Alder Hey Children's NHS
NHS Foundation Trust

Quality Account
2013/14

Inspired by Children

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Quality Report 2013/14

'Constantly Improving' - Alder Hey's Commitment to Quality

Statement on Quality from Louise Shepherd, Chief Executive

In the last two years much progress has been made at Alder Hey with regard to continuous quality improvement but there is still much more to do as we move toward the opening of our new hospital in 2015 and plan for the unique opportunities that this will bring. Our approach to quality is set out in two strategic documents, the Quality Strategy and the Patient Experience Strategy, supported by a set of Quality Aims that were developed in early 2013 with our patients and their families, our staff and our governors.

Alder Hey's Quality Aims are focused on working to achieve three main outcomes:

- Patients should not suffer harm in the Trust's care.
- Patients should receive the most effective, evidence-based care.
- Patients should have the best possible experience.

When signing up to these aims, the Board and senior leaders knew that there was a lot to do in order to achieve them and we recognised that they are very ambitious, but we believe that they are a reflection of the ambition of our staff. The Board is fully committed to supporting our teams to fulfil those ambitions and to continue to be justly proud of the work they do.

There are challenges that we have to meet every day to make sure we make progress towards our aims. Recently, the Trust has seen a significant rise in admissions and in the dependency of the patients it treats. This means at times it is difficult to make sure that resources, particularly staff, are available in sufficient numbers with the right skills to keep up with the change in patient demand. Last year, Alder Hey invested heavily in nursing staff, doctors and other support staff, which is not something that many organisations have been able to do in the current economic climate.

Strong clinical leadership is vital to delivering quality improvement and 2013/14 has seen the ranks of our clinical directors and clinical service group leads bolstered. Together with other members of the Senior Leadership Team, they will drive the charge to deliver the Quality Aims and will work with staff, patients and their families to ensure they are involved in changes and developments.

The clinical leaders also contribute to the quality walkabout programme which each month focusses on one of the Clinical Business Units. In recent months this has been expanded to ensure that more departments are visited and more staff have the opportunity to demonstrate their good work and share concerns.

We recognise that quality improvement is a journey and in the coming year we will encourage and enable as many staff as possible to contribute and get involved. We plan to launch our Quality Manifesto, in order to underline the Trust's commitment to patient safety and share the ground breaking work being done by staff to give patients the very best care and best experience possible.

As Chief Executive I am confident that the information set out in the following report is accurate and a fair reflection of the key issues and priorities that clinical teams have developed within their services. The Board remains fully committed to supporting those teams in every way they can to continuously improve care for our children and young people.

Louise Shepherd

LOUISE SHEPHERD
CHIEF EXECUTIVE
23RD MAY 2014

Priorities for Improvement and Statements of Assurance From the Board

Priorities for Improvement

Progress made in 2013/14 and previous years against quality improvement priorities identified in last year's Quality Report can be found on page 19.

Priorities for Improvement 2013/14

The Alder Hey Quality Strategy utilises the definition of 'Quality' as set out in the Darzi Report, High Quality Care for All (2008) with its three main elements of patient safety, clinical effectiveness and patient experience. The purpose of the strategy is to ensure that we capture the "essence" of quality and translate this effectively by bringing together national policy, strategic direction and regulatory, financial and governance requirements with our stated imperative of providing safe, effective and world class healthcare for each and every child for whom we care, within a culture of openness and continual improvement.

Children, young people and their families are at the centre of this strategy. The Trust Board in consultation with staff, patients, governors, Healthwatch organisations and commissioners have identified key priorities for improvement which have been derived from national and regional priorities, the Trust's performance against quality and safety indicators, risk trend analyses and patient and public feedback. The Trust has agreed that further improvements should be made in relation to the 2013/14 developmental Quality Aims and an additional six developmental Quality Aims have been identified as a priority for improvement for 2014/15:

Priority	Aim
Priority 1: Patient Safety	**Aim - Patients will not suffer harm in our care.** 1. No hospital acquired infection. 2. No drug errors resulting in harm. 3. No hospital acquired pressure ulcers. 4. No avoidable deaths. 5. No unexpected deterioration. 6. No "Never Events".
Priority 2: Clinical Effectiveness	**Aim - Patients will receive the most effective, evidence-based care.** 1. No acute (unplanned) readmission within 48hrs of discharge (including under 4's). 2. All patients treated following recognised protocols/pathways/guidelines. 3. No acute admission of patients with long term conditions (epilepsy, diabetes, asthma, lower respiratory disease). 4. Patients will be discharged on planned day of discharge. 5. Patient outcome will be within national defined parameter.
Priority 3: Patient Experience	**Aim - Patients will have the best possible experience (as reported by patients and/or families).** 1. Patients and families will have received information enabling them to make choices (involvement in care). 2. Patients and families will be treated with respect. 3. Patients and families will know the planned date of discharge. 4. Patients and families will know who is in charge of their care (lead consultant or key worker-long term conditions, mental health). 5. Patients will engage in play and learning.

The Board will monitor progress against these priority areas through the Clinical Quality Assurance Committee. Progress will be reported to commissioners through Clinical Performance and Quality Group meetings and to patients, careers and Healthwatch members through a series of engagement events. The Trust continues to develop the skills of the workforce to deliver quality improvements, through the utilisation of a variety of improvement methodologies.

Statements of Assurance From the Board

Review of Services

During 2013/14 Alder Hey has provided 27 NHS services. Alder Hey has reviewed all the data available to them on the quality of care in all of these services. The income generated by the NHS services reviewed in 2013/14 represents 100% of the total income generated from the provision of NHS services by Alder Hey for 2013/14.

Participation in Clinical Audits and National Confidential Enquiries

Clinical Audit is a key aspect of assuring and developing effective clinical pathways and outcomes.

National clinical audits are either funded by the Health Care Quality Improvement Partnership (HQIP) through the National Clinical Audit and Patient Outcomes Programme (NCAPOP) or funded through other means. Priorities for the NCAPOP are set by the Department of Health with advice from the National Clinical Audit Advisory Group (NCAAG).

During the reporting period 1st April 2013 to 31st March 2014, 14 national clinical audits and one national confidential enquiry covered NHS services that Alder Hey Children's NHS Foundation Trust provides.

During that period Alder Hey Children's NHS Foundation Trust participated in 100% 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 Alder Hey Children's NHS Foundation Trust was eligible to participate in during the reporting period 1st April 2013 to 31st March 2014 are contained in the table below.

The national clinical audits and national confidential enquiries that Alder Hey Children's NHS Foundation Trust participated in, and for which data collection was completed during the reporting period 1st April 2013 to 31st March 2014, 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.

Participation in National Clinical Audits and National Confidential Enquiries During 2013/14

Audit	Participation	% Cases Submitted
Children		
Paediatric Asthma (British Thoracic Society)	Yes	Submitted 67 cases, which was 100% of cases available.
Paediatric Bronchiectasis (British Thoracic Society)	Yes	Submitted 17 cases, which was 100% of cases available.
Childhood Epilepsy (RCPH National Childhood Epilepsy Audit)	Yes	Audit continuing in 2014/15. Submitted 25 cases up to 31/03/2014.
Paediatric Intensive Care (PICANet)	Yes	Submitted 1,103 records, which was 100% of cases available.
Potential Donor Audit (NHS Blood and Transplant)	Yes	Submitted 100% of cases available.
Moderate or Severe Asthma in Children (Care Provided in Emergency Departments) (College of Emergency Medicine)	Yes	Data submission is continuing untill 14/04/2014.
Acute Care		
Severe Trauma (Trauma Audit and Research Network)	Yes	Submitted 165 cases, which was 100% of cases available.
Cardiac		
Cardiac Arrest (National Cardiac Arrest Audit)	Yes	Submitted 13 cases, which was 100% of cases available.
Paediatric Cardiac Surgery (National Institute for Cardiovascular Outcomes Research (NICOR) Congenital Heart Disease Audit)	Yes	Submitted 347 cases, which was 100% of cases available for the period 01/04/2013 -30/0920/13. Data for 01/10/2012 - 31/03/2014 will be submitted by 05/05/2014.
Cardiac Arrhythmia (Cardiac Rhythm Management (CRM)	Yes	Submitted 24 pacemaker, 1 Implantable defibrillator (ICD) and 32 electrophysiology patients to the CRM system, which was 100% of cases available.
Long Term Conditions		
Ulcerative Colitis and Crohn's Disease (National IBD Audit)	Yes	Submitted 50 cases, which was 100% of cases available.
Paediatric Diabetes (RCPH National Paediatric Diabetes Audit)	Yes	Submitted 999 records, which was 100% of cases available.
Renal Replacement Therapy (UK Renal Registry)	Yes	Submitted 45 cases, which was 100% of cases available.
Red Cell Issue Trace Audit (National Comparative Audit of Blood Transfusion)	Yes	Submitted 26 cases, which was 100% of cases available.

National Confidential Enquiries	Participation	% Cases Submitted
Confidential Enquiry into Major Burns in Children (CEMBIC)	Yes	Submitted 2 cases, which was 100% of cases available.

Actions Arising From National Clinical Audits

The reports of 14 national clinical audits were reviewed by the provider in the reporting period April 1st 2013 to March 31st 2014 and Alder Hey Children's NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Actions Taken/To Be Taken As a Result of National Clinical Audits in 2013/14

National Clinical Audit	Actions
Paediatric Asthma (British Thoracic Society)	• Reports expected in April 2014.
Paediatric Bronchiectasis (British Thoracic Society)	• Reports expected in April 2014.
Childhood Epilepsy (RCPH National Childhood Epilepsy Audit)	• The National Epilepsy Audit is continuing into 2014/15.
Paediatric Intensive Care (PICANet)	• The National Audit Report was reviewed and discussed on the Paediatric Intensive Care Unit (PICU); Alder Hey is meeting the majority of the audit standards.
Potential Donor Audit (NHS Blood & Transplant)	• The National Audit Report is to be reviewed at the next Organ Donation Committee meeting. However, it is unlikely that we will be able to draw conclusions as paediatric practice is quite different to adult practice.
Moderate or Severe Asthma in Children (Care Provided in Emergency Departments) (College of Emergency Medicine)	• Audit continuing in 2014/15. • Data collection period extended to 14/04/2014.
Severe Trauma (Trauma Audit and Research Network)	• We are achieving above the audit standards. • Actions from the TARN document are discussed at the Trust Trauma Committee and North West Children's Major Trauma Network Governance meeting. • An audit of length of time to CT scan is continuing into 2014/15.
Cardiac Arrest (National Cardiac Arrest Audit)	• The National Audit Report was discussed at the Trust Resuscitation Committee. • No action plan was required as we are achieving above the audit standards.
Paediatric Cardiac Surgery (NICOR Congenital Heart Disease Audit)	• The National Audit Report was reviewed at the Risk and Governance Meeting and Alder Hey is achieving above the audit standards. An action plan was not required as we are already meeting the audit standards.
National Cardiac Rhythm Management Audit (NICOR)	• The National Audit Report was reviewed and Alder Hey is meeting the audit standards.
Ulcerative Colitis and Crohn's Disaese (National IBD Audit)	• The national reports for both the inpatient care audit and inpatient experience questionnaires will be launched at the British Society of Gastroenterology meeting in June 2014. • Alder Hey reports will be made available for review two weeks prior to this.
Diabetes (RCPH National Paediatric Diabetes Audit)	The National Audit Report was reviewed and discussed at both the Diabetes Multi-Disciplinary Team (MDT) meeting and the Clinical Business Unit (CBU) audit meeting. An action plan has been agreed: • To ensure effective and improved data collection in the future a multi-disciplinary team has explored measures to improve the quality of the data including the introduction of diabetes specific software. • Audit internal HbA1c analysis using the same data, to report accurate data internally including the number of patients HbA1c <58mmol/mol and >75mmol/mol. • Modify and reinforce the existing high HbA1c policy and DNA policy.
Renal Replacement Therapy (UK Renal Registry)	• The Renal Registry National Audit Report was reviewed. • We are meeting the audit standards so no action plan was required. • We have implemented a new Renal IT system that will improve data returns and allow more accurate comparisons.
National Comparative Audit of Blood Transfusion	• Data submission is continuing in 2014/15.

Actions Taken/To Be Taken As a Result of Local Clinical Audits in 2013/14

There were a total of 165 local audits registered in the reporting period 1st April 2013 to 31st March 2014. There are 37 (22%) local audits completed. There are 118 (72%) audits that will continue in 2014/15. There are nine (5%) audits not yet started and one audit has been cancelled (1%).

The reports of the completed local clinical audits were reviewed by the provider in the reporting period April 1st 2013 to March 31st 2014 and examples of the outcomes are listed below.

National Clinical Audit	Actions
Visual Analgesia Stickers for Home Dispensing	This was discussed at a ward meeting and amongst the users. **Action/Recommendation** • All of the nurse led discharge patients where analagesia is given will now have a visual aid sticker attached with an indication of when the medication was given and is next due.
Complications of Mastoid Surgery - Is Daycase Mastoid Surgery Feasable?	Presented at Anaesthetic Update meeting February 2014. **Action/Recommendation** • Develop a pathway for daycase admissions following presentation to ENT surgeons. • Re-audit following implementation.
Specialist Medicine Pathway - Patient Experience	Presented at Specialist Medicine Pathway Group January 2014. **Action/Recommendation** • To develop a document to agree standards based on feedback from parents/ patients, and circulate more widely. • Develop a proposal to improve the care pathway of admissions from and discharge to District General Hospitals. • Propose a 'one stop' / 'park and ride' model. • Re-audit in 12 months.
Microtia Audit	Presented at Royal Society of Medicine, Undergraduate Plastic, reconstructive and Aesthetic Research meeting, London, November 2013. **Action/Recommendation** • Continue outcome monitoring as routine prospective data collection. • Re-audit.
Telephone Audit of Analgesia Post Tonsillectomy	Submitted to Royal College Paediatrics and Child Health spring meeting. **Action/Recommendation** • Conduct a study of post operation analgesia in children following tonsillectomy. • Re-audit when the research is complete and disseminated, to see if national practice has changed.
Lateral Condyle Pin Site Complications: a Re-Audit	Presented at a local Orthopaedic Department Governance meeting in February 2013. **Action/Recommendation** • To develop a more standardised dressing practice. • Re-audit.
Ankle Diastasis at Alder Hey Children's Hospital	Presented at Regional Registrar meeting in December 2013 and nationally at the British Limb Reconstruction Society in March 2014. **Action/Recommendation** • Develop a database with our rheumatology colleagues to get a better understanding of the efficacy of the procedure. • Re-audit in two years.
Audit to Review the Investigations For Development Delay With Alder Hey Community Department	Presented September 2013 at local team meeting and some audit outcomes were presented at an International meeting in Newcastle - European Academy of Childhood Disability (EACD) 2013. **Action/Recommendation** • Develop a pro-forma for data collection. • Develop a plan for introduction of microarray testing in first line investigations. • Alter the current first line investigations to include microarray testing instead of chromosomes and to add ferritin. • Update guidance. • Re-audit compliance in two years.

National Clinical Audit	Actions
Occupational Therapy Clinical Notes Audit	Presented at Occupational Therapy Team staff meeting in February 2013. **Action/Recommendation** • Re-draft consent forms. • Re-audit.
Concordance with NICE Guidelines (TA188) Regarding the Use of Growth Hormone (GH) in Childhood in a Tertiary Endocrine Unit	Presented at a Team Meeting May 2013. **Action/Recommendation** • Develop a proforma to outline the dose of growth hormone and the indication for treatment with growth hormone to aim for greater concordance with NICE guidance. • Re-audit in one year.
An Audit to Compare Rapid RSV Test Kit to Real-Time PCR for RSV	Presented at European Society for Paediatric Infectious Diseases (ESPID) 2014. **Action/Recommendation** • Rapid Respiratory Syncytial Virus (RSV) to be used for general paediatrics. • Real-time PCR (Polymerase Chain Reaction) should be used for critical care patients.
Patient/Family Experience of The Plastic Trauma Service	Presented at Alder Hey Hospital, Plastic Surgery Clinical Governance Meeting January 2014. **Action/Recommendation** • Re-audit as the sample size was too small.
Audit of the Clinical Impact of Multiplex PCR and 16s rDNA Testing in Samples Taken From Sterile Sites in Children	Submitted to European Society for Paediatric Infectious Diseases (ESPID) 2014. **Action/Recommendation** • Only do Kingella Kingae PCR (Polymerase Chain Reaction) in children aged under three years.
Transfusion Management of Patients Undergoing Fronto-Orbital Advancement (FOAR) and Remodelling Surgery	Presented September 2013 Department of Anaesthesia Update meeting. **Action/Recommendation** • Continue to use Thromboelastography (TEG) to manage the correction of coagulopathy associated with massive haemorrhage during FOAR surgery. • Use saline and not heparinised saline to flush lines intraoperatively. • Use TEG to monitor and manage coagulopathy due to massive haemorrhage during FOAR surgery.
Body Mass Index Weight and Height in Paediatric Surgical Admissions: Are Children Evaluated or Screened for Obesity Prior to Anaesthesia and Surgery? (NICE CG43)	The guideline and report contents were presented to the hospital on the following dates: November 2012 Anaesthetics Department. December 2012 Grand Round presentation and January 2013 Pharmacy Department. **Action/Recommendation** • Develop a clear referral pathway for children with obesity working in partnership with our G.P. colleagues.
Audit of Discharges From the Dewi Jones Unit: Jan 2012 - April 2013	Presented to Ward Manager in October 2013. **Action/Recommendation** • Revise the pathway. • Provide weekly updates on progress of discharge reports. • Provide quarterly updates to commissioners. • Re-audit one year.
Audit of Outcomes of Fundoplication +/- Vagotomy/ Pyloroplasty (FVP) for Gastro Oesophageal Reflux	**Action/Recommendation** • To present the results at an international paediatric surgery meeting.
Audit on Day Case Cardiac Catheters	Presented in November 2013 as poster at British Congenital Cardiac Association. Plan to present locally in monthly audit meeting. **Action/Recommendation** • Encourage the team to discharge on the same day of the procedure. • Re-audit one year.

National Clinical Audit	Actions
Audit of Deliberate Self Harm Cases Presenting to Alder Hey A&E (NICE QS34)	Presented in November 2013 to Alder Hey Accident and Emergency Department consultants and nurses. **Action/Recommendation** • Re-audit in one year.
Audit of Practice of Section 136 Assessment at Alder Hey A&E	Presented in November 2013 to Alder Hey Accident and Emergency Department consultants and nurses. **Action/Recommendation** • Use a centralised book to comply with Trust policy. • Re-audit in one year.
Audit of Use of Section 136 Room Located in Alder Hey A&E Department	Presented November 2013 to Accident and Emergency Department nurses and doctors. **Action/Recommendation** • Develop a guideline for the use of section 136 room. • To clearly document the reasons of the use of section 136 room in each case. • Re-audit in one year.
Intravenous Fluid Use and Monitoring in Alder Hey	Presented at the Ground Round July 2013. **Action/Recommendation** • Introduce a new fluid and revised guideline. • Re-audit following implementation.
Audit of the Usage of Infatrini Peptisorb	Presented November 2013 at the Dietetic staff meeting and a summary of the results of the audit are now electronically availabe for dietitians to refer to. **Action/Recommendation** • Produce guidelines on approapriate investigations to be carried out in advance of commencing Infatrini Peptisorb including faecal fat and reducing substances.
Does a Delay in Plastic Surgery Operation Lead to An Increase in Infection Rate Amongst Minor Trauma Patients?	Presented January 2014 to the plastic surgery department at a clinical governance meeting. **Action/Recommendation** • Re-audit in one year as delay to theatre did not impact infection rates.
Consent for Common Paediatric Surgery Conditions - How Well Do We Document Potential Complications?	Presented December 2013 at the Department of Surgery audit meeting. **Action/Recommendation** • To discuss at the general surgery consultant meeting whether we should specifically refer to the complications/risks as given on the Experts in Informed • Consent (EIDO) information sheets, the alternative would be pre-printed consent forms. • Re-audit in six months.
Feverish Illness in Children: Management By the Paediatric Specialist	Presented January 2014 at the Emergency Department senior staff meeting. **Action/Recommendation** • Re-audit in one year as no actions required.
Screening for Children With Down Syndrome in Alder Hey	Presented at a local meeting December 2013. **Action/Recommendation** • Keep a reminder of the national guidelines for annual review in every case note. • Include the review of sleep apnoea in the regular review. • Plot and document the centiles on the Down's chart. • Familiarise staff with the significance of mildly deranged Thyroid Function Tests. • Recommend a regular eye check can be done by high street optician unless otherwise indicated. • Re-audit in one to two years.

National Clinical Audit	Actions
Management of Open Tibial Fractures	Presented June 2013 at local meeting. **Action/Recommendation** • No actions as guidelines are being followed. Antibiotics are being administered. Documentation in Accident and Emergency Department is good. • Surgical debridement is appropriate.
A New Pathway for Propranolol Use In Infantile Haemangiomas	**Action/Recommendation** • Re-audit.
Audit on Completion of Cardiomyopathy (CM) Screen	Presented at a local meeting February 2014. **Action/Recommendation** • Every patient with suspected Cardiomyopathy should have a proforma in their notes and all the investigations should be completed and documented on it. • Re-audit in two years.
Review of Prescribing in St Helen's and Knowsley Re ADHD Medication (NICE QS)	**Action/Recommendation** • Meeting all standards no action required. • Re-audit in one year.
Audit of Systemic Drug Use in Paediatric Eczema	Presented July 2013. **Action/Recommendation** • Better documentation of discussion around immunisation. • Use of specific eczema severity score. • Improve urinalysis in ciclosporin group. • Re-audit.
Is Hip Distraction Post Femoral Head Collapse in Severe Slipped Upper Femoral Epiphysis a Viable Treatment Option?	Presented at the British Limb Reconstruction Society meeting 2014 (Dublin). **Action/Recommendation** Improve the timing of surgery: • At initial presentation. • Before head collapse. • A larger Prospective Study is needed in the future.
Strict Criteria For Accepting Closed Reduction in Developmental Dysplasia Of the Hip. Does it Influence the Rate of Osteonecrosis?	Presented at the British Society for Children's Orthopaedic Surgery (BSCOS) meeting 2014 (Aberdeen). **Action/Recommendation** • In this study the Avascular Necrosis (AVN) rate is low and we believe this is due to following the strict criteria, which also helps us decide whether closed or open reduction should be undertaken.

Participation in Clinical Research

The number of patients receiving NHS services provided or subcontracted by Alder Hey Children's NHS Foundation Trust (Alder Hey) in 2013/14 that were recruited to participate in NIHR Portfolio adopted clinical research was 4,238.

All research is governed by the EU Clinical Trial Directive, UK Ethics Committees and the Trusts R&D Office who carry out governance checks to provide organisational permission. International Research and Education is one of the Trust's four strategic pillars of excellence. Furthermore, the Alder Hey/University of Liverpool integrated ten year Research Strategy states that "Every child (should be) offered the opportunity to participate in a research study/clinical trial". The Trust is a member of Liverpool Health Partners (LHP), a consortium of seven hospitals, the University of Liverpool and the Liverpool School of Tropical Medicine working together to provide a world class environment for research and health education. As a significant stakeholder in LHP, Alder Hey demonstrates a strong commitment to contributing to evidence-based, cutting edge healthcare aimed at improving quality of care whilst holding patient safety, dignity and respect at the centre of everything we do. Being an organisation undertaking high quality patient centred research means that Alder Hey contributes to the health and wealth of Liverpool and the UK as a whole as well as having an international impact on treatments developed for children. The infrastructure of expertise available

at Alder Hey for setting up and successfully delivering clinical research are led and managed by a dedicated team who form the Clinical Research Business Unit (CRBU).

Our clinical staff and associated academics lead and contribute to studies of the latest and new treatment options, genetic profiling of diseases and research looking at drug safety including adverse drug reactions (side effects).

Alder Hey was involved in recruiting patients to 4,238 open NIHR portfolio adopted clinical research studies during 2013/14 which is significant for a Trust of its size. Whilst some studies report outcomes fairly quickly, most will not be ready for publication for a few years. The majority (3,805 or 90%) were research in the area of Medical Specialties reflecting the prevalence of available research studies in these specialties locally and nationally.

01/04/2012 to 31/03/2013 (Q1, Q2, Q3 & Q4 Excluding Mar 2014)

	NIHR Studies	Number of Participants	Non-NIHR Studies	Number of Participants
SG1 (Oncology, Haematology, Palliative Care)	24	264	11	46
SG2 (Nephrology, Rheumatology, Gastro, Endocrinology, Dietetics)	45	249	12	146
SG3 (Respiratory, Infectious Diseases, Allergy, Immunology, Metabolic Diseases)	23	3292	11	121
SG4 (A&E, Gen Paeds, Diabetes, Dermatology, CFS/ME)	8	125	1	0
SG5 (CAMHS Tier 3 and 4, Psychological Services & Dewi Jones)	1	0	2	0
SG6 (Comm. Child Health, Safeguarding, Social Work Dept., Comm Clinics, Neurodisability Education, Fostering, Adoption, Audiology)	2	42	1	7
SG7 (PICU, HDU, Burns)	1	4	8	24
SG8 (Theatres, Day Case Unit, Anaesthetics Pain Control)	0	0	2	28
SG9 (Gen Surgery, Urology, Gynae, Neonatal)	4	65	2	3
SG10 (Cardiology, Cardiac Surgery)	1	4	0	0
SG11 (Orthopaedics, Plastics)	0	0	0	0
SG12 (Neurology, Neurosurgery, Craniofacial, LTV)	13	118	5	12
SG13 (Specialist Surgery, ENT, CL&P, Ophthalmology, Maxillofacial, Dentistry, Orthodontics)	4	62	3	197
SS1 (Radiology)	2	13	3	2
SS2 (Pathology)	0	0	0	0
SS3 (Pharmacy)	0	0	2	22
SS4 (Therapies, EBME, Central Admissions, Bed Management, Medical Records, Generic Outpatients)	0	0	0	0
NON-CBU	1	0	0	0
CNRU	0	0	3	37
RBU	1	0	0	0
Non Classified	0	0	1	0
TOTAL	**130**	**4238**	**67**	**645**

The Quality Account deals with research activity during the 2013/14 period. In addition to this, the CRBU published performance data on the Trust website, indicating the time it takes to set up and study and the time taken to recruit the first patient once all permissions have been granted. Alder Hey performs well in this respect. Furthermore, over 80% of studies conducted at Alder Hey recruit the agreed number of patients within a set time and to agreed targets. In September 2012 Alder Hey opened a National Institute for Health Research Clinical Research Facility (CRF). This was a capital project supported with investment from the Trust and is a clinical area utilised purely for research patients providing a dedicated research environment. This resource helps facilitate research by providing a bespoke location for research on a day to day basis and has successfully been used to care for research participants overnight who need regular intervention or tests on a 24hour basis. One of the many advantages of having a fully operational CRF is that it will enable investigators to not only undertake later phase research studies but also to undertake more complex and earlier phase studies (experimental medicine types of activity) dealing with developing new cutting edge medicines and technologies which are often lacking in children's healthcare. The CRF will lead to improvement in patient health outcomes in Alder Hey, demonstrating a clear commitment to clinical research which will lead to better treatments for patients.

There were over 350 members of clinical staff participating in research approved by a Research Ethics Committee at Alder Hey during 2013/14. These included consultants, nurse specialists, scientists, clinical support staff and research nurses from across all Clinical Business Units.

Over the past four years the Trust has witnessed a growth in commercially sponsored studies. There are currently 32 commercial studies open to recruitment and much focus on the use of novel monoclonal antibodies (mAbS) or disease modifiers. These interventions have been used primarily in Rheumatology and Oncology but are becoming available in other sub-specialities such as Respiratory Medicine and Diabetes. They work by acting on the immune system to overcome the cause of the disease rather than treating the symptoms. Significant quality of life improvements have been witnessed, particularly in Rheumatology patients treated with mAbS, leading to increased mobility and a reduction in pain and inflammation. These drugs are now being licensed for use in children for the first time ever. Several patients at Alder Hey have been the first global recruits into some studies and as such, this bodes well as it demonstrates Alder Hey's commitment to supporting the speedy set up of clinical trials with the support of the Trust R&D office and the NIHR Medicines for Children Local Research Network. The Trust has an established critical mass of research activity in Pharmacology, Oncology, Rheumatology, Infectious Diseases, Respiratory, Endocrinology/Diabetes, Critical Care and Neurosciences but is witnessing a growth in research activity in Gastroenterology, Nephrology, Emergency Medicine and Community Paediatrics.

For more information on the research portfolio at Alder Hey please visit: www.alderhey.nhs.uk/research

Use of the Commissioning for Quality and Innovation Framework (CQUIN) Payment Framework

A proportion of Alder Hey's income in 2013/14 was conditional upon achieving quality improvement and innovation (CQUIN) goals agreed between Alder Hey and any person or body entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for CQUIN Payment Framework. During 2013/14, these commissioning bodies consisted of Liverpool CCG and consortia North West CCG partners for non-specialist services and Cheshire, Wirral and Warrington Area Team (on behalf of NHS England) for specialist services.

For 2013/14 the baseline value of CQUIN was £3.2m which was 2.5% of the total contract value. This means that if Alder Hey did not achieve an agreed quality goal then a percentage of the total CQUIN money would be withheld. For 2013/14 Alder Hey expect to receive 99% of the CQUIN money, due to achieving an amber rating for one target.

Local Commissioner CQUINs 2013-14

Domain	Indicator	Indicator Description	Target	Weighting	Financial Value	End of Year Performance
Safety, Effectiveness and Patient Experience	Paediatric Safety Scan	Development of a National Paediatric Safety Scan prevalence tool to measure paediatric harm. The four areas which will be assessed are: skin integrity, extravasation, early warning risk assessment and pain.	N/A	0.3%	£161,400	Fully achieved
Safety, Effectiveness Patient Experience and Innovation	Ensuring Patient Quality and Safety Across the Health Care System	Trust to reflect Francis Report and its recommendations.	Progress against action plan	0.2%	£107,600	Fully achieved
Safety, Effectiveness Patient Experience and Innovation	Communication: Inpatients	98% of Discharge Summaries to be electronically constructed, integrated TTO's and contains the recommended minimum data set.	98%	0.6%	£322,800	Fully achieved
		95% of Discharge Summaries to be sent from all ward areas to general practice within 24 hours.	95%			
		95% of all patients to receive a copy of their Discharge Summary on day of discharge.	95%			
	Communication: Outpatients	98% of Outpatient correspondence to be electronically constructed, integrated TTO's and contains the recommended minimum data set.	98%			
		95% of Outpatient Correspondence to be sent from all out-patient services to general practice within two weeks of patients appointments.	95%			

Domain	Indicator	Indicator Description	Target	Weighting	Financial Value	End of Year Performance
Safety, Effectiveness Patient Experience and Innovation	Communication: A&E	Submission of Implementation Plan for A&E patient correspondence. Interoperability of Trust system with Merseyside Messaging Hub. Minimum dataset agreed and implemented.				Partially achieved: 1 quarter extension provided
		All A&E correspondence to be sent to General Practice within 24 hours subject to agreed roll out plan.	Q3 - 75% target			
	Communication: Day Cases	Submission of Implementation Plan for Day Case patient correspondence from K1 Surgical. Interoperability of Trust system with Merseyside Messaging Hub.	95%			
		All day case correspondence to be sent to General Practice within 24 hours. Subject to agreed roll out plan.	Q3 - pilot Q4 - deployment			
Safety, Effectiveness, Patient Experience and Innovation	Unplanned Admissions	Reduction in unnecessary use of the Emergency Department at Alder Hey.	Submission provider report	0.60%	£322,800	Fully achieved
Safety, Effectiveness, Patient Experience and Innovation	Transition from CAMHS to Adult Mental Health Services	Improve the transition for young people from CAMHS. Development of an integrated transitional protocol and planning arrangements between services to improve and enhance the patient's journey from children's to adult service and to eliminate risk.	Submission provider report	0.6%	£322,800	Fully achieved
Safety, Effectiveness, Patient Experience and Innovation	Infection Prevention	Reduction in infections prevalent in children's hospitals.	Submission provider report	0.2%	£107,600	Fully achieved

North West Specialised Commissioning Team CQUINs

CQUIN Pick List

Domain	Indicator	Indicator Description	Target	Weighting	Financial Value	End of Year Performance
Clinical Effectiveness, Safety and Innovation	Highly Specialised Services Clinical Outcome Collaborative Audit Workshop and Provider Report	Craniofacial services clinical outcome collaborative audit workshop and Provider Report.	Submission Provider Report	0.13%	£95,007	Fully achieved
Patient Experience	Specialised Cancer: Access To and Impact Of CNS Support On Patient Experience	Access to and impact of clinical nurse specialist support on patient experience.	Survey and report	0.13%	£95,007	Fully achieved
Safety and Effectiveness	HIV - Registration and Communication With GPs About the Care of HIV Patients	Communication with GPs about the care of HIV patients.	100% of those disclosed	0.13%	£95,007	Fully achieved
Clinical Effectiveness, Safety and Innovation	Haemophilia: Joint Scoring	Joint score in severe and moderate Haemophilia A and B (patients aged over 4 years of age).	50%	0.13%	£95,007	?
Clinical Effectiveness and Patient Experience	CAMHS Tier 4 - Optimising Pathways	Optimising pathways.	95%	0.28%	£68,210	Fully achieved
	CAMHS Tier 4 - Care Programme Approach	Improving Patient Experience Through Ensuring Effective care programme Approach (CPA).	Submission provider report	0.28%	£68,210	Fully achieved
	CAMHS Tier 4 - Physical Health	Improving physical healthcare and wellbeing of patients (Perinatal).	100%	0.28%	£68,210	Fully achieved
Safety, Clinical Effectiveness and Patient Experience	Major Trauma - Improving Outcomes of Major Trauma Orthopaedic Injuries	Improving outcomes in major trauma orthopaedic injuries.	100%	0.13%	£95,007	Fully achieved
Clinical Effectiveness, Patient Experience and Patient Safety	Local Cluster CQUINs (see local list)			0.13%	£95,007	

Dashboards						
Clinical Effectiveness, Patient Experience and Patient Safety	Dashboards	BMT	Submission to scheme.	0.12%	£87,699	Fully achieved
		Haemophilia	Submission to scheme.	0.12%	£87,699	Fully achieved
		Burns	Submission to scheme.	0.12%	£87,699	Monitored through IBID
		Cystic Fibrosis	Submission to scheme.	0.12%	£87,699	Fully achieved
		HIV	Submission to scheme.	0.12%	£87,699	Monitored through HPA
		Immunology and Allergy	Submission to scheme.	0.12%	£87,699	Fully achieved
		Paediatric Intensive Care	Submission to scheme.	0.12%	£87,699	Fully achieved
		Paediatric Neurosurgery	Submission to scheme.	0.12%	£87,699	Fully achieved
		Major Trauma	Submission to scheme.	0.12%	£87,699	Monitored through TARN
		CAMHs Tier 4	Submission to scheme.	0.12%	£87,699	Fully achieved
National CQUINs						
Clinical Effectiveness, Patient Experience and Safety	Paediatric Safety Scan		N/A	0.14%	£102,315	Fully achieved
Operational Delivery Networks				0.10%	£73,088	

Further details of the agreed goals for 2013/14 and for the following 12 month period are available online at: http://www.monitornhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275

Statements From the Care Quality Commission (CQC)

Alder Hey is required to register with the Care Quality Commission and its current registration is in place for the regulated activities of: diagnostic and screening procedures, surgical procedures and treatment of disease, disorder or injury. Alder Hey remains registered without conditions.

The Care Quality Commission has not taken any enforcement action against Alder Hey during 2013/14.

Alder Hey has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2013/14:

- Ionising Radiation.
- Outcome 1 (Respecting and involving people who use services), outcome 4 (Care and welfare of people who use services), outcome 7 (Safeguarding people who use services from abuse), outcome 14 (Supporting workers) and outcome 16 (Assessing and monitoring the quality of service provision).
- Outcome 8 (Cleanliness and Infection Control), outcome 11 (Safety, availability and suitability of equipment) and outcome 13 (Staffing).
- Registration as a provider of the regulated activity of: assessment or medical treatment for people detained under the Mental Health Act 1983.

Ionising Radiation by the Care Quality Commission related to the Ionising Radiation (Medical Exposure) Regulations 2000 and amendments made in 2006, known as IRMER. Minor concerns were raised in relation to establishing the pregnancy status of female patients of childbearing age. An action plan was developed by the Radiology Department following the CQC visit; actions completed include: ensuring all clinical trials requiring exposure to ionising radiation now have the protocols sent to the Radiation Protection Advisors (IRS Ltd) for discussion and to agree dose constraints. This has now been completed. An audit of the procedure for the clinical evaluation of dental images was carried out and completed in February 2013. Further rounds of audit have been started and are progressing in 2014. Work is continuing to develop a Trust wide system for the checking of pregnancy status.

The Trust was subject to an unannounced responsive inspection in December 2013 with specific reference to the operating theatres department, across the following standards:

- Outcome 4: Care and welfare of people who use services
- Outcome 14: Supporting workers
- Outcome 16: Assessing and monitoring the quality of service provision
- Outcome 13: Staffing
- Outcome 8: Cleanliness and infection control.

The Trust fully met the standards in cleanliness and infection control, however CQC judged that the standards in the other areas required improvement and as a consequence the Trust has in place a detailed action plan to address the deficits identified. The plan is on target and will be fully delivered in 2014/15.

Alder Hey Children's NHS Foundation Trust is now registered for the regulated activity of assessment and medical treatment for persons detained under the Mental Health Act 1983. The regulated activity covers the Alder Hey hospital site and the Alder Park site in Waterloo. The registration, in August 2103, followed site visits to the Dewi Jones Unit by the CQC which is based in Alder Park. The Dewi Jones is a nationally commissioned children's mental health Inpatient Unit and provides Tier 4 assessment and treatment. No patients have been detained at the Dewi Jones Unit since registration.

Information on Data Quality

Data Quality

Alder Hey Children's NHS Foundation Trust submitted records during 2013/14 to the Secondary Users 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: 99.84% for admitted patient care; 99.64%for outpatient care; and 99.66% for accident and emergency care.
- Which included the patient's valid General Medical Registration Code was: 99.17% for admitted patient care; 95.83% for outpatient care; and 100% for accident and emergency care.

Alder Hey Children's NHS Foundation Trust will be taking the following actions to improve data quality:

- Data Quality reports will continue to run daily and weekly to ensure data is monitored and corrected if necessary.
- Close work with our Information Team to identify areas where data needs to be monitored and new reports written when required.
- Workshops and refresher training sessions arranged

to ensure staff are fully aware of the importance of Data Quality and the integrity of the data is accurate at source.

• Regular audits take place and findings reported back to managers and the monthly Information Governance Steering Group.

• Monthly Data Quality Report is sent to Performance Monitoring meeting chaired by our Chief Operating Officer which includes actions/recommendations as necessary.

• Full review of dictionaries held on our Clinical Information System to ensure selection of correct codes is clear to users.

• Review of Outpatient clinic templates to ensure correct Clinician lead –this is a direct outcome from the IG Toolkit report for outpatient Consultant codes.

Information Governance Toolkit Attainment Levels

Alder Hey Children's NHS Foundation Trust Information Governance Assessment Report overall score for 2013/14 was 82% and was graded as satisfactory (green).

Clinical Coding Error Rate

Alder Hey Children's NHS Foundation Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

• Primary Diagnoses Incorrect 11%
• Secondary Diagnoses Incorrect 10%
• Primary Procedures Incorrect 7%
• Secondary Procedures Incorrect 7%.

The results should not be extrapolated further than the actual sample audited and the services audited during this period included:

• 200 Random Finished consultant episodes.

An Overview of Quality of Care

In order to ensure that we provide the best quality services to everyone who is part of the Alder Hey community, we recognise that we must continue to stretch ourselves and set goals that we can measure in order to demonstrate that we truly put quality at the heart of everything we do. In 2012/13, in consultation with our staff, governors and patients we agreed on a number of goals in each of the quality 'domains' of patient safety, clinical effectiveness and patient experience.

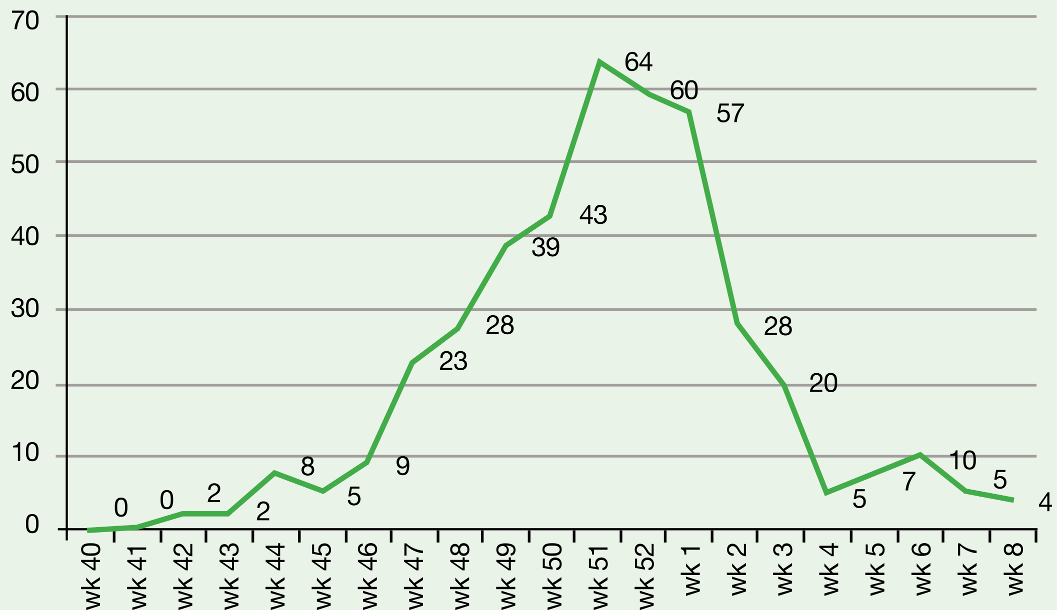
This section of the Quality Account provides an overview of the progress made against the 2013/14 identified priorities, which were:

Priority	Aim
Priority 1: Patient Safety	**Aim - Patients will not suffer harm in our care.** 1. No hospital acquired infection. 2. No drug errors resulting in harm. 3. No hospital acquired Pressure Ulcers.
Priority 2: Clinical Effectiveness	**Aim - Patients will receive the most effective, evidenced based care.** 1. No acute (unplanned) readmission within 48hrs of discharge (including under 4's). 2. No acute admission of patients with long term conditions (epilepsy, diabetes, asthma, lower respiratory disease). 3. Patients will be discharged on planned day of discharge.
Priority 3: Patient Experience	**Aim – Patients will have the best possible experience (as reported by patients and/or families).** 1. Patients and families will have received information enabling them to make choices (involvement in care). 2. Patients and families will be treated with respect. 3. Patients will engage in play and learning.

Patient Safety

Quality Improvement Priority	No Hospital Acquired Infection: Introduction of In-house Rapid Respiratory Virus Testing (Film Array)
Why was this area chosen as a priority for improvement?	Respiratory Syncytial Virus (RSV) is the commonest cause of respiratory illness (Bronchiolitis) in children particularly those less than two years of age. The virus is seasonal and normally occurs for a six week period during the winter months between November and February. RSV is the commonest cause of hospital admissions due to acute respiratory illness in young children and the high numbers of babies requiring admission to the Trust during the winter months places huge pressures on the Trust.

RSC Positive Patients



The Trust Infection Prevention Policy requires any child admitted with acute respiratory illness, including Bronchiolitis/Pneumonia/Empyema or with any unexplained febrile illness should be placed in a single room. When a single room is not available, the patient should be placed in a room with patients who have the same infection (cohorting).

At Alder Hey rapid testing was available only for RSV with the results being available within four hours. As patients may have co-infection with other respiratory viruses they cannot be nursed together in a cohort area unless it has been established that they only have RSV infection. Therefore respiratory samples had to be sent to the Royal Liverpool University Hospital for PCR (Polymerase Chain Reaction) testing. The turnaround for these tests during the winter was a minimum of 36 hours during the week.

The average duration of stay for patients with Bronchiolitis on the Medical Admissions Unit in previous RSV seasons had been less than three days, so patients' Respiratory PCR results were frequently unavailable until the baby was nearing or already discharged from the Trust. As patients couldn't be cohorted together until these results were available, they required isolation in a cubicle for the duration of their stay.

The overall aim was to increase the turnaround time for the detection of respiratory viruses.

What were the aims?	• Review and trial of laboratory systems that enable quick turnaround times for the detection of respiratory viruses. • Introduce the system (Film Array) within critical care all year round. • Use of the system (Film Array) during the respiratory virus season (November–March) Trust wide in order to increase the turnaround time for the detection of respiratory viruses. • Provide information to Infection Prevention and Control (IPC) Team and patient flow, facilitating the cohorting of patients with the same respiratory virus together, thus improving patient flow and availability of cubicles for patients. • Quicker isolation of infectious patients. • Reducing the incidence of hospital acquired respiratory viruses, including outbreaks. • Rapid diagnosis of Influenza can allow treatment to be given at the time of presentation. The Trust Influenza pathway states that in "at risk" children, Oseltamivir must be given within 48 hours of the onset of symptoms to be effective.
How was the improvement monitored?	Improvement was monitored by collecting data on the laboratory result turnaround time, numbers of cases of hospital acquired respiratory viruses (RSV), and the number of outbreaks of respiratory viruses. The data was reported to the bi-monthly IPC Committee.
Evidence of improvement	Film Array was trialled and introduced in the Paediatric Intensive Care Unit (PICU) in autumn 2013. The provision of a 2nd machine in November 2013 allowed patients admitted with respiratory illness to have respiratory viruses detected within two hours, often whilst still in Accident and Emergency Department (AED). This allowed patients with only RSV to be admitted directly into cohort bays, freeing up cubicles for patients with other infections requiring isolation. During the peak RSV season 2013/14 there were three cohort areas for RSV patients (winter ward six bedded bay, ward E2, four bed bay and ward M3 four bed bay). This had a positive effect on patient flow and patient experience as families didn't have as many ward moves.

Incidence of Hospital Acquired RSV and Influenza November 2012 - March 2013 and November 2013 - March 2014

Month	Number of HA-RSV	Number of HA-Influenza	Month	Number of HA- RSV	Number of HA-influenza
Nov 2012	7	0	Nov 2013	1	0
Dec 2012	0	0	Dec 2013	6	0
Jan 2013	2	0	Jan 2014	1	0
Feb 2013	1	2	Feb 2014	1	0
Mar 2013	2	0	Mar 2014	1	0

There hasn't been a huge decrease in the number of HA–RSV in 2013-14 but the cases were not related to outbreaks. The majority of the patients were long stay patients who were already in single rooms and have been visited by siblings with cold-like symptoms so were unavoidable.

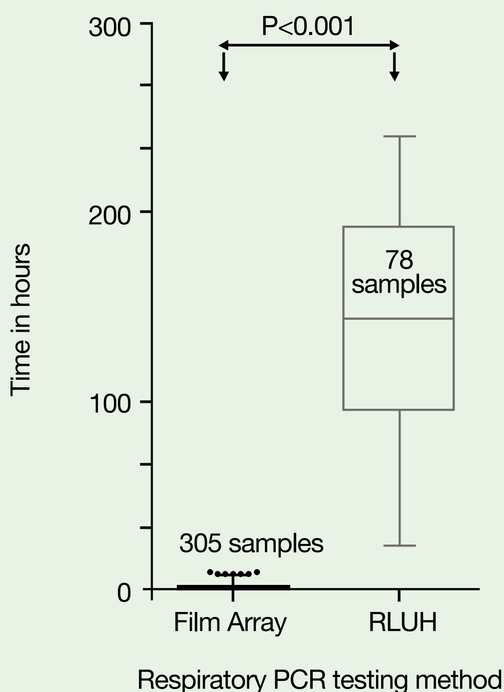
Respiratory Virus Outbreaks

The delay in detection of respiratory viruses can be a factor leading to outbreaks when patients aren't appropriately isolated.

Respiratory Virus Outbreaks 2012-3 November - March	Respiratory Virus Outbreaks 2013-14 November -March
1.hMPV -HDU -3 patients (2 patients required prolonged PICU admission) 2.RSV- NMW – 5 patients (1 patient required HDU admission)	Nil

Graph illustrating turnaround time for Respiratory Virus PCR using the Film Array and sent to the Royal Liverpool University Hospital NHS Trust

Turnaround time of respiratory PCR at RLUH and Film Array respiratory PCR at AHCH in December 2013



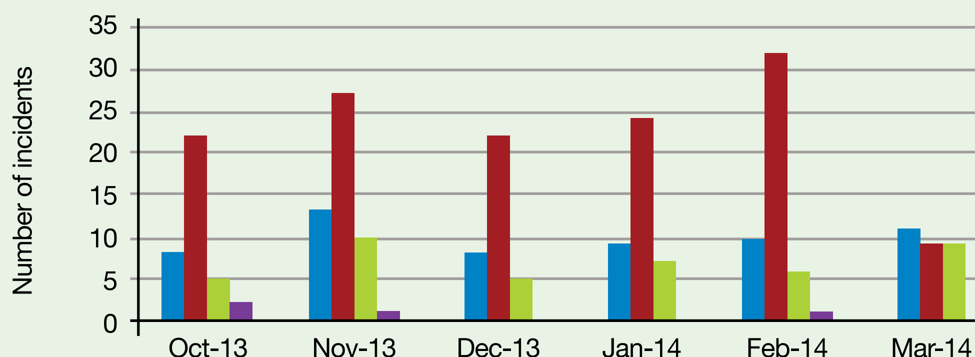
What are the next steps in 2014/15?

Continued use of Film Array within PICU/Oncology all year and re-introduction of testing for respiratory viruses during the winter season.

Expansion of Film Array to include other infections i.e. identification of Enterovirus, a cause of Encephalitis which may impact on length of patient stay.

Name of Quality Improvement Programme	No Drug Errors Resulting in Harm
Why was this area chosen as a priority for improvement?	Almost every patient who is admitted to hospital requires medication. Prescribing, administering and dispensing medicines for children are complex processes and require specialist knowledge and experience. Medication errors are the most common type of incident reported in most hospitals in the UK. We want to reduce the number of medication errors happening in Alder Hey for three main reasons: • Medication errors can harm patients. The majority of the errors which have happened in Alder Hey have not caused harm to patients but a small number have caused harm or might have caused harm if they had not been discovered before reaching a patient. • Medication errors can increase the length of time a patient stays in hospital or increase the cost of their stay because more tests, investigations or treatments are needed. • Being involved in a medication error can be a very difficult experience for patients, their families and the staff involved.
What were the aims?	A target has been set that the number of medication errors reaching patients will be reduced by 25% by the end of March 2015.
How was the improvement monitored?	Medication errors are reported on the Ulysses reporting system. Individual errors are reviewed by the Risk Management Team. The Safe Medication Practice Committee (SMPC) (a subgroup of the Drug and Therapeutics Committee) review monthly trends in reporting. The Trust also holds a "Weekly Meeting of Harm" which reviews any errors that have caused harm to patients in the previous week. The Clinical Quality Steering Group review overall trends in medication error reporting.
Evidence of improvement (simple graphs showing progress to date):	Initiatives developed to try to reduce the number of medication errors reaching patients include: • A pilot study of single checking of paracetamol. • Training for medical staff prescribing Parenteral Nutrition is provided during induction. • The layout of general prescriptions has been changed in response to medication errors. • A Pharmacist and Pharmacy Technician have been seconded to the Electronic Prescribing project. • Patient Safety Champions have been established and include medication safety in their remit. • The Trust has changed to using Morphine following the MHRA warnings associated with Codeine. • A dedicated section of the general prescriptions has been developed for oxygen. • A "Good Catch Award" is being awarded by the SMPC on a monthly basis. During April 2013 to March 2014 there have been 352 medication errors that reached the patient; compared with 328 in the previous year; this equates to a 7% increase. Medication errors resulting in harm increased from 95 to 96; this is a 1% increase.

Harm Related to Medication Incidents



	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Near Miss	8	13	8	9	10	11
No Harm	22	27	22	24	32	9
Minor	5	10	4	7	6	9
Moderate	2	1			1	
Major						

What are the next steps in 2014/15?	This remains a priority for the Trust as we strive to achieve our target of a 50% reduction of medication errors that reach the patient by the end of March 2015. The MHRA have issued an alert on 20/3/14 identifying methods required to increase reporting and learning from medication errors, which the trust is taking into consideration as part of its improvement work.

Name of Quality Improvement Programme	No Hospital Acquired Pressure Ulcers
Why was this area chosen as a priority for improvement?	Pressure Ulcers are an area of localised damage to the skin and underlying tissue due to pressure, friction and shear or a combination of these. They are often seen as a measure of the quality of care given but they are also painful and debilitating. As a result we want to prevent our patients from developing a pressure ulcer whenever possible.
What were the aims?	We aim to reduce the incidence of a patient developing a Pressure Ulcer by at least 16% by the end of March 2015.
How was the improvement monitored?	When Pressure Ulcers develop they are reported as a clinical incident enabling us to record how many have been reported. They are also reported to the Tissue Viability Nurse and each Pressure Ulcer is graded according to its severity using a nationally recognised grading system. Each month the patient safety scan also measures if any patients have a Pressure Ulcer on that particular day. The number, grade and cause of any Pressure Ulcers are recorded monthly providing the information for the Quality Account. The Tissue Viability Nurse in conjunction with the Risk Management Team is accountable for this.

Evidence of improvement	Initiatives developed to try to reduce the number of hospital acquired Pressure Ulcers include: • The introduction of a Pressure Ulcer risk assessment throughout the Trust. • Two study days held for PICU staff with a total of 18 attendees. • Skin care bundle re launched in Paediatric Intensive Care Unit (PICU) with alterations made following outcomes of a root cause analysis (RCA) investigation. This was delivered 'face to face' by the PICU education team to 60% of the staff, the remaining 40% will receive cascade training. • Introduction of Aderma pressure reduction pads. • Introduction of Silfix silicone tape for use under CPAP masks when required. During 2013-14 there has been an increase in the total hospital acquired Pressure Ulcers with 50 acquired as at the end of March 2014, compared with 47 acquired by the end of March 2013; this represents a 6% increase. 58% of Pressure Ulcers acquired occur on PICU. The improvement work has focused on this area, resulting in an increased number reported but a decrease in severity. With the exception of one Grade 4 hospital acquired Pressure Ulcer which was subjected to an RCA to ensure lessons were learnt.

PICU Hospital Acquired Pressure Sore by Grade	Apr 12 - Mar 13	Apr 13 - Mar 14
Grade 1	12	20
Grade 2	12	9
Grade 3	1	
Grade 4		1
Total	**25**	**31**

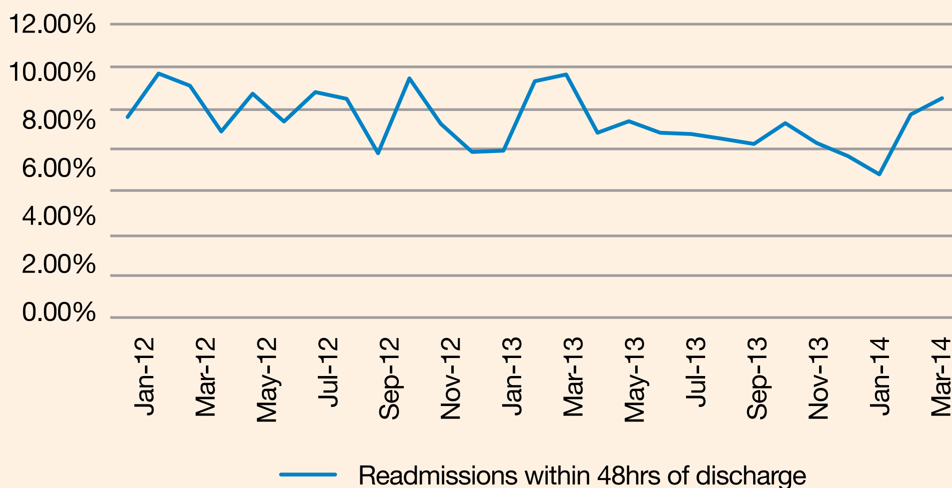
What are the next steps in 2014/15?	This is an ongoing priority for 2014/15. Plans for this year include a: • Rapid Improvement Event providing ward staff education regarding best practice for Pressure Ulcer prevention. • Revised education programme. • Review of support surfaces (mattresses) used in critical care. • Review of the documentation used at ward level.

Clinical Effectiveness

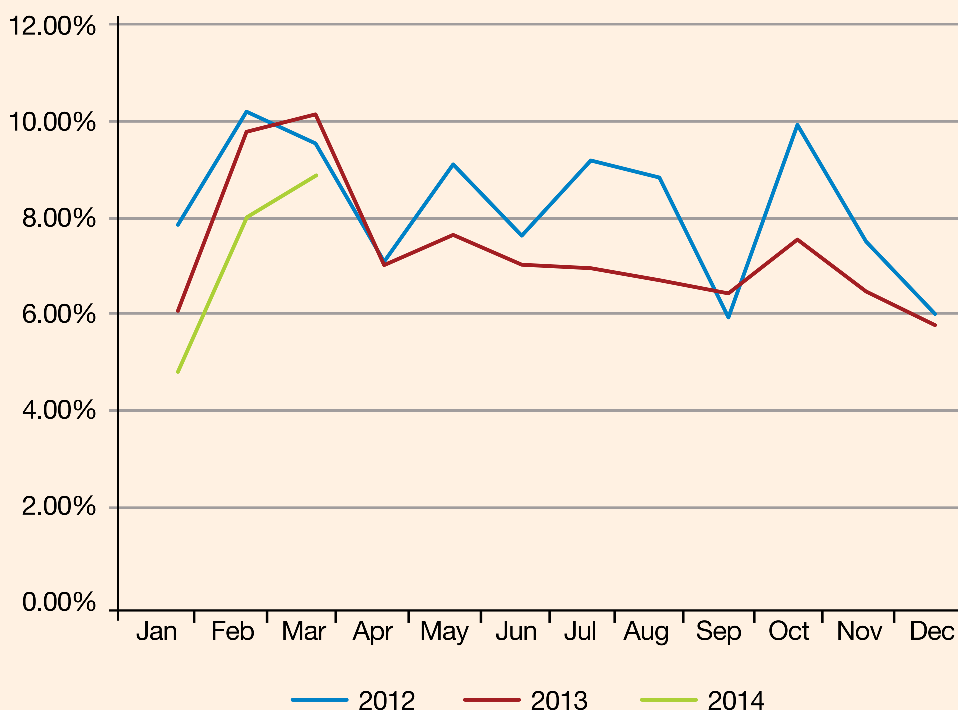
Name of Quality Improvement Programme	No Acute (Unplanned) Readmission Within 48hrs of Discharge (Including Under 4's)
Why was this area chosen as a priority for improvement?	The scope for this piece of work was to look at those children who were being admitted as an emergency with acute abdominal pain pathway and under the care of the general paediatric surgeons. This specific pathway was chosen because there were a large number of children who presented with this condition.
What were the aims?	By understanding this pathway for this condition, there was an expectation that from solutions implemented there would have been a benefit to other children who came under the care of the general surgeons as an emergency patient. The aim was to improve access to a specialist clinical decision maker in order to plan and progress treatment. Readmission was not a primary driver for the improvement and was used as a "balancing measure" and the main aims centred around: • Management of pain • Being informed • Reduction in length of stay • Positive experience.

How was the improvement monitored?	This work was part of a national programme and supported by the Kings Fund using a PFCC (patient and family centred care) approach.
Evidence of improvement	The key successes are demonstrated in the graphs below.

Readmissions Within 48hrs of Discharge



Year On Year Comparison of Readmissions in 48 hours



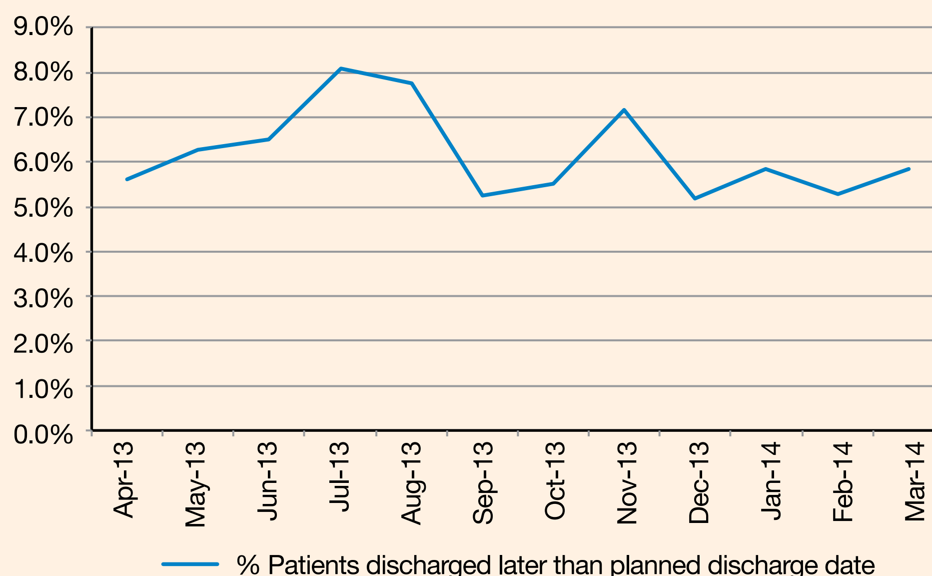
What are the next steps in 2014/15?	Using PFCC methodology is a priority for the Trust and the intention is to widen the scope across key pathways across the organisation.

Name of Quality Improvement Programme	No Acute Admissions With Long Term Conditions: The Breathe Project
Why was this area chosen as a priority for improvement?	The Breathe Project was a programme developed by Merseyside Dance Initiative (MDI) in 2012 and run across several Trusts within Merseyside, Alder Hey being the only paediatric hospital to take part. The project was supported by Asthma UK and initially funded by Liverpool Primary Care Trust. Its aim was to specifically support patients with Chronic Asthma and other respiratory conditions, by introducing gentle dance and movement exercises, posture and relaxation techniques, and giving patients the confidence to take part in exercise in a supported environment. The programme here at Alder Hey was therefore collaboration between the Asthma Nurse Specialists, Arts for Health and the Merseyside Dance Initiative and in part responded to a need from many families for a programme that was non-clinical, sociable and participatory. The pilot project took place from January 2013 for eight weeks and following evaluation and its success, a further programme was developed, in consultation with the patients/families and all agencies involved and ran from September 2013 for 12 weeks. Participants were identified and invited by the Asthma Nurse Specialists, Elaine Kelly and Vicky Worrall and were patients with either poorly controlled Asthma or those on the Difficult to Control Asthma pathway. All patients were on Step 3 or above of the British Thoracic Society (BTS) Guidelines for Asthma. Many patients were on Step 5 of the BTS guidelines and still had troublesome symptoms, preventing them from taking part in exercise, especially physical education at school. Their symptoms led to school absence and in some patients, low self-esteem, difficulty in making friends and participating in normal school life/activity. Participants ranged from 6 to 14 years in age.
What were the aims?	The programme had the following aims: • To improve asthma control in the identified group of children and young people by supporting them to take part in gentle dance and movement exercises. • To improve quality of life for participating children and young people. It is recognised that exercise and breathing exercises can improve health and the quality of life. (Holloway L, Ram FSF, 2001). The programme had the following objectives: • Facilitate a supportive environment for participating in exercise/movement. • Increase exercise tolerance. • Increase confidence and improve self-esteem. • Develop understanding of the importance of breathing techniques.
How was the improvement monitored?	Participants attended a 12 week course of sessions. Each session was held at Alder Hey Hospital on the Direct Admissions Unit every Wednesday after school for one hour. Each session was supported by the Asthma Nurse Specialists, with Elaine Kelly and Vicky Worrall providing assessment and advice prior to and during each session. The Dance Artist, Maxine Brown from MDI, engaged the group in various exercises, movement and breathing techniques to popular music, including dance with different cultural influences. Group activities, for example, using a large parachute, helped break the ice amongst participants and encouraged interaction often leading to friendships. Parents/carers were invited to stay during the session time in an adjacent area to the group. Tea/coffee and biscuits were provided and parents/carers were encouraged to engage with one another, also supported by the Asthma Nurse Specialists. Participants performed Spirometry as part of their assessment at the start and end of the project. This enabled the Asthma Nurses to assess Asthma control and support patients with appropriate advice/medication to be able to participate in the sessions. Participants and parents/carers completed the Asthma Control Test (ACT) (Nathan RA et al, 2004), a quality of life questionnaire, at the beginning of the project, halfway through and also at the end of the project. Evaluation questionnaires were also completed by participants and parents/carers.

Evidence of improvement	The project was well attended with over six participants at nine out of the twelve sessions. Parents/carers and participants showed an admirable commitment to attending the sessions, organising transport and other family/personal commitments in order for their child to attend. Spirometry results indicated improvement in lung function for some patients. This was particularly significant for the time of year, as the winter period is almost certainly the most problematic time of year for this group of patients with increased symptoms, rescue medication, AED attendances, hospital admissions and school absence due to difficult Asthma symptoms. Asthma Control Test (ACT) scores indicated improvement in quality of life in a small number of the participants. However, numbers completing the ACT questionnaire at the end of the project were less, due to reduced attendance at the last session. Those participants and parents/carers whose ACT scores were lower at the end of the session still reported lots of benefit to attending the project in their evaluation form answers/comments, some of which are documented below. Responses to the questions on the evaluation forms were very indicative and supportive of the overall success of the project. Of the 20 forms completed over the period of the project, all answered “Yes” to the question “Did you enjoy the sessions?” Comments From Young Person’s Evaluation Forms In response to the question: ‘What did you like best about the sessions?’ • “Learning how to control my Asthma a better way.” • “Gained confidence and enjoyed the activities.” • “Different to normal activities.” • “It’s fun.” • “Dancing to the music.” • “Breathing exercises.” • “Meeting new people.” • “All the different dances.” Comments From Parents Evaluation Forms In response to the question: ‘What did you like best about the sessions?’ • “The instructor.” • “Controlled environment, she enjoyed it so much.” • “Joining in with other children who understand her condition.” • “Getting some exercise, meeting new children and gaining in confidence.” • “Exercising in a safe controlled environment.” • “The variety of dances available.” • “The dancing and the chance to meet children with the same problems as he has. Increased confidence.” • “I have liked the interaction with different parents, and G has enjoyed the different styles of dancing.” • “To watch my child have freedom to move/dance with other asthmatics.” • “J enjoys the dancing.” In response to the question: ‘Did you like the opportunity to meet other parents and did you find this supportive?’ • “Yes, that was helpful.” • “Very much so, support from other parents is very beneficial.” • “Yes, enjoyed chatting and learning how other parents cope with Asthma.” • “Yes, it was really nice to meet other parents who understood what it was like caring for a child with Asthma.” In response to the question: ‘Did the sessions help improve your child’s Asthma?’ • “Really helped to know we could have contact with asthma professionals when H is struggling- rather than having to go back to GP.” • “Wonderful to know H could have lung function test before session when he had been poorly. Felt supported.”

What are the next steps in 2014/15?	The collaboration between the Asthma Nurse Specialists, Arts for Health and Merseyside Dance Initiative has gone from strength to strength and with secured funding through Arts for Health, a further programme has been planned and developed. The next Breathe Group starts again on 04/06/14 for a further six sessions. Participants who attended the last group have been invited again with a further 19 patients/families sent invites. The Asthma Nurses will continue to support the patients/families attending the sessions, providing assessment and advice and gathering information such as Spirometry results and facilitating completion of the ACT questionnaire and evaluation forms. The Breathe Project - Asthma has recently been awarded (April 2014) Investing in Children Accreditation as an Investing in Children's Service. The Asthma Nurses will continue to engage with their patients ensuring that they are listened to and involved in developing this service further.

Name of Quality Improvement Programme	Patients Will Be Discharged On Planned Day of Discharge
Why was this area chosen as a priority for improvement?	To ensure that patients are discharged on the day planned, if clinically appropriate, which is efficient and effective for patients, families and the Trust.
What were the aims?	To ensure that patients were discharged on the planned day of discharge if, clinically fit.
How was the improvement monitored?	The indicator is reported to the Clinical Quality Steering Group, Clinical Quality Assurance Committee and in the Trust Board Quality Report.
Evidence of improvement	This area is multifaceted. Inpatients can range from a few days to months and years for some patients, especially for children with complex needs. Ideally the planned date of discharge should be set as close as possible to the admission date; however the length of admission and complexity of the patient's condition can make planning a future date difficult, hence not all patients have a planned date of discharge. The following graph demonstrates the percentage of patients with an estimated discharge date discharged later than planned: **Percentage of Patients With an Estimated Discharge Date Discharged Later Than Planned**

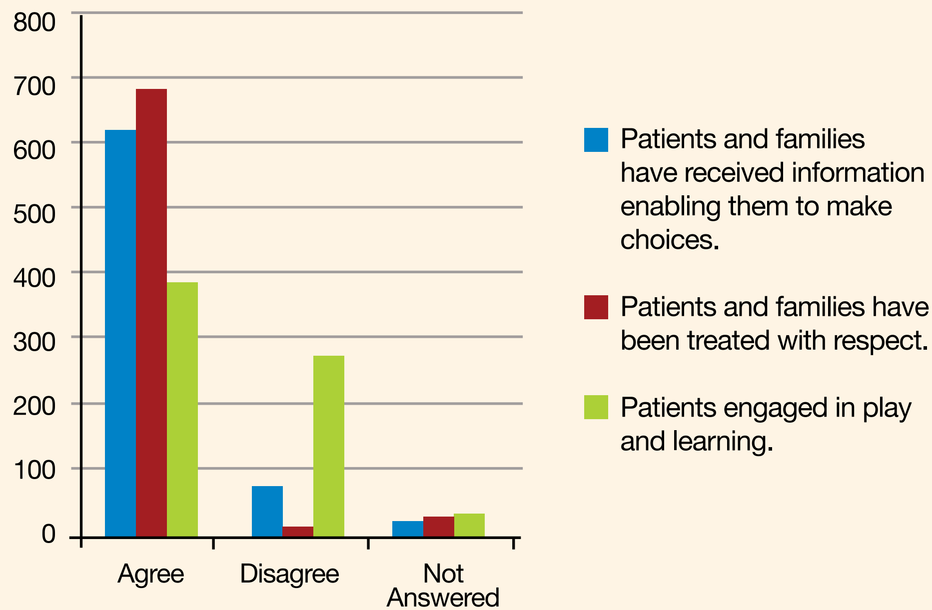


What are the next steps in 2014/15?	Project Group will focus on one specific patient pathway to improve discharge on planned day of discharge and disseminate learning across other patient pathways.

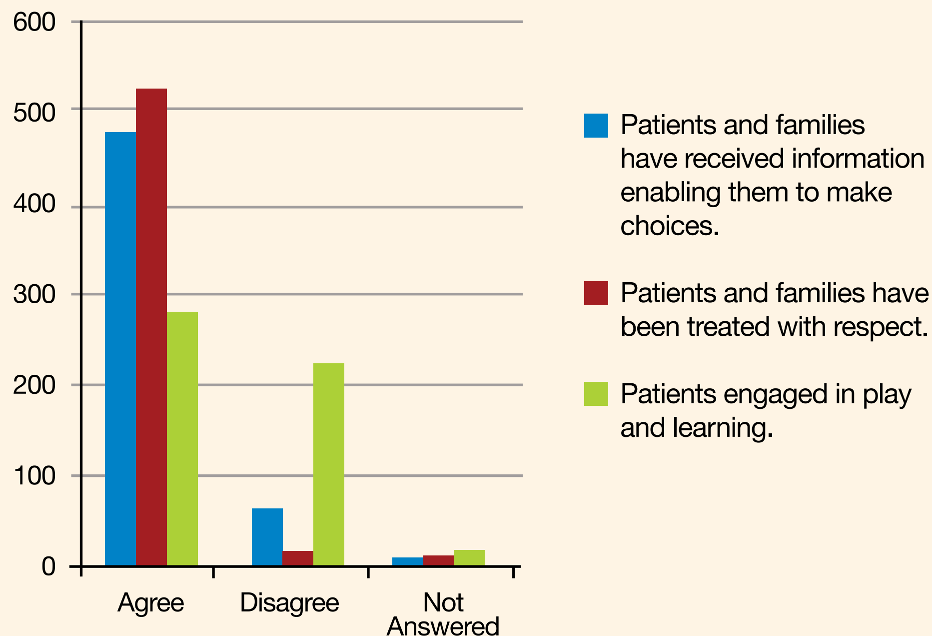
Patient Experience

Name of Quality Improvement Programme	Use Of Fabio Trust-Wide To Improve Patient Experience, Engagement and Feedback
Why was this area chosen as a priority for improvement?	To enable the Trust to capture real time patient experience data, with a focus on the following areas: • Patients and families will have received information enabling them to make choices (involvement in care). • Patients and families will be treated with respect. • Patients will engage in play and learning.
What were the aims?	Collecting, interpreting and responding to patient feedback using key patient experience indicators and feedback trends will be shared and analysed throughout the Trust.
How was improvement monitored?	This information is presented to the Clinical Quality Steering Group and the Clinical Quality Assurance Committee and has been incorporated into the Trust Board Quality Report. Each Clinical Business Unit (CBU) receives information through the CBU dashboards and will receive ward specific reports monthly. This information will populate and update the associated action plan for improvement in the key areas of the developmental Quality Aims. The quantity of responses will be monitored on a monthly basis by the Head of Patient Experience, who will identify areas where response rates are poor. In such circumstances the Ward Manager and Volunteer Services Manager will discuss how resources can be increased to improve compliance.
Evidence of improvement	The following has been achieved: • Fabio training provided by Orovia, manufacturer of Fabio device. • System for identifying location of each Fabio device established. • Installation of new software on each Fabio device to increase flexibility in terms of editing questionnaires. • Provision of training in use of Fabio device for existing and newly recruited volunteers and staff in clinical areas. • Development of timetable for ensuring feedback is collected in all in patient areas. • Provision of patient/carer feedback relating to individual areas. • Review process for collecting feedback in A&E and Outpatient areas. • Discussion with senior nurses regarding responsibilities of clinical staff in collecting patient and family feedback. • Development of baseline measures on which to base KPI and action planning. • Patient experience developmental Quality Aims baseline measures have been obtained for 2013/14 and 2014/15 improvement targets have been agreed.

The following graph shows responses from carers, young people and children between 01 October 2013 and 31 March 2014:

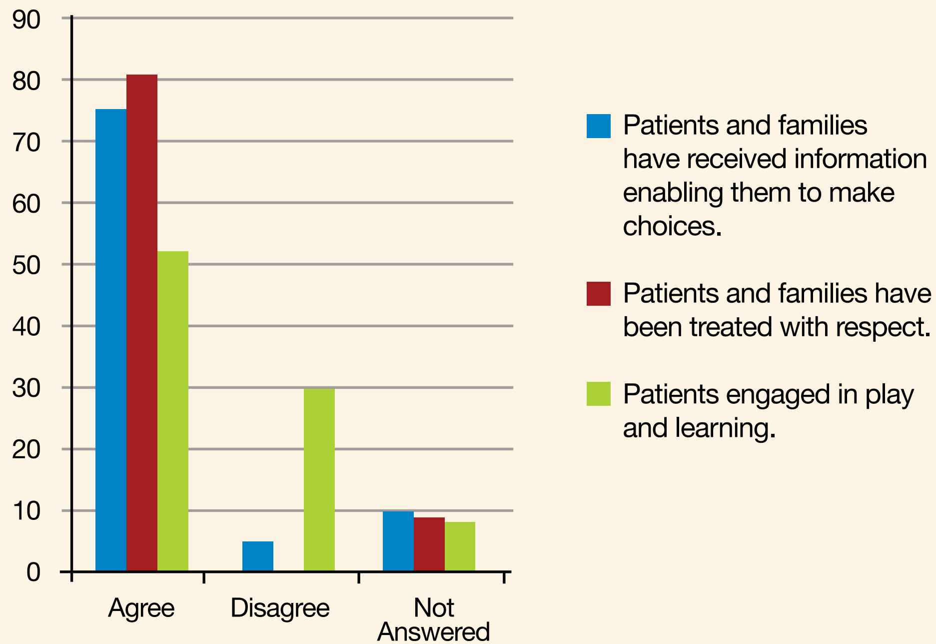


The following graph shows responses from carers, between 01 October 2013 and 31 March 2014:

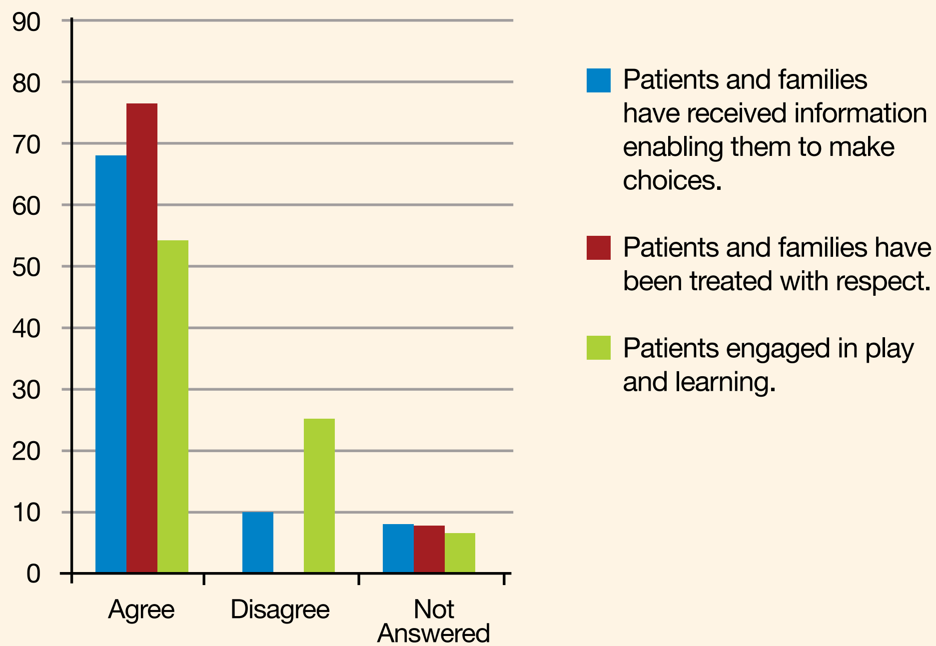


What are the next steps in 2014/15?	This will be an ongoing priority for the Trust to measure patient and family views consistently for continuous improvement. • Ongoing review of questionnaire findings to demonstrate change in trends. • Review of suitability of information to populate ward dashboards. • Implement process for reporting to ward staff, patients and families. • Feedback to Children and Young People's Forum. • 'My Alder Hey' article to be published. • The Patient Experience Team will work in collaboration with each clinical area to increase the amount of feedback collected. • Training and support will continue to be provided to the CBU Team and volunteers as part of their induction period. • Development of action plans for each clinical area. • Review of process for obtaining feedback following discharge from Inpatient stay utilising Fabio device. • Survey questions for AED and Outpatient areas currently being agreed.

The following graph shows responses from young people between 01 October 2013 and 31 March 2014:



The following graph shows responses from children between 01 October 2013 and 31 March 2014:



Performance Against National Priorities

The performance of Alder Hey against the Compliance Framework/Risk Assessment Framework 2013/14 is shown below:

Target or Indicator (Per 2013-14 Risk Assessment Framework)	Threshold	National Performance	Qtr1	Qtr2	Qtr3	Qtr4
Summary Hospital Level Mortality Indicator (SHMI)[1]			n/a	n/a	n/a	n/a
C. Difficile – Numbers			0	0	1	0
C. Difficile - Rates per 100,000 Beddays[2]		6.9	1.5 (2013/14)			
MRSA Bacteraemia			0	0	1	0
18 Week RTT Target Admitted Patients	90%	89.9% (Feb 2014)	90.2%	86.3%	84.2%	74.0%
18 Week RTT Target Non Admitted Patients	95%	96.3% (Feb 2014)	96.8%	96.2%	95.3%	95.1%
18 Week RTT Target Open Pathways (Patients Still Waiting For Treatment	92%	93.5% (Feb 2014)	92.8%	92.1%	92.1%	92.5%
All Cancers: Two Week GP Referrals	100%	95.6% (Qtr 3)	100.0%	100.0%	100.0%	100.0%
All Cancers: One Month Diagnosis (Decision to Treat) to Treatment	100%	98.3% (Qtr 3)	100.0%	100.0%	100.0%	100.0%
All Cancers: 31 Day Wait Until Subsequent Treatments	100%	97.0% (Qtr 3)	100.0%	100.0%	100.0%	100.0%
A&E - Total Time in A&E (95th Percentile) <4 Hours	95%	95.2% (Qtr 4)	98.19%	98.97%	97.73%	97.98%
Readmission Rate Within 28 Days Of Discharge[2] 0 -14 Yrs GT 15 Yrs		8% 8%	9% 8%	8% 8%	7% 7%	7% 7%
Rate of Patient Safety Incidents Per 100 Admissions[2]		7.14	Apr - Sept 5.09			
Patient Safety Incidents and the Percentage That Result in Severe Harm or Death[2]		0.4%	Apr - Sept 0.2%			
Financial and Continuity Of Services Performance Ratings						

[1] Specialist trusts are excluded from SHMI reporting.
[2] Threshold is based on peer performance compared to other Specialist Paediatric Trust.

Alder Hey was compliant with all indicators each quarter, with the exception of the 18 Week Referral to Treatment (RTT) target for admitted patients from Quarter 3. A planned strategy was agreed with Commissioners to reduce the RTT backlog. The backlog had developed as a result of an increased demand for some services and an extended theatre planned maintenance programme that led to capacity constraints during 2013/14.

The Trust considers that this data is as described for the following reasons:

- The indicators are subject to a regular schedule of audit comprising completeness and accuracy checks which are reported monthly to the Performance Management Group.
- The Data Quality Audit Plan will increase the frequency and scope of audits for 2014-15.

The Trust is taking the following actions to improve the scores and the quality of its services by:
- For RTT Performance – increasing capacity and improving waiting times for first appointment.

For all other indicators, the Trust is maintaining and improving current performance where possible.

Statements On the Quality Report by Partner Organisations

Comment by Liverpool Clinical Commissioning Group by Katherine Sheerin, Chief Officer

'Liverpool CCG welcomes the opportunity to comment on Alder Hey Children's NHS Foundation Trust Quality Account for 2013/14, since the national introduction of Quality Accounts.

As Lead Commissioner of care services and on behalf of our co-commissioning CCGs and the local population, we believe this Quality Account demonstrates a commitment to quality improvement and high quality services. NHS England "Everyone Counts: Planning for Patients 2014-15 to 2018/19" sets out NHS England ambitions and commitment in ensuring high quality care for all, now and for future generations and describes quality as spanning three areas: safe, effective and personalised care. This Quality Account provides an overview of these areas and presents a true reflection of the provider's achievement of quality of service delivery against the backdrop of a changing NHS. Delivering care and treatment in an organisation with a wide range of services requires commitment to continuously monitor and deliver high quality patient care.

Liverpool CCG along with our Co-Commissioning CCGs, is aspiring through strategic objectives and 5 year plans to develop an NHS that delivers great outcomes, now and for future generations. That means reflecting the Government's objectives for the NHS set out in their mandate to us, adding our own stretching ambitions for improving health and delivering better services to go even further to tailor care to the local health economy. Providing high quality care and achieving excellent outcomes for our patients is the central focus of our work and paramount to our success.

The CCG recognises that the Trust acknowledges that improvements are required in certain areas and have referenced these in the report. The CCG looks forward to the implementation of these schemes to enhance the quality of service delivered. The CCG enjoys a conducive and productive working relationship with the Trust and looks forward to continuing this collaborative approach and to strive for excellence and deliver high quality care and treatment to our local population.'

Comments by Governors

'An informative, in-depth review of clinical practices, incidents, risk and harm on HDU with good action plans to address any areas of concern, together with an excellent focus on patient care and view of the staff.' **Jeanette Chamberlain, Staff Governor**

'The Quality Account is an accurate account and the trust has been open and honest about any issues that may have occurred.' **Belinda Shaw, Public Governor**

Comment by the Sefton Borough Council Overview and Scrutiny Committee (Children's Services)

'In relation to the clinical effectiveness priority of minimising acute (unplanned) re-admission within 48 hours of discharge and the number of emergency admissions of children presenting with acute abdominal pain, the Trust be urged to ensure that any such cases which are subsequently confirmed to be the result of a non-physical cause are communicated appropriately to schools as well as to parents.

In relation to the clinical effectiveness priority of discharging patients on the planned day of discharge, the Trust be recommended to consider including a patient experience priority for planned discharges in future Quality Accounts.'

Comment on behalf of Halton Borough Council Overview and Scrutiny Committee, Halton Clinical Commissioning Group and Halton Healthwatch by Ellen Cargill, Chair, Health Policy and Performance Board

'Further to receiving a copy of your draft Quality Accounts and the Joint Quality Accounts event held on 6th May where your colleague Gail Hewitt presented a summary of your Quality Accounts, I am writing with the Health Policy and Performance Board comments. The Health Policy and Performance Board particularly noted the following key areas:

During the year 2013/14 the Board notes that a number of priorities were identified under the headings of Patient Safety, Clinical Effectiveness and Patient Experience. Under "No drug errors resulting in harm" the Board noted that there have been 352 medication errors that reached the patient; compared with 328 in the previous year equating to a 7% increase. Medication errors resulting in harm increased from 95 to 96; a 1% increase. The Trust has set a target to reduce this figure by 25% by March 2015 and the Board will be interested to see progress on this next year.

Under "No hospital acquired pressure ulcers" the Board notes that there has been an increase in the total hospital acquired pressure ulcers with 50 acquired as at the end of March 2014 compared with 47 acquired by the end of March 2013. The Board is pleased to note that steps have been put in place to make improvements in this important area.

No acute admissions with long term conditions, the Board were really pleased to note the successful pilot of the Breathe Project. It is good to see the positive collaboration between the Asthma Nurse Specialists, Arts for Health and the Merseyside Dance Initiative. The Board would like to congratulate the Trust on being awarded the Investors in Children Accreditation as an Investing in Children's Service.

The Board would like to thank Alder Hey Children's NHS Foundation Trust for the opportunity to comment on these Quality Accounts.'

Comment by Healthwatch

'Healthwatch Liverpool welcomes this opportunity to comment on the Quality Account of Alder Hey Children's NHS Foundation Trust.

The three priorities set out in this document appear to be appropriate high level priorities for a Trust that is committed to offering a high standard of care. Healthwatch Liverpool is particularly pleased to note the high priority being given to patients receiving the best possible experience. The Trust's stated investment in nursing staff, doctors and other support staff is a positive step towards ensuring that properly skilled staff are available in sufficient numbers to secure the Trusts priorities.

The intention of bringing staff along on the journey towards quality improvements is commendable and should rightly be reflected by an equal commitment to get patients involved in the quality journey too. In respect of this, Healthwatch Liverpool welcomes the intention of the Trust to launch its Quality Manifesto and keenly awaits its publication.

Healthwatch Liverpool is also extremely pleased to observe that the Board has made an explicit commitment to monitor the Trust's progress against the chosen priorities. Importantly, the Quality Account makes reference to the groups and committees that

will take responsibility for monitoring and reporting progress. This systematic approach is a key ingredient in ensuring that quality improvement action plans are implemented effectively.

Healthwatch Liverpool welcomes the commitment made within this Quality Account to report progress back to patients, carers and Healthwatch. However, the proposed mechanism to undertake this element of reporting back i.e. via a series of engagement events, is in the view of Healthwatch Liverpool, inadequate for the purpose of engagement with Healthwatch regarding quality issues.

Healthwatch Liverpool has a volunteer Health and Social Care Ambassador (HASCA) assigned to Alder Hey with the specific role of monitoring the quality and equality performance of the Trust and commenting on the Quality Account. Healthwatch Liverpool has on a number of occasions informed the Trust of the need for regular updates and meetings between the Trust and the HASCA to facilitate that monitoring work. Despite some positive meetings taking place regarding patient experience and equality and diversity, the engagement from the Trust regarding Quality Accounts has been inconsistent up to this point, so Healthwatch Liverpool looks forward to the Trust making improvements in this area prior to the publication of the next Quality Account.

As the public would rightly expect, the performance of the Trust against national priorities generally indicates achievement. However, there is a clearly acknowledged need for improvement regarding the non-achievement of the 18 week Referral to Treatment (RTT) Admitted Patients target, so Healthwatch Liverpool will be interested to receive reports of improvements in this area resulting from the Trust's remedial actions.

In the opinion of Healthwatch Liverpool, this Quality Account does provide useful information on the quality performance of the Trust and it forms a firm basis upon which to build further quality improvements. However in general, quality accounts are not in themselves the best vehicle to adequately inform patients and the public about quality performance, especially where the patients are children, so Healthwatch Liverpool will be keen to observe the Trust as it moves forward with its engagement activities in the coming year.'

Statement of Directors' Responsibilities in Respect Of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 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 the data quality for the preparation of the Quality Report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 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 May 2014
  - Papers relating to Quality reported to the board over the period April 2013 to May 2014
  - Feedback from the commissioners dated 27th May 2014
  - Feedback from governors dated 27th and 28th May 2014
  - Feedback from Local Healthwatch organisations dated 19th May 2014
  - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2014;
  - The 2013 national staff survey dated March 2014
  - The Head of Internal Audit's annual opinion over the trust's control environment dated April 2014
  - CQC quality and risk profiles dated 31st May 2013 and Intelligent Monitoring Reports dated 25th October 2013 and 13th March 2014

• the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;

• the performance information reported in the Quality Report is reliable and accurate;

• there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;

• the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor.gov.uk/annualreportingmanual).

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

By order of the Board

David Henshaw

CHAIRMAN
DATE: 23RD MAY 2014

Louise Shepherd

CHIEF EXECUTIVE
DATE: 23RD MAY 2014

If you would like any more information about any of the details in this report, please contact:

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