

Quality Account 2009/10  
June 2010





Liverpool Women's



# Contents

## 04

Introduction: Our Commitment to Quality

## 05

Statement on Quality from the Chief Executive

## 06

Priorities for Improvement

Looking Back 2009/10

Priority 1 - To investigate, monitor and reduce infection rates within Neonatology and Gynaecology

Priority 2 - To influence the national picture on delivery suite staffing levels for midwives and obstetricians

Priority 3 - To focus on staff attitude and behaviour in order to deliver improved patient experience and staff satisfaction

## 08

Additional Quality Indicators

## 10

Priorities for 2010/11

Looking Forward

1. To investigate, monitor and reduce infection rates
2. To investigate, monitor and reduce mortality rates
3. To monitor and improve patient experience

## 11

Performance against key national priorities and National Core Standards

## 12

Statement of assurance from the Board of Directors

- Review of services
- Participation in Clinical Audits
- Research & Development
- Information on the use of CQUIN
- Information relating to registration with the CQC and periodic special reviews statement
- Data Quality
- Clinical Coding Audit 2009/10

## 15

Commentary by Our Stakeholders

# Introduction: Our Commitment to Quality

At Liverpool Women's NHS Foundation Trust we are passionate about the services we provide. Our aim is to provide the highest standards of care possible for women, babies and their families. In order to achieve this we place quality and continuous quality improvement at the heart of everything we do.

## **We are therefore committed to:**

- **Improving safety and eliminating avoidable harm for both patients and staff**
- **Improving clinical effectiveness and outcomes for our patients**
- **Providing the best possible experience for our patients**
- **Making the most of our resources.**

This quality account describes how we will monitor and continuously improve patient safety, clinical effectiveness and patient experience.

As an organisation, we have a history of achieving and our aim is to build on these strong foundations and to provide care which is recognised as being 'excellent' - locally, nationally and internationally.

In order to do this, we need to know how good our care is, whether the quality of our care is getting better and we need to be able to compare ourselves to others.

## **To achieve this we will:**

- Set specific aims to deliver quality improvement and oversee their achievement at the highest levels within the organisation i.e. by the Board of Directors and the Council of Governors
- Expand our patient and public engagement programme to inform service developments and shape improvements
- Deliver care which reflects best clinical practice and, where we can, measure the outcomes of care to inform improvement activities
- Create a motivational and open learning climate where excellence in clinical care will flourish and where audit, research and development activities are encouraged
- Build improvement capability of the organisation to deliver quality care
- Ensure that all staff understand the contribution that they make (both individually and collectively) to delivering quality and building incentives into our management systems to expect, recognise and reward outstanding individual and team performance.

# Statement on Quality from the Chief Executive

Liverpool Women's NHS Foundation Trust has a well-earned reputation as a centre of excellence at a local, regional and national level. As an NHS organisation that has been awarded and retained NHSLA and CNST level 3 – the highest possible ratings for clinical risk management – Liverpool Women's can demonstrate that it is among the safest hospitals in the country. Our challenge however is to find more ways in which we can prove to our patients and the public that this is consistently true, each and every day. During 2009/10 the Trust made a commitment to a range of national programmes aimed at keeping patient safety at the heart of everything we do and we are in the process of rolling these out across our organisation.

Here at Liverpool Women's the concept of reporting to patients and the public on the quality of our services is not new. The Trust has been publishing a Clinical Annual Report since 2003, a testimony to the commitment of our clinicians to shared learning and continual service improvement. Our reports have developed over time and last year we presented information framed around safety, clinical effectiveness and

the patient experience and this has formed the cornerstone of the quality report that follows. As Chief Executive I am confident therefore that the information set out here is accurate and a reasonable reflection of the key issues and priorities that clinical staff have themselves developed over time.

Clear direction from the Board to champion the quality agenda is important, however a quality-driven culture cannot be developed without effective leadership at all levels in the organisation and this is a goal that we continue to pursue.

*Kathryn Thomson*

**Kathryn Thomson**  
**Chief Executive**



# Priorities for improvement

## Looking Back 2009/10

In its Annual Report for 2008/09 the Trust identified three quality improvement priorities for 2009/10 as follows:

1. To investigate, monitor and reduce infection rates within Neonatology and Gynaecology
2. To influence the national picture on delivery suite staffing levels for both midwives and obstetricians
3. To focus on staff attitude and behaviour in order to deliver improved patient experience and staff satisfaction.

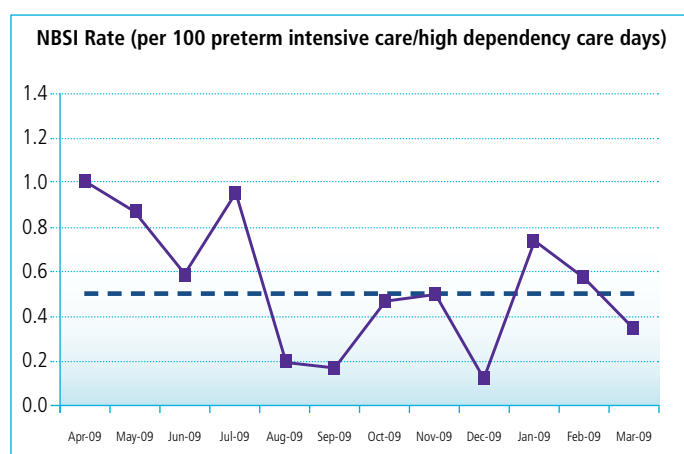
### Priority 1 - to investigate, monitor and reduce infection rates within Neonatology and Gynaecology

#### MRSA and C Difficile

In 2009/10, the Trust had two cases of MRSA bacteraemia and one case of C Difficile, both below the Care Quality Commission targets of three and eight respectively.

#### Infection rates in newborn babies

Late-onset neonatal bloodstream infections (NBSI) in preterm babies (less than 32 weeks gestation and/or less than 1500g birth weight) occurring after three days of age, are one of the commonest complications of premature birth and are an important cause of preterm illness, morbidity and mortality. They are also the major contributor to hospital-acquired infections in this population. It was decided last year that the rate of this particular type of infection would be a good marker of the overall risk of infection on the Neonatal Unit. We set our target at less than 1 episode of infection per 200 days each of our very preterm babies spends on the Neonatal Unit (0.5/100). This target may be revised when appropriate national benchmarks are agreed.



The above graph shows that the rate of NBSI varied between 0.1 and 1.0 in 2009/10. We have implemented the following actions in 2009/10:

- Infection update sessions were held as part of nurse protected teaching
- The Infection Quality Project was developed and funding secured for a lead nurse
- Development of the '3 Steps' initiative designed to improve infection control practice at the cot-side.

Our challenge is to keep the rate of NBSI below the target consistently throughout 2010/11.

#### Post-operative infections in gynaecology

Our "infection rate" (0.2%) in post-operative gynaecological patients is lower than the national standard of four per thousand operations (0.4%) published by CHKS, a nationally recognised organisation which compares the data from similar groups of patients and hospitals.

The Trust has implemented the following initiatives:

- A prospective wound infection surveillance programme to ascertain objective infection rates for the Trust to allow meaningful comparisons.
- The implementation of Root Cause Analysis (RCA) for all cases of MRSA, C Difficile and all non-Coagulase negative staphylococcus (CoNs) infections which is a common bacteria on the skin of premature babies.

Looking forward to 2010/11, trends in late onset NBSI, surgical wound infection and hospital acquired infection will remain as key safety quality indicators for the Trust.

### Priority 2 – To influence the national picture on delivery suite staffing levels for midwives and obstetricians

The Royal College of Obstetricians and Gynaecologists (RCOG) and the Royal College of Midwives (RCM) recommended in the 'Safer Childbirth' report that there should be 168 hours of consultant cover and one to one midwifery care for delivery suites that deliver more than 6000 babies per year such as at Liverpool Women's. The scientific evidence to support this proposal (in terms of improved clinical outcomes) remains inconclusive. There was no cost benefit analysis in the report to justify the implementation of such a costly change in workforce provision. However, the cost of litigation cases relating to obstetric services is responsible for around 60% of the NHS total. We have estimated the true cost of obstetric damages nationally to be in the region of £850m per annum for the last four years. The cash costs are met by an annual insurance payment from each trust into a Department of Health 'pooling' arrangement administered by the NHS Litigation Authority. In its Annual Report for 2008/09 the Authority suggested that the NHS is not good at investing funds 'up front' in relation to patient safety in order to generate savings to the service in terms of reduced negligence claims – money that could be spent elsewhere. It is important therefore to consider carefully the possible impact of delivery suite staffing on litigation costs to the NHS.

#### Current status

In 2008/09 Liverpool PCT provided the Trust with funding to enhance consultant obstetric cover to 98 hours per week; this model was implemented in October 2009 but remains short of the ideal described above. During the year the Trust has provided a number of briefings on this subject, including to the Secretary of State for Health, in order to raise the profile of the issue and its consequences for patient safety.

Looking forward to 2010/11, the Trust will continue to influence the national picture on delivery suite staffing levels for both midwives and obstetricians.

### Priority 3 – To focus on staff attitude and behaviour in order to deliver improved patient experience and staff satisfaction

Achieving our vision of being the recognised leader for women's healthcare will only happen with the continuous commitment and dedication of our staff.

Positive staff attitude and whether they would recommend their organisation as a good place to work links directly to improved patient experience and clinical outcomes. The focus on standards of behaviour and attitude at work is part of our way of making sure our patients and their families have the best possible experience.

Outcomes from the national staff survey showed that positive staff attitude and overall staff satisfaction need to be improved to deliver better patient experience and clinical outcomes.

A number of actions have been taken to deliver improved levels of positive staff attitude and satisfaction:

- Introduction of the Executive team 'visibility programme' whereby directors spend time in clinical areas and corporate departments across the Trust each month
- Development and delivery of a values based customer care programme for all staff called 'Step it Up' which 87 managers and 259 staff have attended to date
- Introduction of a Reflective Practice Programme for consultants and managers: currently 24 participants are involved in this programme which will be evaluated 2010/11 and may be rolled out further, based on the results of that evaluation
- An increased focus on leadership development including active involvement in the:
  - North West Leadership Academy - with staff involved in Chief Executive, Executive stretch, Aspiring Directors and Clinical leadership programmes

- Leading Improvement in Patient Safety (LIPS) programme
- Delivery of an introductory leadership development programme Leading an Empowered Organisation (LEO) which 239 staff have now attended
- Leadership modules for 85 nurses and midwives as part of their multi-professional education and training (MPET) allocations
- Other leadership development programmes for 67 other staff
- Delivery of "Workplace Coaching for Managers" programme in which 19 managers have been involved.

The Trust has begun a process to identify value based behaviours and equip staff with the skills and ability to both show and challenge others who don't show these behaviours.

The above interventions will continue throughout 2010/11 with a focus on delivery of organisational development interventions to show improvement in the staff survey results on the following:

- improve both **quality and quantity** of **Performance Development Reviews (PDR)**
- develop an **engagement** model linking patient experience directly throughout all formal and informal communication and development programmes
- ensure leadership development is directly linked to **leading improvements in patient safety** and continuous improvement of services
- pilot ways of **developing high performing teams**, evaluate this and roll out from the results of that evaluation
- work with staff to agree **value based behaviours** that will deliver high quality outcomes for patients and their families
- targeted **line management development** in key skills to support staff effectively, lead improvement and meet the financial challenges of the years ahead
- support staff in developing **skills, experience and confidence in challenging negative behaviours**, to get positive results from holding difficult conversations with colleagues and patients.

# Additional Quality Indicators

In addition to our three main priorities, we have monitored a series of quality indicators across the domains of Safety, Clinical Effectiveness and Patient Experience as outlined in our Quality Report 2008/09. These are:

## Patient Safety

- Low umbilical cord pH – less than 7.00
- Miscarriage following amniocentesis
- Twin live birth rates for all assisted conception treatments
- Medication errors across the Trust

## Clinical Effectiveness

- Transfer to Intensive Therapy Unit (ITU) per 1000 maternities
- Stillbirth rate of Trust booked maternities
- Readmission rates to gynaecology
- Haemorrhage and haematoma (blood loss and blood clots) following Gynaecological surgery
- Outcome of In Vitro Fertilisation (IVF) and Intra Cytoplasmic Sperm Injection (ICSI) treatment
- Neonatal mortality rate

## Patient Experience

- Rate of epidural for pain relief in labour
- In-patient Survey in Gynaecology

## Patient Safety

### Low umbilical cord pH – less than 7.00

Cord pH is a proxy measure of a baby's condition immediately after birth; the expectation is that healthy babies who coped with labour well would have a cord pH of more than 7.2. A very low cord pH of less than 7.00 is regarded as clinically significant. The Trust's rate of cord pH below 7.00 was 3.8 in every 1000 maternities in 2008 and 4.05 in 2009. There are as yet no agreed national benchmarks.

Looking forward to 2010/11, data on this quality indicator will continue to be collected and will be complemented with the incidence of low Apgar scores (of less than 4), in live babies born after 34 weeks gestation and low heart rate (less than 100) in babies born before 34 weeks gestation.

### Miscarriage following amniocentesis

Amniocentesis is an antenatal invasive procedure that takes place after 15 weeks gestation. It involves taking a sample of the amniotic fluid which surrounds the baby. Assessment of a baby's genes to exclude conditions such as Down's Syndrome is the common indication for this procedure. The overall miscarriage rate following amniocentesis at the Trust was 0.7% in 2008 and 0.77% in 2009 (2 out of 299 and 261 procedures respectively). The RCOG quotes a procedure related miscarriage risk rate of 0.5% to 1%.

Looking forward to 2010/11, this quality indicator will be improved with the introduction of individual performance indicators for the consultants trained to perform these procedures.

### Twin live birth rates for all assisted conception treatments

The incidence of antenatal complications and newborn illnesses associated with multiple pregnancies has led to Human Fertilisation and Embryology Authority (HFEA) guidance which advocates single embryo transfer.

The introduction of single embryo transfer for all women under 35 was implemented at the Trust in April 2009. More than one embryo can be replaced for women over 35, with a history of failed IVF, with poor quality embryos and also as patient choice. The HFEA target for multiple pregnancy rates is 25%, aiming for 20% in 2010/11. The Trust's multiple pregnancy rate for 2009 was 18.9%, already below next year's target.

The challenge for the Unit is to maintain these results without compromising the overall success of treatment.

Looking forward to 2010/11, twin live birth rates for assisted conception treatments will remain as a safety quality indicator for the Trust.

## Medication errors across the Trust

Medication errors feature consistently within Adverse Clinical Event (ACE) reports across clinical areas. There were 213 such reports in 2009/10 which is higher than the national average (170) for Acute Trusts reported by National Patient Safety Agency (NPSA). We believe that this higher rate reflects the willingness of our staff to report such incidents, rather than particular safety issues.

Looking forward for 2010/11, the current indicator will continue, as reporting is encouraged and supported. However, we shall focus our attention on a clearer understanding of the multifactorial reasons and circumstances that lead to such events.

## Clinical Effectiveness

### Transfer to ITU per 1000 maternities

In 2008 the ITU transfer rate was 0.5 per 1000 maternities and 0.63 per 1000 during 2009. This compares favourably with Birmingham Women's Hospital, the only other specialist NHS Trust providing maternity services, whose figure was 0.96 in 2007/08.

Performance Indicator	Source of Data	2008 LWH	2009 LWH	Benchmark
Transfer to ITU	Critical care lead midwife database	0.5 per 1000 maternities	0.63 per 1000 maternities	Birmingham Women's Hospital – 0.96 per 1000 maternities

Looking forward to 2010/11, transfer to ITU per 1000 maternities will continue to be used as a clinical effectiveness quality indicator for the Trust.

### Stillbirth rate

In 2008, the stillbirth rate in women who booked at Liverpool Women's was 6.2 per 1000 maternities and 5.5 per 1000 in 2009. Comparable figure from Birmingham Women's Hospital (BWH) is 7.5 for 2007/08.

Performance Indicator	2008 LWH	2009 LWH	Comparable data from BWH from 2007/08
Stillbirth rate from maternities booked at Liverpool Women's	0.62%	0.55%	0.75%

Looking forward to 2010/11, we will continue to monitor stillbirth rates from booked maternities.



## Readmission rates of gynaecological patients

Readmission rates in 2009/10 remained below the national average.

Performance Indicator	Source of Data	2008 LWH	2009 LWH	National Average 2009/10
Readmission rates of gynaecological patients	CHKS (a national clinical benchmarking organisation)	2.9%	2.5%	5.8%

Looking forward to 2010/11, readmission rates to gynaecology will be used as a clinical effectiveness quality indicator for the Trust.

## Haemorrhage and haematoma (blood loss and blood clots) following gynaecological surgery

The Trust performance is comparable with the national average.

Performance Indicator	Source of Data	2008 LWH	2009 LWH	National Average 2009/10
Haemorrhage and Haematoma rate (blood loss and blood clots) following gynaecological surgery	CHKS	0.6%	0.5%	0.5%

Looking forward to 2010/11, Haemorrhage and haematoma (blood loss and blood clots) following Gynaecological surgery will be monitored regularly at Clinical Business Unit level.

## Outcome of In Vitro Fertilisation (IVF) and Intra Cytoplasmic Sperm Injection (ICSI) treatment

HFEA data for pregnancy rates per cycle of treatment are available on an annual basis and benchmarked nationally.

Performance Indicator	LWH 2008 Calendar year	LWH 2009 Calendar year	National Average
Clinical pregnancy rates for treatment by in vitro fertilisation, intra cytoplasmic sperm injection (ICSI) for patients under 35 years per treatment cycle started	31.3%	28.9%	HFEA data Oct 2007-Sept 2008 36.0%

Our data are below the national average, but HFEA national average data include all units providing IVF/ICSI (NHS and Private) treatment. Adherence to national guidance regarding single embryo replacement has been variable. Transferring more than one embryo may improve success rates but also increases the risk of multiple pregnancy.

Looking forward to 2010/11, the outcome of IVF/ ICSI treatment will continue to be an important clinical effectiveness quality indicator for the Trust.

## Neonatal mortality rate

The Trust delivers babies of mothers booked into the hospital as well as those transferred from other centres, either still pregnant, or in the immediate post partum period. The table below looks at the mortality in all babies delivered and then specifically those "booked" at Liverpool Women's.

	2008 LWH		2009 LWH		ONS 2008
	All births	Booked pregnancies	All births	Booked pregnancies	
Neonatal Mortality rate /1000 live births	7.8	5.3	6.3	3.8	3.2

Source of data - Office of National Statistics (ONS)

The crude neonatal mortality data remain higher than the national average. However, they are at the level expected when adjusted for case mix. Also, the overall figures reflect the population we serve, which include high risk women who chose to have their care at the Trust and also the high deprivation scores in the local population.

Looking forward to 2010/11, the neonatal mortality rate will continue as a clinical effectiveness quality indicator for the Trust.

## Patient Experience

- Rate of epidural for pain relief in labour

The present rate is 18.7% and there is a perception this could and should be higher.

Performance Indicator	2008/09 LWH	2009/10 LWH	National Average 2007/08
Epidural rate for pain relief in labours	16.1%	18.7%	22.2%

However, the numbers may reflect patient choice and we shall continue with in-depth analysis of these trends to ensure that this type of analgesia is available at all times to all women who wish to have it.

Looking forward to 2010/11, the rate of epidural pain relief in labour will continue as a Patient Experience quality indicator for the Trust.

## In-patient Survey in Gynaecology

The 2007 and 2008 surveys included questions concerning a wide range of patient experiences ranging from communications with clinical staff to quality of food. The latest results showed the Trust to be better than the national average on 40 questions.

Performance Indicator	2008/09 LWH	2009/10 LWH
CQC In patient survey	<ul style="list-style-type: none"> <li>• Better than national average in 70%</li> <li>• Worse in 8.5%</li> </ul>	<ul style="list-style-type: none"> <li>• Better than national average 50%</li> <li>• Worse in 5%</li> </ul>

Looking forward to 2010/11, the in-patient survey in Gynaecology will continue as a Patient Experience quality indicator for the Trust.

# Priorities for 2010/11

## Looking Forward

In 2010/11 our main priorities will be:

1. To investigate, monitor and reduce infection rates
2. To investigate, monitor and reduce mortality rates
3. To monitor and improve patient experience.

### 1. To investigate, monitor and reduce infection rates

The Trust wishes to concentrate upon infection prevention and control as one of its priorities for 2010/11. This will embrace the main clinical disciplines of Obstetrics (wound infections after caesarean section) Gynaecology (surgical site infection) and Neonatology where late onset neonatal bloodstream infection remains one of our key areas.

MRSA and C Difficile remain national targets. Although the Trust has low infection rates, they will be monitored monthly by specialty and reported to the Clinical Governance Committee.

### 2. To investigate, monitor and reduce mortality rates

The Trust wishes to concentrate on reducing mortality across the spectrum of our care. Maternal mortality is extremely uncommon but has a devastating consequence. Gynaecological mortality is predominantly related to cancer. Perinatal mortality encompassing the aspects of antenatal and neonatal care will be measured and rigorously compared with appropriate national and international standards. The data will be presented and reported regularly to the Clinical Governance Committee.

### 3. To monitor and improve patient experience

The Trust wishes to concentrate on patient experience as this is a key component to our service delivery. Several methods for capturing patient experiences currently exist, however the Trust is keen to develop this further, particularly with respect to obtaining real time information on patient experience.

### Additional Quality Indicators

In addition to our three main priorities, we shall continue to monitor a series of quality indicators across the domains of Safety, Clinical Effectiveness and Patient Experience. These are:

#### Patient Safety

We shall continue to monitor twin live birth rates for assisted conception and medication errors and add three new measures:

- **Incidence of Apgar scores less than 4 in infants born at more than 34 weeks gestation and heart rate scores less than 100 in infants born less than 34 weeks.** The Trust's Clinical Annual Report for 2008 revealed an apparent increase in the incidence of babies born with either low Apgar scores or cord pH. The cord pH may not be available for all births, particularly births which are difficult either from a maternal or fetal perspective. Therefore, we shall focus on Apgar scores for all live births after 34 weeks and a heart rate of less than 100 at 5 minutes for babies born under 34 weeks. We shall endeavour to obtain national and international comparators for these outcomes.
- **Post operative Deep Vein Thrombosis / Pulmonary Embolism.** The prevention of blood clots after hospital admissions is one of the new Commissioning for Quality and Innovation (CQUINS) targets for 2010. Obtaining accurate data from patients who may develop this complication after being discharged presents a challenge for the whole NHS. We shall aim to develop robust monitoring systems to provide accurate data for comparison with similar hospitals.
- **Excessive ovarian response (more than 20 eggs) in an assisted conception cycle.** Ovarian hyper stimulation syndrome can be a life

threatening event. It is associated with an excessive response to the fertility drugs. More than 20 eggs retrieved in a treatment cycle would be considered excessive.

#### Clinical Effectiveness

We shall continue to monitor transfer to ITU per 1000 maternities, readmission rates in Gynaecology and the outcome of IVF and ICSI treatment. In addition we shall introduce three new measures of effectiveness, namely:

- **Blood transfusion rates following vaginal delivery.** Post-partum haemorrhage is a significant cause of maternal morbidity. It is more common following caesarean section (both elective and emergency). Correct management can reduce the effect on maternal health. Estimated blood loss is notoriously unreliable. A more effective surrogate would be blood transfusion following delivery which is recorded and benchmarkable.
- **Brain injury in preterm babies.** Brain injury (neurodisability) is an important adverse outcome for survivors of neonatal intensive care. Long term neurodevelopmental outcome data takes several years to become available and is incomplete as we rely on other organisations (hospitals with paediatric departments) to follow up our patients. The most important determinant of neurodisability in the most vulnerable premature babies is evidence of brain injury on ultrasound examination of the brain. Reporting rates of severe intraventricular haemorrhage (IVH, bleeding within the brain) and periventricular leukomalacia (PVL, injury due to a low blood flow or infection/inflammation affecting the brain) is used as a surrogate measure for monitoring adverse neurodevelopmental outcome.
- **Care indicators for nursing and midwifery.** New care indicators will enable nurses and midwives to audit their practice with a focus on seven key aspects of care which directly impact on clinical effectiveness, patient safety and experience. The Trust will develop the following suite of care indicators:
  - Medicine prescribing and administration
  - Food and nutrition
  - Pressure area care
  - Pain management
  - Falls assessment
  - Patient observations
  - Infection prevention and control.

In addition, the CQUIN care indicators will be developed to complement the above:

- Reduction in hospital acquired pressure ulcers
- End of life, important choices of where to die when the time comes
- Keeping nourished, getting better
- Preventing falls
- Protection from urinary infection.

#### Patient Experience

The development of the Patient Experience and Involvement Strategy will enable engagement with staff, women and their families about their experiences at Liverpool Women's and together develop a plan of action for the future.

We shall continue to monitor the epidural rates in maternity and the in-patient survey in Gynaecology. We shall introduce one additional new measure:

- **Provision of one to one care in established labour.** The National Service Framework for maternity services stipulates that maternity services should develop the capacity for every woman to have a designated midwife to provide care for them when in established labour 100% of the time.

# Performance against key national priorities and National Core Standards

Our performance against national targets has remained strong throughout the year. We have sustained low waiting times for all our patients and ensured that over 96% of our patients have been able to access treatment in less than 18 weeks from referral by their GP. All patients referred to us with suspected cancer follow agreed clinical

pathways and access appropriate treatment quickly. Our infection prevention and control processes are robust and we have only had one baby on our Neonatal unit with MRSA (2 bouts) and one gynaecology patient with clostridium difficile during the year. We have been able to declare compliance with all the *Standards for Better Health*.

Indicator Name	Performance 2008/09	Target 2009/10	Performance 2009/10
<b>Annual Health Check: national priority</b>			
18 week referral to treatment times: admitted (All specialties)*	90.19%	90%	Qtr 1: 92% Qtr 2: 96.23% Qtr 3: 98.01% Qtr 4: 97.49%
18 week referral to treatment times: non-admitted (All specialties)*	95.03%	95%	Qtr 1: 96.3% Qtr 2: 95.71% Qtr 3: 96.51% Qtr 4: 96.11%
18 week referral to treatment times: non-admitted (Gynaecology, Infertility and RMU)*	New for 09/10	95%	Qtr 4: 95.64%
18 week referral to treatment times: non-admitted (Clinical Genetics)*	New for 09/10	95%	Qtr 4: 100%
18 week referral to treatment times: Non-admitted Data completeness	99%	80-120%	96%
18 week referral to treatment times: Admitted Data completeness	99%	80-120%	101%
All Cancers: two week wait.	98.68%	>=93%	95.42%
All Cancers: one month diagnosis to treatment. (1st definitive)	100.00%	>=96%	97.98%
All Cancers: one month diagnosis to treatment (subsequent)	New for 09/10	>=94%	100%
All Cancers: Two month referral to treatment (GP referrals)	97.50%	>=85%	90.95%
All Cancers: Two month referral to treatment (consultant upgrade)	New for 09/10	>=92.40%**	96.25%
All Cancers: Two month referral to treatment (screening referrals)	New for 09/10	>=90%	100%
Engagement in clinical audits	Yes to all	tbc	Annual Survey
Experience of patients	82.455 85.197 79.959 88.563	tbc	Annual Survey
Incidence MRSA bacterium	0	<=4 2	2
Incidence of Clostridium Difficile	1	<=8	1
Infant health and inequalities: Breastfeeding rate	0.72	>=-5%	2.02%
Infant health and inequalities: Smoking rate	-0.54	<=0%	0.56%
Maternity Hospital Episode statistics: data quality indicator	11.028%	<=15%	Method under review
NHS Staff satisfaction	3.471	tbc	Annual Survey
<b>Annual Health Check: existing commitments</b>			
Data quality on ethnic group (April to December)	97.59%	>=85%	97.80%
Delayed transfers of Care	0.00%	<=3.5%	0.00%
Inpatients waiting longer than the 26 week standard	0.027%	<=0.03%	0.00%
Last minute cancellation for non clinical reasons	0.491%	<=0.8%	0.291%
Last minute cancellation for non clinical reasons not readmitted in 28 days	0.00%	<=5%	0.00%
Outpatients waiting longer than the 13 week standard	0.00%	<=0.03%	0.00%
Total time in A&E (% within 4 hours)	99.98%	>=98%	99.98%
<b>Annual Health Check: Core Standards</b>			
Core Standards: Standards for Better Health	2 exceptions	Full compliance	Full compliance

\* Trusts will be assessed on having maintained this performance during each quarter of the assessment year (April 2009 to March 2010) and in each of the treatment functions in the fourth quarter of the year.

\*\* This is the only target not yet agreed by the Department of Health. The Trust continues to reflect the most recent national benchmark available via Open Exeter (for January 2010 this stood at 92.40%)

# Statements of assurance from the Board of Directors

## Information on the review of services

During 2009/10 Liverpool Women's NHS Foundation Trust provided NHS Services in four core specialty areas.

Liverpool Women's has reviewed all the data available to them on the quality of care provided by its Clinical Business Units (CBU) as listed below:

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

Each CBU reports to Clinical Governance Committee which is a sub-committee of the Board of Directors. CBU clinical governance leads report at least five self-selected clinical outcome indicators that are categorised into safety, effectiveness and experience. These indicators are part of the CBU dashboard and form part of the monthly performance and assurance report for the Board of Directors. Some of the CBU indicators are benchmarked with CHKS national data or other relevant speciality organisations. Data collected has influenced the organisation as identified in its improvement initiatives for 2010/11.

The Trust recognises that access to clinical information and clinical audit capacity and function is an issue in terms of ensuring data quality and accuracy. Therefore two new posts have been approved, a Director for Clinical Audit has been appointed and the position of Head of Clinical Audit will be advertised by June 2010. This commitment to quality will enable the Trust to deliver a comprehensive clinical audit strategy that will enable efficient and effective audit and data quality going forward.

The income generated by the NHS services reviewed in 2009/10 represents 100% per cent of the total income generated by the provision of NHS services by the Liverpool Women's NHS Foundation Trust for 2009/10.

## Participation in Clinical Audits

In 2009/10 LWH staff participated in all five national clinical audits (100%):

- National Comparative Audit of Blood Transfusion
- Audit of the use of Red Cells in neonates and Children (20 cases required to be audited, 20 (100%) cases audited)
- CEMACE Obesity Project
- Elective and Emergency Surgery in the Elderly
- National Neonatal Audit Project

and both national confidential enquiries (100%) :

- NCEPOD (National Confidential Enquiry into Patient Outcomes and Death)
- CEMACH (Confidential Enquiry into Maternal and Child Health)

In addition the Trust reported to the following national perinatal epidemiological studies (UKOSS projects):

- H1N1v in Pregnancy
- Extreme Obesity in Pregnancy

In addition, there were 16 local clinical audits in 2009/10. These are summarised below together with the key outcome of each audit.

### Obstetrics and Imaging

- Audit of pregnancy outcomes of the antenatal bariatric clinic and audit of reasons for emergency Caesarean section in multiparous women
  - Take measures to promote vaginal birth after caesarean section
- Audit of Haemoglobinopathy screening
  - Add information in the current guidelines about action to be taken if findings abnormal
- Audit of intermittent fetal heart rate auscultation during labour
  - Training to be provided at annual mandatory training for midwives
- Audit of Group B Strep positive results
  - Ensure a supply of group B Strep positive stickers are available in all areas
- Audit of Health Professionals' Knowledge and Attitudes to Domestic Violence
  - Increase visibility of domestic violence team so that staff feel more supported and aware of whom to speak to if they encounter domestic violence.

### Genetics and Reproductive Medicine

- Audit of Genetics Cancer Referral Form
  - Referral forms to be submitted to Clinical Reference Group for comment in June 2010
- Clinical Genetics Patient Correspondence audit
  - Standardised letters and templates trialled in early 2010
- Genetic Counsellor First Contact audit
  - Research bid submitted to Research for Patient Benefit and INNOVATE North West.

### Gynaecology and Surgical Services

- Audit of Sacrospinous Fixation
  - Complete data to be entered onto the national database
- Audit of Abdominal Vault Support procedures
  - Patient information leaflet to be produced and consent form to include specific risks
- Audit of Thromboprophylaxis for Hysterectomy
  - New procedure for risk assessment developed.

### Neonatology and Pharmacy

- Evaluation of the Effectiveness on Educational Intervention on Aseptic Non Touch Technique Competence
  - Educational Intervention Programme to be developed
- Audit of Morphine Use on Neonatal Unit
  - Teaching session for staff and update on pain guidelines.

## Research & Development

### Commitment to research as a driver for improving the quality of care and patient experience

The number of patients receiving NHS services provided or sub-contracted by Liverpool Women's NHS Foundation Trust in 2009/10 recruited during that period to participate in research approved by a research ethics committee was 3,281 of which 2,050 were recruited to NIHR research studies.

This increasing level of participation in clinical research demonstrates Liverpool Women's NHS Foundation Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our primary focus is through recruitment to studies on the National Institute for Health Research (NIHR) research portfolio. We also lead some research projects and aim to be an effective environment for industry studies.

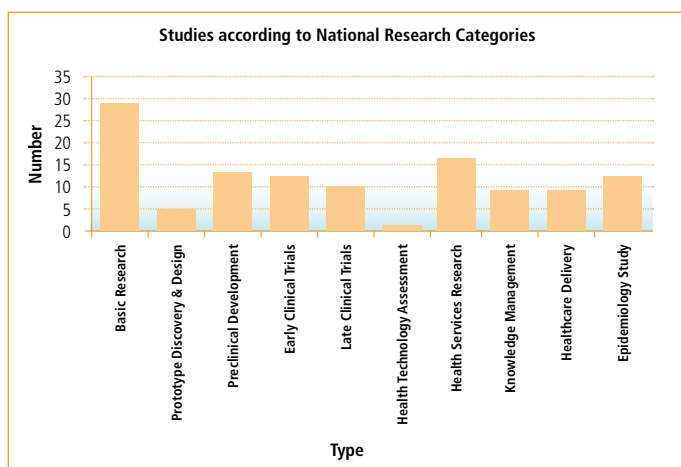
Liverpool Women's NHS Foundation Trust was involved in conducting 137 clinical research studies in 2009/10. Of the studies that were completed during this period, 65% were completed within the agreed time and to the agreed recruitment target. Liverpool Women's NHS Foundation Trust used national systems to manage the studies in proportion to risk.

Of the 56 studies given permission to start in 2009/2010, 80% of the studies processed through the NIHR Coordinated System for gaining NHS Permission (NIHR CSP) were given permission by an authorised person less than 35 days from receipt of a valid complete application. Of the studies (56), 25% were established and managed under national model agreements and 100% of the 23 eligible research projects, which involved external researchers, utilised the NIHR Research Passport system and associated documentation.

In 2009/10 the NIHR supported 46 of the 137 open studies, through its research networks.

In the last three years, 28 publications have resulted from our involvement in NIHR research, helping to improve patient outcomes and experience across the NHS.

The number of studies open at the Trust as at 31st March 2010 (not necessarily NIHR) that fall into each element of the research pipeline is detailed in the chart below.



### Information on the use of CQUIN

A proportion of the Liverpool Women's NHS Foundation Trust income in 2009/10 was conditional on achieving quality improvement and innovation goals agreed between the Liverpool Women's NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the CQUIN payment framework.

CQUIN indicators were negotiated and agreed following discussion between Liverpool PCT (as host commissioner) and Liverpool Women's NHS Foundation Trust and reflect key issues in the local health economy. Progress in achieving targets was reviewed monthly and in March 2010, Liverpool PCT confirmed that the full CQUINS payment of 0.5% of contract income would be paid to Liverpool Women's NHS Foundation Trust in 2009/10 for performance against its CQUINS targets. Total CQUINS income in 2009/10 amounted to £376,365.

Further details of the agreed goals for 2009/10 and for the following 12 month period are available on request from the Director of Service Development.

### Information relating to registration with the CQC and periodic special reviews

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

The Care Quality Commission has not taken enforcement action against Liverpool Women's NHS Foundation Trust during 2009/10.

Liverpool Women's NHS Foundation Trust is not subject to periodic review by the Care Quality Commission. The Trust has not participated in any special reviews or investigations by the CQC in the reporting period.

### Data Quality

Liverpool Women's Hospital NHS Foundation Trust submitted records during April 2009 and end of January 2010 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which:

- Included the patient's valid NHS Number was:
  - 94.6% for admitted patient care
  - 95.2% for Outpatient care; and
  - 96.5% for accident and emergency care.

- Included the patient's valid General Medical Practice was:
  - 100% for admitted patient care
  - 100% for Outpatient care; and
  - 100% for accident and emergency care.

### Information Governance Toolkit attainment levels

The Liverpool Women's NHS Foundation Trust score for 2009/10 for Information Quality and Records Management assessed using the Information Governance Toolkit was 85.7.

**Source:** Data Quality scores from SUS Dashboard  
IG Toolkit attainment levels from National IG Assessment.

## Clinical Coding 2009/10 Audit

The role of the clinical coders is to analyse the patients' clinical record and assign specific codes for the diagnoses, procedures and interventions that take place during the patients' hospital admission. In addition to assigning codes to inpatients' admissions codes are also assigned to outpatients' attendances where a procedure or intervention takes place e.g. cervical smear.

The table below summarises the findings from the 2009/10 independent, targeted external Clinical Coding audit on inpatient activity at Liverpool Women's carried out in October 2009 on data from 1st April to 30th June 2009.

Area audited	Specialty/ Sub- chapter / HRG	% Procedures coded incorrectly		% Diagnoses coded incorrectly		% of episodes changing HRG	% of spells changing HRG
		Primary	Secondary	Primary	Secondary		
Specialty	Obstetrics	2.2	3.0	11.0	9.4	9.0	9.0
Sub-chapter	Digestive system procedures	0.0	2.9	8.6	4.1	0.0	0.0
HRG	Normal Delivery 19 years and over with CC	0.0	0.0	0.0	5.2	6.7	6.7
Overall		0.7	2.2	8.5	6.3	5.5	5.5

As with the two previous audits, the 2009/10 results show that the Trust's clinical coding error rate remains consistently below the national average.

The 2009/10 report states:

*'The Trust's performance is good compared to the overall performance of trusts. In 2008/09 although the Trust HRG error rate has increased compared to the previous audits, it remains below the national average and it has and continued to implement the recommendations from our 2008/09 review, indicating a commitment to improving performance. This year the Trust's HRG error rate is 5.5 %. The national average in 2008/09 was 8.1 %. The financial value of the total or gross errors found is £5,066 from an audit sample of £361,045. The net impact of the errors is that the Trust has overcharged its commissioners by £764 or 0.2 % on the sample tested.'*

The high levels of coding accuracy as demonstrated in all three Payment by Results Data Assurance Framework audits provide financial assurance to Liverpool Women's and Liverpool PCT, its host commissioner. The audit also shows that the coded data accurately reflects the complexities of care provided by the Trust to its patients.

# Commentary by Our Stakeholders

## COMMENTARY ON THE QUALITY ACCOUNT PRODUCED BY THE LIVERPOOL WOMEN'S NHS FOUNDATION TRUST BY THE LIVERPOOL LOCAL INVOLVEMENT NETWORK (LINK)

Due to time constraints this year, Liverpool LINK Core Group has been unable to consult with the wider LINK membership when compiling a statement for this Quality Account. The statement below is therefore made by authorised LINK members based on the available evidence. Liverpool LINK aims to provide a more representative statement in future years.

Liverpool LINK's authorised Health and Social Care Ambassador has carefully studied the Quality Account submitted by the Liverpool Women's NHS FT. This clearly indicates their on-going commitment to excellence in respect of maintaining a high standard of care throughout their prioritised areas; there are measures in place like Patient Involvement Consultations for monitoring and reviewing these practices at regular intervals. These should in turn enhance the patient experience within this Trust.

The Trust identified three "Priorities for improvement" in 2009/10, which included:

### (1) Infection control

The cases of MRSA and C Dif. recorded by the Trust are both below the Care Quality Commission target of three and eight respectively. We are assured that the two areas of infection listed will continue to remain key areas of safety concern within the Trust.

### (2) Staffing levels

The Royal College of Obstetricians and Gynaecologists (RCOG) and the Royal College of Midwives (RCM) recommended level of consultant cover of 168 hours plus one to one midwifery care for delivery suites, as stated within the "Safer Childbirth" report, has been severely affected by a funding shortfall from the PCT resulting in only a 98 hour coverage. The concerns of both the Hospital Trust in respect of providing adequate cover and maintaining patient confidence is put sharply into perspective in respect of the complaints procedures which ultimately end in litigation, the

## COMMISSIONING PCT STATEMENT

On behalf of Liverpool Primary Care Trust, the lead commissioner for Liverpool Women's NHS Foundation Trust I would like to acknowledge the progress made in the drive to deliver high quality care for all those using their services.

As Director for Service Improvement and Executive Nurse in Liverpool PCT I can confirm that to the best of my knowledge this quality account is a true and accurate reflection of the 2009-2010 progress Liverpool Women's NHS Foundation Trust has made against the identified quality standards. The Trust has complied with all contractual obligations and has made good progress over the last year with evidence of significant improvements in key quality measures.

figures nationally are in excess of £850m per annum in this regard. The Trust has shown within the Quality Account that they have provided a number of briefings on this subject which have included the Secretary of State for Health.

### (3) Staff attitude and behaviour in order to deliver

There have been a number of actions put into place to improve these key areas of concern which have been highlighted within the Trust Quality Account, and as a centre of excellence within women's healthcare, they have clearly shown in these pages, their on-going commitment to maintaining a high level of service, and as the document clearly outlines, this desire of "achieving our vision of being the recognised leader for women's healthcare" is clearly shown in various action bullet points which define how they wish to improve the levels of positive staff attitudes and satisfaction, this is indeed commendable.

The Women's Hospital have visibly demonstrated their on-going commitment to those patients who enter their doors, this is backed up by the understanding that they need to constantly review these on-going areas of concern in order to maintain their high level of service delivery at the point of need.

These are general concerns throughout NHS Trust Hospitals and have also been flagged up within the LINK membership. Liverpool LINK will follow closely these proposed improvements and will continue to monitor the progress of the staff and patient relationship and to support the Trust's three selected priorities for 2010/11 concerning the reduction of infection and mortality rates and improved patient experience.

*Response compiled by Rev Maria Renate (Liverpool LINK Health and Social Care Ambassador to Liverpool Women's NHS Foundation Trust)*

*Authorised by Mike Marsh (Chair, Liverpool LINK)*

Liverpool PCT is supportive of the process Liverpool Women's NHS Foundation Trust has taken to engage with patients, staff and stakeholders in developing a set of quality priorities and measures for 2010/11 and applaud their continued commitment to improvement.

We find the submitted quality account to represent an appropriate level of effort and areas of focus for service improvement and we look forward to Liverpool Women's' NHS Foundation Trust continued improvement of quality standards in 2010/11.

*Trish Bennett*

**Trish Bennett**  
Director for Service Improvement  
& Executive Nurse

