We are WHH & We are PROUD to make a difference

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

QUALITY ASSURANCE COMMITTE

AGENDA REFERENCE:	**QAC/20/10/191**			
SUBJECT:	**Quality Account 2019/20 Draft**			
DATE OF MEETING:	6 October 2020			
AUTHOR(S):	Layla Alani, Deputy Director Governance			
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse + Deputy Chief Executive			
LINK TO STRATEGIC OBJECTIVE:	SO1: We will... Always put our patients first through high quality, safe care and an excellent patient experience.			
EXECUTIVE SUMMARY	All NHS providers since June 2010 have had a legal duty to publish an annual Quality Report (Account), and are required to distribute the *draft* version for a formal consultation and response to various groups. This draft document has been disseminated externally to key stakeholders as part of the consultation.			
PURPOSE: (please select as appropriate)	~~Information~~	**Approval**	~~To note~~	~~Decision~~
RECOMMENDATIONS:	The Quality Assurance Committee are asked to note and approve the Quality Account ahead of parliamentary submission in December 2020			
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
NEXT STEPS: ***State whether this report needs to be referred to at another meeting or requires additional monitoring***	**None**			
FREEDOM OF INFORMATION STATUS (FOIA):	**Release in Full**			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

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NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Quality Account

2019/20

Contents

Quality Account

Quality is our number one priority.

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

1. Statement of Quality from the Chief Executive, Simon Constable

Warrington and Halton Teaching Hospitals NHS Foundation Trust is dedicated to the provision of high quality care and clinical excellence. Recognising that our patients and staff deserve nothing less than OUTSTANDING, we have embarked on an organisation- wide journey called 'Moving to Outstanding'.

It is my pleasure to present our Quality Account for 2019/20. The Quality Account reviews the progress that we have made this year and outlines our priorities for the year ahead. It is an opportunity to celebrate our achievements and improvements that have impacted upon the care of our patients and their families. The collaborative approach to the delivery of our services has resulted in the Trust achieving a 'good' CQC rating. We will continue to build upon this work in our move to 'outstanding'.

Throughout 2019/20 every member of staff has contributed to the progress that is reported in this Quality Account and I could not be more proud. We have continued to see and treat an increasing number of patients, with more complex needs, on both a planned and emergency basis.

Looking ahead to 2020/21, we will continue to drive the Trust's quality strategy priorities, in the era of COVID-19. 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: Gram Negative Bloodstream Infections (GNBI), Serious Harm Falls, Deteriorating Patient, Implementation of the Medical Examiner role, Getting It Right First Time (GIRFT) and NICE guidance, CBU Governance, End of Life Serious Illness Programme, Trust Learning Disability Strategy, Reducing Deconditioning and PJ Paralysis.

The priorities have been chosen based upon national and local drivers and our internal governance intelligence, identifying areas for improvement. Emphasis remains upon working across organisational boundaries in partnership with others, to ensure that we provide the efficient and safe patient pathways to optimise health outcomes and experience for our patients.

In conclusion, this Quality Report evidences that, whilst we have made significant progress in improving the care and services that we deliver to our patients, we are committed through our

priorities and quality measures for 2020/21 to continue these improvements and provide the highest quality of care to our local communities.

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

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

Simon Constable

Chief Executive

May 2020

1.1 Introduction from the Executive Medical Director, Alex Crowe and Chief Nurse, Kimberley Salmon-Jamieson

In 2019/20 the Quality Strategy has been embedded within the Trust; forming an integral part of our Quality, People and Sustainability Framework (QPS). The Quality Strategy demonstrates our commitment to improving the quality of care for our patients and describes how we will make this a reality. We believe that supporting our staff and equipping them with the right, skills, training, is fundamental in achieving our vision to deliver the highest quality of patient care, every day.

It is important to recognise that we have made many improvements to the safety and quality of patient care and we are committed to ensuring that we continuously improve, to ensure that we are providing the best care that we can to our patients and their families.

It is with pride that this year we were awarded a 'good' CQC rating. This was achieved through collaborative working and the constant dedication of our staff who continue to ensure that patients are central in all that we do. The Trust is now on a journey to achieve 'Outstanding' for which there are clear action plans in place.

Our aim is to ensure that all staff who work in our hospitals strive for excellence in all that they do and believe that the focus of the organisation is on providing safe care, which is responsive, caring and effective in terms of providing good outcomes for our patients.

The Quality Academy supports the implementation of Quality initiatives throughout the Trust. In June 2019 the Trust held it first Quality Academy Summit. The aim of the summit was to bring the latest innovation, best practice, improvement and research under one roof for the day. We were fortunate enough to have the Innovation Agency co-host the event with us, and we invited the best speakers in these areas and provided staff with opportunity to try the latest tech and innovations that relate to the five themes this year. The themes for the year were Frailty, integrated care, Diabetes, Virtual Clinics with overarching theme being the adoption of innovation. The event was a unique opportunity to see the art of the possible and deliver care in different ways which still provide the best or better outcomes for our patients.

We look forward to continuing working with staff to support the implementation of this strategy. Together we will report measurable success in our Annual Quality Account and commit to celebrating our achievements year on year.

Alex Crowe
Executive Medical Director
May 2020

Kimberley Salmon-Jamieson
Chief Nurse
May 2020

2. Improvement Priorities & Statement of Assurance from Board

Warrington and Halton Teaching 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 clinical income budget of £234 million, 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 Quality, People and Sustainability Framework (QPS); working to achieve nationally and locally set standards to ensure that patients receive the care they need when they need it. 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:

- **Quality - Patient Experience** - By focussing on patient experience we want to place the quality of patient experience at the heart of all we do, where "seeing the person in the patient" is the norm.
- **People - Employee Wellbeing & Engagement** - Create the conditions to promote wellbeing and enable an engaged workforce to improve patient and staff experience.
- **Sustainability - Work with other acute care providers** to ensure that those services which need to be provided in an acute environment are the best that they can be and are clinically and financially sustainable.

2.1 Organisational Structure

Our organisational structure 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 the best for our patients and continuous improvement, transformation and innovation. The structure was developed collaboratively and facilitates clinical specialities to within a Clinical Business Unit (CBU) model. There are six Clinical Business Units within the Trust, who report into the Executive Directors. The Clinical Business Units are supported by 'Clinical Support Services' as well as 'Corporate Support Services'.

The Trust's organisational structure embraces the concept of true leadership synergy between the 'triumvirates' 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 have been created through innovation and collaboration with partners, the Trust aims to improve access and quality of care, whilst being cost efficient.

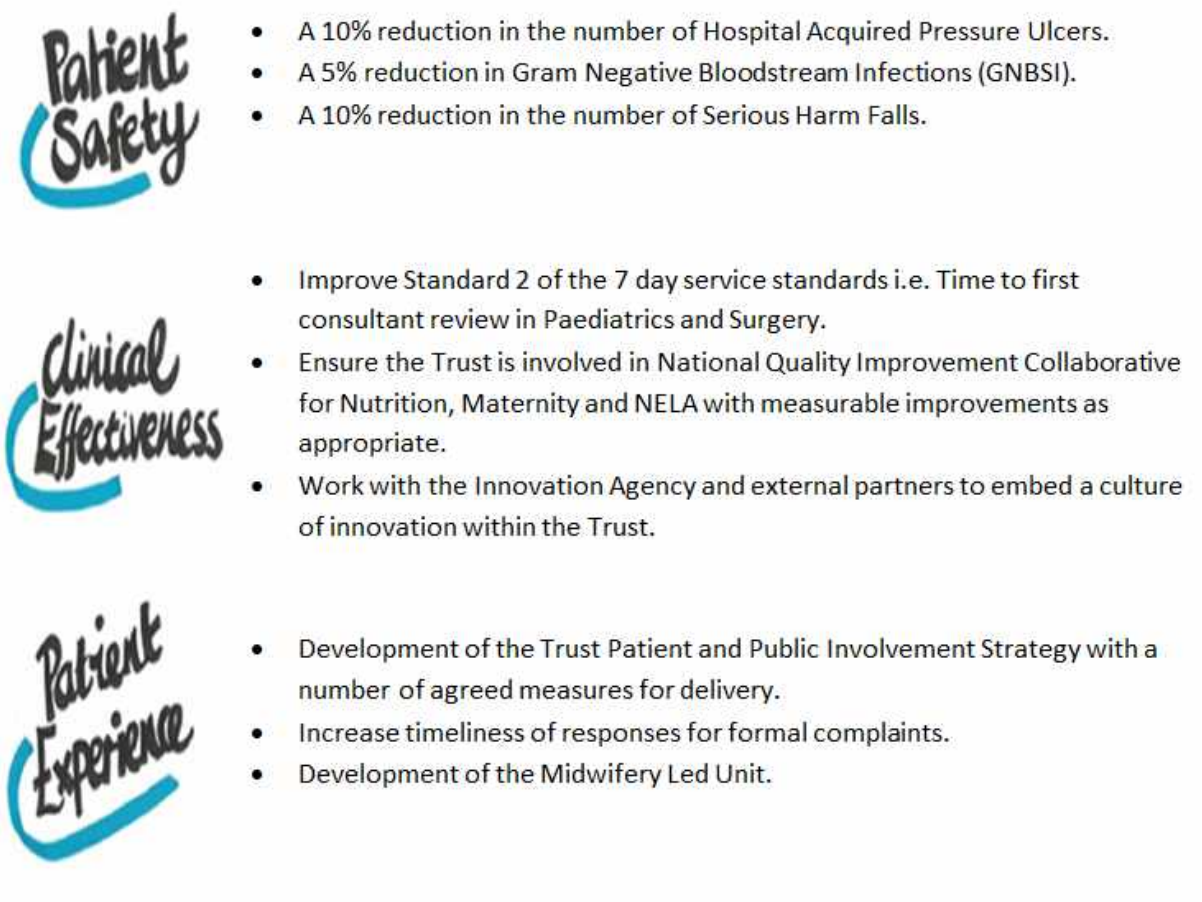
2.2 Priorities for improvement - Improvement Priorities for 2019/20 update

The following improvement priorities and quality indicators were identified following a review of the domains of quality. Our commitment to achieving them was initially reported in the 2018/19 Quality Report.

The progress of each priority is reported on a quarterly basis to the Trust's Patient Safety and Clinical Effectiveness Sub Committee which reports into the Quality Assurance Committee. Where possible we include performance indicators to measure and benchmark our progress. This is reported on a monthly basis, via the Quality Dashboard to the Board of Directors.

The Trust is committed to embracing improvement across a wide range of quality issues to achieve excellence in all areas of care. The 3 quality priorities; Patient Safety, Clinical Effectiveness and Patient Experience are all supported by a separate group of indicators which are detailed below;

The following section includes a report on progress with our improvement priorities for 2019/20 which were:



*NELA – National Emergency Laparotomy Audit

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

- **Pressure Ulcers - A 10% reduction in the number of Hospital Acquired Pressure Ulcers.**

Pressure Ulcers - Background: There are adverse health outcomes associated with pressure ulcers. Pressure ulcers affect a patient's quality of life, morbidity, and mortality. Once a pressure ulcer develops, complications such as infection with the potential for sepsis may occur. This priority links to our Quality Strategy.

How progress will be monitored, measured and reported:
Tissue Viability Meeting monthly.

Patient Safety & Clinical Effectiveness Sub-committee monthly.

A quarterly Quality Report to the Quality Assurance Committee will track milestones for the Quality Account priorities.

Pressure Ulcers – Implementation and Performance: In 2018/19 there were 57 hospital acquired pressure ulcers; The Trust had an ambition to achieve less than 51 at the end of the financial year 2019/20. There have been 65 hospital acquired pressure ulcers year to date. Following recent RCA investigations, it was identified that further training was required on the use of anti-embolism stockings and Parafricta (anti-friction) bootees; this training is underway. An action plan has been produced to address the areas where compliance was low and this will be re-audited in July 2020.

The tables below are extracts from the Trust Integrated Performance Report;

Table 1 shows Category 2 Pressure Ulcers in 2019/20.

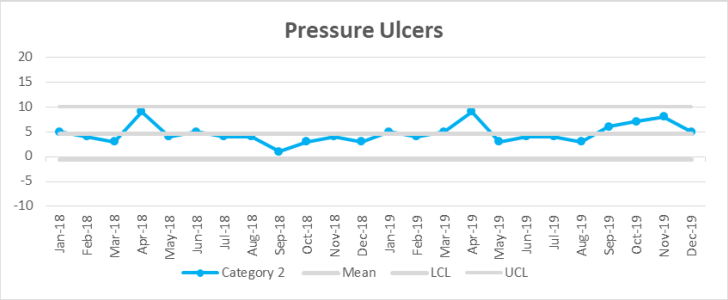


Table 2 shows Category 3 and 4 Pressure Ulcers in 2019/20.

- **Gram Negative Bloodstream Infections - A 5% reduction in Gram Negative Bloodstream Infections (GNBSI)**

Gram Negative Bloodstream Infections – Background: There is a national ambition to reduce healthcare associated Gram-negative blood stream infections (healthcare associated GNBSIs) by 50% by March 2021. This priority links in with our Quality Strategy to develop and enhance patient safety.

How progress will be monitored, measured and reported:
Infection Prevention and Control Sub Committee bi-monthly.

Patient Safety & Clinical Effectiveness Sub-committee monthly.

A quarterly Quality Report to the Quality Assurance Committee will track milestones for the Quality Account priorities.

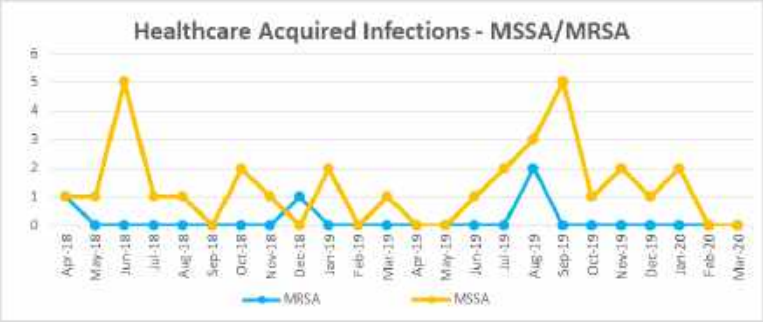
Gram Negative Bloodstream Infections - Implementation and Performance: An overall summary of GNBSI and Healthcare Acquired Infections is as follows;

2 cases - MRSA (Methicillin-resistant staphylococcus aureus) bacteraemia
18 cases – MSSA (Methicillin-sensitive Staphylococcus aureus) bacteraemia*
49 cases (15 unavoidable, 14 avoidable & 20 cases awaiting review by the CCG review panel to determine cause)) - C. difficile cases include community onset/healthcare associated and hospital onset cases
51 cases - E. coli bacteraemia
15 cases - Klebsiella bacteraemia*
4 cases - P. aeruginosa bacteraemia*

*No targets set nationally for MSSA; Klebsiella, P. aeruginosa bacteraemia cases.

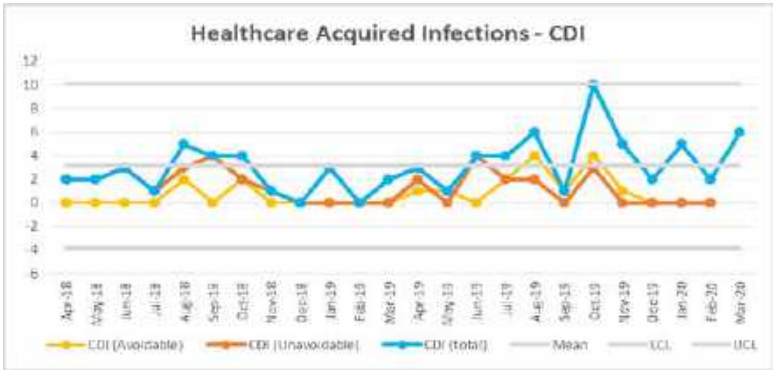
The tables below are extracts from the Trust Integrated Performance Report.

Table 1 shows the results for MSSA bacteraemia and MRSA bacteraemia cases in 2019/20;



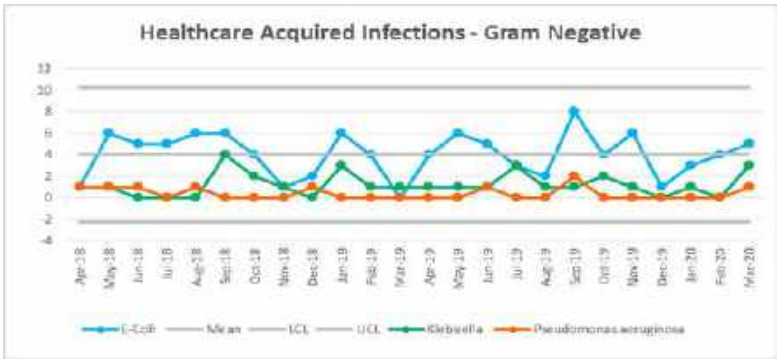
Investigations have been conducted into the two MRSA bacteraemia cases; 1 was considered unavoidable.

Table 2 shows the results for C-Difficile cases in 2019/20;



At the end of year the Trust was over trajectory for C. difficile by 5 cases. There are 20 cases awaiting final review with our Clinical Commissioning Group partners. The C.difficile reviews were delayed due to COVID-19.

Table 3 shows the results for Healthcare Acquired infections in 2019/20;



E. coli bacteraemia is over trajectory by 5 cases.

Improving performance in relation to Healthcare Acquired Infections remains a key priority for the Trust.

- **Serious Harm Falls - A 10% reduction in the overall number of Serious Harm Falls**

Serious Harm Falls – Background: The human cost of falling in hospital can be devastating and may lead to pain, injury, loss of confidence, loss of independence and increased morbidity and mortality. Falling also has an impact on quality of life.This priority links in with our Quality Strategy as we committed to achieve a 20% reduction in Serious Harm Falls by 2020.

How progress will be monitored, measured and reported:
Falls Steering group monthly.

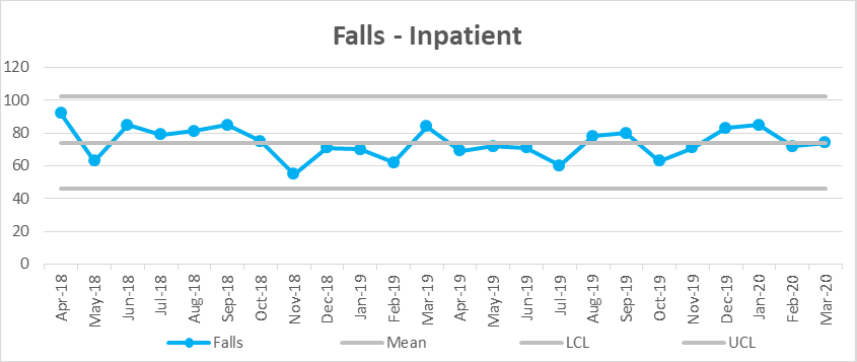
Patient Safety & Clinical Effectiveness Sub-committee monthly.

A quarterly Quality Report to the Quality Assurance Committee will track milestones for the Quality Account priorities.

Serious Harm Falls - Implementation and Performance: An overall summary of falls in 2019/20 is as follows;

- In quarter 1, 2019/20 we re-launched the updated multifactorial documentation and commenced QI Breakthrough series collaborative launch.
- Multifactorial audit pro-forma was completed and an audit conducted in November 2019.
- Ward based Patient Safety Champions identified for all areas with role description completed. The first meeting was held in October 2019.
- Quality improvement programme continued with collaborative learning session held in September 2019.
- Updated patient safety leaflet developed in collaboration with external partners.

Table 1 below is an extract from the Trust Integrated Performance Report and shows inpatient falls for 2019/20. A reduction of 11.9% was noted for inpatient falls for 19/20 compared with the same reporting period for 18/19.



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

- **Improve Standard 2 of the 7 day service standards i.e. Time to first consultant review in Paediatrics and Surgery**

Improve Standard 2 of the 7 day service standards - Background: A recent 7 day services audit has identified a need to deliver an improvement in Standard 2 of the 7 day service which is '*time to first consultant review in Paediatrics and Surgery*'.

How progress will be monitored, measured and reported:
Externally with the CCGs through the Clinical Quality Focus Group quarterly.

Patient Safety & Clinical Effectiveness Sub-committee monthly.

A quarterly Quality Report to the Quality Assurance Committee will track milestones for the Quality Account priorities.

Improve Standard 2 of the 7 day service standards - Implementation and Performance: The 7DS audit conducted in Quarter 1 of 2019 has shown an overall Trust compliance of 82%, with an improvement in the following three areas:

- Acute Medicine
- General Surgery
- Paediatrics

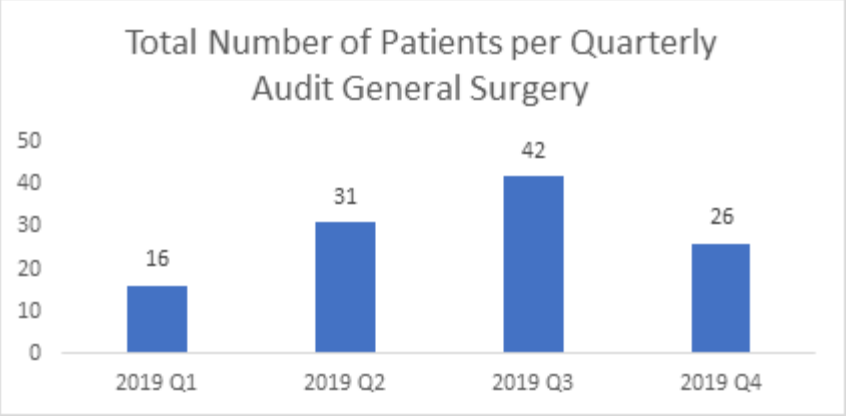
The Trust is performing quarterly audit cycles for Clinical Standard 2 to ensure it meets the over 90% threshold by March 2020.

The audit methodology was adjusted from Quarter 2 onwards for Paediatrics and General Surgery to ensure a more accurate evaluation of their performance against Clinical Standard 2.

2.1 Standard 2: Time to Consultant Review – General Surgery

- 26 applicable admissions
- 24 admissions were seen within 14 hours
- Median of 4.5 hours
- Mean of 4.7 hours
- The shortest length of time to review was upon decision to admit (0 hours) and the longest length of time was 16 hours

Table 1 below provides the breakdown of the number of audits conducted each quarter. Following the implementation of the "Consultant of the Week" in January 2019, General Surgery has achieved a compliance of 92%, during quarter 4 audit.



Data suggests that there was no real variances in compliance, suggesting that the improvements noted utilising the Consultant of the Week model were reliable. To improve compliance the Specialty reviewed patients admitted with the diagnosis of appendicitis, as in previous audits, a number of the cohort were transferred to theatre by a Surgical Registrar and later reviewed by a Consultant, after the 14 hour window. In response the Specialty implemented a Consultant review of patients within the specified 14 hours using a senior staffing rota. The auditor noted that the Specialty's work to reinforce the recording of the time and date of senior review within the patient notes has been beneficial. This was evidenced amongst a high percentage of the patients reviewed as part of the audit and has assisted with overall compliance against standard 2 of the 7 day service standard.

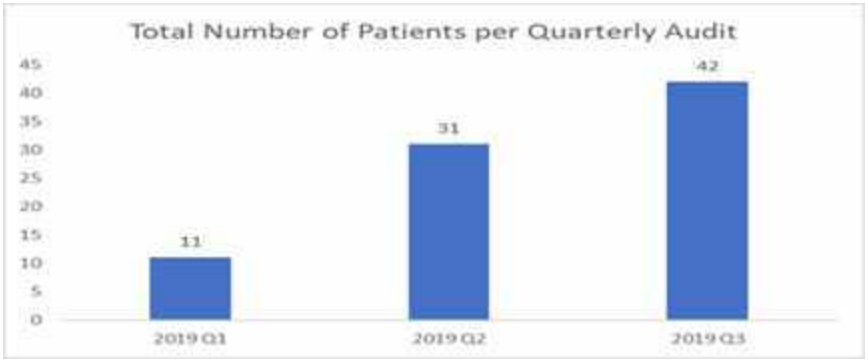
2.2 Standard 2: Time to Consultant Review – Paediatrics:

- 42 applicable
- 38 admissions were seen within 14 hours
- Median of 6 hours
- Mean of 7 hours
- The shortest length of time to review was upon decision to admit (0 hours) and the longest length of time was 37 hours

Review within 14 hours for Paediatric patients is recognised as a national challenge. However, Paediatrics have achieved compliance with Clinical Standard 2 by quarter 3 and resources were then focused on General Surgery as detailed. Paediatrics achieved full compliance of 90% by the end of quarter 3 by completing the following work;

- Locum Consultant presence in addition to Consultant of the week supporting flow and timely reviews
- Issues with flow and lack of beds meant late night reviews to create capacity
- Raised awareness of the 14hrs review among the team
- Reduced activity in Neonatal unit meant that there was a Consultant available on Paediatric wards when resident to review admissions

Table 1 below provides the breakdown of the number of audits conducted each quarter.



- **Ensure the Trust is involved in National Quality Improvement Collaboratives for Nutrition, Maternity and NELA with measurable improvements as appropriate**

National Quality Improvement Collaboratives – Background: NHSI and the Innovation agency are hosting a number of improvement collaboratives and the Trust is keen to participate.

How progress will be monitored, measured and reported:
Quality Academy Board quarterly.

Patient Safety & Clinical Effectiveness Sub-committee monthly.

A quarterly Quality Report to the Quality Assurance Committee will track milestones for the Quality Account priorities.

National Quality Improvement Collaboratives - Implementation and Performance:

Nutrition - Malnutrition affects over 3 million people in the UK with 25-34% of patients admitted to hospital identified as being at risk. Malnutrition costs the NHS £19.6 billion annually and results in complications such as wound infections, chest infections, pressure ulcers; increased length of hospital stay; increased readmission and increased mortality. The Malnutrition Universal Screening Tool (MUST) is an approved standardised tool used to detect malnutrition risk. (BAPEN, 2018).

Change in ward practice - Implementation of a designated staff nurse to identify new admissions to the wards to confirm MUST risk assessments are complete daily. Learning identified challenges in non-compliance for completion of MUST risk assessments on admission. Barriers identified included; Time, staffing levels, equipment availability, and difficulty gathering information to complete MUST risk assessment. Areas for improvement also include the weekly re-screening of MUST and appropriate dietetic referral if MUST ≥2. Additional training and support has been applied in the form of Trust wide single point lessons on MUST, introduction of Nutrition Link Nurse training and ward based MUST training.

Maternity – Maternal and Neonatal health safety collaborative - The Maternal and Neonatal Health Safety Collaborative (MNHSC) was a three-year programme, launched in February 2017. The collaborative was led by the NHS Improvement Patient Safety team and covered all maternity and neonatal services across England.

The aim was to:

- Improve the safety and outcomes of maternal and neonatal care by reducing unwarranted variation and provide a high quality healthcare experience for all women, babies and families across maternity and neonatal care settings in England
- Contribute to the national ambition, set out in Better Births of reducing the rates of maternal and neonatal deaths, stillbirths, and brain injuries that occur during or soon after birth by 20% by 2020

The quality improvement driver to reduce admissions of 'term babies' to the neonatal unit (ATTAIN), with the primary driver of managing hypoglycaemia in the neonatal period formed part of quality improvement.

Wider projects which impacted upon the overall improvement strategy for maternity and neonatal safety collaborative were implemented alongside the main project. The MatNeoSIP programme to reduce term admissions to the neonatal unit progressed well with the introduction of the Warm Care Bundle to reduce hypothermia and hypoglycaemia in newborns. A poster was submitted to the National Learning Event of the Maternal and Neonatal Health Safety Collaborative summarising the achievements of this project. The team at Warrington were invited to deliver a presentation at the event.

NELA – National Emergency Laparotomy Audit - NELA is an ongoing national audit, now into its 6th year. WHH have been part of this audit which aims to reduce the mortality of patients after undergoing emergency laparotomy and improve their care. Overall our mortality has improved and

is comparable to the national average. Into our 6th year, we continue to contribute to the data prospectively via an online NELA database. Compliance with the prospective data entry is closely monitored by the Trust audit department and Dr Murthy Gulyam, Anaesthetic lead for NELA.

- **Work with the Innovation Agency and external partners to embed a culture of innovation within the Trust**

Embed a culture of innovation within the Trust – Background: Through working with the Innovation agency will improve health and care and generate economic growth. This is a key aspect of both the Quality and Quality Academy Strategies.

We will connect with regional networks of the NHS and academic organisations, local authorities, the third sector and industry - responding to the diverse needs of our patients and populations through partnership and collaboration.

Embed a culture of innovation within the Trust – How progress will be monitored, measured and reported:
Quality Academy Board quarterly.

Patient Safety & Clinical Effectiveness Sub-committee monthly.

A quarterly Quality Report to the Quality Assurance Committee will track milestones for the Quality Account priorities.

Embed a culture of innovation within the Trust - Implementation and Performance:

Quality Improvement (QI) Training

The Quality Improvement team developed a programme of monthly QI Practitioner training sessions which were implemented in April 2019. By March 2020, we had trained 102 staff at QI Practitioner level, equating to just over 25% of the Kaiser Permanente recommended dosing numbers for that level. The Kaiser Permanente dosing formula describes the numbers of staff that should have a certain level of quality improvement skills to build capability and capacity for improvement within an organisation. The Trust are working toward achieving 100% compliance and are on trajectory to achieve this by March 2021 in accordance with Kaiser Permanante recommendations. The team have trained 1,825 staff at Foundation QI level which provides staff with the foundation of quality improvement. This equates to <50% of staff and we are on target to achieve 100% by March 2021.

The Quality Academy has created a bespoke improvement training programme for the Trainee Workforce (Foundation Year 1 to Specialist Trainee 8). Foundation Year doctors were provided with a pick list of audits and improvement projects that relate to Trust priority audits and QI work, enabling them to contribute to the Trust quality improvement work. The training has been created following consultation with two Foundation Year 2 doctors and the Associate Medical Directors. The programme was delivered by the Quality Improvement Specialist and the Clinical Audit Manager.

Innovation

Diabetes PreOp

The Trust have been working with external partners to develop an online calculator which will improve outcomes for patients with diabetes prior to undergoing a surgical procedure. The project was led by two Anaesthetists and has been developed with the Diabetes team, Anaesthetic Clinical Lead for Innovation and external partners. Funding has been identified to develop this project further. The development and testing stage of this project will transform recovery for Diabetic patients after surgery.

Chatbot

The Trust has been working with another North West Trust to test a web product they use within hospitals. The web product is a chatbot which uses artificial intelligence to answer queries made by patients, families and carers. This will provide an answer queries more efficiently than contacting the Trust switchboard.

Innovation Agency Work

The Quality Academy is working in collaboration with the Innovation Agency's Cheshire & Merseyside liaison. There are several products that are of interest to Women's Health, ED, Theatres and Respiratory and the Quality Academy facilitates meetings with the specialties and the companies. A quarterly meeting has been arranged between the Innovation Agency, the Clinical Lead for Innovation, Quality Academy Manager and Trust Chief Operating Officer to monitor progress of these new products and assist with the operational implementation.

Priority 3 – Patient Experience *- 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*

- **Development of the Trust Patient and Public Involvement Strategy with a number of agreed measures for delivery**

Development of the Trust Patient and Public Involvement Strategy - Background: We wanted to make a formal commitment to creating opportunities for the participation and involvement of all groups (patients, families, carers, staff, communities, advocates, partners and other stakeholder groups). We want to ensure that ways and means to engage are accessible to all and that all voices are heard and views considered and incorporated wherever possible in service delivery, design and transformation through the championing of co-production.

Development of the Trust Patient and Public Involvement Strategy - How progress will be monitored, measured and reported:

A quarterly Quality Report to the Quality Assurance Committee will track milestones for the Quality Account priorities

Development of the Trust Patient and Public Involvement Strategy - Implementation and Performance:

Your Health Matters - The Trust participates in a local collaborative system named the 'Choose Well' winter campaign (Halton, Knowsley, St Helen's and Warrington). To support the campaign our commissioners have launched 'Help us to Help You' through digital platforms such as social media and Trust websites to promote the campaign to our local population. This joint campaigning has seen significant engagement particularly in December 2019. Further communications were supported by Press Release and global staff message signposting services for use by their friends and families. A similar effort was undertaken throughout October and November 2019 (now part of the Help Us to Help You campaigning) for staff, patients, visitors and members of public.

Governor Elections - The Foundation Trust held Public and Staff Governor elections between 12th September and 8th November 2019. Formal Foundation Trust Member communications took place in those constituencies available for election (3 year terms). Incumbent public Governors were all re-elected with no seats lost, however three constituencies remained vacant. Targeted PPP&I will take place to encourage potential governors to come forward in the next available election which is scheduled for November 2020.

Hospital Food - Considerable work is being undertaken in relation to hospital food, including education and awareness around menu choices, alternatives, dietary requirements and allergies. Key work in the quarter included:

- Test dining event with patients and volunteers on 14th October 2019, tea time Trust Conference Room. Patients were transferred from wards and enjoyed the experience – providing valuable feedback to the Catering team
- The Volunteering team utilised volunteers to support mealtimes (not feeding)
- Observation of mealtimes on A8 'sit and see' so that staff were available to support patients if needed
- Visit to the Kitchens at Warrington by Director of Community Engagement and Head of Patient Experience identified issues relating menu cards for patients i.e. bed numbers without names etc. This was escalated to Digital Services who will install Lorenzo and provide access for Catering managers and supervisors. This will ensure the right meal reaches the right patient at the right time.
- Launched Nutrition Strategy at Team Brief for staff on 19th and 20th December at both sites. Very well received education and awareness event demonstrating menu options and alternatives plus sampling of patient menus over the festive period. High attendance by staff.

Issues with Text Reminder Service - Due to patient feedback we updated the text reminder message to include the location of appointments and the relevant specialty, helping patients with multiple appointments to navigate.

Black History Month - raising Equality, Diversity & Inclusion in the Trust. The Black community uses this history month as an opportunity to share with the world its vast contributions: a time to demonstrate pride in its creativity, respect for its intellectual prowess and a celebration of its cultural identity. The event received praise from staff, patients and visitors.

Accessible Information Standards (AIS) Group - The independently-chaired AIS Group met on 4th November 2019 (next meeting 13 Jan 2020). Key items for the period included:

- Patient Letters – an excellent, highly attended engagement and involvement workshop 'Be the Change' event was held in November 2019 at Whitecross Centre comprising staff, volunteers, advocates and Governors. Feedback was provided with the aim of improving letters – including accessibility factors, directions and maps.
- Project 'Letters Be the Best', which aims to improve outpatient letters is monitored at the AIS group
- Informatics – highlighting alerts
- Reasonable Adjustments – patient story hearing impairment support to access care
- FFT – alternative formats and languages

Always Event: Thurs Jan 16th 2020 9am to 11am - Ophthalmology: 'Point of Care' team meeting- this included patient representation that co-produced the development of the Always Event.

Hearing Impairment: Wed Jan 22nd 2020 10am to 12:30 – We invited staff from the Deafness Resource Centre staff and hearing impaired service users to Warrington Hospital to discuss their experiences. Informal visits to local departments including ED were undertaken and we gained an insight into how they felt when they arrived at appointments where no interpreter was booked, or when an appointment was cancelled.

Implementing the Accessible Information Standard and our obligations:

- An action plan to launch a WHH-AIS Policy on The International Day of Persons with Disabilities on 3rd December 2020 has been developed
- Measures include: Commissioners – local CQUIN, Regulator (CQC Well Led), Legislative (EDS2, NHS Constitution), service user experience measures
- A baseline survey developed for all service leads and patient facing staff (not launched due to Covid-19) plan for Q1/Q2 2020-21
- WHH patient passport in development for all patients (in addition to LD, Veterans)
- Training module for all patient facing staff – plan to implement as part of essential training – paused due to Covid-19
- Alerts system – flagging of patients with additional needs (physical and mental impairment) on electronic patient record – supported by AIS fed into the task and finish group – progress to recommence in 2020-21

Maternity Voices:

An engagement and involvement session, attended by previous and current service users, was held 23rd January 2020 to inform the development of the new Birth Centre. The engagement and involvement session focused on the following, with input being provided to the Estates and Maternity team for incorporation into the new Birth Centre plan

- Communication
- Welcome and arrival on to current Labour ward
- Induction
- The comfort of families and partners staying overnight
- Physical environment current and planned
- What matters most to women in their birthing experience

What Matters to me? Emotional Touchpoints:

- ✓ Meet and greet on arrival and taken straight to room - don't want to sit in a waiting room
- ✓ Being allowed to get settled and not moved – establishment of 'base camp' is important initially to feel settled, unpacked and to feel calm and relaxed

- ✓ Feeling empowered to make decisions is important once they are in the room and settled – these choices and options in the birth suite can be built into the mothers' birth plan
- ✓ Complex care to be reframed in line with the new environment. It feels there is a division between midwifery-led and complex care. Calling all rooms 'Suites' will break down the stigma of being moved from one to the other.
- ✓ Filmed virtual tours also to be considered in 2020/21 for the website to help women and their families feel acquainted with their surroundings before they arrive (this has been completed since the session)

What Matters to Me? – Physical Touchpoints:

- ✓ Shouldn't feel like a clinical space
- ✓ The option to remove the bed if possible from the room
- ✓ Checklist on arrival on how everything works in the suite – possibly on an iPad
- ✓ The provision of a bed or reclining chair for staying partners
- ✓ Ask 'Is it useful for mum?' Some of the items in the rooms add to the clinical feel of the space and can be overwhelming – plastic gloves on show in boxes, folders marked 'resuscitation' on the walls – items which are not required by mum to be stored away from sight where possible.

What Matters to Me? – Design Touchpoints:

- ✓ The overwhelming feedback on the individual suites was the ability to personalise your space
- ✓ Hand held controls for LED lights give the ability to change the lighting throughout labour without having to bother clinical staff to help
- ✓ All rooms to be named Suites
- ✓ Murals of outside spaces to be considered as an option for walls
- ✓ Wireless speakers to connect to Wi-Fi and phones for play lists
- ✓ Colours: Avoid too much white and 'hospital flooring' Greens and natural colours, no pink or blue.

What Matters to Me? – Fundraising Touchpoints:

- ✓ Avoid cartoon-like characters for icons
- ✓ Arms around icons were favourite
- ✓ One logo was clear favourite – this to be developed into different colourways
- ✓ All images were approved – everyone liked the inclusivity
- ✓ Clearer setting of 'Birth Appeal' under the logo
- ✓ Wording to be revised to clearly communicate what/how/why we are fundraising.

Heart Health Month:

- ✓ Comprehensive integrated awareness, education and involvement programme throughout February 2020 inclusive of all stakeholder groups. Support for Staff also offered through OH and Wellbeing Service.

Increase timeliness of responses for formal complaints

Increase timeliness of responses for formal complaints - Background: The Trust has been working on improving complaints management over 2 years which has resulted in an improvement in process, training, timeliness of responses and clear learning from complaints.

We now want to focus on increasing the timeliness of responses to be in-line with national standards.

How progress will be monitored, measured and reported:
Complaints Quality Assurance Group monthly.

Patient Experience Sub-committee monthly.

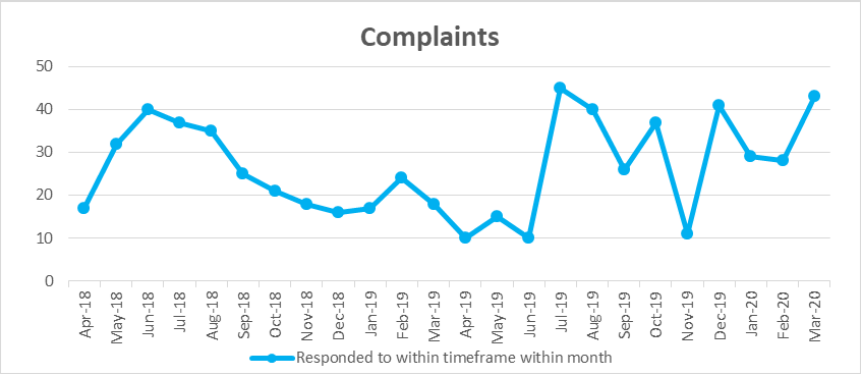
Patient Safety & Clinical Effectiveness Sub-committee monthly.

A quarterly Quality Report to the Quality Assurance Committee will track milestones for the Quality Account priorities.

Increase timeliness of responses for formal complaints - Implementation and Performance:
An overall summary of the work completed to increase the timeliness of responses for formal complaints in 2019/20 is as follows;

- Baseline identified in Q1 2019/20; performance was 29%.
- Trust improvement trajectories set as >90% of complaints will be responded to within timescales by April 2020.
- Collaborative work with the CBUs has increased the percentage of complaints being responded to within timeframe to 100% by the end of March 2020.

Table 1 below is an extract from the Trust Integrated Performance Report and shows the improvement in the number of complaints responded to in timeframe each month.



Development of the Midwifery Led Unit (MLU)

Development of the Midwifery Led Unit (MLU) - Background: Evidence suggests that women actively seek to give birth in maternity units that offer services which value privacy, dignity, choice, and personalised care. Therefore it is essential that we meet these basic standards.

The decision was made to support the relocation of the MLU to enable to Induction of Labour (IOL) bay to be located within the Birth Suite, without affecting the total number of intrapartum beds.

How progress will be monitored, measured and reported:
Patient Safety & Clinical Effectiveness Sub-committee
A quarterly Quality Report will track milestones for the Quality Account priorities

Development of the Midwifery Led Unit (MLU) - Implementation and Performance: The midwifery led unit is still under development. However, the work has continued to progress to ensure that we are taking into account the needs of mothers under our care. The following initiatives are underway;

Maternity Voices – 15 steps is an NHS England strategy in collaboration with maternity voices partnership. It is a way to measure that a service is kind, safe, welcoming and supportive. The 15 steps follow the real patient journey and provide the maternity unit with women led measurable and representative actions for improvement.

Open Day and Wellbeing Event - Maternity Services at Warrington and Halton Teaching Hospitals NHS Foundation Trust will be hosting an Open Day and Wellbeing event in the future for women and their families who are planning to have their baby at Warrington Hospital. The event was due to be held on Saturday 9 March 2020, 10:00am until 2:30pm in the Antenatal Clinic in Croft Wing. However, due to the COVID-19 pandemic this has been postponed. The event was for expectant families or those planning a pregnancy to allow them to be able to meet the midwives who will be involved in their care, find out more about our complementary therapies and take a tour of the unit. The event will be rearranged and provide an opportunity to meet with our specialists in infant feeding, smoking cessation and our consultant midwife.

2.3 Improvement Priorities and Quality Indicators for 2020/21 - How we identify our priorities – 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 priorities have been identified through receiving 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 Quality Assurance Committee and ultimately through to Trust Board.

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.

2.4 Improvement Priorities for 2020/21

The Trust Board, in partnership with staff and Governors, has reviewed data relating to quality of care and agreed that our improvement priorities for 2020/21 will continue to be:

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

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

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.

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

2.5 Local Quality Indicators 2020/21

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 2020/21 will include:

Patient Safety Domain

- Gram Negative Bloodstream Infections - A 5% reduction in Gram Negative Bloodstream Infections (GNBSI)
- A 10% reduction in the overall number of inpatient Serious Harm Falls
- Deteriorating Patient - Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions

Clinical Effectiveness Domain

- Implementation of the Medical Examiner role into the Trust
- Demonstrate that health care is based on the best available, current, valid and reliable evidence from GIRFT and NICE
- CBU Governance to be strengthened, to ensure that CBU Governance is embedded and consistently and effectively applied across all areas

Patient Experience Domain

- Implementation of the End of Life Serious Illness Programme
- Development and implementation of the Trust Learning Disability Strategy
- Reduce deconditioning and PJ Paralysis

2.6 Statements of Assurance from the Board

During 2019/20, the Warrington and Halton Teaching Hospitals NHS Foundation Trust provided and/or sub-contracted seven relevant health services.

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

The income generated by the NHS services reviewed in 2019/20 represents 100 per cent of the total income generated from the provision of relevant health services by the Warrington and Halton Teaching Hospitals NHS Foundation Trust for 2019/20.

2.7 Data Quality

The data is reviewed by 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.

2.8 Participation in National Clinical Audits and National Confidential Enquiries 2019/20

During 2019/20, 29 National Clinical Audit Projects covered relevant health services Warrington and Halton Teaching Hospitals NHS Foundation Trust provides. The National Clinical Audits Warrington and Halton Teaching Hospitals NHS Foundation Trust was eligible to participate in during 2019/20 were as follows:-

	National Clinical Audit Project
1.	Assessing Cognitive Impairment in Older People / Care in Emergency Departments Royal College of Emergency Medicine (RCEM)
2.	BAUS Urology Audit – Nephrectomy British Association of Urological Surgeons (BAUS)
3.	Case Mix Programme (CMP) Intensive Care National Audit and Research Centre (ICNARC)
4.	Falls and Fragility Fractures Audit programme (FFFAP) Royal College of Physicians (RCP) *
5.	Major Trauma Audit Trauma Audit Research Network (TARN)
6.	Maternal, Newborn and Infant Clinical Outcome Review Mothers and Babies: Reducing Risk through

	Audits and Programme Confidential Enquiries across the UK (MBRRACE-UK)
7.	Mental Health - Care in Emergency Departments Royal College of Emergency Medicine (RCEM)
8.	National Asthma and Chronic Obstructive Pulmonary Royal College of Physicians (RCP) Disease (COPD) Audit Programme (NACAP) *
9.	National Audit of Breast Cancer in Older People (NABCOP) Royal College of Surgeons (RCS)
10.	National Audit of Cardiac Rehabilitation (NACR) University of York
11.	National Audit of Care at the End of Life (NACEL) NHS Benchmarking Network
12.	National Audit of Dementia (Care in general hospitals) Royal College of Psychiatrists (RCPsych)
13.	National Audit of Seizures and Epilepsies in Children and Royal College of Paediatrics and Child Health (RCPCH) Young People (Epilepsy12)
14.	National Cardiac Arrest Audit (NCAA) Intensive Care National Audit and Research Centre (ICNARC) / Resuscitation Council UK
15.	National Cardiac Audit Programme (NCAP) Barts Health NHS Trust *
16.	National Diabetes Audit – Adults NHS Digital *
17.	National Early Inflammatory Arthritis Audit (NEIAA) British Society for Rheumatology (BSR)
18.	National Emergency Laparotomy Audit (NELA) Royal College of Anaesthetists (RCOA)
19.	National Joint Registry (NJR) Healthcare Quality Improvement Partnership (HQIP) *
20.	National Lung Cancer Audit (NLCA) Royal College of Physicians (RCP)
21.	National Maternity and Perinatal Audit (NMPA) Royal College of Obstetricians and Gynaecologists (RCOG)
22.	National Ophthalmology Audit (NOD) Royal College of Ophthalmologists (RCOphth)
23.	National Neonatal Audit Programme - Neonatal Intensive Royal College of Paediatrics and Child Health (RCPCH) and Special Care (NNAP)
24.	National Paediatric Diabetes Audit (NPDA) Royal College of Paediatrics and Child Health (RCPCH)
25.	National Prostate Cancer Audit Royal College of Surgeons (RCS)
26.	National Smoking Cessation Audit British Thoracic Society (BTS)
27.	Sentinel Stroke National Audit programme (SSNAP) King's College London
28.	Serious Hazards of Transfusion: UK National Serious Hazards of Transfusion (SHOT) Haemovigilance Scheme
29.	UK Parkinson's Audit Parkinson's UK

*Denotes projects with multiple work streams

The following table presents the National Clinical Audits that Warrington and Halton Teaching Hospitals NHS Foundation Trust was eligible to participate in, and for which data collection was completed during 2019/20 alongside cases submitted:

National Clinical Audit	Participated	Data collected	Stage/Number or % of cases submitted 2019/20
Cardiac Rhythm Management (CRM)	Yes	Yes	Ongoing Data Collection
Myocardial Ischaemia National Audit Project (MINAP)	Yes	Yes	Ongoing Data Collection
Case Mix Programme (CMP ICU)	Yes	Yes	100%
National Audit of Emergency Laparotomy (NELA)	Yes	Yes	87%
National Lung Cancer Audit (NLCA)	Yes	Yes	100%
National Audit of Breast cancer in Older People (NABCOP)	Yes	Yes	Existing sources of patient data is collected by national organisations
National Audit of Care at the End of Life (NACEL)	Yes	Yes	100%
Trauma Audit and Research Network (TARN)	Yes	Yes	100%
National Early Inflammatory Arthritis Audit (NEIAA)	Yes	Yes	Ongoing Data Collection
National Audit of Dementia (NAD)	Yes	Yes	100%
National Ophthalmology Database Audit (NOD)	Yes	Yes	Ongoing Data Collection
British Association of Urological Surgeons (BAUS) Nephrectomy	Yes	Yes	Ongoing Data Collection
Epilepsy 12 Audit: Seizures Epilepsies Child/Young People	Yes	Yes	Ongoing Data Collection (cohort 1 complete)
National Bowel Cancer Audit (NBoCA)	Yes	Yes	49% (Trust submits via MDT)
RCEM: Assessing Cognitive Impairment in Older People / Care in Emergency Departments	Yes	Yes	100%

RCEM: Care of Children in Emergency Departments	Yes	Yes	100%
RCEM: Mental Health - Care in Emergency Departments	Yes	Yes	100%
Maternal, New-born and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Yes	Yes	Ongoing Data Collection
National Prostate Cancer Audit (NPCA)	Yes	Yes	100%
National Comparative Audit of Blood Transfusion Programme	Yes	Yes	Awaiting
Serious Hazards of Transfusion (SHOTS)	Yes	Yes	2019 data analysis not yet available
National Neonatal Audit Programme (NNAP)	Yes	Yes	Ongoing Data Collection
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme	Yes	Yes	Ongoing Data Collection
National Paediatric Diabetes Audit (NPDA)	Yes	Yes	100%
National Heart Failure Audit (NHFA)	Yes	Yes	Ongoing Data Collection
National Audit of Cardiac Rehabilitation (NACR)	Yes	Yes	Ongoing Data Collection
National Maternity & Perinatal Audit (NMPA)	Yes	Yes	Ongoing Data Collection
Sentinel Stroke National Audit Programme (SSNAP)	Yes	Yes	90+%
National Pregnancy in Diabetes (NPID)	Yes	Yes	Ongoing Data Collection
National Joint Registry (NJR)	Yes	Yes	Awaiting
Falls and Fragility Fractures Audit Programme (FFAP)	Yes	Yes	Awaiting
National Cardiac Arrest Audit (NCAA)	Yes	Yes	100%
National Oesophago-gastric Cancer Audit (NOGCA)	Yes	Yes	65% (Trust submits via MDT)
National Diabetes Audit-Adults	Yes	Yes	Ongoing Data Collection

UK Parkinson's' Audit	Yes	Yes	5 (PREMS)
National Smoking Cessation	No	No	Data submitted locally
Inflammatory Bowel Disease (IBD) Biological Therapies Audit	No	No	Trust unable to participate

National Confidential Enquiries

During 2019/20 there were 4 NCEPOD studies, of which WHH were eligible to participate in the following 3;

	National Confidential Enquiries
1	Out of Hospital Cardiac Arrest (OHCA)
2	Dysphagia in Parkinson's Disease
3	Acute Bowel Obstruction

2.8.1 National Clinical Audit

The reports of 14 National Clinical Audits were reviewed by the provider in 2019/20 and Warrington and Halton Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

National Audit Title	Quality Improvement Action Plan
National Audit of Breast Cancer in Older Patients (NABCOP)	Amend MDT proforma to include WHO performance status
National Audit of End of Life Care (NACEL)	Essential/Bespoke training programme to include • Recognising imminent death • Involvement in decision making • Needs of families & others • Individual care plan
National Audit of Dementia (NAD)	Introduction of standardised 4AT screening tool into adult ED
	Introduction of Abbey pain scale into the adult Emergency Department
	Introduction of dementia information leaflet for patient, family or carers on admission to hospital
	Delirium and its relationship to dementia will be included in the dementia awareness face to face session
	Include on the patient menu card the option to order finger foods in replacement of a standard meal
	Inclusion of a 4AT heading within the discharge documentation the occurrence of delirium and/or behavioural symptoms of dementia and recommendations for ongoing assessment or referral to a memory clinic/community team post discharge
	Reporting of inappropriate moves, falls and readmission within 30 days for all dementia patients to the Trust Board
National Sentinel Stroke National Audit Programme (SSNAP)	To investigate the reduction of audit compliance scoring on the SSNAP and ascertain which aspects are causing the impact

	To submit a business case for increased staffing levels of speech and language therapy for stroke
	To increase the intensity of physiotherapy and occupational therapy within existing resources
Bronchiectasis Audit (British Thoracic Society)	CT update checklist by Physiotherapist
National Pregnancy in Diabetes Audit (NPID)	Promote fact that Warrington women can now self-refer without waiting for GP referral using
	Local GPs being encouraged to refer all patients with diabetes and pre-diabetes to structured education programmes which includes information on pre-conception care/targets
	Pre-conception requirements and available pre-conception clinics promoted at local community diabetes sessions
	Promote pre-conception care to potentially fertile patients in WHH service
National Lung cancer Audit (NLCA)	Confirmation of data accuracy regarding pathological confirmation rate
	Confirmation of data discrepancy between actual and adjusted mean for 'Surgery in NSCLC' metric
	Improvement in SACT for NSCLC and SCLC rates by improving MDT working and liaison with Clatterbridge Centre for Oncology (CCO)
	Improvement in Lung CNS metric and ongoing support of lung cancer pathway/ FDS by expansion of Lung CNS hours and confirmed investment in Early Diagnosis Support Worker (EDSW) role
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme (NACAP)	Review impact of 7 day working on number of patients seen and length of stay
	Review spirometry and obtaining results
	Liaise with lifestyle team re better prescription of and access to nicotine replacement therapy
National Hip Fracture Database (NHFD)	Orthogeriatric Consultant post (0.5WTE) to be advertised
	Trauma and Orthopaedic Nurse post to be advertised
	Funding to be identified for the trauma team
	KPIs to be split into categories for visibility on what is consistently being achieved and what is consistently underperforming
	Task and finish groups to be set up with the support of QI Team
National Prostate Cancer Audit (NPCA)	Optimal Pathway- this is being planned through Alliance Network
National Ophthalmology Database (NOD)	Encourage all consultants to input the data of the surgical procedure, the Risk score and the complications in Medisoft / Medisight
	Possibility of standardising the Data between ORMIS and MEDISOFT with the help of IT, to create a more efficient report
National Paediatric Diabetes Audit (NPDA)	Increase uptake of Insulin pumps and continuous glucose monitor (CGM)
	Eye Screening results to follow-up from eye screening team
	Improve recording of blood pressure (BP) and foot examination in annual checks
National Maternity and Perinatal Audit (NMPA)	Continue implementation of Saving Babies Lives 2
	Continue to benchmark against other providers
	Complete a local audit
National Emergency Laparotomy Audit (NELA)	Engage with intensive care team to improve preoperative involvement of intensivist in perioperative management of emergency laparotomy patients including appropriate post-operative admission to critical care
	Elderly medicine specialist reviews in patients > 70 years

2.8.2 Local Clinical Audit

The reports of 88 local clinical audits were reviewed by the provider in 2019/20 and Warrington and Halton Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Local Audit Title	Quality Improvement Action Plan
Clinical Support Services	
Assessing the frequency of snacks offered to inpatients at Warrington Hospital	Agenda item at dietetic team meeting to report audit
	Liaise with ward managers
	Single point lesson
Blood component collection audit	Blood Matters circulated via Communications to all staff to highlight these findings and increase compliance. Slide added to Transfusion Update, which is essential training yearly to staff involved in transfusion.
Management of stable 5th Metacarpal Fracture	Radiographers be reminded of the need for 3 view x-rays
BSH Guidelines for the use of Imaging in the Management of Patients with Myeloma	The audit will be sent to the Radiology department at Warrington hospital for review of possible improvements that can be made with regards to meeting the standard
2019 Administration of Blood Audit: Bedside Practice	Discuss findings with Deputy Head of Nursing and Matron for Diagnostics
	Send 'Blood Matters' out via Communications to highlight the results
Consent for Blood Transfusion Audit 2019	Currently on training for all doctors on Induction, on essential Transfusion Updates for all nursing staff and Consultants
	Discussed at the Patient Safety and Clinical Effectiveness Committee requesting Matrons feedback to all staff the need for consent to be completed prior to starting the transfusion
	Requested the forms are given back to the doctors to complete or they take consent themselves. Elective pre-op patients are given all this information during pre-op assessment
The Radiological Investigation of Suspected Physical Abuse in Children	Meet with the safeguarding team to agree a process for dealing with patients who DNA their follow-up skeletal survey

	Agree a process for ensuring each skeletal survey is allocated to a consultant to provide the 1st and one of the radiologists with a special interest in paediatric imaging is identified to provide the 2nd report
	Limit skeletal surveys to two per day
2019 Administration of Blood Audit: Bedside Practice	Emphasis via training the need for this to be completed on both the doctors training and the nurse's yearly update
Use of Start Back Tool and MSK-HQ Questionnaire in Patients with Low Back Pain	Opt in =1 physio session including: reassurance, advice to keep active and guidance on self-management Provide with the LBP arc booklet and self-help LBP sheet Dated SOS 4 weeks – patient's responsibility to make appointment
	Triage process changes – all spinal referrals to be reviewed by a CAT/physiotherapist – low scores to be sent advice sheet and an opt in letter
Compliance with C&M Lung Cancer Pathway	Review of process to further optimise reporting times for suspected lung cancer CT exams and re-audit
	Extend pathway to IP and OP
	Revise alert codes
	Revise the local pathway to better define timescales for each stage
	Re-audit when implementations to the pathway have been done
Hot Reporting of Fractures	Development of process for hot reporting of fractures to cover annual leave
Prostate Biopsy Audit	Add vascular invasion to the minimum dataset proforma for prostatic carcinoma
	Discuss this with the Urology Consultants
SBAR as a Communication Tool	Flow chart detailing referral process to MSK CATS to be established and displayed in Physiotherapy departments
MSK Physiotherapy Compliance to NG59 Guidelines (low back pain / sciatica)	Literature search to commence to review best evidence available to substantiate appropriateness of manual therapy for the management of low back pain with or without sciatica
Assessment of Immuno-stains Application Reporting Difficult Melanocytic Lesions	To perform P16, HMB45 & Ki 67 immunisations on difficult melanocytic lesions with Spitzoid morphology

Corporate Support Services	
Seven Day Service	Confirm with Integrated Medicine Clinical Business Unit Manager plans for weekend cover for ECHO
	Contact Contracts to ascertain future plans of the Psychiatric Liaison Service from NW Boroughs
	Discussion with Medical Director and meeting with CBU CD confirmed the need for to increase Consultant surgical direct review of patients. This triangulated with learning from incidents/Mortality Review Group
	New rota is to be implemented in January 2019 which provides surgical admissions with access to a Consultant of the week
	Contact Commissioners at Warrington CCG to ascertain plans for increasing service beyond 12 hours per day
	Deep dive into medical patients that were not seen within 14 hours to understand what the barriers are
	Deep dive with Clinical Director for Women's & Child Health CBU to understand what the barriers are
	Audit required ascertaining the adherence to and effectiveness of Handover policy
	The Trust has an action plan in place to tackle GMC National Training survey outliers for clinical supervision of trainees in General Medicine. This action plan is held by Medical Education and is monitored via the Education Governance Sub-Committee
	Gap analysis for which specialties currently have MDT meetings
	Meet with Governance & Audit Specialty Leads where MDT meetings are not taking place to discuss their creation
	Highlighting cases at handovers so that review to be considered provided no sick cases to be managed either in neonatal or wards
	The Trust has Patient Experience Strategy which is underpinned by NICE QS15. The strategy is monitored via the Patient Experience Sub-Committee

Trust-wide Documentation Audit	To be share report with at Ward Managers meeting, nursing and midwifery forum
	Share report with Medical Cabinet
	Share report with Therapy Staff
	To be share report with the governance department and added to CBU governance agendas
	To monitor documentation through the Quality Matrix and reported to Nursing and Midwifery forum, via Lead nurses monthly
	Trust wide documentation audit will now be implemented, managed and monitored in conjunction with the Trust-wide Documentation policy holder
Trust-wide Pressure Ulcer Audit	Disseminate report at tissue viability steering group and discuss action plan
	Patients admitted to hospital or a care home have a pressure ulcer risk assessment within 6 hours of admission
	ED Matron/Ward Manager to raise the importance of timely risk assessments at ED Safety Huddle
	Lorenzo Waterlow form to be updated to incorporate questions regarding advice given to patient on pressure ulcer prevention
Digestive Diseases	
Antibiotic use in Acute Appendicitis	Discussion with Microbiologists to develop specific guidance for WHH
	Quality improvement project to create a pathway for acute appendectomies
Audit of Peri-operative Diabetic Management	Discussion with pre-operative manager and administrators to identify how communication of medical conditions can improve
	Improvement of list management and preoperative fasting advice – new trust guidelines and diabetic patient passport will help to achieve this
	Standardisation of management of diabetic patients on the day of surgery by use of diabetic patient passport to prompt blood glucose checks
	Standardisation of post-operative documentation

	with diabetic patient passport
Breast & Cosmetic Implant Registry (BIR)	Communication sent to Theatres to maintain Unique Identifier number (UID) and place into patient notes
Delayed Discharges in Warrington Hospital	Present the results to hospital management at Patient Flow Sub Committee
Do We Meet NICE Guideline Standards for Providing Patients with Pancreatitis Written Information About their Diagnosis	To introduce and implement a new patient information leaflet for Pancreatitis with guidance from the Quality Improvement team
Endoscopy Unit Questionnaire	Utilise new questionnaire for accreditation
Management of acute Cholecystitis	Implementation of a hot gallbladder service
Mother & Baby Temperatures	Fluid warmer to be used if anaesthetist plans to give >500ml fluids or blood- Email communication to be sent to anaesthetists & ODPs.
Perioperative Hypothermia	Incorporate question about temperature measurement into the WHO checklist
Photo-Documentation in Upper GI Endoscopy	Encourage Endoscpists to photo-document all the anatomical landmarks and re audit the changes
SAU Review After Scans Waiting Time	Instigate new management strategy including Pas on SAU
The Efficiency of Warrington Hospital Breast and General Surgery Theatre Lists with Regards to Late Starts as Compared to Recommended WHH SOP	Introduction of a designated communicator between theatre teams and ward teams to ensure that timings are met and a nominated time keeper in each theatre team to ensure that step of the process is done according to time
	The information/audit should be distributed to all the theatre teams including surgeons, anaesthetists, nurses and all the Breast, General and Colorectal staff and to reiterate that: The huddle must be completed before or by 08:40
	Training to be delivered to wards CDU, A5, A6 and ITU directly (these are the areas who care for the majority of the patients admitted with such injuries)
	Develop standardised letter the pain specialist nurses can use to detail analgesia patient discharged with and pain management plan for step down from strong opiate use.
	Lead within A&E will communicate availability and need to adhere to the pathway
	Pathway to be part of the training delivered on a

	monthly basis offered to all nursing staff
	Lead Consultant to liaise with anaesthetic colleagues regarding techniques and availability of anaesthetist to perform the procedure
Time from Admission to USS/MRCP Following Admission for Suspected Gallstone Disease	Discuss with Radiology Department regarding a hot slot for USS / MRCP
Timing of Definitive Management Following Acute Gallstone Pancreatitis	Make sure that patients with gallstone pancreatitis are listed for elective Lap cholecystectomy (within 2 weeks of discharge) before they are discharged
Integrated Medicine & Community	
Prevalence and Management of Pressure Ulcers and Moisture Lesions in Elderly Patients	Poster in ward as a reminder for staff
	Small session to be introduced on induction for reiteration of documentation
Medical Care	
Accuracy of and Adherence to Gold Score Completion in the Warrington Inpatient Population	Advise how to alter patient care and management dependent on hypoglycaemia risk assessment
	Increase awareness of Gold Score charts on the front of blue insulin charts
Accuracy CTCA Reporting	Standardised terminology for results
Bone Health in Rheumatoid Arthritis Patients	Development of an annual review proforma
Bone Health of Patients on Biologic Therapy for Rheumatoid Arthritis	Contact ICE department to integrate this search function onto the system
	Development of annual review proforma which includes space for height and weight
Comparison of Pump Clinic Against Recently Produced Insulin Pump Clinic Standards	Establish a Diabetes MDT to facilitate discussion of pump starts and document reasons for commencement
	Pump MDT document published and disseminated within team
Compliance with C&M Lung Cancer Pathway	Business case for point of care (POC) eGFR checks
Discharge Summaries	Introducing Electronic Prescription
	Snowmed Coding on E-discharge Letters
Do All AMU Patients with COPD Leave AMU with the Optimal Treatment	All patients admitted with COPD should have the appropriate inhaler prescribed and if already on inhaler will require an inhaler review

	All patients admitted with the diagnosis of COPD will need to ensure diagnosis was made using spirometry. If not, will require organising spirometry or GP to organise investigation
	All patients admitted to AMU with COPD should have a smoking history and if found to be a smoker, will need to be offered smoking cessation advice
Do All Rheumatoid Arthritis Patients have a Bone Health Assessment in Rheumatology Follow-up Clinic	All Rheumatoid Arthritis patients reviewed in follow-up clinic should have annual bone health assessment
Do Diabetes Clinic Letters Meet CCG Agreed Standards	Until electronic diabetes patient record available provide a copy of required data in every clinic room
	Distribute individual data to HCP
Domiciliary Visit Audit	Cost analysis to demonstrate saving from first round of audit
	Implementation of ACP/EOL Domiciliary Visit Service across Trust
IV Fluids Audit	Provision of education on appropriate fluid prescribing, documentation of IV fluid management plans and appropriate fluid charts
NEWS2	A visible schedule of patient observations to be placed outside each bay
	Continue ongoing education with regards to 'Focus on 5,' and increasing frequency of observations in detection of abnormal physiology
	Lead nurses and matrons to address areas of poor overnight compliance with observations, focussing on patient specific requirements rather than task orientation
	NEWS 2 task and finish group to review this interval in light of poor compliance to ensure that 4 hourly observations are meeting evidence based practice without being excessive
Nice Guideline CG172 Secondary Prevention in ACS	Produce a standardised ideal discharge summary which can be displayed in the MDT room on ACCU
	Re-audit the standards where the service achieved 89% or less with the possible exception of 'the discharge summary to include results of investigations
Non Invasive-Ventilation (NIV)	Add NIV prescription to Lorenzo

Outcomes of Patients with Alcoholic Cirrhosis Admitted to ICU	Present data at Gastroenterology Governance Meeting
Post Pneumonia Chest X-ray Follow-up Audit	Set up business case for post pneumonia virtual clinic
Use of Critical Care Local Escalation in Theatre Recovery	Highlight audit findings to Critical Care Senior Nurses and Medical teams
	Highlight audit findings to Recovery Team and Critical Care Senior Nurses and Medical teams
	Present audit at Critical Care Audit Meeting to commence discussion around
	Add to agenda for Critical Care Management Meeting
	Submit report to Patient Flow Subcommittee
Stroke Service Review	Continue to offer all patients an assessment
	Cross check database to ensure all patients accounted for- record drivers on database
Surgical Specialties	
Assessment of Patients With Intermittent Exotropia	Remove standard 12 from protocol as prism adaptation test not being performed at all
	To re-audit compliance of standard 13 Newcastle control score
	To re-audit compliance of standard 6 cover test
Atropine Audit	Staff to document when atropine is offered as a first line treatment
	To amend the current local atropine policy to allow staff to use their clinical judgement in complex cases i.e. patient unable to do pinhole vision/ dosage of atropine/ use of an additional penalized lens
Atropine Guidelines Audit	100% of patients to have near vision and pinhole checked prior to commencing atropine occlusion
	100% of patients must have an accurate GP letter following the Atropine guidelines
	100% on Atropine occlusion must have a pinhole test if their atropinised eye has reduced vision
Audit to Determine if WHH are Complying with the BOAST Fracture Clinical Guidelines	Development of information leaflets for Fracture Clinic
	Development of patient management pathways for

	orthopaedic injuries encountered in ED
BOAST - Ankle Fracture Audit	To improve ankle fracture documentation, classifying ankle fractures and documentation following initial treatment. Re-Audit after posters are printed and disseminated among the A&E and Orthopaedic Doctors
Cataract Audit	All staff to input clinical information in to Medisoft
	All staff who consent patients for cataract surgery must use the ICE system to document if a patient should not be placed in the general pool
	All surgeons must document all complications in the theatre back book
Cataract Difficulty	To add the risk stratification scoring form to the cataract care pathway
Cataract Difficulty Re-audit	To ensure 100% of trainees are aware of the risk stratification form through a 'common procedures template'
	To ensure Risk stratification forms are available at nursing station
	To ensure Risk Stratification Forms are available in 100% clinic rooms
Delay in Distal Biceps Tendon Repair	Creation and ratification of SOP for distal biceps tendon injuries
Diplopia and the DVLA	Create information leaflet on diplopia and driving
Documentation of Neurovascular Status	Decision regarding feasibility of creating a neurovascular documentation form in Exercise Pressor Reflex
ENT Clinic Numbers	Adjust clinic numbers template in ENT general clinics
Eyelid Basal Cell Carcinoma Excision Biopsy – Histological Margin Clearance Rate	Aim for increased macroscopic margins for excision of eyelid BCC: Nodular 2-3mm, Non-nodular 3mm
Factors Affecting Length of Stay in Neck of Femur Patients	Process to be implemented to cancel elective lists if NOF fracture patients have been waiting for >33 hours for operation
Glaucoma Multidisciplinary Service	Introduce pathways
	Clinic structure modifications
How are we Doing in Osteoporosis	Digitalisation of FRAX scores on Lorenzo

Listing For Lower Third Molar Removal	Present findings at mandatory training day
	Design a clinic proforma/decision tree or stamp with clear diagnosis which adhere to NICE
NICE Glaucoma Guidelines – Follow-up Intervals	To clarify with staff members who do GAC assessment the role of EPR – e-mail and verbal discussion
	To reinforce the NICE recommended follow up intervals for OHT Glaucoma suspect and OAG patients – e-mail and verbal discussion
	To re-organise the structure of Glaucoma Service as more staff is being recruited
	Economical evaluation. To examine what impact changes had on efficiency and if it translates into better cost effectiveness
Painful Big Toe Surgery – Have We Improved Our Same Day Discharge Rates	To continue to use Forefoot Surgery Discharge Information Leaflet
Protocol for Children Who Do Not Attend Appointments (DNA)	All orthoptists to read and sign the DNA protocol
	Follow up patients - parents were contacted Snap-shot re audit in 6 months to ensure compliance has improved against specific standards
	Formal vision only patients - appropriate action taken - Snap-shot re audit in 6 months to ensure compliance has improved against specific standards
	Formal vision only patients - parents contacted - Snap-shot re audit in 6 months to ensure compliance has improved against specific standards
	New patients - appropriate action taken - Snap-shot re audit in 6 months to ensure compliance has improved against specific standards
	New patients - parents contacted - Snap-shot re audit in 6 months to ensure compliance has improved against specific standards
Suspected Testicular Torsion Pathway	Pathway template - Review & update, to be put out for approval to ED, Surgery and Urology departments
	Review & update, to be put out for approval to ED, Surgery and Urology departments - Pathway Template
	Review within 2 hours - Teaching session for Surgical

	department after release of updated pathway
	Teaching session for ED team after release of updated pathway - Incident report if not reviewed in time
Vision Screening Service Annual Review	To amend consent letters to account for new GDPR guidance
	To review consent process for children in SEN designated provision units as their test differs from Visual Screening outlined in the generalised consent letter
Urgent & Emergency Care	
Are Antibiotics for Community Acquired Pneumonia (CAP) Prescribed According to Trust Guidelines	Deliver teaching at the acute medical weekly teaching
Do all AMU Patients with COPD Leave AMU with the Optimal Treatment	Education session and poster remainders to be placed around ward A1 with emphasis on: All patients admitted to AMU with COPD should have a smoking history and if found to be a smoker, will need to be offered smoking cessation advice
Prophylactic LMWH for Adult Patients: Are we Completing VTE Assessment Forms and Prescribing Within Recommended Time Frame	All junior doctors will be made aware of the above recommendations; this audit will be presented in 'Audit and morbidity/mortality meetings'
Urinary Tract Infection (UTI)	Produce display with UTI audit findings on UTI noticeboard in ED
	Review TTO packs of nitrofurantoin in ED to 3/7 and 7/7
Women & Children	
Annual Colposcopy Satisfaction Survey	To ensure annual survey on cervical screening rolling programme
	Review external process for issuing patient information leaflets
	Clerical supervisor to review appointments system - explore online booking
	Ensure clear signage for facilities
Audit on Advice and Guidance Requests	More Consultants to support A&G to sustain and improve response time
Audit on Amniocentesis	Changed to one operator - In order to maintain skills and procedure numbers only one operator , if operator on holiday patients to be referred to

	Liverpool Women's
Children Not Brought for Appointments	Develop a joint policy with Bridgewater NHS, re-launch the completed policy and circulate trust wide
Domestic Abuse Audit	Discuss issues with midwives
	Attend clinical areas and reiterate evidencing of domestic abuse screening in notes and the use of bar code sticker
	Promote domestic abuse training for all staff grades
	'Spot Checks' across the unit in relation to routine screening and documentation of domestic abuse
Induction of Labour (CG 70 Induction of Labour)	Participate in Big Baby Trial
Management of MCDA twins (CG129 Multiple Pregnancy)	Disseminate and communicate use of proforma to document management
Maternity Safeguarding Note Audit	Electronic Maternity Special Circumstance Forms to be adopted
	Powerpoint communication to be shared with all staff
	Managers to share information within their teams for staff who do not have access to email in relation to recommendations
Patient Satisfaction with Colposcopy	Annual colposcopy patient satisfaction survey as part of cervical screening pathway service specification standard
Readmission to Hospital of Babies Within 28 Days of Birth with Feeding Related Issues	Ensure robust referral pathways for further support: Review current process of monitoring admissions. Update ICE referral process. Flowchart/safety brief for staff to be issued
	Review support for dyads at risk of readmission: Elective C Section; BMI; Multiple Births; Tongue Tie and consider additional ways of ensuring successful BF. Highlight these issues to all staff via email/poster/social media
	Continue to promote the need for Antenatal conversations and postnatal BF assessments in education sessions during 2020. Consider other formats of promotion and individual updates where failings identified
	Monitor implementation of new weight loss policy. Support Paediatric staff with this through education

	and one to one support

2.9 Participation in Clinical Research and Development

The number of patients receiving NHS services provided or sub- contracted by Warrington and Halton Teaching Hospitals NHS Foundation Trust in 2019/20 that were recruited during that period to participate in research approved by a research ethics committee was 439.

During 2019/20 the Quality Academy Research & Development team were nominated for "Excellence in Commercial Life Sciences Research" as part of the North West Coast Research and Innovation awards for their work in developing a commercial relationship with the life sciences industry to promote research and provide new treatment options to benefit local patients.

2.10 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.

A proportion of Warrington and Halton Teaching Hospitals NHS Foundation Trust's income in 2018/19 was conditional upon achieving quality improvement and innovation goals agreed between Warrington and Halton Teaching 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 2019/20 and for the following 12 month period are available electronically at https://www.england.nhs.uk/nhs-standard-contract/cquin/

The income received in 2019/20, conditional upon achieving quality improvement and innovation goals was £2,528,508 against a target of £2,528,508. The monetary total for the associated payment in 2018/19 was £4,658,317. The reduction in CQUIN income is due to 1.25% being funded through tariff in 2019/20.

The Trust had the following CQUIN goals in 2019/20 which reflected national priorities and Department of Health initiatives.

No.	Name	% of contract value	Total estimated final value
	NATIONAL CQUINS		
CCG1	**Antimicrobial Resistance (AMR)**	**0.25%**	**£484,549**
CCG1a	Antimicrobial Resistance – Lower Urinary Tract Infections in Older People	0.13%	£242,274
CCG1b	Antimicrobial Resistance – Antibiotic Prophylaxis in colorectal surgery	0.13%	£242,274
CCG2	**Staff Flu Vaccinations**	**0.25%**	**£484,549**
CCG3	**Alcohol and Tobacco (A&T)**	**0.25%**	**£484,549**
CCG3a	Alcohol and Tobacco - Screening	0.08%	£161,516
CCG3b	Alcohol and Tobacco – Tobacco Brief Advice	0.08%	£161,516
CCG3c	Alcohol and Tobacco – Alcohol Brief Advice	0.08%	£161,516
CCG7	**Three high impact actions to prevent Hospital Falls**	**0.25%**	**£484,549**
CCG11	**Same Day Emergency Care (SDEC)**	**0.25%**	**£484,549**
CCG11a	SDEC – Pulmonary Embolus	0.08%	£161,516
CCG11b	SDEC – Tachycardia with Atrial Fibrillation	0.08%	£161,516
CCG11c	SDEC – Community Acquired Pneumonia	0.08%	£161,516
	Total	**1.25%**	**£2,422,745**
	NHS ENGLAND CQUINS		
	Dental		£48,328
	SPECIALLY COMMISSIONED CQUINS		
PSS1	**Medicines Optimisation**		£30,875

2.11 Care Quality Commission (CQC) Registration

Warrington and Halton Teaching 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 Teaching Hospitals NHS Foundation Trust during 2019/20.

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 Teaching Hospitals NHS Foundation Trust has not been subject to any special reviews by the Care Quality Commission during 2019/20.

2.12 CQC Inspections

The Trust was inspected by the CQC in March 2019. During this visit the standard of quality and safety of the care provided, based upon the things that matter to people. Considered whether our service is:

- Safe
- Effective
- Caring
- Responsive to people's needs
- Well-led

The key lines of enquiry were investigated using pre-visit information, the onsite inspection and local information about the Trust – including seeking patient, staff and visitor views. In July 2019 the CQC published our report which included a rating by specialty; location and an overall rating for the trust from the inspection.

Our ratings for Warrington and Halton Hospitals NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Warrington Hospital	Good ↑ Jul 2019	Good ↑ Jul 2019	Good →← Jul 2019	Good ↑ Jul 2019	Good ↑ Jul 2019	Good ↑ Jul 2019
Halton General Hospital	Good ↑ Jul 2019	Good →← Jul 2019	Good →← Jul 2019	Good →← Jul 2019	Good ↑ Jul 2019	Good ↑ Jul 2019
Overall trust	Good ↑ Jul 2019	Good ↑ Jul 2019	Good →← Jul 2019	Good ↑ Jul 2019	Good ↑ Jul 2019	Good ↑ Jul 2019

Ratings for Warrington Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good Nov 2017	Good Nov 2017	Good Nov 2017	Requires improvement Nov 2017	Good Nov 2017	Good Nov 2017
Medical care (including older people's care)	Good ↑ Jul 2019	Good ↑ Jul 2019	Good →← Jul 2019	Good ↑ Jul 2019	Good ↑ Jul 2019	Good ↑ Jul 2019
Surgery	Good →← Jul 2019	Good →← Jul 2019	Good →← Jul 2019	Good →← Jul 2019	Good →← Jul 2019	Good →← Jul 2019
Critical care	Good ↑ Jul 2019	Good →← Jul 2019	Outstanding ↑ Jul 2019	Good ↑ Jul 2019	Good →← Jul 2019	Good ↑ Jul 2019
Maternity	Good Jul 2019	Good Jul 2019	Good Jul 2019	Good Jul 2019	Good Jul 2019	Good Jul 2019
Services for children and young people	Good Nov 2017	Good Nov 2017	Good Nov 2017	Good Nov 2017	Good Nov 2017	Good Nov 2017
End of life care	Good Nov 2017	Good Nov 2017	Good Nov 2017	Good Nov 2017	Good Nov 2017	Good Nov 2017
Outpatients and diagnostic imaging	Requires improvement Nov 2017	Not rated	Good Nov 2017	Good Nov 2017	Requires improvement Nov 2017	Requires improvement Nov 2017
Overall*	Good ↑ Jul 2019	Good ↑ Jul 2019	Good →← Jul 2019	Good ↑ Jul 2019	Good ↑ Jul 2019	Good ↑ Jul 2019

Ratings for Halton General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good Nov 2017	Good Nov 2017	Good Nov 2017	Good Nov 2017	Good Nov 2017	Good Nov 2017
Medical care (including older people's care)	Good Nov 2017	Good Nov 2017	Good Nov 2017	Good Nov 2017	Requires improvement Nov 2017	Good Nov 2017
Surgery	Good ↑ Jul 2019	Good →← Jul 2019	Good →← Jul 2019	Good →← Jul 2019	Good →← Jul 2019	Good →← Jul 2019
Outpatients	Good Jul 2019	Not rated	Good Jul 2019	Good Jul 2019	Good Jul 2019	Good Jul 2019
Overall*	Good ↑ Jul 2019	Good →← Jul 2019	Good →← Jul 2019	Good →← Jul 2019	Good ↑ Jul 2019	Good ↑ Jul 2019

The trust can report that the CQC rated Warrington Hospital and Halton Hospital as **Good**. They rated the domain of Caring in the Trust as Good across the board and **Outstanding** in Critical Care.

The trust was given an overall rating of **'Good'** by the CQC. An action plan is in place within the Trust following receipt of the CQC inspection report with actions at both service and Trust level. This has informed our Moving to Outstanding vision and priorities within the Trust. This is monitored by the Moving to Outstanding meeting which has been convened to oversee the action plan implementation.

2.13 Trust Data Quality

Warrington and Halton Teaching Hospitals NHS Foundation Trust submitted anonymised clinical data for patients seen and treated during April – February 2019/20* to the Secondary Uses Service (SUS) for inclusion in the national Hospital Episode Statistics.

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

National Data Set	Trust Valid	National Average Valid
Admitted Patient Care	99.7%	99.4%
Outpatient Care	99.9%	99.7%
A&E Care	99.2%	97.7%

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

National Data Set	Trust Valid	National Average Valid
Admitted Patient Care	100%	99.7%
Outpatient Care	100%	99.6%
A&E Care	100%	97.9%

* provided from SUS – Cumulative year to date to Feb 2019/2020

Warrington and Halton Teaching Hospitals NHS Foundation Trust will be taking the following actions to improve the data quality and validity where it does not achieve 100% completeness.

- The Trust's Data Quality Team will continue to work closely with operational teams to ensure national data items collected on our Trust key systems is accurate and complete.
- A data quality dashboard that was launched in 2019/20 will further support the monitoring of data capture completeness and improvement for key performance indicators derived from the datasets highlighted above.
- The Data Standards and Assurance Group focusses on areas requiring improvement relating to general data quality, Trust key performance indicators, operational areas and finance and contract performance. As part of the Trust governance structure, this Group reports into the Information Governance and Corporate Records Sub-Group which in turn provides assurance to the Quality Assurance Committee.
- A Data Quality Policy is in place that includes role based responsibilities for data quality and is reviewed on a routine basis to ensure it supports reporting and statutory obligations around national datasets.

2.14 Information Governance

The Trust uses the Data Security and Protection Toolkit in conjunction with the Datix Risk Management system to inform the work of its Information Governance and Corporate Records Sub-Committee. The Information Governance and Corporate Records Sub-Committee is accountable to the Quality Assurance Committee which is a sub-committee of the Trust board.

The Trust's Senior Information Risk Owner (SIRO) chairs the Information Governance and Corporate Records Sub-Committee which is also attended by the Trust's Caldicott Guardian. The SIRO (Chief Information Officer) acts as the Board level lead for information risk within the Trust. Any areas of weakness in relation to the management of information risk which are identified, or are highlighted by internal audit review, are targeted with action plans to ensure that we continue to strive to be information governance assured.

The Trust's 2019/20 Data Security and Protection Toolkit assessment was reviewed by Mersey Internal Audit Agency in March 2020 as part of the Trust's annual audit programme. The Governance assurance statement provided in the published review stated that "Warrington and Halton Teaching Hospitals NHS Foundation Trust has demonstrated that it has implemented a robust, active framework to progress its information governance agenda". The overall assurance level awarded for the Trust's 2019/20 Data Security and Protection Toolkit submission is Substantial Assurance.

2.15 Clinical Coding/Payment by Results (PBR)

Warrington and Halton Teaching Hospitals NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2019/20 as they are no longer routinely undertaken within the NHS.

Warrington and Halton Teaching Hospitals NHS Foundation Trust will be taking the following actions to improve data quality;

- Continuous engagement with clinicians to improve documentation and clinically coded data.
- Working with clinicians to migrate from handwritten to digital operation notes.
- On-going programme of internal clinical coding staff audits.
- Supporting the mortality review group with documentation and clinical coding reviews.
- Continuous training and updating of skills for clinical coders.
- Targeted specialty documentation and clinical coding audits.
- Collaboration with Informatics to enhance the usability of Lorenzo to improve the coding process.
- Highlight data quality issues for resolution to the Application Support Team.

2.16 Learning from deaths

In March 2017, The National Quality Board issued "National Guidance on Learning from Deaths: a framework for NHS trusts and NHS foundation trusts on identifying, reporting, investigating and learning from deaths in care". This guidance included the requirements that trusts must publish a Learning from Deaths policy, and that from December 2018 Trusts must collect and publish on a quarterly basis specified information on deaths, through a paper and an agenda item to a public Board meeting. This data should include the total number of the Trust's inpatient deaths and those deaths that the Trust has subjected to case record review. Of those deaths subjected to review,

trusts must estimate how many deaths were judged more likely than not to have been due to problems in care.

Reducing mortality is a priority for the Trust which is now focused through the Mortality Review Group (MRG). The Mortality Review Group performs in-depth investigations using the Structured Judgement Review methodology into groups of patients conforming to agreed criteria as defined within the Trust Learning from Deaths policy.

The Trust has currently trained 11 clinicians in the Royal College of Physicians Structured Judgment Review (SJR) method for recording deaths, mortality reviews and their outcomes. The Trust has invested in the DATIX iCloud (electronic risk management system) which has an additional functionality to log SJRs electronically.

Mortality meetings focus on process and system change, with the aim of developing recommendations to prevent a similar adverse outcome in the future. Any actions and improvements that have been made by the Mortality Review Group are reported to the Patient Safety & Clinical Effectiveness Sub-Committee monthly.

By 31st March 2020, 250 care record reviews (SJR) completed and 9 investigations (Serious Incidents) were carried out in relation to 1,111 of the deaths included above. They occurred in each quarter of that reporting period as follows:

- 49 SJRs completed and 3 Serious Incidents (1 case was subject to both an SJR and Serious Incident Investigation);
- 53 SJRs completed and 3 Serious Incidents (1 case was subject to both an SJR and Serious Incident Investigation);
- 129 SJRs completed and 8 Serious Incident
- 67 SJRs completed and 3 Serious Incidents (1 case was subject to both an SJR and Serious Incident Investigation);

In 3 cases a death was subjected to both a case record review and a serious incident investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was as follows:

- 1 in the first quarter;
- 1 in the second quarter;
- 0 in the third quarter;
- 1 in the fourth quarter

3 representing 0.27% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. It should be noted that 5 investigations are still in progress and are awaiting conclusion, these will be reported on in the 2020/21 report. The 3 cases are SIs that were reported to, and reviewed by, the Trust Board and deemed as preventable harm.

In relation to each quarter, this consisted of:

- 1 representing 0.39% for the first quarter;
- 0 representing 0% for the second quarter;

- 2 representing 0.68% for the third quarter;
- 0 representing 0% for the fourth quarter with 1 case still under investigation and 2 subject to Inquest

In order to support our learning and help improve the treatment of our patients, we disseminate learning from both the case record reviews and serious incident investigations. This provides valuable feedback on all aspects of care and helps us to understand what we may need to improve and equally what has been effective and meaningful for our patients. Here are some of the things that we have learnt and implemented;

- **Quality Academy** - Clinical Coding project - Two Junior Doctors (SAMP) to investigate the 'R' Code (signs & symptoms) coding issue. As a result of the findings from the project a Grand Round in relation to R Codes and documentation was presented. Also created was a training package for the Junior Doctors which is presented by a member of the MRG group and Clinical Coding. Work is still on-going to develop an e-learning teaching package to further support staff with the aim to have this implemented in 2020-21.

- **Prioritised Coding** – Bereavement notes are prioritised for coding which supports the mortality review process. Clinical Coding and a member of the MRG group review all deaths with a primary 'R' code in 1st and 2nd episode and refer back to the responsible consultant for review.

- **Ward Round Accreditation** - Alex Crowe, Medical Director and May Moonan, Associate Medical Director, oversee the Ward Round Accreditation Scheme. Medical ward rounds are complex clinical activities, critical to providing high quality, safe care for patients in a timely, relevant manner. They provide an opportunity for the multidisciplinary team to come together to review a patient's condition and develop a coordinated plan of care, while facilitating full engagement of the patient and/or carers in making shared decisions about care. Adopting these principles will improve patient safety, patient experience, shared learning, collaborative working and efficient use of resources. Success requires a concerted cultural change, with clinical staff, managers and hospital executives all fully engaged and focused on improving the quality of ward rounds. The review of documentation will form part of the accreditation process on each Ward Round.

- **Finished Consultant Episodes** - A Task and Finish group to look at Finished Consultant Episodes has been established and is led by the Trust Mortality Lead. A standard operating procedure has been developed to enable ward clerks to edit the system instead of multiple episodes being created each time a patient is moved; it is believed that this will have a positive impact on HSMR/SHMI going forwards.

- **Working diagnosis and CDC forms** - MRG members are working with the Lorenzo team to develop CDC forms from a mortality perspective. To reduce R codes the team is looking at removing the possibility for clinicians to input words such as 'likely' or 'possibly' into their working diagnosis.

- **Patient Safety Summit** – The Mortality Review Group hosted a Mortality element within the Safety Summit in November 2019/20 where all learning from Mortality was shared.

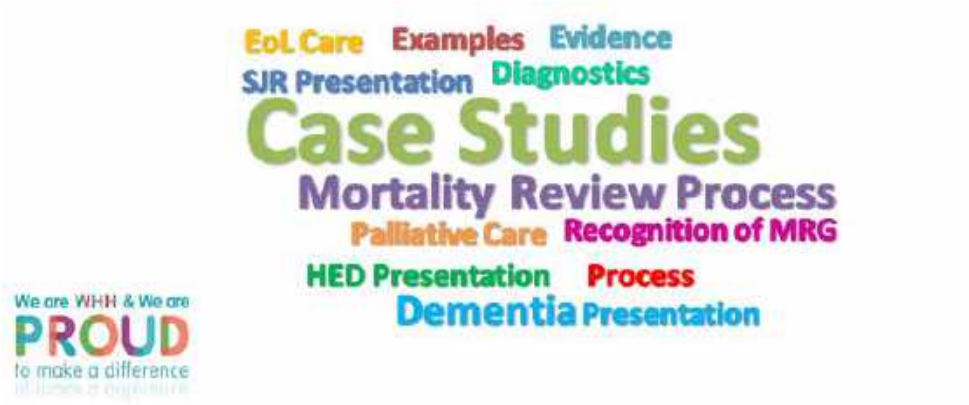
Educational sessions were held with staff to promote areas such as Coding and documentation.

- **Mortality Event** - In February 2020 the Mortality Review Group hosted a multi-agency shared learning event. The objectives of the event were as follows;

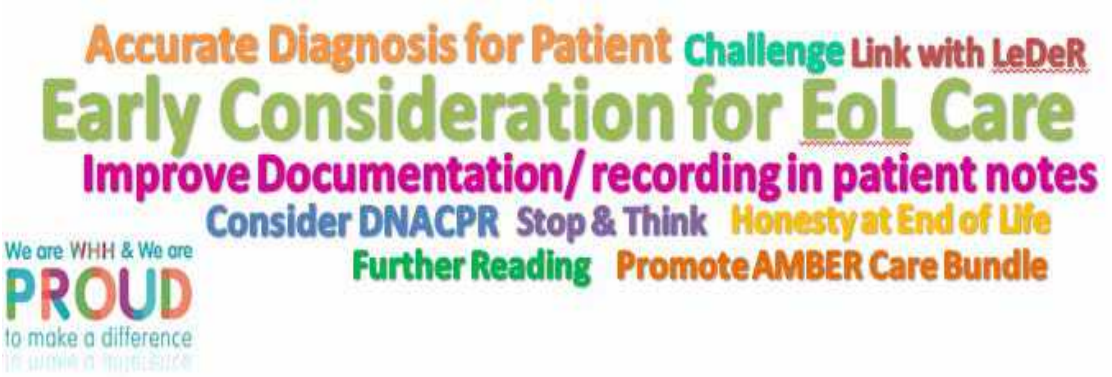
    - To understand how we review mortality at the Trust;
    - Why it is important to understand how and why our patients die;
    - What can we do to improve practice and processes to ensure our patients die well.

Feedback was obtained from attendees and we have formulated their responses to the questions below and presented them in the form of the word clouds;

Q. What was Most Useful About the Session?



Q. What Action You Will Carry Out as a Result of this Event?



Actions and improvements made by the Mortality Review Group will be reviewed during 2020/21 to understand their impact. These actions will be reported to the Patient Safety & Clinical Effectiveness Sub-Committee.

Processes are in place to keep families and carers informed about the screening of a death, the Structured Judgement Review process and / or a serious incident review (in line with Duty of Candour requirements). Advice is given to families and carers by means of the bereavement booklet, explaining that they can raise concerns and that these will be considered when deciding whether or not to further investigate a death.

Communicating with patients, families and carers was, and continues to be, a Patient Experience priority. In 2019/20 the Trust opened its maternity bereavement suite; The Butterfly Suite has had a full refurbishment courtesy of one of our local charities Harry & Co, Golden Square Shopping Centre, Warrington, Assura plc. and Sellafield Ltd. This means that there are now two dedicated bereavement suites with en-suite facilities and a contained kitchen area. To provide families with homely and bespoke accommodation, offers comfort and privacy during a very difficult time in their lives.

The Butterfly Suite is part of our bereavement service and was identified in our recent CQC inspection as an area of outstanding practice, '*the bereavement service had won an award in 2018 for the best hospital bereavement service. There were two en-suite rooms with cuddle cots available. The specialist bereavement midwife was very responsive to individual needs from early losses to term babies*.'

2.17 Core Quality Indicators 2019/20

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.

2.18 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:

DATE PERIOD	TRUST	BANDING	HIGHEST	LOWEST	NATIONAL
November 2018 - October 2019	106.89	2	120.12	68.48	100
October 2018 – September 2019	105.93	2	118.77	69.79	100
October 2017 – September 2018	109.92	3	126.81	69.17	100
July 2016 – June 2017	112.32	2	122.77	72.61	100

NB: This information is re-based so there may be a variation from HED monthly reporting and there is no 2019/20 national comparative data available at present.

https://digital.nhs.uk/data-and-information/publications/clinical-indicators/shmi/current/shmi-data

Warrington and Halton Teaching 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'

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 Teaching 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 of 106.89 in the rolling 12 month periods from November 2018 - October 2019.

The SHMI is one of two mortality measures used in the NHS, the other being HSMR (Hospital Standardised Mortality Ratio), which is 106.36 for the latest data period available (October 2019). 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.

In an aim to improve our SHMI and HSMR we conduct focused reviews where the HED system indicates we are an outlier in a particular diagnostic group, for example Pneumonia.

Where we are above our expected number of deaths in a diagnosis group for over three months we will work alongside specialists within the appropriate specialty to perform case note reviews of the patients' stay. This deep dive provides valuable learning as to what is required to ensure that we have no further triggers within diagnostic groups. Some aspects of learning are applicable to reduce the likelihood of a trigger within a diagnostic group in the future, such as improved documentation and coding. Others are of particular relevance to treatment, such as using a dip stick before diagnosing a patient as having a urinary tract infection.

We share learning from the Mortality Review group using the Mortality and Morbidity (M&M) meetings which are an opportunity for peer review, collective learning and quality improvement. These are held across all CBU's on their allocated audit days.

Mortality and morbidity meetings are a professionally accountable forum based on sound educational principles. They encourage openness, honesty and transparency from participants. They focus upon learning and improvement of systems and processes of care and not on individual performance.

During 2019/20 the first Mortality Review Group Learning Forum was presented for both internal and external stakeholders; further details of this forum can be seen in section 3 of this report.

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

DATE PERIOD	TRUST	ENGLAND	HIGHEST	LOWEST
November 2018 - October 2019	41%	36%	59%	11%
October 2018 – September 2019	40%	36%	59%	12%
October 2017 – September 2018	34.3%	33.4%	59.5%	14.3%
July 2016 – June 2017	41.7%	31.1%	58.6%	11.2%

https://digital.nhs.uk/data-and-information/publications/clinical-indicators/shmi/current/palliative-care-coding

Warrington and Halton Teaching 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 Teaching 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 has improved over the years to a steady rate, which is comparable with the England average. However, we continue to prioritise the coding of patient deaths to ensure that they are coded correctly as palliative care.

2.20 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:-

		Groin hernia	Hip replacement	Knee replacement
Year	Level	Average health gain	Average health gain	Average health gain
2018/2019	Trust	*	0.500	0.324
2018/2019	England	*	0.456	0.336
2017/2018	Trust	0.019	0.341	0.312
2017/2018	England	0.089	0.488	0.345

2016/2017	Trust	0.036	0.455	0.370
2016/2017	England	0.086	0.444	0.324

*2019/2020 and Groin hernia information for 2018/19 data not available at the time of reporting.

https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/patient-reported-outcome-measures-proms

Warrington and Halton Teaching 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 Teaching 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.

2.21 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
2019/20	*	*	*	*

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

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

DATE PERIOD	TRUST	ENGLAND	HIGHEST	LOWEST
2019/20	*	*	*	*

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

Warrington and Halton Teaching 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 Teaching 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.

2.22 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	ACUTE TRUSTS
2019*	65.2%	70.5%
2018	60.7%	71.2%
2017	59.5%	70.6%

http://www.nhsstaffsurveyresults.com/wp-content/uploads/2020/02/NHS_staff_survey_2019_RWW_full.pdf

* The precise wording of the question is '*If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation'*.

Warrington and Halton Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reason, in that this report presents the findings of the 2019 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 51% response rate compared to the Acute Trust Average of 44%. This represents 1,990 staff responding to this survey.

Warrington and Halton Teaching Hospitals NHS Foundation Trust has a number of work streams in place to improve this score, evidenced by the year on year improvement from 2015 onwards. The Trust embrace staff-led change through the 'Be the Change' Team, supporting our workforce to identify and deliver improvements for our patients. The Trust's Quality Academy also supports our workforce to utilise Quality Improvement methodology to implement change.

2.23 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	Q1	Q2	Q3	Q4
2019/2020	90.45%	90.38%	90.60%	*
2018/2019	95.76%	95.02%	95.03%	95.58%

2017/2018	95.18%	95.88%	95.24%	95.62%

* https://improvement.nhs.uk/resources/venous-thromboembolism-vte-risk-assessment-201920/
Quarter 4 data was unpublished at the time of writing this report.

Warrington and Halton Teaching Hospitals NHS Foundation Trust considers that this percentage 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 Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services through focusses work with clinical teams to improve compliance with the VTE electronic risk assessment processes in operation. The Trust has aligned the VTE audit process with the GIRFT framework for further oversight on quality.

2.24 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 Teaching Hospitals NHS Trust Clostridium difficile infections per 100,000 bed days

DATE	TRUST	ENGLAND
2018/2019	65	**
2017/2018	55	13299
2016/2017	65	12847

https://www.gov.uk/government/statistics/clostridium-difficile-infection-annual-data
**England average not available at the time of preparing this report

The Warrington and Halton Teaching 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 Teaching 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
- Participation in the national Anti-Microbial Resistance CQUIN for lower urinary tract infections in older people and antibiotic prophylaxis in colorectal surgery
- 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
- Director of Infection Prevention and Control challenge for antibiotic prescribing non-compliant with Trust Formulary
- 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

- 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
- An Infection Control Operational Group has been set up to monitor and direct improvements in standards of cleanliness
- Action plan in place to reduce MRSA and MSSA bacteraemia cases
- 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
- Gram Negative Bloodstream Infection (GNBSI) reduction Group has been set up and there is an action plan in place with a focus on reducing use of urinary catheters, patient hydration and patient hand hygiene
- Member of the AQuA programme for Action on AMR

2.25 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 2019 – September 2019	48.69	4272	48.5	26.3	103.8
Oct 2018 – Mar 2019	44.68	3964	44.5	16.9	95.94
April 2018 – September 2018	41.6	3833	42.4	13.1	107.4
Oct 2017 – Mar 2018	38.78	3764	42.55	24.19	124
April 2017 – September 2017	41.07	3619	42.84	23.47	111.69

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 2019 – September 2019	0.44% (19)	0.3% (Non-specialist acutes only)	0% (0)	1.6 (58)
Severe Harm and Death Oct 2018 – Mar 2019	0.45% (18)	0.3% (Non-specialist acutes only)	0.009% (1)	1.8 (42)
Severe Harm and Death April 2018 – September 2018	0.73% (28)	0.3% (Non-specialist acutes only)	0% (0)	1.2 (48)
Severe Harm and Death Oct 2017 – Mar 2018	0.37% (14)	0.3% (Non-specialist acutes only)	0% (0)	1.55% (99)
Severe Harm and Death April 2017 – September 2017	0.64% (23)	0.4% (Non-specialist acutes only)	0% (0)	1.98% (121)

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

- The *'Reporting to Improve'* campaign continued 2019-20 which actively encouraged incident reporting by any member of staff at any time and to promote an open and honest culture.
- Continued investigations to the appropriate level dependent upon the severity of the clinical incidents reported.
- Continued training for staff to use the Trust online reporting system, Datix.
- Continued support for senior staff with Risk training to assist them when reviewing incidents for their area.
- Improved monitoring of actions from incidents to ensure that they are completed in time in order to improve care for patients and staff.

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

- Quarterly Governance Reports, including the Learning from Experience Report
- Trust wide safety alerts and notifications
- Safety briefings in clinical areas

- Amendments to policy
- Annual Safety Summits
- Daily Safety Huddles
- Trust wide Safety brief
- Monthly CBU and Specialty Governance Meetings
- Weekly CBU Governance Review Meetings between CBU Managers and CBU Governance Managers

2.26 Freedom to Speak Up (FTSU)

“We consider FTSU in everything we do, all staff will know how to speak up and feel safe doing it. We will become outstanding by listening and learning from our staff.”

The Trust has a named Executive Lead, Non-Executive Lead and a Freedom to Speak up Guardian. In addition, there are over 30 FTSU Champions across the Trust with as many different backgrounds and professions as possible represented. Staff across the Trust can speak up directly to the Guardian or a Champion; they can phone, email or write to FTSU team. If details are shared a member of the FTSU team will get in touch with the person raising the issue and offer a face to face meeting or a chat on the phone. FTSU highlight the purpose of the role and advise on what they can do next, the person raising the issue is then supported by FTSU in whatever action they decide to take. The individual can remain anonymous if they wish and we discuss if this is possible and the impact.

The Trust FTSU team completed quarterly national return on activity and reports to the Trust Board twice a year and Committee quarterly.

The Trust has a FTSU policy which is in line with the national policy stating "If you raise a genuine concern (i.e. held in reasonable belief) under this policy, you will not be at risk of losing your job or suffering any form of reprisal as a result. We will not tolerate the harassment or victimisation of anyone raising a concern. Nor will we tolerate any attempt to bully you into not raising any such concern; in fact any such attempt would warrant you raising a concern. Any such behaviour is a breach of our values as an organisation and, if upheld following investigation, could result in disciplinary action for the person(s) involved. We hope you will feel comfortable raising your concern openly, but we also appreciate that you may want to raise it confidentially. This means that while you are willing for your identity to be known to the person you report your concern to, you do not want anyone else to know your identity. Therefore, we will keep your identity confidential, if that is what you want, unless required to disclose it by law (for example, by the police or if it is require to be disclosed for the purposes of subsequent disciplinary action). You can choose to raise your concern anonymously, but that may make it more difficult for us to investigate thoroughly and give you feedback on the outcome."

Freedom to Speak up links to the QPS aims and objectives of the Trust and the activities of the FTSU Team are reported twice a year to the Board and Quarterly to the Quality Committee and Strategic People Committee. The number of disclosures are benchmarked against similar Trusts and national guidance is reviewed and implemented. The Trust undertakes the toolkits provided by the national office.

2.27 Seven Day Hospital Services (7DS)

NHS England and NHSI changed their methodology for assessing compliance with the Seven Day Services priority clinical standards which has allowed the Trust to focus on Clinical Standard 2 (CS2) to ensure it meets the target of 90% of patients having a review by a Consultant within 14 hours of admission by March 2020.

The other three clinical standards have been actioned and maintained over the past two years therefore our improvement focus can be placed upon Clinical Standard 2. Additionally, from April 2019, the Trust made the delivery of an improvement in Standard 2 of the 7 Day Services, which is Time to First Consultant Review, in Paediatrics and General Surgery a quality priority.

Clinical Standard 2 was audited on a quarterly basis during 2019 and 2020, with the data and improvement work focusing upon Paediatrics and General Surgery. Rather than using random samples we used full admissions to both specialities during the audited week as the numbers would have been too small to have provided an accurate result that was representative of the performance against the standard.

Paediatrics

Paediatrics achieved the required 90% compliance with the standard during the Quarter 3 audit. The specialty's compliance results during Quarter 1 through to Quarter 3 showed steady progress and the actions they implemented have proven responsive. As they had achieved compliance with the standard by Quarter 3, the focus of work for Quarter 4 was on supporting General Surgery to meet the standard. In order to test sustainability with the compliance achieved, a further audit for Clinical Standard 2 will be implemented during 2020/21.

General Surgery

General Surgery achieved the required 92% compliance with the standard during the Quarter 4 audit. The specialty's compliance results during Quarter 1 through to Quarter 4 showed steady progress and the actions they implemented have proven responsive. In order to test sustainability with the compliance achieved, a further audit for Clinical Standard 2 will be implemented during 2020/21.

Quality Report Part 3 - Trust Overview of Quality

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.

Pictured above is an illustration of our Quality Strategy for 2018/21.

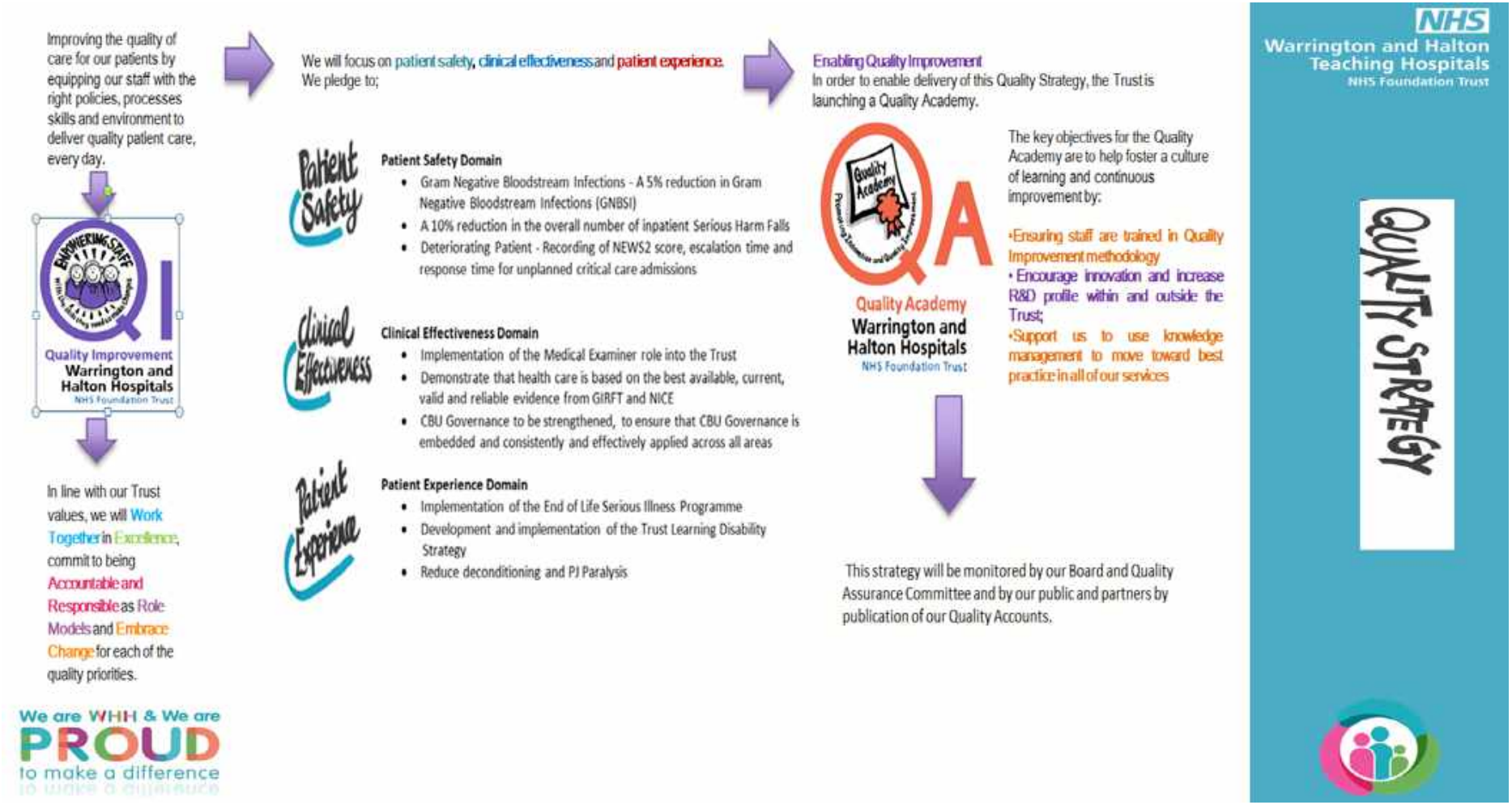
3.1 Introduction - Patient Safety, Clinical Effectiveness & Patient Experience

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 vision is that we will be the change we want to see in the world of health and social care.

To support our overall aim we have developed a Quality Strategy to ensure that all staff who work in our hospitals strive for excellence in all that they do and believe that the focus of the organisation is on providing safe care, which is responsive, caring and effective in terms of providing good outcomes for our patients.

The Quality strategy has been developed based first and foremost to ensure patients are safe in our care; secondly, to provide patients with the best possible clinical outcomes for their individual circumstances; and thirdly, to deliver an experience of hospital care which is as good as it possibly can be. With the above care model in mind we use the following three priority domains:

3.2 Quality Strategy on a page



3.3 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 o der 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.

3.4 Quality Dashboard 2019/20

The clinical indicators in the Quality Dashboard have been reviewed in line with the revised requirements for 2019/20 in relation to the:-

- CQUINs – National
- NHSI 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 improvements are maintained.

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

3.5 Quality Indicators – rationale for inclusion

The following section provides an overview of the quality of care offered by the Trust based on performance in 2019/20 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 available comparative and benchmarked 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.

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.

The quality indicators for 2019/20 can be seen below and have been reported in section 2 of this report:

Patient Safety

- Hospital Acquired Pressure Ulcers
- Gram Negative Bloodstream Infections (GNBSI)
- Serious Harm Falls

Clinical Effectiveness

- 7 day service standards
- National Quality Improvement Collaborative
- Work with the Innovation Agency

Patient Experience

- Patient and Public Involvement Strategy
- Responsiveness to complaints
- Midwifery Led Unit

3.6 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 decision on complaints with regard to 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 progress of cases over the year within the Trust.

	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20
PHSO cases received	1	0	0	1	0	0	1	0	0	0	0	0
PHSO cases closed	1	1	1	2	0	0	1	0	1	0	0	0
Ongoing PHSO Cases at the end of 2019/20 = 5												

3.7 National Survey Results 2019 - National Inpatient Survey 2019 (published but under embargo, date to be confirmed)

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 2019 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 (2019) were received in March 2020.

The survey included a sample size of 1250 consecutively discharged inpatients, working back from the last day of July 2018. The final response sample was 1194 due to changes in respondent's circumstances such as not known at address or deceased. The target response rate is 60%; Trust response rate was 40%, a reduction from 2018 response rate (41%).

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 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 examples of improvement for 2019 benchmarked against 2018 results using the suppressed standardised data provided by Quality Health:

The Trust has improved by 5% or more on the following questions: Results- *Higher is better*		
	2017	**2018**
If you brought your own medication with you to hospital, were you able to take it when you needed to? Yes, always	50%	55%
Did you have confidence and trust in any other clinical staff treating you (e.g. physiotherapists, speech therapists, psychologists)? Yes, always	73%	78%
Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you? Yes, often	11%	6%
Did you feel well looked after by the non-clinical hospital staff (e.g. cleaners, porters, catering staff)? Yes, always	82%	87%

A high majority of scores for Warrington and Halton Teaching Hospitals NHS Foundation Trust are in the intermediate 60% range of Trusts surveyed by Quality Health. Warrington and Halton Teaching 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.

Areas of focus for improvement have been recommended as the hospital ward, where the highest concentrations of the scores in the bottom 20% were found. The Ward Accreditation Scheme within the Trust will help to improve this rating as the aim is to engage staff and empower leadership to ensure we deliver the highest standards of healthcare for our patients.

The National Inpatient Survey key themes had been reviewed in full and have been scrutinised. There has been significant work undertaken by the CBUs, with the implementation of the five work streams of the Patient Experience strategy, led by Lead Nurses and Allied Health Professionals, who provide monthly updates to the Patient Experience Sub Committee. Warrington and Halton Teaching Hospitals NHS Foundation Trust have taken the following actions in response to the personal needs of our patients;

- Communicating effectively with patients is key; Work on the Accessible Information Standard (AIS) has progressed at pace, in the latter part of 2019, and continues in 2020 and beyond, which should result in a more positive experience for the people who use our services
- Consideration of how discharge planning can be improved, resulting in patients spending less time waiting for tests (and results), medical and therapy reviews.
- An NHSE/I collaborative called 'Personalised Care', has commenced, led by therapy staff. This will help to support effective discharge planning discussions at the point of admission, ensuring that any plans are patient centred.
- The Nutritional Care strategy was launched in Dec 2019 and associated work streams aimed at improving patients' experience of food and drink provision. Improved choices and quality should positively influence the scores in the 2020 national survey results. Assurances are in place to monitor the results of patient food questionnaires via the Nutritional Steering group and the Patient Experience Subcommittee meetings.

3.9 Friends and Family

The NHS Friends and Family Test is an opportunity for patients to leave feedback on the care and treatment that they received at Warrington and Halton NHS Foundation Trust. The feedback will be used to review our services from the patients' perspective and enable us to 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. This details 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 are 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 a rating which is reported through to the board of directors via the Quality Dashboard.

The Trust has in place an FFT contract in order to improve the process and increase the response rate e.g. text services.

Friends and Family scores 2018/2019 and 2019/20 are as follows:

*Suspended internally due to COVID-19, no data.

	Inpatient 2018/19	Inpatient 2019/20	A&E 2018/19	A&E 2019/20
Apr	94%	95%	85%	82%
May	94%	96%	86%	84%
Jun	95%	96%	83%	82%
Jul	95%	94%	84%	82%
Aug	97%	95%	86%	83%
Sept	96%	96%	81%	78%
Oct	94%	95%	81%	78%
Nov	94%	96%	78%	77%
Dec	96%	96%	81%	78%
Jan	94%	95%	76%	81%
Feb	94%	95%	77%	81%
Mar	96%	*	80%	*

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

3.10 Duty of Candour

The Patient Safety Manager conducted an audit of duty of candour in 2019. The statutory duty of candour process is monitored by the Clinical Governance team and the letters are included on the Trust risk management system (Datix) against the incident being investigated. The standard of the letters was identified for improvement and the Governance Managers have done extensive work

with the CBUs and the standard of letters has improved. The identified family liaison officer for each new concise or serious incident is also included in the duty of candour process to make contact with the families.

The Trust monitors duty of candour at the weekly Serious Incident meeting held by the Clinical Governance team. Compliance with Duty of Candour is also reviewed at the weekly Executive Meeting of Harm chaired by the Chief Nurse and continues to be reported monthly to the Patient Safety & Clinical Effectiveness Sub-Committee.

For each new serious incident (SI) investigation, a patient or family liaison officer continues to be appointed to provide support and advice. A 1 day programme of training for senior clinical staff related to investigation training is in place within the Trust and this includes a bespoke session on the role of the patient/ family liaison officer role. The Trust has also developed further training for duty of candour, this is completed as a live session and there is also e-learning on ESR.

3.11 Staff Survey Indicators

The most updated results from the 2019 NHS Staff Opinion Survey results for the themes of Equality, Diversity and Inclusion and Safety Environment – Bullying and harassment are as follows:-

Equality, Diversity and Inclusion

The trust scored 9.4 for this theme overall which is a best score nationally, comparing to the Acute Trust average of 9.0.

For question 14- Does your organisation act fairly with regards to career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age the Trust scored 90.1% compared to the Acute Trust average of 84.4%. This was an improvement from the 2018 score.

Safe Environment – Bullying and Harassment

The Trust scored 8.4 for this theme overall, compared to the Acute Trust average of 7.9.

For question 13b – In the past 12 months how many times have you personally experienced bullying, harassment or abuse at work from managers? The Trust scored 9.4% which is an improvement on the 2017 score of 10.2% and lower than the Acute Trust average of 13.1%.

For question 13c – In the past 12 months how many times have you personally experienced bullying, harassment or abuse at work from other colleagues? The Trust scored 14.9% which is a slight increase on the 2018 score but is still lower than the Acute Trust average of 20.3%.

3.12 Quality Academy

The Quality Academy underpins the Trust Quality Strategy and assists in the delivery of Quality Improvement across the Trust.

Objectives

Key priorities for the Quality Academy are:

- **Part of an enabling arm to deliver the Clinical and Quality Strategies.**
- **Help you to implement innovative ideas.**
- **Training in QI Methodology.**
- **Ensuring QI work is linked in with our quality priorities for the service/Trust to stop duplication and silo-working.**
- **Encourage innovation and increase R&D profile within and outside the Trust – maximising opportunities for patients to take part in research.**
- **Support to move toward best practice – benchmarking ourselves against best in class – therefore using knowledge management.**

Quality Academy
Warrington and Halton Hospitals
NHS Foundation Trust

Quality Improvement & Training

We are using Quality Improvement Methodology to deliver Quality Improvement within the Trust.

There will also be a training programme developed within the Trust based on the model shown, whereby there will be differing levels of Quality Improvement training given to individuals within the Trust. All staff will receive Foundation level training.

Engagement

Key to ensuring that we are addressing the right issues with regard to the service we provide is to actively seek, listen and act on feedback received from our patients, the public, our staff and groups such as Governors, HealthWatch and Health Scrutiny Committees.

The Quality Academy work being undertaken with the Patient Experience and patient involvement agenda to ensure that the patient voice is integral to Quality Improvement.

The Quality Academy also works with Workforce & Organisational Development, to ensure that staff engage in the agenda and are empowered and supported to make improvements in their work.

Quality Academy Summit

The Trust held its inaugural Quality Academy Summit in June 2019 to present the latest innovation, best practice, improvement and research. This was hosted by the Innovation Agency and a variety of external speakers were invited. This provided staff with the opportunity to discuss the latest technology and innovations relating to the five themes this year: Frailty, integrated care, Diabetes, Virtual Clinics and the adoption of innovation. The event was unique opportunities to see the art of the possible, and deliver care in different ways provide the best, or better outcomes for our patients. A diverse range of breakout sessions giving staff an opportunity to develop and enhance skills within clinical audit, quality improvement and statistics.

Quality Improvement Collaboratives

Falls Collaborative

The Falls Collaborative entered Phase 3 in January 2020 with the addition of wards A2, A6, B3, B12, B14, and B18. Phase 2 wards are still part of this collaborative and continue to refine and embed their successful tests of change and share across the Innovation wards. They continue to test new ideas using PDSA cycles. **Table 1** below shows an SPC chart for Trust-wide Falls reported on a monthly basis between April 2017 to January 2020 demonstrating a positive performance in the reduction of inpatient falls with a 14.29% reduction in 2019/2020 YTD compared with the same reporting period 2018/2019. The reduced Trust mean has been maintained for a 15 month period.

Table 1: Trust wide Inpatient Falls - April 2017-January 2020

Innovation wards have demonstrated a reduction of 10% for falls between May 2019 to Jan 2020 (141) in comparison with the same period in 2018 (156). We have excluded Jan - March 2018 to enable a true comparison. As the collaborative moves forwards these datasets will be included and as such, the percentage reduction reported will be subject to change.

Pressure Ulcer Collaborative

The Pressure Ulcer Collaborative entered Phase 3 in January 2020 with the addition of wards ACCU, A6, B14, B18, C21 and ITU. It is important to note that the initial innovation wards from Phase 2 are still a part of the collaborative. The below SPC chart shows Trust-wide pressure ulcers and DTIs that have been reported on a monthly basis between April 2017 to January 2020. The median number of pressure ulcers and DTIs (Deep Tissue Injuries) between January 2018 and December 2018 was **4**, in comparison to a median of **5.5** between January 2019 and Dec 2019.

Both Table 2 and Table 3 show a pattern of an increase in pressure ulcers (including DTIs) in the months of April to May year upon year.

Table 2: Trust wide monthly pressure ulcers and DTIs – April 2017-January 2020

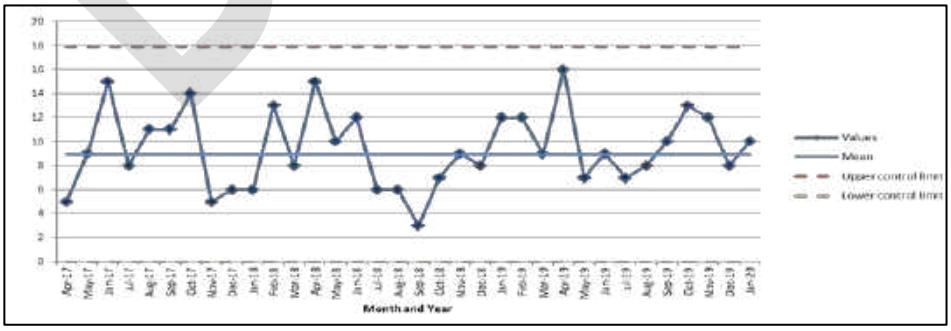
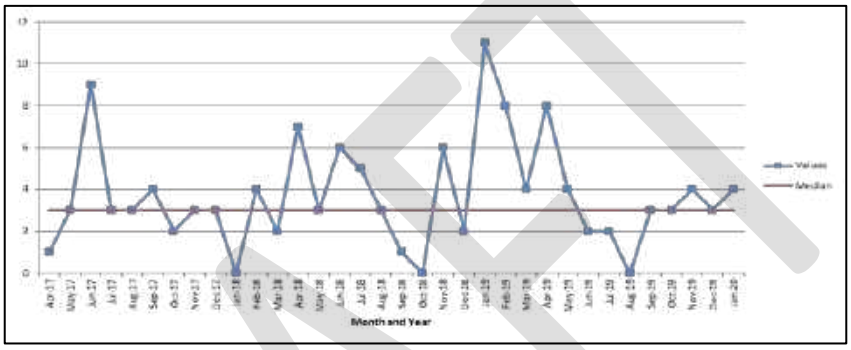


Table 3 shows the six Innovation wards data from Phase 2 between April 2017 and January 2020. The collaborative started in April 2019 and as you can see from the below run chart there was a decrease in the number of pressure ulcers and DTIs reported until September 2019 when 3 were reported. Since then, there have been between 3 and 4 (median) reported which would suggest that the interventions being tested on the wards have contributed to reducing some of the variation that was noted before. It is important to note that there are only four data points and further data is required to provide firmer conclusions.

Table 3: Innovation Ward Monthly Pressure Ulcers and DTIs – April 2017-January 2020



Innovation wards have demonstrated a reduction of 32% for pressure ulcers (including DTIs) from May 2019 to Jan 2020 (25) in comparison with the same period in 2018 (37). We have excluded Jan - March 2018 to enable a true comparison. As the collaborative moves forward these datasets will be included and as such, the percentage reduction reported will be subject to change.

Research & Development

The Quality Academy Research & Development team developed the year 2 delivery plan of the Quality Academy strategy, describing the specialities where the Trust are going to increase its portfolio and commercial research studies. It described how the team will promote research activity in the Trust to increase participation in research both by patients and increasing the number of principal investigators, with particular focus on Nurse-led and AHP-led research studies. A new portfolio study was set up in Cardiology called Orion-4.

The study has inclusion/exclusion criteria that could potentially provide us with a large number of patients to recruit which means it will have a positive impact upon our overall figure for High Level Objective 1 which is to *Increase the number of participants recruited into the National Institute for Health Research Clinical Research (NIHR CRN) Portfolio studies*.

3.13 Local Quality Initiatives

Improving quality provides an opportunity to deliver better outcomes. There are many examples at Warrington and Halton Teaching Hospitals NHS Foundation Trust that show that even relatively small-scale quality improvement initiatives can lead to significant benefits for patients and staff. The section below details some of the positive work that we have achieved in 2019/20.

North West Coast Research and Innovation Awards

Our Quality Academy Research & Development team were runners up for the "Excellence in Commercial Life Sciences Research" award as part of the North West Coast Research and Innovation awards for their work in developing a commercial relationship with the life sciences industry to promote research and provide new treatment options to benefit local patients.

New Patient and Public Participation and Involvement Strategy!

We believe that fostering good relations and maintaining on-going dialogue with our patients, the public and other stakeholders is essential to the quality of care that we give to our patients, the experiences of our staff and sustainability of our services.

We recognise that our patient and public participation and involvement strategy needs to constantly evolve to keep pace with population changes and advances in technology. We aim to continuously learn from and share our experience of participation, to maximise its impact.

We acknowledge that different levels of involvement will be appropriate in different circumstances and that an appropriate and proportionate approach will be required accordingly. As well as involving patients and public in service redesign and experience we also wish to draw potential future Governors from these populations to represent geographical constituencies where service users, or those passionate about local services, may join the Foundation Trust as 'Members'.

We know that we must provide clear and accessible information to patients and the public in a variety of ways to suit their different needs, and to make arrangements as necessary to facilitate their involvement in our work.

We are committed to both asking people how they want to be involved and to provide feedback on their contribution and how it has informed our service development or transformation.

Experience of Care Week 2019

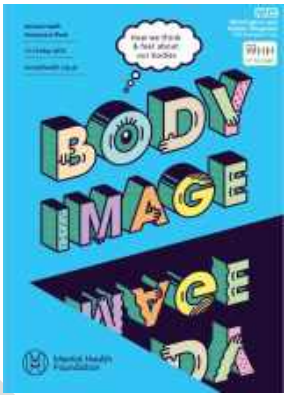
We are committed to achieving our mission together with our patients (our experts by experience), their carers and families; our staff and volunteers, our partners and members of the public - in fact everyone who uses or works within our services or may do so in the future.

With the above in mind we celebrated the national Experience of Care week with a key part being a 'behind the scenes' event at the Cheshire and Merseyside Treatment Centre at our Halton site.

The event was an opportunity for our local communities to meet the teams and see how they work at our prestigious orthopaedic centre.

Mental Health Foundation's Body Image Challenge

In 2019 we worked with the Mental Health Foundation in relation to Body Image.



Having body image concerns can be a risk factor for mental health problems. Research has found that higher body dissatisfaction is associated with a poorer quality of life and psychological distress, a higher likelihood of depression symptoms and the risk of unhealthy eating behaviours and eating disorders. Conversely, body satisfaction and appreciation have been linked to better overall wellbeing and less unhealthy dieting behaviours.

We asked our staff and local communities to support the Body Image challenge by posting on social media a picture of a time or a place when they felt comfortable in their own skin – this could be now, five years ago or at the age of five. Using the hash tags **#BeBodyKind** and **#MentalHealthAwarenessWeek** we published these pictures on our Facebook and Twitter accounts to show our support for this initiative.

Domestic Abuse Pathway and Training

Domestic Abuse Awareness Training has been further developed in conjunction with Halton Domestic Abuse Forum, Co-ordinated Action against Domestic Abuse (CAADA), Warrington Domestic Abuse Partnership, Refuge and Independent Domestic Violence Advocates.

This improved training provides staff with more information in relation to the legal definition of domestic abuse, gives them an understanding of the dynamics of domestic abuse, recognising the signs that a patient has been abused, their role and duty of care and the role of the Independent Domestic Violence Advocates.

This collaborative piece of work will educate our staff and also help to keep our patients safe.

Celebrating 10 years of our Intermediate Care Unit

Our Intermediate Care Unit celebrated its 10th anniversary in 2019 and celebrated with the help of the Mayor of Halton, Cllr Margaret Horabin and the Trust's Chairman Steve McGuirk. The unit was created in 2009 and allows frailer and more medically comprised patients to access the Intermediate Care services provided by Halton Borough Council.

Celebrating 1 years of our Gynaecology Assessment Unit

A unit which aims to help women facing pregnancy loss has treated more than 3,500 women in its first year.

The Gynaecology Assessment Unit at Warrington Hospital celebrated its first birthday in 2019 following an extremely successful year caring for and treating women.

The unit is a specialist service for women with gynaecology emergencies and was opened to help ease pressures in A&E and offer women a more private and relaxed environment in particularly distressing times. Some 3,650 patients, which on average is 70 a week, have been treated in the past year, with the unit receiving 100 per cent positive feedback from patients.

The unit predominately looks after patients with early pregnancy complications and patients experiencing abdominal and pelvic pain or gynaecological problems and has helped women avoid waiting in A&E. The service is able to manage some conditions on an outpatient basis, rather than keep the patient in for treatment. GAU is provided by consultant gynaecologists and obstetricians, specialist nurses and vital support from the team on C20. The aim of the service is to provide efficient, specialist, compassionate care, within the women's health care unit. Patients can be referred direct from their GP, midwife or if they do come to A&E or urgent care centre. It has streamlined effective care and been responsive to women's needs. Women will be seen by a nurse within 30 minutes and the doctor within a maximum of two to three hours.

Emergency Department – winners of the Warrington Guardian Customer Care Award 2019

Many readers contacted the Warrington Guardian to tell them how much they admired the staff working in the Emergency Department and how they 'somehow managed to remain polite and pleasant with patients despite their huge workload'.

One nomination added: "This team is caring passionate and dedicated."

"They work so hard and as we all know the NHS has been very challenging of late and winter has been extremely hard but this team are always there to care for you and your loved ones every single day."

"I am so impressed by the team's resilience and teamwork and never knowing what they are going to face on a daily basis."

Health Service Journal Patient Safety Awards – Finalists in 2 categories

The Trust were finalists for the following 2 of the 22 HSJ Patient Safety Ward Categories;

- **Best Partnership Solution Improving Patient Safety - Improving services for people with mental health needs who present to A&E**
- **Changing Culture Award - Trust Wide Safety Huddle**

The HSJ bureau chief for quality and patient safety Shaun Lintern said: "*All finalist projects selected by our independent judges are making a real difference, representing the vanguard of efforts in all healthcare settings to continuously improve and seek better outcomes*."

WHH Charity raised £100k for pirate-themed outdoor play area on Children's Ward

A pirate-themed outdoor play area on Warrington Hospital's children's ward was formally opened by the Mayor of Warrington Cllr Wendy Johnson – the culmination of two year's intensive fundraising by the hospital charity and its supporters.

WHH Charity launched the *Making Waves* campaign to fund the new bright, colourful and safe space for young patients and their families to enjoy while in hospital and the children were encouraged to draw pictures of their chosen playground theme during their stay.

The fundraising campaign has been supported by foundations, companies, local community, individuals and by hospital staff and included everything from cake bakes to marathon runs to roller skating to abseiling down the hospital's post graduate centre.

Of special note young twins Reuben and Elena Evans-Guillen captured the hearts of the region with their determination to run 100km in 2018 to raise £500 with their 'Running4DrOzzy' campaign. They blew this target away with more than £15K raised to date and in the process were recognised for their achievement with the Young British Citizen's Award at a special ceremony at Westminster.

A very generous grant of £16K from the D M Thomas Foundation (Hilton in the Community) was the final 'icing on the cake' which enabled the completion of the play area; without which the project would be a long way off completion. Corporate support came from Assura and Sellafield Ltd and in the community young Brodie Carr, the Hope Academy ambassadors and Sacred Heart Primary School choir all worked to support the outdoor transformation; supported by many, many community groups and many members of the public who all jumped aboard to support.

Helen Higginson, Head of Fundraising for WHH Charity said,
"*We are so proud to have been part of this incredible journey – working alongside so many passionate and committed staff, companies and individuals is truly an honour. We are so grateful to everyone who has contributed to making our children's dream a reality*."

RoSPA Gold Award for health and safety

The Trust achieved a Gold Award in the internationally-renowned Royal Society for the Prevention of Accidents (RoSPA) Health and Safety Awards, the longest-running industry awards scheme in the UK.

The RoSPA Awards scheme, which receives entries from organisations around the world, recognises achievement in health and safety management systems, including practices such as leadership and workforce involvement.

It's a triple win for our incredible Intensive Care Unit Team!

The team celebrated their **10th Birthday**. Whilst celebrating they had a surprise visit from some of our Executive Team who presented them with the **Trust's first GOLD Ward Accreditation** certificate. The same week the Trust's new CQC status was released where ICU were rated as **OUTSTANDING**!

#Integrated Care - Welcome NHS Improvement

The Trust welcomed NHS Improvement's North West Director Bill McCarthy to the Trust.

The visit included a tour of the Frailty Unit to see integrated care in action – where he heard from staff about the circa 20 bed days per month that are saved by treating frail patients holistically in the unit.

Ward Round Accreditation

Ward Round Accreditation took place in September 2019 to assess methodology for the first time. Medical ward rounds have long been considered the centrepiece of inpatient care. They provide an opportunity for high quality, safe, multidisciplinary patient review while facilitating shared decision making, patient flow and important educational input. Variation in ward round structure is inevitable and there is always a fine line between balancing service needs and providing education.

Accreditation of clinical departments and processes is increasingly being utilised in standardising best practice in clinical care. The Trust is developing an accreditation process at Warrington Hospital with the aim of providing a framework for a consistent yet flexible, efficient and effective multidisciplinary, patient and education focused medical ward round.

This project has engaged multiple stakeholders to demonstrate that there is currently considerable variation in medical ward rounds undertaken across the trust and that standardisation with the implementation of set metrics provide improved patient care, flow and enhanced junior doctor educational experience. The Trust aim to roll out implementation of an accreditation system to allow us to demonstrate improvements in compliance with Royal College of Physicians and Royal College of Nursing guidance; thus providing a systematic, consistent, multidisciplinary, education-filled medical ward round for all.

Butterfly Bereavement Suite

Warrington Hospital's maternity bereavement suite, The Butterfly Suite has had a full refurbishment courtesy of one of our local charities Harry & Co, Golden Square Shopping Centre, Warrington, Assura plc. and Sellafield Ltd. This means that we now have two dedicated bereavement suites with en-suite facilities and a contained kitchen area. To provide families with homely and bespoke accommodation this offers comfort and privacy at the most difficult time of their lives.

The Butterfly Suite is part of our bereavement service, which was singled out in our recent CQC inspection for outstanding practice, '*the bereavement service had won an award in 2018 for the best hospital bereavement service. There were two en-suite rooms with cuddle cots available. The specialist bereavement midwife was very responsive to individual needs from early losses to term babies*.'

The suite was officially opened by the Bishop of Warrington and the Right Reverend Beverley.

Harry & Co have supported the Trust in developing their bereavement facilities for families after the loss of their child, Harry, who was stillborn in 2010. The original Butterfly Suite was made possible by the charity.

WHH strategy team launched the first cohort of strategy ambassadors Strategy Ambassadors

In August 2019 the WHH strategy team launched the first cohort of strategy ambassadors. The strategy ambassador role is open to all staff members from every area of our organisation. Strategy ambassadors will actively disseminate relevant information regarding proposed strategic planning within the organisation to their staff group/working area. In addition, the ambassador will gather feedback from staff relating these strategic developments and relay the feedback to the strategy team.

Congratulations to our HR team on a double win at the Healthcare People Management Association (HPMA) Awards!

Well done to Georgia Stokes, HR Business Partner, who was awarded the National Healthcare People Management Association (HPMA) Rising Star Award, truly deserved.

Also a great achievement for Carl Roberts, Head of Workforce Transformation and Debs Smith, Deputy Director of Human Resources and Organisational Development who won the National Analytics Award.

Congratulations to Maternity Team on a double nomination at the Northern Maternity & Midwifery Festival Awards

Midwives from across the North of England were honoured at the second annual Northern Maternity & Midwifery Festival Awards. The Awards ceremony took place at Old Trafford Football Stadium in Manchester in June 2019. The Festival was attended by more than 400 midwives, doulas and healthcare professionals with many hundreds more watching the live stream of the event online with viewing parties taking place throughout the country.

NORTHERN 2019 MATERNITY & MIDWIFERY FESTIVAL AWARDS

The awards were presented by Conference chair and Midwifery Consultant, Sue Macdonald alongside Dr Yana Richens OBE.

The Trust was highly commended in two areas;

- **The Northern MMF Management Award** recognises an individual who has played a regional, professional or national role above and beyond their day job. The Maternity Management Team at Warrington and Halton Teaching Hospitals Trust, led by Dr Tracey Cooper MBE, has turned their service around in the last two years to create a truly woman and family centred service and were highly commended in this category.
- **The Northern MMF Achievement Award** recognises an individual for a lifetime of service and impact who has made a difference and inspired others. Jonathan Cliffe, midwife received was highly commended for his Midwifery Achievement in breaking down stereotypes and his outstanding contribution to maternity services.

Fair Train's Work Experience Quality Standard - Gold Standards Accreditation

Fair Train's Work Experience Quality Standard is a national accreditation which recognises organisations offering high-quality work experience opportunities for the benefit of all, with the highest possible quality of inputs and outputs and exemplary risk management. The Standard also acts as a framework for development to help organisations to plan, run and evaluate high-quality work experience programmes.

Below is a short summary of activities the Trust does which enabled us to achieve the Gold Standard Accreditation:

- Work Experience - offered to members of the public from aged 15 and upwards.
- Traineeships - a ten week placement for two days each week working in a variety of departments and we currently take a maximum of twelve candidates per year.
- Pre-Employment - a six week placement for two days each week in a variety of departments and we currently take twenty seven candidates per year.
- Supported Interns - we accommodate four candidates each year with each placement lasting up to six months.
- Apprenticeships - we offer a range of apprenticeships for new and existing staff, we currently have sixty eight apprentices of which sixteen are new members of staff.

- Apprentices complete a range of qualifications from level 2 to level 7.

Mouth Cancer Action Month

Mouth Cancer Action Month is an initiative run by the Oral Health Foundation, which takes place in November each year, and has done since 2009. It aims to raise awareness of the issues surrounding the condition and also the symptoms that people should look for.

For our part, the Trust's dedicated Maxillofacial Team offered free Mouth Cancer screening for our local community. No appointment was necessary; they simply presented at the department, located in the Appleton Wing of Warrington Hospital, to make use of this free service. The team supported people to learn more about mouth cancer and the signs and symptoms.

Nursing Times Rising Star Award Winner - Sharon Worgan

Some nurses stand out from the moment they enter the profession. They are natural leaders whose motivation is to constantly improve the quality of their own practice and of the services they work in. Their caring natures ensure they will not only offer compassionate care themselves, but will demand it of those around them and raise concerns if it falls short. They have the capacity to develop essential nursing skills quickly, the creativity to innovate and reshape services, and the ability to engage and motivate those around them. Nurses like these will be a positive influence on the profession throughout their careers.

This award recognises a nurse working in the NHS or independent sector who has been qualified for less than five years, and demonstrates exceptional qualities that embody the best of nursing and the leadership skills to inspire others to

follow their example. The Trust is proud to have one of our nurses recognised as a national rising star.

Radiographer of the Year North West

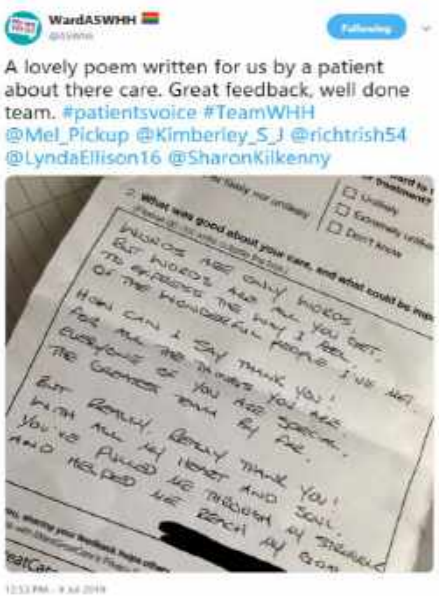
One of our Senior CT Radiographers Chris Grayson has been nominated for and won Radiographer of the Year North West.

Chris was nominated by one of his colleagues for being '*approachable, insightful and always willing to share his knowledge…as a friendly face to everyone in the department…a positive impact on the service provided to patients … passion and motivation which has helped team morale and had a positive all round impact*'

Chris attended the awards ceremony at the British Medical Institute on 6th Nov and was presented with his award by Gill Hodges (President of the Society of Radiographers) at the Radiography awards ceremony.

3.14 Patient Stories - In their own words….our patients share their experiences of our Trust

Poetic Praise for Ward A5



Feedback from George's family for the Emergency Department

'My son George who is severely autistic and has learning difficulties has been coming to the staff at hospital and the ambulance crews for 20 years plus. No matter how tired and busy they are they have always come and said hello give him a hug or wave and made him welcome and feel safe. The ambulance crews have also been amazing and given him a uniform. He helps make beds and put stretchers back on ambulances and also the security guys are also a credit to you they also always come say hello and make him feel so safe. The main reason I'm making the nomination is a few months ago my son feel in shower and split his head open and an ambulance was called and he knew the crew who made him feel so safe and treated him with so much patient and really took his condition in to consideration and got him calm they was awesome a credit to the NHS. Once on arrival one of the nurses seen him and took over got him a quiet corner as his autism affects him badly in busy places Rachael Howard and her team got him into a treatment room this would not of been possible if the staff hadn't been so good in past at always making him feel safe and reassuring which really paid off. The staff get a lot of bad press for not doing enough with kids and adults with disabilities; well I think they are awesome. They managed to glue his head and clean him up without any incidents as George can hit out when frightened or scared so they are a credit to you. Also when I was admitted 3 times for Gall stones the staff always found a quiet room so my son could see me every day and always chatted to him that was so important to me and words cannot thank all the staff.'

Feedback via Warrington Guardian for Ward A4

'I'm writing this letter because we, the general public, are usually quick to criticise but not so quick to praise.

My husband has never been in hospital before and I have to say that although our stay has led us on a heart-breaking, life-changing journey, from admission to discharge we were treated by everybody with the utmost kindness and consideration.

The ward manager Holly and her team of excellent nurses, who work extremely hard for 12 hour shifts, never failed to care for both my husband and me with kindness and compassion.

Ward A4 is certainly not the easiest ward to work on because of its specialised nature and the nurses did have a lot to put up with from some patients.

Throughout, they remained professional giving care to all patients with the same effort for all despite being unnecessarily criticised by some. The nurses could not do their jobs without the teamwork from the cleaners, porters', nursing assistants and everyone involved in the day to day maintenance of a busy ward.

Last but not least, the communication from several different teams of doctors was exceptional. Yes, they gave us news we would rather have not had but this was also done with kindness and empathy.

I am a qualified nurse of nearly 36 years and despite the lack of resources the nurses of today face, the basic nursing care is still there and I congratulate them for continuing to provide excellent care under very difficult circumstances.

So, thank you and well done 'Team A4' because you restored our faith in humanity.

3.15 Performance against key national priorities

Performance against the relevant indicators and performance thresholds.

Figures in red are not finalised

National Targets and Minimum Standards	Indicator	Target 2019/20	2019/20	2018/19
Infection Control	Number of clostridium difficile cases due to lapses in care	<= 27	14	4
	Number of MRSA blood stream infection cases	0	2	2
Cancer: 31 day wait from diagnosis to treatment	% of cancer patients waiting a maximum of 31 days from diagnosis to first definitive treatment	96%	98.77%	98.98%
Cancer: 31 day wait for second or susequent treatment	Anti cancer drugs	98%	100.00%	100.00%
	Surgery	94%	100.00%	100.00%
Cancer: 62 day wait for first treatment	From urgent GP referral (Reallocation position)	85%	85.50%	86.41%
	From the consultant screening service	90%	95.12%	97.46%
Cancer: 2 week wait from referral to date first seen	Urgent GP referral suspected cancer referrals	93%	94.21%	93.82%
	Symptomatic breast patients (cancer not initially suspected)	93%	94.80%	93.01%
Referral to Treatment within 18 weeks	Admitted patients with a clock stop		68.73%	80.01%
	Non-admitted patients with a clock stop		90.07%	90.83%
	Patients on an Incomplete pathway End of March position	92%	90.04%	92.45%
Access to A&E	Patients waiting a maximum of 4 hours in A&E from arrival to admission, transfer or discharge	95%	83.08%	85.11%
Access for patients with a learning disability	The Trust provides self-certification that it meets the requirements to provide access to healthcare for patients with a learning disability	N/A	YES	YES
Cancelled operations on the day for a non-clinical reason	Number of Cancellations not offered a date for readmission within 28 days	0	6	10
	Patients whose operations were cancelled by the hospital for non-clinical reasons on day of or after admission to hospital	<= 2%	0.47%	0.60%
	Patients whose operations were cancelled by the hospital for non-clinical reasons on day of or after admission to hospital, and were not readmitted within 28 days		7.26%	8.17%

3.16 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 patients with a maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.

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

Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.

Due to the COVID-19 global pandemic work on the auditing of the mandated and local indicators has been postponed for this financial year.

Annex 1: Quality Report Statements

Statements from Clinical Commissioning Groups, Healthwatch and Overview and Scrutiny Committees 2019/20

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

Statement from Warrington and Halton Clinical Commissioning Groups

From: CREED, Michelle (NHS HALTON CCG)
Sent: 10 June 2020 22:20
To: MCCAFFREY, Hayley (WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST); ALANI, Layla (WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST)
Cc: EVANS, Stacy (NHS HALTON CCG); TICKLE, Gill (NHS HALTON CCG)
Subject: RE: ANNUAL QUALITY ACCOUNT FOR COMMENT FROM WARRINGTON & HALTON TEACHING HOSPITALS NHS FT

Hi Layla

Apologies for the delay in getting back to you.

From Halton and Warrington CCG's:

Thanks you for sharing the draft 2019-20 Quality Account for WHHT. The Account is comprehensive and includes the NHSE/I additional requirements to include

- priority clinical standards for seven day hospital services
- details of ways in which staff can speak up (including how feedback is given to those who speak up), and how they ensure staff who do speak up do not suffer detriment.
- progress in bolstering staffing in their adult and older adult community mental health services, following additional investment from local CCGs' baseline funding

and furthermore the mandatory reporting requirements relating to 'Learning from Deaths' which came into force for 2017/18 quality accounts continue to apply to 2019/20 reporting and this was a welcome section. The CCG have noted during the clinical performance quality group meetings the positive action the Trust have taken in terms of learning from deaths, in terms of the methodology, process and governance in place and more importantly the positive change to service provision as a result of the findings.
The Patient and Public Involvement Strategy work during 2019-20 was a welcome addition and we would like to acknowledgement the achievement reached in the Trust being recognised in the outcome of being finalists for 2 of the 22 HSJ Patient Safety Ward Categories;

- Best Partnership Solution Improving Patient Safety - Improving services for people with mental health needs who present to A&E

- Changing Culture Award - Trust Wide Safety Huddle

The recognition of the workforce achievements is exemplary and is a clear indication of the cultural change and focus of the Trust over the past 2 years of creating an open, honest learning environment for staff to grow and develop into positive leaders of the future.

We look forward to working with you in 2020/21

Michelle

Many thanks for your email. When I don't send a reply saying thank you or if you have cc'd me into an email for information and I don't respond. It doesn't mean I am not grateful for your email, I am trying to be efficient and reduce our inboxes.

Michelle Creed

Chief Nurse

NHS Halton CCG

NHS Warrington CCG

Tel no: 01928 593575 M: 07823533992

Email: Michelle.Creed@nhs.net

PA Helen Riley

T: 01928 593575

E: Helen.Riley2@nhs.net

Statement from the Halton Health Policy Performance Board
Statement from Warrington Healthwatch

Thank you for your email.

Unfortunately this year Healthwatch Warrington will not be able to comment on your Quality Accounts with your stated deadline below. We have followed guidance from Healthwatch England. Health watch from Cheshire and Mersey have also declined due to current circumstances.

However, we have been informed that QAs may be delayed from other Trusts and shared with local Healthwatch on 15th October, for publication 15th December. If this is the case for WHH, we may be able to consider this working jointly with Healthwatch Halton.

Please could you confirm if your deadline is 5th June 2019?

Many thanks

Lydia Thompson

Healthwatch Warrington Manager

Healthwatch Warrington| The Gateway|Sankey Street| Warrington |WA1 1SR

Tel: 01925 246 893 | email: lydia.thompson@healthwatchwarrington.co.uk

Statement from Warrington Health and Well Being Overview and Scrutiny Committee

WARRINGTON
Borough Council

Steven Broomhead
Chief Executive

Members' Suite
West Annexe
Town Hall
Warrington
WA1 1UH

Warrington & Halton Teaching Hospitals NHS Foundation Trust Quality Accounts 2019/20

Date: 5 June 2020

Dear Ms Alani,

The members of the Warrington Borough Council Health Overview and Scrutiny Committee would like to thank Warrington and Halton Hospitals Foundation Trust for sharing their Annual Quality Account and for the opportunity to comment on the content.

The quality of patient care within the Trust and three priorities for improvement are identified and addressed; Patient Safety, Clinical Effectiveness and Patient Experience. These priorities, along with the quarterly monitoring, measuring and reporting are welcomed.

The Trust and all of its staff are commended for the work that resulted in the awarding of the CQC rating of 'good' overall for the Trust and for the 'outstanding' in the domain of caring in Critical Care in the past year.

The vision and plan for 'Moving to Outstanding' is welcomed. This vision is supported by a number of local quality initiatives including a work stream to promote staff-led change to deliver improvements in the quality of patient care. The innovative Patient and Public Participation and Involvement Strategy is a welcome development in engaging with patients, the public and other stakeholders to understand the patient experience, enable service redesign and to improve the quality of care.

The members of the Health Overview and Scrutiny Committee recognise the contribution that the Trust and all of its staff make to the health of the residents of Warrington, and also its role as part of the wider community. This role and the work of the wider NHS has been drawn into focus by recent events and the role that the Trust has played in caring for those requiring hospital care during the Covid-19 crisis - we thank you for this essential work and your ongoing commitment to improve the quality of patient care and look forward to working with you in the coming year.

Yours sincerely

Councillor P Wright
Chair of the Health Scrutiny Committee

Councillor P Warburton
Deputy Chair – Health Scrutiny Committee

www.warrington.gov.uk

Statement from the Halton Healthwatch
Statement from the Trust's Council of Governors

The Council of Governors welcomes the opportunity to comment on the Trust's Annual Quality Account for 2019/2020.

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 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 Governors have an observer at the Trusts Quality committee who reports to the CoG on the effectiveness of the NED in the role of Chair of the Trusts Quality committee.

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 Reducing Bloodstream infections, and overall number of inpatient falls. The Patient Experience Priority. Implementing the End of Life Serious Illness Programme and the Trust Learning Disability Strategy. Finally, Governors see the Clinical Effectiveness Priorities regarding, Implementation of the Medical Examiner role, being able to demonstrate that health care is based on the best available, current, valid and reliable evidence and strong CBU Governance is embedded and consistently applied across all areas as a key areas for delivery of a better all-round patient path through the hospital.

The Governors are happy that the 2019/20 Quality Report provides data that is more meaningful, understandable, and clearer to all, the report shows indicating trends, and comparisons with the previous year statistics. For the coming year the Governors will review the Quality Report quarterly at our Quality in Care Group thus being up to date through out the year.

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.

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 2019/20 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 2019 to date of signing this statement
    - Papers relating to Quality reported to the Board over the period April 2019 to date of signing this statement
    - Feedback from the Commissioners, Warrington Clinical Commissioning Group and Halton Clinical Commissioning Group dated XXXX
    - Feedback from Governors dated XXXX
    - Feedback from local Healthwatch organisations, Healthwatch Halton dated xxx and Healthwatch Warrington dated XXXX
    - Feedback from Overview and Scrutiny Committee dated XXXX
    - Feedback from Halton Borough Council dated XXXX
    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated XXXX
    - The 2019 national inpatient survey under embargo until June
    - The 2019 national staff survey published – under embargo until June
    - The Head of Internal Audit's annual opinion over the Trust's control environment dated 30th April 2020
    - CQC inspection report dated 24 July 2019

- 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

Xxx Date…… Steve McGuirk **Chairman**

xxx **Date**…… Simon Constable **Chief Executive**

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

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

Due to the COVID-19 global pandemic there will be no Independent Auditor's Assurance Report for this financial year.

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 patients who were admitted to an NHS hospital in 2019.
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