Liverpool Women's
NHS Foundation Trust

Dedicated to you

Quality Report
Liverpool Women's NHS Foundation Trust
2019-2020

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Why publish a Quality Report?

The purpose of a Quality Report is to inform you, the public, about the quality of services delivered by Liverpool Women's NHS Foundation Trust. All providers of NHS Services in England are required to report annually on quality; the Quality Report enables us to demonstrate our commitment to continuous, evidence based quality improvement and to explain our progress to the public. The Quality Report forms an important part of the Trust's Annual Report. This is the Trust's 11th Quality Report.

Statement from the Chief Executive

Welcome to Liverpool Women's NHS Foundation Trust's 9th annual Quality Report. This provides an opportunity for us to report on the quality of healthcare provided during 2019-2020, celebrate our achievements and to share with you the Trust's key priorities for quality in the next reporting year of 2020-21. This is a critically important document for us as it highlights our commitment to putting quality at the heart of everything we do.

By reporting to you annually through our Quality Report we demonstrate how the Trust has performed against the ambitious, specific targets we set ourselves each year. It is through striving to deliver each of these individual targets that we will be able to achieve the long-term objectives in our Quality Strategy. As well as reporting on performance 2019/20, the Quality Report also identifies our priorities for the coming year. These priorities range from nationally published measures through to our own locally selected issues.

The trust monitors data quality through a regular data quality sub-committee that reports through the information governance committee to FPBD and focusses on specific specialties to ensure regular representation from senior managers and clinicians. This provides a forum for informatics and operational staff to discuss issues and key data items relating to their specialty. Regular data quality reports, validations and audits are undertaken provides me with assurance that submitted data is representative of the Trust's activity.

I would like to take this opportunity to discuss some of our quality highlights of 2019-20. Each of them is an initiative or piece of work that we have either led or been involved with over the past 12 months that will change the lives of patients and their families for the better.

It will come as no surprise that towards the end of 2019-20, our services were heavily impacted by the global coronavirus (Covid-19) pandemic. Like all of the NHS, our services and workforce had to respond in a way not seen in peace time. The response of our staff during this period has been astounding and the lengths

that our teams have gone to, to keep not only our patients safe but those of the wider health system has been truly humbling.

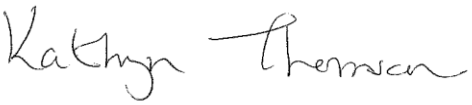
This year has seen the continuation of our £15m project to upgrade and expand our existing Neonatal Unit which will help to keep our most vulnerable patients safe and will improve the facilities and comforts for families of babies being cared for on the unit. Part of the new unit opened in February 2020 and the send phase opening in August 2020. Having been on a number of tours of the new unit during the project, I can confirm that it is a truly fantastic environment that will keep our most vulnerable babies safe.

Following our recent CQC inspection in December 2019 and the Well Led element in February 2020 that Trust was rated 'Good' overall. This is a testament to the quality of our services and the commitment of our staff in demonstrating the excellent care that is delivered to our patients every day.

We continue to work hard to develop plans for the long term future of our services. This started with our Future Generations Strategy in 2015 and has continued through our work with Liverpool CCG and other stakeholders as part of the One Liverpool strategy, which we hope will lead to a public consultation on the future of our services in the near future. We continue to focus on our Future Generations Strategy with the long-term safety of our services and patients being our number one priority.

This report contains many more indicators as to the quality of the care and service provided by all of the staff here at Liverpool Women's and the above are just a small selection. I encourage you to read the report in full and to see the range of measures that are in place to continually improve and sustain quality by reducing harm, reducing mortality and improving the experiences of our patients and families.

In making this statement I can confirm that, to the best of my knowledge, the information contained in this Quality Report is accurate and there are no concerns regarding the quality of relevant health services that we provide or sub-contract.



Kathryn Thomson
Chief Executive


Liverpool Women's
AMBULANCE
EMERGENCY AMBULANCE
North West Ambulance Service NHS Trust
BK09 GAX
EMERGENCY

Part 2

Priorities for improvement and statements of assurance from the board

Priorities for Improvement

The section of the report looks at the Trust's quality priorities, how we have performed against them during 2019-2020 and how we plan to monitor progress during the coming year.

These priorities are a combination of national and local issues and wherever possible are identified by as wide a range of stakeholders as possible; this includes patients, their families, the wider public, our staff and commissioners. The Trust's priorities can be summarised by our 3 goals: to reduce harm, reduce mortality and provide the best patient experience. The Trust priorities ensure that Safety, Effectiveness and Experience, set out by the Department of Health as the 3 central principles of quality healthcare, remain at the core of all activity at Liverpool Women's.

Reduce Harm

Safety is of paramount importance to our patients and is the bottom line for Liverpool Women's when it comes to what our services must be delivering.

Reduce Mortality

Effectiveness is providing the highest quality care, with world class outcomes whilst also being efficient and cost effective.

Provide the best Patient Experience

Our patients tell us that the **experience** they have of the treatment and care they receive on their journey through the NHS can be even more important to them than how clinically effective care has been.

Key
Level 0 – No action to date (red)
Level 1 – Process in place (amber)
Level 2 – Improvement in practice (blue)
Level 3 – Complete (green)

Quality and Safety Improvement Priority	Target	2019-2020	2018-19
Reducing Avoidable Harm (Safety)	Zero never events	**Level 2**	**Level 2**
	Reduce medication incidents resulting in harm	**Level 3**	**Level 3**
	100% sepsis screening	**Level 3**	**Level 3**
	Reduce avoidable admissions	**Level 3**	**Level 2**
	Reduce avoidable returns to theatre	**Level 3**	**Level 2**
	Reduce avoidable term neonatal admissions	**Level 3**	**Level 3**
Reducing Mortality - Achieve the best clinical outcome (Effectiveness)	Zero maternal deaths	**Level 3**	**Level 3**
	Zero unexpected deaths in women having gynaecological treatment	**Level 3**	**Level 3**
	Reduce avoidable stillbirth	**Level 3**	**Level 3**
	Reduce avoidable neonatal deaths	**Level 3**	**Level 3**
	Increase compliance with NICE Quality Standards	**Level 3**	**Level 3**
Providing the Best Patient Experience (Experience)	Increase the percentage of staff recommending the Trust as a place to work	**Level 3**	**Level 3**
	Increase the Trust's staff engagement score	**Level 3**	**Level 3**
	Reduce PALS contacts regarding patient access to triage systems	**Level 3**	**Level 3**
	Health & Wellbeing; to improve staff health and wellbeing	**Level 3**	**Level 3**

Reduce Avoidable Harm

This section of the report looks at how the Trust ensures Safety through the use of its first quality goal, "to reduce 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.

As a specialist Trust, Liverpool Women's has thought carefully about the types of harm that are particularly relevant to the services we provide and the patients we care for. The priorities that have been selected are therefore specific to us and to the issues most relevant to you, our patients and families, and your safety. They give the best overview of how we are tackling harm and working hard to reduce it.

Our Priority Safety	Zero Never Events	Level 3 – Complete

What we said we'd do

The Trust takes extremely seriously its duty to prevent harm and provide care in a safe environment. This will be monitored via our Ulysses incident reporting system and reported to Safety Senate.

What the data shows

The Trust reported 1 'Never Events' in the period 01/04/2019-31/03/2020 and consequently did not meet this target.

An incident occurred on 13th August 2019 in the Obstetric theatres involving a patient undergoing an elective caesarean section. The incident involved a swab being left in the abdomen during a caesarean section. Suturing had been completed prior to the realisation that a swab was unaccounted for. The patient was reopened under the original spinal anaesthetic and the retained swab was removed. The patient was fully informed during and after the incident had occurred.

The incident and investigation has been referred to the Trust's Local Safety Standards for Invasive Procedures (LocSSIPs) working group for inclusion in their ongoing work to ensure the Trust meets the National Standards for Safer Invasive Procedures. The Trust reported 1 'Never Events' in the period 01/04/2019-31/03/2020 and consequently did not meet this target.

Financial Year	No. of Never Events per Financial Quarter				
	Q1	Q2	Q3	Q4	TOTAL
2016-17	0	0	2	1	3
2017-18	1	0	1	0	2
2018-19	0	1	1	0	2
2019-20	0	0	1	0	1

Data Source: Ulysses Risk Management System

What happens next?

Our ongoing aim is to ensure that no 'Never Events' occur and a key to this is staff vigilance as to what are 'Never Events'.

As part of the Trust Risk Management Strategy, the Governance team and the Trust LOcSSIPs working group will continue to work to raise the profile of what 'Never Events' are and the lesson learnt from any which may occur.

Where a 'Never Event' may occur we will continue to report them to the CCG and ensure a full investigation is completed and root causes and lesson learnt identified and disseminated across the organisation.

Our Priority Safety	**Reduce medication incidents resulting in harm**	**Level 3 – Complete**

What we said we'd do

Improving the reporting culture and having the correct processes to review and learn can have a positive impact on patient safety. This will be measured using data from the Trust's Ulysses system and reported to Safety Senate.

What the data shows

There were a total of 762 medication incidents reported during 2019/20 which is a significant increase in the total number from the previous year (583 for 2018/19) and continues to reflect a greater awareness for reporting medication incidents and near misses across the Trust.

Of these 762 incident reports 48 (6%) were recorded as near-misses, 602 (79%) caused no harm, and 111 (15%) were recorded as causing low harm. The Trust reported one medication related incident as causing moderate harm and no incidents relating to severe harm during this period, reflecting the position achieved consistently since 2016/17. As in 2018/19, the large majority of reported medication incidents caused no harm (79% and 80%) and the proportion of incidents causing low harm remained stable (15% and 15%). Low harm medication incidents are defined as 'any medication incident that required extra observation or minor treatment', even if the outcome of the monitoring was normal and there was no actual adverse effect caused by the incident. 2019/20 saw a slight increase in the proportion of near misses when compared to the previous year (6% vs. 5%). The single medication incident that caused moderate harm (Data Source: Ulysses Risk Management System)

What happens next?

Individual service areas across the Trust are responsible for managing medication related incidents and their medication safety programme, with support as required from the governance and pharmacy departments. The Trust's Medicines Management Committee receives bi-annual medication related incident reports from Divisions to increase assurance that key lessons learned from incidents are being disseminated and actioned across the areas. To improve oversight and organisational learning, the Medicines Management Committee has recently introduced a Medicines Safety Group to review medication related incidents on a weekly basis. The primary purpose of the Medicines Safety Group is to improve systems for safer medicines practice throughout the Trust and reduce harm from medication errors.

In the past year, the Medicines Management Committee reviewed the delivery of medicines management training to clinical staff, to provide a greater focus on medication safety and reporting. An interactive eLearning module was launched which highlighted key aspects of overarching medicines management policies and replaced the previous workbook that staff were asked to complete. All clinically-focused staff at Liverpool Women's Hospital must now complete this module upon induction, as well as every 2 years, as part of their mandatory training. In the coming year, the Medicines Management Committee will work with the Trust governance department to increase awareness of Adverse Drug Reactions (ADRs) & Yellow Card reporting. Encouraging ADR reporting is positive and shows that a healthcare team is committed to patient safety.

The Medicines Management Committee is a reporting group of the Trust's Safety Senate and has executive support from the Medical Director to enable it to deliver its work plan.

Our Priority Safety	**100% Sepsis Screening**	**Level 3 – Complete**

What we said we'd do

The Trust takes extremely seriously its duty to recognise and treat sepsis in a prompt and appropriate manner. Quarterly reports are prepared to check compliance with this target.

What the data shows

These data demonstrates that for all patients presenting to the Emergency room with suspected sepsis, and all hospital in-patients who developed symptoms, screening was undertaken in an appropriate manner and compared to previous years, we have seen 100% compliance maintained with our systems and processes of early interventions and diagnoses.

We are continually seeing low numbers of patients being seen and treated at Liverpool Women's Hospital suffering or showing symptoms of Sepsis. However these low numbers can impact on our performance by skewing the figures when benchmarking or comparing with our comparative hospital groups and peers. In all but two cases potentially lifesaving antibiotic therapy was administered within one hour in compliance with National Guidelines.

Timely Identification and Treatment	2016-17	2017/18	2018/19	2019/20
Timely Identification of Sepsis in ED	100%	100%	100%	100%
Timely treatment of Sepsis in ED	20%	93%	100%	100%
Timely identification of Sepsis in Inpatients	100%	100%	100%	100%
Timely treatment of Sepsis in Inpatients	100%	100%	100%	100%

Data Source: LWH IT Performance Team

What happens next?

Sepsis, its recognition and treatment remains a standing agenda item at monthly and quarterly Critical Care Meeting (CCM) meetings, with monthly CQUIN (Commissioning for Quality and Innovations) reporting in place. A rolling monthly audit on sepsis takes place to form the main quarterly report after review at the CCM.

Education on the importance of prompt recognition and management for new medical staff commencing in the Trust will continue. Sepsis awareness week and regular updates. Streamlining data collection process and analysis continues across the Trust. This regime of monitoring and training is providing effective outcomes and improved safety to patients.

To promote our safe service ethos, we will be benchmarking our Trust against other hospitals in our region, using NHS England and Sepsis Trust Data to assist us to maintain our high standards of care and aim to be outstanding.

Our Priority Safety	**Reduce avoidable readmissions**	**Level 3 – Complete**

What we said we'd do

Planning patient discharges as early as possible and ensuring clear discharge plans are in place leads to safer care. Targeted clinical audits to understand patient flow will be in place and reported to Safety Senate.

Each patient, is reviewed and individualised discharge planning commences at the point of admission. Discharge planning is flexible dependent upon which clinical pathway the patient takes which helps to support Expected Date of Discharges.

What the data shows

Data table demonstrating Readmissions 2019-20

KPI ID	Source	Service ID	Target < or >	Target	Value	Trend	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
A&E: Unplanned Reattendances within 7 days (Non Pregnancy Related)						Owner - Head of Nursing Gynaecology												
KPI014	Quality Schedule	Gynaecology	<=	7.0%	Numerator		20	32	28	30	23	19	36	28	19	32	21	35
					Denominator		350	375	340	375	349	304	391	341	275	355	371	263
					Performance		5.71%	8.53%	8.24%	8.00%	6.59%	6.25%	9.21%	8.21%	6.91%	9.01%	5.66%	13.31%
					Trend		▼	▲	▼	▼	▼	▼	▲	▼	▼	▲	▼	▲

Data Source: LWH IT Performance Team

What happens next?

Criteria nurse led discharge is in place for the majority of day case procedures, which is working well and supports enhanced patient flow. Consultant led ward rounds are completed 7 days per week which supports appropriate and timely decision making and discharge planning.

In 2019-20, performance against this metric will be monitored via a quarterly report to the Gynaecology Divisional Governance meeting. This report will also explore and themes or trends in un planned returns or admissions to hospital.

Our Priority Safety	**Reduce avoidable returns to theatre**	**Level 3 – Complete**

What we said we'd do

Monitoring and understanding why patients are returned to theatre unexpectedly including analysing variation as part of the revalidation process. Conducting root cause analysis and learning from these investigations will be reported to Safety Senate.

What the data shows

Looking at the details of the cases returned to theatre, obstetric cases related to management of complications of surgically assisted birth.

In Gynaecology, cases of return to theatre, the indications vary but primary causation is bleeding after major or laparoscopic surgery; post-operative bleeding after loop excision and after hysterectomy and required a further laparotomy.

The number of returns to theatre over the reporting year of gynaecological surgical procedures performed in theatres excludes incomplete surgical evacuation of uterus after miscarriage or termination of pregnancy (which might occur up to 4 weeks from original surgical evacuation procedure).

Returns to theatres in 2019-20

KPI ID	Source	Service ID	Target < or >	Target	Value	Trend	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Returns To Theatre (exc EVACS)		Owner - Clinical Director Gynaecology																
KPI190a	Quality Strategy	Trust	<=	0.7%	Numerator		2	1	0	2	3	3	2	3	5	3	0	4
					Denominator		656	664	647	727	714	701	757	669	628	660	616	652
					Performance		0.30%	0.15%	0.00%	0.28%	0.42%	0.43%	0.26%	0.45%	0.80%	0.45%	0.00%	0.61%

Returns to Theatre figures excluded evacs from September 2018.

Data Source: LWH IT Performance Team

What happens next?

Following an analysis of the detailed information in relation to each return to theatre, are reviewed and reported individually via the Ulysses Risk Management Database. There will be ongoing monitoring of returns to theatre via monthly performance dashboard, scrutiny and overview at Gynaecology Divisional monthly meetings.

Our Priority Safety	**Reduce avoidable term neonatal admissions**	**Level 3 – Complete**

What we said we'd do

A key aim of the Trust and its staff is the safety and welfare of our patients. Minimising term admissions reduces potentially avoidable separation of mothers and babies, reduces unnecessary investigation and treatment and allows better utilisation of resources in the neonatal unit, means that mothers and babies are cared for together whenever possible and is a national priority area.

Reduce harm from avoidable admissions to the neonatal unit in infants born at term (≥ 37 weeks' gestation). A multidisciplinary clinical team from Maternity and Neonatal Services will review all admitted term babies on a case-by-case basis and decide whether or not their admission could have been prevented.

We will identify any learning opportunities and put actions in place to minimise the number of unnecessary admissions. We will monitor the frequency of such admissions and aim to reduce their occurrence.

What the data shows

This table shows the number of babies admitted at term whose admission was deemed to be 'potentially avoidable' has remained at this low level in 2019/20 at 4.1%.

Period	% of total admissions classified as potentially avoidable
2016/17	16.2%
2017/18	9.1%
2018/19	7.1%
2019/20	4.1%

Data Source: Neonatal Admissions Database

What happens next?

We will continue to monitor our overall term admission rates as well as those considered potentially avoidable.

We will continue to enable an admission criteria to try and allow more babies to be cared for in the postnatal wards, thus preventing unnecessary separation of mother and baby.

We will continue to enhance midwifery and neonatal training and education to support staff looking after babies in the postnatal areas.

Reducing Mortality

This section of the report considers how the Trust seeks to "achieve the best clinical outcomes", ensuring the effectiveness of our services for our patients. Given the nature of the services we provide at Liverpool Women's, such as looking after the very premature babies born or transferred here and providing end of life care for cancer patients, we do see deaths, many of which are expected. However, our quality goal is to reduce mortality and improve best clinical outcomes wherever possible.

As is explained on the right, the use of HSMR is not appropriate for this organisation; as it excludes a large number of our deaths, using it may give false concern or reassurance. This has been considered very carefully by the Trust and we have 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. To ensure effectiveness in the Trust is at the absolute forefront of practice, the Trust goes a step further than most other hospitals by ensuring that every case in which there is a death is reviewed individually so that any lessons regarding failures of care may be learned.

Do you use the Hospital Standardised Mortality Rate (HSMR)?
The government uses a standardised measurement to calculate mortality across the NHS. This ratio, HSMR, compares a hospital's actual mortality rate to the mortality rate that would be expected given the characteristics of the patients treated. This is not a useful tool for Liverpool Women's since maternal deaths, stillbirths and neonatal deaths are all excluded.

Our Priority Effectiveness	**Zero Direct Maternal Deaths**	**Level 3 – Complete**

What we said we'd do

A direct maternal death is one which is directly related to a complication of pregnancy (such as haemorrhage, pre-eclampsia or sepsis). We said we would keep this at zero level.

An adult mortality strategy was written and implemented in April 2017 and updated in April 2018.
The strategy prioritises up to date guidelines and audit in order to reduce the risk of adult mortality.

A process for reviewing all adult deaths, using an Adult Mortality Audit sheet which complies with recognised and validated methodology detailed in PRISM studies was implemented on Ulysses in 2017/18. A LeDeR policy was also written. (**National Guidance on Learning from Deaths. National Quality Board (2017) Available at www.england.nhs.uk) (**Learning Disabilities Mortality Review (LeDeR) Programme (2017) Available at **www.bristol.ac.uk/sps/leder)**

What the data shows

-No direct maternal deaths were recorded in 2019-20.

As well as assessing each individual case very closely, the Trust benchmarks using figures provided from MBRRACE-UK. The latest available MBRRACE-UK data shows a national rate of 9.2 direct maternal deaths per 100,000 of the population.
2019 (this report): Surveillance data on maternal deaths from 2015-17.

Direct Maternal Deaths		
2017-18	**2018-19**	**2019-20**
0	**0**	**0**

Data Source: Hospital Episode Submission Data (HES)

What happens next?

The Quality Committee will continue to receive a quarterly mortality report. From February 2019 until the funding runs out, any direct maternal death in the perinatal period (except suicide) will undergo a Health Safety Investigation Branch (HSIB) review.
https://www.hsib.org.uk/maternity/

Investigations will:

- identify the factors that may have contributed towards death or harm
- use evidence based accounts to establish what happened and why

HSIB can bring standardised approach to maternity investigations and will not attribute blame or liability. HSIB will set out the facts of what happened in each case and generate recommendations and aggregate the findings from reports and draw out wider learning for the whole system.

During 2019-20 the Trust has reported 17 cases to HSIB and has continued to be fully involved and support of the investigation process.

Our Priority Effectiveness	**Zero unexpected deaths in women having gynaecological treatment**	**Level 3 – Complete**

What we said we'd do

An unexpected death is one which is not related to an end of life condition or which occurs as a result of treatment received.

We measure using HES data and report mortality rates to the Quality Committee.

In 2019-20 there have been no unexpected death following Gynaecology treatment.

How we help and deal with our patients who have serious or terminal diseases is 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.

We committed in our Quality Strategy to offering palliative end of life care to Gynaecology cancer patients in the Liverpool Women's, and providing help and support for patients and their families whether their preferred place of death is the Liverpool Women's Hospital or home.

What the data shows

There were 7 expected oncology in hospital deaths in Gynaecology in 2018-19 and one death not related to an end of life condition.

Data Source: Hospital Episode Submission Data (HES)

What happens next?

All deaths within the hospital, whether cancer-related or not, are reviewed using the adult mortality tool to ensure the appropriate action was taken (see maternal death section above). The Trust benchmarks its mortality data against peer Trusts using the Capita Healthcare Knowledge System (CHKS).

We will continue to benchmark in this way to complement the close monitoring of our mortality data internally. The Trust's Quality Committee and ultimately the Board have an overview of the delivery of this work. The Trust published an Adult Mortality Strategy in 2017.

This priority will continue to be reported in the Quality Report but will be reported under the redefined priority of Adult Mortality.

Our Priority Effectiveness	Reduce avoidable still birth	Level 3 – Complete

What we said we'd do

We said we would reduce stillbirths due to small for gestational age (SGA) babies by 20% from the 2013 rate of 42.5%.

What the data shows

Following a year on year reduction since 2014, unfortunately for year 2018/19 the analysis shows that the contribution of undetected Small for Gestational Age towards stillbirth cases has increased to 25%. We acknowledge the increase in stillbirth rate due to undetected SGA, the stillbirth committee will review all these cases and report back if this is a true increase or an unexpected temporary deviation from a general trend in the coming financial year. Appropriate recommendations will then be made to address this. It is possible that this increase may be just an anomaly, or may reflect a true increase, as stillbirth is complex and multifactorial and not all causes are detectable or preventable antenatally.

In 2019/20, we have been implementing new recommendations of the Saving Babies Lives-2 and GAP-2 programmes which will address issues around undetected Small for Gestational Age. We will keep this figure under review as new recommendations are implemented, to ensure we provide assurances to our patients and the Trust.

The stillbirth rate for 2018-19 was 3.91/1000. In 2019/20, this rate has reduced to 2.89/1000 suggesting that the Trust is progressing in its aim to reduce stillbirth

- All babies undergo a multidisciplinary review panel meeting
- All parents are informed of the review process and are supported to submit questions through the Honeysuckle Bereavement Team
- The Perinatal Mortality Review Tool (PMRT) review panels have identified some relevant issues which have formed the basis of the action plan for 19/20 and 20/21
- When different care would have prevented the outcome a thorough level 3 investigation has been undertaken
- Adequate progress is being made on the action plan.
    - Screening for pre-term labour is now part of the Meditech booking questions
    - SOP for assessment of domestic violence risk is written, has been approved by safeguarding and is awaiting sign off at division
    - PGD for aspirin prescription and simplifying the aspirin prescription in pregnancy is under discussion
    - Pre-term labour guideline for counselling and management of extreme prematurity labour is on hold due to COVID 19
    - Junior doctor teaching is on hold for COVID – 19
    - Partogram in labour - a lesson of the week has gone out but as this is a culture change it will need consistent reinforcement from shift leaders and senior obstetricians

Stillbirth rate (excluding terminations) per quarter

Quarter	Rate
Q1	4.0
Q2	4.1
Q3	1.5
Q4	1.7

Stillbirths >24 weeks

501 - OBS	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	TOTAL
Total stillbirths	2	8	4	7	7	6	5	2	3	3	1	2	50
Stillbirths (excluding terminations)	1	5	2	4	2	3	1	1	1	1	1	1	23
Births	665	684	666	714	750	711	703	583	664	638	562	608	7949
Rate per 1000 births	3.0	11.7	6.0	9.8	9.3	8.4	7.1	3.4	4.5	4.7	1.8	3.3	6.29
Rate (excluding TOP) per 1000	1.5	7.3	3.0	5.6	2.7	4.2	1.4	1.7	1.5	1.6	1.8	1.6	2.89

What happens next?

The Trust has an action plan for the national Saving Babies Lives Care Bundle.

It will continue to monitor compliance against all elements of this care bundle. Alongside SBL-2 care bundle, we will also continue to implement the GROW/GAP-2 programme through Perinatal Institute Birmingham to align the saving babies lives bundle recommendations into our routine clinical practice

Cessation of Smoking in pregnancy remains a key area for improving outcomes with regards to reducing small for gestational age babies and reducing stillbirth rates and poor neonatal outcomes where a direct link to smoking in pregnancy can be made. This work, will be monitored at both a local and regional level via our dashboard figures and monitoring themes from PMRT reviews.

Our close links to our stop smoking services and local smoking commissioners and public health links will continue to build upon the work already completed within the trust. Work will continue to improve smoking in pregnancy rates by further engaging staff across the maternity division, improvements such as increasing training for midwives in very brief advice and implementing the BabyClear risk perception intervention.

Debrief process needs streamlining to ensure families are debriefed in a consistent and time appropriate manner. If parents do not wish a debrief, a letter should be offered. If parents decline the letter a plan for future pregnancy needs to be documented.

Co-ordination of appointments for non-English speaking women with medical disorders needs to come through the LINK clinic and NEST team. A service evaluation is required to ensure the service is meeting the needs of the women.

Our Priority Effectiveness **To deliver our risk adjusted neonatal mortality within 1% of the national Neonatal Mortality Rate Level 3 – Complete**

What we said we'd do

Neonatal mortality rate (NNMR) is accepted to be a useful indicator of the effectiveness of a perinatal healthcare system and two-thirds of infant deaths occur in the neonatal period (<28 days). The neonatal service at Liverpool Women's cares for one of the largest populations of preterm babies in the NHS and it is extremely important that survival of these babies is monitored to ensure that the quality of the care that we are providing is maintained.

We benchmark our mortality against the national NMR published from the Office of National Statistics, having committed to remaining within 1% of the NMR and reported to Effectiveness Senate. Furthermore, we benchmark against mortality data from VON (Vermont-Oxford Network), a collaborative network of neonatal care providers both nationally and internationally, which is committed to improving the quality of new-born infant care.

What the data shows

The most recent data from the ONS states a UK national NMR of 2.8/1000 live births (2018), in 2019/20 for babies both booked and delivered at LWH the neonatal mortality rate is 2.4/1000 livebirths. The rate is similar to the previous year and remains lower than the NNMR. If we include babies born in LWH following ante-natal transfer for specialist care, including extreme prematurity and congenital abnormalities, the mortality rate is higher at 3.8/1000 live births.

The latest available data (2018) from the VON network for all infants <1500g, born in Liverpool Women's Hospital shows the mortality rate was 24.5%. Though this falls out with the interquartile range for units who participate in VON throughout the UK, it is notable that the data has not been adjusted to take account of the specialist care we provide. We are a regional referral centre for fetal medicine and neonatal intensive care, meaning we look after a large number of high-risk pregnancies. As a result, we would expect to have a higher mortality rate when compared with units that do not provide this same level of specialist care.

Data Source: Office for National Statistics (ONS), Vermont Oxford Network
Note: NMR is calculated as the number of deaths per 1,000 live births

What happens next?

The Trust will continue to benchmark against national data from the Office of National Statistics, annual data from Vermont-Oxford Network and MBRRACE-UK.

All neonatal deaths are reviewed using the national perinatal mortality review tool, with external representation and parental engagement; we will continue to ensure a high quality review process with a focus on learning, reporting and action to improve future care.

Our Priority Effectiveness	**Increase compliance with NICE Quality Standards**	**Level 3 – Complete**

What we said we'd do

Demonstrate compliance with evidenced based practice and aim to be in the top performing 20% of trusts for anticipated critical outcomes by:

- Agreeing implementation plans for NICE Quality Standards in each division.
- Auditing compliance.
- Identifying a suite of clinical indicators for each division, establishing baseline data.
- Developing and implementing improvement plans for clinical indicators that fall outside the top 20% against appropriate peers.
- Increasing oversight of delivery via the Effectiveness Senate and Quality Committee.

What the data shows

The data shows that:

- Implementation plans for all relevant NICE Quality Standards in each division are agreed and recorded bi-monthly.
- All NICE Quality Standards released in 2019-20 have been considered for applicability to the Trust and where applicable, allocated appropriately.
- NICE Quality Standards which are recorded as being 'fully implemented / compliant' were considered for inclusion in the Annual Clinical Audit Forward Plan.
- In order to increase oversight of delivery of the Quality Standards, this is reported monthly to the Information Team via the Governance Databook and quarterly at both the Effectiveness Senate and the Quality Committee.
- Of the 9 NICE Quality Standards deemed applicable; 7 (78%) have completed baseline assessments, 5 (71%) of which we are fully compliant with, 2 (29%) have actions in progress in order for us to become fully compliant and 2 (22%) have baseline assessments in progress to establish compliance

Guidance ID	Guidance Title	Baseline Assessment complete Y/N	Guidance Status
QS183	Physical activity: encouraging activity in the community	Y	**Fully implemented / compliant**
QS187	Learning disability: care and support of people growing older	Y	**Fully implemented / compliant**
QS101 (updated from Oct 2015)	Learning disability: behaviour that challenges	Y	**Fully implemented / compliant**
QS35 (updated from Jul-13)	Hypertension in pregnancy	Y	**Fully implemented / compliant**
QS135 (updated from Oct-16)	Preterm labour and birth	Y	**Fully implemented / compliant**
QS15 (updated from Feb 2012)	Patient experience in adult NHS services	Y	**Fully implemented / compliant**
QS46 (updated from Sep-13)	Multiple pregnancy: twin and triplet pregnancies	Y	**Fully implemented / compliant**
QS190	Flu vaccination: increasing uptake	N	**Actions in progress – relates to 2020/21 winter season**
QS192	Intrapartum care: existing medical conditions and obstetric complications	N	**Fully implemented / compliant**

Data Source: NICE National Quality Standards

What happens next?

To continue with current processes and encourage audit of implemented Quality Standards.

Learning from Deaths

The following section of the report provides information as to how the trust learns from deaths.

The use of Hospital Standardised Mortality Rate (SHMI) is not appropriate for this organisation as it excludes a large number of our deaths. Using it may give false concern or reassurance. This has been considered very carefully by the Trust Board and we have committed to monitoring our mortality by focussing on each clinical area separately and using crude mortality data.

We record our mortality rates in those areas and benchmark against national standards. To ensure effectiveness in the Trust is at the absolute forefront of practice, the Trust goes a step further than most other hospitals by ensuring that every case in which there is a death is reviewed individually so that any lessons regarding quality of care may be learned.

The below table provides an overview of all reviews or investigations conducted for each adult and perinatal deaths within LWH. The quarterly percentage includes both adult and perinatal deaths, in total there were 40 deaths, of this 7 were expected gynaecological oncology patients on a palliative care pathway and the remaining 33 deaths were infants who died as a result of their serverity and/or complexity of their clinical condition

Overall deaths (adult and paediatric deaths)	**%**
Estimate of the number of deaths during reporting period 01 April 2019 – 31 March 2020 for which case review or investigation has been carried out	100%
Number of the patient deaths during the reporting period 01 April 2019 – 31 March 2020 are judged to be more likely than not to have been due to problems in the care provided to the patient	100%
Number of overall deaths as a percentage in Q1 (No of overall deaths 13)	32.5%
Number of overall deaths as a percentage in Q2 (No of overall deaths 11)	27.5%
Number of overall deaths as a percentage in Q3 (No of overall deaths 8)	20%
Number of overall deaths as a percentage in Q4 (No of overall deaths 8)	20%
A revised estimate of the number of deaths during the previous reporting period taking into account the deaths judged to be more likely than not to have been due to problems in the care provided to the patient.	100%

Neonatal

Since January 2019 all neonatal deaths on NICU have been reviewed using the standardised national perinatal mortality review tool (PMRT). There is a monthly multi-disciplinary review meeting with representation from neonatal, obstetrics, bereavement support and palliative care teams. Reviews are planned for 6-8 weeks after the baby has died. Where there has been an in-utero transfer for or a baby has been transferred post-natally for higher level care, the other hospitals or care providers involved are invited to the meeting to complete a joint review encompassing all aspects of care. If a joint review is not possible care at LWH is reviewed and the booking / delivery hospital is contacted and asked to complete a local review. Each case is then assigned a grade (A-D, see below) for each of the following areas: antenatal care, neonatal care and care after the baby has died.

A	No issues with care identified up to the point that the baby was confirmed as having died
B	Care issues which the panel considered would have made no difference to the outcome for the baby
C	Care issues which the panel considered may have made a difference to the outcome for the baby
D	Care issues which the panel considered were likely to have made a difference to the outcome for the baby

Cases where a grading of C or D has been assigned will be then reviewed further as a table-top review, or if deemed appropriate a formal review or serious incident. Local mortality review outcomes and learning are shared within the department and at the Clinical Effectiveness Group for Cheshire and Mersey NWODN. The PMRT outcomes are reported to the regional child death overview panel (CDOP).

The PMRT process encourages parental engagement, all parents are informed of the review process at the time the baby dies, a letter detailing the process and how they can engage is provided. Any comments / questions / concerns which the parents send in are addressed as part of the review and parents are provided a written response and offered an appointment to discuss the response thereafter.

19/20 Neonatal PMRT Summary

	Q1	Q2	Q3	Q4	Total
NICU deaths	9	10	7	8	34
LWH booked NICU deaths	**5**	**7**	**5**	**5**	**22**
Mortality rate /1000 deliveries	4.6	4.8	3.6	4.5	4.4
LWH booked mortality rate / 1000 deliveries	**2.5**	**2.9**	**3.1**	**2.8**	**2.9**
PMRT Reviews completed	9	10	7	6	32
No. of deaths were care issues were identified (grade B/ C/D)	5	6	4	2	18
No. of deaths were care issues may have or were likely to have affected the outcome (grade C/D)	1	0	0	0	1
Non-NICU deaths of babies cared for on NICU	*4*	*6*	*3*	*5*	*18*

Themes

For the year 2019/2020 themes which have emerged from neonatal PMRT reviews include:

- Access to paediatric sub-speciality services
- Unplanned extubation
- Umbilical line dislodgement
- Thermal management
- Timely involvement of palliative care
- Documentation
-

Actions which have been taken to address these themes include:

- Development of the Liverpool Neonatal Partnership
- All unplanned extubations to be reported and reviewed
- Thematic review of umbilical line incidents, in particular fixation of the lines
- Include umbilical line fixation training in junior doctor induction programme
- QIP for thermal management at birth
- Palliative care nurse specialist weekly attendance at ward rounds

Gynaecological (Oncology + Non-oncology) and Maternity (Adult Deaths)

All expected and unexpected adult deaths in the Trust, are reported on the Ulysses Risk management system as soon after death as practicable by the nurse or clinician providing care to the deceased patient.

They will thereafter, complete an Adult Mortality Review on Ulysses Risk Management System within 48 hours of the patient's death. This records performance against a predefined set of standards, using the recognised and validated methodology detailed in PRISM studies. In each clinical area, the Clinical Director provides feedback to clinicians if individual errors or omissions in care have been identified by use of this audit tool. The Risk and Patient Safety Manager and Deputy Medical Director analyse the data and identify any emerging Trust-wide themes. These are highlighted and reported in the Quarterly Adult Mortality Report.

If any deaths are graded as NCEPOD 5 or <3 (very poor/poor care) on structured judgement review then a second stage review will be performed according to the RCP SJR process.

For unexpected gynaecological deaths and all maternal deaths, either a Level 2 or a Level 3 Root Cause Analysis is performed. One of the main aims of the Root Cause Analysis is to identify case-specific errors and systematic flaws. All Root Cause Analyses are scrutinised by the Head of Governance and Quality and risk and Patient Safety Manager, who pool data and identifies any emerging Trust-wide themes.

The lessons learnt and the SMART Action Plans are highlighted in the Quarterly Adult Mortality Report.

Seven Day Hospital Services

Following instruction from NHSE, the Trust will submit its spring return on the seven day services Assurance Framework formally on 30th September 2020. This is a deferred return due to the novel Coronavirus (Covid-19) pandemic. The information describes the Trust's 7DS provisional status as of end March 2020 for assurance purposes.

This most recent survey has shown a significant increase in meeting the target for priority Standard 2. In spring 2020, the Trust reached a position of compliance against this standard for the first time, with 96% of emergency admissions meeting the target. Only one case - a miscarriage - was not seen by a Consultant within 14 hours but was reviewed by a Senior Trainee within 14 hours of admission. The data analysed for this submission pre-dates the 'lockdown' and pre-dates the changes made to rotas in response to the Covid-19 pandemic.

This improvement has come about because of an increasing frequency of Consultant ward rounds, reflected in job plans. Following a further successful round of Consultant recruitment to the Gynae Emergency Dept (GED) on 4th May 2020 we now expect this improved position to be maintained long term. This will also allow further development of the acute Gynaecology service model and the embedding of learning gained from the Covid-19 pandemic response, in terms of triage, efficiency of clinical pathways and the assimilation of new clinical techniques into normal practice.

One admission met the criteria for Standard 8 in the reporting period - management was compliant with requirements involving emergency surgery by a multi-disciplinary team with direct involvement from the acute Trust.

In contrast, there has been no significant progress against the requirements of Standards 5 & 6 as these ostensibly require co-location with an adult acute site to be fulfilled. The possibility of agreeing an over-arching SLA with Liverpool University Hospitals NHS FT continues to be explored by Executive team, however, and LWH's reported performance against Standards 5 & 6 will then be reassessed.

STANDARD	SELF ASSESSMENT	SCORE
Priority Standard 2 – All emergency admissions must be seen by a suitable Consultant at the latest within 14 hours from time of admission (target >90%)	As per agreement with the 7DS assurance service and the CCG, hyperemesis has been excluded from this survey as patients are admitted for management on a defined pathway of rehydration and discharged, this not meeting the criteria for 7DS return. Most other women attending as emergencies are miscarriage related and as such do not necessarily need Consultant review as the process and pathways in GED support decision making to improve the patient pathway. However, in this report, it is clear that all have had review and decisions at senior level. Patients requiring thorough clinical assessment by a suitable Consultant were seen daily by a Consultant. The current job plans do not specifically make reference to 7DS but the on-call rotas cover Consultant ward rounds and emergency admissions. In this survey, 96% of admitted women were assessed in person by a Consultant within 14 hours of admission, a significant improvement and the first time the Trust has been compliant with the standard. Recent appointment of GED Consultants and learning from the changes made during the Coronavirus (Covid-19) pandemic response will help maintain compliance with this further.	Met
Priority Standard 5 – Hospital inpatients must have 7 day access to diagnostic services & Consultant directed diagnostics	No formal arrangements for this but there are pathways in place for ad hoc diagnostics. This access is not ring-fenced and clinicians spent a lot of time negotiating transfers and transport of patients to the acute site.	Not met
Priority Standard 6: Hospital inpatients must have 24 hr access to consultant delivered interventions on site or through formally agreed arrangements	Key consultant delivered interventions can be accessed but these are generally provided outside specialty specific guidance due to stand-alone site of LWH. No formal arrangements but there is an ad-hoc understanding with the acute sites. Feasibility for an over-arching SLA is being explored by the Finance Director for Strategy.	Not met
Priority Standard 8: All HDU patients have twice daily Consultant review and at least once every 24 hrs once a clear pathway has been agreed	100% return achieved with evidence of multi-disciplinary involvement including from adult acute Trust. Care is also provided off – site to women admitted in other hospitals e.g. RLBUHT/Aintree if needed. Increasingly LWH treats women assessed pre-operatively as potentially needing ITU care in the post-operative period at the acute Trust rather than on the stand-alone site.	Met

Providing the Best Patient Experience

We have discussed already our priorities for ensuring our patients are safe and receive effective care. However at Liverpool Women's we also know that the experience that our patients have whilst under our care is of great importance. We understand that many of our patients have contact with us at some of the most significant times in their lives; with that in mind it is our ambition to make the experience of everyone who steps through our doors the best that it can possibly be. We also know that this goal of a great patient experience can only be delivered by a workforce who are engaged, competent and motivated to deliver high quality care.

Our Priority Experience	**Increase the percentage of staff recommending the Trust as a place to work** **Level 3 - Complete**

What we said we'd do

Aim to increase the number of staff who would recommend the Trust as a place to work and increase overall levels of engagement as measured by the Staff Survey.

Actions to improve engagement are varied and include our health and wellbeing strategy, our approach to leadership development, engaging and involving our staff through varied communications channels and ensuring we reward and recognise our workforce.

What the data shows

2019 staff survey results saw a statistically significant increase in the number of staff recommending the Trust as a place to work. Over the last 12 months the link between place to work and place to have treatment has been explored through focus groups and listening events and it is positive to note that both have improved.

LWH Staff Survey Results

Would you recommend as a place to work? (Staff Survey)

2016	2017	2018	2019
56%	61%	60%	67%

Would you recommend as a place to have treatment? (Staff Survey)

2016	2017	2018	2019
81%	80%	78%	81%

Data Source: NHS Staff Survey (Picker Institute)

What happens next?

Progress against these indicators will be tracked via the Year Two action plan of the Putting People First strategy.

All Division and Corporate service have been tasked with and engagement with staff to understand issues developing an action plan to support staff in the workplace and any concerns they have. These will be monitored via the Putting People Frist Committee

Our Priority Experience	**Increase the Trust's staff engagement score**	Level 3 - Complete

What we said we'd do

There are well evidenced links between staff engagement and good outcomes for patients. By supporting our staff to develop, listening to their feedback and involving them in decision –making we aim to improve both staff and patient experience. It is measured via the engagement score in the annual staff survey and reported to Experience Senate.

What the data shows

Since 2016 the engagement trend has been positive and 2019 saw a statistically significant improvement in the engagement score which reflects a period of iterative work where staff engagement has been a focus through the Putting People First strategy.

Overall engagement score (Staff Survey- out of a maximum of 10)

2016	2017	2018	2019
6.9	7.0	7.0	7.2

Data Source: NHS Staff Survey (Picker Institute)

What happens next?

Actions will be tracked through Divisional People Plans and Trust wide actions through the Year 2 Action Plan of the Putting People First strategy.

Action areas are in line with last year in and include investment in leadership training, embedding a talent management process, improving quality of Personal Development Reviews (PDRs) and objectives, continuing with robust workforce planning and succession planning processes.

Our Priority Experience	**We will promote a positive experience that allows the trust to deliver a high quality carer and family experience - Level 3 – Complete**

What we said we'd do

Respond to themes from PALS, Complaints and Feedback and surveys. This will begin with improving patient access to telephone triage systems and will be reported to Experience Senate.

What the data shows

The data shows that **5.7%** of the Patient Advisory and Liaison Service (PALs) contacts for **2019/20** involved an element of telephone calls not being answered in the Trust. This is down from **9.7%** in **2018/19**. 70% of these concerns relate to trying to access the administration and admissions teams. These issues were identified throughout the previous year and steps were put in place to address these. Actions have continued to be taken to increase the staff numbers and bolster the systems. System limitations, such as no engaged tone, IVR messages or queue information, are being addressed which has had an effect of decreasing the issues escalated to the PALS team.

As it was identified that the Friends and Family Test (FFT) response rates continued to require improvement, steps have been taken over the last year to assist with this. We have continued to push this message to staff and provided instructions about the feedback collection methods to ensure all areas understand their responsibilities within this process.

To support the improvement needed in response rates we expanded the roll out of a text message service. This provides patients with a web link to complete, via their mobile phone or other device, the F&F Test once they have had an appointment or contact with the hospital. Roll out this year has continued within Maternity and has been introduced for Gynaecology patients and people using the Genetics service.

This change has already seen a considerable increase in response rates from 5821 in 2018/19 to 18,584 in 2019/20. This will only increase as the Text Service roll out continues into other services in the hospital such as Neonatal, Imaging and Physiotherapy services during 2020/21.

PALS relating to Telephone calls not being answered		FFT Responses	
2018/19	**2019/20**	**2018/19**	**2019/20**
9.7%	⇩ 5.1%	5821	⇧ 18584

Data Source: Power Bi

What happens next?

Telephony improvements will continue to be monitored to ensure they are having the desired impact on patient experience. Friends and Family Test text service roll out will continue into other services in the hospital such as Neonatal, Imaging and Physiotherapy services during 2020/21. Focus for 2020/21 will move away from response rates and focus on the improvements made from feedback and how this is shared across the Trust and the patient population. The progress of these issues will continue to be monitored via the patient experience senate.

Our Priority Experience	**Health & Wellbeing; to improve staff health and wellbeing (HWB) Level 3 – Completed**

What we said we'd do

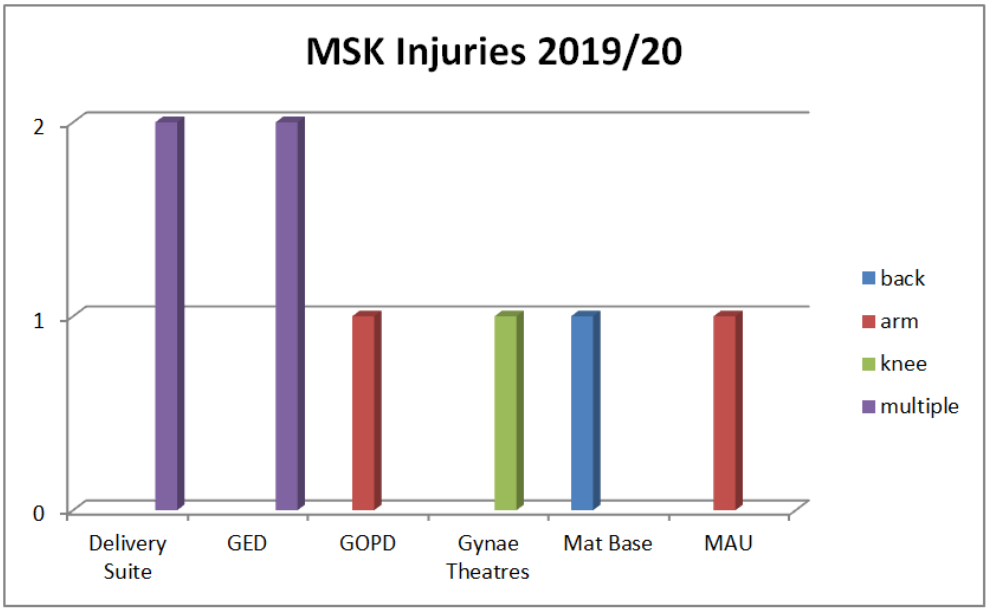
We will strive to create a workforce that is aware of and takes ownership of how to maintain its physical and psychological welfare. This includes a culture in which leadership is focused on the wellbeing of its staff. There will be a range of accessible and utilised facilities, information and resources to support individuals and leaders to maintain a culture of wellbeing.

What the data shows

Staff Survey results over the last 3 years for health and wellbeing remain stable. The significant focus on health and wellbeing over the last year has not resulted in an improvement in staff's overall perception that the organisation takes health and wellbeing seriously. The health and wellbeing committee continues to be very active and has new objectives aligned to those in the Putting People First strategy. There is now an annual programme of health and wellbeing activities and monthly public health campaigns. The Trust has made progress in achieving more elements of the Workplace Wellbeing Charter and has embedded its team of Mental Health First aiders.

MSK Reported Injuries

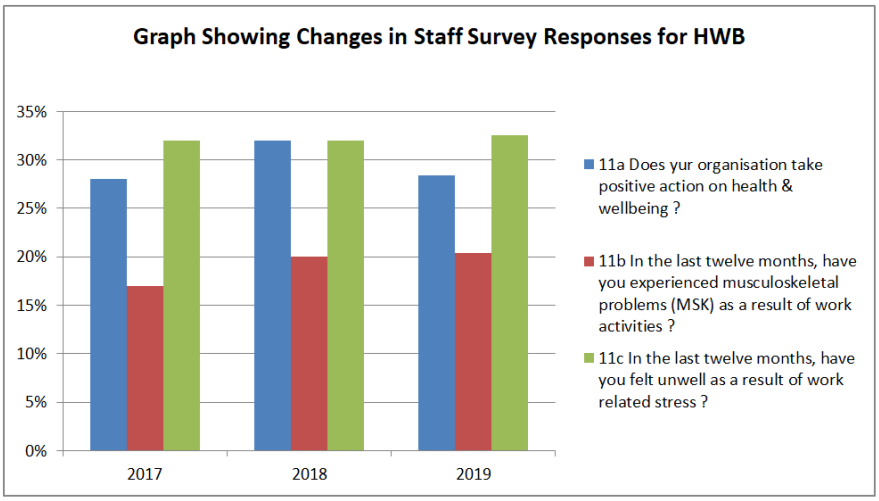
Interrogation of the Ulysses incident reporting system showed that neight incidents of musculoskeletal injuries were reported in the 2019/20 period compared to nine the previous year. This is significantly lower than the comparator group. High compliance rates with mandatory training and early referral to occupational health have supported this.



LWH Staff Survey Health & Well Being Results

Question	LWH	average for acute specialist trusts	average for acute trusts	national average
11a Does yur organisation take positive action on health & wellbeing ?	28%	34%	29%	30%
11b In the last twelve months, have you experienced musculoskeletal problems (MSK) as a result of work activities ?	20%	25%	29%	27%
11c In the last twelve months, have you felt unwell as a result of work related stress ?	33%	36%	40%	40%

Data Source: NHS Staff Survey



Data Source: NHS Staff Survey

What happens next?

All managers now have health and wellbeing objectives as part of their PDRs and the effectiveness of these objectives will be audited.

There are ongoing challenges of taking health and wellbeing activities to the clinical areas. The Covid-19 situation has demonstrated how well mental health, wellbeing and resilience sessions on clinical area have worked. The going home checklists have been another positive way in which staff have been supported.

Mental health first aiders have been working with other staff as part of a wider staff support network and this has proved effective and a wider 'staff support network' will be established once Covid-19 has passed.

The NHS Employers tool *How Are you Feeling Today?*, tool which identifies stress hotspots will be rolled out in other areas. This will be supported by the quarterly online and paper surveys which will be rolled out in Summer 2020 and will include health and wellbeing questions. Follow up interventions will be targeted in areas based on the results of both tools.

HWB will be embedded in the new Leadership Strategy and will support the Fair and Just Culture

Priorities for Improvement in 2020-25

As has been outlined in the report so far, the Trust has 3 clearly defined quality goals; to reduce harm, to reduce mortality and to provide the best patient experience. You have seen already how we have performed during 2019-20; the tables below set out what our priorities will be in the coming 5 years with the new quality and clinical combined strategy.

Our priorities are a combination of national and local issues and wherever possible are identified by as wide a range of stakeholders as possible as well as by the Trust. This includes patients, their families, the wider public, our staff and commissioners. We have held listening events and engagement sessions to allow all our stakeholders the opportunity to assist in choosing this year's priorities. The priorities are driven by the Trust's Quality Strategy and will allow us to achieve our vision of being the recognised leader in healthcare for women, babies and their families

Our Ambitions for Quality Improvement

In keeping with the wider NHS, we use a three-part definition of quality, described in the 2008 Darzi NHS Next Stage Review (Department of Health 2008) as:

- Patient Safety
- Clinical Effectiveness
- Patient Experience.

Three of our Trust aims map directly to our definition of quality, however, we also recognise that work streams within *each* of our five aims have an impact on quality and our ability to improve quality within our clinical services.

At Liverpool Women's, our vision is to become the recognised leader in healthcare for women, babies and their families. We have developed a set of ambitions aligned to our aims, which set the long term direction for our organisation; creating the momentum and mind-set we need to become outstanding in everything we do. Our ambitions help create an environment where we are constantly reaching for excellence and where continuous improvement in quality is always at the top of our agenda.
Our extensive engagement work in preparing this strategy culminated in the identification of a number of key priorities for delivering quality improvement in the first years of this strategy, moving us towards achieving our ambitions and realising our vision. We will monitor, review and refresh where needed these priorities, to make sure we are still firmly on track to deliver outstanding care in all of our services, all of the time.

Quality improvement is a part of everything we do; naturally then some of this work is described elsewhere within our strategies and plans; where this is the case, we have made this clear. We will not duplicate work; we strive to be efficient in how we approach quality improvement throughout our organisation.

WORKFORCE

AMBITION

WE WILL BE AN OUTSTANDING EMPLOYER

- We will value and care for our staff
- We will listen to our staff and act accordingly
- We will welcome staff and volunteers from all parts of our community
- We will attract outstanding people to deliver outstanding care to our patients
- We will invest in our staff to develop them
- We will promote research and foster innovation amongst our teams

QUALITY PRIORITY

Create a Fair & Just Culture

At Liverpool Women's, we are undertaking a long-term programme of cultural change to ensure we embed a culture where the focus is on clear accountability, supporting each other and learning from events, where staff are empowered to act and speak out in the interests of safety. Successful delivery of this programme will have a clear impact on both quality improvement and safety; creating an open environment where we can extract the best learning from incidents and complaints.

Implementation of this work stream is part of the Putting People First Strategy and is monitored by the Putting People First Committee.

Deliver Comprehensive Human Factors Training

Human Factors is an established scientific discipline used in many safety critical industries. It offers an integrated, evidenced and coherent approach to patient safety, quality improvement and clinical excellence. Embedding Human Factors approaches within our clinical services will allow us to deliver optimum outcomes, through better understanding the behaviour of individuals, their interactions with each other and with their complex clinical environments.

Implementation of this work stream is part of the Quality Improvement Strategy and will be monitored by Effectiveness Senate

Supporting Strategies and Plans

Putting People First, Nursing Midwifery & AHPs, Quality Improvement, Leadership and Talent

EFFICIENT

AMBITION

MAXIMUM EFFICIENCY, OPTIMUM USE OF RESOURCES

- We will value the time of every person using or providing our services
- We will make best use of all our resources

QUALITY PRIORITY

Adopt Relevant Tested Interventions

The National Patient Safety Strategy recognises that ensuring the adoption and spread of tested methodologies has a material impact on safety and quality within clinical services. In our Quality Improvement Strategy, we outline our methodology for ensuring that all relevant, tested interventions will be implemented.

Implementation of this work stream is part of the Quality Improvement Strategy and will be monitored through the Effectiveness Senate

Deliver National Targets in the Context of COVID Recovery

National targets provide key benchmarks against which we compare our performance. Meeting national targets is vital to ensure we are achieving both the best outcomes and experience for our women, babies and their families. Performance against national targets has worsened significantly across the NHS as we respond to COVID-19; it is imperative that we retain our focus on meeting these targets as we recover from the pandemic and bring services back online.

Implementation of this work stream is monitored through our Operational Plan and Performance Reports

Supporting Strategies and Plans

Digital.Generations, Operational Plan, LTFM, Nursing, Midwifery & AHPs

SAFE

AMBITION

THE SAFEST CARE FOR OUR WOMEN, BABIES AND THEIR FAMILIES

- We will develop services with safety at their core
- We will learn from the mistakes of ourselves and others

QUALITY PRIORITY

Create a Culture of Safety

The National Patient Safety Strategy sets out what the NHS will do to continuously improve patient safety. It features two key strands; embedding a patient safety culture and a patient safety system. We will develop a local implementation plan to ensure this national strategy is delivered at Liverpool Women's and that staff feel supported and empowered to act and speak out, enabling us to achieve our ambition of zero never events.

Deliver Outstanding Medicines Safety

We will deliver a robust system for ensuring the safe and secure management of medicines across all areas of the Trust to protect patients from harm, meet regulatory requirements and avoid medicines safety errors. We will participate in the national Medicines Safety Improvement Programme, focusing on high risk drugs, situations and vulnerable patients.

Deliver Outstanding Maternity and Neonatal Safety

We will participate in the national Improvement Programme for Maternity and Neonatal Safety, aiming to deliver the goals set out in the national patient safety strategy; reducing the rate of stillbirths, neonatal deaths and asphyxial brain injury by 50% by 2025.

Supporting Strategies and Plans

Putting People First, Nursing Midwifery & AHPs, Risk Management

EFFECTIVE

AMBITION

OUTSTANDING OUTCOMES

- We aim to deliver the 3 zeros - zero stillbirth, zero maternal deaths, zero never events
- We will achieve world leading cancer outcomes

QUALITY PRIORITY

Improve Adult Mortality

Our isolation from other acute adult services at Liverpool Women's Hospital increases the risk to our adult patients in maternity and in gynaecology. It is vital that we maintain the highest possible quality of care at all times, across all of our medical, midwifery and nursing specialties. We will strive to achieve zero maternal deaths, zero unexpected deaths in women having gynaecological treatment and high quality care for women dying as an expected result of gynaecological cancer.

Reduce Still Birth, and Deaths in the First 28 Days of Life

The death of a baby before or after birth is a devastating event. We will strive to ensure there are no avoidable deaths of babies before or after their birth.

Deliver All Possible NICE Quality Standards

At Liverpool Women's NICE Quality Standards are used to review current services and to show that high quality care or services are being provided and highlight areas for improvements. We will demonstrate compliance with evidenced based practice where feasible (some standards are unachievable due to the separation from other services).

Supporting Strategies and Plans

Putting People First, Nursing Midwifery & AHPs, Risk Management, Research and Development Strategy

EXPERIENCE

AMBITION

EVERY PATIENT WILL HAVE AN OUTSTANDING EXPERIENCE

- Service users will be partners in decisions about their care
- We will be accountable to our community, members and governors
- We will be inclusive of all members of our community
- We will seek your views and listen to what you say

QUALITY PRIORITY

Accountability to Our Community

Shared decision making, at both individual and collective levels, leads to better decisions and a better experience. We want to empower our community to inform what we do and shape our services for the future, so that we become as accountable to the community that we serve as we are to our regulators. We will build on our existing relationships and seek out best practice so that we become more accountable to our community.

Learning from Patient Experience

At Liverpool Women's we recognise that we will only deliver the highest quality care and best patient experience when our patients are equal partners in decision making about their care, and when we listen to and act on what patients tell us about their experiences of our services. We will learn from what each of our patients tells us about their experience.

Implementation of this work stream is monitored through the Patient Experience and Nursing, Midwifery and AHPs Strategies

Supporting Strategies and Plans

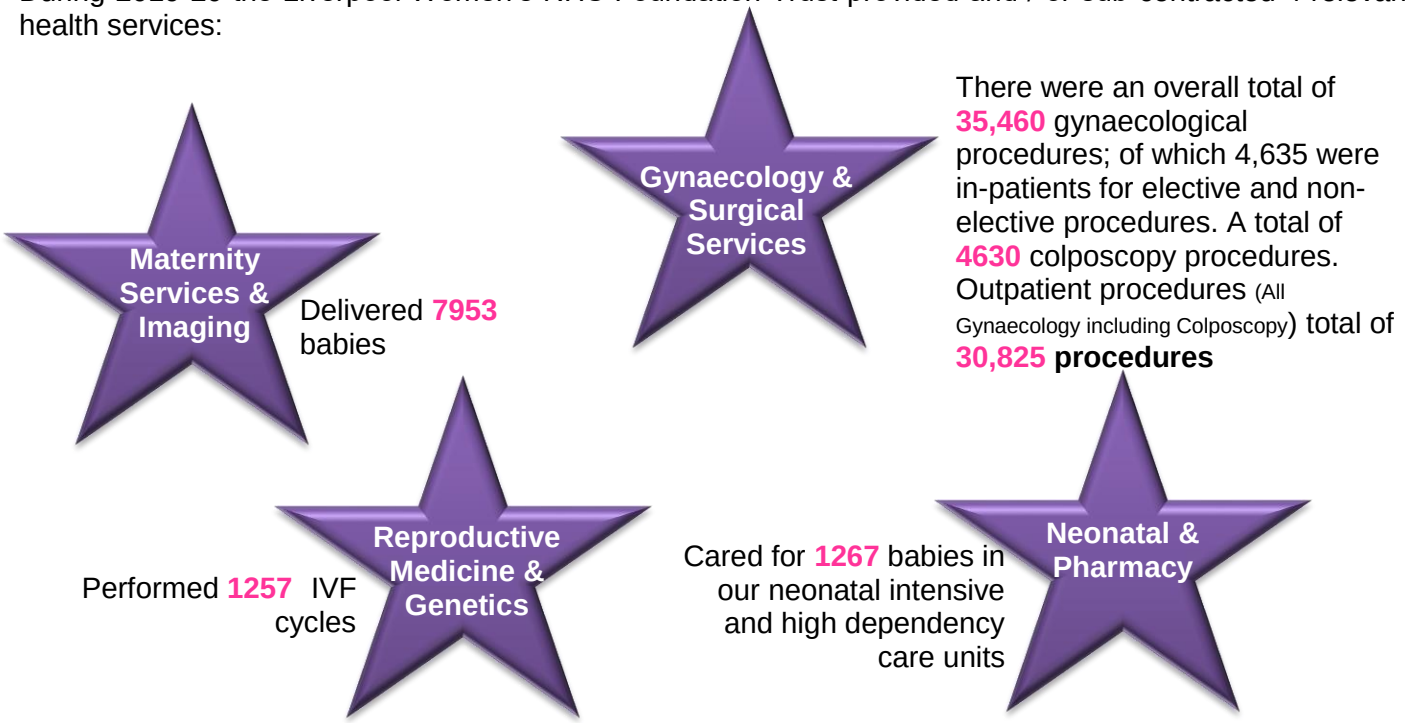
Putting People First, Nursing Midwifery & AHPs, Patient Experience, Communications

Statements of Assurance

The Trust is required to include statements of assurance from the Board. These statements are nationally requested and are common across all NHS Quality Accounts.

Review of Services

During 2019-20 the Liverpool Women's NHS Foundation Trust provided and / or sub-contracted 4 relevant health services:



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.

Participation in Clinical Audit

During 2019-20 8 national clinical audits and 2 national confidential enquiries covered relevant health services that Liverpool Women's NHS Foundation Trust provides. During 2019-20 Liverpool Women's NHS Foundation Trust participated in 100% of national clinical audits and 100% of 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 participated in, and for which data collection was completed during 2019-20, are listed below alongside the percentage of the number of registered cases required by the terms of that audit or enquiry.

Relevant National Clinical Audits	Did the Trust participate?	Cases Submitted
Neonatal Intensive and Special Care (NNAP)	✓	**100%**
National Comparative Audit of Blood Transfusion Programme – Massive haemorrhage	✓	**100%**
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK) – Perinatal Mortality	✓	**100%**
National Pregnancy in Diabetes Audit (NPID)	✓	**100%**
National Maternity and Perinatal Audit (NMPA)	✓	**100%**
Learning Disability Mortality Review Programme (LeDeR)	**No cases to submit**	
National audit of the Management of Maternal Anaemia	✓	**100%**
Serious Hazards of Transfusion (SHOT) *(actions to be included in annual Bedside Transfusion Audit report)*	✓	**100%**

Relevant National Confidential Enquiries	Did the Trust participate?	Cases Submitted
Maternal, New-born and Infant Clinical Outcome Review Programme (MBRRACE-UK) – Maternal Deaths	✓	**100%**
Acute Bowel Obstruction	✓	**N/A** *(Organisational Questionnaire returned. No Casenotes requested).*

The reports of 2 national clinical audits were reviewed by the provider in 2019-20 and the remaining reports are expected later in 2020 and Liverpool Women's NHS Foundation Trust intends to take relevant actions to improve the quality of healthcare provided.

National Clinical Audits	Actions Taken
Neonatal Intensive and Special Care (NNAP)	National report in the process of being reviewed prior to provision of local report and action plan.
National Comparative Audit of Blood Transfusion Programme – Massive haemorrhage	Interim National Report received. No local actions required at this time. Awaiting National Report.

Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK) – Stillbirth	National report in the process of being reviewed prior to provision of local report and action plan.
National Pregnancy in Diabetes Audit (NPID) 2019	As a result of the most recent National Report received which looked at 2017 and 2018 deliveries, a local report including action plan was developed and the following actions are in progress: Promote pre-pregnancy counselling clinics in Aintree and RLUH to patients and primary care. Change format of discharge letters to GP after delivery to emphasise need for pre pregnancy counselling, HbA1c target of <48mmol/mol and 5mg folic acid. Incorporate educational sessions on Continuous Glucose Monitoring (CGM) and diabetes issues in ward based teaching sessions. Audit to explore reasons for higher preterm delivery and large for gestational age (LGA >90th centile) babies in pre-existing diabetes to assess the utility of VRIII for Ante Natal steroids and in labour in adherence to LWH guidelines, specifically looking at compliance to CBG monitoring, timing of administration of steroids, utility of insulin and pregnancy outcomes in these cases. Create an electronic database with the assistance of the I.T. department, for collecting future NPID data.
National Maternity and Perinatal Audit (NMPA)	As a result of the most recent National Report received regarding 2016-17 data the following actions were completed: Due to the lack of understanding of the intrapartum factors associated with variations in the 5 Minute Apgar score, performance metrics were developed and monthly trend analysis are conducted. As a result of higher than expected 5 Minute Apgar scores not being investigated, a Root Cause Analysis (qualitative and quantitative) was conducted. Due to inaccuracy of the Apgar scoring system, an expanded Apgar scoring sheet was developed and implemented. An evaluation of the use of expanded Apgar scoring sheet is to take place including a trend analysis of 5 Minute Apgar scores in Term singleton babies. Awaiting next National Report.
Learning Disability Mortality Review Programme (LeDeR)	Although we planned to participate in this project, we had no cases to submit.

National Audit of the Management of Maternal Anaemia	Awaiting National Report.
Serious Hazards of Transfusion (SHOT) *(actions to be included in annual Bedside Transfusion Audit report)*	Awaiting Final Local Bedside Transfusion Audit Report.

The reports of 49 local clinical audits were reviewed by the provider in 2019-20 and Liverpool Women's NHS Foundation Trust has either already taken or intends to take the following actions to improve the quality of healthcare provided. This is a selection of key actions that have improved healthcare or made a difference to patients as a result of local clinical audit; they are those we feel are most relevant from our Clinical Audit programme this year.

Audit on reporting of radiology images by on-call neonatal consultant
Although the proportion of images with a documented review by any clinician has increased since the previous audit, it is still lower than our standard of 100%. As a result of this, individual feedback is now sent to consultants. A SOP has been modified to include the morning handover as a time when imaging studies from the previous night are performed. This has also been incorporated into the Badger system's induction training. A Lesson of the week for medical trainees and ANNPs about the need to record the consultant's name when they are entering the results of an x-ray review was circulated. Change request forms have been submitted to suppliers of the Badger system to improve the electronic form used to record radiology reviews with prompts for the name of the reviewing consultant.

Information provision on safer sleeping
Following a review of this audit against the January 2019 audit, there has been a significant improvement in all the standards. There is now an option on Meditech to record that a visit is a 36 week visit. All midwives are now recording the antenatal discussion of the safe sleep messages and completing the 36 week check list. The findings of this audit also demonstrated that all of the 54 records reviewed had the antenatal, intranatal and postnatal records, scanned into EDMS. All community midwives are now using the updated 36 week check list. Furthermore patient action plans completed are now being revisited at discharge from the community.

Bladder Care After TVT/Surgery
This audit highlighted that improvement in compliance with the Trial Without Catheter (TWOC) guideline was required.

Following this audit, a printed and laminated copy of the TWOC pathway has been made available to all staff working on the Gynaecology Ward. The full guideline is now also accessible via the Trust Intranet. A flowchart has been created on the Patient Electronic Notes System (PENS) to aid with robust documentation of bladder care following TWOC and gynaecological surgery; Staff on the Gynaecology Ward have also been informed of how to use this document correctly. The current guideline has been reviewed and updated based on findings of this audit and Nursing Staff on the Gynaecology Ward have been informed of the standards outlined in the current guideline.
A re-audit following the introduction of the updated guideline will take place in the 2020-2021 audit year.

Patient Information Process
The results of this audit demonstrated that there is a good process in place with regards to Patient information leaflets within the Trust.

The accessibility of Patient leaflets caters for all and leaflets can also be printed supporting those who may not have access to the internet etc. as Staff can print off required documentation at the time of an appointment or inpatient episode if necessary.

It was identified from this audit that 3 of the Trust leaflets did not receive patient involvement when being produced which is crucial in the development of a Patient leaflet. As a result, the checklist for creating a Patient leaflet has now been amended to include Patient involvement as a mandatory section when being compiling the document.

Audit to Assess Compliance with the Ionising Radiation (Medical Exposure) Regulations 2017
The need to ensure that x-ray examinations are reported on within a set time frame and that a plan is in place to make certain this is happening was noted as a result of this audit. There is currently a standard of practice in place but this will be updated to include a time-frame so that it is clearly documented when the reports should be completed. As a fail safe to ensure that requests are not missed in future, a system will be put in place which assesses x-ray requests weekly to determine whether there is a report on the system. Radiographers will sign a document weekly to confirm that they have assessed all of the requests for the past two weeks to ensure there is a report. If there is not a report on the system, Radiologists will be contacted in a timely manner and advised that this should be completed. A spot check will be performed 6 months following this audit to assess compliance with these new implementations.

Auditing the compliance against Domestic Abuse Protocol/Procedure
This audit found that compliance remains high in respect of routine enquiry and that Staff clearly demonstrate awareness of when it is not safe to complete routine enquiry and that there is understanding and adherence to internal safeguarding referral processes.

With regards to actions for improvement as a result of this audit, Level 3 Children/Adult and also bespoke Safeguarding training will be reviewed to ensure this will improve competence and confidence in understanding the dynamics of domestic abuse and levels of need in respect of children and families. The Safeguarding Team will create an additional essential training competency for Staff required to be able to complete Safe Lives DASH risk assessments. There will be specific training needs analysis (TNA) for areas where there is a known higher likelihood of disclosure. The Safeguarding Team will also work with IT systems to increase Safeguarding prompts within various pathways/assessments.

Re-Audit to assess compliance with new patient triage criteria in Clinical Genetics
The results of this audit found that the majority of referrals are triaged correctly and in line with the triage criteria. This means that the right Patient is seeing the right Clinician, at the right time. The weekly referral meeting catches most of the small number incorrectly triaged but they cannot catch the inappropriate clinics. The findings of this audit were presented and circulated to all relevant Staff and all Clinicians were sent reminders of the triage guidelines via email. As a ‘safety-net, Principal Genetic Counsellors were encouraged to challenge any triages that they deemed incorrect moving forward.

Assess effectiveness of the Hewitt Centres Multiple Birth Minimisation Strategy (MBMS)
This audit identified within a limited data-set, potential trends and findings which if confirmed by future work, provide evidence based methods for revising the current MBMS. Standardisation of data recording and accurate policy documentation has been improved as a direct result of this audit. Conversations were also stimulated with senior Scientific Staff, as to the next moves in terms of both updating the MBMS and exploring options for better embryo selection tools. The results and conclusions of this audit were discussed with the Scientific Director and Lead Embryologists and the data was used for the review and update of the MBMS and local Standard Operating Procedure (SOP) in relation to MBMS.

Bedside Transfusion Re-audit
We have maintained or improved upon the compliance for the majority of the standards for this audit. This includes 100% compliance with patient identification, consent, transfusion episode complete within 4 hours, traceability and fating of blood components.

There were some areas of improvement identified from this audit and appropriate actions have been drawn up to ensure these areas are addressed. Audit findings are to be communicated to all Staff involved in delivering blood transfusions in clinical practice. Relevant department/ward Managers will be advised of the

improvements needed and that all Staff are required to be compliant and up to date with their mandatory training and competency assessments. It will be requested that ward/department Managers identify potential Staff from key areas to be prioritised for cascade training and that this continues to be monitored monthly. Relevant Staff will be informed of any areas of documentation requiring improvement whilst highlighting the importance of this. The Serious Hazards of Transfusion (SHOT) report and review of incident will be circulated alongside the findings of the audit to all of the relevant Staff. The data collection tool for this audit will also be reviewed ahead of the future audit to ensure it is fit for purpose and user friendly.

What is Clinical Audit?
Clinical audit is a quality improvement cycle that involves measurement of the effectiveness of healthcare against agreed and proven standards for high quality, and taking action to bring practice in line with these standards so as to improve the quality of care and health outcomes.

New Principles of Best Practice in Clinical Audit (Healthcare Quality Improvement Partnership, January 2011)

The Trust annually prepares a Clinical Audit Programme. This programme prioritises work to support learning from serious incidents, risks, patient complaints and to investigate areas for improvement. The results of all audits, along with the actions arising from them, are published in the Trust Clinical Audit Annual Report and on the Trust's intranet to ensure all staff are able to access and share in the learning.

Participation in Clinical Research

The Trust is continually striving to improve the quality of its services and patient experience. Research is recognised by the organisation as being pivotal to this ambition.

During 2019/20 we have continued our efforts to contribute to quality National Institute for Health Research (NIHR) studies and to maintain our subsequent numbers of NIHR recruitment accruals. We also continue to focus our efforts on collaborative research with academic partners to ensure the research we conduct is not only of high quality, but is translational, providing clinical benefit for our patients in a timely manner.
Our commitment to conducting clinical research demonstrates our dedication to improving the quality of care we offer and to making our contribution to wider health improvements. Our healthcare providers stay up to date with new and innovative treatment options and are able to offer the latest medical treatments and techniques to our patients.

The number of patients receiving relevant health services provided or sub-contracted by Liverpool Women's NHS Foundation Trust in 2019/20 that were recruited during that period to participate in research approved by a research ethics committee was 1,458 of which, 840 were recruited into NIHR portfolio studies.

Liverpool Women's was involved in conducting 109 clinical research studies across our speciality areas of maternity, neonates, gynaecology oncology, general gynaecology, reproductive medicine, anaesthetics and genetics during 2019/20. At the end of 2019/20 a further 25 studies were in set up, including 6 industry studies.

There were approximately 189 clinical staff contributing to research approved by a research ethics committee at Liverpool Women's during 2018/19. These staff contributed to research covering a broad spectrum of translational research from basic research at the laboratory bench, through early and late clinical trials, to health systems research about healthcare delivery in the community.

Our research has contributed to the evidence-base for healthcare practice and delivery, and in the last year, 75 publications have resulted from our involvement in research, which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS.

Key research achievements during 2019/20 can be summarised as follows:

- A new collaborative world-leading programme of research focused on improving the health and wellbeing of children and their families within the Liverpool City Region (LCR) has been awarded funding from Wellcome. The 'Children Growing-up in Liverpool (C-GULL)' research study and data resource will be used to better understand and improve the lives of LCR children and their families. This will be the first newly established longitudinal birth cohort to be funded in the UK for almost 20 years.

  Currently, Liverpool ranks highly in terms of the highest rates of child mortality and conditions such as asthma, type 2 diabetes, epilepsy and risk factors for poor health such as obesity, poor nutrition and low levels of physical activity. To help develop a better understanding of these issues, researchers will collect information from 10,000 babies and their families, starting in pregnancy and over the first years of life, allowing changes in their health and development to be monitored and recorded over time. The information gathered will provide important evidence for policy, practice and research that will ultimately help improve child health and development in the area.

  C-GULL will launch at Liverpool Women's Hospital next year bringing together citizens, researchers and clinicians across the Liverpool City Region and wider to make one of the largest family studies in the UK.

- In June 2019, had the Trust had the privilege of hosting the annual meeting of the European Network for Individualised Treatment of Endometrial Cancer (ENITEC). ENITEC is a pan-European academic Network for Translational Researchers in Gynaecological Oncology, who gather together to share their expertise in uterine cancer research, with a particular focus on integration of molecular studies to improve and individualize patient care. The ultimate goal of the Network is to improve and individualize treatment of women with uterine cancers by integrating the best science in state of the art clinical care, and enabling every patient to access benefits from translational research.

- Research led by Dr Colin Morgan has led to the development of an idea for a new parenteral nutrition product that comprises a specific amino acid formulation concentration. During 2019/20 the research team, together with the R&D Department and a team of expert patent attorneys have undertaken further work to protect the IP by formally submitting an international patent. This has allowed the team to publish the preliminary data without other parties (especially commercial) using the information for commercial gain whilst additional scientific analysis is undertaken.

- During 2019/20, the Trust was awarded approximately £341,765 by the NIHR Health Technology Assessment programme. The funding will support delivery of the FERN – Intervention or Expectant Management for Early Onset Selective Fetal Growth Restriction in Monochorionic Twin Pregnancy research study. It is anticipated that the clinical research study will commence during 2020/21.

- During 2019/20 the Trust commenced collaborative discussions with the TMRW Group. The TMRW Group, based in New York, have developed an integrated system for automated, software guided embryology and cryo-management. The Hewitt Fertility Centre will be the first in Europe to test out this new cryogenic storage solution during 2020/21.

- The Trust was a finalist in the "Excellence in Commercial Life Science Research" award at the North West Coast Research and Innovation Awards 2020, for its participation in a clinical trial researching effective treatments for premenstrual dysphoric disorder (PMDD). PMDD has a negative effect on a woman's daily life and relationships. No treatments have been developed specifically for the treatment of PMDD, antidepressants are often prescribed with moderate effect and tolerability. The aim of the study was to evaluate the effect of Sepranolone on premenstrual symptoms, provide further understanding of

dose-confirmation and evaluate the safety and effectiveness of this potential new medication for PMDD – leading to the development of better treatment for this debilitating condition. Due to the hard work of the research team comprising, Dr Paula Briggs, Consultant Nurse Kathie Cooke and Research Nurse Pamela Corlett, LWH achieved top UK site status for both consented and randomised participants, and second highest recruitment site according to randomisation across all countries

Use of the Commissioning for Quality and Innovation (CQUIN) Payment Framework

A proportion of Liverpool Women's NHS Foundation Trust's income in 2019/20 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. The main areas covered by the framework are:

- Staff Flu Vaccinations
- Three High impact Falls
- Alcohol & Tobacco – Screening and Advice
- Neonatal Staffing

Further details of the agreed goals for 2019/20 and for the following 12 month period are available electronically at: www.liverpoolwomens.nhs.uk/About_Us/Quality_and_innovation.aspx.

The total monetary value of the income in 2019/20 conditional upon achieving quality improvement and innovation goals was £1,042,774. The monetary total for the actual payment in 2019/20 was ,£950,291 (Please note – CQUIN targets reduced between financial years as half of overall CQUIN value is now reimbursed via tariff

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 2019/20.

Liverpool Women's NHS Foundation Trust has not participated in special reviews or investigations by the Care Quality Commission during the reporting period.

What is the Care Quality Commission?
The Care Quality Commission (CQC) undertakes checks to ensure that Trusts are Safe, Caring, Responsive, Effective and Well-led. All NHS Trusts are required to register with them. If the CQC has concerns about a Trust it can issue a warning notice or even suspend or cancel a Trust's registration.

When Liverpool Women's was last formally inspected, in 3rd to 5th December 2019 for core services and 14th to 16th January 2020, the CQC rated it as **GOOD**. Full results are shown in the table that follows:

Safe	Effective	Caring	Responsive	Well-led	Overall
Good →← Apr 2020	Good →← Apr 2020	Good →← Apr 2020	Good →← Apr 2020	Requires improvement ↓ Apr 2020	Good →← Apr 2020

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

Ratings for Liverpool Women's Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity	Good →← Apr 2020	Good →← Apr 2020	Good →← Apr 2020	Outstanding →← Apr 2020	Good →← Apr 2020	Good →← Apr 2020
Gynaecology	Requires improvement ↓ Apr 2020	Requires improvement ↓ Apr 2020	Good →← Apr 2020	Requires improvement →← Apr 2020	Requires improvement →← Apr 2020	Requires improvement →← Apr 2020
Neonatal services	Good ↓ Apr 2020	Good →← Apr 2020	Good →← Apr 2020	Good →← Apr 2020	Good →← Apr 2020	Good →← Apr 2020
End of life care	Good May 2015	Good May 2015	Good May 2015	Good May 2015	Good May 2015	Good May 2015
Outpatients	Good Mar 2020	Not rated	Good May 2020	Good May 2020	Good May 2020	Good May 2020
Overall*	Good →← Apr 2020	Good →← Apr 2020	Good →← Apr 2020	Good →← Apr 2020	Good →← Apr 2020	Good →← Apr 2020

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

The Trust received an overall rating of 'Good' with a 'Requires improvement' for Well- Led.

- Maternity received an overall 'Good' with **'Outstanding'** for Responsiveness
- Gynaecology received an overall 'Requires improvement' with 'Good' for Caring
- Neonatal services received an overall 'Good'.

During the Core Services inspection conducted 3-5 December 2019, the CQC issued the Trust with a warning notice which stated a failure to ensure that systems and processes were effectively established to ensure the proper and safe management of medicines.

The Trust responded to the warning notice by the 10 January 2020 deadline, noting the immediate steps that had been taken to ensure patient safety was not compromised. An immediate action taken was to implement twice weekly audits of medicine management with any resulting issues escalated as appropriate.

The trust internal audits have demonstrated ongoing compliance with the failings identified by the CQC warning notice. Following a focused inspection in relation to the warning notice the Trust has been informed that the warning notice has been lifted.

Liverpool Women's agreed an Action Plan with the CQC to address the Regulatory Breaches and those areas that the CQC had made recommendations and the Trust felt could be further enhance the care of our patients. The action plan has been monitored monthly via the Trust Quality Committee.

Data Quality

Liverpool Women's NHS Foundation Trust continues to hold regular data quality subcommittees to support the improvement of the data available to clinicians and senior managers within the Trust. These focus on specific specialties and have representation from key decision makers within the Divisions.

The establishment of these meetings has led to an increase in the number of data quality reports available to clinical areas to support the quality of data being provided and identifies key areas for additional training requirements.

The Trust continues to follow an internal programme of audit of important data sets and selected key performance measures and reports a high standard of completeness in the results of these audits.

The Trust recently commissioned an external audit of its RTT and Cancer data in line with NHSI IST guidance. Results showed 100% accuracy for cancer pathways and over 95% for RTT data. The Trust will continue to commission external audits focussing on RTT and Cancer Waiting Times data.

The Trust maintains a high score on the DQMI (%) as measured by NHSD throughout 2019/20, as reported below.

	Apr 19	May 19	June 19	July 19	Aug 19	Sept 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20
AE	99.0	99.2	98.9	99.2	98.2	98.3	97.9	98.1	98.7	98.4	98.5	97.9
APC	99.9	99.9	99.9	99.9	99.9	99.9	99.9	99.9	99.9	99.9	99.9	99.9
OP	99.9	99.9	99.9	99.9	99.9	99.8	99.8	99.6	99.9	99.7	99.7	99.7
MSDS	99.9	99.9	99.9	99.9	99.9	99.8	99.8	99.8	99.8	99.8	99.7	99.9
DID	99.1	99.1	99.3	99.2	99.2	99.2	99.1	99.1	99.1	99.2	99.0	99.0

Date source: https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/data-quality

The DQMI is a monthly publication about data quality in the NHS, which provides data submitters with timely and transparent information.

The percentage of records in the published data which included the patient's valid General Medical Practice Code was:

- 99.1% for admitted patient care
- 99.7% for Outpatient
- 99.5% for accident and emergency

This is important because the patient NHS number is the key identifier for patient records while accurate recording of the patient's General Medical Practice Code is essential to enable the transfer of clinical information about the patient from a Trust to the patient's General Practitioner.

Information Governance

In March 2020, the Trust was faced with the operational challenges of responding to the Covid-19 virus outbreak, which caused disruption in almost every area of the Trust. In response to the outbreak, the requirements for reporting against the Data Security and Protection (DSP) Toolkit were relaxed, meaning that a delay in reporting because of having to manage the outbreak was accepted, if Trusts felt that it was necessary to do so.

Whilst Covid-19 had caused some disruption, it was felt that the Trust was sufficiently prepared for the end of year submission that is was decided to submit the Trust position, as expected, in March 2020. The submitted Trust position was "Standards Met".

In the weeks prior to the DSP Toolkit submission, the Trust was subject to independent audit, which gave an assurance opinion of "Significant Assurance".

There still remain some areas that require review and further development, namely: reviewing the management and central control of computer systems and other information assets; ensuring the continued development of IG compliant processes; reviewing and renewing the trust central registers to ensure they are accurate and up to date; and taking steps to improve the compliance with Information Governance training.

During 2019/2020, the Trust has had no new incidents of sufficient seriousness to require reporting to the Information Commissioner's Office (ICO) but there was one incident that was first identified during the 2018/2019 reporting period that remained under active investigation and carried over into the current reporting period.

That incident, which involved unauthorised use of Trust information for research purposes, has now concluded. The ICO took no action against the Trust having been satisfied that he Trust had taken appropriate actions, had an ethical policy in place at the time and that these were the actions of an individual employee acting in isolation.

Clinical Coding

Liverpool Women's NHS Foundation Trust commissioned an external clinical coding audit in 2019-20 in line with the Data Security & Protection Toolkit guidelines. This found the overall accuracy of clinical coding to be of a high standard, meeting 'Standards Exceeded' level for DSPT. Good practice was noted in relation to the structure of the Clinical Coding department, which was found to provide a supportive working environment with good channels for professional progression within the structure. The audit reported well-structured policies and procedures that effectively support the

running of the department with active engagement from clinical staff. The Trust has a high level of assurance that the clinical coded data submitted is accurate and complete, supporting patient care and contributing to effective management.

Duty of Candour

The Francis Inquiry report into Mid Staffordshire NHS Foundation Trust recommended that a statutory duty of candour be introduced for health and care providers. This is further to the contractual requirement for candour for NHS bodies in the standard contract, and professional requirements for candour in the practice of regulated activity.

In interpreting the regulation on the duty of candour Liverpool Women's NHS Foundation Trust use the definitions of openness, transparency and candour used by Robert Francis in his report. The thresholds and harm definitions of moderate and severe harm are consistent with existing National Reporting and Learning System (NRLS) definitions, including prolonged psychological harm. The Trust records all specified instances in which it applies duty of candour on its Ulysses Risk Management system.

Duty of Candour requirements are covered by the Care Quality Commission's (CQC) Regulation 20. Trust Management are keen to confirm compliance with key aspects of Regulation 20, where they are aware that an incident has arisen requiring a Duty of Candour response.

A Duty of Candour Trust Audit completed in In September 2019 demonstrated that the Trust was 100% compliant with the Regulatory requirement for Duty of Candour. The audit examined the Trust policy and procedures and reviewed all incident where Duty of Candour Applied to identify if all requirements had been completed.

Gosport and Freedom to speak up processes

The Trust is committed to developing and maintaining an open and constructive culture whereby all staff feel comfortable in raising any concerns in the knowledge that they will be taken seriously, that their concerns will be addressed, and without any fear of reprisal of detriment. The ways in which staff can raise a concern are incorporated in the LWH Whistleblowing Policy & Procedure.

As well as the formal roles of the Senior Independent Non-Executive Director and the Freedom to Speak up Guardian, there are a range of other peer supporter roles including Mental Health First Aiders and Dignity at Work Advisors which are currently being amalgamated into one Staff Supporter role, that provide a further avenue for staff to raise concerns. These are supplemented by regular Trust wide Listening Events and smaller focus groups as required, plus quarterly internal staff surveys. The national staff survey shows an improving trend between 2015-2019 where staff confidence to report unsafe clinical practice increased from 67% to 75%.

In the twelve months April 2019 to March 2020, no formal concerns were raised under the Trust's Whistleblowing Policy. In the last 12 months a total of 34 contacts were made to the Freedom to Speak up Guardian (F2SUG). During 2019/20 the Board also completed the 'Freedom to Speak Up Review Tool for NHS Trusts'.

Fair and Just Culture

A Fair and Just (F&J) Steering Committee has been created for the 15 F&J trained leaders and others across the Trust to develop an operational plan and focus on staff and patient engagement.

Policies have been reviewed to incorporate Fair & Just principles and processes. The steering committee continue to review areas where the use of F&J framework can be most beneficial to staff and the Trust. One area where this has become evident relates to individuals who continue not to follow medicines policies are in receipt of appropriate management using a fair and just culture approach.

Summary of Picker Inpatient Survey 2019 – Gynaecology Inpatients

Picker is an international charity dedicated to ensuring the highest quality health and social care for all always.

The National In-Patient Survey data was collected in July 2019. A total of 835 Gynaecology patients from Liverpool Women's Hospital Trust were invited to complete the survey. A total of 362 patients completed the survey, giving a response rate of 45%, which has decreased from the previous year (49%). The average response rate for the 74 'Picker' Trusts was 44%, meaning that as an organisation our response rate is lower than the average.

There are 62 questions which make up the inpatient survey, which are designed to mirror the patient journey through the hospital. The Picker survey enables the Trust to review its historical results from previous surveys and also allows the Trust to benchmark against other organisations. By reviewing the survey results the Trust is able to monitor historical trends and themes, which enables focus on those areas. The results also enable the Trust to review areas where performance has improved, which supports assurance and evidence that the effects of any service improvements or change in practice have occurred.

Respondents:
Of those who responded 15% accessed the Gynaecology service via an urgent or emergency pathway, the remaining patients (83%) were admitted on the elective pathway. The age range of the patients who responded were between 16-and 80+ with the majority of responses (60% coming from patients who were aged 40-69). The reported ethnic group of the patients were predominantly white (96%), other ethnic groups

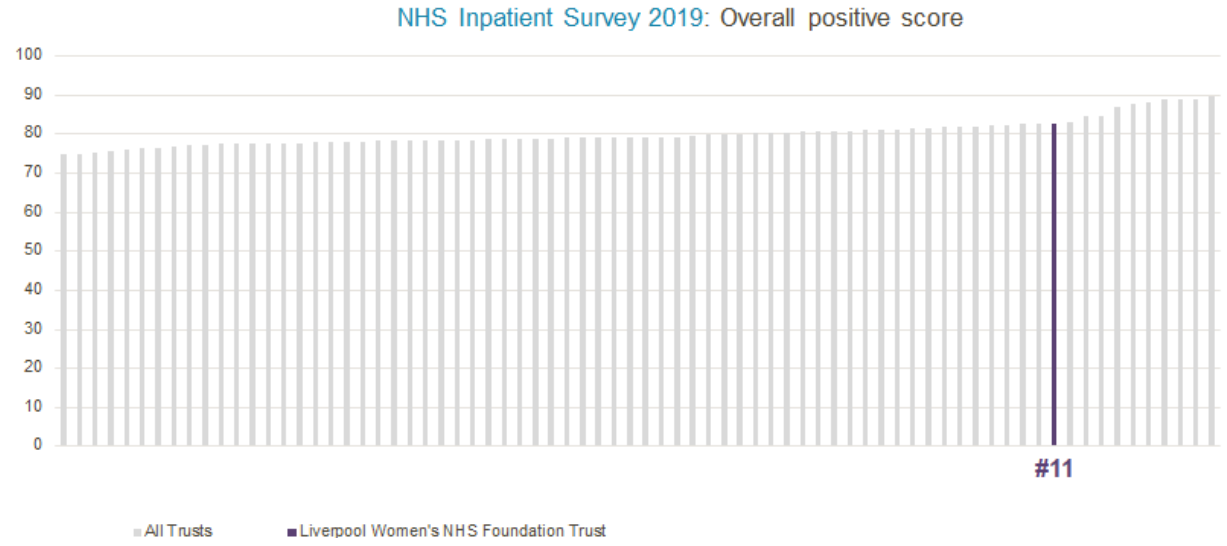
Results
Key improvements:
There have been a number of significant improvements since 2018's survey. LWH have improved in respect of planned admissions, where the admission date was not changed by the hospital. Our patients have reported that during their inpatients stay there is always or nearly enough nurses on duty. During the admission process more patients reported that they did not have to wait long before they were allocated a bed on the ward. In addition to these improvements, patients also reported that staff helped with their care needs within a reasonable time. Patient also reported that they were told what to expect following their procedure or operation.

Compared to other "Picker" Trusts:
When compared to "Picker" average scores. LWH scored better than other Trust in a number of elements. The top five scores were mainly around admission and discharge processes. As mentioned in the previously patients reported that they did not have to wait long before they were allocated a bed on the ward. Regarding discharge patient reported that they were provided with written / printed documentation explaining what they should do /or not do following their discharge. The patients also reported that they were advised of danger signs to look for and they also reported that they were counselled regarding side effects of medications. Patients also reported that Doctors did not talk in front of them as if they were not there.

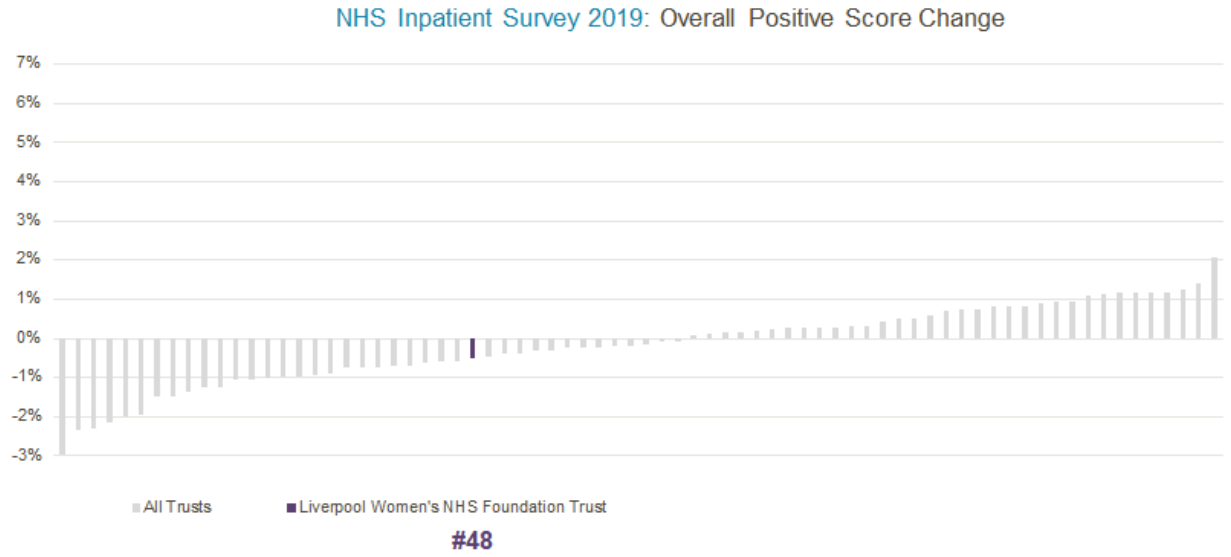
Least Improved from last Survey:
Of the five least improved elements from the survey, four domains related to the discharge of patients from the ward. Patients reported that staff did not discuss the need for additional equipment, that expected care and support was available if it was needed. Specifically around discharge, patients also reported that staff did not discuss the need for further health and social care support or that they actually got enough support from health or social care professionals.

League Table of Results

This year's League table of positive results LWH scores number 11th out of 74 Picker Trusts, last year the Trust were placed at 11th.



The historical league table demonstrates how LWH's overall positive score has changed from last year's survey and how this change compares to other organisations. The Division is delighted to report that this has seen a significant improvement from 77th to 48th.



Historical trends of LWH

Utilising historical trends the Trust is able to identify where we have improved or performance has deteriorated over time. Based upon the 2019 scores LWH have improved in 28 of the survey points, as opposed to improving in only 5 areas in 2019, this is a considerable improvement. Key areas of improvement in scores relate to the care which our patients are given and in relation to nursing staff.

Based upon 2019 scores LWH have deteriorated in 26 areas within the survey compared to 50 areas in 2018. Demonstrating that although LWH have seen a drop in some scores this has not been as significant as the previous year.

Key Themes
Within the data it is quite clear that there are key themes, where we need to focus on improvement. The data demonstrates that our patients are not satisfied with both the food we are providing them nor are we supporting the patients during mealtimes. Patients have also identified that they do not get enough help from staff to wash or keep clean, and access to take their own medications is not supported.

The hospital & ward (part 2 of 2)

		Historical					Organisation type	
		2015	2016	2017	2018	2019	Average	Organisation
Q17+	Hospital: got enough help from staff to wash or keep clean	-	92%	90%	85%	84%	90%	84%
Q18+	Hospital: able to take own medication when needed to	-	92%	85%	84%	82%	79%	82%
Q19+	Hospital: food was very good or good	69%	67%	64%	62%	56%	59%	56%
Q20	Hospital: offered a choice of food	96%	96%	95%	95%	94%	94%	94%
Q21+	Hospital: got enough help from staff to eat meals	92%	88%	92%	79%	73%	82%	73%
Q22	Hospital: got enough to drink	-	-	93%	93%	94%	91%	94%

The other area where a clear theme has been identified is within the discharge from hospital process. Although some of our data evidences that we perform better in some areas than other Trust, this is the area where we have deteriorated the most since the 2018. It is not entirely clear on review why this area has deteriorated since the last report, however the ward has made improvements to the process prior to release of this survey.

Leaving hospital (part 1 of 2)

		Historical					Organisation type	
		2015	2016	2017	2018	2019	Average	Organisation
Q48+	Discharge: felt involved in decisions about discharge from hospital	90%	92%	91%	90%	91%	84%	91%
Q49	Discharge: given enough notice about when discharge would be	93%	94%	94%	92%	93%	87%	93%
Q50	Discharge: was not delayed	75%	79%	73%	71%	73%	60%	73%
Q52	Discharge: delayed by no longer than 1 hour	24%	27%	12%	14%	11%	12%	11%
Q54+	Discharge: got enough support from health or social care professionals	76%	77%	79%	74%	68%	78%	68%
Q55+	Discharge: knew what would happen next with care after leaving hospital	-	89%	90%	88%	85%	84%	85%
Q56	Discharge: patients given written/printed information about what they should or should not do after leaving hospital	87%	93%	90%	87%	84%	63%	84%
Q57+	Discharge: told purpose of medications	98%	97%	98%	97%	96%	91%	96%
Q58+	Discharge: told side-effects of medications	72%	78%	79%	75%	73%	57%	73%

Leaving hospital (part 2 of 2)

		Historical					Organisation type	
		2015	2016	2017	2018	2019	Average	Organisation
Q59+	Discharge: given clear written/printed information about medicines	91%	94%	95%	93%	91%	85%	91%
Q60+	Discharge: told of danger signals to look for	82%	86%	88%	86%	81%	64%	81%
Q61+	Discharge: family or home situation considered	86%	89%	89%	85%	86%	82%	86%
Q62+	Discharge: family, friends or carers given enough information to help care	67%	76%	81%	75%	74%	76%	74%
Q63+	Discharge: told who to contact if worried	94%	95%	96%	93%	91%	76%	91%
Q64+	Discharge: staff discussed need for additional equipment or home adaptation	70%	72%	84%	72%	56%	79%	56%
Q65+	Discharge: staff discussed need for further health or social care services	81%	82%	83%	80%	74%	81%	74%
Q66+	Discharge: expected care and support were available when needed	-	-	-	86%	79%	81%	79%

The Division of Gynaecology have reviewed the entirety of the report and its findings. There are a number of key areas in which we need to focus attention and implement actions to improve our patient's experience of care. In addition to this there are a number of areas which should be celebrated and continued.

Junior Doctor Staffing

In forward planning for the junior doctor workforce for year 19 – 20, the Trust agreed to fund an additional 11 WTE junior doctor posts within obstetrics and gynaecology as in previous years there has been a number of gaps / vacancies within this workforce.

The gaps were expected to continue in 19 – 20, however this has not been the case within O&G. The service received a full rotation resulting in the service being over established. This has enabled the service to run a shadow rota during out of hours giving doctors more support during out of hours from senior junior doctors.

Due to the over establishment in the workforce the Trust is relying less on agency and consultants to cover gaps in the rotas. Although other services are not over established they continue to achieve full staffing with minimal gaps and rota usage.

The trust continues to see under reporting in exception reporting although it is encouraged and the guardian of safe working has not issued any fines to services as all exceptions are settle with TOIL. There has also been an increase in the number of junior doctors able to attend teaching as the services are well staffed. However, there is an issue with ST3 trainees in O&G gaining competencies as the service received an increased number of ST3 trainees in quarter 2 of 2019.

It is important to note that, during this reporting year, an agreement was reached between NHS Employers, the British Medical Association (BMA) and the Department of Health and Social Care (DHSC) on the amendments to the 2016 terms and conditions for doctors in training. The updated contract is referred to as 'Junior Doctors 2018 contract refresh'. The refreshed contract focuses on safety, wellbeing, training, education and includes an investment to support the changes and support an uplift in pay.

The number of gaps fluctuated throughout the year. The highest number of gaps in O&G was 3.5 for a period of 5 months. Anaesthetics, ran with 0.6 – 1 WTE gap over a 9 month period. Neonates gaps were between 1 – 2.8 WTE over a period of 11 months and genetics continued to run with 1 WTE gap. In the main, these gaps were related to maternity leave and long term sickness.

NHS Staff Survey

The Trust is committed to listening to the views of our staff and recognising their achievements on a regular basis. We believe that motivated and engaged staff deliver better outcomes for our patients and our on-going aspiration is to improve levels of staff engagement on a year on year basis, as measured by the NHS Staff Survey. Improving levels of involvement and engagement is one of four priority areas in our five-year Putting People First Strategy and underpins all of our HR, OD and L&D activity.

The NHS Staff Survey is a core tool for the Trust to engage consistently with our staff each year to identify what is important to them and then take action to address identified issues. In 2019, we continued to opt for a full survey of all our staff, included for the first-time electronic surveys and received a positive response rate of 61%, far exceeding the national average.

The table below indicates how the Trust compares to its benchmarking group (Specialist Acute Trusts):

Theme	2019		2018		2017		2016	
	Trust	Benchmarking Group	Trust	Benchmarking Group	Trust	Benchmarking Group	Trust	Benchmarking Group
Equality, diversity & inclusion	**9.4**	9.2	**9.5**	9.3	**9.4**	9.3	**9.5**	9.3
Health & wellbeing	**6.4**	6.3	**6.3**	6.3	**6.3**	6.3	**6.3**	6.3
Immediate managers	**6.9**	7.1	**6.8**	7	**6.7**	6.9	**6.7**	6.9
Morale	**6.3**	6.4	**6.1**	6.3	**---**	---	**---**	---

Quality of care	**7.6**	7.9	**7.6**	7.8	**7.6**	7.7	**7.6**	7.8
Safe environment – Bullying & harassment	**8.7**	8.3	**8.6**	8.2	**8.3**	8.4	**8.4**	8.3
Safe environment – Violence	**9.9**	9.8	**9.9**	9.7	**9.8**	9.7	**9.9**	9.7
Safety culture	**6.9**	7.0	**6.7**	6.9	**6.7**	6.9	**6.6**	6.9
Staff engagement	**7.2**	7.5	**7**	7.4	**7**	7.4	**6.9**	7.5
Team working	**6.6**	6.9	**---**	---	**---**	---	**---**	---

Overall the picture was one of improvement and we improved compared to last year in two overall 'themes' – *safety*, and *staff engagement*. We did not see a statistically significant decline in any of the eleven overall themes. We have moved closer towards the average or exceeded the average for Specialist Acute Trusts over a number of indicators. Areas where we remain further from the average include team working, immediate managers and quality of appraisals. The quality of appraisals has been highlighted as an issue for the last three years and the system will be reviewed in its entirety in 2020.

Analysis of key themes equality

Diversity & Inclusion
Although there was a minor drop from 9.5 in 2018 to 9.4 in 2019 (not statistically significant), this is still comfortably above the national average for our comparison group of 9.2.

Health & Wellbeing
There was a minor **increase** from 6.3 to 6.4 (not statistically significant) which is now above the national average of 6.3. For the specific question regarding whether staff have felt unwell as a result of work-related stress, the Trust figure of 32.2% in considerably lower than the national average for acute specialist Trusts of 36.6%.

Immediate Managers
There was a minor **increase** from 6.8 to 6.9 (not statistically significant) although this remains slightly below the national average of 7.1. It is encouraging that for the six questions that make up this theme, all saw improvements from our 2018 scores.

Morale
This figure **increased** from 6.1 to 6.3 (not statistically significant), which is now just below the national average of 6.4. It is notable that the specific question regarding involving staff in deciding changes that affect them saw an increase from 49.5% in 2018 to 57.2% in 2019. It should also be noted that the three questions regarding any intention to leave the Trust all saw improved scores.

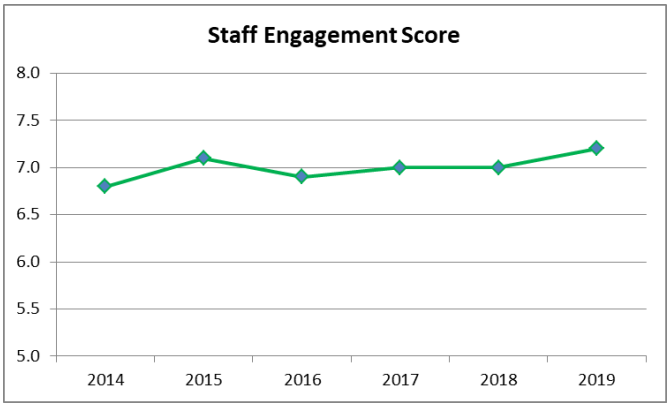
Quality of Care
This score **increased** from 7.5 in 2018 to 7.6 in 2019 (not statistically significant), while the national average remained unchanged at 7.9. The score for the specific question regarding staff being able to deliver the care they aspire to rose from70.7% in 2018 to 74.0% in 2019.

Safe Environment - Bullying & Harassment
This score **increased** from 8.6 to 8.7 (not statistically significant), which is markedly better than the national average of 8.3, and matches the best score nationally for acute specialist trusts. In particular, the score for the specific question regarding bullying by managers fell from 10.9% in 2018 to 7.9% in 2019 (having previously fallen from 15.5% in 2017).

Safe Environment - Violence
Our score remained unchanged at 9.9. This is better than the national average of 9.8, and matched the best score in our comparison group.

Safety Culture
This score **increased** from 6.7 to 6.9 and is now just 0.1 off the national average score of 7.0. Of particular note, the specific question concerning the Trust treating staff who are involved in incidents & near misses fairly saw an improvement from 50.5% in 2018 to 58.5% in 2019, and the number of staff said they would feel secure in raising concerns rose from 69.1% to 73.3%.

Staff Engagement
Our score **increased** from 7.0 in 2018 to 7.2 2019, although this is still below the national average of 7.5. Nevertheless, all nine questions that constitute this theme saw improvements.



Team Working
Our score remained unchanged at 6.6, as did the national average at 6.9. There were no significant changes in the scores for either of the specific questions that make up this theme.

It should also be noted that the scores for staff recommending the Trust as both a *place to receive treatment*, and as *a place to work*, reversed the fall in both these scores seen in the previous year. The significant rise in the score for recommending the Trust as a place to work is particularly encouraging.

Local results have been drilled down to division, directorate and ward/department level, and summaries have been distributed to the respective divisional management teams. They have been tasked with identifying key actions for their areas which will be signed off and monitored by the Divisional Boards. The local summaries also include a simple “you said /we did” pro- forma for local managers to use in sharing the results with their staff.

The results will also be used to refine and enhance the Putting People First Strategy Year 2 Action Plan which is performance managed via the sub-board level ‘Putting People First Committee’. Key Trust wide activities will include the implementation of a revised leadership strategy and the implementation of a talent mapping process. The local internal staff survey process will also be revised and a new paper based and electronic survey mirroring the key themes of the staff survey and other local priorities will be rolled out.

Reporting against Core Indicators

All NHS Trusts contribute to national indicators that enable the Department of Health and other organisations to compare and benchmark Trusts against each other. As a specialist Trust, not all of them are relevant to Liverpool Women's. This section of the report gives details of the indicators that are relevant to this Trust with national data included where it is available for the reporting year.

28 Day Readmission Rates

The first category of patients benchmarked nationally is those aged 0-15. The Trust admits fewer than 10 patients in this age category each year and so benchmarking of readmissions with other Trusts is not of any meaning.

The table below shows the percentage of patients aged 16 and above who were readmitted within 28 days:

Trust 2019/20	Trust 2018/19	National Average 2017/18 figures
3.04%	9.85%	13.8%

Liverpool Women's considers that this data is as described for the following reasons: readmission rates can be a barometer of the effectiveness of all care provided by a Trust. Liverpool Women's is committed to providing effective care .

Liverpool Women's intends to take the following actions to improve this indicator and so the quality of its services: continue to monitor the effectiveness of surgical and post-operative care using this indicator.

Trusts Responsiveness to Personal Needs of Patients

One of the care goals of the Liverpool Women's NHS Foundation Trust is to provide the best patient experience. We use the information provided from our patients to tell us that the experience they have of the treatment and care they receive on their journey through the NHS and how we can be even more important to them than how clinically effective care has been.

To be able to achieve this we work to ensure that all patient individual personal needs are identified and dealt with in the most appropriate manner. Working with patients in partnership is key to a good patient experience which can have a significant impact on their maternity experience and the birth of their baby, experience of the gynaecology services throughout patients department and inpatient ward and their recovery or a peaceful death.

In relation to Neonatal care a close relationship is built up with parents who have babies on the neonatal unit no matter how short a time that may be to ensure not only that the parent scan be involved in their babies care as much as they are able but to also allow them to form a key essential bond with their baby. This has been even further evidenced by the successful completion of the new Neonatal Unit, the design of which was influenced by engagement with the parents of babies who have been on the Unit.

Within the Gynaecology in patient service all patients have an individualised care plans in place form when they are admitted, which are updated as the patient condition changes. These are reviewed by the Matrons and Head of Nursing to ensure that they are of a high quality and meet the patient's needs. There is a close working relationship with eh safeguarding team in relation to ensuring that patient with Learning disabilities have reasonable adjustments in place prior to coming into hospital and for patients with Mental health issues is that there are process and procedures in place to support them whilst in the hospital environment.

Also within the unit there is a process of intentional rounding completed by the ward staff, ward manager and matrons to ensure that core care requirements are being met. This process is monitored via the use of ward nursing metrics system. The gynaecology ward had also introduced a daily huddle to clearly identify patients' needs and where applicable additional support if required.

In relation to the maternity service, all women have an individualised birth plans which is developed during their pregnancy, to ensure that as far as is possible during the woman's maternity care she has the best experience she would like to have to meet with her own personal needs. Birth plans are viewed by one of the Matrons to ensure that the plans are appropriate and written to meet the personal needs of the individual women.

NHS Trusts are required to have robust processes in place to ensure that essential standards of quality and safety are maintained in line with standards set by the Care Quality Commission (CQC) and Health and Social Care Act (2008). The desired outcome is that a patient's experience of care is safe, positive and clinically effective.

The process of Ward Accreditation has been introduced by the Director of Nursing and Midwifery which is a system of assessment of clinical environments to ensure that the highest standards of care and environmental safety are achieved. Where there are issue then an action plan is put in place to address these with oversight by the Quality Committee. One assessed the ward or departments are given an award level, Gold, Siler, Bronze and White. From the first round of assessment Neonatal Unit was given a gold award, Delivery Suite was given a silver award, Midwifery lead Unit was given and Siler award as was Maternity base and the Gynaecology Unit was given a white award.

Staff who would recommend the Trust to their family or friends

All Trusts are asked to record the percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the trust as a provider of care to their family or friends. The table below shows how Liverpool Women's compares with other specialist Trusts nationally:

Recommend as a place to receive treatment:

LWH 2019	LWH 2018	Benchmark Average (2019)
80.9%	77.5%	90.0%

Liverpool Women's considers that this data is as described for the following reasons: although below the national average when measured against Specialist Trusts, Liverpool Women's performs more favourably if grouped with other Acute Trusts

The increase in staff recommending as a place to receive treatment is a positive increase which is in line with the overall increase in the engagement score.

Venous Thromboembolism (VTE)

All Trusts are asked to record the number of patients receiving a VTE assessment expressed as a percentage of eligible 'ordinary' admissions. The table below shows how Liverpool Women's compares nationally:

2019-20	2018-19	2017-18	2016-17	National Target
97%	97%	98%	98%	90%

Liverpool Women's considers that this data is as described for the following reasons: the Trust has well established processes for assessing patients' risk of VTE and consistently performs above average.

Liverpool Women's intends to take the following actions to improve this indicator and so the quality of its services: the Liverpool Women's VTE guidelines have been updated in light of the NICE guidance NG98 2018 Venous thromboembolism in the over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism. The Trust will conduct 6 monthly audits of compliance with VTE guidelines.

Clostridium Difficile

All Trusts are asked to record the rate of Trust apportioned C.difficile per 100,000 bed days. The table below shows how Liverpool Women's compares nationally:

LWFT	LWFT 2018-19	LWFT 2017-18	National Average
0	0	0	N/A

Liverpool Women's considers that this data is as described for the following reasons: the Trust takes extremely seriously its duty to prevent infection and provide care in a safe environment.

Liverpool Women's intends to take the following actions to improve this indicator and so the quality of its services: all cases will continue to be reported to the infection control team, will have a root cause analysis and will be reported nationally. The Trust will also review its range of interventions to ensure they remain fit for purpose.

Patient Safety Incidents

All Trusts are asked to record their number and rate of patient safety incidents per 1,000 bed days. The table below shows this data for Liverpool Women in the period 2019-20:

	LWFT 2019-20*
No. PSIs	**4479**
Total Bed days 2019-20	**88991**
Rate /1000 Bed Days	**50.33**

*Local unmoderated data PSI only data

The Trust considers that this data is as described accurately for the following reasons:

The data for this and the following Severe Harm and Death incidence measure is taken from the Trust's Incident reporting database used in combination with bed days activity data monitored nationally. The Trust has a strong culture of incident reporting giving confidence in incident capture.

The risk team continue to support staff in the reporting of incidents to keep relevant managers and executives aware and involved in the management of incidents ensuring that appropriate action is taken where necessary.

Liverpool Women's intends to take the following actions to improve this indicator and so the quality of its services:

The latest available benchmarking data to March 2020 is not available.

The Trust continues to work positively with the Clinical Commissioning Group and HSIB and values the potential to further improve the effectiveness of its incident management processes and responsiveness of appropriate actions taken.

All Acute Trusts are asked to record the number and proportion of reported incidents that result in severe harm or death in the reporting period. The table below shows this data for Liverpool Women's during 2019-20:

Indicator	LWFT 2019-20*
No. PSIs	**4479**
No. Severe Harm or Death incidents	**1**
Severe Harm and Death incidents as % PSIs	**0.0002%**

* Local unmoderated data

Part 3

Other Information

Performance against Key National Priorities and National Core Standards

NHS improvement sets out their approach to overseeing NHS Foundation Trusts' compliance with the governance and continuity of service requirements of the Foundation Trust licence. This section of the report shows our performance against the indicators NHS Improvement set out in this framework, unless they have already been reported in another part of this report.

Last year was a particularly challenging one for the NHS; all trusts were expected to provide the highest standards of care while achieving demanding efficiency savings. The trust continued to provide safe, high quality care to our patients. With the exception of Referral to Treatment and 62 Day Cancer, the trust continued to deliver the national targets. Alongside this, in a climate where many providers have struggled to achieve their financial plan, the trust has continued to deliver its financial performance.

Details of the national targets that are required to achieve are set out below, together with our actual performance:

Indicator Name	Target	Performance 2019/20	
A&E Clinical Quality - Total Time in A&E under 4 hours (accumulated figure)	95%	**98.86%**	**Achieved**
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral) - post local breach re-allocation (accumulated figure)	90%	**88%**	**Not Achieved**
Cancer 31 day wait for second or subsequent treatment – surgery (accumulated figure)	94%	**77%**	**Not Achieved**
Cancer 31 day wait from diagnosis to first treatment (accumulated figure)	96%	**71%**	**Not Achieved**
Cancer 2 week (all cancers) (accumulated figure)	93%	**95.38%**	**Achieved**
Clostridium difficile due to lapses in care (accumulated figure)	0	**0**	**Achieved**
Never Events	0	**1**	**Not Achieved**
Incidence of MRSA bacterium	0	**1**	**Not Achieved**
Referral to treatment time, 18 weeks in aggregate, incomplete pathways	92%	**82.43%**	**Not Achieved**
Cancer 62 Day Waits for first treatment (from urgent GP referral) - post local breach re-allocation (accumulated figure)	85%	**43.2%**	**Not Achieved**
Maximum 6-week wait for diagnostic procedures	99%	**97.50%**	**Not Achieved**

Overall, the Trust performed well against a range of national standards during the year but failed to achieve the key standards for Referral to Treatment, Cancer 31 day wait from diagnosis to first treatment and Cancer 62-day performance.

For Referral to Treatment, including diagnostics, the Trust has ensured that longest waiting patients are cared for appropriately to mitigate risk of harm where standards are not achieved, and we have worked productively throughout the year with commissioners and partners to effect improvements in performance.

Performance against the Cancer standards has been impaired by clinical capacity and challenges in recruiting consultant staff in shortage specialties. We have worked collaboratively with the Cheshire and Mersey Cancer Alliance to ensure a pan-regional to address challenges associated with the Cancer standard and improve performance. This work has proved successful in identifying areas for further collaboration and facilitated a renewed focus on streamlined models of care and access to diagnostic services.

We were disappointed to record a Never Event during 2019/20 which related to a retained swab following completion of an elective caesarean section procedure. The incident was promptly investigated in accordance with local policy and national guidance and the investigation identified a root cause of both human error and system failure. The Trust responded quickly to address the operational issues raised by the incident and ensured rigorous monitoring to ensure that resultant changes in practice were embedded. Both commissioners and regulators were kept informed at each stage of the process.

Novel Coronavirus (Covid-19) Pandemic: Implications on Quality of Care

The current Novel Coronavirus (Covid-19) Pandemic is affecting most aspects of life in the UK and all aspects of healthcare. For some NHS Trusts, providing treatment for acute Covid-19 presentations is the focus whereas for others such as Liverpool Women's NHS FT (LWH), it is a matter of dealing with the many significant direct and indirect consequences of the pandemic. In this high level summary, the challenges facing LWH are described together with the Trust's responses on behalf of its patients.

Mandated suspension versus continuation of workstreams
LWH has a limited clinical portfolio but provides tertiary level care in each of its specialties. The suspension or continuation of services has been mandated by NHSE on a specialty by specialty basis since the pandemic's arrival in the UK, as follows:

- Maternity – continuation of all aspects of high and low risk care but with altered pathways of care
- Neonatology – continuation of all aspects of care
- Gynaecological Cancers – continuation of services but with altered pathways of care and postponed investigations and treatment if no likely physical impact upon outcomes
- Acute Gynaecology – continuation of all aspects of care
- Benign non-acute gynaecology – suspension of services requiring review in person
- Fertility – suspension of services other than on-going maintenance of laboratory facilities
- Termination of Pregnancy – continuation of all aspects of care but with altered pathways of care
- Genetics / Genomics – suspension of services requiring review in person
- Anaesthetics – key supporting role switching away from elective towards acute care provision.
- Continued workstreams – altering the working model to keep patients and staff safe

The risk of patients and staff passing the coronavirus on to one another has been reduced by an incremental increase in the use of personal protective equipment (PPE) in the Trust in keeping with national guidance from Public Health England and under the guidance of the Trust's own Director of Infection Prevention and Control (DIPC). The availability of PPE has been an area of focus for the Trust and nationally, but to date all necessary equipment has been available at its point of need. The Trust remains vigilant in this respect. Oversight is provided at the Trust's daily Command and Control meetings.

The requirement for rigorous PPE usage has provided an obstacle to rapid clinical response in hyper-acute scenarios such a category one caesarean section (common at LWH) and cardiac arrest (uncommon at LWH). A systematic increased in the use of clinical drills has therefore been implemented across the Trust, lead by the Trust's clinical and resuscitation leads.

With the suspension of several benign workstreams, some staff members have been released from their usual duties and have therefore been able to support other clinical areas in the Trust. This has been important because Covid-related staff absences on clinical rotas have to be covered if acute care is to be provided at normal safe standards. To date, all medical, nursing and midwifery rotas have been covered successfully without compromising clinical care.

The reduction in some clinical services previously described has allowed for the formation of resilience rotas in obstetrics, gynaecology and anaesthetics, giving greater (direct) clinical support and (indirect) psychological support to medical trainees, nursing staff and midwives in those specialties. In obstetrics and anaesthetics, consultant presence on-site has been provided on a 24/7 basis throughout and in gynaecology, a split consultant rota has allowed for a significant increase in the presence of consultant gynaecologists in the Gynaecology Emergency Department.

Suspended workstreams – vigilance for harm
The key areas requiring vigilance for harm have been those subject to suspension including some parts of the gynaecological cancer service and all of the non-acute benign gynaecological services. To maintain safety a number of new measures have been introduced:

- Consultant Gynaecologists are now available by video link to GPs for advice and guidance
- All suspended cases at potential risk of harm are reviewed on paper by consultant gynaecologists
- Women at risk of clinically significant deterioration are contacted for review by a consultant
- If the level of risk is increasing, a proposal for review and / or surgery is put to CAG (see below)
- If surgery is agreed by CAG on clinical grounds, liaison takes place with anaesthetics and theatres

The clinical criteria for surgical intervention include the development of severe pain uncontrollable by other means, the advent of bleeding requiring blood transfusion which is uncontrollable by other means and / or an increased risk of a malignancy developing in a pre-malignant condition.

To date, no harm has been detected in women being cared for in the Trust's suspended services but this remains an area of focus.

Performance
The Trust has continued to monitor all key aspects of its performance despite the suspension of some of its services and despite the unique pressures of the pandemic. Performance will continue to be reported separately to the Quality Committee.

Incident Reporting
A fall in the overall incident reporting rates on Ulysses has been noted during the pandemic. Data concerning incident reporting, serious incidents and never events are provided to the Quality Committee under separate over.

Covid-19 Infection Prevention and Control (IPC) Assurance Framework
An NHSE IPC Covid-19 board assurance framework has been included separately on the agenda. It provides greater detail of the Trust's response to Covid-19 from an IPC perspective.

Workforce Issues
The national response to Covid-19 has thrown up multiple workforce issues including the need:

- to risk assess staff who may be at increased risk of contracting the disease

- to risk assess staff who are more likely to have a poor outcome if they become infected
- to offer swab testing for symptomatic staff and their household members
- potentially to offer swab testing for asymptomatic staff as a screening tool
- to minimise the risk of staff contracting the disease
- to respond in line with all national directives.

The oversight of workforce issues is provided through the Trust's Putting People First Committee so no additional detail is provided in this report.

Governance
A governance structure was created in the Trust at the outset of the pandemic to ensure that an optimal response was provided to the challenges ahead. The system's structure remains intact although the frequency of meetings (other than Command and Control) has reduced slightly as the pace of change has reduced.

The Executive Group meets once weekly (previously twice) in a Covid-specific capacity to provide oversight and to consider material discussed at regional and national forums of relevance to Covid-19. It informs and assures the Trust's Board of Directors.

Command and Control meets daily to note and ensure the enactment of externally mandated changes to service. It is the key operational group. It reports into the Executive Group.

The Clinical Advisory Group meets three times weekly (previously seven) to provide clinical advice and interpretation and to assist with the enactment of changes to service. Its advice is considered by both the Executive Group and Command and Control.

The Huddle predates Covid-19. It takes place daily, shortly before the Command and Control meeting, and is an effective forum for the provision of clinically and operationally relevant information, for the dissemination of information and for the enactment of change.

Our recent successes

Our last Quality Strategy had three key areas of focus; reducing avoidable harm, reducing mortality and providing the best patient experience. We have successfully delivered material improvements in each area we set out to change; improving safety and outcomes, as well as staff and patient experience. The detail behind our performance is reported in our annual quality reports.

As well as our ambitious plans to build a new co-located hospital, our Future Generations Strategy also set out priorities for each service, focused on improving quality and safety while we remain in our current location. While approval to build a new hospital remains out of our control, we have successfully delivered significant improvements across all of our services over the last five years. We have heavily invested in our workforce; increasing our numbers of midwives, specialist nurses and consultants to help us deliver the safest care possible. We have also invested in developing our people; initiating a Fair and Just Culture programme to ensure our staff feel supported and empowered to speak out in the interests of their patients.

We have established formal partnerships across Liverpool; unique quality-driven interactions leading the drive to join up services across the whole city, targeting the specific clinical needs of our population, improving outcomes and helping to reduce health inequalities across our system. We have established the Liverpool Neonatal Partnership in conjunction with Alder Hey NHS FT, ensuring families with babies requiring surgical services experience consistent, trusted and familiar care throughout their whole journey, and we have developed complex gynaecology pathways in partnership with Liverpool University Hospitals NHS FT, delivering safer are and improved outcomes for women.

Neonatal Unit

In 2020 building work completed on our new Neonatal Unit. This 3 year, £15m project was established to address significant concerns regarding the existing Neonatal estate. Part of our planned programme of major enhancements at Crown Street, the unit provides state of the art facilities from which our clinicians can deliver world class tertiary care for our babies and their families.

Successful Partnerships

In recent years we have established a number of successful formal partnerships to improve our patient experience while mitigating some of the clinical risks that arise from our isolated site. We work in partnership to deliver maternal medicine, neonatal, genomics and complex gynaecology services.

Investing in Our Workforce

We have invested in our staff to improve safety, outcomes and experience for our patients. Over the last 5 years we have increased our numbers of midwives, increased consultant numbers in maternity, neonatology, gynaecology and anaesthetics as we aim to provide 24/7 consultant cover, and invested in Advanced Neonatal Nurse Practitioner roles.

Annex 1: Statements from our Partners

Liverpool Women's shares its Quality Report with commissioners, local Health watch organisations and Local Authority Overview and Scrutiny Committees. This section of the report details the responses and comments we have received from them.

Sefton Clinical Commissioning Group is leading on the response this year

NHS South Sefton Clinical Commissioning Group

NHS Liverpool Clinical Commissioning Group

NHS Southport and Formby Clinical Commissioning Group

NHS Knowsley Clinical Commissioning Group

1 Quality Account Statement – Liverpool Women's Hospital NHS Foundation Trust.

South Sefton CCGs hosted a Quality Accounts Day on Friday 9th October 2020. Providers were invited to present their accounts and stakeholders were asked to provide feedback. Stakeholders included:

(1) South Sefton and Southport and Formby CCGs
(2) Liverpool CCG
(3) Knowsley CCG
(4) Healthwatch Sefton, Liverpool and Knowsley
(5) Health Education England
(6) NHS England/Improvement
(7) Sefton MBC
(8) NHSE Specialised Commissioning
(9) CQC

The Stakeholders appreciate the Trust's focus on quality and safety at a time of a global pandemic. They recognise this has required different ways or working during the COVID 19 period and is reflected in the accounts.

The stakeholders welcomed the opportunity to jointly comment on Liverpool Women's Hospital NHS Foundation Trust's Quality Account for 2019/20. The CCGs have worked closely with the Trust throughout 2019/20 to gain assurances that the services delivered were safe, effective and personalised to service users. The CCGs share the fundamental aims of the Trust and supports their strategy to deliver high quality, harm free care.

It is noted that the Quality Account that is being reviewed is a draft version and the stakeholders look forward to receiving the finalised account. The work the Trust has undertaken and described within this Quality Account continues to promote patient safety and the quality of patient experience and endorses the Trust's commitment to promote safety and quality of care.

The Commissioners acknowledge the Quality Account for 2019/20 and the continued focus of work on the following elements:

- Development of a well led, capable, motivated and entrepreneurial workforce
- To be ambitious and efficient and best use of available resources
- Deliver safe services and best experience for patients and staff.

Stakeholders agree with priorities discussed and the Trust's commitment to extending on developing further national and regional priorities relating to Saving Babies Lives and Continuity of Carer. They welcomed the continuing priorities for reducing harm, reducing mortality & providing the best patient experience.
It was noted that:

- The learning from Serious Incident RCAs was open, transparent and honest. The Trust demonstrated a good process for dissemination and implementations of actions as well as organisational shared learning. It showed that there were processes in place to utilise learning from serious incidents in order to action service improvements and to ensure safer services.

- In relation to Freedom to Speak Up. The Trust demonstrated commitment to developing and maintaining an open and constructive culture for staff to raise any concerns including a whistleblowing policy.

- The Trust demonstrated good evidence for meeting quality standards, including zero direct maternal deaths in 2019/20.

The stakeholders note the commitment to improving breastfeeding rates but it would be helpful if they could expand on the Trust plans to progress UNICEF accreditation and how they will work collaboratively with other partners e.g. public health and health visiting, to address continuation rates.

The Trust has successfully completed their 3 year quality strategy 2017-2020 and stakeholders note that the new strategy 2020-2025 is currently in development.

This is a comprehensive report that clearly demonstrates progress within the Trust. It identifies where the organisation has done well, where further improvement is required and the ambitions moving forward. We understand the Trust's Quality Strategy has a number of individual workstreams that will take into account patient feedback on progress made.

Commissioners are aspiring through strategic objectives to develop an NHS that delivers positive outcomes, now and for future generations. This 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 is paramount to our success.

It is felt that the priorities for improvement identified for the coming year are reflective of how the Trust will further improve services to address the current issues across the health economy.

We acknowledge the actions the Trust is taking to improve the quality as detailed in this Quality Account. It is felt that the priorities for improvement identified for the coming year are both challenging and reflective of the current issues across the health economy. We therefore commend the Trust in taking account of new opportunities to further improve the delivery of excellent, compassionate and safe care for every patient, every time.

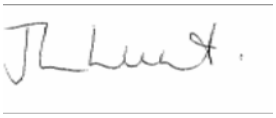
2 South Sefton and Southport & Formby CCGs

Signed

Fiona Taylor, Chief Officer Date: 16th November 2020

3 Liverpool CCG

Signed



Jane Lunt, Chief Nurse Date: 19th November 2020

Signed

Dianne Johnson, Chief Executive Date: 10th November 2020

Health watch Liverpool

Liverpool Women's Hospital Quality Account 2019-20 commentary

Healthwatch Liverpool welcomes the opportunity to comment on the 2019-20 Quality Account for the Liverpool Women's Hospital NHS Foundation Trust.

We base our commentary on the Quality Account report itself, our engagement with the Trust, and feedback and enquiries that we receive throughout the year. Due to the Covid-19 pandemic our annual Listening Event at the Trust could not take place.

The Quality Account highlights the conclusion of the 5-year plan (2015-2020). We are pleased to see that most of the targets the Trust had set itself over 5 years were met, and many improvements achieved.

Although most patient experience priorities focused on staff, it is positive to see that there were increases in the number of staff who recommended the Trust as a place to work and as a place for friends and family to receive treatment. Improved phone systems in reaction to patient feedback are also most welcome.

The Trust has progressed with 7-day working consultant cover, and is exploring a service level agreement with Liverpool University Hospitals Trust (LUFT) to be able to improve this. We believe that increased partnership work between the two Trusts will promote better outcomes for patients.

Other achievements include the opening of the new neonates department which the Trust is rightly proud of, and which should improve the experience of families using these facilities during a difficult time.

Lessons learnt from clinical audits are clearly explained in the report, and examples given of the clinical research the Trust has participated in. We particularly welcome the 'Children Growing-up in Liverpool' research project, which aims to improve child health, and may help to prevent future health inequalities.

We are pleased to note that the Trust once again was rated better than average for overall patient experience in the National Inpatient Survey, which covers patients discharged in July 2019. We look forward to seeing the actions the Trust will take on the themes that were identified for improvement.

At its most recent inspection the Care Quality Commission (CQC) rated most of the Trust as 'good', and it was positive to see that the responsiveness of maternity was rated 'outstanding'. We note that the Trust has been working hard to address those issues identified by the CQC as 'requiring improvement'.

The final quarter of 2019-20 brought rapid changes to services due to the Covid-19 pandemic, and we are pleased to see that the quality account document reflects this. It was particularly reassuring that the Trust has managed to maintain staff rota cover throughout.

However, although the Trust has been working to address cancer treatment waiting times, it is concerning that it was far from meeting several of the national targets. Even with minimal clinical impacts for the patients concerned, the overall effect on their experience is likely to be detrimental. An added concern is that the Covid-19 pandemic has the potential to extend waiting times further.

Future priorities have been set out to cover the next 5 years, in line with the Trust's overall 2020-25 clinical and quality strategy. We are pleased to note that this includes priorities addressing the effects of the Covid-

19 pandemic, and others focusing on patient experience and community engagement. We look forward to learning what practical steps will be taken to progress these priorities in 2020-21.

Due to the pandemic there has been less regular engagement from the Trust, and we are working to try and re-establish this. At the current time we can't visit Trust sites to meet patients and visitors face to face and capture their feedback. We are working in different and new ways, for example by planning and facilitating online focus groups, one of which will be about maternity care.

We look forward to working with Liverpool Women's Hospital in 2020-21, helping to ensure that patients' voices continue to be central in celebrating good practice, and in feeding back if and where improvements could be made.

Inez Bootsgezel
Information and Project Officer- Engagement
2nd November 2020

Commentary from Local Authority Overview & Scrutiny Committees (OSCs)

Knowsley Council - Requested but not received.

Annex 2: Statement of Directors' Responsibilities

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.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

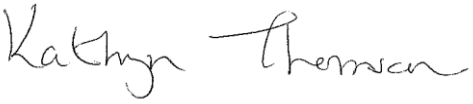
- the content of the quality report meets the requirements set out in the *NHS foundation trust annual reporting manual 2019/20* and supporting guidance *Detailed requirements for quality reports 2019/20*
- the content of the quality report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2019 to May 2020
  - papers relating to quality reported to the board over the period April 2019 to May 2020
  - feedback from commissioners dated 19/11/2020
  - feedback from governors dated 12/11/2020
  - feedback from local Healthwatch organisations dated 02/11/2020
  - feedback from overview and scrutiny committee not provided
  - the trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 20/07/2020
  - the Gynaecology national patient survey July 2020
  - the national staff survey May 2020
  - the Head of Internal Audit's annual opinion of the trust's control environment dated 21/05/2020
  - CQC inspection report dated 22/04/2020
- 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

- the quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting 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.



Robert Clarke
Chair
3 December 2020

Kathryn Thomson
Chief Executive
3 December 2020

Annex 3: External Auditor's Limited Assurance Report

Independent Auditors' Limited Assurance Report to the Council of Governors of Liverpool Women's Hospital NHS Foundation Trust on the Annual Quality Report

N.B – not required due to Covid-19.

Annex 4: Glossary of Terms

Assisted Conception	The use of medical procedures to produce an embryo.
CCG	Clinical Commissioning Group – Local groups of GP practices commissioned health services from the Trust for their patients.
Epidural	Form of regional analgesia used during childbirth.
Established Labour	The period from when a woman is 4 cms dilated and contracting regularly.
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.
HES	Hospital Episodes Submission.
HFEA	Human Fertilisation & Embryology.
HIE	Hypoxic Ischaemic Encephalopathy is an acute disturbance of brain function caused by impaired oxygen delivery and excess fluid in the brain.
HSCIC	Health and Social Care Information Centre.
Intraventricular Haemorrhage	Bleeding within the ventricles of the brain.
Intrapartum	Occurring during labour and delivery.
LWFT (sometimes LWH)	Liverpool Women's NHS Foundation Trust.
Maternity	The period during pregnancy and shortly after childbirth.
MBRRACE -UK	Mother and Baby Reducing Risks through Audits & Confidential Enquiries across the UK.
Neurological	The science of the nerves, the nervous system and the diseases affecting them.
Neonatal	Of or relating to newborn children.
NICE	National Institute for Health and Care Excellence.
NIHR	National Institute for Health Research.
NNAP	National Neonatal Audit Project.
NMR / NNMR	Neonatal Mortality Rate; Deaths of infants in the newborn period.
NRLS	National Reporting & Learning System.
ONS	Office for National Statistics.
PALS	Patient Advice & Liaison Service.
Perinatal	The period surrounding birth.
Periventricular Leukomalacia	A form of brain injury involving the tissue of the brain known as 'white matter'.
PHE	Public Health England.
Postnatal	Term meaning 'After Birth'.
Post-operative	Period immediately after surgery.
Pre-eclampsia	A condition involving a number of symptoms including increased maternal blood pressure in pregnancy and protein in the urine.
RCOG	Royal College of Obstetrics & Gynaecology.
Root Cause Analysis	A method of problem solving used for identifying the root causes of faults or problems.
SGA	Small for Gestational Age.
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.

Ultrasound	Sound or other vibrations having an ultrasonic frequency, particularly as used in medical imaging.
VTE	Venous Thrombo-embolism; this describes a fragment that has broken away from a clot that had formed in a vein.
VLBW	Very Low Birth Weight - babies born weighing less than 1500 grams
VON	Vermont Oxford Neonatal Network.
WHO	World Health Organisation.


NHS
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