Meeting of the Board of Directors
HELD IN PUBLIC
Friday 3 March 2017 at Liverpool Women's Hospital at 1015
Board Room

Item no. 2017/	Title of item	Objectives/desired outcome	Process	Item presenter	Time	CQC Fundamental Standard	BAF Risk
	Thank you to Staff				1015 10mins		
054	Apologies for absence & Declarations of interest	Receive apologies	Verbal	Chair		-	-
055	Meeting guidance notes	To receive the meeting attendees' guidance notes	Written guidance	Chair		R17 – Good Governance	-
056	Minutes of the previous meetings held on 3rd February 2017	Confirm as an accurate record the minutes of the previous meetings	Written	Chair	1025 05mins	R17 – Good Governance	-
057	Action Log and matters arising	Provide an update in respect of on-going and outstanding items to ensure progress	Written/verbal	Chair		R17 – Good Governance	-
058	Learning from Incidents/ Feedback and Harms (i) Learning, Candour & Accountability – Gap Analysis (ii) Learning from Incidents/ Feedback and Harms Presentation (iii) Gynaecology Never Events Assurance (iv) Neonatal Never Events Assurance	To provide assurance to the Board on the Learning from Incidents/ Feedback and Harms	(i) Written (ii) Presentation (iii) Written (iv) Written	Director of Nursing and midwifery/ Head of Governance Clinical Director Clinical Director	1030 (60mins) 05mins 25mins 15mins 15mins	R17 – Good Governance R12 – Safe Care & Treatment	All
059	Chair's announcements	Announce items of significance not elsewhere	Verbal	Chair	1130 10mins	R17 – Good Governance	All

Item no. 2017/	Title of item	Objectives/desired outcome	Process	Item presenter	Time	CQC Fundamental Standard	BAF Risk
		on the agenda					
060	Chief Executive Report	Report key developments and announce items of significance not elsewhere	written	Chief Executive	1140 10mins	R17 – Good Governance	All
BOARD ASSURANCE							
061	Chair's Report from the Finance Performance and Business Development Committee	Receive assurance and any escalated risks	written	Director of Nursing and Midwifery Deputy / Interim Head of Midwifery	1150 05mins	R17 – Good Governance	5 a - f
TRUST PERFORMANCE							
062	Performance Report period 10, 2016/17	Review the latest Trust performance report and receive assurance	Written	Executive	1200 10mins	R12&18: Safe R17 – Good Governance	3a
063	Finance (i) Finance Report period 10, 2016/17 (ii) Uncommitted Single Currency Interim Revenue Support Facility Agreement	To note the current status of the Trusts financial position and re approval of the	Written	Director of Finance	1210 10mins	R17 – Good Governance	5a-f
TRUST STRATEGY							
064	Fit for Future Generations Update	To brief the Board on progress and risks	Verbal	Chief Executive	1220 05mins	All	All
BOARD GOVERNANCE							
065	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair	1225 5mins	R17 – Good Governance	All

Item no. 2017/	Title of item	Objectives/desired outcome	Process	Item presenter	Time	CQC Fundamental Standard	BAF Risk
HOUSEKEEPING							
	Any other business & Review of meeting	Consider any urgent items of other business	Verbal	Chair	Meeting ends 1230	-	-

Date, time and place of next meeting Friday 7 April 2017

Meeting to end at 1230

1230-1245 15mins	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 of Directors

Minutes of the meeting of the Board of Directors
held public on Friday 3 February 2017 at 1000 hrs
in the Boardroom, Liverpool Women's Hospital, Crown Street

PRESENT	
Mr Robert Clarke	Chair
Mr Ian Haythornthwaite	Non-Executive Director/Vice Chair
Mr Tony Okotie	Non-Executive Director/SID
Mr Ian Knight	Non-Executive Director
Mr Phil Huggon	Non-Executive Director
Dr Susan Milner	Non-Executive Director
Ms Jo Moore	Non-Executive Director
Mr David Astley	Non-Executive Director
Mrs Kathryn Thomson	Chief Executive
Mrs Michelle Turner	Director of Workforce & Marketing
Dr Andrew Loughney	Medical Director
Mrs Vanessa Harris	Director of Finance
Mrs Dianne Brown	Director of Nursing & Midwifery Director
Mr Jeff Johnston	of Operations
IN ATTENDANCE	
Mr Colin Reid	Trust Secretary
Mrs Julie King	Interim Deputy Director of Nursing and Midwifery
APOLOGIES	
None	

Thank You

Thank you was awarded to the following for their hard work, support and dedication to the Trust:

Greg Hope, Head of Governance and Alan Clarke, Patient Safety Programme Manager.

Antonia Rooney Team Leader - HR Recruitment & Transactional Team and Janet Hinde, Workforce Information Manager / ESR Manager.

The Communications team comprising of Andrew Duggan, Head of Communications, Marketing and Engagement, Jayne Parr, Digital Communications Officer and Helen Gavin, Communications and Membership Officer

025 **Apologies** – as above.

Declaration of Interests – None

026 Meeting guidance notes

The Board noted the meeting guidance notes.

027 Minutes of previous meeting held on Friday 6 January 2017

The minutes of the meeting held on 6 January 2017 were approved, subject to typographical amendments.

028 Matters arising and action log.

The Board noted that all actions were either complete, on the agenda or to be reported at a future meeting.

029 Chair's Report

The Chair provided a brief verbal report.

Publication of Pre Consultation Business Case (PCBC): The Chair noted that the PCBC had been published immediately after the presentation Liverpool CCG provided to the Board on 6 January 2017.

Alice Hiley Memorial Trust: The Chair, referring to the item in the Chief Executive Report advised that he had met with the family of Alice Hiley to receive the Olympic Brainz Monitor and was humbled by the work the memorial trust did in Alice's name. He thanked the family and the Trust for their support to the Hospital.

Council of Governors: The Chair reported on the work of the Council at its meeting on 25 January 2017, in particular he reported on the agreement of the Council to extend the appointment period of Ian Haythornthwaite, as a non-executive Director for a further one year which would take his appointment to 30th April 2018. Referring to the Council membership the Chair reported that the bi-elections were now underway to elect public governors from the Knowsley and Rest of England and Wales constituencies.

Memorial Service for Prof Llewellyn Jones: The Chair advised that he attended the memorial service for Prof Jones held in the Blair Bell. The memorial service was well attended and a mark of respect for a much loved and respected person in all aspects of his personal and professional life.

The Board noted the Chair's update report.

030 Chief Executive's report

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

CQC mock inspection: the Chief Executive referred to the dates for the next mock inspection and asked that all board members include the date in their diaries

Dedicated to excellence: The Chief Executive advised that the Awards will take place on Thursday, 13th April 2017 at the Marriot Hotel, Liverpool City Centre. There are 8 categories set out in the paper. The Chief Executive advised that this was a fantastic event for staff and Board members are welcome to attend. The Chair advised that he was not able to attend the event and had asked Ian Haythornthwaite to attend in his stead.

The Chief Executive advised she had met with Cathy Warwick CBE, Chief Executive of the Royal College of Midwives (RCM) and support had received the colleges support for the clinical case. She would also be looking to obtain the support of the RCN and BMA.

The Board noted the Chief Executive Report.

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

Susan Milner, Chair of GACA referred to her Chair's report from the meeting on 13 January 2017 and reported on the work of the Committee. She highlighted the three areas the Committee wished to bring to the attention of the Board: the findings of the Mock CQC Inspection, mortality and assurance regarding medicines management.

Susan Milner advised that the Committee had noted the findings of the mock CQC inspection which had highlighted a number of key actions that needed to be addressed. She understood that the action plan was being reviewed on a weekly basis so that the actions were continually reviewed, updated and signed off in time for the next mock inspection in May. The Committee would at its March meeting receive an up to date action plan for consideration.

Susan Milner advised that the Committee was committed to overseeing the work led by the Medical Director in reviewing morbidity and mortality. The Committee saw this as a priority that needs to be progressed with appropriate focus, speed and diligence and asked that the Medical Director update the Board on progress. The Medical Director advised that work was underway to develop a Mortality Strategy and would bring back to the Board at the April meeting following review by GACA in March.

Susan Milner advised that the Committee was not fully assured when it received the medicines management update at the meeting in January. The Director of Nursing and Midwifery advised that she did not believe there was a patient safety risk and that assurance was primarily around the service model and how the service discharged responsibilities. The Chief Pharmacist had been asked to attend the next Committee meeting in March to provide additional assurances.

Susan Milner advised that there were no recommended changes to the Board Assurance Framework.

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

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

Tony Okotie, Chair of PPF presented his Chairs report which was noted. He ran through the items covered by the Committee at the meeting on 27 January 2017 and highlighted key areas of note. He reported that the Committee was not quorate due to the non-attendance of a staff side representative and explained that this was a very unusual occurrence and the consideration would be given to the Terms of Reference of the Committee on whether to amend the quorum requirements of the Committee.

With regard to amendments to the Board Assurance Framework(BAF); the Committee recommendation the following for Board approval that the reduction of BAF Risk 4c 'Junior Doctors Industrial Action' to a score of 4 (1x4) and the rewording of the risk to a more generic risk associated with the potential for industrial action. The Board agreed the recommendations of the Committee to amend the BAF noted that this would be addressed later in the meeting under the BAF agenda item.

The Board noted the work of the Committee and in particular that for future Board agenda the 'Future Generations' standing item be amended to 'Fit for Future Generations'.

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

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

Jo Moore, Chair of FPBD presented the Chairs report from the last meeting of the FPBD held on 30 January 2017 and reported that the Committee had received assurances that the year-end deficit of the Trust would be £6.5m which was £500k better than planned.

Jo Moore referred to the report and in particular to the IM&T Review and EPR Update the Committee had received. She reported that the Committee was assured that the status of the IM&T and EPR implementation plans were progressing in line with plan and that all risks had been addressed. However there was a concern raised, which was being addressed, surrounding clinical engagement in the EPR implementation which was vital to its success and it was important that the Board was seen to be fully behind the implementation of EPR. It was agreed after discussion that Phil Huggon would join the Trusts EPR Project Board to provide clear message that the Board was fully behind of the implementation of EPR. The Medical Director reported that all the Clinical Directors had signed up the project at the Medical Staffing Committee (MSC) and that the Chair of the MSC was a strong advocate for EPR. The Director of Nursing and Midwifery also reported on the support to EPR from the nursing and midwifery staff who receive updates from the EPR project Lead at the Nursing and Midwifery Board.

The Director of Nursing and Midwifery reported that there was still the significant risk within maternity relating to EPR, she advised that the risk wholly sits with the Trust and was not shared with the other partners, the Royal and Aintree, due to the maternity bundle only relating to the Trust. It was important that these risks were fully mitigated. The Board noted the concern raised which had been recognised in previous discussions and asked that the areas of concern be dealt with as a matter of urgency. With regard to the full EPR business case it was noted that it would be brought to the Board in July 2017.

The Board discussed the delivery of CIP and the role of the Turnaround & Transformation Committee and noted changes made to the way CIP would be reviewed going forward by that Committee. The Board noted that there would be greater challenge and scrutiny of schemes with those accountable for delivery of the schemes being invited to the Committee to provide greater clarity on delivery. Responding to a question on whether the Trust had capacity and capability to deliver the Schemes, the Chief Executive advised that the Executive had invested in the PMO who would provide the necessary support to Trust staff in delivery of the schemes and advised that every scheme had an executive director and an operations lead accountable for delivery. The Chair asked that an update on the CIP for 2017/18 be provided to the Board in March following review by the FPBD.

With regard to amendments to the Board Assurance Framework(BAF); the Committee recommendation the following for Board approval:

De-escalation of Risk: That risk 5c – 'To take forward plans to develop services nationally and internationally - Non-delivery of the expected return from expansion investment' is discontinued on the BAF as plans to develop services nationally and internationally were no longer being progressed at this time. Therefore any risks and uncertainties that would have existed were no longer relevant.
Changes to Risk Ratings: That the risk score 5aii 'The Trust does not deliver the 2016/17 financial plan and control total' is reduced from risk score 20 (probable and catastrophic) to 15 (possible and catastrophic) in view of the improvement in the forecast position for 2016/17.
New Risks: The Committee felt that risk 1k and 1n on the register relating to "Isolated Site of LWH - Risk: Location, size, layout and current services do not provide for sustainable integrated care package for quality service provision" and "Suitability of Neonatal Estate - Risk: Inability to safely meet the needs and demands of a changing neonatal service within the confines of the current environment and staffing establishment" should be owned and reviewed by GACA.

The Board agreed the recommendations of the Committee to amend the BAF noted that this would be addressed later in the meeting under the BAF agenda item.

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

035 Chair's Report from the Audit Committee

Ian Knight, Chair of the Audit Committee referred to the Chair report included in the papers and highlighted the work of the Committee at its meeting on 30 January 2017. In particular he highlighted the work that would be undertaken by the External Auditor in the audit of the Trust's Annual report and Accounts, the changes to the Trust Corporate Governance Manual and the review of the waivers and standing orders.

Referring to the follow up of Internal and External Auditors Recommendations he advised that the Committee received assurance from the Medical Director that actions had been taken to implement the recommendations relating to the audit on Consultant Job Plans. David Astley was encouraged that this was now being addressed.

Referring to the proposed process for the appointment of internal auditor, Tony Okotie asked whether the scope of the work covered clinical audits. It was noted that the work of the internal auditor did not include clinical audits; these were performed by the clinical audit team within the Trust, which had a very robust process of audit. It was further noted that Clinical audits were reported through the Trust's integrated governance structure, through the Effectiveness Senet.

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

036 Quality, Operational Performance report Period 9 2016/17

The Director of Operations presented the Performance Dashboard and reported that of the thirty three KPI's RAG rated in the Trust Board Dashboard for December 2016, twenty two were rated Green, eight were rated Red and three Amber. It was noted that all the NHS Improvement nationally mandated KPIs were on target.

Referring to the rate of sickness and absence, the Director of Operations reported that the rate was now reducing to that reported in past Reports. However the rate was still higher than the target. Tony Okotie advised that PPF had focused on the indicator and had implemented actions to address higher rate which was now showing dividend. With regard to Maternity Triage, the Director of Operations advised that significant work had been undertaken to help resolve poor performance; however he was hopeful that the actions being taken would result in delivery in period 12. The Director of Operations advised that a review of the Maternity Triage indicator would be undertaken as part of the overall review of performance indicators reported to the Board to make sure that it was an appropriate indicator.

Tony Okotie referring to "percentage of women that requested and Epidural, but weren't given one for non-clinical reasons" was pleased to see that for month 9 the Trust had actually achieved the target. The Medical Director advised that this would not be the norm recognising the discussion the Board had previously regarding this indicator.

Susan Milner referring to the work being undertaken on both the quality and performance indicators felt that once the Board had settled on the indicators it was mandated to deliver and which were locally identified, it was important not to set targets that were impossible to achieve. She felt that the Board needed to be honest around what could be delivered against aspirational targets. The Director of Nursing advised that it was appropriate to set aspirational targets as these help the Trust to move forward and improve. Ian Haythornthwaite noting the importance of the mandated indicators and the nationally set targets felt that the Board needed to be assured why any locally selected indicators were key to the performance of the Trust. The Director of Finance agreed with the Director of Nursing and Midwifery comment regarding aspirational target setting and advised that setting ambitious targets helped the Board and staff to focus on the right things to improve quality of care and support learning. The Medical Director noted the comments and advised that with regards to the quality strategy and the relevance of indicators he felt that the NICE guidance provided the template of indicators that were both challenging and deliverable.

The Board noted the Performance report and the continuance of the action to bring to the Board at its March 2017 meeting a template performance report for future reporting of agreed metrics, both prescribed and those required locally by the Trust.

031 National Maternity Review update

The Interim Head of Midwifery joined the meeting and provided a presentation on the National Maternity Transformation Programme. She explained that the implementation of better births had the following values running through the programme: putting women and babies at the centre of care; ensuring that safety was a thread running through everything; work on a multi-professional basis across boundaries; listen and build consensus; share best practice; learn from what works and what does not work; and empower and support local change. There were 9 work streams to the programme: Local Transformation; Promoting Safer Care; Choice and Personalisation; Perinatal Mental Health; Workforce transformation; Data and Information; Technology; Payment; and Prevention.

The Interim Head of Midwifery ran through how the programme was being worked through within Cheshire and Merseyside referring in particular the Sustainability Transformation Plan, the Cheshire and Merseyside Vanguard, Local Maternity systems and the merger of Cheshire and Mersey SCN with Lancashire and South Cumbria. The Interim Head of Midwifery went on to explain how the Trust fitted into the programme and explained that Devender Roberts, Clinical Director and Consultant Obstetrician Fetal Medicine at the Trust was the Lead Clinician for the vanguard and she was the Head of Midwifery/ Gynae. The Trust had been identified as the Lead site for the vanguard and went on to explain what this meant in terms of the work the Trust would be involved in, including the early adopter, PMCB pioneer and community hubs resulting in the setting up of continuity of carer better postnatal and PMH Care and safer care working across all boundaries. The Interim Head of Nursing reported on the payment system that was currently being reviewed with an expectation that it would be launched in 2019/20 financial year.

The Chair thanked the Interim Head of Midwifery for her presentation and sought views and comments from the Board. The Chief Executive referring to the continuation of care felt this this was very important to the patient and needed to be protected. The Interim Head of Midwifery supported the view however recognised that one of the key findings of the national review was that patients should have choice. The Director of Operations felt that there could be some chaos in the system if processes were not fully developed and implemented appropriately, referring in particular the possibility of a personalised maternity budget for patients. The Medical Director supported the comment and felt that the systems needed to be clearly defined to keep patients safe. The Chief Executive commented that there was a need to be sure that the system of care for women would deliver expectations, she advised that over the years the Trust had received patient stories of mothers not receiving the same quality of care in different service providers, as a pioneer for women's services the Trust need to highlight this concern. Susan Milner referring to the maternity system development commented on the need for the system to be aligned with social care.

The Chair thanked the Interim Head of Midwifery for her presentation which was noted. The Board recognising that a formal paper was due at the March meeting agreed to extend the time to June, so that the report back would include the visit of Baroness Cumberlege.

037 Financial Report & Dashboard Period 8 2016/17

The Director of Finance presented the Finance Report and financial dashboard for month 9, 2016/17 and reported that Trust was reporting a monthly deficit of £0.945m against a deficit plan of £0.971m which was a negative variance of £0.026m for the month. Cumulatively the Trust was slightly ahead of plan by £0.057m. She advised that following a detailed review in month 9 the Trust was now in a

position to improve the forecast deficit to £6.5m. The Director of Finance reported that the Trust had agreed a fixed level of income for the rest of the financial year with Liverpool, St Helens and Knowsley CCGs. Referring to pay the Director of Finance advised that overall expenditure remained below budget predominantly due to vacancies across a number of services including neonates, Hewitt Centre and genetics: non-pay expenditure was forecast to be above plan predominantly due to the non-delivery of CIP in gynaecology/theatres.

Referring to the future cash requirements, the Director of Finance advised that changes in the type of facility that had been agreed by the Board out of meeting in January could result in a higher rate of interest payable if the Trust was unable to deliver its control totals. She explained that the DH had requested the changes in the type of facility (Single Currency Interim Revenue Support Facility) available for trusts to draw down interim revenue support.

The Board noted its decision out of meeting, ratified the decision regarding the Single Currency Interim Revenue Support Facility - *that on a specified date [30th January 2017] whilst both the agreements remain in force, it is agreed that a utilisation of £3.650,000 will be assumed as having been made on the facility DHPF/ISRWF/REP/2015-04-17/A [the Single Currency Interim Working Capital Revenue Facility Agreement approved by the Board in January 2016] and that the equivalent value shall be assumed to be repaid on facility DHPF/ISWBL/REP/2017-01-12/A [Single Currency Interim Revenue Support Facility Agreement].*

Responding to a question from Tony Okotie regarding the fixing of income mentioned earlier, the Director of Finance advised that the CCG's required certainty surrounding its year end position. She felt that in fixing income it benefited to both parties.

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

038 Future Generations Update

The Board noted that there had been no developments since the publication of the Pre-Consultation Business Case. It was agreed that this standing agenda item would be changed to 'Fit for Future Generations Update'.

039 Board Assurance Framework & Corporate Risk Register

The Board considered the Board Assurance Report (BAF) and Corporate risk register and following review noted the recommendations provided by each of the Board Committees; and approved the amendments to the BAF; confirmed that the BAF and the Corporate Risk Register adequately identify the principal risks to achieving the Trust's strategic objectives; and confirmed that the BAF and the Corporate Risk Register had adequate assurance systems in place to ensure the systems of control were effective and efficient in controlling the risks identified and that appropriate actions are in place where required.

The Board noted that the action relating to the restructure and consolidation of the BAF would be presented to the May 2017 meeting for approval following review and Board workshop to be held in April 2017.

040 Review of risk impacts of items discussed

The Board noted the risks had been discussed during the meeting and the main issue was the related to:

1. Review of the action plan arising from the Mock CQC inspection

2. Medicines management
3. Future review and setting of the appropriate targets in the Performance Report
4. Delivery of CIP and CQINS
5. EPR – improved communication and buy-in from clinical staff.
6. Maternity Review.
7. Potential increase in the interest rates for cash support from 1.5% to 6%.

041 Any other business & Review of meeting

None.

Conduct of the meeting was very good with good challenge, scrutiny and assurance provided. The Chair felt that there was contribution from all members of the Board.

Date and time of next meeting
3 March 2017

TRUST BOARD
March 2017 Action Plan

Meeting date	Minute Reference	Action	Responsibility	Target Dates	Status
6 Jan 2017	2017/010	The Director of Operations to bring to the Board at its March meeting a template performance report for future reporting of agreed metrics, both prescribed metrics and those required locally by the Trust.	Director of Operations	~~3 March 2017~~ 7 April 2017	Action ongoing. An extension of time is required to bring the template to the Board. It is proposed that a template is provided at the 7 April 2017 meeting.
6 Jan 2017	2017/009	The Director of Nursing and Midwifery include in future quarterly SI reports to the Board the matters identified in the discussion.	Director of Nursing and Midwifery	Next report 7 April 2017	Action ongoing
4 Nov 2016	2016/278	Director of Nursing and Midwifery to provide an update to the board on progress made against the action plan regarding the implementation of the National Maternity Review in February 2017.	Director of Nursing and Midwifery	~~February 2017~~ 7 July 2017	*3 March 2017 Update: An update presentation was be provided to the Board on 3 February 2017 with a formal paper presented to the Board at the 7 July 2017 meeting following the visit from Baroness Cumberlege* Action ongoing.
7 Oct 2016	2016/255	The Executive Team to review the risks identified in the BAF and bring back a proposal on whether the risks can be grouped or consolidated.	Trust Secretary/Executive	~~February 2017~~ (i) 7 April 2017 (ii) 5 May 2017	3 February 2017 update: This action has now been superseded following the findings of the CQC mock inspection reported through GACA. A complete review of the BAF has been commissioned that would take into account not only the consolidation of the risks on the BAF (these have continued to be reviewed by the Committees) but also to consider structural changes to the way the BAF reports and manages the risks and its relationship with the Corporate Risk Register. The Executive with the support of the Chair has commissioned an external review of the BAF to make it fit for purpose and accessible by the Board, Board committees and staff. *3 March 2017 Update: a Board workshop on the day of*

					the April Board has been arranged to review the structure of the new BAF and risks following which the final version of the BAF will be circulated prior to being received at the 5 May 2017 meeting, Action ongoing.

Agenda item no:	2017/058(i)

Meeting:	Board of Directors

Date:	3 March 2017

Title:	Learning, Candour & Accountability – Gap Analysis

Report to be considered in public or private?	Public

Where else has this report been considered and when?	Safety Senate – February 2017

Reference/s:	CQC : Learning, candour and accountability – December 2016

Resource impact:	--

What is this report for?	**I**nformation	(✓)	**D**ecision	(✓)	**E**scalation	( )	**A**ssurance	(✓)

Which Board Assurance Framework risk/s does this report relate to?	To deliver SAFE services

Which CQC fundamental standard/s does this report relate to?	Regulation 20

What action is required at this meeting?	a. Take a view as to the assurance that the gap analysis and the Safety Senate's response to it provides b. Agree that the action plan adequately addresses the issues identified by the CQC c. Agree to deliver the actions identified against the Board specific responsibilities.

Presented by:	Dianne Brown, Director of Nursing & Midwifery

Prepared by:	Governance Team

This report covers (tick all that apply):

Strategic objectives:	
To develop a well led, capable motivated and entrepreneurial workforce	✓
To be ambitious and efficient and make best use of available resources	
To deliver safe services	✓
To participate in high quality research in order to deliver the most effective outcomes	✓

To deliver the best possible experience for patients and staff	✓

Other:			
NHS Improvement compliance	✓	Equality and diversity	
NHS constitution		Operational plan	

Publication of this report (tick one)**:**	
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	✓
This report will not be published under the Trust's Publication Scheme due to exemptions under S21 of the Freedom of Information Act 2000, because the information contained is reasonably accessible by other means	
This report will not be published under the Trust's Publication Scheme due to exemptions under S22 of the Freedom of Information Act 2000, because the information contained is intended for future publication	
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	
This report will not be published under the Trust's Publication Scheme due to exemptions under S43(2) of the Freedom of Information Act 2000, because such disclosure would be likely to prejudice the commercial interests of the Trust	

1. Introduction and summary

The Safety Senate received in January the CQC report 'Learning, Candour & Accountability'. Upon reviewing it the Senate requested a gap analysis be prepared assessing the Trust's position against the key findings and recommendations. The Senate then considered the gap analysis in March and agreed a series of actions that would be taken to become fully compliant.

This report provides details of that gap analysis and outlines a small number of board specific responsibilities that require actions to be taken.

2. Key Themes

This review was carried out in response to the very low numbers of investigations or reviews of deaths at Southern Health NHS Foundation Trust. Over a four-year period, fewer than 1% of deaths in Southern Health's learning disability services and 0.3% of deaths in their mental health services for older people were investigated as a serious incident.

The CQC report identified significant gaps in the process for the review and investigation of deaths across all Trust. It identified five specific areas for Trusts to review and improve:

- involvement of families and carers;
- identification and reporting;
- decision to review or investigated;
- reviews and investigations;
- governance and learning.

NHS England has accepted the recommendations in full and from 1 April 2017 will require Trusts to evidence that they have improved the management and reporting of incidents accordingly.

The gap analysis found 18 recommendations from the report applicable to Liverpool Women's. Of these there is currently evidence in place to support 9 of these as being complete. For the remaining 9, actions have been suggested that would allow the Trust to evidence compliance. All have been given timescales within the next 3 months.

3. Conclusion

The trust's gap analysis gives reasonable assurance regarding current practice and provides a clear timeline for becoming fully compliant. The Medical Director is leading efforts through the Effectiveness Senate to provide greater visibility and direction to mortality. This will in turn ensure that the trust board receive an appropriate level of detail regarding patient deaths.

To ensure quality and learning from all harm and particularly the deaths of patients the Trust has recently published an annual review of lessons learnt. There is also a board session planned to discuss learning from harm and ensure appropriate challenge is applied by board members.

Of particular note is the trust's recent participation in the National Learning Disability Review Programme (LeDeR). Liverpool Women's was the first trust in the region to invite independent experts from the programme to participate in one of its serious incident investigations. This is viewed by regulators as best practice and the review team provided extremely positive feedback regarding the robustness of the investigative processes at the trust and the thoroughness of the investigation itself.

4. Recommendations

It is recommended that the Board:

a. Take a view as to the assurance that the gap analysis and the Safety Senate's response to it provides
b. Agree that the action plan adequately addresses the issues identified by the CQC
c. Agree to deliver the actions identified against the Board specific responsibilities.

Appendix: Trust Gap Analysis

Issue Identified	Action Description	Operational Lead	Management Lead	RAG Status	Target Date (Completion Date)	Progress Update / Evidence	Risk Register ?
1. How are families and carers involved and treated?							
Families and carers told us that they have a poor experience of investigations and are not consistently treated with respect, sensitivity and honesty. This is despite many trusts stating that they value family involvement and have policies and procedures in place to support it.	Trust to conduct a full review of how it involves patients in investigations and steps that can be taken to treat families more sensitively and encourage involvement	Head of Governance	Director of Nursing & Midwifery		March 2017	Paper to be presented to Safety Senate in March 2017	
Families are not routinely told what their rights are when a relative dies, what will happen or how they can access support or advocacy.	All families to receive a letter from the Clinical Director following a death signposting support and advocacy	Clinical Directors for Gynaecology, Maternity & Neonatology	Medical Director		May 2017	Template letter from Clinical Director now in use in maternity	
The extent to which families and carers told us they are involved in reviews and investigations of their relative's death varies considerably. Families are not always informed or kept up to date about investigations – something that often causes further distress and undermines trust in investigations.	All families to receive a letter at the outset of an investigation outlining clear investigation timescales	Clinical Directors for Gynaecology, Maternity & Neonatology	Medical Director		May 2017	This information can be included with Duty of Candour notification	

Families and carers are often not listened to, their involvement is tokenistic and the views offamilies and carers are not given the same weight as that of clinical staff.	All families to be provided with the opportunity to ask questions that must then be considered in an investigation	Head of Governance	Director of Nursing & Midwifery		February 2017	All families receive a Duty of Candour letter that includes the opportunity to ask questions. CCG monitor completion of this	
The NHS underestimates the role that families and carers can play in helping to fully understand what happened to a patient. They offer a vital perspective because they see the whole pathway of care that their relative experienced.	Trust to conduct a full review of how it involves patients in investigations and steps that can be taken to treat families more sensitively and encourage involvement	Head of Governance	Director of Nursing & Midwifery		March 2017	Paper to be presented to Safety Senate in March 2017	

2. How are the deaths of people receiving care identified and reported?							
There is variation and inconsistency in the way organisations become aware of the deaths of people in their care across the NHS. This was found to be an issue for acute, community and mental health trusts equally with organisations relying on information being shared by others to identify when a death occurs outside their inpatient services.	Recommendation applies to NHS Digital and NHS Improvement						

Many patients who die have received care from multiple providers in the months before death. These include GPs, acute hospitals, community health services, mental health services, ambulance services, NHS 111 services, out-of-hours doctors services, and urgent care centres. At present there are no clear lines of responsibility or systems for the provider who identifies a death to inform other providers or commissioners.	Review of Trust deaths to take place to ensure commissioners have been informed of deaths involving other providers (Issue identified predominantly applies to NHS Digital and NHS Improvement)	Head of Governance	Director of Nursing & Midwifery		April 2017		
There is no consistent process or method for NHS trusts to record when recent patients die after they have been discharged from the care of the service, either from an inpatient service or from receiving services in the community. This includes the way trusts are able to record when people with mental health conditions or a learning disability die in NHS hospitals or while receiving care from the community services of NHS trusts.	Recommendation applies to NHS Digital and NHS Improvement						
Electronic systems do not support the sharing of information between NHS trusts or with others outside the service who have been involved in a patient's care before their death, for example primary care services or services run by independent health providers or adult social care.	Ensure Trust trust patient record and incident management systems are linked to national databases	Head of Governance	Chief Information Officer		February 2017	Patient record system is connected to the 'NHS Spine', incident system is connected to the National Reporting and Learning System (NRLS)	

3. Making the decision to review or investigate							
Healthcare staff understand the expectation to report patient safety incidents and are using the Serious Incident Framework as the process to support decisions to review and/or investigate when deaths occur. However, this means that investigations will only happen if the care provided to the patient has led to a serious incident being reported	Ensure processes are in place for investigations to take place for all patient deaths	Clinical Directors	Medical Director		February 2017	In addition to investigations of Serious Incidents all deaths are reviewed either at Gynaecology Morbidity & Mortality Meetings, Maternity Stillbirth Review Meetings or Neonatal Multi-Disciplinary Team meetings	
Criteria for deciding to report as an incident and application of the framework varied across trusts, particularly the range of information that needs to be considered by individual staff to identify any problems in care and escalate for further review or investigation. Decision making is inconsistently applied and recorded across the NHS trusts we visited.	Ensure independent oversight of decision making	Head of Governance	Director of Nursing & Midwifery		February 2017	All incidents reported at this Trust are monitored by a dedicated member of clinical staff. All incidents are also reviewed by the Patient Safety Programme Manager for independent oversight and challenge as appropriate. Notification via LeDeR / investigation takes place as appropriate.	

In the absence of a single national framework that specifically supports the review and decisions needed for deaths, recognising them as a significant event that may need a different response to patient safety incidents, clinicians and staff are using different methods to record their decisions. This is leading to variation across NHS trusts, including within the same sectors, and limiting the ability to monitor, audit or regulate the decision-making process in relation to reviewing deaths across the NHS.	Recommendation applies to oversight groups / regulators						
There is confusion and inconsistency in the methods and definitions we use across the NHS to identify and report deaths leading to decisions being taken differently across NHS trusts.	Recommendation applies to oversight groups / regulators						
Decision making must be informed by timely access to information by clinicians and staff, but we found difficulties in getting clinical information about the patient from others involved in delivering care including from primary care services	Escalate any concerns regarding accessing information to the CCG	Patient Safety Programme Manager	Head of Governance		February 2017	The Trust has a positive working relationship with local commissioners, both on an ad hoc basis and through monthly meetings. The occassions where escalation of concerns has been necessary are few but there is evidence this happens when appropriate	

4. Reviews and investigations							
Most NHS trusts follow the Serious Incident Framework when carrying out investigations. Despite this, the quality of investigations is variable and staff are applying the methods identified in the framework inconsistently. This acts as a barrier to identifying the opportunities for learning, with the focus being too closely on individual errors rather than system analysis.	Implement training for investigators to ensure consistent application of SI Framework in investigations	Head of Governance	Director of Nursing & Midwifery		February 2017	Investigation training has been provided to a cohort of 60 staff to ensure consistent and thorough investigations	
Specialised training and support is not universally provided to staff completing investigations; many staff completing reviews and investigations do not have protected time in which to carry out investigations. This reduces consistency in approach, even within the same services.	Ensure appropriate training is arranged for all investigation staff and that protected time is allocated to all divisional Safety Leads	Clinical Directors	Medical Director		April 2017	Training provided. Gynaecology safety lead does not currently have protected time allocated	
There are significant issues with the timeliness of investigations and confusion about the standards and timelines stated in guidance – this affects the robustness of investigations, including the ability to meaningfully involve families.	Review investigation submission standards for 2016-17 and present a compliance report to Safety Senate	Head of Governance	Director of Nursing & Midwifery		April 2017		

A multi-agency approach to investigating is restricted by a lack of clarity on identifying the responsible organisation for leading investigations or expectations to look across pathways of care. Organisations work in isolation, only reviewing the care individual trusts have provided prior to death. This is a missed opportunity for identifying improvements in services and commissioning, particularly for patients with mental health or learning disability needs.	Work with NHS England to implement multi-organisational investigations	Head of Governance	Director of Nursing & Midwifery		February 2017	Head of Governance has attended NHS England workshop and is engaged in this process. SI has already been esclated by LWH for multi-organisational investigation as a result	

5. Do trust boards have effective governance arrangements to drive quality and learning from the deaths of patients in receipt of care?							
There are no consistent frameworks or guidance in place across the NHS that require boards to keep all deaths in care under review or effectively share learning with other organisations or individuals.	Recommendation applies to oversight groups / regulators						
Trust boards generally only receive limited information about the deaths of people using their services other than those that have been reported as serious incidents.	Board to receive quarterly mortality update asking them to give an opinion against the CQC's 9 key bulletpoint questions	Head of Governance	Director of Nursing & Midwifery		July 2017		

When boards receive information about deaths, board members often do not interrogate or challenge the data effectively. Most board members have no specific training in this issue or time that is dedicated to focus on it.	Session to be arranged to train board members in how to challenge mortality data and asking them to consider nominating a non-executive director to lead on mortality and learning from deaths	Head of Governance	Director of Nursing & Midwifery		April 2017		
Where investigations have taken place, there are no consistent systems in place to make sure recommendations are acted on or learning is being shared with others who could support the improvements needed.	All recommendations, learning and sharing to be overseen by Safety Senate	Head of Governance	Director of Nursing & Midwifery		February 2017	Standing agenda item on Safety Senate for all reports to be reviewed and shared. Standing agenda item monitoring implementation of lessons learnt / changes in practice	BAF
Robust mechanisms to disseminate learning from investigations or benchmarking beyond a single trust do not exist. This means that mistakes may be repeated.	Ensure mechanisms are in place for sharing learning outside the organisation	Head of Governance	Director of Nursing & Midwifery		February 2017	Trust has well established arrangements with local CCG for disseminating learning. Any other agencies specifically involved in incidents receive their own copy of the investigation report (including lessons learnt)	

Agenda item no:	*2017/058iii*

Meeting:	LWH Board

Date:	03/03/17

Title:	Learning from incidents/ Feedback and Harms - Gynaecology

Report to be considered in public or private?	Public

Purpose - what question does this report seek to answer?	For Information and assurance

Reference/s:	

What is this report for?	**Information**	✓	**Decision**	✓	**Escalation**		**Assurance**	

Which Board Assurance Framework risk/s does this report relate to?	too deliver SAFE services

Which CQC fundamental standard/s does this report relate to?	Regulation 9, 12, 17 & 20

What action is required at this meeting?	The Board is asked to note the content of the paper and receive assurance that lessons have been learned and shared regarding the adverse incidents and changes made to clinical practices.

Presented by:	John Kirwan CD Gynaecology and Chris McGhee, Head of Nursing

Prepared by:	John Kirwan CD Gynaecology and Chris McGhee, Head of Nursing

This report covers (tick all that applies):

Strategic objectives:	
To develop a well led, capable and motivated workforce	✓
To be efficient and make best use of available resources	✓
To deliver safe services	✓
To deliver the most effective outcomes	✓
To deliver the best possible experience for patients and staff	✓

Other:			
Monitor compliance		Equality and diversity	
NHS constitution		Integrated business plan	

Which standard/s does this issue relate to:	
Care Quality Commission	
Clinical Negligence Scheme for Trusts	
NHS Litigation Authority	

Publication of this report (tick one)**:**	
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	✓
This report will not be published under the Trust's Publication Scheme due to exemptions under S21 of the Freedom of Information Act 2000, because the information contained is reasonably accessible by other means	
This report will not be published under the Trust's Publication Scheme due to exemptions under S22 of the Freedom of Information Act 2000, because the information contained is intended for future publication	
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	
This report will not be published under the Trust's Publication Scheme due to exemptions under S43(2) of the Freedom of Information Act 2000, because such disclosure would be likely to prejudice the commercial interests of the Trust	

Background

This report is to provide assurance to the board that Gynaecology and Theatre Service have investigated appropriately, and revised all relevant clinical practice, procedures, guidance etc. and through the formation and monitoring to completion of action plans has learnt lessons from 3 recent Never Events (outlined below). It is important to note that there was no harm to any patient following these incidents

Never Event 1 – date 19/07/2015

Details – Surgical glove containing surgical swab left in patient vagina post operatively following abdominal gynaecological surgery. This should have been removed at the end or surgery.

Never Event 2 – date 17/11/2016

Details – Patient attend GOPD for follow up appointment, in the outpatient clinic list were 2 patients of the same name, when the nurse called the patients name 1 patient stood and was taken into the Colposcopy room and underwent a colposcopy and biopsy. Identification that this was the wrong patient was identified when the biopsy sample was being put into histology pot.

Never Event 3 – date 12/01/17

Details - Vaginal Occluder (a balloon like expandable device which may be configured to expand into a substantially sealing engagement with an inner wall of the patient's vagina) was left in situ post operatively following Total Laparoscopic Hysterectomy and Salpingo oophorectomy.

In 2015/6 Liverpool Women's Hospital Gynaecology Team completed

- Total Number of Colposcopy procedures completed = 7,721
- Total number of Hysterectomies = 602 broken down as
    - Abdominal Hysterectomies = 370
    - Laparoscopic Hysterectomies =232
- Total number of laparoscopic procedures completed = 1861
- Total number of Outpatient attends in 2015/6 = 73,824

Recent Changes within Gynaecology

The service has a new Head of Nursing and Operations and a new Matron and the emphasis of these nursing leads is to improve visible collective leadership and responsibility.

Mr George Botros has recently been appointed as the new Gynaecology Safety Lead and changes to his clinical work is being identified which will allow him to have dedicated time to complete this role.

Action Undertaken to Prevent Reoccurrence and to learn lessons

In instances 1+2 a full Root Cause Analysis (RCA) has been completed, action plan has been developed and is being monitored. In incident 3 a table top exercise is planned for 02/03/17 to begin the RCA following this identification of process errors and action to prevent reoccurrence will be developed.

Duty of Candour has been applied in all cases and the patients involved given a full and clear explanation of what occurred, how it occurred and our actions to prevent reoccurrence.

The action plan as part of Incident 1 included change of practice from using packed surgical glove to using a Vaginal Occluder to prevent reoccurrence, so it is particularly concerning that the Vaginal Occluder is now the subject of a never event (incident 3)

Learning from Incidents – Changes made to practice

All Never Events and Significant incidents are discussed at monthly Gynaecology Divisional meeting, and at the daily Theatre huddle, when all theatre staff on duty are present . All clinical staff are encouraged to contribute to the improvement of safety in Gynaecology and Theatres.

Incident 1

- Review the Swab, Needle and instrument checks , in particular the counting process
- Development of an SOP to ensure that the white count board process is clear
- Review of safety Huddles
- Review of staff training and understanding of roles and responsibilities
- Trial of Vaginal Occluder

All actions were completed and Vaginal Occluder trial was completed and recommended for use in LWH.

Incident 2

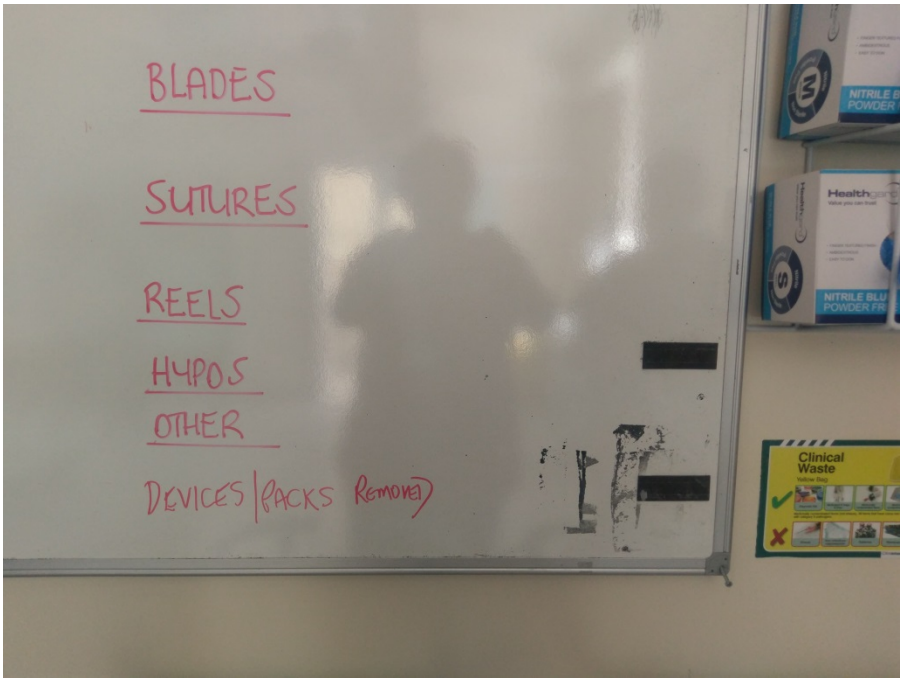
- Review and amendment of the SOP related to calling patients for treatment in Gynaecology OPD has been completed.
- Nurse now check minimum 3 demographics will every patient before taking in for treatment
- Clinician MUST check patients details before commencing consultation.

In**cident 3** – RCA still ongoing but some changes have already been made / recommended and implemented

- Further Review of SOP – the SOP will be reviewed in full as part of the RCA to identify why the correct process was not followed on this occasion
- Changes made to board in theatre that records swabs, needles and instrument check to include permanent line related to any insertions into the patient. (photo below)
- Purchases of a pre-printed board, with fixed sections which cannot be smudged or erased to include a line for insertions / attachments

- Recommendation that before the patient is moved from the table there is a positive affirmation that
    - The surgeon to confirm what operation has been completed, to identify any concerns about the patient or the procedure and that all insertions have been removed
    - The Anaesthetist is to confirm that he is happy with patient The Scrub Nurse to confirm Swab/ needle etc. count is correct and all insertions/ attachments have been removed

Work is continuing with the clinics and service leads and the governance team to complete the NATSSIPs for gynaecology and great progress is being made to complete these which will future improve patient safety.



Conclusions

The overwhelming number of procedures completed by the gynaecology and theatre teams at Liverpool Women's Hospital are completed without incident, however the services constantly strive to improve and learn lessons from adverse incidents.

Full Root Cause analysis is completed for all serious incidents and never events, and the service monitors all action plans to completion, supported by dedicated governance staff.

The service is keen to learn lessons and has appropriate forums for sharing the learning from adverse incidents and changes to clinical practice.

Agenda item no:	*2017/058iv*

Meeting:	LWH Board of Directors

Date:	03/03/17

Title:	Learning from incidents/ Feedback and Harms - Neonatal

Report to be considered in public or private?	Public

Purpose - what question does this report seek to answer?	For Information and assurance

Reference/s:	

What is this report for?	**Information**	✓	**Decision**	✓	**Escalation**		**Assurance**	

Which Board Assurance Framework risk/s does this report relate to?	too deliver SAFE services

Which CQC fundamental standard/s does this report relate to?	Regulation 9, 12, 17 & 20

What action is required at this meeting?	The Board is asked to note the content of the paper and receive assurance that lessons have been learned and shared regarding the adverse incidents and changes made to clinical practices.

Presented by:	Bill Yoxall, CD Neonatal Services

Prepared by:	Bill Yoxall, CD Neonatal Services

This report covers (tick all that applies):

Strategic objectives:	
To develop a well led, capable and motivated workforce	✓
To be efficient and make best use of available resources	✓
To deliver safe services	✓
To deliver the most effective outcomes	✓
To deliver the best possible experience for patients and staff	✓

Other:			
Monitor compliance		Equality and diversity	
NHS constitution		Integrated business plan	

Which standard/s does this issue relate to:	
Care Quality Commission	
Clinical Negligence Scheme for Trusts	
NHS Litigation Authority	

Publication of this report (tick one)**:**	
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	✓
This report will not be published under the Trust's Publication Scheme due to exemptions under S21 of the Freedom of Information Act 2000, because the information contained is reasonably accessible by other means	
This report will not be published under the Trust's Publication Scheme due to exemptions under S22 of the Freedom of Information Act 2000, because the information contained is intended for future publication	
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	
This report will not be published under the Trust's Publication Scheme due to exemptions under S43(2) of the Freedom of Information Act 2000, because such disclosure would be likely to prejudice the commercial interests of the Trust	

Background
A lumbar puncture was performed on a baby on 25th November 2016 based on the results of a blood test taken earlier that morning. While the decision to perform the clinical procedure was appropriate, the initial blood sample had been taken from the wrong baby. This incident was graded as **Actual effect on patient / service** – Low Harm, **Actual severity of incident –** Minor.

This was though declared as a Serious Incident and an investigation has been performed. As the incident was caused by mislabelling of blood samples by the phlebotomists from Alder Hey, the review panel included a Senior Nurse from Alder hey and the Acting Lead Nurse, Medicine & OPD, Alder Hey Children's Hospital.

This incident has been declared as a "Never Event", although the reason for this is not obvious;

The incident does not meet the criteria to be classified as a Never Event as defined in the "Never Events List 2016/2016" published by NHSE.

Lumbar puncture is classified as an "intervention" and not an "invasive procedure" in the NHSE publication "National Safety Standards for Invasive Procedures (NatSSIPs)" September 2015. Invasive procedures are those that have the potential to be associated with a never event.

As per our Duty of Candour Policy, parents were informed when the incident occurred. A meeting was held with baby's mother and grandmother and a follow up letter was sent asking if there was anything specific they would like us to address.

Investigation Findings

Chronology of events

1. Two babies with the same surname were present at the same time on the neonatal unit, but in different high-dependency nurseries.
2. At 09:00 on 25/11/16, Baby A, had blood taken in error by a phlebotomist for a CRP test (used to screen for infection). There was no indication for a blood test in this baby.
3. The blood sample should in fact have been obtained from Baby B, who needed routine blood sampling because of the presence of a central venous line and an intravenous fluid infusion.
4. The sample from Baby A was labelled erroneously as having been taken from Baby B and sent to the lab at Alder Hey, arriving at 09:47.
5. Later that day, blood tests were ordered for Baby B at 10:24 because no bloods had been sent. The time that the blood sample was taken is not known, but it arrived in the Alder Hey lab at 13:10.
6. The CRP from the first sample (from Baby A) was elevated at 30.7 mg/L prompting a septic screen to be performed on Baby B. Blood cultures were taken but a lumbar puncture was unsuccessful. Routine antibiotic therapy was started. The patient identity error was not identified at this stage.
7. The CRP from the second sample (from Baby B) showed a normal result of < 4 mg/L. The fact that there were two very different CRP results on the same day apparently from the same baby gave cause for concern. It was

recognised that there were two babies with same surname and that a patient identity mix-up may have occurred.

8. Following discussion with the attending consultant, another sample of blood was taken from Baby A at 16:10. The CRP from this sample was raised at 28.6 mg/L indicating that the original sample showing a CRP of 30.7 mg/L had been taken erroneously from Baby A instead of Baby B.
9. Baby A was screened and received a full course of antibiotics for an elevated CRP. The baby did well and was ultimately discharged home.
10. Baby B continued to receive antibiotics for 36 hours until blood culture results were confirmed as being negative. A repeat lumbar puncture was not performed. The baby's parents were spoken to and an apology offered. The baby did well and was ultimately discharged home.

Root Cause

Phlebotomist incorrectly identified the patient and, therefore, took blood from the wrong baby and mislabelled the sample that was sent to the laboratory.

Care and service delivery problems

- Phlebotomist incorrectly identified the patient, therefore took blood from the wrong baby and mislabelled the sample that was sent to the laboratory.
- Failure to follow patent identification policy.
- Blood request 'tick list' not completed by staff on the neonatal unit.

Contributory Factors

- Lack of clarity around training provision for phlebotomists and whether staff are up to date with training;
- Lack of a robust system for recording when a baby has had a blood test performed;
- Lack of a SOP for phlebotomy to ensure clear and consistent daily working practice.

Lessons Learned

- Need to develop a SOP for ordering, taking and recording of all neonatal blood samples;
- Improved dissemination of Identification of Patients Policy

Arrangements for sharing learning

Neonatal monthly senior multidisciplinary meeting
Neonatal nurse and consultant mandatory education sessions
Feedback to staff directly involved in the incident
Unit wide feedback
Trust-wide Serious incident feedback form
Alder Hey Childrens Hospital

Next steps

1. A working group is to be convened in order to map a process for ordering, collecting and recording blood samples and to develop a SOP for this process. The Phlebotomy service from AHCH will be discontinued from April 2017. Blood samples

from babies will only be taken by LWH clinical staff caring for thise individual babies in future. The working group will be convened by the end of April 2017 and will be led by the Nurse Consultant /ANNP and the Neonatal Matron.

2. Enhanced training and publication around Identification of Patients Policy. This will be led by the neonatal education team and implemented before the end of April 2017.
3. It was also recommended that we should investigate the use of “Scan for Safety” with Clevermed to use barcode scanning for patient identification. This action has been assigned to the Chief Information Officer, who chaired the investigation panel, with a delivery date of 30/06/2017.

Agenda item no:	17/060

Meeting:	Board of Directors

Date:	3 March 2017

Title:	Chief Executive's Report

Report to be considered in public or private?	Public

Where else has this report been considered and when?	N/A

Reference/s:	N/A

Resource impact:	-

What is this report for?	**Information**	✓	**Decision**		**Escalation**		**Assurance**	✓

Which Board Assurance Framework risk/s does this report relate to?	**All**

Which CQC fundamental standard/s does this report relate to?	**Reg 17: good Governance**

What action is required at this meeting?	To receive and note the report.

Presented by:	Kathryn Thomson, Chief Executive

Prepared by:	Colin Reid, Trust Secretary

This report covers (tick all that apply):

Strategic objectives:	
To develop a well led, capable motivated and entrepreneurial workforce	✓
To be ambitious and efficient and make best use of available resources	✓
To deliver safe services	✓
To participate in high quality research in order to deliver the most effective outcomes	✓
To deliver the best possible experience for patients and staff	✓

Other:			
Monitor compliance	✓	Equality and diversity	
Operational plan		NHS constitution	

Publication of this report (tick one):	
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	✓
This report will not be published under the Trust's Publication Scheme due to exemptions under S21 of the Freedom of Information Act 2000, because the information contained is reasonably accessible by other means	
This report will not be published under the Trust's Publication Scheme due to exemptions under S22 of the Freedom of Information Act 2000, because the information contained is intended for future publication	
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	
This report will not be published under the Trust's Publication Scheme due to exemptions under S43(2) of the Freedom of Information Act 2000, because such disclosure would be likely to prejudice the commercial interests of the Trust	

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.

SECTION A - INTERNAL

Appointments:

Doug Charlton has been appointed Director of Nursing and Midwifery and will take up the post on 1 April 2017, replacing Dianne Brown. Dianne is due to join Aintree University Hospitals NHS Foundation Trust as an Executive Director and Chief Nurse.

Julie King has been appointed to the post of Deputy Director of Nursing and Midwifery

Merseyside Police counter-terrorism exercise: Merseyside Police will be running a counter-terrorism table top exercise for senior staff in the Blair Bell education centre. The workshop will provide a highly valuable opportunity to rehearse and test the Trust's responses to a major incident and exercise business continuity arrangements with expert guidance and support from local Counter Terrorism Security Advisors.

SECTION C – NATIONAL

NHS England (North): Clare Duggan (currently Director of Commissioning Operations for Cheshire and Merseyside) to take up a new role of Regional Director of Transformation to ensure progress is made on the delivery and implementation of the Five Year Forward View (attached letter)

16 February 2017

NHS England (North)
6NE
Quarry House
Quarry Hill
Leeds
LS2 7UE

Telephone: 0113 825 3011

To: See distribution below

Dear Colleague,

To ensure we continue to make progress on the delivery and implementation of the Five Year Forward View, I believe we need a Director to focus on transformational change. Therefore I am creating a new role of Regional Director of Transformation, and I have asked Clare Duggan (currently Director of Commissioning Operations for Cheshire and Merseyside) to take up this role. Clare will work closely with Regional Management Team colleagues and other stakeholders to make sure that we make even greater progress in a range of areas and best support health systems to deliver Sustainability and Transformation Plans across the North.

To enable this change Graham Urwin has agreed to take on Director of Commissioning Operations (DCO) responsibilities for Cheshire and Merseyside. I'd like to thank both Clare and Graham for taking on these different challenges and for the work of both Lancashire and Cheshire and Merseyside teams who are really making a difference to outcomes for patients. Clare and Graham will be transitioning into the new roles over the coming weeks.

Cheshire and Merseyside and Lancashire will remain as two separate teams working with their respective STPs to maintain the important place based focus to delivery. Graham will continue to be DCO for Lancashire, working closely with Dr Amanda Doyle (STP lead for Lancashire and South Cumbria) on the delivery of the STP and ensuring we contribute the right support to this.

I'm sure you will all support Clare and Graham taking on these responsibilities. If you have any queries please talk to your Director or get in touch with me directly.

Yours sincerely

Richard Barker
Regional Director (North)

Distribution:

Chairs and Accountable Officers, CCGs (North)
Chief Executives, Local Authorities (North)
Chief Executives, NHS Provider Organisations (North)
North Regional Management Team, NHS England
STP leaders (North)
Matthew Swindells, National Director: Operations & Information, NHS England
Paul Watson, Regional Director (Midlands and East), NHS England
Anne Rainsberry, Regional Director (London), NHS England
Jennifer Howells, Regional Director (South), NHS England
Lyn Simpson, Executive Regional Managing Director (North), NHS Improvement
Professor Paul Johnstone, Regional Director (North), Public Health England
Laura Roberts, Regional Director (North), Health Education England
Annie Coppel, Implementation Consultant (North West), National Institute for Health and Social Care
Debbie Westhead, Deputy Chief Inspector of Adult and Social Care (North), Care Quality Commission

17/61

Board of Directors

Committee Chair's report of Finance Performance and Business Development Committee meeting held 20 February 2017

1. Meeting Quorate: Yes

2. Agenda items covered

~ Month 10 Finance Report: The Committee was assured that the Trust was on target to deliver £6M deficit at year end. The improved forecasted outturn deficit of £0.5m reported last month will be matched by £0.5m of STF incentive funding.

~ Performance dashboard, Month 10: the Committee noted that the Trust continued to deliver against the NHSI performance targets. Mandatory training had seen a fall in performance over the period due in part to safe staffing to support clinical areas where there has been short term sickness. The Committee recognised that the target set was a stretch target however also recognised the importance that all staff received their mandatory training. The Committee was mindful that the delivery of the mandatory training performance was high on the agenda of the Putting People First Committee.

~ Cost Improvement Programme Review 2017/18: The Committee received an update on the CIP programme proposals for 2017/18. The Committee noted that the Trust must deliver £3.7m of CIP in 2017/18 and the programme provided a level of assurance that the trust would be able to achieve the requirement. The Committee received assurance that detailed plans had been worked up to allow 62% of schemes to be transacted through budgets to date and noted that work continued on the remaining 38%, to enable 100% to be transacted by the start of the 2017/18 financial year. The Committee noted that the delivery of the Schemes would be extremely challenging and that there was risk to delivery, despite the identified mitigations.

3. Board Assurance Framework (BAF) risks reviewed

~ The Committee noted the BAF and agreed that there were not changes to be made. The Committee further noted that the BAF was going through a number of iterations and that the structure of the BAF and the risks were being reviewed.

4. Issues to highlight to Board

~ To note the challenging CIP programme for 2017/18.

5. BAF recommendations

~ None

6. Action required by Board

~ None

Performance and Information Department
Performance Team

Liverpool Women's NHS Foundation Trust

2017/062

Agenda Item No:	2017/062
Meeting:	Trust Board
Date:	February 2017
Title:	Performance Dashboard - Month 10 - January 2017
Report to be considered in Public or Private?	Public
Where else has this report been considered and when?	Performance Group, Trust Management Group, Finance, Operations Board, Finance, Performance and Business Development Board
Reference/s	Quality Strategy, Quality Schedule, CQUINS, Corporate Performance Indicators, Monitor Assurance Framework
Resource impact:	

What is this report for?	**Information**		**Decision**		**Escalation**		**Assurance**	

Which Board Assurance Framework risk(s) does this report relate to?	1. Deliver safe services 3. Deliver the best possible experience for patients and staff 4. To develop a well led, capable and motivated workforce 5 to be ambitious and efficient and make best use of available resources
Which CQC fundamental standard(s) does this report ralet to?	Good Governance Staffing Safety Complaints
What action is required at this meeting?	To Note
Presented by:	Jeff Johnson
Prepared by:	David Walliker

This report covers (tick all that apply):

Strategic objetives:	
To develop a well led, capable, motivated and entrepreneurial **workforce**	✓
To be ambitious and **efficient** and make best use of available resources	✓
To deliver **safe** services	✓
To participate in high quality research in order to deliver the most **effective** outcomes	✓
to deliver the best possible **experience** for patients and staff	✓

Other:

Monitor Compliance	✓		Equality and diversity	
NHS Constitution			Integrated business plan	

Publication of this report (tick one):

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.		
This report will not be published under the Trust's Publication Scheme due to exemptions under S21 of the Freedomn of Information Act 2000, because the information contained is reasonable accessible by other means.		
This report will not be published under the Trust's Publication Scheme due to exemptions under S22 of the Freedomn of Information Act 2000, because the information contained is intended for future publication.		
This report will not be published under the Trust's Publication Scheme due to exemptions under S41 of the Freedomn of Information Act 2000, because such disclosure might constitute a breach of confidence.		
This report will not be published under the Trust's Publication Scheme due to exemptions under S43(2) of the Freedomn of Information Act 2000, because such disclosure would be likely to prejudice the commercial interests of the Trust.		

1. Introduction and summary

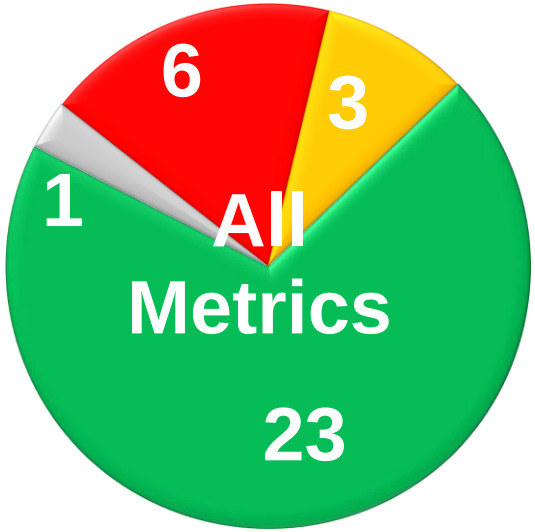
2. Issues for consideration

3. Conclusion

4. Recommendation/s

Liverpool Women's NHS Foundation Trust

Performance Report - Trust Board — Month 10 - January 2017



Performance Summary - Trust Board - Month 10 - January 2017

Overview

Of the 33 KPI's RAG rated in the Trust Board Dashboard for January 2017, **23** are rated Green, **6** are rated Red and **3** are rated as Amber. The figure for Choose and Book is not yet available nationally.

The KPI's rated as Red for January 2017 are:

- Sickness & Absence Rate at 5.92% against a target of <= 4.5%
- Maternity Triage within 30 minutes at 83.1% against a target of >= 95%
- 6 Week Wait for Diagnostic Tests at 98.9% against a target of >= 99%
- 3 x finance KPI's which are reported separately via the Finance Report.

The KPIs rated as Amber for January 2017are:

- HR: Appraisals & PDR at 88% against a target of >= 90%
- HR: Mandatory Training at 91% against a target of >= 95%
- HR: Staff Turnover Rates at 14% against a target of <= 10%

To view the Full TMG/FPBD version of the Performance Dashboard double click the PDF icon to the right.

Performance Summary - Trust Board - Month 10 - January 2017

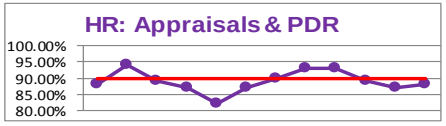
To develop a well led, Capable, Motivated and Entrepreneurial WORKFORCE

HR: Sickness & Absence Levels at 5.92% against a target of <= 5%

There are currently **eleven** services that are now rated as **red.** One is rated as amber (Imaging) and four are under the Trust's target figure of 4.5% and therefore rated as green (Genetics, Human Resources, Medical Staff & Trust Offices.

The split between short and long term sickness absence has changed noticeably. In month nine the split was 40%/60%, while in month ten it was 52%/48%. In terms of the most prevalent diagnoses across the Trust, there was no change from month nine: 'anxiety/stress/depression' was ranked as the most common diagnosis, 'gastrointestinal problems' was second and cold/cough/flu was third.

It is anticipated that sickness levels should reach the Trust's target of 3.5% in quarter one of 2017/18.

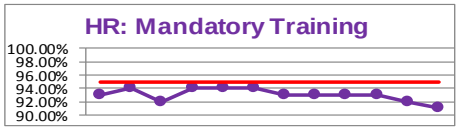


HR: Appraisals & PDR Rates at 88% against a target of >= 90%

The overall Trust compliance rate for PDRs increased by 1% from 87% in month nine to 88% in month ten. This is now 2% under the Trust's target rate of 90% and therefore rated as amber.

Of those areas that remain noncompliant: One area is rated as red – Transport. Nine areas are rated as amber – Genetics, Gynaecology, Human Resources, Imaging, Integrated Governance, Maternity, Medical, Surgical Services and Trust Offices.

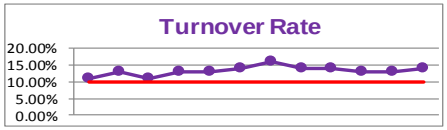
Managers are required to have plans in place to ensure that compliance targets are met and maintained, and these are regularly reviewed and updated. Compliance should be back on target by the end of quarter four.



HR: Mandatory Training Rates at 91% against a target of >= 95%

At service level there were mainly only minor variations of one or two per cent. Overall, five areas are currently rated as green, eleven as amber, and one area (Transport) is currently rated as red.

There has been an on-going issue with the unavailability of conflict resolution training. A program of training for internal trainers is being put in place to address this. Efforts are on-going to reach the overall mandatory training target of 95%, and it is anticipated the target will be reached by the end of quarter four.



HR: Staff Turnover Rates at 14% against a target of <= 10%

In total, there were 18 leavers in month ten, up from 11 in month eight. Fourteen departments are rated as red. The turnover figure for the Trust has been consistently above target since September 2015. It is likely that this trend will continue for the foreseeable future although the aim is to bring the figure under target by quarter one in 2017/18.

All Linear graphs are rolling 12 months

Performance Summary - Trust Board - Month 10 - January 2017

To be EFFICIENT and make best use of available resources

Financial Report will be provided separately (3 x Red KPIs)

To deliver SAFER services

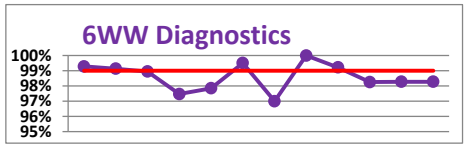
There are no Red or Amber rated KPIs in this section

To deliver the most EFFECTIVE outcomes

There are no Red or Amber rated KPIs in this section

Performance Summary - Trust Board - Month 10 - January 2017

To deliver the best possible EXPERIENCE for patients and staff

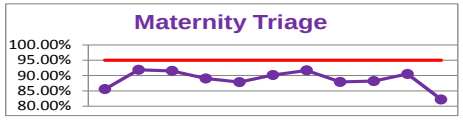


6 Week Diagnostic Waits at 98.6% against a target of >= 99%

Continued pressure within the team resulting in 8 patients breaching the cystometery diagnostic target.
The vacancy for urogynae consultant was filled at the end of November and has therefore added additional capacity for cystometery appointments. This has also released another gynae consultant from sessions who is also backfilling some additional sessions to support services at times of pressure.
Some nurse cystometery clinics are also being supported with the backfill by Consultant Nurses to support the services

When will target be achieved - **Ongoing**

This is being constantly monitored and patients are being partially booked to ensure that patients are seen in order of request date - Exploring options to work differently



Maternity Triage within 30 minutes at 83% against a target of >= 95%

On average the MAU reviews nearly 1000 per month, with a number of factors have contributed to this target not being achieved;

-Women can arrive at any time which means several women may arrive at the same time, which adds pressure of meeting the target.
-If a woman is classified as red, she is seen and assessed as a priority, which may delay other women falling outside the set target.
-Long and short term sickness on maternity assessment unit can impact upon the flow of women throughout the unit
-Medical staff are not always present or available to see those women who require a medical review. Although members of the medical team are assigned to the MAU,
-Delays in the flow of women through the rest of the service, can also impact upon MAU.
-Out of hours the Maternity Day Unit women are seen by MAU, the numbers are variable but put additional pressure on the MAU. Also some women who require scan review or a CTG are also asked to attend the MAU additional pressure

-A task and finish group has commenced looking at factors that impact on triage, to help resolve the issues
-The estate is currently being reviewed to develop a second triage area.
-PSAG board will identify the initial telephone traffic light allocation, to ensure the midwife in charge is aware any women- who may require immediate assessment.
-Current staffing model is being reviewed with a proposal to try to facilitate cover know times of increased activity
-The matron and ward manager for the maternity base are currently reviewing the discharge processes
-The number of women attending from scan and ANC for review or CTG has been reviewed with the ANC ward manager and the plan is for a TG machine to be introduced in to the Ante Natal Clinic and FMU to reduce the amount of patients sent to MAU
-Second midwife is used to triage women to try to reduce the chance of women breaching the 30 minute local t target and a consultant now present on the MAU during day time hours to try and reduce delays and support juniors with decision making
-IT have been asked to stream line of computerised assessment forms to reduce time spent at computer .
Task and Finish Group with an MDT approach to review the current service and identify areas for improvement

When will target be achieved - March 2017

-Awaiting appointment of a ward manger to be appointed as current deputy is retiring
-Possible work to be costed and completed by estate department
Ward re design is currently on going and awaiting process review

Performance Summary - Trust Board - Month 10 - January 2017

Emerging Concerns

There are no emerging concerns from January 2017.

Conclusion

Overall, for January 2017 performance has improved in comparison to December 2016. However, most of the KPI's where the targets have not been attained have been prevalent throughout the year. These include the HR KPIs along with Maternity Triage, Diagnostic Waits. It is anticipated that overall performance will continue to improve when reporting February's position although some of the KPI's that the Trust has failed to achieve through the year will continue to be of concern through to the end of the financial year.

Recommendations

It is recommended that the Trust Board receives and reviews the content of the report in relation to the assurance it provides of Trust performance and request any further actions considered necessary.

Liverpool Women's NHS Foundation Trust

LWH - The Board Report 2016/17

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	Ref	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Staff Friends & Family Test (PULSE)		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant		
HR: Sickness & Absence Rates (Commissioner)		<= 4.5%	4.42%	3.51%	3.05%	3.09%	4.61%	5.03%	5.16%	5.88%	6.32%	5.92%		
HR: Annual Appraisal and PDR		>= 90%	89.00%	87.00%	82.00%	87.00%	90.00%	92.00%	90.00%	89.00%	87.00%	88.00%		
HR: Completion of Mandatory Training		>= 95%	92.00%	94.00%	94.00%	94.00%	93.00%	93.00%	93.00%	93.00%	92.00%	91.00%		
HR: Turnover Rate		<= 10%	11.00%	13.00%	13.00%	14.00%	16.00%	14.00%	14.00%	13.00%	13.00%	14.00%		

To be EFFICIENT and make best use of available resources

Indicator Name	Ref	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Planned Surplus/ Deficit (YTD) £'000		Planned Cumulative	£710	£1,434	£2,104	£2,282	£3,069	£3,480	£3,763	£4,460	£5,431	£5,823	£6,529	£7,000
Actual Surplus / Deficit (YTD) £'000		<= Planned	£696	£1,375	£2,027	£2,297	£3,098	£3,440	£3,741	£4,429	£5,373	£5,622		
Planned CIP (YTD) £'000		Planned Cumulative	£167	£333	£500	£667	£833	£1,000	£1,167	£1,333	£1,500	£1,667	£1,833	£2,000
Actual CIP (YTD) £'000		>= Planned	£46	£114	£170	£226	£283	£511	£793	£1,075	£1,357	£1,357		
Planned Cash Balance (YTD) £'000		Planned Cumulative	£1,189	£1,000	£2,242	£1,001	£1,001	£2,816	£1,001	£1,001	£1,152	£1,000	£1,853	£1,001
Actual Cash Balance (YTD) £'000		>= Planned	£4,913	£4,898	£5,395	£4,517	£4,318	£3,764	£3,568	£3,706	£4,991	£5,713		
Planned Capital (YTD) £'000		Planned Cumulative	£119	£436	£1,113	£1,330	£1,597	£3,049	£3,156	£3,474	£3,722	£3,990	£4,098	£4,314
Actual Capital (YTD) £'000		>= Planned	£89	£220	£311	£602	£914	£1,221	£1,380	£1,549	£2,271	£2,383		
Monitor: Financial Sustainability Risk Rating: Capital Cover		1	1	1	1	1	1	1	4	4	4	4		
Monitor: Financial Sustainability Risk Rating: Liquidity		2 (1 from Sep 2016)	2	2	1	1	1	1	4	4	4	3		
Monitor: Financial Sustainability Risk Rating: I & E Margin		1	1	1	1	1	1	1	4	4	4	4		
Monitor: Financial Sustainability Risk Rating: Variance to Plan		4	4	4	4	3	3	4	1	1	1	1		
Monitor: Financial Sustainability Risk Rating: Overall Score		2	1	2	2	2	2	2	3	3	3	3		
Monitor: Financial Sustainability Risk Rating: Agency Cap		0	51	25	57	88	75	68	138	177	136	158		

Liverpool Women's NHS Foundation Trust

LWH - The Board Report 2016/17

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

To deliver SAFER services

Indicator Name	Ref	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Safer Staffing Levels (Overall - includes Registered and Care Staff)		<= 90%	92.78%	91.92%	92.60%	91.72%	86.86%	89.53%	89.14%	93.55%	89.35%	93.58%		
Serious Incidents: Number of Open SI's		Monitoring Only	23	23	20	20	20	14	17	15	16	18		
Serious Incidents: Number of New SI's		Monitoring Only	1	2	4	2	2	2	5	3	5	3		
% of women seen by a midwife within 12 weeks		>= 90%	96.82%	85.53%	95.70%	94.88%	91.78%	93.28%	92.38%	93.91%	93.38%	91.88%		
Neonatal Bloodstream Infection Rate		TBD	0.11	0.00	0.00	1.30	2.70	1.30	0.00	0.00	0.00	0.00		

To deliver the most EFFECTIVE outcomes

Indicator Name	Ref	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Cancer: Referral to Treating Trust by day 42	EXP_11	100%	50%	50%	50%	100%	None	100%	100%	0%	50%	100%		
Biochemical Pregnancy Rates		> 30% TBC	45.94%	47.62%	46.21%	44.70%	47.13%	48.63%	45.58%	45.13%	54.00%	46.88%		
Still Birth Rate (excludes late transfers)		TBD	0.00	0.01	0.01	0.01	0.00	0.00	0.00	0.00	0.00	0.00		
Neonatal Deaths (all live births within 28 days)		Rate per 1000 TBD	1.44	2.90	6.65	1.33	2.66	5.17	0.00	2.92	1.39	#DIV/0!		
Returns to Theatre		<= 0.7% TBC	0.64%	1.03%	0.50%	0.51%	0.22%	0.21%	0.32%	0.56%	0.74%	1.18%		

To deliver the best possible EXPERIENCE for patients and staff

Indicator Name	Ref	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Maternity: Triage within 30 minutes	KPI_35	>= 95%	91.50%	89.05%	87.86%	90.17%	91.66%	87.90%	88.24%	90.49%	80.48%	83.12%		
Number of Complaints received		<= 15	15	5	13	18	13	19	16	10	8	11		
18 Week RTT Incompletes (aggregate)		>= 92%	95.71%	95.90%	93.86%	95.20%	94.28%	92.63%	92.20%	93.03%	92.86%	92.68%		
Friends & Family Test		> 75%	99.26%	98.47%	98.60%	97.52%	98.37%	99.11%	98.51%	97.85%	98.78%	98.04%		
% Women that requested and Epidural, but weren't given one for non-clinical reasons		<= 5%	6.37%	3.66%	6.29%	6.04%	5.45%	5.66%	7.56%	7.58%	4.32%	5.92%		
% Women given one to one care whilst in established Labour (4cm dilation)		>= 95%	96.86%	96.08%	94.44%	95.74%	95.60%	93.23%	95.97%	99.12%	97.09%	97.50%		
6 Week Wait Diagnostic Tests		>= 99%	98.96%	97.47%	97.85%	100%	97.00%	100%	99.22%	98.26%	98%	99%		
Last Minute Cancellation for non-clinical reasons		<= 4%	4.30%	6.31%	5.81%	5.01%	4.79%	4.20%	2.64%	5.28%	4.40%	8.01%		
Last Minute Cancellation for non-clinical reasons (Not re-admitted within 28 days)		0	0	0	0	0	0	0	0	0	0	0		
Failure to ensure that sufficient appointment slots are available on Choose & Book		< 6%	16.29%	13.23%	3.13%	22.48%	18.47%	Not Available	Not Available	Not Available	Not Available	Not Available		

Liverpool Women's NHS Foundation Trust

Safe Staffing Report Month 10 - January 2017

Ward	RN/RM			Unqualifed			Staff Availability		Care Delivery		Nurse Sensitive Indicators									Patient Experience	
	Fill Rate Day%	Fill Rate Night%	RN/RM CHPPD	Fill Rate Day%	Fill Rate Night%	Total Workforce CHPPD	Sickness %	Vacancy %	Numis Indicators (N)	Numis indicators achieved (N)	Red Flag Incidents Reported (N)	CDT	MRSA	Falls no harm (n)	Falls Harm (N)	HAPU grade 1&2	HAPU Grade 3&4	Drug Admin Errors	New Complaints	FFT (no of responses)	% Recommend this hospital
Gynae	97.7%	100.0%	3.9	99.9%	106.6%	2.6	4.66%	22%			5	0	0	0	0	0	0	1	1	23	100%
Narrative	The medication error was in relation to administration.There was a failure to convert oral antibiotics to intravenous for a patient undergoing surgery . The patient had been on a course of oral antibiotics and because the medication had not been then given intravenously the patient subsequently did not receive 2 doses of the required medication when the patient had become nil by mouth prior to surgery. The review of the incident identified that the patient did not suffer any harm. The ward mangers have discussed this incident with staff at their daily huddles and further to this in February a piece of work is being undertaken to identify any trends in relation to medication incidents. To then enable SMART action plans to be immplemented to address any deficits and start to audit complaince against practice and Trust policy. The 5 red flag incidents had 2 themes in relation to delay or cancellation of activity. Case notes unavialble and without the full medical history being nknown it was not safe to proceed.The second cancellation was due to patient being medicaly un fit due to the onset of chest pain which required further investigation. 2 incidents of staff having to cancell mandtory training due to acuity of patients on the ward. The staff have been booked on the next aviailable training sessions. Staff sickness being proactively manged by the ward mangers and wotrking closely with HR and occupational health to ensure sickness absceness polocy is adhered to and staff are being supported back into the working enviroment.																				
Gynae 2																					
Merged with Ward 1																					
Delivery & Induction Suites	88.2%	89.0%	29.0	106.5%	93.4%	5.1	3.60%	10%			5	0	0	0	0	0	0	0	1	N/A	N/A
Narrative	Delivery suite sickness has reduced from the previous month and all staff are on the appropriate stages within the Sickness and absence policy. The manager continues to work with HR. There has been 1 new complaint during this month and that is being investigated by the ward manager.																				
Mat Base	90.9%	88.7%	31.2	93.5%	93.5%	5.4	3.72%	14%			0	0	0	1	0	0	0	4	1	23	91%
Narrative	Maternity Base sickness has reduced from the previous month and all staff are on the appropriate stages within the Sickness and absence policy. The manager continues to work with HR. There has been 1 new complaint during this month and that is being investigated by the ward manager. There have been 4 incidents regarding Drug administration errors and all incidents have been reviewed by DS ward manager and closed with all actions discussed with the shift leaders.																				
MLU & Jeffcoate	86.7%	84.3%	3.6	83.2%	94.6%	2.0	11.42%	2%			0	0	0	0	0	0	0	0	1	N/A	N/A
Narrative	MLU has a high level of both long and short term sickness. This has been amongst midwives, HCA and ward clerk . Long term sick has been managed through the sickness policy with the advise and help of HR. Towards the end of the month the majority of staff have returned to work. there is 1 LTS currently off sick																				
NICU	106.5%	106.0%	10.8	66.1%	50.0%	0.7	7.35%	12%			0	0	0	0	0	0	0	4	0	N/A	N/A
Narrative	Sickness increase was due to 5 people being off on long term sickness, 2 have returned, 1 will commence stage 3 shortly, and the other 2 are expected to return in the coming month. We have also had a spike in short term sickness this has also been reflected elsewhere in the Trust. This is being managed in a timely manner. Turnover is on the higher side of normal but this is due to a run of retirements, retention remains good. In relation to staffing we are now at numbers which are helping us achieve BAPM compliance, however maternity leave continues to put a strain on the actually numbers per shift (12 wte currently on MAT Leave) Our current number of Nursing Assistants mean that we fall short in meeting 2 wte per shift, however, we have addressed this and we are reducing the number of qualified staff in the next round of recruitment and upping the number of nursing assistants. Medication errors are been managed with the new medicine management tool implemented on the unit.																				

Key Fill Rate		*<80%*		*80.94.9%*		*95-109.9%*	*>110%*
Key Sickness		*> 4.5%*				*<= 4.5%*	
Key Vacancy		*> 10%*				*<= 10%*	
Key F&FT		*< 95%*				*>= 95%*	

Agenda item no:	2017/63(i)

Meeting:	Board of Directors

Date:	3 March 2017

Title:	Month 10 2016/17 Finance Report

Report to be considered in public or private?	Public

Where else has this report been considered and when?	n/a

Reference/s:	Operational Plan and Budgets 2016/17 Operational Plan 2017/18 – 2018/19

Resource impact:	-

What is this report for?	**Information**	✓	**Decision**		**Escalation**		**Assurance**	✓

Which Board Assurance Framework risk/s does this report relate to?	5a, 5b

Which CQC fundamental standard/s does this report relate to?	

What action is required at this meeting?	To note the Month 10 financial position

Presented by:	Vanessa Harris – Director of Finance

Prepared by:	Jenny Hannon - Deputy Director of Finance

This report covers (tick all that apply):

Strategic objectives:	
To develop a well led, capable motivated and entrepreneurial workforce	
To be ambitious and efficient and make best use of available resources	✓
To deliver safe services	
To participate in high quality research in order to deliver the most effective outcomes	
To deliver the best possible experience for patients and staff	

Other:			
Monitor compliance	✓	Equality and diversity	
Operational plan	✓	NHS constitution	

Publication of this report (tick one)**:**	
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	✓
This report will not be published under the Trust's Publication Scheme due to exemptions under S21 of the Freedom of Information Act 2000, because the information contained is reasonably accessible by other means	
This report will not be published under the Trust's Publication Scheme due to exemptions under S22 of the Freedom of Information Act 2000, because the information contained is intended for future publication	
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	
This report will not be published under the Trust's Publication Scheme due to exemptions under S43(2) of the Freedom of Information Act 2000, because such disclosure would be likely to prejudice the commercial interests of the Trust	

1. Executive Summary

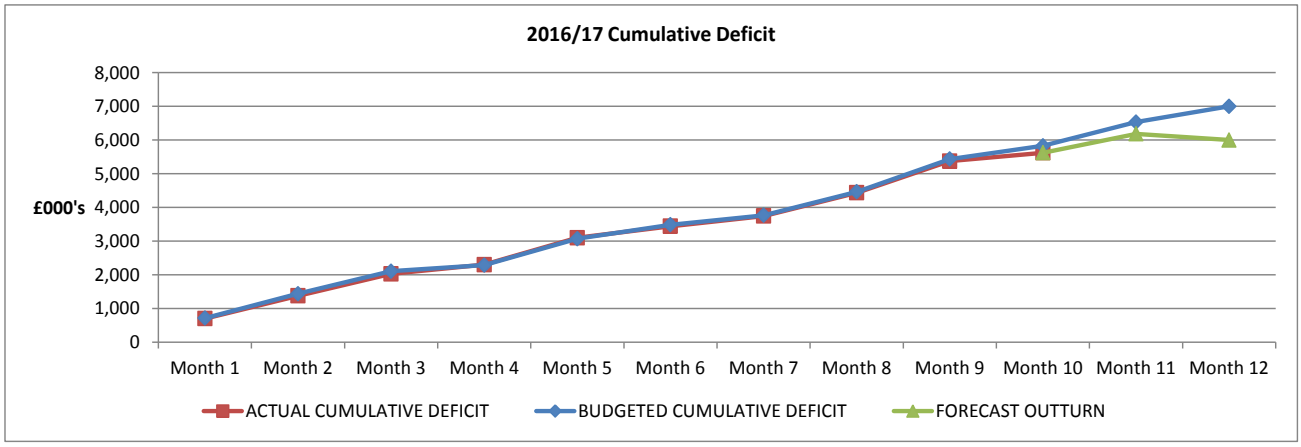
The 2016/17 budget was approved at Trust Board in April 2016. This set out a deficit of £7m for the year (as per the control total set out by NHS Improvement), an FSRR[1] of 2 and a cash shortfall of £7.7m. This planned position assumes receipt in full of £2.8m Sustainability and Transformation Funding (STF).

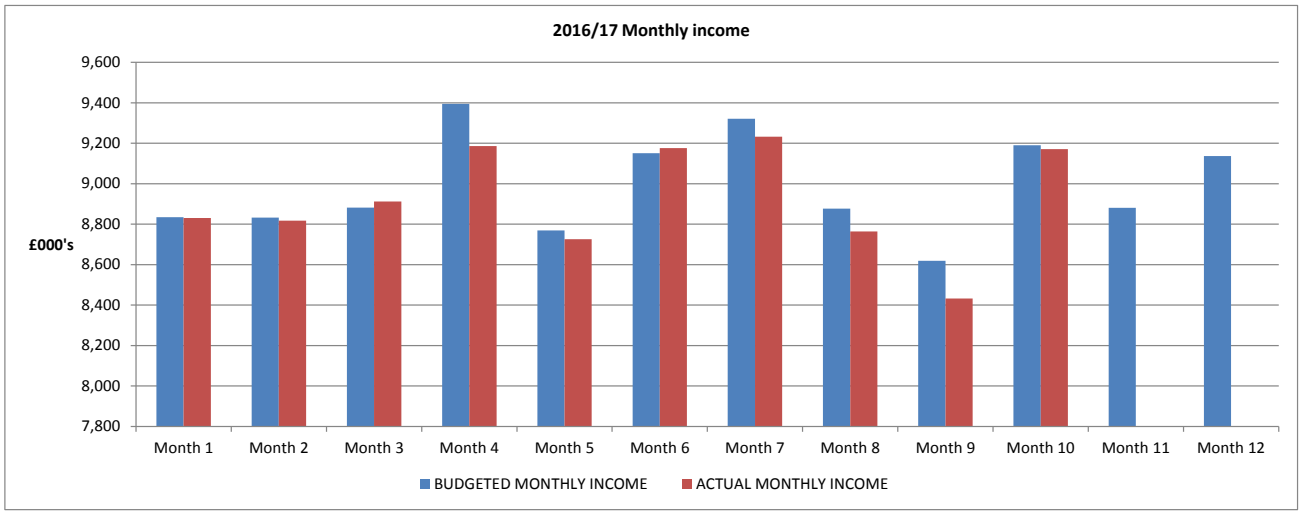
At Month 10 the Trust is reporting a monthly deficit of £0.25m against a deficit plan of £0.39m which is a positive variance of £0.14m for the month. Cumulatively the Trust is ahead of plan by £0.20m on a year to date budget of £5.8m deficit and delivering a Use of Resources Rating of 3 which is equivalent to plan.

The Trust is on track to deliver the overall 2016/17 control total. As reported at Month 9, following detailed review the Trust is reporting a forecast outturn deficit £0.5m better than plan. This improvement will be matched by £0.5m of STF incentive funding centrally. Together this improves the 2016/17 forecast position by £1m compared to plan, which equates to a £6m deficit for the full year.

2. Summary 2016/17 Financial Position

At Month 10 the Trust is reporting a £5.6m deficit against a plan of £5.8m and is forecasting a £6.0m deficit for the year as summarised below. The £6.0m forecast deficit includes £0.5m of STF incentive funding to be recognised in Month 12.





[1] Now replaced by the Use of Resources Rating under the Single Oversight Framework

Month 10 income was only slightly behind plan. This reflects the benefit of the year end block arrangement with Liverpool, St Helens and Knowsley CCGs as well as neonatal income from Health Education England.

Pay expenditure overall remains below budget predominantly due to vacancies across a number of services including neonates, Hewitt Centre and genetics.

Non-pay expenditure is forecast to be above plan predominantly due to the non-delivery of CIP in gynaecology/theatres.

3. Service Review

Maternity
Maternity Services remain on track to out-perform budget in 2016/17. Deliveries are the main driver of income out-performance, which is being partly offset by activity-related expenditure.

Gynaecology and Theatres
Gynaecology activity is forecast to be ahead of plan overall, predominantly across general gynaecology. However, high agency costs in theatres and the non delivery of the inpatient CIP in year continue to more than offset this. Both theatres agency and inpatient CIP are under scrutiny by the Turnaround and Transformation Committee to ensure the required levels of delivery in 2017/18.

Neonates
Neonates is forecast to outperform budget following the receipt of non-recurrent monies from Health Education England and an improvement in the Welsh income position, along with non-recurrent underspend arising from vacancies.

Hewitt Fertility Centre (HFC)
The HFC financial position remains impacted by three key issues

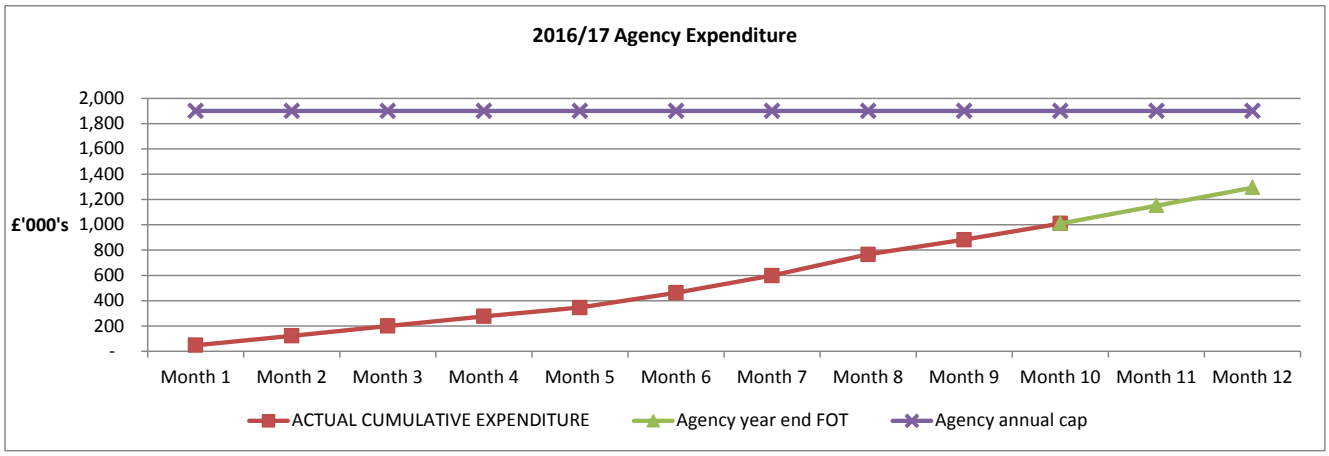
a) Non-delivery of the Kings Joint Venture contribution (CIP scheme) and subsequent losses
b) Deterioration of the North West business
c) Slippage in the delivery of the recovery plans

The financial impact to date is a net £1.1m behind plan with a projected £1.3m full year shortfall. The position includes some mitigations already put in place and takes into account the further loss of planned activity and the share of a loss in relation to the Kings Joint Venture.

Genetics
Genetics income is behind plan year to date as a result of underperformance on the 100,000 genomes contract and decreased lab activity due to staff shortages. However, the majority of the income shortfall is offset by a reduction in pay costs and the service is effectively on plan overall.

4. Agency Spend

The chart below illustrates the level of agency spend in terms of the agency cap set for the Trust.



5. CIP Delivery

The Trust has an annual CIP target in 2016/17 of £2m, which represents c2% of the Trust's income. This is made up of ten schemes and has been transacted through the ledger as part of budget setting.

Under-delivery of the ten identified CIP schemes is £1m for the full year. This arises from two schemes each valued at £0.5m, Hewitt Fertility Centre Growth and Theatre/Inpatient redesign. Non-recurrent mitigations at a Trust level are in place and significant focus has been placed in these two areas to minimise the impact on future years.

A full post implementation review on the 2016/17 schemes will be reported to Finance, Performance and Business Development Committee in April 2017.

6. Cash and borrowings

During 2015/16 the Trust was in receipt of £5.6m Interim Revenue Support from the Department of Health (DH). This is in addition to £5.5m of ITFF capital funds previously drawn down in relation to the Hewitt Fertility expansion and which is now in the process of being repaid at a principle sum of £0.6m per annum.

The Trust's financial plan for 2016/17 indicated a further requirement for cash of £7.7m. The Trust has been utilising a DH working capital facility to manage cash requirements to date. This attracted an interest rate of 3.5%. During January 2017 the Trust was able to convert the working capital facility to an uncommitted loan facility with DH at an improved rate of 1.5%. This rate is available as a result of the Trust being on target to meet the 2016/17 control total.

The Trust has been informed that the following rates will apply to any facility going forward:

- 1.5% Trust meeting control total and not in Financial Special Measures
- 3.5% Trust not meeting control Total and not in Financial Special Measures
- 6% Trust not meeting control total and in Financial Special Measures

At Month 10 the Trust has utilised £3.65m of cash from DH. Spend against the capital programme is anticipated to increase in the final quarter of the year which, along with the continued deficit, will take usage of the facility toward planned levels.

The cash balance as at the end of Month 10 was £5.7m.

7. BAF Risk

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

8. Conclusion & Recommendation

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

Appendix 1

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

FINANCE REPORT: M10

YEAR ENDED 31 MARCH 2017

Contents

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
NHS IMPROVEMENT RATIOS: M10
YEAR ENDED 31 MARCH 2017

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	(321)	(573)	(400)	(38)
(b) PDC + Interest Payable + Loans Repaid	2,056	1,834	2,712	2,382
CSC Ratio = (a) / (b)	**(0.16)**	**(0.31)**	**(0.15)**	**(0.02)**
NHSI CSC SCORE	**4**	**4**	**4**	**4**
Ratio Score **1** = > 2.5 **2** = 1.75 - 2.5 **3** = 1.25 - 1.75 **4** = < 1.25				
LIQUIDITY				
(a) Cash for Liquidity Purposes	(4,927)	(3,907)	(8,924)	(8,924)
(b) Expenditure	90,200	89,797	108,297	107,616
(c) Daily Expenditure	301	299	301	299
Liquidity Ratio = (a) / (c)	**(16.4)**	**(13.1)**	**(29.7)**	**(29.9)**
NHSI LIQUIDITY SCORE	**4**	**3**	**4**	**4**
Ratio Score **1** = > 0 **2** = (7) - 0 **3** = (14) - (7) **4** = < (14)				
I&E MARGIN				
Deficit (Adjusted for donations and asset disposals)	5,817	5,619	6,992	6,013
Total Income	(89,453)	(89,531)	(107,387)	(107,886)
I&E Margin	**-6.50%**	**-6.28%**	**-6.51%**	**-5.57%**
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)		-6.28%		-5.57%
I&E Margin (Plan)		-6.50%		-6.51%
I&E Variance Margin	**0.00%**	**0.23%**	**0.00%**	**0.94%**
NHSI I&E MARGIN VARIANCE SCORE	**1**	**1**	**1**	**1**
Ratio Score **1** = > 0% **2** = (1) - 0% **3** = (2) - (1)% **4** = < (2)%				
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.				
AGENCY SPEND				
YTD Providers Cap	1,603	1,603	1,924	1,924
YTD Agency Expenditure	590	1,011	708	1,294
	-63.20%	**-36.94%**	**-63.20%**	**-32.74%**
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: scoring a 4 on any of the metrics will lead to a financial override score of 3.

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
INCOME & EXPENDITURE: M10
YEAR ENDED 31 MARCH 2017

INCOME & EXPENDITURE £'000	MONTH			YEAR TO DATE			YEAR		
	Budget	Actual	Variance	Budget	Actual	Variance	Budget	FOT	Variance
Income									
Clinical Income	(8,606)	(8,571)	(35)	(84,031)	(83,942)	(89)	(100,881)	(100,875)	(7)
Non-Clinical Income	(584)	(565)	(19)	(5,838)	(5,269)	(569)	(7,006)	(6,692)	(314)
Total Income	**(9,190)**	**(9,136)**	**(54)**	**(89,870)**	**(89,211)**	**(658)**	**(107,887)**	**(107,566)**	**(321)**
Expenditure									
Pay Costs	5,613	5,483	129	56,125	55,285	840	67,352	66,297	1,055
Non-Pay Costs	2,228	2,267	(39)	22,152	22,590	(438)	26,638	27,011	(373)
CNST	1,192	1,192	0	11,923	11,922	0	14,307	14,307	(0)
Total Expenditure	**9,033**	**8,942**	**90**	**90,200**	**89,797**	**402**	**108,297**	**107,616**	**681**
EBITDA	**(157)**	**(193)**	**36**	**330**	**586**	**(256)**	**410**	**49**	**360**
Technical Items									
Depreciation	375	310	65	3,750	3,521	229	4,500	4,208	292
Interest Payable	35	2	33	350	219	131	420	227	193
Interest Receivable	(1)	(1)	0	(8)	(13)	5	(10)	(12)	2
PDC Dividend	140	131	9	1,400	1,309	91	1,680	1,543	137
Profit / Loss on Disposal	0	0	0	0	0	0	0	0	0
Total Technical Items	**549**	**442**	**107**	**5,492**	**5,036**	**456**	**6,590**	**5,966**	**624**
(Surplus) / Deficit	**392**	**249**	**143**	**5,822**	**5,622**	**200**	**7,000**	**6,016**	**984**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 3
EXPENDITURE: M10
YEAR ENDED 31 MARCH 2017

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	337	315	22	3,372	3,351	22	4,047	4,019	28
Medical	1,271	1,217	54	12,706	12,391	315	15,248	14,750	498
Nursing & Midwifery	2,504	2,409	95	25,039	24,294	745	30,047	29,097	951
Healthcare Assistants	391	371	20	3,909	3,877	32	4,691	4,644	47
Other Clinical	543	503	40	5,428	5,003	425	6,513	6,061	452
Admin Support	162	157	5	1,622	1,658	(36)	1,946	1,990	(44)
Corporate Services	355	379	(24)	3,549	3,700	(151)	4,259	4,442	(183)
Agency & Locum	50	132	(82)	500	1,011	(511)	600	1,294	(694)
Total Pay Costs	**5,613**	**5,483**	**129**	**56,125**	**55,285**	**840**	**67,352**	**66,297**	**1,055**
Non Pay Costs									
Clinical Suppplies	733	706	28	7,368	7,397	(29)	8,858	8,900	(41)
Non-Clinical Supplies	613	629	(16)	5,970	6,385	(415)	7,203	7,555	(352)
CNST	1,192	1,192	0	11,923	11,922	0	14,307	14,307	(0)
Premises & IT Costs	415	416	(1)	4,152	4,134	18	4,983	4,947	36
Service Contracts	466	516	(50)	4,661	4,674	(13)	5,594	5,610	(16)
Total Non-Pay Costs	**3,420**	**3,459**	**(39)**	**34,074**	**34,513**	**(438)**	**40,945**	**41,319**	**(374)**
Total Expenditure	**9,033**	**8,942**	**90**	**90,200**	**89,797**	**402**	**108,297**	**107,616**	**681**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
BUDGET ANALYSIS: M10
YEAR ENDED 31 MARCH 2017

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	(3,543)	(3,495)	(49)	(33,997)	(34,514)	516	(40,771)	(41,371)	600
Expenditure	1,698	1,745	(47)	16,981	17,251	(270)	20,378	20,742	(364)
Total Maternity	**(1,845)**	**(1,750)**	**(95)**	**(17,017)**	**(17,263)**	**246**	**(20,393)**	**(20,629)**	**236**
Gynaecology									
Income	(2,048)	(2,148)	101	(20,038)	(20,764)	726	(23,965)	(24,677)	712
Expenditure	879	931	(51)	8,794	9,264	(470)	10,554	11,179	(626)
Total Gynaecology	**(1,168)**	**(1,218)**	**50**	**(11,245)**	**(11,500)**	**255**	**(13,411)**	**(13,497)**	**86**
Theatres									
Income	(42)	(40)	(2)	(420)	(403)	(17)	(504)	(487)	(17)
Expenditure	608	601	7	6,081	6,413	(332)	7,298	7,688	(391)
Total Theatres	**566**	**561**	**5**	**5,661**	**6,009**	**(348)**	**6,794**	**7,202**	**(408)**
Neonatal									
Income	(1,408)	(1,522)	114	(14,089)	(13,957)	(132)	(16,908)	(16,975)	67
Expenditure	997	988	9	9,972	9,794	178	11,967	11,821	145
Total Neonatal	**(411)**	**(534)**	**124**	**(4,117)**	**(4,163)**	**46**	**(4,941)**	**(5,154)**	**213**
Hewitt Centre									
Income	(994)	(938)	(56)	(9,770)	(8,201)	(1,569)	(11,874)	(10,025)	(1,849)
Expenditure	729	672	57	7,324	6,822	502	8,805	8,236	569
Total Hewitt Centre	**(265)**	**(266)**	**1**	**(2,446)**	**(1,379)**	**(1,066)**	**(3,069)**	**(1,789)**	**(1,280)**
Genetics									
Income	(596)	(560)	(36)	(5,952)	(5,718)	(234)	(7,143)	(6,834)	(309)
Expenditure	446	383	64	4,465	4,205	260	5,358	5,075	283
Total Genetics	**(150)**	**(177)**	**28**	**(1,488)**	**(1,513)**	**26**	**(1,785)**	**(1,759)**	**(26)**
Clinical Support									
Income	(23)	(33)	10	(243)	(263)	20	(291)	(318)	27
Expenditure	733	684	49	7,327	7,150	177	8,793	8,571	222
Total Clinical Support	**709**	**650**	**59**	**7,084**	**6,887**	**198**	**8,502**	**8,253**	**249**
Corporate & Trust Technical Items									
Income	(536)	(400)	(136)	(5,360)	(5,391)	31	(6,432)	(6,880)	448
Expenditure	3,491	3,382	109	34,748	33,935	813	41,735	40,269	1,466
Total Corporate	**2,955**	**2,982**	**(28)**	**29,388**	**28,544**	**844**	**35,303**	**33,389**	**1,914**
(Surplus) / Deficit	**392**	**249**	**143**	**5,822**	**5,622**	**200**	**7,000**	**6,016**	**984**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
BALANCE SHEET: M10
YEAR ENDED 31 MARCH 2017

BALANCE SHEET £'000	YEAR TO DATE Opening	M10 Actual	Movement
Non Current Assets	**70,529**	**69,029**	(1,500)
Current Assets			
Cash	3,225	5,713	2,488
Debtors	4,302	9,066	4,764
Inventories	326	360	34
Total Current Assets	**7,853**	**15,139**	**7,286**
Liabilities			
Creditors due < 1 year	(8,056)	(16,482)	(8,426)
Creditors due > 1 year	(1,748)	(1,722)	26
Commercial loan	(10,794)	(14,139)	(3,345)
Provisions	(2,392)	(2,055)	337
Total Liabilities	**(22,990)**	**(34,398)**	(11,408)
TOTAL ASSETS EMPLOYED	**55,392**	**49,770**	**(5,622)**
Taxpayers Equity			
PDC	36,610	36,610	0
Revaluation Reserve	10,019	10,019	0
Retained Earnings	8,763	3,141	(5,622)
TOTAL TAXPAYERS EQUITY	**55,392**	**49,770**	**(5,622)**

Appendix 2 - Single Oversight Framework - Use of Resources Rating

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
NHS IMPROVEMENT RATIOS: M10
YEAR ENDED 31 MARCH 2017

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	(321)	(573)	(400)	(38)
(b) PDC + Interest Payable + Loans Repaid	2,056	1,834	2,712	2,382
CSC Ratio = (a) / (b)	**(0.16)**	**(0.31)**	**(0.15)**	**(0.02)**
NHSI CSC SCORE	4	4	4	4
Ratio Score **1** = > 2.5 **2** = 1.75 - 2.5 **3** = 1.25 - 1.75 **4** = < 1.25				
LIQUIDITY				
(a) Cash for Liquidity Purposes	(4,927)	(3,907)	(8,924)	(8,924)
(b) Expenditure	90,200	89,797	108,297	107,616
(c) Daily Expenditure	301	299	301	299
Liquidity Ratio = (a) / (c)	**(16.4)**	**(13.1)**	**(29.7)**	**(29.9)**
NHSI LIQUIDITY SCORE	4	3	4	4
Ratio Score **1** = > 0 **2** = (7) - 0 **3** = (14) - (7) **4** = < (14)				
I&E MARGIN				
Deficit (Adjusted for donations and asset disposals)	5,817	5,619	6,992	6,013
Total Income	(89,453)	(89,531)	(107,387)	(107,886)
I&E Margin	**-6.50%**	**-6.28%**	**-6.51%**	**-5.57%**
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)		-6.28%		-5.57%
I&E Margin (Plan)		-6.50%		-6.51%
I&E Variance Margin	**0.00%**	**0.23%**	**0.00%**	**0.94%**
NHSI I&E MARGIN VARIANCE SCORE	1	1	1	1
Ratio Score **1** = > 0% **2** = (1) - 0% **3** = (2) - (1)% **4** = < (2)%				
AGENCY SPEND				
YTD Providers Cap	1,603	1,603	1,924	1,924
YTD Agency Expenditure	590	1,011	708	1,294
	-63.20%	**-36.94%**	**-63.20%**	**-32.74%**
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.

Agenda item no:	2017/63(ii)

Meeting:	Board of Directors

Date:	3 March 2017

Title:	Uncommitted Single Currency Interim Revenue Support Facility Agreement

Report to be considered in public or private?	Public

Where else has this report been considered and when?	N/a

Reference/s:	Operational Plan and Budgets 2016/17 Draft Uncommitted Single Currency Interim Revenue Support Facility Agreement

Resource impact:	-

What is this report for?	**Information**	✓	**Decision**	✓	**Escalation**		**Assurance**	

Which Board Assurance Framework risk/s does this report relate to?	5a, 5b

Which CQC fundamental standard/s does this report relate to?	

What action is required at this meeting?	The Board is asked to: 1. approve the terms of, and the transactions contemplated by, the generic uncommitted interim revenue support facility set out in appendix 1 of this report; 2. approve the arrangements for entering into the uncommitted interim revenue support facility as Borrower; 3. authorise the Director of Finance to execute uncommitted interim revenue support facility on behalf of the Trust; and 4. authorise the Director of Finance, to sign and/or despatch all documents and notices in connection with any future uncommitted interim revenue support facility.

Presented by:	Vanessa Harris - Director of Finance

Prepared by:	Jenny Hannon - Deputy Director of Finance

This report covers (tick all that apply):

Strategic objectives:	
To develop a well led, capable motivated and entrepreneurial workforce	
To be ambitious and efficient and make best use of available resources	✓
To deliver safe services	
To participate in high quality research in order to deliver the most effective outcomes	
To deliver the best possible experience for patients and staff	

Other:			
Monitor compliance	✓	Equality and diversity	
Operational plan	✓	NHS constitution	

Publication of this report (tick one)**:**	
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	✓
This report will not be published under the Trust's Publication Scheme due to exemptions under S21 of the Freedom of Information Act 2000, because the information contained is reasonably accessible by other means	
This report will not be published under the Trust's Publication Scheme due to exemptions under S22 of the Freedom of Information Act 2000, because the information contained is intended for future publication	
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	
This report will not be published under the Trust's Publication Scheme due to exemptions under S43(2) of the Freedom of Information Act 2000, because such disclosure would be likely to prejudice the commercial interests of the Trust	

1. Introduction

The 2016/17 budget was approved at Trust Board and included a deficit for the year of £7m and a cash shortfall of £7.7m. The budget included a requirement to fund the cash shortfall of £7.7m by use of loan funding available from the Department of Health (DH).

In the first 10 months of 2016/17 the Trust has drawn down £3.65m of cash funding from its DH working capital facility.

During January 2017, the DH indicated that those trusts on track to deliver their control total in the Month 9 forecast position would be eligible for a decrease in the interest rate levied on the working capital facilities from 3.5% to 1.5%. The Trust is on track to achieve the control total and as a consequence the Trust transferred the £3.65m loan from the working capital facility to a new uncommitted interim revenue support facility (UIRSF) in January 2017 at a rate of 1.5%.

2. Future Uncommitted Interim Revenue Support Requirements

Access to further cash requirements must be transacted through the new UIRSFs. Each future additional drawdown of cash from DH requires separate, discrete UIRSF agreements.

In order to provide the necessary authority to proceed with each new UIRSF agreement, NHSI has recommended that trust Boards approve a generic UIRSF agreement and provide the necessary delegation to an Executive Director, such as the Director of Finance, to authorise future transactions under the new UIRSFs arrangements. The draft generic UIRSF agreement is shown at Appendix 1. It is understood that the terms and conditions of the final UIRSF agreements will not deviate substantially from the draft presented.

The key points of the loan agreement are:

A. Final repayment date

The DH cash support is on an interim basis while more permanent planned support is sought. It is expected that this planned or other support will be used to repay the interim support on or before the repayment date. Current repayment dates are set out in the table below.

B. The interest rate is 1.5% per annum

This is the interest rate for all Trusts that achieve their control total in 2016/17.

The Trust has been informed that the following rates will apply to any facility going forward:

- 1.5% Trust meeting control total and not in Financial Special Measures
- 3.5% Trust not meeting control Total and not in Financial Special Measures
- 6% Trust not meeting control total and in Financial Special Measures

C. Approval

Due to the timing of the receipt of the loan documentation and the Board meeting, it is proposed that the Board approve the generic UIRSF agreement set out at appendix 1 and authorise the Director of Finance to approve all future UIRSF Agreements. If any of the UIRSF agreements deviate significantly from the generic agreement at Appendix 1, the Director of Finance will seek additional authorisation from the Chief Executive and Chair to proceed.

All approved UIRSF agreements will be reported in the Monthly Finance Report at Finance, Performance and Business Development Committee and Board of Directors.

3. Summary of Borrowings

Taking into account the differing loan facilities in place, the Trust will have the following borrowings structure going forward:

Loan type	Total Loan Facility Available	Total Loan Principal Drawndown as at 28th February 2017	Total Planned Loan Principal Balance as at 31st March 2017	Interest rate	Loan Principal Repayment Dates
ITFF loan in relation to Hewitt Centre (2014/15)	£6m	£5.5m	£4.58m	2.0%	Repayment of £0.305m at both M06 and M12 each year until September 2024
DH Interim Revenue Support (2015/16)	£5.6m	£5.6m	£5.6m	1.50%	Full repayment in March 2018
DH Uncommitted Interim Revenue Support (1) (2016/17)	£3.65m	£3.65m	£3.65m	1.50%	Full repayment in January 2020
PLANNED DH Uncommitted Interim Revenue Support (2) (2016/17)	£3.34m	£0.0m	£3.34m	1.50%	Full repayment TBC
Total	**£18.59m**	**£14.75m**	**£17.17m**		

Without the DH cash support the Trust would not have sufficient cash to meet its obligations. The Trust continues to work closely with NHSI and commissioners to identify appropriate solutions to the ongoing deficit.

4. Recommendation

The Board is asked to:

a) approve the terms of, and the transactions contemplated by, the generic uncommitted interim revenue support facility set out in appendix 1 of the report;
b) approve the arrangements for entering into uncommitted interim revenue support facility as Borrower;
c) authorise the Director of Finance to execute uncommitted interim revenue support facility on behalf of the Trust; and
d) authorise the Director of Finance, to sign and/or despatch all documents and notices in connection with any future uncommitted interim revenue support facility.

The Board of Directors confirm that the Trust, as Borrower, would comply with all and any additional terms and conditions that may be requested from time to time in accordance with the arrangements. Compliance would not be unreasonably withheld. Any significant changes to the arrangements would require the additional authorisation of the Chief Executive and Chair.

Appendix 1: Uncommitted Interim Revenue Support Facility Agreement (Draft from NHSI)