High Quality, Safe Healthcare
Quality People Sustainability

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Quality Account

2013-2014

Contents

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

Quality Report Part 1.

Statement of Quality from the Chief Executive.

Warrington and Halton Hospitals NHS Foundation Trust is dedicated to the provision of high quality care and clinical excellence which puts the patient at the centre of everything we do.

Our highly skilled workforce strives to produce the best outcomes for patients through reviewing and re-designing services and through the delivery of patient focussed clinical care. We therefore welcome this opportunity of demonstrating through our Quality Report to patients, their families, and the wider public the relentless focus that the trust has on improving the quality of our services.

Importantly, we believe that our staff, governors, members and patients are the eyes and ears of the organisation and through this positive engagement we ensure their views and observations are captured to guarantee that we are focussing on the things that will make the most difference in supporting our ethos of high quality care for all.

The trust provides services to the community across two sites. Warrington Hospital provides acute and emergency facilities including Accident & Emergency, intensive care, maternity, medicine, surgical services, paediatrics, outpatients and a full range of diagnostic and back up services. The Halton campus provides a range of diagnostic, intermediate care, elective surgical, antenatal and outpatient services including a minor injuries unit for local patients. The Cheshire and Merseyside Treatment Centre at Halton General provides orthopaedic surgery for both sites and includes a diagnostics centre with facility for magnetic resonance imaging (MRI) and computerised tomography (CT) scanning.

During 2013/2014 we have continued to strengthen and perform well on quality, we have invested in our staff by strengthening our clinical teams – more doctors, more nurses and more allied health professionals. The trust has developed a framework of more devolved management through the divisions which is supported by a range of leadership programmes. We have also introduced the *Bright Ideas* scheme to support partnership working with staff in order to develop ideas to enhance quality and reduce costs.

In 2013/14 we introduced the *Improving Quality: Patient Safety; Experience and Clinical Effectiveness Strategy*, which includes within its framework essential indicators which will require consistent review and monitoring to ensure a safe, high quality organisation. These indicators will be monitored closely throughout 2014/15 and beyond. Quality performance information is reviewed and discussed within our governance structures at the following forums:

- Clinical Governance, Audit and Quality Sub-Committee
- Quality in Care Committee (Governors)
- Infection Control Sub-Committee

- Safety and Risk Sub Committee
- Meetings of the Board of Directors
- Meetings with the commissioners of the trust's services

The trust has a robust performance management framework and within the year it has continued to monitor services across the three domains of quality: patient safety, clinical effectiveness and patient experience. Quality performance information is reviewed and discussed within our governance structures and reported on a monthly basis to the trust board. The trust meets on a monthly basis with Commissioners in order to discuss performance against quality performance measures including Commissioning for Quality and Innovation measures (CQUINs) contained within the Contract for Healthcare Services.

This report also offers the trust an opportunity to describe a range of quality initiatives which are central to our strategic framework of QPS - Quality, People, and Sustainability. Importantly, to support and provide assurance to this process we have established dynamic systems for continuously monitoring and improving the quality of our care and services.

This report charts progress on our quality improvement priorities established for 2013-2014, the priorities were identified through feedback and regular engagement with staff, patients, the public, and commissioners of NHS services, scrutiny group and other stakeholders. Progress on the planned improvements is reported through the trust's assurance committees, via the Council of Governors and ultimately through to trust board.

In 2013-2014, our improvement priorities were:

- Zero tolerance to hospital acquired MRSA bloodstream infections
- Reduction in incidents that result in severe or catastrophic harm
- Pressure Ulcers – reduction
- Reduction in medication errors that are related to insulin.
- Reduction in catheter associated UTI's
- 62 day cancer access target
- SHMI – Mortality Rates
- Commissioner priorities – Commissioning for Quality and Innovation measures.

We are pleased to report significant improvements within the improvement priorities during 2013-2014.

Excellent progress has been made in the management of pressure ulcers and the trust has worked hard to achieve a 67% reduction in the development of avoidable grade 3 pressure ulcers and a 33% reduction in the incidence of all grade 2 pressure ulcers (for this grade a distinction is not made between unavoidable and avoidable). However, we want to improve this even further. The management of pressure ulcers is an important aspect of care and will therefore continue as an improvement priority for 2014-2015.

The report details the great progress made in the reduction in medication insulin incidents of 10.5%, and a 20% reduction in the actual number of catheterised patients who developed urinary infection during 2013-2014.

The trust performed well in almost all our improvement priorities, with the exception of the number of reported hospital acquired MRSA bloodstream infections where the trust is reporting 3 cases against a threshold of 0 (an increase from 2012-2013 when performance was 1 MRSA against a threshold of 3) and Clostridium difficile where the trust is reporting 31 cases of hospital acquired Clostridium difficile infections against a threshold of 19 compared to 19 cases against a trajectory of 40 for 2012-2013. Reducing hospital acquired infection remains a high priority and the infection prevention and control team continue to review processes to support the further reduction of HCAIs.

The trust was disappointed when it was named in October 2013 (for the period April 2012 – March 2013), as one of seven NHS trusts who had a higher than expected SHMI, at 112.9. We had already recognised that this was a key area for improvement. We created a number of work streams to evaluate aspects of mortality and thus identified it as a key priority for improvement in 2013/2014. Following a significant focus on mortality reduction in the trust, we are very pleased to report that since the January 2014 HSCIC publication (for the period July 2012 – June 2013) the trust has had an 'as expected' SHMI score. The latest SHMI score available (HED system) is 105 for the period February 2013 – January 2014. The SHMI is one of two mortality measures used in the NHS, the other being HSMR (Hospital Standardised Mortality Ratio), which is 98 for the latest data period available (March 2013 – February 2014).

The trust continues to perform well across all activity including meeting the Accident and Emergency (A&E) four hour waits and we are delighted that A&E has achieved the year end 95% access target for 2013-2014. This is a great achievement and should not be underestimated especially given that many trusts are expected to fail the target this year. The team has worked incredibly hard to ensure compliance with the target.

We understand that the time from when a suspicion of cancer to obtaining a diagnosis and treatment is raised is a particularly distressing and anxious time for both the patient and their family. The 62-day target intends to ensure that these patients are prioritised to receive the tests and procedures they need to confirm or refute cancer diagnosis as quickly as possible, and if cancer is diagnosed to begin treatment as soon as possible. The target is to achieve 85% of patients diagnosed with cancer starting treatment within 62 days of urgent referral with a suspicion of cancer or referral through A&E. In 2013-2014, Warrington and Halton Hospitals NHS Foundation Trust met its National Target and Minimum standards for patients urgently referred with a suspicion of cancer began treatment within 62 days of their referral by GP (Open Exeter Position).

We are delighted to report that the trust has invested in new services including maternity, dementia and the use of IM&T to support enhanced clinical delivery. To underpin these services and changes

in the way we work have also developed a suite of new strategy documents for nursing, dementia, information management and technology (IM&T) and quality. We have successfully implemented the Friends and Family initiative across inpatient; accident and emergency and maternity services, investment in an infrastructure to support this initiative has resulted in a substantial increase in service user participation.

We have taken the opportunity throughout 2013-2014 to review our patient experience services and have invested in the team to ensure that we can provide timely responses to complaints and concerns. We are pleased to report a 26% reduction in the number of written complaints received and are now working toward ensuring that the learning from what we are told by our patients is embedded in every day work. We have been very fortunate to have patient experience representatives on some of our committees, and a particular example of this has been in the area of dementia where their input to service development has been invaluable.

Dementia care was also selected as an area of focus for 2013-2014 with the specific aim of promoting the development of a culture within the organisation where everyone will be able to recognise and help the many patients who now present with dementia. At this trust staff, are dedicated, to providing the best possible care for patients with dementia. Our dementia strategy sets out the framework by which we will achieve this. Within the strategy we have identified ten key areas which are underpinned by action plans monitored by our dementia steering group. Over the past year we have ensured that Dementia Champions are in place at board level with our director of nursing and organisational development leading the way for those patients who are amongst our most vulnerable.

The trust, recognising the importance of ensuring that our environment is dementi a friendly used the Kings Fund toolkits to assess how 'dementia friendly' our wards are. These results were then used to inform our successful bid to the Kings Fund in April 2013, where we were awarded £1.04m to improve the environment for patient with dementia. **Work has now been completed on our £1 million specialist ward which is now open for acute patients with dementia at Warrington Hospital.**

In February the trust held a Quality Improvement Forward Planning event with all key stakeholders to provide information on progress with quality improvement priorities and quality indicators for 2013/2014 as well as planning and agreeing a selection of improvement priorities for 2014/2015 to take back for discussion with the board.

We were visited by the Care Quality Commission on two occasions during 2013/14 and have performed well in relation to external assessment by the Care Quality Commission.

We have engaged throughout the year with our partner organisations to update them on the progress made toward achieving our improvement priorities throughout the year. Early in 2014 we invited our partners to attend an event to discuss the improvement priorities for 2014/15. We were delighted that approximately 25 representatives from key stakeholder organisations including Warrington Healthwatch; Halton Healthwatch; Warrington Borough Council; Governors; Assistant Director of Nursing and Quality at Cheshire, Warrington and Wirral Area Team NHS England and the external auditors for the trust *Price Waterhouse* and *Coopers (PWC) attended the event.* Through a

programme of consultation it has been agreed that our quality improvement priorities for 2014/2015 will be:-

- Complaints – To improve the percentage of complaints responded to within timescales agreed with the patient. To provide detailed reports on themes and lessons learned as a result of complaints.
- Falls – Establish a 10% reduction for falls resulting in moderate - catastrophic harm.
- Improvement in lowest performing indicators in In-Patient Survey – develop plans to make improvements in areas where we fall below national average and have not demonstrated improvement in past two years
- Pressure ulcers – continue work on reducing pressure ulcers.
- Advancing Quality (AQ) Stroke and Pneumonia measures - Work streams to increase compliance with stroke and pneumonia measures to improve patient outcomes.

In conclusion, this Quality Report evidences that we have made encouraging progress in improving the care and services we deliver to our patients, furthermore it demonstrates our determination to continue to improve all our services so that we can show our commitment to our local communities.

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

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

Mel Pickup
Chief Executive
28th May 2014

Quality Report Part 2.

Improvement Priorities & Statement of Assurance from Board

Introduction - Quality People and Sustainability

It is acknowledged by the NHS Trust Development Authority (2013) that the long-planned reforms to the NHS are now in place; "the publication of the report into the serious failings at Mid-Staffordshire NHS Foundation Trust has rightly brought both the quality of care the NHS provides and the accountability for its delivery into a sharper focus than ever before; and the constrained financial environment in which we operate gets tougher as we enter into the business end of delivering quality and productivity improvement plans. How each and every NHS Trust Board responds to the challenges the new environment poses will be critical to their ability to deliver high quality services for their patients and communities – not just for the year ahead but also for the medium and long term. Creating the conditions for success – defining what that looks like, ensuring each organisation can draw on the necessary support to deliver their ambitions, and having clarity on the accountability for delivering it – will be essential to supporting NHS Trust Boards to meet that challenge".

To support this challenge of creating a balance between quality, staff and financial constraints the trust has a strategic framework to improve the performance of the organisation called Quality, People, and Sustainability (QPS). This QPS framework which was developed in consultation with our staff and governors enables us to continue to deliver good performance whilst striving to make year on year improvements.

Quality

Excellence for our patients – Includes safety, effectiveness and experience

People

Caring for our staff – About our workforce, how we engage with you and how we develop leadership and help enhance your careers and use your skills

Sustainability

Here for our community – A focus on good governance, financial viability, the profile and perception of the trust and growth.

QPS Framework

Over the last few years, we have successfully delivered significant changes to the way in which we provide services which has allowed us to both improve the quality of services to our patients and to ensure that we use the resources available to us as efficiently as possible. The development of QPS gives the trust a framework through which we can ensure the future quality and sustainability of our services and the development of our people. During the year we have continued to strengthen and

perform well on quality by investing in our staff in key areas, by strengthening our clinical teams – more doctors, more nurses and more allied health professionals. Leadership programmes are in place including more devolved management through the divisions. We also introduced the "Bright Ideas" scheme in order to work in partnership with staff to avoid redundancies and develop ideas. Importantly in terms of quality the trust has invested in services including maternity, dementia, CMTC and the use of IM&T to support enhanced clinical delivery and we have developed new strategies for nursing, dementia and quality.

We have performed well in relation to external assessment by the Care Quality Commission and have implemented the Friends and Family initiative across inpatient; accident and emergency and maternity services, investment in an infrastructure to support this initiative has resulted in a substantial increase in service user participation. The trust meets on a monthly basis with Commissioners in order to discuss performance against quality performance measures contained within the Contract for Healthcare Services.

However, for 2013/2014 we needed to find savings of at least £11m to meet national NHS efficiency savings targets and in March 2013 we launched our Sustainability Challenge for 2013/2014. We were committed to working in partnership with staff to look at the challenge and ensure that permanent staff would not be affected if at all possible. Work was carried out from March through to May to identify posts from our vacancies that could be removed to save money and this objective has been achieved with minimal impact on permanent staff in the trust. However sustainability was also dependent on the successful delivery of our cost improvement programmes (CIP) schemes and delivering the savings and efficiencies which was difficult to achieve, as such by the end of 2013 we put in place a system of internal financial turnaround until the end of March 2014 in order to take greater and tighter control of the situation.

At the end of 2013/2014 the trust can report that it completed the financial year with a £2.8m deficit which is rolled into next year. The trust has developed a two year plan and for 2014/2015, it is targeting a £1.5m deficit which will require cost savings of £12m.

Clearly 2013-2014 has been a challenging year for the trust but we have worked hard to ensure that the patients we support get the right care, when they need it at the right time on the most suitable site. Importantly, the trust has been successful in achieving all national targets from the operating framework for 2013-2014 in spite of a deteriorating national position. We achieved the 95% Accident & Emergency access target for the year– with a final figure of 95.55% across the year and also the 18 week referral to treatment target. The trust is pleased to report that it has delivered 18wks for over 90% of all referrals for the 6th year in a row.

Improving Quality

During the reporting year we have introduced the "Improving Quality: Patient Safety; Experience and Clinical Effectiveness Strategy", which includes within its framework essential indicators which will require consistent review and monitoring to ensure a safe, high quality organisation. Our mission is to provide 'High Quality, Safe Healthcare'. To enable us to achieve this, we have four strategic objectives. They are:

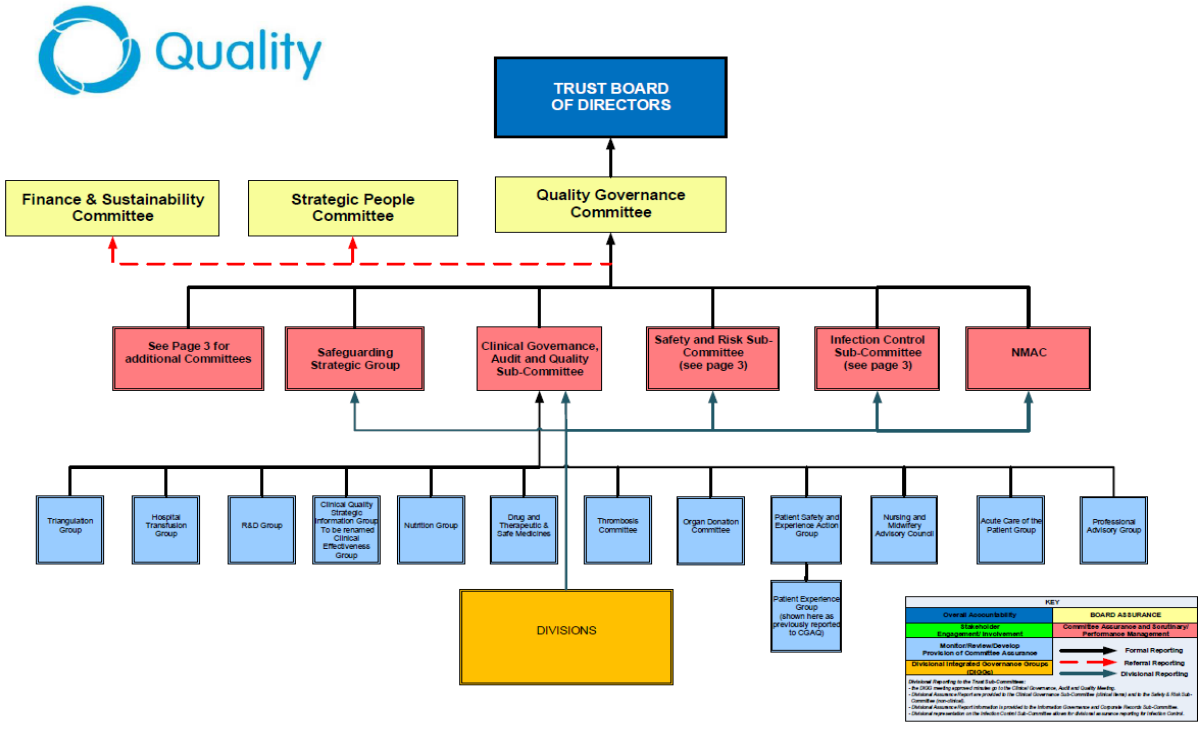
- **To ensure all patients are safe in our care.**
- **To give our patients the best possible experience.**
- To be the employer of choice for the health care we deliver.
- To provide sustainable local health care services.

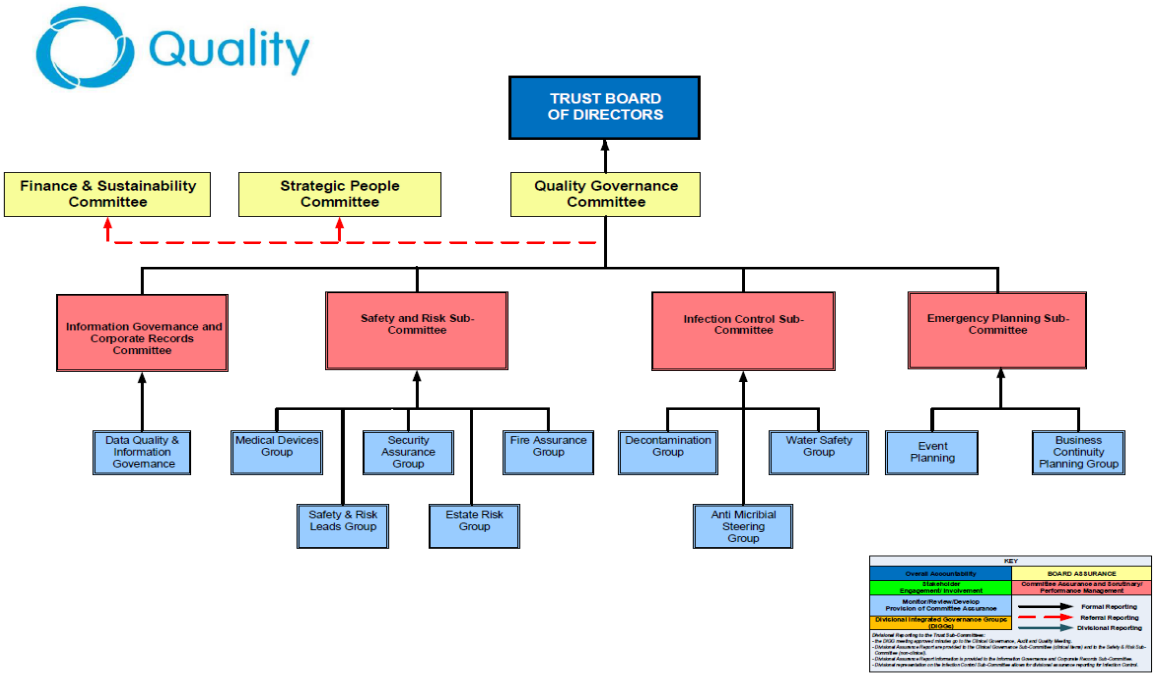
The "Improving Quality" Strategy underpins these four objectives, aiming to deliver high quality safe healthcare in a timely and responsive manner, provided in high quality, safe therapeutic environments and maintaining compassionate and respectful care. It draws together the various initiatives to deliver a clear plan of how the trust will work to achieve this.

These objectives are delivered using the framework of QPS and the strategy aims to deliver the Quality arm from the QPS. The quality performance information is reviewed and discussed within our governance structures as shown below:

- Quality Governance Committee
- Clinical Governance, Audit and Quality Sub-Committee
- Patient Safety and Experience Action Group
- Quality in Care Committee (Governors)
- Infection Control Sub-Committee
- Meetings of the Board of Directors
- Meetings with the commissioners of the trust's service

Quality Governance Structure





2.1 Improvement Priorities

2.1.1 Improvement Priorities for 2013-2014

All of the following improvement priorities were identified following a review of the domains of quality and reported in 2012/2013 Quality Report. We also consulted with patients, governors, commissioners, LINks, Healthwatch and other external agencies in order to inform the board when determining our priorities for 2013/2014. The progress of each priority is discussed and red, amber and green (RAG) rated against performance on a quarterly basis. Where possible we include performance indicators to measure and benchmark progress and they are reported on a monthly basis via the Quality Dashboard to board.

The trust is committed to embracing improvement across a wide range of quality issues to achieve excellence in all areas of care. The following section includes a report on progress with our improvement priorities for 2013/2014.

In 2013/2014, our improvement priorities were:

- Zero tolerance to hospital acquired MRSA bloodstream infections
- Reduction in incidents that result in severe or catastrophic harm
- Pressure Ulcers – reduction
- Reduction in medication errors that are related to insulin.
- Reduction in catheter associated UTI's
- 62 day cancer access target
- SHMI – Mortality Rates
- Commissioner priorities – Commissioning for Quality and Innovation measures.

2.1.1.1 Zero tolerance to hospital acquired MRSA bloodstream infections

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

Within the reporting period the trust has reported 3 cases of hospital acquired MRSA bloodstream infection (against a threshold of 0) compared to 1 case in 2012/13 (against a threshold of 3). These incidents underwent in-depth investigations and key learning points were shared across the trust which included:-

- Selecting an antibiotic to provide cover for MRSA where patients are known to be colonised
- Documentation of long-term urinary catheter insertion and maintenance to ensure appropriate management
- Documentation of peripheral venous catheter site monitoring and dwell time to ensure appropriate management

2.1.1.1.1 Clostridium difficile

Within the reporting period the trust reported 31 cases of hospital acquired Clostridium difficile infections against a threshold of 19 compared to 19 cases against a threshold of 40 for 2012/2013. A variety of activities were focussed on tackling Clostridium difficile after noting an increase in cases in the early part of the year. This included, promoting isolation of symptomatic patients, enhancing environment hygiene, hand washing awareness raising and promoting prudent use of antibiotics. Antibiotics are a recognised risk factor for Clostridium difficile however they are a fundamental aspect of treating infections. To promote prudent use of antibiotics an increase in antibiotic ward rounds has taken place. The trust also participated in the European Antibiotic Awareness Day (EAAD) in November.

Although infection control will not remain as an improvement priority for 2014/15 it will continue to be monitored and reported as a quality indicator for 2014/2015.

- **Please see section 3.2.1 for a more detailed analysis of the management of performance in infection control at the trust.**

2.1.1.2 Reduction in incidents that result in severe or catastrophic harm

It is not usually possible to eliminate all risks but this trust believes it has a critical duty to protect patients as far as 'reasonably practicable'. This means that we consistently review our practise to reduce any unnecessary risk. It is vital that we focus on the risks that really matter – those with the potential to cause harm as such we selected this measure as an improvement priority for 2013/2014.

In December 2013 the trust reported 7 incidents (*all finally approved) resulting in 4 with major harm and 3 with catastrophic harm for the period 1st April 2012 until 31st March 2013. The

improvement priority threshold for 2013/2014 was therefore confirmed at 6 incidents. As at the 31st March 2014 the trust is performing well, with 6 confirmed incidents of this severity however, there are a further 11 incidents of this severity under investigation at this time.
During this reporting period the trust is pleased to report a reduction in the level of harm to our patients in relation to pressure ulcers.

- **Please see section 3.2.2 & 3.2.3**.

Whilst reduction in incidents that result in severe or catastrophic harm will not continue as an improvement priority for 2014/2015, the trust has in consultation with stakeholders decided to continue with pressure ulcers and reintroduce falls as improvement priorities for 2014/2015.

***NB:** The trust has in place a process whereby incidents on datix are assigned an approval status indicating the stage that has been reached in the review process. During the review, the details of the incident are reviewed, investigated as appropriate and the severity of harm caused is identified; this may be a different severity to that initially assigned as this may not be known at the time of reporting (e.g.if a patient is awaiting an x-ray following a fall). An incident is given the status of finally approved when this process has been completed and as part of this, it is possible to assign a final severity of harm

2.1.1.3 Reduction in grade 2-4 pressure ulcers

Pressure ulcers, also sometimes known as bedsores or *pressure sores*, are a type of injury that affects areas of the skin and underlying tissue. Pressure ulcers occur in patients when the skin covering areas where pressure is concentrated may break down causing an ulcer to develop. Pressure ulcers cause misery and pain for patients and the trust has worked hard in recent years to reduce their incidence.

Pressure ulcers can range in severity from patches of discoloured skin to open wounds that expose the underlying bone or muscle. We grade them from Grade 1 which is superficial to Grade 4 which is the most severe type of pressure ulcer. Pressure ulcers tend to affect people with health conditions that make it difficult to move, especially those confined to lying in a bed or sitting for prolonged periods of time. It is estimated that just under, half a million people in the UK will develop at least one pressure ulcer in any given year. This is usually people with an underlying health condition, for example, around one in 20 people who are admitted to hospital with a sudden illness will develop a pressure ulcer. People over 70 years old are particularly vulnerable to pressure ulcers as they are more likely to have mobility problems and ageing of the skin. Unfortunately, even with the highest standards of care, it is not always possible to prevent pressure ulcers in particularly vulnerable people. (NHS Choices)

During 2012/2013 we reported 18 avoidable* hospital acquired Grade 3 pressure ulcers against an improvement target of <=21 and an internal stretch target of <=19 for grade 3-4 pressure ulcers. We also reported 166 hospital acquired grade 2 pressure ulcers (avoidable and unavoidable*) against an improvement target of 232 grade 2 pressure ulcers equating to an overall 36% reduction for the year. The trust was pleased with this performance but still recognises that the continued reduction of pressure ulcers is a challenge and therefore established reduction in pressure ulcer as an improvement priority for 2013/2014 stating an improvement of a further 10% reduction across all grades namely <=149 grade 2 pressure ulcers and <=16 cases for grade 3 and 4 pressure ulcers.

As at the 31st March 2014 the trust is pleased to report the following reduction in grade 2-4 pressure ulcers as a result of the improvement work undertaken throughout the year. There has been a substantial 66.7% reduction in grade 3 pressure ulcers, with 6 confirmed grade 3 pressure ulcers. We can also report a 33% reduction in the incidence of grade 2 pressure ulcers corresponding to 112 grade 2 pressure ulcers compared to 166 grade 2 pressure ulcers in 2012/2013. Reducing the incidence of pressure ulcers remains a high priority for the trust so will continue as an improvement priority for 2014/2015.

* **Avoidable Pressure Ulcer:** "Avoidable" means that the person receiving care developed a pressure ulcer and the provider of care did not do one of the following: evaluate the person's clinical condition and pressure ulcer risk factors; plan and implement interventions that are consistent with the persons needs and goals, and recognised standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate."

Unavoidable Pressure Ulcer: "Unavoidable" means that the person receiving care developed a pressure ulcer even though the provider of the care had evaluated the person's clinical condition and pressure ulcer risk factors; planned and implemented interventions that are consistent with the persons needs and goals; and recognised standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate; or the individual person refused to adhere to prevention strategies in spite of education of the consequences of non-adherence" (Department of Health)

- **A detailed analysis of work and performance monitoring of pressure ulcers can be found at section 3.2.2.**

2.1.1.4 Reduction in medication errors related to insulin.

During 2012/2013 the trust targeted improvements in relation to the reduction of medicine errors. Nationally there is a long history of medication errors associated with the use of insulin so we established a threshold of a 10% reduction in medication errors based on data from Quarter 1 and Quarter 2 2012/2013. The trust also saw an increase in the reporting of clinical incidents involving insulin during 2012/2013 which it felt was due to both an addition of an insulin tick box within the datix incident reporting system and increased awareness of the need to report. We reported 57 insulin related incidents in 2012/2013 and established an improvement target of a further 5% reduction namely <=54 incidents for 2013/2014.

The incidents which are all reported on to the incident reporting system datix are verified and quality checked by the Deputy Chief Pharmacist. The trust has established the following inclusion criteria namely incidents that have had a clinical impact / had the potential to have a clinical impact (near miss) will be included. Incidents that are not patient related e.g. where there are safe and secure handling issues will be excluded. This patient safety indicator is included on the Quality Dashboard which is monitored on a monthly basis by the board. Our Diabetic Nurse Specialist team worked hard to support the ward teams in this reduction and the trust is pleased to report that we reduced insulin incidents by 10.5% from 57 cases to 51 cases and therefore exceeded our threshold of a 5% reduction thus achieving this improvement priority for2013/2014. This will not continue as an improvement priority for 2014/2015.

- **Please see section 3.2.6 for a detailed analysis of performance.**

2.1.1.5 Reduction in catheter associated UTI's

The trust is committed to improving patient care by reducing the incidence of catheter-associated urinary tract infection (CAUTI) which can cause unpleasant symptoms for patients and because it can

be reasonably prevented through application of accepted evidence-based prevention guidelines. As such we selected this as an improvement priority for 2013/2014.

A urinary tract infection (UTI) is an infection involving any part of the urinary system, including urethra, bladder, ureters, and the kidneys. Urinary tract infections account for approximately 40 percent of all hospital-acquired infections annually, with approximately 80 percent of these hospital-acquired urinary tract infections attributable to indwelling urethral catheters. This is when a tube is inserted into the bladder through the urethra to drain urine. Between 15-25% of hospitalised patients receive urinary catheters during their hospital stay and it is well established that the duration of catheterization is directly related to the risk for developing a UTI. With a catheter in place, the daily risk of developing a UTI ranges from 3 percent to 7 percent.

Considerable work has been undertaken which includes the implementation of CAUTI maintenance bundles to optimize the care of patients who require urinary catheterization during acute care, and to ensure that urinary catheters are removed as soon as clinically indicated. These two high impact interventions are based on expert advice and national infection prevention and control guidance to improve and measure the implementation of these key elements of care. The evidence base shows that the risk of infection reduces when all elements within the clinical process are performed every time and for every patient and that it increases when one or more elements of a procedure are excluded or not performed. Regular audits are undertaken within the trust in order to identify when all elements have been performed; to see where individual elements of care have not been performed and finally it enables us to focus our improvement effort on those elements which are not being consistently performed.

The trust has successfully implemented the NHS Safety Thermometer whereby it undertakes a monthly survey on one day of all appropriate patients, to collect data on four outcomes; 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. A decision was made to select CAUTI as an improvement priority going forward for 2013/2014 with agreement that the data source would be the Safety Thermometer.

We did not collect baseline data on catheter associated UTI's for last year's Quality Report but felt that it was important that we were able to produce some benchmarking data from 2012/2013 to assist analysis of performance on this important quality issue. The trust has been submitting data since May 2012 so we decided to extract the 2012/2013 data from the NHS Safety Thermometer and calculate the rolling median as our threshold for 2013/2014.

We used 3 quality indicators to monitor this improvement priority as follows:-

- Number of patients who had a catheter and a UTI as a percentage of patients with a catheter
- Number of patients with catheter and UTI
- Number of patients with catheter and UTI shown as a % of all patients surveyed.

This patient safety indicator is included on the Quality Dashboard which is monitored on a monthly basis by the board. The data shows that overall there has been a reduction in the actual number of

patients with CAUTI and that the rolling median shows an overall reduction throughout the year with the exception of one month when the reported figure was slightly above the baseline. Improvements to the management of CAUTI have resulted in a reduction in infections as such this will not continue as an improvement priority for 2014/2015. However the trust determines this to be an important measure so we will continue to monitor as a quality indicator and will report performance in the Quality Report next year.

- **Please refer to section 3.2.4 for a more detailed analysis of performance on CAUTI.**

2.1.1.6 62 day Cancer Access Target

The time from when a suspicion of cancer is raised is a particularly distressing and anxious time for both the patient and their family. The 62-day target intends to ensure that these patients are prioritised to receive the tests and procedures they need to confirm or eliminate cancer diagnosis as quickly as possible, and if cancer is diagnosed to begin treatment as soon as possible. Although this target is included in national mandatory surveillance the trust decided to select this as an improvement priority to maintain a focus on improving early diagnosis and thus improve outcomes for people with cancer.

The target is to achieve >=85% of patients diagnosed with cancer starting treatment within 62 days of urgent referral with a suspicion of cancer or referral through A&E.

In 2013-2014, Warrington and Halton Hospitals NHS Foundation Trust met its National Target and Minimum standards for patients urgently referred with a suspicion of cancer began treatment within 62 days of their referral by GP (Open Exeter Position). With regards to the reallocation position the trust is now starting to feel the negative impact of moving onto the Manchester model. Quarter 4 demonstrates that we achieved the Cancer Waiting Time Position of 85% but when we look at the percentage including reallocations we did not meet the threshold for January and February but did comply with March. This corresponds to patient deferral and patients' choice and because they are in the diagnostic phase of treatment they cannot be removed from the dataset.

62 day Cancer Wait by percentage

	Target	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual Rate
From Urgent GP Referral To Treatment - Open Exeter Position (Monitor)	>=85%	88.29%	85.96%	89.80%	89.74%	88.93%
From Urgent GP Referral To Treatment - Reallocation Position (CQC/PCT)	>=85%	85.21%	85.53%	85.33%	81.30%	85.28% (adjusted for year-end)

Going forward this will not be an improvement priority for 2014/2015 however the trust will continue to monitor this as part of the national mandatory surveillance programme and will report back in the Quality Report 2014/2015.

2.1.1.7 SHMI – Mortality Rates

The Summary Hospital-level Mortality Indicator (SHMI) reports on mortality at trust level across the NHS in England. This indicator is produced and published quarterly as an experimental 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 less than the expected numbers of deaths and a number above 100 would suggest a higher than expected number of deaths.

The trust was disappointed when, for the first time, it was named in October 2013 (for the period April 2012 – March 2013), as one of seven NHS trusts who had a higher than expected SHMI, at 112.9. We had already recognised that this was a key area for improvement. We created a number of work streams to evaluate aspects of mortality and thus identified it as a key priority for improvement in 2013/2014. Following a significant focus on mortality reduction in the trust, we are very pleased to report that since the January 2014 HSCIC publication (for the period July 2012 – June 2013) the trust has had an 'as expected' SHMI score. The latest SHMI score available (HED system) is 105 for the period February 2013 – January 2014.

The SHMI is one of two mortality measures used in the NHS, the other being HSMR (Hospital Standardised Mortality Ratio), which is 98 for the latest data period available (March 2013 – February 2014).

Mortality ratios are complex indicators and there are multiple factors that contribute to the overall score, including the quality of our documentation and coding. The Clinical Effectiveness Group has responsibility for reviewing mortality and is currently driving progress in this area; particularly focussing on six key areas of activity agreed as priorities for 2013/2014:

- Reviewing the trust's care pathways and best practice care bundles to ensure a high standard of care for every patient, every time.
- Reviewing the care of patients with respiratory conditions to ensure this is optimal at all stages of their care
- Ensuring quality and appropriate care at the end of patients' lives.
- Promoting the effective management of patients whose conditions deteriorate.
- Continue to analyse, understand, report and use mortality and morbidity data to improve outcomes.
- Ensure accurate and comprehensive documentation and coding.

Palliative Care Focus Group November 2013

Whilst the trust has not achieved the required reduction to 100 for the SHMI, it should be stressed that the positive result of work already undertaken is a SHMI score which is falling on a monthly basis and a reduction in the HSMR to below 100 in 2013/2014. Going forward this will not be an improvement priority for 2014/2015 but the trust will continue to monitor this as a quality indicator and will report back in the Quality Report 2014/2015.

- **Please refer to section 3.3.1 for a more detailed analysis of both SHMI and HMSR.**

2.1.1.8 Commissioner priorities

The trust has also achieved compliance against a number of commissioner priorities contained within the CQUIN framework which include:

- Safety Thermometer (National)
- Family and Friends (National)
- Dementia (National)
- VTE (National)
- Advancing Quality - Acute Myocardial Infarction; Heart Failure; Hip and Knee; Pneumonia and Stroke (Local)
- Forget me Not (Local)
- Neonatal Nutrition (Local)
- High Quality Care (Local)
- Effective Discharge (Local)
- Cancer Staging Data (Local)
- Digital Technology - Minimum of 4 media options to disseminate information (Local)
- Telephone Calls - 48 hours following discharge (Local)

Further detail on the compliance against the commissioner priorities can be found in section 2.2.4 of this report.

2.1.1.9 Focus on Quality – Key issues

In addition to the agreed improvement priorities the trust board in partnership with staff and governors also agreed to focus upon a number of key issues around quality improvement as follows:-

- Achieve an improvement in the learning and analysis of complaints with themes relating to attitude, care and treatment
- To revolutionise the way that we manage complaints to provide a responsive patient focussed service
- Develop a culture within the organisation that 'everyone' will be able to recognise and help a patient with dementia
- Develop 'always events', i.e. what must we always do to ensure the quality of service.

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

2.1.2 Improvement Priorities and Quality Indicators for 2014 – 2015

2.1.2.1 How we identify our priorities

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

The trust held a Quality Improvement Forward Planning event with all key stakeholders, approximately 25 representatives from key stakeholder organisations including Warrington Healthwatch; Halton Healthwatch; Warrington Borough Council; Governors; Assistant Director of Nursing and Quality at Cheshire, Warrington and Wirral Area Team NHS England and the external auditors for the trust *Price Waterhouse* and *Coopers (PWC) attended the event.*

Quality Improvement Forward Planning Event – February 2014

The objectives for the event were:-

- Provide an overview of the Quality Report
- Provide an update on progress with quality improvement priorities and quality indicators for 2013/2014
- Planning for improvement priorities for 2014/2015
- Planning for quality indicators for 2014/2015
- Agree a selection of quality improvement priorities and indicators to take back for discussion with the board.

Our staff, governors, members and patients are the eyes and ears of the organisation their views are constantly sought to ensure that we are focussing on the things that will make the most difference.

2.1.2.2 Improvement Priorities for 2014 – 2015

The trust board, in partnership with staff and governors, has reviewed data relating to quality of care and agreed that our improvement priorities for 2014/15 will include:

Priority 1 Complaints

Reason for prioritising: We treat and care for a significant number of people every year and the vast majority of patients have a positive experience however, when things go wrong, we are committed to listening and reviewing practice in order to understand what happened so that we can learn lessons to ensure that meaningful improvements are made. We continue to learn the lessons from the Francis Public Inquiry in to Mid Staffordshire NHS Foundation Trust and be responsive to the published review of the NHS Complaints system by Ann Clwydd, Member of Parliament and Professor Tricia Hart, particularly with regard to listening and learning from complaints.

Goal: – To improve the percentage of complaints responded to within timescales agreed with the patient. To provide detailed reports on themes and lessons learned as a result of complaints.
Timeframe: March 2015

Priority 2 Falls

Reason for prioritising: Whilst the reduction of falls was not an improvement priority for 2013/2014 the trust remained focussed on improvements and worked towards a challenging new threshold in relation to reducing falls resulting in moderate to catastrophic harm. We are committed to continuing the reduction of falls by increased surveillance, risk assessments and review and through the work of the Falls Prevention Group (FPG). The trust has decided select this as a key priority for 2014/15.

Goal: – Establish a 10% reduction for falls resulting in moderate - catastrophic harm.
Timeframe: March 2015

Priority 3 In-Patient Survey - improvement in low performing indicators

Reason for prioritising: Listening to patients' views is essential to providing a patient-centred health service. 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.

Goal: – Develop action plans to improve low performing areas that relate to the inpatient episode of care and where we fall below the national average and have not demonstrated improvement in past two years
Timeframe: March 2015

Priority 4 Pressure Ulcer Reduction
Reason for prioritising: Over the past two years the trust has managed a sustained reduction in grade 2-4 pressure ulcers and has not had a grade 4 pressure ulcer since March 2011. We want to build on this work and continue to evidence further improvement in the management of pressure ulcers and have therefore decided to carry this forward as an improvement priority into 2014/2015.

Goal: The trust continues to implement its planned programme of actions to further reduce pressure ulcers which includes:-

- Review of the trust policy on pressure ulcers is in progress, with particular reference to the process by which we investigate Grade 3/4 pressure ulcers.
- Root cause analysis is conducted on all Grade 3/4 pressure ulcers which develop within the trust;
- Mini investigations of all grade 2 hospital acquired pressure ulcers

Timeframe: March 2015

Priority 5 Advancing Quality (AQ) measures – Stroke and Pneumonia
Reason for prioritising: AQ works with clinicians to provide trusts with a set of quality standards which define and measure good clinical practice. The trust has submitted data on heart attacks, heart failure, hip and knee replacement surgery and pneumonia since AQ was launched in 2008 and subsequently submitted data into the treatment of stroke patients from October 2010. Care in hospital is always tailored to individual needs but trusts must deliver each measure to every patient to ensure they receive the highest standard of care in hospital. AQ refers to this as the Clinical Process Measures and trusts aim to achieve 100 per cent success rate.

Goal: Work streams to increase compliance with stroke and pneumonia measures to improve patient outcomes.
Timeframe: March 2015

2.1.2.3 Local Quality Indicators 2014/2015

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 2014/15 will include:

Patient Experience

- Always Events
- Complaints
- Patient Experience Indicators
- Patient Survey Indicators

Safety

- Falls
- CAUTI
- Nursing Care Indicators
- Medicines Management – development of indicators and on-going monitoring
- HCAI
- Pressure Ulcers

Clinical Effectiveness

- SHMI & HSMR
- Dementia
- PROMS
- Advancing Quality

Our success in achieving these priorities will be measured, where possible, by using nationally benchmarked information (e.g. Healthcare Evaluation Data (HED system) and National Inpatient Survey results) and using measurement tools that are clinically recognised (e.g. the pressure ulcer classification tool of the National Pressure Ulcer Advisory Panel (NPUAP) and European Pressure Ulcer Advisory Panel (EPUAP)). The improvement priorities will be monitored, and recorded via the Quality Dashboard which is reported to board on a monthly basis.

2.2. Statements of Assurance from the Board

During 2013-2014 the Warrington and Halton Hospitals NHS Foundation Trust provided and/or sub-contracted seven relevant health services.

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

The income generated by the relevant health services reviewed in 2013-2014 represents 100% of the total income generated from the provision of relevant health services by the Warrington and Halton Hospitals NHS Foundation Trust for 2013-2014.

2.2.1. Data Quality

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

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

2.2.2. Participation in Clinical Audit and National Confidential Enquiries

During 2013/2014 39 national clinical audits and 4 national confidential enquiries covered relevant health services that Warrington and Halton Hospitals NHS Foundation Trust provides.

During 2013/2014 Warrington and Halton Hospitals NHS Foundation Trust participated in 37 (95%) national clinical audits and 4 (100%) of the national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Warrington and Halton Hospitals NHS Foundation Trust was eligible to participate in during 2013/2014 are as follows:-

National Clinical Audits

Adult critical care (Case Mix Programme – ICNARC CMP)
Emergency use of oxygen (British Thoracic Society)
National Audit of Seizure Management (NASH)
National Emergency Laparotomy audit (NELA)
National Joint Registry (NJR)
Paracetamol overdose (College of Emergency Medicine)
Severe sepsis & septic shock (College of Emergency Medicine)
Severe trauma
National Comparative Audit of Blood Transfusion programme Anti D Audit

Bowel cancer (NBOCAP)
Head and neck oncology (DAHNO)
Lung cancer (NLCA)
Oesophago-gastric cancer (NAOGC)
Care of dying in hospital (NCDAH)
Acute coronary syndrome or Acute myocardial infarction (MINAP)
Cardiac arrhythmia (CRM)
Heart failure (HF)
National Cardiac Arrest Audit (NCAA)
National Vascular Registry
Chronic Obstructive Pulmonary Disease
Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit National Pregnancy in Diabetes
Diabetes (Paediatric) (NPDA)
Inflammatory bowel disease (IBD)
Renal replacement therapy (Renal Registry)
Falls and Fragility Fractures Audit Programme (FFFAP), includes National Hip Fracture Database (NHFD)
Sentinel Stroke National Audit Programme (SSNAP)
Elective surgery (National PROMs Programme)
National Audit of Intermediate Care
National Rheumatoid and early inflammatory arthritis
Child health programme (CHR-UK)
Epilepsy 12 audit (Childhood Epilepsy)
Maternal, infant and Newborn programme (MBRRACE-UK)
Moderate or severe asthma in children - (College of Emergency Medicine)
Neonatal intensive and special care (NNAP)
Paediatric asthma (British Thoracic Society)
National Audit of Seizure Management (NASH) – children
National Gout Audit
National NIPE Audit
Blood Cultures and long line infections on NNU - Part of NNAP Audit

National Confidential Enquiries

Subarachnoid Haemorrhage Audit
Alcohol related Liver Disease
Tracheostomy Audit
Lower limb study

The national clinical audits and national confidential enquiries that Warrington and Halton Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2013/2014 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Clinical Audits 2013/2014

National Clinical Audits	Participated	Data collected	% of cases submitted 2013/2014
Adult critical care (Case Mix Programme – ICNARC CMP)	√	√	On-going data collection
Emergency use of oxygen (British Thoracic Society)	X	NA	NA

National Audit of Seizure Management (NASH)	X	NA	NA
National Emergency Laparotomy audit (NELA)	√	√	23 (100%)
National Joint Registry (NJR)	√	√	On-going data collection
Paracetamol overdose (College of Emergency Medicine)	√	√	50 (100%)
Severe sepsis & septic shock (College of Emergency Medicine)	√	√	50 (100%)
Severe trauma	√	√	On-going data collection
National Comparative Audit of Blood Transfusion programme Anti D Audit	√	√	100%
Bowel cancer (NBOCAP)	√	√	Report not finalised
Head and neck oncology (DAHNO)	√	√	On-going data collection
Lung cancer (NLCA)	√	√	On-going data collection
Oesophago-gastric cancer (NAOGC)	√	√	On-going data collection
Care of dying in hospital (NCDAH)	√	√	50 (100%)
Acute coronary syndrome or Acute myocardial infarction (MINAP)	√	√	357 cases submitted on-going data collection
Cardiac arrhythmia (CRM)	√	√	102 (100%)
Heart failure (HF)	√	√	63 cases submitted on-going data collection
National Cardiac Arrest Audit (NCAA)	√	√	88 (100%)
National Vascular Registry	√	√	161 cases submitted on-going data collection
Chronic Obstructive Pulmonary Disease	√	√	24 cases submitted on-going data collection
Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit National Pregnancy in Diabetes	√	√	20 (100%)
Diabetes (Paediatric) (NPDA)	√	√	On-going data collection
Inflammatory bowel disease (IBD)	√	√	36 (90%)
Renal replacement therapy (Renal Registry)	√	√	On-going data collection
Falls and Fragility Fractures Audit Programme (FFFAP), includes National Hip Fracture Database (NHFD)	√	√	348 cases submitted on-going data collection
Sentinel Stroke National Audit Programme (SSNAP)	√	√	>90%
Elective surgery (National PROMs Programme)	√	√	On-going data collection
National Audit of Intermediate Care	√	√	85/87 (98%)
National Rheumatoid and early inflammatory arthritis	√	√	On-going data collection

Child health programme (CHR-UK)	√	√	Data collection closed April13
Epilepsy 12 audit (Childhood Epilepsy)	√	√	13 cases submitted 21 Questionnaires: On-going data collection
Maternal, infant and Newborn programme (MBRRACE-UK)	√	√	On-going data collection
Moderate or severe asthma in children - (College of Emergency Medicine)	√	√	50 (100%)
Neonatal intensive and special care (NNAP)	√	√	390 (100%)
Paediatric asthma (British Thoracic Society)	√	√	17 (100%)
National Audit of Seizure Management (NASH) - children	√	√	30 (100%)
National Gout Audit	√	√	On-going data collection
National NIPE Audit	√	√	On-going data collection
Blood Cultures and long line infections on NNU - Part of NNAP Audit	√	√	On-going data collection

National Confidential Enquiries 2013/2014

National Confidential Enquiries	Participated	Data collected 2013/2014	% Cases submitted 2013/2014
Subarachnoid Haemorrhage Audit	√	√	100%
Alcohol related Liver Disease	√	√	100%
Tracheostomy Audit	√	√	100%
Lower limb study	√	√	On-going data collection

2.2.2.1. National Clinical Audits – reviewed

The reports of 12 National Clinical Audits were reviewed by the provider in 2013 /14 and Warrington and Halton Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Audit Title	Actions for Improvement
Epilepsy 12	Develop checklist of discussion topics, to be ticked off as covered (dated and updated) and stored in the patients notes. Written information to accompany this.
	Develop guidelines to outline referral criteria for ECG, MRI, Tertiary referral and develop record sheet for the notes.
	Remind GP referrers and Dr Bedford, who filters the outpatient referrals, that all fits should be seen by Lead Consultant.
The Missing Lung Cancers	To encourage data inputting. To look at multiple surgery for history. (Especially from outside the trust e.g. Liverpool Heart & Chest Hospital (LHCH).

	To inform data inputters of potential errors inherent in Lung Cancer Audit Data Set (LUCADA) database and how to avoid them (e.g. Defaulting to null result).
	To provide overview of data and interrogate it for robustness and accuracy.
Fracture Neck of Femur - CEM Audit	To work closer with orthopaedic team.
National Audit of Dementia	Complete admission pathway and forward to ratify at appropriate committee. IT support to facilitate collecting information on re-admissions IT support to record information on delayed discharges. Clear eligibility criteria for patients with dementia going to intermediate care services. Interpreting service can meet the needs of patients with dementia.
	Presentation of repeat audit results.
	Increase the rate of cognition assessment using standard tool for appropriate patients.
	Promote best practice in screening for delirium.
National Audit of Dementia continued	Confusion Assessment Method (CAM) screening tool to be included in local dementia guideline.
	Review existing policies relating to Wandering and Restraint for compatibility with national guidelines for dementia care.
	Therapists to identify which standardised tools will be used to assess function.
	Level of cognitive impairment using standard tool recorded on discharge letter.
	Discharge letters to include any mental health issues.
	Agree criteria of emergency/urgent/routine referrals.
	Dementia champion at directorate level.
	Roll out of admission pathway which incorporates use of 'This is Me' document.
	Roll out the 'This is me document' on all adult wards admitting patients with dementia.
	Discharge policy to include the advice that dementia patients should be moved only for clinical reasons pertaining to care or treatment.
	Introduce the "forget me not" logo for all patients requiring extra time to communicate because of cognitive impairment.
	Develop local guidelines for management of dementia including Behavioural and Psychological Symptoms of Dementia (BPSD).
	Implementation of revised care planning booklet to be given to patients / relatives.
	Promote the use of dementia specific care plans within all adult wards.
	Roll out of admission pathway which incorporates:
	Identification of main carer and discuss level of input into patient's care that they would like to have whilst on the ward
	Use of the 'This is Me' document to facilitate the formulation of the care plan with patient and relatives.

	Discussion of the level of relatives/carer continued input to care on discharge and where support is needed.
BSUG National Audit of Continence & Pelvic floor dysfunction surgery	Re-Audit
BTS National Emergency Oxygen Audit 2012	Oxygen prescription policy
	Continuing training of health professionals, Nursing staff on A7: short sessions on the wards Summer 2013, Induction training for Foundation year 1 (FY1) & other Doctors from August 2013.
	Specialist respiratory nurses input/teaching on Medical wards
National Comparative Audit of Blood Transfusion: "2011 Audit of Use of Blood in Adult Medical Patients – Part 1"	Distribute finding to Foundation year 1'&2's, Speciality Training Doctors / Registrars and Consultants in the form of a "Bloody Matters" newsletter. Include in trusts "Risky Business" newsletter.
	Submit report to the: Transfusion Team Meeting (TTM), Hospital Transfusion Committee (HTC) and Clinical Governance (next meetings: TTM February 2013, HTC April 2013, CG report May 2013)
	Recommendations to be presented to the Medical Consultants at the "Grand Round" (next meeting, as part of another presentation on relevant transfusion issues).
Consultant sign off - CEM Audit	Re-audit nationally when College recommends.
	Aim to have more children in the <1year old febrile group included
	Review current IT to assess for future implementation of audit (on-going).
National Emergency Laparotomy Audit	Use of Doppler for all of these cases.
	Possum scoring of Mortality.
	Further participation in National Audit
National Paediatric Diabetes Audit (NPDA)- Quality Accounts	To Improve collection of care process. (Dietician input, chiropody, retinal screening) HbA1c Leaflet (Blood Test) To raise awareness to all staff.
Moderate / Severe asthma in Children National CEM Audit	Include systolic Blood Pressure on Asthma Pathway.
	Exclude Blood Pressure measurement on audit criteria
	Re-audit in 3 years
	Peak flow – re-educate practitioners regarding peak flow and if unable to perform document reasons why.
	Ensure if any observations are not performed to document why.
Hip Fracture Database	Discuss all the patients who failed Best Practice Tariff (BPT) and look at possible management for the avoidable patients.
	Review the last ten patient's journey to look at any possible trends that may be causing delayed discharges in order to reduce length of stay.

	Introduce the principles of enhanced recovery to the ward staff through a staff survey and education sessions.

2.2.2.2. Participation in Local Clinical Audits

The reports of 257 local clinical audits were reviewed by the provider in 2013/2014 and Warrington and Halton Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Local Clinical Audit – examples showing completion of the audit cycle.

Audit Title	Actions for Improvement
Acute Medicine	
Knowledge of Intranet Hub.	To remove all out of date policies.
	More focus on Hub policies at junior induction.
	Improve policy accessibility.
	Improve search engine i.e. system that will pick up document if spelling Hypomagnasaemia is incorrect.
Patient harm using global trigger tool.	Risk Acute Kidney Injury (AKI) and role medications.
	Awareness risk rehydration especially in elderly.
	AKI pathway for trust.
	Help identify AKI.
	Review and cessation nephrotoxic medication where required.
Anaesthetics.	
Perioperative care for elective joint replacement (current practice).	These findings to be discussed in Enhanced Recovery Pathway (ERP) meeting.
	Need for standardised Enhanced Recovery Pathway (ERP) for joint replacement.
	Further audit after implementing (ERP).
	Data to be presented to Orthopedicians.
30 day mortality following laparotomy.	Risk prediction scoring should be completed in all Emergency laparotomy patients.
	Active surgical and anaesthetic consultant input for all Emergency Laparotomies.
	Perioperative pathway to be put in place for the management of Emergency. Laparotomies.
	Cardiac output to be monitored intra-operatively in all Emergency Laparotomy patients.
Cardiology	
Dual antiplatelet therapy post elective PCI.	Re audit after 6 months, and include higher number of patients.
	Audit of the percentage of elective attending pre op clinic.
	Percutaneous Coronary Intervention (PCI) should be postponed if patient can't attend pre op clinic.
	Audit of time from procedure to follow up.
	Cardiac Specialist Nurses (CSNs) should aim to see all elective Percutaneous Coronary Intervention (PCI) cases within 4 weeks after the procedure.
	Cardiac Specialist Nurses should develop pathway to capture all elective Percutaneous Coronary Intervention (PCIs), so early follow up could be planned in advance.
Inpatient Coronary	To liaise with A&E link for Cardiology regarding increasing awareness of using GRACE scoring on admission.

Angiography for ACS/NSTEMI patients.	Improved awareness of GRACE scoring to be highlighted to new medical staff at induction.
	Standard Operating Procedure (SOP) to be finalised for C21 to have full control of bed flow.
	Re-audit 2014.
Child Health	
Management of the Newborn where Group B. Streptococcus. Confirmed in mother or Newborn.	Dissemination of the Maternal GBS in Pregnancy and Management of the Newborn Audit Report at the following Group Meeting: Maternity Risk Management Meeting.
	To improve compliance to the required best practice standard of 100% compliance with the completion of the Newborn postnatal observations individual staff members who do not comply with the local guideline will be identified and advised on an individual basis regarding the need for compliant documentation supported with a letter.
	Implementation of the new local guideline 'Management of the neonate at risk of early onset infection including GBS sepsis' incorporating the NICE guidance for antibiotic therapy for early onset sepsis in the neonate with red and non-red flag risk factors. Implemented into practice on the 3rd March 2014.
	New Newborn Early Warning Score (NEWS) to be implemented to replace current Newborn Postnatal Observations Chart as part of the new 'Management of the neonate at risk of early onset infection including GBS sepsis' guideline. The NEWS chart provides specific time frames for requesting a paediatric medical review for a Newborn those scores with abnormal observations.
	Implement monthly monitoring of maternal GBS in pregnancy and management of the Newborn cases and use of the NEWS chart from implementation.
	Re audit maternal GBS in pregnancy and management of the Newborn in 6 months to evaluate compliance with completion of the new NEWS chart.
	Dissemination of the results of the Maternal GBS in Pregnancy and Management of the Newborn Audit to all the relevant staff in the Maternity Unit including the Neonatal Unit through the Audit Summary via email.
TPN, Commissioning for Quality and Innovation (CQUIN).	Developing written guidelines for total parenteral nutrition (TPN) administration.
	Raising awareness of planned practice to start TPN on day 1 - 2 for this group of babies – this can be implemented immediately for babies born Sunday to Friday morning.
	Discussion re allowing peripheral TPN initially if delay in achieving central access.
	Purchasing standard TPN bags to enable easy initiation of TPN on day 1.
Support for Parents in Actual or suspected poor outcome - June 12-June 2013.	Continued inclusion of CNST Update in the Neonatal Unit Mandatory Training Programme.
	The Neonatal Unit Manager and Neonatal CNST Lead will identify individuals who are non-compliant with the local guideline and discuss documentation and practice in relation to how they can improve in these key areas with future cases.
	Monitor on an individual basis the Newborn medical records of support for parents documentation for any baby admitted to the Neonatal Unit at term with a suspected or actual poor outcome.
	Engage the Bereavement Lead Midwife in assisting with undertaking the

	Support for Parents in cases of actual or suspected outcome Audit.
Support for Parents in Actual or suspected poor outcome - June 12-June 2013.	Continued inclusion of 'Bereavement Support' update on the Neonatal Unit Mandatory Training Programme.
	Email all neonatal nursing staff and senior paediatric medical staff regarding compliance with the local guideline for Support for Parents in cases of Actual or Suspected Poor Outcome for the Baby in relation to the documentation of all verbal and resource support given to parents.
	Dissemination of results from this Audit to all the Neonatal Unit nursing staff through the Audit Summary Report with signature list.
	Dissemination of results to: Child Health Departmental Meeting / Senior Staff Meeting & Paediatric Audit Meeting.
Unanticipated Admissions to NNU October 13-December 13.	Continued inclusion of a Risk Management Update on the Local Neonatal Unit (LNU) Mandatory Training Programme.
	In cases of non-compliance - individuals will be approached, good practice and areas for improvement with documentation discussed and supported with a letter.
	Continue to monitor the unanticipated admissions of term new-borns to the LNU on a monthly basis and Proforma completion.
Diabetes.	
Endocrine clinic: Comparison of Thyroid management against guidelines.	Attempt to establish full diagnosis in all cases not clearly Graves' Disease.
	Document biochemistry before commencing Autoimmune Thyroid Disease (ATD) in all cases.
	Document repeats Thyrotrophin Receptor Antibiotics (TRAB) before discontinuing ATD in all cases.
	Document Smoking status and cessation advice in all cases.
Introduction of mandatory insulin teaching as part of WHH training.	To continue to provide insulin prescribing and administration courses for nursing staff.
	To teach Foundation level doctors about insulin.
	Evaluate by re-auditing effect of course/training on insulin errors.
General Surgery	
NHS breast screening.	All patients to be listed within 31 days of MDT.
	All patients to be staged with Sentinel Lymph Node Biopsy (SLNB).
	Document choice of operation.
Governance	
Urinary Tract Infections (UTI) Outliers (Dr Foster).	The Palliative Care team has been revitalised in 2012/13 and referrals to the team have increased dramatically. The implementation of the Amber care initiative is further improving end of life care for patients.
	Coding issues: Following the initial review of 20 patients, the reviewers met with the coding department manager to review processes and ensure accurate coding of UTIs. Specific cases from this extended review will be discussed, regarding UTIs and Liverpool Care Pathway (LCP).
	Patients moving between wards and specialities: New acute medicine model of care implemented including the opening of an acute older persons and liaison unit on the 3/12/12. This will allow all patients to be reviewed by a senior doctor within 12 hours of admission and for the patient to be moved once to an appropriate ward if admission is deemed necessary. Audit of hospital acquired pneumonia.
	Quality of UTI diagnosis:

	Raise awareness throughout the division of unscheduled care about making an appropriate diagnosis of a UTI. This could be at induction, audit, grand round, PC screen saver, posters or a combination of all these Repeat snapshot audit on a regular basis to ensure quality of diagnosis improves and is sustained.
	End of Care: The trust Chief Executive Officer (CEO) is the executive sponsor of a collaborative partnership. This includes the acute hospital, older adults both patients and carers, the ambulance service, clinical commissioning group, community services, social services, primary care and the voluntary sector set up this year to develop new ways of working across the whole of our local community.
	Care of specific patients.
	Level 1 investigation to be undertaken.
	Management of patients with UTI.
	Utilising the NICE guidelines, a UTI peer support decision guide can be developed and audited.
	Compliance with trust policies and procedures.
	Regarding medication omissions; quarterly trust wide audits began in Q1 2012/2013, reduction targets have been set and compliance is reported to the Board of Directors in the monthly Quality Dashboard.
	Documentation: Continue to raise awareness and audit medical record documentation. Amend clerking proforma to include comorbidity.
Consent Audit.	Discuss at the May Clinical Governance, Audit and Quality Sub Committee to delegated Consent of the present Trust doctors (Associate Specialists/Staff Grades) to see if they require to have trained delegated Consent or should this just be for new trust Grade Doctors.
	Re- Audit August 2013.
	ADG to meet with all Audit and Governance Leads to ensure the list of delegated procedures is kept up to date.
	ADG to meet with all Audit and Governance Leads to ensure the Audit is discussed at Speciality Audit meetings in conjunction with Audit Department.
	Continue monthly education and training.
Ophthalmology.	
Bacterial Keratitis Audit.	Re-audit to ensure 100% compliance with Royal College of Ophthalmologist (RCO) guidance.
Pathology.	
A Regional Re-Audit on out of hour notification to HPU and Primary Care.	All Laboratories to have a written policy on communication of important results to primary care agreed with GP out of hours. (This policy should be agreed in conjunction with relevant PCT).
	Organisms with potential of causing outbreaks should be notified to Health protection Agency (HPA) now Public Health England (PHE). A list should be agreed with the local Health protection Agency Unit (HPU).
Consent to Blood Transfusion.	Produce 'Safety Alert' on the need to obtain and document consent.
	Alert send 16/07/2013; discuss with CG to the need to re-send this alert – new alert sent 30/10/2013.
	Generate report and submit to the Transfusion Team, HTC, Clinical Governance Quality and Audit Sub Committee (CGQASC).
	Produce 'Bloody Matters' highlighting results of the audit to circulate to all clinical areas and submit for 'Risky Business'.

	Present finding at Laboratory Lunchtime Meeting + slide included into 2014 mandatory training.
Carcinoma in Prostate Chippings.	Appropriate number of blocks should be processed.
	Reports should include additional data in line with recommendations.
	Malignant prostate to be reported by 2 histopathologists.
Radiology	
Evaluate the diagnostic adequacy and safety of percutaneous image guided liver biopsy.	On the page titled "Notes", report as detailed as possible the procedure.
	Coagulation checked and ok.
	Consent obtained and signed.
	LA, dose and type of medication.
	Type of USS guidance.
	Targeted or not, right or left.
	Type of needle, gauge, coaxial, passes.
	Pain score.
	Blood pressure, beats per minute (bpm), Sa02.
Accuracy of Radioscopy lesion localisation technique.	Educate breast radiology team about advantages and efficacy of Radioscopy Lesion Localisation (ROLLS) compared to wire localisation.
	Present findings at a national meeting (to be presented at UK Radiology Congress).
	Re audit in 2 years.
	Discuss findings with Breast surgeons.
Unscheduled Care Division.	
Discharge and Transfer Policy.	To present findings to Director of Nursing and Associate (DoN's) March 2014.
	Discharge service to work with ward managers to achieve 100% compliance.
	To present findings at the Clinical Governance, Audit & Quality Sub Committee in March 2014.
	To present findings to clinical leads for Physiotherapy and Occupational Therapy.
	Re-Audit in 6 months reviewing policy checklist standard.
	To present findings to Divisional Integrated Governance Groups.
	Agreement to include Discharge and Transfer of Care on corporate induction.
Scheduled Care Division.	
World Health Organisation (WHO Checklist).	Continue to monitor the DATA from DWARF and continue to report back to the DIGG.
	Engage the clinical teams in taking ownership in the new WHO checklist. Getting support from our new divisional medical director and trust medical director.
	Continue to report back to the theatre teams on compliance and examples to learn.
	Planning to send staff to visit some other organisations which do the check list a little differently and could support the efficacy of the check list.
Vascular.	
Prevention and Management of Contrast Induced Nephropathy in vascular patients.	All patients should receive intravenous hydration pre- and post-contrast studies. All nephrotoxic medications should be withheld before the contrast studies.
	Renal functions (urea and electrolytes) should be checked before and 24-72 hours after the contrast studies.
	Topics of assessing and managing patients undergoing contrast studies should be included in the induction sessions for the junior doctors.

	Vascular unit and radiology department should set up a risk assessment protocol to stratify the contrast-related nephropathy and to manage patients undergoing contrast studies.
Women's Health.	
Examination of the Newborn Referrals Audit. Update with additional information	Dissemination of results from this Audit at the following Child Health Division Meetings at Senior Staff Meeting and Paediatric Audit Meeting.
	Implementation of oxygen saturation monitoring on all eligible new-borns as part of the full physical Newborn examination.
	In the cases of non-compliance with the local guideline documentation Individuals who are not compliant with the documentation requirements of the local guideline will be identified and advised on an individual basis regarding the need for compliant documentation.
	Development of the input of referrals to the Paediatric Murmur Clinic and Cardiac Clinic via the Meditech System.
	Development of the input of referrals to the Orthopaedic Clinic for hip follow-up via the Meditech System.
	Dissemination of results from this Audit to all the health care professionals who conduct the full physical examination of the Newborn through the Audit Summary Report via email.

KEY:

CEM	College of Emergency Medicine
NNAP	National Neonatal Audit Programme
AE	Emergency care
CG	Clinical Governance
GP	General Practitioner
PN	Practice Nurse
FY1/FY2	Foundation Year 1 & 2
ST	Speciality Training
SpR	Registrar
BSUG	British Society of Urogynaecology
ADG	Associate Director of Governance
NICE	National Institute for Health and Care Excellence
TRAb	Thyrotropin receptor autoantibodies
CNST	Clinical Negligence Scheme for Trusts (Maternity Standards for trusts)
GBS	Group B. Streptococcus.
NNAP	National Neonatal Audit Programme
NNU	Neonatal Units
NBOCAP	National bowel cancer audit programme
DAHNO	Data for Head and Neck Oncologists
DWARF	Data Warehouse
DIGG	Divisional Integrated Governance Group
NLCA	National Lung Cancer Audit
NAOGC	National Oesophago-Gastric Cancer Audit
USS	Ultrasound
ICNARC	Intensive Care National Audit & Research Centre
BTS	British Thoracic Society
NIPE	NHS Newborn and Infant Physical Examination Programme
MBRRACE-UK	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries in the UK
PROMS	Patient Reported Outcome Measures

NPDA	National Paediatric Diabetes Audit (NPDA) | RCPCH
NDA	National Diabetes Audit
CRM	Cardiac Rhythm Management
CHR-UK	Child Health Reviews
PCI	Percutaneous Coronary Intervention
ACS	Acute Coronary Syndrome
NSTEMI	Non-ST segment elevation myocardial infarction
NCDAH	National Care of the Dying Audit
GRACE	Global Registry of Acute Cardiac Events

NB: Full details of the actions taken of all audits can be provided – please contact 01925 662736 for more details

2.2.3. Participation in Clinical Research and Development

The number of patients receiving relevant health services provided or sub- contracted by Warrington and Halton Hospitals NHS Foundation Trust in 2013/2014 that were recruited during that period to participate in research approved by a research ethics committee was 707**.**

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

In 2013-2014 the trust was involved in conducting 95 clinical research studies (a 3% decrease on 2012/2013*)* in research in oncology, surgery, stroke, reproductive health, cardiology, rheumatology, gastroenterology, ophthalmology, as well as paediatric and other studies.

Research and Development at the trust is currently mainly supported through external income from the Cheshire & Merseyside Comprehensive Local Research Network (C&MCLRN) together with income obtained through grants and commercial work; the majority of this research being nationally adopted studies as part of the National Institute for Health Research (NIHR). We also work with th e topic specific research networks and other health providers to increase NIHR clinical research activity and participation in research.

The trust has also adopted the C&MCLRN Research Management and Governance operational procedures and systems, including the NIHR Coordinated System for gaining NHS Permissions and achieved its target over the period. The trust ensures that all NIHR portfolio research activities are conducted to the highest standards and undertaken within the framework of research govern ance, strict legislation and recognised good clinical practice.

Most of the research carried out by the trust is funded by the NIHR. For 2013-2014 the trust received £400,700 which funds 9 research nurses to support Principal Investigators with recruitment and to assist with the management of NIHR studies ensuring that the study runs safely and in accordance with the approved protocol.

In 2013/2014 Warrington and Halton promoted it's Investigator Led Grant Awards Scheme and in this regard recently started partnership working with Manchester University. The aim of this is to

develop projects to take place over the next 12 months which will provide a benefit to patients whilst also developing research investigators locally.

2.2.4. The CQUIN Framework

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

The aim of the CQUIN payment framework is to support a cultural shift by embedding quality improvement and innovation as part of the commissioner-provider discussion. The framework is intended to ensure contracts with providers include clear and agreed plans for achieving higher levels of quality by allowing the commissioners to link a specific modest proportion of providers' contract income to the achievement of locally agreed goals. The locally agreed goals, which should be stretching and realistic, are discussed between trust board, commissioners and providers and included within contracts. Further details of the agreed goals for 2013/14 can be found below and details for the following 12 month period are available online on the trust website.

A proportion of Warrington and Halton Hospitals NHS Foundation Trust's income in 2013/2014 was conditional upon achieving quality improvement and innovation goals agreed between Warrington and Halton Hospitals NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

The monetary total for the amount of income in 2013-2014, conditional upon achieving quality improvement and innovation goals, was £4,617m with a monetary total for the associated payment in 2013/2014 of £4,580m received. In 2012/2013 the trust received a monetary total for the associated CQUIN payment of £4.3m.

The trust achieved full compliance against all of the agreed CQUINs with the exception of the "Forget Me Not" CQUIN whereby we failed to hold a Dementia Conference within the agreed timescale and thus a payment of £36,866 was withheld. The trust had the following CQUIN goals in 2013/2014 which reflected both national priorities and Department of Health initiatives and also reflecting local needs and the views of the patients and commissioners.

CQUIN Report 2013/2014

CQUIN	TITLE	MEASURE	WEIGHTING	FINANCIAL VALUE	ACHIEVED CQUIN TARGET
National	Venous-thromboembolism (VTE) Risk Assessment - Reduce avoidable death, disability and chronic ill health from VTE.	95% of appropriate patients to be risk assessed. Number of Root Cause Analysis carried out on hospital associated thrombosis.	**5.00%**	**£230,850**	
National	Dementia	Carers survey	**5.00%**	**£230,850**	

		Dementia screening, risk assessment and referral. Named Lead for Dementia and appropriate training for staff.			
National	Family and Friends	Establish a F&F Baseline (acute in-patients & A&E combined) of 15% or more Increase in response rate that improves on Q1 and is 20% or over by quarter 4 Improved performance in Staff Survey F&F question - a better result in 2013/2014 compared with 2012/2013, or remaining in the top quartile. Delivery of Friends and Family roll-out for maternity services	**5.00%**	**£230,850**	
National	Safety Thermometer	ST Monthly data collection in relation to pressure ulcers; falls, urinary tract infection. Improvement reduction in the prevalence of pressure ulcers.	**5.00%**	**£230,850**	
Local	Advancing Quality – Application of quality requirements based on evidence and research to yield quality outcomes for:- • Pneumonia • Heart Failure • Acute Myocardial Infarction • Hip and Knee • Stroke	Performance delivery for each condition demonstration annual improvement against the targets. AMI 91.46% Heart Failure 86.85% Hip & Knee 92.23% Pneumonia 75.23% Stroke 62.57% Implementation of new quality targets.	**2.00%**	**£92,340**	
Local	Forget me Not coincide	Review the trust Dementia Strategy, introduce 'Forget me not' Introduce Dementia Champions. Nominate 2 dementia friendly wards. Assess ward environment utilising the tool kit	**5.40%**	**£249,318**	**The trust incurred a minor penalty due to failure to hold the Dementia Conference in Q3, we subsequently agreed with commissioners**

		Assess all medical wards and roll out a plan for the remaining ward areas.			**that the conference would be held to coincide with launch of the Dementia Ward and the penalty will be reimbursed at that point.**
Local	High Quality Care	Provision of high quality care which places the patient at the centre of all care decisions is fundamental to care delivery. This CQUIN requires the trust to demonstrate this through review and implementation of quality and nursing strategies and ensure the following are delivered:- Culture of patient centred care via use of a cultural barometer Effective Leadership Workforce for safe care delivery Competent Health Care Assistants.	**22%**	**£1,014,587**	
Local	Effective Discharge	To support effective discharge and transfer of care the trust is required to implement policies and processes in line with best practice. Increase patient engagement within the discharge process. Ensure effective multi-disciplinary engagement in planning delivery and discharge thereby ensuring that all discharges are safe, patient focused and reduce risk of harm.	**24.30%**	**£1,125,396**	
Local	Cancer Staging Data	Data collection Agree baseline performance set threshold Deliver against threshold, improve by 15% or achieve 60% by end of Q3.	**2.40%**	**£109,653**	

		75% target achieved for 3 consecutive months			
Local	Telephone Calls 48 hours following discharge.	Establish system agree criteria and risk assessment. Commence project and pilot to ensure correct patient cohort. Service contacting 20% of patients. Evaluate project and 45% of patients receiving calls. Evaluate how service has improved patient outcomes and reduced reliance on primary and secondary care	**10.40%**	**£119,754**	
Local	Neonatal Nutrition	Improve proportion of pre-term babies who start TPN by day 2. Undertake quarterly audits and action plans to improve compliance by Q4.	**2.00%**	**£92,340**	
Local	Digital Technology	Programme of work which identifies a minimum of four different options to utilise mixed media process to disseminate information to patients, carers and staff.	**11.50%**	**£530,956**	
TOTAL			**100%**	**£4,617,015**	

2.2.5. Care Quality Commission (CQC) Registration

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

The Care Quality Commission has not taken enforcement action against Warrington and Halton Hospitals NHS Foundation Trust during 2013-2014.

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

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

2.2.5.1 CQC Unannounced Inspection 2013/2014.

The CQC made one unannounced visits to Halton Hospital on the 30th September 2013, to review systems, standards, audit and processes as part of the Regulated Activities for Quality and Safety. The inspection which was unannounced started at the Minor Injuries Unit and then continued onto the wards, pharmacy and Cheshire and Merseyside Treatment Centre (CMTC). The CQC inspected the following standards as part of a routine inspection - care and welfare of people who use services, consent to care and treatment, staffing and management of medicines. The feedback was excellent – quotes from inspectors included that it was "an enjoyable inspection" and they had "never seen such inspirational care as on B1"

- The full report can be found at http://www.cqc.org.uk/directory/RWWHG

Extracts from the CQC inspection 30th September 2013 reported October 2013.

How we carried out this inspection

"We began our inspection on 30th September 2013 by visiting the Minor Injuries Unit outside of normal working hours. We returned the following day 1st October 2013 and visited the Orthopedic, Intermediate Care, Elective Surgical Services and Step down wards.. We saw that staff were well supported and had regular personal development reviews. Training was monitored and we saw evidence that staff had the opportunity to attend more specialist training courses when appropriate. There were enough staff on duty at the time of our inspection and we saw that additional staff could be accessed at short notice if required."

What the inspection revealed.

"We spoke with patients and staff of different grades on all the wards we visited. Patients spoke positively about their experience at Halton General Hospital. One said, "I much prefer this hospital to another, I have been in both for long periods of time and this hospital gives great attention to patient care, I cannot praise staff highly enough, the nurses especially night staff are just fantastic and very dedicated". Patients we spoke to felt that they had a full and clear understanding of their individual programmes of care and treatment. They commented that they felt they were given sufficient details and answers to any questions they may have, which they felt allowed them to make informed decisions. They understood the care and treatment choices available to them and were given appropriate information and support regarding their care or treatment."

2.2.5.2 CQC Themed Review of Dementia Care 2013/2014

The CQC made one unannounced visits to Warrington Hospital on the 28th January 2014, to review systems, standards, audit and processes as part of the themed review of dementia care. This inspection programme reviewed three main issues namely the quality of support provided to people with dementia to enable them to maintain their physical and mental health and wellbeing; how the care provided aims to reduce admissions to hospitals from care homes and avoid unnecessary lengths of stay in hospital and how services work together when people move from one service to another. The CQC visited wards A2, A3, A8, B12 and CDU and inspected the following standards as part of this themed review

- Outcome 4 Care and Welfare of Patients
- Outcome 6 Cooperating with other providers
- Outcome 16 Assessing and monitoring the quality of service provision

The trust report, received in April 2014 showed that we had met all three standards reviewed by the CQC. The full report can be found at http://www.cqc.org.uk/node/316324

2.2.5.3 CQC Intelligence Monitoring

The Care Quality Commission has published its full risk profiles and risk bandings of all NHS trusts for the first time. It's a new system known as Intelligent Monitoring and is a publication that we fully support as a way of highlighting risk in the health service.

The intelligent monitoring is based on 150 indicators that look at a range of information including patient experience, staff experience and statistical measures of performance including detailed mortality rates, waiting time and access information, patient feedback and actual CQC inspection results.

It basically pulls together information from every available accredited source to give an informed view and raise any questions necessary on the quality and safety of each hospital's service. It helps the CQC to know where to focus their new, stringent inspection resources.

The CQC have now banded each trust into one of six categories based on the risk from these indicators that people may not be receiving safe, effective, high quality care - with band 1 being the highest risk and band 6 the lowest risk. In March 2014 Warrington and Halton Hospitals NHS Foundation Trust was placed into the Band 5 category based on these indicators of our services and care.

Whilst these are not to be seen as formal league tables, they do give an indication of the overall performance, quality and safety at a trust and is a good position to be in. We have all been working hard to build a culture of high quality, safe healthcare at Warrington and Halton Hospitals NHS Foundation Trust. Whilst there are always ways we can further improve our services, we can be proud of our achievements. This detailed analysis of performance provided by the report shows that we moving in the right direction in ensuring that we provide our patients with a service that they can trust and that we can be proud of.

- The full reports can be found at http://www.cqc.org.uk/directory/RWW

2.2.5.4 CQC new Inspection Regime (Keogh Framework)

As stated above the trust performance against these surveillance indicators can if the trust is placed in a high risk band trigger an inspection. The CQC will now lead significantly bigger inspection teams headed up by clinical and other experts that include trained members of the public. They will spend longer inspecting hospitals and cover every site that delivers acute services and eight key services areas: A&E; maternity, paediatrics; acute medical and surgical pathways; care for the frail elderly; end of life care; and outpatients. The inspections will be a mixture of unannounced and announced and they will include inspections in the evenings and weekends when it is recognised patients can experience poor care.

This trust invests resources in ensuring that staff, understand these processes and it has since February 2014 provided drop in sessions in order to raise awareness about the new CQC Inspection Regime.

CQC Awareness Sessions – February 2014

2.2.6. Trust Data Quality

Warrington and Halton Hospitals NHS Foundation Trust submitted records during 2013/2014 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:-

Which included the patient's valid NHS Number was:

- for admitted patient care – 99.5%
- for outpatient care – 99.8%
- for accident and emergency care – 98.2%

Which included the patient's valid General Practitioner Registration Code was:

- for admitted patient care – 99.2%
- for outpatient care – 99.5%
- for accident and emergency care – 98.2%

2.2.6.1. Information Governance

Warrington and Halton Hospitals NHS Foundation Trust's Information Governance Assessment overall score for 2013/2014, was 68% and was graded as "not satisfactory".

Performance will be monitored by the Information Governance and Corporate Records Group and then reported to the IM&T Steering Committee which is a sub-committee of the trust board.

Warrington and Halton Hospitals NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2013/2014 by the Audit Commission.

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

- We are working towards compliance at the requisite level 2 standard across all the requirements contained within the Information Governance Toolkit in 2014/2015.The Information Governance Toolkit action plan is monitored at the Information Governance and Corporate Records Group.
- A report on the IG Toolkit for 2013/14 was recently produced by MIAA and was reviewed by Audit Committee - an action plan will be taken forward.

2.3. Core Quality Indicators 2013/2014.

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

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

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

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

2.3.1a. Summary Hospital-Level Mortality Indicator (SHMI):

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

SHMI Coding

DATE PERIOD	TRUST	BANDING	HIGHEST	LOWEST	NATIONAL
October 2012 – September 2013	110.21	2	118.59	63.01	100
Jul 2012 – June 2013	112.06	2	115.63	62.59	100
April 2012 – March 2013	112.9	1	116.97	65.23	100
January 2012 – December 2012	110.69	2	119.19	70.3	100
October 2011 - September 2012	111.26	2	121	68	100
July 2011 - June 2012	109.51	2	125	71	100

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

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

the Healthcare Evaluation Data (HED) benchmarking system to facilitate further analysis. Trusts are banded 1-3 as follows:-

1 the trust's mortality rate is 'higher than expected'
2 the trust's mortality rate is 'as expected'
3 where the trust's mortality rate is 'lower than expected'

To improve this score, and so the quality of its services, Warrington and Halton Hospitals NHS Foundation Trust has:

- made significant progress in managing deteriorating patients, including the creation of a Medical Emergency Team,
- created a Clinical Effectiveness Team and Clinical Effectiveness Group which is attended by two trust board members,
- worked closely with the North West's NHS Advancing Quality Alliance; using their reducing mortality framework and data support to target our improvement efforts,
- ensured that mortality data is widely reported and understood across the organisation.

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

Deaths with Palliative Care Coding

DATE PERIOD	TRUST	ENGLAND	HIGHEST	LOWEST
April 2012 – March 2013	17.2%	19.9%	44%	0.1%
January 2012 – December 2012	14.4%	19.2%	42.7%	0.1%
October 2011 - September 2012	11.6%	18.8%	43.3%	0.2%
July 2011 - June 2012	9.1%	18.2%	46.3%	0.3%

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

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

To improve this score, and so the quality of its services, Warrington and Halton Hospitals NHS Foundation Trust has employed a Palliative Care Consultant, provided specialist palliative care services to a greater number of patients, and held an event to review end of life care provision across the organisation and ensure that patients receive the best care at the end of their lives.

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

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

Patient Reported Outcome Scores.

		Groin hernia	Hip replacement	Knee replacement	Varicose vein
Year	Level	Average health gain	Average health gain	Average health gain	Average health gain
2011/2012	Trust	0.084	0.438	0.31	*
2011/2012	England	0.087	0.416	0.302	0.095
2011/2012	Highest	0.249	0.668	0.537	0.24
2011/2012	Lowest	-0.084	0.282	0.144	-0.134
2010/2011	Trust	0.055	0.382	0.299	*
2010/2011	England	0.085	0.405	0.298	0.091
2010/2011	Highest	0.156	0.503	0.407	0.155
2010/2011	Lowest	-0.020	0.264	0.176	-0.007
2009/2010	Trust	0.075	0.358	0.310	*
2009/2010	England	0.082	0.411	0.294	0.094
2009/2010	Highest	0.136	0.514	0.386	0.150
2009/2010	Lowest	0.011	0.287	0.172	-0.002

*** The trust does not undertake this procedure.**

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

Warrington and Halton Hospitals NHS Foundation Trust has taken the following actions as described below to improve this average health gain score and so the quality of its services, by delegating responsibility for reviewing PROMs data to the Clinical Effectiveness Committee.

2.3.3. Emergency readmissions to hospital within 28 days of discharge.

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 percentage of patients aged

- 0 to 15; and
- 16 or over,

readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.

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

DATE PERIOD	TRUST	ENGLAND	HIGHEST	LOWEST
2011/2012	13.58	10.01	13.58	5.10
2010/2011	12.08	10.15	13.94	5.85
2009/2010	11.77	10.18	14.44	6.38

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

*** Data for 2012/13 is not available from the Information Centre**

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

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

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

*** Data for 2012/13 is not available from the Information Centre**

Data relates to medium sized acute trusts.

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

Warrington and Halton Hospitals NHS Foundation Trust has taken the following actions to improve this rate and so the quality of its services, by making changes to the internal scrutiny and review of readmission data, redesigning the discharge service and continuing to develop readmissions software to support access to improved ward based information

The changes made have resulted in a focused analysis of readmission rates within Divisional Integrated Governance Groups to identify process issues and trend data, which are locally and organisationally acted upon to reduce readmission rates. The learning from which feeds into a whole system urgent care group as the trust continues to support a whole systems approach and work in close collaboration with key partner agencies to reduce readmissions to hospital within 30 days.
The Trust has also redesigned the Hospital Discharge Service whereby patients are risk assessed on admission and those identified with complex discharge needs are robustly tracked and supported through to discharge.

The Trust is engaged in testing a readmission management software package that will potentially support the development of risk stratification on discharge for some cohorts of patients. The focus is on the creation of a rescue plan that would be made available on discharge from hospital to better enable the patient and their carer to manage at home and reduce the need for readmission.

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

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

CQC national inpatient survey:– personal needs.

DATE PERIOD	TRUST	ENGLAND	HIGHEST	LOWEST
2012/2013	66.7	68.1	84.4	57.4
2011/2012	66.2	67.4	85	56.5
2010/2011	67.4	67.3	82.6	56.7

Warrington and Halton Hospitals NHS Foundation Trust considers that this data is as described for the following reasons, central to the trust ethos is the view that patients deserve high-quality

healthcare, and patients' views and experiences are integral to successful improvement efforts. As such it employs Quality Health to undertake a robust and comprehensive survey of patients experience on an annual basis.

Warrington and Halton Hospitals NHS Foundation Trust will take the following actions to improve this percentage and so the quality of its services, by reviewing the inpatient survey results constructing an action plan to improve year on year results. This will be supported by local surveys which focus on the above aspects of the patient experience. The trust has also selected the inpatient survey as an improvement priority for 2014/2015 and will report progress in the Quality Report next year.

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

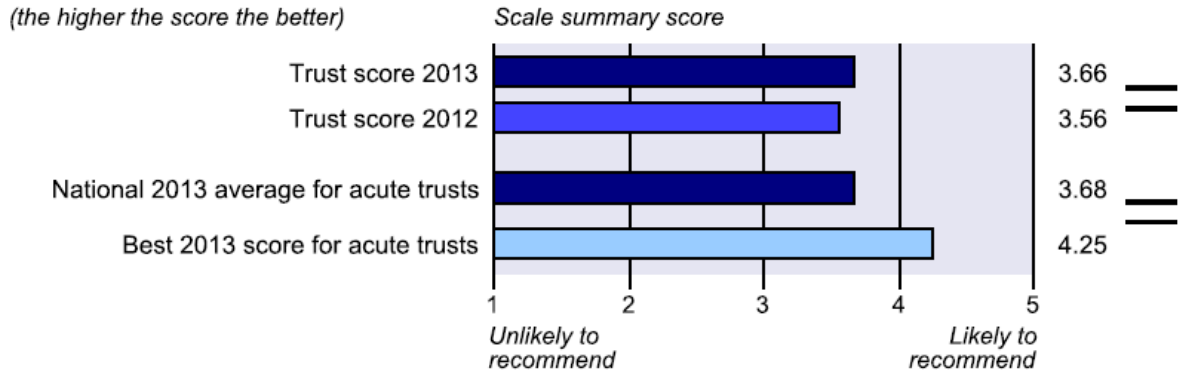
The data is made available to the trust by the Health and Social Care Information Centre via the National NHS Staff Survey Coordination Centre with regard to the percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of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

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

DATE	TRUST	HIGHEST	LOWEST	ACUTE TRUSTS
2013	65%	93.9%	39.6%	67%
2012	58%	69%	35%	65%
2011	57%	89%	33%	65%

NB: National data for acute trusts = national score

Staff who would recommend the provider to friends or family needing care by score – Staff Survey 2013.



Warrington and Halton Hospitals NHS Foundation Trust considers that this data is as described for the following reason, in that this report presents the findings of the 2013 national NHS staff survey conducted by the Picker Institute on behalf of the trust. The Picker Institute utilises high quality research methodology which ensures that appropriate sampling is undertaken across all staff groups resulting in a 43% response rate.

Warrington and Halton Hospitals NHS Foundation Trust has taken the following actions to improve this score and so the quality of its services, by reviewing the staff survey results constructing an action plan to improve year on year results. This is supported by local surveys using transparency audit questions which focus on quality of care.

2.3.6. Percentage of admitted patients risk-assessed for Venous Thromboembolism.

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

Venous Thromboembolism (VTE) – percentage of risk assessments undertaken

Year	Level	Q1	Q2	Q3	Q4
2013/2014	Trust	95.54%.	95.60%	96.50%	*95.76%**
	National Average	95.39%	95.69%	95.80%	**
	Highest	100%	100%	100%	**
	Lowest	78.78%	81.70%	77.70%	**
2012/2013	Trust	95.40%	95.10%	94%	93.90%
	National Average	93.40%	93.80%	94%	94.20%
	Highest	100%	100%	100%	100%
	Lowest	80.80%	80.90%	84.60%	87.90%
2011/2012	Trust	95.60%	96.20%	95.40%	96.20%
	National Average	81%	88%	91%	93%
	Highest	***	***	100%	100%
	Lowest	***	***	32.40%	69.80%

** =Trust internal data only available for this reporting period.*
*** = This data is not currently available from the Information Centre.*
**** = This data has been archived and is unavailable.*

Warrington and Halton Hospitals NHS Foundation Trust considers that this data is as described for the following reasons, in that the trust has a well-developed system for undertaking risk assessments on admission and ensuring the data is collated corporately and incorporated into the Quality Dashboard for monthly review and monitoring by the Clinical Governance Committee and the trust board.

Warrington and Halton Hospitals NHS Foundation Trust has taken the following actions to improve this percentage and so the quality of its services, by revising the logic for cohort to ensure patients receive risk assessment appropriately and streamlining processes to ensure all risk assessments are logged electronically on completion.

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

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

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

DATE	TRUST	NATIONAL
2012/2013	9.4	17.3
2011/2012	21	21.8
2010/2011	35.9	29.6

The Information Centre only provides average by Trust (not by highest and lowest) and 2013/14 data is not currently available.

Warrington and Halton Hospitals NHS Foundation Trust considers that this data is as described for the following reasons in that the trust follows the national Clostridium difficile guidelines. There is a robust system for data entry and validation which ensures all cases are entered onto the data Capture system.

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

- Surveillance of cases/monitoring for increased incidences in defined locations
- Cohort isolation facility maintained to manage cases
- Antimicrobial steering group with feedback to Clinicians on incidences of prescribing non-compliance
- Fidaxomicin introduced for treatment of patients with recurrent Clostridium difficile infection
- Text alerts to senior managers to report Clostridium difficile cases
- Increase in ward based training for management of infectious diarrhoea, viral gastroenteritis outbreaks and use of personal protective equipment
- Safety alerts distributed on the management of potentially infectious diarrhoea

- **Please see section 3.2.1 for further information on improvement actions.**

2.3.8. Patient Safety Incidents

The data is made available to the trust by the National Reporting and Learning System with regard to the number and, where available, rate of patient safety incidents reported within the trust duri ng 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 100 admissions

DATE	TRUST	TRUST NUMBER	MEDIAN	Lowest	Highest
October 2012 – March 2013	9.1	3620	7.6	1.7	16.7
April 2012 – September 2012	8.1	3257	6.7	3.11	14.44
October 2011 – March 2012	8.7	3402	6.7	2.21	10.54

NB: NRLS Report provides median rate of incidents per 100 admissions reported by all medium acute trusts

Patient Safety Incidents Severe Harm / Death - Rate

DATE	TRUST	NATIONAL %	PEER %	LOWEST	Highest
Severe Harm & Death October 2012 – March 2013	0%	0.05%	0.05%	0%	0.2%
Severe Harm April 2012 – September 2012	**0.15% (4)	*<1%	0.6%	0 0%	61 3.1%
Death	0.0% (1)	*<1%	0.2%	0	34

April 2012 – September 2012				0%	1.3%
Severe Harm October 2011 – March 2012	0.2% (4)	*<1%	0.6%	1 0%	80 3%
Death October 2011 – March 2012	0.0% (0)	*<1%	0.2%	0 0%	14 0.6%

NB - The Trust has reported by actual number & percentage by highest/lowest rates please note these will not necessarily be the same trusts.
NB - *National = Severe Harm and Death combined. **Please see comments below.

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

The trust has again moved up in the comparative reporting rate report to 5th best reporter (from 9th last time) having increased to 9.54 per 100 admissions (from 9.1). In addition the trust has maintained the required frequency and the median reporting speed of 5 days.

There is a discrepancy within our reported degree of harm and the degree of harm shown in the latest report. During the reporting period 1st April 2013 until 31st March 2014 the report shows 33 were categorised as severe harm (with a severity of 4 – major) and 9 have been reported with a severity of 5 as catastrophic (death) this should be 4 severe harm and 4 catastrophic harm.

The trust has queried this with NHS England and it appears part of the reason for this is that there is no longer a 2nd reporting deadline as there used to be. The impact is that everything needs to be up to date by the 1st deadline and on this occasion the trust missed this.

The trust continues to work with all the Divisions to review and finally approve their incidents. Weekly audits of all outstanding incidents are sent out. In November 2013 additional mid-week reports have been provided to ensure all incidents are updated by the required time.

Once the trust re-uploads all the data at the end of May 2014 the next NRLS report will be accurate. All of the incidents have since been re-uploaded to the NRLS and since the CQC get their data directly, our CQC profile will not be affected as they will have the most up to date.

2.3.9 Friends and Family Test – Patient.

The data made available by National Health Service Trust or NHS Foundation Trust by the Health and Social Care Information Centre for all acute providers of adult NHS funded care, covering services for inpatients and patients discharged from Accident and Emergency (types 1 and 2)

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

During the reporting period 1st April 2013 until 31st March 2014 the trusts performed above average in comparison with scores for England for inpatient Friends and Family. However a comparison of

Accident and Emergency data against national average reveals under performance which has a negative effect on the overall combined score for the trust.

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

- developing Always Events as an improvement priority for 2014/2015
- ensuring lessons learned from complaints take place
- undertaking local patient survey, developing and implementing actions
- monitoring via patient experience indicators and make changes as required

This indicator is new and not a statutory requirement for 2013/2014.

Friends and Family Net Promoter 2013/2014 (NHS England)

Month	Trust - Inpatient	England - Inpatient	Trust – A&E	England – A&E	Trust - Combined	England - Combined
April	80	71	63	49	76	63
May	76	72	52	55	73	65
June	80	72	54	54	73	64
July	76	70	56	54	70	63
August	76	71	20	56	58	64
September	77	71	46	52	60	62
October	82	71	48	55	63	64
November	75	72	42	56	58	64
December	71	71	35	56	53	64
January	78	72	42	57	60	64
February	81	72	45	55	69	63
March						

NB: England data includes independent sector providers April – June 2013, from July the independent sector is excluded.

Quality Report Part 3

Trust Overview of Quality

3.1 Introduction - Patient Safety, Clinical Effectiveness & Patient Experience

Patients are at the centre of everything we do and providing high quality service for every one of our patients is at the heart of our organisation. Our mission is to provide 'High Quality, Safe Healthcare'. To enable us to achieve this, we have four strategic objectives. They are:-

- **To ensure all patients are safe in our care**
- **To give our patients the best possible experience**
- To be the employer of choice for the health care we deliver
- To provide sustainable local health care services

The quality of patient care and the safe, effective manner in which it is provided is the core business of the NHS, and our trust strives to provide the best possible care in order to remain a sustainable health provider of choice. More recently there has been a major national policy shift to the importance attached to this. Building on the work of Lord Darzi's 'High Quality Care for All' the White paper published in 2010 'Equity and Excellence; Liberating the NHS' outlines the government's intention to establish improvement in quality and health care outcomes as the primary purpose of all NHS funded care.

More recently, the Francis Report (2013) has focussed everyone's attention nationally on the failings of the NHS. This final report of the Public Inquiry into the failings in care at another trust provided a

detailed and systematic analysis of the factors contributing to those failures. It identified that warning signs existed and they could have revealed the issues earlier. Francis has provided the foundations for all health care providers to look at their existing policies and strategies in a different light, to ensure that similar failings are never repeated.
We have responded to the Francis Report and the recommendations of the Francis Report have been developed into an action plan which the trust board has monitored throughout the year. In line with these recommendations we have reviewed and aligned two of our key strategies, Quality Improvement Patient Safety Strategy and our Patient Experience Strategy to provide a single strategy "Improving Quality: Patient Safety, Experience and Clinical Effectiveness Strategy."

Francis also cautioned that "A health service that does not listen to complaints is unlikely to reflect its patients' needs" and "A complaints system that does not respond flexibly, promptly and effectively to the justifiable concerns of complainants not only allows unacceptable practice to persist, it aggravates the grievance and suffering of the patient and those associated with the complaint, and undermines the public's trust in the service." This trust has invested time and resources in reconfiguring the complaints and PALS service into an integrated Patient Experience Team who are committed to providing a responsive patient focussed service.

- **Please refer to section 3.4.3 for information on progress in the management of complaints.**

In line with two key principles of the Francis Report namely to improve experience and reduce harm; to be open and honest with the public we decided to become a member of the 'Open and honest care: driving improvement' programme, established by NHS England. We have made a commitment to publish a set of patient outcomes; patient experience and staff experience measures so that patients and the public can see how we are performing in these areas. This includes regular publication of numbers of patients who develop pressure ulcers and patients that fall while in hospital. This combines the results from the Friends and Family Test, the NHS Safety Thermometer, patient and staff experience surveys, patient stories, staffing levels and never events all in one place, to not only build up a picture of care quality but also of an excellent and open reporting culture. The Open and Honest Reports for this trust can be found on the trust's website.

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

While it is important to identify and deliver against the three separate elements patient safety, clinical effectiveness and patient experience that comprise quality, it is critical to recognise that, though different, they are all aspects of 'high quality care'. Quality is only achieved if all three of these domains are present equally and simultaneously in care and that delivering on just one or two in isolation is not enough. As such it is essential that our approach provides an equal balance and assurance on all aspects of quality within the organisation and that we can demonstrate, measure and improve quality at all levels and throughout all areas of the trust. Our revised strategy draws together the various initiatives to deliver a clear plan of how the trust will work to achieve this.

3.1.1 Data Sources

Throughout 2013/2014 we have continued to develop our quality indicators which are used to evaluate the quality of our service. These indicators are monitored and reported via a monthly 'Quality Dashboard' through the wider committees and to the trust board to provide assurance on progress and improvements made in the areas of patient safety, clinical effectiveness and patient experience. We know how important it is to patients, their families and carers that when they have to come in to hospital that they are going to receive the best possible care. We know they want their care to be delivered in a clean and welcoming environment, where they feel safe and free from harm, so we try to ensure that these issues have been captured within our quality indicators.

The 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. Indicators allow organisations to measure and benchmark progress toward goals and the trust submits and utilises data from the Health and Social Care Information Centre (HSCIC). The HSCIC collates analyses and publishes NHS data on over a thousand indicators for everything from quality to population health and outcomes of treatments. This includes measures such as 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 following safety, risk and governance modules which enable the trust to have a comprehensive oversight of our risk management activities:

- Incident, adverse event and near miss reporting
- Patient relations
- Malpractice claims management
- Risk assessment
- Safety alerts
- Patient experience and feedback
- Accreditation self-assessment
- Complaints, compliments, comments and concerns

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

The trust submits data to the NHS Safety Thermometer which was developed for the NHS by the NHS as a point of care survey instrument, it provides a 'temperature check' on harm that can be used alongside other measures of harm to measure local and system progress 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 four outcomes 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, transparency surveys and observation.
Where available comparative and benchmark data has been included and unless otherwise stated the indicators are not governed by standard national definitions and the source of the data is the trust's local systems.

Trust data systems have been reviewed and amended to more accurately reflect the description of the incident(s), therefore comparative data from local systems may only available across two reporting years and more historical data has not been included.

We are continually implementing quality improvement initiatives to enhance the safety, effectiveness and experience outcomes for our patients.

3.1.2. Data – Mersey Internal Audit Agency (MIAA) Reporting Framework Review

The Francis Report into the failings at Mid Staffordshire NHS Foundation Trust strongly reinforces that quality should be at the heart of a patient-centred NHS. Quality of care provided is a key responsibility of the boards of NHS foundation trusts. Monitor "the sector regulator for health services in England whose job it is to protect and promote the interests of patients by ensuring that the whole sector works for their benefit" considers that maintaining and improving quality is an important indicator of the effectiveness of governance at a trust. More recently we have seen a number of documents issued providing guidance to trusts on the types of information that should be reported to trust boards.

In February 2013, Sir Bruce Keogh was asked to review the quality of care and treatment being provided by a number of hospital trusts in England that had a higher than average mortality rate over the last 2 years. The review process which was based on NHS National Quality Board guidance involved analysing and compiling data for each trust in relation to six key areas: mortality; patient experience, safety, workforce, clinical & operational effectiveness; and leadership and governance. This was the first time so much disparate data had been compiled for the purposes of assessing quality of care in the NHS. (MIAA: Reporting Framework Review, 2014).

It is vital that boards scrutinise data and importantly be confident that the data is meaningful and trustworthy. They need assurance that the processes for the governance of quality are embedded throughout the organisation. Moreover, the board should understand the organisation and that what they're being told is true, accurate, fair and backed up with sufficient evidence. This requires good data quality systems in place to deliver that data and a culture that supports ethics and candour.

To support this process the Director of Nursing and Organisational Development requested our internal auditors MIAA undertake a review of the trusts reporting framework. The overall objective was to undertake a mapping exercise to ascertain whether the information currently reported within the trust is aligned to the Keogh data set. The review also focussed upon:-

- Mapping out the information currently reported to key forums within the trust
- Undertaking a gap analysis against the Keogh data set
- Ensuring that mechanism were in place to escalate areas of concern to the board.

The review has consisted of a series of interviews with lead officers to identify where i information is reported and the process for collating the reported information. The review made three recommendations to improve data requirements and flow for effective quality governance namely: -

- The review identified a number of indicators that are not currently being reported within the trust. It acknowledged that not all information can be reported directly to the trust board. As such, the indicators should be reviewed, with an appropriate committee / sub-committee identified to review the data on a routine basis with a clear escalation process in place to ensure the board are informed should any significant concerns be highlighted by the indicators.
- All indicators should be subject to appropriate validation routines / accuracy checks and that procedure notes are developed to document the process followed
- The trust should ensure that where reported figures are manually input into performance reports / subject to filtering in excel to produce the reported figure, that figures are checked by a second officer to ensure consistency and accuracy of reporting.

3.1.3. Quality Dashboard 2013/2014

The information on this Quality Dashboard is also shared with our Governors and commissioners of services to demonstrate how care for patients is delivered and sustained improvements are maintained.

		Target / threshold	A	M	J	Q1	J	A	S	Q2	O	N	D	Q3	J	F	M	Q4	YTD
Patient Safety			Figures are totals or % for the month / quarter (except where stated)																
HSMR (rolling 12 months, latest data available)		<=100	107	107	107		105	105	105		104	104	103		101				101
SHMI (rolling 12 months, latest data available)		<=100	113	113	112		110	108	108		108	108	106						106
Total deaths in hospital			117	91	99	307	76	80	93	249	72	76	76	224	101	99	89	289	1069
Regulation 28 - Prevention of future deaths report								0	0	0	0	0	1	1	0	0	0	0	1
Incidents resulting in Major or Catastrophic harm		<7 (2012/13 total)	1	1	0	2	0	2	2	4	0	0	0	0	0	0	0	0	6
Incidents of major or catastrophic harm under investigation		N/A	0	0	1	1	0	0	0	0	0	2	1	3	1	3	3	7	11
Falls (moderate, major and catastrophic harm)		<=14 per year	5	0	0	5	1	1	0	2	1	2	0	3	3	1	1	5	15
Falls (moderate, major and catastrophic harm) awaiting approval		N/A	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pressure Ulcers	Grade 3 and 4 Hospital Acquired (Avoidable)	<=16 per year	0	0	1	1	1	1	0	2	0	0	0	0	1	0	1	2	5
	Grade 3 and 4 Hospital Acquired (Unavoidable)	N/A	1	0	0	1	1	0	0	1	1	0	0	1	1	0	0	1	4
	Grade 3 and 4 Hospital Acquired (Not yet determined)	N/A	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1
	Grade 2 Hospital Acquired	<=149 per year	16	6	11	33	7	7	18	32	3	5	9	17	8	6	15	29	111
	Grade 2 Hospital Acquired (under review)	N/A	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MRSA		0 per year	1	0	0	1	0	0	1	1	0	0	0	0	1	0	0	1	3
C difficile		<=19 per year	5	4	3	12	0	1	1	2	4	2	4	10	4	1	2	7	31
Never Events		0 per year	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	1
VTE	% of patients risk assessed	>=95% of patients	95.37	95.05	95.67	95.36	95.97	95.84	95.15	96.26	96.36	96.74	95.21	96.6	95.63	95.14	95.04	96.29	96.29
	% harm free (Safety Thermometer (ST))	TBC	98	98	99		98	98	99		98	97	98		98	99	98		
Medication Errors	Omitted doses (Quarterly audit)	>=10% reduction in yr				334				371				391				399	1495
	Insulin related errors	<=54 per year	4	8	2	14	4	1	1	6	3	8	4	15	6	2	8	16	51
CA – UTI: Number of catheterised patients who developed a UTI (ST)		TBC	6	1	4	11	6	4	5	15	2	3	1	6	3	4	3	10	42
CA – UTI % of catheterised patients who developed a UTI (ST)		TBC	1.11	0.19	0.7		1.13	0.73	0.93		0.38	0.5	0.19		0.53	0.75	0.55		
Dementia Assessment (Part 1)		>=90% of patients	90.43	93.14	91.35	91.67	92.87	95.12	95.12	94.33	95.2	95.13	96.11	95.5	97.67	97.36	94.57	96.5	94.44
Dementia Assessment (Part 2)		>=90% of patients	96.77	100	100	98.78	100	100	93.3	97.4	100	96.43	96.88	98.9	100	100	100	100	99.72
Dementia Assessment (Part 3)		>=90% of patients	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
Clinical Nursing Indicators		>=90% compliant				97				95	No data collected				No data collected				96

Effectiveness																			
Advancing Quality	Acute MI Threshold	>=91.46%	97.14	98.65	97.98	97.98	98.37	97.97	98.30	98.30	98.59	98.77	98.25	98.25					98.25
	Hip and knee	>=92.23%	97.47	97.56	96.77	96.77	96.08	96.46	96.98	96.98	96.30	96.41	96.21	96.21					96.21
	Heart failure	>=86.85%	85.00	90.91	93.59	93.59	93.00	90.84	90.96	90.96	87.95	89.09	88.75	88.75					88.75
	Pneumonia	>=75.23%	64.37	65.36	68.16	68.16	68.90	70.00	70.26	70.26	70.31	70.93	71.80	71.80					71.80
	Stroke	>=62.57%	59.46	55.00	53.49	53.49	55.75	58.33	57.54	57.54	57.14	56.50	56.16	56.16					56.16

3.1.4 Quality Indicators – rationale for inclusion

The following section provides an overview of the quality of care offered by the trust based on performance in 2013/14 against 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 utilised indicators which are deemed to be both locally and nationally of importance to the interests and requirements of patients. The overall purpose of this information is to inform the organisation of its effectiveness and performance and to lead it in a direction of improvement by indicating specific issues/areas that need to be developed.

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

Where these indicators have changed from the indicators used in our 2012/ 2013 report, we have outlined the rationale for why these indicators have changed and where the quality indicators are the same as those used in the 2012/2013 report and refer to historical data, we have checked the data to ensure consistency with the 2012/2013 report.

It should be noted that this section includes quality indicators in support of the improvement priorities outlined in section 2. This allows the trust to provide important historical data to show if improvement work has had an impact on performance.

3.2 Patient Safety

3.2.1. Infection Control

Within the reporting period 2013/2014, the trust threshold was 0 cases of MRSA, the trust has reported 3 cases of hospital acquired MRSA bloodstream infection and 1 MRSA contaminant compared to 1 hospital acquired case in 2012/2013 (against a threshold of 3).

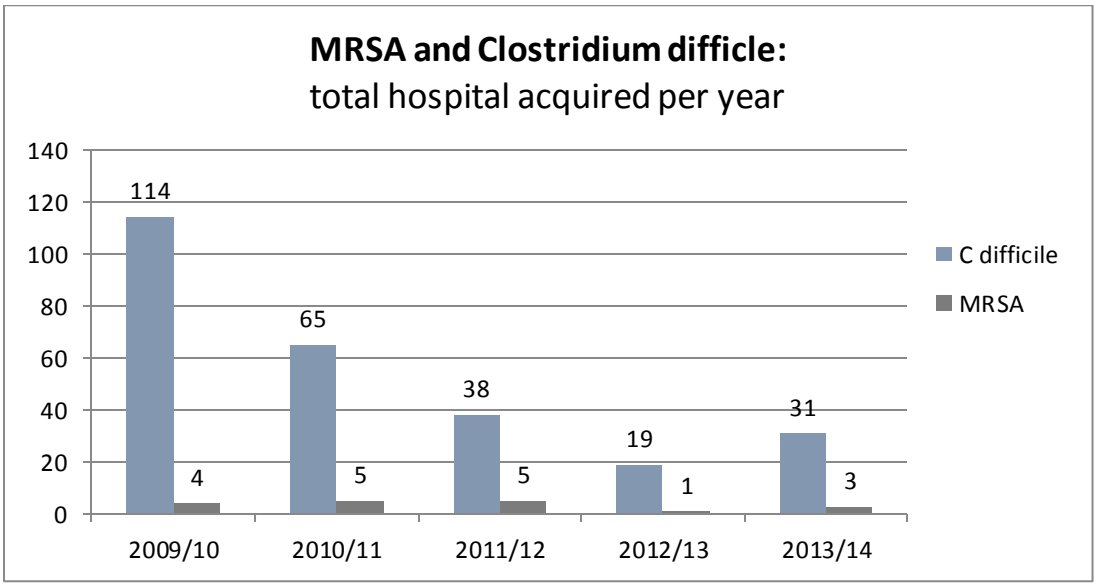
The trust reported 31 cases of hospital acquired Clostridium difficile infections against a threshold of 19 compared to 19 cases against a threshold of 40 for 2012/2013.

Despite the continued focus of activity, the trust was unable to achieve its threshold for Clostridium difficile. Initiatives maintained/implemented this year included but are not limited to:-

- Surveillance of cases/monitoring for increased incidences in defined locations
- Cohort isolation facility maintained to manage cases
- Antimicrobial steering group with feedback to Clinicians on incidences of prescribing non-compliance
- Fidaxomicin introduced for treatment of patients with recurrent Clostridium difficile infection
- Text alerts to senior managers to report Clostridium difficile cases
- Increase in ward based training for management of infectious diarrhoea, viral gastroenteritis outbreaks and use of personal protective equipment
- Safety alerts distributed on the management of potentially infectious diarrhoea
- Weekly multi-disciplinary team review of Clostridium difficile patients
- Revision to hand hygiene signage and awareness raising events
- External review of governance arrangements
- Establishment of a multi-agency Clostridium difficile action group

For the next financial year activity will be focussed on:-

- Increasing pharmacy time to support antibiotic ward rounds
- Review of IT developments to improve access to the antibiotic formulary (i.e. via an iphone app)
- Extending the use of hydrogen peroxide vapour for decontamination of side rooms vacated by Clostridium difficile patients. This requires investment in staff training and will have an operational impact as decontamination of side rooms will take slightly longer than conventional disinfection methods
- A rolling programme for decant and deep cleaning, using hydrogen peroxide vapour following ward upgrades
- Commitment to review the cleaning requirements over the 24 hour period including task team staffing levels
- Sharing learning from each Clostridium difficile case where lapses in quality of care occurred
- Review of evidence on probiotics with a view to implementing a trial in areas with a higher incidence of Clostridium difficile cases.



The data for this indicator is from a nationally prescribed data set, the indicator is monitored via the corporate performance report and the Quality Dashboard. The trust will continue to monitor HCAI as a quality indicator for 2014/2015.

3.2.2. Pressure Ulcers

As previously stated in section 2 the trust continued to focus on the management and reduction of pressure ulcers as an improvement priority for 2013/2014. The Prevention and Treatment of Pressure Ulcers (NICE Clinical Guideline 29; 2005) offers best practice advice on the care of adults and children with pressure ulcers. This trust has ensured that our current Pressure Ulcer Management Policy is aligned to and complies with the NICE Guidance recommendations.

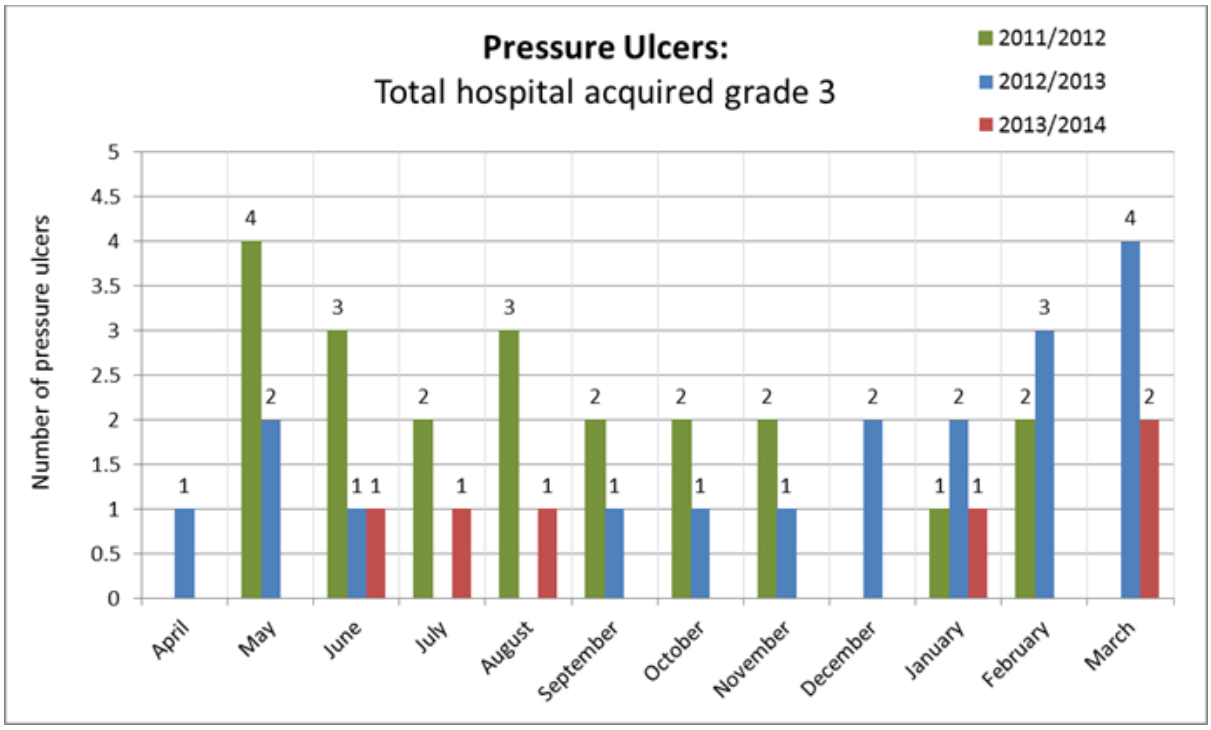
The trust has strengthened a number of processes and sees a strong focus on early patient assessment and the documentation of the patient's skin condition on admission as essential to good practice. This is in line with the NICE Guidance and critical to the prevention of pressure ulcers. The Waterlow risk assessment tool and management plan is used for all patients who are admitted to the hospital. The nursing documentation triggers the need to record skin condition on admission to hospital. The patient care plans promote the need to monitor and record skin condition, with additional specific plans put in place if a patient develops a pressure ulcer.

Importantly the trust has worked towards increased accuracy in reporting of all Grade 2-4 pressure ulcers to the risk management team via the electronic incident reporting system, Datix. The progressive increase in reporting pressure ulcers has provided us with the ability to know where and when pressure ulcers develop which was critical to developing our strategic improvement plan to prevent pressure ulcers. We have worked very hard in the last 18 months to ensure that pressure ulcers are recorded as those acquired in hospital and those acquired in the community so that we can accurately report and act to improve the incidence of pressure ulcers within the trust.

We established a target of a 10% reduction on last year for all grades as such our 10% threshold for grade 3 & 4 avoidable pressure ulcers acquired within the hospital was 16. During the reporting period we had 6 confirmed grade 3 avoidable hospital acquired pressures and no Grade 4 pressure ulcers which represented a 67% reduction on 2012/2013. The trust is pleased to report that the

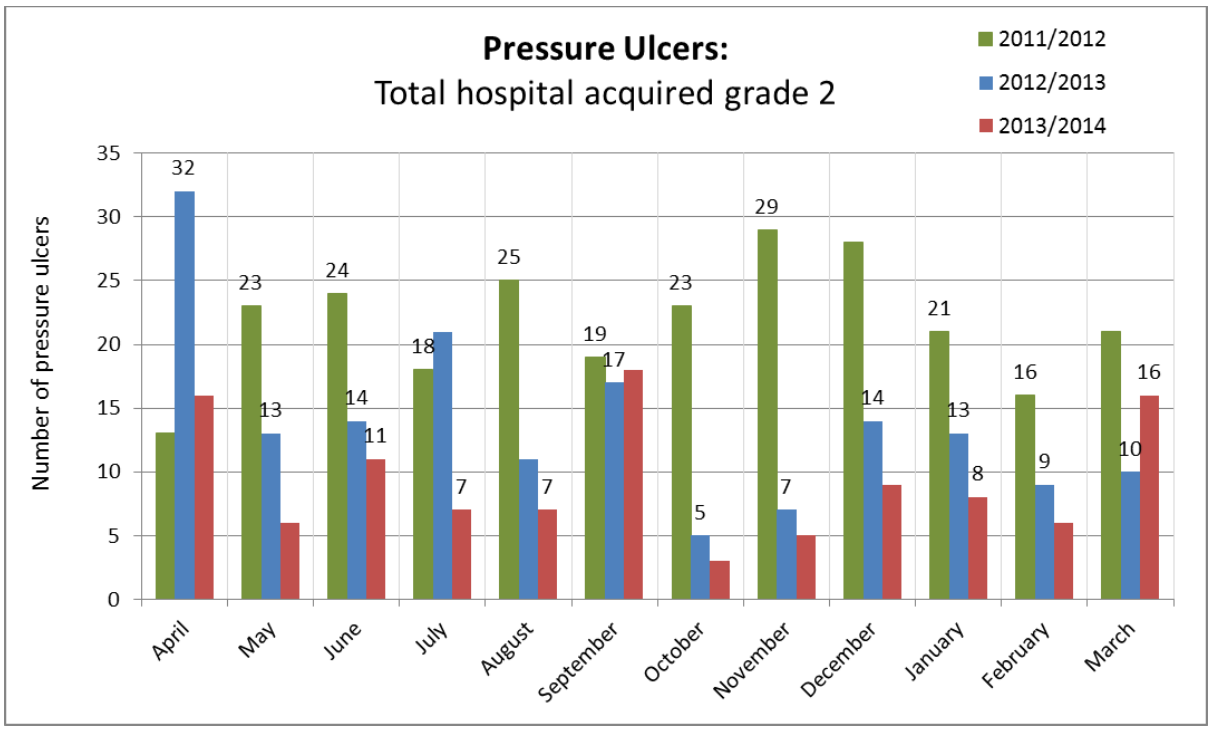
sustained improvement and management of pressure ulcers has resulted in a sustained reduction over a three year period as shown by the following graph.

Pressure Ulcers hospital acquired Grade 3: 2011/12 – 2013/2014



Our threshold for all grade 2 pressure ulcers acquired within the hospital was a further 10% reduction to 149 and during the reporting period we have had 111 hospital acquired Grade 2 pressure ulcers which represents a 33% reduction on 2012/2013.

Pressure Ulcers hospital acquired Grade 2: 2011/2012 – 2013/2014



Two pressure ulcer link study days have been held during 2013/2014 and the key lessons (Single Point Lessons) from the framework for "pressure ulcer prevention" have been reiterated in areas of concern with a positive effect. An example of this is in the Intensive Care Unit where the re-energising of the lessons supported effective leadership and innovative approaches to reducing device related pressure ulcers.

These lessons underpinned the "No Avoidable Pressure Ulcers Campaigns" and the Worldwide Stop Pressure Ulcer Day in November which included using screen savers stating "Pressure Ulcers? Not on our watch. We can prevent them".

The trust also ensures that the correct equipment which conforms to the NICE Guidance is purchased and this includes ensuring that all standard foam mattresses within the trust are made of a high specification pressure reducing foam. The trust hires specialist equipment to meet specific patient needs, these include the dynamic mattress replacement systems such a low air loss therapy, or occasionally air fluidised beds. The majority of beds within the Intensive Care Unit have dynamic mattresses in place, and following assessment staff can order appropriate mattresses.

The 471 electric profiling bed frames within the trust also assist in the prevention of pressure ulcers. The trust participated in a trial of Park House - Phase 111 Mattress Replacement system which is described as incorporating the latest in innovative features to help deliver the optimum in patient and pressure care for both the treatment and prevention of pressure ulcers. Importantly they are recommended for patients who are deemed at a very high risk of developing pressure ulcers. The pilot which was supported by staff from Park House was carried out in two clinical areas namely Intensive Care Unit and A3 which is a Care of the Elderly ward. Both patients and staff provided feedback on performance, comfort, ease of installation and effect on pressure ulcer management in relation to reducing the incidence and deterioration if a pressure ulcer was already present. The product received positive feedback with A3 stating that although they had a number of very unwell patients that importantly they did not report any grade 2 pressure ulcers or deterioration of existing pressure ulcers. Patients also commented that the mattresses were very comfortable and that they slept well, staff reported that they were easy to install and lighter to use which minimised manual handling injuries. The outcome from this audit was that the trust agreed to award the contract and we are currently under negotiations to finalise arrangements. The Tissue Viability Team offers advice on specialist equipment.

Bariatric patients (patients with an increased body weight or size) are at a particular risk and require a collaborative approach to assessment of equipment needs, there is a very limited amount of equipment available to meet the needs of this patient group. The trust has identified this as an area for development in 2013/2014.

The trust has managed a sustained reduction in the number of Grade 2 and 3 pressure ulcers and we have not had a Grade 4 pressure ulcer within the trust since March 2011. We know that it is the efforts of our nursing teams, supported by the Tissue Viability Team in increasing patient care interventions which has prevented Grade 3 pressure ulcers developing into Grade 4. Similarly, our plans to reduce Grade 2's by early intervention and planning are being achieved.

Analysis of Grade 2 and 3 acquired pressure ulcers reveals the following trends:

- Acuity of illness
- Poor nutritional status
- Poor peripheral vascular supply to skin (peripheral vascular disease / inotropic drugs)
- Decrease in mobility

The trust continues to implement its planned programme of actions to further reduce pressure ulcers which includes:-

- Review of the trust policy on pressure ulcers is in progress, with particular reference to the process by which we investigate Grade 3/4 pressure ulcers.
- Root cause analysis is conducted on all Grade 3/4 pressure ulcers which develop within the trust;
- Mini investigations of all grade 2 hospital acquired pressure ulcers

This information is collected using an internationally recognised pressure ulcer grading tool devised by National Pressure Ulcer Advisory Panel (NPUAP) and European Pressure Ulcer Advisory Panel (EPUAP) and our measurement and data collection systems have been given 'significant assurance' by Merseyside Internal Audit Agency.

Pressure Ulcer Grade Definitions

1	Non blanching Erythema (reddened skin which remains reddened on fingertip pressure)
	Discolouration of the skin, warmth, oedema, hardness or pain. Bruising may indicate deep tissue injury (see below).
2	Partial thickness skin loss or blistering without slough (e.g. very superficial top layer of skin)
3	Full thickness skin loss involving subcutaneous tissue but not extending to underlying structures (may or may not have tracking)
4	Full thickness tissue loss with exposed (or directly palpable) bone, tendon or muscle / Ulcer covered with thick necrotic tissue which masks the true extent of the damage
SDTI	Suspected Deep Tissue Injury: An area of pressure related bruising may indicate deep tissue injury. Observe regularly and re-grade as appropriate. Refer to Tissue Viability Nurse Specialist.

***** Not all pressure ulcers are avoidable; there are situations that render pressure ulcer development unavoidable, including hemodynamic instability that is worsened with physical movement and inability to maintain nutrition and hydration status and the presence of an advanced directive prohibiting artificial nutrition/hydration and patient choice that inhibits full patient care. To be determined as 'unavoidable' the full circumstances of the patients care has to be contemporaneously documented within the patients care records.

Across the trust there has been an increase in reporting and importantly in the accuracy of all reporting. The trust is pleased to be in the top 5% of all organisations reporting incidents to the National Patient Safety Agency which demonstrates a real culture of wanting to be open and to learn from incidents that occur. We did see the initial expected increase in reporting of pressure ulcers however this was followed by a sustained reduction over the last three years in all grades of hospital acquired pressure ulcers.

The Trust will continue to monitor pressure ulcers as an improvement priority for 2014/2015.

3.2.2.1 Pressure Ulcer CQUIN

Achieving an improvement on the baseline within the Safety Thermometer for pressure ulcer prevalence was also established as a national CQUIN for 2013/2014. The first part of this CQUIN relates to recording the number of patients recorded as having a category 2-4 pressure ulcer (old or new) as measured using the NHS Safety Thermometer on the day of each monthly survey. The second part of the CQUIN relates establishing a baseline based on the results of the first six of the year and then showing an improvement on this baseline for pressure ulcer prevalence. The trust

established a baseline median of 4.95 from data gathered from the Safety Thermometer for the first six months of the year. The trust agreed this baseline figure with commissioners. We then monitored the rolling median on a monthly basis for the latter half of the 2013/2014 and the trust is pleased to report that we both achieved a reduction and remained below this figure during this period as follows:-

Pressure Ulcer Median Rate

Month	Rate	Baseline
April	5.19	
May	6.04	
June	4.71	
July	3.95	
August	3.83	
September	5.20	
Rolling median	**4.95**	Median 4.95
October	3.58	Annual RM = 4.71
November	4.13	Annual RM = 4.42
December	3.85	Annual RM = 4.13
January	4.23	Annual RM = 4.18
February	2.81	Annual RM = 4.13
March	4.62	Annual RM = 4.18

The Safety Thermometer (pressure ulcer) will continue as a national CQUIN for 2014/2015 and the trust will continue to monitor and report on this data.

3.2.3 Falls - Management and Reduction.

It is recognised that falls are one of our highest priority areas in reducing harm in the hospital setting. A number of successful initiatives have been put in place over the past two years to support falls reduction and they include firstly the falls action scheme where senior nurses and therapists attend wards and departments following a fall in the area and complete a mini-investigation of the fall. The second initiative is the "Falls Change Package" whereby a number of ward-led innovations are embedded into the way our nurses and other staff work to support individual patients who are at risk of falls. These include:

- Care and Comfort Rounds where we proactively take patients to the bathroom when they cannot easily do so themselves without assistance and when we ensure they have their belongings and beverages in reach to avoid slipping when reaching for them.
- Bay tagging where a member of staff would not leave a bay of patients unattended if a patient within that bay was considered at such high risk of falls. If they need to leave the bay, they will 'tag' a colleague who in turn cannot then leave the bay. This is highly successful, with medical staff, porters, therapists and support staff all thoroughly embracing the idea of being 'tagged' to safeguard our patients from falling.
- Toilet/commode tagging where a patient is not left unattended whilst using the commode or toilet, of course in this case it is imperative to maintain privacy and dignity whilst ensuring that a very high risk patient does not fall.
- Changes to staff base where at night during peak times for falls, nurses are based outside the entrance to, or within each individual bay

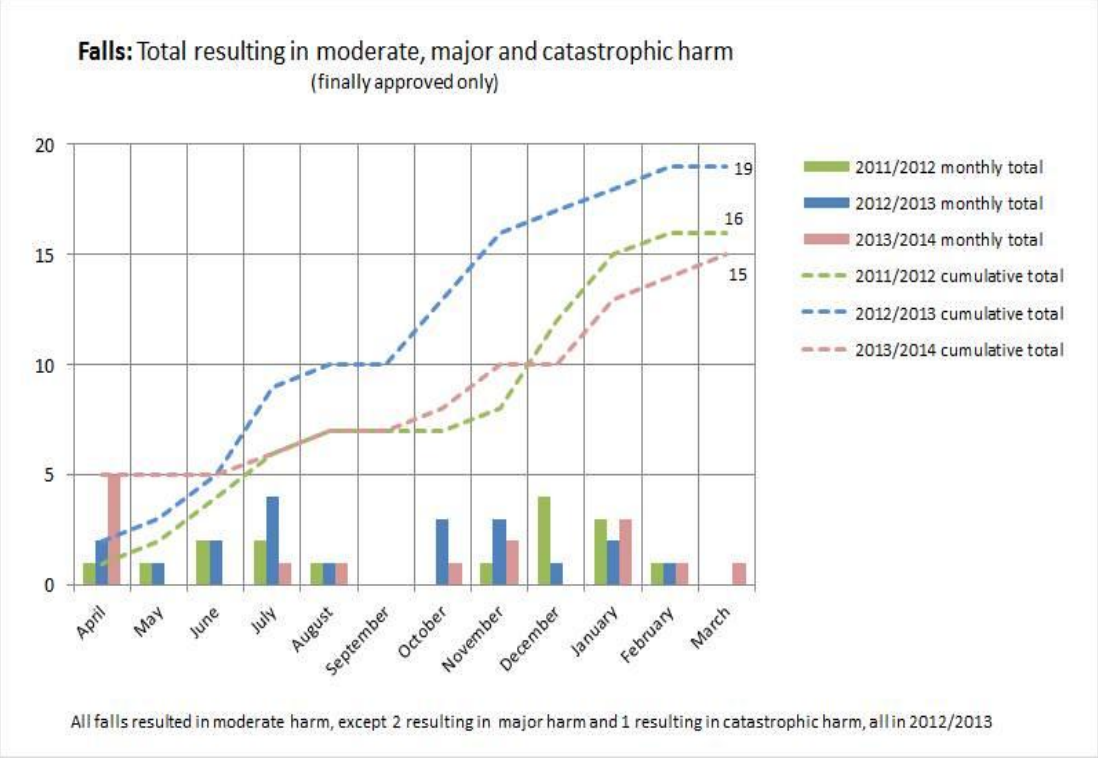
- Safety crosses where we provide real time data to staff, patients and visitors to the number of falls that have occurred on the ward

Overall we have seen a 28.28% reduction in falls since Q1 2012/13 and this trend continues to be sustained. Our aim now is to further drill down into the root causes to effect an improvement in 2014/15.

During 2012/13 our threshold for falls was 18 falls that result in moderate to catastrophic harm, and by the year end we reported 16 moderate harm falls. Whilst the reduction of falls was not an improvement priority for 2013/2014 we remained focussed on improvements and calculated that the trust's new threshold monitored via the quality dashboard should be based on a challenging 10% reduction on 2012/13 thus establishing a threshold of <=14 for this period.

Whilst the trust can report a reduction in moderate to catastrophic falls by year end we were disappointed that we did not achieve our threshold in that there have been 15 approved moderate falls incidents for 2013/2014. There have been no falls resulting in major or catastrophic harm during 2013/2014.

Falls 2011/2012 - 2013/2014



A further breakdown is provided which shows the sustained improvements in falls per quarter since the start of our renewed campaign to reduce all falls in hospital. The table below shows falls where no harm occurred as well as those with minor harm. It also includes for 2013/14 the falls which were classed as moderate (15 in total).

	13/14 Q1	13/14 Q2	13/14 Q3	13/14 Q4
Patient Slips, Trips & Falls	251	256	246	246

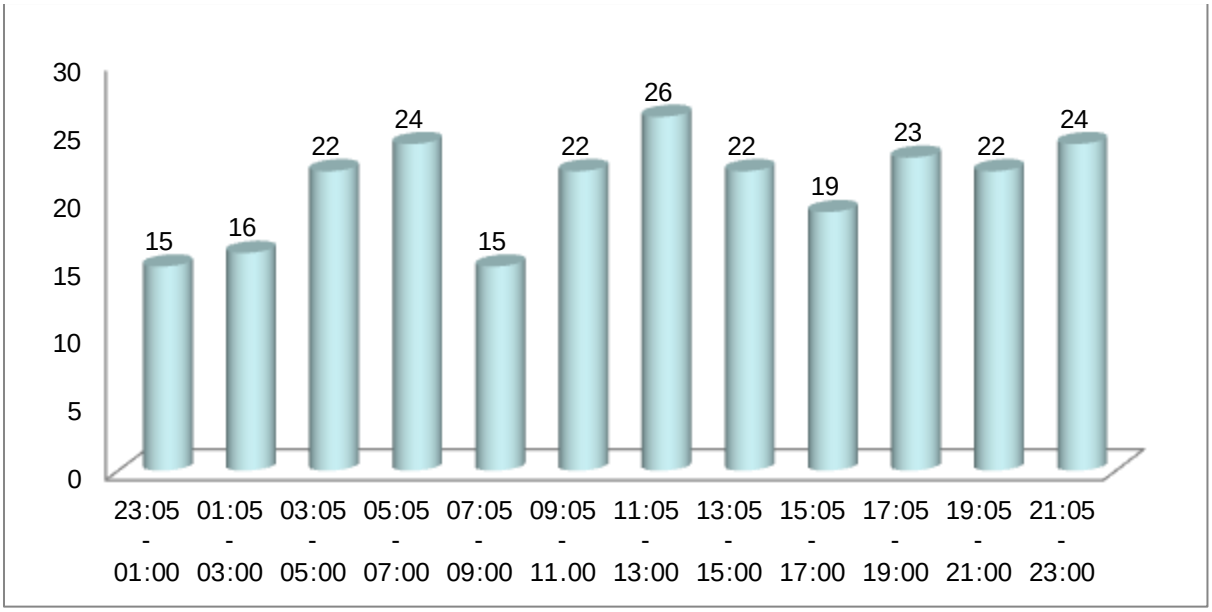
Once an investigation has taken place, each fall is sub-categorised. The table below provides a breakdown of the top 5 sub-categories relating to falls.

	13/14 Q1	13/14 Q2	13/14 Q3	13/14 Q4
Found on floor	92	107	69	86
Fall from bed or trolley	40	33	29	33
Trip	23	14	32	27
Fall from Chair	23	22	18	25
Slip from Bed	17	20	36	23

In the early part of the year we focussed efforts ensuring that when a patient was 'found on the floor' a careful examination of what this meant was undertaken. For example, a patient could only be truly classed as being found on the floor if there had been no witness to the fall, and the patient was unable to explain how they had fallen. This allowed us to more appropriately apportion the fall to a 'trip' for example if the patient was able to say what had happened and/or this had been witnessed. This allow us to then focus attention in 2014/15 on the root causes of falls in a more sophisticated way. We have been fortunate to be able to fund a new post, Patient Safety and Quality Champion and the post-holder will work very closely with the Falls Group to achieve the reduction in falls that we have set ourselves for 2014/15.

Furthermore, throughout 2013/14 our senior nurses, matrons and therapy staff have continued to support our ward based staff to ensure a safe environment for our patients, thus reducing the possibility for falls as far as possible. We have monitored falls by ward and noted the most common times that a patient may fall. This was noted to be in the early hours of the morning; therefore wards have looked again at the activities of staff at that time, as well as at the patterns of night time behaviour for individual patients who are at risk of falling. A recent Safety Walkround on one of our wards noted that in those patients who were frail and elderly there could be a link between the fall and the timings and type of the night-time beverage. We have researched this thoroughly, and are now planning a project group to try and make improvements in that area.

The table below demonstrates the times of falls across all wards in one quarter in 2013/14.



NB – This data is collected via the trust's electronic incident reporting system Datix.

- **Moderate Harm – an injury which may be a fracture, that isn't permanent but which has the ability to reduce mobility/movement**
- **Major Harm – an injury that results in either a fracture or an injury which contributes to long-term reduced movement/mobility**
- **Catastrophic Harm – an injury that causes or significantly contributes to the death of a patient or to such significant permanent injury as to be life changing.**

*The trust has in place a process whereby incidents on datix are assigned an approval status indicating the stage that has been reached in the review process. During the review, the details of the incident are reviewed, investigated as appropriate and the severity of harm caused is identified; this may be a different severity to that initially assigned as this may not be known at the time of reporting (e.g. if a patient is awaiting an x-ray following a fall). An incident is given the status of finally approved when this process has been completed and as part of this, it is possible to assign a final severity of harm. Falls data is extracted from datix and included in the Quality Dashboard and monitored on a monthly basis at board.

When patients fall (regardless of whether they experience harm or not), the incident is reported via the Datix system. This automatically informs a member of the senior nursing team who will visit the ward. A full review of processes and risk assessments required is then undertaken.

If a fall is deemed to be moderate, then in line with policy any investigation is completed within 30 days. In line with the Duty of Candour, the investigations are shared with the family within 10 days of completion and approval through the governance processes. The in-depth investigations we undertake allows us to generate lessons learned, and make recommendations through an action plan which teams work through. We offer support to our staff, families and patients throughout the investigation process as we understand how stressful this can be.

We recognise the anxiety and distress that in-patient falls cause for both the patient and their family. This can be in the form of physical harm such as broken limbs, but often there is unquantifiable psychological harm done to previously independent people whose confidence is destroyed for the rest of their lives. We believe that patients should be safe in our care and should be protected from avoidable harm wherever possible. Therefore the trust has, in consultation with stakeholders agreed to maintain falls management as a quality indicator and reintroduce it as an improvement priority for 2014/2015.

3.2.4 Catheter associated urinary tract infections.

The trust is committed to improving patient care by reducing the incidence of catheter-associated urinary tract infection (CAUTI) it therefore selected this clinical issue as an improvement priority for 2013/2014.

This was not an improvement priority in 2012/2013 so we did not collect CAUTI data on catheter associated UTI's however we felt that it was important that we were able to produce some benchmarking data from 2012/2013 to assist analysis of performance on this key quality issue.

As stated earlier the trust has been submitting data to the Safety Thermometer since May 2012 so this has allowed us to establish a performance baseline based on 2012/2013 data in order to

measure any improvement made during 2013/2014. We established 3 indicators and extracted data from the Safety Thermometer in relation to the following:-

- CA – UTI: Number of catheterised patients who developed a UTI (ST)
- CA – UTI % of catheterised patients who developed a UTI (ST)
- CAUTI rolling median - local agreement to benchmark against rolling median value for last year based on 6 months from 2012/2013 against 2013/2014 median. ST Rolling Median 2012/2013 = 4.2

As stated we collected data over a two year period on both the number and percentage of catheterised patients who developed a urinary tract infection.

Month	CA – UTI: Number of catheterised patients who developed a UTI (ST)		CA – UTI % of catheterised patients who developed a UTI (ST)	
	2012/2013	2013/2014	2012/2013	2013/2014
April	Data collection began in May 2012.	6		1.11
May	9	1	1.56	0.19
June	3	4	0.47	0.7
July	5	6	0.86	1.13
August	4	4	0.73	0.73
September	6	5	1.10	0.93
October	4	2	0.72	0.38
November	5	3	0.91	0.56
December	3	1	0.52	0.19
January	3	3	0.51	0.53
February	2	4	0.34	0.75
March	1	3	0.18	0.55
	45	**36 (*excludes April)**	**0.7**	**0.6**

***NB: Data collection did not take place until May 2012 so for the purpose of comparison we have used data from May 2013 – March 2014.**

For 2013/2014 these two indicators have been reported via the Quality Dashboard to trust board. A comparison with 2012/2013 data indicates an overall improvement of 20% reduction in the actual number of catheterised patients who developed a UTI during 2013/2014. The average percentage of catheterised patients who developed a UTI reduced from 0.7% to 0.6%.

We then employed a third indicator based on on the actual number of patients with a catheter acquired infection as a percentage of all patients surveyed on that day. We measured this through the rolling median because this is deemed to be a statistically strong methodology which smooth's out short-term fluctuations and highlights longer-term trends or cycles. The rolling median which was based on six months of data from 2012/2013 was calculated at 4.2. We then monitored this CAUTI data throughout 2013/2014 to ascertain if the monthly rate remained below this figure. We are pleased to report that with the exception of September 2013 which showed a slight increase that this analysis confirmed a year on reduction in catheter acquired infection.

CAUTI – Rolling Median Data 2013/2014

MONTH	ACTUAL	ROLLING MEDIAN
APRIL	6.7*	*
MAY	1	1
JUNE	3.2	2.1
JULY	4.8	3.2
AUGUST	4.5	3.9
SEPTEMBER	5	4.5
OCTOBER	1.8	3.9
NOVEMBER	2.7	3.2
DECEMBER	1	3
JANUARY	2.9	2.9
FEBRUARY	5	3
MARCH	3.4	3.2

***NB Excluding April data**

This will not continue as an improvement priority for 2014/2015 but the trust believes this to be an important aspect of safety and will continue to monitor the CAUTI indicator rates and will report back in the Quality Report next year.

3.2.5. NPSA 'never events'.

One never event occurred during 2013/2014. The never event recorded on datix was an incident relating to Wrong Implant/Prosthesis whereby a patient for left knee replacement surgery had a right sided femoral component implanted. All actions relating to the recommendations have been completed. The investigation report shows that no harm was caused to the patient and there would be no long-term complications as a result of this incident. The trust explained everything to the patient in line with our Duty of Candour.

The contractual obligation from the 1st April 2013 means that all NHS organisations are required to tell patients if their safety has been compromised which has resulted in moderate (non-permanent harm) and or severe (permanent harm) and or death outcome as a result of something not being done. There must be an apology, appropriate investigation with recommendations to ensure that lessons are learned and thus, reduce the risk of the incident being repeated.

The trust has always embraced a non-contractual duty of openness with patients. However new rules to toughen transparency in NHS organisations and increase patient confidence has resulted in the Government creating regulations that require the NHS Commissioning Board to include a contractual duty of openness in all commissioning contracts from April 2013. This is known as Duty of Candour.

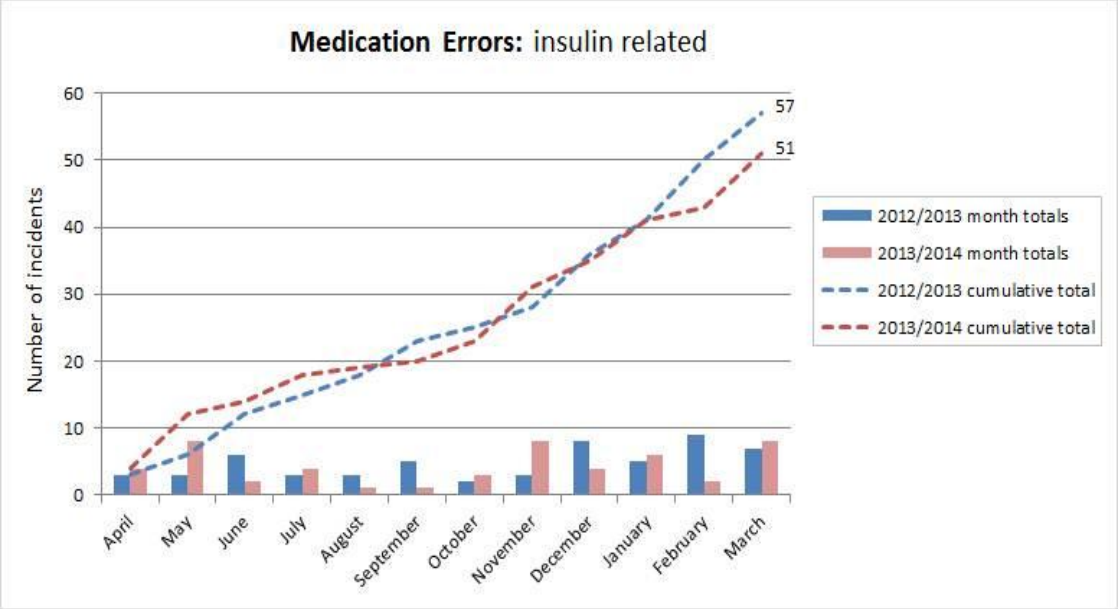
3.2.6. Reduction in medication errors that are related to insulin.

A quarterly trust wide audit of omitted medicines has been carried out since April 2012; this supports the trust in identifying areas of concern thus enabling targeted improvements to be made.

In 2012/13 a target of a 10% reduction based on data from Q1 and Q2 2012/2013 was established. There were 57 incidents related to insulin errors reported in 2012/2013 therefore the trust did not meet its internal target of 10% reduction in errors. However, during that year we did have improved reporting which corresponded to the amendment to the datix system (the addition of an insulin tick box) and the consequent increased awareness of the need to report and by a campaign to focus on allergy related incidents.

For 2013/2014 the trust improvement target was a 5% reduction in medication errors related to insulin, which translated to a reduction in real terms from 57 insulin related incidents to >=54 for 2013/2014. Insulin related medication errors are discussed at the Medicines Safety Committee and reported to board on a monthly basis via the Quality Dashboard. The chart below shows that the trust exceeded its improvement target of a 5% reduction by achieving 10.5% reduction in the number of insulin related errors reported on the trust incident management system datix.

Medication Errors: insulin related – 2012/2013 - 2013/2014.



Quality improvement initiatives to reduce errors include:-

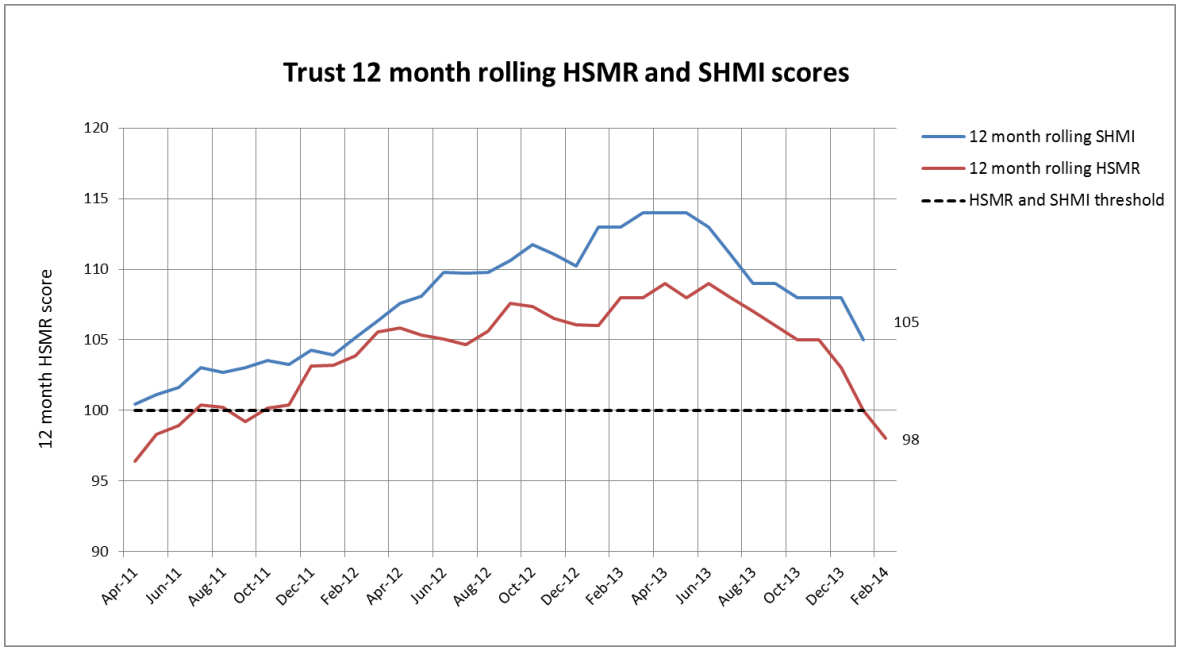
- Diabetes nurses have been delivering training sessions to groups of staff including pharmacists and junior doctors
- Mini-investigations are undertaken on all incidents.
- Increased focus on insulin incidents with immediate follow up and review with staff
- Issuing safety alerts to raise awareness of key issues for staff

Going forward this will no longer remain as an improvement priority but it will be reported as part of the quality indicator on medicines management.

3.3 Clinical Effectiveness

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

Both our SHMI and HSMR scores have been higher than we would have liked in 2013/2014, however, following a significant focus on mortality reduction in the trust, we are very pleased to report a fall in both scores towards the target of 100 or less. Since the January 2014 HSCIC publication (for the period July 2012 – June 2013) the trust has had an 'as expected' SHMI score and the latest SHMI score available (HED system) is 105, for the period February 2013 – January 2014.



The latest HSMR score available (HED system) is 98 for the period March 2013 – February 2014. The chart above shows these rolling 12 month figures since April 2011. We have also improved against other North West trusts, having had the 4th highest SHMI score in 2012/2013 to now having the 9th highest out of 22 trusts, based on the latest available data. The trust has invested in a designated Clinical Effectiveness function, a responsibility of which is to monitor and reports these figures widely across the organisation to a number of forums, and also to support staff and services to understand the detail behind them, to drive improvements.

The Clinical Effectiveness Group has responsibility for reviewing mortality and is currently driving progress in this area. In addition to on-going quality improvement activity for example clinical audit the trust has focussed on six priority areas of activity; these are shown in the table below, with examples of progress made in each area.

Priority Area	Specific activity
Reviewing the trust's care pathways and best practice care bundles to ensure a high standard of care for every patient,	The development of the trust Clinical Effectiveness function affords greater capacity of support to clinical teams in the cycle of continuous improvement. Examples include supporting the revision of pathways for patients with Chronic Obstructive Pulmonary Disease (COPD) and a sepsis pathway.

every time.	Enhanced Recovery Pathways have been implemented in surgery in 2013/2014 to support reduce the time patients have to spend in hospital and promote faster patient recovery. Leadership of the Advancing Quality (AQ) programme has been assumed by the Deputy Director of Nursing, and risks to its implementation and achievement of compliance against the measures have been raised at relevant forums. This new approach has raised the profile of this vital initiative and we believe this will improve our processes and in turn, patient outcomes.
Ensuring quality and appropriate care at the end of patients' lives.	The provision of Specialist Palliative Care has increased significantly in 2013/2014. See section 3.3.6 for more detail.
Reviewing the care of patients with respiratory conditions to ensure this is optimal at all stages of their care	A process mapping exercise has been carried out regarding the patient journey from admission to chest X-ray, to identify any aspects of the process which could be improved. Progress in this area is being monitored by the Clinical Effectiveness Committee. COPD (launched north west wide in April 2014) and Pneumonia are 2 of the Advancing Quality programme measures. With the additional support and senior drive behind this programme, it is anticipated that Pneumonia AQ compliance will improve and COPD AQ compliance will be achieved.
Promoting the effective management of patients whose conditions deteriorate.	The trust has made significant developments in this area with the introduction of a Medical Emergency Team, revision of the Early Warning Scoring system, standardising this across the trust and developing an "I bleep" system, using technology to greater effect in the coordination of key personnel responding to patients who deteriorate. A thorough review was undertaken into the care of patients who had a cardiac arrest; progress against identified actions is being monitored by the Clinical Effectiveness Group.
Continue to analyse, understand, report and use mortality and morbidity data to improve outcomes.	Trust staff awareness and understanding of mortality ratios has increased significantly in 2013/2014. Data is presented at a variety of forums across the organisation and an App has been developed to enable 24hour access to the information from a smart phone, tablet or PC. A detailed mortality report is presented at the monthly Clinical Effectiveness Group and quarterly at trust board. Thorough patient level reviews are carried out where the data highlights the trust as an outlier.
Ensure accurate and comprehensive documentation and coding.	As a member of AQUA's Reducing Mortality Collaborative, the trust has used AQUA's framework for reducing mortality, which largely mirrors the six key areas outlined here. To ensure mortality ratios are useful indicators of the quality of care, trusts must make sure that their documentation and coding is accurate as this is the data from which the scores are produced. The trust has undertaken work to ensure that we continually, accurately and comprehensively document patient's health and the care they receive so that the coding team can assign the correct codes.

We will continue to monitor and report mortality ratios in 2014/2015 and use the data as an indicator of the quality of care we provide, supporting targeted improvements.

3.3.2. Reducing harm to patients who are critically ill – high impact interventions.

Our sickest and most vulnerable patients are the ones treated within our Intensive Care Unit, and we have introduced and monitored a number of care bundles to ensure the best possible safe care is provided. The High Impact Interventions (HII) from the Department of Health 'Saving Lives' initiative are an evidence-based approach to key clinical procedures or care processes that can reduce the risk of infection if performed appropriately. They have been developed to provide a practical way of highlighting the critical elements of a particular procedure or care process (a care bundle), the key actions required and a means of demonstrating reliability. No single action will produce effective infection prevention and control practice and for any planned clinical procedure, there are a number of critical components founded on a solid evidence base that must be undertaken correctly to reduce infection risk.

Sustainable reductions in healthcare associated infections (HCAIs) require the engagement and active involvement of all staff working within the critical care environment, supported by the infection control team and clinical champions. Every clinician has the potential to significantly reduce the risk of infection to their patients by ensuring that they consistently comply with evidence based practice and guidelines when they undertake a clinical procedure.

The trust continues to use the following high impact interventions or care bundles within its Intensive Care Unit:

- Urinary Catheter: insertion
- Urinary Catheter: on-going care
- Ventilator Acquired Pneumonia
- Blood stream infections: CVC on-going care
- CVC insertion
- Peripheral cannula on-going care
- Peripheral cannula insertion

In 2011/2012 the trust achieved 97% compliance for ventilator acquired pneumonia prevention and 100% for urinary catheter infection prevention – we achieved our goals. Our plan for 2012/2013 was to maintain this high standard so the trust established an improvement target of >=90% and achieved compliance with each High Impact Intervention care bundle. The trust did not identify this audit as an improvement priority going forward for 2013/2014 but we felt it was important that we continued to audit practice because regular auditing of the care bundle actions will support cycles of review and continuous improvement in our care settings. The table shows the trust continues to improve compliance evidenced by the following cumulative compliance rates for 2012/2014 reported in the Quality Dashboard:

High Impact Intervention	2012/2013	2013/2014
Urinary Catheter: insertion	100%	100%
Urinary Catheter: on-going care	99%	99%
Ventilator Acquired Pneumonia	94%	96%
Blood stream infections: CVC on-going care.	100%	100%
CVC insertion	100%	99%
Peripheral cannula on-going	96%	97%

care		
Peripheral cannula insertion	99%	99%

3.3.3. Dementia CQUIN and Forget Me Not Campaign

In 2012, a CQUIN for dementia was established to ensure that trusts identified patients with dementia and other causes of cognitive impairment alongside their other medical conditions in order to prompt appropriate referral and follow up after they leave hospital. The trust achieved the CQUIN target of over 90% of patients being assessed at each stage by Quarter 4 as per our contractual obligations reported through UNIFY the central returns dataset and the Quality Dashboard. In 2013/2014 this CQUIN remained a national contractual agreement to ensure that hospitals continued to deliver high quality care to people with dementia. Importantly for 2013/2014 this CQUIN also included additional components namely that trusts:-

- Will need to ensure they have a named lead clinician for dementia and that this role is clearly documented in the individual's job plan.
- Will provide and deliver appropriate training for staff.
- Will need to support carers by agreeing the content of a carers audit with commissioners; undertake a monthly carers audit and ensure the results are presented to the trust board, as well as implementing any actions resulting from them.

The trust has worked hard at implementing the CQUIN and is pleased to report that we achieved full compliance with this dementia CQUIN for 2013/2014.

In addition to this national CQUIN, the trust agreed a local CQUIN called the "ForgetMeNot" Campaign to ensure further improvements to services for our patients with dementia this included:-

- reviewing the trust Dementia Strategy and introducing the 'Forget me Not Campaign'
- introduce Dementia Champions across the trust
- nominating two dementia friendly wards
- assess ward environments utilising the dementia friendly tool kit

Dementia will remain as a national CQUIN and a quality indicator for 2014/2015.

3.3.3.1. Warrington and Halton Hospitals - Dementia Journey

Dementia was also selected as an area of focus for 2013/2014 with the specific aim of promoting the development of a culture within the organisation where everyone will be able to recognise and help patients with dementia.

At this trust the staff are dedicated to providing the best possible care for patients with dementia. The term 'dementia' describes a set of symptoms that include loss of memory, mood changes, and problems with communication and reasoning. There are many types of dementia. The most common are Alzheimer's disease and vascular dementia. Dementia is progressive, which means the symptoms will gradually get worse. (Alzheimers Society)

Our Dementia Strategy sets out the framework by which we will achieve this. Within the strategy we have identified ten key areas which are underpinned by action plans monitored by our Dementia Steering Group. An information leaflet which raises awareness around the ten areas has been developed and distributed to staff. Over the past year we have ensured that Dementia Champions are in place at board level with our Director of Nursing and Organisational Development leading the way for those patients who are amongst our most vulnerable. We have an identified both a senior medical and senior nursing lead for dementia and have in place trained dementia champions both at ward and department level; which include non-clinical and clinical staff.

The trust recognising the importance of ensuring that our environment is dementia friendly used the Kings Fund Toolkits to review how 'dementia friendly' our wards are. These results were then used to inform our successful bid to the Kings Fund in April 2013, where we were awarded £1.04M to improve the environment for patients with dementia. **Work has now been completed on our £1 million specialist ward which is now open for acute patients with dementia at Warrington Hospital.**

Why we want to be dementia friendly

- We want our patients with dementia to be warm, fed and well cared for in the right environment.
- We want their care to maintain their pride and dignity.
- We want to help eradicate the agitation and distress that often comes with dementia.
- We want to help their families and carers to feel that patients with dementia are safe in our care and to know that patients with dementia are a priority for us.
- We want our hospitals to lead the way in dementia care, and to be able to demonstrate success.
- We want our approach to mean that patients with dementia spend as little time in hospital as possible.

Forget Met Not Campaign

This campaign has successfully raised awareness of patients with dementia, and cognitive impairment. We launched the use of the Forget Me Flower symbol behind

the patient's bed. The symbol reminds our staff that the patient either has a diagnosis of dementia or has cognitive impairment and that they should ensure that their approaches to the patient are appropriate. This is accompanied by information to staff, carers and families about what this means for the patient.
A programme of events, the "Forget Me Not Events", provide focussed activities within ward areas aimed at providing stimulation, diversion and helping to reduce the agitation and loneliness that so often accompanies dementia.

"Forget Me Not" muffs (twiddle muffs)
The wards have a suite of activities, including games, memory boxes, and other products aimed at keeping hands busy and stimulating the mind. This programme also includes musical events, and will be developed to include other activities such as poetry recitals. So far this year our wards have been visited by a string quartet, a choir, an a capella group and a ukulele band where patients and their relatives enjoyed a positive and stimulating social experience over tea and cakes with our staff. We have community knitting groups who make "Forget Me Not" muffs (twiddle muffs) to help keep hands busy and reduce anxiety.

Identified wards also have rummage boxes, activity boards, and games to help reduce the symptoms associated with dementia and cognitive impairment.

The trust has also promoted the use of "Forget Me Not" silicone wristbands for patients, carers, staff and families to raise awareness of dementia and cognitive impairment. We monitor the movement of patients with dementia, and put in place actions to restrict moves that are not in their best interest. We are currently auditing a sample group of patients with a diagnosis of dementia or confused state who were readmitted to our hospital within 30 days of their discharge to see what improvements we can make to ensure that they are supported to stay at home as far as possible.

A dementia training programme for staff is vital to ensuring the delivery of high quality care. The trust has purchased two courses from an external training company who work in conjunction with the Alzheimer's Society in the development and delivery of dementia training. These workshops specifically designed to support the Dementia Champion role provide a person centred approach to dementia care offering support that reflects individual needs. We also provide a one day workshop

called "Supporting the Dementia Patient Journey" which is aimed at all staff groups who come into contact with patients that have dementia. The course provides training around a number of areas including definitions of dementia; an understanding of how people with dementia communicate; a virtual dementia tour – a practical exercise exploring the effects of dementia; on line dementia café; maintaining skills – how to promote independence and supporting relationships – how to support people with dementia & their carers

Our Specialist Nurse for Older People has produced a suite of care plans for patients with dementia, delirium or cognitive impairment and we are reviewing our "Dementia Awareness Packs" for the ward and department areas. From April we will be rolling out dementia e-learning and training materials for all staff and we will hold a dementia exhibition on a regular basis to promote the ward and a greater awareness of dementia.

We are proud of our achievements in developing a culture whereby all staff will be able to recognise and help a patient with dementia and in the summer 2014 the trust will hold a Dementia Conference to celebrate and share the innovatory work that has taken place.

3.3.4. Compliance with regional targets set for Advancing Quality – reducing variation

Advancing Quality Alliance (AQuA) is an organisation which aims to improve the quality of healthcare; they are funded by members and customers including Foundation Trusts, Mental Health Trusts and Clinical Commissioning Groups. They work with members and customers to promote and share knowledge of best practice in order to improve the quality of healthcare.

Advancing Quality (AQ) is one of AQuA's programmes which aim to improve healthcare standards provided in NHS hospitals across the North West of England and importantly reduce variation. It was launched in 2008 across all North West hospitals and originally focused on five clinical areas which affect a lot of patients in the region namely heart attacks, heart bypass surgery, heart failure, hip and knee replacement surgery and pneumonia. The programme which is independently researched and evaluated is deemed to be achieving its objectives. Following the early success of the programme, AQ expanded into the treatment of stroke patients in October 2010, followed by dementia and first episode psychosis in January 2011.

AQ works with clinicians to provide trusts with a set of quality standards which define and measure good clinical practice. Care in hospital is always tailored to individual needs but trusts must deliver each measure to every patient to ensure they receive the highest standard of care in hospital. AQ refers to this as the Clinical Process Measures and trusts aim to achieve 100 per cent success rate. For example, if a patient is admitted into hospital suffering from pneumonia, two of the key Clinical Process Measures would be to have their oxygen levels assessed when they arrive in hospital and, if antibiotics are prescribed that the patient receives them within six hours of arriving at hospital. It aims to give all patients a better experience of the NHS by ensuring that every patient admitted to a North West hospital is given the same high standard of care. The idea is, if every hospital achieves the AQ measures, it will help to:-

- Save lives.
- Reduce the number of people being re-admitted into hospital.

- Reduce complications.
- Decrease the length of time patients have to spend in hospital.

The table below provides a five year summary of the trust performance from AQuA which shows compliance with the CQUIN target for this period.

Warrington & Halton NHS Trust - Advancing Quality Data*

YEAR	Heart Attack	Heart Failure	Hip & Knee Surgery	Pneumonia	Stroke
Year 1	97.60%	73.42%	90.53%	82.11%	NRC
Year 2	99.29%	90.12%	94.09%	84.16%	NRC
Year 3	99.56%	90.66%	96.34%	86.52%	NRC
Year 4	99.55%	95.41%	98.02%	88.98%	90.60%
Year 5	99.45%	94.93%	98.48%	90.38%	88.90%
CQUIN TARGET	**91.46%**	**86.85%**	**92.23%**	**75.23%**	**62.57%**

- **NRC – No results collected**
- **** Published on the* AQuA's website**

*AQ is also a local CQUIN for the trust and we are p*erformance managed for each agreed condition Pneumonia; Heart Failure; Acute Myocardial Infarction; Hip and Knee and Stroke in order to demonstrate an annual improvement against the targets. The above table reported via the Quality Dashboard demonstrates that for 2013/2014 the trust has achieved all measures with the exception of pneumonia and stroke.

Advancing Quality Measures 2013/2014
NB Quarter 4 data will not be available until July 2014.

The Advancing Quality Group meet on a monthly basis to discuss performance and to provide

MEASURE	TARGET	APR	MAY	JUN	Q 1	JUL	AUG	SEPT	Q 2	OCT	NOV	DEC	Q3
Heart Attack	>=91.46%	97.14	98.65	97.98	97.98	98.37	97.97	98.30	98.30	98.59	98.77	98.25	98.25
Hip Knee	>=92.23%	97.47	97.56	96.77	96.77	96.08	96.46	96.98	96.98	96.30	96.41	96.21	96.21
Heart Failure	>=86.85%	85.00	90.91	93.59	93.59	93.00	90.84	90.96	90.96	87.95	89.09	88.75	88.75
Pneumonia	>=75.23%	64.37	65.36	68.16	68.16	68.90	70.00	70.26	70.26	70.31	70.93	71.80	71.80
Stroke	>=62.57%	59.46	55.00	53.49	53.49	55.75	58.33	57.54	57.54	57.14	56.50	56.16	56.16

assurance that all clinical areas are reviewed and ensure appropriate monitoring mechanisms are in place.

Going forward for 2014/2015 the AQ measures described above will remain a local CQUIN and additional measures will be included in the CQUIN from April 2014, including Chronic obstructive pulmonary disease (COPD); Hip Fracture; Sepsis; Acute Kidney Injury; Diabetes and Alcoholic Liver Disease.

As previously stated during 2013/2014 the trust experienced issues in meeting all the Stroke and Pneumonia measures and has therefore decided in consultation with stakeholders to include these measures as an improvement priority for 2014/2015.

3.3.5 Reduction in readmissions.

The trust works toward reducing readmissions in accordance with contractual requirements with the commissioners.

Please refer to section 2.3.3 for further information

3.3.6. High Level Quality care at End of Life.

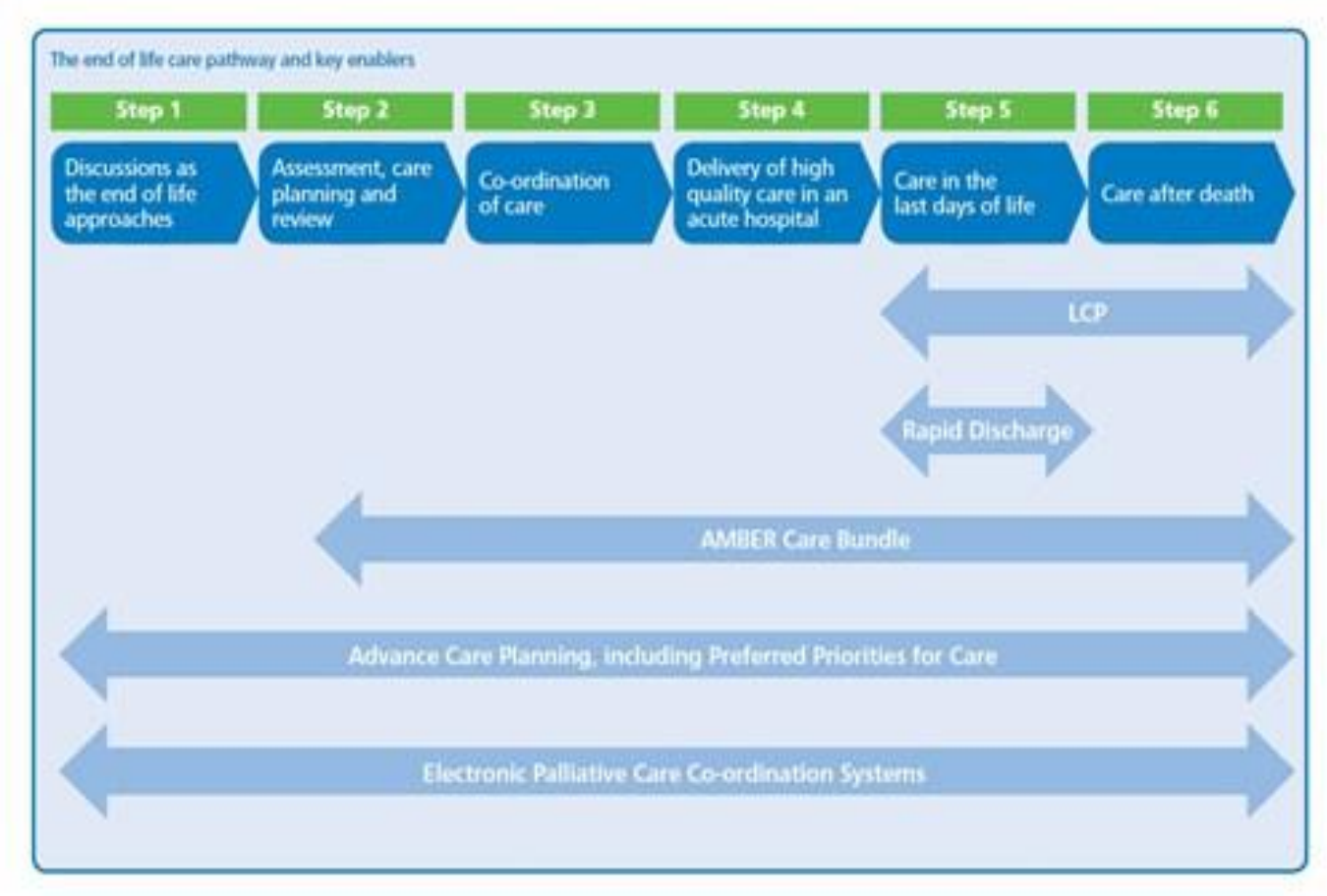
The trust has been part of the national Transform programme which aims to improve end of life care in acute trusts, enabling more people to be supported to live and die well in their preferred place. As part of the programme we have continued to use existing end of life care tools and are in particular working on the implementation of the 5 key enablers:

Key Enabler	Progress
Advance Care Planning	Education about Advance Care Planning is a key priority for the next few months as the AMBER care bundle continues to be used on more wards and will have specific relevance to the opening of the new dementia ward in the hospital. As part of the process of education regarding Advance Care Planning, road

	shows specifically dealing with difficult conversations are planned from June until the end of the year.
Electronic Palliative Care Coordinating Systems (EPaCCS)	EPaCCS provide a shared locality record for health and social care professionals. They allow rapid access across care boundaries, to key information about an individual approaching the end of life, including their expressed preferences for care. There is work on-going with local Palliative Care Services, local healthcare providers and the Cheshire and Merseyside Palliative and End of Life Care Network to develop an EPaCCS system which will suit the needs of the local population.
AMBER Care Bundle	The AMBER care bundle is a simple approach used in hospitals when clinicians are uncertain whether a patient may recover and are concerned that they may only have a few months left to live. It encourages staff, patients and families to continue with treatment in the hope of a recovery, while talking openly about people's wishes and putting plans in place should the worst happen. The trust is implementing the AMBER care bundle as part of the Transform national initiative, led by NHS Improving Quality (NHSIQ). The care bundle has been implemented on 10 wards across the trust, with further implementation planned on the surgical unit. A recent audit of deaths occurring in hospital found that the standard and content of the documentation including medical planning, ceiling of treatment and communication with patients/families was higher where the AMBER Care Bundle was used to support patients whose recovery was uncertain.
Rapid Discharge Home to Die Pathway	Hospital is not where most people would choose to die although we know that it is where the majority of people do die. Where people have been identified as dying and they express a preference to die at home it is sometimes possible to fulfil that wish by arranging discharges at short notice. These discharges are complex however, and there are many elements which must come together to maximise the chances of success. With this in mind the Specialist Palliative Care CNS team has drafted a supporting pathway document to try to ensure that this is done right every time. The document is ready to go out for consultation to the wider healthcare team and it is hoped that it can be implemented within the next year. New anticipatory prescribing guidance for dying patients has recently been launched in the trust along with new processes for administration sheets for these medications to go home with patients so that they can receive symptom control in a timely manner at home. This will complement the rapid discharge pathway work. A unified Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) policy was implemented across the whole of Warrington in October 2013 and this is aimed at reducing the number of unnecessary repeated conversations about CPR when patients move to different settings. It also aims to reduce the number of inappropriate CPR attempts occurring in the community. Consideration of a DNACPR decision will be necessary in planning a rapid

	discharge of someone who is dying.
Liverpool Care Pathway for the Dying patient (LCP).	This is a framework to guide high quality end of life care for those in the last hours and days of life. Since a national review of care of dying patients, it must be phased out in July 2014 and be replaced with individualised care plans. In line with guidance from the Leadership Alliance we in Warrington have continued to use the LCP supported by open discussions with patients and families about this as it has previously been used very appropriately here. There are plans in progress for a new individualised care plan document to be implemented in the Summer to replace the LCP and to support doctors and nurses caring for people who are dying. The trust took part in the 3rd round of National Care of the Dying Hospital Audit in November 2013, and we await the report from this audit. The report benchmarks the trust with other units across the country.

An overview of the use of the key enablers set out by the Transform Programme. Note that where the LCP is mentioned, this will be replaced by an individualised care plan for the dying patient.



The use of the key enablers from the programme has benefitted the trust by:

- Improving the quality of the individual patient experience and the quality of care
- Supporting the patient to die in the place of their choice
- Promoting the development of a skilled workforce with improved staff morale and retention

- Allowing more effective resource management by a reduction in inappropriate interventions
- Managing and reducing unplanned hospital admissions
- Reducing complaints and enhancing the reputation of the trust.

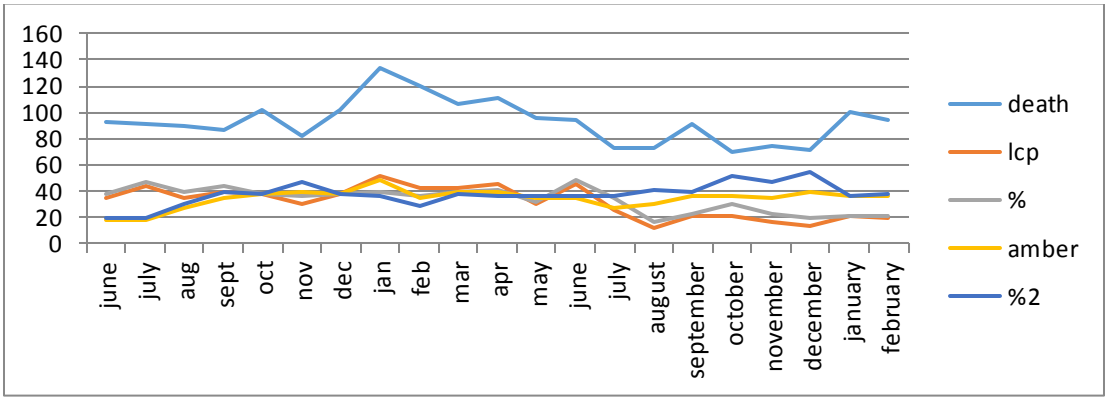
Support has been obtained from the National team in benchmarking the trust against other early implementers and this has enabled monitoring of the progress we are making.
Data from the National End of Life Care Intelligence Network shows that our trust has a lower number of bed days in the last year of life compared to the national average. The reasons for this are several including improved discharge processes, improved identification of people who are approaching the end of life and involvement of the Specialist Palliative Care Team to name but a few.
The activity of the hospital Specialist Palliative Care Team has continued to see a year on year increase with around 700 new referrals to the team in 2013/2014. We can also report an increase in the deaths coded as having input from Specialist Palliative Care. In response to the 'More Care, Less Pathway' review, referral to Specialist Palliative Care has been recommended for all patients who have been identified as dying. The aim of this is to ensure that patients are receiving the care that they need in the last hours and days of life and that families are being supported and also that the doctors and nurses looking after the patients have access to specialist support as they care for these people.

Education
Education has underpinned the improvements seen in the trust in end of life care and all members of the Specialist Palliative Care Team have delivered education to a variety of professionals in the organisation. A well-attended link nurse programme is in operation with ward nurses attending teaching at St Rocco's Hospice led by the Hospital Palliative Care Team and focussing on control of symptoms, identification of dying patients, and other issues pertinent to looking after patients at the end of their lives. Information from these days has been disseminated in the form of single point lessons so that more staff have the opportunity to benefit from this work. There have been several sessions delivered by various team members for junior doctors who have been taught on subjects such as identification and care of dying patients and safe discharges at the end of life.

The AMBER Care Bundle
The continued implementation of the AMBER care bundle owes much to the tireless efforts of Joanne Meredith who is the facilitator for this project, winning an award from the trust in 2013 in recognition of the positive difference this activity makes to patients.

A 20-30 minute training session on the use of the AMBER care bundle has been delivered to 300 medical or nursing staff, they also receive on-going support from the facilitator to enable roll out. More than 600 patients have had their care supported by an AMBER care bundle. An AMBER discharge proforma is now being developed to communicate the discussions that have taken place in hospital that care should be supported at home as per the patients wish and for re-admission to take place only if absolutely vital. A recent case note audit demonstrated that the AMBER Care Bundle used to support patients when recovery is uncertain improved the standard and content of the documentation including medical planning; ceiling of treatment and communication with patients/families.

A sample audit showed 0% rate of readmission for patients that had had care supported using the AMBER care bundle and had been discharged and had died within 100 days of discharge during September and October.



Trend analysis - tools used to support care for patients nearing end of life.

In the trust, approximately 20% of patients who die and whose deaths were expected have their care supported by the Liverpool Care pathway (LCP). There has been an expected reduction in numbers following the review of the LCP in 2013 which recommended the gradual phase out of the pathway, and to discontinue its use in by July 2014. Clinical staff and patients and families are being supported by the specialist Palliative care team and facilitators during this transition period.

3.4 Patient Experience

Following the publication of the Francis report there is heightened awareness and concern about the experience that patients have in healthcare settings. The trust supports the ideology that it needs to collect information; be open and transparent about the experience of patients within its care and that information about patient experience should be publically available. Ensuring that people have a positive experience of care is also a key objective within the NHS Outcomes Framework. This trust supports the view that patient experience is as equally important as the other elements of the quality agenda namely clinical effectiveness and patient safety, and that that it should be embedded across our work to improve quality outcomes. "There is clear evidence that where patients are engaged in their own care and have a good experience of care and treatment, clinical outcomes are better" (NHS England, 2014)

The trust is committed to improving patient experience as set out in the "Improving Quality: Patient Safety, Experience and Clinical Effectiveness Strategy." The implementation of the strategy is supported by a number of work streams and activities identified across all areas of the trust.

Priority actions for the 2013/2014 included:

- Achieve an improvement in the learning and analysis of complaints with themes relating to attitude, care and treatment
- To revolutionise the way that we manage complaints to provide a responsive patient focussed service
- Implementation of the Friends and Family CQUIN
- Develop 'always events', i.e. what must we always do for patients to ensure a quality experience.
- Continue to monitor mixed sex occurrences
- Develop a basket of Patient Experience Indicators
- Evidence of CQC compliance with regulations and outcomes
- Evidence of compliance with the recommendations of the Francis Report
- Improvements demonstrated in our In-patient Survey
- Successful implementation of a Patient Information Centre / Patient Experience 'Hotline'
- Good Healthwatch reports and external reviews

The effective management of complaints and concerns is integral to ensuring a positive patient experience by addressing issues as they arise and ensuring that lessons are learnt and poor practice and systems are addressed.

Our commissioning arrangements for both national and local CQUINs for example the Friends & Family Test continue to reflect the importance of us being responsive to patient feedback to improve patient experience. The trust also participates in all relevant national surveys, and has a number of local approaches to evaluating the patient experience. Importantly, it continues to build its skills and tools to enable it to collect and analyse different sources of feedback from complaints, patient stories, PALS and local surveys in order to identify key issues that need to be addressed and then put in place improvement plans that deliver an improved experience. More recently the trust has also developed a suite of patient experience indicators which will allow us to monitor performance on a

monthly basis in key areas for example collecting data on the rate of "Negative comments posted on patient opinion; NHS Choices and/or the CQC Experience Form."

The evidence also demonstrates that "where there are high levels of co-worker support; good job satisfaction, good organisational climate, perceived organisational support, low emotional exhaustion and supervisor support, there are links to good patient-reported experience. However poor staff satisfaction is associated with worse standards of care" (NHS England, 2014) Within year the trust has undertaken a cultural barometer survey of all staff, developed an action plan and made changes as required. It has also established a project to develop and agree values and behaviours which will shape the organisation, the objective is that the new values and behaviours will drive a philosophy of improving services for the patient.

As well as encouraging staff feedback through national and local surveys we support processes to enhance staff wellbeing. The trust has dedicated web pages to promoting and supporting social and healthy living and also holds annual staff health and wellbeing events. The Staff Engagement and Wellbeing Event held in September 2013 attracted sponsorship from companies and was attended by approximately 350 members of staff. The focus of the event was to promote healthy lifestyles, with the activities such as the smoothie bike, cycling challenge and gym attendances.

The planned Friends & Family Test for staff due to start in 2014 and the staff survey results will also provide a barometer of staff experience. We also ensure that staff feedback around the quality of the patient care provided in our organisations is publicly available through for example Open and Honest, which is available at:

- www.whh.nhs.uk - transparency section

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

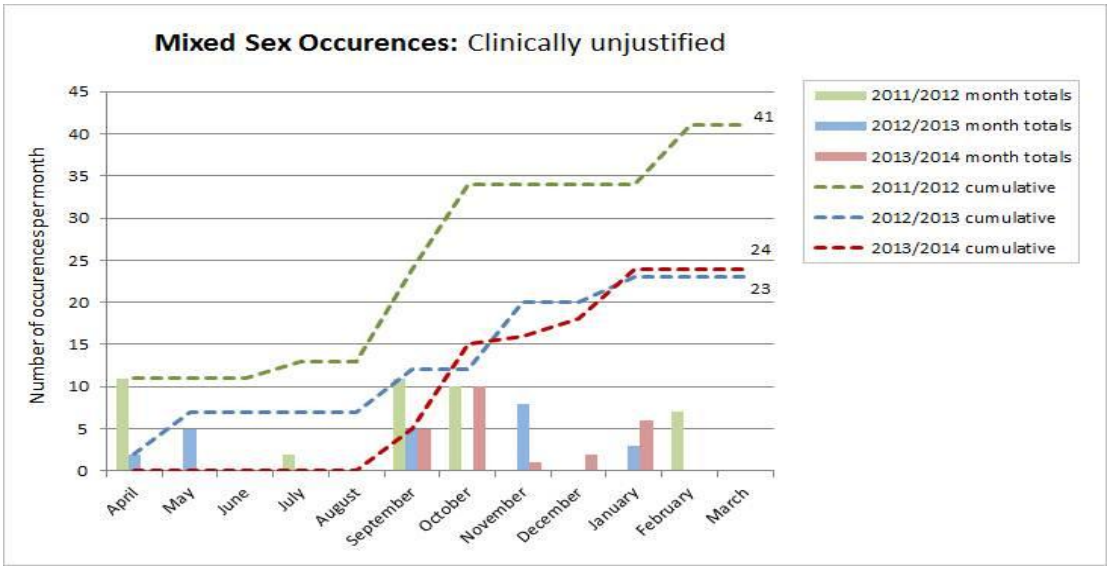
3.4.1. Eliminating Mixed Sex Accommodation.

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

In 2012/2013 the trust threshold was for full compliance with no reported breaches however, whilst we reported 23 mixed sex occurrence breaches, this was a 44% reduction on 2011/12 when the trust had 41 breaches. For 2013/2014 the trust again established a zero tolerance threshold and it was on target to meet this objective until September 2013. Until this time the trust believed that there was a locally agreed protocol with the CCG that stated if an MSO occurred in specific areas of the trust for example the Clinical Decisions Unit and GP Assessment Unit (GPAU) then the breach will not be liable for penalty as long as it is resolved within an 8 hour time limit. However, when the trust made a request to the Department of Health (DoH) to rescind an MSO which after investigation they

discovered had breached for less than 8 hours the DoH refused to grant the revision request stating that the length of time for an MSO is not relevant. The trust then instituted a review and a paper was presented to the Executive Team (ET) for the ET to agree that reporting practise would change in line with further guidance from the DoH. Unfortunately despite rigorous monitoring and changes to patient flow, the trust has continued to report breaches in these areas. However it does ensure that each breach/cluster has been reviewed using a root cause analysis and remedial action plans constructed and submitted to the CCG within fourteen days of month's end in accordance with contractual agreements.

In 2013/2014 the trust can report that following a review as described above that there were no reported breaches for February and March 2014 and a total of 24 breaches by year end. Please see graph below for a three year comparison. The trust will report progress in the Quality Report 2014/2015.



3.4.2. Always Events

In addition to the agreed improvement priorities the trust board in partnership with staff and governors also agreed to focus upon a number of key issues around quality improvement which included the development of "always events." Always events are aspects of patient care that should always happen for patients to ensure a quality experience. The trust has held a number of focus groups with patients; staff and governors to agree a small number of always events which we will monitor throughout 2014/2015. It was important to seek the ideas and suggestions of both staff and patient representatives. Focus Groups for staff and Governors provided lots of ideas about quality measures. A local healthcare event "Get Engaged" provided an opportunity to ask members of the public and representatives of patient groups and third sector organisations what were the always events they would appreciate.

It is vital that Always Events are measurable and can be implemented and monitored within current resources/budgets. Some suggestions, while they would demonstrate excellent quality of care, could not be easily introduced or monitored. A process of distillation has left us with the following Always Events. The next stage is to plan implementation and ensure that there is an audit trail

inherent in the system. We will monitor the Always Events throughout 2014/2015 and report them as a quality indicator in the Quality Report next year.

The Always Events will be:-

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

3.4.3. Complaints and Compliments

The year 2013/14 was a very challenging one in terms of complaints handling in the trust. A combination of staff attrition and system problems in the central complaints handling team and capacity and workload pressures, particularly in the Unscheduled and Scheduled Care Divisions left the trust with a considerable backlog of late complaints and relationships with complainants were sometimes affected.

A real team effort has been made to improve systems in to provide meaningful responses to those complainants where complaints were late, and in ensuring that we kept in touch as far as possible. We spent considerable time in restructuring of the team; the result is that our system is on a more even keel, though we believe there is room for even more improvement. We recognise the hard work and effort of many of our staff across all the divisions, the Patient Experience Team/corporate nursing team and at executive level to improve the handling of complaints.

In order to meet the expectations of the board, the commissioners and, most importantly, the public we must continue to improve the systems in place and ensure that the methods we employ to investigate and learn from complaints provide assurance and demonstrate a transparent and committed process and staff who want to acknowledge failures and learn from them.

The complaints process is an important source of data and feedback for the trust in its plan to improve the patient experience. The priority for the forthcoming year is to build on the progress made during 2013/14. The Patient Experience Team continues to provide support to divisional staff when dealing with complaints and there are regular divisional meetings with key members of staff to discuss the progress and handling of complaints. Having spent the last year improving the strategic systems and working practices, the teams across the trust will look to develop the skills of clinical and managerial leads in investigating complaints and strengthening the learning and assurance aspects of complaints during 2014/2015.

Specific priority actions relating to complaints for 2013/14 included:

- Achieve an improvement in the learning and analysis of complaints with themes relating to attitude, care and treatment
- To revolutionise the way that we manage complaints to provide a responsive patient focused service
- Successful implementation of a Patient Information Centre / Patient Experience 'Hotline'

Until April 2013 this service comprised 1 WTE Patient Relations Manager, 2 WTE Patient Relations Officers, 1 WTE PALS officer, and 1 WTE Administration Assistant. The period from May until December 2013 was one of building a new team and ensuring that they, and the systems could maintain the complaint function whilst developing the service to be more effective and efficient to meet the key performance indicators mandated by the Complaints Regulations (2009) and our commissioners as well as meeting quality standards required by the Care Quality Commission (CQC). Since May 2013 the service has developed to include all patient experience functions and is now called the Patient Experience Team. The Patient Relations Manager (now Patient Experience Matron) is responsible for leadership of the Patient Experience Team, and her remit includes complaints; PALS; Friends and Family, national surveys, growing the volunteer scheme and the development of both formal and informal feedback mechanisms, all of which help to provide a more responsive patient focused service. The Director of Nursing and Organisational Development has executive responsibility and is authorised by the trust board to oversee the trust-wide management of complaints. The Deputy Director of Nursing, Quality and Patient Experience has delegated responsibility for the strategic development of the patient experience agenda.

A remedial action plan was put in place to direct the actions to improve the complaints handling function. Many of the recommendations were predicated on the ability to comprehensively demonstrate that the investigation of complaints is thorough and open and any failings are identified with the appropriate actions put in place and completed. So for this next year, the Trust will concentrate on providing consistently effective investigation and action planning and to ensure divisions are capturing the evidence that this is happening.

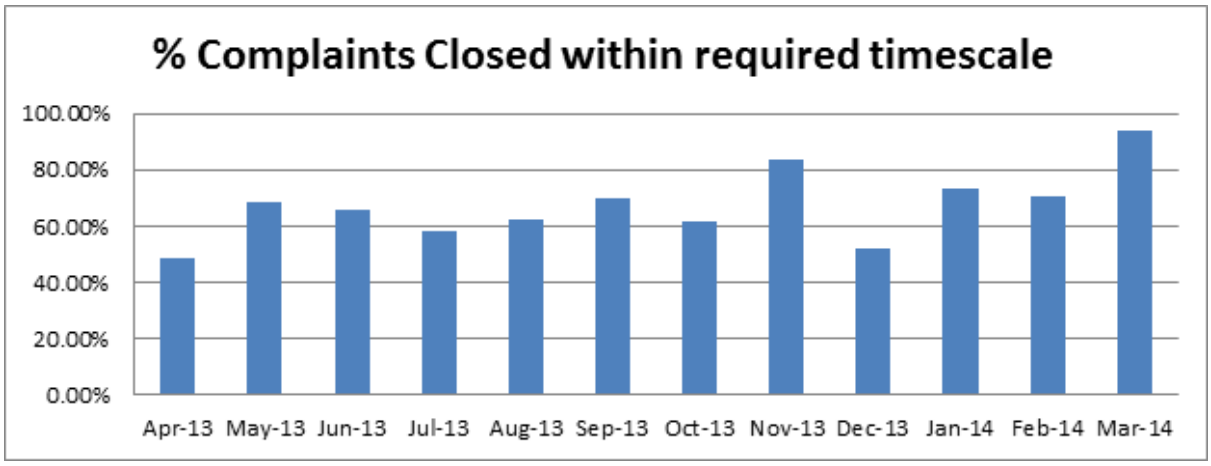
The trust deals with complaints and concerns from patients and users, their family and carers, in accordance with local complaints policies and procedures and the CQC Essential Standards of Quality and Safety. All complaints which are recorded on datix are reviewed by the Director of Nursing and OD prior to response letters being sent to the complainant from the Chief Executive Officer or Deputy Chief Executive Officer. This provides an additional level of assurance that responses are well crafted and answer the questions asked, as well as ensuring that the Director of Nursing and OD has a good grasp of practice issues, patient experience and improvements planned.

Formal Complaints received by Trust 2010/2011 – 2013/2014

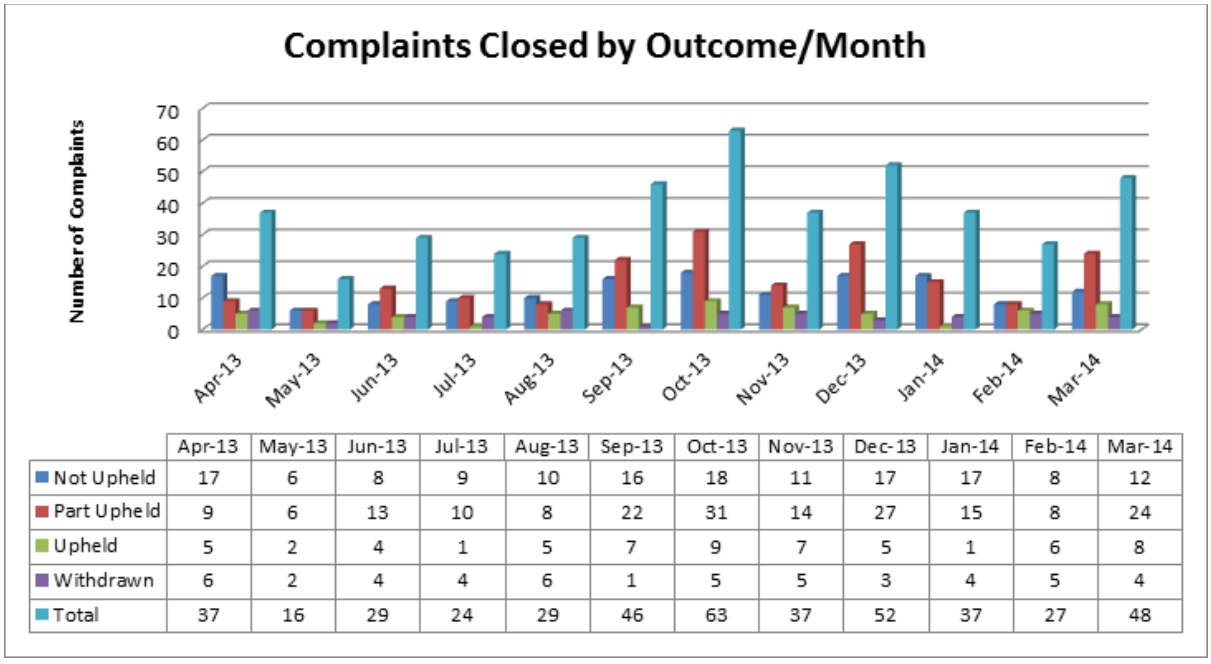
	2010/11	**2011/12**	**2012/13**	**2013/14**
Total formal complaints received	491	505	571	422

Complaints closed within timescale

As can be seen from the table below, in April 2013 the percentage of complaints closed in time was under 50%. The number of complaints already out of agreed timescales has made achieving the 94% target agreed in the local contract very difficult. The close rate for April 2014 did meet the target and recent audits show that the majority of complaints are being answered in a timely manner.



NB: Approximate timeframes - Low to moderate = 15 days; Moderate = 30 days and High to extreme = 50 days The new policy allows the divisional staff investigating a complaint to determine how long they will need to complete the investigation.



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Not Upheld	17	6	8	9	10	16	18	11	17	17	8	12
Part Upheld	9	6	13	10	8	22	31	14	27	15	8	24
Upheld	5	2	4	1	5	7	9	7	5	1	6	8
Withdrawn	6	2	4	4	6	1	5	5	3	4	5	4
Total	37	16	29	24	29	46	63	37	52	37	27	48

Top 5 Complaints Subjects

	12/13 Q3	12/13 Q4	13/14 Q1	13/14 Q2	13/14 Q3	13/14 Q4
Care	84	67	19	21	9	14
Treatment	31	59	10	17	21	20
Waiting Times	24	41	8	14	13	25
Communication Problems	49	38	14	15	16	24
Attitude	32	28	12	12	15	23

The majority of complaints are fall into one of 5 categories in order for the trust to identify the main themes; this enables us to decide what actions we need to prioritise to help us improve the service

we provide to our patients. As described below, improvements in reporting will promote more customised reporting for teams, services and divisions, while still providing the overview of broader themes.

MIAA Review

A review of complaints in April 2013 by Mersey Internal Audit Agency (MIAA) assigned "Limited Assurance". A second review, completed in April 2014 shows "Significant Assurance" to the complaints function of the trust, and while there are still improvements and developments to make, the current systems look to be fit for purpose. We are very proud of our turnaround achievements in this year

Lessons learned

The trust is committed to providing excellent care for all our patients. This means that not only will the care we provide be safe and effective, but that the patients' experience of that care is the best it can be. It is essential that what the patients tell us is listened to and understood, whatever form the feedback takes. This feedback could be in the form of compliments and thanks, comments, concerns, complaints, or completion of satisfaction surveys. We have a duty then, once we have listened and understood, to focus on these experiences and make improvements (lessons learned) based on patients own views and concerns.

The quarterly Governance Report includes examples of lessons learned and reflects divisional reporting of local complaints.

Description of Complaint	Actions	Learning
Division: WCSS Patient received telephone call from the hospital telling her that INR was 1.8 when it was in fact 3.0. This was a transcription error that had prompted the call when the mistake was realised. (this was before drugs were prescribed)	Investigation showed: A contributory factor was an interruption that distracted the staff member's attention and broke her concentration. The anticoagulant staff members have been advised to ensure that they complete a task or get to a safe point before stopping to assist with another task. The anticoagulant staff members have also been advised to locate themselves in a quiet area when they are working on tasks requiring concentration. A copy holder has been provided. This has a ruler that allows the operator to line up the patient's name with their INR result.	Improvement needed: staff working practices needed review and reflection. Notable practice: INR recorded prompted pharmacist to ring patient to check possible cause and led to identification of error.

Description of Complaint	Actions	Learning
	Other safety measures out in place were also shared with complainant.	
Division: WCSS: Complaint about father's discharge, in particular about the physiotherapy input that left father without zimmer frame identified as needed. This was acknowledged as an oversight.	Alert was issued to remind all staff that patients must be discharged with appropriate aids. Also, if aids cannot be taken in homeward bound transport, therapy staff must be informed.	Improved discharge planning and update for, ward staff regarding the importance of ensuring MDT input is properly noted and actioned.
Division: Scheduled Care Patient unhappy as she felt that if she had received surgery on her wrist when she first attended AED she would have had a better outcome to how her wrist has healed. She had been left with residual pain and some loss of function. After receiving her response she remained unhappy.	A meeting with the consultant revealed that the patient felt that the initial conservative treatment of her fracture was influenced by her age and/or the fact that she had attended AED on a weekend. This had not been explicit in the original complaint and was not influenced by any incident during her admission, but by her belief/fear that healthcare is ageist and services are less efficient at weekends. The consultant was able to allay these concerns and review all the decisions made. Patient was reassured that treatment plan had been based on clinical issues and appropriate action was taken.	Reinforces the value of meetings with clinical professionals as a way to ensure patients can articulate their concerns and staff have an opportunity to explain care/treatment face to face. Need to offer meetings early on, not as an option at time of return.
Division Scheduled Care: Family raised their concerns around the manner and attitude of a member of nursing staff	Full investigation by Matron Staff member dealt with through trust disciplinary procedure. Letter of apology sent to family	Individual learning for nurse named in complaint. Monitoring and performance management in place.
Division: Unscheduled Care Daughter of elderly lady with Dementia had serious concerns about the infection control practices on ward, including patient information, cross infection, obtaining of samples. Felt that staff had labelled patient as incontinent of urine, when this wasn't the case. Was upset that her mother's mobility was seriously impaired while she was in hospital and that she was	Meeting arranged and senior divisional nurses were able to answer questions and acknowledge some failings. Main grievances were the decision to admit and the length of time before discharge. Some issues with GP care. Complainant felt it inappropriate for optimum care of someone with Dementia. Other issues were not resolved, e.g. eating and drinking. Complainant felt nurses should strongly encourage eating, as she does, but nurses concerned that they would	Feedback to ward staff – asked to reflect on issues raised. Learning needs re: infection control brought to attention of Infection Control Team. Meeting is often best choice of response to discuss complex issues, to build rapport/relationship with complainant and work constructively with dissatisfied service users.

Description of Complaint	Actions	Learning
unable to walk at the time of her discharge. Felt that she was not encouraged to walk and needed appropriate physiotherapy input. Also that patient's age was the reason she was not appropriately mobilised. Unhappy about essential nursing care provided to her mother, including hygiene measures and cleansing and availability of the nurse call buzzer. She felt that staff did not sufficiently encourage patient in eating and drinking. She feels that she needed more persuading and that nursing staff were unwilling to do this.	be put in position of forcing patient to eat. Complainant accepted this. Associate Director for Infection Control was able to discuss infection control issues raised and highlighted training needs for ward. Senior nurses able to discuss care of patients with dementia and recent new initiatives. Provided Health Passport to complainant and twiddle-muff for her mother. Associate Director of Nursing invited complainant to attend divisional meeting to talk about her experiences. Complainant satisfied with outcome and complaint closed.	
Unscheduled Care: Complaint about personal care provided to late mother on Assessment Ward. Complainant waited unacceptably long time after pulling nurse call to attend to mother's soiled bed linen. Was also unhappy with attitudes of nursing staff (Agency nurse and carer) regarding the incident	Assistant Matron had early meeting with complainant. She was able to reassure complainant of her intentions to address the care and attitude concerns raised with the ward and identified planned support by education department for carers on the ward. Meeting with ward team to highlight issues and discuss improving practice and communication. Ward manager addressed issues raised with Carer and Matron referred to NHSP to be addressed with agency nurse.	Reflection for, ward nursing team on respectful and personal care. Improved communication with relatives. Improved support for carers and flagging of any individual and team issues.

As already explained, it was agreed in the last Quality Report that the success of this new team will be measured via a range of outcomes as follows:

Successful implementation of a Patient Information Centre/Patient Experience Hotline

Calls to the Patient Experience Team out of hours are picked up the next working day and responded to appropriately. We trialled the Patient Experience Officers working later hours in order to ensure that if a complainant contacted us beyond 5pm then we could immediately respond. We found that there were very few calls or queries beyond that time, meaning that we looked at alternative ways of making it easier for people to contact us. A new mail inbox named "patient experience" rather

than "complaints" is being launched with the new trust website. This will encourage patient feedback that is positive, as well as queries and questions, and this will be accessed with sufficient frequency to respond in a proactive way. We will revisit some shift working for the Patient Experience Team following the review of the working practices of PALS; this will be during 2014/15.

We have some very exciting future plans for a Patient Information Centre, and these include utilisation of the current membership office as a patient experience "hub" manned by volunteers and containing the PALS office. Development of the volunteer role within the patient experience team is only just beginning, with volunteers involved in taking and logging PALS calls and administering surveys on our wards. A more responsive PALS service provides an outlet for people in need of support to air concerns and this helps to reduce the number of formal complaints received. The PALS model in place at Warrington and Halton Hospitals is increasingly rare in acute trusts, in that there is a named PALS Officer, now supported by Patient Experience Officers, who is highly visible and accessible to patients, families and the public, based in the main entrance of the main hospital site. The plans to develop and enhance this provide an excellent opportunity to strengthen the service.

Improvement in number of formal complaints
Figures for 2013/2014 have shown a 26% reduction in the number of formal complaints.
Total formal complaints handled 2012/13 - 571
Total formal complaints handled 2013/14 - 422
Total concerns handled 2013/2014 – 92

Whenever the Patient Experience Team is able to close a concern without progression to a formal complaint, the workload on divisional and particularly clinical and shop floor staff is significantly reduced. This has also helped to build the confidence of the Patient Experience Officers who are better able to support the PALS function with this experience.

Improvement in the learning and analysis of themes and trends from complaints, evidenced by reports and to be followed through action planning and monitoring.
There is a need to improve the consistency and quality of action planning and in providing assurance that learning and improvement has happened. More training for staff and support by the divisional teams to ensure those investigating complaints can meet the required standards is required. The divisions are also committed to ensure that the progress and completion of action plans is monitored on the CIRIS system.

Improvements in the Datix system will provide better reporting of themes and trends to support divisional and strategic focus for improvement. This will enable far more timely recognition of poor quality and system issues that are undermining care. For example, for the first time the Pharmacy department will have access to very specific reports about the types of medication issues that patients are complaining about. In the past medication complaints would most likely be assigned under the subject of treatment or care. This will also be the case with nutritional issues, transfer of care, referral and very specifically care associated with mental capacity, end of life care, privacy and dignity. This is all in the spirit of the Francis Report findings and reflects the type of concerns that the media report regularly and that undermine the public confidence in the NHS.

Evidence of CQC compliance with regulations and outcomes
Monitoring of these is included in the new policy and twice yearly audits will be done to monitor compliance. Monthly triangulation meetings ensure that themes and trends across complaints, claims and incidents are tracked and actioned. Quarterly reports of action plans to the Clinical Governance, Quality and Audit Sub Committee will identify good practice and outliers.

Evidence of compliance with the recommendations of the Francis Report
During 2014/15 we will be launching our new quarterly board report, beginning in July 2014. This is intended in response to Mr Francis' recommendation that the board are assured that we have listened to, heard about and learned from the things our complainants tell us. It will also include the quality of complaint responses, standards and performance against targets.

Good LINks reports and external reviews.
As stated MIAA report April 2014 has shown significant improvement in systems and performance. Complaints data and intelligence forms part of the Equality & Diversity System assessments by HealthWatch.

The trust has, in consultation with stakeholders, agreed to maintain complaints management as a quality indicator and also to introduce it as an improvement priority for 2014/2015.

3.4.4. National Surveys Results 2013

Results of the National Surveys inform comprehensive multi-disciplinary action plans focused on these specific areas. The progress of improvements to practice will be monitored throughout the year to ensure that our plan is being successfully implemented.

3.4.4.1. National Inpatient Survey 2013

Listening to patients' views is essential to providing a patient-centred health service. 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.

In 2014/2015 we have selected improvement in low performing indicators from the 2013 In Patient Survey as an improvement priority. We will develop action plans to improve areas where we fall below the national average and have not demonstrated improvement in past two years

3.4.4.2. Inpatient Surveys – National Patient Experience CQUIN

The trust is committed to ensuring a year on year improvement of patient survey responses to how hospitals "patients want to be treated by" improvement in responses to the following 5 key questions:-
(National Patient Experience CQUIN);

- Were you as involved as you wanted to be in discussions about your care?
- Did you find someone to talk to about your worries and fears?
- Were you given enough privacy when discussing your condition or treatment?
- Were you told about medication side effects to watch out for when you went home?
- Were you told who to contact if you were worried about your condition once you left hospital?

CQUIN Inpatient Survey Questions 2011-2013

National Inpatient Survey Question	2011 Results	2012 Results	2013 Results	Other trusts
1. Were you involved as much as you wanted to be in decisions about your care?	47%	48%	57%	57%
2. Did you find a member of hospital staff to talk to about your worries or fears?	38%	31%	41%	41%
3. Were you given enough privacy when discussing your condition or treatment?	72%	70%	70%	77%
4. Did a member of staff tell you about the medication side effects to watch for? (following discharge)	38%	43.%	40%	39%
5. Did hospital staff tell you who to contact if you were worried about your condition? (following discharge)	64%	71%	76%	72%

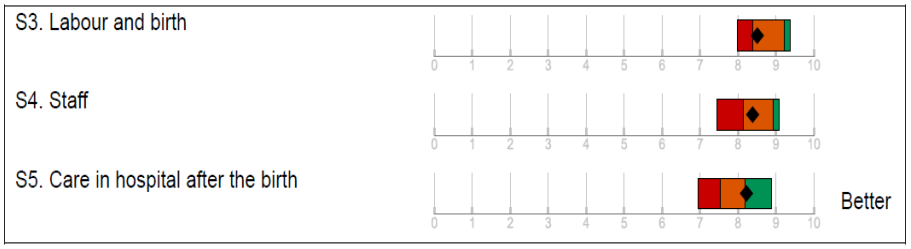
Historically the composite score for the five questions was data was provided to the trust for the CQUIN, however this measure has been suspended so the data is no longer available. Overall the questions with the exception of "Were you given enough privacy when discussing your condition or treatment?" showed that we scored above or equal to other trusts. The above table shows an improved response to three out of five questions.

3.4.4.3. National Maternity Survey 2013

Within the reporting period the trust participated in the 2013 National Maternity Survey which captures data on women's experience of maternity services. The latest publication uses data collected between May and August 2013, from women who gave birth in February 2013. Similar surveys were carried out in 2010 and 2007.

The survey provides information on experience across all three stages of the maternity pathway: before birth (antenatal), during labour and birth, and in the first few weeks after birth (postnatal). For the first time, the 2013 maternity survey provided the opportunity for women to provide free-text comments about their maternity care.

Overall the results were positive showing the trust to be the same as other trusts in managing labour and birth and the quality of staff and better than other trusts in relation to care in hospital after the birth. In relation to post natal care in hospital; breast feeding support and initiation the trust saw a significant improvement in its overall scores in comparison to the 2010 survey. The Maternity Survey report has been reviewed by the division and the department is addressing actions.



3.4.4.4. National Staff Survey 2013

We are pleased to say that the results from the 2013 NHS Staff Survey have been published and have shown an excellent improvement from the previous years in the majority of scores across the trust.

The survey is carried out independently and asks a series of questions to a random sample of 830 staff from across the trust.

In terms of the headline scores:

- We scored above the national average in terms of engaging with staff, with staff ranking the hospital(s) amongst the best 20% in the NHS for being able to contribute towards improvements at work and for staff motivation. We scored 3.80 out of 5 – against a national average of 3.74.
- We scored above the national average for developing staff, support from immediate managers and equality in terms of career progression and development
- Staff experiencing physical violence dropped from 5% in 2012 to 1% in 2013
- The trust also improved its score for staff feeling satisfied with the quality of work and patient care that they deliver.
- Perhaps most importantly, staff recommending the trust as a place to work or receive treatment has risen to be alongside the national average across the NHS.

The trust saw a slight dip in its scores for providing equality and diversity training in the year and for the percentage of staff reporting any errors witnessed in the last month. We still score below the average on health and safety training in the last year – but that's because we have a three year programme for updating health and safety training.

There's been a lot of work in the last year on engaging and communicating with staff and improving health and wellbeing across the trust and the trust is delighted to see the positive scores in the survey. People were at the centre of our QPS framework and the trust is committed to working towards further improvements in staff engagement.

3.4.5. Patient Opinion

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

Patient Opinion website or can post comments on Patient Opinion via a form on the NHS Choices website and both websites publish the comments.

Both websites provide feedback on how users rate the service in terms of whether they would recommend our hospital friends and family if they needed similar care and treatment; cleanliness; staff co-operation; dignity and respect; involvement in decisions; and same sex accommodation. However, NHS Choices provides an overall star rating of 1 – 5 stars and the trust is currently achieving a four star rating based on 87 reviews. Users are also asked to rate aspects of the service as follows:-

Service	Number of ratings	Star rating
Cleanliness	80	
Staff Co-operation	81	
Dignity and Respect	80	
Involvement in decisions	78	
Same-sex accommodation	60	

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

This quality indicator will support the Complaints Management improvement priority and will be reported in the Quality Report 2014/2015.

3.4.6 Friends and Family

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

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

The trust sends the forms to iWantGreatCare to analyse and report on our results on a monthly basis. Patients also the option of leaving a response online at: http://warrington-halton.iwgc.net If a patient is unable to answer the question, a friend or family member is welcome to respond on their behalf. Users are also asked to rate their responses and this is translated into two ratings which are reported through to the board via the Quality Dashboard. The first rating is a star rating to a maximum of 5 stars and the second is the Net Promoter score up to a maximum of 100. The results for 2013/2014 are as follows:-

Friends and Family Ratings 2013/2014

Month	Star Rating	Net Promoter
April	4.7	76
May	4.7	72
June	4.7	73
July	4.7	70
August	4.5	58
September	4.5	59
October	4.6	63
November	4.6	60
December	4.5	56
January	4.6	61
February	4.66	69
March	4.61	65

NB I Want Great Care includes maternity F&F ratings from October 2013

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

The Friends and Family Test is also a national CQUIN aimed at increasing the combined response rate from Accident and Emergency and Inpatient wards from 15% in quarter 1 to 20% or over by the 31st March 2014. This CQUIN also required that Friends and Family was rolled out to maternity services. The trust struggled to achieve the required combined 15% response rate by the end of quarter one but following a review of systems has consistently achieved a combined response in excess of 20% since quarter two. The rollout to maternity services was successfully achieved within the required timescales. Family and Friends will remain a national CQUIN for 2014/2015 in order to roll it out to other departments; increase the overall response rate and improve the net promoter scores.

3.5. Maternity Unit

The Maternity Unit received funding of £450k from the Department of Health for an upgrade to the facilities within the Delivery Suite. The refurbished Delivery Suite opened in the Summer of 2013, the unit now has ensuite facilities in every room and has two birthing pools in its Active Birthing Suite. Ward C23 was also refurbished to include an Induction of Labour Bay. Funding was also made available to update the Bereavement Suite within the Maternity Unit.

The Maternity Unit has its own Facebook page which is very popular with women and holds regular live question and answer sessions.

Midwifery staff now provide a range of complementary therapies which include: aromatherapy; hypnobirthing and pregnancy yoga which is held at the Village Hotel in Warrington. These complementary therapies are also proving to be popular and are fully booked for months in advance.

Our Maternity Services continue to provide the best possible care to mothers and families during pregnancy and childbirth. In March 2014 we put steps in place offer extra monitoring for our women in labour, which has attracted some media attention. The monitoring offer has been in place in response to a small trend of lower birth weights and women presenting with other risks such as decreased fetal movement, which have caused higher risks for some babies in the later stages of pregnancy and labour.

We have identified an increased number of intrapartum events (i.e. issues in labour) over the last 12 months which have been investigated or are currently being investigated. In all instances we have requested external peer review from other maternity units so we can use their independent findings to improve practice. Each individual case has been reviewed very carefully to understand whether there was anything that could have been done differently at any stage in the pregnancy or labour to have prevented the tragic outcomes. These reviews have not shown any causal link between the different cases and have shown that overall we have a very safe service. However because we have seen this small cluster, we have also invited the Royal College of Obstetricians and Gynaecologists to come and carry out an overarching review for us which will take place over the coming weeks."

The Maternity Unit will be implementing GROW which is a personalised system of measuring fetal growth, in June 2014 and all midwifery staff have been trained to use the GROW charts. The department is also reviewing the risk assessment processes and policies.

3.6 Safety Conference – October 2013.

The trusts first Safety Conference a major event aimed at all staff across our hospitals was held in October 2013. The conference which was attended by over one hundred delegates provided a platform to look in detail at a serious patient safety incident, subsequent lessons learned and the work the trust has done to improve safety, comply with the latest national standards and to look at where we are, where we want to be and importantly how all staff could contribute to making improvements. The day included a mix of keynote national and local speakers; interactive workshops and marketplace events. The day included a mix of keynote national and local speakers; interactive workshops and marketplace events.

Mel Pickup (CEO) opened the conference by reflecting on her own experiences of both positive and negative aspects of healthcare. This was followed by a presentation about the serious patient safety incident at this trust where we identified our failings and described the lessons that had been learned following this failure to provide safe care. This was followed by a range of sessions including Duty of Candour; Transparency in Care; NHS Safety Culture; Organisational Approaches to Patient Safety; Reducing Mortality and Leadership for Safety. The marketplace events included stands on Busting the Myth: SHMI and HSMR; Managing the Deteriorating Patient; National Early Warning Score System and Governance Systems and Processes to Provide Assurance. Over half of the delegates completed the evaluation forms stating that the sessions were engaging; excellent and thought provoking. Overall this was an extremely successful event which will be held again in October 2014.

3.7 Speak out Safely (SOS).

SPEAKOUTSAFELY

Warrington & Halton NHS Trust signed up to this new Nursing Times campaign in September 2013. The trust is committed to supporting every member of staff in feeling able to raise concerns about wrongdoing or poor practice when they see it and confident that their concerns will be addressed in a constructive way.

It is about our commitment to acting when staff, identify a genuine patient safety concern and our duty to patients.

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

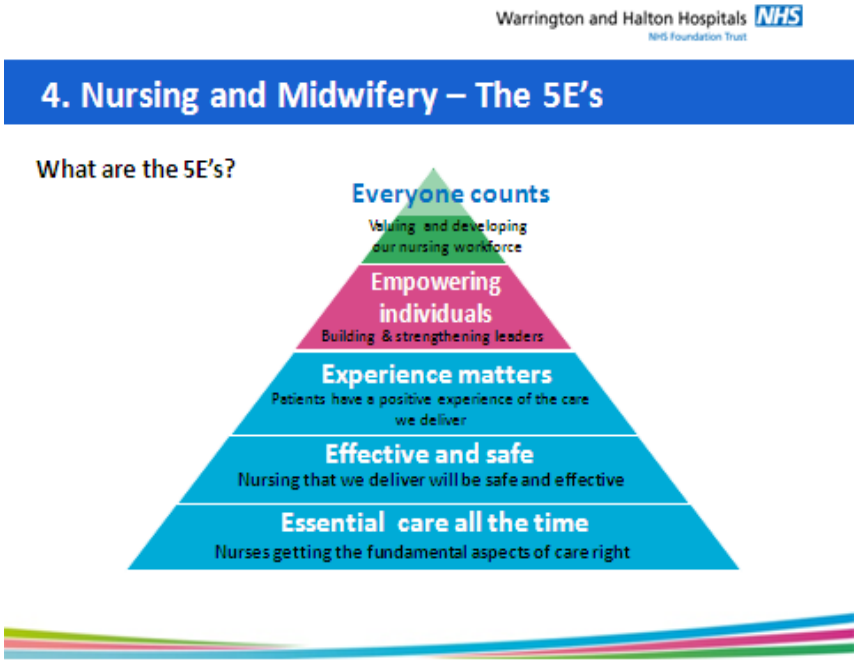
Importantly it is vital that the trust creates a culture in which staff will be supported if they speak up about genuine concerns, and patients need to know that you and the board will act on these

concerns. The trust also has a Whistleblowing Policy which provides a clear process for reporting concerns.

3.8 Nursing Strategy launch – 5 E's (3 year strategy).

During 2013/2014 the trust launched its new strategy for Nursing and Midwifery which describes how we will deliver high quality safe healthcare provided in quality environments in a timely and responsive manner and maintaining compassionate and respectful care.

It draws together the various initiatives to deliver a clear plan of how the nurses and midwives will work to achieve this. The strategy introduces the concept of the 5E's which is our vision on what nursing and midwifery means and how we want nurses and midwives to represent the trust.
The 5E's are:-



3.9 Performance against Key National Priorities (see table below)

Mar-14

Governance Risk Rating - (Monitor) 2013/14

Warrington and Halton Hospitals NHS
NHS Foundation Trust

All targets are QUARTERLY

Level One - National Targets		Target	Weighting	Apr-13	May-13	Jun-13	QTR-1	Jul-13	Aug-13	Sep-13	QTR-2	Oct-13	Nov-13	Dec-13	QTR-3	Jan-14	Feb-14	Mar-14	QTR-4
Clostridium Difficile	Hospital Acquired (Cumulative Qtr1: 5 Qtr2: 10 Qtr3: 14 Qtr4: 19)	19	1.0 **	5	4	3	12	0	1	1	2	4	2	4	10	4	1	2	7
	Total			6	6	4	16	3	4	1	7	8	4	5	17	8	3	5	16
MRSA Bacteraemia - (Hospital Acquired Target)		0	1.0 **	1	0	0	1	0	0	1	1								
All Cancers:31-day wait for second or subsequent treatment	Surgery	>94%	1.0 (Failure for any of the 3 = failure against the overall target)	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	98.00%	99.00%	100.00%	100.00%	100.00%	100.00%
	Anti Cancer Drug Treatments	>98%		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	Radiotherapy (not performed at this Trust)	>94%																	
All Cancers:62-day wait for First treatment	From Urgent GP Referral for Suspected Cancer **(Open Exeter Position)**	>85%	1.0 (Failure for either = failure against the overall target)	87.95%	88.12%	86.89%	88.29%	85.00%	86.89%	86.00%	85.96%	92.00%	85.10%	90.90%	89.80%	85.71%	89.61%	93.06%	89.74%
	From NHS Cancer Screening Service Referral	>90%		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Referral to treatment waiting time	Admitted patients	90%	1.0	90.93%	91.01%	91.41%	91.03%	91.19%	91.02%	90.52%	90.92%	91.70%	91.34%	93.29%	92.06%	92.44%	92.81%	93.37%	92.62%
	Non-admitted patients	95%	1.0	98.04%	97.76%	98.17%	97.99%	97.69%	97.96%	97.77%	97.80%	98.07%	97.78%	97.28%	97.72%	97.26%	98.06%	97.97%	97.65%
	Incomplete Pathways	92%	1.0	92.13%	92.11%	92.46%	92.23%	92.81%	92.41%	92.94%	92.71%	93.31%	93.45%	93.72%	93.49%	94.09%	94.40%	94.66%	94.25%

Level Two - Minimum Standards		Target	Weighting	Apr-13	May-13	Jun-13	QTR-1	Jul-13	Aug-13	Sep-13	QTR-2	Oct-13	Nov-13	Dec-13	QTR-3	Jan-14	Feb-14	Mar-14	QTR-4
All Cancers: 31-Day Wait From Diagnosis To First Treatment		>96%	0.5	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	98.00%	100.00%	100.00%	97.00%	98.00%	98.50%	99.00%	98.50%	98.50%	98.67%
Cancer: Two Week Wait From Referral To Date First Seen	Urgent Referrals (Cancer Suspected)	>93%	1.0 (Failure for either = failure against the overall target)	96.40%	95.60%	95.58%	95.00%	95.81%	95.20%	94.52%	95.18%	93.00%	95.40%	94.40%	94.20%	93.15%	94.02%	96.31%	94.49%
	Symptomatic Breast Patients (Cancer Not Initially Suspected)	>93%		97.70%	96.30%	95.60%	96.00%	94.62%	93.00%	93.98%	94.00%	93.85%	95.54%	97.99%	96.50%	93.55%	93.00%	93.4%	93.32%
A&E Clinical Quality	A&E Maximum waiting time of 4 hrs from arrival to admission/transfer/discharge	>=95%	1.0	93.65%	96.34%	98.03%	96.03%	95.09%	95.29%	95.64%	95.33%	95.23%	94.77%	95.61%	95.20%	94.09%	96.21%	96.96%	95.68%
Failure to comply with requirements regarding access to healthcare for people with a learning disability		N/A	1.0	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No

Other Indicators	Target	Weighting	Apr-13	May-13	Jun-13	QTR-1	Jul-13	Aug-13	Sep-13	QTR-2	Oct-13	Nov-13	Dec-13	QTR-3	Jan-14	Feb-14	Mar-14	QTR-4
Risk of, or actual, failure to deliver commissioner requested services	N/A	4.0	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
CQC compliance action outstanding	N/A	Special	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
CQC enforcement action within last 12 months	N/A	Special	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
CQC enforcement notice currently in effect	N/A	4.0	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Moderate CQC concerns or impacts regarding the safety of healthcare provision	N/A	Special	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Major CQC concerns or impacts regarding the safety of healthcare provision	N/A	2.0	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Trust unable to declare ongoing compliance with minimum standards of CQC registration	N/A	Special	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Overall Governance Risk Rating **Total Points 0 - 0.9 Green, 1 - 1.9 Amber-Green, 2 - 4 Amber-Red, 4 or above Red)**			2.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	2.0	1.0	1.0	2.0	1.0	1.0	1.0

Additional Notes:

18 Weeks Referral to Treatment
Performance is measured on an aggregate (rather than specialty) basis and NHS foundation trusts are required to meet the threshold on a monthly basis.
Consequently, any failure in one month is considered to be a quarterly failure for the purposes of the Compliance Framework.
Failure in any month of a quarter following two quarters' failure of the same measure represents a third successive quarter failure and should be reported via the exception reporting process.
Failure against any threshold will score 1.0, but the overall impact will be capped at 2.0

**** Clostridium Difficile & MRSA Bacteraemia**
Monitor's annual de minimis limit for cases of MRSA reflecting a governance concern is set at 6. the de minimis for C-Diff is set at 12.
See table below for the circumstances in which we will score NHS foundation trusts for breaches of the MRSA objective.
Monitor will assess NHS foundation trusts for breaches of the C. difficile and MRSA objectives against their objectives at each quarter using a cumulative year-to-date trajectory.

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

Assessed at: 25% of the annual centrally-set objective at quarter 1; 50% at quarter 2; 75% at quarter 3; and 100% at quarter 4 (all rounded to the nearest whole number, with any ending in 0.5 rounded up).
Monitor will not accept a trust's own internal phasing of their annual objective or that agreed with their commissioners.

3.10. Governors' visits

The Governors' Council has initiated a series of unannounced visits to ward and department areas to observe issues of care and treatment in order to provide assurance to the m and, importantly, to their constituents about the quality of service provided by the trust.
A summary, provided by the trust's Lead Governor, is available with section 4.1.

3.11. Training & Appraisal

Training and Appraisal Completion

	Target	**Year End Results**
Mandatory Training Health & Safety Fire Safety Manual Handling	 85% 85% 85%	 88% 75% 75%
Additional Fire Safety and Manual Handling sessions are in place to improve these figures.		
Staff Appraisal Non-medical Medical & Dental Consultants Medical & Dental – consultants and career grades (excluding junior doctors)	 85% 100% 100%	 69% 85% 77%

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

3.12 Quality Report request for External Assurance

Warrington and Halton NHS FT has requested the trust auditors PWC 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:

1. C. difficile; - Number of Clostridium difficile (C. difficile) infections, as defined below, for patients aged two or over on the date the specimen was taken.
Data definition - A C. difficile infection is defined as a case where the patient shows clinical symptoms of C. difficile infection, and using the local trust C. difficile infections diagnostic algorithm (in line with Department of Health guidance), is assessed as a positive case. Positive diagnosis on the same patient more than 28 days apart should be reported as separate infections, irrespective of the number of specimens taken in the intervening period, or where they were taken.
Acute provider trusts are accountable for all C. difficile infection cases for which the trust is deemed responsible. This is defined as a case where the sample was taken on the fourth day or later of an admission to that trust (where the day of admission is day one).

2. Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers; Percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer.

Denominator - Total number of patients receiving first definitive treatment for cancer following an urgent GP (GDP or GMP) referral for suspected cancer within a given period for all cancers (ICD-10 C00 to C97 and D05).

Numerator - Number of patients receiving first definitive treatment for cancer within 62 days following an urgent GP (GDP or GMP) referral for suspected cancer within a given period for all cancers (ICD-10 C00 to C97 and D05).

3. Pressure Ulcers (local) - The indicator is the total number of grade 3 or 4 pressure ulcers that are hospital attributable. The indicator is restricted to in-patients only. Pressure ulcers that are present on patients on admission are deemed community attributable

In undertaking their tests for mandated indicators, auditors will need to document the systems used to produce the specified indicators, perform a walkthrough of the system to gain an understanding of the data collection process, and then test the indicators substantively back to supporting documentation to gain assurance over the six dimensions of data quality. The auditor will provide a report on its findings and recommendations for improvements on this indicator to the board of directors and the council of governors of the trust.

3.13. Quality Report amendments post submission for 3rd Party Commentary

Overview of the Outcomes of Governor Observation Visits to Wards July 2013 and September 2013 section (4.7.1) was removed from Quality Report on the 23rd April and replaced with a Summary of Governor Observation Visits for 2013/2014.

The Quality Report (V5) stated the trust reported two Never Events however the incident reported in February was reviewed via trust governance processes and because the patient did not suffer permanent harm this incident does not fit the criteria for a Never Event and was therefore removed.

Pressure Ulcer (3.2.2) removed community pressure ulcer data only related to quarters 1 & 2.

Participation in Research and Development (2.2.3) included 29th April 2014.

Clinical Audit and National Confidential Enquiries (2.2.2) included 29th April 2014.

Falls section (3.2.3) additional paragraph inserted.

Mortality (3.3.1) inserted.

SHMI (2.1.17) data inserted.

High Level Quality Care (3.3.6) updated.

Complaints section (3.4.3) updated with narrative and activity for 2013/2014.

Trust Data Quality (2.2.6) inserted.

Quality Dashboard inserted

Governance Risk Rating inserted

Training and Appraisal (3.10) inserted.

Advancing Quality data inserted (3.3.4)

Typographical error in the final paragraph of the Introduction - Quality People and Sustainability on page 10 of the Quality Report which originally stated deficit of 31.5m but should read £1.5m.
CQUIN Framework (2.2.4) statement inserted and table updated.
Governors Statement on QR (4.7) inserted and later modified 20th May 2014.
Trust request for External Assurance (3.11) inserted.
Maternity Unit (3.5) inserted.
Patient Safety Incidents (2.3.8) supporting narrative inserted.
Pressure Ulcer definition providing clarity between avoidable and unavoidable.
Warrington CCG statement inserted.
Cancer 62 day wait – annual data inserted.
HSMR & SHMI updated data inserted.
CQUIN table – minor amendment to table.

Quality Report Part 4

Statements

Statements from Clinical Commissioning Groups, Healthwatch and Overview and Scrutiny Committees

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

4.1. Statement from Warrington Clinical Commissioning Group

NHS
Warrington
Clinical Commissioning Group

☎ 01925 843690
Please Ask For: John Wharton
John.wharton@warringtonccg.nhs.uk

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

Tel: 01925 843690
PA: Sam Lowe

Samantha.lowe@warringtonccg.nhs.uk
www.warringtonccg.nhs.uk

21st May 2014

Karen Dawber
Director of Nursing
Warrington & Halton Hospitals Foundation Trust
Lovely Lane
Warrington
WA51QG

Dear Karen

Re: Quality Account 2013-2014

Many thanks for the submission of the Quality Account for 2013-2014, and for the presentation to local stakeholders with the Local Area Team. This letter provides the response from Warrington CCG to your Quality Account.

The account affirms the work that is being carried out by the trust and which is regularly discussed through the mechanisms which we have in place; contract monitoring, the established strong focus on quality and the rigorous SUI process are all contributory factors to ensure that both commissioner and provider are working collaboratively to improve care and agree appropriate actions and monitoring when the patient experience has not been to the standard we all aspire too. I believe that these forums have built on our relationship and cemented our united approach to delivering high standards of health care to the local population.

Warrington CCG welcomes the work delivered by the Trust in relation to improving patient care for the local population and wishes to continue the healthy relationship that we have for future planning of health care delivery. We also wish to congratulate you for the impressive work which you have carried out, particularly in the area of reducing pressure ulcers and your continued focus on improving the care of patients with dementia.

Warrington CCG welcomes the confident feedback which you received from your Care Quality Commission (CQC) unannounced visit in the latter part of last year. Our own hospital walkabouts with the trust have also proved highly advantageous to provide assurance to board members and lay representation. The inclusion of your planned Quality Priorities for 2014/15, particularly regarding the planned monitoring and reporting of Always Events and Ward Quality is also most welcome.

I conclude by informing you that we are looking forward to working with the Trust throughout 2014/15, helping to improve the quality and delivery of services for the local population and ensuring that the provider is working towards delivering the three key domains of the CCG'S quality strategy safety, effectiveness and experience remain at the heart of health care provision.

I believe that this is an accurate and honest account of your organisation and wish to congratulate you on your work.

Yours sincerely,

John Wharton
Chief Nurse & Quality Lead
Warrington Clinical Commissioning Group

4.2. Statement from Halton Clinical Commissioning Group

NHS
Halton Clinical Commissioning Group

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

Tel: 01928 593479
www.haltonccg.nhs.uk

21st May 2014

Our Ref: QA/WHHFT/14

Karen Dawber
Director of Nursing
Warrington & Halton Hospitals Foundation Trust
Lovely Lane
Warrington
WA5 1QG

Dear Karen

Re: Quality Account 2013-2014

Many thanks for the submission of the Quality Account for 2013-2014, and for the presentation to local stakeholders on 6th May 2014. This letter provides the response from NHS Halton CCG to the Quality Account.

Although the CCG has been a fully authorised body for just 12 months, we have, I believe had a good working relationship prior to authorisation and since. NHS Halton CCG is a member of the Contract Quality Group, which scrutinises the key quality indictors in the Quality Schedule and CQUINs in partnership with Warrington CCG, who are the co-ordinating commissioner; these are proving to be both effective and useful. The Clinical Focus Group meetings are working well and the ability to maintain links to your clinicians has been very useful.

NHS Halton CCG welcomes the work delivered by the Trust in relation to improving care for patients with Dementia, and congratulates you on your success in this area. The CCG notes the delivery against your planned improvements target, and in particular the delivery of the reduction in Pressure Ulcers and Medicines Related incidents against your internal stretch targets. NHS Halton CCG is also pleased to note the delivery against the commissioner quality priorities and would like to commend the trust on its progress in relation to visible clinical leadership.

NHS Halton CCG notes that the Trust has received very positive feedback from the Care Quality Commission in relation to the unannounced inspection during September 2013. The CCG are also pleased to see the planned Quality Priorities for 2014/2015, in particular the planned monitoring and reporting of Always Events, Ward Quality

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We look forward to working with the Trust throughout 2014/15, helping to improve the quality of services for our patients through the NHS contractual mechanisms and the review and management of Serious Incidents, applying good governance and ensuring lessons are learnt throughout the Trust

Jan Snoddon
Chief Nurse/Quality Lead
NHS Halton CCG

Email: jan.snoddon@haltonccg.nhs.uk

4.3. Statement from the Halton Health Policy Performance Board

HALTON BOROUGH COUNCIL

Ms M Pickup
Chief Executive
Warrington Hospital
Lovely Lane
Warrington
Cheshire, WA5 1QG

Our Ref EST

If you telephone please ask for Emma Sutton-Thompson

Your ref

Date 19th May 2014

E-mail address Emma.Sutton-Thompson @halton.gov.uk

Dear Ms Pickup,

Warrington and Halton Hospitals NHS Foundation Trust Quality Accounts 2014

Further to receiving a copy of your draft Quality Accounts and the Joint Quality Accounts event held on 6th May that your colleagues Alison Lynch and Hannah Grey attended to present a summary of your Quality Accounts, I am writing with the Health Policy and Performance Board comments. The Health Policy and Performance Board particularly noted the following key areas:

During the year 2013/14 the Trust identified a number of priorities to be achieved during this year. The Board noted the following:

- *Zero tolerance to hospital acquired MRSA bloodstream infections* - Trust has reported 3 cases of hospital acquired MRSA bloodstream infection, compared to 1 case in 2012/13. Although this is an increase, the Board notes the initiatives that have been implemented to work towards zero tolerance.

- *Clostridium difficile* – the Trust reported 31 cases of hospital acquired Clostridium difficile infections against a threshold of 19 compared to 19 cases against a trajectory of 40 for 2012/2013.

- *Reduction in grade 2-4 pressure ulcers* – the Trust reported a 72% reduction in grade 3 pressure ulcers and 33% reduction in the incidence of grade 2 pressure ulcers. Whilst these percentage reductions are good, the Board would still like to see the actual number of cases reduced further.

- *Reduction in medication errors related to insulin* - The Board is pleased to note that the Trust reduced insulin incidents by 10.5% from 57 cases to 51 cases and therefore exceeded your trajectory of a 5% reduction thus achieving this improvement priority for 2013/2014.

It's all happening IN HALTON
Communities Directorate
Runcorn Town Hall, Heath Road, Runcorn, Cheshire WA7 5TD
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HALTON
BOROUGH COUNCIL

The Board are pleased to note the following Improvement Priorities for 2014 – 2015:

- *Complaints* - To improve the percentage of complaints responded to within timescales agreed with the patient.
- *Falls* - Establish a 10% reduction for falls resulting in moderate - catastrophic harm.
- *In-Patient Survey* - improvement in low performing indicators - Develop action plans to improve low performing areas that relate to the inpatient episode of care and where we fall below the national average and have not demonstrated improvement in past two years
- *Pressure Ulcer Reduction* - The Trust continues to implement its planned programme of actions to further reduce pressure ulcers which includes:-
  - Review of the Trust Policy on pressure ulcers is in progress, with particular reference to the process by which we investigate Grade 3/4 pressure ulcers.
  - Root cause analysis is conducted on all Grade 3/4 pressure ulcers which develop within the trust;
  - Mini investigations of all grade 2 hospital acquired pressure ulcers
- *Advancing Quality (AQ) measures* – Stroke and Pneumonia - Work streams to increase compliance with stroke and pneumonia measures to improve patient outcomes.

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

Yours sincerely,

E. L. Sutton-Thompson

pp **Councillor Ellen Cargill**
Chair, Health Policy and Performance Board

4.4. Statement from Warrington LINk

– Statement from Warrington LINk was requested on 17th April 2014, however a response was not available at date of publication.

4.5 Statement from Warrington Health and Well Being Overview and Scrutiny Committee – Statement from Warrington Health and Well Being Overview and Scrutiny Committee was requested on 17th April 2014, however a response was not available at date of publication.

4.6 Statement from the Halton Healthwatch

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Sefton House
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Tel 01928 592405

Email: info@healthwatchhalton.co.uk
Web: www.healthwatchhalton.co.uk

Healthwatch Halton's Statement

for the Quality Account

of Warrington & Halton Hospitals NHS Foundation Trust 2013-14

"Healthwatch Halton thanks the Trust for the opportunity to comment on the Quality Account for the year 2013-14.

It is a well prepared report and the Trust should be complimented on this, however, for members of the public, Healthwatch Halton would appreciate a succinct executive summary with clear statements of future priorities and a 'traffic-light' system to measure the progress of last year's priorities.

Members welcomed the continued improvements in addressing the priorities set for the year. Hospital acquired infections such as MRSA and C.difficile have been reduced considerably and members are pleased to note that the Trust will continue to monitor this closely.

Through having a Healthwatch representative on the Patients' Experience Group, we have been able to keep the Healthwatch Manangement Committee up to date on issues within the Trust. Healthwatch members have also valued the opportunities to take part in the PLACE visits at the hospitals.

We welcome the governors' report on the outcomes of their unannounced observation visits.

We recognise the efforts of the Trust to engage with key stakeholders during the past year and we appreciate that feedback from a variety of sources informed the priority choices for 2014-15, however, we feel that some of the goals lack definition.

We hope that on-going meaningful dialogue with patients, carers and the wider community will help the Trust ensure their priorities are achieved."

4.7 Statement from the Trust's Council of Governors

Statement from the Trust's Council of Governors 2013/2014

Q1 Do the priorities reflect those of the population the Trust serves?

Governors think this is true. We 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. Due to the dedication, commitment and hard work of staff, our hospitals continue to enjoy an excellent reputation within our communities. Each year targets are agreed with the hospital's Governors and staff should be congratulated for continuing to achieve many of the improvement targets.

The Quality Report highlights the Trust's focus in reducing the risk of patients acquiring a pressure ulcer or experiencing a serious fall during their stay in hospital. During the last year the risk to patients of acquiring a Grade 2 pressure ulcer was reduced by 33%. The Accident and Emergency department exceeded the national target for seeing 95% or more patients within four hours. The care and treatment of patients who experience dementia is outstanding and targets for treating people who have a heart attack, heart failure, hip and knee surgery have been exceeded.

The Summary Hospital level Mortality Indicator (SHMI) and Hospital Standardised Mortality Rates (HSMR) rates continue to improve and demonstrate that the Trust is being effective in reducing the rates. These improvements show that there is an increased vigilance and drive amongst the Trust's medical and nursing staff to further improve patient care and patient safety.

The likelihood of acquiring a hospital infection has reduced significantly during the last five years. The Governors were disappointed to see a slight increase in the number of cases of MRSA and C.difficile during 2013/2014. Every effort is made to ensure these infections are not passed from one patient to another. We also appreciate this is a problem, not only for our Trust, but for most Trusts in the North West.

Many of the key performance indicators show a successful year with improvements in many areas. In a year of considerable financial pressure and having to make substantial savings through a year on year Cost Improvement Programme, it is a tribute to the management of the Trust and all the staff that these improvements have taken place.

Q2 Are there any important issues missed in the Quality Report

We believe most significant issues have been addressed. The Quality Report is very detailed and thorough and assists the Governors in holding the Board to account. They provide comprehensive information detailing patient's views of the care and treatment they have received. More data has become available during 2013/2014 to enable Governors to monitor patient and staff experiences in the Trust. The Friends and Family Test was introduced in April 2013. The CQUIN Inpatient Survey shows year on year improvements in the positive comments the Trust receives from inpatients. The percentage of staff who would recommend the Trust to friends and family needing care increased in the last year.

The Trust had prioritised complaints as an area where improvements were required and this year has recorded a reduction in them. There is further work to do and Governors are pleased to note that this area has again been included in the Trust's priorities for 2014/2015.

The Trust now participates in the NHS England initiative Open and Honest Care; Driving Improvements. This has further increased the level of accountability and public scrutiny. It is now possible to compare the performance of our Trust in areas of patient safety and patient care with other Trusts in our local area and in the region.

Once a month Governors undertake a Ward Observation Visit. These visits have been welcomed by staff, patients and their relatives. Governors are able to receive first hand assurances that the hospital wards are clean and that the correct procedures for infection control are being used and patients are provided with privacy and dignity. We ask patients for their views about the quality of the nursing and medical care they receive. The visits have provided Governors with an understanding of how hospital wards function and the high standard of medical and nursing care demanded by our patients and the hospital's inspectors the Care Quality Commission (CQC).

Q3 Has the Trust demonstrated that it has involved patients and the public in the production of the Quality Report?

Public, Partner and Staff Governors, Halton and Warrington Health Watch and local authority staff, have been fully involved in discussing the content of the Quality Report during workshops and in the bi monthly and dedicated meetings of Governor's Quality in Care Committee. Focus groups have been introduced for the first time this year and the use of online surveys have taken place to find out the views of the Trust members. Member engagement across the Trust's catchment areas has increased with Trust staff and Governors talking to members in GP practices, town centre shopping areas, outpatient clinics and at large events such as the Hospital's Open Day and Warrington Disability Day.

Governors have actively sought to engage with patients and contribute to a process of improving services. Discharge is an important part of the patient experience. Governors feel this service should be periodically reviewed to ensure patients experience a safe, timely and effective discharge. Governors have involved former inpatients in surveys and spoken to them in a focus group to find out how they think the discharge process could be improved.

Outpatient services are provided at both hospital sites and for most patients it is their first contact with the Trust. Governors have spoken to many outpatients and received suggestions about how the service could be improved. Their comments have been passed on to the Trust for consideration. Carers play a crucial role in supporting many patients during their time in hospital and after they leave. Governors have worked with unpaid carers, hospital staff and local Carers' Centres to develop a Carer Strategy for the Trust.

During the last year Governors have supported measures to improve member, patient and staff feedback and encouraged the Trust to take action on what they have to say about services and the way they are delivered.

The Quality Report shows the Trust is in the process of implementing innovations around delivery of recruitment and training. This is to be welcomed. Governors are aware that the rates for staff receiving mandatory training, in particular, fire safety and manual handling, need to increase.

The Governors were pleased to see an improvement in the number of medical and dental staff receiving an annual appraisal during the last year. We are satisfied that plans are in place to increase the number of non-medical staff receiving an annual appraisal. Governors believe the Trust's staff are its most valuable asset and without their commitment and continual personal development it would not be able to deliver safe, high quality, compassionate care to its patients.

Q4 Is the Quality Report clearly presented for patients and the public?
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. We 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 in their Quality in Care Committee have contributed their views on many aspects of the quality of services provided by our hospitals and endorsed the continued effort to improve the readability and appearance of the Quality Report. Governors encourage all Trust members and others who are interested in our hospitals and their performance to read the Quality Report.

4.7.1. Report on Governor ward observation visits - Ward Inspections 2013/2014

Background and the way we conduct each ward observation visit.

Governor led ward observation visits began in October 2011. They were initiated by the then Lead Governor in consultation with the Director of Nursing. This has led to a broadening of the role of the Governors in this trust. A small team of Governors has been established to undertake the visits and report their findings. A timetable for monthly ward observation visits has been agreed and they will continue until December 2014.

The visits are designed to provide assurance to the Trust's Governors that the best possible standard of medical and nursing care is provided to patients in our hospitals. The Governors use a checklist developed by the Care Quality Commission (CQC). This acts as a guide in assisting the Governors to assess the standard of care being provided. The team undertaking the visits usually consist of 3 to 5 Governors.

The visits usually take place between 11.30am and 2.00pm. A check is made of the display boards outside the wards. These contain important information about whether any patients on the ward have recently had a fall, experienced a pressure ulcer, whether there had been a delayed discharge and what the level of staff sickness is on the ward was . Every visit is unannounced. If a ward has not been visited in the previous 12 months it is likely to be selected.

During 2012/2013 the focus of the visits was on wards specialising in elderly care. In 2013/2014 the focus has been on all adult general medical wards at Warrington Hospital. Due to the innovative nature of the work taking place with patients who have dementia they also visited the ward that specialises in the care and treatment of patients with this condition.

At the end of a ward visit the Governors meet and compose a report detailing all aspects of the visit. A copy of the report is provided to the Director of Nursing and Organisational Development, the Associate Director of Nursing, Quality and Patient Safety, Chief Operations Officer and Deputy Chief Executive. A copy is forwarded to the Care Quality Commission. The Governor's Quality in Care Committee meeting every two months is provided with a copy of the report and has an opportunity to discuss it.

Environment

Overall the Governors found the wards to be busy and active areas. The main corridor in each ward contains the ward clerks, doctors and allied medical professionals such as occupational therapists, physiotherapists and the nursing managers and nursing staff. It contains storerooms, patient toilets and bathrooms and provides access to the bays and side rooms where the patients are located. The buzzer lights indicating a patient requires attention also are located in this area. The team have been present at shift changes and have observed handover meetings between nursing staff. Information about patients and the care they require is communicated between outgoing teams and ingoing teams.

The areas containing the nurse's station were free of clutter and are bright and well illuminated. On one ward the Governors saw the Friends and Family Test score sheet proudly displayed for patients and visitors to see. The ward that specialises in dementia care has drawings of local landmarks displayed and a Warrington Transport Bus Stop.

Staff

In 2013/2014 Governors began to talk to various members of staff on the wards about their roles. This has been very informative and has helped in the understanding of how the wards are managed and the pressures which staff may experience. For example Governors now fully appreciate the role of the housekeeper in the smooth running of the wards. They check that the ward equipment is serviceable and check and order stock in the storerooms. They ensure that the buzzers are working and have been observed serving lunch and taking patients to the toilet. During their visits Governors have met occupational therapists and physiotherapists who ensure patients are mobile and get them out of bed and help them to walk and exercise. Governors have spoken to health care assistants, ward clerks and ward managers who have described what they do to help their ward run smoothly, how their wards are staffed, how beds are allocated and how patient care is managed.

Leadership on the wards is crucial and Governors are pleased to report they have seen many examples of outstanding teamwork.

Governors pay particular attention to the interaction between the nursing, medical staff and the patients. First names are always used and they have never witnessed a member of staff using an inappropriate term when communicating with a patient. Patient name and information is displayed above their bed and this information indicates whether they are at a high risk of a fall or have dementia.

Some staff, on the wards, point out to the Governors items of equipment that may be faulty or changes which would improve patient care or the appearance of the ward. Their views are always included in the Governor's report on the ward visit. In many instances this has led to the staff suggestions being implemented and the improvements being made.

Privacy and Dignity

Governors observe whether the curtains around the patient's bed are fully drawn when a doctor or personal care is required. They listen to and observe how patients are spoken to. They record if patients are appropriately dressed and whether they have they been washed, their hair combed and the men shaved. No concerns have been reported in this area. All patients were presentable and treated with respect and their dignity maintained. For example on a visit to one ward they observed a disorientated patient removing an item of clothing which was promptly dealt with by the nursing staff.

Infection Control

Governors check that staff wash their hands and they wear gloves and aprons when in direct contact with patients. At the end of each bed there may be a hand sanitizer bottle. They check that all medical support staff, health care assistants and nurses use the hand gel when they move from patient to patient. Patients are issued with hand wipes prior to being provided with lunch.

The areas of concern the Governors have reported is occasionally they have observed some doctors wearing long sleeve garments. Patients, on some occasions, have not been asked if they wanted to go to the toilet and be offered hand wipes prior to a meal being served. On

rare occasions Governors have observed equipment, such as a blood pressure cuff and a finger oxygen monitor, has not been cleansed when used on different patients.

Medication
Usually after lunch has been served and cleared away some patients are administered with their medication. Governors will watch the administration of medicines and check that water is available and assistance is provided should it be required.
Each bay has a locked medicine cupboard and Governors observe if checks are made on the identity of the patient before certain medicines are administered.
The team have observed diabetic patients having their blood sugar levels taken and then being advised to reduce/increase their sugar levels.
Some patients have commented to Governors, during their visit, on the level of medication they have been provided with and the regularity they receive it. Their view is the frequency of administering medicine is a decision of the doctors and they will not comment on this area. Some patients have praised the hospital staff for reducing the medication provided by their GP. Governors have not observed any practices in the administration of medicine which have caused concern.

Food
Most patients were found to have been satisfied with the food provided. Occasionally the food ordered in the morning is not what some patients wanted for lunch. Every effort was made to accommodate the patient's wishes and find an alternative. Red trays were provided to indicate that a patient could not feed themselves and required assistance. On one ward, food for an Asian patient, was brought in by a member of his family.
Many patients were coaxed and encouraged to eat and drink. Health care assistants and nursing support were always on hand to offer assistance where it was required. Many staff used this interaction as an opportunity to talk to the patients, sometimes about their family situation or their hobbies. In these situations the Governors have seen considerable care, attention and compassion being provided to patients.

Cleaning
A check is always made on the cleanliness of the patient toilet areas, bathrooms and the length of the emergency cords. The team check behind lockers for dust and whether spillages and items on floors are promptly cleared up.
At no time, in the last year, have they voiced concern about the standard of cleaning. All the wards have dedicated domestic staff. They work tirelessly to maintain a high level of cleanliness. The bathrooms, toilets, floors and all patient areas have been spotlessly clean. Spillages are promptly cleaned up and the floors around patient's beds clear of trip hazards or fallen items. Many domestic staff, in addition to the health care assistants, were observed multi-tasking and assist with the serving of tea and coffee to patients (and occasionally to visiting Governors).

Patients
Patient care should be of the highest standard. The Governors always ask the patients about their views of the health care they are provided with. They ask patients about the food they

are given and the noise levels on the wards during the day and at night. They ask about the nursing and medical care they receive and whether they are satisfied with how they are being treated.
All the patients the Governors have spoken to have praised the nursing care very highly. They all comment on their level of commitment and how hard everybody works. Doctors and other health professionals were also highly praised for their attention to detail and sensitive approach to dealing with the patients in their care. Patients felt they had received information about their condition and the treatment they were being given.

Only on one occasion did we feel ward staff were working under pressure and required additional assistance. On two occasions a patient commented about the level of noise during the night. This was on an acute medical ward where some patients required treatment which disturbed others who were trying to sleep. The patient's comments were reported to the appropriate members of staff.

On a positive note Governors have heard many comments from patients who have used other hospitals. One diabetic patient said he preferred Warrington Hospital to Leighton Hospital. A resident of Liverpool, when taken ill, asked the ambulance to bring him to Warrington Hospital in preference to any Liverpool hospital.

Conclusion
The ward observation visits have become an important part of the role of a Governor. They are designed to provide the trust's Governors with an assurance that patients from Warrington and Halton are being provided with the best possible care. In publishing this report Governors are able to assure the trust's members, staff and their patients that they believe this to be the case. Their findings, during the numerous visits, have been confirmed by a recent unannounced visit by the Care Quality Commission (CQC) to some of the same wards that Governors visited during 2013/2014.

The Governor visits to the wards have helped them to understand how they are managed and the roles of various staff. It demonstrates to the many patients and staff that their trust's Governors not only attend committees but want to see and hear for themselves what it is like to be a patient in Warrington Hospital and Halton Hospital.
At the end of March 2014 23 ward observation visits will have taken place. In 2013/2014 the wards visited were A1, A2, A3, A4, A6, A7, B14, B18, B19 and the Intensive Care Unit (ICU).

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

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

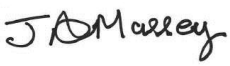
Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the quality report. In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2013/2014;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes for the period April 2013 to April 2014
  - Papers relating to Quality reported to the Board over the period April 2013 to April 2014;
  - Feedback from the Commissioners, Halton Clinical Commissioning Group (CCG) dated 21/05/2014 and Warrington CCG dated 21/05/2014;
  - Feedback from Governors dated 12/05/2014;
  - Feedback from local Healthwatch organisations, namely Healthwatch Halton, dated 20/05/2014;
  - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 28/05/2014;
  - Feedback from other stakeholders involved in the sign-off of the Quality Report, namely Halton Health Policy Performance Board dated 19/05/2014**;**
  - The 2013 national patient survey;
  - The 2013 national staff survey;
  - Care Quality Commission quality and risk profiles dated 31/05/2013;
  - Intelligent Monitoring Reports dated 13/03/2014 and 21/10/2013;
  - The Head of Internal Audit's annual opinion over the Trust's control environment dated 30/04/2014;
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-

nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275

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



Mel Pickup
Chief Executive

Allan Massey
Chairman

28th May 2013

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

We have been engaged by the Council of Governors of Warrington & Halton Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of Warrington & Halton Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2014 (the 'Quality Report') and specified performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2014 in the Quality Report that have been subject to limited assurance (the "specified indicators") consist of the following national priority indicators as mandated by Monitor:

Specified Indicators	***Specified indicators criteria*** (exact Section where criteria can be found in the Quality Report)
Rate of Clostridium Difficile infection	Section 3.12
Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers	Section 3.12

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the specified indicators criteria referred to on pages of the Quality Report as listed above (the "Criteria"). The Directors are also responsible for the conformity of their Criteria with the assessment criteria set out in the NHS Foundation Trust Annual Reporting Manual ("FT ARM") and the "*Detailed requirements for quality reports 2013/14*" issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

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

- The Quality Report does not incorporate the matters required to be reported on as specified in Annex 2 to Chapter 7 of the FT ARM and the "*Detailed requirements for quality reports 2013/14*";
- The Quality Report is not consistent in all material respects with the sources specified below; and
- The specified indicators have not been prepared in all material respects in accordance with the Criteria and the six dimensions of data quality set out in the "2013/14 Detailed guidance for external assurance on quality reports".

We read the Quality Report and consider whether it addresses the content requirements of the FT ARM, and consider the implications for our report if we become aware of any material omissions.

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

- Board minutes for the period April 2013 to April 2014
- Papers relating to Quality reported to the Board over the period April 2013 to April 2014;
- Feedback from the Commissioners, Halton Clinical Commissioning Group (CCG) dated 21/05/2014 and Warrington CCG dated 21/05/2014;
- Feedback from Governors dated 12/05/2014;
- Feedback from local Healthwatch organisations, namely Healthwatch Halton, dated 20/05/2014;
- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 28/05/2014;
- Feedback from other stakeholders involved in the sign-off of the Quality Report, namely Halton Health Policy Performance Board dated 19/05/2014**;**
- The 2013 national patient survey;
- The 2013 national staff survey;
- Care Quality Commission quality and risk profiles dated 31/05/2013;
- Intelligent Monitoring Reports dated 13/03/2014 and 21/10/2013;
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 30/04/2014;
- CQC Inspection reports, for inspections carried out on 28/01/2014 (Warrington) and 01/10/2013 (Halton);
- The trust's quarterly Governance Statements dated 31/07/2013 (Q1), 30/10/2013 (Q2), 29/01/2014 (Q3) and 30/04/2014 (Q4); and
- The trust's 2013/14 Annual Governance Statement.

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

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

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

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 'Assurance Engagements other than Audits or Reviews of

Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- reviewing the content of the Quality Report against the requirements of the FT ARM and "Detailed requirements for quality reports 2013/14";
- reviewing the Quality Report for consistency against the documents specified above;
- obtaining an understanding of the design and operation of the controls in place in relation to the collation and reporting of the specified indicators, including controls over third party information (if applicable) and performing walkthroughs to confirm our understanding;
- based on our understanding, assessing the risks that the performance against the specified indicators may be materially misstated and determining the nature, timing and extent of further procedures;
- making enquiries of relevant management, personnel and, where relevant, third parties;
- considering significant judgements made by the NHS Foundation Trust in preparation of the specified indicators;
- performing limited testing, on a selective basis of evidence supporting the reported performance indicators, and assessing the related disclosures; and
- reading documents.

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

Limitations

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

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

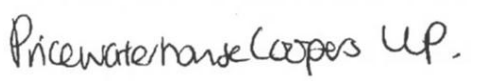
The nature, form and content required of Quality Reports are determined by Monitor. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators in the Quality Report, which have been determined locally by Warrington & Halton Hospitals NHS Foundation Trust.

Conclusion

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

- The Quality Report does not incorporate the matters required to be reported on as specified in Annex 2 to Chapter 7 of the FT ARM and the "*Detailed requirements for quality reports 2013/14*";
- The Quality Report is not consistent in all material respects with the documents specified above; and
- the specified indicators have not been prepared in all material respects in accordance with the Criteria and the six dimensions of data quality set out in the *"2013/14 Detailed guidance for external assurance on quality reports"*.



PricewaterhouseCoopers LLP
Chartered Accountants
Manchester
29/05/2014

The maintenance and integrity of the Warrington & Halton Hospitals NHS Foundation Trust's website is the responsibility of the directors; the work carried out by the assurance providers does not involve consideration of these matters and, accordingly, the assurance providers accept no responsibility for any changes that may have occurred to the reported performance indicators or criteria since they were initially presented on the website.

Appendix

Glossary

Appraisal	method by which the job performance of an employee is evaluated
Bariatric surgery	(weight loss surgery) includes a variety of procedures performed on people who are obese.
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.
Dr Foster	is a provider of healthcare information and benchmarking solutions to enable healthcare organisations to benchmark and monitor performance against key indicators of quality and efficiency.
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?"**
Governance risk rating	MONITOR **publish two risk ratings for each NHS foundation trust, on:** Governance (rated red, amber-red, amber-green or green); and Finance (rated 1-5, where 1 represents the highest risk and 5 the lowest).
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.
Making every contact count (MECC)	is about using every opportunity to talk to individuals about improving their health and well being
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
Monitor	assess NHS trusts for foundation trust status and license foundation trusts to ensure they are well-led, in terms of both quality and finances
MRSA	Methicillin-resistant *Staphylococcus aureus* (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans.
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.
National inpatient survey	collects feedback on the experiences of over 64,500 people, who were admitted to an NHS hospital in 2012.
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)	leads 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.
NNHS 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 produce and publish 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 casemix.
Riddor	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995
Secondary users services (SUS)	The Secondary Uses Service is the single, comprehensive repository for healthcare data which enables a range of reporting and analyses to support the NHS in the delivery of healthcare services
Safety thermometer	is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care.
Subarachnoid haemorrhage (SAH)	Subarachnoid haemorrhage is a leakage of blood beneath the arachnoid membrane of the brain, from a major blood vessel. It affects a person suddenly and usually without any prior warning.
Summary hospital-level indicator (SHMI)	reports mortality at trust level across the NHS in England using standard and transparent methodology.
Urinary tract infection (UTI)	is an infection that affects part of the urinary tract
Venous thromboembolism (VTE)	A venous thrombosis or phlebothrombosis is a blood clot (thrombus) that forms within a vein. A classical venous thrombosis is deep vein thrombosis (DVT), which can break off (embolize), and become a life-threatening pulmonary embolism (PE).