Lancashire Teaching Hospitals NHS Foundation Trust

Quality Account
2013-14

Excellent care with compassion
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The Estates Directorate has been awarded the government’s ‘Customer Service Excellence Standard Award’ for our hotel services.
Chief Executive’s Statement

This report provides an overview of the quality of services provided at Lancashire Teaching Hospitals NHS Foundation Trust for the period April 2013 to March 2014.

Our Safety and Quality Strategy - Safe, Reliable and Compassionate – has been revised during 2013-14 and sets out our ambitions and intention to deliver quality improvements in a transparent and measurable way. This strategy seeks to build on the important work undertaken in recent years and describes the means through which we will achieve our goals.

We recognise that we must continue to focus on those areas of improvement that remain fundamentally crucial to the delivery of safe, reliable and compassionate care.

We recognise that the healthcare landscape continues to evolve and that our strategy needs to be sensitive to and learn from the experiences of staff, patients and their families both here at Lancashire Teaching Hospitals and elsewhere.

I remain, as always, grateful for the continuing commitment and contribution of patients, staff, governors and members in supporting quality improvement activities at the trust, especially during these challenging times.

There were 4 cases of MRSA bacteraemia during 2013-14 against a nationally set target of zero. We remain committed to achieving zero MRSA bacteraemias in 2014-15. In doing so we will continue to focus on achieving and maintaining best practice around management of infusions, appropriate antimicrobial treatment, safe care of patients with urinary catheters and screening and treatment of patients with MRSA.

Although we did not achieve our objective for the reduction in Clostridium difficile infection during 2013-14, we continue to achieve year-on-year reductions. However, we recognise the need for sustained effort in ensuring that the rate continues to fall during 2014-15, and continue to find areas for improvement wherever we can.

Clostridium difficile performance, along with issues related to achievement of referral to treatment targets has triggered an investigation by Monitor. Whilst this process is not yet complete we have introduced a programme of measures that we are confident will lead to improvement.

The results of the 2013 national inpatient survey show some improvement when compared to 2012 results. The introduction of the friends and family test has provided some highly positive feedback with 93% of patients stating they would recommend the ward or emergency department to friends and relatives who needed similar treatment. Our net promoter scores for our emergency department are higher than the national median with inpatient scores on a par. It is also pleasing to note the improvements highlighted in this year’s staff survey, including the responses to the friends and family question.

For the second time, the quality of clinical coding data was recognised and our coding team received a nationally recognised award for data quality. In addition, our research and development team won the Clinical Innovation category at the North West Excellence in Supply Awards 2013, for the development of a new disposable female urinal.

The Estates Directorate has been awarded the government’s Customer Service Excellence Standard Award for our hotel services. The award is in recognition of the high standard of services the team provides across a range of our hotel services, including domestic services, catering, porters, transport, security, and linen services.

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The Adult Oxygen Assessment Team was awarded the title of team of the year at the North West Respiratory Awards. The team were assessed on how well their work delivered the QIPP agenda for Quality, Innovation, Productivity and Prevention.

Dr Martin Myers, Consultant Healthcare Scientist in Biochemistry and Clinical Director of Pathology Services was awarded an MBE for services to healthcare.

A national award for improving treatment for breast cancer patients was presented by NHS Improvement to our breast care specialist nurses for the implementation of a 23 hour breast service, which has reduced the length of hospital stay for breast cancer patients from five days to one day following surgery.

In addition to the teams and individuals mentioned here, I am proud to share within this account some excellent examples of the innovation, commitment and achievements of our staff who have demonstrated that they listen and respond to the needs of our patients and their families. That commitment is reflected in the engagement of staff year-on-year in our quality awards, where this year we saw 53 innovative quality improvement projects submitted by staff, a fantastic achievement.

In summary, I am pleased to present the 2013-14 Quality Accounts. The information provided represents an accurate account of progress and highlights achievements as well as areas that need to improve. More importantly it is an opportunity to reaffirm the trust commitment to improving the patient experience and outcomes of care as a priority for all staff.

I am confident that the information contained within this report is accurate. The trust’s internal auditors will review the processes and mechanisms through which data is extracted and reported in the Quality Account Report 2013-14 to provide further assurance.

Karen Partington
Chief Executive
Priorities for Improvement

Our Safety and Quality Strategy;
‘Safe, Reliable and Compassionate’ was developed in conjunction with staff, patients, the public and governors. This strategy set out a number of ambitious, measurable, patient-centred safety and quality improvement goals.

The key strategic goals to be achieved were:

- **15% reduction** in inpatient mortality
- **15% improvement** in patient safety
- **Year-on-year improvement** in the patient experience

This account provides details of performance in relation to these goals over the life of the strategy and specifically during 2013-14.

The Hospital Standardised Mortality Ratio reduced by a further 1.2% in 2012-13, culminating in a 18.2% improvement against the strategy baseline figure from 2008-9, with a further 2.6 point improvement during 2013-14 (subject to completion of the dataset and national rebasing).

During 2012-13, there was significant reduction in harm events associated with falls (37% reduction), medication administration errors (20% reduction) and hospital acquired pressure ulcers where incidence reduced by 57%. During 2013-14, the number of inpatient falls and harm associated with falls increased only slightly compared to 2012-13 performance and may be reflective of an increase in activity and patient risk, with 2012-13 (with 5.48 falls per 1000 bed days and 1.19 harm events per 1000 bed days). Further reductions have been demonstrated in respect of avoidable pressure ulcers (there were a total of 120 patients with hospital acquired pressure ulcers, compared to 125 during 2012-13) and medication administration errors (the trust reduced harm associated with medicine administration errors by 32%, with 17 recorded harm events against a trajectory of 24).

Although we failed to achieve its national objective of 41 during 2013/14, the 55 cases of Clostridium difficile represent a 15% reduction in rates compared to 2012-13. Performance in respect of MRSA bacteraemia is consistent with 2012-13 with a total of 4 cases. In addition, we maintained high levels of engagement and performance with all elements of the Safety Thermometer programme with a year-end performance level of 97.13% harm-free hospital care, comparing very favourably with the national performance rate. Comprehensive detail relating to all aspects of infection prevention and control is provided in the Infection Prevention and Control Annual Report which is published separately.

Within the previous strategy, the organisation of care focused primarily on access to services, efficient delivery of care and management of discharge process. We recognise that the consistent delivery of safe, reliable and compassionate care relies on more than process. Safe, reliable and compassionate describes the means by which we will develop and sustain the necessary culture to support delivery of the highest standards of care and treatment. This will be achieved through:

- Patient feedback generated through our Empowering Quality Improvement for Patients (EQIP) programme has demonstrated high levels of positive feedback across the majority of services, whilst patient surveys and cancer surveys have also shown areas of improvement.

The strategy has now been reviewed and revised during 2013-14, with the principles of safe, effective care and a positive experience remaining fundamentally central. However, the key indicators have evolved in response to changing local and national priorities and performance against these will be included in the 2014-15 Quality Accounts. These themes and indicators were again selected following a period of consultation and engagement with trust membership, clinical staff, the governing council, managers and commissioning colleagues, and will continue to define the focus of our quality priorities over the next three years.

Within the previous strategy, our Safety and Quality Strategy; ‘Safe, Reliable and Compassionate’ was developed in conjunction with staff, patients, the public and governors. This strategy set out a number of ambitious, measurable, patient-centred safety and quality improvement goals.
Safe, reliable and compassionate describes the means by which we will develop and sustain the necessary culture to support delivery of the highest standards of care and treatment.

The key strategic objectives for the revised strategy are as follows:

- Achievement of **98%** harm-free hospital care and sustained performance as it relates to:
  - Inpatient falls
  - Pressure ulcers
  - Venous thromboembolism, and
  - Catheter associated urinary tract infection

- A reduction in the trust inpatient mortality ratio of **15%** over the life of the strategy

- Achieving and sustaining **90%** positive patient feedback relating to the overall experience of care and treatment within the trust

Delivery of these objectives will be achieved by a programme of improvement activity developed and progress and performance monitored and reported via the three trust improvement groups established for this purpose. The groups will periodically report on performance and progression of the improvement programmes to our Safety and Quality Committee. Performance against the three strategic objectives will also be published in the monthly trust performance dashboard that is available to the public via the trust website.
Statements of Assurance from The Board

During 2013-14 the Lancashire Teaching Hospitals NHS Foundation Trust provided and/or sub-contracted 40 relevant health services.

Lancashire Teaching Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in all of these relevant health services.

The income generated by the relevant health services reviewed in 2013-14 represents 100 per cent of the total income generated from the provision of relevant health services by the Lancashire Teaching Hospitals NHS Foundation Trust for 2013-14.
Participation in Clinical Audits

During 2013-14 34 national clinical audits\(^1\) and 3 national confidential enquiries covered relevant health services that Lancashire Teaching Hospitals NHS Foundation Trust provides.

During 2013-14 Lancashire Teaching Hospitals NHS Foundation Trust participated in 97% 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 Lancashire Teaching Hospitals NHS Foundation Trust was eligible to participate in during 2013-14 are as follows:

### Clinical Audit

<table>
<thead>
<tr>
<th>National clinical audit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute coronary syndrome or Acute myocardial infarction (MINAP)</td>
</tr>
<tr>
<td>Adult community acquired pneumonia</td>
</tr>
<tr>
<td>Adult critical care (ICNARC)</td>
</tr>
<tr>
<td>Bowel cancer (NBOCAP)</td>
</tr>
<tr>
<td>Bronchiectasis</td>
</tr>
<tr>
<td>Chronic obstruction pulmonary disease</td>
</tr>
<tr>
<td>Diabetes (Adult) ND(A), includes national diabetes inpatient audit (NADIA)</td>
</tr>
<tr>
<td>Diabetes (Paediatric)</td>
</tr>
<tr>
<td>Elective surgery PROMS</td>
</tr>
<tr>
<td>Emergency use of oxygen</td>
</tr>
<tr>
<td>Epilepsy 12 (childhood epilepsy) Round 2</td>
</tr>
<tr>
<td>Falls and fragility fractures audit programme, includes national hip fracture database</td>
</tr>
<tr>
<td>Head and neck oncology (DAHNO)</td>
</tr>
<tr>
<td>Heart failure</td>
</tr>
<tr>
<td>Inflammatory bowel disease</td>
</tr>
<tr>
<td>Lung cancer (NLCA)</td>
</tr>
<tr>
<td>Moderate or severe asthma in children (care provided in emergency departments)</td>
</tr>
<tr>
<td>National audit of dementia audit</td>
</tr>
<tr>
<td>National audit of seizure management (NASH)</td>
</tr>
<tr>
<td>National cardiac arrest audit (NCCA)</td>
</tr>
<tr>
<td>National comparative audit of blood transfusion</td>
</tr>
<tr>
<td>National emergency laparotomy audit (NELA)</td>
</tr>
<tr>
<td>National joint registry (NJR)</td>
</tr>
<tr>
<td>National vascular registry, including CIA and elements of NVD (NVR)</td>
</tr>
<tr>
<td>Neonatal intensive and special care (NNAP)</td>
</tr>
<tr>
<td>Non-invasive ventilation - adults</td>
</tr>
<tr>
<td>Oesophago-gastric cancer (NAOGC)</td>
</tr>
</tbody>
</table>
List of national clinical audits as per specification provided by the DH cited on the HQIP website (http://www.hqip.org.uk/national-clinical-audits-for-inclusion-in-quality-accounts-2013-2014)

### National clinical audit

<table>
<thead>
<tr>
<th>Medical and surgical programme: National Confidential Enquiry into Patient Outcome and Death NCEPOD:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tracheostomy care study</td>
</tr>
<tr>
<td>Lower limb amputation study</td>
</tr>
<tr>
<td>Gastrointestinal haemorrhage study</td>
</tr>
</tbody>
</table>

### National Confidential Enquiries

<table>
<thead>
<tr>
<th>Clinical outcome review programmes/National confidential enquiries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child health programme CHR-UK</td>
</tr>
<tr>
<td>Maternal, infant and new-born clinical outcome review programme MBRRACE-UK</td>
</tr>
</tbody>
</table>

1 List of national clinical audits as per specification provided by the DH cited on the HQIP website (http://www.hqip.org.uk/national-clinical-audits-for-inclusion-in-quality-accounts-2013-2014)
The national clinical audits and national confidential enquiries that Lancashire Teaching Hospitals NHS Foundation Trust participated in during 2013-14 are as follows:

### Clinical Audit

<table>
<thead>
<tr>
<th>National clinical audit</th>
<th>Trust participation?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute coronary syndrome or Acute myocardial infarction (MINAP)</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult community acquired pneumonia</td>
<td>Yes - study not collecting data</td>
</tr>
<tr>
<td>Adult critical care (ICNARC)</td>
<td>Yes</td>
</tr>
<tr>
<td>Bowel cancer (NBOCAP)</td>
<td>Yes</td>
</tr>
<tr>
<td>Bronchiectasis</td>
<td>Yes - study not collecting data</td>
</tr>
<tr>
<td>Chronic obstruction pulmonary disease</td>
<td>Yes</td>
</tr>
<tr>
<td>Diabetes (Adult) ND(A), includes national diabetes inpatient audit (NADIA)</td>
<td>No to ND(A)</td>
</tr>
<tr>
<td>Diabetes (Paediatric)</td>
<td>Yes</td>
</tr>
<tr>
<td>Elective surgery PROMS</td>
<td>Yes</td>
</tr>
<tr>
<td>Emergency use of oxygen</td>
<td>Yes</td>
</tr>
<tr>
<td>Epilepsy 12 (childhood epilepsy) Round 2</td>
<td>Yes</td>
</tr>
<tr>
<td>Falls and fragility fractures audit programme, includes national hip fracture database</td>
<td>Yes</td>
</tr>
<tr>
<td>Head and neck oncology (DAHNO)</td>
<td>Yes</td>
</tr>
<tr>
<td>Heart failure</td>
<td>Yes</td>
</tr>
<tr>
<td>Inflammatory bowel disease</td>
<td>Yes</td>
</tr>
<tr>
<td>Lung cancer (NLCA)</td>
<td>Yes</td>
</tr>
<tr>
<td>Moderate or severe asthma in children (care provided in emergency departments)</td>
<td>Yes</td>
</tr>
<tr>
<td>National audit of dementia audit</td>
<td>Yes - study not collecting data</td>
</tr>
<tr>
<td>National audit of seizure management (NASH)</td>
<td>Yes</td>
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<td>National cardiac arrest audit (NCRA)</td>
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<td>Yes</td>
</tr>
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<td>National vascular registry, including CIA and elements of NVR (NVR)</td>
<td>Yes</td>
</tr>
<tr>
<td>Neonatal intensive and special care (NNAP)</td>
<td>Yes</td>
</tr>
<tr>
<td>Non-invasive ventilation – adults</td>
<td>Yes</td>
</tr>
<tr>
<td>Oesophago-gastric cancer (NAOGC)</td>
<td>Yes</td>
</tr>
<tr>
<td>Paediatric asthma</td>
<td>Yes</td>
</tr>
<tr>
<td>Paracetamol overdose (care provided in emergency departments)</td>
<td>Yes</td>
</tr>
<tr>
<td>Prostate cancer</td>
<td>Yes - study not collecting data</td>
</tr>
<tr>
<td>Renal replacement therapy (Renal Registry)</td>
<td>Yes</td>
</tr>
<tr>
<td>Stroke national audit programme (combined Sentinel and SINAP)</td>
<td>Yes</td>
</tr>
<tr>
<td>Severe sepsis &amp; septic shock</td>
<td>Yes</td>
</tr>
<tr>
<td>Trauma (TARN)</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Note:** please see Glossary for an explanation of the abbreviations.
National Confidential Enquiries

<table>
<thead>
<tr>
<th>Clinical outcome review programmes/National confidential enquiries</th>
<th>Trust participation?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child health programme CHR-UK</td>
<td>Yes but no patient identified who comply with inclusion criteria</td>
</tr>
<tr>
<td>Maternal, infant and new born clinical outcome review programme MBRRACE-UK</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical and surgical programme: National Confidential Enquiry into Patient Outcome and Death NCEPOD:</td>
<td></td>
</tr>
<tr>
<td>- Tracheostomy care study</td>
<td>Yes</td>
</tr>
<tr>
<td>- Lower limb amputation study</td>
<td>Yes</td>
</tr>
<tr>
<td>- Gasterointestinal haemorrhage study</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The national clinical audits and national confidential enquiries that Lancashire Teaching Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2013/14, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

<table>
<thead>
<tr>
<th>Title</th>
<th>Clinical cases required</th>
<th>Actual number submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute coronary syndrome or Acute myocardial infarction</td>
<td>Rolling – no sample size specified</td>
<td>RPH - 134 submissions to date CDH - 76 submissions to date</td>
</tr>
<tr>
<td>Bowel cancer</td>
<td>Rolling – no sample size specified</td>
<td>236 submissions to 2013 annual report (published July 2013)</td>
</tr>
<tr>
<td>COPD</td>
<td>COPD admissions between 1st February and 30th April 2014. Deadline for submission – 31st May 2014</td>
<td>Data collection in progress</td>
</tr>
<tr>
<td>National Diabetes Inpatient Audit (NaDIA)</td>
<td>Inpatient diabetes patients between 16th - 20th Sept 2013</td>
<td>CDH - 37 patients RPH - 92 patients</td>
</tr>
<tr>
<td>Diabetes (Paediatric)</td>
<td>All applicable cases</td>
<td>188</td>
</tr>
<tr>
<td>National Elective Surgery (PROMS)</td>
<td>No set number of questionnaires for completion, as patients met criteria</td>
<td>April - Sept 2013 latest quarterly publications (Feb 2014) 48</td>
</tr>
<tr>
<td>Emergency use of oxygen</td>
<td>Min of 1 ward</td>
<td>Submitted data from 10 wards – 100%</td>
</tr>
<tr>
<td>Epilepsy 12 (childhood epilepsy) Round 2</td>
<td>No set number</td>
<td>10 (up to October 2013)</td>
</tr>
<tr>
<td>Hip fracture database</td>
<td>Rolling - no set number, as met criteria</td>
<td>399 submitted to 6th March 2014</td>
</tr>
<tr>
<td>Head and neck oncology</td>
<td>Rolling – no sample size specified</td>
<td>128 submitted to 8th annual report (published July 2013)</td>
</tr>
<tr>
<td>Heart failure</td>
<td>Rolling - at least 20 cases per month</td>
<td>RPH - 453 patients (189%) CDH - 243 patients (101%)</td>
</tr>
<tr>
<td>Inflammatory bowel disease</td>
<td>Admissions between 1st January and 31st December 2013</td>
<td>Submitted 45 admissions (67%)</td>
</tr>
<tr>
<td>Lung cancer</td>
<td>Rolling – no sample size specified</td>
<td>244 submitted to annual report published December 2013</td>
</tr>
<tr>
<td>Moderate or severe asthma in children (care provided in emergency departments)</td>
<td>50 cases between 1st August 2013 and 31st March 2014</td>
<td>Working towards submitting 50 cases by 31st March 2014 – not enough cases yet</td>
</tr>
<tr>
<td>National audit of seizure management (NASH)</td>
<td>30 admissions</td>
<td>30 (100%)</td>
</tr>
<tr>
<td>Title</td>
<td>Clinical cases required</td>
<td>Actual number submitted</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>-------------------------------------------------------------</td>
<td>-------------------------------------------------------------</td>
</tr>
<tr>
<td>Cardiac arrest</td>
<td>No set number, as met criteria</td>
<td>RPH - 79</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CDH - 36</td>
</tr>
<tr>
<td>National emergency laparotomy audit (NELA)</td>
<td>No set number, as met criteria</td>
<td>55</td>
</tr>
<tr>
<td>National joint registry (NJR)</td>
<td>768 relevant procedures undertaken</td>
<td>671 forms submitted (87.4%)</td>
</tr>
<tr>
<td>National vascular registry, including CIA and elements of NVD (NVR)</td>
<td>No set number, as met criteria</td>
<td>The 2 latest reports we published were on carotid endarterectomy in October 2013 and on abdominal aortic aneurysm (AAA) in November 2013. Submissions as follows: 50/52 (96%) of carotid cases. 152/157 (97%) of elective infra-renal AAA</td>
</tr>
<tr>
<td>Neonatal intensive and special care (NNAP)</td>
<td>All babies during the period audited</td>
<td>534 (100%)</td>
</tr>
<tr>
<td>Non-invasive ventilation</td>
<td>Minimum of 1</td>
<td>17 (1700%)</td>
</tr>
<tr>
<td>Oesophago-gastric cancer</td>
<td>Ongoing</td>
<td>52 submitted to 2013 report</td>
</tr>
<tr>
<td>Paediatric asthma</td>
<td>3</td>
<td>8 (267%)</td>
</tr>
<tr>
<td>Paracetamol overdose (care provided in emergency departments)</td>
<td>50 cases between 1st August 2013 and 31st March 2014</td>
<td>50 cases collected – will be submitted by 31st March (100%)</td>
</tr>
<tr>
<td>Renal registry</td>
<td>Rolling</td>
<td>October 2012 – October 2013 – 752 patients (100% of new patients)</td>
</tr>
<tr>
<td>Stroke national audit programme (combined Sentinel and SINAP)</td>
<td>All stroke admissions</td>
<td>678 cases up to 10th March 2014</td>
</tr>
<tr>
<td>Severe sepsis and septic shock</td>
<td>50 cases between 1st August 2013 and 31st March 2014</td>
<td>50 cases collected – will be submitted by 31st March (100%)</td>
</tr>
<tr>
<td>Trauma</td>
<td>Rolling</td>
<td>TARN (RPH only)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total No of submitted cases through 2013 – 770 (117%)</td>
</tr>
</tbody>
</table>
The reports of all national clinical audits were reviewed by the provider in 2013-14 and Lancashire Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

<table>
<thead>
<tr>
<th>Title of audit</th>
<th>Intended actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit of National Neonatal Audit Programme (Child Health)</td>
<td>• The data collection method will be reviewed.</td>
</tr>
<tr>
<td></td>
<td>• Ongoing extended staff training to be provided to band 5, 6 &amp; 7 nurses and tier 1, 2 &amp; 3 doctors.</td>
</tr>
<tr>
<td></td>
<td>• Regular scrutiny of data by domain lead, neonatal lead, matron and administration staff.</td>
</tr>
<tr>
<td></td>
<td>• Real time data insertion on Retinopathy of prematurity by ophthalmologist.</td>
</tr>
<tr>
<td></td>
<td>• More nursing staff have been added to the team and a business plan has been developed to add dedicated psychological support (0.6 WTE) to the team.</td>
</tr>
<tr>
<td></td>
<td>• The duration of clinic appointment time has been increased from 15 minutes to 30 minutes per patient.</td>
</tr>
<tr>
<td></td>
<td>• Annual 1:1 dietician review is available for all patients to provide information regarding carbohydrate counting.</td>
</tr>
<tr>
<td></td>
<td>• Improved patient information through pump awareness evening held in January 2014 and new letters sent to all patients.</td>
</tr>
<tr>
<td>National Paediatric Diabetes Patient &amp; Parent Reported Experience Measures (PREM) (2012-13 – Child Health)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The Emergency Department (ED) has set up a first fit service for patients who present to the ED having had a first fit. Suitable patients are referred directly from the ED for an outpatient appointment with the Neurology Team. Patients are then discharged from the ED with advice regarding their condition and sent an appointment to the specialist clinic within 2 weeks of the referral being made.</td>
</tr>
<tr>
<td>Trauma</td>
<td>• The trust has consistently been above the national average for the quality of data input to TARN and this is due to a vast improvement in the documentation of trauma cases and the introduction of a dedicated data manager working closely with consultants.</td>
</tr>
<tr>
<td></td>
<td>• All deaths with a percentage survival chance of over 75% are reviewed in the trauma clinical reference group alongside all the acute specialty leads that are involved in trauma. As well as numerous learning points and changes in practice, this has provided insight into the points at which the department interacts with others, and how this can be done seamlessly in the future.</td>
</tr>
</tbody>
</table>
# NCEPOD Studies

<table>
<thead>
<tr>
<th>Study title</th>
<th>Study period</th>
<th>Report publication date</th>
<th>Feedback action to date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subarachnoid Haemorrhage</td>
<td>A review of the care of adult (&gt;16 years old) patients who were admitted to hospital with a diagnosis of subarachnoid haemorrhage during the period 30th June 2011 and 30th September 2011</td>
<td>Autumn 2013</td>
<td>Currently benchmarking services against the report recommendations.</td>
</tr>
</tbody>
</table>
| Alcohol Related Liver Disease      | Patients will be selected from all included cases if the patient died during 1st January and the 30th June 2011 | Spring 2013             | The trust is compliant with a number of the recommendations following the establishment of the Hospital Alcohol Liaison Service (HALS). A baseline assessment concluded that:  
  • There had been significant improvement in specialist input for alcohol addiction after the introduction of Hospital Alcohol Liaison Service.  
  • 100% of patients who required thiamine prescribing received it correctly.  
  However, the assessment also identified that:  
  • 41% of patients with decompensated liver disease were not seen by gastroenterologist within 24 hours.  
  • 19% of patients with ongoing alcohol intake had a nutrition review within 24 hours.  
  • 58% of patients with ongoing alcohol intake had no nutrition review at all.  
  In response to the poor performance relating to nutrition, members of the Hospital Alcohol Liaison team have joined the trust Integrated Nutrition and Communication Service and are working closely with the nutrition nurses and dieticians to improve performance. |
| Tracheostomy Care Study            | All patients who undergo the insertion of a new tracheostomy or a laryngectomy between the 25th February – 24th June 2013 will be included in the study | Spring 2014             | National report not yet published.                                                     |
The reports of over 300 local clinical audits were reviewed by the provider in 2013/14 and Lancashire Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

<table>
<thead>
<tr>
<th>Title of audit</th>
<th>Resulting actions</th>
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</table>
| Re-audit of Identification of patients lost to follow up (Orthopaedics) | • More uniform system across the orthopaedic wards, with elimination of non-approved forms.  
  • Staff to clearly indicate whether patient needs follow up on IHDS even if it is on the operation note.  
  **Action:** *Increase awareness at induction.*  
  • Staff information about follow up for common operations at induction.  
  **Action:** *Increase awareness at induction, hand-out or email.* |
| Re-audit of Consent for Plastic Procedures (Plastics) | • Improved confirmation of consent when a period of time has passed since initial consent.  
  **Action:** If more than 48 hours has passed since the initial consent – it should be reconfirmed on the day of surgery by medic prior to surgery. |
| Frozen Sections (Pathology)                         | • Ensure histopathology consultants at LTHTR are aware of the importance of recording time and person when giving a verbal frozen section report.  
  • Develop a more detailed frozen section request form to ensure not only that the histopathologist has sufficient clinical information for reporting a frozen section, but also to provide a record of when and to whom the report is given, and to aid future audits.  
  • Include in the above form a section to be completed if there are difficulties in preparing a frozen section or artefact which affected accuracy of report given, for example in the first false negative where the specimen was fatty and difficult to cut. This could help identify the cause of false negative rates and where improvements can be made.  
  • Continue to ensure no high risk specimens are sent for frozen section.  
  • Educate surgeons regarding the optimum size of specimens. |
| Breech ECV (Women’s Health)                         | • Portable ultra sound scans introduced in antenatal unit to reduce percentage of undiagnosed breech.                                                                                                        |
| Re-audit of operative vaginal delivery (OVD) (Women’s Health) | • Expected standard of documentation of OVD included in the departmental induction programme.  
  • Birth case notes amended to include documentation of bladder care and verbal/written consent for OVD. |
| Perineal wound infection (Women’s Health)           | • Audit findings and recommendations included in red day for practice (training day).  
  • Infection prevention and control discussed with new doctors on induction day.  
  • New suture packs introduced on the delivery suite to minimise infection. |
| Botox audit (Child Health)                          | • Tone management assessment forms reviewed with regards to Gross Motor Function Classification System (GMFCS) level and contraindication for Botox toxin.  
  • Botox toxin admission/check list designed.  
  • More involvement of occupational therapist in pre-assessment. |
<table>
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<tr>
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</table>
| Audit of Rapid Assessment Unit (RAU) Referral Paperwork (Medicine) | • The referral form is to be amended to include details required by the Royal College approved “generic record keeping standards” – clinician, grade and consultant on call.  
• The findings are to be presented at the medicine audit meeting in May.  
• A simple teaching package is to be designed for junior doctors to re-enforce the importance of good record keeping.  
• Re-audit following presentation at the audit meeting. |
| Audit of Clostridium difficile prophylaxis using probiotics (Medicine) | • Following an initial audit, a poster was designed and displayed on medical wards to remind junior doctors to prescribe Actimel when patients were prescribed antibiotics.  
• Re-audit showed the prescribing of Actimel had increased slightly and there was more use of the pre-printed prescribing stickers in the prescription chart. |
| Confirmation of NG tube position: staff awareness (Medicine) | • E-learning programme for all doctors in/entering the trust to provide education and assess competence will be developed in conjunction with Consultant Interventional Radiologist.  
• The Nutritional Nurse Consultant is liaising with the undergraduate team to establish an ‘NG day’ for theoretical and practical learning for medical students. |
| Patient satisfaction with the vocal cord dysfunction (VCD) clinic (Medicine) | • A more formal VCD patient information leaflet is to be produced. This will explain each of the MDT member’s roles in the patient’s treatment. |
| Audit of Early Neonatal sepsis (Child Health) | • Local guidelines amended to reflect NICE guidelines with regards to Benzyl Penicillin and Gentamycin doses.  
• Availability of blood culture results within 36 hours through Telepath system. |
| Re-Audit of investigation of hypoglycaemia in children over 1 week age (Child Health) | • Local protocol amended. Amendments made in 1. Changes to BM threshold (<2.6).  
2. Urine reducing substances removed from the protocol. |
| Audit of Neonatal jaundice (Child Health & Women’s Health) | • Agreed model of referral pathway for babies who need serum bilirubin from the community to ward 8 implemented.  
• Re-audit planned to evaluate implementation of referral pathway. |
| Functional Visual Loss (Ophthalmology) | • A new care pathway has been developed and implemented.  
• Liaison with the child psychology department to organise training for imparting the news of a child’s FVL and of the best way to reassure children and parents.  
• Questionnaires have been developed; a questionnaire for patients to complete prior to being seen and a patient satisfaction questionnaire to be completed post discharge. |
| Occupational Therapy goal setting in acute stroke rehabilitation (Occupational Therapy) | • Training and further experiential practice with the team re setting SMART goals.  
**Action:** Complete training session.  
• Ensure that long term goals are considered and forwarded to the community therapy teams on discharge.  
**Action:** Highlight to the whole team to document goals on the goal setting proforma.  
• Adapting style of goal setting as the integrated therapy team joint with physiotherapy becomes more established following our service restructure.  
**Action:** Trialling new goal setting form jointly with physiotherapy.  
• Re-audit specifically to review that SMART goals are being set consistently. |
<table>
<thead>
<tr>
<th>Title of audit</th>
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| Point prevalence audit of completion of allergy status on in-patient prescription charts (Surgery) | • Information to be disseminated via notices on the wards, intranet bulletin, screensaver info and email, reminding everyone involved in the prescription and administration of medications that the allergy status section is mandatory.  
• Induction and refresher training for every healthcare staff member/student, not only prescribers, on the importance of correct and complete documentation, not only regarding the allergy status but throughout the prescription chart. |
| Audit of Renal Transplantation in the Elderly (Renal)                        | • A group of elderly patients experienced positive outcomes following renal transplantation - this is keeping with renal registry outcomes for transplantation and similar smaller trials from the UK.  
• In the renal department another project has been already completed to look at whether all the patients appropriate for renal transplantation had been referred and listed for transplantation in a timely fashion. |
| Audit of CT Head & Cervical Spine following NICE Guidance (Imaging)          | • Plan for Emergency Department CT installation 2013-2014.                                                                                           |
|                                                                                | • Onsite radiographers for Preston.                                                                                                                  |
|                                                                                | • Re-audit 2015.                                                                                                                                  |
| Adequacy of Orbit X-rays performed to detect metallic intraocular foreign bodies pre-MR scan (Imaging) | • Re-write local guidelines.                                                                                                                        |
|                                                                                | • Increase education for awareness.                                                                                                                  |
|                                                                                | • Do not repeat exposure unless true intraocular foreign bodies (IOFB) detected.                                                                 |
|                                                                                | • Method for formal reporting to be discussed.                                                                                                |
|                                                                                | • Plan to re-audit in 12 months.                                                                                                                     |
| Audit of lens exclusion in Computerized Tomography (CT) examinations of brain (Imaging) | • Develop a protocol for CT brain examinations to exclude the eye lens.                                                                          |
|                                                                                | • Identify exclusions to this protocol (e.g. examination for diplopia, exophthalmos, orbital fractures or orbital infections).               |
|                                                                                | • Re-audit after implementing changes.                                                                                                               |
| PEG Removal Times in Head and Neck Cancer Patients (Speech and Language Therapy) | • Develop a Nutritional policy to inform practice on PEG placement and removal.                                                                  |
|                                                                                | • Collect quality of life (QOL) data to support changes in practice.                                                                                |
|                                                                                | • All head and neck cancer patients treated at LTHTR to be referred to pre and post treatment clinics.                                           |
| Use of Adjuvant Herceptin in HER2-Positive Breast Cancer Patients (Oncology)   | • Development of guidelines for management of falls in EF whilst on Herceptin.                                                                    |
|                                                                                | • Raise awareness of potential issues with patients with EF <55% at the start of Herceptin treatment.                                             |
|                                                                                | • Compare results to ongoing audits at other hospitals within the network.                                                                      |
|                                                                                | • Continue to encourage clear documentation about why Herceptin/chemotherapy is not offered to some patients.                                   |
|                                                                                | • Reaudit with specific attention to cardiac scanning and complications following development of local guidance for monitoring and management. |

Note: please see Glossary for an explanation of the abbreviations.
Research

Participation in clinical research.
The number of patients receiving relevant health services provided or sub-contracted by Lancashire Teaching Hospitals NHS Foundation Trust in April - March 2013-14 that were recruited during that period to participate in research approved by a research ethics committee was 2016.

Recruitment
We recruited 1554 patients to NIHR portfolio adopted studies in 2013-14. We granted NHS Permission for 57 new portfolio studies to commence during that time and had a median time to issue NHS Permission of 8 days against a national benchmark of 30 days. We recruited a further 472 to non-portfolio studies. In total there are currently 212 active research studies recruiting patients in our hospitals.

Research governance
We completed our first year of the new monitoring and audit programme for research. The programme has completed 10 planned audits across 5 specialties with no triggered audits. Themes of good practice and areas for improvement have been identified and are in the process of being developed into training packages for research staff.

New developments in 2013-14
The Innovation Pathway designed in the previous year has completed its first year in pilot form. The success of the pilot has resulted in 2 national awards and the team are now working directly with NICE to refine the pathway ready for a formal launch in 2014.

“The success of the pilot has resulted in 2 national awards”
A proportion of Lancashire Teaching Hospitals NHS Foundation Trust's income in 2013-14 was conditional upon achieving quality improvement and innovation goals agreed between Lancashire Teaching Hospitals NHS Foundation Trust and Greater Preston and Chorley and South Ribble CCG’s and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2013-14 and for the following 12 month period

Further details of the agreed goals for 2013/14 and for the following 12 month period are available online at: http://www.england.nhs.uk/wp-content/uploads/2013/02/cquin-guidance.pdf

The CQUIN goals are divided into three categories:

- National goals that are mandated as part of the National Standard Acute Contract for Hospital Services of which there are two.
- Specialist Commissioner Goals set out by NHS England that are consistent across all acute providers.
- Local Indicators that are subject to agreement and discussion between commissioners and providers.

We received income from the achievement of CQUIN of £8.4 million in 2013-14 conditional upon achieving quality improvement and innovation goals, and a monetary total for the associated payment in 2012-13 of £8.4 million.

Examples of improvements achieved through the CQUIN programme include:

- Establishment of GP direct access diagnostic services for specific pathways.
- Reduction in Out-Patient DNA Rates and Out-Patient short notice cancelled clinics.
- Reductions in waits for dispensing medicines in outpatients.
- Improved standards for timeliness of discharge communications to GPs supported by electronic mailing systems.
- High standards of dementia screening, risk assessment and referral.
- Achievement of VTE risk assessment performance objectives.
- Implementation of the Friends and Family Test across admitted care, A&E and maternity services.
- Royal College of Psychiatrists Quality Mark accreditation for Elderly Friendly Wards within the trust.
- Development of service quality dashboards for specific specialist services such as neonatal intensive care and radiotherapy services.

An audit of length of stay for inpatients on antibiotics demonstrated that there were a significant number of patients in hospital who were there only because they needed intravenous antibiotics.

Microbiologists now attend wards daily to visit these patients to try and reduce their length of stay by suggesting oral antibiotic switches or outpatient parenteral antimicrobial therapy (OPAT).

The OPAT patients visit hospital once a day for the intravenous antibiotics, which has had extremely favourable feedback. Over a 2 year period, 271 patients were treated as part of the OPAT service.
Registration with the Care Quality Commission

Lancashire Teaching Hospitals NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is that the Care Quality Commission has registered and licensed Lancashire Teaching Hospitals NHS Foundation Trust to provide the following services:

- Diagnostic and/or screening services
- Maternity and midwifery services
- Surgical procedures
- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Termination of pregnancies
- Treatment of disease, disorder or injury
- Management of supply of blood and blood derived products

There are no conditions to this registration.

The Care Quality Commission has not taken enforcement action against Lancashire Teaching Hospitals NHS Foundation Trust during 2013-14.

Falls Prevention

Our Falls and Fracture Prevention Service work in close collaboration with health, social and voluntary care stakeholders to improve the falls patient journey.

They have made key developments and contribution towards the safe care of patients at risk of falls including:

- The development of specialist falls clinics at Lancashire Teaching Hospitals
- The introduction of a falls user carer forum
- A Central Lancashire Falls pathway

These developments are underpinned by a unique vision for falls prevention in Central Lancashire aligned to the various national policies and strategies.
Quality of Data

It is generally accepted that good quality data is at the heart of identifying the need to improve. It also provides the evidence that there has been improvement in the quality of care delivered by the trust as a result of changes that it has made.

Lancashire Teaching Hospitals NHS Foundation Trust submitted records during 2013-14 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:

- 99.6% for admitted patient care
- 99.7% for outpatient care
- 97.8% for accident and emergency care

The percentage of records in the published data, which included the patient’s valid General Medical Practice code, was:

- 97.6% for admitted patient care
- 99.1% for outpatient care
- 98.1% for accident and emergency care

Our Information Governance (IG) Assessment Report overall score for 2013-14 was 78% and was graded green. This demonstrates achievement of the minimum level two compliance in 29 out of 45 requirements and achievement of level three compliance in a further 15, with one requirement not relevant to the trust. Internal auditors reported ‘significant’ assurance for the trust. They confirmed the trust has a strong organisational structure with associated processes for identifying, improving and embedding Information Governance issues and improvements.

Lancashire Teaching Hospitals NHS Foundation Trust will be taking the following actions to improve data quality:

- Continuation of the rolling audit programme to raise awareness of good data management and quality assurance, with targeted improvements within specific areas.
- Continuation of Data Quality Assurance workshops aimed at all staff groups (included within the Nursing Interns and Junior Doctors induction programmes).
- Close working with departments/directorates and IT training to ensure that improvements to data quality and underlying processes are fully supported and sustained.
- Enhanced working with clinical governance team to support the consistent data collection processes in place across clinical areas of the organisation.

During 2013/14 we sustained the high level of performance achieved in 2012/13 in relation to a number of audits completed by Mersey Internal Audit Agency regarding quality assurance of specific board reporting areas. We worked with external partners to complete audits of the quality of data relating to mortality and co-morbidity.

Lancashire Teaching Hospitals NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2013-14 by the Audit Commission. In the absence of a Payment by Results clinical coding audit commissioned by the Audit Commission, Lancashire Teaching Hospitals NHS Foundation Trust commissioned an internal Payment by Results audit and the error rates reported in the latest audit for the period for diagnoses and treatment coding (clinical coding) were as follows:

- Primary diagnosis - 5%
- Secondary diagnosis - 9%
- Primary procedure - 5%
- Secondary procedure - 10%

The audit was based on a random selection of records from the general surgery, neurosurgery, cardiology and child health specialties. Improvement actions have been identified in respect of quality of case notes, staff training and accreditation, and staffing levels.

Note: These results should not be extrapolated further than the actual sample audited in the identified specialties.
Review of Quality Performance

Our safety and quality strategy;
Safe, reliable and compassionate was developed in conjunction with staff, patients the public, and governors. This strategy set out a number of ambitious, measurable, patient-centred safety and quality improvement goals.

The improvement focus that described the cornerstones of the our Safety and Quality strategy during 2013-14 are as defined below but, in respect of safe care, have evolved during the life of the strategy to focus on reduction of avoidable harm and classification of levels of harm associated with adverse incidents:

**Safe care**
As defined and measured by a reduction in harm associated with patient falls, medication error and healthcare associated infections. In addition to this, the reliability of care processes will also be monitored in relation to the early recognition of the sick patient and peri-operative care.

**Effective care**
As defined by delivery of optimised patient care processes and outcomes of care in relation to stroke care, end of life care, dementia care and those identified through the Advancing Quality programme. In addition, there is focus on nutritional care, pain management, prevention of venous thromboembolism and tissue viability care and elements of care that impact on the wider patient population.

**Experience of care**
As defined by patients and the public in relation to privacy and dignity, compassion and respect, information giving and involvement in decisions about care and treatment.

The key strategic goals to be achieved during the life of the strategy were:

- **15% improvement in patient safety**
- **15% reduction in mortality**
- **Year-on-year improvement in the patient experience**

Over the life of the previous safety and quality strategy, up to 2012-13, there was significant reduction in harm events associated with falls (37% reduction), medication administration errors (20% reduction). Incidence of hospital acquired pressure ulcers reduced by 57% but this may have been due to some extent to actions taken to strengthen the depth and accuracy of reporting. During 2013-14 further reductions have been demonstrated in respect of pressure ulcers and medication administration errors as detailed in the safe care section of the report.

Although we failed to achieve our national objective of 41 during 2013-14, the 55 cases of Clostridium difficile represent a 15% reduction in rates compared to 2012-13. Harm associated with medication administration errors and hospital acquired pressure ulcers also showed improvement. Despite the introduction of a range of improvement measures including enhanced risk assessment and supervision, environmental improvements and use of monitoring devices, harm associated with inpatient falls has increased slightly, although this may be reflective of a change in case mix. Performance in respect of MRSA bacteraemia is consistent with 2012-13 with a total of 4 cases. In addition, we maintained high levels of engagement and performance with all elements of the Safety Thermometer programme with a year-end performance level of 97.13% harm-free hospital care, comparing very favourably with the national performance rate. Comprehensive detail relating to all aspects of infection prevention and control is provided in the IPC annual report which is published separately.

During 2013-14 we reported 2 never events both were in relation to surgical procedures; a detailed action plan and improvement programme is in place and progress is monitored via the Safety & Quality Sub Committee. We place importance on openness and transparency when reporting incidents and never events; analysis of the never events reported does not show any patterns regarding causation factors.
Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. They can lead to serious adverse outcomes, and can damage patients’ confidence and trust.

They include incidents such as:

- Wrong site surgery
- Retained instrument post operation
- Wrong route administration of chemotherapy

Incidents are considered to be never events if:

- There is evidence that the never event has occurred in the past and is a known source of risk (for example, through reports to the National Reporting and Learning System or other serious incident reporting system).

- There is existing national guidance or safety recommendations, which if followed, would have prevented this type of never event from occurring (for example, for “Retained foreign object post procedure” the referenced national guidance is related to the peri-operative counting and checking processes that would be expected to occur at the time of the procedure, including suturing after a vaginal birth).

- Occurrence of the never event can be easily identified, defined and measured on an ongoing basis.

The Hospital Standardised Mortality Ratio reduced by a further 1.2% in 2012/13, culminating in a 18.2% improvement against the strategy baseline figure from 2008-9, with a further 2.6 point improvement during 2013-14 (subject to completion of the dataset and national rebasing).

Patient feedback generated through the trust Empowering Quality Improvement for Patients (EQIP) programme has demonstrated high levels of positive feedback across the majority of services, whilst patient surveys and cancer surveys have also shown areas of improvement.

Consistent with our commitment to improve the quality of reporting and information, we continue to refine incident reporting policies, processes and systems to ensure systems remain fit for purpose and that the timeliness and completeness of validated data accurately and objectively informs accurate reporting and the identification of meaning improvement actions.

Clinical effectiveness has been strengthened through embedding of systems and processes to support implementation of the growing library of NICE quality standards, and the trusts responses to them. In addition there has been further strengthening of trust and divisional governance arrangements in respect of clinical audit, ensuring that the balance between national, corporate and local priorities is maintained, that audit cycles are completed and that focus is maintained on the improvement of clinical outcomes.

Clinical Governance arrangements have been subject to significant review and improvement throughout 2013-14. A board level Safety and Quality Subcommittee has been introduced whose primary functions are to:

- Promote and lead a safety and quality culture in which staff are supported and empowered to improve services and care;

- Lead and co-ordinate the development and delivery of our Safety and Quality strategy, and;

- Provide the Board of Directors with assurance that patient safety, patient experience and outcomes of care are optimised.

Three improvement groups, who lead and coordinate quality improvement programmes associated with safe, effective care and patient experience, serve the subcommittee.
Patient feedback generated through the trust Empowering Quality Improvement for Patients (EQIP) programme has demonstrated high levels of positive feedback across the majority of services
Safe Care

**MRSA bacteraemia**

Staphylococcus aureus is a bacterium that commonly colonises human skin and mucosa. Most strains of S. aureus are sensitive to the more commonly used antibiotics, and infections can be effectively treated. Some S. aureus bacteria are more resistant. Those resistant to the antibiotic meticillin are termed meticillin-resistant Staphylococcus aureus (MRSA). Bacteraemia occurs when bacteria get into the bloodstream.

Infection prevention and control remains a key priority and the focus on MRSA bacteraemia (and Clostridium difficile infection) has been maintained throughout the life of the safety and quality strategy and has been reported in previous Quality Accounts. During 2013-14, our performance for MRSA bacteraemia was 4 against a national objective of 0. The focus for preventing further avoidable MRSA bacteraemia cases remains on best practice around peripheral and central line management, antimicrobial stewardship, urinary catheter care, MRSA screening and decolonisation. We remain committed to a zero tolerance on avoidable cases.
**Clostridium difficile Infection**

Clostridium difficile infection is the most important cause of hospital-acquired diarrhoea. Clostridium difficile is an anaerobic bacterium that is present in the gut of up to 3% of healthy adults and 66% of infants.

As stated above, infection prevention and control remains a key priority and the focus on the prevention of Clostridium difficile infection has been maintained throughout the life of the Safety and Quality Strategy and has been reported in previous Quality Accounts. During 2013-14 our performance for Clostridium difficile cases was 55 against a national objective of 41. This performance still represents a 15% reduction in the number of cases when compared to the previous year’s total of 65 cases. We have a well-established annualised improvement plan in place, supplemented by an in-year responsive plan to performance data findings. Our focus for preventing Clostridium difficile cases remains on best practice around antimicrobial stewardship, hand and environmental hygiene. We have increased domestic service support and recruited staff for out-of-hours housekeeping roles. We have also introduced the use of actimel across the trust as part of the trusts ongoing commitment to reducing all avoidable cases of Clostridium difficile infection.

As part of our assurance processes we commissioned a peer review of our Clostridium difficile prevention programme by experts from another trust. The review highlighted numerous examples of good practice and recommended minor refinements to support progression of our improvement plans.

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**Research and Development**

Our research and development taskforce, in conjunction with a local manufacturer have developed a female urinal.

It was established that whilst women were in hospital, it was challenging to remain independent when using a bed pan or commode.

Following a number of design iterations based on focus group feedback the disposable female urinal (VernaFem) was developed, offering a practical solution to continence problems and improving safety and independence.

It increases patient privacy and dignity, reduces bed pan related pressure ulcers, reduces delay in toileting and has been found to reduce patient anxiety.

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Falls prevention

Preventing patients from falling is a particular challenge in acute hospital settings. There will always be a risk of falls in hospital given the nature of the patients that are admitted, and the injuries that may be sustained are not trivial. However, there is a lot that can be done to reduce the risk of falls and minimise harm, whilst at the same time allowing patient freedom and mobilisation during their stay.

The reasons why patients fall are complex and influenced by contributing factors such as physical illness, mental health, medication and age, as well as other environmental factors.

Our well-established programme of improvement activities that includes:

• Awareness-raising of the importance of the reporting of falls, resulting in year-on-year increased reporting since 2008-9.

• Ongoing education of ward staff regarding use of the falls assessment tool and corresponding actions to be taken to reduce falls.

• Sustained strong performance across the trust in respect of risk assessment and response to risk, including enhanced supervision of ‘at risk’ patients.

• Embedding of intentional rounding with improved anticipation of patient’s needs and provision of support.

Our monitoring continues to focus on the number of falls, on harm events associated with falls, and on staff compliance with expected standards of assessment and response, as evidenced through the Essentials of Care Audit Programme (ECAP), which directly measures the level of staff compliance with procedures for assessment of risk, responsive planning and intervention against the agreed audit tool. The audit of clinical records is undertaken on 50% of ward patients on a monthly basis. Results are shown below:

Falls ECAP scores 2012-13

Dementia Care

The older person steering group have developed and introduced a range of resources for patients with dementia, which include activity boxes containing a wide range of dementia specific activities to occupy and stimulate and activity blankets.

These blankets, produced by our linen department are designed to provide a range of sensory stimuli and opportunities to address the common problem of ‘restless hands’.
During 2013-14, the number of inpatient falls and harm associated with falls remained consistent with 2012-13 with 5.48 falls per 1000 bed days and 1.19 falls per 1000 bed days (to February 2014) where patients experienced harm. It should however be noted that this sustained performance occurred despite the significant increase seen in the number of patients over the age of 80 admitted to hospital with a corresponding increase in risk and acuity.

The Neurosurgery Pre-operative Information Team and Medical Illustration have developed a series of pre-operative neurosurgical patient information iBooks containing videos, 3D animations, interactive diagrams and 3D models which can currently be downloaded by patients to their iPad or Apple computer.

The iBook is shared with all patients attending pre-operative assessment. The team are developing a series of Women’s Health iBooks and looking to transfer the iBooks to an Android platform to increase the availability for other tablet users. The iBooks are on our website.
Medication errors

The Essentials of Care Audit Programme (ECAP) continues to provide the most reliable method for monitoring safe practice in respect of medicines prescribing and administration. We have continued to collect data through ECAP on a number of indices which provide further detail on specific aspects of performance that could be influential on reducing harm.

The associated criteria are:

- All patient prescription documentation will provide details of ward, patient name, date of birth, hospital/NHS number and allergy status.
- Omission codes will be evident for all medication not administered as prescribed.
- The status of patients with a potential/actual medication allergy will be identified.
- Patients requiring intravenous antibiotics will be a) clinically reviewed on a daily basis and b) have a defined stop date.

During 2013-14, there has been continued strong performance in respect of the medication ECAP audit, which follows the same methodology as the falls ECAP process described above. Overall performance from this audit of 50% of patients in participating wards, undertaken by wards on a monthly basis, was almost 96.7% during the year.

As ECAP data monitors safe practice, so incident reporting is the vehicle for monitoring incidence and outcomes of errors. During 2013/14, the trust reduced harm associated with medicine administration errors by 32%, with 17 recorded harm events against a trajectory of 24.

Special Care Dentistry

The Department of Special Care Dentistry has developed and implemented a simple and user friendly clinical holding framework to help people with learning disabilities and mental ill health.

Clinical holding is the use of physical holds to assist or support a patient to receive clinical dental care or treatment in situations where their behaviour may limit the ability of the dental team to effectively deliver treatment, or where the patient’s behaviour may present a safety risk to themselves, members of the dental team or other accompanying persons.

Patients who would otherwise have been listed for an oral examination and dental treatment under general anaesthesia may now not require it.
Effective Care

Mortality
The Hospital Standardised Mortality Rate (HSMR) is derived from routinely collected data based on 56 diagnostic groups that account for 80% of all hospital deaths. The data is adjusted to take into account a range of factors that can affect survival rates but that may be outside of the direct control of the hospital such as age, gender, associated medical conditions and social deprivation.

The HSMR is defined as the ratio of observed deaths to expected deaths (based on the sum of the estimated risks of death) multiplied by 100. Thus, a rate greater than 100 indicates a higher than expected mortality rate whilst a rate lower than 100 indicates a lower rate.

We recognise the importance of mortality rates as a key factor in promoting confidence in trust services. As such, it has been and remains a key strategic objective. HSMR is monitored on a monthly basis. Where adverse mortality alerts are triggered: an initial analysis of data is undertaken to determine whether a more detailed case note review is required. This is then undertaken by clinical staff and the findings are formally reported to the clinical governance subcommittee and the board of directors. Mortality rates are reported to the board of directors on a monthly basis and quarterly performance reports are also submitted to the clinical governance subcommittee.

The graph below depicts our annual HSMR rate since 2008. The chart demonstrates year-on-year reduction in HSMR despite increased activity across the trust, with a 2.6 point improvement during 2013/14 (subject to completion of the dataset and national rebasing). The trust has identified further reduction in patient mortality as a strategic objective with an ambition to reduce mortality by 15% over the next three years.

![Comparative Hospital Standardised Mortality Ratio 2008-14](image)

![HSMR 2012-2014](image)

*Source: Dr Foster Intelligence Real Time Monitoring. (2013/14 data not rebased)*
However, rebased HSMRs, as demonstrated below have remained slightly higher than the national rebased benchmark of 100. During 2012/13, following rebasing of the data, overall performance was higher than expected. A number of case note reviews undertaken during 2013-14 have not identified any patterns of suboptimal care or treatment that impacted on the patient outcomes. In acknowledgement of the need for timely and detailed information about patient mortality, a mortality and morbidity review process was initiated in January 2014. Approximately 50% of all cases are reviewed by a clinical multidisciplinary team led by a consultant. The review process confirms diagnoses and associated medical conditions and seeks evidence of substandard care. Learning from these reviews is shared on a regular basis with clinical teams against the national benchmark.

During 2013-14, it is anticipated that the HSMR will be around 95 (based on April - December data). Assuming performance is sustained and does not improve or deteriorate further this figure will rise to 105 once rebasing of the national benchmark has taken place.

Sustaining improvement in the face of increased case complexity continues to provide a real challenge for the trust. The trust however maintains the belief that focussing attention on improved safety, effectiveness and close monitoring of patient outcomes will continue to contribute to a reduction in mortality in the trust. The revised safety and quality strategy for 2014-17 will continue to focus attention on clinical pathways and improvement programmes underpinned by Royal College and NICE guidance and linked to commissioning strategies associated with urgent and elective care, long term conditions, and dementia. With continuing engagement from clinical leaders within the Trust and partners outside of it, we will ensure the delivery of these pathways to patients in need.

During 2012, the summary hospital mortality indicator (SHMI) was introduced nationally. SHMI differs from HSMR in that it includes deaths within 30 days of discharge from hospital, does not account for social deprivation, does not exclude patients receiving palliative care, and includes zero length of stay emergencies, maternal deaths and babies. Unfortunately, SHMI data is not as readily available as HSMR data and as of April 2014, SHMI data is only available to June 2013. In view of this, and as HSMR was the mortality indicator of choice at the time the trust quality strategy was launched, HSMR continues to be the primary mortality measure utilised by the trust. As can be seen from the chart below our Summary Hospital Mortality Indicator has been within expected range for quarter 1 of 2013-14 and all but one quarter since its introduction. Q1 performance is improved from Q4 2012-13 with a rate of 102.3.

During 2012, the summary hospital mortality indicator (SHMI) was introduced nationally. SHMI differs from HSMR in that it includes deaths within 30 days of discharge from hospital, does not account for social deprivation, does not exclude patients receiving palliative care, and includes zero length of stay emergencies, maternal deaths and babies. Unfortunately, SHMI data is not as readily available as HSMR data and as of April 2014, SHMI data is only available to June 2013. In view of this, and as HSMR was the mortality indicator of choice at the time the trust quality strategy was launched, HSMR continues to be the primary mortality measure utilised by the trust. As can be seen from the chart below our Summary Hospital Mortality Indicator has been within expected range for quarter 1 of 2013-14 and all but one quarter since its introduction. Q1 performance is improved from Q4 2012-13 with a rate of 102.3.

Weekend mortality rates were highlighted in the latest CQC Intelligent monitoring report as an area of risk. The elevated risk applied to this measure related to weekend mortality rates during the period July 2012 to June 2013. Current performance data for the 12 months to date has demonstrated month on month improvement with the mortality ratio now within the expected range and no longer alerting as a risk.
Tissue Viability - Pressure Ulcer Incidence

National and trust focus on the elimination of avoidable pressure ulcers in NHS provided care continues, with pressure ulcers one of the four indicators measured within the safety thermometer.

The prevention of pressure ulcers has been a key priority throughout the life of the trust Safety and Quality Strategy and has been included in the Quality Accounts in recent years. Pressure ulcers can occur in any patient but are more likely to occur in patients with underlying medical conditions, the elderly, the malnourished and obese.

Pressure ulcers may be acquired in the community or in hospital, measurement systems therefore need to take account of the incidence or the number acquired in hospital and the prevalence which relate to the total number of patients with a pressure ulcer (a proportion of which will relate to acquisition in the community).

Our established programme focuses on prevention and management of pressure ulceration, which has in previous years included key features such as:

- The availability of an electric bed frame for every patient enhancing the ability of patients to assist in pressure redistribution.
- The use of a tissue viability risk assessment on admission and instigation of an appropriate care plan to prevent pressure ulcer formation.
- Strengthening of validation processes, ensuring accurate classification, cause, and avoidability. All Grade 3 and 4 pressure ulcers are subject to root cause analysis. This validation exercise undertaken by senior nurses provides assurance of the accuracy of reporting.
- Grade 3 and 4 pressure ulcer root cause analyses are subject to executive reviews by the nursing director in the same way that MRSA bacteraemia reviews occur.
- The practice of early and regular skin inspection practices and risk assessment of all patients is embedded across our hospitals.
- An e-learning package is available to all staff.

In addition, during 2013-14:

- Reported hospital acquired pressure ulcers of grade 2 and above are investigated by Divisional Heads of Nursing followed by executive review by the Director of Nursing.
- The Medical Illustration Department photograph all hospital acquired pressure ulcers which further informs and strengthens the investigation process.
- All staff are informed of the outcomes, learning and key actions from pressure ulcer review meetings through quarterly distribution of posters in clinical areas. Pressure Ulcer grading posters have also been distributed to all clinical areas to ensure clear, consistent definitions and to improve the reliability of grading.
- There has been a focus on reducing equipment related pressure ulcers resulting in the introduction of pressure reducing oxygen products, gel sheets and change in practice within critical care to use different techniques to retain endotracheal tubes.
- There are now a range of options available for pressure ulcer prevention training to suit all staff learning styles – monthly taught sessions, an e-learning package and a recently developed pressure ulcer workbook.
- We participated in the “World Wide Stop the Pressure Ulcer day” in November.
The measures described above have contributed to the reducing trend in acquired pressure ulcers. We monitor and report pressure ulcer incidence and prevalence in three ways:

- As an annual point-prevalence audit – which is a spot check of all patients who have acquired a pressure ulcer in hospital and as an incidence report detailing all pressure ulcers reported over the course of the year. The 2013-14 prevalence audit, which was conducted by an external organisation, indicated a slight increase compared to 2012-13 with a rate of 2.51% hospital acquired pressure ulcers.

- Via the safety thermometer – a monthly point prevalence audit of all pressure ulcers, including hospital acquired ulcers. The results indicate a very low level of new pressure ulcers with performance better than the national average.

![Acquired pressure ulcer prevalence 2005-2013](image)

Source: Pressure Ulcer Prevalence Report LTH 2013 Arjo Huntleigh 2013

- Via the safety thermometer – a monthly point prevalence audit of all pressure ulcers, including hospital acquired ulcers. The results indicate a very low level of new pressure ulcers with performance better than the national average.

![Safety Thermometer](image)

Source: NHS safety Thermometer

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**Stereotactic Radiotherapy**

Stereotactic Radiosurgery is a specialised type of Radiotherapy which uses specialist equipment to deliver high dose x-rays very precisely at small brain tumours.

It is fast becoming the treatment of choice for patients with small brain metastases, low grade malignant brain tumours and benign brain conditions. The Rosemere Cancer Centre is a European Reference Site for this equipment and has hosted international visitors to demonstrate and share good practice.
Excellent care with compassion

Via incident reporting - There has been a slight reduction in the total number of avoidable pressure ulcers across the organisation. In 2013-14, (there were a total of 120 patients with hospital acquired pressure ulcers, compared to 125 during 2012-13). The chart below suggests a significant reduction in the total number of avoidable pressure ulcers across the organisation since June 2012 compared to the period up to May 2012. It should be noted, however that some changes in reporting were made during this time, which included the identification of avoidable/unavoidable ulcers and exclusion of those deemed unavoidable following validation. As a consequence, the two periods may not be directly comparable. Assuming no further changes direct year-on-year comparison will be more reliable in the 2014-15 report.

The Essentials of Care Audit Programme (ECAP) continues to focus attention on the importance of the tissue viability risk assessment and results show that 98.4% of patients have risk assessments for tissue viability completed within 6 hours of admission or transfer to a ward, representing a 0.4% improvement on 2012-13 performance.

Dementia Care

Our award winning Older Persons Steering Group, consisting of medical, nursing, therapy and estates and facilities staff are committed to develop the trust to be among the best dementia friendly hospitals.

In consultation with patients, carers and support organisations a programme of dementia friendly ward refurbishments was commenced to ensure that the environment meets the needs of patients with dementia. Patients now have greater freedom of movement and comfort within safe and secure ward areas.

In addition, a programme of staff training was introduced and 6 wards are currently seeking accreditation with the Royal College of Psychiatrists Quality Mark for care of the older person.
Nutrition

One of our aims continues to be to ensure that patients admitted and who remain for more than 48 hours (excluding maternity and day case patients) have a nutritional screening assessment on admission.

The assessment is carried out using the Malnutrition Universal Screening Tool (MUST) developed by the British Association for Parenteral and Enteral Nutrition. The screening tool highlights patients who are already malnourished or at risk of malnourishment and determines the need for referral for a more detailed nutrition assessment by a dietician. Audit results indicate that over 96% of patients are assessed within 48 hours of admission.

Overall performance in assessment, planning and intervention in respect of nutritional support, as measured through the trusts Essentials of Care Audit programme, has been strong throughout the year. Overall results are described in the following chart:

An integrated nutrition and communication service has been developed to improve response times and access to expertise – incorporating members of the speech and language therapy department, dieticians, nutrition specialist nurses, members of the Hospital Alcohol Liaison team and members of the Central Venous Access team.

In addition, a total parenteral nutrition outpatient clinic has been initiated to monitor and provide medical review of patients with complex nutritional needs, thereby avoiding the need for hospital admission.

The availability of nutrition nurse has been increased. Nutrition nurses are now available at weekends and bank holiday to provide advice and support.

Following public consultation and a review of catering provision, the hot meal option at suppertime was re-introduced. Other options such as modified textured which includes liquidised, puree and finger food menus are also available. In addition, a multi-cultural, renal, and gluten free menu are available too.

Work is underway to review the nutritional content of the current hospital meals (both puree diet and normal texture), comparing this to national recommendations.
Experience of Care

Improving patient experience was and remains a key priority, and the focus on respect and dignity, patient involvement and effective communication has been maintained throughout the life of the safety and quality strategy and has been described and reported in previous Quality Accounts.

We participated in the two national patient surveys that were undertaken in 2013-14. The national inpatient survey results demonstrated sustained performance in respect of around a quarter of the questions asked, with improvement in respect of almost half. There was significant improvement in respect of GP letters shared with patients, but a significant drop was noted in respect of change of admission date. This change may have been affected by emergency activity levels at the time of the survey. Overall performance was as expected across all sections.

The national maternity survey results demonstrated that performance was also within the expected range for all questions. Performance improved significantly when compared to the 2010 survey in respect of:

- Support and encouragement with feeding
- Information about mothers recovery after the birth, and
- Information about emotional changes that may be experienced

Performance deteriorated in respect of not seeing the same midwife in antenatal clinic. This issue has been addressed through a review of staff allocation processes.

As stated a key objective of the Safety and Quality Strategy is to improve the patient experience. Patient feedback is obtained via a range of sources including complaints PALS activity, NHS choices and other websites, national surveys and friends and family tests. Feedback obtained using the trust patient feedback devices (Empowering Quality Improvement for Patients or EQIP) is utilised to monitor progress in respect of overall patient experience and specifically, experience related to dignity and respect, communication, involvement and responsiveness of care. Performance data suggests consistently high levels of positive responses during 2013-14, with performance improved when compared to 2012-13 performance in respect of overall feedback (2013-14 90.3%, 2012-13 – 90.1%), involvement (2013-14 – 88.36%, 2012/13 – 87.6%), and communication (2013/14 – 85.7%, 2012/13 – 83.4%). Performance relating to respect and dignity reduced very slightly from 92.65% in 2012/13 to 92.5% in 2013-14.

<table>
<thead>
<tr>
<th>Competency</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>90.31</td>
</tr>
<tr>
<td>Respect and Dignity</td>
<td>92.49</td>
</tr>
<tr>
<td>Communication</td>
<td>85.67</td>
</tr>
<tr>
<td>Involvement in care</td>
<td>88.36</td>
</tr>
<tr>
<td>Responsive, prompt care</td>
<td>87.93</td>
</tr>
<tr>
<td>Privacy</td>
<td>91.83</td>
</tr>
<tr>
<td>Feeling safe</td>
<td>93.41</td>
</tr>
<tr>
<td>Assurance of pain control</td>
<td>92.1</td>
</tr>
<tr>
<td>Meeting nutritional needs</td>
<td>93.48</td>
</tr>
<tr>
<td>Promotion of continence</td>
<td>89.17</td>
</tr>
<tr>
<td>Rest and sleep</td>
<td>72.87</td>
</tr>
</tbody>
</table>

The trust’s ambition to be the best dementia friendly hospital has seen the introduction of highly significant improvements during 2013-14.
We have been collecting real-time data from patients since 2008. During 2011, we invested in new devices in order to obtain richer and more detailed feedback from patients. These devices allow the patients the opportunity to respond to a wider range of questions but also to provide free text feedback about their experiences that may not be covered by the survey questions.

Overall patient experience feedback

Patient feedback results and patient comments are available to wards and departments on a near real-time basis. Each ward area has a performance board displaying the feedback results and other quality indicators, and together, they are used to inform areas for improvement within wards and across directorates. Use of the devices and feedback obtained through bedside handovers continue to help to focus staff attention on issues that are important to patients. It also provides a foundation for more detailed engagement with patients.

Within a context of significant response volumes, the results provide a robust indicator of patient perception and experience. They can also provide assurance around standards of care when analysed along with other data sources such as complaints and PALS activity. The board of directors reviews regular reports capturing all these indicators.

During 2013-14 9770 patients have provided responses to questions providing feedback on the quality of services that are over 86% positive across all responses.

Adult inpatient responses were 88% positive, outpatients 83%, day case patients 91% and children and parents 85%. A review of feedback provided by patients aged 65 and over was consistent with the overall scores.

Mixed sex accommodation has been virtually eliminated, with no reported breaches during 2013-14. All new builds and planned refurbishment are reviewed from a privacy and dignity perspective and do not proceed unless same sex compliant.

As described elsewhere in this account, the trust’s ambition to be the best dementia friendly hospital has seen the introduction of highly significant improvements during 2013-14. Major ward refurbishments undertaken during 2013-14 have been informed by consultation with dementia patients and their carers, along with best practice evidence. Wards catering for patients with dementia are now well equipped to provide safe patient focused care and treatment, a warm welcoming and stimulating environment, improved security, clear signage and are purpose designed to maintain safety, and promote respect and protect dignity. Having completed work in two of our wards we plan to introduce these improvements to other wards during 2014-15.

The Friends and Family Test was introduced in March 2013. Following successful implementation of the test within maternity, we achieved the national CQUIN target of a 20% combined response rate in the wards and emergency departments. During March 2014, 93% of patients who expressed a view stated that they would be extremely likely or likely to recommend the ward or department. The net promoter scores

![Overall patient experience feedback graph](image-url)
for the emergency departments was 59
compared to the most recent NHS England
score of 55, and the score for the wards
was equal to the most recent NHS England
score of 72.

During 2013-14, we received 582
complaints, a reduction of 11 compared
to 2012-13 figures, following two years
of increased numbers between 2011-13.
99.2% of complainants who contacted us
were contacted within 3 working days of
receipt of the complaint.

Just over 50% of complaints related to
inpatient care, 36% to outpatient care, and
11% linked to visits to the accident and
emergency departments. 15 complaints
were raised either by relatives or visitors to
the hospital.

We defended 253 of the 596 complaints,
with the remainder found to be fully or partly
justified.

Approximately 19% related to clinical
treatment or procedure, 16% to issues
about admission discharge or transfer, 13%
related to dissatisfaction with staff attitudes
and 13% to communication as the primary
reason for complaint.

1430 patients or visitors raised concerns
through the Patient Advice and Liaison
Service (PALS) who were able to resolve
their concerns promptly without the need to
submit a formal complaint in writing.

23 complaints were reviewed by
the Parliamentary Health Services
Ombudsman (PHSO) during 2013-14,
where complainants had reported that we
had not resolved their complaints to their
satisfaction by the trust. Of these, 18 were
either not investigated, required no further
action or were not upheld by the PHSO. 2
were referred back to the trust for further
resolution, 2 were partially upheld, and 1
other upheld. Action plans were identified
in respect of the 3 complaints upheld
or partially upheld and shared with the
complainant.

In addition we received a total of 5088
compliments and thank you cards during
2013-14.

During 2013-14 we undertook a review
of its complaints handling procedures
and introduced a range of improvements
including:

• Enhanced triage processes to identify
opportunities for prompt review and
response to complaints.

• Introduction of a PALS outreach service
to promote greater access to the team,
supporting local resolution of concerns.

• Introduction of a peer review process
underpinned by Patient Association
standards. Sample complaints are
reviewed by a panel whose members
include executive and non-executive
directors and governors, who consider
the quality of investigations and
response letters.

• The introduction of a feedback
survey. All complainants are provided
with opportunity to feedback on their
experiences with the complaints
process and satisfaction with the
response received.

• Revised information including leaflets
and posters with details on the ways
in which patients, relatives and the
public can provide feedback and make
a complaint.

Mixed sex accommodation
has been virtually eliminated
Performance Against Key National Priorities

As a foundation trust our performance is measured against a range of patient safety, access and experience indicators identified in the Monitor Compliance Framework and the Acute Services Contract.

We achieved compliance against a range of measures within the Monitor Compliance Framework including access standards such as A&E waiting times, non-admittance and incomplete 18 week referral to treatment and access to cancer treatment.

In addition we maintained performance against a range of other measures identified in the Acute Services Contract. However, we failed to achieve our objectives in relation to 18 week admission access target, 62 day cancer treatment, and operations cancelled for non-clinical reasons and patients readmitted within 28 days following cancellation. This was largely due to significant emergency demand during quarter 4 of 2012-13 and Q1 of 2013/14 that adversely impacted on the Elective Care Programme. Particularly evident were an increase in non-elective admissions of elderly, frail patients and an increase in arrivals by ambulance suggestive of greater acuity. We introduced a number of initiatives during 2013-14 to identify and utilise additional capacity to move back into a position of compliance by the end of Q4 2013-14.

Following the pressures experienced in Q4 2012-13 a health economy wide Urgent Care Review was commissioned in 2013-14. The review focussed on the development of a whole system Urgent Care Transformation Programme. The core themes of the programme are service integration, system wide capacity planning and A&E access points.

The summary position detailing performance against key national and local targets and priorities for 2013-14 is shown in the table opposite.
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Target</th>
<th>Cumulative performance</th>
<th>Achieved</th>
<th>Current period</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E - 4 hour standard</td>
<td>95</td>
<td>94.97</td>
<td>N</td>
<td>% - Cumulative to End Feb 2014</td>
</tr>
<tr>
<td>A&amp;E - Trolley waits greater than 12 hours</td>
<td>0</td>
<td>0</td>
<td>Y</td>
<td>% - Cumulative to End Feb 2014</td>
</tr>
<tr>
<td>Cancer - 2 week rule (All Referrals) - New method</td>
<td>93</td>
<td>94.75</td>
<td>Y</td>
<td>% - Cumulative to End Feb 2014</td>
</tr>
<tr>
<td>Cancer - 2 week rule - Referrals with breast symptoms</td>
<td>93</td>
<td>94.03</td>
<td>Y</td>
<td>% - Cumulative to End Feb 2014</td>
</tr>
<tr>
<td>Cancer - 31 day target</td>
<td>96</td>
<td>96.82</td>
<td>Y</td>
<td>% - Cumulative to End Feb 2014</td>
</tr>
<tr>
<td>Cancer - 31 Day Target - Subsequent treatment - Surgery</td>
<td>94</td>
<td>95.39</td>
<td>Y</td>
<td>% - Cumulative to End Feb 2014</td>
</tr>
<tr>
<td>Cancer - 31 Day Target - Subsequent treatment - Drug</td>
<td>98</td>
<td>100</td>
<td>Y</td>
<td>% - Cumulative to End Feb 2014</td>
</tr>
<tr>
<td>Cancer - 62 day target - total</td>
<td>85</td>
<td>81.28</td>
<td>N</td>
<td>% - Cumulative to End Feb 2014</td>
</tr>
<tr>
<td>Cancer - 62 Day Target - Referrals from NSS (Summary)</td>
<td>90</td>
<td>94.7</td>
<td>Y</td>
<td>% - Cumulative to End Feb 2014</td>
</tr>
<tr>
<td>MRSA</td>
<td></td>
<td>0</td>
<td>Y</td>
<td>No of Patients - Cumulative to End March 2014</td>
</tr>
<tr>
<td>Clostridium difficile - Monitor Plan</td>
<td>41</td>
<td>55</td>
<td>N</td>
<td>No of Patients - Cumulative to End March 2014</td>
</tr>
<tr>
<td>Cancelled Operations - Non Clinical (% of Elective FFCE's)</td>
<td>0.8</td>
<td>0.95</td>
<td>N</td>
<td>% - Cumulative to End Feb 2014</td>
</tr>
<tr>
<td>Cancelled Operations - Not Readmitted Within 28 Days</td>
<td>5</td>
<td>14.19</td>
<td>N</td>
<td>% - Cumulative to End Feb 2014</td>
</tr>
<tr>
<td>Delayed Discharges - Acute</td>
<td>3.5</td>
<td>2.28</td>
<td>Y</td>
<td>% - Average to End Feb 2014</td>
</tr>
<tr>
<td>Medical Outliers</td>
<td>5</td>
<td>3.83</td>
<td>Y</td>
<td>% - Single month of Feb 2014</td>
</tr>
<tr>
<td>Stroke Care - Admission to a designated stroke ward within 4 hours of presentation</td>
<td>90</td>
<td>59.29</td>
<td>N</td>
<td>% - Cumulative to End Jan 2014</td>
</tr>
<tr>
<td>Stroke Care - 90% of stay within designated stroke ward</td>
<td>80</td>
<td>83.48</td>
<td>Y</td>
<td>% - Cumulative to End Jan 2014</td>
</tr>
<tr>
<td>TIA - Commencement of treatment within 24 hours</td>
<td>60</td>
<td>82.95</td>
<td>Y</td>
<td>% - Cumulative to End Feb 2014</td>
</tr>
<tr>
<td>18 weeks - Referral to Treatment - Admitted Patients</td>
<td>90</td>
<td>77.35</td>
<td>N</td>
<td>% - Single month of Feb 2014</td>
</tr>
<tr>
<td>18 weeks - Referral to Treatment - Non-admitted patients</td>
<td>95</td>
<td>95.33</td>
<td>Y</td>
<td>% - Single month of Feb 2014</td>
</tr>
<tr>
<td>18 weeks - Referral to Treatment - Incomplete Pathways</td>
<td>92</td>
<td>92.13</td>
<td>Y</td>
<td>% - Single month of Feb 2014</td>
</tr>
<tr>
<td>18 weeks - Number of patients that have waited over 52 weeks for treatment</td>
<td>0</td>
<td>9</td>
<td>N</td>
<td>% - Cumulative to End Feb 14</td>
</tr>
<tr>
<td>% direct access audiology within 18 weeks in month</td>
<td>95</td>
<td>100</td>
<td>Y</td>
<td>% - Cumulative to End Feb 14</td>
</tr>
<tr>
<td>% patients waiting greater than 6 weeks for diagnostics</td>
<td>&lt;1</td>
<td>1.79</td>
<td>N</td>
<td>% - Cumulative to End Feb 2014</td>
</tr>
<tr>
<td>Same Sex Accommodation Breaches</td>
<td>0</td>
<td>0</td>
<td>Y</td>
<td>Number of Patients - Cumulative to End Feb 2014</td>
</tr>
<tr>
<td>Health &amp; Social Care Needs Assessment within 12 weeks and 6 days of pregnancy</td>
<td>90</td>
<td>91.5</td>
<td>Y</td>
<td>% - Single month of Feb 2014</td>
</tr>
<tr>
<td>Infant Health: Smoking During Pregnancy</td>
<td>18.6</td>
<td>16.06</td>
<td>Y</td>
<td>% - Cumulative to End Feb 2014</td>
</tr>
<tr>
<td>Infant Health: Breastfeeding Initiation</td>
<td>70.8</td>
<td>69.76</td>
<td>N</td>
<td>% - Cumulative to End Feb 2014</td>
</tr>
<tr>
<td>Certification against compliance with requirements regarding access to healthcare for people with a learning disability</td>
<td>NA</td>
<td>100%</td>
<td>Y</td>
<td>Compliance with all objective</td>
</tr>
</tbody>
</table>

* Position is inclusive of Q1-3 reallocations. Does not take account of any potential Q4 reallocations
** Absolute Figures (i.e. number of patients) Note full year threshold included
*** Target was 0 with a deminimus of 6 allowed
### Summary table of performance against core indicators

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) the value of banding of the summary hospital-level mortality indicator (‘SHMI’) for the trust for the reporting period</td>
<td>Trust = 1.02</td>
<td>Trust = 1.02</td>
<td>Trust = 1.037</td>
</tr>
<tr>
<td></td>
<td>National average: 1.0</td>
<td>National average: 1.0</td>
<td>National average: 1.0</td>
</tr>
<tr>
<td></td>
<td>Low = 0.89</td>
<td>Low = 0.65</td>
<td>Low = 0.63</td>
</tr>
<tr>
<td></td>
<td>High = 1.12</td>
<td>High = 1.17</td>
<td>High = 1.18</td>
</tr>
<tr>
<td>(b) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period</td>
<td>Trust = 15.39%</td>
<td>Trust = 16%</td>
<td>Trust = 19.4%</td>
</tr>
<tr>
<td></td>
<td>National = NA</td>
<td>National = NA</td>
<td>National = NA</td>
</tr>
<tr>
<td></td>
<td>High = 44.2%</td>
<td>High = 43.9%</td>
<td>High = 44.8%</td>
</tr>
<tr>
<td></td>
<td>Low = 0</td>
<td>Low = 0.1%</td>
<td>Low = 0</td>
</tr>
</tbody>
</table>

Lancashire Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- It represents performance that is within the expected range, reflecting the effectiveness of clinical treatment within the trust.
- Although there has been an increase in relation to palliative care coding, it has been recognised that historical trust rates were lower than expected and the current rate is in response to actions to improve the coding rate and is not inconsistent with the hospital case-mix.

Lancashire Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by:

- Introducing patient level review of inpatient deaths, with a focus on accuracy of clinical documentation and coding, assessment of standards of care and treatment, and assessment of the impact of delivered care and treatment on the patient outcome.
- Shared learning of findings.
- Improvements in access to the hospital specialist palliative care team (HSPCT) and accurate identification and documentation of HSPCT activity.
18. PROMS; The Trust’s patient reported outcome measures for:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>April 2011–March 2012</th>
<th>April 2011–March 2012</th>
<th>April-Dec 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>EQ5D (Health gain)</td>
<td>Oxford score</td>
<td>Aberdeen score</td>
</tr>
<tr>
<td>(i) groin hernia repair</td>
<td>Trust = 0.079</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>National = 0.087</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>(ii) varicose vein surgery</td>
<td>Trust = 0.105</td>
<td>NA</td>
<td>Trust = 0.099</td>
</tr>
<tr>
<td></td>
<td>National = 0.095</td>
<td>National = -7.896</td>
<td>National = 0.039</td>
</tr>
<tr>
<td></td>
<td>Trust = 0.382</td>
<td>NA</td>
<td>Trust = 0.436</td>
</tr>
<tr>
<td>(iii) hip replacement surgery</td>
<td>Trust = 0.276</td>
<td>Trust = 15.812</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>National = 0.302</td>
<td>National = 15.148</td>
<td>National = 0.318</td>
</tr>
</tbody>
</table>

Patient Reported Outcome Measures (PROMS) is a survey through which patients are asked about their health and quality of life before they have an operation, and about their health and the effectiveness of the operation afterwards. In this way the impact of treatment on an individual patient can be measured. The higher the score, the greater the impact on the patient. The PROMS programme uses three measures:

- The EQ5D tool provides a generic measure of quality of life
- The Oxford specifically measures the impact of knee replacement surgery on quality of life and is only used for patients undergoing knee surgery, whilst
- The Aberdeen score measures the impact of varicose vein surgery on quality of life and is only used for patients undergoing varicose vein surgery

Lancashire Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- PROMS performance was positive and broadly in line with national performance and positive in respect of groin hernia repair but lower than the national score in respect of hip replacement. This may be a reflection of referral practices or patient expectations. Non-adjusted health gain for knee replacement is lower than the national figure in respect of EQ5D but better in respect of the Oxford score. This appears to reflect a better condition and treatment specific outcome.
- For varicose vein surgery, whilst performance was negative in respect of health gain this was consistent with national performance and consistent with evidence suggesting limited clinical value of the procedure.
- Knee replacement PROMS performance has been highlighted in the CQC Intelligent monitoring report as a risk. Patient level data is currently being reviewed to identify possible reasons for variance in performance and will inform development of improvement actions. In addition, compliance with 9 standards of care related to fractured hip was also identified in the same report as a risk and may impact on the perceived health gain for patients

Lancashire Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services, by reviewing and responding to patient level data. The appointment of an Orthogeriatrician has already improved compliance with hip fracture standards significantly and removed this issue as a risk. It is hoped that this will also impact positively on the PROMS hip replacement score.
19. Readmission rate within 28 days of discharge

<table>
<thead>
<tr>
<th></th>
<th>2009-10</th>
<th>2010-11</th>
<th>2011-12 split under and over 16 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-14 years</td>
<td>Trust = 12.07</td>
<td>Trust = 12.23</td>
<td>Trust = 11.91</td>
</tr>
<tr>
<td></td>
<td>National = 10.18</td>
<td>National = 10.15</td>
<td>National = 10.09</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>High/low performing trusts - NA</td>
</tr>
<tr>
<td>15 years and over</td>
<td>Trust = 10.96</td>
<td>Trust = 10.87</td>
<td>Trust = 11.06</td>
</tr>
<tr>
<td></td>
<td>National = 11.16</td>
<td>National = 11.42</td>
<td>National = 11.88</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>High/low performing trusts - NA</td>
</tr>
</tbody>
</table>

Lancashire Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons;

- Readmission rates for over 15 year old patients remains consistently lower than the national average but slightly higher for 0-14 year old patients and may be reflective of case complexity in respect of neonatal services.

Lancashire Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services, by reviewing the impact of any significant shift in case mix on readmission rates and responding where areas of improvement are identified.

20. Responsiveness to patients personal needs

<table>
<thead>
<tr>
<th></th>
<th>2010-11</th>
<th>2011-12</th>
<th>2012-13</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Trust = 69.4</td>
<td>Trust = 62.9</td>
<td>Trust = 67</td>
</tr>
<tr>
<td></td>
<td>National = 67.3</td>
<td>National = 67.4</td>
<td>National = 68.1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>High = 79.5</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Low = 57.4</td>
</tr>
</tbody>
</table>

Lancashire Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons;

- Trust scores show a significant improvement on 2011-12 performance. Unfortunately improvement measures had not been fully embedded by the time of the 12-13 survey and as such, performance had not at that time returned to 2010-11 levels.

Lancashire Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services, by the development and implementation of quality improvement programmes which will include the introduction of always events. It is anticipated that these will positively enhance responsiveness to patient need.

“Readmission rates for over 15 year old patients remains consistently lower than the national average.”
The combined response rates and net promoter score for inpatients who would recommend the hospital to friends and family who needed similar treatment

<table>
<thead>
<tr>
<th>Jan 2014</th>
<th>Feb 2014</th>
<th>Mar 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient response rate = 15.7%</td>
<td>Inpatient response rate = 23.4%</td>
<td>Inpatient response rate = 41.5%</td>
</tr>
<tr>
<td>National response rate = 31%</td>
<td>National response rate = 34%</td>
<td>National response rate = 34.8%</td>
</tr>
<tr>
<td>High = 100%</td>
<td>High = 100%</td>
<td>High = 100%</td>
</tr>
<tr>
<td>Low = 10.9%</td>
<td>Low = 16.2%</td>
<td>Low = 10.9%</td>
</tr>
<tr>
<td>Inpatient net promoter score = 76</td>
<td>Inpatient net promoter score = 73</td>
<td>Inpatient net promoter score = 73</td>
</tr>
<tr>
<td>National net promoter median score = 72</td>
<td>National net promoter median score = 72</td>
<td>National net promoter median score = 72</td>
</tr>
<tr>
<td>High = 100</td>
<td>High = 100</td>
<td>High = 100</td>
</tr>
<tr>
<td>Low = 27</td>
<td>Low = 18</td>
<td>Low = 28</td>
</tr>
</tbody>
</table>

The combined response rates and net promoter score for emergency department (ED) who would recommend the hospital to friends and family who needed similar treatment

<table>
<thead>
<tr>
<th>Jan 2014</th>
<th>Feb 2014</th>
<th>Mar 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED response rate = 12.3%</td>
<td>ED response rate = 17.6%</td>
<td>ED response rate = 21.2%</td>
</tr>
<tr>
<td>National response rate = 17.4%</td>
<td>National response rate = 18%</td>
<td>National response rate = 18.5%</td>
</tr>
<tr>
<td>High = 52.4%</td>
<td>High = 66.1%</td>
<td>High = 53.5%</td>
</tr>
<tr>
<td>Low = 1.7%</td>
<td>Low = 1.5%</td>
<td>Low = 1.6%</td>
</tr>
<tr>
<td>ED net promoter score = 59</td>
<td>ED net promoter score = 58</td>
<td>ED net promoter score = 58</td>
</tr>
<tr>
<td>National net promoter median score = 57</td>
<td>National net promoter median score = 55</td>
<td>National net promoter median score = 55</td>
</tr>
<tr>
<td>High = 92</td>
<td>High = 90</td>
<td>High = 90</td>
</tr>
<tr>
<td>Low = 0</td>
<td>Low = -5</td>
<td>Low = 1</td>
</tr>
</tbody>
</table>

Lancashire Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons;

- As a result of improvements undertaken in response to complaints and other feedback
- Lancashire Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services, by:
  - Increasing response volumes through a review of data collection processes
  - Implementation of always events promoting positive staff/patient interaction and experience

21. %age of staff who would recommend the trust to their family and friends

<table>
<thead>
<tr>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust = 62</td>
<td>Trust = 56</td>
<td>Trust = 64</td>
</tr>
<tr>
<td>National = 60</td>
<td>National = 63</td>
<td>National = 65</td>
</tr>
</tbody>
</table>

High/Low score - NA

Lancashire Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons;

- The staff survey friends and family score improved significantly in 2013 and is now consistent with the national median.
- Lancashire Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by:
  - Increased focus on staff development and appraisal
  - Positive regard, recognition and feedback of good practice and high standards
  - Promotion of positive corporate values, attitudes and behaviour in the workplace
  - Increased board visibility and engagement
23. Percentage of patients admitted who were risk assessed for Venous thromboembolism (VTE)

<table>
<thead>
<tr>
<th></th>
<th>Q1 2013-14</th>
<th>Q2 2013-14</th>
<th>Q3 2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust</td>
<td>95.7%</td>
<td>96.0%</td>
<td>96.4%</td>
</tr>
<tr>
<td>National</td>
<td>95.5%</td>
<td>95.7%</td>
<td>95.8%</td>
</tr>
<tr>
<td>High</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>74.1%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Lancashire Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:
- Compliance with VTE assessment remains above the national median. Performance in respect of root cause analysis has improved significantly during 2013/14 and by year-end all root cause analysis have been completed within the prescribed period.

Lancashire Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services, by:
- Continued root cause analysis of all patients with VTE
- Shared learning and dissemination of good practice via patient safety champions in the workplace

24. C Difficile rates (/100000 bed days) amongst patients aged 2 or over

<table>
<thead>
<tr>
<th></th>
<th>2011-12</th>
<th>2012-13</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust</td>
<td>22.7</td>
<td>21.7</td>
<td>18.0</td>
</tr>
<tr>
<td>National</td>
<td>21.7</td>
<td>17.3</td>
<td>NA</td>
</tr>
<tr>
<td>High</td>
<td>57.4</td>
<td>30.8</td>
<td>High/Low = NA</td>
</tr>
<tr>
<td>Low</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

(based on 2012-13 population pending confirmation of 2013-14 population figures)

Lancashire Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons;
- Clusters of increased incidence during Q3 and Q4
- Figures include a number of cases that are subject to appeal and may, if successful, lead to a reduction in rate

Lancashire Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by:
- Ensuring that focus for preventing Clostridium difficile cases remains on best practice around antimicrobial stewardship, hand and environmental hygiene.
- Increasing domestic service support and recruiting staff for out-of-hours housekeeping roles.
- Introducing the use of actimel across the trust as part of the trusts ongoing commitment to reducing all avoidable cases of Clostridium difficile infection.
### 25. Patient safety incidents and the percentage that results in severe harm or death

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>(i) Rate of Patient Safety Incidents per 100 Admissions</strong></td>
<td>Number = 3723</td>
<td>Number = 3902</td>
<td>Number = 9867</td>
</tr>
<tr>
<td></td>
<td>Rate/100 admissions = 2.96</td>
<td>Rate/100 admissions = 3.1</td>
<td>Rate/100 admissions = 7.6</td>
</tr>
<tr>
<td></td>
<td>National rate/100000 pop = 603</td>
<td>National rate/100000 pop = 643</td>
<td>National rate/100000 pop = NA</td>
</tr>
<tr>
<td><strong>(ii) % of Above Patient Safety Incidents = Severe/Death</strong></td>
<td>SEVERE HARM OR DEATH Number = 16</td>
<td>SEVERE HARM OR DEATH Number = 11</td>
<td>SEVERE HARM OR DEATH Number = 57</td>
</tr>
<tr>
<td></td>
<td>Rate/100 admissions = 0</td>
<td>Rate/100 admissions = 0</td>
<td>Rate/100 admissions = 0</td>
</tr>
<tr>
<td></td>
<td>National rate/100000 pop = 5.07</td>
<td>National rate/100000 pop = 5.22</td>
<td>National rate/100000 pop = NA</td>
</tr>
</tbody>
</table>

Lancashire Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- The increase in reporting of incidents and corresponding increase in those cases reported as severe harm or death is as a result of improvements made to trust structures, processes and utilisation of the Datix incident reporting system to support increased reporting. Ongoing organisational focus on the importance of incident reporting and development of a positive safety culture with improved staff engagement in incident reporting has also contributed to this increase.

Lancashire Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services, by:

- Ongoing recruitment of patient safety champions to provide local and specialist advice on management of risks and to support incident reporting.

Source: Health and Social Care Information Centre (HSCIC)
Care Quality Commission Compliance

- Lancashire Teaching Hospitals NHS Foundation Trust has declared compliance against 16 of the 16 Core Outcomes.

- Lancashire Teaching Hospitals NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

- The Care Quality Commission has not taken enforcement action against Lancashire Teaching Hospitals NHS Foundation Trust during 2013-14.

However an unannounced inspection of Royal Preston Hospital was conducted, an overview of the inspection and findings is provided below.

<table>
<thead>
<tr>
<th>Date</th>
<th>Review</th>
<th>Findings</th>
</tr>
</thead>
</table>
| 14 - 18th Nov    | Emergency Pathway involving the Emergency Department, Medical Assessment Unit, Rapid Assessment Unit and two medical wards | MET THE STANDARDS:  
  - Cleanliness and Infection Control  
  - Assessing and Monitoring and the Quality of service provision  
  ACTION NEEDED (MINOR):  
  - Care and welfare of people who use services  
  - Staffing  
  - Complaints |
| 26th - 27th Nov  | Emergency Pathway involving the Emergency Department, Medical Assessment Unit, and one medical ward | MET THE STANDARDS:  
  - Cleanliness and Infection Control  
  - Assessing and Monitoring and the Quality of service provision  
  - Care and welfare of people who use services  
  - Staffing  
  - Complaints |

An action plan to address concerns was agreed with the CQC and implemented within the required timescales, following which a follow up inspection will take place.

Quality Risk Profiles have ceased to be published by the CQC during 13-14 and have been replaced by the Intelligent Monitoring reports which are reviewed on publication and presented to the Risk Management Committee and Board.
Annexes

Annex 1:
Statements from External Stakeholders

Greater Preston/Chorley and South Ribble Clinical Commissioning Group.

We have received an initial response from the Clinical Commissioning Groups as follows:

NHS Greater Preston CCG welcomes the opportunity to comment on the Lancashire Teaching Hospitals NHS Foundation trust’s annual quality account.

The process that we have undertaken has been to forward the account to the Joint Quality and Performance Committee, which is a sub-committee of the CCG’s Governing Body, for review and comments.

Throughout the year the trust and CCG, in partnership, have reviewed and discussed quality on a monthly basis. Through these discussions and the review of supporting evidence, it is our belief that the information contained within the trust’s quality account gives an overarching view of the quality of services provided over the last year.

We are pleased to note the number of awards that Lancashire Teaching Hospitals NHS Foundation Trust has achieved over the past 12 months:

- Customer Services Excellence Standard Award for hotel services
- The Adult Oxygen Assessment Team Award for Quality, Innovation, Productivity and Prevention
- National Award for improvement in Breast Care Services

These awards align themselves to the overall vision of the NHS to promote an improved standard of care that not only improves point of care standards but also takes into consideration the importance of the environment in which we care for patients and services users.

We feel the trust has missed an opportunity to document their success by not discussing the two national awards that have been achieved through participation in the Innovation Pathway pilot.

The CCG has noted the high number of Clinical Audits, the trust contributed to during 2012-13, which demonstrates a commitment to improve standards and clinical pathways through research participation. We would have liked the trust to provide evidence of the progress on the actions and recommendations of the national and local Clinical Audits documented in the published quality account for 2012-13. This would allow the CCG to share the findings with our associates across the network.

Research and Development is key to improving services and products that are available to assist in the delivery of high quality care for patients. We are pleased to see that the trust has recruited over 2000 patients to take part in the 212 active research studies at the trust.

Further information on the themes of good practice identified and the training packages being developed would give an opportunity to share good practice across the network and for the trust to present its own success.

We note the quality performance data detailed within the quality account and are encouraged to note the improved performance in the key strategic goals. The strategic focus on Safe Care, Effective Care and Experience of Care is clearly demonstrated and has been proved to increase the standards of clinical effectiveness within the trust.

Whilst we note the improvement in the overall Hospital Standardised Mortality Rate reduction of 1.2%, we would like to see further detail on the Hospital Standardised Mortality Rate at the weekends. We assume our colleagues in Specialist Commissioning will respond to the trust’s quality account relating to other key areas, for example around cancer targets.

The CCG is mindful of the challenges the trust has faced during the last 12 months. The partnership arrangements to address these have resulted we will hope to maintain throughout the new financial year. The CCG is encouraged by the goals agreed for 2014-15 and would like to see these more clearly documented within the quality account, in particular the 7 Day Access CQUIN as this aligns itself to the recommendations highlighted in the Keogh Report.

There has been a variation of results throughout the year, associated to the Friends and Family Test; however we note that the trust has significantly improved its systems and processes within the A&E Department which has had a positive impact.

We would like to recommend that the trust publishes more detail on the results of the staff survey carried out, along with details on the current workforce and the actions in place to address the concerns raised by staff members.
The CCG was aware of the actions required within the trust following the CQC unannounced visit. We feel that the quality account would benefit from further detail of these along with the improvements made.

NHS Greater Preston CCG values the collaborative relationship established with colleagues at Lancashire Teaching Hospitals NHS Foundation Trust and looks forward to continuing to work closely on the quality agenda in order to further improve the safety, effectiveness and experience for patients over the coming year.

**Healthwatch**

We have received apologies from Healthwatch and been advised that they will respond as soon as possible.

**Governors**

Governors have not provided further comment, aside from some observations relating to formatting and grammar that have been addressed.

**Our response to Statements**

Lancashire Teaching Hospitals NHS Foundation Trust acknowledges the feedback provided by colleagues and partners. Specifically, feedback provided by commissioners as it relates to weekend mortality rates and awards have been considered and revisions made to the narrative within the quality report. In fact, the final version provides a higher level and depth of detail than that covered by the initial draft.

Much of the information requested as it relates to the Trust workforce and detail related to CQUIN programmes is provided through other forums and reporting mechanisms, but we will explore with commissioner colleagues ways in which we can share learning from audit and research more widely and effectively to mutual benefit. We also look forward to continuing to work closely with commissioning colleagues to the benefits of patients and the public over the coming year.
Annex 2:
Statement of Directors’ responsibilities for the Quality report.

The directors are required under the Health Act 2009 and the National Health Service Quality Accounts Regulations to prepare quality accounts for each financial year.

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 NHS foundation Trust Boards should put in place to support 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 2013-14;
- 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 2013 to March 2014;
  - Papers relating to Quality reported to the Board over the period April 2013 to March 2014;
  - Feedback from commissioners dated 09/05/2014;
  - Feedback from governors dated 14/05/2014;
  - Feedback from local Healthwatch organisations dated 13/05/2014
  - The trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 28/05/2014;
  - The latest national patient survey 17/04/2014;
  - The latest national staff survey 25/02/2014;
  - The Head of Internal Audit’s annual opinion over the trust’s control environment dated 21 May 2014; and
  - Care Quality Commission quality and risk profiles published through 2013-14;
- The quality report presents a balanced picture of the NHS Foundation Trust’s performance over the period covered;
- The performance information reported in the quality report is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- The quality report has been prepared in accordance with Monitor’s annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

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

By order of the Board

Stuart Heys
Chairman
28 May 2013

Karen Partington
Chief Executive
28 May 2013
Independent Auditor’s Report to the Council of Governors of Lancashire Teaching Hospitals NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of Lancashire Teaching Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of Lancashire Teaching Hospitals NHS Foundation Trust’s Quality Report for the year ended 31 March 2014 (the ‘Quality Report’) and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2014 subject to limited assurance consist of two of the three national priority indicators as mandated by Monitor:

For acute NHS foundation trusts:

- Emergency readmissions within 28 days of discharge from hospital.
- 62 Day cancer waits - Percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer.

We refer to these national priority indicators collectively as the ‘indicators’.

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources - specified in the Detailed Guidance for External Assurance on Quality Reports; and,
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Guidance for External Assurance on Quality Reports.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes for the period April 2013 to May 2014;
- Papers relating to Quality reported to the Board over the period April 2013 to May 2014;
- Feedback from the Commissioners dated May 2014;
- Feedback from local Healthwatch organisations dated May 2014;
- The trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, 2013-14;
- The 2013-14 national patient survey;
- The 2013-14 national staff survey;
- Care Quality Commission quality and risk profiles-intelligent monitoring reports 2013-14; and
- The 2013-14 Head of Internal Audit’s annual opinion over the Trust’s control environment.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the ‘documents’). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council
of Governors of Lancashire Teaching Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting Lancashire Teaching Hospitals NHS Foundation Trust’s quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2014, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Lancashire Teaching Hospitals NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) - ‘Assurance Engagements other than Audits or Reviews of Historical Financial Information’ issued by the International Auditing and Assurance Standards Board (‘ISAE 3000’). Our limited assurance procedures included:

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators.
- Making enquiries of management.
- Testing key management controls.
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation.
- Comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report.
- Reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

The scope of our assurance work has not included governance over quality or nonmandated indicators which have been determined locally by Lancashire Teaching Hospitals NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2014:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources specified above; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual.

KPMG LLP
St James’ Square
Manchester
M26DS
28 May 2014
If you have any queries regarding this report, or wish to make contact with any of the directors or governors, please contact:

Paul Howard  
Trust Secretary  
Lancashire Teaching Hospitals NHS Foundation Trust  
Royal Preston Hospital  
Sharoe Green Lane  
Fulwood  
Preston  
PR2 9HT

☎ 01772 522205  
✉ Paul.Howard@lthtr.nhs.uk

Additional information on our work is available at:  
🌐 www.lancsteachinghospitals.nhs.uk