Warrington and Halton Hospitals NHS Foundation Trust

Quality Report

2016-2017

Contents

NB: Please note that this Quality Report which is required by Parliament is also published on NHS Choices as the Quality Account under Department of Health guidance.

Quality Report

Quality is our number one priority.

Our quality report sets out how we have performed against the targets we set last year and what we will achieve in the coming year.

1. Statement of Quality from the Chief Executive

Mel Pickup, Chief Executive

Warrington and Halton Hospitals NHS Foundation Trust is dedicated to *creating tomorrow's healthcare today*, firstly by the provision of high quality care and clinical excellence which puts the patient at the centre of everything we do, and secondly by ensuring we are in the best possible position to respond to the challenges facing the NHS and delivering what our population needs from their NHS.

This five year vision for the future of our hospitals, and our way forward, has been established to ensure that we become the most clinically and financially successful integrated healthcare provider in the mid-Mersey region.

We welcome this opportunity of demonstrating, through our Quality Report, to our patients, their families and the wider public, the relentless focus that our staff have on continuously improving the quality of our services.

Throughout 2016/2017, progress has been achieved through the hard work, commitment and dedication of every single member of staff. We have continued to see and treat an increasing number of patients, with more complex needs, on both a planned and emergency basis.

Within the reporting year the Trust has continued to work towards achieving all national targets from the operating framework. The national target for referral to treatment targets look at the waiting times for patients waiting to start treatment at the end of each month. I am pleased to say that in 2016/17 we had achieved 93.13% of patients being seen within 18 weeks but more importantly half of patients were seen within 6 weeks. In relation to the Accident & Emergency 4 hour access target of 95%, which is recognised nationally as a challenging target, we did not achieve the 95% target set. However, NHS Improvement set an individual performance target for the Trust of 90% which we exceeded for 2016/17 as the overall result was 90.60%, an increase on the year-end position of 2015/16 which was 88.09%. The Trust has achieved the majority of all quarterly cancer targets particularly in the first half of the year. Areas that we have not achieved and will strive to improve over 2017/18 were in relation to 2 months from urgent GP referral to treatment and symptomatic breast patients waiting a maximum of 2 weeks from urgent GP referral to date first seen.

With regards to health care acquired infections (HCAI) during 2014/2015, the Trust threshold was 0 cases of MRSA bacteraemia and despite the continued focus on managing HCAI, during 2015/2016 the Trust reported 2 cases of MRSA bacteraemia against a threshold of 0. I am pleased to announce that through our quality work, the Trust can report that in 2016/17 there have been no cases of MRSA bacteraemia and that the Trust has had a period of 18 months free of MRSA bacteraemia in our hospitals.

A revised, easy to follow sepsis pathway has also recently been developed and the potential for training to enable the sepsis team and critical care team to prescribe antibiotics, is currently being explored, which will save valuable time in being able to diagnose and treat patients, which is key to reduction or mortality from sepsis.

We have also made significant progress towards establishing a high quality and effective mortality review process and have achieved all our quarterly thresholds to date, with a reduction being seen

in 2016/17 in the Trust's mortality indices- which is how trust' are benchmarked nationally on mortality rates.

The Care Quality Commission (CQC), the body responsible for checking that all hospitals in England and Wales meet national standards, inspected Warrington and Halton Hospitals NHS Foundation Trust from 7th – 10th March 2017. They assessed the quality and safety of the care we provide, based on the things that matter to people. They looked at whether our service is safe; effective; caring; responsive to people's needs and well-led. At the time of writing this report we are awaiting the publication of our overall rating.

One of the most significant achievements in 2016/2017 is in relation to Warrington Hospital's Maternity Unit, who has been named the best in the Country by the Royal College of Midwives (RCM). The service won the Midwifery Service of the Year award at the RCM's Annual Midwifery Awards in March 2017. Following significant improvement work, recognised in 2014/15, the unit's staff were determined to make our service the best it could be for our patents, and through two years of sustained focus and energy, we have seen the whole team work together to rebuild the midwifery-led unit; it is great recognition for the whole team to have won such an award.

Our midwifery team developed the Your Pregnancy, Your Birth, Your Choice campaign, which became the driver for change, using a bottom-up approach and working closely with patients and former patients to achieve a best-in-class service. Our team delivers quality, safe and compassionate maternity care to women and their families who consistently highly recommend this Trust as a place to give birth and enjoy a superior patient experience.

In 2016-2017 the Trust was involved in conducting 59 clinical research studies in research in oncology, surgery, stroke, reproductive health, anaesthetics, rheumatology, gastroenterology, ophthalmology, as well as paediatric and other studies.

Most of the research carried out by the Trust is funded by the National Institute for Health Research (NIHR). For 2016-2017 the Trust received £400,000 which funds 9 research nurses to support Principal Investigators with recruitment and to assist with the management of NIHR studies ensuring that the study runs safely and in accordance with the approved protocol. We will continue to encourage and drive or research and development profile.

Looking ahead to 2017/18, we will continue to drive the Trust's quality strategy improvement priorities. These are as follows:

Priority 1 - We will reduce harm and focus on having no avoidable deaths by managing and reducing clinical and operational risks.

Priority 2 - We will improve outcomes, based on evidence and deliver care in the right place, first time, every time.

Priority 3 - We will focus on the patient and their experience, adopting 'no decision about me without me' as a way of life and we will get the basics right so our patients will be warm, clean, well fed and well cared for.

The areas we have chosen to focus on as priority areas are; to review safety culture in undertaking surgical and invasive procedures in the Trust, reduction of falls that result in harm, reduction of the impact of serious infections as a result of sepsis, supporting proactive and safe discharge, implementing the learning from deaths national policy, development of a lessons learned framework, improving our complaints processes, implementing our patient experience strategy and improving our services for patents with mental health needs, who present to A&E.

The areas we have chosen as our priorities are based upon national and local drivers and are also based on our internal governance intelligence, identifying areas for improvement. There is also an emphasis on working across organisational boundaries and in partnership to ensure that we can provide the best patient pathways that we can.

In conclusion, this Quality Report evidences that, whilst we have made significant progress in improving the care and services we deliver to our patients, we are committed through our priorities and quality measures for 2017/2018 to continue these improvements and show our commitment in providing high quality care to our local communities.

I am pleased to present this year's Quality Report and the outline of the governance processes that has allowed me and the Trust Board to authorise this document as a true and actual account of quality at Warrington and Halton Hospitals NHS Foundation Trust.

Signed by the Chief Executive to confirm that, to the best of her knowledge, the information in this document is accurate.

Mel Pickup

Chief Executive

May 2017

Quality Report Part 2. Improvement Priorities & Statement of Assurance from Board

Introduction

Warrington and Halton Hospitals NHS Foundation Trust provides services at Warrington Hospital, Halton General Hospital and the Cheshire and Merseyside Treatment Centre, located in the North West of England. The Trust has a budget of nearly £215 million each year, employs over 4,200 staff and provides nearly 500,000 appointments or treatments each year. The majority of our emergency care and complex surgical care is based at Warrington Hospital, whilst Halton General Hospital in Runcorn is a centre of excellence for routine surgery. The Cheshire and Merseyside Treatment Centre is home to our orthopaedic surgery and treatment services located on the Halton campus.

Our vision is laid out in our five year strategy document creating tomorrow's healthcare today. It explains how we want to be the most clinically and financially successful integrated health care provider in our part of the region. We work to a number of nationally and locally set targets - including our own QPS (Quality, People and Sustainability) framework, to ensure that service users receive the care they need when they need it, and importantly to the highest national quality and safety standards. We also provide, like all NHS trusts, those services within a financial budget, which we are responsible for delivering. Some of the challenges we have set ourselves are:

- **Using technology to improve health** - introducing new IT that will free up more time to care for our staff
- **Development of our services** - working in new ways and through collaboration so your town's hospitals have a secure future
- **Delivering quality** - a series of clear measures to ensure quality is amongst the very best in the NHS at your hospital

Organisational Structure

Since the previous Quality Account the Trust has implemented a new organisational structure in April 2016 which allows us to be more responsive to challenges through improved clinical engagement, strong and resilient leadership at all levels, with an emphasis on responsibility and accountability to achieve transformation and innovation. The new structure was developed collaboratively with the clinical divisions and facilitates the clinical specialities to work more closely within Clinical Business Units (CBU). It embraces the concept of true leadership synergy between the 'triumvirate' which brings together lead doctors, nurses/allied health professionals and managers working seamlessly with the wider corporate teams responsible for the clinical, operational and financial functioning of their CBU. The CBUs are built around the needs of the patients and their pathways and, through innovation and collaboration with partners, the Trust aims to improve access and quality of care whilst minimising costs. Operating under the leadership and management of one of two divisions, each CBU is a vehicle for greater devolvement of accountability and responsibility and allows decision making to take place closer to the patient/professional interface.

2.1 Improvement Priorities & Quality Indicators

2.1.1 Improvement Priorities for 2016-2017 update

All of the following improvement priorities and quality indicators were identified following a review of the domains of quality and our commitment to achieving them was reported in the 2015/2016 Quality Report.

The progress of each priority is discussed and red, amber and green (RAG) rated against performance on a quarterly basis. Where possible we include performance indicators to measure and benchmark progress and they are reported on a monthly basis via the Quality Dashboard to the board.

The Trust is committed to embracing improvement across a wide range of quality issues to achieve excellence in all areas of care. The following section includes a report on progress with our improvement priorities for 2016/2017 which were:

Priority 1 Pressure Ulcer - Reduction

Priority 2 MUST Nursing Care Indicator – compliance and outcomes maintaining body weight in patients =>75 years

Priority 3 Mortality Review – learning from reviews

Priority 4 Every patient has a voice – implementing Experience of Care Strategy

2.1.1.1 Priority 1. Pressure Ulcer - Reduction

Reason for prioritising: The Trust continued to focus on the management and reduction of pressure ulcers as a quality indicator for 2016/17. The Prevention and Treatment of Pressure Ulcers (NICE Clinical Guideline 29; 2005) offers best practice advice on the care of adults and children with pressure ulcers. Although the Trust has strengthened a number of processes, including a strong focus on early patient assessment and the documentation of the patient's skin condition on admission as essential to good practice, we believed that further work and interventions were required to ensure our patients did not develop pressure ulcers of any grade.

Lead(s): Tissue Viability Team and Matrons

Monitored: Patient Safety and Effectiveness Sub Committee; Patient Safety Sub Committee & Quality Dashboard

Goal: Achieve 5% reduction in avoidable grade 2 pressure ulcers; no incidence of grade 4 pressure ulcers and maintain grade 3 pressure ulcers at =<current rate. Achieve mini root cause analysis on 95% of grade 2 pressure ulcers.

Timeframe: March 2017

Progress: The situation at March 2017 for incidence of avoidable grade 3 and grade 4 pressure ulcers is as follows:-

Grade 2 – threshold is established as <=82. Year to date there are 36 reported Grade 2 pressure ulcers; this is a decrease on 2015/2016 when the Trust reported 102 Grade 2 pressure ulcers for the full year.

Grade 3 - threshold is established as <=3 and year to date there have been 4 approved hospital acquired avoidable grade 3 pressure ulcers; therefore we have not achieved this threshold.

Grade 4 – the zero tolerance threshold had been achieved until December 2016. Whilst significant work takes place throughout the Trust to prevent occurrences of this severity, with zero cases reported since 2013, we are disappointed to report that we are currently reviewing 1 grade 4 hospital acquired pressure ulcer.

We can further report the following progress:-

- Mini RCAs are completed on grade 2 pressure ulcers and work is currently being undertaken by Matrons to ensure this becomes embedded in practice
- Analysis of current data indicates that out of 44 reported Grade 2 Pressure Ulcers there are 9 that are deemed to be avoidable. There has been a substantial decrease of 56.8% in avoidable Pressure Ulcers across the Trust year to date. The Tissue Viability Nurse Specialist will be undertaking further work to ensure that RCA processes are being undertaken appropriately to provide assurance of the avoidable/unavoidable decision.
- A review of the tissue viability service was conducted by an External tissue viability nurse on 3rd April 2017 and we are currently awaiting their findings.

2.1.1.2 Priority 2. MUST Nursing Care Indicator – compliance and outcomes maintaining body weight in patients =>75 years

Reason for prioritising: High Quality Care was a local CQUIN for 2013/2014 and we continued the work through to 2016/17. The care indicators audit was a process which was developed, as part of a CQUIN (Commissioning for Quality and Innovation) to audit compliance with risk assessments for Falls, Waterlow (pressure ulcer) and MUST (nutritional) Risk Assessments. Whilst we have seen improvements in all these risk assessments, we continued to focus on increasing compliance with MUST risk assessments and importantly ensuring that patients maintain their body weight during their hospital stay. This was seen as particularly relevant to the elderly frail patient and patients =>75 years of age.

Lead(s): Matrons and Dietician

Monitored: Patient Safety and Effectiveness Sub Committee; Patient Safety Sub Committee & Quality Dashboard

Goal: Quarter 1 – establish systems for data collection. Monitor >=75years who have been an inpatient for >48 hours by taking weight on admission and discharge. No patient >=75 years old to lose more than 10% of body weight and if this occurs it is to be incident reported as a moderate harm.

Timeframe: March 2017

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
91%	98%	96%	*	*	97%	92%	94%	91%	91%	**	**

**** Problems with Nursing Care Indicators database mean that we cannot retrieve MUST Risk Assessment data for February and March 2017.

Progress: The Trust has continued to monitor compliance with the MUST Risk Assessment via the Nursing Care Indicators process and reporting to Patient Experience Sub Committee and can report the following for 2016/2017.

*NB In July a new nursing care indicator (NCI) electronic process was established for NCI data collection which, due to lack of training on the system, resulted in poor data recording. Education and support was increased and data collection improved.

Risk assessments are now recorded in our electronic system Lorenzo, from March 2017; this will enable ward managers and matrons to electronically review the risk assessment.

The NCI process was developed to incorporate key milestones for this improvement priority as part of an on-going audit programme. The Nursing Care Indicators (NCI) now includes the following questions:-

- Is the patient aged 75 or over?
- Has the patient lost 10% or more of their original body weight since admission?
- If yes to the above has Duty of Candour been completed and documented?
- Has a datix been completed?

Going forward the process needs to be embedded within practice, it is felt that this will be supported by:-

- Lorenzo will further enhance the risk assessment process and referral to the dietician
- Lessons learned from reviews of patients will improve care of patients and reduce risk of malnutrition

2.1.1.3 Priority 3. Mortality Review – learning from reviews

Reason for prioritising: Since 1st October 2015, deaths are peer reviewed through a straightforward process, which is escalated to the Mortality Review Group (MRG) as necessary and where learning and improvement is the underlying rationale. We assessed ourselves against NHS England's Mortality Good Governance Guide (December 2015), and were confident that we had aligned to

their approach and timescales in this important area, and continued to work towards phase 2 improvement aim of reducing avoidable mortality by 20%. This remained a priority for the Trust, in order to embed mortality review and achieve 100% compliance and to increase learning from the reviews, importantly ensuring a collaborative approach with medical staff that have cases under review.

Lead(s):- Trust Lead Clinician for Mortality and Clinical Effectiveness Manager

Goal: –Improve screening compliance to 100% by March 2017. Develop an inclusive approach to learning from mortality reviews.

Monitored: Clinical Effectiveness Sub Committee and Quality Dashboard

Timeframe: March 2017

Progress: The plan in place to screen 100% of patient's deaths by Quarter 4 2017 has been affected by a number of factors. These include administrative issues and difficulty in engaging a number of Consultants with the process, resulting in a backlog of mortality reviews required for deaths that occurred in 2016. We have analysed the deaths and used a number of risk factors (age, comorbidities, patients without a DNACPR in place, mortality risk, cause of death, ICD-10 diagnosis codes and patients that trigger due to Deprivation of Liberty (DoLS), mental health or learning disabilities), to produce a list of patients whose deaths are screened as a matter of urgency.

	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	FEB	MAR
MORTALITY PEER REVIEW*	50%	37%	51%	36%	23%	18%	6%	2%	0%	76%	77%	77%	100%

*NB figures change as reviews are conducted. Q1 – 70%: Q2 – 80%: Q3 – 90%: Q4 – 100%

More recently a greater number of Consultants are engaging with the process, which will ensure that we can share lessons and meet our agreed trajectory for undertaking mortality reviews. The Trust receives monthly reports from the Healthcare Evaluation Database (HED) and these provide us with areas for future investigation, where we are alerting on mortality for a particular disease area. Examples include HSMR (Hospital Standardised Mortality Ratio) alert for Pneumonia deaths, SHMI (Summary Hospital-level Mortality Indicator) & HSMR alert for UTI (Urinary Tract Infection) deaths and an HSMR alert for Cancer of the Rectum and Colon deaths. These deaths are reviewed by Consultants, with support from the Clinical Effectiveness team. Learning from these reviews are identified and disseminated through the Trust's Mortality Review Group and speciality Mortality and Morbidity meetings.

In addition to this, we are conducting further reviews into patient deaths triggered as follows:

- They are an elective patient
- They are subject to DoLS, mental health act or have a learning disability
- A screening review has indicated that a further secondary review is required
- Any deaths that are subject to a complaint or incident.

Learning Identified from Mortality Reviews

Issue	Identification method	Outcome
Medical patients admitted who have possible surgical diagnosis (bowel ischaemia/obstruction.	Focused review into Regional Enteritis and Ulcerative Colitis.	Review undertaken by the Digestive Diseases CBU Lead. Guidelines and timelines agreed for a number of diagnoses presented at the surgical and medical Governance and Audit meetings for dissemination.
Identification and recognition of patients with possible adrenal insufficiency.		Guidance to be produced into general management of patients on steroids (short and long term). Being undertaken by Dr Paula Chattington.
Patient with renal failure and high potassium waiting for dialysis and a bed at the Royal Liverpool University Hospital (RLUH).	Secondary reviews	Referral and Transfer Pathway drawn up by the RLUH visiting nephrologist to Warrington & Halton Hospitals (WHH).
Patients admitted as a day case who require stay in as an inpatient as a result of a complication of a procedure not known to out-of-hours/weekend on-call team. Gastroenterology and respiratory patients involved.		All such patients to be handed over directly to the medical registrar on-call to ensure managed as an acute admission and reviewed by the on-call team.
Poor/inadequate management of patients who have been stepped-down from ITU due to inadequate handover (medical).		Paper discharge form detailing ceilings of care provided to be available immediately in notes (there is a 2-3 day delay in transferring information to Lorenzo).
Pneumoperitoneum on chest x-ray missed by reviewing medical staff.		Case presented at the medical Audit and Governance forum to highlight the case and refresh knowledge of pneumoperitoneum on chest x-ray.
Poor/delayed recognition and treatment of sepsis.		Trust Sepsis Lead invited to Mortality Review Group to present the work now being done on sepsis, the new Sepsis Pathway and the plans for dissemination and training.
Very poor correlation between the death certificate cause of death and the cause of death identified by a consultant undertaking a secondary review. This is a recurring theme.	Identified on numerous secondary reviews and focused reviews.	Work Group set up to look at best practice guidance and bringing recommended guidance and training plans to the Medical Cabinet.
Trauma patient with fall and head injury – thoracic injuries not recognised.	Identified as part of the Trauma reviews for trauma patients.	Reinforced the importance of following the Thoracic Injury Pathway at the surgical/orthopaedic/A&E Audit meetings.

Patients under an Oncology consultant who present as an acute admission to the Trust. Teams unaware patient is receiving therapy or indeed unaware in some cases that the patient has a known malignancy. Not managed appropriately as a result.	Regional Enteritis & Ulcerative Colitis and Pneumonia focused reviews	Taken to the Patient Safety and Clinical Effectiveness Sub Committee. Also to be taken to the Lead Manager for Cancer Services and Lead Clinician for Cancer for action.
Review by HED into the Trust's high SHMI/HSMR since July 2016 suggested depth of coding issues. High number of R codes identified by AQUA Inadequate co-morbidity documentation.	Identified as part of MRG review of HMSR/SHMI even though we are aware that there is a month-on-month reduction in the levels. Also noted that all of the patients reviewed as part of the focused pneumonia deaths were patients who should have all been 'expected to die'.	We are meeting with AQUA to help us identify areas where we should target for changes.

2.1.1.4 Priority 4. Every patient has a voice – implementing Experience of Care Strategy

Reason for prioritising: The Government is committed to enabling hospitals to become better at listening, understanding and responding to the needs and wishes of patients and the public. The White Paper, Equity and Excellence: Liberating the NHS (Department of Health 2010) highlights the central aim of putting patients and the public first, to offer greater choice and control ,underpinned by the principle 'nothing about me without me.' The Health and Social Care Act (2012) underlines a commitment to put patients at the centre, by providing them with better information, more choice and a stronger voice, and the Care Quality Commission's Essential Standards outline how the NHS can provide the services and experience that patients expect.

We have developed our Experience of Care Strategy through involvement with patients, relatives, carers and the public, to ensure high quality services are delivered to our patients. The strategy demonstrates our commitment in ensuring the patient journey is a positive experience.

The strategy is structured into work streams and the Patient Experience Sub Committee will decide which work streams will be achieved by the end of the reporting year and will monitor progress until compliance is achieved. Identified work streams are:-

1. Develop a blue print for clinical business units (CBU) to meet the expectations for experience of care measurement.
2. Developing the capability and skills of staff.
3. Working together: exploring the connection between staff engagement, morale and the patients' experience of care.
4. Short term developments e.g. FFT Scorecard & template for national survey results.

Importantly the Trust through consultation with stakeholders has agreed to focus upon effective management of high risk complaints by reducing timescales and introducing 72 hour review.

Lead(s):- Complaints Manager

Goal: – Identify and agree key work streams and timescales for implementation within 2016/2017. Develop the process for 72 hour review of high risk complaints and monitor in quarter(s) 3 and 4 for 2016/2017.

Monitored: Patient Safety and Effectiveness Sub Committee and Quality Dashboard

Timeframe: March 2017

Progress: The expectations of the CBUs relating to complaints are detailed with the recently updated Complaints and Concerns Policy.

The importance of local resolution of concerns within the ward or department is being promoted. The new PALS posters have been distributed in both Warrington and Halton Hospitals.

The Staff Friends & Family and current Staff Survey will be analysed to provide evidence for exploring the connection between staff engagement, morale and the patients' experience of care. Human Resources led on the staff survey published in February 2017.

Short term developmental work is on-going in relation to FFT Scorecard; namely this is reported via the Quality Dashboard and is now included in the Trust Engagement Dashboard received by Board and also reported via Team Brief.

A system is now in place to escalate all high risk complaints to the CBUs within 72 hours. The high risk complaints, along with moderate and low risked complaints are reported to the Board of Directors on a weekly basis. All high risk complaints are discussed at the weekly Patient Experience Team meeting, and more recently an option of 72 hour review has been added into the notify box within the Datix, thus enabling reports to be generated and to record if the CBU have requested an extension to the 72 hour review.

More recently all 4 work streams have been reviewed in a Patient Experience Strategy. The attendees for the day include a wide range of clinical staff and also external representation from both Healthwatch and the CCG.

2.1.2 Local Quality Indicators 2016/2017

The Trust Board of Directors, in partnership with staff and Governors, reviewed performance data relating to quality of care and the agreed that, in addition to the improvement priorities that the quality indicators for 2016/2017 would include:

Patient Safety 2016/2017

- Nursing Care Indicators
- Medicines Management – development of indicators and on-going monitoring
- HCAI
- WHO Checklist (ORMIS)

NB: Pressure Ulcers will be an improvement priority for 2016/2017 and has therefore been removed as a quality indicator

Clinical Effectiveness 2016/2017

- Dementia
- Advancing Quality Measures - Pneumonia, COPD (Chronic Obstructive Pulmonary Disease) & Diabetes
- SHMI HMSR

Patient Experience 2016/2017

- Patient Experience Indicators
- Complaints including satisfaction survey of complaints process
- Complaints reduce number of returned complaints
- Patient Survey Indicators

Progress on these quality indicators can be found in **Part 3** of this report.

2.1.3 Improvement Priorities and Quality Indicators for 2017/2018

2.1.3.1 Stakeholder Engagement

The Trust has a duty to fully engage with stakeholders and members to ensure that we are listening to their views on quality and quality priorities moving forward.

The improvement priorities were discussed with a host of representatives from key organisations including Governors, Warrington and Halton Clinical Commissioning Groups, along with our own staff including non-executive directors.

A paper was created and presented at various meetings with the aim to:

The aim of the presentations was to:

- Provide an overview of the Quality Report and our reporting requirements
- Provide an update on progress with quality improvement priorities and quality indicators for 2016/2017
- Planning for improvement priorities and quality indicators for 2017/2018

- Agree with the selection of quality improvement priorities and indicators to take back for discussion with the Board.

2.1.3.2 How we identify our priorities

The priorities have been identified through receiving regular feedback and regular engagement with governors, staff, patients, the public, and commissioners of NHS services, overseeing scrutiny groups and other stakeholders. Progress on the planned improvements will be reported through the Trust's assurance committees, via Quality in Care - Governors and ultimately through to Trust Board. Divisional Annual Planning 'Strategy' events have also been held to discuss and agree priorities and to discuss the quality aspects of these priorities.

Our staff, governors, members and patients are the eyes and ears of the organisation and their views are constantly sought to ensure that we are focussing on the things that will make the most difference. We surveyed staff, patients and visitors, through the Staff Survey and the Friends and Family Test and from those results we capture the views of the staff and wider public in relation to the range of priorities.

2.1.3.3 Improvement Priorities for 2017–2018

The Trust Board, in partnership with staff and Governors, has reviewed data relating to quality of care and agreed that our improvement priorities for 2017-18 will include:

Priority 1 - We will reduce harm and focus on having no avoidable deaths by managing and reducing clinical and operational risks.

Priority 2 - We will improve outcomes, based on evidence and deliver care in the right place, first time, every time.

Priority 3 - We will focus on the patient and their experience, adopting 'no decision about me without me' as a way of life and we will get the basics right so our patients will be warm, clean, and well cared for.

In order to embed the above improvement priorities, we have established nine local quality indictors to support their implementation.

Priority 1 is supported via the Patient Safety indicators relating to Safer Surgery, Falls and Sepsis. All three patient safety indicators aim to reduce harm and focus on no avoidable deaths.

Priority 2 is supported via the Clinical Effectiveness indicators relating to Safe Discharge, Mortality and Lessons Learned. All three clinical effectiveness indicators aim to improve outcomes based on evidence and deliver care in the right place, first time, every time.

Priority 3 is supported via the Patient Experience indicators relating to Mental Health, PALs & Complaints and Patient Experience Strategy implementation plan roll out. All three Patient Experience indicators aim to improve outcomes based on the patient and their experience.

Full details of the Patient Safety, Clinical Effectiveness and Patient Experience indictors can be seen in section 2.1.4.4 below.

2.1.3.4 Local Quality Indicators 2017/2018

The Trust board, in partnership with staff and Governors, has reviewed performance data relating to quality of care and agreed that in addition to our improvement priorities that our quality indicators for 2017/2018 will include:

Patient Safety 2017/2018

- Safer Surgery - Evidence of avoidable harm, attitudes and practices need to change to promote safer surgery and invasive procedures
- Falls - Reduce injurious inpatient falls and increase the reporting of patient falls.
- Sepsis – Reducing the impact of serious infections (Antimicrobial resistance and Sepsis).

Clinical Effectiveness 2017/2018

- Safe Discharge – Supporting proactive and safe discharge
- Mortality – Monitor and improve mortality rates.
- Lessons Learned – Develop a lessons learned framework.

Patient Experience 2017/2018

- Mental Health – Improving services for people with mental health needs who present to A&E
- Patient Experience Strategy Roll Out
- PALs and Complaints - A full review of the Trust's complaints and PALS processes with development and investment in order to ensure these are open and transparent, and promote learning.

Patient Safety Priorities	
1. Safer Surgery - Ensure that the Trust fully embraces the culture of safer surgery in theatres and in those areas that undertake invasive procedures	
Why we chose this priority	**What success will look like**
Safety Culture and Quality Improvements in Safer Surgery will include theatres and how we have implemented the National Safer Surgery for Invasive Procedures (NatSSIPs) agenda. This was identified as a priority as a result of high profile surgery incidents.	Improvement in staff culture as measured in the Safety Culture Survey. Delivery of Quality Improvement programmes including the WHO checklist and all appropriate areas having established LocSSIPs (Local Safety Standards for Invasive Procedures). No Never Events to occur.
Implementation Plan	**How progress will be monitored and reported**
Quarter 1 – Undertake a Safety Culture Survey to identify baseline. Define what will be measured, and identify target trajectory. **Quarter 2** - Finalise action plan following improvement audit. Establish safety improvement champions. **Quarter 3** – Report progress of actions, highlighting areas for improvement. **Quarter 4** - Continue reporting, highlighting areas for	WHO checklists will be monitored via the IPR Dashboard that is presented to Board. A quarterly Quality Report will track milestones for the Quality Account priorities.

improvement. Report progress of actions, identify further actions as appropriate	
2. Falls – Reduction of injurious inpatient falls and increase the reporting of patient falls	
Why we chose this priority	**What success will look like**
This was identified as a priority as it was identified as a theme in the Trust's incidents and complaints received.	Establish a 10% reduction for falls resulting in moderate - catastrophic harm.
Implementation Plan	**How progress will be monitored and reported**
The Trust has employed a Falls Nurse who will commence in post in April 2017. **Quarter 1** - Complete scoping exercise across all areas; review existing policies and procedures; develop appropriate set of local standards; devise training method, and complete training needs analysis **Quarter 2** - Roll out new standards across all areas; develop an action plan to monitor compliance; **Quarter 3** – Monitor action plan; **Quarter 4** – Report on improvement.	Results in relation to the action plan following implementation will be reported through divisional governance structures and the IPR for Board. Ward dashboards will also track Falls figures. A quarterly Quality Report will track milestones for the Quality Account priorities.
3. Sepsis – Ensuring timely identification and treatment of sepsis, as per the Sepsis care bundle	
Why we chose this priority	**What success will look like**
Sepsis work continues to be a key deliverable for the Trust. Sepsis is a National CQUIN and is a local priority regarding harm reduction.	• Timely identification of sepsis in emergency departments • Timely treatment for sepsis in emergency departments and acute inpatient settings • Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours. • Reduction in antibiotic consumption per 1,000 admissions.
Implementation Plan	**How progress will be monitored and reported**
Quarter 1 – Review CQUIN requirements and establish Leads for the work. **Quarter 2** - Continued monitoring **Quarter 3** - Continued monitoring **Quarter 4** - Report progress	Monthly CQUIN meetings will track the progress of the work and escalate to Quality Committee. Results in relation to the CQUIN will be reported through divisional governance structures and the IPR for Board.

	A quarterly Quality Report will track milestones for the Quality Account priorities.
Clinical Effectiveness Priorities	
1. Supporting Proactive and Safe Discharge	
Why we chose this priority	**What success will look like**
This is a system wide priority to ensure reduction of delayed transfers of care and admissions avoidance. This priority is linked to a National CQUIN for 2017/18.	An increase in the number of patients who, after being admitted via a non-elective route, will be discharged to their usual place of residence within 7 days of admission.
Implementation Plan	**How progress will be monitored and reported**
Quarter 1 – Review CQUIN and establish Leads for the work. **Quarter 2** - Continued monitoring **Quarter 3** - Continued monitoring **Quarter 4** - Report progress	Monthly CQUIN meetings will track the progress of the work and escalate to Quality Committee. Results in relation to the CQUIN will be reported through divisional governance structures and the IPR for Board. A quarterly Quality Report will track milestones for the Quality Account priorities.
2. Mortality – implementation of the revised national mortality review processes	
Why we chose this priority	**What success will look like**
In December 2016 the Care Quality Commission reported that learning from deaths was not being given sufficient priority in some organisations and those valuable opportunities for improvements were being missed. Work has been ongoing with the Royal College of Physicians to develop a standardised tool and process for mortality reviews. Trusts must have a learning from deaths policy in place in 2017, as well as publishing preventable deaths.	A Structured Judgement Review (SJR) will be set up to meet weekly to review deaths within the Trust. Publication of preventable deaths from April 2017.
Implementation Plan	**How progress will be monitored and reported**

Q1 – Learning from Deaths policy to be drafted. Business case for the SJR will be completed and we will commence the use of SJR methodology to review patient deaths. Q2 – SJR meetings will commence. Q3 – Ensure learning from mortality reviews is linked to individual and collaborative practice, as per the Trust's learning framework. Q4 – Monitor and review	A quarterly Quality Report will track milestones for the Quality Account priorities. Results will be reported through divisional governance structures and the IPR for Board.
3. Lessons Learned – Implement a Lessons Learned Framework within the Trust	
Why we chose this priority	**What success will look like**
The aim of this priority is to ensure that we share, locally and Trust-wide, the key learning, improvements and best practice identified from all our means of review. Significant work will be completed over the next 12 months to improve governance systems and processes to promote learning.	Improvements within the Trust's 'Datix' risk management system; improvements in investigation of incidents and complaints; improved feedback from inquests and claims; improvements in clinical audit; and undertaking mortality reviews. Structured learning framework to establish how we will disseminate learning both from good practice and requirements for improvement. This will include different communication and learning methods such as round table events, newsletters, training events, and communication bulletins.
Implementation Plan	**How progress will be monitored and reported**
Q1 – Baseline assessment action and development of action plan Q2 – Deliver action plan. Q3 – Deliver action plan. Q4 – Evaluation and next steps.	Monthly reporting via Quality Committee A quarterly Quality Report will track milestones for the Quality Account priorities.
Patient Experience Priorities	
1. To improve the Trust's responsiveness to complainants and overall experience for patients/relatives/public to raise concerns	
Why we chose this priority	**What success will look like**
The Trust has an improvement plan in place regarding management of complaints, in relation to timeliness, quality of responses and learning. There will be new policies and processes and therefore in 2017-18 we are focusing on the development,	• Reduction in the number of complaints open more than 6 months – to be zero by the end of the financial year. • Increase in the numbers of staff trained in complaints handling • PHSO referrals to decrease. • Reduction of complaints between 30

implementation and effectiveness of these new processes.	days and 6 months old. • Improve the response times for complaints.
Implementation Plan	**How progress will be monitored and reported**
Quarter 1 – Continue work in relation to the complaints improvement action plan **Quarter 2** – Continued reporting of actions and performance improvement **Quarter 3** - Continued reporting of actions and performance improvement **Quarter 4** - Continued reporting of actions and performance improvement	Complaints will be monitored via the IPR Dashboard that is presented to Board. A quarterly Quality Report will track milestones for the Quality Account priorities.
2. Patient Experience Strategy	
Why we chose this priority	**What success will look like**
The patient experience strategy relates to the QPS framework under the focus of 'Quality' and as such supports our goals to keep the patients at the centre of everything we do, by: • Listening to our patients and carers • Learning together from their feedback • Leading change based on patient experiences • Ensuring our patients are consistently put first as we continuously improve our communication, care, environment, and processes.	Introduction of quality dashboards designed in line with the National Patient Survey results and based on 'What Matters Most' to our patients and carers. Patient experience feedback will also be shared with patients and carers, alongside actions taken, using a '...you said, we did...' approach. National survey results and FFT data will be analysed alongside patient stories to determine priorities for improvement and celebrate successes. We will build QI capability at a faster rate across the organisation and create a culture where continuous improvement, based on patient feedback, becomes an everyday activity for all staff. We will create 'always events' that support communication based on what matters most to each patient, care based on each patient's individual needs, environments that support healing and processes that are simplified.
Implementation Plan	**How progress will be monitored and reported**
Q1. Develop the programmes of work and establish sub-groups of the Patient Experience Sub Committee. Q2. Monitor the sub-groups as they will direct task and	Patient Experience Sub-committee via the relevant sub-groups.

finish groups to ensure delivery of the patient experience priorities. Q3 Continue to monitor Q4 Evaluate performance	Results will be reported through divisional governance structures and the IPR for Board.
3. Patient Experience for those patients with mental health needs who attend A&E	
Why we chose this priority	**What success will look like**
Improving services for people with Mental Health needs who present to A&E.	Reduce by 20% the number of attendances to A&E for those within a selected cohort of frequent attenders who would benefit from mental health and psychosocial interventions, and establish improved services to ensure this reduction is sustainable.
Implementation Plan	**How progress will be monitored and reported**
Q1 – Identify the cohort of patients. Q2 – Review and develop a co-produced care plan for each person in the cohort which includes a focus on preventing avoidable A&E attendances. Q3 – Develop and strengthen existing / new services to support this cohort of people better and offer safe and more therapeutic alternatives to A&E where appropriate. Monitor the number of attendances. Q4 – Monitor the number of attendances and improve the quality of A&E diagnostic coding for mental health needs ensuring that the coding for the final quarter of the year is complete and accurate. Conduct an internal audit of mental health diagnostic coding to provide assurance of data quality.	Monthly CQUIN meetings will track the progress of the work and escalate to Quality Committee. A quarterly Quality Report will track milestones for the Quality Account priorities. Results will be reported through divisional governance structures and the IPR for Board.

2.2. Statements of Assurance from the Board

During 2016/17 the Warrington and Halton Hospitals NHS Foundation Trust provided and/or sub-contracted seven relevant health services.

The Warrington and Halton Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in all of these relevant health services.

The income generated by the relevant health services reviewed in 2016/17 represents 100 per cent of the total income generated from the provision of relevant health services by the Warrington and Halton Hospitals NHS Foundation Trust for 2016/17.

2.2.1 Data Quality

The data is reviewed through the Board of Directors monthly review of the Quality Dashboard. The data reviewed covers the three dimensions of quality – patient safety, clinical effectiveness and patient experience. Our success in achieving the improvement priorities will be measured, where possible, by using nationally benchmarked information from the NHS Information Centre; Healthcare Evaluation Data (HED system); Advancing Quality Alliance (AQuA); NHS England datasets including the Safety Thermometer; Friends and Family, Dementia and VTE Risk Assessments and national survey results. The trust also uses measurement tools that are clinically recognised for example the pressure ulcer classification tool of the National Pressure Ulcer Advisory Panel (NPUAP) and European Pressure Ulcer Advisory Panel (EPUAP).

The processes that we use to monitor and record our progress have been, or are scheduled to be, audited by Mersey Internal Audit Agency to provide assurance on the accuracy of the data collection methods employed.

2.2.2 Participation in National Clinical Audits and National Confidential Enquiries 2016/2017

During 2016/17, 39 National Clinical Audits and 5 National Confidential Enquiries covered relevant health services that Warrington and Halton Hospitals NHS Foundation Trust provides.

During 2016/17, Warrington and Halton Hospitals NHS Foundation Trust participated in 37/39 (95%) national clinical audits and 4 (80%) national confidential enquiries of the national clinical audits and national confidential enquiries, in which it was eligible to participate.

The National Clinical Audits and National Confidential Enquiries that Warrington and Halton Hospitals NHS Foundation Trust was eligible to participate in during 2016/2017 are as follows:-

	National Clinical Audit & Enquiry Project name
1	Endocrine and Thyroid National Audit
2	Nephrectomy audit
3	Stress Urinary Incontinence Audit
4	Adult Asthma
5	Paediatric Pneumonia
6	Smoking Cessation
7	UK Cystic Fibrosis Registry
8	Elective Surgery (National PROMs Programme)

	National Clinical Audit & Enquiry Project name
9	National Diabetes Audit - Adults
10	National Joint Registry (NJR)
11	Inflammatory Bowel Disease (IBD) programme
12	Case Mix Programme (CMP)
13	National Cardiac Arrest Audit (NCAA)
14	Maternal, New born and Infant Clinical Outcome Review Programme
15	Child Health Clinical Outcome Review Programme
16	Medical and Surgical Clinical Outcome Review Programme
17	Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)
18	Cardiac Rhythm Management (CRM)
19	National Heart Failure Audit
20	National Comparative Audit of Blood Transfusion programme
21	Asthma (paediatric and adult) care in emergency departments
22	Severe Sepsis and Septic Shock - care in emergency departments
23	Consultant Sign Off - care in emergency departments
24	National Ophthalmology Audit
25	Diabetes (Paediatric) (NPDA)
26	Neonatal Intensive and Special Care (NNAP)
27	National Chronic Obstructive Pulmonary Disease (COPD) Audit programme
28	National Lung Cancer Audit (NLCA)
29	Sentinel Stroke National Audit programme (SSNAP)
30	Falls and Fragility Fractures Audit programme (FFFAP)
31	National Audit of Dementia
32	Bowel Cancer (NBOCAP)
33	National Prostate Cancer Audit

	National Clinical Audit & Enquiry Project name
34	Head and Neck Cancer Audit
35	National Emergency Laparotomy Audit (NELA)
36	Oesophago-gastric Cancer (NAOGC)
37	Major Trauma Audit
38	Renal Replacement Therapy (Renal Registry)
39	7 Day Service Audit – NHS England

	National Confidential Enquiries
1	Mental Health
2	Acute Pancreatitis
3	Acute Non Invasive Ventilation
4	Young People Mental Health
5	Cancer in Children, teens and Young Adults

The National Clinical Audits and National Confidential Enquiries that Warrington and Halton Hospitals NHS Foundation Trust was eligible to participate in, and for which data collection was completed during 2016/2017 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.

National Clinical Audit & Enquiry Project name	Participated	Data collected	% of cases submitted 2016/2017
Endocrine and Thyroid National Audit	**No**	**NA**	**NA**
Nephrectomy audit	**√**	**√**	**Data unavailable**
Stress Urinary Incontinence Audit	**No**	**NA**	**NA**
Adult Asthma	**√**	**√**	**21/54 (39%) Data submitted**

National Clinical Audit & Enquiry Project name	Participated	Data collected	% of cases submitted 2016/2017
Paediatric Pneumonia	√	√	**23 cases submitted – data is still being collected**
Smoking Cessation Current smoking	√	√	**100 (100%)** **16/20 (80%) cases submitted**
UK Cystic Fibrosis Registry	√	√	**29 (100%) cases submitted**
Elective Surgery (National PROMs Programme) **Pre-operative** All procedures: Groin Hernia Hip Replacement Knee Replacement Varicose Vein **Post-operative** **All procedures:** Groin Hernia Hip Replacement Knee Replacement Varicose Vein	√ √	√ √	**307/365 (84%)** 31/44 (71%) 110/121 (91%) 159/192 (83%) 7/8 (88%) **68/148 (46%)** 14/24 (58%) 22/51 (43%) 31/70 (44%) 1/3 (33%) **Data is still being collected**
National Diabetes Audit - Adults	√	√	**14 (100%) cases Submitted**
National Joint Registry (NJR) Hips Knees Ankles Elbows Shoulders	√	√	**28** **31** **0** **2** **3** **No %'s are available as data is still being collected**

National Clinical Audit & Enquiry Project name	Participated	Data collected	% of cases submitted 2016/2017
Inflammatory Bowel Disease (IBD) programme	√	√	**24/29 (83%) cases submitted**
Case Mix Programme (CMP) ICNARC	√	√	**601/601 (100%)**
National Cardiac Arrest Audit (NCAA)	√	√	**72/72 (100%)** **Data is still being collected**
Maternal, New born and Infant Clinical Outcome Review Programme	√	√	**14 cases reported – data is still being collected**
Child Health Clinical Outcome Review Programme	√	√	**Data unavailable**
Medical and Surgical Clinical Outcome Review Programme	√	√	**Data unavailable**
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	√	√	**332 cases submitted – data is still being collected**
Cardiac Rhythm Management (CRM)	√	√	**Data unavailable**
National Heart Failure Audit	√	√	**155 cases submitted – data is still being collected**
National Comparative Audit of Blood Transfusion programme 2016 Audit of Red Cell and Platelet Transfusion in Adult Haematology Patients	√	√	**27 (100%) cases submitted**
Asthma - care in emergency departments	√	√	**50 (100%) cases submitted**
Severe Sepsis and Septic Shock - care in emergency departments	√	√	**50 (100%) cases submitted**

National Clinical Audit & Enquiry Project name	Participated	Data collected	% of cases submitted 2016/2017
Consultant Sign off - care in emergency departments	√	√	**100 (100%) cases submitted**
National Ophthalmology Audit	√	√	**Data unavailable**
Diabetes (Paediatric) (NPDA)	√	√	**Data unavailable**
Neonatal Intensive and Special Care (NNAP)	√	√	**511 (100%) cases submitted**
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme	√	√	**Data unavailable**
National Lung Cancer Audit (NLCA)	√	√	**Data unavailable – data is still being collected**
Sentinel Stroke National Audit programme (SSNAP)	√	√	**Data unavailable**
Falls and Fragility Fractures Audit programme (FFFAP)	√	√	**Data unavailable – data is still being collected**
National Audit of Dementia	√	√	**51 (100%) cases submitted**
Bowel Cancer (NBOCAP)	√	√	**Data unavailable – data is still being collected**
National Prostate Cancer Audit	√	√	**Data unavailable – data is still being collected**
Head and Neck Cancer Audit	√	√	**Data unavailable – data is still being collected**
National Emergency Laparotomy Audit (NELA)	√	√	**102/156 (68%) cases submitted** **Data is still being**

National Clinical Audit & Enquiry Project name	Participated	Data collected	% of cases submitted 2016/2017
			collected
Oesophago-gastric Cancer (NAOGC)	√	√	Data unavailable – data is still being collected
Major Trauma Audit	√	√	202 cases submitted HES 286-361 Completion 56-70.5%
Renal Replacement Therapy (Renal Registry)	√	√	Data unavailable Warrington data received via Liverpool
7 Day Service Audit	√	√	192 (100%) cases submitted

National Confidential Enquiries

	Participated	Data collected 2016/2017	% Cases submitted 2016/2017
Mental Health	√	√	3/6 (50%) cases submitted
Acute Pancreatitis	√	√	3/5 (60%) cases submitted
Acute Non Invasive Ventilation	√	√	1/4 (25%) cases submitted
Young People Mental Health	√	√	Data is still being collected
Cancer in Children, teens and Young Adults	TBC	TBC	-

2.2.2.1 NATIONAL CLINICAL AUDIT

The reports of 20 National Clinical Audits were reviewed by the provider in 2016/2017 and Warrington and Halton Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Audit Title	Quality Improvement Action Plan
35796 - TARN: Major Trauma: The Trauma Audit & Research Network - Case note presentation only.	Standards Of Procedure to be put in place regards the process of The Trauma Audit and Research Network (TARN) deaths.
	Three Deaths – Secondary review at Mortality and

Audit Title	Quality Improvement Action Plan
	Morbidity meeting – to be actioned.
22967 - National Emergency Laparotomy Audit (NELA) – update.	Continue data input for NELA and audit compliance with standards proposed.
55162 - National Emergency Laparotomy Audit (NELA) – Mortality Data (December 2015 – November 2016)	Awaiting Quality Improvement Action Plan.
33958 - Neonatal Intensive and Special Care (NNAP) - 2014/2015	Annual Re-Audit to ensure standards are being met.
	Cross checking of data by data clerk for all NNAP National data.
34818 - British Thoracic Society Paediatric Asthma Audit 2015	Re-audit to monitor compliance as per BTS guidelines.
32116 - Royal College of Emergency Medicine (RCEM) - VTE Prophylaxis	Communications re-launch pathway and Emergency Department Safety brief and Governance newsletter.
	Poster to be displayed for minor's area.
	Ensure Electronic Import Delivery Order (EIDO) RCEM leaflet available. Add to Emergency Department intranet.
26998 - National Pregnancy in Diabetes (NPID) - Quality Accounts 2015 Data	Make poster that can go on TV screens to be played in General Practices (GP) across Warrington.
	Continue NPID audit and benchmark against national standards and local improvement.
	Notice for GP e-magazine re pre-conception advice and existence of clinic.
	Present NPID data to obstetric team - (finding presented on the 16/08/17).
35310 - National Lung Cancer	Better and more meaningful data interrogation.
	Improve Clinical Nurse Specialist (CNS) contact rate by increasing CNS hours.
	Improvement in stage record.
24942 - 2015 National End of Life Care Audit - Led by the RCP	Identify a Non-Executive Director with responsibility for End of Life Care, succession planning for replacement of current board members with responsibility for End of Life Care.
	Review of compliance with NICE Guideline NG31.
	Present findings at Surgical audit meeting – (findings presented 20/05/16)
26770 - Myocardial Ischaemia National Audit Project MINAP, Annual Report 2013 – 2016	Risk stratification Re-Audit has been complete and positive improvements have been made: · 88% had GRACE score calculated compared to 31% at last audit

Audit Title	Quality Improvement Action Plan
	· 60% admitted to CCU compared to 50% previously · 65% undergo coronary angiogram within 72 hours from admission, although the NICOR/MINAP figure uses a different criteria and results show 55% with 72 hours.
	Work is underway to review and update the Chest Pain Pathway.
	Annual training programs for nurses and junior doctors are scheduled: · July 2017 – ACS & Heart Failure study day · October – F1 training session
34336 - 2016 National Comparative audit of Red Cells and platelet transfusions in haematology	The guideline for the 'Use of Blood/Blood Components' be update to include recommendation 2a.
	Agree a plan for local audit by rotating doctors within Haematology.
	Disseminate audit finding to: Transfusion Team, Hospital Transfusion Committee and Patient Safety and Effectiveness Committee.
24701 - National Chronic Obstructive Pulmonary Disease (COPD) Pulmonary Rehab Audit - Warrington Data	Source suitable alternative to Chronic Obstructive Pulmonary Disease Assessment Test (CAT) questionnaire.
	Review resistance training assessment and delivery.
26921 - National COPD Pulmonary Rehab Audit - Halton	Improve length of time from referral to assessment; review discharge practice.
	Capacity to see discharged patients from hospitals within 1 month for Pulmonary Rehab.
	Referral pattern of consultants versus General Practices: - Education/Advertising of Pulmonary Rehab.
	Spirometry: - Evidence of predicted FEV1/other diagnostic tools. (CT Computed Tomography scans etc.)
	Practice test for 6 months. Capturing other 6 months results e.g. for AOT assessment previous Pulmonary Rehab attendance, to help compliance with National Standards.
38551 - Retinopathy of Prematurity (ROP) Screening	Re-Audit in one year time.
39742 (24942) - National End of	Identify Non-Executive Director with responsibility for

Audit Title	Quality Improvement Action Plan
Life Care - Led by RCP	End of Life Care, succession planning for replacement of current board members with responsibility for End of Life Care.
	Impact of this audit on education and teaching – updating information and processes.
	Review of NICE Guideline NG31.
	Lorenzo and use of IPOC.
51889 - Adherence to National Standards for Infectious Disease screening in Antenatal period	Trust is exceeding the achievable performance threshold of ≥ 99.0% for all three standards
	Performance demonstrates failsafe systems for booking bloods are effective
	Continue good practice to keep meeting achievable standard
	Offer screening to all unbooked women who present in labour and ensure follow up of results. Can be offered postnatally if unable to do so when in labour.
51892 - Compliance to standards for New-borns Bloodspot Programme	Improvement in record keeping imperative to maintain accurate figures.
	Reduction in the number of avoidable repeats – this has been achieved previously but not maintained Faster response times when repeat samples are requested from Alder Hey and also improved documentation in the community office.
	Continued auditing of new born bloodspot to achieve all standards.
	Present audit to community midwives at a community meeting to increase awareness of issues.
7 Day Service Audit – NHS England	Participate in the 3rd round of the National Audit. Awaiting Quality Improvement Action Plan
35329 - National Joint Register NJR) Audit	Re-audit annually to ensure standards are being met. Continue data collection for National Audit.
NELA National Audit	Highlight findings to Surgeons – at 16/03/17 meeting. Continue with the National Data collection.

2.2.2.2 LOCAL CLINICAL AUDIT

The reports of 284 local clinical audits were reviewed by the provider in 2016/2017 and Warrington and Halton Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Audit Title	Quality Improvement Action Plans
Advancing Quality Programme	
37455 - Advancing quality in hip fracture management	Work with Emergency Department to improve pain assessment and analgesia within 60 minutes.
	Work with patient flow, ward nurses and Emergency Department team to improve four hour target to the ward.
	Work with ward nurses to improve pressure ulcer assessment within 6 hours and nutritional screen within 24 hours of admission.
	Re-audit to ensure compliance is being met.
Anaesthetic Audit Programme	
37316 - A review of pre-op investigations	Management meeting about improving efficiency in theatres by moving pre-op closer and increasing staff to allow for staggered start times.
	Implementation of Electronic based Pre-op Assessment Proforma.
	Management meeting about List Planning (start times) and increasing time for perioperative care according to GPAS guidelines.
	Education of Anaesthetic Staff on minimum criteria for pre-op assessment.
37363 - QI survey of sedation in endoscopy at Warrington Hospital	No formal action plan required.
49584 - Audit looking at the significance of the red wristbands	No formal action plan required.
27913 - Survival of patients receiving ICU care following cardiac arrest	Re-audit over period Jan-April 2016.
25154 - Audit on pre-operative anaesthetic referrals	Awaiting Quality Improvement Action Plan.
47040 - Obstetric admissions to HDU over 12 months (38141)	Audit obstetric sepsis – scheduled to present in September Audit Meeting.
	Consultant involvement to be documented – shown by repeat audit.
	Expression of interest for PROMPT training.
	Training midwives questionnaire.

Audit Title	Quality Improvement Action Plans
25152 - Audit on Anaesthetic cancellations of patients in CMTC	Awaiting Quality Improvement Action Plan.
36747 - Survey of fluid prescriptions and relationships to cannula in diagnosed AKI 3 patients	To deliver this presentation at Grand Round or medical Audit meeting.
	To have the laboratory bleep the responsible doctor for ordering tests (we have to put bleeps in for a reason; the lab should bleep the requestor and if out of hours, the on call foundation doctor).
	Educate the new foundation doctors at induction.
44517 - Re-Audit CT Head Injury Audit	Check registrar reports as soon as possible (secretaries to follow-up and remind).
	Secretaries to verify on typing CT Head reports, when clinical states head injury and it's a consultant report.
21377 - Safety of acute pain management	Improved attendance at training sessions.
46486 - Pre-op Investigations	Awaiting Quality Improvement Action Plan.
40228 - ICU Always event	Awaiting Quality Improvement Action Plan.
36157 - Patient Reported outcomes in Day case Surgery	None
41412 - Spinal Audit: Safety of Pain Management	Approve attendance at training sessions.
38548 - Times to CT for Trauma team activations Jan-Oct 2015	Meeting both Network and National CT targets.
	Rapid decision making for CT to be done in a timely manner - awareness to all staff.
	Designated scribing.
28674 - 0.3 and 0.4mg intrathecal diamorphine for LSCS	Awaiting Quality Improvement Action Plan.
42246 - Head Injuries	Awaiting Quality Improvement Action Plan.
41342 - Acute Care Team feedback	Awaiting Quality Improvement Action Plan.
38141 - Obstetric admissions to ITU over 12 months	Audit obstetric sepsis - scheduled to present in September Audit Meeting.
	Training midwives questionnaire.
	Consultant involvement documented.
	Expression of interest for PROMPT training.
34399 - Merseyside anaesthetic group for improving quality - Mersey intubation checklist (MAGIQ-MIC)	Redesign of check list to include intubation details in ICU- This will ensure every intubation starts with check list and completes with intubation details
	Re audit the use of new airway form in ICU to see the compliance

Audit Title	Quality Improvement Action Plans
	Improved training of Intensive Care Unit (ICU) staff for RSI assistant role in ICU and new DAS guidelines- Onsite training or training on attendance to WAM course
	Improved training of ODPs, recovery nurses for new DAS guidelines and use of rapid sequence induction (RSI) check list.
10652 - Anaesthetic cancellations on the day of surgery - can these be reduced by effective pre and peri-operative planning	Single pre-op pathway.
	Improve fasting information and medications.
	Timely access to pre-op clinic +/- anaesthetist.
33624 - NICE IV fluids in Emergency Patients	Present findings at Critical Care Audit meeting on the More training / education amongst juniors Senior support / review. Everyone is responsible – daily review of fluids needed including documenting a 24 hour plan. Incident reporting of fluid mismanagement so we can learn from our mistakes.
48923 - Patient information on pain relief during labour – re audit	Liaise with midwifery department further about distributing the booklets to expectant mothers. Re-audit.
53528 - Stabilisation Trolley	Audit complete – No further action.
50460 - Elective Laparoscopic Cholecystectomy	Prospective audit - to look at why: Start from pre-op – why not booked as day case. Why are drains being used? If PONV/pain delays discharge, what anaesthetic technique/post-op care is given and can this be modified?
50467 - Use of the RSI checklist and apnoeic oxygenation	Highlight abbreviated checklist as option in high risk out of theatre Rapid Sequence Induction (RSI). Checklist available in all areas. ODP empowerment and involvement important.
	Improve awareness of apnoeic oxygenation with standard nasal cannula.
	Present findings to ODP staff next audit meeting Address O2 cylinder availability.
52975 - Audit of the use of the new emergency theatre booking form	Theatre coordinators to prompt urgency category from booking team.
	Adjustments to booking form in development – streamlined to essential information only, emphasising communication, availability and accessibility.
	Re-audit the use of the updated and simplified form
Children's Health Audit Programme	
35011 - Placental pathology and neonatal outcomes	No action required.

Audit Title	Quality Improvement Action Plans
41789 - Term Admission - CQUIN	Unanticipated admissions proforma.
	MDT review to identify lessons learnt.
39174 - Maternal Transfer	Update Situation, Background, Assessment and Recommendation (SBAR) form in guidelines.
38743 - Infant deaths North West 2013-2015	Child Death Administrator Role Clearly defined.
	CARI: Care of At Risk Infants (Family history of child deaths) Clinic started.
39800 - Neonatal Cooling Therapy audit	Rectal probe for monitoring temperature.
	Recording target temperature achieved time or documenting discharge temperature in case of not achieving target temperature at the time of transfer.
26546 - Home administration of Intravenous (IV) Medications for Cystic Fibrosis (CF) Patients	Continue to input data in to the Cystic Fibrosis Registry.
	At clinic reviews look at whether the children who could use a nebuliser should be tried on Dornase alfa.
	Work with Alder Hey on the interim reviews.
31656 - Trust wide use of the DNA section of the Safeguarding Children Policy.	To review the DNA process within the safeguarding children policy.
	To complete this audit annually – to comply with section 11 self-assessment tool.
	To circulate information regarding neglect and the impact of DNAs.
	To review the audit data collection sheet.
40771 - Young people mental health study	Submit the data to National Confidential Enquiry into Patient Outcome and Death (NCEPOD) national study.
33867 - Audit of Actim Partus for threatened preterm labour.	Single point lesson produced to be disseminated to all staff via clinical leads.
53478 - Annual Meningitis Audit	All standards met. Repeat audit next year to ensure standards are maintained.
40987 - Surfactant use Re-Audit	Awaiting PowerPoint Presentation / Quality Improvement Action Plan.
45997 - Completion of Paediatric admission proforma on Lorenzo	Update the proforma.
	Re-audit to investigate if recommendations have been implemented. Increase awareness of juniors by highlighting the importance of completing the proforma completely during all acute admission – at induction, governance and audit meetings.
56899 - Paediatric Observation	The impending arrival of the Paeds ANP will undoubtedly be a positive influence, but this does not absolve the Paediatric matron and nursing team of responsibility – these issues need actioned with some urgency.
	I have emailed this presentation to the Adult and Paeds ED senior nurses and matron, and I have asked the Paediatric team for an action plan for how they propose to implement the recommendations.

Audit Title	Quality Improvement Action Plans
	Many similar issues were and remain prominent in the main ED. We have been focusing on, and improving standards such as BM testing. Staff can liaise with the ED nurses should advice be required.
26853 - Paediatric Head Injuries	Awaiting Quality Improvement Action Plan.
39744 - Review of standards for paediatric	Radiological report should indicate whether follow up imaging is required and what image is recommended.
imaging in Non-Accidental Injury (NAI)	Objective indicators for NAI to be included within the guidelines.
	Many radiological reports stated "signing physician" at the end of the report. However, for completeness it should state the name and grade of the radiologist.
47532 - Insulin pump in the reduction of HbA1c	Awaiting PowerPoint presentation / Quality Improvement Action Plan.
Corporate Governance Audit Programme	
40297 - Re-Audit Lorenzo - Case Note Documentation Audit	Re-audit to be carried out in 2017 to ensure compliance is being met.
Corporate Nursing Audit Programme	
20341 - Annual Infection Control Audit	Awaiting Quality Improvement Action Plan.
38667 - Deterioration Recognition Audit (NEWS)- Sep 15 - March 16	All wards to be audited to ensure 100% compliance in progress.
	Ward managers to address / forward findings to those wards that haven't achieved targets.
36682 - ITU Falls Audit	Proforma to be updated with appropriate changes that is applicable to ITU.
	Findings of this audit to be emailed to all staff on ICU for awareness.
53047 - Falls Audit	Develop a business case for a dedicated falls practitioner.
	Regular audits of compliance (Deputy Chief Nurse).
	Findings of this audit to be emailed to all CBU's for awareness and action.
30454 - Deterioration Recognition Audit (NEWS) May 2016 – July 2016	Meetings set up with ward managers and link nurses for those wards that are below nice guidelines compliance.
	All wards to be audited to ensure 100% compliance in progress.
56434 - Mental Capacity Act Audit /DoLs	MCA and DoLS Training provision should be reviewed immediately. A meeting is to be arranged with the Associate Director of Education and the Organisational Development Team to discuss training to look at the content of level three MCA and DoLS training and how this

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	can be delivered to the nursing and medical teams.
	Support is required across the CBU's to embed and support the wards and departments with the MCA and DoLS statutory obligations and Trust policy and procedures. The group of staff responsible for this support must undergo training as soon as dates are confirmed along with other priority staff, i.e. ward managers and ward sisters.
	Repeat this audit in three months' time to assess the effectiveness of the training program and follow up with regular audits thereafter.
55925 - Deterioration Recognition Audit (NEWS) - December 2016 - January 2017.	Meet with Ward Managers and Link Nurses to highlight themes for improved compliance.
	All wards to be re-audited as per NEWS audit schedule.
Health Record Audit for Electronic Patient Record (Lorenzo) ID:52621	All fields < 75% must be addressed with nursing/clinical teams. Senior ward staff should communicate to the ward team that all fields of documentation should be compliant and that their documentation will be and is subject to audit.
	Those staff found to be non-complaint during audit should be supported to guide them to compliance; if no improvement is noted then staff are to be counselled regarding the importance of excellent standards of documentation.
	Ward managers are to keep a record of who requires support so that those who require further interventions are evident. Report to be disseminated with Ward/departmental managers, CBU Triumvirate & SMT for shared learning.
Emergency Care Audit Programme	
40375 - Are patients dying without DNA CPR forms not being resuscitated	Present findings to acute care group.
	Present findings to Mortality review group.
	Review use DNA CPR - (work group WHH).
24730 - A&E Medical Documentation	Update the whole department re: coding.
	Feedback personalised audit results to all doctors, with constructive advice.
	Repeat the audit in one year in a new agreed format.
39182 – Documentation Audit	Enforce better control and registration of TAC cards.
	Inform all staff to identify them when using a TAC card. This question needs to be asked at the beginning of every shift and at daily safety brief?
	Clinical Decisions Unit (CDU) discharge document, dates not being entered. Give list of the cases to Roy, who should be able to tell us how this happened. Then educate all.

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	Inform individuals
	3 ALN entries (by people other than Jim)
	1 Epilepsy Nurse
	2 Geriatrician Consultant notes
	Regarding blank templates:
	Consider removing blank templates from Lorenzo.
	Remind nursing staff of obligations re documentation standards.
	Ensure receptionist / progress chaser scans in the correct set of items. A checklist of what should be scanned in, and where, needs creating.
	Clinicians to decide which documents needs to be scanned in. This applies to both admission (transfer from ED, Emergency Department) and discharge (home or wherever) We need to work with administrative staff to create a checklist of which items are needed.
	Educate all medical staff about the importance of the ED discharge summary.
	Educate re use of the 'Transfer of Care note' – this would mainly be for those who do the CDU Ward Round.
	Create a Lorenzo document for Mental Health Team referral. It should also include a capacity and risk assessment.
	Check with Mental Health team whether we should be scanning in any of their notes.
	Provide feedback to governance team with the suggested modifications to the audit template.
39184 - Renal Colic Pathway Audit	Reminder (e.g. poster) to properly and accurately document urine dipstick results - and possibly being able to upload data onto ICE for future audits.
	Re-audit with larger sample size.
32169 - Sedation in the Emergency Department	Further training in the use of the Electronic Sedation Logbook - update QRG for use of the Electronic Sedation Logbook. To ensure completion of the Electronic Sedation Logbook for all patients undergoing sedation - introduce automated email reminder systems. To improve the early recognition of patients requiring sedation - to incorporate this in the initial streaming/handover assessment. To undertake training in sedation for all professional groups - to work with the departmental medical and nursing leads and the Trust Sedation Lead to develop educational materials and opportunities.
38273 - Emergency Nurse Practitioner Halton	Datix of missing documentation.
	So that IT can look into this issue of unsaved notes.

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Documentation Audit	Feedback of individual practitioners audit result so that they can reflect and adapt practice to improve documentation.
	Re audit in 1 year.
47434 - SBAR (Situation Background Assessment Recommendation Audit)	Awaiting Audit Report / Quality Improvement Action Plan.
51595 - An audit on the immediate discharge of paediatric patients with torus fractures	Introduce the new process in Urgent Care Centre [formally Minor Injuries Unit] and Emergency Department.
	Develop similar processes for other minor fractures [working with Trauma &Orthopaedic.
47737 - Warrington A&E Reception: Documentation Audit	Circulate results and raise awareness
	Re audit in 1 year
	Re-audit – Contact numbers, Next Of Kin (NOK) and schools
44083 - MET Survey Audit	Present findings at Acute Care team Meeting.
	Foundation teaching programme 2016/17.
	Present findings at Acute Care team Meeting
	Try and identify Medical Emergency Team (MET) entry clearly on Lorenzo.
44517 - Re-Audit CT Head Injury Audit	Check registrar reports as soon as possible (secretaries could chase / remind).
	Secretaries to verify on typing CT Head reports, when clinical states head injury and it's a consultant report.
38270 - Emergency Nurse Practitioner (ENP) Documentation Audit - Warrington	Disseminate findings to all Emergency Nurse Practitioners (ENPs).
	Repeat the audit in one year in a new agreed format.
51234 - Management suspect scaphoid injuries.	Present findings at Radiology Audit Meeting and with Orthopaedic Representative on the 22/02/17 – presented.
38548 - Times to CT for Trauma team activations Jan-Oct 2015	Meeting both Network and National CT targets.
	Rapid decision making for CT to be done in a timely manner - awareness to all staff.
	Designated scribing.
42246 - Head Injuries	Awaiting PowerPoint presentation / Quality Improvement Action Plan.
56899 - Paediatric Observation	The impending arrival of the Paeds ANP will undoubtedly be a positive influence, but this does not absolve the Paediatric matron and nursing team of responsibility – these issues need actioned with some urgency.
	I have emailed this presentation to the Adult and Paeds ED senior nurses and matron, and I have asked the Paediatric team for an action plan for how they propose to implement the recommendations.
	Many similar issues were and remain prominent in the main ED. We have been focusing on, and improving standards such as BM testing. Staff can liaise with the ED nurses should advice be required.

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26853 - Paediatric Head Injuries	Awaiting Quality Improvement Action Plan.
39744 - Review of standards for paediatric imaging in Non-Accidental Injury (NAI)	Radiological report should indicate whether follow up imaging is required and what image is recommended.
	Objective indicators for NAI to be included within the guidelines.
	Many radiological reports stated "signing physician" at the end of the report. However, for completeness it should state the name and grade of the radiologist.
47532 - Insulin pump in the reduction of HbA1c	Awaiting PowerPoint presentation / Quality Improvement Action Plan.
ENT Audit Programme	
39797 - Nasal Fracture Re-Audit	Continue to utilise the stamp and re audit in 1 year.
52999 - Re-Audit of Theatre Documentation.	Pink sheet needs adding time and elective/emergency procedure column. Redesigning of the pink sheet for better documentation.
56376 - Tongue Tie Clinic	Re Audit to ensure compliance is being maintained.
22978 - Nasal symptom improvement with turbinoplasty	No actions – it is safe to carry on with Tubinoplasty.
48988 - Audit on Ear Dressing Clinic service use.	Inform GP practices, A&E and Urgent care centre of new service – work with Communications team. To develop the service further with expansion of role, re-audit as service develops to compare results
45313 - NICE Guideline in Middle Ear Effusion Management (grommet audit)	To re-audit in 1 years' time.
40707 - Coblation versus Cold Steel tonsillectomy: A Prospective study comparing Visual Analogue Scale (VAS) scoring in a Paediatric population.	Continue to collect data for study including pain scores and post op complications.
34554 - A 10 year overview of thyroglossal cyst experience - recurrence and compliance	Operative proforma / Repeat audit.
39369 - Audit on day case paediatric tonsillectomy	To consider pain management to reduce the overnight stay.
General Medicine & Elderly Care Audit Programme	

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44757 - ACE - Quality Improvement Project	Awaiting Quality Improvement Action Plan.
21471 - The management of BPSD on the FMN ward	Individual care plan for BPSD to be included in discharge information to social care agencies / care facilities, for patients discharged from the FMN ward
	Cognitive Assessment Team (CAT) nurses to calculate, record and inform FMN ward of transferring patient's Pittsburgh Agitation Scale (PAS) score pre-admission
	PAS score to be recorded in case notes for those patients being discharged from FMN ward. (CAT Nurses)
	Continue to educate care practitioners in the use of non-pharmacological methods to manage the symptoms of Behavioural & Psychological Symptoms of Dementia (BPSD). (CAT Nurses)
27527 - Diabetic Nephropathy and CKD Audit	Ordering US renal if Glomerular Filtration Rate (GFR) <30 if done elsewhere
	Improve Documentation especially medication each visit.
	Re-audit in 3 years to see whether improvement in management of Chronic Kidney Disease (CKD)
	Refer to Renal team on time – look at those not referred may be end of life patients
	Making sure that patients on appropriate medications and having regular blood/urine tests based on the nice guideline.
40375 - Are patients dying without DNA CPR forms not being resuscitated	Present finding acute care group.
	Present findings Mortality review group.
	Review use DNA CPR - (work group WHH).
39182 - Documentation Audit	Enforce better control and registration of TAC cards.
	Inform all staff to identify them when using a TAC card. This question needs to be asked at the beginning of every shift and at daily safety brief?
	Clinical Decisions Unit (CDU) discharge document, dates not being entered. Give list of the cases to Roy, who should be able to tell us how this happened. Then educate all.
	Inform individuals
	3 ALN entries
	1 Epilepsy Nurse
	2 Geriatrician Consultant notes
	Regarding blank templates
	Consider removing blank templates from Lorenzo.
39182 - Documentation Audit (continued)	Remind nursing staff of obligations re documentation standards.

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	Ensure receptionist / progress chaser scans in the correct set of items. A checklist of what should be scanned in, and where, needs creating.
	Clinicians to decide which documents needs to be scanned in. This applies to both admission (transfer from ED, Emergency Department) and discharge (home or wherever) We need to work with administrative staff to create a checklist of which items are needed.
	Educate all medical staff about the importance of the ED discharge summary.
	Educate re use of the 'Transfer of Care note' – this would mainly be for those who do the CDU Ward Round.
	Create a Lorenzo document for Mental Health Team referral. It should also include a capacity and risk assessment.
	Check with Mental Health team whether we should be scanning in any of their notes.
	Provide feedback to governance team with the suggested modifications to the audit template.
22428 - VTE Risk assessment in AMU	New VTE forms to be introduced which will be easier to complete.
	Formal Venous Thrombo Embolism (VTE) training sessions for all junior doctors.
	VTE nurse to do random short audits to assess compliance.
40188 - Management of decompensated alcoholic liver disease: are we doing it right?	Re-Audit in one year
	Increase Awareness of Alcohol Related Liver Disease (ARLD) management pathway
43330 - Audit of documentation referring to Rapid Access to Chest Pain Clinic (RACPC)	Continue to promote awareness of new version form to GP practices. ICE referral form modified to direct referrals to appropriate clinic. Re-audit in 12 months.
32818 - Audit of Accommodation of Patients at End of Life - Single Rooms or not	Share this data with ward managers.
	Continue to collect data on relatives' views on care and respond to this.
	Update Clinical Effectiveness Committee so awareness of impact of low numbers of single rooms is made more visible at hospital management level.
35936 - Impact of new medical system on call on consultants reviews CMT feedback	Consider one of Post Take Ward Round (PTWR) to be started at 8a.m.
	Re audit in 1 year.
	Making sure that CMT doctors get feedback during acute medical take.
48412 - Excess deaths coded as diabetes with complication	BG monitoring frequency added to observation SOP Bid to increase diabetes nurse inpatient support.

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37435 - Risk Stratification in ACS (Re-Audit)	Review Chest Pain Pathway.
	Share these findings with A&E, Acute Medicine and Patient flow team. Revise and agree admission pathways for patients with ACS CNS to review A1 admissions from Lorenzo daily. Continue this audit alongside MINAP, report quarterly at Cardiology Speciality meeting.
48952 - Inpatient Audit (Endoscopy)	Re-audit to ensure Recommendations have been put in place.
27984 - NICE Compliance of Rapid Access to Chest Pain Clinic (RACPC)	Disseminate to GPs need to send bloods with referral form. To continue with present proforma as guidance and education programme and re-audit in 2 years.
44083 - MET Survey Audit	Present findings at Acute Care team Meeting
	Foundation teaching programme 2016/17
	Present findings at Acute Care team Meeting
	Try and identify Medical Emergency Team (MET) entry clearly on Lorenzo
48575 - Nutrition Screening	Improve weight documentation and Malnutrition Universal Screening Tool (MUST) score completion: Education of nurses/student nurses/HCS's As part of induction Reminders on wards E-Learning
	Improve weight loss documentation and MUST score interpretation:
	Introduce MUST e –learning as part of junior doctors induction
	Reminders on the ward
	Lorenzo template for weight+ BMI+ MUST
	Improve monitoring of weight and completion of food charts:
	Set a specific day in week for weighing patients.
	Re-Audit in 6 months
52535 - VTE Prophylaxis May - July	Continue data collection for period August - October 2016.
33874 - Serum Blood testing for Hyperlipidaemia in ACS Re-Audit (15006)	Re-audit in 6 months (aiming to analyse ~ the same time of year).
48944 - Endoscopy in Upper GI Bleeding	Look at list location – flexible plan. Re-audit to ensure recommendations have been put in place.
48936 - 30 Day Mortality and 8 Day Readmission post endoscopy	Continue to monitor and ensure safe place, Re-audit.
48952- Diagnostic biopsies during colonoscopy for unexplained diarrhoea	Educate / share results to staff. Re-audit to ensure recommendations have been put in place.

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39649 - Ongoing audit of use of single rooms at end of life	Data collection proforma – to be updated
	Communication Skills Training included in consultant mandatory training from January 2017
39710 - Orthostatic Hypotension - Lying standard BP	Educating all medical areas about consideration and importance of measuring Lying standing BP in patients with falls. Falls liaison person in each individual clinical area to be trained to help the staff as well as monitor prevention efforts. Constant re- education. Consider re audit next year.
26365 - Non pharmacological measures taken in patients rooms to prevent delirium	Discussed in audit meeting to make sure Abbreviated Mental Test (AMT) done on initial clerking/post take for elderly patient.
	Nursing staff to encourage relatives to bring familiar objects from home for elderly patients to give them more homely environment/minimize noise levels in elderly wards.
	Discuss with ward managers/bed managers to make sure elderly patient moved to appropriate wards when they are moved from A1.
39361 - Snapshot audit of confused patients who have been prescribed sedation.	Further full retrospective audit of sedation use for confused patients to be completed.
36612 - Audit of discharge summaries not completed at time of discharge on A1.	Assign Junior To Be in charge of “box”.
	Audit Quality of Discharge Summaries.
	Re-audit.
47673 - Outpatient management of hyperthyroidism compared to ATA guidelines	Ensure status of eyes is fully documented at all appointments- particularly in the context of Grave’s Disease
	Consider repeat Audit in 3-5 years’ time
	Ensure FBC and LFT are checked before Anti Thyroid Drug (ATD) treatment
27314 - Audit of management of hypothyroidism in pregnancy	WHH guidance on hypothyroidism in pregnancy.
	Present findings of audit to midwives.
	Article for CCG magazine re risks hypothyroidism in pregnancy.
	Re-audit 2018.
38722 - Audit of proportion of patients recorded as being diagnosed with Malignancy of Unknown Origin (MUO) / Cancer of Unknown Primary (CUP) that are registered with the central CUP MDT.	Awaiting presentation / Quality Improvement Action Plan.

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49639 - NICE IV fluid guidelines	Present findings at Critical Care Audit meeting on the 22/02/17 – presented. More training / education amongst juniors Senior support / review. Everyone is responsible – daily review of fluids needed including documenting a 24 hour plan. Incident reporting of fluid mismanagement so we can learn from our mistakes.
52529 - VTE Prophylaxis Jan - Apr 16	Email and present findings (F1 induction, mandatory training, ward managers, meet-up with staff).
	VTE Training to be included in Trust essential training.
	To Audit between 30-50 patients on a weekly basis.
	Timely completion of Venous Thromboembolism (VTE) risk assessment prescription and administration of prophylaxis.
15089 - Insulin and oral hypoglycaemic agent prescribing and management	Using a root cause analysis pathway approach to deal with insulin errors the Diabetes specialist nurses targeted groups and individual people who have made errors. ELearning now mandatory one off course for all appropriate staff.
49327 - PTWR 14 hour - Re-Audit	The Acute Medical Unit (AMU) consultant rota to be discussed by the Acute Medical Unit (AMU) Team and the Deputy Medical Director. Investigate why one patient not seen in 48 hours and implement change to avoid this happening again. Re-audit in 12 months' time.
52536 - VTE Prophylaxis August - October	Continue data collection (Nov - Dec 2016).
	1. Lorenzo Indicator - further investigate with IT the possibility of a highlighting "flag" in Lorenzo when VTE risk assessment is not completed.
	2. Inpatient Admission Note - spoken with the Information Team regarding the feasibility for an automatic report to be generated from Lorenzo identifying the doctor who has clerked a patient on the "Inpatient Admission Note" and not completed the VTE risk assessment. This would be to identify if there are any training issues.
	3. Daily Outcome of VTE Assessment Report - meet with the Information Team to check if a report can be available to print which highlights the outcome of VTE risk assessment.
33072 - Medicine & Elderly Care Documentation Audit 2016	Re audit in 1 year
30139 - Hydration in the Dying Patient	Use of IPOC to support dying patients
	Review of NICE Guideline NG31 and use of IPOC
	Impact of this audit on education and teaching – updating information and processes
29519 - Regional AF diagnosis and anticoagulation - A quality	All patients with AF should have: Stroke risk documented using CHA_2DS_2VASc score.

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improvement project	Bleeding risk documented using HAS-BLED.
56676 - The Management of Hyperthyroid patient; a re-audit and guideline **comparison**	Ensure FBC and LFT are checked before ATD treatment
	Ensure status of eyes is fully documented at all appointments- particularly in the context of Grave's Disease.
	Consider repeat Audit in 3-5 years.
43972 - Epilepsy Pathway Audit – Pathway admitted with a Seizure	Re-Audit in 3 years.
41983 - Multiple MET Calls	Take summary of this audit to mortality review group or acute care group.
	Work with palliative care team re end of life care education.
	Continue to look at deaths in bereavement office and evidence end of life care planning.
ICU Audit Programme	
37350 - Think Kidney, then act	Awaiting Quality Improvement Action Plan.
43477 - Ventilator Associated Pneumonia (VAP) Audit	Continue Ventilator Associated Pneumonia (VAP) audit.
	Audit of tracheal tube cuff pressure.
	Sedation level assessment- discussion regarding proposed algorithm.
	(ICU consultants responsible).
50912 - Audit of body weight of critically ill patients.	Awaiting presentation / Quality Improvement Action Plan.
47241 - Weaning in ICU	Ward round daily management sheet to be put in place – actioned.
46138 - NPSA Alert NGT Audit	Awaiting Quality Improvement Action Plan.
16312 – Tracheostomy Ward Audit	Revised audit sheet: Item not relevant at all. Item needed on ward only (not bed). ? DATIX incident logged.
1180 - Epidemiology and Outcomes of Post-Cardiac Arrest Patients admitted to ICU	Develop guidance for temperature management post cardiac arrest.
	Develop guidance for neurological prognostication following cardiac arrest.
38222 - Network Ventilator Associated Pneumonia (VAP) Audit	To continue our ongoing Ventilator Associated Pneumonia (VAP) unit audit.
	To feed back our VAP audit data to the network regularly.
Occupational Health Programme	

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36621 - Reasons for needle stick follow up. Are they necessary?	No action required.
Ophthalmology Audit Programme	
34565 - Vision Screening Service Annual Audit	To liaise with Special Educational Needs (SEN) team to arrange for them to attend schools to see SEN children.
	Re-audit annually.
	Implement administrative changes.
44412 - (44415) Outcomes of Strabismus Surgery	Relaunch the prospective audit proforma / database from 1st January 2017.
	Re audit 2 years to ensure results have improved.
43319 - Cataract Surgery and Complications 2015	Future Audit using Medisoft / Ormis.
	Request patient details of complicated cases from all doctors in clinic (On-going).
33530 - Ophthalmology Documentation Audit	Annual Re-Audit (Trust requirements).
47066 - Management of AMD patients - ECLO review of AMD patients	To Re-audit once recommendations have been actioned.
	Miss Mandal to discuss findings with Clinical Business Unit (CBU) lead.
47804 - Audit of new referrals to diabetic retinopathy clinic.	Prospective Audit to start mid-2017.
	Design Pathway and use for Prospective Audit.
33879 - Service review of the Orthoptic Stroke and Neuro service	Orthoptists to have access to the patients on the Sentinel Stroke National Audit Programme (SSNAP).
	Explore ways of identifying more of the stroke population.
42775 - Amblyopia review	Re-audit in 24 months' time including atropine occlusion.
35247 - Ophthalmic Day Surgery Cancellations Audit - Re-Audit 15421	New cancellation proforma to facilitate collection of more accurate data.
	Re-Audit in 1 year – what is the effect on cancellation rate after the introduction of Lorenzo.
	Nurse in charge on Ophthalmic Day Surgery (ODS) should ensure that the proforma is completed correctly on the day.
34646 - Audit of MIGS - micro invasive glaucoma surgery XEN gel stent and iStent trabecular micro bypass	Continuous audit - EPR
	PROM PREM as routine for surgical glaucoma patients
	Economical evaluation.
20542 - Visual symptoms following (YAG) laser peripheral iridotomies	Complete retrospective data collection and re-interview prospective patients 1+ year after their laser treatment to establish persistence of symptoms. Further data collection.
	Prospective data collection – standardised forms on 1st post-op visit. Form to develop.
	Perform Peripheral Iridotomy (PI) as per recommendation based on superior lid position. Recommendation to write.
55167 - Intravitreal injections: Process Audit	Explore option to use Lorenzo/e-Outcome to discharge patients from injection lists; list would be only for the

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	purpose of internal organisation of patients/follow up. As patients are attending as 'day surgery'. Re-Audit.
34629 - Patient Satisfaction within the eye clinic	Re audit in 1 year.
31215 - Evaluation of Pre-operative Assessment Clinic	Re audit in 12 months the impact of these changes in our 45 minute booking slot, medisoft and pre op documentation for GA/Sedation Patients.
34662 - Audit of penetrating glaucoma surgery - Trabeculectomy, deep sclerectomy, glaucoma drainage device	Awaiting Quality Improvement Action Plan.
34623 - Additions to Clinic (Re-Audit of 1162)	Re audit 2017 looking at the inappropriate referrals received from Emergency Care and GP surgeries.
38598 - Age-related macular degeneration (AMD) Service Review	Improve medisoft data input
	Reduce waiting time for first appointment
	Maintaining New patient record
	ICG Training
47273 - Diabetic eye laser documentation audit	Follow up issues to be raised with appointments and senior management. Propose instigation of E-Outcome for laser list
	Amend laser discharge letter to remove "discharged" from template. Clinicians to individualize letters and add details of follow up where possible
	Emails regarding laser patient follow up to be sent from ward email to improve audit trail
	New reception role to be made. Making follow up appointments for laser patients on the day will be incorporated into job description
56691 - School Age Pathway Audit	Update the pathways.
	To write on all patient notes who attend special school the pathways they follow.
	To Re-Audit in 12 months to assess if recommendations have been implemented.
Optometry Audit Programme	
42578 - Audit of Contact Lens Solutions	Notice in CL solution areas reminding staff to label bottles when opened
	Date Labels supplied in CL solution storage area (in case pens don't work)
	No more ordering of large saline bottles or Oxysept 1 step
	Increase small saline holding stock
	Decrease AOSept Plus holding stock
	Re-audit CL solution stock sheet completion and dating of CL solutions.
34607 - Trends in Management of Keratoconus	Use of protocol for referral of Keratoconus (all optometrists)

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	Fit contact lenses apical fit (all optometrists)
	Re audit in 2 years
45309 - Audit of Record Keeping by Optometrists in the Community Refraction Clinics	Awaiting Quality Improvement Action Plan.
Orthodontic Audit Programme	
48084 - Audit to assess the complication rates with IV sedation within the Warrington and Halton OMFS outpatient department.	Awaiting PowerPoint presentation / Quality Improvement Action Plan.
38427 - An audit on written communication with the referring general dental practitioners	Development of a series of standard template to ensure General Dental Practitioner (GDP) receives all the relevant information.
	Develop a key stage letters protocol for each unit.
	Consultants should ensure that letters are generated at all crucial stages, using standard templates by the trainees or specialists.
	New specialist trainees are made aware of the protocol and the template.
Orthoptic Audit Programme	
49893 - Cycloplegic Refraction Audit	For all Orthoptists to ensure they are adhering to all standards when administering cyclopentolate or any other dilating drops. To continue to use cyclo consent labels. Re-audit in 3 years' time to ensure standards are maintained.
35204 - Orthoptic SPLD Documentation Audit	Aim to increase the use of Test of Word Reading Efficiency (TOWRE) at last visit, where time permits this.
	To test Accommodation on ALL patients.
	To test Jump Convergence on ALL patients, where necessary.
	For patients having treatment for tracking difficulties ensure Full Developmental Eye Movement (DEM) tested.
42086 - Visual Field assessments in children with Special Educational Needs (SEN)	Review literature on methodology of Visual Fields (VF) testing in Special Educational Needs (SEN) cases. Special Educational Needs (SEN team).
	Review current practice in view of this literature. Special Educational Needs (SEN team).
	Determine guidelines for assessment of Visual Fields (VF) in specific cases within Special Educational Needs schools. Special Educational Needs (SEN team).
	Re-audit in 12 months.

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37869 - Orthoptic Record Keeping audit	Repeat audit annually.
	Update standards of record keeping including patient label to be placed on both sides of continuation sheet.
46141 - Parent / Guardian Satisfaction audit of the School Eye Care Service	To re-audit again in 2 years - Next audit should we get child's opinion?
52074 - Stroke Satisfaction Survey	Re-audit in 24 months' time.
46142 - The 2nd Parent / Guardian Satisfaction Audit of The Special Schools Eye Care Service	To give feedback to parents (brief written piece for the school newsletters). To give feedback to the schools (email the head teacher). Re-design the questionnaire for next audit.
Pathology - General Audit Programme	
38542 - 2016 Audit on the Use of O RhD Negative Blood	Submit report to Hospital Transfusion Committee and Transfusion Team.
	Change protocol for selecting the emergency blood in the laboratory.
	Re-audit.
38683 - Review of phoning CRP results if > 200mg/l to primary care/outpatients in relation to current practice of phoning only results >300mg/l	Currently no further action required: However, implement any actions proposed by the amended Royal College document which is currently under review.
47390 - 2016 Audit of collection and labelling of transfusion samples	Produce a 'Bloody Matters' newsletter.
	Discuss findings with St Rocco's Hospice.
	Submit report to the Hospital Transfusion Committee (HTC), the Transfusion Team (TT) and to the Patient Safety and clinical Effectiveness Committee.
42400 - 2016 Audit of the Blood Collection Process	Disseminate findings to the Hospital Transfusion Committee, Transfusion Team, and Patient Safety Committee.
	Discuss with Risk Manager of Women's Health the need to collect the anti-D when the patient is in clinic.
	Discuss with Antenatal Day Unit (ANDU) and ANC to remind their staff to collect anti-D when the patient is in clinic.
	Agree recommendations for collecting albumin.
	Produce 'Bloody Matters Newsletter' to send to all the wards.
30213 - An audit of the diagnosis and management of septic arthritis	Inform the microbiology laboratory staff about this audit and to ensure consistent reporting.
	To inform infection control team.
	Re-audit in 2018.

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	To inform AE matron.
35911 - An Audit of compliance with British Committee for Standards in Haematology (BCSH) guidelines on obtaining consent for systemic anti-cancer referrals	Re-Audit in 1 year due to consent form changing (3B) to see if any improvement in consenting.
	Distribute to Haematology team including nurses so aware of finding.
42850 - Re-audit: Appropriate Use of O PhD Negative Units of Blood	Submit finding to the Hospital Transfusion Committee (HTC).
34599 - Review of AKI 3 Patients	Review phoning with lab staff.
	Re-Audit 2018.
35903 - Re-audit (1250) of Lenalidomide use as per NICE	Compliance, so therefore continue practice. No actions required.
37345 - Audit of haemorrhage protocol activations for 2015	Submit report to Transfusion Team, Hospital Transfusion Committee and Patient Safety Sub Committee.
	Present finding of report to Trauma Team Meeting, Obstetrics and Anaesthetics.
32600 - 2015 Administration of Blood: Audit of Bedside Practice	Present findings to the Hospital Transfusion Team, Hospital Transfusion Committee and the Patient Safety Sub Committee.
	Produce "Bloody Matters" newsletter and submit to Governance for inclusion into the "Risky Business" newsletter.
	Add one slide to the Mandatory Training Sessions for 2016 summarising main results/standards.
46600 - A re-audit on microbiology testing and antibiotic treatment for severe CAP at Warrington General Hospital	Inform the Advancing Quality Team (AQUA team), respiratory consultants and the Executive lead with Quality remit. They need to monitor the appropriate testing.
36615 - Post- Operative Red blood cell transfusion in patients with fractured neck of femur	Present at the Hospital Transfusion Committee (HTC), Transfusion Team Meeting (TTM) and Patient Safety Sub Committee (PSSC).
	Bloody Matters Newsletter.
	Present to all appropriate areas.
39634 - Regional audit of Microbiology)	Consider to include in Antibiotic formulary: Pneumococcal Ag for moderate severity pneumonia:
investigations and antibiotic guidance in adult	At present we do this test for CURB-65 score of 3+ only (severe pneumonia).
patients admitted to hospitals with Community Acquired Pneumonia (CAP	Antibiotic formulary emphasises on clinical judgement in interpreting the severity assessment. Also the compliance with urinary pneumococcal antigen testing in severe pneumonia is quite poor as reflected by a different audit. This needs to be improved before implementing this test for moderate severity pneumonia.

Audit Title	Quality Improvement Action Plans
	Cost will be a prohibitory factor.
Pathology - Histopathology Audit Programme	
44475 - Prostate core biopsy measurement	Re-Audit in one year to ensure compliance is being met.
47688 - Re-Audit on squamous cell carcinoma	Amended reports have been issued and accurate AJCC 7th stage done.
40213 - Reporting of renal cell ca - compliance with RCPath MDS - re audit	Re-Audit in 2 years.
40216 - Procedure codes in Histopathology - re-audit	Re-audit in 12 months' time.
52560 – MDT Review 2015 lung and colposcopy	Repeat audit in 1 year time.
33950 - Re-audit on urgent histopathology requests (1011)	Re-audit against the RCPath standards and local guidelines after two to three years.
37326 - A comparative assessment of endoscopic findings in lower GI pathology with Histological diagnosis	To Present findings at the Surgical Audit Meeting.
44479 - Audit of ungraded CIN	Issue Guidelines. Re-Audit.
39388 - Re-Audit of adequacy of cervical biopsies	Remind pathologists to mention Transformation Zone (TZ) in reports.
	Inform colposcopists of results.
	Re audit in 1 year.
52567 - Audit of reporting profiles in cervical biopsies	Distribute data to individual pathologists. Re-audit end of 2017.
Pharmacy Audit Programme	
1423 - Medicine Policy Audit	Awaiting completed audit report.
18625 - Management of patients once a positive diagnosis of VTE is made	Review and update current Trust Anticoagulant Guidelines.
	Present results of Audit to the Trust Thrombosis Committee.
	Review and update the current Trust Anticoagulant Prescription chart.
22788 - Medicines Reconciliation	Awaiting completed audit report.
52529 - VTE Prophylaxis Jan - Apr 16	Email and present findings (F1 induction, mandatory training, ward managers, meet-up with staff).
	VTE Training to be included in Trust essential training.
	To Audit between 30-50 patients on a weekly basis.

Audit Title	Quality Improvement Action Plans
	Timely completion of Venous Thromboembolism (VTE) risk assessment prescription and administration of prophylaxis.
52535 - VTE Prophylaxis May - July	Continue data collection for period August - October 2016 – completed.
52536 - VTE Prophylaxis August - October	Continue data collection (Nov - Dec 2016).
	1. Lorenzo Indicator - further investigate with IT the possibility of a highlighting "flag" in Lorenzo when VTE risk assessment is not completed.
	2. Inpatient Admission Note - spoken with the Information Team regarding the feasibility for an automatic report to be generated from Lorenzo identifying the doctor who has clerked a patient on the "Inpatient Admission Note" and not completed the VTE risk assessment. This would be to identify if there are any training issues.
	3. Daily Outcome of VTE Assessment Report - meet with the Information Team to check if a report can be available to print which highlights the outcome of VTE risk assessment.
56526 - Point Prevalence Audit: **Oxygen prescribing for Inpatients at** **WHH NHS FT on 16/2/2017**	Escalate to Deputy Medical Director, Divisional Chiefs of Service and Deputy Chief Nurse.
	Produce a safety alert highlighting the issues surrounding oxygen prescribing. – For all prescribers and staff who administer oxygen.
	Medical Education Pharmacist to arrange teaching to doctors regarding oxygen prescribing.
	Discuss at pharmacists meetings so they are aware of the need to review oxygen prescriptions.
	Re-audit in 6 months' time.
53311 - Pharmacist prescription intervention Audit	Awaiting completed audit report.
Radiology Audit Programme	
56189 - Timing Panscan report	Awaiting Quality Improvement Action Plan.
42896 - Audit of Radiology Alerts communication and comparison with UK standard.	Need for Result Acknowledgement System.
46764 - Accuracy of pre MRI orbit image reporting by radiographers.	Re Audit in one year.
38844 - Appropriateness of usage of computed tomography pulmonary angiography (CTPA)	Planning to improve the ICE ordering system so it better reflect the locally-agreed protocol. If adopted, it should ask the clinician a series of questions to ensure the protocol is adhered to and the correct imaging is ordered.

Audit Title	Quality Improvement Action Plans
investigation of suspected pulmonary embolism	The locally-agreed protocol is available on Lorenzo but it is not interactive. A future version could enable the clinician to enter results as they become available and save a copy in the patient record.
	Will need to be agreed by IT, Radiology, AED and medical departments.
43741 - GP Plain film turnaround times	Re audit to ensure standards are being adhered too.
35516 - NG Feeding tube re-audit	Report to be sent to Trust Governance Lead for action – outside remit of radiology.
40244 - Availability of emergency equipment and expertise in the Radiology Department	Introduce formal Rota for checking of resuscitation equipment and drugs.
	Hospital pharmacy to perform regular checks on drugs.
38580 - An audit of the use of MRI in lobular breast carcinoma	Re-Audit 3 years to ensure good practice.
42263 - Review of imaging for MDT meetings	No further action required.
44517 - Re-Audit CT Head Injury Audit	Check registrar reports as soon as possible (secretaries could chase / remind).
	Secretaries to verify on typing CT Head reports, when clinical states head injury and it's a consultant report.
43497 - Accuracy of Cranial CT Reporting by Advanced Practice Radiographers	Re-audit in 1 year.
38583 - Audit of chest x-ray reporting by advanced practitioner radiologist	Re-audit in 1 year.
42856 - Artefacts on paediatric chest x-ray (CXR)	Share learnings regards CXR artefacts with radiographers.
	Re audit in 2 years.
38548 - Times to CT for Trauma team activations Jan-Oct 2015	Meeting both Network and National CT targets.
	Rapid decision making for CT to be done in a timely manner - awareness to all staff.
	Designated scribing.
31360 - AED Plain film turnaround time	Re-audit with CRIS data covering all days
	Discuss in Advanced Practice Meeting and Consultant Meeting
38573 - Audit of accuracy of pre-operative MRI compared to final surgical histology in patients with Breast Cancer undergoing Neo-adjuvant Chemotherapy.	None. Re-Audit unlikely to be beneficial
42246 - Head Injuries	Awaiting presentation / Quality Improvement Action Plan.

Audit Title	Quality Improvement Action Plans
47684 - World Health Organization (WHO) checklist use in Interventional Radiology	Scan World Health Organization (WHO) form onto Lorenzo. Ask Nurses to enforce World Health Organization (WHO) form completion. Unify the procedure form, World Health Organization (WHO) form into Local Safety Standards for Invasive Procedures (LocSSIPs), if possible.
53918 - NM Parathyroid Scan in WHH	Re-audit in 3 years.
42107 - Lens Exclusion in CT Head	Define circumstances / patient subtype & radiographers that should be excluded from re-audit.
	Phased implementation – aim to achieve 70% in 2 months.
	Encourage documentation of difficult cases.
	Head or gantry tilt – training if necessary.
29576 - An audit of short term recall cases Warrington Breast Unit 2013/2014	Repeat with larger numbers and review by 2 radiologists
	Better adherence to NHS BSP and local protocols (as per QA visit July 2016)
56611 - Management of Potential Scaphoid Injuries	Consider use of MRI in patients at secondary review with suspected Scaphoid fractures, re-audit in 2018.
56852 - Audit of Warrington & Halton Hospitals Compliance with Cheshire & Merseyside (C&M) Timed Lung Cancer Pathway	Ensure all relevant staff are aware of the lung cancer pathway. Re-audit in a years' time with a larger sample size.
Rheumatology Audit Programme	
39375 - Tocilizumab Prescribing	Awaiting Quality Improvement Action Plan.
36065 - Audit initiating biologic agents in inflammatory arthritis	Re audit Nice guidelines for initiating biologics in Psoriatic Arthritis (PsA), Rheumatoid Arthritis (RA) Ankylosing Spondylitis (AS).
	Developing Disease Activity Score (DAS) and Basdai sheets for Lorenzo.
	Developing 6 months follow-up sheets in Lorenzo.
45091 - Prolia shared care	Re audit.
	Develop a template for Prolia discharge patients with enclosed information re necessary monitoring.
	Write Se Ca level and eGFR on prescription so the pharmacist who dispense the drug knows that it was checked.
Surgical Audit Programme	
46959 - Two Stage Consent	Re-audit to assess compliance and improvement.

Audit Title	Quality Improvement Action Plans
35501 - Co-prescription of laxative with opioid prescribing.	Awaiting presentation / Quality Improvement Action Plan.
42643 - Urinary catheter discharge advice questionnaire	To devise and implement a urinary catheter passport. To implement within the Trust and across community services
	To change the Trust's catheterisation policy's to include the guidelines for the discharge process.
	To re-educate the staff on the catheter discharge process to include ward visits, posters in clinical areas to support. Advertise on the extranet
42316 - Accuracy of hernia ultrasound	Present findings at surgical audit meeting
31745 - Fissurectomy combined with high dose botulinum toxin A is a safe and effective treatment for chronic anal fissure and a promising alternative to surgical spincterotomy.	We have met all the standards but we need to maintain close monitoring so that we maintain or even improve the outcomes.
20309 - Prostate Cancer	Re-Audit 1-2 years' time.
44517 - Re-Audit CT Head Injury Audit	Check registrar reports as soon as possible (secretaries could chase / remind).
	Secretaries to verify on typing CT Head reports, when clinical states head injury and it's a consultant report.
20330 - Surgical Site Infection Rates	Register with National Public Health Surveillance Programme.
20313 - Urinary Incontinence in Women	Provision of logistics for MDT?
	Inclusion in job plan.
	Improvement in diagnostics evaluation and adherence to management guidelines.
	Development of pathways.
	Findings to be presented to the Women's Health.
36472 - Management of appendicitis in children	Awaiting presentation / Quality Improvement Action Plan.
38548 - Times to CT for Trauma team activations Jan-Oct 2015	Meeting both Network and National CT targets.
	Rapid decision making for CT to be done in a timely manner - awareness to all staff.
	Designated scribing.
53905 - Delegated Consent Form Audit	Continue with larger sample size audit.
	Share with Clinical Business Unit (CBU's) via Senior Management Team (SMT).
25834 - Trust documentation / record keeping Audit	Raise awareness by discussing finings with colleagues.
	Present findings at audit meeting.
42246 - Head Injuries	Awaiting presentation / Quality Improvement Action Plan.

Audit Title	Quality Improvement Action Plans
48958 - Enhancing the quality of discharge summaries	Re Audit in 3 months.
46194 - Management of Acute Cholecystitis	Awaiting presentation / Quality Improvement Action Plan.
40813 - Audit of Accommodation of Patients at End of Life - Single Rooms or not	Share this data with ward managers.
	Update Clinical Effectiveness Committee so awareness of impact of low numbers of single rooms is made more visible at hospital management level.
	Continue to collect data on relatives' views on care and respond to this.
47063 - Utility of (Magnetic Resonance cholangiopancreatography) (MRCP)in gallstone pancreatitis	Larger study - Re-audit in 6 months.
40809 - Hydration in the Dying Patient	Impact of this audit on education and teaching – updating information and processes.
	Use of IPOC to support dying patients.
	Review of NICE Guideline NG31 and use of IPOC
50460 - Elective Laparoscopic Cholecystectomy	Prospective audit - to look at why: Start from pre-op – why not booked as day case. Why are drains being used? If PONV/pain delay discharge, what anaesthetic technique/post-op care is given and can this be modified?
50467 - Use of the RSI checklist and apnoeic oxygenation	Highlight abbreviated checklist as option in high risk out of theatre Rapid Sequence Induction (RSI). Checklist available in all areas. ODP empowerment and involvement important.
	Improve awareness of apnoeic oxygenation with standard nasal cannula.
	Present findings to ODP staff next audit meeting Address O2 cylinder availability.
52975 - Audit of the use of the new emergency theatre booking form	Theatre coordinators to prompt urgency category from booking team.
	Adjustments to booking form in development – streamlined to essential information only, emphasising communication, availability and accessibility.
	Re-audit the use of the updated and simplified form
Therapies Audit Programme	
36876 - Appropriateness of Oral Nutritional Supplements in the Community	No formal actions.

Audit Title	Quality Improvement Action Plans
Trauma & Orthopaedic Audit Programme	
48918 - Documentation of Neurovascular status (upper & lower limb)	Explore feasibility of creating neurovascular documentation form in Exercise Pressor Reflex (EPR).
	Education regards documentation at induction, teachings etc. (posters).
	Re audit 6 Months.
48571 - Improving the quality of Trauma & Orthopaedic discharge summaries	Improving the Quality of the Trauma + Orthopaedic (T+O) Discharge Summaries by using "Hash's T+O Discharge Summary Checklist".
	Discharge summary pocket cards to be given to all juniors at Induction.
	Re-Audit in 6 months to ensure recommendations are achieved.
43347 - Spinal questionnaires - Do they come back?	No action plan. Data collection has ceased due to lack of personnel to implement Spine Tango data collection.
38276 - Trauma and Orthopaedic Trust Documentation Audit	Re audit in 1 year.
47483 - Management paediatric buckle fracture of distal radius.	Awaiting Quality Improvement Action Plan.
40172 - 5th Metacarpal Fracture - Audit it's management	Guidelines for AE to refer 5th metacarpal fractures to Fracture Clinic -Information leaflet. -Direct referral to Hand Therapist. -3 X-ray views required (AP, Oblique and True lateral). Early involvement of Hand therapist. -Reduce the need for follow up in Fracture clinic. -Better outcome for patient care. Re-audit and close the loop.
41760 - Re-Audit of compliance to protocol of 1st time shoulder dislocations.	Raise awareness regarding BESS/BOA Guidelines. Early upper limb referral regarding management.
48985 - Slips, Trips and Falls - Risk assessment	Feedback to falls prevention group. Feedback to Trust – If Trust's policy is to follow NICE guidelines then need to consider updating. Individualise approach to falls risk assessment and to management of that risk, multifactorial assessment and a multifactorial intervention.

Audit Title	Quality Improvement Action Plans
48862 - Improving the quality of Trauma + Orthopaedic discharge summaries (Re-Audit)	Improving the Quality of the Trauma + Orthopaedic Discharge Summaries by using "Hash's T+O Discharge Summary Checklist". Discharge summary pocket cards to be given to all juniors at Induction.
	Re-Audit in 6 months to ensure recommendations are achieved.
47207 - To determine if WHH are complying with the fracture clinic guidelines set by BOAST.	Re-audit in 12 months.
	Develop patient management pathways for orthopaedic injuries encountered in Emergency Department.
	Develop patient information leaflets.
36615 - Post- Operative Red blood cell transfusion in patients with fractured neck of femur	Update of hospital transfusion mandatory training for doctors and nurses.
	Introduction of transfuse and check initiative.
	Present Critical Care meeting.
34000 - Impact of removal of hip precautions in hemiarthroplasties - April 2015 to March 2016	Dissemination of audit results to all staff concerned.
31501 - Accuracy of recording operative site details on theatre lists	Re-Audit after the introduction of the new scheduling system.
33760 - Initial result of SYNOVASURE test for suspected periprosthetic infection.	Further study with larger group of patients and better methodology is required. - There is NO plan to start this action until we have more evidence in literature.
38816 - Audit of fracture neck of femur with delayed surgery beyond 36 hours.	Inform anaesthetists about NHFD guidelines. Re Audit in 12 months' time.
34569 - Primary care spinal assessment and imaging to secondary care - How long does it take?	Increase the sample size audit referrals from CATS/physiotherapy via therapists that dually work in spinal clinic at Halton to orthopaedic spinal service from May 2015 – April 2016.
	Audit the outcomes of New Patients in to the spinal clinic.
49211 - Re-audit of pre-operative investigations in Trauma patients	Display the NICE guidelines clearly in the trauma room for SHOs to see.
	Highlight the extra bloods being ordered to A&E staff.
	To include guidance in junior doctor teaching.
48927 - Slips, Trips and Falls - 2 Post fall documentation	Education of haw falls ought to be documented.
	Feedback to the Falls Prevention Group.
	Consider creating a new Falls Pathway template on Lorenzo. Re-Audit in 6 months' time.
44517 - Re-Audit CT Head Injury Audit	Check registrar reports as soon as possible (secretaries could chase / remind).
	Secretaries to verify on typing CT Head reports, when clinical states head injury and it's a consultant report.

Audit Title	Quality Improvement Action Plans
30251 - Re-Audit Unplanned transfers from CMTC to Warrington - Elective emergencies.	Awaiting presentation / Quality Improvement Action Plan.
47712 - Initial treatment of distal radius fractures (NG38)	Raise awareness and present findings regarding NICE CG at audit meeting on the 16/03/17. Regular Trauma List at CMTC. Early Senior decision regarding management.
43958 - Re-Audit: Haemoglobin checking after post-operative blood transfusion in patients with Hip fracture.	Re-audit in 3 months.
	Reminder email to current orthopaedic team.
37455 - Advancing quality in hip fracture management	Work with Emergency Department to improve pain assessment and analgesia within 60 minutes.
	Work with patient flow, ward nurses and Emergency Department team to improve four hour target to the ward.
	Work with ward nurses to improve pressure ulcer assessment within 6 hours and nutritional screen within 24 hours of admission.
	Re-audit to ensure compliance is being met.
32720 - The Outcome of Lumbar disc arthroplasty at Warrington Hospital.	Awaiting Quality Improvement Action Plan.
37135 - Monitoring our practice of using drains in reverse shoulder arthroplasty and evaluating outcomes.	There is no conclusive benefit of using drains in Reverse Shoulder Arthroplasty (RSA) therefore drains should not be used routinely.
	Re audit end of 2017.
24849 - Is dry needling an effective treatment for chronic non insertional Achilles Tendinopathy	No actions required.
31639 - Patient care and outcome improvement to SCARF Osteotomy - closing the loop (Re-Audit 1344)	No actions required.
49243 - What percentage of new fracture clinic referral are seen within 72 hours of referral in last 3 months.	Standardised fracture clinic template (Follow-up / new patients). Consider trauma triage/virtual fracture clinic model.
38548 - Times to CT for Trauma team activations Jan-Oct 2015	Meeting both Network and National CT targets.
	Rapid decision making for CT to be done in a timely manner - awareness to all staff.
	Designated scribing.

Audit Title	Quality Improvement Action Plans
40169 - Fracture neck of femur - Mobilisation strategies Post OP	Mr Sherry to carry out training to Orthopaedic Consultants on how to add operations notes on to Lorenzo.
36810 - Audit of EPIDURAL STEROID INJECTION practice at Warrington and Halton Hospitals NHS Foundation Trust	Continue to use Procedural template. Improve on Imaging archive. Improve on Discharge letter information. Consider including specific/key steps with technique/ procedure to full comply with guidelines. Re- audit to review improvement.
42246 - Head Injuries	Awaiting Presentation / Quality Improvement Action Plan.
34300 - Perioperative warming in arthroscopic shoulder surgery	Continue to raise awareness of hypothermia guidelines – present findings at audit meeting 16/03/17 (Orthopaedic).
49185 - Preliminary results of Medial Patellofemoral Ligament (MPFL) reconstruction.	Continue current protocol for Medial Patellofemoral Ligament (MPFL).
	Re-Audit 3 years when larger group.
56611 - Management of Potential Scaphoid Injuries	Consider to use of MRI in patients at secondary review with suspected Scaphoid fractures, re-audit in 2018.
Women's Health Audit Programme	
43356 - Ovarian stimulation and follicular tracking	Book appropriate appointments for Fertility Clinics. Discussion to be held with appointments. Introduction of a Fertility Nurse to see new patients first. Adjust Information leaflet to 6 cycles only.
35011 - Placental pathology and neonatal outcomes	No action required.
41789 - Term Admission - CQUIN	Unanticipated admissions proforma.
	MDT review to identify lessons learnt.
43362 - Electronic fetal monitoring	Distribute findings to midwives and doctors
	Re-audit in 12 months.
33077 - Management of ectopic pregnancy 2014	To improve documentation (on Lorenzo) that trainees are performing surgery.
	If no IUP on USS HCG has to be done on the same day with a senior review and management plan and follow up until its < 20.
43157 - Hysteroscopic morcellation of uterine fibroids (Myosure)	Re-audit as per NICE criteria in 1 year.
	Modify proforma to include.
	discussion with patient pre op.
	Include review of symptoms and quality of life at 3/52 assessment.
	Improve documentation – proforma completion and referral pictures.
39174 - Maternal Transfer	Update Situation, Background, Assessment and Recommendation (SBAR) form in guidelines.

Audit Title	Quality Improvement Action Plans
36609 - Invasive cervical cancer meeting	Further audit suggested based on breaches.
33245 - Failed Instrumental Delivery	Prospective audit of full dilatation CS
52953 - Effectiveness of acupuncture on pain conditions in pregnancy (Pelvic Girdle, Back Pain, Sciatica)	Awaiting presentation / Quality Improvement Action Plan.
44404 - Test of Cure Smear Outcome after LLETZ	Improve excisional techniques to meet targets of: – Single specimen. – Minimum depth 7 mm.
	Depth of excision to be mandatory field on Compuscope database. Rationale for multiple piece Large loop excision of the transformation zone (LLETZ) specimen to be mandatory field on Compuscope.
	Re-audit 2016/17 Treatment outcomes.
38743 - Infant deaths North West 2013-2015	Child Death Administrator Role Clearly defined.
	CARI: Care of At Risk Infants (Family history of child deaths) Clinic started.
47046 - Trust documentation / record keeping	Buddy system to be implemented to improve Senior reviewing. Annual re-audit 2017.
46124 - Audit of management of hypothyroidism in pregnancy	No Actions from Women's Health Meeting.
39800 - Neonatal Cooling Therapy audit	Rectal probe for monitoring temperature.
	Recording target temperature achieved time or documenting discharge temperature in case of not achieving target temperature at the time of transfer.
47040 - Obstetric admissions to HDU over 12 months (38141)	Audit obstetric sepsis.
	Consultant involvement to be documented – shown by repeat audit.
	Expression of interest for PROMPT training.
	Training midwives questionnaire.
38710 - Timing of Elective Caesarean Section	Raise awareness of timing and validity of indications.
	Documentation of reasons if <39 weeks Use of steroids if <39 weeks.
	Review again in 12-18 months.
55030 - The Use of the Modified Early Obstetric Warning Score (MEOWS Audit	Remind staff of the need to appropriately action the triggers on the MEOWS chart, within a timely manner as per the action flow chart.
	Circulate this audit to all staff to ensure all staff are aware

Audit Title	Quality Improvement Action Plans
	of the areas in which improvement is required.
	Continue MEOWS training on the mandatory study days.
	Remind staff to record observation on the partogram when in labour as this information cannot be recorded on MEOWS.
45324 - Midwifery Led Unit On-going Auditing of **Services & Outcomes (care in labour audit)**	Continue monthly audits to monitor compliance and feedback to midwives, share good practice and audit findings to team.
	Amendments to Intrapartum risk assessment to combine fetal monitoring tool, to reduce duplication and confusion.
48066 - Consent Form Documentation Audit	Re-Audit: December 2017.
34945 - Audit referrals to Colposcopy clinic	To start one stop cervical minor procedure clinic.
33867 - Audit of Actim Partus for threatened preterm labour.	Single point lesson produced to be disseminated to all staff via clinical leads.
43012 - Maternal transfer from the "low risk" to "high risk" intrapartum pathway during labour	Monthly prospective audit of all maternal transfers and annual report. Prospective audit of all maternal transfers and annual report.
	Benchmark maternal transfer rates against birth place study.
43135 - Ultrasound guided cervical dilation for cervical stenosis.	No actions required.
49665 - Audit of outcomes for patients undergoing Urogynaecology surgery at Warrington Hospital – British Society of Urogynaecology Audit	Awaiting Quality Improvement Action Plan.
40210 - Laparoscopy vs. Laparotomy for gynaecology cases.	No actions required.
38141 - Obstetric admissions to ITU over 12 months	Audit obstetric sepsis.
	Training midwives questionnaire.
	Consultant involvement documented.
	Expression of interest for PROMPT training.
55600 - Compliance to KPI standards for Sickle Cell and Thalassaemia Programme	Awaiting Quality Improvement Action Plan.
34399 - Merseyside anaesthetic group for improving quality - Mersey intubation checklist	Redesign of check list to include intubation details in ICU- This will ensure every intubation starts with check list and completes with intubation details.

Audit Title	Quality Improvement Action Plans
(MAGIQ-MIC)	Re audit the use of new airway form in ICU to see the compliance.
	Improved training of Intensive Care Unit (ICU) staff for RSI assistant role in ICU and new DAS guidelines- Onsite training or training on attendance to WAM course.
	Improved training of ODPs, recovery nurses for new DAS guidelines and use of rapid sequence induction (RSI) check list.
21739 - Patient Questionnaire	To audit the waiting times from referral to treatment / to produce an audit more specific to the diagnostic service at WHH.
	Holistic needs assessment clinic sessions to be organised in a more formal environment.
	To ensure Cancer Nurse Specialist is present at the time of diagnosis.
55626 - Timely Assessment of Women with Hepatitis B 1st January 2016 – 31st December 2016	Awaiting Quality Improvement Action Plan.
51899 - Adherence to Regional Screening Committee Standards for The Vaccination of babies born to Hepatitis B positive women.	Continue annual audit. Continue to highlight any issues regarding programme at local and regional screening meetings.

2.2.3 Participation in Clinical Research and Development

The number of patients receiving relevant health services provided or sub- contracted by Warrington and Halton Hospitals NHS Foundation Trust in 2016/17 that were recruited during that period to participate in research, approved by a research approved by the a research ethics committee, was 587**.**

Warrington and Halton Hospitals NHS Foundation Trust recognises that participation in clinical research demonstrates our commitment to improving the quality of care we offer both by helping ensure our clinical staff stay abreast of the latest possible treatment options and because active participation in research leads to successful patient outcomes.

In 2016-2017 the Trust was involved in conducting 59 clinical research studies in research in oncology, surgery, stroke, reproductive health, anaesthetics, rheumatology, gastroenterology, ophthalmology, as well as paediatric and other studies.

Research and Development at the Trust is currently mainly supported through external income from the North West Coast Local Research Network together with income obtained through grants and commercial work; the majority of this research being nationally adopted studies as part of the National Institute for Health Research (NIHR). The Trust has worked with the network and other

health providers over the year to increase NIHR clinical research activity and participation in research.

The Trust has also adopted the Health Research Authority (HRA) procedures which moved the emphasis towards acceptance of HRA assessment within the framework of research governance, strict legislation and recognised good clinical practice and local assessment of capability and capacity to run a study.

Most of the research carried out by the Trust is funded by the NIHR. For 2016-2017 the Trust received £400,000 which funds 9 research nurses to support Principal Investigators with recruitment and to assist with the management of NIHR studies ensuring that the study runs safely and in accordance with the approved protocol.

2.2.4. The CQUIN Framework

The Commissioning for Quality and Innovation (CQUIN) framework forms one part of the overall approach on quality, which includes: defining and measuring quality, publishing information, recognising and rewarding quality, improving quality, safeguarding quality and staying ahead.

The aim of the CQUIN payment framework is to support a cultural shift by embedding quality improvement and innovation as part of the commissioner-provider discussion. The framework is intended to ensure contracts with providers include clear and agreed plans for achieving higher levels of quality by allowing the commissioners to link a specific modest proportion of providers' contract income to the achievement of locally agreed goals. The locally agreed goals, which should be stretching and realistic, are discussed between Trust Board, commissioners and providers and included within contracts.

A proportion of Warrington and Halton Hospitals NHS Foundation Trust's income in 2016/2017 was conditional upon achieving quality improvement and innovation goals agreed between Warrington and Halton Hospitals NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2016/17 and for the following 12 month period are available electronically at www.whh.nhs.uk.

The monetary total for the amount of income in 2016/17, conditional upon achieving quality improvement and innovation goals, was £4,476,672 with a monetary total for the associated payment in 2016/17 of £4,126,057 received. However, the associated payment received could have been £3,782,057 if a year-end deal had not been agreed with Warrington and Halton CCG. In 2015/16 the trust received a monetary total for the associated CQUINs of £4,248,324 against a target of £4,334,164.

The Trust had the following CQUIN goals in 2016/2017 which reflected both national priorities and Department of Health initiatives and also reflecting local needs and the views of the patients and commissioners.

CQUIN Report 2016/2017

No.	Description	% of contract value	Total estimated value
	NATIONAL CQUINS		
1	NHS Staff Health and Wellbeing	0.25%	£430,204
1a	Introduction of health & wellbeing initiatives Option B		
1b	Healthy food for NHS staff, visitors and patient	0.25%	£430,204

No.	Description	% of contract value	Total estimated value
1c	Improving the uptake of flu vaccinations for front line staff within Providers	0.25%	£430,204
2	Timely identification and treatment of Sepsis		£0
2a	Timely identification and treatment for Sepsis in emergency depts.	0.125%	£215,102
	Screening		
	Review		
2b	Timely identification and treatment for Sepsis in acute IP settings	0.125%	£215,102
	Screening		
	Review		
3	Antimicrobial Resistance and Antimicrobial Stewardship		
3a	Reduction in antibiotic consumption per 1,000 admissions	0.20%	£344,163
3b	Empiric review of antibiotic prescriptions	0.05%	£86,041
	TOTAL NATIONAL CQUIN VALUE	1.25%	£2,151,019
	LOCAL CQUINs		
4	AQ		
4a	AQ COPD	0.02%	£34,416
4b	AQ Diabetes	0.02%	£34,416
4c	AQ Pneumonia	0.02%	£34,416
5	Frailty	1.00%	£1,720,815
6	Dementia - John's Campaign	0.19%	£326,955
	TOTAL LOCAL CQUIN VALUE	1.25%	£2,151,019
	SPECIALIST COMMISSIONING CQUINS		
	Neo Natal Admissions		£15,300
	Innovations on transitional care in neonates		£60,099
	Nationalised standardised dose banding Adult IV systemic Anticancer Therapy		£10,010
	TOTAL SPEC COMM VALUE		£85,409
	NHSE PUBLIC HEALTH CQUINS		
	Dental		£47,775
	Cancer Screening Programme		£31,724
	TOTAL NHSE PUBLIC HEALTH VALUE		£79,499
TOTAL VALUE OF ALL CQUINS		**£4,466,946**	

2.2.5 Care Quality Commission (CQC) Registration

Warrington and Halton Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is registered without conditions.

The Care Quality Commission has not taken enforcement action against Warrington and Halton Hospitals NHS Foundation Trust during 2016-2017.

The Trust is registered to provide the following services:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures

- Family planning
- Maternity and midwifery services
- Surgical procedures
- Termination of pregnancies
- Treatment of disease, disorder or injury

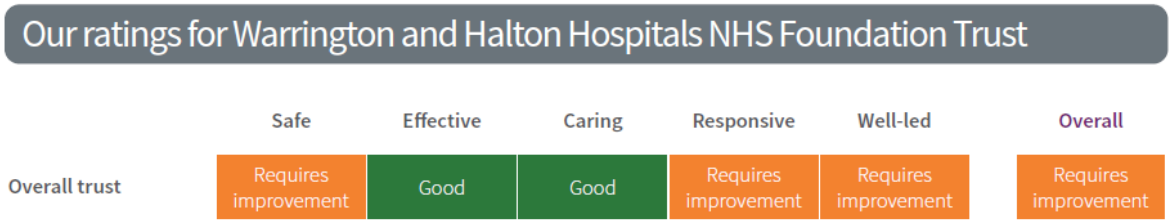
Warrington and Halton Hospitals NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

2.2.5.1 CQC Inspections

The Trust was inspected by the CQC in March 2017.

At the time of writing the Trust is awaiting the CQC's detailed analysis, formal report, and ratings.

The rating below are in relation to the previous Trust inspection which was conducted in 2015; the CQC rated Halton Hospital as **good**, Bath Street Health and Wellbeing Centre (in Warrington where several clinic services are provided) as **good** and Warrington Hospital as **requires improvement**. They rated caring and effectiveness in the Trust as good across the board in all of its services.



2.2.6 Trust Data Quality

Warrington and Halton Hospitals NHS Foundation Trust submitted records during 2016/17 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics, which are included in the latest published data.

The percentage of records in the published data which included the patient's valid NHS Number was:

Admitted Patient Care	99.76%
Outpatient Care	99.91%
A&E Care	99.31%

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

Admitted Patient Care	99.98%

Outpatient Care	99.99%
A&E Care	98.98%

Warrington and Halton Hospitals NHS Foundation Trust will be taking the following actions to improve the data quality. The Trust's data quality team work closely with operational teams to ensure data collected Trust wide on our systems is accurate and completeness.

A detailed action plan supports improvement in key areas relating to general data quality, Trust key performance indicators, finance and contract performance. Progress against the Data Quality work plan is monitored by the Data Quality and Management Steering Group, which reports to the Finance and Sustainability Committee.

2.2.6.1 Information Governance

Warrington and Halton Hospitals NHS Foundation Trust's Information Governance Assessment overall score for 2016/2017 was 67%, and was graded as green ('satisfactory').

During the 2017/2018 financial year, progress against the Information Governance work plan and associated action plans will be monitored by the Information Governance and Corporate Records Sub-Committee which reports to both the Finance and Sustainability and Quality Committees.

The Trust was subject to an assurance review of its Information Governance self-assessment by the Trust's internal auditors (Mersey Internal Audit Agency) in March 2017. Following review of the available evidence to support the IG Toolkit returns for 2016/17 the Trust was provided with a Significant Assurance rating.

2.2.6.2 Clinical Coding/Payment by Results (PBR)

In 2016 Warrington and Halton Hospitals NHS Foundation Trust underwent a clinical coding audit by the Trust's internal auditors (Mersey Internal Audit Agency) and achieved the following results:

Primary Diagnosis	91.18%
Secondary Diagnosis	93.90%
Primary Procedure	89.66%
Secondary Procedure	91.11%

The overall accuracy of clinically coded data was categorised as very good in the May 2016 Mersey Internal Audit Agency report and meets the level 2 standard defined in requirement 14-505, contained in version 14 of the NHS Digital Information Governance Toolkit.

2.3. Core Quality Indicators 2016/2017

The 2012 Quality Account Amendment Regulations (10) state that Trusts are required to report against a core set of quality indicators using the following standardised statement set out as follows:

Where the necessary data is made available to the Trust by the Health and Social Care Information Centre, a comparison of the numbers, percentages, values, scores or rates of the Trust (as applicable) are included for each of those listed with:-

- The national average for the data.
- The NHS Trusts and NHS foundation Trusts with the highest and lowest of the same, for the reporting period.
- Present, in a table format, the percentage/proportion/score/rate/number for at least the last two reporting periods.

Trusts are only required to include indicators that are relevant to the services they provide.

2.3.1a Summary Hospital-Level Mortality Indicator (SHMI)

The value and banding of the summary hospital-level mortality indicator (SHMI) for the Trust for the reporting period was:

SHMI

DATE PERIOD	TRUST	BANDING	HIGHEST	LOWEST	NATIONAL
October 2015 – September 2016	108.52	2	116.02	68.91	100
July 2015 – June 2016	110.12	1	117.45	70.03	100
April 2015 – March 2016	112.44	1	118.50	68.00	100
January 2015 – December 2015	117.94	1	117.94	68.00	100
October 2014 – September 2015	114.08	1	117.74	65.16	100
July 2014 – June 2015	114.36	1	120.89	66.05	100
April 2014 – March 2015	114.45	1	120.98	66.96	100
January 2014 – December 2014	115.58	1	124.34	65.53	100
October 2013 – September 2014	111.21	2	119.82	59.66	100
July 2013 – June 2014	109.40	2	119.80	54.10	100
April 2013 – March 2014	108.20	2	119.70	53.90	100
January 2013 – December 2013	109.20	2	117.60	62.40	100
October 2012 – September 2013	110.21	2	118.59	63.01	100
July 2012 – June 2013	112.06	2	115.63	62.59	100
April 2012 – March 2013	112.90	1	116.97	65.23	100
January 2012 – December 2012	110.69	2	119.19	70.30	100

NB: This information is re based so there may be a variation from HED monthly reporting.

Warrington and Halton Hospitals NHS Foundation Trust considers that this data is as described for the following reasons, in that this is a nationally accepted dataset, which is submitted to the Department of Health at agreed frequency. The Trust is also able to extract this information from the Healthcare Evaluation Data (HED) benchmarking system to facilitate further analysis. Trusts are banded 1-3 as follows:-

1. The Trust's mortality rate is 'higher than expected'
2. The Trust's mortality rate is 'as expected'
3. Where the Trust's mortality rate is 'lower than expected'

SHMI – Mortality Rates

The Summary Hospital-level Mortality Indicator (SHMI) reports on mortality at Trust-level across the NHS in England. This indicator is produced and published quarterly, as an official statistic by the Health and Social Care Information Centre (HSCIC) with the first publication in October 2011. The SHMI is the ratio between the actual number of patients who die at the Trust, or within 30 days of being discharged, and the number that would be expected to die, on the basis of average England figures. A number below 100 indicates fewer than the expected numbers of deaths, and a number above 100 would suggest a higher than expected number of deaths.

The Warrington and Halton Hospitals NHS Foundation Trust has taken the following actions to improve this rate and so the quality of its services, by monitoring mortality ratios on a monthly basis using the HED system and reported an 'as expected' score in the rolling 12 month periods from October 2015 to September 2016. This is a marked improvement, as our score for the period January 2015 to December 2015 was 'higher than expected' at 117.94. Our crude death rates remain comparable with local peer Trusts; however we will continue to progress with the actions in the areas outlined in section 3.3.1.

The SHMI is one of two mortality measures used in the NHS, the other being HSMR (Hospital Standardised Mortality Ratio), which is 106.58 for the latest data period available (February 2015 to January 2016). This is within the range of 'as expected'.

Mortality ratios are complex indicators and there are multiple factors that contribute to the overall score, including the quality of our documentation and coding.

2.3.1 Percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust for the reporting period

Deaths with Palliative Care Coding

DATE PERIOD	TRUST	ENGLAND	HIGHEST	LOWEST
October 2015 - September 2016	28.80%	27.29%	95.23%	1.04%
July 2015 - June 2016	25.38%	26.76%	94.73%	0.27%
April 2015 – March 2016	23.48%	26.05%	96.20%	0.27%
January 2015 – December 2015	25.49%	25%	99%	0.26%
October 2014 - September 2015	27.5%	23.7%	52.8%	10.1%
July 2014 - June 2015	28.2%	23.1%	47.8%	9.3%
April 2014 – March 2015	27.5%	22.5%	46.2%	7.7%
January 2014 – December 2014	27.6%	22.3%	44.6%	6.7%

October 2013 - September 2014	26.4%	21.7%	46.7%	6.1%
July 2013 - June 2014	30.5%	24.6%	49%	7.4%
April 2013 – March 2014	27.7%	23.6%	48.5%	6.4%
January 2013 – December 2013	22.8%	22%	46.9%	1.3%
October 2012 - September 2013	19.9%	20.9%	44.9%	2.7%
July 2012 - June 2013	18.9%	20.3%	44.1%	4.2%
April 2012 – March 2013	17.2%	19.9%	44%	0.1%
January 2012 – December 2012	14.4%	19.1%	42.7%	0.1%

***The palliative care indicator is a contextual indicator.**

Warrington and Halton Hospitals NHS Foundation Trust considers that this data is as described for the following reasons, in that this is a nationally accepted dataset which is submitted to the Department of Health at agreed frequency. The Trust is also able to extract this information from the Healthcare Evaluation Data benchmarking system to facilitate further analysis.

Warrington and Halton Hospitals NHS Foundation Trust intends to take the following actions to improve the rate and so the quality of its services by investigating the detail behind the ratio numbers, we identified that our rate of service provision was the lowest in the North West prior to 2012/2013, and we have worked hard to now be in a position in which we compare favourably with local peers. The Trust was below the England average but has improved over the years to a steady rate, which is comparable with the England average. We now have a Head of Coding in place since May 2016 and a lot of improvement work has been conducted around correctly coding our palliative patients.

2.3.2 Patient reported outcome measures (PROMs) for (i) groin hernia surgery, (ii)* varicose vein surgery, (iii) hip replacement surgery, and (iv) knee replacement surgery.

*PROMs also exist for varicose vein; however the Trust does not undertake this procedure

This data is made available to the Trust by the Health and Social Care Information Centre with regard to the Trust's patient reported outcome measures scores for— groin hernia surgery, varicose vein surgery, hip replacement surgery, and knee replacement surgery, during the reporting period were:-

Patient Reported Outcome Scores

		Groin hernia	Hip replacement	Knee replacement
Year	**Level**	**Average health gain**	**Average health gain**	**Average health gain**
2014/2015	Trust	0.065	0.414	0.315
2014/2015	England	0.084	0.436	0.357

2014/2015	Highest	0.123	0.523	0.357
2014/2015	Lowest	0.038	0.381	0.269
2013/2014	Trust	0.062	0.415	0.335
2013/2014	England	0.085	0.436	0.323
2013/2014	Highest	0.139	0.544	0.424
2013/2014	Lowest	0.007	0.310	0.214
2012/2013	Trust	0.062	0.428	0.357
2012/2013	England	0.085	0.438	0.318
2012/2013	Highest	0.153	0.539	0.416
2012/2013	Lowest	0.014	0.319	0.209
2011/2012	Trust	0.084	0.438	0.310
2011/2012	England	0.087	0.416	0.302
2011/2012	Highest	0.249	0.668	0.537
2011/2012	Lowest	-0.084	0.282	0.144

http://www.hscic.gov.uk/catalogue/PUB11359

Warrington and Halton Hospitals NHS Foundation Trust considers that this data is as described for the following reason in that the PROMs data is a nationally agreed dataset. The data is collected, processed, analysed and reported to the Health and Social Care Information Centre by a number of organisations, including hospital Trusts which perform PROMs procedures. PROMs calculate the health gains after surgical treatment using pre and post-operative surveys. The Health and Social Care Information Centre is responsible for scoring and publishing of PROMs data as well as linking it to other data sets such as Hospital Episodes Statistics.

Warrington and Halton Hospitals NHS Foundation Trust intends to improve the rate and so the quality of its services by ensuring that PROMs data will be monitored by the Patient Experience Sub-Committee.

2.3.3 Emergency readmissions to hospital within 28 days of discharge

NB: This data is not available on HSCIC and the technical specification for the dataset is not available so the Trust cannot replicate the data using local information.

It has been acknowledged that an error was made in the drafting of the regulations and that the split of patients for this indicator should be

0 to 15; and

16 or over,

This indicator on the HSCIC Indicator Portal was last updated in December 2013 and the proposed update that was due to take place in August 2016 was postponed, therefore there is no up to date information.

Emergency readmissions to hospital within 28 days of discharge (age 16<) *

DATE PERIOD	TRUST	ENGLAND	HIGHEST	LOWEST
2014/2015	*	*	*	*
2013/2014	*	*	*	*

2012/2013	*	*	*	*
2011/2012	13.58	10.01	13.58	5.10
2010/2011	12.08	10.15	13.94	5.85
2009/2010	11.77	10.18	14.44	6.38

NB: Information Centre provides data by 16> not 15>

*** Data for 2012/15 is not available from the Information Centre**

Emergency readmissions to hospital within 28 days of discharge (age 16>) *

DATE PERIOD	TRUST	ENGLAND	HIGHEST	LOWEST
2014/2015	*	*	*	*
2013/2014	*	*	*	*
2012/2013	*	*	*	*
2011/2012	12.44	11.45	13.50	8.96
2010/2011	11.66	11.42	12.94	7.6
2009/2010	11.75	11.16	13.17	7.3

NB: Information Centre provides data by 16> not 15>. Data relates to medium sized acute Trusts.

*** Data for 2012/15 is not available from the Information Centre**

Warrington and Halton Hospitals NHS Foundation Trust considers that this data is as described for the following reasons, in that this is a nationally accepted dataset which is submitted to the Department of Health at agreed frequency. The Trust is also able to extract this information from the Healthcare Evaluation Data benchmarking system to facilitate further analysis.

Warrington and Halton Hospitals NHS Foundation Trust has taken the following actions to improve this data and so the quality of its services, by reporting all data to the Trust Board and the Clinical Operational Board.

2.3.4 Responsiveness to inpatients' personal needs in the CQC national inpatient survey

The following data for two reporting periods with regard to the Trust's responsiveness to the personal needs of its patients during the reporting period is made available to the Trust by the Health and Social Care Information Centre.

CQC national inpatient survey – personal needs

DATE PERIOD	TRUST	ENGLAND	HIGHEST	LOWEST
2015/2016	70.9	69.6	86.2	54.4
2014/2015	72.0	68.9	86.1	59.1
2013/2014	69.4	68.7	84.2	54.4
2012/2013	66.7	68.1	84.4	57.4

2011/2012	66.2	67.4	85	56.5
2010/2011	67.4	67.3	82.6	56.7

Warrington and Halton Hospitals NHS Foundation Trust considers that this data is as described for the following reasons, central to the Trust ethos is the view that patients deserve high-quality healthcare, and patients' views and experiences are integral to successful improvement efforts. As such it employs Quality Health to undertake a robust and comprehensive survey of patients experience on an annual basis.

Warrington and Halton Hospitals NHS Foundation Trust intends to continue work to improve this percentage and so the quality of its services.

2.3.5 Percentage of staff who would recommend the provider to friends or family needing care.

The data is made available to the Trust by the Health and Social Care Information Centre via the National NHS Staff Survey Coordination Centre with regard to the percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.

Staff who would recommend the provider to friends or family needing care by percentage

DATE	TRUST	HIGHEST	LOWEST	ACUTE TRUSTS
2016	57%	85%	49%	70%
2015	54%	93%	38%	70%
2014	61%	89%	38%	65%
2013	65%	93.9%	39.6%	67%
2012	58%	69%	35%	65%
2011	57%	89%	33%	65%

Warrington and Halton Hospitals NHS Foundation Trust considers that this data is as described for the following reason, in that this report presents the findings of the 2016 national NHS staff survey conducted by Quality Health on behalf of the trust. Quality Health utilises high quality research methodology and mixed method collection resulting in a 38% response rate.

This year the Trust decided to give all staff the opportunity to respond to the staff survey rather than a statically representative sample. Therefore with a response rate of 38% almost 1500 WHH staff responded to the survey. The response rate also indicates an increase of 5% on the 2015 survey and improves the trusts performance and puts the trust in the average response rates for acute trusts for the first time. The trusts view is that the results are statistically representative.

Warrington and Halton Hospitals NHS Foundation Trust intends to take the following actions to improve to improve this score and so the quality of its services by using the percentage of staff

recommending the trust as a place of work and treatment within the staff survey alongside the quarterly staff friends and family test results. The percentages are compared with the qualitative detail that these surveys also give and action plans are developed as appropriate. The key themes are reported to Clinical Business Units and departments to give managerial ownership of the findings. The results are also reported to the Strategic People Committee where an overall report is given on actions taken to improve the scores. The Trust is currently still working to develop the staff voice and embed the Trust 'We are' values and behaviours framework across the trust and hope that this should continue to improve a number of the factors, improving engagement levels and therefore patient care.

2.3.6 Percentage of admitted patients risk-assessed for Venous Thromboembolism

The data made available to the National Health Service Trust or NHS foundation Trust by the National Commissioning Board with regard to the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.

Venous Thromboembolism (VTE) – percentage of risk assessments undertaken

Year	Level	Q1	Q2	Q3	Q4
2016/2017	Trust	90.19%	92.50%	94.26%	**
	National Average	95.73%	95.51%	95.64%	**
	Highest	100%	100%	100%	**
	Lowest	80.61%	72.14%	76.48%	**
2015/2016	Trust	96.6%	96.1%	88.56%	88.37%
	National Average	96%	95.9%	95.5%	95.53%
	Highest	100%	100%	100%	100%
	Lowest	86.1%	75%	61.5%	48.63%
2014/2015	Trust	95.70%	95.60%	95.00%	95.93%
	National Average	96.00%	96.10%	96.00%	96.00%
	Highest	100%	100%	100%	100%
	Lowest	87.20%	86.40%	81.00%	79.23%
2013/2014	Trust	95.54%.	95.60%	96.50%	96.00%
	National Average	95.39%	95.69%	95.80%	96.00%
	Highest	100%	100%	100%	100%
	Lowest	78.78%	81.70%	77.70%	79.00%
2012/2013	Trust	95.40%	95.10%	94.00%	93.90%
	National Average	93.40%	93.80%	94.00%	94.20%
	Highest	100%	100%	100%	100%
	Lowest	80.80%	80.90%	84.60%	87.90%
2011/2012	Trust	95.60%	96.20%	95.40%	96.20%
	National	81.00%	88.00%	91.00%	93.00%

	Average				
	Highest	***	***	100%	100%
	Lowest	***	***	32.40%	69.80%

******* ***= This data is not currently available from the Information Centre.***

********* ***= This data has been archived and is unavailable.***

The Warrington and Halton Hospitals NHS Foundation Trust considers that this data is as described for the following reasons in that this is a nationally accepted dataset which is submitted to the Department of Health at agreed frequency.

Warrington and Halton Hospitals NHS Foundation Trust has a well-developed system for undertaking risk assessments on admission and ensuring the data is collated corporately and incorporated into the Quality Dashboard for monthly review and monitoring by both the Quality Committee and Trust board. More recently in November 2015 the Trust introduced a new Electronic Patient Record (EPR) system (Lorenzo). Unfortunately whilst Lorenzo has provided significant benefits and opportunities for the Trust overall, since 'go live' there have been issues with accessing accurate data for quality indicators for example dementia and VTE screening.

Issues identified:

1. Medical staff do not always complete the VTE risk assessment when clerking patients in.
2. On some occasions the VTE risk assessment form is attached to the wrong encounter or a different Trust risk assessment form is used and consequently these then appear as not completed.
3. VTE risk assessments completed in ED are not picked up by the reporting system when ED have not recorded the decision to admit time (DTA)
4. The report from information does not pick up the "inpatient admission note" if it is created in ED.
5. Although a Clinical Indicator has been developed by the Information Team to highlight missing VTE risk assessments, this indicator does not pick up risk assessments that are completed in ED rather than the inpatient encounter.
6. Some patients do not require a VTE risk assessment and can be cohorted (included in the figures as 'action completed'. However since the cohorts were created a further group of patients have been identified for inclusion in the cohort group but this action has not yet taken place (requires approval

Actions that we have taken:

1. Clinical Directors have conducted education sessions with all doctors to ensure that they complete VTE risk assessments when clerking in the patients on the inpatient admission note.
2. The Emergency Department are ensuring that we monitor that the Diagnostic Test Accuracy is recorded for all patients.
3. Further assurance work is being undertaken by our IT department to ensure that all inpatients admission notes are picked up for reporting.
4. IT to investigate if it is possible to get around the current limitation in the indicator report.
5. In order to provide accurate report, IT are amending the cohort table to include the identified additional groups of patients.

When the data is corrected to include VTE risk assessments that are not captured via the information report, VTE risk assessment completion rates for November, December 2016 and January, February 2017 are exceeding the 95% risk assessment target.

2.3.7. Treating Rate of C. difficile per 100,000 bed days amongst patients aged two years and over

The data made available to the National Health Service Trust or NHS foundation Trust by the Health and Social Care Information Centre with regard to the rate per 100,000 bed days of cases of C.difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period.

Warrington & Halton NHS Trust Clostridium difficile infections per 100,000 bed days

DATE	TRUST	NATIONAL
2015/2016	17.4	14.9
2014/2015	16.9	15.1
2013/2014	16.3	14.7
2012/2013	9.4	17.3 (now 17.4)
2011/2012	21 (now 19.2)	21.8 (now 22.2)
2010/2011	35.9 (now 34)	29.6 (now 29.7)

The Information Centre only provides average by Trust (not by highest and lowest) and 2016/17 data is not currently available.

The Warrington and Halton Hospitals NHS Foundation Trust considers that the data is as described for the following reasons there is a robust system for data entry and validation which ensures all cases are entered onto the data Capture system.

The Warrington and Halton Hospitals NHS Foundation Trust has taken the following actions to improve this rate and so the quality of its services, by:

- Action plan in place to reduce Clostridium difficile
- Increase in hours to the Antimicrobial Pharmacist role
- Participation in the national AMR CQUIN
- Participation in European Antibiotic Awareness Day
- Fidaxomicin used for treatment of patients with recurrent Clostridium difficile infection
- Antimicrobial steering group with feedback to Clinicians on incidences of antimicrobial prescribing non-compliance
- Surveillance of cases/monitoring for increased incidences in defined locations
- Improvements to methods of investigation for Clostridium difficile cases
- Cohort isolation facility maintained to manage cases
- Text alerts to senior managers to report Clostridium difficile cases
- Increase in ward based training for management of infectious diarrhoea, viral gastroenteritis outbreaks and use of personal protective equipment and single point lessons on Clostridium difficile and use of SIGHT mnemonic
- Environment Group re-established to monitor and direct improvements in standards of cleanliness

- Action plan in place to reduce MRSA and MSSA bacteraemia
- Participation in the national Sepsis CQUIN to promote timely blood culture sampling and IV antibiotic treatment
- Revision to post infection review template for bacteraemia cases
- Review of all MRSA positive cases and advice provided on suppression therapy and where required antibiotic treatment

2.3.8 Patient Safety Incidents

The data is made available to the Trust by the National Reporting and Learning System with regard to the number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.

Patient Safety Incidents – Rate of incidents per 1000 bed days

DATE	TRUST	TRUST NUMBER	MEDIAN	LOWEST	HIGHEST
April 2016 – September2016	37.78	3643	40.02	21.15	71.81
Oct 2015 – Mar 2016	38.62	3706	39.31	14.77	75.91
April 2015 – September 2015	39.41	3721	38.25	18.07	74.67
Oct 2014 - Mar 2015	38.6	3584	35.3	3.6	82.2
April 2014 – September 2014	36.89	3339	35.89	0.24	74.96
October 2013 – March 2014	37.1	3513	33.3	5.8	74.9

NB: NRLS Report provides median rate of incidents per 1000 bed days reported by all non-specialist acute Trusts.

Patient Safety Incidents Severe Harm / Death – Rate

DATE	TRUST	NATIONAL	LOWEST	HIGHEST
Severe Harm and Death April	0.3% (10)	0.4% (Non-specialist acutes	0% (0)	1.9% (111)

DATE	TRUST	NATIONAL	LOWEST	HIGHEST
2016 – September 2016		only)		
Severe Harm and Death Oct 2015 – Mar 2016	0.1% (2)	0.4% (Non-specialist acutes only)	0% (0)	2.8% (122)
Severe Harm and Death April 2015 – September 2015	0.4% (15)	0.4 (Non-specialist acutes only)	0.03% (1)	3.6% (111)
Severe Harm & Death October 2014 - March 2015	0.1% (5)	0.5% (non-specialist acutes only)	0.05% (2)	5.19% (128)
Severe Harm & Death April 2014 – September 2014	0.1% (5)	0.5% (non-specialist acutes only)	0% (0)	1.85% (97)
Severe Harm & Death October 2013 – March 2014	0.17% (6)	Clarify scope	0.03% (1)	1.47% (72)
Severe Harm & Death April 2013 – September 2013	1.08% (42)	Clarify scope	0% (0)	3.10% (106)
Severe Harm & Death October 2012 – March 2013	0%	0.05%	0%	0.2%
Severe Harm April 2012 – September 2012	**0.15% (4)	*<1%	0 0%	61 3.1%
Death April 2012 – September 2012	0.0% (1)	*<1%	0 0%	34 1.3%
Severe Harm October 2011 – March 2012	0.2% (4)	*<1%	1 0%	80 3%
Death October 2011 – March 2012	0.0% (0)	*<1%	0 0%	14 0.6%

NB - The Trust has reported by actual number & percentage by highest/lowest rates please note these will not necessarily be the same Trusts.

NB - *National = Severe Harm and Death combined. **Please see comments.

Warrington and Halton Hospitals NHS Foundation Trust considers that this data is as described for the following reasons in that it downloads all incidents via DATIX to the National Reporting and Learning System within the agreed timescales.

Warrington and Halton Hospitals NHS Foundation Trust has taken the following actions to improve this indicator and so the quality of its services, Warrington and Halton Hospitals NHS Foundation Trust has:

Completed investigations to the appropriate level dependant on the severity of the clinical incidents reported

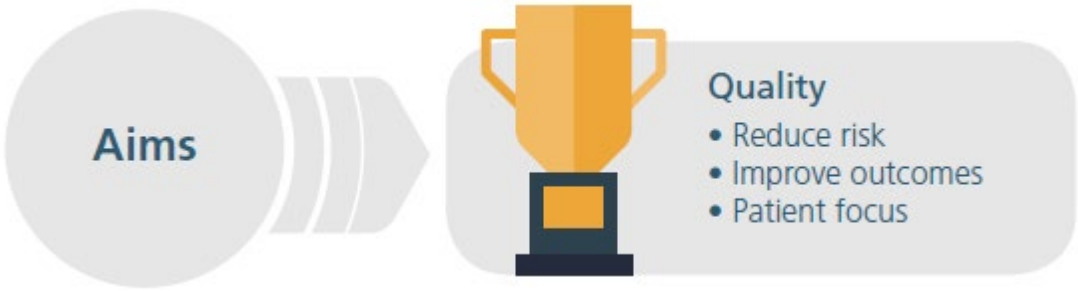
Shared analysis, learning and improvement identified from clinical incidents across the Trust via the following routes:

- Quarterly Governance Reports
- Trust wide safety alerts and notifications
- Safety briefings in clinical areas
- Amendments to policy
- Weekly and Monthly meetings with Governance Managers to manage the incident process

Patients are at the centre of everything we do and providing high quality service for every one of our patients is at the heart of our organisation.

Our primary objective is the safety of our patients.

Quality Report Part 3 - Trust Overview of Quality



3.1 Introduction - Patient Safety, Clinical Effectiveness & Patient Experience

Our aim is to be a learning organisation that consistently transforms practice by continuous learning in order to provide the best possible health care. The Trust's strategic objective is to ensure that all care is rated amongst the top quartile in the North West of England for patient safety, clinical outcomes and patient experience.

Our Quality Strategy consolidates this approach by defining the combination of structures and processes at and below Board level to lead on Trust-wide quality performance to ensure that required standards are achieved by:

- Investigating and taking action on sub-standard performance
- Planning and driving continuous improvement
- Identifying, sharing and ensuring delivery of best practice
- Identifying and managing risks to quality of care

The strategy also defines the priorities for quality improvement and sets realistic, measurable goals which include reductions in pressure ulcers; falls; mortality ratios and hospital acquired infections. It also specifies improvements in compliance with risk assessments; advancing quality measures; complaints responses and always events. It identifies the risks to quality and the steps needed to mitigate these risks; and sets out the vision for quality in a way that engages staff, patients and the local community.

The delivery of high quality services, together with the ability to demonstrate a programme of continuous service improvement, is seen as one of the most important indicators of a successful health care organisation

It is vital that we are able to provide assurance that national and local clinical and quality requirements have been identified and processes and systems are in place to implement and monitor quality within the Trust. We will ensure that we develop and integrate these tools and processes into the quality agenda to ensure a sophisticated whole systems approach. This will include and not be exclusive to an internal annual review of our systems and processes using both the Well Led Framework and the CQC Outcome framework. We will also instruct our internal auditors to undertake audits of quality in order to provide assurance that systems are in place to address national and local clinical and quality requirements to ascertain if they are fit for purpose.

We are also committed to being transparent in relation to patient outcomes; patient experience and staff experience measures so that patients and the public can see how we are performing in these areas. This includes a transparency page on our internet site signposting the public to quality information and includes the monthly publication of Open and Honest Reports outlining the number of pressure ulcers and falls in addition to the results of Friends and Family Test, NHS Safety Thermometer and patient and staff experience surveys.

We continue to work collaboratively with patients and staff to provide open and honest care, and through implementing quality improvements, further reduce the harm that patients sometimes experience when they are in our care.

3.1.1 Data Sources

Intelligent information is collated from, whenever possible, sources which can be benchmarked with other organisations in order to indicate the Trust's performance in relation to others. The Trust submits and utilises data from the Health and Social Care Information Centre (HSCIC) which includes for example Patient Reported Outcome Measures (PROMs) in England whereby patients undergoing elective inpatient surgery for four common elective procedures (hip and knee replacement, varicose vein surgery and groin hernia surgery) funded by the English NHS are asked to complete questionnaires before and after their operations to assess their perceived improvement in health.

The Trust also subscribes to datix, which is web-based patient safety software for healthcare risk management. It delivers the safety, risk and governance modules which enable the Trust to have a comprehensive oversight of our risk management activities including incident reporting and complaints, compliments, comments and concerns.

In addition to this the Trust has invested in a clinically-led benchmarking system called Healthcare Evaluation Data (HED), an online solution delivering information, which enables the Trust to drive clinical performance in order to improve patient care.

The Trust submits data to the NHS Safety Thermometer which was developed as a point of care survey instrument, providing a 'temperature check' on harm that can be used alongside other measures of harm in providing a care environment free of harm for our patients. The Trust undertakes a monthly survey on one day of all appropriate patients, to collect data on pressure ulcers, falls, urinary tract infection (UTI) in patients with catheters and VTE. The Safety Thermometer measures the percentage of patients who have experienced harm in relation to any of these issues and allows the Trust to identify weaknesses; make changes to practice and measure improvement.

Other sources of information come from Friends and Family; Inpatient, Outpatient and Staff Surveys and in-house sources including audit and transparency surveys.

3.1.2 Quality Dashboard 2016/2017

The clinical indicators in the Quality Dashboard have been reviewed in line with the revised requirements for 2016/2017 in relation to the:-

- CQUINs – National
- MONITOR KPI
- Quality Contract
- Quality Account - Improvement Priorities
- Quality Account – Quality Indicators
- Care Quality Commission
- Sign up to Safety – national patient safety topics

- Open and Honest

This is part of a wider review of quality to align reporting with the committee structure under safety; effectiveness and experience and reporting to the Quality Committee to provide assurance on progress. The information on this Quality Dashboard is also shared with our Governors and commissioners of services to demonstrate how care for patients is delivered and sustained improvements are maintained.

From April 2016 the Board has received an integrated performance dashboard which triangulates data on workforce, quality and financial information.

3.1.3 Quality Indicators – rationale for inclusion

The following section provides an overview of the quality of care offered by the Trust based on performance in 2016/17 against a minimum of 3 indicators for each area of quality namely patient safety; clinical effectiveness and patient experience. These indicators were selected by the Board in consultation with stakeholders and discussions with the Quality in Care Committee of the Council of Governors. In the main, the Trust has employed indicators which are deemed to be of local and national importance to the quality of care for patients.

The report provides an explanation of the underlying reason(s) for selection and wherever possible we refer to historical data and benchmarked data if available, to enable readers to understand our progress over time and performance compared to other providers. We have also referenced the data sources for the indicators and if applicable included whether the data is governed by standard national definitions.

Where these indicators have changed from the indicators used in our 2015/2016 report, we have outlined the rationale for why these indicators have changed / removed and where the quality indicators are the same as those used in the 2015/2016 report and refer to historical data, we have checked the data to ensure consistency with the 2015/2016 report.

Where available comparative and benchmark data has been included and unless otherwise stated the indicators are not governed by standard national definitions and the source of the data is the Trust's local systems and may only be available across two reporting years as such more historical data has not been included.

The improvement priorities and quality indicators were monitored and recorded via the Quality Dashboard and the Improvement Priority Quarterly Report reported to the Quality Committee on a monthly basis.

NB The Quality Dashboard was reported to Board until August 2016 when it was replaced by the Integrated Dashboard.

The quality indicators for 2016/17 included:

Safety

- HCAI
- Nursing Care Indicators
- Medicines Management – development of indicators and on-going monitoring
- WHO Checklist (ORMIS)

NB: Pressure Ulcers is an improvement priority for 2016/2017 and has therefore been removed as a quality indicator

Clinical Effectiveness

- SHMI HMSR
- Dementia

- Advancing Quality - Pneumonia, COPD (Chronic Obstructive Pulmonary Disease) & Diabetes

Patient Experience

- Patient Experience Indicators
- Complaints
- Patient Survey (inpatient and children) Indicators

NB: Essential ward transfer has been removed as a quality indicator for 2016/2017 and will be reinstated when information systems are refined.

3.2 Patient Safety

3.2.1 HCAI - Infection Control

Healthcare associated infections (HCAIs) are infections that are acquired as a result of healthcare interventions. There are a number of factors that can increase a patient's risk of acquiring an infection, but high standards of infection control practice reduce this risk. Although hospital acquired infections are subjected to national mandatory surveillance this Trust is committed to reducing the risk of harm associated with these infections and as such selected this to continue as a quality indicator for 2016/2017.

During 2014/2015, the Trust threshold was 0 cases of MRSA bacteraemia and despite the continued focus on managing HCAI during 2015/2016 the Trust was reported 2 cases of MRSA bacteraemia against a threshold of 0. Year to date for 2016/2017 the Trust is pleased to report that there have been no cases of MRSA bacteraemia and that the Trust has had a period of 18 months free of MRSA bacteraemia. Work undertaken to maintain an MRSA free Trust includes:-

- Action plan in place to reduce MRSA and MSSA bacteraemia
- Participation in the national Sepsis CQUIN to promote timely blood culture sampling and IV antibiotic treatment
- Revision to post infection review template for bacteraemia cases
- Review of all MRSA positive cases and advice provided on suppression therapy and where required antibiotic treatment

During 2014/2015 the Trust reported 31 cases of hospital acquired Clostridium difficile infections against a threshold of 26 cases. However in 2015 the Trust engaged in partnership working with a CCG panel to review Cdiff cases to exclude some cases from the contractual penalties. This system investigates all hospital apportioned cases of Clostridium difficile and where no lapses in care are identified, cases are removed from those counted for the purpose of contractual sanctions. In 2016/2017 the Trust reported 24 cases of Clostridium difficile (C Diff) against a threshold of 27 cases and 13 were deemed not to be due to a lapse in care.

CDIFF Monitor Report 2015/2017

*Please note that the categorisation numbers for the 2015/16 results have changed since the last report due to the completion of the reviews into each case.

	*2015/2016	2016/2017
Due to lapses in care	17	11
Deemed not to be due to lapse in care	16	13
Under Review	0	0
Total C.Diff	33	24

Actions agreed, implemented and maintained within year included but not limited to include:

- Action plan in place to reduce Clostridium difficile
- Increase in hours to the Antimicrobial Pharmacist role
- Participation in the national AMR CQUIN
- Participation in European Antibiotic Awareness Day
- Fidaxomicin used for treatment of patients with recurrent Clostridium difficile infection
- Antimicrobial steering group with feedback to Clinicians on incidences of antimicrobial prescribing non-compliance
- Surveillance of cases/monitoring for increased incidences in defined locations
- Improvements to methods of investigation for Clostridium difficile cases
- Cohort isolation facility maintained to manage cases
- Text alerts to senior managers to report Clostridium difficile cases
- Increase in ward based training for management of infectious diarrhoea, viral gastroenteritis outbreaks and use of personal protective equipment and single point lessons on Clostridium difficile and use of SIGHT mnemonic
- Environment Group re-established to monitor and direct improvements in standards of cleanliness

Methicillin-sensitive Staphylococcus aureus (MSSA)

MSSA bacteraemia is caused by Staphylococcus aureus is a serious infection associated with high morbidity and mortality and often results in metastatic infections such as infective endocarditis, which have a negative impact on patient outcomes

14 MSSA bacteraemia cases have been reported YTD. All cases undergo root cause analysis investigation. 2 cases are under review, 5 have been attributed to intravascular devices, 3 sources unknown, 1 to foetal scalp electrode and 3 related to deep seated infections identified 48 hours after admission but likely community

The data for this indicator is from a nationally prescribed data set, the indicator is monitored via the corporate performance report and the Quality Dashboard.

3.2.2 Nursing Care Indicators – MUST; Waterlow and Falls

The care indicators audit was developed as part of a local CQUIN to audit compliance with risk assessments for Falls, Waterlow and MUST. Reports received throughout 2013/2014; 2014/2015 to 2015/2016 showed improved compliance with Falls and Waterlow and more recently with MUST. It was agreed that the Trust should continue to monitor compliance against the established threshold >=95%. The Trust is pleased to report that results for 2016/2017 indicate further improvement to compliance with risk assessments.

Risk Assessment Compliance 2015/2016

	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
FALLS	82%	92%	93%	97%	97%	93%	96%	94%	96%	92%	97%	96%
WATERLOW	77%	93%	92%	96%	95%	92%	96%	95%	97%	94%	97%	94%
MUST	78%	85%	89%	91%	80%	87%	90%	88%	93%	93%	-	-

Risk Assessment Compliance 2016/2017

	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
FALLS	99%	97%	96%	*	*	100 %	100 %	99%	97%	99%	100 %	*
WATERLOW	99%	98%	98%	*	*	100 %	95%	93%	100 %	100 %	100 %	*
MUST	91%	98%	96%	*	*	97%	92%	94%	91%	91%	100 %	*

***NB: issues with training for the new electronic process resulted in poor data collection during these months. - Information not available. Data ceased to be captured in March 2017.**

During the latter part of 2016/2017 the Trust also focussed upon compliance with the interventions associated with risk assessment(s) to ensure that patients are being managed appropriately. This is managed through an enhanced Nursing Care Indicator process where nursing staff audit all aspects of care associated with the risk to ensure compliance with the pathway of care. In relation to falls the staff would ensure that a risk assessment is carried out both on admission and after a change in the patient's condition e.g. post-operative. In addition to this they would also check if the patient had received a bed rail; moving handling and incontinent assessment and if the correct footwear and walking aids were present. Substantial work has taken place to improve the process; monitoring and ensuring changes to practice if required. This work which will continue throughout 2017/2018 will be reported in the next Quality Account.

3.2.3 Medicines Management – development of indicators and on-going monitoring

The medicines management dashboard was created in response to earlier targeted work in reducing medication errors and insulin related incidents. During 2012/2013, the Trust targeted improvements on a 10% reduction in medicine errors with a specific focus on reducing insulin related incidents by 5%. By the year end even though we had reduced insulin incidents by 10.5%, it was agreed that we should include the development and monitoring of medicine indicators, including the safety thermometer, as a quality indicator and this work has continued to date. The indicators that are included in the dashboard are medicines reconciliation; discharge prescription turnaround time; outpatient prescription turnaround time; discharge prescriptions reviewed on ward; medication incidents resulting in harm; compliance with the antibiotic formulary; performance against medicines related questions in CQC surveys; medicines related complaints; prescribing audit and the pilot of the medicines safety thermometer. The dashboard is reported via the Medicines Safety Committee.

Running parallel to the development of the dashboard was the implementation of the medicines safety thermometer by the Deputy Chief Pharmacist. The Medication Safety Thermometer is a measurement tool for improvement that focuses on Medication Reconciliation, Allergy Status, Medication Omission, and Identifying harm from high risk medicines in line with Domain 5 of the NHS Outcomes Framework. It is a point of care survey which identifies the percentage harm free care occurring from medication error

Data can be used as a baseline to direct improvement efforts and then to measure improvement over time. The safety thermometer indicates a high level of safe care around medication as follows:-

% of patients free from harm (medicines safety thermometer) quarterly reporting

	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB
2014/2015	P	P	P	P	P	98.3%	99.2%	97.4%	99.2%	98.6%	
2015/2016	100%	97.5%	98.1%	100%	100%						
2016/2017	100%	69.9%	NA	100%	NA	97.8%	100%	98.8%			

P – Pilot, NA – No Audit

There are still some inconsistencies in this tool for example the lower harm free percentage in November 2014 and May 2016 was because they assessed ITU who had a number of sedated patients that triggered as harm (which was the intended outcome for these patients as they were on ITU). The lead contacted Haelo and they advised that they still should be recorded as the harm trigger even though it was the intended treatment.

3.2.4 Safer Surgery – World Health Organisation (WHO) Checklist

The WHO Surgical Safety Checklist was developed after extensive consultation aiming to decrease errors and adverse events, and increase teamwork and communication in surgery. The 19-item checklist has gone on to show significant reduction in both morbidity and mortality and is now used by a majority of surgical providers around the world.

Surgical Safety Checklist

World Health Organization | Patient Safety

Before induction of anaesthesia (with at least nurse and anaesthetist)

Has the patient confirmed his/her identity, site, procedure, and consent?
- ☐ Yes

Is the site marked?
- ☐ Yes
- ☐ Not applicable

Is the anaesthesia machine and medication check complete?
- ☐ Yes

Is the pulse oximeter on the patient and functioning?
- ☐ Yes

Does the patient have a:

Known allergy?
- ☐ No
- ☐ Yes

Difficult airway or aspiration risk?
- ☐ No
- ☐ Yes, and equipment/assistance available

Risk of >500ml blood loss (7ml/kg in children)?
- ☐ No
- ☐ Yes, and two IVs/central access and fluids planned

Before skin incision (with nurse, anaesthetist and surgeon)

- ☐ **Confirm all team members have introduced themselves by name and role.**
- ☐ **Confirm the patient's name, procedure, and where the incision will be made.**

Has antibiotic prophylaxis been given within the last 60 minutes?
- ☐ Yes
- ☐ Not applicable

Anticipated Critical Events

To Surgeon:
- ☐ What are the critical or non-routine steps?
- ☐ How long will the case take?
- ☐ What is the anticipated blood loss?

To Anaesthetist:
- ☐ Are there any patient-specific concerns?

To Nursing Team:
- ☐ Has sterility (including indicator results) been confirmed?
- ☐ Are there equipment issues or any concerns?

Is essential imaging displayed?
- ☐ Yes
- ☐ Not applicable

Before patient leaves operating room (with nurse, anaesthetist and surgeon)

Nurse Verbally Confirms:
- ☐ The name of the procedure
- ☐ Completion of instrument, sponge and needle counts
- ☐ Specimen labelling (read specimen labels aloud, including patient name)
- ☐ Whether there are any equipment problems to be addressed

To Surgeon, Anaesthetist and Nurse:
- ☐ What are the key concerns for recovery and management of this patient?

This checklist is not intended to be comprehensive. Additions and modifications to fit local practice are encouraged.

Revised 1 / 2009

Theatres have a daily audit tool for measuring compliance with the WHO checklist. All patient safety data has been inputted into ORMIS and gives assurance that the Safe Surgery Check list is compliant. This includes the 5 Steps to safer surgery and SBAR handovers, which are both electronically completed.

WHO compliance is checked on the ORMIS programme and any anomalies are corrected and approved by the theatre management team and the report is shared monthly at the Theatre meetings and Divisional Quality Bi- lateral Meeting for dissemination.

WHO Checklist compliance 2016/2017

	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
WHO Checklist	100%	100%	100%	100%	99.8%	100%	100%	100%	100%	100%	100%	100%

Compliance with the checklist is included in the Quality Dashboard and monitored on a monthly basis via the Quality Committee. The Trust can report full compliance in 2016/2107 with the exception of August when there was one case of non-compliance, which related to a maternity procedure – emergency caesarean section. The Head of Theatres stated that this incident had been fully investigated and there have been major improvements in compliance with the WHO Checklist in the maternity theatres. To provide additional assurance the local audit on the WHO Checklist will continue and will report via a high level briefing paper to the theatre governance meetings which report into the CBU Governance meeting.

3.2.5 NPSA 'never events'

Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. They include incidents such as:

- wrong site surgery
- retained instrument post operation
- wrong route administration of chemotherapy

Incidents are considered to be never events if:

- there is evidence that the never event has occurred in the past and is a known source of risk (for example, through reports to the National Reporting and Learning System or other serious incident reporting system)
- there is existing national guidance or safety recommendations, which if followed, would have prevented this type of never event from occurring (for example, for 'Retained foreign object post procedure' the referenced national guidance is related to the peri-operative counting and checking processes that would be expected to occur at the time of the procedure, including suturing after a vaginal birth)
- occurrence of the never event can be easily identified, defined and measured on an ongoing basis

The threshold for never events is set at zero for contractual purposes and Trust is disappointed to report that three never events took place between April 2016 and March 2017.

The never event that occurred in April 2016 has been fully investigated and is waiting to be closed by the clinical commissioning group.

The further 2 never events occurred in March 2017 and are currently still being investigated. However, at the time of writing this report the following actions are underway;

- 72 hour review for both cases
- Retraining for all staff
- Investigation commenced led by Associate Medical Director of Quality
- Quality Account priority regarding safer surgery – safety culture/human factors /quality improvement champions

3.2.6 SEPSIS

Sepsis is defined as an infection (definite or suspected) with systemic inflammation which can deteriorate quickly into severe sepsis or septic shock. It occurs when bacteria enters the body, for example via a tissue injury.

Sepsis is common – it kills around 44,000 people each year in the UK

- Mortality rate is around 30% - 5 x more than STEMI (heart attacks) and stroke!
- Early recognition and treatment halves the death rate.
- For every hour that appropriate antibiotic administration is delayed, there is an increased risk of mortality. For example a four hour delay in administering antibiotics increases the risk of mortality from 15% to 45%!

Sepsis Six

The **Sepsis Six** is the name given to a bundle of medical therapies designed to reduce the mortality of patients with **sepsis**. The **Sepsis Six** consists of three diagnostic and three therapeutic steps – all to be delivered within one hour of the initial diagnosis of **sepsis**.

- Give high-flow oxygen
- Take blood cultures
- Give IV antibiotics
- Start IV fluid resuscitation
- Check lactate
- Monitor hourly urine output

During the year 1st January 2016 to 31st December 2016 the Trust treated 794 patients with Sepsis recorded as the primary or secondary illness.

The challenges relating to Sepsis at WHH are;

- Sepsis being diagnosed late
- Sepsis either being diagnosed or ruled out
- Gaps in Monitoring – Observations - Urine Output - Checking blood results
- Delays in recognition and escalation of deteriorating patients

The Trust has made major improvements namely funding for two sepsis nurses, one of who is newly appointed and in post, the other due to commence in post shortly. In addition, a new ELearning module has been developed, which is to become part of mandatory training for all clinical staff.

Sepsis six boxes, containing special sepsis bags with all the equipment required in cases of suspected sepsis are currently being rolled out to all clinical areas, which will free up the nursing staff to obtain the required IV antibiotics.

A revised, easy to follow sepsis pathway has also recently been developed and the potential for training to enable the sepsis team and critical care team to prescribe, is currently being explored, which will save valuable time.

Performance has improved significantly following the promotion of sepsis awareness by the Emergency Department (ED) Consultant and Sepsis Lead. Sepsis screening for ED has risen from 32% in quarter 1 to 81% in quarter 3 and for inpatients from 9% to 76%.

3.2.7 Falls - Management and Reduction

The Trust cares for many vulnerable patients, who may have a history of falls and who are therefore at risk of further falls when admitted to the Trust. A specialist falls prevention nurse is being recruited and as an interim measure the Lead Nurse for Airway breathing and Circulation (ABC) CBU, is leading a new 'Falls Programme' to help understand how we can help reduce the number of falls across the Trust.

As part of the programme, a pilot scheme has commenced on Wards A7 and A8, to trial new coloured slipper socks, yellow for 'high risk' falls and red for patients who don't have footwear. In addition, a new initiative 'SWARM' has been introduced, whereby in the event of a fall, a SWARM is initiated as soon as possible after an adverse incident or undesirable event occurs. Like bees, staff swarm to discuss the incident with an RCA being completed at the time of the incident.

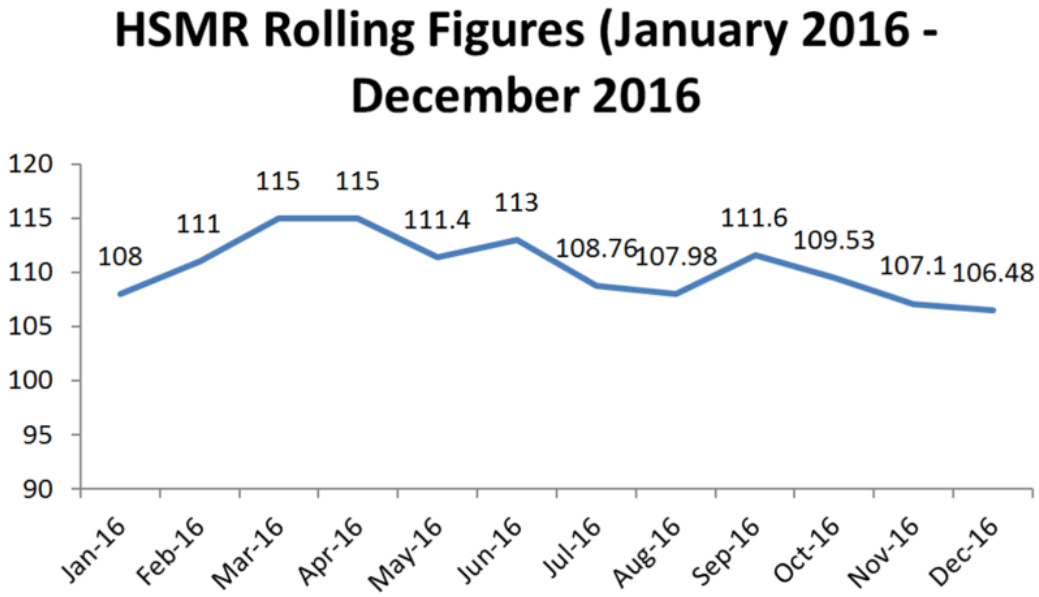
Other measures introduced include:

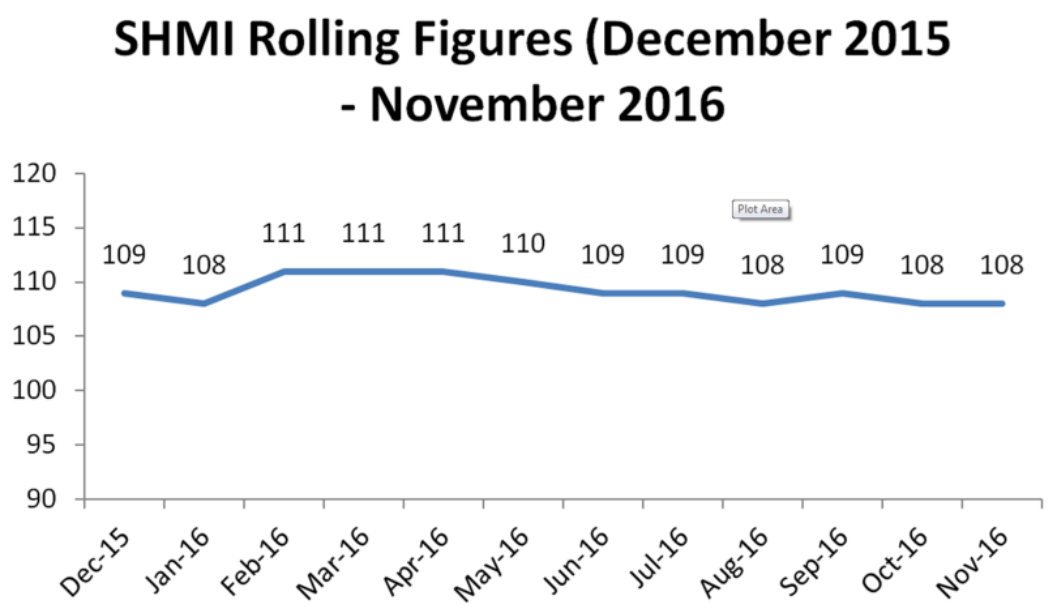
- The Trust's 'moving and handling' therapist is currently trialling and evaluating falls equipment.
- Special 'falls' blankets have been introduced to help identify patients at high risk of falls
- The Matron for older people's services is currently undertaking an enhanced specialised monitoring project based on people at risk of falls
- A 'Falls Steering Group' has also been re-established, to explore ways of preventing and managing falls within the Trust

3.3 Clinical Effectiveness

3.3.1 Mortality - Summary Hospital-level Mortality Indicator (SHMI) & Hospital Standardised Mortality Review (HSMR)

We agreed to continue to monitor and report mortality ratios in 2016/2017 and use the data as an indicator of the quality of care we provide, supporting targeted improvements. The latest available figures for HSMR is 106.48 for the period January 2016 to December 2016 and SHMI 108.12 for the period December 2015 to November 2016 (HED system). The chart below shows these rolling 12 month figures since January 2016. The SHMI was in the range of 'higher than expected' until November 2015, however this is now 'as expected' for the period January 2015 – December 2015. The HSMR is 'as expected' throughout this period. Our crude death rates compare favourably with local peer Trusts and across the North West.





The Trust has continued its commitment to reducing avoidable mortality. Key developments include:

- We have introduced a process over the last twelve months were all of our patients who have died are having a case note review by a Consultant other than the Consultant in charge of the patient to assess for areas of improvement or areas which would require further investigation. In the event of either of these being identified, the case is then being reviewed in detail and presented to the Trust Mortality Review Group by a member of that group. Where we identify areas for improvement this is cascaded across the Trust. The screening of deaths is a work in progress. Our aim was to have every death screened, however due to unforeseen difficulties in ensuring the process has been fully adhered to, as it requires the Consultant to complete the form. The process has been strengthened as a result we aim to have 100% of deaths screened for 2017. We have noted a steady decrease in SHMI over the last twelve months. Other areas where we are aware affects the SHMI are correct diagnosis by doctors and good documentation of the patients' comorbidities which allows our coders to accurately code the patients. This is an ongoing improvement project and we expect to see continuing improvements in these areas.
- A number of focused reviews that have been conducted have found that care is generally good for those patients.
- A review into Regional Enteritis patients highlighted a delay in obtaining surgical consultation, requiring an improvement in the interface between medicine and surgery. These two cases were presented at Patient Safety & Clinical Effectiveness Sub-Committee and Clinical Business Unit meetings to ensure the learning is disseminated across relevant areas of the organisation. A pathway was introduced to ensure referrals to surgery are made in a timely and appropriate manner.
- A review into pneumonia deaths we are currently completing found:
    - Death certification process review needed. We have started a quality improvement project with foundation year trainees to look at improving the accuracy of death certification recording.
    - End of life care could have been started earlier and earlier DNACPR. This will require a general review of care pathways for end of life, palliative and DNACPR patients which will take place once this review has been completed.

- Accuracy of coding could have been improved in cases. The Coding Department have looked at 50% of the cohort to allow us to identify specific improvements to documentation and coding.
- Lack of senior review by a Consultant within 12 hours in 6 cases. This review was from a cohort of patient from January 2016 and since then senior review of patients within 12 hours has been put in place. This is monitored via the screening review process and where senior review is more than 12 hours, assessment is required to ascertain whether this was detrimental to the patient's care.
- Two of the patients could have remained in the community to die in peace. Work with Warrington CCG is due to be started to improve the setting for these patients.
- Need a clear pathway or process for ensuring patients with a known cancer or being investigated for a suspected cancer is picked up at every admission and acute oncology informed. Continuing to develop the relationship between medics and coders, so that they can jointly better understand the impact of how they document and then code this information

We will continue to monitor and report mortality ratios in 2017/2018 and use the data as an indicator of the quality of care we provide, supporting targeted improvements.

3.3.2 Dementia CQUIN

In 2012, a CQUIN for dementia was established to ensure that Trusts identified patients with dementia and other causes of cognitive impairment alongside their other medical conditions in order to prompt appropriate referral and follow up after they leave hospital. In the last two years the Trust achieved all three elements of Find; Assess and Refer of the CQUIN target of over 90% of patients being assessed at each stage by Quarter 4. It was agreed to continue to report on this as a quality indicator for 2016/2017. This will also be supporting the local CQUIN Johns Campaign where the Trust will be monitoring information being given to family and carers on open visiting times.

The Trust with stakeholders agreed that we should continue to include dementia CQUIN as a quality indicator for the 2015/2016 Quality Report. As the table reveals our compliance has been somewhat varied from November 2015 which was as a result of data management issues relating to the introduction of Lorenzo. The Trust had discussions with our CCGs who accepted that we are experiencing issues with validating data from the new PAS and agreed not to invoke any penalties for under performance on either Part for November and December. Importantly, they accepted our assurances that patients were still being reviewed and assessed as per guidance and that the issue related to data extraction problems. As the table indicates these issues were resolved by January 2016 when the Trust was able to evidence compliance as per guidance. Compliance has continued throughout 2016/2017.

Dementia Assessments FAIR 2013 - 2017

Dementia	A	M	J	J	A	S	O	N	D	J	F	M
Part 1 2013/2014 FIND	90.43	93.14	91.3	92.87	95.12	95.12	95.2	95.13	96.1	97.76	97.36	94.57
Part 1 2014/2015 FIND	94.55	95.69	95.43	94.26	96.59	92.45	92.7	96.61	96.29	96.93	94.81	N/A
Part 1 2015/20	96.85	97.62	95.53	96.80	94.86	94.36	92.18	81.30	26.9	90.3	92.78	90.42

16 FIND											
Part 1 2016/2017 FIND	92.21	93.29	91.02	94.72	94.41	93.26	98.74	95.53	94.32	92.13	93
Part 2 2013/2014 INVESTIGATE	96.77	100	100	100	100	93.3	100	96.43	96.88	100	10
Part 2 2014/2015 INVESTIGATE	100	100	100	100	100	91.89	100	100	97.22	96.77	10
Part 2 2015/2016 INVESTIGATE	100	100	100	100	100	100	85.71	73	88.9	96.7	97
Part 2 2016/2017 INVESTIGATE	98.78	93.75	100	95.08	98.75	93.33	100	97.73	98.99	100	98
Part 3 2013/2014 REFER	100	100	100	100	100	100	100	100	100	100	10
Part 3 2014/2015 REFER	100	100	100	100	100	100	100	100	100	100	10
Part 3 2015/2016 REFER	100	100	100	100	100	100	100	100	100	100	10
Part 3 2016/2017 REFER	100	100	100	100	100	100	100	100	100	100	10

Dementia Training

To determine that appropriate Dementia training is available to staff through locally determined training programme.

We provide the Commissioners with quarterly reports to provide assurance that:

- Numbers of staff who have completed the training are improving each quarter;
- We regularly review overall percentage of staff training.

Dementia Awareness training is now a requirement for all staff and the training can be completed via e-learning by accessing the e-Dementia: Introduction to Dementia (Learning Certification). This course is a nationally agreed e-learning tool which provides an introduction to dementia and guidance on supporting those living with dementia, along with their carers. The training enables staff to:-

- Describe dementia, its effect on the brain, and its common signs and symptoms
- Identify some of the complex difficulties experienced by people with dementia
- Challenge some of the common myths and negative attitudes about dementia
- Identify ways of communicating effectively with someone with dementia
- Describe the importance of living well with dementia and how the HCP can facilitate this
- Discuss other sources of support for those with dementia and their carers
- Outline the elements of best quality practice in caring for the individual with dementia, to include end-of-life care

Current results demonstrate >85% compliance with dementia awareness training.

Patient Experience

We have introduced a 'carer's card' to the Trust which is offered to all main carers of patients with memory problems to facilitate unrestricted visiting and if appropriate, to support in the delivery of care as recommended in our dementia guidance. This and other 'carer aware' initiatives have established the Trusts involvement with a national campaign called 'Johns List' which is a campaign for the right of people with dementia to be supported by their carers in hospital.

Carers are welcome Here!

If you are the main carer for a person in the ward who has memory problems please let the staff know who you are and request a Carers Card to enable you to visit outside of hospital visiting hours.

The Observer newspaper supports John's Campaign and has established a dedicated page on the Guardian website which will lists all the hospitals in the UK where carers are welcome, WHHFT is included in the first 100 Trusts on this list and has selected John's Campaign as a local CQUIN for 2016/2107 – we are currently compliant with this CQUIN.

3.3.3 Compliance with regional targets set for Advancing Quality – reducing variation

AQUA monitor the quality of services delivered at hospitals through a programme called Advancing Quality (AQ). It aims to make sure every patient admitted to hospital is given the same high standard of care no matter which hospital they attend. Each hospital is measured against how many of their patients get the appropriate care they need for the best outcome from their surgery

The AQ programme was established in the North West in 2008, in order to measure that hospitals carry out the right steps with patients, at the right time, during their care. It is currently being used in two large areas of secondary care in the North West and South East coast of England. The participation in the programme was voluntary and this Trust joined the programme at the start in 2008.

Initially it focused on five clinical conditions that were deemed to be most critical for patients in the North West.:-

- Heart Failure
- Acute Myocardial Infarction
- Hip and Knee Replacements
- Heart bypass surgery
- Pneumonia

Subsequently the following clinical focus areas were added:-

- Stroke
- Hip Fracture

- Alcohol Related Liver Disease (ARLD)
- Diabetes
- COPD
- Sepsis
- AKI

NB: Presently, AMI and Stroke have been retired from AQ. Heart Failure will retire from September 2016 discharges. In 2015, WHH decided not to participate in Sepsis and AKI, as the two conditions were part of the national CQUIN requirements. AKI is not a CQUIN in 2016/17.

The objective of the AQ Programme is to provide hospitals with a list of key evidence based measures, which should be delivered to every single patient, to ensure they receive the highest standard of care. After the first year of the launch of the programme in 2008, it was transferred to local CQUIN requirement.

Each condition has an associated performance target set by the AQ Reference Board. The targets are specified in terms of Appropriate Care Score (ACS). ACS measures the proportion of patients that received all of the **relevant** interventions for each individual patient, and is therefore a measure of 'perfect care' for each patient.

Currently the AQ conditions, under local CQUIN for 2016/17, (January 2016 to December 2016 discharges) are:

- COPD ACS 50% target
- Diabetes ACS 50% target
- Pneumonia ACS 78% target

ADVANCING QUALITY (2016/2017 cumulative targets and figures)

		APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV
***COPD**	50%	44.19%	42.19%	45.51%	47.12%	47.35%	47.84%	48.35%	48.61%
DIABETES	50%	13.64%	12.24%	16.92%	17.39%	18.58%	18.38%	18.18%	20.23%
PNEUMONIA	78%	73.38%	73.62%	73.63%	73.14%	73.68%	73.59%	73.60%	72.85%

* **CHRONIC OBSTRUCTIVE PULMONARY DISEASE**

It should be noted that collecting AQ data is resource intensive and the thresholds are inflexible; nevertheless the Trust is disappointed that, despite enormous effort and changes to practice, we did not achieve the AQ thresholds. The following changes have been taken place:-

- New blood glucose monitors – Wi-Fi connectivity
- DKA Policy
- Electronic foot assessment on Lorenzo
- Working with smoking cessation team to simplify process of referral

- COPD Care bundle under development

The Trust continues to measure non CQUIN AQ conditions for which data is collected and reported namely ARLD Hip Fractures and Hip & Knee Replacement as follows :-

Heart Failure - Data collected from January 2016 – September 2016 discharge population prior to transition of programme to National Heart Failure Audit data.

WHH achieved an Appropriate Care Score (ACS) of 57.3% and was second top provider of care out of the 8 participating regional Trusts. Areas for improvement include heart failure specialist review within 72 hours of documentation of heart failure diagnosis and the issue of heart failure information on discharge from hospital.

Hip & Knee Replacement Surgery - Elective hip and knee replacement measures were revised and released in April 2016. WHH has provided 94.2% of patients with appropriate care over the 12 months of monitoring. WHH are the top provider for delivery of care in the region for an NHS organisation.

Hip Fracture - WHH have participated in the hip fracture measure set in 2016. Improvement plans and improvement opportunities have been identified to ensure that patients admitted to hospital with hip fractures have appropriate care.

Alcohol Related Liver Disease - WHH have participated in the ARLD AQ measures for the last 12 months. As part of the programme they have introduced an ARLD care bundle to ensure patient delivery of care meets required standards. 87.7% of patients of non-elective admissions with ARLD are now commenced on a care bundle support delivery of care.

3.4 Patient Experience

The Trust supports the ideology that it needs to collect information; be open and transparent about the experience of patients within its care, and that information about patient experience should be publically available. Importantly it will place equal emphasis on responding to the qualitative feedback from stories, as on the quantitative evidence from numbers

Ensuring that people have a positive experience of care is also a key objective within the NHS Outcomes Framework. This Trust supports the view that patient experience is as equally important as the other elements of the quality agenda, namely clinical effectiveness and patient safety, and that that it should be embedded across our work to improve quality outcomes.

“There is clear evidence that where patients are engaged in their own care and have a good experience of care and treatment, clinical outcomes are better” (NHS England, 2014). In addition to the development of a Patient Experience Strategy and work streams which are an improvement priority for this year the Trust is committed to improving patient experience through implementing and monitoring patient experience indicators as set out in the Quality Report for 2015/2016.

Patient experience indicators for 2016/2017 include:

- Complaints
- Friends and Family Test – inpatients; accident and emergency and maternity services.

- Develop and monitor 'always events', i.e. what we must always do for patients to ensure a quality experience.
- Continue to monitor mixed sex occurrences
- Review our In-patient Survey

The Trust participates in all relevant national surveys. The planned Friends & Family Test which began in 2014 (section 3.4.6) and the staff survey results (section 3.4.4) also provide a barometer of staff experience. We also ensure that staff feedback around the quality of the patient care provided in our organisations is publicly available through, for example Open and Honest, which is available at:

http://www.whh.nhs.uk/page.asp?fldArea=1&fldMenu=5&fldSubMenu=2&fldKey=178

The following section provides an appraisal of progress against the patient experience key priorities.

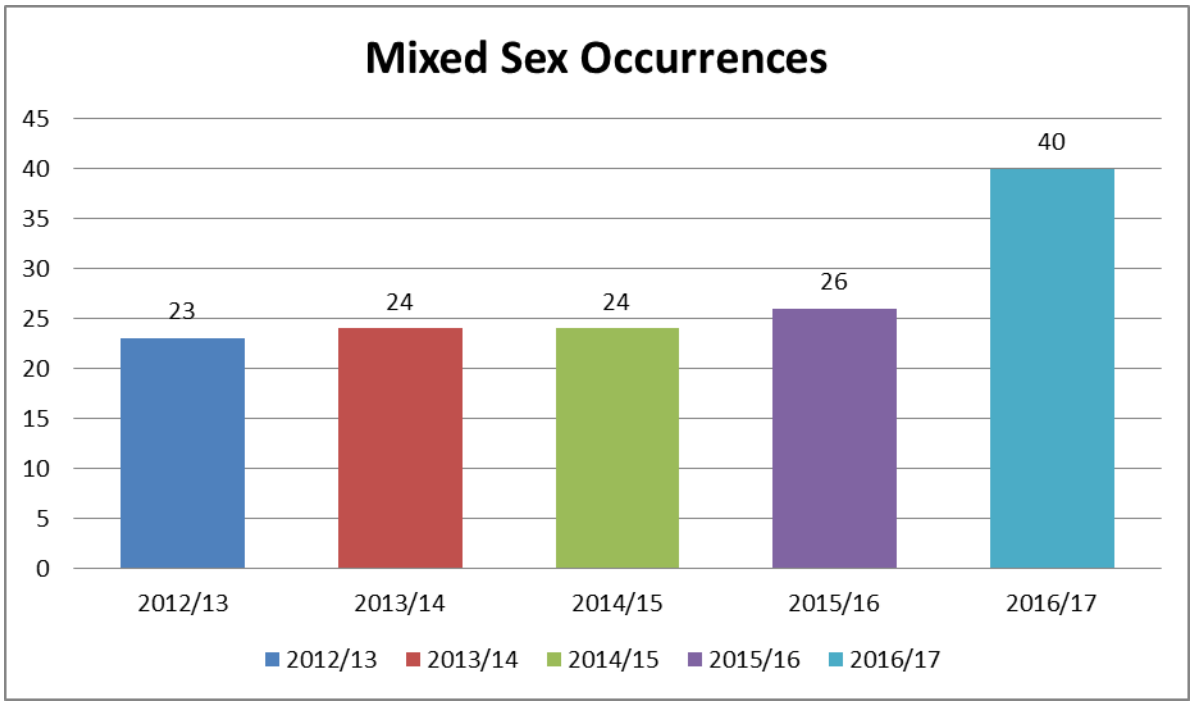
3.4.1. Eliminating Mixed Sex Accommodation

All providers of NHS funded care are expected to eliminate mixed-sex accommodation, except where it is in the overall best interest of the patient, in accordance with the definitions set out in the Professional Letter CNO/2010/3. The Trust measures, in line with nationally prescribed guidance any occurrence of mixed sex accommodation, by determining whether they are 'clinically justified' (i.e. "in the overall best interest of the patient" such as when both male and female patients are in the Intensive Care Unit) or 'non-clinically justified' (when male and female patients share either sleeping accommodation or bathrooms and toilets).

In 2012/2013 the Trust threshold was for full compliance with no reported breaches however, whilst we reported 23 mixed sex occurrence breaches, this was a 44% reduction on 2011/2012 when the Trust had 41 breaches. However in subsequent years the Trust has been unable to achieve the threshold set at zero. To date there have been 40 mixed sex occurrence breaches in 2016/2017.

A review has been conducted by Corporate Nursing to address the rising number of mixed sex occurrences. Improvements have been made to the escalation process once a mixed sex occurrence has been identified, so that it is escalated to the relevant management team, in order to prevent a breach from occurring. Further work is also being conducted to reduce the number of delayed discharges which also impact on the number of mixed sex occurrences and we aim to see a reduction in the number of breaches at the end of 2017/18.

Please see graph below for the five year comparison.



3.4.2. Always Events

In addition to the agreed improvement priorities, the Trust Board of Directors, in partnership with staff and governors, also agreed to focus upon a number of key issues around quality improvement which included the development of "always events."

Always events are aspects of patient care that should always happen for patients to ensure a quality experience. The Trust held a number of focus groups, including a local healthcare event "Get Engaged" with patients; staff and governors, to agree a small number of always events, which we developed, piloted and monitored throughout 2014/2015.

It is vital that Always Events are measurable and can be implemented and monitored within current resources/budgets. Some suggestions, while they would demonstrate excellent quality of care, could not be easily introduced or monitored. We then used the first six months of 2014/2015 to plan implementation and ensure that there was an audit trail inherent in the system. We began monitoring the Always Events in October 2014 via the Dawes Ward Assessment process and reported them as a quality indicator in the Quality Dashboard through to board.

The Always Events are:

- **Every patient has a jug and glass that is within reach and has sufficient fluid.**
- **The name of the patients named nurse will always be displayed above the bed**
- **Any complaint or concern will be addressed as soon as possible and as close to the bedside as possible. Staff will bleep senior nurse to deal with complaint if needed.**
- **Pain relief is administered on time, every time.**

The pilot results were very positive and the Trust continued to monitor the always events as a quality indicator for 2016/2017 as follows:-

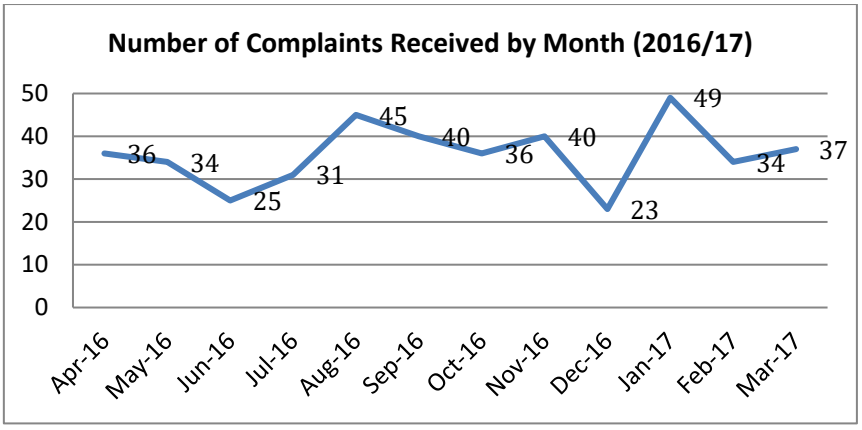
	A	M	J	J	A	S	O	N	D	J	F	M
2015/2016	89%	90%	92%	96%	96%	88%	94%	96%	96%	97%	87%	97%
2016/2107	97%	95%	97%	N/A	N/A	95%	97.35%	93%	94%	98%		

3.4.3 Complaints

In accordance with the *NHS Complaints Regulations* (2009), the Complaints Report(s) annual and quarterly set out a detailed analysis of the nature and number of formal complaints. Following the organisational restructuring of the Trust, the expectations of the CBUs relating to complaints are detailed with the recently updated Complaints and Concerns Policy.

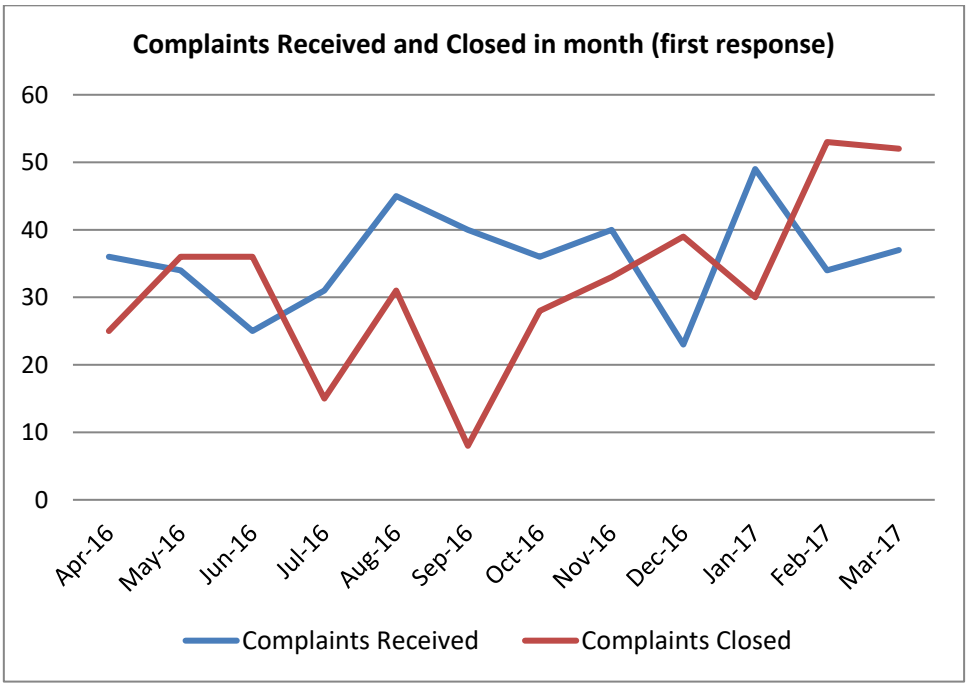
The Trust sees complaints as an opportunity to reflect on the experience of our patients and learn from their experience, making amendments to services as appropriate to ensure we improve patient care and the quality of the services the Trust provides.

The Trust received a total of 430 formal complaints from 1 April 2016 – 31 March 2017. This represents an increase of 6.7**%** compared to the previous year when 403 formal complaints were received. Of the 430 complaints received they were triaged as follows; Low Harm 155, Moderate Harm 240 and High Harm 35.



In the last financial year, from the total of 239 closed complaints, a total of 22 complainants were unhappy at the outcome of the investigation. That represents a figure of 9.3%, a decrease of 0.6% in comparison to the figures from 2015/16.

Of the 430 complaints received between 1 April 2016 and 31 March 2017 we closed 386 complaints during the same time period. The table below highlights the number of complaints received and closed by month.



3.4.3.1 Lessons Learned

Below are examples of closed complaints and actions taken by the divisions who are responsible for implementing and monitoring lessons learned. Each division has specific systems in place to feedback learning from complaints, firstly during/after the investigations and then through divisional groups, e.g. Divisional Integrated Governance Groups (DIGG, senior nurse/ward manager meetings.

- Access to BSL interpreters - as soon as it is identified that a patient may require a BSL interpreter this is recorded on Lorenzo and therefore when an outpatient appointment is booked this triggers a request to book an appropriate interpreter. This also highlights, should a patient attend A&E, and allows for interpreter services to be accessed quickly.
- Long admission process from A&E - comfort rounds in A&E have been introduced and the Lead Nurse, Clinical Director and CBU Manager are working with Trust Transformation Team to ensure a more efficient admission process for patients.
- Template Letters – the Endoscopy team are reviewing all template letters following concerns raised into lack of information about cancellation and re-scheduled procedures.
- Patient Transfers – the Ward has implemented a transfer book which documents where patients have been transferred to and whether next of kin have been informed to ensure that families are kept fully informed of a patient's location.
- As required medication – the Ward no longer locks inhalers in the patient's locker. These are left within easy reach of the patient.

3.4.3.2 Parliamentary and Health Service Ombudsman (PHSO)

The PHSO is a free and independent service, set up by Parliament. Their role is to investigate complaints were individuals feel they have been unfairly treated or have received poor service from government departments; other public organisations and the NHS in England. The PHSO make the final decisions on complaints about these public services for individuals.

Complainants dissatisfied with the Trust's response have the right to ask the Parliamentary Health Service Ombudsman (PHSO) to consider their complaint. However, the complainant must be able to provide reasons for their continued dissatisfaction (in writing) to the PHSO. The Trust may also refer the complainant to the PHSO if they feel that the response has been thoroughly investigated and responded to.

The PHSO will consider the complaint file, medical records and any other relevant information as necessary. The PHSO may decide not to investigate further and no further action will be required from the Trust. Alternatively, recommendations might be made for the Trust to consider. The PHSO may decide to conduct a full investigation which might result in the Trust being required to make an apology, pay compensation and / or produce an action plan to describe what actions are planned to rectify the situation and prevent further occurrences.

The table below details the PHSO and Hospital and Community Health Services Complaints Collection (KO41a) data for local Trusts for the year 2015/16 (published September 2016). An appropriate comparison is the rate of conversion for complaints to PHSO enquiries which runs at 12.4%. This is in line with other local trusts except Countess of Chester, which currently runs at a conversion of 8.9%.

Trust	Complaints Received by the PHSO 2015/16	Complaints Accepted for investigation by the PHSO 2015/16	Fully or Partially Upheld 2015/16	Not upheld 2016/16	Total Complaints Reported (KO41) 2015/16	% of complaints converting to PHSO Enquiries
Warrington & Halton Hospital NHS Foundation Trust	56	16	7	6	421	12.4%
St Helens and Knowsley Teaching Hospitals NHS Trust	34	7	5	5	276	12.3%
Wirral University Teaching Hospital	53	10	5	11	416	12.7%
Wrighton, Wigan and Leigh NHS Foundation Trust	40	14	5	5	365	10.9%
Countess of Chester Hospital NHS Foundation Trust	22	10	3	6	245	8.9%

*https://www.ombudsman.org.uk/organisations-we-investigate/what-our-data-tells-us/quarterly-reports-complaints-about-nhs-organisations & http://content.digital.nhs.uk/catalogue/PUB21533

The formal information relating to cases from 2016/17 is due to be published in September 2017. The table below details the progress of cases over the year within the Trust.

	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17
PHSO cases received	3	3	3	1	1	1	0	1	2	1	0	0
PHSO cases closed	0	1	0	2	2	1	4	3	2	4	1	1
Ongoing PHSO Cases	15	17	20	19	18	18	14	12	12	9	8	7

Of the 21 cases closed by the PHSO in 2016/17 the outcomes were as follows;

10 cases were partially upheld

9 cases were not upheld

2 cases were upheld

3.4.4 National Survey Results 2016

3.4.4.1 National Inpatient Survey 2016 (published but under embargo until 8th June)

Listening to patients' views is essential to providing a patient-centred health service. The annual National Inpatient Survey is a Care Quality Commission (CQC) requirement with the aim of obtaining feedback to improve local services for the benefit of the patients and the public. Survey results are reported to the CQC, who use the information as part of the Hospital Intelligent Monitoring. Patients are eligible for the survey if they are aged over 16 years or older, and have spent at least one night in hospital, and were not admitted to maternity or psychiatric units.

The 2016 Inpatient survey was undertaken by Quality Health, on behalf of the Trust and covers all aspects of patient's admission, care and treatment, operations and procedures and discharge from hospital from the inpatient specialties of General Surgery; Urology; Trauma and Orthopaedics, Cardiology, Acute Internal Medicine, Stroke and Respiratory Medicine. The initial results of the Inpatient Survey (2016) were received in March 2017. 1193 patients were randomly selected during an inpatient stay in July 2015 and 40% responded compared to a response rate of 44% last year. 50% of respondents were over the age of 65 and 44% were male and 56% female.

The NHS in patient survey provides the Trust with intelligence around the overall patient experience and it is vital that we review and act upon this information to address poor performance.

The Picker Institute coordinates all the national results on behalf of the CQC, who publish reports which include benchmarks against best and worst performance. Seventy-six questions are asked and categorized into twelve domains as follows:

- Admission to hospital
- A&E Department
- Waiting List and Planned Admission
- All types of Admission
- The Hospital and Ward
- Doctors
- Nurses
- Your Care and Treatment
- Operations and Procedures
- Leaving Hospital
- Overall views on care and Services
- About you

The following are the main headlines for 2016 benchmarked against 2015 results:

The Trust has deteriorated by 5% or more on the following questions: Higher is better		
	2015	**2016**
All types of Admissions		
Patients did not have to wait a long time to get a bed on a ward	76%	64.9% ↓
The Hospital & Ward		
Patients got enough help from staff to eat their meals	77%	65.7% ↓
Nurses		
Patient felt that there were enough nurses on duty	75%	68.2% ↓
Your Care and Treatment		
Hospital staff worked well together	90%	84.8% ↓
Hospital staff did not give contradictory information	86%	80.9% ↓
Patients were able to find somebody to talk to about their worries and fears	58%	52.7% ↓
Patients thought that staff did everything to control their pain	84%	78.9% ↓
Length of time to get help after using the call button	65%	59% ↓
Leaving hospital		
Patients were given enough notice about their discharge	74%	67.1% ↓
Discharge not delayed due to wait for medicines/ to see a Dr/ for ambulance	66%	59.8% ↓
Discharge delayed for no longer than four hours	78%	72.9% ↓
Staff explained the purpose of medication in an understandable way	85%	78.7% ↓
Staff explained about the medication side effects to be aware of	54%	44.7% ↓
Patients were told in an understandable way how to take their medication	85%	78.9% ↓

Patients were told about what danger signals to watch for after their return	60%	54.8% ↓
Hospital staff took the home situation into account when planning discharge	75%	69.1% ↓
Patients were told who to contact if they were worried about their condition after they had left hospital	81%	72.2% ↓
Overall		
Patients received information on how to complain to the hospital about the care they received	29%	22% ↓

The Trust performed significantly better than the national average in the top 20% of Trusts in relation to "Before leaving hospital patients were given written information on what they should or should not do after leaving". The Trust's performance on a further thirty-two questions are within the lowest 20% nationally, equating to 42% of responses. These results require focus and attention to surpass the current average scores. Issues around care and treatment and matters relating to leaving hospital and discharge appear to be highlighted.

The Trust showed some improvement on 5 questions. The Trust has deteriorated by 5% or more on 18 questions equating to 23% and is in lowest 20% national threshold for a further 32 questions or 42% of responses

The main themes to focus on are leaving "hospital and discharge" and "hospital care and treatment".

The new WHH Patient Experience Strategy will align work streams to address the highlighted themes within the In Patient Survey and will provide a biannual update to the Quality Committee via the Patient Experience Sub Committee.

3.4.5 Patient Opinion

Patient Opinion was founded in 2005, and is an independent non-profit feedback platform for health services. Its philosophy is to support honest and meaningful conversations between patients and health services, with the view that patient feedback can help make health services better. Basically health service users can share their story of using a health service; patient opinion will send their story to staff so that they can learn from it; the Trust can offer a response with the ultimate goal being to help staff change services.

Patients can submit their comments directly onto the Patient Opinion website, or can post comments on Patient Opinion via a form on the NHS Choices website and both websites publish the comments.

Both websites provide feedback on how users rate the service in terms of whether they would recommend our hospital friends and family if they needed similar care and treatment; cleanliness; staff co-operation; dignity and respect; involvement in decisions; and same sex accommodation.

However, NHS Choices provides an overall star rating of 1 – 5 stars and for 2016/2017 the Trust was rated 3 stars by 19 respondents.

A review of Patient Opinion indicates that 15 people would recommend this service and 11 people would not recommend this service.

Cleanliness		**19 ratings**
Environment		**24 ratings**
Information		**23 ratings**
Involved		**42 ratings**
Listening		**24 ratings**
Medical		**19 ratings**
Nursing		**17 ratings**
Parking		**19 ratings**
Respect		**42 ratings**
Timeliness		**42 ratings**

The Trust is committed to acknowledging all comments and if the service user expresses concerns we will try to address them in our response or encourage the reviewer to contact the PALS Team for further discussions.

3.4.6 Friends and Family

The NHS Friends and Family Test is an opportunity for patients to leave feedback on their care and treatment they received at Warrington and Halton NHS Foundation Trust. The feedback will be used to review our services from the patient perspective and enable us to celebrate success and drive improvements in care.

When patients visit our Accident and Emergency (A&E) Department for treatment, or are admitted to hospital, they are asked to complete a short postcard questionnaire when they are discharged. They basically tell us how likely they are to recommend the ward/ A&E department to friends and family if they needed similar care or treatment. The patient's response is anonymous and they will be able to post the card into the confidential box on their way out of the ward or A&E. The boxes are emptied regularly to process the information and provide reports to the ward manager and matron.

If a patient is unable to answer the question, a friend or family member is welcome to respond on their behalf. Users are also asked to rate their responses and this is translated into two ratings which are reported through to the board via the Quality Dashboard. The first rating is a star rating to a maximum of 5 stars and the second up to July 2014 is the Net Promoter score up to a maximum of 100. The Trust is currently procuring a new FFT contract in order to improve the process and increase the response rate e.g. text services and we are in the process of meeting with meeting several companies who provide this service.

The results for 2014/2017 are as follows:

Friends and Family scores 2013/16

	Star Rating 2014/15	Star Rating 2015/16	Star Rating 2016/17	Inpatient 2014/15	Inpatient 2015/16	Inpatient 2016/17	A&E 2014/15	A&E 2015/16	A&E 2016/17
Apr	4.54	4.61	4.73	76	97	96	42	83	90
May	4.5	4.66	4.77	74	98	95	35	86	90
Jun	4.58	4.70	4.75	81	98	96	41	88	92
Jul	4.53	4.66	4.78	76	98	98	40	87	96
Aug	4.6	4.65	4.73	77	96	94	80	90	92
Sept	4.59	4.72	4.79	94	97	96	82	85	93
Oct	4.6	4.71	4.78	95	96	95	85	86	93
Nov	4.6	4.70	4.76	97	96	94	87	85	94
Dec	4.59	4.73	4.77	96	96	93	84	82	96
Jan	4.59	4.72	4.81	96	94	95	87	76	94
Feb	4.55	4.67		97	95	94	84	81	94
Mar	4.61	4.69		96	96	*	83	84	*

***Awaiting publication on NHS England website and requested from STC**

The ratings are published on both NHS Choices and in the Open and Honest publication which is published on the NHS England Trust websites.

3.4.6.1 Friends and Family – Maternity Services

This CQUIN also required that Friends and Family was rolled out to maternity services. The rollout to maternity services was successfully achieved within the required timescales. It was agreed to maintain this as a patient experience indicator for 2016/2017.

F&F question is asked at four stages along the maternity pathway and the following table indicates the Trust performs well in relation to the national average:-

	TRUST ANTENATAL CARE	ENGLAND ANTENATAL CARE	TRUST BIRTH	ENGLAND BIRTH	TRUST POSTNATAL	ENGLAND POSTNATAL	TRUST POSTNATAL COMMUNITY	ENGLAND POSTNATAL COMMUNITY
MARCH 2017								
FEBRUARY 2017								
JANUARY 2017	93	96	100	97	83	94	NA	98
DECEMBER 2016	82	96	98	96	93	94	NA	98
NOVEMBER 2016	98	96	97	97	94	94	100	97
OCTOBER 2016	95	95	94	96	94	94	100	98
SEPTEMBER 2016	100	96	90	96	98	94	100	98
AUGUST 2016	100	95	98	96	91	93	100	97
JULY2016	96	95	98	97	100	93	100	98
JUNE 2016	98	95	94	97	94	94	100	98
MAY 2016	97	96	91	97	98	94	100	98
APRIL 2016	95	96	98	96	94	94	NA	97
MARCH 2016	NA	95	94	96	100	94	NA	98

FEBRUARY 2016	94	95	90	96	95	94	NA	98
JANUARY 2016	NA	96	87	97	95	94	NA	98
DECEMBER 2015	100	95	NA	97	NA	94	100	98
NOVEMBER 2015	91	96	88	96	96	94	NA	98
OCTOBER 2015	97	95	78	96	94	94	100	98
SEPTEMBER 2015	97	95	95	97	95	93	100	98
AUGUST 2015	96	95	95	97	100	94	100	98
JULY 2015	98	94.6	98	96.8	93	94.2	100	97.5
JUNE 2015	96	95.9	98	96.9	98	93.4	100	97.7
MAY 2015	98	95.9	96	97	100	93.3	100	97.8
APRIL 2015	98	95.3	100	97.2	98	93.7	100	97.7

3.5 Royal College of Midwives National Award – Midwifery Service of the Year

Warrington and Halton Hospitals NHS FT was named 'Midwifery Service of the Year' in the Royal College of Midwives' national awards held in London in March 2017. There was firm competition from Barking, Havering and Redbridge University Hospitals, Lancashire Teaching Hospitals and NHS Highland in this category, which was sponsored by Kellogg's All-Bran. Earlier in the year the service reached the finals of the national HSJ Awards in the Patient Safety category.

'Learning from When Things Go Wrong' told of the difficult, often emotional, journey to rebuild the service and restore the confidence of women and their families as well as its workforce over the past two years. The team developed the ***YOUR PREGNANCY, YOUR BIRTH, YOUR CHOICE*** campaign which became the driver for change, using a bottom-up approach and working closely with patients and former patients to achieve a best-in-class service. The final part of the recovery journey saw the new Midwifery Led Unit open in May 2016 - a real platform for the future of midwifery and childbirth at the Trust.

3.6 Duty of Candour

Last year the Trust reported that the Investigating Panel, as part of each Serious Incident investigation, check that Duty of Candour has been followed. The Trust also developed staff and patient information leaflets, located on the Trust internet, to inform people about the process. Duty of Candour also formed part of Medical Mandatory Training in 2013 to 2015. In the previous Quality Account, we reported that the Trust has not at the time of this report ever had any issues brought to its attention where Duty of Candour has not been undertaken as required. However in February 2017, an audit of Duty of Candour was undertaken, and the Trust could not demonstrate a central monitoring system for Duty of Candour and that the Trust was routinely complying with the requirement of notification by letter within 10 days of becoming aware that a patient had been moderately or severely harmed.

The clinical governance team have undertaken a substantial review of Duty of Candour and actions and processes have now been applied to ensure the Trust complies with Duty of Candour requirements and evidences this appropriately going forward, including now having a central mechanism for monitoring via the Datix system.

The role of Family Liaison Officer is being developed in the Trust, to have highly trained individuals supporting patients and/or families when a Serious Incident occurs.

3.7 Sign up to Safety

Sign up to Safety is a national patient safety campaign that was announced in March 2014 by the Secretary of State for Health. It launched on 24 June 2014 with the mission to strengthen patient safety in the NHS, and make it the safest healthcare system in the world.
The Secretary of State for Health set out the ambition of halving avoidable harm in the NHS over the next three years, and saving 6,000 lives as a result. This is supported by a campaign that aims to listen to patients, carers and staff, learn from what they say when things go wrong and take action to improve patient's safety helping to ensure patients get harm free care every time, everywhere.
We agreed to 3 central commitments when we signed up to safety namely:-

- To describe the actions we will undertake in response to the five Sign up to Safety pledges and agree to publish this on our website for staff, patients and the public to see.
- Turn our proposed actions into a Safety Improvement Plan which will show how the Trust intends to save lives and reduce harm for patients over the next 3 years.
- Identify within our Safety Improvement Plan the safety improvement areas that we will focus on.

Our Trust agreed to focus upon three key areas namely;

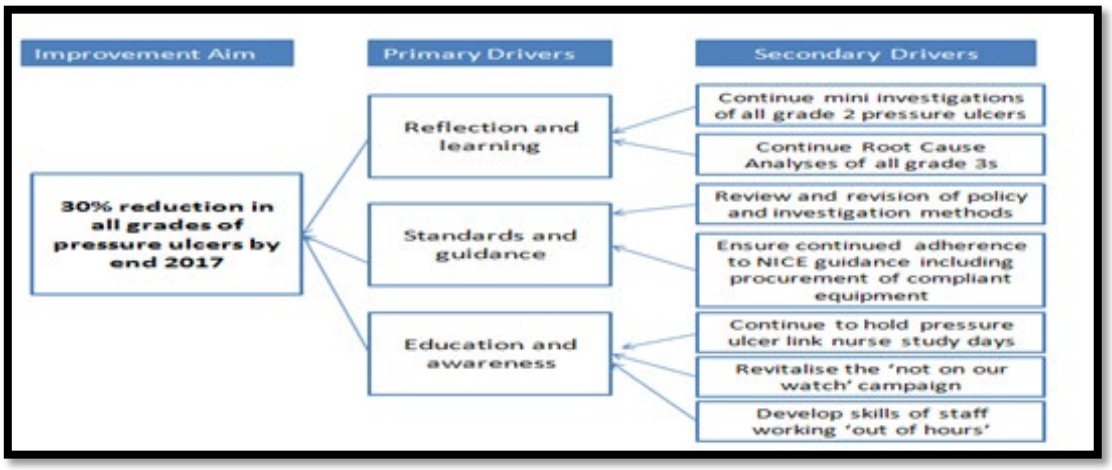
- Reducing avoidable mortality
- 30% reduction in moderate falls
- 30% reduction in all grades of pressure ulcers by 2017.

3.7.1 Sign up to Safety – Pressure Ulcer reduction

Sign up to Safety aims to deliver harm free care for every patient, every time, everywhere. It champions openness and honesty and supports everyone to improve the safety of patients. Sign up

to Safety's three year objective is to reduce avoidable harm by 50% and save 6,000 lives across the NHS.

The driver document articulates the Trust's strategy for a 30% reduction in all grades of pressure ulcers by 2017. The Trust is pleased to report that it has met this sign up to safety objective for pressure ulcers by the end of year one with a 39.83% reduction in all pressure ulcers.



3.7.2 Sign up to Safety – reducing mortality

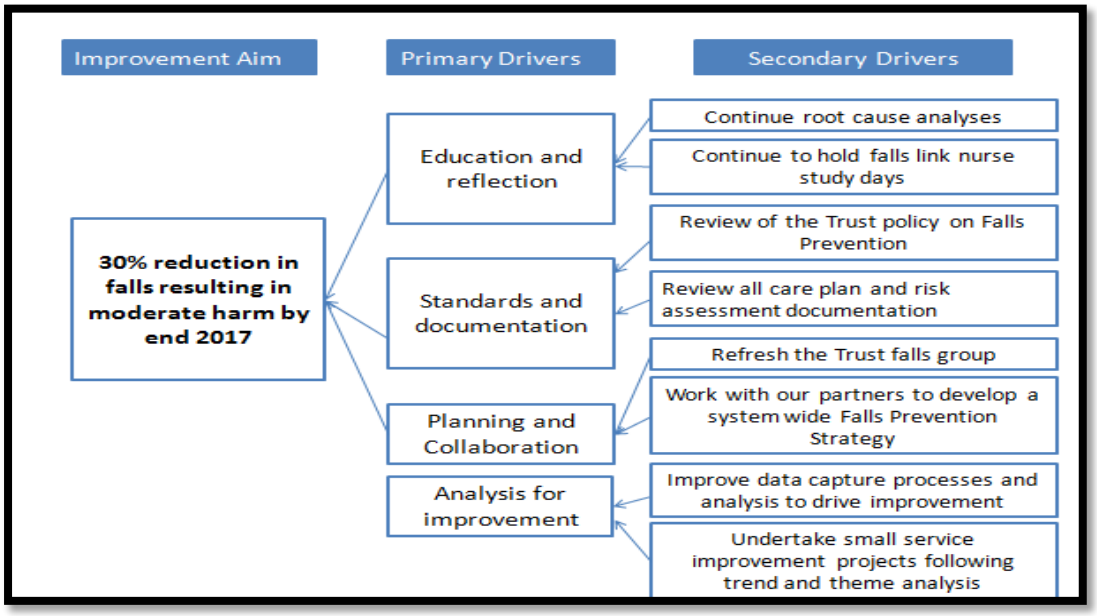
Reducing avoidable mortality (Mortality Review) was identified as a 'Sign up to Safety' (SU2S) priority when the Trust signed up to this three year initiative in 2014/15. Our aim for phase 1 (end of quarter 1 2015/16) was to identify areas for improvement. Whilst we were conducting mortality review at that time and identifying minor aspects of care which could be improved, we were not in a position, by quarter 1 2015/16 to use the findings to drive large improvement projects. Since SU2S was launched, the Trust has undergone significant change, some of which has inadvertently delayed our achievement of this aim, but all of which has underpinned the implementation of a robust system of mortality review. Key developments include:

- A new Medical Director with a change in focus, to consultants peer reviewing all deaths
- The implementation of a new electronic patient record, Lorenzo, which required a change in approach, but then enabled streamlining of the process
- The Mortality Review Group has increased medic, nursing and CCG involvement
- Valuable collaboration with our CCG partners; in the Mortality Review Group (MRG) and in reviewing patients' whole pathways of care
- New Associate Medical Director roles, in Governance (MRG chair) and Service Improvement have lent weight to the successful implementation, for example with the engagement of medics
- Development of an IT system to support mortality review, now into phase two of development
- Integration of corporate and specialty mortality review systems

Further information in relation to reducing mortality can be seen in section 2.3.1 of this report.

3.7.3 Sign up to Safety – reduction of moderate falls

During 2014/2015 the Trust has also identified falls as a Sign up to Safety goal. The driver document articulates the Trust's strategy for a 30% reduction in moderate falls by 2017.



The Trust did agree a 10% reduction in falls where moderate harm occurs by March 2015 for stage one of Sign up to Safety but as with the improvement priority we have failed to reach this threshold. As such we concentrated efforts to reduce moderate falls during 2015/2016 and set a reduction threshold of an additional 10% moderate falls of <=12 by March 2016 (overall 20% reduction for 2014/2016). For this year we can report that there have been 9 moderate falls approved compared to 15 moderate falls in 2013/2014 which constitutes a 40% reduction and as such the Trust has achieved this sign up to safety indicator of a 30% reduction by 2017.

3.8 Staff Survey Indicators

The most recent NHS Staff Survey results for indicators KF26 (percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months) and KF21 (percentage believing that Trust provides equal opportunities for career progression or promotion) are as follows;

In relation to the percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months (KF26) the Trust score was 23% a slight but not statistically significant deterioration and is still better than the acute Trust average. The indicator for the percentage of staff believing that the Trust provides equal opportunities for career progression or promotion (KF21) was 91% above the national average for acute Trusts and puts the Trust's results were in the top 20% of all acute Trusts.

3.9 Speak out Safely

Warrington and Halton Hospitals NHS Foundation Trust supports the national Speak Out Safely campaign. This means we encourage any staff member who has a genuine patient safety concern to raise this within the organisation at the earliest opportunity.

Patient safety is our prime concern and our staff are often best placed to identify where care may be falling below the standard our patients deserve. In order to ensure our high standards continue to be met, we want every member of our staff to feel able to raise concerns with their line manager, or another member of the management team. We want everyone in the organisation to feel able to highlight wrongdoing or poor practice when they see it and confident that their concerns will be addressed in a constructive way.

We promise that where staff identify a genuine patient safety concern, we shall not treat them with prejudice and they will not suffer any detriment to their career. Instead, we will support them, fully investigate and, if appropriate, act on their concern. We will also give them feedback about how we have responded to the issue they have raised, as soon as possible.

We are passionate about creating an open and listening culture where patient and staff views contribute to the running of the organisation. We now have a Freedom to Speak up Guardian, Jane Hurst, who will help support the Trust to become a more open, transparent place to work by listening to staff and supporting them to raise concerns.

3.10 Performance against key national priorities

(Please see table below)

Performance against the relevant indicators and performance thresholds set out in Appendix A of Monitor's risk assessment framework'. Where any of these indicators have already been reported on in Part 2 of the quality report, in accordance with the Quality Accounts Regulations, they do not need to be repeated here.

Mar-17

Monitor Access Targets & Outcomes - 2016/17

Warrington and Halton Hospitals NHS
NHS Foundation Trust

All targets are QUARTERLY

Target or Indicator		Threshold	Weighting	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4
Referral to treatment waiting time	Admitted patients	90%	N/A	84.65%	83.99%	81.46%		83.61%	84.29%	81.74%		79.32%	81.26%	81.48%		75.57%	80.22%	78.51%	
	Non-admitted patients	95%	N/A	95.00%	94.68%	94.11%		93.78%	93.68%	94.02%		93.59%	94.24%	95.00%		94.29%	93.35%	92.82%	
	Incomplete Pathways	92%	1.0	92.37%	93.00%	92.90%		93.04%	94.16%	93.50%		93.56%	93.54%	92.82%		93.30%	92.34%	93.01%	
A&E Clinical Quality	A&E Maximum waiting time of 4 hrs from arrival to admission/transfer/discharge	>=95%	1.0	90.45%	92.29%	93.52%	92.12%	92.69%	92.88%	94.75%	93.43%	92.05%	91.59%	85.13%	89.61%	85.85%	84.49%	90.74%	87.16%
All Cancers:62-day wait for First treatment	From urgent GP referral - **post** local breach re-allocation (CCG)	85%	1.0 (Failure for either = failure against the overall target)	85.88%	85.54%	90.70%	87.40%	85.92%	86.08%	85.71%	85.91%	86.15%	90.32%	79.10%	85.05%	85.19%	62.96%	76.67%	73.78%
	From NHS Cancer Screening Service referral - **post** local breach re-allocation	90%		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	From urgent GP referral - **pre** local breach re-allocation (Open Exeter - Monitor)	85%		86.42%	87.34%	92.86%	88.93%	86.11%	85.33%	85.71%	85.71%	86.15%	90.32%	79.10%	85.05%	81.67%	75.29%	74.44%	76.60%
	From NHS Cancer Screening Service referral - **pre** local breach re-allocation	90%		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
All Cancers:31-day wait for second or subsequent treatment	Surgery	>94%	1.0 (Failure for any of the 3 = failure against the overall target)	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%			87.50%	87.50%	100.00%	100.00%	92.31%	96.15%
	Anti Cancer Drug Treatments	>98%		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%		100.00%	100.00%		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	Radiotherapy (not performed at this Trust)	>94%																	

All Cancers: 31-Day Wait From Diagnosis To First Treatment		>96%	1.0	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	96.30%	93.18%	95.79%	96.23%	95.24%	97.14%	96.24%
Cancer: Two Week Wait From Referral To Date First Seen	Urgent Referrals (Cancer Suspected)	>93%	1.0 (Failure for either = failure against the overall target)	93.46%	93.11%	94.78%	93.79%	93.20%	93.96%	93.49%	93.57%	93.24%	93.73%	93.58%	93.52%	87.91%	93.50%	95.25%	92.52%
	Symptomatic Breast Patients (Cancer Not Initially Suspected)	>93%		93.64%	93.33%	93.83%	93.63%	93.10%	93.55%	93.33%	93.33%	94.57%	93.90%	91.49%	93.28%	80.00%	93.26%	79.10%	84.55%
Clostridium Difficile - Hospital acquired **(CUMULATIVE)**	Due to lapses in care	27 (for the Yr)	1.0 **	1	1	1	1	2	2	2	2	2	2	5	5	7	8	11	11
	Not due to lapses in care			0	2	3	3	5	6	6	6	6	7	8	8	10	11	13	13
	Total (including: due to lapses in care, not due to lapses in care, and cases under review)			1	3	4	4	7	8	8	8	8	9	13	13	17	19	24	24
	Under Review			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Failure to comply with requirements regarding access to healthcare for people with a learning disability		N/A	1.0	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No

Cumulative
Qtr1: 7 Qtr2: 14
Qtr3: 21 Qtr4: 27

Target or Indicator	Target	Weighting	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4
Risk of, or actual, failure to deliver Commissioner Requested Services	N/A	Report by Exception	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Date of last CQC inspection	N/A		March 2017- report not received (last inspection March 2015)															
CQC compliance action outstanding (as at time of submission)	N/A		No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
CQC enforcement action within last 12 months (as at time of submission)	N/A		No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
CQC enforcement action (including notices) currently in effect (as at time of submission)	N/A		No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Moderate CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission) Breach of regulation 23 (1) (a) HSCA 2008 (Regulated Activities) Regulations 2010 regarding the safety of healthcare provision	N/A		March 2015 Inspection Report - Requires Improvement															
Major CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission) Breach of regulation 23 (1) (a) HSCA 2008 (Regulated Activities) Regulations 2010 regarding the safety of healthcare provision	N/A		No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Overall rating from CQC inspection (as at time of submission)	N/A		No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
CQC recommendation to place trust into Special Measures (as at time of submission)	N/A		No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Trust unable to declare ongoing compliance with minimum standards of CQC registration	N/A		No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Trust has not complied with the high secure services Directorate (High Secure MH trusts only)	N/A																	

Service Performance Score	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	5.0	3.0	2.0	3.0	4.0	3.0

NHS foundation trusts failing to meet at least four of these requirements at any given time, or failing the same requirement for at least three quarters, will trigger a governance concern, potentially leading to investigation and enforcement action

18 Weeks Referral to Treatment

Performance is measured on an aggregate (rather than specialty) basis and NHS foundation trusts are required to meet the threshold on a monthly basis.

Consequently, any failure in one month is considered to be a quarterly failure for the purposes of the Risk Assessment Framework.

Failure in any month of a quarter following two quarters' failure of the same measure represents a third successive quarter failure and should be reported via the exception reporting process.

Failure against any threshold will score 1.0, but the overall impact will be capped at 2.0

**** Clostridium Difficile**

Monitor's annual de minimis limit for cases of C-Diff is set at 12. However, Monitor may consider scoring cases of <12 if Public Health England indicates multiple outbreaks

Monitor will assess NHS foundation trusts for breaches of the C. difficile objective against their objective at each quarter using a cumulative year-to-date trajectory.

Criteria	Will a score be applied
Where the number of cases is less than or equal to the de minimis limit	No
If a trust exceeds the de minimis limit, but remains within the in-year trajectory# for the national objective	No
If a trust exceeds both the de minimis limit and the in-year trajectory for the national objective	Yes
If a trust exceeds its national objective above the de minimis limit	Yes

Assessed at: 25% of the annual centrally-set objective at quarter 1; 50% at quarter 2; 75% at quarter 3; and 100% at quarter 4 (all rounded to the nearest whole number, with any ending in 0.5 rounded up).

Monitor will not accept a trust's own internal phasing of their annual objective or that agreed with their commissioners.

In relation to the above A&E data, it is important to note that May 2016 and October 2016 data was incorrectly submitted for the national statistics. The percentages obtained above are locally sourced percentages. The published data for May 2016 is 92.18% and for October 2016 is 92.06%.

The above Referral to Treatment targets include non NHS commissioned pathways. The nationally published Referral to Treatment figures show that as a Trust we achieved a year end average of 93.13%. Monthly data is as follows;

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
92.38%	93.02%	92.91%	93.05%	94.17%	93.5%	93.57%	93.55%	92.81%	93.3%	92.35%	93%

3.11 Governors' visits

The Governors' Council has initiated a series of unannounced visits to ward and department areas to observe issues of care and treatment in order to provide assurance to them and, importantly, to their constituents about the quality of service provided by the Trust.

A summary, provided by the Trust's Lead Governor, is available with section 4.7

3.12 Training & Appraisal

Training and Appraisal Completion

	Target	**Year End Results**
Mandatory Training Health & Safety Fire Safety Manual Handling	 85% 85% 85%	 94.91% 87.77% 89.90%
Additional Fire Safety and Manual Handling sessions are in place to improve these figures.		
Staff Appraisal Non-medical Medical & Dental staff Medical & Dental (excluding consultants) Consultants	 85% in last 12 months 85% 85% 85%	 86.08% 70.35% 63.29% 74.15%

Each division and professional group are now being performance monitored on a monthly basis to identify improvements they have made to compliance with training requirements. Divisions have been reminded of the need to make further progress and Clinical Leads will be giving this matter greater priority.

3.13 Quality Report request for External Assurance

Warrington and Halton NHS FT has requested the Trust auditors Grant Thornton UK LLP to undertake substantive sample testing of two mandated indicators and one local indicator (as selected by the governors) included in the quality report as follows;

Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period.

Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge.

Safer Surgery.

Annex 1 Quality Report Statements

Statements from Clinical Commissioning Groups, Healthwatch and Overview and Scrutiny Committees 2015/2016

Statements from the following stakeholders are presented within this document unedited by the Trust and are produced verbatim.

4.1 Statement from Warrington Clinical Commissioning Group

NHS
Warrington
Clinical Commissioning Group

Arpley House
110 Birchwood Boulevard
Arpley House
Birchwood
Warrington
WA3 7QH

www.warringtonccg.nhs.uk

☎ 01925 843636

Please Ask For: John Wharton

E-mail: john.wharton@warringtonccg.nhs.uk

Date: 22nd May 2017

Kimberley Salmon Jamieson
Chief Nurse
Warrington & Halton Hospitals NHS Trust
Executive Offices
Kendrick Wing
Warrington Hospital
Warrington
WA5 1QG

Dear Kimberley

In accordance with the national guidance around provider Quality Accounts and on behalf of NHS Warrington Clinical Commissioning Group I hereby supply the organisation's official response.

Many thanks for submitting your quality account to us and its presentation by Hayley Mannin, Quality Assurance Lead for the organisation. Whilst the CCG is aware that you are still awaiting the outcome of a recent Care Quality Commission (CQC) review of the organisation, the group unanimously agreed that the account was focused and informative. This was viewed as an improvement over those that have previously received. The group acknowledged the cultural change in the organisation has impacted on the account providing a stronger assurance with regards to the main determinants of quality; safety, effectiveness and patient experience.

Invited representation from NHS England, local Patient Participation Groups (PPGs) and Warrington Healthwatch, along with GP Commissioners from the organisation, used the opportunity to request further assurance and detail to ensure that concerns that they had identified in the account were raised. Questions about the account included; how the organisation will assure themselves and the commissioners about their priorities for 2016/17 that were RAG rated Amber but were not included in the priorities for 2017/18? Why were these priorities not rolled forward into this year? In terms of the patient experience there were concerns raised that whilst there have been significant pieces of work to embed the patient experience, Staff Strategy Development sessions were not attended by senior clinical staff. Further observations suggested that the lack of senior staff representation appears to be having an adverse effect on staff morale. Other questions were raised regarding the management of patients with mental health problems in the Accident & Emergency (A&E) Department and the ongoing work to improve liaison psychiatry in the department was also discussed.

There are obvious areas of improvement in the account and the way it is presented and there are aspects of the account which could be further improved by the addition of more detailed information. One area that we would have welcomed greater detail is the organisation's future plans for their workforce and how the staff's Personal Development Reviews (PDRs) are being used as a basis for future planning. Are these plans linked to investment for a strong and competent workforce able to deliver high standards of care and meet the future challenges of health and social care? Whilst Hayley offered her own personal account of how she has been treated since joining the organisation, the account didn't offer a positive narrative of how the organisation is planning for the workforce needs of the future. The group also commented on the lack of information in the organisation's account regarding the roll out of plans for seven day working and the impact of this change on quality.

Finally, the group concluded that the account offers a solid foundation on which the Trust will build, particularly the work to improve processes and systems in the area of complaints and concerns, from both patients and staff. The group were also impressed with the improved relationships with the CCG. Areas highlighted were the reporting of serious incidents and the established mortality reviews. This was seen as assurance that the organisation is eager to learn from incidents and acknowledge when care has failed to meet the standards commissioned.

In conclusion, I believe that this account highlights the organisation's intent to move forward and work with partner organisations and commissioners to ensure that they deliver high standards of care for the local population but equally learn lessons when this has not been achieved. I believe that this is a true and honest account of a health care organisation on the precipice of delivering significant change.

Yours sincerely

John Wharton
Chief Nurse & Quality Lead
Warrington Clinical Commissioning Group

c.c. Hayley Mannin, Quality Assurance Lead

4.2 Statement from Halton Clinical Commissioning Group

NHS
Halton Clinical Commissioning Group

First Floor
Runcorn Town Hall
Heath Road
Runcorn
Cheshire
WA7 5TD

Tel: 01928 593479
www.haltonccg.nhs.uk

12th May 2017

Ms M Pickup
Chief Executive
Warrington and Halton Hospitals NHS
Foundation Trust
Lovely Lane
Warrington
WA5 1QG

Dear Mel,

Quality Accounts 2016 - 2017

I am writing to express my thanks for the submission of Warrington and Halton Hospitals NHS Foundation Trust Quality Report for 2016 2017 and for the presentation given by Ursula Martin to local stakeholders on 25th April 2017. This letter provides the response from NHS Halton Clinical Commissioning Group to the Quality Report 2016-2017

NHS Halton CCG understands the pressures and challenges for the Trust and the local health economy in the last year and would like to congratulate and thank the Trust for the level of partnership working and support in this year.

NHS Halton CCG noted the Priorities and progress made in 2016 – 2017:

1. Reduction in **Pressure Ulcers** with the Trust goal to achieve
   - 5% reduction in avoidable grade 2 pressure ulcers – The Trust achieved this in reporting 36 with a threshold of 82.
   - Maintain grade 3 pressure ulcers at 2015/16 rate – The Trust marginally missed this target reporting 4 against a threshold of 3.
   - Zero incidences of grade 4 pressure ulcers - the Trust reported 1.

   It was noted that overall there has been substantial decrease of 56.8% in avoidable Pressure Ulcers across the Trust in 2016/17.

2. Compliance with the **MUST Nursing Care Indicator** in patients over the age of 75 years of age. The Trust achieved 91% against a target of 100% and further improvements will include:
   - Risk assessments are now recorded in your electronic system Lorenzo, from March 2017.
   - Changes to on-going audit to include new questions as a result from learning.

3. Learning from **Mortality Reviews** by improving screening to 100% by March 2017. The screening target was achieved. Learning from these reviews are identified and disseminated through the Trust's Mortality Review Group and speciality Mortality and Morbidity meetings. The latest reported figures for HSMR is 106.48 for the period January 2016 to December 2016 and SHMI 108.12 for the period December 2015 to November 2016 (HED system). The SHMI was in the range of 'higher than expected' until November 2015, however this is now 'as expected' for the period January 2015 – December 2015. The HSMR is 'as expected' throughout this period.

4. Implementing **Experience of Care Strategy** with a focus on developing the process for 72 hour review of high risk complaints and monitor in quarter(s) 3 and 4 for 2016/2017 and ensuring every patient has a voice. NHS Halton CCG acknowledge that the Trust have undertaken a significant amount of work in

Q4 with regard to complaints management and a system is now in place to escalate all high risk complaints to the Clinical Business Units within 72 hours.

- The high risk complaints, along with moderate and low risked complaints are reported to the Board of Directors on a weekly basis.
- All high risk complaints are discussed at the weekly Patient Experience Team meeting and more recently an option of 72 hour review has been added into the notify box within the Datix system.

In terms of patient experience one area stakeholders highlighted was with regard to the National Survey 2016 and the Trust's performance, in that thirty-two questions are within the lowest 20% nationally, equating to 42% of responses. Issues around care and treatment and matters relating to leaving hospital and discharge appear to be highlighted. The Trust has deteriorated by 5% or more on 18 questions equating to 23% and is in lowest 20% national threshold for a further 32 questions or 42% of responses. The main themes are "leaving hospital and discharge" and "hospital care and treatment". It was noted that supporting safe and proactive discharge is a priority for 2017/2018.

5. **Patient Safety and Effectiveness** Indicators:
   - Medicines Management - 97% of patients were free from medicine related harm.
   - Health Care Acquired Infections (HCAI) - 2016/2017 the Trust reported zero cases of MRSA bacteraemia and that the Trust should be commended in having a period of 17 months free of MRSA bacteraemia. To date in 2016/2017 there have been 18 cases of Clostridium Difficile against a threshold of 27 and 8 cases are deemed not to be due to a lapse in care.
   - WHO Checklist (ORMIS) the Trust reported full compliance in 2016/2017 with the exception of August when there was one case of non-compliance, which related to a maternity procedure. Audit has shown improvements in compliance with the WHO Checklist in the maternity theatres and is reported via the theatre governance meetings which report into the CBU Governance meeting

NHS Halton CCG noted the Trusts Improvement Priorities for 2017 – 2018:

Priority 1 – The Trust will reduce harm and focus on having no avoidable deaths by managing and reducing clinical and operational risks. Focussing on Safer surgery, Falls and Sepsis management.
Priority 2 – The Trust will improve outcomes based on evidence and deliver care in the right place, first time, every time. Focussing on supporting proactive and safe discharge, Mortality and Lessons learned.
Priority 3 – The Trust will focus on the patient and their experience adopting 'no decision about me without me' as a way of life and we will get the basics right so our patients will be warm, clean, and well cared for. Focussing on patient experience; mental health and A&E.

NHS Halton CCG recognises the challenges for providers in the coming year but we look forward to working with the Trust during 2017-2018 to deliver continued improvement in service quality, safety and patient experience and also on the partnership work as we move forward with our One Halton model of service delivery

NHS Halton CCG would like to congratulate the trust on the hard work of its staff and their commitment to the care of the people of Halton thanking local staff and managers for their on-going commitment locally and for the opportunity to comment on the draft Quality Account for 2016/2017.

Yours sincerely,

Michelle Creed

Michelle Creed
Chief Nurse

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4.3 Statement from the Halton Health Policy Performance Board

HALTON BOROUGH COUNCIL

Ms M Pickup
Chief Executive
Warrington and Halton Hospitals NHS
Foundation Trust
Lovely Lane
Warrington
WA5 1QG

Our Ref	EST
If you telephone please ask for	Emma Sutton-Thompson
Your ref	
Date	12th May 2017
E-mail address	Emma.Sutton-Thompson @halton.gov.uk

Dear Ms Pickup

Quality Accounts 2016 - 2017

Further to receiving a copy of your draft Quality Accounts and the Joint Quality Accounts event held on 26th April that your colleague Ursula Martin attended to present 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 2016/17 the Board were pleased to note that the Trust made progress against the following priorities;

- Pressure Ulcer Reduction - to achieve 5% reduction in avoidable grade 2 ulcers no increase of grade 3 pressure ulcers and no incidence of grade 4 pressure ulcers. The Board were pleased to note the Trust had achieved the target of reducing grade 2 ulcers by 2% and were interested to hear about the measures being put in place regarding the difficulties in meeting targets regarding grade 3 and 4 pressure ulcers.
- MUST Nursing Care Indicator – to establish systems for data collection and monitor inpatients ≥75 years to ensure no more than 10% weight loss. The Board noted that there had been problems in collecting data and increasing nutritional assessments to which a plan was underway to embed into practice and collect information electronically via Lorenzo.
- Mortality Review – to improve screening compliance to 100% by March 2017. The Board were pleased to note the Trust achieved this priority.
- Patient Experience – a system is now in place to escalate all high risk complaints within 72 hours. The Board noted that the Trust would continue into 2017/18 with a focus on the backlog of complaints and resolving complaints where possible at the bedside.

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Runcorn Town Hall, Heath Road, Runcorn, Cheshire WA7 5TD
Tel: 0151 907 8300
www.halton.gov.uk

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HALTON BOROUGH COUNCIL

In terms of Safety Indicators the Board were pleased to note that results for 2016/17 indicated improvement to compliance with risk assessments, medicines management and that the Trust had been free from MRSA infections for 17 months.

Regarding Clinical Effectiveness, the Board were pleased to note the work the Trust has been progressing around Dementia, including supporting Carers through John's Campaign. Whilst COPD was not within target, the Board noted the indicators are improving over time.

The Board are pleased to note the following Improvement Priorities for 2017 – 2018:

- Safer Surgery – The Trust have had two never events in the last two months which has prompted a review in observation audits and procedures. Progress will be monitored via a dashboard which is presented to the Executive Board at WHHFT.
- Falls – The Trust has employed a Falls Nurse and is aiming to reduce falls resulting in moderate/catastrophic harm by 10%.
- Sepsis – In line with the National CQUIN, the Trust will work to achieve timely assessment, identification and treatment of Sepsis within emergency departments and acute inpatient settings.
- Supporting Proactive and Safe Discharge – Linked to a National CQUIN to ensure reduction of delayed transfers of care and admission avoidance.
- Mortality – Following on from a report by CQC which highlighted that opportunities for improvement should be prioritised regarding preventable deaths.
- Lessons Learnt – To ensure that best practice, key learnings and improvements is shared locally and Trust-wide via a wide variety of communication methods.
- Patient Experience for those patients with MH needs attending A&E – The Board were very interested to hear about the Trust's plans to reduce the number of people with MH needs attending A&E. The Trust are developing and strengthening existing and new services to offer safe and more therapeutic alternatives to A&E.

The Board would like to thank Warrington and Halton Hospitals NHS Foundation Trust for the opportunity to comment on these Quality Accounts.

Yours sincerely,

Councillor Joan Lowe
Chair, Health Policy and Performance Board

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4.4 Statement from Warrington Healthwatch

healthwatch Warrington

Healthwatch Warrington
The Gateway
89 Sankey Street
Warrington
WA1 1SR
Tel 01925 246892

contact@healthwatchwarrington.co.uk
www.healthwatchwarrington.co.uk

17th May 2017

Dear Hayley,

Re: Healthwatch Watch Warrington's Response to Warrington and Halton Hospitals NHS Foundation Trust (WHHFT) Draft Quality Account Document 2016 - 2017 (May 2017)

Healthwatch Warrington is pleased to have the opportunity to review WHHFT's 2016 - 2017 Quality Account and reflect on the information given within the document.

As a consumer champion for health and social care, we recognise the fundamental impact that values and a person-centred approach have in shaping the quality and safety of service delivery, as well as patient experience. Though the WHHFT QA comprises a vast array of medical data and evidence, the document and narrative feel very clinical. It is unfortunate that the WHHFT QA does not centre from the beginning on a person-centred focus e.g. using the Trust's values/mission statements. We often find that this values-based approach sets a tone for a QA, and indeed a services approach, and is well received by the public.

As Healthwatch Warrington, it must be said that most of the feedback that we receive through our online public feedback centre (www.healthwatchwarrington.co.uk) is largely positive. Our feedback centre allows reviewers to rate health and social care services accessed by Warrington residents out of 5 stars (1 being the lowest, 5 being the highest rating). The feedback centre also allows comments and responses by providers, to have their say and respond directly to reviewers (who can choose to leave feedback anonymously).

Overall, the Hospital Trust is rated positively, with a rating of 4/5 stars from 136 reviews over the 2016/17 period. Quality of care, in particular treatment explanation and staff attitude are positive aspects of patient experience, with a rating of 4.5/5 stars each. Waiting times and quality of food are, however, less well rated with just 3.5/5 stars. These ratings indicate that though there are positive areas experienced in care at the Trust, there are aspects of patient access and services received to improve upon. Capacity of staff continues to be an access issue for the Trust, within our feedback. Overall feedback, as captured by our feedback centre, indicates that quality of care is very high at WHHFT, with 91% positive feedback. Staff attitude is also rated very highly, with over 90% positive experiences recounted to Healthwatch. Access to services, however, is weighted equally - 46% reviewing waiting times refer to them as negative, while 46% rate them as positive.

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The report clearly states the four key priorities of the Trust during 15/16; Pressure ulcer reductions, must Nursing Indicator, Mortality Review and Patient Voice. Given that the QA reports a 56.8% reduction in Grade 2 Pressure Ulcers, it is still concerning that around 21% of Grade 2 Pressure Ulcers reported were avoidable - the role of a Tissue Viability Nurse Specialist is to be commended, as there is evidently further work to be done around this. The QA reports a 5% reduction in Grade 2 Pressure Ulcers, which is a positive step - the development of Grade 3 and Grade 4 pressure sores however, is concerning. As the QAs across the region have shown, pressure ulcers continue to be an area for improvement for most acute trusts - perhaps there is learning to be done from those Trusts who are actively succeeding in addressing this.

Again, given the ever growing pressure of an ageing population and rising complex needs, the Trust's work to mitigate risk of falls and harm by addressing and monitoring body weight for those patients 75yrs plus using the MUST Nursing Care Indicator is a step in the right direction. The Trust's work on the Mortality Review and the achievements measured so far show a commitment to improve learning from patient deaths. Progressing screening of 100% of patient deaths from 2% in Q2 to 77% in Q4 shows an aim to address and learn from incidents. The Trust's work to review the Death certification processes and improve accuracy of Death certification recording is important for the Trust itself, as well as families and carers, given that delays in this process or inaccuracies can cause significant distress and anxiety as seen during some of our advocacy work. An aim to learn and improve the quality of the process as a result of this work is needed.

End of Life Care, DNACPRs and documentation is noted as requiring review, to explore where palliative care could have been started earlier - as a Healthwatch, we are aware of this need through our Advocacy support work. We are also aware that there is a need for clearer End of Life pathways within the Trust, as well as a review for process, information and communication about patient's/families' preference of setting e.g. moves to transfer patients home or to other care settings (hospice) at palliative stage. This need has also been highlighted by the local Hospice (St Rocco's) - work is being undertaken to develop better links and communication with GPs and other services so those in need are better able to access palliative care support as early as possible.

The Experience of Care Strategy focussing on shared decision making ('nothing about me, without me') is admirable - to be successful, this approach must be embraced, lived and supported by all levels of the Trust, from all frontline staff, senior members and executives, to clinical staff in all departments e.g. Consultants and Specialists. Shared decision making is also a key project for Healthwatch Warrington, working in partnership with AQuA and Bridgewater Community Healthcare Trust and others, where we are working on developing and delivering training to help patients have better and more effective care conversations with professionals (the Expert in Me project).

We are pleased to see recruitment of a new Chief Nurse and Deputy Chief Nurse - we hope this is a way forward for the Trust to develop, and will establish a continuous commitment and drive to include staff and clinicians in delivery of quality care.

The QA also states that "the importance of local resolution of concerns within the ward or department is being promoted". Again, this immediate aim to localise resolutions as soon as they occur could best serve patient need and help minimise patient/family/carer distress and

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concerns. These issues however, should still be recorded and monitored to identify and address trends or issues.

Healthwatch Warrington's advocacy support work for patients/families/carers with experience of the Trust has shown us that there are some consistent issues within the Trust - lack of timely intervention in care, limited consistency in policies and procedures and late cancellations of procedures. Other issues arising include follow up appointments being missed/not occurring where patients are unsure of whose responsibility it is for booking appointments in Outpatients. Patients, families and carers also shared that communications can be limited/disjointed, especially during staff changes to the rota, and that information is sometimes not always clearly communicated with GPs or other professionals, and feedback to patients is limited/late.

The Trusts' future priorities for 2017/18 are clear and concise; to reduce harm e.g. sepsis, safer surgery and falls and focus on no avoidable deaths, to focus on safe discharge, learning from incidents, to improve outcomes "care in the right place, first time, every time", and to focus on patients and their experiences 'no decision about me, without me'.

A Falls Nurse is now in post (from April 2017), which can help to direct activity and preventative work around falls. Falls prevention is a key area for most trusts and the local authority, use of schemes like coloured socks (yellow for those who are deemed high risk, red for those with no footwear) will hopefully help staff at a glance to understand patient needs while on wards. Use of falls equipment, falls blankets and greater monitoring of those at risk could help address needs as well. Learning from other good practice within acute trusts could also help inform this work e.g. falls prevention work with infrared technology sited in bathrooms/toilets at The Walton Centre, awareness raising poster campaigns on keeping patients mobile ("Let's Keep Moving") at James Paget University Trust.

The QA states that there is an aim to "increase the number of patients who, after being admitted via a non-elective route, will be discharged to their usual place of residence within 7 days of admission". Though this will lead to less extended stays in hospital and the ability for patients to recuperate at home, there is a need for supportive services e.g. home adaptations, sensory services, to have a 7 day turnaround to enable safe discharge of these patients. There will also be a need for an effective MDT approach to ensure staff, families, carers and support services are able to work together within those 7 days.

The Trust states that there is a comprehensive need to improve responsiveness to complaints, experiences and concerns. Our advocacy support work reflects this, highlighting that contact/follow up from the Trust PALS/Patient Engagement Team is limited and that resolution and complaints handling can be a drawn-out affair. We welcome the Trust's work on new policies and processes to be put in place in the forthcoming year to address this. The Trust aims to reduce complaints which are open for 6 months plus, and has set a key aspiration to reduce this to 0 by the end of the financial year. The Trust also aims to recuce those complaints with a duration between 30 days to 6 months. In terms of complaints handling/feedback, the Trust could also be more proactive at responding to feedback on the online Healthwatch Warrington Feedback Centre, which acts as a rich source of qualitative feedback from those using WHFT.

Increasing the number of staff trained in complaints handling will again help to address complaints more readily, and the Trust aims to decrease PHSO referrals. Parts of the narrative

of complaints handling/patient experience in the QA feel centrally driven - the commentary in the document at times feels NHS England-led rather than Trust driven, which lends a certain distance to those areas. These parts of the QA could be enhanced by leading with the Trust's wishes and aims to address patient needs within complaints/feedback and using NHS England's framework/evidence to underpin this.

The Patient Experience Strategy aims to focus on 4 key areas; listen, learn, lead change and put patients first. Though these aims are statistically measurable, there could be benefits to be gained by gathering and learning from qualitative data. Other Trust approaches can be built on for this benefit e.g. Clatterbridge Cancer Centre.

The Trust shows a willingness to learn and change, by developing areas in need of focus e.g. the Sepsis Six, Mortality Review process etc. The Sepsis Six pathway is particularly transferrable throughout the hospital and will ensure a clear and consistent approach to identifying and monitoring sepsis/early diagnosis. Screening in the Emergency Department has increased significantly - from 32% in Q1 to 81% in Q3. Inpatients sepsis screening has also increased significantly, from 9% to 76% in Q3. Though there is evidence of a learning culture throughout the report, there could be more done within the Trust to be patient-led in its learning and developing of services, rather than reacting to areas of concern.

As a Healthwatch, we are aware that cultivating positive staff attitudes and taking on board their ideas are essential ingredients for good care outcomes. This QA document unfortunately evidences rather low levels of staff satisfaction at the Trust. With 38% of staff returning feedback, the evidence gathered on is statistically relevant. Staff who would recommend the provider to friends or family needing care is rated at 57% (in 2016), while the average rating in an acute Trust is 70%. Again, there could be learning gleaned from those organisations with high staff satisfaction rates e.g. The Walton Centre, St Rocco's Hospice, Clatterbridge Cancer Centre.

In our experience, the presence and support offered by WIRED Carer's Centre and Halton Carer's Centre is a significant support for patients, families and carers accessing the Trust, and should be praised. With John's Campaign to be further established and built upon, even more support will be available to carers. Likewise, provision of a carer's card to help support unrestricted visiting and parking is commendable.

Dementia E-training available throughout WHHFT offers to build staff awareness to describe, identify, challenge, discuss and utilise best practice in Dementia care - with a greater than 85% uptake this approach has the potential for staff to really lead the way in Dementia awareness and treatment. Alongside this, work around Always Events will hopefully lead to further equity of care and a more positive experience for patients, families and carers throughout the Trust.

Regrettably the CQC National Inpatient Survey (2015/16) data within the QA outlines poor experiences for patients in a variety of areas, including; waiting time, enough staff on duty, staff working together, contradictory info, pain control, ability to talk about concerns/issues, delays for discharge, medications and support, medications explanations. Again, this is a reflection of the feedback received by Healthwatch Warrington.

Though improvement and quality indicators have previously been measured statistically will be measured the same way in the future, there is a limitation of qualitative data to

accompany this. Overall, the QA is medically driven which though quantifiab.e does not lend itse.f to being easily read or interpreted intc identifiable experiences for readers/members of the public.

In the year ahead, we look forward to supporting WHHFT's engagement strategy by encouraging wider public participation in events and sub groups and strengthening the voice of patients in other ways.

We look forward to hearing from you and being involved in future developments.

Kind regards,

Lydia Thompson
Chief Executive Officer
Healthwatch Warrington

4.5 Statement from Warrington Health and Well Being Overview and Scrutiny Committee

THIS WAS REQUESTED BUT NOT RECEIVED

4.6 Statement from the Halton Healthwatch

healthwatch Halton

Commentary on Warrington & Halton Hospitals NHS FT
Quality Account 2016-17

We welcome the opportunity to provide this commentary on Warrington & Halton Hospitals NHS Foundation Trust Quality Account for 2016/17.

The Trust is to be congratulated on what is very comprehensive report which gives a good overview of the work carried out by the Trust to improve the quality of its services.

In responding to this year's Quality Account we have tried to answer the following questions:

1. Does the draft Quality Account reflect people's real experiences as told to local Healthwatch by service users and their families and carers over the past year?
2. From what people have told Healthwatch Halton, is there evidence that any of the basic things are not being done well by the provider?
3. Is it clear from the draft Quality Account that there is a learning culture within the Trust that allows people's real experiences to be captured and used to enable the provider to get better at what it does year on year?
4. Are the priorities for improvement as set out in the draft Quality Account challenging enough to drive improvement and it is clear how improvement has been measured in the past and how it will be measured in the future?

From the comments we are receiving on the Trust, and the experiences we are hearing about while we are out in the community, we would state that overall the Quality Account report reflects people's real experiences of using the service.

It appears that the Trust gets the basics right the majority of the time. Local people are telling us that they value the services provided by the Trust, with Halton Hospital coming in for particular praise.

It is clear though, as shown from the deterioration by 5% or more on some of the results from the National Inpatient Survey, that there is a need for some improvements around the care, treatment and discharge of patients. We do worry that as the Trust gets busier patient care may suffer.

Also, while understanding that it is recognised nationally as a challenging target, we are disappointed to see that the 95% A&E 4 hour access target is consistently being missed.

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We note that Trust plan to focus on these issues in the next year and we look forward to seeing improvements. We would welcome the Trust working with both Healthwatch Halton and Healthwatch Warrington on ways to improve patient care and particularly for improvements around patient discharge.

We are pleased to note the improvements in infection control with Clostridium difficile cases dropping to 19 compared to 33 for the previous year. We note the actions put in place to reduce MRSA, MSSA and C Diff over the coming year and we look forward to further improvements next year.

We also welcome the reduction in falls and the re-establishment of the Falls Steering Group. Initiatives such as the trial of coloured socks for patients at higher risk of falls and SWARM are to be applauded.

The Trust's focus on reducing the number of deaths from Sepsis is a positive move. We hope that the funding of two sepsis nurses and the introduction of a revised sepsis pathway will help the Trust meet its target of reducing the number of deaths from sepsis.

The achievements of Warrington Hospital's Maternity Unit, named best in the Country by the Royal College of Midwives, are to be congratulated and highlight how an organisation can learn, improve and raise the level of service provided to patients.

The three improvement priorities for 2017-18 of Patient Safety, Clinical Effectiveness and Patient Experience are welcomed. It is difficult for us to say whether all the priorities are challenging enough for the Trust but we believe they all offer the opportunity to drive improvement. We would suggest that the Trust involve both local Healthwatch in its work on improving patient experience during the next year.

From the information supplied in the Quality Account, and our close work with the Trust over the past 4 years, we can say that it is clear how improvements have been measured in the past and how they will be measured for these priorities.

During the next 12 months we will continue to offer challenge to the Trust on key priorities and work with it to help improve the experience of patients who use both local hospitals.

Kind regards

Brian Miller & Dave Wilson
Healthwatch Halton Quality Account Leads

15th May 2017

4.7 Statement from the Trust's Council of Governors 2016/2017

The Council of Governors welcomes the opportunity to comment on the Trust's Annual Quality Account for 2016/17.

The Quality Report is very detailed and thorough and assists the Governors in holding the Non-Executive Directors to account for the performance of the Board of Directors.

As Governors one of our prime roles, is too particularly to focus on quality. As part of the Council's governance structure it meets regularly at its Governor Quality in Care Group. At the Governor Quality in Care Group, the Governors receive the latest performance information and have the chance to analyse it and raise questions.

The formal public governor's council meeting programme is a small part of the governors' work in the trust. The Governors have a number of committees which they lead on, which allows them to bring information and views to the main council meeting. Other agenda items include updates from those committees and other topics of interest.

The Governors strongly support the emphasis on patient safety, patient experience and clinical effectiveness documented throughout the Quality Report. Patients, their relatives, carers and the hospital's key stakeholders have all identified these as three areas of paramount importance.

For the coming year, the Governors agree with the priorities established. The Patient Safety Priority relating to Safer Surgery will help the Trust to achieve its objective in relation to Never Events which is to have zero Never Events within the year and to improve patient safety. The Patient Experience Strategy will provide a wider range of better quality information from which to drive improvement and the Governors look forward to receiving the quality dashboards that will be designed in line with the National Patient Survey results and based on 'What Matters Most' to our patients and carers. There is further work to do in the complaints area, and Governors are pleased to note that there is a specific Patient Experience Priority dedicated to improving the Trust's responsiveness to complaints and the overall experience for patients, relatives, public to raise concerns. Finally, Governors see the improvement of care for Mental Health patients in A&E as an important initiative that the Trust is establishing to improve the experience for those patients, as well as strengthening working relationships with our Community and Mental Health partners.

Governors find the format and section headings helpful. The Quality Report contains considerable detail commensurate with the complex and diverse range of services provided by an Acute Hospital Trust. The Governors believe the Quality Report to be accurate. The graphs and accompanying explanations help the public and members to understand clearly the progress made in many areas of patient safety and patient care.

The Governors are aware that the 2017/18 Quality Report is to be amended by the Chief Nurse to provide data that is more meaningful, understandable and clearer to all, the report will show indicating trends, and comparisons with the previous year statistics.

Governors encourage all Trust members and others who are interested in our hospitals and their performance to read the Quality Report.

Annex 2: Statement of directors' responsibilities in respect of the Quality Report

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

NHS Improvement 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:

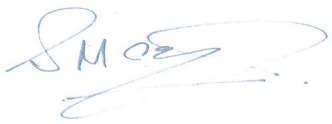
- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2016/2017 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2016 to date of signing this statement
    - Papers relating to Quality reported to the Board over the period April 2016 to date of signing this statement
    - Feedback from the Commissioners, Warrington Clinical Commissioning Group dated 22nd May 2017 and Halton Clinical Commissioning Group dated 12th May 2017
    - Feedback from Governors dated 27th April 2017
    - Feedback from local Healthwatch organisations, Healthwatch Halton dated 15th May 2017 and Healthwatch Warrington dated 17th May 2017
    - Feedback from Overview and Scrutiny Committee – statement requested but not received
    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 2nd May 2017
    - The 2016 national inpatient survey published March 2017 but under embargo until 8th June 2017
    - The 2016 national staff survey published February 2017
    - The Head of Internal Audit's annual opinion over the Trust's control environment dated 24th April 2017
    - CQC inspection report dated 10th July 2015

- 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 NHS Improvement's annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the Board



25 May 2017 **Date**…… Steve McGuirk **Chairman**

25 May 2017 **Date**…… Mel Pickup **Chief Executive**

[NB: sign and date in any colour ink except black]

Independent Auditor's Limited Assurance Report to the Council of Governors of Warrington and Halton Hospitals NHS Foundation Trust on the Annual Quality Report.

Appendix

Glossary

Appraisal	method by which the job performance of an employee is evaluated
Care quality commission (CQC)	Independent regulator of all health and social care services in England. They inspect these services to make sure that care provided by them meets national standards of quality and safety.
Clinical audit	Is a process that has been defined as "a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change.
Clinical commissioning group (CCCG)	Clinical commissioning groups (CCGs) are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England.
Clostridium difficile (C diff)	A Clostridium difficile infection (CDI) is a type of bacterial infection that can affect the digestive system. It most commonly affects people who are staying in hospital. (CMCLRN) Cheshire and Merseyside Comprehensive Local Research Network
Commissioning for Quality and Innovation (CQUIN)	This is a system introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of care.
Friends and Family test (FFT)	Since April 2013, the following FFT question has been asked in all NHS Inpatient and A&E departments across England and, from October 2013, all providers of NHS funded maternity services have also been asking women the same question at different points throughout their care : "How likely are you to recommend our [ward/A&E department/maternity service] to friends and family if they needed similar care or treatment?"
Governors	Governors form an integral part of the governance structure that exists in all NHS foundation trusts; they are the direct representatives of local community interests in foundation trusts
Healthwatch	Healthwatch is a body that enables the collective views of the people who use NHS and social care services to influence policy.
Healthcare evaluation data (HED)	Clinical benchmarking system to support clinical experts in more effective management of clinical performance.
Hospital episode statistics (HES)	Is a database containing information about patients treated at NHS providers in England.
Hospital Standardised Mortality Review (HSMR)	Is an indicator of healthcare quality that measures whether the death rate at a hospital is higher or lower than you would expect.
Information governance	Ensures necessary safeguards for, and appropriate use of, patient and personal information.

Mandatory training	The Organisation has an obligation to meet its statutory and mandatory requirements to comply with requirements of external bodies e.g. Health & Safety Executive (HSE), training is provided to ensure that staff are competent in statutory and mandatory
MRSA	Methicillin-resistant *Staphylococcus aureus* (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans.
MSSA	Methicillin-sensitive *Staphylococcus aureus* (MSSA) is a bacteraemia caused by Staphylococcus aureus which is a serious infection associated with high morbidity and mortality and often results in metastatic infections such as infective endocarditis, which have a negative impact on patient outcomes
National confidential enquiries (NCEPOD)	The purpose of NCEPOD is to assist in maintaining and improving standards of medical and surgical care for the benefit of the public by: reviewing the management of patients; undertaking confidential surveys and research; by maintaining and improving the quality of patient care; and by publishing and generally making available the results of such activities.
NHS Improvement	NHS Improvement is responsible for overseeing NHS foundation trusts, NHS trusts and independent providers, helping them give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable.
National inpatient survey	Collects feedback on the experiences of over 64,500 people who were admitted to an NHS hospital in 2016.
National institute for health and clinical excellence (NICE)	Is responsible for developing a series of national clinical guidelines to secure consistent, high quality, evidence based care for patients using the National Health Service.
National institute of health research (NIHR)	Organisation supporting the NHS.
National patient safety agency (NPSA)	Lead and contributes to improved, safe patient care by informing, supporting and influencing organisations and people working in the health sector.
National reporting and learning system (NRLS)	Is a central database of patient safety incident reports. Since the NRLS was set up in 2003, over four million incident reports have been submitted. All information submitted is analysed to identify hazards, risks and opportunities to continuously improve the safety of patient care.
Never Events	Are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
NHS outcomes framework	Reflects the vision set out in the White Paper and contains a number of indicators selected to provide a balanced coverage of NHS activity. To act as a catalyst for driving up quality throughout the NHS by encouraging a change in culture and behaviour.
Open and Honest	North of England Trusts produces and publishes monthly reports on key areas of healthcare quality.

Palliative care	Focuses on the relief of pain and other symptoms and problems experienced in serious illness. The goal of palliative care is to improve quality of life, by increasing comfort, promoting dignity and providing a support system to the person who is ill and those close to them.
Patient Reported Outcome Measures (PROMs)	Provide a means of gaining an insight into the way patients perceive their health and the impact that treatments or adjustments to lifestyle have on their quality of life.
Payment by results (PBR)	Provide a transparent, rules-based system for paying trusts. It will reward efficiency, support patient choice and diversity and encourage activity for sustainable waiting time reductions. Payment will be linked to activity and adjusted for case mix.
Safety thermometer	Is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care.
Summary hospital-level indicator (SHMI)	reports mortality at trust level across the NHS in England using standard and transparent methodology.
Urinary tract infection (UTI)	is an infection that affects part of the urinary tract
Venous thromboembolism (VTE)	A venous thrombosis or phlebothrombosis is a blood clot (thrombus) that forms within a vein. A classical venous thrombosis is deep vein thrombosis (DVT), which can break off (embolize), and become a life-threatening pulmonary embolism (PE).