Meeting of the Board of Directors
HELD IN PUBLIC
Friday 2 March 2018 at 1000 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			1000 (10mins)	caring
061	Apologies for absence Declarations of interest	Receive apologies	Verbal	Chair		-
062	Meeting guidance notes	To receive the meeting attendees' guidance notes	Written guidance	Chair		Well Led
063	Patient Story	To receive a patients story	Presentation	Acting Director of Nursing and Midwifery	1010 (20mins)	
064	Minutes of the previous meeting held on 2 February 2018	Confirm as an accurate record the minutes of the previous meetings	Written	Chair	1030 (5mins)	Well Led
065	Action Log and matters arising	Provide an update in respect of on-going and outstanding items to ensure progress	Written/verbal	Chair		Well Led
066	Chair's announcements	Announce items of significance not elsewhere on the agenda	Verbal	Chair	1035 (10mins)	Well Led
067	Chief Executive Report	Report key developments and announce items of significance not elsewhere	Verbal/Written	Chief Executive		Well Led

Item no. 2018/	Title of item	Objectives/desired outcome	Process	Item presenter	Time	CQC Domain
BOARD COMMITTEE ASSURANCE						
068	Chair's Report from Finance, Performance and Business Development Committee	Receive assurance and any escalated risks	Written	Committee Chair	1045 (10mins)	Well Led
069	Chair's Report from Quality 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						
070	Serious Incident Report Q3	Receive assurance and any escalated risks	Written	Medical Director	1055 (15mins)	Safe Well Led
TRUST PERFORMANCE - TO DELIVER THE MOST EFFECTIVE OUTCOMES; TO BE EFFICIENT AND MAKE BEST USE OF AVAILABLE RESOURCES						
071	Safer Nurse/Midwife Staffing Monthly Report 10	The Board is asked to note the content of the report	Written	Acting Director of Nursing and Midwifery	1110 (10mins)	Safe Well Led
072	Performance Report period 10, 2017/18	Review the latest Trust performance report and receive assurance	Written	Director of Operations	1120 (10mins)	Safe Well Led
073	Finance Report period 10, 2017/18	To note the current status of the Trusts financial position	Written	Director of Finance	1130 (10mins)	Well Led
TRUST STRATEGY						
074	Fit for Future Generations Update	To brief the Board on progress and risks	Verbal	Chief Executive	1140 (5mins)	All
BOARD GOVERNANCE						
075	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair		Well Led
HOUSEKEEPING						
076	Any other business	Consider any urgent items	Verbal	Chair	1145 meeting	Well Led

Item no. 2018/	Title of item	Objectives/desired outcome	Process	Item presenter	Time	CQC Domain
	& Review of meeting	of other business			ends	

Date, time and place of next meeting Friday 6 April 2018

Meeting to end at 1145

1145-1200	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

Liverpool Women's

16/077

Meeting attendees' guidance, May 2013

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

Before the meeting

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

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

At the meeting

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

Attendance

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

After the meeting

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

Standards & Obligations

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

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

Page 129 Handbook to the NHS Constitution 26th March 2013

Board Agenda item 2018/064

Board of Directors

Minutes of the meeting of the Board of Directors
held in public on Friday 2 February 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 Jenny Hannon	Director of Finance
Mr Ian Haythornthwaite	Non-Executive Director/Vice Chair
Dr Andrew Loughney	Medical Director & Deputy Chief Executive
Mrs Julie King	Acting Director of Nursing and Midwifery
Mr Jeff Johnston	Director of Operations
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
Mr Tony Okotie	Non-Executive Director/SID

IN ATTENDANCE

Mr Colin Reid	Trust Secretary

APOLOGIES

Mrs Michelle Turner	Director of Workforce & Marketing

NB During the meeting a number of matters were taken out of sequence. The minutes have been produced taking this into account

2018	
	Thank You The Chief Executive provided a thank you on behalf of the Board to Gill Scanlon, Clinical Lead & Theatre Co-ordinator and David Pasco, IM&T. The Chief Executive advised the Board that Gill had joined the Hospital as when it was at Mill Road in 1987 and enrolled as a scrub nurse. Gill had always had the best interest of the patients the Hospital treats at heart in all that she does. She thanked Gill for her service with the Trust and hoped she enjoys her well-earned retirement. The Chief Executive turned to David Pasco and thanked him for his help over the previous weekend when he was asked to drop what he was doing in his own personal time to undertake an urgent request for a court hearing on the Monday following the weekend. She felt that both encapsulated the essence of staff working at the Trust that was always willing to go above and beyond.
032	**Apologies** – as above. **Declaration of Interests** – None **Welcome:** The Chair opened the meeting and welcomed Jenny Hannon to the Board in her new role of Director of Finance and Andrew Loughney in his role as Medical Director and Deputy Chief Executive.

033 Meeting guidance notes

The Board received the meeting attendees' guidance notes.

034 Palliative and End of Life Care

Chris Webster, Macmillan CNS and Lead cancer nurse presented her paper on Palliative and End of Life Care and in particular explained where the Trust was in delivery of the national strategy ambitions; Ambition 1 "Each person is seen as an individual"; Ambition 2 "Each person has fair access to care"; Ambition 3 "Maximising comfort and wellbeing"; Ambition 4 "Care is coordinated"; Ambition 5 "All staff are prepared to care"; and Ambition 6 "Each community is prepared to help". She explained that the strategy seeks to be shaped around individual care. Referring to the key enablers, Chris Webster advised that this included the IT systems (EMIS, EPaCCS, PENS, EPR); understanding patients' experiences; and education and training which she felt was key to delivering the most appropriate care to patients. Chris Webster advised that having an understanding not only of the patients experience but also the families experience supported the delivery of the best possible care to patients and to bereaved families.

Referring to potential risks, Chris Webster advised that there needed to be succession plans in place to support the loss of Dr Leslie Allsopp should she decide to leave the post and herself who was due to retire at the end of the year. With the potential that the Trust would be moving to another site and the possible amalgamation of service providers and services she felt that the Trust could be at risk of taking a step back from where it currently was. The Chief Executive thanked Chris Webster for her presentation and thanked her on behalf of the Board for her and Dr Allsopps work in delivering to patients the care they were afforded. In response to a question from Ian Haythornthwaite on the risks of amalgamation, Chris Webster advised that presently she and Dr Allsopp were able to provide education to staff in the Trust on a 1:1 basis which helped in getting across the importance of EOLC, she felt that this would not be delivered on the same basis in a bigger organisation due to the nature of illnesses and requirements of ELOC in an acute setting.

The Chair thanked Chris Webster for her presentation and felt that the Board needed to continue to be sighted on the risks going forward.

035 Minutes of previous meeting held on Friday 12 January 2018

The minutes of the meeting held on 12 January 2018 were approved.

036 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.

043 Quarter 3 Mortality Report

Devender Roberts, Associate Medical Director presented the Quarter 3 Mortality Report and explained that the Report details how the Trust was meeting the requirements laid down by the National quality Board and CQC and provides details of mortality within the Trust during Quarter 3 of 2017-18. The Associate Medical Director advised that the Report concludes that there was evidence available that progress was being made in meeting the national requirements and that mortality rates were within expected ranges. The Associate Medical Director advised that the report was overseen by Effectiveness Senate and Quality Committee within the Trust governance structure.

Referring to the section on prevention the Board noted the number of Trust wide policies and SOPs that required review had reduced in number from the previous report however it was felt that by the next report there should be no Trust wide policies and SOPs that were out of date. The Associate Medical Director advised that she would seek to address the out of date policies and SOPs with the Governance team.

Referring to the in hospital deaths, the Associate Medical Director advised that a review of each had been undertaken. She explained the process of the review and reported that all adult gynaecology deaths would be discussed at the Gynaecology Morbidity & Mortality meeting and that as part of this process an adult mortality sheet would be completed indicating any potential areas for improvement in care to support learning. All unexpected adult gynaecology deaths trigger a serious incident investigation as would all direct maternal deaths trigger serious incident investigation and the learnings from these deaths would feed through the SI process.

The Associate Medical Director advised that the new mortality review tool had been developed that allowed for reporting risks and incidents through the reporting system Ulysses. She advised that this avoided retention of paper documents (which was the current system) and allowed for better searching, monitoring and auditing.

Referring to the out of hospital deaths for 2017/18, the Associate Medical Director advised that there were two maternal deaths reported externally via MBRRACE-UK national reporting system; both were due to indirect causes. She reported that work was ongoing with other trusts in developing an alert process of expected or unexpected deaths of patients who had previously been under the care of the Trust and advised that Aintree Hospital had already agreed to be part of the alert system.

The Director of Finance, referring to the in hospital deaths, recognised the work of the EOLC team and asked whether there was any linkage to patients going home to die and therefore classified as out of hospital deaths. The Associate Medical Director advised that she would look into this and report if there were any linkages. Phil Huggon asked whether the Trust was able to benchmark in order to garner additional learning. In response the Medical Director advised that the Trust would need to gather data from other trusts as there was no national benchmarking data. He explained that gathering such data would be difficult as there were no exact comparator trusts to benchmark against. The Chief Executive felt that the reporting and learning from deaths had massively improved from what was reported previously and learning was being identified. She recognised however that the numbers of deaths were extremely low and therefore it was important to also look at avoidable harm.

Tony Okotie felt that it was important that all policies are up to date as they were in place to avoid harm to patients. He felt it was therefore important that the Trust should get a grip on policies and SOPs so that none fell outside of their respective review dates without good reason. The Board supported this view and expected to see a much improved reported position next quarter as indicated by the intentions of the safety senate.

The Chair thanked the Associate Medical Director for her report which was noted.

Referring to a presentation on the Mortality toolkit the Board noted that this would now take place at a later date.

037 Chair's Announcements

The Chair was pleased to report the positive comments he had received from Governors regarding the setting up of the Governor groups that mirrored the Board Committee structure. He felt that the Groups allowed Governors the opportunity to discuss, Quality, Patient Experience, Finance and Trust performance in smaller groups allowing for a more in depth understanding; this had a positive impact on the operation of the Council.

The Chair advised on the meetings arranged with the Boards of The Walton Centre NHS Foundation Trust and Liverpool Heat and Chest NHS Foundation Trust to explain the Trust's Future Generations Strategy.

The Board noted the Chair's verbal update.

038 Chief Executive's report

The Chief Executive reminded the Board that the Staff Dedicated to Excellence awards were to be held on 20 April 2018 and asked all Board members to clear their diaries so that they could attend the event.

The Chief Executive advised that the Trust had received letter of congratulations from the Rt Hon Jeremy Hunt MP, Secretary of State for Health regarding the Trust's improved performance in diagnostics.

The Board noted the Report from the Chief Executive.

039 Chair's Report from Quality Committee

Susan Milner, Chair of the Quality Committee highlighted the work of the Committee at its meeting on 15 January 2018. Referring to the MIAA Quality Spot Check follow up report 2017/18, Susan Milner advised that the Committee had received assurance that there had been significant improvements made in clinical areas.

Susan Milner referred the Board to the paragraph relating to the annual stillbirth report 2016/17 and a Trust response to the MBRRACE UK national report. She reported that the Committee had been advised that due to the nature of the speciality it was difficult for the Trust to accurately compare against other providers and consequently was identified as an outlier within the MBRRACE UK report. Susan Milner advised that the Committee had received assurance that after the review the Trust was demonstrating good standards of practice and variations were due to case mix.

Referring to the matters to highlight to the Board, Susan Milner advised that there was a risk relating to not having a Paediatric Resuscitation Policy in place at the Trust. The Committee received assurance from the Medical Director that the risk had been escalated to the corporate risk register and that there was progress in putting in place the policy. She advised that the Committee had requested a progress update from the Safety Senate to ensure action was taken swiftly.

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

040 Chair's Report from Finance, Performance and Business Development Committee (FPBD)

Jo Moore, Chair of FPBD presented the Chairs Report of the FPBD covering the meeting held on 22 January 2018 and ran through the main items discussed and where assurance was obtained.

Jo Moore referred to the concern within gynaecology in terms of ensuring that sufficient clinical capacity was available to book patients and that the CQUIN sepsis position remains a concern. The Committee understood that plans were in place to recover the position and it was noted that there was no further financial consequences as this had already been provided for in forecasted position. Jo Moore referred to the recent transformational changes undertaken and the Committee was assured that there was no link between the current sickness within the Operations Team 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 and a number of staff had stepped forward to support the initiative.

Jo Moore advised that the Trust would outperform the full year control total for 2017/18 by £0.3m which would be matched by an equivalent amount of STF incentive funding leading to an overall forecast deficit of £3.4m. Cash requirement for the financial year was less than planned.

Jo Moore advised that given the improvement in the forecast year end position the Committee agreed to recommend that the BAF risk in relation to Failure to deliver the Annual Financial Plan 2017/18 should be reduced from risk score of 20 to 15. The Board agreed the change in risk score on the BAF relating to the 'Failure to deliver the Annual Financial Plan 2017/18', recognising the improved forecasted position for the financial year.

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

041 **Chair's Report from Audit Committee**

Ian Knight, Chair of the Audit Committee presented the Chairs Report covering the meeting held on 22 January 2018 and ran through the main items discussed and where assurance was obtained.

Ian Knight advised that the Committee had received an updated position on follow up of Internal Audit and External Audit Recommendations and noted that a communication had been issued to all staff involved in the Internal Audit process stressing the importance of only closing recommendations on the 4Action system when they had been implemented and where there was evidence to support the closure. He advised that there had been a small number of cases where this had not been the case. The Committee also noted that two recommendations from the IT Resilience and Recovery audit had been allocated as high risk. Assurance had been received that these risks would be monitored at the Executive Committee to ensure that they were implemented by the agreed deadlines.

Ian Knight confirmed that, as the overarching Board committee, the Committee had been informed that a full review of BAF content was underway to address any gaps, misstatements and action plan updates by the executive and each Board Committee. He stated that it was important that the Board committees were responsible to the Board to comprehensively review the BAF risks aligned to them. Referring to the EPR programme reported under the FPBD agenda item, Ian Haythornthwaite recognised the significant risks of implementation of the new systems and the importance of staff available to support implementation together with the training of staff. He felt that there was a significant risk that would need to be articulated. The Chair noted that the Board would be receiving an update on EPR at the next Board session and felt it important that the risks were articulated in the update.

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

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

Tony Okotie, Chair of PPF presented the Chairs Report covering the meeting held on 26 January 2018 and ran through the main items discussed and where assurance was obtained.

Referring to the concerns expressed in the other Board Committees regarding Gynaecology, Tony Okotie felt that the Board needed to be sighted on the issues in one place and asked the Chair if a paper could be brought to the next Board.

Action 2018/042: The Director of Operations to bring a paper to the Board that provided sight on the overarching concerns identified within Gynaecology and actions to be taken.

Referring to the remainder of the Report, Tony Okotie advised that since the last meeting there had been no lapses in nursing professional registration and felt the work done by the Trust to highlight the importance of personally keeping up their registrations was working well.

Tony Okotie advised that the Committee had received an overview of the draft Health and Workforce

Strategy produced by Health Education England as reported in the Chief Executive report at the last Board meeting. He advised that Committee members had been asked to provide feedback and that in order to get a collective Trust response the Strategy was being shared at clinical forums.

Tony Okotie referred to the poor uptake of leadership development programme and advised that the Committee had requested more detailed information surrounding staff attendance.

Referring WRES, Tony Okotie advised that the Trust was, in comparison to other local Trusts, performing favourably and that a WRES action plan was being monitored by the Diversity and Inclusion Committee. With regards to EDS, Tony Okotie advised that the Committee had received an update on progress to date in achieving the EDS2 outcomes. He advised that the Trust had identified a staff member to undertake the role of E&D advisor for workforce E&D within the HR team and that two clinical leads within the nursing workforce had also been identified to take forward a patient action plan. Tony Okotie advised that the Trust would be assessed on its EDS2 outcomes by a group including HealthWatch, Staff and Staff Side representatives by September 2018. He reported that the Committee was assured that the Experience Senate would be monitoring the EDS2 action plan to ensure progress.

The Medical Director reported on a recent manslaughter case against a doctor which included access to revalidation and appraisal documentation as part of the case to identify any concerns regarding the professional performance of the Doctor. He advised that there was some concern regarding the access to such data by the courts and this concern would be addressed with the Revalidation Associate Medical Director and if appropriate taken through the relevant committees once the matter had been investigated further.

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

044 Safer Nurse/Midwife Staffing Monthly Report Period 9

The Acting Director of Nursing and Midwifery presented the Month 9 Safe Staffing report and advised that the data presented in the report demonstrated the effective use of current Nursing & Midwifery resources for all inpatient clinical areas. She reported that 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 and that all errors were investigated and appropriate action taken; the error had resulted in harm to any patient.

The Acting Director of Nursing and Midwifery reported that care hours per day remained at a sustained level indicating a consistent level of care nursing/midwifery resource to provide care to the Trust's patients with staffing across the inpatient ward areas for November 2017 were appropriate to deliver safe and effective high quality family centred patient care day and night. The Board noted that the information relating to falls reported at the last meeting had been included in the report.

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

045 Performance Report Period 9 2017/18

The Director of Operations presented the Performance Report for period 9 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 would be delivered after reallocation had taken place for the quarter.

Referring to the content of the report following the implementation by NHSI of the single oversight framework, the Director of Operations advised that he did not recommend any changes to the indicators currently reported and felt that they continued to be the most appropriate indicators for

the Board to have oversight of. He advised that the report would be amended to include additional indicators requested by NHSI as set out in the report.

Referring to the emerging concern highlighted in previous reports; gynaecology patient access and Nursing indicators both were not performing as strongly as expected. He advised that dates had been agreed for the Head of Nursing and Matron to return to work in January and February respectfully and that there was a plan developed with the service improvement manager to improve overall performance in quarter 4 and the beginning of quarter 1 of the new year. The Board noted the emerging concern and recognised that an action had been placed on the Director of Operations to present a paper to a Board session on the issues within Gynaecology and what actions were being taken to address them so that the Board would be fully sighted of them.

The Board noted the Performance Report for period 9 2017/18 report.

046 Financial Report & Dashboard Period 8 2017/18

The Director of Finance presented the Finance Report and financial dashboard for month 9, 2017/18 and reported that at Month 9 the Trust was £0.066m favourable against the planned £3.390m deficit, and was forecasting delivery of the full year control total following receipt of the £3.2m STF.

The Director of Finance reported that the Trust delivered a "Use of Resources" Rating of 3 in month which was equivalent to plan. She explained that the Trust's activity continued to be below block contract activity levels as discussed in previous meetings, however highlighted the volatility of Maternity which saw a significant increase in activity from what had been reported in November. She felt with this increase in activity in Maternity that by the end of the year maternity activity may balance out. This was not the same for Gynaecology noting the concerns expressed at the Board committees and earlier in the meeting.

The Chair thanked the Director of Finance for presenting the Financial Report & Dashboard Period 9 2017/18 which was noted together with the changes to the BAF risk score.

047 Fit for Future Generations Update

The Chief Executive provided a verbal update on future generations and reported that there was little to report. She advised that meetings had been held with the CCG to receive assurance that the trust and the CCG were continuing to progress to public consultation as soon after the local elections in May. David Astley asked if the STP leadership were on board with the Trust's direction of travel. The Chief Executive advised that this was her view and that noted the support of the STP Chief Executive and referring to the STP Chair's agreement to visit the Trust.

The Board noted the position.

048 Changes to Trust Constitution

The Board received the report that outlined amendments to the Trust constitution that had previously been approved by the Council of Governors at its meeting on 24 January 2018.

The Board approved the amendments.

049 Review of risk impacts of items discussed

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

- The need for a Paediatric Resuscitation Policy to be in place
- Gynaecology Service concerns expressed through the Board and each Board committee
- EPR impact on staff training needs
- Uptake of leadership development programme reported in the PPF Chairs Report

050 Any other business & Review of meeting

The Director of Nursing and Midwifery advised that she had now undertaken the Caldecott Guardian training and had fully assumed the role for the Trust.

The Board enjoyed frank and challenging discussion on items presented.

Date of next meeting

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

Agenda Item 2018/065

Liverpool Women's NHS Foundation Trust

TRUST BOARD
2 March 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~~ 4 May 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. *The Board extended the presentation of the toolkit to a later date to allow for bedding in of the process.*
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
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.
2 Feb 2018	2018/042	The Director of Operations to bring a paper to the Board that provided sight on the overarching concerns identified within Gynaecology and actions to be taken.	Director of Operations	3 March 2018	This action will be discussed at a session of the Board on 3 March 2018.

	Completed actions: concluded before the next board or on the agenda of the next Board
	In Progress - either at Committee stage or awaiting presentation at Board or Board workshop
	in progress - missed original deadlines agreed at Board

Agenda Item	2018/067

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Chief Executive Report**
DATE OF MEETING:	Friday, 02 March 2018
ACTION REQUIRED	**For Discussion**
EXECUTIVE DIRECTOR:	Kathy Thomson, Chief Executive
AUTHOR(S):	Colin Reid, 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 FUNDAMENTAL STANDARDS	***Which standard(s)?*** **1.** SAFE ☒ **2.** CARING ☒ **3.** RESPONSIVE ☒ **4.** EFFECTIVE ☒ ***5.*** WELL LED ☒
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 content of the Chief Executive's Report***	
PREVIOUSLY CONSIDERED BY:	**Committee name**	Not Applicable Or type here if not on list: ***Click here to enter text.***
	Date of meeting	***Click here to enter a date.***

Executive Summary

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

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

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

Kathy Thomson.
Chief Executive.

Report

SECTION A - INTERNAL

Apprentice Employer Award: The Trust has been selected as the winner of an Apprentice Employer Award by Southport College and will receive the award at the Apprentice Star Award Ceremony on 13 March 2018. Special thank you to Anne Bridson, Learning and Development Facilitator who manages the apprentice schemes at the trust.

Gender Pay Gap Reporting: The Trust is on target to meet the deadline of 30th March and meet its statutory duty to publish gender pay gap data. The information to be reported is:

- Mean gender pay gap
- Median gender pay gap
- Mean bonus gender pay gap
- Median bonus gender pay gap
- Proportion of males and females receiving a bonus
- Proportion of males and females in each quartile band

A modification has been undertaken in ESR to enable trusts to pull this data from the system. Data will be published on the Trust website and on the government data reporting service in line with reporting requirements.

General Data Protection Regulation (GDPR): GDPR the enabling European Directive will see the implementation of a replacement for the Data Protection Act 1998. The new legislation will becomes law on the 25th May 2018. Generally the GDPR will require all staff to:

- Ensure timely reporting of data breaches as soon as they become aware
- Ensure that all information processing is lawful and in line with Privacy Notices

- Ensure that privacy is considered as an inherent part of any initiative or project

To support staff with the requirements of the new legislation a new Intranet page will be populated.

Electronic Patient Record: The Trust will be implementing a new EPR system "TrakCare" as a replacement for MediTech and is scheduled to go-live in October 2018. The system will replace every module MediTech currently provides.

SECTION B – LOCAL

SECTION C - NATIONAL

NHSI/NHSE: Annual planning guidance has been published

At the NHSI Board meeting, the chair summarised developments in the closer alignment of the work of NHS England (NHSE) and NHS Improvement (NHSI), including one initiative to have cross representation on each other's boards.

The NHSI board has appointed David Roberts (deputy chairman, NHSE) as a non-voting associate NED on a two year term from February. Richard Douglas (NED, NHSI) will join the NHSE board in a similar capacity. Richard and David will co-chair the NHSE/NHSI Joint Finance Committee to ensure that both organisations have a common understanding of the financial targets and performance of the health system as a whole.

NHSI and NHSE intend to have two joint board meetings in 2018, which are planned for May and September.

Liverpool Women's NHS Foundation Trust

Board of Directors

Committee Chair's report of Finance, Performance and Business Development Committee meeting held 19 February 2018

1. Was the quorate met? Yes

2. Agenda items covered

~ Month 10 2017/18 Operational Performance: The Committee received Month 10 performance dashboard. The Committee was formally briefed on a cancer target reporting incident which has been reported via STEIS. A full SUI review will be undertaken which will include an external independent investigating officer and an external cancer manager on the panel.

~ Month 10 2017/18 Finance Performance Review: The Committee received Month 10 2017/18 finance position, and noted an overall forecast deficit for the year of £3.4m. The Committee noted the block shortfall projected as £3.4m across all services for the full year. It was acknowledged that this shortfall is expected to be covered by the Acting as One arrangement in 2018/19 however it poses a risk into 2019/20. The Committee was informed that the Trust had made a submission to draw down £1.5m of Distressed Financing in month 12 taking the full drawdown for the year to £2m, as previously reported.

~ Operational Planning Update 2018/19: The Committee noted that the Trust had received a control total for 2018/19 from NHSI. It was reported that under current planning assumptions the control total is unachievable for 2018/19. Executive led discussions with the CCG and NHSI will continue to negotiate for a control total that reflects the true costs during 2018/19. The Committee discussed the consequences of not signing up and agreeing to the control total. The draft plan will be presented to the Board of Directors on 2 March 2018 and is due to be submitted to NHSI on 8 March 2018.

~ Cost Improvement Programme Update 2018/19: The Committee received an update of progress against the 2018/19 CIP schemes which are being managed via the Turnaround and Transformation Committee. The internal governance processes will continue to be followed for all 2018/19 schemes. The Committee noted the proposal to launch the MARS scheme for early 2018/19, and the requirement to permanently remove a post from the establishment to deliver savings for those applications accepted. There was a discussion with regards to the types of schemes identified and the necessity to review all potential schemes.

~ IM&T Update: The Committee received an updated position with regards to GDPR, Resilience, EPR and GDE Fast Follower. The Committee noted the outcome from an MIAA audit review of resilience and acknowledged a Trust review in response to this recommendation. The Committee noted the assurances that Trust processes are robust and are compliant with numerous ISO standards. It was noted that as it was the first IM&T audit conducted with MIAA it had identified learning between the Trust IT department and the auditors who will be conducting IM&T audits in the future. It was recommended to the Committee to introduce a new BAF risk on EPR due to potential risks to financial cost, operations and patient safety. It was agreed that the Board of Directors would have a discussion on key issues, risks and milestones associated with delivering EPR in March 2018.

~ Neonatal Capital Build Award: The Committee received an update of the process undertaken to date to appoint a principle supply chain partner under the Department of Health's ProCure 22 National Procurement Framework. The Committee was advised that the procurement protocol dictates that the Trust must award the contract to the most economically advantageous tender based on the scoring. The Trust sought further due diligence with respect to the company that was ranked first following the selection exercise. It was recommended that the Committee should

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support an initial appointment to proceed with the design and market testing stage only; purchase a construction performance bond; and continue with the appointment of a Trust own project management team to oversee the project.

- **Liverpool Women's Health Consultancy Business Development Update:** The Committee received an update of consultancy activities and collaborative discussions. It was noted that initial enquiries for consultancy support have been received from the Birla Hospital Group in India.
- **Overseas Visitor Policy:** The Committee reviewed the policy. It was recommended that a section on GDPR rules should be included. It was also advised that costs associated with neonatal care should be clarified as there is currently no reference. The Committee approved the policy subject to the queries being addressed.
- **Sub Committee Chairs reports received**
  - Turnaround and Transformation Committee held 29 January, 5 & 12 February 2018
  - Emergency Planning Resilience and Response Committee held 5 February 2018
  - Digital Hospital Sub-Committee held 25 January 2018

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. Following a review of the BAF risks a number of changes had been made to the narrative prior to circulation to the Committee however no changes have been recommended to the risk scores.
- It was recommended to the Committee to introduce a new BAF risk on EPR due to potential risks to financial cost, operations and patient safety. It was agreed that the Board of Directors would have a discussion on key issues, risks and milestones associated with delivering EPR in March 2018.

4. Escalation report to the Board on FPBD Performance Measures

- Cancer target reporting incident: Committee received a detailed briefing and noted a planned SUI review to be undertaken including external panel representation. The outcome of the SUI to be shared with the Board upon completion.

5. Issues to highlight to Board

- Financial and Operational Planning 2018/19: Note the revised control total at February 2018 and the steps taken to have this amended in light of the Trust's clinical case for change. Board will receive the draft plan at its March meeting.
- Electronic Patient Records (EPR): In addition to introducing a new BAF risk in relation to EPR, it was recommended that the Board of Directors have a session on key issues, risks and milestones associated with delivering EPR at the meeting on 2 March 2018.
- Neonatal Capital Build Award: The Committee supported the proposal to instruct an initial appointment to proceed with the design and market testing stage only; purchase a construction performance bond; and continue with the appointment of a Trust own project management team to oversee the project.

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 Quality Committee (formerly GACA) meeting held 19 February 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 reviewed and approved a new template for sub-committee chair reports, and requested a further addition of 'learning demonstrated'. It was recommended that this section should also be introduced to the Board Committee Chair's report.
- **Quarter 3 Serious Incident & Learning Report:** It was noted that the Committee did not receive a quarterly report but received a bi-monthly report as per previous reporting schedules. It was confirmed that there had been zero never events during this reporting period. The Committee noted that the CCG had introduced monthly meetings with the Trust to review and close off serious incidents more timely. Reports would now be presented quarterly.
- **Quality and Regulatory Improvement Requirements:** The Committee noted that the Care Quality Commission (CQC) had conducted an unannounced inspection visit late January 2018. No further unannounced visits have taken place however they are anticipated. The Committee noted that the CQC Well-led inspection is planned for 26-28 February 2018.
- **Draft Research and Innovation Strategy:** The Committee received an updated strategy and was asked to feedback any comments to the Medical Director. The Committee considered the gap of nursing and midwifery senior leadership within research and development. The Committee supported the approach that research and innovation should become everyone's responsibility to drive forward. The final strategy would be submitted for approval to the Board of Directors on 2 March 2018.
- **Quarter 3, Safety, Effectiveness & Experience Report (SEE):** The Committee noted key elements from the SEE report including PALS & complaints, incident reporting, friends and family test, litigation and health and safety. The Committee supported a review of the SEE report to develop the content into a triangulated report to provide comprehensive analysis across all areas of governance and demonstrate lessons learnt.
- **Quality Performance Dashboard Report – Month 10:** The Committee received Month 10 2017/18 performance dashboard. The Committee was formally briefed on a cancer target reporting incident which has been reported via STEIS. A full SUI review will be undertaken which will include an external independent investigating officer and an external cancer manager on the panel.
- **Review of Quality Strategy Quarter 3:** The Committee reviewed the progress update against the Quality Strategy. It was agreed to reformat the report to clarify its link against the Quality Strategy. The Committee was assured by progress to date.
- **Review of Quality Sub-Committee Terms of Reference:** The Committee reviewed its sub-committee terms of reference and approved the terms of reference for the Safety Senate, Effectiveness Senate and the Experience Senate. It was noted that a formal review of the terms of reference for Corporate Risk Committee and Hospital Safeguarding Board will take place in March 2018.
- **Quarter 3 Adult Mortality Report:** The Committee received for information only, as previously considered by the Board of Directors in February 2018.

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3. Board Assurance Framework (BAF) risks reviewed

~ The Committee reviewed the quality related BAF risks it is responsible for on behalf of the Board. Following a review of the BAF risks by the Director of Nursing and the Head of Governance a number of changes have been made to the narrative however no changes have been recommended with regards to the risk scores.

~ The Committee noted the introduction of a new BAF risk relating to the implementation of Electronic Patient Records (EPR) due to potential risks to finances, operations and patient safety. It was noted that the Executive Committee are considering the narrative and positioning of this risk and would submit a recommendation to the Board of Directors in March 2018, as part of a wider discussion on the key issues and risks associated with delivering EPR. It was acknowledged that the BAF risk could be reported to the Quality Committee or the FPBD Committee.

4. Escalation report to the Board on Quality Committee Performance Measures

~ Cancer target reporting incident: Committee received a detailed briefing and noted a planned SUI review to be undertaken including external panel representation. Committee supported Trust action to contact patients as per Duty of Candour requirements as soon as possible.

5. Issues to highlight to Board

~ Electronic Patient Records (EPR): The Committee supported the introduction of a new BAF risk in relation to EPR and recommended wider Board discussion to clarify the risk narrative and positioning of the risk, however would request that Quality Committee has oversight over the patient safety elements.

~ Amendment to Board Committee Chairs reports: After review of the sub-committee chairs report template the Committee recommends that a section on 'learning identified at meeting' be added to the Board Committee Chair reports.

6. Action required by Board

None

Susan Milner
Chair of Quality Committee

Agenda Item	2018/070

MEETING	**Trust Board**
PAPER/REPORT TITLE:	**Serious Incident Report – Quarter 3**
DATE OF MEETING:	Friday, 02 March 2018
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Andrew Loughney, Medical Director
AUTHOR(S):	Christopher Lube, Head of Governance
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):	2. This report will not be published under the Trust's Publication Scheme due to exemptions under S21 of the Freedom of Information Act 2000, because the information contained is reasonably accessible by other means			
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	***Note the contents 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.***	

Executive Summary

There were 7 serious incidents (SI's) declared on the StEIS system as per NHS England StEIS reporting criteria during 2017/18 Q3.

Of the 7 SI's reported on StEIS, 2 of these related to Pseudomonas Infection in 2 babies at the same time on the NICU. This has been investigated and identified that the strain of infection were not the same, so there was no direct link between the babies. The NICU underwent comprehensive environmental screening and no significant issues were identified. The Director for Infection Control has been closely involved in the whole investigation and review of these cases. There were no other trends in this timeframe.

The StEIS incident 2017/28257 was initially classed as a SUDI, but following a recent coroner's inquest this has now been downgraded and confirmed as death due to natural causes. This will now allow for the Trust SI investigation to progress as it has been on hold due to the possible SUDI and police involvement.

Report

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

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

Internally, Serious Incidents are managed operationally through the Safety Senate and through the Quality Committee (previously GACA).

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

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

The table below provides a brief overview of the StEIS serious incidents reported in the quarter and their current status.

Service	StEIS Ref.	Ulysses Ref	StEIS Reported Date	StEIS Reporting SBAR	StEIS Report Due Date
Gynaecology	SI2017/25770	52070	19/10/2017	SBAR W1396338 52070.docx	16/01/2018 extension to 05/02/2018.
Neonatal Unit	2017/25780	52071	19/10/2017	SI 201725780 -72 Hours Report FINAL.(	16/01/2018
Neonatal Unit	2017/26912	51895	02/11/2017	SI 2017-26912 Rapid Review .docx	29/01/2018
Neonatal Unit	2017/26922	52318	02/11/2017	SI 2017-26922 Rapid Review.docx	29/01/2018
Gynaecology	2017/28102	52566	15/11/2017	72 Hours Report 52566.docx	12/02/2018
Maternity	2017/28257	52560	17/11/2017	72 Hours Report 2017 SUDI 15 11 17.(	14/02/2018

Maternity	2017/29856	52738	06/12/2017	72 Hours Report 2017.docx	05/03/2018

Lessons learnt from serious incidents submitted in Q3 2017/18

During the Q3 period a total of 3 SI's have had final reports submitted to the CCG for consideration and request to close the incident on the StEIS system.

Service	StEIS Ref.	Ulysses Ref	StEIS Submitted Date	Report & Action Plan
Maternity	2017/15940	49506	16/10/2017	Final draft report 2017 15940.pdf
Gynaecology	2017/22885	51336	07/12/2017	SI Report 2017_22885 FINAL 0
Neonatal Unit	2017/25780	52071	16/01/2018	SI2017-25780 Report and Action Pla

Overview

There were 7 SI's reported in Q3 making a total of 20 SI's reported for the year to date for 2017/18. This is a decrease as compared to the same period in 2016/17 where 27 SI's were reported. The following table shows the trend in SI's numbers in the Trust the all quarters in 2016/17 and the first 3 quarters in 2017/18

Year	Quarter	Total
2016/17	1	7
	2	5
	3	13
	4	4
	2016/17 Total	**29**
2017/18	1	6
	2	7
	3	7

Duty of Candour

As reported in the previous reporting period, MIAA conducted an audit of patient records looking for documented evidence of the completion of duty of candour where an incident with reported moderate, severe or catastrophic harm occurred. Three actions were agreed from this and the following progress made.

Medical staff have been reminded of their responsibilities in relation to Duty of Candour.

The Legal services team in conjunction with Hill Dickinson have commenced a training programme with a first session being held as part of the 'Great day' and with further sessions planned for January.

The Governance team have evidenced the Ulysses feature and procedure for recording Duty of Candour on the system including the associated user guide and have drafted a specific record sheet for Duty of Candour in the patient record.

Conclusion

The report which has been presented, provides an update as to the number of SI's reported on StEIS and clearly demonstrates that the Trust continues to have an open culture of reporting and a robust process of investigation and provision of final investigation reports to the CCG, which provide clear root causes and lesson learnt.

Recommendation

It is therefore recommended that the Board note the contents of this paper and take assurance as to the robust process in place for the reporting and investigation of SI's.

Agenda Item	**2018/071**

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Safer Nurse/Midwife Staffing Monthly Report**
DATE OF MEETING:	2 March 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 **2.** Operational Plan **3.** NHS Compliance	☐ ☐ ☒	**4.** NHS Constitution **5.** Equality and Diversity ***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. The monthly report identifies staffing fill rates to demonstrate nursing and midwifery and care support levels. Fill rates of 100% mean that all planned staff were on duty. Fill rates of greater than 100% represent increased staffing levels to meet unplanned demand to meet patient care needs.

Fill rates of less than 100% reflect unplanned sick leave, vacancy or when staff are moved to work in another clinical area of greater clinical needs, due to low occupancy rates on their own area, or where by demands are greater in another clinical area.

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.
- Trust wide review of nursing flags and red indicators, and reporting mechanism.
- ACE incident submissions related to staffing and red flags, related to staffing are monitored daily to act as an early warning system and inform future staffing 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 97.43% day time, 99.97% night time, the average fill rate non registered staff 99.8% day time, 88.1% night time trust wide. Maternity division displayed the lowest fill rate due to a seasonal spike in short term sickness, coupled with long term sick and maternity leave, agreements in place to recruit to cover maternity leave.

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 2 red flag incidents, reported under the nursing/midwifery red flag staffing criteria, one for maternity services in relation to lack of a midwifery examination of the new born midwife for one 7.5 shift, the other was reported by neonatal services but involves lack of support from Health

Visitor liaison service managed by the Local authority (not a true LWH red nursing flag), both managed appropriately and no harm to patients were noted.

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 third 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 January, 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. Recruitment, in maternity is on going to cover maternity leave.

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 (%)
Jan-18	Gynaecology	99.3%	96.63%	100.00%	100.00%

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 (%)
Jan-18	Induction&Delivery Suites	78.7%	114.5%	85.6%	81.7%
	Maternity Base	84.7%	84.5%	88.0%	89.2%
	MLU & Jeffcoate	78.5%	109.7%	84.4%	106.5%
	Maternity Total	80.3%	95.2%	85.9%	88.5%

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 (%)
Jan-18	Neonatal Care	112.7%	108.1%	113.5%	75.8%

Agenda Item	2018/072

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	Performance Dashboard Month 10
DATE OF MEETING:	2 March 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. NHSI Targets – Access Targets including Cancer targets

There have been two incidents reported via STEIS with regard to the reporting of cancer and referral to treatment performance indicators. This has been reported to NHSI, NHSE and the host commissioner and the cancer targets have been discussed at FPBD and the Quality committee. A Serious Untoward Incident review panel is currently being arranged. Preliminary investigations into the cancer target breach have included a harm review by the Clinical Director for gynaecology that concluded no harm to patients. This will be further reviewed at the cancer multi-disciplinary team. All patients affected by this have been written to, to provide reassurance and offer them a further discussion if they wish.

In January the Trust has not achieved the 62 day Cancer Target before reallocation due to one breach on a LWH pathway and 2 late referrals. Two of these patients had extremely complicated pathways and co morbidities-

The patient treated on day 119, initial pathway delay in diagnosis as couldn't tolerate outpatient hysteroscopy and was requested further anaesthetic review for general anaesthetic (resulting in 57 days delay 1st pre-op to TCI), only 9 days for result to come back, then subsequent delay clearing pre-op for surgery (26 days pre-op to TCI).

The patient transferred to CCC on day 116, patient seen @ LWH and was keen for surgery but an anaesthetic risk. Key delays, patient delayed initial LWH appointment delayed by patient (14 day), anaesthetic review (12 days).

All delays for Anaesthetic reviews are linked to extra specialist opinions ie, Cardiologists

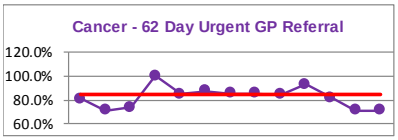
Due to the two late referrals the Trust has also failed the 42 day referral target to another Trust (referrals received day 56 and day 53)

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.

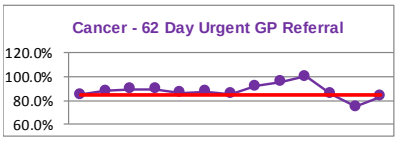
Unfortunately, there remains a potential for patients to be referred late. However, all patients who are treated after day 62, undergo full RCA which includes clinical review and involves originating Trusts. These RCA's are then reviewed with our commissioners to support originating Trusts with their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

From the current performance it is unlikely that the Trust will achieve the target after re-allocation in January. The review from the STEIS and further work with the tracking and cancer team is already underway to provide assurance for the future.

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	Jan-18
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%	71.4%
Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

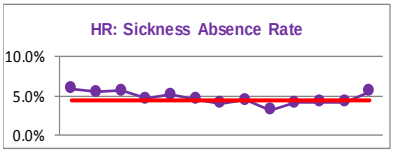


All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (After Re-allocation) Provisional Position	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
Actual	85.0%	88.2%	89.5%	89.5%	86.4%	87.5%	85.7%	92.3%	95.7%	100.0%	85.7%	75.0%	83.3%
Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%



2.1 Sickness

HR: Sickness Absence Rate	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
Actual	5.9%	5.6%	5.7%	4.6%	5.2%	4.6%	4.1%	4.5%	3.3%	4.2%	4.3%	4.3%	5.6%
Target	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%



Sickness increased in all of the three largest areas: Gynaecology increased by 3.40%, Maternity increased by 0.66%, and Neonates increased by 1.88%.

There are now seven services rated as green, three are rated as amber and seven are rated as red (Finance, Gynaecology, Hewitt Centre, IT & Information, Maternity, Neonates, and Operational Support Services).

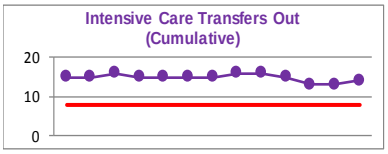
Overall there was a slight increase in short term sickness absence. The proportion of overall sickness split by short term & long term changed from 36%/64% in month nine, to 39%/61%

In terms of diagnoses, cold/cough/flu became the most common diagnosis, followed by anxiety/stress/depression and then gastrointestinal problems.

3. 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 14 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	Jan-18
Actual	15	15	16	15	15	15	15	16	16	15	13	13	14
Target	8	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. Conclusion

There are concerns with regard to the reporting of cancer targets and referral to treatment times that have been escalated to regulators and are currently being investigated as part of the serious untoward incident process.

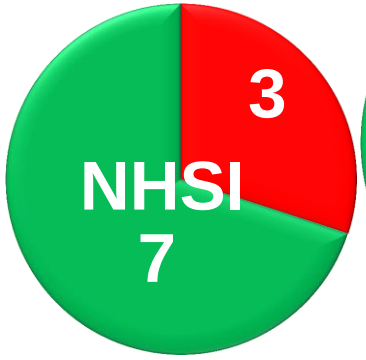
ITU transfers remain a continuing clinical risk that is managed by robust clinical policies and procedures and the experience of clinicians, this particular issue remains a strong focus of our long term strategy. A significant improvement has been made in terms of the sickness rate.

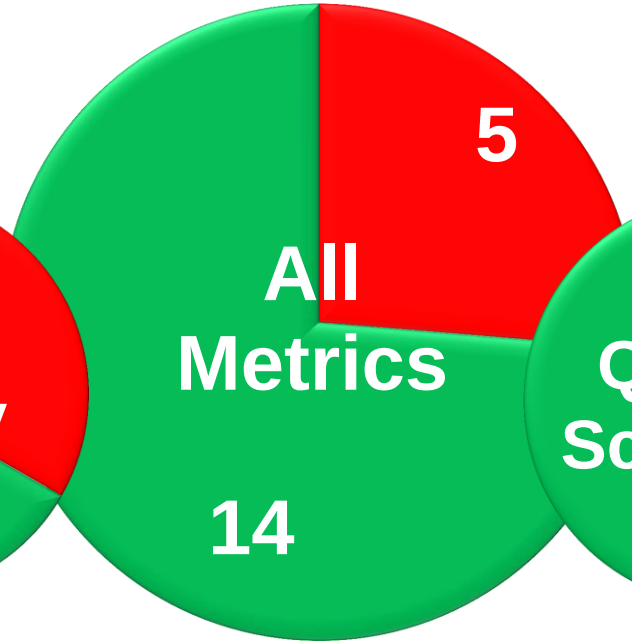
5. Recommendation

The Board note the content of the report

Liverpool Women's NHS Foundation Trust

Performance Report for Trust Board — Month 10 - January 2018





* 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 10 - January 2018

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 (Number)	KPI104 (EAS5)	Infection Control	1	0	0	0		0	0	0		0	0	0		0			
Infection Control: Clostridium Difficile - infection rate (12-month rolling) 1 Qtr Behind	KPI320	Infection Control		Qtrly	Qtrly	0.0		Qtrly	Qtrly	0.0		Qtrly	Qtrly	0.0		Qtrly	Qtrly		
Meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate (12-month rolling) 1 Qtr Behind	KPI105 (EAS4)	Infection Control		Qtrly	Qtrly	0.0		Qtrly	Qtrly	0.0		Qtrly	Qtrly	0.0		Qtrly	Qtrly		
Meticillin-sensitive Staphylococcus aureus (MSSA) rates (12-month rolling) 1 Qtr Behind	KPI335	Infection Control		Qtrly	Qtrly	0.0		Qtrly	Qtrly	0.0		Qtrly	Qtrly	0.0		Qtrly	Qtrly		
Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI) rates (12-month rolling) 1 Qtr Behind	KPI336	Infection Control		Qtrly	Qtrly	79.7		Qtrly	Qtrly	93.1		Qtrly	Qtrly	93.4		Qtrly	Qtrly		
Never Events	KPI181	Head of Governance	0	1	0	0		0	0	0		1	0	0		0			
NHSE / NHSI Safety Alerts Outstanding	KPI193	Head of Governance	0	0	0	0		0	0	0		0	0	0		0			
Mortality Rates: Hospital Standardised Mortality Rates (HSMR) Gynaecology (1 Month Behind)	KPI321	Medical Director	Refer to qtrly Mortality report																
Mortality Rates: Summary Hospital Mortality Indicator (SHMI) (1 Month behind)	KPI322	Medical Director	Refer to qtrly Mortality report																

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	Human Resource	4.5%	4.64%	5.17%	4.56%		4.05%	4.51%	3.26%		4.15%	4.29%	4.28%		5.58%			

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)	Operational Manager	92%	94.55%	95.31%	94.83%	94.90%	94.25%	93.67%	93.45%	93.78%	94.71%	93.64%	92.79%	93.76%	92.87%			
All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (Before re-allocation) Provisional Position	KPI031 (EB12)	Cancer Lead	>= 85%	100.00%	85.00%	87.50%	91.38%	85.71%	85.71%	84.62%	85.19%	93.33%	81.82%	71.43%	81.03%	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)	Cancer Lead	>= 85%	100.00%	85.00%	76.19%	85.45%	90.91%	95.83%	84.00%	90.14%	100.00%	86.36%	68.42%	82.00%				
All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (After Re-allocation) Provisional Position	KPI030 (EB12)	Cancer Lead	85%	89.47%	86.36%	87.50%	87.50%	85.71%	92.31%	95.65%	92.00%	100.00%	85.71%	75.00%	85.45%	83.33%			
All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (After Re-allocation) Final Reported Position	KPI030 (EB12)	Cancer Lead	85%	87.50%	85.00%	88.89%	87.04%	95.24%	*95.83%*	*95.45%*	95.52%	100.00%	90.48%	*72.22%*	85.42%				
All Cancers: 62 day wait for first treatement from NHS Cancer Screening Service referral - Numbers (if > 5, the target applies)	KPI033 (EB13)	Cancer Lead	< 5	0.0	1.0	0.5	1.5	0.0	0.0	0.5	0.5	0.0	0.0	0.5	0.5	0.5			
All Cancers: 62 day wait for first treatement from NHS Cancer Screening Service referral - Percentage	KPI034 (EB14)	Cancer Lead	>= 90%	No Pts Applicable	100%	100%	100%	No Pts Applicable	No Pts Applicable	100%	100.00%	No Pts Applicable	No Pts Applicable	100%	100.00%	100%			
Complaints: Number Received	KPI038	Ward Manager	<= 15	10	9	5		5	11	9		14	9	6		2			

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%	5.58%		

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	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	223		
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%	99.0%		

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%	5.6%		

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	0		
Mortality Rates: Summary Hospital Mortality Indicator (SHMI) (1 Month behind)	KPI322	Medical Director	Refer to qtrly Mortality report												

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	2		

Liverpool Women's NHS Foundation Trust

LWH Trust Objectives 2017/18 Month 10 - January 2018

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%	0.44%		
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%	0.30%		

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	15	16	14		

Agenda Item	2018/073

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Month 10 Finance Report**
DATE OF MEETING:	Friday, 02 March 2018
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Jenny Hannon, Director of Finance
AUTHOR(S):	Janet Parker, Acting Deputy Director of Finance Andy Large, Head of Finance
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** 1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☐ 2. To be ambitious and *efficient* and make the best use of available resource ☒ 3. To deliver *safe* services ☐ 4. To participate in high quality research and to deliver the most *effective* Outcomes ☐ 5. To deliver the best possible *experience* for patients and staff ☐
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust* ☐ ***2.*** *The Trust is not financially sustainable beyond the current financial year* ☐ ***3.*** *Failure to deliver the annual financial plan* ☒ ***4.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision* ☐ ***5.*** *Ineffective understanding and learning following significant events* ☐ ***6.*** *Inability to achieve and maintain regulatory compliance, performance and assurance* ☐ ***7.*** *Inability to deliver the best clinical outcomes for patients* ☐ ***8.*** *Poorly delivered positive experience for those engaging with our services* ☐
CQC DOMAIN	***Which Domain?*** ***SAFE-*** *People are protected from abuse and harm* ☐ ***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☐ ***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐ ***RESPONSIVE –*** *the services meet people's needs.* ☐ ***WELL-LED -*** *the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ☒ ***ALL DOMAINS*** ☐

LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution ☐ **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 10 Financial Position***	
PREVIOUSLY CONSIDERED BY:	**Committee name**	Finance, Performance & Business Development Committee
	Date of meeting	19 February 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 10 the Trust is £0.088m favourable against the planned £3.438m deficit.

As reported at Month 9 following a detailed review of the overall position, the Trust has been 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.

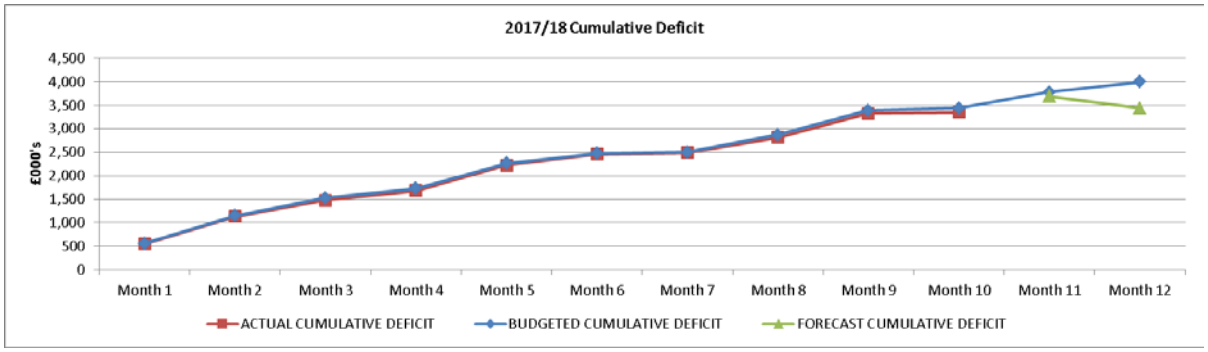
The Trust delivered a finance and use of resources' of 3 in month which is equivalent to plan.

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

Report

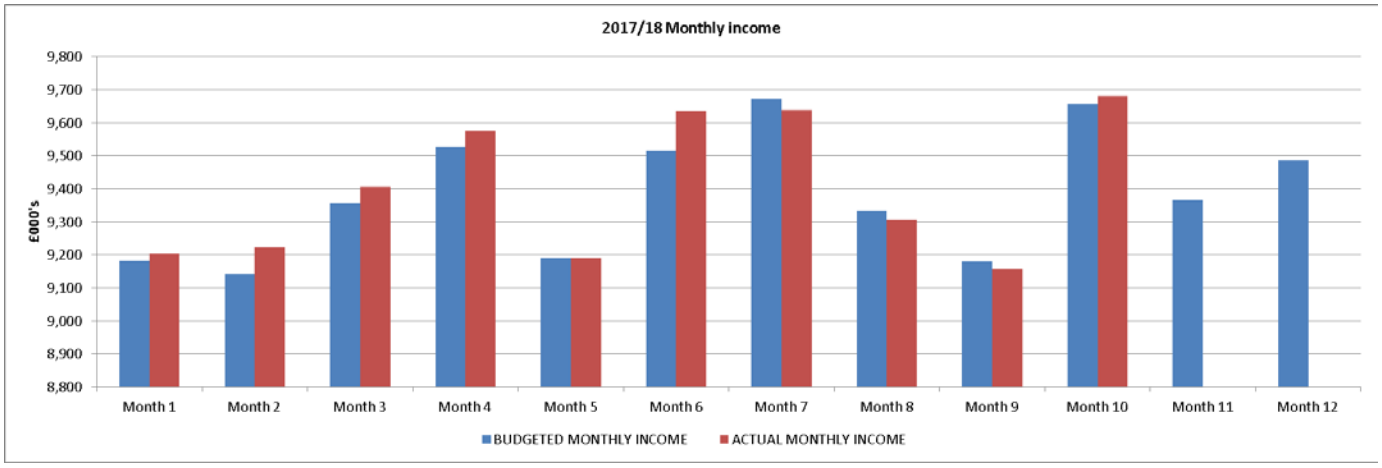
1. Month 10 2017/18 Summary Financial Position

The 2017/18 deficit is profiled below.



The Trust is achieving the planned deficit at Month 10 and is forecasting a £0.3m non-recurrent improvement at Month 12 (which will be matched by STF).

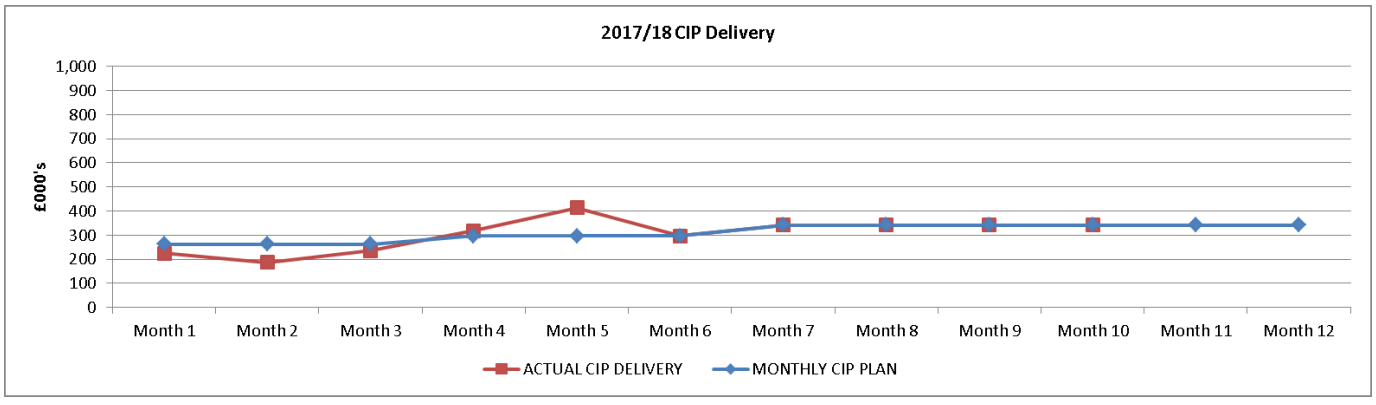
Despite a large proportion of income being under block contract with the Trust's main commissioners, there remains an element of payment by result (PbR) in the income plan. Within the financial plan the block is profiled to reflect expected activity levels in each month.



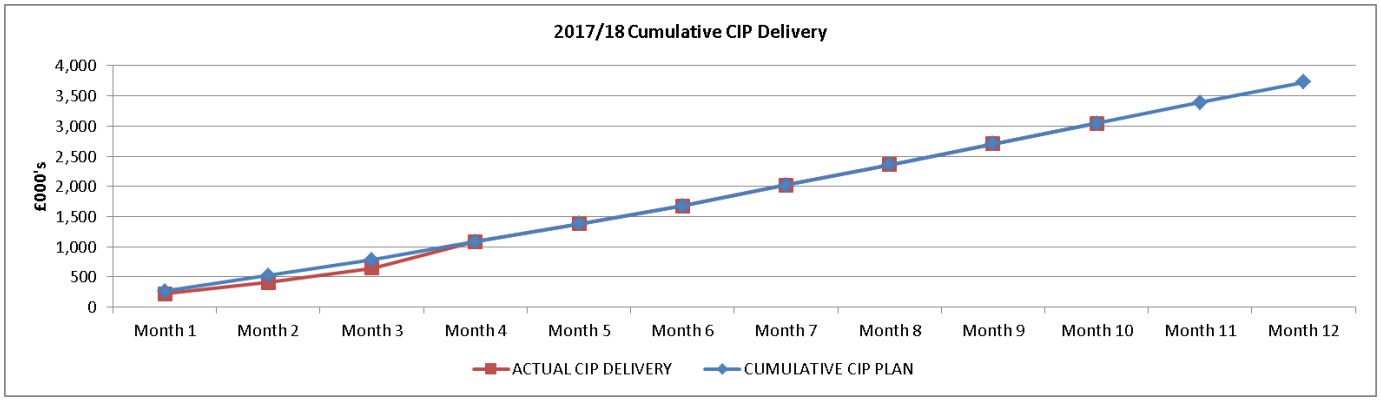
To date, the CCG block payment has been £2.8m higher than what would have been received under PbR for the level of activity during 2017/18. This has arisen particularly across both Gynaecology and Maternity, with activity levels in each currently below plan. The Trust has performed a detailed review into this performance as previously reported to FPBD, with recovery plans being actioned.

2. Month 10 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 £0.347m in month which includes £0.055m 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 the 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 £2.5m 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.

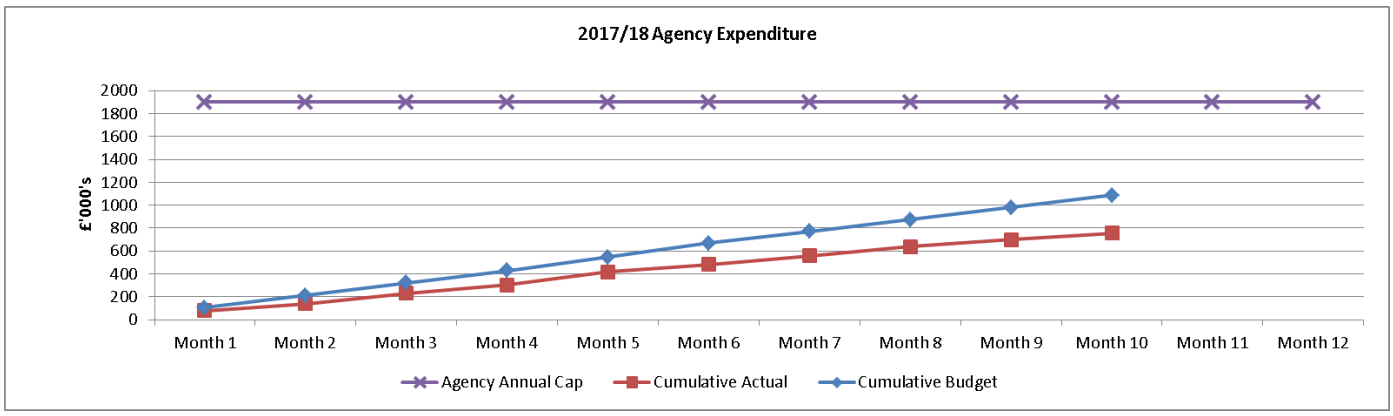
The maternity service is now forecasting an underspend on pay given the current and further expected attrition of midwives in line with lower births. However, income is forecast to remain significantly down due to non-block underperformance.

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 10 the Trust incurred £0.057m of agency expenditure (cumulative £0.754m) and plans to remain within the cap for the financial year.



5. Cash and borrowings

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

However towards the end of 2016/17 the Trust was able to improve the deficit through non-recurrent improvement and additional STF funding. This led to an improvement in the closing I&E position of £2.3m and an improved 2017/18 brought forward cash balance.

This position has supported the Trust's 2017/18 in-year cash balances and as reported at month 9 the Trust has drawn down £0.5m in Month 10. A submission has also been made to draw down the additional £1.5m in Month 12 taking the full drawdown for the year to £2m, as previously reported to Board.

6. BAF Risk

It is not proposed to make any changes to the risk scores to the two finance risks on the BAF. Following a review of the BAF risks a number of changes have been made to the narrative which were reported to FPBD.

7. Conclusion & Recommendation

The Committee are asked to note the Month 10 financial position.

Appendix 1 – Board pack

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

FINANCE REPORT: M10

YEAR ENDING 31 MARCH 2018

Contents

1 NHSI Score

2 Income & Expenditure

3 Expenditure

4 Service Performance

5 Balance Sheet

6 Cashflow statement

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
NHS IMPROVEMENT RATIOS: M10
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	1,838	1,847	2,341	2,792
(b) PDC + Interest Payable + Loans Repaid	1,906	4,106	2,532	4,700
CSC Ratio = (a) / (b)	**0.96**	**0.45**	**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	(2,069)	(5,822)	(2,598)	(4,636)
(b) Expenditure	91,927	92,188	110,277	110,508
(c) Daily Expenditure	300	301	302	303
Liquidity Ratio = (a) / (c)	**(6.9)**	**(19.3)**	**(8.6)**	**(15.3)**
NHSI LIQUIDITY SCORE	2	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)	3,438	3,347	3,998	3,440
Total Income	(93,757)	(94,019)	(112,608)	(113,277)
I&E Margin	**-3.67%**	**-3.56%**	**-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)		-3.56%		-3.04%
I&E Margin (Plan)		-3.67%		-3.55%
I&E Variance Margin	**0.00%**	**0.11%**	**0.00%**	**0.51%**
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	1,600	1,600	1,924	1,924
YTD Agency Expenditure	1,083	755	1,301	878
	-32.31%	**-52.81%**	**-32.38%**	**-54.36%**
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: M10
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	(8,912)	(8,832)	(80)	(86,833)	(86,853)	20	(103,786)	(103,837)	51
Non-Clinical Income	(745)	(849)	105	(6,923)	(7,166)	243	(8,822)	(9,439)	618
Total Income	**(9,656)**	**(9,681)**	**25**	**(93,757)**	**(94,019)**	**262**	**(112,608)**	**(113,277)**	**669**
Expenditure									
Pay Costs	5,609	5,606	3	56,286	56,298	(12)	67,503	67,463	40
Non-Pay Costs	2,260	2,288	(28)	22,535	22,784	(249)	27,046	27,317	(271)
CNST	1,311	1,311	0	13,107	13,107	0	15,728	15,728	0
Total Expenditure	**9,179**	**9,205**	**(25)**	**91,927**	**92,188**	**(261)**	**110,277**	**110,508**	**(231)**
EBITDA	**(477)**	**(476)**	**(1)**	**(1,829)**	**(1,831)**	**1**	**(2,331)**	**(2,769)**	**437**
Technical Items									
Depreciation	366	364	2	3,676	3,760	(85)	4,419	4,510	(91)
Interest Payable	36	21	15	360	219	141	432	262	170
Interest Receivable	(1)	(3)	2	(8)	(17)	8	(10)	(23)	13
PDC Dividend	124	121	3	1,240	1,219	21	1,488	1,463	25
Profit / Loss on Disposal	0	0	0	0	(1)	1	0	(1)	1
Total Technical Items	**525**	**503**	**23**	**5,268**	**5,181**	**87**	**6,329**	**6,211**	**118**
(Surplus) / Deficit	**49**	**26**	**22**	**3,438**	**3,350**	**88**	**3,998**	**3,443**	**555**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
EXPENDITURE: M10
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	342	(2)	3,403	3,534	(131)	4,085	4,252	(167)
Medical	1,253	1,269	(16)	12,422	12,513	(91)	14,928	15,049	(121)
Nursing & Midwifery	2,484	2,488	(5)	25,044	25,105	(61)	30,009	30,089	(80)
Healthcare Assistants	406	402	4	4,111	4,046	65	4,924	4,833	90
Other Clinical	538	565	(27)	5,379	5,333	46	6,454	6,468	(14)
Admin Support	140	161	(22)	1,399	1,570	(170)	1,679	1,879	(201)
Corporate Services	342	321	21	3,442	3,443	(1)	4,125	4,016	110
Agency & Locum	106	57	49	1,086	754	332	1,299	877	423
Total Pay Costs	**5,609**	**5,606**	**3**	**56,286**	**56,298**	**(12)**	**67,503**	**67,463**	**40**
Non Pay Costs									
Clinical Suppplies	704	714	(10)	7,062	7,173	(111)	8,471	8,597	(126)
Non-Clinical Supplies	508	484	24	5,184	5,090	94	6,197	6,119	78
CNST	1,311	1,311	0	13,107	13,107	0	15,728	15,728	0
Premises & IT Costs	438	452	(15)	4,393	4,487	(93)	5,268	5,396	(128)
Service Contracts	610	637	(27)	5,895	6,034	(138)	7,110	7,205	(95)
Total Non-Pay Costs	**3,570**	**3,598**	**(28)**	**35,642**	**35,890**	**(249)**	**42,774**	**43,045**	**(271)**
Total Expenditure	**9,179**	**9,205**	**(25)**	**91,927**	**92,188**	**(261)**	**110,277**	**110,508**	**(231)**

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	(3,900)	(3,901)	1	(38,104)	(37,754)	(350)	(45,612)	(45,182)	(430)
Expenditure	1,698	1,633	65	17,001	17,020	(19)	20,398	20,263	135
Total Maternity	**(2,202)**	**(2,268)**	**66**	**(21,103)**	**(20,734)**	**(369)**	**(25,214)**	**(24,919)**	**(295)**
Gynaecology									
Income	(2,152)	(2,158)	6	(21,504)	(21,608)	105	(25,742)	(25,653)	(89)
Expenditure	859	835	24	8,599	8,607	(8)	10,317	10,349	(32)
Total Gynaecology	**(1,293)**	**(1,324)**	**30**	**(12,904)**	**(13,001)**	**97**	**(15,425)**	**(15,304)**	**(121)**
Theatres									
Income	(42)	(38)	(3)	(416)	(385)	(31)	(499)	(462)	(37)
Expenditure	640	612	28	6,399	6,407	(8)	7,679	7,659	20
Total Theatres	**598**	**574**	**25**	**5,984**	**6,022**	**(39)**	**7,180**	**7,197**	**(17)**
Neonatal									
Income	(1,352)	(1,374)	23	(13,546)	(13,950)	404	(16,249)	(16,679)	430
Expenditure	945	957	(12)	9,451	9,556	(105)	11,341	11,475	(134)
Total Neonatal	**(407)**	**(418)**	**11**	**(4,095)**	**(4,394)**	**299**	**(4,908)**	**(5,204)**	**297**
Hewitt Centre									
Income	(951)	(958)	8	(8,270)	(8,330)	59	(9,971)	(10,119)	147
Expenditure	623	667	(44)	6,225	6,311	(85)	7,471	7,610	(140)
Total Hewitt Centre	**(328)**	**(292)**	**(36)**	**(2,045)**	**(2,019)**	**(26)**	**(2,501)**	**(2,508)**	**8**
Genetics									
Income	(600)	(595)	(5)	(6,004)	(5,924)	(79)	(7,204)	(7,084)	(120)
Expenditure	461	437	24	4,612	4,365	247	5,535	5,275	260
Total Genetics	**(139)**	**(158)**	**19**	**(1,391)**	**(1,559)**	**168**	**(1,669)**	**(1,810)**	**140**
Clinical Support									
Income	(23)	(21)	(2)	(245)	(283)	38	(295)	(331)	36
Expenditure	759	675	84	7,645	7,493	153	9,164	9,007	157
Total Clinical Support & CNST	**736**	**653**	**83**	**7,400**	**7,210**	**190**	**8,869**	**8,675**	**193**
Corporate & Trust Technical Items									
Income	(636)	(634)	(3)	(5,668)	(5,784)	116	(7,037)	(7,767)	730
Expenditure	3,720	3,892	(172)	37,261	37,610	(349)	44,702	45,082	(380)
Total Corporate	**3,083**	**3,258**	**(175)**	**31,593**	**31,826**	**(234)**	**37,666**	**37,316**	**350**
(Surplus) / Deficit	**49**	**26**	**22**	**3,438**	**3,350**	**88**	**3,998**	**3,443**	**555**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 5
BALANCE SHEET: M10
YEAR ENDING 31 MARCH 2018

BALANCE SHEET £'000	YEAR TO DATE Opening	M10 Actual	Movement
Non Current Assets	**72,688**	**72,368**	(320)
Current Assets			
Cash	4,897	5,381	484
Debtors	8,201	8,428	227
Inventories	366	456	90
Total Current Assets	**13,464**	**14,265**	**801**
Liabilities			
Creditors due < 1 year	(10,577)	(16,845)	(6,268)
Creditors due > 1 year	(1,717)	(1,691)	26
Loans	(17,175)	(15,007)	2,168
Provisions	(3,011)	(2,768)	243
Total Liabilities	**(32,480)**	**(36,311)**	(3,831)
TOTAL ASSETS EMPLOYED	**53,672**	**50,322**	**(3,350)**
Taxpayers Equity			
PDC	37,420	37,420	0
Revaluation Reserve	12,233	12,233	0
Retained Earnings	4,019	669	(3,350)
TOTAL TAXPAYERS EQUITY	**53,672**	**50,322**	**(3,350)**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
CASHFLOW STATEMENT: M10
YEAR ENDING 31 MARCH 2018

CASHFLOW STATEMENT £'000	YEAR TO DATE M10 Actual	 Forecast
Cash flows from operating activities	(1,930)	(1,740)
Depreciation and amortisation	3,760	4,510
Movement in working capital	5,199	735
Net cash generated from / (used in) operations	**7,029**	**3,505**
Interest received	17	23
Purchase of property, plant and equipment and intangible assets	(3,584)	(5,962)
Proceeds from sales of property, plant and equipment and intangible assets	133	133
Net cash generated from/(used in) investing activities	**(3,434)**	**(5,806)**
PDC Capital Programme Funding - received	0	31
Loans from Department of Health - received	500	3,920
Loans from Department of Health - repaid	(2,668)	(2,974)
Interest paid	(166)	(262)
PDC dividend (paid)/refunded	(777)	(1,463)
Net cash generated from/(used in) financing activities	**(3,111)**	**(748)**
Increase/(decrease) in cash and cash equivalents	**484**	**(3,049)**
Cash and cash equivalents at start of period	4,897	4,897
Cash and cash equivalents at end of period	**5,381**	**1,848**