Warrington and Halton Hospitals NHS
NHS Foundation Trust

Warrington and Halton Hospitals NHS Foundation Trust

Quality Account 2011-2012

High Quality, Safe Healthcare
Quality People Sustainability

Contents

1. Statement on quality from the chief executive

Warrington and Halton Hospitals NHS Foundation Trust is committed to provide high quality care and clinical excellence that puts patients at the centre of everything we do.

Our trust objectives, by which we deliver all of our services, are to:

- Ensure all our 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.

In order to ensure that we meet these objectives, the trust has, over the past year, continued to observe, monitor and demonstrate how we are performing and, most importantly, how we are improving the experience patients receive.

The trust ensures that quality and patient safety is incorporated within all of its decision making processes and is an important factor in how it plans the future direction of the organisation. Formal reports on the various metrics used to measure patient safety, clinical effectiveness and the patient's experience are shared across the organisation and with the people who commission our services. This enables us to show the improvements we have made and to learn how we can share evidence of best practice across the whole trust and with our partners in delivering care.

A key component in ensuring that the voice of the patient isn't lost in all of the work carried out by the trust; is the introduction in 2011/12 of unannounced visits to wards by groups of our publically elected governors. Working in a structured manner, these visits have the advantage of a group of informed individuals who are detached from the clinical teams, providing constructive insights into the way in which patients are cared for, how their dignity is maintained and how they are included in decisions about their care. The results from these visits are shared with the Director of Nursing and with the specific ward teams on the understanding that the Governors' Council receives more formal feedback on any issues that the visits have raised.

The trust was exceptionally pleased at the result of the unannounced visit by the Care Quality Committee this year (2011/12) when they undertook an inspection into the care of older people with regard to nutrition and dignity. The inspector's report highlighted the very positive experience that our staff provide to this most vulnerable group of people. The report commented that "all patients spoken with said that staff treated them with respect and that their dignity was maintained at all times".

In the past year we have made some significant achievements in relation to patient safety:

- rates of hospital acquired Clostridium difficile have fallen by 42%
- the number of hospital acquired pressure ulcers (grade 3 & 4) have reduced by 49%

- a reduction in the number of falls that have resulted in major or catastrophic harm of 67%

There have been significant improvements in a whole range of ways in which we provide high quality care for our patients. To ensure that we retain the clear focus of our priorities in the coming year, the trust has produced two significant documents to guide the work we will carry out. The Quality Improvement and Patient Safety Strategy and the Patient Experience Strategy will be the main vehicles of ensuring that our values of safety and patient involvement are maintained.

We know that we need to challenge some of the ways in which we do things if we are to continue to improve. The recent National Inpatient Survey told us that we need to improve the way in which we plan and prepare patients for a safe discharge from hospital – this is now the focus of a significant piece of work to make the whole process more effective and valued by our patients.

Despite making significant improvements in the prevention of hospital acquired Clostridium difficile, the rates for MRSA bloodstream infections has not decreased from last year's rate. This is a major disappointment to the trust and again, is an issue that we will strive to improve on in the forthcoming year.

During the year, as part of our standard process of improvement in relation to monitoring and measuring how we are doing, we have undertaken an internal review of all falls causing a moderate to catastrophic harm to confirm that they are accurately and consistently reported and to perform root-cause analysis on these falls.

As a result of this review, we have calculated a 'confirmed falls' number for 2011/12 of 20 incidents of falls within the hospital, that have resulted in a moderate to catastrophic harm. For the year 2012/13 we will be recording and monitoring the "confirmed falls" figure as the actual incident of harm. As this is a different way of calculating the number of falls that cause harm, we have used both sets of metrics within the report - to compare against last year's figures (to be consistent in how we have reported) and the new approach (so as to clearly identify our progress over the next 12 months).

In conclusion, this Quality Account will demonstrate that we have made positive strides in improving the care and services we deliver to our patients and our determination to continue to improve all our services so that we can demonstrate our commitment to our local communities.

I am pleased to present this year's Quality Account 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.

Mel Pickup
Chief Executive
29th May 2012

2. Our Priorities for improvement and statutory information

The trust has developed a suite of performance markers to provide assurance of its progress in developing patient safety, a quality patient experience and clinical effectiveness.

The performance information is reviewed and discussed at:

- Nursing and Midwifery Advisory Council (the trust's senior nursing committee)
- Governors' Council Quality Committee
- Meetings of the Board of Directors
- Meetings with the commissioners' of the trust's services

In addition to the presentation of the performance information, the improvement initiatives are also discussed and presented at various trust committees to gain assurance on the processes taken and to ensure that the projects goals meet the overall trust objectives.

In 2011/12, our improvement priorities included:

- Achievement of the infection control standards set for the trust
  - no more than 4 MRSA blood stream infections to be acquired within the trust
  - no more than 54 Clostridium difficile cases to be acquired within the trust

- A reduction in the number of falls within the trust which result in moderate to severe harm by 10%

- A reduction in hospital acquired pressure ulcers (grade 3 and 4) to no more than 29 within the year.

The trust was successful in reducing the rate of hospital acquired Clostridium difficile cases by 42% (38 cases); reducing falls in hospital (causing moderate to severe harm) by 25% and a 49% reduction in hospital acquired pressure ulcers (grade 3 and 4). The trust reported the acquisition of 5 MRSA blood stream infections within the year and therefore did not achieve this objective. Further detail on the compliance against these priorities can be found in Section 3 of this report.

The Trust Board has agreed that our improvement priorities for 2012/13 will include:

- Improve the way in which we plan and prepare patients for a safe discharge from hospital:
  - Contact if patients had fears on leaving hospital
  - Details on side effects of medications taken home
- Reduce the numbers of hospital acquired MRSA bloodstream infections

- Achieve the quality improvement programme as identified within the Quality Improvement and Patient Safety Strategy (i.e. an improvement in the reduction in harm to patients)
- Achieve an improvement in the priorities included within the Patient Experience Strategy (i.e. engagement and increasing the patient's voice in operating services)
- Commissioner priorities.

How we identify our priorities

The priorities have been identified through receiving regular feedback and through regular engagement with staff, patients, the public, and commissioners of NHS services, scrutiny group and other stakeholders. Progress on the planned improvements will be reported through the trust's assurance committees, via Governor forums and ultimately through to Trust Board.

As part of the trust's growth strategy the trust will develop full pathway care to facilitate the active management of demand by maintaining patients in the community to reduce hospital attendances. This will cover outreach services for long term conditions, frail elderly, out patients based services dementia etc. This strategy covers a time period for the next three years.

Our success in achieving these priorities will be measured, were possible, by using nationally benchmarked information (e.g. National Inpatient Survey results, Dr Foster, CRAB (Copeland Risk Adjusted Barometer)**)** 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 processes that we use to monitor and record our progress have been (or are scheduled to be) audited by Merseyside Internal Audit Agency to provide assurance on the accuracy of the data collection methods employed.

Statements of assurance from the Board

During 2011-2012 the Warrington and Halton Hospitals NHS Foundation Trust provided and/or sub-contracted seven NHS services.

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

The income generated by the NHS services reviewed in 2011-2012 represents 100% of the total income generated from the provision of NHS services by the Warrington and Halton Hospitals NHS Foundation Trust for 2011-2012.

Audit and Research

Audit

Clinical audit "is a quality improvement process that seeks to improve patient care and outcomes through systematic reviews of care against explicit criteria and the implementation of change". The trust participates with three main types of clinical audit processes. The national clinical audits and national confidential enquires that Warrington and Halton Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2011-2012, 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.

During 2011-2012 106 national clinical audits and four national confidential enquiries covered NHS services that Warrington and Halton Hospitals NHS Foundation Trust provides.

During 2011-2012 Warrington and Halton Hospitals NHS Foundation Trust participated in 89% national clinical audits and 75% 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 the trust was eligible to participate in during 2011/12 are as contained within appendix 1 (Section 6.1)

The national clinical audits and national confidential enquiries that Warrington and Halton Hospitals NHS Foundation Trust participated in during 2011/12 are as follows:

	Total	% Participated in
National Audits	106	89%
National Confidential Enquires	4	75%

The national clinical audits and national confidential enquiries that the trust participated in, and for which data collection was completed during 2011/12, 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.

The reports of 106 national clinical audits were reviewed by the provider in 2011-2012 and the trust intends to take the following actions to improve the quality of healthcare provided. Examples of which are provided in Appendix 6.2.

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

The reports of 125 local clinical audits were reviewed by the provider in 2011/12 and Warrington and Halton Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided. Examples are provided in Appendix 6.3.

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

Information on participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by Warrington & Halton Hospitals NHS Foundation Trust in 2011–2012 who were recruited to participate in research approved by a Research Ethics Committee was 1,844.

This figure only includes National Institute for Health Research (NIHR) portfolio studies and does not include non-portfolio studies.

The White Paper *Equity and Excellence: Liberating the NHS* (DH July 2010) says: "Research is even more important when resources are under pressure - it identifies new ways of preventing, diagnosing and treating disease. It is essential if we are to increase the quality and productivity of the NHS, and to support growth in the economy."

Participation in clinical research demonstrates trusts commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff are up to date with the latest treatment possibilities ensuring active participation in research to promote successful patient outcomes.

In 2011 – 2012 the trust was involved in conducting 95 clinical research studies (a 5% increase on 2010-2011) mainly in Cancer, Stroke, Paediatrics, Reproductive Health, Rheumatology, Critical Care, Cardiovascular, Diabetes, Musculoskeletal, Ophthalmology, Oral and Gastrointestinal.

The Research and Development department is working closely with the Cheshire & Merseyside Comprehensive Local Research Network, Topic Specific Networks and other health providers to increase NIHR clinical research activity and participation in research. Doubling the number of participants taking part in clinical trials and other well designed research studies over the next 3 years is a major priority for the trust. Measures will be put in place to assess actual total recruitment against targets. This will ensure that 80% of studies achieve 100% predicted recruitment at planned close of recruitment.

The trust has also adopted the Comprehensive Local Research Network (C&MCLRN) Research Management and Governance operational procedures and systems, including National Institute for Health Research Coordinated System for gaining NHS Permissions.

The trust will ensure that all NIHR portfolio research activities are conducted to the highest standards and undertaken within the framework of research governance, strict legislation and recognised good clinical practice.

Most of the research carried out is funded by the NIHR. For 2011-2012 the trust received £480,213. We fund eight research nurses to support principal Investigators with recruitment and assist with the management of NIHR studies ensuring that the study runs safely and in accordance with the approved protocol.

The Research & Development Strategy for 2010-2013 will set out a number of key objectives over the next three years for the delivery of high quality research.

Information on the use of 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 co-ordinating commissioners and providers and included as part of contracts.

A proportion of trust income in 2011-2012 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 NHS services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2011-2012 and for the following 12 month period are available online at the Monitor website –

http://www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275

Monetary total for the amount of income in 2011-2012, conditional upon achieving quality improvement and innovation goals, was £2,490,830, with a monetary total for the associated payment in 2011/12 of £2,490,830 received.

For purposes of clarity, a description of the national, regional and local CQUIN is illustrated below with the identified targets and achievement status. - CQUIN schemes and performance to date in provided on the graphs below – we are achieving the requirements for all areas at this stage.

Target					
		Scheme	**Target**	**Performance**	**Achieved**
National	1	Reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE)	90% cumulative for the year	The Trust have achieved >95% VTE assessment level per month i.e. over 5% above the national threshold.	✓
	2	Improve responsiveness to personal needs of patients	67.4 = 70% 68.4 = 80% 69.4=90% 70.4 = 100%	66.2% (NB – this is a score derived from the results of 5 questions, within the National Inpatient Survey)	x
Regional	3	AQ – AMI (Acute Myocardial Infarction)	100% = 95%	Cumulative to December 99.47%	✓
	4	AQ – HF (Heart Failure)	75% = 93.78% 25% = new measures	Cumulative to December 95.03% All new measured being reported	**x** ✓
	5	AQ – H&K (Hip & Knee)	75% = 95% 25% = new measures	Cumulative to December 99.39% All new measured being reported	✓ ✓
	6	AQ - Pneumonia	75% = 87.28% 25% = new measures	Cumulative to November 88.61% All new measured being reported	✓ ✓
	7	AQ – Stroke	75% = 90% 25%=ACS 50%	Cumulative to December 90.88% Cumulative to December 63.93%	✓
	8	AQ PEMS. (Patient Experience)	25% return rate for year	Cumulative to January 39.0%	✓
	9	TARN (Trauma Audit & Research Network)	Level 4	Level 4 on target	✓
Local	10	Patient Experience Strategy	Qtr 1 – Strategy Qtr2 – Increase data capture / baseline Qtr 3 improvement	Strategy and system improvements completed	✓
	11	To promote clinical effectiveness, safety and patient experience through improved health economy management of patients with 'senility and organic disorder'.	Qtr 2 - Report	Analytical requirements completed.	✓
	12	Improved Prescribing both as inpatients and post-discharge	Qtr 1 - 4	Medication changes completed	✓

NB – please note that AQ results are released sometime after the actual end of the quarter and so the figures within this table represent the most current results available.

Information relating to registration with the Care Quality Commission and periodic/special reviews

Warrington and Halton Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is registered. Warrington and Halton Hospitals NHS Foundation Trust has no conditions on registration.

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.

The Care Quality Commission has not taken enforcement action against Warrington and Halton Hospitals NHS Foundation Trust during 2011-2012.

The Care Quality Commission made an unannounced visit to Halton General hospital early in 2011-2012 as part of its review into dignity and nutrition for older people. The inspection team produced a most positive and encouraging report into the way in which the trust provides care for this most vulnerable group of patients. A quote from the CQC's report seems to sum up the overall visit "all patients spoken with said that staff treated them with respect and that their dignity was maintained at all times".

There have been a further two unannounced visits by the CQC within the year. These did not require any improvements to be made and they did not raise any concerns about our services or processes.

A 'moderate concern' was removed from our risk rating profile in August 2010 following an incident which occurred in 2010. The CQC were satisfied that the trust had carried out all the appropriate improvement work that it had agreed to.

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.

Information on the quality of data

Warrington and Halton Hospitals NHS Foundation Trust submitted records during 2011-2012 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 99.62% for admitted patient care; 99.80% for outpatient care; and 98.58% for accident and emergency care.

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

- 99.39% for admitted patient care; 99.47% for outpatient care; and
- 99.169% for accident and emergency care.

Information Governance (against the Information Governance Toolkit v. 9)

Warrington and Halton Hospitals NHS Foundation Trust's Information Governance submission overall score for 2011-2012 was 59%. It was graded red.

However, this is an increase of 19% on the 2010-2011 submission.

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

- Reporting regularly on progress against the trust's Information Governance action plan at the Information Governance and Corporate Records Sub-Committee. This committee is chaired by the director of governance and workforce. Performance progress will also be monitored by the Governance Committee, which is a sub-committee of the trust board.

- Adhering to an Information Governance Annual Work Plan which demands that progress against the action plan, a review of Information Governance risks and incidents and divisional and departmental assurance on Information Governance issues, is presented at each meeting of the Information Governance and Corporate Records Sub-Committee.

- Working towards compliance at the requisite level 2 standard across all the requirements contained within the Information Governance Toolkit in 2012/13.

The trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were 9%.

The sample was 100 finished consultant episodes from trauma & orthopaedics and 100 finished consultant episodes across the whole range of activities covered by a mandatory tariff. These results should not be extrapolated further than the actual sample audited.

3: Patient safety, clinical effectiveness & patient experience

Overview of the quality of care based on performance in 2011/12 against indicators

Priorities for improving patient safety for 2011-2012 were set out in the Trust's L**eading** I**mprovement in** P**atient** S**afety** (LIPS) programme. This was expanded to also include programmes to improve clinical effectiveness and patient experience. Throughout the year, a dashboard of performance against each of the agreed targets for improvement has been presented to the trust board (and the wider committee groups) to provide assurance on progress and improvements made in the areas of patient safety, clinical effectiveness and patient experience.

This information is also shared with our Governors and commissioners of services to demonstrate how care for patients is delivered and sustained improvements are maintained.

The information is collated from, whenever possible, sources which could be benchmarked with other organisations in order to indicate the trust's performance in relation to others. As such, Dr Foster and CRAB (Copeland Risk Adjusted Barometer) are used wherever relevant. Developments in practice have come from our participation with the LIPS programme.

Other sources of data collection come from in-house sources (audit, survey, incident reporting, complaints and observation).

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.

From April 2012, the recently produced Quality Improvement and Patient Safety Strategy and Patient Experience Strategy will support the trusts developments in quality over the next 3 years.

The indicators selected for inclusion within this Quality Account have been included after consultation and discussion with the Quality Committee of the Board of Governors. It was agreed that indicators that were a measurement of the priorities from the 2010-2011 report should feature in order to demonstrate the effectiveness of actions taken by the trust in its quality improvement initiatives.

In the main, the indicators are issues that have a nationally high profile of patient's interest and as such, it was felt that by including these within the Quality Account, the trust would be up front in demonstrating that it was taking seriously the issues raised by the public.

3.1 Patient safety

3.1.1 Infection Control

- ***In 2010-2011 we had five MRSA bloodstream infections and 65 cases of Clostridium difficile acquired within the hospital***
- ***In 2011-2012 our goal was to have no more than four cases of MRSA bloodstream infections and 65 cases of Clostridium difficile acquired within the hospital.***
- ***We had five cases of MRSA bloodstream infections and 38 cases of Clostridium difficile acquired within the hospital in the year. We have partially achieved our goal.***
- ***Our plan for 2012-2013 is to have no more than three cases of MRSA bloodstream infections and 40 cases of Clostridium difficile acquired within the hospital.***

This information is collected using clinically recognised diagnostic tools and is reported to the Health Protection Agency.

Healthcare Associated Infections	**Hospital Acquired Cases**		
	2009/2010	**2010/2011**	**2011/12**
MRSA bloodstream infection	4	5	5
Clostridium difficile	114	65	38

An MRSA bacteraemia is defined as a positive blood sample test for MRSA on a patient. MRSA cases disclosed include all MRSA positive blood cultures detected in the laboratories, whether clinically significant or not and whether treated or not, acquired in the trust (any time 48 hours after admission). Positive results on the same patient more than 14 days apart are reported as separate episodes.

It is disappointing that the trust didn't achieve its aim of having no more than four cases of MRSA bloodstream infections and it is working hard to meet the goal of trying to reduce this to no more than 3 cases in the year 2012/13.

The trust has introduced antiseptic non-touch technique training for all clinical staff to ensure that practice is maintained to the highest standard of care to patients when caring for them. The trust has launched a new series of patient and visitor information to help everyone play their part in keeping our patients safe.

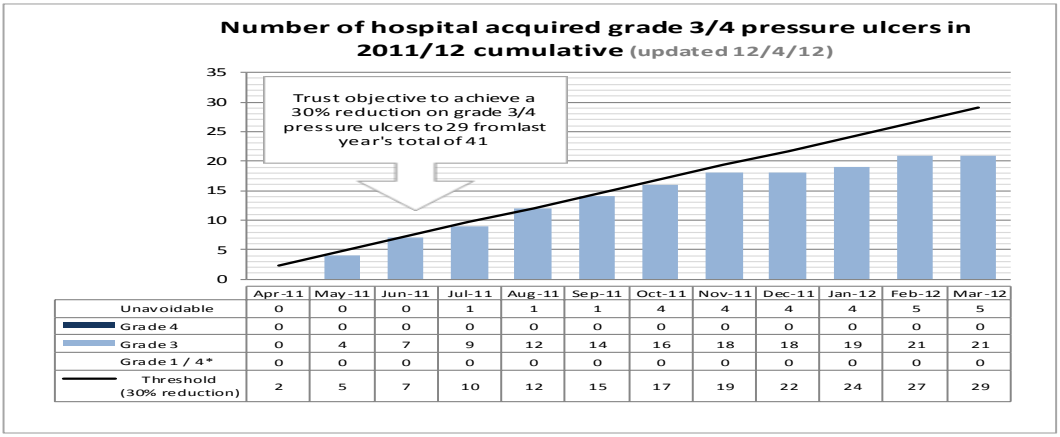
The 42% reduction in hospital acquired Clostridium difficile cases is an endorsement that the strict processes our staff take in managing this infection are working. The use of a cohort (isolation) ward for patients with Clostridium difficile has meant that these patients can be safely and appropriately cared for whilst reducing the risk of spreading the infection with others.

The challenge for the next twelve months is to maintain and improve all our infection prevention and control measures across all clinical areas, at all times and with the involvement of all our staff.

3.1.2 Pressure Ulcers

- ***In 2010-2011 we had 41 cases of grade 3 & 4 hospital acquired pressure ulcers.***
- ***In 2011-2012 our goal was to have no more than 29 cases of grade 3 & 4 hospital acquired pressure ulcers (a 30% reduction).***
- ***We had 21 cases of hospital acquired pressure ulcers grade 3 & 4 – a reduction of 49%. We have achieved our goal.***
- ***Our plan for 2012/13 is to have no more than 21 grade 3 & 4 pressure ulcers acquired within the hospital.***

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.



	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12
Unavoidable	0	0	0	1	1	1	4	4	4	4	5	5
Grade 4	0	0	0	0	0	0	0	0	0	0	0	0
Grade 3	0	4	7	9	12	14	16	18	18	19	21	21
Grade 1 / 4*	0	0	0	0	0	0	0	0	0	0	0	0
Threshold (30% reduction)	2	5	7	10	12	15	17	19	22	24	27	29

The trust has had 21 grade 3 and no grade 4 avoidable* hospital acquired pressure ulcers against a threshold of 29 for 2011-2012. The successful reduction of 49% on the previous year's results were achieved following a trust-wide quality improvement initiative that engaged our clinical staff in developing a series of changes in practice that had been identified as reducing the risk of patients developing pressure ulcers whilst in hospital.

The trust is also working with its partners in the local community to help identify ways of reducing the numbers of patients coming into hospital with pressure ulcers being acquired at home or in nursing homes. We intend to further develop our improvements in the coming year to continue to reduce the numbers of pressure ulcers.

Definition of a Grade 3 Pressure Ulcer: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunnelling.

Definition of a Grade 4 Pressure Ulcer: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunnelling.

***** 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.

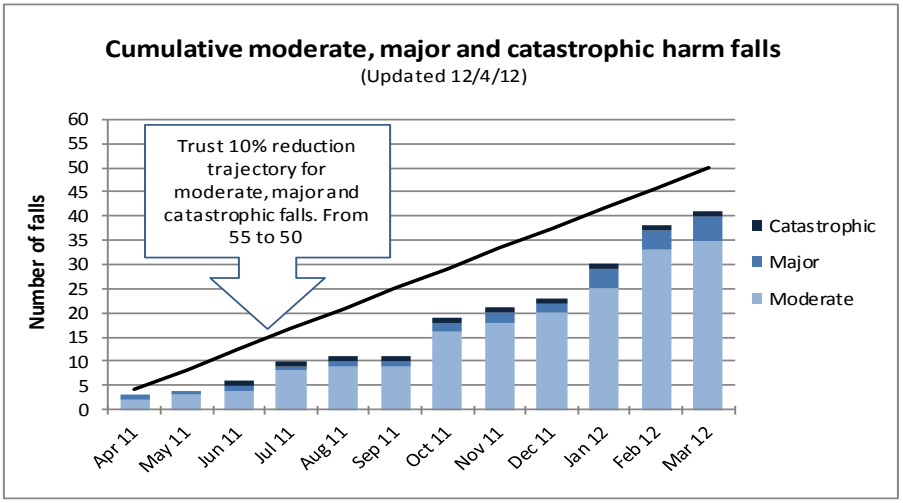
3.1.3 Falls

- ***In 2010-2011 we reported to Trust Board that we had 55 incidents of a fall, in hospital, which caused a moderate to catastrophic harm.***
- ***In 2011-2012 our goal was to have no more than 50 incidents of a fall (a 10% reduction), in hospital, which caused a moderate to catastrophic harm.***
- ***We have reported to Trust Board that we had 41 such falls (an overall 25% reduction – which includes a 67% reduction in major and catastrophic harm) and have achieved our goal.***

During the year, as part of our standard process of improvement in relation to this area, we have undertaken an internal review of all falls causing a moderate to catastrophic harm to confirm that they are accurately and consistently reported and to perform root-cause analysis on these falls.

As a result of this review, we have calculated a 'confirmed falls' number for 2011-2012 of 20 incidents of falls within the hospital, that have resulted in a moderate to catastrophic harm. For the year 2012/13 we will be recording and monitoring the "confirmed falls" figure as the actual incident of harm.

Our plan for 2012/13 is to have a reduction of no less than 10% of incidents of a confirmed fall, in hospital, which caused a moderate to catastrophic harm.



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

- Moderate Harm – an injury, 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.

3.1.4 Clinical effectiveness

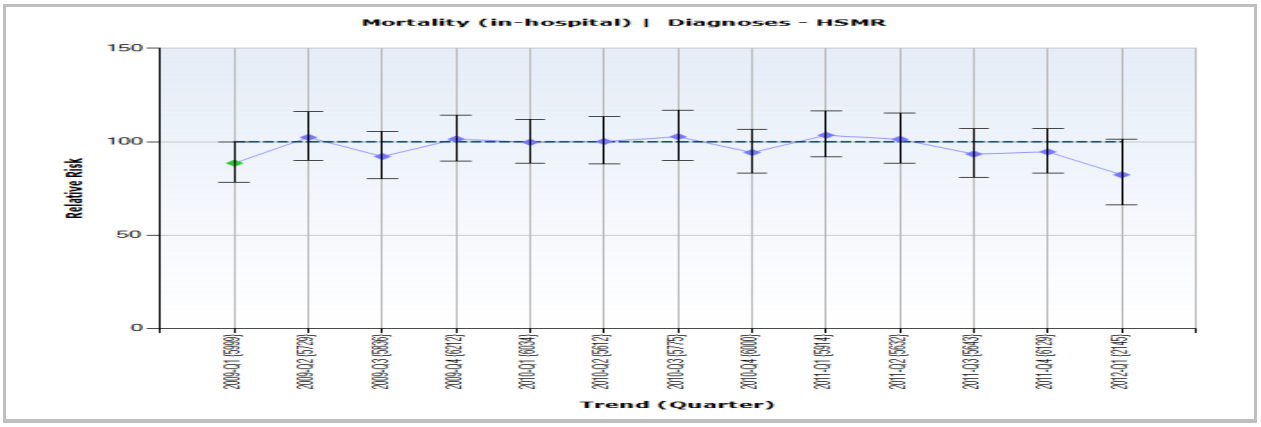
Hospital Standardised Mortality Review (HSMR)

The HSMR scoring system works by taking a hospital's crude mortality rate (actual deaths) and adjusting it for a wide variety of factors such as population size, age profile, level of poverty, range of treatments and operations provided etc. By taking these facts into account for each hospital, it is possible to calculate two scores – the mortality rate that which would be expected for NHS hospitals of a particular type and the observed rate for an individual hospital within that group.

HSMR is an important indicator in alerting trusts to potential issues that would adversely affect the quality of care provided.

Nationally the expected HSMR score for a trust such as Warrington and Halton NHS Foundation Trust is set at a score of 100. This figure does not represent deaths – it is just a baseline number used to compare performance. A number below 100 (as shown on this trend graph) indicates that the hospital has been able to show that there are now less than the expected numbers of deaths.

NB – the HSMR score is recorded by Dr Foster and the information they use comes from the clinical coding of patient episodes within the trust. Our goal is to remain under 100 and to demonstrate a sustained reduction below that rate.



Reducing harm to patients who are critically ill

- ***In 2010-2011 we achieved a compliance of 95% for ventilator acquired pneumonia prevention and 100% for urinary catheter infection prevention in patients within the critical care unit.***
- ***In 2011-2012 our goal was to maintain this high level of compliance. We achieved 97% compliance for ventilator acquired pneumonia prevention and 100% for urinary catheter infection prevention – we achieved our goals.***
- ***Our plan for 2012-2013 is to maintain this high standard.***

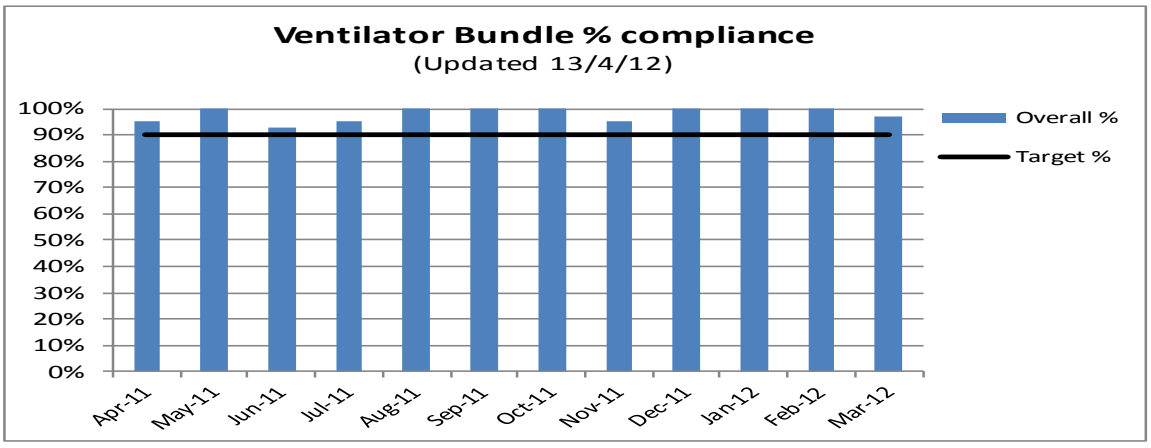
This information is derived from hospital audit data following clinical criteria established in national high impact interventions (HII) as set out by the department of health.

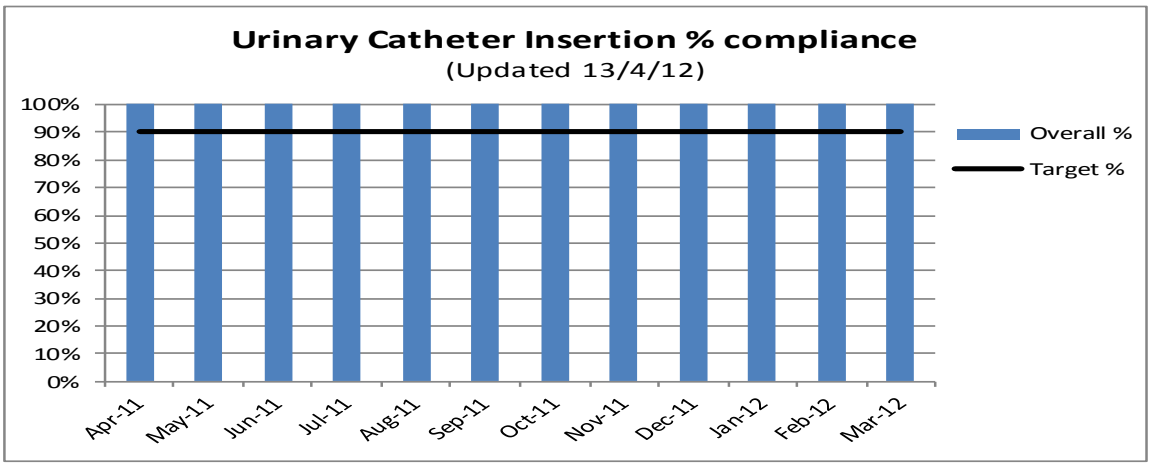
Every clinician has the potential to significantly reduce the risk of infections to their patients by ensuring that they consistently comply with evidence based practice and guidelines every time they undertake a clinical procedure.

The High Impact Interventions (HII) in the Department of Health document 'Saving Lives' have identified the critical elements of a particular procedure, (e.g. inserting a urinary catheter) the key actions required and a means of demonstrating reliability using compliance measurement.

They are based on a 'care bundle' approach - each element needs to be undertaken to reduce the risk of infection not one element on its own. The next graphs outline compliance percentage for critical care bundles and in brief the care that makes up the bundle for each high impact intervention procedure - some of these have two elements to the care process for example its insertion (putting a line or tube in) and its on-going care. A target of 90% compliance with the care bundle has been set and actual performance against this is monitored and presented in the charts and supporting information which follow.

Our successful achievement for these is demonstrated in the following graphs



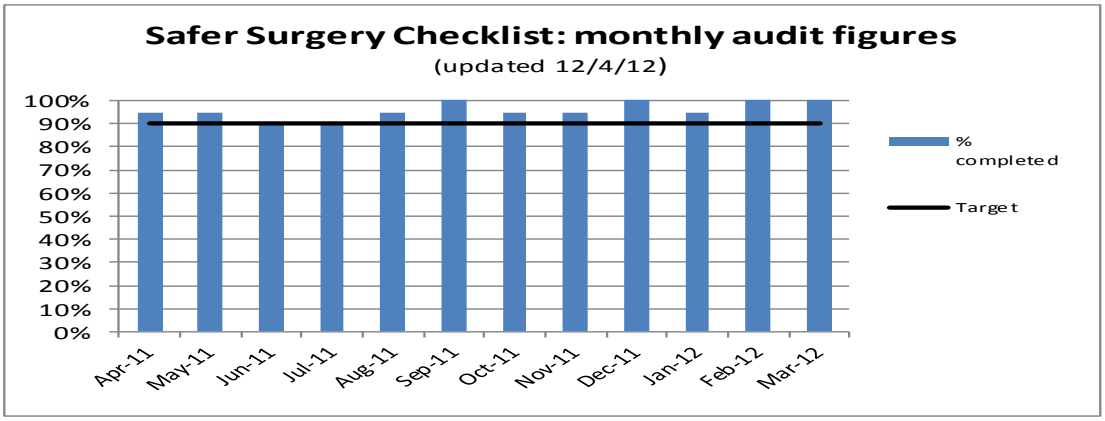


Ensuring Safer Surgery

- ***Our aim for 2010-2011 was to achieve 90% compliance in completing the 'safer surgery checklist -We achieved a compliance rate of 87%***
- ***Our plan for 2011-2012 was to achieve and maintain a compliance rate of 90% - we have maintained and achieved this compliance rate (95% - 99%) - Our goal for 2012=-2013 is to maintain this level of compliance.***

The principal of the Safer Surgery Checklist is to improve the safety of surgical care around the world by ensuring adherence to proven standards of care. This is derived from a World Health Organisation initiative that has been shown to improve compliance with standards and decreased complications from surgery. We have achieved this level of 90% compliance.

This information is recorded following audit of hospital records and is governed by a standard national definition.



Stroke

The trust has continued to perform well against the National Stroke Indicator with a problem having been identified with 90% of stroke patients treated on a Stroke Ward.

Since changing a Stroke Pathway in 2011, the under 24 hour stoke patients are treated and discharged and as such would not clinically need to go onto a Stroke Unit, thus distorting our return. In addition to which, the designation of Stroke Unit will take in the acute Stroke Ward and the Stroke Rehabilitation Ward alongside four protected beds to ensure speed of access. This will provide a more reflective position of our performance in future accounts.

3.2 Patient Experience

3.2.1 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 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 2010/11 the trust had 619 episodes when of mixed-sex accommodation. In this year (2011/12) this has been reduced to 41 – a reduction of 93% within the year. This has been achieved by a concerted effort by trust staff to ensure that we maintain the privacy and dignity of our patients.

This is a new indicator within the Quality Account for 2011/12. It has been included because of the great importance placed upon the trust in maintaining patient's privacy and dignity. Obviously, it is also an area that the public are very keen to see organisations perform well on. Information is collected using the trust's incident reporting systems using criteria set out by the Department of Health.

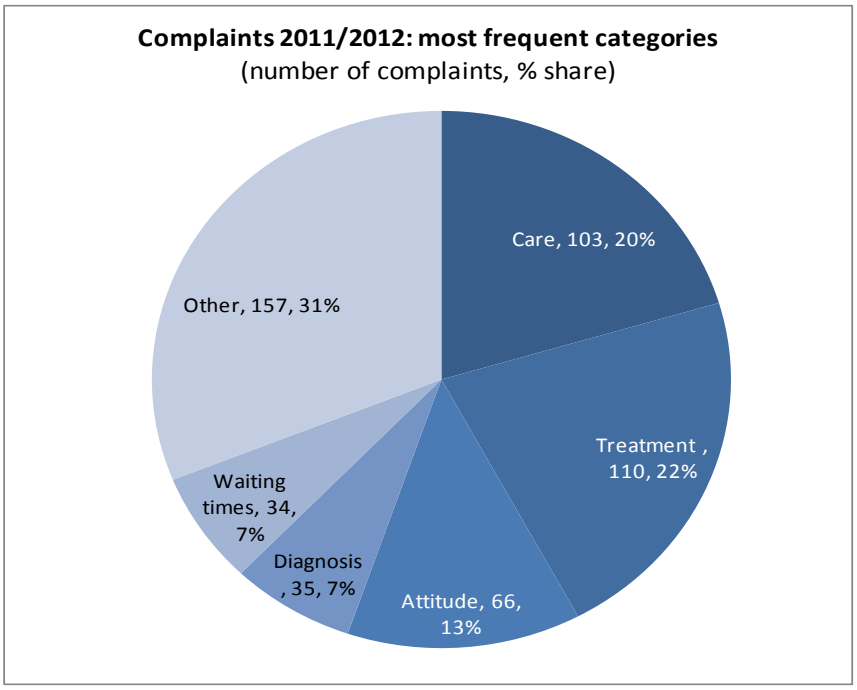
3.2.2 Complaints

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 2010-2011. The Patient Relations Team continues to provide support and guidance for Divisions when dealing with complaints and the Patient Relations Manger attends regular meetings with key members of staff to discuss the handling of individual complaints.

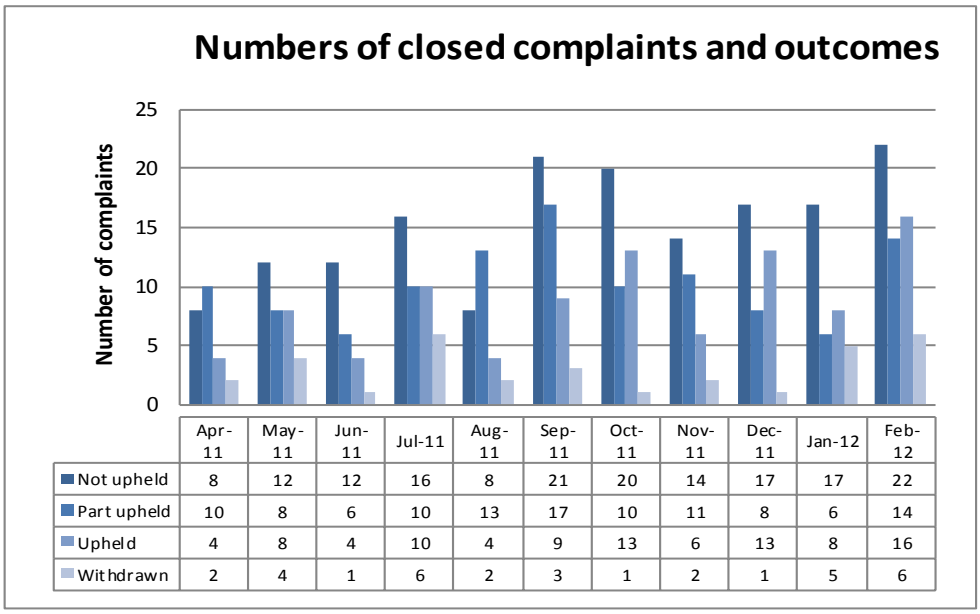
All complaints are investigated in accordance with trust policy and wherever appropriate, action is taken to achieve service improvements.

	2010/11	2011/12
Total formal complaints received	**491**	**505**

The majority of complaints are put into one of five 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. These category subjects are different than those used last year and have been adapted to provide a much more useful approach and is in line with the approach taken by the Parliamentary and Health Service Ombudsmen.



'Other' denotes small clusters of issues raised by complainants that cannot be easily attributed to the five main categories (e.g. food, heating, car parking, hospital signage, quality of seating areas). However, each issue is addressed and raised with the relevant manager to address.



	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12
Not upheld	8	12	12	16	8	21	20	14	17	17	22
Part upheld	10	8	6	10	13	17	10	11	8	6	14
Upheld	4	8	4	10	4	9	13	6	13	8	16
Withdrawn	2	4	1	6	2	3	1	2	1	5	6

This graph demonstrates the numbers of complaints closed each month (April 2011 to February 2012) and whether the complaint is upheld or not or withdrawn. Definitions of status are listed below:

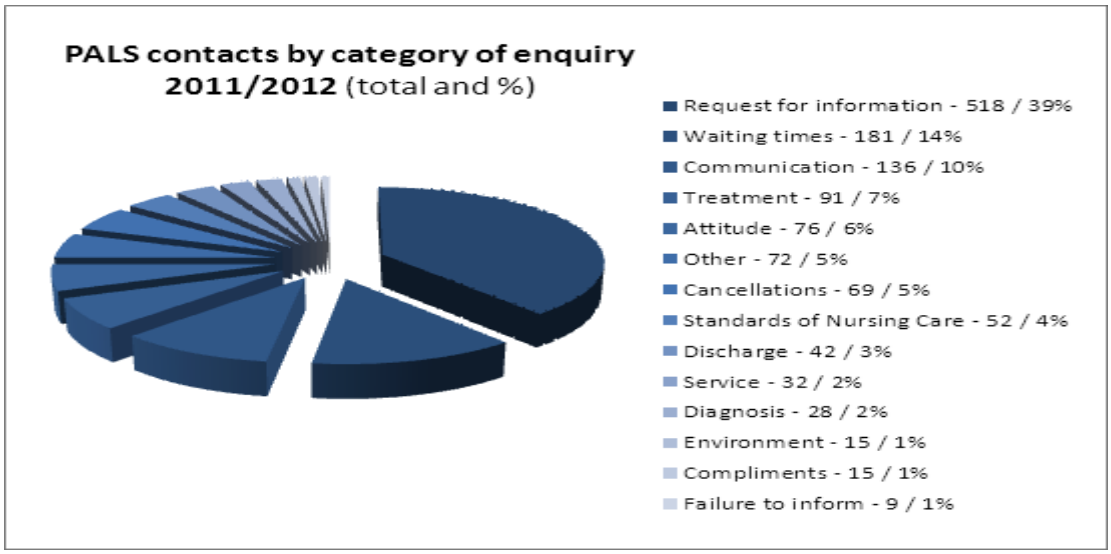
- **Upheld:** Is when the trust concludes a complaint is well founded and there have been errors/failings on the trust's part.
- **Part Upheld:** Is when a complaint has various issues however the trust concludes only some issues are well founded, and the Trust has defended our actions on other issues.
- **Not Upheld:** Is when the trust has defended its actions and has found no failings/error in our service.
- **Withdrawn:** Is when the trust receives a complaint however the complainant decides later to withdraw it. Or when the trust receives a complaint and have written asking for signed consent from the patient, and after two letters the trust receives no further contact from the complainant.

Our goal for 2012-2012 is to be able to demonstrate the appropriate completion of complaints within agreed time scales with the complainants.

3.2.3 PALS

The Patient Advice & Liaison Service (PALS) is an informal but valuable way of gaining patient feedback. PALS play a significant and important role in the patient and public experience within the trust in dealing with concerns at the first level to help resolve issues before these escalate into formal complaints. Significantly, the main role that PALS has is the way in which it provides information and support to patients and visitors – these are not as a result of people voicing concerns about the service they have received; it is a service provided in addition to that provided by clinical staff.

These category subjects are different than those used last year and have been adapted to provide a much more useful approach and is in line with the approach taken by the Parliamentary and Health Service Ombudsmen.



	2010/11	2011/12
Total PALS contacts	**1253**	**1336**

The main issues raised by members of the public with PALS that has caused there to be an increase in 2011-2012 were requests for information, questions/dissatisfaction with waiting times and issues relating to communication (either dissatisfaction with the way in which they have received information or the lack of available good quality written information).

Our goal for 2012-2013 is to be able to demonstrate the actions taken to address the issues raised within the more frequent contact points with PALS.

3.2.4 National survey 2011 results

The trust's results in this year's survey continue to show that patients feel that they are treated with dignity and respect whilst receiving care at Warrington and Halton Hospitals NHS Foundation Trust. Our aim is to continue to improve on this and make the experience of our patients even better in the next year.

There are issues in which we need to improve and the trust is determined to look at ways in which we can improve the experience for everyone using our service.

The specific areas that we need to address are:

- Involving patients in decisions about their care and treatment
- Availability of hospital staff to talk to about worries and fears
- Provision of privacy when discussing condition/treatment
- Information about medication side effects to watch or when the patient went home
- Contact details if the patient is worried about their condition or treatment after they left hospital.

The trust has identified these issues as its requirement for immediate improvement and so a planned programme of improvements is already being implemented. The progress of these

changes to practice will be monitored throughout the year to ensure that our plan is being successfully implemented.

3.2.5 Governor's visits

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

A summary, provided by the trust's Lead Governor, is available with section 4.7.1

3.2.6 Performance against key national priorities

Performance against key national priorities is detailed within the Governance Risk Rating table as follows:

Mar-12

Governance Risk Rating - (Monitor) 2011/12

Warrington and Halton Hospitals NHS
NHS Foundation Trust

All targets are QUARTERLY

Level One - National Targets		Target	Weighting	Apr-11	May-11	Jun-11	QTR-1	Jul-11	Aug-11	Sep-11	QTR-2	Oct-11	Nov-11	Dec-11	QTR-3	Jan-12	Feb-12	Mar-12	QTR-4
Clostridium Difficile	Hospital Acquired	54	1.0	2	3	5	10	2	4	7	13	1	5	4	10	2	2	1	5
	Total			4	3	8	15	7	9	13	29	4	11	8	23	6	2	2	10
MRSA Bacteraemia - (Hospital Acquired Target)		6	1.0	0	1	1	2	0	1	0	1	0	0	1	1	0	0	1	1
All Cancers:31-day wait for second or subsequent treatment	Surgery	>94%	1.0	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%
	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 To Treatment **(Open Exeter Position)**	>85%	1.0	92.68%	95.45%	90.00%	91.67%	90.67%	92.19%	91.30%	91.04%	90.80%	97.62%	94.40%	93.81%	90.91%	92.65%	86.30%	91.85%
	From Consultant 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%	99.00%	100.00%	90.90%	100.00%	97.80%
Referral to treatment waiting time (Failure in any Month is a failure for the Quarter)	Admitted patients (95th percentile)	<23Wks	1.0	20.65	20.98	20.67	20.75	20.69	21.13	22.53	21.35	22.05	22.99	24.23	22.94	22.90	22.95	22.84	22.90
	Non-admitted patients (95th percentile)	<18.3Wks	1.0	13.24	14.12	14.12	13.83	15.46	14.93	14.43	14.99	16.18	15.64	15.79	15.94	17.81	16.27	16.08	16.67

Level Two - Minimum Standards		Target	Weighting	Apr-11	May-11	Jun-11	QTR-1	Jul-11	Aug-11	Sep-11	QTR-2	Oct-11	Nov-11	Dec-11	QTR-3	Jan-12	Feb-12	Mar-12	QTR-4
All Cancers: 31-Day Wait From Diagnosis To First Treatment		>96%	0.5	100.00%	100.00%	98.00%	99.40%	98.00%	100.00%	98.00%	98.68%	100.00%	100.00%	98.00%	99.10%	100.00%	100.00%	100.00%	100.00%
Cancer: Two Week Wait From Referral To Date First Seen	All Cancers	>93%	0.5	97.40%	96.61%	95.90%	96.60%	97.90%	95.38%	95.00%	96.09%	95.01%	97.80%	94.60%	96.50%	97.90%	97.10%	96.30%	97.90%
	Symptomatic Breast Patients (Cancer Not Initially Suspected)	>93%		98.40%	94.44%	96.50%	97.50%	95.40%	96.52%	95.70%	95.87%	95.03%	98.02%	94.3%	96.00%	97.00%	97.00%	95.6%	97.00%
A&E Clinical Quality	% A&E and MIU throughput within 4 hours	>=95%	1.0	95.46%	95.15%	97.28%	95.96%	95.49%	96.06%	97.65%	96.38%	96.00%	95.58%	93.55%	95.09%	93.04%	93.21%	95.94%	94.14%
Stroke Indicators (To be confirmed)																			
Certification against compliance with requirements regarding access to healthcare for people with learning disability		N/A	0.5	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Other Indicators	Target	Weighting	Apr-11	May-11	Jun-11	QTR-1	Jul-11	Aug-11	Sep-11	QTR-2	Oct-11	Nov-11	Dec-11	QTR-3	Jan-12	Feb-12	Mar-12	QTR-4
Risk of, or actual, failure to deliver mandatory services	N/A	4.0	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
CQC improvement notice(s) received within last 12 months	N/A	Special	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
CQC compliance action outstanding	N/A	2.0	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 regarding the safety of healthcare provision	N/A	1.0	Yes	Yes	Yes	Yes	Yes	No	No	No	No	No	No	No	No	No	No	No
Major CQC concerns 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
Moderate or Major CQC concerns regarding Outcomes 4 or 16 only	N/A	Special	TBC	Yes	Yes	Yes	Yes	No	No	No	No	No	No	No	No	No	No	No
Unable to maintain, or certify, a minimum published CNST level of 1.0 or have in place appropriate alternative arrangements	N/A	2.0	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Score of 7 or less in standard 1 assessment at last NHSLA CNST inspection (maternity or all services)	N/A	Special	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
Failure to rectify a compliance or restrictive condition(s) by the date set by CQC within the condition(s) (or as subsequently amended with the CQC's agreement)	N/A	4.0	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Registration conditions imposed by Care Quality Commission	N/A		No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Restrictive registration conditions imposed by Care Quality Commission	N/A		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)**			1.0	1.0	1.0	1.0	1.0	0.0	0.0	0.0	0.0	0.0	2.0	1.0	1.0	1.0	0.0	1.0

NB - The final annual outturn for the percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer is 91.43%

NB - Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers - Indicator criteria

Number of patients receiving first definitive treatment for cancer within 62 days following an urgent GP referral as a percentage of the total number of patients receiving first definitive treatment for cancer following an urgent GP.

3.2.7 Training & Appraisal

	Target	**Year End Results**
Mandatory Training		
Health & Safety	85%	91% (88% in 2010/11)
Fire Safety	85%	69% (61% in 2010/11)
Manual Handling	85%	77% (70% in 2010/11)
Additional Fire Safety and Manual Handling sessions are in place to improve these figures.		
Staff Appraisal		
Non-medical	85%	66% (83% in 2010/11)
Medical & Dental Consultants	85%	50% (59% in 2010/11)
Medical & Dental (career grades)	85%	39% (37% in 2010/11)
Medical & Dental – consultants and career grades (excluding junior doctors)	85%	47% (52% in 2010/11)
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.		

4: Statements from primary care trusts, Local Involvement Networks 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

The Clinical Commissioning Group have reviewed the final draft of the Quality Account for Warrington & Halton Hospitals NHS Foundation Trust and are pleased to report that there is strong evidence to support that the acute provider has worked successfully to improve the delivery of care.

The CCG congratulates the hospital on their current direction of travel and recognises the many improvements that the organisation has implemented to ensure that health care provision remains of a high standard for our local population. The response covers three main areas:

Patient Safety
There is no doubt that the safety of patient care delivery is paramount and this is indeed obviously a high priority for the trust. This is clearly illustrated in the organisations successful reduction of 49% in the number of grade 3/4 hospital acquired pressure ulcers. This is a testament of the organisation's intent to improve their systems and processes for the identification and treatment of patients with pressure ulcers.

We believe that further evidence of the trusts commitment to patient safety and care can be found in their successful report from the CQC who visited the organisation and were impressed by the standards and care around dignity and nutrition for elderly patients, and the way this was delivered.

The CCG noted that while a number of targets were successfully achieved;

- rates of hospital acquired Clostridium difficile fallen by 42%
- a reduction in the number of falls that have resulted in major or catastrophic harm of 67%
  The CCG share your disappointment that the rates for MRSA – blood stream infections remain unchanged for a second year.

The CCG welcomes the production of two significant documents by the trust which will help to guide the organisation to retain its strong focus on future priorities to ensure that their values for patient safety and involvement remain at the heart of future health care delivery.

Areas for consideration
The CCG would have like to have seen more evidence in the account of patient/public involvement. However, we have assurance that this remains one of the organisation 'priorities for improvement' along with commissioner priorities, achievement of quality improvement and patient safety strategy.

The quality account identifies some disappointing performance around staff training and the appraisal process. The CCG are concerned regarding the attendance of staff at manual handling and fire safety updates. Regarding the appraisal process, the CCG are anxious that the appraisal system is not being fully utilised to identify future training for all grades of staff and offering staff the opportunity to access appropriate training to improve their knowledge and skills for care delivery to reach the highest standards for local health care delivery.

Meeting the needs of the local population
The CCG welcomes the inclusion of safe and effective patient discharge as part of the organisations priorities for improvement. The seamless transition of patient care delivery being effectively communicated to fellow

health colleagues and care organisations is an integral part of the discharge process, and will improve patient satisfaction and help to reduce delays in the discharge process.

We have assurance through the account that you already have plans in place to address a number of areas which you have already acknowledged through the National Survey 2011 results. Improvements around patient decision-making, privacy, improved pharmacy information and contact details on discharge will help to improve the patient journey are being monitored throughout the year in an effort to improve the safety and effectiveness of patient discharge.

The CCG welcomes the inclusion of the Governors inspections of wards and departments in the account which again highlights the trust's commitment to improving the patients experience and offered the governors an ideal opportunity to see patient care at the interface of delivery.

Conclusion
The consortium believes that the quality account is clear and concise and addresses the areas where improvements can be made. The report is informative and offers a balanced picture of the trust's performance over the reporting period.

4.2 Statement from Halton Clinical Commissioning Group

Comments requested but no responses have been received.

4.3 Statement from Warrington LINk

The Warrington LINk welcomes the opportunity to be able to comment on the Trust's Quality Account.

Warrington LINk and the Trust have a good relationship with LINk members involved in various meetings within the Trust and a LINk member being a Public Governor at the Trust representing the LINk. The LINk agrees with the Trust's main improvement priorities for 2012/13.

The LINk welcomes that improvements will be made to discharge from the hospital, with the LINk, OSC and OPEG, the Older Persons Engagement Group, having previously been involved in work around discharge. The LINk recognises that improvements have been made, with the production of A discharge pack and a "What to look out for" discharge checklist but the process can still be improved upon.

Infection Control
The LINk recognises new techniques have been introduced by the Trust to reduce the number of MRSA and Clostridium difficile cases, and will be reviewing the number of cases throughout the coming year.

Patient Experience
The LINk welcomes the priority to eliminate mixed sex accommodation, no issues have been raised with the LINk regarding this issue.

The effective process of feeding in comments and issues raised by the LINk continues with the Trust. Monthly comments and issues are shared and within 20 days a response, with actions and outcomes. Over the last 12 months 20 issues have been raised by individuals and carers, and comments raised through LINk events. Through the LINks Care Navigation Role a further 7 issues have been raised and dealt with. The majority of issues can be categorised as: communication issues, cleanliness, length of waiting times, and attitudes of staff.

Over the past year the LINk has continued to undertake Enter and View visits, 4 visits have taken place including 2 PEAT Visits. Reports have been shared with the Trust and improvements have been actioned.

At the Productive Ward celebration day a LINk member gave feedback on the productive ward congratulating the wards on their openness by displaying the results of monthly audits of areas of basic care. The LINk welcomes the reduction in the number of pressure ulcers and falls. The productive ward gives the visitor and patient the feeling the wards are well run and efficient.

Privacy and Dignity
The Warrington Link have played a part in ensuring bathing facilities are fit for purpose and privacy and dignity are maintained.

Improvements have taken place but there are some areas that need upgrading. The LINk will continue to monitor and identify where facilities are not adequate.

Safety
The LINk believes that safety is paramount. The LINk will continue to monitor staffing levels in areas where there are highly dependent patients. Where staffing levels drop below acceptable levels the LINk will monitor the Trust policy on providing staff to these areas, ensuring safety is not compromised

Other priorities for the LINk over the past year have been the Vascular Service Review, with the LINk promoting the consultation and producing a statement for the OSC. Also continued work on the A&E Liaison Service Team, this will remain a priority in 2012 – 13.

4.4 Statement from the Halton LINk

Halton LINk thanks the Trust for the opportunity to comment on the Quality Account for the year 2011-12.

Members were pleased to have been given the opportunity to contribute at a presentation given by the Director of Nursing. He told members where improvements had been made in last year's targets and how the Trust was putting in plans for improving areas where needed.

It is appreciated that considerable improvements have been made in patient experience, including privacy and dignity, with the elimination of mixed sex accommodation; hospital infections and reduction in falls. This has been noted in hospital visits, including PEAT inspections and through monitoring statistics presented at various committees attended by LINk representatives. Areas still of concern are: safe integrated discharge procedures, parking and food, though it is recognised that the Trust is taking measures to improve these areas where they can.

However, it is disappointing that our concerns raised last year, on targets for training and appraisal rates for staff, have not been achieved, as only one out of seven targets was met."

Through having a LINk representative on the Governors' Council and other committees such as Governors Quality Committee; Compliance with Authorisation Committee; Governors' Council Staff & Patient Care Committee and Patients Experience Group, we have been able to keep the LINk Board constantly informed on quality issues within the Trust.

Members welcomed the Trust's list of priorities for the coming year, particularly the implementation of a safe discharge from hospital and the development of a strategy for a full pathway of care for patients with long-term conditions and for frail elderly patients, especially those with dementia.

We also appreciated the improved format of the accounts, noting that a number of the suggestions we put forward last year had been implemented. This Account is clear and the data is now easy to understand. Members were pleased to see that the statistics identify the previous year's targets and to what extent the Trust has or has not achieved them.

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

Comments requested but no responses have been received.

4.6 Statement from the Halton Health Policy Performance Board

(Provided by Cllr Ellen Cargill, Chair, Health Policy and Performance Board)

Thank you for the opportunity to comment on your Quality Account.

The Health Policy and Performance Board particularly note the following achievements against targets set, as follows:

(1) In 2011/12 the Trust's goal was to have no more than 4 cases of MRSA bloodstream infections and 54 cases of Clostridium difficile acquired within the hospital – The Trust has 5 cases of MRSA bloodstream infections and 38 cases of Clostridium difficile acquired within the hospital in the year. Goal was partially achieved.

(2) In 2011/12 the Trust's goal was to have no more than 29 cases of grade 3 & 4 hospital acquired pressure ulcers (a 30% reduction) – The Trust had 21 cases of hospital acquired pressure ulcers grade 3 & 4 – a reduction of 49%. The Trust achieved its goal.

(3) In 2011/12 the Trust's goal was to have no more than 50 incidents of a fall (a 10% reduction), in hospital, which caused moderate to catastrophic harm – The Trust has had 41 such falls (an overall 25% reduction – which includes a 67% reduction in major and catastrophic harm) and have achieved this goal.

The Board notes that during the period 1st April 2011 to 31st March 2012 there has been a slight increase on the number of complaints, 505 formal complaints, compared to 491 formal complaints received in 2010/11. The main themes of complaints received were as follows:

- Care
- Treatment
- Attitude
- Diagnosis
- Waiting times
- Other – e.g. food, heating, car parking, hospital signage, quality of seating areas

The Board also notes that there has been a slight increase in contacts made to the Patient Advice & Liaison Service (PALS), which is an informal but valuable way of gaining patient feedback. From 1st April 2011 to 31st March 2012, 1301 people contacted PALS compared to 1225 in 2010/11. The main issues raised by members of the public with PALS that has caused there to be an increase this year, were requests for information, questions/dissatisfaction with waiting times and issues relating to treatments (either dissatisfaction or questions as to how treatments could be accessed).

It is noted from the information received, that the Trust has done significant work over the last 12 months to achieve good performance against a series of indicators including infection control and falls. From results received from the National Survey 2011, the Board note that the Trust has also been able to identify key areas to be addressed in the forthcoming year, which are:

- Involving patients in decisions about their care and treatment
- Availability of hospital staff to talk about worries and fears
- Provision of privacy when discussing condition/treatment
- Information about medical side effects to watch or when the patient went home
- Contact details if the patient is worried about their condition or treatment after they have left hospital

The Trust has identified that these areas require immediate improvement and therefore a programme of improvements has been implemented. The Health Policy and Performance Board welcomes this programme of improvements and the benefits these will bring to the overall experience a patient has when in hospital.

4.7 Statement from the trust's Governors' Council

Governors comment on the Quality Accounts on behalf of members of the trust as well as patients and the public. They have scrutinised the final Quality Accounts for 2011-2012 and are pleased to say that they find them very encouraging.

The Quality Accounts tell a good story of achievement and success in developments and are honest in acknowledging where improvements are needed. Governors believe that the accounts provide assurance that the trust is constantly striving towards establishing excellence in all it does. Governors were pleased to be

involved with the Trust throughout the year in reviewing the Quality data and seeing the way the trust has responded to positive as well as negative trends. In their role of holding the Board of Directors to account on behalf of members of the Trust, the Governors have been diligent to see that patients' safety has been paramount and the quality of service provision has been constantly improved and they have worked with the trust to maintain standards. As last year, comments are based around four main questions, which it is believed members would like answered.

Do the priorities reflect those of the local population?
Governors believe this is so. The emphasis on patient safety, which is very important to local people and mentioned in the Chief Executive's statement, confirms that this aspect is at the heart of all decisions. The Trust Chairman has been attending a national pilot patient safety ambassadors' course and is keen to put this into practice. The results of members' surveys indicate the same priorities as are outlined in section 2 and each topic in section 3, shows that there are plans in place to address every issue. It is pleasing that C.Diff. infections, pressure ulcers, falls and safer surgery statistics have improved, although there are areas which need improvement, such as planning for seamless discharge. Governors are glad that these areas are clearly outlined and are disappointed that the training and appraisal statistics for staff are still poor. Governors have worked with the Trust to establish a Cares Strategy, which will help in improving the patients' pathway experience. They have contributed to the patient strategy and the volunteer strategy and look forward to the development of a strategy to deal with older vulnerable patients.

Are there any important issues missed in the Quality Accounts?
Governors feel, as last year, that the quality accounts are comprehensive, but suggest that some further attention could be paid to the known aspirations of patients and the development of interaction with members, patients and the public. In particular, the trust needs to ensure that by working with partners, facilities are in place for safe and smooth discharge, into community settings. It would be helpful if more detail about successful discharge was included. Information regarding family and carers' contribution to patient planned pathway of care could be usefully recorded, where appropriate, as would information about the contribution of volunteers. Governors appreciate the support they have received from the Director of Nursing and the Membership Office staff and it may be considered helpful to record in some way how Governor involvement has contributed to the quality of provision within the Trust

Has the Trust demonstrated that it has involved patients and the public in the production of the Quality Accounts?
This has been developed during the year. Governors, which include elected public and staff governors and appointed partner governors, including representatives from LINks in Warrington and Halton, through their Quality Committee, have been regularly involved in discussing Quality information and identifying areas of under achievement and, where appropriate, suggesting ways to improve. In particular, they have developed, with the Director of Nursing, a system of unannounced structured visits to wards, as reported by the Chief Executive and described in detail in the appendix. These have been well received and proved useful in understanding and contributing information to the Quality Accounts. Governors have suggested, on behalf of their members, improvements to the format and text, as well as areas where more detailed information could be included. Patient surveys and collection of patient views from wards has been a regular feature used in the compilation of accounts. Also the complaints and PALs information has been carefully analysed

Is the Quality Account clearly presented for patients and the public?
Governors believe the format and section headings, where each topic shows last year's position, what targets were set, to what extent they have been achieved and what plans there are for improvement, is clear and understandable. The definition of acronyms is useful, as is the arrangement of the appendices separated from the main text. Governors think that the Quality Accounts are well presented and easy to read and hope that patients and the public find them interesting and helpful.

4.7.1 Report on Governor inspections of wards and departments
(Provided by Janet Walker, Lead Governor)

We have carried out four ward inspections so far. Each one was unannounced and only the leader of the team knew of the destination before the day. The inspections cover approximately three hours, beginning just before lunch and ending after the medication round. Members of the team were stationed in designated areas with an observations sheet and the staff requested to carry on as normal.

Having regard for the fact that many of the reports which have made news headlines have been in relation to the care of elderly patients, and their nutrition and hydration, our visits so far, have concentrated on the wards where elderly patients are nursed. The team arrive at the wards in time to see preparation of patients and the ward before a meal, serving of the meal, with special attention to placement, assistance and substitution if requested, and clearing of the meal and attention to patients' toilet and cleansing needs. The team particularly noted the care with which infirm patients were assisted with their meals. All patients were asked if they were satisfied with the meal and if they had enough to eat.

Attention was paid to water jugs, their placement and topping-up where necessary, and provision of beakers and assistance with drinking.

The inspection also included privacy and dignity aspects in the way curtains were drawn and patients covered when being moved and voices kept discreetly low wherever possible, also correct addressing of patients. A complaint about a patient who was not covered adequately whilst being transferred was relayed to the Matron.

The medication round was observed to ascertain that medication was administered correctly and that staff observed the patient taking the medication, or assisted them if need be. Patients were asked if they were consulted, wherever possible, about their treatment and any changes. With the exception of one patient, they all confirmed they were and that they understood. That patient had several complaints, all of which had been was dealt with by the Ward Manager, to his satisfaction, before our arrival.

Cleanliness and hygiene were noted and storerooms and bathrooms checked for these aspects and for general tidiness of the ward. Comments were made if areas could have been cleaner or hand hygiene or correct clinical dress not adhered to.

Governors had specifically asked that the incidence of falls should be given special attention and their numbers reduced. There are now large red notices over the beds of patients to whom special attention should be given in relation to these, and even whole bays designated for patients at risk of falling, with more staff attention given to these areas. As a result we have seen a 67% reduction in falls which have resulted in major and catastrophic harm.

Staff were also requested to try to keep noise levels low, especially at night. Patients were asked to comment on noise levels and these comments, where critical, passed on to management.

There was a very high level of satisfaction from patients, relating to the standard of care and dedication of staff. This included the ones with some complaint, as the complaints related to one or two incidents or members of staff, which were dealt with promptly.

The team was very impressed with the level of caring and dedication of the staff, and particular comment was made of these aspects (the care and dedication of staff) in relation to dementia patients. The cleanliness of the wards was also commented on by the governors.

Some of the long-term patients reported they didn't want to go home.

5: 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 2010 as amended 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 2011-12;
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2011 to June 2012
    - Papers relating to Quality reported to the Board over the period April 2011 to June 2012
    - Feedback from the commissioners dated 14th May 2012
    - Feedback from governors dated – 16th May 2012
    - Feedback from Halton LINk dated 18th May 2012.
    - Feedback from Warrington LINk dated 11th May 2012
    - Feedback from Halton Health Policy Performance Board dated 25th April 2012
    - Feedback from the Warrington Health and Well Being Overview and Scrutiny Committee dated – **nil received.**
    - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated April 2012 (CLIPS Report);
    - The latest national patient survey (2011)
    - The latest national staff survey (2011)
    - The Head of Internal Audit's annual opinion over the trust's control environment dated April 2012
    - CQC quality and risk profiles dated September 2011 – April 2012

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

- The Quality Report presents a balanced picture of the trust's performance over the period covered;
- The performance information reported in the Quality Report is reliable and accurate;
- The 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, confirms 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 Report regulations) (published at:

www.monitornhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the Board

Allan Massey
Chairman

Mel Pickup
Chief Executive

29th May 2012

6: Independent Auditor's Limited Assurance Report

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

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

Scope and subject matter

The indicators in the Quality Report that have been subject to limited assurance consist of the national priority indicators as mandated by Monitor.

- MRSA; and
- Annual outturn in relation to Maximum 62 day waiting time from urgent GP referral to first treatment for all cancers.
  We refer to these national priority indicators collectively as the 'specified indicators'.

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 assessment criteria referred to in Section 5 of the Quality Report (the 'criteria'). The Directors are also responsible for their assertion and the conformity of their Criteria with the assessment criteria set out in the NHS Foundation Trust Annual Reporting Manual ('FT ARM') issued by the Independent Regulator of NHS Foundation Trusts ('Monitor'). In particular, the Directors are responsible for the declarations they have made in their Statement of Directors' Responsibilities.

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;
- The Quality Report is materially inconsistent with the sources specified below; and
- The specified indicators have not been prepared in all material respects in accordance with the criteria.

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:

- Board minutes for the period April 2011 to April 2012;
- Papers relating to Quality reported to the Board over the period April 2011 to April 20012;
- Feedback from the Commissioners dated 14/05/2012;
- Feedback from LINKS dated 18/05/2012 and 11/05/2012;

- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 2011/12.
- The 2011 national patient survey.
- The 2011 national staff survey.
- Care Quality Commission quality and risk profiles dated 02/04/2012; and
- The Head of Internal Audit's annual opinion over the trust's control environment dated March 2012.

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 Governors' Council of Warrington and Halton Hospitals NHS Foundation Trust as a body, to assist the Governors' Council in reporting Warrington and 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 2012, to enable the Governors' Council 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 Governors' Council as a body and Warrington and 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:

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators.
- Making enquiries of management.
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation.
- Comparing the content requirements of the FT ARM to the categories reported in the Quality Report.
- Reading the 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 by 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 Directors' interpretation of the Criteria in section 5 of the Quality Report.

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/organisations/entities.

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 and 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,

- 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;
- The Quality Report is materially inconsistent with the sources specified about and
- The specified indicators have not been prepared in all material respects in accordance with the criteria.

PriceWaterhouseCoopers LLP
Chartered Accountants
101 Barbirolli Square
Lower Moseley Street
Manchester M2 3PW

30 May 2012

7. Appendix

7.1 Appendix 1

The national clinical audits and national confidential enquiries that Warrington and Halton Hospitals NHS Foundation Trust was eligible to participate in during 2011/12

National Clinical Audits	Participation	% Submitted
Perinatal mortality (MBRRACE-UK)	No	n/a
Paediatric pneumonia (British Thoracic Society)	No	n/a
Paediatric asthma (British Thoracic Society)	No	n/a
Emergency use of oxygen (British Thoracic Society)	No	n/a
Pleural procedures (British Thoracic Society)	No	n/a
Chronic pain (National Pain Audit)	No	n/a
Adult Asthma (British Thoracic Society)	No	n/a
Bronchiectasis (British Thoracic Society)	No	n/a
Hip, knee and ankle replacements (National Joint Registry)	No	n/a
Elective surgery (National PROMs Programme)	No	n/a
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	No	n/a
Carotid interventions (Carotid Intervention Audit)	No	n/a
Carotid arrhythmia (Carotid Intervention Audit)	No	n/a
Oesophago-gastric cancer (National O-G Cancer Audit)	No	n/a
Risk Factors (national Health Promotion in Hospitals Audit)	No	n/a
Spinal Injections	Yes	100%
GTT Audit	Yes	100%
Temporal Arteritis - GP referral and biopsy	Yes	100%
Perioperative Temperature Control After the Introduction of Inditherm Mattresses in Patients Undergoing Major Surgery	Yes	100%
Children's Anaesthetic Experience survey - patient questionnaire	Yes	100%
ROLLS & WLCS	Yes	100%
CDU Audit	Yes	100%
MRCP findings, ERCP correlation	Yes	100%
Growth Hormone Replacement in Adults	Yes	100%
Management of Testicular Cancers	Yes	100%
Dislocated Shoulder	Yes	100%
Audit of Sedation Practice	Yes	100%

MRI correlation in rectal carcinoma after long course chemotherapy	Yes	100%
Cataract Surgery & Complications	Yes	100%
Outcome of Hip Referrals	Yes	100%
Re-Audit NICE Compliance with Anto TNF (Enbrel, Humira, Cimzia)	Yes	100%
Non-Invasive Ventilation 2011 Audit Results	Yes	100%
Ventilator Associated Pneumonia	Yes	100%
Management of CBD Stones	Yes	100%
Back to Action Audit	Yes	100%
Salivary Gland FNAs	Yes	100%
Paracetamol Poisoning	Yes	100%
Thromboprophylaxis in Atrial Fibrillation	Yes	100%
Review of AMD service	Yes	100%
Diabetes in Pregnancy	Yes	100%
COPD Admissions Audit and Prevalence of Cardiovascular Disorders	Yes	100%
2010 National Comparative Re-Audit of the Use of Platelets	Yes	100%
Inpatient Diabetic Foot Problems	Yes	100%
Venous Thromboembolism Prophylaxis in Critical Care patients	Yes	100%
Re-Audit of Frozen Section Reporting	Yes	100%
Pregnancy Screening in Elective patients	Yes	100%
The Use of Oxytocin for Induction and Augmentation of Labour	Yes	100%
DNAR Audit	Yes	100%
Fever in Children	Yes	100%
Physiotherapy & Fragility Fractures	Yes	100%
Pain in children	Yes	100%
Prostate biopsies referred to specialist	Yes	100%
Post Falls Assessment	Yes	100%
VTE Risk Assessment of Pregnant Women	Yes	100%
Stereotactic wire localisation performed by Radiographers	Yes	100%
Amniocentesis ROCG Guidelines	Yes	100%
Middle Ear Effusion	Yes	100%
COPD	Yes	100%
Renal Colic CEM Standards	Yes	100%
Re-Audit Diabetic Retinopathy Screening	Yes	100%

National Diabetes Inpatient Audit	Yes	100%
National Diabetes Audit	Yes	100%
Acute Medical Unit and preventable deaths in 48 hours of admission	Yes	100%
Caesarean Section	Yes	100%
Management of new-born with maternal GBS	Yes	100%
Intraoperative documentation and post op analgesia prescription	Yes	100%
Universal Definition of Myocardial infarction flowchart	Yes	100%
Infective Endocarditis Management	Yes	100%
MRI inpatients with lobular breast cancer	Yes	100%
Medical Prescribing Audit	Yes	100%
UK HIV Testing Guidelines in Patients Receiving Secondary Care & Diagnosed with Clinical Indicator Disease in non-GU setting	Yes	100%
National Sentinel Audit 2010 results	Yes	100%
Management of Women When a Foetal Abnormality is Detected	Yes	100%
National Neonatal Audit	Yes	100%
National Familial Hypercholesterolemia Audit	Yes	100%
ICNARC CBEMIX Programme	Yes	100%
KPI in Biochemistry	Yes	100%
Certolizumab pegol	Yes	100%
Incontinence in Elderly Women	Yes	100%
NICE Guidance on secondary prevention for Stroke	Yes	100%
'New-born Screening for Congenital Heart Disease - Comparison with NICE Standards	Yes	100%
Epilepsy 12 National Audit	Yes	100%
Acute Coronary Syndrome - The patient journey	Yes	100%
Basal Cell carcinoma of Skin Reporting, Compliance with the Minimal Datasets of the RCP Pathologists	Yes	100%
Spontaneous Pneumothorax	Yes	100%
Shoulder Dislocation	Yes	100%
Perineal Trauma	Yes	100%

National Confidential Enquiries	
Bariatric Surgery	100%
Cardiac Arrest Procedures	100%
Surgery in Children	100%
Peri-Operative Care	Did not participate

7.2 Appendix 2

Examples of actions taken to improve the quality of care following completion of national audits

Title of the audit	Actions to be taken to improve quality of care
Growth Hormone Replacement in Adults	• Attach an audit sheet to case notes. • Ensure Quality of Life (QoL) questionnaire is completed before initiation of treatment. • Review change in QoL after initiation of treatment. • Consider withholding treatment and assessing for change in QoL. • Re-audit in 1-2 years
Incontinence in Elderly Women	• Include basic continence assessment and management in foundation doctors teaching programme. • Link nurses study day – The first of these have already been held. • Re-audit in 6 months
Thromboprophylaxis in atrial fibrillation	• All patients with acute atrial fibrillation should have stroke and thromboembolic risk assessment carried out. • CHADS2 risk ratification tool should be used for initial assessment. • CHA2DS2-VASc should be used when the initial score is less than 2. • The benefits and risk of the therapy should be discussed with the patient. • All risk assessments should be documented in the patient's case file. • A risk assessment tool, incorporating all of the above should be available to assist in this process.
Diabetes in pregnancy	• Update the audit sheet to collect creatinine + ACR. • Use aspirin post week 12. • Reinstate the issue of early referrals and pre-conceptual care at GP and Practice Nurse meetings. • Midwifery staff diabetes update. • Cardiac scan by end of week 20 by anomaly scan being completed by medical obstetrician. • Ask if community pharmacists could do pre-conceptual medication review opportunistically.

7.3 Appendix 3

Examples of actions taken to improve the quality of care following completion of local audits

Speciality	Title of Audit	Actions to improve the quality of care
Children's Health	Outcome of Babies with Cleft Lip & Palate Born at Warrington Hospital	• Incorporate proper examination of palate in junior doctors' induction • Regular updates and teaching by cleft team • Re-audit in 3-4 years and compare data to look at trends, both statistics and management
Medical & Elderly Care	Direct Admissions to the Stroke Unit	• Further training to the nursing staff on the bed flow process • Audit Report to be sent to A&E and request support for all stroke patients to be sent to the stroke unit and reiterate that patients do not need to be referred to medics • A&E to send all TIA patients to the stroke unit • Maintain the current complement of 4 assessment beds • Audit Report to be sent to Patient Flow Team • Prospective audit of direct admission compliance (highlight issues of concern appropriately) • Monitor compliance of admission process through stroke database
Medical & Elderly Care	Management of Diabetic Ketoacidosis (DKA)	• Lecture DKA to medical juniors • New DKA guidelines posted on intranet • Diabetic Specialist Nurse team now allocated to specific wards • Encourage print out of DKA pathway and audit forms • On-going prospective audit – audit form on intranet • Intensive monitoring bay for DKA patients to be discussed at trust management group

Medical & Elderly Care	National Diabetes in Patients Audit	• Re-enforce the need for care in prescribing, checking and administering drugs used to treat diabetes, particularly insulin. • Act to prevent, and treat promptly any hypoglycaemia. • Education on the condition, treatment and the use of the 'Hypo boxes'.
Ophthalmology	One stop pre-operative assessment clinic	• Develop appointment slots for patients requiring pre-op assessment. • Investigate ways to prepare notes. • Re-audit in 12 months
Women's Health	Handover of Care	• All staff to be reminded to complete risk assessment for each delivered patient. • All Staff to be reminded to sign every entry in the health records. • Random checks of health records to assess compliance against protocol • All staff to be reminded to be aware of the accuracy of documentation. • All staff to be reminded of the security reasons for checking baby labels and to be aware of their documentation of same.

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