Meeting of the Board of Directors
HELD IN PUBLIC
Friday 1 June 2018 at 1000hrs
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
156	Apologies for absence Declarations of interest	Receive apologies	Verbal	Chair		-
157	Meeting guidance notes	To receive the meeting attendees' guidance notes	Written guidance	Chair		Well Led
158	Patient Story	To receive a patients story	Presentation	Patient's parent	1010 (20mins)	Safe, Experience, Well led
159	Minutes of the previous meeting held on 4 May 2018 and 19 May 2018	Confirm as an accurate record the minutes of the previous meetings	Written	Chair	1030 (5mins)	Well Led
160	Action Log and matters arising	Provide an update in respect of on-going and outstanding items to ensure progress	Written	Chair		Well Led
161	Chair's announcements	Announce items of significance not elsewhere on the agenda	Verbal	Chair	1035 (10mins)	Well Led
162	Chief Executive Report	Report key developments and announce items of significance not elsewhere	Written	Chief Executive	1045 (10mins)	Well Led

BOARD COMMITTEE ASSURANCE						
163	Chair's Report from Audit Committee	for assurance and any escalated risks	Written	Committee Chair	1055 (15mins)	Well Led
164	Chair's Report from Finance, Performance and Business Development Committee	for assurance and any escalated risks	Written	Committee Chair		Well Led
165	Chair's Report from Quality Committee	for assurance and any escalated risks	Written	Committee Chair		Safe 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						
166	CQC Inspection Report 2018	For assurance	Written	Acting Director of Nursing and Midwifery	1110 (5mins)	
167	Update on the implementation of the National Maternity Review and Community Midwives Re-design	For assurance	Written / Presentation	Acting Director of Nursing and Midwifery	1115 (30mins)	Well Led
168	Director of Infection Prevention and Control (DIPC) Annual Report 2017/18	For approval	Written	Acting Director of Nursing and Midwifery	1145 (15mins)	Safe Well Led
TRUST PERFORMANCE - TO DELIVER THE MOST EFFECTIVE OUTCOMES; TO BE EFFICIENT AND MAKE BEST USE OF AVAILABLE RESOURCES						
169	Safer Nurse/Midwife Staffing Monthly Report period 1 2018/19	For assurance and any escalated risks - To note the content of the report	Written	Acting Director of Nursing and Midwifery	1200 (5mins)	Safe Well Led
170	Performance Report period 1, 2018/19	For assurance -Review the latest Trust performance report and receive assurance	Written	Director of Operations	1205 (10mins)	Well Led
171	Finance Report period 1, 2018/19	For assurance - To note the current status of the Trusts financial position	Written	Director of Finance	1215 (10mins)	Well Led
TRUST STRATEGY						
172	Future Generations	To note	verbal	Chief Executive	1225 (5mins)	Well Led
BOARD GOVERNANCE						

173	Compliance with FT4 – Corporate Governance statement	To approve	Written	Director of Nursing and Midwifery	1230 (5mins)	Well Led
174	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair	1235 (10mins)	Well Led
HOUSEKEEPING						
175	Any other business & Review of meeting	Consider any urgent items of other business	Verbal	Chair	1245 Meeting ends	Well Led

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

Meeting to end at 12:45

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

Board Agenda item 2018/159

Board of Directors

Minutes of the meeting of the Board of Directors
held in public on Friday 4 May 2018 at 1000 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
Mrs Michelle Turner	Director of Workforce & Marketing
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 Tony Okotie	Non-Executive Director/SID
Mr Phil Huggon	Non-Executive Director
Dr Devender Roberts	Associate Medical Director (Agenda item 127 only)
Mrs Chris McGhee	Freedom To Speak Up Guardian (Agenda item 126 only)
Mr Kevin Robinson	Freedom To Speak Up Guardian (Agenda item 126 only)

IN ATTENDANCE

Mr Colin Reid	Trust Secretary

APOLOGIES

2018	
	Thank You Individual Board thank you. **Individual** The Director of Finance thanked on behalf of the Board Claire Scott, Head of Management Accounts for her commitment and hard work within the financial management team. Claire works incredibly hard and consistently goes above and beyond, offering support to the wider areas of the Trust. The Director of Workforce and Marketing thanked on behalf of the Board Emily Speers, Diane Manifold, Sue Rogerson and Michelle Calland who had been jointly awarded the Medical Administration Apprentice of the Year award and Christine Evans who had been awarded the Health and Medical Support Services award.
116	**Apologies** – as above. **Declaration of Interests** – None **Welcome:** The Chair opened the meeting and welcomed members of the public to the meeting held in public.
117	**Meeting guidance notes** The Board received the meeting attendees' guidance notes.

118 Patient Story

The Board received a patient story from Val Irving, Matron for Neonatal Services relating to a patient who had used the Trust's Neonatal Services. The Patient story was different to previous neonatal stories as it concentrated on the mother rather than the baby and her experiences in using the service. The Board was told that Becky had originally been booked into the Trust and was comfortable and assured that she would get the best possible care, however due to there being no room on NICU if she delivered at the Trust, the baby would have to be transferred to another hospital for the neonatal care. Becky was offered an antenatal transfer to Wirral University Teaching Hospital NHS Foundation Trust (Arrowe Park) which she agreed to although she was fearful of what to expect at Arrowe Park having been comfortable and assured with her booking at the Trust.

Val Irving explained to the Board the experiences Becky and her partner had at Arrowe Park, advising that they were both able to stay in the hospitals parent accommodation and were happy with the care provided. There was some consternation that after 5 weeks on NICU at Arrowe Park, Connor would be ready to transfer to the Trust as this would result in Becky and her Partner not being able to stay with Connor at the Hospital overnight, as was the case at Arrowe Park; Becky could not bear the fact that she would have to leave the hospital without her baby.

Val Irving explained the comparisons that Becky had provided to her in relation to the two hospitals and the points of interest provided.

The Board discussed the presentation noting the concerns expressed regarding the lack of parent accommodation at the Trust against that provided at Arrowe Park and the lack of privacy when expressing milk. The Board was assured that both concerns would be addressed both within the current refurbishment of Neonates and in any potential new build.

The Chair thanked Val Irving for presenting the patient story and special thanks to Becky for providing the story.

119 Minutes of previous meeting held on Friday 4 May 2018

The minutes of the meeting held on 2 March 2018 were approved subject to an amendment to the final paragraph under section 2018/091.

120 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.

121 Chair's Announcements

Council of Governors: The Chair reported on the meeting of the Council off Governors held on 25 April 2018 and advised that at the meeting the Council had received the first draft of the Annual Report and Quality Report 2017/18 and a presentation on the year end position and operational plan for 2018/19. The Council had approved the appointment of Jo Moore as Vice Chair and the re-appointment of Tony Okotie as a Non-Executive Director for a further three years from 1 June 2018. The Chair congratulated both on their respective appointments.

Shadowing sessions with Community Midwife and Chaplin: the Chair advised on his day of shadowing Sue Rixon a community midwife from Oak Team, Liverpool Central. He advised that having seen clinics in other community settings the flow and pace of consultation in the link clinic he observed was very different with the usual multitasking of the midwife hampered by the translation. The Chair advised that he was impressed with staff patience, dedication in keeping clinic running, even when it was running late due in part to the translations issues.

The Chair reported on his morning shadowing session with the chaplaincy and reported on the valuable multi-faith pastoral service the Trust provided.

Dedicated to Excellence: the Chair thanked all staff, Board members, Governors and Volunteers for attending the event and the Communications team who had organised and made the event a success.

The Board noted the Chair's verbal update.

122 Chief Executive's report

The Chief Executive referred to her report and advised on the following.

2018 Dedicated to Excellence Awards: The Chief Executive echoed the thanks given by the Chair. She advised that her CEO award was given to Bill Yoxall, Neonates Clinical Director which was well deserved and received by all those at the event. She advised that the Communications team were looking at refreshing the event for next year.

Patient Experience Strategy and EPR: The Director of Workforce and Marketing advised that the Patient Experience Strategy would be launched at the beginning of July. The Chief Executive reported that EPR awareness and taster sessions were taking place across the Trust to get staff engaged in readiness for future training as the Trust moves towards go-live in October.

The Board noted the Report from the Chief Executive.

123 Chair's Report from Putting People First Committee

David Astley presented the Chairs report from the Putting People First (PPF) Committee and highlighted the key areas discussed at the Committee. With regards to Service Workforce Assurance and Risk Report – Maternity, David Astley advised that there was considerable discussion around maternity staff headroom and whether it was sufficient to support taking staff out of the workplace to undertake mandatory training. The Board discussed the issues regarding balancing work requirements and making sure that essential training was undertaken. It was noted that the Education Governance Committee, which reported to PPF, was currently working on developing training packages for midwifery that were mission critical and that the Executive had a line of sight on its development.

David Astley advised the Board that changes had been made to the Board Assurance Framework in light of the Committees review and these were reported both within his report and within the Board Assurance Framework paper on the agenda.

The Chair thanked David Astley for his report which was noted. The Chair asked the Board to approve the terms of reference of the Committee and receive the Committees Annual report 2017/18. The Board after consideration of the two documents approved the PPF terms of reference and received the PPF Annual Report 2017/18.

124 Chair's Report from Finance, Performance and Business Development Committee

Jo Moore, Chair of the Finance, Performance and Business Development Committee (FPBD) presented her report for the meeting held on 23 April 2018. She advised that the Committee had received an update on the current status of the RTT and 62 Day Cancer action plans which would be picked up later in the meeting by the Director of Operations under his Operations Report. Jo Moore advised that the Committee was assured that there was appropriate and sufficient resource available to address the two matters.

Jo Moore reported on the year end finance position and was pleased to report that the Trust had not

only delivered its control total but had bettered it. This would be addressed by the Director of Finance in her report later in the meeting. Referring to the Cost Improvement Programme, Jo Moore advised that the Committee had received a progress update against the 2018/19 CIP schemes including quality impact assessments and equality impact assessments which had been signed off by the Medical Director and the Acting Director of Nursing and Midwifery. She felt that the Trust was in a reasonable position to deliver its CIP in 2018/19; she was not however as confident for 2019/20.

Jo Moore reported on the update the Committee had received with regards to the Electronic Patient Records (EPR). She advised that the Committee had noted the continued work to manage and deliver the EPR programme in October 2018; however there were risks that needed to be addressed regarding the delivery of the EPR within timescales.

The Chair thanked Jo Moore for her report which was noted. The Board further noted the approval of the control total for 2018/19 that had taken place out of meeting and received the FPBD Annual Report 2017/18.

125 Chair's Report from Quality Committee

Susan Milner, Chair of the Quality Committee highlighted the work of the Committee at its meeting on 23 April 2018 and advised that the Committee had received further assurance from the Director of Operations that the action plans reported at the last meeting of the Committee were being reviewed by FPBD to address the two Serious Incidents (SI) relating to 62 day Cancer and RTT breaches. The Committee had received an update on the increase in referrals in February and March which had resulted in delays in recovery of the Cancer 62day target.

Susan Milner ran through the items in her report and advised that the Committee was in a reflective mode, considering its role in terms of obtaining the appropriate assurances so that these could be passed onto the Board.

Susan Milner advised that there were changes made to the BAF that had been incorporated in the paper that would be discussed later in the meeting.

The Chair thanked Susan Milner for her report which was noted. The Board received the Quality Committee Annual Report 2017/18.

The Chair agreed to take the Quarter 4 Adult Mortality Report out of sequence with the agenda.

127 Quarter 4 Adult Mortality Report

The Associate Medical Director joined the meeting and presented the Quarter 4 Adult Mortality Report. She advised that there were two in hospital deaths in the year 2017/18, the first in Q1 and the second in Q4 and both occurred in Gynaecology Oncology. This represented an overall rate of 2.1 per 1000 Oncology discharges for Q1-4 of 2017/18. The Associate Medical Director advised that all adult gynaecology deaths were discussed at the gynaecology Morbidity & Mortality meeting and as part of the process an adult mortality sheet was completed indicating any potential for improvement in care.

Referring to out of hospital deaths the Associate Medical Director informed the Board that there were two maternal deaths reported externally via MBRRACE-UK national reporting system. Both were due to indirect causes: brain haemorrhage and leukaemia. She advised that work was ongoing on a process for triangulating out of hospital deaths with the MBRRACE-UK midwives and the surrounding trusts so that the information provided was as complete as possible.

The Associate Medical Director advised that deep dive reviews into the two in-hospital deaths had shown that there was opportunity for further learning to be drawn from the reviews and went on to

explain the next steps in the process.

Responding to a question from the Chair regarding the triangulation process with other trusts in relation to babies born at the Trust, the Associate Medical Director advised that were babies are born at the hospital and die within 8 weeks, they are treated as direct deaths, and those from 8 weeks up to 1 year were indirect deaths.

Tony Okotie referring to the number of out of date policies had understood from the last Q3 report that the Trust would be fully compliant and would not have any out of date policies at the end of Q4. The Medical Director recognised the comment made previously and advised that the current position was that all mortality related policies where up to date and in place. He explained that there was a very good process in place to keep the policies updated, however there needed to be a step change to make sure all policies were in date. The Chair asked that addressing the out of date policies needed to be escalated so that the Board was not in a similar position in Q1 2018/19. The Medical Director agreed and advised that it would be prudent to separate those policies that had an impact on mortality so that the Board could receive the necessary assurances.

Ian Knight asked whether the Trust could learn from mortality reviews in other trusts. The Medical Director advised that nationally, data of this nature did not specifically relate to the Trust's specialities and therefore difficult to benchmark. The Associate Medical Director advised that she would look to see if she could garner data from other trusts specific to our services and would report back in Q1 whether this had been possible.

In response to a question from Susan Milner regarding the reporting of neonatal/perinatal mortality to the Board, it was agreed that a proposal on how this would be reported to the Board and at what frequency (annual/bi-annual) would be progressed through the Quality Committee.

The Board noted that there was progress against the requirements laid out by the National Quality Board and confirmed that there was effective governance arrangements in place to drive quality and learning from the deaths of patients in receipt of care at this Trust.

126 Whistleblowing and Speak Up Guardian Annual Report

Chris McGhee and Kevin Robinson, Freedom to Speak Up Guardians joined the meeting to present the Whistleblowing and Speak Up Guardian Annual Report.

Chris McGhee advised that in the previous 12 months a total of twenty three contacts had been made to the Freedom to Speak Up Guardian (F2SUG) requesting support to raise a concern and in addition to these another fourteen contacts were made requesting a safe space to talk through a work related issue. She explained that in the majority of cases a member of staff would request anonymity and required the F2SUG to raise the matter on their behalf, stating that they felt that there would be repercussions if they raised it in their own name. Three members of staff were happy to raise in their own name, but requested support from the Guardian when raising the concern with a senior member of staff. Concerns were raised by a wide range of staff groups with Nurses and Midwives representing the main group for contact.

Chris McGhee advised that feedback to the Guardian was collected at the end of an episode of raising concerns; with staff feedback being wholly positive. She went on to advise that the only negative comments had been received from respondents, which related to the length of time taken to investigate concerns by managers once the concern had been raised with them. To counter this Chris McGhee reported that she and Kevin Robinson were developing a process that would provide a timeframe for managers to respond.

Referring to the CQC inspection in February, Chris McGhee reported that she had met with the CQC

Inspectors under the well-led framework and was questioned about how the role had been received by staff and senior managers within the Trust. She was able to report that there had been no difficulties or barriers in place for concerns to be raised and that concerns raised by staff were listened to by managers and investigated appropriately.

Chris McGhee referred to the future arrangements being put in place and explained the appointment of Kevin Robinson as the second F2SUG which would provide for cover on matters where a member of staff may feel the F2SUG had a conflict due to their other staff role within the Trust. She advised that there would be a re-launch of the Guardians role now that Kevin had been appointed and she and Kevin would continue to work with the regional and national guardians to improve communications and standards of working and reporting of serious concerns.

In response to the Chief Executive, Chris McGhee advised that she had found very little resistance from managers who saw the value of the role. She felt that there were times when she was dealing with a respondent who felt due to her other staff role there was a perceived conflict of interest, however over the last year this had improved. Chris McGhee did feel that with the appointment of the additional F2SUG any such concerns would be neutralised as advised earlier. The Director of Workforce and Marketing had a sense that fewer staff were going outside the Trust to raise concerns now that the F2SUG was established; with a track record and the benefits of the role were being acknowledged.

The Chair thanked Chris McGhee and Kevin Robinson for attending the Board and recognised the benefits of the roles within the Trust. The Board noted the content of the report.

128 Corporate Objectives 2017/18 and 2018/19

The Board reviewed and noted the delivery of the corporate objectives 2017/18 and approved the corporate objectives 2018/19.

129 Safer Nurse/Midwife Staffing Monthly Report Period 12

The Acting Director of Nursing and Midwifery presented the Month 12 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.

Referring to the five red flag incidents reported under the nursing/midwifery red flag staffing criteria, The Acting Director of Nursing and Midwifery advised that all were managed appropriately and there was no harm to patients identified or reported. She reported that twelve drug errors were reported in neonatal services relating to omissions and that maternity services also reported three drug errors which related to late administration or omission of medication.

The Director of Nursing and Midwifery was pleased to report that Gynaecology had a nil return for the fifth consecutive month for red flag incidents. The Acting Director of Nursing and Midwifery advised that the Deputy Director of Nursing and Midwifery had led a focus group and work stream to develop red flag reporting including, definition, reporting and escalation; the results of this work would be reported in the June Board report.

Referring to the content of the paper, the Chief Executive advised that as part of the interview process for the Director of Nursing and Midwifery post, each candidate had received a copy of the safe nursing and midwifery staffing reports and all had seen the staffing as a real positive in coming to the Trust to work.

Tony Okotie referring to the levels of assurance from the report felt that the report needed to be fleshed out to understand the backing information that feeds into the Report. The Director of Workforce and Marketing advised that this would be covered in the Bi-Annual staffing report that

would ordinarily have been presented to the Board this month. She advised that before it was presented to the Board it should be reviewed at the Putting People First (PPF) Committee. The Board noted the position and agreed to receive the Bi-Annual Staffing Report at the July Board having first been reviewed by the PPF Committee in June.

David Astley referring to the paper felt that this sent a positive message to staff and the public, which was not the case in a large number of trusts across the country. The Chief Executive asked the Acting Director of Nursing and Midwifery to provide benchmarking evidence that supported the view that the Trust was performing well against other trusts across the country.

Action 2018/129: The acting Director of Nursing to provide safe staffing benchmarking evidence that supported the view that the rust was performing well against other trusts across the country.

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

130 Performance Report Period 12 2017/18

The Director of Operations presented the Performance Report for period 12 2017/18 and reported that the Trust was continuing to deliver the national targets to date with the exception of RTT 18 weeks and 62 day cancer. The Director of Operations advised that the Trust had requested an additional week extension to submitting RTT compliance to ensure that a full validation of information was completed as it had done in February 2018. He reported that the full validation performance was completed on the 25/04/18 and confirmed 87% achievement against a target of 92% and the recovery plan of 86%. Referring to the recovery plan the Director of Operations advised that this was being monitored and challenged at FPBD as reported earlier in the meeting.

The Director of Operations advised that the Trust was on target to return to RTT compliance by July 2018; however he expected that RTT performance would reduce slightly before an improving position in May onwards. The Director of Operations advised that the Trust performance should be reported against the national position and explained that RTT for gynaecology nationally for February was 87.9%. Referring to 62 day cancer, the Director of Operations advised that March had seen a similar picture to February with four patient breaches of the GP referral 62 day target; three very complex patients not being treated until days 108, 109 and 85 respectively and one other breach at 75 days due to issues of capacity to treat within 62 days. He advised that all of the 62 day cancer targets reported had failed as reported at FPBD. The Director of Operations advised that the key reasons for failure included: increases in referrals; shortages in consultant availability; and the complexity of patients covered by the 62 day standard who require pre-operative intervention that was not covered within the Trust's portfolio of services including: pathology; echo; MRI; and CT. Work was underway: to better align capacity to meet spikes in demand; to redesign clinical pathways to achieve earlier diagnosis; to establish appropriate timescales for pre-operative work up and access to investigations external to this Trust.

The Director of Operations advised that escalation processes had been reviewed to provide early warning of capacity issues for first appointment and to identify at the earliest opportunity the need for additional operating capacity. He explained that the use of an external company to provide additional capacity for colposcopy was being reviewed, together with a review of the "Directory of Services" in order to reduce any clinically unnecessary demand. Job plans of the specialist surgeons were also being reviewed and where possible, the surgeons would be freed up from general gynaecology commitments to provide more capacity.

The Director of Operations advised that delivery against the 62 day pathway would require pathway redesign and agreed ways of working with the Trust's partners, which would take some time to address, whilst the Pathology steering Group would be looking at the unacceptable waits for

histological diagnosis for patients on the cancer pathway.

David Astley commended the management on the actions being taken to address both RTT and 62 day cancer and commented that the open and transparent way the management had dealt with both matters was important in giving confidence to the public and regulators that the Trust was putting the matters to rights. The Chief Executive supported the comments made and advised that it was important that the focus of the Trust was to make sure no harm had been caused to patients and that they were treated on the correct pathway.

Referring to the remainder of the report the Director of Operations advised that sickness levels had increased in all of the three largest areas: Gynaecology; Maternity; and Neonates were all in excess of the target of 4.5%. He reported that the proportion of overall sickness split by short term & long term changed from 39% and 61% respectively in month nine, to 48% and 52%. Managers continued to actively manage sickness to the Trust policy.

Director of Operations referred to the A & E performance and reported that the Department had experience 9 days in the month were the number of patients and the acuity had spiked. This had caused a number of patients to breach the 4 hour wait in A & E, however overall the service achieved the target of 95% seen within 4 hours.

The Board noted the Performance Report for period 12 2017/18 and recognised that the recovery plan for RTT 18 week target was being met by the Trust; however with regards to the cancer targets the Board noted that this was more difficult to rectify due to the significant increase in the number of referrals in February and March and the number of complex patients finalising treatment. The Chair thanked the Director of Operations for his report.

131 Financial Report & Dashboard Period 12 2017/18

The Director of Finance presented the Finance Report and financial dashboard for month 12, 2017/18 and reported that at month 12 the Trust had delivered its 2017/18 control total, improving on the original plan by £0.3m, which was matched by £0.3m of incentive STF. She explained that a further £2.0m of bonus STF had been allocated to the Trust resulting in the total value of STF received of £5.5m. The Director of Finance advised that the final outturn for 2017/18 was a deficit position of £1.3m. The Trust delivered a 'finance and use of resources' rating of 3 in month which was equivalent to plan.

With regard to CIP, the Director of Finance advised that the Trust had delivered the full £3.7m CIP target for 2017/18, with mitigations reflected in the reported position; £0.7m of the delivered CIP was delivered on a non-recurrent basis, with £0.2m of this remaining non-recurrent into 2018/19 and was reflected in the 2018/19 CIP target. Referring to the year end cash position the Director of Finance advised that the cash balance at the end of Month 12 was £6.0m compared to a prior year-end position of £4.9m and a plan of £1.9m. She advised that cash was higher than the expected position due to a number of reasons: receipt of STF income of £1m during March 2018 which NHS Improvement request was excluded from cash forecasts; PDC funding for GDE Fast Follower of £1m received in March 2018 plus a further £1m of cash in relation to the Neonatal Build; and some NHS bodies made payments to the Trust on the last day of for NHS payments to be made which was not expected to be received.

The Director of Finance advised that in 2018/19 the Trust made a drawdown of £2m of Distressed Finance Loans against a plan of £4m and that repayment of the £5.6m Interim Revenue Loan from 2015/16 had been extended by a year to March 2019.

Reporting on the BAF risk; delivery of the 2017/18 financial plan, the Director of Finance advised that as the control total had been delivered and bettered the BAF risk had been reduced from a risk score

of 15 to 10. She explained that as the Trust entered the new financial year 2018/19, the risk relating to the delivery of the 2018/19 Operational Plan would reflect a risk score of 25. The Director of Finance advised that FPBD had discussed the opening risk score and was satisfied with the recommendation.

The Director of Finance advised that the Operational Plan 2018/19 had been submitted to NHSI within agreed timescales. The Chair on behalf of the Board thanked the Director of Finance and the Executive team in delivering an excellent year end given the challenges the Trust faced over the year. David Astley felt that going forward the Trust would find it increasingly difficult to deliver future savings without impacting on the current operations and felt that there would be some increasingly difficult decisions that would need to be made in order to deliver the control total for 2018/19. The Chair supported the comment noting that 2019/20 would be a crunch year in terms of any future savings.

The Chair thanked the Director of Finance for presenting the Financial Report & Dashboard Period 12 2017/18 which was noted.

132 Risk Appetite Statement 2018/19

The Board approved the risk appetite statement noting the outcome of discussions at the Board committees on the statement had been reported through the Chairs report for each committee.

133 Board Assurance Framework

The Trust Secretary presented the Board Assurance Framework 2017/18 and the Board Assurance Framework 2018/19. He explained the process that had been undertaken regarding the year-end review by the sub-committees which had been completed for the close out of the 2017/18 financial year and the commencement of the 2018/19 financial year.

The Board discussed the content of the report noting in particular the target risk scores to be achieved by 31 March 2019 and whether there was mitigations that could be put in place to deliver a lower target score than the 'current risk score'. It was agreed that as the BAF had been in place for 12 months that a Board workshop should be held in the near future to assess whether the BAF was providing the necessary assurances that the strategic risks are being mitigated appropriately.

The Board approved the BAF closure for 2017/18 and the resetting for 2018/19.

134 Review of risk impacts of items discussed

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

- Delivery of EPR
- Delivery of control total and operational plan 2018/19
- Out of date policies – impact on operations and service delivery

135 Any other business & Review of meeting

The Board noted the transparent, 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 1 June 2018.

Board Agenda item 2018/159 (i)

Board of Directors

Minutes of the meeting of the Board of Directors
held public on Friday 18 May 2018 at 1115hrs
in the Boardroom, Liverpool Women's Hospital, Crown Street

PRESENT	
Mr Robert Clarke	Chair
Mrs Kathryn Thomson	Chief Executive
Ms Jo Moore	Non-Executive Director /Vice Chair
Mr Ian Knight	Non-Executive Director & Chair of Audit Committee
Mrs Vanessa Harris	Acting Chief Executive & Director of Finance
Mrs Michelle Turner	Director of Workforce & Marketing
Mr Doug Charlton	Director of Nursing & Midwifery
Mr Phil Huggon	Non-Executive Director
Dr Andrew Loughney	Medical Director
Mr Tony Okotie	Non-Executive Director/SID
Mr David Astley	Non-Executive Director
Mrs Jenny Hannon	Director of Finance
IN ATTENDANCE	
Mr Colin Reid	Trust Secretary
APOLOGIES	
Mr Jeff Johnston	Director of Operations

149 **Apologies** – As above

The Chair opened the meeting and reported that the meeting had been called to approve the Annual Report and Accounts 2018. He advised that just prior to the meeting the Audit Committee had met with all the Board members in attendance, together with the internal and external auditor and key members of staff who had been involved the production of the Annual Reports and Accounts.

150 **Meeting guidance notes**
The Board noted the meeting guidance notes.

151 **Declaration of Interests**
There were no declarations of interest.

152 **Annual Report and Accounts, including Quality Report, Annual Governance Statement and Letters of Representation**
The Chair asked Ian Knight, Chair of the Audit Committee to update the Board on the discussions at the Audit Committee and the recommendations the Committee had agreed to bring to the Board.

Ian Knight, Chair of the Audit Committee reported on the discussions that had taken place at the Audit Committee. He advised that the Committee had received a draft set of papers that included the

Annual Report and Accounts. He advised that the documents in the Annual Report and Accounts 2017/18 including: Forward from the Chair and Chief Executive; Performance Report; Accountability Report, which was broken down into salient sections prescribed by NHS Improvement in the FTARM guidance and including the Annual Governance Statement; Quality Report; and the Annual Accounts.

Ian Knight advised that discussion at the Committee had identified a number of suggested amendments to the reports and these would be addressed prior submission date.

Ian Knight further advised that the Committee had also received from the External Auditor, KPMG the ISA 260 report which set out the key findings of the audit and included the Enhanced Audit Opinion 2017/18 to be included in the Annual Report and Accounts and letters of representation. He advised that the Trust, as with last year, had prepared the accounts on a going concern basis and in the statement recognises the financial challenges it faced.

Referring to the audit generally, Ian Knight advised that the Audit partner was very complimentary of the work of the Trust and she had highlighted in particular the clean audit of the accounts that had not identified any concerns or issues.

Ian Knight, as Chair of the Audit Committee recommended the Annual Report and Accounts 2017/18 together with the letters of representation for approval.

The Chair thanked Ian Knight for his verbal report from the Audit Committee meeting and sought the board's approval.

The Board after careful consideration of the papers presented to it and following recommendation from the Audit Committee approved the Annual Report and Accounts 2017/18, which would be subject to amendment prior to submission to NHS Improvement and approved the letters of representation. The Board noted that the final submission date for the Annual Report and Accounts to NHSI was Tuesday 29 May 2018.

153 Compliance with General Condition 6 and Continuity of Services 7 of the Trust Provider Licence

The Trust Secretary presented the paper setting out the Trust's compliance with General Condition 6 and continuity of services 7 contained in the provider licence.

The Board approved compliance with general condition 6 and continuity of services 7. It was noted that with regards to designated commissioner requested services (CRS), the Trust provides designated CRS to NHS England; those the services provided to Liverpool CCG under contract were not categorised as designated for the purposes of the declaration.

154 Any other business

None

155 Review of risk impacts of items discussed

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

156 Review of meeting

Conduct of the meeting was very good and kept to time.

The Chair thanked the Board and attendees for their diligence during the approval process.

Date and time of next meeting

Friday 1 June 2017 Boardroom

Agenda Item 2018/160

Liverpool Women's NHS Foundation Trust

TRUST BOARD
1 June 2018 Action Plan

Meeting date	Minute Reference	Action	Responsibility	Target Dates	Status
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	Please see agenda item: 2018/167
4 May 2018	2018/129	The acting Director of Nursing to provide safe staffing benchmarking evidence that supported the view that the rust was performing well against other trusts across the country.	Acting Director of Nursing	6 July 2018	To be presented in the Bi-annual Staffing report that will be presented to PPF prior to its presentation to the Board on 6 July 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	2018/162

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Chief Executive Report**
DATE OF MEETING:	Friday, 01 June 2018
ACTION REQUIRED	**For Noting**
EXECUTIVE DIRECTOR:	Kathy Thomson, Chief Executive
AUTHOR(S):	Executive
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.*** *Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of junior medical staff with the capability and capacity to deliver the best care. ……* ☒ ***3.*** *The Trust is not financially sustainable beyond the current financial year……* ☒ ***4.*** *Failure to deliver the annual financial plan ……* ☒ ***5.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ……* ☒ ***6.*** *Ineffective understanding and learning following significant events……* ☒ ***7.*** *Inability to achieve and maintain regulatory compliance, performance and assurance……* ☒ ***8.*** *Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) ……* ☒ ***9.*** *Inability to deliver the best clinical outcomes for patients……* ☒ ***10.*** *Potential for poorly delivered positive experience for those engaging with our services..* ☒
CQC DOMAIN	***Which Domain?*** ***SAFE-*** *People are protected from abuse and harm* ☐ ***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☐ ***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐ ***RESPONSIVE –*** *the services meet people's needs.* ☐

	WELL-LED** - the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ☐ ***ALL DOMAINS ☒			
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution ☒ **2.** Operational Plan ☒ **3.** NHS Compliance ☒		**4.** NHS Constitution ☒ **5.** Equality and Diversity ☒ ***6.*** Other: **Click here to enter text.**	
FREEDOM OF INFORMATION (FOIA):	1. This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting			
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	***Board is asked to 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.***	

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

Employment Tribunal Judgement - Dr Mark Tattersall: The Trust has recently received Judgment from the Employment Tribunal in relation to the above case. The Employment Tribunal found in favour of the Trust in relation to all claims brought by Dr Tattersall. The only point that the Tribunal found in Dr Tattersall's favour was a point already admitted by the Trust, namely that the Trust did not issue Dr Tattersall with a contract of employment at the outset of his employment with the Trust on 1st January 2011. This case has taken several years to bring to conclusion and required the input and attendance of many current and ex-employees of the Trust at the Tribunal. The Trust is currently taking legal advice on the potential to seek to recover costs in this case.

Serious Incident Reviews – Management of Cancer Referrals & 18 Weeks Referral to Treatment: The two formal Incident Reviews have now concluded and have been submitted to the CCG in accordance with the prescribed timescale. There are comprehensive Action Plans accompanying each SI report which will now form part of the CCGs monitoring

process. Internally, progress and compliance with the Action Plans will be monitored through the Safety Senate with assurance provided to Board via the Quality Committee's quarterly review of Serious Incidents.
A reflective learning event has been scheduled for the cohort of staff across operational management, patient access and information services based on the findings of the SI investigation.

Genetics: Tender submission made by the April deadline. A challenge meeting has taken place with NHSE on the 20/05/18 to test the strength of the bid. Overall, the meeting went well with concerns raised I two area's that is a common feature to all bids

- Providing robust informatics services over multiple sites
- Financial cost of the services all exceed state tariff

NHSE were particularly impressed with the financial submission in terms of transparency and understanding of cost base that provided explanation of costs exceeding tariff. It is expected that NHSe will make some contract offers in June but it may not be in full.

Single Neonatal Service on two sites: The Business case that was submitted to NHSE is working its way through the governance structure. Further work is has been undertaken on the financial costs with both Trusts and NHSE, this particularly focused on alternative staffing models that would be safe although not compliant with BAPM. LWH have strengthened the governance model and sent to Alder Hey for consideration before submitting to NHSE. A meeting is being arranged with NHSE for early June to consider the next steps.

Quality Report: Local commissioners and external stakeholders at Liverpool CCG provided positive comments on the Trust's 2017/18 Quality Report presented to them at a meeting on 4 May 2018. Commissioners were particularly impressed with the PALs Plus (reducing complaints)initiative, and consequently the Trust has been invited to present it to external stakeholders in July/August, with a view to assisting other providers improve their services. The Trust is also currently working with Aintree to roll out our complaints handling process.

CQC Inspection: Our CQC inspection was a success, with 5/5 KLOEs rated as 'GOOD', which is an improvement from our previous inspection in 2015 when we achieved 4/5.

Seven Day Services: the Trust completed the latest six monthly Seven Day Services survey this month and are awaiting the outcome. The Medical Director attended a Seven Day Services peer support group meeting in Manchester, that provided for sharing of experiences from across the NW.

SECTION B – LOCAL

Cancer Alliance: The Cancer Alliance have asked the Trust to host a gynaecology regional cancer navigator role to ensure cancer patients across the region are treated to agreed timeframes and pathways across the region. This should particularly help in terms of timely referrals to LWH Cancer Centre. This is a one year pilot funded by transformational monies.

Liverpool Health Partners (LHP): The Medical Director attended the Board meetings of LHP, ensuring that under the agreed theme of 'making a good start in life' the interests of R&D at LWH are well represented.

LHP has also recently announced the appointment of Professor Tony Marson as Director of Research Programmes. Professor Marson is Professor of Neurology at the University of Liverpool and Honorary Consultant Neurologist at the Walton Centre NHS Foundation Trust. The Director of Research Programmes is LHP's academic director and as such, Tony Marson will lead the development of LHP's workstreams and play a key role in leading LHP's role regionally, nationally and internationally. He will also play an important role in establishing LHP's effective and productive relationships across the region's NHS and Universities. The Trust's Medical Director was on the appointments panel for this post.

R&D The Trust was represented by the Medical Director at the University of Liverpool Task and Finish Group, which is considering the future of Medical Research in the city. This month, cancer and infection strategies have been completed and a suite of broader recommendations agreed for inclusion in the final Task and Finish Group Report. Women and Children's Health has been identified as an area that warrants support.

Liverpool CCG: The trust received notification from Simon Bowers, Chair of Liverpool CCG that his term of Office as a governing body member and chair will end on 31st May. The newly elected CCG Governing Body will elect a new chair in early June and the Trust will be advised following the elections.

SECTION C – NATIONAL

NHS England and NHS Improvement: On 24 May 18 it was announced that NHS England and NHS Improvement are moving to a single financial and operational planning and performance regime under a shared chief finance officer. This includes the majority of national functions moving to single integrated teams reporting to both organisations, or hosted teams working in one organisation on behalf of both. The Boards of each organisation are expected to remain with no change in legislation.

NHSE nurse staffing workforce initiative: The Trust has been invited to join a new regional NHSE nurse staffing workforce initiative. The acting Director of Nursing and Midwifery will be attending on behalf of the Trust.

NHS Providers Briefing: Ahead of the EU Council Summit in June and as the EU (Withdrawal) Bill nears the end of its passage through the Lords, NHSP have summarised recent key Brexit developments in the attached briefing, which is attached. This includes the March agreement setting out the terms of the transition deal, and ongoing questions over immigration and future customs arrangements between the UK and EU – and how they would apply to the Irish Border.

Liverpool Women's NHS Foundation Trust

Board of Directors

Committee Chair's report of Audit Committee meeting held 18 May 2018

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

2. **Agenda items covered**
   - ~ Code of Governance Compliance 2017/18: the Committee reviewed the outcome of a review on compliance with the code of governance and confirmed that the Trust continued to be compliant with the requirements and that the required statements had been included in the Annual Report 2017/18
   - ~ Annual Report, Financial Accounts & Quality report 2017/18 including Annual Governance Statement – The Committee received and approved the Annual Report, Financial Accounts & Quality report 2017/18. It noted that there were a number of amendments and insertions that would be required to be made to the Quality Report prior to submission to NHS Improvement. The Committee approved the Annual Reports and Accounts 2017/18 noting that the Annual Report and the Quality Report were subject to amendment and recommended them for approval at a convened meeting of the Board on 18 May 2019.
   - ~ External Audit Findings & Management letter – Draft (ISA260) & Letters of Representation: The Committee received the External Audit ISA 260 noting that overall there was no outstanding matters from the audit. The Committee noted that as with previous years the audit opinion had been based on their belief that the Trust would continue as a going concern, but that disclosure would be required regarding uncertainties. Overall there were no significant outstanding matters from the audit.

3. **Board Assurance Framework (BAF) risks reviewed**
   - ~ None

4. **Escalation report to the Board**
   - ~ None.

5. **Issues to highlight to Board**

6. **Action required by Board**
   - ~ Approval of the Trust's Annual Report and Accounts 2017/18

Ian Knight
Chair of Audit Committee

NHS

Liverpool Women's NHS Foundation Trust

Board of Directors

Committee Chair's report of Finance, Performance and Business Development Committee meeting held 21 May 2018

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

2. **Agenda items covered**
   - ~ **Operational Performance Month 1 2018/19 including RTT and Cancer Targets:** The Committee received Month 1 performance dashboard. It was noted that the 18 week RTT and Cancer recovery plans are progressing well and it is envisaged that RTT and Cancer targets will achieve national targets by July 2018 with the exception of the Cancer 62 day target, which is anticipated to be compliant by October 2018.
   - ~ **Finance Performance Review Month 1 2018/19:** The Committee received Month 1 2018/19 finance position. It was noted that at Month 1, the Trust is reporting a deficit of £0.576m against a deficit budget of £0.582m. The Trust is forecasting delivery of the £1.6m control total deficit. It was confirmed that the Trust delivered a 'finance and use of resources' rating of 3 in month which is equivalent to plan. The Committee noted that CIP delivery remains a key risk to the delivery of the 2018/19 financial control total. The Committee also noted the underperformance against the block contract.
   - ~ **Strategic Outline Case Update:** The Committee received a status update.
   - ~ **Reference Cost Process Sign off 2017/18:** The Committee received and approved the Reference Cost Process for 2017/18 on behalf of the Board of Directors as per NHSI best practice guidance.
   - ~ **Electronic Patient Records (EPR) Update:** Potential delays for the EPR programme were highlighted to the Committee's attention. The Committee was briefed on the challenges faced, and of the actions being taken and proposals to move forward. It was agreed to reiterate the EPR risks within the financial BAF risk. The Committee noted progress made against cyber security and resilience issues and GDPR. It was confirmed that the Trust has appointed Mersey Internal Audit Agency to provide Data Protection Officer provision for the Trust for an initial period of 6 months.
   - ~ **Neonatal Redevelopment Project:** The Committee noted that the second Project Board had taken place and considered the Project Report Summary.
   - ~ **Liverpool Women's Health Consultancy Business Development Update:** The Committee received a position update..
   - ~ **Sub Committee Chairs reports received**
     - o Turnaround and Transformation Committee held 14 May 2018
     - o Emergency Planning Resilience and Response Committee held 14 May 2018
     - o Information Governance Committee held 27 April 2018
     - o Digital Hospital Sub-Committee held 27 April 2018

     The Committee noted and approved the above Chairs reports of its reporting sub-committees.

3. **Board Assurance Framework (BAF) risks reviewed**
   - ~ The Committee reviewed the BAF risks it is responsible for on behalf of the Board.

     The Committee would recommend to the Quality Committee an increase to the current risk score for BAF risk 2184 - Failure to deliver an integrated EPR against agreed Board plan from 20 to 25.

4. **Escalation report to the Board on FPBD Performance Measures**
   - ~ Noted within the Operational Performance update above, item 2.0.

NHS

5. Issues to highlight to Board

- EPR Programme delivery risks: the Committee highlights risks of delays to EPR go live and would articulate further within the financial BAF risk.
- CIP delivery: remains a key risk to the delivery of the 2018/19 financial control total.
- Block contract under-performance: this will present a significant financial risk to the Trust from 2019/20.

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 meeting held 21 May 2018

1. Was the quorate met? Yes

2. Agenda items covered

~ Subcommittee Chairs reports:
  - Experience Senate held 8 May 2018
  - Effectiveness Senate held 20 April 2018
  - Safety Senate held 11 May 2018

  The Committee noted and approved the above Chairs reports of its reporting sub-committees.

~ Director of Infection Prevention and Control Annual report 2017/18: The Committee reviewed and approved the content of the annual report. It was noted that this is a public document and would be made available to the public on the Trust website. The Committee was aware that the annual report would be submitted to the June Board of Directors for final ratification.

~ Quality & regulatory Improvement Requirements: The Committee noted that the Trust is waiting to receive the final Care Quality Commission (CQC) inspection report which will also be published on the CQC website. Upon receipt of the final inspection report a task and finish group will be tasked to manage any actions resulting from recommendations.

~ Mortality Quarterly report, Quarter 4 2017/18: The Committee was asked to review the report and identify any issues of concern. It was noted that the requested amendments to this report by the Board of Directors in May 2018 had been made.

~ Stillbirth Annual Report (draft): The Committee considered the draft Stillbirth Annual report. The difficulty to source comparative data was noted. A final report would be presented to the Committee in June 2018.

~ Saving Babies Lives (SBL): The Committee received an update on the care bundle for reducing stillbirth and noted progress made with compliance. It was noted that a further progress update would be provided to the next Executive Committee with regards to achieving compliance against the 10 CNST requirements and SBL, prior to discussion at the next Board of Directors meeting.

~ Quality Committee Performance Dashboard Report – Month 1: The Committee received Month 1 performance dashboard. It was noted that the 18 week RTT and Cancer recovery plans are progressing well and it is envisaged that RTT and Cancer targets will achieve national targets by July 2018 with the exception of the Cancer 62 day target, which is anticipated to be compliant by October 2018. The Committee considered the performance targets breeched in Month 1.

~ Risk Management Strategy Annual Review: The Committee received an annual review against the Risk Management Strategy and was assured that the Strategy remains fit for the purpose of delivering effective Risk Management as a part of the trust's governance framework. The Risk Management Strategy would also be considered by the Trust's Audit Committee.

~ Research and Innovation Strategy (final): The Committee approved the final Research and Innovation Strategy noting that amendments requested by the Board of Directors in March 2018 had been included.

3. Board Assurance Framework (BAF) risks reviewed

The Committee reviewed the quality related BAF risks it is responsible for on behalf of the Board.

The Committee received an escalation request from the Finance, Performance and Business Development (FPBD) Committee with regards to BAF risk 2184 - Failure to deliver an integrated EPR

NHS

against agreed Board plan from 20 to 25. This is in response to a number of issues highlighted at the FPBD meeting with regards to the delivery of EPR.

4. Escalation report to the Board on Quality Committee Performance Measures
   See section 2, within Quality Key Performance Indicator Report Month 1.

5. Issues to highlight to Board
   EPR Risk

6. Action required by Board
   To note increase in BAF risk 2184 - Failure to deliver an integrated EPR to 25

Susan Milner
Chair of Quality Committee

Agenda Item	2018/166

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**CQC Inspection report published May 2018**
DATE OF MEETING:	Friday, 01 June 2018
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Julie King, Acting Director of Nursing and Midwifery
AUTHOR(S):	Julie E. King
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.*** *Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of junior medical staff with the capability and capacity to deliver the best care. ……* ☐ ***3.*** *The Trust is not financially sustainable beyond the current financial year……* ☐ ***4.*** *Failure to deliver the annual financial plan ……* ☐ ***5.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ……* ☐ ***6.*** *Ineffective understanding and learning following significant events……* ☐ ***7.*** *Inability to achieve and maintain regulatory compliance, performance and assurance……* ☒ ***8.*** *Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) ……* ☐ ***9.*** *Inability to deliver the best clinical outcomes for patients……* ☐ ***10.*** *Potential for 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):	4. This report will not be published under the Trust's Publication Scheme due to exemptions under S41 of the Freedom of Information Act 2000, because such disclosure might constitute a breach of confidence			
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	***The Board is asked to note the suggested actions and recommendations of this report***			
PREVIOUSLY CONSIDERED BY:	**Committee name**		***Choose an item.*** Or type here if not on list: Executives	
	Date of meeting		Thursday, 24 May 2018	

Executive Summary

The Trust has now received the 2018 unannounced CQC inspection reports, both of which have a number of suggested 'should do' recommendations. There was 1 requirement Trust wide (respecting patient's privacy & dignity).

As a result of LWH receiving the reports, an action plan will be developed by the Acting Director of Nursing & Midwifery to ensure full and comprehensive compliance with all of the recommendations and requirement. The action plan will be 'task & finish' methodology, will be monitored through the executive committee on a bi weekly basis and will include:

- Executive Sponsor
- Operational Lead
- Responsible assurance committee
- Recommendation description
- Action description
- Link to appropriate risk register
- Target date for completion of the formulated action.

Report

Introduction

LWH received an unannounced full comprehensive CQC inspection in January 2018, with the 'well led' element being completed on an announced basis in February 2018. Overall the Trust has been rated 'GOOD'; with an improvement from the previous 2015 inspection by obtaining 5/5 'good' key lines of enquiry (KLOE) outcomes. No requirement notices were issued, 1 regulatory requirement (Regulation 10, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as amended 2015) – patient's privacy & dignity, was issued; and a number of recommendations for improving practice were given.

Issues for Consideration

An emerging theme of the reports clearly show record keeping, and accessing patient's notes in a timely manner to be issues of concern for CQC. This is supported in the narrative of the reports in the form of staff feedback and direct observation by the inspection team. Culture in the organisation in terms of staff feeling supported by management, and the nursing & midwifery "voice", are also areas of increased focus. Training, PDRs, appraisals and development are additional areas of improvement.

Actions Taken

All staff have been notified and thanked for their participation in the inspection success. A CQC task & finish group will be established by the Acting Director of Nursing & Midwifery, and will be meeting on a bi-weekly basis, reporting back via the executive team to CQC (this is a requirement) on evidenced progress against all suggested areas of improvement.

Conclusion

Overall this has been a successful outcome for LHW, and we welcome the opportunity to further improve our services. The Acting Director of Nursing & Midwifery will provide regular progress updates to the Board as requested, and will highlight any risks or areas of concern that could hinder compliance.

Recommendation

Board are asked to note the content of this brief and request updates as needed.

Liverpool Women's NHS Foundation Trust

Inspection report

Liverpool Women's Hospital
Crown Street
Liverpool
Merseyside
L8 7SS
Tel: 01517089988
www.liverpoolwomens.nhs.uk

Date of inspection visit: 29 Jan to 28 Feb 2018
Date of publication: xxxx> 2018

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

Overall rating for this trust	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Summary of findings

Background to the trust

Liverpool Women's NHS Foundation Trust is a specialist Trust that specialises in the health of women, babies and their families. The trust is one of only two such specialist trusts in the UK.

The annual delivery rate is around 8,000 babies each year. The trust provides inpatient and community midwifery services, which supports women and their families on their journey throughout pregnancy, birth and the postnatal period.

Women receive antenatal and post-natal care in many venues, including children's centres and GP practices and in women's homes by named midwives committed to providing continuity of care.

Women with uncomplicated low risk pregnancies could choose to have their babies at home and be cared for by community midwives. The trust also has a small team of midwives dedicated to caring for women who require enhanced care and support for a variety of reasons.

Services at the trust are commissioned by Liverpool Clinical Commissioning Group.

Overall summary

Our rating of this trust stayed the same since our last inspection. We rated it as Good 

What this trust does

Liverpool Women's NHS Foundation trust provides a range of services including maternity, gynaecology, neonatology, genetics and fertility services from the main hospital site. It provides care for more than 50,000 patients from Liverpool, the surrounding areas and across the UK.

The trust provides inpatient and community midwifery services, which supports women and their families on their journey throughout pregnancy, birth and the postnatal period. Women receive antenatal and post-natal care in many community venues, including children's centres and GP practices and in women's homes by named midwives committed to providing continuity of care.

Women with uncomplicated low risk pregnancies could choose to have their babies at home and be cared for by community midwives. The trust also has a small team of midwives dedicated to caring for women who require enhanced care and support for a variety of reasons.

Liverpool Women's hospital has the only dedicated 24 hour emergency gynaecology department in the UK which is open to all women who require urgent gynaecological or early pregnancy advice or treatment. The trust has 36 gynaecology beds, located across the gynaecology unit, gynaecology high dependency unit and Bedford Centre. The trust offers the 31 elective surgery sessions per week and provides an ambulatory care service for minor surgical procedures. The trust offers a range of gynaecological services including adolescent gynaecology, colposcopy, hysteroscopy and uro-gynaecology. The trust is also the specialist regional centre for gynaecology oncology within the Manchester and Cheshire cancer network.

The trust also provides a range of services from the Aintree Centre for Women's Health, based at Aintree University Hospitals NHS Foundation Trust, including antenatal and booking clinics, foetal medicine clinics and a full range of gynaecology outpatient services including consultation, diagnostics and treatment.

From April 2016 to March 2017 the trust delivered 8891 babies, undertook 5551 gynaecological procedures, cared for 1038 babies in neonatal intensive and high dependency care units and performed 1413 cycles of in vitro fertilisation.

Summary of findings

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

Between and 29 January 2018 and 31 January 2017 we inspected some of the core services provided by this trust at its main hospital as part of our ongoing inspection programme.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well-led key question at the trust level. Our findings are in the section headed is this organisation well-led?

What we found is summarised in the section headed, Is this organisation well-led? The well-led inspection took place between 26 and 29 February 2018.

What we found

We rated well-led at the trust level as good.

We rated three of the trust's core services as part of this inspection. We rated safe, effective, caring and responsive as good and Well Led as good. In rating the trust we took into account the current ratings of the services not inspected this time.

Our decisions on overall ratings take into account, for example, the relative size of services and we use our professional judgement to reach a fair and balanced rating.

Overall trust

Our rating of the trust stayed the same. We rated it as good because:

- Safety systems, processes and standard operating procedures were reliable or appropriate to keep women and babies safe. Staff followed policies and national guidance.
- The trust assessed patient risk well. Staff identified risks to patients and took appropriate measures to mitigate these risks.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- The service had enough staff with the right qualifications, skills, experience and training to keep patients safe from avoidable harm and abuse, and to provide them with the care and treatment they needed. Ward managers matched staffing levels to patient need and could increase staffing when care demands rose by rotation of staff.
- The trust provided specialist clinics and staff with enhances skills to support women with special needs.

Summary of findings

- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- There was an established Maternity Services Liaison Committee (MSLC), which provided an effective channel for users of maternity service to influence the local provision of maternity services.
- The trust had managers with the right skills and abilities to run a service providing high-quality sustainable care.
- Community staff made prompt and timely referrals for women and babies that were identified as vulnerable and there was evidence that the trust worked closely with the enhanced midwifery team, safeguarding team and social services.
- The maternity service had an escalation policy whereby on-call community midwives were required to provide additional staffing to the hospital.
- There were regular divisional and managerial meetings to discuss all incidents in maternity services, including progress on investigations. Feedback to staff was given via face-to-face discussions, emails, staff handovers, staff huddles and team meetings.
- The trust used a combination of National Institute for Health and Care Excellence (NICE) and Royal Colleges' guidance to determine the treatment provided such as supporting a home or water birth and women who did not attend appointments.
- Parents were involved in choices about their baby's birth both at booking and throughout the antenatal period. Those we spoke with said they had felt involved in their care; they understood the choices open to them and were given options of where to have their baby.

However:

- We found that some governance structures, processes and initiatives were recently developed and had yet to be fully embedded and audited in practice.
- Community managers informed us that they completed a training and development log for all their community midwives for mandatory training requirements. However, they did not have complete oversight or use a scoping tool to assess when midwives last undertook a homebirth, pool birth or when community midwives last sutured following a delivery.
- Staff did not always have access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had access to an electronic records system that they could all update however there were many systems in current use which made it laborious and difficult to access information quickly.
- Within the gynaecology core service we found that staff did not always take time to interact with patients outside of essential conversations during observations or examinations.
- Maternity Early Warning score (MEWS) audit results in 2017 were overall good. However, some areas scored low or were scored as "not applicable". This highlighted some inconsistencies with either the staff completing the MEWS incompletely or issues with the audit process.
- Computer information systems needed to be enhanced, streamlined and developed further to reduce and mitigate risks.

Are services safe?

Our rating of safe improved. We rated it as good because:

Summary of findings

- Performance shows a track record and steady improvements in safety.
- Across areas of the trust that we inspected, risks to people who used services were consistently assessed, monitored and managed on a day-to-day basis. These included signs of deteriorating health and completion of risk assessments. We found risks assessments were consistently in place or reviewed regularly.
- In surgical areas staff consistently meet good practice standards in relation to controlled drugs. Records did not consistently have two signatures and wastage records were not consistently completed.
- Across all areas of the trust, there was clear use of systems to record and report safety concerns, incidents and near misses. When things went wrong, reviews and investigations were sufficiently thorough. Necessary improvements were made when things went wrong. Learning from incidents was not consistently shared across the trust to prevent recurrence of incidents.
- Safeguarding adults, children and young people at risk was given sufficient priority. Staff took a proactive approach to safeguarding and focus on early identification. They took steps to prevent abuse or discrimination, responded appropriately to any signs or allegations of abuse and worked effectively with others, including people using the service, to agree and implement protection plans.
- Since our last inspection there was significant improvement in safeguarding training completion levels.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- Across most areas, staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times. Staff shortages were responded to quickly and adequately. Where relevant, there were effective handovers and shift changes to ensure that staff could manage risks to people who use services.
- Openness and transparency about safety was encouraged. Staff understood their responsibilities to raise concerns and report incidents and near misses.
- Staff met good practice standards described in relevant national guidance, including in relation to non-prescribed medicines. People received their medicines as prescribed, staff managed medicines consistently and safely.

However:

- Learning from incidents was not consistently shared across the trust to prevent recurrence of incidents.
- Systems, processes and standard operating procedures were not always reliable or appropriate to keep people safe.
- Monitoring whether new safety systems were implemented and embedded over time, was not always robust.
- In some clinical areas, we observed that patient records were stored in trolley's with zip security access only (not securely locked) and stored in corridors where patients and the public had access. This did not assure us that patient records were stored confidentially at all times.
- We were told that the Medicines Policy covered all areas trust wide. However the Deputy Chief Pharmacist acknowledged that each division currently worked in isolation when considering incidents, in response to our inspection we were told a weekly meeting of harm was going to be initiated immediately to include each division to ensure there would be sharing of best practice.

Summary of findings

Are services effective?

Our rating of effective stayed the same. We rated it as good because:

- People have good outcomes because they receive effective care and treatment that meets their needs.
- Outcomes for people who used services were above expectations compared with similar services.
- People have comprehensive assessments of their needs, which include consideration of clinical needs (including pain relief), mental health, physical health and wellbeing and nutrition and hydration needs. The expected outcomes are identified and care and treatment is regularly reviewed and updated, and appropriate referral pathways are in place to make sure that needs are addressed.
- People's care and treatment is planned and delivered in line with current evidence-based guidance, standards, best practice, legislation and technologies.
- Where people are subject to the Mental Health Act 1983 (MHA), their rights are protected and staff comply with the MHA Code of Practice.
- Across the trust, consent to care and treatment was obtained in line with legislation and guidance.
- Applications to authorise a deprivation of liberty using the Deprivation of Liberty safeguards were made appropriately in a timely way.
- Information about people's care and treatment, and their outcomes, is routinely collected and monitored. This information is used to improve care.
- There is participation (that includes all relevant staff) in relevant local and national clinical audits and other monitoring activities such as reviews of services, benchmarking and approved service accreditation schemes.

However:

- There are gaps in the management and support arrangements for staff, such as appraisal, supervision and professional development.
- Staff did not always have access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had access to an electronic records system that they could all update however there were many systems in use which made it difficult to access information quickly.

Are services caring?

Our rating of caring stayed the same. We rated it as good because:

- Feedback from people who used the service and those who are close to them was positive. We observed that patients were treated with dignity, respect and kindness during their interactions with staff. People we spoke with told us that they felt supported and said staff cared about them.
- Across most areas, staff responded compassionately when people needed help and they supported them to meet their basic personal needs as and when required. Staff supported people and those close to them to manage their emotional response to their care and treatment.
- During our inspection we observed that people who used services, carers and family members were involved and encouraged to be partners in their care and in making decisions, and received support they needed. We observed how staff communicated with people and provided information in a way that they could understand it.
- People we spoke with told us they understood their condition and their care, treatment and advice. People and staff worked together to plan care and in most areas there was shared decision making about care and treatment.

Summary of findings

- People who used services, those close to them and most staff understood the expectations of the service around privacy and dignity. Staff recognised the importance of people's privacy and dignity and our observations showed staff behaving in a respectful manner at all times.

However:

- Across several areas of the trust, people's confidentiality was not respected at all times.
- Staff did not always take time to interact with patients outside of essential conversations during observations or examinations.

Are services responsive?

Our rating of responsive stayed the same. We rated it as good because:

- Services took into account patients' individual physical needs. Patients with complex needs such as a learning disability, dementia or a mental health needs were identified in order for staff to provide additional person centred support.
- Managers and staff understood and followed procedures to manage access to treatment, particularly at times of increased need.
- National targets to ensure that patients could access the services when they needed them were being met.
- The trust treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

However:

- The service did not always take account of patients' individual emotional needs. The emotional needs of patients were not always taken into account when planning services.
- Patients' privacy was not consistently considered by staff. Consultations took place behind a curtain in the colposcopy clinic waiting area where conversations could be overheard.

Are services well-led?

Our rating of well-led stayed the same. We rated it as good because:

- Services had effective systems for identifying risks, and planning to eliminate or reduce them.
- The leadership teams had an understanding of the current challenges and pressures impacting on service delivery and patient care.
- There was evidence of service innovations to benefit the local population.
- There was evidence of good multidisciplinary working in most areas.
- There had been significant improvements in the midwifery staffing numbers since the last inspection.
- We were told by patients and families during our inspection of positive examples of caring, compassionate care. Patients gave us positive feedback about the care they received.

However.

- Incident reporting was inconsistent across services and learning from serious incidents was not effective across divisions.

Summary of findings

- Whilst there was a clear leadership structure in place, we noted that where staff had changed roles or managers were absent staff were not always clear who filled their place.
- The Information Technology (IT) infrastructure was very poor and posed potential clinical risks. There were many systems patched together, resulting in very slow systems affecting service delivery.
- Not all staff were actively engaged so that their views could be used to improve services.

Liverpool Women's Hospital:

- We rated safe, responsive, effective and well led and caring as good.
- Of the services we inspected we rated two services as good and one service as requires improvement.
- The ratings for the services we inspected showed maternity [in patient] and maternity [outpatient] had improved. Gynaecology had gone down since our last inspection.
- Staff we spoke with talked positively about local clinical ward based leadership at Liverpool Women's hospital. The leadership teams had an understanding of the current challenges and pressures impacting on service delivery and patient care.

See sections on individual services at Liverpool Women's Hospital below for more information.

Ratings tables

The ratings tables in our full report show the ratings overall and for each key question, for each service, hospital and service type, and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

Outstanding practice

We found examples of outstanding practice during the inspection. For more information, see the outstanding practice section in this report.

Areas for improvement

We found areas for improvement including breaches of legal requirements that the trust must put right. We also found things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve the quality of services.

Action we have taken

We issued one requirement notice to the trust. That meant the trust had to send us a report saying what action it would take to meet these requirements. Our action related to breaches legal requirements in medical care, surgery, critical care, maternity and children and young people.

For more information on action we have taken, see the sections on areas for improvement and regulatory action.

What happens next

We will make sure that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

Summary of findings

Outstanding practice

We found the following outstanding practice:

- The maternity service had neonatal resuscitation equipment designed to allow a new-born baby to be placed in the correct position for optimal cord clamping while clinical staff had the necessary access to the baby during resuscitation.
- The maternity service had two height adjustable baby cots with handset-operated controls for women with disabilities.
- Midwives liaised with local projects and charities in the city of Liverpool to support new mothers who were struggling to meet the financial and practical burden of looking after a new baby.
- Enhanced midwifery team provided individualised needs-based holistic care to women with significant mental health problems, alcohol, substance misuse, social care involvement, learning disabilities.
- Staff worked collaboratively with a wide range of services, completing joint visits in order to provide a seamless support service to women before and after the birth of their baby.
- Community services evaluate their service, using a wide range of tools, including the hospital anxiety and depression score, maternal antenatal attachments score and the maternal postnatal attachments score.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve

Gynaecology

- The service must ensure that patients' privacy is maintained at all times.

Action the trust SHOULD take to improve

Maternity [in patient]

- The trust should ensure that all governance structures, processes and initiatives that were recently developed are fully embedded and audited in practice.
- The trust should continue to monitor access and flow, timely review of women by medical and midwifery staff and timely access and response within the telephone systems in Triage and Maternity Assessment Unit.
- The trust should ensure that all staff have completed their mandatory training.
- The service should ensure that all staff receive an annual appraisal review.
- The trust should continue to audit the MEWS charts to ensure full compliance and completion by all staff.
- The trust should ensure that all patient records are stored confidentially at all times in all clinical areas.
- The trust should mitigate risks relating to using of both electronic and paper documentation simultaneously.

Summary of findings

- The trust should ensure that all staff competencies for medical devices training are up to date.

Maternity [Community]

- The trust should undertake a scoping exercise to assess when community midwives last undertook homebirths, pool births or suturing following a delivery to ensure all staff are confident and competent to undertake such roles.
- The service should continue to review and increase their homebirth rate.
- The trust should ensure that all guidelines on the intranet are up to date and staff are using the most up to date documents concerning foetal monitoring.
- The trust should continue to develop and monitor the development of an electronic patient system and ensure standardised use among all staff.
- The trust should continue to monitor and resolve IT issues experience by staff in the community.

Gynaecology

- Record reasons for missed medications in each occurrence.
- The trust should ensure that patient records are stored securely at all times.
- The trust should review mandatory training rates against the trust target and put an action plan in place to meet those targets.
- The trust should audit infection control measures in place in gynaecology theatres.
- The trust should make sure electronic records are accessible to staff in a timely manner.
- The trust should provide training for staff around providing counselling or emotional support to patients experiencing a miscarriage or termination of pregnancy.
- The trust should enable new staff members to become familiar with online records systems prior to using them in practice.
- The trust should consider providing contraceptive services to women who attend for a termination of pregnancy.
- The trust should have health information leaflets available in languages other than English.
- The trust should consider the needs of local people when planning service delivery.
- The trust should consider putting pathways in place for women who present to the emergency department that are not pregnant.
- The trust should consider the length of time patients are expected to wait in the admissions lounge on the gynaecology unit prior to surgical procedures.
- Consider what activities are made available to inpatients within the gynaecology unit.
- The trust should review any assessment/quiet rooms used for any mental health patients that may attend the hospital. Specifically in relation to the management of any ligature risks within these rooms.

Summary of findings

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

This was our first review of well led at the trust under our next phase methodology. We rated well led as good because:

- The senior leadership team had the skills, knowledge, abilities and commitment to provide high-quality services. New members of the management team were being embedded through the different management levels in the trust; however, the embedding of new staff was still to be completed and required further works to ensure the new leadership structures were effective across the trust.
- There was a clear structure in place to support good governance and management. The trust had systems for identifying risks, planning to eliminate or reduce them and coping with both the expected and unexpected.
- Managers and staff embraced innovation and tried hard to improve the quality and sustainability of services.
- Managers across the service generally promoted a positive culture that supported and valued staff. In most service areas this created a sense of common purpose based on shared values.
- The senior management team collected, analysed, managed and used information well to support activities, using secure electronic systems with security safeguards.
- The trust was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.
- The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.
- The trust used a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.
- Leadership teams had an understanding of the current challenges and pressures impacting on service delivery and patient care.
- Most staff we spoke with described a continued improvement in the culture since our last inspection and spoke positively about the leadership team.

However:

- Governance frameworks were established; however this work was not fully embedded trust wide. We were assured there was an overall 'line of sight', but there remained variation in the management of risk, staffing and performance frameworks across divisions within the trust.
- The information technology infrastructure was miss-matched across the trust and posed potential clinical risks. There were many systems patched together, resulting in slow systems which affected service delivery.
- Trainee medical staff told us that they were not given enough time to learn to use the systems before having to use them in practice.

Summary of findings

- Within the gynaecology division, staff we spoke with were not aware of a divisional strategy for the service. Managers at all levels expressed a lack of direction or vision for the service. Senior managers we spoke to were also unable to articulate a clear vision for the gynaecology service.
- Staff expressed to us that there was “silo” working within the trust. Medical, nursing and theatre staff worked separately to resolve issues and did not always engage in opportunities to collaborate.
- We were told that the Medicines Policy covered all areas trust wide. However the Deputy Chief Pharmacist acknowledged that each division currently worked in isolation when considering incidents. This meant that learning from medication incidents was not effectively shared across the trust.
- Actions identified on the Workforce Race Equality Standard [WRES] action plan 2016-2017 had not yet been completed.

Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	→←	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Good ↑ May 2018	Good →← May 2018	Good →← May 2018	Good →← May 2018	Good →← May 2018	Good →← May 2018

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for Liverpool Women's Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity	Good ↑ May 2018	Good →← May 2018	Good →← May 2018	Outstanding ↑ May 2017	Good →← May 2018	Good →← May 2018
Gynaecology	Good ↑ May 2018	Good →← May 2018	Good →← May 2018	Requires improvement ↓ May 2018	Requires improvement ↓ May 2018	Requires improvement ↓ May 2018
Neonatal services	Good May 2015	Good May 2015	Good May 2015	Good May 2015	Good May 2015	Good May 2015
End of life care	Good May 2015	Good May 2015	Good May 2015	Good May 2015	Good May 2015	Good May 2015
Outpatients	Good May 2015	Not rated	Good May 2015	Good May 2015	Good May 2015	Good May 2015
Overall*	Good ↑ May 2018	Good →← May 2018	Good →← May 2018	Good →← May 2018	Good →← May 2018	Good →← May 2018

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Liverpool Women's Hospital

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www.liverpoolwomens.nhs.uk

Key facts and figures

Liverpool Women's Hospital specialises in the health of women, babies and their families. It is the largest women's hospital of its kind in Europe.

The hospital provides a range of services, including maternity, gynaecology, neonatology, genetics and fertility services from the main hospital site. It provides care for more than 50,000 patients from Liverpool, the surrounding areas and across the UK.

The hospital has the only dedicated 24-hour emergency gynaecology department in the UK, which is open to all women who require urgent gynaecological or early pregnancy advice or treatment.

The hospital is also the specialist regional centre for gynaecology oncology within the Manchester and Cheshire cancer network.

The Bedford Centre is located within the hospital and is a day case unit providing termination of pregnancy services.

Liverpool Women's NHS Foundation Trust also provides a range of services from the Aintree Centre for Women's Health, including antenatal and booking clinics, foetal medicine clinics and a full range of gynaecology outpatient services including consultation, diagnostics and treatment.

Liverpool Women's Hospital is one of the largest employers locally with more than 1,400 whole time equivalent staff.

The annual delivery rate is around 8,000 babies each year. The trust provides inpatient and community midwifery services, which supports women and their families on their journey throughout pregnancy, birth and the postnatal period.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

Summary of services at Liverpool Women's Hospital

Good ➔➔

Our rating of services stayed the same. We rated it them as good because:

- There were enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.

Summary of findings

- The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- Staff assessed patient risk well. Staff identified risks to patients and took appropriate measures to mitigate these risks.
- Medicines were prescribed, administered, recorded and stored well. Patients received the right medication at the right dose at the right time.
- There was an established Maternity Services Liaison Committee (MSLC), which provided an effective channel for users of maternity service to influence the local provision of maternity services.
- Community staff made prompt and timely referrals for women and babies that were identified as vulnerable and there was evidence that the trust worked closely with the enhanced midwifery team, safeguarding team and social services.
- Parents were involved in choices about their baby's birth both at booking and throughout the antenatal period.

However:

- We found that some governance structures, processes and initiatives were recently developed and had yet to be fully embedded and audited in practice.
- Staff did not always have prompt access to up-to-date, accurate and comprehensive information on patients' care and treatment.
- Managers across the hospital did not always promote a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- Computer information systems needed to be enhanced, streamlined and developed further to reduce and mitigate risks.

Maternity

Good ↑

Key facts and figures

Liverpool Women's NHS Foundation Trust is a specialist trust that specialises in the health of women, babies and their families. The trust is one of only two such specialist trusts in the UK.

The annual delivery rate is around 8,000 babies each year. The trust provides inpatient and community midwifery services, which supports women and their families on their journey throughout pregnancy, birth and the postnatal period.

Women receive antenatal and post-natal care in many venues, including children's centres and GP practices and in women's homes by named midwives committed to providing continuity of care.

Women with uncomplicated low risk pregnancies could choose to have their babies at home and be cared for by community midwives. The trust also has a small team of midwives dedicated to caring for women who require enhanced care and support for a variety of reasons.

During our visit, we spoke with 14 patients, two doctors, six maternity support workers and 27 staff senior and junior midwives.

We observed care and treatment to assess if patients had positive outcomes and looked at the care and treatment records for 10 patients. We also reviewed three medicine prescription charts.

Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- Staff recognised and reported incidents well. However, initiatives for shared learning to reduce recurrence were relatively new and still needed to be embedded into practice.
- Safety systems, processes and standard operating procedures were reliable or appropriate to keep women and babies safe. Staff followed policies and national guidance.
- Staff identified potential safeguarding risks, involved relevant professionals and had systems in place to manage it.
- The service had enough staff with the right qualifications, skills, experience and training to keep patients safe from avoidable harm and abuse, and to provide them with the care and treatment they needed. Ward managers matched staffing levels to patient need and could increase staffing when care demands rose by rotation of staff within the unit.
- Performance and patient outcomes on the maternity dashboard were good.
- Stillbirth rates were monitored closely and were on a downward trend.
- There was an established mandatory training programme for midwives and medical staff.
- The service had specialist clinics and staff with enhances skills to support women with special needs.
- Enhanced midwifery team provided individualised needs-based holistic care to women with significant mental health problems, alcohol, substance misuse, social care involvement, learning disabilities. They provide one-to-one care within a setting, which was comfortable for the woman (Better births, 2017).

Maternity

- Patients' needs and preferences were considered and acted on to ensure that services were delivered in a way that met their needs.
- The maternity service had two height adjustable baby cots with handset-operated controls for women with disabilities.
- There were 8 cots dedicated for transitional care of babies situated on the maternity ward.
- There was an established bereavement system in place following the loss of a baby.
- There was an established Maternity Services Liaison Committee (MSLC), which provided an effective channel for users of maternity service to influence the local provision of maternity services.
- The culture among staff was good.
- Patients were positive about their care.
- Staff was aware of the maternity vision and strategy plan or the maternity service development plan.
- Senior managers had a good oversight and awareness of issues within the services and there was evidence of plans to improve these.
- Midwives had implemented a new "reconciliation" process, which monitored closely all medicine stocks. This aimed to reduce medication errors, monitor supplies and expiry dates and improve traceability of the drugs. This was an improvement since the last CQC inspection in 2015.

However:

- Some governance structures, processes and initiatives were recently developed and had yet to be fully embedded and audited in practice.
- There were access and flow issues within the triage and Maternity Assessment Unit (MAU).
- We observed issues in antenatal clinic regarding the environment, cleaning schedules, infection control and cleanliness, effectiveness of the self-check in service and fridge temperature recordings.
- Timely advice and support via the telephone triage line was not always available.
- Maternity Early Warning score (MEWS) audit results in 2017 were overall good. However, some areas scored low or were scored as "not applicable". Therefore, this highlighted some inconsistencies with either the staff completing the MEWS incompletely or issues with the audit process.
- Patient records were not stored confidentially at all times in some clinical areas.
- Mandatory training rates showed that compliance rates were below the trust target of 95% in three of the four main inpatient clinical areas.
- Compliance rate for safeguarding training for inpatient midwifery and medical staff was under the trust target of 95%.
- Not all staff had received annual appraisal reviews.
- Some ward staff had not completed medical device training since 2014.
- The homebirth rate was low.
- Computer information systems needed to be developed further to reduce and mitigate risks.

Maternity

Is the service safe?

Good ↑

Our rating of safe stayed the same. We rated it as good because:

- The service managed patient safety incidents well.
- Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. The service used information to improve the service.
- The service controlled infection risk well**.** Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- The service had suitable premises and equipment and looked after them well**.**
- The maternity service had neonatal resuscitation equipment designed to allow a new-born baby to be placed in the correct position for optimal cord clamping while clinical staff had the necessary access to the baby during resuscitation.
- The service prescribed, gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time. Since the last CQC inspection in 2015, community staff had implemented a new "reconciliation" process, which monitored all medicine stocks closely. This aimed to reduce medication errors, monitor supplies and expiry dates and improve traceability of the drugs.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. The majority of staff in community midwifery services (between 96 and 100%) had completed training in level 3 safeguarding adults and children. Training completion levels in inpatient midwifery services ranged from 79% to 100%.
- Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and available to all staff providing care.
- The service provided mandatory training in key skills to all staff. Data received from the trust confirmed that mandatory training and safeguarding compliance rates were between 87 and 96% completion by staff. However we noted that this fell below the trust target of 95% inpatient services.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.
- The service planned for emergencies and staff understood their roles if one should happen.

However:

- Maternity Early Warning score (MEWS) audit results in 2017 were good overall. However, some areas scored low or were scored as "not applicable". Therefore, this highlighted inconsistency indicating either the staff were completing the MEWS incompletely or there were issues with the audit process.

Maternity

- Staff were currently using two different recording systems on the delivery unit and there were some concerns raised by staff about duplication of documentation, confusion and room for errors. Senior medical staff agreed that using two systems (electronic and paper documentation) could potentially be a cause for concern.
- There were still some inconsistencies following incidents and improvements needed to be implemented. There were relatively new staff in post who were working closely to improve timely processes, outcomes and feedback to staff and reduce risks of reoccurrence.
- In some clinical areas, such as the anti-natal clinic, we observed that patient records were stored in trolleys with zip security access only (not securely locked) and stored in corridors where patients and the public had access. This did not assure us that patient records were stored confidentially at all times.
- Clinical areas used cloth curtains in the bedded and cubicle bays. We did not observe cleaning labels on the curtains to highlight when they were last changed or cleaned. Staff we asked were unaware of the cleaning rota and when the curtains were last changed or cleaned. The trust provided us with evidence that the curtains in the clinical areas were audited and changed approximately every six months. Curtains on delivery suite where changed “as and when” however, there was no visible record of this.

Is the service effective?

Good

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients’ religious, cultural and other preferences.
- The service monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.
- The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- Staff always had access to up-to-date, accurate and comprehensive information on patients’ care and treatment. All staff had access to an electronic records system that they could all update.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care

However:

- Managers did not have complete oversight or use a scoping tool to assess when midwives last undertook homebirths, pool births or suturing following a delivery. As the homebirth rate was low and community midwives did not routinely rotate into the acute trust, managers were not fully aware of all staff competencies and staff confidence to undertake such roles.
- Not all inpatient staff had completed an annual appraisal.

Maternity

Is the service caring?

Good  

Our rating of caring stayed the same. We rated it as good because:

- Care and treatment throughout the wards and departments providing care to maternity inpatients were delivered by caring and compassionate staff.We observed staff treating patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff involved patients and those close to them in decisions about their care and treatment.
- Staff provided emotional support to patients to minimise their distress.
- Women were involved in choices about their baby's birth both at booking and throughout the ante-natal period.
- Staff were skilled at building trusting relationships with patients and their partners/relatives in a short space of time.

Is the service responsive?

Outstanding 

Our rating of responsive improved. We rated it as outstanding because:

- Maternity services were responsive to patients' needs. Services were tailored, planned, and delivered to meet the individual needs of women and were delivered in a way to ensure flexibility, choice and continuity of care.Patients' preferences were considered and acted on to ensure that services were delivered in a way that met their needs.
- There was a proactive approach to understanding the needs of different groups of people and to deliver care in a way that met these needs. This included people in vulnerable circumstances or those who had complex needs. Staff liaised with local projects and charities in the city of Liverpool to support new mothers who were struggling to meet the financial and practical burden of looking after a new baby. Staff told us about contacting these local projects, to source baby equipment and personnel items when women were struggling to but such items themselves. This was a proactive and supportive approach to meet the needs of women in vulnerable circumstances.
- Patients' care and treatment was coordinated with other services and other providers in order to meet their individual needs. There were midwives with specialist skills in conditions such as diabetes and substance misuse who were available to advise and support women. The enhanced midwifery team worked collaboratively with a wide range of services that supported the team in completing joint visits providing a seamless support service to the women and her unborn/baby. They evaluate their service using the hospital anxiety and depression score, maternal antenatal attachments score and the maternal postnatal attachments score. This was a proactive and multidisciplinary approach to understanding the needs of different groups of people and delivering care in a way that met these complex needs.
- There were processes in place to support women with mental health concerns. A service level agreement was in place to access consultant psychiatric support from a neighbouring trust within normal working hours and from the mental health crisis team out of hours.

Maternity

- Facilities and premises were appropriately adapted to meet the individual needs of patients. The maternity service had two height adjustable baby cots with handset-operated controls for women with disabilities. This was an innovative approach to providing extra support for women with complex needs, as the design of the cots enabled women to care for and access their babies more easily and independently.
- There were innovative approaches to providing care that involved other service users.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

Is the service well-led?

Good  

Our rating of well-led stayed the same. We rated it as good because:

- The trust had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.
- Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The trust used a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.
- The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.
- The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.
- The trust was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.
- Staff were positive about the support they received from their line managers and felt comfortable and confident about raising concerns.

However:

- Some governance structures, processes and initiatives were only recently developed and needed to be fully embedded and audited in practice to ensure effectiveness.

Outstanding practice

We found examples of outstanding practice in this service. See the Outstanding practice section above.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Gynaecology

Requires improvement 

Key facts and figures

Liverpool Women's NHS Foundation trust offers a range of gynaecological services including adolescent gynaecology, termination of pregnancy, colposcopy, hysteroscopy and uro-gynaecology.

The trust is also the specialist regional centre for gynaecology oncology within the Merseyside and Cheshire cancer network.

The Bedford Centre is located within the hospital and is a day case unit providing termination of pregnancy services.

Liverpool Women's hospital has the only dedicated 24 hour emergency gynaecology department in the UK which is open to all women who require urgent gynaecological or early pregnancy advice or treatment.

The trust has 52 gynaecology beds, located across the gynaecology unit (24 beds), gynaecology high dependency unit (two beds), surgical day cases (16 beds) and Bedford Centre (10 beds).

The trust offers the 31 elective surgery sessions per week and provides an ambulatory care service for minor surgical procedures.

Summary of this service

Our rating of this service went down. We rated this service as requires improvement because:

- The service did not have a vision for what it wanted to achieve and had not developed plans with involvement from staff, patients, and key groups representing the local community.
- Managers across the service did not always promote a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service did not use a systematic approach to continually improving the quality of its services.
- The service did not always plan and provide services in a way that met the needs of local people.
- The emotional needs of patients were not always taken into account when planning services.
- Staff did not always take time to interact with patients outside of essential conversations during observations or examinations.
- Staff did not consistently provide emotional support to patients to minimise their distress.
- Patients' privacy was not maintained at all times. Consultations of patients attending the colposcopy clinic could be overheard by patients in the waiting area.
- Staff did not always have prompt access to up-to-date, accurate and comprehensive information on patients' care and treatment.

However:

- The service managed patient safety incidents well.
- The service assessed patient risk well. Staff identified risks to patients and took appropriate measures to mitigate these risks.

Gynaecology

- The service prescribed, gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff involved patients and those close to them in decisions about their care and treatment.
- The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.

Is the service safe?

Good 

Our rating of safe improved. We rated it as good because:

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The service assessed patient risk well. Staff identified risks to patients and took appropriate measures to mitigate these risks.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- The service had suitable premises and equipment and looked after them well.
- The service prescribed, gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time.
- Staff kept appropriate records of patients' care and treatment. Records were up-to-date and available to all staff providing care.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service provided mandatory training in key skills to all staff.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.
- The service planned for emergencies and staff understood their roles if one should happen.

Gynaecology

Is the service effective?

Good ➔➔

Our rating of effective stayed the same. We rated it as good because:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other preferences.
- Staff ensured that patients received adequate pain relief and regularly assessed their needs.
- The service monitored the effectiveness of care and treatment and used the findings to improve them.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

However:

- Staff did not always have access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had access to an electronic records system that they could all update however there were many systems in use which made it difficult to access information quickly.

Is the service caring?

Good ➔➔

Our rating of caring stayed the same. We rated it as good because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- The service had systems and facilities in place to provide emotional support to patients and relatives.
- Staff involved patients and those close to them in decisions about their care and treatment.

However:

- Staff did not always take time to interact with patients using the gynaecology day case unit outside of essential conversations during observations or examinations.
- Staff did not consistently provide emotional support to patients to minimise their distress In the Bedford unit staff did not have time to offer emotional support to patients outside of their appointment time.

Gynaecology

Is the service responsive?

Requires improvement  

Our rating of responsive went down. We rated it as requires improvement because:

- The service did not always plan and provide services in a way that reflected the needs of local people.
- The service did not always take account of patients' individual needs. The emotional needs of patients were not always taken into account when planning services.
- Patients' privacy was not always considered by staff. Consultations took place behind a curtain in the colposcopy clinic waiting area where conversations could be heard.

However:

- People could access the service when they needed it. Waiting times for treatment were minimal and arrangements to admit treat and discharge patients were in line with good practice.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

Is the service well-led?

Good  

Our rating of well-led went down. We rated it as requires improvement because:

There was a vision and strategy for the service however none of the staff we spoke to were able to articulate what this was. This was of particular note among nursing staff.

- Managers across the service did not always promote a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service was not always proactive in driving innovation and instead often took a reactive approach to making improvements in response to identified risks within the service.
- The service did not always engage well with patients, staff, the public and local organisations to plan and manage appropriate services.

However:

- The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.
- The service collected, analysed, managed and used information well to support activities, using secure electronic systems with security safeguards.
- There was a clear structure in place to support good governance and management.
- The service had effective systems for identifying risks, and planning to eliminate or reduce them.

Gynaecology

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

Our inspection team

Julie Hughes, Inspection Manager, led this inspection. An executive reviewer, Ms Lisa Knight, Director of Nursing, supported our inspection of well-led for the trust overall.

The team also included three inspectors, five specialist advisers, and an expert by experience.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.

Agenda Item	2018/167 (a)

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Better Births Update Report**
DATE OF MEETING:	Friday, 01 June 2018
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Julie King
AUTHOR(S):	Jenny Butters Matron
STRATEGIC OBJECTIVES:	***Which Objective(s)?***
	1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☒
	2. To be ambitious and *efficient* and make the best use of available resource ☒
	3. To deliver *safe* services ☒
	4. To participate in high quality research and to deliver the most *effective* Outcomes ☐
	5. To deliver the best possible *experience* for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?***
	1. *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust* ☒
	2. *The Trust is not financially sustainable beyond the current financial year* ☐
	3. *Failure to deliver the annual financial plan* ☐
	4. *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision* ☐
	5. *Ineffective understanding and learning following significant events* ☐
	6. *Inability to achieve and maintain regulatory compliance, performance and assurance* ☐
	7. *Inability to deliver the best clinical outcomes for patients* ☒
	8. *Poorly delivered positive experience for those engaging with our services* ☐
CQC DOMAIN	***Which Domain?***
	SAFE- *People are protected from abuse and harm* ☒
	EFFECTIVE - *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☒
	CARING - *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☒
	RESPONSIVE – *the services meet people's needs.* ☒
	WELL-LED - *the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ☒
	ALL DOMAINS ☒

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

Executive Summary

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

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

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

The review calls for:

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

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

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

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

Report

LWH Self-Assessment against Better Births

No	Recommendation	Trust Position	Actions
1.	**Personalised Care**	Compliant	
2.	**Continuity of care**	Compliant	
3.	**Safer Care**	Compliant	
4.	**Perinatal Mental Health**	Compliant	
5.	**Multi Professional Working**	Compliant – Maternity Non- complaint from IT perspective	Digital maternity hand held notes part of the EPR project estimated time for implementation Jan 2019
6.	**Working Across Boundaries**	Partial compliance	Full compliance relies on Community Hubs progress relies on CCG / Healthy Liverpool progress regarding cost neutral estates.
7.	**Payment System**	Non- complaint	Awaiting clarification from a national perspective in relation to maternity tariff payments expected advice from DOH early 2019

Updates on Progress

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

Personalised Care

The Maternity pioneer work continues with the booklet outlining choices being given to all women booking into the service. A pilot is taking place with 4 midwives from the Liverpool area who discusses the financial costs of care with women. The pilot is planned to finish at the end of June after which NHS England will evaluate the findings.

Safer Care

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

Perinatal Mental Health

- Appointment of perinatal mental health specialist midwife
- National funding has increased team of CPN and Psychologist support available to women
- Strengthened Consultant presence through links with Merseycare
- Nominated Consultant Obstetrician

Working Across Boundaries

Community midwifery hubs established in four areas however the vision for super hubs where all community midwifery is co- located with other services such as community paediatrics and health visiting is reliant on external factors. Please see paper relating to community redesign update.

Continuity of Carer

Better births sets out a vision for safe, efficient models of Maternity care: safer care, joined up across disciplines, reflecting women's choices and offering continuity of care (CoC) along the pathway.

The ambition laid down by the Secretary of State is that in March 2019 - 20 % of women across LMS's booking into maternity services will be cared for in a continuity of care pathway.

The development of continuity of care models for women is now the prime focus of maternity services redesign to comply with national and local targets set by NHS England. The trajectory from NHS England and locally through the LMS indicates LWH needs to see 3.5% of its bookings by 2019 be allocated to COC pathways and 5% by 2020.

- Trusts will self-declare compliance within the LMS who will then report to NHS England.

Update on Progress

- Senior midwifery team have met with team from NHS England and other members of Cheshire and Mersey LMS. Aim of the meeting to unlock the challenges faced by trusts.
- Clear message from NHS E that CoC cannot be implemented across the whole system due to workforce challenges including recruitment, engagement, and age profile of midwifery workforce.
- Start small and scale up
- Senior team have scoped of possible work streams where continuity of care could be achieved at LWH including homebirth, enhanced pathway for vulnerable women and elective caesarean sections.
- All women booking for care at LWH are allocated a named midwife.

- Scoping of homebirth team – 5 expressions of interest has been received from the current midwifery workforce, HR aspects currently being worked through.

Next Steps

- A launch event for staff is planned in June to motivate and engage staff.
- Workforce and HR issues to be worked through with corporate services.

J Butters
May 2018

Agenda Item	2018/167(b)

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	Community Midwifery Re-design progress report
DATE OF MEETING:	Friday, 01 June 2018
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Julie King
AUTHOR(S):	Jenny Butters Matron
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** 1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☒ 2. To be ambitious and *efficient* and make the best use of available resource ☒ 3. To deliver *safe* services ☒ 4. To participate in high quality research and to deliver the most *effective* Outcomes ☐ 5. To deliver the best possible *experience* for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust* ☒ ***2.*** *The Trust is not financially sustainable beyond the current financial year* ☐ ***3.*** *Failure to deliver the annual financial plan* ☐ ***4.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision* ☐ ***5.*** *Ineffective understanding and learning following significant events* ☐ ***6.*** *Inability to achieve and maintain regulatory compliance, performance and assurance* ☐ ***7.*** *Inability to deliver the best clinical outcomes for patients* ☒ ***8.*** *Poorly delivered positive experience for those engaging with our services* ☐
CQC DOMAIN	***Which Domain?*** ***SAFE-*** *People are protected from abuse and harm* ☒ ***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☒ ***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☒ ***RESPONSIVE –*** *the services meet people's needs.* ☒ ***WELL-LED -*** *the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ☒ ***ALL DOMAINS*** ☒

LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution ☐ **2.** Operational Plan ☒ **3.** NHS Compliance ☒	**4.** NHS Constitution ☒ **5.** Equality and Diversity ☐ ***6.*** Other: **Click here to enter text.**
FREEDOM OF INFORMATION (FOIA):	1. This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting	
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	***The Board is asked to note the current status of the Community Midwifery re-design Project***	
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

This paper is to provide an update to the Board of Directors on the progress of the community redesign project and the development of the Continuity of Care Model as recommendation from the National Maternity Review – Better Births.

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

Other significant drivers include:

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

Report

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

- Identification of suitable hubs.
  Following a scoping exercise undertaken with the transformation team and community matron to identify suitable community based hubs that are cost neutral but offering a holistic model of care supporting an integrated services that include ultrasound imaging services, obstetric clinics, antenatal education and other services such as smoking cessation, along with services which support the public health agenda for women, babies and families. There is a focus on midwives being highly visible to the local community.

Currently there are four hubs delivering the above services however to absorb the whole of the community services in these hubs would not be tenable due to capacity. The work undertaken identified that much larger accommodation would be required to facilitate all bookings, antenatal follow up, consultant clinic and ultrasound services, thus having a cost implication.

Alongside this is the need for greater integration of other services such as health visiting, allied health care professional groups and community paediatric services in line with Healthy Liverpool Project vision of co – located hub working.

Liverpool CCG are undertaking a scoping of the estates available to move towards a co-location of community services of which Liverpool Women's is integral to, however this work remains incomplete and therefore we are unable to progress and further at the present time.

- **IT services in Community.**
  The IT provision for community was reviewed, some network issues were identified and improvements are underway to increase network coverage across the geographical area.

  Community midwives have mobile phones that are currently being upgraded to smart phones that will enable midwives to access emails and policies remotely which will improve communication with services and service users.

  The development of an App for community was worked up however it was deemed not fit for purpose and due to the implementation of the new electronic patient record including community services and possibly a patient portal it has been decided to wait for development of this for the community IT plan to progress.

- **Antenatal Clinic Redesign**
  The redesign has been modified due to lack of capacity in community hubs to relocate all the hospital bookings however work has been undertaken to improve to efficiency and experience.

- **Link clinic**
  To reduce variation in the current service provision, this particular cohort of women will be delivered care in a case loading model to provide continuity of care and equity of service provision.

- **Enhanced Midwifery service**
  The criteria for referral to this team have been extended to include young women and asylum seekers and a restructure of the existing team has been undertaken which has strengthened the leadership within the team. The appointment of a perinatal mental health specialist midwife has enhanced the expertise of this team and strengthened links with the wider perinatal mental health team, this has enabled the number of women requiring extra midwifery support to increase thus focussing on improved outcomes in the postnatal period.

  Continuity of Care Model Update is addressed in a separate paper.

Conclusion

The community redesign has made some definite progress resulting in a more positive and responsive service user experience however the two main issues of hubs and IT services are not able to be fully resolved at this present time due to reliance on external factors and potential cost implications. Alongside this other developments for maternity services have been made a priority and include the continuity of care model. The development of continuity of care models for women is now the prime focus of maternity services redesign to comply with national and local targets set by NHS England. The trajectory from NHS England and locally through the LMS indicates LWH needs to see 3.5% of its bookings by 2019 be allocated to COC pathways and 5% by 2020. Liverpool Women's Hospital community service will continue to engage with local CCG regarding the wider development of hubs working towards maternity services being co-located with other community services.

Jenny Butters
Matron

Agenda Item	2018/168

MEETING	Board of Directors
PAPER/REPORT TITLE:	Director of Infection Prevention and Control Annual Report
DATE OF MEETING:	Friday 1 June 2018
ACTION REQUIRED	For Approval
EXECUTIVE DIRECTOR:	Julie King, Acting Director of Nursing and Midwifery
AUTHOR(S):	Tim Neal, Director of Infection, Prevention and Control
STRATEGIC OBJECTIVES:	*Which Objective(s)?* 1. To develop a well led, capable, motivated and entrepreneurial ***workforce*** ☐ 2. To be ambitious and ***efficient*** and make the best use of available resource ☐ 3. To deliver ***safe*** services ☒ 4. To participate in high quality research and to deliver the most ***effective*** Outcomes ☐ 5. To deliver the best possible ***experience*** for patients and staff ☐
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust* ☐ ***2.*** *The Trust is not financially sustainable beyond the current financial year* ☐ ***3.*** *Failure to deliver the annual financial plan* ☐ ***4.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision* ☐ ***5.*** *Ineffective understanding and learning following significant events* ☐ ***6.*** *Inability to achieve and maintain regulatory compliance, performance and assurance* ☐ ***7.*** *Inability to deliver the best clinical outcomes for patients* ☐ ***8.*** *Poorly delivered positive experience for those engaging with our services* ☐
CQC DOMAIN	*Which Domain?* *SAFE- People are protected from abuse and harm* ☐ *EFFECTIVE - people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☐ *CARING - the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐ *RESPONSIVE – the services meet people's needs.* ☐ *WELL-LED - the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ☐ *ALL DOMAINS* ☒
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution ☐ **2.** Operational Plan ☐ **3.** NHS Compliance ☒ **4.** NHS Constitution ☐ **5.** Equality and Diversity ☐ ***6.*** Other: Click here to enter text.
FREEDOM OF INFORMATION (FOIA):	1. This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting

RECOMMENDATION: *(eg: The Board/Committee is asked to:-….)*	***Approve the IPC annual report.***	
PREVIOUSLY CONSIDERED BY:	**Committee name**	Infection Prevention and Control Committee Quality Committee
	Date of meeting	Friday, 27 April 2018

Infection Prevention & Control Annual Report 2017-2018

Dr Tim Neal, Director of Infection Prevention & Control

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TABLE OF ABBREVIATIONS

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

1 Summary of Key Achievements and Main Findings

1.1 Key Achievements 2017-18

The Trust was compliant with the prescribed MRSA bacteraemia target

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

The Trust reported 10% reduction in E.coli sepsis

Table 1: Trust Attributable HCAI 2015-18

Organism	April 2015 - March 2016	April 2016 - March 2017	April 2017 - March 2018
Clostridium difficile infection (CDI)	0	0	0
Meticillin resistant *Staphylococcus aureus* (MRSA) sepsis	1	0	0
Meticillin sensitive *Staphylococcus aureus* (MSSA) sepsis	0	0	2
E,coli sepsis Total and (HCAI)	7	8	6

1.2 Main Findings

1.2.1 Education

The IPCT has organised and delivered 78 training sessions on ANTT in addition to other regular training sessions

1.2.2 Guidelines

The Trust Water Safety Policy has been reviewed in line with new Trust Policy Process.

1.2.3 Environmental and Clinical Practice Audits

128 (100%) environmental, 107 (91%) clinical practice ward audits and 58 (36.5%) community midwives' combined clinical audits have been completed in accordance with the Trust plan.

1.2.4 MRSA

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

1.2.5 C. difficile

There have been no Trust acquired *C.difficile* infections in 2017-18

1.2.6 Bacteraemia

There have been no MRSA bacteraemias reported in 2017-18

There were 3 MSSA bacteraemias in 2017-18 (2 Neonates, 1 Adult)

14 neonates had significant Gram-negative sepsis (4 congenital) and 12 neonates had significant Gram-positive infections (9 congenital).

There were 10 E.*coli* bacteraemias in 2017-18 (7 neonates and 3 adults). There is a national target of 10% reduction from the previous year's figures which was achieved.

There were no glycopeptide resistant enterococcal bacteremias in 2017-18

1.2.7 Surgical Site Infection Surveillance

For the period April – September
0.9% of elective caesarean sections and 1.1% of Emergency Caesarean sections resulted in an SSI.

1.8 % of open gynaecological abdominal surgery and 0.3% of Laparoscopic abdominal surgery resulted in an SSI

Wound surveillance was suspended in November 2017 due to a reduction of staff in the Infection Prevention and Control team.

2 Infection Prevention & Control Team Members

During 2017- 18 the Infection Prevention and Control Team (IPCT) has been supported by a seconded Midwife, a seconded Gynaecology Nurse and a Neonatal Nurse

Miss K Boyd
Infection Prevention & Control Analyst (part time 0.80 WTE - 30 hours/week Infection Prevention and Control Analyst, 0.20 WTE - 7.5 hours/week Policy Officer for the Governance Team)
Mrs D Fahy
Infection Prevention & Control Nurse - (0.60 WTE – 22.50 hours/week)
Dr T J Neal
Consultant Microbiologist – Infection Control Doctor and Director of Infection Prevention and Control (DIPC) (2 sessions / week worked on LWFT site)
Mrs Anne-Marie Roberts
Secondment Link Midwife (0.40 WTE - 16 hours)
Mrs Julie Burns
Seconded Link Nurse (0.40 WTE - 16 hours) **(Left the Trust 03.12.18)**
Mrs Eleanor Walker
Neonatal Link Nurse (0.40 WTE – 15 hours)

The IPCT is represented at the following Trust Committees:

Safety Senate	Monthly
Clinical Supplies Meeting	Monthly until November 2017
Infection Prevention & Control	Bi-Monthly
Medicines Management	Bi-Monthly
Water Safety Meetings	Twice yearly
PLACE	Ad-hoc
Building Planning	Ad-hoc

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

3 Role of the Infection Prevention & Control Team

The following roles are undertaken by the IPC Team:-

- Education
- Surveillance of hospital infection
    - Surgical Site data collection (until October 2017)
    - National bacteraemia data reporting
    - PHE data reporting
- Investigation and control of outbreaks
- Development, Implementation and monitoring of Infection Prevention and Control policies
- Audit
- Assessment of new items of equipment
- Assessment and input into service development and buildings / estate works
- Patient care/ incident reviews

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

4 Infection Prevention and Control Committee

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

Reports received include those from:

- Estates and Operational Services
- Occupational Health
- Decontamination
- Divisions/departments
- Link Group
- Water Safety group
- Infection Prevention and control team members

The Terms of Reference of the IPCC are included as **Appendix A**

The IPCT report quarterly to IPCC and the DIPC reports quarterly to Safety Senate (SS) which also receive minutes of the IPCC meetings. The Quality committee (QC) receives minutes from SS. The Trust Board also receives an annual presentation and report from the DIPC.

Trust IPC issues, processes and surveillance data are relayed to the public via Infection Prevention and Control posters, patient information leaflets, the Trust website (copy of this

report) a notice board in the main reception which is updated on a monthly basis and departmental notice boards in ward areas.

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

- Suspended Wound surveillance due to reduced staffing within the team
- Cannula Audits undertaken by department as of October 2017
- The IPCT have identified that ANTT training is required more frequently this has been agreed at IPCC and ANTT training is being delivered in relevant departments.
- Pool Audits undertaken by department as of October 2017
- IPCT more visible within areas

5 External Bodies

5.1 Health Care Act & Care Quality Commission

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

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

4.1 Liverpool Clinical Commissioning Group (CCG) Assurance Framework

Assurance data is reported monthly to the CCG and bi-monthly at IPCC it incorporates performance data, exception reporting audit data and screening compliance.

4.2 Mandatory Surveillance

The Trust submits data on MRSA, MSSA, *E.coli, Clostridium difficile, Klebsiella* and *Pseudomonas infections* by the 15th day of each month to the Public Health England via an online Health Care Associated Infection Data Capture System. HCAI data is also submitted each month for the Trust Quality Report and Corporate Information.

6 Education

6.1 Mandatory training and Induction:

Mandatory training in Infection Prevention and Control is a requirement for all Trust staff including clinical, non-clinical staff and contractors. The IPCT update the training package

annually and ensure that it reflects best practice, national recommendations and issues identified as non-compliant in the previous year. All staff receive training in infection prevention and control every three years via electronic learning and a Hand Hygiene Assessment. The electronic package is incorporated into the NLMS and linked to OLM. Ten hand hygiene sessions have been delivered on corporate induction throughout 2017-18

Training continues to be provided by the IPCT for medical staff which includes consultants, trainees and ad-hoc mandatory training for corporate services. Five formal teaching sessions have been delivered by the DIPC throughout 2017-18

The IPCT has provided 20 general training sessions in 2017-18 (Including, the use of standard precautions, and Audit/NUMIS training)

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

6.2 Link Staff

The IP&C link staff meetings are held bi-monthly and Professional Development Days held twice yearly. The programme is organised to reflect current initiatives, implementation of new guidance and reinforcement of any non-compliance relating to IPC. The number of attendees on each development day was 8 (23%) and 14 (40%). Link staff meetings and professional development days are included in the TNA provision for Link Staff.

6.3 ANTT Training

A review of ANTT training was undertaken in 2016, and it was agreed at IPCC in July 2016 that training would continue to be annual for Neonatal Unit and change from once only to 2 yearly for the rest of the Trust.

It was agreed that due to the number of staff requiring an ANTT update the IPCT would complete the initial drive with a plan for Link staff to assist with assessments in clinical practice, where necessary. On completion of the initial drive the plan was for ANTT to be reinstated on the training matrix on a 2 yearly basis.
78 sessions were provided by the IPC team in 2017-18. This included planned and ad hoc sessions in the clinical area in order to accommodate staff attendance. These sessions were not always well attended due to staff workload and availability.

A new plan was put in place for ANTT to be included in the Obstetric training days from Jan 2018 and clinical assessors were trained to assess staff in clinical practice.

7 Guidelines/Policies

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

- Water Safety Policy has been reviewed

8 Audits

8.1 ICNA Trust audit programme

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

The IPS Clinical Practice audits, Saving Lives audits and monthly '5 moment's' audits are entered onto the NUMIS system allowing real-time oversight of results and compliance by local managers. A total of ~~124~~ 107 (91%) Clinical Practice audits and ~~232~~ 198 (88%) Hand Hygiene audits have been carried out by ward department staff and have been reviewed by the IPCT

Environmental audits using the IPS audit tools are carried out unannounced by the IP&C team and where possible accompanied by a member of departmental staff. A total of ~~140~~ 128 Environmental scheduled audits (Including general environment, linen, waste and kitchen) over 26 clinical areas have been carried out by the IPCT. Individual department scores, main themes of non-compliance and areas of improvement are recorded and available on NUMIS.

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

Audit	Mean Score (%)	Range (%)
Ward Environment	91%	68- 98
Ward Kitchen	93%	68-100
Linen	96%	80-100
Departmental Waste	99%	85-100
Patient Equipment	95%	82-100
Hand Hygiene	99%	97- 100
Personal Protective Equipment	99%	91- 100
Sharps safety	98%	90- 100
Monthly 5 moments	95%	73- 100

Community midwives were expected to complete a combined self –assessment clinical practice audit of Sharps, PPE and Hand Hygiene twice a year. Community midwives completed an audit in October 2017 but unfortunately this was completed after the audit time frame for the first audit period, of April –September 2017. Therefore one of the two yearly audits was missed which is reflected in the low percentage in numbers of audit. The mean score for the audit however was 97% and actions have been discussed with the Matron, Team Leaders and IPCT. It is expected that the community midwives audits will continue twice yearly.

8.2 Peripheral cannula audits

The IPCT continued to audit the ongoing care of cannulae in both Maternity and Gynaecology areas on a fortnightly basis until September 2018, with ad hoc cannula audits being undertaken since. A total of 37 cannula audits were undertaken with scores ranging from 28 - 100% (mean 84%), insufficient documentation on the VIIAD chart remains the most common identified deficit. From September 2018 ownership of cannula audits returned to ward areas.

8.3 Mattress audits

Mattress audits are completed in all areas in the Trust. The audit examines cleanliness and mattress integrity. Results are reported through the Divisional Report to IPCC. The audits are forwarded to IP&C Team but local areas have ownership for replacement and condemning of any mattress not fit for purpose. There is a system in place for the provision and storage of replacement mattresses across the Trust. The most recent audit identified a non–compliance issue with MAU trolleys with regards to accessibility of difficult to clean areas, new trolleys were ordered.

8.4 Birthing Pool Audits

Pool audits were completed on a fortnightly basis by IPCT until September 2018. 19 audits were undertaken by IPCT during this time with scores having ranged from 57-100% with a mean score of 78%. Areas of non-compliance related to the documentation of the daily cleaning of the pools and before and after patient use. IPCT notified Ward Managers, Matrons and Link staff of audit results. From September 2018 ownership of pool audits returned to ward areas and reporting of compliance reported at IPCC. IPCT provided an audit template for pool cleaning compliance. Main concerns remains to be documentation of pool cleaning.

9 Other Issues

9.1 Water Safety

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

9.2 Building Projects & Design Developments

The team remain reliant on the Estates Department and the Divisions alerting and involving the Team in impending projects via the Infection Prevention and Control Committee meetings.

2017-18 projects requiring IPC Team involvement included:

- Gynae Outpatients, Imaging LWH OPD entrance Improvement programme
- MAU design
- Discussions about NICU refurbishment project

9.3 Soft FM

The IPCT were involved in the tendering and evaluation of the Trust Soft FM services contract which was given to OCS and commenced on 1st July 2017. This included the establishment of a rapid response team and updated service level agreements.

10 Surveillance of Infection

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

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

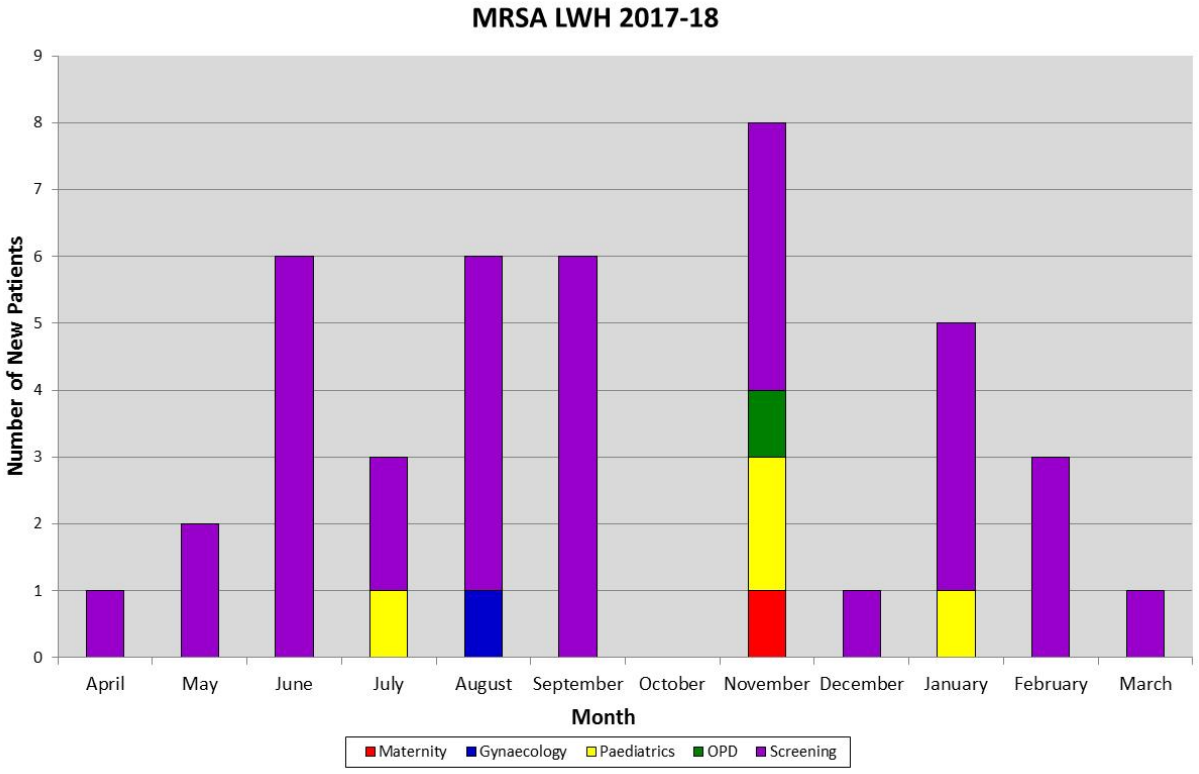
Surveillance of bacteraemias (blood stream infections) for both national mandatory and in house schemes is also undertaken. National mandatory reporting of blood stream infections has been extended this year to include *Klebsiella* and *Pseudomonas* in addition to *E.coli* and *S.aureus.*

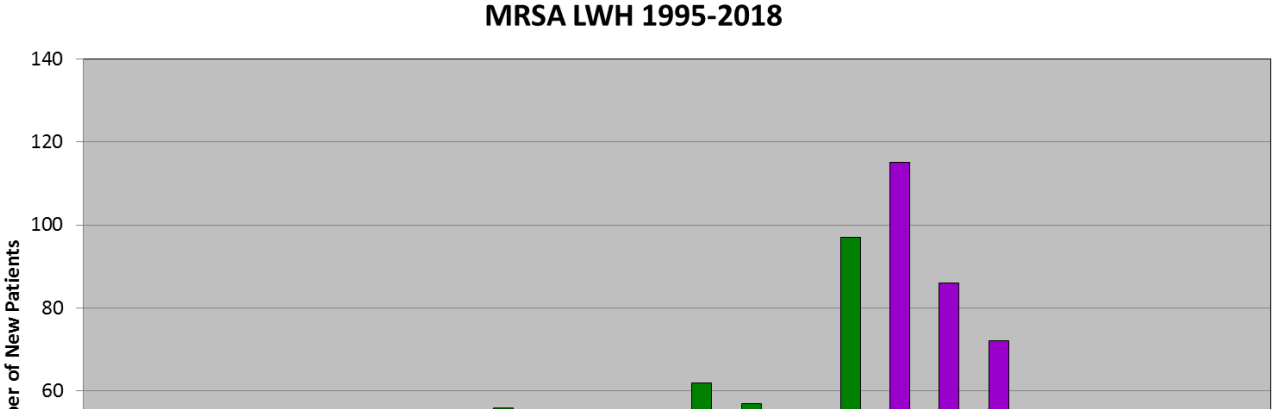
The surveillance system for surgical site infections by the IPCT ~~has~~ was suspended in November this year as staffing levels in the IPCT were depleted.

10.1 Alert Organism Surveillance

10.1.1 MRSA

The total number of patients identified carrying Methicillin Resistant *Staphylococcus aureus* (MRSA) in the Trust during the year 2017-18 was 42, primarily identified from screening samples. The charts below show the number of new patients identified with MRSA and the annual totals for the period 1995 – 2018.





As outlined in previous Annual Reports the Government had established targets for screening such that all elective admissions and all eligible emergency admissions to hospital should be screened for carriage of MRSA prior to, or on, admission. The IPCT have an MRSA screening policy outlines actions for patients found to be positive on screening. During 2017-18 the criteria for screening patients for MRSA was modified following consultation with the IPCC and a formal risk assessment, patients attending for day case and ambulatory surgery were excluded from the screening programme.

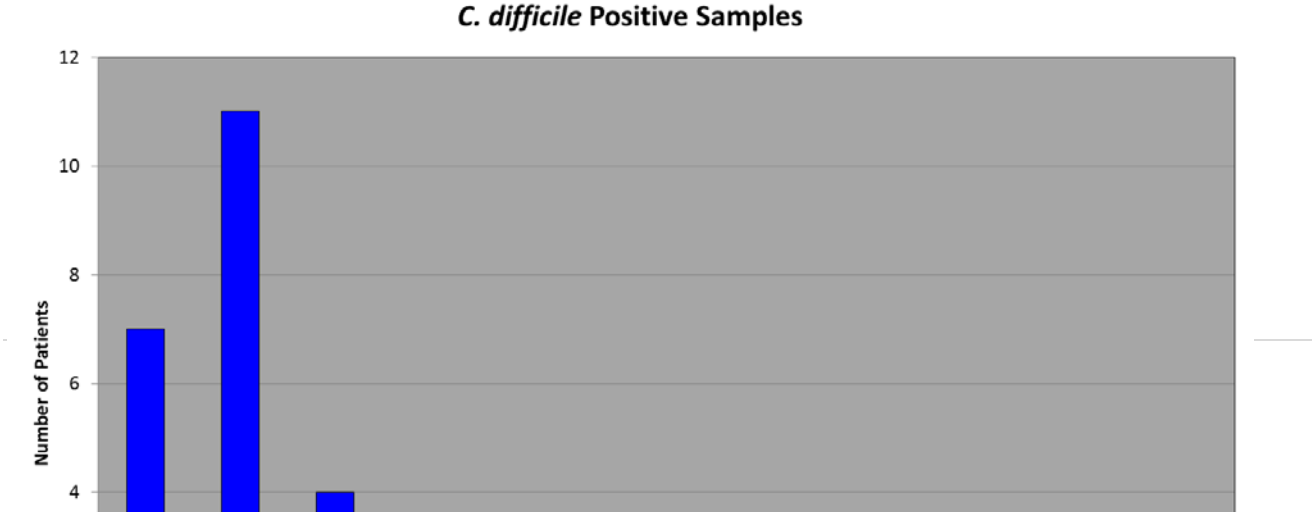
In the period April 2017 to March 2018 4091 adult patients were screened for MRSA carriage; 36 (0.9%) were positive.

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

During the period of this report 4 babies were identified with MRSA. There was no identified epidemiological link between the babies and no evidence of spread on the neonatal unit. There was a link between one of the maternal cases and one of the neonatal cases.

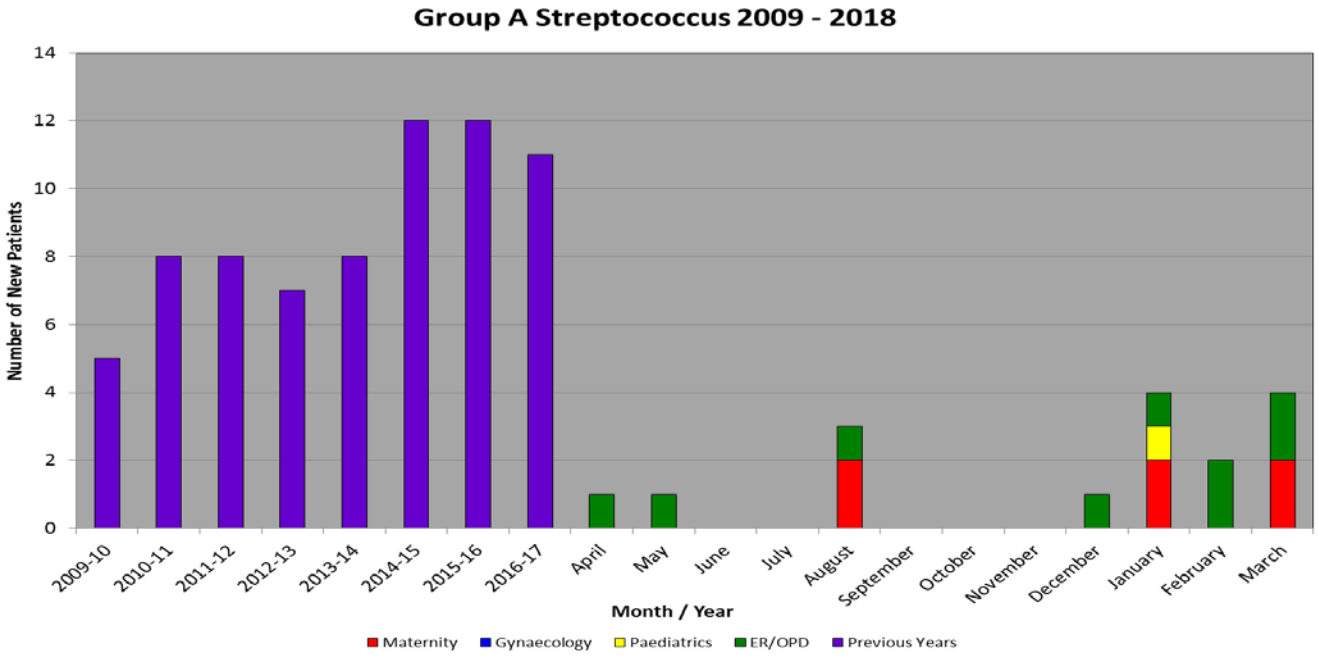
10.1.2 Clostridium difficile

Mandatory reporting of this disease commenced in January 2004 and includes all patients over 2 years old. Historically the number of cases at LWFT has been low (see chart below).
The prescribed trajectory for this disease for the Trust in 2017-18 was one.
During the period April 2017 to March 2018 there were two patients identified with *C.difficile* infection in the Trust, both these patients were admitted with community-onset infection and therefore do not count against the Trust's trajectory.



10.1.3 Group A Streptococcus

In the period April 2017 to March 2018, 14 patients were identified with Group A streptococcus as detailed below. Two adult patients presented with invasive Group A Streptococcal infection (iGAS), septicaemia. Both had established infection at the time of admission. The paediatric patient was linked to one of these iGAS patients, but apart from this there was no obvious epidemiological link between patients.



There was no identified transmission of Group A streptococci in the Trust.

10.1.4 Glycopeptide Resistant Enterococcus (GRE)

There were no GRE bacteraemia's reported.

10.1.5 Carbapenemase Producing Enterobacteriaceae

The screening for multidrug - resistant organisms was incorporated into National Guidance and in 2014 LWH commenced screening patients in high risk groups for Carbapenemase producing enterobacteriaceae (CPE). In June 2016 the screening process was extended. All patients who have been an inpatient in any other hospital within the preceding 12

months require screening. Meditech facilitates the risk assessment. CPE screening compliance is audited weekly by the IPCT
Overall compliance 88%

Month	Screening Compliance
Apr 17- June 17	96%
July 17– Sept 17	82%
Oct 17 – Dec 17	89%
Jan 18 – Mar 18	73%

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

10.1.6 Routine Neonatal Surveillance

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

As colonisation is a precursor to invasive infection the purpose of this form of surveillance is to give an early warning of the presence of resistant or aggressive organisms and to ensure current empirical antimicrobial therapy remains appropriate. Action points are embedded in the neonatal unit and IPC policies linked to thresholds of colonisation numbers to limit spread of resistant or difficult to treat organisms.
As well as resistant or aggressive organisms focus has remained on both *Pseudomonas spp*. and *Staphylococcus aureus* as potential serious pathogens. The median number of babies colonized with pseudomonas each week was 1, and with *S.aureus* was 5, both figures unchanged from 2016-17.

10.2 Bacteraemia Surveillance

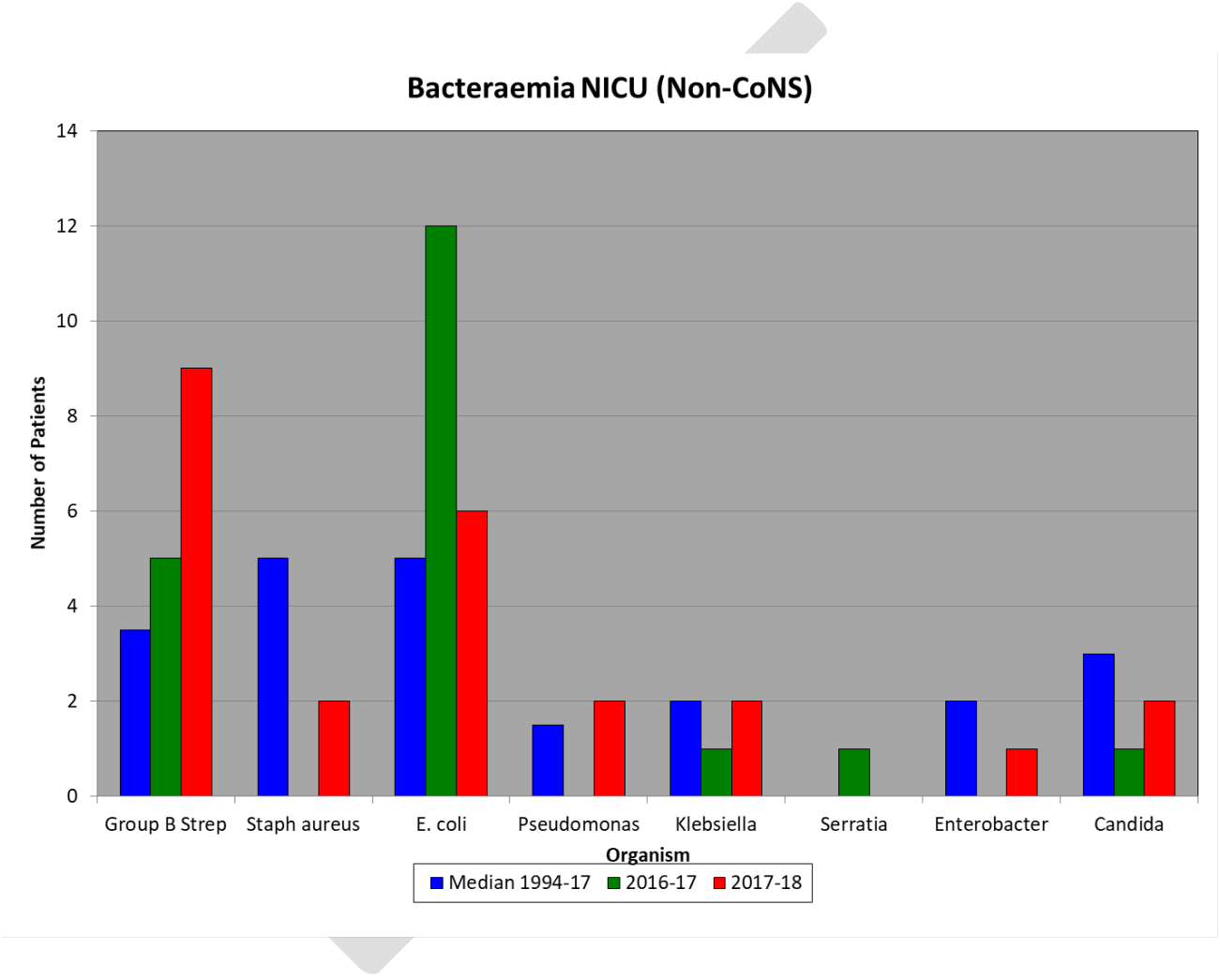
10.2.1 Neonatal Bacteraemia

As always the commonest organism responsible for neonatal sepsis was, the common skin organism, coagulase-negative staphylococcus (CoNS). In the period April 2017 – March 2018 14 babies (14 in 2016-17 and 15 in 2015-16) had infections with Gram-negative organisms, 3 of these infections (2 Haemophilus and 1 *E coli)* occurred in the first 5 days of life and were congenitally acquired, one *P.aeruginosa* occurred on day 5 and most probably represented a late presentation of congenital infection. The remaining 10 Gram-negative infections occurred after 5 days (1 *P.aeruginosa*, 1 *Enterobacter koserii,* 1 *Stenotrophomonas maltophilia, 2 Klebsiella sp* and 6 *E.coli* (in one instance a relapse of congenital infection))

There were 12 episodes of infection with significant Gram-positive pathogens; 8 cases were congenitally acquired Group B streptococcus and 1 congenitally acquired *Streptococcus millerii*. There were 3 late-onset infection (1Group B streptococcus and 2 *S.aureus*).

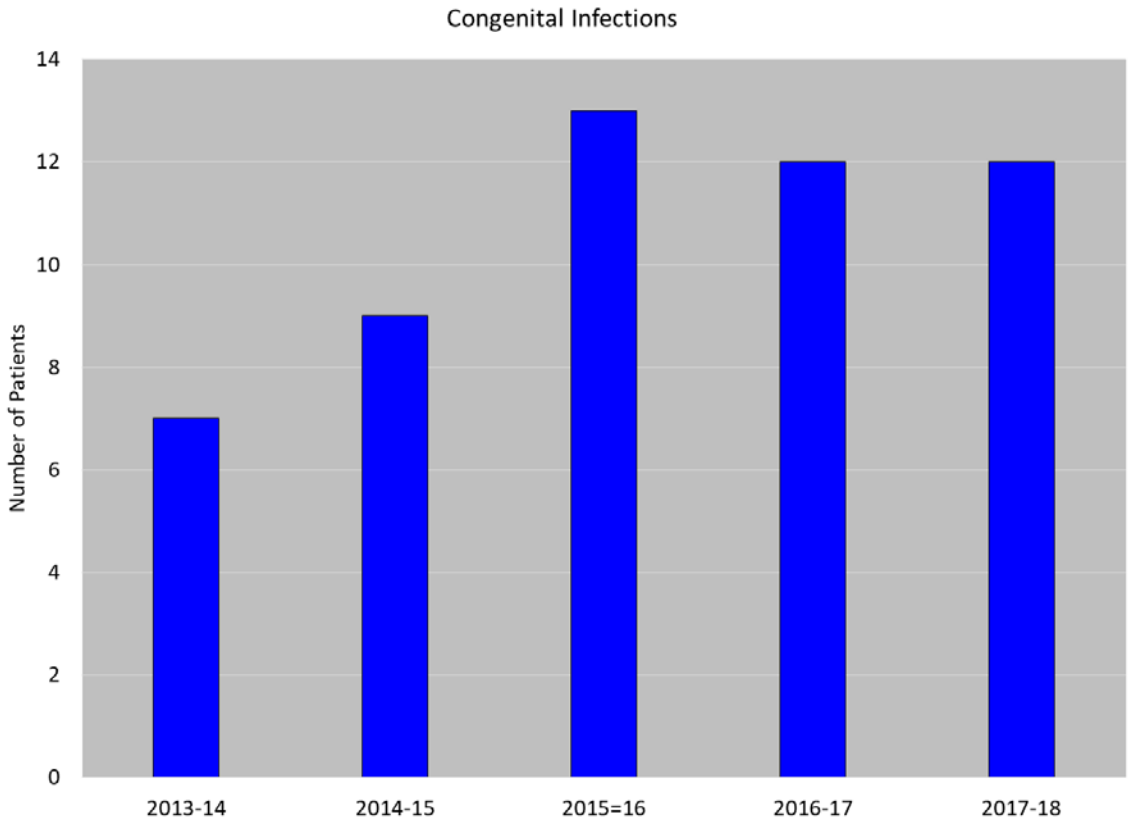
There were 2 babies in 2017-18 who developed invasive infection with Candida

All non-coagulase-negative staphylococcal sepsis on the unit is subject to a review to determine the focus of infection, precipitating causes and the appropriateness of care.
The bar chart below describes the pattern of 'definite-pathogen' neonatal bacteraemia in the current year in comparison to last year and the median value for each organism for preceding years. Although there is considerable variability in the figures from year to year (probably reflecting the complex of pathogen host relationship in this group). 2 babies developed infection with *P.aeruginosa,,*as this was the first such incident for 5 years an investigation was undertaken.(See section 11 and appendix E)

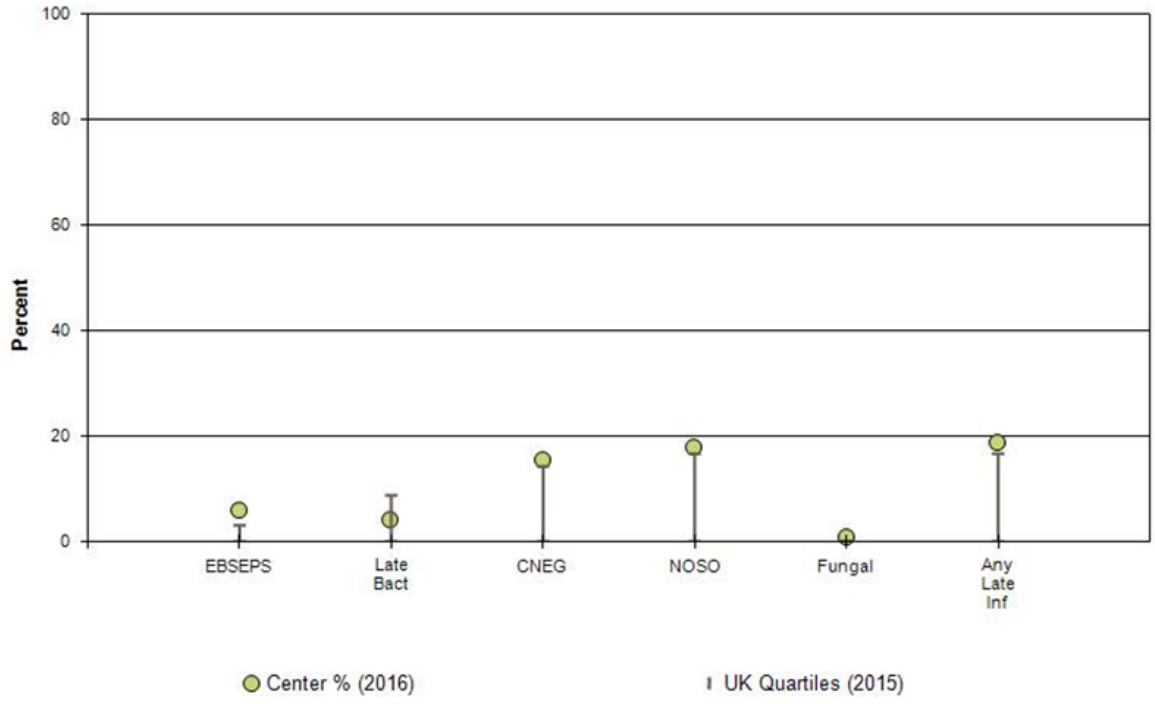


As outlined in last year's report the IPCT have been monitoring the number of neonatal infections classified as 'congenital'. 12 babies this year had congenital infection.

The



Neonatal Unit continues to monitor standardised infection rates. The most recent data (2016) show overall rates of bloodstream infection are either within the IQR (e.g. late bacterial infections and fungal infections) or at the upper quartile (CONS infections). However, there has been a gradual increase in late-onset bloodstream infections with CONS since 2013.



10.2.2 Mandatory Bacteraemia Surveillance

There have been no MRSA or MSSA bacteraemia cases in adult patients in the period April 2017 to March 2018, however 2 neonates developed MSSA bacteraemia (see section 11.1)

The CCG has a prescribed target to reduce E.coli bacteraemia by 10% in 2017-18. Although this is not a Trust target the IPCT have been working with regional groups facilitated by the CCG to reduce *E.*coli sepsis. In 2017-18 the Trust reported 7 *E.coli* bacteraemias in neonates (1 categorised as congenital). In the same period there were 3 *E.coli* bacteraemias in adult patients (12 in 2015-16). The IPCT expect clinical areas to undertake an RCA of all significant bacteraemias to establish any elements of sub-optimal care.

In addition to the mandatory surveillance the IPCT has been collecting clinical data on bacteraemic adults in the Trust; 29 patients were identified with positive blood cultures from 323 cultures submitted (9%). 13 (45% of positives, 4% of total) of these were contaminated with skin organisms. Of 16 significant bacteraemias one was considered to be possibly healthcare associated. Details are provided in Appendix D

10.3 Surgical Site Surveillance

Surgical Site Infection (SSI) is one of the most common healthcare associated infections, estimated to account for 15% of HCAI. National surveillance for abdominal hysterectomy suggests an SSI incidence of 1.5%. There is no national data for caesarean sections however studies report rates between 2% & 20% with the highest incidence being in emergency sections.

Surgical site wound surveillance in both Maternity and Gynaecology was re-established in 2014/15 to include all abdominal procedures and groin node dissections. In April 2016 wound surveillance extended to include perineal surgical site infections. Data has been collected by a member of the IPCT/TVN using a standard surveillance sheet. Surveillance includes the inpatient period for all patients and the post discharge period until the 30th day. Unfortunately in August 2017 the TVN left the Trust as a consequence wound surveillance data has only been collected for the first 6 months of the year.

10.3.1 Maternity

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

In the 6 month period April 2017 – September 2017) 1219 Caesarean Sections were undertaken (571 elective, 648 emergency). 14 patients with potential SSI were reviewed with 12 fulfilling the criteria for SSI. Of the 12 infections, 5 were in elective and 7 in emergency cases (0.9% and 1.1% respectively).

Perineal Surgical Site Infections – 659 episiotomies were undertaken, 16 SSI have been identified (2.4%).

10.3.2 Gynaecology

1134 abdominal procedures were undertaken in the 6-month period in Gynaecology / Gynae-oncology with 224 procedures being open and 906 being laparoscopic. The

IPCT/TVN reviewed 13 patients with potential infections. 7 SSI were identified, 4 in open and 3 in the laparoscopic category (1.8 % and 0.3% respectively).

4 groin infections were identified

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

11 Outbreaks of Infection

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

In October 2017 two babies on the neonatal unit developed septicaemia caused by *Pseudomonas aeruginosa.* As this is an uncommon event, the last being over 5 years ago, this was treated as a significant incident. PHE and commissioners were informed and the incident was investigated. The incident team concluded that the two episodes of infection were unrelated and this was not therefore an outbreak. A report on the incident prepared for the Trust's Safety Senate is attached as Appendix E.

12 Risk Register

- 1652 - Risk of hospital acquired infection due to potential lapses in practice and non-adherence with Infection Control policies resulting in potential serious harm or death to a patient, prolonged LOS, unsatisfactory patient experience; significant financial loss; loss of stakeholder confidence; and/or a material breach of CQC conditions of registration
- 1578 - Risk of infectious diseases causing disruption to Trust services including risk to patient and staff safety requiring the implementation of emergency preparedness intervention

13 Health & Wellbeing

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

14 Infection Control Team Work Plan

14.1 Infection Control Team Work Plan 2017-18

Work Plan	Completion Date	Comments
Training • Continue all Trust mandatory & induction training • Continue to support link staff personal development	Ongoing	See section 6
Audit • Continue with ICNA/IPS Audit Programme • Continue Saving Lives audits including cannulation • Continue monitoring of pool cleaning	Ongoing	See section 4 & 8 Cannulation and Pool audits devolved to the wards from October 2017
Surveillance • Continue 'Alert Organism' surveillance focused on resistant pathogens • Continue to monitor cases mandatorily reportable infections • Continue wound surveillance for surgical site infection including perineal surgical site infections • Undertake a comprehensive review surgical site infections where figures indicate a rising incidence • Implement actions identified through RCA of bacteremia's and C.difficile infections • Continue to work with external agencies to understand if congenital infection rate rising and any preventable factors • Work with the CCG to deliver their target of 10% reduction in E.coli sepsis.	Ongoing	See Section 10 Perineal Wound surveillance stopped October 2017 Surgical site surveillance suspended since November 2017 TJN attends CCG meetings on behalf of LWH
Health Act & NICE • Review compliance and evidence • Review and ensure Trust maintains its compliance with current NICE guidance relating to infection, infection control, sepsis and antimicrobial stewardship.	March 2018	See section 5 Reviewed and submitted as part of the Monthly Assurance Report

14.2 Infection Control Team Work Plan 2018-19

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

15 Appendices

15.1 Appendix A – Terms of Reference - Infection Prevention and Control Committee Terms

INFECTION PREVENTION AND CONTROL COMMITTEE TERMS OF REFERENCE

Constitution:	The Committee is established by the Trust Board and will be known as the Infection Prevention and Control Committee.
Duties:	The Committee is responsible for providing assurance to the Trust Board in relation to those systems and processes it monitors and ensure compliance with external agency's standards e.g.: CQC etc. 1. Agree and disseminate the systems and processes for effective Infection Prevention and Control. 2. Develop the strategic direction of Infection Prevention and Control, ensuring that the team is resourced sufficiently to achieve improvement in performance. 3. Review and approve the work of the Infection Prevention & Control team members in line with Trust objectives through the IPCC team work plan. 4. Review and endorse all policies relating to Infection Prevention & Control and evaluate their implementation. 5. Receive and review regular reports of infection incidents or outbreaks and ensure that reports are forwarded to appropriate external authorities. 6. Ensure that lessons identified from incidents, outbreaks, or reports from external organisations are actioned by relevant Divisions in the organisation. 7. Implement a regular reporting timetable including comprehensive Division reports and reports from support services at regular intervals. 8. Ensure that effective Infection Prevention and Control is being delivered in Divisions and monitor evidence of prevention and control practice. 9. Promote and facilitate the education of staff of all grades in hand hygiene Infection Prevention & Control and related topics Receive, discuss and endorse the annual Infection Prevention & Control report produced by the Infection Prevention & Control team prior to submission to the Safety Senate Committee and Trust Chief Executive.

Membership:	The Committee membership will consist of: • The Chair – Director of Nursing, Midwifery or Representative of CEO • Director of Infection Prevention and Control • Infection Prevention & Control Nurse • Trust Decontamination Lead • Representative of Public Health England • Estates or Patient Facilities Manager • Health and Safety Advisor • Occupational Health Nurse • Matron from Gynaecology • Matron from the Maternity • Matron from Neonatal • Matron from Reproductive Medicine Unit • Antibiotic Pharmacist • Representative from Clinical Commissioning Group • Maternity Safety Lead • Neonatal Safety Lead • Gynaecology Safety Lead • Surgical Services Safety Lead • Reproductive Medicine Unit Safety Lead Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum The Committee will appoint a member of the Committee as Chair of the Infection Prevention and Control Committee and another member to be Vice Chair from the outset. The Vice Chair will automatically assume the authority of the Chair should the latter be absent.
Quorum:	Chair (or approved Deputy) IPCN or DIPC Representative from each Division (either Safety Lead or Matron) Representative from Facilities Department
Voting:	Each member will have one vote with the Chair having a second and casting vote, if required. Should a vote be necessary a decision will be determined by a simple majority?
Attendance:	**a. Members** Members will be required to attend a minimum of 75% of all meetings. Safety Leads and external representatives will be required to attend a minimum of 50% of all meetings. **b. Officers** The DIPC / Director of Nursing, Midwifery shall normally attend meetings. Other officers and staff of the Trust will be invited to attend the

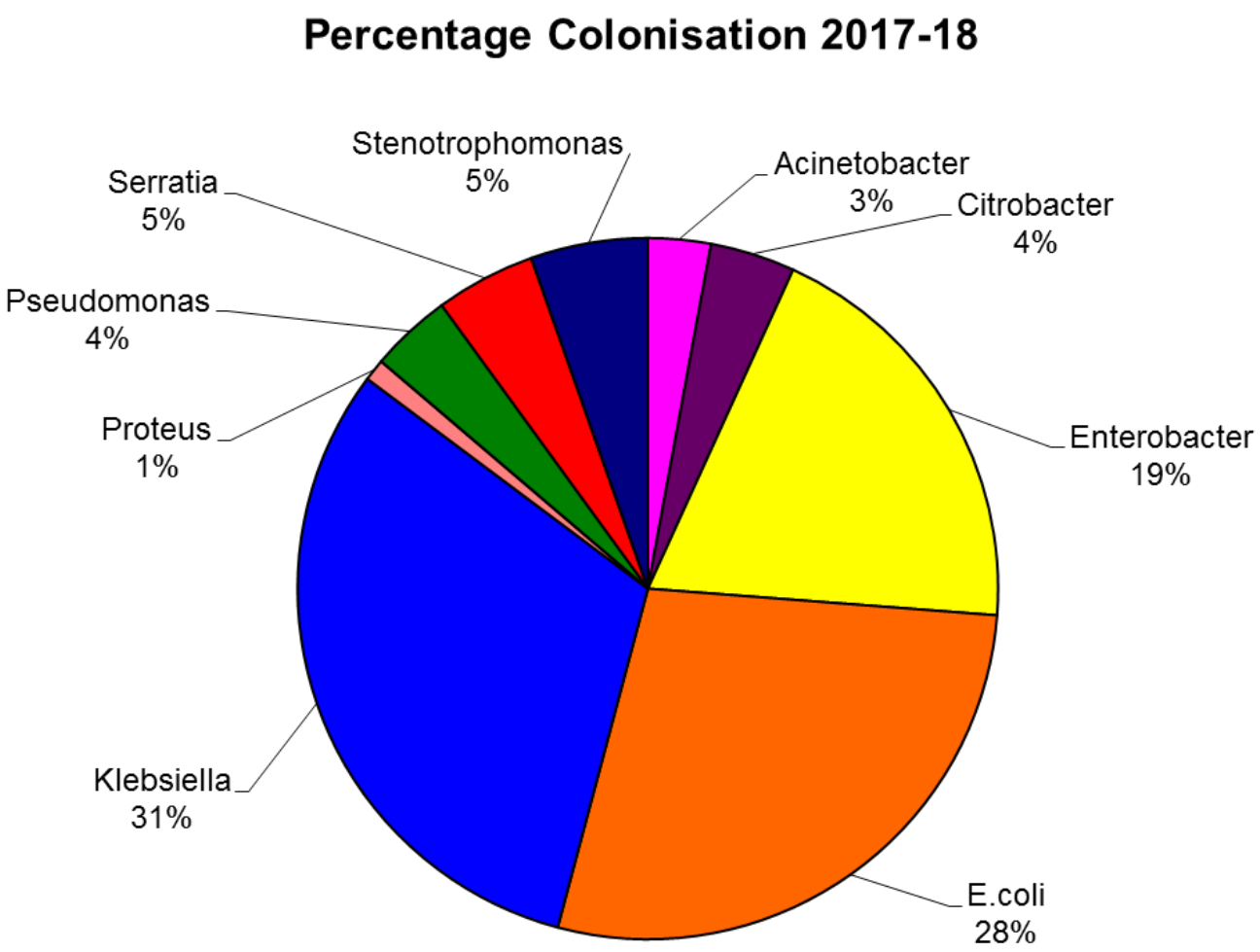
	meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed. Representatives from partner organisations or other external bodies may be invited to attend as appropriate. Such representatives will not have voting rights.
Frequency:	Meetings shall be held a minimum of [6] times per year. Additional meetings may be arranged from time to time, if required, to support the effective functioning of the Trust.
Authority:	The Committee is authorised by the Trust to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee
Accountability and reporting arrangements:	The Committee will be accountable to the Chief Executive and Trust Board. The minutes of the Committee will be formally recorded and submitted to the Quality Committee (QC). The Chair of the Committee shall draw to the attention of the QC any issues that require disclosure to it, or require executive action. The Committee will report to the Board annually on its work and performance in the preceding year. Trust standing orders and standing financial instructions apply to the operation of the Infection Prevention and Control Committee.
Monitoring effectiveness:	The Infection Prevention and Control Committee / IPC Team will undertake an annual review of its performance against its duties in order to evaluate its achievements.
Review:	These terms of reference will be reviewed at least annually by the Infection Prevention and Control Committee.
Reviewed by [Committee/ Subcommittee/Group]:	Infection Prevention and Control Committee
Approved by [name of establishing Committee]:	Infection Prevention and Control Committee
Review date:	May 2019
Document owner:	Julie King, Acting Director of Nursing and Midwifery Julie.king@lwh.nhs.uk

15.2 Appendix B – Health Care Act

Criterion	Additional Quality Elements	Baseline Assurance Apr 17	Update Mar 18	Responsibility	RAG
1.8 An infection prevention and control infrastructure should encompass: In acute healthcare settings for example, an ICT consisting of appropriate mix of both nursing and consultant medical expertise (with specialist training in infection control) and appropriate administrative and analytical support, including adequate information technology. The DIPC is a key member of the ICT		Awaiting implementation at Host Laboratory site prior to implementation at LWFT	Awaiting implementation at Host Laboratory site prior to implementation at LWFT	Director of Nursing / Midwifery / Director of Infection Prevention and Control	Amber

15.3 Appendix C - Neonatal Colonisation Surveillance

	2007/08	2008/09	2009/10	2010/11	2011/12	2012-13	2013/14	2014/15	2015-16	2016-17	2017-18
Acinetobacter	1	1	1	2	1	3	3	6	3	3	3
Citrobacter	3	2	4	2	6	6	4	3	4	7	4
Enterobacter	15	12	16	15	21	21	17	14	17	22	19
E.coli	26	29	30	30	23	20	30	27	21	22	28
Klebsiella	34	32	33	31	38	32	34	39	41	35	31
Proteus	1	3	2	4	0	3	1	1	1	1	1
Pseudomonas	14	18	10	9	6	11	5	4	3	3	4
Serratia	4	1	3	4	2	2	2	1	3	2	5
Stenotrophomonas	2	2	1	3	3	2	4	4	7	5	5



15.4 Appendix D - Adult Bacteraemia Surveillance 2017 - 18

29 Positive blood cultures

13 Coagulase-negative staphylococcus or other contaminant.

16 Pathogens

Directorate	Organism	Potentially Hospital Associated	Likely Source
Gynaecology	*Klebsiella spp*	Y	Focus not identified on review
	Bacteroides spp	N	Peritonitis
	Bacteroides spp	N	Necrotic fibroid
	Bacteroides spp	N	Pelvic malignancy
	S.aureus	N	No focus identified
	Group A Streptococcus	N	Community onset
	E.coli	N	UTI
Maternity	Haemophilus	N	RPOC
	S.pneumoniae	N	Community Acquired Pneumonia
	E.coli	N	Perineal infection
	E.coli	N	UTI
	Group B Streptococcus	N	Peripartum
	Group B Streptococcus	N	Peripartum
	Group A Streptococcus	N	Peripartum
	Granalicatella spp	N	Community onset
	Klebsiella spp	N	UTI

15.5 Appendix E - Pseudomonas Incident Report

MEETING	**Safety Senate**	
PAPER/REPORT TITLE:	**Pseudomonas Incident NICU Q3**	
DATE OF MEETING:	12th January 2018	
ACTION REQUIRED	**For Assurance**	
EXECUTIVE DIRECTOR:	Choose an item.	
AUTHOR(S):	Dr Tim Neal	
LINK TO STRATEGIC OBJECTIVES:	3. To deliver safe services Choose an item. Choose an item. Choose an item.	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Safe:*** *Choose an item* *Choose an item* *Choose an item* ***Efficient:*** *Choose an item.* ***Experience:*** *Choose an item.*	***Effective:*** *Choose an item.* ***Well Led:*** Choose an item.
WHICH CQC KLOE FUNDAMENTAL STANDARD/S DOES THIS REPORT RELATE TO?	***Safe:*** *1.1 Safe - Reg12 Safe care and treatment* *Choose an item.* *Choose an item.* *Choose an item.* ***Caring****:* *Choose an item.* ***Responsive:*** *Choose an item.*	***Effective:*** *Choose an item.* *Choose an item.* ***Well Led:*** *Choose an item.* *Choose an item.*
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT (e.g.: NHS Improvement Compliance/E&D/NHS Constitution)	*Choose an item.* *Choose an item.*	
FREEDOM OF INFORMATION STATUS (FOIA):	Choose an item.	
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***		
PREVIOUSLY CONSIDERED BY:	**Committee name**	Not Applicable
	Date of meeting	

Executive Summary

Summary

2 babies on the neonatal unit developed fatal Pseudomonas *aeruginosa* sepsis during October 2017. Prior to this the last instance of *P. aeruginosa* sepsis had been in 2012. 16 babies were colonised with *P.aeruginosa* in the period immediately prior to and following the two episodes of sepsis. An incident team was convened and investigated potential sources of the infection including testing of the water supply on the unit. The two episodes of infection were caused by distinct strains of *P.aeruginosa*. The majority of colonising strains were also distinct as were strains identified in the sink traps. Water sources repeatedly tested negative for *P.aeruginosa.*

Report

Key Time Points

24/08/17 2 babies identified colonised with P.aeruginosa – barrier nursing implemented for these individuals

See timeline (appendix 1) for details of babies involved, room details and date of colonisation/infection.

03/09/17 3rd baby identified (colonised from admission)

04/09/17 Request made by DIPC for testing of water sources on NICU

19/09/17 Water sampling test results from all clinical rooms on NICU 'No *P.*aeruginosa detected'

24/09/17 Baby 7 delivered and admitted to NICU room 7, not colonised on admission

27/09/17 Baby 5 (colonised since 15/09/17) moved to room 7.

01/10/17 Baby 9 develops sepsis and dies, blood cultures grew *P.aeruginosa*

03/10/17 Sepsis review for Baby 7 and review of current colonisation and potential links

09/10/17 Water in room 7 retested and in additional non clinical rooms 'No *P.aeruginosa* detected'

20/10/17 Barrier nursing of whole unit introduced

20/10/17 Pseudomonas strain typing results for babies 5 & 9 received demonstrating indistinguishable strains (Strain A).

24/10/17 Meeting with DIPC and key unit personnel to discuss additional actions – cohorting considered but at this point only one baby on unit known to be colonised

24/10/17 Environmental sampling of shared equipment and sinks undertaken on NICU – *Pseudomonas* isolated from sink plugholes but not from any other environmental or equipment source.

27/10/17 Baby 12 (colonised with *P.aeruginosa* from birth) develops overwhelming sepsis and dies.

27/10/17 DIPC discusses possible risks with neonatal consultant and agrees change in antibiotic policy for late onset sepsis to maximise cover against Pseudomonas.

29/10/17 Organism causing sepsis in Baby 12 confirmed as *P.aeruginosa*. Multidisciplinary discussion between DIPC, neonatal medical and nursing staff, agreed temporarily to move to sterile water for baby cares.

29/10/17 DIPC discussed incident with PHE consultant.

30/10/17 Incident meeting held on the unit (notes and actions attached). Concerns about the estate were raised at the meeting in particular the lack of space between cots in HDU, some old style sinks remaining in non-clinical areas of the unit and the poor facilities for laundry and equipment cleaning.

31/10/17 Meeting of DIPC and neonatal staff to review actions agree patient information letter and press holding statement.

31/10/17 Additional water and environmental sampling of delivery suite undertaken

08/11/17 Pseudomonas typing result for Baby 12 received confirming a distinct strain (Strain E) from the organism causing sepsis in Baby 7. Other typing results confirm a mixture of Pseudomonas strains indicating i.e. not an outbreak or common source.

14/11/17 Meeting with DIPC and neonatal team, agreed that a transmission event had occurred between babies 5 and 9 (probably in room 7) which resulted in HCAI septicaemia. The second septicaemic event was unrelated but was due to an organism colonising Baby 12 from birth. The incident was closed and additional infection control measures stood down.

Outstanding Actions

Although the incident was closed a number of actions relating to the neonatal unit estate remain outstanding, primarily the identification of a suitable area for cleaning and decontamination of equipment separate from the area used to clean laundry. A number of sinks both on delivery suite and in non-clinical room on the neonatal unit require replacement with modern compliant sinks with rear drains.

Agenda Item	2018/169

MEETING	**Board of Directors**	
PAPER/REPORT TITLE:	**Safer Nurse/Midwife Staffing Monthly Report**	
DATE OF MEETING:	I June 2018	
ACTION REQUIRED	**For Assurance**	
EXECUTIVE DIRECTOR:	Julie E. King, Acting Director of Nursing & 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. Work has been undertaken to include this metric in May's board report (which will be presented to Board in July) including a peer score for nursing and midwifery CHPPD rates.

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 April 2018 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, completed in Maternity and Neonatal, and gynaecology and the reporting mechanism has been reviewed across the acute services.
- 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 thermo cooling resulting in an Each Baby counts report

The inpatient wards have been able to maintain fill rates during the month of April 2018; the average fill rate for registered staff was greater than 97.66% day time, 98.35% night time, and the average fill rate non registered staff 87.90% day time, and 91.26% night time. 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 – interviews held on April 6th, second round of interviews for both maternity leave cover and substantive posts to be held on 3rd May 2018.

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 7 incidents, reported under the nursing/midwifery red flag staffing criteria,
5 arose from staffing shortfalls across MAU, Gynaecology theatres, and Gynaecology emergency department, and 2 for a delay in treatment from MAU and Gynaecology inpatient ward. Drug errors reported this month, 4 across all inpatient services, and 2 from neonatal for omission of medication, 1 from gynaecology for the late administration of a medication, and 1 from delivery suite for an omission, it is to note neonatal reported a marked decrease in reportable drug errors this month.

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.

3.0 Summary

During the month of April 2018, 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 maternity services, due to long term sickness, a spike in short term sickness, maternity leave and vacancy, recruitment within maternity is ongoing to address vacancy and maternity leave cover, 1:1 care in established labour remains a green KPI, and midwifery indicators such as BF rates have not seen a decline in performance. Gynaecology will become the main focus for reporting and ensuring that red flags are reported and discussed with the Gynaecology senior management team. April saw the first reporting from within gynaecology services following a review of the red flag process from the Acting Deputy Director of Nursing and Midwifery.

Work will continue within gynaecology outpatients to review safe staffing and gynaecology outpatient nursing staffing model, this is not required on a UNIFY return as it only applies to inpatient staffing. All professional heads of are required to fulfil their bi – annual staffing report, work is ongoing to be present to the board in summer 2018.

4.0 Recommendations

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

Appendix 1

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 (%)
Apr-18	Gynaecology	98.9%	100.00%	98.96%	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 (%)
Apr-18	Induction&Delivery Suites	80.0%	78.9%	84.4%	87.8%
	Maternity Base	95.7%	75.3%	91.4%	92.2%
	MLU & Jeffcoate	69.4%	110.0%	75.0%	93.3%
	Maternity Total	81.6%	80.4%	84.2%	90.5%

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 (%)
Apr-18	Neonatal Care	112.5%	83.3%	111.9%	83.3%

Agenda Item	2018/170

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Performance Dashboard Month 1 2018/19**
DATE OF MEETING:	Friday, 01 June 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:	☐ ☐
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 note the content of the report.***			
PREVIOUSLY CONSIDERED BY:	**Committee name**		Finance Performance and Business Development Committee Quality Committee	
	Date of meeting		Monday, 21 May 2018 Monday, 21 May 2018	

1. Introduction

The Trust Board dashboard is attached in **Appendix 1** below. Due to the timeframe for submission of both 18 week RTT and cancer targets to the national database and the internal sign off process to ensure correct validation, ownership and accountability in line with recent SI investigation recommendations, only finalised figures are entered onto the performance dashboards from April 2018, meaning that some indicators will be reported one month in arrears. To provide some assurance of the in-month performance to the committee provisional figures (not fully validated) will be provided in the narrative of this internal report.

2. Performance

The five areas to highlight to the Committee are as follows:-

2.1 NHSI Targets – Access Targets including Cancer targets

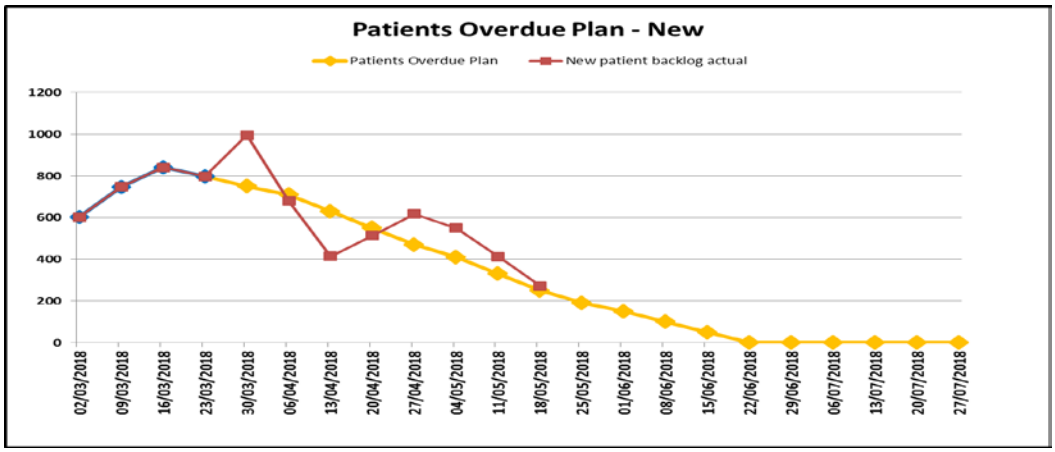
2.1.1 18 weeks RTT

The recovery of 18 weeks RTT target and the management of backlog queue of patients remains on plan to the recovery trajectory. The key measure (percentage of patients with an open pathway waiting less than 18 weeks at month end) was 87.5% for March (that is, 12.5% patients waiting in excess of 18 weeks.) This has improved to 89% in April after full validation, which is better than the recovery trajectory. The RTT trajectory is included at **Appendix 2**. The number of 52 week breaches is also likely to have reduced, at around 19. As patients who are overdue for their follow up continue to be seen, the number of patients on a non-admitted pathway who are beyond 18 weeks continues to decrease, whilst patients who are converting to needing an operation on the admitted pathway is increasing, such that admitted performance as a subset of the overall figure is around 84% of patients waiting less

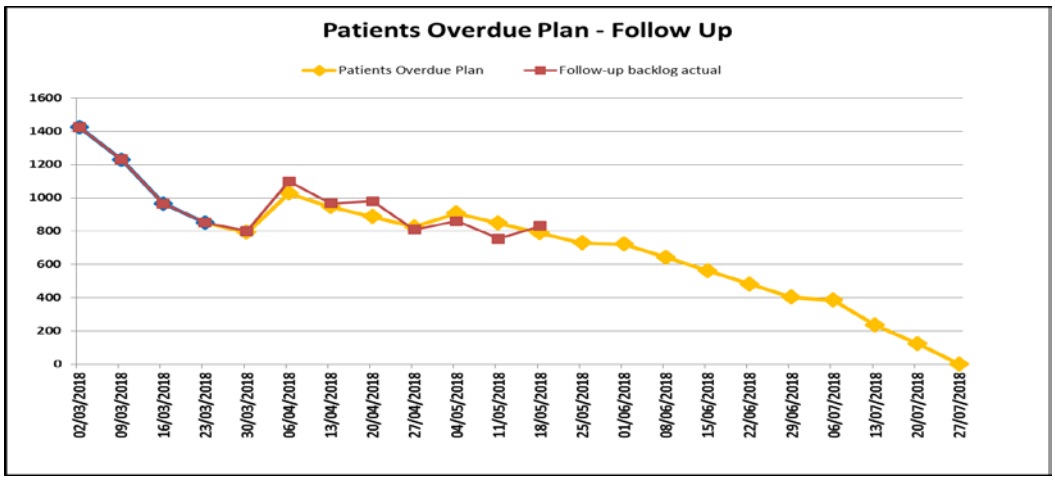
than 18 weeks from referral. This pattern is expected and planned for in terms of additional capacity being made available.

2.1.2 Backlogs

The effective management of backlogs as part of ensuring safe robust patient pathways is key to delivery of the RTT standard. The number of new patients referred in to the service and who are without a planned appointment has reduced down to 272 as at 18th May 2018. This is compared to a position of 996 at the end of March 2018, and is in line with the planned trajectory to reduce this to zero by the end of June 2018 to enable paper switch off and full implementation of the electronic Referral System as part of the national wave 2 (this is a contractual requirement from October 2018.)



With regard to the follow up backlog (patients who have gone beyond when the responsible clinician requested the follow up to have taken place and do not have an appointment booked) has reduced down to 831 as at 18th May 2018. This compares to over 1,400 at the beginning of March 2018. It is now planned that this will reduce significantly in June as a result of additional locum manpower being in place and a commitment from the clinicians with the longest waits to provide additional clinics and going forward to redesign clinical pathways.



2.1.3 Cancer Targets

All figures for April remain provisional until final sign off via Open Exeter (4th June 2018) and potential of further impact of diagnosed patients and shared breach allocations with other Trusts.

Confirmed performance for **March** 2018 was as follows:-

- 2 week wait – **Target 93%** - **performance 92.89%** (222 out of 239 patients seen within 2 weeks) – marginally failed 93% standard due to a spike in demand and insufficient capacity to meet this.
- 31 days DTT – **Target 96% - performance 91.67%** (22 out of 24 patients treated within 31 days of decision) – marginally failed 96% standard due to availability of operating time and patient availability.
- 62 days – **Target 85% - performance 45.45%** (5 out of 11 patients treated within 62 days of urgent referral) – significant failure due to sub-optimal pathways, lack of pro-active tracking and complexity of patients requiring input from outside the Trust before being optimised for surgery. This is the post breach reallocation position, and includes 2 patients who breached 104 days (RCAs undertaken.)
- 62 day upgrade – **local Target 90% - performance 66.67%** (4 out of 6 patients treated within 62 days of upgrade decision) – reasons as above.

Performance against all of the above cancer standards **provisional April 2018 position:-**

- 2 week wait **– 93.69%** (193 out of 206 patients seen within 2 weeks) – **achieved.**
- 31 days DDT – **88.46%** (23 out of 26 patients treated within 31 days of decision) – still short of the 96% standard as a result of limited operating session availability and patient availability.
- 62 days – **56.25%** (4.5 out of 8 patients treated within 62 days of urgent referral). This is subject to change as a result of reallocation between Trusts and delays in histopathology reports confirming or excluding a cancer diagnosis of patients treated in month.
- 62 day upgrade – **83.33%** (5 out of 6 patients treated within 62 days of upgrade decision) – improvement though still short of 90% standard.

The key indicators are expected to reach compliance targets in the following timeframes:-

2ww – April 2018 – achieved.
31 days – June 2018
62 days – October 2018
62 day upgrade – July 2018

Patient pathways are now being pro-actively managed and additional capacity made available, including the provision of additional medical manpower across Gynaecology to fill gaps in the workforce. This includes the ability of clinicians involved in the care of cancer patients to be re-focussed on the service to deal with spikes in demand, with additional resources covering the more general and routine elements of the workload. The standards that are completely within the control of the Trust will be achieved within the next 1 to 3 months.

However, more transformational work is required to manage end to end pathways and to understand the variety of complex reasons why patients do not commence treatment within 62 days. This includes the setting of expectations of the work up requires in DGHs before patients are referred in to the tertiary MDT. It also includes better liaison and routes of escalation with our partners to ensure pre-operative optimisation and access to specialist investigations and opinions that LWH, as a specialist Women's Hospital, does not provide. The majority of patients breaching are clinically complex and require input from outside the Trust, and realistically the new

pathways are unlikely to become operational until Autumn. Alongside this, delays persist in the LCL Pathology service in getting results back in a timely manner to support appropriate patient management, and this is already the subject of escalation discussions.

In summary , the key challenges are shortages in consultant manpower and the complexity of patients covered by the 62 day standard who require pre-operative intervention that is not covered within LWH's portfolio of services (pathology, echo, MRI, CT).

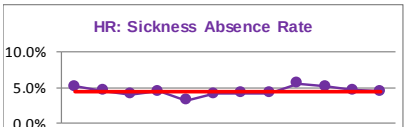
Work is underway to better align capacity to meet spikes in demand, and to redesign clinical pathways to achieve earlier diagnosis and to establish appropriate timescales for pre-operative work up and access to investigations external to this Trust.

Escalation processes have been reviewed to provide early warning of capacity issues for first appointment, and to highlight the need for additional operating capacity. The colposcopy service has now managed to meet demand without the use of an external provider.

The service will respond as quickly as possible to rectify the performance on waits for first appointment. The service is confident that 2 Week wait and 31 day standards will be achieved in line with the above trajectory. However, to deliver against the 62 day pathway will require pathway redesign and agreed ways of working with partners, which will take some time to address.

2.1.4 Sickness

HR: Sickness Absence Rate	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Actual	5.2%	4.6%	4.1%	4.5%	3.3%	4.2%	4.3%	4.3%	5.6%	5.2%	4.7%	4.5%
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%



The overall single month sickness figure fell by 0.14% from 4.66% in month twelve to 4.52% in month one. This is currently 1.02% above the Trust target figure of 3.50%, and therefore rated as red. As this is month one of the financial year, the financial year to date cumulative figure is also 4.52%.

Both PPF and the Quality committee's receive detailed analysis of service line performance.

Overall, in month there has been a decrease in long term sickness absence. The proportion of overall sickness split by short term and long term changed from 30%/70% in month twelve, to 48%/52% in month one.

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

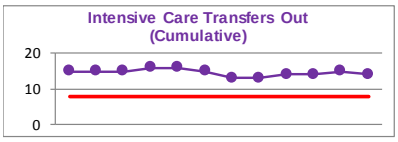
The Human Resources Department provide detailed absence information and advice to support managers in addressing sickness absence. They also provide training to new and existing managers in how to effectively manage sickness absence.

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

2.1.5 Intensive Care Transfers 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)	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Actual	15	15	15	16	16	15	13	13	14	14	15	14
Target	8	8	8	8	8	8	8	8	8	8	8	8



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

3 Conclusion

The 18 week RTT and Cancer recovery plans are progressing well and it is envisaged that RTT and Cancer targets will achieve national targets by July 2018 with the exception of the Cancer 62 day target. This indicator is not anticipated to be compliant until October 2018. This is due to the complexity of pathways, capacity and diagnostic waits that will take a little longer to resolve due to the multi provider landscape.

4 Recommendation

The committee is requested to note the contents of this report.

Appendix 1 – Scorecard

Performance Dashboard Board - Ap

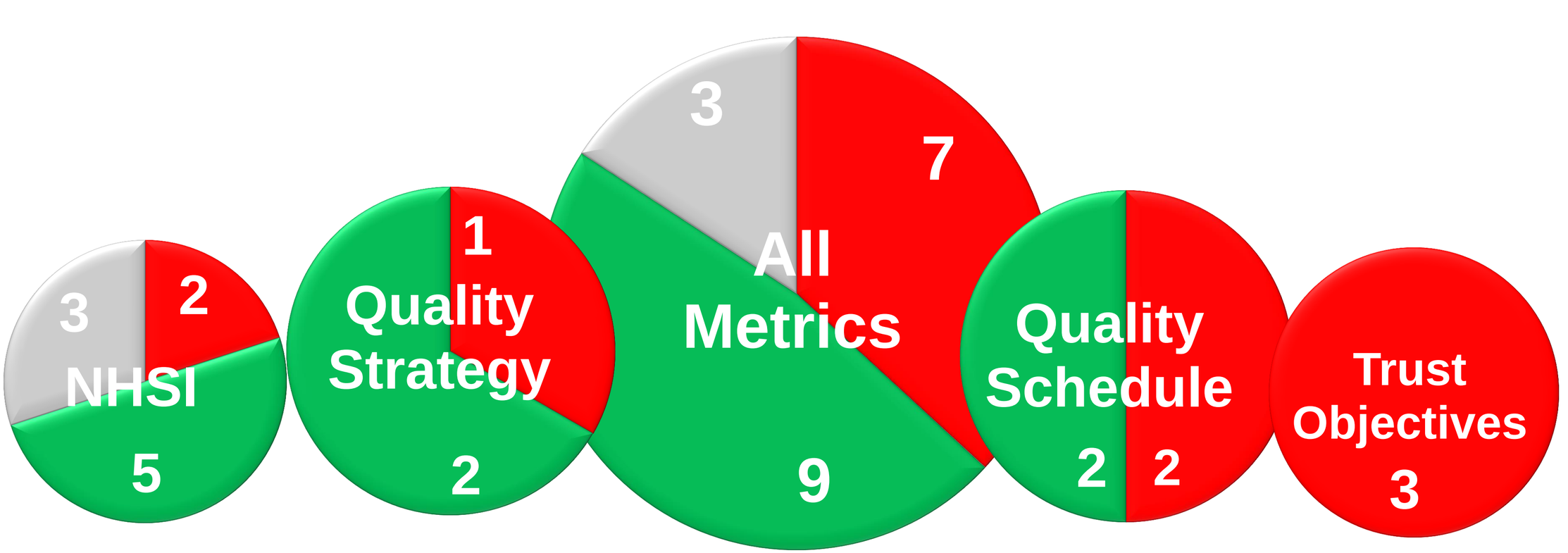
Appendix 2 – RTT & backlog trajectory & actual

Appendix2.xlsx

Performance and Information Department
Performance Team

Liverpool Women's NHS Foundation Trust

Performance Report for Trust Board — Month 01 - April 2019



* 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 2018/19 Month 01 - April 2019

To be EFFICIENT and make the best use of available resources

Indicator Name	Ref	Owner of KPI	Target	Apr-18	May-18	Jun-18	Qtr1	Jul-18	Aug-18	Sep-18	Qtr2	Oct-18	Nov-18	Dec-18	Qtr3	Jan-19	Feb-19	Mar-19	Qtr4
Financial Sustainability Risk Rating: Overall Score	KPI087	Head of Finance	3	3															

To deliver SAFER services

Indicator Name	Ref	Owner of KPI	Target	Apr-18	May-18	Jun-18	Qtr1	Jul-18	Aug-18	Sep-18	Qtr2	Oct-18	Nov-18	Dec-18	Qtr3	Jan-19	Feb-19	Mar-19	Qtr4
Infection Control: Clostridium Difficile (Number)	KPI104 (EAS5)	Infection Control Lead	1	0															
Infection Control: Clostridium Difficile - infection rate (12-month rolling) 1 Qtr Behind	KPI320	Infection Control Lead	Refer to Infection Control																
Meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate (12-month rolling) 1 Qtr Behind	KPI105 (EAS4)	Infection Control Lead	Refer to Infection Control																
Meticillin-sensitive Staphylococcus aureus (MSSA) rates (12-month rolling) 1 Qtr Behind	KPI335	Infection Control Lead	Refer to Infection Control																
Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI) rates (12-month rolling) 1 Qtr Behind	KPI336	Infection Control Lead	Refer to Infection Control																
Never Events	KPI181	Head of Governance	0	0															
NHSE / NHSI Safety Alerts Outstanding	KPI193	Head of Governance	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-18	May-18	Jun-18	Qtr1	Jul-18	Aug-18	Sep-18	Qtr2	Oct-18	Nov-18	Dec-18	Qtr3	Jan-19	Feb-19	Mar-19	Qtr4
HR: Sickness Absence Rate	KPI101	Head of Workforce	4.5%	4.52%															

To deliver the best possible EXPERIENCE for patients and staff

Indicator Name	Ref	Owner of KPI	Target	Apr-18	May-18	Jun-18	Qtr1	Jul-18	Aug-18	Sep-18	Qtr2	Oct-18	Nov-18	Dec-18	Qtr3	Jan-19	Feb-19	Mar-19	Qtr4
Maximum time of 18 weeks from point of referral to treatment in aggregate - Incompletes	KPI003 (EB3)	Head Of Operations Gynaecology	92%	89.41%															
KPI003 Numerator				4137															
KPI003 Denominator				4627															
All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (Before re-allocation) Final Reported Position	KPI031 (EB12)	Head Of Operations Gynaecology	>= 85%																
KPI1031 Final Numerator																			
KPI1031 Final Denominator																			
All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (After Re-allocation) Final Reported Position	KPI030 (EB12)	Head Of Operations Gynaecology	85%																
KPI1030 Final Numerator																			
KPI1030 Final Denominator																			
All Cancers: 62 day wait for first treatement from NHS Cancer Screening Service referral - Numbers (if > 5, the target applies)	KPI033 (EB13)	Head Of Operations Gynaecology	< = 5																
Complaints: Number Received	KPI038	Head of Nursing / Midwifery	<= 15	10															

Performance and Information Department
Performance Team

Liverpool Women's NHS Foundation Trust

LWH Quality Schedule 2018/19 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-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**
HR: Sickness Absence Rate	KPI101 (KPI_27)	Head of Workforce	<= 4.5%	4.52%											

To deliver the best possible EXPERIENCE for patients and staff															
Indicator Name	**Ref**	**Owner of KPI**	**Target 2017/18**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**
18 Week RTT: Incomplete Pathway > 52 Weeks	KPI002 EBS4)	Head Of Operations Gynaecology	0	19											
A&E: Total Time Spent in A&E 95th percentile	KPI012 (KPI_62)	Head of Nursing	<= 240	230											
Friends & Family Test (Upper quartile will recommend)	KPI089	Head of Nursing	>= 75%	94.6%											

LWH Quality Strategy 2018/19 LWH Quality Strategy

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

To develop a well led, Capable, Motivated and Entrepreneurial WORKFORCE															
Indicator Name	**CCG Ref**	**Owner of KPI**	**Target 2017/18**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**
Sickness & Absence Rate	KPI101	Head of Workforce	<= 4.5%	4.52%											

To deliver SAFER services															
Indicator Name	**Ref**	**Owner of KPI**	**Target 2017/18**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**
Never Events	KPI181	Head of Governance	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-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**
Complaints: Number Received	KPI038	Head of Nursing	<= 15	10											

Liverpool Women's NHS Foundation Trust

LWH Trust Objectives 2018/19 Month 01 - April 2019

To deliver SAFER services

Indicator Name	Ref	Owner of KPI	Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Deaths (All Live Births within 28 Days) All live births	KPI168	Head of Operations & Nursing Neonates	< 6.1%	0.0%											
Deaths (All Live Births within 28 Days) Booked births	KPI168	Head of Operations & Nursing Neonates	< 4.6%	0.0%											

To deliver the most EFFECTIVE outcomes

Indicator Name	Ref	Owner of KPI	Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Intensive Care Transfers Out (Cumulative)	KPI107	HDU Lead	8 per year (Rolling year)	14											

To deliver the best possible EXPERIENCE for patients and staff

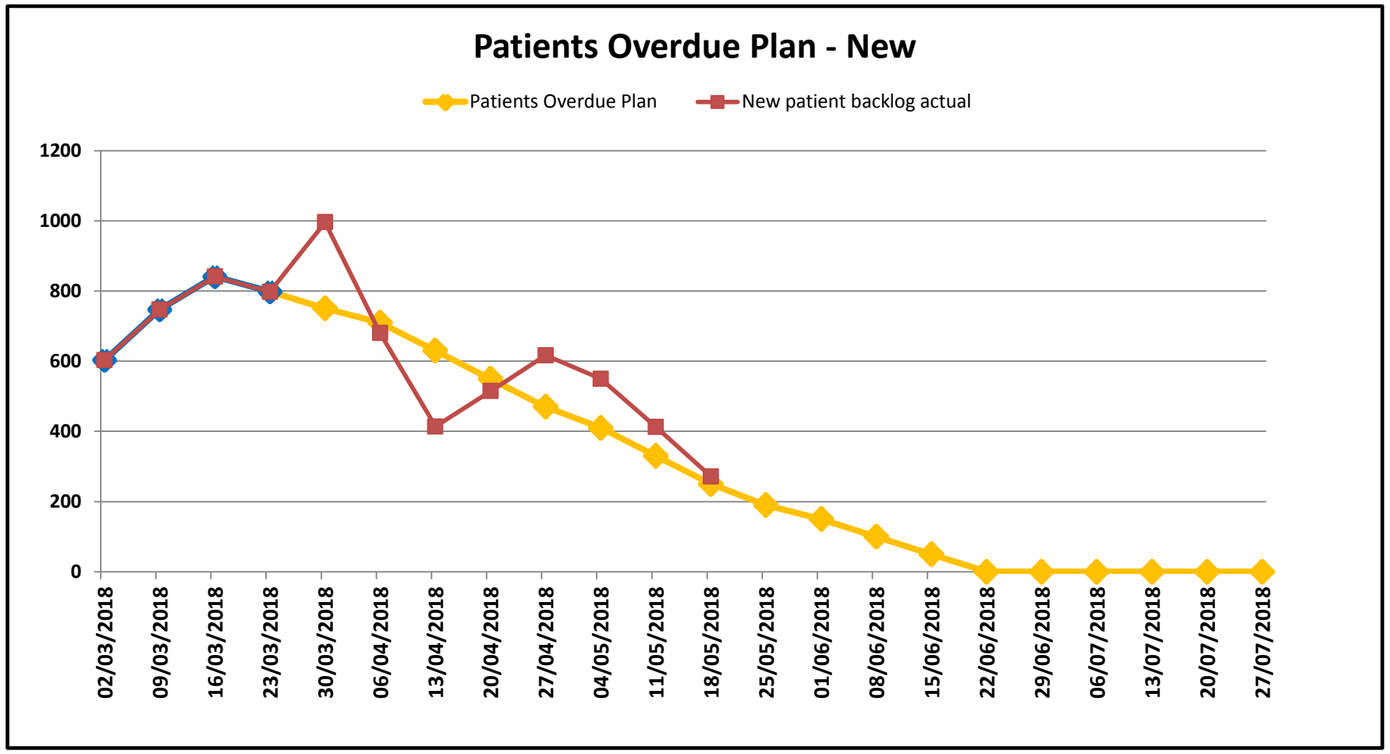
Indicator Name	Ref	Owner of KPI	Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
18 Week RTT: Admitted	KPI001	Head of Operations Gynacology	>= 90%	85.3%											
KPI1001 Numerator				412											
KPI1001 Denominator				483											
18 Week RTT: Non-Admitted	KPI004	Head of Operations Gynacology	>= 95%	91.0%											
KPI1004 Numerator				1580											
KPI1004 Denominator				1737											

APPENDIX 2

Week Ending	02/03/2018	09/03/2018	16/03/2018	23/03/2018	30/03/2018	06/04/2018	13/04/2018	14/04/2018	15/04/2018	16/04/2018	17/04/2018	18/04/2018	19/04/2018	20/04/2018	21/04/2018	22/04/2018	23/04/2018	24/04/2018
New patient backlog actual	603	747	841	798	996	680	414	515	617	550	413							

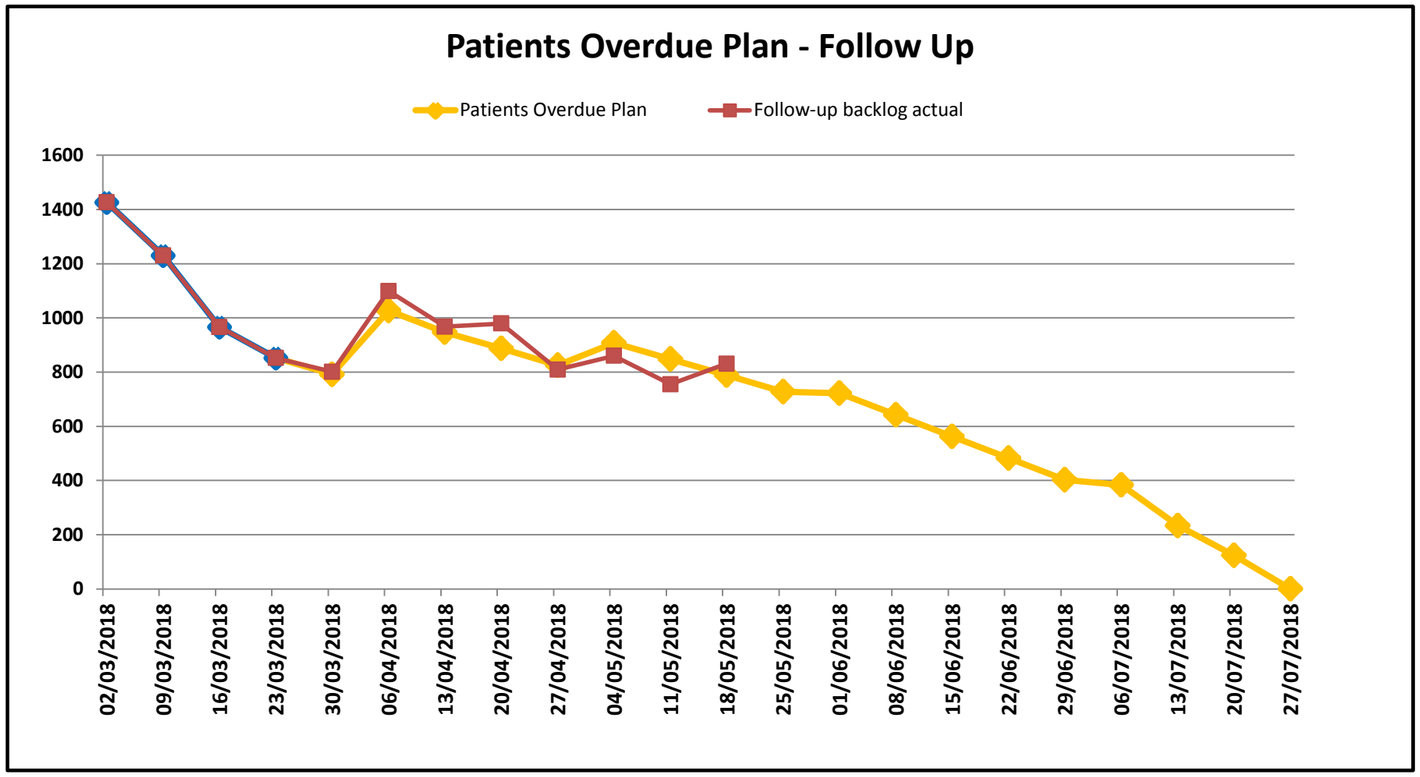
New ASI	246	271					
New paper referra	357	476					

Date	Patients Overdue Plan	New patient backlog actual
02/03/2018	603	603
09/03/2018	747	747
16/03/2018	841	841
23/03/2018	798	798
30/03/2018	750	996
06/04/2018	710	680
13/04/2018	630	414
20/04/2018	550	515
27/04/2018	470	617
04/05/2018	410	550
11/05/2018	330	413
18/05/2018	250	272
25/05/2018	190	
01/06/2018	150	
08/06/2018	100	
15/06/2018	50	
22/06/2018	0	
29/06/2018	0	
06/07/2018	0	
13/07/2018	0	
20/07/2018	0	
27/07/2018	0	

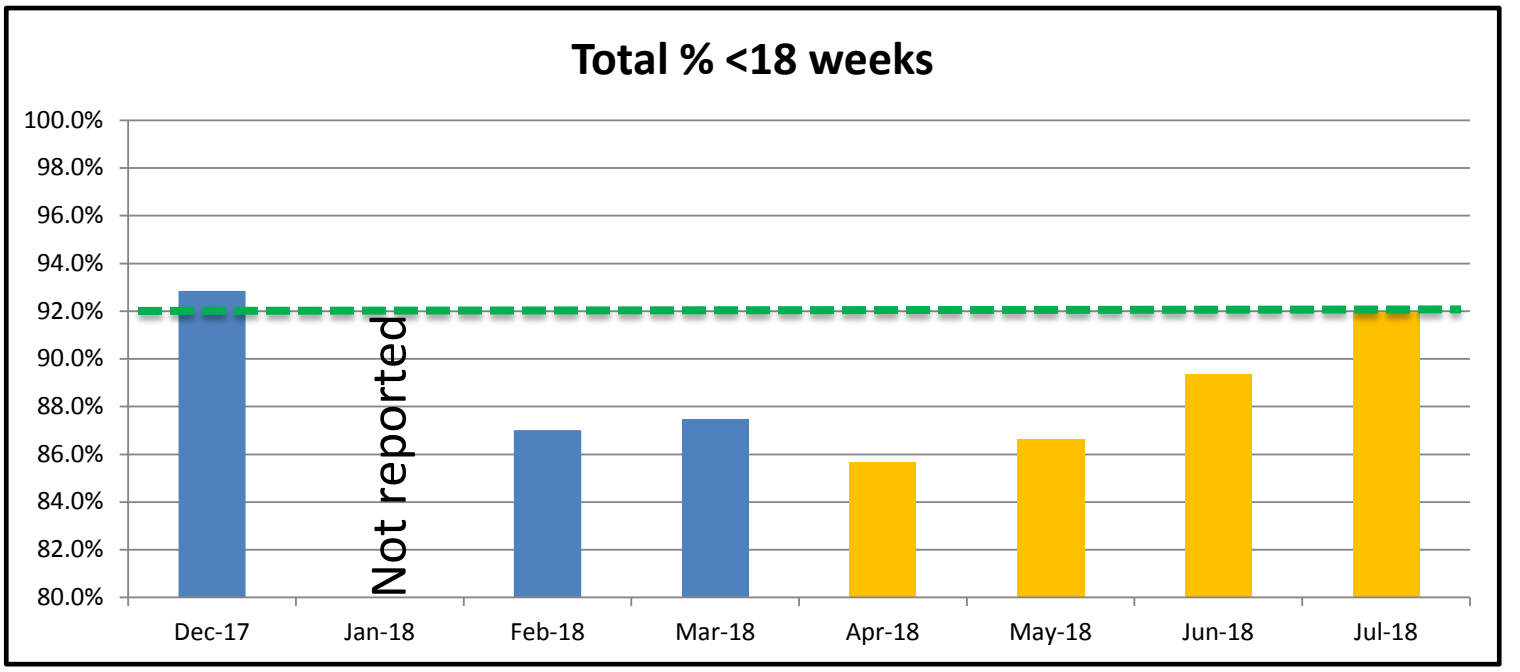


Week Ending	02/03/2018	09/03/2018	16/03/2018	23/03/2018	30/03/2018	06/04/2018	13/04/2018	14/04/2018	15/04/2018	16/04/2018	17/04/2018	18/04/2018	19/04/2018	20/04/2018	21/04/2018	22/04/2018	23/04/2018	24/04/2018
Follow-up backlog actual	1426	1230	966	852	801	1099	968	979	809	860	755							

Date	Patients Overdue Plan	Follow-up backlog actual
02/03/2018	1426	1426
09/03/2018	1230	1230
16/03/2018	966	966
23/03/2018	852	852
30/03/2018	792	801
06/04/2018	1027	1099
13/04/2018	947	968
20/04/2018	887	979
27/04/2018	825	809
04/05/2018	908	860
11/05/2018	848	755
18/05/2018	788	831
25/05/2018	728	
01/06/2018	722	
08/06/2018	642	
15/06/2018	562	
22/06/2018	482	
29/06/2018	402	
06/07/2018	384	
13/07/2018	234	
20/07/2018	124	
27/07/2018	0	



Total Open Pathways at month end	Total % <18 weeks	Total % >18 weeks	Admitted < 18 weeks	Admitted >18 weeks	Non-Admitted <18 weeks	Non-Admitted >18 weeks
Dec-17	92.9%	7.1%	549	86	2180	124
Jan-18						
Feb-18	87.0%	13.0%	501	92	2749	393
Mar-18	87.5%	12.5%	440	143	3374	403
Apr-18	85.7%	14.3%	690	165	3050	460
May-18	86.6%	13.4%	720	180	3100	410
Jun-18	89.3%	10.7%	750	145	3150	320
Jul-18	92.0%	8.0%	730	110	3100	225



black = actual

red = trajectory

Agenda Item	2018/171

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Month 1 Finance Report**
DATE OF MEETING:	Friday, 01 June 2018
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Jenny Hannon, Director of Finance
AUTHOR(S):	Andy Large, Head of Finance Jennifer Huyton, Acting Deputy Director of Finance
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** 1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☐ 2. To be ambitious and *efficient* and make the best use of available resource ☒ 3. To deliver *safe* services ☐ 4. To participate in hig 5. h quality research and to deliver the most *effective* Outcomes ☐ 6. To deliver the best possible *experience* for patients and staff ☐
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust* ☐ ***2.*** *The Trust is not financially sustainable beyond the current financial year* ☐ ***3.*** *Failure to deliver the annual financial plan* ☒ ***4.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision* ☐ ***5.*** *Ineffective understanding and learning following significant events* ☐ ***6.*** *Inability to achieve and maintain regulatory compliance, performance and assurance* ☐ ***7.*** *Inability to deliver the best clinical outcomes for patients* ☐ ***8.*** *Poorly delivered positive experience for those engaging with our services* ☐
CQC DOMAIN	***Which Domain?*** ***SAFE-*** *People are protected from abuse and harm* ☐ ***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☐ ***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐ ***RESPONSIVE –*** *the services meet people's needs.* ☐ ***WELL-LED -*** *the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ☒ ***ALL DOMAINS*** ☐

LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution **2.** Operational Plan **3.** NHS Compliance	☐ ☒ ☒	**4.** NHS Constitution **5.** Equality and Diversity ***6.*** Other: **Click here to enter text.**	☐ ☐
FREEDOM OF INFORMATION (FOIA):	1. This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting			
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	***Note the Month 1 Financial Position***			
PREVIOUSLY CONSIDERED BY:	**Committee name**	FPBD		
	Date of meeting	Monday, 21 May 2018		

Executive Summary

The 2018/19 budget was approved by Trust Board in April 2018. This set out a control total deficit of £1.6m for the year after the delivery of £3.6m CIP, and receipt of £3.6m from the Provider Sustainability Fund (PSF; formerly referred to as Sustainability and Transformation Funding or STF).

The control total includes £0.5m of agreed investment in the costs of the clinical case for change identified in the 2018/19 operational plan, in addition to the £1.0m 2017/18 investment.

At Month 1 the Trust is reporting a deficit of £0.576m against a deficit budget of £0.582m. The Trust is forecasting delivery of the £1.6m control total deficit.

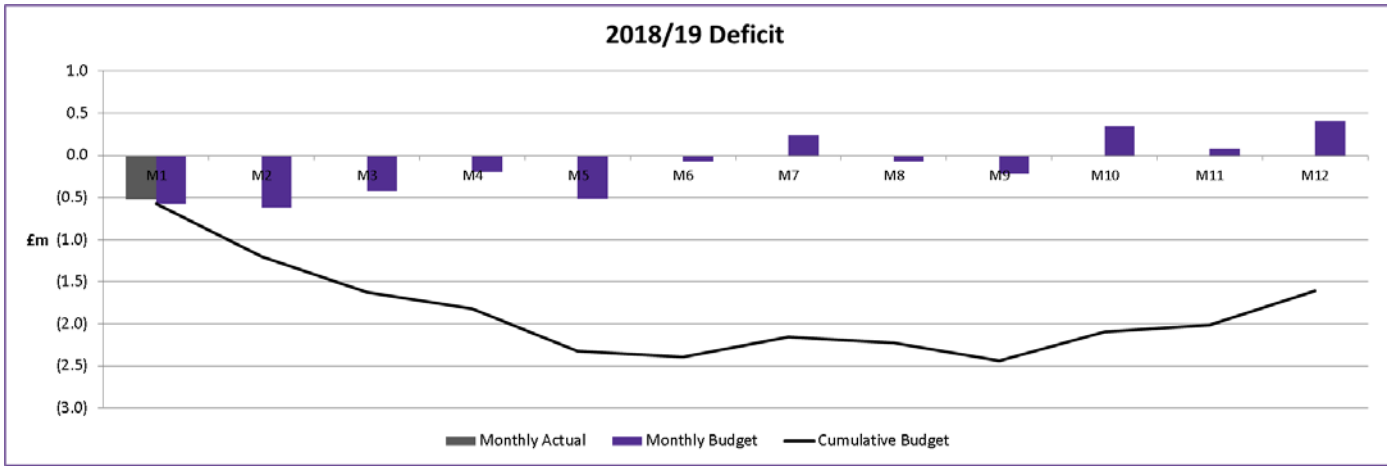
The Trust delivered a 'finance and use of resources' rating of 3 in month which is equivalent to plan.

The Month 1 financial submission to NHSI is consistent with the contents of this report.

Report

1. Summary Financial Position

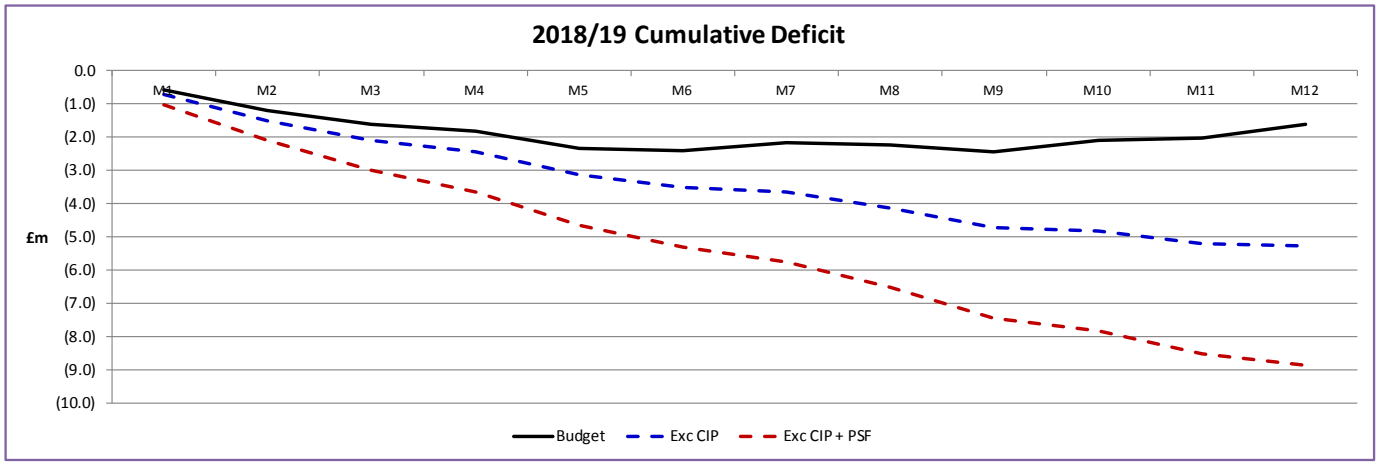
At Month 1 the Trust is reporting a deficit of £0.576m against a deficit budget of £0.582m. The Trust is forecasting delivery of the £1.6m control total after the receipt of £3.6m PSF.



In 2018/19 the Trust will continue to benefit from a level of financial stability secured through the 'Acting as One' contract arrangement with main CCG Commissioners, and the NHSE block contract, which collectively account for 72% of total Trust income.

During 2017/18, the 'Acting as One' block payment was £3.8m higher than would have been received under PbR, and this has continued into 2018/19 with a £0.4m variance at Month 1. This continued contract under-performance presents a significant financial risk to the Trust from 2019/20. The Trust is looking to engage with commissioners at an early stage to enable timely understanding of commissioning intentions.

CIP delivery remains a key risk to the delivery of the 2018/19 financial control total. The Trust has a £3.6m CIP target for 2018/19. Failure to deliver the CIP would in turn result in the loss of £3.6m PSF as illustrated below.



2. Service Summary Overview

Financial grip and control across the organisation remains strong, with expenditure budgets showing an overall underspend at Month 1.

Maternity continues to see reduced bookings and deliveries into 2018/19. Despite the block contract protecting income, lower birth numbers have also impacted upon PbR income, however this has been offset by reduced expenditure.

Gynaecology has also continued to see reduced activity into 2018/19. Despite the block contract protecting income, oncology activity has impacted upon PbR income, which has been offset by reduced expenditure.

The Neonatal service has been impacted by reduced Transitional Care income in Month 1, which has been only partly offset by reduced expenditure. This is expected to recover in Month 2.

The Hewitt Fertility Centre has plans in place to deliver a £3m contribution in 2018/19, and at Month 1 delivered a favourable budget position.

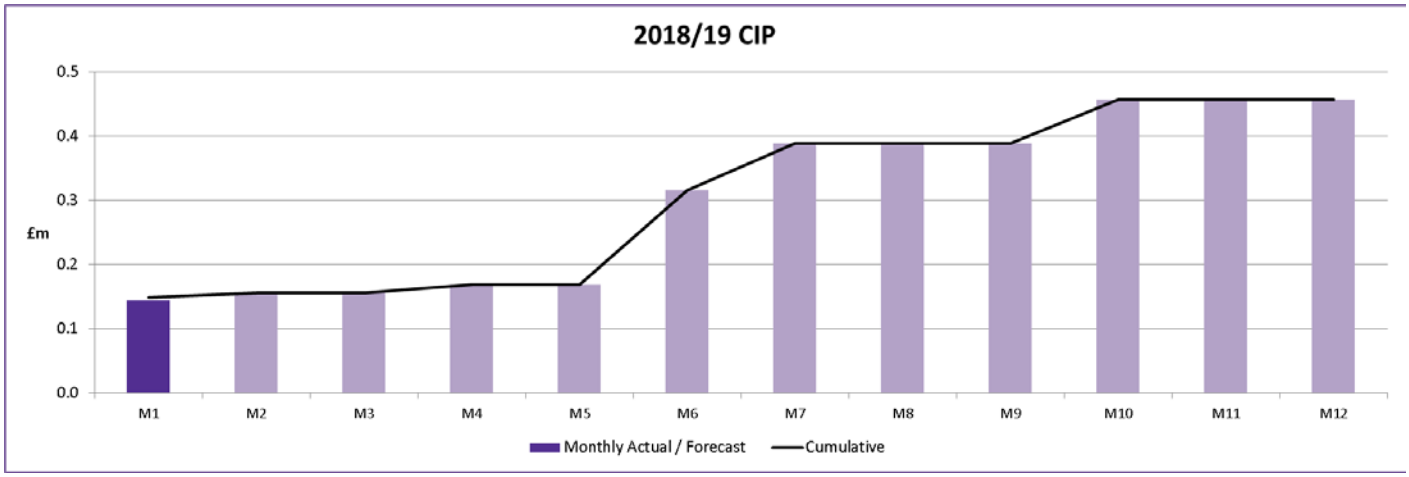
Genetics and Clinical Support services delivered within budget.

Corporate Services are reporting agency cover for vacancies for which recruitment is under way, and heightened support for RTT recovery.

The Trust incurred £57k against the £1.8m agency cap set by NHSI, and forecasts that it will continue to operate within this limit in 2018/19.

3. CIP

At Month 1 the Trust has delivered £0.144m against the in-month target of £0.150m, and is forecasting full delivery of the £3.6m CIP. The 2018/19 CIP has been profiled in line with planned delivery, which shows the target increasing throughout the year as follows.



The profile changes are predominantly driven by the NHS Resolution Maternity Incentive Scheme in relation to legal premiums, which is planned to deliver from Month 6.

The target of £3.6m in 2018/19 represents 3.3% of operational expenditure and is recognised as difficult to deliver. The Trust continues to maintain focus on scheme performance and continued CIP delivery into future financial years via the Turnaround and Transformation Committee and the Finance, Performance and Business Development Committee.

4. Contract Performance

Trust performance within the 'Acting as One' block payment was a £0.4m variance at Month 1 with activity levels falling below the contract payment.

The Gynaecology and Maternity services account for 91% of the block contract under-performance at Month 1 as set out below.

BLOCK PERFORMANCE £000	CCG	Month 1 Block	Month 1 Actual	Month 1 Variance	Year
Maternity	Liverpool	2,396	2,223	(173)	29,999
Maternity	Knowsley	343	341	(3)	4,294
Maternity	South Sefton	569	494	(75)	7,128
Maternity	Southport & Formby	47	59	13	585
Maternity Total		**3,355**	**3,117**	**(237)**	**42,005**
Gynaecology	Liverpool	989	927	(62)	12,312
Gynaecology	Knowsley	213	170	(43)	2,655
Gynaecology	South Sefton	262	246	(16)	3,264
Gynaecology	Southport & Formby	37	31	(6)	464
Gynaecology Total		**1,501**	**1,374**	**(128)**	**18,695**
Hewitt	Liverpool	128	116	(13)	1,574
Hewitt	Knowsley	36	28	(8)	442
Hewitt	South Sefton	33	29	(4)	401
Hewitt	Southport & Formby	21	16	(6)	262
Hewitt Total		**219**	**188**	**(31)**	**2,680**
Other	Liverpool	11	8	(3)	131
Other	Knowsley	3	2	(1)	34
Other	South Sefton	3	2	(1)	36
Other	Southport & Formby	0	0	(0)	5
Radiology Total		**17**	**12**	**(5)**	**205**
Total		**5,092**	**4,691**	**(401)**	**63,585**

Block contract under-performance presents a significant financial risk to the Trust from 2019/20, and full action plans to address this will be developed through Turnaround & Transformation Committee during Q1.

5. Cash and borrowings

The cash balance at the end of Month 1 was £7.6m compared to a 2017/18 year end position of £6.0m.

The Trust has an operational cash borrowing requirement of £1.6m for 2018/19. The Trust continues to submit 13 week cash flow statements each month to DH, there was no requirement for a cash drawdown in Month 1.

6. BAF Risk

No changes to the BAF scores are proposed at Month 1.

7. Conclusion & Recommendation

The Board is asked to note the Month 1 financial position
Appendix 1 – Board Pack

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

FINANCE REPORT: M1

YEAR ENDING 31 MARCH 2019

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: M1
YEAR ENDING 31 MARCH 2019

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	(27)	(53)	5,053	5,053
(b) PDC + Interest Payable + Loans Repaid	173	167	2,684	2,684
CSC Ratio = (a) / (b)	**(0.16)**	**(0.32)**	**1.88**	**1.88**
NHSI CSC SCORE	**4**	**4**	**2**	**2**
Ratio Score 1 = > 2.5 2 = 1.75 - 2.5 3 = 1.25 - 1.75 4 = < 1.25				
LIQUIDITY				
(a) Cash for Liquidity Purposes	(3,093)	(1,903)	(2,385)	(2,385)
(b) Expenditure	9,414	9,239	111,627	111,627
(c) Daily Expenditure	304	298	306	306
Liquidity Ratio = (a) / (c)	**(10.2)**	**(6.4)**	**(7.8)**	**(7.8)**
NHSI LIQUIDITY SCORE	**3**	**2**	**3**	**3**
Ratio Score 1 = > 0 2 = (7) - 0 3 = (14) - (7) 4 = < (14)				
I&E MARGIN				
Deficit (Adjusted for donations and asset disposals)	582	576	1,601	1,601
Total Income	(9,385)	(9,184)	(116,656)	(116,656)
I&E Margin	**-6.2%**	**-6.3%**	**-1.4%**	**-1.4%**
NHSI I&E MARGIN SCORE	**4**	**4**	**4**	**4**
Ratio Score 1 = > 1% 2 = 1 - 0% 3 = 0 - (-1%) 4 < (-1%)				
I&E MARGIN VARIANCE FROM PLAN				
I&E Margin (Actual)		-6.27%		-1.37%
I&E Margin (Plan)		-6.20%		-1.37%
I&E Variance Margin	**0.00%**	**-0.07%**	**0.00%**	**0.00%**
NHSI I&E MARGIN VARIANCE SCORE	**1**	**1**	**1**	**1**
Ratio Score 1 = 0% 2 = (1) - 0% 3 = (2) - (1)% 4 = < (2)%				
AGENCY SPEND				
YTD Providers Cap	150	150	1,805	1,805
YTD Agency Expenditure	107	57	1,284	1,284
	-28.7%	**-62.0%**	**-28.9%**	**-28.9%**
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: M1
YEAR ENDING 31 MARCH 2019

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	(8,630)	(8,440)	(190)	(8,630)	(8,440)	(190)	(106,078)	(106,078)	0
Non-Clinical Income	(755)	(744)	(12)	(755)	(744)	(12)	(10,578)	(10,578)	0
Total Income	**(9,385)**	**(9,184)**	**(202)**	**(9,385)**	**(9,184)**	**(202)**	**(116,656)**	**(116,656)**	**0**
Expenditure									
Pay Costs	5,819	5,676	143	5,819	5,676	143	69,491	69,491	0
Non-Pay Costs	2,320	2,289	32	2,320	2,289	32	27,868	27,868	0
CNST	1,275	1,275	0	1,275	1,275	0	14,268	14,268	0
Total Expenditure	**9,414**	**9,239**	**175**	**9,414**	**9,239**	**175**	**111,627**	**111,627**	**0**
EBITDA	**29**	**56**	**(27)**	**29**	**56**	**(27)**	**(5,029)**	**(5,029)**	**0**
Technical Items									
Depreciation	382	356	26	382	356	26	4,586	4,586	0
Interest Payable	30	24	6	30	24	6	356	356	0
Interest Receivable	(2)	(3)	1	(2)	(3)	1	(24)	(24)	0
PDC Dividend	143	143	0	143	143	0	1,716	1,716	0
Profit / Loss on Disposal	0	0	0	0	0	0	0	0	0
Total Technical Items	**553**	**521**	**32**	**553**	**521**	**32**	**6,634**	**6,634**	**0**
(Surplus) / Deficit	**582**	**576**	**6**	**582**	**576**	**6**	**1,605**	**1,605**	**0**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 3
EXPENDITURE: M1
YEAR ENDING 31 MARCH 2019

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	361	345	16	361	345	16	4,331	4,331	0
Medical	1,377	1,363	14	1,377	1,363	14	16,521	16,521	0
Nursing & Midwifery	2,501	2,457	44	2,501	2,457	44	29,768	29,768	0
Healthcare Assistants	395	382	13	395	382	13	4,690	4,690	0
Other Clinical	562	553	9	562	553	9	6,696	6,696	0
Admin Support	159	152	7	159	152	7	1,914	1,914	0
Corporate Services	357	366	(9)	357	366	(9)	4,286	4,286	0
Agency & Locum	107	57	50	107	57	50	1,285	1,285	0
Total Pay Costs	**5,819**	**5,676**	**143**	**5,819**	**5,676**	**143**	**69,491**	**69,491**	**0**
Non Pay Costs									
Clinical Suppplies	731	722	9	731	722	9	8,930	8,930	0
Non-Clinical Supplies	510	503	7	510	503	7	6,009	6,009	0
CNST	1,275	1,275	0	1,275	1,275	0	14,268	14,268	0
Premises & IT Costs	459	450	9	459	450	9	5,303	5,303	0
Service Contracts	620	614	7	620	614	7	7,625	7,625	0
Total Non-Pay Costs	**3,595**	**3,563**	**32**	**3,595**	**3,563**	**32**	**42,136**	**42,136**	**0**
Total Expenditure	**9,414**	**9,239**	**175**	**9,414**	**9,239**	**175**	**111,627**	**111,627**	**0**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
BUDGET ANALYSIS: M1
YEAR ENDING 31 MARCH 2019

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	(3,839)	(3,751)	(87)	(3,839)	(3,751)	(87)	(47,997)	(47,997)	0
Expenditure	1,775	1,616	159	1,775	1,616	159	21,332	21,332	0
Total Maternity	**(2,063)**	**(2,135)**	**72**	**(2,063)**	**(2,135)**	**72**	**(26,665)**	**(26,665)**	**0**
Gynaecology									
Income	(2,107)	(2,074)	(33)	(2,107)	(2,074)	(33)	(26,139)	(26,139)	0
Expenditure	894	881	12	894	881	12	10,557	10,557	0
Total Gynaecology	**(1,213)**	**(1,193)**	**(20)**	**(1,213)**	**(1,193)**	**(20)**	**(15,582)**	**(15,582)**	**0**
Theatres									
Income	(39)	(38)	(1)	(39)	(38)	(1)	(467)	(467)	0
Expenditure	668	640	28	668	640	28	8,036	8,036	0
Total Theatres	**629**	**601**	**28**	**629**	**601**	**28**	**7,569**	**7,569**	**0**
Neonatal									
Income	(1,367)	(1,291)	(76)	(1,367)	(1,291)	(76)	(16,388)	(16,388)	0
Expenditure	1,010	945	65	1,010	945	65	12,148	12,148	0
Total Neonatal	**(358)**	**(346)**	**(11)**	**(358)**	**(346)**	**(11)**	**(4,240)**	**(4,240)**	**0**
Hewitt Centre									
Income	(742)	(748)	7	(742)	(748)	7	(10,555)	(10,555)	0
Expenditure	626	625	2	626	625	2	7,556	7,556	0
Total Hewitt Centre	**(115)**	**(124)**	**9**	**(115)**	**(124)**	**9**	**(2,999)**	**(2,999)**	**0**
Genetics									
Income	(603)	(601)	(2)	(603)	(601)	(2)	(7,246)	(7,246)	0
Expenditure	472	463	9	472	463	9	5,620	5,620	0
Total Genetics	**(131)**	**(138)**	**7**	**(131)**	**(138)**	**7**	**(1,625)**	**(1,625)**	**0**
Clinical Support									
Income	(25)	(23)	(2)	(25)	(23)	(2)	(330)	(330)	0
Expenditure	751	744	7	751	744	7	8,813	8,813	0
Total Clinical Support & CNST	**725**	**720**	**5**	**725**	**720**	**5**	**8,483**	**8,483**	**0**
Corporate & Trust Technical Items									
Income	(664)	(656)	(8)	(664)	(656)	(8)	(7,534)	(7,534)	0
Expenditure	3,771	3,846	(75)	3,771	3,846	(75)	44,199	44,199	0
Total Corporate	**3,108**	**3,190**	**(82)**	**3,108**	**3,190**	**(82)**	**36,665**	**36,665**	**0**
(Surplus) / Deficit	**582**	**576**	**6**	**582**	**576**	**6**	**1,605**	**1,605**	**0**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 5
BALANCE SHEET: M1
YEAR ENDING 31 MARCH 2019

BALANCE SHEET £'000	YEAR TO DATE Opening	M1 Actual	Movement
Non Current Assets	**76,313**	**76,210**	(103)
Current Assets			
Cash	6,013	7,576	1,563
Debtors	8,407	9,711	1,304
Inventories	452	451	(1)
Total Current Assets	**14,872**	**17,738**	**2,866**
Liabilities			
Creditors due < 1 year	(11,258)	(14,613)	(3,355)
Creditors due > 1 year	(1,686)	(1,683)	3
Loans	(17,221)	(17,221)	0
Provisions	(4,514)	(4,501)	13
Total Liabilities	**(34,679)**	**(38,018)**	(3,339)
TOTAL ASSETS EMPLOYED	**56,506**	**55,930**	**(576)**
Taxpayers Equity			
PDC	38,451	38,451	0
Revaluation Reserve	15,366	15,366	0
Retained Earnings	2,689	2,113	(576)
TOTAL TAXPAYERS EQUITY	**56,506**	**55,930**	**(576)**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
CASHFLOW STATEMENT: M1
YEAR ENDING 31 MARCH 2019

CASHFLOW STATEMENT £'000	M1 Actual
Cash flows from operating activities	(412)
Depreciation and amortisation	356
Movement in working capital	1,864
Net cash generated from / (used in) operations	**1,808**
Interest received	3
Purchase of property, plant and equipment and intangible assets	(248)
Proceeds from sales of property, plant and equipment and intangible assets	0
Net cash generated from/(used in) investing activities	**(245)**
PDC Capital Programme Funding - received	0
Loans from Department of Health Capital - received	0
Loans from Department of Health Revenue - received	0
Loans from Department of Health - repaid	0
Interest paid	0
PDC dividend (paid)/refunded	0
Net cash generated from/(used in) financing activities	**0**
Increase/(decrease) in cash and cash equivalents	**1,563**
Cash and cash equivalents at start of period	6,013
Cash and cash equivalents at end of period	**7,576**

Agenda Item	2018/173

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Compliance with Provider Licence Condition FT4 – Corporate Governance Statement**
DATE OF MEETING:	Friday, 01 June 2018
ACTION REQUIRED	**For Approval**
EXECUTIVE DIRECTOR:	Colin Reid, Trust Secretary
AUTHOR(S):	Click here to enter text.
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.*** *Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of junior medical staff with the capability and capacity to deliver the best care. ……* ☒ ***3.*** *The Trust is not financially sustainable beyond the current financial year……* ☒ ***4.*** *Failure to deliver the annual financial plan ……* ☒ ***5.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ……* ☒ ***6.*** *Ineffective understanding and learning following significant events……* ☒ ***7.*** *Inability to achieve and maintain regulatory compliance, performance and assurance……* ☒ ***8.*** *Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) ……* ☒ ***9.*** *Inability to deliver the best clinical outcomes for patients……* ☒ ***10.*** *Potential for poorly delivered positive experience for those engaging with our services..* ☒
CQC DOMAIN	***Which Domain?*** ***SAFE-*** *People are protected from abuse and harm* ☐ ***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☐ ***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐ ***RESPONSIVE –*** *the services meet people's needs.* ☐

	WELL-LED *- the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ☐ ***ALL DOMAINS*** ☒			
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution ☒ **2.** Operational Plan ☐ **3.** NHS Compliance ☒		**4.** NHS Constitution ☒ **5.** Equality and Diversity ☒ ***6.*** Other: **Click here to enter text.**	
FREEDOM OF INFORMATION (FOIA):	1. This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting			
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	***The Board is asked to approve the FT4 submission for publication on the Trust website in accordance with the requirements of the Provider Licence.***			
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

Introduction

NHSI revised its governance reporting requirements for trusts in 2013/14. In order to comply with both the provider licence and the Risk Assessment of their licence, the Trust is required to provide a "forward looking governance statement" in the form of a Corporate Governance Statement (CGS) to NHS Improvement. The statement, which is required to be declared by 30 June 2018, will confirm compliance with the licence condition FT4 and provide any risks to compliance with this condition during the next year and any mitigating actions it proposes to take to manage such risks.

Licence Condition FT4 - sets out the criteria that the Trust has to assess itself against when completing the Corporate Governance Statement. In addition the Trust was required to describe the ways in which it was able to assure itself of the validity of its Corporate Governance Statement in its Annual Governance Statement (AGS). The AGS was submitted with the Trust Annual Report and Accounts 2017/18 as part of the year end reporting timetable. The CGS replaces the board statements that NHS Foundation Trusts were previously required to submit with their annual plans under the FT Compliance Framework.

Additional compliance statements are also required relating to Joint Ventures and Governor Training.

Corporate Governance Statement (CGS)

	Corporate Governance Statement A	Current arrangements B	Response C	Risks and mitigating actions D
1	The Board is satisfied that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	• NHS Improvement well-led review undertaken by Deloitte's which recognised that the Trust had principles, systems and standards of good corporate Governance in place. • CQC inspection provided the Trust with a 'good' well led rating. • CQC recognition of the Trusts fit and proper person test processes for board and senior staff. • Review of NHSI Code of Governance – No Non Compliance. • Membership of NHS Providers and the Company Secretary networks • Reviews of NHSI and other bulletins by the board and regular updates from the external auditors through the audit committee. • The Trust has an internal audit programme and assurance cycle. • External auditors provide assurance on the content of the Trust Annual Report and Accounts, the Quality Report and provide an opinion on Trust annual governance statement. • Effectiveness review of Board committees undertaken through the receipt of Committee annual reports and reviews of terms of reference. Effectiveness of GACA undertaken in year.	Confirmed	
2	The Board has regard to such guidance on good corporate	• Trust Secretary in post, identification of any changes	Confirmed	

	governance as may be issued by NHS Improvement from time to time	in guidance. • Receipt and Review of regular updates from NHS Improvement • Membership of NW FT Company Secretary network and NHS Providers Company Secretary Network. • Regular communications from legal advisors and internal and external auditors.		
3	The Board is satisfied that the Trust implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	• Review of Board and Committee structure undertaken. Constant review of performance of Board and committee's undertaken and annual report from each committee is presented to the Board for noting. • Annual Governance statement provides the Board with assurance surrounding the responsibilities of the Board and its committees. • Board approved terms of reference of Board Committees providing details of reporting lines, responsibilities and membership. • Clear reporting lines within the Board, Executive and service areas provided through the Trusts governance framework and Workforce strategies developed in line with Trust's Vision, Aims and Value's • Additional review of divisional structures being undertaken so that accountabilities are appropriate across the Trust. • Annual review of all committee and subcommittee reviews of terms of reference undertaken	Confirmed	
4	The Board is satisfied that the Trust effectively implements systems and/or processes:		Confirmed	The Board noted the

	(a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;	a) Strong systems of financial and quality governance in place. All statutory audits and reporting requirements fulfilled via Audit Committee and or the Finance Performance and Business Development Committee. The External Audit opinion 2017/18 provided additional assurances with regards to the Trust duty to operate efficiently, economically and effectively by providing a qualified conclusion that they were satisfied that in all significant respects the Trust had put in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources for the year ended 31 March 2018. This was a qualified opinion against the backdrop of a significant financial sustainability risk due to the ongoing deficits and the requirement for distressed financing. The long term financial sustainability is on the BAF as a significant risk.		qualified opinion of the auditor for financial year 2017/18 and recognises the significant risk of financial sustainability due to the ongoing deficits and the requirement for distressed financing. The Board believes that the Trust has in place strong systems of financial and quality governance processes to manage the risk. The Financial Sustainability risk is one of the most significant risks impacting on the Trust and is on Board Assurance Framework together with the specific controls in place, gaps, mitigations and action plans.
	(b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations;	b) Performance review, service reporting arrangements, service review, performance dashboards at all levels within the organisation with systems for appropriate escalation and review to ensure timely and effective scrutiny and oversight of all operations.		
	(c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;	c) Effective systems and processes in place to ensure with national and local healthcare standards - internal and external assurance systems are in place and reported through the Trust's integrated governance framework.		
	(d) For effective financial decision-making, management	d) Financial and operational plans in place approved by		

	and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);	the Board and discussed with Governors. Cost Improvement programme agreed with services and corporate departments. Contracts and business development managed appropriately. Workforce strategies developed to meet service demands, and workforce plans reviewed to minimise the use of agency/temporary staff. Robust procurement scrutiny to minimise costs and number of tender waivers. Annual and rigorous review of the Trust as a Going Concern overseen by Audit Committee and reported to Board.		
	(e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;	e) Robust integrated governance structure in place. Board and committee structures fully serviced. Accurate, comprehensive, timely, up-to-date information available for Board and Board committees.		
	(f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;	f) Financial and operational risks identified in planning process and reported through the Board Assurance Framework/Corporate Risk Register. Oversight of the risks are provided through the integrated governance framework/structure and reported to the Board. GC6 and CoS7 approved by Board as "in compliance" with the licence.		
	(g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and	g) Effective Strategic and business planning arrangements in place embedded within the trust and reviewed with Governors, CCG and NHSI (through monthly NHSI Oversight and Support meetings).		
	(h) To ensure compliance with all applicable legal	h) Applicable legal requirements, against principal objectives and activities of the organisation reviewed		

	requirements.	and managed appropriately as part of the Trust's governance arrangements. Each Executive areas of responsibility require that they take account of any changes to legal requirements.		
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;	a) Board capability reviewed against strategic direction and business plans. Focus on quality of care. Robust appraisal arrangements in place across the Trust. Medical Revalidation and appraisal systems in place and Leadership Management Development implemented across the Trust. b) Quality of care fully integrated within all planning and decision-making processes. c) (and d) Performance and SEE reports, patient experience and quality of care initiatives routinely provided to Board Committees and reported to the Board by exception. Board receives overarching Performance (operations and Finance) reports. d) Board receives a Patient Story at each Board meeting unless one is not available and receives presentations on quality of Care at both Board and Board committees and where necessary at Board development workshops. Quality is prominent within each Board and Board Committee agenda, now enhanced with the change of name of GACA to the Quality Committee.	Confirmed	

	(e) That the Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	e) Board and Board Committees receive Patient Stories and presentations from staff on quality of care provided by the trust. Executive and NED ward and department visits to be undertaken to assess staff and patient care. Friends and Family Test systems in place and reported through the Governance Structure. Quality Strategy and Patient Experience Strategy in place and reviewed by QC and Board. The Board through QC receives reports on complaints (SEE Report). There is active engagement between the Board and the Council of Governors (CoG) - Board members attend all CoG meetings. f) Escalation of reporting embedded in the Trust. Systems in place to allow for escalation to the Board as required through the integrated governance structure.		
6	The Board is satisfied that there are systems to ensure that the Trust has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Constitution sets out required numbers and qualifications for Board members. • Reviews undertaken by the Board and Governors Nominations Committee at time of recruitment of Executive and Non-Executive directors on the board mix, need and experience • The NEDs provide challenge and scrutiny through attendance at Board and Board Committees regarding appropriate staffing levels. • Through use of board assurance framework and risk management Strategy at Board, Board Committees and Sub Committees and Groups within the Trust Governance Structure • The financial and operational plan includes details	Confirmed	

		on transformation and HR requirements including mitigation of risks associated with future workforce requirements. • Board in receipt of monthly and bi annual safe staffing reports • Guardian of safe working appointed and active in the trust.		

Other Statements:

The numbering in this document follows that provided in the NHS Improvement template.

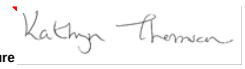
	Corporate Governance Statement	**Current arrangements**	**Response**	**Risks and mitigating actions**
6	Training of Governors			
	The Board is satisfied that during the financial year most recently ended the Trust has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Governors receive induction training and will have, as part of the induction, one to one sessions with the Trust Secretary at appointment. External training is provided through the NW Secretaries Group. Internal training is also provided at and during Council, Council Committee meetings and workshops to deal with specific areas of their roles and responsibilities. The Trust Secretary is available to respond to any matters that Governors may require clarification and if appropriate ad hoc training is provided should this be necessary. The Council committee structure provides additional training on matters relating to quality and patient experience, finance and performance measures and any additional requirements.	Confirmed	

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

1	Corporate Governance Statement	Response	Risks and Mitigating actions	
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	[including where the Board is able to respond 'Confirmed']	Please complete Risks and Mitigating actions
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	[including where the Board is able to respond 'Confirmed']	Please complete Risks and Mitigating actions
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed		Please complete Risks and Mitigating actions
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and	Confirmed	The Board noted the qualified opinion of the auditor for financial year 2017/18 and recognises the significant risk of financial sustainability due to the ongoing deficits and the requirement for distressed financing. The Board believes that the Trust has in place strong systems of financial and quality governance processes to manage the risk. The Financial Sustainability risk is one of the most significant risks impacting on the Trust and is on Board Assurance Framework together with the specific controls in place, gaps, mitigations and action plans.	Please complete Risks and Mitigating actions
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed		Please complete Risks and Mitigating actions
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	[including where the Board is able to respond 'Confirmed']	Please complete Risks and Mitigating actions

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature  **Signature** 

Name Robert Clarke **Name** Kathryn Thomson

Further explanatory information should be provided below where the Board has been unable to confirm declarations under

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Please Respond