Heatherwood and Wexham Park Hospitals NHS

NHS Foundation Trust

Quality Account 2012/13

Contents

Part 1 - *Statement on Quality from the Chief Executive*

I am pleased to introduce the Heatherwood and Wexham Park Hospitals NHS Foundation Trust Quality Account for 2012/13, my second as Chief Executive of the Trust.

This document complies with the Trust's statutory duties under the National Health Service (Quality Accounts) Regulations 2010 and allows the Trust to place on record the steps we have taken and will be taking in future to drive healthcare improvement and quality.

As is consistent with the Trust's recent history, 2012/13 has been a challenging year from a financial and operational performance perspective but significant steps forward have been made. Indeed, whilst the Trust remains in breach of its Terms of Authorisation with Monitor (as it has done since 2009) due to historical financial underperformance, the Trust will deliver a £6.9m end-of-year deficit in 2012/13, achieving its pre-year forecast and substantially improving upon the c. £14m deficit declared at the end of 2011/12.

Operational pressures, particularly with regard to non-elective A&E attendances during the 2012/13 winter period, have put the Trust's frontline services under immense strain. Whilst an element of the increased non-elective demand is likely to be linked to the closure of the A&E service at Wycombe Hospital towards the end of 2012, beyond this, the entire region has been under significant pressure. In turn this has had an adverse impact upon the Trust's attainment of the four hour A&E target and led to an increase in cancelled elective work, with elective areas being used for 'escalation space'.

It is acknowledged that patients have been inconvenienced throughout the period and staff have worked under difficult conditions. Plans to increase the Trust's bed base are in place and will be implemented by April 2013. For the longer term, the Trust is undertaking a comprehensive piece of work to better understand the pressures on the 'front end' of the Hospital. This work will provide a detailed analysis of the capacity (bed numbers and type) the hospital requires to ensure it can proactively meet the future peaks and troughs in demand. These developments will alleviate the current pressures being experienced and will lead to the development of a more sophisticated and 'scenario sensitive' operational capacity model for 2013/14. In the context of the financial and operational challenges the Trust is facing, the level of clinical performance, quality of care and patient safety that our staff have been able to deliver has been excellent. The Trust continues to improve against a wide range of clinical quality indicators, many of which were included in the 2012/13 Quality Account and have been measured throughout the year directly by the board, for example:

- The Trust has sustained the dramatic improvement it made in increasing the number of Venous Thromboembolism (VTE) assessments for inpatients in 2012/13, this is an important step in reducing the risk of hospital acquired VTE. This has been achieved through extensive training programmes, patient, public and staff health awareness campaigns and careful performance monitoring. In recognition of the hard work and improvements made the Trust was delighted to be given a coveted national award from the VTE prevention charity 'Lifeblood' for the most improved Trust 2011/12.

- The Trust has undertaken a number of activities to increase staff awareness of dementia and to promote early assessment of cognitive impairments in patients. During the year the 'Sunflower Lounge' was opened. This room was designed especially for patients with dementia, offering a homely environment where patents can reminisce, providing stimulation which can enhance mental well-being and

result in an improved health outcome. Dementia Champions have been introduced across the Trust and 267 members of staff have attended the dementia training day.

- The Trust has achieved its 2012/13 target with regard to instances of pressure ulcers at Grades 3 and 4. Prevention of pressure ulcers will also form part of the 2013/14 high impact patient safety and quality campaign.

- The Trust continues to perform at a 'best in class' standard with regard to reducing occurrences of MRSA infection (no occurrences throughout 2012/13) and has continued to maintain a very low rate of CDAD infection.

- The Trust recognises the value of learning lessons from when things go wrong. The Trust's level of incident reporting has risen steadily throughout the year after an effective engagement campaign with staff to ensure that all incidents and near misses are reported in a timely manner.

Despite these achievements, the Trust fully recognises that the need for continual clinical improvement remains ongoing and the clinical priorities identified in Part 2 highlight key aspects of the Trust's clinical strategy for 2013/14.

In addition, one need only look at the Trust's national patient survey results in 2012/13 to see that, whilst the Trust may be performing well on safety issues, a real emphasis is required on improving the overall patient experience of the Trust's services. Consequently, the Trust has a number of plans in place to address this in 2013/14, not least of which involves investment in the Trust estate and IT infrastructure, in addition to ensuring that as much as possible of the Trust's clinical and nursing establishment is filled by substantive, permanent staff. I am hopeful that these changes will positively impact the outcomes of the 'Friends & Family Test', a national qualitative measure of the patient experience which was rolled out across the Trust from April 2013. The clinical priorities outlined in this document have been chosen in close consultation with our internal and external stakeholders and I would like to take this opportunity to express my gratitude for the contributions and feedback that has been received.

As is my statutory duty, I can confirm on behalf of the Trust Board of Directors that all content detailed within this Quality Account is accurate.

Philippa Slinger
Chief Executive Officer

24th May 2013

Part 1 - *About Us*

Heatherwood and Wexham Park Hospitals NHS Foundation Trust provides hospital services to a large and diverse population of more than 450,000 which includes Ascot, Bracknell, Maidenhead, Slough, south Buckinghamshire and Windsor.

There are approximately 30 languages spoken in the area, the top six of which (excluding English) are Hindi, Polish, Urdu, Somali, Romanian and Punjabi.

On the whole, the general health of people in the area is better than the England average. Priorities for the region include; childhood obesity, cardiovascular disease, early detection of dementia and falls prevention, early diagnosis of cancers including prostate, skin and colorectal and prevention and early detection of long-term conditions, heart disease and stroke.

The Trust became a Foundation Trust in 2007 and with approximately 3,200 staff, we provide acute services that include cardiology, maternity, stroke and emergency from two main sites at Wexham Park (Slough) and Heatherwood (Ascot).

We also offer a range of outpatient, breast screening and diagnostic services from four other sites:

- King Edward VII Hospital in Windsor
- St. Mark's Hospital in Maidenhead
- Fitzwilliam House in Bracknell
- Chalfonts Outpatients (part of Gerrards Cross Hospital) in Chalfont St Peter

Each we year we see approximately:

- 30,000 day cases and elective inpatients
- 39,000 emergency inpatients
- 4,500 births
- 118,000 A&E attendances
- 60,000 new outpatient appointments
- 179,000 outpatient follow-up appointments

We also perform over 61,000 procedures and have more than 560,000 patient contacts.

For the last eight years the Trust has achieved a CHKS Top 40 Hospitals award covering safety, clinical effectiveness, health outcomes, efficiency, patient experience and quality of care.

Our priorities 2012/13 Review of Quality Performance

A summary of our progress and achievements is shown in the table below with further detail in the following section.

Achieved ●	Improved ●	Further work ●
Early assessment patients with cognitive impairment	Length of stay for patients with Fractured neck of femur	Cancellation of operation on the day
Recording of preferred place of death on ICP	Percentage of mothers attempting vaginal birth after caesarean section	Cancelled clinic appointments and DNA rates
80% pts to be operated on within 36 hours – fractured neck of femur	Patients receive appropriate prophylaxis	

To ensure the early assessment of patients with cognitive impairment – Safety Domain

Rationale

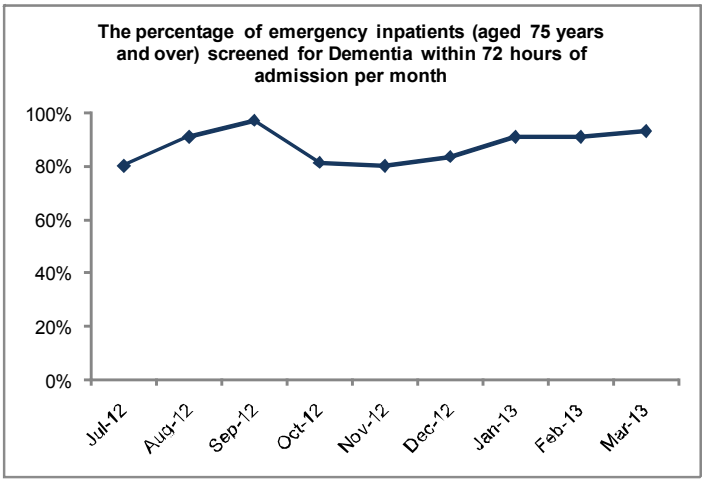
Recent reports and research have highlighted shortcomings in the current provision of dementia services in the UK, largely due to the fact many patients are not formally screened and diagnosed. Dementia presents a huge challenge to society, both now and increasingly in the future. There are currently 700,000 people in the UK with dementia, of whom approximately 570,000 live in England. Dementia costs the UK economy £17 billion a year and, in the next 30 years, the number of people with dementia in the UK will double to 1.4 million, with the costs trebling to over £50 billion a year.

Target

By Q4 90% of patients aged 75 or over have been asked the dementia screening question.

Results

It should be noted that Q1 of FY12/13 was assigned to CQUIN planning and project initiation. The Trust achieved the Q4 target of 90%.



To ensure that patients receive appropriate VTE prophylaxis – Safety Domain

Rationale
One of the key priorities for implementation from the NICE clinical guideline 92-Venous thromboembolism: reducing the risk, is to ensure that methods of VTE prophylaxis being used are suitable and used correctly.

The Trust is also working towards becoming an exemplar centre for VTE. One of the key quality indicators set by the National Exemplar Centre Network in making an application for Exemplar centre status is that at least 90% of patients must have appropriate thromboprophylaxis.

Target
By the end of Q4 90% of patients receive appropriate prophylaxis.

Results
At the end of Q4 87% of patients were receiving appropriate prophylaxis.

To develop and launch the Enhanced Recovery Programme for fractured neck of femur – Effectiveness Domain

Rationale
It has been shown in numerous studies that organisational factors in the patient's treatment are a major determinant of patient survival. The crucial factor is how long the patient has to wait for surgery, with longer wait times associated with higher mortality rates.

Target
a) For 80% of patients to be operated on within 36 hours of admission.
b) To achieve a length of stay reduction from a baseline figure of 17 days (from 11/12 data)

- Q1 and 2 – set up pathway
- Q3 – reduction in length of stay by 1 day to 16 days for 75% of patients
- Q4 – reduction in length of stay by 1 day to 15 days for 75% of patients

Results
In Q4 83% of patients were operated on within 36 hours of admission and 67% of patients were discharged within 15 days.

To increase the percentage of mothers attempting Vaginal Birth after Caesarean Section – Effectiveness Domain

Rationale
To encourage and enable women to have the choice of a vaginal birth after a previous Caesarean section. Birth by caesarean section has been on the increase globally. There is an international drive to keep birth by intervention to a minimum and promote natural

child birth. The literature states that the success rate for a vaginal birth after caesarean section is up to 90%. The Trust currently has a high caesarean section rate and the aim of this priority is to reduce the rate within this group of mothers.

Target

a) Of the total percentage of mothers who have had one previous caesarean section, the trust aims to achieve an increase of 10% in those who are clinically able to and choose a VBAC by the end of Q4.

- 44% by the end of Q1
- 46% by the end of Q2
- 48% by the end of Q3
- 50% by the end of Q4

b) Of the total percentage of mothers who have had one previous caesarean section who attempt a vaginal birth, the trust aims to achieve by the end of Q4, an 80% success rate.

- 75% by the end of Q1
- 76% by the end of Q2
- 78% by the end of Q3
- 80% by the end of Q4

Results

a) Q1 - 35%
Q2 - 45%
Q3 - 44%
Q4 - 38%

b) Q1 - 68%
Q2 - 77%
Q3 - 71%
Q4 - 64%

To improve the patient referrals and outpatient appointments booking system – Effectiveness Domain

Rationale

The Trust's Complaints systems and feedback received from local GPs and commissioners highlight a common concern with regard to the effectiveness of the Trust's patient referrals and appointments booking system.

Target

a) The Trust will aim to reduce hospital generated outpatient appointment cancellations (less than 6 weeks notice) by 20% from the baseline figure of 2011/12.

b) The Trust will aim to reduce its appointment 'Did Not Attend' (DNA) rate from an average of 8.98% during 2011/12 to:

- Reduction to 8.5% by the end of Q1
- Reduction to 8% by the end of Q2
- Reduction to 7.5% by the end of Q3
- Reduction to 7% by the end of Q4

Results
a) The number of hospital generated cancellations (less than 6 weeks notice) in 2012/13 was 16,555; a 3.7% rise from 15,967 in 2011/12.

b) At Q4 the Trust's DNA rate for outpatient appointments was at 9.29%.

Further work plan 2013/14

A project has commenced in conjunction with a company called Newton to review the Outpatient Processes and to ensure that improvements are made to a range of areas. Less than six week notice cancellations have been identified as a key area for improvement and the focus is on reducing this by 20% from the baseline figure. Base line data has been provided to the divisions to show trends and cancellation reasons. Agreement is being sought from the Operations Directors on a workable process to enable them to manage their clinic cancellation approval process. Performance reports have been developed to monitor this KPI and are being reported to the Newton Steering Board.

DNA rates have not seen any significant sustained change with trust rate of 9.5% in January. Further work is planned with Newton to look at the rates and to advise as to how we can achieve the targets set. A specific piece of work has been commenced in rehab which saw rates as high as 15% although a review of booking processes and data capture has been completed within rehab and as a result process changes made that have begun to show an improvement in their DNA rates.

Work has commenced with a company called Drdoctor who are looking to improve our SMS text messaging service to enable us to make the service more interactive and customer focused. A review of all clinics across the Trust is being undertaken to identify suitable clinics for the text reminder service. A new clinic request process and form has been developed to ensure that all elements of the clinic set up process are captured including the set up of the text reminder service.

Improving the patient pathway
– Patient Experience Domain

Rationale
Cancelling a patient's operation on the day contributes to a poor experience and impression of the Trust. Currently the Trust cancels more than 3% of patients on the day of admission, against a target figure of 0.8%.

Target
By Q4 2012/13 the Trust aims to reduce to 0.8% the number patients whose operations are cancelled on the day.

Results
The percentage of surgical operation cancellations on the day as at Q4 was 6.12%. However, please see further work plan below.

Further work plan 2013/14

Division A is acutely aware of the high number of cancellations on the day of surgery. These are for a number of reasons

Theatres have traditionally not started to operate on any patients until the beds have been identified that the patients will go into, and they are assured that a bed will be available. The Division has now begun to investigate the theatre lists the day before and inform theatre that the lists can start on time and that the beds will be made available. This has resulted in theatres now starting on time. This has meant that they also finish on time and patients are not cancelled due to lack of time.

Unfortunately due to the increase in non-elective admissions during the winter period it has been necessary for non-surgical patients requiring inpatient care to use some of the beds that surgical patients would have normally used. This has resulted in the availability of appropriate beds for patients requiring elective surgery being reduced. As a result Division A management obtain the theatre lists prior to the day of surgery and, in conjunction with the patient access team, make early decision if it is likely that the bed will not be available the next day. These decisions are taken using clinical markers such as the urgency of the operation, there are a number of surgical procedures that we never cancel due to the urgency of the presenting condition, patients are then prioritised by the team using markers such as have they been cancelled before or the social arrangements that have been made to make the admission possible.

Pre-operative assessment do on occasions make decisions that patients can be operated on at Heatherwood Hospital and then on the day of surgery the anaesthetic team make the decision that the patients should be operated on in the more acute setting of Wexham Park. Pre-operative assessment is now working more closely with the anaesthetic teams to minimise this happening.

Division A is also increasing the bed base by 16 beds and Division C are increasing their bed base by 12, from April 2013 and it is expected that this will allow the model of care to change in Division A with the new beds being used for short stay patients and day surgery being used only for patients requiring day surgery allowing the longer stay patients to have available beds on the acute wards.

Improving the documentation of preferred place of death – Patient Experience Domain

Rationale

Over the past few years, a major drive has been underway to ensure that people nearing the end of their lives and their relatives and carers receive a high standard of care allowing them to make informed choices about where they wish to die.

Evidence shows that around half the annual 500,000 deaths in England currently occur in acute hospitals, with people spending an average of 18 days as in-patients during the last year of their life, often spread over several admissions. National Audit Office research shows that 40% of those who die in hospital have no medical need to be there.

Most people would prefer to die in a place of their choosing, whether that is hospital, their own homes, a care home, hospice or other care setting. This requires people and their families to be involved in decision making and planning for the end of life, and for appropriate community based support and care to be put in place.
Evidence suggests that having a documented advance care plan in place that includes preferred priorities for care/death and where this is communicated to members of the care team will increase the chance of a person achieving their preferred place of death.

Target
By Q4, a 20% improvement in the recording of the preferred place of death for patients on the integrated care pathway for the dying compared to the baseline audit of September 2012.

Results
By March 2013 the Trust was able to evidence recording of Expressed Preferred Place of Death for 95% of patients. This level of performance had been maintained as evidenced by the September 2012 audit.

The Trust has identified priorities within the three domains of safety, effectiveness and patient experience in accordance with the guidance issued by Monitor.

1. Safety

a. 100% incidents concerning falls categorised as major or extreme will have followed the appropriate post fall pathway.

- Checks by clinical staff for signs or symptoms of fracture or potential for spinal injury before the patient is moved
- Safe manual handling methods for patients with signs or symptoms of fracture or potential for spinal injury
- Frequency and duration of neurological observations for all patients where head injury has occurred or cannot be excluded (e.g. unwitnessed falls) based on National Institute for Health and Clinical Excellence (NICE) Clinical Guideline 56: Head Injury
- Timescales for medical examination following a fall (including fast track assessment for patients with signs of serious injury, or high vulnerability to injury, or who have been immobilised)

Rationale
When a serious injury occurs as a result of an inpatient fall, safe manual handling and prompt assessment and treatment is critical to the patient's chances of making a full recovery.

How it will be measured
All cases of falls that are categorised as major or extreme will be subject to a root cause analysis and investigation to ensure the appropriate preventative and post falls actions were initiated. These will be presented at Patient Safety and will be shared with teams to support reflective learning. Monthly figures will be presented to the Trust Board.

b. Reduce the number of non clinical moves - zero tolerance

Rationale
Moving patients from area to area has a detrimental effect on their experience, can increase the length of stay and increase the risk of hospital acquired infection.

How it will be measured
Monthly ward reports to be included in the board paper.

c. 20% decrease in patient who have a urinary catheter and develop a urinary tract infection in hospital

Rationale
From data sources the Trust is aware that at times we have a higher than expected rate of patients with catheters and urinary tract infections. A work programme has been launched and new documentation is to be introduced.

How it will be measured
A monthly audit will be undertaken.

2. Effectiveness

a. To reduce the number of cardiac arrest calls on general areas

Rationale
If staff monitor and respond appropriately to patients whose condition is deteriorating then they should not reach the point of cardiac arrest.

How it will be measured
Cardiac arrest call data will be monitored and cases will be reviewed by a specialist group.

b. Increase the percentage of neonates receiving total parenteral nutrition by day 2 of life

Rationale
Neonates receiving TPN by day 2 of life is a best practice measure. Optimal nutritional support to infants below 30 weeks gestation, or below 1500g.

How it will be measured
Data is submitted monthly on all admissions. This will be monitored and reported monthly

c. Sepsis pathway – baseline audit Q1 with trajectory set for Q4

- Sepsis recognised
- Blood cultures obtained prior to administration of antibiotics
- Administration of a broad spectrum antibiotic within 3 hours of sepsis being suspected

Rationale
Sepsis claims over 37,000 lives in the United Kingdom annually. Research shows that early recognition and intervention saves lives.

How it will be measured
An audit will be carried out in Q1 and a trajectory and work programme commenced. A repeat audit will be carried out in Q4.

3. Patient Experience

a. Increase timely discharge of patients prior to 12 noon

Rationale
Data shows that the majority of patients at present in the Trust are discharged after noon.

How it will be measured
From the computer system used in the Trust a report will be collated monthly and reported to board.

b. Reduce number of operations cancelled on the day to 0.8% by the end of Q4

Rationale
Cancelling a patient's operation on the day contributes to a poor experience and impression of the Trust. This is a priority that is continuing from last year as there is further work that needs to be completed this year.

How it will be measured
Monthly data will continue to be collected and reported to the Trust board.

c. A minimum of 90% of complaints received in 2013/14 will be responded to on time. A minimum of 90% of complaints will be acknowledged in 72hrs

Rationale
The Trust's complaints process is a key learning tool which the Trust uses to learn from patient feedback. Additionally, there is evidence to suggest that the timely and effective management of patient complaints has a positive result on the patient experience, reassuring complainants that particular matters of concern are fully investigated and addressed.

How it will be measured
All complaints are on a tracker and the time taken respond is monitored. This will be reported to the Trust board on a monthly basis.

d. Reduce the number of complaints concerning communication and professional conduct by 15%

Rationale
Feedback shows that the Trust has a higher number of complaints regarding communication and professional conduct than is acceptable.

How it will be measured
The subject of all complaints will be monitored and this will be reported to the Trust board on a monthly basis.

Review of Services

During 2012/13 HWPH provided or subcontracted 15 NHS services.
HWPH has reviewed all the data available to them on the quality of care in 12 of these NHS services.

The income generated by the NHS services reviewed in 2012/13, at month 10, represents 92% per cent of the total income generated from the provision of NHS services by Heatherwood and Wexham Park Hospitals NHS Foundation Trust for 2012/13.

Participation in clinical audits and national confidential enquiries

During 2012/13, 39 national clinical audits and three national confidential enquiries covered NHS services that Heatherwood and Wexham Park Hospitals NHS Foundation Trust provides.

During 2012/13, Heatherwood and Wexham Park Hospitals NHS Foundation Trust participated in 95% national clinical audits and 100% national confidential enquiries of the eligible national clinical audits and national confidential enquiries.

The national clinical audits and national confidential enquiries that Heatherwood and Wexham Park Hospitals NHS Foundation Trust was eligible to participate in, and for which data was collected during 2012/13, are listed in Annexe 1.

The reports of local clinical audits completed in 2012/13 were reviewed by Heatherwood and Wexham Park Hospitals NHS Foundation Trust and the provider intends to take actions such as the following to improve the quality of healthcare provided:

- Continued Trust wide Venous Thromboembolism (VTE) strategy to facilitate all adult inpatients admitted to the Trust are assessed for VTE risk and offered appropriate thromboprophylaxis if required and if not contraindicated in line with the Trust VTE Policy.
- Implementing a Trust-wide dementia strategy to achieve better awareness, early diagnosis and improve the care and experience of people with dementia during their inpatient stay.
- Continue to improve communications with primary care partners through improved discharge summaries and letters on discharge at the end of treatment courses.

Engagement in clinical audits

Heatherwood and Wexham Park Hospitals NHS Foundation Trust encourages and fully supports clinical audits. Nationally managed audits are designed to enable learning and promote improved patient outcomes across a wide range of conditions. These audits are a priority for the Trust and are included in the Trust's Clinical Audit Forward Plan. They enable clinicians to compare their clinical practice against standards and to use this information to deliver better outcomes in the quality of treatment and care. These national audits are designed to ensure that all patients receive the most effective, up-to-date and appropriate treatment, delivered by clinicians with the right skills and experience.

The Trust Position Statement emphasises that the clinical audit programme will be aligned to the acute contract as well as to the National Clinical Audit and Patient Outcomes Programme (NCAPOP). The annual Clinical Audit Forward Plan identifies high priority, national and local audits for the relevant financial year in line with the Trust's corporate requirements for assurance and relevant national requirements.

Within the Trust, a wide range of local nursing and medical clinical audits are undertaken within each clinical speciality. These audits are undertaken to examine whether treatments or services are meeting standards of best practice such as NICE, or they may be specific audits identified to monitor compliance to internal standards, policies and protocols.

The Trust has a robust governance process to monitor clinical audits and ensure improvements in patient safety, clinical effectiveness and quality of care. To meet the demanding need of Clinical assurance a Head of Clinical Effectiveness was recruited in November 2012 to provide continued leadership for clinical assurance including clinical audits and NICE Guidance implementation.

The Trust Clinical Effectiveness Group continues to be operational at the direction of the Trust Healthcare Governance Committee to provide greater oversight to clinical assurance within the Trust. The group reviews and approves the annual audit programme, and leads on the consideration and implementation of recommendations and actions resulting from relevant NICE guidance, national confidential enquiries and clinical audits. Findings of clinical audits, along with any identified risks, recommendations and action plans are presented to the relevant specialty and divisional clinical governance committees, before being reported to the Clinical Effectiveness Group, Healthcare Governance Committee and the Audit and Assurance Committee of the Trust Board.

Information on Participation in Clinical Research

The number of patients receiving NHS services provided or sub-contracted by Heatherwood and Wexham Park Hospitals NHS Foundation Trust that were recruited during 2012/13 to participate in research approved by a research ethics committee was 449. The Trust achieved the Thames Valley Cancer Network recruitment targets for both non randomised and randomised controlled trials for the year.

Department	Patients recruited into clinical trials 2010/11	Patients recruited into clinical trials 2011/2012	Patients recruited into clinical trials 2012-2013 (up to 25/3/13)
Cancer Services	155	209	161
Cardiovascular	10	2	39
Reproductive Health	118	4	15
Paediatrics	4	1	39
Musculoskeletal	5	9	5
ENT	70	26	31
Stroke	2	0	0
Neurology	2	9	24
Infection	0	2	31
Generic Relevance	0	256	0
Accident & Emergency	0	0	62
Critical Care	0	0	42
Other	11	0	0
Total	377	518	449

Information on the use of the CQUIN framework

A proportion of Heatherwood and Wexham Park Hospitals NHS Foundation Trust's income in 2012/13 was conditional upon achieving quality improvement and innovation goals agreed between the Trust and NHS Berkshire 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. These sets of initiatives are an important component of the Trust's continuous quality improvement programme and incorporate purposely challenging targets. In 2011/12 no specific final monetary value can be solely attributed to CQUINs as the globally agreed financial settlement with our PCT Commissioners was deemed a fair remuneration for the improvements made over the year. The original CQUIN payment value under the contract was £1,982,515.

In 2012/13 The CQUIN payment value under the contract was circa £3.5 million.

CQUIN Title	Final Indicator	Progress
VTE Risk Assessment	% of all adult inpatients who have had a VTE risk assessment on admission to hospital	Achieved
VTE Prophylaxis	% of all adult inpatients assessed as high risk of VTE who have received appropriate thromboprophylaxis	Achieved
Dementia Element 1 (Find)	% of all patients aged 75 and above admitted as emergency inpatients who are asked the dementia case finding question within 72 hours of admission or who have a clinical diagnosis of delirium on initial assessment or known diagnosis of dementia.	Achieved
Dementia Element 2 (Assess / Investigate)	% of all patients aged 75 and above admitted as emergency inpatients who have scored positively on the case finding question, or who have a clinical diagnosis of delirium and who do not fall into the exemption categories reported as having had a dementia diagnostic assessment including investigations.	Achieved
Dementia Element 3 (Refer)	% of all patients aged 75 and above, admitted as an emergency inpatient who have had a diagnostic assessment (in whom the outcome is either "positive" or "inconclusive" who are referred for further diagnostic advice/ follow up.	Achieved
Safety Thermometer	Submission of data	Achieved
Patient experience	% Involved in decisions about treatment/care	Not achieved
	% Hospital staff available to talk about worries/concerns	
	% Privacy when discussing condition/treatment	
	% Informed about medication side effects	
	% Informed who to contact if worried about condition after leaving hospital	
Enhanced Recovery NOF LOS	75% of patients discharged within 16 days	Not achieved
	75% of patients discharged within 15 days.	Not achieved
NOF Time to Theatres	The percentage of patients who are admitted to hospital with a primary diagnosis of Fractured Neck of Femur are operated on within 36 hours of admission.	Achieved
End of Life	Documentation of preferred place of death (Integrated Care Pathway for the Dying)	Achieved
Shared Decision Making	Joint production of appropriate protocols in Gastroenterology	Achieved
Unscheduled Care	Provide a full data set from July 2012/13 for patients attending A&E suitable for treatment in the community	Achieved
Unscheduled Care	Demonstrate 584 'accepted' referrals to named community services	Achieved
High Impact Innovations	Digital by default - Planning for Urology Skype Service	Achieved
	Full implementation of Intraoperative Fluid Management Technologies	Partially achieved

Registration with the Care Quality Commission (CQC)
Heatherwood and Wexham Park Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and is currently registered. Heatherwood and Wexham Park Hospitals NHS Foundation Trust currently has no conditions on its registration.

The Care Quality Commission has not taken enforcement action against Heatherwood and Wexham Park Hospitals NHS Foundation Trust during 2012/13.

Heatherwood and Wexham Park Hospitals NHS Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2012/13.

April 2012: Maternity Outlier Alert
The Trust was contacted by the CQC in April 2012 regarding non-elective Maternal readmissions within 42 days of delivery. The data submitted suggested that the Trust was an outlier in relation to:

a) Percentage of non-elective Maternal readmissions within 42 days of delivery
b) Percentage of readmissions due to Obstetric surgical site infections (SSIs)

A review following receipt of the alert, including a detailed case note audit of all non-elective maternal readmissions during the period concerned (April-August 2011) revealed the following:

- Trust practice of admitting well mothers accompanying their unwell child on the Trust PAS system. This was introduced in April 2011
- Presence of a systematic clinical coding error for this group of women
- Governance processes within O&G clinical team had already identified SSIs as an issue and appropriate steps had been taken to change clinical process to address it. SSI rates have returned to within the expected range

Action taken as a result of the CQC Alert:
- Coding error has been corrected.
- SSI rates in Obstetrics continue to be audited routinely to ensure improvement has been sustained.

April 2012: Responsive Review of Maternity and Gynaecological services - Outcome 1,4,14 and 16 Fully Compliant and meeting all essential standards

June 2012: Responsive 2 day review of Medical and Surgical Wards and Emergency areas - Outcome 1,4,5,6,11 and 16 – fully compliant and meeting all essential standards.

Data Quality
Heatherwood and Wexham Park Hospitals NHS Foundation Trust submitted records during 2012/13 to the Secondary User Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records for 2012/13 April-November 2012

Valid NHS Number

- Admitted Patient Care – 98.8%
- Outpatient care – 99.5%
- Accident and Emergency – 95.3%

Valid General Practitioner Registration Code

- Admitted Patient Care – 99.8%
- Outpatient care – 99.9%
- Accident and Emergency – 99.4%

Data Quality Information Improvement Programme

The Trust is continuing to improve data quality in terms of accuracy, completeness and timeliness. This is in the context of a national picture of increasing reliance on good quality information, development of Service Line Reporting and a growing interest in data mining all of which provides a challenge to data quality. In addition to the agreed plan with the PCT several initiatives are underway including improvement in clinical coding , performance reporting, reference data and information assurance.

The Trust has worked closely with its lead commissioner on areas in the 2012/13 contract schedule in the agreed Data Quality Improvement Plan (DQIP). In particular work has been done on improving NHS Number completeness and verification status compliance which is now in excess of 99% on all activity for current patients. Other elements of the plan are also on track or have been completed.

The clinical coding team now have over 30% of the team qualified to exacting national standards, have a rigorous programme of internal and external audit and a rolling plan for clinical engagement.

The Trust is working with KPMG, the external auditors, to review performance reporting and tying it in to the Trust's governance and assurance structures. Included in this work is the development of an Information Assurance Framework to give the Board systematic reporting on the status, validity, function, and definition etc. of each KPI.

The Trust has implemented a new product, UK Health dimensions that provide NHS reference data which is updated every week and fed directly into the Trust's information systems. This significantly improves data quality and allows the Trust to be synchronised in terms of reference data with our main commissioner.

Information Governance Toolkit Attainment Levels

Heatherwood and Wexham Park Hospitals NHS Foundation Trust attained level 2 status for the Information Governance Toolkit in 2012/13, with an overall score of 79%.

Payment by Results (PbR) and the Audit Commission Results

Heatherwood and Wexham Park Hospitals NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission.

Core Quality Indicators

Mortality

INDICATOR	April 2011 - March 2012	July 2011 - June 2012
The value and banding of the summary hospital level mortality indicator (SHMI)	1.01 Banding 2	1.01 Banding 2
The percentage of patient deaths with palliative care coded at either diagnosis or speciality level	30.3	32.3

	July 2011 - June 2012
National average score	1.00
Highest Trust score	1.26
Lowest trust score	0.71

Heatherwood and Wexham Park Hospitals NHS Foundation Trust considers this data is as described for the following reasons. This score and banding is as expected with a banding of 2 being average.

The Heatherwood and Wexham Park Hospitals NHS Foundation Trust has taken the following actions to improve this score and so the quality of its services, by undertaking mortality and morbidity meetings by speciality. Mortality rates are reported in the Trust board papers.

Patient Reported Outcome Measure Scores

INDICATOR	April 2011 - March 2012	April 2012 - Sept 2012
Groin hernia surgery	0.089	0.073
Hip replacement surgery	0.411	*
Knee replacement surgery	0.284	*

*Return rate for questionnaires that could be analysed was below the number required

2011/2012	Groin Hernia	Hip	Knee
Score for England	0.087	0.416	0.302
Highest Trust score	0.143	0.532	0.385
Lowest trust score	0.030	0.306	0.180

Heatherwood and Wexham Park Hospitals NHS Foundation Trust consider this data is as described for the following reasons. The return rate for questionnaires that could be analysed has been below the number required.

Heatherwood and Wexham Park Hospitals NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services, by running a campaign on PROMS and ensuring that the patients are fully aware of when they will be asked to complete questionnaires and how to complete them fully. The Trust will also emphasis to the patients that the feedback is valued, reported and actioned.

Readmission within 28 days

INDICATOR	2009/2010	2010/2011
Patients aged 0 – 14 yrs (<16)	9.29	11.67
Patients 15 yrs and over	11.94	12.12

Heatherwood and Wexham Park Hospitals NHS Foundation Trust considers this data is as described for the following reasons, A1 Banding against the national average and Improvement Banding D.

The Heatherwood and Wexham Park Hospitals NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, by conducting an adult readmission audit which will now be carried out bi annually and setting up a multi agency discharge group. The work programmes for 2013/14 concerning admissions and discharges will impact on this indicator.

Responsiveness to personal needs of patients

INDICATOR	2010/2011	2011/12
Data from the national patient survey	65.9	63.0

	2010/2011	2011/2012
Score for England	67.3	67.4
Highest Trust score	82.6	85.0
Lowest trust score	56.7	56.5

Heatherwood and Wexham Park Hospitals NHS Foundation Trust considers this data is as described for the following reasons. The response rates being low and the higher than average percentage of patients who completed the survey following an emergency admission.

Heatherwood and Wexham Park Hospitals NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by continuing the Enhancing your experience programme with division training. The aim of the programme is improving both staff and patient experience.

Recommendation of the Trust by staff

INDICATOR	2011	2012
Percentage of scores agree/highly agree for the question on the staff survey If a friend or relative needed treatment I would be happy with the standard of care provided at this Trust	50%	51%

2012	Result in 1st Quartile	Average score 1st Quartile 49.98%	4th Quartile – top performers

Heatherwood and Wexham Park Hospitals NHS Foundation Trust considers this data is as described for the following reasons. Over a quarter of respondents answer to the question was neither agree or disagree. The overall response rate was lower than average.

Heatherwood and Wexham Park Hospitals NHS Foundation Trust intends to take the following actions to improve this percentage, and so the quality of its services, by building upon the wide range of initiatives commenced this year. These include improving engagement and communication in a variety of ways including social media, and actively encouraging suggestions for improvement.

Assessment for Venous thromboembolism

INDICATOR	Q2 2012/13	Q3 2012/13
Percentage of patients risk assessed in agreed timescale	92.5%	91.3%

	Q2	Q3
National average score	93.8%	94.1%
Highest Trust score	100%	100%
Lowest trust score	80.9%	84.6%

Heatherwood and Wexham Park Hospitals NHS Foundation Trust considers this data is as described for the following reasons. A successful campaign has been running during this year to improve the rates of assessment.

Heatherwood and Wexham Park Hospitals NHS Foundation Trust intends to take the following actions to improve this percentage, and so the quality of its services, by building upon the work completed in this year. This includes awareness campaigns for both staff, patients and visitors, daily ward rounds with reminder stickers and education for staff.

Clostridium Difficile

INDICATOR	April 2010 - March 2011	April 2011 - March 2012
Rate per 100,000 bed days patients aged 2 and over	28.3	32.2

	April 2010 - March 2011	April 2011 - March 2012
National average score	29.6	21.8
Highest Trust score	71.8	51.6
Lowest trust score	0.0	0.0

Heatherwood and Wexham Park Hospitals NHS Foundation Trust considers this data is as described for the following reasons. The Trust has a robust policy and the rate has been on a downward trajectory.

Heatherwood and Wexham Park Hospitals NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, by the infection control team providing training to the staff and ensuring adherence to policy and regularly visiting clinical areas.

Patient Safety Incident Reporting

INDICATOR	Oct 2011 - March 2012		April 2012 - Sept 2012	
Number/Rate of patient safety incidents reported	Rate 6.7		Rate 6.71	
Number and percentage that resulted in severe harm or death	33	1.4%	33	1.3%

	April 2012 - Sept 2012	
Highest Trust score	Rate 14.44	Severe 61 Death 34
Lowest trust score	Rate 3.11	Severe 0 Death 0

Heatherwood and Wexham Park Hospitals NHS Foundation Trust considers this data is as described for the following reasons. The approach taken by the Trust is one of avoiding blame (fair blame) of individuals and encouraging an open and honest approach to the reporting of adverse events. The Heatherwood and Wexham Park Hospitals NHS

Foundation Trust has taken the following actions to improve this rate, and so the quality of its services: by running a patient safety campaign on incident reporting with drop in sessions for training on the computer system used and on incident categories/grading. These sessions will continue to be run regularly in the next year.

Note

We have robust processes in place to capture incidents. However there are risks at every Trust relating to the completeness of data collected for all incidents (regardless of their severity) as it relies on every incident being reported. Whilst we have provided training to staff and there are various policies in place relating to incident reporting, this does not provide full assurance that all incidents are reported. We believe this is in line with all other Trusts.

There is also clinical judgement in the classification of an incident as "severe harm" as it requires moderation and judgement against subjective criteria and processes. This can be evidenced as classifications can change once they are reviewed. Therefore, it could be expected that the number of severe incidents could change, so the figure reported could change from that shown here due to this review process.

Performance Targets 2012/13

Overview of Care

Year-End Performance Target Attainment, Based upon the Targets Highlighted within Monitor's Compliance Framework.

CQC Performance
Monitor Targets

		#		Current Month	Prior Month		Quarter Position			Current Quarter		Prior Quarter
		Target Position	Period	Position	Position	Trend	Monitor Weighting	Monitor Target	Monitor Period	Monitor Performance	Score	Monitor Performance
C-DAD Toxin Detection (Cumulative)		37	Mar-13	26	22	NA	1	37	Q4	26	0.0	15
MRSA (Cumulative)		1	Mar-13	0	0	NA	1	1	Q4	0	0.0	0
Cancer	- 2 Week Wait from urgent GP Referral	93%	Mar-13	93.6%	93.5%	▼	0.5	93%	Q4	93.2%	0.5	95.9%
Cancer	- 2 Week Wait from Breast Symptematic Referral	93%	Mar-13	84.4%	80.9%	▼		93%	Q4	85.0%		95.2%
Cancer	- 31 Days from Diag to Treat (First)	96%	Mar-13	100.0%	99.1%	►	0.5	96%	Q4	99.7%	0.0	99.3%
Cancer	- 31 Days for second or subsequent treatment (Surgery)	94%	Mar-13	100.0%	96.3%	►	1	94%	Q4	97.0%	0.0	100.0%
Cancer	- 31 Days for second or subsequent treatment (Drug)	98%	Mar-13	100.0%	100.0%	►		98%	Q4	100.0%		100.0%
Cancer	- 62 Days to Treatment (GP 2 Weeks)	85%	Mar-13	82.8%	86.5%	▼	1	85%	Q4	85.1%	0.0	89.4%
Cancer	- 62 Days to Treatment (Screening)	90%	Mar-13	100.0%	88.9%	►		90%	Q4	93.3%		94.0%
18 Weeks	- Admitted	90%	Mar-13	90.3%	90.1%	▲	1	90%	Q4	90.2%	0.0	90.3%
18 Weeks	- Non-Admitted	95%	Mar-13	95.7%	95.8%	▼	1	95%	Q4	96.0%	0.0	97.0%
18 Weeks	- Incomplete	92%	Mar-13	90.2%	88.8%	▼	1	92%	Q4	91.0%	1.0	94.5%
A&E	- Percentage of patients who waited less than 4 hours	95%	Mar-13	80.3%	85.7%	▼	1	95%	Q4	84.4%	1.0	92.3%
											2.5	
Number of 28 CQC core targets failing		0/28		0.0							2.5	

Please Note:
Please bear in mind that the Quarterly position doesn't reflect the Full Qtr position, it will only come into effect at the quarter months

Processes Around Quality Indicator Selection

The Trust has established several mechanisms and sources for determining its local key priorities for quality improvement. These include, but are not restricted to:

- Patient surveys
- Patient safety campaigns
- Trust risk assurance framework
- Outcomes of clinical audit
- Discussion with key stakeholders
- Care Quality Commission assessments
- Outcomes of complaints and incident investigations
- CQC Quality & Risk Profile (more information detailed below)
- Patient safety and quality reports
- The Trust's CQUINs quality performance indicators, as contained within the acute services contract.

The determination of the Quality Report priorities is eventually established in the context of the Trust's wider Quality Strategy which is refreshed each year. In formulating the Strategy, in addition to the sources listed above, the Trust engages with staff throughout the organisation to gain 'ownership' and support of the Trust's clinical priorities. Ultimately, the Strategy is signed off by the Board.

Protecting Patients from Infection

MRSA

The cumulative target set for MRSA for 2012/13 was 1. The Trust has had no cases of MRSA reported in 2012/13, therefore achieving this target. The last case was in April 2011.

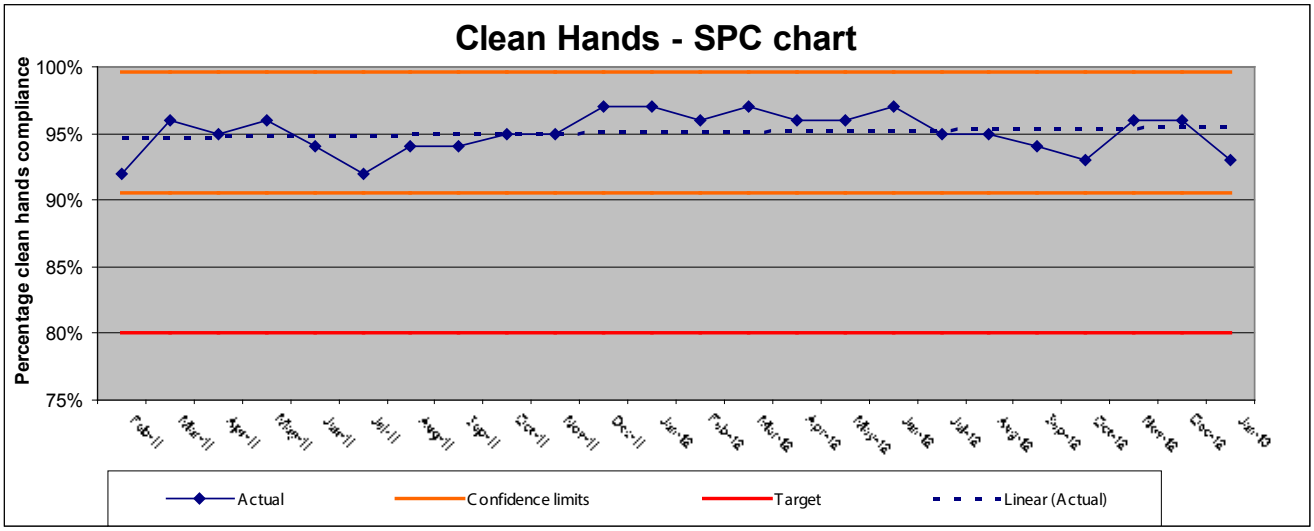
CDAD (C-difficile associated diarrhoea)

The cumulative CDAD incidence target for the year 2012/13 was 37. The Trust is below this figure and has therefore achieved this target.

	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
CDAD target	288	171	135	108	53	37
CDAD actual	184	168	104	51	58	28

Hand Hygiene

Hand hygiene audits throughout the year have consistently been above the target of 80%



Keeping Patients Safe Campaigns

The Trust's patient safety/quality campaigns are aligned with the Trust's objectives. Regional/national patient quality and safety priorities continue to be implemented and are performance monitored by the designated subcommittee of the Trust's Healthcare Governance Committee. This provides the committee with assurance on the improvement against the specific campaign.

2012/13 Campaign

Local Involvement Network (LINks)

The Trust has continued to work with its local LINks. Slough has continued to audit the use of protected mealtimes at Wexham Park Hospital during summer 2012 which demonstrated some of the improvements which had been made by the Trust highlighted in previous audits. Further collaborative working with Slough LINks has been encouraged by the Trust with attendance of Trust staff at the LINks meetings and a presentation given by the Trust at the Slough LINks Annual General Meeting.

Several members of Windsor and Maidenhead and Slough LINks are represented at some Trust meetings to ensure further collaborative working. More recently Windsor and Maidenhead LINks undertook a protected mealtime audit at Heatherwood Hospital. The audit results showed that they considered that the key points of the policy were being met. The three wards chosen for this visit had varied remits and a wide variety of patients, in terms of medical conditions and ages. The majority of the patients expressed their satisfaction with the meals served.

Learning Disabilities
The Trust continues to work collaboratively with the Community Team for People with Learning Disabilities (CTPLD) and to strengthen this process following the Winterbourne View serious case review the Lead Nurse for Outpatients is now the Lead Nurse for Learning Disabilities within the Trust. During recent months the Trust has received Learning Disability training from Berkshire Healthcare Foundation Trust CTPLD.

Safeguarding
The safeguarding children's team continues to foster and drive forward the objective of promoting the welfare of children, to raise awareness of safeguarding children across the organisation. An example of this can be demonstrated by the Trust's engagement with Slough Local Authority's Peer Review of Safeguarding in November 2012. As a partner agency key staff from Children's and Maternity Services and A&E discussed issues and progress made from the previous CQC/Ofsted Inspection.

The reviewers acknowledged the drive and good work they had seen within the Trust. In the last 12 months an alert system has been introduced which identifies children at risk when presenting at the hospital. This has enabled immediate escalation of cases and improved access to information for all parties involved in safeguarding. A named Midwife has also been recruited to assist with safeguarding in the maternity department. This has provided significant additional capacity and capability within a previously challenging area (in terms of volumes of safeguarding cases).

Since 2012 there has been an Independent Domestic Violence Advocate who is employed by Berkshire East and South Bucks Womens' Aid. The post was funded by the Crime Innovation Fund on behalf of the Home Office. The aim of this role was to promote Domestic Abuse awareness throughout the Trust, deliver staff training and set up the service and referral process. Unfortunately funding for this service expired on 28 March 2013. Berkshire East and South Bucks Womens' Aid is addressing this. To date no funding has been secured.

During 2012 the Trust has addressed the time of day which patients are discharged. Patients over the age of 75 or those who are considered to be vulnerable are only discharged with patient transport after 20:00 if the Senior Duty Nurse or the ward Matron has reviewed their needs. Some discharges are late due to the timings of care packages, availability of beds at Heatherwood or at Community rehabilitation providers. Other patients are discharged safely to nursing or residential homes with agreement with the individual home.

Dementia
Training on the Mental Capacity Act, Deprivation of Liberty safeguards and caring for people with learning disabilities has continued to be provided throughout 2012. The dementia training has also continued throughout the year for all hospital staff and continues to be supported by a dementia volunteer who helps train our clinical staff in caring for our patients with dementia. This is since her husband was diagnosed with Alzheimer's disease in 2006 and after a long battle, died in January 2012.

"I didn't want the whole experience to be in vain so I decided to share my experiences and try to help others in a similar situation that I was...I feel very privileged to be able to share my experiences with the staff at the trust and I am proud to be involved with the great work that they are doing."

The Trust has continued to develop good working relationships with the local carers associations and members from the association have participated in training for staff on the role of carers. The Trust also participated in a Slough Carers event in November 2012 to reach out to the local community.

Wexham Park Hospital cares for many patients who, once recovered from the acute phase of their illness, are unable to be discharged immediately back to their own homes. In 2012 a room was designed especially for patients with dementia, called the Sunflower Lounge, this room offers a homely environment in order to support these patients further and to improve the experience of those who have to remain in hospital as they continue to need treatment. We know that when patients are given the opportunity to reminisce it can provide stimulation which may enhance mental well-being and result in an improved health outcome.

Carer's comments
"Having been a carer of a loved one living with dementia, I can see how the lounge will help the nurses and carers when working with the patients",

"It is a great idea and a real asset to the hospital."

The lounge is the first of its kind to be installed in an acute hospital in the South and is in the style of a 1950's living room, complete with authentic furniture and a fully working vintage television and radio. The aim of the therapeutic room is to help patients who live with dementia to feel more comfortable and to help them reminisce about times gone by, improving their ability to recall their own pasts.

Patient Surveys
The Trust has continued to participate in a number of National Patient Experience surveys (Inpatient, Outpatient, Cancer, Day Surgery and Emergency Department) and will utilise the findings from these surveys to make improvements. In all the surveys a lack of patient information was a common theme and this has been addressed in a number of different ways to improve the service.

For example the clinic letter for Outpatients has been revised to provide improved information to patients. There has been training for clinicians and nursing staff to improve the way in which test results are explained to the patients. Other improvements across the Trust have included additional updated posters and leaflets to inform patients of the complaints process. Ward areas have improved information given to visitors and patients with updated information of ward information. Other improvements following feedback from the surveys has seen increased visibility of hand gels in general areas throughout the Trust.

The surveys have highlighted that a lack of privacy is sometimes an issue for patients.

This has been addressed in a number of ways which include improvements made to the curtains around the cubicles and signage to prompt staff not to enter the cubicle without first asking permission.

Over the last 12 months the surveys have demonstrated that although the Trust has previously committed to improving the patient meal time experience there is still more work to do. Other improvements have included recruiting and training meal time volunteers - this group of staff support the ward to create a more social meal time experience and are also able to offer some assistance to patients to eat and drink. Further improvements have been made using the 'red trays' to ensure that any patients who require some assistance are given time and support. Ward Matrons have been fully supported in enforcing the protected meal time to ensure that staff are not disturbing the patients meal time. Improvements are being introduced to the way in which the food is cooked.

The other key theme from the surveys over the last 12 months is the way the Trust communicates with patients and relatives. To address this each Division has undertaken further work to ensure improvements are made. Within the Surgical Division our 'Enhancing Your Experience' customer care programme is being rolled out. A key element of the customer care programme is to improve ways of keeping our patients informed. Improvements have been made to ensure that Ward Matrons undertake daily rounds to improve their visibility to both patients and relatives to give ample opportunity to listen and respond to concerns.

Patient/Carer information

The Trust continues to work to ensure that there is a wide range of leaflets reflective of the services provided by the Trust and the health conditions that the Trust provides care, support and treatment for. There are now 200 patient information leaflets published on the Trust website, which has 8,000 visits per week (25,000 page views) (based on Jan/Feb 2013). Improvements in the range of leaflets have shown a steady increase from 60 page views per week to more recently 120 per week. All patient information leaflets follow a strict information protocol involving clinician and patient reviews. For patients with special educational needs and learning disabilities we have access to the Easy Read health information website via our Trust site.

The Trust now offers a dedicated MacMillan information centre within Wexham Park Hospital. This centre is an excellent source of information giving patients, relatives and carers the opportunity to discuss concerns and queries with staff members. This information centre also offers information for non cancer illnesses such as dementia.

The Trust continues to work closely with service users and now offers the 'This is me' Alzheimer's Society patient information leaflet. This encourages loved ones to share information about the person being cared for in order to enhance and individualise the care given. The Trust has also developed a newsletter for both patients and carers to provide information regarding developments in dementia care within the Trust.

Staff Survey 2012
Overall the survey outcomes in 2012 were more positive than those in 2011 and show progress in a number of areas. 46% of the outcomes are average or above compared with other acute trusts - this is an increase on the 2011 result of 18%.

The Trust is in the best 20% of acute trusts for two findings, both of which have improved since last year:

- % staff feeling satisfied with the quality of work and patient care they are able to deliver (statistically significant positive change since last year)
- % working extra hours

For 11 other findings, the Trust scores are above average or average, including:
- % agreeing that their role makes a difference to patients
- % having well structured appraisals
- % receiving training, learning and development
- % reporting errors, near misses or incidents
- Fairness and effectiveness of incident reporting procedures (increase since 2011)
- Staff motivation at work

However, 15 findings (54%) were below average, compared with 82% last year. 9 of the scores for 2012 are in the worst 20% of acute trusts, including:
- % staff receiving health and safety training
- % suffering work related stress
- Support from immediate managers
- % experiencing harassment, bullying or abuse from patients, relatives or the public
- % experiencing harassment, bullying or abuse from staff
- % able to contribute towards improvements at work
- Staff job satisfaction (although this has shown a statistically significant positive change)
- Staff recommendation of the trust as a place to work or receive treatment (although this has shown a statistically significant positive change)
- % experiencing discrimination at work in last 12 months

Our overall staff engagement score has improved from 3.43 to 3.59 (still below average of 3.69).

Complaints
In 2012/13 the Trust received 477 formal complaints, with the numbers per month typically increasing during and immediately after the winter period. This reflects the greater level of operational pressure which the Trust currently experiences through these periods. For each month the number of compliments was more than the number of formal complaints received.

The Board receives a breakdown of the thematic 'subject' of complaints on a monthly basis. When aggregated across the year the 'top five' subjects of complaint for 2012/13 were:

- Treatment and Diagnosis 20%
- Communication 14%
- Professional Conduct 12%
- Appointment Issues 12%
- Discharge 5%
- Surgical/Invasive Procedures 5%

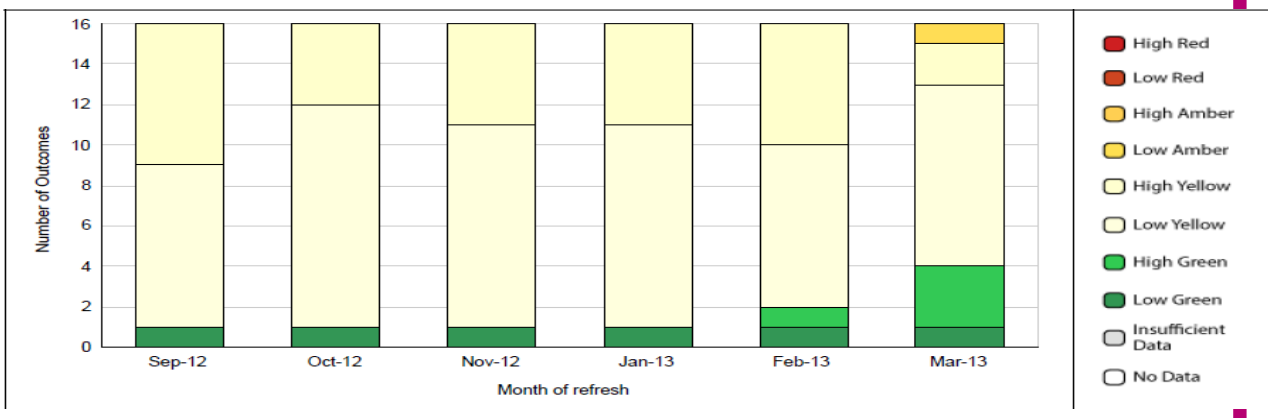
The data represents an extract from the 2012/13 Annual Complaints Report. The full Annual Complaints Report will be submitted for approval at the July Trust Board meeting.

Care Quality Commission - Quality & Risk Profile

The Trust uses the CQC's monthly Quality & Risk Profile (QRP) to inform its own CQC standard self-assessment. The QRP uses a plethora of local and national performance indicators on each of its Essential Standards to provide an indication of the Trust's risk position in relation each of these standards, with each standard being 'RAG rated' on this basis. As of March 2013, the Trust had the following level of performance within the QRP:

Trust Risk Estimate for March 13	CQC Outcome
Low Green	Outcome 11: Safety, availability and suitability of equipment
High Green	Outcome 8: Cleanliness and infection control Outcome 12: Requirements relating to workers Outcome 14: Supporting staff
Low Yellow	Outcome 1: Respecting and involving people who use services Outcome 2: Consent to care and treatment Outcome 4: Care and welfare of people who use services Outcome 6: Cooperating with other providers Outcome 7: Safeguarding people who use services from abuse Outcome 10: Safety and suitability of premises Outcome 13: Staffing Outcome 16: Assessing and monitoring the quality of service provision Outcome 21: Records
High Yellow	Outcome 5: Meeting nutritional needs Outcome 17: Complaints
Low Amber	Outcome 9: Management of medicines
High Amber	No outcomes rated as 'High Amber'
Low Red	No outcomes rated as 'Low Red'
High Red	No outcomes rated as 'High Red'

The six month trend of QRP scores is highlighted by the following graph:



Clinical Coding

Clinical coding is the translation of medical terminology, as written by the clinician, to describe a patient's complaint, problem, diagnosis, treatment or reason for seeking medical attention, into a coded format which is nationally and internationally recognised. This information is recorded by the clinical coding team and is reported for every episode of inpatient care and is used for clinical governance, outcome and quality indicators, public health and payment.

There has been substantial improvement in the Trust's quality of clinical coding which is reflected in improvements in KPIs. An improvement programme continues, the key elements of which are:

- Team development
- Clinical engagement
- Improved access to coding information sources
- Audit and monitoring

There is a rigorous training programme in place which has increased the number of nationally accredited coders in the team. The work of every coder is subject to regular external and internal audit. Clinical engagement is also continuing to improve through education and feedback to clinicians.

In response to audit findings, where access to information was impeding clinical coding, the Trust has introduced case note tracking and improved access to electronically stored information. Work is also underway to prevent loss of income through better data capture, improved accuracy, visibility and timely capture of comorbidities to aid patient care and safety.

In summary, Heatherwood and Wexham Park Hospitals NHS FT was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission. However the regular programme of audits, both internal and externally supported, continued to provide assurance that the clinical coding function was meeting professional standards.

Annex 1

National Clinical Audits and National Confidential Enquiries

	Title of National Clinical Audit / Confidential Enquiry	Eligible	Trust Participated	% of required cases
Peri-and Neo-natal				
1	Perinatal mortality (MBRRACE-UK)	Yes	Yes	100
2	Neonatal intensive and special care (NNAP)	Yes	Yes	100
Children				
3	Paediatric pneumonia (British Thoracic Society)	Yes	Yes	100
4	Paediatric asthma (British Thoracic Society)	Yes	Yes	>90
5	Pain management (College of Emergency Medicine)	Yes	Yes	100
6	Childhood epilepsy (RCPH National Childhood Epilepsy Audit)	Yes	Yes	100
7	Paediatric intensive care (PICANet)	No	No	NA
8	Paediatric cardiac surgery (NICOR Congenital Heart Disease Audit)	No	No	NA
9	Diabetes (RCPH National Paediatric Diabetes Audit)	Yes	Yes	100
Acute care				
10	Emergency use of oxygen (British Thoracic Society)	Yes	Yes	100
11	Adult community acquired pneumonia (British Thoracic Society)	Yes	No (participating in a similar Improving Quality Programme)	NA
12	Non invasive ventilation -adults (British Thoracic Society)	Yes	Yes	100
13	Pleural procedures (British Thoracic Society)	Yes	Yes	100
14	Cardiac arrest (National Cardiac Arrest Audit)	Yes	No (not participating due to resource shortages)	NA
15	Severe sepsis and septic shock (College of Emergency Medicine)	Yes	Yes	100
16	Adult critical care (ICNARC CMPD	Yes	Yes	100
17	Potential donor audit (NHS Blood and Transplant)	No	No	NA
18	Seizure management (National Audit of Seizure Management)	Yes	Yes	100
Long term conditions				
19	Diabetes (National Adult Diabetes Audit)	Yes	No (not participating due to resource shortages)	NA
20	Heavy menstrual bleeding (RCOG National Audit of HMB)	Yes	Yes	100

	Title of National Clinical Audit / Confidential Enquiry	Eligible	Trust Participated	% of required cases
21	Chronic pain (National Pain Audit)	Yes	Yes	100
22	Ulcerative colitis and Crohn's disease (UK IBD Audit)	Yes	No (not participating 2011/12)	100
23	Parkinson's disease (National Parkinson's Audit)	Yes	Yes	100
24	Adult asthma (British Thoracic Society)	Yes	Yes	100
25	Bronchiectasis (British Thoracic Society)	Yes	No (not participating 2011/12)	100
Elective procedures				
26	Hip, knee and ankle replacements (National Joint Registry)	Yes	Yes	100
27	Elective surgery (National PROMs Programme)	Yes	Yes	100
28	Intra-thoracic transplantation (NHSBT UK Transplant Registry)	No	No	NA
29	Liver transplantation (NHSBT UK Transplant Registry)	No	No	NA
30	Coronary angioplasty (NICOR Adult cardiac interventions audit)	Yes	Yes	100
31	Peripheral vascular surgery (VSGBI Vascular Surgery Database)	Yes	Yes	100
32	Carotid interventions (Carotid Intervention Audit)	No	No	NA
33	CABG and valvular surgery (Adult cardiac surgery audit)	Yes	No (participating in a similar Improving Quality Programme)	NA
Cardiovascular disease				
34	Acute Myocardial Infarction and other ACS (MINAP)	Yes	Yes	100
35	Heart failure (Heart Failure Audit)	Yes	Yes	100
36	Acute stroke (SINAP)	Yes	No (not participating in 2011/12)	NA
37	Cardiac arrhythmia (Cardiac Rhythm Management Audit)	Yes	Yes	100

	Title of National Clinical Audit / Confidential Enquiry	Eligible	Trust Participated	% of required cases
Renal disease				
38	Renal replacement therapy (Renal Registry)	No	No	NA
39	Renal transplantation (NHSBT UK Transplant Registry)	No	No	NA
Cancer				
40	Heavy menstrual bleeding (RCOG National Audit of HMB)	Yes	Yes	100
41	Bowel cancer (National Bowel Cancer Audit Programme)	Yes	Yes	100
42	Head and neck cancer (DAHNO)	Yes	Yes	100
43	Oesophago-gastric cancer (National OG Cancer Audit)	Yes	Yes	100
Trauma				
44	Hip fracture (National Hip Fracture Database)	Yes	Yes	100
45	Severe trauma (Trauma Audit and Research Network)	Yes	Yes	100
Psychological conditions				
46	Prescribing in mental health services (POMH)	No	No	NA
47	Schizophrenia (National Schizophrenia Audit)	No	No	NA
Blood transfusion				
48	Bedside transfusion (National Comparative Audit of Blood Transfusion)	Yes	Yes	100
49	Medical use of blood (National Comparative Audit of Blood Transfusion)	Yes	Yes	100
Health promotion				
50	Risk factors (National Health Promotion in Hospitals Audit)	No	No	NA
End of life				
51	Care of dying in hospital (NCDAH)	No	No	NA
National Confidential Enquiries				
1	Peri-Operative Care	Yes	Yes	100
2	Surgery in Children	Yes	Yes	100
3	Cardiac Arrest Procedures	Yes	Yes	100
4	Bariatric Surgery	Yes	Yes	100

Annex 2

External Statements

The content of this Quality Account was shared with various external stakeholders at a draft stage during the development of the document. The detail of this is included below.

Healthwatch
The draft Quality Account was shared with each of the four local Healthwatch organisations (Slough; Bracknell & Ascot; South Buckinghamshire and Windsor, Ascot & Maidenhead) on 17 May 2013.

Windsor, Ascot & Maidenhead Healthwatch
Healthwatch (Windsor, Ascot & Maidenhead) welcomes the opportunity to comment on the Heatherwood and Wexham Park Hospitals Quality Report.

We are pleased to note that the Trust continues to make progress in their quality improvements programme and have achieved a number of important priority targets and quality indicators. Healthwatch recognises and commends the commitment of hospital staff in maintaining the quality of care and patient safety in particular over the recent winter period.

The 2012/13 quality report clearly shows that there remain a number of important quality aspects yet to be dealt with. The Trust's proposed 'priorities for improvement 2013/14' and 'further work plan' are considered to be relevant and appropriate to improving performance in these areas.

The particular areas of concern that have been raised by patients and the public during 2012/13 have included: patient referrals and appointments; cancelling patient operations; poor patient experience and staff engagement. Recent patient and staff surveys quoted by the Trust illustrate the under-performance in these areas. In this quality report, the Trust has committed to a challenging programme of improvement activities, perhaps the Trust might consider the benefits of a greater public engagement in monitoring progress on these through out the year.

The report notes the role of carer organisations and their members in the training of hospital staff for dementia patients, but the wider role carers play in supporting patients in hospital and their recovery has not been commented on. A programme of activities for the improvement of working relationships with carers would have a positive out come for the Trust.

Other aspects raised by carers and patients identify the need for accessible information regarding the care plan and patient pathway and being able to identify key members of ward staff as factors in improving patient experience.

Healthwatch has a key role, backed by statutory powers, to strengthen the collective voice of local patients and public in all aspects of commissioning and delivery of health care services. We look forward to establishing good working relationships with the Foundation Trust that ensures the views and experience of patients, carers and the public are taken into account to improve the quality of health care services provided by the Trust.

Bucks Healthwatch
The Bucks Healthwatch feedback recognised that the Quality Report fulfilled a statutory purpose and made the point that, for this reason, aspects of the Report, were not drafted in a 'public-friendly' manner. There were also general points made with regard to the ordering of the data within the Report. Bucks Healthwatch said that the report should include statements about the standards of care that patients and the public should expect the trust to provide.

Bucks Healthwatch noted the trust's low scores on patient experience in relation to the patient survey and welcomed the trust's continuing focus in these areas.

Council of Governors and FT Members
The draft Quality Account was an item on the 15 May 2013 Council of Governors agenda. Prior to this, the quality account clinical priorities for 2013/14 had been shared with the governors through the Joint Clinical Assurance Group, a sub-group of the Council, and through a seminar on the Trust's Quality Strategy held in April which governors attended.

Whilst generally supportive of the Trust's quality objectives for 2013/14 and the wider Quality Strategy that they relate to, the Council of Governors agreed that the Trust's overall quality priority was encapsulated by the team 'zero patient harm' and that achievement of this aim was only possible by instilling a positive working culture throughout the organisation.

In addition to governor engagement, the Trust circulated its draft clinical priorities for 2013/14 to its FT membership base for comment. A large proportion of responders expressed their delight at being consulted. At a general level, many expressed the view that more information was needed on the rationale behind the choice of priorities. They also wanted to understand how the targets had been agreed, and more understanding of timescales and what actions would be taken to achieve the targets.

There was also the common view that nursing staff should not be overburdened with paperwork in order to achieve the priorities.

Members were keen that the Trust's performance against the clinical priorities were made publicly available throughout the year. More specific comments received from members have been fed back to the Corporate Nursing team.

Commissioners
The draft Quality Account was shared with the Chief Officer of the Clinical Commissioning Group 'federation' covering NHS Bracknell & Ascot CCG, NHS Slough CCG and NHS Windsor, Ascot & Maidenhead CCG on 11 April 2013. A formal response was received on 23 May 2013:

Berkshire East Federation Clinical Commissioning Group has reviewed Heatherwood and Wexham Park Hospitals NHS Foundation Trust's Quality Account. The Quality Account provides information across a wide range of quality measures and provides an overview of the quality improvements made during 2012/13.The Quality Account also sets out the Trust's quality improvement priorities for 2013/14. We would have like to have seen how

these priorities were identified and those stakeholder groups involved in this process, as this would have been helpful toward demonstrating shared ownership of these quality priorities.

The Quality Account is supported by relevant data used to support the comprehensive review of the quality improvements made by the Trust during 2012/13. The CCGs have reviewed these data and are satisfied that these are accurate and provide appropriate evidence of the Trust's quality improvement progress. These priorities are reflected in those set out in the Berkshire PCT Cluster Quality handover Document.

Berkshire East CCGs, acknowledge the significant challenges Heatherwood and Wexham NHS Foundation Trust (HWPFT) have experiences during the last year. These have in part been due to the unprecedented increase in patient

activity within its accident and emergency service. This increase reflects not only a national trend but also the impact of service reconfiguration elsewhere in the local health system. As a result of this, the Trust has experienced difficulties in meeting its Stroke and A&E performance targets and the CCGs are surprised that these areas have not been included within the Trust's Quality Account priority areas. CCGs are supportive of the work the Trust is undertaken to responds to these challenges and its work on improving its processes for patient discharges.

The Trust's overall staff survey engagement score for 2012 was 3.59 compared to the national average of 3.69 for similar trusts; putting the Trust in the lowest 20%. However, it is acknowledged that the survey does highlight an improvement on the previous staff survey in staff reporting that they 'felt satisfied with the quality of work and patient care' and in 'making a difference to patients', which was above the national average for these areas.

The Trust's Quality Account does not make explicit reference to the recommendations from the Francis Report enquiry into the quality failings at Mid-Staffordshire Hospital. Berkshire East Federation CCGs have asked the Trust to undertake a gap analysis of the organisation governance processes alongside these recommendations to ensure improvement actions are planned and implemented where necessary. These recommendations will also support the Trust improvement highlighted in its Quality Account in relation to patient complaints and incident investigation.

The CCGs look forward to the Trust's work in partnership with other healthcare providers across the local health economy to reduce non-elective admissions, pressure ulcers and urinary tract infections. This is a new and challenging approach with the CCGs support across multiple healthcare organisations and we look forward to a successful outcome from this approach in the years ahead.

Overview & Scrutiny Committees

The draft Quality Account was shared with each of the Overview & Scrutiny Committees relevant to the Trust's geographical area in early April 2013, including that attached to Slough Borough Council, Bracknell Forest Borough Council and the Royal Borough of Windsor & Maidenhead.

Bracknell Forest Council
The Council provided the Trust with detailed feedback on its draft Quality Account. Whilst the majority of this related to specific questions and points; at a summary level, the feedback focused upon the following:

- Concern over the affect of winter pressures upon A&E and seeking assurances of how the Trust will manage this in future;
- Concern over the number of cancelled operations and procedures in year;
- The need to focus upon providing high quality outcomes from complaint and incident investigations;
- Recognition of the disappointing patient survey results for 2012/13 and that aspects of the staff survey, whilst indicating slight improvement overall, remain concerning.

Slough Health Scrutiny Panel
The Health Scrutiny Panel noted that the incident reporting figures now included the reporting of near misses, however, felt that it would be useful to have this broken down in order to understand which are near misses and which are full incidents. In disucssing the cancellation of operations, Members questions the reasons behind this and whether more information could be provided in order to understand why operations are being canceled in order to judge whether there was an issue which needed resolving.

The Panel also felt more information could be provided on the following issues in order to give the public more understanding of the quality issues involved and how they were being dealt with: cardiac arrests, improving the outcomes around discharged procedures, complaints relating to communication and professional conduct and IT infrastructure improvements. Members also suggested that a table setting out the targets for the coming year should be included early in the document.

Statement of Directors' responsibilities in respect of the Quality Account

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Account (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the Quality Account.

In preparing the Quality Account, Directors are required to take steps to satisfy themselves that:

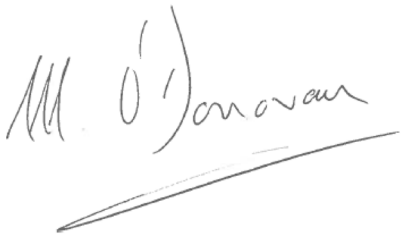
- The content of the Quality Account meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual;
- The content of the Quality Account is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2012 to March 2013;
    - Papers relating to quality reported to the board over the period 2012 to March 2013;
    - Feedback from the commissioners dated 23 May 2013;
    - Feedback from governors dated 15 May 2013;
    - Feedback from Healthwatch (x2) dated 23 and 28 May 2013;
    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated for the year 2011/12 and the information available at the time of writing for 2012/13;
    - The 2012 national patient survey;
    - The 2012 national staff survey;
    - The Head of Internal Audit"s draft annual opinion over the Trust's control environment dated 15 May 2013;
    - Care Quality Commission quality and risk profiles dated March 2013.

- The Quality Account presents a balanced picture of the NHS foundation trust's performance over the period covered;
- The performance information reported in the Quality Account is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, 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 Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Account has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Account (available at www.monitor-nhsft.gov.uk/annualreportingmanual).

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

By order of the Board

Philippa Slinger
Chief Executive Officer



Mike O'Donovan
Chairman

Date: 28 May 2013