

# Liverpool Women's NHS Foundation Trust



## Quality Report 2011/12

For Publication June 2012

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## ***Introduction – Our Commitment to Quality***

Welcome to Liverpool Women's NHS Foundation Trusts third Annual Quality Report.

Liverpool Women's NHS Foundation Trust Quality Report is a review of the quality of services provided to our stakeholders, that is, patients, public, staff, commissioners and partners. This report has been prepared in consultation with our stakeholders and we are grateful for their comments and input which have helped us to produce our Quality Report for 2011/12 which includes plans for 2012/13.

Looking back over the past year we have, despite the recognised economic pressures, continued to work hard to maintain our focus on quality, clinical effectiveness, patient safety and both patient and staff experience.

The report refers to a number of quality initiatives focussed on providing quality care to the patients and families that use our services; identifies where we need to improve and how improvement in clinical care will be measured.

### **About Liverpool Women's**

Liverpool Women's NHS Foundation Trust provides a comprehensive range of health care for women and babies from Liverpool and surrounding areas. It is the largest women's hospital in Europe and has been an NHS Foundation Trust since 1 April 2005.

Prior to that it had operated as Liverpool Women's Hospital NHS Trust, created in 1995, when all services for women and babies in Liverpool came together under one roof at Liverpool Women's Hospital in Toxteth, Liverpool. In 2000, the Trust began operating the Aintree Centre for Women's Health, which provides services to women from north Liverpool, Sefton and Knowsley.

Some 59% of the Trust's income comes from contracts with Liverpool, Sefton and Knowsley Primary Care Trusts; this figure having dropped by 8% from that of the previous period.

In 2011/ 2012 we:

- Delivered 8,396 babies
- Undertook gynaecological in-patient procedures on 6,189 women
- Cared for 1,269 babies in our neonatal intensive and high dependency care units
- Performed 1,255 cycles of in-vitro fertilisation (IVF).

## Our vision, aims and values

Our Vision is to be the recognised leader in healthcare for women, babies and their families.

### Our aims are:

- To develop a well led, capable and motivated workforce
- To be efficient and make best use of available resources
- To deliver safe services
- To deliver the most effective outcomes
- To deliver the best possible experience for patients and staff

### And our values are:

**Caring** – we show we care about people

**Ambition** – we want the best for people

**Respect** – we value the differences and talents of people

**Engaging** – we involve people in how we do things

**Learn** – we learn from people past, present and future

## *Our commitment to Quality*

Last year on page 15 of the Annual Report and Accounts 2011, we stated, in summary of our Safety, Effectiveness and Experience achievements that:

*'We will build on these achievements throughout 2011/12 and beyond'*

And so we did. However the Quality Report is part reflection and part look forward, it is an opportunity to provide plain and simple evidence of improvement in our services over the last year combined with highlighting what we hope to achieve next.

The NHS landscape is changing and our successes in 2011/12 will count for very little unless we constantly strive to do better in 2012/13, 2013/14 and further. As one of only two organisations in the NHS dedicated to the provision of services to Women and their families, we will look to measure our performance against the very best nationally and internationally. We will do this openly, sharing with you results that can give you confidence in the services we provide.

Last year, I wrote of the 'long and relentless quest to improve services wherever possible', I very much recommitted myself, the Board of Directors and every member of staff in the organisation to delivering that clear and straightforward objective. Whilst this report details a wealth of sophisticated measures and metrics, the purpose is simple:

- Provide assurance and confidence that clinical performance and standards are high
- Identify where further improvement can and will be made

I hope you will find a little time to review this Quality Report – as ever Liverpool Women's Hospital NHS Foundation Trust welcomes feedback – if you have any questions or thoughts about the Quality Report – we would be delighted to hear from you, in the first instance by e-mail at: [Quality.Report@lwh.nhs.uk](mailto:Quality.Report@lwh.nhs.uk)

## Our Staff Our greatest asset

Our people are the most valuable asset we have to deliver services that are safe, effective, efficient and achieve the best possible experience for patients and their families.

As at 31<sup>st</sup> March 2012 we employed 1,349 staff in a variety of clinical and support roles (1,141.88 whole time equivalents) not including those who work for our external contractors or staff seconded out to other organisations.

Following restructuring of the four Clinical Business Units into two Divisions our people work within three main areas across the Trust:

50% Maternity, Neonatal & Clinical Support Services Division

31% Gynaecology, Anaesthesia & Theatres, Hewitt Centre & Genetics Division

19% Corporate Support Services (Human Resources & Organisational Development/ Finance/ IM&T / Estates & Facilities, Booking, Scheduling & administrative Services, Governance, Quality Assurance Cervical Screening and Switchboard staff and Support Services from G4S and OCS)

The staff group distribution of our employees is shown in the following table:

Staff Group (WTE not Headcount)	Current WTE (as at 31 March 2012)
Registered Nurses and Midwives	561.71
Doctors	61.25
Other Clinical Services Staff	201.55
Healthcare Scientists	33.77
Additional Professional, Scientific and Technical	27.19
Allied Health Professionals	10.79
Administrative and management	237.62
Estates and Ancillary	8.00
Totals	1141.88

## Focus on Quality

We have continued to shape and influence the quality agenda as one of our key priorities during the year. We have focussed on a number of projects and initiatives to improve the safety and outcomes of clinical services as well as improving the experience of patients. Below are some examples of the work we have been doing.

### Energising for Excellence.

Energising for Excellence (E4E) is a national initiative, which defines and demonstrates the contribution of nursing and midwifery to patient experience, outcomes and staff experience. Having undertaken the preparatory work during 2011/12, we launched within the Trust on the 15<sup>th</sup> March 2012. Over the past months we have been engaging in a number of national E4E events, as well as undertaking local preparation, developing systems to capture data and working with our ward and department teams to define which initiatives and metrics they wish to use for their own areas.

### Enhanced Recovery Programme

The Enhanced recovery Programme is an NHS initiative that focuses on the care of patients before during and after their operation. The programme encourages patients to take ownership of their own care and aims to reduce complications, the length of their stay in hospital and the readmission rate, whilst increasing patient involvement in clinical decisions.

Following a successful pilot of enhanced recovery with a cohort of oncology patients, in February 2012, the project team have now implemented enhanced recovery pathways for all elective gynaecology patients.

There are 5 specific pathways in place

1. Urogynaecology
2. Complex gynaecological surgery
3. Laparoscopic gynaecological surgery
4. 24-36hrs intermediate surgery
5. 3-4 days major surgery

The team have also developed a pathway to support gynaecological day surgery.

Feedback from patients is fundamental to any new project and recent ward assessments have reported that patients said:

*'The enhanced recovery pathway was excellent and made me feel involved in my care'*

*'It helped me plan for going home, and what to expect'*

*'I was able to share with my family the diary and what was going to happen'*

## **Liverpool - Mulago Partnership**

Liverpool Women's has the largest maternity unit in this country, delivering over 8000 babies a year; Mulago Hospital is the largest in Uganda with 30,000 births a year. Through our Liverpool-Mulago partnership set up in 2009, we continue to support the Mulago Hospital in Uganda to improve the care it is able to offer women and babies in Uganda.

Since the partnership was established, doctors, midwives and other people from Liverpool Women's have been spending time in Mulago, sharing their expertise and helping in the training of staff. At the same time, staff from Mulago have travelled to Liverpool to experience how we work and share with our teams the expertise that they have in dealing with conditions now rarely seen in the UK.

With help from our staff, a high dependency unit has now been set up at Mulago. It is not the sort of high tech, well equipped unit we have here but a room cleaned and decorated by Liverpool staff. It has six beds and the basic essentials. Even so, it is already helping to save the lives of women with life threatening conditions such as pre-eclampsia, haemorrhage and ruptured uterus who would rarely lose their lives in our country. There is also an assessment room now so that it can quickly be recognised when a woman has developed dangerous symptoms. There is still much more to be done and Liverpool Women's looks forward to the continuation of this partnership.

Our Medical Director, Jonathan Herod, a gynaecological and oncology surgeon, has recently spent time in Mulago and found there is a huge problem with cervical cancer which is usually diagnosed in its late stages while deaths from gynaecological and obstetric complications are commonplace. He said on his return: "It is a very humbling experience to see how big the gap is between the services we can provide and those in Mulago Hospital. Staff there are treating large numbers of very ill patients with minimal resources."

As part of our ongoing effort, he is hoping we may be able to develop some training opportunities here in Liverpool for the Mulago Oncology team and is collaborating with Canadian doctors from British Columbia to try and develop a gynaecology oncology service in Mulago.

A research centre is also to be set up at Liverpool Women's with the University of Liverpool which will be named after Edith Sanya; a Mulago patient who unfortunately died after complications that led to the rupture of her uterus and a fatal haemorrhage. The centre will concentrate on improving the care of women like her in developing countries.

## *Part 1. Statement of Quality from the Chief Executive*

The Liverpool Women's NHS Foundation Trust Quality Report for 2011/12 is our third Quality Report. It gives us the opportunity to look back at what we have already achieved over the past year and forward to what we hope to achieve in the future. We at Liverpool Women's NHS Foundation Trust recognised that it is easy and tempting to focus on areas of strength, but that a successful organisation must understand both its strengths and weaknesses and should strive to improve in all areas.

In our pursuit of providing excellence in everything we do, we continue to maintain our focus on patient safety, the clinical effectiveness of our services, and patient experience. There is much work in progress and many new initiatives that have been developed in the Trust during the last 12 months. We have worked hard to improve our recording of accurate and relevant data about our services over a broad range of outcome indicators and aim to use this information to assure quality and further drive improvement through the establishment of clinically meaningful metrics.

Last year, I wrote of the 'long and relentless quest to improve services wherever possible', I very much recommitted myself, the Board of Directors and every member of staff in the organisation to delivering that clear and straightforward objective. Whilst this report details a wealth of sophisticated measures and metrics, the purpose is simple:

- Provide assurance and confidence that clinical performance and standards are high
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I hope you will find a little time to review this Quality Report – as ever Liverpool Women's Hospital NHS Foundation Trust welcomes feedback – if you have any questions or thoughts about the Quality Report – we would be delighted to hear from you, in the first instance by e-mail at: [Quality.Report@lwh.nhs.uk](mailto:Quality.Report@lwh.nhs.uk)

As Chief Executive, I am pleased to see the progress that has been made since the publication of our last Quality Report for 2010/11. We are particularly proud at achieving our second successive year without any MRSA infection and are pleased to see the ongoing development of rigorous and timely automated data collation processes to inform our monitoring and quality improvement initiatives.

Highlights of our achievements in 2011-12 include:

- The opening of the first phase of the Big Push building project on the site of the Women's Hospital, giving en-suite facilities to all patients who have their baby with us

- Our close work with Liverpool, Sefton and Knowsley LINK (Local Involvement Network) groups in the redesign of the services to be provided from Aintree Centre for Women's Health in 2012/13
- Becoming a founder member of Liverpool Health Partners which will work to integrate clinical services and research across the city
- Our development and piloting of a prototype trolley for neonatal resuscitation that allows a newborn baby to be cared by next to their mother in the minutes after birth.
- We achieved top education provider in the country for General Practitioner/ Vocational Training Scheme placements as measured by the trainees themselves through General Medical Council survey

The Trust has continued to reinvest in its estate, medical equipment and Information technology for the benefit of patients. Details of capital expenditure for 2011/12 are detailed in the table below:

<b>Capital expenditure</b>	<b>2011/12</b>
	<b>£000s</b>
Big Push (enhancement of maternity accommodation)	3,139
Centre for Women's Health (with Liverpool University)	720
Medical Equipment	917
Information technology	331
Estates and Environmental Programme	1,062
Total	6,169

The year has not been without its challenges, however, particularly as the ongoing economic downturn continues to require even greater efficiencies. The Trust has been through a challenging programme of organisational restructuring and delivered an ambitious cost improvement programme. As shown on the pages that follow, we have successfully made the efficiencies required without compromising the quality of care we provide, and we are proud that both our clinical and financial performance remains strong.

Plans not achieved in-year:

- Development of our Quality Strategy; work commenced in-year to identify priority areas. This work will be integrated in 2012/13 with our service redesign and efficiency programmes
- Development of private patient services; following the passing of the Health and Social Care Bill the Trust will now scope the potential to introduce paid for services to supplement NHS services provided
- Review of pharmacy services; this review commenced in-year and will continue into the first part of 2012/13 focusing on governance and efficiency
- Review of theatres; the review is underway to provide the most efficient and clinically effective service to all planned and emergency patients. The review will be completed by the end of September 2012.

A further challenge was the Care Quality Commissions identification of a moderate concern with respect to medicines management and particularly regarding the reporting by staff in interview, of an inappropriate means of disposal of small unused quantities of a particular controlled drug used in patient Controlled Analgesia (PCA) during an unannounced visit. The Trust took immediate action to prevent further inappropriate disposals, provided new disposal kits for this specific purpose and alerted staff to the issue and the new means of disposal. In addition, the reported practice was treated as a serious incident and the Trust conducted a root cause investigation, which was reported with recommendations to NHS Merseyside. A planned external review of the Trust's pharmacy services and medicines management was expedited and the review commenced on 20<sup>th</sup> February 2012.

This year's publication is the next step in our quest for improvement and includes our priorities for 2012/13 aimed at further improving services wherever possible.

I am confident 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.

On behalf of the Trust Board of Directors and myself, I would again like to offer a big thank you to our staff, patients and our community for a very successful, quality driven and productive year.

*Kathryn Thomson*

Kathryn Thomson  
Chief Executive  
28 May 2012

## *Part 2. Looking back 2011/12 Review of Quality Performance*

### **Priorities for improvement**

Liverpool Women's NHS Foundation Trust aims to provide its users and their families with care of the highest safety and quality. This document sets out our approach to achieving this and includes our look back at the past year (2011-12) and our quality priorities for 2012-13.

Key to our commitment to safety and quality, is our desire to ensure that we learn from the experiences of our patients and staff and from the information they provide improve what we do in future. Intelligence gathered from the complaints made by our patients, the issues they raise with our Patient Advice and Liaison Service (PALS) and that from the reporting of serious incidents and other feedback is reviewed and reported through our governance structure to ensure that we capture learning opportunities and make responsive changes to address the issues and improve the services and patient experience we provide.

Examples of the changes made from this process are included here and in the patient experience review of this report.

In response to a patient comment that they did not receive a breakfast fitting their dietary and care requirements until 10.00 am; we re-launched the "red tray" system with the ward staff and the new catering company that started in April. (The red tray system is a national scheme to ensure patients who need assistance with nutrition receive the help required). We also introduced ward hostesses who are aware of all the patients catering needs in their areas.

When we learned that dentures had been "lost" on the ward we secured a supply of denture pots which are now included in the 'To Come In' , or 'TCI' packs provided to patients at admission; (these contain undergarments, hat, theatre gown and denture pot and a patient property bag). We also introduced the use of a patient property bag to return patients' property such as their dressing gown, when they return from theatre and this also includes a denture pot.

Changes arising from issues and deficiencies identified in the investigation of serious incidents include:

- Updated guidelines for Intermittent Auscultation (non-continuous listening to the fetal heart beat) and updates to both National and Local Guidance on the requirement for ultrasound hip examination after birth for all cases where the fetus was in the breech position on any occasion after 36 completed weeks gestation.

- Creation of field within Meditech, the Trust's patient information system, to record breech presentation at any stage beyond 36 completed weeks gestation.
- Audits on efficacy of records management system to identify and ensure the availability of all separate records relevant to IVF appointments.
- Requirement for re-suturing of opened abdominal wounds post surgery to be performed under direct vision of the surgeon performing the task.
- Provision of controlled drugs disposal kits to clinical areas to facilitate appropriate safe disposal of controlled drugs and cessation of inappropriate disposal 'down the sink'.
- Increase from 50% to 100%, the proportion of Neonatal Consultants trained in the scanning procedure required to diagnose Pericardial / Cardiac Tamponade.

Over 2011/12 we have sought to monitor the same measures and metrics as we scrutinised in 2010/11. We have done this deliberately to aid us in measuring the improvement year on year and to ensure that staff across the organisation become increasingly familiar with how we measure our own success. We have used familiar headings to describe and monitor our quality quest in 2011/12:

- **Patient Safety**
  - Gynaecology Surgical Site Infections
  - Ovarian Hyper Stimulation Syndrome
  - Incidence of multiple pregnancy
  - Late onset Neonatal bloodstream infections
  - APGAR scores<sup>1</sup> < 4 in infants born at more than 34 weeks
  - Heart Rate < 100 in infants born at less than 34 weeks
  - Delivery Cord PH < 7.00 for babies born alive after 24 weeks gestation.
  - Wound infections following Caesarean Section
  - Incidence methicillin-resistant staphylococcus aureus (MRSA) Bacterium,
  - Incidence of Clostridium Difficile
  - Incidence of methicillin-sensitive staphylococcus aureus (MSSA) Bacterium
  - Medication Errors
  - Accidental Perforation or Damage
- **Clinical Effectiveness**

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<sup>1</sup> The Apgar score is a number arrived at by scoring 5 features (Heart rate, Respiratory effort, Muscle tone, Skin Colour and Response to a catheter in the nostril. Each of these objective signs can receive 0, 1 or 2 points. A score of 10 indicates that the infant is in the best possible condition. An infant with an Apgar score of 0-3 needs immediate resuscitation. The Apgar score is done routinely 60 seconds after the birth of the infant and then is commonly repeated at 5 minutes after birth. In the event of a difficult resuscitation it may be done again at 10, 15 and 20 minutes.

- Readmission Rates in Gynaecology
  - Mortality Rate in Gynaecology
  - Biochemical Pregnancy Rates in in-vitro fertilisation (IVF), Intracytoplasmic sperm injection (ICSI) and frozen embryo transfer (FET) treatments
  - Brain Injury in preterm babies (Severe intraventricular haemorrhage and Periventricular Leukomalacia)
  - Perinatal Mortality
  - Transfer to intensive therapy unit (ITU) per 1000 maternities
  - Stillbirth Rate
  - Blood Transfusion Rates following Vaginal Delivery
  - Mortality Rate in Maternity
  - Care Indicators for Nursing and Midwifery
- 
- **Patient Experience**
  - Patient Experience & Involvement Strategy
  - One to one care in established labour 100% of the time

## Part 2 – Review of Performance

Please note: In the following sections the charts presented show the monthly instances for the measure in bars and may have a blue line showing the level of activity and a black line showing the trend in the data. Where possible, two years data is shown with 2010/11 on the left and 2011/12 on the right. Some measures were introduced in 2011/12 and show only the one year's data. Each chart is accompanied with an improvement indicator in accordance with the following key:

		
Improvement in performance against the measure shown over the period.	Performance against the measure shows Stable / insignificant change or cannot be judged due to concerns described in associated text	Performance against the measure showed a decline over the period.

## Patient safety

### Surgical Site Infections

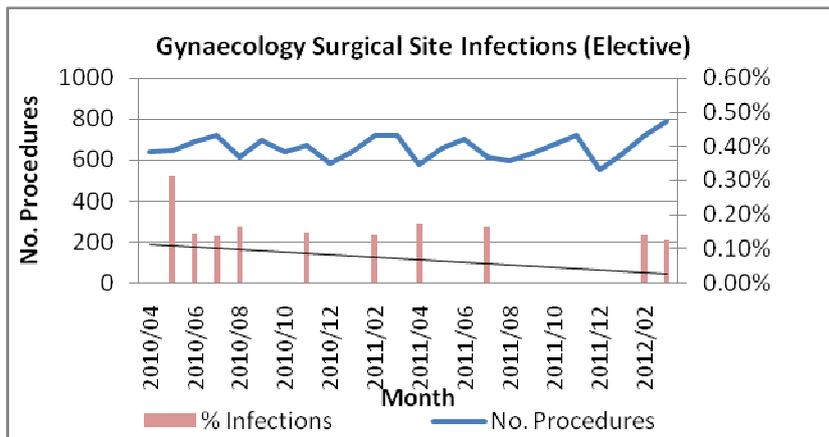
Surgical site infection is one of the commonest causes of post operative morbidity and delayed recovery. A reduction in the incidence of infection will have a significant impact on patient recovery. The prevention and treatment of surgical site infections is outlined in NICE Clinical Guidelines (2008). CG74. The following graph shows the percentage of patients who underwent elective surgical procedures reported with a surgical site infection by month at the Trust.

### Elective Surgical Site Infections

*Definition: The number of patients undergoing an elective Gynaecological surgical procedure where an infection has been identified at the surgical site during their inpatient episode. The number is expressed as a percentage of all patients undergoing a Gynaecological surgical procedure.*

*Data source: Meditech*

In the year 2011-12 the Trust encountered 4 elective surgical site infections in 7,866 elective procedures, a rate of 0.05% or approximately 1 per 2000 procedures. The following figure shows these as percentages of the monthly procedures.



Improvement?



	Procedures	Infections	%
2010-11	7965	7	0.09%
2011-12	7866	4	0.05%

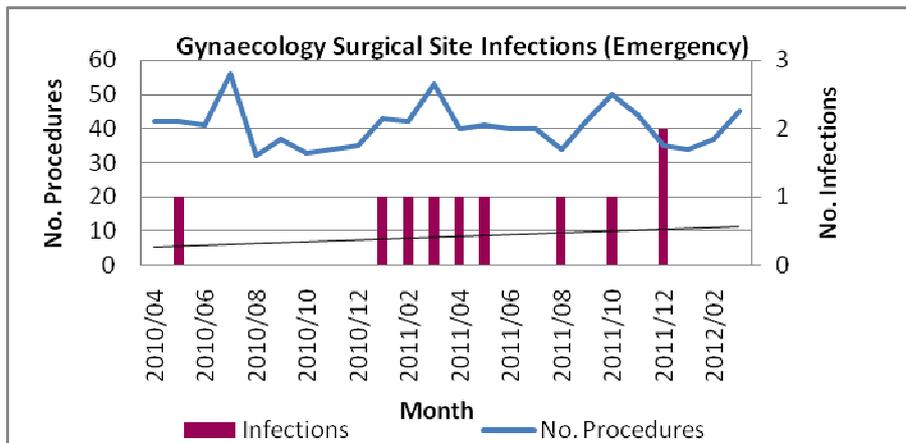
Although these figures are retrospective, and are known to underestimate the true infection rate (due to under reporting and patient treatment outside the hospital), the continued fall over several years of a consistently measured assessment of infection is greatly encouraging, and a testament to the effectiveness and hard work that has gone into infection reducing measures, such as hand washing, the WHO surgical checklist, and the No Touch Technique for all invasive interventions.  
 – Mr Robert MacDonald, Consultant Gynaecological Oncologist/ Gynaecology Clinical Governance lead.

### Non-Elective Surgical Site Infections

*Definition: The number of patients undergoing a non-elective Gynaecological surgical procedure where an infection has been identified at the surgical site during their inpatient episode. The number is expressed as a percentage of all patients undergoing a Gynaecological surgical procedure.*

Data source: Meditech

In the year 2011-12, the Trust encountered 6 non-elective surgical site infections in 535 emergency procedures, a rate of 1.12% or approximately 1 in 90 procedures. The following chart shows monthly instances of infection and the monthly number of procedures. The black line is a plot of the trend in the data.



Improvement?



	Procedures	Infections	%
2010-11	490	4	0.82%
2011-12	482	6	1.24%

The lack of fall in infections in emergency operations (in contrast to the success in improvement in elective cases) shows this to be the next area for focus for the hospital. - Mr Robert MacDonald, Consultant Gynaecological Oncologist/ Gynaecology Clinical Governance lead.

### Ovarian Hyper Stimulation Syndrome -Eggs Collected >20

Ovarian hyper stimulation syndrome (OHSS) is a potentially life threatening condition attributed to an excess of fertility drugs given to a patient as part of her fertility treatment. Most fertility patients are healthy before the start of treatment, so making someone sick should be considered a failure on the part of the clinical team.

Every IVF cycle sets out to stimulate the woman’s ovaries in order to obtain a few more eggs than normal with the aim of increasing the chance of a pregnancy. The treatment aim is to do this in a controlled manner. Some patients are very sensitive to the drugs used and it is the clinician’s responsibility to identify those patients and modify treatment accordingly. Ovarian Hyper Stimulation Syndrome is discussed in NICE Guidelines (2004), Fertility: assessment and treatment for people with fertility problems.

*As explained in the Quality Report for the previous period, from 2010-11 we decided to choose number of eggs collected in excess of 20 as ‘indicative’ of ovarian hyper*

stimulation as the definition is not universally agreed upon. More than 20 eggs would be considered by most IVF units to be too many. Our unit average was then about 10 eggs retrieved per collection.

*Definition: The number of egg collections where >20 eggs are obtained / the total number of egg collections in period.*

*Data source: "IDEAS", the Reproductive medicine database system*

The following chart shows the continuing downward trend in the proportion of egg collections from which more than 20 eggs were obtained as evidenced in the data available to January 2012.

In 2010, we felt that the number of patients having more than twenty eggs collected was too high as this can lead to the potentially fatal condition of ovarian hyperstimulation syndrome (OHSS). We therefore amended our stimulation protocol by reducing the dose of gonadotrophins administered and also introduced a 'mild IVF' stimulation protocol option. We also altered our egg collection policy. As a result, it is pleasing to see a far lower rate of excess egg numbers obtained (4% down from 16%). For 2012, we wish to continue to look at OHSS, but will alter the way we measure this to record the number of patients admitted to the gynaecology ward as a reflection of severity of symptoms. OHSS requiring hospital admission is now a reportable incident to the Human Fertilisation & Embryology Authority (HFEA).  
 - Andrew Drakeley, Consultant Gynaecologist / Reproductive Medicine Clinical Governance Lead



### Multiple Pregnancy Rate

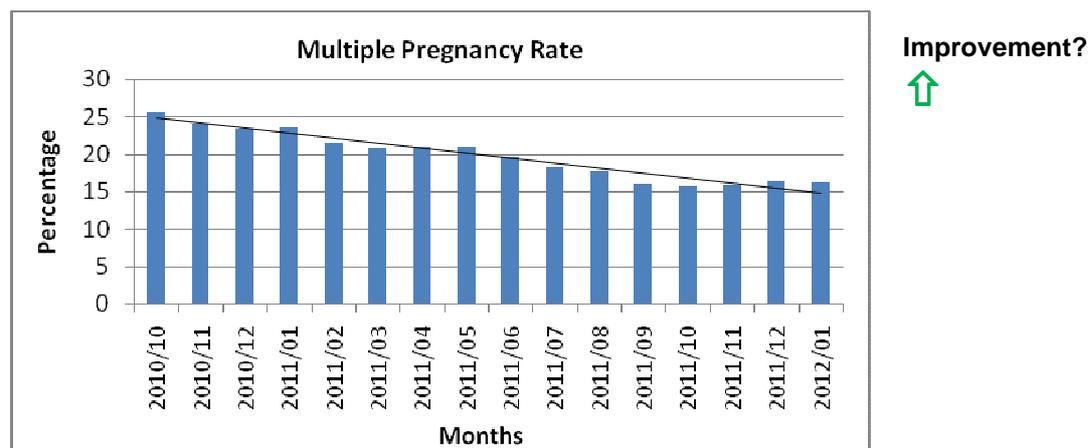
*Definition: The multiple pregnancy rates (MPR) are calculated as number twins (and triplets) / number clinical pregnancies x 100. This is one of the Hewitt Fertility Centre's Quality Indicators and is examined on a monthly basis by looking at the MPR for the previous 12 month period. This allows us to assess our performance in*

relation to the HFEA's targets (please note the HFEA target is multiple birth rate not multiple pregnancy rate).

Data source: "IDEAS" the Reproductive medicine database.

For some couples, twins bring an 'instant complete family' and for childless couples this may be an attractive thought. In addition, once one child is born, the couple subsequently lose entitlement to any more NHS funded fertility treatment. As a consequence there can be a lot of pressure applied to fertility clinics to replace more than one embryo. However twin pregnancies are much more complicated than a normal singleton pregnancy. In particular there is a higher risk of premature delivery which can lead to developmental problems or even loss of baby.

It is becoming more widely accepted that the increased multiple pregnancy rate associated with fertility treatment is not a good thing and should be lowered. The fertility regulator HFEA has set an upper limit of 15% multiple pregnancy live birth rate for clinics to achieve in the period April 2011- March 2012. NICE (2004), Fertility: Assessment and treatment for people with fertility problems, also covers multiple pregnancy in fertility.



The above bar chart shows the decreasing proportion of multiple pregnancies over the period October 2010 to January 2012.

The fertility regulator, Human Fertilisation & Embryology Authority (HFEA) has mandated that all fertility clinics should be able to demonstrate that they are making every attempt to reduce their multiple birth rates, as this is associated with far higher obstetric & neonatal problems than a singleton pregnancy. Clearly, we are aiming to achieve this without a drop in overall pregnancy rates. Currently, we are aiming for a 15% live twin rate, however from October 2012 this level is set to reduce further to 10%. It is very pleasing to see that following the introduction of a selective embryo transfer policy, our twin rate has fallen month on month towards the 15% mark. The most recent monthly figure at the time of writing was 13.8%. We need to continue to re-examine this policy in order to achieve the new lower rate by the end of 2012.

Note that the HFEA targets are 'live' birth rates, whereas we are able to more easily measure ongoing 'clinical' pregnancy rates (heart beat seen on scan). Some twin pregnancies early on ultimately deliver a single baby. To help manage this, the HFEA are introducing an alert system for clinics to pre-warn them that their registered clinical pregnancy rates are falling outside of the accepted national range so that they can react earlier and further amend their embryo transfer policies.  
 – Andrew Drakeley, Consultant Gynaecologist / Reproductive Medicine Clinical Governance Lead.

### Late Onset Neonatal Blood Stream Infections

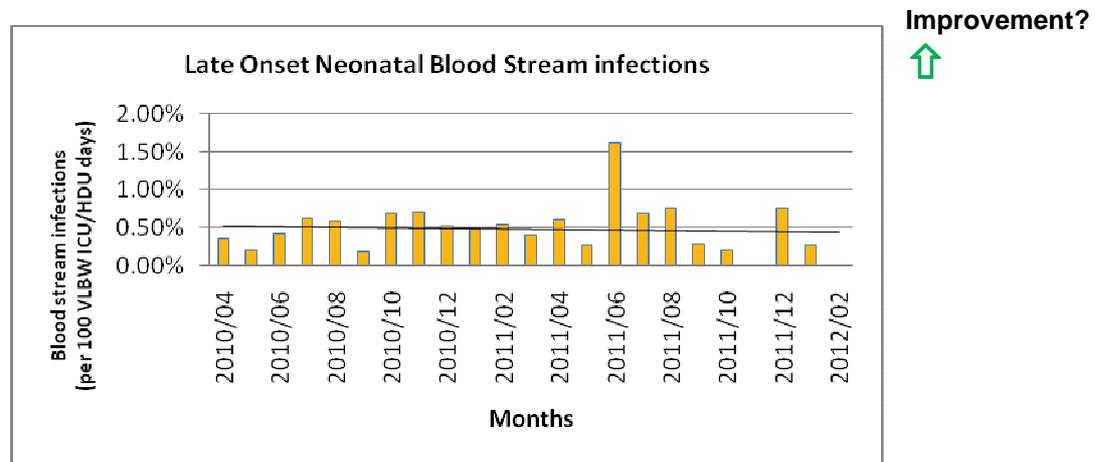
*Definition: The number of pre-term babies (<30wks gestation) with late onset (post 72hrs) bloodstream infections per total number of days that very low birth weight (VLBW) babies have spent in either intensive or high dependency care. [Where VLBW means a birth weight below 1500grams]*

*It should be noted that congenital infections (i.e obtained from the mother) within 3 days and repeated positive blood tests are excluded from the numbers.*

*Data source: "Badger" the Neonatal database system.*

Late-onset NBSI in preterm infants has been chosen as a marker of quality because it is a good measure of patient safety in neonates. Hospital-acquired infections are one of the commonest complications of preterm birth and are a significant cause of morbidity and mortality in newborn babies. NBSI is also one of the national quality markers in neonatal medicine adopted by the NICE Quality Standards and National Neonatal Audit Programme.

The following chart shows the preterm late-onset NBSI rate for 2010-2012. The monthly rate of NBSI varied between 0 and 1.6 infections per 100 ICU/HDU days.



Although there is no nationally agreed benchmark for neonatal infection, we have

previously set ourselves a target of maintaining an overall infection rate of below 0.5 infections per 100 ICU/HDU (i.e. one infection per 200 care days). The mean rate during this period was 0.48 and 0.49 infections per 100 ICU/HDU days in very low birth weight babies, in 2010/11 and 2011/12, respectively. The high infection rate in June 2011 related to three cases of methicillin-sensitive Staphylococcus Aureus infection. Despite no specific cause being identified, infection control and prevention practices were reinforced and ongoing infection surveillance has demonstrated a return to low baseline monthly infection rates.

- Nim Subhedar, Consultant Neonatologist/ Neonatal Clinical Governance Lead

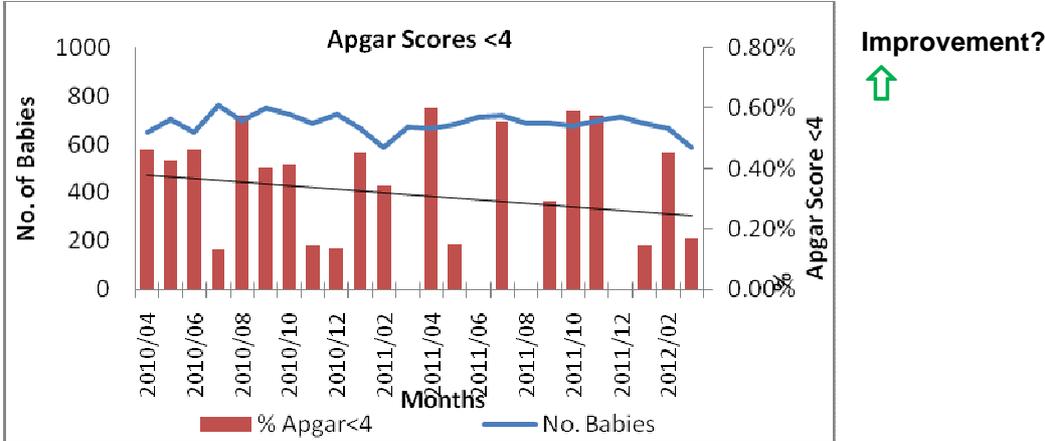
N.B. The nature of this measure forces a lag time in establishing monthly data and as a consequence March 2012 data is unavailable at the time of writing.

**Apgar Scores <4 (at 5 mins)**

*Definition: The number of live births after 34 weeks gestation where the Apgar Score at 5 minutes is less than 4. The number is expressed as a percentage of all live babies born after 34 weeks gestation. (Exclusions apply to these calculations where baby has been born before arrival of midwife).*

Data source: Meditech

The Apgar score is a measure of a baby’s condition at birth. Although developed as an indicator to aid with resuscitation, a low Apgar score (<4 out of 10) is an indicator that the baby has been born in poor condition and not coped well with the rigours of labour. All babies born with low Apgars should have the mothers notes reviewed to identify pre-delivery risks missed, or sub-optimal labour care. NICE Guideline - Intrapartum Care: Care of healthy women and their babies during childbirth (2007) covers all aspects of Maternity Care.



.In the year 2011-12 the Trust reported 24 of 8178 babies with an Apgar score <4, or 2.9 per 1000 babies. This rate is slightly down on the previous period. (3.2 in 2010/11, 3.7 in 2009/10) - Mark Clement-Jones, Consultant Obstetrician.

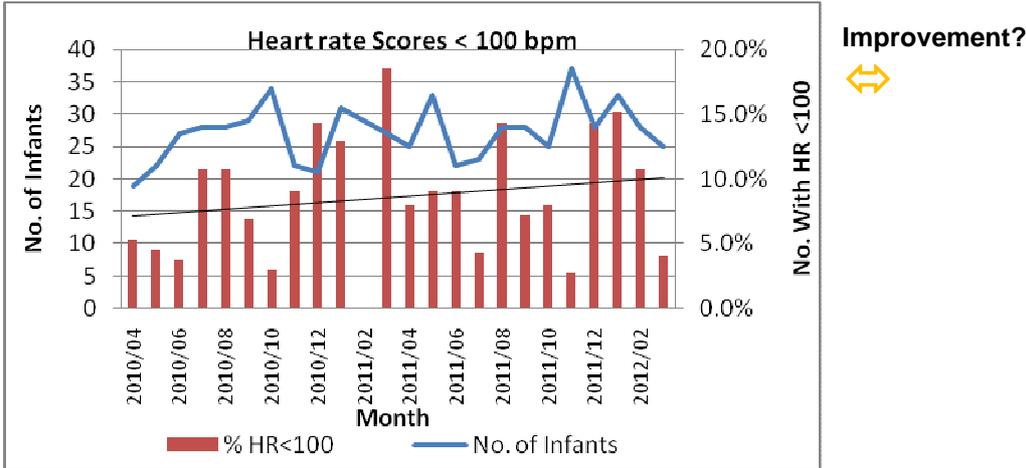
Statistical Process analysis indicates that the data shows normal variation.

**Baby Heart Rates <100**

*Definition: The number of live births born before 34 weeks where the baby heart rate is less than 100. The number is expressed as a percentage of all live babies born before 34 weeks. ( Exclusions apply to these calculations where baby has been born before arrival of midwife).*

Data source: Meditech

For babies born less than 34 weeks gestation, the use of the Apgar score is less useful, due to active measures at birth to resuscitate the infant. For these babies, the most useful indicator of neonatal wellbeing at birth is probably a heart rate greater than 100, at 5 minutes. Therefore this is the measure used rather than Apgar <4 at 5 minutes for infants born below this gestation. Again as for Apgar score, it is a measure of the quality of intrapartum care. In the Year 2011-12, the Trust reported 30 infants with a heart rate below 100 beats per minute (bpm) in 335 babies born at less than 34 weeks gestation. This equates to a figure of 8.96% and compares with figures of 6.84% in 2009/10 and 8.01% in 2010/11. – Mark Clement-Jones, Consultant Obstetrician.



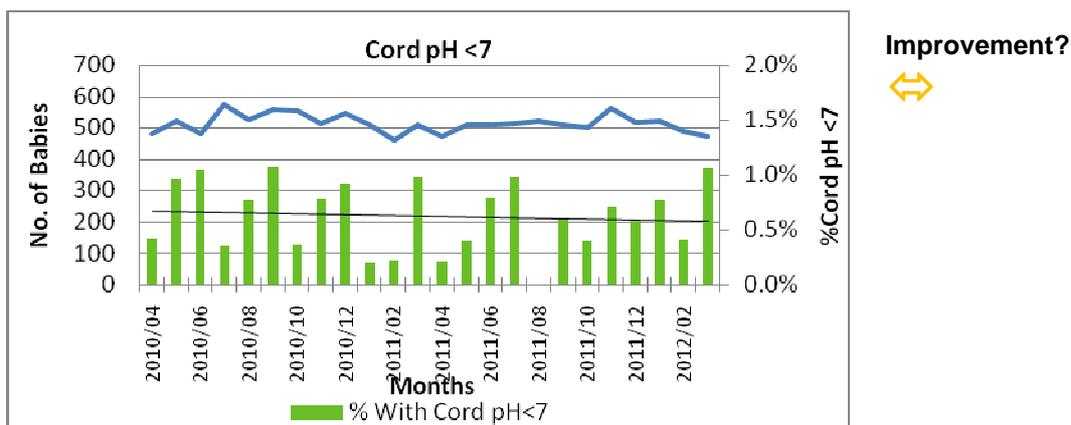
Statistical Process analysis indicates that the data shows normal variation.

## Delivery Cord pH <7

*Definition: The number of live births after 24 weeks gestation with a where the arterial cord pH is recorded as less than 7. The number is expressed as a percentage of all births after 24 weeks with a recorded pH. (Exclusions apply to these calculations where baby has been born before arrival of midwife and for babies born on Midwifery Led Unit).*

Data source: Meditech

The cord blood pH analysis is a measure of a baby's condition at birth. All babies born with low cord blood pH (less than 7.00) should have the mother's notes reviewed to identify pre-delivery risks missed, or sub-optimal labour care. Appropriate NICE guidance includes: Intrapartum Care: Care of healthy women and their babies during childbirth (2007), Postnatal Care: Routine postnatal care of women and their babies (2006) and Antenatal Care: Routine care for the healthy pregnant woman (2008). In the year 2011-12 the Trust reported 35 of 6,085 babies with a cord pH less than 7; an incidence of 5.7 per 1000, this compares with figures of 5.53 for 2010/11 and 5.8 for 2010/11. – Mark Clement Jones, Consultant Obstetrician.



Statistical Process analysis indicates that the data shows normal variation.

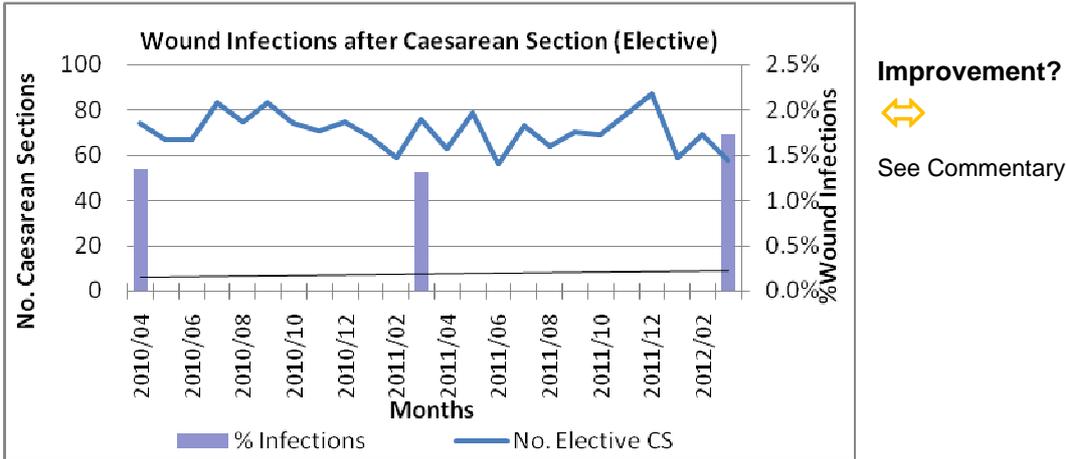
## Wound Infections Post Caesarean Section

Wound infection following caesarean section is a significant complication following delivery, which is potentially avoidable. NICE Guidelines covering this area include Caesarean Section (2004), Intrapartum Care: Care of healthy women and their babies during childbirth, Surgical Site Infection: Prevention and treatment of surgical site infection (2008) and Postnatal Care: Routine postnatal care of women and their babies (2006).

**Wound Infections Post Caesarean Section (Elective)**

*Definition: The number of patients undergoing an elective Caesarean Section who exhibit signs of an infection at the surgical site during their inpatient episode. The number is expressed as a percentage of all patients undergoing an elective Caesarean Section.*

Data source: Meditech

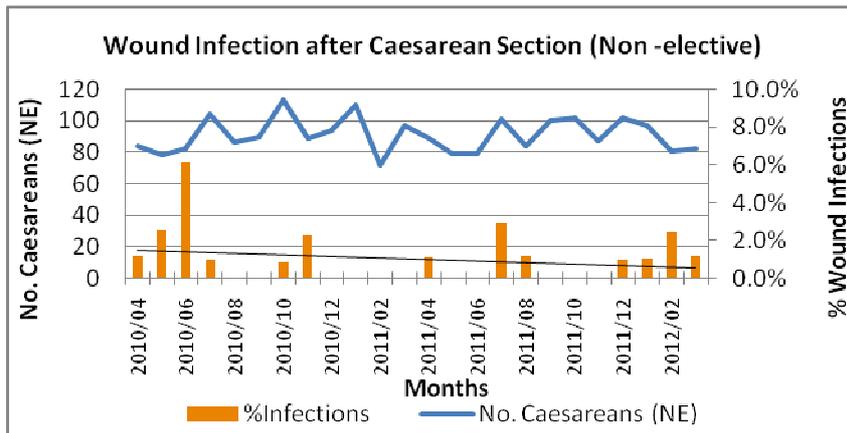


In the Year 2011-12 the Trust reported a single case of wound infection following an elective caesarean section amongst 825 performed equating to an annual incidence of 0.12%.

**Wound Infections Post Caesarean Section (Non-Elective)**

*Definition: he number of patients undergoing a non-elective Caesarean Section who exhibit signs of an infection at the surgical site during their inpatient episode. The number is expressed as a percentage of all patients undergoing a non-elective Caesarean Section.*

Data source: Meditech



Improvement?



See Commentary

In the Year 2011-12 the Trust reported 10 instances of wound infection following Non-elective Caesarean section in a total of 1083 performed. This equates to an incidence of 0.92% or approximately 9 per 1000 non-elective Caesareans.

Although we closely monitor the rate of infection following caesarean-section delivery, our clinical systems allow us to identify only the infections that occur during the period when the patient is under our direct care. We are aware that infections can be contracted during the patient's stay but only become apparent after the patient has been discharged. One of the challenges for us going forward is to work more closely with our partners in the community and diagnostic services to improve measurement and, therefore, reporting.

### Infection Incidence for Methicillin Resistant *Staphylococcus Aureus*, *Clostridium difficile* & Methicillin Sensitive *Staphylococcus Aureus*

#### MRSA

*Definition: The number of MRSA infections identified by a positive MRSA laboratory test each month. Only cases after 48hrs of admission are counted as hospital acquired rather than community acquired. Repeat positive tests >14 days apart are considered separate infection episodes.*

*Data source: Microbiology Laboratory Royal Liverpool University Hospital*

MRSA is Methicillin-Resistant *Staphylococcus aureus*. *Staphylococcus aureus* is a bacterium (germ) and is often found on the skin or in the nose of healthy people. Most *S. aureus* infections can be treated with commonly used antibiotics. However, MRSA infections are resistant to the antibiotic methicillin and also to many other types of antibiotics. Infections with MRSA are usually associated with high fevers and signs of the infection. As mentioned, most commonly these are infections of the skin

and soft tissues (like boils and abscesses). Less commonly, MRSA can cause pneumonia and urine infections.

### ***Clostridium difficile***

*Definition: The number of C. difficile infections identified by a positive Clostridium difficile laboratory test each month in patients over 2 years of age.*

*Only cases where the Trust is deemed responsible; i.e. where the sample was taken on or after the patients 4<sup>th</sup> day as an in-patient are counted. Nb. For long stay patients positive results >28 days apart are considered as separate infection episodes.*

*Data source: Microbiology Laboratory Royal Liverpool University Hospital.*

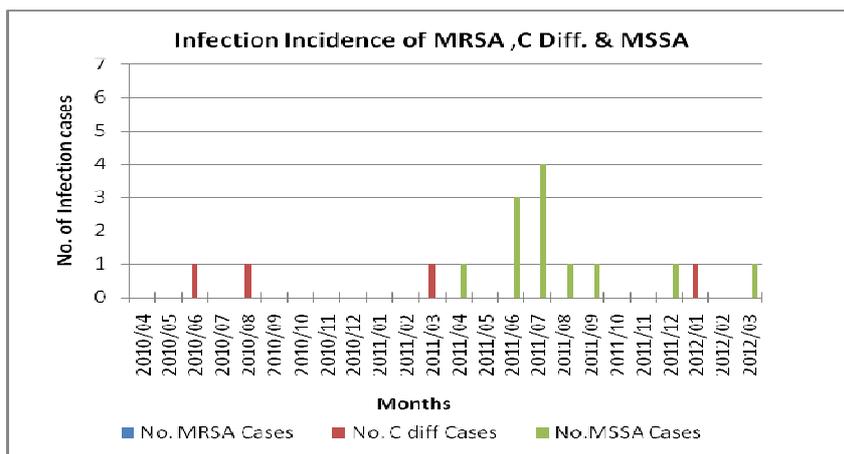
*Clostridium difficile (C. difficile) are bacteria that are present naturally in the gut of around two-thirds of children and 3% of adults. C. difficile does not cause any problems in healthy people. However, some antibiotics that are used to treat other health conditions can interfere with the balance of 'good' bacteria in the gut. When this happens, C. difficile bacteria can multiply and produce toxins (poisons), which cause illness such as diarrhoea and fever.*

### ***MSSA***

*Definition: The number of MSSA infections identified by a positive MSSA laboratory test each month. Only cases after 48hrs of admission are counted as hospital acquired rather than community acquired. Repeat positive tests >14 days apart are considered separate infection episodes.*

*Data source: Microbiology Laboratory Royal Liverpool University Hospital.*

The term MSSA (Meticillin Sensitive *Staphylococcus aureus*) is used to describe those strains of the *Staphylococcus aureus* bacterium (germ) that are sensitive (not resistant) to the antibiotic Meticillin. Trusts are now required to collate data on the incidence of infections involving MSSA and the data for 2011-12 is included in the following chart. As the factors which lead to infection with MSSA in adults are identical to those for MRSA the inclusion of MSSA within the National Surveillance data set is expected to demonstrate similar success in reducing infections.



Improvement?



Source: Clinical Coding Data

Infection Instances	MRSA	C.diff	MSSA
2009-10	2	1	Not Collected
2010-11	0	3	Not Collected
2011-12	0	1	12

In the year 2011-2012, the Trust reported no instances of MRSA infection, a single case of Clostridium difficile infection and 12 cases of MSSA infection. The Trust takes extremely seriously its duty to prevent infection and provide care in a safe environment. For the second successive year no patients developed MRSA bacteraemia. A single adult patient developed bacteraemia as a consequence of MSSA infection; however this infection was associated with community acquisition and not related to the care delivered in the Trust. The remaining 11 infections with MSSA occurred in patients cared for on the neonatal unit. There was a single patient with *C. difficile* infection which is a reduced incidence compare to previous years.

– Dr Tim Neal, Consultant Microbiologist / Director for Infection Prevention and Control.

## Medication Errors

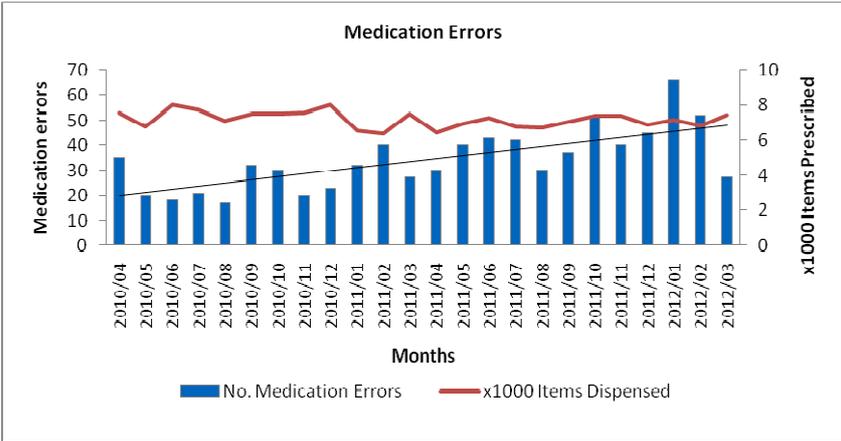
*Definition: The number of recorded instances where an error has occurred at any point during the administration of medication.*

*Data source: "Ulysses", the Trusts Incident / Risk database system.*

The data presented here represents medication related incident reports that were downloaded onto the Trust Incident Reporting system each quarter. Sometimes an incident, (known as an ACE report) is made up of a number of events which

contributed to the incident occurring. Pharmacy analyse each medicine incident reported taking this into account. As a result of this, the number of incidents reported can be contributed to a number events happening when they should not have done, or not happening when they should. As such, each incident can be made up of a number of events. The number of incidents reported represents the reporting activity only.

The data shows 503 medication errors amongst 84248 items prescribed in the year 2011-12, this equates to an error rate of ~0.6%. This compares to a rate of 0.35% for the previous year. Although the medication error rate appears to be increasing as shown by the trend line on the chart, it is thought that the rise is due to an increase in reporting rather than an increase in errors, this conclusion is consistent with a known shift from 'batch' reporting of some incidents to separate reporting of individual incidents. There has been a drive to encourage staff to report errors as this information is vital for us to identify and analyse the incidents. The more information we have helps us to reduce the risk factors that result in medication errors.



Improvement?



See Commentary

The pharmacy are currently working with the Risk team on an electronic tool to review medication administration errors so that errors can be effectively risk scored consistently across the Trust. The aim will be to use the concept of this tool to review other medication error types and potentially develop other non medication incidents risk scoring tools. - Eileen Reynolds, Chief Pharmacist.

**Accidental Perforation or Damage**

*Definition: The number of patients undergoing a Gynaecological surgical procedure where accidental perforation has been identified and occurred during the surgical procedure. The number is expressed as a percentage of all patients undergoing a Gynaecological surgical procedure.*

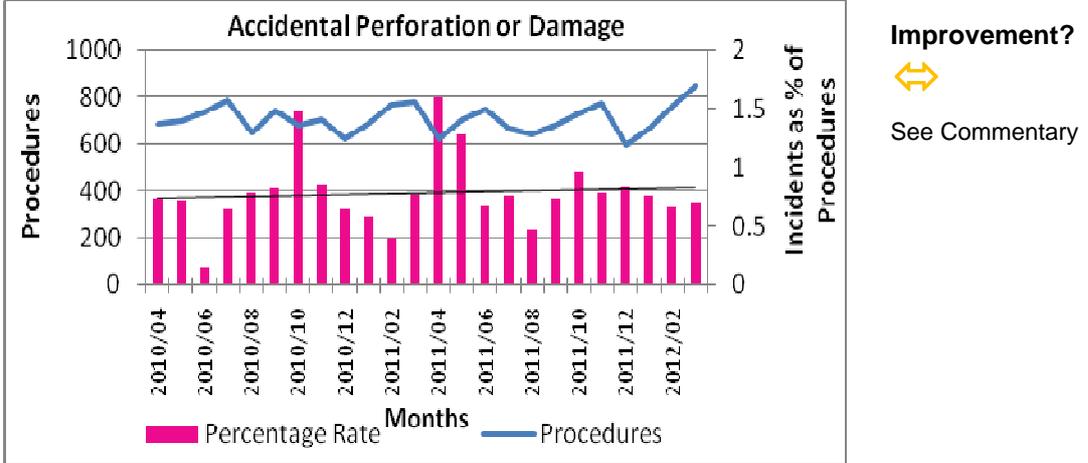
Data source: Meditech

Originally an internal measure in Gynaecology, this measure was introduced in the Quality Report for 2011-12. Data is collated on the number of patients during surgery who experience accidental perforation or damage to an organ or vessel.

This may have been identified during the procedure and repaired, or it may be identified post operatively, requiring the patient to undergo further surgery. As a Trust, this indicator is important as it identifies when difficulties or complications during surgery have occurred. This information is then shared with clinical staff and reviewed to identify trends. In some cases it may support the need for additional training and competency.

Following discharge, all of a patient’s care is clinically coded. The specific code for accidental perforation or damage is recorded against the patient episode. This information is then stored within the Trust’s main electronic data storage facility (data warehouse), which can be reported on as required. The division reports on this indicator monthly, with instances being recorded as episodes and as a percentage of procedures performed.

The Division aims to audit all cases where accidental perforation or damage has occurred to assess for trends and take appropriate action as required.



The data shows that 71 instances of accidental perforation or damage were recorded by the Trust in the year 2011-12 this equates to an incidence of 0.84% or approximately 1 in 119. The gradual creep upwards of the accidental perforation rate (injury to the patient during surgery) within Gynaecology has coincided with the increasing complexity of the Gynaecological surgery (particularly in Gynaecological Oncology) that has developed over the past 2-3 years. However, this is not to assume the rate is acceptable, and in view of this, a review of cases of accidental injury over the past year by the Gynaecological Oncology consultants is underway, and prospectively, a monthly review of all cases coded as an accidental injury is due

to commence in May/June 2012 to ensure any potential recurring problem is not overlooked.

– Mr Robert MacDonald, Consultant Gynaecological Oncologist / Gynaecology Clinical Governance lead.

## Clinical Effectiveness

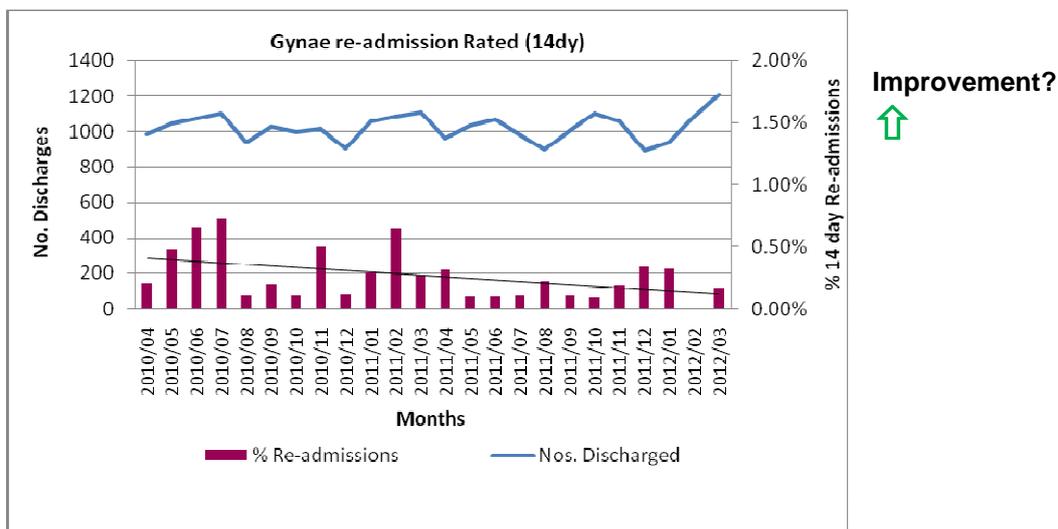
### Re-admission rates in Gynaecology

Measurement of re-admissions is part of the CQUIN payment framework<sup>2</sup> and the Enhanced Recovery Programme. CQUINS is a required national process, whilst the Enhanced Recovery Programme, which started in the Liverpool Women's Hospital NHS Foundation Trust in February 2011, is an internally driven programme to improve patients' journey through the hospital, aiming to reduce complications, reduce readmissions and improve patient experience. Measurement of the readmission rate, both early (14 days) and late (30 days) will be integral to the planned improvements.

#### 14 Days Gynaecological Re-Admissions

*Definition: The number of hospital admissions where the patient has a recorded discharge from a hospital spell within the last 14 days. The number is expressed as a percentage of all discharges. (Exclusions apply for diagnoses and procedures that conform to the allowed list of exclusions agreed with PCT).*

Data source: Meditech



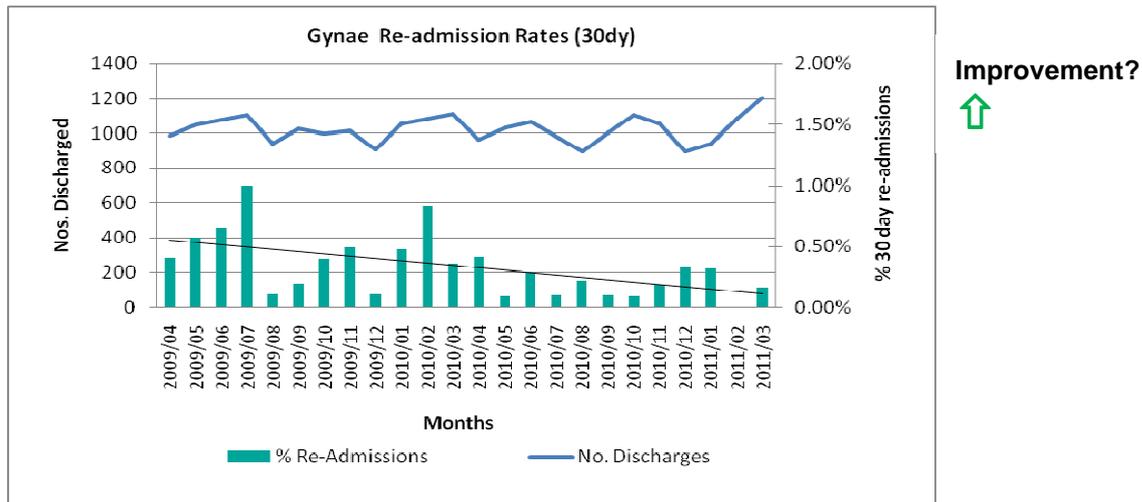
14-day	Discharges	Readmissions	%
2009-10	12599	45	0.36%
2010-11	12334	45	0.36%
2011-12	12217	20	0.16%

<sup>2</sup> The CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals.

## 30 Day Gynaecological Re-Admissions

*Definition: The number of hospital admissions where the patient has a recorded discharge from a hospital spell within the last 30 days. The number is expressed as a percentage of all discharges. (Exclusions apply for diagnoses and procedures that conform to the allowed list of exclusions agreed with PCT).*

Data source: Meditech



30-Day	Discharges	Readmissions	%
2009-10	12599	73	0.58%
2010-11	12334	59	0.48%
1011-12	12217	23	0.19%

The data for 2011-12 shows that 20 of 12,217 discharged patients were re-admitted within 14 days; an incidence of 0.16% or approximately 1 in 625.

By the 30-day benchmark, 23 of the 12,217 discharged patients had been re-admitted; an incidence of 0.19% or approximately 1 in 526.

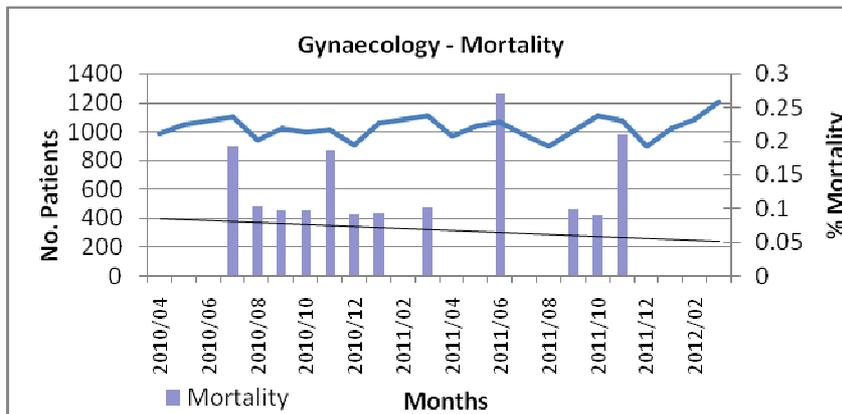
The continued fall in readmissions (at 14 and 30 days) is to be welcomed. With the initiation of the Enhanced Recovery Programme<sup>3</sup> (aimed at improving patient outcome but also reducing the length of stay), there was a possible concern that readmissions could rise as a consequence of early discharge. Thankfully, this has not happened, and the long term fall in readmissions has continued.  
- Mr Robert Macdonald, Consultant Gynaecological Oncologist / Gynaecology Clinical Governance lead.

<sup>3</sup> Enhanced Recovery Programme, see Introduction, Enhanced Recovery Programme

## Mortality Rate in Gynaecology

*Definition: The number of instances of death occurring during a Gynaecological episode.*

*Data source: Meditech*



**Improvement?**



See Commentary

In the year the Gynaecology Division reported 8 cases of patient mortality, this equates to an incidence of 0.06% or approximately 1 in 1542.

There is no aim or target for the Hospital Standardised Mortality Rate in the Liverpool Womens. In contrast to most District General hospitals, all the deaths within the Trust usually relate to Gynae Oncology<sup>4</sup>, are palliative in nature and are of women who are known to be in the terminal phase of their illness. Indeed, it is possible that our mortality rate may well rise over the coming years, as the excellent nursing care provided by the Gynae Oncology nursing staff (supported by the Gynaecology Macmillan nurses) and the facilities provided in the Mulberry Suite mean that more women actively choose the Womens Hospital for their end of life care. – Mr Robert MacDonald, Consultant Gynaecological Oncologist / Gynaecology Clinical Governance lead.

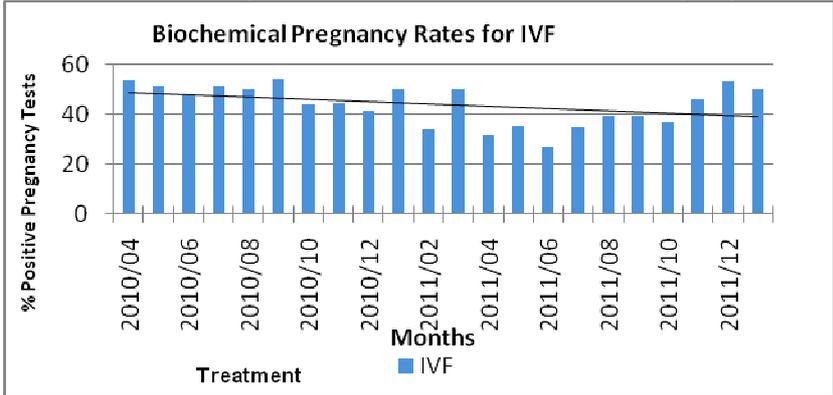
<sup>4</sup> Within this document, we include reporting of the Trusts first case maternal mortality in 15 years.

**Biochemical Pregnancy Rates in in-vitro fertilisation (IVF), intracytoplasmic sperm injection (ICSI) and frozen embryo transfer (FET) treatments.<sup>5</sup>**

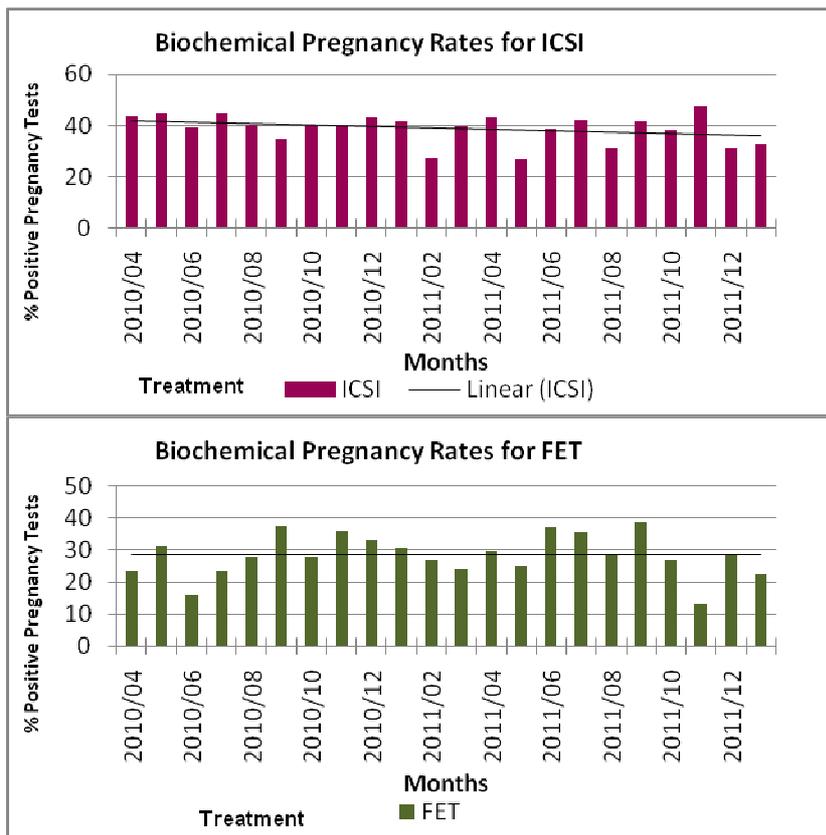
*Definition: This is the most useful and rapidly obtainable marker of how the whole system (drug stimulation, egg quality, lab performance) is working and is defined as the number of positive pregnancy tests per number of embryo transfers for a given time period.*

*Data source: "IDEAS" the Reproductive medicine database system*

Every couple embarking on fertility treatment wants to know how likely it is to work. Whilst live birth rates are perhaps more meaningful to lay people and academics, those data are only available a year or so after the event. What is perhaps more meaningful is clinical pregnancy rate (the incidence of fetal heart(s) on scan) or biochemical pregnancy rate (the incidence of positive pregnancy tests) as these are available as soon as two weeks after treatment and are a more immediate reflection on the performance of the service allowing meaningful reactive management. The attainment of a pregnancy is why we are here and why patients come to us. It is therefore fundamental to know how we are performing. NICE guidelines on this issue are found in Fertility: Assessment and treatment for people with fertility problems 2004).



<sup>5</sup> IVF is a fertility treatment involving bringing egg and sperm together in the laboratory to achieve fertilisation. ICSI is a fertility treatment involving the manual injection of a sperm into an egg to achieve fertilisation. FET is 'frozen embryo transfer' a process by which embryos from successful fertilisations are grown briefly then retained in frozen storage for later thawing and transfer to the mother's womb.



Improvement?



Improvement?



See Commentary

Biochemical pregnancy rates over the last two years have been at a respectable 35 to 50%. The biochemical rate is a more immediate reflection of how the laboratory is working. In addition to that, we have had to implement a selective single embryo transfer policy as directed by the Human Fertilisation & Embryology Authority (HFEA). A slight dip was seen in the middle of 2011, but monthly rates have picked up since then after a slight adjustment to the embryo transfer policy.

- Mr Andrew Drakeley, Consultant Gynaecologist/ Reproductive Medicine Clinical Governance Lead.

### Brain Injury in premature babies - Severe Intraventricular Haemorrhage & Periventricular Leukomalacia (PVL)

Cranial ultrasounds should be performed on all Very Low Birth Weight (VLBW) babies with a birth weight <1,501g during their period on the neonatal unit to look for evidence of brain injury (periventricular haemorrhage (PVH) or periventricular leukomalacia (PVL)). The following data are based on all inborn VLBW babies admitted to the neonatal unit. Data is collated and analysed annually and the full calendar year data available are presented in the table below:

	2009		2010		2011	
	No.	%	No.	%	No.	%
Number Scan Not Performed	35		37		22	
Number transferred / did not survive to scan	(25)		(19)		(11)	
Total Scanned	134		117		120	
PeriVentricular Leukomalacia	4	3.0	8	6.8	4	3.3
PVH grade 4	3	2.2	8	6.8	4	3.3
Total with no evidence of serious injury (no PVL, PVH grade<3)	119	88.8	99	84.6	103	85.8

There are a small number of VLBW babies who do not have a cranial ultrasound scan during their period of admission. The majority of these babies are babies who are transferred to other units or do not survive sufficiently long for the scan to be performed.

There has been some variation in the incidence of some types of abnormality across the past 3 years, but the numbers are small and there is no obvious pattern of improvement or deterioration. The proportion of babies who have no evidence of serious injury on their scan is high and appears to be stable across the past 3 years.

### **Benchmarking**

We benchmark our brain injury data by collaboration in the Vermont Oxford Neonatal (VON) network. The data for 2011 are not yet published.

The VON report for 2010 reports standardised rates of major PVH across 2008 to 2010. Standardised rate of severe PVH at LWH in 2008-2010 was 1 (with a 95% Confidence Limit = 0.77 to 1.23), so is not statistically different for the expected rate given the case mix of babies cared for.

The incidence of PVL across the VON network during 2008 to 2010 was 3.1% (interquartile range 1.1% to 4%). The rate at LWH was 3.3%, within the interquartile range.

## Conclusions

The rates of brain injury seen in VLBW babies cared for at LWH is in keeping with the rate that is seen in other neonatal units and appears to be stable.

## Perinatal Mortality

### Neonatal Mortality

The following table shows the neonatal mortality rate for babies born at Liverpool Women's Hospital between 2009 and 2011.

	2009	2010	2011
Live births (Total)	8,259	8,583	8,430
Live births (from booked pregnancies)	8,106	8,466	8,252
Neonatal deaths (total)	52	61	45
Neonatal deaths (from booked pregnancies)	31	41	29
Neonatal mortality rate (NNMR) expressed as deaths per 1000 live births.			
NNMR (Total)	6.3	7.1	5.3
NNMR (booked pregnancies)	3.8	4.8	3.5
UK NNMR <sup>6</sup>	3.1	4.2	
LWH gestation corrected NNMR (total)	4.2	4.7	3.2
LWH gestation corrected NNMR (booked pregnancies)	3.1	3.6	3.7

Crude NNMR for all babies born at LWH is higher than the published UK rate. Most of this apparent excess is explained by the fact that a significant number of women transfer their care to LWH during pregnancy or labour due to known fetal malformation, pregnancy complications or preterm labour with no local neonatal care availability. These are high risk pregnancies with a high NNMR.

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<sup>6</sup> UK NNMR data. The UK figure is published by the Office for National Statistics and is not yet available for 2011.

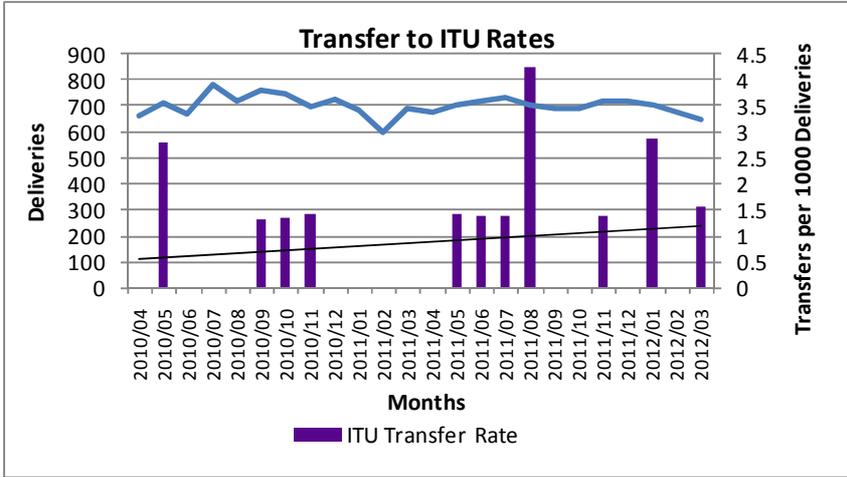
Over 60% of neonatal deaths occur in babies born before 31 weeks gestation. 1% of babies in UK are born before 31 weeks gestation. In our booked population this rate was 1.8% at LWH in 2009 and 2010 but had fallen to 1% in 2011. When the mortality rate is corrected for the gestation profile of our population, the NNMR for babies at LWH is comparable with national figures.

**Transfers to Intensive Therapy Unit (ITU)**

*Definition: The number of transfers to the Intensive Therapy Unit per 1000 maternities.*

*Data source(s): Number of ITU Transfers: ITU data team.  
Maternity data: Meditech*

The transfer of a woman before or post-delivery to ITU is an indicator of both the pre-morbid status (prior state of health) and/or the development of severe pregnancy associated morbidity. The identification and regular review of all women transferred to ITU is important to monitor the quality of our care for high risk pregnancies and complications. This care is as per NICE guidance Intrapartum Care: Care of healthy women and their babies during childbirth (2007) and Postnatal Care: Routine postnatal care of women and their babies (2006).



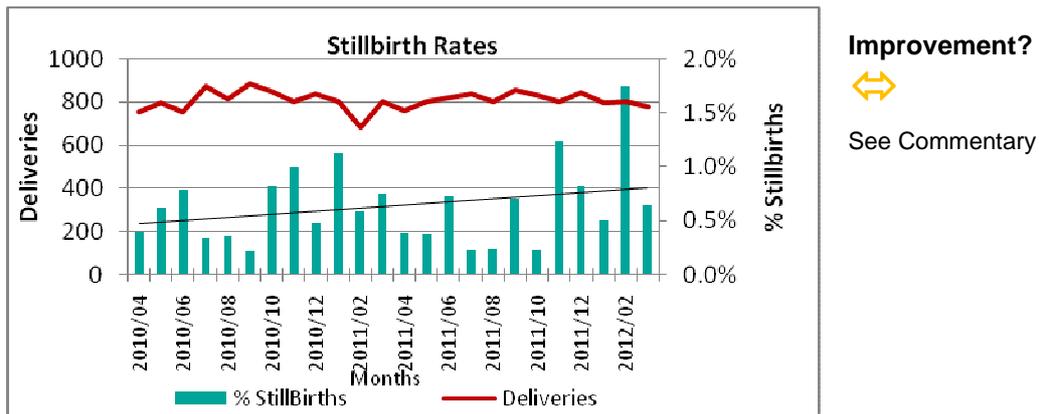
In the year 2011-12 the data shows that the Trust had an annual transfer to ITU rate of 0.12% or 1.2 per 1000.

**Stillbirth rates**

*Definition: The number of babies born who are classified as stillborn. The number is expressed as a percentage of all births.*

Data source: Meditech

Clearly the aim of antenatal and intrapartum care is a healthy mother and healthy baby. A stillbirth is unfortunately a relatively common (1 in 200) event and we should be constantly aware of our still birth rate, and identify trends or spikes in the rate, and investigate when appropriate. Available guidelines for this are covered by NICE in Antenatal Care: Routine care for the healthy pregnant woman (2008) and Intrapartum Care: Care of healthy women and their babies during childbirth (2007).



In the year 2011-12 the Trust experienced an annual stillbirth rate of 0.66% or an incidence of approximately 1 in 152 births. The rate is up slightly on 0.55 and 0.59; the rates for the last two years – Mark Clement- Jones, Consultant Obstetrician.

Statistical Process analysis indicates that the data shows normal variation.

### Transfusions Post Spontaneous Vaginal Delivery

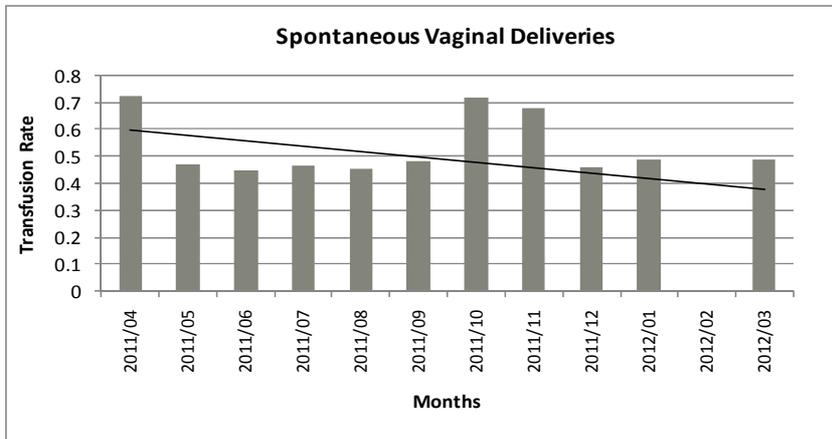
*Definition: The number of units transfused per 100 deliveries for patients having a spontaneous vaginal delivery.*

Data sources:            *Transfusion data: Haematology Laboratory*  
                                   *Delivery data: Meditech*

‘Transfusions following Vaginal Delivery’ was a new indicator for 2010/11. Upon review at the close of 2010-11 the Trust decided to report the transfusion rates for all modes of delivery, hence the data presented is for the 2011-12 period only. The transfusion rate in the following charts is expressed as a number of transfusions per 100 deliveries.

Post-partum haemorrhage is a significant cause of maternal morbidity. Correct management can reduce the effect on maternal health. Estimated blood loss is

notoriously unreliable. This surrogate measure will hopefully be more effective and be easier to benchmark. NICE Guidelines include Intrapartum Care: Care of healthy women and their babies during childbirth (2007), Postnatal Care: Routine postnatal care of women and their babies (2006) and Antenatal Care: Routine care for the healthy pregnant woman (2008).

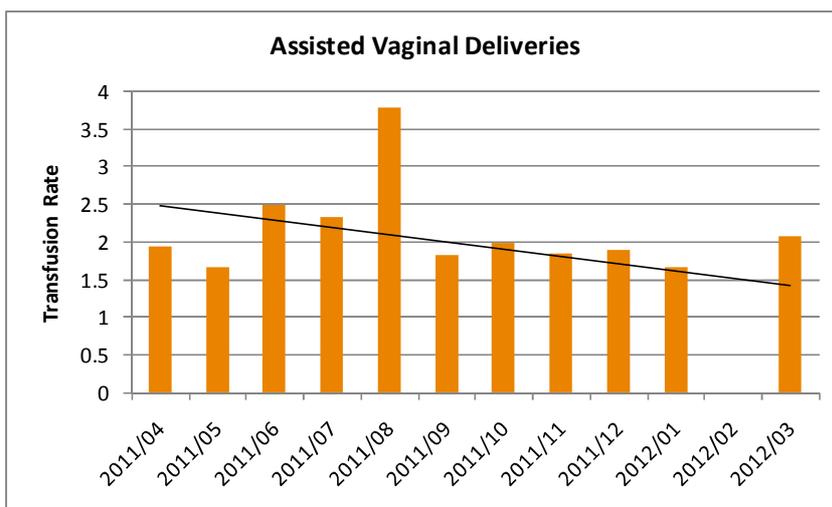


Improvement?  
↑

### Transfusions following Assisted Vaginal Delivery

*Definition: The number of units transfused per 100 deliveries for patients having an assisted vaginal delivery.*

*Data sources: Transfusion data: Haematology Laboratory  
Delivery data: Meditech*

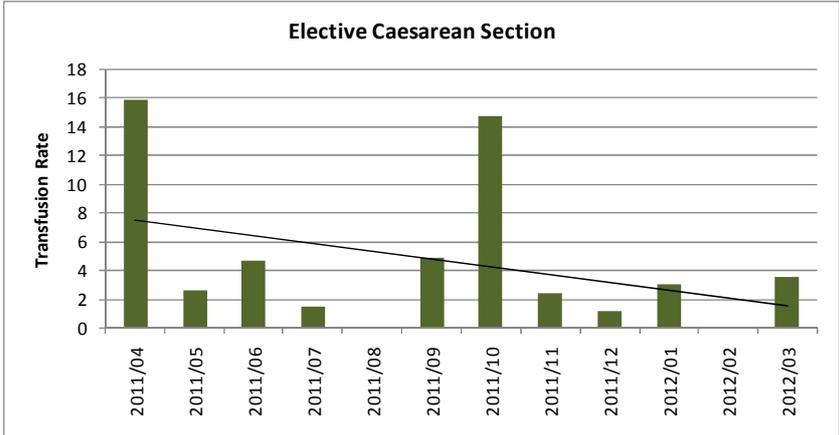


Improvement?  
↑

### Transfusions following Elective Caesarean Section

Definition: The number of units transfused per 100 deliveries for patients having an elective Caesarean Section.

Data sources: Transfusion data: Haematology Laboratory  
 Delivery data: Meditech

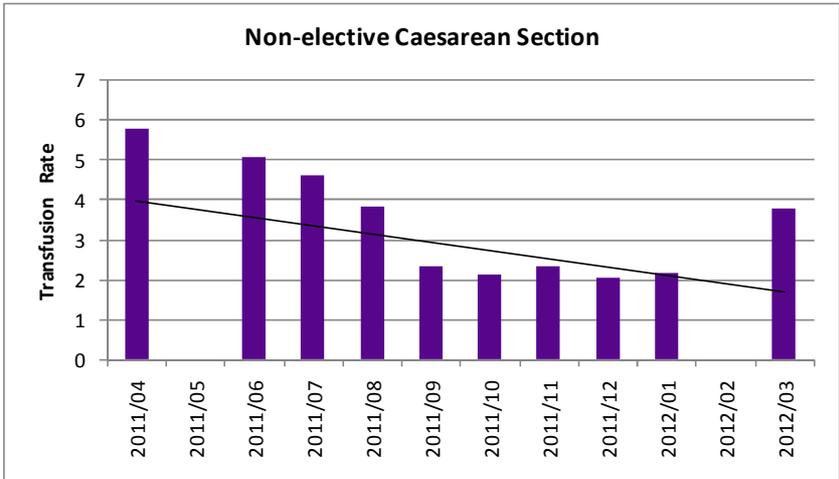


Improvement?

### Transfusions following Non-Elective (Emergency) Caesarean Section

Definition: The number of units transfused per 100 deliveries for patients having an emergency Caesarean Section.

Data sources: Transfusion data: Haematology Laboratory  
 Delivery data: Meditech



Improvement?

As the trend lines in the above charts show the transfusion rates for each mode of delivery showed a downward trend during 2010-12. In the 2010-11 period the

number of units of blood transfused to women having vaginal deliveries was 0.45 per 100 Deliveries. The rates for the 2011-12 data are presented in the table below:

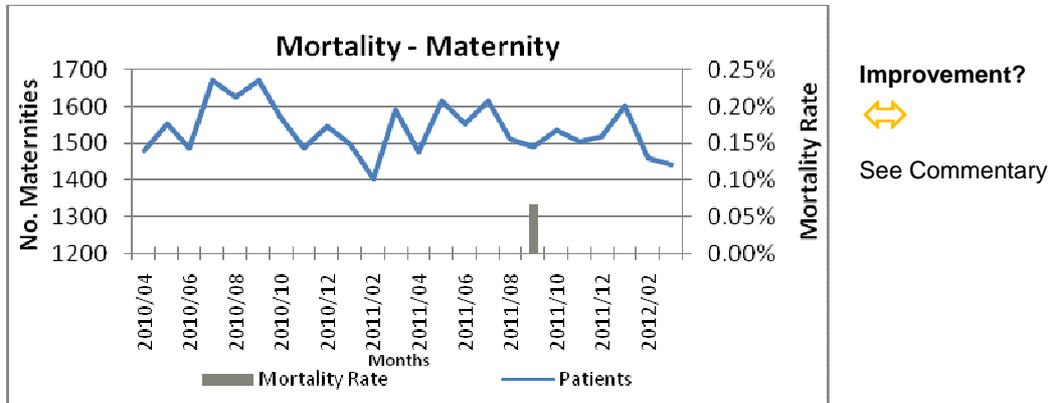
<b>Mode of Delivery</b>	<b>Spontaneous Vaginal</b>	<b>Assisted Vaginal</b>	<b>Elective Caesarean</b>	<b>Non-Elective Caesarean</b>
<b>Transfusion Rate</b>	0.45	1.78	4.19	2.5

The stratification of the original measure for Vaginal births into spontaneous and assisted cohorts and the addition of the caesarean groups makes comparison of this data with that of the previous period impracticable. However, the data will be used as a baseline measure for future analysis. As discussed under 'Clinical Indicator Priorities 2012 / 13' later in this Report, from 2012-13 these data will be measured and monitored internally, but will not be included in future Quality Reports.

## Mortality Rate in Maternity

Definition: The number of instances of death occurring during a Maternity episode.

Data source: Meditech

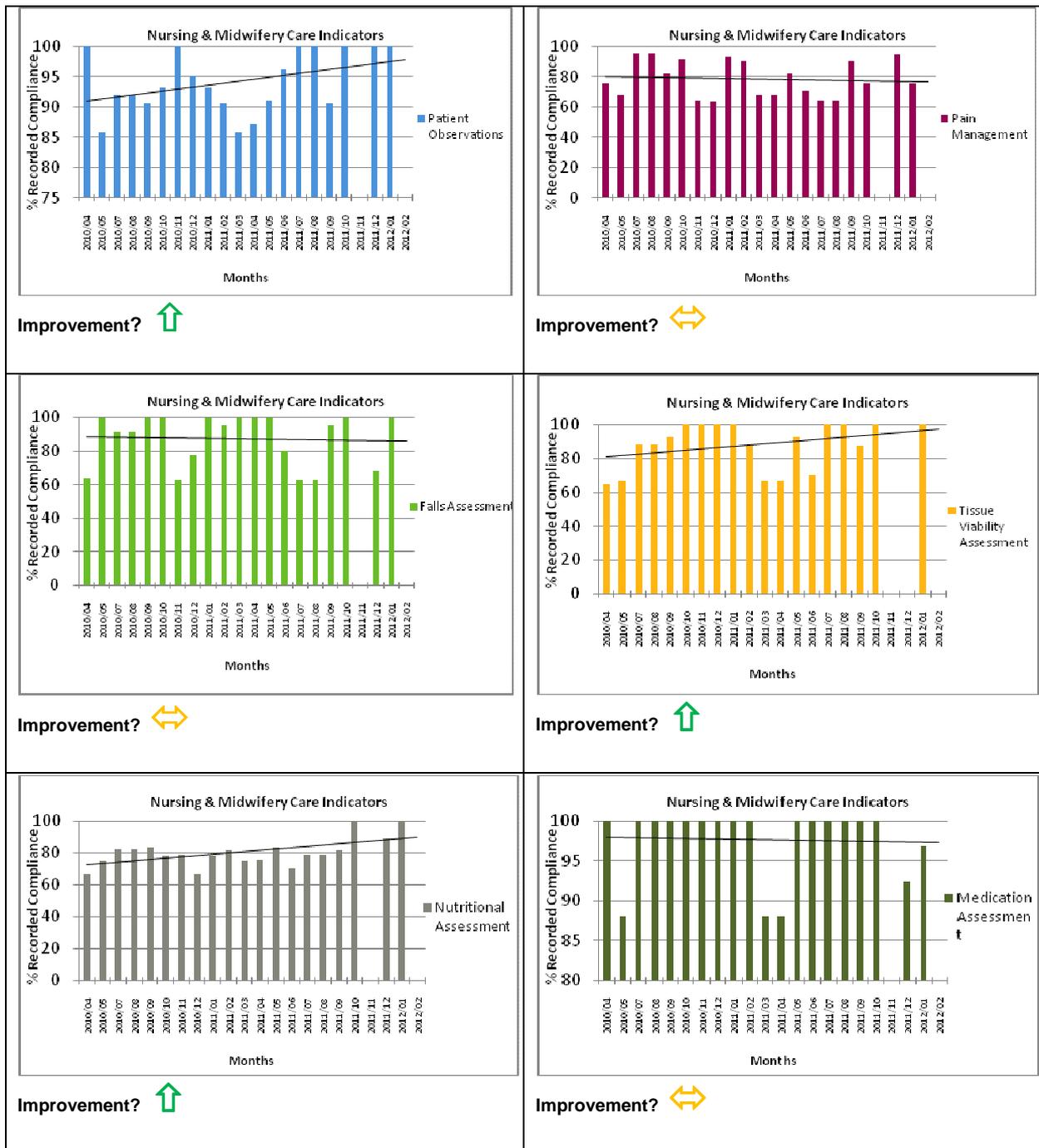


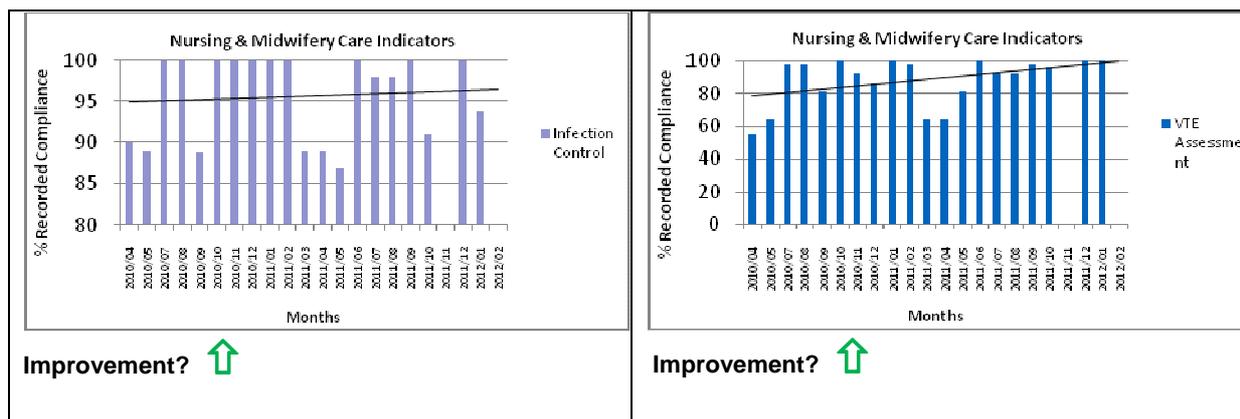
As the data shows the Trust experienced a single inpatient maternal death in the year 2011-2012; its first in 15 years. This was reported as a serious incident to NHS Merseyside and was subject to root cause analysis investigation.

## Nursing Indicators

Care indicators enable nurses and midwives to undertake spot-check audits on the quality of care received by patients. By undertaking monthly audits, teams can assess quality of care provided and identify areas for improvement. This provides the Divisions with monthly assurance that care is being regularly and consistently measured.

### Gynaecology





*Definition: Audits of a range of basic care indicators in the Gynaecology Specialty calculated as a percentage compliance to defined standards.*

*Data source: Nurse Matron Gynaecology*

Data for November 2011 is not available; however the average compliance with the requirements of these measures from the available data for the periods April – Oct 2011 and December 2011 – January 2012 is shown in the following table.

Gynaecology Measure	Patient Observation	Pain Management	Assessments					Infection Control	Personal Care
			Falls	Tissue Viability	Nutrition	Medication	VTE		
Average Compliance	96.1%	76.5%	85.5%	89.6%	84.2%	97.5%	91.7%	95.2%	96.7%

The measurement of key performance indicators relating to the delivery of nursing care allows the nursing management and the local nursing teams, to take responsibility and ownership where remedial actions are required to improve performance.

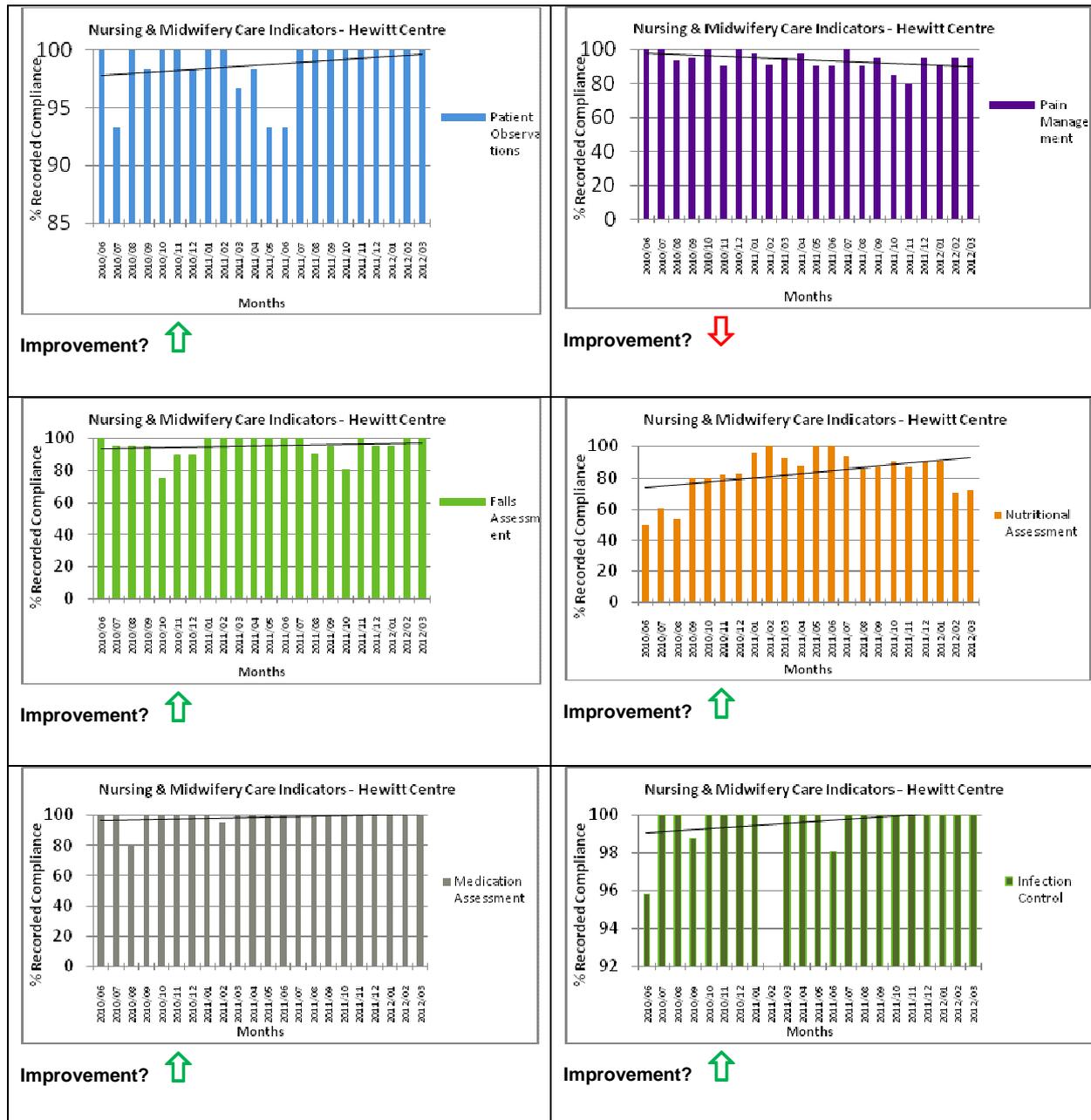
There have been significant challenges in relation to admission assessments, and as such a daily and weekly admissions assessment report has now been devised in conjunction with the Governance Team that provides detailed analysis of non compliance and information for action in a timely manner.

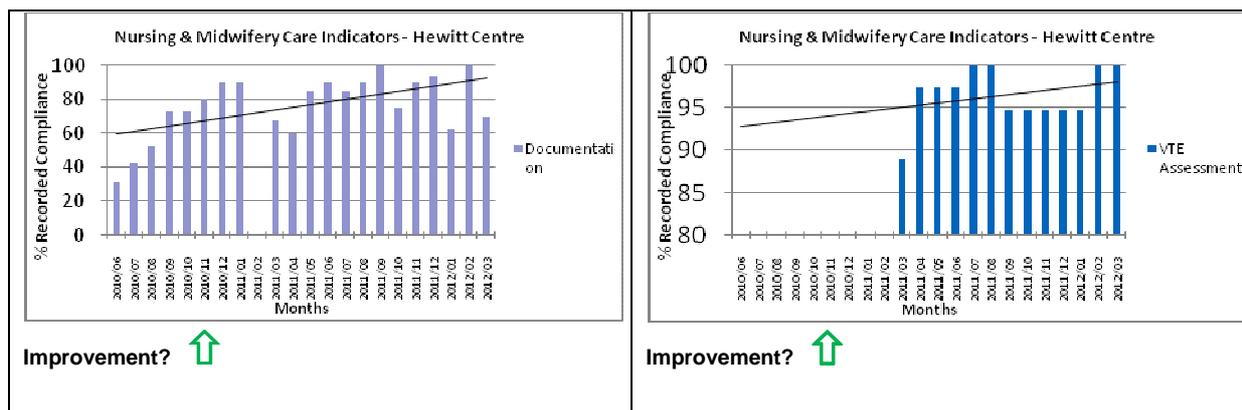
Going forward into 2012, we are embracing the Energising for Excellence initiative and have reviewed all of our current nursing indicators to ensure that they are all meaningful and add value to both patient safety and experience.

We have developed an additional set of indicators for theatres, Emergency room and outpatients that will focus more actively on the views and feedback from our patients.

They are designed to facilitate both internal and external benchmarking, and it is hoped that they will become a vehicle for real time feedback and engagement with our patient throughout the year. –Dianne Brown – Head of Nursing.

### Hewitt Centre





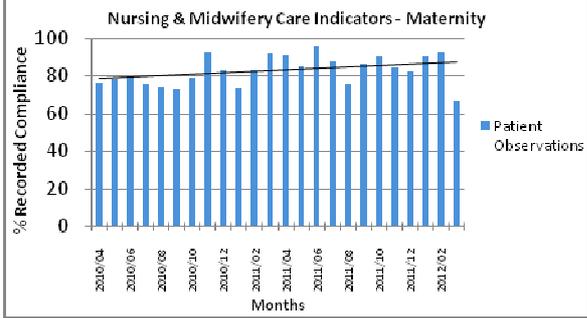
*Definition: Audits of a range of basic care indicators in the Reproductive Medicine Unit Specialty calculated as percentage compliance to defined standards.*

*Data source: Nurse Matron Reproductive Medicine Unit.*

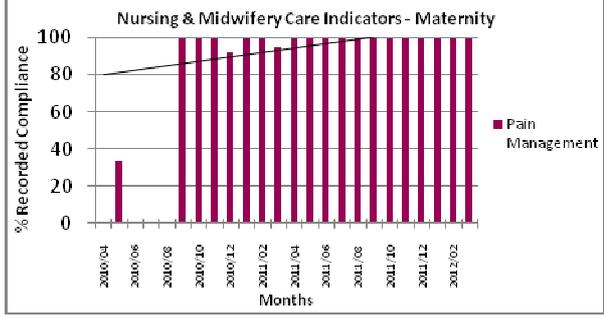
Hewitt Centre Measure	Patient Observation	Pain Management	Assessments				Infection Control	Documentation
			Falls	Nutrition	Medication	VTE		
Average Compliance	98.7%	91.9%	96.2%	87.8%	100%	97.2%	99.8%	83.3%

The Care Indicators are recorded from patient case notes post oocyte collection. The results are then discussed locally at nursing and departmental meetings. Although these are nursing indicators some require medical action and when there are medical omissions these are discussed at the appropriate executive meeting to be fed back to the medical team by the clinical director. Although there is still room for improvement, there has been an marked increase in compliance since introduction of the indicators, which is extremely encouraging. – Jane Mutch, Hewitt Centre Matron

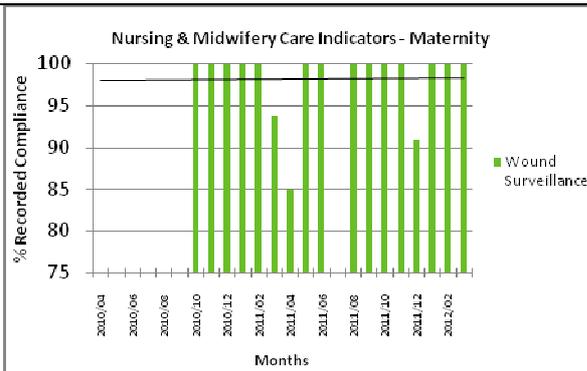
# Maternity



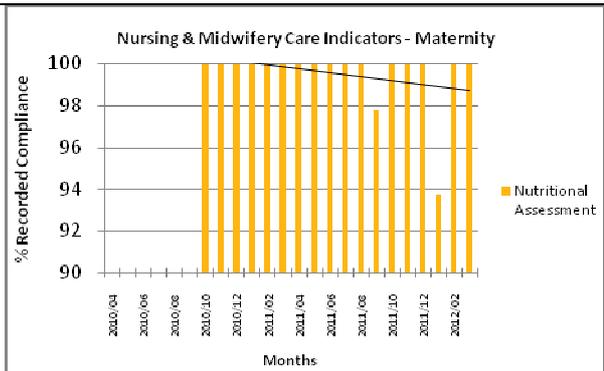
Improvement?



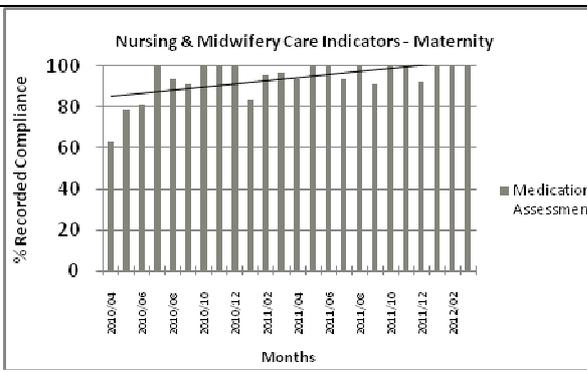
Improvement?



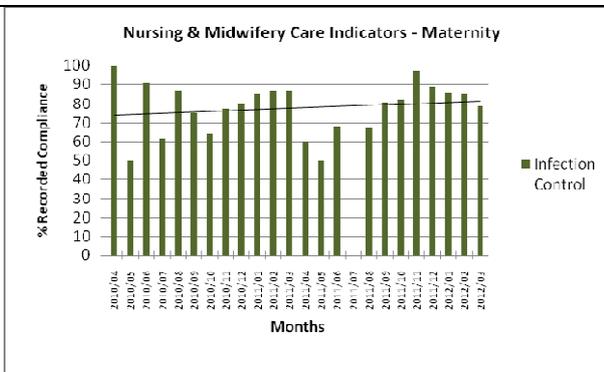
Improvement?



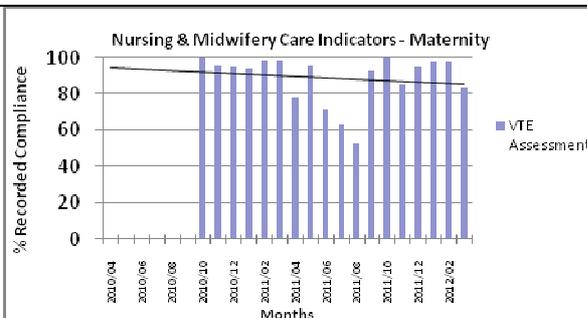
Improvement?



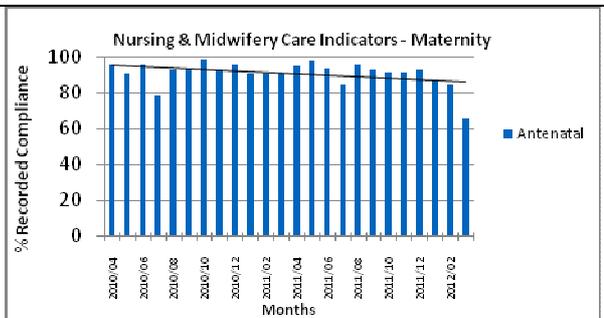
Improvement?



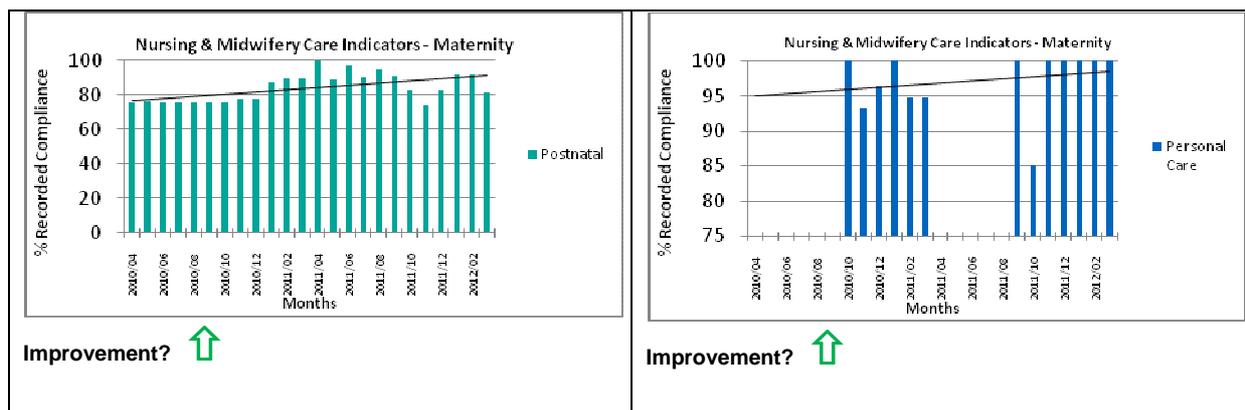
Improvement?



Improvement?



Improvement?



*Definition: Audits of a range of basic care indicators in the Maternity Specialty calculated as percentage compliance to defined standards*

*Data source: Nurse Matron Maternity*

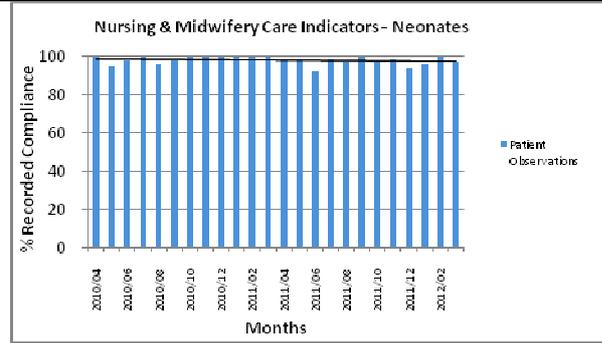
There are gaps in the data available for some of these measures, due to re-establishment of an agreed measure or in a minority of cases missing data. The average compliance from the data available, with the requirements of these measures is shown in the following table.

Maternity Measure	Patient Observation	Pain Management	Wound Surveillance	Assessment			Infection Control	Antenatal	Intrapartum	Postnatal	Personal Care
				Nutrition	Medication	VTE					
Average Compliance	85.8 %	100%	97.8 %	99.3 %	97.6 %	84.4 %	76.7 %	89.4 %	88.4 %	88.8 %	97.9 %

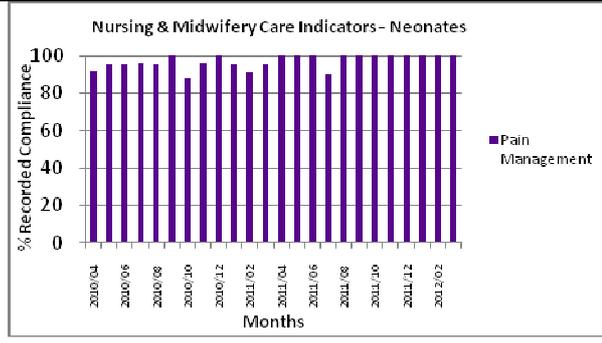
These midwifery indicators are measured on a monthly basis by senior midwives. The results are then discussed at ward level where improvements in care can be identified and implemented.

- Cathy Atherton, Head of Midwifery

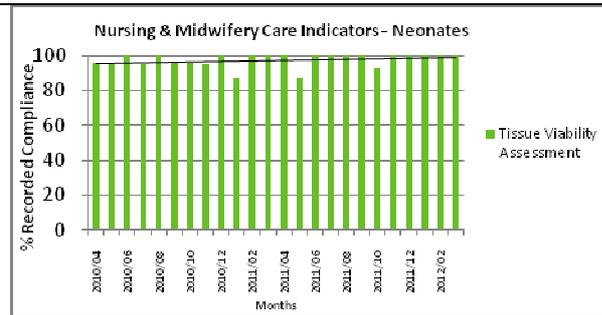
# Neonates



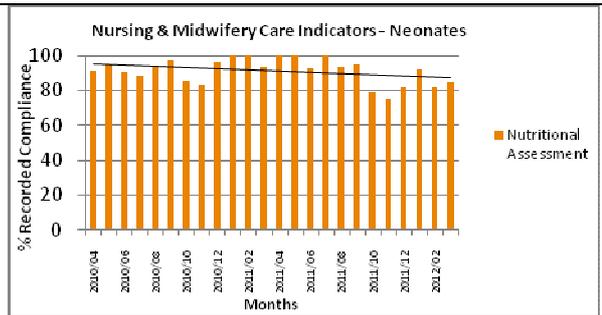
Improvement? ⇄



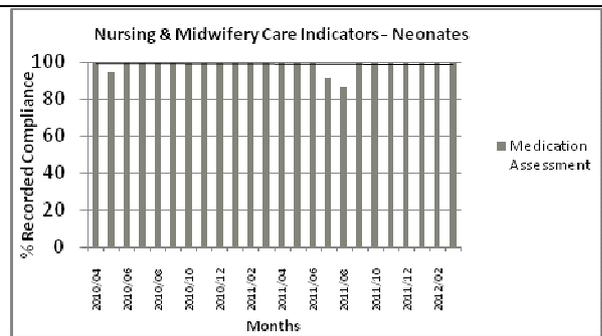
Improvement? ⇄



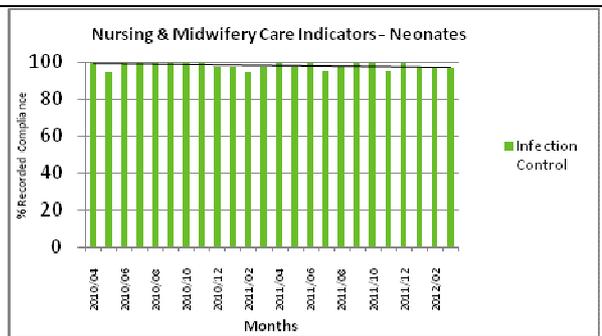
Improvement? ↑



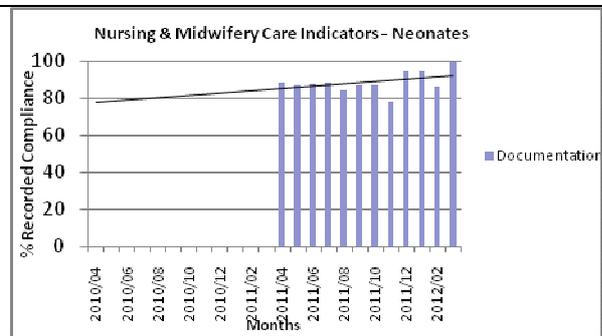
Improvement? ↑



Improvement? ⇄



Improvement? ⇄



Improvement? ↑

*Definition: Audits of a range of basic care indicators in the Neonate Specialty calculated as percentage compliance to defined standards.*

*Data source: Specialist Nurse Neonatal Unit.*

The average compliance with the requirements of these measures is shown in the following table.

Neonatal Measures	Patient Observations	Pain Management	Assessments			Infection Control	Documentation
			Tissue Viability	Nutrition	Medication		
Average Compliance	97.3%	99.2%	98.3%	89.7%	98.2%	98.2%	88.9%

Ten sets of infant records are randomly selected from infants admitted within the current month. The results are discussed at the operational meeting and disseminated to staff through team meetings, as well as being displayed on the notice board in the staff room.

Any actions required are carried out within the month and during 2011/12 there was no one factor which gave cause for concern in respect of delivery of nursing care.

Staff have been involved in deciding new factors for the forth coming year in order to improve the nursing care provided to sick term and preterm infants within the neonatal setting.

- Val Irving, Matron for Neonates and Imaging.

### **One to One Care in Labour**

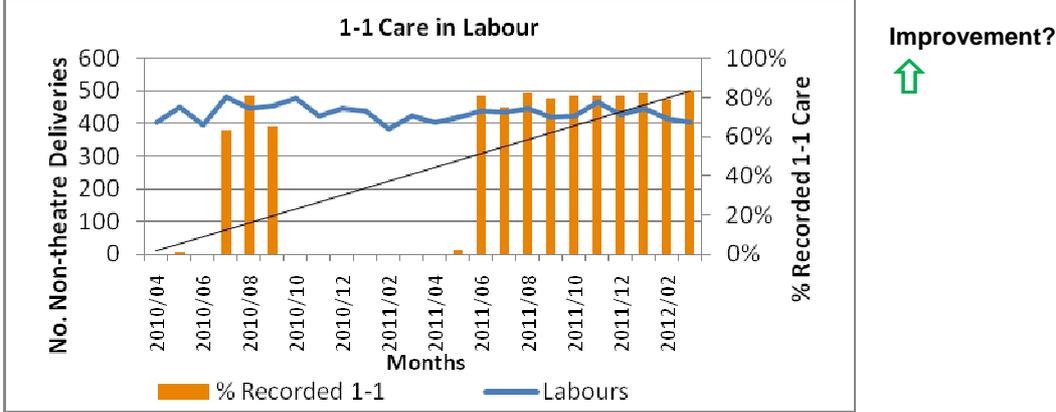
*Definition: The number of patients receiving one to one care during labour. The number is expressed as a percentage of all maternity episodes of care.( Exclusions apply for patients with Elective Caesarean Section).*

*Data source: Meditech*

This measure relates to women in established labour receiving care from an identified, midwife whilst she is in labour.

In the year 2011-12, the annual figure for recorded 1-1 care was approximately 68%. As the following chart shows for most of the year the monthly figures were around 80%, with a lack of recording in the early part of the year (due to re-establishment of

the definitions) accounting for the lower annual figure. During the time where the monthly figures are shown to be low, the maternity service was further developing the tool used to measure this standard and the data was not collected. Once this was agreed the chart shows an increase in women receiving one to one care in labour.  
 - Cathy Atherton, Head of Midwifery



**Patient Experience and Involvement**

The Trust is committed to achieving its vision and aims and the best possible experience for all service users and their families. The Patient Experience and Involvement Strategy has been developed to clearly detail the methods and processes used within the organisation to learn from patients, their families and visitors and to involve them in all aspects of Trust business. Our membership strategy, devised by our Council of Governors, similarly seeks to involve our members on helping to shape, develop and improve the services we provide.

**Gathering patient experience information**

The Trust has and will continue to use traditional methods of collecting feedback from complaints, PALS, comment cards, national surveys and service evaluations.

‘Real time’ surveys have been conducted in many areas using specifically designed electronic devices enabling a speedy analysis of the data collected. Patients and visitors, where appropriate, are invited to comment on their experience at the Trust using this innovative resource. At the time, there were only 3 devices in use, which were not enough as surveys needed to be completed in all areas. Thus at the moment it is being considered as to what is the best device that can be used and one is currently being tried out in the clinical areas. If this device is found to be suitable, then it is planned to purchase devices for all clinical areas. It is considered vital that when patient experience feedback is gathered it is taken from all areas.

## **Patient Involvement**

This is an area that is being looked at as it is absolutely crucial that we are able to liaise with all public members about our services and to get their feedback.

Patient Experience plan to work with the Trust Secretary and the Council of Governors to discuss and develop a robust plan for Patient Involvement, this could include independent surveys and the use of a “mystery patient” activity.

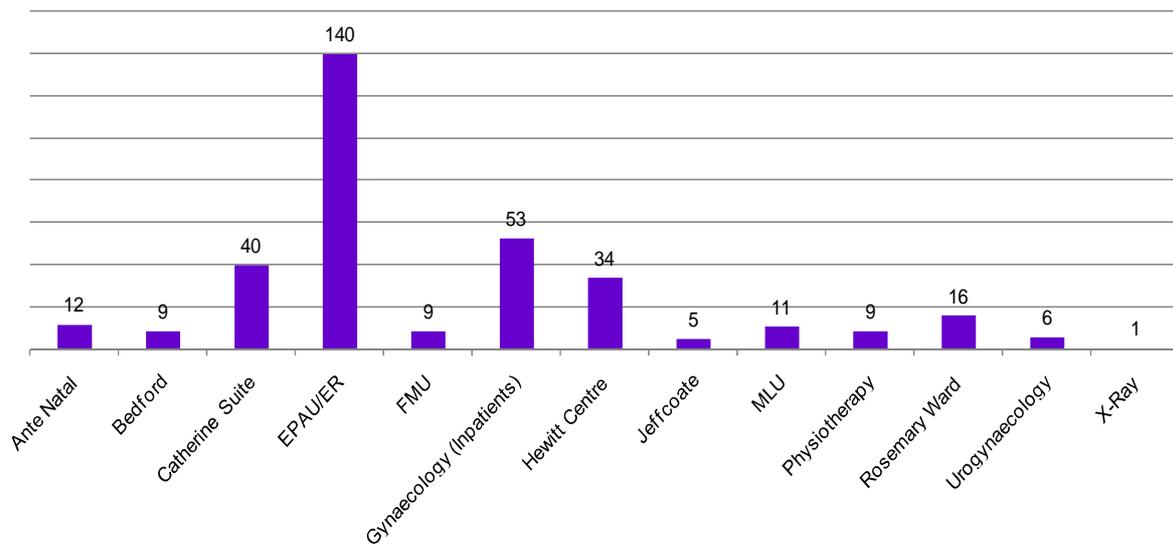
Recently we met with a hard of hearing lady and her sign language interpreter. This was a very interesting meeting as she was able to talk about her journey as a patient from the perspective of a hard of hearing person. Issues raised included the comment that when they press a buzzer to gain access to an area they are not able to hear if staff reply. In response to this feedback and their advice, we are investigating the possibility of making the buzzer light up when staff reply. We are also in the process of reviewing what interpreters are provided as hard of hearing patients may depend upon ‘sign’ as a standalone language, and this does not equate to a literal translation of the written / spoken word. This may mean they require information usually provided in leaflet form to be translated to sign language.

This is just the first step of looking at ways that we are able to communicate with all our patients regardless of their needs.

## **Patient Experience**

High on the agenda for all the staff who work at the Trust is to provide a positive patient experience. Sometimes a poor clinical outcome cannot be avoided and may not be the one that the patient wishes for but we can still make their experience of Liverpool Women’s a positive one. One of the greatest rewards for staff comes when patients they have cared for through a poor outcome leave the hospital thanking them for their support.

To be able to support a patient and provide them with what they want, we need to know what it is that they want. For this reason we continue to use the comment cards. In quarter 3 we received 345 comment cards from various areas across the Trust as shown below:



The feedback they provided is presented as the total number of all comments made in Q3 of about a certain theme are presented below:

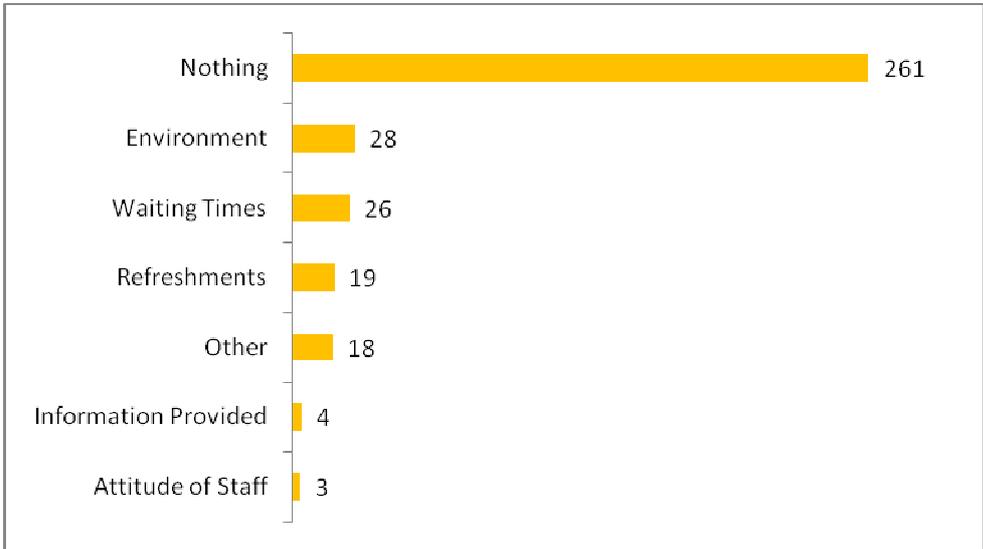
### Overall, What Was Good About Your Care?



The data presented are the total number of all comments made in Q3 about a certain theme. Other topics included:

Comfortable	6
Privacy	5
Food	5
Quality of Care	3
Honesty of Staff	3

**What Do We Need to Improve?**



An exciting development this year has been the introduction of Patient Stories as told by them. It is very powerful to hear in their words how they have been affected by what has happened to them. The Patient Story was originally introduced to the Trust Board by the Director of Nursing, Midwifery and Patient Experience and has gone on to be introduced at many of the meetings that take place. It is a reminder to everyone what our service is there for and how much impact we can have on a patient. No matter what we are planning and discussing whether it be money, or the building, always at the heart of it is what difference it will make to the patient.

At one Board meeting, the patient herself attended to talk about her experience. It was nerve wracking for the patient but afterwards she said how empowering it was for her and how reassuring to know that staff wanted to hear what she had to say.

Many of the patient stories are used as a teaching tool for the staff so that they can see how what happens to the patient affects them and in some cases using the patient's story has driven through change.

### Examples of changes made in response to Patient feedback

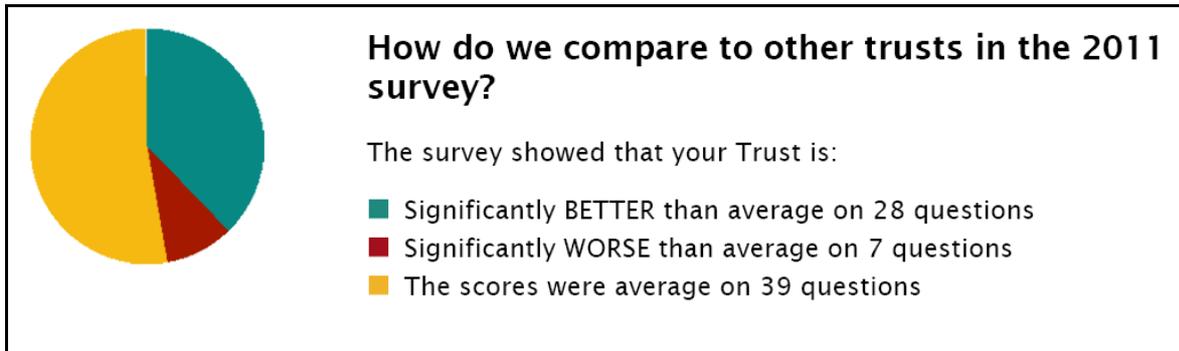
Problem	Change
Patient not given her breakfast until 10am	<p>Relaunching of the “red tray” system with the ward staff and the new catering company that started in April.</p> <p>(Red tray system is a national scheme to ensure patients who need assistance with nutrition receive the help required)</p> <p>Introduction of the ward hostesses who are aware of all the patients needs re catering.</p>
Regular medication not given in a timely manner.	<p>Nursing staff ensure the Senior House Officer prescribes medication on Meditech when patient admitted, if not done they escalate to senior staff until the job is complete.</p> <p>The importance of the need for the medication to be prescribed in a timely manner to be highlighted on the care plan</p>
Dentures were “lost” on the ward	<p>A supply of denture pots now kept in “forward wait” in theatre.</p> <p>Denture pots to be included in the TCI packs (contain undergarments, hat, theatre gown and denture pot and patient property bag)</p> <p>To use a patient property bag to return patients property such as dressing gown back from theatre and this will include denture pot.</p>
Patient attends Emergency Room for a scan, is sent down 2 floors to the scan department, then had to make her way back to the ER after receiving bad news	<p>After walking the patient’s journey and discussion with the scan department, the scans are now carried out in the ER</p>

## National Surveys

This year 2 national surveys were carried out, they were for Gynaecology Out-patients and Gynaecology In-patients

### Gynaecology Out-patients

The Response rate for Liverpool Women's NHS Foundation Trust was **47%** with 399 of 850 eligible patients responding. The average response rate nationally was 49% (74 NHS trusts).



### Gynaecology In-patient Results

The Response rate for Liverpool Women's NHS Foundation Trust was **51%** with 342 of 842 eligible patients responding. The average response rate nationally was 50% (73 NHS Trusts).

Admission types: 84% were planned admissions; 11% admitted urgent



These reports are encouraging as they indicate that in relation to the out-patient measures, the Trust matched or bettered the national average for 90.5% of the indicators and significantly exceeded the national average for 38% of the measures. In relation to in patient measures the Trust match or bettered the national average for 97% of indicators and significantly exceeded

the national average for 56% of the measures. The results also identify the areas where we need to improve to meet and surpass national performance.

The criteria for which the Trust’s performance was **better** than average included:

Hospital:

- Bothered by noise at night from either other patients or staff
- Bothered / feeling threatened by other patients / visitors

Communication Doctors & Nurses:

- Did not always get clear answers to questions Talked in front of patients as if they were not there
- Did not always wash their hands between touching patients & Nurses)
- Some / none knew enough about condition / treatment

Surgery communication – various elements

Discharge information elements - medication purpose, taking, side effects, danger signs and who to contact if worried

Some of the survey criteria for which the Trust’s performance was **worse** than average are highlighted below with the Trust’s draft proposals to address them:

Criterion	Improvement Proposals
Not fully aware what would happen during appointment	<ul style="list-style-type: none"> <li>• Include question on hand held device and survey 25 patients a month to pinpoint problem areas</li> <li>• Development of GOPD board displaying indicator information for patients and staff</li> <li>• Review patient information provided and map whom provides what, when</li> <li>• Admin redesign- Ensure requirements regarding correspondence are communicated to admin teams</li> <li>• Devise clinic guidelines/ clinic rules- raise awareness amongst staff of importance of introductions, welcoming script and explanations</li> <li>• Information regarding one stop pre op assessment to be reviewed and revised</li> <li>• Patient information Review- Represent GOPD Ensure process changes have positive influence</li> <li>• Patient Records Committee undertaking work regarding quality of patient correspondence</li> </ul>

Not given the name of person appointment would be with	<ul style="list-style-type: none"> <li>• Review of patient clinic correspondence</li> <li>• Review of patient information leaflets relating to whom appointment will be with</li> </ul>
Patient Not told why they had to wait	<ul style="list-style-type: none"> <li>• Ensure clinic guidelines/ clinic rules- include requirement for explaining reasons for delays</li> <li>• Include question on hand held device and survey 25 patients a month to pinpoint problem areas</li> <li>• Development of GOPD board displaying indicator information for patients and staff</li> <li>• Links with admin teams/ reception staff to be further developed</li> </ul>
Nobody apologised for the delay when waiting to be seen	<ul style="list-style-type: none"> <li>• Ensure clinic guidelines/ clinic rules- delays encourage staff to apologise for delays</li> <li>• Include question on hand held device and survey 25 patients a month to pinpoint problem areas</li> <li>• Development of GOPD board displaying indicator information for patients and staff</li> </ul>
Other Member of staff did not know enough about medical history	<ul style="list-style-type: none"> <li>• Admin review and monitoring of clinical information in case sheets timely</li> </ul>
Did not receive copies of letters sent between hospital doctors and family doctors	<ul style="list-style-type: none"> <li>• Admin review action to address</li> <li>• Patient records committee reviewing discrepancies in clinical correspondence re demographics/ GPs links with national spine</li> </ul>
Clinic delays	<ul style="list-style-type: none"> <li>• Standardised agreement/ guidelines regarding clinic templates to be revised, launched and monitored, deviations to be reported ( including overbooking</li> <li>• Clinics known to persistently over run/ long delays to be subjected to deep dive to establish specific remedial action required</li> </ul>

### ***Part 3. Other Information***

This section includes additional information including other measures and monitoring of performance conducted by the Trust in period beyond that included in the preceding review section and gives an overview of the quality of care based on the presented indicators. The reader is referred to the preceding section for an overview of the quality of care in relation to the presented indicators under the Patient Safety, Clinical Effectiveness and Patient Experience headings.

### **Performance against key national priorities and National Core Standards**

Our performance against national targets has remained strong throughout the year. Whilst we have experienced slight slippage in our compliance with 18 week patient referral to treatment times; with exceptions of the figures for non-admitted patients in Gynaecology, infertility and reproductive medicine and two of the categories for 'All cancers: two month diagnosis to treatment' the remaining results are above target and remain in excess of 97%.

All patients referred to us with suspected cancer followed agreed clinical pathways and access to appropriate treatment quickly.

Our infection prevention and control processes are robust and we have for another year had no incidences of MRSA. In the period, we had a single patient with *Clostridium difficile*; a reduction from 3 in 2010-11.

Indicator Name	Target	Performance	
		2010 / 2011	2011 / 2012
<b>Care Quality Commission: national Priority:<sup>7</sup></b>			
18 week Referral to treatment times: admitted (all Specialties)	90%	97.97%	97.52%
18 week Referral to treatment times: non-admitted (all Specialties)	95%	97.57%	97.15%
18 week Referral to treatment times: non-admitted (Gynaecology, Infertility and reproductive medicine)	95%	97.35%	96.84%
18 week Referral to treatment times: non-admitted (Clinical Genetics)	95%	99.46%	99.61%
18 week Referral to treatment times: non-admitted data completeness	80-120%	105.12%	97.19%
18 week Referral to treatment times: admitted data completeness	80-120%	99.67%	95.71%
All cancers: two week wait	≥ 93%	97.30%	97.54%
All cancers: one month diagnosis to treatment (first definitive)	≥ 96%	97.99%	98.54%
All cancers: one month diagnosis to treatment (subsequent surgery)	≥ 94%	98.36%	100%
All cancers: one month diagnosis to treatment (subsequent drug)	≥ 94%	None applicable	100%
All cancers: two month diagnosis to treatment (GP referrals)	≥ 79% <sup>8</sup>	89.96%	91.67%
All cancers: two month diagnosis to treatment (Consultant upgrade)	≥ 94% <sup>9</sup>	91.89%	92.45%
All cancers: two month diagnosis to treatment (screening referrals)	≥ 90%	100%	88.37%
Experience of patients	To be confirmed	Annual Surv	-
Incidence of MRSA bacterium	≤ 2	0	0
Incidence of Clostridium difficile	≤ 3	3	1
Infant health and inequalities: breastfeeding rate	≥ -5%	-1.92%	-2.10%
Infant health and inequalities: smoking rate	≤ 0%	1.14%	0.68%
Cont'd overleaf.....	Cont'd.....	Cont'd.....	Cont'd.....

<sup>7</sup> Data included in the above table is calculated as per the published guidance: <http://www.monitor-nhsft.gov.uk/our-publications/browse-category/guidance-foundation-trusts/mandatory-guidance/compliance-framework--0>The "All cancers: two month diagnosis to treatment (GP referrals) measure is expressed as a percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral ( a referral subject to maximum 2 week waiting time to first being seen by a consultant) for suspected cancer only. The 62 day limit is counted from the date the Trust receives the referral and the clock stops on the date that the patient receives the first definitive cancer treatment.

<sup>8</sup> The national target is 85%, however the Trust has a further tolerance of 6% given the specialist nature of referrals received (Department of Health 2009, Monitor 2011

<sup>9</sup> This target is not confirmed by the Department of Health. The Trust continues to reflect the most recent national benchmark available as of quarter 3 of 2011/12 (94%) – <http://transparency.DH.gov.uk/2012/02/24/waiting-times-cancer-q3>

Maternity Hospital Episode statistics: data quality indicator	≤ 15%	-	Method under review
NHS Staff satisfaction: Overall staff engagement (Specialist Trusts)	2011-12 Nat'l Average 3.77	3.51	3.49
<b>Care Quality Commission: existing commitments</b>			
Data quality on ethnic group	≥ 85%	98.30%	97.08%
Delayed transfers of care	≤ 3.5%	0%	0%
Last minute cancellation for non-clinical reasons	≤ 0.8%	0.54%	0.71%
Last minute cancellation for non-clinical reasons not readmitted in 28 days	≤ 5%	1.72%	1.33%
Total time in Accident & emergency (% seen within 4 hours)	≥ 98%	99.91%	99.82%

**Key:** Green= Target met or exceeded, Red= Target not met

### Data Quality:

The trust runs weekly Patient Tracing Lists (PTLs) for Cancer and episode data within 18 wks (Out-patient / Diagnostic/ Definitive treatment episodes) and hold weekly PTL meetings with the Divisional leads. The Trust Information Analyst conducts monthly audit of the work of the divisional trackers work to highlight and take action on any errors. The Information Analyst also holds monthly validation meetings with the trackers to discuss in detail in order to verify breaches prior to providing breach analysis reports and releasing data.

### Commentary:

In respect of the targets we did not achieve, the following remedial action is being taken:

- All cancers (two months referral to treatment consultant upgrade); this indicator does not have a nationally defined target for performance. The Trust has previously benchmarked itself against the most recent national performance data. There were only 2 patient breaches against this indicator in 2011/12
- Smoking rates; the Trust has struggled to impact sustainable improvement in this area of public health promotion. We identify and refer women to the primary care service. The update of the service is limited and the Trust is working more collaboratively with commissioners and service providers to develop a more effective model for smoking cessation

## Performance against DH 2011/12 Operating Framework

Measure	Target/ Threshold	Performance 2011-12
1 HCAI (MRSA / C. diff Inc)	MRSA :1, C Diff: 2	MRSA 0, C Diff 1
2. Patient experience survey		See National surveys p58
3. Referral to treatment rates (95th centile)	Admitted<23wk Non-Admitted<18.3wk	Admitted 17.0 Non-admitted 17.3
4. MSA breaches	Cumulative 4	Cumulative 0
5. A&E quality indicators		
Total time in A&E	<240 mins	Median 102, 95 <sup>th</sup> Centile 218, max 239
Time to initial assessment	<15 mins	Median 3, 95 <sup>th</sup> Centile 9, max 29
Time to Treatment decision	<60 mins	Median 60, 95 <sup>th</sup> Centile 178, max 391
Unplanned re-attendance rate	<5%	9.11%
Left without being seen rate	<5%	3.04%
6. Ambulance quality	Not Applicable	N/A
7.Cancer 2 week, 62 day waits	>93% , >79%	97.54%, 91.67%
8. Emergency re-admissions		(See Part 2. Review of Performance)

## Priorities for improvement 2012/13

During 2011/12 the organisation underwent a significant period of change in terms of the alignment of staff directly associated with the delivery of Patient Safety, Effectiveness and Experience, integrating these valued staff into a team has been completed. 2012/13 will be the first opportunity for the Governance Team to demonstrate the value and benefit of this significant change. Bringing together for the first time the combined knowledge, experience and talent across the Governance spectrum (Patient Safety, Risk Management, Health & Safety, Clinical Audit & Effectiveness, Research & Development, Information Governance, Infection Prevention & Control, Complaints, Patient Advice and Liaison, Chaplaincy, Bereavement and Volunteer Services) to help the clinical services design, run, maintain safe, effective, patient focused services.

Over the course of the year the Trust will develop a long term commitment to quality which dovetails seamlessly with the other key drivers in any public sector organisation:

- Value for money/customer focus
- Efficiency
- Service development and longevity

## Quality Improvement Strategy

To further strengthen the quality focus, Liverpool Women's NHS Foundation Trust are engaged in partnership with the Northwest Advancing Quality Alliance (AQuA) to pull all the existing quality work streams together into an overarching Quality Improvement Strategy, which we hope to launch in September 2012.

## Clinical Indicator Priorities for 2012/13

The Trust is mindful of the fact that the quality indicators it has previously committed to and reported through the Annual report remain of value and are worthy of continued monitoring; and of the feedback received from the audience of its earlier Quality Reports indicating that the content was too extensive and detailed.

Therefore, the Trust has decided to retain the priorities previously declared:

- To investigate, monitor and further reduce infection rates
- To investigate, monitor and reduce mortality rates
- To monitor and improve patient experience

and to continue to measure and monitor the indicators included in the 2010-11 report, but from the 2012-13 report to include data and commentary on those more pressing indicators itemised below. The current means of measuring and monitoring employed in 2011-12 will be carried forward into the next period and any changes and enhancements made during the period explained and justified in the next report.

The Gynaecology consultants have committed to completing the commenced review of Accidental perforations and damage and to the proposed prospective review and monitoring of cases commencing May-June 2012, but as explained above, this will not be included in the report from 2012-13.

*NB. For continuity this report with the exception of 'Rates of epidural pain relief for analgesia in labour' measure, which was abandoned in favour of a CQUIN measure reflecting patient choice in the selection of pain relief, reports on the indicators included in the report for 2010/ 11.*

## Patient Safety

- VTE assessment (Nursing / Midwifery Care indicator) and Post operative deep vein thrombosis / pulmonary embolism following discharge.
- Gynaecology surgical site infections (*Note particularly the reference to the "...lack of fall in infections in emergency operations (in contrast to the success in improvement in elective cases)." in performance review section.*)
- Incidence of Multiple pregnancy

- Apgar scores <4 in infants born at more than 34weeks gestation
- Delivery Cord pH<7.00
- Incidence of methicillin resistant staphylococcus aureus (MRSA bacterium)
- Incidence of Clostridium difficile
- Medication Errors

Whilst the Gynaecological Oncology consultants are committed to complete the review of cases of accidental injury that is underway, and to prospectively conduct a monthly review of all cases coded as an accidental injury from May/June 2012; the measure will not be amongst the reported measures in the Quality Report for 2012 /13.

### Clinical Effectiveness

- Readmission Rates in Gynaecology
- Hospital Standardised Mortality Rate in Gynaecology
- Biochemical Pregnancy rates in *In-vitro* fertilisation (IVF), Intracytoplasmic sperm injection (ICSI) and frozen embryo transfer (FET) treatments
- Brain injury in preterm babies (Severe Intraventricular haemorrhage and Periventricular leukomalacia).
- Perinatal mortality
- Stillbirth Rate
- Care indicators for Nursing and Midwifery

### Patient Experience

- Commitment to implementation of Patient experience & Involvement Strategy
- One to one care in established labour 100% of the time
- Patients receiving pain relief of choice (NB. This measure replaces the previous measure of Rates of epidural pain relief for analgesia in labour in recognition of patient choice).

## Statements of assurance from the Board of Directors

### Review of services

During 2011-12 Liverpool Women's NHS Foundation Trust provided services in four core specialty areas within its two Clinical Divisions.

Liverpool Women's NHS Foundation Trust has reviewed all the data available to them on the quality of care provided by the services within its Clinical Divisions.

#### **Gynaecology Division:**

Gynaecology and Surgical Services

Reproductive Medicine and Medical Genetics

#### **Maternity Division:**

Maternity Services and imaging

Neonatal and Pharmacy

Each Clinical Division reports to the Clinical Governance Committee, which is a sub-committee of the Board of Directors. Their Clinical Governance leads report on their self selected clinical outcome indicators categorised into Patient safety, Clinical effectiveness and Patient experience.

These indicators are part of the divisional dashboard and form part of the monthly performance and assurance report to the Board of Directors. Some of the indicators are benchmarked with the CHKS<sup>10</sup> national data or other specialty organisations. Data collected has influenced the organisation as identified in its improvement initiatives for 2012-13.

The income generated by the NHS services reviewed represents 100% of the total income generated from the provision of NHS services by Liverpool Women's NHS Foundation Trust for 2011/ 12.

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<sup>10</sup> CHKS is a part of Capita plc's health division; they have been independent providers of healthcare benchmarking intelligence and quality improvement services since 1989.

## Clinical Audit

For those unfamiliar with what clinical audit actually is, clinical audit involves us looking at aspects of our care to ensure that what we do is in line with particular standards or guidelines. Clinical audit is one of the main ways that we review the quality of the care we provide and is particularly useful for providing assurances about our standards or care, identifying areas for improvement or, once we have done an audit and implemented changes, demonstrating that our standards have improved.

## National Clinical Audit and Confidential Enquiries

During 2011-2012, 4 national clinical audits and 2 national confidential enquiries covered NHS services that Liverpool Women's NHS Foundation Trust provides. During 2011-12 Liverpool Women's NHS Foundation Trust participated in 100% (4 out of the 4) national clinical audits and collected data for 100% (2 out of 2) national confidential enquiries which we were eligible to participate in, as follows:

### National Clinical Audits

#### **Peri-and Neo-natal**

Neonatal intensive and special care (NNAP)

#### **Blood transfusion**

Bedside transfusion (National Comparative Audit of Blood Transfusion)

Medical use of blood (National Comparative Audit of Blood Transfusion)

#### **Long term conditions**

Heavy menstrual bleeding (RCOG National Audit of HMB)

### Confidential Enquiries

National Confidential Enquiry into Patient Outcome and Death (NCEPOD)

Confidential Enquiry into Maternal and Child Health (CMACE) – note that data collection ongoing, although submission currently suspended at national level due to changes in the process for NCEPOD.

The national clinical audits and national confidential enquiries that Liverpool Women's NHS Foundation Trust participated in, and for which data collection was completed or ongoing during 2010-2011, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry. The report of 1

national clinical audit (NNAP) was reviewed by us in 2011/12 (in line with the availability of national reports). The findings from the audit have been reviewed within the Neonatal speciality, presented at our Breakfast Meetings and discussed more widely at Clinical Audit Committee. When compared to other Trusts, the quality of care provided by Liverpool Women's (as audited by the NNAP) was extremely high in a number of core areas. However, in a small number of areas the national audit data suggests that we could be doing better. We have instigated a programme of additional audit in 2012-13 to provide us with more detailed information as to the quality of care we provide in these areas and have a detailed action plan in place to improve specific areas of care for our mothers and babies.

National Audit	Number Of Cases Included	Number Of Cases As % Of Eligible Cases
Neonatal intensive and special care (NNAP)	1239	this data not yet available to LWH
Bedside transfusion (National Comparative Audit of Blood Transfusion)	60	LWH required to audit 40
Medical use of blood (National Comparative Audit of Blood Transfusion)	11 (phase 1)	11 (Phase1)
Heavy Menstrual Bleeding (HMB) Audit	452	47% (452/960)*

\*The denominator for the HMB audit is calculated on the number of women eligible to take part as calculated from national hospital activity data. However the methodology employed in Phase 1 of the national HMB audit (1<sup>st</sup> February 2011 to 31<sup>st</sup> January 2012) required participating Trusts to identify eligible women when they booked in for their outpatient appointment (against the specific criteria for inclusion set by the national project team) and then for Trusts to offer eligible women the opportunity to participate. We are aware that although we screened 2,493 women and discussed the HMB audit with them personally, given the year long process we may not have identified all eligible women. Additionally, a small number of women opted not to take part. It is worthy of note however, that the Royal College of Obstetricians and Gynaecologists (who are involved in running the HMB audit in conjunction with IPSOS Mori) commended Liverpool Women's on its approach to the HMB audit and its recruitment.

### Additional Data regarding the HMB audit:

Number of Women Screened in our Gynaecology Outpatient Clinics	2,493
Number of Women Eligible	486
Number of Women Agreeing to Take Part	452

In addition to the national clinical audits and enquiries that LWH participates in, further audit projects are undertaken within the clinical specialities and across the Trust as whole. These may reflect requirements placed on us by our regulators, regional audits or areas of care we have identified as being important to us at a local level. In addition, we also instigate audit projects in-year, to reflect new guidance or to explore specific aspects of care which merit review.

In 2011-2012, Liverpool Women's NHS Foundation Trust undertook a major review of its clinical audit activity and introduced a new strategy to ensure that our clinical audit programme and individual projects provide us with confidence about the standards of care we provide and/or are used to stimulate quality improvement activities. Each of our clinical specialities has a designated Senior Clinician as the Speciality Clinical Audit Lead and each speciality prospectively identifies key clinical audit projects to be undertaken during the forthcoming year. These may be in relation to national audit projects (such as the heavy menstrual bleeding (HMB) audit and neonatal intensive and special care (NNAP) regional audits (such as Vitamin D) or specific audits which are particularly important to us as they link to our quality priorities. We may also instigate audit projects in areas which we have audited in the past and where action plans have been completed or as a result of a specific concern.

During 2011-12 we have recruited a patient representative onto our clinical audit committee and this has brought significant benefit to the clinical audit process overall. We are currently in the process of developing a range of information for patients and our wider membership about audit projects and outcomes and will be strengthening the role of the patient representative during 2012-13.

In 2011-12 we undertook over 250 audit projects, covering services across the Trust. The largest proportion of our audit activity was in Maternity, although all clinical specialities are involved in clinical audit projects. We have seen an increasing number of non-medical staff undertaking audits and staff at all levels are becoming more involved in audit activities. Our high dependency nursing team, for example, undertake an audit of the management of patients with sepsis and the genetic counselling team have embarked on a major programme of audit, looking at a range of different aspects of their service. Our midwifery teams are all actively involved in audit projects and our audits in maternity cover over 80 different topics.

The reports of over 100 local clinical audits were reviewed by Liverpool Women's in 2011-12 and we intend to take the following organisation wide actions to improve the quality of healthcare provided:

- improve our monitoring of the implementation of action plans linked to audits and provide support to action plan leads
- introduce a quarterly review of progress against delivery of our annual audit programme
- focus a significant proportion of the audit programme in 2012-13 on re-auditing areas where we know that there have been improvement programmes in place
- develop a risk-sensitive audit programme, linking audit to other areas of quality
- provide a wider programme of training to clinical staff to support high quality audit

(Please note that it is not practical to detail the action plan for every local audit project undertaken, rather the information above illustrates how we intend to improve the quality of our audit programme per se, thus ensuring that actions are implemented and embedded and we can demonstrate high quality care in specific areas).

During 2010-11 Liverpool Women's was subject to an external review by the NHS Litigation Authority (NHSLA). The NHSLA set out standards for NHS organisations in general and for providers of maternity care in particular. The standards cover a number of different aspects of care (from care of women in labour, to making sure staff receive appropriate training to medicines management). The aim of the standards is to ensure that organisations manage risk effectively and that we can demonstrate that the policies we have in place are implemented and monitored so as to ensure the highest standards of care. Following the 2 assessments (for the general standards across the Trust and for the maternity service in particular), we were awarded the highest level of accreditation possible – one of very few Trusts in the country to achieve this. Our approach to audit was also recognised by the Care Quality Commission (the organisation which regulates health and social care in England) who, following on from a recent inspection, specifically commented on how we are using clinical audit to review and improve standards across the hospital and the high profile of audit more generally.

## Clinical Research

### Commitment to research

The Trust is continually striving to improve the quality of its services and recognises that participation in research is pivotal to this ambition. The Trust also recognises that research is of the utmost importance in achieving cost improvement measures across the organisation. The White Paper Equity and Excellence: Liberating the NHS (DH July 2010) highlights that “Research is even more important when resources are under pressure – it identifies new ways of preventing, diagnosing and treating disease. It is essential if we are to increase the quality and productivity of the NHS and to support growth in the economy”.

In 2011/12 we have continued our efforts to contribute to quality National Institute for Health Research (NIHR) studies and to increase subsequent NIHR recruitment accruals. We also continue to focus our efforts on collaborative research with academic partners to ensure the research we conduct is not only of high quality, but is translational, providing clinical benefit for our patients in a timely manner.

The number of patients receiving NHS services provided or sub-contracted by Liverpool Women’s NHS Foundation Trust in 2011/12 that were recruited during the period 1<sup>st</sup> April 2011 to 31<sup>st</sup> January 2012 to participate in research approved by a research ethics committee was 3,023 of which, 1,916 were recruited into NIHR portfolio studies.

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 improvement. Our healthcare providers stay abreast of cutting-edge treatment options and are able to offer the latest medical treatments and techniques to our patients.

Liverpool Women’s was involved in conducting 101 clinical research studies across our speciality areas of maternity, neonates, gynaecology oncology, general gynaecology, reproductive medicine and genetics during 2011/12. At the end of 2011/12 a further 12 studies were in set up including 4 industry studies (anaesthesia, neonates, gynaecology and reproductive medicine).

Clinical research leads to better treatments for patients. At Liverpool Women’s we focus our research efforts on answering pressing questions, with an emphasis on translational research; moving innovative changes in treatment from the laboratory bench to clinical practice. A number of studies being led by Liverpool Women’s were completed during 2011/12, the results of which have directly impacted clinical practice. Studies completed during this period which have had a direct bearing on healthcare delivery, recruited 902 patients. These studies were concerned with

blood-clotting in emergency surgery, failure to progress in labour (women with diabetes), blood monitoring in babies, out-patient monitoring in labour, and obesity in pregnancy, and have all influenced healthcare delivery in their respective areas for the benefit of patients. We continue to lead on a number of studies, including studies adopted onto the NIHR portfolio, which will influence healthcare delivery in assisted conception, neonatal nutrition, antimicrobial use in neonates, obesity in pregnancy, and foetal medicine.

There were 71 clinical staff contributing to research approved by a research ethics committee at Liverpool Women's during 2011/12. These staff contributed to research covering a broad spectrum of translational research from basic research at the laboratory bench, through early and late clinical trials, to healthcare delivery in the community.

Our research has contributed to the evidence-base for healthcare practice and delivery, and in the last year, 87 publications have resulted from our involvement in research (with 21 NIHR publications), which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS.

### **Clinical Quality and Innovation (CQUINs)**

A proportion of the Liverpool Women's NHS Foundation Trust's income in 2011/12 was conditional on achieving quality improvement and innovation goals agreed between 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 Commissioning for Quality and Innovation payment framework.

The CQUIN indicators were negotiated and agreed following discussions between the Trust and Liverpool Primary Care Trust (LPCT), the host commissioner. These indicators reflect the key issues in the local health economy and National Health issues. Progress against these indicators was reviewed in detail at set intervals throughout the year.

In March 2012, Liverpool Primary Care Trust and North West Specialist Commissioning Trust confirmed that £934,000 out of the full CQUIN total of £1,071,000 would be payable to the Trust. A further payment would then be made post 31<sup>st</sup> March providing the Trust could demonstrate achievement against any outstanding targets.

Further details of the agreed CQUIN targets for 2011/12 and for the following 12 months are available on request from the Director of Nursing, Midwifery and Patient Experience. Alternatively, further information can be found at the following web site:

[http://www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/\\_openTKFile.php?id=327](http://www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=327)

### About Our CQUIN Measurement Process

Our CQUIN measurement dashboard is a tool that we use for internal monitoring of some of our quality improvement initiatives and whilst we are happy for this information to be published, the fact that this is an internal monitoring means it is important that we provide some explanation of what is being viewed.

Each year the Trust will agree a series of quality improvement targets with the local Primary Care Trust and these will generally be implemented over the course of the following 12 months.

In order to do this we will need to make changes within our organisation and this inevitably takes time. Sometimes the changes we need to make take just a few weeks but others can take us a whole year.

Regardless of the changes we are making and the time it takes to implement them, we will try to monitor the changes straightaway. Many of our measures, therefore, show us apparently under-performing when, in fact, it is simply that we are making the changes within the organisation but they have yet to be fully implemented.

Another aspect of our monitoring system is that occasionally we will make changes in the middle of the year that will inevitably impact on our performance. We may need to implement training programmes for our staff in order to familiarise themselves with new ways of working and, therefore, our activity may be affected whilst we introduce and embed those changes.

Regardless of the changes that are being made, we continue to monitor them as our monitoring system provides an effective method of judging how successful our changes have been.

We can also reach the end of the year and the data or information that informs us of any changes may not yet be available to us at the time and so cannot be published within this report.

A summary of the Trust's performance against CQUIN targets is provided in the following dashboard.

Liverpool Women's NHS Foundation Trust - CQUIN Dashboard

Indicator	Number	Goal	achieve	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Patient Experience		Involved in decisions about treatment/care					48%	35%	29%	34%	91%	26%	100%	100%	100%	
		Hospital staff available to talk about worries/concerns					42%	28%	26%	24%	86%	19%	100%	89%	100%	
		Privacy when discussing condition/treatment					48%	33%	29%	29%	100%	23%	100%	96%	100%	
		Being informed about side effects of medication					44%	5%	7%	13%	88%	13%	100%	85%	92%	
		Being informed who to contact if worried					46%	20%	20%	31%	97%	26%	100%	100%	94%	
Harm Free Nursing	3.1	Your skin matters		NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	
	3.2.1	Falls - Patients risk assessed for falls ( <b>Gynae: Meditech</b> )	>=98%	89%	90%	95%	92%	93%	86%	89%	95%	100%	99%	96%	93%	
	3.2.1	Falls - Patients risk assessed for falls ( <b>Maternity: Audit</b> )	>=98%	80%	76%	96%	80%	92%	68%	68%	60%					
	3.2.2	Falls - Patients at risk to have a care plan ( <b>Gynae: Meditech</b> )	>=98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
	3.2.2	Falls - Patients at risk to have a care plan ( <b>Maternity: Audit</b> )	>=98%	0%	NIL											
	3.2.3	Falls - RCA completed for all falls	100%	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	
	3.3.1	Weight Loss - Patients screened for malnutrition on elective admission	>=95%	100%	100%	100%	100%	100%	100%	61%	80%	96%	95%	87%	83%	
	3.3.2	Weight Loss - Patients screened for malnutrition on emergency admission	>=90%	100%	100%	100%	100%	100%	100%	57%	74%	91%	90%	85%	80%	
	3.3.3	Weight Loss - Patients at risk to have care plan	100%	NIL	NIL	NIL	NIL	0%	NIL	33%	66%	52%	71%	89%	59%	
	3.3.4	Weight Loss - Patients high risk referred to dietician	100%	NIL	NIL	NIL	NIL	0%	NIL	58%	66%	67%	86%	72%	73%	
	3.4.1	End of Life - Patients are cared for on LCP	100%	NIL	100%	0%	NIL	NIL	0%	100%	100%					
			>=35%	Redefined measure reporting from December									NIL	NIL	100%	NIL
	3.4.2	End of Life - Preferred place of care recorded	>=98%	NIL	100%	0%	NIL	NIL	100%	100%	100%					
			>=95%	Redefined measure reporting from December									NIL	NIL	100%	NIL
	3.4.3	End of Life - Patient has personalised care plan	>=98%	NIL	100%	100%	NIL	NIL	100%	100%	100%	NIL	NIL	100%	NIL	
	3.4.4	End of Life - Patient died in preferred place of care	>=60%	NIL	100%	100%	NIL	NIL	100%	100%	100%					
			>=70%	Redefined measure reporting from December									NIL	NIL	100%	NIL
	3.4.5	End of Life - Patient assessed for pain	>=98%	NIL	100%	100%	NIL	NIL	100%	100%	100%					
		End of Life - Pain assessed and controlled	>=80%	Redefined measure reporting from December									NIL	NIL	100%	NIL
	3.4.6	End of Life - Patient pain controlled	>=90%	NIL	100%	100%	NIL	NIL	100%	100%	100%					
	End of Life - Symptoms assessed and controlled	>=80%	Redefined measure reporting from December									NIL	NIL	100%	NIL	
3.4.7	End of life - Patient symptom controlled	>=80%	NIL	100%	100%	NIL	NIL	100%	100%	100%						
	End of Life - Fax sent to GP to support supportive care template	>=80%	Redefined measure reporting from December									NIL	NIL	100%	NIL	

Brief Interventions	3.5	Fit & Well - Sickness & Absence in nurses & midwives	>=96%	96%	96%	96%	96%	95%	95%							
			>=95.5	Q3 & Q4 Target 95.5 (see spec)						94.0%	95.3%	94.5%	95.8%	96.3%	95.6%	
	3.6	Nurse led discharge	>= 97%	87%	90%	93%	91%	98%	97%	97%	99%	97%	99%	98%	98%	
	3.7	Reduce infections following c-section	<= 10	1	0	0	3	1	0	0	0	1	1	2	1	
	3.8.1	Increase in staff training for promoting normal births (VBAC)	>=95%													
		Increase the number of staff supporting physiological birth	>=95%	Redefined measure reporting from December							78%	80%	82%	69%		
	3.8.2	Increase in number of pts offered appt at VBAC clinic at 36 weeks	>=95%													
		Increase in number of pts offered appt to discuss pain relief and choice of birth	>=95%	Redefined measure reporting from December							56%	44%	88%	84%		
	3.8.3	Increase normal births as % of total births	>75.8%	77%	77%	79%	77%	78%	75%	75%	76%	73%	76%	78%	78%	
	4.1	Identify a Trust Board Executive Champion		Complete												
	4.2	Identify a Lead Officer		Complete												
	4.3	Submit Public Health Strategy														
	4.4	Staff to complete Brief Advice train the trainer course		3 Staff												
	4.5	BA trained staff to cascade to other staff														
	4.6.1	Brief Advice given to smokers	>= 90%	100%	100%	100%	100%	100%	100%	100%	98%	96%	97%	97%	99%	
	4.6.2	Brief Advice given to drug/ alcohol issues	>= 90%	50%	50%	50%	50%	63%	87%	76%	80%	76%	76%	76%	76%	
	4.6.3	Brief advice given to patients with BMI 30+	>= 90%	50%	50%	50%	50%	55%	87%	85%	89%	91%	86%	89%	90%	
	4.6.4	Communication system identified with GPs to highlight Public health issues														
	4.7	No. patients with smoking status recorded	>=95%	86%	87%	86%	87%	86%	85%	99%	98%	100%	99%	100%	98%	
	4.8	Brief Intervention to smoking patients at booking (12 weeks)	>=95%	96%	99%	98%	99%	98%	98%	99%	99%	98%	96%	94%	97%	
4.9	Refer smokers into specialist stop smoking services	>=40%	27%	40%	34%	59%	61%	69%	65%	55%	57%	54%	56%	60%		
4.10	Increase in women at booking offered a CO2 reading - System setup															
	Increase in women at booking offered a CO2 reading - Measurement									27.7%	78.9%	59.0%	42.5%	44.2%		
4.11	Participate in evaluation process coordinated by LPCT															
4.12	Health Start Training	>=80%														
4.13	1:1 discussion with women at 12 wks and mothers at birth re: Healthy Start	>=80%														
4.14	Increase sign up of patients to Health Start Vitamin Scheme	>=95%														

	5a.1	Est. discharge discussion within 24hrs of inpatient admission	>=90%	74%	73%	77%	73%	76%	71%	65%	80%	87%	90%	87%	90%	
	5a.2	Discharge summaries to contain CRG dataset	>= 98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
	5a.3	Discharge summaries received by GP within 24 hours	>=95%	96%	98%	98%	98%	99%	99%	99%	99%	99%	99%	98%	98%	
	5b	Implementation plan to provide electronic method		Complete												
	5c	Discharge summary given to patient on discharge	>=95%	81%	82%	82%	85%	88%	87%	98%	98%	98%	99%	98%	96%	
	5d	Discharge letter received by GP in 2 weeks	>=98%	100%	99%	99%	95%	97%	97%	98%	100%	98%	97%	93%	98%	
	5e	Discharge of inpatients prescribing	>=98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Optimum Care Package	6.1	Patients assessed for clinical triage assessment within 1/2 hour	>98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
	6.2 A	No Patients completing questionnaire in community services	>=98%	0%	0%	0%	0%	0%	0%	0%	0%	100%	100%	100%	100%	
	6.2 B	Patient offered a choice of pain relief (Yes)	>=98%	0%	0%	0%	0%	0%	0%	0%	0%	88%	91%	100%	100%	
	6.2 C	Patient received pain relief of choice in a timely manner (Yes)	>=98%	0%	0%	0%	0%	0%	0%	0%	0%	100%	100%	83%	85%	
	6.2 D	Patient satisfied pain was managed in labour (As expected or better)	>=98%	0%	0%	0%	0%	0%	0%	0%	0%	86%	86%	93%	100%	
	6.3 A	Reducing LOS - Patient discharged within 12 hours	>16.0%	20%	22%	20%	20%	21%	21%	20%	19%	27%	29%	20%	22%	
	6.3 B	Reducing LOS - Patient discharged within 24 hours	>41.7%	42%	46%	43%	43%	42%	45%	43%	40%	51%	47%	41%	44%	
	6.4 A	Patient Experience - Number of patients receiving a questionnaire	>98%	0%	0%	0%	0%	0%	0%	0%	0%	100%	100%	100%	100%	
		Patient Experience - Overall rating of hospital food (Good/Very Good)		0%	0%	0%	0%	0%	0%	0%	0%	71%	71%	79%	61%	
		Patient Experience - How clean was ward and toilets (Clean or Very Clean)		0%	0%	0%	0%	0%	0%	0%	0%	96%	96%	92%	100%	
		Patient Experience - Suitability for Breastfeeding (Yes)		0%	0%	0%	0%	0%	0%	0%	0%	100%	100%	100%	100%	
	6.4 B	Patient Experience - Response Rate		0%	0%	0%	0%	0%	0%	0%	0%	3%	3%	2%	3%	
6.5 A	Skin to Skin Contact		85%	85%	86%	87%	86%	86%	84%	87%	86%	88%	85%	83%		
6.5 B	Skin to Skin Contact - 1 Hour						48%				52%					
Neonatal optimum care package	1	Benchmark against NICE 2010 Quality Standards		Complete												
	2	Initiation of Common Assessment Framework for all eligible babies (<1500g)	100%	Complete												
	3	Questionnaire on Discharge from Neonatal services							78%		100%	81%				
	4	Increase in very low birth weight babies being breast fed by mother	>=90%	91%	100%	95%	86%	94%	75%	87%	85%	100%	88%	100%	82%	
	2	Manage demand of counselling for at risk couples by introducing referral protocol		Complete												

## Registration with the Care Quality Commission (CQC)

The Care Quality Commission (CQC) is an independent regulator of health and social care in England. It regulates care provided by NHS, local authority, private and voluntary organisations. It aims to make sure better care is provided for everyone – in hospitals, care homes and their own homes and seeks to protect the interests of people whose rights are restricted under the Mental Health Act.

Two unannounced visits were made to the Trust during Quarter 4 by the Care Quality Commission. The first, on 7 February 2012, was made by six inspectors including two pharmacists, who reviewed Key CQC Outcomes 01, 04, 07, 09, 14 and 16. The final report of the Commission's compliance review was overwhelmingly positive reporting excellent feedback from patients, their families and staff. A moderate concern was identified in respect of the management of medicines and for which actions were swiftly taken. In particular a planned review of the Trust's pharmacy services and medicines management was expedited and an external review commenced on 20 February 2012.

## Statements from the CQC

Liverpool Women's NHS foundation Trust is required to register with the Care Quality Commission and its current registration status is fully compliant. Liverpool Women's NHS Foundation Trust currently does not have any conditions on registration.

The Care Quality Commission did not take any enforcement actions against Liverpool Women's NHS Foundation Trust during the 2011-12 reporting period.

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

The Trust is assured that it satisfies the CQC registration requirements through its monitoring of its CQC Quality & Risk Profile (QRP).

## Data Quality

The Liverpool Women's Hospital NHS Foundation Trust submitted records 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 valid NHS Number was:

- 94.8% for admitted patient care

- 93.9% for Outpatient care; and
- 91.4% for accident and emergency care

Included the patients valid General Medical Practice was:

- 100% for admitted patient care
- 100% for Outpatient care; and
- 100% for accident and emergency care

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

- Development of Data Quality dashboard at departmental level
- Actionplan in place to improve batch tracing processes to improve NHSA numbers
- Improved data quality monitoring processes being developed with Booking, Scheduling and Administration service

### **Information Governance Toolkit attainment levels**

The Liverpool Women's Hospital NHS Foundation Trust's Information Governance Assessment Report score overall score for the March 2012 assessment was 62% and was graded not satisfactory.

Due to turnover in personnel a significant level of evidence was not submitted at this time, but which had been submitted in previous quarters within the year 2011/12. Of the 13 Requirements that were below level 2 in this submission, an internal assessment identified clear evidence to support a level 2 standard for 11 out of the 13 requirements and two which were at risk of not achieving a level 2. This assessment is similar to many other NHS Trusts which have scored an overall level 2 for Information governance.

The Trust is confident that these issues can be resolved by the end of Quarter 1 2012/13 in time for the next submission.

### **Clinical Coding**

Liverpool Women's NHS Foundation Trust was granted exemption from the Audit Commission's clinical coding audit during 2010/11 due to its demonstration of high levels of accuracy in three previous Payment by Results (PbR) Data Assurance Framework audits. However, in 2011/12 all Acute NHS Trusts were subject to re-audit.

Liverpool Women's NHS Foundation Trust was subject to the Payment by Results clinical coding audit during the period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were as presented below.

Clinical coding error rates:

- Primary Diagnoses Incorrect 5%
- Secondary Diagnoses Incorrect 7.4%
- Primary Procedures Incorrect 0%
- Secondary Procedures Incorrect 3.2%

The services audited during this period included:

- Locally determined speciality – Obstetrics 100 spells
- Random selection from SUS – 100 spells

The coding accuracy rates are excellent and equate to level 3 in the Information Governance toolkit.

***It is important to note that these results cannot be extrapolated further than the actual sample audited.***

## *Annex -Commentary by Our Stakeholders*

### **Commentary for Liverpool Women's NHS Foundation Trust Quality Report 2011/12 from Head of Clinical Quality Improvement and Patient Safety, NHS Merseyside**



2011/12 Quality Account

NHS Merseyside Statement

In line with the NHS (Quality Accounts) Regulations 2011, NHS Merseyside can confirm that we have reviewed the information contained within the account and checked this against data sources where this is available to us as part of existing contract/performance monitoring discussions and is accurate in relation to the services provided. We have reviewed the content of the account and can confirm that this complies with the prescribed information, form and content as set out by the Department of Health.

As Director for Service Improvement and Executive Nurse for NHS Merseyside I believe that the account represents a fair and balanced view of the 2011/12 progress that Liverpool Women's NHS Foundation Trust has made against the identified quality standards. The Trust has complied with its contractual obligations and has made good progress over the last year with evidence of improvements in key quality & safety measures.

A handwritten signature in black ink that reads "Trish Bennett".

Trish Bennett  
Director of Service Improvement & Executive Nurse  
NHS Merseyside

## **Liverpool LINK Commentary for Liverpool Women's NHS Foundation Trust Quality Report 2011/12**

Liverpool LINK once again welcomes the opportunity to comment on Liverpool Women's NHS Foundation Trust's Quality Account.

We would like to congratulate the Trust on its efforts to meet the very ambitious number of priorities it set itself during 2011/12 and we are particularly pleased to note that there has been steady improvement regarding the majority of these priorities. However, without having access to data from other trust that are comparable with Liverpool Women's, it is hard for the lay person to judge exactly how well the hospital is performing in relative terms. This is a general weakness with quality accounts when dealing with hospitals that are fairly unique in a number of respects, but where in future there are opportunities to give some narrative on benchmarking for a particular priority this would be welcome if included in Quality Accounts.

The use of the Quality Accounts monitoring data by the Trust to inform future actions, as exemplified regarding the lack of a fall in emergency operations leading to a future focus on this issue, show the real value of the Quality Accounts exercise in driving up standards at the Trust.

The Quality Account document is reasonably easy to read and understand, and the graphs are somewhat informative in terms of absolute performance against specified targets. However, the sheer amount of data that needs to be covered by the Quality Account means that it is desirable, if one requires to explore any priority in detail, to be able to ask questions of Trust Officers rather than just relying on the text. So, Liverpool LINK welcomed the opportunity that the Trust afforded for LINK members and the public to engage at an event organised by and at the Trust. We also thank the Trust for its participation in the joint LINK Quality Accounts consultation event held at Knowsley LINK on 23/5/2012. Therefore, Liverpool LINK members have engaged adequately with the Trust to inform this commentary.

In terms on ongoing LINK engagement with the Trust, Liverpool LINK has a member designated to engage with Liverpool Women's NHS Foundation Trust on an ongoing basis and we have started to visit the Trust to gather patient experience with the full cooperation of the Trust and also in cooperation with Knowsley and Sefton LINKs.

We will be interested to monitor progress against the quality priorities chosen for 2012/13 with a particular focus on Patient Experience and Involvement. With this in mind, we will be seeking to instate quarterly meeting with the Trust to receive updates on Quality Accounts and Equality Delivery System progress. The fact that this Quality Account gives Liverpool LINK a firm focus for our ongoing engagement with Liverpool Women's NHS Foundation Trust is one of its major benefits to both patients and the public.

**Reverend Sister Maria Renate, Liverpool LINK**

## Knowsley LINK Commentary for Liverpool Women's NHS Foundation Trust Quality Report 2011/12



Knowsley LINK is pleased to be able to provide a commentary in support of the Liverpool Women's NHS Foundation Trust Quality Account for 2011-12. This response was compiled following the review of a draft copy of the Quality Account and formal presentation to LINK members to provide further information on the content of the Account. The Quality Account was provided to LINKs in a timely manner and presented in detail during a question and answer session held in May 2012.

Over the past 12 months there has been ongoing involvement between the Trust and LINKs. The Trust has worked with LINKs in supporting the patient experience information stands held regularly by LINKs (Sefton, Liverpool and Knowsley) on the hospital site. Knowsley LINK members have also been part of an ongoing piece of work with the Liverpool Women's Hospital to look at increasing the number of services provided and available within local community settings.

The collaboration work, described within the Quality Account presentation, with Clatterbridge and Alder Hey Children's Hospital was particularly welcomed by LINK members. This is seen as a positive initiative within an NHS environment which increasingly seems to be focused on competition.

LINK members welcomed the focus around medication and the development of a method of reviewing and analysing medication errors to reduce risk. This is an area in which LINKs would be keen to monitor progress over the coming year.

It was felt that the Priorities for Improvement identified for the coming year are both challenging and reflective of the issues Community Members, Service Users and LINK members are keen to see addressed. The decision to retain the priorities monitored in previous years Quality Accounts is welcomed as this will help provide a clear picture of performance moving forward.

The focus on patient experience and the implementation of the Patient Experience and Involvement Strategy is again an area of work which Knowsley LINK is committed to supporting.

Knowsley LINK looks forward to building on the work completed so far and providing an ongoing critical friend relationship.

Sefton LINK would like to thank the Trust for their continued partnership work with the LINK over the past 12 months. This response was completed following a review of the draft copy of the Quality Account and from LINK members receiving a presentation. Members also attended a stakeholder event to gain a greater understanding of progress with priorities.

We congratulate the Trust on the work they have undertaken on the ambitious priorities which were set for 2011/12 and on the success of the 'Enhanced Recovery Programme', which is now implemented for all elective gynaecology patients.

Gathering patient experience and learning from those experiences to enhance the quality of services is vital. We are pleased that the Trust will look at patient experience and how the Trust is able to liaise with patients further over the coming year. It would have been useful for more information to have been provided within the account relating to patient experience as we found the information within this section to be lacking. We would like to suggest that the Trust review the patient experience section and provide further details on who will be involved in this work. We would be keen to get involved in this work over the next 12 months and to continue the patient experience stands we hold in partnership with Knowsley and Liverpool LINK at the Trust every month.

Within the patient experience section it would have been useful to highlight the partnership work which the Trust has been undertaking with Local Involvement Networks in improving access to services closer to home for gynaecological services.

We have noted the work of the Trust in reporting medication errors and would welcome an update on this work. We are interested in an update on progress and any actions which are put in place to reduce medication errors.

We appreciate that the Trust is unique in the services it provides and therefore it is hard to provide comparison data but it would be useful for the reader to be informed of this issue.

Little information is provided on the issues raised via the Patient Advice and Liaison (PALS) Service and this would have been useful. We would welcome copies of the reports which the PALS service produce and will progress this issue with the Trust.

The report is easier to read than some but there are a number of abbreviations and initials used throughout the report. Although the glossary is a useful tool and provides us with terminology, abbreviations are not provided and this would be helpful. We felt

from reading the document that it was very clinical in its content (a large proportion of the report is dedicated to clinical effectiveness). The document could have included some of the work it has undertaken with the community and work in health promotion and well being.

We look forward to our work with the Trust over the coming 12 months to ensure that local people receive quality services.

**Prepared by Sefton LINK.**

### **Liverpool Overview and Scrutiny Committee Commentary for Liverpool Women's NHS Foundation Trust Quality Report 2011/12**

"We thank you for the submission of the Quality Accounts for this year, which we formally note as received and reviewed. We particularly note your high standards of commitment to patient safety and experience and the ongoing commitment of your Board to maintain standards."

- From the Liverpool Adult Social Care and Health Select Committee

### **Knowsley Overview and Scrutiny Committee Commentary for Liverpool Women's NHS Foundation Trust Quality Report 2011/12**

The Knowsley Overview and Scrutiny Board welcome the opportunity to provide a commentary on the Liverpool Women's NHS Trust Quality Account.

The Board has delegated responsibility for considering Quality Accounts to the Chair of the Overview and Scrutiny Board in consultation with the Lead and Deputy Lead Member for the Wellbeing theme. A meeting was convened on Wednesday 9<sup>th</sup> May to consider the Quality Account document received by the Liverpool Women's NHS Hospital Trust. The three members spent time considering the document and made a number of observations which have formed the basis of the Board's commentary, as set out below.

We focussed our discussions around three priority areas. Our first was the Trust's Improvement Priorities for 2012-2013 and the achievements highlighted over the previous year. We discussed where we thought work should be commended and whether there were areas where we felt more information may have been useful. Our final observations referred to the layout, style and format of the document, particularly focussing on how the document related to and/or involved the public.

We noted, in the first instance, that we had been given the opportunity to consider some of the Trust's activity at their consultation and engagement event in April prior to receiving a Quality Account. We felt that this enabled us to provide a more detailed assessment of the information contained within the document.

Having considered the Trust's priorities for improvement, we felt they were an accurate reflection of the issues identified in the main body of the report. The achievements section was very detailed and thorough and provided us with a clear understanding of the area being reported on. We thought it was important that the Trust had made the information accessible to the lay person.

In terms of Patient Safety we recognised that there had been a continued fall over several years in elective surgical infections and commend the Trust for their work in this area. We noted that there was a lack of fall in infections in emergency operations and we supported the Trust's decision to focus on this area over the next few years. The Trust's performance in terms of hospital acquired infections was very good and we felt it was important that the Trust takes its duty to prevent infection seriously, particularly in relation to the protecting vulnerable new babies. We thought it was good practice that the Trust monitored Late Onset Neonatal Blood Stream Infections and had set its own target despite there not being any nationally agreed benchmark.

We thought there was a general reduction in re-admission rates which had been helped by the introduction of the Enhanced Recovery Programme. We recognised that stillbirths were common but we would have appreciated some further information on the slight increase in rates over the past two years.

We were particularly pleased to see that the Trust had developed Patient Stories which were becoming an integral part of the meetings that took place across the organisation. We hoped that the Patient Stories will help to support improvements in the future. From the information on the comment cards, we were pleased to see that the reports were positive but we would have liked more information about the results. We also felt from our experience of other Trusts' practices, that there was more that the Trust could do to capture and learn from patient experiences.

We thought the layout and style of the report was very good. The descriptions of each area of work and the analysis of performance were clear, honest and demonstrated that the Trust continually aims for improvement in all elements of its work. We would welcome the opportunity to comment on the Trust's Quality Account next year in order to compare progress against priority outcomes and achievements.

This commentary has been provided by Councillor Mal Sharp (Chair of Overview and Scrutiny Board), Councillor Bob Swann (Lead Member for Wellbeing) and Councillor Kay Moorhead (Deputy Lead Member for Wellbeing) on behalf of Knowsley Overview and Scrutiny Board.

## **Sefton Overview and Scrutiny Committee Commentary for Liverpool Women's NHS Foundation Trust Quality Report 2011/12**

The Committee received the draft Quality Report for 2011/12.

### **NHS Liverpool Clinical Commissioning Group Commentary for Liverpool Women's NHS Foundation Trust Quality Report 2011/12**

NHS Liverpool Clinical Commissioning Group welcomes the opportunity to receive and comment on Liverpool Women's NHS Foundation Trust Quality Accounts for 2011/12.

In preparation for the formal establishment of the CCG in April 2013, NHS Liverpool have led the contractual arrangements over the past year and this account is consistent with reports received and development of priorities for 2012/13.

It is clear to the CCG that Liverpool Women's NHS Foundation Trust has a clear commitment to quality improvement and engagement with patients and staff. Clear progress has been made through the year.

We have established excellent working arrangements between the CCG and the Trust and look forward to developing our relationship further over the coming years as we collaboratively seek to improve health outcomes for the population of Liverpool.

Signed

Dr. Nadim Fazlani,  
Chair Liverpool Central Locality,  
NHS Liverpool Clinical Commissioning Group

Dr. Simon Bowers,  
Chair Liverpool Matchworks Locality,  
NHS Liverpool Clinical Commissioning Group

Ray Guy,  
Chair, Liverpool North Locality,  
NHS Liverpool Clinical Commissioning Group

## Statement of Directors' responsibilities in respect of the Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year.

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

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

- The content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2011-12
- 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 2011 to June 2012
  - Papers relating to quality reported to the Board over the period April 2011 to June 2012
  - Feedback from the commissioners dated 28/05/2012.
  - Feedback from governors dated 14/04/2012 and 18/04/2012. (Quality Event and Meeting of Council of Governors respectively).
  - Feedback from Liverpool Local Involvement Network (LINK) dated 25/05/2012, Knowsley LINK dated 29/05/2012 and Sefton LINK dated 29/05/2012.
  - Feedback from Liverpool City Council Overview & Scrutiny Committee dated: 30/05/2012
  - Feedback from Knowsley Borough Council Overview & Scrutiny Committee dated: 29/05/2012
  - Feedback from Sefton Borough Council Overview & Scrutiny Committee (Health and Social Care) dated 29/05/2012
  - Feedback from NHS Liverpool Clinical Commissioning Group dated: 30/05/2012.

- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints, (Publication pending).
  - Regulations 2009 dated 12/11/2010.
  - The national patient survey 2011/12
  - The national staff survey 2011/12
  - The Head of Internal Audit's annual opinion over the Trust's control environment dated March 2012.
  - CQC quality and risk profiles dated 02/04/2012.
- The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered.
  - The performance information reported in the Quality Report is reliable and accurate
  - There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice.
  - The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at <http://www.monitor-nhsft.gov.uk/annualreportingmanual>) as well as the standards to support data quality for the preparation of the Quality Report (available at [www.monitor-nhsft.gov.uk/annualreportingmanual](http://www.monitor-nhsft.gov.uk/annualreportingmanual)).

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board.

Signed:

*Kathryn Thomson*

*Ken Morris*

Chief Executive

Chairman

## Who has been involved

The 2011/12 Quality Report for Liverpool Women's Hospital has been completed with the help of the following persons and groups:

<b>Mr Jonathan Herod:</b>	Medical Director
<b>Gail Naylor:</b>	Director of Nursing, Midwifery and Patient Experience
<b>Richard Sachs:</b>	Head of Governance
<b>Julie McMorran:</b>	Trust Secretary
<b>Russell Cowell:</b>	Head of Information Governance
<b>Alan Clark:</b>	Governance Quality Manager
<b>Tony Rowan:</b>	Assistant Director of Finance
<b>Michelle Turner:</b>	Director of Human Resources & Organisational Development
<b>Dr Tim Neal:</b>	Consultant Microbiologist / Director for Infection Prevention and Control
<b>Gill Vernon:</b>	Research & Development Manager
<b>Dr Katherine Birch:</b>	Head of Clinical Audit
<b>Anne Bridson:</b>	Corporate Matron for Patient Experience
<b>Dianne Brown:</b>	Gynaecology Head of Nursing
<b>Carol Frodsham:</b>	Head of Clinical Coding
<b>Jane Mutch:</b>	Matron, Hewitt Centre
<b>Eileen Reynolds:</b>	Chief Pharmacist
<b>Mr Andrew Drakeley:</b>	Consultant Gynaecologist / Reproductive Medicine Clinical Governance Lead
<b>Val Irving:</b>	Matron for Neonates and Imaging
<b>Cathy Atherton:</b>	Head of Midwifery

**Bill Yoxall:** Clinical Director of Neonatology & Pharmacy

**Nim Subhedar:** Consultant Neonatologist/ Neonatal Clinical Governance Lead

**Mark Clement-Jones:** Consultant Obstetrician

**Cathy Fox:** Associate Director of Informatics

**Hayley McCabe:** Information & Performance Manager

**Nicola Remmington:** Trust Information Analyst

## *Glossary of Terms*

<b>Analgesia –</b>	The relief of pain without loss of consciousness.
<b>Antenatal –</b>	Occurring before birth, also called prenatal.
<b>Epidural –</b>	Form of regional analgesia used during childbirth.
<b>Gynaecology –</b>	Medical practice dealing with the health of the female reproductive system.
<b>Gynaecological Oncology –</b>	Specialised field of medicine that focuses on cancers of the female reproductive system.
<b>Haemorrhage –</b>	The flow of blood from a ruptured blood vessel.
<b>Intraventricular Haemorrhage -</b>	Bleeding within the ventricles of the brain.
<b>Intrapartum –</b>	Occurring during labour and delivery.
<b>ITU (Intensive Therapy Unit) –</b>	Specialised department in a hospital that provides intensive-care medicine.
<b>Laparoscopic -</b>	Description of a surgical procedure carried out using a flexible fibre optic instrument that enables the surgeon to examine the inside of the body through only a small incision.
<b>Matron –</b>	Term given to a very senior nurse.
<b>Maternity –</b>	The period during pregnancy and shortly after childbirth.
<b>Morbidity –</b>	Incidence of a particular disease.
<b>Mortality -</b>	Death
<b>Neonatal –</b>	Of or relating to newborn children.
<b>Perioperative Care –</b>	Time period describing the duration of a patient's surgical procedure.
<b>Periventricular Leukomalacia -</b>	A form of brain injury involving the tissue of the brain known as 'white matter'.
<b>Post operative –</b>	Period immediately after surgery

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