Liverpool Women's
NHS Foundation Trust

Dedicated to you

Quality Report
Liverpool Women's NHS Foundation Trust
2021-2022

Contents

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.

Part 1 Statement on Quality from the Chief Executive

Welcome to Liverpool Women's NHS Foundation Trust's 11th annual Quality Report. This provides an opportunity for us to report on the quality of healthcare provided during 2021/2022, celebrate our achievements and to share with you the Trust's key priorities for quality in the next reporting year of 2022/23. This is a critically important document for us as it highlights our commitment to putting quality at the heart of everything we do.

Towards the end of 2020, the Trust published it's Clinical and Quality Strategy for 2021-25. Our vision as an organisation is to become the leading provider of healthcare for women, babies and their families. We have created a strategic framework, within which there are several aligned strategies and plans, mapping out the future direction for our organisation and the steps we need to take to realise our vision. This Clinical and Quality Strategy forms a pivotal part of that framework and is a key driver in shaping the overall direction for the Trust.

The Strategy sets out our ambitious goal of the three Zeros - zero stillbirths, zero maternal deaths, and zero never events. This is a challenging and ambitious strategy and by reporting to you annually through our Quality Report, we demonstrate how the Trust has performed towards these goals. As well as reporting on performance in 2021/22, the Quality Report also identifies our priorities for the coming year.

Whilst the impact of COVID-19 has been less acute than in 2020/21, our activity this year has continued to be delivered against the backdrop of the pandemic. Our staff have once again gone above and beyond in working to deliver our quality priorities and achieving what we have has only been possible through their dedication and by working together and with our partners.

Whilst acknowledging the continuing challenges brought about by the pandemic, we do not accept that we should only target recovering back to pre-COVID-19 levels. During the year, the Trust has approved a Quality Improvement (QI) framework and has continued to strengthen its approach in this area. Details of this and some of the projects undertaken during the year are outlined in the report.

I would also like to take this opportunity to discuss some of our quality highlights of 2021/22. 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:

- The Trust invested in 2021/22 in a Robotic Surgery Programme for Gynaecology. We are the only dedicated Women's Trust in the UK with a Robotic Gynaecology Programme. We have 6 surgeons trained and theatre teams and in the first year performed nearly 300 procedures using this technology. As well as attracting and retaining surgeons at LWH the programme has seen significant quality outcomes including reducing length of stay and post operative complications. A mid-year review conducted in 2021/22 identified that for those patients who

were suitable for and had been treated through robotic assisted surgery, their outcomes in relation to complications, length of stay and readmissions were considerably better than with other methods. A further 12-month review is scheduled to take place through Q1 22/23.

- The neonatal unit introduced Europe's first neonatal telemedicine service. This allowed Neonatologists and specialists to be at the cot side of any baby cared for within the neonatal partnership within 5 minutes. This service has been recognised nationally and internationally. The system is now being used by our maternity teams to attend pregnant women being cared for in intensive care units in other hospitals
- The Fetal Medicine Unit has moved its estate and expanded its service during 2021/22 and is led by Professor Asma Khalil. The Fetal Medicine Unit provides a specialist commissioned tertiary and quaternary level service to Cheshire and Merseyside, Isle of Man, and North Wales. The Fetal Medicine unit now provides a Twin-to-Twin laser service and has treated four cases and this will further increase throughout 2022/23.

Following our CQC inspection in December 2019 and the Well Led element in February 2020 (the Trust was rated 'Good' overall), the Trust has continued to seek assurance throughout 2021/22 that the necessary actions have been implemented and embedded to ensure that improvements have been sustainable. This involved undertaking an internal audit on the status of the action tracker and following up on identified further work.

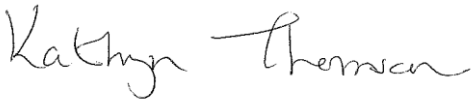
We continue to work hard to develop plans for the long-term future of our services and whilst remaining on a single isolated site remains the most significant risk to the safety and sustainability of our services, our Crown Street Enhancements Programme has made important strides during 2021/22. As noted above, our new Fetal Medicine Unit (FMU) opened, and a new CT scanner is now in place. We have secured funding for the creation of a Community Diagnostic Centre (CDC). Scheduled to open in 2023, the CDC will see a permanent CT, MRI and a wide range of diagnostic activity accessible to all patients across the city as well as giving Liverpool Women's patients access to timely and more convenient diagnosis in emergency situations.

A significant quality issue during 2021/22 has been the response to the Interim Ockenden Report. The Trust has made good progress during the year against the Immediate and Essential Actions and positive external assurance has been received from a planned visit from the Regional Chief Midwife (RCMW) team and the Cheshire and Mersey Local Maternity System representatives (LMNS).

The Final Ockenden Report was published on 30 March 2021. Everyone connected with maternity care will know that anyone who is receiving or providing maternity care – at Liverpool Women's and elsewhere – will have found reading this report particularly difficult. However difficult to read, the issues raised are vital for improving the safety of maternity care and we thank Donna Ockenden for leading the review but most importantly we thank the families who showed extreme bravery in sharing their experiences and whose contribution will help improve the safety of maternity services in the future. This will be an ongoing journey for all of us. We will be working and closely engaging with our staff, women, families, and partner organisations to make sure that we achieve and deliver on the essential actions in full. We will do this together through collaboration, learning and most importantly by listening to the women and families we care for.

I encourage you to read this 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
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Part 2 Priorities for improvement and statements of assurance from the Board

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

On 31 December 2019, the World Health Organization (WHO) was informed of a cluster of cases of pneumonia of unknown cause detected in Wuhan City, Hubei Province, China.

On 12 January 2020, it was announced that a novel coronavirus had been identified in samples obtained from cases. This virus is referred to as SARS-CoV-2, and the associated disease as COVID-19.

The World Health Organization declared the outbreak a Public Health Emergency of International Concern on 30 January 2020, and a pandemic on 11 March 2020.

The first case in the UK was confirmed on 31st January 2020 and between then and the end of March 2022 the UK recorded over 21 million cases and approximately 170,000 deaths.

LWH has managed 280 inpatients with Covid-19 infection since the commencement of the pandemic, 199 of these in 2021-22. The majority of patients have been maternity patients. There were a further 241 patients identified by screening prior to planned surgery or procedures.

The Infection Prevention & Control Team (IPC Team) has been instrumental to devising pathways and safe systems to allow the Trust to provide services to its priority patients and mutual aid to other local organisations. In addition to the workload generated by Covid-19 the IPCT has continued to oversee education, guidelines as the Trust transitions to the Governments @Living with Covid Strategy'

There was one nosocomial (healthcare acquired) case of COVID-19 in 2021-22.

All other patients with COVID-19 cared for at LWH were community onset cases determined pre-admission or on admission. There have been no patient COVID-19 infection outbreaks. Throughout the pandemic the Trust has implemented national guidance both on PPE (to ensure the safety of staff) and infection control to reduce the risk of transmission in the hospital. The IPC team worked closely with other stakeholders to devise pathways for the safe placement of patients.

2 Priorities for Improvement in 2021/22

At Liverpool Women's (LWH), our vision is to become the recognised leader in healthcare for women, babies, and their families. We believe that to achieve quality in the services we provide, we must focus on achieving excellence in four key areas: Patient Safety, Clinical Effectiveness, Patient Experience, and Staff experience (our quadruple aim). These components formed the foundations for our ambitions for quality, which are outlined in our Clinical Quality Strategy. Our ambitions set the long-term direction for our organisation; creating the momentum and mind-set we need to become outstanding in everything we do

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2.1 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 and 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 LWH 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.

ZERO

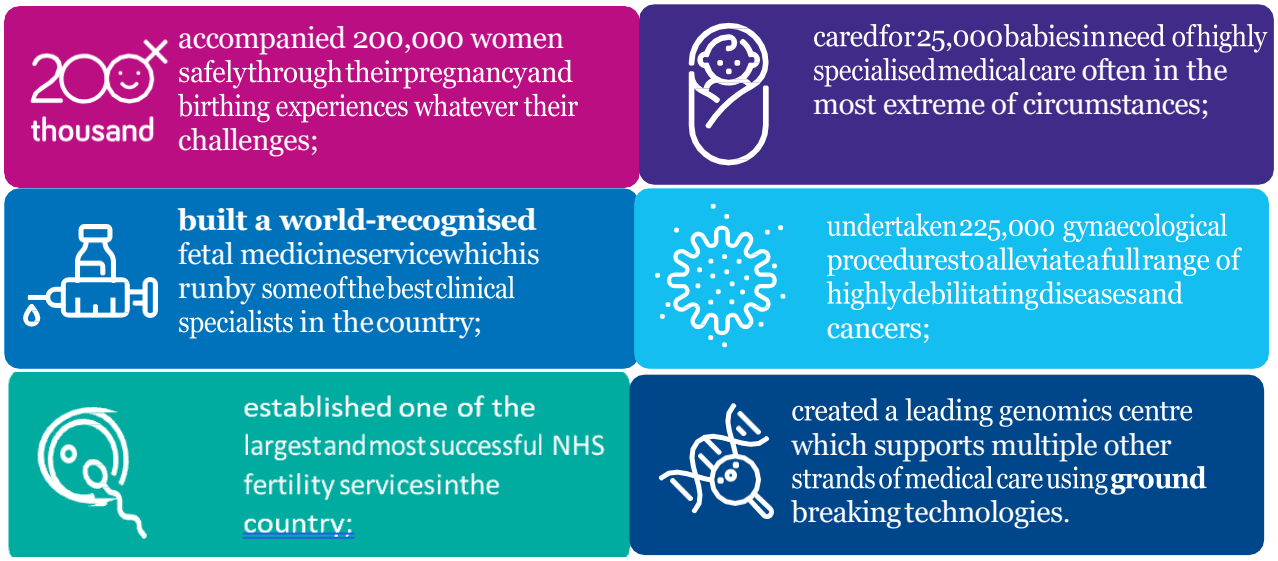
STILLBIRTHS | MATERNAL DEATHS | NEVER EVENTS

3 Clinical and Quality Strategy Aims and Priorities for 2020-2025

LWH has a proud history of providing world-leading clinical care to women, babies and their families dating back to 1796, when a dedicated group of local people set up the 'Ladies Charity' to help care for women in the city who were giving birth.

Over the years we have delivered our unique set of services from a variety of locations across the city, coming together under one roof in our current location on Crown Street in 1995. From here we now provide care to thousands of people from Liverpool and beyond every year, as the country's only standalone specialist Trust for women and their babies.

Since 1995 Liverpool Women's Hospital has:



4 Quality Improvement Framework

Following the outcomes of the previous CQC inspection, the trust has reviewed its existing quality improvement processes and developed a strategy and framework for improvement. A formal programme of expert support to refresh, train, embed and sustain effective Quality Improvement (QI) arrangements and culture throughout the Trust is currently underway.

Our Quality Improvement Framework has been published. This underpins the Trusts strategy across all areas of the organisation and not just clinical services. This has been co-produced and co-designed by engaging with people who work at the trust, prior to approval from the Trust Quality Committee.

Quality Improvement is the term used to describe a process of using a specific set of tools such as Plan, Do, Study, Act (PDSA) cycle, Driver diagram and SWOT Analysis (Strength, Weaknesses, Opportunities, Threats Analysis) to better understand what is going on, identify problems and opportunities, then plan and test small changes to lead us to improvement. There are different models that are used for Quality Improvement such as Six Sigma, Lean and The Model for Improvement, which is our chosen model for Quality Improvement

Our Quality Improvement Framework sets out our commitments and aims to develop and sustain a culture of continuous improvement that drives quality in everything we do and is evident from the experience of our patients. This framework allows us to outline the actions the Trust will take to make this happen and communicates the methodologies we use in the QI work we carry out across our Trust. It is one of many strategies that we have developed to meet our organisational strategic aims.

5 Quality Priorities

5.1 Priority 1 - Create a fair and just culture. Deliver comprehensive Human Factors training

The Fair and Just Culture Programme commenced in April 2018 and a short while later the Trust identified the Fair and Just Culture model advocated by David Marx, an author and CEO of Outcome Engenuity, as the preferred model for the Trust.

Phase 1 commenced in 2018-19 and focused on planning and data gathering, phase 2 in 2019-20 successfully developed and tested the model, phase 3 was planned for 2020-21 to review, embed and engage. Unfortunately, due to Covid-19 the Fair and Just Culture work was paused and phase 3 was not able to be fully completed and this work continues into 2022-23.

In April 2021 a new role of Head of Culture and Staff Experience was developed and the Fair and Just Culture Programme work recommenced with the support of a cohort of leaders who have been developed in the Fair and Just Culture approach. In 2021-22 the Trust has launched positive behaviours aligned to Trust Values. The Trust increased the number of Fair and Just Leaders, whose role will be to support as a Trust as we implement and embed the culture across the organisation.

In 2022-23 all managers and leaders within the Trust will complete training in the Fair and Just Culture approach, policies and serious incident processes will be reviewed to reflect a Fair and Just Culture and increased communication with staff about the implementation and embedding will be shared through various internal communication platforms and engagement groups.

Human Factors Training will be part of the patient safety training (levels 1-3) that is to be rolled out over the coming months. We are currently reviewing costings with a view to start rolling out the training for circa 1100 staff.

5.2 Priority 2 - Adopt relevant tested interventions. Deliver national targets in context of COVID-19 recovery.

Delivering high quality, timely and safe care are the key priorities for the organisation and there has been no doubt that the COVID-19 pandemic has continued to provide unprecedented and significant challenges for the organisation in maintaining these standards. These challenges continued into 2021/22 with the emergence of further COVID-19 variants and the pressure this placed on staffing, patient availability and the ability to recover from the significant reduction in services in 20/21.

The unpredictable sickness absence related to COVID-19 on top of 'normal' absence has continued to be one of the most significant factors affecting operational performance throughout the whole year. As COVID-19 restrictions were lifted and the public gained greater confidence and assurance in accessing healthcare services, this led to significant increases in referrals to clinical services, particularly General Gynaecology and Gynae-Oncology. This resulted in increases of 15-20% on referrals previously seen prior to the pandemic, further adding to the number of patients requiring to be seen who had suffered a delay in care because of the pandemic.

From the outset of the pandemic, the Trust enacted business continuity measures in response to the major incident and was also placed into 'command and control' arrangement by NHS Improvement / England (NHSI/E). The Trust continued to deliver this model during 2021/22, responding to new variants and increased challenges seen as a result i.e., Omicron variant, and the challenges this posed for the workforce.

5.3 Priority 3 - Create a Culture of safety. Deliver outstanding medicines safety, maternity, and neonatal safety

Neonates
We pride ourselves in a strong reporting culture on the unit and report at the national average of 4% of our unit admissions. We have introduced twice monthly incident review meetings where staff are invited along to discuss how they have investigated and closed incidents. We have also introduced monthly Safety drop ins where staff are encouraged to escalate concerns to the medical and nursing safety champions.

Medication errors continue to be our highest rate of incidents. There is a monthly neonatal medicines meeting where patterns of incidents are discussed and plans made to reduce them with emphasis on the systems around people to help to reduce errors. They have introduced locked filing cabinets in all of the rooms with prescribing stickers available for practitioners to use to prescribe from to standardise prescriptions and therefore reduce errors. There is also a programme of work to keep introducing ready made infusions to help nurses reduce errors. The neonatal unit rolled out telemedicine so that during the COVID-19 pandemic surgeons from Alder Hey could continue to carry out ward rounds at LWH without having to step onto the unit and similarly the LWH neonatal consultants could carry out ward rounds at the Alder Hey surgical site. This saved travel time and the movement of individuals between units and aided in reducing footfall between the units which was an important safety consideration during the height of the pandemic.

Maternity

Telemedicine: Implementation of the Robot for review of maternity patients admitted to ITU. This allows timely review of patients and a full MDT approach. This project is likely to lead to further use of this technology to support patient care and improve safety .

Maternity Safety Check-in: Monthly meeting set up by the Maternity Safety Champions to ensure that staff on the shop floor hear about the safety concerns that are escalated to Board. The Perinatal Quality Surveillance Dashboard is circulated in advance, all maternity staff are invited, the session is recorded to allow wider distribution of information.

Local and regional Placenta Accreta MDT: These are now up and running and allow cases to be discussed local and across the region. This has helped support diagnosis and thoroughly plan management of cases to ensure patient safety.

Increase in Obstetric Consultant hours on site: The resident Obstetric Consultant hours have increased from 96 hours per week to 110. The Obstetric Consultant is now present from 0830 until midnight. This supports trainees, midwives, improves the flow of maternity patients and ensures that the team are well supported. There has also been a change the daytime working of the Obstetric Consultants to provide a dedicated Consultant to the MAU during the day, this provides a senior support to the staff on MAU.

Ockenden: The Family Health Division have provided evidence of compliance against the 7 IEA of the initial Ockenden report. Many of these actions focus on ensuring safety for maternity care.

Medicine Safety

Weekly Safety Check In webinar for staff covering a medicines safety topic – the content is based on recent medication incidents that have occurred in the hospital and the learning is shared across all Divisions.

Roll out of the Monika electronic temperature monitoring system to allow 24/7/365 monitoring of medication storage areas across the hospital. The system facilitates regulatory compliance by automating accurate collection and logging of temperature data. It also eliminates manual temperature monitoring and enables healthcare staff to focus on their patients and clinical tasks.

Initiation of the Trust wide Meditech Expanse project which will make significant improvements to the prescribing process by having prescribing, administration and pharmacy integrated within a single system to inform clinical decisions and offer treatment protocols, including fully digitising the order process and introducing close loop medications for improved patient safety.

Expansion of Medicines Safety Group (MSG) membership and improved engagement with Divisions across the Trust. Initial discussions across MSG to further increase medicines safety work across the organisation by recruiting a dedicated Lead Medicines Safety Nurse/Midwife to engage with frontline staff and facilitate a good medicines safety culture**.**

5.4 Priority 4 – Outcomes will become best in class.

LWH wants to ensure our services are financially sustainable in the long term, to do this we need to expand our existing partnerships, building on learning and partnership working throughout the COVID-19 pandemic and playing a key role in establishing the Cheshire and Merseyside Integrated Care System, we also need to develop a clear plan for all desirable partnerships during 2021, ensuring robust governance structures are in place and progress our research strategy and foster innovation within the Trust (please see the research section further on in this report)

LWH want to fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership. We wanted to achieve a well-led 'good' rating by 2021, achieve a well-led 'outstanding' rating by 2023 and achieve an overall rating of outstanding by 2025 (please see the CQC section further on in this report)

LWH wants to ensure our services are financially sustainable in the long term and ensure we have efficient and effective use of all available resources, we have an updated, balanced long term financial plan in place by 2021/22, we pursued appropriate opportunities to maximise Trust income for the benefit of our patients and appraise options for future organisational form (up to and including merger) by 2022. Going forward LWH want to develop the Trust's commercial strategy during 2022.

5.5 Priority 5 - Improve adult mortality and extended perinatal mortality. Deliver all NICE quality standards.

This section of the report focuses on three main areas in relation to mortality and the Trust work to reduce this: Zero Direct Maternal Deaths, Zero unexpected deaths in women having gynaecological treatment, To deliver our risk adjusted neonatal mortality within 1% of the national Neonatal Mortality Rate and Learning from Deaths. Given the nature of the services we provide at LWH, 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, and there are only a small number of deaths in our gynaecology patients. Using this metric has been considered 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.

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 LWH since maternal deaths, stillbirths and neonatal deaths are all excluded.

To ensure effectiveness in LWH is at the absolute forefront of practice, LWH 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.

Our Priority Effectiveness	Zero Direct Maternal Deaths - achieved in 2021-22
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 2017 and updated in 2018 and 2019. 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 continued to be undertaken via the Trust Ulysses system. A LeDeR policy remains in place. (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) The Quality Committee have continued to receive quarterly mortality reports and as part of the serious incident report HSIB cases are also identified. From February 2021 all HSIB cases have to be reported on StEIS in line with HSIB reporting criteria: 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/.

What the data shows

No direct maternal deaths were recorded in 2021-22.

As well as assessing each individual case, the Trust benchmarks using figures provided from MBRRACE-UK. The latest available MBRRACE-UK data for 2017-2019 shows that 8.8 women per 100,000 died during pregnancy or up to six weeks after childbirth or the end of pregnancy.

LWH Direct Maternal Deaths				
2017-18	**2018-19**	**2019-20**	**2020-21**	**2021-22**
0	**0**	**0**	**0**	**0**

Data Source: Hospital Episode Submission Data (HES)

What happens next?

The following has been included in the New Clinical and Quality Strategy for 20-25:

Improve Adult Mortality; Our isolation from other acute adult services at LWH 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 continue to achieve zero maternal deaths, have zero unexpected deaths in women having gynaecological treatment and provide high quality care for women dying as an expected result of gynaecological cancer.

Our Priority Effectiveness

Zero unexpected deaths in women having gynaecological treatment - not achieved in 2021-22

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. 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's Quality Committee and ultimately the Board have an overview of the delivery of this work. The Trust published an Adult Mortality Strategy in 2019. This priority will continue to be reported in the Quality Report but will be reported under the redefined priority of Adult Mortality.
What the data shows	In 2021-22 there has been 1 unexpected death following Gynaecology treatment. There were 3 expected oncology deaths in hospital in Gynaecology in 2021-22 Data Source: Hospital Episode Submission Data (HES)
What happens next?	The following has been included in the New Clinical and Quality Strategy for 20-25: Improve Adult Mortality; Our isolation from other acute adult services at LWH 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.

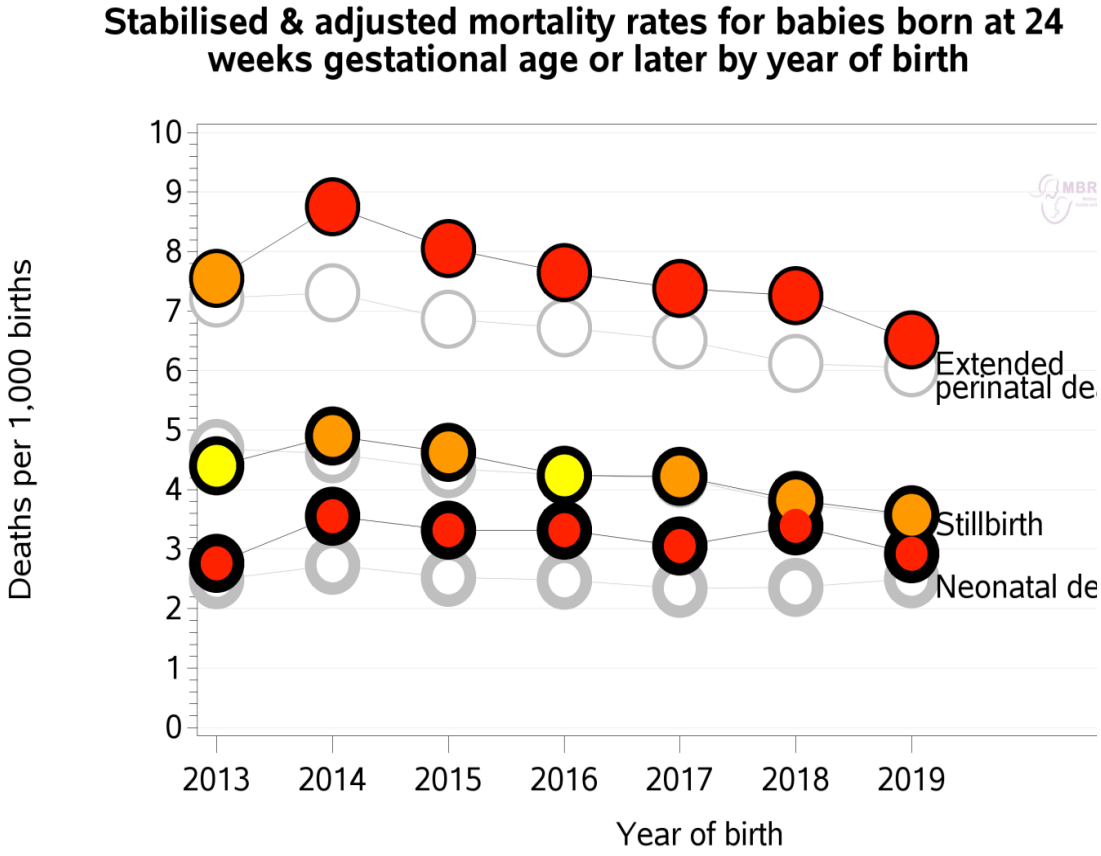
Our Priority Effectiveness	To deliver our risk adjusted neonatal mortality within 1% of the national Neonatal Mortality Rate – achieved 2021/22

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 LWH 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 care we are providing is maintained. We benchmark our mortality against the national NMR published from the Office of National Statistics, having previously committed to remaining within 1% of the NMR and reported to Safety and Effectiveness Sub Committee. We also benchmark against mortality data from MBRRACE-UK, NNAP (UK national neonatal audit programme) and 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 crude UK national NMR of 2.7/1000 live births (2020), in 2021/2022 for all babies delivered at LWH the neonatal mortality rate is 3.9/1000 livebirths. If we exclude babies born in LWH following ante-natal transfer for higher level specialist care, including extreme prematurity and congenital abnormalities, the mortality rate for the local LWH booked population is 2.6/1000 live births, lower than the national rate. However, it should be noted that we do not benchmark as favourably with MBRRACE-UK and VON.

MBRRACE-UK monitor neonatal mortality rates annually, the most recent data available is for 2019. MBRRACE data allows benchmarking of crude data but also stabilised and adjusted rates benchmarking against similar high risk level 3 NICU with neonatal surgery.

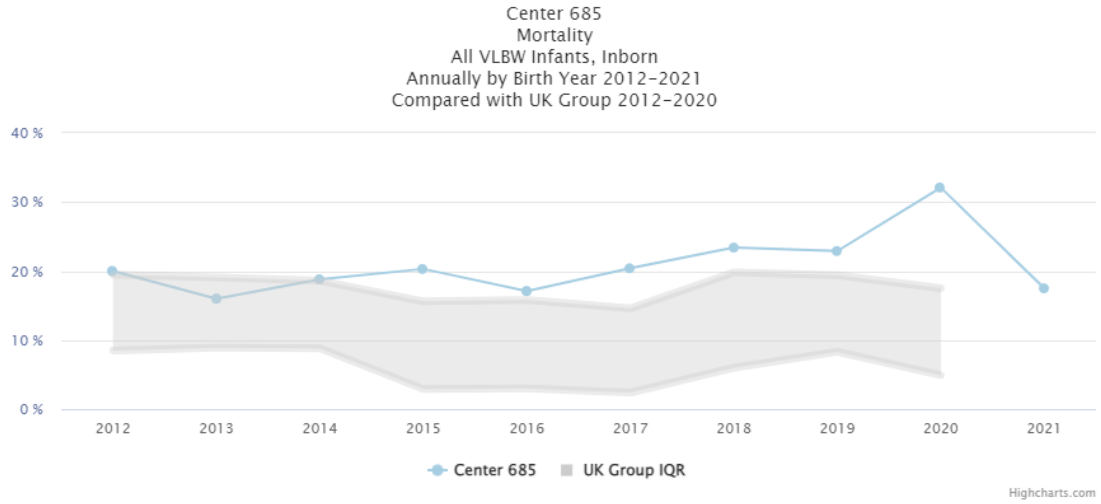


The above graph shows that LWH has remained above the national average for units providing level 3 care with neonatal surgery, however in 2019 there is a trend closer towards the mean.

VON 2021, LWH mortality: inborn VLBW <1500g

The mortality rate for LWH in 2021 was 17.5%. This falls at the upper limit of the interquartile range for units who participate in VON throughout the UK.

The 2020 deviation away from the interquartile range is marked but in 2021 we can see the rate has fallen below 20% a reassuring return to towards the interquartile range.



The VON 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.

MBRRACE and VON data demonstrate that although we have achieved the target of staying within 1% of the ONS reported national NMR for pregnancies booked at LWH, LWH has a higher than average mortality when benchmarked in other ways. The difference in mortality rate is greatest in the extremely preterm infant group. LWH has been identified through NWODN benchmarking as a network outlier for preterm mortality. LWH is working with the NWODN on a review to understand and explore potential explanations for the mortality rate differences between the two level 3 NICUs with neonatal surgery in the NWODN. The final report is due to be published soon.

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. We also have benchmarking data through the NWODN on a quarterly basis. 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. The Trust will continue to undertake review internally of all neonatal death and provide a quarterly report to the Quality committee and Trust board as part of the Trust Learning from Deaths Policy.

Compliance with NICE Quality Standards

During 2021-22 the Trust ensured to continue to maintain its robust approach to the reviewing and actioning of NICE Quality Standards which are relevant to the services provided by LWH. The information below provides an update for the 2021-22 period.

Our Priority Effectiveness	Increase compliance with NICE Quality Standards
What we said we'd do	Deliver All Possible NICE Quality Standards NICE Quality Standards are used to review current services and to show that high quality care or services are being provided - LWH will demonstrate compliance with all possible standards.

What the data shows

The data shows that:
Implementation plans for all relevant NICE Quality Standards in each division are agreed and recorded monthly.
All NICE Quality Standards released in 2021-22 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 Performance Report (Power BI) and at both the Safety & Effectiveness Sub Committee and the Quality Committee.
Of the 5 NICE Quality Standards deemed applicable 4 (80%) have completed baseline assessments, 1 (25%) of which LWH are fully compliant with and 3 (75%) have actions in progress in order for LWH to become fully compliant and 1 (20%) has a baseline assessment in progress to establish compliance.

6 Statements of Assurance from the Board

6.1 Review of Services

Delivered **7770** babies

There were an overall total of **27606** gynaecological procedures; of which 3399 were in-patients for elective and non-elective procedures. A total of **6238** colposcopy procedures. Outpatient procedures (All Gynaecology including Colposcopy) total of **24207 procedures**

Performed **1206** IVF cycles

Cared for **1235** babies in our neonatal intensive and high dependency care

LWH has reviewed all the data available to them on the quality of care in all of these relevant health services. The Gynaecology and IVF figures are lower than in 2021-22 due to the impact of Covid-19 and the stand down in elective activity for a number of months. A recovery plan is in place following national guidance for 2022-23.

6.2 Participation in Clinical Audits and National Confidential Enquiries

During 2021-22, 7 national clinical audits and 3 national confidential enquiries covered relevant health services that LWH provides. During 2021-22 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 2021-22, 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%
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK) – Stillbirth	✓	100%
National Pregnancy in Diabetes Audit (NPID)	✓	100%
National Maternity and Perinatal Audit (NMPA)	✓	100% *(Data routinely collected from Maternity Services Dataset-MSDS).*
National Comparative Audit of Blood Transfusion (NCABT): 2021 Audit of Patient Blood Management & National Institute for Health & Care Excellence (NICE) Guidelines	✓	100%
Serious Hazards of Transfusion (SHOT) *(actions to be included in annual Bedside Transfusion Audit report)*	✓	61%*
** The Transfusion Team reported all incidents that were brought to their attention. However, in Jan '22 they were asked to prepare a report specifically around Anti D incidents in 2021. During this, Governance conducted a retrospective Ulysses search for all of 2021 which revealed additional anti D incidents, some of which fitted SHOT criteria, which had been closed locally without being brought to the attention of the transfusion team.*		

The team couldn't report all these additional incidents to SHOT due to lack of resources, and difficulty gathering information retrospectively, but they have produced a detailed local report and action plan which has been presented to Safety & Effectiveness Sub Committee and thereafter Quality Committee. Each division has provided an action plan which also includes review of the process by which these incidents are reported to the Transfusion Team and therefore SHOT. *There were 18 SHOT reportable incidents in total and 11 were reported to SHOT.* *This has also been raised at the Mersey Transfusion Group.*	
Learning Disability Mortality Review Programme (LeDeR)	No cases to submit

Relevant National Confidential Enquiries	Did the Trust participate?	Cases Submitted
Maternal, New-born and Infant Clinical Outcome Review Programme (MBRRACE-UK) – Maternal Morbidity	✓	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK) – Perinatal Morbidity & Mortality	✓	100%
Transition from child to adult services	✓	100%

The report of 1 national clinical audit was reviewed by the provider in 2021-22 and the remaining reports are expected later in 2022 and LWH 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.
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK) – Stillbirth	Awaiting National Report.
National Pregnancy in Diabetes Audit (NPID)	Awaiting National Report.
National Maternity and Perinatal Audit (NMPA)	Awaiting National Report.
National Comparative Audit of Blood Transfusion (NCABT): 2021 Audit of Patient Blood Management & National Institute for Health & Care Excellence (NICE) Guidelines	Awaiting National Report. Carried over to 2022-23.
Serious Hazards of Transfusion (SHOT) *(actions to be included in annual Bedside Transfusion Audit report)*	Awaiting Local Bedside Transfusion Audit Report.
Learning Disability Mortality Review Programme (LeDeR)	Although Liverpool Women's NHS Foundation Trust planned to participate in this project,

	LWH had no cases to submit.

6.2.1 Actions arising from Clinical Audits

The reports of 49 local audits were reviewed by the provider in 2021-22 and LWH 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 the LWH Clinical Audit programme this year.

Duty of Candour
This audit found that there was compliance related to Serious Incident Investigations and Patient Safety Incidents graded as moderate or above. In relation to Serious Incidents, there was 100% compliance with Duty of Candour. When an incident is identified as a Serious Incident, it follows a defined investigation process with an identified Investigation Officer. It is this defined process, which is managed by the Divisional Governance Manager that ensures the required process is followed and this has been identified as an improvement. The Duty of Candour policy is to be re-launched across the divisions, weekly harm review meetings for all Patient Safety Incidents graded as moderate will be introduced to ensure correct grading has occurred, and an email will be sent to Divisional Governance Managers to ensure Surveys of patients/families involved in Duty of Candour meetings are recorded on Ulysses.

Re-audit of the management of pregnant women with epilepsy
The aim of this re-audit was to generate a pregnancy in epilepsy joint management toolkit that would include the management of women in labour and the postpartum period. Since the previous audit, the pregnancy Multi-Disciplinary Team toolkit and documentation improved 100%. Also, all patients had documentation stating that they were taking 5mg of folic acid in the 1st trimester. The epilepsy in pregnancy guideline has been updated at LWH, which includes management of women in status epilepticus and is awaiting ratification from the Walton Centre.

Usage of Sodium Bicarbonate in Extreme Preterm Babies
This audit aimed to assess the usage of sodium bicarbonate in preterm babies less than 28 weeks of gestation at LWH. 30 preterm babies born less than 28 weeks gestation were given sodium bicarbonate during this audit period of 6 months. There was very good compliance for the audit standard of metabolic acidosis for potential hydrogen (pH). This was achieved in 98 percent of doses. Sodium levels pre and post bicarbonate infusion were within acceptable range and met criteria in 96 percent of doses. As a result of this audit, a Lesson of the Week is to be circulated and presented at the Neonatal Clinical Governance meeting to increase awareness regarding utilising the bicarbonate and base excess values in addition to pH values in the blood gas report when deciding about sodium bicarbonate treatment. Additionally, the guideline will be updated in order to reduce the use of sodium bicarbonate further.

Recommendation (SBAR) and Weekly Update of Cases Re-audit
This re-audit set out to ensure appropriate prenatal referrals to the Clinical Genetics department were input onto the prenatal SBAR database with patient identification number documented, clear reason for referral outlined and evidence of handover and review by the Multidisciplinary Team

(MDT) entered for all cases. As a result of this series of audits and subsequent actions, the prenatal SBAR database has now been successfully integrated into clinical practice providing assurance. The SBAR use and its content is continually discussed and monitored at the weekly MDT case discussion meeting to enhance skills and knowledge in relation to the prenatal SBAR and ensure consistency of its use.

Auditing the Compliance Against Domestic Abuse Protocol / Procedure

This annual audit demonstrated there is 100% compliance in cases being referred to the Safeguarding Team when a disclosure of domestic abuse has been made, or there is known domestic abuse concerns. In all cases an appropriate response was provided to patients when a disclosure of domestic abuse was made. The large majority of audit findings are positive and demonstrate staff members understanding of domestic abuse and application of appropriate responses is robust and effective. Training compliance requires some further improvement and outcomes will be highlighted via the Safeguarding Operational Group (SOG) to ensure this compliance falls in line with the Care Quality Commission (CQC) and Clinical Commissioning Group (CCG) expected levels. The importance in documenting routine enquiry will be highlighted to the Named Doctor for Safeguarding Adults to ensure the Trust holds robust evidence locally of this. Areas for improvement highlighted will be reviewed in the next audit to ensure continual monitoring.

Audit of Emergency Theatre List Timing and Effectiveness

This audit set out to determine compliance with the Trusts theatre management protocol, identify areas causing delays in the lists and to use these data to suggest modifications to the operation of the list to improve performance. The emergency theatre list now has a designated Anaesthetic consultant with the effects of this already visible with in between case times significantly shortened. Changes in theatre listing, or list frequency has been highlighted to Senior staff who will address the volume of the cases as well as reprioritisation needs on a day. This should improve compliance with theatre start times and over-running lists. Practitioners, including new rotating doctors are formally reminded that pre-op documentation is crucial and can be easily completed via a new 'Gynaecology Admission Pathway' embedded on the Patient Electronic Notes System (PENS). Completion of this will ensure compliance with the expected standard and will also triangulate where delays might occur. To further ensure input from stakeholders, the audit was also shared widely via the Trusts 'GREAT Day'.

Venous Thromboembolism (VTE) Scoring and Prophylaxis Prescribing in Early Pregnancy

This audit was carried out to determine compliance with current VTE guidance; specifically for early pregnancy patients, and to compare compliance between the gynaecology VTE guidance and the antenatal VTE guidance assessing whether patients would be more safely managed scored by the antenatal guidance rather than the gynaecology one. The audit identified that VTE risk assessments are completed via Meditech (electronic data system), whilst patient notes are completed via a separate electronic database, the Patient Electronic Notes System (PENS). Consequently, a reduction in the number of VTE risk assessments completed can be noted and discussions around the possibility of moving the VTE risk assessment onto PENS are underway. The Gynaecology VTE risk assessment was identified as being unfit for purpose for pregnant patients and discussion and possible commencement of the use of the obstetric VTE assessment will begin if agreed as appropriate. The dosage of low-molecular-weight heparins (LMWH) will be standardised to fall in line with the Royal College of Obstetricians and Gynaecologists (RCOG) guidance of dosage based on weight class. Poor reassessment of VTE risk will be addressed with a minimum of 72- hour reassessment for inpatients, and reassessment following miscarriage or ectopic pregnancy surgery. Following ectopic pregnancy surgery or miscarriage / pregnancy loss, women with a persisting VTE risk score of 2 or more will be offered 7 days of LMWH. Depending on VTE risk assessment, patients

with ongoing pregnancies will be prescribed LMWH at discharge for minimum 7 days, sometimes until risk factors decreased or throughout pregnancy. Outcomes of multi-disciplinary team (MDT) discussions will determine if improvement work moving forward should sit within Maternity or Gynaecology and influence the type of project suitable for monitoring progress and improvement moving forward.

Pain Management in Gynaecology Patients Under the Age of 18
To assess compliance with the Trust policy relating to pain management in Gynaecology patients under the age of 18, this audit was crucial in identifying that the paediatric pain tool is not being utilised and that staff on the Gynaecology ward are currently unaware of the paediatric pain tool. As a result, a large piece of work is underway to review the Standard Operating Procedure (SOP), pain tool and Policy to ensure it is suitable for all patients. Once complete, these documents will be ratified, circulated, and highlighted to all staff with a re-audit to re-assess compliance scheduled to monitor improvement. As a result of the audit, the Trust is now better informed of the actions required to improve patient care in relation to under 18's pain management.

Re-audit for Image Quality of Posterior-Anterior (PA) Chest X-rays (CXR's)
The results of this audit have positively confirmed that radiographs taken at this Trust are of a diagnostic standard and therefore help to ensure that the adult x-ray provision provided is safe and effective. Individual factors still demonstrate a need for improvement, particularly the need for more accurate beam collimation. The audit has also highlighted the impact of other factors which can potentially reduce the image quality such as a high body mass index (BMI) affecting penetration, and that inspiration may be reduced for a patient with breathing difficulties. Significant improvement can be noted in the number of examinations with Dose Area Product (DAP) being documented on Clinical Record Interactive Search system (CRIS) and positive confirmation of diagnostic images are being produced by the department. Action will be taken to ensure that optimal collimation is being performed and that the individual factors; projection, definition, and artefacts, are improved further. The importance of this will be highlighted to relevant staff and a spot check will be performed prior to the annual re-audit to ensure continual monitoring of improvement.

Analgesia Efficacy for Major Gynaecological Procedures Re-audit
This re-audit demonstrated excellent compliance against pre-determined standards with 100% of patients having pain assessed in the recovery room with simple multimodal analgesia prescribed unless contraindicated. Lack of documentation via the pain round document available on the Patient Electronic Notes System (PENS) remains an issue which will be highlighted and discussed at the Anaesthetic Journal Club. Where documentation is in evidence, pain scores are encouraging across all modalities of anaesthesia used intraoperatively. Rectus sheath catheters and patient-controlled analgesia (PCA) remain very reliable methods. Sample size and inadequacy of documentation serve to hamper this audit. Pain scores of 3 or less are demonstrable in 71% pain assessment episodes across the 48-hour assessment period within the remit of this analysis. Where length of stay is prolonged, it is clear that failure of analgesia is not an association.

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 can access and share in the learning.

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)

6.3 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.

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.

In response to the outbreak of SARS-CoV-2 and the subsequent statement by the Department of Health and Social Care, the set-up of all new clinical research projects and the participation of individuals in the majority of active clinical research projects were halted in March 2020. Exception was made to those studies where discontinuing them would have a detrimental effect on the ongoing care of individual participants involved. Following this decision the Trust prioritised the delivery of COVID-19 research activity, a key element of the Government's overall response to the pandemic.

As the peak incidence of individuals admitted to hospital with COVID-19 reduced significantly in 2021/22, attention was given to the identification of which of the portfolio of clinical research studies could start to reopen at the Trust. During the latter half of 2021/22 the Trust continued its efforts to contribute to quality National Institute for Health Research (NIHR) studies; focus efforts on collaborative research with academic partners to ensure the research conducted is of high quality, translational, providing clinical benefit for our patients in a timely manner; whilst balancing the prioritisation of the delivery of COVID-19 research activity.

Despite the challenges faced by the Trust, the number of patients receiving relevant health services provided or sub-contracted by LWH in 2021/22 that were recruited during that period to participate in research approved by a research ethics committee was 2,330 of which, 1,262 were recruited into NIHR portfolio studies, and 227 were recruited into COVID-19 research studies.

The Trust was involved in conducting 123 clinical research studies across our speciality areas of maternity, neonates, gynaecology oncology, general gynaecology, reproductive medicine, anaesthetics and genetics during 2021/22. This figure also included 7 COVID-19 related studies that were delivered at the Trust during the year. At the end of 2021/22 a further 28 studies were in set up, including 6 industry studies.

There were approximately 172 clinical staff contributing to research approved by a research ethics committee at the Trust during 2021/22. 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, individuals affiliated to the Trust contributed to 148 research publications, which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS.

Key research achievements during 2021/22 can be summarised as follows:

- In response to a surge in COVID-19 research activity in Liverpool, the Trust continued to actively support the Liverpool School of Tropical Medicine with the delivery of the Astra Zeneca / Oxford, COMCOV II and COV009 vaccine trials.

- Commencement of COPE: The Carboprost or Oxytoin haemorrhage Effectiveness study. A grant award of approximately £1.8 million in response to a commissioned call by the National Institute for Health Research HTA will support a 4 year study aiming to randomise nearly 4,000 women following a clinician's decision to give treatment to stop bleeding caused by a postpartum haemorrhage.

- Dr Paula Briggs (Consultant in Sexual and Reproductive Health) in association with Robinson Healthcare, developed a speculum to assist in the diagnosis of urogenital atrophy for use in both primary and secondary care. The validation of this objective method of diagnosing urogenital atrophy and assessing response to treatment will facilitate ongoing research in relation to this condition.
- 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 the Wellcome Trust. The 'Children Growing-up in Liverpool (C-GULL)' research study is led by Professor Louise Kenny. The 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 badly 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 follow the lives of over 10,000 babies and their families, starting in pregnancy and onwards to adulthood, to understand more about what influences the health and wellbeing of children living in our City and how in turn early experience influence later life outcomes.

Due to COVID-19 the launch of C-GULL was delayed. However, initiation of the programme at the Trust is planned for early 2021/22, which will bring together citizens, researchers and clinicians across the Liverpool City Region to make one of the largest family studies in the UK.

- HPV Vaccine Trial – High risk HPV is the main cause of cervical cancer. The trial will test whether the investigational vaccine is safe and well tolerated and whether it helps to clear infection with high risk human papillomavirus (HPV) that will not go away on its own. Recruitment for this extremely important trial is currently underway.

- PREG-COV – a collaboration with St George's Hospital, London. This vaccine trial in pregnant women seeks to determine the immune response to immunisation and reactogenicity of Covid-19 vaccines between shorter and longer dosing intervals of the Pfizer or Moderna Covid vaccines to determine which, if any, is superior. The Trust is currently one of the top trial recruiters within the UK.

- Research led by Professor Colin Morgan has led to the development of an idea for a new parenteral nutrition product that comprises a specific amino acid formulation concentration. A programme of further work to examine the changes in gene expression present in arginine supplemented infants <30 weeks' gestation between day 3 and day 10 of postoperatively has commenced. The changes in gene expression will be compared with those seen between day 3 and day 10 in unsupplemented preterm and term infants.

6.4 Use of the Commissioning for Quality and Innovation (CQUIN) payment framework

The CQUIN schemes were suspended in 21/22 due to the Covid-19 pandemic.

6.5 Statements from the Care Quality Commission (CQC)

The last comprehensive inspection of LWH was conducted by CQC in December 2019. The Hospital was rated good overall, with well led rated requires improvement. Liverpool Women's at Aintree was last inspected In February 2015, rated good overall.

A further focused inspection of LWH was conducted in April 2020. This was to follow up a Warning Notice that was served in relation to the safe management of medicines at the previous inspection. Sufficient improvements had been made to meet the requirements of the Warning Notice. The service was not rated on this inspection.

The trust is rated good overall. All locations and services will retain their individual ratings until the next inspection.

The ratings for the trust and all its locations and services are outlined below.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led
Good – April 2020	Good – April 2020	Good – April 2020	Good – April 2020	Requires Improvement – April 20

Ratings for acute services/acute trust (Liverpool Women's Hospital)

Safe	Effective	Caring	Responsive	Well-led
Good – April 2020	Good – April 2020	Good – April 2020	Good – April 2020	Good – April 20

Ratings for Liverpool Women's Hospital

Core service	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity	Good – April 2020	Good – April 2020	Good – April 2020	Outstanding – April 2020	Good – April 2020	Good – April 2020
Gynaecology	Requires Improvement – April 20	Requires Improvement – April 20	Good – April 2020	Requires Improvement – April 20	Requires Improvement – April 20	Requires Improvement – April 20
Neonatal services	Good – April 2020	Good – April 2020	Good – April 2020	Good – April 2020	Good – April 2020	Good – April 2020
End of Life	Good - May 2015	Good - May 2015	Good - May 2015	Good - May 2015	Good - May 2015	Good - May 2015
Outpatients	Good – March 2020	Not rated	Good - May 2020	Good - May 2020	Good - May 2020	Good - May 2020
Overall	Good - April 2020	Good - April 2020	Good - April 2020	Good - April 2020	Good - April 2020	Good - April 2020

Ratings for Liverpool Women's Hospital at Aintree

Core service	Safe	Effective	Caring	Responsive	Well-led	Overall
Outpatients and diagnostic imaging	Good – May 2015	Not rated	Good – May 2015	Good – May 2015	Good – May 2015	Good – May 2015
Overall	Good – May 2015	Good – May 2015	Good – May 2015	Good – May 2015	Good – May 2015	Good – May 2015

As we progress towards a potential date for a CQC inspection, the Corporate Governance Team have begun work to assess the current position with regards to being always 'CQC inspection ready'. This is being carried out in collaboration with the Senior Leadership Teams for services within the trust and a programme of 'CQC Self Assessments' for each division is underway.

To support this piece of work, the Finalised 'CQC Preparedness Framework 2022/23 – From Good to Outstanding, Be Brilliant' was approved at Trust Quality Committee in April 2022. This provides assurance that work is on-going to ensure the trust is compliant with the regulations CQC inspects.

This also strengthens its approach to CQC inspections increasing understanding, buy in and awareness of this with its staff.

Our approach is set out below with further updates to be provided to the Trust Quality Committee as this work progresses throughout 2022/23.

Completion of legacy action plans from previous CQC inspections

With the support of MIAA (Mersey Internal Audit Agency), each division within the Trust devised a CQC action plan following their CQC inspections. The agreed actions have been monitored through the Trust Quality Committee, overseen by the Deputy Director of Nursing & Midwifery and the Risk & Patient Safety Manager. The vast majority of the 'Must do' and 'should do' actions have now been completed and closed. Work is on-going to ensure this work is completed.

The Senior Leadership Teams within each division have been asked to review these action plans as part of the Divisional Self-Assessment and outlined below.

Divisional Self-Assessments and Ward Accreditation Process

There is a monthly focus on CQC compliance and closing of associated risks at Executives Team Meetings.

Each division assesses themselves against the CQC Key Lines of Enquiry (KLOE's) for each of the questions CQC will ask, are services safe, effective, caring, responsive & well-led? Following this assessment, divisions will rate where they believe their service is at for each key question. The options are outstanding, good, requires improvement or inadequate. Each Senior Leadership Team will then present its findings to Executives and produce an associated action plan thereafter. This process will be completed twice annually for each division.

Each division has been provided with CQC core service frameworks to support this process. The frameworks are in line with what CQC use as part of their inspection planning and site visits. This process will be updated and led by the Associate Director of Quality & Governance as and when CQC update their approach to inspection as outlined above.

This will provide a chance for the information in the Divisional Self-Assessment presentations and action plans (as outlined above) to be reviewed and the evidence scrutinised/challenged (where appropriate) as part of the Ward Accreditation Process. It is anticipated that Ward Accreditation Process for each area will be undertaken twice a year.

Following receipt of the findings and presentation to Executives, the divisional teams are expected to take this process, and actions arising through their local divisional assurance groups and add appropriate actions to their service improvement plans.

The findings of the Ward Accreditation Process and high-level monitoring of the action taken by local committees will be presented to The Safety & Effectiveness Sub Committee and then onto the Trust Quality Committee. This is anticipated to be on a quarterly basis. Alongside quality dashboards and the information from the CQC's Insight reports, this should significantly strengthen the opportunity for assurance and regulatory scrutiny.

Data Requests

CQC are reviewing its approach to prevent an unnecessary burden on providers in relation to requests for data. They'll regulate in a more dynamic and flexible way so they can adapt to the future changes they anticipate – as well as those they can't. Smarter use of data, including the use of CQC insight tool, means they will target their resources where we can have the greatest impact, focusing on risk and where care is poor, to ensure they are an effective, proportionate, and efficient regulator.

Site visits are vital in their assessments and essential to observe care – but they're not the only way to assess quality. They will use all our regulatory methods, tools and techniques to support robust and proportionate decision-making.

Up-to-date and high-quality information will reflect how people experience care, so ratings will be more dynamic and meaningful. Therefore, supportive and constructive relationships with providers will minimize unnecessary workload.

To support this, CQC channels for each division will be created within Microsoft teams. This will enable the divisions to update its evidence for each of the key questions CQC will ask in real time, thus minimising the burden on staff teams when such request for data is received.

Learning from past inspections

The inspections undertaken previously represent a significant opportunity to learn from those areas that needed to improve but also the areas that achieved 'Outstanding'. Collaboration between all Senior Leadership Teams for each division is required to ensure continual review and improvement of key areas.

To assist with the outstanding element, the trust has produced a Quality Improvement (QI) Framework with the support of MIAA. The QI Framework can be read in conjunction with this document to understand the work planned for the trust for 2021-25 as it embarks on a journey to outstanding.

To further enhance the database and evidence gathering, there will be an emphasis placed on divisions to know their own data and journey. Divisional teams and senior leaders will be supported with sessions about CQC preparedness but will also be asked to complete their own assessment of their divisions as a 'Core Service' review.

Supporting the "Well-Led" domain and inspection preparation

The Corporate Governance Team will provide ongoing leadership in the delivery of agreed actions relating to Well-Led. This includes:

- direct support to executives;
- ensuring oversight of fundamental standards at Exec level;
- evaluation of progress against the "Well-led" domain as part of a mock review

To support executive oversight of delivery against the fundamental standards, each executive is aligned to fundamental standards that match with their portfolio. The allocation of leads and responsible groups is the first step towards embedding a culture of compliance.

The Corporate Governance Team will hold regular meetings with executive team members with portfolio responsibility where they will provide advice on current progress and emerging risks. This will inform both the reports that are presented to Quality Committee and can be used separately in the immediate pre-inspection phase where the Associate Director of Quality Governance can facilitate Executive Workshops and collective discussion of the capacity and capability in leadership of care quality and the impact this will have within each CQC domain.

The Corporate Governance Team will ensure there is regular feedback to the Executive Team on the impact of work to support frontline staff in quality improvement delivery. This will include observations on the Trusts progress to a robust, realistic strategy for achieving its priorities and embedding its newly developed vision, values and objectives. This will include feedback on staff knowledge and understanding of their role in delivering the shared purpose of the Trust and assessment of whether there is a culture centred on the needs and experience of people who use services.

The Trust executives and senior leadership team will be expected to ensure the Corporate Governance Team have access to them, particularly in the immediate pre-inspection phase when there will be the opportunity to facilitate stakeholder interviews. There will also be the expectation that there is participation as a senior leadership team, providing peers with support, critical challenge and problem solving. Although the Corporate Governance Team will be able to lead, facilitate and provide expert advice, the senior leadership team are required to progress the required actions collegiately to contribute to planned progress.

Having undertaken this work, the Corporate Governance Team will assess the Trust's maturity in relation to the elements of well-led that will be looked at by CQC during a mock well-led review. As part of the process for preparing senior leaders across the Trust for the level of regulatory scrutiny they can expect, a series of mock interviews will be undertaken. Feedback will be given, and this exercise will be repeated later in the year to assess progress. The well-led review will also include a formative risk assessment against the key lines of enquiry.

6.6 Data Quality

LWH monitors data quality through a regular Data Quality Sub-Committee that reports through the Digital Hospital Sub-Committee to the Finance, Performance and Business Development Committee and focusses on specific specialties to ensure regular representation from senior managers and clinicians. This provides a forum for digital and operational staff to discuss issues and key data items relating to their specialty. Regular data quality reports, validations and audits are undertaken to provide assurance that submitted data is representative of the Trust's activity. To further improve engagement and awareness across the Trust regular Data Quality and Information Reporting updates will be provided through divisional boards.

The Trust continues to follow an internal programme of validation of important data sets and selected key performance measures. The Trust utilises benchmarking tools to focus on data quality improvements and a bi-weekly working group is focussed on making improvements in the Trusts statutory submissions and Data Quality Maturity Index, which is also reported through divisional boards and committees. An internal clinical coding audit programme continues to show high levels of coding accuracy and focussed audits are undertaken based on benchmarking data to ensure this data can be used with confidence.

The quality of performance information used across the Trust is assessed using a structured approach. All patient NHS numbers are checked and validated against national data on a weekly basis, patient level activity data is validated against plan on a monthly basis, including consistency checking across hospital/clinical patient record systems and a central data warehouse, and datasets are verified through external sources. Our data is then further reviewed against other providers to ensure our data quality is satisfactory or better using data provided via CHKS (an independent provider of healthcare benchmarking intelligence and for validation against national expectations using data provided by SUS (Secondary Uses Service) which is part of the NHS, as well as other NHS benchmarking tools such as the SUS+ dashboards. Summary and data level reports are provided to our clinical divisions following a quality checking process to allow them to correct any errors and review data entry processes.

Performance reports are in place across meetings and committees and the Trust has implemented the use of statistical process control (SPC) charts across KPIs measuring both performance and the underlying data. Performance reports have undergone redevelopment through 21/22 to provide focussed reports highlighting both positive developments and areas for improvement identified through changes in performance over time.

6.7 Data Security and Protection

The defining feature of the last 2 years has been the impact that Covid-19 healthcare emergency has had on almost every area of the Trust. As well as affecting the operations of the Trust, the Covid-19 emergency also changed the compliance external reporting requirements to which the Trust must operate.

Ordinarily, all Trusts are required to submit their end of year Data Security and Protection Toolkit position at the end of March of each year but the effects of Covid-19 has meant that those deadlines have moved from the end of March to the end of June of each year.

Because of this change, at the end of each financial year, and at the time of writing this report, the Trust does not have a Data Security and Protection Toolkit submitted position to report on that represents the 2021/2022 financial year. The last submitted position for the Trust was June 2021 and, whilst this was submitted within the financial year 2021/2022, it represented the compliance activity for the financial year 2020/2021. The submitted position, which was validated by an independent audit at the time, was “Standards Exceeded”.

During the 2021/2022 financial year there were two matters dealt with that involved some level of interaction with the Information Commissioner’s Office. The first related to misdirected correspondence, which has now been concluded. The second matter relates to information that may have been released by a third-party supplier in response to a Subject Access Request made by one of their employees to that supplier. Liaison with the Information Commissioner’s Office is ongoing in respect of the second matter.

6.8 Clinical Coding

LWH conducts an annual clinical coding internal audit programme. In 2021/22 the overall accuracy of clinical coding was found to be of a good standard, achieving the ‘Standards Met’ level. The Trust

has a good level of assurance that the clinical coded data submitted is accurate and complete, supporting patient care and contributing to effective management.
All clinical coding staff are up to date with the specialist training required for the role. The last external clinical coding audit in 2019/20 noted good practice in relation to the structure of the clinical coding department, which was found to provide a supportive working environment, well-structured policies and procedures that effectively support the running of the department, and active engagement from clinical staff.

6.9 Learning 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 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.

In 2021-22 there were 41 neonatal deaths and 4 adult deaths. All deaths have been subjected to a detailed review process

Neonatal
All neonatal deaths on Neonatal Intensive Care Unit (NICU) are 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. Where there has been an in-utero transfer 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 the mother and babies' care. The care provided for each case is then assigned a grade (A-D, see below) for each of the following areas: care of the mother up to the birth of the baby, care of the baby from birth to death and care of the mother (family) 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 care issues identified may have or are likely to have affected the outcome (a grade C or D) are then reviewed in more detail 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.

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.

6.10 Freedom to Speak Up

At LWH we are committed to developing and maintaining an open and constructive culture whereby all staff feel comfortable in raising any concerns they might have regarding the Trust and the services that it provides. All staff should feel able to raise concerns in the knowledge that they will be taken seriously, that their concerns will be addressed, and without any fear of reprisal of detriment.

In 21/22 the Trust launched an awareness campaign aimed at increasing the visibility of the promotional materials for speaking up and also committed to biannual "temperature check" surveys with the staff relating to the accessibility and visibility of the Freedom to Speak Up Guardians at the Trust.

The guardians play an active and visible role in raising awareness of the importance of speaking up, developing staff and dealing with concerns, while ensuring that our governance processes are robust and effective.

In 21/22 the organisation launched the first of three e-learning modules aimed at workers of all levels. The first module launched, “speak up, which is for all workers will be followed up by “listen up” for managers and “follow up” for senior leaders and directors during 2022/23.

The number of contacts and their nature are openly and transparently shared on a quarterly basis with the National Guardian’s Office and published on their public website.

6.11 Statement on Junior Doctors

Junior doctors play a pivotal role in keeping the services at LWH safe and make up a large percentage of the medical workforce. However, across the junior doctor workforce there has been a reduction in the number of doctors in training working at the Trust. This was and still is most predominant in Obstetrics and Gynaecology (O&G), however the Trust is seeing this trend across Anaesthetics (in the main due to a change in training) and Neonates. There has been an increase in sickness due to mental health and restrictive working patterns due to covid and pre-existing health conditions and services have seen an increase in maternity leave.

Obstetrics and Gynaecology
The Trust continued to fund additional Trust employed doctors who are employed to support the junior doctor rotas within O&G. Although there has been much success over the years, there was a financial impact to the Trust as the O&G rotation was over established in August. The service is keen to continue with the research posts as the posts benefit the Trust by covering gaps and supporting the rotas, whilst the research posts give the doctors a good foundation in research enabling them to apply for future subspecialty posts. The service has reviewed these posts and there is a recruitment process underway to recruit to the vacant Trust funded posts.

The over establishment allowed the service to double up some trainees during out of hours ensuring that when doctors left the rotation the gaps were covered. This was also put in place to ensure the less experienced doctors such as foundation and GP trainees had support when working out of hours as some of these doctors have not worked in obstetrics before and could at times find it daunting. There has also been an increase in mental health illness amongst trainees and again, these trainees are well supported when on shift. It also, when necessary enables struggling trainees to work part of an on call block. The rotation was reviewed at 6 months and it was evident the staffing numbers had dropped significantly leaving gaps across the middle and senior grade rota. The current cohort of doctors who are familiar with the patients and hospital systems and protocols have filled in the gaps as locum doctors reducing the reliance on agency doctors.

Anaesthetics
Anaesthetics continue to workforce plan by appointing Trust grade doctors who are in-between training or those who need some additional support when sitting their exam to gain ST3 placements. As the Anaesthetic service receives a number of CT2 trainees who do not have obstetric experience the Trust grade doctors support the rotas whilst the CT2 trainees are trained in obstetrics enabling them to work out of hours safely. Due to the national change in training there is a concern that the Trust will receive less skilled trainees (grades of ST3+) this may impact on the consultant workforce for support and increase the need to recruit to Trust doctor posts.

Neonates

As previously detailed, the neonates' junior doctor staffing is well supported by Neonatal Advance Nurse Practitioners. There are no current concerns around the junior workforce across neonates.

Genetics
Staffing in genetics remains consistent with no concerns regarding staffing. The service does not work out of hours therefore there is no requirement to cover vacancies.

6.12 Seven Day Hospital Services

A Seven Day Services Self-Assessment Tool (7DSAT) has been developed to ensure that all Trusts are measuring their progress against four priority standards (see below). We await clarity from the NHSE-I regional Medical Directors with regards to how they wish to seek assurance to the delivery of this particular agenda. It is assumed this will be via a local assurance process with Commissioners, but this has not been confirmed. We have continued to collate this data for internal use.

Findings (Self-Assessment in March 2022)

Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission.
The standard is to meet this requirement in 90% of cases. Of the 16 gynaecology admissions, 12 were seen within 14 hours (75%). This is an improvement from the previous period though the numbers are small and it is not significant.

The 4 cases that were not are described below

- seen on the ward round 14 hours and 17 minutes after attending in the previous evening.
- discussed with a consultant and proceeded to surgical miscarriage management, seen by the consultant the following day (this was the longest time to review by a consultant of 23hrs 53 m).
- transferred from another acute provider for a review by a specific gynaecologist, who reviewed the following afternoon.
- Admitted just after the ward round and seen the following day.

Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week.
The score previously achieved has not changed. Consultants can order tests 7-days per week, but some are conducted off site. The mobile CT scanner on the LWH site is now operational with LWH patients being able to access this service from Q1 2022-23. The development of the Community Diagnostic Centre is planned to result in the opening of MRI, echocardiography and other diagnostic tests by Q3/4 2022-23. The provision of 7-day access to these tests will be reviewed in the development of the CDC.

Standard 6: Hospital inpatients must have timely 24-hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.
The standard is measured by a provider self-reporting 7-day access on-site or by formal arrangement with another trust for critical care, emergency general surgery, interventional endoscopy, interventional radiology, renal replacement therapy and urgent radiotherapy.

This standard was previously scored at 0% (a no return) because although key consultant directed interventions can be accessed from non-obstetric and gynaecological specialties, these are generally provided outside of relevant specialty guidelines, due to the isolated nature of the Trust's Crown Street site.

Three of the areas are not applicable to the Trust (primary percutaneous coronary intervention (PPCI), cardiac pacing and thrombolysis for stroke).

Emergency surgery is available either by transfer of the patient to the acute site or in extreme emergency situations, by the surgeon attending Crown Street. Working groups for gynaecology, obstetrics and anaesthetics services between LUFHT and LWH are commencing in Q1 22/23 to formalise the working practices that have occurred for several years. This will result in SOPs and SLAs for each area/intervention.

Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant twice daily (including all acutely ill new admissions and all other in-patients who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway.

The standard is achieved when a provider reports that 90% of its patients receive a daily or twice daily review by a consultant as required as per the criteria set out in the national guidance. Overall compliance with this standard is achieved if a provider assesses itself as meeting the standard both on weekdays and at weekends for patients requiring once-daily and twice-daily reviews.

No patient fitting this criterion in the period surveyed but previous reports have shown 100% compliance with this standard. Care is provided to women off-site, for example, LUHFT site for intensive care. The Telemedicine service has commenced to allow the MDT from LWH to review these women remotely. This is being evaluated to determine if this approach will be appropriate and supported in the future.

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%)	In this survey, 75% of admitted women were assessed in person by a Consultant within 14 hours of admission. An increase in the Trust compliance since the last survey. Most women attending as emergencies are miscarriage related and as such do not necessarily need Consultant review as the process and pathways in Gynaecology Emergency Department (GED) support decision making to improve the patient pathway. In this and previous reports, all have review and decisions at senior level.	**Not met**

	The current job plans do not specifically make reference to 7DS but the on-call rotas cover Consultant ward rounds and emergency admissions. Weekend ward round are Consultant delivered and the majority start at 9am on Saturday and Sundays.	
Priority Standard 5 – Hospital inpatients must have 7-day access to diagnostic services & Consultant directed diagnostics	Memorandum of Understanding with LUHFT in place and there are pathways in place for ad hoc diagnostics. Mobile CT scanner now on site and CDC will improve access for MRI and echocardiography. Development of the CDC will include consideration of 7 day service.	**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. MoU with LUHFT in place. Working groups set up for each speciality to develop formal SOPs and SLAs.	**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	Nil return in this report as none required it, but previously 100% achieved with evidence of multi-disciplinary involvement including from adult acute Trust. Care is also provided offsite 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, i.e. the surgery occurs elsewhere if ITU is anticipated.	**N/A**

6.13 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.

30 Day Emergency 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 as an emergency within 30 days:

	Target	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Readmissions within 30 days (Reporting 1 Month Behind)	TBC	4.20 %	3.24 %	2.85 %	3.75 %	2.65 %	2.94 %	1.58 %	1.15 %	0.92 %	1.70 %	0.91 %	1.22 %
Returns to Theatre	<=0.7 %	0.49 %	0.30 %	0.44 %	0.14 %	0.15 %	0.88 %	0.75 %	0.00 %	0.47 %	0.15 %	0.00 %	0.74 %

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.

Patient Safety Incidents

There were 6957 Patient Safety Incidents in 21/22, 5 severe harm and 2 deaths relating to patient safety incidents (7 in total). This makes a 0.1 % ratio.

2 cases were deemed appropriate care (severe harm).
5 were potential for improvement as follows – Communication Themes:

Appropriate antenatal care and planned delivery by CS Twin pregnancy.
Discussion with surgeons but not formally referred opportunity for review of images at Trust 2 prior to returning to Trust 1 with potential for admission to Trust 2 for management/ return to Trust 2 with surgical oversight

The MDT review at PMRT concluded a missed opportunity to detect SGA and therefore there was a possibility of an earlier intervention in a high-risk pregnancy. Due to a prolonged scan interval of 5 weeks this was Graded D at the review.

Part 3 Other information – Quality Performance in 2021/22

7 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.

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

Indicator Name	Target	Performance 2021/22	Achieved/Not Achieved
A&E Clinical Quality - Total Time in A&E under 4 hours (accumulated figure)	95%	**95.8%**	**Achieved**
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral) - post local breach re-allocation (accumulated figure)	90%	**21%**	**Not Achieved**
Cancer 31 day wait for second or subsequent treatment – surgery (accumulated figure)	94%	**61%**	**Not Achieved**
Cancer 31 day wait from diagnosis to first treatment (accumulated figure)	96%	**76%**	**Not Achieved**
Cancer 2 week (all cancers) (accumulated figure)	93%	**92.3%**	**Not Achieved**
Clostridium difficile due to lapses in care (accumulated figure)	0	**0**	**Achieved**
Never Events	0	**1**	**Not Achieved**
Incidence of MRSA bacterium	0	**0**	**Achieved**
Referral to treatment time, 18 weeks in aggregate, incomplete pathways	92%	**58.5%**	**Not Achieved**
Cancer 62 Day Waits for first treatment (from urgent GP referral) - post local breach re-allocation (accumulated figure)	85%	**26.5%**	**Not Achieved**
Maximum 6-week wait for diagnostic procedures	99%	**86.42%**	**Not Achieved**

2021/22 was another significantly challenging year for the NHS.

The Trust was able to deliver all essential services and begin our elective recovery and restoration programme against a backdrop of a year that had significant Covid 19 waves.

The Trust maintained our good performance on the Cancer 2 week waits despite a significant increase in referrals and towards the end of the year and saw a significant improvement in our 31 day position as our Cancer Task and Finish Recovery group established. Moving into 2022/23 the Trust will look to meet the national recovery asks in terms of treatments and surgery for Cancer in collaboration with the Cheshire and Mersey Cancer Network.

The Trust has no long (2 year waits) although has seen a significant increase in those patients waiting longer than a year for treatment as we prioritised those with greatest clinical need. Increasing our performance for the long waiting patients will be a key feature of the 2022/23 elective recovery programme

Our urgent care and diagnostic performance remained good throughout the year

The Trust took on the Charing of the Cheshire and Mersey Maternity Operational Cell in the year to support a pan regional response to operational challenges in Maternity.

8 Ockenden Report – LWH Trust Response

On the 10 December 2020, Donna Ockenden, Chair of the independent review into maternity services at the Shrewsbury and Telford Hospital NHS Trust published an interim report following a clinical review of the first 250 cases where concerns had been raised over the care the patients received from the maternity unit at that Trust[1].

The report described important and emerging findings from the significant concerns raised from these reviews and their associated actions for all Maternity Units in England. The report outlined 7 immediate and essential actions (IEAs), with an associated 12 urgent clinical priorities (UCPs) that all NHS Trusts must implement.

The Board received a detailed report at an Extraordinary Board Meeting on 3 March 2022[2] which outlined the actions and work that had been undertaken at that point to enable the Trust to provide assurance that the full implementation of the Ockenden Essential and Urgent recommendations was underway. The report also provided an opportunity to reflect on the wider issues raised by the Ockenden Report (in addition to the points of compliance) that were identified by the Board in January 2021 and to consider the progress made against these and what future actions may be necessary. This report builds upon this assurance and provides an updated position on progress.

[1] https://www.gov.uk/government/publications/ockenden-review-of-maternity-services-at-shrewsbury-and-telford-hospital-nhs-trust

[2] https://www.liverpoolwomens.nhs.uk/media/4112/20220303-trust-board-public.pdf

On 30 March 2022, Donna Ockenden published the final report detailing the findings, conclusions, and essential actions. This paper will outline the continuing themes between the final and interim report, highlighting any additional items or matters that will require enhanced focus. The paper will continue to outline the Trust's response to date since the publication of the final report and provide assurance to the Board that appropriate processes are being developed and implemented to ensure a robust response.

Progress against the Interim Report

In response to the publication of the Interim report on 10 December 2020, an Extraordinary Board was formed for the 7 January 2021. This meeting was the starting point of the assurance process for the Board. Progress reports continued to be provided to the Quality Committee and the Board with the most recent of these updates being provided in March 2022.

Subsequently, on the 12 April 2022 the Trust received a planned visit from the Regional Chief Midwife (RCMW) team and the Cheshire and Mersey Local Maternity System representatives (LMNS). LWH was the first of eighteen trusts in the northwest region to welcome the RCMW Team. This 'Insight Visit' was planned to give the organisation an opportunity to showcase the final pieces of evidence and work completed to demonstrate compliance with the Interim Ockenden Report.

The Acting Head of Midwifery (HOM), the Quality & Safety Matron and the Consultant Obstetrician for Risk & Safety provided a presentation demonstrating the final stages of the progress to completion of the outstanding IEAs and UCPs, which was positively received by the Team and LWH Senior Leadership Team. This detailed our self-assessment of full compliance in 11 of the 12 UCPs. The RCMW team spent time discussing and analysing our final evidentiary work and was escorted around the Maternity Unit, where front line clinical staff were able to meet the visiting team. The team interviewed some of the available Family Health Leadership Team as well as other key members of the Maternity Team on the visit including:

- Interim Acting HOM (Deputy HOM Substantiative post)
- Quality & Safety Matron
- Consultant Obstetrician for Risk & Safety
- Governance Manager for Maternity
- Fetal Surveillance Lead MW
- Fetal Surveillance Lead Consultant.
- Educational Lead MW
- Antenatal and Newborn Screening Lead MW
- Maternity Safety Champions

There followed several in-depth discussions that centred around:

- Maternity Staffing – Challenges, the role of the preceptorship and retention programme, sickness and absence pressures relating to COVID-19 and recruitment difficulties.
- Saving Babies Lives Care Bundle Implementation and the challenges faced with some of the associated requirements

- Maternity Training – Core competency framework, LWH agreement to increase head room.
- Senior Leadership Investment with the recent appointment of a HOM and a Director of Midwifery (DOM).
- MVP engagement and the requirement of a rapid but quality appointment to the recently departed MVP Chair

The team gave some initial feedback on the day, which was positive and encouraging in nature. The team commented on the quality and content of the presentation and that the 'bar had been set high' for other organisations within the region to follow. It was noted that the Family Health Division leads had worked to an outstanding level of commitment and with a position of candour and openness where we initially deemed ourselves non-compliant, and subsequently undertaken the work to improve services at LWH. As such, the team commented that the Trust remained potentially overly self-critical in relation to the outstanding UCP of partial-compliance and had self-assessed too harshly. The Team commented on the inquisitive nature of the clinical staff and were pleased to see that staff felt comfortable in approaching them to discuss the findings of the interim report and what had been done locally, as well as the national challenges for front line staff working in Maternity. At the time of writing, a full, detailed response and review of the Insight Visit is awaited, but confirmation of full compliance with all IEAs and UCPs is anticipated.

The Northwest Regional Team requested that the Trust submit evidence of the Ockenden One Year On Report being discussed at public board in March 2022. In response to this, the BAAT which underpinned this was returned to the LMNS and regional Team by the Acting HOM following executive oversight. We await further feedback considering this submission at the time of writing.

Ockenden Final Report

As noted above, the final Ockenden Report was published on 30 March 2022. Everyone connected with maternity care will know that anyone who is receiving or providing maternity care – at LWH and elsewhere – will have found reading this report particularly difficult. However difficult to read, the issues raised are vital for improving the safety of maternity care and we thank Donna Ockenden for leading the review but most importantly we thank the families who showed extreme bravery in sharing their experiences and whose contribution will help improve the safety of maternity services in the future.

Recognising that this would be a challenging time for both staff and patients, the Trust took immediate action to produce a staff bulletin and to enhanced senior leadership visibility. Information was also communicated via the Trust's social media channels.

Comparison between the Interim and Final Reports

The Interim Report listed seven essential actions:

1. Enhanced Safety
2. Listening to women and families
3. Staff training and working together
4. Managing complex pregnancy

5. Risk assessment throughout pregnancy
6. Monitoring fetal wellbeing
7. Informed consent
8.

The Final Report includes 15 essential actions:

1. Workforce planning and sustainability
2. Safe staffing
3. Escalation and accountability
4. Clinical governance-leadership
5. Clinical governance – incident investigation and complaints
6. Learning from maternal deaths
7. Multidisciplinary training
8. Complex antenatal care
9. Preterm birth
10. Labour and birth
11. Obstetric anaesthesia
12. Postnatal care
13. Bereavement care
14. Neonatal care
15. Supporting families

The final report builds on the findings of the first Ockenden report reinforcing the importance of establishing and improving critical oversight of patient safety in maternity units. The patterns of poor clinical care identified in the final report mirror issues identified by previous national reports into maternity care. Themes include failures to follow national guidelines, work collaboratively across disciplines, escalate concerns and delays in transfer. Furthermore, the report highlights significant failings in governance procedures and leadership which resulted in repeated missed opportunities and failures to learn.

The review also acknowledges the huge pressure maternity services and staff continue to face, which have been compounded by the pressures arising from Covid-19. The most significant addition from the interim report, is the focus given to the importance of workforce planning and also the recognition of funding issues impacting workforce challenges, particularly in terms of recruitment and retention of midwives and obstetricians.

Trust response to Final Report

The final report has extensive published actions that require a detailed response from all Divisions within the Trust, inclusive of Neonatal, Governance, Maternity, Anaesthesia, Operational and Clinical Support Services. The approach that the organisation proposes to take in its strategic and operational response to the Final Report and the 15 essential actions will be comprised of:

- A comprehensive self-assessment and GAP analysis within all Trust Divisions to enable further learning from the final report.

- A formal governance and reporting structure will be established to provide scrutiny and assurance to Quality Committee and Trust Board on the progress against all Ockenden Report requirements. This will be overseen by the Chief Nurse & Midwife.
- Digital solutions to be sought to enable sighting of Ockenden Final Action Plan into the Trust Board Performance Report. As part of this, the Digital Team have been requested to explore the feasibility of creating an Ockenden Dashboard demonstrating evidence of progress against the essential actions.
- Discussion to be held with the Council of Governors on 12 May 2022 to provide assurance and identify key priorities for the communities we serve.
- Identification of leads at Divisional, Operational and Executive Level.
- Third line assurance planned with MIAA to undertake audit in Quarter 4 2022/23 on progress (scope to be agreed).

This will be an ongoing journey for all of us. We will be working and closely engaging with our staff, women, families, and partner organisations to make sure that we achieve and deliver on the essential actions in full. We will do this together through collaboration, learning and most importantly by listening to the women and families we care for. An update on progress will be provided to each Board meeting throughout the year, and if necessary, beyond.

https://www.liverpoolwomens.nhs.uk/media/4189/2022-05-05-final-boardbook-public-board.pdf

9 Providing the Best Patient Experience

We believe that we cannot be the recognised leader in health care for Women, babies, and their families unless we deliver outstanding care, and we understand that the experience of that care, and we understand that the experience of that care can have just a significant impact as clinical outcomes. Our ambition is to exceed expectations and deliver an outstanding experience for everyone who uses are services. This means ensuring that people who use our services are valued as individuals and listened to: that what is important to them is important to us and that patients and families are informed and supported so that they can be equal partners in making meaningful decisions about their care.

A new Patient Experience Matron (PEM) was recruited in 21/22, The PEM has now been in post for 6 months. During this time the PEM has started to develop relationships with key stakeholders both internally and externally. The work of the PEM will be ongoing, and updates will be provided at the Trust Patient Involvement and Experience subcommittee. The purpose will be to provide assurance that LWH is progressing towards every patient having an outstanding experience as per the Women, Babies and Family's Strategy. PEM, from commencement in post, leads on arranging the patient stories that are taken to the Trust Board meetings. The feedback from The Executive Team had been very positive and thought provoking. The PEM has taken a blended approach when identifying stories to take to Board. These have included a registered blind patient attending with her guide dog, A member of Liverpool deaf community whose first language is British sign language.

Feedback from patients has included “I can’t believe that I could go to Trust board and tell our story to the chief Executive”. This was feedback from Merseyside Society for Deaf People.

The Executive Team are now gaining first-hand some of the small things that we don’t get right for patients and the huge impact that it would have in improving their experience if we did. The PEM works across all areas in the Trust to ensure that Experience key performance indicators are regularly reviewed. To identify any quality improvements that will ensure that every patient achieves an outstanding experience. Examples of this are the two patients’ stories that were taken to Trust Board have similar themes in relation to accessible information. Both have said that they will work with IT developments to look at ways in improving accessible information. One has already reviewed our translation policy and feedback their comments.

A new Culture Midwife has been recruited in 21/22, this role is a pivotal role to introduce and be Link midwife for Black, Asian and Diverse Ethnic (BAME) women & pregnant people. This is a key aspect of the NHS Long Term Plan (2019) for maternity providers to ensure that women from Black, Asian and diverse ethnic groups receive continuity of carer, as evidence demonstrates that this will help to address poor mortality rates for this cohort of women and their babies. This new exciting role will contribute to the delivery of the partner Trust’s strategic objectives for midwifery by interpreting national guidance and evidence based practice, such as delivery of Continuity of Carer to ensure 75% of minority ethnic women are in receipt of CofC by 2024 and embedding the Saving Babies Lives Care Bundle v2.

The Culture Midwife will establish key links in the community and will establish professional relationships with key stakeholders. Understand the local demographics and outcomes for women from diverse backgrounds and monitor this closely and share learning from this.

There has been a trial with an Interpreter on wheels that the Culture Midwife has been ensuring it is used across Maternity and the feedback from both patients and staff has been

phenomenal. A member of staff said that one of the patient she used it for was quite emotional and very thankful that she was able to be heard and understood through using the Interpreter on wheels as it served an immediate response to her needs.

Other objectives of this role going forward is to have an awareness and be part of the local neighbourhood team`s agenda, educate staff around the diversity of concerns and how to refer appropriate support agencies as necessary, be focused and develop services within the Ethnically diverse Communities and providing and leading service provision within an MDT approach.

Equality, Diversity & Inclusion at LWH achievements during 2021 included Membership of Inclusive Companies for professional support on EDI and to share and learn from other organisations (public and private) who have positive initiatives and experiences for staff from protected characteristics.
Entered the Inclusive companies IT50 (inclusive top 50) and placed 41st with positive feedback and recommendations on how we can improve on this position moving forward. Recruited to two further new roles in 2021/22 within the Trust with key focus on EDI and patient, these are Equality, Diversity and Inclusion Lead and Head of Culture and Staff Experience

9.1 Complaints 21/22

Complaints are a valuable source of information on the quality of service the Trust is providing. The trust regularly reviews the factors that may lead to complaints, what can be done to address these factors, and whether the Trust's response to complaints can be deemed to be both appropriate and sufficient. Making a complaint is never easy and it is important that there is an effective and sympathetic process for dealing with complaints. Those who complain should feel that they have been listened to and that learning has taken place. The Trust continues to work hard to ensure that its complaint process is personal and responds to the needs of the individual to ensure that their experience is listened to and put right simply and quickly. This philosophy aligns with the Health Service Ombudsman's Principles of Good Complaints Handling which promotes a customer focused complaints system.

The key findings in 2021-22 were:-

- There were 54 complaints received which shows a slight increase from the 48 the previous year as services have started to reopen.
- The primary issue in the majority of complaints related to Clinical Treatment. Individual instances of these were noted a total of 132 times in the 54 complaints received.

- The amount of Heads of Complaint (HOC) per complaint received rose from an average of 5.3 HOC per complaint in 2020/21 to 6.8 HOC per complaint which shows the concerns being raised cover a wider range of issues.
- 58 complaints were resolved in the last year which includes complaints received in 2020/21. This is an increase from 43 the previous year.
- Of the 58 complaints closed 8 complaints have been upheld, 9 complaints have not been upheld and 39 complaints have been partially upheld. 2 complaints were withdrawn.

9.2 Complaint Levels

The Trust received 54 complaints in 2021-22, which is higher from the previous year figure of 48.

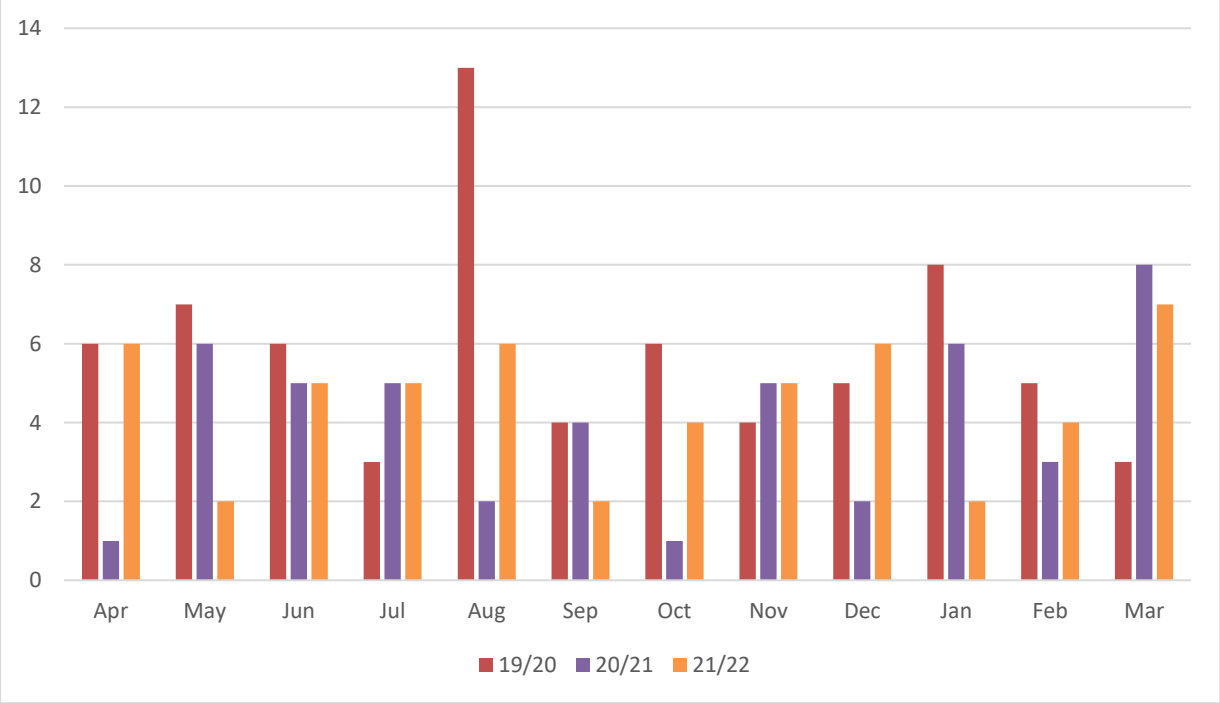


Figure 1: LWHFT Complaints comparison by month

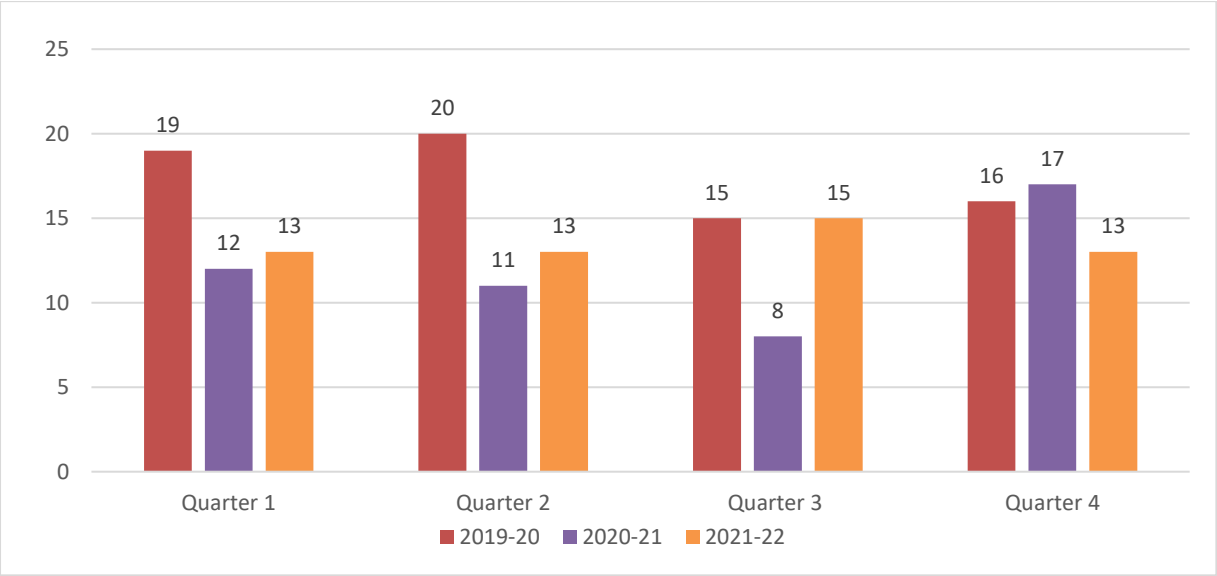


Figure 2: LWHFT Complaints by Quarter, yearly comparison

9.3 Lessons Learnt

Repairing relationships is the primary focus of complaint handling. An investigation is concerned with establishing the facts in order to reach a judgment in the matter of complaint and organisational learning is a by-product of the activity. The trust is committed to implementing the learning and recommendations from every complaint where improvements have been identified and recommended.

During 2021 - 22 some examples of the lessons learnt and the actions taken are:

Issue identified/ Lesson Learnt by Investigation	Action Details
Physio appointment cancelled in error as staff member was unsure of referral process	A standard operating procedure (SOP) compiled to instruct staff how to make a direct referral to another healthcare provider.
Patient unclear on procedure undertaken and description in consent	Gynaecology & Fertility Division reviewed the Consent Process to ensure procedure specific consent forms are in place to avoid any confusion

Falls assessment not reassessed weekly and no falls reassessment following fall.	Ward Managers now ensure that falls assessments are repeated weekly on patients and in the event of any change in the patients ability or they fall, documentation in care notes supports nursing interventions to reduce further risk.
A copy of the letter from theatre should have also been sent to the Hewitt for information.	This issue was raised with the theatres department to ensure there is a process in place that this occurs routinely.
Incorrect use of ERA test results	Whilst the departmental Standard Operating Procedure MED- SOP-80 was clear that the ERA test should not be carried out for use in a fresh cycle, this has now been updated and is even more explicit with regards the recommendations for use of the ERA test
Delay in surgical diagnosis in pregnancy	A formal review of care was carried out and that learning is shared amongst medical and midwifery staff. This case has been presented at the Liverpool Women's Hospital multi-disciplinary morbidity meeting to highlight the way in which the patient presented and opportunities for earlier diagnosis. Lesson of the week shared prior to formal review.
Epidural not checked	Inspection of Epidural catheter is added to the Trust Guardian system, as a reminder to staff to inspect the Epidural site.
Lack of information given to patient on discharge	Discharge videos to be created for patients to watch prior to discharge and available on LWH intranet.
There was a delay of at least a week in diagnosing non-continuing pregnancy or miscarriage	MDT review undertaken to reflect on what could have been done differently to improve this (or other similar) experience.
There were delays and communication issues with the lab regarding the cytogenetics and karyotype testing.	A clearer SOP agreed with the cytogenetic lab about the processes for requesting, carrying out and reporting of respective tests.

Patient unaware that trainee would be present or involved in her Novasure procedure - nor did she agree to it. Trainee did not complete introductions prior to procedure.	It is good practice for trainees to introduce themselves to patients prior to being involved with their surgery albeit under consultant supervision. Discussion with all trainees undertaken to highlight this issue.

9.4 Friends and Family Test (FFT)

The Friends and Family Test (FFT) is a survey which asks patients, amongst other things whether they would recommend the NHS service they have received to friends and family who need similar treatment or care. The national FFT and family data can be found at: https://www.england.nhs.uk/fft/friends-and-family-test-data/

LWH contacts patients who have received care or attended appointment via text message to ask them to complete the online survey. The survey is also available to complete via the LWH website at any time.

The overall results in 2021/22 showed:

Recommendation score - this score is based on the responses to the question "Thinking about the service we provided, overall, how was your experience of our service?"	92.28%
Overall experience score (satisfaction report) – this score is based on the responses to the question "Please rate your overall experience (Poor=1 to Good=10)"	89.92%
Total number of responses	11029
Total Number of responses with free text comments	10963

The FFT ask patients some equality monitoring questions to enable us to monitor if any of these characteristics are having a detrimental impact on their experience by comparing both overall experience and recommendation scores. These are reviewed under 3 categories:

- Age
- Ethnicity
- Disability

All information collected in from the FFT is made available daily via Power BI. This contains full details of all the positive and negative comments from the respondents along with suggestions for improvements they would like to see. There is an ability by divisional and departmental leaders to record in Power BI the actions they have taken in response to the individual comments left

9.5 Staff Survey Results

The 2021 National Staff Survey was conducted from October to November 2021, with the results being published nationally in March 2021. The survey period coincided with a major incident at Liverpool Women's Hospital, and whilst a short extension was granted, it is possible that this might have had an effect of some of the results.

Overall Theme Scores

In analysing the results, the areas where there has been a statistically significant change (+/- 5%) have been focused on.

There were 22 questions where there was a statistically significant decline in the score and 6 questions where there had been a statistically significant improvement in the score.

Our overall '**staff engagement'** score has reduced from **7.1** in 2020 to **6.9** in 2021, following a pattern of gradual increase over the previous years.

Responses for other questions remained comparable to with the 2020 results.

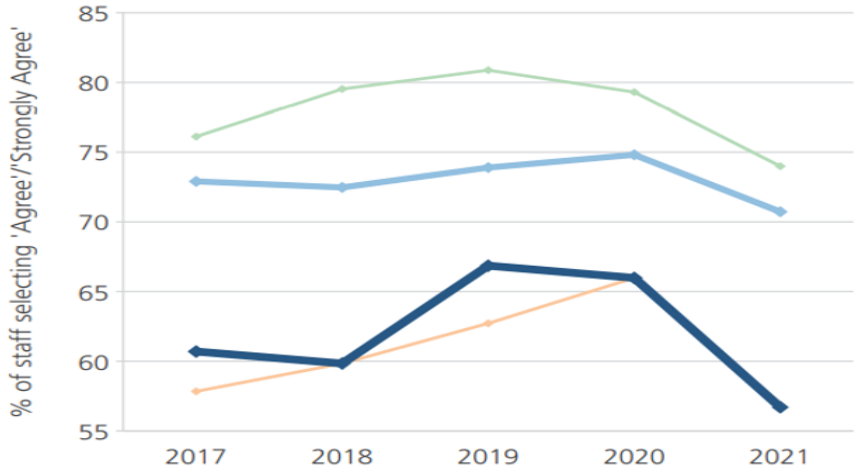
As the questions have been grouped under the People Promise themes for the first time in 2021, direct comparison with the theme scores in 2020 is not possible. It is however, evident that LWH scores below the average score (for the 13 comparator Trusts) across all 9 themes.

The national picture has reported a decline in many of the scores from questions with some being at their lowers in the past 5 years. The national average response rate was 48% and the graph below demonstrates the national responses over the past 5 years.

Liverpool Women's Hospital have in previous years paid particular attention to the questions '*would you recommend the organisation as a place to work'* and '*if a friend or relative needed treatment, would you be happy with the standard of care in this organisation'*.

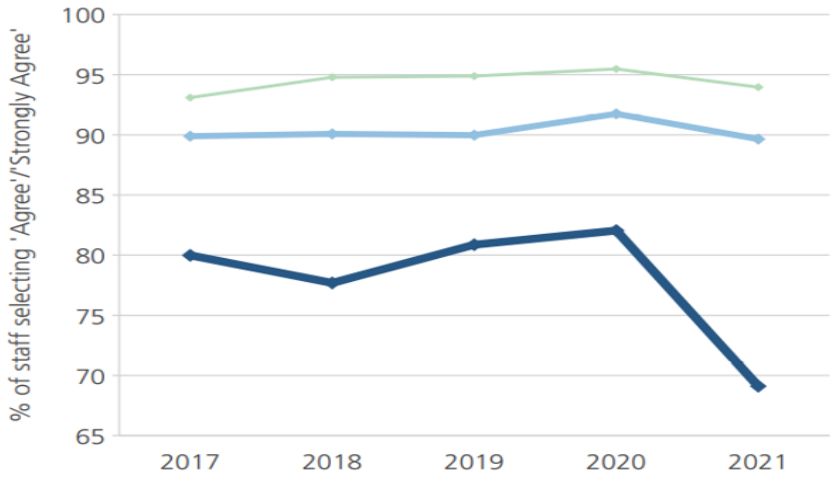
By their nature, these questions are a good barometer of how employees feel about Liverpool Women's as a whole. These questions, along with questions relating to morale, job satisfaction and employee voice, are combined to create the overall 'Staff Engagement Score'. Both these questions have seen a statistically significant decrease in positive scores, and we are the lowest scoring specialist Trust in both categories.

Q21c) I would recommend my organisation as a place to work



	2017	2018	2019	2020	2021
Best	76.1%	79.5%	80.9%	79.3%	74.0%
Your org	60.7%	59.8%	66.9%	66.0%	56.7%
Average	72.9%	72.5%	73.9%	74.8%	70.7%
Worst	57.8%	59.8%	62.7%	66.0%	56.7%
Responses	863	866	820	790	778

Q21d) If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation



	2017	2018	2019	2020	2021
Best	93.1%	94.8%	94.9%	95.5%	94.0%
Your org	80.0%	77.7%	80.9%	82.0%	69.1%
Average	89.9%	90.1%	90.0%	91.7%	89.6%
Worst	80.0%	77.7%	80.9%	82.0%	69.1%
Responses	864	861	820	793	777

9.6 Duty of Candour

20/21 was completed last year. 21/22 and 22/23 will be rolled in to 1 audit which will be completed during this year.

9.7 Trusts Responsiveness to Personal Needs of Patients

Despite the restrictions brought about by the pandemic and the subsequent pressures on available resources, the service and experience the Trust provides in both gynaecology and maternity, to those with additional needs continues to reflect its aspiration to provide equality of access and the highest quality of care.

In the most recent audit, covering 2021/22 the following were evidenced:

- The arrangements in place to identify and flag patients with learning disabilities, autism and or dementia from the point of admission through to discharge were effective.

- Reasonable adjustments to care pathways were made to ensure patients were able to access highly personalised care and achieve equality of outcomes.

- Those providing care had the specialist knowledge and skills to meet the unique needs of people with learning disabilities, autism and or dementia.

- The experiences of those included in the audit were equal to the Trust Friends and Family Test (FFT) scores for patients without a learning disability, autism or dementia

Moving forward, this year has also seen the Trust ratify the Supporting Patients with Additional Needs Strategy.

This strategy sets out a three-year strategic plan detailing how we will respond to the profile of our local population and work with our patients, carers, staff, and partners to deliver high quality, person-centred care for people with additional needs and their carers/families.

It sets out the journey we will take over the next three years to ensure we continue to improve patient outcomes; patient experience and partnership working and describes our intention to:

- Respect and promote the rights of those with additional needs

- Enable staff to develop a better understanding of people with additional needs; including those with dementia, learning and or physical disabilities and autism and to equip them to deal more effectively with the needs of the individual.

- Improve the health and wellbeing of people with additional needs who access the Trust, working in partnership with people with additional needs, their families, carers and the local community.

Whilst the Trust is committed to promoting equality and non-discriminatory, this strategy focuses on how we will continue to promote the rights of those with additional needs that meet the definition of having a disability as described in the Equality Act 2010.

These include but are not restricted to those with a learning disability, autism, dementia, mental illness and or a physical disability.

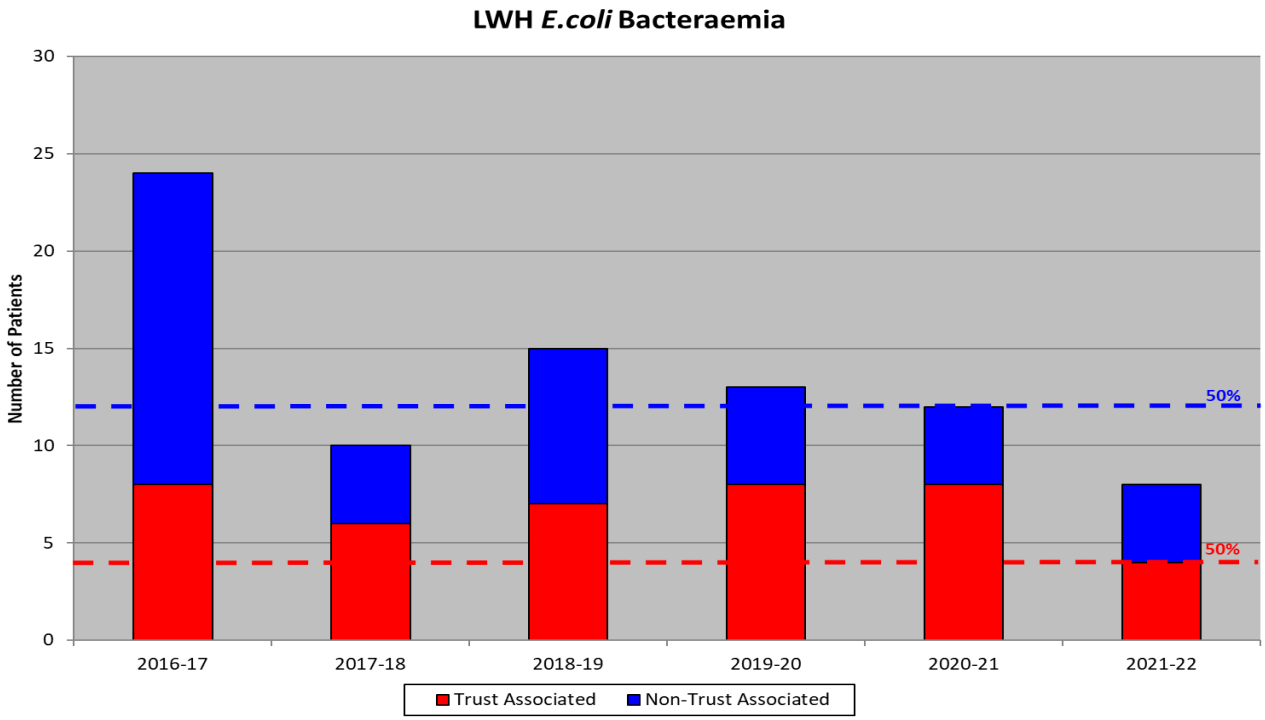
9.8 Infection, Prevention and Control

Trusts are required under the NHS Standard Contract to minimise rates of both C. difficile and of Gram-negative bloodstream infections so that they are no higher than the threshold levels set by NHS England and Improvement. A focus across ICSs on reducing infection levels is important as actions to reduce the risk of infections and to support early diagnosis and appropriate treatment will have beneficial effects for both patient outcomes and service demand.

All Trusts are asked to record the rate of Trust apportioned C.difficile per 100,000 bed days. LWH Trust trajectory is 0 which the Trust has maintained since 2017.

Organism	Target/Trajectory	April 2019 - March 2020	April 2020 - March 2021	April 2021 - March 2022
***Clostridioides difficile* infection (CDI)**	0	0	0	0

There is a national ambition to reduce Gram-negative bacteraemia (particularly *E.* coli) by 50%. Although this is not a specific Trust target the IPCT have been working with regional groups facilitated by the CCG to reduce *E. coli* sepsis. Both the total number of *E. coli* bacteraemia's and those categorised as Trust associated (defined by time from admission) are reduced this year.



COVID-19
The Trust reported 0 staff outbreaks of Covid-19 infection in 2021 -22
There have been no patient COVID-19 infection outbreaks in 2021-22

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.

Liverpool Clinical Commissioning Group is leading on the response this year

NHS Liverpool Clinical Commissioning Group
NHS Knowsley Clinical Commissioning Group
NHS Sefton Clinical Commissioning Group
NHS Southport and Formby Clinical Commissioning Group
NHS Halton and Warrington Clinical Commissioning Group
NHS St Helens Clinical Commissioning Group
NHS England and Improvement Specialised Commissioning

Quality Account Statement 2021-22
Liverpool Women's Hospital NHS Foundation Trust

NHS Liverpool, Sefton, Southport & Formby, Knowsley, Halton and Warrington and St Helens CCG's along with NHSE/I Specialist Commissioning welcome the opportunity to jointly comment on the Liverpool Women's Hospital Foundation Trust Draft Quality Account for 2021-22. It is acknowledged that the submission to Commissioners was draft and that some parts of the document require updating. Commissioners look forward to receiving the Trusts final version of the Quality Account.

Trust has continued in 2021/22 to manage the challenges posed due to the ongoing COVID-19 pandemic. We would like to take this opportunity to thank the Trust and its staff for the work it has undertaken through the different waves of the pandemic to adapt and deliver care and for their support in providing mutual aid to support the wider system and by supporting the COVID vaccination program.

We have worked closely with the Trust throughout 2020-21 to gain assurances that the services they delivered were safe, effective, and personalised to service users. The CCGs share the fundamental aims of the Trust and support their strategy to deliver high quality, harm free care. The account reflects good progress on most indicators.

This account indicates the Trust's commitment to improving the quality of the services it provides and supports the key priorities for improvement of quality during 2021/22. Commissioners note the priorities and for 2020/21 were:

1: Reduce avoidable harm
2: Achieve the best clinical outcomes
3: Provide the best Patient Experience

This is a comprehensive report that clearly demonstrates progress within the Trust. It identifies where the organisation has done well, where further improvement is required and what actions are needed to achieve these goals, in line with the Trust Clinical and Quality Strategy Aims and Priorities for 2020-2025.

Through this Quality Account and on-going quality assurance process the Trust clearly

demonstrates their commitment to improving the quality of care and services delivered.

The Trust places significant emphasis on its safety agenda; demonstrating commitment to continuous evidence based quality improvement and promotion of a fair and just culture with a commitment to increase its Fair and Just Leaders and implement a program of human factors training. This is reflected in the ongoing work that the Trust has undertaken towards the Ockenden Report requirements for which the Trust have collated the available evidence and assessed itself against the urgent clinical priorities identified and reported to NHSE/I as required. The publication of the final Ockenden report in March 2022 includes extensive published actions that require a detailed response from all Divisions within the Trust, inclusive of Neonatal, Governance, Maternity, Anaesthesia, Operational and Clinical Support Services. The Trust has set out its approach in its strategic and operational response to the Final Report and the 15 essential actions. The Trust acknowledges that this will be an ongoing journey which will require working with and engaging with staff, women, families, and partner organisations to make sure that they achieve and deliver on the essential actions in full. The Trust will do this through collaboration, learning and most importantly by listening to the women and families they care for.

The work that the Trust has undertaken to improve outcomes in 2021/22 on the following work streams is of particular note.

- The Trust invested in 2021/22 in a Robotic Surgery Programme for Gynaecology. LWH are the only dedicated Women's Trust in the UK with a Robotic Gynaecology Programme.
- The neonatal unit introduced Europe's first neonatal telemedicine service. This allowed Neonatologists and specialists to be at the cot side of any baby cared for within the neonatal partnership within 5 minutes. This service has been recognised nationally and internationally. The system is now being used by the maternity teams to attend pregnant women being cared for in intensive care units in other hospitals
- The Fetal Medicine Unit has moved its estate and expanded its service during 2021/22. The Fetal Medicine unit now provides a Twin-to-Twin laser service and has treated four cases, and this will further increase throughout 2022/23.
- Recruitment of a new Patient Experience Matron & Culture Midwife
- The Trust have secured funding for the creation of a Community Diagnostic Centre (CDC). CDC will see a permanent CT, MRI and a wide range of diagnostic activity accessible to all patients across the city as well as giving Liverpool Women's patients access to timely and more convenient diagnosis in emergency situations.

The CCGs acknowledge the Trust's work with commissioners and the continued involvement of patients and carers in developing options for the future, based on strong clinical evidence and the most rigorous standards of quality. Commissioners would like the Trust to continue to demonstrate a focus on clinical sustainability and safety as a stand-alone site through the implementation of the new Clinical and Quality Strategy.

Commissioners are aspiring through strategic objectives and five year plans to develop an NHS that delivers great 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 stretchingambitions 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 forour 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 thecurrent issues across the health economy. The priorities being:

Priority 1 - Create a fair and just culture. Deliver comprehensive Human Factors training

Priority 2 - Adopt relevant tested interventions. Deliver national targets in context of COVID-19 recovery.

Priority 3 - Create a Culture of safety. Deliver outstanding medicines safety, maternity, andneonatal safety

We therefore commend the Trust in taking account of opportunities to further improve thedelivery of excellent, compassionate, and safe care for every patient, every time.

Jane Lunt Chief Nurse
NHS Liverpool CCG

Signed on behalf of the Chief Nurses for NHS Liverpool, South Sefton, Southport & Formby andKnowsley Halton and Warrington and St Helens CCG's

Healthwatch Liverpool

Liverpool Women's Hospital Quality Account 2021-2022 commentary

Healthwatch Liverpool welcomes the opportunity to comment on this 2021-22 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 continuing Covid-19 pandemic our usual Listening Event at the Trust could not take place again during 2021-22.

The document highlights both positive steps and some of the issues that the Trust has had to deal with in the past year. Although the Covid-19 pandemic appears to have been managed with no patient or staff outbreaks reported, existing pressures on staffing levels were exacerbated by sickness absence, and backlogs in treatment continued to grow (as they did across the NHS). Regrettably - but perhaps inevitably - the number of patients waiting for treatment for more than a year increased, and although the 2-week target for cancer referrals was nearly met, further cancer waiting times were not. We are aware that this is linked to wider NHS pressures, but also know of the impact these delays can have on patients. However, we realise that this is something that the Trust cannot resolve on its own.
In addition to Covid pressures, the terror-related incident in November 2021 had a temporary impact on services, but may have had a longer lasting impact on the staff's and patients' sense of safety and security.

However, the Quality Account also describes welcome developments such as the robotic surgery programme introduced in gynaecology, with its initial findings that this has resulted in improved outcomes for patients. We were also pleased to learn about other innovative ways of working, for example the development of the neonatal telemedicine service.
The Crown Street Enhancement programme is another positive step forward; having more diagnostic services on site will not only benefit patients cared for by the Trust, but many other patients locally.

Instead of annual quality priorities the Trust has continued to focus on its 3 aims for 2020-2025: zero stillbirths, zero maternal deaths, and zero never events. We welcome that the Trust has continued to have zero maternal deaths.

We were pleased to see the appointment of a Cultural Liaison Midwife, especially in light of the MBRRACE report. We also welcome the appointment of a Patient Experience Matron as an additional measure to ensure that patients' voices are heard at all levels of the Trust.

It was positive to note the reassurance that the Trust received from the Regional Chief Midwife Team and Mersey Local Maternity System representatives about the Trust's response to the 2020 interim Ockenden report. The final Ockenden report was published at the end of March 2022 and included further recommendations relevant to all maternity services. We know that the

Trust will be looking to implement changes as a result of the recommendations where necessary, and we look forward to learn more about this in due course.

We have had regular and constructive engagement with the Trust this year, and we aim to recommence our face-to-face engagement with patients and visitors at the Trust during 2022-23. We look forward to our ongoing work with Liverpool Women's Hospital, 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.

Commentary from Local Authority Overview & Scrutiny Committees (OSCs)

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.

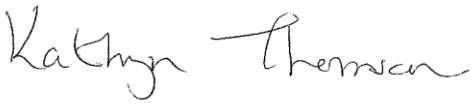
In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets NHS England's Quality Accounts requirements 2021/22
- 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 2021 to May 2022
  - papers relating to quality reported to the Board over the period April 2021 to May 2022
  - feedback from commissioners dated 24 June 2022
  - feedback from local Healthwatch organisations dated 14 June 2022
  - the national staff survey May 2021
  - the Head of Internal Audit's annual opinion of the trust's control environment dated 16 June 2022
  - CQC inspection report dated 22 April 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 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
20 June 2022

Kathryn Thomson
Chief Executive
20 June 2022

Annex 3: 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.