Liverpool Women's
NHS Foundation Trust

Annual Report and Accounts

for the year ended 31 March 2015

Liverpool Women's NHS Foundation Trust

Annual Report and Accounts for the year ended 31 March 2015

Presented to Parliament pursuant to Schedule 7,

Paragraph 25(4)(a) of the National Health Service Act 2006

Contents

Introduction from the Chair and Chief Executive

We are pleased to present the annual report and accounts of Liverpool Women's NHS Foundation Trust for 2014/15.

The year was both a very successful and extremely challenging one for the Trust. The Trust continued to provide excellent healthcare for women, babies and their families in a safe, friendly and caring environment. Positive highlights during the year included:

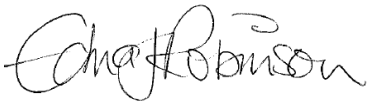
- Investing £1.7m in 25 whole time equivalent additional midwives and 10 whole time equivalent additional neonatal nurses to ensure services continue to be clinically safe and patients have an excellent experience of care;
- Published a Quality Strategy for 2014/17, setting out ambitious targets to reduce harm in respect of infection, avoidable birth injury, medication errors and multiple pregnancy as a result of infertility treatment, and also to reduce mortality in neonates, gynaecology and maternity (including maternal death and stillbirth);
- More than 50% of *in vitro* fertilisation procedures carried out in our Hewitt Fertility Centre resulted in a biochemical pregnancy;
- Establishing partnerships between the Trust's Hewitt Fertility Centre and Wrightington, Wigan and Leigh NHS Foundation Trust and King's College Hospital NHS Foundation Trust to provide fertility services, making our internationally recognised service available to even more patients;
- Taking part in 126 clinical research studies and recruiting 1,881 patients to take part in research;
- Relocation of the hospital's Emergency Room from the first floor to the ground floor providing improved ease of access to those attending in an emergency situation;
- Liverpool Women's featuring on the ground-breaking Channel 4 television series 'One Born Every Minute' and hosting a broadcast of BBC Radio 4's Woman's Hour programme;
- Developing the Trust's Future Generations strategy aimed at ensuring services are clinically and financially available for the future. You can read more about this exciting programme of work on page 17;
- The Trust's Neonatal Team were voted as the best in the country at the Mothers and Midwives Alliance Awards.

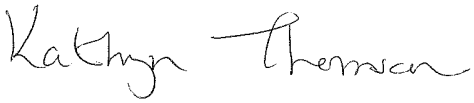
This report shares with you the details of these and many other highlights together with information about our performance during the year.

The year has not been without its challenges, however. The 4% year on year savings which the NHS is required to make have continued to tested the Trust's ability to be even more efficient in order to make cost improvements without impacting negatively on clinical care. As is shown in this report those efficiencies were successfully made whilst clinical standards continued to improve. However the Trust ended the year with a financial deficit of £2.7m.

Further challenges were the issuing of two warning notices by the Care Quality Commission and the opening of an investigation into the Trust by Monitor. Both notices were lifted and the investigation was closed during the year. You can read more about the challenges being faced by the Trust, and the positive action being taken in response to them, on pages 17-19.

We would like to end our introduction with a series of thanks. Firstly, thanks go to those who choose to have care at Liverpool Women's and for giving the Trust's staff the privilege of caring for them and sharing with them in significant life moments. Being excellent at all we do is the focus of the Trust each and every single day and it will always be so. Thanks also go to the Trust's staff, Governors, members, volunteers and fundraisers who together make Liverpool Women's the great place it is.





Edna Robinson

Chair

22 May 2015

Kathryn Thomson

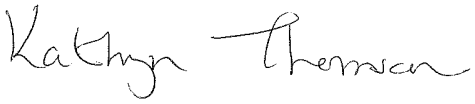
Chief Executive

22 May 2015

Statement from the Board of Directors

The Directors are responsible for preparing this annual report and accounts. We hereby state that we consider that the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy.

Signed for and on behalf of the Board of Directors:



Edna Robinson	Kathryn Thomson
Chair	Chief Executive
22 May 2015	22 May 2015

Strategic report

What is Liverpool Women's?

Liverpool Women's NHS Foundation Trust is a specialist Trust providing maternity, gynaecology and genetics services in Liverpool and the North Mersey conurbation. It is also the recognised specialist provider in Cheshire and Merseyside of high risk maternity care including fetal medicine, the highest level of neonatal care, complex surgery for gynaecological cancer, reproductive medicine and laboratory and medical genetics.

The Trust:

- Is the largest hospital in Europe to exclusively care for the health needs of women.
- In 2014/15 the Trust:
    - Delivered 8,456 babies – an average of 23 babies born at Liverpool Women's every day;
    - Undertook gynaecological procedures on 5,884 women;
    - Cared for 1,134 babies in our neonatal intensive and high dependency care units;
    - Performed 1,676 cycles of *in vitro* fertilisation (IVF).

Our vision, aims and values are:

Our vision:	To be the recognised leader in healthcare for women, babies and their families
Our strategic aims – WE SEE:	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.
Our values – We CARE and	*Caring* – we show we care about people;
we LEARN:	*Ambition* – we want the best for people
	Respect – we value the differences and talents of people;
	Engaging – we involve people in how we do things;
	LEARN – we learn from people past, present and future.

We became Liverpool Women's NHS Foundation Trust on 1 April 2005. Before this date, the Trust operated as Liverpool Women's NHS Hospital Trust. That Trust was created in 1995 when all services for women and babies in Liverpool came together under one roof at Liverpool Women's Hospital on Crown Street in Toxteth, Liverpool, a purpose-built hospital designed for providing care in the twenty-first century. We also began providing services at the Aintree Centre for Women's Health in 2000, which provides care to women from north Liverpool, Sefton and Knowsley.

Business review

The Board of Directors are pleased to present a fair review of the Trust's business during the year.

Achievements against our strategic aims are outlined below.

We will develop a well led, capable, motivated and entrepreneurial workforce

We have:

- Seen local and national recognition for [1]leaders in the Trust including:
    - Dianne Brown, Director of Nursing and Midwifery, Angela Douglas, Scientific Director for Genetics and Ann Marie Ellard, Miscarriage Specialist Nurse were nominated through the Health Service Journal as being amongst the top 50 most inspirational women in health in 2014;
    - Angela Douglas, Scientific Director for Genetics, was awarded the Healthcare Scientist of the Year award, she was also highly commended in the 'Inspiring the Workforce of the Future' category of the Advancing Healthcare Science awards;
    - Dr Colin Morgan, Consultant Neonatologist, won the Bliss Charity award for research;
    - The Communications Team won the 'In-House Marketing Team of the Year' award at the Northern Marketing Awards and were also shortlisted in seven categories at the Association for Healthcare Communications and Marketing awards;
    - Julie McMorran, Trust Secretary, was awarded the Duncan Medal for services to women's health across Merseyside;
    - Ann Maria Ellard, Miscarriage Specialist Nurse, was shortlisted for the NHS Employers Federation Kate Granger award;
    - The Neonatal Team were voted as the best in the country at the Mothers and Midwives' Alliance (MAMA) Awards.
- Seen a team of 20 Trust staff ride 107 miles from Birmingham Women's Hospital on their bicycles to raise over £7,000 for the hospital's charity, The Kitty Appeal;

[1]See also 'Our People' section from page 19.

- Welcomed the election of Mr David Richmond, Consultant Urogynaecologist at the Trust and current President of the Royal College of Obstetricians and Gynaecologists, as Vice Chair of the Academy of Medical Royal Colleges;
- Saw Mr Roy Farquharson, Consultant Gynaecologist, confirmed as the Chair for the European Society of Human Reproduction and Embryology.

We will be ambitious and efficient and make best use of available resources

We have:

- Seen biochemical pregnancy rates per embryo transfer achieved in 50.9% of IVF (*in vitro* fertilisation), 51.9% of ICSI (intra-cytoplasmic sperm injection) and 45.8% of frozen embryo transfers;
- Extended the neonatal transport team to reach across to Wales;
- Grown our colposcopy service which is now provided to women previously seen at the Royal Liverpool and Broadgreen University Hospital NHS Trust, following agreement with that Trust;
- Developed a new multi-gene panel for neuropathy, epilepsy and spasticity;
- Improved BCG vaccination from 48% to 96% of babies being vaccinated before they leave Liverpool Women's Hospital. The remaining 4% of babies are vaccinated in the community;
- Entered into a partnership agreement with the Royal Liverpool and Broadgreen University Hospital NHS Trust for the management of the Trust's pharmacy department;
- Achieved a Continuity of Services Rating of 3 and a Green Governance Rating from Monitor;
- Identified £11m of safe cost reduction plans for 2014/15 and 2015/16;
- Received the report of an efficiency review commissioned externally by the Trust, indicating that the Trust is efficient and managed well financially.

We will deliver safe services

We have:

- Invested £1.7m in additional midwives and neonatal nurses;
- Achieved one of the lowest hospitals lengths of stay in a peer group of 11 Trusts of similar size (1.8 days);
- Published a Quality Strategy for 2014/17, setting out ambitious targets to reduce harm in respect of infection, avoidable birth injury, medication errors and multiple pregnancy as a result of infertility treatment, and also to reduce mortality in neonates, gynaecology and

maternity (including maternal death and stillbirth);

- Maintained accreditation for our Genetics Laboratories;
- Achieved one of the lowest multiple birth rates in the UK following infertility treatment; the UK average is 10% and the Trust's Hewitt Fertility Centre is achieving 7.8%;
- Maintained zero incidence of MRSA (methicillin-resistant staphylococcus aureusis);
- Significantly strengthened our safeguarding team and safeguarding arrangements by appointing a Named Nurse for Adult Safeguarding, improving our governance and assurance systems and internal referral processes and commended specific Mental Capacity Act training for all staff.

We will participate in high quality research in order to deliver the most effective outcomes

We have:

- Successfully led the Liverpool Health Partners bid for the North West Coast Genomics Medical Centre, part of the 100,000 Genomes Project launched by the Prime Minister which will transform diagnosis and treatment for patients with cancer and rare diseases;
- Been selected by Wellbeing of Women as the recipient of a £1m grant to pioneer vital research into premature birth, together with the University of Liverpool;
- Extended maternity research into the area of clinical psychology, working with Professor Pauline Slade who is leading on a series of studies exploring post-traumatic stress and psychological support and well-being throughout pregnancy;
- Been at the forefront of developments over the timing of cord clamping. Consultant Obstetrician Professor Andrew Weeks and Consultant Neonatologist Dr Bill Yoxall led a multi-centre study running the biggest ever randomised trial of the timing of cord clamping for premature babies;
- Undertaken research into the physiology of endometriosis, led by Consultant Gynaecologist Ms Dharani Hapangami. The Trust was also the lead UK site for an international industry clinical trial exploring the pain management of endometriosis;
- Participated in 126 clinical research studies, recruited 1,881 patients to participate in research and published 73 research articles.

We will deliver the best possible experience for patients and staff

We have:

- Relocated the Emergency Room from the first to the ground floor. This facility offers emergency care to women presenting with gynaecological problems and also accommodates the Early Pregnancy Assessment Unit;

- Commenced refurbishment of the Midwifery Led Unit;
- Seen the Trust's maternity department be awarded level three baby friendly status by UNICEF, the largest maternity hospital in Europe to achieve this rating;
- Introduced a private maternity pathway;
- Established partnerships between the Trust's Hewitt Fertility Centre and Wrightington, Wigan and Leigh NHS Foundation Trust and King's College Hospital NHS Foundation Trust to provide fertility services, making our internationally recognised service available to even more patients;
- Seen further improvements in our patient and staff survey results.

Performance against key targets

Our performance against national targets has remained strong during the year. Details of the targets we are required to achieve are set out below, together with our actual performance:

Indicator name	Target	Performance 2014/15
18 week referral to treatment times: admitted (all specialties)	90%	**95.63%**
18 week referral to treatment times: non-admitted (all specialties)	95%	**95.63%**
18 week referral to treatment times: incomplete pathways (admitted and non-admitted) [(A)]	92%	**93.82%**
All cancers: two week wait	≥93%	**96.36%**
All cancers: one month diagnosis to treatment (first definitive)	≥96%	**97.49%**
All cancers: one month diagnosis to treatment (subsequent surgery)	≥94%	**99.12%**
All cancers: one month diagnosis to treatment (subsequent drug treatment)	≥98%	N/A (as there were no patients on this pathway during the year)
All cancers: one month diagnosis to treatment (radiotherapy)	≥94%	N/A (the Trust does not provide radiotherapy)

Indicator name	Target	Performance 2014/15
[2]All cancers: two month referral to treatment (GP referrals) [(A)]	≥85%	**89.26%**
All cancers: two month diagnosis to treatment (consultant upgrade)	≥94%	**94.20%**
All cancers: two month referral to treatment (screening referrals)	≥90%	**100.00%**
Incidence of MRSA bacterium	0	**0**
Incidents of Clostridium difficile	0	**0**
NHS staff satisfaction	National average for staff engagement – 3.74 (national average for acute specialist Trusts)	**3.74**
Delayed transfers of care	≤3.5%	**0%**
Last minute cancellation for non-clinical reasons	≤0.8%	**0.54%**
Last minute cancellation for non-clinical reasons, not readmitted in 28 days	≤5%	**0%**
Total time in Accident & Emergency % seen within 4 hours)	≥95%	**99.91%**

Regulatory ratings

Monitor is the sector regulator for health services in England. When assessing our performance, Monitor uses a risk rating system for financial performance/continuity of services and governance. The purpose of the Continuity of Services ratios is to assess the level of risk to the ongoing availability of key services.

[(A)]Indicator mandated outside of the Quality Account Regulations and subjected to limited assurance audit

[2] The national target is 85%, however the Trust has a further tolerance of 6% given the specialist nature of referrals received (Department of Health 2009, Monitor 2011)

What the ratings mean

- Continuity of Service (CoS) – this assesses the level of risk to the ongoing availability of key NHS services and takes into account our liquidity and capital servicing capacity. A scale of 1 – 4 is used with 4 indicating the lowest risk and 1 the highest;

- Governance – this takes into account our performance against selected national access and outcomes standards, CQC judgements on the quality of care provided, relevant information from third parties, a selection of information chosen to reflect quality governance at the organisation, the degree of risk to continuity of services and other aspects of risk relating to financial governance, and any other relevant information. A traffic light system is used to indicate the rating given, based on green and red, where green indicates no evident concerns and red where enforcement action is being taken.

In 2014/15 the Trust achieved an overall Continuity of Services rating of 3 and a Green governance rating, as measured by Monitor. This is consistent with the Trust's plan. In the financial year 2013/14 the ratings were 4 and green respectively.

The breakdown of our ratings and a comparison with last year is below:

2014/15	**Annual Plan**	**Q1**	**Q2**	**Q3**	**Q4**
Continuity of service rating	3	3	4	4	3
Governance rating	Green	Under review	Under review	Green	Green

2013/14	**Annual Plan**	**Q1**	**Q2**	**Q3**	**Q4**
Under the Compliance Framework					
Financial risk rating	3	3	3		
Governance risk rating	Green	Amber-Green	Green		
Under the Risk Assessment Framework					
Continuity of service rating				4	4
Governance rating				Green	Green

In Q1 the Trust's governance rating was placed under review as a result of an investigation launched by Monitor, further details of which can be found on page 224. The investigation was closed and the Trust's rating reverted to green in Q3.

We confirm that there were no formal interventions from Monitor during the year.

Strategy and business model

The Trust's strategy is to remain at the forefront of providing high quality clinical care to women, babies and families within a service model that achieves clinical excellence and is financially sustainable. The Trust's business model is that of an NHS Foundation Trust. NHS Foundation Trusts are legal entities in the form of public benefit corporations and operate under a licence which is issued by Monitor, the sector regulator for health services in England. The model has a framework of local accountability through a unitary Board of Directors, members and a Council of Governors, which replaced central control from the Secretary of State for Health.

The strategy for the future

As part of the Trust's ongoing commitment to continually review and improve its services, we have begun work on a strategy for the future which will be developed during 2015/16. This strategy will set out the options for the future provision of women's services in Liverpool that will preserve the prominence and excellence of the services we provide, in a contemporary context. It will provide a compelling clinical case for change based on best practice clinical care standards.

This work is entirely complementary to the Healthy Liverpool Programme that is being led by Liverpool Clinical Commissioning Group and which has set out a vision for a healthcare system in Liverpool that is person-centred, supports people to stay well and provides the very best in care. The vision is underpinned by three ambitious outcomes:

- Health outcomes will have improved relative to the rest of England and health inequalities will have narrowed;
- The quality of care received by Liverpool patients will be consistent and of high quality; and
- There will be a new model of care which is clinically and financially sustainable for the long-term.

The Healthy Liverpool Programme has already identified women's and children's services as one of the key areas of focus. The development of our Future Generations strategy will need to be closely aligned with the Healthy Liverpool Programme in order to optimise effort and minimise duplication.

The Trust is proud of its services and their long history in Liverpool but recognises that they need to be kept under constant review to ensure they continue to meet the right, nationally recognised quality standards and service specifications. Our commitment is to continually strive to deliver the best services possible in order to achieve the best outcomes for patients. We also need to ensure that our services remain clinically sustainable in order to keep services local for our patients today and for future generations.

We also want to make sure we protect those aspects of our services that are most valued by patients and staff and which create a positive and unique care experience for women and their families.

Developing the Future Generations strategy has, and will, involve:

- Identifying the clinical standards we want to achieve in each of our services, now and in the future;
- Being clear about which services need to be provided together in order to manage clinical risks effectively;
- Exploring how our services can be remodelled in order to provide care closer to patients' own homes;
- Thinking about which of our services need to grow and develop;
- Defining how we need to operationally organise our services – what happens where, when for whom;
- Reviewing our options for operational changes in each service, including estates and Information Management and Technology;
- Listing and engaging with the public, patients, members, our partners and our staff to make the right choices for our clinical services;
- Setting out clearly the clinical case for change from which to develop a business case.

Principal risks and uncertainties

The principal risks and uncertainties facing the Trust include:

- Delivering the Trust's strategic intention in order to be clinically and financially sustainable. The Trust will enter the 2015/16 financial year with a deficit of £8m which will cause a breach of its provider licence issued by Monitor. The deficit results from a number of structural causes including:
    - a significant legal liability following a group action relating to the practice of a Consultant Urogynaecologist once employed by the Trust. The Trust's Clinical Negligence Scheme for Trusts premium will increase by £2.75m with an outstanding liability of £35m;
    - the need to invest in additional midwives and neonatal nurses in order to provide safe clinical services and satisfy Care Quality Commission requirements. The national Payment by Results tariff – the basis of which hospitals receive money to provide services - is calculated based on an average historical staffing levels and costs, therefore the current tariff cannot support the nationally recommended staffing levels as outlined in the[3]National Audit Office (NAO) and [4]Public Accounts Committee reports. The Trust operates at staffing levels above the average levels cited in the NAO report but do not receive any additional funding over and above the tariff to support this;
    - the requirement to achieve 4% year-on-year savings;

[3]Maternity Services in England, National Audit Office (November 2013)

[4]Maternity Services in England, House of Commons Committee of Public Accounts (January 2014)

As a result of this deficit the Trust has made application for distressed funding in order to fully develop its strategic options during 2015/16. These options are being developed with partner organisations including Liverpool Clinical Commissioning Group, NHS England and Monitor with a view to agreeing a whole system solution to the clinical and financial challenges the Trust is facing. However because of its financial position the organisation is at risk of regulatory intervention by Monitor during the course of the year.

- The separate site on which the Trust is based presents a clinical safety risk as it does not provide for sustainable integrated care. This risk will be fully considered as the Trust's strategic options are developed;
- Maintaining safe staffing levels;
- Complying with national standards in respect of safeguarding adults and children;
- Delivering the Trust's financial plans for 2015/16;

For 2015/16 the These factors are likely to affect the Trust's future development, performance and position and our operational plan for 2015/16 – 2016/17 will set out our approach to addressing them in a way which achieves our strategic objectives.

Our most valuable asset – our people

Our people are the most valuable asset we have to deliver services that are safe, effective and efficient and achieve the best possible experience for patients and their families.

As at 31 March 2015 we employed 1,647 staff in a variety of clinical and support roles (1,304.52 whole time equivalents) not including those who work for our external contractors or staff seconded out to other organisations.

Our people work within four main areas across the Trust:

47.54%	Maternity, Neonatal and Clinical Support Services
21.97%	Gynaecology, Anaesthesia and Theatres, and Genetics
14.75%	Corporate Support Services
6.86%	Hewitt Fertility Centre

Staff Group	**Whole time equivalent as at 31 March 2015**	**Headcount as at 31 March 2015**
Registered Nurses and Midwives	626.42	779
Doctors	59.68	82
Other clinical services staff	207.73	290
Healthcare Scientists	57.86	63

Staff Group	Whole time equivalent as at 31 March 2015	Headcount as at 31 March 2015
Additional Professional, Scientific and Technical	22.91	27
Allied Health Professionals	17.14	40
Administrative and management	302.26	367
Estates and Ancillary	10.53	12
Totals	1,304.52	1,660

As at 31 March 2015 the breakdown of the number of male and female Directors and staff at the Trust was:

Group	Male	Female	Total
Directors	3	8	11
Staff	192	1,468	1,660

Our Human Resources and Learning and Development teams expertly support to our staff to deliver the very best services for women, babies and their families. We continue to be focused on creating a great place to work where staff are treated fairly and equitably, are given an opportunity to grow and develop their skills, feel recognised and rewarded for the contribution that they make, and are engaged in decisions that affect them, and the services they provide.

This commitment is outlined through the four NHS Constitution pledges to staff. Significant achievements were made during 2014/15 in the following areas:

Staff pledge 1 – ensure there are clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients

- We have seen an ongoing improvement in the number of staff who report they have had access to their annual Personal Development Review (PDR) and the quality of those discussions has improved from last year's staff survey results;
- The Employee of the Month and Team of the month programme continues to go from strength to strength with increasing numbers of nominations each month;
- This year saw many more staff recognised locally and nationally for the work they do. Angela Douglas, our Scientific Director for Genetics, was awarded the Healthcare Scientist of the Year award; she was also highly commended in the 'Inspiring the Workforce of the Future' category of the Advancing Healthcare Science awards. Our Neonatal Team were voted as the best in the country at the Mothers and Midwives Alliance Awards. Ann Maria Ellard, Miscarriage Specialist Nurse, was shortlisted for the NHS Employers Federation Kate Granger award. Julie McMorran, Trust Secretary, was awarded the Duncan Medal for services to women's health across Merseyside. Our maternity department was awarded level three baby friendly status by UNICEF, the largest maternity hospital in Europe to achieve

this rating. Dr Colin Morgan, Consultant Neonatologist, won the Bliss Charity award for research. Our Communications Team won the 'In-House Marketing Team of the Year' award at the Northern Marketing Awards and were shortlisted in seven categories at the Association for Healthcare Communications and Marketing awards too;
- The range and quality of submissions for our annual awards process (Dedicated to Excellence) has continued to improve, with a wide number of previous years submissions being shortlisted in a range of local, regional and national awards.

Areas for improvement and continuous focus for 2015/16:

- Continuing focus on ensuring that all staff receive a Personal Development Review that gives meaningful feedback on their individual contribution to patient care;
- In response to staff survey feedback, explore with our staff what would contribute to them gaining increased job satisfaction;
- Implementation of a pay progression policy which explicitly links achievement of objectives to incremental pay progression.

Staff pledge 2 – provide personal development, access to training and development and line management support to succeed

- Supported our aspirant leaders to attend high quality postgraduate leadership programmes such as the Elizabeth Garrett Anderson and Mary Seacole programmes via the NHS Leadership Academy;
- We received an outstanding report form Health Education England for medical education, highlighting the trust as providing excellent standards in medical education and maintained our high ranking by trainees on a national level across both speciality doctors and GP placements;
- Continued roll out and expansion our work experience and outreach programmes to support people in the local community seeking work;
- We have continued to run a number of successful GP Education events which gives an opportunity to share our expertise and showcase the hospital and the outstanding services we provided to patients;
- Each member of staff has been issued with a mandatory training 'passport' to increase ownership and accountability for completion of mandatory training.
- LWH App for medical trainees has been fully rolled out and has been nominated for a Health Service Journal award;
- The re-introduction of NVQ programmes for Band 2 – 5 staff, has given this staff group a morale boost and will help staff with their career progression and support the trusts succession planning.

Areas for improvement and continuous focus for 2015/16:

- Ensure that leaders are held to account for the climate they create for their teams and that they respond to feedback from their teams;
- Ensure the right values and behaviours are promoted and recognised through our PDR process as well as recognising an individual's skills and abilities;;
- We will roll out Team Coaching across all teams in the organisation to support our people to be the best they can be;
- We will further roll out Liverpool Women's 360 appraisal for all leaders at Band 7 and above.

Staff pledge 3 – provide opportunities for staff to maintain their health, well-being and safety

- During this year we successfully retained the prestigious Occupational Health accreditation Safe Effective Quality Occupational Health Services (SEQOSH);
- Some 77.4% of our staff took up the flu vaccine this last campaign. This was a 3.8% increase on the previous year's uptake exceeding the national target of 75%;
- We continued to see a positive impact of early intervention clinics to support staff experiencing mental health problems and musculoskeletal conditions and preparing for planned surgery;
- A varied programme of events for staff to improve their physical activity levels continues to be provided including the cycle to work scheme, Zumba classes, Liverpool Women`s running club and the Liverpool Women's Team Challenge. This year's team challenge was themed 'It`s a Knock Out' and saw members of staff compete against each other in a number of sports day activities. Some staff participated in `Women on 2 Wheels` which involved staff cycling from Birmingham Women`s to home at Liverpool Women`s and Birmingham Women`s staff cycled from Liverpool Women`s home to Birmingham Women`s. Staff participated in the NHS Games and also in the NHS 5k run; a member of our staff actually won the 5k run. Some staff also took part in the Hospital Challenge at Aintree. The hospital challenge saw 6 of our staff take part in both physical and mental activities which include absailing down the Aintree site;
- The delivery of 'Stress Resilience' training sessions accessible to and for all staff and managers continues and has been well received;
- The continued support re case management group/meetings for sickness absence reviews where a multi-disciplinary approach is taken to support staff back into work after long term illness;
- 'Revitalise' web based Health and Wellbeing Zone for staff and their families continues to be accessed and has an increased staff membership. This web site can be accessed remotely and has proven popular. Monthly anonymised usage reports are received via the 'Revitalise' administrator. This is a useful tool to identify current trends in usage and interest on which health programmes may be considered or introduced for staff year on year;
- Sustained focus on sickness absence, identifying underlying reasons for increasing absence and taking specific actions to address this by supporting our staff effectively to be 'happy, healthy and here';
- The delivery of 'Compassionate Conversations' to support the emotional and psychological wellbeing of all staff;
- The introduction of Staff Communication Boards in all areas and departments has enabled easier promotion of Health and Wellbeing initiatives in the workplace;
- The Work Health and Wellbeing offer is promoted to staff at induction and throughout employment.

Staff pledge 4 – provide opportunities for staff to engage in decisions that affect them and the services they provide

- As part of the preparation for our CQC inspection we recruited a cohort of staff from a range of specialties and bands to be 'CQC champions' who promoted awareness about the CQC standards;
- As part of our Future Generations strategy, staff from across the disciplines and bands have been actively involved in designing the clinical services of the future;
- Bi-weekly briefings and the monthly 'In the Loop' team briefings delivered by the Executive Team both continued to ensure staff are fully aware of the financial and strategic challenges facing the Trust and give them an opportunity to input their ideas;
- An internal communications plan was rolled out to clinical areas ensuring all teams receive the same opportunity to have their say on how care is delivered including manager drop ins, daily briefings, team meetings and 'vision and values' events;
- We continued our drop in sessions with Directors around 'raising concerns' at which staff could speak openly about any issues or anything that may be getting in the way of speaking out safely in the interests of patients;

- We continued our ‘Listening Sessions’ where directors visit wards and departments to hear any issues of concern to staff and support them to make improvements in their own areas. This year there was a particular focus on safety and CQC standards.

Areas for improvement and continuous focus for 2015/16:

- Refresh of ‘Pulse’ questions based on feedback from CQC to ensure we are asking staff about what is important to them;
- Feedback and key themes from Executive Walkabouts to be shared with all staff as part of the monthly ‘In the Loop’ team briefing sessions;
- All managers to be tasked with personal objectives to improve the overall number of staff recommending the Trust as a place to work or receive care;
- Ensuring that good practice in local communications at ward and department levels (daily briefings’, huddles, manager drop ins) is replicated in all areas so all staff have the chance to be involved and have their say.

Working with our partners and communities

The Trust is committed to supporting our staff to reach out into the local community and beyond, taking the values of the Women’s into those communities, working with schools, colleges and universities, voluntary and charitable organisations, groups, families and individuals.

We actively work with partner organisations to support women in the community e.g. breastfeeding, health promotion and support those organisations with shared values and aims to achieve their goals in the community.

We share our great jobs, our personal and professional experience and our facilities with children in school, from primary to secondary, promoting healthcare careers and aspiration in young women for themselves and their families and have undertaken a number of careers events at the Trust for students as well as speaking at local schools and careers fairs.

We provide tailored and interesting work experience placements which are universally well evaluated, with 130 young people undertaking placements in all areas of the Trust over the last 12 months, giving them valuable insight into a career in healthcare as well as work taster sessions and after school skills clubs.

We continue to create value added volunteering opportunities for those who wish to support our organisation and the services we provide both inside and outside the hospital.

In order to ensure we have a steady flow of well trained staff into our lower banded posts, and to fulfil our obligations to our local community, the successful pre-employment programme run by the Trust in partnership with local colleges and the job centre has offered 16 people the opportunity to gain valuable training in the NHS in the last year, 8 of these have gone on to gain permanent employment with Liverpool Women’s Hospital in a variety of roles including patient records and Health Care Assistants.

Health and well-being of the workforce

The sickness absence rate of staff within the organisation has increased from 4.41% in March 2014 to 4.94% (cumulative year to date figures). The total number of days lost in 2014/15 was 14,501 (1,284 total staff years) or an average of 11 working days lost per whole time equivalent staff member. However ongoing work to support staff with long term conditions back into work and manage sickness effectively is coming to fruition with a downward trend visible from March 2014.

The NHS staff survey results for 2014 have identified that 37% of staff had suffered work related stress over the last 12 months (compared to 38% in 2013). Stress resilience and support is a feature of our Health and Wellbeing strategy as is on-going support to managers to manage and support staff to return to work as soon as possible following a sickness absence as soon as they have recovered.

The Trust employs Occupational Health Specialist Practitioners with experience in public health, thus demonstrating the Trust's on-going commitment to proactively supporting the health and well-being of our people.

The Health and Well Being Strategy 'Happy, Healthy, Here' continues to be implemented with a working group containing representatives from all wards and departments who will have the responsibility to communicate and advertise the strategy and make it more accessible and visible across the Trust.

Valuing our staff

Valuing the skills, contribution and motivation of our people is absolutely central to ensuring that the Trust achieves its vision of being the leader in healthcare for women, babies and their families. We are committed to equality and human rights as a component part of our approach to valuing staff with appropriate skills and expertise irrespective of their background, age, disability, gender, family or marital status, race, religious belief, or sexual orientation.

Equal opportunities for staff

Part of our commitment to valuing staff is taking action on specific areas where we have identified that improvement in our approach is required. Following the success of our 'Count Me In' equality data capture campaign with staff, we are now able to monitor key staff related policies by protected characteristic to identify any areas where staff from particular protected groups may be disadvantaged. We also provide reports relating to all stages of the recruitment and selection process, disciplinary and grievance procedures and bullying and harassment complaints by protected characteristic to ensure no particular group(s) are involved in these HR processes more often than other groups who don't share the same protected characteristic.

We are currently in the process of engaging with local Health Watch groups and other relevant stakeholders to carry out our EDS2 assessments for 2015/16.

The outcomes we are hoping to progress from developing to (as a minimum) achieving this year are:

- Outcome 1.5: screening, vaccination and other health promotion services reach and benefit all local communities;
- Outcome 2.3: people report positive experiences of the NHS;
- Outcome 3.3 Training and development opportunities are taken up and positively evaluated by all groups of staff;
- Outcome 3.6: staff report positive experiences of their membership of the workforce;
- Outcome 4.2: managers support staff to work in culturally competent ways within a work environment free from discrimination.

Recruitment of staff with a disability

The Trust continues to be a 'Two Ticks Symbol' employer which is a quality symbol providing assurance to individuals with a disability that we welcome applications from all individuals including those with a disability. We continue to work with Job Centre Plus around flexibility in our recruitment and selection processes to make reasonable adjustments to our internal processes to make them more accessible to disabled applicants, particularly those who may have a learning disability.

Reasonable adjustments for staff with a disability

The Trust's policy for the management of sickness absence provides for adjustments to be made to enable employees becoming disabled to remain in employment. To support this policy a more structured approach has been developed to carrying out work risk assessments for staff returning to work following a period of sickness absence. Both generic and stress based risk assessments are carried out to ensure that staff are supported to safely return to work. Temporary and permanent adjustments and modifications to duties are regularly employed to ensure that staff with a disability are supported to fulfil their potential in the workplace.

Equality, Diversity and Human Rights Training

Equality, Diversity and Human Rights Training is provided to all staff at their corporate Induction either in a classroom session or using e learning, with staff updating their training every 3 years using the e learning package. Compliance with this training has increased year on year, and 86% of staff are now up to date with their training. Future developments in the training offered will include e learning packages related to each individual protected characteristic, along with cultural and spiritual awareness guides to ensure our staff are supported to work in and provide an environment which is both culturally aware and free from discrimination.

Listening to staff

We are committed as a Trust to listening to the views of our staff and recognise their achievements on a regular basis. We believe that motivated and engaged staff deliver better outcomes for our patients and our ongoing aspiration is to improve levels of staff engagement on a year on year basis, as measured by the NHS Staff Survey.

The NHS staff survey is a core tool for the Trust to engage consistently with our staff each year to identify what is important to them and then take action to address identified issues. In 2014, we continued to opt for a full survey to ensure that every member of staff has the chance to give their views on an annual basis and we were pleased to receive an above average response rate of 61%, which was the same as in 2013.

The overall trend was positive. We improved in more areas and did worse in fewer areas when compared to the national average for all Trusts.

Compared to 2013:

- We scored better in 14 of 27 questions;
- We scored worse in 9 of 27 questions;
- We stayed the same in 4 of 27 questions.

The Staff Engagement Score is made up of three questions: staff motivation, ability to suggest improvements and recommending the Trust as a place to have care or treatment. Our staff engagement score is **3.74**, the same as last year and the same as the average national score for acute Trusts. Looking at other acute and specialist Trusts in the North West Region, the highest staff engagement score was 3.97 and the lowest was 3.48.

Top 5 ranking scores when compared to other Acute Specialist Trusts:

	Liverpool Women's NHS Foundation Trust	**Average for Acute Specialist Trusts**
% of staff appraised in the last 12 months	89%	84%
% of staff experiencing physical violence from patients, relatives or the public	4%	6%
% of staff working extra hours	69%	72%
% of staff witnessing potentially harmful errors, incidents or near misses	26%	29%
Effective Team Working	3.84	3.83

Bottom 5 ranking scores when compared to other Acute Specialist Trusts:

	Liverpool Women's NHS Foundation Trust	Average for Acute Specialist Trusts
Staff recommendation as a place to work or receive treatment	3.69	4.14
Staff job satisfaction	3.61	3.72
% of staff able to contribute to improvements at work	69%	71%
Work pressure felt by staff	2.91	3.07
% of staff suffering work related stress in the last 12 months	37%	35%

Areas where Liverpool Women's has improved the most since 2013

	2013	2014
% of staff receiving equality and diversity training	55%	68%

Overall as a Trust we are pleased that the 2014 Staff Survey showed an increase in positive responses for the majority of questions, and that the number of staff who would recommend the organisation as a place to work or have treatment has improved year on year. Our results are on a par with other acute Trusts but compare less well with specialist Trusts. We recognise that there is more work to do to fully engage our workforce in a shared vision for Liverpool Women's.

We recognise that the Staff Survey is one opportunity of many to hear the views of our staff. We have been running a PULSE survey since April 2013 which provides all staff with the opportunity to answer 12 questions every month. The questions mirror the themes of the staff survey and include the question of whether they would recommend Liverpool Women's as a place to work or have treatment. Themes coming from the survey are discussed by managers with their staff on a regular basis via team meetings and communications briefings. We have recently developed a new style report where managers are required to collate on a monthly basis the suggestions staff have made during that month and the action that is being taken in response. In the next few months the PULSE survey questions will be refreshed to ensure that we are capturing the issues of greatest importance to our staff.

Sustainability – environmental matters and climate change

As reported in previous years our commitment to minimising any negative impact on the environment continues. This year we have continued our collaboration with two local NHS Foundation Trusts – Aintree and The Walton Centre – in respect of a tender for a Combined Heat and Power unit (CHP). This work has been overseen by the Carbon Energy Fund and during the year a preferred bidder was identified. Installation of the CHP is now anticipated during 2015/16. This initiative will also comprise additional energy initiatives such as the introduction of LED lighting and photovoltaic panels which will reduce energy demand.

In order to reduce the amount of sharps waste which is incinerated and therefore has a high carbon impact, the Trust is moving to the use of a reusable sharps disposal container. The Sharpsmart system will be installed early in 2015/16.

Also in 2015/16 the Trust will introduce an 'offensive waste' stream. This will improve the amount of waste dealt with by high energy treatment via incineration or autoclave.

The first of two planned electric vehicle charging points was installed during the year.

Our performance in respect of gas, electricity, water, clinical waste and domestic waste for 2014/15, and the previous two years, is summarised below:

	Annual usage			**Annual cost (£)**		
Utilities	2012/13	2013/14	2014/15	2012/13	2013/14	2014/15
Gas (Kwh)	6,570,428	5,692,279	5,441,753	217,028	219,509	196,902
Electricity (Kwh)	5907263	5862352	5957378	662,495	715,949	753,389
Totals	12477691	11554630	11399132	879,524	935,458	950,291
Water (m3)	30859	32,895	32,776	47,127	52,080	52,860
Clinical waste (tonnes)	201	201	211	105,397	111,108	108,613
Domestic waste (tonnes)	488	584	530	70,387	63,976	68,319

Partnerships, social, community and human rights issues

Our commitment to playing a positive role as a part of the communities we offer services to, and from which much of our workforce is drawn, continues. Our Council of Governors plays an important part in linking the Trust with its members and the public and is able to act as a conduit for information and views.

In celebration of International Women's Day 2015, our Council of Governors hosted a partnership summit during the year and met with local voluntary and partnership organisations who share a commitment to enhancing the lives of women and their families and ensuring services are as accessible as possible. The summit provided a great opportunity for discussion of the Trust's strategic future and what is the 'essence' of its services, networking, sharing information and exploring further opportunities for collaborative working.

This year we also worked with:

- **Patients** – whose feedback about the care we offer drives our relentless efforts to excel. This feedback is provided through a variety of channels, much of which is included in the regular reports to our Board of Directors' Governance and Clinical Assurance Committee and Council of Governors, detailing complaints, litigation, incidents and contacts with our Patient Advice and Liaison Service. Our Board of Directors continues to hear a patient story at the beginning of each of its meetings, sometimes told by the patient themselves in person or through a video or audio recording, or by a clinical member of staff on their behalf and with their consent. The Trust remains committed to learning from, and responding to, all feedback we receive from patients.

  During the year our Patient Advice and Liaison Service was strengthened with the opening of a staffed office in the main reception area of Liverpool Women's Hospital and the installation of information boards promoting the service around the Trust. With the help of local community groups we have ensured the new service is visible, accessible and user friendly to all patients and their families whatever their needs are.

  Further details of our work in respect of patient experience and patient involvement, are included in our quality report which starts on page 47.

- **Volunteers** – whose commitment, enthusiasm and passion continues to positively contribute to the experience of our patients and the work of the Trust. Amongst many other things they talk to and befriend patients, support a wide range of events at the hospital such as our service of remembrance, breast feeding support events, annual members' meeting and open day and the launch and introduction of an electronic kiosk in our ante natal clinic.

  In 2014/15 our active volunteers gave a total of 11,234 hours of their time to helping patients, relatives and staff at the hospital. On average, our wards and departments have been supported by 54 volunteers on a weekly basis.

  Healthwatch – in December 2014 Healthwatch Liverpool undertook an 'Enter and View' visit to the Trust and produced a very positive report in respect of our gynaecology services. Healthwatch also met with members of our Council of Governors in order to identify areas of common concern and ways of working together.

- **Hotel services** – 2014/15 was our fourth year of working with G4S who provide our cleaning and catering services. This year the role of Duty Manager was introduced to provide for a senior manager on site up to 2000 hours each day, to review activities and be available to attend to any issues that may arise. Our ward hostesses continue to meet with patients each morning to discuss with them what meals they would like.

  In the second year of the annual PLACE assessment (Patient Led Assessment of the Care Environment) the Trust again scored above the national average. Scores were 99.86% for cleanliness (national average = 97.25%), 89.28% for quality of food (national average = 88.79%), 88.35% for privacy and dignity (national average = 87.73%) and 96.48% for condition and appearance (national average = 91.97%).

- **Safeguarding** – safeguarding can only be achieved through effective inter-agency working and public engagement, ensuring a shared ownership and understanding of both the problems and the solutions across all organisations, professionals and the public. This work is coordinated through the Local Safeguarding Children's and Vulnerable Adults Board, of which the Trust is an active member. This ensure that as an organisation the Trust is able to focus on specific priority areas that will build on its core safeguarding activities from prevention through to protective interventions.

- **Liverpool Clinical Commissioning Group** – during the year we worked closely with the CCG as a part of our strategic work to secure the future clinical and financial sustainability of the services we provide. This has proved challenging. However we have needed to seek support funding from a range of sources. Regular contract monitoring meetings were held in respect of the services the CCG purchases from the Trust, including scrutiny of our quality performance. The CCG leads the Healthy Liverpool Programme in which the Trust is actively engaged.

- **Healthy Liverpool Programme** – the Trust has continued to be an active participant in this programme which is being led by Liverpool CCG. Its aim is to act as a vehicle to design, commission and secure a health service model for the people of Liverpool which is sustainable, ensures high quality and achieves value.

- **Liverpool City Council** – we continued to enjoy a very positive working relationship with Liverpool City Council, in particular by meeting with the Mayor and deputy Mayor to discuss the Mayor's Health Commission, the Healthy Liverpool Programme and the future strategic direction of the Trust.

- **University of Liverpool** – with whom we continue to enjoy a strong partnership. We are proud that its Centre for Women's Health Research is located on the site of Liverpool Women's Hospital, bringing together in one location a number of research focused organisations and initiatives including the Centre

for Better Births, the University Departments of Physiology and Women's and Children's Health, the Cochrane Pregnancy and Childbirth Group and the Sanyu Research Centre.

- **Edge Hill University** – with whom we continue to enjoy a partnership in respect of the people and services at our Hewitt Fertility Centre. The Centre's Professor Charles Kingsland, Consultant Gynaecologist, has a Chair at the University and Dr Stephen Troup, the Centre's Scientific Director, is a visiting Reader.

  We continued the distance learning MSc for nurses who wish to specialist in reproductive medicine and during 2014/15 Professor Kingsland developed a Medical Masters with the University, for doctors who wish to specialise in this area of medicine. The new course is due for validation in May 2015 with the first cohort of students planned for Autumn 2015. These courses are critical to the Hewitt Fertility Centre's expansion plans which will depend on staff being available with the requisite skills to achieve high success rates.

- **Liverpool Health Partners (LHP)** – is a collection of high quality research partners from across the Merseyside and Cheshire region and whose strategic role is set to strengthen. Liverpool Women's NHS Foundation Trust is a founding partner of LHP whose vision is to create a leading national and global centre, where world-class research, teaching and clinical practice are brought together to improve the health of people across the region and beyond. LHP is driving North West Coast Genomics Healthcare which aims to bring together the considerable genomics expertise over this footprint. Its three main work streams are research, service and education. This initiative is also supported by the North West Coast Academic Science Network.

The Trust implemented the Equality Delivery Scheme 2 (EDS2) system from April 2014. EDS2 is a generic tool designed for both NHS providers such as Liverpool Women's NHS Foundation Trust, and NHS commissioners. It requires organisations to consider the question "how do people from protected groups or other disadvantaged groups fare compared with people overall?

In 2014 the Trust, in collaboration with Cheshire and Merseyside NHS equality and diversity leads, developed and delivered training to local Healthwatch groups, to help build their capacity and ability to assess the Equality Delivery System 2 (EDS2) goals. The Trust is now in the process of carrying out its 2014/15 assessments with Healthwatch and members of staff side organisations.

The Trust participated in the British Institute of Human Rights road-show in October 2014, by hosting its second BIHR event in collaboration with the Royal Liverpool and Broadgreen University Hospital NHS Trust and Asylum Link, a local support service for asylum seekers in Liverpool. Once again the day was well attended with delegates from the Trust and many other sectors including the police, advocacy centres,

mental health workers, local asylum seekers' groups, local Councils and housing associates. Delegates came from as far afield as Cumbria and Birmingham.

All Trust policies are subject to an Equality Impact Assessment as part of a stringent policy assurance process. The aim of the assessment is to identify any areas of potential discrimination and take appropriate measures to reduce this risk prior to the policy being released for use by our staff. Based on the procedures in place the Trust is confident that it is taking all practicable measures to prevent discriminatory practices within all of its policies. In addition to policies the Trust carries out Equality Impact Assessments in respect of all Cost Improvement plans to ensure any discrimination can be identified and eliminated at the earliest opportunity.

Going concern statement

These accounts have been prepared on a going concern basis.

Liverpool Women's NHS Foundation Trust faces a significant financial challenge and is forecasting a deficit of £8m in 2015/16 with a £7.8m cash shortfall. This will lead to a Monitor Continuity of Services Ratio of 1, with the position further deteriorating in 2016/17. The Board of Directors predicted this position in June 2014 when the five year plan indicated that the Foundation Trust would no longer be financially sustainable in a 'do nothing' position, and commissioned a strategic options review that would address both the financial and clinical challenges ahead so as to develop plans for the continuity of its services.

The Board has taken comfort from internal and external audit regarding the financial controls within the Foundation Trust, coupled with a recent efficiency review commissioned externally by the Foundation Trust, indicate that the Foundation Trust is efficient and managed well financially. The financial challenges arise from structural problems, notably from within the maternity tariff and from Clinical Negligence insurance premiums.

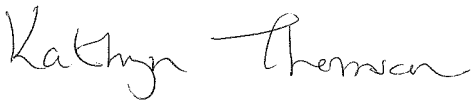
The Foundation Trust has applied for £7.8m of Distressed Funding from the Department of Health and will be informed in June 2015 as to whether this application has been successful. If the application is successful the Trust will achieve a Continuity of Services of 2, but the application will lead to a Monitor investigation and the requirement for a financial recovery plan in 2015/16. If the application is unsuccessful the Trust anticipates enhanced regulatory action. This represents a material uncertainty, which may cast significant doubt about the Trust's ability to continue as a going concern.

The National Health Service has a process for managing organisations that are in financial distress which will enable the services provided by Liverpool Women's NHS Foundation Trust to continue and ensure that all staff and suppliers are paid. This will ensure that the financial stability issues are managed in a controlled manner which does not adversely impact on the services provided to patients. On this basis, the Directors have a reasonable expectation that the Liverpool Women's NHS Foundation Trust will continue in operational existence for the coming 12 month period and for this reason they continue to adopt the going concern basis in preparing the accounts.

Preparation of the accounts

The accounts included in this report have been prepared under a direction issued by Monitor under the National Health Service Act 2006.

This Strategic report was approved by the Board of Directors on 22 May 2015.



Kathryn Thomson

Chief Executive

22 May 2015

Directors' report

The Directors are pleased to present their report. In doing so they have ensured that so far as they are aware, there is no relevant audit information of which the auditors are unaware and the Directors have taken all steps that they ought to have taken in order to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

The Board of Directors is responsible for determining the Trust's strategy and business plans, budget, policies, accountability, audit and monitoring arrangements, regulation and control arrangements, senior appointment and dismissal arrangements and approval of the Trust's annual report and accounts. These are amongst the matters reserved for the Board of Directors as set out in its scheme of reservation and delegation. The scheme also sets out those decision delegated by the Board to its committees and Trust management. This arrangement allows the efficient operation and success of the Trust. The Board is also responsible for ensuring the Trust acts in accordance with the requirements of its Foundation Trust license.

A policy in respect of the Non-Executive Director composition of the Board is in place, as confirmed by the Council of Governors. Overall Board composition is in accordance with the Trust's constitution.

During the year, the following were directors of the Trust:

Non-Executive Director	Date of appointment	Length of appointment
Edna Robinson, Chair (from 1 September 2014)	September 2014	3 years
Ken Morris, Chair (1 April 2014 – 14 August 2014)	August 2011 April 2008 August 2005	3 years 3 years 3 years
Allan Bickerstaffe	February 2012	3 years
Steve Burnett, Senior Independent Director	March 2012 March 2012	3 years 3 years
Liz Cross, Vice Chair (acting Chair, 15 – 31 August 2014)	February 2010 February 2013	3 years 3 years
Ian Haythornthwaite	May 2011	3 years
George Kissen	February 2015	3 years
Pauleen Lane	April 2010 April 2013	3 years 3 years

Executive Director	Date of appointment
Kathryn Thomson, Chief Executive	September 2008
Dianne Brown, Director of Nursing & Midwifery (acting into role from 1 May 2014, substantively in post from 1 June 2014)	June 2014
Vanessa Harris, Director of Finance	September 2009
Jonathan Herod, Medical Director (1 April 2014 – 13 February 2015)	October 2010
Gail Naylor, Director of Nursing, Midwifery & Operations (1 – 4 May 2014)	June 2009
Joanne Topping, interim Medical Director (from 13 February 2015)	February 2015 (interim)
Michelle Turner, [5]Director of Workforce & Marketing	April 2010

Appointment and removal of Non-Executive Directors is the responsibility of the Trust's Council of Governors. Non-Executive Director appointments may be terminated if individuals become ineligible to hold the position during their term of office, details of which are set out in the Trust's constitution.

Based on criteria set out in the [6]Code of Governance, and following consideration by the Council of Governors when recommending the former Trust's Chair Ken Morris for a third, three year term of office, the Board of Directors considers that all of its Non-Executive Directors are independent.

The attendance of Directors at Board and other meetings is given on page 185

Arrangements in place to govern service quality

Arrangements are in place to govern the quality of services provided at Liverpool Women's NHS Foundation Trust. These are supported by the Trust's Quality Strategy and its Quality Report, the latter of which can be found from page 47. Our work to enhance service quality is monitored by the Trust's Clinical Governance Committee which reports to the Board's Governance and Clinical Assurance Committee (GACA).

Led by one of our Consultant Obstetricians acting as the Trust's Director of Clinical Audit, a programme of clinical audit is in place which supports delivery of the Trust's strategic aims. The programme is monitored

[5]Previously this post was Director of Human Resources and Organisational Development. The title was updated to reflect a change in portfolio as agreed by the Board of Directors' Nomination Committee.

[6]The NHS Foundation Trust Code of Governance, Monitor (2014)

by our Clinical Audit Committee which reports to the Clinical Governance Committee, which in turn reports to GACA.

The Trust uses a system called SAFEGUARD to register all incidents, complaints, claims and contacts with our Patient Advice and Liaison Service (PALS). This information is used by our clinical services to identify areas for improvement, flag themes and trends that are occurring and to support the sharing of lessons to prevent further recurrence of issues raised. Reports from the system are regularly presented and reviewed in detail by GACA and in addition they are reported to the Board of Directors. SAFEGUARD is also used to support the medical revalidation process. Operational performance is routinely reviewed by the Board and its Finance, Performance and Business Development Committee together with GACA.

In April 2014 the Care Quality Commission (CQC) undertook an inspection of our services. Following on from the inspection the Trust was issued with a compliance notice regarding its handling of complaints and was asked to make improvements. A great deal of work went into tackling this with the result that there have been considerable improvements in complaints management across the trust. Posters displayed throughout the hospital building describe how to comment on, or make a complaint about the service provided at Liverpool Women's Hospital. Signage identifying the location of the Patient Advice and Liaison Service (PALS) has been put in place and the PALS service is at the front of the main building which has made a significant improvement on the number of PALS contacts the Trust now receives. The PALS service is often an important point of contact for expressing concerns about the patient experience and receiving information on how to make a complaint. It is particularly important for people who need to make a verbal complaint which they may not feel able to make directly to the people involved. This service enables us to address concerns as they arise and make immediate changes or offer support to patients and their families or carers. Amendments have been made to the Trust's website so that information regarding how to comment or complain is easier to locate. A screen saver for all staff using the Trust's intranet contains information on the complaints process and an awareness campaign for existing staff has been undertaken. The management of complaints for all new staff has been included in the corporate induction programme. And patient information packs have been introduced at the bedside which included information for patients on how to comment or complain, should they wish to do so.

The Trust was nominated and then shortlisted as a finalist for a National Patient Experience Award for the work carried out on its PALS service this year. The hospital relocation of the PALS office and increased engagement efforts led to an increase of 101% in PALS contacts. This is unprecedented and testament to the huge efforts made by the team and has also contributed to a reduction in complaints of around 10% during Quarter 4. A thematic analysis carried out of the project showed significant improvements in communication and engagement. The CQC specifically commented in their report following a further visit to the Trust in October 2014 how impressed they were, noting the efforts to encourage patients to comment on, or make a complaint about the service provided at the hospital.

There remains more to do in ensuring that lessons are learnt as a result of complaints and concerns. In particular we are reviewing our data systems and processes for the recording and management of complaints in order to ensure that real and significant changes in practice are brought as a result of them and to optimise the identification of learning opportunities to improve the safety and experience of our patients.

An action plan is in place which sets out how the Trust is responding to the findings of the Francis, Keogh and Berwick reports published in 2013 into numerous failings elsewhere in the NHS. This action plan is monitored across the Trust's governance structure and ultimately by the Board of Directors. There has been good progress in implementing the actions agreed and there is a summary of the actions taken on the Trust's website.

A new Board Assurance Framework (BAF) is now in place which details key risks to delivery of the Trust's strategic objectives. The BAF underwent comprehensive review during the year and is considered by the Board of Directors on a bi-monthly basis. It informs the Board of Director's agenda to ensure its focus on organisational risks and each risk is assigned for oversight to an Executive Director and an assurance Committee of the Board.

Internal control arrangements are in place across the Trust's activities, both clinical and non-clinical. These controls are reviewed by the Trust's internal auditors. The Trust's Audit Committee is responsible for reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the Trust. It provides an independent and objective view on internal control and probity.

The Trust's approach to governing service quality has due regard to Monitor's quality governance framework.

Further, comprehensive details of the Trust's arrangements to govern service quality can be found in the Annual Governance Statement and Quality Report sections of this annual report.

Care Quality Commission

As required, the Trust is registered with the Care Quality Commission (CQC). During 2014/15 it was registered without any conditions.

In April 2014 the CQC visited the Trust by way of follow-up to their unannounced inspection in July 2013. Following their April 2014 visit the CQC issued the Trust with two Warning Notices in May 2014. The Warning Notices were in respect of staffing (Outcome 13) and assessing and monitoring the quality of service provision (Outcome 16). Compliance action was also required in respect of the Trust's management of patient complaints. The challenges identified by the CQC were known to the Trust and were already being actively addressed through a comprehensive action plan.

The actions taken included:

- Investment in and recruitment of an additional 25 whole time equivalent midwives;
- Adoption of a standard definition of providing 1:1 care to women in established labour;
- Established standard definitions for delays and non-clinical denial of epidural pain relief;
- Revision of the Trust's risk management policy to include clearer definition of risk management and risk treatment;
- Development of an improved Board Assurance Framework and arrangements for Board and Committee scrutiny of risk;
- Provision of additional risk management training for staff;
- Enhanced monitoring of incidents;
- Relocation of the Patient Advice and Liaison Service to the hospital's main reception area, and placing of 60 information boards around the Trust promoting the service;
- Enhanced analysis and triangulation of top themes from incidents, complaints, claims and Patient Advice and Liaison Service contacts;
- Increased staffing resources in respect of the complaints function;
- Developed a bedside information pack about how to raise a concern, make a complaint or comment.

The CQC made a follow-up unannounced visit to the Trust on 30 September 2014 and subsequently lifted the two Warning Notices and confirmed that the Trust was fully compliant in respect of complaints.

The Warning Notices were issued after the CQC revisited the Trust in April 2014 by way of follow-up to their unannounced visit in July 2013 when the Commission registered three concerns. Those concerns were (a) a minor concern in respect of the care and welfare of people who use our services (Outcome 4); (b) a moderate concern in respect of people being cared for by staff who are properly qualified and able to do their job (Outcome 13), and (c) a minor concern in respect of supporting our workers (Outcome 14). The matters identified by the CQC were well known to the Trust and were already being actively addressed. All actions required as a result of the three CQC concerns have now been completed.

Also during the year the Trust received three CQC outlier alerts. The alerts related to elective caesarean section rates, perinatal mortality and post natal sepsis. Each was considered carefully by the Trust's Clinical Governance Committee and by the Executive Team, details below:

- Perinatal mortality – the Trust was shown as an outlier in respect of perinatal mortality largely because of the number of women who come to Liverpool Women's Hospital requesting late therapeutic termination of pregnancy as a result of significant fetal abnormalities. These procedures are correctly classified as stillbirths because of the gestational age of the fetus and the Trust operates entirely within the legal framework for this procedure. Analysis of data showed that if babies born following late

therapeutic termination were excluded, the Trust's perinatal mortality rate was slightly lower than average.

- Post natal sepsis – there was accidental miscoding of some patients with urinary or other infections as having post natal sepsis. When this data was corrected, the Trust's post natal sepsis was seen to be 30% lower. Appropriate arrangements have been put in place to reduce the likelihood of this happening again and the Trust has committed to reducing sepsis as part of its 'Sign up to Safety' campaign.

- Elective caesarean section rates - an inadvertent transposition of data was discovered where emergency caesareans were being reported as elective caesareans. When this data was corrected, the Trust's elective caesarean section rate was within the normal range.

Progress towards targets agreed with local commissioners

A proportion of the Trust's income is conditional on achieving quality improvement and innovation goals, known as CQUIN (Commissioning for Quality and Innovation) targets. These initiatives are agreed by the Trust and all commissioners of our service.

During the year we successfully achieved the CQUIN measures set in respect of the Friends and Family Test, dementia and electronic discharges (paper-free discharges from hospital).

A further initiative called 'The Maternity Bundle' measures a number of different indicators relating to the care of patients such as administration of vitamin D and breastfeeding initiatives. We have made steady progress in respect of this CQUIN with a continued focus on patients' BMI (Body Mass Index) and breast feeding initiation.

We have significantly progressed the electronic sharing of information with General Practitioners following a patient's inpatient episode of care and we are working to extend this in respect of outpatients. The electronic sharing of information is no longer a CQUIN for 2015/16 and is being replaced by a Digital Maturity CQUIN to assess the effective use of technologies, system functionality and care record sharing with the Trust.

New initiatives for 2015/16 will look to develop and monitor the enhanced recovery pathway for both elective gynaecology and maternity patients, improving the transition of children to adult services, the Maternity Safety Thermometer and the screening of sepsis for all appropriate patients.

Business overview

In 2014/15 the Trust had in place two main contracts for its income which are essential for our business. These were with Liverpool Clinical Commissioning Group and NHS England – Specialist Commissioning from whom we received £37,770k and £16,355k respectively. These contracts represent 56% of the Trust's total income and 60% of the Trust's clinical income.

In common with the majority of NHS organisation the Trust continues to face significant financial challenges. The need to deliver efficiency savings remains and plans are in place to deliver £5m savings in 2015/16. The Trust has a strong record of delivering these efficiencies whilst continuing to develop the standard of clinical care to our patients.

Private Patient Income

During the year Liverpool Women's NHS Foundation Trust generated income due to the provision of private patient services in a number of areas but most significantly in that of fertility services. The income received from this source in 2014/15 was £3,592k, 4% of all Trust income.

This satisfies the requirements of Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) where the income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes.

Any profits arising from the provision of private patient services are reinvested into patient care at the hospital.

Capital

Details of capital expenditure for 2014/15 are given in the table below from which it can be seen that the Trust continues to reinvest in its estate, medical equipment and information technology for the benefit of patients.

Capital expenditure	**2014/15 £000s**	**2013/14 £000s**
Buildings	1,001	1,813
Assets under Construction	853	0
Fixtures and fittings	44	9
Information Technology	2,666	1,021
Medical Equipment	894	959
Intangibles	45	220
Total	**5,503**	**4,022**

The Assets under Construction are in relation to the Hewitt Fertility Centre expansion at both the Knutsford and King's College Hospital NHS Foundation Trust sites and the Midwifery Led Unit refurbishment on the Trust's site, all of which are due to open in 2015/16.

Better payment practice code

The Better Payment Practice Code requires that 95% of undisputed invoices relating to trade creditors are paid within 30 days of receipt. Our performance during 2014/15 and 2013/14 is shown below:

Better Payment Practice Code	**2014/15**	**2013/14**
Value of invoices paid within 30 days	82%	75%
Number of invoices paid within 30 days	81%	75%

During 2014/15 our performance against the Better Payment Practice Code improved. This has been caused by an improvement in process and control within this function of the Trust during the year. We expect to continue this improvement during 2015/16 and beyond.

No interest was paid to suppliers under the Late Payments of Commercial Debts (Interest) Act 1998.

Cost allocation and charging requirements

The Trust has complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information guidance.

Accounting policies for pensions and other retirement benefits

The accounting policies for pensions and other retirement benefits are set out in note 8 to the accounts.

Details of senior employees' remuneration can be found on page 179 of the remuneration report.

Financial risk management

The key financial risk to the Trust is maintaining financial sustainability and this is articulated in detail in the Board Assurance Framework. This is reviewed regularly by the Board of Directors and its relevant Board assurance committees. The key components of the Trust's financial risk and mitigating actions are below:

Key Risk	**Maintaining financial sustainability**
Mitigating actions	
1. Sufficient cash to maintain services	Applications made to commissioners and to Monitor for financial support whilst the Trust develops its Future Generations strategy to secure a longer-term solution to both clinical and financial sustainability.

Key Risk	Maintaining financial sustainability
2. Breach of licence	The Trust will breach its licence during the year as a result of its financial position. Mitigation is the preparation of robust financial plans to reach a position of recovery. The Trust will maintain ongoing dialogue with Monitor in order to provide assurance in respect of its future sustainability.

Research and development

Research and development continues to be a key activity for the Trust. During 2014/15 we have continued our efforts to contribute to quality National Institute for Health Research (NIHR) studies and to maintain the number of women and babies recruited to these.

The number of patients receiving NHS services provided or subcontracted by Liverpool Women's NHS Foundation Trust in 2014/15 that were recruiting during the year to participate in research approved by a Research Ethics Committee, was 1,881 or which 1,077 were recruited into NIHR portfolio studies.

Liverpool Women's was involved in conducting 126 clinical research studies across our specialty areas during the year. And at the end of 2014/15 a further 17 studies were in set-up.

There was 76 clinical staff contributing to research approved by a Research Ethics Committee. The research covered a broad spectrum of translational research from basic research at the laboratory bench through to early and late clinical trials, to health systems research about healthcare delivery in the community.

Our research has contributed to the evidence-based for healthcare practice and delivery, and in the last year 73 publications have resulted from our involvement in research which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS.

Details of our research activity can be found in the quality report section of this document from page 127.

Information management and technology

In 2014/15 the Trust's Information Management and Technology (IM&T) department began the deployment of IM&T strategy "Doing IT Right" which was approved by Trust's Board of Directors in February 2014.

This has resulted in the progression of the digitization of our paper records, integration of our clinical systems and improved access to records for our patients. The Trust is committed to the paperless 2018 vision, with this initiative being part-funded by the Safer Hospital, Safer Ward Technology Fund. With electronic bed management solutions, patient self-service, patient free wifi and digital assistants have been commissioned. Furthermore IM&T was central to the successful 100,000 genomics tender and will be providing the technical infrastructure and data intelligence for the North West Coast GMC.

The IM&T department remains committed to improving its services to the optimum standards and has been successful in maintaining the following international standards:

• ISO 27001 accreditation in data security;
• ISO 9001 accreditation in quality;

• ISO 14001 accreditation in environmental management.

Health and safety

During the year the Trust's Health and Safety Team developed, reviewed and implemented health and safety policies to meet both internal and external requirements in order to keep our patients, staff and visitors safe. The team further engaged with our clinical staff to effectively relieve the burden of risk assessments by supporting those clinicians responsible for health and safety within their clinical area, allowing the time freed up to be used for clinical and other managerial duties. An interactive classroom-based health and safety and risk training session was designed, tested and rolled out to corporate induction and mandatory study days making sure that Trust staff have appropriate health, safety and risk knowledge.

Monitoring of health and safety related non-clinical incidents was carried out throughout the years and identifiable trends and RIDDORs investigated and acted upon. Electronic registers were established for DSE assessors, fire wardens, cascade manual handling trainers and first aid staff.

During 2015/16 the team will continue to improve on health and safety performance, training and awareness including the delivery of in-house training in an IOSH equivalent 'Managing Safely' course, aimed at all managers who have health and safety responsibilities and duties, and a DSE assessors' course. Risk assessments will be further modernized including annual workplace audits, both aimed at reducing the overall health and safety workload for managers and also improving reporting.

Emergency preparedness, resilience and response (EPRR)

Under the terms of the Civil Contingencies Act 2012 the Trust must be resilient in the event of emergency situations/major incidents and have robust plans in place to enable an effective response to a range of potentially disruptive challenges. Responsibility for this requirement rests with the Trust's Associate Director of Operations who is the Accountable Emergency Officer for the organisation. All business relating to EPRR is conducted via the Trust's Operational Board.

Business continuity management is also an important component of EPRR and the Trust has in place a robust system to plan, test and train staff in order to enable continuation of critical services in the event of such disruptive challenges whilst delivering optimum care to patients.

The Trust's major incident plan and business continuity plans were tested on several occasions during the year, in both live incidents and 'table top' exercises. Staff responses were timely and efficient as a result of the plans being well rehearsed. Lessons learned from each test are captured and shared across the organisation.

During the year the plan to train departmental managers, managers with on-call responsibilities and shift leaders in respect of EPRR arrangements locally and nationally was completed. This followed the training provided in 2013/14 to the Trust's risk team, loggists and executive Directors.

Local Security Management Specialist

The overall objective of the Trust's Local Security Management Specialist is to deliver an environment that is safe and secure so that the highest standards of clinical care can be made available to patients. This objective was achieved by providing a security management service for the Trust, continuing to work towards the creation of a pro-security culture and ensuring security activity in respect of NHS Protect's four areas of priority, namely tackling violence and aggression against staff; protecting paediatric and maternity unit; protection of drugs, prescription forms and hazardous materials, and; protecting Trust property and assets.

Countering fraud and corruption

The Trust is committed to countering fraud and corruption. We engage the services of a registered counter fraud specialist and we are compliant with the requirements of the counter fraud manual. The Trust fully cooperates with NHS Protect and responds to the national proactive reviews. Our work in respect of countering fraud and corruption is overseen by the Trust's Audit Committee.

There is clear strategic support for anti-fraud and bribery work at the Trust. The Local Counter Fraud Service (LCFS) is actively supported by the Deputy Director of Finance and the Audit Committee. A counter fraud work plan is agreed with the Deputy Director of Finance at the start of each year and provided to the Audit Committee for approval. The work plan outlines the core LCFS activities to be undertaken during the financial year and allocates resource against each NHS Protect standard for providers which enables all activities to be delivered.

Counter fraud policies are set out in the Trust's Standing Financial Instructions which form a part of our corporate governance manual, reviewed annually. We also have in place a whistle-blowing policy. The Trust's accountable officer for fraud is the Director of Finance.

The Trust underwent audit by NHS Protect during the year in respect of its counter fraud arrangements. Auditors tested the Trust's arrangements in respect of informing and involving staff and rated this as amber, and also in respect of holding to account which it rated as red. The red rating was given due to the limited number of incidents that had occurred and thus the auditors were not able to obtain comprehensive assurance.

Serious incidents involving data loss or confidentiality breach

There have been no serious incidents relating to information governance including data loss or confidentiality breaches which would be classified by the Information Governance Incident Reporting Tool and no cases have been reported to the Information Commissioner's Office.

Consultations

No formal consultations in respect of proposed changes to the Trust's services were carried out during the year but plans commenced in respect of consulting our patients, staff and stakeholders in respect of the proposed future strategic direction for women's health services.

The position of the Trust at 31 March 2015

The Trust ended the year with a deficit of £2.7m after all expenditure was accounted for. This reflects the structural financial issues being faced by the Trust which are detailed elsewhere in this report.

The Trust also achieved an overall Continuity of Services rating of 3 and a green governance rating, as measured by [7]Monitor. The breakdown of our Continuity of Services rating is provided below alongside a comparison with last year:

Monitor Ratings	2014/15	2013/14
Under the Risk Assessment Framework		
Liquidity	4	3
Capital Servicing capacity	2	4
Overall Continuity of Service rating	**3**	**4**

Full details of the Trust's financial performance in 2014/15 can be found in the annual accounts from page 234 of this report.

Branches outside the UK

Liverpool Women's NHS Foundation Trust had no branches in operation outside the UK in 2013/14. It continues to investigate international opportunities in relation to the provision of fertility services for the future.

Directors' and Governors' significant interests

All members of the Board of Directors and Council of Governors are required to disclose any other significant interests which may conflict with their responsibilities. Both Directors' and Governors' register of interests can be found on the Trust's website at www.liverpoolwomens.nhs.uk.

Likely future developments

In 2015/16 the Trust will continue to consider a series of strategic options aimed at ensuring services for women, babies and families remain clinically and financially viable.

Our plans can be found on the Trust's website at www.liverpoolwomens.nhs.uk.

Important events since the end of the financial year

There have been two important events since the end of the financial year:

[7]See page 16 for an explanation of how Monitor's methodology for measuring Trusts' changed during the year from the Compliance Framework to the Risk Assessment Framework.

- On 29 April 2015 the Council of Governors appointed a new Non-Executive Director to the Board of Directors. Tony Okotie took up the role on 1 July 2015 for a three year term of office;
- In May 2015 the Trust received the final report of the Care Quality Commission's inspection which was conducted in February and March 2015. The Trust received a 'Good' rating from the CQC.

Disclosures included in Strategic Report

A number of disclosures required to be made in this Directors' Report have instead been included in the Strategic Report. This is because they relate to our staff and the Strategic Report includes a comprehensive section in respect of our people and the disclosures can therefore be considered in the context of our work with our staff. The disclosures are: (a) policies applied for giving full and fair consideration to applications for employment made by disabled persons; (b) policies applied for continuing the employment of, and for arranging appropriate training for, employees who have become disabled persons; (c) policies applied for the training, career development and promotion of disabled employees; (d) actions taken to provide employees systematically with information on matters of concern to them; (e) actions taken to consult employees or their representatives on a regular basis so that their views can be taken into account in making decisions which are likely to affect their interests; (f) actions taken to encourage the involvement of employees in the Trust's performance; (g) actions taken to achieve a common awareness on the part of all employees of the financial and economic factors affecting the performance of the Trust.

Quality Report

Liverpool Women's NHS Foundation Trust

2014-15

This page is intentionally blank

Foreword

This is the 6th Quality report compiled by the Liverpool Women's NHS Foundation Trust and reports achievements during 2014-15. The Quality Account provides an opportunity for us to review the quality of healthcare provided at Liverpool Women's over the year and to share the key priorities for quality for the Trust in the forthcoming year.

The document is prepared with consideration of all current requirements and guidance relating to the production of the Annual Report and Quality Account, as identified by periodic internet searches conducted by the Trust Secretary and Governance Quality Manager, as the officers responsible for compiling these documents within this Trust.

It is laid out in a number of sections in accordance with the requirements and includes mandated statements as defined in the cited guidance.

In **Part One** we provide an overview of the services provided by the Trust with a supportive statement of fact by the Chief Executive Officer.

Part Two of the Quality Account is separated into two sections.

Part 2a describes our priorities for improvement for 2015-16. This part of the account also describes the reason for choosing these priorities and by how much we are looking to improve. This section of the report also advises how the Trust will monitor progress against the priorities described. Progress against these priorities will be reported in next year's Quality Account Report.

Part 2b provides a review of services provided by the Trust against NHS contract and the quality of care provided. Information within this section includes data relating to performance against contracts and information relating to audit and research activity undertaken by the Trust.

In **Part 3** progress against the Quality Improvement agreed for 2014-15 is demonstrated. This section of the report provides data and narrative to describe our achievements and any further actions planned.

Annexe 1 provides statements from Commissioners and other interested parties on the content of the Quality Accounts and the priorities agreed for 2015-16.

Annexe 2 is a mandated section required to provide assurance of responsibilities and provide a declaration of honesty with respect to the content of the Quality Accounts.

Guidance
NHS foundation trust annual reporting manual 2014/15 (ARM), Monitor, December 2014
Detailed requirements for quality reports 2014/14, Monitor, February 2015
Risk assessment framework, Monitor, August 2013, Appendix C updated April 2014
Change of the headline measure used for the Friends and Family Test (FFT) http://www.england.nhs.uk/ourwork/pe/fft/fft-test-review/
Detailed requirements for external assurance on quality reports 2014/15, Monitor , February 2015
Quality Account's Data Dictionary 2014/15, NHS England , May 2014
Quality Accounts: Reporting arrangements2014/15, NHS England , Gateway reference: 03123, March 2015

Part

1 Statement on quality from the Chief Executive of Liverpool Women's NHS Foundation Trust

Our quality strategy states our intention to focus on projects that will reduce harm and mortality, improve patient experience and make the care that we give to our patients reliable and grounded in the foundations of evidence based care. This report sets out how we have performed against the ambitious targets we have set and our priorities for the coming year. I would however like to take this opportunity to highlight some of the potentially life changing quality initiatives we have embarked on in 2014-15.

Liverpool Women's was selected as one of only eleven centres across England that will lead the way in delivering the 100 000 Genome Project. This project aims to transform the diagnosis and treatment for patients with cancer and rare diseases. The project will provide some of the patient's involved, with immediate clinical benefit, because a better treatment will be identified for them, or their condition will be diagnosed for the first time. For most, the benefit will be in knowing that they will be helping people like them in the future through research on their genome data which they generously allow to be studied, but all will know that because of their involvement, an infrastructure will be developed which, in the future, will enable the NHS to offer genomic services much more widely, to any patient who might benefit.

In our Neonatal Intensive Care Unit we have installed the full 'HeRO' system. We are the first trust in the UK to fully implement the system and are currently evaluating its impact and effectiveness. The 'HeRO monitor is a non-invasive system which monitors heart rate variability in babies, it allows the early detection of sepsis, before any clinical signs are apparent or any other tests become abnormal. A rise in HeRO' score prompts the team to review the baby and start treatment much earlier than we have previously been able to do. It is estimated that 'HeRO' will save between five to seven babies lives each year on the unit where every baby in the Intensive Care and High Dependency unit will be monitored.

In all aspects of care patient experience is central to what we do. To improve the opportunities for the patient voice to be heard we have transformed our PALS (Patient Advise and Liaison) services making them highly visible and accessible to patients.

Moving forward In December 2014, we engaged in the three year ‘Sign up to Safety’ campaign which is focused on the reduction of avoidable harms.

Specifically, we aim to reduce avoidable harm by 50% in 3 years by:

- Reducing the incidents of babies born with Grade 2/3 Hypoxic Ischaemic Encephalopathy;
- Reducing the incidence of sepsis through increasing awareness, ensuring prompt identification and appropriate treatment of infection including the prevention of mortality and morbidity;
- Improving medicines safety with a focus on high risk medicines and reducing the severity of medication errors;
- Reducing the number of readmissions and returns to theatre within gynaecology.

To complete our year in February 2015 the CQC carried out an announced inspection of the trust and on the 4th of March an unannounced inspection.

In Mid – May, during preparation of this report , the Care Quality Commission (CQC), published its finalised report following these announced and unannounced inspections earlier this year, which confirmed that they had given an overall rating of ‘good’ to the Trust.

We have received extremely positive feedback from the team of inspectors that visited the Trust. Their report picks up on the passion and enthusiasm that our staff have for the jobs they do and the people they care for, and also highlights how proud they are of the service we provide.

As for any organisation, there are areas that we can improve on, and we have already begun putting processes in place to make these improvements, especially around how we manage the storage of medicines, but the report shows that the people of Liverpool and beyond have every reason to be confident that they will receive the very best care possible should they choose Liverpool Women’s.

Since previous inspections in 2014, the CQC found that the Trust had significantly improved the level of staffing across its maternity department and that governance and risk management processes were now more robust than they had been. The report also highlighted that staff felt supported by senior teams across the hospital.

Chief Inspector of Hospitals, Professor Sir Mike Richards, said: “Liverpool Women’s has a lot of to be proud of. Apart from providing essential specialist services to women and babies from Liverpool and the surrounding areas, it is a major centre for research. We found maternity inpatient services, gynaecology, neonatal services, end of life care and outpatients services to be good. Staff at every level were committed and passionate about their work and the quality of care they provided.”

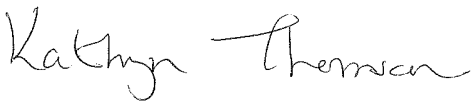
“Since our previous inspections in April and September 2014, the trust has clearly worked hard to make significant improvements to its governance and risk management systems. We found the senior team was visible and accessible to staff, and managers were seen by staff as supportive and approachable”.

Amongst a lot of very positive comments, the CQC gave special praise to how clean the hospital is, how skilled and committed our medical staff are and how caring and compassionate our nurses and midwives are.

The inspection team commented on how positively our patients, both past and present, had spoken about their experiences of our hospital, and the inspectors themselves found that our staff treated patients and their families with dignity and respect.

I declare that to the best of my knowledge the information within this document is accurate.

Signed



Kathryn Thomson
Chief Executive
Liverpool Women’s NHS Foundation Trust

22 May 2015

Part 2 Priorities for improvement and statements of assurance from the board

2.1 Priorities for improvement 2014-15

Please note: Where indicator titles include a forward slash, the title to the left of it is the historical description of the indicator; the title to the right is the revised descriptor agreed in the 2014-15 review of the quality strategy and formulation of the 'Sign up to Safety 'plan. The latter descriptor will include a target element for measurement of success.

2.1.1 Patient Safety

2.1.1.1 Elective surgical site Infections / To reduce the number of elective surgical site infections in gynaecology to an average of not more than 3 per calendar month.

Description:

In previous years this indicator was defined as the number of elective Gynaecology patients with an infection expressed a percentage of all elective Gynaecology patients undergoing a surgical procedure. During the review of the Trusts Quality goals, it was determined that there should be a defined target for improvement set at an average of no more than 3 per calendar month. Henceforward the data will be presented as instances per month.

Why and how this priority goal was selected

Surgical site infection and its reduction is an important part of national guidance (NICE Clinical Guidance on Surgical Site Infection CG74) and national programmes to improve patient care (Enhanced Recovery Programmes developed by the Department of Health and the WHO Surgical Site Checklist).
Post-operative infections are important both to the individual patients involved, but also to the hospital as they can provide a marker as to the effectiveness of our care of patients before during and after operations hence it has been used as a quality indicator and reported in all the trust's Quality Reports.
It was again identified in the 2014-15 review of the Trust's Quality Goals that this indicator provides a means to monitor and measure our progress in reducing this aspect of avoidable harm against a defined target.

Why this is important / what difference does this make to patients?

A reduction in the incidence of infection will have a significant impact on patient recovery.

Progress made in report period 2014-15

New Data Format (Number of *elective Gynaecology patients with an infection per month).*

Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Av.
2014/15	1	0	1	0	0	1	0	0	0	1	0	1	0.41
2013/14	0	1	0	1	2	0	0	0	1	1	3	2	0.91

Previous data format *(NB. Number of elective Gynaecology patients with an infection expressed a % proportion of all elective Gynaecology patients undergoing a surgical procedure).*

Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Av.
2014/15	0.11	0.00	0.10	0.00	0.00	0.11	0.00	0.00	0.00	0.11	0.00	0.11	0.05
2013/14	0.17	0.00	0.00	0.16	0.00	0.00	0.00	0.00	0.00	0.00	0.14	0.13	0.05

Data Source: CHKS

The Liverpool Women's NHS Foundation Trust considers that this data is as described for the following reasons:

- Various initiatives over several years (WHO surgical checklist, Enhanced Recovery Programme, changes to the skin cleaning preparation in theatre) have helped reduce this reported rate, and this past financial year has seen it drop further to just 0.05% recorded infections related to elective Gynaecological surgery.

How progress to achieve the priority goal is monitored and measured

Data is collated from the information produced by the hospital Coding Department from contemporaneous hospital records and drawn together on a monthly basis by the Information department.
The individual service areas are responsible for managing quality priorities and indicators of relevance to them and are required to report on them monthly to their local Quality Improvement forum in a standardised format dashboard.

How progress to achieve the priority goal is reported

As described in the Trust's Quality Strategy, service level quality improvements forum(s) report quarterly to the Clinical Quality Governance Committee, who raise exceptions and concerns with the Operational Board and report quarterly to the Governance and Clinical Assurance sub-committee, which in turn reports biannually to the board. Thus the Trust's Clinical Quality Governance Committee and ultimately the Board have an overview of the delivery of the work streams in respect of this and all quality priorities and indicators. Infection data is also reviewed twice monthly within the Matrons report to the Infection Control Committee.

The Liverpool Women's NHS Foundation Trust has taken the following actions to improve this indicator, and so the quality of its services:

- The aim to reduce elective surgical site infections is included as a continuing focus within Safety Goal 1 (to Reduce Harm) as declared in the Trusts Quality Strategy.

2.1.1.2 Non-elective Surgical site infections

Description:

The number of non-elective Gynaecology patients with an infection expressed a percentage of all non - elective Gynaecology patients undergoing a surgical procedure.

Why and how this priority goal was selected:

Surgical site infection is one of the commonest causes of post-operative morbidity and delayed recovery. Surgical site infection and its reduction is an important part of national guidance (NICE Clinical Guidance on Surgical Site Infection CG74) and national programmes to improve patient care (Enhanced Recovery Programmes developed by the Department of Health and the WHO Surgical Site Checklist). It was also highlighted within the Trust as part of our involvement in the Leading Improvement in Patient Safety (LIPS) programme from 2010 onwards.

Why this is important / what difference does this make to patients?

A reduction in the incidence of infection will have a significant impact on patient recovery. Post-operative infections are important both to the individual patients involved, but also to the hospital as they can provide a marker as to the effectiveness of our care of patients before during and after operations.

Post-operative infections occur in approximately 5% of all patents post operatively, but patients undergoing emergency surgery are at a significantly high risk. Past data has suggested our infection rate following emergency surgery is higher than for elective cases, and needed to be a focus for the Trust.

Progress made in report period 2014-15

Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Av.
2014/15	0.00	6.90	1.82	0.00	1.56	3.39	0.00	4.92	0.00	0.00	0.00	1.45	1.61
2013/14	4.26	2.56	2.86	0.00	2.38	0.00	2.94	4.44	8.33	0.00	1.75	2.08	2.63

Data Source: CHKS

In 2013-14 the reported infection rate in non-elective surgery was over 3%, a considerable difference compared to the elective surgery. A focus of this, coupled to a multidisciplinary review of the data in conjunction with Clinical Coding, has produced an encouraging fall; this last year the reported infection rate in non-elective surgery was down to 1.66%. This equates to an average of just 1 case of a surgical site infection in emergency surgical cases per month.

The Liverpool Women's NHS Foundation Trust considers that this data is as described for the following reason(s):

- Data is collated from the information produced by the hospital Coding Department from contemporaneous hospital records and drawn together on a monthly basis by the Information department.

How progress to achieve the priority goal is monitored, measured and reported

The individual service areas are responsible for managing quality priorities and indicators of relevance to them and are required to report on them monthly to their local Quality Improvement forum in a standardised format dashboard.

The Liverpool Women's NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, by reviewing the non-elective surgical site infection rates over the past year, clarifying the data, and thus demonstrating an improvement in the infection rate following non-elective (emergency) surgery.

2.1.1.3 Incidence of multiple pregnancy / To ensure that no more than 10% of liveborn pregnancies after fertility treatment are multiples.

Description

Though data recorded by reproductive medicine units **and HFEA** is entitled "multiple liveborn pregnancies" it is universal practice that centres and the HFEA calculate multiple pregnancy rates as a proportion of all clinical pregnancies.

Why and how this priority goal was selected

The Human Fertilisation & Embryology Authority (HFEA), the UK fertility regulator sets a target for fertility centres to meet in its drive to reduce the number of multiple pregnancies arising from fertility treatments. Currently the target is that fertility clinics should aim to have a live birth multiple pregnancy rate under 10%. Hence these data are collected to measure the Hewitt Fertility Centre's progress in meeting the challenge. The Trust decided to retain this improvement priority and metric during the review of the Trust's Quality Strategy in quarter of 2014-15.

Why this is important / what difference does this make to patients?

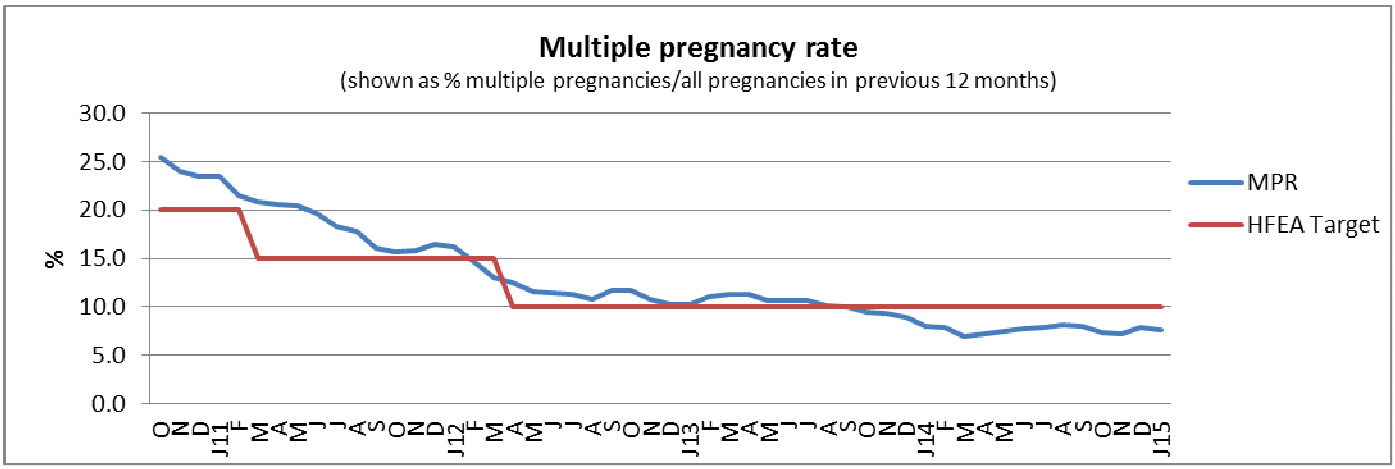
As assisted conception treatment improves, replacing more than one embryo at a time now more frequently results in a multiple pregnancy. This leads to a more complicated pregnancy with a much higher incidence of preterm birth.

As preterm birth is well recognised to be associated with physical and development problems, reducing the incidence of multiple pregnancies was selected as a priority goal contributing to a reduction in harm by the Unit Management team.

Collection of multiple pregnancy outcome data on a monthly basis allows the Hewitt Fertility centre to monitor its performance in relation to the HFEA's targets and, where necessary make adjustments to its Multiple Birth Minimisation Strategy, the latter being an HFEA requirement.

Progress made in report period 2014-15

The following chart shows the continuing downward trajectory for multiple birth rates over the last 4 years. The chart shows that the <=10% target has been met throughout the 2014/15 period. Further to this, we have been told by the HFEA that the Hewitt Fertility Centre has one of, if not the lowest multiple pregnancy rate in the country.



The Liverpool Women's NHS Foundation Trust considers that this data is as described since there is a regulatory requirement to provide these data to the HFEA who continually monitor and benchmark against their targets.

How progress to achieve the priority goal is monitored and measured

The individual service areas are responsible for managing quality priorities and indicators of relevance to them and are required to report on them monthly to their local Quality Improvement forum in a standardised format dashboard.

How progress to achieve the priority goal is reported

As described in the Trust's Quality Strategy, service level quality improvement forum(s) report quarterly to the Clinical Quality Governance Committee, who raise exceptions and concerns with the Operational Board and report quarterly to the Governance and Clinical Assurance sub-committee, which in turn reports biannually to the board. Thus the Trust's Clinical Quality Governance Committee and ultimately the Board have an overview of the delivery of the work streams in respect of this and all quality priorities and indicators.

Data from the unit is reported to the Human Fertilisation & embryology Authority (HFEA).

The Liverpool Women's NHS Foundation Trust has taken the following actions to improve this indicator, and so the quality of its services, by:

- Monitoring of multiple pregnancy rate and the review of the multiple birth minimisation strategy is a requirement of the HFEA.

- The constant review of clinical and laboratory methodologies and strategies which strive to provide every patient with a successful outcome, this being a healthy singleton live birth.

2.1.1.4 Apgar scores <4 in live births >34 weeks gestation

Description

The number of babies born with an Apgar score less than 4 at 5 minutes and with a gestation >34 weeks expressed as a percentage of all births with a recorded Apgar score.

Why and how this priority goal was selected:

This indicator was originally chosen by the directorate following a multidisciplinary discussion at the division meeting about what was highest impact. Whilst there was no direct patient and public involvement- the impact of the selected Maternity indicators (Apgar score <4 at 5 mins, Cord pH <7.0 in liveborns >24 weeks gestation and Stillbirths) are common reasons for patient complaints and litigation locally and nationally. NICE Guideline – "Intrapartum Care: Care of healthy women and their babies during childbirth" (2007), which covers all aspects of Maternity Care.

Why this is important / what difference does this make to patients?

The Apgar score is a measure of a baby's condition at birth. Although developed as an indicator to aid with resuscitation, there is low level evidence that a low Apgar score (<4 out of 10) at 5 minutes is moderately accurate at predicting neonatal death and cerebral palsy.

Progress made in report period 2014-15 (Data Source: Meditech /Clinical Coding)

Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Av.
2014/15	0.31	0.30	0.15	0.15	0.14	0.27	0.26	0.14	0.16	0.47	0.16	0.28	0.23
2013/14	0.00	0.62	0.35	0.00	0.41	0.00	1.05	0.44	0.43	0.44	0.33	0.00	0.34

The data in the above table shows a decline in the percentage of babies in this group with An APGAR score less than 4.

The Liverpool Women's NHS Foundation Trust considers that the data is as described for the following reasons.

- The data is taken directly from 'Meditech' records. The figures show an overall small decrease in the incidence of low Apgar scores at 5 minutes, this is possibly due to the investment in additional midwives or the introduction of the "fresh eyes " approach on delivery suite.

How progress to achieve the priority goal is monitored and measured

The data is produced automatically on or around the 5th of each month from the information team. The data is presented and monitored at the Intrapartum working group and actions escalated to the Maternity clinical group.

How progress to achieve the priority goal is reported

The Liverpool Women's NHS Foundation Trust currently reports the data collectively for the Intrapartum areas.

No other organisation collects data on Apgar scores at <4 at 5 minutes, making it impossible to benchmark against other organisations. It is the trusts intention to replace this metric with another marker of perinatal outcome Hypoxic Ischaemic Encephalopathy.

2.1.1.5 Delivery Cord pH <7.00

Description

The number of live births after 24 weeks gestation where the arterial cord pH is recorded as less than 7.00 expressed as a percentage of all births after 24 weeks with a recorded pH.

Why and how this priority goal was selected

This indicator was originally chosen by the directorate following a multidisciplinary discussion at the division meeting about what was highest impact. Whilst there was no direct patient and public involvement- the impact of the selected Maternity indicators (Apgar score <4 at 5 mins, Cord pH <7.0 in liveborns >24 weeks gestation and Stillbirths) are common reasons for patient complaints and litigation locally and nationally. NICE guidance includes: “Intrapartum Care: Care of healthy women and their babies during childbirth” (2007), “Postnatal Care: Routine postnatal care of women and their babies” (2006) and “Antenatal Care: Routine care for the healthy pregnant woman” (2008).

There is limited evidence that cord pH is a predictor of neonatal death or cerebral palsy, however, if paired samples of blood gases are normal this excludes hypoxic ischaemic brain damage (Intrapartum brain damage). Therefore this is routinely performed on all high risk births. For births in the low risk areas this is undertaken for any unexpectantly compromised infant.

During review of the Trust’s Quality strategy and priorities for improvement in quarter 3, it was determined that it would be better to use a measure based on actual harm against the Trusts goal to reduce harm, rather than moderately accurate predictors. The decision was made to use the incidence of Grade 2/ 3 hypoxic ischaemic encephalopathy as the measure and cease reporting of this Cord pH measure in future quality reports.

Why this is important / what difference does this make to patients?

The cord blood pH analysis is a measure of a baby’s condition at birth. All babies born with low cord blood pH (less than 7.00) require paediatric review and possible admission to the neonatal unit for observation.

Progress made in report period 2014-15

Monthly percentage incidences **(Data source: Meditech / Clinical coding)**

Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Av.
2014/15	0.39	0.59	0.39	0.56	0.36	0.17	0.16	0.90	0.56	0.37	0.80	0.35%	0.46
2013/14	0.41	1.01	0.66	0.39	0.37	0.37	0.59	0.39	0.20	0.00	0.41	0.57	0.45

The Liverpool Women’s NHS Foundation Trust considers that this data is as described for the following reasons. The trust performance against this standard is within expected limits when compared to other organisations. Analysis of identified cases shows that care is appropriate.

How progress to achieve the priority goal is monitored and measured

The data is produced automatically on or around the 5th of each month from the information team. The data is presented and monitored at the Intrapartum working group and actions escalated to the Maternity clinical group.

The individual service areas are responsible for managing quality priorities and indicators of relevance to them and are required to report on them monthly to their local Quality Improvement forum in a standardised format dashboard.

How progress to achieve the priority goal is reported

It is the trusts intention to replace this metric with another marker of perinatal outcome Hypoxic Ischaemic Encephalopathy, it will remain part of the maternity dashboard.

2.1.1.6 Episodes of late onset (>72hr) bloodstream infection in preterm babies / To achieve a proportion of preterm babies who develop a late-onset bloodstream infection below the median benchmarked against the VON-UK network.

Description

Though originally described as episodes in the 2013-14 Quality Report commitment for reporting, this measure is presented below as the proportion of inborn babies below 30 weeks' gestation admitted to the neonatal unit that have one or more episodes of late-onset bloodstream infection. This revised descriptor protects the measure from activity related fluctuations and also ensures parity with the VON benchmark.

Why and how this priority goal was selected

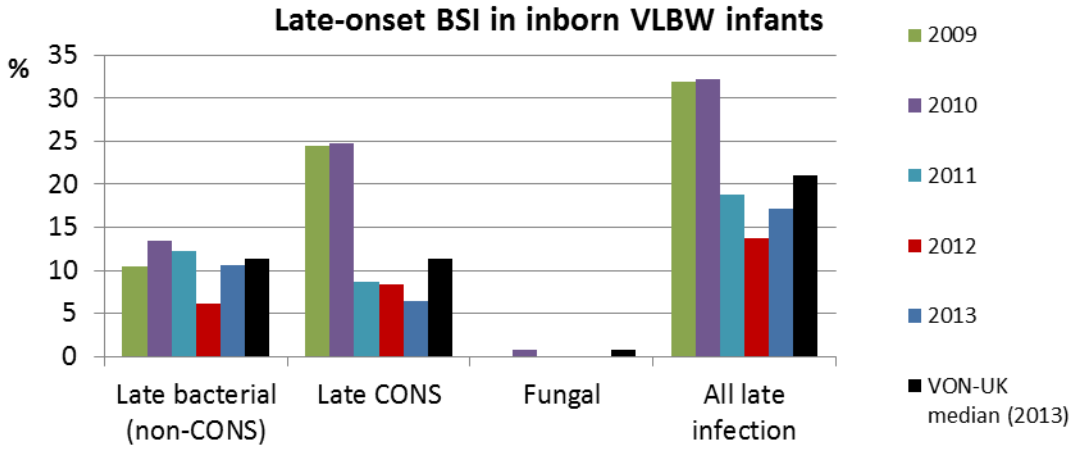
Late-onset neonatal infection is an important, but potentially avoidable, complication of preterm birth. Premature babies below 30 weeks are the most vulnerable to bloodstream infections and in whom infection has the potential to cause significant morbidity and mortality.

Why this is important / what difference does this make to patients?

Because it is a marker of quality of neonatal care which impacts on various short and long-term clinical outcomes such as mortality and chronic lung disease. It is widely accepted that bloodstream infections are an important indicator of performance and infection rates are collected nationally as part of the National Neonatal Audit Programme.

Progress made in report period 2014-15:

The latest data currently available to us comes from the Vermont Oxford Neonatal Network (VON) for the calendar year 2013. Data from 2014 will not be reported until September 2015.



Data Source: VON network BSI – Blood Stream Infection; VLBW = Very Low Birth Weight; CONS = Coagulase Negative Staphylococcus (infections) - A group of bacteria most commonly responsible for infections in infants.

The Liverpool Women's NHS Foundation Trust considers that this data is as described for the following reason(s):

- Data are collected through the Badger electronic patient record and microbiology databases.

The rate for all late bloodstream infections (and the individual components therein) was below the median value for VON-UK units. Given that our population of admitted babies is likely to be smaller and sicker than most of the other units represented in the VON-UK collaboration, this is a satisfactory position. Although the overall rate is higher than the previous year, this is likely to represent background variation rather than a true increase in infections.

How progress to achieve the priority goal is monitored and measured

Data are collected through the Badger electronic patient record and microbiology databases. Bloodstream infection is defined by VON as a pure growth of a known pathogen or a skin commensal/mixed growth with one or more clinical signs treated with a five day course of antibiotics.

The individual service areas are responsible for managing quality priorities and indicators of relevance to them and are required to report on them monthly to their local Quality Improvement forum in a standardised format dashboard.

How progress to achieve the priority goal is reported

As described in the Trust's Quality Strategy, service level quality improvements forum(s) report quarterly to the Clinical Quality Governance Committee, who raise exceptions and concerns with the Operational Board and report quarterly to the Governance and Clinical Assurance sub-committee, which in turn reports biannually to the board. Thus the Trust's Clinical Quality Governance Committee and ultimately the Board have an overview of the delivery of the work streams in respect of this and all quality priorities and indicators.

This measure is not reported externally.

There are no changes planned for 2015/16.

2.1.1.7 Total episodes of bloodstream infection (early and late) in all neonates (term and pre-term)

Whilst the Trust declared in section 2.2.1 of the previous quality that it intended to report against this measure as described, a clinically led review of our Quality Strategy determined that the best indicators for early infection were those reported elsewhere in this report with an associated 'activity level' denominator to make a rate or proportion accounting for the impact of admission numbers This measure was of little value, hence the Trust has made the decision to retire this measure without reporting in 2014-15 and to report and retain the other infection related measures which offer the added benefit of available benchmark data in 2015-16.

2.1.2 Clinical Effectiveness

2.1.2.1 Mortality Rate in Gynaecology/ To have no non-cancer related deaths in Gynaecology.

Delivered by using Serious Incident review, Morbidity and Mortality meetings and staff education bulletins to ensure any lessons from such rare events are learnt by all staff.

Description

In previous years this has been reported as the number of Gynaecology Inpatients that have died expressed as a proportion of all Gynaecology Inpatients. During the clinical review of the trusts Quality Strategy it was determined that with an increasing number of gynaecological oncology patients opting to benefit from the Trusts provision of End of Life care, it was more appropriate to focus on ensuring there were no non-cancer related deaths.

Why and how this priority goal was selected

This is a local mortality Indicator used in place of unavailable national Standardised Hospital Mortality Index data for this Trust. Mortality data is crucial for all hospitals, and is an important focus of our Gynaecological Oncology service.

This indicator was identified as a measure to monitor progress with the Trust's second Priority – To Reduce Mortality as it reports on avoidable mortality within Gynaecology.

Why this is important / what difference does this make to patients?

How we help and deal with our patients who have serious or terminal diseases is so important both in our dealings with the clinical issues around their care, but also in terms of the support and assistance we give to the patients and their families during this time. There is no formal staff or patient involvement in determining the data collected, but a concern raised by the hospital Mortality data would be important information for the Oncology team to review.

Progress made in report period 2014-15

Historic Data	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2013/14	0.00%	0.19%	0.10%	0.00%	0.18%	0.00%	0.00%	0.09%	0.00%	0.09%	0.27%	0.35%
2012/13	0.30%	0.29%	0.00%	0.09%	0.30%	0.10%	0.00%	0.09%	0.00%	0.18%	0.20%	0.19%

Data source: CHKS

There have been 13 deaths in the Liverpool Women's Hospital Gynaecology department over the past year, out of almost 12,000 admissions – a mortality rate of 0.11%. All of these patients were treated by the Gynaecological Oncology team with suspected or terminal Gynaecological cancers. There was only one non-cancer related death and this was the subject of a Serious Incident Review. The conclusion was that the death could not have been avoided, but changes in practice particularly around Safeguarding have been implemented as a result of the review.

There is no specific target relating to the hospital mortality data, and indeed with the Mulberry and Orchid Suites on Gynaecology Ward 1 there are many of our patients who choose to spend their last days

supported by the Gynaecology nursing and medical staff they have come to know. All hospital deaths are reviewed within the Gynaecological Oncology MDT to ensure all care and actions were appropriate.
The Liverpool Women's NHS Foundation Trust considers that this data is as described for the following reasons:

- The data is compiled from in-house death certification records.

How progress to achieve the priority goal is monitored and measured

The individual service areas are responsible for managing quality priorities and indicators of relevance to them and are required to report on them monthly to their local Quality Improvement forum in a standardised format dashboard.

How progress to achieve the priority goal is reported

As described in the Trust's Quality Strategy, service level quality improvements forum(s) report quarterly to the Clinical Quality Governance Committee, who raise exceptions and concerns with the Operational Board and report quarterly to the Governance and Clinical Assurance sub-committee, which in turn reports biannually to the board. Thus the Trust's Clinical Quality Governance Committee and ultimately the Board have an overview of the delivery of the work streams in respect of this and all quality priorities and indicators.

There is no target or aim for the hospital mortality rate, as the vast majority of deaths are in known cancer patients in the palliative phase of their care, and most of whom chose the Liverpool Women's Hospital as their Preferred Place of Care for their final days. One palliative care death in a patient with suspected cancer was the subject of a Serious Incident review, but all deaths within the hospital are reviewed to ensure the appropriate action was taken.

2.1.2.2 Biochemical Pregnancy Rates: Invitro fertilisation (IVF), Intracytoplasmic sperm injection (ICSI) and Frozen embryo transfer (FET)

Description:

The number of positive pregnancy tests per number of embryo transfers for a given time period. Whilst live birth rate data is most important to an infertile couple, the biochemical pregnancy rate is a more immediate reflection of how a fertility laboratory is performing. This. Indicator was previously reported aligned to the technique applied, here it is reported by technique and as an aggregate percentage.

Why and how this priority goal was selected:

This is the most useful and rapidly obtainable marker of how the whole system (drug stimulation, egg quality, lab performance) is working.

We submit, as we are required, to the HFEA fertility regulator data for each licensed treatment episode on different aspects of the couples care. These are then benchmarked nationally. The Hewitt Fertility Centre management selected this required measure as one of its Quality Indicators, whilst not involved in this selection the indicator is clearly of interest to those who have need of fertility services.

Why this is important / what difference does this make to patients?

Couples do not choose to go for IVF treatment. When they need to, they have a right to know that they are to be well cared for and are most likely to achieve a family in their clinic of choice.

Progress made in report period 2014-15

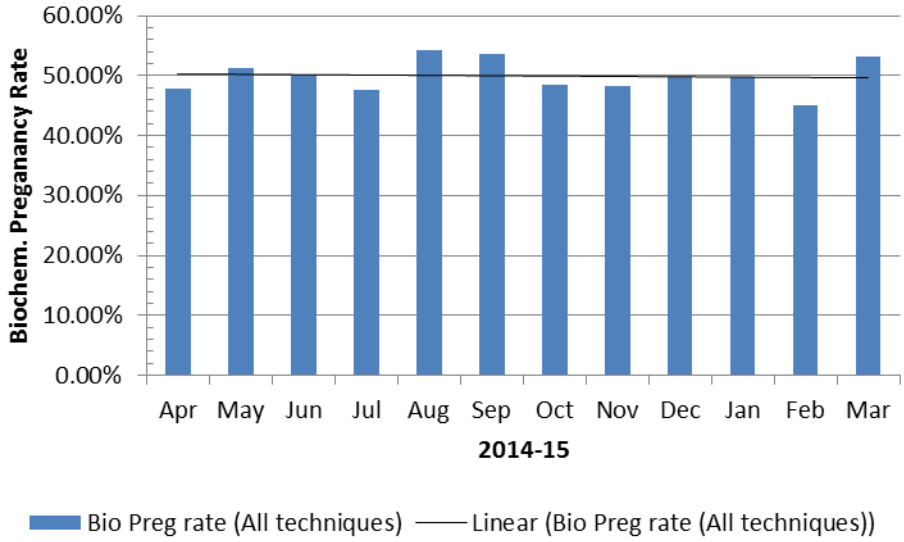
IVF	% of Embryo transfers with positive pregnancy test												
Year	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Av.**
2014/15	48.2	52.2	56.5	47.1	47.1	46.4	57.1	47.4	58.3	42.9	53.2	N/A	-
2013/14	53.8	43.9	48.8	43.9	48.0	39.0	48.8	34.4	50.0	46.0	56.4	52.1	47.1

ICSI	% of Embryo transfers with positive pregnancy test												
Year	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Av.**
2014/15	51.9	58.5	52.1	52.5	58.8	58.0	50.0	43.3	55.6	41.2	49.2	N/A	-
2013/14	43.5	43.2	50.9	42.9	48.4	54.4	50.7	45.2	25.0	51.0	48.5	49.3	46.1

FET	% of Embryo transfers with positive pregnancy test												
Year	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Av.**
2014/15	42.9	51.9	51.9	44.2	40.7	45.6	39.3	44.1	48.6	54.7	45.7	N/A	-
2013/14	47.4	55.6	38.6	49.1	34.0	56.7	35.0	52.3	36.4	46.2	47.5	49.3	45.7

Aggregated Pregnancy rate from all techniques:

The chart below demonstrates that the Hewitt Centre has maintained its achieved pregnancy rates over the reporting period. In the last 12 months we have attracted patients from over 45 different catchment areas in the UK. As the pregnancy rate achieved by the unit is amongst the best nationally and internationally, this indicator has been retired as a quality improvement priority for the Trust and whilst data will still be collated and submitted to HFEA, it will not be reported in future Quality Reports.



Data source: IDEAS data base, Hewitt Centre, LWFT

The Liverpool Women's NHS Foundation Trust considers that this data is as described for the following reasons:

- It is a regulatory requirement to collect and submit specified live data to the HFEA.

How progress to achieve the priority goal is monitored and measured

The number of positive pregnancy tests per number of embryo transfers for a given time period, as recorded on the Hewitt Fertility Centres 'IDEAS' database and delineated by technique. Once treatment is initiated, data is submitted externally to the HFEA before the eventual outcome is known.

How progress to achieve the priority goal is reported

Pregnancy rate data is shared internally at the Hewitt Centre monthly Quality meeting and executive meeting, 6 monthly at the Trust Clinical Governance meeting and externally with the HFEA continually. The Liverpool Women's NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, by:

- Investing heavily in state of the art laboratory facilities with the latest developments on time lapse imaging and other innovations. This has borne fruit and resulted in better than ever before pregnancy rates across all age groups.

2.1.2.3 Brain injury in pre-term babies (Severe Intraventricular haemorrhage and Preventricular leukomalacia)/ To reduce the number of very low birth weight babies (<1500g) who have ultrasound evidence of periventricular haemorrhage (grade 3 or 4) or periventricular leukomalacia to be in the lowest quartile of benchmarking peers (VON)

Description:

The proportion of surviving inborn very low birth weight (birth weight below 1500g) babies cared for at Liverpool Women's Hospital who have ultrasound evidence of severe periventricular haemorrhage (grade 3 or grade 4) and/or periventricular leukomalacia. Data are reported by calendar year to allow benchmarking with the rest of the Vermont Oxford Neonatal Network (VON).

Why and how this priority goal was selected:

Neurological disability as a consequence of perinatal brain injury is an important adverse outcome in babies who survive preterm birth. Many of the VLBW babies born here are followed up at other hospitals. There is no national system for recording information on preterm babies, so monitoring disability rates in children who have been cared for on our unit is difficult.

Cranial ultrasound examination should be performed on all babies with a birth weight <1501g during their period on the neonatal unit to look for evidence of brain injury (periventricular haemorrhage (PVH) or periventricular leukomalacia (PVL).

Cranial ultrasound abnormalities can predict serious disability reasonably accurately, so these are used here as a surrogate marker for disability rates.

Important because:

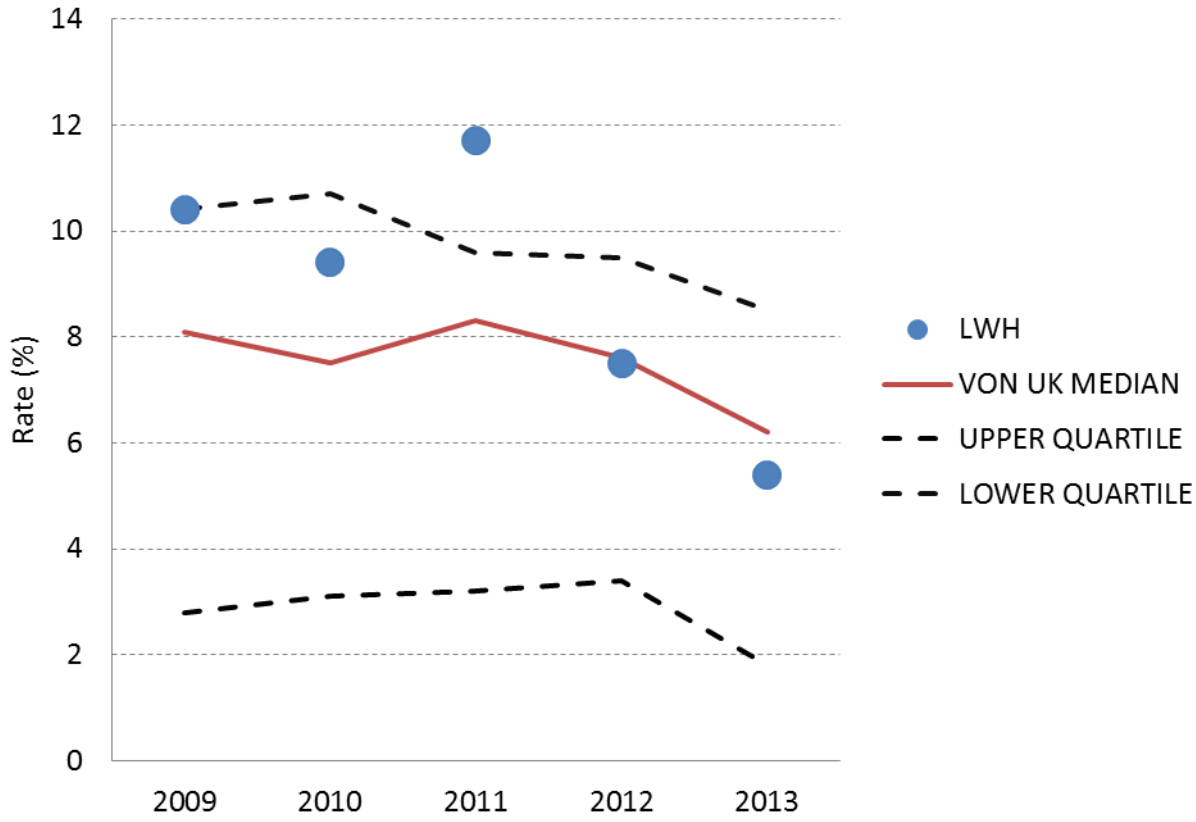
Neurological disability is an important adverse outcome in children who survive preterm birth. It has implications for the individual and the family as well as health and educational services. The quality of care provided in the perinatal period may impact on the incidence of these injuries. Monitoring and benchmarking these outcomes for our babies allows us to ensure that the high quality of care that we provide is being maintained.

Progress made in report period 2014-15

The proportion of VLBW babies with ultrasound evidence of perinatal brain injury continues to decrease across time.

The unit is a member of VON and the rates of severe PVH and PVL are benchmarked against the rest of the network. The most recently published VON data are from the year 2013.

The rate of major periventricular haemorrhage and PVL in inborn babies born with a weight between 500g and 1500g and cared for at LWH has fallen each year over recent years and is now below the median for the 38 neonatal units across UK that benchmark using the VON system (Charts 1 and 2).



Source: Vermont Oxford Neonatal Network (VON).

Chart1. Rate of major IVH in babies born at and cared for at LWH with a birth weight between 500g and 1500g between 2009 and 2013 compared to other VON-UK centres.

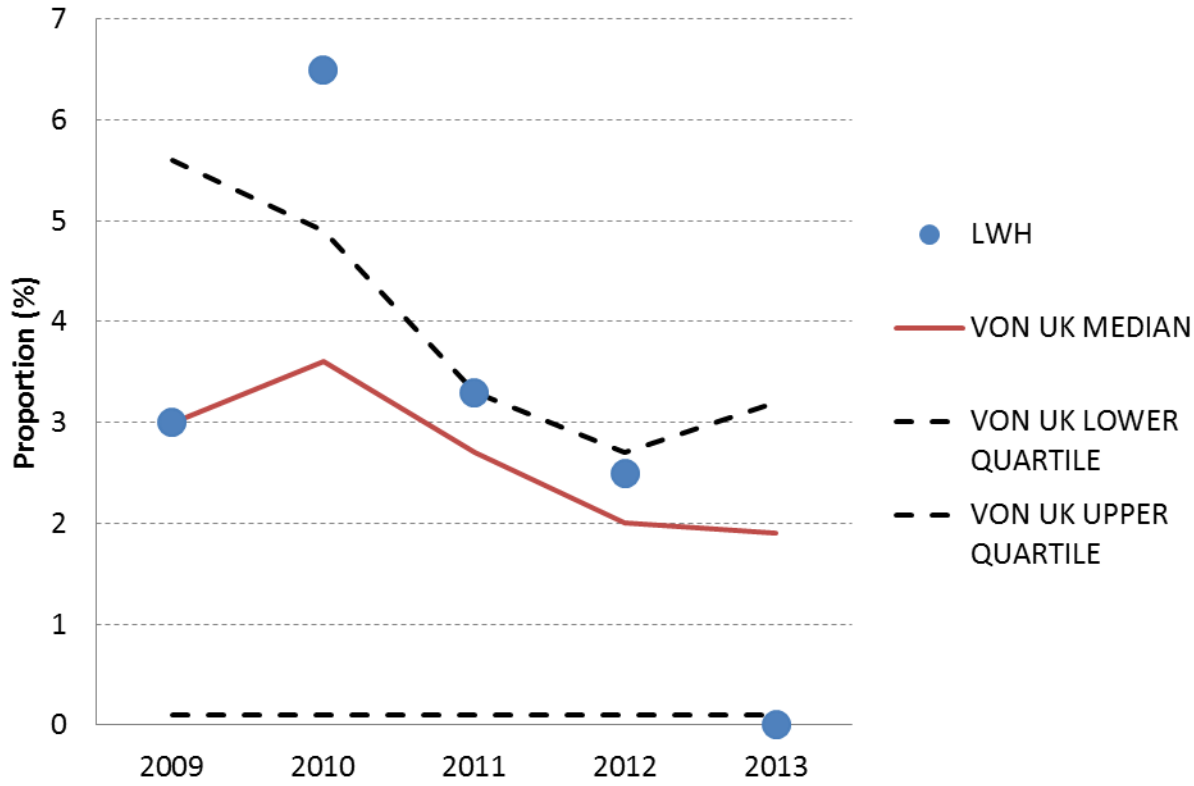


Chart 2. Rate of PVL in babies born at and cared for at LWH with a birthweight between 500g and 1500g between 2009 and 2013 compared to other VON-UK centres.

The Liverpool Women's NHS Foundation Trust considers that this data is as described for the following reason(s):

- These data are collected in and abstracted from the Neonatal Unit information system (Badger) and submitted to the VON network for independent analysis and benchmarking.

How progress to achieve the priority goal is monitored and measured

These data are collected in and abstracted from the Neonatal Unit information system (Badger system) before submission to VON. There is a robust system to ensure data completeness and validity in the collection of these data. The VON analysis is from the VON "Nightingale" system.

How progress to achieve the priority goal is reported

The VON data are reviewed as part of the VON annual report. These are reviewed and discussed at the Clinical Governance meeting within the unit. The data are also reported to the trust Clinical Governance Committee and discussed in that forum.

The Liverpool Women's NHS Foundation Trust intends to take the following actions to improve this indicator, and so the quality of its services, by continued monitoring and implementation of new evidence based interventions to prevent or reduce preterm perinatal brain injury as they become available.
In the longer term, we would hope to be able to report disability rates as national neonatal data collection systems are developed.

2.1.2.4 Neonatal Mortality/

To deliver our risk adjusted neonatal mortality (deaths within 28 days of birth following a live birth) within 1% of the national Neonatal Mortality Rate as published by ONS.

Description:

1. Death within 28 days of birth following live birth at Liverpool Womens Hospital, or home birth under the care of LWH during the calendar year 2014.

2. Survival to discharge for inborn babies born in the calendar year 2014 with a birth weight between 500g and 1500g.

Why and how this priority goal was selected:

Neonatal mortality is accepted to be a useful indicator of the effectiveness of a perinatal healthcare system.

1. National data for neonatal mortality by gestation are published annually by the Office for National Statistics and we have used these for benchmarking purposes. The most recent data are those from 2012, published in October 2014.

2. Survival to discharge for preterm babies is an important indicator of the quality of neonatal care. We are members of the Vermont Oxford neonatal network. This allows us to benchmark our mortality figures against 30 other UK Neonatal Units.

Important because:

2/3rds of infant deaths occur in the neonatal period. 2/3rds of neonatal deaths occur in babies born before 31 weeks gestation. The neonatal service at LWH cares for one of the largest populations of preterm babies in the NHS. It is important that survival of these babies is monitored to ensure that the quality of the care that we are providing is maintained

Progress made in report period 2013-14

There were 8380 live births in the Trust in 2014. 53 of these babies died in the first 28 days of life, including 9 babies who died following transfer to Alder Hey Children's Hospital either for surgical treatment of necrotising enterocolitis (2) or with life threatening cardiac malformations (7). This gives an overall Neonatal Mortality rate (NNMR) of 6.3/1000. This is higher than the ONS rate of 2.7/1000 in 2012. There are three main drivers for the high rate of NNMR in babies born at LWHFT.

1. **The specialist nature of the services provided within the Trust attracts a large number of high risk pregnancies**. The Trust provides a regional centre for fetal medicine and neonatal intensive care. There are a number of women who initially book for maternity care at other trusts that subsequently deliver at LWH because of antenatally diagnosed fetal malformations or medical complications of pregnancy. These are high risk pregnancies. There were 138 such deliveries in 2014 and 12 of these babies died (NNMR 87/1000). If these are excluded from the analysis, so that

only babies born to women who were initially booked for antenatal care at this Trust are considered, the NNMR for 2014 was 5/1000.

2. **There is a greater readiness to acknowledge live birth at pre-viable gestations at LWHFT than elsewhere across England and Wales**. There were 17 babies born alive at pre-viable gestations (before 23 completed weeks) at LWHFT in 2014. This is 2/1000 live births. This is three times higher than the rate of 0.6/1000 reported across England and Wales in the ONS data. These babies account for 41% of the neonatal deaths at LWHFT. We believe that our practise in acknowledging these lives is technically and ethically correct and is an important part of helping the families that we care for to cope with these bereavements.

3. **There is a high rate of preterm birth within our booked population because of the high levels of deprivation in the population that we serve.** Babies born at gestations between 23 and 31 weeks account for 54% of neonatal deaths across England and wales. The proportion of live births between 23 weeks and 31 weeks gestation within the 'booked' population at LWHFT was 1.6%. This is 50% higher than the rate of 1.1% seen across England and Wales. There is a well described relationship between social deprivation and prematurity. 2/3ds of women delivering babies at LWHFT live in post code areas with a social deprivation score within the poorest 20% of the UK population.

The gestation corrected NNMR for all live births at LWHFT in 2014 is 2.6/1000, which is the same as the rate reported by ONS. These data are shown in Table 1.

	2011	2012	2013	2014
Live births (Total)	8430	8506	8112	8380
Live births (from booked pregnancies)	8252	8359	7984	8235
Neonatal deaths (all live births)	45	42	37	53
Neonatal deaths (from booked pregnancies)	29	30	22	41
NNMR (all live births)	5.3	4.9	4.6	6.3
NNMR (booked pregnancies)	3.5	3.6	2.8	5
UK NNMR	3	2.7	-	-
LWH gestation corrected NNMR (all live births)	3.2	3.2	2.8	3.3
LWH gestation corrected NNMR (booked pregnancies)	3.7	2.3	2.3	2.6

Table 1: Neonatal Mortality rate for babies born at LWH over the preceding 4 years; comparison with UK rates and the effect of adjusting for case mix.

Survival to discharge for babies with birth weights between 500g and 1500g born at and cared for in LWH has improved over recent years (Table 2). We benchmark our outcomes against the other 38 UK neonatal units that make up the VON-UK network. The latest published VON figures relate to the year 2013. In comparison to the rest of the VON-UK network survival at LWH has improved with Mortality levels moving from the upper quartile to just above the median (Chart 1).

Year	Inborn	Survived to discharge	Survival (%)
2009	165	131	79.4
2010	156	123	78.8
2011	149	121	81.2
2012	121	100	82.6
2013	126	108	85.7
2014	154	132	85.7

Table 2. Survival to discharge for babies born at LWH with a birth weight between 500g and 1500g.

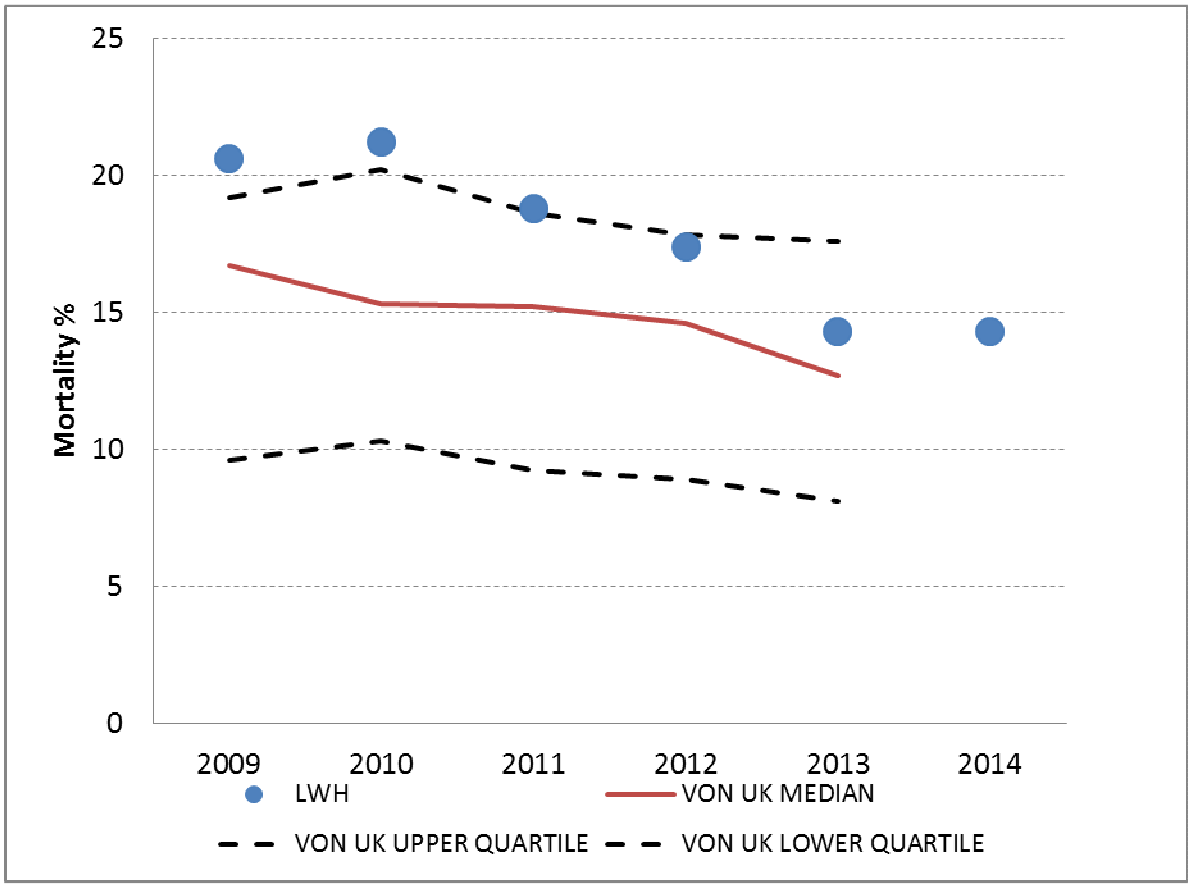


Chart 1 – Survival to discharge for babies with birth weight 500g to 1500g born and cared for at LWHFT compared to the rest of the VON-UK network.

The Liverpool Women's NHS Foundation Trust considers that this data is as described for the following reason(s):

- Data are collected from Trust Information systems (i.e. Meditech and Badger systems).
- To ensure completeness, additional data are sought from Alder hey hospital to ascertain neonatal survival for babies transferred there within the first 28 days of life.

How progress to achieve the priority goal is monitored and measured

Data are collected from Trust Information systems (Meditech and Badger system). Additional data are sought from Alder hey hospital to ascertain neonatal survival for babies transferred there within the first 28 days of life.

Benchmarking data are collected from the Office for National Statistics website (http://www.ons.gov.uk/ons/index.html) and from the Vermont Oxford Network "Nightingale" system.

How progress to achieve the priority goal is reported

Neonatal mortality is reported each month on the neonatal dashboard and reviewed by the Neonatal MDT. A prospective system is in place to review each death in order to identify learning points that can drive service improvements.

The Liverpool Women's NHS Foundation Trust has taken the following actions to improve this indicator, and so the quality of its services; by increasing the number of hours per week with a neonatal consultant on site, prospective review of all deaths and prioritising a reduction in nosocomial infection.

2.1.2.5 Stillbirth Rate

Description:

The number of babies born stillborn expressed as a percentage of all babies born.

Why and how this priority goal was selected:

This indicator was originally chosen by the directorate following a multidisciplinary discussion at the division meeting about what was highest impact. Whilst there was no direct patient and public involvement- the impact of the selected Maternity indicators (Apgar score <4 at 5mins, Cord pH <7.0 in liveborns >24 weeks gestation and Stillbirths) are common reasons for patient complaints and litigation locally and nationally.

The Trust's rates for stillbirth are within the expected range for the UK however the stillbirth rate in the UK is one of the high compared to many other European countries. The Trust is therefore committed to try to reduce the stillbirth rate for the women we look after.

Why this is important / what difference does this make to patients?

The impact of stillbirth on families is impossible to quantify. On occasion when a stillbirth is reviewed it is felt that an alternative management plan may have altered the outcome. It is the trusts aim to reduce the number of these cases to the lowest level possible for our patients through the monitoring of our stillbirth rate, the reviewing of cases and the implementation of any identified care improvement opportunities**.**

Progress made in report period 2014-15 **(Data Source: Meditech / Clinical Coding)**

Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014/15	0.61%	0.46%	0.50%	0.45%	0.56%	0.49%	0.49%	0.49%	0.58%	0.52%	0.51%	0.49%
2013/14	0.67%	0.25%	0.28%	0.51%	0.69%	0.12%	0.25%	0.63%	0.97%	1.15%	1.12%	0.63%

The Liverpool Women's NHS Foundation Trust considers that this data is as described for the following reasons. The trust in 2014/15 implemented two strategies to decrease the stillbirth rate.

1. Implementation of a new guideline on the management of women experiencing decreased fetal movements, with the addition of new patient information to raise awareness.

2. The Implementation of GROW a package designed to identify those women at risk of growth restriction and implement serial growth scans to identify small babies and the implementation of the customised growth chart which is thought to be better at detecting small babies. These measures are designed to allow timely intervention if growth restriction is identified.

How progress to achieve the priority goal is monitored and measured.

A report identifying births and whether or not they were live or still born is run each month. For 2014/15 a target was calculated as the average percentage for 2013/14 which was 0.61%. This metric has no exclusions based on gestation or late transfers. The calculation used is shown below:-

$$\frac{\textit{number of babies still born}}{\textit{total number of births}} \times \textit{100} = \textit{\% Still births}$$

If there is a 'breach' of the target, the service are required to produce an action plan, highlighting a) reason(s) for the occurrence and b) actions to reduce occurrence. However, there were no breaches of this target in 2014/15. If an exclusion criteria based on late transfers in is applied the data for 2014-15 is shown.

How progress to achieve the priority goal is reported

The individual service areas are responsible for managing quality priorities and indicators of relevance to them and are required to report on them monthly to their local Quality Improvement forum in a standardised format dashboard

As described in the Trust's Quality Strategy, service level quality improvements forum(s) report quarterly to the Clinical Quality Governance Committee, who raise exceptions and concerns with the Operational Board and report quarterly to the Governance and Clinical Assurance sub-committee, which in turn reports biannually to the board. Thus the Trust's Clinical Quality Governance Committee and ultimately the Board have an overview of the delivery of the work streams in respect of this and all quality priorities and indicators.

The on-going audit on stillbirths led by Dr Roberts has indicated that there is a small decline in the number of stillbirths but that the stillbirths related to Small for Gestational Age babies appear to be over represented within the data. Hence the current initiatives are largely aimed at reducing the risk of stillbirth in this group. It is our intention to replace the cumulative stillbirth rate with the proportion of stillbirths that are attributable to Small for Gestational Age.

2.1.3 Care indicators for Nursing & Midwifery

The Trust declared 5 priority indicators in the 2013-14 Quality Report, performance against these indicators is reported in this section.

2.1.3.1 36 week Antenatal Risk assessments

Description

The 36 week antenatal assessment should be offered to all women who reach this gestation of pregnancy. It is a method of assessing clinical / social risk factors pertaining to choices around place of birth and the early postnatal period and giving the woman the opportunity to plan for her birth taking into account any identified issues.

Why and how this priority goal was selected

The 36 week antenatal assessment was chosen as a quality indicator as this is an ideal opportunity to discuss and plan the mother's wishes for birth and the early postnatal period in conjunction with a thorough risk assessment to identify any factors that may affect her choices.

With the aim of keeping the woman at the centre of her care provision it is anticipated that the woman will have a more positive birth experience by taking into account any risk factors that may affect her choices, a birth plan can be created in a partnership between the woman and the midwife, the assessment allows the time for many important issues such as infant feeding in line with the Baby Friendly Initiative choice of place of birth and strategies for coping with pain, recognising labour. Following the birth early postnatal issues for mum and baby including emotional wellbeing can be discussed.

The 36 week assessment tool is reviewed on a regular basis to ensure effectiveness and is circulated to local maternity services liaison committees to ascertain service user views.

Why this is important / what difference does this make to patients?

The 36 week assessment is clearly defined in the appointments plan for pregnancy in the handheld notes, more time is given to the appointment and can be carried out in the woman's home giving the woman the opportunity to discuss practical issues such as baby's sleeping place or if considering home birth as part of her birth plan suitability of her chosen area can be discussed. At this stage of pregnancy birth is close so women value the opportunity to be able to make their plan and the midwife is able to identify any risks that may affect her choices. The service user experience is enhanced by the opportunity to make a birth plan as any concerns and worries can be resolved and choices can be recorded. In turn this can help the woman to feel empowered and have an element of control in her care.

Progress made in report period 2014-15

Compliance rates (%)

	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec14	Jan 15	Feb 15	Mar 15
36 week choice of birth discussion took place	91.42	100		100	88.57	83.33	100	55.55	100	70	91.66	

Key:	Less than 80%		80-89.99%		90-100%	

Data source: LWFT 'NUMIS' information system

The Liverpool Women's NHS Foundation Trust considers that this data is as described for the following reason(s):

- Data is collected directly from the information system and reflects the number of women per month who have choice of place of birth discussed .This information is monitored closely by the Maternity service leads.

How progress to achieve the priority goal is monitored and measured

A Meditech report can be generated that describes the woman's choice of place of birth and whether it was achieved. Local notes audits reflect the quality of the 36 week assessment.

The individual service areas are responsible for managing quality priorities and indicators of relevance to them and are required to report on them monthly to their local Quality Improvement forum in a standardised format dashboard.

How progress to achieve the priority goal is reported

As described in the Trust's Quality Strategy, service level quality improvements forum(s) report quarterly to the Clinical Quality Governance Committee, who raise exceptions and concerns with the Operational Board and report quarterly to the Governance and Clinical Assurance sub-committee, which in turn reports biannually to the board. Thus the Trust's Clinical Quality Governance Committee and ultimately the Board have an overview of the delivery of the work streams in respect of this and all quality priorities and indicators.

The Liverpool Women's NHS Foundation Trust has taken the following actions to improve this indicator], and so the quality of its services, by:

- Reviewing community services and ensuring that choice of place of birth is fully risk assessed and discussed with all women.
- Midwives will work to ensure that this antenatal visit is given enough time to reassure women as to their choice of place of birth and discuss options fully.
- Women are offered home birth or birth in the Midwifery Led Unit if suitable . On transfer home from hospital midwives record onto the data system whether preferred choice of place of birth has been achieved.

2.1.3.2 One to One Care in Labour

(See section 2.1.4.1 in Patient Experience section below).

2.1.3.3 Avoidable repeats for Antenatal screening and newborn screening blood sampling

Description

This is the number of babies having to undergo an avoidable newborn blood spot repeat expressed as a percentage of all newborn blood spots performed during that time period. These are 'avoidable' because they are for reasons such as quality of blood spot and/or documentation errors by the clinician performing the blood spot. All babies undergo the newborn blood spot at 5-8 days of age in order to screen for 9 conditions that if left untreated can be debilitating, but if caught early by this screening programme, can lead to a healthy life with the right treatment and pathways.

Why and how this priority goal was selected

This goal was selected as it is a UK wide nation screening target set by the Public Health England commissioning body for screening (UK NSC), in order to reduce the number of avoidable repeats for newborn blood spots to less than 1%. We adhere to this nationwide set target in this Trust. It is important to the Trust for the mum's and babies that this target is reached and improved upon.

Why this is important / what difference does this make to patients?

This target is important and makes a vast difference to babies and their parents due to the unacceptable level of avoidable repeats. As this is set to a national standard by the UKNSC this is something every Trust is working towards. Avoidable repeats create distress to the baby, the parents and indeed the midwife. In order to treat these conditions, if found; timeliness is of the essence. An avoidable repeat delays that process. We are striving to achieve an acceptable <1% avoidable repeat rate.

Progress made in report period 2014-15

Q1	Q2	Q3			Q4		
		Oct	Nov	Dec	Jan	Feb	Mar
45 **2145**	50 **2271**	12 **816**	19 **708**	12 **705**	14 **675**	15 **673**	11 **785**
2.10%	**2.20%**	**1.93%**			**1.90%**		

Data Source: Pathology Laboratories, Royal Liverpool Children's Hospital, Alder Hey.

The Liverpool Women's NHS Foundation Trust considers that this data is as described for the following reasons: it is received directly from the Alder hey labs were the samples are sent and audited. The Antenatal & Newborn Screening Coordinator receives these figures monthly and quarterly and informs the local Trust Performance & Information team and Public Health England Screening & Immunisations teams.

How progress to achieve the priority goal is monitored and measured

All staff involved in conducting newborn blood spots are trained through observation, completing a competency pack, attending Alder hey lab for training and completing the UK NSC eLearning package. We have in place the Northgate newborn blood spot IT Failsafe system for daily checking that lab samples have been taken and not missed and have arrived at the lab in a timely fashion. This is checked daily by the community midwifery admin support and overseen by the screening coordinator.

Any avoidable repeats that come into the community office are addressed at the time by the team leader with the individual concerned. Also, the monthly figures from Alder hey are reported to the Antenatal & Newborn Screening Coordinator, along with names and areas of those creating the avoidable repeat. She then shares these figures and names with the team leaders and managers in each responsible area

(Community, postnatal wards & NICU). Any good work is praised and those with avoidable repeats are addressed by a three point management plan to address any training issues identified, supervisory concerns and suspension of undertaking newborn blood spots if necessary.

The individual service areas are responsible for managing quality priorities and indicators of relevance to them and are required to report on them monthly to their local Quality Improvement forum in a standardised format dashboard.

How progress to achieve the priority goal is reported

As described in the Trust's Quality Strategy, service level quality improvements forum(s) report quarterly to the Clinical Quality Governance Committee, who raise exceptions and concerns with the Operational Board and report quarterly to the Governance and Clinical Assurance sub-committee, which in turn reports biannually to the board. Thus the Trust's Clinical Quality Governance Committee and ultimately the Board have an overview of the delivery of the work streams in respect of this and all quality priorities and indicators.

All avoidable repeats are reported locally to the Trust Performance and Information Team and RAG ratings created with Action Reports created for any concerns. They are reported quarterly to Public Health England (PHE) and the Screening Coordinator liaises with them regularly for timely action and communication. These figures are benchmarked across the northwest via the PHE Screening & Immunisations lead.
The Liverpool Women's NHS Foundation Trust has taken the following actions to improve this avoidable repeat rate, and so the quality of its services, by the management and failsafe actions as above.

2.1.3.4 'Skin to Skin'

Description

The percentage of babies who receive skin to skin contact following birth for at least one hour or until completion of the first feed.

Why and how this priority goal was selected

This indicator was chosen as a priority for 2014-15 due to the commitment to improve our breast feeding initiation rate and the known benefits to mothers and babies. The data has demonstrated that we are not consistently meeting our target of 76% and we are committed to achieving this.

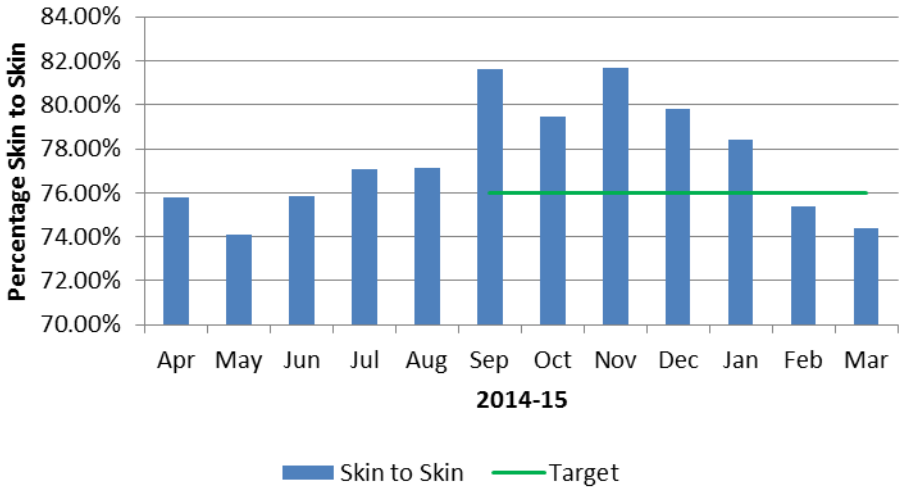
Why this is important / what difference does this make to patients?

An immense amount of research on the value of skin to skin contact has been done into mother and baby bonding as well as health and infant development. Babies need to be close to their mothers in order to trigger certain instincts and brain functions and mothers need to be close to their babies to encourage the release of natural hormones necessary for milk production.

The immediate benefits of skin to skin for babies include stabilising body temperature, heart rate and blood pressure. It can reduce crying up to ten times. Baby is more likely to latch on and breast feed and for longer. Baby has less stress and has higher blood sugars. Hormones released during the skin to skin contact encourage the unique bonding between mother and child and are important in the development of the infant's brain and nervous system.

Skin to skin contact is also an important element in the UNICEF Baby Friendly Initiative to promote breast feeding. The trust now has full accreditation of this Baby Friendly Award.

Progress made in report period 2014-15



Data Source: Meditech patient information system

The Liverpool Women's NHS Foundation Trust considers that this data is as described for the following reasons.

- Skin to skin contact is measured through reporting and documentation after the birth by the midwife. The Maternity Unit has recruited 25.5 whole times equivalent midwives within the last 12 months, we have identified that we require additional data support to support these new recruits. We have also identified that skin to skin contact in theatre requires some additional support, these two highlighted areas account for the drop in the % of babies reported as receiving skin to skin contact for at least one hour.

How progress to achieve the priority goal is monitored and measured

This target is monitored monthly through our performance dashboard and linked into breast feeding initiation rates. The data is retrieved through the 'Meditech' system from the delivery summary completed by the midwife after the birth.

Action plans are completed if the target is not achieved.

The individual service areas are responsible for managing quality priorities and indicators of relevance to them and are required to report on them monthly to their local Quality Improvement forum in a standardised format dashboard.

How progress to achieve the priority goal is reported

Progress and this target is discussed with all the staff responsible for initiating skin to skin contact at mandatory training and 1:1 Infant feeding sessions. This target is reported through the Maternity dashboard.

The Liverpool Women's NHS Foundation Trust intends to take the following actions to improve this percentage, and so the quality of its services, by:

- Improving communication to all staff about the importance and benefits of skin to skin contact and the recording of the data.
- Reviewing data collection and recording and engaging all stakeholders.
- Ensuring that we offer skin to skin for all mothers and babies if possible and the mother wishes to include the theatre and recovery setting.
- Promoting the benefits of skin to skin to mothers in the antenatal period.

2.1.3.5 Patients opting for surgical treatment of miscarriage undergo procedure within 72 hours of their decision

Description

This priority seeks to determine the time interval between the decision to undergo surgical treatment of miscarriage and the receiving that surgery against the stated aim that this should be provided within 72 hours.

Why and how this priority goal was selected

Delays in the pathway for surgical treatment of miscarriage were identified through both formal and informal complaints from patients. It was determined that this should be investigated by sample audit to determine the extent of the problem and identify potential opportunities for improvement.

Why this is important / what difference does this make to patients?

Patients and families whom experience a miscarriage face difficult choices at a difficult and distressing time. Ideally patients should be able to choose what treatment to have and unless they need emergency treatment, they should be given time to choose the best way forward for them. When patients have made their choice to have surgical management of miscarriage, we should be responsive to the patient's preference and be able to accommodate surgery in a timely manner to ensure their experience is a best as it can be.

Progress made in report period 2014-15

The Head of Nursing conducted an audit of 12 randomly selected case notes from the women identified as having undergone surgical treatment for miscarriage. The Audit was to identify for each case, the intervals between miscarriage awareness, time of the decision to proceed to surgery and the actual surgery and determine the adequacy of the record in respect of these data.

Average time between awareness of miscarriage and confirmation of surgical option	4 mins (Majority of cases were 0 mins)
Average time between decision and procedure	34 hrs.
Range of times between decision and procedure	0.5 hrs. – 77 hrs.
Procedures carried out within 72hrs of decision being made	90%

Data source: In house snap shot audit.

The Liverpool Women's NHS Foundation Trust considers that this data is as described for the following reasons. A small sample- 12 case notes were reviewed, time of confirmed miscarriage was obtained from Nursing and medical documentation within the patient's case notes. Some patients made their preference for surgical management known during their attendance at the point of diagnosis of miscarriage, whilst others required further time to go home and review their options. In patients whom took further time to consider their decision, documentation did not always record the time of contacting ER and making their preference known for surgical management.

Meditech theatre records were checked to confirm the date and time of arrival in theatre for surgical management of miscarriage.

One patient waited > 72hrs, however the decision was made on Friday and surgery scheduled for the following Monday.

How progress to achieve the priority goal is monitored and measured

Data was obtained from Clinical records to determine date and time of diagnosis of miscarriage, this was cross checked with clinic schedules, attendances and scan date and time.

Where patient's decisions for surgical management were made at point of diagnosis the time of this was noted and compared with the time Meditech identified the patient attending theatre. The hours elapsed were recorded to determine the times between the decision and procedure.

For in patients whom took further time to consider their decision, documentation regarding telephone contact from the patient expressing surgical management was obtained from telephone records. This was not always recorded and this omission in records made it not possible to determine waiting times in 2 incidences.

The individual service areas are responsible for managing quality priorities and indicators of relevance to them and are required to report on them monthly to their local Quality Improvement forum in a standardised format dashboard.

How progress to achieve the priority goal is reported

As described in the Trust's Quality Strategy, service level quality improvements forum(s) report quarterly to the Clinical Quality Governance Committee, who raise exceptions and concerns with the Operational Board and report quarterly to the Governance and Clinical Assurance sub-committee, which in turn reports biannually to the board. Thus the Trust's Clinical Quality Governance Committee and ultimately the Board have an overview of the delivery of the work streams in respect of this and all quality priorities and indicators.

The Liverpool Women's NHS Foundation Trust has taken the following actions to improve this indicator and so the quality of its services, by achieving the following:

- Additional emergency theatre lists to improve capacity and flexibility to respond to patients requiring surgery.
- Review of shift patterns through workforce review in theatre to improve ability to respond to demands for theatre capacity.

The Liverpool Women's NHS Foundation Trust intends to take the following actions to improve this indicator and so the quality of its services, by achieving the following:

- Progress the 7 day working initiative.
- Improve record keeping/ documentation of time of decision.
- Report via incident management system patients whom wait > 72hrs after making their preferred management choice known, and monitor this through established incident review processes.

2.1.4 Patient Experience

2.1.4.1 1:1 care in established labour provided to >=95% of women

Description:

The number of patients receiving one to one care during established labour expressed as a percentage of all maternity episodes of care. (Exclusions apply for patients with Elective Caesarean Section and emergency no labour Caesarean sections). This measure was introduced in June 2014, hence data is not available for April and May.

Why and how this priority goal was selected:

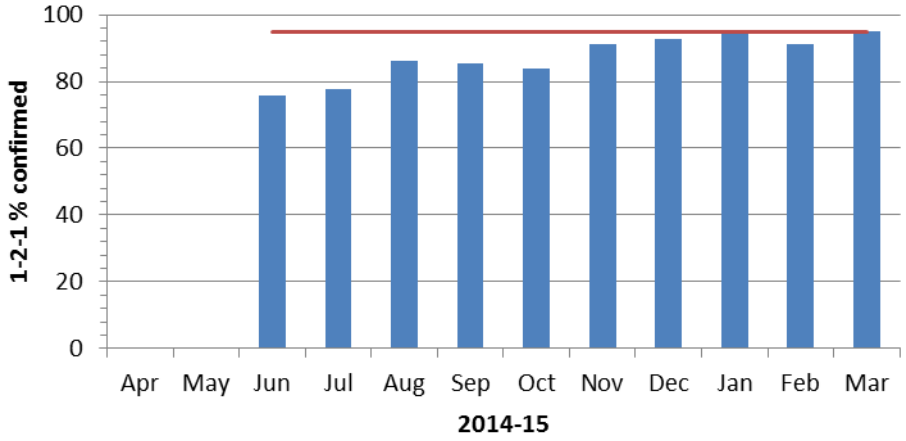
This goal was selected by clinical nomination by senior midwifery staff and gained divisional approval due to the importance of support for a woman and her family during established labour and birth.

Why this is important / what difference does this make to patients?

Delivering 1:1 care to women in established labour is known to promote normal birth, reduce intervention together with enhancing the woman's birth experience. We are striving to achieve 95%.

The one to one care and support delivered by a midwife, when a woman is in established labour promotes a sense of safety and trust. If the woman reports a less anxious state, she is more likely to achieve a birth that she has planned previously and will require less intervention. This 1:1 care in established labour has a positive effect on mother, baby and midwife.

Progress made in report period 2014-15



Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014/15	-	-	75.61	77.54	86.03	85.39	83.97	91.20	92.77	94.84	91.01	95.00
2013/14	79.01	79.64	75.41	72.64	72.75	77.09	79.20	78.91	76.92	77.05	77.72	78.79

Data Source: Meditech patient information system

The Liverpool Women's NHS Foundation Trust considers that this data is as described for the following reasons:

- The measure is derived from an extraction report from Meditech, the Trust's Patient Information System.
- Data is entered by the midwifery staff at the point of delivery.
- Weekly reports of 1:1 care in established labour monitored by departmental managers/ matrons and Head of midwifery.

How progress to achieve the priority goal is monitored and measured

The number of patients receiving 1 to 1 care in labour expressed as a proportion of patients receiving maternity care excluding patients where the baby was born before arrival or where the patient is a planned elective caesarean section or had an emergency caesarean section but did not labour. The measure is derived from an extraction report from Meditech and is completed by the midwifery staff at the point of delivery. Data is entered into 'Meditech' by the midwife following the birth. The rate is calculated from the number of eligible births.

The individual service areas are responsible for managing quality priorities and indicators of relevance to them and are required to report on them monthly to their local Quality Improvement forum in a standardised format dashboard.

How progress to achieve the priority goal is reported

This is now reported daily for the midwife led unit and delivery suite and will be submitted monthly to the executive board.

As described in the Trust's Quality Strategy, service level quality improvements forum(s) report quarterly to the Clinical Quality Governance Committee, who raise exceptions and concerns with the Operational Board and report quarterly to the Governance and Clinical Assurance sub-committee, which in turn reports biannually to the board. Thus the Trust's Clinical Quality Governance Committee and ultimately the Board have an overview of the delivery of the work streams in respect of this and all quality priorities and indicators.

The Liverpool Women's NHS Foundation Trust intends to take the following actions to improve this percentage, and so the quality of its services, by

- Making the daily report available to the intrapartum areas.
- Monthly reporting to and monitoring by the executive board.

2.1.4.2 Pain relief of choice in labour: To provide epidural pain relief to all women requesting it, where possible and clinically appropriate

Description

The number of women declined an epidural service for a non-clinical reason is expressed as a proportion of patients requesting an epidural service. We set our performance target at greater than 95% compliance. (i.e. <= 5% declined for non-clinical reason).

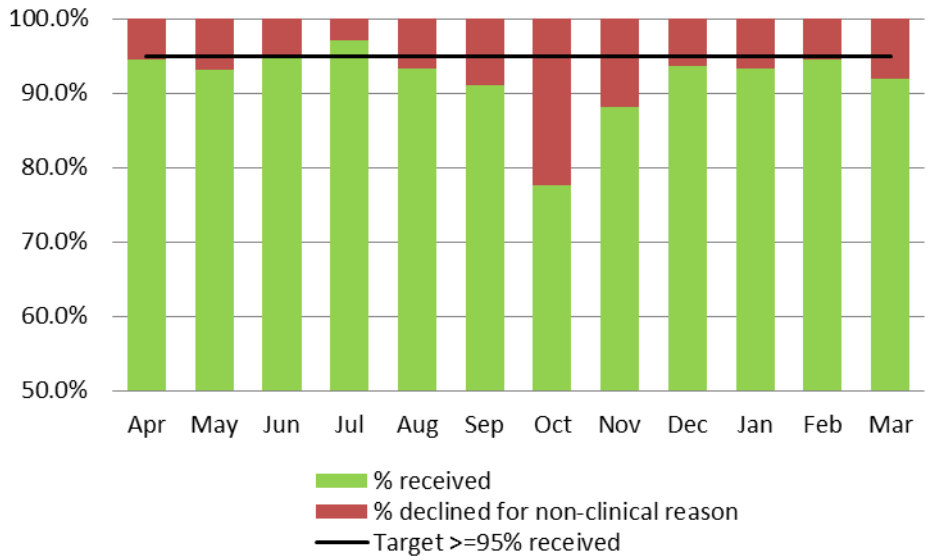
Why and how this priority goal was selected

This goal was selected from the previous quality account work in 2013-2014, whereby we highlighted a deficit in the provision of an epidural for a non-clinical reason. This goal gained divisional approval due to the importance for adequate analgesia for women who request an epidural.

Why this is important / what difference does this make to patients?

This target is important to women who access our maternity service to ensure we can provide an epidural on request in established labour. The inability to provide an epidural for a non-clinical reason creates distress to our women and families. The provision of an epidural on patient request promotes a sense of safety and trust, if a women reports a less anxious less painful state, she is more likely to achieve the birth she has planned, this ability to request and achieve an epidural has a positive effect on both mother, baby and midwife.

Progress made in report period 2014-15



Data source: In house weekly audit data

The Liverpool Women's NHS Foundation Trust considers that this data is as described for the following reasons:

- The data is based on aggregated data from weekly audits of the provision of all requested epidurals from women in both intrapartum areas, of high risk central delivery suite, and low risk midwifery led unit.

How progress to achieve the priority goal is monitored and measured

We audit on a weekly basis the provision of all requested epidurals from women in both intrapartum areas, of high risk central delivery suite, and low risk midwifery led unit.

The Liverpool Women's NHS Foundation Trust considers that this data is as described for the following reasons:

- The measurement is derived from an extraction report from Meditech, the Trusts patient information system.
- Data is entered by the midwifery staff at the point of delivery.
- Weekly reports of the non-provision of an epidural for a non-clinical reason are monitored by departmental managers/matrons and Head of Midwifery.

How progress to achieve the priority goal is reported

At divisional level

The number of women declined an epidural service for a non-clinical reason is expressed as a proportion of patients requesting an epidural service. The measurement is derived from an extraction report from Meditech and is completed by the midwife at delivery, this information is clinically audited and validated by departmental mangers on a weekly basis, and a monthly performance report is monitored by the Head of Midwifery through the Operations Board.

We report figures of the non-provision of an epidural for a non-clinical reason for example staffing in relation to midwives or anaesthetic staff, acuity of the maternity floor at the time of patient request.
As described in the Trust's Quality Strategy, service level quality improvements forum(s) report quarterly to the Clinical Quality Governance Committee, who raise exceptions and concerns with the Operational Board and report quarterly to the Governance and Clinical Assurance sub-committee, which in turn reports biannually to the board. Thus the Trust's Clinical Quality Governance Committee and ultimately the Board have an overview of the delivery of the work streams in respect of this and all quality priorities and indicators.

The Liverpool Women's NHS Foundation Trust intends to take the following actions to improve this indicator, and so the quality of its services,

- The introduction of performance reporting for time of epidural request to time of adequate pain relief.
- Making this data report available to all the intrapartum areas.
- Monthly reporting of all Epidural service data to the Executive board.

2.1.4.3 Reduction in number of complaints relating to care

Description

The number of complaints received in the 'Care and Treatment' category.

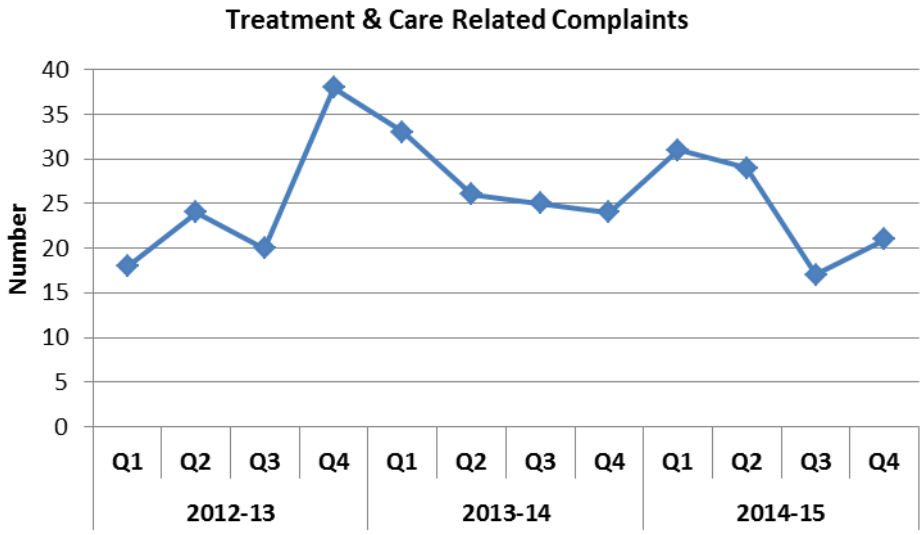
Why and how this priority goal was selected

This indicator was selected as a priority for action in 2014-15 by the membership of the Nursing & Midwifery board in response to their monitoring of complaints received by the Trust in relation to care.

Why this is important / what difference does this make to patients?

Patients complain when we do not meet their expectations, sometimes this is due to unforeseen and unavoidable circumstances, but on other occasions it is because we have not adequately explained things to them or indeed we got it wrong. It is important that we listen to all forms of feedback including complaints and learn from such mistakes, improve our services to optimise the patient experience. Part of this improvement is the prevention of recurrence of the events which lead to these complaints.

Progress made in report period 2014-15



Year	Q1	Q2	Q3	Q4	Total
2014-15	31	29	17	21	98
2013-14	33	26	25	24	108
2012-13	18	24	20	38	100

Data source: LWFT In house data

The Liverpool Women's NHS Foundation Trust considers that this data is as described as it submits these figures to NHS England and publishes them as part of its Annual Complaints Report.

How progress to achieve the priority goal is monitored and measured

Complaints are recorded and managed on the Trust's Ulysses database and separated by category of complaint. The Patient Experience Team submits complaints figures monthly as part of the Trust Performance report. The individual service areas are then responsible for managing complaints of relevance to them and are required to provide an overview of any relevant to them.

Where deviations from the expected performance are identified it is expected that an action plan will be drawn up informing senior managers of the reasons for the deviation and any remedial measures that are being put in place.

How progress to achieve the priority goal is reported

As described above the Performance Report is generated monthly and discussed at both the Trust performance Meeting and in detail at the Operations Board. Quarterly reports on complaints, in conjunction with litigation, incidents and PALS, are submitted quarterly to the Clinical Quality Governance Committee, with any exceptions or trends highlighted. These quarterly reports are made available to the Governance and Clinical Assurance sub-committee for assurance purposes.

The Liverpool Women's NHS Foundation Trust has taken the following actions to improve this indicator, and so the quality of its services:

- Throughout the course of the year the Trust has continued to focus on the recruitment of staff and to develop the nursing strategy to reflect the values and behaviours the Trust expects of its employees. This has resulted in a 9.3% reduction in complaints relating to care.
- The Trust has recruited a new Head of Patient Experience who will assume responsibility for overseeing complaints and ensuring progress continues.

2.2 Priorities for improvement 2015-16

The Trust reviewed its Quality Strategy during the third quarter of 2014-15 and declared the following Quality goals:

1. To reduce harm.
2. To reduce mortality.
3. To improve the patient experience.

2.2.1 Quality Goal 1 – To reduce harm

We recognise the national priorities with respect to this goal relate to reducing harm relating to pressure ulcers, catheter associated urinary tract infection, venous thromboembolism (VTE) and falls, but the nature of our services is such that very few of our patients suffer harm as a result of them. After considering carefully the harms of particular relevance to our services and the patients we care for we have agreed that our priorities for reducing harm are:

1. Infection.
2. Avoidable birth injury.
3. Medication errors and,
4. Multiple pregnancy as a result of fertility treatment.

2.2.1.1 Infection

Our improvement priorities for improvement with respect to infection are:

- To reduce the number of elective surgical site infections in gynaecology to an average of no more than 3 per calendar month.
- To work to cleanse data for emergency patients and determine underlying infection complication rates.
- To achieve zero MRSA infection.
- To achieve zero C-Difficile infection.
- To achieve neonatal infection rates as follows:
  a. A proportion of preterm babies who develop a late-onset bloodstream infection i.e. the proportion of preterm babies below 30 + 0 weeks' gestation admitted who have a late-onset bloodstream infection (one occurring > 72 hours of age) below the median benchmarked against the VON-UK network.
  b. A rate of late-onset bloodstream infections in preterm infants i.e. the number of episodes of late-onset bloodstream infection in preterm babies below 30 + 0 weeks' gestation per 100 VLBW intensive care and high dependency days below 0.5 infections per 100 VLBW IC and HD days.

2.2.1.2 Avoidable birth injury

Our priorities for improvement with respect to avoidable birth injury are:

- To reduce the incidents of babies born with avoidable Grade 2/3 Hypoxic Ischaemic Encephalopathy by 50% over 3 years.
- To reduce the number of very low birth weight babies (<1500g) who have ultrasound evidence of periventricular haemorrhage (grade 3 or 4) or periventricular leukomalacia to be in the lowest quartile of benchmarking peers (VON).

2.2.1.3 Medication Errors

Our priorities for improvement with respect to medication errors are:

- To increase reporting of all medication error incidents by 10% quarter on quarter (~16% in year) to enable identification and resolution of causal factors.
- To ensure that all medication incidents rated at >/=10 are subject to a Root Cause Analysis (in order to capture and implement learning and reduce the number of serious medication error incidents).

2.2.1.4 Multiple pregnancy as a result of fertility treatment

Our priority for improvement with respect to multiple pregnancies as a result of assisted conception treatment is:

- To ensure that no more than 10% of live births are multiples.

2.2.2 Quality Goal 2 – To Reduce Mortality

2.2.2.1 *What is mortality & why is it an important measure?*

Sadly, patients die whilst in hospital and Liverpool Women's is no different. The NHS uses a standardised measurement (Hospital Standardised Mortality Ratio (HSMR)) to calculate mortality across the NHS. This risk adjusted mortality ratio compares a hospital's actual mortality rate to the mortality rate that would be expected given the characteristics of the patients treated; this gives a risk adjusted expected mortality rate. In calculating this, many factors are taken into account, such as the age and sex of patients, their diagnosis, whether their hospital stay was planned or an emergency and any other conditions the patient may have. If a hospital has a mortality rate of 100 that means that the number of patients who died was exactly as was expected. A mortality rate above 100 means more patients died than would be expected and below 100 means that fewer than expected died.

This assessment of mortality using HSMR is not a useful tool for this hospital since instances of maternal deaths, stillbirths and neonatal deaths which are relevant to our services are excluded from these calculations. The remaining deaths in the Trust are in gynaecology and are of such small numbers that the use of HSMR may give false concern or reassurance; particularly as the Trust has seen an increase in the number of patients choosing to use this hospital's end of life care service.

This matter has been considered very carefully and we are committed to monitoring our mortality by focussing on each clinical area separately. We will record our mortality rates in those areas and benchmark against national standards. Each case will be reviewed individually so that any lessons regarding failures of care may be learned.

Given the nature of the services we provide at Liverpool Women's, including end of life care for cancer patients and the very premature babies born or transferred here, we do see deaths, many of which are expected However, our quality goal is to reduce mortality wherever possible in the following areas:

- Neonates
- Gynaecology
- Maternity (including maternal death & stillbirth).

2.2.2.2 Neonates

Our improvement priority for neonatal mortality is:

- To deliver our risk adjusted neonatal mortality (deaths within 28 days of birth following a live birth) within 1% of the national Neonatal Mortality Rate as published by ONS.

2.2.2.3 Gynaecology

Our improvement priority for gynaecology mortality is:

- No non-cancer related deaths in Gynaecology.

Delivered by using Serious Incident review, Morbidity and Mortality meetings and staff education bulletins to ensure any lessons from such rare events are learnt by all staff.

2.2.2.4 Maternity

Our improvement priorities for maternity are as follows:

- Zero 'Direct maternal deaths'.
- To reduce the incidence of stillbirths attributed to Small for Gestational Age (SGA) by 20% by early implementation of the NHS England saving babies' lives care bundle.
- Introduce the national 'safety thermometer' for maternity services.

2.2.3 Quality Goal 3 – To provide the best patient experience

2.2.3.1 Why is experience an important quality measure?

The experience that our patients have whilst under the care of our organisation is of utmost importance to us. We understand that many of our patients have contact with us at some of the most significant times in their lives and it is our ambition to make each patient's experience the best that it can possibly be.
A great patient experience is delivered by a workforce who are engaged, competent and motivated to deliver high quality care.

Our priorities for Patient experience are:

- 1:1 care in established labour provided to >=95% of women.
- Pain relief of choice in labour: To provide epidural pain relief to all women requesting it, where possible and clinically appropriate.
- To be in the upper quartile of Patient Surveys across all pathways.

Also in Quarter 3 of 2014-15 the Trust signed up to the 'Sign up to Safety' campaign and developed its Sign up to Safety Plan containing its safety improvement priorities and plans for delivery, whist some of these align directly with the Quality Strategy priorities, others were also identified. Performance in 2014-15 against all of these priorities is included in the next section, where available.

2.3 Performance against our 2015-16 quality goals and safety priorities for improvement during 2014-15.

2.3.1 Patient Safety

2.3.1.1 To reduce the number of elective surgical site infections in gynaecology to an average of 3 per calendar month

(See section 2.1.1.1 for progress against this priority during 2014-15).

2.3.1.2 To achieve a proportion of preterm babies who develop a late-onset bloodstream infection below the median benchmarked against the VON-UK network.

(See section 2.1.1.6 for progress against this priority during 2014-15).

2.3.1.3 To ensure that no more than 10% of liveborn pregnancies after fertility treatment are multiples

(See section 2.1.1.3 for progress against this priority during 2014-15).

2.3.1.4 To work to cleanse data for emergency patients and determine underlying infection complication rates

In October of 2014, the Infection Prevention and Control department within the Trust re-invigorated its wound surveillance programme to validate surgical site infection coding by reviewing cases highlighted from information received via regular coding reports, ward referrals infection and tissue viability reports, if the SSI cannot be confirmed the coding is reviewed and where necessary amended.

2.3.1.5 To achieve zero MRSA infection

Description

The number of reported instances of MRSA bacteraemia infections amongst patients receiving care within the Trust.

Why and how this priority goal was selected:

MRSA is Meticillin-Resistant Staphylococcus aureus. Staphylococcus aureus is a bacterium (germ) and is often found on the skin or in the nose of healthy people. Most S. aureus infections can be treated with commonly used antibiotics. However, MRSA infections are resistant to the antibiotic meticillin and also to many other types of antibiotics. Infections with MRSA are usually associated with high fevers and signs of infection. Most commonly these are infections of the skin (like boils and abscesses). Less commonly, MRSA can cause pneumonia and urine infections. The Trust takes extremely seriously its duty to prevent infection and provide care in a safe environment and having achieved zero instances of MRSA bacteraemias for four consecutive years wished to monitor and maintain this record.

Why this is important / what difference does this make to patients?

The Trust takes extremely seriously its duty to prevent infection and provide care in a safe environment.

Progress made in report period 2014-15

The Trust had no reported instances of MRSA Bacteraemia in 2014-15.

Commentary

The Trust takes extremely seriously its duty to prevent infection and provide care in a safe environment and having achieved zero instances of MRSA bacteraemia for four consecutive years wishes to monitor and maintain this record.

The Liverpool Women's NHS Foundation Trust considers that this data is as described for the following reasons.

- Infection data is collated manually by the infection control analyst from reports to infection prevention and control team.

How progress to achieve the priority goal is monitored and measured

The individual service areas are responsible for managing quality priorities and indicators of relevance to them and are required to report on them monthly to their local Quality Improvement forum in a standardised format dashboard.

The infection prevention and control team record and investigate any instances of MRSA bacteraemias reported.

How progress to achieve the priority goal is reported

All cases of MRSA bacteraemia occurring in the Trust are reported through the Trust reporting structures i.e. Infection Control Committee and Clinical Governance Committee monthly, Clinical and Governance Assurance Committee and Trust Board quarterly. All cases (and nil returns) are reported monthly onto the National mandatory reporting database.

As described in the Trust's Quality Strategy, service level quality improvements forum(s) report quarterly to the Clinical Quality Governance Committee, who raise exceptions and concerns with the Operational Board and report quarterly to the Governance and Clinical Assurance sub-committee, which in turn reports biannually to the board. Thus the Trust's Clinical Quality Governance Committee and ultimately the Board have an overview of the delivery of the work streams in respect of this and all quality priorities and indicators. Infection data is also reviewed twice monthly within the Matrons report to the Infection Control Committee.

The Liverpool Women's NHS Foundation Trust has in place a number of interventions to prevent infection with this organism; these interventions will be reviewed to ensure they remain fit for purpose to maintain the safety of patients.

2.3.1.6 To achieve zero Clostridium-difficile (C-diff) infection

Description:

The reported instances of Trust apportioned *Clostridium difficile* infection in persons aged 2 or over.

Why and how this priority goal was selected:

Clostridium difficile are bacteria that are present naturally in the gut of around two-thirds of children and 3% of adults. *C.difficile* does not cause any problems in healthy people. However, some antibiotics that are used to treat other health conditions can interfere with the balance of 'good' bacteria in the gut. When this happens, *C.difficile* bacteria can multiply and produce toxins (poisons), which cause illness such as diarrhoea and fever. *C.difficile* infection is the commonest cause of healthcare associated diarrhoea. Having achieved zero instances of Clostridium difficile infection during 2012-13 the Trust wished to monitor and maintain this record.

Why this is important / what difference does this make to patients?

The Trust takes extremely seriously its duty to prevent infection and provide care in a safe environment. Preventing infection improves patient, care, experience and safety.

Progress made in report period 2014-15

	No. of Reported C. difficile Infections											
Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014/15	0	0	1*	0	0	0	0	0	0	0	0	0
2013/14	0	0	0	1	0	0	0	0	1	0	0	0

*As shown in the table above, the Trust recorded a single case of Clostridium difficile infection during 2014-15, however at a subsequent appeal the case was re-attributed as community acquired. Hence the Trust's true achievement was zero C-diff infections for 2014-15.

The Liverpool Women's NHS Foundation Trust considers that this data is as described for the following reason:

- Infection data is collated manually by the infection control analyst from reports to infection prevention and control team.

How progress to achieve the priority goal is monitored and measured

The individual service areas are responsible for managing quality priorities and indicators of relevance to them and are required to report on them monthly to their local Quality Improvement forum in a standardised format dashboard.

The infection prevention and control team record and investigate with a full root cause analysis any instances of *C.difficile* reported.

How progress to achieve the priority goal is reported

All cases of *C.difficile* infection occurring in the Trust are reported through the Trust reporting structures i.e. Infection Control Committee and Clinical Governance Committee monthly, Clinical and Governance Assurance Committee and Trust Board quarterly. All cases (and nil returns) are reported monthly onto the National mandatory reporting database.

As described in the Trust's Quality Strategy, service level quality improvements forum(s) report quarterly to the Clinical Quality Governance Committee, who raise exceptions and concerns with the Operational Board and report quarterly to the Governance and Clinical Assurance sub-committee, which in turn reports biannually to the board. Thus the Trust's Clinical Quality Governance Committee and ultimately the Board have an overview of the delivery of the work streams in respect of this and all quality priorities and indicators. Infection data is also reviewed twice monthly within the Matrons report to the Infection Control Committee.

The Liverpool Women's NHS Foundation Trust has in place a number of interventions to prevent infection with this organism; these interventions will be reviewed to ensure they remain fit for purpose to maintain the safety of patients.

2.3.1.7 To achieve a rate of late-onset bloodstream infections in preterm infants below 0.5 infections per 100 VLBW IC and HD days

Description

The number of episodes of late onset bloodstream infection in preterm babies below 30+0 weeks gestation per 100 very low birth weight (<1500g) intensive care and high dependency days.

Why and how this priority goal was selected

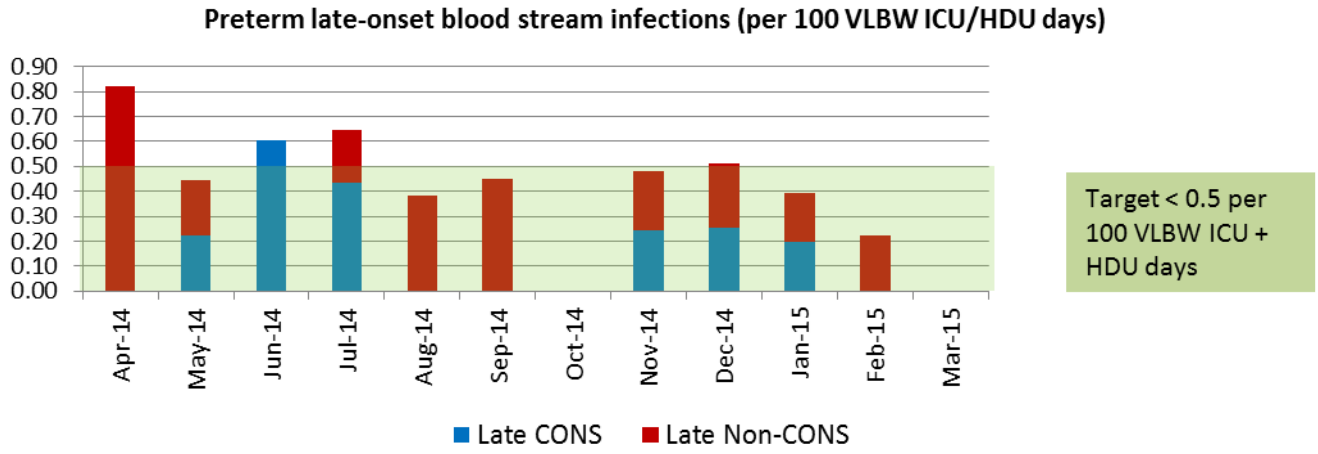
Late-onset neonatal infection is an important, but potentially avoidable, complication of preterm birth. Premature babies below 30 weeks are the most vulnerable to bloodstream infections and in whom infection has the potential to cause significant morbidity and mortality.

Why this is important / what difference does this make to patients?

Because it is a marker of quality of neonatal care which impacts on various short and long-term clinical outcomes such as mortality and chronic lung disease. It is widely accepted that bloodstream infections are an important indicator of performance and infection rates are collected nationally as part of the National Neonatal Audit Programme.

Progress made in report period 2014-15

The mean rate for 2014/15 was 0.41 infections per 100 very low birth weight (<1500g) intensive care and high dependency days which is below our target of 0.5, and slightly better than the rate of 0.44 in 2013/2014.



CONS = Coagulase Negative Staphylococcus (infections) - A group of bacteria most commonly responsible for infections in infants.

The Liverpool Women's NHS Foundation Trust considers that this data is as described for the following reason(s):

- Data are collected through the Badger electronic patient record and microbiology databases.

How progress to achieve the priority goal is monitored and measured

Data are collected through the Badger electronic patient record and microbiology databases. Bloodstream infection is defined according to the national definition endorsed by BAPM and NDAU. The denominator of 100 VLBW ICU+HDU days is used to reflect the fact that most late-onset BSIs occur in the intensive care/high dependency setting. These infection data are calculated and reported monthly and constitute one of the items in the neonatal performance dashboard.

The individual service areas are responsible for managing quality priorities and indicators of relevance to them and are required to report on them monthly to their local Quality Improvement forum in a standardised format dashboard.

How progress to achieve the priority goal is reported

As described in the Trust's Quality Strategy, service level quality improvements forum(s) report quarterly to the Clinical Quality Governance Committee, who raise exceptions and concerns with the Operational Board and report quarterly to the Governance and Clinical Assurance sub-committee, which in turn reports biannually to the board. Thus the Trust's Clinical Quality Governance Committee and ultimately the Board have an overview of the delivery of the work streams in respect of this and all quality priorities and indicators.

This measure is not reported externally. There are no changes planned for 2015/16.

2.3.1.8 To reduce the incidents of babies born with avoidable Grade 2/3 Hypoxic Ischaemic Encephalopathy by 50% over 3 years

Description

The incidence of babies born with avoidable grade 2 or 3 hypoxic Ischaemic encephalopathy (HIE) per 1000 term births excluding caesarean section deliveries.

Why and how this priority goal was selected

Hypoxic Ischaemic Encephalopathy is an acute disturbance of brain function caused by impaired oxygen delivery and perfusion of the brain. When considering its safety plan priorities in 2014-15 Qtr3, the Trust identified this as a priority with potential for improvement and consequently included it in the Trust's 'Sign up to Safety' plan, setting a target of reducing the incidence of this grade 2/3 HIE by 50% in three years.

Why this is important / what difference does this make to patients?

The prognosis for babies born with this condition can be severe, and lead to life-long care needs; improving care to prevent it occurring is of benefit to the families using our services and also the Trust as it will reduce the number of unexpected admissions to the neonatal unit and, reduce the number of serious incidents requiring investigation related to these scenarios.

Progress made in report period 2014-15

In 2014-15 the rate was 1.48 per 1000 births. This forms the baseline for this priority metric going forward.
Data source: LWFT data, Meditech/ Badger/ Clinical coding

The data presented above represents the base line data for this newly identified priority.

The Liverpool Women's NHS Foundation Trust considers that this data is as described for the following reasons.

- The numerator for this calculation is derived from confirmed diagnosis data.
- The denominator for this calculation is derived directly from coding data by the information department.

How progress to achieve the priority goal is monitored and measured

All babies treated with therapeutic hypothermia will have an in depth review of their care in line with "Every Baby Counts" methodology to identify any themes of deficiency in care.

HIE data can be inaccurate because of the complexity of the diagnostic criteria. It is proposed for this indicator we monitor the number of babies born at LWH who require treatment with therapeutic hypothermia, this will capture those babies with potential intrapartum asphyxial brain injury. It is presented as a rate per 1000 term births excluding caesarean section deliveries.

The individual service areas are responsible for managing quality priorities and indicators of relevance to them and are required to report on them monthly to their local Quality Improvement forum in a standardised format dashboard.

How progress to achieve the priority goal is reported

As described in the Trust's Quality Strategy, service level quality improvements forum(s) report quarterly to the Clinical Quality Governance Committee, who raise exceptions and concerns with the Operational Board and report quarterly to the Governance and Clinical Assurance sub-committee, which in turn reports biannually to the board. Thus the Trust's Clinical Quality Governance Committee and ultimately the Board have an overview of the delivery of the work streams in respect of this and all quality priorities and indicators.

The Liverpool Women's NHS Foundation Trust intends to take the following actions to improve this indicator, and so the quality of its services, by achieving the following goals:

- All babies treated with therapeutic hypothermia will have an in depth review of their care in line with "Every Baby Counts" methodology to identify any themes of deficiency in care.
- Achieve 95% compliance with staff training on fetal monitoring including the RCOG E learning package.
- Monthly monitoring via dashboard and performance reports within the Clinical Division.
- Increase staff confidence and skills in CTG interpretation by enhanced training and support within mandatory training sessions, e learning and clinical area support.
- Strive to commit to inter-collaborative working across health care Trusts sharing improved learning and results with the potential to offer externally attended study days within the next 3-5 years.

2.3.1.9 To increase reporting of all medication error incidents by 10% quarter on quarter (~16% in year), to enable identification and resolution of causal factors

Description

A quarterly review of the number of medication incidents reported via the Trust incident reporting system.

Why and how this priority goal was selected

The administration of medication is the most frequent medical intervention a patient receives in hospital. The EQUIP[8] study, a large multi-centre study on prescribing errors shows a prevalence of an 8.9% prescribing error rate.

Evidence suggests approximately 6.5% of admissions to an acute trust are associated with an adverse drug reaction[9].

There is a significant financial and morbidity burden associated with medication errors.
A recent MHRA patient safety alert articulates the potential for identifying and learning from medication errors[10].

[8] Dornan, T, Ashcroft, D, Heathfield, H, Lewis, P, Miles, J, Taylor, D, Tully, M, Wass, V. An in depth investigation into causes of prescribing errors by foundation trainees in relation to their medical education. EQUIP study. General Medical Council: 3 December 2009.

[9] Pirmohamed M, James S, Meakin S, Green C, Scott AK, Walley TJ, Farrar K, Park BK, Breckenridge Am Adverse drug reactions as cause of admission to hospital: prospective analysis of 18,820 patients. BMJ, 2004:329:15-

[10] MHRA Patient safety alert. NHS/PSA/D/2014/005 Stage Three: Directive Improving medication error incident reporting and learning. 20 March 2014. http://www.england.nhs.uk/wp-content/uploads/2014/03/psa-med-error.pdf

Figures for LWH are likely to be different because of the population variance. Never the less there is significant potential to learn from medication errors.

This goal was selected because improving the reporting culture around medication errors and having the right processes to review and learn from them can have a positive impact on patient safety.

Why this is important / what difference does this make to patients?

Increased reporting will help learning from errors and hence reduce harm from medication errors.

- Reduce harm from errors.
- Reduction in certain error types where work has been undertaken to design out error.
- Enabling patients to have confidence in medication regimes, improved adherence to medication.
- Shows the trust to be an open and transparent organisation that recognises its mistakes and learns from them.

Progress made in report period 2014-15

In 2014-2015 there were 294 medication distributed as shown in the following table.

Year	Qtr1 Apr, May, Jun	Qtr2 Jul, Aug, Sep	Qtr3 Oct, Nov, Dec	Qtr4 Jan, Feb, Mar	Av.
No. 2014/15	**71**	**91**	**61**	**71**	**74**
% 2014/15	**24**	**31**	**21**	**24**	**N/A**

Data source: LWFT 'Ulysses' incident reporting system

It should be noted this work stream was identified Q4 2014/5. Existing data represents baseline reporting and natural variance.

The average number of reported medication errors in 2014-2015 per quarter was 74.
Hence, for a 10% increase quarter on quarter for 2015-2016, medication errors reporting should be 81 for Q1, 90 for Q2, 98 for Q3 and 108 for Q4.

The Liverpool Women's NHS Foundation Trust considers that this data is as described for the following reasons:

- The data is extracted from trust incident and reporting system.

Promotion of reporting across the MDT (doctors, nurses, midwives, pharmacists etc.) and robust systems to review medication errors have been implemented and are expected to make a difference in 2015/16.

How progress to achieve the priority goal is monitored and measured

The individual service areas are responsible for managing medication related incidents. Medication errors are reported monthly to their local Quality Improvement forum in a standardised format dashboard. Oversight of all medication incidents is provided by medicines management committee (MMC) where cross divisional trends can be identified.

How progress to achieve the priority goal is reported

As described in the Trust's Quality Strategy, service level quality improvements forum(s) and MMC report quarterly to the Clinical Quality Governance Committee, who raise exceptions and concerns with the Operational Board and report quarterly to the Governance and Clinical Assurance sub-committee, which in turn reports biannually to the board. Thus the Trust's Clinical Quality Governance Committee and ultimately the Board have an overview of the delivery of the work streams in respect of this and all quality priorities and indicators.

The Liverpool Women's NHS Foundation Trust in the following actions to improve this indicator, and so the quality of its services, by:

- Generalised promotion of incident reporting.
- Targeted promotion of incident reporting by reviewing error reporting by area and profession and Bimonthly focus at medicines management committee.
- Medication safety officer who is engaged in the National Medication Safety Network to share and learn from other medication safety initiatives across the health economy

2.3.1.10 To ensure that all medication incidents rated at >/=10 are subject to a Root Cause Analysis (in order to capture and implement learning and reduce the number of serious medication error incidents)

Description

All medication incidents scoring 10 or more after moderation will have a RCA completed so lessons can be learnt and an action plan created and monitored.

Why and how this priority goal was selected

The administration of medication is the most frequent medical intervention a patient receives in hospital. The EQUIP[11] study, a large multi-centre study on prescribing errors shows a prevalence of an 8.9% prescribing error rate.

Evidence suggests approximately 6.5% of admissions to an acute trust are associated with an adverse drug reaction[12].

There is a significant financial and morbidity burden associated with medication errors.
A recent MHRA patient safety alert articulates the potential for identifying and learning from medication errors[13].

[11] Dornan, T, Ashcroft, D, Heathfield, H, Lewis, P, Miles, J, Taylor, D, Tully, M, Wass, V. An in depth investigation into causes of prescribing errors by foundation trainees in relation to their medical education. EQUIP study. General Medical Council: 3 December 2009.

[12] Pirmohamed M, James S, Meakin S, Green C, Scott AK, Walley TJ, Farrar K, Park BK, Breckenridge Am Adverse drug reactions as cause of admission to hospital: prospective analysis of 18,820 patients. BMJ, 2004:329:15-

[13] MHRA Patient safety alert. NHS/PSA/D/2014/005 Stage Three: Directive Improving medication error incident reporting and learning. 20 March 2014. http://www.england.nhs.uk/wp-content/uploads/2014/03/psa-med-error.pdf

Figures for LWH are likely to be different because of the population variance. Never the less there is significant potential to learn from medication errors.

This goal was selected because improving the reporting culture around medication errors and having the right processes to review and learn from them can have a positive impact on patient safety.

Where incidents have triggered a high score in terms of severity or likelihood the enhanced scrutiny of an RCA will allow the best opportunity for lessons to be learnt and future incidents prevented.

Why this is important / what difference does this make to patients?

This initiative is important in order to capture and implement learning and reduce the number of serious medication error incidents. Hence reducing harm to patients.

Progress made in report period 2014-15

In 2014-2015 there were 294 medication incidents, two (0.7%) medication incidents scored above 10. Reviewing what happened to these one had a full RCA investigation. One did not, on closer inspection there was difficulty in obtaining information.

The Liverpool Women's NHS Foundation Trust considers that this data is as described for the following reason(s):

- The data is extracted from the Trust incident and reporting system (Ulysses).

It should be noted this work stream was identified Q4 2014/5. Existing data represents baseline reporting and natural variance. The enhanced focus and attention should mean shorter turnaround times and 100% compliance.

How progress to achieve the priority goal is monitored and measured

The individual service areas are responsible for managing quality priorities and indicators of relevance to them and are required to report on them monthly to their local Quality Improvement forum in a standardised format dashboard.

How progress to achieve the priority goal is reported

As described in the Trust's Quality Strategy, service level quality improvements forum(s) report quarterly to the Clinical Quality Governance Committee, who raise exceptions and concerns with the Operational Board and report quarterly to the Governance and Clinical Assurance sub-committee, which in turn reports biannually to the board. Thus the Trust's Clinical Quality Governance Committee and ultimately the Board have an overview of the delivery of the work streams in respect of this and all quality priorities and indicators.

The Liverpool Women's NHS Foundation Trust has taken the following actions to improve this indicator and so the quality of its services, by:

- Mandating that all medicines incidents scoring 10 or more undergo RCA to allow lessons to be learnt.
- Incident scores are monitored regularly to ensure when needed an RCA is triggered.

2.3.1.11 Reducing the incidence of sepsis through increasing awareness, ensuring prompt identification and appropriate treatment of infection including the prevention of mortality and morbidity

Sepsis is an important metric because it has the potential to lead to patient shock, multiple organ failure and death. If the clinical signs of sepsis are not detected early then mortality increases and there is good evidence that prompt and appropriate management of sepsis saves lives. Every hour delay of the sepsis bundle increases the risk of death by 8%, (MBRRACE- UK 2014). Microbiologically confirmed sepsis is a straight forward metric which can be used to determine rates of sepsis and through a process of RCA the Trust's response to the event.

The Trust has committed in its Sign up to Safety plan to reducing the incidence of sepsis and reiterates that commitment here.

2.3.2 Clinical Effectiveness

2.3.2.1 To reduce the number of very low birth weight babies (<1500g) who have ultrasound evidence of periventricular haemorrhage (grade 3 or 4) or periventricular leukomalacia to be in the lowest quartile of benchmarking peers (VON)

(See section 2.1.2.3 for progress against this priority during 2014-15).

2.3.2.2 To deliver our risk adjusted neonatal mortality (deaths within 28 days of birth following a live birth) within 1% of the national Neonatal Mortality Rate as published by ONS.

(See section 2.1.2.4 for progress against this priority during 2014-15).

2.3.2.3 To have no non-cancer related deaths in Gynaecology.

Delivered by using Serious Incident review, Morbidity and Mortality meetings and staff education bulletins to ensure any lessons from such rare events are learnt by all staff.
(See section 2.1.2.1 for progress against this priority during 2014-15).

2.3.2.4 Zero 'Direct maternal deaths'

Description

To have no maternal deaths as a result of a complication directly related to the pregnancy.

Why and how this priority goal was selected

A "Direct" maternal death refers to those women whose death is directly related to a complication of pregnancy such a haemorrhage, pre-eclampsia or sepsis. Direct maternal deaths account for 32% of all maternal deaths.

This measure was identified as an indicator to monitor the Trust's second Priority Goal – To Reduce Mortality as it reports any maternal mortality within our maternity service.

Why this is important / what difference does this make to patients?

Life style factors such as obesity and advanced maternal age are significant contributory factors to complications of pregnancy. With the increased prevalence of these factors within the population the risk of a significant complication is increased.

Progress made in report period 2014-15

There were no direct maternal deaths reported at LWH in 2014- 2015. (Data source LWFT 'Ulysses incident reporting system).

The Liverpool Women's NHS Foundation Trust considers that this data is as described for the following reason:

- Any Direct maternal death is classed as a "Never Event "and would be reported and recorded as such.

How progress to achieve the priority goal is monitored and measured

Any Direct maternal death is classed as a "Never Event "and would be reported and recorded as such
The individual service areas are responsible for managing quality priorities and indicators of relevance to them and are required to report on them monthly to their local Quality Improvement forum in a standardised format dashboard.

How progress to achieve the priority goal is reported

As described in the Trust's Quality Strategy, service level quality improvements forum(s) report quarterly to the Clinical Quality Governance Committee, who raise exceptions and concerns with the Operational Board and report quarterly to the Governance and Clinical Assurance sub-committee, which in turn reports biannually to the board. Thus the Trust's Clinical Quality Governance Committee and ultimately the Board have an overview of the delivery of the work streams in respect of this and all quality priorities and indicators.

This would be reported to the CCG as a "Never Event" and is also reportable nationally to MBRRACE
The Liverpool Women's NHS Foundation Trust intends to take the following actions to maintain this standard:

- Increased delivery of multidisciplinary "Clinical Skills simulations" "within the high risk areas.
- Work within the Merseyside and Cheshire maternity clinical network to develop regional guidelines for the management of severe pre-eclampsia and other pregnancy related conditions.

2.3.2.5 To reduce the incidence of stillbirths attributed to Small for Gestational Age (SGA) by 20% by early implementation of the NHS England saving babies' lives care bundle

Description

To decrease by 20% the number of babies who are stillborn because of Small for gestational age by the implementation of a care bundle involving

1. Targeting smoking cessation
2. Gap programme (continuation of Individualised Growth charts and targeted scanning for at risk individuals)
3. Increased awareness of babies movements
4. Fresh eyes approach to monitoring during labour.

Why and how this priority goal was selected.

When a baby is stillborn the cause of death is classified according to CMACE categories. In many cases there is no intervention that would have affected the outcome. However in those babies whose death has been attributed to small for gestational age there is the potential that early detection may have allowed an earlier delivery to be planned. The overall data suggest a downward trend in stillbirths, when the full NHS England saving babies lives care bundle is implemented we need to know the impact for this targeted group.

The care package was developed with the support of SANDS (Stillbirth and neonatal death charity) which is a patient led organisation.

This measure was identified as an indicator to monitor the Trust's second Priority Goal – To Reduce Mortality as it reports any stillbirths within our maternity service.

Why this is important / what difference does this make to patients?

The impact of stillbirth on families is impossible to quantify, but is likely to be even more profound if the cause of the stillbirth is something that could possibly have been identified and acted on preventing the stillbirth. Although we will never be able to prevent all stillbirths it is important to put all processes in place to minimise the number of avoidable deaths.

Progress made in report period 2014-15

This is a new priority for 2015-16. However the ongoing stillbirth audit historical data suggests that approximately 30% of stillbirths occur in babies who are small for gestational age.
The Liverpool Women's NHS Foundation Trust considers that this data is as described for the following reason(s):

- We perform an annual stillbirth audit of all stillbirths from 24+0 weeks' gestation and obtain their birth weight centile from the GROW calculator (Perinatal Institute).
- SGA is defined by internationally agreed criteria and our results are similar to published data from other sources.

How progress to achieve the priority goal is monitored and measured

The stillbirth audit will produce annual figures for stillbirth and following multidisciplinary team review assign the cause of death, they will report the percentage of stillbirths attributed to Small for Gestational Age.

How progress to achieve the priority goal is reported

As described in the Trust's Quality Strategy, service level quality improvements forum(s) report quarterly to the Clinical Quality Governance Committee, who raise exceptions and concerns with the Operational Board and report quarterly to the Governance and Clinical Assurance sub-committee, which in turn reports biannually to the board. Thus the Trust's Clinical Quality Governance Committee and ultimately the Board have an overview of the delivery of the work streams in respect of this and all quality priorities and indicators.

The Liverpool Women's NHS Foundation Trust has taken the following actions to improve this indicator and so the quality of its services, by:

The implementation of a care bundle involving:

1. Targeting smoking cessation
2. Gap programme (continuation of Individualised Growth charts and targeted scanning for at risk individuals)
3. Increased awareness of babies movements
4. Fresh eyes approach to monitoring during labour.

2.3.2.6 Introduce the national 'safety thermometer' for maternity services

The Trust has decided to participate in the Maternity Safety Thermometer in 2015/16. The safety thermometer allows our teams to measure how many of our maternity patients receive care without harm during the course of the working day and to capture how many harms and the nature of the harms as they occur. This information will assist us to improve care and experience for our patients. The information is collected on one day per calendar month and is collected on women who have delivered babies. Information will be collected from clinics, the post natal delivery ward and in post natal clinics.

2.3.3 Patient Experience

2.3.3.1 1:1 care in established labour provided to >= 95% of women

(See section 2.1.4.1 for progress against this priority during 2014-15).

2.3.3.2 To provide epidural pain relief to all women requesting it, where possible and clinically appropriate

(See section 2.1.4.2 for progress against this priority during 2014-15).

2.3.3.3 To be in the upper quartile of Patient Surveys across all pathways (Friends & Family Test – In patients)

Description

The NHS Friends and Family Test (FFT) is a feedback tool that provides people who use our services the opportunity to provide feedback on their experience. The feedback is then used to improve services for our patients. It provides a mechanism to identify areas of both good and bad performance. It also encourages staff to make improvements where services have not met patient's expectations.

Why and how this priority goal was selected

The Friends and Family Test has been mandated for implementation in all NHS Acute Trusts.

Although it is mandatory for Trusts to implement Friends and Family for Inpatients, Accident and Emergency (Emergency Room) and Maternity, the decision was taken to implement across all areas of the Trust.

Why this is important / what difference does this make to patients?

The FFT tool provides feedback in a timely manner in comparison to other surveys where there can be delays in obtaining feedback. It enables staff from boards to wards to have access to up to date patient feedback and act accordingly where deficits in care have been identified.

In particular a thematic approach can be used to address issues/concerns identified and this can be used at ward level in action plans to move along a continuum of service improvement. This approach enables monitoring of progress of actions to improve any deficits, for example, in care, the environment and nutrition.

It is also important that staff receive the many positive comments that are made by patients, which helps in raising and maintaining morale.

Progress made in report period 2014-15

The Trust has continued to consolidate the collection of Friends and Family across the Trust and has been placing more emphasis on improving the response rates (and quality of feedback) in areas that have previously not been responding to the same degree as other areas.

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
No. Responses Received	481	488	453	779	848	695	833	723	551	724	676	626
No. Would Recommend Trust	464	462	439	752	755	656	794	705	538	705	661	611
Would Recommend Trust (%)	96.5%	94.7%	96.9%	96.5%	89.0%	94.4%	95.3%	97.5%	97.6%	97.4%	97.8%	97.6%

Data source: LWFT internal data.

The Liverpool Women's NHS Foundation Trust considers that this data is as described for the following reasons:

- The Friends & Family Test is the nationally recommended method for garnering patient experience feedback. The process of providing the feedback is both anonymous and entirely independent of the Trust and its staff.

How progress to achieve the priority goal is monitored and measured

The individual service areas are responsible for managing quality priorities and indicators of relevance to them and are required to report on them monthly to their local Quality Improvement forum in a standardised format dashboard.

In Gynaecology the results from FFT are discussed each month at the patient experience quality meeting. On a monthly basis the ward managers receive an overview of the FFT results and the names of staff who have been named as providing a positive experience. If staff are named where a patient has described a negative experience then the ward manager will meet and discuss with the staff member.

In Maternity the FFT scores and themes are discussed at the Quality Meeting with the managers. The managers also receive a report monthly to inform them of the scores for their areas with comments. These are displayed locally on the wards for patients and visitors to read. The managers also receive notification of the staff named in feedback with pleased and displeased comments. If staff are named as displeased they will be seen by the ward manager and this will be monitored.

How progress to achieve the priority goal is reported

As described in the Trust's Quality Strategy, service level quality improvements forum(s) report quarterly to the Clinical Quality Governance Committee, who raise exceptions and concerns with the Operational Board and report quarterly to the Governance and Clinical Assurance sub-committee, which in turn reports biannually to the board. Thus the Trust's Clinical Quality Governance Committee and ultimately the Board have an overview of the delivery of the work streams in respect of this and all quality priorities and indicators.

Gynaecology

A number of themes have been identified in Gynaecology through FFT.

These have included:

- Noise at night.
- Emergency Department environmental issues.
- Communication.
- Staff attitude.

The Liverpool Women's NHS Foundation Trust has taken the following actions to improve this indicator, and so the quality of its services:

Some examples of what has been implemented to improve services:

- Staff huddles.
- Introduced bedside patient information books.

- Introduced “Hello my name is” board at the patient bedside.
- Investment in emergency department. This helped to address confidentiality in reception, the seating and room availability to assess patients.
- Introduction of comfort rounds in the emergency department and outpatient areas.

Some examples of the impact on the patient experience.

- Emergency department assessments improved.
- Access to Wi-Fi.
- Patient communication improved.

Maternity

Maternity have been working hard to improve and act on feedback from the FFT.
Some common themes over the last 12 months have been:

- Staff attitude.
- Lack of support caring for baby.
- Post-operative care and support.
- Waiting for painkillers.
- Delays in call bells being answered.
- Discharge delays from the Post natal wards.

The post natal areas have worked together to improve.

Some examples of changes to improve are:

- Introduction of 2hrly Comfort and Safety Rounds.
- Review of Infant Feeding support team and restructure to increase clinical hours on the wards.
- Use of volunteers in the clinical areas to support the ward teams.
- Introduction of bedside dispensing for medication to prevent delays.
- Increase of staffing levels to reduce midwife to women ratio.
- Review of the discharge process to include pharmacy and prescriptions.

Improvement in the feedback from women has been noted and the names of displeased staff have reduced for the clinical areas in Maternity. Improvements in patient experience have been found through the feedback and complaints received. Prevention of discharge delays and delays in medication has been supported by the staffing increases in the post natal areas.

Neonatal Unit – Transitional Care

The Transitional Care ward has 6 beds so the number of responses is lower than in other areas and are collated quarterly. 23 responses were obtained from Nov 14 – Feb 15. The overall feedback from mothers and families is extremely good (score 9.3 with 21/23 scoring the service 9-10) with very positive comments examples of which are :-

- Great support both practically with feeding and emotionally following NICU couldn’t of done without TC, All were very personable, supportive and with a tailored approach.
- you can read all the books watch videos but you can’t beat experienced caring staff walking and talking new parents through a daunting time, invaluable.

- Staff were excellent supportive and went out of their way to help.
- I have been a patient on TC for over a week now I have never meet such lovely caring staff throughout my stay here, don't know what I would do if this place didn't exist the only thing I would change would be to make it bigger.

To improve the service further Transitional Care staff are working with maternity staff to try to ensure that the beds are not used for maternity mothers when there are neonatal mothers waiting to be admitted to the area.

Hewitt Centre

All feedback from the Exit cards has been positive however our local patient satisfaction audits have highlighted the following :

Waiting times
Reducing waiting times continues to be one of our biggest challenges. Although this has generally seen a big improvement in the last year. The larger majority of extended waiting times are related to the scan service.

We have appointed 3 part time consultant ultra- sonographers who are supporting the one stop infertility pathway and nurse ultrasound training. We are hoping therefore that as more nurses become competent scanners, waiting times for scan appointments will reduce.

RED CARE INDICATORS	CHALLENGES	Action points
Waiting times unacceptable	Reducing waiting times continues to be one of our biggest challenges. Although this has generally seen a big improvement in the last year. Unfortunately this has dipped in October 2014 and has given us our first red for waiting times this year. The larger majority of extended waiting times are related to the scan service.	We have appointed 3 part time consultant ultra-sonographers who are supporting the one stop infertility pathway and nurse ultrasound training. We are hoping therefore that as more nurses become competent scanners, waiting times for scan appointments will reduce.
Documentation	Documentation and completion of HFEA consents has seen a big improvement in the last year although disappointingly we have seen 2 red indicators in September and October.	As a result of recent audits we set up 2 consent workshops in September and October to provide both new staff and old a refresher around checking consent and documentation. We hope to see an improvement over the next few months.

2.3.4 Nursing and Midwifery Priorities for Improvement 2015-16

The priorities for improvement in 2015-16 as identified by the Nursing & Midwifery Board are summarised in the following tables.

Priority	Rationale for Selection	How Measured	How Monitored	How Reported
1:1 care in established labour (Patient Experience)	This goal was selected by senior clinical midwifery staff and gained divisional approval due to the importance of support for a woman and her family during established labour and birth.	The number of women receiving 1:1 care during established labour expressed as a percentage of all maternity episodes of care. (Exclusions apply for patients with Elective Caesarean Section and emergency no labour Caesarean Sections).	The data is entered at delivery by midwifery staff, the measure is derived from an extraction report from Meditech, the Trust's Patient Information System.	Weekly reports are delivered to departmental ward managers and matrons who clinically validate data, this is then reported monthly to Operations board by the Head of Midwifery.
Avoidable repeats for Antenatal screening and new born screening blood sampling (Clinical Effectiveness)	This goal was selected as it is a UK nation screening target set by Public Health England commissioning body for screening (UK NSC), we aim to reduce the number of avoidable repeats for new born blood spots to less than 1%.	This is the number of babies undergoing an avoidable new born blood spot repeat expressed as a percentage of all new born blood spots performed during that time period.	At LWH we have in place the Northgate newborn blood spot IT failsafe system for daily checking of lab samples. Any avoidable repeats are addressed with staff by team leaders, monthly report generated from the local Children's Trust are reported to the Antenatal and newborn screening co-ordinator, were staff are identified and a local training plan is put into place.	All avoidable repeats are reported locally to the Trust Performance and Information team and RAG ratings created with Action Reports created for any serious concerns. They are reported quarterly to Public Health England (PHE) and the screening co-ordinator liaises with PHE for timely action and communication. These figures are benchmarked across the northwest via the PHE Screening and Immunisations lead.
Breast Feeding Initial Rates (Clinical Effectiveness)	There is a CQUIN Target 60% by year end, which is not being met. We have full BFI accreditation and have adjusted the training to include recommendations from the new standards.	This priority is measured by using the question asked on the 'Meditech' transfer summary on discharge from the hospital to community midwifery. The question asks " Did the baby receive any breast milk in the first 48 hours ? " This is the BFI standard for recording the initiation of breast feeding.	Breast feeding rates are monitored through the monthly performance reports and action plans completed if the target is not achieved.	Rates are reported as a percentage of mothers delivered in the month.

Priority	Rationale for Selection	How Measured	How Monitored	How Reported
Home Birth (Patient Experience)	The choice to give birth at home should be available to all low risk women, the community redesign project aims to increase homebirth by 0.5 % in the first year and thereafter.	The number of women who are eligible at 36 weeks following risk assessment for a home birth expressed as a percentage of all maternity episodes of care.	Monitored through the Operations Board.	Reported to Operations Board.
Reduction of unplanned Gynaecology re-admissions through conducting a quarterly thematic review into all non – planned Gynaecology re-admissions in order to identify trends and implement measures to reduce. (Clinical Effectiveness)	To identify areas of improvement and work with primary care in order to reduce hospital re-admissions. It is acknowledged that some re-admissions into hospital could be avoided by improved partnership between Primary and Secondary care. It will also encourage secondary care to regularly review effectiveness of discharge planning and patient pathways.	Rate of thematic reviews carried out on all elective gynaecology unplanned readmissions.	The data will be provided by the information department and the number of thematic reviews will be recorded and monitored through the operational board performance meetings.	Thematic reviews will be reported to operational board , included in the performance report and presented by the Head of Nursing / Head of Operations.
To ensure a quarterly increase in the number of patients on a Gynaecology Enhanced Recovery Pathway receiving a post-operative telephone call. Milestones: 60% - Q1. 70% - Q2. 80% - Q3. 90% - Q4. (Clinical effectiveness)	To support the Enhanced Recovery Pathway, empower patients to self-care and manage potential symptoms post operatively. Provides support to patients. It will ensure that the relationship between the hospital and the patient is consistent and continues after the patient is discharged.	Measured electronically on Meditech which will provide information of number of patients on enhanced recovery pathway who have received post-operative telephone call, who have not received call and who have not responded to contact attempts.	The data will be entered into Meditech by nursing staff and the data will be obtained by an extraction report.	The compliance of enhanced recovery post -operative telephone calls will be reported to operational board, included in the performance report and presented by the Head of Nursing / Head of Operations.

2.4 Statements of assurance from the board

During 2014-15 the Liverpool Women's NHS Foundation Trust provided and / or sub-contracted 4 relevant health services:

- Gynaecology and Surgical Services.
- Reproductive Medicine and Medical Genetics.
- Maternity Services and Imaging.
- Neonatal and Pharmacy.

The Liverpool Women's NHS Foundation Trust has reviewed all the data available to them on the quality of care in all of these relevant health services, relating to the following activities.

- Delivered 8456 babies (registered births).
- Number of gynaecological in-patient [Day case, Elective, Non-elective procedures] performed – 7,652 [NHS patients only] / 7,769 [including Private Patients (PPs) and Overseas visitors (OSVs)].
- Cared for 1,123 babies in our neonatal intensive and high dependency care units.
- Number of IVF cycles performed – 1,648 (NHS patients only) / 1,676 (including PP and OSV).

The income generated by the relevant health services reviewed in 2014-15 represents 100% of the total income generated from the provision of relevant health services by the Liverpool Women's NHS Foundation Trust for 2014-15.

2.4.1 Clinical Audit

During 2014-15, 3 national clinical audits and 2 national confidential enquiries covered relevant health services that Liverpool Women's NHS Foundation Trust provides.

During 2014-15 Liverpool Women's NHS Foundation Trust participated in 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Liverpool Women's NHS Foundation trust was eligible to participate in during 2014-15 are as follows:

National Clinical Audits

- Neonatal Intensive and Special Care (NNAP).
- National Comparative Audit of Blood Transfusion Programme – Patient Information and Consent.
- Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK) – Perinatal Mortality.

National Confidential Enquiries

- Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK) – Maternal Deaths.
- Sepsis.

The national clinical audits and national confidential enquiries that Liverpool Women's NHS Foundation Trust participated in, and for which data collection was completed during 2014/15, are listed below

alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Table 1. Relevant National Clinical Audits

National Clinical Audit	Did the Trust participate?	Cases submitted
Neonatal Intensive and Special Care (NNAP).	✓	**100%**
National Comparative Audit of Blood Transfusion Programme – Patient Information and Consent.	✓	**100%**
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK) – Perinatal Mortality.	✓	**100%**

Table 2 Relevant National Confidential Enquiries

Confidential Enquiry	Did the Trust participate?	Cases submitted.
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK) – Maternal Deaths.	✓	**100%**
Sepsis.	✓	**No applicable cases.**

The reports of 3 national clinical audits were reviewed by the provider in 2014-15 and Liverpool Women's NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Neonatal Intensive and Special Care (NNAP):

The most recent National report was published in October 2014. Admission temperatures are well documented in babies admitted to the Neonatal Unit, although there remain some data issues. This is as Liverpool Women's has a stand-alone Badger 3 system (Clevermed UK) which provides a full EPR for our patients. This system is not fully compatible with the national system. Attempts to match data items captured by the two systems have been made, but are imperfect. The Unit is in the process of migrating from the "Badger 3" system to a "Badgernet full EPR" system that will retain all of the functionality that our current Badger 3 system provides and will be fully compliant with the National Badger system. This migration has been slower than anticipated and has been held up by difficulties encountered by the supplier, not the Trust. Overall early thermal care at LWH is excellent and compares very well with the national performance.

National comparative audit of the patient information and consent:

Overall, the audit showed that in 80% of the cases reviewed, the standardised blood transfusion consent form was utilised. In cases where it was used, it was evident that adequate documentation of the consent process was achieved. 100% of cases were consented by a doctor.

The consent e-learning module was re advertised to all relevant clinical staff which can be accessed via the www.learnbloodtransfusion.org.uk and NLMS system. We have continued to advocate the use of the standardised national consent form to all the mandatory training sessions, junior doctors' induction, junior anaesthetists' induction and annual consultant training sessions. All junior doctors, junior anaesthetists and consultants receive transfusion training incorporating the transfusion consent process during each induction and mandatory training session.

Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK) – Perinatal Mortality:

The report relating to this period is not expected to be published until later in the year. The latest national report on this audit was published in December 2014. It made 9 national recommendations, each of which the Trust has benchmarked against locally. Where potential improvements or changes in practice have

been identified they are now being implemented, with updates provided to Clinical Governance Committee in February 2015.

The reports of 53 local clinical audits were reviewed by the provider in 2013-14 and Liverpool Women's NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Table 3 Local Audit actions

Local Audit Title	Actions
To review the management of patients with HIV at LWH in comparison to the recommended management detailed in the British HIV Association (BHIVA) guidelines for the management of HIV infection in pregnant women (2012) RCOG guidelines for the management of HIV in pregnancy (2010) (Otherwise known as “Audit of HIV in pregnant women”).	As women are now delivering in all intrapartum areas, there is a need to update information within each area of when babies post-exposure prophylaxis (PEP) to be given and where it is kept. Therefore re-enforcement is required on all intrapartum areas highlighting the need to give PEP within 4 hours. This was presented in a poster format for Lesson of the Week and presented at BHIVA meeting with some additional information from RLUH.
Audit of use of Placental Growth Factor (PlGF) for the management of hypertension in pregnancy.	Continued usage of PlGF as part of standard clinical management for women with hypertension in pregnancy <35 weeks was agreed and actioned. A new coloured, easier recognisable sheet, for women managed with PIGF is now kept in handheld notes. Audit findings, especially regarding timings of PlGF tests, were fed back to Midwifery Assessment Unit staff.
Annual stillbirth audit 2013-14.	Audit of customised ‘Gestation Related Optimal Weight’ (‘GROW’) charts was recommended. This has been added to the 2015-16 forward plan. GROW charts are now included in all notes. A database for 2014 stillbirth audit was designed and built. Following findings from audit, British National Formulary (BNF) were notified of possible adverse side effect of medication. The Safeguarding team were contacted regarding a high risk patient as issues were raised. Future presentations to have GROW charts included to highlight awareness. Awareness was raised to ensure all women (including those from Ireland) have formal booking process completed, and all intrapartum stillbirths are recorded as serious incidents. 4 CESDI (Confidential Enquiries into Stillbirths and Deaths in Infancy) were presented at the perinatal morbidity and mortality meeting. Women booked at LWH but who receive antenatal care elsewhere did not have charts completed, therefore obesity guideline was updated to include aspirin 75mg and folic acid 5mg.
The use of maternal magnesium sulphate for fetal neuro protection.	To raise staff awareness of the importance of use of maternal magnesium sulphate for fetal neuro protection and to disseminate audit results. This audit was presented at the Better Breakfast meeting in June and at the Fetal Medicine Study day in July. An email discussion was held amongst consultants and the audit was presented at the GREAT day in September.

Local Audit Title	Actions
Audit of 2011 NICE guidance multiple pregnancies (NICE Guideline 129).	Overall, the audit evidenced that antenatal care of multiple pregnancies at LWH, using the NICE Guideline 2011 as a standard, are well managed. However it was recommended that the use of LWH proformas, particularly Place, Timing and Mode of Delivery (PTMD), should be encouraged. Midwives and Obstetricians working in the Multiple Pregnancies Clinical were informed and advised to use these forms. On reviewing the guideline, it was noted that the ladies do not need to be seen in the Multiple Pregnancy clinic at 34wks, but can have a community review. This was highlighted to the community midwives that 34 week reviews should be encouraged. Presented at the Better Breakfast meeting on 5th September 2014.
Antenatal documentation of Small for Gestational Age (SGA).	Additional training for junior doctors about use of GROW charts. Raised awareness and teaching regarding the importance of putting "do not use" stickers over the population growth charts in current antenatal notes, and removing these from future antenatal notes. A new Meditech field was created on the Delivery Summary section to document whether SGA was identified antenatally. This audit to feed into larger audit of "SGA detection" which was underway at the time.
Low cord pH & HIE audit / Unexpected admission of term babies to Special Care Baby Unit (SCBU)	Increase incidence of adverse clinical events (ACE) reporting by encouraging staff to do this in the workplace. Despite clear guidelines about when an ACE report should be submitted some cases are still being missed. Therefore to highlight these issues and raise awareness, the full report and findings were presented at the Better Breakfast meeting on 4th July 2014 and 9th January 2015. Development of continuous monitoring.
Annual audit of practice and outcomes of invasive procedures in the Fetal Medicine Unit 2013-14.	Dissemination to individual operators – Give individual operators their personal data for appraisal and reflection. Incomplete / inaccurate data entry on viewpoint system in Fetal Medicine Unit (FMU) – Discuss data entry improvement (all fields and accuracy) with all operators. Anti-D administration to Rh negative women (91.2%) Std 100% - Discuss data entry improvement while giving anti-D with FMU midwives. Communicate need to continue to work towards reducing >1 insertion for amnio aiming to reach standard of <2%. If >1 entry documented why procedure difficult e.g. High BMI, difficult access due to placental site. Review at re-audit of 2014 procedures. Culture failure rates for Chorionic Villus Sampling (CVS) higher than Std of 1% To discuss with lab reasons behind high culture failure rates.

Local Audit Title	Actions
Emergency Caesarean Section.	The only action is to re-audit in a year or two and to also consider analysing the whole year's data.
Shoulder Dystocia.	Reminder to staff about the diagnosis of shoulder dystocia as part of mandatory training. This was completed in the form of Lesson of the week (LOTW).
Incidence, detection and outcome (management) of IUGR Combined with Antenatal Detection of SGA/IUGR births following implementation of GROW charts at LWHFT and assess performance against units with highest detection rates.	All nominated leads are to ensure that staff in their areas are up to date with GAP training. A Consultant Obstetrician is now the administrator and monitor for all staff involved. Consultant Obstetrician now meets with Maternity team to facilitate day to day issues with GAP. Consultant Obstetrician now facilitates midwifery GAP training on rolling study days. A new midwifery education lead for GAP training was identified. Audit identified missed IUGR cases from ACE reports and this issue was raised with Risk Leads. Intra-Uterine Growth Restriction (IUGR) detection rates will now be monitored on an annual basis – Re-audit on annual basis.
Placenta Praevia re-audit.	Audit results were presented at the Better Breakfast meeting on 5th December 2014. There were no new actions from this re-audit.
To assess compliance with LWH Primary Postpartum Haemorrhage Guideline	Increased awareness of the appropriate team to call and better documentation of members present at the PPH is required. Therefore a memo email is to be sent to all delivery suite staff with a reminder to trigger the massive obstetric haemorrhage protocol. Staff are to be made aware of and use of the major obstetric haemorrhage trigger for ongoing bleeding over 1500ml, and to record all members of the team present as well as a reminder to staff as to who should be called. The increased use of cell saver should be discussed between obstetricians, anaesthetists and theatre staff. Therefore an email was sent to all staff as a reminder to clearly state the level at which blood is required and to document this in the notes. Encourage clear communication to the blood transfusion team as to the level required for blood transfusion. Therefore, a formal discussion between anaesthetic team, theatre staff and obstetricians should be instigated to discuss maximising the use of cell saver for likely post-partum haemorrhages. Presented at Better Breakfast meeting on 6.2.15.

Local Audit Title	Actions
Audit to assess antenatal/intrapartum/postnatal complications of women with BMI greater than 30	Training to highlight importance of obtaining and documenting accurate Body Mass Index (BMI) on booking visit. Raise awareness to ensure that all women with obesity undergo gamma-glutamyl transferase testing (GGT) between 24-28 weeks gestation, and are appropriately followed up in consultant led clinic if positive. Raise awareness to ensure that all women are adequately counselled on potential complications of being obese in pregnancy. Encourage women to positively engage with healthcare professional to minimise risk of complications. Ensure that bariatric checklist is used by all multi-disciplinary teams as an aid to both identify risk, and as a prompt to initiate early implementation risk reducing measures.
Are we screening too much for retinopathy of prematurity (ROP)?	Audit results were disseminated locally, nationally and internationally. The audit findings were presented to all staff at the GREAT day on 29.06.14 which was followed by discussion. Re-audit is unnecessary as performance is now audited through National Neonatal Audit Programme.
Cheshire and Merseyside Network audit on term admissions to Neonatal Intensive Care Unit. (An NNAP audit)	This is a network audit. Currently no actions are required for LWH as a consequence of this audit. Audit findings presented at Clinical Governance Group meeting.
Bereavement care in Cheshire and Merseyside Neonatal Network.	There are now protected teaching sessions on paperwork and documentation. Shift leaders were reminded via email to document the reason if paperwork is not completed if unable to do so and sign sheet when completed. Protected teaching sessions now include importance of parents being offered opportunity to take their baby home after death. Debrief now takes place after each death. A new consultant led on this and the number of debriefing sessions and the number of debriefs has improved.
Post-operative complications in necrotising enterocolitis surgery.	Audit was fed back to medical and nursing teams for discussion and training purposes highlighting improvement to documentation of nutritional strategies for post-operative care was required. A nominated lead nurse for stoma care was created in April 2013 and enrolled in The Paediatric Stoma Case and Continence management at Birmingham University in Sept 2013 completing this module in December 2013. Staff to inform her of any stomas so that the more effective product can be applied. There were no set guidelines in LWH for stoma care, therefore this was a benchmarking audit. New LWH guidelines were formulated, utilising other centres, and agreed and adopted. Presented at the Combined Neonatal Surgical Meeting on 10th July 2013.

Local Audit Title	Actions
Management of pain on Neonatal Units (a network audit)	Highlighted in “Lesson of the Week” for staff:- 1. Consistency of documenting actions taken when assessing pain, 2. Pharmacological pain relief a) should be adjusted according to pain score, b) should consider ngl and mol as an alternative to morphine, 3. Administration and documentation of pain relief during procedures. It was agreed that parents should be involved in providing pain relief for their babies; therefore a leaflet was written and made available for parents regarding pain management. Protected teaching sessions put in place for nursing staff.
Bacillus Calmette–Guérin (BCG) vaccination audit.	Midwives are not to discharge babies home before BCG if a baby is identified as being eligible for the vaccination. Community midwives to refer all eligible babies for immunisation. All midwives informed of change in practice, and this will be re-audited in 2014-15 to check if these changes have been implemented.
National Neonatal Audit Programme (NNAP)	Now ensured that there is a documented consultation with parents/carers by a senior member of the neonatal team should occur within 24 hours of admission. This issue was highlighted via Lesson of the Week.
Management of infants at risk of hypoglycaemia re-audit.	Lesson of the Week in July 2014 reiterated the importance of starting feeds within one hour and having regular three hourly feeds in at risk babies on the postnatal ward to the midwifery team. To ensure blood sugars are monitored as per protocol on both postnatal wards and Neonatal Intensive Care Unit. To reiterate importance of voiding >120ml/kg fluids before day 4 when appropriate and reducing the IV fluid rate once sugars stable.
Compliance with LWH Guideline on position of Umbilical venous catheter (UVC).	Education about UVC position and documentation was required. Therefore the audit was presented at Neonatal consultants meeting, at Senior House Officer / Registrar teaching and via Lesson of the Week. UVC thoracic vertebrae level to be documented on badger daily summary. A new tab for lines and reviewing line position daily if had x-ray was created. Also highlighted in Lesson of the Week. Method of securing UVC to be reviewed and compared with other level 3 units. It was agreed to re-audit in Spring 2016.
Re-audit Random prescription safety audit on Neonatal Intensive Care (includes Gentamicin).	To continue junior doctors’ prescription competency training and assessment. Review and enhance context of junior doctors’ induction programme in relation to good prescribing practice. Emphasise the importance of legible signatures during this session. Extend regular prescription competency training and assessments to Advanced Neonatal Nursing Practitioners.

Local Audit Title	Actions
BCG vaccination re-audit.	Review of booking screen and move risk assessment to booking was implemented. Review of neonatal discharge screen in Meditech was required, following which amendments were made to the discharge screen. Prescription and administration of immunisations on the neonatal unit uses a paper based system; therefore all immunisations on neonatal unit are now prescribed electronically and administration is recorded electronically (Badger system). Existing data is not fit for the purpose of providing accurate data for populating the performance dashboard agreed with Clinical Commissioning Group. Therefore review of data collection processes after implementation of above.
Audit of line associated infection in babies with femoral arterial and venous lines	The use of femoral vessel catheterisation is to be continued in babies in whom other forms of vascular access are not possible. Catheter associated blood stream infection (CABSI) rates are to be monitored prospectively. The need for central vascular access is now reviewed (monitored) on a daily basis by Neonatal Consultants.
Infusion safety on the Neonatal Unit.	Teaching on infusion safety to Neonatal staff to be continued. This is now part of induction for junior doctors and nursing staff as part of their induction training, which is currently in place. Poster was presented at regional meeting.
Audit to assess outcomes of infants who have stomas (audit in conjunction with Alder Hey Children's Hospital).	No issues raised, this was preliminary data that needs confirmation from other centres and will therefore be submitted for publication. To re-audit in 5 years' time – it will take this length of time in order to have a large enough cohort of patients.
Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) re-audit.	Disseminate findings to Maternity and Gynaecology consultants. After discussion, agree an education/awareness plan.
To assess if abnormal or unexpected findings in gynaecological or general ultrasound reports are being highlighted and acted upon (National Patient Safety Alert).	Sonographers reminded about alert code policy via notice.
Audit of bedside transfusion practice.	Enhanced mandatory training and assessment for all staff involved in delivering blood transfusions.
Management of coagulopathy in Massive Obstetric Haemorrhage.	All standards met. Continuous monitoring in progress.

Local Audit Title	Actions
Appropriate use of Emergency O RhD Negative red cells at LWH.	Education of clinical and lab staff on the national guidelines and standards through presentations and teaching sessions; also incorporated into the induction programme for new doctors and lab staff at the trust, as well as into regular teaching programmes. Massive haemorrhage protocol displayed in all relevant clinical areas and education on its use and details to raise awareness and encourage compliance. Findings of this audit distributed and discussed trust-wide via transfusion committees and risk meetings. Staff educated on the protocols for transfusion out-of hours and the possibility to open the lab for group-specific blood. Good communication and systems put in place with the lab in working hours to get group-specific blood as soon as possible. Staff educated on the importance of clear documentation for reasoning behind use of O RhD negative blood and in particular the number of units needed. Monthly monitoring of all emergency O RhD negative units transfused implemented.
Patient controlled analgesia (PCA) Remifentanil in labour.	Improved teaching presentations for Anaesthetists and Midwives regarding the use of PCA remifentanil in labour. New guideline with recording chart implemented.
Audit of delay or non-provision of epidural analgesia in labour	Meditech reporting and analysis updated, including changes to epidural screen for midwife and anaesthetist to capture relevant timings to ensure more accurate information provision regarding 'non-provision of epidural analgesia in labour'. Introduction of sticker in case notes to make it easier to record relevant timings and reasons for delays. Trust epidural guideline updated to make it clear which patients need blood tests before epidural, to prevent patients having inappropriate bloods taken or waiting for unnecessary bloods. Information added to anaesthetic trainee's induction pack re; epidural wait times and blood tests. Information included in Midwives' epidural update re; wait times and blood tests.

Local Audit Title	Actions
Current Management of Elective C section including a review of fasting times, length of stay in order to develop new guidelines.	Review of fasting times planned due to them exceeding national standards. Business case to be formulated to purchase carbohydrate drinks to prevent/reduce ketosis. Staff to encourage patients to mobilise as soon as the regional anaesthetic effects have worn off and ideally within 6-12 hours after surgery. Staff to ensure that catheters are removed as soon as the patient is able to mobilise after the effect of the spinal has worn off or 12 hours after last epidural top-up.
Team Brief and World Health Organisation (WHO) checklist for Theatres	Gynaecology: Implementation of ongoing observational audits ensuring that a minimum of 20 per month are completed. Encourage any observed non-compliance to be reported and support staff with additional training. Line managers will be responsible for monitoring continued non-compliance and this may result in performance management. Results of audit to be discussed at relevant staff meetings. Awareness of the WHO Check List Audits continued. Obstetrics: WHO checklist to be re-launched in Obstetric theatres. Encourage any observed non-compliance to be reported and support staff with additional training. Line managers will be responsible for monitoring continued non-compliance and this may result in performance management. Results of audit to be discussed at relevant staff meetings. Considering modified WHO Checklist for Category 1 sections – contacting other Maternity units to see if they have a modified WHO Checklist for Category 1 sections.
Urinary incontinence in women Re-audit.	No changes in practice required. This is a re-audit to ensure improvement following implementation of actions from previous audit.
Record Keeping Audit – Health Professional referral letters (HPL).	Following appointment of new Head of Safeguarding, intention to redesign the HPL specific to safeguarding, with a risk assessment attached.

Local Audit Title	Actions
Diagnosis of management of molar pregnancy 2013 (re-audit).	31 day target to replace 28 day target for time from notification of histology to registration to reflect calendar month clinic, rather than four-weekly clinic. Patients where there is a delay in clinic review should be offered registration when contacted to inform of histology result with verbal consent taken for permission to register. It has been agreed that where patients are distressed by the news attempts will be made by the molar pregnancy team to arrange an earlier review and registration by Dr Scanlon (new molar pregnancy lead). Continue with the molar pregnancy clinic on a regular monthly basis. Discuss with the histology department regarding the time frame between intervention and histology report, e.g. confirm their departmental protocol/target. Keep an accurate record of referral times via the molar pregnancy database. Keep the pathologists apprised of audit results by emailing them the presentation and inviting them to attend the trust presentation, welcoming comments for future audits. Reapply for continuous audit to allow monitoring of referral times and provide feedback for the service.
Laparoscopic injury (NPSA alert)	Aintree patients now receive copy of patient information leaflet on laparoscopic surgery. Discussion with/ education for Gynaecology ward staff on information after laparoscopic hysterectomy.
Audit of Midurethral tapes for urinary stress incontinence at LWH against NICE guideline CG171.	Introduction of multi-disciplinary team (MDT) proforma and work with pre-op nurses to ensure this is implemented. Individual cases of de novo overactive bladder and urinary retention after mid-urethral tapes should be seen by a consultant at follow up and consideration should be made about discussion at MDT to identify ongoing trends A new departmental guideline has been introduced
Non pregnant unplanned re-attenders within 7 days.	All non-pregnant unplanned re attenders to be reviewed by senior clinician. Post-operative patients currently reviewed on ER should be reviewed on the ward.

Local Audit Title	Actions
Audit of Patient Initiated Paracentesis Service at LWH	Improvement of recording nursing intervention – New Meditech screen implemented. Improvement in communication back to GP – New Meditech screen implemented. Limited documentation on the use of diuretics post paracentesis – Change to Meditech screen implemented.
Re-audit of Surgical Management of endometrial cancer and the impact of the enhanced recovery programme.	New gynaecology Enhanced Recovery Pathways have been created.
Audit of incisional site infection.	New Standard Operational Procedure for 'Skin Preparation and Draping Prior to Surgery' has been implemented.
Audit of the management of Bartholin's abscesses.	Dr Melisa Thomas provided postgraduate teaching to junior doctors during the Friday afternoon teaching programme on the procedure of the removal of the Bartholin's Abscess.
Audit to assess effectiveness of Colposcopy Service for patients with symptoms suspicious of cervical cancer.	No change in practice.
Adherence to European Consensus Guidelines for Genetic Testing in Long QT Syndrome: a cross specialty	Score to be given or calculated at referral Discussion of all borderline cases at joint meeting prior to testing. Adapt new long QT proforma to allow more space for diagnostic information. Ascertain if able to collect genotypic data via Meditech.
Audit to review Clinical Genetics practice of paediatric fail to attend policy.	Department to clarify how and where all fail to attend paediatric patients are to be recorded in the department. New 'fail to attend' flow chart has been completed. New Healthcare Assistant role will be to check bulletin board on all patients. For all clinicians seeing paediatric patients to ensure all appropriate health professionals informed of patients failure to attend clinical genetics appointment. In Safeguarding Children's Policy.
National Beckwith-Wiedemann Syndrome – Wilms Tumour Surveillance Audit.	No change in practice.

Local Audit Title	Actions
Send away tests – re audit.	Explore the possibility of an IT solution to ensure that send-away tests have been discussed and approved. Review the send-aways quarterly to monitor the amount spent. Analyse the cardiac send-away tests further e.g. clinician, diagnostic versus predictive. Explore the possibility of using some of the funding from the Chester Service Level Agreement to pay for the additional tests we will fund when we have merged with the Chester service.
Double Embryo Transfer (Nice Guideline 156 Fertility).	Presented results at the clinical meeting in the Hewitt Centre. New patient information leaflet about multiple pregnancy risks has been produced. Embryologists have been trained to make sure that the patients sign the consent form if they request double embryo transfer against advice. The new In Vitro Fertilisation (IVF) Standard Operating Procedure has been activated and distributed to all relevant staff in the Hewitt Centre.

2.4.2 Clinical Research

In 2014/15 we have continued our efforts to contribute to quality National Institute for Health Research (NIHR) studies and to maintain our subsequent numbers of NIHR recruitment accruals.
The number of patients receiving relevant health services provided or sub-contracted by Liverpool Women's NHS Foundation Trust in 2014/15 that were recruited during that period to participate in research approved by a research ethics committee was 1,881, of which, 1,077 were recruited into NIHR portfolio studies.

Liverpool Women's was involved in conducting 126 clinical research studies across our speciality areas of maternity, neonates, gynaecology oncology, general gynaecology, reproductive medicine and genetics during 2014/15. At the end of 2014/15 a further 17 studies were in set up.

There were 76 clinical staff contributing to research approved by a research ethics committee at Liverpool Women's during 2013/14. These staff contributed to research covering a broad spectrum of translational research from basic research at the laboratory bench, through early and late clinical trials, to health systems research about healthcare delivery in the community.

Our research has contributed to the evidence-base for healthcare practice and delivery, and in the last year, 73 publications have resulted from our involvement in research, which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS.

2.4.3 CQuIns

A proportion of Liverpool Women's NHS Foundation Trust's income in 2014-15 was conditional upon achieving quality improvement and innovation goals agreed between Liverpool Women's NHS Foundation Trust and any other person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2014-15 and for the following 12 month period are available electronically at: http://www.liverpoolwomens.nhs.uk/About_Us/Quality_and_innovation.aspx .
The total monetary value of the income in 2014-15 conditional upon achieving quality improvement and innovation goals was £ £1,955,007. The monetary total for the associated payment in 2013-14 was £1,850,285.

The Trust reported performance against CQuIns targets for 2014-15 are provided in the following table.

CQUINs Dashboard for 2014/15

Goal Number	Indicator Number	Indicator Name	Weighting	£ Weighting	Apr	May	Jun	Target	Qtr1	Jul	Aug	Sep	Target	Qtr2	Oct	Nov	Dec	Target	Qtr3	Jan	Feb	Mar	Target	Qtr4
1		**Friends and Family Test**		**£72,802**																				
	1.1	Implementation of Staff F&FT	0.0375%	£21,841	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	157	118	105	38	Compliant	261	50	0	0	Compliant	50
	1.2	Early implementation Day Cases and Outpatients	0.01875%	£10,920	Compliant	Compliant	Compliant	Compliant	Compliant	1.9%	1.7%	1.0%	Compliant	1.5%	1.1%	1.5%	1.1%	Compliant	1.2%	0.7%	1.8%	0.0%	Compliant	0.8%
	1.3	Improvement in A&E	0.01875%	£10,920	25.8%	25.8%	24.4%	15%	25.3%	47.4%	39.2%	29.4%	20%	38.9%	40.1%	31.2%	35.6%	>20%	35.7%	45.9%	43.7%	34.7%	>20%	41.2%
	1.4	Response rate improvement In patients	0.05%	£29,121	25.7%	19.5%	26.3%	25%	23.9%	23.4%	40.6%	39.2%	30%	33.4%	43.0%	59.5%	43.2%	>30%	48.6%	48.9%	59.6%	50.0%	>30%	52.7%
	1.5	Provide timely, granular feedback from patients about their experience	0.0750%	**£43,861**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
2		**NHS Safety Thermometer – Data Collection**		**£72,802**																				
	2.1	National Safety Thermometer	0.0625%	£36,401	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
	2.2	Reduction in Pressure Ulcers	0.0625%	£36,401	None	None	None	95%	None	None	None	None	>Qtr1	None	None	None	None	>Qtr2	None	None	None	None	>Qtr3	None
3		Dementia		**£72,802**																				
	3.1.i	FAIR - Find, Assess, Investigate & Refer	0.0750%	£43,681	100.0%	100.0%	100.0%	90%	100.0%	100.0%	100.0%	100.0%	90%	100.0%	100.0%	100.0%	None	90%	100.0%	None	None	#DIV/0!	90%	100.0%
	3.1.ii	Clinical Diagnosis of delerium etc			None	None	None	90%	None	None	None	None	90%	None	None	None	None	90%	None	None	None	None	90%	None
	3.1.iii	Further assessment/ diagnostics for Dementia			None	None	None	90%	None	None	None	None	90%	None	None	None	None	90%	None	None	None	None	90%	None
	3.2	Clinical Leadership (Compliant Yes or No)	0.0125%	£7,280	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
	3.2B	Clinical Leadership: Staff Dementia Training			Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
	3.3	Supporting carers (Compliant Yes or No)	0.0375%	£21,841	Biannual Report								Compliant	Compliant - no patients to audit	Compliant - no patients to audit	Compliant - no patients to audit	Compliant - no patients to audit	Compliant	Compliant - no patients to audit	Compliant no patients to	Compliant - no patients to audit	Compliant no patients to	Compliant	Compliant - No Patients to audit
4		**Maternity Bundle**		**£349,449**																				
	4.1	Breastfeeding Initiation	0.1%	£58,242	54%	54%	50%	53%	52%	52.9%	52.5%	55.5%	>53%	53.7%	49.7%	51.1%	55.1%	>Qtr2	51.8%	53.8%	53.6%	50.4%	>Qtr3	50.3%
	4.2.i	Maternal Smoking status captured at 38 Weeks	0.1%	£58,242	100.0%	100.0%	100.0%	65%	100.0%	100.0%	100.0%	100.0%	75%	100.0%	100.0%	100.0%	100.0%	85%	100.0%	100.0%	100.0%	100.0%	95%	100.0%
	4.2.ii	% maternal smokers offered referral to smoking cessation services			100.0%	100.0%	100.0%	45%	100.0%	100.0%	100.0%	100.0%	50%	100.0%	100.0%	100.0%	100.0%	55%	100.0%	100.0%	100.0%	100.0%	60%	100.0%
	4.3	Vitamin D	0.1%	£58,242	N/A	N/A	N/A	NA	#DIV/0!	81.4%	80.2%	77.7%	40%	79.8%	76.9%	76.8%	74.1%	75%	75.9%	77.8%	83.6%	82.6%	82%	81.3%
	4.4	Flu Vaccinations Pregnant Women (Offered)	0.1%	£58,242	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	95.5%	75%	95.5%	92.9%	95.9%	93.9%	65%	94.2%	93.4%	94.0%	87.9%	75%	91.8%
		Flu Vaccinations Pregnant Women (Refused)										48.60%		48.60%	4.19%	5.44%	3.99%		4.5%	6.08%	7.63%	37.51%		17.00%
		Flu Vaccinations Pregnant Women (Given at GP)										4.37%		4.37%	8.74%	16.19%	20.07%		14.9%	16.42%	17.20%	11.65%		15.09%
		Flu Vaccinations Pregnant Women (Given at Booking)										0.90%		0.90%	0.00%	5.31%	7.36%		4.2%	4.26%	0.46%	0.00%		1.62%
	4.5	Pregnant women are cared for by a named midwife throughout their pregnancy	0.1%	£58,242				65%	N/A	Compliant	Compliant	Compliant	65%	Compliant	Compliant	Compliant	Compliant	65%	Compliant	Compliant	Compliant	Compliant	65%	Compliant
	4.6	BMI index	0.1%	£58,242				Compliant	Compliant	81.6%	95.2%	88.5%	TBC	88.0%	86.2%	88.6%	85.1%	86%	86.8%	86.6%	80.5%	78.8%	90%	82.0%

CQUINs Dashboard for 2014/15

CQUINs Dashboard for 2014/15

Goal Number	Indicator Number				Apr	May	Jun	Target	Qtr1	Jul	Aug	Sep	Target	Qtr2	Oct	Nov	Dec	Target	Qtr3	Jan	Feb	Mar	Target	Qtr4
5		**Cancer**		**£145,604**																				
	5.1	First diagnostic test by day 14	0.125%	£72,802	92.0%	88.1%	88.1%	85%	89.3%	94.1%	94.2%	95.2%	85%	94.3%	95.93%	97.44%	95.35%	85%	94.33%	94.82%	95.45%	90.78%	85%	93.9%
	5.2	Referral to treating trust by day 42	0.125%	£72,802	100.0%	100.0%	None	85%	100.0%	None	None	None	85%	None	100%	50%	None	85%	50.0%	0.00%	None	100.00%	85%	50.0%
6		**Effective Discharge Planning Maternity -**		**£291,208**																				
	6.1	Signed off Action Plan (Compliant Yes or No)	0.125%	£72,802	Action Plan	Action Plan	Action Plan	Action Plan	Action Plan	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
	6.2	Discharges with appropriate care packages?	0.125%	£72,802	Action Plan	Action Plan	Action Plan	Action Plan	Action Plan	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
	6.3	Discharge Checklist Audit (Compliant Yes or No % completed)	0.125%	£72,802	Action Plan	Action Plan	Action Plan	Action Plan	Action Plan	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
	6.4	Annual Discharge Survey (Numbers surveyed?)	0.125%	£72,802	Action Plan	Action Plan	Action Plan	Action Plan	Action Plan	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
7		**Electronic Discharge Summaries**		**£407,691**																				
	7.1.i	In-Patient Electronic Discharge Summaries to GPs within 24 Hrs	0.2%	£116,483	Action Plan	Action Plan	Action Plan	Action Plan	Action Plan	Compliant	Compliant	Compliant	75%	Compliant	Compliant	Compliant	Compliant	85%	Compliant	Compliant	Compliant	Compliant	95%	Compliant
	7.1.ii	In-Patient Electronic Discharge Summaries to Patient same day as Discharge			Action Plan	Action Plan	Action Plan	Action Plan	Action Plan	Compliant	Compliant	Compliant	75%	Compliant	Compliant	Compliant	Compliant	85%	Compliant	Compliant	Compliant	Compliant	95%	Compliant
	7.2	Outpatient Correspondence	0.2%	£116,483	Action Plan	Action Plan	Action Plan	Action Plan	Action Plan	Compliant	Compliant	Compliant	TBC	Compliant	Compliant	Compliant	Compliant	TBC	Compliant	Compliant	Compliant	Compliant	TBC	Compliant
	7.3	Emergency Room/Day Cases Correspondence	0.15%	£87,362	Action Plan	Action Plan	Action Plan	Action Plan	Action Plan	Compliant	Compliant	Compliant	TBC	Compliant	Complaint	Compliant	Compliant	TBC	Compliant	Compliant	Compliant	Compliant	TBC	Compliant
7.4	7.4	**ILINKS Transformation Programme**	0.05%	£29,121																				
	7.4.i	A named IM&T Lead to take co-ordinating responsibility for Communications CQUINS from within the Trust			Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant		Compliant	Compliant	Compliant	Compliant		Compliant	Compliant	Compliant	Compliant		Compliant
	7.4.ii	The aforementioned Lead to attend monthly CQUIN meetings and review quarterly milestones with an assigned Informatics Merseyside representative			Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant		Compliant	Compliant	Compliant	Compliant		Compliant	Compliant	Compliant	Compliant		Compliant
	7.4.iii	Trust to agree to aprticipate in iLinks Transofromation Programme and Clinical Informatics Advisory Group			Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant		Compliant	Compliant	Compliant	Compliant		Compliant	Compliant	Compliant	Compliant		Compliant
	7.4.iv	Trust to nominate a clinical and informatics representative			Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant		Compliant	Compliant	Compliant	Compliant		Compliant	Compliant	Compliant	Compliant		Compliant
	7.4.v	Trust representatives to attend bi-monthly forums			Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant		Compliant	Compliant	Compliant	Compliant		Compliant	Compliant	Compliant	Compliant		Compliant
	7.4.vi	Trust to commit to supporting and developing the informatics 'Guiding Principle' (as detailed in the ILINKS Transofrmation Programme Update February 2014)			Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant		Compliant	Compliant	Compliant	Compliant		Compliant	Compliant	Compliant	Compliant		Compliant
	7.4.vii	Trust to participate in health economy wide benefits realisation as part of the iLINKS Transformation Programme via the Programme Board.			Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant		Compliant	Compliant	Compliant	Compliant		Compliant	Compliant	Compliant	Compliant		Compliant

CQUINs Dashboard for 2014/15

CQUINs Dashboard for 2014/15

Goal Number	Indicator Number	Indicator Name	Weighting	£ Weighting	Apr	May	Jun	Target	Qtr1	Jul	Aug	Sep	Target	Qtr2	Oct	Nov	Dec	Target	Qtr3	Jan	Feb	Mar	Target	Qtr4
	7.6	**Systems Interoperability and clinical data sharing**	0.05%	£29,121																				
	7.6.i	Firm plans submitted of how providers will achieve "interoperability" to view shared data within own existing systems (Not stand alone clients).			TBD	TBD	TBD	TBD	TBD	Compliant	Compliant	Compliant		Compliant	Compliant	Compliant	Compliant		Compliant	Compliant	Compliant	Compliant		Compliant
	7.6.ii	Strategy - where applicable to reduce stand alone EMIS clients for read only access across Health Economy by 2015			TBD	TBD	TBD	TBD	TBD	Compliant	Compliant	Compliant		Compliant	Compliant	Compliant	Compliant		Compliant	Compliant	Compliant	Compliant		Compliant
	7.6.iii	Continuation of Agreed Data Sharing Schemes			TBD	TBD	TBD	TBD	TBD	Compliant	Compliant	Compliant		Compliant	Compliant	Compliant	Compliant		Compliant	Compliant	Compliant	Compliant		Compliant
	7.6.iv	A plan to be submitted to and agreed by CCG as a coherent means of sharing clinical data across the Trust			TBD	TBD	TBD	TBD	TBD	Compliant	Compliant	Compliant		Compliant	Compliant	Compliant	Compliant		Compliant	Compliant	Compliant	Compliant		Compliant

CQUINS - Specialist Commissioner

	SC																							
	SC1	Improved access to maternal breast milk in preterm infants			Establish Baseline	Establish Baseline	Establish Baseline	Establish Baseline	Establish Baseline	12.5%	12.5%	41.7%	>24.5%	25.0%	60.0%	34.8%	38.1%	TBC	42.4%	42.9%	52.9%	26.3%	TBC	40.0%
	SC2	Access to Array CGH for Prenatal Diagnosis			Qtr3	Qtr3	Qtr3	Qtr3	Qtr3	Qtr3	Qtr3	Qtr3	Qtr3	Qtr3	Qtr3	Compliant	Compliant	TBC	Compliant	100.0%	100.0%	100.0%	TBC	100.0%

A comparable dashboard is being developed to record and report CQuIns 2015-16 and is due to be completed in May 2015

2.4.4 Care Quality Commission

Liverpool Women's NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is 'Registered without conditions'.

The Care Quality Commission has taken enforcement action against Liverpool Women's NHS Foundation Trust during 2014-15.

Liverpool Women's NHS Foundation Trust has not participated in special reviews or investigations by the Care Quality Commission relating to the following areas during the reporting period:

- Special Reviews – Nil.
- Unannounced inspections - April 9th 2014. September 2014.
- Announced Inspections - 30th September 2014, 16th February 2015.

The Care Quality Commission (CQC) is responsible for inspecting the services provided by the Trust and making sure that they meet regulatory requirements. On 9 April 2014 the CQC undertook an unannounced inspection of our services. Following on from the inspection the Trust was found to not be meeting two of the outcomes they assessed, Outcomes 13 and 16, and issued warning notices to the Trust which required us to make urgent improvements.

Outcome 13 related to providing safe staffing levels within inpatient maternity services. The Trust reviewed maternity staffing levels and recruited the equivalent of an additional 25 full time midwives to improve staffing levels and provide one to one care in established labour. We also reviewed processes for measuring acuity in labour (what additional needs women may have based on their health and risk factors) to make sure that additional staff were available to meet their needs.

Outcome 16 related to our governance arrangements. The CQC were critical of the way we managed complaints and risk, and how we learnt lessons following incidents and complaints. In response to this we reviewed and changed our complaints management processes, had our governance arrangements reviewed by Deloittes, reviewed our governance structures and re-launched our risk management strategy and risk management processes.

All the actions were completed by 1 September 2014 and the warning notices were lifted by the CQC in October 2014.

The Trust had a further inspection undertaken by the CQC in February 2015. This inspection was announced and was undertaken by a team of 40+ inspectors. The inspection team reviewed our services using the new inspection methods introduced following the Keogh review. At the time of writing this report, the CQC report following this inspection has not been published.

In February 2015, the Care Quality commission visited the Trust to undertake a scheduled assessment under the new inspection regime.

In Mid – May, during preparation of this report , the Care Quality Commission (CQC), published it finalised report following these announced and unannounced inspections earlier this year, which confirmed that they had given an overall rating of 'good' to the Trust.

2.4.5 Submission to Hospital Episodes Statistics & Data Quality

Liverpool Women's NHS Foundation Trust submitted records during 2014-15 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

— **which included the patient's valid NHS number was**:

98.80% for admitted patient care;
98.82% for outpatient care; and
98.39% for accident and emergency care.

— **which included the patient's valid General Medical Practice Code was**:

99.06 % for admitted patient care;
97.04 % for outpatient care; and
98.22 % for accident and emergency care.

Liverpool Women's NHS Foundation Trust will be taking the following actions to improve data quality:

- The Trust has a monthly data quality sub-committee, a forum for discussion on data quality. This is overseen by the information governance committee and provides escalation point for areas of concern.
- The Trust has developed a series of reports to allow identification and improvement of poor data quality.
- A robust audit plan has been developed to focussing on the Trusts national data submissions to further improve data quality.

2.4.6 Information Governance

Liverpool Women's NHS Foundation Trust's Information Governance Assessment report overall score for 2014-15 was 66% and was graded RED 'Not Satisfactory'.

2.4.7 Clinical Coding

Liverpool Women's NHS Foundation Trust was subject to the Payment by Results clinical coding audit during 2014-15 by the Audit Commission and the error rates reported in the latest published data for that period for diagnoses and treatment coding (clinical coding) were:

Primary Diagnosis	96.5%.
Secondary Diagnosis	95.1%.
Primary Procedure	97.9%.
Secondary Procedure	95.4%.

Note:
The audit was based on health resource groups rather than services. 200 episodes were audited from the following areas:

100 MA Female Reproductive System Procedures.

50 FZ Digestive System Procedures and Disorders.
50 LB Urological and Male Reproductive System Procedures and Disorders.

The majority were gynaecology patients with a small number from obstetrics.

These results should not be extrapolated further than the actual sample audited.

Liverpool Women's NHS Foundation Trust will be taking the following actions to improve data quality:

- The clinical coding department will continue with its annual audit cycle. This will be expanded to include outpatient coding in 2015/16.
- A second audit cycle has been implemented consisting of joint audits with consultants.
- CHKS is used to monitor significant changes in clinical coding and investigate any potential discrepancies.
- The Trust will continue to support clinical coders in sitting the national clinical coding qualification. In 2014/15 two clinical coders were successful and attained accredited clinical coder status.

2.4.8 Reporting against core indicators

2.4.8.1 Summary high-level mortality (SHMI)

As specified in January 2013 by the Information Centre for Health and Social Care, specialist Trusts, such as Liverpool Women's NHS Foundation Trust are exempt from this indicator and no data available from HSCIC, however, there are other sections within this document reporting on Mortality (Mortality Rates in Gynaecology and Neonatal Mortality).

2.4.8.2 Patient reported outcome measures scores

Although the core indicators for Acute Trusts include reporting this data for:

- Groin hernia surgery.
- Varicose vein surgery.
- Hip replacement surgery, and
- Knee replacement surgery.

These procedures fall outside of this Specialist Acute Trust's service portfolio, hence there is no data to report from either local sources or HSCIC. However, the Catherine Suite has made an application to undertake varicose vein surgery. If this is successful and the service established, then the Trust will report against this measure in the 2015-16 Quality Report.

2.4.8.3 28 day Readmission rates ages (a) 0-15yrs and (b) 16yrs and over

Description:

Emergency Readmissions to the Trust within 28 days of discharge from the Trust, delineated into two age bands 0-15 years and 16 years and over.

Why and how this priority goal was selected:

The aim and hope after surgery is that all patients go home promptly and recover without complications. However, a small proportion of patients either visit their GP with minor concerns or sometimes need readmission to hospital with significant post-operative problems. As the issues may arise some weeks after surgery and not just in the immediate few days after discharge, we look at all readmissions up to a month after the original surgery.

These measures are a prescribed reporting requirement for Quality Accounts determined by Monitor. As well as being a required assessment nationally, readmission rates can give us a worthwhile view of the effectiveness of the surgical and post-operative care of our patients.

Why this is important / what difference does this make to patients?

Readmission rates can be a barometer of the rest of the hospital care, in particular when changes in practice are planned to aim to improve patient care. For example, after the introduction of the Enhanced Recovery Programme during 2010-12, we were aware that a rise in the readmission rates would be an

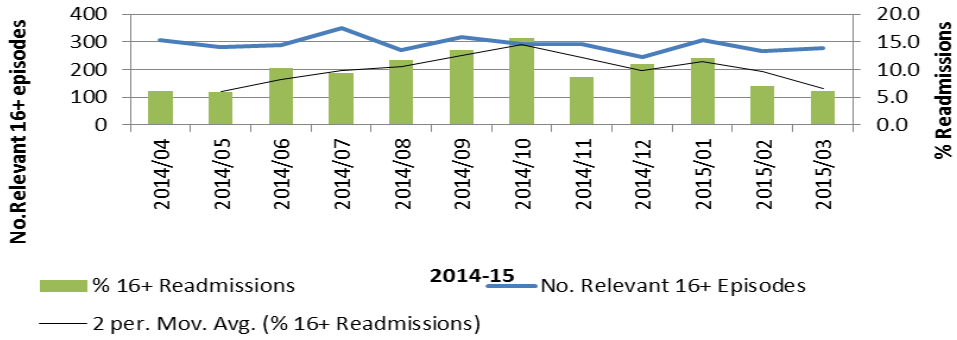
early indication of a problem with the aim for early discharge. Encouragingly, the readmission rate remained stable whilst the length of stay fell after the start of ERP, suggesting no harm was falling on patients as a result of the changes within the hospital.

Progress made in report period 2014-15

a) 28 day Readmission rates Patients aged 0-15yrs

In the 2013/14 period the Trust admitted 8 patients in this age group of which two were re-admitted. In 2014-15 only one patient in this age group was admitted (in October), and was also re-admitted. With such very low numbers it is difficult to make any sound conclusions.

b) 28 day Readmission rates Patients aged 16yrs and over



% Readmission rates ages 16yrs+													
Year	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Av.**
2013/14	6.69	5.28	8.24	11.03	2.61	6.07	7.87	9.76	9.88	6.03	7.20	5.10	7.11
2014/15	6.21	6.01	10.34	9.43	11.76	13.48	15.65	8.59	10.93	12.01	7.12	6.14	9.85

Data source: LWFT 'Meditech' patient information system.

This data shoes an increase in patient readmissions for the period 2014-15.
The Liverpool Women's NHS Foundation Trust considers that this data is as described for the following reasons:

The Trust date presented is extracted from the Trust's Patient information system and the methodology has been twice validated by the Trust's auditors (2012-13 & 2013-14).

Available Benchmarking data

Emergency readmissions to hospital within 28 days of discharge from hospital: children of ages16+		2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
LWFT	Readmissions	199	146	124	130	N/A	N/A	N/A
	Discharges	3100	3047	2789	2422	N/A	N/A	N/A
	%	6.4%	4.8%	4.4%	5.4%	N/A	N/A	N/A
BWH	Readmissions	132	138	108	111	N/A	N/A	N/A
	Discharges	2084	2023	1934	1686	N/A	N/A	N/A
	%	6.3%	6.8%	5.6%	6.6%	N/A	N/A	N/A
Specialist Acute Trusts	Readmissions	4860	4832	4969	4844	N/A	N/A	N/A
	Discharges	78230	78921	79728	74421	N/A	N/A	N/A
	%	6.2%	6.1%	6.2%	6.5%	N/A	N/A	N/A
Indirectly age, sex, method of admission, diagnosis, procedure standardised percent	LWFT	11.70%	8.70%	7.49%	9.14%	N/A	N/A	N/A
	BWH	11.18%	12.03%	10.03%	11.70%	N/A	N/A	N/A
	Specialist Acute Trusts	9.83%	9.55%	9.61%	9.73%	N/A	N/A	N/A

Source HSCIC Portal (Unique data ID: P00913), http://nww.indicators.ic.nhs.uk/webview/
N.B. national data for 2012/13 and 2013/14 not yet posted on this site.

How progress to achieve the priority goal is monitored and measured

Data for the last three years are not available from the Health & Social Care Information Centre (HSCIC). In order to report on readmission rates the Trust has derived its own data from 'Meditech' the Trust Patient Information system. The results from this are not standardised and hence are not directly comparable to the national standardised data. The technical specification for the data extraction (without the age delineation) was provided in the previous year's Quality Report available at:

http://www.liverpoolwomens.nhs.uk/Library/about_us/LWH_Quality_Account_2012-13.pdf .

It should be noted that the extraction method uses discharges with admissions on a subsequent date; hence it does not identify the extremely rare instances of re-admission on the same day as the initial discharge.

How progress to achieve the priority goal is reported

The individual service areas are responsible for managing quality priorities and indicators of relevance to them and are required to report on them monthly to their local Quality Improvement forum in a standardised format dashboard.

How progress to achieve the priority goal is reported

As described in the Trust's Quality Strategy, service level quality improvements forum(s) report quarterly to the Clinical Quality Governance Committee, who raise exceptions and concerns with the Operational Board and report quarterly to the Governance and Clinical Assurance sub-committee, which in turn reports biannually to the board. Thus the Trust's Clinical Quality Governance Committee and ultimately the Board

have an overview of the delivery of the work streams in respect of this and all quality priorities and indicators.

The Liverpool Women's NHS Foundation Trust has taken the following actions to improve this indicator, and so the quality of its services, by:

- Monitoring and reviewing readmission rates within Gynaecology and Gynae Oncology; rates which are consistently lower than our peers (2014-15 - 2.7% in General Gynaecology and 3.5% in Gynae Oncology). This has remained static over several years despite a consistent fall in the average patient Length of Stay. (Thus demonstrating improvement in both clinical effectiveness and patient experience. Within Gynaecology, we will continue to monitor this data, but currently there is no indication to change current practice.

  (*NB. the Gynaecology focus in these actions reflects the fact that re-admission of mothers after birth would be to a local acute Trust and readmission of babies would be to the local Children's Trust and hence fall out with this indicator*).

2.4.8.4 Responsiveness to the Personal needs of its patients

Description:

A composite measure (rating) of the organisation's responsiveness to the needs of its patients, derived from responses to 5 questions included within the CQC co-ordinated adult inpatient survey.

- Were you involved as much as you wanted to be in decisions about your care and treatment?
- Did you find someone on the hospital staff to talk to about your worries and fears?
- Were you given enough privacy when discussing your condition or treatment?
- Did a member of staff tell you about medication side effects to watch for when you went home?
- Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

Why and how this priority goal was selected:

This composite measure is a prescribed reporting requirement for Quality Accounts determined by Monitor.

Important because:

Not all patients are alike, they have individual and varying needs, individuals fears and concerns and circumstances specific to themselves, their condition and treatment. It is important that these are recognised and accommodated to ensure optimal care and treatment.

Progress made in report period 2014-15

The NHS National Patient Survey Programme conduct surveys of Trusts on a rolling programme, with different NHS settings surveyed in different years. Settings include inpatients, outpatients, community mental health, and accident and emergency. The survey programme is designed to collect structured and systematic feedback on service delivery from the patients' actual experience. The programme is coordinated by the Care Quality Commission (CQC), but each survey is paid for and carried out by individual NHS organisations.

During this year the setting chosen for surveying was Accident & Emergency. The Trust does not have an Accident & Emergency department and as a result was not included in the programme during 2014-15 and data for this Trust for 2014-15 is not available via the HSCIC site. Liverpool Women's NHS Foundation Trust will continue to be involved in the survey when services it provides are surveyed in the future.
The following table shows the Trust's performance against this measure with data available to 2013-14. Included in the data where available, is the average score for Birmingham Women's Hospital (BWH, its recognised benchmark Trust) and the national average and range.

Year	LWFT Score	BWH Score	National Average	Annual Range
2014/15	Not applicable	Not applicable	77.3	67.2-83.5
2013/14	80.8*	74.9	68.7	54.4 – 84.2
2012/13	77.5	77.1	68.1	57.4 – 84.4
2011/12	76.6	73.8	67.4	56.5 – 85.0

** 2013-14 data for LWFT reported last year as 80.5, when HSCIC data for 2013-14 unavailable and the Trust used the tool kit available at: http://www.england.nhs.uk/statistics/statistical-work-areas/pat-exp/sup-info/ to derive it's 2013-14 score from the picker Inpatient survey response data for the above questions.*

The Liverpool Women's NHS Foundation Trust considers that this data is as described for the following reasons:

- It is taken from the HSCIC repository and derived from the responses to the abovementioned questions in the Picker report on annual Inpatient surveys as calculated in a prescribed manner for Liverpool Women's NHS Foundation Trust and other participating organisations.
- The surveys are conducted independently by the Picker Institute.

The Liverpool Women's NHS Foundation Trust intends to take the following actions to improve this indicator, and so the quality of its services, by:

- Continuing to respond to direct patient feedback to the Patient Experience department (PALS and Complaints) and Friends and Family test (FFT) responses.
- Taking responsive action to intelligence gathered from in-house walkabouts and key lines of enquiry audits and from external assessments (e.g. PLACE, CQC).
-

NB. these actions are ongoing and generic and independent of this year's A&E inpatient survey and results which this Trust and our recognised benchmark Trust could not participate in.

2.4.8.5 Percentage of Staff employed or under contract to the Trust in period who would recommend the Trust as a provider of care to their family or friends

Description:

The measure used for this indicator is the percentage of respondents to question 12(d) in the NHS annual Staff survey who state that they agree or strongly agree with the following statement-
" If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation".

Why and how this priority goal was selected:

This measure is a prescribed reporting requirement for Quality Accounts determined by Monitor.

Important because:

This question indicates the staff opinion of the quality of the services provided by the organisation and is an expression of their confidence in them.

Progress made in report period 2014-15

Trust / Group	2012-13	2013-14	2014-15
Liverpool Women's NHS FT	62%	67 %	73%
Birmingham Women's NHS FT	78%	76%	75 %
Average for All Acute / Specialist Acute Trusts	65%	67%	70%
Range for All Acute / Specialist Acute Trusts	51.1-77.3%	39.6-93.9%	60-81%

Data source: http://www.nhsstaffsurveys.com/Caches/Files/ST14_support3_sheet5_mean_5-1.xls

The data is presented is that for this Trust and Birmingham Women's Hospital our recognised comparable bench mark Trust compared to the average and range for all Acute and Specialist Acute Trusts nationally. In 2013-14 we were unable to present LWFT performance compared to only other Acute Specialist Trusts as the data was unavailable for this cohort nationally. However the data is available nationally for 2014-15 and is presented below:

Trust / Group	2014
Liverpool Women's NHS FT	73%
Birmingham Women's NHS FT	75%
Median for Specialist Acute Trusts	89%
Range for All Specialist Acute Trusts	67.5 -92.8%

The Liverpool Women's NHS Foundation Trust considers that this data is as described for the following reasons:

- The data is collected independently of the Trust.

Commentary:

Liverpool Women's is compared to other 'acute specialist' Trusts. When compared to other acute Trusts the Trust compares more favourably.

How progress to achieve the priority goal is monitored and measured

The data for this measure is collated independently of the Trust and via the NHS National Staff Survey and is reported back to the Trust annually.

How progress to achieve the priority goal is reported

The results of the Annual Staff Survey are reported through the Putting People First committee.
The Liverpool Women's NHS Foundation Trust has taken the following actions to improve this indicator, and so the quality of its services, by the following means:

- The Trust already asks the question on a regular basis as part of its monthly team briefing sessions.
- We will further explore the question through existing forums, for example:
    - Making the question a standard item on team for discussion on meetings
    - Incorporating via executive director listening events
    - Conducting focus groups in departments where the number of staff who would recommend the Trust as a place to have care is low.

2.4.8.6 Percentage of patients admitted to Hospital and who were risk assessed for venous thromboembolism (VTE)

Description:

The number of patients receiving a VTE assessment expressed as a percentage of eligible 'ordinary' admissions (Patients admitted for at least an overnight stay, thus excluding day cases).

Why and how this priority goal was selected:

Venous Thromboembolism (a fragment that has broken away from a clot that had formed in a vein) is a significant cause of mortality, long-term disability and chronic ill health. It was estimated in 2005 there were around 25,000 deaths from VTE each year in hospitals in England and VTE has been recognised as a clinical priority for the NHS by the National Quality Board and the NHS Leadership Team. Whilst this indicator had already been adopted by the Trust it was made mandatory for all Trusts to report in their Quality Report from 2012-13.

Important because:

If a risk of VTE is established in a patient, then appropriate prophylaxis treatment can be offered to manage that risk and hopefully avoid the adverse outcomes described above.

Progress made in report period 2014-15

Local Data:

Table 4 VTE Assessment Compliance LWFT

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
97.61 %	97.61 %	97.46 %	97.54 %	98.24 %	98.58 %	98.39 %	97.60 %	97.26 %	97.12 %	97.34 %	98.25 %

Data Source: LWFT Meditech / Clinical coding

Benchmarking Data

Data only available to January 2015.

Table 5 VTE assessment rates – Monthly

2014-15	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
LWH Activity	1630	1651	1746	1877	1687	1721	1795	1655	1599	1691			
LWH: No. VTE Assessments	1591	1619	1703	1844	1663	1711	1752	1629	1553	1647			Av.
LWFT %	**98%**	**98%**	**98%**	**98%**	**99%**	**99%**	**98%**	**98%**	**97%**	**97%**			**98%**
BWH %	**97%**	**96%**	**97%**	**96%**	**96%**	**97%**	**98%**	**98%**	**98%**	**97%**			**97%**
All Acute Providers	**96%**	**96%**	**96%**	**96%**	**96%**	**96%**	**96%**	**96%**	**96%**	**96%**			**96%**
LWFT vs. All Acute Providers Average	**Better than**	**Better than**	**Better than**	**Better than**	**Better than**	**Better than**	**Better than**	**Better than**	**Bette r than**	**Bette r than**			

Data source: http://www.england.nhs.uk/statistics/statistical-work-areas/vte/vte-risk-assessment-2014-15/

This comparative data has traditionally been collected and reported monthly. Following consultation, NHS England has determined that from April 2015 it will be published quarterly and for ease of reference this data is presented in a quarterly format below:

Table 6 VTE assessment rates – Quarterly

2014-15	Q1	Q2	Q3	Q4
LWFT Activity	5027	5218	5049	
LWH:No. VTE Assessments	4913	5285	4934	
LWFT %	**97.7%**	**98.7%**	98%	
BWH%	**97.0%**	**96.5%**	98%	
All Acute Providers	**96%**	**96.1%**	96%	
LWFT vs. All Acute Providers Average	**Better than**	**Better than**	**Better than**	

Previous years:

Key:	% Assessments Completed												
		>95%			>=80 <=95%			<80%					
2013-14	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	
LWH Activity	1660	1665	1545	1712	1608	1637	1756	1742	1639	1751	1560	1697	
No. VTE Assessments	1577	1602	1508	1672	1547	1583	1701	1692	1601	1703	1593	1739	**Average**
LWH %	95.00%	96.22%	97.61%	97.66%	96.21%	96.70%	96.87%	97.13%	97.68%	97.26%	97.93%	97.58%	96.99%
All Acute Providers	95.14%	95.50%	95.71%	95.96%	95.67%	95.58%	95.90%	96.00%	95.60%	N/A	N/A	N/A	95.67%
LWH vs. All Provider Average	Worse than	Better than	Better than	Better than	Better than	Better than	Better than	Better than	Better than	N/A	N/A	N/A	

Previous years:

2012-13	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	
LWH Activity	1621	1741	1600	1734	1685	1677	1804	1726	1578	1665	1577	1657	
No. VTE Assessments	1546	1683	1531	1662	1622	1615	1715	1647	1501	1591	1506	1574	**Average**
LWH %	95.37%	96.67%	95.69%	95.85%	96.26%	96.30%	95.07%	95.42%	95.12%	95.56%	95.50%	94.99%	95.65%
All Acute Providers	93.40%	93.60%	93.30%	93.90%	93.90%	94.00%	94.30%	94.40%	93.80%	94.30%	94.10%	94.10%	93.93%
LWH vs. All Provider Average	Better than	Better than	Better than	Better than	Better than	Better than	Better than	Better than	Better than	Better than	Better than	Better than	

The Liverpool Women's NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust has well established processes for assessing patients risk of VTE and consistently performs better than other acute providers.
-

The Liverpool Women's NHS Foundation Trust intends to take the following actions to improve this indicator, and so the quality of its services, by reviewing cases where assessment has not taken place and providing education to staff to further improve performance to support the reduction of potential harm for patients.

2.4.8.7 Rate per 100,000 bed days of cases of C.difficile reported within the Trust amongst patient aged 2 or over

Description:

The reported instances of Trust apportioned *Clostridium difficile* infection in persons aged 2 or over.

Why and how this priority goal was selected:

Clostridium difficile are bacteria that are present naturally in the gut of around two-thirds of children and 3% of adults. *C.difficile* does not cause any problems in healthy people. However, some antibiotics that are used to treat other health conditions can interfere with the balance of 'good' bacteria in the gut. When this happens, *C.difficile* bacteria can multiply and produce toxins (poisons), which cause illness such as diarrhoea and fever. *C.difficile* infection is the commonest cause of healthcare associated diarrhoea. Having achieved zero instances of Clostridium difficile infection during 2012-13 the Trust wished to monitor and maintain this record.

Why this is important / what difference does this make to patients?

The Trust takes extremely seriously its duty to prevent infection and provide care in a safe environment. Preventing infection improves patient, care, experience and safety.

Progress made in report period 2014-15

National Data for 2014-15 is not available from external sources including the HSCIC and Public Health England websites for this measure and so only the most recently available12-month Trust data provided by Public Health England (PHE) is reported below.

Quarterly C difficile Rates per 100,000 Bed days	2013-14 Qtr. 4	2014-15 Qtr1	2014-15 Qtr2	2014-15 Qtr3	2014-15 Qtr4
Liverpool Women's NHS Foundation Trust	0	10.62	0	0	0
Cheshire & Merseyside: Maximum	31.84	27.12	32.21	39.80	
Cheshire & Merseyside: Average	15.41	14.14	18.77	17.05	
Cheshire & Merseyside: Minimum	0	0	0	0	

Data Source: HCAI Monthly Report Cheshire & Merseyside February 2015', Public Health England

Data available for the financial years 2010-2014 inclusive is available via HSCIC and PHE web sites and is reported here.

Name of NHS Trust	C.difficile Infection reports for patients aged 2 years and above									
	2010-11		2011-12		2012-13		2013-14		2014-15	
	Trust Apportioned Reports	Trust App'd Rate per 100'000 Bed Days	Trust Apportioned Reports	Trust App'd Rate per 100'000 Bed Days	Trust Apportioned Reports	Trust App'd Rate per 100'000 Bed Days	Trust Apportioned Reports	Trust App'd Rate per 100'000 Bed Days	Trust Apportioned Reports	Trust App'd Rate per 100'000 Bed Days
LWFT	2	5.2	1	2.6	0	0	2	5.3	n/a	n/a
BWH	1	3.2	0	0	0	0	0	0	n/a	n/a
National Data										
Minimum	0	0	0	0	0	0	0	0	n/a	n/a
Maximum	247	71.8	185	51.6	154	30.8	144	37.1	n/a	n/a
Average	62.4	27.9	45.9	20.6	37	16.1	31.4	13.9	n/a	n/a
Total	10417	29.6	7670	21.8	5974	17.3	5031	14.7	n/a	n/a

Data source: https://www.gov.uk/government/statistics/clostridium-difficile-infection-annual-data

The Liverpool Women's NHS Foundation Trust considers that this data is as described for the following reasons:

- all instances of C.difficile are reported to the infection control team.
- all cases have a root cause analysis performed.
- all cases are confirmed and reported to the National database.

The Liverpool Women's NHS Foundation Trust has in place a number of interventions to prevent infection with this organism; these interventions will be reviewed to ensure they remain fit for purpose to maintain the safety of patients.

2.4.8.8 Number / rate of Patient Safety Incidents and Number / percentage of such resulting in severe harm or death.

a) Number / rate of Patient Safety Incidents

Description:

Incidents reported as patient safety incidents (PSIs) within period on the Trust's Ulysses incident database.

Why and how this priority goal was selected:

These two measures are mandated for inclusion in Quality Reports by Monitor.

Important because:

The measure indicates the organisation's level of reporting of incidents to the National Reporting and Learning Service and gives a background to the 'Incidents Resulting in Severe Harm or Death' measure below.

The National Patient Safety Agency points out '*Organisations that report more incidents usually have a better and more effective safety culture. You can't learn and improve if you don't know what the problems are*.'

Progress made in report period 2014-15

	2011-12	2012-13	2013-14	2014-15
Patient Safety Incidents reported in period	2523	2970	2127	2551

Data source: LWFT 'Ulysses' incident reporting system.

Whilst the number of patient safety incidents fell in 2013-14 and were a cause for concern in early 2014-15 the above data shows an increased level of reporting and this is supported by the most recent NRLS report, (April 2015), which shows the Trusts improved position relative to other similar providers.
The Liverpool Women's NHS Foundation Trust considers that this data is as described for the following reason(s):

- It is taken directly from the Trusts Incident reporting database (Ulysses).

Benchmarking data

	All Reported Incidents			
	Oct'12-Mar'13	Apr'13-Sep'13	Oct'13-Mar'14	Apr'14-Sep'14
Total Incidents Reported to NRLS by Birmingham Women's NHS Foundation Trust	670	619	891	745
Total Incidents Reported to NRLS by Liverpool Women's NHS Foundation Trust	1138	763	1193	1347

Data source: The presented benchmarking data above is derived from that available from the NRLS web site, compares the Trust's performance with that of its recognised benchmark Trust, Birmingham Women's Foundation Trust.

NRLS report, (April 2015)

NHS
National Reporting and Learning System

Organisation Patient Safety Incident Report

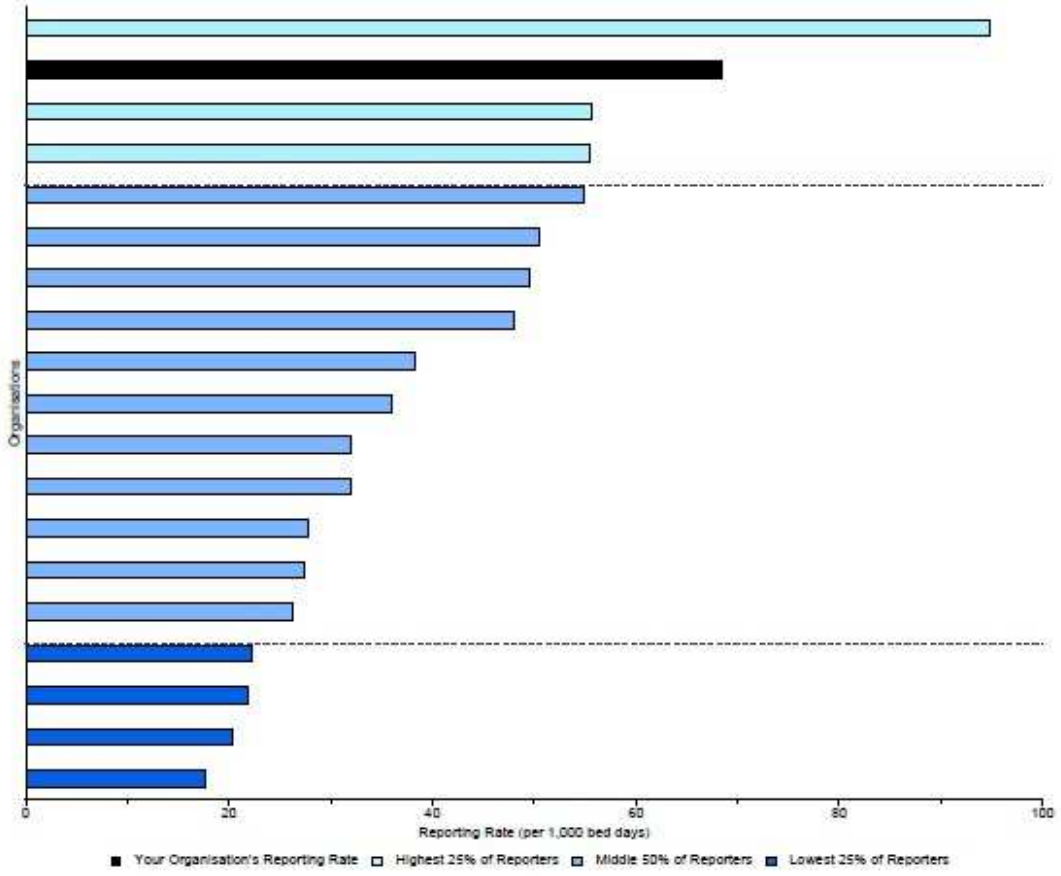
Reported incidents between 01 April 2014 to 30 September 2014

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
Organisation type: Acute specialist organisation

Are you actively encouraging reporting of incidents?

The comparative reporting rate summary shown below provides an overview of incidents reported by NHS organisations to the National Reporting and Learning System (NRLS) occurring between 01 April 2014 to 30 September 2014. Your organisation reported 1,347 incidents (rate of 68.48) during this period.

Figure 1: Comparative reporting rate, per 1,000 bed days, for 20 Acute specialist organisations.



The median reporting rate for this cluster is 36.82 incidents per 1,000 bed days.

Organisations that report more incidents usually have a better and more effective safety culture. You can't learn and improve if you don't know what the problems are.

The presented benchmarking data derived from that available from the NRLS web site, compares the Trust's performance with that of its recognised benchmark Trust, Birmingham Women's Foundation Trust. Liverpool Women's NHS Foundation Trust has taken the following actions to improve this indicator, and so the quality of its services, by:

- Revision and re-issue of the Risk Management Strategy
- Continuing to promote Incident reporting through distribution of annually updated 'Trigger List' posters.
- Removing the need to use a log-in password when reporting an incident via the web –based reporting tool which it is hoped will improve access to the system and result in the levels of incident reporting increasing
- Continued Governance team involvement in reviewing the daily incident report generated automatically from the Ulysses system. This facilitates a timely escalation process to ensure incidents are appropriately assigned serious incident status and undergo full root cause investigation to identify opportunities for improvement that lessen or eliminate the likelihood of recurrence of similar incidents and are then effected through the development, implementation and monitoring of specific action plans and testing of embedded changes in practice.
- Continued feedback regarding serious incidents through the process identified in the 2014/15 Quality report which also now includes the use of staff notice boards managed by HR which include a lessons learnt section for which the risk leads provide information on a monthly basis.
- Within Gynaecology, Anaesthesia and Theatres there are now regular Morbidity and Mortality meetings held to discuss difficult cases or problems identified such as returns to theatre, accidental bowel injury during surgery or adverse medication reactions.
- Also within Gynaecology, Anaesthesia and Theatres from January 2015 incident criteria were agreed that would automatically require a formal review. It is hoped that by conducting more formal reviews the likelihood of the incident happening again will be reduced and the service to the patients will ultimately improve.
- Risk management training is being developed that will be IOSHH accredited which it is hoped will raise awareness of the need for incident reporting and assist in the risk scoring of incidents so that as an organisation we will come into line with comparative organisations in our region in our reporting to the NRLS and our grading of such incidents.

b) Percentage of Patient Safety Incidents resulting in severe harm or death

Description:

Incidents reported within period on the Trust's Ulysses incident database and classified as a Patient Safety Incident with an actual impact of 'Severe Harm' or 'Death'.

Why this is important / what difference does this make to patients?
Incidents with severe or catastrophic consequences are by definition most damaging to the victims, their families and the organisation and hence should be particularly targeted for investigation to determine and address their causal factors; thereby eliminating or at least reducing the likelihood of recurrence.

Progress made in report period 2014-15

Liverpool Women's NHS Foundation Trust	2014-15 Qtr1		2014-15 Qtr2		2014-15 Qtr3		2014-15* Qtr4		Annual Total	
Reported Patient Safety Incidents	668		666		576		641		2551	
Actual Impact of Incident	**No.**	**%of all PSIs**	**No.**	**%of all PSIs**	**No.**	**%of all PSIs**	**No.**	**%of all PSIs**	**No.**	**%of all PSIs**
Severe Harm as a result of the PSI	4	0.60%	13	1.95%	7	1.22%	5	0.78%	29	1.14%
Death as a result of the PSI	0	0.00%	0	0.00%	0	0.00%	2	0.16%	2	0.08%
Total Severe Harm or Death as a result of the PSI	4	0.60%	13	1.95%	7	1.22%	6	0.94%	31	1.22%

Data source: LWFT 'Ulysses' incident reporting system

Historic data:

Liverpool Women's NHS Foundation Trust	2012-13		2013-14		2014-15	
Actual Impact of Incident	**No.**	**As % of all PSIs**	**No.**	**As % of all PSIs**	**No.**	**As % of all PSIs**
Severe Harm as a result of the PSI	45	1.50%	31	1.45%	29	1.14%
Death as a result of the PSI	6	0.20%	1	0.05%	2	0.08%
Total Severe Harm or Death as a result of the PSI	51%	1.70%	32	1.50%	31	1.22%

All incidents where patients have suffered severe harm or death within the Trust have been reported to external agencies and have undergone a full investigation to determine the reasons for the harm occurring. This information is shared within the Trust and confidentially within the NHS to enable and support learning and to make changes of practice, where necessary, to prevent further harms occurring. The Trust will continue its work to achieve a year on year reduction in these levels of harm.

Benchmarking data:

		As Percentage of all Reported Incidents					
		Oct'11-Mar'12	Apr'12-Sep'12	Oct'12-Mar'13	Apr'13-Sep'13	Oct'13-Mar'14	Apr'14-Sep'14
Severe Harm	Acute Specialist Organisations	0.50%	0.40%	0.30%	0.40%	0.40%	0.40%
	Birmingham Women's NHS Foundation Trust	0.30%	0.30%	0.00%	0.00%	0.00%	0.50%
	Liverpool Women's NHS Foundation Trust	1.30%	1.30%	1.80%	1.60%	2.20%*	1.80%
Death	Acute Specialist Organisations	0.10%	0.10%	0.10%	0.10%	0.10%	0.10%
	Birmingham Women's NHS Foundation Trust	0.30%	0.30%	0.00%	0.20%	0.20%	0.10%
	Liverpool Women's NHS Foundation Trust	0.40%	0.20%	0.10%	0.30%	0.00%	0.00%

Data source: NRLS Organisational patient safety incident reports (available at: http://www.nrls.npsa.nhs.uk/resources/).

* As mentioned previously the trust experienced a reduced level of incident reporting in 2013-14. Investigation revealed that our reporting levels reduced in the less severe categories, which could explain the increased proportion of severe harm incidents shown for 2013-14.
The Liverpool Women's NHS Foundation Trust considers that this data is as described for the following reasons:

- The PSI data presented was extracted directly from the Trust incident reporting database.
- Deaths can be more accurately recorded on the Incident database since Qtr. 1 2013-14. (See below).

How progress to achieve the priority goal is monitored and measured
The measures are now calculated as follows:

$$\frac{\text{No. PSI's with actual harm = Severe Harm}}{\text{No. PSI's reported to National Reporting and Learning Service (NRLS)}}$$

$$\frac{\text{No. PSIs with actual harm = Death as result of incident}}{\text{No. PSI's reported to National Reporting and Learning Service (NRLS)}}$$

These mandated measures were first introduced in early 2013. The Trust extracted the data from its 'Ulysses' incident database using the 'Actual Impact' field to determine those incidents to be included in the numerator, this revealed that deaths could only be described as being a consequence of a patient safety, though there were instances were care was appropriate and had not contributed to the death. Such cases were manually filtered out. On identification of this issue, the system was updated to include two death categories; one being non-contributory to the death thus allowing more accurate recording and improved extraction of such data.

How progress to achieve the priority goal is reported

Incident reports are prepared by Governance Risk Leads and presented and discussed at divisional risk forums.

Data is regularly uploaded from the Trust's incident reporting database and submitted to NRLS usually on a weekly basis This NRLS data is published in 6 monthly reports by NRLS.

The Liverpool Women's NHS Foundation Trust has taken the following actions to improve this indicator, and so the quality of its services, by:

- Ensuring that all incidents where patients have suffered severe harm or death within the Trust have been reported to external agencies and have undergone a full investigation to determine the reasons for the harm occurring. This information is shared within the Trust and confidentially within the NHS to enable and support learning and to make changes of practice, where necessary, to prevent further harms occurring.

Part 3 Other Information

3.1 Overview of Quality

This section of the Quality Accounts provides information on the Trust's quality performance during 2014-15. Performance against the priorities identified in the Trust's previous quality account and performance against the relevant indicators and performance thresholds set out in Monitor's Risk Assessment Framework are outlined.

The Trust's priorities from improvement in 2014-15 were selected following a review of key patient safety measures. Positive progress in a number of areas is highlighted including a reduction in complaints made about treatment and care, reduction in readmission rates for patients aged 0-15 years, zero cases of C. difficile and MRSA bacteraemia cases, a reduction in the number of infections seen following planned surgery, improvement in pregnancy rates for women undergoing IVF treatment and an increase in the number of incidents reported which demonstrates that the Trust has a good safety culture.

In Part 2 of this document we describe the progress made against Priorities for 2014-15 and refer the reader to the sections indicated in the following table for further details

3.2 Performance against key national priorities and National Core Standards

Indicator Name	Target	Performance		
		2012 / 2013	2013 / 2014	2014-15
18 week Referral to treatment times: admitted (all Specialties)	90%	96.95%	97.61%	95.63%
18 week Referral to treatment times: non-admitted (all Specialties)	95%	96.06%	95.37%	95.63%
18 week Referral to treatment times: non-admitted (Gynaecology, Infertility and reproductive medicine)	95%	95.62%	94.82%	94.81%
18 week Referral to treatment times: non-admitted (Clinical Genetics)	95%)	99.54%	100%	96.47%
18 week referral to treatment times: Incomplete Pathways (admitted & non-admitted) **(A)**	92%	93.14%	94.68%	93.82%
18 week referral to treatment times: Incomplete Pathways (gynaecology, infertility & reproductive medicine)*	92%	92.79%	94.16%	93.03%
18 week referral to treatment times: Incomplete Pathways (clinical genetics)	92%	99.69%	100%	97.46%
* All cancers: two week wait	≥ 93%	96.81%	97.56%	96.36%
All cancers: one month diagnosis to treatment (first definitive)	≥ 96%	97.17%	98.40%	97.49%
All cancers: one month diagnosis to treatment (subsequent surgery)	≥ 94%	99.26%	98.71%	99.12%
All cancers: one month diagnosis to treatment (subsequent drug)	≥ 98%	100%	No Patients	N/A
All cancers: one month diagnosis to treatment (radiotherapy)[14]	≥94%	N/A	N/A	N/A
All cancers: two month diagnosis to treatment (GP referrals) **(A)**	≥ 85%[15]	89.87%	87.04%	89.26%
All cancers: two month diagnosis to treatment (Consultant upgrade)	≥ 94%	96.92%	95.45%	94.20%
All cancers: two month diagnosis to treatment (screening referrals)	≥ 90%	94.87%	100%	100%
Incidence of MRSA bacterium	0	0	0	0
Incidence of Clostridium difficile	0	0	2	0
Infant health and inequalities: breastfeeding rate	≥ -5%	0.55%	-2.86%	-0.72%
Infant health and inequalities: smoking rate	≤ 0%	0.87%	1.30%	-3.86%
NHS Staff satisfaction: Overall staff engagement (Acute Trusts)	**2014-15** Nat'l Average **3.74**	3.57	3.73	3.74
Delayed transfers of care	≤ 3.5%	0%	0%	0%
Last minute cancellation for non-clinical reasons	≤ 0.6%	0.79%	0.50%	0.54%
Last minute cancellation for non-clinical reasons not readmitted in 28 days	≤ 5	5.81%	0.56%	0.00%
Total time in Accident & emergency (% seen within 4 hours)	≥ 95%	99.92%	99.81%	99.91%

(A)= Indicator mandated outside of the Quality Account regulations and subjected to limited assurance audit by PwC.

[14] Liverpool Women's NHS Trust does not provide a radiotherapy service hence this priority does not apply.

[15] The national target is 85%, however the Trust to 2013-14has a further tolerance of 6% given the specialist nature of referrals received (Department of Health 2009, Monitor 2011).

3.3 National Surveys in which LWH has participated

3.3.1 Picker National Inpatient Survey 2014

Introduction & Methodology

The National Inpatient Survey 2014 was carried out by Picker Institute Europe on behalf of Liverpool Women's NHS Foundation Trust. The survey is based on a sample of consecutively discharged patients who attended the Trust June, July or August 2014. The survey was undertaken by a postal questionnaire, sent to patients' home addresses.

Patients were sent a questionnaire, a covering letter from the Trust's Chief Executive, a multiple language sheet offering help with the survey, and a freepost envelope. Patients wishing to complete the survey filled it in and returned it to the Picker Institute in the freepost envelope. Non-responders were sent a reminder card after 2-3 weeks and another questionnaire after a further 2-3 weeks.

839 patients were eligible for the survey, of which 418 returned a completed questionnaire, giving a response rate of 50% (the national average was 45%). This represents a slight decrease in response for the Trust from the 2013 survey when the response rate was 54%.

High Level Findings

The survey asks patients 68 questions. The 68 questions are grouped into 8 sections, mirroring the patient journey. The following chart shows the difference between the overall Trust score in each section compared to both its own historical results and the results of all other participating Trusts.

	LWH vs Other Trusts	LWH vs. LWH 2013
Admission to Hospital	**9%**	**3%**
The Hospital & Ward	**6%**	**0%**
Doctors	**14%**	**3%**
Nurses	**9%**	**1%**
Care & Treatment	**9%**	**1%**
Operations & Procedures	**5%**	**-1%**
Leaving Hospital	**9%**	**0%**
Overall Experience	**6%**	**4%**

The Trust scored better than other Trusts for all 8 sections. The Trust scored better than in 2013 for 5 sections, worse in 1 and the same in 2.

Detailed Findings

Results were significantly better than the average of other Trusts for 53 questions, similar for 8 and significantly worse for 1 question. This outlier is shown below:

	Liverpool Women's	Average of Other Trusts	Liverpool Women's 2013
Discharge: Staff did not discuss need for additional equipment or home adaptation	37%	18%	32%

The Trust improved its 2013 score significantly in 5 questions and was significantly worse in 0 questions. The 5 significant improvements are shown below:

	Liverpool Women's	Liverpool Women's 2013	Average of Other Trusts
Planned admission: admission date changed by hospital	13%	19%	21%
Hospital: room or ward not very or not at all clean	0%	1%	3%
Hospital: food was fair or poor	30%	38%	42%
Care: not always enough privacy when being examined or treated	5%	9%	9%
Overall: not asked to give views on quality of care	61%	70%	68%

3.3.2 Picker Day case Survey 2014

Day Case Survey 2014 was carried out by Picker Institute Europe on behalf of Liverpool Women's NHS Foundation Trust. The survey is based on a sample of consecutively discharged patients who attended the Trust for day surgery in May 2014. The survey was undertaken by a postal questionnaire, sent to patients' home addresses.

Patients were sent a questionnaire, a covering letter from the Trust's Chief Executive, a multiple language sheet offering help with the survey, and a freepost envelope. Patients wishing to complete the survey filled it in and returned it to the Picker Institute in the freepost envelope. Non-responders were sent a reminder card after 2-3 weeks and another questionnaire after a further 2-3 weeks.

834 patients were eligible for the survey, of which 276 returned a completed questionnaire, giving a response rate of 33% (the national average was 51%). Of the 276 patients who responded to the survey:

- 21% were aged 16-39; 55% were aged 40-59; 15% were aged 60-69; 9% were aged 70.
- 96% stated their ethnic background as White; 1% Mixed; 2% Asian; 1% Black/Black British; 0% Arab or other ethnic group.
- 28 calls were made by Trust patients to the Freephone survey helpline.

High Level Findings

The survey asks patients 68 questions. The 68 questions are grouped into 9 sections, mirroring the patient journey. The following chart shows the difference between the overall Trust score in each section compared to both its own historical results and the results of all other participating Trusts (a lower score is better).

	LWH vs Other Trusts	LWH vs. LWH 2013
Before Your Visit	-7%	3%
Arriving At Hospital	0%	0%
Operations & Procedures	2%	4%
The Hospital And Ward/Recovery Area	-3%	0%
Doctors	-2%	0%
Nurses	2%	3%
Your Care And Treatment	4%	2%
Leaving Hospital	3%	3%
Overall	1%	1%

The Trust scored better than other Trusts for 3 sections, worse in 5 and the same in 1. The Trust scored better than in 2013 for 0 sections, worse in 6 and the same in 3.

Detailed Findings

Results were significantly better than the average of other Trusts for 7 questions but significantly worse for 6 questions. These are shown below:

(lower scores are better)

	Liverpool Women's	Average of Other Trusts	Liverpool Women's 2013
Before visit: should have been admitted sooner	13%	25%	10%
Before visit: not given choice of appointment dates	46%	65%	41%
Before visit: appointment date changed by hospital	13%	18%	14%
Before visit: not given printed information about condition or treatment	13%	21%	13%
Hospital: shared a room or bay with opposite sex	4%	21%	3%
Doctors: talked in front of patients as if they were not there	6%	15%	6%
Nurses: talked in front of patients as if they weren't there	8%	13%	9%
Care: not enough opportunity for family to talk to doctor	52%	40%	39%
Care: not always enough privacy when discussing condition or treatment	26%	17%	20%
Discharge: felt length of stay was too long or too short	15%	10%	13%
Discharge: family not given enough notice about discharge	29%	22%	24%
Discharge: not given any written/printed information about what they should or should not do after leaving hospital	27%	19%	28%
Discharge: family not given enough information to help	53%	35%	46%

The Trust improved its 2013 score significantly in 0 questions but was significantly worse in 5 questions. These are shown below:

(lower scores are better)

	Liverpool Women's 2014	Liverpool Women's 2013	Average of Other Trusts
Surgery: what would be done during operation not fully explained	26%	18%	23%
Surgery: anaesthetist / other member of staff did not fully explain how would put to sleep or control pain	14%	8%	13%
Hospital: toilets not very or not at all clean	2%	0%	1%
Care: not enough opportunity for family to talk to doctor	52%	39%	40%
Discharge: was delayed	11%	6%	10%

3.3.3 National Cancer Patient Experience Survey

Introduction & Summary

The National Cancer Patient Experience Survey (NCPES) is designed to monitor national progress on cancer care. It was carried out by Quality Health on behalf of NHS England. It is designed to help Trusts monitor safety, effectiveness and patient experience by ensuring standards are being maintained or improved. 153 acute hospital NHS Trusts providing cancer services took part in the survey, accounting for every Trust that provides adult cancer care in England.

The survey included all adult patients (aged 16 and over) with a primary diagnosis of cancer who had been admitted to an NHS hospital as an inpatient or as a day case patient, and had been discharged between 1st September and 30th November 2013. Postal surveys were sent to patients' home addresses following their discharge. Up to two reminders were sent to non-responders. A freepost envelope was included for their replies. Patients could call a free telephone line to ask questions, complete the questionnaire verbally, or to access an interpreting service.

Issues for Consideration

The survey consisted of 70 questions; 66 of these were applicable to this Trust. There was a response rate of 54%; this compares to a national response rate of 64%. The Trust was in the bottom 20% of Trusts in 12 questions; this compares to 6 questions in the 2013 survey. The Trust was in the top 20% of Trusts in 20 questions; this compares to 38 questions in the 2013 survey. The Trust scored lower in this survey than in the 2013 survey for 39 of the 66 questions.

The 12 questions in which this Trust was in the bottom 20% of all Trusts were as follows:

		LWH %	Threshold for lowest 20%	Threshold for highest 20%	Trust Responders
Q1	Saw GP once/twice before being told had to go to hospital	62%	72%	79%	47
Q11	Patient told they could bring a friend when first told they had cancer	68%	71%	79%	53
Q12	Patient felt they were told sensitively that they had cancer	75%	82%	87%	59
Q14	Patient given written information about the type of cancer they had	65%	68%	76%	51
Q45	Patient did not think hospital staff deliberately misinformed them	81%	86%	91%	54
Q55	Family definitely given all information needed to help care at home	52%	56%	65%	46
Q59	Staff definitely did everything they could to help control pain	68%	79%	86%	25
Q60	Hospital staff definitely gave patient enough emotional support	62%	66%	76%	45
Q62	Doctor had the right notes and other documentation with them	91%	95%	98%	55
Q63	GP given enough information about patient`s condition and treatment	89%	93%	97%	45
Q64	Practice staff definitely did everything they could to support patient	53%	62%	71%	43
Q69	Patient did not feel that they were treated as a `set of cancer symptoms`	75%	78%	84%	59

There were 6 questions in which it was identified that there had been significant changes in the Trust score between 2013 and 2014. These were as follows (the 5 “Reds” are also included in the above list of questions in which this Trust was in the bottom 20% of all Trusts):

		LWH 2013 %	LWH 2014 %		Threshold for highest 20% in 2014
Q9	Given complete explanation of test results in understandable way	75%	89%		82%
Q45	Patient did not think hospital staff deliberately misinformed them	94%	81%		91%
Q60	Hospital staff definitely gave patient enough emotional support	81%	62%		76%
Q62	Doctor had the right notes and other documentation with them	98%	91%		98%
Q63	GP given enough information about patient`s condition and treatment	100%	89%		97%
Q64	Practice staff definitely did everything they could to support patient	73%	53%		71%

Conclusion & Actions

All of the 12 questions in which the Trust performed poorly were discussed at the gynaecology oncology business meeting on 31st October 2014 and appropriate actions allocated. Details of the actions, along with progress, are as follows:

Issue	Trust %	Lowest 20% Threshold	Highest 20% Threshold	Actions to be Agreed	Lead	RAG
Saw GP once/twice before being told had to go to hospital	62%	72%	79%	Lead cancer nurse network group to form a working group around collective issues from the NPES	CW	**A**
Patients told they could bring a friend when first told they had cancer	68%	71%	79%	All LWH letters have an invitation to bring a friend Teams at Units encouraged to emphasise this to patients they refer to LWH	CW	**G**
Patient told sensitively that they had cancer	75%	82%	87%	--Patient feedback report checked and nil obvious to action from LWH --Referring cancer units advised on this issue being raised by patients -- LWH Nurse consultants will do an evaluation re phone diagnoses	CW	**G**
Patient given written information about the type of cancer they had	65%	68%	76%	---CNS's to ensure patients with cancer of ovary have retrospective leaflet	CW	**G**
Patient did not think hospital staff deliberately misinformed them	81%	86%	91%	-- patient feedback checked and nil found to explain this --NHS "ask 3 questions" shared decision making leaflets on display	CW	**G**
Family definitely given all information needed to help care at home	52%	56%	65%	--patient focus group to write new leaflet for carers – January 2015	CW	**A**
Out Patient / Day care Staff definitely did everything they could to help control pain	68%	79%	86%	--education of staff via AMIGO'S programme to be rolled out to a second group of staff in day ward and outpatients Jan 2015	CW	**G**
Out Patient / Day care Hospital staff definitely gave patient enough emotional support	62%	66%	76%	--education of staff via AMIGO'S programme to be rolled out to a second group of staff in day ward and outpatients Jan 2015	CW	**G**
Doctor had right notes in front of them	91%	95%	98%	--introduction of electronic case notes at both LWH and CCC		**G**
GP given enough information about condition and treatment	89%	93%	97%	--Both clinic and ward discharge letters go out within 24/48 hrs. --CNS's have commenced end of treatment summaries for GP's at post treatment holistic assessment clinic visit October 2014	CW	**G**
Practice staff definitely did everything they could to support patient	53%	62%	71%	Lead cancer nurse network group to form a working group around collective issues from the NPES	CW	**A**
Patient did not feel that they were treated as a `set of cancer symptoms`	75%	78%	84%	--share this with Unit and CCC staff --change of clinic template to allow longer time slots	RDM	**A**

The Cancer patient survey focuses on day case and inpatient cases who have been coded with a diagnosis of cancer. In a tertiary treatment trust a patient may have had a full set of diagnostics and outpatient appointments with another trust prior to arriving for treatment. As the patient survey is a generic form that includes questions about the whole patient experience. It is difficult to ascertain for some of the questions as to whether the responses are related to issues within the trust or are referring to the original referring trust (less than 50% of the patients treated for cancer originate with the hospital).

Within the comments fed back to us from Quality Health, several patients made reference to other hospitals in both positive and negative ways. Despite this potential discrepancy, we have attempted in our action plans to address the issues raised by the survey.

3.3.4 Neonatal Survey 2014

The report from this survey has been received by the Neonatal Matron. It is to be taken for review and discussion at their MDT. They will then set up working parties with nursing staff and parent representatives to review it. From this they will develop achievable actions and timescales. The Head of Patient Experience will then work with The Neonatal Matron on the action plan.

3.1 Pulse' – Staff Survey and Opinions

In April 2013 the Trust introduced the 'Pulse' staff survey, within which staff were invited, as frequently as they wished, to respond to a series of questions that were based on the National Staff Survey. Although staff could respond as often as they wished to, they were encouraged to respond monthly, which would, if fully implemented, provide a valuable and frequent insight into the attitudes of staff.

The basis of the Pulse Survey measurement changed in 2014 to the percentage of staff that answered positively (i.e. Likely/Extremely Likely or Agree/Strongly Agree expressed as a percentage of respondents). This was to fit with national changes in reporting requirements for the Friends & Family test.

2014-15 data:

There are no results for the first three months of 2014, as survey cards had to be developed and printed and were unavailable until 30th June. Similarly technical aspects of the electronic recording and reporting systems had to be revised and implemented.

	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 14	Feb 14	Mar 14
Q01. Would Recommend LWH to Friends and Family if need care or treatment				80	67.7	81.2	86.4	86.7	94.7	96	98.4	100
Q02. Likely to Recommend LWH to Friends and Family as a Place to Work				62.7	51.6	68.7	61.8	71.6	71.0	80	76.5	88.8
Q03. Care of women, babies and their families is the Trust's top priority				60	58.0	81.2	80.5	78.3	89.4	94	89.0	91.1
Q04. I know how my role makes a difference to women, babies and families				77.2	74.1	75	76.2	84.9	89.4	98	89.0	86.6
Q05. I'm proud of the standard of care provided by the Trust				60	54.8	81.2	68.6	72.6	76.3	86	89.0	88.8
Q06. Am able to make suggestions to improve work of my team/department				69.0	58.0	81.2	61.0	81.1	81.5	86	84.3	73.3
Q07. I am clear about what I need to achieve as part of my job				83.6	77.4	75	83.0	85.8	81.5	94	95.3	88.8
Q08. The people I work with treat me with respect				69.0	67.7	68.7	70.3	81.1	76.3	88	84.3	88.8
Q09. I am trusted to do my job				82.7	77.4	81.2	83.0	83.9	86.8	90	89.0	91.1
Q10. I enjoy my job				74.5	77.4	81.2	72.0	78.3	76.3	88	82.8	88.8
Q11. We learn from mistakes and take action to prevent from happening again				63.6	51.6	68.7	61.0	70.7	81.5	82	81.2	86.6
Q12. My Appraisal/PDR has helped me to do my job better for patients				39.0	51.6	43.7	41.5	50	47.3	60	60.9	53.3

Key (represents the % of staff answering positively): <50% >=50% and <70% >=70%

Key Findings and Responsive Actions

Pulse survey response rates have declined over the last 6 months from an average of 25% in 13/14 to around 5% over the last 6 months. The cards are going to be reviewed and *reissued* with a reduced number of questions. The questions will be revised in light of the latest staff survey results and also themes emerging from the CQC report.

Managers must be held to account for encouraging completion and feeding back the results and this is an objective in the PDR of all ward / department managers.

Managers receive notification of the results of the PULSE survey throughout the month. They are required to update the report to demonstrate where staff feedback has been received in the last month and where they have taken action in response to staff feedback. Reports are displayed on the staff noticeboards. (Examples attached).

Feedback from PULSE is used as part of team meetings and the themes raised will be used as part of the team coaching sessions being run in the Trust over the coming months.

The comments from the PULSE survey provide valuable information for managers on the immediate concerns and views of their team. Last month 13 staff from MLU responded, a 25% response rate and 100% of comments were positive which the manger was able to share with the team and celebrate the improvements made by the whole team in the last 12 months. The comments included:

• Outstanding care • I believe we give the best care • Staff do care and provide excellent services • One to one care and ideal for normal birth and expert care, excellent support and well led departments • Great care and compassion, great place to work- second home • Because all staff work as a team- I have recommended, and the care given was excellent, it is a pleasant working environment • Empathy, compassion and professionalism shown by staff, great rapport between staff a little family • One to one care, passionate staff, competent staff, very supportive, evidence based practice

4 Annex 1: Statements from commissioners, local Healthwatch organisations and Overview and Scrutiny Committees

4.1 Commentaries from Clinical Commissioning Groups (CCGs)

4.1.1 NHS England

As more than 50% of the relevant health services provided by the Liverpool Women's NHS Foundation Trust in the reporting period is provided under contracts, agreements or arrangements with Liverpool Clinical Commissioning Group and not NHS England, there is no requirement for the Trust to submit the Quality Report to NHS England prior to publication for comment and no legal obligation on the part of NHS England to do so.[16]

4.1.2 Liverpool CCG

Liverpool CCG – Quality Account Statements – Liverpool Women's NHS Foundation Trust

Liverpool CCG welcomes the opportunity to comment on Liverpool Women's NHS Foundation Trust Draft Quality Account for 2014/15. We have worked closely with Liverpool Women's throughout 2014/15 to gain assurances that the services they delivered were safe, effective and personalised to service users. The CCG shares the fundamental aims of the Trust and supports their strategy to deliver high quality, harm free care.

We have reviewed the information provided within the Quality Account and checked the accuracy of data within the account which was submitted as part of the trusts contractual obligation. All data provided corresponds with data used as part of the on-going contract monitoring process.
This Account indicates the Trusts commitment to improving the quality of the services it provides and Liverpool CCG supports the key priorities for improvement during 2014/15.

- To reduce harm
- To reduce mortality
- To improve the patient experience

This is a comprehensive report that clearly demonstrates progress within the Trust. It identifies where the organisation has done well, where further improvement is required and what actions are needed to achieve these goals. The Quality Account sets out the priorities for improving patient safety, patient experience and clinical effectiveness across all services provided by Liverpool Women's Hospital.

Liverpool Women's places significant emphasis on its safety agenda, with an open and transparent culture, and this is reflected throughout the account with work continuing on reporting and learning from incidents. This commitment is also supported through the participation in the Sign Up to Safety Campaign and the pledges put forward to improving patient safety across the organisation.

Liverpool CCG welcomes the transparency within the report regarding the CQC inspection during routine and unannounced inspections during 2014. The Trust has demonstrated considerable improvements over

[16] Detailed requirements for quality reports 2014-15, Monitor, February 2015 available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/406537/Detailed_req_for_qual_repts_update24feb.pdf

the last twelve month and we acknowledge the hard work and commitment of Liverpool Women's to ensure patients remain at the centre of care.

Central to the Quality Account is a commitment by the Trust to strengthen the patient voice and therefore ensure that patient experience drives improvement in the quality of services through the National Friends and Family survey. As part of this approach, it is important that there is access to real time patient feedback and we are encouraged by the initiatives that the Trust is introducing in particular. The thematic approach used to address issues/concerns identified at ward level. This approach supports the monitoring of actions and improves service improvement across the organisation.

It is felt that the priorities for improvement identified for the coming year are both challenging and reflective of the current issues across the health economy. We therefore commend the Trust in taking account of new opportunities to further improve the delivery of excellent, compassionate and safe care for every patient, every time. As coordinating commissioner, we look forward to continuing to work in partnership with the Trust and supporting them to deliver these quality priorities.

Signed 26th May 2015

Katherine Sheerin
Chief Officer

4.1.3 Knowsley CCG

Requested but not received.

4.1.4 Sefton CCG

Requested but not received.

4.1.5 Southport & Formby CCG

Requested but not received.

4.1.6 Halton CCG

Requested but not received.

4.1.7 St Helens CCG

Requested but not received.

4.2 Commentaries from Local HealthWatch Groups

4.2.1 Liverpool HealthWatch & Sefton HealthWatch

Healthwatch Liverpool and Healthwatch Sefton are pleased to have the opportunity to comment on the 2014 – 2015 Quality Account for Liverpool Women's NHS Foundation Trust. This commentary relates to the contents of a draft Quality Account document that was made available to the Healthwatch organisations prior to its publication.

As this is a specialist Trust some of the outcomes are difficult to compare, but the impression Healthwatch gains from the report overall is that the Trust provides a good service and wants to keep improving on the services it offers.

The document provides a wealth of information, including audits and lessons learnt, but it is not very accessible for a lay person in terms of how easy it is to understand the information provided, although a small glossary is provided at the end of the document.

The Quality Account sets out the Trust's priorities for 2014-15 under the headings of patient safety, clinical effectiveness, and patient experience. The document also outlines the chosen priorities for 2015-16, namely to reduce harm, to reduce mortality, and to provide the best patient experience. Details about the Trust's performance for all priorities are provided within the report.

The document shows that there have been quite a few improvements made across the Trust during the year. It was particularly positive to note that staffing levels in maternity have continued to increase, that infection rates have continued to fall in elective gynaecological surgery, and that the Trust maintained its good records on MRSA and C-diff infections for 2014-15. Additionally, it was positive to see that there was a lower level of multiple pregnancies in women receiving fertility treatment. However, the report also shows that re-admission rates to the Trust, although low, did increase.

It was clear that Friends and Family Test data is being used by the Trust to identify areas where improvements could be made. The Picker survey shows mixed results, but the Trust displays what actions it is taking to improve. Healthwatch was pleased to note that a 'Patient Senate' has been founded by the Trust this year, thus helping to ensure that data and information about patient experience is brought together in one forum.

In February 2015, the Care Quality commission visited the Trust to undertake a scheduled assessment under the new inspection regime. The final report from this assessment is still awaited and we look forward to reviewing the findings from the visit.

There was no information about what the Trust does to ensure the equity of its serivces in the report. This is something that Healthwatch would like to see in future, as it is important for the Trust to be able to demonstrate that it is conscious of the need to ensure that all people can equally access its services and have a positive experience of it.

Healthwatch Liverpool is pleased to note that there has been a marked improvement in engagement from the Trust this year. Healthwatch Sefton would like to see more engagement with the organisation over the next 12 months and would be keen to meet with the new head of patient experience.

Healthwatch is aware that the Trust is currently looking at the future of local women's health services, and Healthwatch will be pleased to find out more regarding the Trust's engagement with patients and the wider public about this during the year.

Healthwatch aims to continue, and is looking forward to, regular engagement with the Trust in 2015-16, in order to be able to monitor the progress of the Quality Account priorities and other quality considerations.

4.2.2 Knowsley HealthWatch

Requested but not received.

4.2.3 Halton HealthWatch

Requested but not received.

4.2.4 St Helens HealthWatch

Requested but not received.

4.3 Commentary from Local Authority Overview & Scrutiny Committees (OSCs)

4.3.1 Liverpool Council

Requested but not received.

4.3.2 Knowsley Council

Requested but not received.

4.3.3 Sefton Council

Requested but not received.

4.3.4 Halton Borough Council

HALTON
BOROUGH COUNCIL

Kathryn Thompson
Chief Executive
Liverpool Women's Foundation Trust
Crown Street
Liverpool
L8 7SS

Our Ref	EST
If you telephone please ask for	Emma Sutton-Thompson
Your ref	
Date	20th May 2015
E-mail address	Emma.Sutton-Thompson @halton.gov.uk

Dear Kathryn,

Quality Accounts 2015

Further to receiving a copy of your draft Quality Accounts and the Joint Quality Accounts event held on 13th May that your colleague Allison Edis attended to present a summary of your Quality Accounts, I am writing with the Health Policy and Performance Board comments. The Health Policy and Performance Board particularly noted the following key areas:

As a general comment, the Quality Account report is not easy to read and it would be useful for the format of future reports to be revised to make them easier for the public to understand. There is a lot of use of abbreviations which does not make it easy read.

The Board was pleased to note the Trust achieving "good" from a recent Care Quality Commissions (CQC) inspection.

The Board noted that the Trust have been open about the challenges they currently face, in particular the financial challenges.

During the year 2014/15 the Trust identified a number of priorities to be achieved during this year. The Board noted the following:

- *1:1 care in established labour provided to >=95% of women* – the Board is pleased to note that there has been an increase in this area and hopes to see this trend continue.

It's all happening **IN HALTON**
Communities Directorate
Runcorn Town Hall, Heath Road, Runcorn, Cheshire WA7 5TD
Tel: 0151 907 8300
www.halton.gov.uk

HALTON
BOROUGH COUNCIL

- *To be in the upper quartile of Patient Surveys across all pathways (Friends & Family Test – In patients)* – the Board is pleased to see the continued high percentage of patients that would recommend the Trust to others.

The Board are pleased to note the following Improvement Priorities for 2015 – 2016:

- *To reduce harm, including:*
  - Infection;
  - Avoidable birth injury;
  - Medication errors and;
  - Multiple pregnancy as a result of fertility treatment

- To reduce mortality in:
  - Neonates
  - Gynaecology
  - Maternity (including maternal death & stillbirth).

- *To provide the best patient experience*
  In addition to these, the Board would be pleased to see more of a focus on Dignity.

The Board would like to thank Liverpool Women's Foundation Trust for the opportunity to comment on these Quality Accounts.

Yours sincerely,

Councillor Joan Lowe
Chair, Health Policy and Performance Board

It's all happening **IN HALTON**
Communities Directorate
Runcorn Town Hall, Heath Road, Runcorn, Cheshire WA7 5TD
Tel: 0151 907 8300
www.halton.gov.uk

Public Health Comments on Quality Accounts

Liverpool Women's

- **Providing breastfeeding support to women following delivery**- Increasing breastfeeding initiation is a key local priority in Halton. Therefore Public Health is particularly supportive of the review of the Infant Feeding Support Team to increase the number of hours spent with new mothers on the wards.
- **"Skin to Skin" contact** – As the report rightly points out skin to skin contact for mother and baby is of crucial importance in the post-natal period and can contribute to a number of improved health outcomes, including breastfeeding which is a local priority. We would therefore support further work to improve progress in this area.
- **Cancer Treatment-** Cancer is a key local priority in Halton and we are pleased to note that diagnosis to treatment indicators are progressing well. We would continue to support improvement in this area to enable us to further improve on local targets.

4.3.5 St Helens Council

Requested but not received.

4.4 Directors' Responsibilities

Statement of directors' responsibilities for the Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, Directors are required to take steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual for 2014/15 and supporting guidance;

- The content of the Quality Report is not inconsistent with internal and external sources of information including:

  - Board minutes and papers for the period April 2014 to March 2015.
  - Papers relating to Quality reported to the Board over the period April 2014 to March 2014.
  - Feedback from the commissioners: Liverpool Clinical Commissioning Group dated 26 May 2015.
  - Feedback from Governors dated 7 May 2015.
  - Feedback from local HealthWatch organisations dated: 26 May 2015 – HealthWatch Liverpool, 26 May 2015 – HealthWatch Sefton.
  - Feedback from Overview and Scrutiny Committee dated: 20 May 2015 – Halton Borough Council.
  - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2015 (final ratification pending).
  - The 2014/15 national patient survey issued February 2015.
  - The 2014/15 national staff survey issued February 2015.
  - The Head of Internal Audit's annual opinion over the Trust's control environment dated 16 March 2015.
  - CQC Intelligent Monitoring Reports dated July, October and December 2014 and May 2015 (draft).

- The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered.

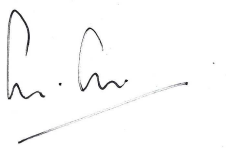
- The performance information reported in the Quality Report is reliable and accurate.

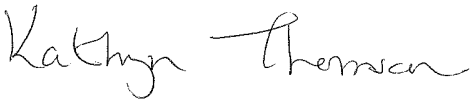
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice.

- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- The Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts Regulations) (published at www.monitor.gov.uk/annualreporting manual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor.gov.uk/annualreportingmanual).

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board.





Liz Cross	Kathryn Thomson
Vice Chair	Chief Executive
22 May 2015	22 May 2015

4.5 External Auditors Limited Assurance Report

Independent Auditors' Limited Assurance Report to the Council of Governors of Liverpool Women's Hospital NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Council of Governors of Liverpool Women's NHS Foundation Trust to perform an independent assurance engagement in respect of Liverpool Women's NHS Foundation Trust's Quality Report for the year ended 31 March 2015 (the 'Quality Report') and specified performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2015 subject to limited assurance (the "specified indicators"); marked with the symbol Ⓐ in the Quality Report, consist of the following national priority indicators as mandated by Monitor:

Specified Indicators	***Specified indicators criteria*** (exact page number where criteria can be found)
Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period	Section 3.2 of the Quality Account
Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers	Section 3.2 of the Quality Account

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the specified indicators criteria referred to on pages of the Quality Report as listed above (the "Criteria"). The Directors are also responsible for the conformity of their Criteria with the assessment criteria set out in the NHS Foundation Trust Annual Reporting Manual ("FT ARM") and the "Detailed requirements for quality reports 2014/15" issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- The Quality Report does not incorporate the matters required to be reported on as specified in Annex 2 to Chapter 7 of the FT ARM and the "Detailed requirements for quality reports 2014/15";
- The Quality Report is not consistent in all material respects with the sources specified below; and
- The specified indicators have not been prepared in all material respects in accordance with the Criteria and the six dimensions of data quality set out in the "2014/15 Detailed guidance for external assurance on quality reports".

We read the Quality Report and consider whether it addresses the content requirements of the FT ARM and the "Detailed requirements for quality reports 2014/15; and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with the following documents:

- Board minutes for the financial year, April 2014 and up to March 2015 (the period);
- Papers relating to quality report reported to the Board over the period April 2014 and up to March 2015;
- Feedback from the Commissioners Liverpool Clinical Commissioning Group dated 26/05/2015;

- Feedback from Governors dated 07/05/2015;
- Feedback from Local Healthwatch organisations Healthwatch Liverpool dated 26/05/2015 and Healthwatch Sefton 26/05/2015;
- Feedback from Overview and Scrutiny Committee, Halton Borough Council, dated 20/05/2015
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2015 (final ratification pending);
- The 2014/15 national and local patient survey dated February 2015;
- The 2014/15 national and local staff survey dated February 2015;
- Care Quality Commission Intelligent Monitoring Reports dated July 2014, October 2014 and December 2014;
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 16/03/2015

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the **"**documents**"**). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales ("ICAEW") Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Liverpool Women's NHS Foundation Trust as a body, to assist the Council of Governors in reporting Liverpool Women's NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2015, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Liverpool Women's NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- reviewing the content of the Quality Report against the requirements of the FT ARM and "Detailed requirements for quality reports 2014/15";
- reviewing the Quality Report for consistency against the documents specified above;
- obtaining an understanding of the design and operation of the controls in place in relation to the collation and reporting of the specified indicators, including controls over third party information (if applicable) and performing walkthroughs to confirm our understanding;
- based on our understanding, assessing the risks that the performance against the specified indicators may be materially misstated and determining the nature, timing and extent of further procedures;
- making enquiries of relevant management, personnel and, where relevant, third parties;
- considering significant judgements made by the NHS Foundation Trust in preparation of the specified indicators;
- performing limited testing, on a selective basis of evidence supporting the reported performance indicators, and assessing the related disclosures; and
- reading the documents.

A limited assurance engagement is less in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the assessment criteria set out in the FT ARM the "Detailed requirements for quality reports 2014/15 and the Criteria referred to above.

The nature, form and content required of Quality Reports are determined by Monitor. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different [NHS Foundation Trusts/organisations/entities].

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators in the Quality Report, which have been determined locally by Liverpool Women's NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that for the year ended 31 March 2015,

- The Quality Report does not incorporate the matters required to be reported on as specified in Annex 2 to Chapter 7 of the FT ARM and the "Detailed requirements for quality reports 2014/15";
- The Quality Report is not consistent in all material respects with the documents specified above; and
- the specified indicators have not been prepared in all material respects in accordance with the Criteria and the six dimensions of data quality set out in the "Detailed guidance for external assurance on quality reports 2014/15".

PricewaterhouseCoopers LLP

PricewaterhouseCoopers LLP
Manchester
28 May 2015

The maintenance and integrity of Liverpool Women's NHS Foundation Trust's website is the responsibility of the directors; the work carried out by the assurance providers does not involve consideration of these matters and, accordingly, the assurance providers accept no responsibility for any changes that may have occurred to the reported performance indicators or criteria since they were initially presented on the website.

Remuneration report

The remuneration and pension benefits of our senior employees for the year ended 31 March 2015 are given in the tables on pages 179 - 181. These senior managers are all Executive and Non-Executive Directors of the Board of Directors who served during the financial year 2014/15 and also include the Trust's Associate Director of Operations who attends meetings of the Board in a non-voting role. This group of staff are referred to throughout this report as Executive Directors. These tables plus their associated narrative (including pay multiples) are subject to external audit review.

The Remuneration Committee of the Board of Directors determines the remuneration, terms and conditions of the Trust's Chief Executive and Executive Directors. It does so based on job evaluation, market intelligence and inflation alongside any guidance from national recommendations for NHS senior managers. The Committee also considers Executives' annual appraisals and achievement of the Trust's corporate objectives for the year. In determining this group of staff's remuneration the Committee has regard to the remuneration of other Trust employees who hold contracts under terms and conditions agreed nationally and locally.

Each Executive Director has objectives set at the beginning of the financial year which are drawn from the Trust's agreed corporate objectives. Performance against these objectives is reviewed annually by the Chief Executive and details shared with the Board's Remuneration Committee. The Chair appraises the Chief Executive who in turn appraises Executive Directors and the Trust Secretary.

The remuneration of the Chief Executive and Executive Directors comprises annual basic salary and normal NHS pension contributions. Performance is not a determinant of the Chief Executive and Executive Directors' remuneration; market rate and portfolio content are the key factors used to determine the levels of remuneration.

The Chief Executive and Executive Directors are employed on permanent contracts of employment, subject to six months' notice on either side. Any termination payments would be subject to review and approval by the Board of Directors' Remuneration Committee if outside of statutory entitlements.

Pension benefits

The audited remuneration and pension benefits of senior managers is disclosed in this report and can be found at page 181. Accounting policies for pensions are set out in note 1.3. There are no entries in respect of pensions for Non-Executive Directors as they do not receive pensionable remuneration. Additionally there were no contributions to Stakeholder Pensions on behalf of any of the Directors of the Trust.

In 2013/14 the All Pension Related Benefits for Caroline Salden (former Chief Operating Officer) were disclosed as a negative value. The Annual Reporting Manual for Foundation Trusts 2014/15 has stipulated that negative values in the table 'Salary Entitlements for Senior Managers' on pages 179-180 disclosed as a £nil value. Therefore to be compliant with the Manual the Trust has disclosed the negative All pension Related Benefits as £nil and adjusted the total accordingly.

Salary Entitlements of Senior Managers 2014/15								
Name	**Position Held**	**Salary and Fees**	**All Taxable Benefits**	**Annual Performance Related Bonuses**	**Long Term Performance Related Bonuses**	**All Pension-Related Benefits**	**Total**	**Expenses**
		(in bands of £5,000)	**(total to the nearest £100)**	**(in bands of £5,000)**	**(in bands of £5,000)**	**(in bands of £2,500)**	**(in bands of £5,000)**	**(in bands of £100)**
Kathryn Thomson	Chief Executive	145 - 150	-	-	-	-	**145 - 150**	1 - 2
Jonathan Herod	Medical Director *In post to 13 February 2015*	140 - 145	-	30 - 35	-	-	**170 - 175**	12 - 13
Joanne Topping	Acting Medical Director *In post from 13 February 2015 (joined Pension Scheme on 1 March 2015)*	15 - 20	-	0 - 5	-	-	**15 - 20**	4 - 5
Gail Naylor	Director of Nursing, Midwifery & Operations *In post to 4 May 2014*	10 - 15	-	-	-	70 - 72.5	**80 - 85**	-
Dianne Brown	Director of Nursing & Midwifery *In post from 1 June 2014*	75 - 80	-	-	-	32.5 - 35	**110 - 115**	-
Vanessa Harris	Director of Finance	115 - 120	-	-	-	-	**115 - 120**	-
Caroline Salden	Chief Operating Officer *In post to 31 January 2014*	N/a	N/a	N/a	N/a	N/a	**N/a**	N/a
Jeffrey Johnston	Associate Director of Operations *In post from 1 June 2014*	75 - 80	-	-	-	-	**75 - 80**	0 - 1
Michelle Turner	Director of Human Resources & Organisational Development	105 - 110	-	-	-	-	**105 - 110**	1 - 2
Ken Morris	Chair *In post to 14 August 2014*	10 - 15	-	-	-	N/a	**10 - 15**	-
Edna Robinson	Chair *In post from 1 September 2014*	20 - 25	-	-	-	N/a	**20 - 25**	1 - 2
Pauleen Lane	Non Executive Director	10 - 15	-	-	-	N/a	**10 - 15**	-
Liz Cross	Non Executive Director	10 - 15	-	-	-	N/a	**10 - 15**	-
Ian Haythornthwaite	Non Executive Director	10 - 15	-	-	-	N/a	**10 - 15**	7 - 8
Allan Bickerstaffe	Non Executive Director *in post to 31 January 2015*	10 - 15	-	-	-	N/a	**10 - 15**	3 - 4
Steve Burnett	Non Executive Director	10 - 15	-	-	-	N/a	**10 - 15**	9 - 10
George Kissen	Non Executive Director *in post from 1 February 2015*	0 - 5	-	-	-	N/a	**0 - 5**	-
	Band of Highest Paid Director's Remuneration (in band of £5,000)	170 - 175						
	Median Total Remuneration (£)	28,071						
	Ratio	6.1						

Salary Entitlements of Senior Managers 2013/14								
Name	**Position Held**	**Salary and Fees**	**All Taxable Benefits**	**Annual Performance Related Bonuses**	**Long Term Performance Related Bonuses**	**All Pension-Related Benefits**	**Total**	**Expenses**
		(in bands of £5,000)	**(total to the nearest £100)**	**(in bands of £5,000)**	**(in bands of £5,000)**	**(in bands of £2,500)**	**(in bands of £5,000)**	**(in bands of £100)**
Kathryn Thomson	Chief Executive	150 - 155				55 - 57.5	**205 - 210**	2 - 3
Jonathan Herod	Medical Director *In post to 13 February 2015*	160 - 165		40-45		82.5 - 85	**285 - 290**	13 - 14
Joanne Topping	Acting Medical Director *In post from 13 February 2015 (joined Pension Scheme on 1 March 2015)*	N/a	N/a	N/a	N/a	N/a	**N/a**	N/a
Gail Naylor	Director of Nursing, Midwifery & Operations *In post to 4 May 2014*	115 - 120				177.5 - 180	**295 - 300**	-
Dianne Brown	Director of Nursing & Midwifery *In post from 1 June 2014*	N/a	N/a	N/a	N/a	N/a	**N/a**	N/a
Vanessa Harris	Director of Finance	115 - 120				92.5 - 95	**205 - 210**	1 - 2
Caroline Salden	Chief Operating Officer *In post to 31 January 2014*	75 - 80				-	**75 - 80**	-
Jeffrey Johnston	Associate Director of Operations *In post from 1 June 2014*	N/a	N/a	N/a	N/a	N/a	**N/a**	N/a
Michelle Turner	Director of Human Resources & Organisational Development	105 - 110				130 - 132.5	**235 - 240**	2 - 3
Ken Morris	Chair *In post to 14 August 2014*	35 - 40				N/a	**35 - 40**	-
Edna Robinson	Chair *In post from 1 September 2014*	N/a	N/a	N/a	N/a	N/a	**N/a**	N/a
Pauleen Lane	Non Executive Director	10 - 15				N/a	**10 - 15**	-
Liz Cross	Non Executive Director	10 - 15				N/a	**10 - 15**	-
Ian Haythornthwaite	Non Executive Director	10 - 15				N/a	**10 - 15**	7 - 8
Allan Bickerstaffe	Non Executive Director	10 - 15				N/a	**10 - 15**	6 - 7
Steve Burnett	Non Executive Director	10 - 15				N/a	**10 - 15**	15 - 16
George Kissen	Non Executive Director *in post from 1 February 2015*	N/a	N/a	N/a	N/a	N/a	**N/a**	N/a
	Band of Highest Paid Director's Remuneration (in band of £5,000)	205 - 210						
	Median Total Remuneration (£)	27,901						
	Ratio	7.4						

Name	Position Held	Real increase in pension at age 60 (bands of £2,500)	Real increase in pension lump sum at aged 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2015 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2015 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2014	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2015
		£000	£000	£000	£000	£000	£000	£000
Kathryn Thomson	Chief Executive	(2.5 - 5)	(7.5 - 10)	55 - 60	170 - 175	1,050	- 16	1,062
Jonathan Herod	Medical Director *In post to 13 February 2015*	(0 - 2.5)	(5 - 7.5)	50 - 55	160 - 165	983	- 10	998
Joanne Topping	Acting Medical Director *In post from 13 February 2015 (joined Pension Scheme on 1 March 2015)*	(0 - 2.5)	(0 - 2.5)	35 - 40	105 - 110	691	2	728
Gail Naylor	Director of Nursing, Midwifery & Operations *In post to 4 May 2014*	0 - 2.5	0 - 2.5	50 - 55	150 - 155	815	7	917
Dianne Brown	Director of Nursing & Midwifery *In post from 1 June 2014*	0 - 2.5	2.5 - 5	15 - 20	45 - 50	212	30	254
Vanessa Harris	Director of Finance	(0 - 2.5)	(0 - 2.5)	30 - 35	90 - 95	513	1	528
Caroline Salden	Chief Operating Officer *In post to 31 January 2014*	N/a	N/a	N/a	N/a	353	N/a	N/a
Jeffrey Johnston	Associate Director of Operations *In post from 1 June 2014*	(2.5 - 5)	(7.5 - 10)	30 - 35	95 - 100	612	- 39	582
Michelle Turner	Director of Human Resources & Organisational Development	(2.5 - 5)	(10 - 12.5)	35 - 40	115 - 120	735	- 42	713

Pay Multiples

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid Director in their organisation and the median remuneration of the organisation's workforce. The banded remuneration of the highest paid Director in Liverpool Women's NHS Foundation Trust in the financial year 2014/15 was £172,500 (£207,500 in 2013/14). This was 6.1 times the median remuneration of the workforce (7.4 times in 2013/14) which was £28,071 (£27,901 in 2013/14). In 2014/15 five employees received remuneration in excess of the highest paid director (0 in 2013/14). Remuneration ranged from £172,522 to £210,001 (not applicable in 2013/14).

The main reason for the movement from the prior year is that the highest paid Director for 2014/15 was only in post until 13 February 2015 (0.87 whole time equivalent). If the highest paid Director had been in post for the full financial year the ratio in the current year would have been 7.0. The median total remuneration has also increased in 2014/15 compared to 2013/14 as a result of increment rises.

In 2014/15 the average total number of whole time equivalent staff employed at the Trust was 1,373 (1,240 in 2013/14).

Remuneration Committees

During the year, membership of the Board's Remuneration Committee comprised the Trust's Chair and three Non-Executive Directors. The Trust Secretary acted as Secretary to the Committee. At the Committee's invitation and in accordance with its terms of reference, the Chief Executive and Director of Workforce and Marketing attended the meeting.

Committee member – **Non-Executive Director**	**Remuneration Committee** **meetings attended**
Ken Morris, Chair	1 of 1
Allan Bickerstaffe	0 of 1
Liz Cross	1 of 1
Pauleen Lane	1 of 1
Attendees	
Kathryn Thomson, Chief Executive	1 of 1 (ex-officio)
Michelle Turner, Director of Workforce and Marketing	1 of 1 (ex-officio)
Julie McMorran, Trust Secretary	1 of 1 (ex-officio)

The Remuneration Committee of the Trust's Council of Governors determines the remuneration and terms and conditions of the Chair and Non-Executive Directors of the Board. It does so by using benchmarking data provided by the Foundation Trust Network

which is drawn from information provided by all NHS Foundation Trusts. The results of Non-Executive Directors' appraisals are also taken into account by the Council.

Objectives for the Chair and Non-Executive Directors are set at the beginning of each financial year. Performance against those objectives is reviewed annually and shared with the Council of Governors' Remuneration Committee. The Chair assesses Non-Executive Directors' performance and undertakes their annual appraisal. The Senior Independent Director (SID) undertakes the Chair's appraisal, with input from members of the Board and the Council of Governors. The SID's appraisal is conducted by the Vice Chair. This arrangement ensures that there is proper segregation between the person being appraised and the person undertaking the appraisal.

The Chair and Non-Executive Directors are appointed by the Council of Governors for fixed terms of office.

Membership of the Council's Remuneration Committee comprises three public, one staff and one appointed Governor together with the Trust's Lead Governor. During the year they were Paul Moran (Committee Chair), Ana Alfirevic, John Foley, Maureen Kelly, Mary McDonald and Dorothy Zack-Williams (Lead Governor).

The Committee met once during the year. Present were Ana Alfirevic, John Foley, Maureen Kelly, Mary McDonald and Dorothy Zack-Williams. The Trust Secretary acted as Secretary to the Committee.

Off-payroll Engagements

The use of off-payroll engagements is covered by the Trust's Temporary Staffing Policy which details the controls that the Trust has in place. These controls include that all bookings must be made via the temporary staffing team, based in the Human Resources department, and agency requests can only be taken forward using the Trust's list of approved suppliers.

Additional checks are in place in respect of contracts with highly paid staff which meet the threshold used by HM Treasury. The Trust ensures that there are contractual clauses giving the Trust the right to request assurance in relation to income tax and National Insurance obligations. Assurance is also requested to ensure compliance for a sample of off-payroll arrangements as stipulated in the guidance.

Below are details off-payroll engagements made by the Trust during the year. The disclosures relate to public sector appointees not on the Trust's payroll:

Off-payroll engagements as of 31 March 2015, for more than £220 per day and that last for longer than six months:

Number of existing engagements as of 31 March 2015	19
Of which:	
• Number that have existed for less than one year at the time of reporting	6
• Number that have existed for between one and two years at the time of reporting	2
• Number that have existed for between two and three years at the time of reporting	11
• Number that have existed for between three and four years at the time of reporting	0
• Number that have existed for four or more years at the time of reporting	0

New off-payroll engagements, or those that reached six months in duration, between 1 April 2014 and 31 March 2015, for more than £220 per day and that last longer than six months:

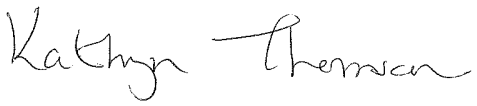
Number of new engagements, or those that reached six months in duration, between 1 April 2013 and 31 March 2014	8
Number of the above which include contractual clauses giving the Trust the right to request assurance in relation to income tax and National Insurance obligations	8
Number for whom assurance has been requested	2
Of which:	
• Number for whom assurance has been received	2
• Number for whom assurance has not been received	0
• Number that have been terminated as a result of assurance not being received	0

For any off-payroll engagements of Board members, and/or senior officials with significant financial responsibility, between 1 April 2014 and 31 March 2015:

Number of off-payroll engagements of Board members, and/or senior officials with significant financial responsibility during the financial year	0
Number of individuals that have been deemed "Board members and/or senior officials with significant financial responsibility" during the financial year. This figure should include both off-payroll and on-payroll engagements	0

Governors' expenses

No expenses were claimed by Governors in the year 2014/15 (£nil in 2013/14).



Kathryn Thomson

Chief Executive

22 May 2015

Board of Directors

Directors' meeting attendances

Membership of the Board of Directors during the year is given on page 185.

During 2014/15 the Board of Directors met 11 times. Directors' attendance at meetings of the Board and its committees held during the year, possible and actual, is shown below.

Director	Board of Directors	Audit Committee	Governance & Clinical Assurance Committee	Putting People First Committee	Finance, Performance & Business Develop-ment Committee
Allan Bickerstaffe	5 of 9		4 of 6	2 of 3	
Dianne Brown	8 of 10		5 of 6	3 of 3	
Steve Burnett	9 of 11	3 of 4	7 of 7		
Liz Cross	9 of 11			3 of 3	
Vanessa Harris	10 of 11		3 of 7		9 of 9
Ian Haythornthwaite	9 of 11	4 of 4			9 of 9
Jonathan Herod	9 of 10		6 of 6		
George Kissen	2 of 2		1 of 1		1 of 1
Pauleen Lane	11 of 11	4 of 4			9 of 9
Ken Morris	2 of 4		[17]1 of 3		[18]1 of 3
Gail Naylor	1 of 1		1 of 1		
Edna Robinson	7 of 7		[19]1 of 4		
Kathryn	10 of 11				5 of 9

[17]Attendance of the Trust Chair at any meeting of a Board Committee counts towards its quorum.

[18]As above.

[19]As above.

Director	Board of Directors	Audit Committee	Governance & Clinical Assurance Committee	Putting People First Committee	Finance, Performance & Business Develop-ment Committee
Thomson					
Joanne Topping	1 of 1		1 of 1		
Michelle Turner	7 of 11			2 of 3	

Pen portraits of members of the Board

Edna Robinson – Chair (from 1 September 2014)

Edna Robinson joined the Trust as its new Chair in August 2014. She has a public/social business background and she is also Chair of the Big Life Group of companies, the largest Social business in the North West and Chair of Trafford Housing Trust since 2013.

As Chief Executive of the NHS Soft Intelligence Service she is supporting clinicians to stay connected to best practice. Edna has held several Chief Executive Positions within the NHS, including a Primary Care Trust and Hospital Trust. She is the founder of NHS Networks, a web based network system, currently used by 70,000 people per week.

Edna has been a Special Advisor to the Secretary of State for Communities and Local Government, and also the Chair of the Advisory Board to Richard Branson's Virgin Health Group. Her other roles have included Board member and Advisor to the Home Secretary in the establishment of the National Police Improvement Agency.

Ken Morris – Chair (1 April – 14 August 2014)

Ken Morris joined the Trust in August 2005. Following a successful appraisal process, he was reappointed in April 2008 for a further 3 years, and again in July 2011 for a third and final 3 year term of office. Ken has had over 20 years experience of working at executive and Non-Executive Director level in a variety of organisations in the public, private and not-for-profit healthcare sectors.

Immediately prior to joining the Trust Ken was Chair of a successful Primary Care Trust. His management consultancy experience has centred on change and improving overall performance in a variety of heal and not-for-profit organisations. He has chaired and been a member of a number of national committees.

In 2008/09 Ken was elected to the Board of the national Foundation Trust Network and in 2011 became the Chair of its Audit Committee. He was also Chair of the Foundation Trust Network in the North West, a member of the Department of Health's Independent Trust

Financing Facility. And in 2012 Ken was instrumental in establishing the National Women's NHS Provider Alliance which he also chaired.

Allan Bickerstaffe – Non-Executive Director

Allan joined the Board in February 2012 and until the end of March 2012 was employed by Liverpool John Moores University as a Pro Vice Chancellor. In earlier times he also served as University Bursar and Director of Finance. Allan has spent his entire working life in Liverpool, employed by several large private and public sector organisations, including United Biscuits, Merseyside Passenger Transport Executive, Arriva Limited and Liverpool City Council. He has held roles, past and present, with many voluntary organisations in the area.

Allan also has experience as a Non-Executive Director with a number of private and public sector companies, both regionally and nationally. In June 2011 he ended a five year term of office as a Non-Executive Director with the North West Ambulance Service NHS Trust, where he was Chair of the Audit Committee.

By profession Allan is a Chartered Secretary and through work with his professional body has been involved with the development of governance best practice over many years and utilises this experience in his role with Liverpool Women's. Allan chaired the Board's Governance and Clinical Assurance Committee and was a member of its Putting People First Committee.

He has three grown up sons, each of whom was born at the Trust's former hospital locations at Oxford Street and Mill Road.

Steve Burnett – Non-Executive Director and Senior Independent Director

Steve joined the Board in March 2012. He is a qualified actuary and spent 35 years in the financial services sector during which time he was Chief Executive of two large Merseyside companies, Swiss Life and Royal Liver. In recent years Steve has actively promoted the values of mutuality and is a keen supporter of member engagement in the setting of strategy and the governance of organisations.

Steve has now successfully diverted his attention to new areas and to the public sector in particular, with Liverpool Women's joining the Wales Audit Office and the Homes and Communities Agency as diverse areas where he now has non-executive roles.

He chairs the Board's Governance and Clinical Assurance Committee and sits on the Trust's Audit Committee and Charitable Funds Committee.

Liz Cross BSc (Hons), MBA, MBPS, Non-Executive Director and Vice Chair (acting Chair, 15 – 31 August 2014)

Joining the Trust as a Non-Executive Director in February 2010, Liz Cross is an experienced Executive and Non-Executive Director. With over 25 years in leadership and governance roles, Liz founded, and is Managing Director of, The Connectives – a values based consultancy practice – that works with private, public, social enterprises and voluntary/ charitable organisations locally, nationally and internationally.

She has helped mature billion pound businesses grow and change, as well as working with individuals in communities to establish start-up groups and businesses that deliver social as well as economic benefits to the people served.

Liz has worked with many organisations over the years to advance women's health and wellbeing. At a personal level she began her interest in helping to change the NHS having the first water assisted delivery in a Manchester hospital, raising the funds and securing the commitment to open a birthing pool for St Mary's Women and Children's Hospital in the early 1990s.

Liz is also Chair of Blackburne House Group in Liverpool, actively involved in many aspects of its work and development in 1992. She chairs a social business delivering coaching to offenders and ex offenders as well as being a founder and trustee of a charity working with a local community in the slums of Bangalore delivering health, education and community development programmes. She has been an active school governor in Moss Side, Manchester since 1988 and is a member of the advisory group for Common Purpose in the North West.

Liz chairs the Trust's Putting People First Committee and its Charitable Funds Committee. On 1 February 2012 she was appointed as the Board's interim Vice Chair and subsequently appointed to the role substantively. In January 2013 the Trust's Council of Governors

Liz chairs the Trust's Putting People First Committee and its Charitable Funds Committee. On 1 February 2012 she was appointed as the Board's interim Vice Chair and subsequently appointed to the role substantively. She acted as the Trust Chair from 15 – 31 August 2014.

In January 2013 the Trust's Council of Governors reappointed Liz to the Board for a further term of three years.

Ian Haythornthwaite – Non-Executive Director

Ian joined the Trust in May 2011 and is a fellow member of the Chartered Institute of Management Accountants, with extensive public sector management experience.

Ian is currently Director of Finance for the BBC, controlling a budget of £4bn per annum. Previously he was Finance Director for BBC North based at Media City which opened in May 2011. Prior to the BBC, Ian was Deputy Chief Executive at the North West Development Agency which led on the economic regeneration of the North West of England. And prior to this he was the Finance Director and then Pro Vice Chancellor at the University of Central Lancashire. As an Executive Director of the group he was responsible for the regional strategy, business interaction, commercial and intellectual property exploitation and innovation. In addition he was responsible for executive management of the University estate and facilities including all trading and service provisions.

Ian chairs the Trust's Audit Committee and is a member of its Finance, Performance and Business Development Committee.

In January 2014 the Council of Governors reappointed Ian for a further term of three years from April 2014.

George Kissen – Non-Executive Director

Dr George Kissen was a GP in Trafford for 30 years until 2012, a hospital practitioner in Paediatric Oncology at the Royal Manchester Children's Hospital for 20 years until 2005 and was Medical Director of NHS Trafford from 2009 until 2013. A student at St Andrew's University and Manchester University, George qualified in 1978.

George's clinical interests are broad but include child health and the development of integrated care for patients of all ages. Now retired from clinical practice, he continues as clinical lead for Trafford Clinical Commissioning Group for the commissioning of care for children and young people. He is a Clinical Champion for the Greater Manchester Transformation programme Healthier Together.

As a GP, George was involved in the development of the Delamere Centre where four GP practices merged and co-located with community health services as the largest practice in Trafford.

As a hospital practitioner in Paediatric Oncology he developed the first national guidelines for long-term follow up of survivors of childhood cancer and co-authored the first national guidelines for diagnosis of childhood cancer.

George has maintained an involvement in the organisation of the health economy throughout his career, occupying various roles including Chair of Salford and Trafford Local Medical Committee, a member of the Professional Executive Committee of Trafford Primary Care Trust and previously Trafford Primary Care Group, as a Clinical Director in Trafford Clinical Commissioning Group and Medical Director of the Trafford Primary Care Trust. In this role George has been instrumental in the development of integrated care and service reconfiguration in Trafford.

Pauleen Lane – Non-Executive Director

Pauleen joined the Trust's Board of Directors in April 2010. She is a civil engineer by profession who has held a number of Board level appointments in the North West and nationally as well as teaching on the master courses at Manchester University. Pauleen is currently the Group Manager for National Infrastructure at the Planning Inspectorate.

She has been a member of the Audit Commission with special responsibility for improvement in local Council performance, Chair of Infrastructure for the North West Development Agency, Chair of Environment for the Coal Authority and Deputy Chair of English Partnerships. She was Mayor and Deputy Leader of Trafford Metropolitan Borough Council and was awarded the CBE for services to local government in 2005. Pauleen has been the specialist engineering advisor to the Theatres Trust and is a Board member of the Sports Ground Safety Authority, set up after Hillsborough to ensure safety for spectators in all sports grounds.

Pauleen chairs the Trust's Finance, Performance and Business Development Committee, is a member of its Audit Committee and has a special interest in the development of the Hewitt Fertility Centre at the Trust. Pauleen is also a member of Central Manchester and South

Manchester University NHS Foundation Trusts. She has two small boys and enjoys cycling, swimming and camping with them.

In January 2013 the Trust's Council of Governors reappointed Pauleen to the Board for a further term of three years.

Kathryn Thomson MCIPD – Chief Executive

Kathryn joined the Trust in September 2008 from the University Hospital of South Manchester NHS Foundation Trust (UHSM), where she was an Executive Director for six years. During that time she supported the Trust through a major financial and performance recovery plan and subsequent achievement of Foundation Trust status. UHSM had a substantial service and research portfolio and investments were made in significantly improving both services and research in a number of areas including the Medicines Evaluation Unit and breast cancer, through alignment into the state of the art Genesis Centre and investment in a Cardiac Centre including the North West Heart Transplant Centre.

Kathryn's professional background is Human Resources and Organisational Development and she continues to maintain a focus in these areas. For some years she has chaired the Cheshire and Merseyside Local Workforce and education Group and she is a Board member of the North West Coast Academic Health Science Network, Liverpool Health Partners and the North West Health Education Board.

Dianne Brown – Director of Nursing & Midwifery (acting into role from 1 May 2014 and substantively in post from 1 June 2014)

Dianne joined the Trust in 2007 and has held a variety of leadership and managerial roles prior to her successful appointment as the Trust's Director of Nursing and Midwifery.

Dianne has worked throughout her long career in the NHS in all aspects of women's health and is passionate about providing safe, effective and compassionate care for women, babies and their families at Liverpool Women's.

Vanessa Harris BSc, ACA, MBA – Director of Finance

Vanessa joined the Trust in September 2009 as Director of Finance. She has held a number of senior posts in the health service and the independent sector, including previous Director of Finance posts. Vanessa has experience of leading and managing organisations through periods of change and improving financial performance.

Jonathan Herod BSc, MBChB (Hons), MRCOG – Medical Director (1 April 2014 – 13 February 2015)

Jonathan joined the Board as its Medical Director in October 2010. He is also a Consultant Gynaecological surgeon and Oncologist at the Trust and an Honorary Lecturer at the University of Liverpool.

Jonathan has worked in Liverpool since 1999 having trained in gynaecology oncology at St Bartholomew's and The Royal Marsden hospitals in London. During his time at Liverpool

Women's he has carried out many posts, most recently as Clinical Director for Gynaecology immediately prior to his appointment as Medical Director.

He is a member of the Royal College of Obstetricians and Gynaecologists, British Gynaecological Cancer Society, an Executive Committee member of the British Society for Colposcopy and Cervical Pathology and of the National Quality Assurance Committee for Cervical Screening.

Gail Naylor RCG, RM, MBA – Director of Nursing, Midwifery and Operations (1 – 4 May 2014)

Gail joined the Trust in June 2009. She trained as a nurse in 1983 at North Manchester General Hospital and then as a midwife in 1987. She continued to work in a variety of clinical roles at North Manchester General Hospital until 1993, when she moved to Bolton Hospitals NHS Foundation Trust until she joined Liverpool Women's.

Gail's background is in leading and managing women and children's services and she has held a variety of senior clinical leadership and managerial roles. Gail is passionate about the impact high quality care can have on women, the wider family unit, and the health economy.

Gail left the Trust at the end of April 2014 to take up post as Director of Nursing and Midwifery at an NHS Trust in Cumbria.

Joanne Topping MB ChB FRCOG – interim Medical Director (from 14 February 2015)

Jo has been a Consultant Obstetrician at Liverpool Women's since August 2000 and has a long term interest in intrapartum care. She was the lead clinician for the delivery suite between 2007 and 2010. Jo established the Trust's Early Pregnancy Assessment Unit and is published on early pregnancy care. She teaches on regional and national courses on intrapartum care.

Jo has respect for all disciplines that offer care to women and babies, and is committed to good multidisciplinary team working. It is her strong belief that this is the best way to ensure the provision of high quality care which should be tailored to a woman's individual needs.

Michelle Turner MCIPD – Director of Workforce and Marketing

Michelle joined the Trust in April 2010. Committed to creating great places to work, Michelle is responsible for ensuring the Trust has a competent, engaged and truly motivated workforce focused on delivering the best possible patient experience. She is also responsible for the Trust's communications and marketing functions.

A member of the Chartered Institute of Personnel and Development, Michelle has a long a varied NHS career, working in patient-facing roles early in her career and undertaking senior human resources roles more recently.

The Trust confirms the balance, completeness and appropriateness of the membership of the Board.

Performance evaluation of the Board, its Committees and individual Directors is undertaken in a number of ways:

- The whole Board reviews its performance each year. In 2014/15 this review was conducted independently for the Trust by Deloitte LLP and was based on Monitor's recently published well-led framework for governance reviews. As a part of the process Deloitte's officers observed a number of Board and Committee meetings, met with individual members of the Board, held focus groups with patients, Governors and staff and interviewed key people in partner organisations.

  Deloitte's report of their review made 46 recommendations for how the Board might enhance its performance and governance arrangements event further. These recommendations are the subject of an action plan that is regularly reviewed by the Board of Directors and is scheduled for completion in the first half of 2015/16. In summary, Deloitte reporting observing:

    - A Board which demonstrates the ability to make bold strategic and commercial decisions;
    - A Board with a cohesive and dynamic approach to overall decision making;
    - A Board which puts patient care, clinical excellence and patient safety at its heart; and
    - A Board with a willingness to learn and a motivation to ensure that the organisation is able to continually evolve.

  At the request of Monitor, who drew on this review as part of its investigation into the Trust during the year, the Trust has commissioned a follow-up review which will be conducted during Q2 of 2015/16.

- At the conclusion of each meeting the Board and its Committees assesses the effectiveness of the meeting.
- The Board of Directors receives an annual report of achievements from each of its Committees.
- All Directors undergo appraisal each year during which there is an evaluation of their performance against their objectives as set at the beginning of the year:
    - The Chair appraises all Non-Executive Directors save for the Senior Independent Director. The Senior Independent Director appraises the Chair and invites the views of other Directors and members of the Council of Governors as a part of the process. The Vice Chair appraises the Senior Independent Director.
    - The Chief Executive appraises Executive Directors and the Chair appraises the Chief Executive. A report on the outcome of these appraisals is presented each year to the Remuneration Committee of the Board of Directors.

The Chair's other significant commitment are detailed page 186 and within the Board of Directors' register of interests. Members of the public can find the register of interests at www.liverpoolwomens.nhs.uk.

Directors can be contacted by email via the ‘contact’ link on the Trust’s website at www.liverpoolwomens.nhs.uk/Contact_Us/ or via the Executive Assistant to the Chair and Chief Executive, Sacha Keating, at sacha.keating@lwh.nhs.uk or on 0151 702 4038.

Audit Committee

The Audit Committee is the principle means by which the Board of Directors ensures effective internal control arrangements are in place. It also provides an independent check of the executive arm of the Board. During the year Trust's Audit Committee was chaired by Non-Executive Director Ian Haythornthwaite. Its other members were Non-Executive Directors Steve Burnett and Pauleen Lane. The three members' attendance at meetings held during 2014/15 is shown on page 185.

During the year the Audit Committee reviewed the Trust's annual report and accounts for 2013/14 including the Annual Governance Statement, Quality Report, external audit findings and external audit management letter (ISA260). In addition it also reviewed the Trust's compliance with Monitor's Code of Governance and approved the external and internal audit plans and counter fraud plan for 2015/16. Other key activities included a review of the Trust's assurance processes, integrated governance, risk management and internal control arrangements. Finally, a review of the corporate governance manual and registers of Directors' and Governors' interests were reviewed.

Each time it met the Committee received an update on actions taken in response to internal audit recommendations. It focused on ensuring that actions were undertaken fully and expeditiously and that officers responsible were held to account. It queried the number of waivers to standing orders and challenged executives and senior officers in respect of orders placed without going through the appropriate procurement procedures. Strengthened controls were put in place in response and a significant reduction subsequently reported.

The Committee considered the issue of the Trust's non-compliance with National Patient Safety Alerts following a report from internal audit which offered no assurance in respect of the systems and processes in place to respond to alerts and ensured that these were addressed. It also considered outstanding actions in respect of an audit of medical devices competencies and a follow-up audit concerning end user databases. The Committee proactively held Executive Directors to account to ensure robust systems and processes were put in place as indicated by audit findings.

PricewaterhouseCoopers LLP (PwC) were the Trust's external auditors during the year, having been appointed by the Trust's Council of Governors in October 2011.

A review of the effectiveness of the Trust's external audit process is regularly undertaken by the Audit Committee's members and participants. The outcome is shared with the external auditors and their response shared with the Committee. The Trust has access to an independent review partner at PwC to deal with any issues where it is not possible to resolve them directly with the nominated audit partner. This was not used during the year.

Where work outside of Monitor's audit code for NHS Foundation Trusts has been purchased from its external auditors, the Trust ensures their independence has not been compromised. During the year PwC undertook non-audit work relating to a strategic options appraisal for the Trust in support of its strategic plan from 2015/16 which forms part of the Future Generations strategy as well as an efficiency review. The value of this non-audit work was £252,070. Their appointment was overseen by the Audit Committee and reported to the Council of Governors.

In situations where the Trust is contemplating the appointment of outside management consultants, consideration is given to whether the external auditors can be included in the list of firms from which a selection may be made. If inclusion would potentially compromise the external auditors' independence then they may be excluded.

The Trust appointed new internal auditors in 2013/14. Baker Tilly (formerly RSM Tenon) provides the internal audit service for the Trust and they presented their internal audit plan for 2014/15 to the Audit Committee in March 2014. During the year they executed an internal audit plan approved by the Audit Committee which focused on business critical systems using a risk based approach. Internal audit reports were received by the Committee and provided a level of assurance in respect of the Trust's governance of both financial and non-financial risk. The work of the internal auditors is one of the key means through which the Audit Committee reviews the Trust's systems of integrated governance, risk management and internal control across its activities, both clinical and non-clinical.

Through the Chief Executive as the Trust's Accounting Officer, Directors are responsible for preparing the accounts as presented in this report. The Directors take this opportunity to state that so far as they are aware there is no relevant audit information of which the Trust's auditors are unaware. The Directors have taken all of the steps that they ought to have taken as Directors in order to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

Nomination Committees

During the year the Trust had two Nomination Committees:

- **Nomination Committee of the Council of Governors**. This Committee oversees the appointment of Non-Executive Directors (NED) to the Board. It is chaired by the Trust's Chair though for some of its meetings in 2014/15 it was chaired by the Trust's Vice Chair, Liz Cross when its focus was on the appointment of a new Chair of the Trust. The Committee's other members during the year were Governors, Mary McDonald, Gail Mannion and Dorothy Zack-Williams (Lead Governor).

  During the year the Committee met on three occasions. At each meeting it considered succession planning for the Board, including the appointment of a new Chair given that the final term of office of Ken Morris was scheduled to end in in August 2014. It also considered the appointment of two new NEDs, one to succeed Allan Bickerstaffe whose tenure ended in January 2015 and another to fill an outstanding vacancy. Following appropriate competitive processes, executive search agents Gatenby Sanderson were appointed to support the recruitment to these Board positions. All appointments were subject to open advertisement via the national and regional press and online recruitment sites. In considering these new appointments the Committee gave particular consideration to Board diversity.

  The appointment of a new Chair for the Trust was approved by the Council of Governors in April 2014. Edna Robinson joined the Trust as its Chair on 1 September 2015, for a three year term of office. One new NED was also appointed during the year for a term of three years. Following approval by the Council of Governors in January 2015, Dr George Kissen joined the Board of Directors on 1 February 2015.

  The Committee agreed to recommend the reappointment of Non-Executive Director Steve Burnett whose term was due to end in February 2015. His reappointment was recommended following consideration of his contribution to the Board as reported by the Trust's Chair, including the outcome of his most recent appraisal. Steve Burnett confirmed his wish to be reappointed and the Council of Governors accepted its Nomination Committee's recommendation that he be reappointed for a further term of three years.

  At the end of the year the Committee prepared to interview for the remaining NED vacancy. It short-listed candidates and went on to a formal selection process, recommending an appointment to the Council of Governors in April 2015 which was accepted. New NED Tony Okotie will join the organisation in June 2015 for a three year term of office.

- **Nomination Committee of the Board of Directors**. This Committee oversees the appointment of Executive Directors to the Board. It is chaired by the Trust's Chair and during the year its members were at least three Non-Executive Directors plus the Chief Executive (unless the Chief Executive is being appointed). The Committee met twice times during the year and Directors' attendance is shown below:

Director	Nomination Committee of the Board of Directors
Ken Morris, Chair	2 of 2
Allan Bickerstaffe	1 of 2
Liz Cross	2 of 2
Ian Haythornthwaite	1 of 1
Pauleen Lane	1 of 2
Kathryn Thomson, Chief Executive	2 of 2
Michelle Turner, Director of Workforce & Marketing	2 of 2 (ex-officio)

The Committee considered the appointment of a new Director of Nursing, Midwifery and Operations following the departure of Gail Naylor in May 2014. An open and competitive process was held after the post was advertisement via the national press and online recruitment sites, with support from executive search agents Gatenby Sanderson. Following short-listing and interview the Committee agreed to appoint Dianne Brown to the role of Director of Nursing and Midwifery, with effect from 1 June 2014. Dianne Brown had been acting into the role since the departure of her predecessor, Gail Naylor.

The Committee also agreed that the operations function, which originally formed a part of the role, should be separated out from it and formed into the post of Associate Director of Operations. Jeff Johnston was appointed to this role with effect from 1 June 2014. Whilst the Associate Director of Operations is not a formal member of the Board of Directors, he attends Board meetings in a non-voting capacity.

Remuneration Committee

Please see remuneration report on page 178.

Code of Governance

Liverpool Women's NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

The Trust remains committed to the principles of good corporate governance as outlined in the [20]NHS Foundation Trust Code of Governance which is published by Monitor. Each year an assessment of the Trust's position against each of the Code provisions is undertaken, which states the current position and any actions required together with a statement against the principle of 'comply or explain'.

For the year 2014/15 the Trust can confirm that it complies with the provisions of the Code with one exception, which was for part-year only. This exception is detailed below in red. The Code was updated in 2013 and now requires the Trust to make a series of disclosures even where it complies with the provision, and these disclosures are also below:

Code provision	Trust position	Comply or explain?
A.1.1 The Board of Directors (Board) should meet sufficiently regularly to discharge its duties effectively. There should be a schedule of matters specifically reserved for its decision. The schedule should include a clear statement detailing the roles and responsibilities of the Council of Governors (Council). This statement should also describe how any disagreements between the Council and Board will be resolved. The annual report should include this schedule of matters or a summary statement of how the Board and Council operate, including a summary of the types of decisions to be taken by each and which are delegated to the executive management of the Board. These arrangements should be kept under review at least annually.	In 2014/15 the BoD met formally on 11 occasions. Matters reserved for the Board, including the types of decisions it takes and which are delegated to committees and executive management, are included in the Trust's Corporate Governance Manual and summarised in the Director's report on page 34 and the Annual Governance Statement on page 212. The general duties of governors are stated in the Trust's constitution. Matters for which the Council of Governors is responsible and makes decisions on is outlined in the section of this report in respect of the Council on page 204. A general statement on the handling of disputes is contained in the Trust's constitution.	**Comply**
A.1.2 The annual report should identify the Chair, deputy Chair,	This information is provided in the Directors' report on page 34, the	**Comply**

[20]The NHS Foundation Trust Code of Governance published by Monitor can be found at www.monitor.gov.uk

Code provision	Trust position	Comply or explain?
Chief Executive, Senior Independent Director (SID) and the Chair and members of the Nominations, Audit and Remuneration Committees. It should also set out the number of meetings of the Board and those committees and individual attendance by directors.	Remuneration report on page 178, directors' meeting attendances on page 185, Board pen portraits on page 186 the Nomination Committees report on page 196, Audit Committee report on page 194 and the Annual Governance Statement on page 212.	
A.5.3 The annual report should identify the members of the Council, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor. A record should be kept of the number of meetings of the Council and the attendance of individual Governors and it should be made available to members on request.	Full details of Governors and their terms of appointment is given in the Council of Governors' section of this report on page 204. A register of governors' attendance at meetings is maintained and recorded in meeting minutes. Details of attendance are given from page 205. The Trust's Lead Governor is public Governor Dorothy Zack-Williams.	**Comply**
B.1.1 The Board should identify in the annual report each Non-Executive Director (NED) it considers to be independent. The Board should determine whether the director is independent in character and judgement and whether there are relationships or circumstances which are likely to affect, or could appear to affect, the director's judgement. The Board should state its reasons if it determines that a director is independent despite the existence of relationships or circumstances which may appear relevant to its determination.	NEDs are asked each year to confirm their independence or otherwise as per the criteria outlined in the Code of Governance; One of the independence criteria included in the Code is where a director has served on the Board for more than six years from the date of their first appointment. During 2011/12 the Trust's Council of Governors reappointed the incumbent Chair for a third and final three year term of office. Ken Morris had already served two three-year terms. In reaching its decision the Council's Nominations Committee took this Code provision fully into account. Its interview of Ken Morris focused in particular on assessing his	**Explain** (for the period 1 April – 14 August 2015) **Comply** (for the period 15 August 2014 – 31 March 2015)

Code provision	Trust position	Comply or explain?
	independence, which the Committee agreed remained intact. Governors were also mindful of the need for some continuity on the Board of Directors given that three new NEDs were joining the Board during 2011/12. The terms of office of the NEDs who held the roles of the Board's Vice Chair and Senior Independent Director ended early in 2012 hence these roles were due to fall to new NEDs. Accordingly, the Committee did not consider that a change in Chairmanship at this time was in the best interests of the Trust. Ken Morris's third and final term of office came to an end on 14 August 2014. From 15 August 2014 the Trust has complied with this provision.	
B.1.4 The Board should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the Board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the Trust. Both statements should also be available on the Trust's website.	Please see Board pen portraits section on page 186.	**Comply**
B.2.10 A separate section of the annual report should describe the work of the nominations committee/s, including the process it has used in relation to Board appointments. The main role and responsibilities of the nominations committee should be set out in publicly available, written terms of reference.	Please see Nomination Committees section on page 196. The committees' terms of reference are available on request from Corporate Support Manager Louise Florensa at louise.florensa@lwh.nhs.uk.	**Comply**

Code provision	Trust position	Comply or explain?
B.3.1 For the appointment of a Chair, the nominations committee should prepare a job specification defining the role and capabilities required including an assessment of the time commitment expected, recognising the need for availability in the event of emergencies. A Chair's other significant commitments should be disclosed to the Council before appointment and included in the annual report. Changes to such commitments should be reported to the Council as they arise, and included in the next annual report. No individual, simultaneously whilst being a Chair of a Foundation Trust, should be the substantive Chair of another Foundation Trust.	The Trust's constitution provides for the job description and person specification of the Chair to be devised by the Board. The significant commitments of those recommended for appointment as Chair are disclosed to the Council before appointment. The Chair's other significant commitments are included in the Board pen portraits section of this report on page 186. Changes to the Chair's commitments are reported to the Council of Governors as they arise. Neither of the Trust's Chairs during this period have been the substantive Chair of another Foundation Trust during their tenure.	**Comply**
B.5.6 Governors should canvass the opinion of the Trust's members and the public, and for appointed governors the body they represent, on the Trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the Board. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	Please see section on 'our members' on page 209.	**Comply**
B.6.1 The Board should state in the annual report how performance evaluation of the Board, its committees, and its directors, including the Chair, has been conducted, bearing in mind the desirability for independent assessment, and the reason why the Trust adopted a particular method of performance evaluation.	See Board pen portraits section of this report on page 186.	**Comply**

Code provision	Trust position	Comply or explain?
B.6.2 Evaluation of the Board should be externally facilitated at least every three years. The evaluation needs to be carried out against the Board leadership and governance framework set out by Monitor. The external facilitator should be identified in the annual report and a statement made as to whether they have any other connection to the Trust.	Evaluation of the Board was undertaken during 2014/15 based on Monitor's 'Well-led' framework. Deloitte LLP were commissioned as external facilitators for this work. See further details in the pen portraits section of this report on page 186.	**Comply**
C.1.1 The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy. There should be a statement by the external auditor about their reporting responsibilities. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report).	Please see statement from the Board of Directors on page 9, the Annual Governance Statement on page 212 and the auditor's report on page 227.	**Comply**
C.2.1 The Board should maintain continuous oversight of the effectiveness of the Trust's risk management and internal control systems and should report to members and governors that they have done so. A regular review should cover all material controls, including financial, operational and compliance controls.	An annual review of the system of internal control is conducted on the instruction of the Trust's Audit Committee by internal auditors. Please see Audit Committee section of this report on page 194 and the Annual Governance Statement at page 212.	**Comply**
C.2.2 A Trust should disclose in the annual report if it has an internal audit function, how the function is	Please see Audit Committee section on page 194.	**Comply**

Code provision	Trust position	Comply or explain?
structured and what role it performs or if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.		
C.3.5 If the Council does not accept the Audit Committee's recommendation, the Board should include in the annual report a statement from the Audit Committee explaining the recommendation and should set out reasons why the Council has taken a different position.	Not applicable.	**Comply**
C.3.9 A separate section of the annual report should describe the work of the committee in discharging its responsibilities.	See Audit Committee section at page 194.	**Comply**
D.1.3 Where a Trust releases an executive director, for example to serve as a NED elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.	This has so far not occurred at the Trust.	**Comply**
E.1.4 The Board should ensure that the Trust provides effective mechanisms for communication between Governors and members from its constituencies. Contact procedures for members who wish to communicate with Governors and/or Directors should be made clearly available to members on the Trust's website and in the annual report.	See 'our members' section on page 209 and Board pen portraits on page 186.	**Comply**
E.1.5 The Board should state in the annual report the steps they have	See Council of Governors' section from page 204.	**Comply**

Code provision	Trust position	Comply or explain?
taken to ensure that the members of the Board, and in particular the NEDs, develop an understanding of the views of governors and members about the Trust.		
E.1.6 The Board should monitor how representative the Trust's membership is and the level and effectiveness of member engagement and report on this in the annual report.	Information about the Trust's membership is reviewed by the Council's Membership Strategy Committee and is available to the Board. See 'our members' section of this report on page 209.	**Comply**

Council of Governors

The Trust's Council of Governors has a number of statutory duties, namely to hold the Board of Directors to account via its Non-Executive Directors, to appoint, remove and decide the terms of office (including remuneration) of the Chair and Non-Executive Directors, approving the appointment of the Chief Executive, appointing or removing the Trust's external auditors, receiving the annual report and accounts and external auditor's report, and expressing a view on the Trust's forward plans. The Council also ensures that the interests of the community served by the Trust are appropriately represented.

Each year the Council of Governors meets on at least three occasions, in public. Between April 2014 and March 2015 the Council met on 4 occasions.

The Council has a number of Committees, namely a Membership Strategy Committee, Nomination Committee and Remuneration Committee. The Membership Strategy Committee leads preparation of the Trust's membership strategy and oversees all membership activities. The work of its Nomination and Remuneration Committees is outlined on pages 196 and 178. Each of the Council's Committees reports to the full Council of Governors and makes recommendations for its consideration as appropriate.

The tables below details the names of those who were Governors during the reporting period, whether they were elected or appointed to the role and the length of their appointment. Also shown is attendance of individual Governors at formal meetings of the Council held during the year.

Public Governor (elected)	Area	[21]Term of office	From	To	Council of Governors' meetings attended, April 2014 – March 2015
Arshad, Mohammed	South Liverpool	3 years	2013	2016	4 of 4
[22]Bedding, Kate	Central Liverpool	3 years	2011	2014	0 of 1
Burke, Pauline	Sefton	2 years	2014	2015	2 of 4
[23]Croft, Jayne	Rest of England & Wales	1 year	2014	2014	1 of 2
[24]Hannon, Jenny	Central Liverpool	2 years	2014	2015	1 of 1
[25]Kearney, Kathleen	Central Liverpool	3 years	2014	2017	1 of 1
Kelly, Maureen	Sefton	3 years	2011	2014	1 of 2
Kerr, Barbara	North Liverpool	3 years	2012	2015	4 of 4
McDonald, Mary	South Liverpool	3 years	2012	2015	4 of 4
Moran, Paul	Central Liverpool	3 years	2011	2014	0 of 2

[21]Terms of office begin and end at the annual members' meeting, held in October each year. In the case of a Governor being elected part-way through a year as a result of a bi election, the term of office has been rounded up to the nearest year.

[22]Resigned during Q1.

[23]Elected during Quarter 4 of 2013/14 (bi election).

[24]Resigned seat during Quarter 2 due to a change in eligibility.

[25]Term ended in Q4 because of change in eligibility.

Public Governor (elected)	Area	[21]Term of office	From	To	Council of Governors' meetings attended, April 2014 – March 2015
[26]Phillips, Sheila	Knowsley	3 years	2014	2017	2 of 4
Speed, Pat	Sefton	3 years	2014	2017	2 of 2
Tattersall, Geoffrey	Rest of England & Wales	3 years	2013	2016	3 of 4
White, Helen	Rest of England & Wales	3 years	2014	2017	1 of 2
Zack-Williams, Dorothy	Central Liverpool	3 years	2012	2015	2 of 4

Staff Governor (elected)	Class	[27]Term of office	From	To	Council of Governors' meetings attended, April 2014 – March 2015
Foley, John	Clinical Support Staff & non-clinical staff	3 years	2012	2015	5 of 5
[28]Mannion, Gail	Scientists, Allied Health Professionals &	3 years	2014	2017	4 of 5

[26]Re-elected to seat during the year.

[27] Terms of office begin and end at the annual members' meeting, usually held in September each year.

[28]Re-elected to seat during the year.

	Technicians				
[29]Mehigan, Simon	Midwives	2 years	2013	2015	0 of 0
Soltan, Adel	Doctors	3 years	2013	2016	4 of 4
[30]Walker, Gillian	Midwives	1 year	2014	2015	2 of 2

Appointed Governors (appointed	**Organisation**	**Council of Governors' meetings attended, April 2014 – March 2015**
Alfirevic, Ana	University of Liverpool	4 of 4
Arnall, Del	Knowsley Council	2 of 4
Casstles, Helen	Liverpool City Council	3 of 4
[31]Johnston, Kate	Partnership organisation	0 of 0
Killen, Nina	Sefton Borough Council	2 of 4

Some of the seats on the Council were vacant during the course of the year. These were in the public seats of Central Liverpool, Sefton, Knowsley and the rest of England and Wales, the staff seats for Midwives and Scientists & Allied Health Professionals and three partnership organisation seats.

Elections and bi elections to the Council were held during the year in respect of 9 seats that became vacant either because the term of office had ended at the conclusion of the 2014 annual members' meeting or because of Governor resignation, change in eligibility to hold the seat or removal from the Council for reasons of non-attendance. Of these, 4 were elected unopposed, 2 were elected following a contested election and no nominations were received in respect of 3 of the seats. All public and staff governors are elected by members in their constituency, by secret ballot and the Electoral Reform Service acts as returning officer. The exception to this is where Governors were elected unopposed as a result of

[29]Eligibility changed during Quarter 1 meaning he could no longer hold the seat.

[30]Elected during Quarter 3 of 2014/15 (bi election).

[31]Employment of partner organisation came to an end upon her retirement in Quarter 1 and she was no longer eligible to hold the seat.

being the sole candidate for an available seat. Partnership governors were appointed by their appointing organisation.

There continues to be a positive and constructive working relationship between the Council of Governors and the Board of Directors. Governors effectively fulfill their statutory duties and the Council provides both constructive challenge and support to the Board. Members of the Board of Directors regularly attend meetings of the Council of Governors in order to understand Governors' views and concerns and all Directors receive agenda for the Council's meetings. The Chief Executive has a standing invitation to attend all meetings of the Council.

Governors receive agenda for meetings of the Board of Directors and meeting minutes, and Governors and Directors meet informally on a regular basis.

Governors are not remunerated but they are entitled to claim expenses in connection with their duties. Governors did not claim any expenses during the year.

A Governors' register of interests is maintained. Members of the public can find the register of interests at www.liverpoolwomens.nhs.uk.

Directors' attendance at meetings of the Council of Governors held during 2014/15 is given below:

Director	**Council of Governors' meetings attended, April 2014 – March 2015**
Allan Bickerstaffe	0 of 4
Dianne Brown	4 of 4
Steve Burnett	3 of 4
Liz Cross	4 of 4
Vanessa Harris	4 of 4
Ian Haythornthwaite	0 of 4
Jonathan Herod	2 of 4
George Kissen	0 of 0
Pauleen Lane	3 of 4
Ken Morris	2 of 2
Gail Naylor	1 of 1
Kathryn Thomson	4 of 4
Joanne Topping	0 of 0

Director	Council of Governors' meetings attended, April 2014 – March 2015
Michelle Turner	3 of 4

Our members

Any member of the public over the age of 12 years who lives in England and Wales is able to be a member of Liverpool Women's NHS Foundation Trust. Most of our members come from the areas where we provide clinical services, namely the local authority areas of Central Liverpool, North Liverpool, South Liverpool, Knowsley and Sefton. Some 1,350 of our members come from outside these areas, the constituency known as Rest of England and Wales.

Membership of the Trust is made available to all Trust staff automatically where they have a permanent contract of employment or have worked for the Trust for at least 12 months.

As at 31 March 2015 the Trust had 11,173 members:

Public	**Number**
Central Liverpool	2,859
North Liverpool	1,651
South Liverpool	1,394
Knowsley	1,173
Sefton	1,289
Rest of England and Wales	1,416
Total public membership	9,782
Staff	**Number**
Doctors	95
Nurses	326
Midwives	314
Scientists, technicians and allied healthcare professionals	151
Administrative, clerical, managers, ancillary and other support staff	505
Total staff membership	1,391

Led by its Membership Strategy Committee, the Trust's Council of Governors developed and approved a three year membership strategy in July 2014. The Strategy provides a 'roadmap' for the Trust's membership work over the next three years. At its heart is the desire to make membership relevant, interesting and rewarding. Its key focus is on putting in place robust arrangements for ensuring that our members have a loud and clear voice within the organisation, that they have an avenue to contribute to the development of the organisation and that the Trust's services take full account of members' views, ideas and concerns.

A key component of our membership work over the next three years will be improving the coordination of our membership work with that in respect of patient experience / patient and public involvement, corporate social responsibility, equality, diversity and human rights and marketing and communication. It will also focus on improving what we know about our members including what their interests are and how they would like to be involved with the Trust. In this way we aim to improve the level and range of member engagement.

Throughout the year Governors attended a number of community events where they represented the Trust, recruited new members and engaged with members of the public. In October 2014 we held our Annual Members' meeting hich coincided with International Day of the Girl. Governors collaborated with Girlguiding UK (previously Girl Guides), to put on a tailor made event which saw 171 Rainbows, Brownies, Guides and Seniors (age range 5 – 25) come into the Hospital. The overall aim of the day was to provide the girls with unique learning experience and it was a great success.

In March 2015, by way of celebrating International Women's Day, our Governors hosted the Trust's 4th Partnership Summit. The day brought together organisations from across the city with an interest in women's healthcare in order to discuss what they felt was most valued about the services provided by Liverpool Women's and where we need to focus our improvement efforts.

We continued to publish our members' newsletter, Generations, which is sent to all our members several times each year.

Members can contact Governors and Directors at the Trust by:

- Post – Trust Offices, Liverpool Women's NHS Foundation Trust, Crown Street, Liverpool L8 7SS;
- Telephone – 0151 702 4018;
- Email – communications@lwh.nhs.uk or to contact Governors, governor@lwh.nhs.uk.

Statement of the Chief Executive's responsibilities as the accounting officer of Liverpool Women's NHS Foundation Trust

The NHS Act 2006 states that the Chief Executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by Monitor.

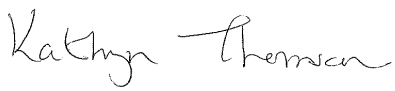
Under the NHS Act 2006, Monitor has directed Liverpool Women's NHS foundation trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Liverpool Women's NHS foundation trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statements;
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance; and
- prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in Monitor's NHS Foundation Trust Accounting Officer Memorandum.



Kathryn Thomson
Chief Executive
22 May 2015

Annual governance statement

Scope of responsibility
As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

The purpose of the system of internal control
The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and priorities the risks to the achievement of the policies, aims and objectives of Liverpool Women's NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Liverpool Women's NHS Foundation Trust for the year ended 31 March 2015 and up to the date of approval of the annual report and accounts.

Capacity to handle risk
The Trust's risk management strategy sets out the responsibility and role of the Chief Executive in relation to risk management which, as Accounting Officer, I have overall responsibility for. I have delegated the following responsibilities to Executive Directors:

- The Director of Finance has responsibility for financial governance and associated financial risk;
- The Director of Nursing and Midwifery has joint authority for clinical governance and absolute delegated authority for quality, improvement, risk management and complaints, and is executive lead for health and safety, emergency planning, safeguarding and infection control;
- The Medical Director is responsible for all aspects of clinical risk management and clinical governance and has responsibility for the Trust's Quality Report;
- All Executive Directors have responsibility for the management of strategic and operational risks within individual portfolios. These responsibilities include the maintenance of the corporate risk register and the promotion of risk management to staff within their directorate. Executive Directors have responsibility for monitoring their own systems to ensure they are robust, for accountability, critical challenge and oversight of risk.

The Trust's clinical divisional structure comprises a division which incorporates maternity, gynaecology, surgical services, neonates, genetics and clinical support services led by the Associate Director of Operations who reports directly to the Chief Executive. A division comprising reproductive medicine and private medical care comes under the executive leadership of the Director of Finance.

A framework for managing risks across the Trust is provided through the risk management strategy. It provides a clear, structured and systematic approach to the management of risks to ensure that risk assessment is an integral part of clinical, managerial and financial processes at all levels across the organisation.

A committee structure supports the Trust's integrated governance processes and facilitates the appropriate identification of risk ensuring it is properly mitigated, monitored and reported. As Chief Executive I chair the Corporate Risk Committee which coordinates and prioritises all categories of risk management. In fulfilling its role the Committee meets bi-monthly to review all significant corporate risks and considers whether any risks need to be escalated to its parent committee and/or entered onto the Board Assurance Framework (BAF). The Committee is also responsible for ensuring that where lessons learned from risks need to be communicated across the Trust, this is done so effectively. The Corporate Risk Committee reports to the Governance and Clinical Assurance Committee of the Board of Directors.

The risk management strategy clearly identifies the Chief Executive as providing leadership and accountability to the Trust for risk management and quality improvement. The Board of Directors aims to receive annual training in risk management as do senior managers and all staff receive basic risk management training via the Trust's mandatory training programme. In addition, specific staff are trained to a higher level in risk management techniques such as root cause analysis or IOSH (Institution of Occupational Safety and Health) working and managing safely, as identified through the training needs analysis process. Ad hoc training on use of the Trust's risk software is also provided across the organisation. The Trust's annual staff performance and development review process is used to identify where and if additional, enhanced risk management training is required. Taken together these arrangements ensure staff are trained or equipped to manage risk in a way appropriate to their authority and duties.

Details of all known adverse incidents are captured within the Trust using a centralised system (ULYSSES, SAFEGUARD). Data from this system informs trend reports to the Board, its Governance and Clinical Assurance Committee and to operational risk and quality committees. Reports focus on the performance management of actions and recommendations and thus eliminate any risk of false assurance. During the year a number of 'deep dives' were undertaken to test how embedded agreed actions were following the investigation of a serious untoward incident. This process will continue in respect of a small, random selection of incidents to ensure that actions planned following their investigation are properly and fully embedded within the organisation.

The Audit Committee has overarching responsibility for the management of risk systems and processes within the organisation. The Trust's three assurance committees – the Governance and Clinical Assurance Committee, the Finance, Performance and Business Development Committee and the Putting People First Committee – monitor the Trust's BAF which identifies the key risks to its strategic objectives. These Committees have oversight of progress against action plans prepared in respect of risk issues and each Committee reports directly to the Board of Directors. The Board itself reviews the BAF at least bi-monthly; however any BAF risks which increase would be escalated to the Board at the next available opportunity by one of its assurance committees.

The BAF in place at the Trust has been reviewed and considered by its internal auditors in preparing their Head of Internal Audit Opinion and Annual Report for 2014/15. In this Opinion/Report significant assurance is given that the Trust has a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently.

Developing a risk aware and risk sensitive culture remains an ongoing aim for the Trust. This is to enable risk management and risk management decisions to occur as near as practicable to the source of the risk. It is also to facilitate appropriate escalation of those risks that cannot be dealt with at the local level.

The risk and control framework
The Trust's BAF is the principal mechanism through which the organisation identifies, quantifies, prioritises and monitor's the Trust's most significant risks to the achievement of its strategic objectives. The most significant risks, both in-year and on-going, are contained within the Trust's corporate risk register. The register drives a dynamic process that changes in response to the changing profile and status of the risks it contains.

Significant risks to the organisation are identified through risk reporting and through the work of committees which are informed by the Trust's risk management and quality improvement functions. The Board agrees and reviews the risks outlined in the BAF and makes informed decisions about risk treatments and interventions based on the best intelligence available. In this way the Board is able to determine its risk appetite. Decisions relating to the organisation's response to individual identified risks are therefore determined by the Trust's appetite.

During the year the Trust's greatest risks, as described in the BAF, were the Trust's clinical and financial viability, maintaining appropriate and safe staffing levels, complying with national standards for the safeguarding of children and adults, appropriately responding to NICE guidance, ensuring lessons are learnt, shared and change enacted from the reporting and investigation of incidents locally and across the wider NHS community, maintaining regulatory compliance, developing and supporting a comprehensive clinical audit provision, systems and processes for pharmacy and medicines management, isolation of the Trust's hospital site, ensuring research adds value, meeting and exceeding patients' expectations, maintaining a competent, capable and engaged workforce, minimising service disruption during periods of industrial action, delivering the financial plan for 2014/15, 2015/16 and beyond, progression of plans to develop services nationally and internationally, achieving benefits from the Trust's information technology strategy and developing a sustainable genomic centre.

During 2014/15 the Trust continued to operate a model of integrated governance. This best practice model is defined by having in place effective systems, processes and behaviours governing quality assurance and operating within a transparent dynamic that encourages challenge. There are defined clinical and patient safety performance metrics within the Trust's broad governance work-streams which are monitored through the Trust's internal control systems (clinical governance) and external assurance(s), accreditation and regulation including Monitor, the CQC and the Human fertility and Embryology Authority (HfEA).

The quality of performance information used across the Trust is assessed using a structured approach. All patient NHS numbers are checked and validated against national data on a weekly basis, patient level activity data is validated against plan on a monthly basis, including consistency checking across hospital/clinical patient record systems and a central data warehouse, and datasets are verified through two external sources. Our data is then further reviewed to compare against other providers to ensure our clinical performance is satisfactory or better using data provided via CHKS, an independent provider of healthcare benchmarking intelligence and for validation against national expectations using data provided by SUS (Secondary Uses Service) which is part of the NHS. Summary and data level reports are provided to our clinical divisions following the quality checking process to allow them to correct any errors and review data entry processes. The performance report is then reviewed at the Trust's Operational Board, its Finance, Performance and Business Development Committee, Governance and Clinical Assurance Committee and ultimately the Board of Directors.

The Trust operates a principle whereby risks are identified early and are resolved as close as possible to where the risk originated. The dynamic risk register in place is actively monitored by senior managers within clinical and corporate departments and serious risks and/or risks that have remained unresolved for a period of time are escalated for action as appropriate. The risk register operates as part of a coordinated process within the Trust's BAF.

The reporting of incidents, including serious incidents, is actively encouraged. Reporting is via SAFEGUARD, the Trust's web-based incident reporting system. During the year the number of incidents reported, and learning from reported incidents, has fallen for the latest published period. This is currently subject to a review to understand the root causes of this decline. Any decline in quality would be detected via a triangulation of intelligence from a number of valid sources including incidents, complaints, contact with our Patient Advice and Liaison Service, dialogue with patient representative organisations, input from our primary care stakeholders and feedback from GPs, alongside clinical performance benchmarking data. During 2014/15 the Trust held a series 'raising concerns' drop-in sessions for staff to escalate any safety concerns that they might have.

Quality and equality impact assessments are integrated into the core business of the Trust and has been adopted as a prerequisite for all significant cost improvement programmes with sign-off provided by the Medical Director and the Director of Nursing and Midwifery.

All Trust policy documents go through a streamlined and robust approvals process which ensures appropriate standardisation of documentation, including completion of equality impact assessments.

Risks to data security are managed and controlled as part of our risk and control framework. The Trust is ISO 27001 certified which brings our information and data security under explicit management control. Our Director of Finance, as Senior Information Risk Owner, is responsible for information governance, performance against which is monitored through our Governance and Clinical Assurance Committee, which receives regular updates from the Trust's Information Governance Committee.

Patients continue to be involved in the risk management process in a number of ways. A patient story is told at the beginning of every meeting if the Board of Directors, sometimes by the patient in person, via a video or audio recording or on their behalf by the Director of Nursing and Midwifery or a clinical member of Trust staff. Organisational learning from each story told is identified and actions taken in response are reported back to the Board. The Trust also considers complaints, litigation and PALS (Patient Advice and Liaison Service) feedback as important indicators of quality. The Board and its relevant committees regularly receive reports detailing this feedback.

The Trust has in place a governance structure to support compliance with the NHS Foundation Trust condition 4 (Foundation Trust governance). Its Board of Directors is composed of six Non-Executive Directors including the Chair and five Executive Directors including the Chief Executive.

The Board of Directors is responsible for determining the Trust's strategy and business plans, budget, policies, accountability, audit and monitoring arrangements, regulation and control arrangements, senior appointment and dismissal arrangements and approval of the Trust's annual report and accounts. It acts in accordance with the requirements of its terms of license as a Foundation Trust.

A number of committees report directly to the Board:

- The Audit Committee is responsible for providing assurance to the Board of Directors in respect of the process for the Trust's system of internal control by means of independence and objective review of corporate governance and risk management arrangements, including compliance with laws, guidance and regulations governing the NHS. In addition it has responsibility to maintain an oversight of the Trust's general risk management structures, processes and responsibilities, including the production and issue of any risk and control related disclosure statements;
- The Finance, Performance and Business Development Committee is responsible for providing information and making recommendations to the Board of Directors in respect of financial and operational performance issues and for providing assurance that these are being managed safely. The Committee maintains an overview of the strategic business environment in which the Trust is operating and identifies strategic business risks and opportunities. The Committee considers any relevant risks within the BAF and corporate risk register as they relate to the remit of the Committee, as part of the reporting requirements. It reports any areas of significant concern to the Corporate Risk Committee or the Board of Directors as appropriate;
- The Governance and Clinical Assurance Committee is responsible for providing the Board of Directors with assurance on all aspects of quality in respect of clinical care, governance systems including risks for clinical, corporate, workforce, information and research and development issues, and for regulatory standards of quality and safety. The Committee considers any relevant risks within the BAF and corporate risk register as they relate to the remit of the Committee, as part of the reporting requirements. It reports any areas of significant concern to the Corporate Risk Committee or the Board of Directors as appropriate;
- The Putting People First Committee is responsible for providing the Board of Directors with assurance on all aspects of governance systems and risks related to the Trust's workforce, and regulatory standards for human resources. The Committee considers any relevant risks within the BAF and corporate risk register as they relate to the remit of the Committee, as part of the reporting requirements. It reports any areas of significant concern to the Corporate Risk Committee or the Board of Directors as appropriate;
- The Remuneration Committee determines the remuneration, terms of service and other contractual arrangements relating to the Chief Executive and Executive Directors. It is also responsible for succession planning in respect of executive appointments and for any disciplinary or termination matters relating to the executive management team;
- The Nomination Committee which oversees the recruitment and selection of the Chief Executive and Executive Directors and for reviewing the structure, size and composition of the executive management team on the Board of Directors.

Each Board committee is chaired by a Non-Executive Director and has terms of reference setting out its duties and authority, including matters delegated to it by the Board of Directors. Membership of the Audit Committee and Remuneration Committee is composed only of Non-Executive Directors.

The Board reviews it effectiveness on an annual basis, often with an external facilitator. Each Board committee reviews it effectiveness at the conclusion of each year and prepares an annual report setting out how it has fulfilled its terms of reference. Committee annual reports are then submitted to the Board for review. The Audit Committee reviews its effectiveness with input from the Trust's internal and external auditors. Each Board committee routinely receives the minutes of meetings held by its subordinate committees.

Directors' responsibilities are set out in their job descriptions in which reporting lines and accountabilities are identified. Their specific roles are:

- The Chair leads the Board of Directors in being accountable to the Council of Governors and leads the Council in holding the Board to account. She ensures the Board develops vision, strategies and clear objectives whilst ensuring it understands its own accountability for governing the Trust. The Chair provides visible leadership in developing a healthy culture for the organisation and ensures this is reflected and modelled in their own and the Board's behaviour and decision making. They lead and support a constructive dynamic within the Board and also hold the Chief Executive to account for the delivery of strategy;
- Non-Executive Directors are responsible for bringing independence, external perspectives, skills and challenge to strategy development. They hold the executive directors to account for the delivery of strategy, offer purposeful, constructive scrutiny and challenge, and chair or participate as members of key committees that support accountability. Non-Executive Directors account individually and collectively to the Council of Governors for the effectiveness of the Board. They actively support and promote a healthy culture for the organisation and reflect this in their own behaviour whilst providing visible leadership in developing a healthy culture so that staff believe they provide a safe point of access to the Board for raising concerns;
- The Chief Executive is responsible for leading the strategy development process and deliver of the strategy. She acts as Accountable Officer and establishes effective performance management arrangements and controls. The Chief Executive provides visible leadership in developing a healthy culture for the organisation, and ensure that this is reflected in their own and the Executive Directors' behaviour and decision making;
- Executive Directors take a lead role in developing strategic proposals, leading the implementation of strategy within functional areas and managing performance within their areas of responsibility. The actively support and promote a positive culture for the organisation and reflect this in their own behaviours. Executive Directors nurture good leadership at all levels.

All directors operate as members of the unitary Board.

Principal risks to compliance with condition 4 relate to changes in membership of the Board of Directors and amongst the Trust's senior management team. In respect of Board membership, a new Chair came into post in September 2014 following the nine year tenure of her predecessor and following a comprehensive recruitment process led by the Council of Governors' Nomination Committee. One of the Board's Non-Executive Directors left at the conclusion of his first term of office and was succeeded by another Non-Executive Director, following a recruitment exercise also led by the Council of Governors' Nomination Committee. The Director of Nursing, Midwifery and Operations left the Trust and was succeeded by a Director of Nursing and Midwifery who leads in respect of the Trust's quality governance arrangements including its risk management systems and processes. The Trust's Medical Director resigned from the role in February 2015 and an interim Medical Director was appointed. Recruitment to the Medical Director role will be undertaken early in 2015/16. And finally during the year, an Associate Director of Operations was appointed to lead the Trust's operational performance and development.

Following the departure of its Head of Governance early in the year the Trust appointed an interim Associate Director of Governance who has led a comprehensive review of the Trust's risk management and quality governance arrangements including its BAF. Early in 2015/16 the Trust Secretary will leave the organisation. Mitigation against the risks posed by the departure of this senior staff member is in place to ensure that pending the appointment of successors the role is fulfilled on a temporary basis by expert interim staff.

The Trust submits a report to Monitor on a quarterly basis which provides accurate information in respect of compliance with the Trust's licence and any associated risks to compliance. The report details the Trust's financial and operational performance for the quarter, including quality performance. It is reviewed by the Trust's executive team prior to consideration and approval by the Board of Director's Finance, Performance and Business Development Committee on behalf of the Board.

Each time it meets the Board of Directors receive the latest available information in respect of the Trust's performance. Reports focus on exceptions to target performance and Executive Directors outline improvement plans and mitigating actions. Three of the Board's Committees (Finance, Performance and Business Development, Governance and Clinical Assurance, and Putting People First) review aspects of the Trust's performance each time they meet.

The Trust is able to assure itself of the validity of its Annual Governance Statement by referring to the Board's annual review of effectiveness, the annual reports of Board committees, reports of its internal and external auditors and reviews of the Trust's performance and compliance against national and local standards.

Risk management is embedded in the activity of the organisation in a variety of ways. The agenda for all meetings, from the Board downwards, include an item to consider whether any new risks have been identified during the course of discussion. Where new risks are identified, mitigation is considered and agreed and there is appropriate entry onto the Trust's risks register or BAF. Each meeting would also consider whether a known risk had changed in any way and the risk register of BAF would then be updated accordingly.

The Trust's Cost Improvement Programme (CIP) includes a process of quality impact assessment (QIA). CIP schemes undergo impartial QIA by the Trust's governance department and all schemes relating to clinical care must be approved by the two clinical Executive Directors confirming it will not impact negatively on patient safety and quality.

During 2014/15 the Trust held a series of 'raising concerns' drop-in sessions where staff could meet and speak in confidence with an Executive Director and/or senior manager. The sessions aimed to promote and encourage the reporting of concerns and incidents and to explain how the Trust's systems operated. In addition, the Trust continued to promote the Nursing Times' Speak out Safely campaign during the year. In the 2014 staff survey, Trust staff were positive about the feedback they received from incidents they had reported or been involved in, a key driver to improving incident reporting levels.

Public stakeholders are involved in managing risks which impact on them in a number of ways. Liverpool Clinical Commissioning Group (CCG) is involved through the monthly clinical performance and quality review meeting held with them and which is chaired by the CCG. This meeting is used to discuss the Trust's contract and quality performance and to identify any concerns which may become risks. The Trust also makes the CCG aware of risks during this meeting. Our local Healthwatch is involved by alerting the Trust to issues of concern put to them by their members relating to our services, which we consider and define as risks where appropriate. Other local NHS providers are also involved through a mutual exchange of intelligence and a commitment to addressing risks, for example through the development of patient pathways. Our Council of Governors also plays a role in representing the interests of those we serve and holding the Board to account for the services provided by the Trust.

Liverpool Women's NHS Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission. Assurance is obtained on compliance with

CQC registration requirements via the six monthly Hospital Intelligent Monitoring report. This is reviewed by members of the executive team and via the Board's Governance and Clinical Assurance Committee and the Trust's Clinical Governance Committee. The Trust's CQC registration status is also confirmed in the monthly performance report which is received and reviewed across the organisation's governance structure.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The Foundation Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of economy, efficiency and effectiveness of the use of resources
As Accounting Officer I am responsible for ensuring that the organisation has arrangements in place for securing value for money in the use of its resources.

Each year the Trust prepares an operational plan which details the Trust's plans, its budget and efficiency targets and is approved by the Board of Directors. The Trust's Council of Governors is invited to contribute to the development of the plan. Reports on performance against the plan are presented to the Board of Directors and Council of Governors during the year.

The Audit Committee commissions reports on specific issues relating to economy, efficiency and effectiveness through the internal audit plan. Implementation of recommendations is overseen by the Audit Committee and the executive team.

The Board reviews the financial position of the Trust each time it meets via a performance and assurance report. This provides integrated information on financial performance, including the achievement of efficiency targets and other performance measures.

There is a scheme of delegation in place and the key governance committees of the Board are a part of this process, principally the Audit Committee, Finance, Performance and Business Development Committee and the Governance and Clinical Assurance Committee.

Information governance
There have been no serious incidents relating to information governance including data loss or confidentiality breaches which would be classified by the Information Governance Incident Reporting Tool and no cases have been reported to the Information Commissioner's Office.

Annual Quality Report
The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS Foundation Trust Boards on the form

and content of the annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

The Quality Report is contained within this annual report. Key controls are in place to prepare and publish the Quality Report, responsibility for which is discharged through the Trust's Medical Director who provides leadership. Each of the Trust's clinical functions has a designated clinical governance lead who is a consultant clinician. Clinical governance leads are responsible for operationally managing delivery of the Quality Report which focuses on patient safety, clinical effectiveness and patient experience. Clinical Directors and senior managers are accountable for delivering all aspects of the Quality Report.

A key role is played by the Trust's Clinical Governance Committee in preparing the Trust's Quality Report each year. Chaired by the Trust's Medical Director, this Committee provides a forum for discussion and challenge in respect of quality indicators and enables a balanced view to be presented in the published Quality Report. Led by the Medical Director, Deputy Director of Nursing and Midwifery and Governance Quality Manager, a stakeholder event in respect of our draft Quality Report is to be held in early May 2015. At that event our stakeholders will, as in previous years, be invited to comment upon and question our draft report. The Medical Director, Director of Nursing and Midwifery, Deputy Director of Nursing and Midwifery and the Governance Quality Manager have also attended events hosted by a number of Local Authorities to whom we relate, to present our Quality Report and address comments and questions from these stakeholders. The input of our stakeholders adds further to the balanced view presented in the Quality Report.

A quality performance report and dashboard is in place in order to review and report the quality metrics. This is updated monthly and is regularly reviewed by the Trust's Clinical Governance Committee.

During the year the Trust published a revised Quality Strategy for 2014/17. It also formulated a safety plan which was submitted to the national 'Sign up to Safety' campaign and was successful in securing £100,000 towards its implementation. Both documents state the Trust's quality improvement priorities and its quality performance dashboard is currently being revised in order to capture metrics to support and evidence progress against these priorities. The dashboard will also be key to delivery of the Trust's Quality Report 2015/16.

Delivery of the Quality Report is also supported by the Trust's Head of Clinical Audit, Deputy Director of Nursing and Midwifery, Head of Information for Governance and the officers of the Information Department who combined, provide the skills necessary to compile, analyse and audit the accuracy of data which informs the quality metrics. Data sources used include the Trust's Nursing and Midwifery indicators, data reported under CQUINS (Commissioning for Quality and Innovation payment framework), Inpatient Commissioning Dataset, Trust activity data drawn largely from Meditech, IDEAS reproductive medicine database, clinical audit data, Ulysses incident reporting system, CHKS and SUS data, inpatient and day case survey results and our staff survey results. There is also a series of policies in place at the Trust which underpin the quality of care provided and include clinical guidelines and standard operating procedures.

The Trust employs the services of Pricewaterhouse Coopers LLP as external auditors to provide a limited assurance report in relation to compliance with the requirements of the National Health Service (Quality Accounts) Regulations and to the quality and accuracy of the report through audit of three representative measures (two of three mandated by Monitor and a third selected by the Trust's Council of Governors) and a consistency check of the

contents of the report with a range of internal Trust documents and records. For 2014/15 the mandated measures are:

- Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways;
- Maximum waiting time of 62 days from urgent GP referral to the first treatment for all cancers;
- The provision of one-to-one care in established labour (as selected by the Council of Governors).

The Trust's waiting time data is verified weekly at operational level prior to being reported monthly via its performance framework. The Trust further assures itself of the accuracy of the data by undertaking internal and external auditors of its processes. Two such audits took place in 2013/14 and 2014/15 and were reported via the Trust's Audit Committee.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report attached to this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board and the Audit Committee the Governance and Clinical Assurance Committee, the Clinical Governance Committee and the Corporate Risk Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Head of Internal Audit has provided me with a positive opinion on the overall adequacy and effectiveness of the organisation's system of internal control. The assurance framework in place provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives has been reviewed. The Head of Internal Audit has stated that in his opinion, significant assurance can be given that there is a generally sound system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.

The Head of Internal Audit's opinion makes reference to three specific issues flowing from reviews undertaken at the request of Trust management, who recognised a lack of assurance in these areas. Two resulted in red rated audit reports and one resulted in an amber/red report. The first of the red reports concerned the maintenance of community based equipment and identified a weakness in respect of the control environment, in contrast to the strong control environment in place for the Trust's hospital based equipment. The second was in respect of the control framework weaknesses in relation to sickness absence management. Executive Directors identified actions to address these weaknesses and through the Trust's internal recommendation tracking process, improvements have been monitored via the Executive Team and reported to the Audit Committee.

The one red/amber report referred to in the Head of Internal Audit's opinion highlighted weaknesses in relation to pre-employment checks undertaken by the third party payroll provider the Trust was in contract with for part of the year. A new third party payroll provider was appointed part-way through the year and pre-employment checks were brought in house.

All recommendations from internal audit, external audit and the Local Counter Fraud Service are monitored by the Audit Committee using tracking software, to ensure recommendations are followed through to implementation. It will be noted that the Head of Internal Audit did not consider these three matters identified in his Opinion to be of sufficient concern to cause his overall opinion to be negative.

My review of effectiveness is also informed by reports and minutes from the Audit Committee, Governance and Clinical Assurance Committee, Finance, Performance and Business Development Committee, Putting People First Committee, Clinical Governance Committee, Clinical Audit Committee, Emergency Preparedness, Resilience and Response Committee and Infection Prevention and Control Committee. Other relevant assessments to which the Trust responds includes relevant CQC reviews, the Patient Led Assessments of the Care Environment (PLACE) undertaken, national confidential inquiries, reports from the Centre for Maternal and Child Enquiries and Ombudsman's reports. Independent assessment has been provided by the NHS Litigation Authority assessors who re-accredited the Trust as Level III for general standards in May 2011 and re-accreditation at Level III of the Clinical Negligence Scheme for Trusts for maternity standards in June 2011. There was an external audit of clinical coding in February 2015, undertaken as part of Monitor's data assurance framework. This provided high levels of assurance with regard to clinical coding at the Trust.

In reviewing the system of internal control I am fully aware of the roles and responsibilities of the following:

- The Board of Directors whose role is to provide active and visible leadership of the Trust within a framework of prudent and effective controls that enable risk to be assessed and effectively managed. The Board is collectively accountable for maintaining a sound system of internal control and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system;
- The Audit Committee which, as part of our governance structure, is pivotal in advising the Board on the effectiveness of the system of internal control. This includes tracking the Trust's response to internal control weaknesses identified by internal audit;
- The Board's assurance committees namely the Governance and Clinical Assurance Committee, the Finance, Performance and Business Development Committee and the Putting People First Committee, each of which provides strategic direction and assurance to the Board in respect of risk management;
- The Clinical Governance Committee which is instrumental in preparing our Quality Report and monitoring performance against agreed quality indicators;
- The programme of clinical audit in place which is designed to support achievement of the Trust's strategic objectives. The programme is monitored by the Clinical Audit Committee which reports to the Clinical Governance Committee;
- Internal audit provides regular reports to the Audit Committee as well as full reports to the Director of Finance and executive team. The Audit Committee also monitors action taken in respect of audit recommendations and the Director of Finance and Deputy Director of Finance meet regularly with the internal audit manager;
- External audit provides an annual audit letter and progress report through the year to the Audit Committee.

Significant control issues would be reported to the Board via one of its Committees. All significant risks identified within the BAF have been reviewed in-year by the Board and relevant Committee and appropriate control measures put in place.

During the year, specific management reviews were undertaken as a result of risks to performance identified from the performance management system. These included:

- In May 2014 the CQC issued the Trust with two Warning Notices. The notices were in respect of staffing (Outcome 13) and assessing and monitoring the quality of service provision (Outcome 16). Compliance action was also required in respect of the Trust's management of patient complaints. The challenges identified by the CQC were known to the Trust and were already being actively addressed through a comprehensive action plan.

  The actions taken included:

  - Investment in and recruitment of an additional 25 whole time equivalent Midwives;
  - Adoption of a standard definition of providing 1:1 care to women in established labour;
  - Established standard definitions for delays and non-clinical denial of epidural pain relief;
  - Revision of the Trust's risk management policy to include clearer definition of risk management and risk treatment;
  - Development of an improved Board Assurance Framework and arrangements for Board and Committee scrutiny of risk;
  - Provision of additional risk management training for staff;
  - Enhanced monitoring of incidents;
  - Relocation of the Patient Advice and Liaison Service to the hospital's main reception area, and placing of 60 information boards around the Trust promoting the service;
  - Enhanced analysis and triangulation of top themes from incidents, complaints, claims and Patient Advice and Liaison Service contacts;
  - Increased staffing resources in respect of the complaints function;
  - Developed a bedside information pack about how to raise a concern, make a complaint or comment.

  The CQC made a follow-up unannounced visit to the Trust on 30 September 2014 and subsequently lifted the two Warning Notices and confirmed that the Trust was fully compliant in respect of complaints.

  The Warning Notices were issued after the CQC revisited the Trust in April 2014 by way of follow-up to their unannounced visit in July 2013 when the Commission registered three concerns. Those concerns were (a) a minor concern in respect of the care and welfare of people who use our services (Outcome 4); (b) a moderate concern in respect of people being cared for by staff who are properly qualified and able to do their job (Outcome 13), and (c) a minor concern in respect of supporting our workers (Outcome 14). The matters identified by the CQC were well known to the Trust and were already being actively addressed. All actions required as a result of the three CQC concerns have now been completed.

- In July 2014 Monitor opened a formal investigation into the Trust's compliance with its licence. The investigation was opened due to concerns arising from the CQC's April

2014 unannounced inspection of the Trust, which resulted in two Warning Notices. The Trust submitted a schedule of information to Monitor in support of its investigation and the Board was required to meet with Monitor's officers to explain and provide evidence as to the nature and strength of its governance arrangements.

The Trust had commissioned a governance review from Deloitte LLP, based on Monitor's published 'Well led' guidance. The review took place during August – December 2014 and Deloitte LLP made its report available in January 2015. The report was provided to Monitor who considered the report together with the findings of its investigation. In February 2015 Monitor concluded that the Trust was not in breach of its licence and the investigation was closed.

- In March 2013, Liverpool CCG undertook a quality review visit of the Trust in line with the National Quality Board guidance. The review focused on the electronic management of pathology results and the Trust's preparations for a paperless system. Over the course of 2013/14 the Trust successfully addressed all but two of the thirty-three resulting actions. The CCG revisited the Trust twice during 2013/14 to be assured of progress towards completing the action plan and confirmed that it was satisfied all actions had been taken in March 2015.

- During the year there was a single indirect maternal death at the Trust. A Coroner's Inquest was held and the death found to be attributable to natural causes with no modifiable factors. The death was reported as a serious untoward incident and underwent full investigation at the Trust. A number of recommendations have been identified following the investigation, including the need for enhanced information sharing between organisations. The number of maternal deaths occurring at the Trust is still significantly below the national average.

- The Trust experienced its first Never Event in May 2013. It related to Never Event number 17 in respect of Transfusion of ABO-incompatible blood components. A full root cause analysis, involving external and impartial experts, was conducted. The resulting action plan saw the roll-out of an electronic blood track and traceability system in September 2014. The Trust was open and transparent with both the patient concerned (who suffered no ill effect as a result of the incident) and the CCG.

- The Trust received three CQC outlier alerts during the year. The first related to perinatal mortality. It was fully reviewed and data showed that the Trust conducted a significantly higher number of late therapeutic terminations of pregnancy. Whilst these were being correctly coded, they were being classified as perinatal mortality. Analysis of the data showed that if babies born following late therapeutic termination were excluded, the Trust's perinatal mortality rate was slightly lower than average. This was advised to the CQC who passed the matter to the Trust's local CQC inspection team who followed up on the Trust's progress with implementing actions in response.

  CHKS monitoring of HES data identified that the Trust had a higher than expected rate of postnatal complications, specifically sepsis. Investigation revealed accidental miscoding of some patients with urinary and other infections, who were being coded as having post natal sepsis. When these data were corrected the Trust's post natal sepsis rate was 30% lower. The Trust improved its coding processes and data for 2014/15 indicates that the Trust is comparable with other Trusts with more than 7,000 births per annum.

  The Trust received a CQC outlier alert in respect of elective caesarean sections. An inadvertent transposition of data was discovered in respect of this alert, revealing that

some emergency caesareans were being inadvertently reported as elective caesareans. When these data were corrected the Trust's elective caesarean section rate was within the normal range.

- National Patient Safety Alerts. In December 2012 the Trust received a report from internal audit offering no assurance in respect of its systems and processes to respond to alerts issued by the National Patient Safety Agency (NPSA). It made four recommendations namely the need to continuously monitor compliance with alerts, have in place completed action plans for all NPSA alerts to demonstrate compliance, ensure that NPSA alerts were properly received and acted upon by designated leads and that data from the central alert system (CAS) needed to be transferred to the Trust's SAFEGUARD CAS. The Trust took swift action to respond to the recommendations and progress against was monitored by the Board's Audit Committee and Governance and Clinical Assurance Committee.

  During 2013/14 and under guidance of the CCG, the Trust continued to develop its assurances in respect of NPSA alerts with a clear commitment to either becoming compliant or making available suitable mitigation in order to keep patients safe.

  The Trust sought further assurance from internal audit in 2014/15 that its system of responding to alerts is effective. The audit focused on the Trust's implementation of the new national Patient Safety Alerting system which was launched nationally by NHS England in January 2014, following its transfer from the National Patient Safety Agency. The purpose of the new system was to introduce a three stage system for highlighting patient safety risks in NHS organisations and to reduce risk by formulating and implementing actions.

  The audit found that further work was required to improve the Trust's compliance with the new system, to ensure it is not exposed to risk. Five 'medium' priority recommendations and two 'low' priority recommendations were highlighted based on the findings of the audit. The audit recommendations were completed by January 2015, including:

  - The Trust Central Alerting System Policy and Procedure manual was reviewed and updated; it includes NPS alerts and internal safety alerts, with a clear flowchart of the alert process also revised and includes strict deadlines for actions to be completed by the CAS leads and CAS Liaison Officer;

  - There are now formal processes for how staff document responses to alerts which they are responsible for including an action plan template;

  - The audit found that there was no agreed procedure for management to authorise the closure of alerts. All level three NPS alerts are now authorised for closure by the Clinical Governance Committee;

  - The Clinical Governance Committee received reports on Patient Safety Alerts; the reports that were produced did not provide the Committee with any information relating to the responses to the alerts. This was rectified and the new format reports have been submitted to the Corporate Risk Committee since mid-year 2015. However, due to the improvements in the management of the CAS, a full monthly report has been replaced by a monthly exception report;

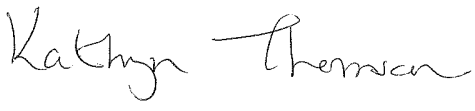
- An increase in CAS Administrators, a dedicated CAS Liaison Officer and revalidation of CAS Leads has seen an improvement in response and meeting deadlines, with 100% closure deadline compliance since the above changes were made.

- In previous annual reports I have reported that the Trust had cause to review the surgical practices of one of its consultants during 2008/09. This review led to the recall of a number of patients in order for the Trust to be satisfied that they have received the quality of care expected for all patients. All of these patients were signposted to further treatment or they were discharged, whichever was most appropriate for them. An independent review of governance arrangements was commissioned by the Trust to determine the lessons that could be learned and identify any areas for further improvement. The outcome of this review was considered by the Board of Directors in January 2010. It concluded that the Trust's governance arrangements were generally strong and that the issues that triggered the review was not systemic. An action plan was developed based on the report's recommendations and which was implemented and monitored through the Trust's governance structure from 2010/11 onwards. An independent review of its implementation was also commissioned and undertaken during 2010/11, to provide robust assurance that all required actions had been satisfactorily completed or were on target for completion, and the report of this review was considered by the Board of Directors in April 2011.

  The Trust then commissioned its internal audit service in 2012/13 to provide some external assurance that the organisation had adopted, embedded and learned from the recommendations made in the independent review of governance. This review led to a finding of limited assurance and indicated that further work was required in respect of two of the recommendations. This further work was undertaken during 2013/14 when the Board's Putting People First Committee developed a comprehensive medical workforce recruitment and development strategy, and the Clinical Governance Committee oversaw the collection, collation and reporting of outcome measures in the Trust's urogynaecology service by ensuring all of its clinicians collected BSUG (British Society of Urogynaecologists) audit data.

The Board of Directors is committed to continuous improvement and the development of systems of internal control.

Conclusion
There have been no significant control issues identified during 2014/15 and up to the date of approval of the annual report and accounts.



Kathryn Thomson
Chief Executive
22 May 2015

Independent auditors' report to the Council of Governors of Liverpool Women's NHS Foundation Trust

Report on the financial statements

Our opinion

In our opinion, Liverpool Women's NHS Foundation Trust's ("the Trust's") financial statements (the "financial statements"):

- give a true and fair view of the state of the Trust's affairs as at 31 March 2015 and of its income and expenditure and cash flows for the year then ended; and
- have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2014/15.

Emphasis of matter

In forming our opinion on the financial statements, which is not modified, we have considered the adequacy of disclosures made in note 1 (Accounting policies and other information) to the financial statements concerning the Trust's ability to continue as a going concern. The Trust is currently developing plans for the continuity of its services and is forecasting a deficit for 2015/16 and a cash shortfall which will lead to a Continuity of Services Ratio of 1. The Trust anticipates that it will receive external funding to ensure it is able to meet its liabilities as they fall due, however the approval of funding will not be known until June 2015. These conditions, together with the other matters explained in note 1 of the financial statements, indicate the existence of material uncertainty, which may cast significant doubt about the Trust's ability to continue as a going concern. The financial statements do not include the adjustments that would result if the Trust was unable to continue as a going concern.

What we have audited

The Trust's financial statements comprise:

the Statement of Financial Position as at 31 March 2015;

the Statement of Comprehensive Income for the year then ended;

the Statement of Cash Flows for the year then ended;

the Statement of Changes in Taxpayer's Equity for the year then ended;

the notes to the financial statements, which include a summary of significant accounting policies and other explanatory information.

The financial reporting framework that has been applied in the preparation of the financial statements is the NHS Foundation Trust Annual Reporting Manual 2014/15 issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Our audit approach

Overview

Overall materiality: £1,945,000 which represents 2% of total revenue.

In establishing our overall approach we assessed the risks of material misstatement and applied our professional judgement to determine the extent of testing required over each balance in the financial statements.

The audit was conducted at the Trust's hospital site in Liverpool as that is where the Trust's finance function is based.

Our key areas of focus are

Management override of controls and risk of fraud in revenue recognition;

Financial position and sustainability.

The scope of our audit and our areas of focus

Liverpool Women's NHS Foundation Trust specialises in the health of women and their babies in a hospital environment as well as out in the community. The Trust focusses on providing maternity services through caring for women and babies from conception to delivery as well as gynaecology services which entail caring for women with varied conditions associated with the female reproductive system. The Trust also has renowned fertility and genetics teams to support the services provided.

The Trust's principal commissioner is Liverpool Clinical Commissioning Group (CCG) which represents over 41.3% of the Trust's revenue.

Monitor currently rates the Trust as green for governance and has a continuity of service rating of 3. The continuity of service rating is Monitor's view of the risk that the Trust will fail to carry on as a going concern, a rating of 1 indicates the most serious risk and 4 the least risk.

We conducted our audit in accordance with International Standards on Auditing (UK and Ireland) ("ISAs (UK & Ireland)").

We designed our audit by determining materiality and assessing the risks of material misstatement in the financial statements. In particular, we looked at where the directors made subjective judgements, for example in respect of significant accounting estimates that involved making assumptions and considering future events that are inherently uncertain. As in all of our audits, we also addressed the risk of management override of internal controls, including evaluating whether there was evidence of bias by the directors that represented a risk of material misstatement due to fraud.

The risks of material misstatement that had the greatest effect on our audit, including the allocation of our resources and effort, are identified as "areas of focus" in the table below. We have also set out how we tailored our audit to address these specific areas in order to provide an opinion on the financial statements as a whole, and any comments we make on the results of our procedures should be read in this context. This is not a complete list of all risks identified by our audit.

Area of focus	*How our audit addressed the area of focus*
Management override of controls and risk of fraud in revenue recognition *See note 1 to the financial statements for the directors' disclosures of the related accounting policies, judgements and estimates relating to the recognition of income.* It is an inherent risk in every organisation that management is in a position where they can manipulate and override controls in order to misreport or perform/conceal fraudulent reporting within the financial statements in order to influence results and maximise performance. We focussed on this area because there is a heightened risk due to: • the incentive for the Trust to improve or maintain its quality ratings; • the pressure it is under to achieve a surplus and maximise revenue in any accounting year; and • the timing and complexity of the intra-NHS balance reconciliation process.	***Journals*** We tested the potential for manipulation of journal postings to the ledgers by selecting a sample of manual and automated journals which have been recognised within income and expenditure. We focussed around those journals which are material, were recognised close to year end and are included within accrued or deferred income. We considered each journal and traced back to supporting evidence such as invoices, delivery notes or proof of payment. We also evaluated the business rationale underlying significant transactions. Our testing confirmed that the journals selected were supported by appropriate documentation and that the related income and expenditure was recognised in the correct accounting period. ***Estimates*** We evaluated and tested management's estimates (such as the property, plant and equipment valuation, accruals, provisions, deferred income and the bad debt provision) and the basis of their calculation. For each estimate, we reviewed the accounting estimate

Area of focus	*How our audit addressed the area of focus*
Income The Trust's income comes primarily from other NHS bodies and more specifically from Clinical Commissioning Groups ('CCGs'). The service level agreements ('SLAs') with the CCGs are renegotiated annually and consist of standard monthly instalments and quarterly over/under performance invoices or credit notes, which are negotiated with the CCG and are therefore subject to management judgement regarding the value and recoverability of the related income. We considered whether there were any complex contractual arrangements in place which may be more susceptible to management manipulation. We did not identify any additional risks that have not already been addressed through our significant risk of management override of controls and risk of fraud in revenue recognition.	for bias and evaluated whether circumstances producing any bias or representing a risk of material misstatement existed. We also considered the prior estimate for accuracy given the current year activity. Our testing did not identify any material issues. ***Income*** For CCG income, we obtained copies of the signed contract and reviewed the terms of said contracts. We agreed the income recognised in the year to the terms and any correspondence between the Trust and the CCG regarding over/under performance. We agreed income back to invoices and cash receipts. We considered the Trust's main contractual arrangements and found that they include some degree of management judgement but are not inherently complex. For a sample of the Trust's SLAs, we tested the total value to a signed agreement and authorised variations where applicable. We examined that the final March 2015 payment was correctly accounted for. We evaluated the SLAs for any monies for specific purposes or potential deferred income items and ensured these have been accounted for appropriately. For other operating income, we agreed a sample of transactions back to invoices and third party documentation. We tested a sample of revenue transactions recognised close to year end (both before and after the year end) to check that cut-off procedures were appropriately applied. This involved agreeing the revenue transactions to supporting invoices and goods despatch note (where applicable). Our testing did not identify any material issues. ***Intra-NHS balances*** We tested intra NHS confirmations of debtors and creditors as well as income and expenditure mismatches by reference to the Monitor agreement of balances reports and investigated with management the resolution of any disputed amounts. We considered the impact these disputes had on the value of income and expenditure recognised in 2014/15 and did not identify any issues with all the unresolved mismatches immaterial.
Financial Position and Sustainability *The Trust's future business plans are discussed in detail on pages 17 to 18 of the Strategic Report. The Trust's*	We evaluated the composition of management's annual plan and future cash flow forecasts and the process by which they were drawn up. We compared the current year actual results with the

Area of focus	*How our audit addressed the area of focus*
finances for the year ended 31 March 2015 are also discussed on pages 11 to 14 of the Strategic Report. The Trust reported a Continuity of Services Risk Rating ('CoSRR') of 3 as at 31 March 2015 and for the financial year then ended. Monitor therefore does not currently identify there to be a material level of financial risk at the Trust. The Trust achieved an underlying deficit of £2.7m in the current financial year. The deficit resulted from several factors including the push to improve staffing levels to be compliant with recommended midwives to patient ratios. The Trust has however achieved the original cost improvement programme ("CIP") target of £5.6m of cost savings for 2014/15. The annual plan for 2015/16 prepared by the Trust forecasts a further decline, with the requirement for a £7.8m cash injection. The financial challenge arises from structural issues including Clinical Negligence Scheme for Trusts premiums and maternity tariffs over which the Trust has no influence. This has an impact on the Trust's forecast cash position and hence its ability to meet its obligations; however the Trust has applied for central Distressed Funding of £7.8m from the Department of Health via Monitor. The 2015/16 plan relies on the assumption that the funding will be obtained and a CIPs target of £5m will be achieved which will lead to a £8.0m deficit in 2015/16 and a CoSRR rating of 2. This annual plan has been reviewed and approved by the Board of Directors. We identified this as an area of focus because the assessment of the Trust's financial position and financial sustainability requires significant levels of judgement in choosing appropriate assumptions and these assumptions directly impact the Trust's CoSRR for 2015/16.	2014/15 figures included in the prior year plan to consider whether any forecasts included assumptions that, with hindsight, had been optimistic. Actual performance of the Trust was found to be lower than had been expected, however management has reflected that this was caused by factors outside of the Trust's influence and therefore were not within its power to predict at the time of the original forecast. We reviewed the 2015/16 operational plan and considered forecasting accuracy in light of current year outturn. We also challenged management's assumptions in the forecasts for increases in clinical revenue and increases in employee pay expenses. We further challenged these assumptions by agreeing tariff deflators and inflation rates to Monitor guidance; considering whether the planned increases in clinical revenue are consistent with 2015/16 SLAs and other contracts; and assessing if any non recurrent income and expenditure had been excluded from the forecasts. We found the assumptions to be consistent and within an acceptable range. We however noted that any change in these assumptions would have an impact on the Trust's result and cash flow forecast for 2015/16. The 2015/16 CIPs were compared against the prior year performance to establish whether they are achievable. We found that the Trust has met its 2014/15 CIP targets and recognise that the 2015/16 CIPs are challenging but deliverable. We challenged management on the adequacy of their sensitivity calculations within the Trust's annual plan. We calculated the degree to which these assumptions would need to move before the CoSRR rating worsened from a 2 to a 1, including the Trust's cash balance being reduced to £NIL. We noted that the Trust would be most sensitive with regards to its liquidity in the year and challenged management on the likelihood of such movements. We found that the Trust's planned forecasts and CoSSR are dependent on the receipt of £7.8m Distressed Funding from Monitor. Based on the information currently available, there is therefore a material uncertainty around the future cash requirements of the Trust over the next 12 months. An Emphasis of Matter paragraph is included in our opinion to highlight this uncertainty.

How we tailored the audit scope

We tailored the scope of our audit to ensure that we performed enough work to be able to give an opinion on the financial statements as a whole, taking into account the structure of the Trust, the accounting processes and controls, and the environment in which the Trust operates. In establishing our overall approach we assessed the risks of material misstatement, taking into account the nature, likelihood and potential magnitude of any misstatement. Following this assessment, we applied professional judgement to determine the extent of testing required over each balance in the financial statements. The audit was conducted at the Trust's hospital site in Liverpool as this is where the finance function is based.

Materiality

The scope of our audit was influenced by our application of materiality. We set certain quantitative thresholds for materiality. These, together with qualitative considerations, helped us to determine the scope of our audit and the nature, timing and extent of our audit procedures and to evaluate the effect of misstatements, both individually and on the financial statements as a whole.

Based on our professional judgement, consistent with last year, we determined materiality for the financial statements as a whole as follows:

Overall materiality	£1,945,000 (2014: £1,885,220).
How we determined it	2% of revenue
Rationale for benchmark applied	We have applied this benchmark, which is a generally accepted measure when auditing not for profit organisations, because we believe this to the most appropriate financial measure of the performance of a Foundation Trust.

We agreed with the Audit Committee that we would report to them misstatements identified during our audit above £90,000 (2014: £90,000) as well as misstatements below that amount that, in our view, warranted reporting for qualitative reasons.

Other required reporting in accordance with the Audit Code for NHS foundation trusts

Opinions on other matters prescribed by the Audit Code for NHS foundation trusts

In our opinion:

- the information given in the Strategic Report and the Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements; and
- the part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2014/15.

Consistency of other information

Under the Audit Code for NHS foundation trusts we are required to report to you if, in our opinion:	
• information in the Annual report is: – materially inconsistent with the information in the audited financial statements; or – apparently materially incorrect based on, or materially inconsistent with, our knowledge of the Trust acquired in the course of performing our audit; or – otherwise misleading.	We have no exceptions to report arising from this responsibility.
• the statement given by the directors on page9, in accordance with provision C.1.1 of the NHS Foundation Trust Code of Governance, that they consider the Annual Report taken as a whole to be fair, balanced and understandable and provides the information necessary for members to assess the Group's and Parent Trust's performance, business model and strategy is materially inconsistent with our knowledge of the Group's and Parent Trust acquired in the course of performing our audit.	We have no exceptions to report arising from this responsibility.
• the section of the Annual Report on page 194, as required by provision C.3.9 of the NHS Foundation Trust Code of Governance, describing the work of the Audit Committee does not appropriately address matters communicated by us to the	We have no exceptions to report arising from this

Audit Committee.	responsibility.
• the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2014/15 or is misleading or inconsistent with information of which we are aware from our audit. We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.	We have no exceptions to report arising from this responsibility

Economy, efficiency and effectiveness of resources and Quality Report

Under the Audit Code for NHS Foundation Trusts we are required to report to you if, in our opinion:	
• we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.	We have no exceptions to report arising from this responsibility
• we have qualified, on any aspect, our opinion on the Quality Report	We have no exceptions to report arising from this responsibility

Responsibilities for the financial statements and the audit

Our responsibilities and those of the directors

As explained more fully in the Directors' Responsibilities Statement, the directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view in accordance with the NHS Foundation Trust Annual Reporting Manual 2014/15.

Our responsibility is to audit and express an opinion on the financial statements in accordance with the National Health Service Act 2006, the Audit Code for NHS Foundation Trusts issued by Monitor and ISAs (UK & Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

This report, including the opinions, has been prepared for and only for the Council of Governors of Liverpool Women's NHS Foundation Trust as a body in accordance with paragraph 24 of Schedule 7 of the National Health Service Act 2006 and for no other purpose. We do not, in giving these opinions, accept or assume responsibility for any other purpose or to any other person to whom this report is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

What an audit of financial statements involves

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of:

whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed;

the reasonableness of significant accounting estimates made by the directors; and

the overall presentation of the financial statements.

We primarily focus our work in these areas by assessing the directors' judgements against available evidence, forming our own judgements, and evaluating the disclosures in the financial statements.

We test and examine information, using sampling and other auditing techniques, to the extent we consider necessary to provide a reasonable basis for us to draw conclusions. We obtain audit evidence through testing the effectiveness of controls, substantive procedures or a combination of both.

In addition, we read all the financial and non-financial information in the Annual Report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Certificate

We certify that we have completed the audit of the financial statements in accordance with the requirements of Chapter 5 of Part 2 to the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

Fiona Kelsey (Senior Statutory Auditor)
for and on behalf of PricewaterhouseCoopers LLP
Chartered Accountants and Statutory Auditors
Manchester
28 May 2015

(a) The maintenance and integrity of the Liverpool Women's NHS Foundation Trust website is the responsibility of the directors; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the website.

(b) Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

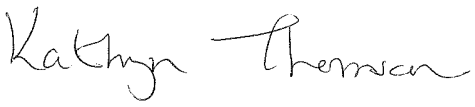
Liverpool Women's NHS Foundation Trust

FINANCIAL ACCOUNTS

Liverpool Women's NHS Foundation Trust Annual accounts for the year ended 31 March 2015

Foreword to the accounts

These accounts, for the year ended 31 March 2015, have been prepared by Liverpool Women's NHS Foundation Trust under Schedule 7 of the National Health Service Act 2006, paragraphs 24 and 25 and in accordance with directions given by Monitor, the sector regulator for health services in England.



Kathryn Thomson
Chief Executive
22 May 2015

Liverpool Women's NHS Foundation Trust is a public benefit corporate domiciled in England. The principal activities of the Trust are to serve the community by the provision of goods and services for the purpose of the health service in England. This includes education and training, research, accommodation and other facilities related to the provision of health care.

Registered address: Crown Street, Liverpool L8 7SS

Statement of Comprehensive Income

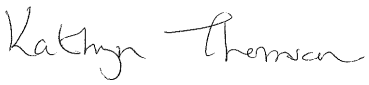
	Note	2014/15 £000	2013/14 £000
Operating income from patient care activities	3	89,826	84,395
Other operating income	4	7,440	9,866
Total operating income from continuing operations		**97,266**	**94,261**
Operating expenses	5, 7	(98,070)	(92,313)
Operating surplus/(deficit) from continuing operations		**(804)**	**1,948**
Finance income	10	19	26
Finance expenses	11	(69)	(13)
PDC dividends payable		(1,881)	(1,694)
Net finance costs		**(1,931)**	**(1,681)**
Share of profit of associates/joint arrangements	15	10	-
Surplus/(deficit) for the year from continuing operations		**(2,725)**	**267**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	6	(13)	-
Revaluations	14	1,860	3,154
Share of comprehensive income from associates and joint arrangements	15	-	-
Total comprehensive income/(expense) for the period		**(878)**	**3,421**

Statement of Financial Position

	Note	31 March 2015 £000	31 March 2014 £000
Non-current assets			
Intangible assets	12	270	313
Property, plant and equipment	13	67,245	63,799
Investments in associates (and joint arrangements)	15	10	-
Trade and other receivables	18	51	-
Total non-current assets		**67,576**	**64,112**
Current assets			
Inventories	17	310	308
Trade and other receivables	18	3,930	3,799
Cash and cash equivalents	19	6,108	5,388
Total current assets		**10,348**	**9,495**
Current liabilities			
Trade and other payables	20	(7,441)	(8,212)
Other liabilities	21	(787)	(794)
Borrowings	22	(306)	-
Provisions	23	(930)	(274)
Total current liabilities		**(9,464)**	**(9,280)**
Total assets less current liabilities		**68,460**	**64,327**
Non-current liabilities			
Trade and other payables	20	-	-
Other liabilities	21	(1,675)	(1,720)
Borrowings	22	(5,194)	-
Provisions	23	(599)	(1,426)
Total non-current liabilities		**(7,468)**	**(3,146)**
Total assets employed		**60,992**	**61,181**
Financed by			
Public dividend capital		36,365	35,675
Revaluation reserve		8,659	6,812
Income and expenditure reserve		15,968	18,694
Total taxpayers' equity		**60,992**	**61,181**

The notes on pages 240 to 274 form part of these accounts.

The financial statements on pages 235 to 239 were approved by the Board of Directors on 22 May 2015 and signed on its behalf by:



Name Kathryn Thomson
Position Chief Executive
Date **22 May 2015**

Statement of Changes in Equity for the year ended 31 March 2015

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2014 - brought forward	**35,676**	**6,812**	**18,693**	**61,181**
Surplus/(deficit) for the year	-	-	(2,725)	**(2,725)**
Impairments	-	(13)	-	**(13)**
Revaluations	-	1,860	-	**1,860**
Share of comprehensive income from associates and joint arrangements	-	-	-	**-**
Public dividend capital received	689	-	-	**689**
Taxpayers' and others' equity at 31 March 2015	**36,365**	**8,659**	**15,968**	**60,992**

Statement of Changes in Equity for the year ended 31 March 2014

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2013 - brought forward	**35,210**	**3,658**	**18,427**	**57,295**
Surplus/(deficit) for the year	-	-	267	**267**
Impairments	-	-	-	**-**
Revaluations	-	3,154	-	**3,154**
Share of comprehensive income from associates and joint arrangements	-	-	-	**-**
Public dividend capital received	465	-	-	**465**
Taxpayers' and others' equity at 31 March 2014	**35,675**	**6,812**	**18,694**	**61,181**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust. Additional PDC may also be issued to NHS foundation trusts by the Department of Health. A charge, reflecting the cost of capital utilised by the NHS Foundation Trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the NHS Foundation Trust.

Statement of Cash Flows

	Note	2014/15 £000	2013/14 £000
Cash flows from operating activities			
Operating surplus/(deficit)		(804)	1,948
Non-cash income and expense:			
Depreciation and amortisation	5.1	3,905	3,388
(Gain)/loss on disposal of non-current assets	5.1	26	-
(Increase)/decrease in receivables and other assets		(182)	5,139
(Increase)/decrease in inventories		(2)	20
Increase/(decrease) in payables and other liabilities		(967)	(9,250)
Increase/(decrease) in provisions		(198)	(1,869)
Other movements in operating cash flows		-	(12)
Net cash generated from/(used in) operating activities		**1,778**	**(636)**
Cash flows from investing activities			
Interest received		19	26
Purchase of intangible assets		(45)	(220)
Purchase of property, plant, equipment and investment property		(5,314)	(4,238)
Sales of property, plant, equipment and investment property		16	25
Net cash generated from/(used in) investing activities		**(5,324)**	**(4,407)**
Cash flows from financing activities			
Public dividend capital received		689	465
Movement on loans from the Independent Trust Financing Facility		5,500	-
Other interest paid		(42)	-
PDC dividend paid		(1,881)	(1,694)
Net cash generated from/(used in) financing activities		**4,266**	**(1,229)**
Increase/(decrease) in cash and cash equivalents		**720**	**(6,272)**
Cash and cash equivalents at 1 April		**5,388**	**11,660**
Cash and cash equivalents at 31 March	19.1	**6,108**	**5,388**

Notes to the Accounts

Note 1 Accounting policies and other information

Basis of preparation
Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the FT ARM which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the FT ARM 2014/15 issued by Monitor. The accounting policies contained in that manual follow IFRS and HM Treasury's FReM to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Going concern
These accounts have been prepared on a going concern basis.

Liverpool Women's NHS Foundation Trust faces a significant financial challenge and is forecasting a deficit of £8m in 2015/16 with a £7.8m cash shortfall. This will lead to a Monitor Continuity of Services Ratio of 1, with the position further deteriorating in 2016/17. The Board of Directors predicted this position in June 2014 when the five year plan indicated that the Foundation Trust would no longer be financially sustainable in a 'do nothing' position, and commissioned a strategic options review that would address both the financial and clinical challenges ahead so as to develop plans for the continuity of its services.

The Board has taken comfort from internal and external audit regarding the financial controls within the Foundation Trust, coupled with a recent efficiency review commissioned externally by the Foundation Trust, indicate that the Foundation Trust is efficient and managed well financially. The financial challenges arise from structural problems, notably from within the maternity tariff and from Clinical Negligence insurance premiums.

The Foundation Trust has applied for £7.8m of Distressed Funding from the Department of Health and will be informed in June 2015 as to whether this application has been successful. If the application is successful the Foundation Trust will achieve a Continuity of Services of 2, but the application will lead to a Monitor investigation and the requirement for a financial recovery plan in 2015/16. If the application is unsuccessful the Foundation Trust anticipates enhanced regulatory action. This represents a material uncertainty, which may cast significant doubt about the Trust's ability to continue as a going concern.

The National Health Service has a process for managing organisations that are in financial distress which will enable the services provided by Liverpool Women's NHS Foundation Trust to continue and ensure that all staff and suppliers are paid. This will ensure that the financial stability issues are managed in a controlled manner which does not adversely impact on the services provided to patients. On this basis, the Directors have a reasonable expectation that the Liverpool Women's NHS Foundation Trust will continue in operational existence for the coming 12 month period and for this reason they continue to adopt the going concern basis in preparing the accounts.

Note 1.1 Consolidation

Liverpool Women's NHS Foundation Charitable Trust
The Liverpool Women's NHS Foundation Trust is the corporate trustee of the Liverpool Women's NHS Foundation Charitable Trust (Registration No. 1048294). The Foundation Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the foundation trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable trust and has the ability to affect those returns and other benefits through its power over the trust.

The charitable trust's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Generally Accepted Accounting Principles (UK GAAP). The Foundation Trust has not consolidated the Liverpool Women's NHS Foundation Charitable Trust in its accounts on the grounds of materiality.

Joint ventures
Joint ventures are arrangements in which the Foundation Trust has joint control with one or more other parties, and where it has the rights to the net assets of the arrangement. Joint ventures are accounted for using the equity method.

Segmental Reporting

The Foundation Trust's core activities fall under the remit of the Chief Operating Decision Maker (CODM), which has been determined to be the Board of Directors. These activities are primarily the provision of NHS healthcare, the income for which is received through contracts with commissioners. The contracts follow the requirements of Payment by Results where applicable and services are paid for on the basis of tariffs for each type of clinical activity. The planned level of activity is agreed with our main commissioners for the year. The Foundation Trust's main commissioners are listed in the related party disclosure (see Note 29).

The Foundation Trust comprises of two clinical divisions, Maternity and Gynaecology. These divisions have been aggregated into a single operating segment because they have similar economic characteristics, are managed by a single divisional manager, the nature of the services they provide are the same (NHS care), and they have the same customers. The majority of the Foundation Trust's customers come from the City of Liverpool and surrounding areas, although the Foundation Trust also has contracts to treat patients from further afield including Wales and the Isle of Man. Both divisions have the same regulators (Monitor, the Care Quality Commission and the Department of Health). The overlapping activities and interrelation between the divisions also suggests that aggregation is appropriate. The divisional management teams report to the CODM, and it is the CODM that ultimately makes decisions about the allocation of budgets, capital funding and other financial decisions.

Note 1.2 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Foundation Trust is contracts with commissioners in respect of health care services.

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.

Other operating income is recognised when, and to the extent, performance occurs. It is measured at the fair value of the consideration receivable. The main source of this income is from CCG's, NHS England, NHS Foundation Trusts and NHS Trusts. It includes Education and Training Income, which arises from the provision of mandatory education and training as set out in the Trust's Terms of Authorisation. This income is recognised as costs are incurred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Finance income relates to interest receivable from balances held in bank accounts and amounts placed on short term deposit which is accrued on a time basis by reference to the principal outstanding and the interest rate applicable.

Note 1.3 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs
NHS Pension Scheme
Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. It is not possible for the NHS foundation trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employers pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Foundation Trust commits itself to the retirement, regardless of the method of payment.

Holiday Pay Accrual
For all staff the amount of outstanding annual leave as at 31 March 2015 was requested across the whole Foundation Trust. The accrual was then calculated based on the full population of responses.

Note 1.4 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.5 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes;
• it is probable that future economic benefits will flow to, or service potential be provided to, the Foundation Trust;
• it is expected to be used for more than one financial year; and
• the cost of the item can be measured reliably.
• the item has cost of at least £5,000; or
• Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
• Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Measurement
Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at fair value.

Fair value of land and buildings are based on advice received from DTZ professional valuers.
Valuations provided by the professional valuers for land and buildings as at 31 March 2015 have been reflected in the 2014/15 accounts.

The valuations are carried out primarily on the basis of depreciated replacement cost for specialised operational property and existing use value for non-specialised operational property. The value of land for existing use purposes is assessed at existing use value. For non-operational properties including surplus land, the valuations are carried out at open market value.

Subsequent expenditure
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful economic lives using the straight line method. Freehold land is considered to have an infinite life and is not depreciated.

Assets in the course of construction are not depreciated until the asset is brought into use.

Revaluation gains and losses
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments
In accordance with the FT ARM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition
Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

• the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
• the sale must be highly probable ie:

- management are committed to a plan to sell the asset;
- an active programme has begun to find a buyer and complete the sale;
- the asset is being actively marketed at a reasonable price;
- the sale is expected to be completed within 12 months of the date of classification as 'held for sale'; and
- the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated assets
Donated property, plant and equipment assets are capitalised at their fair value on receipt. The donation is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the donation are to be consumed in a manner specified by the donor, in which case, the donation is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Useful Economic lives of property, plant and equipment
Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life	**Max life**
	Years	**Years**
Land	-	-
Buildings, excluding dwellings	41	90
Dwellings	75	75
Assets under construction	-	-
Plant & machinery	1	15
Information technology	1	10
Furniture & fittings	1	10

Note 1.6 Intangible assets

Recognition
Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Foundation Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets
Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

• the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
• the Foundation Trust intends to complete the asset and sell or use it;
• the Foundation Trust has the ability to sell or use the asset;
• how the intangible asset will generate probable future economic or service delivery benefits, eg, the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
• adequate financial, technical and other resources are available to the trust to complete the development and sell or use the asset; and
• the Foundation Trust can measure reliably the expenses attributable to the asset during development.

Software
Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

Measurement
Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at fair value. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment.

Intangible assets held for sale are measured at the lower of their carrying amount or “fair value less costs to sell”.

Amortisation
Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful economic life of intangible assets

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	Max life Years
Intangible assets - purchased		
Software	1	7

Note 1.7 Revenue government and other grants

Government grants are grants from Government bodies other than income from commissioners or NHS trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

Note 1.8 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the weighted average cost method. Net realisable value represents the estimated selling price less all estimated costs to completion and selling costs to be incurred. No provision is made for obsolete or slow

moving items as they are not included within inventory valuations.

Note 1.9 Financial instruments and financial liabilities

Recognition
Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Foundation Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

All other financial assets and financial liabilities are recognised when the Foundation Trust becomes a party to the contractual provisions of the instrument.

De-recognition
All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Foundation Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement
Financial assets are categorised as "loans and receivables".
Financial liabilities are classified as "other financial liabilities".

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.

The Foundation Trust's loans and receivables comprise: cash and cash equivalents, NHS receivables, accrued income and "other receivables".

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Cash is cash-in-hand and deposits with any financial institution repayable without penalty.

Other financial liabilities
All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Impairment of financial assets
At the Statement of Financial Position date, the Foundation Trust assesses whether any financial assets, other than those held at "fair value through income and expenditure" are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of a bad debt provision.

A provision for the impairment of receivables has been made against specific debtor amounts where there is reasonable uncertainty of obtaining settlement.

Note 1.10 Leases

Operating leases
Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Where the Foundation Trust acts as the Lessor, operating lease income is recognised for the lease of buildings or land where the risks and rewards of ownership of the leased asset are retained by the Foundation Trust. Lease income received in advance is deferred over the life of the lease.

Note 1.11 Provisions

The NHS Foundation Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs
The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS Foundation Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS foundation trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS Foundation Trust is disclosed at note 23.2 but is not recognised in the NHS Foundation Trust's accounts.

Non-clinical risk pooling
The NHS Foundation Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises.

Pension provisions
Pension provisions relating to former employees, have been estimated using the life expectancy from the Government's actuarial tables. Provisions are recognised when the Foundation Trust has a present legal or constructive obligation as a result of a past event, Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate of 2.2% in real terms (1.30% for employee early departure obligations).

Legal claims
Legal claims provisions relate to employer and public liability claims. Expected costs are advised by the NHS Litigation Authority or other legal professionals.

Other provisions
Other provisions are in respect of costs arising from organisational restructure and potential abortive costs, and are calculated using appropriate methodology in line with IAS 37.

Note 1.12 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 24 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 24, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.13 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the NHS Foundation Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS foundation trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded assets), (ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.14 Value added tax

Most of the activities of the NHS Foundation Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.15 Corporation tax

The Foundation Trust has determined that it is has no corporation tax liability having reviewed "Guidance on the tax treatment of non-core health care commercial activities of NHS Foundation Trusts" issued by HM Revenue and Customs supplemented by access to specialist advice when necessary.

Note 1.16 Foreign exchange

The functional and presentational currency of the Foundation Trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

No assets or liabilities denominated in a foreign currency are held at the Statement of Financial Position date by the Foundation Trust.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Note 1.17 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS Foundation Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

Note 1.18 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS foundation trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.19 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2014/15.

Note 1.20 Standards, amendments and interpretations in issue but not yet effective or adopted

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2014-15. The application of the Standards as revised would not have a material impact on the accounts for 2014-15, were they applied in that year:

IFRS 9 Financial Instruments - subject to consultation - subject to consultation
IFRS 13 Fair Value Measurement - subject to consultation
IFRS 15 Revenue from Contracts with Customers

Note 1.21 Critical accounting estimates and judgements

In the application of the Foundation Trust's accounting policies, management is required to make judgments, estimates and assumptions regarding the carrying amount of assets and liabilities that are not readily apparent from other sources. These estimates and associated assumptions are based on historical experience and other factors considered of relevance. Actual results may differ from those estimates as underlying assumptions are continually reviewed. Revisions to estimates are recognised in the period in which the estimate is revised.

The areas requiring critical judgments in the process of applying accounting policies are.

• Asset valuation and lives (including capitalisation of costs in respect of assets in the course of construction)
• Impairments of receivables
• Holiday pay accrual
• Pension provisions
• Legal claims and entitlements

Further detail of these policies can be found in their specific accounting policy notes.

Note 2 Operating Segments

Liverpool Women's operates in a single segment, the provision of NHS care. There are therefore no reportable segments.

Income from transactions with CCGs and NHS England is in excess of 10% of total income at £80,540k (2013/14, £78,080k).

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)

	2014/15	2013/14
	£000	£000
Acute services		
Elective income	9,708	10,163
Non elective income	18,255	18,230
Outpatient income	10,756	10,816
A & E income	1,139	1,091
Other NHS clinical income	43,696	40,059
All services		
Private patient income	3,592	3,183
Other clinical income	2,680	853
Total income from activities	**89,826**	**84,395**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2014/15	2013/14
	£000	£000
CCGs and NHS England	80,540	78,080
Local authorities	249	224
Other NHS foundation trusts	2,129	2,041
NHS trusts	885	777
Non-NHS: private patients	3,592	3,183
Non-NHS: overseas patients (chargeable to patient)	135	83
NHS injury scheme (was RTA)	82	7
Non NHS: other	2,214	-
Total income from activities	**89,826**	**84,395**
Of which:		
Related to continuing operations	89,826	84,395
Related to discontinued operations	-	-

Note 3.3 Overseas visitors (relating to patients charged directly by the NHS foundation trust)

	2014/15	2013/14
	£000	£000
Income recognised this year	135	83
Cash payments received in-year	105	-
Amounts added to provision for impairment of receivables	15	-
Amounts written off in-year	-	-

Note 4 Other operating income

	2014/15	2013/14
	£000	£000
Research and development	928	875
Education and training	5,095	5,218
Non-patient care services to other bodies	6	-
Rental revenue from operating leases	304	224
Other income	1,107	3,549
Total other operating income	**7,440**	**9,866**
Of which:		
Related to continuing operations	7,440	9,866
Related to discontinued operations	-	-

Note 4.1 Analysis of Other Operating Income - Other	2014/15	2013/14
	£000	£000
Car parking	485	190
Clinical excellence awards	555	-
Property rentals	41	-
Other	26	3,359
Total Other Operating Income - Other	**1,107**	**3,549**

Note 5.1 Operating expenses

	2014/15	2013/14
	£000	£000
Services from NHS foundation trusts	2,597	3,065
Services from NHS trusts	2,703	2,535
Services from CCGs and NHS England	11	24
Purchase of healthcare from non NHS bodies	59	47
Employee expenses - executive directors	912	813
Employee expenses - non-executive directors	112	116
Employee expenses - staff	60,541	55,625
Supplies and services - clinical	5,731	5,524
Supplies and services - general	3,175	3,039
Establishment	1,434	1,282
Research and development	-	946
Transport	378	449
Premises	4,602	4,107
Increase/(decrease) in provision for impairment of receivables	(137)	-
Increase/(decrease) in other provisions	-	(101)
Change in provisions discount rate(s)	87	-
Inventories written down	-	26
Drug costs	575	659
Inventories consumed	1,879	1,741
Rentals under operating leases	77	-
Depreciation on property, plant and equipment	3,817	3,339
Amortisation on intangible assets	88	48
Audit fees payable to the external auditor		
audit services- statutory audit	61	57
other auditor remuneration (external auditor only)	252	77
Clinical negligence	6,722	5,955
Loss on disposal of non-current assets	26	-
Legal fees	284	178
Consultancy costs	539	1,368
Training, courses and conferences	295	224
Patient travel	13	15
Hospitality	3	11
Insurance	73	67
Other services, eg external payroll	168	325
Losses, ex gratia & special payments	6	-
Other	987	752
Total	**98,070**	**92,313**
Of which:		
Related to continuing operations	98,070	92,313
Related to discontinued operations	-	-

Note 5.2 Other auditor remuneration

	2014/15	2013/14
	£000	£000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	-	-
2. Audit-related assurance services	-	-
3. Taxation compliance services	-	-
4. All taxation advisory services not falling within item 3 above	-	-
5. Internal audit services	-	-
6. All assurance services not falling within items 1 to 5	-	-
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-
8. Other non-audit services not falling within items 2 to 7 above	252	77
Total	**252**	**77**

Note 5.3 Limitation on auditor's liability

The limitation on auditors' liability for external audit work is £1m (2013/14: £5m).

Note 6 Impairment of assets

	2014/15	2013/14
	£000	£000
Impairments charged to the revaluation reserve	13	-
Total net impairments	**13**	**-**

The impairment charge for 2014/15 was in respect of changes in market price and is as a result of a professional valuation of land and buildings carried out as at 31 March 2015 by DTZ, a firm of professional valuers (MRICS).

Note 7 Employee benefits

			2014/15	2013/14
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	49,298	1,913	**51,211**	47,347
Social security costs	3,434	-	**3,434**	3,608
Employer's contributions to NHS pensions	5,215	-	**5,215**	5,046
Pension cost - other	1	-	**1**	-
Agency/contract staff	-	2,039	**2,039**	1,232
Total staff costs	**57,948**	**3,952**	**61,900**	**57,233**
Included within:				
Costs capitalised as part of assets	65	382	**447**	-

Note 7.1 Monthly average number of employees (WTE basis)

	Permanent Number	Other Number	2014/15 Total Number	2013/14 Total Number
Medical and dental	52	1	**53**	133
Administration and estates	291	-	**291**	265
Healthcare assistants and other support staff	169	-	**169**	150
Nursing, midwifery and health visiting staff	618	-	**618**	572
Scientific, therapeutic and technical staff	126	-	**126**	119
Social care staff	-	-	**-**	1
Agency and contract staff	-	75	**75**	-
Bank staff	-	41	**41**	-
Total average numbers	**1,256**	**117**	**1,373**	**1,240**
Of which:				
Number of employees (WTE) engaged on capital projects	11	5	**16**	-

Note 7.2 Retirements due to ill-health

During 2014/15 there were 4 early retirements from the Foundation Trust agreed on the grounds of ill-health (none in the year ended 31 March 2014). The estimated additional pension liabilities of these ill-health retirements is £203k (£0k in 2013/14).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

7.3 Directors' remuneration

The aggregate amounts payable to directors were:

	2014/15 £000	2013/14 £000
Salary	786	951
Taxable benefits	-	-
Performance related bonuses	33	45
Employer's pension contributions	93	114
Total	**912**	**1,110**

Further details of directors' remuneration can be found in the remuneration report.

Note 8 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities.

Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years".
An outline of these follows:

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2015, is based on valuation data as 31 March 2014, updated to 31 March 2015 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates. The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total

pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as “pension commutation”.

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) has been used and replaced the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year’s pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC’s run by the Scheme’s approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

Note 9 Operating leases

Note 9.1 Liverpool Women's NHS Foundation Trust as a lessor

The minimum lease receipts relate to rental income due to the Foundation Trust.

	2014/15	2013/14
	£000	£000
Operating lease revenue		
Minimum lease receipts	304	224
Total	**304**	**224**

	31 March 2015	31 March 2014
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	31	29
- later than one year and not later than five years;	118	118
- later than five years.	1,577	1,587
Total	**1,706**	**1,734**

Note 9.2 Liverpool Women's NHS Foundation Trust as a lessee

All operating leases relate to lease cars, vending machines, photocopiers, printers and water fountains.

	2014/15	2013/14
	£000	£000
Operating lease expense		
Minimum lease payments	77	135
Total	**77**	**135**

	31 March 2015	31 March 2014
	£000	£000
Future minimum lease payments due:		
- not later than one year;	81	51
- later than one year and not later than five years;	175	84
- later than five years.	-	-
Total	**256**	**135**

Note 10 Finance income

	2014/15	2013/14
	£000	£000
Interest on bank accounts	19	26
Total	**19**	**26**

Note 11.1 Finance expenditure

	2014/15	2013/14
	£000	£000
Interest expense:		
Loans from the Independent Trust Financing Facility	42	-
Unwinding of discount on provisions	27	-
Other	-	13
Total interest expense	**69**	**13**

Note 11.2 The late payment of commercial debts (interest) Act 1998

No payments were made for the late payment of commercial debts (2013/14: £nil).

Note 12.1 Intangible assets - 2014/15

	Software licences	Total
	£000	£000
Valuation/gross cost at 1 April 2014 - brought forward	**475**	**475**
Additions	45	**45**
Gross cost at 31 March 2015	**520**	**520**
Amortisation at 1 April 2014 - brought forward	**162**	**162**
Provided during the year	88	**88**
Amortisation at 31 March 2015	**250**	**250**
Net book value at 31 March 2015	**270**	**270**
Net book value at 1 April 2014	**313**	**313**

Note 12.2 Intangible assets - 2013/14

	Software licences	Total
	£000	£000
Valuation/gross cost at 1 April 2013 - as previously stated	**255**	**255**
Additions	220	**220**
Valuation/gross cost at 31 March 2014	**475**	**475**
Amortisation at 1 April 2013 - as previously stated	**114**	**114**
Provided during the year	48	**48**
Amortisation at 31 March 2014	**162**	**162**
Net book value at 31 March 2014	**313**	**313**
Net book value at 1 April 2013	**141**	**141**

Note 12.3 Intangible assets financing 2014/15

	Software licences	Total
	£000	£000
Net book value at 31 March 2015		
Purchased	270	**270**
Finance leased	-	**-**
Donated and government grant funded	-	**-**
NBV total at 31 March 2015	**270**	**270**

Note 12.4 Intangible assets financing 2013/14

	Software licences	Total
	£000	£000
Net book value 31 March 2014		
Purchased	313	**313**
Finance leased	-	**-**
Donated and government grant funded	-	**-**
NBV total at 31 March 2014	**313**	**313**

Note 13.1 Property, plant and equipment - 2014/15

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2014 - brought forward	**4,000**	**57,127**	**400**	**301**	**19,635**	**8,273**	**412**	**90,148**
Additions	-	1,001	-	853	894	2,666	44	**5,458**
Impairments	-	(13)	-	-	-	-	-	**(13)**
Reclassifications	-	-	-	(301)	-	301	-	**-**
Revaluations	-	1,838	22	-	-	-	-	**1,860**
Transfers to/ from accumulated depreciation		(8,297)	(152)	-	-	-	-	**(8,449)**
Disposals / derecognition	-	-	-	-	(243)	-	-	**(243)**
Valuation/gross cost at 31 March 2015	**4,000**	**51,656**	**270**	**853**	**20,286**	**11,240**	**456**	**88,761**
Accumulated depreciation at 1 April 2014 - brought forward	**-**	**7,437**	**149**	**-**	**14,021**	**4,384**	**358**	**26,349**
Provided during the year	-	860	3	-	1,312	1,602	40	**3,817**
Revaluations	-	-	-	-	-	-	-	**-**
Transfers to/ from accumulated depreciation		(8,297)	(152)	-	-	-	-	**(8,449)**
Disposals/ derecognition	-	-	-	-	(201)	-	-	**(201)**
Accumulated depreciation at 31 March 2015	**-**	**-**	**-**	**-**	**15,132**	**5,986**	**398**	**21,516**
Net book value at 31 March 2015	**4,000**	**51,656**	**270**	**853**	**5,154**	**5,254**	**58**	**67,245**
Net book value at 1 April 2014	**4,000**	**49,690**	**251**	**301**	**5,614**	**3,889**	**54**	**63,799**

Note 13.2 Property, plant and equipment - 2013/14

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2013 - as previously stated	**4,000**	**52,175**	**385**	**301**	**18,701**	**7,252**	**403**	**83,217**
Additions - purchased/ leased/ grants/ donations	-	1,813	-	-	959	1,021	9	**3,802**
Revaluations	-	3,139	15	-	-	-	-	**3,154**
Disposals / derecognition	-	-	-	-	(25)	-	-	**(25)**
Valuation/gross cost at 31 March 2014	**4,000**	**57,127**	**400**	**301**	**19,635**	**8,273**	**412**	**90,148**
Accumulated depreciation at 1 April 2013 - as previously stated	**-**	**6,621**	**146**	**-**	**12,763**	**3,214**	**266**	**23,010**
Provided during the year	-	816	3	-	1,258	1,170	92	**3,339**
Accumulated depreciation at 31 March 2014	**-**	**7,437**	**149**	**-**	**14,021**	**4,384**	**358**	**26,349**
Net book value at 31 March 2014	**4,000**	**49,690**	**251**	**301**	**5,614**	**3,889**	**54**	**63,799**
Net book value at 1 April 2013	**4,000**	**45,554**	**239**	**301**	**5,938**	**4,038**	**137**	**60,207**

Note 13.3 Property, plant and equipment financing - 2014/15

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2015								
Owned	4,000	51,536	268	853	5,154	5,254	58	**67,123**
Finance leased	-	-	-	-	-	-	-	**-**
Government granted	-	-	-	-	-	-	-	**-**
Donated	-	120	2	-	-	-	-	**122**
NBV total at 31 March 2015	**4,000**	**51,656**	**270**	**853**	**5,154**	**5,254**	**58**	**67,245**

Note 13.4 Property, plant and equipment financing - 2013/14

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2014								
Owned	4,000	49,547	251	301	5,607	3,889	54	**63,649**
Finance leased	-	-	-	-	-	-	-	**-**
Government granted	-	-	-	-	-	-	-	**-**
Donated	-	143	-	-	7	-	-	**150**
NBV total at 31 March 2014	**4,000**	**49,690**	**251**	**301**	**5,614**	**3,889**	**54**	**63,799**

Note 14 Revaluations of property, plant and equipment

Valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Standards. An assessment of the value of the Trust's land and buildings was carried out by DTZ, a firm of professionally qualified, RICS Registered surveyors and valuers, at 31 March 2015. The Depreciated Replacement Cost (DRC) basis of valuation was used to value land and buildings.

Note 15.1 Investments - 2014/15

	Investments in associates (and joint arrangements)
	£000
Carrying value at 1 April 2014	**-**
Share of profit/(loss)	10
Carrying value at 31 March 2015	**10**

Note 15.2 Investments - 2013/14

	Investments in associates (and joint arrangements)
	£000
Carrying value at 1 April 2013	**-**
Share of profit/(loss)	-
Carrying value at 31 March 2014	**-**

Note 16 Disclosure of interests in other entities

A Joint Venture Agreement between Liverpool Women's and Kings College Hospital (KCH) was approved on 6 November 2014 in relation to the provision of assisted conception services. Profits and Losses of the Joint Venture will be shared between Liverpool Women's and KCH on a 50/50 basis. Details of the profit in the accounts of Liverpool Women's is disclosed in note 15.

The gross assets of the Joint Venture shared between Liverpool Women's and KCH are £342k (2013/14: £0k).

Note 17 Inventories

	31 March 2015	31 March 2014
	£000	£000
Drugs	166	164
Consumables	144	144
Total inventories	**310**	**308**

Inventories recognised in expenses for the year were £1,879k (2013/14: £1,741k). Write-down of inventories recognised as expenses for the year were £0k (2013/14: £26k).

Note 18.1 Trade receivables and other receivables

	31 March 2015	31 March 2014
	£000	£000
Current		
Trade receivables due from NHS bodies	2,173	2,152
Receivables due from NHS charities	445	269
Provision for impaired receivables	(538)	(687)
Deposits and advances	21	26
Prepayments (non-PFI)	930	595
Accrued income	231	189
VAT receivable	104	176
Other receivables	564	1,079
Total current trade and other receivables	**3,930**	**3,799**
Non-current		
Provision for impaired receivables	(12)	-
Other receivables	63	-
Total non-current trade and other receivables	**51**	**-**

Note 18.2 Provision for impairment of receivables

	2014/15	2013/14
	£000	£000
At 1 April as previously stated	**687**	**687**
Prior period adjustments	-	-
At 1 April - restated	**687**	**687**
At start of period for new FTs	**-**	**-**
Transfers by absorption	-	-
Increase in provision	298	628
Amounts utilised	-	-
Unused amounts reversed	(435)	(628)
At 31 March	**550**	**687**

The current provision for impairment of receivables has been identified following a review of all debt greater than 90 days old. This is conducted on a line by line basis to determine whether the debt is deemed collectable or not.

The non-current provision for impairment of receivables is in respect of injury cost recovery income due. A percentage of the amount receivable is provided for which is currently set at 18.9%.

Note 18.3 Analysis of impaired receivables

	31 March 2015		31 March 2014	
	Trade receivables	Other receivables	Trade receivables	Other receivables
Ageing of impaired receivables	**£000**	**£000**	**£000**	**£000**
0 - 30 days	-	12	-	-
30-60 Days	-	-	-	-
60-90 days	-	-	-	-
90- 180 days	247	-	274	-
Over 180 days	291	-	413	-
Total	**538**	**12**	**687**	**-**
Ageing of non-impaired receivables past their due date				
0 - 30 days	1,043	-	3,204	-
30-60 Days	152	-	-	-
60-90 days	105	-	-	-
90- 180 days	394	-	-	-
Over 180 days	157	-	-	-
Total	**1,851**	**-**	**3,204**	**-**

The Foundation Trust has no concerns over the credit quality of receivables above that are neither past due nor impaired.

Note 19.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2014/15	2013/14
	£000	£000
At 1 April	**5,388**	**11,660**
Prior period adjustments	-	-
At 1 April (restated)	**5,388**	**11,660**
At start of period for new FTs	**-**	**-**
Transfers by absorption	-	-
Net change in year	720	(6,272)
At 31 March	**6,108**	**5,388**
Broken down into:		
Cash at commercial banks and in hand	69	1
Cash with the Government Banking Service	6,039	5,387
Deposits with the National Loan Fund	-	-

Other current investments	-	-
Total cash and cash equivalents as in SoFP	**6,108**	**5,388**
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	**6,108**	**5,388**

Note 19.2 Third party assets held by the NHS foundation trust

Liverpool Women's NHS Foundation Trust held no monies on behalf of patients or other parties at 31 March 2015 (31 March 2014: £nil).

Note 20.1 Trade and other payables

	31 March 2015	31 March 2014
	£000	£000
Current		
Receipts in advance	-	-
NHS trade payables	1,286	977
Amounts due to other related parties	-	-
Other trade payables	2,436	2,206
Capital payables	144	-
Social security costs	535	1,210
VAT payable	-	-
Other taxes payable	564	528
Other payables	601	1,070
Accruals	1,875	2,221
PDC dividend payable	-	-
Total current trade and other payables	**7,441**	**8,212**

Note 21 Other liabilities

	31 March 2015	31 March 2014
	£000	£000
Current		
Other deferred income	787	794
Total other current liabilities	**787**	**794**
Non-current		
Other deferred income	1,675	1,720
Total other non-current liabilities	**1,675**	**1,720**

Note 22 Borrowings

	31 March 2015	31 March 2014
	£000	£000
Current		
Loans from the Independent Trust Financing Facility	306	-
Total current borrowings	**306**	**-**
Non-current		
Loans from the Independent Trust Financing Facility	5,194	-
Total non-current borrowings	**5,194**	**-**

Note 23.1 Provisions for liabilities and charges analysis

	Pensions - other staff	Other legal claims	Re-structurings	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2014	**670**	**862**	**168**	**-**	**1,700**
Change in the discount rate	87	-	-	-	**87**
Arising during the year	-	43	159	188	**390**
Utilised during the year	(62)	(76)	(10)	-	**(148)**
Reversed unused	(62)	(307)	(158)	-	**(527)**
Unwinding of discount	27	-	-	-	**27**
At 31 March 2015	**660**	**522**	**159**	**188**	**1,529**
Expected timing of cash flows:					
- not later than one year;	61	522	159	188	**930**
- later than one year and not later than five years;	246	-	-	-	**246**
- later than five years.	353	-	-	-	**353**
Total	**660**	**522**	**159**	**188**	**1,529**

"Pensions - other staff" provisions are for early retirements and reflect actuarial forecasts in respect of duration of payments, the life expectancy of the persons involved and current value of the future stream of payment flows.

"Other Legal Claims" provisions comprise amounts due as a result of third party and employee liability claims. The values are informed by information provided by third party solicitors. In respect of the LTPS provision this reflects the probability of the cases being settled as estimated by the NHS Litigation Authority.

"Re-structurings" provisions have arisen form the outcome of organisational change proposals that are anticipated to be finalised within the next year.

The "Other" provision is for abortive costs relating to the Combined Heat and Power (CHP) Project if the Foundation Trust is to withdraw following the signing of the Preferred Bidder Letter.

Note 23.2 Clinical negligence liabilities

At 31 March 2015, £133,047k was included in provisions of the NHSLA in respect of clinical negligence liabilities and Existing Liabilities Scheme of Liverpool Women's NHS Foundation Trust (31 March 2014: £115,852k).

Note 24 Contingent assets and liabilities

	31 March 2015	31 March 2014
	£000	£000
Value of contingent liabilities		
NHS Litigation Authority legal claims	(15)	-
Employment tribunal and other employee related litigation	-	-
Redundancy	-	-
Other	-	-
Gross value of contingent liabilities	**(15)**	**-**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(15)**	**-**
Net value of contingent assets	**-**	**-**

"NHS Litigation Authority Legal Claims" contingent liabilities are in relation to the legal claims notified by the NHS Litigation Authority in relation to the LTPS.

Note 25 Contractual capital commitments

	31 March 2015	31 March 2014
	£000	£000
Property, plant and equipment	3,900	36
Intangible assets	-	-
Total	**3,900**	**36**

Note 26 Financial instruments

Note 26.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Foundation Trust has with commissioners and the way those commissioners are financed, the Foundation Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than

would be typical of listed companies, to which the financial reporting standards mainly apply. Financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Foundation Trust in undertaking its activities.

The Foundation Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Foundation Trust's standing financial instructions and policies agreed by the board of directors. The Foundation Trust's treasury activity is subject to review by the Foundation Trust's internal auditors.

Currency risk

The Foundation Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Foundation Trust has no overseas operations and only had negligible foreign currency income or expenditure transactions. The Foundation Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Foundation Trust borrows from the Department of Health in the form of the Independent Trust Financing Function (ITFF). The borrowing is for 10 years and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Foundation Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Foundation Trust's revenue comes from contracts with other public sector bodies, the Foundation Trust has low exposure to credit risk. The maximum exposures as at 31 March 2015 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Foundation Trust's operating costs are incurred under SLAs with other NHS providers, which are financed from resources voted annually by Parliament. The Foundation Trust receives regular monthly payments from CCGs based on an agreed contract value with adjustments made for actual services provided. The availability of a working capital facility with the Foundation Trust's bankers mitigates the risk arising from potential variations in income arising from delivery of patient care services. The Foundation Trust funds its capital expenditure from either internally generated funds or PDC made available by the Department of Health. The Foundation Trust is not, therefore, exposed to significant liquidity risks.

Price risk

The contracts from NHS commissioners in respect of healthcare services have a predetermined price structure which negates the risk of price fluctuation.

Note 26.2 Financial assets

	Loans and receivables	Total
	£000	£000
Assets as per SoFP as at 31 March 2015		
Trade and other receivables excluding non financial assets	2,716	**2,716**
Cash and cash equivalents at bank and in hand	6,108	**6,108**
Total at 31 March 2015	**8,824**	**8,824**

	Loans and receivables	Total
	£000	£000
Assets as per SoFP as at 31 March 2014		
Trade and other receivables excluding non financial assets	3,204	**3,204**
Cash and cash equivalents at bank and in hand	5,388	**5,388**
Total at 31 March 2014	**8,592**	**8,592**

Note 26.3 Financial liabilities

	Other financial liabilities	Total
	£000	£000
Liabilities as per SoFP as at 31 March 2015		
Borrowings excluding finance lease and PFI liabilities	5,500	**5,500**
Trade and other payables excluding non financial liabilities	6,906	**6,906**
Provisions under contract	1,529	**1,529**
Total at 31 March 2015	**13,935**	**13,935**

	Other financial liabilities	Total
	£000	£000
Liabilities as per SoFP as at 31 March 2014		
Borrowings excluding finance lease and PFI liabilities	-	**-**
Trade and other payables excluding non financial liabilities	6,474	**6,474**
Provisions under contract	1,700	**1,700**
Total at 31 March 2014	**8,174**	**8,174**

Note 26.4 Maturity of financial liabilities

	31 March 2015	31 March 2014
	£000	£000
In one year or less	8,142	6,748
In more than one year but not more than two years	674	1,036
In more than two years but not more than five years	2,020	-
In more than five years	3,100	390
Total	**13,935**	**8,174**

Note 26.5 Fair values of non-current financial liabilities at 31 March 2015

	Book value	Fair value
	£000	£000
Non-current trade and other payables excluding non financial liabilities	-	-
Provisions under contract	599	599
Loans	5,194	5,194
Other	-	-
Total	**5,793**	**5,793**

Note 27 Losses and special payments

	2014/15		2013/14	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	1	1	-	-
Total losses	**1**	**1**	**-**	**-**
Special payments				
Ex-gratia payments	2	5	-	-
Total special payments	**2**	**5**	**-**	**-**
Total losses and special payments	**3**	**6**	**-**	**-**
Compensation payments received		-		-

Note 28 Events after the reporting date

There were no events after the reporting period.

Note 29 Related parties

Transactions with related parties are undertaken on a normal commercial basis.

During the year none of the Department of Health Ministers, Foundation Trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Liverpool Women's NHS Foundation Trust.

Liverpool Women's NHS Foundation Trust is a public interest body authorised by Monitor, the Independent Regulator for NHS foundation trusts. It undertakes as part of its ongoing provision of healthcare services, in accordance with the terms of its authorisation, a number of transactions with bodies defined as being within the

scope of the Whole of Government Accounts (WGA) including the Department of Health and other entities that the Department is regarded as the parent department.

During the year Liverpool Women's has had a significant number of material transactions (totalling £1million or more) with the Department, and with other entities for which the Department is regarded as the parent Department. In addition, the Foundation Trust has material transactions with other government departments. Transactions and balances with these organisations are disclosed below.

	Receivables		Payables	
	31 March 2015	31 March 2014	31 March 2015	31 March 2014
	£000	£000	£000	£000
NHS Halton CCG	12	(41)	-	-
NHS Knowsley CCG	126	23	-	-
NHS Liverpool CCG	519	279	-	-
NHS South Sefton CCG	229	65	-	-
NHS Southport and Formby CCG	10	123	17	-
NHS St Helens CCG	43	6	-	-
NHS Warrington CCG	3	(29)	-	-
NHS Wirral CCG	-	(63)	22	-
Health Education England	1	23	-	-
Cheshire, Warrington and Wirral Area Team	-	36	-	-
Aintree University Hospitals NHS Foundation Trust	16	7	62	49
Alder Hey Childrens NHS Foundation Trust	94	138	506	123
Royal Liverpool & Broadgreen University Hospitals NHS Trust	303	-	280	-
NHS Litigation Authority	-	-	-	-
NHS Pension Scheme	-	-	742	700
HM Revenue and Customs	104	-	1,099	1,038
Welsh Health Bodies - Betsi Cadwaladr University Local Health Board	9	(26)	-	-
Total	**1,469**	**541**	**2,728**	**1,910**

	Income		Expenditure	
	2014/15	2013/14	2014/15	2013/14
	£000	£000	£000	£000
NHS Halton CCG	1,462	1,446	-	
NHS Knowsley CCG	6,509	6,015	-	
NHS Liverpool CCG	37,096	35,522	-	
NHS South Sefton CCG	9,266	9,066	-	
NHS Southport and Formby CCG	1,178	1,056	-	
NHS St Helens CCG	1,197	1,146	-	
NHS Warrington CCG	1,199	1,196	-	
NHS Wirral CCG	2,469	2,577	-	
Health Education England	5,052	5,218	-	
Cheshire, Warrington and Wirral Area Team	16,386	16,177	-	
Aintree University Hospitals NHS Foundation Trust	158	179	1,182	1,388

Alder Hey Childrens NHS Foundation Trust	445	454	1,132	1,058
Royal Liverpool & Broadgreen University Hospitals NHS Trust	442	-	2,792	2,882
NHS Litigation Authority	-	-	6,689	5,955
NHS Pension Scheme	-	-	5,215	5,046
HM Revenue and Customs	-	-	3,442	3,608
Welsh Health Bodies - Betsi Cadwaladr University Local Health Board	1,032	695	-	-
Total	**83,891**	**80,747**	**20,452**	**19,937**

Liverpool Women's NHS Foundation Trust

Crown Street

Liverpool

L8 7SS

Telephone: 0151 708 9988

Fax: 0151 702 4028

Web: www.liverpoolwomen.nhs.uk

Twitter: @LiverpoolWomens