Liverpool Women's NHS Foundation Trust

Dedicated to you

Quality Report

Liverpool Women's NHS Foundation Trust

2013-14

Contents

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

These are challenging times and the life of a Chief Executive is both demanding and difficult. It is also a rewarding one and an enormous privilege. Despite the financial pressures that we cannot ignore, Liverpool Womens has placed a strong emphasis on maintaining, delivering and celebrating the provision of high quality care for our patients. This Quality Report seeks to recognise some of those achievements whilst identifying areas where we are striving to improve the care we provide. I hope it provides a useful source of information for all those who take an interest in the care we provide.

There have been many highlights during a year in which the Trust celebrated the 18th birthday of the Liverpool Women's Hospital at Crown Street.

In April we were joined by Dame Sally Davies, Chief Medical Officer for the opening of our Centre for Women's Health Research and Centre for Better Births in collaboration with the University of Liverpool. We are delighted to be working together with our partners in the University of Liverpool and hope that our research will benefit not only the women of Liverpool but women all over the world.

Following significant investment in new technologies, and led by our world-leading team of clinicians and scientists, the Hewitt Fertility Centre is achieving the best outcomes for embryo implantation rates in the UK (and comparable with best in world). They achieved the world's first birth using Eeva technology to assess embryo quality and were shortlisted in HSJ's innovation in Healthcare award. We have now opened a satellite clinic in Knutsford allowing us to offer the benefits of this quality service to more couples needing fertility treatment.

This year we received an unannounced visit by the CQC who raised a concern about staffing levels in midwifery. The issue was not a surprise to us and is something we have been aware of and responding to for some time. We have worked for several years to influence the Maternity tariff nationally as it has been clearly demonstrated that the maternity tariff is inadequate to provide recommended staffing levels of doctors or midwives. The problem was recently raised before and discussed by the Parliamentary audit committee. Despite this we have invested significantly in appointing more midwives to our Trust with an aim to provide a better experience for all our women and our staff. A reflection of the work that we have carried out over the year and in response to the CQC visit is that the CQC's Intelligent Monitoring report, March 2014 classified the Trust in Band 6 which is the lowest risk band.

Moving forward, the Trust is keen to improve our response to complaints and to develop a robust system for the ordering, reporting and reviewing of investigation results. These are 2 areas that we have identified that can improve the quality and safety of our services. We will also continue with our efforts to build on the success of our social media development following the successful launch of out Twitter and Facebook accounts which clearly appeal to many of our service-users.

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

1.1 Service Vignettes

We present below, some brief narratives explaining changes in practice and quality improvement effected in the last 12 months.

1.1.1 Maternity / Neonatal - Transitional Care (TC) Service

The TC service was re-launched in October 2013 following relocation to an improved area, giving mothers more space and natural daylight. The staffing establishment for this service was also increased with the aim of having one registered, and one non-registered, staff member on every shift. This additional input from the registered staff member allowed for more direct care planning within the TC area, and allowed earlier identification of babies on the maternity wards who might require admission to the neonatal unit.
Since the service has been in place there has been a reduction in term admissions from 8.1% to 4.9% with an additional average of 7 babies, 37 weeks or more and 3 babies under 37 weeks staying with their mother rather than being admitted to NICU.
During this period the average score on the friends and family test results was 9.59 out of a possible score of 10 with comments such as:

- “I cannot praise the staff highly enough, particularly the neonatal nurses on TC. They have provided outstanding physical, emotional and moral support.”
- “Without TC I would not be able to have my baby by my side which left me emotional and also gave me the opportunity to bond”

1.1.2 Neonatal - High Flow Therapy

High Flow Oxygen Therapy is a relatively new technique enabling the delivery of humidified oxygen to babies. In 2013, this method of respiratory support was trialled on the unit. Nurses and parents whose babies had been on our usual method of support (nasal CPAP) were asked for their opinions on the therapy. The therapy was used in 19 babies with 38 parents completing questionnaires. All the parents who responded preferred the high flow therapy to nasal CPAP. Half of the babies were able to establish feeds on the therapy and half were able to be given their first bath, neither of which is possible with CPAP.. Following this successful evaluation, high flow therapy has now been introduced as a routine treatment on the neonatal unit.

1.1.3 Neonatal - Discharge Planning

The discharge of babies from the neonatal unit can be complicated both by medical and social issues. Previously discharge planning would be left until only a few days prior to discharge. A new system was introduced Autumn 2013 in which health and social concerns are explicitly identified and documented on all babies on the neonatal unit at a weekly multidisciplinary meeting. This approach allows earlier identification of issues and liaison and sharing of concerns with external agencies (such as social services) earlier in each neonatal admission than previously and enables the provision of more holistic care. A recent evaluation (April 2014) identified that 100% of babies who were on the unit (n=87) were discussed at least once at the discharge planning meeting.

1.1.4 The Cheshire and Merseyside Genetics Service – Patient Story

The Cheshire and Merseyside Genetics Service is based in Liverpool Women's Hospital and is one of only 23 Regional Genetic Services in the UK. The Service provides Genetic testing for a population of 2.8 million across the Region and uses state-of-the-art technology to ensure the provision of the most up to date testing for the patients served.

The NHS Constitution (March 2013) states that *"The NHS belongs to the people…..It works at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health…"* This is a value that is reflected daily, in the delivery of service provision from the Genetic Service at Liverpool Women's Hospital. A value that is reflected in the exemplar practices evidenced in this Genetic Service, that was highlighted in the Barnes Review of Pathology Quality Assurance (January 2014) and the National Quality Dashboards against which this Service is benchmarked for quality. This Regional Genetic Service is a flagship of what works well in the NHS providing services at the highest quality standards and using validated and assured state of the art technology.

What does this mean to patients?

John is a Patient in Genetics; we have been seeing John, in Genetics, as an outpatient for 18 years. A diagnosis has eluded us all that time because we just have not previously had the technology that is sensitive enough to find out what was wrong with John. John came to our attention when he was born 18 years ago at Liverpool Women's with hypotonia and was a 'floppy' baby. He was admitted to the Neonatal unit and discharged 5 weeks later, having shown some progression, but we had not managed to diagnose the cause of his clinical condition based on the technology at that time. When he was 5 years old John presented at Alder Hey Children's Hospital with progressive wasting of muscles in his hands and feet, caused by damage of nerves. This progressed to clumsiness due to shrinking and damage to his cerebellum. In the past 10 years, John has become immobile and needs a wheelchair, and yet we have struggled to diagnose him and provide his family with the information they so desperately needed on the cause of this.

John's care over the past 18 years has included more than 50 clinic visits, 100's of esoteric and expensive laboratory tests including neurophysiological tests, which were unpleasant. John has been subjected to 4 (MRI /PET /ECG / Ultrasound) scans. He has had tests sent to a collection of EU laboratories, each test costing between £700 and £800. In total the NHS has spent around £25,000 over 18 years trying to get diagnosis for John and for this family. This is not an unusual story for patients like John.

Late last year John's mother found she was pregnant, the families major concern was that this child might also suffer the same disorder as John and this caused them a great deal of anxiety.

Because we had recently introduced new Genomic technology called microarrays or array comparative genomic hybridization (aCGH) for both prenatal and postnatal patients, we were able to carry out whole genome analysis using a microarray technology on a DNA sample form John, this test cost only £300. We were able to detect an abnormality so small it was not previously seen by the old technology, this abnormality affects the development pathway, it was not previously thought about as a cause for John's problems because infants with these disorders rarely survive.

We were then able to look for this abnormality in the fetus, carried by John's Mother, we were able to reassure the family that the fetus did not carry the abnormality and would therefore not have the problems John had experienced, which reassured the parent's.

As for John, having a diagnosis has made his condition easier to live with; the clinical team has now been able to tailor his management and treatment to more effectively handle his condition.

If a family has a diagnosis it may not always be possible to treat the individuals affected, but there are clear benefits to having a diagnosis, for family members and for future reproduction. Having a diagnosis also allows us to understand the mechanism of disease, manage patients better, provide them with valuable information they are desperately seeking and produce new treatments**.**

The advent of this state-of-the art technology such as Genomics in Liverpool Women's Hospital has provided us with the tools to tackle difficult problems and save money. By Testing Individuals up front we are able to now diagnose 25% more cases previously too difficult to diagnose, and save these individuals a whole raft of other unnecessary tests.

1.1.5 Social Media

During the last year the Trust has continued to develop its internet and social media presence.

There are regular Blogs posted on the Trust Web site, for the Chief Executive and Director of Nursing & Midwifery and both a Clinical and Patient Blog.

The Trust has also established the following Twitter accounts:
@LiverpoolWomens, @HewittFertility, @ Catharine_Med and the Maple team in Kirkby have set up 'Tweet the Midwife'.

For Facebook accounts please search for: Liverpool Women's Hospital, The Hewitt Fertility Centre and Catharine Medical Centre.

We encourage you to use these media to engage with the Trust and to see for yourself the experiences and comments posted by our patients.

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

2.1 Progress with Priorities for Improvement 2013-14

2.1.1 Patient Safety

2.1.1.1 Elective Surgical Site Infection

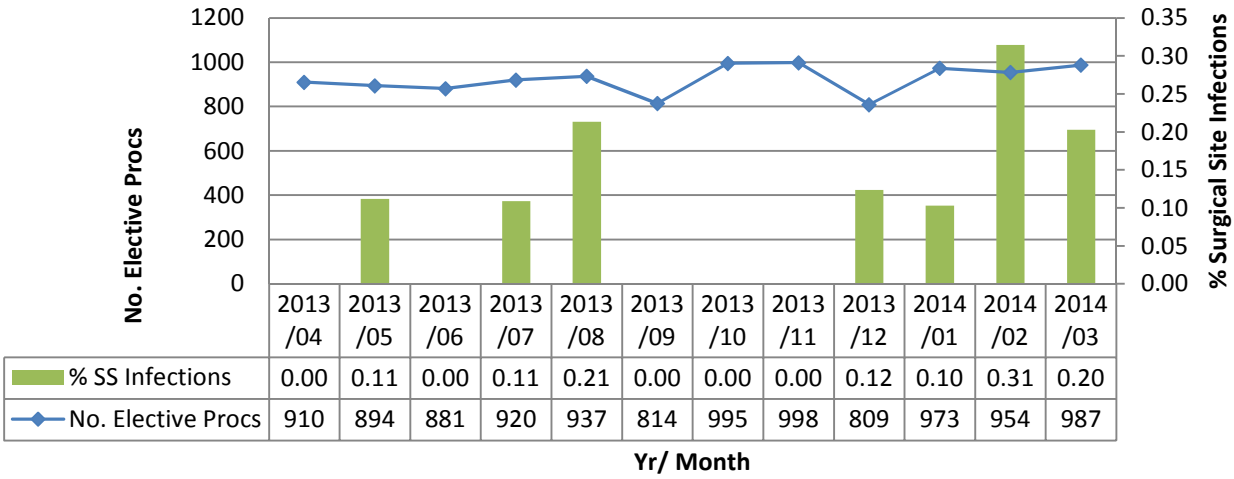
Description:
The number of elective Gynaecology patients with an infection expressed a proportion of all elective Gynaecology patients undergoing a surgical procedure.
Post-operative infections are important both to the individual patients involved, but also to the hospital as they can provide a marker as to the effectiveness of our care of patients before during and after operations.

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.
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.

Important because:
Post-operative infections occur in about 5% patients after operations, and can cause delays in recovery and return to health A reduction in the incidence of infection will have a significant impact on patient recovery.

Trust Sponsor / Lead: Mr Robert McDonald, Consultant Gynaecological Oncologist/ Gynaecology Clinical Governance lead.

Progress made in report period 2013-14



	2013/04	2013/05	2013/06	2013/07	2013/08	2013/09	2013/10	2013/11	2013/12	2014/01	2014/02	2014/03
% SS Infections	0.00	0.11	0.00	0.11	0.21	0.00	0.00	0.00	0.12	0.10	0.31	0.20
No. Elective Procs	910	894	881	920	937	814	995	998	809	973	954	987

Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Av.
2011/12	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
2012/13	0.00	0.00	0.00	0.00	0.12	0.12	0.00	0.12	0.34	0.13	0.12	0.23	0.10
2013/14	0.00	0.11	0.00	0.11	0.21	0.00	0.00	0.00	0.12	0.10	0.31	0.20	0.10

Data from 2010 suggested a recorded infection rate of 0.3%. Since then the rate has fallen to a consistent 0.1% recorded-post operative infection rate.

The Liverpool Women's NHS Foundation Trust considers that this data is as described for the following reason:
Data collected from hospital records is a limited snap shot of actual patient experience, but is an effective way of comparing our performance over time as the data collection is consistent. WE cannot exclude the possibility that the actual rate of wound infection post operatively may be considerably higher than that recorded here, due to many factors (patients presenting post operatively to their GP and not to the hospital, or incomplete recording of information in the hospital records), but it does provide a record of our performance over time.

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.

How progress to achieve the priority goal is reported

Infection rates are reported on a 6 monthly basis to the Clinical Governance Committee, and also reviewed twice monthly within the Matrons report to the Infection Control Committee.

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:

- Continuing to focus on infection as a priority, with ongoing development of the WHO surgical checklist and its implementation, training and education of staff around No Touch Technique for invasive procedures, and regular review of the infection data collected.

2.1.1.2 Non-Elective Surgical site Infection

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.

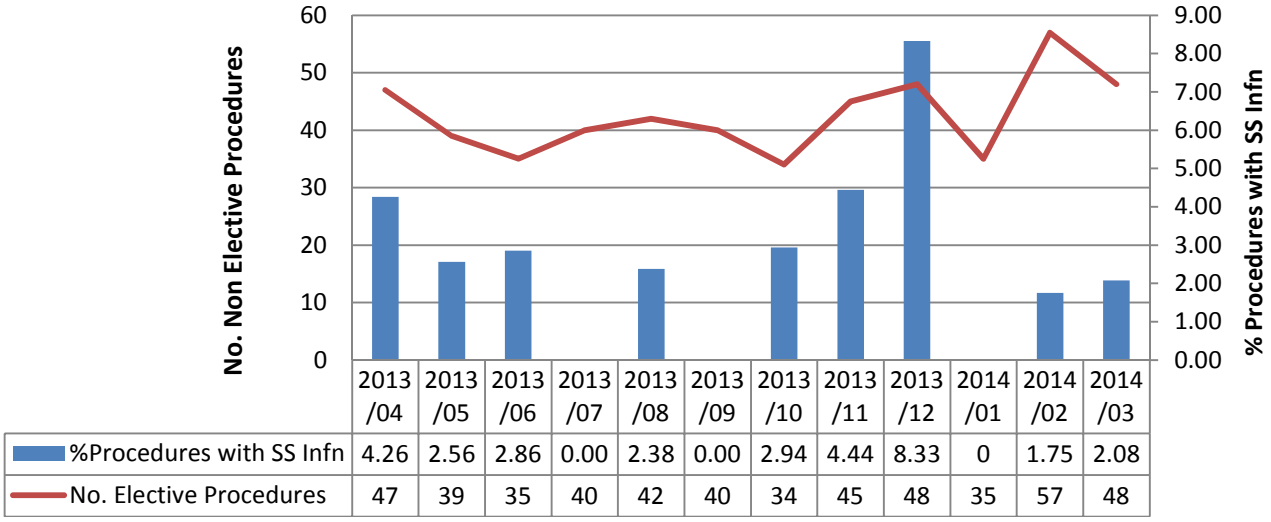
Important because:
A reduction in the incidence of infection will have a significant impact on patient recovery. Post-operative infections are important both to the individual patients involved, but also to the hospital

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 high than for elective cases, and this need to be a focus for the Trust.

Trust Sponsor / Lead: Mr Robert MacDonald, Consultant Gynaecological Oncologist/ Gynaecology Clinical Governance lead.

Progress made in report period 2013-14



Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Av.
2011/12	2.50	2.44	0.00	0.00	2.94	0.00	2.00	0.00	5.71	0.00	0.00	0.00	1.30
2012/13	0.00	0.00	0.00	0.00	0.00	0.00	0.00	2.13	0.00	4.88	0.00	0.00	0.58
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

An average post-operative infection rate of 3% is markedly higher than the elective rate of 0.1%. The greater risk of complications after emergency surgery is in part related to this, but with no improvement in this figure (and indeed a worsening of the data for Dec 2013 shown below) this needs further attention and focus.
The increase in infections has been registered and is part of the Gynaecology Risk agenda for the coming year. There are no clear causes known at this time (indeed a recent audit of post-operative wound infections in 2014 showed a good compliance with antibiotic prophylaxis and skin preparation prior to surgery) but the information in this report will be highlighted with the clinical staff and a plan to focus on infection in emergency cases developed over the coming months.

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

- This relative discrepancy between the elective and emergency data is in part due to the higher risk of post-operative complications in emergency situations, but also needs further work to identify what can be done to improve this.

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.

A monthly review of the emergency infection data is underway, with a report back to the Clinical Governance committee and Infection Control Committee during 2014.

How progress to achieve the priority goal is reported

This measure will be part of Gynaecological Clinical Governance reports in June 2014 and the Quality report in 2015

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:

- a review of the use of the WHO surgical checklist in emergency cases and a focus on emergency admissions and surgery in staff training and education.

2.1.1.3 Incidence of Multiple Pregnancy

Description:

The multiple pregnancy rates calculated as a proportion of all clinical pregnancies.

Why and how this priority goal was selected:

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 by the Unit Management team.

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.

Important because:

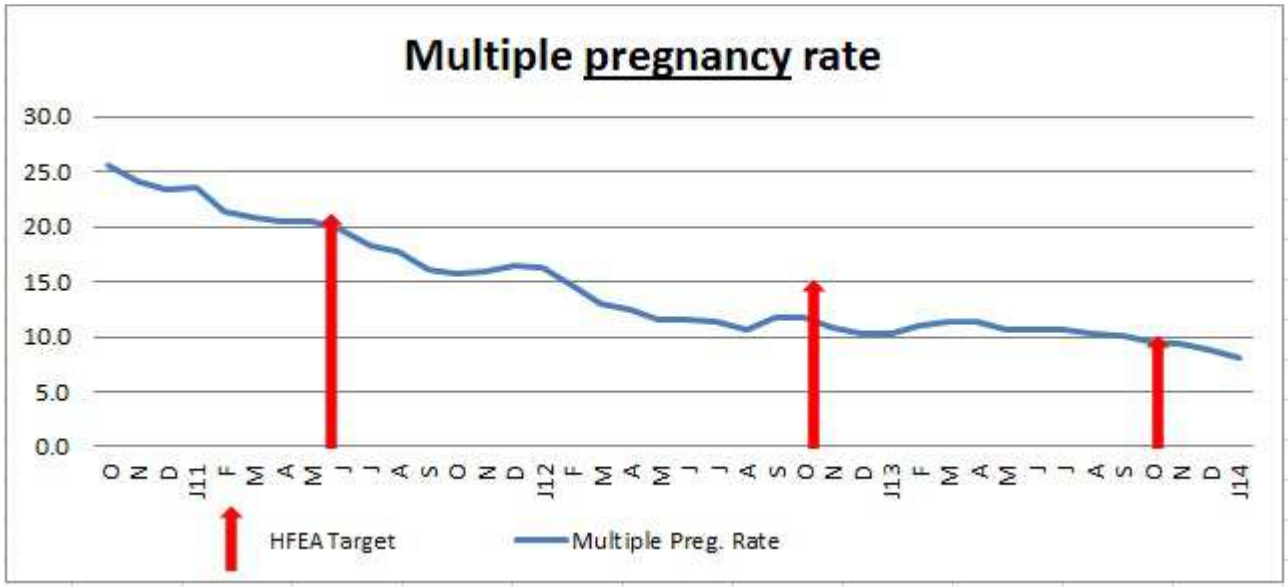
Collection of multiple pregnancy rate data on a monthly basis allows the Hewitt Fertility centre to monitor its performance in relation to the HFEA's targets and, where necessary make adjustments to its Multiple Birth Minimisation Strategy, the latter being an HFEA requirement.

Trust Sponsor / Lead: Andrew Drakeley, Consultant Gynaecologist / Karen Schnauffer, Consultant Clinical Embryologist

Progress made in report period 2013-14

The figure below shows the multiple pregnancy rate on a monthly basis for the previous 39 month period. This allows us to monitor progress towards the HFEA's targets (shown below by red arrows) The HFEA target for the period Oct 12 - Sept 13 was that no more than 10% of live births generated in this period should be multiples.

The graph demonstrates that the Hewitt Centre has achieved the HFEA target of 10% multiple pregnancy rate. Note that we show the clinical pregnancy rate (fetal heart beat seen on scan). The live birth rate for month follows 9 months later and will be slightly lower still.



Nb. Red arrows indicate the introduction and level of the HFEA's reducing targets for incidence of multiple births

	2013/01	2013/02	2013/03	2013/04	2013/05	2013/06	2013/07	2013/08	2013/09	2013/10	2013/11	2013/12	2014/01
No singletons	467	461	446	471	480	493	512	529	538	555	582	573	628
No twins	53	57	57	60	57	59	61	60	60	58	60	56	55
No trips	0	0	0	0	0	0	0	0	0	0	0	0	0
Multiple Pregnancy Rate	10.2%	11.0%	11.3%	11.3%	10.6%	10.7%	10.6%	10.2%	10.0%	9.5%	9.3%	8.9%	8.1%

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 multiple pregnancy rates (MPR) are calculated as the number of fetal hearts detected by ultrasound scan divided by the number clinical pregnancies x 100.

Data is supplied by the Reproductive Medicine unit. Once received the data is manually entered into the storage data table. Please note though that the data is always approximately 3 months behind.

By employing a selective single embryo transfer policy and monitoring the biochemical and clinical pregnancy rates on a monthly basis, as a more immediate check on twin rate, we have been able to show a steady decline in twin rate, whilst maintaining our overall clinical pregnancy rate.

How progress to achieve the priority goal is reported

Multiple pregnancy rate data derived and examined within the Hewitt Fertility Centre are supplied monthly to the Trust. Once received these data are manually entered into the storage data table. Please note, however, that the data are always approximately 3 months behind due to the time taken to establish a pregnancy. Outcome data is shared internally at the Hewitt Centre Quality

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 percentage 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 (at 5 mins)

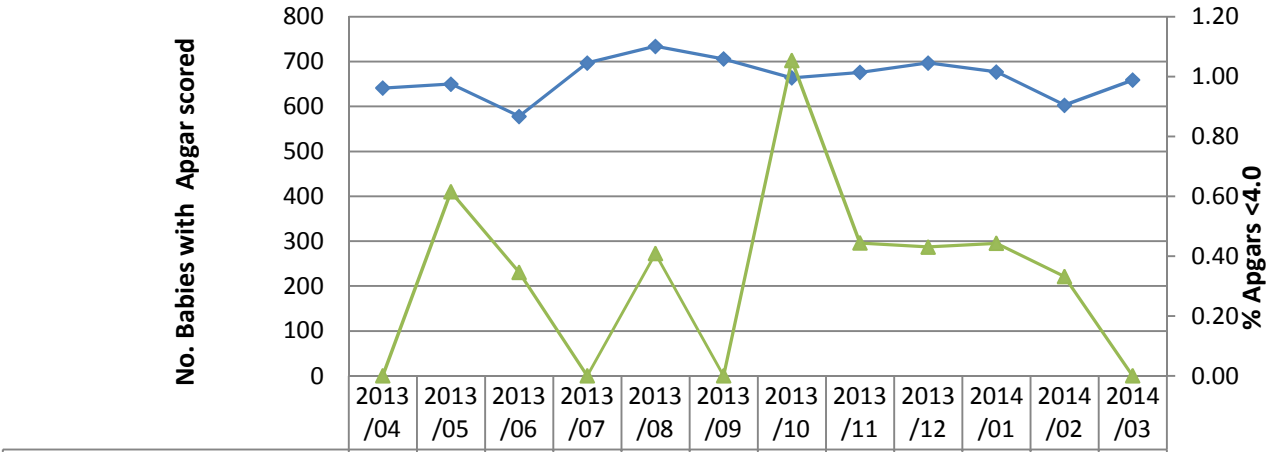
Description:
The number of babies born with an Apgar score at 5 minutes and with a gestation >34 weeks expressed as a percentage of all births with a recorded Apgar score.

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.

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

Trust Sponsor / Lead: Intrapartum Clinical leads

Progress made in report period 2013-14



	2013/04	2013/05	2013/06	2013/07	2013/08	2013/09	2013/10	2013/11	2013/12	2014/01	2014/02	2014/03
Babies with Apgar scored	641	650	578	697	734	706	664	676	697	677	603	659
% Apgars <4.0	0.00	0.62	0.35	0.00	0.41	0.00	1.05	0.44	0.43	0.44	0.33	0.00

Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Av.
2011/12	0.60	0.15	0.00	0.56	0.00	0.29	0.59	0.57	0.00	0.15	0.45	0.16	0.29
2012/13	0.15	0.40	0.00	0.75	0.27	0.43	0.68	0.15	0.58	0.17	0.50	0.64	0.39
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 Liverpool Women's NHS Foundation Trust considers that the data is as described for the following reasons. The figures reflect the increase in associated co morbidities in the maternal population of women who attend this Trust and the fact that Liverpool Women's is a tertiary referral centre and therefore a significant number of babies with low Apgar scores would be expected as these babies would not have been expected to be born in optimal condition due to clinical factors.

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 will be 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, however the high risk birth mentioned previously will occur within the central delivery suite.

It is therefore our intention to separate the data for the two Intrapartum areas and homebirths to identify the incidence in the low risk births.

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:

- Separate the data for the two Intrapartum areas and homebirths to identify the incidence in the low risk births.

2.1.1.5 Cord pH <= 7.00 in livebirths >=24 weeks gestation

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.

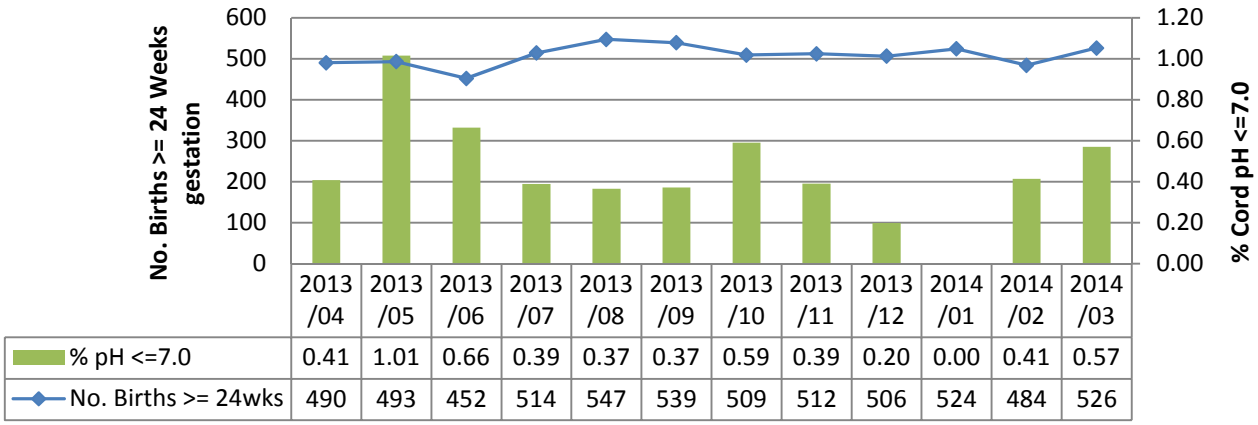
NICE guidance includes: "Intrapartum Care: Care of healthy women and their babies during childbirth" (2007), "Postnatal Care: Routine postnatal care of women and their babies"(2006) and "Antenatal Care: Routine care for the healthy pregnant woman"(2008).

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 expectantly compromised infant.

Important because:
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
Following birth the mother's notes are reviewed to identify if there were any alterations in the Intrapartum care would / may have altered the outcome.

Trust Sponsor / Lead: Intrapartum clinical leads

Progress made in report period 2013-14



	2013/04	2013/05	2013/06	2013/07	2013/08	2013/09	2013/10	2013/11	2013/12	2014/01	2014/02	2014/03
% pH <=7.0	0.41	1.01	0.66	0.39	0.37	0.37	0.59	0.39	0.20	0.00	0.41	0.57
No. Births >= 24wks	490	493	452	514	547	539	509	512	506	524	484	526

Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Av.
2011/12	0.21	0.39	0.79	0.98	0.00	0.59	0.40	0.72	0.58	0.77	0.41	1.06	0.58
2012/13	1.26	0.37	0.98	0.39	0.36	0.00	0.36	0.60	0.61	0.21	0.42	0.41	0.50
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. Actions that have been put into place have resulted in a small but significant reduction in cases.

How progress to achieve the priority goal is monitored and measured
The data is recorded within and extracted from 'Meditech', the patient Information System. Exclusions apply to these calculations where baby has been born before arrival of midwife and for babies born on Midwifery Led Unit.

How progress to achieve the priority goal is reported
The data will be presented and monitored at the Intrapartum working group and actions escalated to the Maternity clinical group.

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

- Implementing a continuous programme of CTG interpretation.
- Implementation of the 'fresh eyes' approach. This is a process by which a second person reviews a CTG to minimise the risk of individual error.

2.1.1.6 Incidence of meticillin resistant staphylococcus aureus (MRSA) bacteraemia 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 three consecutive years wished to monitor and maintain this record.

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

Trust Sponsor / Lead: Dr Tim Neal, Consultant Microbiologist,
Director for Infection Prevention and Control.

Progress made in report period 2013-14

	No. of Reported MRSA Bacteraemias											
Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2011/12	0	0	0	0	0	0	0	0	0	0	0	0
2012/13	0	0	0	0	0	0	0	0	0	0	0	0
2013/14	0	0	0	0	0	0	0	0	0	0	0	0

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 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.

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

- Putting in place a process for root cause analysis of all cases to identify learning outcomes, all cases are reported through the Trust governance structures to ensure

transparency, in addition there is regular audit of antimicrobial prescribing and infection control practices to ensure the quality of service is improved.

2.1.1.7 Incidence of Clostridium difficile

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.

Important because:
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.

Trust Sponsor / Lead: Dr Tim Neal, Consultant Microbiologist,
Director for Infection Prevention and Control.

Progress made in report period 2013-14

	No. of Reported C. difficile Infections											
Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2011/12	0	0	0	0	0	0	0	0	0	1	0	0
2012/13	0	0	0	0	0	0	0	0	0	0	0	0
2013/14	0	0	0	1	0	0	0	0	1	0	0	0

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 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.

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

- Putting in place a process for root cause analysis of all cases to identify learning outcomes, all cases are reported through the Trust governance structures to ensure transparency, in addition there is regular audit of antimicrobial prescribing and infection control practices to ensure the quality of service is improved.

2.1.1.8 Medication Incidents

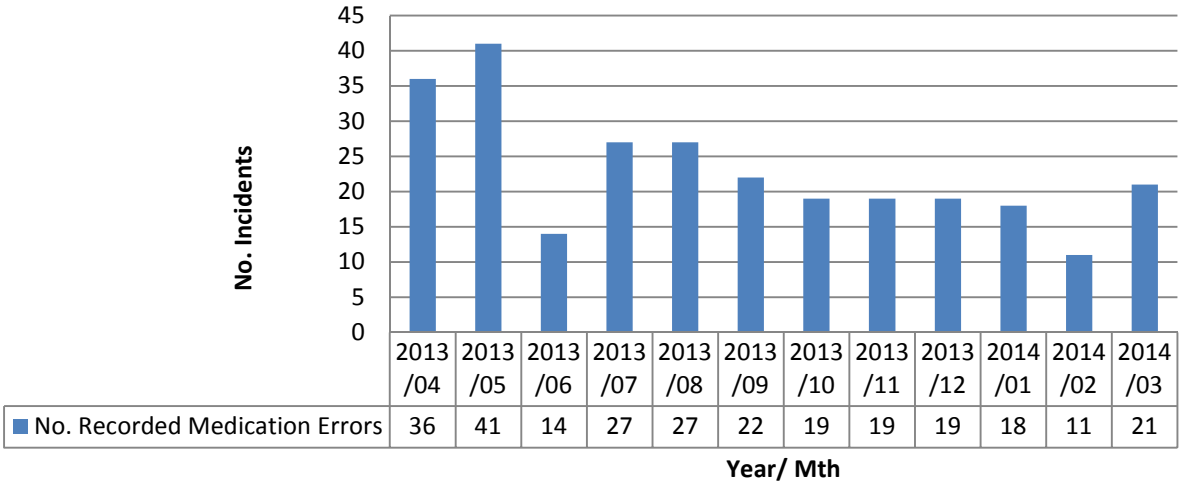
Description:
Number of Medication incidents recorded by the Trust on the electronic incident reporting system 'Ulusses'.
Trust staff report any misadventure with medicines as part of the provision of good assurance. The reporting of medicines incidents and near misses is a key requirement both to commissioners and for the greater national learning via the NPSA's National Reporting and Leaning Scheme

Why and how this priority goal was selected:
The recording of all incidents is vital to ensure that contributing causal factors are identified and addressed. The measure allows progress to be monitored.

Important because:
Errors in the prescribing, storage, supply and administering of drugs obviously have the potential to cause serious harm and must be reduced as near to elimination as possible.
Patients have a right to prompt and appropriate treatment with medicines. The reporting of incidents helps to identify a need to improve practice, review standards and introduce or improve training.

Trust Sponsor / Lead: Prashant Sanghani, Interim Chief Pharmacist

Progress made in report period 2013-14



	No. of Recorded Medication Errors												
Year	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Av.**
2011/12	30	40	43	42	30	37	51	40	46	69	58	65	45.9
2012/13	70	95	54	53	64	47	45	45	39	40	34	35	51.8
2013/14	36	41	14	27	27	22	19	19	19	18	11	22	22.9

The Liverpool Women's NHS Foundation Trust considers that these data are as described for the following reasons: The trust has defined and differentiated between a pharmacy intervention [a routine improvement in prescribing quality] and an intervention [an unplanned improvement in care]. This may have led to a reduction in reported incident.

How progress to achieve the priority goal is monitored and measured

Medication incidents are recorded by all clinical staff into the Ulysses incident reporting system. A Medication Incident is any error involving any medication. Data is downloaded from the Ulysses incident reporting system and saved on the Trust network. The period of download is 01/04/2011 to the end of the month to be reported up to. Once the file is saved the system calculates the number of errors per month.

All medicines incidents are reported to local teams which, with the support of their risk leads, take appropriate steps to reduce a recurrence. All incidents are also reviewed by the Medicines Incident Review Subcommittee [MIRS] of the Medicines Management Committee [MMC]. The MIRS scrutinises local actions taken and identifies local and trust-wide themes. The MMC develops actions for improvement.

How progress to achieve the priority goal is reported

The goal for reported incidents is to have increasing numbers and for the proportion of these graded as serious to decline. Local teams have been informed of the need to promote incident reporting.

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

- Advising local teams of the need to promote incident reporting and reporting incidents describing ideal clinical practice.

2.1.2 Clinical Effectiveness

2.1.2.1 Mortality Rates in Gynaecology

Description:

The number of Gynaecology Inpatients that have died expressed as a proportion of all Gynaecology Inpatients

Why and how this priority goal was selected:

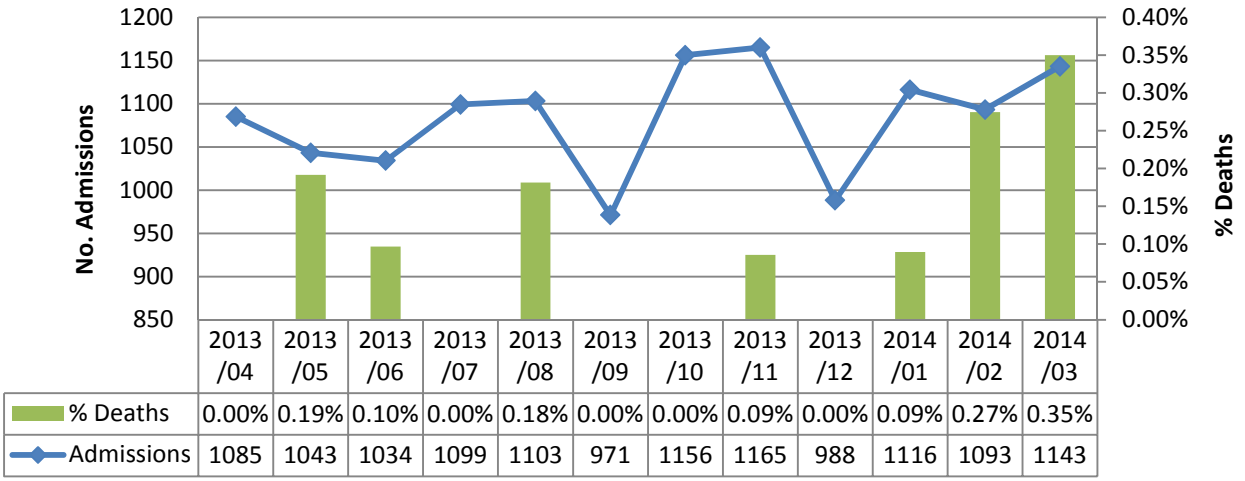
This is a local mortality Indicator used in place of unavailable national Standardised Hospital Mortality Index data for this Trust. Mortality data is crucial for all hospitals, and is an important focus of our Gynaecological Oncology service. All the patient deaths in the past year were in patients who had a Gynaecological cancer.

Important because:

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 the data collected, but a concern raised by the hospital Mortality data would be important information for the Oncology team to review.

Trust Sponsor / Lead: Mr Rob Macdonald, Consultant Gynaecological Oncologist/ Gynaecology Clinical Governance lead.

Progress made in report period 2013-14



	2013/04	2013/05	2013/06	2013/07	2013/08	2013/09	2013/10	2013/11	2013/12	2014/01	2014/02	2014/03
% Deaths	0.00%	0.19%	0.10%	0.00%	0.18%	0.00%	0.00%	0.09%	0.00%	0.09%	0.27%	0.35%
Admissions	1085	1043	1034	1099	1103	971	1156	1165	988	1116	1093	1143

Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Av.
2011/12	0.00%	0.19%	0.09%	0.00%	0.00%	0.10%	0.09%	0.09%	0.00%	0.00%	0.09%	0.08%	0.06%
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%	0.14%
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%	0.11%

How progress to achieve the priority goal is monitored and measured

There is no specific target figure for the hospital Mortality rates. Indeed, with the development of the Mulberry Suite and more recently the Orchid Suite in Gynaecology for seriously ill Oncology patients, we have had patients wishing to spend their last days within the support of the hospital. All hospital mortalities are reviewed within the Oncology Multidisciplinary team to ensure care and actions were appropriate.

How progress to achieve the priority goal is reported

Hospital Mortality data is reported to the Clinical Governance committee on a 6 monthly basis.

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 all hospital deaths over the past 5 years and assessing the patient care. No major concerns were identified around patient care during the review, but this will need to be regularly reassessed to ensure our patients receive the best care both during treatment and also at the end of life.

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.

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.

Important because:
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.

Trust Sponsor / Lead: Andrew Drakeley, Gynaecologist & Karen Schnauffer, Embryologist

Progress made in report period 2013-14
The tables demonstrate that the Hewitt Centre has shown a steady improvement in pregnancy rates over the reporting period. In the last 12 months we have seen an increase in activity of 20% and now attract patients from over 45 different catchment areas in the UK.

IVF	% of Embryo transfers with positive pregnancy test												
Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Av.
2011/12	31.9	35.6	27.3	34.8	39.4	39.7	37	46.3	53.3	50	39.2	51.8	40.5
2012/13	36	39.1	52.4	34.1	49.2	48.5	52.6	40.6	43.6	44.8	43.1	38.6	43.6
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.
2011/12	42.9	26.7	38.7	42.1	31.4	41.8	38.2	47.5	31.3	32.8	37.3	49.2	38.3
2012/13	30.5	37.8	35.3	41.1	40.7	56.5	42	30.4	34.5	55.2	45.5	51.6	41.7
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.
2011/12	29.6	25	37	35.4	28.6	39	26.7	13.3	28.6	22.5	25	14.7	27.1
2012/13	14.3	25.8	25	43.5	25.9	36.4	38.1	30.8	20	29.7	44.1	31.0	30.4
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

The Liverpool Women's NHS Foundation Trust considers that this data is as described as it is a regulatory requirement to collect and submit 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 over the last two years 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)

Description:

The proportion of very low birth weight (birth weight below 1500g) babies born 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.

Trust Sponsor / Lead:

Dr Bill Yoxall, Clinical Director, Neonatal Unit.

Progress made in report period 2013-14

	2010		2011		2012		2013	
No scan performed	37		22		15			*17*
PVH (grade)	n	*%*	n	*%*	n	*%*	n	*%*
0	65		57		81		54	
Minor (1 or 2)	41	*35.0*	49	*40.8*	62	*38.0*	54	*47.0*
3	10	*8.5*	5	*4.2*	7	*4.3*	6	*11.1*
4	1	*0.9*	9	*7.5*	13	*8.0*	1	*1.9*
4	1	*0.9*	9	*7.5*	13	*8.0*	1	*1.9*
PVL	8	*6.8*	4	*3.3*	4	*2.5*	*0*	*0.0*
Total scanned	**117**		**120**		**163**		***115***	
Total with no evidence of serious injury (no PVL, PVH <3)	99	*84.6*	103	*85.8*	143	*87.7*	108	*93.9*

The proportion of VLBW survivors with ultrasound evidence of perinatal brain injury is decreasing 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 rate of PVH and PVL on a unit is influenced by case mix as well as the quality of care. The rates of these outcomes for our babies have been risk adjusted by VON and these are shown for the past 6 years in the charts below. The rates of these abnormalities in our patients is at the level expected across the rest of the VON network, given our case mix.

Chart 1 – Risk adjusted rate of severe IVH in VLBW babies born LWH over the past 6 years

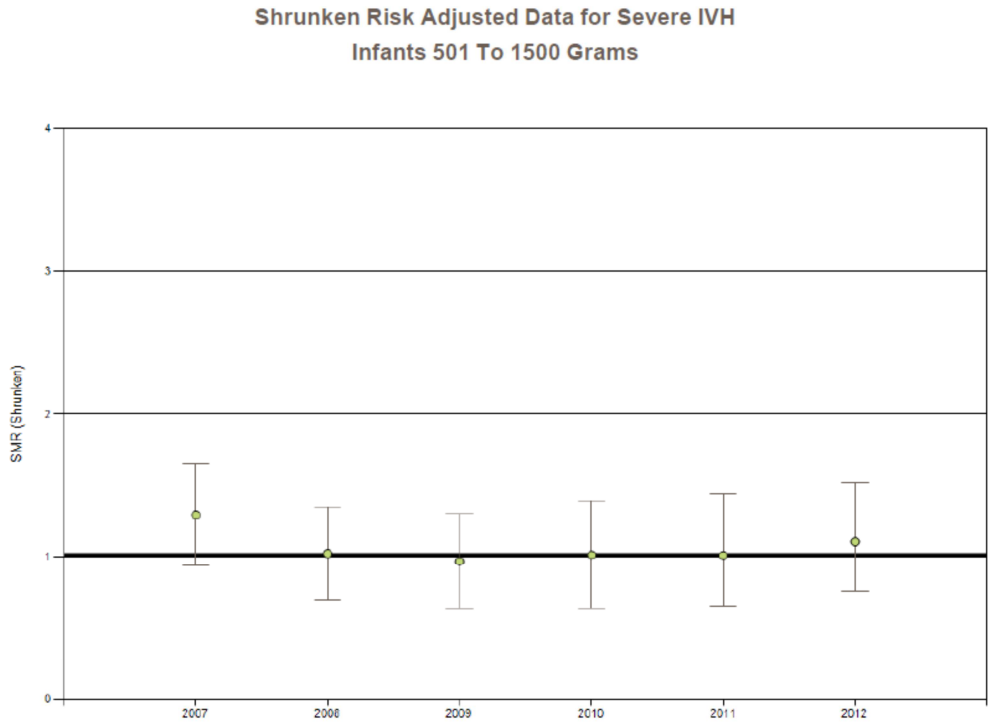


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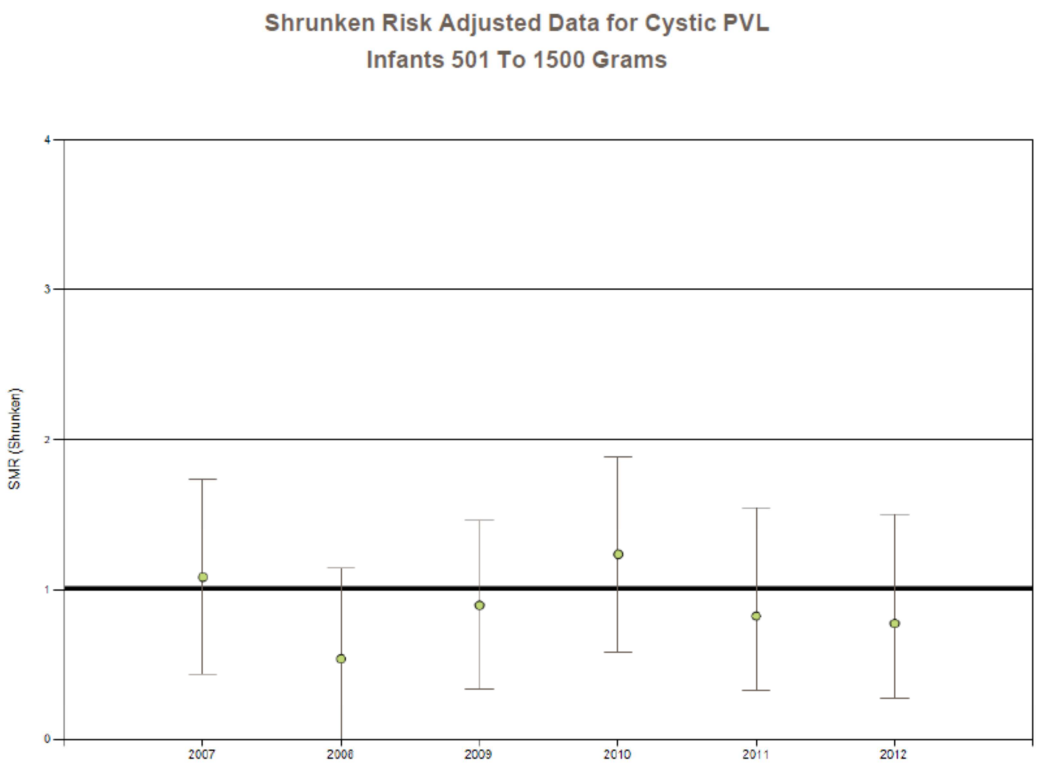
Chart 2 – Risk adjusted rate of PVL in VLBW babies born at LWH over the last 6 years.



How progress to achieve the priority goal is monitored and measured

These data are collected in and extracted 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's 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

Description:
Death within 28 days of birth following live birth at Liverpool Women's Hospital, or home birth under the care of LWH during the calendar year 2013.
Survival to discharge for inborn babies born in the calendar year 2013 with a birth weight between 500g and 1500g.

Why and how this priority goal was selected:
Neonatal mortality rate (NNMR) is accepted to be a useful indicator of the effectiveness of a perinatal healthcare system.
National data for neonatal mortality by gestation are published annually by the Office for National Statistics (ONS) and we have used these for benchmarking purposes. The most recent data are those from 2011, published in October 2013.
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:
2/3 of infant deaths occur in the neonatal period. 2/3 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 monitored to ensure that the quality of the care that we are providing is maintained

Trust Sponsor / Lead:
Dr Bill Yoxall, Clinical Director, Neonatal Unit.

Progress made in report period 2013-14

Neonatal mortality at each week of gestation for babies born at LWH is close to the ONS mortality rate (Graph 1). The apparently high neonatal mortality rate for all babies born at LWH (4.6/1000 – Table 1) is a reflection of the complex case mix cared for at LWH. When the NNMR is corrected for the gestation profile, it is close to the national rate and if the high risk babies transferred into LWHFT antenatally are excluded, the NNMR is below the national NNMR.

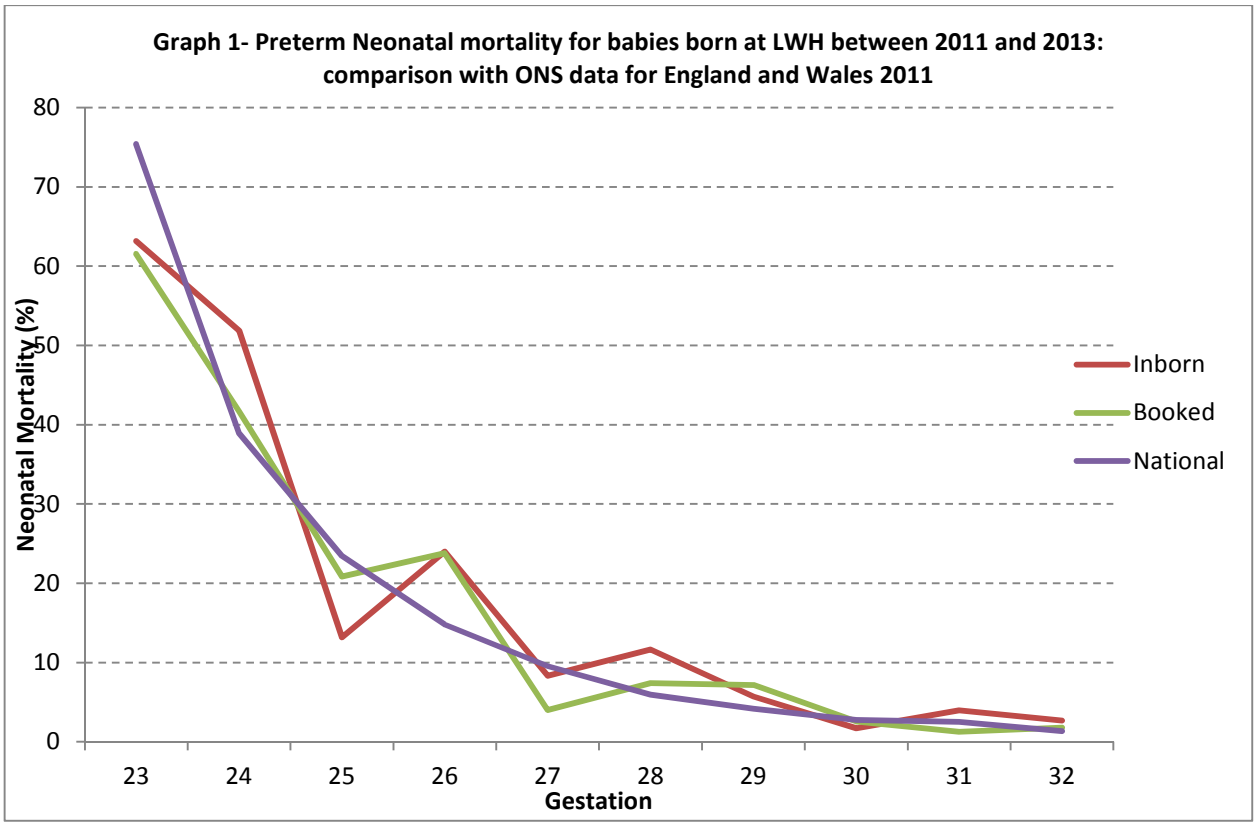
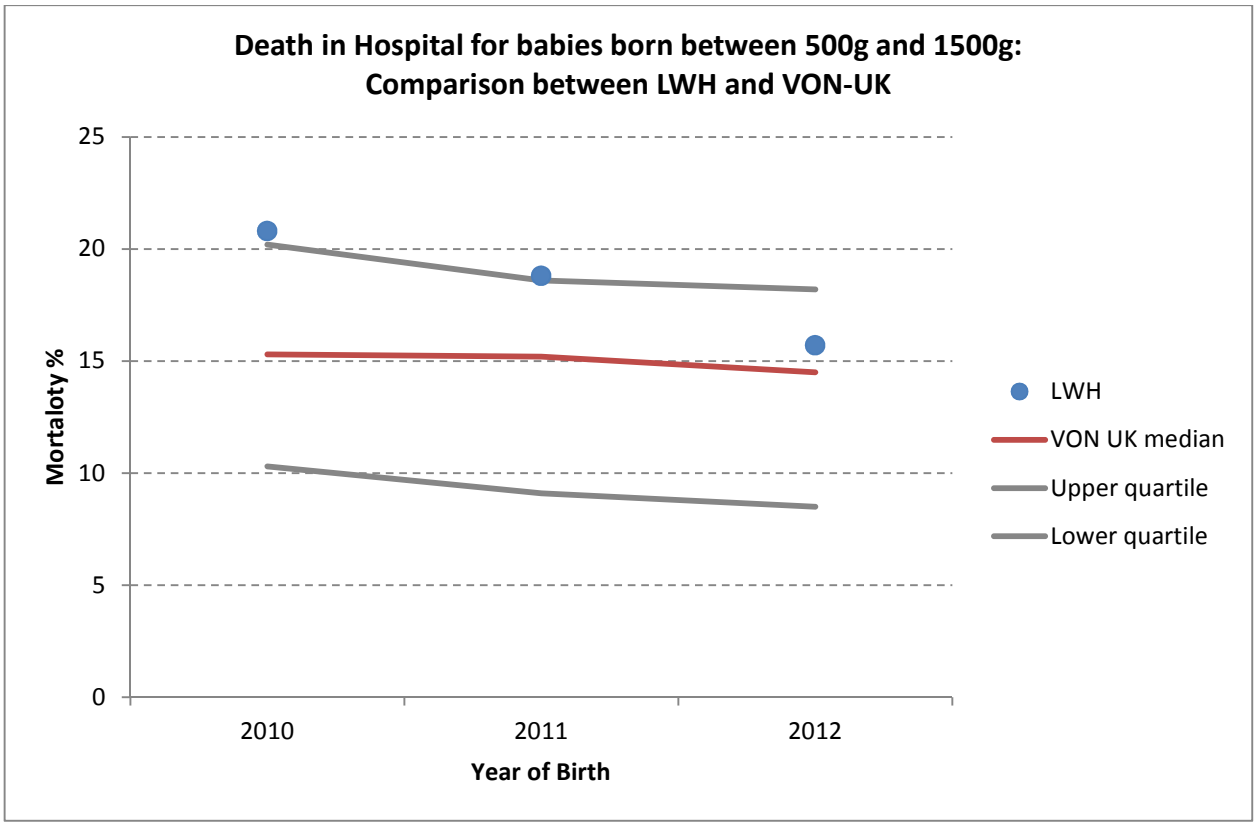


Table 1: Neonatal Mortality rate for babies born at LWH over the preceding 4 years; comparison with UK rates and the effect of adjusting for case mix.

	2010	2011	2012	2013
Live births (Total)	8583	8430	8506	8112
Live births (from booked pregnancies)	8466	8252	8359	7984
Neonatal deaths (all live births)	61	45	42	37
Neonatal deaths (from booked pregnancies)	41	29	30	22
NNMR (all live births)	7.1	5.3	4.9	4.6
NNMR (booked pregnancies)	4.8	3.5	3.6	2.8
UK NNMR	3.0	3.0	2.9	TBC
LWH gestation corrected NNMR (all live births)	4.7	3.2	3.2	2.8
LWH gestation corrected NNMR (booked pregnancies)	3.6	3.7	2.3	2.3

(N.B. NNMR expressed as No. per 1000)

In comparison to other Neonatal units in the VON network, death before discharge for Very Low Birth Weight (VLBW) babies born at LWH has improved over recent years from the upper quartile to just above the median.



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 Executive Committee. A prospective system is in place to review each death in order to identify learning points that can drive service improvements. Individual cases are discussed at the Perinatal mortality section of the Trust wide GREAT day and the annual mortality figures are also presented and reviewed at that meeting.

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

- Increasing the number of hours per week with a neonatal consultant on site
- Prospective review of all deaths
- Prioritised 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.

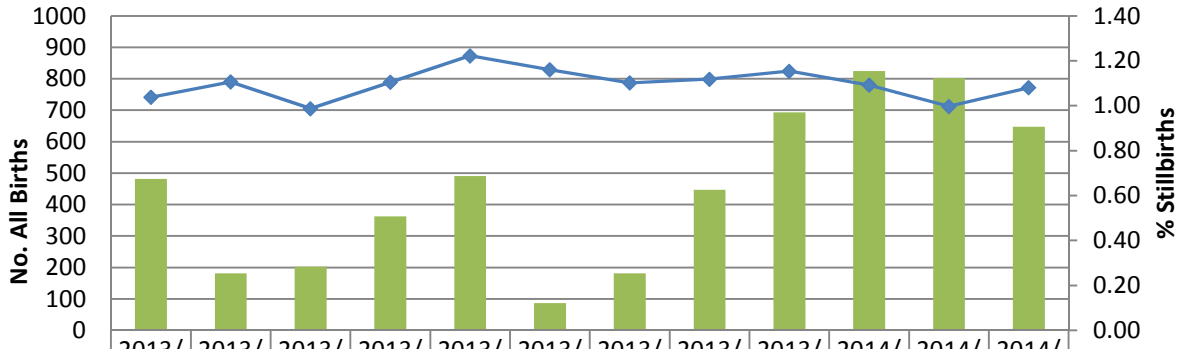
Why and how this priority goal was selected:
This indicator was originally chosen by the directorate following a multidisciplinary discussion at the division meeting about what was highest impact. Whilst there was no direct patient and public involvement- the impact of the selected Maternity indicators (Apgar score <4 at 5 mins, 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.

Important because:
It is a sad fact of life that a small proportion of pregnancies result in unavoidable miscarriage or stillbirth through natural causes The results 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.

Trust Sponsor / Lead: Dr Devender Roberts

Progress made in report period 2013-14



	2013/04	2013/05	2013/06	2013/07	2013/08	2013/09	2013/10	2013/11	2013/12	2014/01	2014/02	2014/03
% Stillbirths	0.67	0.25	0.28	0.51	0.69	0.12	0.25	0.63	0.97	1.15	1.12	0.91
No. All Births	741	790	705	789	873	829	787	799	824	780	712	772

Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Av.
2011/12	0.39%	0.37%	0.73%	0.24%	0.25%	0.70%	0.24%	1.24%	0.83%	0.50%	1.74%	0.66%	0.66%
2012/13	0.99%	0.34%	0.48%	1.22%	0.23%	1.13%	0.23%	0.13%	0.48%	0.83%	0.70%	0.79%	0.63%
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%	0.60%

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

- The rate is comparable to the national average and it is recognised that indices of social deprivation can increase stillbirth rate. Many of the programmes that are currently being

instituted to decrease the stillbirth rate are long term projects over the life span of a pregnancy therefore it is too early to demonstrate a significant reduction although the initial suggestion of a downward trend is encouraging.

How progress to achieve the priority goal is monitored and measured

The Trust has working party led by Dr Devender Roberts who have devised an action plan and are overseeing its implementation.

How progress to achieve the priority goal is reported

The findings and action of this group are reported to the Women's and Children's service and GACA.

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

- A review panel is held twice per year to identify if care could have been altered that would/ may have altered the outcome (A process similar to that used for Maternal deaths). As a result of this we have been able to identify that babies with unrecognised growth restriction are over represented in those who are stillborn. In response to this we have instituted the use of customised growth charts which are felt to identify growth restriction more accurately and allow us to intervene at an appropriate time.
- Adoption of the RCOG guideline of decreased fetal movement.
- The reduction in stillbirth rate has been identified as a priority by the newly formed Merseyside and Cheshire Maternity network and Dr D. Roberts is leading the working group to develop a Merseyside and Cheshire action plan.

2.1.3 Patient Experience

2.1.3.1 One –to-One Care in Established Labour

Description:

The number of patients receiving one to one care during 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).

Why and how this priority goal was selected:

This goal was selected by clinical nomination and directorate approval due to the importance of support for a woman and her family during labour and birth.

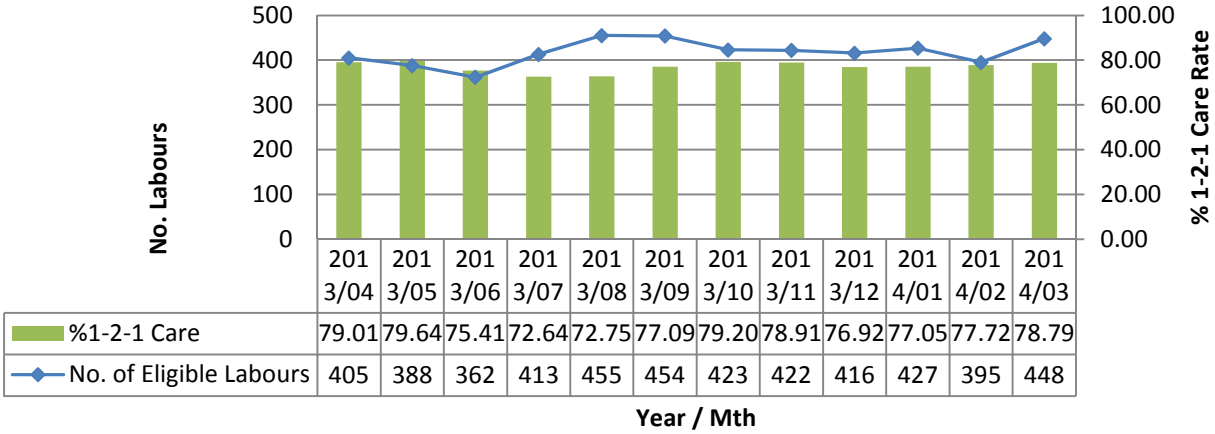
Important because:

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 100%.

The one to one care and support when the woman is in established labour promotes a sense of safety and trust. If the woman is less anxious she is more likely for labour and birth to be straightforward and require less intervention. This will have an effect on both the mother and baby.

Trust Sponsor / Lead: Head of Midwifery

Progress made in report period 2013-14



Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Av.
2011/12	0.25	1.90	80.91	75.17	82.14	79.81	81.18	80.60	80.75	82.29	79.18	83.21	67.28
2012/13	79.55	75.11	77.70	76.18	72.97	73.53	61.18	75.97	72.77	78.57	73.39	71.08	71.08
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	77.09

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.

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 patient 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 nursing and 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.

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.

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

- Discussion with the CCG regarding additional numbers of midwives required to achieve an increase in the current percentage
- Making the daily report available to the intrapartum areas.
- Monthly reporting to and monitoring by the executive board.

2.1.3.2 Patients receiving pain relief of choice in Labour

Description:
The number of patients receiving the pain relief of choice during labour expressed as a percentage of discharges following birth.

Why and how this priority goal was selected:
This indicator was selected following discussions with Liverpool GPs. Their patients had reported that this was an issue and a requirement; hence this became a CQUIN measure, which the Trust committed to report on in 2012-13. Initially, the Trust reported indirectly on the topic in the 2012-13 report using the responses to CQuIns related questions around patient satisfaction with the pain management they experienced. The questions used in the optimum Care Package Questionnaire were:

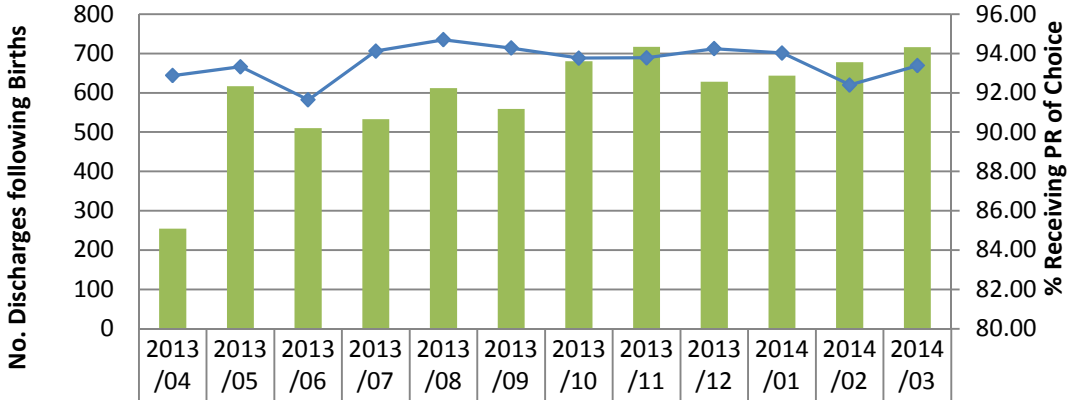
1) Did you receive Pain Relief Quickly?
2) If yes, did it work as well as you thought?
3) How good were staff at managing pain?

The Trust completed implementation of a field in the discharge screen of the Meditech patient Information system to gather this information directly in April 2013, making direct reporting possible for the 12 month period April 2013-March 2014 only. It is not comparable with the composite methodology used previously.

Important because:
The importance of women having choice and control of the method of pain relief in labour is well documented. This enhances patient satisfaction and birth experience.

Trust Sponsor / Lead: Cathy Atherton, Head of Midwifery

Progress made in report period 2013-14



	2013/04	2013/05	2013/06	2013/07	2013/08	2013/09	2013/10	2013/11	2013/12	2014/01	2014/02	2014/03
% Pts Receiving PR of Choice	85.09	92.34	90.21	90.65	92.24	91.18	93.60	94.34	92.56	92.87	93.55	94.32
Number of Discharges following Births	644	666	582	706	735	714	688	689	712	701	620	669

% Patients Receiving Pain Relief of Choice during Labour – Historical data													
Year	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Av.**
2011/12	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2012/13	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2013/14	85.1%	92.3%	90.2%	90.7%	92.2%	91.2%	93.6%	94.3%	92.6%	92.9%	93.5%	94.3%	91.9%

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

- This data has been collected in this form since April 2013. It continues from other pain relief related questions that were previously addressed. Whist the overall compliance rate continues to be above 90% it shows room for improvement. This may relate to occasions when women do not receive an epidural when requested due to a number of reasons. This area will continue to be monitored.

How progress to achieve the priority goal is monitored and measured
This goal is recorded on the Meditech electronic database and will be monitored via the quality and risk committee.

How progress to achieve the priority goal is reported
This was part of the CQUIN – MATERNITY Bundle for last year and was reported internally through Trust Management Group, the Trust Board and externally through CQUINS.

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

- Prioritising women requiring transfer to delivery suite from the midwife led unit, for epidural.
- Working together with anaesthetists to enable the facility

2.1.3.3 Priority Goal Timely Genetics Testing

Description:
Ensure that users (clinicians) and patient's needs and expectations are met through timely reporting times, improving the patients experience and assuring effective and efficient testing.

Why and how this priority goal was selected:
This priority goal was selected as it is a National Benchmark measure for the Medical Genetics Clinical Reference Group (CRG E01) and NHS England, used to assure patients tests are completed in a timely manner.

Important because:
The data assures effective and efficient testing that meets the needs and expectations of both users (clinicians) and patients.

Trust Sponsor / Lead: Angela Douglas, Trust Genetic Scientific Director

Progress made in report period 2013-14
From the chart it can be seen that the Genetics Laboratories at Liverpool Women's Hospital perform well when benchmarked against other Regional Genetic Services for test turnaround times (the timeliness of getting results back to patients).

Table 1 Genetics turnaround for Tests - Benchmarked against 16 Regional Genetic Services

Quality Indicator	Indicator Description	National Mean Percentage in target	LWH Percentage in target	Meets national average (+/_ 5%)	Exceeds national average by>10%	Below national average by >10%
GEN01	Proportion of tests that return a positive result for affected patients	20.8	23.9	✓		
GEN04ai	Proportion of urgent High Priority tests within 3 working days	97.8	94	✓		
GEN04aii	Proportion of Urgent Postnatal blood tests within 10 calendar days	96.1	80.4	✓		
GEN04aiii	Proportion of Urgent Prenatal and Haematology/Leukaemia tests within 14 calendar days	88.7	92.2	✓		
GEN04aiv	Proportion of Routine Haematology/Leukaemia tests within 21 calendar days	73.3	92.5		✓	
GEN04av	Proportion of Routine Postnatal and microarray and/or PCR/FISH tests within 28 calendar days	57.7	41.7			✓
GEN04avi	Proportion of Routine microarray tests for parents referred together with child within 56 calendar days	89.7	87.6	✓		
GEN04bi	Proportion of urgent PCR-based tests for prenatal diagnosis completed within 3 working days	95.9	99	✓		
GEN04biii	Proportion of Non-urgent PCR-based tests within 4 weeks	88.1	96.0	✓		
GEN04biv	Proportion of routine Mutation screening completed within 8 weeks	85.9	89.4	✓		

A good performing laboratory would be within 5% or better than the National average performance figure. From the table it can be seen that 2 measures (GEN04aiv and 4av) are more than 25% better than the national average. One measure (GEN01) is more than 15% better than the national average. One Measure is more than 10% better than the national average. Five measures (GEN04ai, 4aiii, 4avi, 4bi and 4biv) are all within 5% of the national average. Only one measure is considered poor at 10% below the national average. This measure will need to be

improved. This provides Liverpool Women's Hospital assurance of the excellent performance of the laboratories, when benchmarked against other Regional Genetic Services. Only one measure (GEN04aii) is an outlier at 10% below the national average. The delay in reporting times in this category is due to the complexity of the abnormal cases, which require additional (microarray/FISH) confirmation tests, resulting in delays to the reporting times. Nevertheless, this provides an area for quality improvement, which the laboratory will be working on over the next 3 months to ensure this categories data moves closer to the national average or better.

The Liverpool Women's NHS Foundation Trust considers that this data is as described for the following reasons; the data is collated independently by the CRG, Liverpool Women's submits data from the Laboratory database, which is also monitored by users through an annual Service Level Agreement. Finally, the data is presented at Clinical Governance in the 6 monthly Genetics Reports.

How progress to achieve the priority goal is monitored and measured

This priority Goal is monitored externally by the National Clinical Reference Group for Medical Genetics and NHS England through quarterly submissions and benchmarking against the data submitted by the other 16 Regional Genetics Services in England. Progress is also monitored internally through weekly Genetics Head of Section meetings, the Genetics Division Executive meeting and the Trust's Clinical Governance Committee.

How progress to achieve the priority goal is reported

Progress is reported weekly through the Genetics Head of Section meetings, which report into the monthly Genetics Division Executive meetings and through the 6 monthly reports to the Clinical Governance Committee.

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:

1) Focusing on improving the efficiency of testing through introduction of Automated FISH analysis by July 2014.
2) Increasing the workforce in the section with the poor indicators by decreasing the workforce in the area that is over performing, to ensure equal spread of capacity and demand across all sections.

2.1.3.4 Patient Feedback and Friends & Family Test

Patient Feedback

At the start of 2013, the Trust began a new patient feedback process with the introduction of a redesigned Patient Exit Card and the launch of a web based feedback page. As a part of this new feedback process the Trust began asking patients for their views on a number of different aspects of the care they received, such as:

- Whether they would recommend the ward or department to their Friends and Family if they needed similar care of treatment and what factors influenced their responses (the Friends and Family Test)
- How they rated the Trust overall on a score of 0 to 10 (0=Low, 10=High)

The patients are also asked for a comment, in their own words, on their experience at the Liverpool Women's Hospital.

In October 2013, a further change was made to the patient feedback process, which provided an opportunity for the patients to name a member (or members) of staff with whom they are particularly pleased or displeased with.

The Friends and Family Test

On the 25 May 2012, the Prime Minister announced the introduction of the 'Friends and Family Test' to improve patient care and identify the best performing hospitals in England.

The Friends and Family Test (FFT) is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care. Within Liverpool Women's NHS Foundation Trust, it was introduced for patients seen within the Emergency Room and Inpatients on the 1st April 2013 and then within Maternity on the 1st October 2013.

Although the Trust was obligated only to implement in the above areas, a decision was made to gradually implement the Friends and Family Test across all services in the Trust. The Friends and Family Test was introduced as part of that newly introduced patient feedback process.

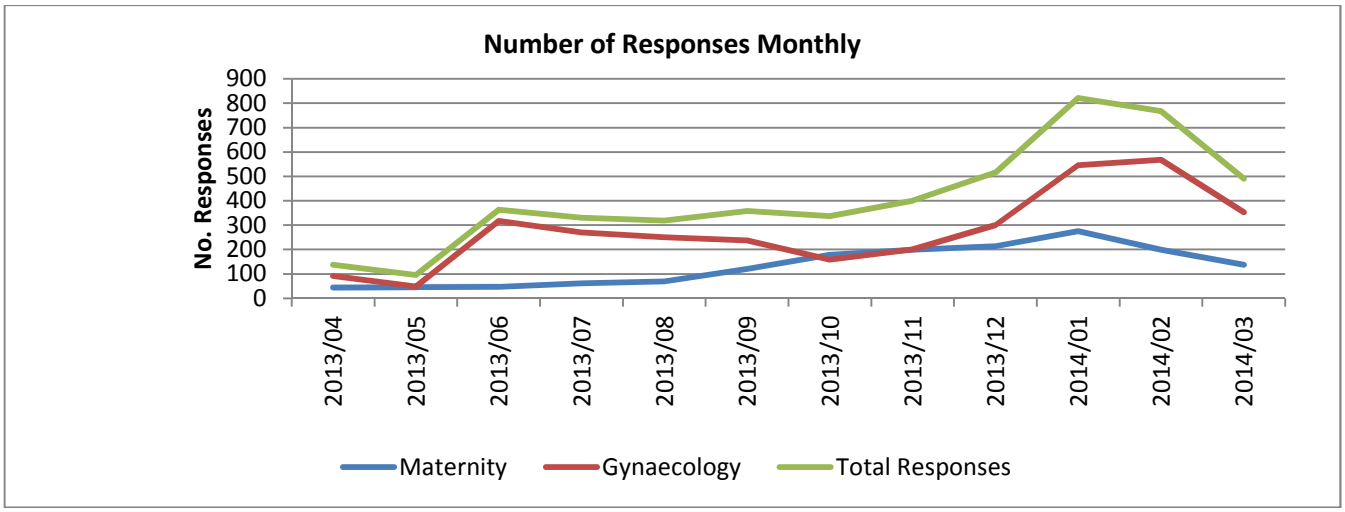
Number of Responses

The following table shows the number of responses that have been received since the introduction of the new patient feedback process.

Table 1, Number of responses by area / month

Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar*	Tot
Maternity													
Antenatal (at 36 Weeks)	2	13	5	18	22	45	41	3	12	27	15	20	**223**
Delivery (or Homebirth)	0	0	0	0	1	1	14	48	76	116	82	47	**385**
Postnatal Ward	2	5	8	6	21	35	92	116	88	122	101	64	**660**
Community Discharge	12	0	1	1	0	10	11	8	18	5	1	0	**67**
Other Maternity	29	28	33	36	25	29	20	24	20	6	0	7	**257**
Total Maternity	**45**	**46**	**47**	**61**	**69**	**120**	**178**	**199**	**214**	**276**	**199**	**138**	1592
Gynaecology													
Emergency Room (A&E)	19	18	190	179	153	146	65	61	208	345	331	193	**1908**
Gynaecology Inpatients	17	7	99	72	55	56	59	81	41	96	99	77	**759**
Other Gynaecology	56	24	28	19	42	36	35	59	52	105	138	83	**677**
Total Gynaecology	**92**	**49**	**317**	**270**	**250**	**238**	**159**	**201**	**301**	**546**	**568**	**353**	3344
Total Responses	**137**	**95**	**364**	**331**	**319**	**358**	**337**	**400**	**515**	**822**	**767**	**491**	4936

The Trust saw a gradual increase in the number of instances of feedback received over the past 12 months. This has partly been due to a general increase in the numbers received from the earlier established departments combined with the introduction of Patient Exit Cards to other areas not previous covered.



Response Rates

For the Emergency Room and Gynaecology Inpatients, a mandatory target was to achieve response rates of 15% from April 2013 to December 2013 (inclusive) rising to 20% from January 2014 to March 2014 (inclusive).

Response rate = No. of Responses / No. Eligible Patients

Table 2 Formal reported response rates as part of the Friends and Family Test initiative

Response Rates	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14
Emergency Room	2.41	1.42	21.77	20.53	18.15	18.01	5.66	6.98	27.80	36.28	42.2	34.2
Gynae Inpatient	5.77	0.76	37.50	26.13	17.89	19.13	20.00	20.81	11.61	27.43	25.3	24.3
Overall Gynaecology Response Rate	3.21	1.26	25.49	21.86	18.09	18.29	8.78	11.24	22.57	34.22	37.1	31.2

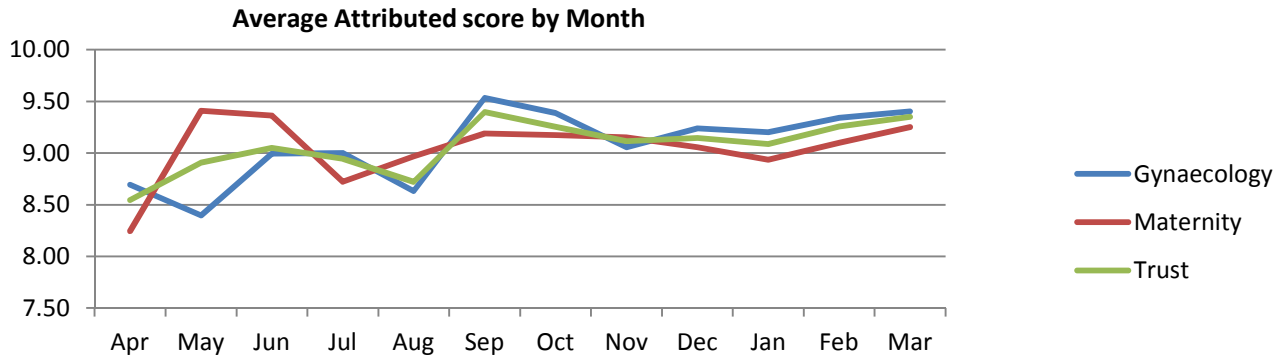
Key: Green = Target met, Red = Target missed.

Table 3 Average Patient Attributed Friends & Family Scores (i.e. How patients rated the Trust overall on scale 1-10)

Division	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14
Gynaecology	8.69	8.40	8.99	9.00	8.63	9.53	9.39	9.06	9.24	9.20	9.34	9.40
Maternity	8.24	9.41	9.36	8.72	8.97	9.19	9.17	9.15	9.06	8.93	9.10	9.25
Trust	8.54	8.91	9.05	8.95	8.72	9.40	9.25	9.12	9.15	9.09	9.26	9.35

Key:
Where the average score is less than 9.00 – Amber (requires improvement)
Where the average score is greater than or equal to 9.00 – Green (Satisfactory)

The following graph shows the average score the patient assigned to the Trust during their visit



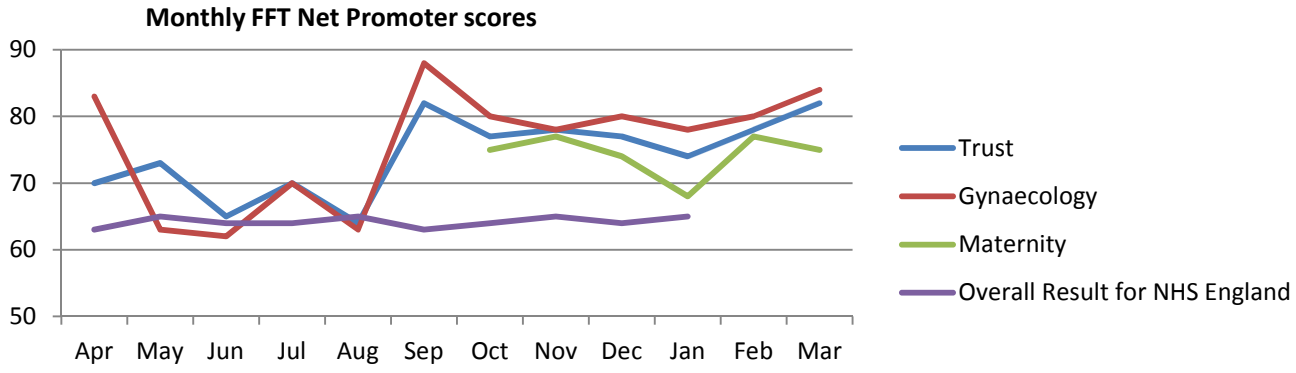
The Friends and Family Test Score

The Friends and Family Test Score is derived using a modification of the 'Net Promoter Score', which is a well-recognised way of expressing the proportion of patients that stated that were 'Extremely Likely' to Recommend the Ward or Department to their Friends and Family if they needed similar care or treatment.

Table 4 showing the results achieved for the Friends and Family Test using the Net Promoter Calculation

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Trust	70	73	65	70	64	82	77	78	77	74	78	82
Gynaecology	83	63	62	70	63	88	80	78	80	78	80	84
Maternity	Maternity collection began fully in October						75	77	74	68	77	75
Overall Result for NHS England	63	65	64	64	65	63	64	65	64	65	No Data	

Key: Red: Below Overall Result for NHS England. Green: Above Overall Result for NHS England.
NB. Includes NHS & Private Sector Providers



The above table and chart compare the results achieved for all areas within Gynaecology, all areas within Maternity and the Trust overall derived figure, with the results achieved for the rest of England. This demonstrates that the LWH responses are good in respect of the All of England performance.

Breakdown of Responses into Cause Group and Themes

The patient feedback process asks the patients to specify the reasons that they have responded to the Friends and Family Test question in the way that they have. Patient may select from a list of reasons (see table below for details) or may select "Other" and provide a comment specifying any other reasons that they wish to give.

These ‘themes’ are then categorised to provide an insight into which particular aspect of their experience influences how they feel and, therefore, how they respond.

Table 5 the number of responses received and the theme(s) that have been stated by the patients, a patient may choose more than one category within the same feedback instance should they wish to.

Response	Care	Environment	Food	Medical Treatment	Staff Attitude	Other	Total
Extremely Unlikely	14	7	3	10	27	33	**94**
Unlikely	14	7	1	11	18	45	**96**
Neither Likely Nor Unlikely	8	6	3	8	11	28	**64**
Likely	424	134	57	290	303	75	**1283**
Extremely Likely	2608	1142	478	1994	2474	472	**9168**

Number of Instances of Closure Management

The process adopted by the Trust to manage the feedback and the comments being received is a two-stage process. When collating the feedback into the Trust systems, the Governance Department will ‘Close’ any feedback that requires no response or action from the clinical nursing managers.

Any feedback that contains information that requires a response or action from the clinical nursing managers is visible in real time to them, which then allows for further management. Only when appropriate actions have been taken in response to the feedback is the instance of patient feedback finally ‘Closed’ by the nursing teams.

The tables below provide an overview of the status of the Trust management of patient responses and the number that have been actively ‘Closed’ by either the Governance Department or the Clinical Teams.

Where all the comments received in that month have been responded to and ‘Closed’ the numbers appears with a background; if this is not the case they are displayed with a Red background.

Gynaecology	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Number Received	92	49	317	270	250	238	159	201	301	546	568	375
Number Closed on Entry	66	39	268	235	208	218	142	175	276	488	504	359
Number Passed to Clinical Teams	26	10	49	35	42	20	17	26	25	58	64	34
Number Closed	26	10	49	35	42	20	17	26	25	58	64	34

Maternity	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Number Received	47	51	55	67	90	155	270	315	302	398	300	202
Number Closed on Entry	44	50	53	60	80	142	220	281	262	323	227	186
Number Passed to Clinical Teams	3	1	2	7	10	13	50	34	40	75	73	17
Number Closed	3	1	2	7	10	13	50	34	40	75	73	17

Specifically Named Staff

The Trust provides an opportunity for the patients to specifically name a member (or members) of staff that they were particularly pleased or displeased with. The Trust collates the names of the staff into its electronic system and whether the patient is 'Pleased' or 'Displeased' with that particular member of staff.

The actual names of the staff where the patient is 'Pleased' is made available to the clinical teams in real time and they are then able to ensure that positive feedback is given to the staff in the clinical areas. The names of staff where a patient is 'Displeased' are returned to the senior nurse managers for further local management.

The following tables shows the breakdown of instances where patients have specifically named a member (or members) of staff.

Area	Response	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	%
Maternity	Displeased	0	0	6	5	4	1	0	**16**	**1.70%**
	Pleased	20	131	141	153	185	174	121	**925**	**98.30%**
Gynaecology	Displeased	0	1	1	2	5	7	1	**17**	**3.10%**
	Pleased	7	29	54	30	126	156	129	**531**	**96.90%**
Trust	Displeased	0	1	7	7	9	8	1	**33**	**2.22%**
	Pleased	27	160	195	183	311	330	250	**1456**	**97.78%**

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

- Launch of our Nursing and Midwifery Strategy
- Promotion of Trust Values
- Nursing and Midwifery staffing review, monthly reporting to Trust Board and displaying staffing levels publicly
- Investment in Estate and relocation of Gynaecology Emergency room
- Values based recruitment
- Compliance with triennial reviews
- Strengthen Nursing and Midwifery leadership.

2.2 Priorities for improvement 2014-15

The Trust has reviewed the currently reported priorities for improvement and determined that the priorities for improvement for the coming period and for reporting in the Quality Report for 2014 - 15 are as follows:

2.2.1 Patient safety

- Gynaecology surgical site infections
- Incidence of Multiple pregnancy
- Apgar scores <4 in infants born at more than 34weeks gestation
- Delivery Cord pH<7.00
- Total episodes of late-onset (> 72h) bloodstream infection in preterm babies
- Total episodes of bloodstream infection (early and late) in all neonates (term and preterm)

2.2.2 Clinical Effectiveness

- Hospital Mortality Rate in Gynaecology
- Biochemical Pregnancy rates in In-vitro fertilisation (IVF), Intracytoplasmic sperm injection (ICSI) and frozen embryo transfer (FET) treatments
- Brain injury in preterm babies (Severe Intraventricular haemorrhage and Periventricular leukomalacia)
- Neonatal mortality
- Stillbirth Rate
- Care indicators for Nursing and Midwifery [NMB to select Priority indicators annually]
    - 36 week Antenatal risk assessment
    - One to One care in Labour (See Patient experience below)
    - Avoidable repeats for Antenatal screening and newborn screening blood sampling
    - Skin to Skin
    - Patients opting for surgical treatment of miscarriage undergo the procedure within 72 hours of their decision

2.2.3 Patient Experience

- One to one care in established labour
- Patients receiving pain relief of choice in Labour
- Reduction in number of complaints relating to care

The majority of the priorities listed above are current and the means of measurement, monitoring and reporting described elsewhere within this document. The arrangements for the new priorities are explained in the table below.

Priority	Rationale for Selection	How Measured	How Monitored	How Reported
Total episodes of late-onset (> 72h) bloodstream infection (preterm babies)	Infection is an on-going issue. It is an important marker of quality our staff believe all neonatal units should be reporting. It continues to be a priority for us. No direct involvement of patients or wider public.	The number of pre-term babies (<30wks gestation) with late onset (post 72hrs) bloodstream infections per total number of days that very low birth weight (VLBW) babies have spent in either intensive or high dependency care. [Where VLBW means a birth weight below 1500grams] It should be noted that congenital infections (i.e. obtained from the mother) within 3 days and repeated positive blood tests are excluded from the numbers.	Data collated from badger and entered into monitoring spreadsheet, Data monitored through monthly KPI review by Neonatal Executive.	Data displayed on Infection prevention and Control Board on the unit, Reported quarterly to Infection Prevention & Control Committee Reported 6-monthly to Clinical Governance Committee (CGC).
Total episodes of bloodstream infection (early and late) in all neonates (term and preterm)		Total Blood stream infections per total number of care days for all babies		
36 week Antenatal risk assessment	Identified as a concern in staff review of Nursing & Midwifery Indicators	Quarterly audit of Patient Record on 'Meditech'	Nursing & Midwifery Board	Maternity Risk Clinical Governance Committee
Avoidable repeats for Antenatal screening and newborn screening blood sampling	Identified as needing improvement from staff review of Key Performance Indicators	Compliance in documentation of antenatal and new-born screening	Through the monthly performance report. Nursing & Midwifery Board	Maternity Risk Clinical Governance Committee
Skin to Skin	Identified as a concern in review of Nursing & Midwifery Indicators.	Electronic patient records of 10 randomly selected babies admitted in the month are examined to establish if parents were offered skin to skin with their baby within the last 24hours	Reported monthly via NUMIS system and. Visible within the Neonatal Unit to staff, parents and visitors. Discussed at Unit, Operational and Team meetings.	Reviewed at Nursing and Midwifery Board
Patients opting for surgical treatment of miscarriage undergo the procedure within 72 hours of their decision	Delays in pathway Identified through formal and informal complaints from patients.	Medical notes from ER- 10 randomly selected patients admitted for surgical management to establish decision to treat to admission time and admission time to transfer to theatre	Retrospective audit – initially- review Meditech ability- Can this be incorporated into NUMIS??	Gynae Risk Committee
Reduction in number of complaints relating to care.	Bulk of Complaints. Identified in Maternity.	Monthly performance via Complaints recorded on Ulysses system	Nursing & Midwifery Board as part of Nursing / Midwifery Strategy	Quarterly Report to CGC

2.3 Statements of assurance from the board

During 2013-14 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 8286 babies (registered births)
- Number of gynaecological in-patient [Day case, Elective, Non-elective procedures] performed – 7,639 [NHS patients only] / 7,739 [including Private Patients(PPs) and Overseas visitors (OSVs)]
- Cared for 1,140 babies in our neonatal intensive and high dependency care units
- Number of IVF cycles performed – 1,149 (NHS patients only) / 1,598 (including PP and OSV)

The income generated by the relevant health services reviewed in 2013-14 represents 100 per cent of the total income generated from the provision of relevant health services by the Liverpool Women's NHS Foundation Trust for 2013-14.

2.3.1 Clinical Audit

During 2013-14, 4 national clinical audits and 1 national confidential enquiry covered relevant health services that the Liverpool Women's NHS Foundation Trust provides.

During 2013-14 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 2013-14 are as follows:

National Clinical Audits

- Long Term Conditions – National Pregnancy in Diabetes (NPID)
- Peri and Neo-natal - Neonatal Intensive and special care (NNAP)
- Blood Transfusion - National comparative audit of the patient information and consent
- MBRRACE – UK – Perinatal Mortality

National Confidential Enquiries

- MBRRACE –UK – Maternal Deaths

The national clinical audits and national confidential enquiries that Liverpool Women's NHS Foundation Trust participated in during 2013/14 are as follows:

National Clinical Audits

- Long Term Conditions – National Pregnancy in Diabetes (NPID)
- Peri and Neo-natal - Neonatal Intensive and special care (NNAP)
- Blood Transfusion - National comparative audit of the patient information and consent
- MBRRACE – UK – Perinatal Mortality

National Confidential Enquiries

- MBRRACE –UK – Maternal Deaths

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 2013/14, 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 6. Relevant National Clinical Audits

National Clinical Audit	Did the Trust participate?	Cases submitted
Long Term Conditions		
National Pregnancy in Diabetes (NPID)	✓	**100%**
Peri-and Neo-natal		
Neonatal Intensive and special care (NNAP)	✓	**100%**
Blood Transfusion		
National comparative audit of the patient information and consent	✓	**100%**
MBRRACE – UK		
Perinatal mortality	✓	**87%***

* Due to a change in staffing the information has been delayed in being entered and all data for 2013/14 will be on the MBRACCE system by the end of June 2014.

Table 7 Relevant National Confidential Enquiries

Confidential Enquiry	Did the Trust participate?	Cases submitted
MBRRACE – UK		
Maternal Deaths	✓	**0 cases**

The reports of 4 national 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.

National Pregnancy in Diabetes (NPID):
National report not due until September 2014

Neonatal Intensive and special care (NNAP):
LWH performance exceeded or met national standards for measuring admission temperatures and mothers receiving antenatal steroids. 97% of the eligible babies were screened for retinopathy of prematurity (ROP), but only 73% were screened on time as per national standards.

But this is an improvement from 29.5% in 2011 following change in protocols as a direct consequence of the NNAP results. LWH continues to not meet the standard for documented parental consultations within the first 24 hours although the figure has improved from 42.6% in 2011 to 56% in 2012. Plans are in place to include forced prompts in the new Electronic Patient Record (EPR) to be introduced soon on the neonatal unit to meet this target. It is hoped with the introduction of the new EPR platform- BADGERnet, LWH will be able to contribute to all the NNAP audit questions from 2015. For 2013 and 2014 LWH has contributed data for 100% of the eligible babies for the same five audit questions.

National comparative audit of the patient information and consent:
National report not due until summer 2014

MBRRACE – UK
The report that comes from this submission won't be published until May/June 2015. There has been a gap in annual reports since Confidential Enquiries into Maternal and Child Health (CEMACH) was replaced by MBRRACE so there are no previous reports that need to be actioned.
The reports of 62 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 8 Local Audit actions

Local Audit Title	Actions
Audit of third degree tears	Information cascaded into GREAT Day presentation and lesson of the week plan
Re-audit Clinical letters	Pre-operative preparation to include a check to ensure that the last clinical letter is available on the day of surgery
Reaudit of the Rapid Access Clinic	RAC clinicians now write to GP as required.
Reaudit of diagnosis and management of molar pregnancy commencing 2012	Clinics dropped to every 4 weeks with facility to hold ad hoc clinics if required due to number of patients with GTD dropping.
Audit of the use of and any complications with shelf pessary	To produce a Standard Operating Procedure To produce a new guideline Train new staff in pessary procedure
Audit to assess the initial investigation and management of chronic pelvic pain and the use of diagnostic laparoscopy	To update and amend consent form and to create a diagnostic lap pathway
Audit to assess practice of clean intermittent self catheterisation (CISC) after urogynaecological procedures	A new guideline based on MDT consensus and audit results for preoperative teaching of clean intermittent self-catheterisation has been developed
Audit of vault prolapsed surgery at LWH and its outcomes compared to evidence from NICE/RCOG/BSUG on vaginal vault prolapse	To continue with on-going training.
Audit to assess the compliance to Electronic patient assessment questionnaire (e-PAQ) guidelines	Post-op vouchers are to be assessed with the same standards as pre-op.
Audit of pilot of GC led inherited cardiac condition clinics	Introduced a standard proforma.

Audit of Predictive testing protocol for conditions which preventative measures are available (BRCA 1/2 and Lynch Syndrome)	Introduced a standard proforma.
Audit of Diagnostic genetic testing for hypertrophic cardiomyopathy and Long QT syndrome	The Trust results for this audit were exceptional so not changes in practice needed as a result of this audit.
Audit of BSG Guidelines on Genetic Testing in children	Introduction of child specific consent form
Audit of the Management of carriers of BMD and DMD	GPs can now be asked to refer patients for cardiac screening unless they are symptomatic – if symptomatic, referrals will be made to cardiology directly
Audit of Measuring and improving vitamin D promotion and prescribing to prenatal and postnatal pregnant women	A pathway was established whereby all Liverpool women have access to Vitamin D in pregnancy
Audit of Pregnancy outcomes from women managed in a high risk pre-term labour clinic at LWH	PTL clinic database was established and maintained on shared drive. Introduction of new Meditech code for booking, ensuring capturing of all women with previous cervical surgery.
Placenta Praevia Audit	RCOG elective caesarean section consent form has been adapted for use at LWH and monitoring of compliance. Meditech field was modified for monitoring of compliance.
Risk factors and outcome of women Booking for antenatal Care after 12 weeks and 6 days Audit	Develop guideline for management of those who book after 20/40 Review data for those who book 13+0-19+6 to look for system failures Add field to meditech booking form to ask if patients are transferring or booking late
Comparative audit of outcomes in women with BMI of 35-40 who labour on Delivery Suite and MLU for CGC Assurance and audit to assess compliance with LWH Guidance on antenatal care in obese women	Audit met all standards so no actions required.
Audit of 2011 NICE guidance in Caesarean Section (NICE guideline 132)	Discussions between auditor, Anaesthetics and Maternity highlighted the need for documentation to be recorded accurately. This was highlighted to all staff.
Audit of the compliance with clinical pathways for antenatally diagnosed renal/urological abnormalities	Review of pathway and investigate possibility of creating pathway on Meditech.
Audit of current management of chromosomally normal pregnancies with a low serum PAP-A (<0.3MoM) in the first trimester	New protocol was produced and disseminated to the FMU consultants and antenatal screening midwife within the Trust.
Re-audit to validate breastfeeding statistics	Increased awareness at ward level about the need to have accurate data recorded on meditech
Annual invasive diagnostic procedures audit in the Fetal Medicine Unit 2012	Individual operators to be given their personal data for appraisal and reflection Communicate need to continue to work towards reducing >1 insertion for CVS aiming to reach standard of < 5% If >1 entry document why procedure difficult eg.

Annual stillbirth audit	Introduced customised growth and SFH charts. Produced patient information leaflet regarding reduced fetal movements. Guideline for late transfer of patients. Perinatal Pathologist now present at twice yearly review panel.
Re-audit of debriefing after emergency Caesarean Section	Training for midwives so that they can debrief patients with less complicated indications for the caesarean section. Debrief proforma disseminated in theatres and placed in the notes by the theatre staff as the patient is being discharged from the recovery room back to the wards.
Audit of the integrated elective Caesarean Section Care pathway for all women booked for Elective Caesarean.	Re- launch of the pathway with clear instructions for staff on its completion/ changes made. Changes required on meditech fields to capture changes to practice within the pathway
Low cord PH and HIE audit/Unexpected Admission of term babies to SCBU.	Development of continuous monitoring
Audit of the accuracy of ultrasound estimated fetal weight (EFW) determination in twin pregnancy	Audit met all standards so no actions required.
Audit of the evaluation of nasal injuries caused by nCPAP (Audit of CPAP management on the neonatal unit)	Education provided for nursing staff regarding the importance of correct sized hat, prongs/mask. Check list developed for “quality” CPAP standardised care regarding use of chin strap, suction, free drainage by developing new CPAP guideline. Developed a CPAP quality team to provide clinical supervision and education.
Re audit Prospective Review of Neonatal Deaths (Neonatal Mortality Review)	Multi-professional mortality review panels set us to review objectively the category of care provided. Enhanced education and training around the importance of administering antibiotics within 30 mins of admission/cannulation and of administering surfactant within 15 minutes of intubation in preterm babies.
Audit to assess Compliance with LWH Guidance on Metabolic Bone Disease of prematurity	MBD and Vitamin D policies aligned. MBD included in Senior House Officer teaching programme.
Audit of transport of neonates during periods off nasal CPAP	Network audit – Audit achieved standard. No changes required.
Audit of Cooling Treatment for Babies with Grade 2 or Grade 3 Hypoxic Ischaemic Encephalopathy born at or greater than 36 weeks gestation (Neonatal Network Audit)	Network audit – Audit achieved standard. No changes required.
Audit of 2 year follow up of premature neonates (<30 weeks gestation)	Paper copies of the two year follow up data collection form are now created and freely available in the outpatient clinics to aid capture of outcome data. Infant due to follow up are now highlighted by placing sticker on notes at discharge.
Audit of the detection of major congenital heart defects in babies born in Liverpool Women's Hospital	Formal review of the case of truncus arteriosus not diagnosed antenatally despite a family history of the same condition. Added for ACE review.

Audit to assess compliance with LWH protocol on Neonatal Early Warning Scores (NEWS)	NEWS chart modified. Staff trained on altered chart.
Audit to assess compliance with the NPSA/2010/RRR013 'Safer use of Insulin' guidance	Implemented a robust ordering system to ensure availability of pre-printed insulin prescribing and administration labels at all times. Education around the safe use of insulin is now included at nursing and medical staff induction and ongoing programmes of education. Compliance is now monitored regarding insulin prescribing and administration through the recording of pharmacy interventions and the Trust incident reporting system
Audit of term admissions to NNU	Amended hypoglycaemia policy
Audit of the use of CPAP in preterm infants	Staff informed that clinical practice of alternating masks/prongs is to continue. Staff continuing to use the skin integrity tool as a guide when nasal injury is seen.
Audit of Prescription Safety audit on Neonatal Intensive Care	Now emphasised importance of clear prescriber signatures and continue audits and monitoring of prescriptions on NICU New field on BADGER system for chart details/Gentamicin pathway
Audit of Blood Transfusion in Pre-term infants	Audit met all standards so no actions required.
Audit of central line associated infection on NICU (Femoral line infection)	Audit met all standards so no actions required.
Audit of the Outcomes for Congenital Diaphragmatic Hernia 2012	Audit met all standards so no actions required.
RE-AUDIT: To assess compliance with the NPSA/2010/RRR013 'Safer use of Insulin' guidance	Audit met all standards so no actions required.
Audit to look at compliance with cold chain traceability of blood products between AHCH and LWH	Staff awareness of the importance of always scanning blood products out, that bolus infusions must have start and stop time recorded and that platelets should be given as soon as possible following arrival at LWH.
Audit to assess compliance with LWH guideline on suspected infection in neonates managed on the Postnatal ward	Review suspected infection guidelines in particular need for daily blood tests, method for detecting babies with suspected sepsis and method for reviewing babies on antibiotics is required. To be presented and discussed at clinical governance afternoon. Following this, guideline is to be reviewed and recommended changes to be implemented.
FASP re-audit	Copies of Information Poster have been placed in each ultrasound room to remind Sonographers during scan.
Audit to assess NPSA 16 – Failure to act upon radiological reports (abnormal or clinically significant findings)	A new standard operating procedure has been developed for management of faxes.
DQASS Audit (Down's Syndrome Screening Quality Assurance Support Service)	Information sheet highlighting ways to improve CRL and NT measurements to improve screening service has been developed and disseminated to all sonographers in Imaging Dept. Poster also displayed on the notice board and antenatal scan room.

Management of Linen	The temporary space for storage of linen was unsuitable, therefore another more suitable temporary space has been found. A permanent space still to be agreed. Service Level Agreement to be developed with G4S Cleaning standards and storage to be included in Service Level Agreement being developed with G4S. Estate environment to be determined when new location identified. Reported non-compliance to individual ward managers to action via IPC clinical audit process - Awareness sessions via link staff communication. - Featured in IP&C Quarterly reports to IPCC
Audit Assessing compliance with clinical guidelines for the management of ovarian hyperstimulation and HFEA reporting requirements	Establish an effective system to identify, review and report OHSS. Examine and refine all protocols for OHSS prevention. Create new guidelines for OHSS clinical management.
Team Brief and WHO checklist for Gynae' theatres (Nursing Indicator) audit	All staff are reminded that the Safer Steps to Surgery is a mandatory theatre document that requires 100% completion, If there is no requirement for staff input or action, this is to be clearly indicated using a dash or the word “None: Awareness to remind all staff to sign each area of the WHO checklist. A newly re-designed perioperative care pathway to integrate the WHO checklist is in progress and Safer steps to surgery to be incorporated into specification for next generation of Theatre Management software
Difficult/Failed Intubation audit	Intubation trolley has been moved from Obstetric Theatre 3 to Obstetric Theatre 2 where most emergency cases are performed
Anaesthetic Record Keeping audit	New version of anaesthetic software V3.0 has been implemented
Anaesthetic activity for NAP5 project (baseline audit) (DG06 Depth of Anaesthesia Monitors)	Awaiting National report - no actions required at present
National comparative audit of the labelling of blood samples for transfusion	Continued mandatory education on a monthly basis to help reduce blood sampling errors, ongoing monthly sample rejection analysis and Lesson of the month on blood transfusion best practice
PONV following surgery audit	Implementation of procedure for all anaesthetists to give anti-emetics according to Apfel score and operation risk
Audit of the Efficiency of intra-op rectus sheath blocks at reducing post-op pain, reducing the need for opioid analgesia and improving overall pt recovery (Pain management following Gynae' surgery)	Implementation of a standard technique to be used by all teams regarding Rectus Sheath Blocks for Gynae' Surgery
Audit of pain relief using oral morphine for analgesia following elective C section	Awaiting changes in practice

Routine Enquiry procedures	Continue to deliver domestic abuse/routine enquiry training to all midwives as part of 'Obstetrics 2' mandatory training day, ensure all staff complete x 3 yearly after attendance on initial 4 hour training session, continue to offer bespoke domestic abuse training for staff upon request or as need arises, continue to quality assure all health professionals letters/children's service referrals/other forms of communication, continue to complete Adverse Clinical Event (ACE) forms where policy has not been adhered to and safeguarding risk has been increased due to this failure and change Meditech system to ensure mandatory fields are set up to include partner names/accompanied and if so by whom/PCI bulletin board checked
Health Record Content	Trust wide action plan to improve compliance is in progress

2.3.2 Clinical Research

The number of patients receiving relevant health services provided or subcontracted by Liverpool Women's NHS Foundation Trust in 2013-14 that were recruited during that period to participate in research approved by a research ethics committee was 1,401, of which, 1,308 were recruited into NIHR portfolio studies.

In 2013/14 we have continued our efforts to contribute to quality National Institute for Health Research (NIHR) studies and to increase subsequent NIHR recruitment accruals.

Liverpool Women's was involved in conducting 102 clinical research studies across our speciality areas of maternity, neonates, gynaecology oncology, general gynaecology, reproductive medicine and genetics during 2013/14. At the end of 2013/14 a further 26 studies were in set up including 5 industry studies.
There were 66 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 healthcare delivery in the community.
Our research has contributed to the evidence-base for healthcare practice and delivery, and in the last year, 71 publications have resulted from our involvement in research (with 15 NIHR publications), which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS.

2.3.3 CQuIns

A proportion of Liverpool Women's NHS Foundation Trust's income in 2013-14 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 2013-14 and for the following 12 month period are available electronically at:
http://www.liverpoolwomens.nhs.uk/About_Us/Quality_and_innovation.aspx ,

in addition Information on 2014-15 contracts including CQuINs is available at:
(http://www.england.nhs.uk/nhs-standard-contract/)

The total monetary value of the income in 2013-14 conditional upon achieving quality improvement and innovation goals was £1,843,466. The monetary total for the associated payment in 2012-13 was £1,767,961.

The Trust reported performance against CQuIns targets for 2013-14 are provided below and followed by the dashboard developed for CQuIns monitoring in 2014-15.

CQUINS Quarter 4 Update												
	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
1.1 Extend Friends and Family Test to Maternity												
Requirement	N/A						Maternity FFT to be implemented					
Status	N/A						Maternity FFT has been implemented					
1.2 Improve Response Rate of Friends and Family Test (Target Value = 15% rising to 20% by year end)												
Response Rate	3.2	1.3	25.5	21.9	18.1	18.3	8.8	11.2	22.6	34.2	37.2	31.2
Responses	35	14	285	244	201	198	109	135	247	408	410	381
Episodes of Care	1089	1108	1118	1116	1111	1082	1241	1201	1094	1192	1103	1221
1.3 Improve NHS Staff Survey Friends and Family Test												
Question Considered "If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation"												
	Strongly Disagree		**Disagree**		**Neither Agree Nor Disagree**		**Agree**		**Strongly Agree**			
2012 Staff Survey	5		12		21		50		12		**3.53**	
2013 Staff Survey	3		5		25		50		18		**3.75**	
Comment	Comparative results between 2012 and 2013 Staff Survey show an improvement in the year to year score											
1.4 Provide Evidence of Responses to Patient Feedback												
Evidence of Response	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
2.1 Send NHS Safety Thermometer to NHS Information Centre												
Status	Sent	Part	Sent	Sent	Sent	Sent	Sent	Sent	Sent	Sent	Sent	Sent
3.1.1. Assess Emergency Admissions >= for Demenia (Target Value = 90%)												
Assessment Rate	100	NIL	NIL	100	NIL	NIL	75	75	67	100	50	0
No Assessed	2	0	0	1	0	0	3	3	2	1	1	0
No Patients	2	0	0	1	0	0	4	4	3	1	2	1

3.1.2. Refer Postivie Assessed Dementia Patients for Diagnostics (Target Value = 90%)

Diagnostic Rate	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	100	NIL
Diagnostics Completed	0	0	0	0	0	0	0	0	0	0	1	0
Positive Assessments	0	0	0	0	0	0	0	0	0	0	1	0

3.1.3. Refer Positive Diagnostic Dementia Patients to Specialised Services (Target Value = 90%)

Referral Rate	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL
Referrals	0	0	0	0	0	0	0	0	0	0	0	0
Positive Diagnostics	0	0	0	0	0	0	0	0	0	0	0	0

3.2 Confirm Lead Clinican for Demenia and complete appropriate training for staff

Status	The CQUIN has been implemented and is considered complete

3.3 Undertake a quarterly audit of Carers of Patients with Dementia to ensure they feel appropriatelt supported

Status	NIL	NIL	NIL	NIL

4.1 Ensure all eligible patients receive a VTE assessment (Target Value - 95%)

Assessment Rate	95	96	98	98	98	97	97	97	98	97	98	98
No Assessed	1577	1602	1508	1672	1567	1583	1701	1692	1601	1703	1560	1697
No eligible	1660	1665	1545	1712	1608	1637	1756	1742	1639	1751	1593	1739
Comment												

4.2 Ensure all instances of Hospital Aquired Thrombosis have a RCA carried out (TV = 100%)

RCA Rate	NIL	NIL	100	NIL	NIL	NIL	100	NIL	NIL	NIL	NIL	NIL
No Completed	0	0	1	0	0	0	1	0	0	0	0	0
No VTEs	0	0	1	0	0	0	1	0	0	0	0	0
Comment												

5.0 Provide a quarterly update on the implementation of the Francis Report	
Quarter 1	The Trust has an action plan that has been approved by the Clinical Governance Committee. It has also been presented to the Governance and Clininical Assurance Committee
Quarter 2	Francis Report is now a permanenent agenda item at Clinical Governance Committee. Recommendations and Trust actions progressing. Have been assigned to an executive and operational lead
Quarter 3	Francis Report remains a permanent agenda item at Clinical Governance Committee. Recommendations and Trust actons progressing well in this quarter with support of the executive and operational leads
	The Trust has continued to implement the recommendations of the Francis Report. As of March, the Trust had fully implemented 73% of the recommendations. 27% were partly though not yet fully implemented. There were no recommendations that had not been implemented to some degree
Comment	

6.1 Provide a quarterly update on the implementation of Electronic Transmission of Inpatient Correspondence	
Quarter 1	All inpatient discharge summaries are now electronicaly constructed and contain the recommended minimum dataset. The Trust regards this CQUIN measure as complete given that this was introduced in 2012-2013
Quarter 2	As per Quarter 1
Quarter 3	As per Quarter 1
Quarter 4	As per Quarter 1

6.1.1 Electronic Inpatient Summaries to Contain Minimum Dataset (Target Value = 100%)												
Compliance Rate	100	100	100	100	100	100	100	100	100	100	100	100
Comment												

6.2 Provide a quarterly update on the Implementation of Electronic Transmission of Outpatient Correspondence	
Quarter 1	An implementation plan has been developed and is available
Quarter 2	The project is progressing in accordance with the revised implementation plan
Quarter 3	The project is progressing in accordance with the revised implementation plan
Quarter 4	Project progressing, and piloted, but further work required to ensure clarity on the scope of the project. Project will require further implementation time (during 2014/2015) in order to reach completion
Comment	

6.3 Provide a quarterly update on the implementation of Electronic Transmission of Emergency and Day Case Correspondence	
Quarter 1	An implementation plan has been developed and is available
Quarter 2	The project is progressing in accordance with the Q1 implementation plan
Quarter 3	The project is progressing in accordance with the Q1 implementation plan
Quarter 4	Project progressing, and piloted, but further work required to ensure clarity on the scope of the project. Project will require further implementation time
Comment	

7.1 Ensure CWT patients referred receive their first diagnostic test on or before Day 14 (Target Value = 85%)												
14 Day Test Rate	-	-	-	-	-	-	-	-	-	-	-	-
Comment	The standard (and list of diagnostic tests) has not been signed off by the CCG's within the Cheshire and Merseyside Strategic Clinical Networks. At the last network meeting (15/04/14) it was confirmed that some, but not all CCG's had ratified the standard. The Trust uderstands that It is now expected that the standard will be introduced during 2014-15, but there is no date for introduction, or if it will be backdated to the start of 2014-15											

7.2 Ensure CWT patient referral made by Day 42 (Target Value= 85%)												
42 Day Test Rate	100	89	50	67	67	0	0	100	100	50	0	100
No Patients by Day 42	2	8	4	2	2	0	0	1	1	1	0	1
No Patient Referrals	2	9	8	3	3	1	6	1	1	2	1	1
Comment												

8.1 Improve Breastfeeding Rates (Target Value = 60%)												
42 Day Test Rate	52	52	54	51	51	51	55	52	53	55	54	53
No Patients by Day 42	331	342	307	361	373	362	374	351	370	382	324	349
No Patient Referrals	636	660	570	704	731	703	678	573	699	690	601	658
Comment												

8.2.1 Incorporate Brief Intervention Training into Mandatory Training												
Quarter 1	Head of Midwifery to discuss with CCG colleagues. Clarification required											
Quarter 2	Awaiting response from CCG colleagues. Head of Midwifery obtiaining figures of when midwives have had previous brief intervention training. Will retrain if required											
Quarter 3	Training is provided to all midwives annually as part of Maternity Study Day 1 with records kept on the Trust OLM system to ensure all staff are captured											
Quarter 4	Brief intervention training is now incorporated into the Trust annual training and will be on going through out 2014											
Comment												

8.2.2 Ensure Maternal Smoking Status is captured at 38 weeks (Target Value = 95%)												
Capture Rate	100	100	100	100	100	100	100	100	100	100	100	100
No Patients Asked	636	666	582	704	735	714	685	687	700	696	618	669
No Deliveries	636	666	582	704	735	714	685	687	700	696	618	669
Comment												

8.2.3 Provide Brief Intervention Advice to Maternal Smokers (Target Value = 95%)												
Advice Rate	95	95	97	97	99	94	96	95	95	95	96	97
No Interventions	143	136	141	161	140	127	152	147	104	158	160	148
No Smokers	150	143	145	166	141	135	159	154	109	167	166	153
Comment												

8.2.4 Provide Onward Referral to Stop Smoking Service for Maternal Smokers (Target Value = 50%)												
Advice Rate	99	100	99	98	99	99	99	99	99	99	99	99
No Interventions	149	143	144	162	140	133	157	153	108	166	164	151
No Smokers	150	143	145	166	141	135	159	154	109	167	166	153
Comment												

8.3 Provide a quarterly update in the Implementation of Vitamin D Guidelines	
Quarter 1	Awaiting clarification and direction fromm CCG on availability of Vitamin D. Head of Midwifery to discuss implementation with CCG
Quarter 2	Awaiting action from public health regarding how LCH get vitamin D into children's centres. Pharmacy in LWH currently developing PGD guidelines.
Quarter 3	Universal Vitamin D is in the process of being implemented. PGD has been deemed necessary fir this so is in the process if e=being formatted and circulated. There is also an SOP outlining how women will receive the vitamins.
Quarter 4	The actions for the implementation of Vitamin D have been completed from LWH. There is ongoing communication with children's centres and public health
Comment	

8.4 Provide a quarterly update on Implementation of BFI Audit Tools	
Quarter 1	Updated Action Plan is available
Quarter 2	Updated Action Plan is available
Quarter 3	Updated Action Plan is available
Quarter 4	Awaiting feedback from BFI regarding accreditation for stage 3. Actions completed, expected green.
Comment	

8.3 Provide a quarterly update on the Implementation of the Flu Vaccinations to Pregnant Women	
Quarter 1	Awaiting clarification and direction from CCG on availability of Flu Vaccine. Head of Midwifey to discuss
Quarter 2	Teleconference booked with Dan Seddon re: this on 25/09/2013. Plan to offer in all areas that women are scanned plus by community midwives. Alltraining for midwives arranged
Quarter 3	triage and assessment. We also offered it to inpatient antenatal women. Between the dates if 18.11.2013 and 31.01.2014 over 300 women were vaccinated on Crown Street site, this is in addition to the signposting by community midwives to the practice nurse flu clinic in the GP surgeries. We hope to extend this services across other site next year
Quarter 4	This quarter fell outside of the recognised flu season, therfore vaccinations were not given. LWH did however continue to discuss the flu season update with the CCG
Comment	

Table 9. CQuIns 2014-15

CQUINS Dashboard - 2014/15 - April 2014 Report Date: #NAME? at #NAME?

Goal Number	Indicator Number	Indicator Name	Weighting	YTD	Apr	May	Jun	Qtr 1 Target	Qtr1	Jul	Aug	Sep	Qtr 2 Target	Qtr2	Oct	Nov	Dec	Qtr 3 Target	Qtr3	Jan	Feb	Mar	Qtr 4 Target	Qtr4
1		**Friends and Family Test**																						
	1.1	Implementation of Staff F&FT	0.0375%					Compliant					Compliant					Compliant					Compliant	
	1.2	Early implementation Day Cases and Outpatients	0.01875%					Compliant					Compliant					Compliant					Compliant	
	1.3	Improvement in A&E	0.01875%					15%					20%					>20%					>20%	
	14	Response rate improvement Inpatients	0.05%					25%					30%					>30%					>30%	
	1.5	Provide timely, granular feedback from patients about their experience	0.0750%					Compliant					Compliant					Compliant					Compliant	
2		**NHS Safety Thermometer – Data Collection**																						
	2.1	National safety thermometer – reduction targets for Pressure Ulcers	0.0625%					Compliant					Compliant					Compliant					Compliant	
	2.2	Reduction targets for Pressure Ulcers	0.0625%					95%					>Qtr1					>Qtr2					>Qtr3	
3		**Dementia**																						
	3.1.i	FAIR - Find, Assess, Investigate & Refer	0.0750%					90%					90%					90%					90%	
	3.1.ii	Clinical Diagnosis of delerium etc						90%					90%					90%					90%	
	3.1.iii	Further assessment/ diagnostics for Dementia						90%					90%					90%					90%	
	3.2	Clinical Leadership (Compliant: Yes or No)	0.0125%					Compliant					Yes					Yes					Yes	
	3.3	Supporting carers (Compliant: Yes or No)	0.0375%					N/A					Yes					Yes					Yes	
4		**Maternity Bundle**																						
	4.0	Breastfeeding Initiation	0.1%					53%					>53%					>Qtr2					>Qtr3	
	4.0.1	Maternal Smoking status captured at 38 Weeks	0.1%					65%					75%					85%					95%	
	4.0.2	% maternal smokers offered referral to smoking cessation services						45%					50%					55%					60%	
	4.0.3	Vitamin D	0.1%					NA		Set Baseline			TBC					75%					75%	
	4.0.4	Flu Vaccinations Pregnant Women	0.1%		ActionPlan			Compliant		Update Plan			Compliant					65%					75%	
	4.0.5	Pregnant women are cared for by a named midwife throughout their pregnancy	0.1%					65%					65%					65%					65%	
	4.0.6	BMI index	0.1%		etablish electronic system			Compliant					TBC					TBC					TBC	
5		**Cancer**																						
	5.1	First diagnostic test by day 14	0.125%					85%					85%					85%					85%	
	5.2	Referral to treating trust by day 42	0.125%					85%					85%					85%					85%	
6		**Effective Discharge Planning Maternity -**																						
	6.1	Signed off Action Plan (Compliant Yes or No)	0.125%		Action Plan			Compliant		Action Plan			Compliant		Progress of ActionPlan			Compliant		Progress of Action Plan			Compliant	
	6.2	Discharges with appropriate care packages?	0.125%		Action Plan			Compliant		Action Plan			Compliant		Progress of ActionPlan			Compliant		Progress of Action Plan			Compliant	
	6.3	Discharge Checklist Audit (Compliant Yes or No % completed)	0.125%		Action Plan			Compliant		Action Plan			Compliant		Progress of ActionPlan			Compliant		Progress of Action Plan			Compliant	
	6.4	Annual Discharge Survey (Numbers surveyed?)	0.125%		Action Plan			Compliant		Action Plan			Compliant		Progress of ActionPlan			Compliant		Progress of Action Plan			Compliant	

CQUINS - Specialist Commissioner

Goal Number	Indicator Number	Indicator Name		YTD	Apr	May	Jun	Qtr 1 Target	Qtr1	Jul	Aug	Sep	Qtr 2 Target	Qtr2	Oct	Nov	Dec	Qtr 3 Target	Qtr3	Jan	Feb	Mar	Qtr 4 Target	Qtr4
SC	SC1	Improved access to maternal breast milk in preterm infants						25%					TBC					TBC					TBC	
	SC2	Access to Array CGH for Prenatal Diagnosis						TBC					TBC					TBC					TBC	
	SC3	Perinatal pathology reporting time 70% in 6 weeks						70%					70%					70%					70%	

2.3.4 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 not taken enforcement action against Liverpool Women's NHS Foundation Trust during 2013-14.

Liverpool Women's NHS Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2013-14:

- Special Reviews – Nil
- Unannounced inspection, July 2013.

In July 2013 the CQC made an unannounced visit to the Trust as a result of which it registered three concerns. These 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).

Inspection	Standard(s) Reviewed	Outcome	
		Finding(s)	CQC Judgement
Unannounced inspection 7-8 July 2013	Outcome 4- People should get safe and appropriate care that meets their needs and supports their rights.	People didn't always experience timely care, treatment and support to meet their needs.	Minor Impact – Action needed.
	Outcome 13 – People should be cared for by staff who are properly qualified and able to do their job.	There were insufficient numbers of qualified, skilled and experienced staff on duty to meet the needs of people using the service	Moderate Impact – Action needed.
	Outcome 14 – Staff should be properly trained and supervised, and have the chance to develop and improve their skills.	People were cared for by staff who were not always fully supported to deliver care and treatment to an appropriate standard.	Minor Impact – Action needed.

The matters identified by the CQC were well known to the Trust and were already being actively addressed. A comprehensive action plan was prepared subsequently and closely monitored throughout the year via the Trust's Maternity Service Risk Management Committee, Clinical Governance Committee and Governance and Clinical Assurance Committee, and reported through to the Board of Directors. Three action points from the plan remain outstanding.

Liverpool Women's NHS Foundation Trust intends to take the following action to address the conclusions or requirements reported by the Care Quality Commission (See table below).

Liverpool Women's NHS Foundation Trust has made the following progress by 31st March 2014 in taking such action: See status column of table below.

Action	Status
Implement e-Rostering, to manage Midwifery and Nursing staffing.	In Progress
Provision of additional on-site parental accommodation for parents with Babies in neonatal intensive care unit. Funding identified, awaiting outcome of option appraisal project	In Progress
Increase midwifery staff to full establishment in MAU to provide increased staffing at peak times and address waiting times.	Completed
Introduce a mechanism to record time of woman's arrival, and point at which 30 minutes will elapse to highlight easily to staff women that have not been seen. (This information displayed in telephone triage room which has no patient access and so no issue around confidentiality).	Completed
Introduce escalation SOP for times of extreme activity and for women not triaged and treated within 2hrs.	Completed
Overview of activity on Delivery suite and MAU and medical staff allocated accordingly. Escalation to the 100 bleep if activity increases or women have been waiting for more than 30 minutes in order to flex the medical team throughout the Trust.	Completed
Development of an SOP which includes escalation to consultant on call if women are waiting for medical review from the registrar. Process currently in place	Completed
White board location and content has been reviewed. Board to be relocated to telephone triage room (not visible to public). In the interim only patient initials are displayed on the board. Handover moved to the telephone triage room to protect confidentiality.	Completed
Staff breaks- Individual areas to identify own mechanisms to ensure staff have adequate breaks. Shift leaders being tasked with pro-actively managing this with support from senior staff. A designated workforce proforma to be implemented for use on each shift to ensure staff breaks are recorded.	Completed
Implement Escalation policy for management of high acuity/ occupancy	Completed
Update Incident Reporting Trigger List Poster including reporting of Staffing issues and with reporting figures for last year included. SOMs to encourage their supervisees to report incidents appropriately.	Completed
Previously cancelled Annual Audit meeting for SOMs to be rearranged (Audit Meeting organised for the 22/10/13)	Completed
The Maternity Service committed to undertaking 25% of outstanding PDRs for October, November and December 2013 to recover the performance back to the Trust standard of 95%.	In Progress
Development of a Comprehensive mandatory training recovery plan by the Education leads monitored on a weekly basis.	Completed
Additional midwives to be appointed to support the professional development co-ordinator.	Completed
Mandatory training action plan to be developed with a target of 100% completion by December 2013. (As at 10/01/14 awaiting latest data on mandatory training compliance)	In Progress

The CQC revisited the Trust in April 2014 and a draft report of that revisit, accompanied by two warning notices, has recently been received. The warning notices are in respect of:

- Regulation 22 - sufficient numbers of suitably qualified, skilled and experienced persons employed
- Regulation 10 - effective operation of systems designed to:
  1) regularly assess and monitor the quality of the services provided; and
  2) identify, assess and manage risks relating to the health, welfare and safety of service users and others.

The CQC's inspection process allows for the inspected organisation to make representations if the inspected organisation thinks that the notice has been wrongly served. The Trust intends to make representations to the CQC, and has until mid-June to do so. The Trust's intention is to provide the CQC with further evidence in respect of the matters raised in its draft report and warning notices.

2.3.5 Information Governance

Liverpool Women's NHS Foundation Trust's Information Governance (IG) Assessment report overall score for 2013-14 was 75% and was graded "Not Satisfactory".

The failure to match last year's "Satisfactory" grading reflects the Trust's difficulties in moving toward a fully electronic IG training solution. When implemented in 2014-15 this training solution will provide the Trust with far more robust assurance regarding staff knowledge and security of patient information but the transition state has led to a short-term reduction in training levels.

2.3.6 Clinical Coding

Liverpool Women's NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2013-14 by the Audit Commission.

Liverpool Women's NHS Foundation Trust has taken the following actions to improve data quality:

- Three clinical coders have been studying to sit the National Clinical Coding Examination in March 2014 and all clinical coders have protected study time to ensure they are up to date with national coding standards.
- The Trust has an extensive internal audit programme which has seen a steady improvement in clinical coding accuracy throughout the year and will continue in to 2014/15.
- Clinical coders have also been working closely with clinicians to improve the quality of clinical coding through education on clinical coding rules.

The Liverpool Women's NHS Foundation Trust will be taking the following actions to improve data quality:

- The Trust will continue to support all clinical coders wishing to sit the National Clinical Coding Qualification.
- The Trust will continue its extensive internal audit programme in to 2014/15.

2.3.7 Submission to Hospital Episodes Statistics & Data Quality

Liverpool Women's NHS Foundation Trust submitted records during 2013-14 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:**
98.16% for admitted patient care;
98.94% for out-patient care; and
97.82% for accident and emergency care.

— **which included the patient's valid General Medical Practice Code was:**
99.73% for admitted patient care;
97.98% for out-patient care; and
98.31% for accident and emergency care.
(*Data taken from the IG toolkit report provided by Liverpool CSU for April 2013 to January 2014*).

Liverpool Women's NHS Foundation Trust will be taking the following actions to improve data quality:

- Newly formed Data Quality sub-group will manage and have oversight of data quality issues, assign ownership, approve actions and escalation processes.
- Improved reporting mechanisms have been introduced to improve efficiency and delivery of activity and associated data quality reports to the Trust.
- Implement a new data warehousing systems to provide further assurance of data processing and reporting.

2.3.8 Reporting against core indicators

2.3.8.1 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 (2.1.2.1 Mortality Rates in Gynaecology and 2.1.2.4 Neonatal Mortality).

2.3.8.2 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.

2.3.8.3 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.

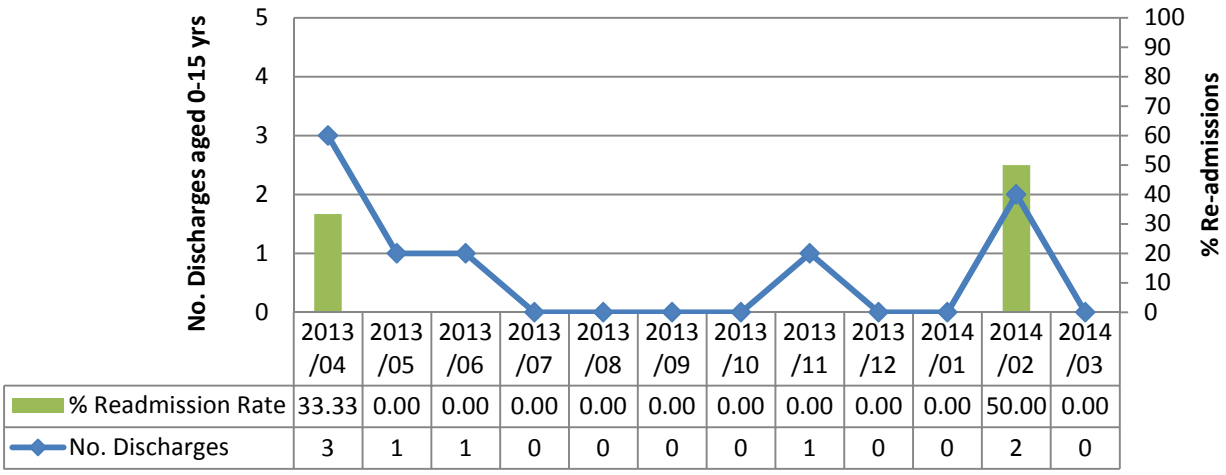
Why and how this priority goal was selected:
The aim and hope after surgery is that all patients go home promptly and recover without complications. However, a small proportion of patients either their GP with minor concerns. Or sometimes need readmission to hospital with significant post-operative problems. 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.

Important because:
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 2013-14

a) 28 day Readmission rates Patients aged 0-15yrs



	2013/04	2013/05	2013/06	2013/07	2013/08	2013/09	2013/10	2013/11	2013/12	2014/01	2014/02	2014/03
% Readmission Rate	33.33	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	50.00	0.00
No. Discharges	3	1	1	0	0	0	0	1	0	0	2	0

% Readmission rates ages 0-15yrs													
Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Av.
2011/12	Not Collected												
2012/13	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2013/14	33.33	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	50.00	0.00	25.00

N.B. The definition of this 28 day re-admissions indicator has been revised since 2013-14 to delineate the data into the two age groups. The historic data presented is not that previously reported, but a reflection of the application of the new specification on the previous period. The data was not available for 2011-12.

The data shows a total of 8 patients discharged in this age group with two re-admissions (⅓ and ½) in separate months equating to an overall rate of 25%; however since the Trust has so few patients in this age group no useful conclusions can be drawn from the data.

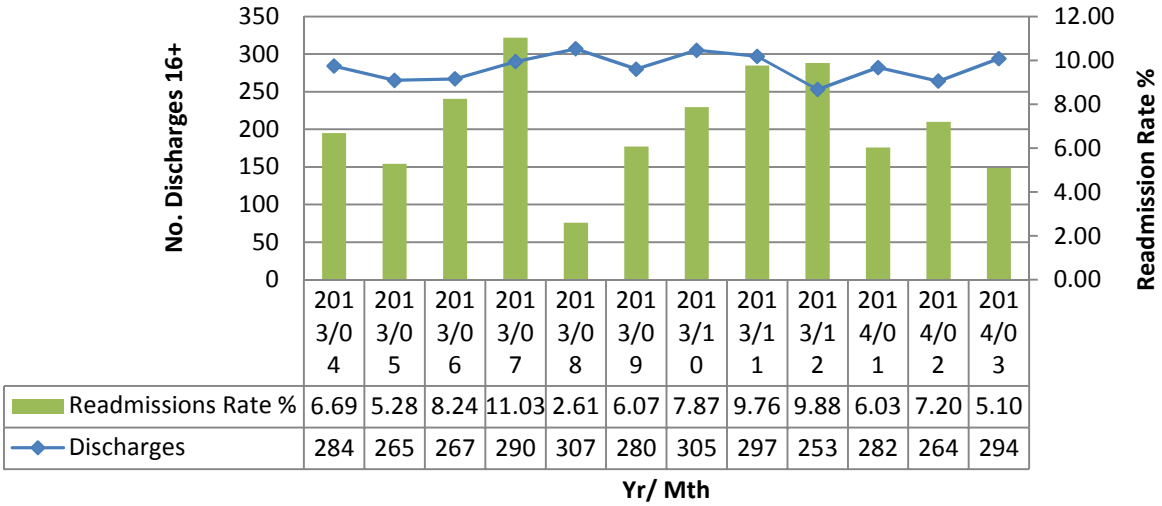
Available Benchmarking Data:

Emergency readmissions to hospital within 28 days of discharge from hospital: children of ages 0-15		2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
LWFT	Readmissions	9	4	5	2	N/A	N/A
	Discharges	71	59	46	25	N/A	N/A
	%	12.7%	6.8%	10.9%	8.0%	N/A	N/A
BWH	Readmissions	14	22	11	10	N/A	N/A
	Discharges	171	223	156	127	N/A	N/A
	%	8.2%	9.9%	7.1%	7.9%	N/A	N/A
Sp Acute Trusts	Readmissions	5281	5940	6506	5082	N/A	N/A
	Discharges	50705	58271	62295	53537	N/A	N/A
	%	10.4%	10.2%	10.4%	9.5%	N/A	N/A
Indirectly age, sex, method of admission, diagnosis, procedure standardised percent	LWFT	11.94%	7.57%	11.48%	6.71%	N/A	N/A
	BWH	7.38%	7.94%	6.89%	6.97%	N/A	N/A
	Sp Acute Trusts	11.15%	10.96%	11.02%	10.70%	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.

b) 28 day Readmission rates Patients aged 16yrs and over

N.*B. The definition of this 28 day re-admissions indicator has been revised since 2013-14 to delineate the data into the two age groups. The historic data presented is not that previously reported, but a reflection of the application of the new specification on the previous periods*.



	2013/04	2013/05	2013/06	2013/07	2013/08	2013/09	2013/10	2013/11	2013/12	2014/01	2014/02	2014/03
Readmissions Rate %	6.69	5.28	8.24	11.03	2.61	6.07	7.87	9.76	9.88	6.03	7.20	5.10
Discharges	284	265	267	290	307	280	305	297	253	282	264	294

% Readmission rates ages 16yrs+													
Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Av.
2011/12	4.26	3.23	5.04	7.26	8.59	6.80	6.36	7.49	11.85	6.02	8.86	8.29	7.01
2012/13	6.11	8.60	6.10	7.83	6.64	8.90	7.42	7.17	4.72	8.46	9.76	8.17	7.49
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

Although fluctuating, the readmission rate have remained static over the past 3 years – highly encouraging despite the increasing complexity of the surgery undertaken at the Trust and the increasing morbidity of our patients due to age and other factors.

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
LWFT	Readmissions	199	146	124	130	N/A	N/A
	Discharges	3100	3047	2789	2422	N/A	N/A
	%	6.4%	4.8%	4.4%	5.4%	N/A	N/A
BWH	Readmissions	132	138	108	111	N/A	N/A
	Discharges	2084	2023	1934	1686	N/A	N/A
	%	6.3%	6.8%	5.6%	6.6%	N/A	N/A
Sp Acute Trusts	Readmissions	4860	4832	4969	4844	N/A	N/A
	Discharges	78230	78921	79728	74421	N/A	N/A
	%	6.2%	6.1%	6.2%	6.5%	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
	BWH	11.18%	12.03%	10.03%	11.70%	N/A	N/A
	Sp Acute Trusts	9.83%	9.55%	9.61%	9.73%	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.

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 validated by the Trust's auditors.

How progress to achieve the priority goal is monitored and measured

Data for the last two years are not yet 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

With a stable readmission rate in the face of significant clinical and in patient changes, no specific action is required at present, though ongoing review will be necessary.

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

- Reviewing its data from these newly defined measures to establish and address any causative trends and themes.

2.3.8.4 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?*

This data for 2013-14 is not available via the HSCIC site, the Trust has 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.

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.

Trust Sponsor / Lead: Director of Nursing, Midwifery & Operations.

Progress made in report period 2013-14
The following table shows the Trust's performance against this measure with data available from 2003 to 2013. Included in the data where available is the average score for the Trust's parent region (SHA), data for the same period for Birmingham Women's Hospital (BWH, its recognised benchmark Trust) and the national average and range.

Year	LWH Score	SHA Average	BWH Score	National Average	Annual Range
2013/14	80.5	N/A	N/A	N/A	N/A
2012/13	77.5	69.1	77.1	68.1	57.4 – 84.4
2011/12	76.6	68.6	73.8	67.4	56.5 – 85.0
2010/11	76.5	68.3	75.6	67.3	56.7 – 82.6
2009/10	74.6	67.5	78.3	66.7	58.3 – 81.9
2008/09	74.2	68.4	75.9	67.1	56.9 – 83.4
2007/08	71.3	67.2	78.1	66.0	54.6 – 83.1
2006/07	72.6	68.1	69.6	67.0	55.1 – 84.0
2005/06	73.6	69.6	75.9	68.2	55.8 – 82.6
2003/04	69.5	69.2	71.2	67.4	56.6 – 83.3

The Trust's achievement in 2013-14 exceeded the national average and is comparable with BWH our recognised benchmark Trust.
The Liverpool Women's NHS Foundation Trust considers that this data is as described for the following reasons:

- It is derived from the responses to the abovementioned questions in the Picker report on the Inpatient survey 2013 for Liverpool Women's NHS Foundation Trust and has calculated in the prescribed manner.
- The survey was conducted independently by the Picker Institute.

How progress to achieve the priority goal is monitored and measured

The constituent questions are derived from questions used in the Picker In-patient survey and hence are considered by the Nursing and Midwifery Board in their review of the Trust's Picker in-patient Survey.

How progress to achieve the priority goal is reported

The results of the individual questions in the inpatient survey and the combined measure are considered by the Nursing and Midwifery Board in their review of the Trust's Picker in-patient Survey.

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

- Including the contributing questions within the set of bespoke questions and assessments that our nursing staff have to collate each month. The questions that are identified in the national survey are also asked of patients in the care setting on a regular basis. This enables locally led remedial plans to address in a timely manner any areas of concern or non-compliance.
- The Ward and department managers are supervisory and therefore have been able to role model the behaviours and attitudes required to provide the very highest standards of care to our patients. This has been supported by an internal development programme
- Introducing 'intentional rounding'.
- Introduction of a bespoke communication training package within inpatient Gynaecology.

2.3.8.5 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.

Trust Sponsor / Lead:

Progress made in report period 2013-14

Trust / Group	2012-13	2013-14
Liverpool Women's NHS FT	62%	67.4%
Birmingham Women's NHS FT	78%	75.9%
Average for All Acute / Specialist Acute Trusts	65%	67.1%
Range for All Acute / Specialist Acute Trusts	51.1-77.3%	39.6-93.9%

NB. *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. Last year we reported a range for all Specialist Acute Trusts, but this is not available from the source data for the 2013 survey*.

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

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.

The data presented was taken from downloadable spread sheets available at:
http://www.nhsstaffsurveys.com/Search/?search=staff%20survey%202012%20detailed%20spreadsheets

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 score and so the quality of its services, by:

- Focussing on ensuring that staff have the opportunity to get involved with improving patient care. This has been achieved in a number of ways:
    - Monthly Listening events with Executive Directors to hear staff ideas on how better care can be delivered
    - Service improvement and transformation events for clinical services where staff are involved in redesigning services for the benefit of patients
    - Investment in leadership training for managers
    - Timely and proactive recruitment to maintain consistent staffing levels
    - Changes to team structures with shift leaders and team leaders managing smaller teams
    - Local PULSE surveys giving managers the information to address staff issues in a timely fashion
    - Introduction of the staff bank ensuring effective responses to short term staffing issues
    - Introduction of e-rostering to ensure rotas are planned efficiently to meet the demands of the service.

- On an ongoing basis, staff in all clinical areas are being asked to get involved with projects to improve clinical care and regular engagement events are taking place to ensure that staff are informed about events and have an opportunity to influence positive change.

2.3.8.6 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.

Trust Sponsor / Lead: Medical Director / Acting Director of Nursing, Midwifery & Operations

Progress made in report period 2013-14:

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	

2011-12	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
LWH Activity	1640	1681	1719	1694	1569	1595	1743	1679	1627	1670	1686	1762	
No. VTE Assessments	1548	1613	1626	1583	1493	1515	1643	1603	1575	1596	1604	1644	Average
LWH %	94.39%	95.95%	94.59%	93.45%	95.16%	94.98%	94.26%	95.47%	96.80%	95.57%	95.14%	93.30%	94.92%
All Acute Providers	82.90%	84.40%	85.70%	87.20%	88.30%	89.50%	89.90%	91.40%	91.00%	92.10%	92.50%	92.90%	88.98%
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 local data is taken directly from the Patient Information System 'Meditech' on which admission and VTE assessment activity are recorded.
- The calculation is a simple percentage calculation of comparing the number of conducted assessments with the number of admissions of at least an overnight duration.

The National benchmarking data (Target 95%) included above is available at:

- http://www.england.nhs.uk/statistics/statistical-work-areas/vte/.
- http://webarchive.nationalarchives.gov.uk/20130107105354/http://transparency.dh.gov.uk/2011/04/01/vte-data/
- http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/VTERiskAssessment/index.htm

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

Admission and VTE assessment data are recorded onto 'Meditech', the Trust's patient information system. The Trust employs a live Nursing and Midwifery indicator reporting system linked to 'Meditech', which allows managers to see admissions and outstanding assessments and actively manage compliance . The percentage figure is calculated as:

$$\frac{\text{No. VTE assessments conducted x 100}}{\text{No. 'Ordinary' Admissions}}$$

Matrons receive non-compliance reports and validate with relevant department managers. Incidents of VTE are reported and formal reviews undertaken. Remedial actions are agreed. The development of Managers dashboards in 2014-15 will facilitate on-going monitoring.

How progress to achieve the priority goal is reported

Data is collected from Meditech and forwarded to the Divisions for validation. The information is submitted by the Trust's Information Department to the Department of Health and NHS Information Centre via UNIFY 2.

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

- Developing and maintaining the live nursing & midwifery care indicator system, which enables managers to see admissions and outstanding assessments and actively manage compliance.
- Where a patient is confirmed as having a venous thromboembolism then the Trust is expected to implement root cause analysis on each and every case.

2.3.8.7 Rate per 100,000 bed days of cases of C.difficile reported within the Trust amongst patient aged 2 or over

National Data for 2013-14 is not available from external sources including the HSCIC and Public Health England websites for this measure and so only Trust data provided by PHE is reported here, however, the data available for the financial years 20010-2013 inclusive is available via HSCIC and PHE web sites and is reported here.

Name of NHS Trust	*C.difficil* e infection reports for patients aged 2 years and over								
	2010-11			2011-12			2012-13		
	Trust Apportioned	Total	Trust App'd Rate per 100,000 Bed-days	Trust Apportioned	Total	Trust App'd Rate per 100,000 Bed-days	Trust Apportioned	Total	Trust App'd Rate per 100,000 Bed-days
LWH	2	3	5.2	1	1	2.6	0	0	0
BWH	1	1	3.2	0	0	0	0	0	0
National Data									
Minimum	0	0	0	0	0	0	0	0	0
Maximum	247	470	71.8	185	392	51.6	154	358	30.8
Average	**62.4**	**130**	**27.9**	**45.9**	**108.5**	**20.6**	**37**	**91**	**16.1**
Total	**10,417**	**21,707**	**29.6**	**7,670**	**18,005**	**21.8**	**5,974**	**14,687**	**17.3**

The most recently available12-month data provided to the Trust by Public Health England is as follows:

Quarterly C difficile Rates per 100,000 Bed days	2012-13 Qtr 4	2013-14 Qtr1	2013-14 Qtr2	2013-14 Qtr3	2013-14 Qtr4
Liverpool Women's NHS Foundation Trust	0	0	12.73	12.73	0

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 taken the following actions to improve this indicator, and so the quality of its services, by:

- Putting in place a process for root cause analysis of all cases to identify learning outcomes, all cases are reported through the Trust governance structures to ensure transparency, in addition there is regular audit of antimicrobial prescribing and infection control practices to ensure the quality of service is improved.

2.3.8.8 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*.'

Trust Sponsor / Lead: Mr Richard Sachs, Head of Governance

Progress made in report period 2013-14

	2011-12	2012-13	2013-14
Patient Safety Incidents reported in period	2523	2970	2127

The data shows a reduction in the number of incidents reported in the period 2013-14.

Benchmarking data

	All Reported Incidents			
	Oct'11-Mar'12	Apr'12-Sep'12	Oct'12-Mar'13	Apr'13-Sep'13
Total Incidents Reported to NRLS by Birmingham Women's NHS Foundation Trust	693	709	670	619
Total Incidents Reported to NRLS by Liverpool Women's NHS Foundation Trust	1378	1720	1138	763

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.

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 Risk team have committed to investigate this fall and report back to the Trust's Governance Committee.
- The Clinical Governance leads have been asked to promote and encourage the reporting of incidents and their timely review.

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'.

Important because:
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.

Trust Sponsor / Lead: Mr Richard Sachs, Head of Governance

Progress made in report period 2013-14

Liverpool Women's NHS Foundation Trust	2013-14 Qtr1		2013-14 Qtr2		2013-14 Qtr3		2013-14 Qtr4		Annual Total	
Reported Patient Safety Incidents	446		472		619		590		2127	
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	8	1.79%	7	1.49%	9	1.45%	7	1.19%	31	1.46%
Death as a result of the PSI	1	0.22%	0	0.00%	0	0.00%	0	0.00%	1	0.05%
Total Severe Harm or Death as a result of the PSI	9	2.01%	7	1.48%	9	1.45%	7	1.19%	32	1.50%

Liverpool Women's NHS Foundation Trust	2011-12		2012-13		2013-14	
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	25	1.00%	45	1.50%	31	1.45%
Death as a result of the PSI	2	0.08%	6	0.20%	1	0.05%
Total Severe Harm or Death as a result of the PSI	27	1.08	51%	1.70%	32	1.50%

The single case of death caused by the patient safety incident was declared as a Serious Incident, investigated and reported to the Commissioners and the responsive actions to the learning points identified from causal factors have been completed.
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:

- Providing a web –based reporting tool across all areas of the Trust to facilitate the recording of incidents and learning from them.
- Promoting Incident reporting through distribution of annually updated 'Trigger List' posters, including data of the previous year's reporting numbers for the categories listed.

- Issuing and updating an easily accessible Incident reporting SOP with focussed direction on how to report and escalate incidents appropriately.
- Heightened Governance team involvement in 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.
- Further enhanced staff feedback mechanisms to disseminate learning from serious incidents through:
  - Mandatory feedback e-mails to reporters of incidents via the Ulysses system
  - Face to face feedback on the outcome of serious incident investigations to those directly involved / reporting.
  - Reporting feedback through the various risk forums.
  - Issue of brief serious incident feedback forms for inclusion on departmental noticeboards.

Part 3 Other Information

3.1 Overview of Quality

Elsewhere in this report reference is made to the financial pressures the Trust faces (in common with other public services) and specifically the national Payment by Results tariff which cannot support nationally recommended staffing levels for maternity services. Taken together these issues heighten the challenge to adapt and to maintain and improve the quality of services.

Despite this the Trust has achieved undoubted successes to be proud of; our performance against national and local targets has remained strong, the expansion of services such as the opening of the Hewitt Centre in Knutsford has increased access to our reproductive medicine services, the opening of the Catharine Medical Centre means we can offer private care to generate income to support our NHS services. These and other improvements are described in relation to measures reported in this report.

The Hewitt Centre has both continued to meet the changing HFEA targets for the reduction of multiple pregnancies by reducing the number of embryos implanted whilst simultaneously improving its pregnancy rates for all its techniques to amongst the best nationally and internationally.

Though the Trust had 2 instances of attributed Clostridium difficile infection during 2013-14 it maintained its zero incidence of MRSA bacteraemias for a fourth successive year.

The neonatal service has achieved further reductions in the neonatal mortality rate and in the proportion of babies in its care experiencing severe brain injury.

The Trust has reported fewer medication incidents in the year, but has also seen an overall reduction in incident reporting during the year, despite measures to encourage reporting to ensure learning is captured and recurrences avoided. This is something the risk team have committed to investigate and understand in order to reverse the trend.

The maternity service has seen slight improvement in its attempts to reduce the incidence of low APGAR scores and that of cord pH values below 7.0 in babies born beyond 24 weeks gestation, but there remains room for further improvement as is the case for 1-2-1 care of women in established labour by a midwife, which though improved falls short of the 100% target and for the proportion of patients receiving the pain relief of their choice, which though now over 90% could be better still.

In Gynaecology, though there is no set target for mortality, a slight decrease in the average monthly figure is evident, though sporadic peaks appear over the year and the rates are affected by the fact that seriously ill oncology patients are choosing to spend the last days of their life within the support of our services, something we welcome – and are proud of - as an indication of the quality of service delivered. This is in keeping with the high Friends and Family Test (FFT) scores the Trust is receiving from patients participating in the survey.

Being a specialist Trust means that some of the core national priorities do not apply to the services we provide. But amongst those that do, we see improvement in score for our responsiveness to the personal needs of patients, which in the previous three years has been both greater than the national average and that of our benchmark Trust. The percentage of patients admitted to hospital who were assessed for venous thromboembolism (VTE) again rose improving on our own previous performance and in the data available for the first three quarters of 2013-14 exceeding the rate for all acute providers.

We are pleased that our annual NHS staff survey results for 2013-14 showed an increase in the percentage of our staff who would recommend the Trust as a provider of care to their family and friends. We are also pleased that our score exceeds the national average, however it is lower

than our recognised benchmark Trust, hence we will work even harder to get even higher scores. To improve this we plan to implement a number of initiatives to engage with staff and include them in service development and improvement.
As the report explains the Trust has for some years reported on a set group of quality indicators, and this year has reviewed them to determine those that have achieved their purpose and achieved stable or improved performance. We have also identified some new priorities for improvement from intelligence gathered within the organisation. Adherence to this review process will support the Trust's drive for continual quality improvement.

3.2 Performance against key national priorities and National Core Standards

Indicator Name	Target	Performance		
		2011 / 2012	2012 / 2013	2013 / 2014
18 week Referral to treatment times: admitted (all Specialties)	90%	97.52%	96.95%	97.61%
18 week Referral to treatment times: non-admitted (all Specialties)	95%	97.15%	96.06%	95.37%
18 week Referral to treatment times: non-admitted (Gynaecology, Infertility and reproductive medicine)	95%	96.84%	95.62%	94.82%
18 week Referral to treatment times: non-admitted (Clinical Genetics)	95%)	99.61%	99.54%	100%
18 week referral to treatment times: Incomplete Pathways (admitted & non-admitted) *	92%	-	93.14%	94.68%
18 week referral to treatment times: Incomplete Pathways (gynaecology, infertility & reproductive medicine)*	92%	-	92.79%	94.16%
18 week referral to treatment times: Incomplete Pathways (clinical genetics)	92%	-	99.69%	100%
* All cancers: two week wait	≥ 93%	97.54%	96.81%	97.56%
All cancers: one month diagnosis to treatment (first definitive)	≥ 96%	98.54%	97.17%	98.40%
All cancers: one month diagnosis to treatment (subsequent surgery)	≥ 94%	100%	99.26%	98.71%
All cancers: one month diagnosis to treatment (subsequent drug)	≥ 98%	100%	100%	No Patients
All cancers: two month diagnosis to treatment (GP referrals)	≥ 79%[1]	91.67%	89.87%	87.04%
All cancers: two month diagnosis to treatment (Consultant upgrade)	≥ 94%	92.45%	96.92%	95.45%
All cancers: two month diagnosis to treatment (screening referrals)	≥ 90%	88.37%	94.87%	100%
Incidence of MRSA bacterium	0	0	0	0
Incidence of Clostridium difficile	0	1	0	2
Infant health and inequalities: breastfeeding rate	≥ -5%	-2.10%	0.55%	-2.86%
Infant health and inequalities: smoking rate	≤ 0%	0.68%	0.87%	1.30%
NHS Staff satisfaction: Overall staff engagement (Specialist Trusts)	**2013-14** Nat'l Average 3.91	3.49	3.57	3.73
Delayed transfers of care	≤ 3.5%	0%	0%	0%
Last minute cancellation for non-clinical reasons	≤ 0.8%	0.71%	0.79%	0.50%
Last minute cancellation for non-clinical reasons not readmitted in 28 days	≤ 5%	1.33%	5.81%	0.56%
Total time in Accident & emergency (% seen within 4 hours)	≥ 95%	99.82%	99.92%	99.81%

[1] 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).

3.3 National Surveys in which LWH has participated

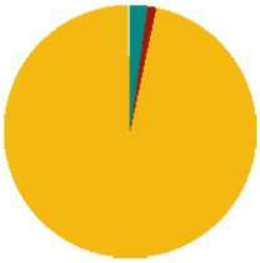
3.3.1 Picker Inpatient Survey 2013

The Trust satisfied the care Quality Commission requirement to participate in the Inpatient Survey 2013, conducted by the Picker Institute.

Survey Response

Survey Participation Data	2012	2013
National Participation	69 Trusts	76 Trusts
LWH Patient Response Rate	54% (441/824 Eligible returns)	54% (456/849 Eligible returns)
National Average Response rate	48 %	46%

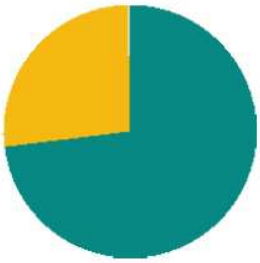
Summary results for Liverpool Women's NHS Foundation Trust from the Inpatient Survey 2013[2]:



Have we improved since the 2012 survey?

A total of 85 questions were used in both the 2012 and 2013 surveys.
Compared to the 2012 survey, your Trust is:

- Significantly BETTER on 2 questions
- Significantly WORSE on 1 question
- The scores show no significant difference on 82 questions



How do we compare to other trusts?

The survey showed that your Trust is:

- Significantly BETTER than average on 63 questions
- Significantly WORSE than average on 0 questions
- The scores were average on 23 questions

[2] The following graphics and tables relating to Liverpool Women's NHS Foundation Trust's performance in the 2013 Picker Inpatient survey are sourced from the Picker Institute's Inpatient Survey 2013, Executive Summary Report

The following tables show the questions for which the Liverpool Women's NHS Foundation Trust responses for 2013 changed significantly from those in the 2012 survey.

The Trust has improved significantly on the following questions:		
	Lower scores are better	
	2012	2013
Admission: had to wait long time to get to bed on ward	15 %	10 %
Discharge: did not receive copies of letters sent between hospital doctors and GP	30 %	22 %

The Trust has worsened significantly on the following questions:		
	Lower scores are better	
	2012	2013
Nurses: did not always get clear answers to questions	17 %	24 %

As shown in the pie chart above the Liverpool Women's NHS Foundation Trust results in 2013 were significantly better than the survey average for 63 of the 85 questions, with the Trust's results for all other questions being average for the survey.

Those questions for which the Trust was significantly better than the survey average are shown in the following 2 tables below. (NB. The third table shown from the survey report confirms that in no cases were the Trust results for any question significantly worse that the survey average).

Your results were significantly better than the 'Picker average' for the following questions:

Lower scores are better

	Trust	Average
A&E Department: waited 4 hours or more for admission to bed on a ward	[7] %	28 %
Planned admission: should have been admitted sooner	15 %	21 %
Planned admission: not given enough notice of admission date	1 %	4 %
Planned admission: not given choice of admission date	54 %	65 %
Planned admission: not given printed information about condition or treatment	11 %	22 %
Admission: process not at all or fairly organised	20 %	32 %
Admission: had to wait long time to get to bed on ward	10 %	33 %
Hospital: patients using bath or shower area who shared it with opposite sex	1 %	12 %
Care: did not always get help in getting to the bathroom when needed	21 %	27 %
Hospital: didn't get enough information about ward routines	49 %	63 %
Hospital: bothered by noise at night from other patients	24 %	38 %
Hospital: bothered by noise at night from staff	15 %	19 %
Hospital: room or ward not very or not at all clean	1 %	3 %
Hospital: toilets not very or not at all clean	2 %	6 %
Hospital: felt threatened by other patients or visitors	1 %	3 %
Hospital: nowhere to keep personal belongings safely	35 %	58 %
Hospital: food was fair or poor	38 %	42 %
Hospital: not offered a choice of food	16 %	20 %
Hospital: patients did not get the food they ordered	12 %	22 %
Hospital: did not always get enough help from staff to eat meals	21 %	34 %
Doctors: did not always get clear answers to questions	20 %	30 %
Doctors: did not always have confidence and trust	13 %	19 %
Doctors: talked in front of patients as if they were not there	8 %	24 %
Doctors: did not always get opportunity to talk to when needed	31 %	46 %
Doctors: some/none knew enough about condition/treatment	6 %	11 %
Nurses: did not always get clear answers to questions	24 %	31 %
Nurses: did not always have confidence and trust	18 %	24 %
Nurses: talked in front of patients as if they weren't there	9 %	19 %
Nurses: sometimes, rarely or never enough on duty	31 %	41 %
Nurses: did not always get the opportunity to talk to when needed	28 %	37 %
Nurses: some/none knew enough about condition/treatment	9 %	16 %
Care: staff contradict each other	23 %	31 %
Care: wanted to be more involved in decisions	32 %	43 %
Care: not enough (or too much) information given on condition or treatment	14 %	20 %
Care: not enough opportunity for family to talk to doctor	43 %	50 %

Care: could not always find staff member to discuss concerns with	41 %	58 %
Care: not always enough emotional support from hospital staff	33 %	43 %
Care: staff did not do everything to help control pain	23 %	29 %
Care: more than 5 minutes to answer call button	10 %	17 %
Tests: results not explained in a way that could be understood	22 %	37 %
Surgery: risks and benefits not fully explained	13 %	17 %
Surgery: what would be done during operation not fully explained	19 %	23 %
Surgery: questions beforehand not fully answered	16 %	21 %
Surgery: not told how to expect to feel after operation or procedure	33 %	42 %
Surgery: not enough time to discuss operation or procedure with consultant	23 %	29 %
Surgery: anaesthetist / other member of staff did not fully explain how would put to sleep or control pain	10 %	15 %
Surgery: results not explained in clear way	26 %	31 %
Discharge: did not feel involved in decisions about discharge from hospital	36 %	45 %
Discharge: Not given notice about when discharge would be	32 %	43 %
Discharge: was delayed	22 %	40 %
Discharge: not given any written/printed information about what they should or should not do after leaving hospital	12 %	29 %
Discharge: not fully told purpose of medications	15 %	23 %
Discharge: not fully told side-effects of medications	47 %	58 %
Discharge: not told how to take medication clearly	13 %	23 %
Discharge: not given completely clear written/printed information about medicines	16 %	25 %
Discharge: not fully told of danger signals to look for	41 %	54 %
Discharge: Family or home situation not considered	26 %	36 %
Discharge: not told who to contact if worried	6 %	20 %
Discharge: did not receive copies of letters sent between hospital doctors and GP	22 %	31 %
Discharge: letters between hospital doctors and GP not written in a way that could be understood	18 %	23 %
Overall: not treated with respect or dignity	16 %	19 %
Overall: rated experience as less than 7/10	11 %	17 %
Overall: Did not receive any information explaining how to complain	49 %	58 %

Your results were significantly worse than the 'Picker average' for the following questions:

Lower scores are better

NONE

The Trust welcomes the encouraging results of this survey showing that the service experience reported by our patients exceeds the national average for the survey in the majority of the measured aspects and for criteria where this was not the case, that our performance at least matched the national average for the survey.

Whilst our performance against one criterion was significantly worse than that reported in the 2012 survey, it was still better than the national average.

We recognise that there is still room for improvement and the Matron for Gynaecology has proposed a target cohort of 11 criteria for which our performance did not exceed the national average for action planning to further improve performance. These will be considered by the Nursing and Midwifery Board when it formally reviews the findings of the survey.

Table 10. Proposed focus for improvement Picker Inpatient Survey 2013.

Source	Issue
Proposed Focus on 11 of the 23 Average Responses Picker Inpatient Survey 2013 Published February 2014	A&E did not always have confidence and trust in doctors and Nurses
	Planned Admission, Admission date changed by Hospital
	Admission: Member of staff did not explain reason for wait
	Hospital Not all staff introduced themselves
	Handwash Gels not available or empty
	Not Always Healthy Food on menu
	Not always enough privacy when discussing care or treatment
	Not always enough privacy when being examined
	Discharge delayed by 1 hour or more
	Not given a reason for discharge delay
	Staff did not discuss need for additional equipment for home adaption

3.4 Trust's Nursing and Midwifery Indicators

The Nursing and Midwifery Care Indicators are locally defined and evolving set of parameters to monitor a changing set of elements of care, They are classified into the three domains shown in the Dashboards below (Patient safety, Clinical effectiveness and Patient Experience).The evolution of the criteria means there is no directly comparable historic data to present, Nor is there any direct link to a National standard and therefore any aligned benchmarking data.

The dashboard data provided below is sourced from front line data collated either from patients directly or from their case notes and entered by clinical staff onto the local Nursing & Midwifery indicator system called NUMIS.
The data presented below represents a high level overview of individual measures and criteria grouped into the three domains of Patient Safety, Clinical Effectiveness and Patient Experience based on numerous criteria around topics including:

- Patient involvement in decisions re treatment / provider
- Environment / Cleanliness/ Hygiene/ Privacy
- Communication / Information & Support
- Care planning / Aspects of Care / Onward referrals
- Staff attitudes / Competence/ Manner/ Helpfulness
- Waiting times
- Assessments
- Nutrition
- Pain management
- Documentation

The NUMIS dashboards are considered at local Quality forums and the Nursing & Midwifery Board, where performance is suboptimal (Amber / Red) actions to improve are formulated.

The Nursing and Midwifery Board has used these indicators to identify it priorities for 2014-15 and has included this commitment within this report, see section 2.2.2.

3.4.1 Patient Safety

Key: Less than 80% 80-90% Greater than 90%

	PATIENT SAFETY	Report	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14
Response	NEONATAL UNIT		92.56	96.92	96.99	93.51	95.27	98.41	98.4	97.41	95.2	96.94	93.89	94.65
Response	REPRODUCTIVE MEDICAL UNIT			99.24	100	99.11	94.82	98.24	96.39	97.39	100	97.32	98.21	96.49
Response	MATERNITY			87.38	79.45	90.59	85.03	85.57	89.35	91.3	93.44	83.03	87.64	86.95
Response	GYNAECOLOGY INPATIENTS		91.85	88.57	95.77	89.55	83.33	89.7	96.15	81.63	81.42	87.02	89.02	100
Response	GYNAECOLOGY BEDFORD		98.14	97.18	94.44	95	97.43	98.55	98.78	100	100	100	100	97.89
Response	GYNAECOLOGY DAY WARD		96.66	100	95.23	100	100	100	96.55	83.33	92	90.9	95.45	90
Response	GYNAECOLOGY OUTPATIENTS		87.5	100	95.23	91.66	90.9	100	100	95.45	94.11	90.47	95	90.9
Response	GYNAECOLOGY EMERGENCY ROOM		95.83		98.38	100	95.08	93.75	100	100	100	100	100	96
Response	GYNAECOLOGY THEATRES		78.57	73.01	85.71	91.83	94.73	89.79	88.96	87.61	91.83	92.85	93.4	100
Response	MATERNITY THEATRES		81.66	94.64	75.71	81.25	100	95.31	88.05	94.93	98.43	94.23	94.2	100

3.4.2 Clinical Effectiveness

Key: Less than 80% 80-90% Greater than 90%

	CLINICAL EFFECTIVENESS Report	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14
Response	NEONATAL UNIT	88.23	86.41	96	91.78	92.75	94.59	94.59	91.78	97.26	97.56	92.1	98.68
Response	REPRODUCTIVE MEDICAL UNIT		60	60	80	100	90	70	80	70	80	80	90
Response	MATERNITY		78.12	65.42	81.48	90.95	92.22	92.03	91.71	94.44	70.53	76.74	89.84
Response	GYNAECOLOGY INPATIENTS	59.74	70.83	55.88	82.05	97.14	96.77	86.84	88.88	92.59	98.33	87.71	93.33
Response	GYNAECOLOGY BEDFORD UNIT	92.45	98.61	83.87	88.7	91.93	83.33	91.04	94.66	96.55	96.9	80.64	83.54
Response	GYNAECOLOGY DAY WARD	100	100	100	100	97.22	85.71	88.88	96.66	88.88	91.66	100	100
Response	GYNAECOLOGY OUTPATIENTS	97.43	100	93.47	91.3	93.87	100	98	97.67	97.14	95	90	100
Response	GYNAECOLOGY EMERGENCY ROOM	88.23		94.44	100	100	100	100	100	90.9	100	100	87.5
Response	GYNAECOLOGY THEATRES	100	100	100	93.33	100	100	100	88.23	93.75	100	92.85	78.94
Response	MATERNITY THEATRES	83.33	100	95	100	85.71	100	100	100	100	94.44	95.45	90.9

3.4.3 Patient Experience

Key: Less than 80% 80-90% Greater than 90%

	PATIENT EXPERIENCE	Report	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14
Response	NEONATAL UNIT		84.61	91.66	94	88.46	89.13	82.35	93.61	89.58	79.59	83.33	81.63	87.75
Response	REPRODUCTIVE MEDICAL UNIT			100	97.04	98.06	100	97.68	99.55	96.25	99.55	99.06	95.21	97.42
Response	MATERNITY			76.21	82.2	90.81	87.64	90.65	88.57	89.53	90.65	75.39	76.66	89.35
Response	GYNAECOLOGY INPATIENTS		92.47	89.03	93.1	92.41	91.3	89.17	94.57	98.69	92.68	90.15	96.45	92.68
Response	GYNAECOLOGY BEDFORD		90.06	83.9	94.18	91.66	92.07	93.57	97.57	96.95	97.45	96.89	96.29	97.2
Response	GYNAECOLOGY DAY WARD		100	100	95.71	95.65	96.42	100	97.61	91.48	98.97	95.52	98.73	97.36
Response	GYNAECOLOGY OUTPATIENTS		91.56	97.8	95.51	86.72	92.4	92.57	91.96	94.44	98.85	93.27	96.81	99.03
Response	GYNAECOLOGY EMERGENCY ROOM		100		99.12	95.65	89.47	91.89	100	94.44	98.33	98	98.75	95.31
Response	GYNAECOLOGY THEATRES		97.14	93.44	91.07	96.84	97.18	97.8	98.43	95.45	98.73	98.11	92	92.85
Response	MATERNITY THEATRES		88.29	93.05	93.18	93.84	83.73	89.47	91.95	92.43	87.2	88.5	89.21	90.9

3.5 '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.

CARE IS LWH TOP PRIORITY	4.09	3.84	4.03	4.06	4.42	4	4.28	4.27	4.17	4.12	3.84	4
KNOW HOW MY ROLE MAKES A DIFFERENCE	4.27	4.08	4.17	4.38	4.59	4.37	4.37	4.39	4.29	4.29	4.18	4.2
PROUD OF STANDARD OF CARE PROVDED	3.55	3.45	3.64	3.55	4.26	3.82	3.85	3.77	3.75	3.72	3.66	3.68
ABLE TO SUGGEST IMPROVEMENTS	3.83	3.54	3.51	3.87	4.14	3.77	3.90	3.84	3.86	3.78	3.76	3.56
CLEAR ABOUT WHAT I NEED TO ACHIEVE	4.25	4.01	3.97	4.34	4.64	4.24	4.30	4.41	4.25	4.33	4.09	4.2
PEOPLE TREAT ME WITH RESPECT	3.83	3.68	3.58	4.08	4	3.85	4.18	4.12	4.09	4.03	3.84	3.88
I AM TRUSTED TO DO MY JOB	4.44	4.02	4.05	4.48	4.5	4.23	4.40	4.39	4.37	4.32	4.13	4.24
RECOMMEND LWH AS A PLACE TO WORK	3.65	3.14	3.23	3.55	4.11	3.60	3.78	3.51	3.62	3.40	3.46	3.52
I ENJOY MY JOB	3.97	3.61	3.77	4.10	4.33	4.02	4.14	3.88	4.13	3.93	3.89	3.8
WE LEARN FROM OUR MISTAKES	3.90	3.47	3.50	3.75	4.21	3.83	3.96	3.91	3.85	3.77	3.55	3.88
PDR HAS HELPED DO JOB BETTER	2.79	2.57	3.00	3.20	3.64	3.05	3.30	3.04	3.10	2.98	2.98	2.96

At the same time as implementing the Pulse staff survey, the Trust also took the decision to introduce the Friends and Family Test question for staff. Although it was not mandatory at that stage, it was felt that it would be a wise step to understand the views of staff in response to the Friends and Family question.

Trust Overall Score	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Locally Developed Measure	4.17	3.9	3.88	4.12	4.26	4.1	4.08	3.91	4.04	3.98	3.95	4.06

Extremely Likely	5
Likely	4
Neither Likely Nor Unlikely	3
Unlikely	2
Extremely Unlikely	1

Although the Staff Friends and Family Test Question had been introduced, the method of calculation was a locally developed measure in accordance with the assignments on the left. The reported values are the average scores achieved.

From April 2014 onwards, the Staff Friends and Family is to become one of the trust CQUINs and, therefore, the method of reporting and the phrasing of the questions etc. will be modified to align with national requirements for calculation the Friends and Family Test, called the Friends and Family Test Score and using a calculation method called the Net promoter Score

Key Findings and Responsive Actions

Over the last 12 months there has been an overall positive trend. The area which has scored consistently lower is 'My PDR has helped me to do my job better'. A revised performance

management system which is accessible to staff plus training for managers is being designed in response to this feedback.

Average scores for the Pulse survey over a 12 month period:

April 2013- April 2014	
Question	**Average Score**
Care of women, babies and their families is Liverpool Women's top priority	4.15
I know how my role makes a difference to women, babies and their families	4.28
I am proud of the standard of care provided by Liverpool Women's	3.77
I am able to make suggestions to improve the work of my team/department	3.88
I am clear about what I need to achieve as part of my job	4.24
The people I work with treat me with respect	4.03
I am trusted to do my job	4.31
I would recommend Liverpool Women's as a place to work	3.57
I enjoy my job	3.97
At Liverpool Women's we learn from mistakes and take action to prevent them from happening again	3.73
My Appraisal/PDR has helped me to do my job better for patients	3.16

In order to ensure that Directors had the chance to meet with frontline staff on a regular basis, 'Listening Events' were introduced in April 2013. Directors visit the same department for consecutive months and meet with staff on an informal basis to talk about key issues such as patient safety and patient experience. The issue of whether there are any barriers stopping them recommending the Trust to their friends and family is also explored.

Key themes which emerged were a lack of ownership and clarity amongst staff about how they could make positive changes in their wards and departments. In response to this, dedicated staff engagement sessions are taking place across the Trust to:

- Feedback 12 months of themes from staff survey / pulse survey/ listening events;
- Develop a values statement / vision for the ward / department;
- Identify change and improvement projects staff can be involved in and lead on.

In addition we continue with other established methods to hear the views of staff including opportunities to have coffee with the Chief Executive and fortnightly briefings on the strategy and financial performance of the Trust. We are also introducing monthly sessions called 'compassionate conversations' which will provide staff with the opportunity to explore issues and challenges at work in a supportive team setting facilitated by a clinical psychologist.

Through all of these activities our objective is to ensure that every staff member at every level has a chance to have their views heard and contribute to the future success of Liverpool Women's.

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 Liverpool CCG

Liverpool CCG – Quality Account Statement Liverpool Women's NHS Foundation Trust

Liverpool CCG welcomes the opportunity to comment on Liverpool Women's NHS Foundation Trust Quality Account for 2013/14, the forth quality account since the national introduction of Quality Accounts.

As Lead Commissioner of care services and on behalf of our co-co-Commissioning CCGs and the local population, we believe this Quality Account demonstrates a commitment to quality improvement and high quality services. NHS England "Everyone Counts: Planning for Patients 2014-15 to 2018/19" sets out NHS England ambitions and commitment in ensuring high quality care for all, now and for future generations and describes quality as spanning three areas: safe, effective and personalised care. This Quality Account provides an overview of these areas and presents a true reflection of the provider's achievement of quality of service delivery against the backdrop of a changing NHS. Delivering care and treatment in an organisation with a wide range of services requires commitment to continuously monitor and deliver high quality patient care.

There have been many highlights during a year in which the Trust celebrated the 18th birthday of the Liverpool Women's Hospital at Crown Street. Also following significant investment in new technologies the Hewitt Fertility Centre is achieving the best outcomes for embryo implantation rates in the UK and comparable with best in world.

Liverpool CCG along with our co-commissioning CCGs is aspiring through strategic objectives and 5 year plans to develop an NHS that delivers great outcomes, now and for future generations. That means reflecting the Government's objectives for the NHS set out in their mandate to us, adding our own stretching ambitions for improving health and delivering better services to go even further to tailor care to the local health economy. Providing high quality care and achieving excellent outcomes for our patients is the central focus of our work and paramount to our success.

The CCG recognises that the Trust acknowledges that improvements are required in certain areas and have referenced these in the report. The Trust has demonstrated considerable improvements following the unannounced inspection by the CQC and have invested significantly in appointing more midwives to the Trust with an aim to provide a better experience for all our women and our staff. A reflection of the work that has been carried out over the year and in response to the CQC visit is that the CQC's Intelligent Monitoring report, March 2014, classified the Trust in Band 6 which is the lowest risk band.

The CCG looks forward to the implementation of these schemes to enhance the quality of service delivered. With the quality systems and programmes Liverpool Women's NHS Foundation Trust has demonstrated and the introduction of improvements, Liverpool CCG and co-commissioning CCGs are confident that patient safety, clinical effectiveness and patient experience on the whole, is a positive encounter whilst under the care and treatment of the NHS.

The CCG enjoys a productive working relationship with the Trust and looks forward to continuing this collaborative approach to strive for excellence and deliver high quality care and treatment to our local population.

Signed  27 May 2014

Katherine Sheerin
Chief Officer

4.1.2 Halton CCG

NHS
Halton Clinical Commissioning Group

First Floor
Runcorn Town Hall
Heath Road
Runcorn
Cheshire
WA7 5TD

Tel: 01928 593479
www.haltonccg.nhs.uk

23rd May 2014

Our Ref: QA/LWH /14

Mrs Dianne Brown
Director of Nursing & Midwifery
Liverpool Women's NHS Foundation Trust
Crown Street
Liverpool L8 7SS

Dear Dianne

Re: Quality Account 2013-2014

Many thanks for submission of the Quality Acco8nt for 2013-2014 and for the presentation to local stakeholders on 6th May 2014. This letter provides the response from NHS Halton CCG to the Quality Account.

NHS Halton CCG is linked to Contract Quality Group, which scrutinises the key quality indictors in the Quality Schedule and CQUINs which is led by Liverpool CCG as the co-ordinating commissioner; these are proving to be both effective and useful.

NHS Halton congratulates the Trust on the delivery of leading edge research and development programmes across all areas of care the trust delivers. The CCG would like to compliment the trust on the use of service vignettes within the Quality Account. The trust is also to be commended on its programme of engagement to develop quality priorities and gain user views.
NHS Halton CCG notes that the Trust has made progress in the delivery if its quality priorities and the successful implementation of Friends and Families Test for Maternity Services.

We look forward to working with the Co-ordinating Commissioner and the Trust through 2014/15, helping to improve the quality of services for our patients through the NHS contractual mechanisms and the review and management of Serious Incidents, applying good governance and ensuring lessons are learnt throughout the Trust

Jan Snoddon
Chief Nurse/Quality Lead
NHS Halton CCG

Email: jan.snoddon@haltonccg.nhs.uk

4.1.3 Knowsley CCG

Quality Report provided and commentary invited, none received.

4.1.4 South Sefton CCG
Quality Report provided and commentary invited, none received.

4.1.5 Southport & Formby CCG
Quality Report provided and commentary invited, none received.

4.1.6 St Helens CCG
Quality Report provided and commentary invited, with the e-mail response below:

Dear Alan

Your email to Lynda Carey has been passed to me for action. I am pleased to say that St Helens CCG is happy with the Quality Report and does not wish to submit a commentary.

Best wishes.

Paula

Paula Guest
Quality Improvement and Patient Experience Manager
St Helens CCG

T: 01744 621749
M: 0775 749 7415
E: paula.guest@sthelensccg.nhs.uk
St Helens Chamber of Commerce, Salisbury Street, St Helens, Merseyside WA10 1AU

4.2 Commentaries from Local HealthWatch Groups

4.2.1 Liverpool HealthWatch

Healthwatch Liverpool is pleased to have the opportunity to comment on the 2013 – 2014 Quality Account for Liverpool Women's NHS Foundation Trust. As the Trust is aware, for Healthwatch to write an informed Quality Account commentary, regular engagement with the Trust and patients is vital. Unfortunately Healthwatch Liverpool does not feel that the Trust has embedded timely engagement opportunities with Healthwatch Liverpool, which should be throughout the year. This commentary solely relates to the contents of a draft Quality Account document that was made available to Healthwatch Liverpool prior to Quality Account publication.

The Quality Account document sets out how the Trust has continued to focus on patient safety, clinical effectiveness and patient experience. The report makes clear that as a specialist Trust some of its outcomes are difficult to compare, but the impression Healthwatch Liverpool gains from the report is that the Trust offers a high quality service overall, and wants to keep improving on that service.

Healthwatch Liverpool notes from the report that there have been challenges, including staffing levels and higher post-surgery infection rates in patients undergoing emergency surgery compared to patients undergoing elective surgery.
We are pleased to note that staffing levels have increased and that the Trust achieved most of the CQUIN targets for 2013-14, although the target for improving breastfeeding rates was not achieved. Breastfeeding initiation will be a CQUIN for 2014-15, and we will follow its development with interest.

Healthwatch Liverpool would be interested to find out more about how patient experience feedback from the Friends and Family Test and the Picker Survey is incorporated in ensuring improvements are made throughout the Trust. We are pleased to see that a reduction in the number of complaints relating to care has been chosen as a priority for improvement in 2014-15.

The Trust states it will continue to focus on patient safety, clinical effectiveness and patient experience. Healthwatch Liverpool hopes for improved, regular engagement with the Trust in 2014-15, in order to be able to monitor the progress of the Quality Account priorities and other quality considerations.

Healthwatch Liverpool.

4.2.2 Halton HealthWatch
Quality Report provided and commentary invited, none received.

4.2.3 Knowsley HealthWatch
Quality Report provided and commentary invited, none received.

4.2.4 Sefton HealthWatch

Healthwatch Sefton
Sefton CVS
3rd Floor, Suite 3B
North Wing, Burlington House,
Crosby Road North, Waterloo
L22 0LG
Tel:(0151) 920 0726 ext 240

info@healthwatchsefton.co.uk
www.healthwatchsefton.co.uk

Liverpool Women's NHS Foundation Trust 2013 - 2014 - Quality Account Commentary.

Healthwatch Sefton would like to thank the Trust for the opportunity to comment on the Quality Account.

We submitted a report to the Trust during this period detailing experiences which we had received from Sefton residents who had accessed services. The experiences within the report mirrored what the Trust was already aware of, in that some patients view their quality of

treatment as a positive experience whereas other patients view it as a negative experience. The sample size for the report was small (5 experience forms). Although the report was not responded to within the statutory time frame, a response from the Director of Nursing was received 3rd January 2014.

Within the report we shared an experience relating to access to information in accessible formats. We were informed within the response to the report that the Trust was currently about to start a review of all available patient information and that a process would be in place to allow a registered blind person to access relevant information. It would have been useful within the quality account to have read more about the review of patient information and the outcome from the review.

Within the same report we shared an experience about the lack of coordination between services and we were informed within the response from the Trust that maternity services were constantly under review and that the community midwives team were being re-organised. We would welcome information within the account about the work of the community midwives and the work they are undertaking. We were encouraged by the use of Twitter, particularly the 'Tweet the Midwife' set up in Knowsley.

One of the forms shared with us and detailed within our report detailed a positive experience of the breastfeeding volunteer support programme which is delivered in one of our Healthy Living Centres in Sefton, The May Logan. There is little information about this within the account and it would have been useful to read about this further.

Discharge is an area which we again highlighted within our report and it was pleasing to note that work during this period has been undertaken on neo-natal discharge planning and within the Picker Inpatient survey 2013 that the Trust has improved significantly within the area of discharge and communication. We would be keen to work with the Trust further on this area.

In terms of readability, the account includes a glossary but we feel that its inclusion at the beginning of the document would help. The document includes a mix of text and diagrams but when using percentages as a statistic it would be useful to state the number it relates to.

We would like to work closely with the Trust over the coming 12 months to independently gather the experiences/voice of local residents accessing the services of Liverpool Women's NHS Foundation Trust. We have been informed that a lead for Patient Experience is currently being recruited and we look forward to working with them.

(492)

4.2.5 St Helens HealthWatch

Quality Report provided and commentary invited, with the response below:

Hi Alan and thanks but no commentary from us this time.
Thanks, Emma.

Emma Rodriguez Dos Santos
Healthwatch St.Helens Support Manager
Email: erds@healthwatchsthelens.co.uk
Telephone: 01744 457119 (direct line)

Company No. 8567187

Tell us your stories - www.healthwatchsthelens.co.uk or freephone 0300 111 0007

4.3 Commentary from Local Authority Overview & Scrutiny Committees (OSCs)

4.3.1 Liverpool Council

Quality Report provided and commentary invited, none received.

4.3.2 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	19th May 2013
E-mail address	Emma.Sutton-Thompson @halton.gov.uk

Dear Kathryn,

Liverpool Women's Foundation Trust Quality Accounts 2014

Further to receiving a copy of your draft Quality Accounts and the Joint Quality Accounts event held on 6th May that your colleagues Jonathan Herod and Alan Clark 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:

During the year 2013/14 the Trust identified a number of priorities to be achieved during this year under Patient Safety, Patient Experience and Clinical Effectiveness. Although not all of the priorities were achieved, the Board was pleased to note the following areas:

- *Incidence of MRSA bacteraemia infection*- the Board were pleased to note that this figure continues to be at zero.
- *Incidence of Clostridium difficile* – the Board noted that the Incidence of Clostridium difficile were only at two in the year, although this was two more than the previous year.
- *Medication Incidents* – The Board is pleased to note that Medication Incidents are lower than in previous years.

The Board is pleased to note the Clinical and Quality Goals for 2013/14 and looks forward to hearing progress made in these areas next year. In particular:

- ***Patient Safety*** – Gynaecology surgical site infections and Incidence of Multiple pregnancy

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- ***Clinical Effectiveness*** - Hospital Mortality Rate in Gynaecology, Biochemical Pregnancy rates in In-vitro fertilisation (IVF), Intracytoplasmic sperm injection (ICSI) and frozen embryo transfer (FET) treatments and Brain injury in preterm babies (Severe Intraventricular haemorrhage and Periventricular leukomalacia)

- ***Patient Experience*** - One to one care in established labour, Patients receiving pain relief of choice in Labour and Reduction in number of complaints relating to care

The Board would like to thank Liverpool Women's Foundation Trust for the opportunity to comment on these Quality Accounts.

Yours sincerely,

E.L. Sutton-Thomson.

pp **Councillor Ellen Cargill**
Chair, Health Policy and Performance Board

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Runcorn Town Hall, Heath Road, Runcorn, Cheshire WA7 5TD
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INVESTOR IN PEOPLE

4.3.3 Knowsley Council

Quality Report provided and commentary invited, none received.

4.3.4 Sefton Council

OVERVIEW AND SCRUTINY COMMITTEE (HEALTH AND SOCIAL CARE) - MONDAY 12TH MAY, 2014

74. LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

The Committee received a presentation from Alan Clark, Governance Quality Manager and Diane Brown, Acting Director of Nursing, Liverpool Women's NHS Foundation Trust, on the Trust's draft Quality Account for 2013/14 and the work of the Trust in general.

The presentation outlined information on the following:-

Overview:

- 5th Quality Account prepared by the Trust;
- Performance against :
  - 1. Core indicators required by Monitor; and
  - 2. Local indicators committed to in the previous report.
- Reduction in indicators but inclusion of emerging priorities; and
- Digestible and 'bite size' - facilitates conversion to leaflets/ posters/ web pages for further dissemination and wider engagement.

Trust Highlights:-

- Use of Social Media - Twitter and Facebook, Chief Executive Blogs, Accounts for HFC and the Catherine Medical Centre Suite;
- Hewitt Fertility Centre in Knutsford;
- Extensive Refurbishments of Trust Estate; and
- Developing ICE Electronic Reporting.

ICE - Replaces paper based system, response to monitoring concerns, gives audit trail of review and actions, due for completion by May 2014.

Reasons to be Proud:-

- 18th Birthday Celebrations;
- Dorothy Zack-Williams, Lead Governor – winner of 'Women Caring' category at Merseyside Woman of the Year awards;
- David Richmond – President of Royal College of Gynaecology;
- The "Me Effect", for staff; and
- The Trust won 'Best Professional Service Provider' at the Family Go Live Awards.

Challenges for the Year Ahead:-

- Innovation of services;
- Better use of Benchmarking Information and Intelligence;
- Financial Challenge; and
- Final implementation of Francis Recommendations.

Trust Response to Francis Report:-

- Report and Recommendations published in February 2013; and
- Performance against the 63 recommendations relevant to the Trust is closely monitored.

Care Quality Commission Findings:-

- July 2013 - CQC Unannounced Visit, concerns in 3 areas:
  - Staffing Levels;
  - Supporting Staff; and
  - Care and Welfare of People who use services.
- February 2014 the CQC rated Liverpool Women's as in the lowest risk group in its Intelligent Monitoring report, highlighting it as one of the safest places in the country to receive care; and
- April 2014 the CQC Unannounced Visit – feedback awaited, early positive indications.

Patient Survey Results and comparison with other Trusts:-

- Picker Survey, 9 indicators;
- Friends and Family;
- Friends and Family for Staff; and
- PULSE, an ongoing staff survey accessible via Hospital Intranet.

External Factors:-

- Financial Challenge:
  1. Appropriateness of maternity tariff;
  2. Expansion and Introduction of New Services; and
  3. Private Service Income to support NHS services.
- Staffing Levels:
  1. E-Rostering; and
  2. Ward Staffing Boards.
- Meeting Regulatory Commitments, such as Monitor.

The Committee had previously been supplied with the full version of the Trust's draft Quality Account.

Members of the Committee asked about financial pressures on NHS Trusts, particularly in relation to maternity services and discussed the necessity for the Trust to build on private income to support NHS services; the use of the laborato+ry at the Royal Liverpool and Broadgreen University Hospitals NHS Trust for tests; and breast feeding rates.

The representatives of the Liverpool Women's NHS Foundation Trust explained that increased financial pressures and the need to produce efficiencies were required at a time when improvements in staffing, standards, etc. were demanded. Fortunately, the Trust was able to build on its reputation and brand, particularly with regard to cases with complications, and the representatives advised that the maternity tariff was the same across the country. An increasing customer approach was now being adopted in respect of laboratory services; and although breast feeding rates could be improved and there was work to be done challenging cultural influences, for the Trust the major priority area remained the time of delivery as this presented potentially the largest risk factors.

RESOLVED:

That the presentation and the draft Quality Account for 2013/14 from the Liverpool Women's NHS Foundation Trust be received.

Minute provided via e-mail 20/05/2014 by: Debbie Campbell, Senior Democratic Services Officer, Democratic Services, Sefton MBC, Town Hall, Trinity Road Bootle

4.4 External Auditors Limited Assurance Report

Independent Auditors' Limited Assurance Report to the Council of Governors of Liverpool Women's 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 2014 (the 'Quality Report') and specified performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2014 in the Quality Report that have been subject to limited assurance (the "specified indicators") consist of the following national priority indicators as mandated by Monitor:

Specified Indicators	***Specified indicators criteria*** (exact page number where criteria can be found)
Emergency re-admissions within 28 days of discharge from hospital	Section 2.3.8.3 of the Quality Report (Page 62)
Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers	Section 3.2 of the Quality Report (Page 76)

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 2013/14*" 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 2013/14*";
- 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 "2013/14 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 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 period April 2013 to the end of April 2014;
- Papers relating to Quality reported to the Board over the period April 2013 to the end of April 2014;
- Feedback from the Commissioners - Liverpool Clinical Commissioning Group dated 11/05/2014 and 27/05/2014, Halton Clinical Commissioning Group dated 19/05/2014;
- Feedback from Governors dated 12/05/2014;
- Feedback from local Healthwatch organisations - Healthwatch Sefton received 22/05/2014, Healthwatch St Helens received 23/05/2014, Healthwatch Liverpool received 23/05/2014;
- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2014 (final ratification pending);
- The 2013 national patient survey dated February 2014;
- The 2013 national staff survey dated February 2014;
- Care Quality Commission quality and risk profiles dated 31/05/2013, 30/06/2013, 31/07/2013;
- Intelligent Monitoring Reports dated 21/10/2013 and 13/03/2014; and
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 23/05/2014.

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 2014, 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 2013/14";
- 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 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 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.

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 2014,

- 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 2013/14*";
- 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 *"2013/14 Detailed guidance for external assurance on quality reports"*.

PricewaterhouseCoopers LLP
Chartered Accountants
Manchester
29th May 2014

The maintenance and integrity of the 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

5 Annex 2:

5.1 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 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 2013-14*
- 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 2013 to March 2014.
    - papers relating to Quality reported to the Board over the period April 2013 to March 2014.
    - feedback from the commissioners Liverpool Clinical Commissioning Group: 11/05/2014 & 27/05/2014, Halton Clinical Commissioning Group: 19/05/2014.
    - feedback from governors dated 12/05/2014.
    - feedback from local Healthwatch organisations dated: 22/05/2014 (HealthWatch Sefton), 23/05/2014 (St Helens HealthWatch), 23/05/2014 (HealthWatch Liverpool).
    - feedback from Local Authorities dated:20/05/2014 (Sefton MBC), 22/05/2014 Halton BC).
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2014(Final ratification pending).
    - 2013/14 national patient survey issued February 2014.
    - 2013/14 national staff survey 24/02/2014 issued 2014.
    - The Head of Internal Audit's annual opinion over the Trust's control environment dated 23/05/2014.
    - CQC quality and risk profiles dated 31/05/2013, 30/06/2013 and 31/07/2013 and CQC Intelligent Monitoring Reports dated 21/10/2013 and 13/03/2014.
- 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) (as well as the standards to support data quality for the preparation of the quality report.

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 (NB: sign and date in any colour ink except black)

23/05/2014……*Ken Morris*……Chairman

23/05/2014……*Kathryn Thomson*……..Chief Executive

5.2 Declaration from all Directors in office at the time of the account.

The Trust is committed to adopting relevant recommendations from the Francis report and consequently includes the following declarations in compliance with recommendation No. 249.

I declare the contents of the account to be true t to the best of my knowledge and belief.

~~I am unable to declare the contents of the account to be true to the best of my knowledge and belief because….~~

23/05/14 Date ……Chair of Board of Directors

Ken Morris

I declare the contents of the account to be true t to the best of my knowledge and belief.

~~I am unable to declare the contents of the account to be true to the best of my knowledge and belief because….~~

29/5/14 Date ……Chief Executive

Kathryn Thomson

I declare the contents of the account to be true t to the best of my knowledge and belief.

I am unable to declare the contents of the account to be true to the best of my knowledge and belief because....

2/6/2014 Date ..... Medical Director
Jonathan Herod

I declare the contents of the account to be true t to the best of my knowledge and belief.

I am unable to declare the contents of the account to be true to the best of my knowledge and belief because....

G.Naylor Date 27/5/14 Director of Nursing, Midwifery & Operations
Gail Naylor

I declare the contents of the account to be true t to the best of my knowledge and belief.

I am unable to declare the contents of the account to be true to the best of my knowledge and belief because....

V. Harris

Date 28/5/14.

Director of Finance
Vanessa Harris

I declare the contents of the account to be true t to the best of my knowledge and belief.

I am unable to ~~declare the contents of the account to be true to the best of my knowledge and belief~~ because….

Date 2/6/14

Director of Human Resources

Michelle Turner

I declare the contents of the account to be true t to the best of my knowledge and belief.

Date 29th May 2014

Trust Secretary
Julie McMorran

I declare the contents of the account to be true t to the best of my knowledge and belief. ✓

~~I am unable to declare the contents of the account to be true to the best of my knowledge and belief because….~~

31.5.14 Date

Non-Executive Director/
Vice Chair
Liz Cross

I declare the contents of the account to be true t to the best of my knowledge and belief.

I am unable to declare the contents of the account to be true to the best of my knowledge and belief because....

28/5/14 ..... Date ..... Non-Executive Director / Senior Independent Director **Steve Burnett**

I declare the contents of the account to be true t to the best of my knowledge and belief.

I am unable to declare the contents of the account to be true to the best of my knowledge and belief because....

29/5/14 ... Date ..... Non-Executive Director **Allan Bickerstaffe**

I declare the contents of the account to be true t to the best of my knowledge and belief.

I am unable to declare the contents of the account to be true to the best of my knowledge and belief because....

23.5.14 ... Date ..... Non-Executive Director **Pauleen Lane**

6 Glossary of Terms & Acronyms

Analgesia	The relief of pain without loss of consciousness
Antenatal	Occurring before birth, also called prenatal
Apgar Score	The Apgar scale is determined by evaluating the newborn baby on five simple criteria on a scale from zero to two, then summing up the five values thus obtained. The resulting Apgar score ranges from zero to 10. Apgar was the name of the medic who devised the scale and the five criteria are summarized using words chosen to reflect this: **A**ppearance, **P**ulse, **G**rimace, **A**ctivity, **R**espiration
BWH	Birmingham Women's Hospital. (Our recognized equivalent Trust for benchmarking)
CPAP	Continuous Positive Airway Pressure
CTG (Cardiotocograph)	A technical means of recording the fetal heartbeat and the uterine contractions during pregnancy. The machine used to perform the monitoring is called a cardiotocograph, more commonly known as an electronic fetal monitor (EFM) and produces outputs a graphical 'trace'
Epidural	Form of regional analgesia used during childbirth
GTD	Gestational trophoblastic disease (GTD)
Gynaecology	Medical practice dealing with the health of the female reproductive system
Gynaecological Oncology	Specialised field of medicine that focuses on cancers of the female reproductive system
Haemorrhage	The flow of blood from a ruptured blood vessel
HSCIC	Health and Social Care Information Centre
Hypotonia	Hypotonia is a medical term that describes decreased muscle tone
Intraventricular Haemorrhage	Bleeding within the ventricles of the brain
Intrapartum	Occurring during labour and delivery
ITU (Intensive Therapy Unit)	Specialised department in a hospital that provides intensive-care medicine
Laparoscopic	Description of a surgical procedure carried out using a flexible fibre optic instrument that enables the surgeon to examine the inside of the body through only a small incision
LWFT	Liverpool Women's NHS Foundation Trust
Matron	Term given to a very senior nurse
Maternity	The period during pregnancy and shortly after childbirth
MAU	Maternity Assessment Unit
MBRRACE -UK	Mother and Baby Reducing Risks through Audits & Confidential Enquiries across the UK
MDT	Multi-Disciplinary Team
Morbidity	Incidence of a particular disease
Mortality	Death
Neonatal	Of or relating to newborn children
NIHR	National Institute for Health Research
NNAP	National Neonatal Audit Project
NNMR	Neonatal Mortality Rate; Deaths of infants in the newborn period.
NRLS	National Reporting & Learning System
PDR	Personal Development Review
Perioperative Care	Time period describing the duration of a patient's surgical procedure
Periventricular Leukomalacia	A form of brain injury involving the tissue of the brain known as 'white matter'
PHE	Public Health England

Post operative	Period immediately after surgery
Post partum	Period beginning immediately after the birth of a child
Pre-eclampsia	A condition involving a number of symptoms including increased maternal blood pressure in pregnancy and protein in the urine
Pre-operatively	Period immediately before surgery
RCOG	Royal College of Obstetrics & Gynaecology
SOP	Standard Operating Procedure
Tissue Viability	Tissue Viability is about the maintenance of skin integrity, the management of patients with wounds and the prevention and management of pressure damage
Urogynaecology	A medical specialty involving the treatment of the urinary tracts and reproductive organs in women
Uterus	The womb
Venous Thromboembolism	Often referred to as a 'VTE'. This term describes a fragment that has broken away from a clot that had formed in a vein
VON	Vermont Oxford Network