **MEETING** | **Board of Directors** |
| **PAPER/REPORT TITLE:** | **Month 7 Finance Report** |
| **DATE OF MEETING:** | Friday, 01 December 2017 |
| **ACTION REQUIRED** | **For Assurance** |
| **EXECUTIVE DIRECTOR:** | Vanessa Harris, Director of Finance |
| **AUTHOR(S):** | Andy Large, Head of Finance |
| | |
| **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 ☐<br>**2.** Operational Plan ☒<br>**3.** NHS Compliance ☒ | **4.** NHS Constitution ☐<br>**5.** Equality and Diversity ☐<br>***6.*** Other: |
| | | |
| **FREEDOM OF INFORMATION (FOIA):** | 3. This report will not be published under the Trust's Publication Scheme due to exemptions under S22 of the Freedom of Information Act 2000, because the information contained is intended for future publication | |
| | | |
| **RECOMMENDATION:** ***(eg: The Board/Committee is asked to:-….)*** | ***Note the Month 7 Financial Position and Forecast Outturn*** | |
| **PREVIOUSLY CONSIDERED BY:** | **Committee name** | FPBD |
| | **Date of meeting** | November 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 7 the Trust is £0.013m favourable against the planned £2.504m deficit, and is forecasting delivery of the full year control total.

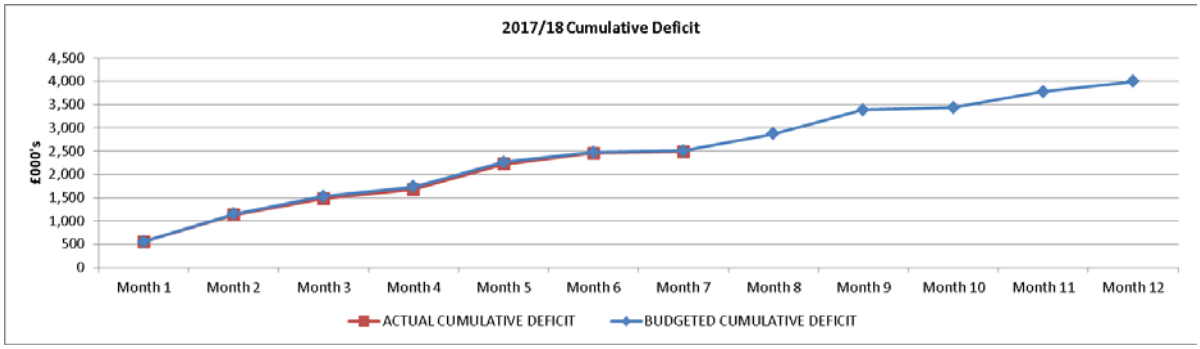
The Trust delivered a finance and use of resources' of 3 in month which is equivalent to plan.

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

## Report

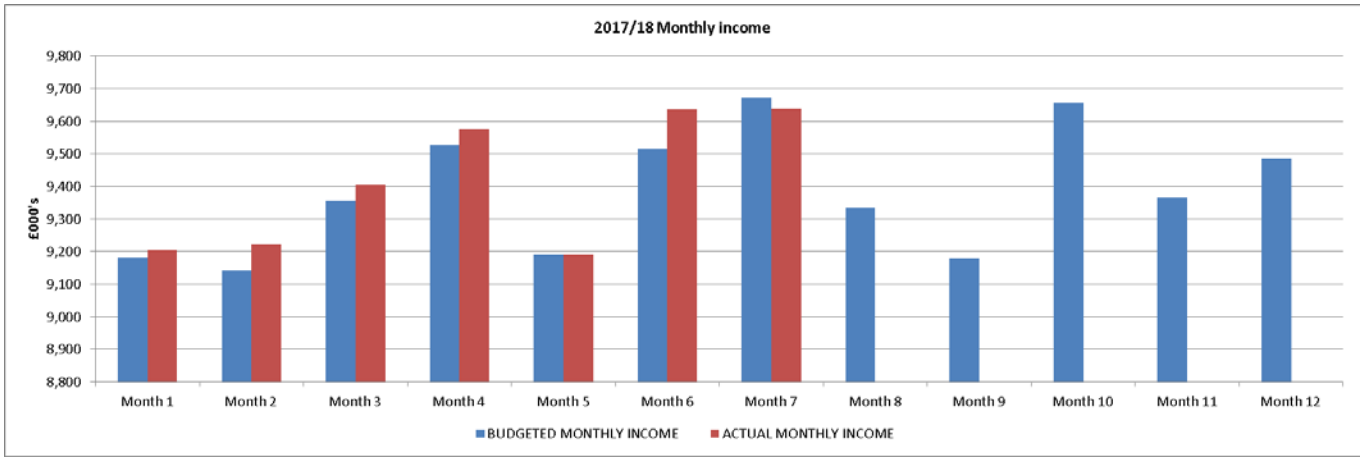
### 1. Month 7 2017/18 Summary Financial Position

The 2017/18 deficit is profiled below.




The Trust is achieving the planned deficit at Month 7.

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.

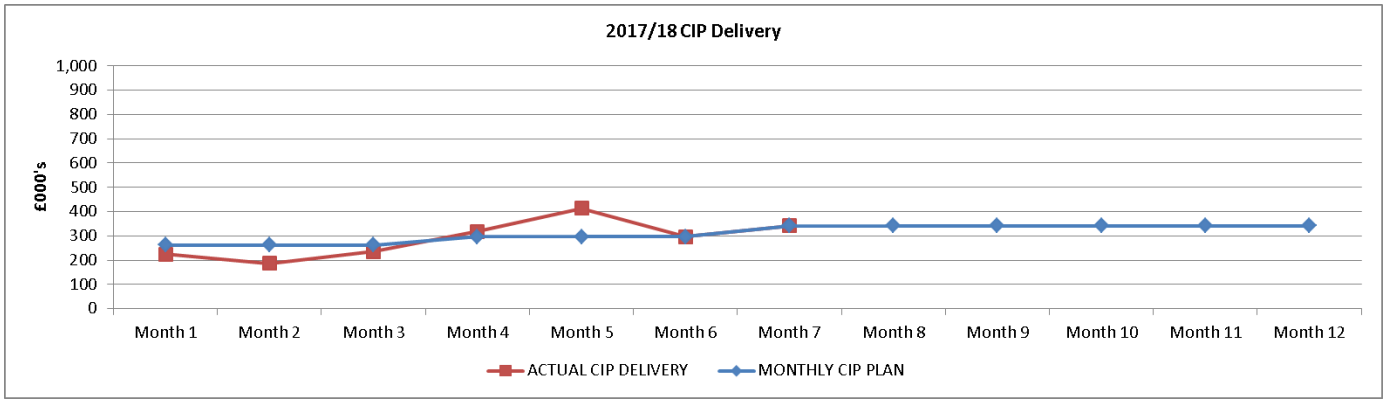



To date, the CCG block payment has been higher than what would have been received under PbR for the level of activity during 2017/18. This has arisen particularly across both Gynaecology and Maternity, with activity levels in each currently below plan. The Trust has performed a detailed review into this performance as reported to FPBD, with recovery plans being actioned. Despite a shortfall in activity, overall income remains ahead of plan due predominantly due to neonatal revenue.

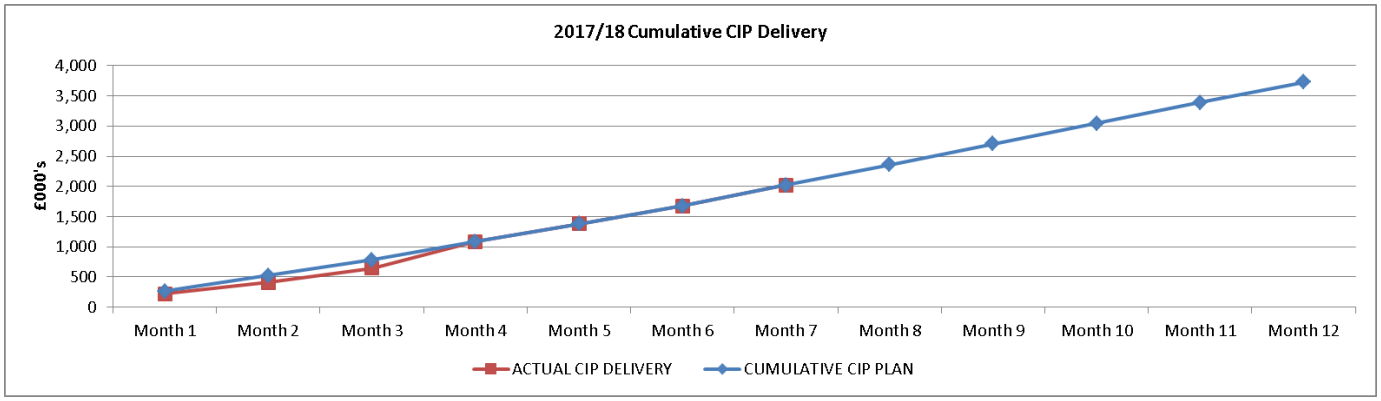
Pay expenditure is expected to slightly exceed plan as a result of the recruitment of additional midwives in year and the costs of delivering neonatal transport service. This is in addition to some admin support overspends in areas where CIP delivery has been delayed. Non-pay expenditure is also expected 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 7 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 £0.342m in month which includes £0.059m of mitigations against the plan. Both in month and cumulatively the Trust is on plan overall.




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

Both maternity and gynaecology are performing under block levels which could present a financial risk to the Trust. Significant work is underway to mitigate and respond to the changes in activity detailed of which are reported through Finance, Performance and Business Development Committee.

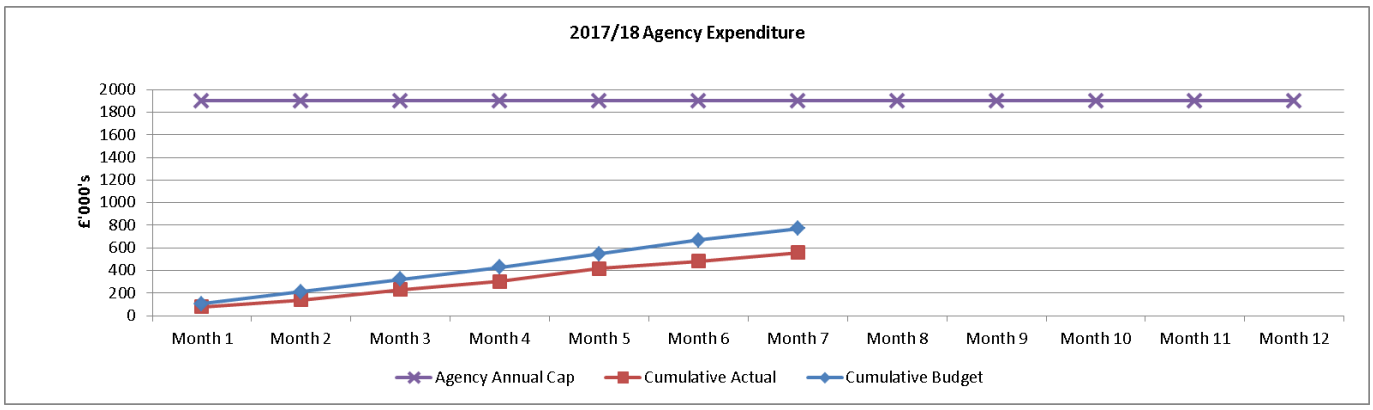
The maternity service is forecasting an overspend on pay - arising from additional recruitment in midwifery in response to concerns raised within the service.

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 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 with schemes identified within the Trust's CIP plan to this value.

## 4. Agency Spend

The annual agency cap set by NHSI for the Trust is £1.9m. In Month 7 the Trust incurred £0.076m of agency expenditure (cumulative £0.558m) and plans to remain within the cap for the financial year.



## 5. Cash and borrowings

The Trust identified an operational cash borrowing requirement of £4m 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 expect to require the full planned drawdown 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 7 financial position.

**Appendix 1 – Board pack**

APPENDIX 1

# LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

# FINANCE REPORT: M7

# YEAR ENDING 31 MARCH 2018

## Contents

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
NHS IMPROVEMENT RATIOS: M7
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 | 1,187 | 1,205 | 2,341 | 2,270 |
| (b) PDC + Interest Payable + Loans Repaid | 1,426 | 3,692 | 2,532 | 4,719 |
| **CSC Ratio = (a) / (b)** | **0.83** | **0.33** | **0.92** | **0.48** |
| **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 | (2,494) | (5,844) | (2,598) | (4,711) |
| (b) Expenditure | 64,406 | 64,677 | 110,277 | 110,691 |
| (c) Daily Expenditure | 301 | 302 | 302 | 303 |
| **Liquidity Ratio = (a) / (c)** | **(8.3)** | **(19.3)** | **(8.6)** | **(15.5)** |
| **NHSI LIQUIDITY SCORE** | 3 | 4 | 3 | 4 |
| Ratio Score 1 = > 0 2 = (7) - 0 3 = (14) - (7) 4 = < (14) | | | | |
| **I&E MARGIN** | | | | |
| Deficit (Adjusted for donations and asset disposals) | 2,504 | 2,489 | 3,998 | 3,995 |
| Total Income | (65,588) | (65,873) | (112,608) | (112,935) |
| **I&E Margin** | **-3.82%** | **-3.78%** | **-3.55%** | **-3.54%** |
| **NHSI I&E MARGIN SCORE** | 4 | 4 | 4 | 4 |
| Ratio Score 1 = > 1% 2 = 1 - 0% 3 = 0 - (-1%) 4 < (-1%) | | | | |
| **I&E MARGIN VARIANCE FROM PLAN** | | | | |
| I&E Margin (Actual) | | -3.78% | | -3.54% |
| I&E Margin (Plan) | | -3.82% | | -3.55% |
| **I&E Variance Margin** | **0.00%** | **0.04%** | **0.00%** | **0.01%** |
| **NHSI I&E MARGIN VARIANCE SCORE** | 1 | 1 | 1 | 1 |
| Ratio Score 1 = 0% 2 = (1) - 0% 3 = (2) - (1)% 4 = < (2)% | | | | |
| **AGENCY SPEND** | | | | |
| **YTD Providers Cap** | 1,120 | 1,120 | 1,924 | 1,924 |
| **YTD Agency Expenditure** | 756 | 557 | 1,301 | 1,018 |
| | **-32.50%** | **-50.27%** | **-32.38%** | **-47.09%** |
| **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: M7**
**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 | (8,756) | (8,712) | (43) | (60,770) | (60,896) | 126 | (102,883) | (103,024) | 140 |
| Non-Clinical Income | (918) | (925) | 8 | (4,818) | (4,978) | 160 | (9,725) | (9,911) | 187 |
| **Total Income** | **(9,673)** | **(9,638)** | **(36)** | **(65,588)** | **(65,873)** | **286** | **(112,608)** | **(112,935)** | **327** |
| **Expenditure** | | | | | | | | | |
| Pay Costs | 5,609 | 5,594 | 14 | 39,459 | 39,513 | (53) | 67,503 | 67,607 | (104) |
| Non-Pay Costs | 2,255 | 2,265 | (10) | 15,772 | 15,989 | (217) | 27,046 | 27,356 | (310) |
| CNST | 1,311 | 1,311 | 0 | 9,175 | 9,175 | 0 | 15,728 | 15,728 | 0 |
| **Total Expenditure** | **9,174** | **9,170** | **4** | **64,406** | **64,677** | **(270)** | **110,277** | **110,691** | **(414)** |
| **EBITDA** | **(499)** | **(468)** | **(31)** | **(1,181)** | **(1,196)** | **15** | **(2,331)** | **(2,244)** | **(87)** |
| **Technical Items** | | | | | | | | | |
| Depreciation | 366 | 363 | 3 | 2,571 | 2,673 | (102) | 4,419 | 4,523 | (104) |
| Interest Payable | 36 | 20 | 16 | 252 | 158 | 94 | 432 | 260 | 172 |
| Interest Receivable | (1) | (1) | 0 | (6) | (9) | 3 | (10) | (25) | 15 |
| PDC Dividend | 124 | 118 | 6 | 868 | 866 | 2 | 1,488 | 1,485 | 3 |
| Profit / Loss on Disposal | 0 | 0 | 0 | 0 | (1) | 1 | 0 | (1) | 1 |
| **Total Technical Items** | **525** | **500** | **25** | **3,685** | **3,687** | **(2)** | **6,329** | **6,243** | **87** |
| **(Surplus) / Deficit** | **26** | **33** | **(6)** | **2,504** | **2,491** | **13** | **3,998** | **3,998** | **(0)** |

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 3
EXPENDITURE: M7
YEAR ENDING 31 MARCH 2018

| EXPENDITURE £'000 | MONTH Budget | MONTH Actual | MONTH Variance | YEAR TO DATE Budget | YEAR TO DATE Actual | YEAR TO DATE Variance | YEAR Budget | YEAR FOT | YEAR Variance |
|---|---|---|---|---|---|---|---|---|---|
| **Pay Costs** | | | | | | | | | |
| Board, Execs & Senior Managers | 341 | 343 | (2) | 2,381 | 2,476 | (95) | 4,085 | 4,157 | (72) |
| Medical | 1,253 | 1,262 | (9) | 8,663 | 8,722 | (60) | 14,928 | 14,948 | (20) |
| Nursing & Midwifery | 2,485 | 2,491 | (6) | 17,590 | 17,618 | (28) | 30,009 | 30,132 | (122) |
| Healthcare Assistants | 405 | 399 | 6 | 2,894 | 2,867 | 28 | 4,924 | 4,886 | 37 |
| Other Clinical | 538 | 520 | 18 | 3,764 | 3,659 | 105 | 6,454 | 6,425 | 29 |
| Admin Support | 140 | 153 | (14) | 981 | 1,102 | (121) | 1,679 | 1,873 | (194) |
| Corporate Services | 343 | 349 | (6) | 2,415 | 2,510 | (95) | 4,125 | 4,169 | (43) |
| Agency & Locum | 104 | 76 | 27 | 771 | 558 | 214 | 1,299 | 1,019 | 281 |
| **Total Pay Costs** | **5,609** | **5,594** | **14** | **39,459** | **39,513** | **(53)** | **67,503** | **67,607** | **(104)** |
| **Non Pay Costs** | | | | | | | | | |
| Clinical Suppplies | 702 | 721 | (19) | 4,953 | 5,038 | (84) | 8,471 | 8,651 | (180) |
| Non-Clinical Supplies | 595 | 563 | 33 | 4,051 | 4,153 | (102) | 7,018 | 7,030 | (12) |
| CNST | 1,311 | 1,311 | 0 | 9,175 | 9,175 | 0 | 15,728 | 15,728 | 0 |
| Premises & IT Costs | 438 | 445 | (7) | 3,080 | 3,113 | (33) | 5,268 | 5,270 | (2) |
| Service Contracts | 520 | 536 | (16) | 3,688 | 3,686 | 2 | 6,289 | 6,405 | (116) |
| **Total Non-Pay Costs** | **3,566** | **3,576** | **(10)** | **24,947** | **25,164** | **(217)** | **42,774** | **43,084** | **(310)** |
| **Total Expenditure** | **9,174** | **9,170** | **4** | **64,406** | **64,677** | **(270)** | **110,277** | **110,691** | **(414)** |

| INCOME & EXPENDITURE £'000 | MONTH Budget | MONTH Actual | MONTH Variance | YEAR TO DATE Budget | YEAR TO DATE Actual | YEAR TO DATE Variance | YEAR Budget | YEAR FOT | YEAR Variance |
|---|---|---|---|---|---|---|---|---|---|
| **Maternity** | | | | | | | | | |
| Income | (3,898) | (3,848) | (50) | (26,726) | (26,598) | (128) | (45,612) | (45,475) | (137) |
| Expenditure | 1,698 | 1,748 | (49) | 11,906 | 11,991 | (84) | 20,398 | 20,544 | (146) |
| **Total Maternity** | **(2,200)** | **(2,101)** | **(99)** | **(14,819)** | **(14,607)** | **(212)** | **(25,214)** | **(24,931)** | **(283)** |
| **Gynaecology** | | | | | | | | | |
| Income | (2,206) | (2,202) | (3) | (15,151) | (15,134) | (17) | (25,742) | (25,717) | (25) |
| Expenditure | 859 | 877 | (18) | 6,023 | 6,028 | (5) | 10,317 | 10,358 | (41) |
| **Total Gynaecology** | **(1,347)** | **(1,325)** | **(22)** | **(9,128)** | **(9,106)** | **(22)** | **(15,425)** | **(15,359)** | **(66)** |
| **Theatres** | | | | | | | | | |
| Income | (42) | (38) | (3) | (291) | (270) | (21) | (499) | (462) | (37) |
| Expenditure | 640 | 665 | (25) | 4,480 | 4,539 | (59) | 7,679 | 7,719 | (40) |
| **Total Theatres** | **598** | **627** | **(28)** | **4,189** | **4,269** | **(80)** | **7,180** | **7,257** | **(77)** |
| **Neonatal** | | | | | | | | | |
| Income | (1,356) | (1,305) | (51) | (9,490) | (9,686) | 195 | (16,249) | (16,558) | 309 |
| Expenditure | 945 | 960 | (14) | 6,616 | 6,672 | (56) | 11,341 | 11,523 | (182) |
| **Total Neonatal** | **(411)** | **(346)** | **(65)** | **(2,875)** | **(3,014)** | **139** | **(4,908)** | **(5,035)** | **127** |
| **Hewitt Centre** | | | | | | | | | |
| Income | (899) | (911) | 11 | (5,881) | (6,007) | 126 | (9,971) | (10,176) | 204 |
| Expenditure | 623 | 637 | (15) | 4,358 | 4,432 | (74) | 7,471 | 7,671 | (200) |
| **Total Hewitt Centre** | **(277)** | **(273)** | **(3)** | **(1,523)** | **(1,575)** | **52** | **(2,501)** | **(2,505)** | **4** |
| **Genetics** | | | | | | | | | |
| Income | (600) | (625) | 25 | (4,202) | (4,158) | (45) | (7,204) | (7,098) | (106) |
| Expenditure | 461 | 452 | 9 | 3,229 | 2,974 | 255 | 5,535 | 5,220 | 315 |
| **Total Genetics** | **(139)** | **(173)** | **34** | **(974)** | **(1,184)** | **210** | **(1,669)** | **(1,879)** | **209** |
| **Clinical Support** | | | | | | | | | |
| Income | (24) | (24) | (1) | (176) | (213) | 37 | (295) | (330) | 35 |
| Expenditure | 759 | 733 | 26 | 5,368 | 5,341 | 27 | 9,164 | 9,157 | 6 |
| **Total Clinical Support & CNST** | **735** | **709** | **26** | **5,192** | **5,128** | **64** | **8,869** | **8,828** | **41** |
| **Corporate & Trust Technical Items** | | | | | | | | | |
| Income | (648) | (684) | 36 | (3,671) | (3,809) | 139 | (7,037) | (7,120) | 84 |
| Expenditure | 3,715 | 3,599 | 116 | 26,113 | 26,389 | (276) | 44,702 | 44,742 | (39) |
| **Total Corporate** | **3,066** | **2,915** | **151** | **22,442** | **22,579** | **(139)** | **37,666** | **37,621** | **44** |
| **(Surplus) / Deficit** | **26** | **33** | **(6)** | **2,504** | **2,491** | **13** | **3,998** | **3,998** | **0** |

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 5
BALANCE SHEET: M7
YEAR ENDING 31 MARCH 2018

| BALANCE SHEET £'000 | YEAR TO DATE Opening | M7 Actual | Movement |
|---|---|---|---|
| **Non Current Assets** | **72,688** | **72,764** | 76 |
| **Current Assets** | | | |
| Cash | 4,897 | 5,640 | 743 |
| Debtors | 8,201 | 8,157 | (44) |
| Inventories | 366 | 451 | 85 |
| **Total Current Assets** | **13,464** | **14,248** | **784** |
| **Liabilities** | | | |
| Creditors due < 1 year | (10,577) | (16,763) | (6,186) |
| Creditors due > 1 year | (1,717) | (1,699) | 18 |
| Loans | (17,175) | (14,507) | 2,668 |
| Provisions | (3,011) | (2,862) | 149 |
| **Total Liabilities** | **(32,480)** | **(35,831)** | (3,351) |
| **TOTAL ASSETS EMPLOYED** | **53,672** | **51,181** | **(2,491)** |
| **Taxpayers Equity** | | | |
| PDC | 37,420 | 37,420 | 0 |
| Revaluation Reserve | 12,233 | 12,233 | 0 |
| Retained Earnings | 4,019 | 1,528 | (2,491) |
| **TOTAL TAXPAYERS EQUITY** | **53,672** | **51,181** | **(2,491)** |

**LIVERPOOL WOMEN'S NHS FOUNDATION TRUST**
**CASHFLOW STATEMENT: M7**
**YEAR ENDING 31 MARCH 2018**

| CASHFLOW STATEMENT<br>£'000 | YEAR TO DATE<br>M7 Actual |
|---|---|
| Cash flows from operating activities | (1,477) |
| Depreciation and amortisation | 2,673 |
| Movement in working capital | 5,864 |
| **Net cash generated from / (used in) operations** | **7,060** |
| | |
| Interest received | 9 |
| Purchase of property, plant and equipment and intangible assets | (2,876) |
| Proceeds from sales of property, plant and equipment and intangible assets | 133 |
| **Net cash generated from/(used in) investing activities** | **(2,734)** |
| | |
| Loans from Department of Health - received | 0 |
| Loans from Department of Health - repaid | (2,668) |
| Interest paid | (138) |
| PDC dividend (paid)/refunded | (777) |
| **Net cash generated from/(used in) financing activities** | **(3,583)** |
| | |
| **Increase/(decrease) in cash and cash equivalents** | **743** |
| | |
| **Cash and cash equivalents at start of period** | 4,897 |
| **Cash and cash equivalents at end of period** | **5,640** |