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Quality Strategy

Liverpool Women's NHS Foundation Trust

2014-2017

Version 2

February 2015

Contents

1 Foreword

Our vision is to be the leading provider of healthcare for women, babies and families. Our Quality Strategy is ambitious and builds on our successes to date.

We aspire to deliver safe and effective care for every patient whilst at the same time ensuring that they are treated with compassion, dignity and respect. The Quality Strategy sets out how we at Liverpool Women's will deliver high quality care by putting patients at the centre of all we do.

Our Quality Goals are:

- To reduce harm
- To reduce mortality
- To improve the patient experience

We will focus our attention on projects that will reduce harm and mortality, improve patient experience and make the care that we give to our patients reliable and grounded in the foundations of evidence based care.

To achieve these challenging goals, our people will have to demonstrate unwavering determination and a commitment to quality improvement despite internal and external challenges.

We will build on our performance and efficiency to create a culture of continuous quality improvement. Our goal is to become a learning organisation in which every member understands their role in delivering clinical quality and works towards that goal every day.

We will place considerable emphasis on understanding the systems, practices and behaviours that underpin clinical quality, working towards excellence in clinical systems and engaging all of our employees in improvement and learning.

Throughout the lifetime of the Strategy we will annually review and amend our quality indicators, and build on our existing governance and safety infrastructure to drive continuous improvement.

This strategy sets out the quality goals that we have set ourselves for the next 3 years. We start by reiterating the Trust's long standing strategic aims which encompass the defining work done by Lord Darzi before setting out clearly each of our 3 main quality goals.

For each high level quality objective we include the specific targets to which we aspire and go on in section 4 to list some of our intended feedback mechanisms to ensure that we hear what our patients, governors and staff have to say about the quality of care which we provide.

In section 5 we commit ourselves to using the Quality Governance Model developed by our regulator, Monitor, and set out the governance arrangements which will ensure that we are held accountable for delivery.

The appendices include the comprehensive metrics for the Trust which encompass all our areas of clinical care.

Accountability for delivery of this the LWH Foundation Trust Quality Strategy rests with the board and its delivery will be led by the Medical Director and the Director of Nursing and Midwifery.

Kathryn Thomson
Chief Executive
Liverpool Women's NHS Foundation Trust

September 2014

1.1 What is our Vision and what are our Aims and Values?

Table 1 Vision, Aims & Values

Our Vision
We will be the recognised leader in healthcare for women, babies and their families.
Our Aims – WE SEE
• To develop a well led, capable, motivated and entrepreneurial **W**orkforce • To be ambitious and **E**fficient and make the best use of available resources • To deliver **S**afe services • To participate in high quality research in order to deliver the most **E**ffective outcomes • To deliver the best possible **E**xperience for patients and staff
Our Values – we CARE and we LEARN
• **C**aring – we show we care about people • **A**mbition – we want the best for people • **R**espect – we value the differences and talents of people • **E**ngaging – we involve people in how we do things • **L**earn – we learn from people past, present and future

1.2 The Trust Board

The Trust Board has overall responsibility for the activity, integrity and strategy of the Trust and has a statutory duty of quality, as part of its role, to ensure high standards of quality governance.

The Trust Board is pivotal in setting the organisational culture in relation to quality and promoting continuous quality improvement, particularly in providing challenge and seeking assurance that we are achieving our aims. It will carry out this role both corporately as a Board and via the Governance and Clinical Assurance Committee.

1.3 The Core Elements of the Strategy

This Quality Strategy sets out the objectives and scope and aims of the Trust. The strategy identifies what 'Quality' means for the Trust, gives clear direction and a shared vision for how we ensure this is a priority at all levels in the Trust. It also outlines how Quality is organised within the Trust as part of a whole-system approach to improving standards and protecting the public from sub-optimal standards of care.

In 'High Quality Healthcare for All'[1], Darzi states that quality is the organising principle for the NHS with emphasis on patient safety, patient experience and the effectiveness of care. "High quality care should be as safe and effective as possible, with patients treated with compassion, dignity and respect. As well as clinical quality and safety, quality means care that is personal to each individual." This strategy details how these fundamental aspects of quality care will be achieved.

Darzi described quality as having three essential components:

Table 2 Quality Components

Patient Safety	Clinical Effectiveness	Patient Experience

i. **The safety of treatment and care provided to patients** – safety is of paramount importance to patients and is the bottom line when it comes to what NHS services must be delivering.

ii. **Effectiveness of the treatment and care provided to patients** – measured by both clinical outcomes and patient-related outcomes. There is much evidence of wide variation in the clinical effectiveness of care delivered across the country;

iii. **The experience patients have of the treatment and care they receive** – how positive an experience people have on their journey through the NHS can be even more important to the individual than how clinically effective care has been.

1.4 What do we want to achieve?

At Liverpool Women's NHS Foundation Trust, we aim to achieve high quality care by putting patients at the centre of all we do, getting it right first time, every time for every patient. We will do this by ensuring:

- Continuous improvement and effective patient care and excellent clinical outcomes for patients
- A patient centred and patient led approach to care that includes treating patients courteously and compassionately, involving them in decisions about their care and keeping them informed.

High quality care for all: NHS Next Stage Review final report, ISBN 978-0-10-174322-8

- The Services are developed in response to feedback from patients, the public and other key stakeholders.
- We reduce the risk from clinical errors and adverse events, as well as a commitment to learn from mistakes and share learning across the Trust.
- An environment which is safe for both patients and staff and supports their needs and well-being.
- The Trust is well managed and compliant with regulatory requirements.
- Engagement of all our staff in services which are clinically led and owned.
- We have an open and transparent culture, that encourages staff to speak out in the interest of patients (if they are concerned).

Over the lifetime of this strategy we will aim to achieve our quality goals.

1.5 Learning and well -led

- **Inspiring vision – developing a compelling vision and narrative**
  Over the life time of this strategy the Board will continue to engage staff with a compelling vision that inspires them to work towards common goals. The Board need to demonstrate commitment to the vision and take actions to embed this throughout the organisation.

- **Governance – ensuring clear accountabilities and effective processes to measure performance and address concerns**
  The Board will be clear about who is accountable for maintaining standards of care; they will establish systems to monitor performance, and fair processes for staff and patients to voice concerns.

- **Leadership, culture and values – developing open and transparent cultures focused on improving quality**
  The Board will develop leaders throughout the organisation and create strong cultures, based on values and expected behaviours.

- **Staff and patient engagement – focusing on engaging all staff and valuing patients' views and experience**
  The Board will ensure that staff are engaged in the work of the organisation and that the experiences and views of patients are understood and acted on.

- **Learning and innovation – focusing on continuous learning, innovation and improvement**
  The Board will develop a culture of continuous learning and improvement to support staff to provide the best possible care within the resources available.

  The Trust has committed to NHSLA sign-up-to-safety campaign and have aligned the quality indicators to a safety improvement plan.

2 Achieving our Quality Goals

2.1 Quality Goal 1- to Reduce Harm

2.1.1 What is harm?

Despite the best efforts of every healthcare professional, harm occurs every day to patients in every hospital. Catastrophic events are rare but we acknowledge that unintentionally a significant number of patients experience some harm in the course of their care. Given the nature of the services we provide, harm can sometimes result in lifelong consequences for women, babies and families.

We recognise that the national priorities with respect to reducing harm to patients relate to

- Pressure ulcers
- Catheter associated urinary tract infection
- Venous thrombo-embolism (VTE)
- Falls

Given the nature of the services we provide at Liverpool Women's, very few of our patients would suffer harm as a result of any of the above. That does not mean we do not cause avoidable harm. We have thought carefully about those harms which are particularly relevant to the services we provide and the patients we care for. We have agreed these are

- Infection
- Avoidable birth injury
- Medication errors
- Multiple pregnancy as a result of fertility treatment

Our Improvement Priorities for each of the Harms

Our priorities for improvement with respect to infection are:

- To reduce the number of elective surgical site infections in gynaecology to an average of 3 per calendar month.
- To work to cleanse data for emergency patients and determine underlying infection complication rates.
- To achieve zero MRSA infection
- To achieve zero C-Diff infection
- To achieve neonatal infection rates as follows:
    - A proportion of preterm babies who develop a late-onset bloodstream infection i.e. the proportion of preterm babies below 30 + 0 weeks' gestation admitted who have a late-

onset bloodstream infection (one occurring > 72 hours of age) below the median benchmarked against the VON-UK network.

- A rate of late-onset bloodstream infections in preterm infants i.e. the number of episodes of late-onset bloodstream infection in preterm babies below 30 + 0 weeks' gestation per 100 VLBW intensive care and high dependency days below 0.5 infections per 100 VLBW IC and HD days..

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

- To reduce the incidents of babies born with avoidable Grade 2/3 Hypoxic Ischaemic Encephalopathy by 50% over 3 years. All still births on review are coded according to CMACE classification, one of which is growth restriction. We will be able to identify any improvement by the ongoing continuous stillbirths audit.

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

Our priorities for improvement with respect to medication errors are:

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

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

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

2.2 Quality Goal 2 – To Reduce Mortality

2.2.1 What is mortality & why is it an important measure?

Sadly, patients die whilst in hospital and Liverpool Women's is no different. The NHS uses a standardised measurement to calculate mortality across the NHS. This risk adjusted mortality ratio compares a hospital's actual mortality rate to the mortality rate that would be expected given the characteristics of the patients treated; this gives a risk adjusted expected mortality rate.

In calculating this, many factors are taken into account, such as the age and sex of patients, their diagnosis, whether their hospital stay was planned or an emergency and any other conditions the patient may have. If a hospital has a mortality rate of 100 that means that the number of patients

who died was exactly as was expected. A mortality rate above 100 means more patients died than would be expected and below 100 means that fewer than expected died.

This assessment of mortality using HSMR is not a useful tool for this organisation since maternal deaths, stillbirths and neonatal deaths which account for the great majority of deaths are excluded from those calculations. The remaining deaths in the Trust are in gynaecology and are of such small numbers that the use of HSMR may give false concern or reassurance. This matter has been considered very carefully and we are committed to monitoring our mortality by focussing on each clinical area separately. We will record our mortality rates in those areas and benchmark against national standards. Each case will be reviewed individually so that any lessons regarding failures of care may be learned.

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

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

Our Improvement Priorities

Our improvement priority for neonatal mortality is:

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

Our improvement priority for gynaecology mortality is:

- No non-cancer related deaths in Gynaecology.
  Delivered by using Serious Incident review, Morbidity and Mortality meetings and staff education bulletins to ensure any lessons from such rare events are learnt by all staff.

Our improvement priorities for maternity are as follows:

- Zero 'Direct maternal deaths'.
- To reduce the incidence of stillbirths attributed to Small for Gestational Age (SGA) by 20% by early implementation of the NHS England saving babies' lives care bundle. Every still birth is reviewed and categorised according to CMACE categorisation, of which small for gestational age is one. Ongoing audit will identify a decrease in the number of cases assigned to this category.
- Introduce the national 'safety thermometer' for maternity services

2.3 Quality Goal 3 – To provide the best patient experience

2.3.1 Why is experience an important quality measure?

The experience that our patients have whilst under the care of our organisation is of utmost importance to us. We understand that many of our patients have contact with us at some of the most significant times in their lives and it is our ambition to make each patient's experience the best that it can possibly be.

A great patient experience is delivered by a workforce who are engaged, competent and motivated to deliver high quality care.

Our priorities for Patient experience are:

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

3 Measuring Quality - Key Performance Indicators (2014-15)

The Trust measures quality performance in three ways, through:

- Quality Report (annual Indicators) – Appendix A
- CQUIN measurement – Appendix B
- The CCG Quality Schedule – Appendix C

3.1 Data Quality

Our data quality is founded on the principles:

Accuracy	Is data recorded correctly and is it in line with the methodology for calculation?
Validity	Has the data been produced in compliance with relevant requirements?
Reliability	Has data been collected using a stable process in a consistent manner over a period of time?
Timeliness	Is data captured as close to the associated event as possible and available for use within a reasonable time period?
Relevance	Does all data used to generate the indicator meet eligibility requirements as defined by guidance?
Completeness	Is all relevant information, as specified in the methodology, included in the calculation?

3.2 Impact Assessments

In April 2014 a new equality measurable was introduced into the quality schedule which states 'providers must provide evidence that any relevant redesign of services or cost improvement initiatives have been subject to an equality impact assessment report' these assessments and reports have to be submitted quarterly in accordance with the quality contract reporting schedule and will be reviewed by the clinical commissioning groups.

3.3 Quality Report

In our quality report of 2013-14 we set out our quality indicators and priorities for improvement in 2014-15. We will publish our progress in meeting these aims in 2015, together with our Financial Accounts. (See Appendix B).

3.4 CQUIN 2014-15

Commissioning for Quality and Innovation (CQUIN) targets. (See Appendix C).

3.1 Quality Schedule

The requirements of the Quality Schedule are outlined in Appendix D.

4. Patient and Public Engagement

The Trust's aim "To deliver the best possible **Experience** for patients and staff" is reflected in the Trust's declared work streams in the Patient Experience domain within the Quality Report. (See Appendix B)

3.2 Patient Feedback and Surveys

The Trust recognises the value of having patients, governors, members and the public at the heart of its quality strategy. This is particularly significant when planning redesign and transformation of services. This strategy is underpinned by an ethos of involvement and engagement which will ensure the quality strategy dovetails our membership strategy. Indeed, in this second year of the strategy, members of the Council of Governors have been invited to participate in their own "Patient Safety Walkabouts" following a piloting of the associated framework tool by the Board of Directors.

The Trust also welcomes the opportunity to engage with Commissioners to ensure services across the broader health economy are fit for purpose and of an excellent quality. This is particularly pertinent to women's healthcare as a high quality positive experience of women's services can have a very profound impact on the wider health and wellbeing of the family unit.

Patient views on quality are actively sought through:

- Annual surveys and service specific surveys of patients who have recently used Trust services
- The use of frequent feedback surveys (real time feedback)
- Nursing and Midwifery Care surveys
- Friends & Family test
- Feedback forms, the Trust's social media accounts and e-mail contact
- NHS Choices web site
- A variety of other initiatives looking at patient outcomes.

3.2.1 LWFT Involvement in external partnerships and committees

LWFT staff also attend a variety of external engagements to provide information and feedback about the quality of services provided by the Trust as summarised below:

Internal	External
Clinical Quality Governance Committee	Clinical Commissioning Groups
Governance and Clinical Assurance Committee	Local Authority Overview & Scrutiny Committees
Board of Directors	Community / Patient groups.
LWFT Council of Governors	Local HealthWatch groups

4 Strategy Implementation

4.1 Corporate Responsibility and Accountability

The Chief Executive has overall accountability for Quality Governance, delegating the executive responsibility to the Director of Nursing and Midwifery and Medical Director who in turn are responsible for reporting to the Trust Board on the quality governance agenda and ensuring that any supporting strategy documents are implemented and evaluated effectively.

Individual Board members; both Executive and Non-executive are expected to champion quality and to do this visibly by participating in a regular programme of walkabouts, engaging with staff and patients and gathering feedback.

To support delivery of this strategy we will be guided by Monitor's Quality Governance Framework:

Source: Monitor Quality Governance

4.1.1 Quality and Risk Team

Whilst the main delivery of quality occurs within each of the services, the team has a crucial role in:

- Providing support and impetus for action, interpreting and acting on national guidance.
- Facilitating change within services, providing them with the tools, skills and methodologies.
- Ensuring consistency of approach and linkages between clinical services and corporate departments.
- Providing advice to the clinical services on patient safety issues; providing intelligent information on incidents, near misses and investigation outcomes;

leading investigations relating to serious untoward incidents; and overseeing the implementation of patient safety strategies and work streams.

- Ensuring the effective management of complaints, liaising with PALS, Claims and the Clinical Services and providing intelligent information on patient experiences to aid organisational learning.

4.1.2 Role of 'Our People'

Our people are our biggest asset in delivering safe, effective services underpinned by a positive patient and staff experience. In order to improve quality staff need to understand what is expected of them. They also need the opportunity to identify and act on issues they know could adversely affect or improve quality of services.

Service Managers take responsibility for, and are accountable for, the quality of their services, recognising that sustained improvement delivers the best results when championed and actioned locally. To achieve this we work closely with all our people to ensure they understand where the issues are and help them to achieve the improvement. This may involve training in quality improvement and service redesign. It also requires regular, accurate and consistent information and intelligence about the services we provide.

4.1.3 Senior Operational Management Team

Senior Management are accountable for the delivery of the Quality Strategy within their areas. It is their responsibility to ensure that the governance values are embedded in their services and this means:

- **Awareness**
  - All staff should know that quality improvement is a key priority for the Trust and understand how they can contribute to the agenda.
  - All staff should be aware of what CQC compliance is and the purpose of the 'Essential Standards of Quality and Safety'.
  - All staff should be aware of the key policies and processes and should comply with them.

- **Compliance**
  - All services should use the CQC standards to plan a programme to support the Quality Strategy, to ensure improvement year on year and ensure the CQC registration and compliance requirements applicable to them are met. (This supports the operational business plan).

- **Assurance**
  - Each Management team should be 'assured' (i.e. by evidence collation, walkabouts, surveys, audits etc) of, and be able to demonstrate compliance with the standards and other relevant accreditation requirements.

- **Sharing and learning**

  - Services should be sharing areas of good practice and learning across the Trust, both when things go well and when things could be improved.

- **Leadership and drive for results**

  - Each service needs to support the Trust goal of being a centre of excellence and provider of choice by continually striving to improve and ensure the Trust can set itself apart by the quality of its care.

4.2 Governance arrangements

A key component of Quality Governance is sound risk management practice and the Trust has set clear risk management objectives to support the achievement of the Quality Strategy objectives. The Trust is committed to providing high standards of patient centred care in all settings. All services are required to focus on patient safety, experience, outcomes and quality of care whilst acting with responsibility within the financial and performance framework of the Trust.

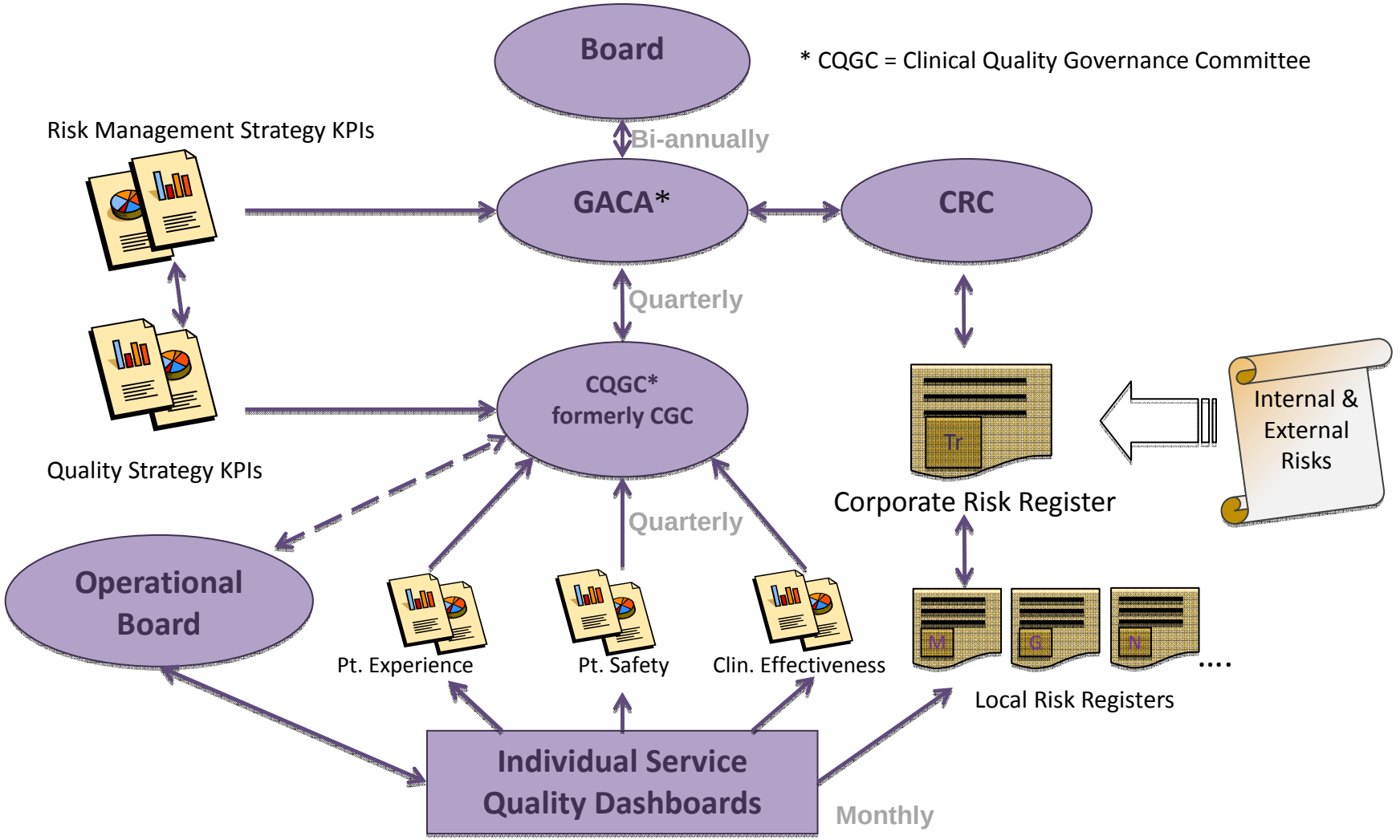
Two committees are responsible for matters of Quality and Safety. They are the Governance and Clinical Assurance Committee (GACA), a sub-committee of the Board and the Clinical Quality Governance Committee (formerly known as the Clinical Governance Committee), which reports into GACA.

The individual service areas are responsible for managing those quality priorities and indicators of relevance to them and are required to report on them monthly to their local Quality Improvement Group or forum in a standardised format dashboard. These groups report quarterly to the Clinical Quality Governance Committee, who raises exceptions and concerns with the Operational Board and reports quarterly to the Governance and Clinical Assurance sub-committee, which in turn reports biannually to the board. Thus the Trust's Clinical Quality Governance Committee and ultimately the Board have an overview of the delivery of the work streams in respect of all quality priorities and indicators as illustrated in fig.2.

4.3 Relationship with other strategies

The Trust recognises the interdependencies of other strategies within the organisation that work alongside the quality strategy and support delivery of our quality priorities.

Figure 1 Quality Governance reporting framework



5 Appendices:

5.1 Appendix A - Quality Strategy Work Plan

In setting out the direction and pace of our quality improvement journey, we are committing to delivering the following phased deliverables.

Table 3 Quality Strategy Work Plan

Objectives- Engagement on Quality	
Key:	2014-15 Complete / On track; 2015-16 Objectives; 2016-17 Objectives
	Agree quality improvement methodology by consulting with Senior Management Team and Clinical Governance Committee
	Ensure leadership development programmes enable leadership capability for quality improvement
	Launch Quality Strategy
	Deliver priorities outlined in Quality Account
	Refine data collection systems to underpin identification of measurable improvement
	Implement quality dashboards across the organisation
	Establish Patient Safety walkabouts
	Implement Friends and family test across the organisation
	Establish framework for demonstrating improvement as a result of patient experience feedback
Objectives- Gaining insight and foresight into Quality	
	Identify a single quality goal that is relevant to patients and to staff as a priority for improvement for each of our clinical areas.
	(Maternity / Gynaecology / Anaesthetics / Neonatal Paediatrics / Reproductive Medicine and Genetics).
	Analyse the Trust's performance on key quality indicators, benchmarked against national/international comparisons.
	Develop a strategy for each of the quality goals over a 3-5 year period with agreed improvement targets
	Seek representation in the Improvement groups from the public / stakeholders
	Establish processes and procedures to support realisation of the ambitions to fulfil the post-Francis requirements under the Duty of Candour and embedding of an open , honest and transparent culture.
	Ensure that clinical quality remains a core feature of mainstream reporting to the Board
	Consider engaging with a partner to deliver a total quality management system for Liverpool Women's

Objectives-Accountability for Quality

	Ensure that quality information is used to drive improvement in quality performance
	Embed a systematic process for following up any issues in which quality information has been challenged
	Analyse the Trust's performance on key quality indicators, benchmarked against national/international comparisons and against the Trust's improvement performance over the past 2 years to enable identification of future quality improvement priorities
	Review governance structure to support the quality agenda
	Ensure committees embrace quality through their respective terms of reference
	Ensure internal and external audit collaborate and are cohesively aligned to the quality agenda
	Define and develop a team of staff to lead for each of the quality goals

Objectives- Managing Risks to Quality

	Review best practice, nationally and internationally in relation to total quality management systems both in health and other sectors
	Ensure that quality measurement is seen as mainstream business throughout the organisation from Board level to staff delivering care
	Ensure that the BAF identifies and addresses risk to its quality objectives
	To continue to use good practice to improve learning from incidents
	To utilise quality impact assessments when considering CIP's

5.2 Appendix B – Quality Report Indicators

Table 4 LWFT Quality Report indicators

Quality Indicators 2014-15	Quality Goal	Quality Domain	Metrics	How*
•Reduce Gynaecology surgical site infections	1- Reduce Harm	Patient Safety	Remain below peer group (as per CHKS data)	
•Maintain the incidence of multiple pregnancy after fertility treatment at <=10%.	1- Reduce Harm	Patient Safety	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.	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.

****All Quality metrics are reported through the Quality Governance Reporting framework shown in figure 2.***

•Total episodes of late-onset (> 72h) bloodstream infection in VLBW (very low birth weight) and or <30 weeks gestation babies – to have no increase in rate	1- Reduce Harm	Patient Safety	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 monthly Multi-Disciplinary meetings. -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)	1- Reduce Harm	Patient Safety	Total Blood stream infections per total number of care days for all babies	As for preterm babies above
•Brain injury in preterm babies (Severe Intraventricular haemorrhage and Periventricular leukomalacia)	1- Reduce Harm	Clinical Effectiveness	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	Vermont Oxford Neonatal Network Annual data
Babies with grade 2 or 3 HIE (hypoxic Ischaemic encephalopathy) is an acute disturbance of brain function caused by impaired way of delivery and perfusion of the brain	1-Reduce harm	Patient safety	Simply gathering the babies with a diagnosis of grade 2 or 3 HIE from the Badger system is inaccurate because of the complexity of the diagnostic criteria. For purposes of this indicator we will review 100% of babies who require treatment with therapeutic hypothermia. The criteria for use of therapeutic hypothermia are: • Evidence of intrapartum hypoxic ischaemia • Evidence of encephalopathy	100% of babies treated with therapeutic hypothermia

•Hospital Mortality Rate in Gynaecology.	2- Reduce Mortality	Clinical Effectiveness	100% of patient deaths will be clinically reviewed. (In 13/14 LWH was 0.11% vs peer at 0.6%, the higher number for LWH is attributed to higher proportion of patients choosing hospital setting for end of life care which is expected to increase).	100% review of mortality.

**All Quality metrics are reported through the Quality Governance Reporting framework shown in figure 2.*

•Neonatal mortality	2- Reduce Mortality	Clinical Effectiveness	No. of Deaths<=28dys post birth at home or LWH as a proportion of the number of babies surviving to discharge with birth weight between 500g and 1500g.	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.
•Stillbirth Rate	2- Reduce Mortality	Clinical Effectiveness	Adjusted Still birth rate i.e. excluding fetal abnormalities should be at regional rate or below	Meditech and coding. Triangulation via EMBRACE Annual Still Birth Audit
•Increase biochemical pregnancy rates following infertility treatments [In-vitro fertilisation (IVF), Intracytoplasmic sperm injection (ICSI) and frozen embryo transfer (FET)] by 5% over 5 years.	3- To Provide the best experience	Clinical Effectiveness	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. N.B. 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.
•Care indicators for Nursing and Midwifery [NMB to select Priority indicators annually]:	3- To provide the best experience	Clinical Effectiveness	Target across Nursing and Midwifery Indicators at >= 90% compliance	
-36 week Antenatal risk assessment	3- To provide the best experience	Clinical Effectiveness	Increase the % of completed 36 week risk assessments in community.	Meditech and case note audit Reported to Operational board by exception and maternity risk committee.
- One to One care in Labour (See Patient experience below)	3- To provide the best experience	Clinical Effectiveness	See below.	See below.

****All Quality metrics are reported through the Quality Governance Reporting framework shown in figure 2.***

-Avoidable repeats for Antenatal screening and newborn screening blood sampling	3- To provide the best experience	Clinical Effectiveness	To reduce the % of avoidable repeats <0.5%	Quartile audit from Case notes and Meditech for Antenatal screening, monthly audits for Newborn Blood Spot. Reported to Operational Board in monthly performance and quartile in relation to Downs's screening.
-Skin to Skin	3- To provide the best experience	Clinical Effectiveness	Increase the % of skin to skin contact within 1 hour post birth.	Meditech and case note audit Reported to Maternity Risk
-Patients opting for surgical treatment of miscarriage undergo the procedure within 72 hours of their decision.	3- To provide the best experience	Clinical Effectiveness	To establish baseline and achieve Incremental increase in patients having procedure < 72hrs. To be reviewed Quarterly.	Case note audit of 10 per month
• At least 95% of women receive One to one care in established labour (> 4cm)	3- To provide the best experience	Patient Experience	% of women receiving one to one care in established labour (>4cm)	Data from Meditech Exception reporting to Operational board in Monthly performance report
•At least 95% of women who request an epidural, excluding those where there is a medical reason this is not possible, receive this.	3- To provide the best experience	Patient Experience	%of women who request an epidural, excluding those where there is a medical reason this is not possible.	Data from Meditech Exception reporting to Operational board in Monthly performance report
•Reduction in number of complaints relating to care	3- To provide the best experience	Patient Experience	Monthly performance via Complaints recorded on Ulysses system.	Nursing & Midwifery Board as part of Nursing / Midwifery Strategy. Quarterly Report to CGC.
• 75 % of patients recommend us in the family friends test.	3- To provide the best experience	Patient Experience	Friends & Family Test	
• Staff survey results in upper quartile	3- To provide the best experience	Patient Experience	National Staff survey and local 'Pulse' staff survey	
• Patient satisfaction surveys in upper quartile by 2018.	3- To provide the best	Patient Experience	Local patient surveys Picker surveys	

	experience			

• Excellence in Patient Led Assessments of Care Environments (PLACE)	3- To provide the best experience	Patient Experience		

**All Quality metrics are reported through the Quality Governance Reporting framework shown in figure 2.*

5.3 Appendix C - CQUINS 2014-15

Table 5 CQuINs 2014-15

Friends and Family Test	• Implementation of Staff F&FT • Early implementation Day Cases and Outpatients • Improvement in A&E • Response rate improvement Inpatients • Provide timely, granular feedback from patients about their experience
NHS Safety Thermometer – Data Collection	• National safety thermometer • Reduction targets for Pressure Ulcers
Dementia	• FAIR - Find, Assess, Investigate & Refer • Clinical Diagnosis of delirium etc • Further assessment/ diagnostics for Dementia • Clinical Leadership (Compliant: Yes or No) • Supporting carers (Compliant: Yes or No)
Maternity Bundle	• Breastfeeding Initiation • Maternal Smoking status captured at 38 Weeks • % maternal smokers offered referral to smoking cessation services • Healthy Start Vitamins • Flu Vaccinations Pregnant Women • Pregnant women are cared for by a named midwife throughout their pregnancy • BMI index
Cancer	• First diagnostic test by day 14 • Referral to treating trust by day 42
Effective Discharge Planning - Maternity	• Signed off Action Plan (Compliant Yes or No) • Discharges with appropriate care packages? • Discharge Checklist Audit (Compliant Yes or No % completed)

	• Annual Discharge Survey (Numbers surveyed?)
In-Patient Electronic Discharge Summaries	• In-Patient Electronic Discharge Summaries to GPs within 24 Hrs • In-Patient Electronic Discharge Summaries to Patient same day as Discharge • Outpatient Correspondence • Emergency Room/Day Cases Correspondence
iLINKS Transformation Programme	• A named IM&T Lead to take co-ordinating responsibility for Communications CQUINS from within the Trust • The aforementioned Lead to attend monthly CQUIN meetings and review quarterly milestones with an assigned Informatics Merseyside representative • Trust to agree to participate in iLinks Transformation Programme and Clinical Informatics Advisory Group • Trust to nominate a clinical and informatics representative • Trust representatives to attend bi-monthly forums • Trust to commit to supporting and developing the informatics 'Guiding Principle' (as detailed in the ILINKS Transformation Programme Update February 2014) • Trust to participate in health economy wide benefits realisation as part of the iLINKS Transformation Programme via the Programme Board.
Business Continuity Planning	• Plans should detail how Trust systems respond to "rejected" messaging. • Plans should detail processes within the Trust to enable the safe removal of the paper process • Plan should detail how to re-enable the paper process if and when required • Plan should include Problem Management procedures when various issues arise • The plan should be submitted for approval within an agreed timeframe • Implementation of paperless processes to GP practices requires the agreed plan to be signed off and approved by CCG
Genetics	• To increase the availability of array CGH as a first line test to replace karyotyping on prenatal samples to provide a rapid and detailed screen for chromosome imbalance in pregnancies at increased risk of a genetic abnormality. • The number of prenatal samples received by a regional genetics laboratory for chromosome analysis (excluding familial translocations) that are tested by aCGH instead of karyotyping, following a normal rapid aneuploidy test result. • The number of prenatal samples received by a regional genetics laboratory for chromosome analysis (excluding familial translocations) that have a chromosome analysis following a normal rapid aneuploidy test result.
Systems Interoperability and clinical data sharing	• Firm plans submitted of how providers will achieve "interoperability" to view shared data within own existing systems (Not stand alone clients). • Strategy - where applicable to reduce stand alone EMIS clients for read only access across Health Economy by 2015 • Continuation of Agreed Data Sharing Schemes • A plan to be submitted to and agreed by CCG as a coherent means of sharing clinical data across the Trust

****All Quality metrics are reported through the Quality Governance Reporting framework shown in figure 2.***

5.4 Appendix D – Quality Schedule

Table 6 Agreed CCG Quality Schedule Requirements 2014-15 (*All Quality metrics are reported through the Quality Governance Reporting framework shown in figure 2.)

Ref	Measure	Reporting Frequency
Exception Reporting		
ST_02	Trust to respond to any in year alerts or concerns and provide assurance of appropriate systems in place to demonstrate compliance with standards as outlined by CQC for all services they are registered to provide.	Exception
ST_03	Statutory Notices - The Trust must notify CCG within 48 hours of receipt of any statutory improvement notice that is served on the Trust from ALL External Organisations e.g. Care quality Commission, Health and Safety Executive, General Medical Council for example. Notices can include enforcement , improvement or prohibition notices	Exception
SUI_01	Providers to report SUI's within 48 hours of the provider becoming aware of the incident.	Exception
SUI_03	Actions plans produced as a result of SUI investigations are executed within the timescales set by the reporting organisation. Any additional requests for further evidence of assurance/information by CCG SUI/Complaints Management Group are executed within the required timescales or agreed extension. This includes requests for updated action plans.	Exception
IC_02	All cases of MRSA are investigated using a root cause analysis approach based on the health economy.	Exception
IC_03	All cases of C difficile are investigated using a root cause analysis approach based on the health economy	Exception
IC_04	All outbreaks (all causes) and clusters of infection that involve ward closure to be reported within 1 working day.	Exception
E&D_02	Equality Delivery Systems 2- completion of EDS 2 self-assessment within agreed timescales and delivery against at least 5 outcomes.	Exception
E&D_04	Any relevant redesign of services (subject to the Public Sector Equality Duty) needs to include an equality analysis report and evidence that it has been considered by decision makers	Exception
Monthly Reporting		
NR_02	Publication of Formulary	Monthly
NR_03	Duty of Candour - Each failure to notify patients/carers of a suspected or actual patient safety incident that resulted in severe harm or death. (as per Guidance)	Monthly
ST_01	Trust to maintain registration with routine restrictive conditions as agreed by CQC	Monthly

ST_05	Quality Risk Profiles - Trust to respond to commissioner with details of actions in place to address latest quality risks published within CQC monthly QRP reports including; Involvement & Information, Treatment & Support, Safeguarding & Safety, Suitability of staff, Quality & Management and Suitability of management	Monthly
SUI_02	Completion and submission of Investigation reports (in line with NPSA Framework) submitted to co-ordinating commissioner within 45 working days or within the agreed extension.	Monthly
M_01	Provider to provide a monthly update in relation to "in-hospital mortality" for those listed in their intelligence monitoring report.	Monthly
IC_01	Trust to submit the HCAI Assurance Framework to Commissioner within the agreed timescales.	Monthly
LD_04	Learning Disability Risk Assessment - In-patients with a learning disability have had a risk assessment completed within 48hours of admission to hospital using a recognised risk assessment tool.	Monthly
Quarterly Reporting		
ST_04	Hospital Intelligent Monitoring tool- Trust to respond to commissioner with details of actions in place to address latest risk scores which relate to the five 5 key questions are they safe, effective, caring, responsive and well-led.	Quarterly
ST_07	Central Alerting System (CAS) - Trust to provide a quarterly update of actions in place to close alerts reported as on-going within the quarter.	Quarterly
ST_08	Central Alerting System (CAS) - Trust to evidence the process and actions taken to demonstrate full compliance with the closed CAS alerts within the reporting period. Commissioner to identify the alerts for further validation.	Quarterly
C&I_01	Complaints and Patient Feedback - Required elements of reports submitted by trust to commissioner to provide full details of complaints and outcomes on as near a real time basis as possible (RF120) ,the number of complaints /patient feedback received and lessons learnt for all complaints.	
C&I_02	Low to Moderate Incidents: Evidence of timely reporting, analysing and learning from low to moderate incidents resulting in demonstrable service improvements.	
M_02	Early Warning system and have clinically appropriate escalation procedures for deteriorating, high-risk patients (in particular at weekends and out of hours). (Keogh ambition 1)	
IC_05	Acute Providers to demonstrate compliance against Public Health England "Acute trust toolkit for the early detection, management and control of carbapenemase-producing Enterobacteriaceae"	
CE_02	All NICE publications applicable to the provider.	
CE_03	NICE Clinical guidelines and Quality Standards - Baseline assessment with appropriate action plan to be completed for the following:- (individual for each provider)	Quarterly
CE_04	Military and Veterans Health; Develop systems to identify secondary care contract activity by service (e.g. mental health), specialty/HRG, value, provider in order to allow 2012/13 contracts to separately identify shadow NCB / CCG responsibilities.	Quarterly

CE_05	Military and Veterans Health; Provide priority treatments including appropriate mental health treatment for veterans with conditions related to their service, subject to the clinical needs of others.	Quarterly
LD_03	Learning Disability Identification - Provider to identify people with moderate to severe learning disabilities at point of contact with the provider. Details to be recorded electronically on patient record.	Quarterly
PSE_01	National Staff Survey; Compliance and targets in line with National Standards and Reporting. Including areas; Overall staff engagement, Staff ability to contribute towards improvements at work, Staff recommendation of the trust as a place to work or receive treatment and Staff motivation at work	Quarterly
PSE_02	National Surveys; Provider to demonstrate methods to improve survey results within the areas identified. Including areas; Treated with respect and dignity while in hospital, Rate of care received, Local Patient Experience Intelligence	Quarterly
PSE_03	Local patient experience surveys - Trust Wide Surveys to be undertaken over a 12 month period with a representative patient sample size and to capture equality target groups and the views of carers.	Quarterly
PSE_04	Patients and carers should be represented throughout the governance structures of the providers. (Berwick Rec 3) especially in relation to the monitoring of the safety and quality of care (Berwick Rec 8)	Quarterly
MM01	Medication related incidents - Provision of medication error statistics.	Quarterly
MM02	Antimicrobial guidance compliance - Locally agreed antimicrobial audit to deal with local issues of adherence to local and national best practice in this area.	Quarterly
MM03	Adherence to Pan Mersey APC joint formulary - The Pan Mersey Formulary is part of the Pan Mersey Area Prescribing Committee strategy to supporting a coordinated approach to medicines use across the constituent organisations of the health economy.	Quarterly
MM04	Participate in Area Prescribing Committee(APC) - Participate in the Pan Mersey Area Prescribing Committee including provision of representation at APC and subcommittees. Incorporate APC recommendations into Trust policy /formulary. No decisions affecting medicines use in primary care should be made without prior consultation with CCGs via the APC.	Quarterly
MM05	Prescribing in line with APC classification of Red, Amber or Green - All newly initiated "red" classified drugs to be prescribed by acute trust. All Amber drug prescribing to be referred to GP at the end of stabilisation period, in line with agreed shared care, unless clinically appropriate not to do so. Where GP does not prescribe Amber drug, Acute Trust to continue prescribing.	Quarterly
MM06	Individual Funding Requests (IFRs) - IFRs to be processed internally via trust medicines management processes and to be counter-signed by Chief Pharmacist/Deputy.	Quarterly

Bi-Annual Reporting		
ST_06	NHS Litigation Authority (NHSLA) - Providers to work within the framework and standards for NHSLA.	Bi-Annual
ST_10	Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Adult Policy to be implemented and associated audit is undertaken on a regular basis.	Bi-Annual
SUI_04	Provider to conduct an Aggregated Review of all Serious Untoward Incidents.	Bi-Annual
CE_01	Clinical Audit Programme; Completion of clinically relevant audits	Bi-Annual
CE_07	Achievement of UNICEF Baby Friendly Initiative full accreditation by 2013	Bi-Annual
E&D_01	Production and implementation of an agreed SMART statutory Equality Objective plan including the specified equality components.	Bi-Annual
E&D_03	Compliance with Equality Act 2010 Specific duties.	Bi-Annual
Annual Reporting		
ST_09	Patient Led Assessment of the Care Environment (PLACE) - Annual assessment of trusts performance in the following areas; Cleanliness, Hydration and Food Privacy, Dignity, well-being and condition and appearance and maintenance. Action plans required if latest ratings have dropped compared to previous years and national average.	Annual
CE_06	Quality Account - Annual Report	Annual
E&D_05	Evidence of an analysis of usage of Translation and interpretation services (language and disability) against the expected requirements given local demographics / patient population	Annual
LD_01	People with learning disabilities and/or autistic spectrum conditions (ASC) should be able to access mainstream services when necessary; Reasonable adjustments are made to services to allow access to mainstream mental health and other services as necessary	Annual
LD_02	Health & Social Care Self Assessment Framework - Learning Disabilities	Annual
KPI_13	Trust to develop a policy to evidence the clinical involvement in re-allocation of cancelled appointment (Cancelled by Provider).	Annual
CE_02	All NICE publications applicable to the provider.	Annual
PSE_01	National Staff Survey; Compliance and targets in line with National Standards and Reporting. Including areas; Overall staff engagement, Staff ability to contribute towards improvements at work, Staff recommendation of the trust as a place to work or receive treatment and Staff motivation at work	Annual

**The provider is only expected to update annual measures once in a 12 month period.*

5.5 Appendix E - Quality Schedule – Performance Information Metrics

Ref	KPI	Operational Standards	Threshold	Frequency
CB_B1	RTT	Percentage of admitted Service Users starting treatment within a maximum of 18 weeks from Referral	90%	Monthly
CB_B2	RTT	Percentage of non-admitted Service Users starting treatment within a maximum of 18 weeks from Referral	95%	Monthly
CB_B3	RTT	Percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral	92%	Monthly
CB_S6	RTT	Zero tolerance RTT Waits over 52 weeks	0	Monthly
CB_B4	Waiting Times	Percentage of Service Users waiting less than 6 weeks from Referral for a diagnostic test	99%	Monthly
CB_B5	A&E	Percentage of A&E attendances where the patient was admitted, transferred or discharged within 4 hours of their arrival at an a&e department	95%	Monthly
CB_B6	Cancer	Percentage of patients referred urgently with suspected cancer by a GP waiting no more than two weeks for first outpatient appointment	93%	Monthly
CB_B7	Cancer	Patients referred urgently with breast symptoms (where cancer was not initially suspected) waiting no more than two weeks for first outpatient appointment	93%	Monthly
CB_B8	Cancer	Percentage of patients waiting no more than one month (31 days) from diagnosis to first definitive treatment for all cancers	96%	Monthly
CB_B9	Cancer	Percentage of patients waiting no more than 31 days for subsequent treatment where that treatment is surgery	94%	Monthly
CB_B10	Cancer	Percentage of patients waiting no more than 31 days of subsequent treatment where that treatment is an anti-cancer drug regimen	98%	Monthly
CB_B11	Cancer	Percentage of patients waiting no more than 31 days of subsequent treatment where treatment is a course of radiotherapy	94%	Monthly
CB_B12	Cancer	Percentage of patients waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer	85%	Monthly
CB_B13	Cancer	Percentage of patients waiting no more than 62 days from referral from an NHS Screening service to first definitive treatment for all cancers	90%	Monthly

CB_B14	Cancer	Percentage of patients waiting no more than 62 days for first definitive treatment following a consultants decision to upgrade the priority of a patient (all cancers)	85%	Monthly
CB_B17	MSA	Sleeping Accommodation Breach	0	Monthly
CB_B18	Cancelled Op's	All Service Users who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the Service User's treatment to be funded at the time and hospital of the Service User's choice	0	Monthly
CB_S10	Cancelled Op's	No urgent operation should be cancelled for a second time	0	Monthly
CB_A15	Infections	Zero tolerance of MRSA	0	Monthly
CB_A16	Infections	Minimise rates of Clostridium difficile	0	Monthly
NR_04	SUS	Completion of a valid NHS number field in mental health and acute commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	99%	Monthly
NR_05	SUS	Completion of a valid NHS number field in mental health and acute commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	95%	Monthly
D4_1	Choose and Book	Provider failure to ensure that "sufficient appointment slots" are made available on the Choose & Book system	TBA	Monthly
KPI_09	Mortality	Hospital Standardised Mortality Ratio (HSMR)	100	Monthly
KPI_11	Out-Patient Appointments & DNA Rates	Out Patient DNA rates. Percentage of outpatient appointments where the patient DNA a first appointment	TBM	Monthly
KPI_12	Out-Patient Appointments & DNA Rates	Out Patient DNA rates . Percentage of outpatient appointments where the patient DNA a follow up appointment	TBM	Monthly
A&E_01	A&E Quality Indicators	Patient Impact - Unplanned re-attendance rate - Unplanned re-attendance at A&E within 7 days of original attendance (including if referred back by another health professional) (Non Pregnancy related returns only as previously agreed)	5.00%	Monthly
A&E_02	A&E Quality Indicators	Patient Impact - Left department without being seen rate	5.00%	Monthly
A&E_03	A&E Quality Indicators	Timeliness - Time to initial assessment - 95th centile	<15	Monthly
A&E_04	A&E Quality Indicators	Timeliness - Total time spent in A&E department - 95th centile	<240	Monthly
A&E_05	A&E Quality Indicators	Timeliness - Time to treatment in department - median	<60	Monthly

CB_S7a	A&E Handover	All handovers between ambulance and A&E must take place within 15 minutes		Monthly
CB_S7b	A&E Handover	All handovers between ambulance and A&E must take place within 15 minutes		Monthly
KPI_32	Maternity 12 weeks	% women who have seen a midwife by 12 weeks and 6 days of pregnancy	90%	Monthly
KPI_34	Breastfeeding Peer Support	Total women informed of service	90%	Monthly
KPI_35	Breastfeeding Peer Support	Women who initiate breastfeeding in hospital will be seen or contacted by a peer supporter during their hospital stay	90%	Monthly
KPI_04	Smoking Indicators	Ascertain smoking status of all patients in Maternity & Gynaecology	95%	Quarterly
KPI_06	Smoking Indicators	All Smokers to be offered referral to an intensive Stop Smoking Specialist Service which provides at least 4 weeks of treatment.	50%	Quarterly
KPI_07	Smoking Indicators	Offer smoking intervention to all pregnant women who smoke at 12 week booking appointment	95%	Quarterly
KPI_16	Falls Prevention	All adults to be risk assessed across the appropriate departments using an appropriate tool	98%	Quarterly
KPI_17	Falls Prevention	Of the patients identified as at risk of falling to have a care plan in place.	98%	Quarterly
KPI_18	Falls Prevention	Engage carers and patients representatives in falls management and prevention	100%	Quarterly
KPI_19	Falls Prevention	Completion of a Root Cause Analysis for all falls sustained whilst under the care of the organisation. As a referral for a fall or fall sustained during treatment RCA's to be carried out on all falls which have resulted in injury to the patient.	100%	Quarterly
KPI_20	Keeping Nourished	Adult in-patients screened for malnutrition on admission using the MUST tool	95%	Quarterly
KPI_21	Keeping Nourished	Patients with a score of 2 or more to receive an appropriate care plan	100%	Quarterly
KPI_22	Keeping Nourished	Patients scoring high risk (2 or more) are referred to dietician	100%	Quarterly
KPI_29	Fit and Well to Care	Sickness Absence rate for all staff	5%	Quarterly
KPI_30	Cancer Network	Reduce 'did not attend'/cancellations of first appointments - The provider should work with its main CCG (identified by volume of urgent suspected cancel referrals) to recue the number of missed or re-arranged first appointments following an urgent suspected cancer referral (two week referral)	TBM	Quarterly

A&E_06	A&E Quality Indicators	Attendances at Emergency Departments for self-harm per 100,000	TBM	Quarterly
A&E_07	A&E Quality Indicators	Percentage of attendances at Emergency Departments for self-harm that received a psychosocial assessment	80%	Quarterly
KPI_56	Optimum Care Package - Trust to provide 12 months data to be reviewed for new targets to be applied for 14/15	Patients to be assessed for clinical triage assessments within 30 minutes of attending the triage and assessment unit	95%	Quarterly
KPI_59	Optimum Care Package - Trust to provide 12 months data to be reviewed for new targets to be applied for 14/15	Skin to Skin Contract; Trust to maintain end of year position 14/15 in the number of women having skin to skin contact for at least one hour or until after the first feed.	TBC	Quarterly
KPI_51	Fetal Anomaly Scan	93% undertaken between 18+0 to 20+6 weeks gestations	93%	Quarterly
KPI_52	Fetal Anomaly Scan	% of women to be offered within 23 weeks	100%	Quarterly
KPI_53	Fetal Anomaly Scan	% of women seen by obstetric ultrasound specialist within 3 working days or seen by a fetal medicine unit within 5 working days	100%	Quarterly
KPI_54	Fetal Anomaly Scan	% of women with a designated midwife throughout pregnancy who have had a abnormality diagnosed	100%	Quarterly
KPI_55	Fetal Anomaly Scan	Annual Detection Rates (DR) and Annual Screen Positive Rates (SPR) for 11 conditions within detail	100%	Quarterly

6 References

1. Monitor - Quality Governance: How does a board know that its organisation is working effectively to improve patient care? Guidance for boards of NHS provider organisations, April 2013.
2. Monitor- Quality Governance Framework, July, 2010
3. Kings Fund - Exploring CQC's well-led domain - How can boards ensure a positive organisational culture? November, 2014
4. Liverpool Women's NHS Foundation Trust, Quality Report, 2013-14