Meeting of the Board of Directors
HELD IN PUBLIC
Friday 2 February 2018 at 1015 hrs
Liverpool Women's Hospital
Board Room

Item no. 2018/	Title of item	Objectives/desired outcome	Process	Item presenter	Time	CQC Domain
	Thank you	To provide personal and Team thank you – above and beyond			1015 (15mins)	caring
032	Apologies for absence Declarations of interest	Receive apologies	Verbal	Chair		-
033	Meeting guidance notes	To receive the meeting attendees' guidance notes	Written guidance	Chair		Well Led
034	Palliative and End of Life Care	To receive an update	Written/Presentation	Dr Leslie Allsopp & Chris Webster Macmillan CNS and Lead cancer nurse	1030 (20mins)	
035	Minutes of the previous meeting held on 12 January 2018	Confirm as an accurate record the minutes of the previous meetings	Written	Chair	1050 (5mins)	Well Led
036	Action Log and matters arising	Provide an update in respect of on-going and outstanding items to ensure progress	Written/verbal	Chair		Well Led
037	Chair's announcements	Announce items of significance not elsewhere on the agenda	Verbal	Chair	1055 (10mins)	Well Led

Item no. 2018/	Title of item	Objectives/desired outcome	Process	Item presenter	Time	CQC Domain
038	Chief Executive Report	Report key developments and announce items of significance not elsewhere	Verbal/Written	Chief Executive	1105 (10mins)	Well Led
BOARD COMMITTEE ASSURANCE						
039	Chair's Report from Quality Committee	Receive assurance and any escalated risks	Written	Committee Chair	1115 (20mins)	Well Led
040	Chair's Report from Finance, Performance and Business Development Committee	Receive assurance and any escalated risks	Written	Committee Chair		Well Led
041	Chair's Report from Audit Committee	Receive assurance and any escalated risks	Written	Committee Chair		Well Led
042	Chair's Report from Putting People First 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						
043	Quarter 3 Mortality Report	Receive assurance and any escalated risks	Written	Associate Medical Director	1135 (10mins)	Safe Well Led
TRUST PERFORMANCE - TO DELIVER THE MOST EFFECTIVE OUTCOMES; TO BE EFFICIENT AND MAKE BEST USE OF AVAILABLE RESOURCES						
044	Safer Nurse/Midwife Staffing Monthly Report 9	The Board is asked to note the content of the report	Written	Acting Director of Nursing and Midwifery	1145 (10mins)	Safe Well Led
045	Performance Report period 9, 2017/18	Review the latest Trust performance report and receive assurance	Written	Director of Operations	1155 (10mins)	Safe Well Led
046	Finance Report period 9, 2017/18	To note the current status of the Trusts financial position	Written	Director of Finance	1205 (10mins)	Well Led
TRUST STRATEGY						

Item no. 2018/	Title of item	Objectives/desired outcome	Process	Item presenter	Time	CQC Domain
047	Fit for Future Generations Update	To brief the Board on progress and risks	Verbal	Chief Executive	1215 (5mins)	All
BOARD GOVERNANCE						
048	Changes to Trust Constitution	To Agree the changes to the Trust Constitution	Written	Trust Secretary	1220 (10mins)	Well Led
049	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair		Well Led
HOUSEKEEPING						
050	Any other business & Review of meeting	Consider any urgent items of other business	Verbal	Chair	1230 meeting ends	Well Led

Date, time and place of next meeting Friday 2 March 2018

Meeting to end at 1230

1230-1245	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

Agenda Item	2018/034

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Palliative and End of Life Care Update**
DATE OF MEETING:	Friday, 02 February 2018
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Julie King, Acting Director of Nursing and Midwifery
AUTHOR(S):	Chris Webster, Macmillan CNS and Lead cancer nurse
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** 1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☐ 2. To be ambitious and *efficient* and make the best use of available resource ☐ 3. To deliver *safe* services ☒ 4. To participate in high quality research and to deliver the most *effective* Outcomes ☐ 5. To deliver the best possible *experience* for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust* ☐ ***2.*** *The Trust is not financially sustainable beyond the current financial year* ☐ ***3.*** *Failure to deliver the annual financial plan* ☐ ***4.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision* ☐ ***5.*** *Ineffective understanding and learning following significant events* ☐ ***6.*** *Inability to achieve and maintain regulatory compliance, performance and assurance* ☐ ***7.*** *Inability to deliver the best clinical outcomes for patients* ☒ ***8.*** *Poorly delivered positive experience for those engaging with our services* ☒
CQC DOMAIN	***Which Domain?*** ***SAFE-*** *People are protected from abuse and harm* ☒ ***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☐ ***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☒ ***RESPONSIVE –*** *the services meet people's needs.* ☒ ***WELL-LED -*** *the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ☐ ***ALL DOMAINS*** ☐

LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution ☐ **2.** Operational Plan ☐ **3.** NHS Compliance ☒		**4.** NHS Constitution ☒ **5.** Equality and Diversity ☒ ***6.*** Other: **Click here to enter text.**	
FREEDOM OF INFORMATION (FOIA):	1. This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting			
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	***The Board is asked to note the current status of Palliative and End of Life Care within the Trust.***			
PREVIOUSLY CONSIDERED BY:	**Committee name**		***Choose an item.*** Or type here if not on list: ***Click here to enter text.***	
	Date of meeting		***Click here to enter a date.***	

Executive Summary

The Liverpool Women's Hospital Trust recognises the specific challenges in the provision of EOL care to patients and families for women with gynaecological malignancy and as a result put forward an EOL care Strategy for the Trust in order to drive the agenda relating to End Of Life Care.

End of Life Care is now recognised as a national priority for all care settings. This is on the back of some key high profile papers and documents which include

- National End of Life Care Strategy DOH 2008
- Francis Report Feb 2013
- More Care, Less Pathway July 2013
- One Chance to get it right, Leadership Alliance for care of dying people June 2014

EOLC is now one of the 8 key line domains that CQC hold trusts accountable for and is reviewed on a regular basis.

The National Transform Programme for Care of the Dying in Acute Hospitals with the main aim of improving end of life care for patients in the acute hospital setting. It recognises 5 key enablers of care which include

- **Advance Care Planning**
- **Electronic palliative care coordination systems (EPaCCS)**
- **Amber Care Bundle**
- **Rapid discharge home to die**
- **Individualised care plan**

In 2015 the National Palliative and EOL care partnership developed the Ambitions for Palliative and EOL Care, a National framework for local action. It highlights six ambitions or priorities of care and the strategy within the LWH trust was developed on the back of this document. The Strategy highlights the six priorities and highlights foundations upon which we can build the ambitions. The LWH EOL Strategy is based on these 6 ambitions.

Report

Where are we up to with the strategy in LWH?

Ambition 1 "Each person is seen as an individual"

- Use of individualised care plan on gynae unit for EOLC
- Use of unified DNACPR form which can cross all care settings
- Advance Care Planning Policy with use of ACP documents to help facilitate documentation of such discussions
- ACP now recorded as part of the SPCT MDT Wednesday mornings
- Access to communication skills training

Ambition 2 "Each person has fair access to care"

- Recording of Place of Death of patients
- Data collection via Somerset database

Ambition 3 "Maximising comfort and wellbeing"

- Audit of five priorities of care for all patients who die at the Trust (1 death 2017)
- Use of EOL comfort charts on the ward
- Access to SPC telephone advise via Marie Curie Hospice OOH and weekends
- All patients are known to the gynaeoncology CNS
- Team participate in N West Coast Palliative Care Audit Group Guideline programme
- Be spoke education for staff relating to end of life care

Ambition 4 "Care is coordinated"

- LWH is part of the locality plan for EMIS web access role out later in 2018
- Use of PENS within outpatient and inpatients, allows access to patient episodes elsewhere e.g. RLUH
- All patients have a key worker who they can contact at any point in their journey
- Holistic assessments and referral to community services by the keyworker at regular points of patient pathways

Ambition 5 "All staff are prepared to care"

- Bespoke education programme that takes education to the wards
- Access to courses within the locality and nationally

Ambition 6 "Each community is prepared to help"

- Team participate in Dying Matter week , locality meetings relating to community engagement
- EVOC support group and small grants

Education Programme

The education programme continues via a bespoke AMIGOS (advisory mentoring in gynaecology oncology and palliative care) programme. As part of the action plan from the recent palliative care meeting the programme is due for both evaluation of the teaching by staff and a gap analysis of the programme. This will be ready for the review of the current education plan which is due in May 2018. See action plan and education programme embedded at end of this paper. We have included a brief review of the numbers of education sessions delivered so far during the period 01/07/16 to 31/ 12/17

Sharing significant news ……14
End of life care ……23
General pall care symptoms ……9
Hydration ……4
Advanced care planning ……11
Bowel obstruction ……3
Care at death ……4
Opioids ……2
Nausea ……5

Audit of Care of the Dying in LWH Jan 17 - Dec 17

The audit involved retrospective review of case notes, MEDITECH, individualised care plan and Somerset database for all expected deaths that occurred on the gynaecology wards over a 12 month period. During this time there were 113 deaths of patients known to the gynaeoncology team; this includes expected and unexpected deaths. Preferred priorities of death was recorded for 10 of these patients and achieved for 8. 105 patients PPD was unknown. 2 patients did not achieve their PPD. When we looked at where these patients died – 20 died at home, 5 in nursing home, 32 in hospital, 34 in hospices and 22 were unknown. There was no rapid discharge home to die during this period of time. One patient died at the Women's Hospital during this time. This is likely to be due to fact that during this time the wards were relocated in order for the new gynae unit to be built. Also CCC no longer provide chemotherapy as a day case at the Liverpool Women's Hospital and as a result of this we have seen a significant drop in the number of palliative care patients being admitted to the wards – they are now being admitted into other acute trusts where they are receiving their chemotherapy. The emerging role of acute oncology within all district trusts means patients are advised when unwell to go those trusts rather than LWH which may also be a contributory factor. Within the locality there is a focus on Advance Care Planning (ACP) which may also be impacting on the choices of where people choose to die and the preparation and planning for this. More patients appear to be invited to day care via the hospice teams so are known to them at an appropriately earlier point in their care needs pathway. The Trust has an ACP policy which is in use including documentation.

It is therefore difficult to say much from an audit point of view regarding the single death. However the death was a very positive experience for the family at a time of great change on the ward and the staff should be commended for their care and support of this lady and her family. The audit is based on the five priorities of care of the dying patient. Key findings from review of notes

Priority 1 – Recognition of the dying phase

- Documented evidence that the patient was entering the dying phase and evidence of discussion at Multidisciplinary level
- Use of aide memoire to focus care
- Daily review of the patient
- Psychological, spiritual, social needs were addressed

Priority 2 - Communication

- Patient was offered a discussion regarding the situation but declined
- Discussion with relatives that loved one was dying and evidence of opportunity for relatives to discuss fears and anxieties

Priority 3- Dying person and those important to them involved in decision making

- Evidence of engagement with patient regarding their wishes for end of life care
- No evidence that ACP was explored with the patient
- DNACPR was in place, endorsed by senior clinician and discussed with relatives, patient declined discussion
- Preferred place of death documented in the clinical notes and PPD achieved

Priority 4 – Needs of families and others

- Evidence that needs of person important to patient was assessed including their information needs

Priority 5 – Care is tailored to the individual

- Individualise care plan in use and completed
- Days on care plan – 24
- Care plan discussed with relatives, patient declined discussion
- Patients medication was reviewed, rationalised and all anticipatory medicines were appropriately prescribed
- Evidence that symptoms were reviewed at least daily
- EOLC comfort chart in use – with evidence of frequent mouth care
- Patients hydration and nutritional status assessed in last 24 hours of life however not done on a daily basis

We also looked at care after death and there was evidence that personal care was carried out within 4 hours after death, that there was timely verification of death and also timely certification of death (within 72 hours) . The patients GP was informed however there was no evidence that the DWP booklet was provided to the family after death. However a LWH bereavement booklet was given and from the new December 2017 bereavement specification for our network this is a preferred specification anyway.

The findings have highlighted the need for ongoing education amongst the staff regarding ACP and also the daily assessment and documentation of the patient's ability to take on fluids and diet during the dying phase.

Evaluation of Adult End of Life and Bereavement Care – Results

In order to obtain feedback regarding the provision of end of life care at the Liverpool Women's Hospital a survey was sent to those bereaved relatives who's loved ones died at the Women's Hospital during the period of Jan 16-Dec 17. The survey was adapted from the VOICES survey used as part of the National Audit of Care of the Dying in Acute Hospitals. Only 3 surveys were returned during this time. The team roll out this survey on an annual basis but in 2016 we changed the way we presented the survey to bereaved relatives. The ward staff now introduces the concept of the survey prior to the family leaving the ward for the final time. This is then followed up with a bereavement call from the Macmillan nurses and at that point the survey is sent out to the relative.

Key findings from the survey:

- Patients treated with respect and dignity by hospital Drs and nurses – Always 100%
- Dr and Nurses knew enough about relatives' medical condition – All 100%
- 100% relatives felt they were able to discuss worries or concerns with staff, as much as they wanted
- Relatives felt that they were always kept up to date with their loved ones condition 100%
- 100% relatives felt information provided was easy to understand
- 100% relatives felt their loved ones received enough help to meet personal care needs, nursing care and had adequate privacy
- 100% relatives felt that the relief of pain and other symptoms was excellent

- 100% relatives felt fully informed
- 1 relative stated that their loved one would not have wanted a certain decision about treatment but all relatives stated that they were happy with the decisions made about care / treatment
- All relatives felt their loved ones probably knew they were in last days of life and felt news was delivered in a sensitive and caring manner
- All relatives were informed of imminent deterioration
- Two patients had not stated to their loved ones where they would have wished to die and one had wished to die at LWH. Two relatives felt that their loved ones had enough choice to where they wished to be cared for, one relative wasn't sure.
- All relatives felt they were given appropriate support at the time of death and felt they had died in the correct place
- After death all relatives felt they were supported in a sensitive manner and overall they all rated their loved ones care in the last 3 months as excellent.
- The small numbers of deaths and feedback from relatives does not reflect the input of the team onto the wards and in the outpatient department for palliative patients. Data from the Somerset cancer dataset for the period of 1/1/17 to 31/12/17 show the following

Contact Type	**Number of Contacts**	**Time Spent (mins)**
Telephone	448	5928
Face to face	265	6956
Other	29	79
Written notes	97	736
Total	895	13973

The palliative care team has discussed surveys at their team meetings and there is an action going forward to develop a survey / questionnaire to gain feedback not only from bereaved relatives but also patients who are being supported by the palliative care team in the inpatient and outpatient settings. The team are in the process of devising a questionnaire that could be handed to all palliative care patients asking about their experience of involvement of the team. The gynae unit is also now open and fully functioning and we are beginning to see increased numbers coming on to the unit again.

Recommendation
The Board is asked to note the report

Palliative care Working Group
Action Log

Meeting date	Agenda Ref	Action	By whom?	By when?	Status	Update
17/1/18	17/18/019	GG and NHS to review wound care and pressure area skin care medications	**GG/NHS**	next meeting	ongoing	costed but needs medicines management approval and education and comparison with CCG practice
17/1/18	17/18/018	new bereavement guidelines and leaflet to be written that align with network gold standards	**CW/NHS**	next meeting	ongoing	NHS/CW part of LWH bereaevement steering group and commenced the guidelines and leaflet
17/1/18	17/18/021	expansion of the feedback we obtain on patient and carer experience---LBA to contact woodlands team	**LBA**	next meeting	ongoing	woodands and LHC surveys to be adapted to LWH needs and volunteers to help with taking forward
17/1/18	17/18/018	new subcutaneous fluids guidance written that needs feedback before submission for ratification	**LBA**	immediate	complete	discussed in meeting and will be finalised and sent for review
17/1/18	17/18/018	DVG to send copy of opioid guidance for topical use to GG to then update guidance	**DVG/GG**	next meeting	ongoing	
17/1/18	17/18/020	do not disturb notices and colour colded PEGS for use on ward	**DR/GB**	next meeting	ongoing	
17/1/18	17/18/023	education programme gap analysis and new evalaution form to be devised	**CW**	next meeting	ongoing	

Palliative care education plan Liverpool Women's Hospital 2016-18

Introduction and setting the scene

The Liverpool Women's Hospital is a tertiary referral centre for women presenting with gynaecological malignancy. Patients are referred from across the network and occasional from outside the network for multidisciplinary assessment and subsequent management.

The ethos of palliative care is incorporated into the patient's gynaecological cancer journey very early on due to the dual role of the Clinical Nurse Specialists. The Clinical Nurse Specialists in the Liverpool Women's Hospital are trained in both gynaecology oncology and specialist palliative care.

The aim of the specialist palliative care gynaecology oncology service is:

- To enhance the quality of life for women with gynaecological cancer who have complex physical, psychosocial, sexual, emotional and or spiritual needs

The service extends to meet the needs of women and their families from diagnosis into bereavement.

As a specialist Trust we are acutely aware of the need to adapt the National and Network plans into the service needs of the patients and workforce of this Trust. The remit of education is one such example of how the palliative care macmillan team and the lead clinician Dr Allsopp have flexed the palliative and end of life care training to match the local service and staff requirements.

This plan has been developed to ensure the required training and education to meet the requirements for "Once chance to get it right" (2014) and the "Quality Standard for end of lie care for adults "(2011). It also aims to train staff to be able to support patients and families to the levels required in the NICE NG31 " Care of the dying adult in the last days of life" 2016

Level A staff work in specialist palliative care

Level B staff frequently deal with end of life care as part of their role

Level C staff work within other services and infrequently have to deal with end of life care

Level B staff work on Gynaecology ward base one where the vast majority of oncology and palliative care patients are nursed.

Level C staff work on **gynaecology base two** and the **day ward** and only occasionally nurse patients with palliative care needs and never look after patients at end of life. Nursing staff in **gynaecology outpatients** will see patients and their families with palliative care needs alongside the macmillan CNS team. **The emergency room** occasionally see patients with palliative care needs and there is trained nurse in the department who is a Champion for oncology and palliative care in that area who links with the lead cancer nurse for education to be able to cascade and support staff in that department.

Level A staff

Level A staff in LWH are the Macmillan clinical nurse specialist (CNS) team. The team currently comprises;

3 CNS's who support patients both with gynaecology oncology needs and then into palliative care and end of life with bereavement

1 CNS who supports patients with gynaecology oncology needs and will then refer onto the other 3 CNS's for palliative care

1 CNS who supports patients with gynaecology/oncology needs and is the lymphedema practitioner so will support patients with palliative lymphedema needs

Educational courses/programmes for level A staff

1. Macmillan courses in relation to all aspects of support for both patients and self care for the CNS's (ie Mindfulness)
2. Rolling programme of Masterclasses-----delivered by the palliative care consultant Dr Allsopp on all aspects of palliative care symptom management
3. The Marie Curie Merseyside and Cheshire audit programme----bimonthly audit sessions for 2 hours that produce the Standards and guidelines that are applied in palliative care practice in our Network.
4. Attendance at mortality and morbidity meetings within LWH----extend knowledge around learning points and practice.

Beyond this the team members identify within their PDR , with the team leader, other educational requirements that will enhance their care delivery.

Level B Staff

Educational courses/programmes for level B staff

1. The End of life one day course run by the specialist palliative care educator at the Royal Liverpool hospital has been very successfully evaluated by both trained and health care assistant staff and as this is funded by Liverpool CCG---All trained and health care assistants on gynae base one have been on this course or are dated for this year.
2. Intermediate communication skills course----- All trained and health care assistants on gynae base one will have either completed the ENB 237 oncology course which included advanced communication skills training or will be attending the Network intermediate commincation skills course during 2016-17
3. All staff in level B are encouraged to attend the LWH mortality and morbidity meetings
4. All staff in Level B are also encouraged to attend the LWH Breaking bad news sessions delivered by a Senior medic
5. AMIGOS----------

A.M.I.G.O.S Project

This stands for Advisory mentoring in Gynaecology oncology service and was run as a pilot project from April 2013 to April 2014. The reasons it was initiated were that:

Old link nurse group had not achieved its aim of cascade of training or information
Base 2 staff had no oncology learning
There had been no time for formal teaching
Debriefs after difficult scenarios or deaths took place but not recognised or valued
There was a need for succession planning in the Macmillan team

Aims of AMIGOS project are;

- To increase the confidence of staff in gynaecology oncology and palliative care knowledge.
- To improve the debriefing for staff after difficult patient scenarios
- To involve staff more in the planning of care for patients
- For the macmillan team members to feel that they are more closely able to provide individual education for the ward staff

Each AMIGO is regularly given a Flash Card that covers important points around symptom management or principles of oncology and palliative care and these have proved very popular and helpful. Each clinical nurse specialist has two groups of 12 AMIGOS and aims to be a resource for advice and support on an individual level.

A programme of educational sessions is advertised for ALL gynaecology staff which is delivered by either one of the CNS's or the palliative care consultant on a Wednesday morning from 9am to 9.30. these sessions cover all the topics on the flash cards and any other relevant subject within the gynaecology oncology and palliative care area of care.

Advanced Care Planning education

Twice a month during the ward “huddle” when staff meet to discuss patient care, either the palliative care consultant or a CNS will attend to facilitate support and educational opportunities for staff. The introduction of advanced care planning documentation and the process is being rolled out through these sessions with staff to ensure it is embedded in all practice.

Opening the Spiritual Gate

All Level B staff are expected to either do the online or face to face “opening the spiritual gate” course to ensure they are confident in the support of patients and families around spiritual assessment and care.

Shadowing

Level B Health care assistants are going to be offered the opportunity to shadow staff at the local hospice with the aim of expanding their knowledge and experience of end of life care

Level C staff

Educational courses/programmes for level C staff

1. The End of life one day course run by the specialist palliative care educator at the Royal Liverpool hospital has been very successfully evaluated by both trained and health care assistant staff and as this is funded by Liverpool CCG--- A number of trained and health care assistants on gynae base two and the day ward have been on this course or are dated for this year.
2. Basic and Intermediate communication skills course---a number of both trained and health care assistants have been allocated days for whichever is most appropriate for these communication skills courses

A number of gynaecology base two, day ward and outpatient staff (level C staff) are also included in the second AMIGOS project as we aim to expand the knowledge, competencies and support for this group of staff over the next twelve months. This group will also be allocated a place on the end of life study days

Board Agenda item 2018/035

Board of Directors

Minutes of the meeting of the Board of Directors
held in public on Friday 12 January 2018 at 1015 hrs
at Liverpool Women's NHS Foundation Trust, Crown Street Liverpool.

PRESENT

Mr Robert Clarke	Chair
Mrs Kathryn Thomson	Chief Executive
Mrs Vanessa Harris	Director of Finance & Deputy Chief Executive
Mr Ian Haythornthwaite	Non-Executive Director/Vice Chair
Mrs Michelle Turner	Director of Workforce & Marketing
Dr Andrew Loughney	Medical Director
Mrs Julie King	Acting Director of Nursing and Midwifery
Mr Jeff Johnston	Director of Operations
Mrs Jenny Hannon	Director of Strategy and Planning
Dr Susan Milner	Non-Executive Director
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

APOLOGIES

Mr Tony Okotie	Non-Executive Director/SID

2018

Thank You

The Trust Secretary advised that the personal thank you's would be undertaken at a time when the individual members of staff were available. He advised that the Honeysuckle members of staff, Pauline McBurnie and Sarah Martin were engaged with a patient at this time. A big thank you goes to both for their commitment to the Trust, and for their dedication and hard work to ensure that the Honeysuckle Team had continued to provide an excellent service to the Trust's patients and families during what the Board knows to be a very challenging time.

Nadia Aboarook, who was nominated for the thank you for going above and beyond in the support of a patient and her family during a recent baby incident on Maternity Base. Nadia had provided the family with midwifery advice and support through a police investigation and provided support for over 6 hours through the most difficult of times. Nadia had displayed professionalism and a true Trust midwifery attitude going above and beyond in her duties to ensure this family was supported during this traumatic time. She embodies both the Trust and midwifery values and was a credit to both.

With regard to the Team award, the Trust Secretary reported that both Maternity Base and Neonatal Unit were extremely busy and that the thank you would need to be delayed until later in the meeting.

001 **Apologies** – as above.
Declaration of Interests – None
Welcome: The Chair opened the meeting and welcomed those present.

002 **Meeting guidance notes**
The Board received the meeting attendees' guidance notes.

003 **Patient Story**
Gill Walker, Gynaecology Matron and Michelle Morgan, Head of Patient Experience presented a patient Story relating to a Gynaecology patient who had raised concerns through PALs.

Gill Walker advised that the patient had suffered with severe pain in her pelvis and was advised to have a laparoscopy. The patient attended her pre-operative assessment when a pregnancy test was completed which was shown to be negative and the procedure undertaken. The patient suffered with pain following the procedure and was admitted to both outpatients and inpatients where it was found that 2 cysts had grown on her ovaries. These were drained at Aintree Elective Care Centre and an ectopic pregnancy was identified. The patient was informed that she had suffered from an ectopic pregnancy following the procedure.

Gill Walker advised that the patient continued to suffer with pain following discharge and had difficulty looking after her two year old daughter, dealing with ectopic pregnancy, previous diagnosis and potential problems with future conception. The patient advised the Trust that had she been informed, prior to the laparoscopy, that she was pregnant she would not have undergone the procedure; believed that a second pregnancy test should have been completed prior to the surgery; and that the Trust was negligent for not doing this. The patient believed that if this had been done closer to the time of the procedure or on the day of the procedure she would not have suffered with an ectopic pregnancy and therefore wanted to make a formal complaint.

Gill Walker advised that following assessment of the concern and in line with the new complaints policy, the informal PALs+ process was deemed the most appropriate process to resolve the concerns. Gill Walker reported on the PALs+ process and explained that the procedure meant that the concerns should be discussed and agreed with the patient; the Gynaecology division Matron; and Consultant. This meant that a meeting date would need to be agreed to be held within 5 working days of the complaint and a meeting was duly arranged with the patient and her father who attended to support the patient. Gill Walker advised that the meeting took place in the PALs meeting room which was a private non clinical area, protecting patient confidentiality and privacy. The patient was shown the relevant documents on the computer confirming a pregnancy test had been carried out prior to her procedure which was the patient's main concern. To re-inforce assurance a member of the Biochemistry lab was also able to join the meeting via speakerphone to confirm a pregnancy test had been carried out and that the test was negative. The consultant was able to review and explain the procedure the patient had undergone in more detail and the patient was allowed opportunity to ask questions that had been playing on her mind about the pregnancy. Gill Walker advised that the bereavement support and counselling team was offered if the patient wished to use the service.

Gill Walker was please to advise that the patient received the assurance she needed under the new PALs+ process, in particular she felt that the importance of close working between areas and having the appropriate staff available to address concerns with the patient worked to the benefit of patients in allaying any concerns they had.

Responding to a question on the difference between the PALs and PALs+ process, Michelle Morgan, advised that the target was to get the patient/complainant into a meeting with relevant staff within 5 days the complaint had been raised to see if the matter can be dealt with quickly to the satisfaction of the patient. He advised that the PALs process continued in the background and if no satisfactory

outcome was found the PALs process would continue to be followed.

The Chair thanked Gill Walker and Michelle Morgan for the presentation and welcomed the new more expedient process for dealing with complaints.

Thank You

The Board was joined by staff from Maternity Base and Neonatal Unit. The Acting Director of Nursing and Midwifery provided the thank you on behalf of the Board and advised that both teams had been nominated for their recent care during a sudden unexpected death in infancy (SUDI) on maternity base displaying professionalism and caring for both the family involved and the staff. She explained that both teams have displayed true Trust values and was a credit to the Trust which was noted by external bodies including the police. The Acting Director of Nursing and Midwifery advised that this thank you was well-deserved and reflected on a true multi-disciplinary team which brought together all parts of the team from OCS to consultants in Obstetrics and Neonatal to deliver truly women focused care.

004 Minutes of previous meeting held on Friday 1 December 2017

The minutes of the meeting held on 1 December 2017 were approved subject to a couple of amendments provided by Tony Okotie.

005 Matters arising and action log.

The Board noted that all actions had either been completed, were on the agenda for the meeting or were for action at a future meeting.

Referring to action 2017/330, the Chair asked that on an annual basis the Board and Board committees should review the performance indicators. The Director of Operations supported the comment and agreed that this would be undertaken in time for the start of each financial year. The Trust Secretary was asked to add this to the Board work plan.

Action 2018/005: The Trust Secretary to include in the Board and Board Committee work plans in April each year an annual review by the Board and Board committees of the performance indicators relating to their areas of responsibility.

006 Chair's Announcements

The Chair made the following announcements:

Health Education England: The Chair noted the comment raised in the Chief Executive Report regarding the consultation on draft health and care workforce strategy for England and noted that the Board Committee Putting People First would be reviewing the draft strategy and if appropriate provide comment. He felt it was important that the Trust consider fully the impact of the Strategy on the Trust.

Council of Governors Meeting and Governor Elections: The Trust Secretary advised that the Trust was unable to find public governors candidates for the Knowsley (two vacancies) and Rest of England and Wales (one vacancy) constituencies. These vacancies would remain until the next round of election in the Summer. With regard to the elections in the staff constituencies, Gill Walker had been appointed the Nursing constituency whilst a vacancy existed in the Scientist, AHP & Technicians constituency and as with the public vacancies would remain vacant until the next round of elections in the summer.

The Board noted the Chair's verbal update.

007 Chief Executive's report

Neonates: The Chief Executive referred to the news that on 22 December 2017 the Trust was informed by NHSI that the £15m neonatal unit capital financing application has been approved. She advised that this was fantastic news for the Trust and the Neonatal Unit and dealt with the risks for Unit whilst the Trust remained on the current site; it did not however address the longer term risks faced by the Trust as articulated in the clinical case for change, PCBC and Northern England Senate Report. The Board welcomed the funding which was in the form of a capital loan and supported the comments of the Chief Executive.

Director of Finance: The Chief Executive was pleased to report on the appointment of Jenny Hannon to the post of Director of Finance. Jenny Hannon would take up the post following the departure of Vanessa Harris.

Dedication to Excellence: The Chief Executive asked all Board members to keep the date in the diary for the Dedication to Excellence awards which will be held on 20 April 2018. This was a great opportunity to show off the Trust's amazing staff and celebrate the great things that happen every day at the Trust.

Executive Pro Vice Chancellor – University of Liverpool: The Chief Executive advised the Board on her meeting with Louise Kenny who has recently been appointed the Executive Pro Vice Chancellor at the University of Liverpool. She explained that Louise Kenny was an obstetrician who had undertaken her training at the Trust. The Chief Executive welcomed the appointment and felt that this would continue to develop the close relationships the Trust had with the University.

Freedom to Speak Up Guardian: In response to the question raised on the temporary arrangements for the provision of a Freedom to Speak Up Guardian whilst the Trust's Guardian was unavailable, the Director of Workforce and Marketing advised that there had been no contact by staff during the temporary period. She explained that this was not a worrying position as the frequency of use of the guardian was relatively low. Referring to the appointment of a joint Guardian at the Trust, the Director of Workforce and Marketing advised that this had been put on hold temporarily until the Trust Guardian returned to work. She advised that there was a short list of suitable candidates and she was looking to undertake interviews during February 2018.

Consultant Recruitment: The Medical Director reported on the Obstetrics and Gynaecology consultant interviews that was due to take place on 17 January 2018 and advised that there was an excellent pool of candidates. Referring to other areas in the Trust, the Medical Director advised that there were less available pool of consultants for Neonatal and with regard to Anaesthetics there was even less. In both instances the Trust was seeking to grow its own consultant base and went on to advise that this meant that the individuals would still have to undertake an open competition process and where not guaranteed a position at the end of their training.

Emergency Pressures: The Director of Operations reported on the emergency arrangements that had been put in place in order to support the local health system within the Trust footprint. He explained that in order to free up staff, some elective work would need to be cancelled so that staff could be utilised by other trusts, such as Southport and Ormskirk due to the pressures on their services. The Director of Operations advised that this would have an impact on the Trust's 18 week target. The Board supported the actions taken to support the local health system.

The Board noted the Report from the Chief Executive.

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

Phil Huggon, Chair of CFC presented his report on the work of the Committee held on 5 December

2017. He referred to the funding applications the Committee had approved at the meeting and the status of the Funds financial position.

Phil Huggon advised that at the meeting the Committee had also reviewed the Charities Annual Report and Accounts 2016/17 and recommended them to the Board for approval on half of the Corporate Trustee, Liverpool Women's NHS Foundation Trust.

The Board approved the Charities Annual Report and Accounts 2016/17.

The Interim Director of Strategy and Planning thanked the team on producing a more engaging Annual Report which was a credit to them.

009 Board and Exec visit to Community Hubs. Feedback report.

The Director of Operations presented the action plan from the Board and Executive visits to the Community Hubs. He ran through the key themes from the visits and explained what was being done to address them. The Director of Operations assured the Board that all the actions were in hand to be delivered or had already been delivered and a feedback to staff would be undertaken through "you said, we did". The Medical Director felt that it was also important that any issues that could not be addressed were also explained to staff so that they were made fully aware of the reasons. The Acting Nursing and Midwifery advised that she and the Director of Operations were undertaking a "back to the floor" initiative so that concerns from staff could be picked up and dealt with expediently.

The Board noted the Feedback Report. The Chair felt that there was not a requirement to bring any follow up report to the Board unless there were any circumstances that required the Board's input.

010 Safer Nurse/Midwife Staffing Monthly Report

The Acting Director of Nursing and Midwifery advised that the report had been reviewed and amended in light of comments made by the Board at the last meeting. She was happy with the content that provided a more concise position regarding staffing levels at the Trust and demonstrates the effective use of current nursing & midwifery resources for all inpatient clinical areas.

Referring to the Report, the Acting Director of Nursing and Midwifery advised that the overall fill rates versus planned remain high with the reallocation of nursing and midwifery resources where necessary to maintain safe staffing levels across the Trust. The Acting Director of Nursing and Midwifery reported that the nurse sensitive indicators continued to highlight the good practice of reporting medication errors especially in the neonatal unit and explained that all errors were investigated and appropriate action taken; no error resulted in harm to any patient.

The Acting Director of Nursing and Midwifery advised that the introduction of the "care hours per patient day" (CHPPD) metric was still under development and advised that subsequent reports would be amended accordingly.

Referring to the staffing of the inpatient wards the Acting Director of Nursing and Midwifery advised that the Trust had been able to maintain fill rates during November; the average fill rate for registered staff was greater than 97%, the average fill rate for non-registered staff was 88% Trust wide.

Regarding the red flag incidents the Acting Director of Nursing and Midwifery advised that there were four incidents relating to falls within the Trust, three in maternity regarding post epidural status and one in gynaecology following surgery. All were investigated regarding staffing levels and it was concluded that staffing levels and skill mix were safe at the time and did not contribute directly to incidents. The Director of Workforce and Marketing asked whether the number of falls was correct; the Acting Director of Nursing and Midwifery agreed to look at the figures and report back to the

Board the reasons behind the number of falls reported.

Action 2018/010: The Acting Director of Nursing and Midwifery agreed to look at the figures relating to falls and report back to the Board the reasons behind the number of reported in the Safe Staffing report.

The Chair thanked the Acting Director of Nursing and Midwifery for the report and felt that the report painted a very good picture that staffing levels continued to be met in the Trust. He noted that the Board had at a previous meeting asked if staffing levels for outpatients could also be included in the report and asked the Acting Director of Nursing and Midwifery to consider this request.

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

011 Performance Report Period 8 2017/18

The Director of Operations presented the Performance Report for period 8 2017/18 and reported that the Trust was continuing to deliver all national targets to date. Referring to the red rating for 62 day cancer, the Director of Operations advised that this had now been delivered after reallocation had taken place.

Referring to the emerging concern within gynaecology, the Director of Operations reported that a service improvement manager was reviewing both capacity and the systems and processes in gynaecology to ensure that capacity and patient flow was improved. He advised that once improved this he believed would impact positively on the indicator.

The Director of Operations advised that intensive care transfer out continued to be a concern and would continue to be a concern whilst the Trust remained on an isolated site and not linked to an adult acute provider. The Medical Director advised that the Trust continued to look after patients in HDU who should in reality be transferred to a critical care unit at an adult acute provider. He explained that the Critical Care Network felt that the Trust should not be looking after those patients due the inherent risks of doing so as had been previously reported in the clinical case for change and his paper on critically ill women. The Board noted the position and the concerns raised by the Medical Director.

Referring to Theatre throughput, Phil Huggon asked what was being done to address underperformance. The Director of Operations advised on the work done to date which had seen an improved position; however there were still improvements that could be made both in Theatres and Outpatients.

The Board noted the Performance Report for period 8 2017/18 report.

012 Financial Report & Dashboard Period 8 2017/18

The Director of Finance presented the Finance Report and financial dashboard for month 8, 2017/18 and reported that at Month 8 the Trust was £0.054m favourable against the planned £2.870m 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. She explained that the Trust activity continued to be below block contract activity levels as discussed in previous meetings. She recognised that action plans were being developed to increase activity however they would not achieve the levels anticipated in the contract for both Maternity and Gynaecology. Referring to CIP, the Director of Finance advised that the Trust was on target to deliver the full £3.7m for 2017/18 and explained that for 2018/19, CIP would be extremely difficult to deliver.

Susan Milner referring to activity against the block contract was concerned that the Trust would be in the position in 2019/20 of having a reduced income if activity continued to remain at its current

levels. She felt that the Board needed to be clear why activity levels had fallen. The Director of Finance advised that this work was ongoing and that the work on the Operational plan would include this review. Referring to the reduction in activity in Maternity the Director of Finance advised that this had been discussed at length by the Board and had seen fluctuations both locally and nationally in maternity activity.

Jo Moore felt that the Board should recognise the great story that had developed over the year in being able to keep on track in order to deliver the agreed control total.

The Chair thanked the Director of Finance for presenting the Financial Report & Dashboard Period 8 2017/18 which was noted.

013 Fit for Future Generations Update

The Chief Executive provided a verbal update on future generations and referred to the receipt of capital funding from the Department of Health for the extension of the Neonatal Unit. She advised that the funding was in the form of an interest bearing loan and addressed the 'here and now' risks for the neonatal unit on the Crown Street site. It did not address any of the other key risks referred to in the clinical case for change, Pre-consultation business Case and the Norther England Clinical Senate Report.

Referring to the timing of the public consultation, the Chief Executive noted that the Board had hoped to be undertaking the consultation in January 2018; however it was now clear that any public consultation would take place following the local elections in May. She went on to report that due to delays it would be necessary for the Board to review the base line assumptions in the Strategic Outline Case. The Medical Director supported the comments of the Chief Executive and advised that it was important that the Board continue to focus on the clinical need for change which, whilst focused on all risks of remaining on an isolated site, was based on adult risks and advised that although improvements would be made for neonatal babies, the situation for adults would continue to get worse.

The Board noted the position.

014 Board Assurance Framework (BAF)

The Chair opened the discussion on the BAF noting that the Board had received a number of amendments through the Board committees since the BAF last came to the Board. He understood that all changes had been made but noted that some work still needed to be done to make sure the content of the BAF was updated around dates and actions. This, the Chair felt, must rest with the Board Committees to review and report any changes to the Board.

Action 2018/014: the Board Committees to review the BAF risks allocated to them to make sure that the content is updated.

The Board discussed the some of the amendments that needed to be made and noted the BAF.

015 Review of risk impacts of items discussed

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

- Support to local providers due to winter pressures; impacting on Trust delivery of its indicators;
- Neonatal Loan impact.
- Risk of falls
- Transfer out of high risk patients
- SOC review of base line assumptions

016 Any other business & Review of meeting

The Chair reminded the Board of the Council of Governors meeting to be held on 24 January 2018 and the two Governor Group meetings; Quality and Patient Experience Group – 15 January and Finance and Performance Group – 22 January.

Conduct of the meeting was very good and continued to show good challenge, scrutiny and assurance. The Chair felt welcomed the patient story presented by a member of staff which not only provided the patient story but also that of a MDT approach to dealing with the matter in a positive way.

Director of Finance – Vanessa Harris.

The Chair informed the Board that this would be Vanessa Harris's last Board meeting and asked the Chief executive to say a few words on behalf of the Board.

The Chief Executive gave a massive thank you to Vanessa Harris as a great Director of Finance and colleague to work with over last 8 years. She had provided the so much commitment to the Trust over the time period and wished her every success for the future.

Vanessa Harris responded and thanked the Chief Executive and Board both past and current for the great opportunity that was given to her in being appointed t the role and wished the Board and Trust the very best for the future.

Date and time of next meeting

The Chair reported that the next meeting of the Board in public would be 2 February 2018

Agenda Item 2018/036

Liverpool Women's NHS Foundation Trust

TRUST BOARD
2 February 2018 Action Plan

Meeting date	Minute Reference	Action	Responsibility	Target Dates	Status
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	2 February 2018	A demonstration of the toolkit will be provided on 2 February 2018 Board meeting to coincide with the Q3 Mortality Report. Board workshop itinerary 2 February 2018
1 Dec 2017	2017/328	The Acting Director of Nursing and Midwifery to provide an update on the implementation of the National Maternity Review and Community Midwives Re-design at the Board meeting on 1 June 2018	Acting Director of Nursing	1 June 2018	To be reported at the 1 June 2018 meeting. Action ongoing
1 Dec 2017	2017/330	The Director of Operations to consider whether seasonal data should be provided that would indicate previous year's performance against current performance.	Director of Operations	6 April 2018	This will be considered as part of the review of the performance report arising from changes that will be required as part of the single oversight framework requirements moving into 2018/19. To be reported under agenda item 2018/045
12 Jan 2018	2018/005	The Trust Secretary to include in the Board and Board Committee work plans in April each year an annual review by the Board and Board committees of the performance indicators relating to their areas of responsibility.	Trust Secretary	2 February 2018	Complete
12 Jan 2018	2018/010	The Acting Director of Nursing and Midwifery agreed to look at the figures relating to falls and report back to the Board the reasons behind the number of	Acting Director of Nursing and Midwifery	2 February 2018	Complete see agenda item 2018/044

		reported in the Safe Staffing report.			
12 Jan 2018	2018/014	The Board Committees to review the BAF risks allocated to them to make sure that the content is updated	Board Committee's/ Acting Director of Nursing and Midwifery	By 31 March 2018	Each Executive have now reviewed the BAF and provided amendments for consideration of the Board Committees. The Board committees will review the amendments at the next available meeting of the Committee.

Liverpool Women's NHS Foundation Trust

Board of Directors

Committee Chair's report of Quality Committee (formerly GACA) meeting held 15 January 2018

1. Was the quorate met? Yes

2. Agenda items covered

~ Subcommittee Chairs reports: The Committee considered the sub-committee chair's reports. The Committee noted the risk to the organisation with regards to the lack of a Paediatric resuscitation policy being in place and requested an update paper to ensure that a policy is put into place. It was confirmed that this had been added to the Genetics Risk Register and will be managed through the Corporate Risk Committee.

~ Care Quality Commission (CQC) Statement of Purpose: The Statement of Purpose was discussed at the Committee and a number of comments were raised on the content. The Committee agreed that the Statement of Purpose is reviewed in light of the comments and discussed further with relevant executives. The Acting Director of Nursing and Midwifery would make the necessary changes to the statement of purpose and send an amended version to the Chair of the Committee for sign off with the final version sent to other members of the Committee.

~ Mersey Internal Audit Agency (MIAA) Quality Spot Checks Audit Final Report: The Committee noted the findings from the MIAA Quality Spot Check follow up report 2017/18. The Committee felt assured by the process undertaken by MIAA and recognised the significant improvement in clinical areas.

~ Thematic Aggregated review of incidents April – September 2017: The Committee noted the overview position of clinical incidents. No concerns were raised.

~ Serious Incident and Learning Update Report: The Committee was informed that there had been five serious incidents reported during November – December 2017. It was also noted that one SI had been submitted to the Clinical Commissioning Group for review. The concern surrounding the closure of action plans within timeframes was discussed and it was noted that there were consistency issues due to the Quality Committee meeting dates and the Safety Senate meeting date which impacts on some actions not being closed at one meeting but closed at the other.

~ Quality and Regulatory Improvement Requirements: The Committee noted that there were no matters that were required to be reported under this agenda item at this time.

~ MBRRACE UK: Stillbirth report 2016/17 and Response to MBRRACE: The Committee received the annual stillbirth report 2016/17 and a Trust response to the MBRRACE UK national report. It was reported that MBRRACE UK groups and categorises all Trusts together and does not account or mitigate for any differences, for example providers of level 3 neonatal units and neonatal surgery. As such, by not considering specialities it is difficult for the Trust to accurately compare against other providers. Due to the Trust presenting as an outlier within the MBRRACE UK report, the Clinical Director for Neonatology prepared a response document to understand the Trust's data more fully. The Medical Director assured the Committee that after review the Trust is demonstrating good standards of practice and variations are due to case mix.

NHS

- **Research and Development Summary Performance and Activity Update:** The Committee received a performance update in respect of research and development performance and activity during the first half of 2017/18. The Committee noted positive performance against its peers.
- **Draft Research and Innovation Strategy:** The Committee considered a combined draft research and innovation strategy. The strategy will continue to be developed for final submission to the Board of Directors in March 2018 and would be presented to the Committee at its February meeting.
- **Quality Performance Dashboard Report – Month 8:** The Committee received Month 8 2017/18 performance dashboard. The Trust had underachieved on one CQUIN target relating to Sepsis which was likely to impact on the CQUIN payment. The Committee noted the recommendations to the Senates to ensure action was taken to meet KPI targets.

3. **Board Assurance Framework (BAF) risks reviewed**
   The Committee reviewed the BAF risks it was responsible for. The BAF is currently under review and will be presented at the next Quality Committee.

4. **Escalation report to the Board on Quality Committee Performance Measures**
   Please see SI Reporting and Quality Committee Performance Dashboard Reports.

5. **Issues to highlight to Board**
   - The Committee escalated the organisational risk of not having a Paediatric resuscitation policy in place. It was confirmed that this risk has been escalated on to the corporate risk register. The Committee has requested a progress update from the Safety Senate to ensure action is taken swiftly.

6. **Action required by Board**
   None

Susan Milner
Chair of Quality Committee

Liverpool Women's NHS Foundation Trust

Board of Directors

Committee Chair's report of Finance, Performance and Business Development Committee meeting held 22 January 2018

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

2. **Agenda items covered**
   - **Month 9 2017/18 Operational Performance:** The Committee received Month 9 performance dashboard and noted the emerging concern within gynaecology in terms of ensuring that sufficient clinical capacity is available to book patients and that the CQUIN sepsis position remains a concern, however plans are in place to recover this position and it was noted that there are no further financial consequences attached as these have been provided for. The Committee was asked to note the depleted operational management team due to sickness. The Committee considered the recent transformational changes undertaken but was assured that there was no link between the current sickness and the CIP programme. The Committee also noted that the Trust had responded to NHSI and NHS England request to ask gynaecology nurses to self-nominate themselves to work at Southport and Ormskirk Hospital Trust for a period of time.
   - **Month 9 2017/18 Finance Performance Review:** The Committee received Month 9 2017/18 finance position. Following a detailed review at Month 9, it is forecast that the Trust will outperform the full year control total for 2017/18 by £0.3m. This will be matched by an equivalent amount of STF incentive funding leading to an overall forecast deficit of £3.4m. It was also noted that the cash requirement for the financial year was forecast at £2m, against the original plan of £4m as a result of brought forward cash balances. Given the forecast improvement the Committee agreed to recommend that the BAF risk in relation to failure to deliver the annual financial plan should be reduced.
   - **Month 9 Treasury Management Report:** The Committee received the report following a best practice recommendation from Internal Audit. The Committee noted the detailed cash flow, an update on capital loans, age of debt review and BPPC performance.
   - **Cost Improvement Programme Update 2017/18 and 2018/19:** The Committee received the mid-year post implementation review of the CIP programme for 2017/18 and noted that the CIP total would be achieved. The Clinical Transformation Lead presented her findings from the formal mid year review of 2017/18 CIP Scheme QIA and EIA's. Overall all of the clinical schemes are achieving or working towards achieving their objectives, and action plans are in place to address issues raised as part of the review. A final review will be undertaken in May 2018. The Committee noted that a formal review of QIA and EIAs for the 2018/19 CIP schemes will be undertaken and presented to the Committee in February 2018. The Committee considered the achievability of the gynaecology CIP for 2018/19 and was advised that these schemes would be facilitated by the Director of Operations and the Director of Transformation to support the operational management team.
   - **Cheshire and Mersey System Update:** The Committee received a verbal update with regards to regional progress to deliver financial savings. It was noted that the Cheshire and Merseyside Health and Social Care Partnership have a particular focus on place based care and acute sustainability.
   - **Financial and Operational Planning 2018/19:** The Committee noted that NHSI has indicated that the Trust will be required to submit a refresh of the 2018/19 financial and operational plan in quarter 4 of 2017/18. Currently the Trust is waiting to receive the planning guidance which is due to be issued in January 2018. The Committee noted the draft financial plan as at January 2018 and considered the risks against the achievability of the control total.

NHS

- ~ **Neonatal Project Plan Overview:** The Committee noted that the Department of Health had approved the Trust bid for a £15m loan for the extension and light refurbishment of the Neonatal Unit in December 2017. The Committee was asked to consider two options as a procurement approach to appoint a building contractor. It was noted that the Executive Committee supported the approach to adopt the Procure 22 Framework however would recommend to retain an internal costing team and estates team to oversee the works. The Committee requested that an updated report including planned governance structures should be submitted to the Board of Directors in February 2018.
- ~ **Liverpool Women's Health Consultancy Business Development Update:** The Committee received an update of consultancy activities and collaborative discussions.
- ~ **Review of Marketing Strategy:** The Committee received assurance on the delivery of the Communications, Marketing and Engagement Strategy 2016-2020 and the costs/benefits entailed. The Committee noted progress made to achieve the 2017/18 action plan.
- ~ **IMT Review: Electronic Patient Record (EPR) Update:** The Committee was informed that the Trust was continuing to deliver a 'go live' timescale of October 2018. It was noted that unfortunately the appointed Programme Director has declined the position for personal reasons. A further recruitment process would be undertaken. It was reported that the Trust would also be appointing its own Project Manager on site to co-ordinate the implementation of EPR directly.
- ~ **General Data Protection Regulations (GDPR) Briefing:** The Committee was informed that Mersey Internal Audit Agency has conducted an assessment of how ready the Trust was for implementation of GDPR. An action plan has been devised from the recommendations and is daily managed by the IM&T team. It was noted that an Executive Director requires to be assigned as the Data Protection Officer.
- ~ **FPBD Sub-Committee terms of reference review:** The Committee requested that all terms of reference should be following the standard template. The Committee formally approved the Emergency planning resilience and response committee terms of reference. It was noted that the Turnaround and transformation committee terms of reference required some changes.
- ~ **Sub Committee Chairs reports received**
  - o Turnaround and Transformation Committee held 12 January 2018
  - o Emergency Planning Resilience and Response Committee held 8 January 2018
  - o Digital Hospital Sub-Committee held 24 November 2017

3. Board Assurance Framework (BAF) risks reviewed

~ Board Assurance Framework (BAF): The Committee reviewed the financial related BAF risks it is responsible for on behalf of the Board.

Given the forecast improvement in the outturn position discussed in Month 9 Finance Performance Review, it is proposed that the current risk level in relation to 1663 (failure to deliver the annual financial plan) is reduced with the likelihood score of 4 (likely) being reduced to 3 (possible) giving an overall score of 15.

It is not proposed to make any changes to the risk around the future of the Trust.

4. Escalation report to the Board on FPBD Performance Measures

~ None

5. Issues to highlight to Board

~ Neonatal Project Plan Overview: Due to the potential risks in relation to procuring a building contractor and the subsequent implementation of the scheme, the Committee requests that

the Board allocates time to receive and consider the neonatal project plan and governance structures at its February meeting.

6. Action required by Board

~ None

Jo Moore
Chair of FPBD

Liverpool Women's NHS Foundation Trust

Board of Directors

Committee Chair's report of Audit Committee meeting held 22 January 2018

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

2. **Agenda items covered**
   - ~ **Follow up of Internal Audit and External Audit Recommendations**: The Committee received an updated position on outstanding recommendations but not yet due from 2017/18 and 2016/17. The Committee noted that a communication has been issued to all staff involved in the Internal Audit process stressing the importance of recommendations only being closed on the 4Action system when they have been implemented and there is evidence to support the closure. The Committee also noted that two of the recommendations from the IT Resilience and Recovery audit are high risk, and were assured that these high risk recommendations will be monitored at the Executive Committee to ensure that they are implemented by the agreed deadline dates.
   - ~ **Internal Audit Agency Progress Reports**: The Committee received an update of finalised audit reports and recommendations. The Committee noted the critical and high risk recommendations which are in relation to Duty of Candour patient file content and letters to patients, and IT Resilience and Recovery Backup solutions limited and Back Up Servers Security Limitations. It was also noted that a follow up quality spot check audit had been undertaken since the last report and significant improvement was evidenced within each objective.
   - ~ **Counter Fraud Progress Report**: The Committee received the update report. It noted the establishment of the National Health Service Counter Fraud Authority as of November 2017, which replaces NHS Protect. The counter fraud team will monitor how the change will impact on local delivery of anti-fraud work at the Trust and notify the Trust accordingly.
   - ~ **External Audit Plan for 2017/18**: The Committee welcomed the newly appointed external auditors, KPMG. KPMG advised that upon review and assessment, they have set a materiality level of £1.5m, propose to report all unadjusted differences greater than £75k to the Committee, and identified two significant opinion risks: valuation of land and buildings; and existence of NHS income and receivables.
   - ~ **External Audit Technical Update**: The Committee noted the update for information.
   - ~ **Register of Waivers of standing orders**: The Committee received the register of waivers covering the period quarter 3 2017/18. The Committee noted that strong controls remain in place to manage the waiver process. It was also noted that the Trust in collaboration with Aintree Trust, has recently become members of HealthTrust Europe GPO. This should support a further reduction on the reliance on waivers as it creates additional opportunities to access appropriate contract and frameworks.
   - ~ **Clinical Audit Annual Report**: The Committee noted the Clinical Audit Annual report 2016/17. It was noted that it had been a successful year and recommended that the findings should be publicised to demonstrate improvements to patient care.
   - ~ **Review of Declarations of Interest, Sponsorship and Gifts**: The Committee received the registers of board, governors and staff interests, sponsorships and gifts. These are also publically available on the Trust website. It was noted that the Trust is pursuing a web-based system to declare interests.
   - ~ **Review of effectiveness of internal audit**: The Committee considered the effectiveness of the internal audit providers since joining the Trust. It was agreed that performance is satisfactory.

3. **Board Assurance Framework (BAF) risks reviewed**
   - ~ Board Assurance Framework (BAF): The Committee was advised that a review of BAF risk content is underway. The Chair clarified the importance of Board Committee responsibility to comprehensively review the BAF risks aligned to them.

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

5. Issues to highlight to Board
   ~ None

6. Action required by Board
   ~ None

Ian Knight
Chair of Audit Committee

Liverpool Women's NHS Foundation Trust

Board of Directors

Committee Chair's report of Putting People First Committee meeting held 26 January 2018

1. Was the quorate met? Yes

2. Agenda items covered

~ **Staff Experience Story – Bedford Ward:** The Committee welcomed a newly appointed Deputy Ward Manager from the Bedford Ward, who has over 15 years experience working as a registered nurse on the Bedford Ward. She described her experiences of working in the department since qualifying as a nurse and of the future direction of the ward. It was acknowledged by the Committee that there were some morale issues at this present time due to staff vacancies and the recent retirement of the long standing ward manager.

~ **Service Workforce Assurance and Risk Report – Gynaecology:** The Committee noted that there is a high level of sickness within the senior management team which potentially is impacting on KPI standards not being achieved. Alternative senior management resource has been aligned to Gynaecology for the interim and planned return to work dates has been agreed for the absent staff. The Committee received a presentation detailing key workforce challenges and identified areas of change. It was acknowledged that the issues identified within the report have also been considered recently at FPBD and QC. The Committee considered that due to the significant workforce change via the major transformational schemes for 2018/19, the identified gaps in the leadership team and doctor workforce, and the information that each Committee has now received, that the matter should be escalated to the Board of Directors.

~ **Director of Workforce Report:** The Committee noted updates on issues including the proposal to combine the Health and Wellbeing Strategy into the Putting People First Strategy, a potential new communications and engagement tool 'Go engage' which would replace the 'PULSE' survey, and a 50% sign up of Band 7's onto the Leadership Development Programme. The Committee was concerned about the attendance of Band 7's on to the development programme, particularly when issues of poor leadership are being discussed. The Committee requested more detailed information with regards to sign up and attendance of those that the Leadership Programme is mandated training.

~ **Workforce Key Performance Indicator (KPI) Report (Month 9):** The Committee received M9 KPI report. The Committee noted that there have been no professional registration lapses since the last report received. The Committee also noted that the outsourced recruitment service became effective as of 1 January 2018 and appropriate SLAs and KPIs have been set to manage the service. There was a discussion with regards to the mandatory training compliance level and target. It was suggested that an internal audit be undertaken in this regard.

~ **Overview of Health Education England's Draft Health and Care Workforce Strategy for England to 2027:** The Committee received an overview of the draft Health and Workforce Strategy produced by Health Education England. Committee members were asked to feedback any comments to the Director of Workforce. It was noted that the Strategy is being shared at clinical forums to receive feedback to enable a collective response from the Trust to the national consultation process.

~ **Talent Management and Succession Planning Update:** The Committee received a progress update of the talent management and succession planning at the Trust.

~ **Apprenticeship Programme Review:** The Committee received an update on apprenticeship activity in the Trust. It was noted that key challenges continue to be a lack of appropriate national training standards and the business impact of apprentices. The Committee was assured that the Trust is making steady progress towards meeting targets and noted the proactive steps being taken to meet its public sector duty and utilise the Apprenticeship Levy.

~ **Workforce Risk and Mitigation:** The Committee noted the current position and suggested action to mitigate the ongoing gaps in the junior doctor workforce. It was noted that the Trust is in preliminary stages of a Trust grade doctors partnership with Wigan, Wrightington and Leigh NHS Trust and Edge Hill University. It was reported that this is a well established process in other clinical specialities and

NHS

could provide a medium term solution. It was also noted that a facilitated engagement event is being held on 14 February 2018 for the medical workforce to meet and discuss the future strategic direction of the medical workforce. The Medical Director has taken executive sponsorship for this piece of work.

- **Equality Delivery System 2 (EDS2) Equality Objective Plans:** The Committee received an update on progress to date with achieving the EDS2 outcomes. It was confirmed that the Trust had identified a staff member to undertake the role as E&D advisor for workforce E&D within the HR team. It was noted that two clinical leads within the nursing workforce have also been identified to take forward the patient action plan. The Trust will be assessed on their EDS2 outcomes by a group including HealthWatch, Staff and Staff Side representatives by September 2018. The Committee was assured that the Experience Senate would be monitoring the EDS2 action plan to ensure progress.
- **Workforce Race Equality Scheme (WRES) findings from National Report:** The Committee received an overview of the Trust's WRES performance benchmarked against all other Trusts in the UK. In comparison to other local Trusts, it was noted that LWH is performing favourably. It was noted that the WRES action plan is monitored by the Diversity and Inclusion Committee.
- **Guardian of Safe Working Hours Quarter 3 2017/18:** The Committee considered the report and noted the increasing volume of locum shifts to cover junior doctor rota gaps. It was acknowledged that the rota gaps and use of locum shifts is creating pressures both administratively and clinically. It was also noted that the lack of junior doctors to cover the acute care required, will begin to affect the ability of the Trust to deliver elective care in the same volume as it currently does. The Committee received assurance that the Executive Committee weekly review and sign off all locum shifts requested.
- **Policies for approval:** The Committee reviewed and ratified the Temporary Working Policy.
- **PPF Sub-Committee terms of reference review**: The Committee reviewed its sub-committee terms of reference. The Committee formally approved the Partnership Forum, Education Governance Committee and the Joint Local Negotiating Committee subject to changes to job titles and templates.
- **Sub Committee Chair reports**
    - Space Utilisation Task and Finish Group held 18 December 2017: This meeting was held in response to feedback received from an IM&T staff story and assurance report received in September 2017. A response document will be submitted to the Trust Management Group for action.
    - Education Governance Committee held 30 November 2017
    - Partnership Forum held 12 December 2017
    - Health and Wellbeing Group held 15 January 2018
    - Nursing and Midwifery Board no meeting held

3. Board Assurance Framework (BAF) risks reviewed

Board Assurance Framework (BAF): The Committee noted that the Director of Workforce and Deputy Director of Workforce had met with the newly appointed Head of Governance to review the PPF related BAF risks prior to circulation of the committee papers. It was noted that the Head of Governance had advised that the contents of the Sources of assurance section can be removed as historic data.

The Committee reviewed the BAF risks it is responsible for on behalf of the Board and agreed that there would be no amendments.

4. Escalation report to the Board on PPF Performance Measures

See section 2, within Workforce Key Performance Indicator Report Month 9.

5. Issues to highlight to Board of Directors

~ Workforce and Assurance Report for Gynaecology: The Committee wishes to highlight increasing concern with regards to workforce, performance and activity within Gynaecology, which has similarly been noted at each Board Committee. As such, the Committee requests that an assurance report detailing how 2018-19 plans will be implemented is provided to the Board of Directors.

~ Leadership Development Programme: The Committee is concerned about the leadership skills demonstrated by the workforce and supported the approach to introduce the Leadership Development Programme as a mandatory requirement for Band 7 and upwards. The Committee notes that there are difficulties to release clinical staff for training however requests that management is supportive to ensure that this training is undertaken.

~ EDS2: The Board of Directors is asked to note their role in evidencing outcomes 4.1 and 4.2 as part of the EDS2 assessment, which are directly related to members of the Board.
4.1 – Boards and senior leaders demonstrate their commitment to promoting equality within and beyond the organisation. 4.2 – Papers that come before the Board and other major Committees identify equality related impacts including risks, and say how these risks are to be managed.

~ Key Workforce Risks and Mitigation: The Committee requests the Board to note the ongoing workforce risks detailed in report in the challenge to support training programmes whilst meeting CIP targets.

~ Occupational Health Intranet site: The Chair noted the launch of the Occupational Health and Wellbeing intranet page.

6. Action required by Board of Directors

None

AUTHOR NAME: Tony Okotie
DATE: JANUARY 2018

Agenda Item	2018/043

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Adult Mortality Report 17/18 Q3**
DATE OF MEETING:	Friday, 02 February 2018
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Andrew Loughney, Medical Director
AUTHOR(S):	Devender Roberts – Associate Medical Director Amanda Cringle – Quality Improvement Lead
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** 1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☐ 2. To be ambitious and *efficient* and make the best use of available resource ☐ 3. To deliver *safe* services ☒ 4. To participate in high quality research and to deliver the most *effective* Outcomes ☒ 5. To deliver the best possible *experience* for patients and staff ☐
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust* ☐ ***2.*** *The Trust is not financially sustainable beyond the current financial year* ☐ ***3.*** *Failure to deliver the annual financial plan* ☐ ***4.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision* ☐ ***5.*** *Ineffective understanding and learning following significant events* ☒ ***6.*** *Inability to achieve and maintain regulatory compliance, performance and assurance* ☒ ***7.*** *Inability to deliver the best clinical outcomes for patients* ☒ ***8.*** *Poorly delivered positive experience for those engaging with our services* ☐
CQC DOMAIN	***Which Domain?*** ***SAFE-*** *People are protected from abuse and harm* ☐ ***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☐ ***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐ ***RESPONSIVE –*** *the services meet people's needs.* ☐ ***WELL-LED -*** *the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ☒ ***ALL DOMAINS*** ☐

LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution **2.** Operational Plan **3.** NHS Compliance	☐ ☒ ☐	**4.** NHS Constitution **5.** Equality and Diversity ***6.*** Other: **Quality Strategy & Quality Schedule**	☐ ☐
FREEDOM OF INFORMATION (FOIA):	1. This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting			
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	The Board is asked to: a. Take assurance that there is adequate progress against the requirements laid out by the National Quality Board b. Confirm that the Board are confident there are effective governance arrangements in place to drive quality and learning from the deaths of patients in receipt of care at this trust			
PREVIOUSLY CONSIDERED BY:	**Committee name**		*Choose an item.* Or type here if not on list: Effectiveness Senate	
	Date of meeting		Friday, 16 February 2018	

Executive Summary

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

This report details how the trust is meeting the requirements laid down externally and provides details of mortality within the Trust during Quarter 3 of 2017-18. It concludes that there is currently evidence available that adequate progress is being made and that mortality rates are within expected ranges. The report outlines the work taking place operationally and being overseen by Effectiveness Senate and Quality Committee.

Report

Introduction

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

Issues for Consideration

- Each in-hospital death has a mortality review. All adult gynaecology deaths are discussed at the gynaecology Morbidity & Mortality meeting. As part of this process an adult mortality sheet is completed indicating any potential for improvement in care. Unexpected adult gynaecology deaths trigger a serious incident investigation.
- All direct maternal deaths trigger serious incident investigation.
- A new mortality review tool has been developed for risk and incident reporting system Ulysses. This avoids losing any paper documents (current system) and allows for searching, monitoring and auditing of an electronic system.

Adult Mortality Quarter 3		
	Maternity	**Gyneacology**
No of Adult Deaths	0	0
No of Mortality Reviews completed	0	0
No of deaths requiring RCA's	0	0
No of deaths due to deficiencies in care	0	0
Mortality Themes	N/A	N/A
Progress v Smart Plans	N/A	N/A
Mortality Outcomes	N/A	N/A
Measures for ongoing scrutiny	N/A	N/A

Actions Taken

Out of hospital deaths 2017-18 Quarters 1- 3

There were two maternal deaths reported externally via MBRRACE-UK national reporting system. Both were due to indirect causes: brain haemorrhage and leukaemia.

Work is now ongoing with other Trusts in developing an alert process of expected or unexpected deaths of patients who had previously been under the care of LWH. Aintree Hospital has already agreed an alert system.

The AMD and Governance team have put in a place a process for triangulating out of hospital deaths with the MBRRACE-UK midwives and the surrounding Trusts to get better ascertainment.

Table below depicts the number of adult deaths in-hospital, including expected and unexpected deaths.

Reporting Quarter	**2015-2016**		**2016-2017**		**2017-2018**	
	In-hospital	**Out-hospital**	**In-hospital**	**Out-hospital**	**In-hospital**	**Out-hospital**
Q1	1	-	3	-	1	2
Q2	4	-	2	-	0	-
Q3	4	-	3	2	0	-
Q4	5	-	1	-	-	-
Total	**14**	**-**	**9**		**1**	
		-		2		2
Overall total deaths	**14**		**11**		**3**	

Conclusion/Recommendation

There have been no gynaecological, obstetric or LeDer (Learning disability) deaths within quarter 3 reporting period. Work against the Adult Mortality Strategy is progressing steadily.

It is recommended that the Board:

a. Take assurance that there is adequate progress against the requirements laid out by the National Quality Board

b. Confirm that the Board are confident that there are effective processes in place to assure the board regarding governance arrangements in place to drive quality and learning from the deaths of patients in receipt of care at the Trust

Adult Mortality Quarterly Report

17/18 Quarter 3 – (Oct, Nov & Dec)

- Adult Mortality Q3 report prepared by A. Cringle
- Clinical Author: D. Roberts

Executive Summary

This report updates the Board regarding the Trust systems and processes to review and learn from deaths of patients under their care. This is in accordance with recommendations by the National Quality Board and the Care Quality Commission. It outlines the work taking place operationally and being overseen by Effectiveness Senate and GACA.

Key findings:

- There were no in-hospital deaths during Quarter 3 of 2017-18.
- Adequate progress is being made in systems to reduce mortality
- The Trust rates are within the expected low levels for a specialty hospital.
- The Trust is getting better ascertainment of out of hospital deaths by triangulating with other acute Trusts and MBRRACE-UK midwives

No actions have been identified from this report but due to the small number of deaths, the Governance team will perform a 'deep dive' into 2016/17 & 2017/18 deaths to gain more information on unexpected deaths.

1. Introduction

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

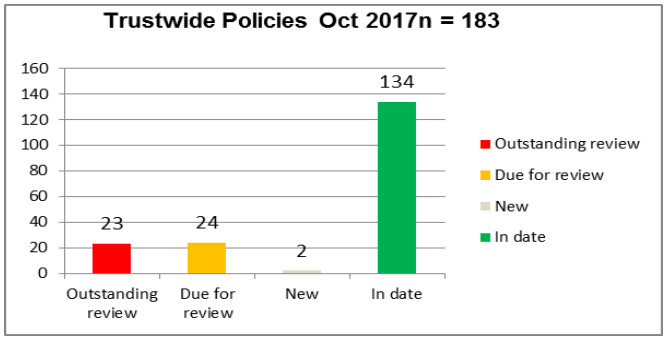
This overview outlines the most recent Trust figures and headline findings in regards to mortality. It provides details to the Board of their own accountabilities while setting out the responsibilities of the Quality Committee and Effectiveness Senate to monitor progress regularly and escalate as required;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

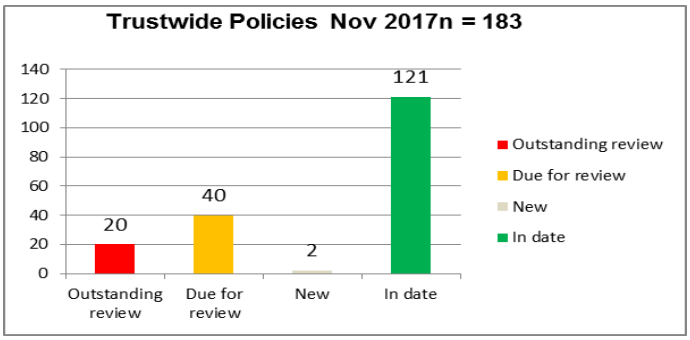
Liverpool Women's NHS Foundation Trust recognises that although most of the adult death it encounters is the expected end point of a known disease process, the principles described above are equally valid to its own services. In the Trust's Risk Management Strategy, commitment is given to minimise risk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

2. Prevention

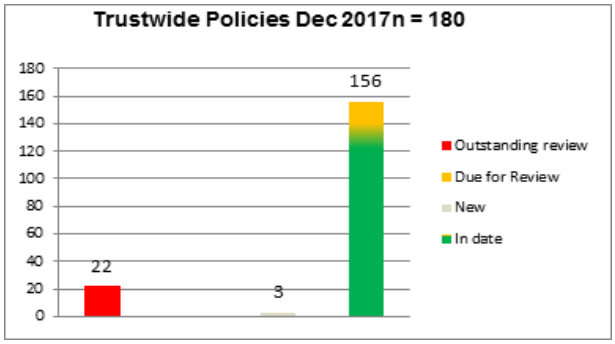
The below charts are extracted from a 'real time' database, therefore on any given day the numbers could fluctuate slightly either positively or negatively. Outstanding review means that the document is over the due date for document expiry; due for review means 3 months before document expiry date. In date refers to all documents are all current and up to date.

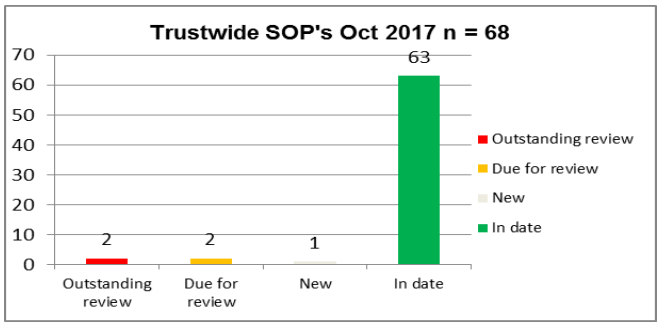
a) Trust wide policies and SOPs (Q3)

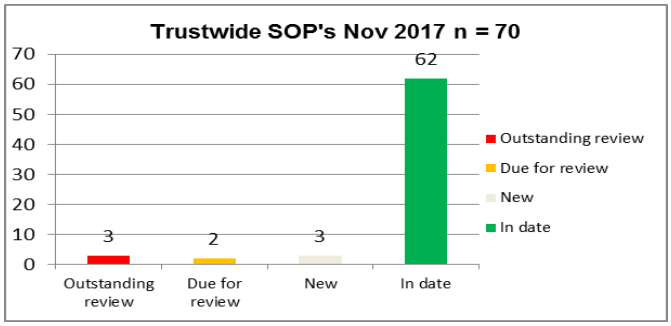


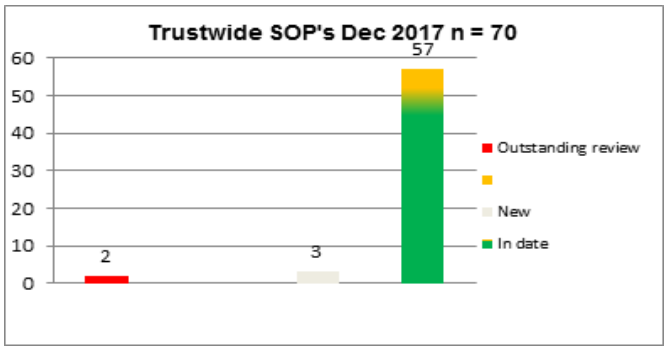


Documents in the amber bar chart are those within 3 months of requiring review



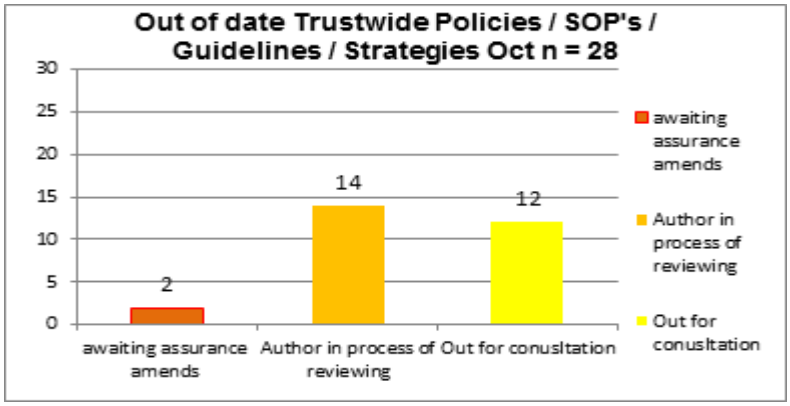


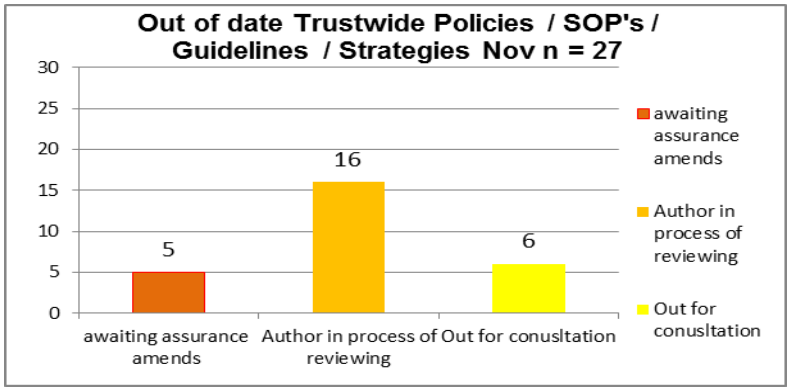


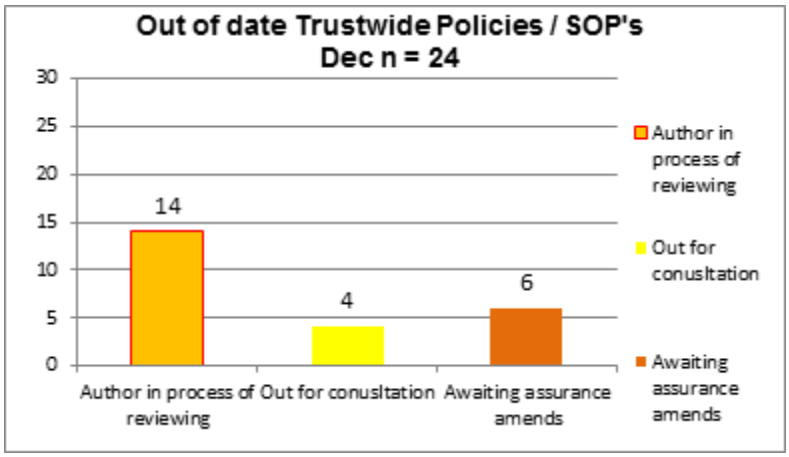


Those documents outstanding for review are going through the ratification processes via each appropriate scrutiny committees at both divisional level and then corporate ratification.

b) In the below three charts for October, November and December 2017,there are currently 26 Trust wide Policies, SOP's, Guidelines and Strategies out of date. Out of the 26 documents 22 are policies; of which 4 are awaiting assurance amendments before final upload and 3 are awaiting ratification. The residual 15 documents are in process of being reviewed. The remaining 4 out of date documents consist of 2 Guidelines and 2 SOP's.



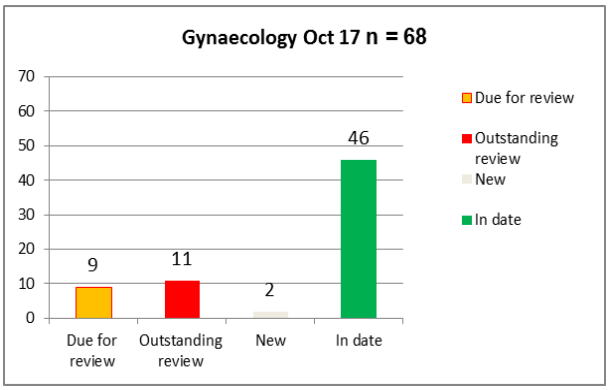


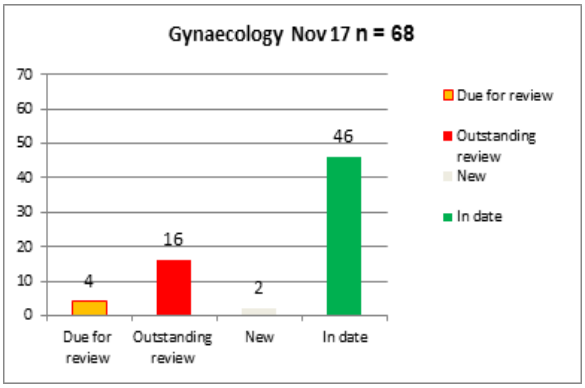


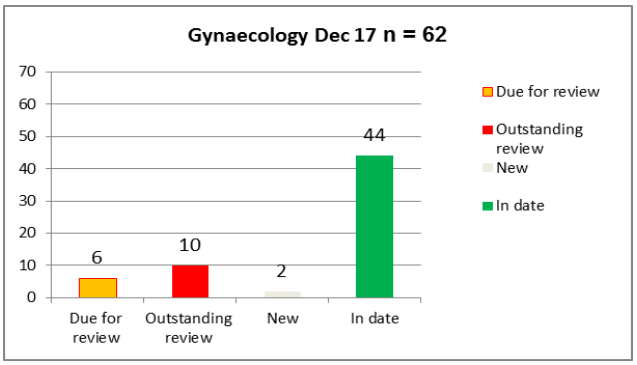
The data processing for reporting has now changed from December, the bars on the charts are now in the process order as a policy or SOP works the way through the document monitoring system.

Gynaecology Policies and Guidelines

c) Policies / guidelines are currently being monitored via Gynaecology Clinical meeting; there are 10 documents outstanding review, of which 12 are awaiting ratification from the October meeting.

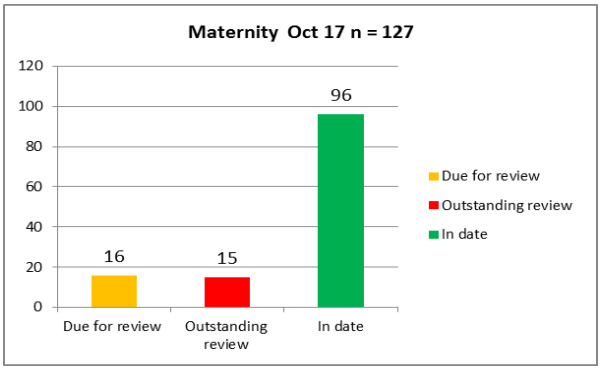


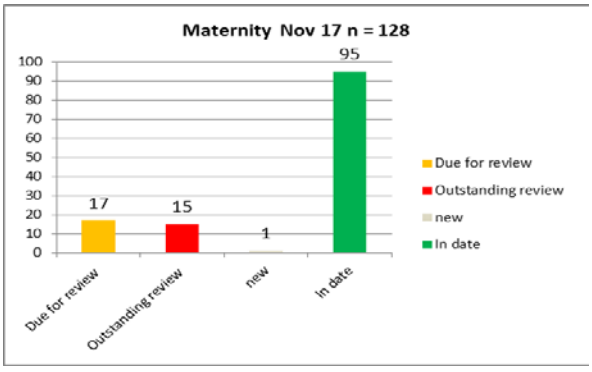


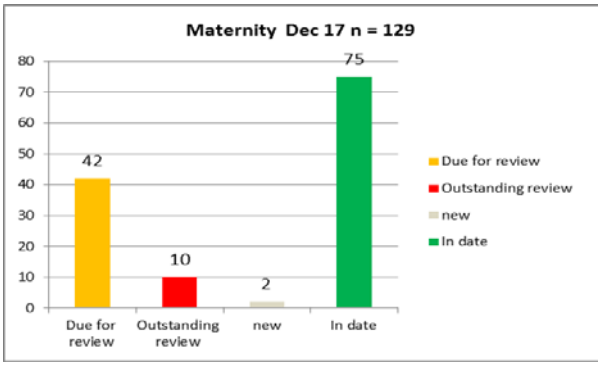


Maternity Policies and Guidelines

Policies / guidelines are currently being monitored via Maternity Clinical meeting; there are 10 documents outstanding review, of which 3 are awaiting ratification. The remaining 7 are currently being reviewed and updated by the author.







The Effectiveness Committee has agreed that by the end of Quarter 4 there should be no outstanding Guidelines or SOPS. The Effectiveness leads have been tasked with improving performance on all guidelines and SOPs within their Divisions.

3. Audit

From April 2017 the Trust has committed to the principle that it must include work of relevance to the highest risk areas for adult mortality in the Clinical Audit Forward plans - including:

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

The Annual Audit Programme for 2017 – 18 had been informed by intelligence from a number of different audits in Quarter 2; See below progress table for clinical audits.

Adult Mortality – Clinical Audit progress October 2017

Topic	Clinical Audit Title/s	Progress
Haemorrhage	Use of O Negative blood	Data collection in progress. Provision of report including action plan deadline extended from Dec-17 to Feb-18. (Amber on audit database)
	Bedside transfusion (including consent)	Data collection in progress. Provision of report including action plan deadline extended from Dec-17 to Jan-18. (Amber on audit database)

	SHOT NCA of TACO prevention	Received report and evidence of action implementation. (Green 1 on audit database)
Psychiatric disease	Antenatal Perinatal mental health management and outcome at Liverpool Women's Hospital	Audit in the process of being registered. Report including action plan expected Aug-18. (Red 1 on audit database)
Sepsis	Audit of the management of pregnant women with asymptomatic bacteuria at booking visit *(Previously titled: "Maternal and Congenital sepsis")*	Audit has been registered and data collection ongoing. Report including action plan expected Mar-18. (Amber on audit database)
	SEPSIS bundle – Maternity	Data being captured via NUMIS The HDU delivery group and Sepsis lead will collate themes for presentation in Quarter 4 report. (No audit required)
	Audit of the management of patients with sepsis/compliance to the 1 hour Sepsis Bundle – Gynaecology	Data being captured via NUMIS. AMD has met with Sepsis lead. Sepsis guideline will be updated in line with current recommendations. The HDU delivery group and Sepsis lead will collate themes for presentation in Quarter 4 report. (Red 1 on audit database)
	Postoperative surgical site infections following caesarean sections	Received report including action plan. Overall, we were compliant with guidelines, with all patients receiving prophylactic

		antibiotics. Therefore, a re-audit is not required. The Maternity Division is exploring vaginal douching prior to CS as an infection risk reduction strategy Audit completed
Venous thromboembolism	Assess LWH Gynaecology admissions against NICE QS 03 – VTE in Adults; reducing the risk	Received report including action plan. Re-audit in progress.
Neurological Disease	An audit of outcomes in women who attend the Joint Obstetrics/Neurology clinic	This will be on 2018-2019 audit plan

4. Mortality Dashboard

Due to the small number of in-hospital deaths, it has been agreed with the Head of Governance, that the following table showing the total mortality and the rate of death per 1000 discharges will be used as the mortality dashboard.

501 - OBS	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	TOTAL
Total Mortality	0	0	0	0	0	0	0	0	0	0
Discharges	1665	1873	1751	1790	1792	1712	1726	1791	1666	15766
Rate per 1000 Discharges	0	0	0	0	0	0	0	0	0	0

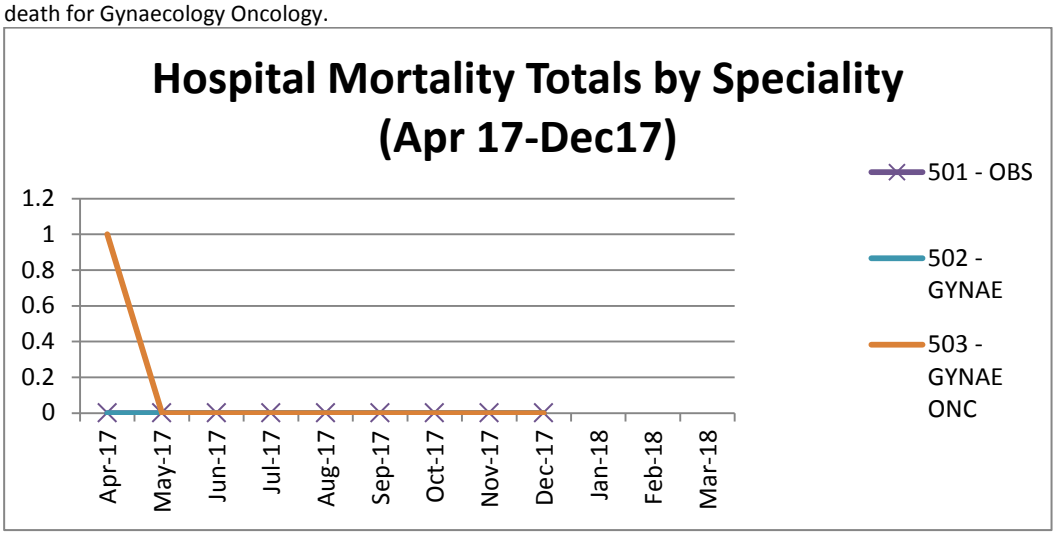
502 - GYNAE	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	TOTAL
Total Mortality	0	0	0	0	0	0	0	0	0	0
Discharges	925	934	1054	1018	1035	1050	1014	1026	821	8877
Rate per 1000 Discharges	0	0	0	0	0	0	0	0	0	0

503 - GYNAE ONC	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	TOTAL
Total Mortality	1	0	0	0	0	0	0	0	0	1
Discharges	93	90	81	92	71	69	101	86	74	757
Rate per 1000 Discharges	10.8	0	0	0	0	0	0	0	0	1.3

The single death in April for Gynaecology Oncology represents an overall rate of 1.3 per 1000 Oncology discharges for Q1-3 of 2017/18.

Adult Gynaecological Deaths

Figure 1 below: Cumulative Adult Gynaecology Deaths: Apr 2016-Dec 2017
There have been no deaths recorded in hospital for Obstetrics or Gynaecology, there has only been 1 expected death for Gynaecology Oncology.



Out of hospital deaths 2017-18 Quarters 1- 3

There were two maternal deaths reported externally via MBRRACE-UK national reporting system. Both were due to indirect causes: brain haemorrhage and leukaemia.

Work is now ongoing with other Trusts in developing an alert process of expected or unexpected deaths of patients who had previously been under the care of LWH. Aintree Hospital has already agreed an alert system.

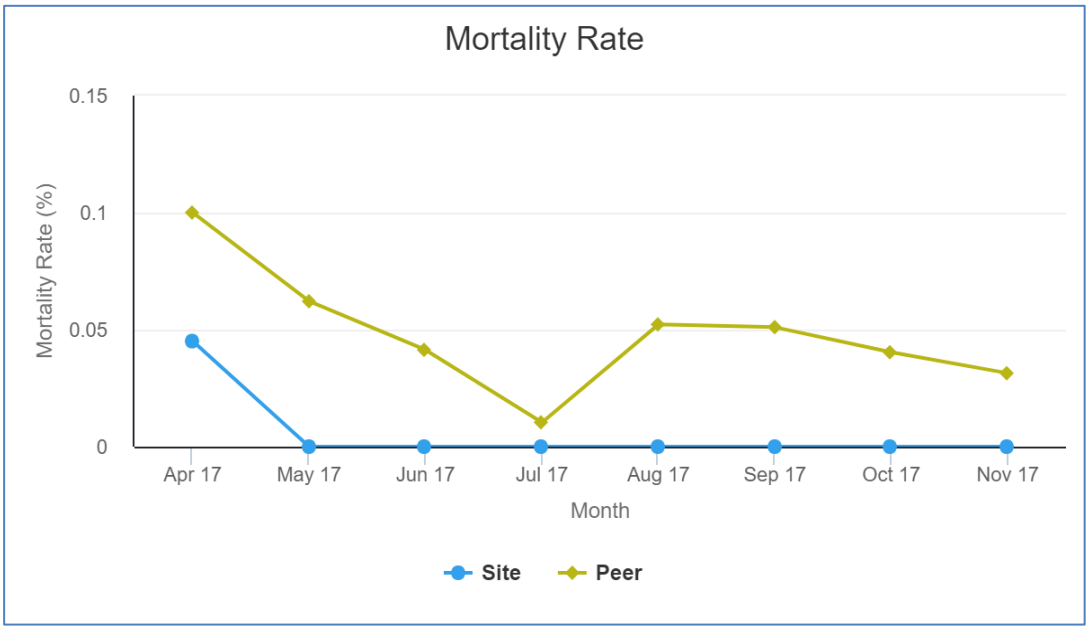
The AMD and Governance team have put in a place a process for triangulating out of hospital deaths with the MBRRACE-UK midwives and the surrounding Trusts to get better ascertainment.

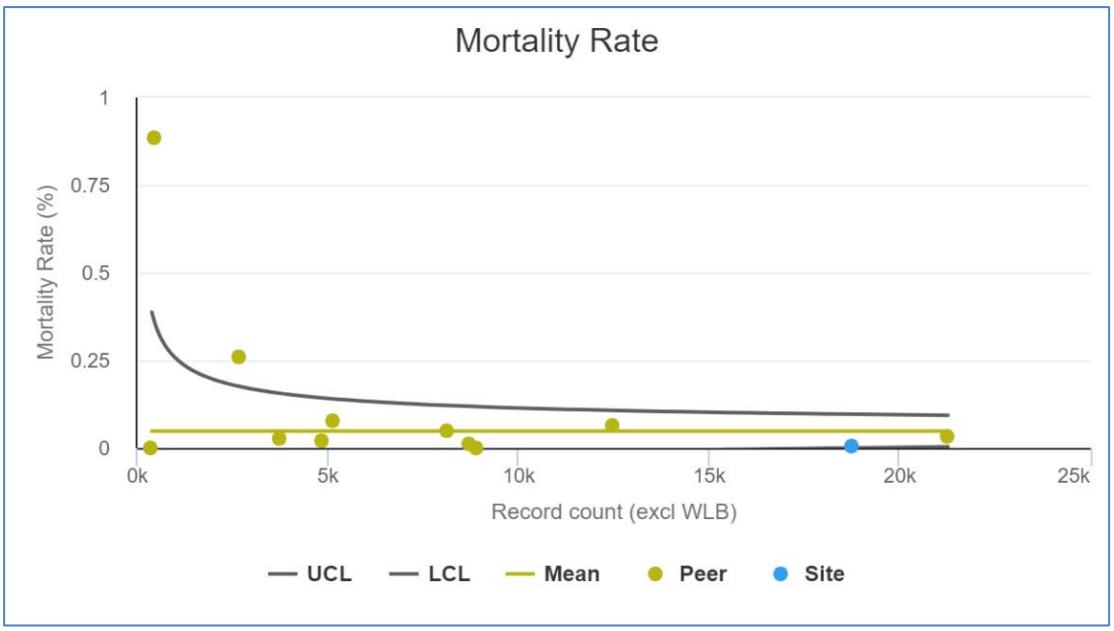
Table below depicts the number of adult deaths in-hospital, including expected and unexpected deaths.

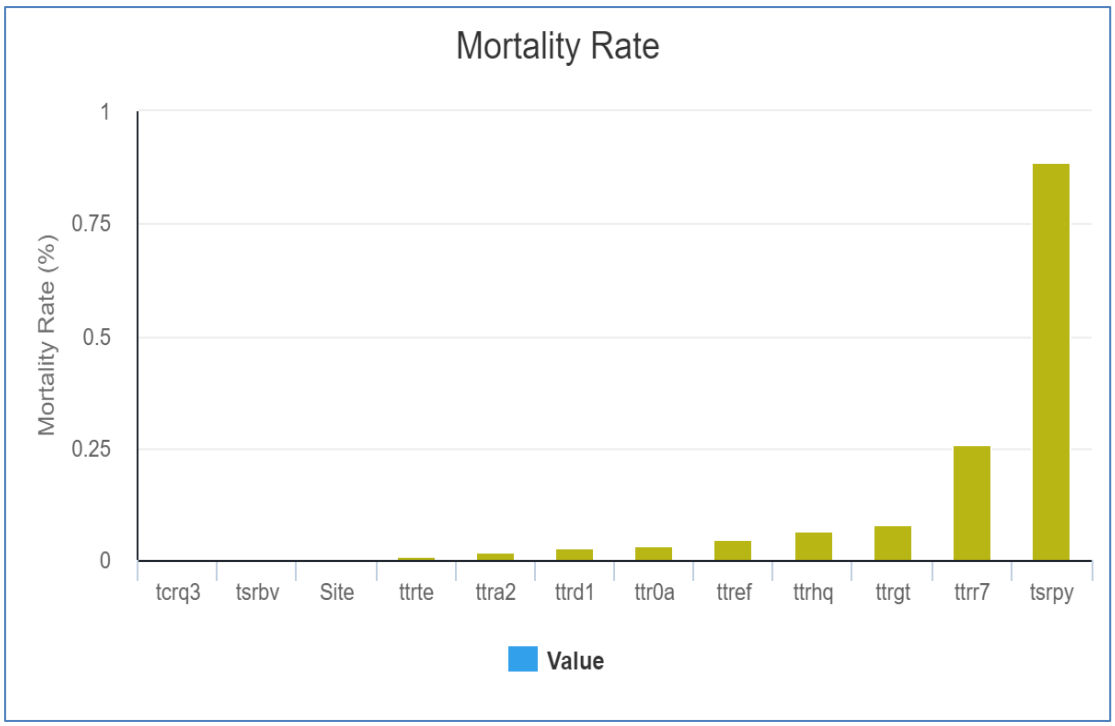
Reporting Quarter	2015-2016		2016-2017		2017-2018	
	In-hospital	Out-hospital	In-hospital	Out-hospital	In-hospital	Out-hospital
Q1	1	-	3		1	2
Q2	4	-	2		0	
Q3	4	-	3	2	0	
Q4	5	-	1			
Total	**14**	**-**	**9**		**1**	
				2		2
Overall total deaths	**14**		**11**		**3**	

5. Benchmarking

CHKS excludes Bedford and Hewitt patients for better comparison with other Trusts. The chart shows that for the time period April 2017 – Nov 2017 LWH mortality rate is below average compared to other peer Trusts.







Date range: April 2017 to November 2017

Filters: Treatment Function = 501 – Obstetrics, 502 – Gynaecology, 503 - Gynaecological Oncology; excluding Hewitt Centre and Bedford Clinic

Peer group:

RQ3 - Birmingham Children's Hospital NHS Foundation Trust *(now Women's and Children's)*

RBV - The Christie NHS Foundation Trust

RPY - The Royal Marsden NHS Foundation Trust

R0A - Manchester University NHS Foundation Trust

RA2 - Royal Surrey County Hospital NHS Foundation Trust

RD1 - Royal United Hospital Bath NHS Trust

REF - Royal Cornwall Hospitals NHS Trust

RGT - Cambridge University Hospitals NHS Foundation Trust

RHQ - Sheffield Teaching Hospitals NHS Foundation Trust

RR7 - Gateshead Health NHS Foundation Trust

RTE - Gloucestershire Hospitals NHS Foundation Trust

For the charts above, peers are based on Gynaecology units of a similar size and type to Liverpool Women's Trust. The adult mortality figures for LWH are historically low as the majority of deaths that occur are 'expected' deaths within gynaecology and oncology units.

6. Mortality reviews and Key Themes

Each in-hospital death has a mortality review. All adult gynaecology deaths are discussed at the gynaecology Morbidity & Mortality meeting. As part of this process an adult mortality sheet is completed indicating any potential for improvement in care. Unexpected adult gynaecology deaths trigger a serious incident investigation.

All direct maternal deaths trigger serious incident investigation.

A new mortality review tool has been developed for risk and incident reporting system Ulysses. This avoids losing any paper documents (current system) and allows for searching, monitoring and auditing of an electronic system.

Adult Mortality Quarter 3		
	Maternity	**Gyneacology**
No of Adult Deaths	0	0
No of Mortality Reviews completed	0	0
No of deaths requiring RCA's	0	0
No of deaths due to deficiencies in care	0	0
Mortality Themes	N/A	N/A
Progress v Smart Plans	N/A	N/A
Mortality Outcomes	N/A	N/A
Measures for ongoing scrutiny	N/A	N/A

7. Progress / Learning from Deaths

Currently there have been no deaths to comment on in which to provide specific learning from death outcomes. However, we are going to perform a deep dive on the two unexpected deaths in 2016/17 in order to provide assurance to the Board.

8. Horizon Scanning

NICE Guidance:

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

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

Other Professional Organisations:

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

Horizon Scanning Summary for guidance, reports and publications

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

Period: November 2017 – January 2018

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

CQC – no updates found for the period covered

NCPOD – no updates found for the period covered

NHS Digital – no updates found for the period covered

NHS Resolution – no updates found for the period covered

Public Health England – no updates found for the period covered

RCOG – Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013–15

MBRRACE-UK
This report into maternal mortality and morbidity shows an overall fall in maternal deaths from 11 per 100,000 in 2006-08 to 10 per 100,000 in 2010-12. The RCOG & RCM joint statement on this report can be accessed here

9. Conclusion

There have been no gynaecological, obstetric or LeDer (Learning disability) deaths within quarter 3 reporting period. Work against the Adult Mortality Strategy is progressing steadily.

10. Recommendations

It is recommended that the Board:

a. Take assurance that there is adequate progress against the requirements laid out by the National Quality Board

b. Confirm that the Board are confident that there are effective processes in place to assure the board regarding governance arrangements in place to drive quality and learning from the deaths of patients in receipt of care at the Trust

Agenda Item	2018/044

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Safer Nurse/Midwife Staffing Monthly Report – Period 9**
DATE OF MEETING:	2 February 2018
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Julie King, Acting Director of Nursing and Midwifery
AUTHOR(S):	Clare Fitzpatrick Acting Deputy Director of Nursing and Midwifery
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** 1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☐ 2. To be ambitious and *efficient* and make the best use of available resource ☐ 3. To deliver *safe* services ☒ 4. To participate in high quality research and to deliver the most *effective* Outcomes ☐ 5. To deliver the best possible *experience* for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust* ☒ ***2.*** *The Trust is not financially sustainable beyond the current financial year* ☐ ***3.*** *Failure to deliver the annual financial plan* ☐ ***4.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision* ☐ ***5.*** *Ineffective understanding and learning following significant events* ☐ ***6.*** *Inability to achieve and maintain regulatory compliance, performance and assurance* ☒ ***7.*** *Inability to deliver the best clinical outcomes for patients* ☒ ***8.*** *Poorly delivered positive experience for those engaging with our services* ☒
CQC DOMAIN	***Which Domain?*** ***SAFE-*** *People are protected from abuse and harm* ☐ ***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☒ ***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐ ***RESPONSIVE –*** *the services meet people's needs.* ☐ ***WELL-LED -*** *the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ☒ ***ALL DOMAINS*** ☐

LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution	☐	**4.** NHS Constitution	☐
	2. Operational Plan	☐	**5.** Equality and Diversity	☐
	3. NHS Compliance	☒	***6.*** Other: **NHS England Compliance**	
FREEDOM OF INFORMATION (FOIA):	1. This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting			
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	The Board is asked to note: • The content of the report and be assured appropriate information is being provided to meet the national and local requirements. • The organization has the appropriate number of nursing & midwifery staff on its inpatient wards to manage the current clinical workload as assessed by the Director of Nursing & Midwifery			
PREVIOUSLY CONSIDERED BY:	**Committee name**		***Choose an item.*** Or type here if not on list: ***Click here to enter text.***	
	Date of meeting		***Click here to enter a date.***	

Executive Summary

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

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

Nurse sensitive indicators continue to highlight the good practice of reporting medication errors especially in the neonatal unit. All errors are investigated and appropriate action taken. No error resulted in harm to any patient.

The use of CHPPD as a benchmark within and against other organisations is still under development by NHS Improvement and subsequent reports will be amended accordingly, presently CHPPD is featured alongside fill rates for each ward and department.

Care hours per day remain at a sustained level indicating a consistent level of care nursing/midwifery resource to provide care to our patients. The staffing across the inpatient ward areas for November remained appropriate to deliver safe and effective high quality family centred patient care day and night.

Ward Staffing Levels – Nursing and Midwifery Report

1.0 Purpose

1.1 Introduction

This report provides a monthly summary of Safe Staffing on all inpatient wards across the Trust. It includes exception reports related to staffing levels, related staffing incidents and red flags which are triangulated with a range of quality indicators both nursing and midwifery.

2.0 Safer staffing exception report

The safe staffing exception report (appendix 1), provides the established versus actual fill rates on ward by ward basis. Fill rates are accompanied by supporting narrative by exception at ward level, and a number of related factors are displayed alongside fill rates to provide an overall picture of safe staffing.

- Sickness rate and vacancy rate are the two main factors affecting fill rates, a growing trend is maternity leave, especially within maternity division, and this is being closely monitored.
- The monthly audit of nursing indicators was suspended in September 2017 by the previous DON. The trust is currently developing a ward accreditation system which will support the collection of quality indicators alongside real time patient safety flags. It is envisaged that this work will be completed by summer 2018.
- ACE incident submissions related to staffing and red flags are monitored daily to act as an early warning system and inform future planning:
- Nurse sensitive indicators demonstrate outcome for patients measuring harm:
- Cases of Clostridium Difficile (CDT)
    - Pressure Ulcers grade 1&2/Grades 3&4
    - Falls resulting in harm / not resulting in physical harm
    - Medication errors resulting in harm/ not resulting in harm
    - Babies requiring thermos cooling resulting in an Each Baby counts report

The inpatient wards have been able to maintain fill rates during the month of December; the average fill rate for registered staff was greater than 91.62% day time, 89.8% night time, the average fill rate non registered staff 139.1% (due to a change in DS process)day time, 90.96% night time trust wide.

Safe staffing for each ward is assessed on a daily basis by the relevant Divisional Matrons, and, during the evenings and weekends the duty manager for each division, in combination with the on call senior manager has the responsibility for ensuring safe staffing of all ward areas across the Trust.

There have been 10 red flag incidents, reported under the nursing/midwifery red flag criteria, 6 of these relate to medication errors, within neonatal division (which are reported through the medication failsafe system and are managed through the neonatal governance process, none of these medication errors resulted in patient harm or where attributed to staffing levels. Maternity 4 incidents, one related to a delay in treatment due to delivery suite acuity, a clinical incident (Shoulder dystocia), miscommunication between wards regarding staffing, one due to a baby falling from the incubator (not secured properly by mum), again no incidents were recorded as patient harm and non from a staffing perspective.

Investigations into these concluded that staffing levels and skill mix were safe at the time and did not contribute directly to incidents. All incidents were reviewed within the recommended timeframes and action plans commenced if appropriate. Gynaecology reported a 0 return for the second month for red flag incidents discussions with the senior gynaecology team have been undertaken to ensure correct reporting is undertaken.

3.0 Summary

During the month of December, the wards were considered safe with low levels of harm and positive

patient experience across all inpatient areas indicating that safe staffing has been maintained. There has been a noted slight decrease in fill rate within inpatient Delivery suite due to an increase in short term sickness due to seasonal flu, this has not impacted on service delivery. Maternity has undertaken a change in induction process, which has affected the fill rate for unregistered staff within delivery suite, this will reviewed and the modal changed for January month reporting.

Work will continue within gynaecology outpatients to review safe staffing and gynaecology outpatient nursing staffing modal, this is not required on a UNIFY return as it only applies to inpatient staffing.

4.0 Recommendations

The board is asked to receive the paper for information and discussion.

Safer Staffing Fill Rate - Gynaecology

		Day		Night	
	Ward name	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
Dec-17	Gynaecology	97.0%	93.48%	105.06%	94.12%

Safer Staffing Fill Rate - Maternity

		Day		Night	
	Ward name	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
Dec-17	Induction&Delivery Suites	89.6%	306.5%	68.0%	80.6%
	Maternity Base	87.1%	84.5%	86.6%	94.6%
	MLU & Jeffcoate	79.0%	96.8%	81.7%	96.8%
	Maternity Total	86.7%	141.5%	76.2%	88.9%

Safer Staffing Fill Rate - Neonatal Care

		Day		Night	
	Ward name	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
Dec-17	Neonatal Care	105.4%	114.5%	107.3%	88.7%

Month:	December 17				

Nurse Sensitive Indicators

	Falls no harm (n)	Falls Harm (N)	Drug Admin Errors	New Complaints	Red Flag Incidents Reported (N)
Gynae Unit					
Delivery Suite					3
Induction					
Matbase		2		1	1
MLU					
Jeffcoate					
Neonatal			6		6
Total	**0**	**2**	**6**	**1**	**10**

Nurse Sensitive Indicators (Reference Numbers)

	Falls no harm (n)	Falls Harm (N)	Drug Admin Errors	New Complaints	Red Flag Incidents Reported (N)
Gynae Ward Unit					
Delivery Suite					53331 53405 53400
Induction					
Matbase		53254 52791		17/074	53294
MLU					
Jeffcoate					
Neonatal			52838 53140 53079 53080 53175 53291		52838 53140 53079 53080 53175 53291

Agenda Item	2018/045

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	Performance Dashboard Month 9
DATE OF MEETING:	2 February 2018
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Jeff Johnston, Director of Operations
AUTHOR(S):	Jeff Johnston, Director of Operations
STRATEGIC OBJECTIVES:	***Which Objective(s)?***
	1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☒
	2. To be ambitious and *efficient* and make the best use of available resource ☒
	3. To deliver *safe* services ☒
	4. To participate in high quality research and to deliver the most *effective* Outcomes ☐
	5. To deliver the best possible *experience* for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?***
	1. *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust* ☒
	2. *The Trust is not financially sustainable beyond the current financial year* ☐
	3. *Failure to deliver the annual financial plan* ☐
	4. *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision* ☐
	5. *Ineffective understanding and learning following significant events* ☒
	6. *Inability to achieve and maintain regulatory compliance, performance and assurance* ☒
	7. *Inability to deliver the best clinical outcomes for patients* ☒
	8. *Poorly delivered positive experience for those engaging with our services* ☒
CQC DOMAIN	***Which Domain?***
	SAFE- *People are protected from abuse and harm* ☒
	EFFECTIVE - *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☒
	CARING - *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐
	RESPONSIVE – *the services meet people's needs.* ☐
	WELL-LED - *the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ☒

	ALL DOMAINS ☐	
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution ☐ **2.** Operational Plan ☐ **3.** NHS Compliance ☐	**4.** NHS Constitution ☐ **5.** Equality and Diversity ☐ ***6.*** Other: **Click here to enter text.**
FREEDOM OF INFORMATION STATUS (FOIA):	1. This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting	
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	The Board note the content of the report	
PREVIOUSLY CONSIDERED BY:	**Committee name**	***Choose an item.*** Or type here if not on list: ***Click here to enter text.***
	Date of meeting	***Click here to enter a date.***

1. Introduction

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

2. Single Oversight Framework

The NHSI single oversight framework has been consulted on and changes have been considered to ensure that the Trust is sighted on the relevant performance indicators. This section of the report considers each change and a recommendation on how to manage with the current framework.

The major changes are as follows:-

Removal of:

- Readmissions within 30 Days: *we already have this as a quality strategy metric and will continue to monitor.*
- Aggressive cost Reduction plans: *This would still be a useful metric* and monitored via FPBD

Addition of:

- Meticillin-sensitive Staphylococcus aureus (MSSA) rates: *this will be a new KPI*
- Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI) rates: *this will be a new KPI*

Currently, the infection control committee (monthly) and the Quality meeting (quarterly) review these indicators via reports. The quarter 3 report highlights that the trust has had zero MSSA and e-coli (12 patients per year currently 6 reported) has reduced by 10% from the previous year. It is recommended that due to the nature of these indicators and the Trusts services that the current process of reporting is maintained.

- CQC inpatient survey: *this will be a new KPI (annual)*
- Dementia assessment and referral standards: Three new indicators
  a. who have a diagnosis of dementia or delirium or to whom case finding is applied
  b. who, if identified as potentially having dementia or delirium, are appropriately assessed and
  c. where the outcome was positive or inconclusive, are referred on to specialist services

These indicators we already collect and are reviewed by the Quality committee and the Trust is compliant with current targets. It is recommended to leave the indicators with the Quality meeting.

Changes to

- Mortality Rates: Hospital Standardised Mortality Rates (HSMR) – weekend / Mortality Rates: Hospital Standardised Mortality Rates (HSMR) – weekday : *these become one indicator, it is recommended to the board that these indicators are reviewed as part of the Quarterly Mortality reports provided by the Medical Director.*
- Executive Team Turnover Rate: *This is not explicitly an indicator, however is still being considered at the centre for that reason recommend this stays on the dashboard.*
- Financial Sustainability Risk Rating: Overall Score: *This is not explicitly an indicator, although it is recommended that this remains as a metric for the Trust as provides an overall measure of performance.*

3. Performance

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

3.1 NHSI Targets – Access Targets including Cancer targets

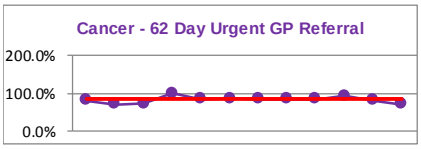
The Trust is achieving the NHSI access targets accept for the 62 day Cancer Target before reallocation. The Trust has received 4 patients who were referred after 39 days to LWH in fact the earliest referral was 47 days and the longest 183 days.

The cancer services already engage with all referring Trusts, via cancer networks and the alliance and NHS-I teleconferences, to improve the timely onward referral to Specialist MDT.

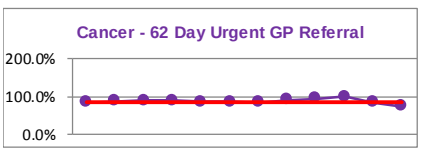
Unfortunately, there remains a potential for patients to be referred late. However, all patients who are treated after day 62, undergo full RCA which includes clinical review and involves originating Trusts. These RCA's are then reviewed with our commissioners to support originating Trusts with their own pathways.

The Trust will need to wait until the finalised position to understand if this target has not been achieved.

All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (Before re-allocation) Provisional Position	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Actual	81.0%	71.4%	73.9%	100.0%	85.0%	87.5%	85.7%	85.7%	84.6%	93.3%	81.8%	71.4%
Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%



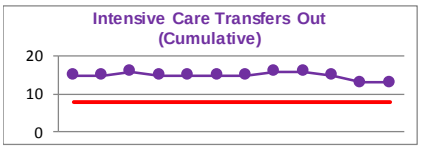
All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (After Re-allocation) Provisional Position	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Actual	85.0%	88.2%	89.5%	89.5%	86.4%	87.5%	85.7%	92.3%	95.7%	100.0%	85.7%	75.0%
Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%



3.2 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 13 patients, the group consider the transfers to be appropriate.

Intensive Care Transfers Out (Cumulative)	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Actual	15	15	16	15	15	15	15	16	16	15	13	13
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.

4. Emerging concerns

As highlighted in previous reports gynaecology patient access and Nursing indicators are not performing as strongly as expected. There are now agreed dates for the Head of Nursing and Matron to return to work in January and February. There will be plan with the service improvement manager to improve overall performance in quarter 4 and the beginning of quarter 1 of the new year.

5. Conclusion

There are a number of changes recommended by the NHSI oversight framework that have been considered and recommendations provided to the Board.

The Trust is achieving all its National access and A & E targets, however, there are concerns that the overall cancer target may be breached for the first time this year even after reallocation.

There is an emerging concerning within gynaecology in terms of ensuring that sufficient clinical capacity is available to book patients and nursing quality indicators, there is a new service improvement manager proactively managing these issues which will be supported by the return to work of two senior nurse leaders.

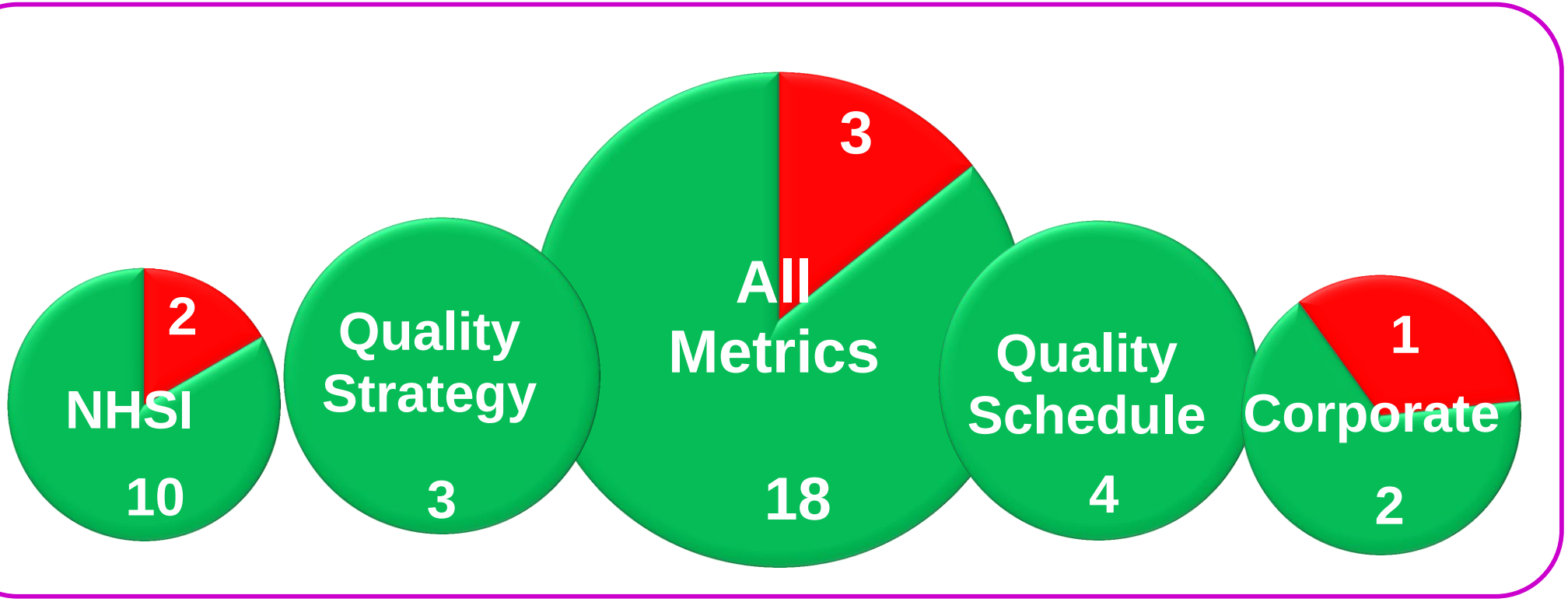
ITU transfers remain a continuing clinical risk that is managed by robust clinical policies and procedures and the experience of clinicians, this particular issue remains a strong focus of our long term strategy. A significant improvement has been made in terms of the sickness rate.

6. Recommendation

The Board accept the recommendations on how to manage the new NHSI oversight framework indicators and note the content of the Board.

Liverpool Women's NHS Foundation Trust

Performance Report for Trust Board — Month 9 - December 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 9 - December 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	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	0	0					
Infection Control: MRSA	KPI105 (EAS4)		0	0	0	0		0	0	0		0	0	0					
Never Events	KPI181	Greg Hope	0	1	0	0		0	0	0		1	0	0					
NHSE / NHSI Safety Alerts Outstanding	KPI193	Greg Hope	0	0	0	0		0	0	0		0	0	0					
Infection Control: Clostridium Difficile - infection rate	KPI320	ICT	TBC	0	0	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	0	0					
Mortality Rates: Hospital Standardised Mortality Rates (HSMR) - weekday (1 Month behind)	KPI321		TBC	0	0	0		0	0	0		0	0	0					
Mortality Rates: Summary Hospital Mortality Indicator (SHMI) (1 Month behind)	KPI322		TBC																

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%	4.29%	4.28%					

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%	93.64%	92.79%					
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%	81.82%	71.43%					
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%	100.00%	86.36%						
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%	85.71%	75.00%					
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%	100.00%	90.48%						
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	0.0	0.5					
All Cancers: 62 day wait for first treatement from NHS Cancer Screening Service referral - Percentage	KPI034 (EB14)	Chris Webster	>= 90%	No Pts Applicable	100%	100%	100%	No Pts Applicable	No Pts Applicable	100%	100.00%	No Pts Applicable	No Pts Applicable	100%					
Complaints: Number Received	KPI038	Debi Rice	<= 15	10	9	5		5	11	9		14	9	6					

Liverpool Women's NHS Foundation Trust

LWH Quality Schedule 2017/18 LWH Quality Schedule

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

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

Indicator Name	CCG Ref	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%	4.29%	4.28%			

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	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	214	204			
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%	97.6%	98.8%			

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%	4.29%	4.3%			

To deliver SAFER services

Indicator Name	Ref	Owner of KPI	Target 2017/18	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Never Events	KPI181	Greg Hope	0	1	0	0	0	0	0	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	9	6			

Liverpool Women's NHS Foundation Trust

LWH Corporate 2017/18 Month 9 - December 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%	0.31%	0.15%	0.16%			
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%	0.16%	0.00%	0.16%			

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	13	13			

Agenda Item	2018/046

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Month 9 Finance Report**
DATE OF MEETING:	Friday, 02 February 2018
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Jenny Hannon, Director of Finance
AUTHOR(S):	Janet Parker, Acting Deputy Director 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 ☐ **2.** Operational Plan ☒ **3.** NHS Compliance ☒	**4.** NHS Constitution ☐ **5.** Equality and Diversity ☐ ***6.*** Other:
FREEDOM OF INFORMATION (FOIA):	1. This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting	
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	***Note the Month 9 Financial Position and Forecast Outturn***	
PREVIOUSLY CONSIDERED BY:	**Committee name**	Finance, Performance & Business Development Committee
	Date of meeting	22 January 2018

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 9 the Trust is £0.066m favourable against the planned £3.390m deficit.

Following a detailed review of the overall position at Month 9, the Trust is able to improve the forecast deficit to £3.7m on a non-recurrent basis. This will attract additional STF of £0.3m which brings the overall forecast deficit for the year to £3.4m.

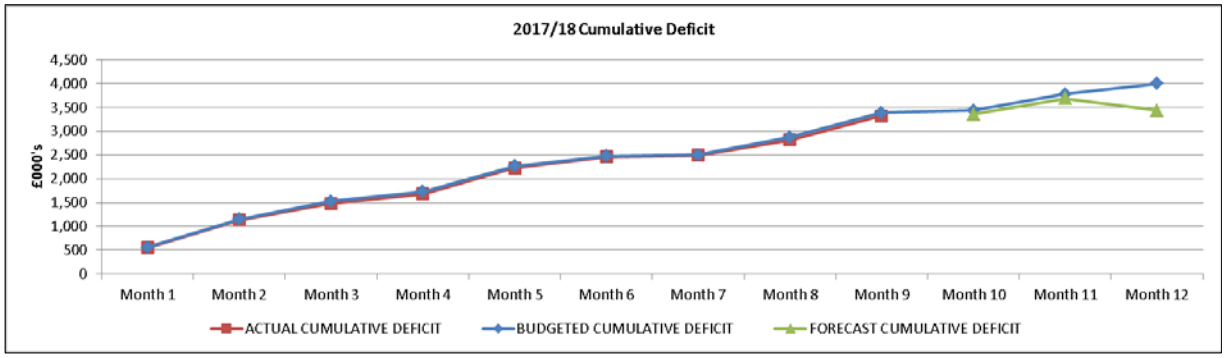
The Trust delivered a finance and use of resources' of 3 in month which is equivalent to plan.

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

Report

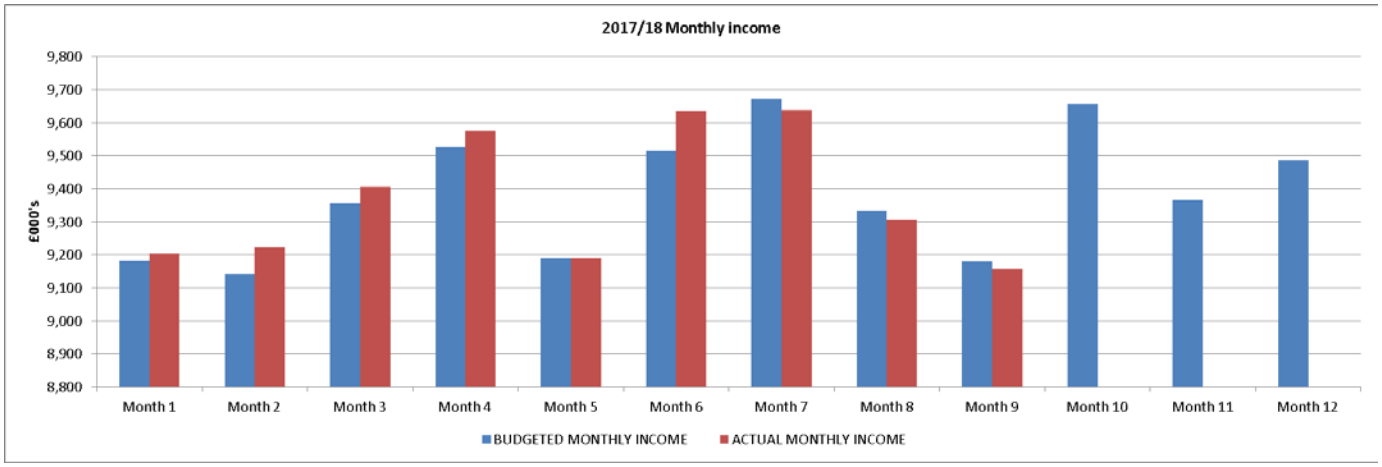
1. Month 9 2017/18 Summary Financial Position

The 2017/18 deficit is profiled below.



The Trust is achieving the planned deficit at Month 9 and is forecasting a £0.3m non-recurrent improvement at Month 12 (which will be matched by STF).

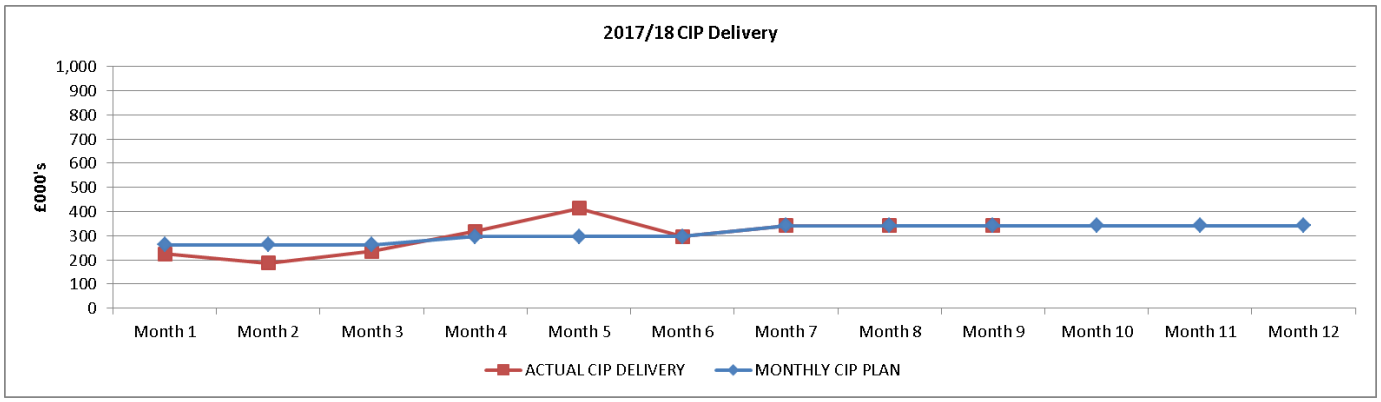
Despite a large proportion of income being under block contract with the Trust's main commissioners, there remains an element of payment by result (PbR) in the income plan. Within the financial plan the block is profiled to reflect expected activity levels in each month.



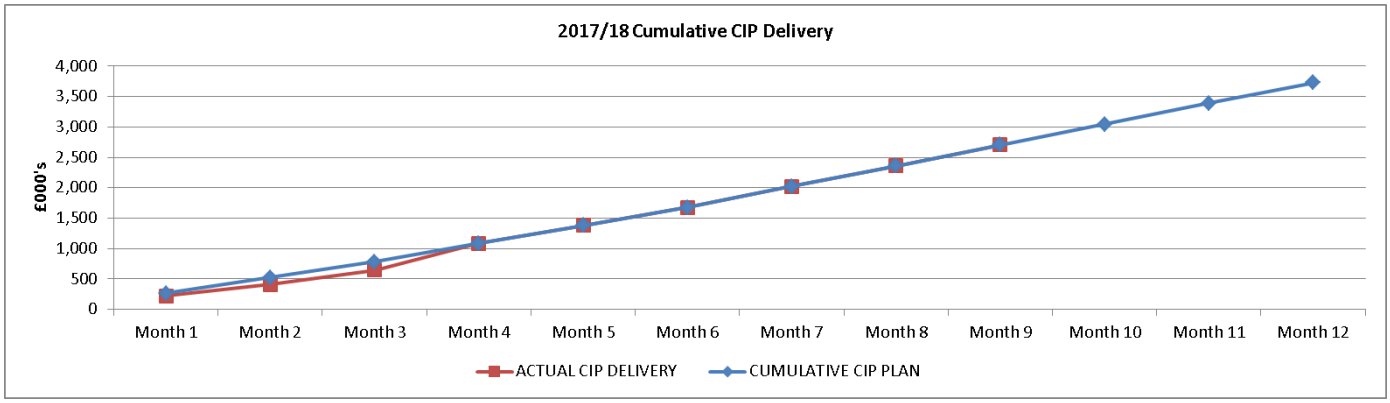
To date, the CCG block payment has been £2.3m higher than what would have been received under PbR for the level of activity during 2017/18. This has arisen particularly across both Gynaecology and Maternity, with activity levels in each currently below plan. The Trust has performed a detailed review into this performance as reported to FPBD, with recovery plans being developed and actioned.

2. Month 9 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, with £0.2m of this remaining non-recurrent into 2018/19.



Actual CIP delivery is £0.342m in month which includes £0.037m 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 for these services cumulatively amounts to £2m YTD. The full year impact of the block shortfall is projected as £3.4m across all services at the current run rate. It is expected that this will be covered by the Acting as One arrangement into 2018/19 while the Trust assesses the ongoing impact, however this poses a risk into 2019/20.

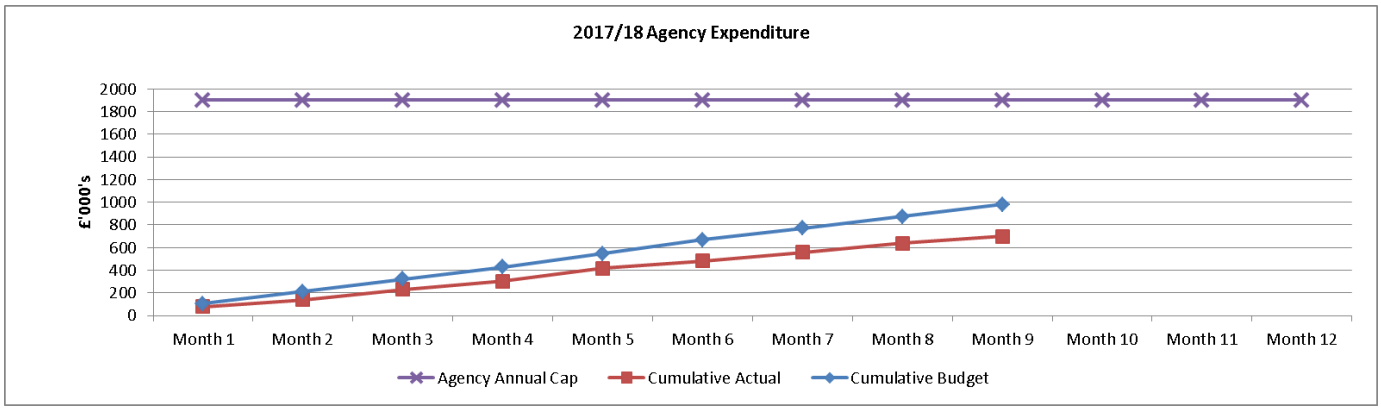
The maternity service is no longer forecasting an overspend on pay given the current and further expected attrition of midwives in line with lower births. Income is significantly down from the previous month due to non-block underperformance.

The neonatal service 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. Areas have been identified which enable the service to meet the £3m required level of contribution in 2018/19.

4. Agency Spend

The annual agency cap set by NHSI for the Trust is £1.9m. In Month 9 the Trust incurred £0.059m of agency expenditure (cumulative £0.697m) and plans to remain within the cap for the financial year.



5. Forecast Outturn and Out-Performance of 2017/18 Control Total

Following a detailed review at Month 9, it is forecast that the Trust will outperform the control total by £0.3m. This is as a net result of;

- The release of a historic balance in the balance sheet which the auditors have agreed can be released
- A review of the Trust's bad debt provision to ensure that it is sufficient

The improvement to the position is on a non-recurrent basis in year arising from a 'one off' gain and does not impact on the following year's plans.

As was the case in 2016/17, NHS Improvement have informed the Trust of a national incentive scheme whereby, if a Trust can deliver a financial position better than its planned control total, it can apply for 'STF incentive' funding. This means that for every £1 delivered over and above the control total the Trust will receive £1 additional revenue from the STF incentive fund. Whilst this funding is aimed at improving the bottom line financial position of the Trust, it is received in the form of cash which is also of benefit to the Trust as it enables the Trust to repay some of its outstanding revenue loans as it has done earlier this financial year.

This impacts on the deficit as follows:

	£m
Control Total Deficit	**(4.0)**
Trust FOT Improvement	0.3
STF incentive matched revenue	0.3
Forecast Overall Trust Deficit 17/18	**(3.4)**

The above position has been notified to NHSI as part of the monthly returns.

6. Cash and borrowings

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

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

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

This position has supported the Trust's 2017/18 in-year cash balances and to date the Trust has not yet drawn down any cash although a submission has been made for a drawdown of £0.5m in Month 10. It is still envisaged that the Trust will not require drawdown of the full £4m in 2017/18 as previously reported to Board. The Trust is currently forecasting a drawdown of £2m as follows:

Full year planned requirement	**£4.0m**
Surplus cash carried forward to 2017/18	(£1.5m)
Drawdown forecast – at month 6	£2.5m
Improvement in working capital	(£0.5m)
Drawdown forecast in 2017/18	**£2.0m**

This will bring the Trust's cumulative Distressed Finance borrowings to £12.3m by the end of 2017/18.

7. BAF Risk

There are currently two finance risks on the BAF as follows:

No	BAF Risk	Current risk level
1986	The Trust is not financially sustainable beyond the current financial year	L5 x I5 = 25
1663	Failure to deliver the annual financial plan	L4 x I5 = 20

Given the forecast improvement in the outturn position discussed in section 5 it is proposed that the current risk level in relation to 1663 (failure to deliver the annual financial plan) is reduced with the likelihood score of 4 (likely) being reduced to 3 (possible) giving an overall score of 15.

8. Conclusion & Recommendation

The Board are asked to note the Month 9 financial position and forecast outturn.

The Board is asked to approve a reduction in the BAF score in relation to 1663 (failure to deliver the annual financial plan) from 20 to 15.

Appendix 1 – Board pack

Appendix 1

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

FINANCE REPORT: M9

YEAR ENDING 31 MARCH 2018

Contents

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
NHS IMPROVEMENT RATIOS: M9
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	1,358	1,368	2,341	2,797
(b) PDC + Interest Payable + Loans Repaid	1,746	3,965	2,532	4,710
CSC Ratio = (a) / (b)	**0.78**	**0.35**	**0.92**	**0.59**
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	(2,332)	(6,125)	(2,598)	(4,636)
(b) Expenditure	82,750	82,984	110,277	110,562
(c) Daily Expenditure	301	302	302	303
Liquidity Ratio = (a) / (c)	**(7.7)**	**(20.3)**	**(8.6)**	**(15.3)**
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)	3,390	3,322	3,998	3,440
Total Income	(84,100)	(84,338)	(112,608)	(113,336)
I&E Margin	**-4.03%**	**-3.94%**	**-3.55%**	**-3.04%**
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)		-3.94%		-3.04%
I&E Margin (Plan)		-4.03%		-3.55%
I&E Variance Margin	**0.00%**	**0.09%**	**0.00%**	**0.52%**
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	1,440	1,440	1,924	1,924
YTD Agency Expenditure	974	697	1,301	908
	-32.36%	**-51.60%**	**-32.38%**	**-52.81%**
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: M9
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	(8,542)	(8,510)	(31)	(78,125)	(78,021)	(104)	(102,883)	(102,706)	(177)
Non-Clinical Income	(638)	(648)	10	(5,975)	(6,317)	342	(9,725)	(10,629)	905
Total Income	**(9,179)**	**(9,158)**	**(21)**	**(84,100)**	**(84,338)**	**238**	**(112,608)**	**(113,336)**	**727**
Expenditure									
Pay Costs	5,609	5,593	16	50,677	50,692	(15)	67,503	67,492	11
Non-Pay Costs	2,254	2,258	(4)	20,277	20,496	(219)	27,046	27,342	(296)
CNST	1,311	1,311	0	11,796	11,796	0	15,728	15,728	0
Total Expenditure	**9,173**	**9,162**	**12**	**82,750**	**82,984**	**(234)**	**110,277**	**110,562**	**(285)**
EBITDA	**(6)**	**4**	**(10)**	**(1,350)**	**(1,355)**	**4**	**(2,331)**	**(2,773)**	**442**
Technical Items									
Depreciation	366	366	0	3,308	3,397	(89)	4,419	4,506	(87)
Interest Payable	36	20	16	324	198	126	432	262	170
Interest Receivable	(1)	(2)	2	(7)	(14)	6	(10)	(24)	14
PDC Dividend	124	119	5	1,116	1,099	17	1,488	1,474	14
Profit / Loss on Disposal	0	0	0	0	(1)	1	0	(1)	1
Total Technical Items	**525**	**502**	**23**	**4,740**	**4,678**	**62**	**6,329**	**6,217**	**113**
(Surplus) / Deficit	**519**	**506**	**13**	**3,390**	**3,324**	**66**	**3,998**	**3,443**	**555**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
EXPENDITURE: M9
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	376	(35)	3,063	3,192	(129)	4,085	4,267	(183)
Medical	1,253	1,268	(15)	11,169	11,244	(75)	14,928	15,047	(119)
Nursing & Midwifery	2,485	2,497	(12)	22,560	22,617	(57)	30,009	30,109	(99)
Healthcare Assistants	405	379	27	3,705	3,645	60	4,924	4,825	98
Other Clinical	538	557	(19)	4,841	4,768	73	6,454	6,454	1
Admin Support	140	157	(17)	1,260	1,408	(148)	1,679	1,862	(183)
Corporate Services	342	301	42	3,100	3,122	(22)	4,125	4,021	105
Agency & Locum	105	59	45	980	697	283	1,299	908	392
Total Pay Costs	**5,609**	**5,593**	**16**	**50,677**	**50,692**	**(15)**	**67,503**	**67,492**	**11**
Non Pay Costs									
Clinical Suppplies	703	699	4	6,358	6,459	(101)	8,471	8,611	(140)
Non-Clinical Supplies	593	569	24	5,236	5,250	(14)	7,018	6,948	71
CNST	1,311	1,311	0	11,796	11,796	0	15,728	15,728	0
Premises & IT Costs	438	453	(16)	3,955	4,034	(79)	5,268	5,393	(126)
Service Contracts	520	536	(16)	4,728	4,752	(24)	6,289	6,390	(101)
Total Non-Pay Costs	**3,565**	**3,569**	**(4)**	**32,073**	**32,292**	**(219)**	**42,774**	**43,070**	**(296)**
Total Expenditure	**9,173**	**9,162**	**12**	**82,750**	**82,984**	**(234)**	**110,277**	**110,562**	**(285)**

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	(3,732)	(3,535)	(197)	(34,204)	(33,853)	(350)	(45,612)	(45,190)	(421)
Expenditure	1,698	1,715	(17)	15,303	15,387	(84)	20,398	20,432	(34)
Total Maternity	**(2,034)**	**(1,820)**	**(214)**	**(18,901)**	**(18,466)**	**(435)**	**(25,214)**	**(24,758)**	**(456)**
Gynaecology									
Income	(2,024)	(2,119)	95	(19,351)	(19,450)	99	(25,742)	(25,615)	(127)
Expenditure	859	889	(30)	7,740	7,772	(32)	10,317	10,334	(18)
Total Gynaecology	**(1,165)**	**(1,230)**	**65**	**(11,611)**	**(11,678)**	**67**	**(15,425)**	**(15,281)**	**(144)**
Theatres									
Income	(42)	(38)	(3)	(374)	(347)	(28)	(499)	(462)	(37)
Expenditure	640	622	18	5,759	5,795	(35)	7,679	7,718	(39)
Total Theatres	**598**	**583**	**15**	**5,385**	**5,448**	**(63)**	**7,180**	**7,257**	**(76)**
Neonatal									
Income	(1,351)	(1,533)	182	(12,194)	(12,575)	381	(16,249)	(16,675)	426
Expenditure	945	961	(16)	8,506	8,599	(93)	11,341	11,500	(159)
Total Neonatal	**(406)**	**(572)**	**165**	**(3,688)**	**(3,976)**	**288**	**(4,908)**	**(5,175)**	**267**
Hewitt Centre									
Income	(535)	(457)	(78)	(7,320)	(7,371)	52	(9,971)	(10,142)	171
Expenditure	623	609	13	5,603	5,644	(41)	7,471	7,602	(131)
Total Hewitt Centre	**87**	**153**	**(65)**	**(1,717)**	**(1,727)**	**10**	**(2,501)**	**(2,540)**	**39**
Genetics									
Income	(600)	(586)	(14)	(5,403)	(5,329)	(74)	(7,204)	(7,067)	(138)
Expenditure	461	482	(21)	4,151	3,928	223	5,535	5,270	265
Total Genetics	**(139)**	**(104)**	**(36)**	**(1,252)**	**(1,401)**	**149**	**(1,669)**	**(1,796)**	**127**
Clinical Support									
Income	(23)	(21)	(2)	(222)	(261)	39	(295)	(332)	37
Expenditure	759	733	26	6,886	6,818	68	9,164	9,068	95
Total Clinical Support & CNST	**736**	**712**	**24**	**6,664**	**6,556**	**108**	**8,869**	**8,737**	**132**
Corporate & Trust Technical Items									
Income	(871)	(868)	(3)	(5,032)	(5,150)	119	(7,037)	(7,853)	817
Expenditure	3,714	3,652	62	33,541	33,719	(177)	44,702	44,853	(151)
Total Corporate	**2,843**	**2,784**	**59**	**28,510**	**28,568**	**(59)**	**37,666**	**37,000**	**666**
(Surplus) / Deficit	**519**	**506**	**13**	**3,390**	**3,324**	**66**	**3,998**	**3,443**	**555**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 5
BALANCE SHEET: M9
YEAR ENDING 31 MARCH 2018

BALANCE SHEET £'000	YEAR TO DATE Opening	M9 Actual	Movement
Non Current Assets	**72,688**	**72,200**	(488)
Current Assets			
Cash	4,897	4,754	(143)
Debtors	8,201	8,007	(194)
Inventories	366	457	91
Total Current Assets	**13,464**	**13,218**	**(246)**
Liabilities			
Creditors due < 1 year	(10,577)	(16,090)	(5,513)
Creditors due > 1 year	(1,717)	(1,693)	24
Loans	(17,175)	(14,507)	2,668
Provisions	(3,011)	(2,780)	231
Total Liabilities	**(32,480)**	**(35,070)**	(2,590)
TOTAL ASSETS EMPLOYED	**53,672**	**50,348**	**(3,324)**
Taxpayers Equity			
PDC	37,420	37,420	0
Revaluation Reserve	12,233	12,233	0
Retained Earnings	4,019	695	(3,324)
TOTAL TAXPAYERS EQUITY	**53,672**	**50,348**	**(3,324)**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
CASHFLOW STATEMENT: M9
YEAR ENDING 31 MARCH 2018

CASHFLOW STATEMENT £'000	YEAR TO DATE M9 Actual	 Forecast
Cash flows from operating activities	(2,042)	(1,733)
Depreciation and amortisation	3,396	4,506
Movement in working capital	4,983	737
Net cash generated from / (used in) operations	**6,337**	**3,510**
Interest received	14	24
Purchase of property, plant and equipment and intangible assets	(3,044)	(5,929)
Proceeds from sales of property, plant and equipment and intangible assets	133	133
Net cash generated from/(used in) investing activities	**(2,897)**	**(5,772)**
Loans from Department of Health - received	0	3,920
Loans from Department of Health - repaid	(2,668)	(2,974)
Interest paid	(138)	(260)
PDC dividend (paid)/refunded	(777)	(1,474)
Net cash generated from/(used in) financing activities	**(3,583)**	**(788)**
Increase/(decrease) in cash and cash equivalents	**(143)**	**(3,049)**
Cash and cash equivalents at start of period	4,897	4,897
Cash and cash equivalents at end of period	**4,754**	**1,848**

Agenda Item	2018/048

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Changes to the Trust Constitution**
DATE OF MEETING:	Friday, 02 February 2018
ACTION REQUIRED	**For Approval**
EXECUTIVE DIRECTOR:	Choose an item.
AUTHOR(S):	Trust Secretary
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** 1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☒ 2. To be ambitious and *efficient* and make the best use of available resource ☐ 3. To deliver *safe* services ☒ 4. To participate in high quality research and to deliver the most *effective* Outcomes ☐ 5. To deliver the best possible *experience* for patients and staff ☐
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust* ☐ ***2.*** *The Trust is not financially sustainable beyond the current financial year* ☐ ***3.*** *Failure to deliver the annual financial plan* ☐ ***4.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision* ☐ ***5.*** *Ineffective understanding and learning following significant events* ☐ ***6.*** *Inability to achieve and maintain regulatory compliance, performance and assurance* ☒ ***7.*** *Inability to deliver the best clinical outcomes for patients* ☐ ***8.*** *Poorly delivered positive experience for those engaging with our services* ☐
CQC DOMAIN	***Which Domain?*** ***SAFE-*** *People are protected from abuse and harm* ☐ ***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☐ ***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐ ***RESPONSIVE –*** *the services meet people's needs.* ☐ ***WELL-LED -*** *the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ☒ ***ALL DOMAINS*** ☐

LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution ☒ **2.** Operational Plan ☐ **3.** NHS Compliance ☐	**4.** NHS Constitution ☐ **5.** Equality and Diversity ☐ ***6.*** Other: **Click here to enter text.**
FREEDOM OF INFORMATION (FOIA):	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:-….)***	***The Board is asked to approve the recommended changes to the trust Constitution.***	
PREVIOUSLY CONSIDERED BY:	**Committee name**	*Choose an item.* Or type here if not on list: *Click here to enter text.*
	Date of meeting	*Click here to enter a date.*

Executive Summary

An action was placed on the Trust Secretary by the Council of Governors to review the Trust Constitution and propose amendment to take account of changes to the Council of Governors membership regarding Student Appointed Governor Representative, dispute resolution and any ancillary areas that would be deemed appropriate such as consistency check, change of organisation names etc. Copies of both the constitution and code of conduct can be obtained from the Trust Secretary.

For any amendment of the Trust constitution to be effective both the Council of Governors and Board of Directors are required to approve the amendment in each forum.

The Board is asked to consider the amendments recommended by the Council of Governors agreed at their meeting held on 24 January 2018 and if thought appropriate approve the amendments.

Report

The following table set out the changes proposed and the reasons for the amendment to the Constitution.

	Constitution Reference	From	To	Reason
1.	Throughout	Monitor	NHS Improvement or NHSI	Change of regulator name
2.	Annex 3; 3.4	One governor appointed jointly by: • Liverpool Hope University • Liverpool John Moores University • Edge Hill University • **Merseyside Learning & Skills Council**	One governor appointed jointly by: • Liverpool Hope University • Liverpool John Moores University • Edge Hill University	Merseyside Learning and Skills Council has ceased to exist and has been removed from the list.
3.	Annex 3; 3.5	New clause	One Student Governor appointed jointly by the student councils of: • University of Liverpool • Liverpool Hope University • Liverpool John Moores University • Edge Hill University	To support the Councils view that a representative was required, appointed by the students from the four main universities that the Trust has a link with. Following comments at the last CoG meeting agreement will be reached with the Student

				bodies that any appointment from each of the universities would be for a maximum of two years and that the appointee would be taken on a rota basis.
4.	Annex 6; 9	Further provisions as to eligibility to be a Director **9.** A person may not become a Director of the Trust, and if already holding such office, will immediately cease to do so if: **9.1** subject to 9.2 below, she is a member of the Council of Governors, or a Governor or Director of an NHS body or another NHS Foundation Trust; **9.2** in the case of a non-executive Director of the Trust, a person so appointed may hold one or more additional non-executive directorships in other NHS bodies;….	Further provisions as to eligibility to be a Director **9.** A person may not become a Director of the Trust, and if already holding such office, will immediately cease to do so if: **9.1** ~~subject to 9.2 below,~~ she is a member of the Council of Governors, or a Governor ~~or Director~~ of an NHS body or another NHS Foundation Trust; ~~**9.2** in the case of a non-executive Director of the Trust, a person so appointed may hold one or more additional non-executive directorships in other NHS bodies;~~	In 2015 the Council and Board agreed to remove the restriction on the appointment of Non-Executive Directors holding NED posts in other NHS bodies The amendment supports the position that the Trust would be able to appoint an Executive Director who is also an Executive Director of another NHS Trust. The future direction of NHS Trusts has seen the move towards the sharing of executive director posts in order to reduce cost and provide continuity. ***NB The Board of Directors have considered the amendment and approved the removal of the restriction on Executive Director posts at its meeting on 1 December 2017***
5.	Annex 7; 37	Quorum for a Council of Governors Meeting **Ten** governors shall form a quorum, at least **five** of whom must be Public Governors.	Quorum for a Council of Governors Meeting ~~Ten~~ Eight (8) governors shall form a quorum, at least ~~five~~ four (4) of whom must be Public Governors.	Given that we have been unable to recruit to the public constituency of Knowsley and the rest of England and Wales. The number of public governors available for the meetings of the

				council is 14 when all seats are filled. Currently there are 11 Public Governors.
6.	Annex 8; 31	The composition of the Board shall be: • A Non-Executive Chair • Not more than **six** other non-executive Directors	The composition of the Board shall be: • A Non-Executive Chair • Not more than ~~six~~ **seven** other non-executive Directors	Consistency brings the maximum number of NEDs on the Board in line with the main body of the constitution at 23.2.
7.	Annex 9; 7&8	Dispute Resolution Procedures 7. Every unresolved dispute which arises out of this constitution between the Trust and: • a member; or • any person aggrieved who has ceased to be a member within the six months prior to the date of the dispute; or • any person bringing a claim under this constitution; or • an office-holder of the Trust is to be submitted to an arbitrator agreed by the parties. The arbitrator's decision will be binding and conclusive on all parties. 8. Any person bringing a dispute must, if required to do so, deposit with the Trust a reasonable sum (not exceeding £100) to be determined by the Council of Governors and approved by the Secretary. The arbitrator will decide how the costs of the arbitration will be paid and what should be done with the deposit.	Dispute Resolution Procedures NEW Clauses 7&8 7. In the event of any dispute about the entitlement to membership, the dispute shall be referred to the Chair who shall make a determination on the point in issue. If the person in dispute is aggrieved at the decision of the Chair she may appeal in writing within 14 days of the Chair's decision to the Council of Governors whose decision shall be final. 8. In the event of any dispute about the eligibility and disqualification of a Governor the dispute shall be referred to the Council of Governors whose decision shall be final.	Advice received from the Trust Solicitors is that the Dispute Resolution Clause is not fit for purpose and creates confusion on how to implement the clause. It is recommended that the clauses are amended to make sure that any decision relating to member and governors is approved by the Council