University Hospitals of Morecambe Bay NHS Foundation Trust

Quality Report 2012/2013

May 2013

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Glossary of terms and abbreviations used within this report.

Bundle	A number of measures/interventions to be implemented together as part of the care package for patients
CCG	Clinical commissioning group
CDU	Clinical decision unit
CHKS	A commercial company providing a clinical performance data analysis system.
CQUAT	
CQC	Care Quality Commission
CQUIN	Commissioning for quality and innovation
DNA	Did not attend
DoLS	Depravation of liberty
DSSA	Delivering same sex accommodation
EMSA	Eliminating mixed sex accommodation
EQIP	Efficiency and Quality Improvement Programme
EWS	Early warning system
GSF	Gold standard framework
GURU	An online database named GURU. The GURU database provides a simple overview of performance at ward level against a range of indicators.
HSC	Local authority – Health Scrutiny Committee
LINKs	Local involvement networks
Lorenzo	A software programme. The electronic patient management system
LCP	Liverpool care pathway
MAU	Medical assessment unit
MQUAT	Midwifery quality assessment tool
MRSA	Methicillin resistant staphylococcus aureus (superbug)
MUST	Malnutrition universal screening tool
NPSA	National patient safety agency
NQUAT	Nursing quality assessment tool
OSC	Local authority – Overview and Scrutiny Committee
PBC	Practice based commissioners
PCAS	Primary care assessment service
PCT	Primary care Trust
PEMs	Patient experience measures
PMB	Programme management board
PMO	Programme management office
POTTS	Physiological track and trigger system
PROMs	Patient recorded outcome measures
VTE	Venous thrombo embolism
SHMI	Standardised hospital mortality index

Part 1

The Quality Account 2012/13 is an annual review of the quality of NHS healthcare services provided by University Hospitals of Morecambe Bay NHS Foundation Trust during 2012/13. It also outlines the key priorities for quality improvement in 2013/14. The Trust recognises the importance of the quality account to the public and has noted the recommendations contained in the Francis Report.

The Quality Account comprises four distinct sections.

Part 1 includes a brief overview of the Trust, a statement about what quality means to the Trust, signed by the Chief Executive, and highlights some of the Trust's key quality achievements in 2012/13.

Part 2 constitutes a review of the Trust's performance against the objectives set in the 2011/12 Quality Account and in relation to key national standards.

Part 3 includes the priorities for improving the quality of services in 2013/14 that were agreed by the Board of Directors in consultation with stakeholders. Each priority is sub-divided into specific indicators, audits and initiatives, which have been chosen to address local and national quality challenges.

Part 4 includes legislated statements of assurance from the Board of Directors and comments from partner organisations.

The Trust received four Warning Notices from the Care Quality Commission in the period from September 2011 to February 2012. The Trust was found in significant breach of its authorisation under section 52 of the Health and Social Care Act 2008 on 11 October 2011 following declaration of a major incident and the identification of an issue that resulted in a significant number of patients not receiving their outpatient appointments within the required timescale. The Trust was found in significant breach for a second time on 6 February 2012, and Monitor intervened with the introduction of a new Chairman, Interim Chief Executive and a turnaround team.

The Trust has engaged with the Care Quality Commission, Monitor, Commissioners, NHS specialists and other expert resources to review the issues and develop a recovery plan.

In 2012, the Trust started its recovery and stabilisation phase, initially concentrating on ensuring the safety of everyone that uses its hospitals and taking the time to fully understand the issues before making further change. It was clear that a disconnect existed between managers and clinicians when making decisions. In response to this, clinicians were put in charge of clinical services, seeing doctors, nurses, midwives and health professionals making the decisions, with support from managers, not the other way around. This move was key to putting patients at the heart of decision making. In March 2013, the Trust confirmed that these interim arrangements were made permanent.

Following the intervention of Monitor in February 2012, a Programme Management Office was implemented to oversee the progress of key improvement projects, in

areas such as mortality, stroke care, governance and maternity services. The Programme Management Office provides essential oversight and assurance on progress to the Trust Board, evidence is presented bi-weekly to the Executive Team, ensuring immediate action can be taken when needed to ensure delivery against objectives.

A draft version of the Quality Account 2012/13 was shared with our stakeholders in April 2013 as part of the assurance process. The stakeholders are: Cumbria Clinical Commissioning Group, Lancashire North Clinical Commissioning Group, Health Watch Cumbria, Health Watch Lancashire, Cumbria Health and Wellbeing Scrutiny Committee and Lancashire Health Scrutiny Committee. Each organisation was asked to review the draft report and provide a written statement for publication (unedited) in Appendix One of the Quality Account. In addition, the Quality Account was shared with the governing council's Patient Experience Committee.

The Statement of Directors' Responsibilities in respect of the Quality Account is published as Appendix Two of this report.

The external auditor has provided a Limited Scope Assurance Report on the content of the Quality Report, as required by Monitor, the Independent Regulator of foundation trusts. The auditor also gives a limited assurance opinion on the mandated indicators (C. Diff and 28 day readmissions). The external auditor's report is included in Appendix Three.

Every effort has been made to use clear and understandable language wherever possible during the production of this Quality Account. Given the nature of the quality improvement in healthcare, the inclusion of some medical and healthcare terms is unavoidable. Further information about health conditions and treatments is available on the NHS Choices website, at www.nhs.uk. The final public version of the Quality Account (as laid before Parliament) will include a glossary of terms and also a version will be produced in a more accessible manner, as well as being available in other formats, such as large print and other languages, for free, upon request.

About University Hospitals of Morecambe Bay NHS Foundation Trust

University Hospitals of Morecambe Bay NHS Foundation Trust (UHMB) operates from three main hospital sites: Furness General Hospital in Barrow, Royal Lancaster Infirmary in Lancaster and Westmorland General Hospital in Kendal. The Trust has approximately 5,000 valued staff. In 2012/13, the Trust had an income of £280 million.

Furness General Hospital and the Royal Lancaster Infirmary have a range of 'General Hospital' services, with full Accident and Emergency Departments, Critical/Coronary Care units and Consultant led beds. Westmorland General Hospital provides a range of General Hospital services, together with a Primary Care Assessment Service (PCAS) with GP led inpatient beds, operated by the Cumbria Partnership NHS Foundation Trust.

All three sites provide a range of planned care, including outpatients, diagnostics, therapies, day-case and inpatient surgery. In addition a range of local outreach

services and diagnostics are provided from a number of community facilities across the community.

Chief Executive's Statement

On behalf of myself, the Board of Directors, the Council of Governors and the staff of University Hospitals of Morecambe Bay NHS Foundation Trust, I am pleased to offer you the Quality Account for the year just ended, 2012/13.
Patient care is at the heart of what we do and fundamental to this principle is our continued desire to deliver and develop care which is of the highest quality, the safest, and offering the best patient experience which can be sustained for many years to come.

I believe the Trust has made, and will demonstrate in this Account, some good progress on several goals set during 2012/13; however I know we still have more to do to ensure all services are of a standard that our public deserve. I am particularly pleased in our reduction in mortality rates and the improvement we have made in how we work and treat people who have had a Stroke. Unfortunately, although I and several members of the Board have only been in post a short time, I have to report that several lines of reporting are not at the quality I, the Board or patients would expect. Indeed, some of the targets the Trust set itself last year on having a reduction in the number of patients who fall, obtain pressure ulcers and our re-admission to hospital rate has just not been of the standard we require. These important quality priorities are being taken forward in 2013/14 and details are included in this report.

In year, the Trust Board has taken action to establish a new Governance Directorate which will focus solely on driving up improvements in quality, safety and the patient experience when they come into contact with our hospitals. These are essential targets and directly affect the care and experience of our patients, we will continue to work hard and concentrate our efforts in these areas for the benefit of patients.

From this, whilst we believe we have some positive stories of quality improvement to share with you, we would wish to reassure you that we are fully committed to obtaining a greater focus on continuous improvement. We have included some of the important goals we are pursuing in 2013/14.

The Board of Directors has reviewed the 2012/13 Quality Account and confirms that it is a true and fair reflection of the performance of University Hospitals of Morecambe Bay NHS Foundation Trust. We hope that the Quality Account provides you with evidence of the Trust's commitment to quality, safety and the aim of improving the patient experience.

Jackie Daniel
Chief Executive

I confirm that to the best of my knowledge the information in this document is accurate.

Signed

Chief Executive

28 May 2013

Part 1a

Summary of Regulator Reviews

University Hospitals of Morecambe Bay NHS Foundation Trust were reviewed by the Care Quality Commission; a summary of the reviews is outlined in the table below.

Service	Outcomes Assessment	Standard Met
September 2012		
Maternity RLI	13 – Staffing 16 - Assessing and monitoring the quality of care	Yes
Maternity FGH	01 - Respecting and involving people who use services 08 - Cleanliness and infection control 10 - Safety and suitability of premises 13 - Staffing 16 - Assessing and monitoring the quality of service provision 21 - Records	Yes
Emergency Department RLI	01 - Respecting and involving people who use services 04 - Care and welfare of people who use services 13 - Staffing 14 - Supporting workers	Yes
Emergency Department FGH	04 - Care and welfare of people who use services 13 - Staffing 14 - Supporting workers	Yes
22 March 2012		
Termination of Pregnancy Services FGH	21: People's personal records, including medical records, should be accurate and kept safe and confidential	Partially
Termination of Pregnancy Services RLI	21: People's personal records, including medical records, should be accurate and kept safe and confidential	
1 March 2013		
Nutritional Needs Assessment RLI	5 Meeting Nutritional Needs	Yes

Part 2

2a. Priorities for improvement

The Trust's proposals for quality improvement 2012 onwards are based on saving lives by reducing hospital mortality rates, preventing harmful events, reducing variations in fundamental aspects of basic care, and continuously improving patient satisfaction and outcomes.

The Trust aims to provide an exemplary patient experience in a safe and effective manner. In the quality report for 2011/12 the Trust identified the 2012/13 priorities for improvement in relation to Safety, Clinical Effectiveness and Patient Experience. This section provides information on how we have progressed against the identified priorities in each of these areas.

Review of quality improvement priorities 2012/2013

Safety - Outpatient Improvements

2012/13 Target	**Outpatients – harms assessment and reporting and development of Outpatient Booking Hubs**
Lead	Medical Director
Rationale	Implementation of harms measurement will provide assurance to the Board and the public that our services are provided in a safe manner.
What will be measured	Assessment of harms using NPSA tool and to openly communicate with patients the findings of the review in to their care. Outpatients booking hubs are being established to provide a robust mechanism for ensuring patients receive appointments at the correct time and are not 'missed'. Hubs in all areas will be established by May 2012.
Outcome	Establish baseline level of harms experienced during outpatient episodes.

Actual outcome:
An initial independent review was undertaken by the Medical Director from the Countess of Chester Hospital. Following this it was identified that 1185 patients had been potentially harmed; a further clinical review of each case identified 630 patients as suffering harm following a delayed appointment. The patients were written to and offered an appointment with their consultant to discuss the clinical implications and treatment plan.

There has been a significant reduction in the numbers of patients waiting past their guaranteed activity date. In February 2012 there were 11321 patients waiting past their guaranteed activity date; by February 2013 this had fallen to 617 patients whom the Trust has contacted and a reply is awaited.

The HUB project closed at the end of March 2013 as it has gone through its sustainability phase and review. Outpatient HUBs will continue to deliver this service for patients.

Improvements made in 2012/13:

- All speciality HUBs were implemented by October 2012. Hubs are based within the community patient contact centre or within the specialities themselves.
- Work has continued with capacity and demand modelling for each speciality in medicine resulting in new baseline capacity being set. Aligned to this an Outpatient reminder system is being piloted to reduce do not attend rates, this uses new methods of contacting patients such as by text messaging reminders to patients. At the start of the pilot this was 11% and at the end was 7.8% across the 5 specialities tested.
- The way in which these patients are managed has changed throughout the life of the project to give patients a greater choice in appointments and to offer improved communication about appointments.

Further planned improvements:

- Outpatient efficiency and performance will be managed through divisional performance and the patient efficiency groups.
- Performance on the number of patients past their guaranteed activity date is reviewed at weekly performance meetings with the Chief Operating Officer.

Safety - Enhanced Risk Management

2012/13 Target	**Enhanced Risk Management**
Lead	Executive Chief Nurse
Rationale	The CQC and Monitor reviews of Maternity services in 2011/12 identified a shortfall in incident management processes. A number of issues have arisen during the year which has confirmed the issue requires addressing throughout the Trust. Monitoring of this indicator will provide assurances that robust systems are in place to manage and learn from all serious untoward incidents (SUIs).
What will be measured	Time taken for the completion of all action arising from SUIs (including feedback to the team).
Outcome	To be measured against Trust policy (45 days normally – 60 days for external investigation). Measured every month. Aim for 100% compliance.

Actual outcome:

In 2011/12 there were 50 Serious Incidents Requiring Investigation (SIRI formally SUI) of which 9 were closed within timescales, a closure rate of 18%.

In 2012/13 there were 69 Serious Incidents Requiring Investigation (SIRI formally SUI) of which 12 were closed within timescales, a closure rate of 17%.

The target of completion of reviews and actions were not met.

Data collection to monitor the process is evolving and could not provide adequate monitoring of completion dates, as it was dependant on both internal and complex external systems. This is a key issue to be taken forward.

Improvements made in 2012/13:

- The Trust established a Serious Incident Requiring Investigation (SIRI) Panel under the chairmanship of a Non-Executive Director with the following remit:
    - The SIRI Panel will have a key role in quality assuring incident investigations, ensuring they are undertaken in a timely manner and to a high quality.
    - The SIRI Panel will also identify the lessons learnt from incidents which need to be promulgated across the Trust and more widely across the NHS.
    - Where necessary the SIRI Panel will recommend to the Clinical Governance and Quality Committee any further advice, action or investigation (internal or external) that may be necessary to ensure that the conclusions of investigations are robust and objective.
- The panel met monthly and developed processes, along with commissioning partners, to ensure the above objectives were achieved.

As a result organisational learning from incident analysis has improved:

- Improved medical engagement in the review of incidents
- Strengthened the process for escalation of serious incidents
- Improved processes that reduce documentation errors
- Strengthened staff performance review
- Introduced patient stories into Trust Board Meetings
- Strengthened processes for patient surveillance

Further planned improvements:

This approach has taken some time to embed in the Trust and the target of 100% compliance in the year has not been achieved. The work continues into 2013/14 with Care Commissioning Groups to improve closure times.`

<u>Safety - Reduce the number of falls</u>

2012/13 Target	**"Harm Free Care" – Falls**
Lead	Executive Chief Nurse
Rationale	Reduce incidence of falls causing moderate or significant harm to patients using enhancing monitoring and interventions including learning lessons from previous incidents.
What will be measured	A target of 25% reduction in the number of falls compared to the baseline in 2010/11 level of 2,174. In 2011/12 falls reduced to 2,049.
Outcome	Target reduction to 1,631 falls.

Actual Outcome:

In 2011/12 there were 2,049 falls of which 32 resulted in moderate or major harm.

In 2012/13 there were 2,035 falls of which 57 resulted in moderate or major harm.

The target of reduction in falls was not met.

Improvements made in 2012/13:

- The Falls Group has continued to monitor and review falls by ward and department, time of day and severity of falls. Actions to date include:
    - Establishing Falls Champions in clinical areas
    - Running a study day combined with dementia awareness
    - Review of the documentation and assessment of falls risk
    - Piloting of a variant of intentional rounding in acute medicine
- During the year it was recognised that the 2012/13 target had been based on a simple number count and not related to patient throughput and activity. Work commenced on developing a more robust and accurate method of defining trajectories for 2013/14.
- The Falls Group developed traffic light system with a range of measures. This is currently being transferred to a computerised on-line system to enable clinical staff to have access to more real-time information and therefore improve monitoring and the identification of actions to be taken.

Further planned improvements:
Falls continue to be a priority in 2013/14 and have been included in Harm Free Care, details can be found in part 2b

Safety - Reduce the number of pressure ulcers

2012/13 Target	**"Harm Free Care" – Pressure Ulcers**
Lead	Executive Chief Nurse
Rationale	The Trust is aiming to build on the work undertaken in 2011/12 and reduce all grades of pressures ulcers and particularly the most significant grade 3 and 4 pressure ulcers This work is an on-going project and needs to maintain a high profile to continue making improvements.
What will be measured	Reduction of all hospital acquired pressure ulcers, particularly the most serious grade 3 and 4 ulcers. The overall indicator is to reduce all pressure ulcers acquired in hospital by 80% by March 2013 from the 2010/11 baseline figures of 256.
Outcome	Original target – 51. Grade 3 and 4 pressure ulcers to be less than 9.

Actual outcome:

In 2011/12 there were 263 hospital acquired pressure ulcers of which 9 were grade 3 or grade 4.

In 2012/13 there were 356 hospital acquired pressure ulcers of which 14 were grade 3 or grade 4.

The target reduction was not achieved and it was identified that increased awareness by staff may have contributed to an increased level of reporting of the lowest grade of pressure ulcers.

There were a total of 14 Grade 3 or 4 hospital acquired pressure ulcers. The target reduction was not met.

Improvements made in 2012/13:

- Link nurses have been identified in clinical areas
- Improved diagnosis of pressure ulcers
- Increased utilisation of pressure relieving devices
- Ward level monthly review of incidence at ward level
- Piloting of a variant of intentional rounding in acute medicine
- A thematic review of pressure ulcers was presented to the Serious Incident requiring Investigation Panel
- The Trust developed traffic light system with a range of measures. This is currently being transferred to a computerised on-line system to enable clinical staff to have access to more real-time information and therefore improve monitoring and the identification of actions to be taken.

Further planned improvements:
Pressure ulcers continue to be a priority in 2013/14 and have been included in Harm Free Care, details can be found in part 2b.

Safety - Improving the use of Early Warning Scoring

2012/13 Target	**"Harm Free Care" – Patient Monitoring "Early Warning Scores" (EWS)**
Lead	Executive Chief Nurse
Rationale	The Care Quality Commission issued the Trust with a Warning Notice in February 2012 with regard to non-compliance with the Trust's procedures in relation to physiological observations and early warning signs. The Trust has escalated surveillance and monitoring across the emergency pathway to provide assurance on compliance and address issues where non-compliance with procedures is identified. Additional training and support has been given to staff.
What will be measured	Compliance with Patient Safety Express initiative measures.
Outcome	100% compliance.

Actual outcome:

Continual audit of EWS usage during 2011/12 showed that an annual average of 94% of all measures was correctly documented. In 2012/13 this had increased to 96%.

The patient measures monitored are basic physiological parameters such as heart rate, breathing rate, blood pressure and temperature. When these are looked at together it helps clinical staff detect when a patient's condition starts to deteriorate so appropriate clinical intervention can be started at an early stage.

Improvements made in 2012/13:

- The Trust amended the arrangements for audit and monitoring of the use of the early Warning Scoring System
- Introduced an escalation process which triggered an intensive audit process in areas where compliance had reduced. In such circumstances, audit frequency is increased
- Implemented unannounced audit by senior nursing staff are introduced until compliance increases to acceptable levels.
- Increased education and awareness for clinical staff.

As a result, good levels of compliance were maintained throughout 2012/13.

Further planned improvements:
The successful audit programme and mechanism will continue during 2013/14 with real time results being available to clinical staff and managers through a computerised system (GURU).

Safety - Adult Safeguarding

2012/13 Target	**Safeguarding Review (Adults)**
Lead	Executive Chief Nurse
Rationale	The Trust recognises a need to improve safeguarding and governance arrangements and to enhance safeguarding capacity and capability at operational and Board level. This includes multi-agency relationships. The level of care for vulnerable patients will be enhanced.
What will be measured	Monthly number of potential instances of safeguarding identified for investigation increases. Training – Number of staff trained per quarter. Indicated as a percentage of those identified as requiring training. Uniformity/Evidence - reporting package of statistics on all safeguarding and MCA DoLS cases reviewed by Trust safeguarding lead.
Outcome	Number of investigations will increase. Number of staff trained will increase. Quality of reporting will increase.

Actual outcome:

During 2012/13 the number of potential instances of adult safeguarding incidents has increased when compared with the previous year, demonstrating increased awareness by staff.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	**Total**
2011/12	0	2	1	1	0	1	1	3	1	1	3	3	**17**
2012/13	5	3	2	3	5	4	3	7	10	9	9	4	**64**

In 2012/13 the Trust commenced monitoring of MCD DoLS and the numbers are now included in the monthly safeguarding dashboard of information.

Staff training commenced in Q3 2012/13 with 2% of staff identified as requiring training completed. This figure had increased to 48% at the end of March 2013, with a further 15% having booked dates for training.

Improvements made in 2012/13:

- An adult safeguarding strategy was developed
- Leads for divisional areas have been identified
- Appointed a lead nurse for adult safeguarding
- Staff requiring training were identified and a training programme commenced
- Safeguarding resources were made available on the intranet
- Policies were revised and peer reviewed
- An event to re-launch revised policies was held in February 2013
- The incident management system has been reviewed and developed to improve the management of safeguarding incidents
- A safeguarding information traffic light system was developed and trialled for use in reporting to the Clinical Governance and Quality Committee

Further planned improvements:

- Continue to deliver training for staff
- Continue to develop the information traffic light system
- Develop adult safeguarding audits

<u>Safety – Safeguarding Children</u>

2012/13 Target	**Safeguarding Review (Children)**
Lead	Executive Chief Nurse
Rationale	The Trust recognises a need to improve safeguarding and governance arrangements and to enhance safeguarding capacity and capability at operational and Board level. This includes multi-agency relationships. The level of care for vulnerable children will be enhanced.
What will be measured	Final measures to be determined on receipt and evaluation of CQC report.
Outcome	Final measures to be determined on receipt and evaluation of CQC report.

Actual outcome:
At the end of March 2013, 37% of staff identified as requiring training had been trained and a further 7% had booked dates for training. Rates of training in critical areas has been higher with 87% of staff in the Emergency Departments and 78% of staff in the Women's and Children's Division having completed training or had booked dates for training.

Throughout the year the Trust has worked closely with the two Local Safeguarding Children's Boards. A joint review was undertaken in October 2012 which concluded that satisfactory progress was being made.

Improvements made in 2012/13:
- An expert panel review was undertaken in late 2012
- Identified Children's Champions for divisional areas have been identified
- Appointed a lead nurse for children's safeguarding
- Staff requiring training were identified and a training programme commenced
- Safeguarding resources were made available on the intranet
- A list of safeguarding triggers was developed
- Policies were revised and peer reviewed
- An event to re-launch revised policies was held in February 2013
- A safeguarding information traffic light system was developed and trialled for use in reporting to the Clinical Governance and Quality Committee
- The development of an audit programme
- Commenced casualty card audits in the Emergency Department

Further planned improvements:
Children's safeguarding continues to be a priority in 2013/14, details can be found in section 2b.
- Development of "alerts" on the Lorenzo patient administration system
- Continue to deliver training for staff
- Continue to develop the information traffic light system
- Implement safeguarding audits

Clinical Effectiveness - Stroke improvement

2012/13 Target	**Stroke Pathways Improvement**
Lead	Medical Director
Rationale	Following the Stroke Network Peer review, a number of concerns were raised regarding care for acutely ill stroke patients. The Trust has initiated a programme to improve the quality of care provided to stroke patients in line with national standards including an interim plan to identify dedicated beds for acutely ill stroke patients at the Royal Lancaster Infirmary.
What will be measured	Continue to improve the quality of care provided to stroke patients in line with national standards. Key performance indicators(KPI) are: • 80% of stroke patients to spend 90% of time in hospital on stroke unit

	• Direct admission within 4 hours • Brain scan within 24 hours • Aspirin given - if patients suitable for Aspirin • Target 100% of patients weighed • All patients to be assessed by Physiotherapist within 72 hours of admission • Occupational Therapy assessment within 4 working days • Swallowing screening by Dysphagia trained staff within 24 hours • Assessment of mood completed on discharge
Outcome	PMO to monitor implementation and progress against KPIs on a monthly basis

Actual outcome:

	2011/12 Monthly average	2012/13 Monthly average	Target	Final month
80% of stroke patients to spend 90% of time in hospital on stroke unit	**49%**	**78%**	**80%**	**87%**
Direct admission within 4 hours	**29%**	**72%**		**97%**
Brain scan within 24 hours	**82%**	**90%**		**97%**
Aspirin given - if patients suitable for Aspirin	**72%**	**84%**		**82%**
Target 100% of patients weighed	**94%**	**94%**	**100%**	**91%**
All patients to be assessed by Physiotherapist within 72 hours of admission	**75%**	**82%**		**73%**
Occupational Therapy assessment within 4 working days	**80%**	**87%**		**94%**
Swallowing screening by Dysphagia trained staff within 24 hours	**75%**	**83%**		**73%**
Assessment of mood completed on discharge	**81%**	**75%**		**91%**

Data Source: PMO Workbook

Improvements made in 2012/13:

- Implementation of an Acute Stroke Unit at the RLI on Ward 39
- Creation of Clinical Nurse Specialist for Stroke
- More patients arrive on a Stroke Ward within 4 hours
- More patients spend more than 90% of time on a specialist stroke area
- More patients access brain imaging within target times
- Patients have quicker access to physiotherapy (within 72 hours) and occupational therapy (within 4 days)
- An average reduction in length of stay in hospital from 27 to 17 day in a 12 month period.
- The improvement in Stroke has been a Multi-Disciplinary Team approach and is totally reliant on all members of the team remaining highly motivated to achieve the standards required.

On-going arrangements:

- Submission of Clinical Nurse Specialist role on each site for Stroke as part of the CQINN for 2013/14 with a view to a business case for substantive position in this area.
- Increase in nurse, therapy and medical staff to patient ratio.
- Target improvements in the time of arrival to brain imaging and commencement of thrombolysis agent in the Emergency Department
- Move to 7 day working
- Standard Operating Procedure for stroke services and interventions

Stroke services continue to be a priority in 2013/14, details can be found in part 2b.

Clinical Effectiveness - Improving readmission rates

2012/13 Target	**Readmissions**
Lead	Director of Operations
Rationale	The readmission rate provides an overall indicator on the quality and efficacy of services provided. Patient care should be optimised throughout their stay to ensure that the need for emergency readmission is minimised.
What will be measured	Emergency readmissions to hospital within 28 days of discharge.
Outcome	The percentage of patients of all ages and genders who were readmitted to hospital within 28 days of being discharged. This is to be compared against the national average.

Actual Outcome:

The data is part of the national indicators in Part 3 on p41.
Readmission rates for patients below 15 years of age rose from 10.4% in 2011/12 to 11% in 2012/13, which compares to peer rates of 8.4%.
Readmission rates for patients above 14 years of age rose from 6.1% in 2011/12 to 6.7% in 2012/13, which compares to peer rates of 5.7%.

Improvements made 2012/13:

- A clinical review of readmissions was jointly undertaken with Commissioners, both Cumbria and North Lancs.
- A number of lessons were learnt from the reviews:
    - Problems with medication started at first admission
    - Complex case reasons were a combination of primary & secondary care plus patient choice
    - Earlier intervention at home by Social worker was sometimes needed
    - A number of patients should have been sent home and not admitted
- Cumbria held a county-wide' lessons learnt' session on 1st November which was attended by contributors to the audits. Specific cases were discussed as examples of avoidable admissions and how they could be avoided in future. One of the main themes was to improve communications and investigation into setting up a shared alerts system across the care sectors, many of the readmitted were known to have care management plans that were not shared.

Further planned improvements:
A detailed analysis of all emergency re-admissions within 30-days of discharge has been undertaken. This data has been reviewed within Clinical Divisions as this has identified a number of areas requiring further analysis to identify the causes.

Where the percentage of re-admissions are above peer 'best in class' Clinical Specialty Leads are being tasked to audit re- admissions to determine whether the admission could have been avoided or whether there was an expectation the patient would re-present. Once this further analysis and audits have been undertaken re-admission targets at specialty level will be established along with timescales to return to compliance. Progress will be monitored at Trust Board and Divisional level.

Clinical Effectiveness - Improve mortality indicators

2012/13 Target	**Mortality**
Lead	Medical Director
Rationale	The Trust performed poorly against the target indices. An on-going project is in place to improve mortality ratings. Achieving levels of the best performing Trusts will restore public confidence in the Trust whilst also providing assurance to the Board.
What will be measured	The aim is to improve performance against all published indices. Hospital mortality rates and risk-adjusted rates are dependent upon clinical information, clinical care and arrangements for end of life care in a primary care setting.
Outcome	Monthly monitoring statistics will be produced via the CHKS clinical performance database. Target is to achieve performance in line with our peer group average.

Actual outcome:
All measures were within target and showed improvement throughout the year.

The trust mortality rate is the percentage of patients who die in hospital as a proportion of the total number of patients admitted; this has been less than similar Trusts throughout the year.

The Risk Adjusted Mortality Index is a calculated value of mortality taking patient conditions into account. A value of 100 is the national average, with a value below this showing better performance. This measure is being replaced by SHMI (see part 3) as the national measure for mortality.

Mortality Rate (%) - The 12 month mortality rate

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2012/13	Trust	1.3	1.27	1.26	1.22	1.23	1.34	1.25	1.24	1.26	1.27	1.29	1.31
	Peer	1.3	1.3	1.31	1.32	1.32	1.31	1.30	1.31	1.29	1.31	1.31	1.32

Data Source: CHKS

CHKS Risk Adjusted Mortality Index (2012 Base) - The initial target was to achieve an index of 100 by July 2012, thereafter falling into top performance of CHKS peer within 12 months.

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		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2012/13	Trust	99	95	94	93	93	92	92	91	90	90	90	89
	Target	102	101	100	100	98	96	94	92	90	90	89	89

Data Source: CHKS

Standardised Hospital Mortality Index (SHMI) - Details are included in Part 3 on p45. Targets were met throughout the year and the index has continually fallen.

Improvements made in 2012/13:

- Reviewing clinical coding of palliative care and end of life care to ensure correct practices are in place
- Improving the recording of initial diagnosis by clinical staff
- Reviewing mortality audit meetings in all specialities
- Reviewing clinical pathways in high risk conditions through the urgent care project in the Emergency Department
- Establishing a lead consultant to review all deaths at Furness General Hospital
- Implementing a Mortality Review Group to oversee all aspects of mortality and report to the Clinical Governance and Quality Committee

Further planned improvements:

- Establish a lead consultant to review all deaths at Royal Lancaster Infirmary

<u>Patient Experience - Improving care in the Emergency Department</u>

2012/13 Target	**Transforming Unscheduled Care**
Lead	Medical Director
Rationale	The CQC review of the emergency department identified a number of issues relating to the provision of emergency care. This indicator will provide assurance to the public and Board that the current and planned changes to the whole emergency care pathway are improving the quality and effectiveness of service provision.
What will be measured	Improvement in the overall experience for patients requiring urgent unscheduled care. An improvement project has been set up within the Trust with detailed action plans and measures in place.
Outcome	Key indicator to be monitored is the time spent in the Emergency department should be less than 4 hours for 95% of patients.

Actual outcome:

The percentage of patients seen in the Emergency Department who spent less than 4 hours in the department was 93.49%. The target was not achieved.

Improvements made in 2012/13:
Transforming care at the Royal Lancaster Infirmary:

- A new model of care was introduced allowing GP referred patients to go directly to the Medical Assessment Unit
- Capacity for ambulatory assessment was increased
- A Short Stay Unit opened for patients with an expected length of stay of < 72 hours Nursing establishments were increased
- Morning board rounds have been introduced on specialty wards
- An early discharge initiative, 'Bed before 10', has been implemented.

A new Acute Medical Unit opened in October incorporating the existing MAU and Short Stay wards with an expanded ambulatory assessment unit.

Transforming care at Furness General Hospital:

- A pilot project to combine Primary Care Assessment Service (PCAS), Clinical Decisions Unit (CDU), and Single Point of Access (SPA) ran for three months and is now being evaluated
- A short stay medical area and surgical assessment unit were set up on existing wards with a significant impact on length of stay
- Funding was secured from Cumbria CCG until the end of March 2013 to facilitate the appointment of two locum acute physicians to introduce an Acute Medical Service
- Additional posts were also established in patient flow and ED
- Daily bed meetings were revamped to take place three times a day with the additional meeting at 9am.
- 'Bed before 10' has been rolled out, supported by changes to job plans to support morning ward rounds

Further planned improvements:

- A Length of Stay project has since been set up which is continuing to take forward improvements in the patient pathway and reviewing ward configurations.
- the Medical Director has requested that an audit of all the changes which have taken in unscheduled care should be undertaken in Summer 2013 to understand their impact and identify what further work may be required.

Patient Experience - Improving End of Life Care

Priority	**End of life care**
Lead	Medical Director
Rationale	This project began in 2011/12 and actions have been implemented. The Trust has not yet met the standards required. In line with the national End of Life Care Strategy, promote high quality care for all adult patients at the end of life.
What will be measured	Increase the percentage of all adult patients, who are identified as on the End of Life care instances and receive the appropriate care pathway.
Outcome	An improvement project has been set up within the Trust with detailed action plans and measures in place.

Actual Outcome
The outcomes were not measured throughout the year as early work on the pathways changed the work significantly and it was decided with commissioners and stakeholders that additional senior clinical staff were required to progress the programme.

Improvements made in 2012/13:
- Funding has been secured from CCGs to support the appointment of Specialist Palliative Care consultant, in collaboration with St John's Hospice, Lancaster.
- The Gold Standards Framework has been adopted, with a planned roll-out to run through into 2013/14. This links in with community initiatives to provide increased support for patients at home, to reduce unnecessary admissions and ensure that patients are treated, and die, in their preferred place of care.
- The Liverpool Care Pathway has been the focus of much media attention nationally, and as such, the approach to this has changed from that identified at the outset of the project, to ensuring it is used appropriately and always in consultation with relatives and carers.
- A bereavement office was established at the Royal Lancaster Infirmary to facilitate improved support to relatives and help understand how the Trust can continue to improve services for bereaved relatives.
- A survey of experience following a bereavement has been introduced

Further planned improvements:
All End of Life CQUIN targets for 2012/13 were achieved. This work will be taken forward into 2013/14 as an identified priority.
- Funding has been secured from CCGs to support the appointment of Specialist Palliative Care consultant, in collaboration with St Mary's Hospice, Ulverston.

Patient Experience - Improving maternity services

2012/13 Target	**Maternity Patient Experience**
Lead	Executive Chief Nurse
Rationale	The CQC and Monitor's reviews of Maternity services in 2011/12 identified a shortfall in patient engagement and feedback. A number of issues have arisen during the year which has confirmed the issue. Monitoring of this indicator will provide assurances that robust systems are in place to engage with women and develop robust feedback/communication mechanisms relating to maternity services.
What will be measured	Ensure the quality of patient experience is measured and monitored on a regular basis. Ensure patient feedback is registered and used to influence practice and service development. Consult stakeholders in proposals for change to enable service users views to influence models of care.
Outcome	An improvement project has been set up within the Trust with detailed action plans and measures in place.

Actual Outcome
The Maternity Service consulted service users through patient experience questionnaires. They also undertook public surveys and focus group sessions as part

of the maternity strategy review. The review included input from nine external organisations representing health providers, commissioners and the public.

Improvements made in 2012/13:
The resulting driving forces within the Division were those of improving and thereafter maintaining safety and high quality services. The Maternity Services project aimed to mitigate the risks outlined in the diagnostic review undertaken by a team from Central Manchester University Hospitals and commissioned by Monitor.

The review identified 118 risks/concerns which were categorised into 13 sections of workforce, education and training, guidelines, leadership, audit, teamwork, risks and incidents, environment, complaints, equalities, patient experience, board assurance and infection control. A large number of changes and improvements have been made in these areas.

The project also created an assurance framework to evidence the improvements that had been made against the 118 risk areas. Of the 118 risks, 110 now have documented mitigations and evidence. A large number of improvements have been implemented, which include:

- Improving staffing levels with the appointment of 11 additional midwives and a further 15 midwives on a fixed term basis
- Reviewing training and improving the processes for delivering training to doctors and midwives along with processes for assuring staff have undertaken appropriate training and education
- Reviewed and improved treatment guideline, establishing a framework for their continual improvement
- Improved the arrangements for clinical input into the running of the Division and services
- Improved systems for audit of the care of patients and planned an audit schedule for the future audits
- Significantly increased awareness of patient safety, implementing rigorous processes for reporting incidents, investigating incidents, learning lessons from incidents and managing risks through a robust risk assessment
- Responding to patient's concerns in a more timely manner and implementing measures to obtain patient feedback on a wide range of services. An example of this is the SCBU survey which resulted in changes to facilities and information for parents.

The improvements were reviewed and endorsed by external assessments by the Local Supervisory Authority and the Nursing and Midwifery Council.

Further planned improvements:
The Maternity Service project is currently on hold while action planning work is undertaken to determine next steps.

Patient Experience - Improving discharge arrangements

2012/13 Target	Discharge
Lead	Director of Operations
Rationale	A number of issues need to be addressed to improve care and the safe and effective discharge of patients. Key issues are: • Delayed transfers of care to a more appropriate care environment • Ensuring care is provided in the most appropriate environment and reducing outliers • Improving information and communication relative to the whole discharge process.
What will be measured	Ensure that the discharge processes and procedures meet patient's needs and expectations. The Trust has consistently failed to provide a high standard of discharge experience. This is reflected in the National In-Patient Survey where a number of discharge related indicators are significantly worse than the average for other Trusts.
Outcome	An improvement project is being set up within the Trust with detailed action plans and measures in place.

Actual Outcome

The care Quality commission survey of adult inpatients which took place between September 2012 and January 2013 was published in March 2013. The Trusts overall score for the section on leaving hospital was 6.8 out of 10. This was classed as similar to the national average for trusts and was an improvement over 2011/12. There were 17 separate questions on aspects of discharge, scores ranged from 8.5 out of 10 to 4.3 out of 10 and all were similar to national average with the exception of patients receiving copy letters, were the score was classified as being in the worst performing Trusts.

Improvements made in 2012/13:

The project focused from the start of an admission to the end of the discharge process and resulted in major benefits:

- A standard operating procedure for the identification of "outliers" has been developed and implemented.
- Bed management meeting take place three times a day
- The Trust participates with stakeholders in Urgent Care Network meetings
- Complex discharge meeting have been introduced weekly
- Plans made to bring the complex discharge process within the Acute Medicine Division
- "Board" rounds with consultants have been introduced to identify patients who are ready for discharge

Further planned improvements:

A wide range of actions have been identified for implementation in 2013/14 including:

- A project lead will be appointed

- An electronic system for referral to social services will be implemented
- "Step Up Step Down" services will be implemented
- The current discharge assessment tool will be reviewed
- The time taken to complete decision support meetings (to assess care funding) will be reviewed
- A patient information book about discharge will be produced
- A standardised discharge checklist will be implemented and training for staff introduced
- A review of the single assessment process, including rapid response

A follow-up project has been included in the 2013/14 CQUIN scheme. Details can be found in part 2b on page 32.

Patient Experience - Improving dementia care

2012/13 Target	**Dementia Care**
Lead	Executive Chief Nurse
Rationale	The demographics within the Trust catchment areas are showing an increase in the elderly population and linked to this is an increase in the incidence of dementia. There has been a national strategy for dementia and the momentum to improve this area has increased and the Trusts need to respond to and enhance care given to this group of patients.
What will be measured	Percentage of all patients aged 75 and over who: • have been screened following admission to hospital • have had a dementia risk assessment within 72 hours of admission • who are referred for specialist diagnosis.
Outcome	Key indicators (National CQUIN) 90% of all patients in the 3 separate indicators over 3 consecutive months in the first year.

Actual outcome:

	Jan	Feb	Mar
Percentage of patients screened on admission	94.60%	90.60%	95.5%
Percentage of patients assessed for dementia risks within 72 hours of admission	49.40%	64.9%	69.1%
Percentage of patients with dementia referred for specialist diagnosis	12.70%	13.5%	9.1%

Data Source: PMO Workbook

Progress in 2012/13:

- Recruited a Clinical Nurse Specialist for dementia
- Introduced screening and assessment for dementia
- Rolled out the Butterfly Scheme
- Identified and launched Dementia Champions
- Initiated improvements to the environment in line with the requirements of patients with dementia.

This work took into consideration a development of an integrated care pathway for staff to follow as outlined in the Department of Health Dementia Strategy of 2009.

Further planned improvements:
The treatment of dementia continues to be a priority in 2013/14, details can be found in section 2b.

2b. Quality improvement priorities 2013/14

In selecting the priorities for 2013/14 the Trust has considered the regulatory reviews undertaken in 2012/13 and the issues these reviews identified. The improvement priorities for 2013/14 have been approved by the Trust Board.

Throughout 2012/13 board members have had oversight of the projects within the PMO through the Transition Board and approved the projects at meetings on the 27 February 2013 and 27th March 2013. This has given confidence that the PMO is the best mechanism to monitor change and provide board assurance through the Clinical governance and Quality committee in 2013/14.

The priorities have been set in line with the recovery plan and the workstreams developed in the Programme Management Office. Other key influences include the objectives set out in the Quality Report 2011/12, Quality Improvement Strategy 2010/13, the NHS Outcomes Framework and feedback from Trust activity and monitoring.

The Trust has also considered the following:-

- Staff and patients via NHS surveys
- Governors via meetings and workshops (lead by Chair, Director of Service and Commercial Development and Specialist Advisers.)
- NHS Choices ,Patient reported outcomes ,Matrons' questionnaires
- Primary Care Trusts, Practice Based Commissioners and partner organisations
- Customer care for complaints, concerns and compliments
- LINks - local involvement networks (community groups)
- Health Overview Scrutiny Committees
- Care Quality Commission

Monitoring of performance and progress will be through Programme Management Office (PMO), Transition Board (TB), CQUIN (Commissioning for Quality and Innovation), national teams and the Trust committee structure.

Safety - Paediatrics

Rationale
The Women's and Children's division have identified a number of critical areas associated with quality and safety that need to be addressed with partner organisations, stakeholders and feedback from service users. This was through the SCBU patient survey, paediatric survey, review of comments and complaints, review of incidents and staff feedback. In addition, there were concerns that the Mitchell Report (2009) and the Craft Campbell Report (2012) have not been addressed within children's services. Further to these concerns, there are a number of high-level risks identified within paediatrics that warrant consideration for a project which will seek to make a step change in the quality and safety of the paediatric services. To ensure that there are robust governance systems and processes in place within children's services at University Hospitals Morecambe Bay Foundation Trust, a Paediatrics project will be initiated.

What do we intend to achieve?
The project will achieve the following: • A safe and efficient service to patients within paediatrics • That credible assurances are provided to the Trust Board and external partners and regulators • To establish and implement robust governance/risk systems and processes • To ensure risk within the service is being managed effectively • To ensure that staffing establishment meets national standards • To ensure the workforce within paediatrics is trained and educated and that leaders are provided with knowledge, tools and access to information when needed.
What are the main things we will measure?
Key performance indicators will be identified for each project objective to include: • All identified staff are trained in root cause analysis • Increase patient satisfaction scores in the SCBU patient survey • Increase patient satisfaction scores on paediatric patient survey

Safety - Safeguarding Children

Rationale
Following CQC / Ofsted reviews of Cumbria and Lancashire PCTs earlier in 2012, both commissioners issued action plans to address the short-comings in the overall system of support for children who may be subject to abuse. As a result of these action plans an expert review took place in September 2012 that highlighted issues particular to UHMB FT. The project aims to continue to work closely with Local Childrens Safeguarding Boards and external stakeholders to address these issues as well as ones identified by the Trust in order to produce a more robust and effective safeguarding system for children across Morecambe Bay.
What do we intend to achieve?
• Ensure the Trust's safeguarding system, policies and procedures are adequate for children across the Trust • Ensure that child safeguarding across the Trust meets the minimum standards as defined by the commissioners' contracts • Establish robust procedures for assurance to the Trust Board
How do we expect to achieve it?
• Redraft Safeguarding Policies and procedures • Redesign the Safeguarding System • Devise a training strategy and ensure all relevant staff (and especially high risk groups) are adequately trained (to Level 2 and/or Level 3 as required) • Define the governance arrangement for safeguarding • Setup a system of KPIs and audit to ensure that child safeguarding across the Trust is consistent and effective. This will ensure the new system is adhered to and provide tangible assurance to the Trust Board
What are the main things we will measure?
Key performance indicators will be identified for each project objective to include: • 80% of identified staff trained to level 2 by July 2013 • 100% of identified Emergency Department staff trained to Level 2 by July 2013 • 100% of identified WACS department staff trained to Level 2 by July 2013

- 100% of identified WACS and Emergency Department staff trained to Level 3 by July 2013

Safety - Harm free care

Rationale
The Trust recognised that progress in 2012/13 on key areas of falls and pressure ulcer prevention were inadequate. In response to this the project will focus on the four "Harms" (pressure ulcers, falls, urinary catheter infections and VTE) and deploy strategies within the specific work streams to reduce harms incurred. This will support delivery of CQUIN targets identified under the "Harm Free Care" heading.
What do we intend to achieve?
The objectives will be defined once the CQUIN targets have been agreed. This will be around the reduction of specific harms such as pressure ulcers and falls.
How do we expect to achieve it?
The implementation of "Intentional Rounding" will be a key focus for 2013/14. This is an initiative to ensure all patients are observed and has interactions with clinical staff hourly, which has been shown where implemented in other organisations to reduce the number of patient falls and pressure ulcer incidence. In addition there will be other, smaller scale, initiatives identified and implemented to reduce falls where severe or moderate harm occurs, and to reduce pressure ulcers.
What are the main things we will measure?
Key performance indicators will be identified for each project objective to include: • Target 15% reduction from 2012/13 total falls during 2013/14 • Target 15% reduction from 2012/13 total falls causing moderate or more harm during 2013/14 • Target 20% reduction from 2012/13 total Grade 2 pressure ulcers during 2013/14 • Target 25% reduction from 2012/13 total Grade 3 or 4 pressure ulcers during 2013/14

Patient Experience - Complaints

Rationale
The Trust recognised that comments and complaints is one of the key mechanisms to obtain patient feedback and one which often provides a focus on weaknesses, therefore giving a significant opportunity to learn and improve. The aim of the Complaints Management project is to ensure that the Trust: • Consistently and conclusively responds to complaints within target deadlines • Ensures that a greater number of issues are locally resolved and that data is captured to demonstrate this • Formally captures compliments and thanks received into the Trust
What do we intend to achieve?
We intend to improve patient experience by delivering the following: • **Improvements in complaints handling** - 90% compliance rate with the Trust's 35-day agreed response target, eliminating the backlog of overdue cases that currently exists • **A reduction in the volume of formal complaints** – through increasing the resolution of informal concerns at the point of care
How do we expect to achieve it?

Improvements in Complaints Handling

- Ensure a cultural shift toward engaging with complaints to secure a change in the hearts of minds of Trust staff responsible for complaints resolution
- Optimise the process for dealing with complaints to reduce inefficiencies and delays
- Establish a permanent patient liaison service and reinforce divisional responsibilities

Reduction in volume of formal complaints

- Improve complaints resolution and facilitate speedy resolution of complaints through (frontline) pro-active local resolution initiatives
- Deliver a programme of Customer Care training to support a cultural shift and train staff in the effective deflection and resolution of complaints
- Use the issues raised via complaints and Incidents and Claims to inform the Trust's Action Planning to mitigate against similar issues recurring
- Incorporate the learning from complaints, as illustrated in the Francis Report, to inform the patient experience programme
- Set up an expert patient reference group/forum to oversee and advise the Trust's response to patient feedback

What are the main things we will measure?

Key performance indicators will be identified for each project objective to include:

- 90% compliance rate with the Trust's 35 day response target from October 2013

Clinical Effectiveness - Medical records

Rationale

The Trust is aware from patient feedback and reported incidents that getting a patient's medical record to the right place at the right time is crucial to support clinical treatments and investigations. The Trust identified in 2012 an expanding requirement to manage clinical records and an increasing clinical risk to patients in the availability of records at the point of care. Options were reviewed and approved by the Board for an internal solution with sustainable workstreams being;

- Move towards a paper-light/paperless system in all outpatient areas maximising the use of Lorenzo (Accelerated Clinical Content Approach ACCA)
- Medical records service improvement project to address the immediate and medium-term challenges including the use of an off-site storage facility.

What do we intend to achieve?

- To achieve a 99% compliance of casenote availability across outpatients, which currently stands between 90% and 95%.
- To maximise the use of Lorenzo as the primary patient record system moving towards a paperlite/paperless system for case notes.
- To improve the storage and management of casenotes in a secure and appropriate environment.

How do we expect to achieve it?

Lorenzo workstream This is to optimise patient information on Lorenzo in replacing the outpatient reliance on the paper casenotes. The project team are working closely with 3 clinical areas, Ophthalmology, Gastroenterology and Breast Surgery, to pilot this approach, learn lessons and to roll out at speed across the Trust. Medical Records Improvement workstream Case notes currently located within the RLI site will be moved to a new off-site facility run by UHMBT staff in Lancaster. The case notes would be electronically tracked in and out of the library, filed and retrieved using electronic tracking.
What are the main things we will measure?
Key performance indicators will be identified for each project objective to include: • 96% availability of patient casenotes in outpatients by July 2013 – this is part of a programme of increasing targets and introduction of computerised clinical information within outpatients • Development of electronic record in 3 specialities by July 2013

CQUIN SCHEMES

The key aim of the CQUIN framework for 2013/14 is to secure improvement in the quality of services and better outcomes for patients, whilst maintaining strong financial management. Schemes have been established at national level to support national priorities. At regional level the wide ranging Advancing Quality programme continues to improve the treatment of thousands of patients in the Trust who are admitted with pneumonia, heart attacks, heart failure, stroke or have major joint surgery. These have been augmented by local priorities set by the CCGs. Detailed targets and timescales for each CQUIN scheme is included in the contract signed between the Trust and it's commissioners.

- **Cardiology**

Description
The aim of the UHMBT Cardiology CQUIN for 2013/14 is to provide assurance that good quality care is being delivered for cardiology patients, particularly during their time as inpatients, this will incorporate three broad areas: • Audit • Inpatient Management • Heart Failure Management
Rationale for inclusion
The CQUIN measures seek to address the issues raised by UHMBT clinicians and supported by the Cardiac and Stroke Network in October 2012 and to build on the work undertaken in heart failure (HF) management in 2012/13.
Frequency of reporting to the commissioners
Quarterly progress to be reported to the cross-bay cardiology group. This will meet at least quarterly, featuring clinical leads for cardiology in UHMBT, Lancashire North CCG and Cumbria CCG (Furness and South Lakes localities).

- **End of life**

Description
End of life care
Rationale for inclusion

To continue the implementation of the National End of Life Care Strategy 2007 & subsequent updates.
Frequency of reporting to the commissioners
Quarterly

- **Harm free care**
  - **Intentional Rounding**

Description
Harm Free Care – Intentional Comfort Rounds
Rationale for inclusion
Intentional comfort rounds impacts positively on staff and patient experience and quality of care. Staff use intentional comfort rounds as part of the nursing care process. Intentional comfort round has an impact on a variety of harms but specifically: ▪ Reducing pressure ulcers ▪ Reduction in falls Intentional comfort round also support to: ▪ Measure impact of nursing care ▪ Improving handovers (focusing on key aspects of care) ▪ Enhance patient experience of care
Frequency of reporting to the commissioners
Quarterly

  - **Discharge Medication**

Description
Harm Free Care – Optimising Medication Safety on Discharge Direct pharmacy input with patients before discharge as part of the dispensing medicines process to include: • Information on Medicines dispensed for patients to take home at discharge. • Signposting to a member of the trust pharmacy team for enhanced information • Follow up after discharge for patients with the enhanced input • Signposting to the Community New Medicines Service for future development.
Rationale for inclusion
Medication errors continue to be a significant source of avoidable harm to patients who are admitted and then discharged back to primary care. Studies show that when pharmacists are involved in transitions of care and take measures to reduce the prevalence of drug therapy problems, the quality of the discharge process is improved and there is a reduction in adverse drug problem and readmissions rates are reduced. The ‘hand over’ of care is important between care providers but also in communicating with patient and their carers to ensure they are empowered to look after their own health care. This provides a significant opportunity to reduce avoidable harm as well as unnecessary readmission to hospital.
Frequency of reporting to the commissioners
Quarterly

- **Indwelling catheter**

Description
Harm Free Care – Indwelling Catheter Review strategies to decrease the use and duration of indwelling urethral catheters • Adapt the use of Integrated Care Pathway and record and report catheter days. • Establish a baseline from the data collected in the first six month period and reduce the number of catheter days by 15%* by the end of the six month period. *This is a provisional goal and could be subject to change based on our baseline findings.
Rationale for inclusion
The use of indwelling urinary catheters in hospitalized patients presents an increased risk of the development of complications, including catheter-associated urinary tract infection. The national average of catheterised patients stands at 11.6% and it is estimated that between 15% and 25% of hospitalised patients may receive short-term indwelling urinary catheters. A number of Acute hospitals across the country have taken initial steps to review strategies to decrease the use and duration of urinary indwelling catheters with their patients. This will lead to a reduction in the overall use of Urinary Catheter devices, reduce risk, improve personal experience for the patient and reduce cost of treatment.
Frequency of reporting to the commissioners
Quarterly

- **Children's pathway development**

Description
Children & Young Peoples Pathway Development Pathway development for lower respiratory infections and asthma, looking at the interface between organisations, setting baselines, establishing an urgent advice line and to provide training to address any requirements identified.
Rationale for inclusion
The objective is to reduce the unnecessary and preventable emergency admissions in lower respiratory infections and asthma. The Northwest experiences high rates of emergency hospital admissions for asthma, diabetes and epilepsy in 0 to 18year olds. In 2008/09 there were nearly 5,600 emergency hospital admissions for asthma among 0 to 18year olds in the North West, this is significantly higher than the rate for England.
Frequency of reporting to the commissioners
Quarterly

- **Stroke**

Description
Stroke Patients Admitted to a Stroke unit with 4 hours

The percentage of Stroke Patients directly admitted to a Stroke Unit within 4 hours of hospital arrival.
Rationale for inclusion
All patients with a suspected stroke should be admitted directly to a specialist stroke unit following initial assessment, either from the community or from an Emergency Department. A stroke unit is a discrete area in the hospital that is staffed by a specialist stroke team. Evidence shows that being treated in a stroke unit reduces deaths and increases the number of independent and non-institutional stroke survivors (NICE Clinical Guideline 68, July 2008). Currently, performance at UHMB is significantly below other trusts in the North West and the Trust has identified it as an area for improvement. Improving stroke care is also a priority for Cumbria CCG. It is also important that stroke care is improved across all sites, reducing health inequalities and improving outcomes for stroke patients equally across Morecambe Bay
Frequency of reporting to the commissioners
Monthly

- **Patient experience**
  - **Hip and knee**

Description
Patient Experience – Expectations of Hip & Knee patients To review best practice evidence for peer support groups, design satisfaction survey for patients and establish a patient support group.
Rationale for inclusion
To improve patient expectations on the outcomes of their surgery following input from patient peer groups.
Frequency of reporting to the commissioners
Quarterly

  - **Customer care – Outpatients**

Description
Customer care and Outpatient Services
Rationale for inclusion
To further improve the experience of patients who use our hospital services supporting the changing culture within the organisation, promoting a quality service within the workforce.
Frequency of reporting to the commissioners
Quarterly

  - **Your Welcome – Paediatrics**

Description
You're Welcome sets out principles to help commissioners and service providers improve the suitability of health services for young people. It covers themes which include: • ensuring services are accessible for young people and raising awareness of

services
- addressing issues of confidentiality, consent and safeguarding
- developing an appropriate environment and atmosphere
- involving young people in developing, monitoring and evaluating services

This CQUIN is for Acute Provider caring for teenage and young adults with long tern conditions of Asthma, Diabetes or Epilepsy.

Rationale for inclusion

There is growing recognition that teenagers and young adults with long-term conditions have specific emotional and social needs. Many will be entering relationships or starting work. For many it is a difficult time as they experience greater independence.

Sometimes the pressure of this responsibility can lead them to stop taking their medication or stop attending clinic appointments, simply in a bid to feel more 'normal'. Additionally, teenagers and young adults who transfer from paediatric care to adult services find difficulty in the systems expectation for them to take much greater responsibility and to actively participate in the management of their condition.

Frequency of reporting to the commissioners

Monthly

2c. Statements of assurance from the board.

Information on the review of services.

During 2012/13 the University Hospitals of Morecambe Bay NHS Foundation Trust provided and/or sub-contracted 46 NHS services.

The University Hospitals of Morecambe Bay NHS Foundation Trust has reviewed all the data available to them on the quality of care in 46 of these NHS services.

The income generated by the NHS services reviewed in 2012/13 represents 99 per cent of the total income generated from the provision of NHS services by the University Hospitals of Morecambe Bay NHS Foundation Trust for 2012/13.

The data reviewed covers the three dimensions of quality – patient safety, clinical effectiveness and patient experience.

Clinical audits and national confidential enquiries

During 2012/13 there were a total of 50 national clinical audits and 6 national confidential enquiries covered relevant health services that University Hospitals of Morecambe Bay NHS Foundation Trust provides.

During 2011/12 University Hospitals of Morecambe Bay NHS Foundation Trust participated in 95% of national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that University Hospitals of Morecambe Bay NHS Foundation Trust was eligible to participate in during 2012/13 are as follows:

Category	Name of audit	Eligible to participate	Participated	Number of cases submitted
NCEPOD	Subarachnoid Haemorrhage	Yes	Yes	4 (80%)
	Alcohol Related Liver Disease	Yes	Yes	6 (83%)
	Cardiac Arrest Procedures	Yes	Yes	4 (100%)
	Bariatric Surgery	No		
Confidential Inquires / Enquiries	Maternal, infant and new-born programme (MBRRACE-UK)	Yes	Yes	Still open
	Mental Health programme: National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH)	No		
Women's & Children	Child health programme (CHR-UK)	Yes	Yes	Still open
	Epilepsy 12 audit (Childhood Epilepsy)	Yes	Yes	Still open
	Neonatal intensive and special	Yes	Yes	Continuous

	care (NNAP)			
	Paediatric asthma (British Thoracic Society)	Yes	Yes	10 (FGH) 21 (RLI)
	Paediatric fever (College of Emergency Medicine)	Yes	Yes	9 (FGH) 50 (RLI)
	Paediatric intensive care (PICANet)	No		
	Paediatric pneumonia (British Thoracic Society)	Yes	Yes	Still open (FGH) 12 (RLI)
Acute	Adult community acquired pneumonia (British Thoracic Society)	Yes	Yes	Still open
	Adult critical care (Case Mix Programme – ICNARC CMP)	Yes	Yes	Continuous
	Emergency use of oxygen (British Thoracic Society)	Yes	Yes	17 (FGH)
	National Joint Registry (NJR)	Yes	Yes	Continuous
	Non-invasive ventilation - adults (British Thoracic Society)	Yes	Yes	Still open
	Renal colic (College of Emergency Medicine)	Yes	Yes	40 (RLI)
	Severe trauma (Trauma Audit & Research Network, TARN)	Yes	Yes	Continuous
Long term conditions	Adult asthma (British Thoracic Society)	Yes	Yes	10 (FGH) 18 (RLI)
	Bronchiectasis (British Thoracic Society)	Yes	Yes	27 (RLI)
	National Diabetes Inpatient Audit (NADIA)	Yes	Yes	38 (FGH) 60 (RLI)
	Diabetes (Paediatric) (NPDA)	Yes	Yes	Awaiting figures
	Inflammatory bowel disease (IBD)	Yes	Yes	Still open
	National Review of Asthma Deaths (NRAD)	Yes	Yes	Still open
	Pain database	Yes	Yes	(part 1 only)
	Renal replacement therapy (Renal Registry)	No		
	Renal transplantation (NHSBT UK Transplant Registry)	Yes	Yes	Continuous
Heart	Acute coronary syndrome or Acute myocardial infarction (MINAP)	Yes	Yes	Continuous
	Adult cardiac surgery audit (ACS)	No		
	Cardiac arrhythmia (HRM)	Yes	Yes	Continuous
	Congenital heart disease (Paediatric cardiac surgery) (CHD)	No		
	Coronary angioplasty	No		
	Heart failure (HF)	Yes	No	
	National Cardiac Arrest Audit (NCAA)	Yes	No	

	National Vascular Registry	Yes	Yes	Continuous
	Pulmonary hypertension (Pulmonary Hypertension Audit)	No		
Cancer	Bowel cancer (NBOCAP)	Yes	Yes	Continuous
	Head and neck oncology (DAHNO)	Yes	Yes	Continuous
	Lung cancer (NLCA)	Yes	Yes	Continuous
	Oesophago-gastric cancer (NAOGC)	Yes	Yes	Continuous
Blood and Transplant	Intra-thoracic transplantation (NHSBT UK Transplant Registry)	No		
	National Comparative Audit of Blood Transfusion programme - Audit of blood sample collection and labelling	Yes	Yes	3 (FGH) 100% 3 (RLI) 100% 1 (WGH) 100%
	National Comparative Audit of Blood Transfusion programme - The medical use us of blood	Yes	Yes	35 (x-bay) 100%
	Potential donor audit (NHS Blood & Transplant)	Yes	Yes	Continuous
Older People	Carotid interventions audit (CIA)	Yes	Yes	Continuous
	Fractured neck of femur	Yes	Yes	22 (FGH) 13 (RLI)
	Hip fracture database (NHFD)	Yes	Yes	Continuous
	National audit of dementia (NAD)	Yes	Yes	43 (FGH) 40 (RLI)
	Parkinson's disease (National Parkinson's Audit)	Yes	Yes	20 (FGH) 25 (RLI) 25 (WGH)
	Sentinel Stroke National Audit Programme (SSNAP) -	Yes	Yes	Continuous
Other	Elective surgery (National PROMs Programme)	Yes	Yes	Continuous
Mental Health	National audit of psychological therapies (NAPT)	No		
	Prescribing Observatory for Mental Health (POMH)	No		
Total 56				

The reports of all 56 national clinical audits were reviewed in 2012/13 and University Hospitals of Morecambe Bay NHS Foundation Trust intends to follow through and complete all recommendations arising from the audits. The following actions have been identified and have or are being implemented:

National clinical audit published	**Description of actions**
National non-invasive ventilation audit	1. Review and rewriting of the NIV protocol with clearer indications for its use and direction to further

	management and to include advanced decisions to be documented in the notes should NIV fail. 2. Clearer instructions as to appropriate management of the NIV settings now attached to the NIV machines. 3. Newly designed NIV observation chart now being used in the Respiratory and Acute admission wards 4. Newly designed weaning chart and plan now being used in respiratory and acute admission wards
National Pneumonia audit	1. Improve awareness of CURB65 scoring. Achieved by use of new Cross-Bay MAU proforma. 2. Share information with colleagues. Achieved by adding Pneumonia Advancing Quality data to monthly audit meetings. This resulted in achieving CQUIN for the first time. 3. Increase awareness and resource input for smoking cessation service. The Medical Division has been formally notified. 4. Re-audit. Ongoing Dec 12 – Jan 13.
National Diabetes audit	1. Completing the 'Safe Use of Insulin module' has since been including in the mandatory training for nursing staff. 2. We have adopted the 'Think Glucose' assessment tool for all patients admitted to FGH (and RLI) that have diabetes. This means that every person with diabetes is assessed using the tool as to whether they need to be seen by the diabetes team (red, amber and green referral pathways where red patients are seen within 24 hours Mon-Fri). 3. The assessment and referral to the specialist team is all electronic via Lorenzo.
National comparative audit of blood transfusion programme - the medical use of red blood cells	1. The results were presented to the physicians on both sites. This has increased awareness of indications for blood transfusion in medical patients
National comparative audit of blood transfusion programme - Audit of blood sampling and labelling.	1. Our trust is below average on the amount of samples that are rejected. However it was decided to include a section on the importance of correctly identifying the patient in the mandatory workbook which has just come out. 2. One of the issues raised from the audit was the different ways that the rules and "zero tolerance" was enforced between not only laboratories but staff within the labs. The hospital transfusion team plans to review this in the next couple of months.
National adult asthma audit	1. Increase availability of PEFR meters in ward – accomplished [with help from Pharmacy] 2. Ensuring PEFR was done according to standard – teaching to Respiratory Doctors and nurses – two sessions on Wednesday am – done

	3. Discharge standards- Need of increasing input from Specialist nurses realised- division been engaged and extra 20 hours of Specialist Nursing to respiratory Nursing funding approved. Person appointed and started early April 4. Discharge bundle including patient education and Follow up ensured at ward by specialist Nurse review- accomplished 5. Revision of a new peak flow chart with staff education in progress – draft ready 6. Memo regarding all the changes been circulated 7. Ne audit on acute admission planned 8. Continued commitment to take part in National Audit – maintained 9. Work on Asthma care bundle on-going
BTS paediatric pneumonia improvements made since previous audit in 2011/12	1. Increased awareness of correct use of antibiotics and indications for performing chest x-ray. 2. Better adherence to BTS guideline.
BTS paediatric asthma improvements made since previous audit in 2011/12	1. Asthma discharge proforma that included follow-up plan, information given & medication changes was designed.
Paediatric Diabetes Audit 2011 (most recent report)	1. Two extra Consultants. 2. 24 hour on call diabetes service. 3. New transition clinic running. 4. Three new polices currently awaiting publication following ratification.

Local Audits are vital in measuring and benchmarking clinical practice against agreed national and local standards. The Trust Clinical Audit Department ensures that the full cycle of clinical audit is maintained. A total of 108 local clinical audits were reviewed by the provider in 2012/13.

University Hospitals of Morecambe Bay NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided as a result of audits undertaken in 2012/13:

- Local and national audits will continue to be presented to specialty audit meetings.
- Any recommendations are taken forward by the relevant clinical team supported by the Clinical Directors and discussed within the Division where relevant action plans are developed.
- Improvements may include a change to the patient pathway, a change in a policy or procedure and any necessary education and training as required.
- Audit reports were reviewed at the divisional clinical governance groups and Clinical Audit and Effectiveness Sub-committee and will in future report quarterly to the Clinical Governance and Quality

Committee and speciality Divisional Governance Groups to ensure audits are followed through to implementation of the recommendations.

Information on participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by University Hospitals of Morecambe Bay NHS Foundation Trust that were recruited during that period to participate in research approved by a research ethics committee was 1293.

Information on the use of the CQUIN framework

A proportion of University Hospitals of Morecambe Bay NHS Foundation Trust income in 2012/13 was conditional upon achieving quality improvement and innovation goals agreed between University Hospitals of Morecambe Bay 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. Further details of the agreed goals for 2012/13 and for the following 12 month period are available online at: ***http://www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/openTKFile.php?id=3275***

An income of £5.454 million was conditional upon University Hospitals of Morecambe Bay NHS Foundation Trust achieving quality and innovation goals. University Hospitals of Morecambe Bay NHS Foundation Trust received an income of £5.007 million from the goals achieved.

Information relating to registration with the Care Quality Commission and periodic/special reviews

University Hospitals of Morecambe Bay NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is full registration without any conditions.

The Care Quality Commission has not taken enforcement action against University Hospitals of Morecambe Bay NHS Foundation Trust during 2012/13.

University Hospitals of Morecambe Bay NHS Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2012/13:-

- Royal Lancaster Infirmary, Maternity – Standards 13 and 16
- Furness General Hospital, Maternity – Standards 1,8,10,13,16 and 21
- Royal Lancaster Infirmary, Emergency Department – Standards 1,4,13 and 14
- Furness General Hospital, Emergency Department – Standards 4,13 and 14
- Royal Lancaster Infirmary, Termination of Pregnancy Service – standard 21
- Furness General Hospital, Termination of Pregnancy Service – standard 21
- Royal Lancaster Infirmary, Nutritional Needs Assessment – Standard 5

University Hospitals of Morecambe Bay NHS Foundation Trust intends to take the following actions to address the conclusions or requirements reported by the Care Quality Commission:

- The Trust met the standards in all cases and as a result of recommendations made one amendment to the registration of a service.

University Hospitals of Morecambe Bay NHS Foundation Trust has made the following progress by 31 March 2013 in taking such action:

- During the year the CQC published the findings and recommendations of a section 48 investigation under the Health and Social care Act 2008. These were discussed at Trust Board in July 2012 and a comprehensive action plan was implemented. In March 2013 the Trust responded to the Care Quality Commission with a summary of actions and evidence against the 40 recommendations made.
- Warning notices were lifted in September 2012

Information on the quality of data

University Hospitals of Morecambe Bay NHS Foundation Trust submitted records during 2012/13 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- which included the patient's valid NHS Number was:
99.7% for admitted patient care
99.8% for outpatient care
98.3% for accident and emergency care.

- which included the patient's valid General Practitioner Registration Code was:
100% for admitted patient care
100% for outpatient care
100% for accident and emergency care.

University Hospitals of Morecambe Bay NHS Foundation Trust Information Governance Assessment Report overall score for 2012/13 was 75% and was graded Green. The assessment made ten recommendations, each of which is being acted upon (see table below).

Recommendation	Action
National data definitions, standards, values and validation programmes are incorporated within key systems and local documentation is updated as standards develop.	Maintain updates to systems, policies and procedures introduced via ISN notices
External data quality reports are used for monitoring and improving data quality.	SUS data quality traffic light system monitored regularly. CDS data all checked for validity of format and volume. Information Assurance programme will be reviewed as part of the imminent changes in the Information/Informatics structure and

	Governance arrangements These changes are expected to take place summer 2013
Documented procedures are in place for using both local and national benchmarking to identify issues and analyse trends in information over time, ensuring that large changes are investigated and explained.	Regular reviews of benchmarked data against peer groups are provided in the monthly IPR.
A robust programme of internal and external data quality/ clinical coding audit in line with national requirements.	Recommendations noted and action plans with actions uploaded**.**
A documented procedure and a regular audit cycle for accuracy checks on service user	Data quality checks are carried out weekly on CDS data. A flow chart showing the CDS load and release process is available.
The completeness and validity check for data has been completed and passed.	Elective admission data checks need to be developed.
Clinical/care staff are involved in validating information derived from the recording of clinical/care activity.	Weekly validations of data are in place for Access plans, RTT and clinical coding data. A Compliance system is being piloted and will be rolled out across the Trust during 2013
Training programmes for clinical coding staff entering coded clinical data are comprehensive and conform to national standards.	Training is formalised with regular specific updates via workshops, training programmes etc

University Hospitals of Morecambe Bay NHS Foundation Trust was subject to the Payment by Results clinical coding audit during the reported period by the Audit Commission. The following conditions were examined:

<u>COPD admissions without intubation or NIV</u>
A sample of 36 care spells were audited, of which 36.1% had errors that affected the price. The commissioner was under-charged by £9,661 for the errors in the sample.

<u>Major knee procedures using cement in admitted patient care</u>
A sample of 20 care spells were audited, of which 15.0% had errors that affected the price. The commissioner was under-charged by £212 for the errors in the sample.

<u>Obstetrics in admitted patient care</u>
A sample of 18 care spells were audited, of which 12.9% had errors that affected the price. The commissioner was over-charged by £322 for the errors in the sample.

<u>Cardiology in admitted patient care</u>
A sample of 43 care spells were audited, of which 9.3% had errors that affected the price. The commissioner was under-charged by £3,083 for the errors in the sample.

There were both administrative errors and coding errors identified during the audit. University Hospitals of Morecambe Bay NHS Foundation Trust will be taking the following actions to improve data quality:

- Improve the quality of patient casenotes through Accelerated Clinical Content and Paper-light projects in 2013/14
- Improve the documentation and coding of co-morbidities by working with clinicians to review the processes and improve training
- Provide further training for coding staff in the coding of COPD and the coding of infections during delivery
- Improving the accurate recording of admission and discharge dates on Lorenzo
- Review the IT system used for clinical coding

Part 3.

Performance against key national indicators
From 2012/13 all trusts are required, under the NHS (Quality Accounts) Amendment Regulations 2012 to report performance against the following nine core indicators, using a standardised statement:

SHMI
The University Hospitals of Morecambe Bay NHS Foundation Trust considers that this data is as described for the following reasons:

- To prevent people from dying prematurely
- To enhance quality of life for people with long term conditions

The University Hospitals of Morecambe Bay NHS Foundation Trust has taken the following actions to improve this index, and so the quality of its services:

- Undertaking a mortality reduction programme as described in part 2a on p19.

The table below shows the Standardised Hospital Mortality Index, which the indicator for mortality comparison throughout the NHS. It includes deaths in hospital and deaths in England within 30 days of a discharge. An index of 100 is the national average and Band 2 indicates that the trust index is within the range of values expected.

SHMI Scores:

	Trust Index	Band	National Max	National Min
Oct 2010 to Sep 2011	112.25	2	122.95	67.47
Jan 2011 to Dec 2011	110.7	2	124.73	69.01
Apr 2011 to Mar 2012	107.48	2	124.75	71.02
Jul 2011 to Jun 2012	106.26	2	125.59	71.08
Oct 2011 to Sep 2012	103.5	2	121.07	68.49

Data Source: Health and Social Care Information Centre (standard national definition)

Deaths with palliative care coding
The University Hospitals of Morecambe Bay NHS Foundation Trust considers that this data is as described for the following reasons:

- To prevent people from dying prematurely
- To enhance quality of life for people with long term conditions

The University Hospitals of Morecambe Bay NHS Foundation Trust has taken the following actions to ensure this percentage accurate and appropriate, and so the quality of its services, by

- Undertaking a mortality reduction programme as described in section 2a on p19.

The indicator is a contextual indicator for SHMI. The table shows a comparison of the percentage of patient deaths were the clinically coded record indicates the patient had received care from the palliative care team. The Trust monitors this rate against our peer hospitals to highlight any level of coding that is unusual, so it can be investigated. The Trust average level of coding palliative care for 2012/13 is 12.54% and the peer rate is 12.64%, this gives assurance that the coding rate is not unusual.

Percentage of deaths with palliative care coding:

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2010/11	Trust	6.4	2.5	2.3	4.7	6.6	2.6	3.7	5.0	3.1	7.5	4.7	5.6
	Peer	16.6	19.1	18.7	14.8	13.9	14.4	14.5	13.7	9.8	8.2	10.1	11.7
2011/12	Trust	2.4	5.0	6.3	18.5	22.6	14.7	15.9	16.1	13.8	17.4	13.6	11.8
	Peer	11.6	13.3	11.0	14.6	12.3	13.0	13.7	13.5	11.0	13.8	12.9	11.0
2012/13	Trust	10.2	13.6	7.8	11.4	14.0	14.3	17.2	14.6	7.3	10.4	10.0	18.55
	Peer	11.1	13.8	13.2	14.2	15.4	14.7	12.8	12.8	10.0	10.8	12.3	9.23

Data Source: CHKS

Patient reported outcome measure scores:

The University Hospitals of Morecambe Bay NHS Foundation Trust considers that this data is as described for the following reasons:

- To help people recover from episodes of ill health or following injury

The University Hospitals of Morecambe Bay NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by:

- Encouraging patients complete the survey on admission for the procedure
- Participating in the Advancing Quality programme for major joint replacements
- Selecting Hip and Knee replacements as a priority quality programme for 2013/14

The following tables show the EQ5D index average score health gain for the four conditions included in PROMS. EQ5D is a health questionnaire that asks general questions about health and specific questions about quality of life improvements related to the individual conditions. The tables contain the latest data from HES On-line which is from April to December 2012.

Groin hernia surgery

	Trust Average	National Average
2011/12	0.070	0.087
2012/13	0.070	0.090

Data Source: HES On-line

Varicose vein surgery

	Trust Average	National Average
2011/12	0.077	0.094
2012/13	0.084	0.089

Data Source: HES On-line

Hip replacement surgery

	Trust Average	National Average
2011/12	0.431	0.416
2012/13	0.484	0.429

Data Source: HES On-line

Knee replacement surgery

	Trust Average	National Average
2011/12	0.294	0.302
2012/13	0.310	0.321

Data Source: HES On-line

Readmissions within 28 days for 0-14 year olds and for 15 year olds or over

The University Hospitals of Morecambe Bay NHS Foundation Trust considers that this data is as described for the following reasons:

- To help people recover from episodes of ill health or following injury

The University Hospitals of Morecambe Bay NHS Foundation Trust intends to take the following actions to improve this number, and so the quality of its services, by

- Continuing to review readmissions as stated in part 2a p18.

To date, the national data has not been published by the Health and Social Care Information Centre. Data has therefore been taken from trust data which has been sent centrally through contract data sets to CHKS. This information allows comparison with a group of peer trusts.

Number of patients aged 0-14 readmitted within 28 days:

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2011/12	72	60	57	61	67	60	60	74	78	70	94	88
2012/13	88	54	92	62	63	56	61	79	102	103	103	88

Data Source: CHKS

	Trust Rate	Peer Rate
2011/12	10.4	7.9
2012/13	11.0	8.4

Data Source: CHKS

Number of patients aged 15 and over readmitted within 28 days:

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2011/12	453	467	488	453	490	464	440	436	467	435	460	534
2012/13	534	467	514	539	514	523	486	531	488	484	542	522

Data Source: CHKS

	Trust Rate	Peer Rate
2011/12	6.1	5.1
2012/13	6.7	5.7

Data Source: CHKS

The Trusts responsiveness to the personal needs of its patients

The University Hospitals of Morecambe Bay NHS Foundation Trust considers that this data is as described for the following reasons:

- To ensure that people have a positive experience of care

The University Hospitals of Morecambe Bay NHS Foundation Trust intends to take the following actions to improve this rate, and so the quality of its services, by

- Improve the provision of information to patients at the time of their discharge from hospital
- Improve a range of support services by moving to a seven day service

National Patient Survey Programme - Average weighted score of 5 questions relating to responsiveness to personal needs (out of 100):

The full national data from the 2012 survey has not been published; however, the Trust has its own results which allows calculation of the average weighted value for the Trust.

	Trust Average	National Average
2009/10	67.2	66.7
2010/11	67.0	67.3
2011/12	65.3	67.4
2012/13	69.2	To be published

Data Source: Health and Social Care Information Centre

The percentage of staff who would recommend the trust as a provider of care to their family or friends

The University Hospitals of Morecambe Bay NHS Foundation Trust considers that this data is as described for the following reasons:

- To ensure that people have a positive experience of care

The University Hospitals of Morecambe Bay NHS Foundation Trust has taken the following actions to improve this score and so the quality of its services, by:

- Developing an annual action plan to address specific areas of the staff survey. This will include focus groups with staff to identify the actions needed
- The introduction of the monthly staff 'temperature' checks to gauge how staff are feeling.
- Introducing a Chief Executive's Leadership Group, with membership from both clinical and non-clinical areas of the Trust. The group will be a forum for staff who have a passion and commitment to improving what we do to work with the Chief Executive on a range of key topics.
- Introducing a new team brief process to ensure that key messages are delivered to a wide range of managers across all sites. This will be led by Executives and will ensure we are increasing our face to face communications activity. Management Conferences led by the Executive team will also be delivered on a quarterly basis throughout the year.
- Developing a new Workforce and Organisational Development Strategy which will help us to address issues raised by the Staff Survey responses. The OD activity will be focused on:
    - Developing the culture of the organisation, with specific interventions on developing and promoting our values;

- Improving service excellence, with a focus on customer service and attitudes of staff;
- Developing the role of volunteers in the workforce;
- Developing our approach to talent management. This will include identifying recruitment and attraction strategies as well as a structured approach to succession planning

NHS Staff Survey Questions KF24 or KF34 (out of 5):

	Trust Average	National Banding
2011	3.33	Worst 20%
2012	3.31	Worst 20%

Data Source: NHS Staff Survey Co-ordination Centre

Percentage of patients who were risk assessed for VTE

The University Hospitals of Morecambe Bay NHS Foundation Trust considers that this data is as described for the following reasons:

- To treat and care for people in a safe environment and protecting them from avoidable harm

The University Hospitals of Morecambe Bay NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by

- Maintained the assessment processes and data collection introduced in 2010/11
- Introduced root cause analysis for all cases of post-operative PE and VTE

Percentage of patients assessed for VTE:

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2011/12	90	93	92	94	99	93	92	100	95	99	98	100
2012/13	96	96	96	98	92	97	97	98	100	98	99	89

Data Source: Health and Social Care Information Centre

	Trust Average	National Average
2011/12	95.42%	93.0% (Q4)
2012/13	96.25%	94.2% (Q4)

Data Source: Health and Social Care Information Centre

Rate of C.Difficile infection in patients aged 2 and over

The University Hospitals of Morecambe Bay NHS Foundation Trust considers that this data is as described for the following reasons:

- To treat and care for people in a safe environment and protecting them from avoidable harm

The University Hospitals of Morecambe Bay NHS Foundation Trust has taken the following actions to reduce the number of cases, and so the quality of its services, by:

- Prescribing
  - The Trust Antibiotic Prescribing Policy has been reviewed, with a schedule of future updates

- The Antibiotic formulary on the reverse of the BNF is current and updated annually
- Antimicrobial prescribing audit each quarter
- Results of audits are disseminated and an action plan to address shortcomings are and presented to IPCC
- Reports on the current status of the action plan will be provided by the Consultant Microbiologist to IPCC
- Audit usage of PPIs

- Hand Hygeine
  - A policy on hand hygiene and glove selection is available on the Infection Prevention Website
  - Compliance with hand hygiene will be audited in each clinical area weekly using the WHO 5 moments
  - Compliance results will be recorded on GURU, and reported through IPCC. Department managers will provide an action plan when compliance falls below 80%
  - Hand hygiene training and assessment is captured through the TMS
  - Divisions complete covert monitoring of hand hygiene of other Divisions and report findings via Divisional report at IPCC

- C. Diff Pathway
  - All patients with CDI will be commenced on a CDI pathway
  - All patients with CDI will have a high impact intervention audit commenced which forms part of care pathway
  - All Trust attributed cases of CDI undergo a root cause analysis
  - All Trust attributed cases are given a CDI card and distribution audited
  - All Trust attributed cases trigger an unannounced antimicrobial audit
  - Medical staff are contacted individually when a patient is diagnosed with C Difficile and doctors to complete a rapid review of medication and contributory factors

Unfortunately a cluster of infections occurred in the last month of the year and a series of short term measures were implemented:

- Event in April 2013 at Furness General Hospital to highlight rising infection rates
- Support from Clinical Skills and Practice Educators in clinical areas
- Increased vigilance at ward and department level
- Engagement from medical teams via Clinical Directors and medical forums to inform of situations and expectations
- Increased multi-disciplinary surveillance and scrutiny of antimicrobial prescribing in high risk areas
- Review of cleanliness and infection prevention intervention surveillance

<u>Number of cases of C.Diff in patients over 2 years old:</u>

	Total Number	**Rate per 100,000 Bed Days**	**National rate per 100,000 Bed Days**
2010/11	161	26.9	29.6
2011/12	142	23.2	21.8

2012/13	48	20.4	Unavailable from Public Health England

Data Source: Public Health England (2012/13 Trust source)

Number and rate of patient safety incidents reported and the number that resulted in severe harm or death.

The University Hospitals of Morecambe Bay NHS Foundation Trust considers that this data is as described for the following reasons:

- To treat and care for people in a safe environment and protecting them from avoidable harm

The University Hospitals of Morecambe Bay NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by

- Increasing staff awareness of risk and incidents
- Encouraging an open reporting culture

Number of patient safety incidents reported:

		Rate /100 admissions	
	Reports	**Trust**	**NHS Median**
Apr 2010 to Sep 2010	3143	7.06	5.4
Oct 2010 to Mar 2011	3467	7.79	5.7
Apr 2011 to Sep 2011	3396	7.75	5.9
Oct 2011 to Mar 2012	4193	9.6	5.9
Apr 2012 to Sep 2012	6024	13.61	6.2
Oct 2012 to Mar 2013	5639	Unavailable from NRLS	

Data Source: National Reporting and Learning System

Percentage of patient safety incidents by harm category:

		No harm	**Low harm**	**Moderate harm**	**Severe harm**	**Death**
Apr 2011 to Sep 2011	Trust	68.2	27.8	3.7	0.3	0.0
	Large Acute Trust Average	71.2	22.0	6.0	0.6	0.1

Data Source: National Reporting and Learning System

		No harm	**Low harm**	**Moderate harm**	**Severe harm**	**Death**
Oct 2011 to Mar 2012	Trust	68.3	26.7	4.4	0.6	0.1
	Large Acute Trust Average	69.8	23.6	5.9	0.6	0.1

Data Source: National Reporting and Learning System

		No harm	**Low harm**	**Moderate harm**	**Severe harm**	**Death**
Apr 2012 to Sep 2012	Trust	71.9	23.4	4.4	0.3	0.1
	Large Acute Trust Average	71.5	22.4	5.3	0.6	0.1

Data Source: National Reporting and Learning System

		No harm	**Low harm**	**Moderate harm**	**Severe harm**	**Death**
Oct 2012 to Mar 2013	Trust	64.4	31.0	3.8	0.6	0.2
	Large Acute Trust Average	Unavailable from the National Reporting and Learning System				

Data Source: Trust Risk Management System

Performance against key local priorities
This section provides an overview of the quality of care offered by the NHS Foundation Trust based on performance in 2012/13 against indicators selected by the board in consultation with stakeholders. The indicators include measures on patient safety, clinical effectiveness and patient experience. The indicators selected are to promote quality improvement and are based on saving lives by reducing hospital mortality rates, preventing harmful events, reducing variations in fundamental aspects of basic care and continuously improving patient satisfaction and outcomes. The Trust aims for provide an exemplary patient experience in a safe and effective manner.

Patient Safety – Medical records improvement
The project objective was to improve patient case note availability at the point of care to 100%.

Actual Outcome:
- Note availability as of February 2013 was 96
- Compliance with information governance training for the medical records staff has increased from 50% to 85%.

Improvements made in 2012/13
- Restructuring of site based libraries to enable improved management and leadership.
- Provision of additional temporary build to accommodate patient records on RLI site has allowed more space in site based libraries to improve housekeeping.
- Introduction of Trust wide Tracking and Tracing Standard operating procedure
- Redesign of processes for requesting notes
- Audits of departments to assess adherence to SOP for tracking and tracing
- Audits of specialities where case note not available in clinics
- The medical records managers and service managers have under gone the IHRIM training and are awaiting final assessments

Further planned improvements:
- Continue with short term action plan to deliver 96% records by May 2013.
- Move RLI records library to off-site storage.
- Use of barcoding in new premises to improve location management of notes
- Align medical records work to ACCA plan to achieve 100% patient records at point of care.

Patient Experience – Switchboard improvements
The project objective was to support a robust plan to deal with the early issues identified in relation to the operation of the trust centralised switchboard which include difficulties with the format and time taken to use the on-call rota, use of an out of date telephone database, lack of awareness both amongst trust staff and the public of the hospital department telephone numbers and a lack of training of switchboard operators.

Actual Outcome:

KPI	March 2013	Target
% trained switchboard staff	100%	100%
% of calls to the switchboard to be answered within 20 seconds	91.8%	70%
% of calls to the switchboard waiting more than 40 seconds	3.9%	5%
Total number of abandoned calls after 10 seconds	4012	4151

Improvements made in 2012/13

- Develop an electronic rota which is owned by the divisions and used by the switchboard operators to source the correct on-call personnel
- Review staff contact including wards and department telephone database directories to ensure contact details are current and up to date
- Plan and deliver a standard switchboard operator training package
- Review trust website to include ward / department contact information and update as required
- Identified IT based equipment which can address call handling

Further planned improvements:

- Implementation of a newly formed switchboard service development group
- Development of local and regional NHS switchboard networking group

Patient Experience – Consultant led Referral To Treatment (18 week RTT) standards

A recovery plan to achieve the admitted RTT standard was implemented in 2012/13. The specific focuses were on Trauma & Orthopaedics, General Surgery and Ophthalmology admitted patients, with a broader scope to support the overall reduction of the percentage backlog of patients waiting over 18 weeks RTT to no more than 8% across the Trust.

Actual Outcome:

Percentage of patients waiting to start treatment at the end of the month, who are within 18 weeks of referral:

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2012/13	Trust	93.8	94.0	93.3	93.1	92.6	92.6	92.9	93.3	93.3	94.7	95.7	96.4
	Target	92	92	92	92	92	92	92	92	92	92	92	92

Data Source: NHS Commissioning Board Statistics

Percentage of patients who started treatment during the month within 18 weeks of referral:

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2012/13	Trust	88.1	89.7	90.5	90.1	90.1	88.0	86.0	85.8	89.1	91.3	90.8	90.2
	Target	90	90	90	90	90	90	90	90	90	90	90	90

Data Source: NHS Commissioning Board Statistics

Percentage of patients whose treatment that did not involve admission to hospital (out-patients) that were treatment commenced within 18 weeks of referral:

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2012/13	Trust	96.3	96.7	96.6	96.4	95.6	95.3	95.5	95.5	95.6	96.3	96.3	97.2
	Target	95	95	95	95	95	95	95	95	95	95	95	95

Data Source: NHS Commissioning Board Statistics

Performance has significantly improved in quarter 4 of 2012/13 and the Trust has achieved all 3 of the national standards every month since January 2013. There has been a huge improvement in the percentage of patients still waiting for treatment that have waited longer than 18 weeks, which puts the Trust in a robust position to achieve the standards in all Specialties going forward.

Improvements made in 2012/13

- RTT progress has been performance managed through the weekly Trust Performance meetings with representation from the Divisional General Managers, the Chief Operating Officer and the Performance Team.
- Weekly divisional Performance meetings established with wider members of the clinical divisional teams, to monitor operational management of RTT
- Suitable patients were identified for transfer to the Independent Sector
- Trajectories were set for number of procedures each week, which was based on a capacity and demand analysis for theatres in order to achieve RTT standards. A number of additional activity sessions were provided on a weekly basis to meet this required activity.
- Cancelled operations were reviewed and managed
- Following the closure of the Ramsay unit at Westmorland General Hospital a business case was developed, approved and implemented to re-open this area as an additional theatre and day case unit, providing additional capacity for elective orthopaedic activity, which was the most challenged Specialty.
- Changes to waiting list management were introduced, including escalation of patients waiting beyond trigger points in the patient pathway, increased pooling of patients to standardise waiting times between Consultants and targeting of the longest waiting patients.

Patient Experience – Outpatient improvement, Guaranteed Activity Dates

Following a patient safety incident about a patient who had not been followed up in Outpatients as required, the Trust identified 37,000 access plans had Guaranteed Activity Dates that had been missed.

Actual Outcome:

Major Incident and GAD Management

- All patients were contacted and either met with or confirmed as unavailable or not needing to meet for an appointment.
- The treatment of those either unavailable for or not requiring an appointment has now be passed back to GPs (which has been agreed with the Incident Co-Ordination Group).

Harms assessment

- All 630 patients were contacted. Where a request was made via the helpline for a further meeting, that meeting was set up in all instances.

- The helpline closed on 24th August after a period of 8 weeks. During this period 164 calls were received and 55 Consultant led meetings arranged.

Improvements made in 2012/13

- All access plans were reviewed and validated.
- 19,000 patients required to be seen which was achieved by September 2012
- An independent review of the harms assessment plan was commissioned by the Trust to be undertaken by the Countess of Chester Medical Director.
- Following feedback from this review, the next step in the process was to review those patients identified to have suffered harm to undertake a second clinical review of patient case notes and this was completed for 1185 patients.
- As a result of the review work performed by the Trust a total of 630 patients were identified as suffering harm following a delayed appointment.
- At 16th August 2012 all 630 patients had been written to providing an offer to meet with a Consultant to discuss the clinical implications and treatment plan, including details of the helpline in place through which to book.
- To date, 55 patients have met with their consultant to discuss the implications of the delay on their health.
- In respect of deceased patients there were no (zero) instances of a proven link between the patients cause of death and the delay in attending an appointment to discuss the reported condition that they were due to attend for.
- To prevent this issue from happening again in the future the Trust actively reviewed it's processes regarding outpatients bookings and other areas of GAD Management to ensure all patients are seen in a timely manner.

Patient Experience – Patient Information, Projects Barrow, Kendal and Lancaster

Projects Kendal, Barrow and Lancaster (KBL) were initiated to generate ideas to improve the physical environment of the hospitals.

The Patient Information project was set up to improve information provided to patients to ensure that service users, patients and carers consistently get the right information at the right time to ensure that they can make informed decisions about care, treatment or services.

Improvements made in 2012/13

Patient Information:

- Project Plans were established under nine workstreams
- Site visits were undertaken to a number of identified "best practice" sites to review their systems for ensuring the provision of consistent, high quality information to patients.
- Approval was secured to appoint a single supplier of printed patient information, with an on-line portal for production of leaflets, all of which would be quality assured and produced on a standard template.
- Work was progressing on reviewing standard patient letters, and providing patients with copies of all letters sent to their GPs.

Projects KBL:

- Ideas were generated by holding focus groups with patients, staff and GPs, facilitated by an independent researcher.
- The groups were given clear guidelines on the measures of the project and likely budget available in order that the groups are as effective as possible.
- The ideas considered to have the most impact within the budgetary constraints were sent for approval to a panel

Further planned improvements:
Work resulting from both projects continues.

Patient Experience – Comments, Concerns and Complaints

The Trust continues to actively seek the views of patients on the quality of their care through a range of approaches. The trust continues to focus on learning from comments, concerns and complaints to improve services for patients, staff and visitors. During 2012/13 these have included:

- Matrons questionnaires
- Advancing Quality patient experience Measures
- Compliments and complaints
- NHS Choices
- Patient experience questionnaires
- Patient stories

The top five themes for complaints in 2012 /13 are in relation to: Inadequate care treatment, Admin Procedures, Treatment, Diagnosis all of which show an increase in the number of complaints received against this category in the previous year, and Attitude of staff which shows a continued decrease over the past two years in the number of complaints received against this category.

The Trust has seen a 100% increase in the number of complaints and concerns received during the last 5 years. Efforts are currently underway to reconfigure the system for the management of complaints to introduce new efficiencies into the complaints management process and also to resolve complaints at the point of initiation. A complaints project management plan is in the final stages of development with a view to a new robust system being put in place by October 2013.

The numbers of contacts are as follows:

	2011/12	2012/13
Total Comments	43	75
Total Concerns	716	373
Total Complaints	597	753
Total PALS contacts	1129	1237

Data Source: Trust

Clinical Effectiveness - Advancing Quality

This is a North West quality initiative that has been included in the CQUIN for 2012/13. There are 5 clinical conditions included and the aim of the Trust is to achieve the individual targets set for those conditions.

Actual Outcome:

Results are through audit of all cases of each condition and are therefore approximately 6 months retrospective. The latest data is:

Condition	Target Score	Q2 2012/13	Oct 2012	Nov 2012	Dec 2012
Pneumonia	83.93	86.2	86.8	83.73	87.4
Hip or Knee Replacement	95	95.4	98.8	96.3	98.9
Acute Myocardial Infarction	95	99.2	99.1	97.5	99.1
Heart Failure	81.86	71.7	68.3	55	61.6

Stroke indications have been included in part 2 on p16.

The trust is currently achieving the targets in 3 of the 5 conditions.

Improvements made in 2012/13:

Following a re-launch in February 2012 there have been a number of significant interventions:

- Heart Failure nurses have been appointed at the Royal Lancaster Infirmary and Furness General Hospital who will see each patient and ensure that discharge information is consistently given
- The pneumonia clinical pathway has been reviewed and changes have been made to the way smoking cessation and the recording of CURB65 are undertaken
- Major joint replacement information is now captured in real-time, which allows improved monitoring of all indicators.

Further planned improvements:

Advancing Quality is included as the 2013/14 regional CQUIN.

Annex 1:

Statements from Primary Care Trusts, Local Involvement Networks and Overview and Scrutiny Committees.

Comments from Lancashire North CCG

We would like to thank you for forwarding a draft copy of the Trust Quality Account for 2012/13 in accordance with the requirements of the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010.

We are pleased to provide the response from Lancashire North Clinical Commissioning Group.

Overall the Lancashire North Clinical Commissioning Group felt that the document describes in year activity and recognises the areas described. It provided aspects of information on how the Trust has performed during 2012/13 and demonstrated improvement from the previous year in some areas but it was also noted that in some areas performance had not progressed.

The Clinical Commissioning Group monitors quality and performance at the Trust throughout the year and continually works with the Trust to strengthen presentations and timeliness of information through frequent on-going dialogue as issues arise.

When significant incidents occur the Trust is evidencing its ability to conducts robust multidisciplinary investigations, so that lessons are learned and improvements can be made.

Review 2012/13

Overall the Trust has been open about its achievements and areas for continued improvement and focus, however we feel there are certain areas where the Trust could have identified more clearly the significant amount of work that has been completed during 2012/13 e.g. dementia care, safeguarding children and adults and the management of serious untoward incidents, plus the work it has planned in 13/14 e.g. actions to improve care regarding prevention of pressure ulcers, harm from falls and early warning systems of the deteriorating patient.

We would have liked to see a clearer explanation of the quality governance arrangements and how the trust is developing and will sustain its ability to deliver and monitor improvement, stating how activity was measures and how gaps were responded to.

In view of the importance of staff/patient interface and the recent negative media spotlight commissioners felt the document would have benefited from including this element providing the platform for the Trust to describe specifics of how they have listened and responded to patients and both clinical and non-clinical staff.

Priorities 2013/14

We are pleased to note the Trust has recognised that measurement for improvement needs to be robust and reliable and wishes to acknowledge how that the Trust has worked collaboratively with Commissioners including Clinician's to agree the 2013/14 CQUIN. The considerable input of clinicians' has helped to focus attention on what matters to our local population's health and care needs and will facilitate improved outcomes.

Throughout 2013/14 the Clinical Commissioning Group will build on positive relationships and work constructively with the Trust and other partners to continually monitor the overall aims of 2013/14 and will be kept updated of the developments for

improving the safety, effectiveness and patient experience to a level our local population expect.
The CCG believes 2013/14 is a pivotal year for quality improvement in the Trust to address identified problems and rebuild public confidence in local services.

Comments from NHS Cumbria CCG
Thank you for the opportunity to review and comment on your quality account 2012/13. This account has been reviewed by the local commissioners, the Quality & safety team and the Senior Management team within NHS Cumbria CCG. I would like to apologise for the delay in returning HNS Cumbria's comments to you.

We appreciate that there are a number of challenging issues facing you in the forthcoming year and anticipate that these will be managed jointly through our monthly Quality & Performance board with yourselves and Lancashire North CCG.

We are pleased to see a reference to the excellent work that has been done in relation to safeguarding adults and children as well as reference to maternity services and special care baby unit and also the inclusion of regular reports on GAD and maternity.

The proposed harm free care project and initiatives like "intentional rounding" should lead to a reduction to falls and pressure ulcers and we will be monitoring this through 2013/14.

We note the implementation of the @assessment of harms NPSA tool', and we would be grateful for a lead contact, so that our Quality Team can understand more about this initiative.

We acknowledge the achievements in the stroke patient pathway, and the work still to be done to bring performance up and improve outcomes for stroke patients, supported by the CQUIN programme. However, the figures quoted on p16 do not accord with data we have received from AQuA on stroke achievement, which show much lower figures.

We are pleased to see the plans to improve the quality of care for patients with dementia, the new initiatives, and improved pathway of care.

We note that the Trust achieved compliance with the CQC improvement notices, the improvements made and evidence submitted to the CQC in March 2013.

We acknowledge the issues raised in the data quality audit and in the PBR clinical coding audits, and expect the actions proposed improve the accuracy.

The document is not visually appealing to patients and users and we would suggest the inclusion of graphs, charts and/or pictures would improve the document.

There does not appear to be any reference to the CQUIN target around recording of patient experience (Care4U).

We are unable to find any reference to the on going clinical strategy work. Neither are we able to find any financial statements and would expect to see your cost improvement programme clearly identified.

For a Trust that is so open to public scrutiny, we would recommend that you would clearly identify your key priorities and public concerns at the beginning of the document, to ensure that the public are assured ofyour candour.

In conclusion, we are pleased that you have invited comments and we hope these comments are useful to the production of the final document. If you require any further information please do not hesitate to contact me or Dr David rogers, Deputy Clinical Chair.

Comments from Cumbria Health Scrutiny Committee

The Cumbria Health Scrutiny Committee welcomes the opportunity to comment on the draft Quality Account for 2012/13, and would like to acknowledge the improvements that have been made in terms of the presentation and levels of information in this document over recent years. One element found to be of particular use was part 3 where the Trust's performance was benchmarked against national comparators not solely selected comparator authorities. This it was felt helps to provide a clearer overall picture of performance.

The Committee are aware that the version they saw was a draft and that further developments will be made prior to finalisation, however in terms of style there are one or two points that the Committee would like to suggest are incorporated in this and future Quality Accounts. These points include:

- Ensuring that the context of the operating environment and any wider issues are provided in the document so that the reader can better understand the information detailed.
- Where the document cross references information to other sections include page numbers to enable the reader to easily read through.
- The language of the report needs to be in plain English avoiding jargon and overlong explanations that add no further value to what is being said.

One key area the Committee would like to mention is the use of hard data within the Quality Account. Members were disappointed to note that much of the information in the body of this key document was explanatory rather than clearly showing performance against targets. It is felt that clear demonstration of the Trust's evidence base to support its performance and delivery of priorities is key, and where possible should be included in this document. Where it is not possible to include in this year's Quality Accounts the Committee would strongly recommend that it is embedded and clearly shown in the following year's document.

As a final note, the Committee, are aware of a recent Care Quality Commission inspection of Furness General Hospital which advises that action is needed. Whilst Members are aware that this inspection report falls into the following financial year, they believe that as the issues themselves relate to both years and that it would be beneficial to reference this inspection, and that improvements have been put in place, in this document. A full analysis could then be provided in the following year's quality accounts.

Overall, we appreciate the co-operation received and look forward to continuing to work with the Trust during the coming year to help drive up quality

Comments from Cumbria Healthwatch:

Our overall impression of the Quality Account is that it is a well laid out document that is easy to read and follow. We admire the honesty of the Trust, which openly admits to where problems are, and highlights where targets have not been met. We like how the Trust explains exactly where they haven't achieved planned outcomes, but describes future plans that will aim to correct this.

Despite the fact that targets are not always achieved, the Trust does describe the improvements that have been made over the past year to show they are working on the issues. The report advises of further planned improvements, alluding to issues such as the staff training programme on issues like Adult Safeguarding.

In Section 2A each project is clearly set out, followed by what they intend to achieve, how they expect to do that, plus outcomes. We think this structure is easy to follow and understand. Again, we admire the Trust's honesty in admitting where they have failed to hit targets.

Section 2B is again easy to follow, highlighting specific criteria to measure success in the future. It will be interesting to see what progress is made in future reports.

In Section 2C, which explains what reviews and audits have taken place, the table used is laid out neatly. We believe this makes it concise and easy to follow.

Section 3 measures performance indicators against key national priorities. Once again, the Trust honest in including the findings of the NHS Staff Survey findings, which make uncomfortable reading. The use of tables to highlight statistics is effective and the information is laid out clearly.

Perhaps our only criticism is the length of the document, which requires a lot of concentration to read and digest. A recommendation may be to provide a shorter, summary document which highlights key findings and statistics, that is more accessible to people.

Comments from Lancashire Health Scrutiny Committee

The Lancashire Health Scrutiny Committee has made a commitment to ensure that members are aware of, and take a keen interest in the facilities, services and performance of the Trust. To maintain this they will continue to have an overview of the design and development of quality services provided to the residents of Lancashire. In addition a priority of the Committee is to reassure the public that an honest and transparent relationship is developed with the Trust to enable effective scrutiny to take place.

Comments from Lancashire Healthwatch

As you will be aware, Lancashire LINk ceased operations on 31st March 2013. Many of its functions, including responsibility for commenting on health trust's quality accounts, have been transferred to Healthwatch Lancashire.
Healthwatch Lancashire is a very new organisation which is in the process of setting up its structures, including a new board, and is not in a position to undertake any major pieces of work in the immediate future. Therefore it has been decided that this year Healthwatch Lancashire will not provide a formal statement on health trust quality accounts. We will, of course, provide analysis and advice about the draft documents which we would expect to be given due consideration. We will soon be fully operational and will be able to provide a formal statement for inclusion in your quality accounts next year.

Annex 2:

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 Reports 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 2012/13;
- 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 2012 to 28 May 2013
    - Papers relating to Quality reported to the Board over the period April 2012 to 20 May 2013
    - Feedback from the commissioners dated 20 May 2013
    - Feedback from governors dated 20 May 2013
    - Feedback from LINks dated 20 May 2013
    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated between May 2012 and March 2013
    - The national patient survey March 2013
    - The national staff survey February 2013
    - The Head of Internal Audits annual opinion over the Trusts control environment dated May 2013
    - CQC quality and risk profiles dated 31 January 2013
- the Quality Report presents a balanced picture of the NHS Foundation Trusts 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 www.monitor-nhsft.gov/uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report.
- Complaints information has been taken from the Customer Care Module of the Trusts computerised risk management system

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

28 May 2013 .....Chairman

28 May 2013 .....Chief Executive