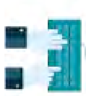
Warrington and Halton Hospitals NHS
NHS Foundation Trust

Warrington and Halton Hospitals NHS Foundation Trust

Quality Account

2014-2015

Creating tomorrow's healthcare today



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Quality is our number one priority.

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

1. Statement of Quality from the Chief Executive

Mel Pickup, chief executive

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

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

We have also launched our new Quality Strategy which focuses on three core components: delivering a safe organisation; a clinically effective organisation; and an excellent quality of experience for our patients. The purpose of this strategy is to provide assurance that national and local clinical and quality requirements have been identified and processes and systems are in place to implement and monitor quality within the trust.

The Forget Me Not ward opened at the hospital at the end of May 2014 and the feedback has been excellent from patients, visitors and staff alike. The ward features a number of innovative design features including its own mock bus stop, lounge area with traditional looking fireplace, quiet room with a 1960s style TV and a special dementia garden area.

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

Throughout 2014/2015 we have made good progress; progress which has largely been achieved as a result of the hard work, commitment and dedication of every single member of staff. We have continued to see and treat an increasing number of patients with more complex needs on both an elective and non-elective basis. However as more people attend, more people are required to care for them. This in turn has created significant financial and operational pressure for the trust and thus impacted upon our ability to deliver the full £11.9m savings plan.

Throughout 2014/2015 we have made good progress and have had **a relentless focus on improvement.**

The trust has been in contact with Monitor – the regulator for Foundation Trusts – on a regular basis to ensure that they are fully aware of the increasing challenges and levels of risk faced by us. The trust has reforecast its financial plan, and we have informed Monitor of a revised forecast of a potential full year deficit of £5.88m. The trust welcomes the announcement that Monitor has opened an investigation to look into our financial position after declaring a larger than expected deficit plan for the current financial year. Monitor released figures in quarter three last year that showed that 31 of the 38 trusts across the country of comparable size to this trust are in deficit this financial year. The regulator's investigation will seek to understand why our finances have changed and the plan to improve them. It will also examine how we are working with other local NHS bodies to address the problems.

Clearly, 2014-2015 has been a challenging year for the trust but we have worked hard to ensure that the patients we support get the right care, when they need it, at the right time on the most suitable site. Reducing the incidence of pressure ulcers continued as an improvement priority for 2014/2015

and the trust achieved all stated measures and is pleased to report a 41% reduction in grade 2 pressure ulcers and a slight reduction in grade 3 pressure ulcers from 6 cases in 2013/14 to 5 cases in 2014/15 with zero incidence of grade 4 pressure ulcers. Our intention is to eradicate the incidence of pressure ulcers so the trust will continue to monitor this important area of care as a quality indicator for 2015/2016.

During 2014/2015 the trust also identified pressure ulcers as a Sign up to Safety goal. Sign up to Safety aims to deliver harm free care for every patient, every time, everywhere. It champions openness and honesty and supports everyone to improve the safety of patients. Sign up to Safety's three year objective is to reduce avoidable harm by 50% and save 6,000 lives across the NHS. The trust articulated an objective to achieve a 30% reduction in all grades of pressure ulcers by 2017. The trust is pleased to report that it has met this sign up to safety objective for pressure ulcers by the end of year one with a 39.83% reduction in all pressure ulcers.

We're pleased to report a **39.83% reduction in all forms of pressure ulcers** this year.

During 2014/2015 we also established an improvement priority to reduce a reduction for falls resulting in moderate - catastrophic harm by 10% which equates to <=13 falls. Whilst the trust is pleased to report a 3.8% reduction in all falls it is disappointed to report that we had 16 confirmed moderate to catastrophic falls during 2014/2015 (with a further 9 cases awaiting approval) and have thus failed to achieve the threshold. The report provides assurance that our continued efforts have reduced our falls per 1000 bed days over the last four years from 8.30 to 5.35 against a national average of 5.60. The trust will continue to monitor the management of falls as an improvement priority for 2015/2016.

Although within the reporting year the trust was unsuccessful in achieving all national targets from the operating framework, its failure in achieving the 95% Accident & Emergency access target (with the exception of June 2014) reflected a deteriorating national position. However, the trust is pleased to report that it has achieved its referral to treatment waiting time target and all quarterly cancer targets including the 62 day wait for first treatment and the 31 day wait from diagnosis to first treatment. With regards to health care acquired infections (HCAI) the trust is disappointed to report that despite the continued focus on managing processes to reduce HCAI during 2014/2015 we have been unable to achieve its threshold for MRSA and Clostridium difficile. By the end of the reporting year we had 31 cases of hospital acquired Clostridium Difficile against a threshold of 26 and 3 cases of hospital acquired MRSA against a threshold of zero, the trust is committed to reducing infections and this will remain a high priority for 2015/2016. The trust was identified as an outlier (higher than the average rate) for methicillin sensitive *Staphylococcus aureus (*MSSA) bacteraemia cases both nationally and in the northwest region during 2012/2013 and this position continued into the start of this financial year. Local surveillance identified that cases were occurring in a variety of clinical locations with a higher incidence in the adult Intensive Care Unit (ICU). Improvement actions were implemented and an overall decrease was noted in the number of trust apportioned cases being reported. We are pleased to report that this audit was presented to the 12th Annual Critical Care Symposium and resulted in the team receiving and award for the best poster presentation.

The Quality Report also provides progress in relation to both national and local Commissioning for Quality and Innovation CQUINs payment framework and I am pleased to report that the trust achieved all the national CQUINs. We have worked hard to implement Friends and Family and can report that in March 2015, 96% of inpatients (national average of 95%) based on a 40.5% response rate recommending the trust to friends and family. With regards to Accident and Emergency patients we achieved 22.1% response with 83% recommending the trust which was slightly lower than the national average of 87%. Our Quality Report also provides a detailed review of national and local clinical audits and we are pleased to report that the trust participated in 97% of national audit and 100% of national confidential enquiries that it was eligible to participate in.

The Care Quality Commission (CQC) inspected Warrington and Halton Hospitals NHS Foundation Trust from 27th – 29th January 2015. They looked at the quality and safety of the care we provide, based on the things that matter to people. They looked at whether our service is:

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

These key lines of enquiry were investigated using pre-visit information, the onsite inspection and local information about us – including seeking patient, staff and visitor views. The CQC will provide a rating by specialty; location and an overall rating for the trust from the inspection. . The trust is awaiting the publication of the CQC Report and will provide commentary on this in the Quality Report 2015/2016.

We have engaged throughout the year with our partner organisations to update them on the progress made toward achieving our improvement priorities throughout the year. Early in 2015 we invited our partners to attend an event to discuss the improvement priorities for 2015/16. We then engaged in a wider programme of consultation with staff, patients and the public.

Our quality improvement priorities for 2015/2016 will be:

- Priority 1 "Every patient has a voice" - Developing a Patient Experience Strategy
- Priority 2 Strengthening Mortality Review
- Priority 3 Improving quality of care at the End of Life
- Priority 4 Reduction of falls – to include 5% reduction in all falls and a threshold of <=13 moderate, major and catastrophic harm falls

The Quality Indicators for 2015/2016 will be:-

Patient Experience

- Essential ward transfers only
- Patient Experience Indicators
- Complaints
- Patient Survey (inpatient and children) Indicators

Safety

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

Clinical Effectiveness

- Dementia

- Advancing Quality
- SHMI HMSR

The improvement priorities and quality indicators will be monitored, and recorded via the Quality Dashboard which is reported to board on a monthly basis.

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

We have made encouraging progress in **improving the care and services that we deliver.**

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

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

Mel Pickup
Chief Executive
28th May 2015

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

Introduction

Warrington and Halton Hospitals NHS Foundation Trust provides services at Warrington Hospital, Halton General Hospital and the Cheshire and Merseyside Treatment Centre located in the North West of England. The majority of our emergency care and complex surgical care is based at Warrington Hospital whilst Halton General Hospital in Runcorn is a centre of excellence for routine surgery. The Cheshire and Merseyside Treatment Centre is home to our orthopaedic surgery and treatment services located on the Halton campus. Although each of our centres specialises in particular aspects of care, we provide outpatient clinics for all our specialties and diagnostic (scanning) services at both Warrington and Halton, and Bath Street Clinic so patients can access their initial appointments close to home wherever possible. We also provide some outpatient and other services in the local community.

Over the last 12 months, working with our governors and external stakeholders, we have defined the long term vision for the trust in a simple statement supported by a set of strategic objectives. Our vision is to be the most clinically and financially successful integrated healthcare provider in the mid-Mersey region. This demonstrates our plans to move from deficit to a balanced financial position whilst continuing to invest in services to continually improve quality and safety for patients.

In order to achieve our vision we believe we need to focus on the quality of our services, on the people who deliver them and on ensuring our organisation's sustainability. We call this our Quality People Sustainability (QPS) Framework which is the framework for everything that we do.

QUALITY

- We will reduce harm and focus on having no avoidable deaths by managing and reducing clinical and operational risks
- We will improve outcomes, based on evidence and deliver care in the right place, first time, every time
- We will focus on the patient and their experience, adopting 'no decision about me without me' as a way of life
- We will get the basics right so our patients will be warm, safe, clean, well fed and well cared for.

PEOPLE

- We will ensure that our teams are skilled, available in the right numbers to deliver our services and fit and well in work so that we improve their working lives
- We will communicate openly with our teams and expect the same from them in return. We expect staff to take accountability for their actions and will support them to do so
- We want to be an employer of choice and we encourage loyalty from our staff and recognise their discretionary efforts
- We will reward talent, supporting the development of leaders as role models within the organisation and invest in the education, training and development of our teams.

SUSTAINABILITY

- We will ensure we have effective leadership and provide robust assurance to our board of directors, ensuring compliance across all areas of regulation and develop and encourage our governors and members
- We will ensure we have robust contracts for services provided and develop service line management so that we understand how effectively we use our resources, invest in IM&T and look for opportunities to collaborate on services for reciprocal benefit
- We will be recognised as a good corporate citizen, market our services effectively and develop and diversify our business whilst also pursuing the collection of charitable funds.

We've called our five year strategy 'Creating Tomorrow's Healthcare Today' because that is what we are doing at Warrington and Halton Hospitals - creating a sustainable organisation for the future that will deliver what our local population needs from their NHS hospital services.

This strategy sets out our vision for the next five years for our hospitals. It describes the plans that we have to continue to deliver these and other improvements in line with the local and national picture and changes taking place in the wider NHS.

Over the last few years, we have successfully delivered significant changes to the way in which we provide services which has allowed us to both improve the quality of services to our patients and to ensure that we use the resources available to us as efficiently as possible. Our strategy outlines all of our commitments which are based on improving the patient experience and delivering high quality safe healthcare by developing sustainable, appropriate and high performing services. We intend to meet the challenges we face through the development and delivery of this strategy which encompasses several on-going work streams within the organisation. This includes a five year clinical services strategy, the implementation of a comprehensive programme of service redesign and through developing a variety of partnerships and networks both within the local health economy and also regionally and beyond.

At the end of 2013/2014 the trust reported that it completed the financial year with a £2.8m deficit we developed a two year plan and for 2014/2015, it targeted a £1.5m deficit requiring cost savings of £11.9m. Throughout this year we have made good progress; progress which has largely been achieved as a result of the hard work, commitment and dedication of every single member of staff.

Throughout 2014/2015 we have continued to see and treat an increasing number of patients with more complex needs on an elective and non-elective basis. This is significant because part of our original savings plan was to improve productivity as well as to better contain costs from spend on temporary clinical staffing. However as more people attend, more people are required to care for them. This in turn has created significant financial and operational pressure for the trust and thus impacted upon our ability to deliver the full £11.9m savings plan. The trust has been in contact with Monitor – the regulator for Foundation Trusts – on a regular basis to ensure that they are fully aware of the increasing challenges and levels of risk faced by us.

The trust has reforecast its financial plan, and we have informed Monitor of a revised forecast of a potential full year deficit of £5.88m. This reduced the trust's continuity of service rating (CoSRR) from a planned 3 to a 2. The trust has also indicated to Monitor that any further deterioration in the financial forecast could have a significant impact on our liquidity and planned 2014/15 year end cash balance.

The trust has welcomed the announcement that Monitor - the sector regulator of health care services - has opened an investigation to look into our financial position after declaring a larger than expected deficit plan for the current financial year. Monitor released figures last week that showed that 31 of the 38 trusts across the country of comparable size to this trust are in deficit this financial year.

The regulator's investigation will seek to understand why our finances have changed and the plan to improve them. It will also examine how we are working with other local NHS bodies to address the problems.

The Care Quality Commission (CQC) inspected Warrington and Halton Hospitals NHS Foundation Trust from 27th – 29th January 2015. They looked at the quality and safety of the care we provide, based on the things that matter to people. They looked at whether our service is:

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

These key lines of enquiry were investigated using pre-visit information, the onsite inspection and local information about us – including seeking patient, staff and visitor views. The CQC will produce a report which will include a rating by specialty; location and an overall rating for the trust from the inspection. The trust is awaiting the publication of the CQC Report and will provide commentary on this in the Quality Report 2015/2016.

Clearly 2014-2015 has been a challenging year for the trust but we have worked hard to ensure that the patients we support get the right care, when they need it at the right time on the most suitable site. Although within the reporting year the trust was unsuccessful in achieving all national targets from the operating framework and its failure in achieving the 95% Accident & Emergency access target (with the exception of June 2014) reflected a deteriorating national position. However the trust is pleased to report that it has achieved its referral to treatment waiting time target and all quarterly cancer targets including 62 day wait for first treatment and 31 day wait from diagnosis to first treatment. With regards to health care acquired infections the trust is disappointed to report that by the end of the reporting year we had 31 cases of hospital acquired Clostridium Difficile against a threshold of 26 and 3 cases of hospital acquired MRSA against a threshold of zero.

Improving Quality

Quality is the golden thread that must run through all of our services, business plans and objectives. As we aim to be the most clinically and financially successful healthcare provider in the mid-Mersey region by 2019 we must clearly articulate what this means for the trust and ensure that this is communicated to and developed in partnership with our staff, patients and key stakeholders.

During the reporting year we have also introduced our Quality Strategy which focuses on three core components: delivering a safe organisation; a clinically effective organisation; and an excellent quality of experience for our patients. The purpose of this strategy is to provide assurance that national and local clinical and quality requirements have been identified and processes and systems are in place to implement and monitor quality within the trust. We recognise that what happened in another organisation was not only a system failure (in part relating to roles of different external organisations and agencies), but that it was a failure of the organisation itself to listen and learn from incidents, near misses, complaints, and concerns raised by both patients and staff. This strategy supports our goal of continually learning; improving the quality and safety of care provision as well as improving the patients' experience of that care. We will do it by:

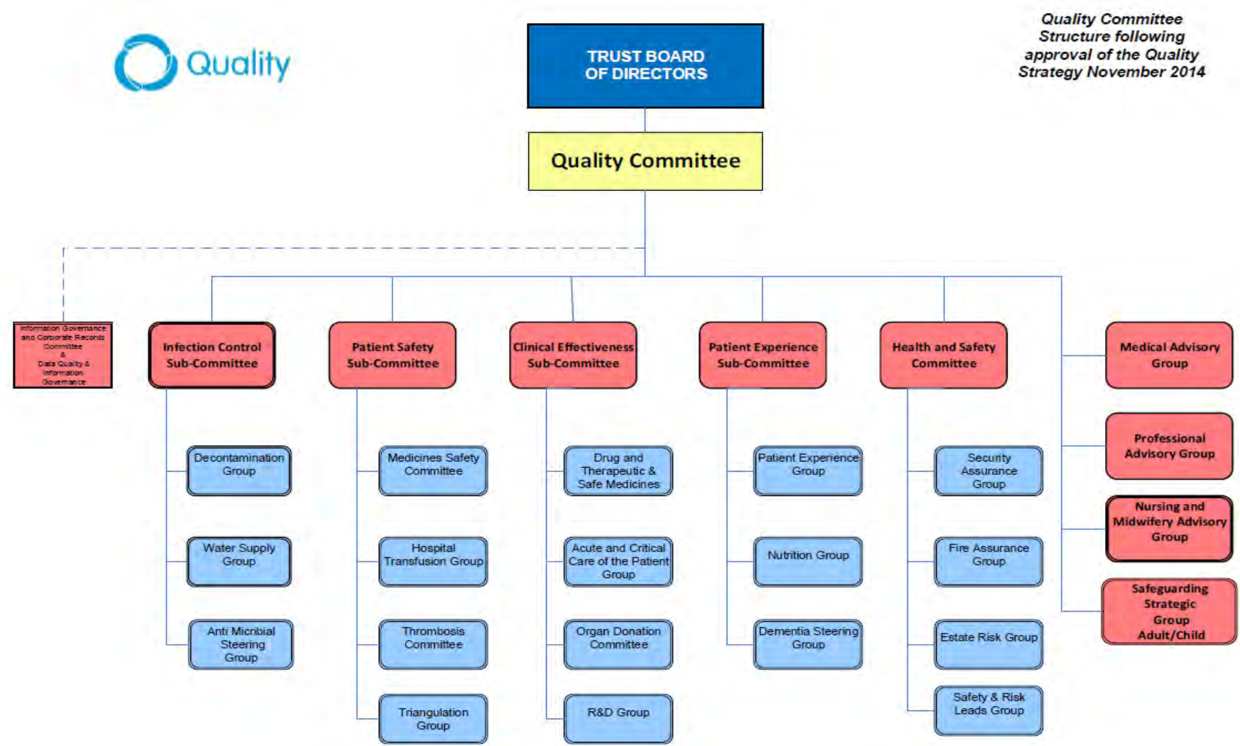
- Obtaining assurance that the trust is well managed and compliant with regulatory requirements including compliance with the Care Quality Commission standards and with Monitors Quality Governance Framework

- Making quality and quality improvement a core responsibility for and owned by all staff and ensuring that they are supported to fulfil this role
- Continuous improvement of patients' experience, safety and outcomes
- Reducing the risk from clinical errors and adverse events, as well as being committed to learning from mistakes and importantly sharing the learning across the trust
- Ensuring that patients receive the right treatment, at the right time, in the right place, have their individual needs taken into account and be treated/cared for in a safe environment taking into account best practice
- Implementing quality standards and pathways - responding to the needs of patients and users as individuals and using best practice and evidence based care to deliver a personal service. For example, supporting people who are at the end of their life to die where they wish and ensuring when patients with dementia are cared for in our hospitals we provide an environment that reflects their specific care and well-being needs
- Supporting staff in their training and development, through appraisal, revalidation, and personal development plans, to ensure they are equipped to deliver high quality health care
- Meeting all the requirements of both national and local CQuINs
- Ensure participation in national and local clinical audit which is now a statutory and contractual requirement for healthcare providers
- Ensuring a patient centred and patient led approach to care that includes treating patients courteously, involving them in decisions about their care and embracing the principle of shared decision making. (Liberating the NHS: No decision about me without me – DoH 2010).

Quality has three main elements: patient safety, clinical effectiveness and patient experience (Darzi Report, High Quality Care for All: June 2008). High quality organisations are safe, effective, person centred, timely, efficient and equitable. The trust has restructured the committees in line with this approach to ensure that we provide an equal balance and assurance on all aspects of quality within the organisation and that we can measure and improve quality at all levels and throughout all areas of the trust.

Quality is only achieved if all three of these domains are present and delivering on just one or two in isolation is not enough. The three committees (and other feeder committees) will manage the "quality" function of our QPS Framework through to the Quality Committee. This Committee is accountable to the Board for the development and implementation of the Quality Strategy and for promoting and assuring quality so that patients have effective and safe care with a positive experience of services delivered by the trust.

Quality Committee Structure



Ultimately, it is the Board of Directors who, are responsible for overseeing the quality of care being delivered across all services and assuring itself that quality and good health outcomes are being achieved throughout the organisation. Effective governance requires that the board pays equal attention to quality of care as they do to the management of finances and that our processes support the provision of intelligent information to facilitate this.

2.1 Improvement Priorities

2.1.1 Improvement Priorities for 2014-2015

All of the following improvement priorities and quality indicators were identified following a review of the domains of quality and our commitment to achieving them was reported in the 2013/2014 Quality Report.

We consulted with patients, governors, commissioners, LINks, Healthwatch and other external agencies in order to inform the board when determining our priorities for 2014/2015.

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

The trust is committed to embracing improvement across a wide range of quality issues to achieve excellence in all areas of care. The following section includes a report on progress with our improvement priorities for 2014/2015 which were:

- Complaints
- Falls
- In-patient Survey
- Pressure Ulcer Reduction
- Advancing Quality (AQ) measures – Stroke and Pneumonia.

2.1.1.1 Priority 1 - Complaints

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

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

Timeframe: March 2015

Progress 2014/2015 -

We reported in last year's Quality Report that 2013/14 was a very challenging time in terms of complaints handling in the trust. A combination of staff attrition and system problems in the central complaints handling team and capacity and workload pressures, particularly in the Unscheduled and Scheduled Care Divisions left the trust with a considerable backlog of late complaints and did not provide complainants with a service that was fit for purpose.

We are pleased to report that we have both restructured the patient experience team and improved systems to ensure that complainants receive a timely meaningful response and importantly if there is a delay in constructing the response we ensure that complainants are informed of the issues.

We believe there is still room for more improvement however we recognise the hard work and effort of many of our staff across all the divisions, the Patient Experience Team, Corporate Nursing Team and at executive level to improve the handling of complaints.

In order to meet the expectations of the board, the commissioners and, most importantly, the public we are committed to improving the systems in place and ensuring that the methods we employ to investigate and learn from complaints provide assurance and demonstrate a transparent and committed process from a trust that endeavours to acknowledge failures and learn from them.

The complaints process is an important source of data and feedback for the trust in its plan to improve the patient experience. During 2014/2015 we built upon the progress made during 2013/14. The Patient Experience Team has continued to provide support to divisional staff when dealing with complaints and there are regular divisional meetings with key members of staff to discuss the progress and handling of complaints, importantly we have strengthened the learning and assurance aspects of complaints during 2014/2015.

The trust deals with complaints and concerns from patients and users, their family and carers, in accordance with local complaints policies and procedures and the CQC Essential Standards of Quality and Safety. All complaints which are recorded on Datix are reviewed by the Deputy Director of Nursing and or the Director of Nursing prior to response letters being sent to the complainant from the Chief Executive Officer or Deputy Chief Executive Officer. This provides an additional level of

assurance to ensure that responses are well crafted and answer the questions asked, as well as ensuring that the Director of Nursing and OD has an in-depth knowledge of practice issues, patient experience and planned improvements.

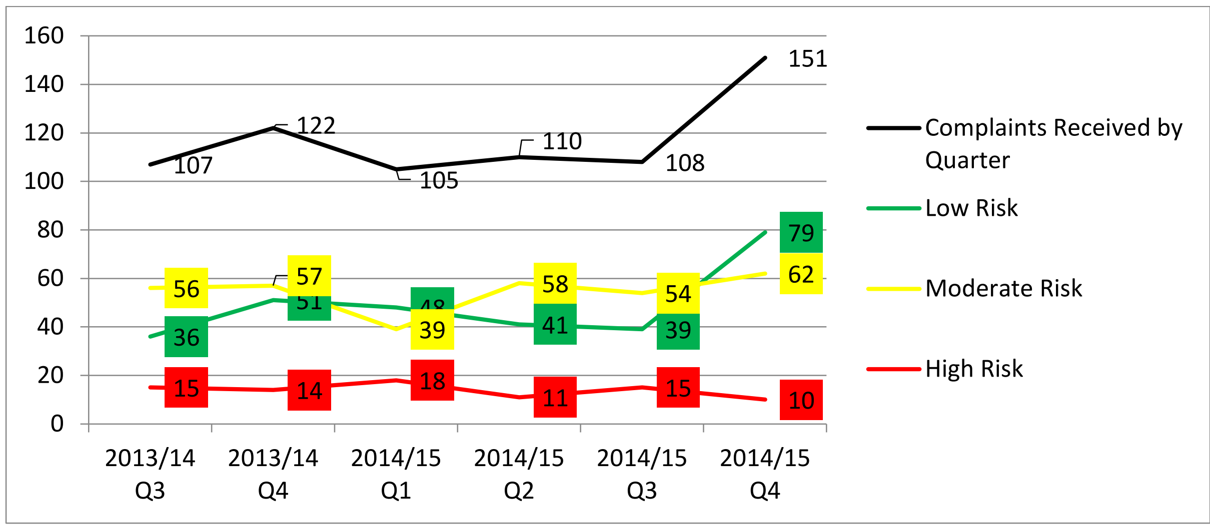
The quality contract determines that 94% of complaints should be resolved within the agreed timescale and until April 2013 the percentage of complaints closed in time was under 50%. By the end of 2013/2014 the trust did achieve the threshold however we felt that this was an important factor in relation to the patient experience both in terms of responding quickly to patients and using the information to change practice so we selected this as an improvement priority.

We are pleased to report that we have throughout 2014/2015 achieved the >=94% threshold as follows:

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

The following graph provides data on the number of formal complaints received during 2013/2014 quarter 3 to 2014/2015 quarter 4 importantly we have a more robust methodology for recording contact with complainants and in addition to formal complaints we can report that in addition to the complaints we recorded 96 concerns for 2014/2015 compared to 93 for 2013/2014. Total formal complaints handled in 2012/2013 - 571; 2013/2014 - 422 and this financial year there was an increase to 474 formal complaints.

The graph below also provides an analysis of complaints and if they were classified as a low, medium or high risk complaint.



Formal Complaints / Risk Assessed Q3 2013/14 – Q4 2014/15

The improvement priority also included our commitment to providing detailed reports on themes and lessons learned as a result of complaints. During 2014/15 we launched our new quarterly board report, beginning in July 2014. This commitment was intended as a response to Mr Francis' recommendation that the board are assured that we have listened to, heard about and learned from the things our complainants tell us. It also includes an analysis of the quality of complaint responses, standards and performance against targets.

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

We recognised that there needed to be improvement in the consistency and quality of action planning and also in providing assurance that learning and improvement has happened. We have introduced more training for staff and support for the divisional teams to ensure those investigating complaints can meet the required standards is required. The divisions are also committed to ensuring that the progress and completion of action plans are updated and monitored on the CIRIS system.

A detailed analysis of work and performance monitoring of complaints and patient experience indicators can be found at section 3.

The trust will continue to monitor complaints as a quality indicator for 2015/2016.

2.1.1.2 Priority 2 Reduction in Falls

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

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

Progress 2014/2015

With 30% of people over 65 and 50% of over 80 falling at least once a year according to the National Institute of Clinical Excellence (NICE) falls are a common and serious problems for people aged 65 and over.

As well as the impact on the person who has fallen which can include pain, loss of confidence and in extreme cases mortality it also affects the wider family members and the carers of those who have fallen. According to NICE it is estimated that falls cost the NHS more than £2.3 billion per year.

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

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

NICE Clinical Guideline 161 (June 2013) also recommends that patients aged 65 and over should be considered for a multifactorial assessment for their risk of falling during their hospital stay. In our trust patients receive this falls risk assessment within 6 hours of admission and a care plan is implemented accordingly. Since its publication, compliance with these recommendations have been monitored across the organisation by the use of:-

- Department and Ward evaluation Scheme (DAWES)
- Care indicators
- Ward based audits.

The trust is currently working with partners locally to establish a system-wide working group to facilitate a multi-agency approach to understanding the falls issue across the local economy. Partners include Warrington Public Health, Warrington CCG, North West Ambulance Service (NWAS),

Community Falls & Rehabilitation Team, Care Home leads and other key professionals/organisations. There is a particular need to understand and join up data in relation to falls across the system in order to produce a clear strategy to reduce and ultimately prevent falls across the system.

During 2014/2015 the trust continued to implement its planned programme of actions to further reduce falls which includes:

- Review of the trust policy on Falls Prevention with particular reference to the process by which we investigate falls where moderate or above harm occurs
- Root cause analysis is conducted on all falls where moderate or above harm occurs
- Refresh the falls group and work closely with our partners to produce a system wide Falls Prevention Strategy
- Review all care plans and risk assessments
- Improvements in the categories of falls to better understand themes and trends
- Smarter use of data (time of day, location, days of week) to focus our falls prevention work
- Focus on small service improvement projects following trend and theme analysis
- Continue to hold falls link study days.

Serious Untoward Incidents - Reporting of fractures via the STEIS System

A recent CQC Inspection highlighted that we did not report falls that result in fractures via the STEIS System. Although the trust assured them that falls which result in a fracture are always subject to a comprehensive Level 1 investigation; which mirrors the Level 2 (Serious Untoward Incident) investigation procedures. This level of harm had not been STEIS reported previously following a directive from the then Strategic Health Authority and Primary Care Trust in 2011. However following discussions at the trust and after discussion with NHS England and the Clinical Commissioning Group the trust has implemented, the following actions:-

- Any patient fall resulting in a fracture will be automatically reported on STEIS (the exception being finger or toe as per RIDDOR notification)
- Our Incident Investigations Policy has been updated to reflect these changes
- Any fractures fitting the criteria for SUI will be investigated using the Level 2 investigation template
- A Safety Briefing outlining the change to practise has been sent to all staff.

During 2012/13 our threshold for falls was 18 falls that result in moderate to catastrophic harm, and by the year end we reported 16 moderate harm falls. Whilst the reduction of falls was not an identified improvement priority for 2013/2014 we remained focussed on improvements and calculated that the trust's new trajectory monitored via the quality dashboard should be based on a challenging 10% reduction thus establishing a threshold of <=14 for this period. We were disappointed when 15 falls occurred in this year and whist it is understood that not all falls are avoidable we have continued during this reporting year to actively explore ways in which we can reduce this number.

As stated earlier our improvement priority for 2014/2015 established a 10% reduction for falls resulting in moderate - catastrophic harm which equates to <=13 falls. Whilst the trust is pleased to report a 3.8% reduction in all falls it is disappointed to report that we had 16 confirmed moderate to

catastrophic falls during 2014/2015 (with a further 9 cases awaiting approval) and have thus failed to achieve the threshold.

The trust will continue to monitor the management of falls as an improvement priority for 2015/2016.

A detailed analysis of work and performance monitoring of falls can be found at section 3.

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

Reason for prioritising: Listening to patients' views is essential to providing a patient-centred health service. The NHS in patient survey provides the trust with intelligence around the overall patient experience and it is vital that we review and act upon this information to address poor performance.

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

Timeframe: March 2015

Progress 2014/2015

The CQC use national surveys to find out about the experience of service users receiving care and treatment from healthcare organisations and mental healthcare providers. The 2013 Inpatient Survey was undertaken between September 2013 and January 2014, a questionnaire was sent to 850 recent inpatients at each trust and responses were received from 374 (46%) patients at Warrington and Halton Hospitals NHS Foundation Trust. The survey results were published on the 8th April 2014.

Listening to patients' views is essential to providing a patient-centred health service. The NHS inpatient survey provides the trust with intelligence around the overall patient experience and it is vital that we review and act upon this information to address poor performance.

Overall the results have improved across all low performing measures when compared to the average results of similar trusts. The measures relating to the trust's responsiveness to the personal needs of its patients also improved from 66.7% to 69.4%.

The following table includes the measures where in 2013 we fell below the national average and have not demonstrated improvement in past two years. The actions for improvement are included underneath each measure.

The table includes the performance for 2014 and the trust is pleased to report that we have achieved this priority by showing improvement on all measures with the exception of "waiting a long time to get to a bed on a ward." Importantly the percentage of patients rating their experience as very good has increased from 26% to 30%.

National Inpatient Survey Question	2011 Results	2012 Results	2013 Results	2014 Results	Other trusts
Were you given enough privacy when being examined or treated in the A&E Department? DEFINITELY	**73%**	**67%**	**66%**	**73%**	**78%**
Action PLACE Assessments Patient Experience Tracker					
From the time you arrived at the hospital did you feel that you had to wait a long time to get to a bed on a ward? DEFINITELY	**20%**	**22%**	**18%**	**22%**	**14%**
Action					

DAWES					
Did you feel threatened during your stay in hospital by other patients or visitors? YES	**3%**	**2%**	**5%**	**4%**	**3%**
Action Identified as the gastro ward – is action plan in place? Violence and Aggression monitoring – Security Management Specialist					
How would you rate the hospital food? VERY GOOD / GOOD	**46%**	**41%**	**50%**	**57%**	**59%**
Action PLACE Assessments					
Were you offered a choice of food? ALWAYS	**70%**	**72%**	**72%**	**75%**	**81%**
Action PLACE Assessments Housekeepers					
In your opinion, were there enough nurses on duty to care for you in hospital? ALWAYS/NEARLY ALWAYS	**48%**	**52%**	**53%**	**54%**	**59%%**
Action Monthly staffing levels monitored and published Six monthly Staffing Update Report					
How much information about your condition or treatment was given to you? NOT ENOUGH	**24%**	**27%**	**23%**	**20%**	**20%**
Action Patient Experience Tracker					
Were you given enough privacy when discussing your condition or treatment? ALWAYS	**72%**	**70%**	**70%**	**73%**	**76%**
Action PLACE Assessments Transparency Questions					
Do you think the hospital staff did everything they could to help control your pain? DEFINITELY	**66%**	**66%**	**67%**	**72%**	**70%**
National Inpatient Survey Question	**2011 Results**	**2012 Results**	**2013 Results**	**2014 Results**	**Other trusts**
Action Always Events monitored via the DAWES					
Beforehand, were you told how you could expect to feel after you had the operation or procedure? COMPLETELY	**59%**	**55%**	**54%**	**63%**	**59%**
Action DAWES					
Delayed discharge due to waiting for doctor	**11%**	**13%**	**15%**	**11%**	**14%**
Action Perfect Week					
Did a member of staff tell you about any danger signals you should watch for after you went home? COMPLETELY	**43%**	**42%**	**45%**	**52%**	**43%**
Action Discharge follow up					
Did you receive copies of letters sent between hospital doctors and your family doctor (GP)? YES	**27%**	**35%**	**31%**		**58%**
Action Recorded via BIS					
Overall, did you feel you were treated with respect and dignity while you were in the hospital? ALWAYS	**77%**	**79%**	**74%**	**81%**	**82%**
Action Patient Experience Tracker PLACE Assessments					
Overall, the rating of your experience was? 1 = POOR – 10 = VERY GOOD **7-10** **8-10** **10**	**0%**	 **77%** **61.5%** **21%**	 **73%** **65%** **26%**	 **81%** **72%** **30%**	 **84%** **73.8%** **27.3%**
Action					

PLACE Assessments Patient Experience Tracker Transparency Questions Always Events Friends and Family					
Did you see, or were you given, any information explaining how to complain to the hospital about the care you received? NO	**27%**	**13%**	**18%**	**26%**	**26%**
Action Revised complaints leaflet to be included in the Discharge Pack Always Events					

The trust will continue to monitor measures from the inpatient survey as a quality indicator for 2015/2016.

2.1.1.4 Priority 4 - Pressure Ulcer Reduction

Reason for prioritising: During 2011/2012 to 2013/2014 the trust managed a sustained reduction in grade 2-4 pressure ulcers and it has not had a grade 4 pressure ulcer since March 2011. We wanted to build on this work and continue to evidence further improvement in the management of pressure ulcers and therefore decided to carry this forward as an improvement priority into 2014/2015.
Goal: The trust continues to implement its planned programme of actions to further reduce pressure ulcers which includes:-

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

The trust introduced two measures at the beginning of 2014/2015 namely to maintain or reduce grade 3 and 4 Hospital Acquired (Avoidable) pressure ulcers at the level reported for 2013/2014, this represented <=6 pressure ulcers and to reduce grade 2 pressure ulcers by 10% with an additional stretch target 20% - all of which has been reported via the Quality Dashboard.

Timeframe: March 2015

Progress 2014/2015

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

Pressure ulcers can range in severity from patches of discoloured skin to open wounds that expose the underlying bone or muscle. We grade them from Grade 1 which is superficial to Grade 4 which is the most severe type of pressure ulcer. Pressure ulcers tend to affect people with health conditions that make it difficult to move, especially those confined to lying in a bed or sitting for prolonged periods of time. It is estimated that just under, half a million people in the UK will develop at least one pressure ulcer in any given year. This is usually people with an underlying health condition, for example, around one in 20 people who are admitted to hospital with a sudden illness will develop a pressure ulcer. People over 70 years old are particularly vulnerable to pressure ulcers as they are

more likely to have mobility problems and ageing of the skin. Unfortunately, even with the highest standards of care, it is not always possible to prevent pressure ulcers in particularly vulnerable people. (NHS Choices)

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

As at the 31st March 2014 the trust was pleased to report a substantial 66.7% reduction in grade 3 pressure ulcers, with 6 confirmed grade 3 pressure ulcers. We also reported a 33% reduction in the incidence of grade 2 pressure ulcers corresponding to 112 grade 2 pressure ulcers compared to 166 grade 2 pressure ulcers in 2012/2013.

Reducing the incidence of pressure ulcers continued as an improvement priority for 2014/2015 and the trust is pleased to report that it has achieved all measures detailed in the improvement priority. The trust has reviewed its policy on pressure ulcers, with particular reference to the process by which we investigate grade 3/4 pressure ulcers. Mini investigations have taken place on all grade 2 hospital acquired pressure ulcers during 2014/2015 and a root cause analysis has been conducted on all grade 3/4 pressure ulcers during 2014/2015.

The improvement priority stated that we would maintain or reduce grade 3 and 4 hospital acquired (avoidable) pressure ulcers at the level reported for 2013/2014, this represented <=6 pressure ulcers of this severity. We are pleased to report that 5 hospital acquired grade 3 pressure ulcers (1 under review) occurred during this period. This represented a 16% reduction on 2013/2014.

We also stated that we would aim to reduce hospital acquired grade 2 pressure ulcers by 10% equated to = <101 cases with a stretch threshold of 20% reduction which equates to =<90 cases for 2014/2015. We can report that for 2014/2015 66 cases of this severity and a further 5 cases under review which represents a 41% reduction on 2013/2014 and therefore we are pleased to report that the trust is achieving both goals.

The trust will continue to monitor pressure ulcers as a quality indicator for 2015/2016.

* **Avoidable Pressure Ulcer:** "Avoidable" means that the person receiving care developed a pressure ulcer and the provider of care did not do one of the following: evaluate the person's clinical condition and pressure ulcer risk factors; plan and implement interventions that are consistent with the persons needs and goals, and recognised standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate."
Unavoidable Pressure Ulcer: "Unavoidable" means that the person receiving care developed a pressure ulcer even though the provider of the care had evaluated the person's clinical condition and pressure ulcer risk factors; planned and implemented interventions that are consistent with the persons needs and goals; and recognised standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate; or the individual person refused to adhere to prevention strategies in spite of education of the consequences of non-adherence" (Department of Health)

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

A detailed analysis of work and performance monitoring of pressure ulcers can be found at section 3.

2.1.1.5 Priority 5 Advancing Quality (AQ) measures – Stroke Ⓐ and Pneumonia.

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

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

Timeframe: March 2015

Progress 2014/2015

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

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

AQ works with clinicians to provide trusts with a set of quality standards which define and measure good clinical practice. Care in hospital is always tailored to individual needs but trusts must deliver each measure to every patient to ensure they receive the highest standard of care in hospital. AQ refers to this as the Clinical Process Measures and trusts aim to achieve 100 per cent success rate.

For example, if a patient is admitted into hospital suffering from pneumonia, two of the key Clinical Process Measures would be to have their oxygen levels assessed when they arrive in hospital and, if antibiotics are prescribed that the patient receives them within six hours of arriving at hospital. It aims to give all patients a better experience of the NHS by ensuring that every patient admitted to a North West hospital is given the same high standard of care. The idea is, if every hospital achieves the AQ measures, it will help to:-

- Save lives.
- Reduce the number of people being re-admitted into hospital.
- Reduce complications.
- Decrease the length of time patients have to spend in hospital.

AQ is also a local CQUIN for the trust and we are performance managed for each agreed condition Pneumonia; Heart Failure; Acute Myocardial Infarction; Hip and Knee and Stroke in order to demonstrate an annual improvement against the targets. During 2013/2014 the trust achieved all measures with the exception of pneumonia and stroke, as such it was agreed that we should focus on these conditions as an improvement priority for 2014/2015. AQ measures are monitored and

reported via a designated monthly AQ Group meet to share good practice and explore ways of improving compliance.

With regards to the stroke measures processes to monitor non-compliance have been improved and if any measures are missed they raise this with the individual nurse. It was recognised that in order to achieve this measure, the 4 hour target for direct admission needs to improve. Compliance with patients reaching the stroke unit within 4 hours of admission is one of seven factors measured for this indicator and agreement was reached to ring fence four beds for 4 hour stroke admission. The issue with inappropriate use of ring fenced stroke beds for non-stroke patients still remains, but staff are working hard to keep these beds available for stroke patients however with the general bed situation this is not always possible. AQ Adjudicators have also stated that the timing for the 4 hour stroke measure is to be taken from the notes when the patient reaches the ward and not MEDITECH which has previously resulted in breaches for the 4 hour Stroke measure. These KPIs are monitored by the AQ Group and the CQUIN Group and reported to board via the Quality Dashboard.

As with stroke there are a number of requirements which the trust needs to meet to achieve the pneumonia measure. However non-compliance did not appear to be based on one specific requirement so the team select individual issues to improve compliance. They focussed attention on three issues firstly antibiotics being received with 6 hours of arrival, secondly putting action plans are in place to ensure all doctors are trained in the requirements and finally improving information on smoking cessation. As with stroke these measures are monitored via the AQ Group and CQUIN Group and reported via the Quality Dashboard to board.

Monthly reports are always delayed by approximately three month due to processing and data cleansing issues. However the trust can report that whilst performance targets were not achieved the clinical teams were able to give assurance to Warrington and Halton Clinical Commissioning Groups of the high quality services and care that they deliver.

Measure	threshold	April	May	June	July	August	September	October	November	December
Pneumonia	>=73.9%	68.6	72.8	74.4	75.1	76.1	75.2	74.66	73.36	73.85
Stroke	>=60.4%	69.7	62.4	57	58.3	60	60.7	61.76	61.30	58.98

NB: Please note that this data is cumulative.

The trust will continue to monitor advancing quality measures as a quality indicator for 2015/2016.

2.1.1.6 Local Quality Indicators 2014/2015

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

Safety

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

Clinical Effectiveness

- SHMI & HSMR
- Dementia
- PROMS
- Advancing Quality

Patient Experience

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

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

2.1.1.7 Commissioner priorities

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

- Safety Thermometer (National)
- Family and Friends – staff and patients (National)
- Dementia (National)
- Advancing Quality - Acute Myocardial Infarction; Heart Failure; Hip and Knee; Pneumonia and Stroke (Local)
- Advancing Quality – developmental measures including COPD; Hip Fracture; Sepsis; Acute Kidney Injury; Diabetes and Alcoholic Liver Disease (Local)
- Health Inequality CQUIN – Local Health Inequalities applicable to the breast screening programme provided by WHHFT (Specialist Commissioning CQUIN)
- Neonatal intensive care (NIC) – Retinopathy of prematurity (ROP) screening. (Specialist Commissioning CQUIN)
- National Neonatal Dataset (Specialist Commissioning CQUIN)
- Improved access to maternal breast milk in preterm infants. (Specialist Commissioning CQUIN)
- Improvement in the care and experience of patients with dementia (Local)
- Effective Discharge and Transfer of Care (Local)
- Ward Assessment Scheme (Local)
- Improvement in the care and experience of patients with diabetes by the assessment of the diabetic foot and prevent the risk of developing a foot ulcer or manage any ulceration identified (Local)
- Recognition of and action taken with patients who display signs of deteriorating in general ward areas through use of the National Early Warning System (Local)
- Recognition of and action taken with children who display signs of deteriorating in paediatric ward areas through use of the Paediatric Early Warning System (Local)
- Timely clinical assessment and interventions in Surgical Assessment Unit (SAU) (Local)
- Digital Technology - Procure and implement an integrated health solution (Local)

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

2.1.2 Improvement Priorities and Quality Indicators for 2015–2016

2.1.2.2 Stakeholder Engagement

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

Quality workshop

An event held on the 14th January 2015, was attended by, approximately 35 representatives from key organisations including: Warrington HealthWatch; Halton HealthWatch; Warrington Borough Council; Governors; Assistant Director of Nursing and Quality at Cheshire, Warrington and Wirral Area Team NHS England and Warrington and Halton Clinical Commissioning Groups along with our own staff the Chairman and non-executive directors.

The aim of the event was to:

- Provide an overview of the Quality Report and our reporting requirements
- Provide an update on progress with quality improvement priorities and quality indicators for 2015/2016
- Planning for improvement priorities for 2015/2016
- Planning for quality indicators for 2015/2016
- Agree and propose a selection of quality improvement priorities and indicators to take back for discussion with the Board.

2.1.2.2 How we identify our priorities

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

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

The quali-tree – inspiring new thinking

In addition to this event and to ensure that we captured the views of the wider public we developed a 'qualitree' and posted the range of priorities that had been identified during the forward planning day on the branches of the tree. We then asked the public and staff to place tabs on the priorities which were important to them.

The data was collated and the quality priorities that received the highest number of votes were presented to Board for final approval.

2.1.2.3 Improvement Priorities for 2015–2016

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

Priority 1 "Every patient has a voice" - Developing a Patient Experience Strategy

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

The publication of the Francis Report (2010) focused on the poor delivery of basic care patients received in Mid Staffordshire NHS Trust. In 2011 this has been followed by the Parliamentary and Health Service Ombudsman, Care and Compassion Report, that focuses on the failings of a number of hospital trusts in the care of older people. Both reports detail failings of care and compassion to patients and go against the core values of this trust.

It is widely acknowledged that the care outlined in both reports is unacceptable and we feel that by having this strategy in place, the trust can ensure that patients are involved and receive an experience that meets and exceeds their physical and emotional needs and expectations. The strategy will demonstrate our commitment in ensuring the patient journey is a positive experience. We will develop a strategy through involvement with patients, relatives, carers and the public to ensure high quality services are delivered to our patients. The strategy will be structured into achievable work streams and the Patient Experience Committee will decide which work streams will be achieved by the end of the reporting year. Key themes to be agreed including complaints; claims; PALS; Healthwatch; surveys; food; environment.

Goal: – Patient Experience Strategy 2015-2018 developed in conjunction with key stakeholders. We will identify and agree key work streams and timescales for implementation within 2015/2016.

Timeframe: March 2016

Monitored: Patient Experience Sub Committee and Quality Dashboard.

Priority 2 Strengthening Mortality Review

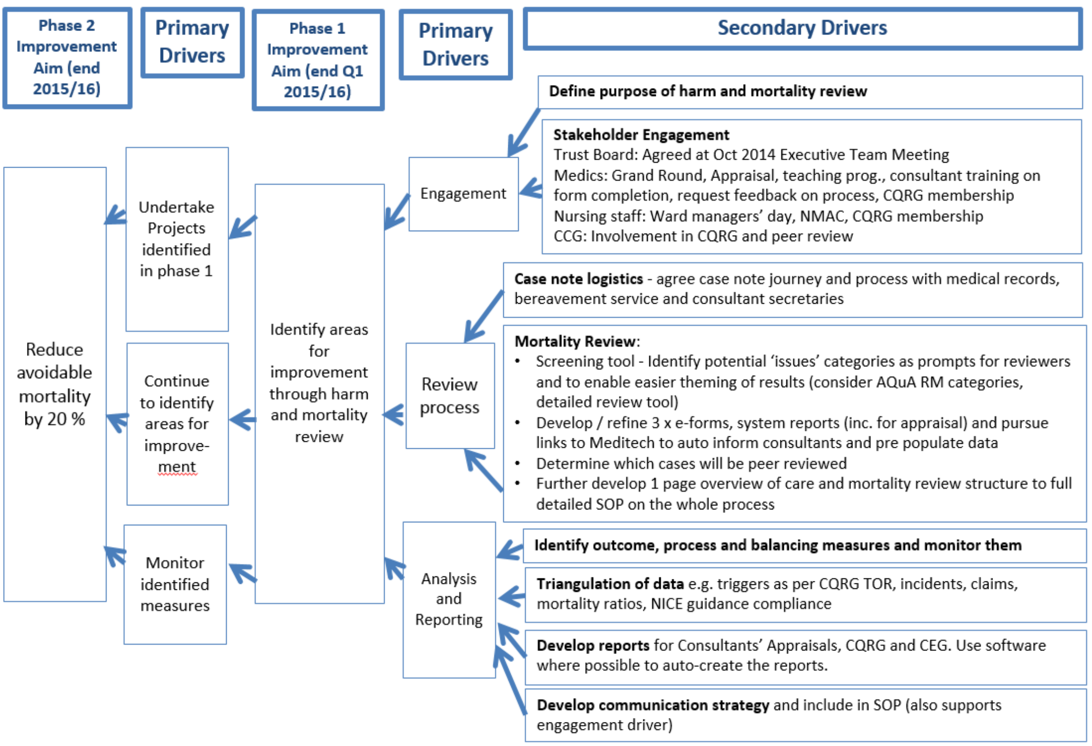
Reason for prioritising: The early draft findings of a review conducted by Mersey Internal Audit Agency (at our request), reflects our concerns that despite there being clear processes in place, a compliance rate of only 40% is being achieved. This then impacts on the amount and value of information gleaned from the reviews, to then drive forward focussed improvement. To address these issues, our Medical Director has gathered together key staff to meet in 2015 to review the current process with the aims of increasing engagement, reintroducing peer review, integrating the

centralised and specialty processes and strengthening organisational learning. The following provides a suggested framework including improvements that we aim to achieve by March 2016.

Goal: Agree trust wide process and improve compliance to >=95% by March 2016.

Timeframe: March 2016

Monitored: Clinical Effectiveness Sub Committee and Quality Dashboard



Sign up to Safety – reducing mortality driver diagram.

Priority 3 Improving quality of care at the End of Life

Reason for prioritising: Care provided at the end of someone's life is about helping someone to live as comfortably as possible with their illness. It is about seeing them as a living person, supporting those closest to them and adding life to days, whether or not days can be added to lives. Our team want to undertake a review of the current service, to develop and augment skills by a variety of methods, including communication training in essential areas and improved signposting to bereavement services based on individual's needs. Our Palliative Care Team will lead this change to support our colleagues in delivering the impeccable care deserved by the patients of Warrington and Halton and those close to them in their last days of life. Where chronic illness plays a part we want to support patient and those close to them in the months leading up to death, if someone's last illness is unexpected and short that support should still be available. Therefore communication and a combined approach with our community and hospice colleagues is essential.

Goal: to further develop a skilled and confident workforce to deliver high quality end of life care for patients in our care. Aim to deliver this service in Warrington and Halton hospitals and the community by working and planning our strategy across all healthcare settings. This will be measured through the development of an End of Life Strategy; communication training for staff and the development of an outpatient survey.

Timeframe: March 2016

Monitored: Clinical Effectiveness Sub Committee.

Priority 4 Reduction of falls – to include 5% reduction in all falls and a threshold of <=13 moderate, major and catastrophic harm falls

Reason for prioritising: Whilst the reduction of falls was not an improvement priority for 2013/2014 the trust remained focussed on improvements. The trust decided select this as a key priority for 2014/15 with a focus on a 10% reduction in moderate, major and catastrophic harm falls which unfortunately the trust failed to achieve. The trust is committed to continuing the reduction of falls by increased surveillance, risk assessments and review and through the work of the Falls Prevention Group (FPG) and this was supported by key stakeholders at the forward planning events who suggested that this should remain as a priority for 2015/2016.

Goal: In addition to the 10% reduction in moderate, major and catastrophic harm falls the priority includes a 5% reduction in all falls (possibly a stretch target of 10% reduction in all falls)

Timeframe: March 2016

Monitored: Patient Experience Sub Committee & Quality Dashboard.

2.1.2.4 Local Quality Indicators 2015/2016

The trust board, in partnership with staff and governors, has reviewed performance data relating to quality of care and agreed that in addition to our improvement priorities that our quality indicators for 2015/2016 will include:

Patient Experience

- Essential ward transfers only
- Patient Experience Indicators
- Complaints
- Patient Survey (inpatient and children) Indicators

Safety

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

*CAUTI has been removed as a quality indicator to be monitored via Patient Safety Committee

Clinical Effectiveness

- Dementia
- Advancing Quality
- SHMI & HMSR

* PROMS has been removed as a quality indicator to be monitored via Clinical Effectiveness Committee

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

2.2. Statements of Assurance from the Board

During 2014/15 the Warrington and Halton Hospitals NHS Foundation Trust provided and/or sub-contracted seven relevant health services.

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

The income generated by the relevant health services reviewed in 2014/15 represents 100 per cent of the total income generated from the provision of relevant health services by the Warrington and Halton Hospitals NHS Foundation Trust for 2014/15.

2.2.1. Data Quality

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

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

2.2.2. Participation in Clinical Audit and National Confidential Enquiries

During 2014/15 33 national clinical audits and 4 national confidential enquiries covered relevant health services that Warrington and Halton Hospitals NHS Foundation Trust provides.

During 2014/15 Warrington and Halton Hospitals NHS Foundation Trust participated in 97% national clinical audits and 100% of the national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Warrington and Halton Hospitals NHS Foundation Trust was eligible to participate in during 2014/15 are as follows:

National Clinical Audits
Adult community acquired pneumonia
Pleural procedure
Bowel cancer (NBOCAP)
Head and neck oncology (DAHNO)
Lung cancer (NLCA)
National Pregnancy in Diabetes NPID
Elective surgery (National PROMs Programme)
National Joint Registry (NJR)
Case Mix Programme (CMP) ICNARC
National Cardiac Arrest Audit (NCAA)

Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)
Acute coronary syndrome or Acute myocardial infarction (MINAP)
Cardiac Rhythm Management (CRM)
National Heart Failure Audit
Medical and surgical clinical outcome review programme: National confidential enquiry into patient outcome and death
National Comparative Audit of Blood Transfusion programme
Rheumatoid and early inflammatory arthritis
National emergency laparotomy audit (NELA)
Diabetes (Paediatric) (NPDA) National Paediatric Diabetes Audit
Epilepsy 12 audit (Childhood Epilepsy)
Inflammatory bowel disease (IBD)
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme
Falls and Fragility Fractures Audit Programme (FFFAP) National Hip Fracture Database (NHFD)
Sentinel Stroke National Audit Programme (SSNAP)
Oesophago-gastric cancer (NAOGC)
Prostate Cancer
Mental health (care in emergency departments)
Older people (care in emergency departments)
Fitting child (care in emergency departments)
Neonatal intensive and special care (NNAP)
Renal replacement therapy (Renal Registry) Data submitted by Royal Liverpool for Warrington patients
Severe trauma (Trauma Audit & Research Network, TARN)
National Complicated Diverticulitis Audit (CAD)
National Confidential Enquiries
Sepsis
Gastrointestinal Haemorrhage
Lower Limb Amputation
Tracheostomy Care

The national clinical audits and national confidential enquiries that Warrington and Halton Hospitals NHS Foundation Trust participated in during 2014/15 are as follows:

National Clinical Audits
Adult community acquired pneumonia
Pleural procedure
Bowel cancer (NBOCAP)
Head and neck oncology (DAHNO)
Lung cancer (NLCA)
National Pregnancy in Diabetes NPID
Elective surgery (National PROMs Programme)
National Joint Registry (NJR)
Case Mix Programme (CMP) ICNARC
National Cardiac Arrest Audit (NCAA)
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)
Acute coronary syndrome or Acute myocardial infarction (MINAP)
Cardiac Rhythm Management (CRM)
National Heart Failure Audit

Medical and surgical clinical outcome review programme: National confidential enquiry into patient outcome and death
National Comparative Audit of Blood Transfusion programme
Rheumatoid and early inflammatory arthritis
National emergency laparotomy audit (NELA)
Diabetes (Paediatric) (NPDA) National Paediatric Diabetes Audit
Epilepsy 12 audit (Childhood Epilepsy)
Inflammatory bowel disease (IBD)
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme
Falls and Fragility Fractures Audit Programme (FFFAP) National Hip Fracture Database (NHFD)
Sentinel Stroke National Audit Programme (SSNAP)
Oesophago-gastric cancer (NAOGC)
Prostate Cancer
Mental health (care in emergency departments)
Older people (care in emergency departments)
Fitting child (care in emergency departments)
Neonatal intensive and special care (NNAP)
Renal replacement therapy (Renal Registry) Data submitted by Royal Liverpool for Warrington patients
Severe trauma (Trauma Audit & Research Network, TARN)

National Confidential Enquiries
Sepsis
Gastrointestinal Haemorrhage
Lower Limb Amputation
Tracheostomy Care

The national clinical audits and national confidential enquiries that Warrington and Halton Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2014/15 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Clinical Audits 2014/15

National Clinical Audits	Participated	Data collected	% of cases submitted 2014/2015
Adult community acquired pneumonia	√	√	59 Ongoing data collection
Pleural procedure	√	√	8 (100%)
Bowel cancer (NBOCAP)	√	√	180 (98%)
Head and neck oncology (DAHNO)	√	√	14 (74%)
Lung cancer (NLCA)	√	√	297 (98%)
National Pregnancy in Diabetes NPID	√	√	15(100%)
Elective surgery (National PROMs Programme)	√	√	Ongoing Data collection
National Joint Registry (NJR)	√	√	888 Ongoing Data collection
Case Mix Programme (CMP) ICNARC	√	√	568

			Ongoing Data collection
National Cardiac Arrest Audit (NCAA)	√	√	Ongoing Data collection
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	√	√	2 (100%) Ongoing data collection
Acute coronary syndrome or Acute myocardial infarction (MINAP)	√	√	Ongoing Data collection
Cardiac Rhythm Management (CRM)	√	√	98 Ongoing data
National Heart Failure Audit	√	√	199 Ongoing Data collection
Medical and surgical clinical outcome review programme: National confidential enquiry into patient outcome and death	√	√	Ongoing Data collection
National Comparative Audit of Blood Transfusion programme	√	√	23 cases
Rheumatoid and early inflammatory arthritis	√	√	46 Ongoing Data collection
National emergency laparotomy audit (NELA)	√	√	142 Ongoing Data collection
Diabetes (Paediatric) (NPDA) National Paediatric Diabetes Audit	√	√	155 (100%)
Epilepsy 12 audit (Childhood Epilepsy)	√	√	13 (100%)
Inflammatory bowel disease (IBD)	√	√	Inpatient care audit Participated 35/50 (70%) cases submitted Inpatient experience questionnaires – Participated - <6 Organisational audit Participated Biological therapy audit Participated <6 cases submitted ongoing audit
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	√	√	36 (100%)
Falls and Fragility Fractures Audit Programme (FFFAP) National Hip Fracture Database (NHFD)		√	309 (100%)
Sentinel Stroke National Audit Programme (SSNAP)	√	√	548 (100%) Ongoing Data collection
Oesophago-gastric cancer (NAOGC)	√	√	93 (80%)
Prostate Cancer	√	√	Ongoing Data collection
Mental health (care in emergency departments)	√	√	50 (100%)
Older people (care in emergency departments)	√	√	100 (100%)
Fitting child (care in emergency departments)	√	√	50 (100%)
Neonatal intensive and special care (NNAP)	√	√	Ongoing Data collection

Renal replacement therapy (Renal Registry) Data submitted by Royal Liverpool for Warrington patients	√	√	Ongoing Data collection
Severe trauma (Trauma Audit & Research Network, TARN)	√	√	402 Ongoing Data collection

National Confidential Enquiries 2014/15

National Confidential Enquiries	Participated	Data collected 2014/2015	% Cases submitted 2013/2014
Sepsis	√	√	Ongoing data collection
Gastrointestinal Haemorrhage	√	√	Ongoing Data collection
Lower Limb Amputation	√	√	6 (100%)
Tracheostomy Care	√	√	10 (100%)

2.2.2.1 National Clinical Audits – reviewed

The reports of 28 national clinical audits were reviewed by the provider in 2014 /15 and Warrington and Halton Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Audit Title	Quality Improvement Actions
National Emergency Laparotomy Audit (NELA) Update	Roll out Peri-operative care pathway for emergency laparotomy patients across the specialties.
	Audit regularly compliance with the pathway and monitor its use
	Continue data input for National Emergency Laparotomy Audit (NELA) for next 12 months and audit compliance with standards proposed.
	Feedback these results to relevant specialties. Emergency Care (A&E) and surgical assessment unit (SAU) to audit adherence to sepsis pathway and use of sepsis bundles.
	Start Multidisciplinary Mortality and Morbidity (M&M) meetings initially on monthly basis and feedback the findings to relevant departments.
	Liaise with department of elderly medicine to get regular post-operative review by a Consultant. This will need a separate job description or a new appointment
Matching Michigan ITU	Continue Audit and Report to M&M yearly. Continue High Standards
National Neonatal Audit Programme (NNAP) annual summary	Annual re-audit Improve volume and quantity of data entered into Badger system-ongoing.
	Encourage all staff to use Badger
	Staff awareness and training - posters
	Data entry guideline produced by National Neonatal Audit Programme (NNAP)
	Cross checking of data by data clerk in future?
	Consider a computer in room 2 / handheld computers to make data entry more convenient
NASH- National Audit of seizure management in Hospitals	To improve documentation / education Satisfies National Institute for Healthcare & Excellence (NICE) guidelines and quality standards that all patients with a 1st seizure should be seen within 2 weeks.

	Could be based from A&E and led by Epilepsy Specialist Nurses
	Referral would require ALL relevant information, including a neurological examination.
	Documentation of appropriate information given to patients/parents needed.
	There is a patient information leaflet. ? Design a sticker for the notes.
The Missing Lung Cancers	Continue practice & continue National Data collection & re-audit Clean up data entered onto data base yearly
Unified Do Not Attempt Cardiopulmonary Resuscitation (UDNACPR)	uDNACPR Education Event
	Re-audit uDNACPR
	Attend audit and divisional meetings for doctors to present DNACPR presentation.
Compliance with the National Hip Fracture Database (NHFD)	Aim has to be 100% accuracy for both fracture type and operation type recorded for all patients. Continue training of trauma nurse(s) Clear Consultant documentation on Meditech of fracture type pre-operatively, and post-operatively of operation performed. Continue National Data Collection.
College of Emergency (CEM) Paracetamol Overdose 2015	All Emergency Department clinicians should carry out a plasma test if unable to ascertain overdose size. Having a treatment pathway proforma in place will assist with this.
	All Emergency Department (ED) clinicians should ensure that capacity to consent is recorded in every case of declined treatment where possible. Audit leads should review documentation to ensure that capacity can be simply recorded.
	Emergency Departments appearing above the upper quartile for plasma level tests taken earlier than 4 hours after ingestion should review their practice, and delay testing. Brief guidance notes could be provided as a reminder
	All Emergency Departments, particularly those falling below the lower quartile, should aim to treat patients with N-acetylcysteine within 8 hours of ingestion. A treatment pathway summary can assist with this.
	Patients presenting after 8 hours ingestion with a toxic (large or staggered) overdose who received N-acetylcysteine within 1 hour of arrival: all EDs should assess the reasons for their scores, and take action where necessary - particularly those with a score equal to or below the median.
	Compliance with Medicines & HealthCare Products and regulatory Agency (MHRA) guidelines: EDs performing below the median should investigate their processes, and take steps to improve their performance.
	All audit leads should look at improving the detail and accuracy of data entered in patient records. A structured proforma may support this.
Trauma Audit & Research Network (TARN) - 2014	Continue with National Audit data collection, present findings annually at Joint Trauma Review Meeting
	Trauma Team Leader – change of practice
	To ensure clock is on the wall in AE
	CT Audit to be carried out looking at time to CT results.
Emergency Laparotomy - Anaesthesia without walls	Abstract – Royal College of Anaesthetists (RCA) Task and Finish group, Twitter. Post-operative pathway Continue data collection
National Cardiac Arrest Audit	Present to Acute and Critical Care of the Patient Group (ACCPG)
	Recommend notes review of patients that have experienced cardiac arrest during admission at WHH to Clinicians.

	Present to Resuscitation Committee each Quarter 2013/2014-Quarter 3/4
British Thoracic Society Paediatric Asthma Audit 2013	Re-audit to monitor compliance.
Advancing Quality - Diabetes November and December 2014 Data	Improve A+E part of diabetes pathway Sole use of connectivity meter in A+E. Promote foot screening for all diabetics Foot screening document with all admission notes March 2014
	Revise hypoglycaemia form to improve documentation CHO times and discussions.
National Heart Failure (HF)	Pulling board on C21 to identify patients on outlying wards that require a cardiology bed; with aim to improve bed flow of patients to cardiology.
	Ongoing participation in National Heart Failure audit
National Cardiac Arrest Audit-Quarter 1	Amber and Ceilings of Care Continue National Cardiac Arrest Audit (NCAA)
	Recommend further audit to Acute and Critical Care of the Patient (ACCP) group of 'time of day' resources that potentially affect incidence of Cardiac Arrest
	Recommend need for Resuscitation Lead with dedicated time to Medical Director
	Present audit findings to Medical Audit
	Recommend audit of each cardiac arrest to Acute and Critical Care of the Patient (ACCP)
Surgical intervention in Inflammatory Bowel Disease patients (IBD)	Continue good communication between medical and surgical teams. Monitor elective vs emergency surgical admissions in IBD to ensure the number of emergency admissions does not increase
	Good record keeping of surgery performed and indications, whether it was elective or emergency with summaries of prior treatment
Paracetamol Overdose National CEM Audit - 2014	To make pathways more readily available: Hard copies on the "Wall of Wisdom" Incorporate into Symphony
	As part of the review of the ED Processes, "See & Decide" to be adopted as the standard way of working in the "Trolley Triage" and "Ambulatory Areas".
	To continue to teach the management of Paracetamol poisoning: as part of the SHO Induction Programme [CDU] for the nursing staff
Mothers & Babies, risk through Audits and confidential enquiries (MBRRACE)	Continue participation with Maternal, Newborn and Infant
	Clinical Outcome Review Programme (MBRRACE) data reporting in 2015.
Royal College of Radiologists (RCR)National audit on accuracy of emergency CT abdomen done out of hours	Reiterate need for double reading for all out of hour's registrar reports. Need for appropriate clinical information from surgeons.
Emergency Laparotomy - P-Possum levels of care	Audit next 100 National emergency laparotomy audit (NELA) cases
	Abstract to Royal College of Anaesthetists (RCoA) Spring Symposium: Perioperative Medicine.
Sentile Stroke - National Audit programme (Quality Accounts)	Achieve nursing staffing levels as stated by RCP
	Provision of in-patient psychology service
	Reintroduce ring fenced beds.
Fitting Child Royal College of Emergency Medicine (RCEM) Audit (Quality Accounts)	Improve documentation: Eyewitness account, Seizure type & duration of seizures.
	Measuring BM's – Results in Ambulances – transcribing into AE notes.
College of Emergency Medicine (CEM) Asthma in Children	If your ED is in the lower quartile for vital signs recording you should assess the reasons for this and take appropriate actions where necessary.

	Regarding the measurement and recording of peak flow, many EDs should review their practice and make changes where required.
	Departments in the lower quartile for beta agonist administration should look at their practice and make changes as appropriate
	All departments should review their practice in relation to giving beta agonists to patients within 10 minutes of arrival.
	There is room for improvement regarding the administration of Intravenous Hydrocortisone or oral prednisone in most departments.
	All departments should consider their processes for repeating vital signs in all patients especially after an intervention that may have a significant effect on those vital signs has been given.
	All departments should have a standard discharge proforma including advice / discharge medications and follow up advice for these patient
Severe sepsis and septic shock - National CEM Audit	Awaiting Report
Diabetes NPDA National Audit Impact of Best Practice Tariff for Accessing Psychological Service By Diabetic Children and Young People	Children and family members should receive support from Diabetes Care Team and expert attention from mental health professionals.
	Psychologist should be part of MDT team
	Increase the Psychology sessions to 0.2 whole time equivalent (WTE)
National Joint Registry	Continue to participate in National Audit
	To present findings at Audit Meetings
National Comparative audit of patient identification and Consent	Ensure the NHS Blood and Transplant (NHSBT) leaflet is available on all wards.
	Link emailed to all Ward Managers.
	Ensure that doctors are aware that consent can be printed off via the Trust's intranet and in different languages
	All doctors emailed to inform them of the NHSBT leaflets on all wards / printable versions off the intranet, and availability in different languages October 2014
	Submit report to the Transfusion Team, Hospital Transfusion Committee and to Trust Board for dissemination and to raise awareness
	To raise awareness amongst doctors and nurses for the need to gain consent, explain about risks, benefits and alternative to transfusion and document this in the case notes by completing the "Consent Box" on the Transfusion form On induction training for new doctors (F1, ST), SaBTO recommendations given out as a hand-out, and on Consultant update 2014. On the 2014 and 2015 training sessions for Transfusion to raise awareness – available on request. Alerts previously sent to all doctors. Alert sent 12th January 2015
National Diabetes In-Patient Audit (NaDia) 2013	Increase number patients having foot screening in the first 24 hours-incorporate foot screening with initial nursing documentation
	Increase number patients with foot ulcer seen Multi-Disciplinary Team foot team in the first 24 hours
	Improve insulin prescribing and reduce risk errors (fee recently introduced for insulin prescribing module on mandatory training. Working on replacement module)
	Review insulin prescribing DATIX then targeted education where individual input is required
	Education ward staff and Junior doctors around insulin prescribing
	To do in house audit of insulin and oral hypoglycaemic prescribing

2.2.2.2 Participation in Local Clinical Audits

The reports of 288 local clinical audits were reviewed by the provider in 2014/15 and Warrington and Halton Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Audit Title	Quality Improvement Actions
Acute Medicine	
Acute oncology management on Acute admissions unit	On admission, liaise with oncology team regards to patient whether for active management or palliative.
Audit of Urinary Tract Infection (UTI) sensitivities	Update antibiotic formulary
	Look at automating urine dip stick
	Audit urine dip stick results on admission
Anaesthetics	
Day Case Laparoscopic Cholecystectomy at Halton Hospital	Increase awareness among medical & nursing staff to treat Lap chole as day case.
	To do patient satisfaction survey for those discharged as daycase
	Repeat audit to assess improvement in day case rates.
Epidural Fever in Obstetric Patients	Increase awareness of temperature rise with epidurals.
	Epidural update teaching session for maternity staff to be carried out.
Childrens Health	
HIV in pregnancy – pitfalls and Lessons	Continue with multidisciplinary antenatal meetings for each case.
	Develop hospital guidelines for the care of HIV positive women in pregnancy including care of the baby.
	Improve the communication between laboratories regarding the adequacy of PCR sample at birth.
Management of the New-born with meconium stained liquor present at delivery	Dissemination of the results of the Management of the Newborn with Meconium Stained Liquor present at Delivery Audit to all the relevant staff in the Maternity Unit including the Neonatal Unit through the Audit Summary via email.
	Inform midwifery staff of the importance of performing Newborn observations on time through the Maternity Services Newsletter
	Reminder to midwifery and neonatal nursing staff to perform Newborn observations on time through the Safety Brief
	Dissemination of the Management of the Newborn with Meconium Stained Liquor present at Delivery Audit Report at the following Meetings: • Maternity Risk Management Meeting • Child health Audit
	Re-audit in 12 months as part of annual audit cycle to ensure implementation of recommendations and evidence of change in clinical practice.
	Provided Community Midwifery teams access to National Early Earning Scores (NEWS) Charts to take out onto the community and complete in cases of unexpected Grade 1 meconium
	Non-compliance: To improve compliance to the required best practice standard of 100% compliance with the completion of the Newborn postnatal observations individual staff members who do not comply with the local guideline will be identified and advised on an individual basis regarding the need for compliant documentation supported with a letter.
Admission to the Local Neonatal Unit (LNU)	Introduction of Admission to the LNU information gathering tool
	Weekly informal audit of medical notes
	Informal training for the neonatal shift leaders on completing the daily communication Proforma correctly.
	Look to redesigning neonatal resuscitation Proforma to be more user friendly and reduce duplication

User satisfaction questionnaire Antenatal screening	Improvement in recording of results in right part of notes Re-Audit
Annual Meningitis Audit 2015	Community staff (e.g. GP's RHV's and SHA's) remain aware of the importance of a timely audiological assessment
	Continue Annual audit
	Remind admin and audiology staff of prompt action to arrange Auditory Brainstem Response (ABR) if needed and to remind the hospital audiology staff of the 4 week deadline.
	Maintain timely referrals from acute service
Neonatal Hip Referrals March/May 2013	Disseminate results of the Newborn Hip Referrals Audit to the Child Health Senior Staff Meeting
	Dissemination of the results of the Newborn hip Referrals Audit to Orthopaedic Consultant in charge, Clinical Lead for Radiology, Acting Divisional Business Development Manager & Business Support Manager Scheduled Care.
	Undertake a Risk Assessment on the impact of non-compliance with the National Screening Committee (NSC) (2008) Newborn and Infant Physical Examination Programme (NIPE) Standards for examination of the hips for new-borns requiring a referral to the Orthopaedic Clinic for follow-up.
	Risk Assessment to be uploaded to Critical Infrastructure Response Information System (CIRIS) for discussion at the DIGG Meeting and escalation to the Trust Risk Register for non-compliance with national standards for examination of the hips in new-borns.
Total Parenteral Nutrition (TPN) Commissioning for Quality & Innovation (CQUIN) September 2014 update	Disseminate information to all staff in NICU Continue data collection on matching Michigan Re audit in 2 years and to include metabolic complications. To continue to collect data on Badger
Unanticipated Admissions of the NNU Jan-Apr 14	Disseminate results of the Unanticipated Admission to the LNU Quarterly Report to the Neonatal Unit nursing staff through the Audit Summary Report
	Continued inclusion of a Risk Management Update on the Local Neonatal Unit Mandatory Training Programme.
	In cases of non-compliance with the local Admission to the Neonatal Guideline where the Unanticipated Admission Proforma and DATIX Incident report is not completed individuals will be approached, good practice and areas for improvement with documentation discussed and supported with a letter.
	Introduction of an anticipated admission diary to include infants raised at the fetal management meeting and the Child protection forum as well as Planned transfers from other hospitals to be monitored at each shift by the shift leader
	Continue to monitor the unanticipated admissions of term new-borns to the LNU on a monthly basis and Proforma completion. Continue to monitor the completion of DATIX Incident reports for unanticipated admissions of term Newborn to the LNU on a monthly basis and report on the Message of the Week for the Neonatal Unit.
	A Transitional Care Service within the Maternity Unit would significantly reduce the number of avoidable admissions to the Neonatal Unit and minimise the number of new-borns being separated from their mothers requiring admission to the Neonatal Unit under the current LNU Admission Criteria. Preliminary meeting regarding Transitional Care facility planned for April '14
Nursing	
Standards Operating Procedure (SOP) for reduced urine output	To continue with effective bleep filtering and encourage staff to adhere to new iBleep, NEWS and Medical Emergency Team (MET) Call policies.
	Encourage staff to complete SBAR documentation with continual education
	Ensure staff and Acute Care Nurse Specialist (ACNS) are aware of all documents in relation to excellent catheter care and accurate fluid balance monitoring and these are adhered too.
	For all ACNS to be aware and educated in Acute Kidney Injury (AKI) Guidelines
SOP for Shortness of Breath	Encourage staff to complete SBAR documentation and continual education

	Acute care team to continue to document in line with the SOP guidelines
	Continue to encourage staff to adhere to policies and procedures in place regarding electronic IBleep, NEWS and MET Calls.
	All Acute Care Nurses to have a full knowledge and understanding of shortness of breath SOP and act accordingly as per guidelines
Deterioration Recognition Audit	Discuss the result findings at the Acute and Critical Care of the Patient Group (ACCPG) Meeting in May.
	NEWS chart to be amended.
	Matrons to cascade to ward managers with individual action plans
	Information to be disseminated to all Matrons.
	NEWS audit tool to be amended.
	Rolling audits to commence.
Corporate services	
Medical Records Policy National Health Service Litigation Authority (NHSLA)	Safety Notification regarding security and storage of records within wards & departments.
	Advertise further training for the use of the new case note folder.
Critical Care	
ICU Referrals	Improve documentation of ICU staff to ensure compliance with 12hourly review targets.
	Increase awareness among medical consultants of importance of their involvement in patients admitted to ICU, and their follow up following admission
ICU MSSA Bloodstream Infection - An Addendum	All Lines to be dressed with Tegaderm CHG. Review use of femoral lines with loose stools (type 7). Use of heparin in HF lines to improve flow. Highlight higher risk with the confused sweaty Patient Clarify the Duty of Candour process ownership Naseptin use replaced with bactroban.
Diabetes	
Hypo Boxes	Hypo box content audit – checking correct contents and presence hypo guidance
	Ward staff education to ensure hypo boxes are maintained
	Ward staff education on hypo management
	Targeted education for wards with high incidence of hypos
	F1 and medical student teaching regards appropriate management of hypos, carry out Hypo box audit
Management of Hypoglycaemia in None Hospital Settings	Re launch guideline and suggests Nursing Home keep a hypo box at one of the above programmes to carers and nurses
	Feedback to Bridgewater Community Healthcare NHS Trust via Care Homes Matron to commission an education programme for care home staff.
	Encourage all Nursing Homes to have a hypoglycaemic policy (could base on WHH one)
	Re-audit 12 months after implementation of education
Elderly Care	
Antipsychotic Audit Tool Feb 2014 – May 2014	Cognition Assessment Team to publicise the 'Aid to Antipsychotic prescribing' guidance on all adult wards
	Results of antipsychotic audit presented to Clinicians
	Launch of dementia guidance and care planning including good practice guidance In the assessment of Behavioural & Psychological Symptoms of Dementia (BPSD)
STOP START Medication Audit	Education to be delivered to the Juniors on the ground in the medical division. "Clean Slate" thinking – start with a blank Kardex and add what they need – don't be coerced into prescribing unnecessary stuff by others (Nursing/pharmacy staff). Re-Audit 12 months (Nov 2015) following the intervention, analysis and further recommendations – Roll out to primary care?

Cardiology	
A retrospective audit of driving advice given to patients admitted and discharged from ward C21 with a cardiovascular diagnosis: September-December 2013	Poster on DVLA guidelines for ward Re-audit taking into account diagnosis and whether advice is actually warranted and also acknowledging other sources of documentation/ information (Recovery Guidelines Booklet, PPM lab discharge advice)
An audit into complications rates of permanent pacemaker insertions at Warrington Hospital	To investigate possibility of initiating remote tele monitoring locally
	To start a complications / interesting case book within the catheter lab to run in conjunction with the recommendations from a different audit (the angiogram complication audit) for learning purposes.
Stroke	
To determine frequency. of large anomalies between SNOBS (Standardised Nursing Observations of Stroke) and therapy assessment when required after TIA	Education re. SNOBS
	Forward results to A&E and unscheduled care ward managers.
	Re-Audit SNOB's use in February 2015
Therapies	
Women's Health physiotherapy outcomes	Liaise with IT to ensure Meditech report has essential information and have mandatory fields on discharge report.
	Staff to use telephone appointments to evaluate clinical outcome for AQP patients who Do Not Attend (DNA) Unable To Attend (UTA) their last appointments.
	Adapt outcome measures section on assessment form to facilitate clinician to conduct initial/baseline.
	Liaise with IT regarding DWARF being able to pull Meditech data from discharge report.
	Staff to use appropriate ICIQ questionnaire for patient’s problem
	Develop postal system for retrieving clinical outcomes for patient who DNA/UTA last appointment
	Annual review into clinical outcomes
Emergency Care	
Sedation Audit	To “fast-track” patients requiring sedation.
	To incorporate this in the initial streaming/handover assessment.
	To undertake training in sedation for all professional groups.
	Information & Consent.
	Update the ED Sedation Policy.
	Training in the use of the Electronic Sedation Logbook.
	Produce standard consent for sedation including patient advice sheet.
	To work with the departmental medical and nursing leads and the Trust Sedation Lead to develop educational materials and opportunities e.g. multi-disciplinary Trust Sedation Course.
Audit on in-patient transfers from CMTC to Warrington Hospital	Provision of Resident Medical Officer (RMO) teaching and training. To explore possible rotation of RMO's within Ortho geriatrics.
	Utilisation of the SBAR tool for transfer.
	Medical registrar training to specifically include accessing a medical opinion and the transfer policy from Halton and CMTC.
	Introduction of pathways of common post-operative conditions
	Re audit in 6 months’ time from implementation of these actions.
	Present audit at the Joint Medical & A&E audit meeting
	To develop the process of accessing a timely medical opinion for acute and semi acute situation.
Clinical Decisions Unit (CDU) Readmissions Audit	Clinical Coding Department to receive copy of this audit, and then Clinical Coding Department to themselves consider how they might make moves to address the important mismatch in correct diagnosis vs their interpretation.

	Moves towards stopping social care pathway patients going to Clinical Decision Unit (CDU)
	Actions in the community to reduce admission of elderly care patients (Clinical Commissioning Group (CCG) & GPs etc.)
	Better mental health care in the community to ensure A&E becomes a place of last resort for mental health patients rather than the default one. (CCG)
Surgical	
Clinical vacation in practice of Laparoscopic Cholecystectomy and Surgical Outcomes	Allow access to SAU for 48 hours post-op for laparoscopic cholecystectomy patients
Re-Audit of appropriate use of abdominal x-rays	Re-audit 2 years
	Continued education of junior staff
Audit of co-prescription of laxative with opioid prescribing	Education to junior staff at Foundation Year 1/Foundation Year 2 Wednesday teaching
	Education of new Foundation Year 1 intake
	Re-audit for monitoring practice
Sepsis in Emergency general surgery admissions	Increase awareness on diagnosis and management of Sepsis throughout the department Re-Audit
ENT	
Joint Voice Clinic (JVC) Outcomes 2014	A working party has been established to review the service Speech And Language Therapy (SLTs) are offering to patients within the JVC who exhibit signs of Laryngopharyngeal Reflux (LPR). This will include discussion of the points mentioned in the Learning and Improvement Identified section of this report.
Myringoplasty Documentation and Outcomes	Re-Audit in one year
	Arrange follow up for all patients undergoing Myringoplasty
	Clear documentation of size and site of perforation
Audit on gastro oesophageal reflux in ENT	To re-audit in 12 months and follow the NICE guidelines for (Proton-pump inhibitors) PPI dosage and duration.
Governance	
Trust Consent Policy July-Sept 2014	Re-audit June for the July 2015 Clinical Governance, Audit and quality Sub Committee
	Discuss at the November 2014 Clinical Governance, Audit and Quality Sub Committee
	Provide Audit to Education Governance Committee via Dr Briggs to take forward with Trainees
Trust Consent Policy Nov 14	Re-Audit November 2014 Clinical Governance, Audit and Quality Sub Committee
	Associate Directors of Nursing to reaffirm that no nurse/midwife should take delegated consent at the request of the Consultant without their review and approval and that this information is registered as part of CIRIS register process
	Discuss at the July Clinical Governance and Quality Sub Committee particularly surrounding providing patient information and Consent forms has the risks, benefits and alternatives to treatment.
	Provide Audit to Education Governance Committee via Dr Briggs to take forward with Trainees
Ophthalmology	
Cataract surgery visual outcomes	Avoid use of Kenalog in uncomplicated cataracts
	Personal book of complications
	Patients with ocular comorbidities brought back to consultant clinic
Age-related Macular Degeneration (AMD) Audit	Prospective Data collection
	Maintain Logbook of Injections
	Maintain Logbook of New Referral to AMD clinic

	Record date and source and date of referral on medisoft, Visual Acuity in letter score, discharge summary on medisoft
Assessment of utilisation of Visual field Appointments	Separating visual field appointments for glaucoma patients from neuro-ophthalmology field slots and other.
	Provide urgent, protected field slots for every session to be used as needed.
	Set up assessment clinics for glaucoma patients with field slots including new referrals.
Yearly update of SPLD service, SPLD clinic Patient Satisfaction.	Target the SENCos in the schools in Halton and surrounding areas
	Improve the visual sequential memory exercises
	Re-Audit SpLD service for current year 2015
	Look more closely at the clinical uses of the developmental eye movement test
	New Audit of school satisfaction
Warrington vision screening audit 2013 / 2014	For WBC to contact schools to encourage schools to work with us Amend opt out consent letter & put in school bag system Outcome forms out into notes to remind colleagues to complete outcome form for every child referred. Re-test any borderline fails (borderline VA's/negative) on catch up sessions to try reduce false positives Continue with annual competency assessments & training with OA's
	Lead Orthoptist to attend VS SIG meeting Continue with current referral criteria but to conduct service improvement project to review current VA pass criteria Re audit annually to compare data
Pathology	
An Audit on the Compliance to Prescribed Transfusion Times	Produce 'Bloody Matters' highlighting results of the audit to circulate to all clinical areas and submit for 'Risky Business' (Clinical Governance newsletter).
	Generate report and submit to the Transfusion Team (TT), Hospital Transfusion Committee (HTC), Clinical Governance Quality and Audit Sub Committee (CGQASC)
	Produce 'Safety Alert' on the need to follow the prescribed transfusion times set by the clinician.
	Present finding at Laboratory Lunchtime Meeting and pathology Audit Day + included into 2014 mandatory training.
Sample Labelling Audit 2014	Produce summary report and submit to Transfusion Team (TT), Hospital Transfusion Committee (HTC) and Clinical Governance (CGAQSC)
	Circulate a "Bloody Matters" newsletter with the findings of this audit, to all clinical areas, to disseminate the results and emphasis practice.
Audit of the Reporting of Cervical Biopsies	Make sure p16 antibody is working
	Inform gynaecologists of outcomes at next Colp MDT Meeting
	Inform all histopathologists of outcomes
Turnaround time for Cancer Cases	All Malignant cases should be reported within the RCPath guidelines
	In complicated or difficult cases (require IHCs or additional procedures) an interim report should be issued followed by a final report
	Ensure cover is provided during interrupted reporting cycle
Primary immune thrombocytopenia	To do Virology screen on every patient presented with Immune Thrombocytopenia (ITP)
	To do the H-pylori test only for Immune Thrombocytopenia (ITP) patients who are refractory to treatment
Pharmacy	
Ward Controlled Drug Checks	Improve the labelling of liquids
	Provide wards/departments with a copy of their audit
	Review the Audit Tool and provide training on its use
	Prepare and Issue a Safety Briefing
	Improve the standard process for issuing requisition books

Consent and patient information for Anti D re audit	Complete report and submit to the Transfusion Team(TT), Hospital Transfusion Committee (HTC) and Trust Board via the Clinical Governance, Audit and Quality Sub Committee (CGAQSC) for dissemination of the results
	Presented at the Obstetric Audit Morning 17/12/2014 (verbally informed them of the results when presenting the national results recently received, this audit report was not written up at the time).
	Present findings to Haematology
	Send "Bloody Matters" to the Risk Manager of Women's Health for dissemination of results.
Radiology	
CT Head Injury Audit	Present audit at Joint Trauma Audit meeting in July
	Re audit in 12 months
	Reducing time interval at several levels where radiology department has control
	Reducing time from typing to verification
Axillary ultrasound accuracy in the symptomatic breast service	Target met – no action required
Scheduled Care	
Post-operative management after laparoscopy	The current laparoscopic post-operative pathway should be updated to include the key point 1 of the SOP.
	Matrons to address staff on improving documentation to ensure that all cases include a discharge summary.
	Clinical Lead for surgery to address VTE assessment at the specialty meeting.
	Collect data from records monthly for re- audit and annual report using the SOP criteria.
Trauma & Orthopaedic	
Safety Attitudes in the Operating Theatre: Re-Audit	Continue to offer workshops and raise awareness of the need for debriefings and continue to offer staff places on courses in human factors
Audit of current treatment of mallet finger injuries against literature	Re-audit treatment of mallet finger following protocol promotion
	Produce an evidence based mallet finger protocol
Medium term outcomes of arthroscopic shoulder surgery	Modify SAD technique to reduce the critical angle of the acromion then re-audit in 1-2 years.
	Include this information in the patient information leaflets.
	Use this information to council patients for elective surgery.
Initial & Re-audit of our service to Trauma Patients waiting at home for an operation.	Plan of increased drive for dedicated Trauma lists at CMTC for planned trauma patients.
	Ensure home waiting patients are updated and informed of their progress & treatment.
Cervical Spine Surgery pre-op risk stratification and post op complications	Develop a risk category scoring system with the anaesthetic team suitable for the Warrington and CMTC design and system
	Develop an "Advanced Recovery Programme" for cervical spine surgery at Warrington
Outcomes following Elbow Surgery - 891	Discuss physiotherapists and look at protocols
	Obtain pre-operative scores for future work
	Continue to offer treatment to patients who fail conservative management alone
Unscheduled Care	
Re audit of Individualised Consultant record Keeping	Circulate presentation to all consultants and add to appraisal folders
	Re audit in one year
	All medical consultants to have documentations reviewed at their next appraisal
VTE prophylaxis in patients over 100kg	Weighing patients in A&E
	Education for nursing/support staff with the aid of the dietician teams
	Education for junior and senior doctors

	Present at Trauma & Orthopaedic Meeting
	Liaising with pharmacy department
	Re-Audit May - July 2015. Present at Surgical Meeting
NEWS - National Early Warning Score	Rolling audits to commence
	Discuss the result findings at the Acute and Critical Care of the Patient Group Meeting in May
	NEWS audit tool to be amended
	Matrons to cascade to ward managers with individual action plans
	NEWS chart to be amended
	Information to be disseminated to all Matrons
AMBER care quality Audit	AMBER e learning package
	Revisit all wards using AMBER to firm up skills and check understanding of the underpinning evidence for the interventions documented on the bundle
	Further training around identification of patient that may be nearing the end of their life and have an uncertain outcome on this admission, on all wards already using the bundle.
Women's Health	
Audit of outcomes for HPV positive low grade smears and borderline nuclear abnormalities Colposcopy Satisfaction Questionnaire	Audit the smear reports of the current subset of women in 3 years
	Consider implementation of Dysis for more targeted biopsy
	Disseminate report to all staff involved in colposcopy. Discuss results at operational meeting.
	Repeat audit bi-annually
	Ensure clear signage for facilities
	Revise patient information sheets
Antenatal Intrapartum and Postnatal Bladder Care	Inform the community team leaders / antenatal clinic manager of the findings regarding taking an MSSU at booking to disseminate to their team (other persons booking women under our care)
	Circulate this audit to all staff to ensure all staff are aware of the minimum requirements which need to improve
	Repeat the audit in one year to assess the improvement in bladder care in 1) Antenatal care 2) Intrapartum care 3) Postnatal care
	Add to the monthly continuous audit schedule (for the next 6 months) the monitoring of all indwelling catheters post spinal/epidural in theatre and the use of a fluid balance chart for all women with an indwelling catheter.
Midwifery Staffing	The risk assessment and action plan should be monitored by the Maternity Risk Management Group until the risk has been reduced.
	Continue with data collection using the Intrapartum Scorecard to monitor service provision
	Undertake Birth-rate Plus assessment to enable maternity services to determine the number of midwives and support staff required to provide a quality standard of care
Fetal Monitoring in Labour	Liaise with the practice development midwife to disseminate to staff during CTG training the need for Improved compliance with filling out the CTG hourly assessment stickers and the use of fresh eyes specifically.
	Circulate this audit to all staff to ensure all staff are aware of the requirements which need to improve
	Repeat the audit in October to assess the improvement in comparison from the third quarter to the data from the first quarter of this year
Dysis: New Adjunctive Colposcopy Technology Should we incorporate it into our Cervical Screening Programme at WGH	Very few PCB patients (4%) had CIN and therefore there is little benefit in adding DySIS to PCB patient colposcopy evaluation. DySIS may be valuable for patients referred to Colposcopy with mild/moderate dyskaryosis and high risk HPV as it will allow us to discharge them if normal colposcopy . To consider the cost effectiveness for implementing DySIS

	To consider for the extra time needed for the DySIS in the clinic.
Outpatient Hysteroscopy Practice in women with heavy menstrual bleeding	Communicate with local GP surgeries for direct referral to RAPAC / OPD hysteroscopy clinics for eligible patients.
	Discuss at consultant and managerial level meeting to introduce telephone clinic for results of patients attending OPD hysteroscopy and RAPAC services.
	Myosure audit to be presented in July audit meeting.
Audit of outcomes for HPV positive low grade smears and borderline nuclear abnormalities	Audit the smear reports of the current subset of women in 3 years
	Consider implementation of Dysis for more targeted biopsy
	Disseminate report to all staff involved in colposcopy. Discuss results at operational meeting.

KEY:

ADG	Associate Director of Governance
AE	Emergency care
AMBER	The AMBER care bundle (**a**ssessment, **m**anagement, **b**est practice, **e**ngagement where **r**ecovery is uncertain)
BSUG	British Society of Urogynaecology
CG	Clinical Governance
CCG	Clinical Commissioning Groups are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services
CEM	College of Emergency Medicine
CT	A computerised tomography (CT) scan
Datix	Risk management system
DIGG	Divisional Integrated Governance Group
DNA	Did not attend
DVLA	Driver and Vehicle Licensing Agency
DWARF	Data Warehouse
DySIS	A new type of colposcope
ED	Emergency Department
GP	General Practitioner
HIV	Human immunodeficiency virus
HPV	Human papilloma virus
Kenalog	Injection
MBRRACE-UK	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries in UK
MET	Medical emergency team
MSSU	Midstream urine sample
Myringoplasty	Operation to repair the perforation in the eardrum
NCDAH	National Care of the Dying Audit
NDA	National Diabetes Audit

NEWS	NHS early warning score
NICE	National Institute for Health and Care Excellence
NICU	Neonatal intensive care unit
NNAP	National Neonatal Audit Programme
NNU	Neonatal Units
PCR	Polymerase Chain Reaction, a test method used to detect the genes of the virus
PN	Practice Nurse
PROMS	Patient Reported Outcome Measures
RCPath	Royal College of Pathologists
SaBTO	Advisory Committee on the Safety of Blood, Tissues and Organs
SBAR	Situation Background Assessment Recommendation
SHO	Senior house officer
SPLD	Specific learning difficulties
ST	Speciality Training
SpR	Registrar
Thrombocytopenia	A reduction in the platelet count below the normal lower limit
USS	Ultrasound

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

2.2.3. Participation in Clinical Research and Development

The number of patients receiving relevant health services provided or sub- contracted by Warrington and Halton Hospitals NHS Foundation Trust in 2014/15 that were recruited during that period to participate in research approved by a research ethics committee was 911**.**

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

In 2014-2015 the Trust was involved in conducting 94 clinical research studies in research in oncology, surgery, stroke, reproductive health, cardiology, rheumatology, gastroenterology, ophthalmology, as well as paediatric and other studies.

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

The Trust has also adopted the Network Research Management and Governance operational procedures and systems, including the NIHR Coordinated System for gaining NHS Permissions and achieved its target over the period. The Trust ensures that all NIHR portfolio research activities are

conducted to the highest standards and undertaken within the framework of research governance, strict legislation and recognised good clinical practice.

Most of the research carried out by the Trust is funded by the NIHR. For 2014-2015 the Trust received over £400,000 which funds 9 research nurses to support Principal Investigators with recruitment and to assist with the management of NIHR studies ensuring that the study runs safely and in accordance with the approved protocol.

2.2.4. The CQUIN Framework

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

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

A proportion of Warrington and Halton Hospitals NHS Foundation Trust's income in 2014/2015 was conditional upon achieving quality improvement and innovation goals agreed between Warrington and Halton Hospitals NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2014/15 and for the following 12 month period are available electronically at:
http://www.whh.nhs.uk/page.asp?fldArea=1&fldMenu=5&fldSubMenu=0&fldKey=161

The monetary total for the amount of income in 2014/15, conditional upon achieving quality improvement and innovation goals, was £4,169,862m with a monetary total for the associated payment in 2014/15 of £3,961,369 received. In 2013/14 the trust received a monetary total for the associated CQUIN payment of £4,617m.

The trust achieved full compliance against all of the agreed CQUINs with the exception of two Advancing Quality measures reporting partial year non-compliance with heart failure and stroke. The trust had the following CQUIN goals in 2014/2015 which reflected both national priorities and Department of Health initiatives and also reflecting local needs and the views of the patients and commissioners.

CQUIN Report 2014/2015

CQUIN Description	% of contract value	Total estimated value	Achieved
Friends and Family Test – Implementation of Staff FFT	3.75%	£156,370	
Friends and Family Test – early implementation	1.88%	£78,393	
Friends and Family Test – Increased or Maintained Response Rate	1.88%	£78,393	
Friends and Family Test – Increased Response Rate in acute inpatient services	5.00%	£208,493	
Reduction in the prevalence of pressure ulcers	12.50%	£521,233	
The proportion of patients aged 75 and over to whom case finding is applied following emergency admission, the proportion of those identified as potentially having dementia who are appropriately assessed, and the number referred on to specialist services. Each patient admission can only be included once in each indicator but not necessarily in the same month, as the identification, assessment and referral stages may take place in different months.	7.50%	£312,740	
Named lead clinician for dementia and appropriate training for staff	1.25%	£52,123	
Ensuring carers feel supported	3.75%	£156,370	
Sub-total National CQUINS	37.51%	**£1,564,115**	
AMI - The Appropriate Care Score (ACS) aggregates delivery of several underlying clinical interventions into a single measure of quality.	5.00%	£208,493	
Heart Failure - The Appropriate Care Score (ACS) aggregates delivery of several underlying clinical interventions into a single measure of quality.	5.00%	£208,493	
Hip & Knee - The Appropriate Care Score (ACS) aggregates delivery of several underlying clinical interventions into a single measure of quality.	5.00%	£208,493	
Pneumonia - The Appropriate Care Score (ACS) aggregates delivery of several underlying clinical interventions into a single measure of quality.	5.00%	£208,493	
Stroke - The Appropriate Care Score (ACS) aggregates delivery of several underlying clinical interventions into a single measure of quality.	5.00%	£208,493	
New CFA: COPD - Data Collection April - June 2014. From July 2014 - March 2015 - The Appropriate Care Score (ACS) aggregates delivery of several underlying clinical interventions into a single measure of quality.	1.00%	£41,699	
New CFAs coming on line in year (5 in total - Hip Fracture; Sepsis; Acute Kidney Injury; Diabetes and Alcoholic Liver Disease)	5.00%	£208,493	
Sub-total Advancing Quality	31.00%	£1,292,657	
Sub-total National & AQ	68.51%	£2,856,772	
Specialist Commissioning CQUINs			
(Health Inequality CQUIN) – Local Health Inequalities applicable to the breast screening programme provided by WHHFT. (Year 1 of 2 year CQUIN)			
Neonatal intensive care (NIC) – Retinopathy of prematurity (ROP) screening			

National Neonatal Dataset			
Improved access to maternal breast milk in preterm infants.			
Local CQUINs			
Improvement in the care and experience of patients with dementia. Year 1 of 2 year CQUIN	4.75%	£198,068.43	
Effective Discharge and Transfer of Care - Year 1 of 2 year CQUIN	4.75%	£198,068.43	
Ward Assessment Scheme. Year 1 of 2 year CQUIN	4.75%	£198,068.43	
Improvement in the care and experience of patients with diabetes by the assessment of the diabetic foot and prevent the risk of developing a foot ulcer or manage any ulceration identified. This is intended to be Part 1 of a 2 year CQUIN	2.50%	£104,246.54	
Recognition of and action taken with patients who display signs of deteriorating in general ward areas through use of the National Early Warning System	2.75%	£114,671.20	
Recognition of and action taken with children who display signs of deteriorating in paediatric ward areas through use of the Paediatric Early Warning System	2.00%	£83,188.74	
Timely clinical assessment and interventions in Surgical Assessment Unit (SAU)	2.00%	£83,188.74	
Procure and Implement an Integrated Health Solution Part 1 of a 2 year CQUIN	8.00%	£333,588.93	
Sub-total Local	31.49%	£1,313,089.43	
		£4,169,862	

2.2.5 Care Quality Commission (CQC) Registration

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

The Care Quality Commission has not taken enforcement action against Warrington and Halton Hospitals NHS Foundation Trust during 2014-2015.

The trust is registered to provide the following services:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Family planning
- Maternity and midwifery services
- Surgical procedures
- Termination of pregnancies
- Treatment of disease, disorder or injury.

Warrington and Halton Hospitals NHS Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to maternity and theatres during 2014/15.

Warrington and Halton Hospitals NHS Foundation Trust intends to take the following action to address the conclusions or requirements reported by the Care Quality Commission. Please see action plan at the following link:

http://www.whh.nhs.uk/page.asp?fldArea=1&fldMenu=5&fldSubMenu=9&fldKey=248

Warrington and Halton Hospitals NHS Foundation Trust has made the following progress by 31st March 2015 in taking such action. Please follow this link for progress:

http://www.whh.nhs.uk/page.asp?fldArea=1&fldMenu=5&fldSubMenu=9&fldKey=248

2.2.5.1 CQC Unannounced Inspection 2014/2015 Maternity

The CQC made one inspection carried out on 30 June and 1 July 2014 to review systems, standards, audit and processes as part of the Regulated Activities for Quality and Safety. This was a responsive inspection following a review of information provided to us by the trust in relation to 10 intrauterine deaths. They had also received concerning information about theatre services at the trust. In response to the information about the maternity services the CQC liaised with Warrington Clinical Commissioning Group and reviewed the information sent to them which included a review of the investigations that had been undertaken and the root cause analyses completed to identify any common factors. This information also included the decision of the trust to deviate from the National Institute for Health and Care Excellence: 'Intrapartum care: care of healthy women and their babies during childbirth' (NICE) CG55 guidance in relation to the care of low risk mothers during labour.

This inspection was conducted to review the trusts management and safety related to promoting the wellbeing of women at low risk of having their babies at Warrington Hospital. In the course of preparing for this inspection concerns were also raised with the CQC by the Royal College of Midwives.

In relation to maternity services they found that the trust had not adequately reviewed and monitored the risks for women and babies in light of their decision to deviate from NICE CG55 and, midwives were not adequately supported in respect of this change in practice. The CQC outlined two areas that we needed to take some further action raised after their inspection visit in June were they found moderate non-compliance with the Health and Social Care Act 2008.

In response to the concerns about the theatre department they reviewed information which they stated addressed their concerns and during our inspection of the theatres they found that theatre services at the trust were safe and managed in accordance with best practice guidance.

The full report can be found at http://www.cqc.org.uk/location/RWWWH/reports

Extracts from the CQC inspection - How we carried out this inspection and what the inspection revealed.

People should get safe and appropriate care that meets their needs and supports their rights (outcome 4) CQC determined that the trust had not met this standard

They checked that people who use this service experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

They looked at the personal care or treatment records of service users, carried out a visit on 30 June 2014 and 1 July 2014, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with staff, reviewed information given to us by the provider and talked with other regulators or the Department of Health. They were accompanied by a specialist advisor.

Their judgement was that care and treatment was not always planned and delivered in a way that ensured people's safety and welfare because care and treatment to low risk women during labour did not reflect relevant research and guidance.

The reasons for their judgement, was that the women who used the maternity services were generally content with the care provided.

Women, although happy with the outcome, also described some stressful moments during child birth and gaps in antenatal care. For example, one patient said: "I don't think I was told enough before the birth and I definitely wasn't told about choices because I would have considered a home birth… I've been really good throughout the pregnancy no illness at all...When I got here they put two straps round me and you could hear her on a machine, this was for the full labour and at the very end the midwife was struggling to hear it so was going to put something on her head but then she came out. I wasn't going to stay in hospital but I'm glad I have because I've picked up a lot of tips."

Staff should be properly trained and supervised, and have the chance to develop and improve their skills (outcome 14) CQC determined that the trust had not met this standard

The CQC checked that people who use this service are safe and their health and welfare needs are met by competent staff. The CQC looked at the personal care or treatment records of people who use the service, carried out a visit on 30 June 2014 and 1 July 2014, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. They talked with people who use the service, talked with staff, reviewed information given to them by the trust and talked with other regulators or the Department of Health. They were accompanied by a specialist advisor.

Their judgement was that maternity staff were not supported to deliver care and treatment an appropriate standard because the trust had not created an environment where clinical excellence could do well.

The reasons for their judgement were that they talked with 13 members of staff about the skills and support of midwives. Staff we talked with included consultant gynaecologists and obstetricians; Band 8, 7, 6 and 5 midwives; a student midwife; midwifery health care assistants and a member of the domestic staff. Many of the midwifery staff they talked with felt that the trust board and senior management team did not support senior managers for the maternity department. Each member of the clinical staff stated that morale and confidence amongst the midwives had been affected because they now lacked confidence in their skills to determine whether labour was proceeding without complications.

We talked with senior midwifery staff including a number of Supervisors of Midwives (SoMs) who are appointed to the trust by the Local Supervising Authority Midwifery Officer to oversee the work of midwives to ensure that high standards of care are provided. All practising midwives must have a SoM who are are experienced midwives who have had additional training and education to enable them to support midwives to provide safe and best quality midwifery care. The SoMs we talked with confirmed that midwives shared issues appropriately with them. The SoMs and senior midwifery staff considered the sudden change in policy relating to continual electronic fetal monitoring had reduced the confidence of some midwives to provide midwifery care to low-risk women in accordance with best practice guidance.

2.2.5.2 CQC new Chief Inspectors Regime (Keogh Framework)

The CQC now lead significantly bigger inspection teams headed up by clinical and other experts that include trained members of the public. They spend longer inspecting hospitals and cover every site that delivers acute services and eight key services areas: A&E; maternity, paediatrics; acute medical and surgical pathways; care for the frail elderly; end of life care; and outpatients. The inspections are a mixture of unannounced and announced and they included inspections in the evenings and weekends when it is recognised patients can experience poor care. The CQC inspected Warrington and Halton Hospitals NHS Foundation Trust from 28 - 29 January 2015. During their visit they looked at the quality and safety of the care we provide, based on the things that matter to people. They looked at whether our service is:

Safe

Effective

Caring

Responsive to people's needs

Well-led.

These key lines of enquiry were investigated using pre-visit information, the onsite inspection and local information about us – including seeking patient, staff and visitor views. The CQC will provide a rating by specialty; location and an overall rating for the trust from the inspection. . The trust is awaiting the publication of the CQC Report and will provide commentary on this in the Quality Report 2015/2016.

2.2.5.3 CQC Intelligent Monitoring

The Care Quality Commission has since March 2014 published full risk profiles and risk bandings of all NHS trusts. This system is known as Intelligent Monitoring and we fully support this as a way of highlighting risk in the health service. The intelligent monitoring is based on 150 indicators that look at a range of information including patient experience, staff experience and statistical measures of performance including detailed mortality rates, waiting time and access information, patient feedback and actual CQC inspection results.

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

The CQC have now banded each trust into one of six categories based on the risk from these indicators that people may not be receiving safe, effective, high quality care - with band 1 being the highest risk and band 6 the lowest risk. . In March this trust was banded as a 5 with a total of five risks including one elevated risk, the higher the number of risks the lower the banding.

The following table provides a summary of the bandings and risks for 2014/2015:-

	Threshold	A	M	J	J	A	S	O	N	D	J	F	M
Banding	Not set				3					5			
Number of elevated risks	Not set				2					1			
Number of risks	Not set				5					3			

Whilst these are not to be seen as formal league tables, they do give an indication of the overall performance, quality and safety at a trust and if weak performance is identified can also trigger an inspection. The full reports can be found at http://www.cqc.org.uk/directory/RWW

2.2.6 Trust Data Quality

Warrington and Halton Hospitals NHS Foundation Trust submitted records during 2014/2015 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

Which included the patient's valid NHS Number was:

for admitted patient care – 99.72%

for outpatient care – 99.86%

for accident and emergency care – 98.91%

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

for admitted patient care – 99.60%

for outpatient care – 99.85%

for accident and emergency care – 98.94%

2.2.6.1 Information Governance

Warrington and Halton Hospitals NHS Foundation Trust's Information Governance Assessment overall score for 2014/2015, was 64% and was graded as "not satisfactory".

Not Satisfactory

Performance will be monitored by the Information Governance and Corporate Records Group and then reported to the Quality Committee which is a committee of the trust board.

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

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

Authoring a new Data Quality work plan for 2015/16 to ensure that data quality KPIs are monitored

Expanding data quality KPI's to more key clinical systems used by the Trust

Appointing Information Asset Owners as data quality leads for key systems in order to improve ownership of data quality within divisions

Appointing a Clinical Coding Engagement Manager to improve the completeness of the Clinical Coding.

2.3. Core Quality Indicators 2014/2015.

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

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

The national average for the data.

The NHS trusts and NHS foundation trusts with the highest and lowest of the same, for the reporting period.

Present, in a table format, the percentage/proportion/score/rate/number for at least the last two reporting periods.

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

2.3.1a Summary Hospital-Level Mortality Indicator (SHMI)

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

SHMI

DATE PERIOD	TRUST	BANDING	HIGHEST	LOWEST	NATIONAL
October 2013 – September 2014	111.21	2	119.82	59.66	100
July 2013 – June 2014	109.40	2	119.80	54.10	100
April 2013 – March 2014	108.20	2	119.70	53.90	100
January 2013 – December 2013	109.20	2	117.60	62.40	100
October 2012 – September 2013	110.21	2	118.59	63.01	100
July 2012 – June 2013	112.06	2	115.63	62.59	100
April 2012 – March 2013	112.90	1	116.97	65.23	100
January 2012 – December 2012	110.69	2	119.19	70.30	100
October 2011 - September 2012	111.26	2	121	68	100
July 2011 - June 2012	109.51	2	125	71	100

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

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

1. The trust’s mortality rate is ‘higher than expected’
2. The trust’s mortality rate is ‘as expected’
3. Where the trust’s mortality rate is ‘lower than expected’

SHMI – Mortality Rates

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

Following a significant focus on mortality reduction in the trust, we improved from a previously 'higher than expected' SHMI score, to having an 'as expected' score between June 2013 and August 2014. The latest published SHMI figure is 109, for the period July 2013 – June 2014. We monitor mortality ratios on a monthly basis using the HED system and have reported internally a 'higher than expected' score in the rolling 12 month periods ending August 2014, October 2014, November 2014 and December 2014 when it increased to 115. Our crude death rates remain comparable with local peer trusts, however we will of course continue to progress with the actions in the areas outlined in section 3.3.1.

The SHMI is one of two mortality measures used in the NHS, the other being HSMR (Hospital Standardised Mortality Ratio), which is 107 for the latest data period available (February 2014 to January 2015). This is within the range of 'as expected'.

Mortality ratios are complex indicators and there are multiple factors that contribute to the overall score, including the quality of our documentation and coding. The key areas of focus in 2014/2015 were:

- Reviewing the trust's care pathways and best practice care bundles to ensure a high standard of care for every patient, every time
- Mortality Review (including collaboration with local peers)
- Ensuring quality and appropriate care at the end of patients' lives
- Promoting the effective management of patients whose conditions deteriorate
- Continue to analyse, understand, report and use mortality and morbidity data to improve outcomes.
- Ensure accurate and comprehensive documentation and coding

The trust achieved a reduction in the HSMR to below 100, which was sustained for the first six months of 2014/2015. As stated, we have seen a recent rise in this figure and the SHMI. Warrington and Halton Hospitals NHS Foundation Trust intends to take the following actions to improve the rate and so the quality of its services by going forward this will continued to be monitored as a quality indicator and we will report back in the Quality Report 2015/2016.

We will continue our focus on the areas outlined above, in line with the Advancing Quality Alliance's (AQuA) recommended approach to reducing mortality. Key developments to date include:

- Significant steps taken to enhance the mortality review process to fully integrate specialty and corporate systems, and fully utilize technology to ensure information is more easily available to consultants reviewing the quality of care we provided.
- Introducing new Advancing Quality measures, for example Sepsis, Diabetes, COPD, which will assure us, as well as our patients that we adhere to the best available evidence in treating these conditions.

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

Deaths with Palliative Care Coding

DATE PERIOD	TRUST	ENGLAND	HIGHEST	LOWEST
October 2012 - September 2013				
July 2013 - June 2014	30.5%	24.6%	49%	7.4%
April 2013 – March 2014	27.7%	23.6%	48.5%	6.4%
January 2013 – December 2013	22.8%	22%	46.9%	1.3%
October 2012 - September 2013	19.9%	20.9%	44.9%	2.7%
July 2012 - June 2013	18.9%	20.3%	44.1%	4.2%
April 2012 – March 2013	17.2%	19.9%	44%	0.1%
January 2012 – December 2012	14.4%	19.1%	42.7%	0.1%
October 2011 - September 2012	11.6%	18.9%	43.3%	0.2%
July 2011 - June 2012	9.1%	18.2%	46.3%	0.3%

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

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

Warrington and Halton Hospitals NHS Foundation Trust intends to take the following actions to improve the rate and so the quality of its services by going forward this will continued to be monitored and we will report back in the Quality Report 2015/2016.

We have worked hard to ensure that patients who are at the end of the lives receive excellent palliative care from specialist staff. In July 2013 – June 2014, our figures were greater than the national average, a position which we aspire to maintain in 2015/2016.

2.3.2. Patient reported outcome measures (PROMs) for (i) groin hernia surgery, (ii) varicose vein surgery, (iii) hip replacement surgery, and (iv) knee replacement surgery. PROMs also exist for varicose vein, however the trust does not undertake this procedure.

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

Patient Reported Outcome Scores.

		Groin hernia	Hip replacement	Knee replacement
Year	**Level**	**Average health gain**	**Average health gain**	**Average health gain**
2012/2013	Trust	0.062	0.428	0.357
2012/2013	England	0.085	0.438	0.318
2012/2013	Highest	0.153	0.539	0.416
2012/2013	Lowest	0.014	0.319	0.209
2011/2012	Trust	0.084	0.438	0.310
2011/2012	England	0.087	0.416	0.302

2011/2012	Highest	0.249	0.668	0.537
2011/2012	Lowest	-0.084	0.282	0.144
2010/2011	Trust	0.055	0.382	0.299
2010/2011	England	0.085	0.405	0.298
2010/2011	Highest	0.156	0.503	0.407
2010/2011	Lowest	-0.020	0.264	0.176
2009/2010	Trust	0.075	0.358	0.310
2009/2010	England	0.082	0.411	0.294
2009/2010	Highest	0.136	0.514	0.386
2009/2010	Lowest	0.011	0.287	0.172

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

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

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

2.3.3. Emergency readmissions to hospital within 28 days of discharge

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

The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of patients aged

0 to 15; and

16 or over,

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

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

DATE PERIOD	TRUST	ENGLAND	HIGHEST	LOWEST
2012/2013	*	*	*	*
2011/2012	13.58	10.01	13.58	5.10
2010/2011	12.08	10.15	13.94	5.85
2009/2010	11.77	10.18	14.44	6.38

NB: Information Centre provides data by 16> not 15>
*** Data for 2012/13 is not available from the Information Centre**

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

DATE PERIOD	TRUST	ENGLAND	HIGHEST	LOWEST
2012/2013	*	*	*	*

2011/2012	12.44	11.45	13.50	8.96
2010/2011	11.66	11.42	12.94	7.6
2009/2010	11.75	11.16	13.17	7.3

*** NB: Information Centre provides data by 16> not 15>**
*** Data for 2012/13 is not available from the Information Centre**
Data relates to medium sized acute trusts.

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

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

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

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

CQC national inpatient survey – personal needs.

DATE PERIOD	TRUST	ENGLAND	HIGHEST	LOWEST
2013/2014	69.4	68.7	84.2	54.4
2012/2013	66.7	68.1	84.4	57.4
2011/2012	66.2	67.4	85	56.5
2010/2011	67.4	67.3	82.6	56.7

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

Warrington and Halton Hospitals NHS Foundation Trust will take the following actions to improve this percentage and so the quality of its services, by reviewing the inpatient survey results constructing an action plan to improve year on year results. This will be supported by local surveys which focus on the above aspects of the patient experience. During 2015/2016 the trust will continue to undertake work around the low performing indicators from the National Inpatient Survey and report progress via the Patient Experience Committee.

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

The data is made available to the trust by the Health and Social Care Information Centre via the National NHS Staff Survey Coordination Centre with regard to the percentage of staff employed by,

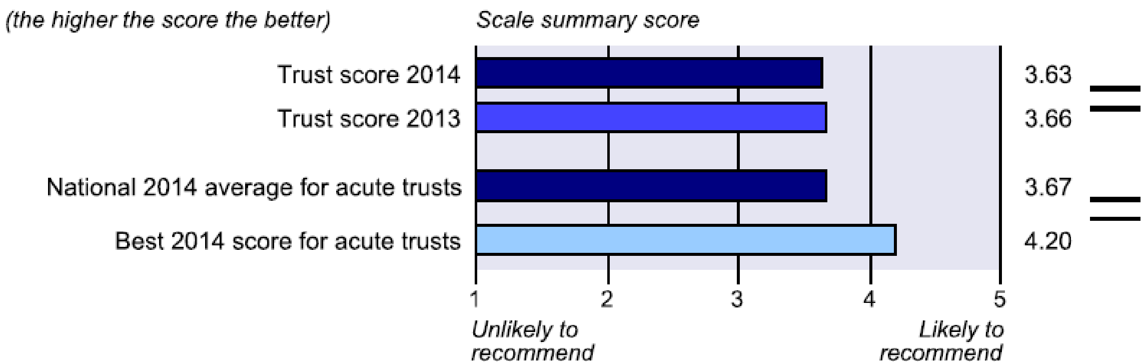
or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.

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

DATE	TRUST	HIGHEST	LOWEST	ACUTE TRUSTS
2014	61%	89%	38%	65%
2013	65%	93.9%	39.6%	67%
2012	58%	69%	35%	65%
2011	57%	89%	33%	65%

NB: National data for acute trusts = national score

Staff who would recommend the provider to friends or family needing care by score – Staff Survey 2014.



Warrington and Halton Hospitals NHS Foundation Trust considers that this data is as described for the following reason, in that this report presents the findings of the 2014 national NHS staff survey conducted by the Picker Institute on behalf of the trust. The Picker Institute utilises high quality research methodology which ensures that appropriate sampling is undertaken across all staff groups resulting in a 30% response rate. 252 staff at Warrington and Halton Hospitals NHS Foundation Trust took part in this survey. This is a response rate of 30% which is in the lowest 20% of acute trusts in England, and compares with a response rate of 46% in this trust in the 2013 survey. We believe that the low response rate is attributable to the fact that this is the first year that we have used e-mail to undertake survey

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

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

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

Venous Thromboembolism (VTE) – percentage of risk assessments undertaken

Year	Level	Q1	Q2	Q3	Q4
2014/2015	Trust	95.70%	95.60%	95.00%	96.59%*
	National Average	96.00%	96.10%	96.00%	**
	Highest	100%	100%	100%	**
	Lowest	87.20%	86.40%	81.00%	**
2013/2014	Trust	95.54%.	95.60%	96.50%	96.00%
	National Average	95.39%	95.69%	95.80%	96.00%
	Highest	100%	100%	100%	100%
	Lowest	78.78%	81.70%	77.70%	79.00%
2012/2013	Trust	95.40%	95.10%	94.00%	93.90%
	National Average	93.40%	93.80%	94.00%	94.20%
	Highest	100%	100%	100%	100%
	Lowest	80.80%	80.90%	84.60%	87.90%
2011/2012	Trust	95.60%	96.20%	95.40%	96.20%
	National Average	81.00%	88.00%	91.00%	93.00%
	Highest	***	***	100%	100%
	Lowest	***	***	32.40%	69.80%

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

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

Warrington and Halton Hospitals NHS Foundation Trust has taken the following actions to improve this percentage and so the quality of its services, by undertaking ward assessments to ensure patients receive risk assessment appropriately and streamlining processes to ensure all risk assessments are logged electronically on completion. The Thromboprophylaxis Nurse Specialist monitors completion of VTE risk assessments and ensures all non-compliance issues are addressed.

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

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

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

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

The Information Centre only provides average by Trust (not by highest and lowest) and 2014/15 data is not currently available.

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

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

- Action plans in place to reduce MRSA and Clostridium difficile
- Health Economy Clostridium difficile action group – audits of primary care prescribing for long-term UTI prophylaxis
- Participation in European Antibiotic Awareness Day
- Changes to methods of investigation for Clostridium difficile cases
- Surveillance of cases/monitoring for increased incidences in defined locations
- Cohort isolation facility maintained to manage cases
- Antimicrobial steering group with feedback to Clinicians on incidences of prescribing non-compliance
- Fidaxomicin introduced for treatment of patients with recurrent Clostridium difficile infection
- Text alerts to senior managers to report Clostridium difficile cases
- Increase in ward based training for management of infectious diarrhoea, viral gastroenteritis outbreaks and use of personal protective equipment
- Safety alerts distributed on the management of potentially infectious diarrhoea

Please see section 3.2.1 for further information on improvement actions.

2.3.8. Patient Safety Incidents

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

Patient Safety Incidents – Rate of incidents per 1000 bed days

DATE	TRUST	TRUST NUMBER	MEDIAN	Lowest	Highest
April 2014 – September 2014	36.89	3339	35.89	0.24	74.96
October 2013 – March 2014	37.1	3513	33.3	5.8	74.9

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

Patient Safety Incidents – Rate of incidents per 100 admissions

DATE	TRUST	TRUST NUMBER	MEDIAN	Lowest	Highest
October 2013 – March 2014	8.61	3513	8.02	2.41	16.76
April 2013 – September 2013	9.54	3892	7.47	3.54	14.49

October 2012 – March 2013	9.1	3620	7.6	1.7	16.7
April 2012 – September 2012	8.1	3257	6.7	3.11	14.44
October 2011 – March 2012	8.7	3402	6.7	2.21	10.54

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

Patient Safety Incidents Severe Harm / Death – Rate

DATE	TRUST	NATIONAL %	PEER %	LOWEST	Highest
Severe Harm & Death April 2014 – September 2014	0.1% (5)	0.5% (non-specialist acutes only)	N/A (no longer reported by Trust size)	0% (0)	1.85% (97)
Severe Harm & Death October 2013 – March 2014	0.17% (6)	Clarify scope	0.65% (medium sized acutes)	0.03% (1)	1.47% (72)
Severe Harm & Death April 2013 – September 2013	1.08% (42)	Clarify scope	0.67% (medium sized acutes)	0% (0)	3.10% (106)
Severe Harm & Death October 2012 – March 2013	0%	0.05%	0.05%	0%	0.2%
Severe Harm April 2012 – September 2012	**0.15% (4)	*<1%	0.6%	0 0%	61 3.1%
Death April 2012 – September 2012	0.0% (1)	*<1%	0.2%	0 0%	34 1.3%
Severe Harm October 2011 – March 2012	0.2% (4)	*<1%	0.6%	1 0%	80 3%
Death October 2011 – March 2012	0.0% (0)	*<1%	0.2%	0 0%	14 0.6%

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

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

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

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

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

- Quarterly Governance Reports
- Trust wide safety alerts and notifications
- Safety briefings in clinical areas
- Trust wide Risky Business Newsletter
- Amendments to policy

2.3.9 Friends and Family Test – Patient.

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

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

A review of the FFT was published in July 2014 and made a number of recommendations. The FFT Review suggested that the presentation of the data should move away from using the Net Promoter Score (NPS) as a headline score and use an alternative measure. In line with this recommendation the NHS England statistical publication has moved to using the percentage of respondents that would recommend / wouldn't recommend the service in place of the NPS.

During the reporting period 1st April 2014 until 31st March 2015 the trust performed above average in comparison with scores for England for inpatient Friends and Family. A comparison of Accident and Emergency data against national average reveals that with the introduction of the new scoring system that the A&E performance has substantially improved and indicates scores in line with or slightly under the England rate.

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

Continued development and monitoring of Always Events for 2015/2016

Ensuring lessons learned from complaints take place

Undertaking local patient surveys, developing and implementing actions

Monitoring via DAWES and patient experience indicators and make changes as required.

This indicator is new and not a statutory requirement for 2014/2015.

Friends and Family Net Promoter 2013/2015 (NHS England)

Month	Trust - Inpatient	England - Inpatient	Trust – A&E	England – A&E	Trust - Combined	England - Combined
April 2014	76	73	42	55	*	*
May	74	73	35	54	*	*
June	81	73	41	53	*	*
July	76	73	40	53	*	*
August	77 (95%)	73 (94%)	45 (80%)	57 (87%)	*	*
September	94%	93%	82%	86%	*	*
October	95%	94%	85%	87%	*	*
November	97%	95%	87%	87%	*	*
December	96%	95%	84%	86%	*	*

January	96%	94%	87%	88%	*	*
February	97%	95%	84%	88%	*	*
March 2015	96%	95%	83%	87%	*	*
April 2013	80	71	63	49	76	63
May	76	72	52	55	73	65
June	80	72	54	54	73	64
July	76	70	56	54	70	63
August	76	71	20	56	58	64
September	77	71	46	52	60	62
October	82	71	48	55	63	64
November	75	72	42	56	58	64
December	71	71	35	56	53	64
January	78	72	42	57	60	64
February	81	72	45	55	69	63
March 2014	79	72	39	54	*	*

NB: England data includes independent sector providers April – June 2013, from July the independent sector is excluded.
*** Trust and England combined score is no longer published**

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

Our primary objective is the safety of our patients.

Quality Report Part 3 - Trust Overview of Quality

3.1 Introduction - Patient Safety, Clinical Effectiveness & Patient Experience

Our aim is to be a learning organisation that consistently transforms practice by learning from both our mistakes and those of others in order to provide the best possible health care.

Our Quality Strategy consolidates this approach by defining the combination of structures and processes at and below Board level to lead on trust-wide quality performance to ensure that required standards are achieved. This will be supported and achieved via MONITOR's Quality Governance approach by:

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

This strategy establishes and defines the Darzi committee structure which will be a new approach to managing quality within the trust. The strategy also defines the priorities for quality improvement and sets realistic, measurable goals. This includes measurable reductions in pressure ulcers; catheter acquired urinary tract infections; falls; mortality ratios and hospital acquired infections. It also specifies improvements in compliance with risk assessments; advancing quality measures; complaints responses and always events. It identifies the risks to quality and the steps needed to mitigate these risks; and sets out the vision for quality in a way that engages staff, patients and the local community.

The quality of patient care and the safe, effective manner in which it is provided is the core business of the NHS, and our organisation strives to provide the best possible care in order to remain a sustainable health provider of choice. The delivery of high quality services, together with the ability to demonstrate a programme of continuous service improvement, is seen as one of the most important indicators of a successful health care organisation

The development of QPS provides the trust with a framework to ensure the future quality and sustainability of our services and the development of our workforce.

QPS Framework

QUALITY		PEOPLE		SUSTAINABILITY	
SAFETY	-We will reduce harm -We will have no avoidable deaths -We will manage and reduce risk	WORKFORCE	-We will develop the competency of all our staff and provide them in the right numbers -We will be 'European Working Time Directive' compliant -We will support our staff to be 'fit and well' to work -We will continually review the Terms and Conditions of our staff	GOOD GOVERNANCE	-We will be complaint across all areas of regulation -We will provide robust assurance to our board of directors -We will be an effective board of directors -We will develop and encourage our Governors and members
EFFECTIVENESS	-We will improve clinical outcomes -We will use evidence based practice -We will support research and development, audit and innovation -We will deliver right care in the right place and at the right time	ENGAGEMENT	-We will communicate with all our staff -We expect all our staff to take accountability -We aim to be the employer of choice -We encourage staff loyalty and recognise their discretionary effort	FINANCIAL VIABILITY	-We will agree robust contracts for services -We will develop service line management -We will review how we use our estate -We will look to collaborative working with other healthcare providers -We will invest in IT to support innovative working
EXPERIENCE	-We will have an ethos of good customer care and personalisation -We will support 'No Decision About Me, Without Me' -We will get 'the basics' right (warm, safe, clean, fed, cared for)	LEADERSHIP	-We will develop and reward talent -We will support the development of good leaders and role models -We will invest in education, training and development	PROFILE AND PERCEPTIONS	-We will be a good corporate citizen -We will effectively market our services and look to grow and develop commercially for strategic advantage -We will pursue the collection of charitable funds to support our development and enhance patient care.

It is vital that we are able to provide assurance that national and local clinical and quality requirements have been identified and processes and systems are in place to implement and monitor quality within the trust. We do this by:

- Obtaining assurance that the trust is well managed and compliant with regulatory requirements including compliance with the Care Quality Commission standards and with Monitors Quality Governance Framework
- Making quality and quality improvement a core responsibility for and owned by all staff and ensuring that they are supported to fulfil this role
- Continuous improvement of patients' experience, safety and outcomes
- Reducing the risk from clinical errors and adverse events, as well as being committed to learning from mistakes and importantly sharing the learning across the trust
- Ensuring that patients receive the right treatment, at the right time, in the right place, have their individual needs taken into account and be treated/cared for in a safe environment taking into account best practice
- Implementing quality standards and pathways - responding to the needs of patients and users as individuals and using best practice and evidence based care to deliver a personal service. For example, supporting people who are at the end of their life to die where they wish and ensuring when patients with dementia are cared for in our hospitals we provide an environment that reflects their specific care and well-being needs
- Supporting staff in their training and development, through appraisal, revalidation, and personal development plans, to ensure they are equipped to deliver high quality health care
- Meeting all the requirements of both national and local CQuINs
- Ensure participation in national and local clinical audit which is now a statutory and contractual requirement for healthcare providers

- Ensuring a patient centred and patient led approach to care that includes treating patients courteously, involving them in decisions about their care and embracing the principle of shared decision making. (Liberating the NHS: No decision about me without me – DoH 2010).

Quality is the golden thread that must run through all of our services, business plans and objectives. As we aim to be the most clinically and financially successful healthcare provider in the mid-Mersey region by 2019 we must clearly articulate what this means for the trust and ensure that this is communicated to and developed in partnership with our staff, patients and key stakeholders.

Quality has three main elements: patient safety, clinical effectiveness and patient experience (Darzi Report, High Quality Care for All: June 2008). High quality organisations are safe, effective, person centred, timely, efficient and equitable. The trust has restructured the committees in line with this approach to ensure that we provide an equal balance and assurance on all aspects of quality within the organisation and that we can measure and improve quality at all levels and throughout all areas of the trust.

The trust will ensure that we develop and integrate these tools and processes into the quality agenda to ensure a sophisticated whole systems approach. This will include and not be exclusive to an internal annual review of our systems and processes using both the Quality Governance Framework and the CQC Outcome framework. We will also instruct our internal auditors to undertake a whole systems audit of quality in order to provide assurance that systems are in place to address national and local clinical and quality requirements to ascertain if they are fit for purpose.

We have also since 2013 made a commitment to publish a set of patient outcomes; patient experience and staff experience measures so that patients and the public can see how we are performing in these areas. This includes regular publication of numbers of patients who develop pressure ulcers and patients that fall while in hospital. This combines the results from the Friends and Family Test, the NHS Safety Thermometer, patient and staff experience surveys, patient stories, staffing levels and never events all in one place, to not only build up a picture of care quality but also of an excellent and open reporting culture. The Open and Honest Reports for this trust can be found at:-

- https://www.warringtonandhaltonhospitals.nhs.uk/page.asp?fldArea=1&fldMenu=8&fldSubMenu=7&fldKey=1241

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

3.1.1 Data Sources

Throughout 2014/2015 we have continued to develop our quality indicators which are used to evaluate the quality of our service. These indicators are monitored and reported via a monthly 'Quality Dashboard' through the wider committees and to the trust board to provide assurance on progress and improvements made in the areas of patient safety, clinical effectiveness and patient experience. We know how important it is to patients, their families and carers that when they have to come in to hospital that they are going to receive the best possible care. We know they want their care to be delivered in a clean and welcoming environment, where they feel safe and free from harm, so we try to ensure that these issues have been captured within our quality indicators.

The information is collated from, whenever possible, sources which can be benchmarked with other organisations in order to indicate the trust's performance in relation to others. Indicators allow organisations to measure and benchmark progress toward goals and the trust submits and utilises data from the Health and Social Care Information Centre (HSCIC). The HSCIC collates analyses and

publishes NHS data on over a thousand indicators for everything from quality to population health and outcomes of treatments. This includes measures such as Patient Reported Outcome Measures (PROMs) in England whereby patients undergoing elective inpatient surgery for four common elective procedures (hip and knee replacement, varicose vein surgery and groin hernia surgery) funded by the English NHS are asked to complete questionnaires before and after their operations to assess their perceived improvement in health.

The trust also subscribes to datix, which is web-based patient safety software for healthcare risk management. It delivers the following safety, risk and governance modules which enable the trust to have a comprehensive oversight of our risk management activities:

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

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

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

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

Where available comparative and benchmark data has been included and unless otherwise stated the indicators are not governed by standard national definitions and the source of the data is the trust's local systems.

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

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

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

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

good data quality systems in place to deliver that data and a culture that supports ethics and candour.

To support this process the Director of Nursing and Organisational Development requested our internal auditors MIAA undertake a review of the trusts quality framework. This work began within the reporting year and will continue into 2015/2016.

3.1.3. Quality Dashboard 2014/2015

The information on this Quality Dashboard is also shared with our Governors and commissioners of services to demonstrate how care for patients is delivered and sustained improvements are maintained. Within year we have undertaken a review of the Quality Dashboard and aligned it to a range of quality initiatives including CQUINs; improvement priorities; quality contract; Monitor; CQC and operating framework. The Quality Dashboard is produced with the caveat that the data for some of indicators can change month on month. This applies to incidents (including pressure ulcers and falls), as incident type and severity can alter once reviewed, complaints and concerns as complaints can become concerns (and vice versa), with the agreement of complainants, and to mortality data which is rebased. These changes are always articulated in the exceptions reports.

This ensures that the board receives monthly information including exceptions reports on all key quality indicators.

	Threshold	IC	A	M	J	Q1	J	A	S	Q2	O	N	D	Q3	J	F	M	Q4	YTD
Intelligent Monitoring																			
Banding March 14 = 5	Not set						3						5		CQC Inspection				
Number of elevated risks March 2014 = 1	Not set						2						1		CQC Inspection				
Number of risks March 2014 = 4	Not set						5						3		CQC Inspection				
Safety																			
Mortality																			
HSMR (12 month rolling)	<=100 = G, As expected = A, Higher than expected = R	QI, IP, QC	98	98	98		98	98	99		101	102	105		107				107
SHMI (12 month rolling)	<=100 = G, As expected = A, Higher than expected = R	QI, IP, QC	109	110	110		110	112	111		112	112	115						115
Total deaths in hospital	Not set		99	89	76	264	74	81	97	252	95	80	133	308	136	84	89	309	1133
Regulation 28 - Prevention of future deaths report	Not set		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Incidents resulting in Moderate, Major or Catastrophic harm																			
Incidents resulting in moderate, major or catastrophic harm	TBC	QC	6	9	6	21	4	5	9	18	6	7	7	20	1	1	0	2	61
Incidents of moderate, major or catastrophic harm under investigation	N/A		1	0	2	3	0	0	2	2	1	0	10	11	7	21	38	66	82

	Threshold	IC	A	M	J	Q1	J	A	S	Q2	O	N	D	Q3	J	F	M	Q4	YTD
Falls																			
All falls (approved)	Not set		91	78	87	256	88	76	79	243	71	68	91	230	69	77	86	232	961
Moderate, major and catastrophic harm falls (approved)	<=13 per year	IP	1	3	2	6	1	2	3	6	0	4	0	4	0	0	0	0	16
Moderate, major and catastrophic harm falls (awaiting approval)	N/A		0	0	0	0	0	0	0	0	0	0	2	2	4	2	1	7	9
Major and catastrophic harm falls (approved)	<=2 per year	QC	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Pressure Ulcers																			
Grade 3 and 4 Hospital Acquired (Avoidable)	<=6 per year	IP	1	1	0	2	0	0	0	0	2	0	0	2	0	1	0	1	5
Grade 3 and 4 Hospital Acquired (Unavoidable)	<=10	QC	0	0	0	0	1	0	2	3	0	0	1	1	0	0	0	0	4
Grade 3 and 4 Hospital Acquired (Under review)	N/A		0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1
Grade 2 Hospital Acquired	<=101 per year	IP	3	8	2	13	11	3	3	17	9	5	8	22	7	3	4	14	66
Grade 2 Hospital Acquired – stretch target	<=90 per year	IP	3	8	2	13	11	3	3	17	9	5	8	22	7	3	4	14	66

(20% reduction)																			
	Threshold	**IC**	**A**	**M**	**J**	**Q1**	**J**	**A**	**S**	**Q2**	**O**	**N**	**D**	**Q3**	**J**	**F**	**M**	**Q4**	**YTD**
Grade 2 Hospital Acquired (under review)	N/A		0	0	0	0	0	0	0	0	0	0	0	0	0	2	1	3	3
% RCA / mini investigation completed	100%	IP	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
% of patients with a pressure ulcer (Community or hospital acquired) (ST)	<=3.99% (November 2014 – March 2015) (median YTD)	C	4.92	3.07 amended	3.73		3.37	5.63 amended	4.95		4.34	5.90	4.65		3.60	5.20	4.59		RM 4.62
Health Care Acquired Infections																			
MRSA	0= green, 1-5=amber, >5 red	QC, IP	0	1	0	1	0	0	1	1	0	0	1	1	0	0	0	0	3
Clostridium difficile	<=26 per year	QC, IP	2	3	2	7	1	7	1	9	3	1	3	7	1	2	5	8	31
MSSA	Not set		1	0	1	2	1	0	0	1	1	1	2	4	2	2	1	5	12
Out of hours transfers	TBC	BK	1	2	5	8	1	5	1	7	3	0	7	10	3	3	1	7	32
Never Events	0 per year	QC	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Number of cardiac arrests in hospital wards, outside A&E, Theatres, CCU and ICU'.	Annual: <75 = G 75 – 85 = A >85 = Red	QC	8	11	7	26	3	11	6	22	5	7	13	25	12	5	6	23	96
Medicines Safety Thermometer % harm free (ST)	TBC	IP	PILOT	PILOT	PILOT		PILOT	PILOT	98.3		99.2	97.4	99.2		Quarterly Reporting	Quarterly Reporting			

	Threshold	**IC**	**A**	**M**	**J**	**Q1**	**J**	**A**	**S**	**Q2**	**O**	**N**	**D**	**Q3**	**J**	**F**	**M**	**Q4**	**YTD**
VTE																			
% of patients risk assessed	>=95%	QC	95.55	95.92	95.61		95.33	95.30	95.31		95.64	95.91	95.47		95.27	96.83	92.59*		
% of eligible patients having prophylaxis (ST)	100%	QC	92	99.8	93		100	99.6	100		100	100	100		99.83	100	100		
Number of patients who developed a HA VTE	Baseline TBC	QC	7	8	5	20	12	4	3	19	6	4	1	11	Delay due to late coding	Delay due to late coding			50
Number of patients who developed a HA VTE (under review)			0	0	1	1	1	5	4	10	8	2	4	14	2	6			33
% free from harm (ST)		OH	97.3	99.2	97.8		98	96.4	98		97.4	96.5	98		97.2	96.6	98.4		
Catheter Acquired Urinary Tract Infections																			
CA – UTI: Number of catheterised patients who developed a UTI (ST)	<=3 per month <=36 annual	IP	4	2	2	8	2	4	5	11	0	5	1	6	2	2	2	6	31
CA – UTI % of catheterised patients who developed a UTI (ST)	<=0.6% each month	IP	0.76	0.38	0.39		0.40	0.89	0.99		0	0.92	0.19		0.34	0.40	0.36		
Dementia																			
Dementia Assessment % (Part 1)	>=90%	C	94.55	95.69	95.43*		94.26	96.59	92.45		92.70	96.61	96.29		96.93	94.81	97.17		
Dementia Assessment % (Part	>=90%	C	100	100	100*		100	100	91.89		100	100	97.22		96.77	100	95		

2)	Threshold	IC	A	M	J	Q1	J	A	S	Q2	O	N	D	Q3	J	F	M	Q4	YTD
Dementia Assessment % (Part 3)	>=90%	C	100	100	100*		100	100	100		100	100	100		100	100	100		
Care Indicators																			
Falls - risk assessment % compliance	>=95%	IP	100	95	95	96.6	98.8	98.9	98	98.7	99	98	99	97	90	100	99.3	96.3	
Waterlow - risk assessment % compliance	>=95%	IP	98	92.7	88.3	93	95.6	93.3	83	90.6	96	98	100	95	91	100	99.3	95.6	
MUST - risk assessment measures	>=95%	IP	57.2	59.4	60	58.9	81.6	71.1	75	75.9	83	83	94	77	60	81.8	93.3	80	
Effectiveness																			
Advancing Quality % compliance (cumulative scores)																			
Acute MI	>=95%	IP, C	100	98.4	98.9		98.4	98.8	99		98.37	97.90	98.15						98.15
Hip and Knee	>=95%	IP, C	95.2	96.5	95		96.4	96.7	96.9		97.23	97.57	97.44						97.44
Heart failure	>=90.2%	IP, C	100	90.9	87.9		83.1	84.3	83.7		84.31	81.42	82.21						81.21
Pneumonia	>=73.9%	IP, C	68.6	72.8	74.4		75.1	76.1	75.2		74.66	73.36	73.85						73.85
Stroke	>=60.4%	IP, C	69.7	61.4	57		58.3	60	60.7		61.76	61.30	58.98						58.98
COPD (data not yet released)	>=50%	IP, C						PILOT	PILOT										
Patient Reported Outcome Measures (PROMS)																			
Hip replacement (Average health gain)	0.44 (latest England average Mar 2014)	IP,QC		Still provisional data													0.41		0.41
Knee replacement (Average health gain)	0.32 (latest England average Mar 2014)	IP,QC		Still provisional data													0.34		0.34
Groin surgery (Average health gain)	0.085 (latest England average Mar 2014)	IP,QC		Still provisional data													0.065		0.065

	Threshold	IC	A	M	J	Q1	J	A	S	Q2	O	N	D	Q3	J	F	M	Q4	YTD
Patient Experience																			
Always events (Q1&2 implementation, Q3 data collection)	% completed TBC	IP									84	100	100		100	100	100	100	
Mixed sex occurrences	0	QC	6	3	0	9	0	0	0	0	0	0	5	5	3	6	1	10	24
Friends and family (F&F) test (patients' views)																			
F&F Test. **Star rating**	TBC		4.54	4.5	4.58		4.53	4.6	4.58		4.6	4.61	4.59		4.59	4.55	4.61		
F&F Test Inpatients **Net promoter changed to % recommending Trust – November 2014.**	>=95% (National average changes each month including independent)	OH	76	74	81		76	77	94		95	97	96		96	97			
F&F Test A&E **Net promoter changed to % recommending Trust – November 2014.**	>=88% (National average changes each month)	OH	42	35	41		40	45	82		85	87	84		87	84			
F&F response rate (A&E)	Q1 – >=15% Q4 - >=20%	C	23.08	18.52	20.79	20.75	19.55	17.58	14.51	17.26	13.57	17.86	16.48	15.93	19.74	23.61	22.09	21.80	18.90
F&F response rate (inpatients)	Q1 – >=25% Q4 - >=30% March 2015 achieve >=40%	C	27.32	26.83	34.62	29.55	32.20	30.02	26.39	29.55	32.85	30.99	28.44	30.77	26.69	33.04	40.50	33.28	30.73
Friends and family test (staff views)																			
Staff friends and family question (needing care) (Extremely likely and likely responses from F&F quarterly staff survey)	TBC Q3 Staff survey results. Last year = 65	C				70.9				72				STAFF SURVEY 61					

	Threshold	IC	A	M	J	Q1	J	A	S	Q2	O	N	D	Q3					
Staff F&F place to work (as above)	Q3 Staff survey results. Last year = 60					66.8				67				STAFF SURVEY 59					
Complaints and concerns																			
Number of concerns received	Not set	IP	2	10	6	18	17	10	9	36	9	0	7	15	4	11	6	21	91
Number of complaints received **Please see note below.**	2013/2014 received 422 (No threshold set)	IP	31	38	38	107	51	30	29	110	47	29	32	108	40	53	60	153	478
% of complaints resolved within the agreed timescale	>=94%	IP	94.44	95.24	100	96.51	96.88	100	97.5	98.23	97.92	100	100	99.1	100	100	100	100	98.39

ST = Safety Thermometer. This is a survey carried out on one day a month on all wards. The survey provides a point prevalence figure e.g. of the number of inpatients who have a hospital acquired pressure ulcer on that day. The figure is NOT the total number of incidents in the month.

Key: YTD = Year to date, ST = Safety Thermometer (monthly point prevalence survey), IC = Inclusion criteria
Inclusion criteria key: Improvement priority (IP), National Quality related CQUINs (C), Local quality related CQUINs by exception* (CE), Quality Account indicators (QI), CQC Intelligent Monitoring quality related 'Elevated risks' and 'risks'(CQC), National Patient Safety Priorities (related to Sign up to Safety campaign) (SS), Contract KPIs (Quality section only) not considered at other forums (QC), Directive from Sir Bruce Keogh (BK), Open and Honest (OH)

3.1.4 Quality Indicators – rationale for inclusion

The following section provides an overview of the quality of care offered by the trust based on performance in 2014/15 against a minimum of 3 indicators for each area of quality namely patient safety; clinical effectiveness and patient experience. These indicators were selected by the board in consultation with stakeholders and discussions with the Quality in Care Committee of the Council of Governors. In the main, the trust has utilised indicators which are deemed to be both locally and nationally of importance to the interests and requirements of patients. The overall purpose of this information is to inform the organisation of its effectiveness and performance and to lead it in a direction of improvement by indicating specific issues/areas that need to be developed.

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

Where these indicators have changed from the indicators used in our 2013/2014 report, we have outlined the rationale for why these indicators have changed and where the quality indicators are the same as those used in the 2013/2014 report and refer to historical data, we have checked the data to ensure consistency with the 2014/2015 report.

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

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

The quality indicators for 2014/15 include:

Safety

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

Clinical Effectiveness

- SHMI & HSMR
- Dementia
- PROMS
- Advancing Quality

Patient Experience

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

3.2 Patient Safety

3.2.1 Infection Control

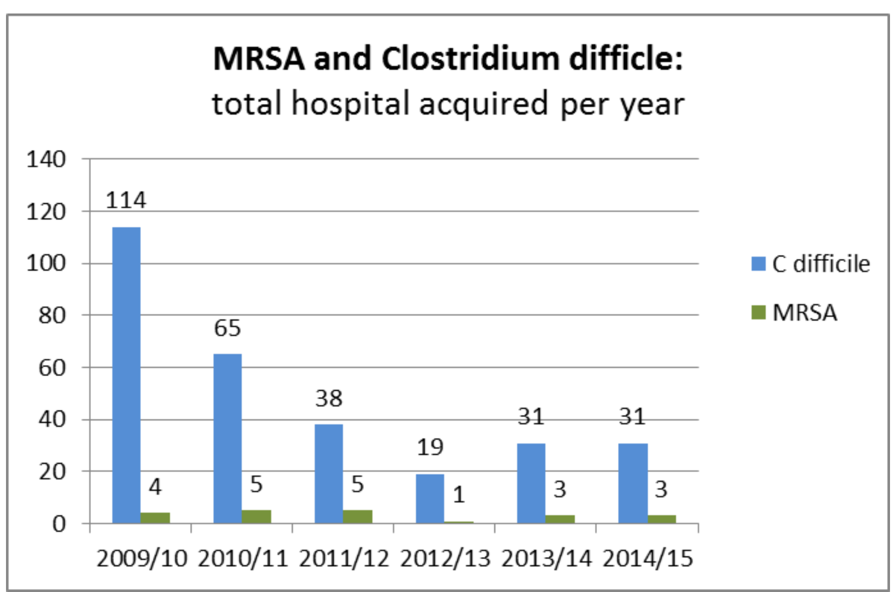
Healthcare associated infections (HCAIs) are infections that are acquired as a result of healthcare interventions. There are a number of factors that can increase a patient's risk of acquiring an infection, but high standards of infection control practice reduce this risk. Although hospital acquired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

During 2014/2015, the trust threshold was 0 cases of MRSA, the trust reported 3 cases of hospital acquired MRSA bloodstream infection compared to 3 hospital acquired case and 1 MRSA contaminant in 2013/2014. During 2014/2015 the trust reported 31 cases of hospital acquired Clostridium difficile infections against a threshold of 26 cases. This is the same number of cases as for 2013/2014.

Despite the continued focus on managing processes to reduce HCAI during 2014/2015 the trust has been unable to achieve its threshold for MRSA and Clostridium difficile. Initiatives maintained/implemented this year included but not limited to were:

- Action plans in place to reduce MRSA and Clostridium difficile
- Health Economy Clostridium difficile action group – audits of primary care prescribing for long-term UTI prophylaxis
- Participation in European Antibiotic Awareness Day
- Changes to methods of investigation for Clostridium difficile cases
- Surveillance of cases/monitoring for increased incidences in defined locations

- Cohort facility maintained
- Antimicrobial steering group
- Revision of the Antibiotic Formulary
- Ward based training for management of infectious diarrhoea, viral gastroenteritis outbreaks and use of personal protective equipment
- Weekly multi-disciplinary team review of *Clostridium difficile* patients
- Guidance on sampling published



The data for this indicator is from a nationally prescribed data set, the indicator is monitored via the corporate performance report and the Quality Dashboard. The trust will continue to monitor HCAI as a quality indicator for 2015/2016.

3.2.1.1 MSSA – Reduction on ICU

The trust was identified as an outlier for methicillin sensitive ***Staphylococcus aureus*** *(*MSSA) bacteraemia cases (higher than the average rate) both nationally and in the northwest region during 2012/2013. This outlier position continued into the start of this financial year.

Local surveillance identified that cases were occurring in a variety of clinical locations with a higher incidence in the adult Intensive Care Unit (ICU). The following improvement actions were implemented and an overall decrease was noted in the number of Trust apportioned cases being reported. These actions included:-

- documentation sheet for blood culture sampling introduced and safety alert circulated (9th July 2013)
- maximum barrier sterile precautions for central IV line insertions in ICU confirmed
- review of MSSA colonisation status ICU patients. All MSSA bacteraemia cases (except 1) were MSSA colonised at time of ICU admission
- MSSA ICU admission screening introduced 16th September 2013
- suppression therapy prescribed for patients colonised with MSSA
- antibiotic prophylaxis advised if MSSA colonised patients require invasive procedures (e.g. tracheostomy insertion)
- decision making procedure for insertion of tracheostomy reviewed (dictated by clinical condition of the patient)
- ventilator associated pneumonia (VAP) audit tool reviewed and revised

Between April 2013 and February 2014 (11 month period) the Trust reported 42 MSSA bacteraemia cases, 17 of which are apportioned to this Trust. This compares favourably to the previous financial year (12 month period) where 46 cases were reported, 26 of which were attributed to the Trust.

The Trust's rate fell from 17.87 per 100,000 bed days (April - June 2013) to 5.96 per 100,000 bed days (July - September). This rate was maintained in October to December 2013. The rate per 100,000 bed days for January – February 2014 is unavailable at the time of writing this report.

Despite this overall downward trend in rate and fall in overall reported cases, an increase in cases reported by ICU has occurred compared to the previous financial year. For the 11 month period, year to date, 10 cases have been reported by ICU, compared to 7 cases for the preceding financial year.

All MSSA bacteraemia cases are investigated using the National Patient Safety Agency's (NPSA) root cause analysis (RCA) tool kit. The current root cause analysis investigation method often identifies risk factors and not necessarily root causes. The Infection Control Team worked in partnership with ICU colleagues to review the number of cases arising within this department and following a review of RCA findings, 3 of the cases were excluded from acquisition on ICU. Following exclusion of these cases from ICU acquisition, the numbers of cases arising in ICU has remained constant for the last 2 years (i.e. 7 cases). This is despite improvement measures being introduced e.g. MSSA admission screening and provision of suppression therapy to colonised patients.

Some persistent themes emerge from the RCA investigations in relation to documentation of line insertion and insertion site monitoring. This aspect of IV device management is audited monthly.

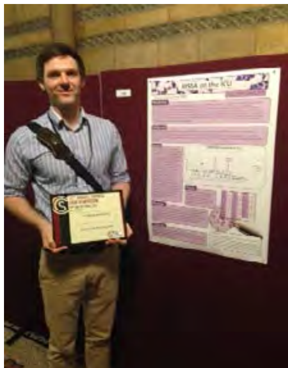
An updated systematic review, EPIC 3 (2013) has been published which includes 'new' recommendations for infection prevention and control practices. As a result of this the following actions took place:

- The root cause analysis process has been reviewed. MSSA bacteraemia cases will be investigated using an adapted version of the methicillin resistant *Staphylococcus aureus (*MRSA) bacteraemia post infection review toolkit
- A further review meeting with ICU is scheduled for March 2014
- The MSSA action plan is updated quarterly
- Divisional Governance Managers have been advised of non-completion of Datix reports and a summary of incidents provided
- Healthcare associate infection incidents has been added as an agenda item (quarterly) at the Divisional Governance Meetings
- Assurance has been requested from the Divisional Governance Managers that all Action Plans arising from these incidents have been completed and signed off

After reviewing governance arrangements and findings of RCA investigations, the following recommended actions were made:

- Review the effectiveness of MSSA screening and suppression therapy for MSSA colonised patients
- Ensure MSSA bacteraemia case investigation is supported by the clinical team to facilitate identification of (a) root cause(s)
- Where audits identify lower compliance with invasive device management, rapid improvements will be requested to alter focus from auditing performance to auditing for improvement
- Seek alternative positioning of invasive devices for non-compliant patients
- Seek improvements to medical engagement by notifying the Divisional Medical Director of cases in addition to the patient's consultant

- Feedback on findings from MSSA bacteraemia investigations are provided to the Infection Control Sub-Committee
- Analysis is required to ensure the 'new' recommendations in EPIC 3 are considered against evidence to support their effectiveness and implemented where appropriate.



Nick Lower receiving the award for the best poster presentation at the 12th Annual Critical Care Symposium

Conclusion

The rate per 100,000 bed days and region/national position cannot be relied on as a sole indicator of performance. Local surveillance of MSSA bacteraemia cases will continue and governance will be strengthened by use of Datix reporting and review of Action Plans by the Divisional Governance Groups.

The trust is pleased to report that work undertaken around reducing cases MSSA specifically on the ICU has resulted in Jerome McCann Consultant-Anaesthetist and the team receiving best poster presentation at the 12th Annual Critical Care Symposium held on in Manchester in April.

3.2.2 Pressure Ulcers

As previously stated in section 2 the trust continued to focus on the management and reduction of pressure ulcers as an improvement priority for 2014/2015. The Prevention and Treatment of Pressure Ulcers (NICE Clinical Guideline 29; 2005) offers best practice advice on the care of adults and children with pressure ulcers. This trust has ensured that our current Pressure Ulcer Management Policy is aligned to and complies with the NICE Guidance recommendations.

The trust has strengthened a number of processes and sees a strong focus on early patient assessment and the documentation of the patient's skin condition on admission as essential to good practice. This is in line with the NICE Guidance and critical to the prevention of pressure ulcers.

The Waterlow risk assessment tool and management plan is used for all patients who are admitted to the hospital. The nursing documentation triggers the need to record skin condition on admission to hospital. The patient care plans promote the need to monitor and record skin condition, with additional specific plans put in place if a patient develops a pressure ulcer. Analysis of grade 2 and 3 acquired pressure ulcers reveals the following trends:

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

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

The 471 electric profiling bed frames within the trust also assist in the prevention of pressure ulcers. The Phase 111 Mattress Replacement system includes the latest in innovative features to help deliver the optimum in patient and pressure care for both the treatment and prevention of pressure ulcers. Importantly they are recommended for patients who are deemed at a very high risk of developing pressure ulcers. The Tissue Viability Team also offers advice on specialist equipment for

example in relation to bariatric patients (patients with an increased body weight or size) who are at a particular risk and require a collaborative approach to assessment of equipment needs.

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

Pressure ulcers are logged onto DATIX and the Tissue Viability team are notified and a review of the patient undertaken. The ward manager is informed so that a root cause analysis is commenced. This must be completed and presented to the Deputy Director of Nursing and Tissue Viability Nurse at the given date and time. After an investigation a hospital acquired pressure ulcer can be deemed to be either avoidable or unavoidable:

> **Avoidable Pressure Ulcer:** "Avoidable" means that the person receiving care developed a pressure ulcer and the provider of care did not do one of the following: evaluate the person's clinical condition and pressure ulcer risk factors; plan and implement interventions that are consistent with the persons needs and goals, and recognised standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate."
>
> **Unavoidable Pressure Ulcer**: "Unavoidable" means that the person receiving care developed a pressure ulcer even though the provider of the care had evaluated the person's clinical condition and pressure ulcer risk factors; planned and implemented interventions that are consistent with the persons needs and goals; and recognised standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate; or the individual person refused to adhere to prevention strategies in spite of education of the consequences of non-adherence"

During 2014/2015 the trust reported 4 unavoidable pressure ulcers against a threshold of <=10 which was established as part of the requirements of the Quality Contract.

For 2013/2014 we established a 10% reduction on the previous year for all grades as such our 10% threshold for grade 3 & 4 avoidable pressure ulcers acquired within the hospital was 16. During 2013/2014 we had 6 confirmed grade 3 avoidable hospital acquired pressures and no grade 4 pressure ulcers which represented a 67% reduction on 2012/2013. Our threshold for all grade 2 pressure ulcers acquired within the hospital was a further 10% reduction against 149 pressure ulcers and during the reporting period we reported 111 hospital acquired grade 2 pressure ulcers.

As stated earlier the trust has achieved its 2014/2015 improvement priority by implementing within year the following changes to further reduce pressure ulcers:-

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

The improvement priority also stated that we would maintain or reduce grade 3 and 4 Hospital Acquired (Avoidable) pressure ulcers at the level reported for 2013/2014, this represented <=6 pressure ulcers of this severity. The trust reports for 2014/2015 that 5 confirmed grade 3 avoidable

pressure ulcers and no avoidable grade 4 occurred during this period with 1 grade 3 pressure ulcer still under review.

The trust also stated that we would aim to reduce hospital acquired grade 2 pressure ulcers by 10% which equated to = <101 cases with an additional stretch threshold of 20% reduction which equates to =<90 cases for 2014/2015. The trust is pleased to report that by year end there have been 66 cases of this severity and a further 5 cases under review which represents a 41% reduction on last year.

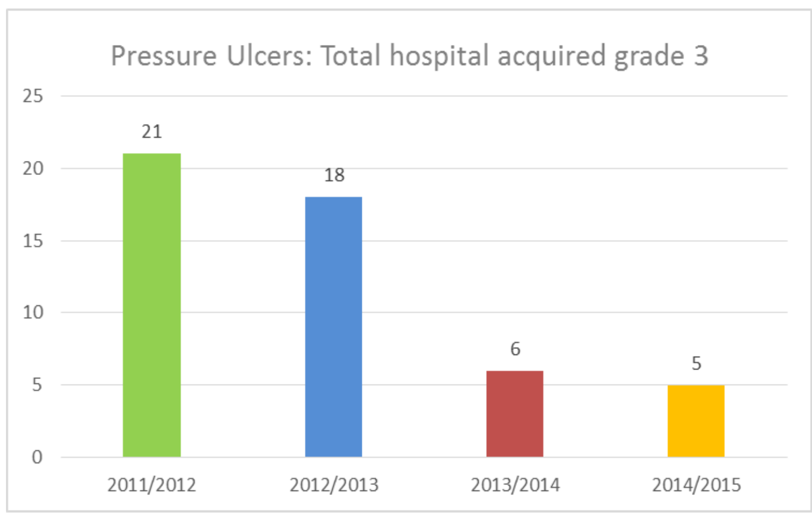
Pressure Ulcer Grade Definitions

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

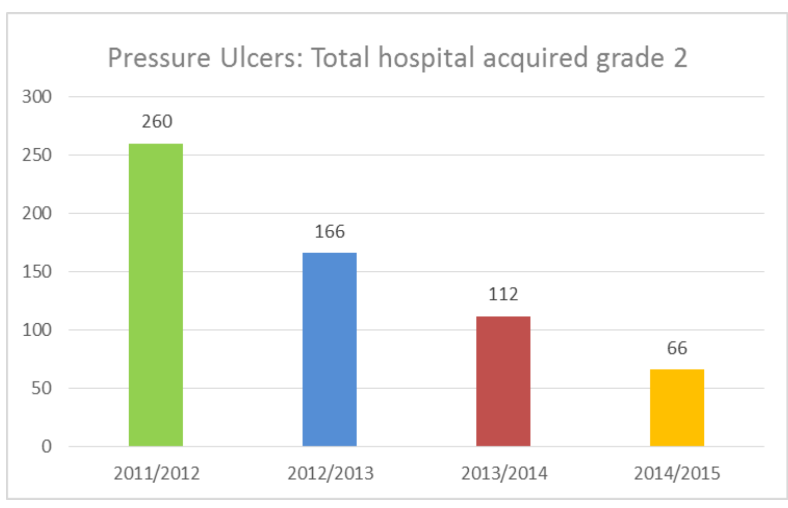
***** Not all pressure ulcers are avoidable; there are situations that render pressure ulcer development unavoidable, including hemodynamic instability that is worsened with physical movement and inability to maintain nutrition and hydration status and the presence of an advanced directive prohibiting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

The trust is pleased to report that the proactive management of pressure ulcers has resulted in a sustained reduction over a four year period as shown by the following graphs.

Pressure Ulcers hospital acquired grade 3: 2011/12 – 2014/2015



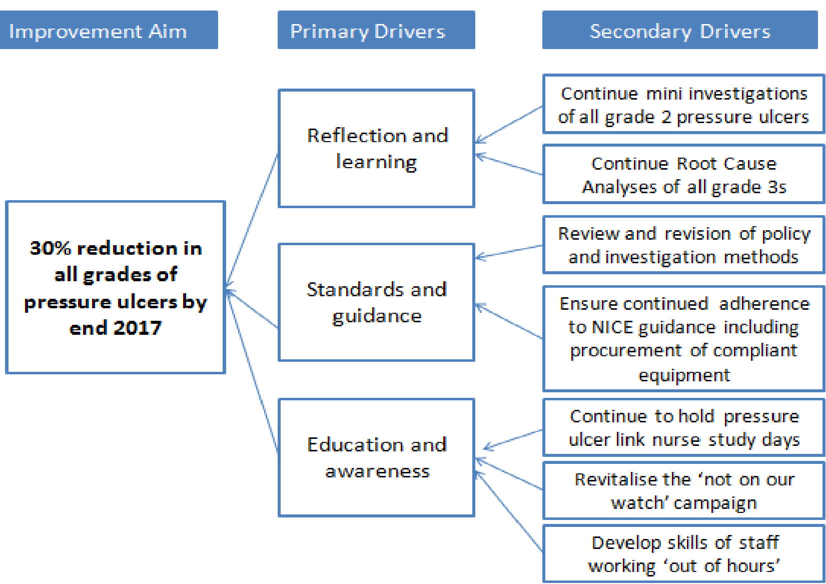
Pressure Ulcers hospital acquired grade 2: 2011/2012 – 2014/2015



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.

During 2014/2015 the trust has also identified pressure ulcers as a Sign up to Safety goal. Sign up to Safety aims to deliver harm free care for every patient, every time, everywhere. It champions openness and honesty and supports everyone to improve the safety of patients. Sign up to Safety's three year objective is to reduce avoidable harm by 50% and save 6,000 lives across the NHS. The driver document articulates the trust's strategy for a 30% reduction in all grades of pressure ulcers by 2017. The trust is pleased to report that it has met this sign up to safety objective for pressure ulcers by the end of year one with a 39.83% reduction in all pressure ulcers.

The trust will continue to monitor pressure ulcers as a quality indicator for 2015/2016.



3.2.2.1 Pressure Ulcer CQUIN

Achieving an improvement on the baseline within the Safety Thermometer for pressure ulcer prevalence was also established as a national CQUIN for 2013/2014.

The first part of this CQUIN related to recording the number of patients recorded as having a category 2-4 pressure ulcer (old – community acquired and new – hospital acquired) as measured using the NHS Safety Thermometer on the day of each monthly survey.

The second part of the CQUIN related to establishing a baseline based on the results of the first six of the year and then showing an improvement on this baseline for pressure ulcer prevalence. The trust established and agreed with commissioners a baseline median of 4.95 from data gathered from the Safety Thermometer for the first six months of the year. We then monitored the rolling median on a monthly basis for the latter half of the 2013/2014 and the trust was pleased to report that for 2013/2014 we achieved a reduction and remained below this figure during this period as follows:

Pressure Ulcer Median Rate 2013/2015

Month	2013/2014	2014/2015
April	5.19	4.92
May	6.04	3.07
June	4.71	3.73
July	3.95	3.37
August	3.83	5.63
September	5.20	4.95
Rolling median	**4.95**	**4.33**
October	3.58	4.34
November	4.13	5.90
December	3.85	4.65
Rolling median		**4.65**
January	4.23	3.60
February	2.81	5.20
March	4.62	4.59
Rolling Median	**3.99**	**4.62**

The Safety Thermometer (pressure ulcer) continued as a national CQUIN for 2014/2015. Trusts were asked to agree a new baseline based on median data from October 2013 to March 2014 which was established and agreed with commissioners at 3.99. We were then required to show an improvement in the period November 2014 to March 2015. Unfortunately when in November and December we did not achieve a threshold of <=3.99, the trust met with the commissioners to explain that we were struggling to achieve the required reduction and an analysis of old to new shows that the high rate is due to old pressure ulcers namely those acquired in the community prior to admission. The trust appreciated that the primary focus of the CQUIN is harm the patient has experienced and not attribution of harm as such we recognised that in order to achieve this CQUIN we would have to push beyond our internal pressure ulcer management to evidence that we are working in partnership across the health economy in order to improve care for patients across organisational boundaries, putting the patient at the centre of patient safety.

The Commissioners agreed that a report outlining community vs hospital acquired; identification of the patients who are admitted from care homes and directly from home and then identified themes for example the pressure ulcer site and the number of patients with long term conditions to be shared with care homes and GP's would support this CQUIN. The trust has submitted the report to the Commissioners who concur that it addresses concerns and its continued work with the community and as such has provided sufficient evidence to achieve the CQUIN.

3.2.3 Falls - Management and Reduction.

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

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

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

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

We recognise the anxiety and distress that in-patient falls cause for both the patient and their family. This can be in the form of physical harm such as broken limbs, but often there is unquantifiable psychological harm done to previously independent people whose confidence is

destroyed for the rest of their lives. We believe that patients should be safe in our care and should be protected from avoidable harm wherever possible.

Our journey to date has been very successful with a 57% reduction in all falls between 2011 and 2014. At the end of this reporting period the trust is pleased to report a further 3.8% reduction in all falls. Importantly we recorded “no harm” in 72% of all falls.

Falls 2013-2015

Patient Slips, Trips & Falls	2013/2014	2014/2015
Q1	251	256
Q2	256	243
Q3	246	230
Q4	246	232
TOTAL	999	961

In 2010 the National Patient Safety Agency (NPSA) “Slips trips and falls data update” stated that acute trusts had requested a benchmark for falls and in response to this a mean rate initially formulated in 2005/6 of 5.6 falls per 1,000 bed days had been provided. However the NPSA cautioned that comparison between organisations may not be particularly helpful for falls prevention and that they would encourage organisations to focus more on improvement over time within their own organisation than on whether the fall rates are higher or lower than in similar organisations. The rationale was based on the fact that firstly, organisations with very low rates may indicate a poor culture of reporting falls rather than robust prevention of falls. Secondly, falls rates will be expected to vary between organisations due to:

- differences in the local population (e.g. hospitals serving towns which are popular retirement spots may have higher rates than hospitals serving a younger inner-city population)
- differences in specialist services (e.g. services focused on rehabilitation or people with dementia are likely to see higher rates)
- reporting culture (i.e. how consistently falls, especially no-harm falls, are reported).

The data in the 2010 NPSA Report showed less variation between extremes than the 2005/06 data; and it was felt that this is likely to reflect more consistent reporting of falls at a local level, and that the current mean rate of 5.6 falls per 1,000 bed days is more likely to be accurate than the 2005/06 rate which was affected by a number of organisations reporting implausibly low numbers of falls.

In 2012 the Royal College of Physicians presented the results of the inpatient falls pilot 2011. This “Report of the 2011 inpatient falls pilot audit” was commissioned by the Healthcare Quality Improvement Partnership (HQIP) as part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP). They stated that there is evidence of substantial variation between hospital service providers in terms of reported falls (indicating variation both in the effectiveness of local inpatient falls prevention and in the effectiveness of current systems for reporting and learning from inpatient falls). In acute hospitals, the average reported rate is 5.6 falls per 1000 bed days, but the rates reported by individual hospitals range from one to ten falls per 1000 bed days. In the absence of any additional benchmarking data the trust has decided to measure its’ falls performance against this mean rate as follows.

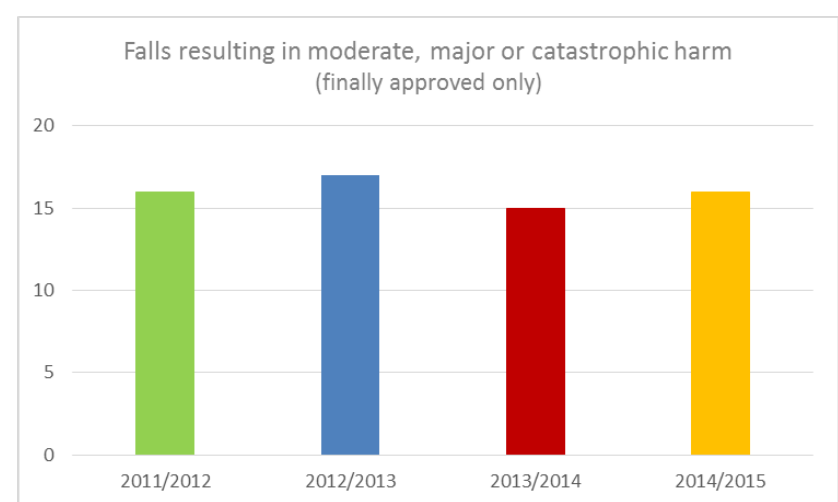
YEAR	BED DAYS	FALLS (ALL)	FALLS PER 1000 BED DAYS	NATIONAL
2011/2012	194018	1610	8.30	5.6
2012/2013	197003	1520	7.72	5.6
2013/2014	186516	999	5.36	5.6
2014/2015	179667	961	5.35	5.6

This data substantiates the assessment that the falls management improvement plan has resulted in both a substantial year on year reduction and in the last two years achieving below the agreed national average across acute trusts.

During 2012/13 our threshold for falls was 18 falls that result in moderate to catastrophic harm, and by the year end we reported 16 moderate harm falls. Whilst the reduction of falls was not an improvement priority for 2013/2014 we remained focussed on improvements and calculated that the trust's new threshold monitored via the quality dashboard should be based on a challenging 10% reduction on 2012/13 thus establishing a threshold of <=14 for this period. We were disappointed that we did not achieve our threshold in that there were 15 approved moderate falls incidents for 2013/2014, importantly no falls resulting in major or catastrophic harm during that period.

As stated earlier our improvement priority for 2014/2015 established a 10% reduction for falls resulting in moderate - catastrophic harm which equates to <=13 falls. Whilst the trust is pleased to report a 3.8% reduction in all falls it is disappointed to report that we had 16 confirmed moderate to catastrophic falls during 2014/2015 (with a further 9 cases awaiting approval) and have thus failed to achieve the threshold.

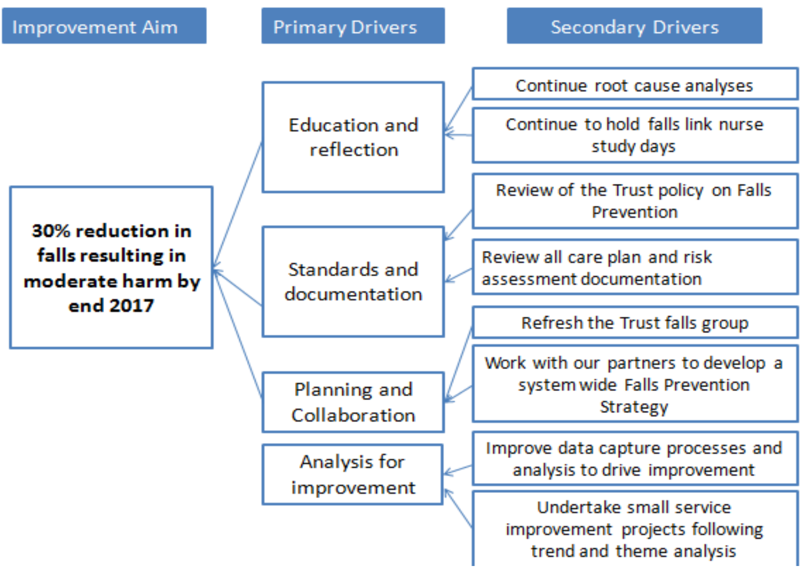
Falls – moderate, major and catastrophic 2011/2012 - 2014/2015



According to NICE a large proportion of inpatient falls are unwitnessed and "found on floor" remains the highest subcategory across our organisation. As such we have implemented initiatives such as bay tagging, commode tagging and 1:1 caring for those patients who are most likely to get up without asking for assistance and risk falling. The number of patients who have been found on the floor this year compared to last has reduced by 36%.

We have monitored falls by ward and noted the most common times that a patient may fall identified to be in the early hours of the morning. Wards have re-examined the activities of staff at that time, as well as at the patterns of night time behaviour for individual patients who are at risk of falling. In addition to this a Safety Walk-round on one of our wards noted that there could be a link

between falls in those patients who were frail and elderly and the timings and type of the night-time beverage. We have researched this thoroughly, and are now planning a project group to try and make improvements in that area.



During 2014/2015 the trust has also identified falls as a Sign up to Safety goal. Sign up to Safety aims to deliver harm free care for every patient, every time, everywhere. It champions openness and honesty and supports everyone to improve the safety of patients. This is something that our trust has been working towards over the last few years. The driver document articulates the trusts strategy for a 30% reduction in moderate falls by 2017.

The trust did agree a 10% reduction in falls where moderate harm occurs by March 2015 for stage one of Sign up to Safety but as with the improvement priority we have failed to reach this threshold. As such we will concentrate efforts and ensure that we address this shortfall in stage two for 2015/2016.

Reduction in all falls and falls resulting in moderate – catastrophic harm will remain an improvement priority for 2015/2016.

3.2.4 Catheter associated urinary tract infections.

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

Considerable work has been undertaken which includes the implementation of CAUTI maintenance bundles to optimize the care of patients who require urinary catheterization during acute care, and to ensure that urinary catheters are removed as soon as clinically indicated. These two high impact interventions are based on expert advice and national infection prevention and control guidance to improve and measure the implementation of these key elements of care.

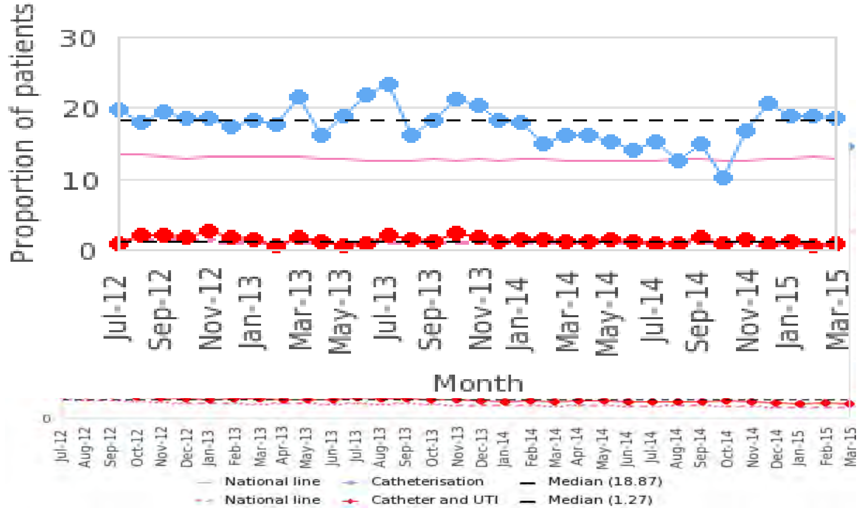
The evidence base shows that the risk of infection reduces when all elements within the clinical process are performed every time and for every patient and that it increases when one or more elements of a procedure are excluded or not performed. Regular audits are undertaken within the trust in order to identify when all elements have been performed; to see where individual elements of care have not been performed and finally it enables us to focus our improvement effort on those elements which are not being consistently performed.

The trust is committed to improving patient care by reducing the incidence of catheter-associated urinary tract infection (CAUTI) it therefore selected this clinical issue as an improvement priority for 2013/2014. This did not continue as an improvement priority for 2014/2015 but the trust believed this to be an important aspect of safety and continued to monitor the CAUTI indicator rates through quality indicators and report it in this 2014/2015 Quality Report.

The trust has been submitting data to the Safety Thermometer since May 2012 so this has allowed us to establish a performance baseline for 2012/2013 data in order to measure any improvement made during 2013/2014 and subsequently 2014/2015.

There is a significant amount of research based practice available especially in relation to care bundles. The analysis of Safety Thermometer data in relation to acute trusts does show that this trust compares favourably in relation to CAUTI as shown by the following graphs.

Warrington and Halton NHS FT rate of CAUTI within the Safety Thermometer (shown by the red line).



Acute Trust (National) rate of CAUTI within the Safety Thermometer (shown by the red line).

However we felt that it was also important to undertake a local trend analysis to identify annual improvement in reducing infections at this trust. We established 3 indicators and extracted data from the Safety Thermometer in relation to the following:-

CA – UTI: Number of catheterised patients who developed a UTI (ST)

CA – UTI % of catheterised patients who developed a UTI (ST)

CAUTI rolling median.

We have now collected the data over a three year period on both the number and percentage of catheterised patients who developed a urinary tract infection.

	CA – UTI: Number of catheterised patients who developed a UTI (ST			CA – UTI % of catheterised patients who developed a UTI (ST)		
	2012/13	2013/14	2014/15	2012/13	2013/14	2014/15
April		6	4		1.11	0.76
May	9	1	2	1.56	0.19	0.38
June	3	4	2	0.47	0.7	0.39
July	5	6	2	0.86	1.13	0.40
August	4	4	4	0.73	0.73	0.89
September	6	5	5	1.10	0.93	0.99
October	4	2	0	0.72	0.38	0
November	5	3	5	0.91	0.56	0.92
December	3	1	1	0.52	0.19	0.19
January	3	3	2	0.51	0.53	0.34
February	2	4	2	0.34	0.75	0.40
March	1	3	2	0.18	0.55	0.36
	45	**42**	**31**	**0.7**	**0.65**	**0.5**

(2012/2013 comparison with 2013/2014 excludes April)

From 2013/2014 these two indicators have been reported via the Quality Dashboard to trust board. A comparison with 2012/2013 data showed a 20% reduction in the actual number of catheterised patients who developed a UTI during 2013/2014. The average percentage of catheterised patients who developed a UTI reduced from 0.7% to 0.65.

For 2014/2015 the trust can report that the actual number of catheterised patients who have developed a UTI has reduced by 26.2% when compared to the same period in 2013/2014. The average percentage of catheterised patients who developed a UTI reduced from 0.65% to 0.5% across the two years.

We then employed a third indicator based on on the actual number of patients with a catheter acquired infection as a percentage of all patients surveyed on that day. We measured this through the rolling median because this is deemed to be a statistically strong methodology which smooth's out short-term fluctuations and highlights longer-term trends or cycles.

The rolling median which was based on data from 2013/2014 was calculated at 3.2. We then monitored this CAUTI data throughout 2014/2015 to ascertain if the median rate had reduced for 2014/2015 and at year end the rate is lower at 2.6 thus confirming a further reduction in catheter acquired infection. Reducing the use of catheters and the development of UTI remains an important issue for the trust and it is agreed that whilst this indicator can be removed as a quality indicator that CAUTI indicators will continue to be monitored via the Patient Safety Committee.

CAUTI – Rolling Median Data 2013/2014 – 2014/2015

MONTH	2013/2014 ACTUAL	2014/2015 ACTUAL	2013/2014 ROLLING MEDIAN	2014/2015 ROLLING MEDIAN
APRIL	6.7*	4.7	6.7*	4.7
MAY	1	2.5	1	3.6
JUNE	3.2	2.8	2.1	2.8
JULY	4.8	2.6	3.2	2.7

AUGUST	4.5	6.3	3.9	2.8
SEPTEMBER	5	6.6	4.5	3.8
OCTOBER	1.8	0	3.9	2.8
NOVEMBER	2.7	5.5	3.2	3.8
DECEMBER	1	0.9	3	2.8
JANUARY	2.9	1.8	2.9	2.7
FEBRUARY	5	2.1	3	2.6
MARCH	3.4	1.9	3.2	2.6

***NB Excluding April data**

3.2.5 Nursing Care Indicators – MUST; Waterlow and Falls

High Quality Care was a local CQUIN for 2013/2014. The care indicators audit was a process which was developed as part of this CQUIN to audit compliance with risk assessments for Falls, Waterlow and MUST Risk Assessments. Reports received throughout 2013/2014 showed exceptional compliance with Falls and Waterlow.

However whilst there was a temporary improvement with compliance to MUST to over 90% in December it dropped below 70% in the last quarter of 2013/2014. The trust identified this as an important aspect of quality of care and thus agreed to continue monitoring as a quality indicator for the Quality Report in 2014/2015.

The threshold was established at >=95% and the Patient Quality & Safety Champion has increased surveillance and feedback around risk assessments in order to improve compliance going forward.

MONTH	FALLS	WATERLOW	MUST
MARCH 2015	99.3	99.3	93.3
FEBRUARY 2015	100	100	81.8
JANUARY 2015	90	91	60
DECEMBER 2014	99	100	94
NOVEMBER 2014	98	98	83
OCTOBER 2014	99	96	83
SEPTEMBER 2014	98	83	75
AUGUST 2014	98.9	93.3	71.1
JULY 2014	98.8	95.6	81.6
JUNE 2014	95	88.3	60
MAY2014	95	92.7	59.4
APRIL 2014	100	98	57.2
MARCH 2014	100%	98%	57.2%
FEBRUARY 2014	91.1%	90.6%	45.5%
JANUARY 2014	100%	93.3%	68.9%
DECEMBER 2013	93.9%	91.6%	90.60%
NOVEMBER 2013	93.3%	82.2%	60.6%
OCTOBER 2013	93%	88%	73.3%
SEPTEMBER 2013	87%	78.20%	65.9%
AUGUST 2013	92.22%	75.56%	62.22%

NB: Monitor sample on a monthly basis 2013/2015

The results (random sample) from January 2015 indicate that all of the risk assessments have dropped below the threshold and specifically the reduction in MUST screening to 60% was a concern. In mitigation the trust is moving from sampling patients to roll out across all wards. These

percentages reflect the position on A1; A2; A3 and C20 as they were the only wards to complete this self-assessment. The Patient Safety Champion formulated a recovery plan to ensure that all the wards participate in the self-assessment and also that completion of risk assessments improve with a specific focus on MUST Risk Assessments. Furthermore, the pressure ulcer RCA tool has been amended to identify if the MUST score was correctly completed on admission; further increasing focus on this important assessment. February and March compliance rates show an overall improvement across all risk assessments which the trust will continue to monitor to board via the quality dashboard for 2015/2016.

The nursing care indicators will continue to be monitored as a quality indicator throughout 2015/2016.

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

During 2012/2013 the trust targeted improvements in relation to the reduction of medicine errors. Nationally there is a long history of medication errors associated with the use of insulin so we established a threshold of a 10% reduction in medication errors based on data from Quarter 1 and Quarter 2 2012/2013.

The trust also saw an increase in the reporting of clinical incidents involving insulin during 2012/2013 which it felt was due to both an addition of an insulin tick box within the datix incident reporting system and increased awareness of the need to report.

We reported 57 insulin related incidents in 2012/2013 and established an improvement target of a further 5% reduction namely <=54 incidents for 2013/2014. This patient safety indicator was included on the Quality Dashboard which is monitored on a monthly basis by the board. Our Diabetic Nurse Specialist team worked hard to support the ward teams in this reduction and the trust was pleased to report that we reduced insulin incidents by 10.5% from 57 cases to 51 cases and therefore exceeded our threshold of a 5% reduction thus achieving this improvement priority for 2013/2014. Whilst a decision was made to discontinue this issue as an improvement priority for 2014/2015, it was agreed that we should include the development and monitoring of medicine indicators including the safety thermometer as a quality indicator for this reporting year.

The medicines management dashboard was created, and reported via the Medicines Safety Committee. The indicators that are included in the dashboard are medicines reconciliation; discharge prescription turnaround time; outpatient prescription turnaround time; discharge prescriptions reviewed on ward; medication incidents resulting in harm; compliance with the antibiotic formulary; performance against medicines related questions in CQC surveys; medicines related complaints; prescribing audit and the pilot of the medicines safety thermometer.

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

As a point of care survey The Medication Safety Thermometer follows a three step process in order to identify harm occurring from medication error. Data are collected on one day each month and enable wards, teams and organisations to understand the burden of medication error and harm, to measure improvement over time and to connect frontline teams to the issues of medication error and harm, enabling immediate improvements to patient care.

Data can be used as a baseline to direct improvement efforts and then to measure improvement over time. Establishing this data collection is both complex and resource intensive so it was agreed

to use quarter one and two for system setup and then begin reporting via the quality dashboard in quarter three. It was initially rolled out across two wards in quarter one and then seven wards in quarter two and the first results for the percentage of medicines safety harm free care were reported on quality dashboard from September 2014 as follows:-

	Threshold	A	M	J	J	A	S	O	N	D	J
Medicines Safety Thermometer % harm free (ST)	TBC	PILOT	PILOT	PILOT	PILOT	PILOT	98.3	99.2	97.4	99.2	98.6

Both the dashboard development and the safety thermometer provide different forms of evidence of medicines management within the trust and will continue to be reviewed throughout 2015/2016.

Going forward this will remain as a quality indicator for 2015/2016 and be reported in the Quality Report next year.

3.2.7 NPSA 'never events'.

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

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

Incidents are considered to be never events if:

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

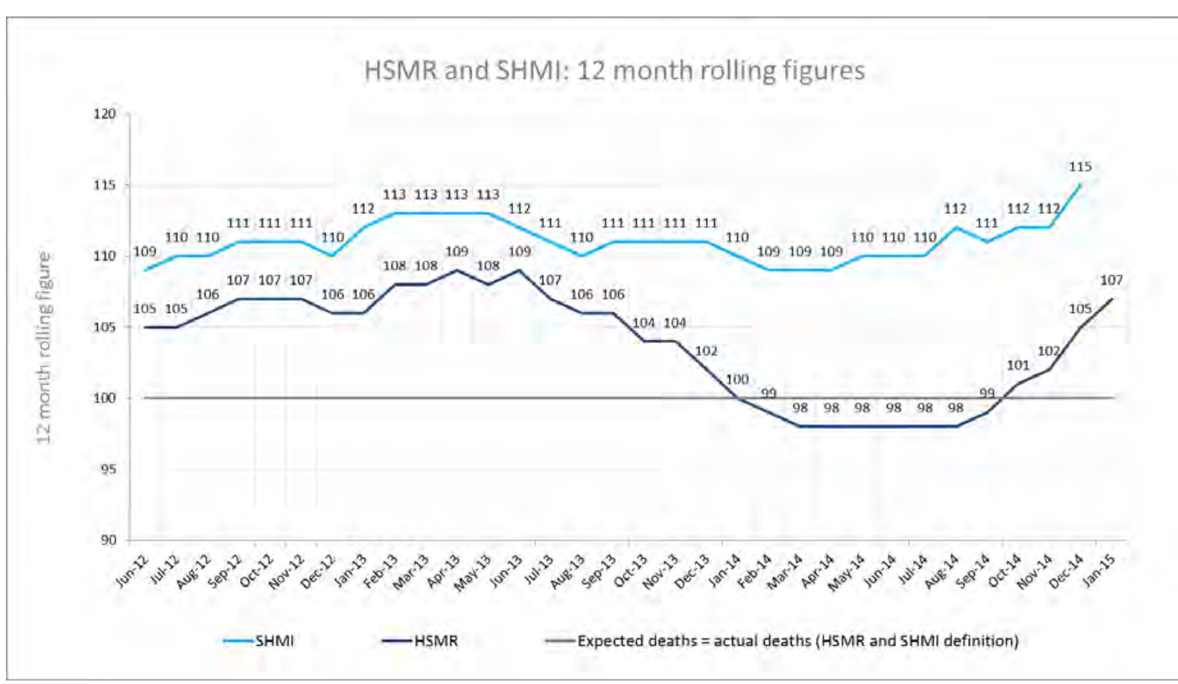
The threshold for never events is set at zero and trust is pleased to report zero never events for 2014/2015.

3.3 Clinical Effectiveness

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

Since the January 2014 HSCIC publication (relating to the period July 2012 – June 2013) the trust has had an 'as expected' published SHMI figure. The latest published SHMI figure is 109, for the period July 2013 – June 2014. The latest available figures are: HSMR 107 for the period February 2014 –

January 2015 and SHMI 115 for the period January 2014 – December 2014 (HED system). The chart below shows these rolling 12 month figures since June 2012.



We have made significant improvements in our HSMR, since mid-2013, however there has been a rise in recent months for each ratio. The HSMR remains within the range of 'as expected'. The SHMI was 'higher than expected' in the rolling 12 month periods ending August 2014, October 2014, November and December 2014. We have identified that there is a strong correlation between the mortality ratios and the crude (actual) numbers of deaths. In December 2014 and January 2015 there was a marked increase in the number of deaths in the Trust (consistent with the national figures), which has affected our mortality ratios. Our crude death rates remain comparable with local peer trusts, however we will of course continue to progress with the actions already identified in the following key priority areas. Recent analysis of data reveals that the crude rate has reduced since February 2015 so we believe this will be reflected in the mortality ratios when they are published in June 2015.

Priority Area	Specific activity
Reviewing the trust's care pathways and best practice care bundles to ensure a high standard of care for every patient, every time.	The trust has worked hard to prepare for and /or implement (depending on the timing of the regional launch of each) the new Advancing Quality measures of COPD, Sepsis, Acute Kidney Injury, Diabetes, Hip Fracture and Alcoholic Liver Disease. For the existing measure of Hip and Knee, the Trust was the top performer in the North West for 2015/16 as at November 2014 (latest data available as at 4th March 2015). The Trust has met the Pneumonia measure target since June 2014 and is performing significantly better against the Stroke measure in 2014/15; meeting the target in 4 out of 7 months, compared with no months in 2013/14.
Ensuring quality and appropriate care at	The provision of Specialist Palliative Care has increased significantly since Q3 2012/13, with an increase every quarter except in Q4 2014/15. The Clinical Effectiveness Team

the end of patients' lives.	work closely with the Specialist Palliative Care Team to ensure that measuring effective care includes the care at the end of a patient's life. The trust invited members of Warrington CCG to attend our Care Quality Review Group. A key benefit of this is that both partners can review the care in the community and in hospital, and to follow the patient's journey and identify any areas for improvement.
Mortality Review	Following many years of mortality review being carried out within departments such as ITU, paediatrics and surgery, the trust piloted an additional centralised process, towards the end of 2013/14, focussing on a sample of all other deaths. In mid-2014, a decision was made to review all deaths and a process was developed and launched in October 2014. The trust asked Mersey Internal Audit Agency to review our mortality review processes. The early draft findings reflect our concerns that despite there being clear processes in place, there is room for improvement in the number reviewed as well as in the type of information captured during the review, to then drive forward improvement. To address these issues, the new Medical Director is directing a review of the current process, and we are collaborating with local trusts, with the aim of increasing engagement, strengthening peer review, integrating the centralised and specialty processes and fostering improved organisational learning.
Promoting the effective management of patients whose conditions deteriorate.	In December 2014, the trust recognised (as part of a close monitoring system of crude deaths and mortality ratios), that there was a higher than usual number of deaths, alongside a rise in death rate. The Medical Director led a small group of consultants and senior nurses, to review these deaths. As the trust began to see the national picture, we realised that this increase in both the number of deaths and the death rate in December 2014 and January 2015 reflected the national increase during this period. Although this review highlighted no areas of significant concern, it did reveal areas for improvement which will be integrated into the work of Acute and Critical Care of the Patient Group and other appropriate committees. The Acute and Critical Care of the Patient Group continue to progress improvements in this area.
Continue to analyse, understand, report and use mortality and morbidity data to improve outcomes.	Trust staff awareness and understanding of mortality ratios has further increased in 2014/2015. Data is presented at a variety and increasing range of forums across the organisation, from divisional ward managers meetings to divisional governance meetings and via the Vital Signs report which is widely distributed. Thorough reviews of the quality of patient care are carried out, informed by close monitoring of a variety of national and local intelligence sources.
Ensure accurate and comprehensive documentation and coding.	The trust continues to use AQUA's (Advancing Quality Alliance) framework for reducing mortality, which is closely aligned to the areas outlined here. To ensure mortality ratios are useful indicators of the quality of care, trusts must make sure that their documentation and coding is accurate as this is the data from which the scores are produced. We will continue to undertake work to ensure that we continually, accurately and comprehensively document patient's health and the care they receive so that the coding team can assign the correct codes.

We will continue to monitor and report mortality ratios in 2015/2016 and use the data as an indicator of the quality of care we provide, supporting targeted improvements.

Strengthening mortality review has been selected as an improvement priority for 2015/2016.

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

The trust has reported on the following high impact interventions or care bundles used within its Intensive Care Unit for the past two Quality Reports:

Urinary Catheter: insertion

Urinary Catheter: on-going care

Ventilator Acquired Pneumonia

Blood stream infections: CVC on-going care

CVC insertion

Peripheral cannula on-going care

Peripheral cannula insertion

In 2011/2012 we reported that the trust achieved 97% compliance for ventilator acquired pneumonia prevention and 100% for urinary catheter infection prevention – we achieved our goals. Our plan for 2012/2013 was to maintain this high standard so the trust established an improvement target of >=90% and achieved compliance with each High Impact Intervention care bundle. The trust did not identify this audit as an improvement priority going forward for 2013/2014 but we felt it was important that we continued to audit practice because regular auditing of the care bundle actions will support cycles of review and continuous improvement in our care settings. During 2013/2014 the trust improved and maintained compliance at >95% so it was agreed that this should be removed as a quality indicator for 2014/2015.

3.3.3 Dementia CQUIN

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

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

In 2014/2015 this CQUIN remained a national contractual agreement to ensure that hospitals continued to deliver high quality care to people with dementia.

The trust has worked hard at implementing the CQUIN and is pleased to report that we have achieved full compliance as determined within this dementia CQUIN.

Dementia	A	M	J	J	A	S	O	N	D	J	F	M
Part 1 2013/2014	90.43	93.14	91.3	92.87	95.12	95.12	95.2	95.13	96.1	97.76	97.36	94.57
Part 1 2014/2015	94.55	95.69	95.43	94.26	96.59	92.45	92.7	96.61	96.29	96.93	94.81	N/A
Part 2 2013/2014	96.77	100	100	100	100	93.3	100	96.43	96.88	100	100	100
Part 2 2014/2015	100	100	100	100	100	91.89	100	100	97.22	96.77	100	N/A
Part 3 2013/2014	100	100	100	100	100	100	100	100	100	100	100	100
Part 3 2014/2015	100	100	100	100	100	100	100	100	100	100	100	N/A

Local CQUIN – Improve the Care of patients with dementia

As part of our local CQUIN we have agreed to improve the care and experience of patients with dementia further throughout the next 2 years.

We have worked toward setting an effective foundation for appropriate management of patients allowing significant improvements in the quality of care and substantial savings in terms of shorter lengths of stay. This effective foundation is further supported by our successful King's Fund bid under the 'Improving Environment of Care for People with dementia'. Since the opening of the Forget Me Not Unit (FMNU) we have monitored the following:

- Length of stay
- Number of completed Dementia Assessments – including This is Me and initial assessment documentation
- Falls
- Pressure Ulcers
- Number of reported incidents of violent and aggressive behaviour on the FMNU
- Level of the need for (1:1) nursing on the FMNU
- Re-admissions with 7 days of patients on the FMNU
- Re-admissions within 30 days of patients with clinically coded dementia
- Number of patients from the FMNU in permanent admissions to care homes
- Carer feedback
- Staff sickness in FMNU
- Number of complaints.

We have achieved compliance with the CQUIN and developed further measures for year 2 which include dementia training for staff.

The trust will continue to monitor dementia as a quality indicator for 2015/2016.

3.3.3.1 Warrington and Halton Hospitals NHS Trust - Dementia Strategy

At Warrington and Halton Hospitals our staff are dedicated to providing the best possible care for patients with Dementia, our Strategy sets out the framework by which we will achieve this with ten key areas identified which are underpinned by action plans monitored by the Dementia Steering Group.

Dementia Champions

Our dementia champions include trained non-clinical and clinical staff in place at ward and department levels who have received additional training. We have an identified senior medical and senior nursing lead for dementia within the trust. A dementia champion is in place in almost every clinical area. The ward/department based champions come together regularly to gain up to date knowledge and skills in relation to patients with dementia in our hospital. They then cascade and disseminate that information in their own clinical area.

Dementia Information

Every ward has a dementia information board, which is updated by the Dementia Champion. Information is provided on both the hospital and local dementia services. The dementia web community holds information for staff, and we will continue to develop both this and the trust website during 2015/16. The cognitive assessment team (CAT) are developing Dementia Awareness packs which focus on:

- Improving the quality of care delivery and information patient and relatives to expectations
- Pre-operative assessment / screening of patients who either have dementia or who may develop post-operative delirium. This is being developed by the pre-operative team.

Additionally our clinical librarian has developed a regular electronic dementia awareness bulletin that can be accessed by all grades of staff with links to latest dementia research and knowledge.

Dementia Training

Staff access and undertake training on e-learning through the NHS e-learning portal. Staff also undertake a level 2 national qualification in the principles of dementia care. This award is achieved through completion of workbooks approved by the Northern Council for Further Education (NCFE).

The table below demonstrates the number of staff who have completed or who are working towards NCFE level 2.

Number Completed	Work Area
4	Car Parking and Security
22	Nursing
2	Allied Health/Scientists
4	Administration

Number Working towards	Work Area
7	Allied Health
5	Nursing
3	Administration/Other

The trust is also required to make quarterly returns to Health Education Northwest on the numbers of staff and staff groups who have undertaken Tier 1 training in dementia. Tier 1 dementia training

is defined as staff recognising and understanding dementia, interacting with those with dementia, and to be able to signpost patients and carers to appropriate support. The number of staff trained by staff group is as follow:-

	Medical	**Registered Nurses**	**ST and T**	**Clinical Support**	**Information Support**	**TOTAL**
Quarter 1	35	210	80	153	4	482
Quarter 2	35	227	92	180	11	545

A training needs analysis is to be submitted to the Clinical Education Department that highlights the level, duration and content of training required by specific staff groups. Our Specialist Nurse for Older People has also developed links with Countess of Chester Dementia Training lead to explore the possibility of joint future training requirements.

Personalised Care Planning

Our new nursing care booklet includes individual patient assessment relating to the following

- Privacy and dignity
- Nutrition and hydration
- Pain assessment and control
- Communication
- Continence
- Carer and family involvement

However we also recognised that a more bespoke care planning method is required to support this this our Specialist Nurse for Older People has produced a suite of care plans for patients with Dementia, delirium or cognitive impairment launched in November 2014.

Patient Experience

We have developed a survey to seek the opinion of carers in relation to the care provided to patients with dementia. We have also developed some unique ways ascertaining levels of patient satisfaction that is separate to the trust’s current approach. The following are the results of an audit of our new approach, called the Forget Me Not Wheel, to gathering the views of patients and carers on their experience of the Forget Me Not unit.

RECEPTION	GARDEN	TOILETS/ENSUITE	LOUNGE/DINING AREA	PATIENT BAY/SIDE ROOM	QUIET ROOM
welcoming	N/A	Very clean well equipped	friendly	excellent	N/A
lively	beautiful	ok	Very nice	excellent	N/A
Gave good information	Beneficial in good weather	Always very clean and tidy	Clean and tidy	Always clean and tidy	Welcoming and restful
adequate	Tranquil and very impressive	fantastic	Peaceful and calming. Well thought out	Very necessary and ideal for patients who need peace and quiet	Small but suitable for purpose
Bright, cheerful, spacious, friendly, inviting	Peaceful, pleasant, calm, welcoming, accessible	Large, clean, airy, bright, good facilities	Comfortable, colourful, friendly, relaxing, cheerful	Open, roomy, spacious, bright, friendly	Peaceful, calm, pleasant, quiet, tranquil
Very good	Lovely to have fresh air	good	good	Very good and happy	good
Well signposted	N/A	N/A	Well equipped	Spacious side rooms but more space needed around bedside	small
Bright and convenient	Neat and tidy	N/A	Smart and suitable	Clean tidy and bright	Very compact
Big, nice, bright, busy, cheerful and clean	N/A	Well signposted, clean and nice, big enough, light	N/A	Happy feeling, bright and cheerful, nice curtains, view of children's playground	N/A Patient on oxygen so bedside and toilet only
Quite good, like the colours and meeting others, like being able to chat to others	N/A	Clean not dirty, reasonable amount of room	N/A	Staff always available, Colour codes helpful, like visiting times	N/A

Enhancing the Healing Environment

Every single one of our Board members is aware of the excellent progress that has been made in the last six months to B12, which has become our Forget Me Not Unit. The Forget Me Not ward opened at the hospital at the end of May 2014 and the feedback has been excellent from patients, visitors and staff alike. The ward features a number of innovative design features including its own mock bus stop, lounge area with traditional looking fireplace, quiet room with a 1960s style TV and a special dementia garden area.

Everything is designed to provide relaxation and stimulation for patients who need hospital care but who also have dementia. We were one of the largest beneficiaries from a £50 million national fund released by the Department of Health last year for dementia care environments. The Forget Me Not ward has been designed to look unlike a typical hospital ward and provides a calm and relaxing environment for care using state of the art design principles, use of colour and light. It also has its own extensive garden area.

Remembrance service on the Forget Me Not Unit.

Other wards have also adopted a range of the characteristics that make a ward 'dementia friendly'. For example, the wall and door colours are contrasting where appropriate, and bathroom furniture is also designed to be dementia friendly.

Additionally, we have regular sessions in place on the Forget Me Not Unit and other wards where 'enhanced healing' through interaction takes place as follows:

- Reminiscence sessions with groups of patients with similar interests (strictly come dancing is popular)
- Music groups and bingo sessions to encourage interaction
- String quartet performances
- Ukulele band
- Interactive singing sessions and using basic musical instruments
- Remembrance day service with the hospital chaplain in the day room.

Dementia Conference July 2014

We were incredibly proud to host our first ever dementia conference. Over 100 trust staff were joined by expert national speakers, patients and carers to learn and share best practice and hear the impact that high quality, compassionate staff interaction has on patients and families. A second dementia conference is planned for 2015.

We were also delighted to showcase our Forget Me Not Unit when Jeremy Hunt, Secretary of State for Health visited us in September 2014. The Secretary of State said that our dementia unit was one of the best examples of dementia care provision he had seen.

The Secretary of State for Health visits the Forget Me Not Unit in October 2014

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

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

Warrington & Halton NHS Trust - Advancing Quality Data*

YEAR	Heart Attack	Heart Failure	Hip & Knee Surgery	Pneumonia	Stroke
Year 1	97.60%	73.42%	90.53%	82.11%	NRC
Year 2	99.29%	90.12%	94.09%	84.16%	NRC
Year 3	99.56%	90.66%	96.34%	86.52%	NRC
Year 4	99.55%	95.41%	98.02%	88.98%	90.60%
Year 5	99.45%	94.93%	98.48%	90.38%	88.90%
Year 6	99%	93%	99%	85%	85%
CQUIN TARGET	**95%**	**90.2%**	**95%**	**73.9%**	**60.4%**

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

AQ is also a local CQUIN for the trust and we are performance managed for each agreed condition Pneumonia; Heart Failure; Acute Myocardial Infarction; Hip and Knee and Stroke in order to demonstrate an annual improvement against the targets.

The Advancing Quality Group meet on a monthly basis to discuss performance and to provide assurance that all clinical areas are reviewed and ensure appropriate monitoring mechanisms are in place.

During 2014/2015 the AQ measures described above remained as a local CQUIN and additional measures were included in the CQUIN from April 2014, including Chronic obstructive pulmonary disease (COPD); Hip Fracture; Sepsis; Acute Kidney Injury; Diabetes and Alcoholic Liver Disease.

As previously stated during 2013/2014 the trust experienced issues in meeting all the Stroke and Pneumonia measures and has therefore decided in consultation with stakeholders to include these measures as an improvement priority for 2014/2015. The trust response can be found in section 2.1.1.6.

The trust will continue to monitor AQ measures as a quality indicator for 2015/2016.

3.3.5 PROMS - Patient Reported Outcome Measures

PROMs data is a nationally agreed dataset. The data is collected, processed, analysed and reported to the Health and Social Care Information Centre by the trust. PROMs calculate the health gains after surgical treatment using pre and post-operative surveys. The Health and Social Care Information Centre is responsible for scoring and publishing of PROMs data as well as linking it to other data sets such as Hospital Episode Statistics.

For 2013/14 and beyond, it remains a NHS Standard Contract Requirement for all providers of NHS-funded hip replacements, knee replacements, varicose vein surgery and groin hernia procedures to collect and report PROMs data.

PROMs data remains a key priority with its importance confirmed in the Mandate document between the Department of Health and NHS England. The NHS Outcomes Framework continues to identify PROMs as a source of information about outcomes from planned procedures. NHS and Foundation Trusts we also report on PROMs data in section 2.3.2 of this Quality Report. Following a restructuring of the Quality Committees the management of PROMS data will be managed via the Clinical Effectiveness Committee and will no longer be included as a quality indicator.

3.3.6 High level quality care at End of Life.

The trust has in consultation with stakeholders agreed to include this as an improvement priority for 2015/2016. Please see section 2.1.2.3 Improvement Priorities for 2015/2016 Priority 3.

3.4 Patient Experience

Following the publication of the Francis report there is heightened awareness and concern about the experience that patients have in healthcare settings.

The trust supports the ideology that it needs to collect information; be open and transparent about the experience of patients within its care and that information about patient experience should be publically available. Ensuring that people have a positive experience of care is also a key objective within the NHS Outcomes Framework. This trust supports the view that patient experience is as equally important as the other elements of the quality agenda namely clinical effectiveness and patient safety, and that that it should be embedded across our work to improve quality outcomes.

“There is clear evidence that where patients are engaged in their own care and have a good experience of care and treatment, clinical outcomes are better” (NHS England, 2014).

In addition to complaints management which was established as an improvement priority for this year – section 2.1.1.2, the trust is committed to improving patient experience through implementing and monitoring patient experience indicators as set out in the Quality Report for 2013/2014.

Patient experience indicators for 2014/2015 include:

- Complaints
- Friends and Family Test – inpatients; accident and emergency and maternity services.
- Develop and monitor ‘always events’, i.e. what must we always do for patients to ensure a quality experience.
- Continue to monitor mixed sex occurrences
- Improvements demonstrated in our In-patient Survey
- Successful implementation of a Patient Information Centre / Patient Experience ‘Hotline.’

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

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

More recently the trust has also developed a suite of patient experience indicators which will allow us to monitor performance on a monthly basis in key areas for example collecting data on the rate of negative comments posted on patient opinion; NHS Choices and/or the CQC Experience Form.

The evidence also demonstrates that “where there are high levels of co-worker support; good job satisfaction, good organisational climate, perceived organisational support, low emotional exhaustion and supervisor support, there are links to good patient-reported experience.

However poor staff satisfaction is associated with worse standards of care” (NHS England, 2014) Within year the trust has undertaken a cultural barometer survey of all staff, developed an action plan and made changes as required.

It has also established a project to develop and agree values and behaviours which will shape the organisation, the objective is that the new values and behaviours will drive a philosophy of improving services for the patient.

As well as encouraging staff feedback through national and local surveys we support processes to enhance staff wellbeing.

The planned Friends & Family Test which began in 2014 (section 3.4.6) and the staff survey results (section 3.4.4) also provide a barometer of staff experience. We also ensure that staff feedback around the quality of the patient care provided in our organisations is publicly available through, for example Open and Honest, which is available at: http://www.warringtonandhaltonhospitals.nhs.uk/page.asp?fldArea=1&fldMenu=8&fldSubMenu=7&fldKey=1241

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

3.4.1. Eliminating Mixed Sex Accommodation.

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

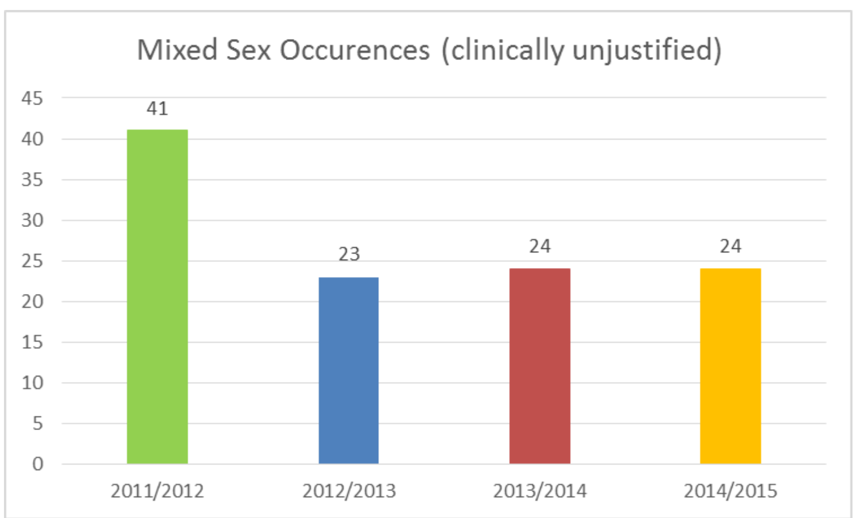
In 2012/2013 the trust threshold was for full compliance with no reported breaches however, whilst we reported 23 mixed sex occurrence breaches, this was a 44% reduction on 2011/12 when the trust had 41 breaches. For 2013/2014 the trust again established a zero tolerance threshold and it was on target to meet this objective until September 2013.

Until this time the trust believed that there was a locally agreed protocol with the CCG that stated if an MSO occurred in specific areas of the trust for example the Clinical Decisions Unit and GP Assessment Unit (GPAU) then the breach will not be liable for penalty as long as it is resolved within an 8 hour time limit. However, when the trust made a request to the Department of Health (DoH) to rescind an MSO which after investigation they discovered had breached for less than 8 hours the DoH refused to grant the revision request stating that the length of time for an MSO is not relevant.

The trust then instituted a review and a paper was presented to the Executive Team (ET) for the ET to agree that reporting practise would change in line with further guidance from the DoH. Unfortunately despite rigorous monitoring and changes to patient flow, the trust has continued to report breaches in these areas. However it does ensure that each breach/cluster has been reviewed using a root cause analysis and remedial action plans constructed and submitted to the CCG within fourteen days of month's end in accordance with contractual agreements.

In 2013/2014 the trust can report that following a review as described above that there were no reported breaches for February and March 2014 and a total of 24 breaches by year end. In 2014/2015 the trust has continued to monitor and report MSO breaches via the quality dashboard and to the commissioners and is disappointed to report that there have been 24 breaches by year end. The trust will continue to focus on this quality measure as a patient experience indicator and will report progress in the Quality Report 2015/2016. Please see graph below for a four year comparison.

Mixed Sex Occurrences - 2011 – 2015



3.4.2. Always Events

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

Always events are aspects of patient care that should always happen for patients to ensure a quality experience. The trust held a number of focus groups including a local healthcare event "Get Engaged" with patients; staff and governors to agree a small number of always events which we developed, piloted and monitored throughout 2014/2015. It was vital that we did not develop the always events in isolation and that the measures were developed from the suggestions made by the public and representatives of patient groups and third sector organisations to ensure that we included always events that they felt were important.

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

The Always Events are:

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

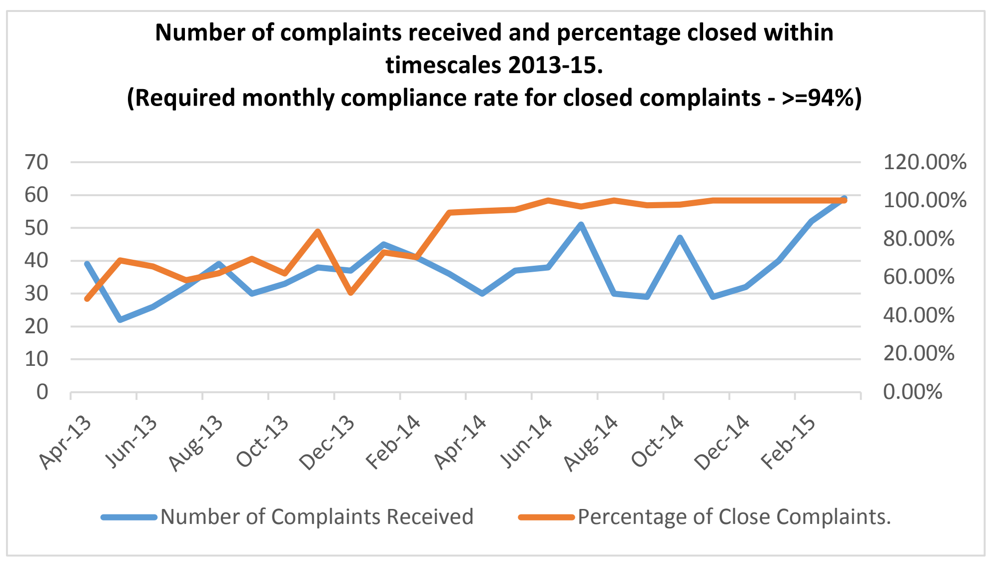
The results are very positive and apart from October 2014 when we achieved 84% compliance we have achieved the desired 100% since then.

The trust will continue to monitor patient experience indicators as a quality indicator for 2015/2016.

3.4.3. Complaints and Compliments

In accordance with the *NHS Complaints Regulations* (2009), the Complaints Report(s) annual and quarterly set out a detailed analysis of the nature and number of formal complaints. They also offers feedback from other sources, compliments, NHS Choices and PALS to provide a more rounded picture of the nature of feedback and to emphasise good and bad, with an emphasis on how clinicians and managers are supported by this intelligence in planning service improvement and to celebrate that which is positive and applauded.

Whilst the processes in place to support handling of formal complaints are more robust than in previous years, there remains scope and the will to make improvements and to enhance the performance of the trust in this area.



The above graph shows the number of formal complaints received by the trust on a monthly basis and compares this against the number of complaints closed within the required timescales. The trust has a contractual target of 94% complaints closed within timescales each month and failure to achieve this has both a negative impact on the complainant and their perception of the trust as well as incurring a financial penalty on the trust. The trust is pleased to report that it has for 2014/15 achieved the >=94% threshold and from November 2014 achieved 100% compliance. This is due firstly to the reconfiguration and improvements within the Patient Experience Team resulting in a skilled mature team who respond effectively to complaints issues within prescribed timescales and secondly to the work undertaken by the divisions in responding to complaints.

A complainant may decide to withdraw a formal complaint and this is then reassigned as a concern, during 2014/15 the trust recorded 96 concerns compared to 93 concerns in the previous year.

Whilst there has been an increase in the number of complaints particularly in quarter four there has been a corresponding increase in the number of low risk complaints and notably 22 of these are attributed to car parking issues.

Overall Complaints by risk level 2013/14 (Q3) – 2014/15 (Q4)

	2013/14 Q3	2013/14 Q4	2014/15 Q1	2014/15 Q2	2014/15 Q3	2014/15 Q4
Complaints Received by Quarter	107	122	105	110	108	151
Low Risk	36	51	48	41	39	79
Moderate Risk	56	57	39	58	54	62
High Risk	15	14	18	11	15	10

During the reporting year complaints about attitude represented the second highest number of complaints, after treatment. This echoes national trends.

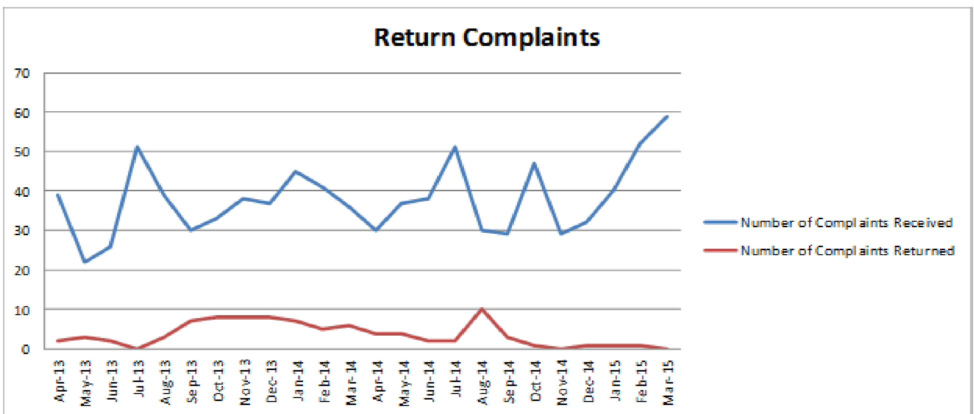
The Health & Social Care Information Centre report for 2013 – 2014 (derived from the annual KO41a submission by all Trusts) says that of a total of 114,788 written complaints reported, 13,269 were about staff attitude, an increase of 966 (8%) on the previous year. This rise prompted the Board to request an assurance report that was reviewed in March 2015. The report included the following recommendations:-

- Where there is a complaint about a member of staff's attitude, the manager or clinical lead for that person should be the one to respond. Complainants are not likely to be impressed by a response from the person they had a problem with. This also means that the manager can speak about the individual's usual performance and instigate disciplinary processes if these are indicated, either because this is one of several issues, or because of the seriousness of the incident. The manager is also in a position to monitor future performance and identify appropriate development activities
- In addition to apologising, there should be some evidence that the individual has reflected, learned, improved etc. Though apologies are important, it is also important to demonstrate that action was taken. Complainants often only want to ensure that what happened to them will not happen to someone else
- If the member of staff is very insistent that there was no inappropriate behaviour or attitude on their part, this needs to be clearly stated and not confuse the issue by then identifying actions or training to be taken
- Also interview any witnesses and include their accounts in the investigation and response
- Managers must note any repeated complaints about attitude and review actions to be taken to prevent future problems

This issue will be re-visited and updated as part of the Complaints Annual Report presented to board in May 2015 and available on request from Patient.ExperienceTeam@whh.nhs.uk

Importantly the trust can also report that there has been a reduction and plateauing in the number of returned complaints. Returned complaints occur when the complainant is dissatisfied with the response and requests that the trust re-examines the complaint.

A high number of returned complaints can be indicative of poor complaints management, the following graph shows that even when the trust observes an increase in the number of formal complaints the number of returns since September has reduced to one or zero.



All formal complaints were received in the English language with no requests made by a complainant (or enquirers) for the use of the trust Interpreter Service. Within year there has been one formal complaint from the carer of a woman with learning disabilities where a disability was declared.

3.4.3.1 Lessons Learned

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

Description of Complaint	Actions	Learning
Scheduled Care: Complainant was unhappy with the attitude of the consultant towards his wife during his consultation. The consultant told his wife that if she continued to interrupt he would ask her to leave.	Consultant apologised for his manner. He had felt that he could not get a good history from the patient because of his wife's interjections, but he was sorry to upset her with his request for her to let him complete his questions of her husband.	Review of complaint during investigation. Consultant will reflect on complaint during his annual PDR as part of the revalidation process.
Scheduled Care: The foster mother of a lady with learning disabilities was very unhappy with the care provided. The patient was admitted through AED in July 2013. She had emergency surgery on the night of her admission and was later found to have an elevated blood sugar. She suffered a great deal of distress over the next few days when staff needed to take blood from her. Concerns raised: Why couldn't her bloods have been taken while she was under anaesthetic? Doctors and nurses did not talk to the patient to explain what they wanted to do. Three doctors attempted to take one sample and the patient became extremely distressed. Complainant asked them to stop as they were ignoring her screams and protests. This upset other patients in the bay.	Complainant attended a meeting to discuss her concerns with staff. The consultant was unable to attend on the day but a statement from him was fed back at the meeting. It was explained that blood sugars had not been high at the time patient went to theatre, so no blood had been drawn. The complainant was keen to ensure that other patients would not have the same experience as her foster daughter. The Matron for the ward, Patient Experience Matron and the Health Facilitator for 5BP (learning disabilities team) were able to identify actions that reassured the complainant that her concerns were taken seriously. It was agreed that if patient is being readmitted (either electively or as an emergency) in the future, she would contact	Matron fed back to ward team to raise awareness of the need to: Work with/involve carers in care and make an effort to adopt a communication style that will promote compliance. Assess and make reasonable adjustments, i.e. time with patient. Individual feedback to member of nursing team who complainant felt was insensitive and brusque. Health Facilitator presented at the "Grand Round" on 9th January 2015 to provide key messages for care of people with learning disabilities in acute hospitals. Patient Experience Matron participated in Grand Round presenting this story (with consent) as an ideal opportunity to reach a large audience of clinical professionals. Short guidance document for staff who need to obtain blood tests from patients who have

One doctor commented that "this has been a good experience for us", which the complainant felt was insensitive and inappropriate. Patient was so affected by the experience she is terrified to come to hospital again.	the PALS Officer to ensure that staff are aware of her anxieties and needs.	a fear or phobia being developed. This will include cues for possible solutions and escalation of problems. This will be included in the updated Learning Disabilities guidance available on policy/procedure pages of the Intranet.
Unscheduled Care: Complainant felt that the AED staff were unhelpful in responding to the issue of the patient being expected to wait in a crowded area at risk of infection. Patient at times waited in the car but was told staff would not come out to notify her when it was her turn to be seen as they were too busy. Complainant said that AED staff did not contact the on-call haematology team and have, on one occasion, inappropriately sent patient away with oral antibiotics; only for haematology consultant to arrange admission the following day for IV antibiotics.	Consultant investigated this complaint. He informed the complainant that he had raised this issue with all the staff and instructed triage nurses to inform the medical and nursing co-ordinator immediately when they assess a patient with potential neutropenia so that arrangements can be made: • for them to be suitably housed away from other patients • so that blood count can be checked as soon as possible in their attendance. Consultant informed complainant that this system does seem to be working better for this type of patient. The alert card the patient carries has been updated to include information that she is neutropenic. Apologies were made for the brusque attitude of AED staff in taking the history.	New way of working when patients with neutropenia are triaged. Inappropriate and unprofessional communication fed back to all staff with expectations for professional and respectful communication.
Unscheduled Care: Patient's wife made a complaint about his care in WHH and the consultant from Clatterbridge. Issues for WHH concerned nurses' attitudes and poor communication with the patient and family. Complainant found staff unprofessional. The complainant raised concerns about telephone conversations where staff refused to provide updates, despite there being a password in order to facilitate better communication.	Clatterbridge Complaints department provided a response regarding the consultant's attitude and treatment. Care was reviewed by Consultant Nurse in Palliative Care and Matron. Concerns regarding A4 were reviewed and explanation made of nurse's conversation regarding moving and handling. Though information was correct the sister apologised for the manner in which it was communicated. Communication issues raised about A9 were investigated and an action plan drawn up. The Ward Manager monitored and evaluated to action plan.	Issues fed back to teams in safety briefings and reviewed at team meeting – completed October 2014. This included: Correct employment of password for close relatives to use to get more detailed updates when ringing the ward. Accurate, timely and regular updates to family. Documentation of all communication with family in case notes. Discussion of appropriate and professional manner (including body language, tone of voice) to be used in communicating with patients and families. Ward Manager to address individual issues in real time. Time taken to answer nurse call. This was monitored by ward coordinator and raised with individuals when issues observed. Reviewed at ward meetings.
WCSS: The mother of a child attending AED was unhappy with the attitude of a health care assistant from the children's department. She was upset that she was questioned as to why she had not brought her son in the night before and if social services were involved with the family.	Matron investigated the complaint and apologised for the poor experience. She had discussed the concerns with the HCA who saw them. Matron explained that the questions asked were mandatory as part of safeguarding rules. She did apologise if the way in which these questions were asked was in any way offensive. The HCA passed on her apologies.	The matron described the following actions: HCA asked to reflect on the way she approaches her questions and to listen to the child and parent first. HCA to complete the Trust 'care and compassion' booklet (a reflective workbook carried out under the supervision of a clinical manager). HCA to feedback her assessments to the qualified staff. Matron will keep HCA under review to ensure that there are no repeats of this episode.
WCSS: Mother made a complaint following her attendance at AED with her five year old son, following a fall. She was very happy with reception staff, but not the attitude of a health care assistant. She felt the HCA was	Complaint was investigated by Assistant Matron for child health. The HCA was interviewed and apologised for any upset caused.	HCA asked to complete the following actions/learning: Reflect on her attitude and approach and to listen more to parents and children.

"frosty". She also felt upset that the HCA asked if social services were involved	Though it was explained that asking about social services involvement is part of information needed by staff, it was acknowledged that this is a sensitive subject and the manner of delivery may have been unhelpful when the mother was already upset. Assistant Matron to monitor the member of staff to ensure no repeats of this unfortunate incident.	Complete care & compassion reflective workbook, under the supervision of a senior member of the team. Always feedback her assessments to senior member of staff.

3.4.3.2 Compliments

During 2014/2015 the trust received 40 formal compliments through letters sent directly to the Chief Executive. In March 2015 the patient experience team asked the divisions to send copies of compliment letters, cards and other tributes from patients and their families in order to gain a comprehensive overview of compliments within the trust.

Tributes received and reported for March 2015 are as follows:-

March 2015	A6	B1	B12
Thank you cards	14	6	5
Chocolates	4	23	10
Biscuits	1	-	6
Flowers	-	1	-
Donations (£)	-	1	-
Bottles of juice	-	-	4

NB: This was only March and 3 wards sent information through to the team.

3.4.3.3 Parliamentary and Health Service Ombudsman (PHSO)

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

The PHSO make the final decisions on complaints about these public services for individuals. They also use what they learn from complaints to help the public services improve get better. Last year over 40,000 people contacted the PHSO. In November 2014, a representative of the PHSO met with the Patient Experience Team to discuss the work of the PHSO and to strengthen working relationships.

At the start of 2014/15 eight complaints that had been referred to the PHSO in the previous financial year were closed during Quarter 1, of these 2 were upheld and the trust was required to formulate and implement action plans and a further 10 cases were ongoing from 2013/2014.

During 2014/2015 the ombudsman contacted the trust in relation to 9 complaints and the outcomes to date are as follows:-

Complaint received by Trust	PHSO contacted about Complaint	Outcome
Apr-13	Sep-14	Ongoing
Jun-13	Mar-14	Partly Upheld
Oct-13	May-14	Not Upheld
Dec-13	Jul-14	Not Upheld
Jan-14	Oct-14	Partly Upheld
Jul-13	May-14	Upheld
Sep-13	Jul-14	Partly Upheld
Nov-13	Apr-15	Ongoing
Nov-13	Sep-14	Partly Upheld

Evidence of CQC compliance with regulations and outcomes

Monitoring of these is included in the new policy and twice yearly audits will be done to monitor compliance. Monthly triangulation meetings ensure that themes and trends across complaints, claims and incidents are tracked and actioned.

The trust will continue to monitor complaints as a quality indicator for 2015/2016.

3.4.4 National Survey Results 2014

3.4.4.1 National Inpatient Survey 2014

Listening to patients' views is essential to providing a patient-centred health service. The NHS in patient survey provides the trust with intelligence around the overall patient experience and it is vital that we review and act upon this information to address poor performance.

In 2014/2015 we have selected improvement in low performing indicators from the 2013 In Patient Survey as an improvement priority. We have developed action plans to improve areas where we fall below the national average and have not demonstrated improvement in past two years – please see section 2.1.1.4. It is difficult to evidence improvement in surveys due to proximity of one survey reporting and the next one beginning data collection, however key changes from the results of the 2014 survey evidence improvement across all one of the measures namely “waiting a long time to get to a bed on a ward”.

This indicator will continue to be monitored as a patient experience indicator for 2015/2016

3.4.4.2 Inpatient Surveys – National Patient Experience CQUIN

The trust is committed to ensuring a year on year improvement of patient survey responses to how hospitals “patients want to be treated by” improvement in responses to the following 5 key questions:-

(National Patient Experience CQUIN);

Were you as involved as you wanted to be in discussions about your care?

Did you find someone to talk to about your worries and fears?

Were you given enough privacy when discussing your condition or treatment?

Were you told about medication side effects to watch out for when you went home?

Were you told who to contact if you were worried about your condition once you left hospital?

CQUIN Inpatient Survey Questions 2011-2014

National Inpatient Survey Question	2011 Results	2012 Results	2013 Results	2014 Results	Other trusts
1. Were you involved as much as you wanted to be in decisions about your care?	47%	48%	57%	53%	57%
2. Did you find a member of hospital staff to talk to about your worries or fears?	38%	31%	41%	42%	39%
3. Were you given enough privacy when discussing your condition or treatment?	72%	70%	70%	73%	76%
4. Did a member of staff tell you about the medication side effects to watch for? (following discharge)	38%	43.%	40%	44%	39%
5. Did hospital staff tell you who to contact if you were worried about your condition? (following discharge)	64%	71%	82%	82%	78%

Historically the composite score for the five questions was data was provided to the trust for the CQUIN, however this measure has been suspended so the data is no longer available. Overall the questions with the exception of "Were you involved as much as you wanted to be in decisions about your care?" showed that we scored above the 2013 result. The above table shows an improved response to all trusts in three out of five questions.

3.4.4.3 National Staff Survey 2014

We are pleased to say that the results from the 2014 NHS Staff Survey have been published and whilst it is felt that this year has been a turbulent time for NHS which has impacted on national staff survey results showing a deterioration in 15 findings. Within this trust only two findings have had statistically significant negative change:

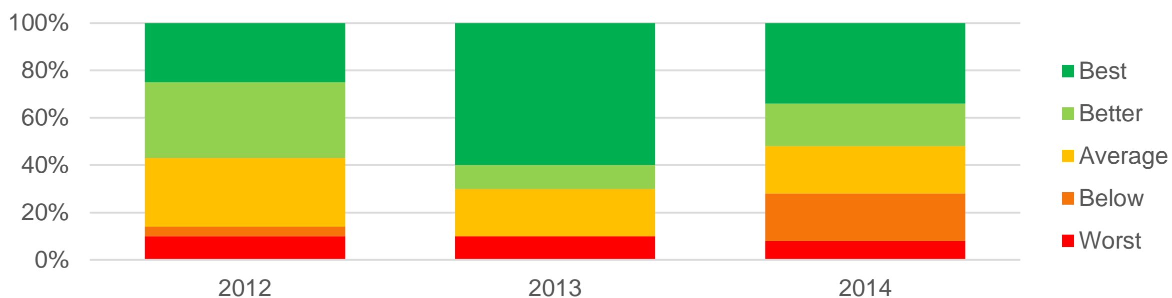
Staff motivation

Extra hours worked

The trust response rate has dropped to 30% (compared with 46% last year) this is attributed to an unsuccessful trial of electronic surveys. Analysis by Age, Ethnicity and Gender shows no apparent disparity

There are two new key findings within the survey:

- Percentage of staff agreeing that they would feel secure raising concerns about unsafe clinical practices – were the trust scored average
- Percentage of staff agreeing feedback for patient/service users is used to make informed decisions in their directorate/department – were the trust scored above (Better than) average.



The top 5 ranked results for the trust were the trust is in the top 20% of all trusts is as follows:-

Staff job satisfaction

Fairness and effectiveness of incident reporting procedures

Low percentage of staff experiencing discrimination at work in last 12 months

Low percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

Percentage of staff agreeing that their role makes a difference to patients

The bottom 5 ranked results are as follows:-

- Percentage of staff receiving health and safety training in the last 12 months – the 12-month cycle is not a true reflection of levels of training in the Trust, as WHH training is three-yearly
- The year to date figures for staff having received training in the last 3 years is 91% well above the 85% target
- Percentage of staff having equality and diversity training in the last 12 months – the 12-month cycle is not a true reflection of levels of training in the Trust, as WHH training is three-yearly. The year to date figure for staff receiving training in the last 3 years is 63% (Equal to national average but below the Trust target of 85%)
- Percentage of staff able to contribute towards improvements at work
- Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver
- Percentage of staff receiving job-relevant training learning or development in last 12 months.

Results of the National Surveys inform comprehensive multi-disciplinary action plans focused on these specific areas. Summary of actions to be taken include:-

Divisional and Medical ownership and involvement

New Internal Communications Strategy

New Engagement & Wellbeing Strategy

Review of “Big ideas” scheme

Keep the momentum of the “SHINE” campaign

Conduct focus groups

Management briefings

The progress of improvements to practice will be monitored throughout the year to ensure that our plan is being successfully implemented.

3.4.5. Patient Opinion

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

Both websites provide feedback on how users rate the service in terms of whether they would recommend our hospital friends and family if they needed similar care and treatment; cleanliness; staff co-operation; dignity and respect; involvement in decisions; and same sex accommodation. However, NHS Choices provides an overall star rating of 1 – 5 stars and for 2014/2015 the trust was rated 5 stars by 69.2% of the respondents as follows:-

Star rating	Warrington	Halton	CMTC	Total 2014/2015
★★★★★	50	35	17	97
★★★★	8	1	1	10
★★★	3	0	0	3
★★	4	0	0	4
★	24	2	0	26

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

3.4.6 Friends and Family

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

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

The trust sends the forms to iWantGreatCare to analyse and report on our results on a monthly basis. Patients also have the option of leaving a response online at: http://warrington-halton.iwgc.net

If a patient is unable to answer the question, a friend or family member is welcome to respond on their behalf. Users are also asked to rate their responses and this is translated into two ratings which are reported through to the board via the Quality Dashboard. The first rating is a star rating to a maximum of 5 stars and the second up to July 2014 is the Net Promoter score up to a maximum of 100.

A review of the FFT was published in July 2014 and made a number of recommendations. The FFT Review suggested that the presentation of the data should move away from using the Net Promoter Score (NPS) as a headline score and use an alternative measure. In line with this recommendation the NHS England statistical publication will move to using the percentage of respondents that would recommend / wouldn't recommend the service in place of the NPS.

The results for 2013/2015 are as follows:

Friends and Family scores 2013/15

Month	Star Rating 2013/2014	Star Rating 2014/2015	Inpatient 2013/2014	Inpatient 2014/2015	A&E 2013/2014	A&E 2014/2015
April	4.7	4.54	80	76	63	42
May	4.7	4.5	76	74	52	35
June	4.7	4.58	80	81	54	41
July	4.7	4.53	76	76	56	40
August	4.5	4.6	76	77(95%)	20	45 (80%)
September	4.5	4.59	77	94	46	82
October	4.6	4.6	82	95	48	85
November	4.6	4.6	75	97	42	87
December	4.5	4.59	71	96	35	84
January	4.6	4.59	78	96	42	87
February	4.66	4.55	81	97	45	84
March	4.61	4.61	79	96	39	83

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

The Friends and Family Test is also a national CQUIN for 2014/2015 aimed at increasing the response rate as follows:-

achieving a response rate for A&E services Quarter 1 of least 15% improved to 20% by Quarter 4

achieving a response rate for inpatient services Quarter 1 at least 25% improved to 30% by Quarter 4

Achieve a response rate of 40% or more for inpatient services for March 2015

Delivery of Friends and Family roll-out for in outpatient and day case departments, by 1 October 2014.

The trust is pleased to report that it achieved this CQUIN for 2014/2015. The trust will continue to monitor Friends and Family as a patient experience indicator for 2015/2016.

3.4.6.1 Friends and Family – Maternity Services

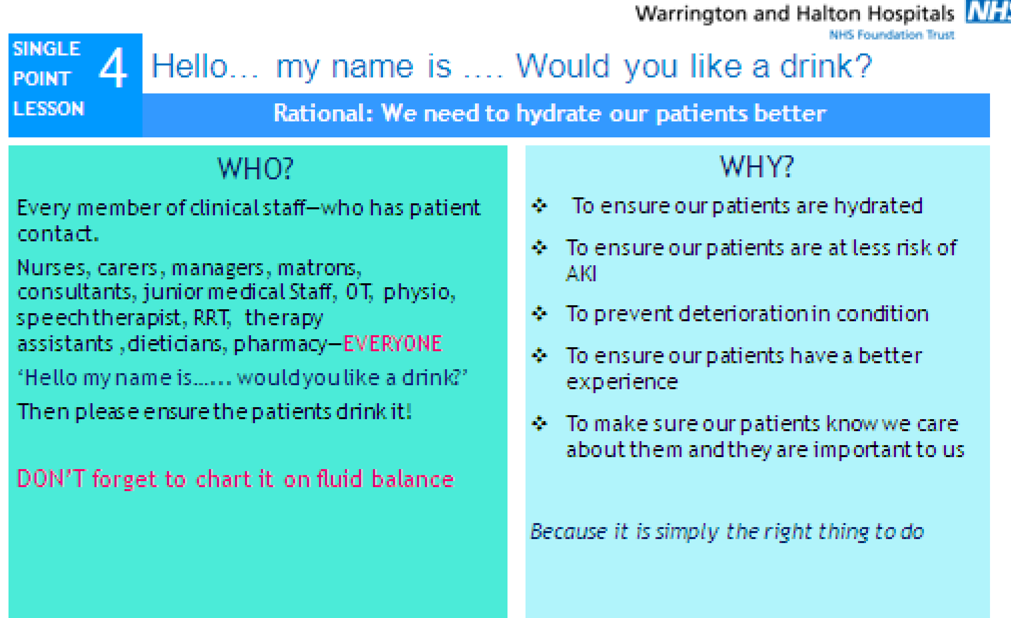
This CQUIN also required that Friends and Family was rolled out to maternity services. The rollout to maternity services was successfully achieved within the required timescales.

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

MONTH	TRUST ANTENATAL CARE	ENGLAND ANTENATAL CARE	TRUST BIRTH	ENGLAND BIRTH	TRUST POSTNATAL	ENGLAND POSTNATAL	TRUST POSTNATAL COMMUNITY	ENGLAND POSTNATAL COMMUNITY
MARCH 2015	100	95	98	97	96	93	100	98
FEBRUARY 2015	89	95	100	97	97	93	NO DATA	98
JANUARY 2015	95	95	100	97	94	93	100	97
DECEMBER 2014	96	96	100	97	97	93	NO DATA	98
NOVEMBER 2014	93	96	100	97	97	93	93	95
OCTOBER 2014	88	95	95	95	95	91	100	96
SEPTEMBER 2014	91	95	94	95	90	91	96	96
AUGUST 2014	57	66	77	78	65	65	-50	76
JULY 2014	50	62	73	77	62	65	71	75
JUNE 2014	42	67	81	77	74	67	67	77
MAY 2014	61	67	65	77	59	65	78	77
APRIL 2014	73	65	74	76	67	64	100	77
MARCH 2014	77	67	80	77	74	64	77	74
FEBRUARY 2014	77	67	63	75	74	64	65	75
JANUARY 2014	80	67	78	78	68	65	73	75
DECEMBER 2013	80	65	79	76	75	66	82	75
NOVEMBER 2013	64	65	72	77	69	66	88	72
OCTOBER 2013	100	64	60	76	47	65	29	71

3.5 May 2014 - Hello my name is… would you like a drink?

The Acute Care Team are leading the campaign to improve patient hydration, accurate fluid balance and acute kidney Injury. Single point lessons were developed which could be accessed on the hub and posters supporting the 'Hello my name is…… would you like a drink?' initiative were placed around the trust.



3.6 Sign up to Safety

Sign up to Safety is a new national patient safety campaign that was announced in March by the Secretary of State for Health. It launched on 24 June 2014 with the mission to strengthen patient safety in the NHS and make it the safest healthcare system in the world.

The campaign set out the ambition of halving avoidable harm in the NHS over the next three years, and saving 6,000 lives as a result. This campaign aims to listen to patients, carers and staff, learn from what they say when things go wrong and take action to improve patient's safety helping to ensure patients get harm free care every time, everywhere.

This trust has Signed up to Safety with a commitment to strengthen patient safety by developing safety improvement plan (including a driver diagram) which will show how we intend to save lives and reduce harm for patients over the next 3 years by:

30% reduction in all grades of pressure ulcers by 2017

30% reduction in moderate falls by 2017

20% reduction in avoidable mortality by 2017

3.7 Lorenzo Electronic Patient Record (EPR) system.

Lorenzo is a nationally available EPR system that is already live in 13 NHS organisations with a further five planning to deploy over the next year. NHS trusts in the North, Midlands and East can make bids for central Department of Health funding for software and deployment costs if they can provide a robust business case for deploying the system. After a process of clinical evaluation from our staff, and financial evaluation, we chose the Lorenzo system and have been successful in our bid for funding.

A great amount of work has been undertaken by staff across all departments including IT, clinical teams, finance and other departments who have supported it through the many stages to get to this position.

Our technology transformation programme is now fully underway after our bid for Department of Health funding to support the deployment of the new Lorenzo Electronic Patient Record (EPR) system.

The new EPR is one part of a multi-million pound programme which will revolutionise how patient care is delivered over the coming years at the trust. Currently there are a number of different patient record systems used within the trust's hospitals and community services. In future, the new system will bring together the various pieces of information held about a patient, putting it directly at our fingertips. It will replace the Meditech and Symphony systems and see a significant shift away from paper-based records towards electronic records.

Good use of IT can help improve care for patients. At the moment the efficiency of our teams across the hospitals can be hindered by some of the IT systems which we have had in place for many years. That can impact on the quality of the patient experience and we now have the opportunity to change that. Implementation work has now started with CSC – the company that provides Lorenzo - and a go-live date for the first phase of the system is planned for the end of 2015.

3.8 Staffing Levels

From June 2014, NHS England has stipulated that Trusts with inpatient beds are required to submit staffing data to UNIFY and publish their monthly staffing levels (planned versus actual) in hours on the NHS Choices website. Trusts are also required to publish this data on their own website, on a ward by ward basis. This information sits alongside a range of other indicators relating to the Trust which supports patients and members of the public to see clearly how hospitals are performing in relation to staffing in an easy and accessible way.

It is also a requirement of NHS England that Trust Boards receive this information on a monthly basis to ensure that they are apprised of staffing within the organisation. Shift by shift staffing data is also displayed outside each ward to ensure that we are open and transparent to the public.

The information demonstrates the staffing information per ward and details planned staffing versus actual, stating which shifts have not met their staffing ratio and reasons for this. Where staffing compliance is not at 100%, the paper details the reasons why and the action taken to address the shortfall. On a daily basis professional judgement is used to ensure that the wards have the appropriate staff and skill mix in place to ensure that safe quality care is delivered to patients and their families.

3.9 Speak out Safely

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

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

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

3.10 Performance against key national priorities (Please see table below)

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

NB: Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers' and 'Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways' have been audited by PricewaterhouseCoopers (PWC) to inform the Independent Auditor's Limited Assurance Report to the Council of Governors. Ⓐ

The indicators "Referral to treatment waiting time - Incomplete pathways" and "All Cancers: 62-day wait for first treatment - From urgent GP referral, post local breach re-allocation (CCG)" in the table below have been subject to external assurance from our auditors based on the annual out-turn performance. Following their work, both indicators have been subject to adjustment, moving from 94.41% to 94.25% (RTT) and 85.68% to 85.76% (62 Day).

Mar-15

Monitor Governance Risk Rating - 2014/15

All targets are QUARTERLY

Target or Indicator		Target	Weighting	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4
Referral to treatment waiting time	Admitted patients	90%	1.0	92.61%	93.21%	93.58%	93.14%	90.70%	90.34%	92.04%	91.04%	92.07%	92.73%	92.99%	92.60%	92.93%	92.18%	92.54%	92.57%
	Non-admitted patients	95%	1.0	98.03%	97.63%	98.54%	98.07%	97.79%	97.72%	98.14%	97.89%	97.62%	96.99%	97.51%	97.38%	96.99%	97.27%	97.21%	97.15%
	Incomplete Pathways	92%	1.0	94.55%	94.56%	94.94%	94.68%	94.88%	95.29%	94.94%	95.03%	94.50%	94.33%	93.96%	94.27%	93.49%	93.87%	93.60%	93.66%
A&E Clinical Quality	A&E Maximum waiting time of 4 hrs from arrival to admission/transfer/discharge	>=95%	1.0	94.54%	92.66%	95.01%	93.97%	91.74%	93.54%	93.26%	92.74%	93.00%	91.23%	83.75%	89.67%	84.08%	81.82%	79.81%	81.98%
All Cancers:62-day wait for First treatment	From urgent GP referral - post local breach re-allocation (CCG)	85%	1.0	90.00%	87.65%	85.51%	85.45%	85.90%	84.81%	90.41%	85.19%	90.24%	80.28%	85.26%	86.38%	81.54%	83.00%	86.00%	83.51%
	From NHS Cancer Screening Service referral - post local breach re-allocation	90%	1.0	100.00%	100.00%	98.00%	99.33%	100.00%	98.00%	99.00%	99.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	From urgent GP referral - pre local breach re-allocation (Open Exeter - Monitor)	85%		87.80%	92.21%	88.06%	87.91%	88.57%	89.04%	91.67%	85.45%	92.50%	93.00%	90.91%	89.10%	85.48%	89.33%	88.61%	87.81%
	From NHS Cancer Screening Service referral - pre local breach re-allocation	90%		100.00%	100.00%	98.00%	99.33%	100.00%	98.00%	100.00%	99.00%	100.00%	98.00%	100.00%	99.00%	100.00%	100.00%	100.00%	98.00%
All Cancers:31-day wait for second or subsequent treatment	Surgery	>94%	1.0 (Failure for any of the 3 = failure against the overall target)	96.00%	98.00%	97.00%	97.00%	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%	98.00%	99.33%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	Radiotherapy (not performed at this Trust)	>94%																	
All Cancers: 31-Day Wait From Diagnosis To First Treatment		>96%	1.0	96.00%	96.00%	98.00%	96.67%	98.00%	99.00%	100.00%	99.00%	98.00%	98.00%	97.00%	97.70%	98.00%	100.00%	97.00%	98.33%
Cancer: Two Week Wait From Referral To Date First Seen	Urgent Referrals (Cancer Suspected)	>93%	1.0 (Failure for either = failure against the overall target)	93.10%	92.90%	93.05%	93.00%	93.80%	92.70%	93.80%	93.50%	93.50%	95.20%	94.70%	94.80%	94.80%	94.80%	93.00%	94.40%
	Symptomatic Breast Patients (Cancer Not initially Suspected)	>93%		93.05%	93.00%	93.10%	93.05%	93.75%	91.90%	93.90%	93.30%	92.99%	94.20%	94.20%	93.10%	93.50%	92.90%	93.0%	93.13%
Clostridium Difficile - Hospital acquired (CUMULATIVE)	Due to lapses in care	26 (for the Yr)	1.0	1	3	4	4	4	4	4	4	4	4	4	4	5	5	5	5
	Total (including: due to lapses in care, not due to lapses in care, and cases under review)			2	5	7	7	8	15	16	16	19	20	23	23	24	26	31	31
	Under Review			1	2	3	3	4	11	12	12	15	16	19	19	19	21	26	26
Failure to comply with requirements regarding access to healthcare for people with a learning disability		N/A	1.0	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No

Cumulative
Qtr1: 3 Qtr2: 12
Qtr3: 20 Qtr4: 26

Please note the cancer targets will not be confirmed for a further 4 weeks and the access policy describes a 4 week process for review of any underperformance requiring validation before submission

Target or Indicator	Target	Weighting	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4
Risk of, or actual, failure to deliver commissioner requested services	N/A		No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
CQC compliance action outstanding (as at time of submission)	N/A		No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
CQC enforcement action within last 12 months (as at time of submission)	N/A		No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
CQC enforcement action (including notices) currently in effect (as at time of submission)	N/A		No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Moderate CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission)	N/A	Report by Exception	No	No	No	No	No	No	No	No	Yes	No	No	No	No	No	No	No
Major CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission)	N/A		No	No	No	No	No	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		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		No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Trust unable to declare ongoing compliance with minimum standards of CQC registration	N/A		No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
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	2.0	0.0	1.0	1.0	3.0	1.0	1.0	2.0	2.0	1.0	1.0	1.0	1.0	1.0	1.0

All Cancers: The reporting position for Qtr4 does not close until 05/05/2015

Additional Notes:

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

**** Clostridium Difficile**
Monitor's annual de minimis limit for cases of C-Diff is set at 12. However, Monitor may consider scoring cases of <12 if Public Health England indicates multiple outbreaks
Monitor will assess NHS foundation trusts for breaches of the C. difficile objective against their objective at each quarter using a cumulative year-to-date trajectory.

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

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

3.11 Governors' visits

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

A summary, provided by the trust's Lead Governor, is available with section 4.1.

3.12 Training & Appraisal

Training and Appraisal Completion

	Target	Year End Results
Mandatory Training		
Health & Safety	85%	47%
Fire Safety	85%	74%
Manual Handling	85%	72%
Additional Fire Safety and Manual Handling sessions are in place to improve these figures.		
Staff Appraisal		
Non-medical	85% in last 12 months	71%
Medical & Dental staff	85%	81%
Medical & Dental (excluding consultants)	85%	69%
Consultants	85%	87%

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

3.13 Quality Report request for External Assurance

Warrington and Halton NHS FT has requested the trust auditors PricewaterhouseCoopers (PwC) to undertake substantive sample testing of two mandated indicators and one local indicator (as selected by the governors) included in the quality report as follows:

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

Where the numerator is the number of patients receiving first definitive treatment for cancer within 62 days following an urgent GP (GDP or GMP) referral for suspected cancer within a given period for all cancers (ICD-10 C00 to C97 and D05) and the denominator is the total number of patients receiving first definitive treatment for cancer following an urgent GP (GDP or GMP) referral for suspected cancer within a given period for all cancers (ICD-10 C00 to C97 and D05). Reallocation of breaches between trusts are made depending on when the referral has been transferred to a secondary trust for further treatment, with referrals made before day 42 resulting in breaches being allocated to the treating trust but referrals after day 42 resulting in breaches being reallocated to the referring trust.

Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways

Where the numerator is the number of patients on an incomplete pathway at the end of the reporting period (monthly) who have been waiting no more than 18 weeks and the denominator is the total number of patients on an incomplete pathway at the end of the reporting period.

Advancing Quality Measure - Stroke (local governor selected indicator)

Based on SUS data, Advancing Quality provide the Trust with a number of stroke patients discharged in the prior month for which the Trust must upload data showing compliance with seven key measures relating to the patient's care. The Trust's Appropriate Care Score (ACS) is based on the percentage of patients compliant across all seven measures.

NB: Indicators included in the Quality Report have been marked with ⓐ

3.14 Quality Report amendments post submission for 3rd Party Commentary

2.2.3.	Participation in Clinical Research and Development inserted 22nd April 2015.
3.8	Staffing Levels inserted 23rd April 2015.
3.12	Medical and dental staff changed to 69%
2.1.1.2	The trust will continue to monitor the management of falls as an improvement priority for 2015/2016 inserted in this section.
2.1.1.3	The trust will continue to monitor measures from the inpatient survey as a quality indicator for 2015/2016 inserted in this section.
2.1.1.4	The trust will continue to monitor pressure ulcers as a quality indicator for 2015/2016 inserted in this section.
2.1.1.5	The trust will continue to monitor advancing quality measures as a quality indicator for 2015/2016 inserted in this section.
2.3.1a	Warrington and Halton Hospitals NHS Foundation Trust intends to take the following actions to improve the rate and so the quality of its services by going forward this will continued to be monitored as a quality indicator and we will report back in the Quality Report 2015/2016 inserted in this section.
3.2.3	Falls Management and Reduction – inserted narrative and table around falls per 1000 bed days.
3.2.4	CAUTI – inserted Safety Thermometer graphs.
2.2.2.	Participation in Clinical Audit and National Confidential Enquiries – all sections inserted.
3.9	Speak out Safely inserted.
3.2.1.1	MSSA – Reduction on ICU inserted in this section.
Clinical audit key inserted on page 36	
3.1.3.	Quality Dashboard 2014/2015 inserted into this section.
3.11	Training & Appraisal inserted into this section.
3.10	Performance against key national priorities inserted into this section.
Statement from the Trust's Council of Governors 2014/2015	
3.4.3	Complaints and compliments inserted into Quality Report.
Section one	CEO Statement inserted into report
Priority 4	Reduction in falls – goal for all falls reduced from 10% - 5% and stretch target reduced to 10%

Quality Report Part 4 – Statements

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

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

4.1 Statement from Warrington Clinical Commissioning Group

NHS
Warrington
Clinical Commissioning Group

☎ 01925 843636
Please Ask For: John Wharton
E-mail: john.wharton@warringtonccg.nhs.uk

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

www.warringtonccg.nhs.uk

Date: 26nd May 2015

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

Dear Karen

Re: Quality Account 2014-2015

Many thanks for the submission of the Quality Account for 2014-2015, and for the presentation to local stakeholders with the Local Area Team. This letter provides the response from Warrington CCG to your Quality Account.

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

Warrington CCG welcomes the work delivered by the Trust in relation to improving patient care for the local population and wishes to continue the healthy relationship that we have for future planning of health care delivery. We also wish to congratulate you for the impressive work which you have carried out, particularly in improving the trusts response to complainants and the positive impact that has on their experience of the trust. The CCG is pleased to see the continued improvement in the area of reducing pressure ulcers and welcomes the partnership approach with the CCG to this work. Your continued focus on falls and the reduction in harm associated with falls is good to see and share your disappointment that you were unable to meet this year's threshold.

Warrington CCG acknowledges the challenging year that the Trust has experienced and its impact on achieving the 95% Accident & Emergency access targets and acknowledges the work the Trust has undertaken to meet the target. The CCG also share your disappointment at exceeding your threshold in relation to the hospital acquired Clostridium Difficile target and welcome the opportunity to support this work during 2015/2016.

Clinical Chief Officer : Dr Andrew Davies MB ChB

Warrington CCG welcomes the feedback which you received from your Care Quality Commission (CQC) in relation to Maternity Services and the Theatre department and acknowledge the work undertaken to address the concerns raised. The inclusion of your planned Quality Priorities for 2015/16, particularly regarding improving the quality of care at the End of Life and the focus on mortality reviews is also most welcome.

I conclude by informing you that we are looking forward to working with the Trust throughout 2015/16, helping to improve the quality and delivery of services for the local population and ensuring that the provider is working towards delivering the three key domains of the CCG'S quality strategy safety, effectiveness and experience remain at the heart of health care provision.

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

Yours sincerely

John Wharton
Chief Nurse & Quality Lead
Warrington Clinical Commissioning Group

4.2 Statement from Halton Clinical Commissioning Group

NHS
Halton Clinical Commissioning Group

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

Tel: 01928 593479
www.haltonccg.nhs.uk

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

26th May 2015

Re: QA WHHFT14-15 JS

Dear Karen

Re Quality Account 2014-2015

Many thanks for the submission of the Quality Account for 2014-2015 and for the presentation to local stakeholders on 13th May 2015. This letter provides the response from NHS Halton Clinical Commissioning Group to the Quality Account 2014-2015.

NHS Halton CCG notes and understands the pressures and challenges for trust and the local health economy in the last year and would like to congratulate and thanks the Trust for the level of partnership working and support with NHS Halton CCG in this year in relation to Urgent Care centre developments.

As you are aware NHS Halton CCG works closely with the co commissioners NHS Warrington CCG through Contracting and Quality arrangements through which all indicators and CQUINs schemes are reviewed and monitored. Whilst this year the trust has struggled in some areas good progress on managing problem areas has been made through the monitoring of action plans for improvement. The programme of Clinical Focus Groups have provided a process through which we maintain good links with clinicians within the trust and has been useful in enabling some very effective service changes and quality improvements. .

NHS Halton CCG congratulates the trust on the continued work in relation to dementia and notes the progress made by the trust in many of this year's improvement priorities. The CCG understands that a CQC Full inspection has been completed during 2014-2015 and looks forward to publication of the final report.

NHS Halton CCG looks forward to working with the Trust during 2015-2016 to deliver continued improvement in service quality and patient experience and also on the partnership work as we move forward with our One Halton model of service delivery.

Yours sincerely

Jan Snoddon
Chief Nurse/Quality Lead
NHS Halton CCG
Email jan.snoddon@haltonccg.nhs.uk

4.3 Statement from the Halton Health Policy Performance Board

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

Our Ref	EST
If you telephone please ask for	Emma Sutton-Thompson
Your ref	
Date	20th May 2015
E-mail address	Emma.Sutton-Thompson @halton.gov.uk

Dear Ms Pickup,

Quality Accounts 2015

Further to receiving a copy of your draft Quality Accounts and the Joint Quality Accounts event held on 13th May that your colleague Alison Lynch attended to present a summary of your Quality Accounts, I am writing with the Health Policy and Performance Board comments. The Health Policy and Performance Board particularly noted the following key areas:

During the year 2014/15 the Trust identified a number of priorities to be achieved during this year. The Board noted the following:

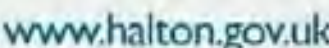
- *Complaints* – the Board are pleased to note that the Trust has both restructured the patient experience team and improved systems to ensure that complainants receive a timely meaningful response to their complaints and ensuring that complainants are kept informed of progress. This is a really important area, in particular, using the learning from complaints to make future improvements. The Board looks forward to seeing further improvements in this area.

- Falls – the Board were pleased to note the initiatives that have been put in place to help reduce falls, in particular the "Falls Change Package" supporting individual patients who are at risk of falls. The Board also notes that there is no standardised reporting of falls, and a suggestion to be considered is Chief Nurses looking at the viability of standardised reporting in this area.

- *In-patient Survey – improvement in low performing indicators* – The Trust had poor performance in this area in 2013, and the Board are pleased to note that last year improvements were made in this area, apart from "waiting a long time to get to a bed on a ward." This is an area the Board would be very interested to see an improvement in.

It's all happening **IN HALTON**

Communities Directorate
Runcorn Town Hall, Heath Road, Runcorn, Cheshire WA7 5TD
Tel: 0151 907 8300



Pressure ulcers – The Board were pleased to note that As at the 31st March 2014 the Trust reported a substantial 66.7% reduction in grade 3 pressure ulcers, with 6 confirmed grade 3 pressure ulcers, and a 33% reduction in the incidence of grade 2 pressure ulcers corresponding to 112 grade 2 pressure ulcers compared to 166 grade 2 pressure ulcers in 2012/2013.

The Board are pleased to note the following Improvement Priorities for 2015 – 2016:

- *Pressure Ulcer Reduction* – Although there has been an improvement in this area last year, the Board were pleased to note it as a continued priority and look forward to seeing more improvements.
- *Every Patient Has a Voice* – The Board noted this priority in terms of developing a patient experience strategy.
- *Improving the Quality of Care at the End of Life* – The Board are pleased to note this priority area as it is so important for people to be able to live as comfortably as possible with the illness they may have.

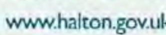
The Board would like to thank Warrington and Halton Hospitals NHS Foundation Trust for the opportunity to comment on these Quality Accounts.

Yours sincerely,

Councillor Joan Lowe
Chair, Health Policy and Performance Board

It's all happening **IN HALTON**

Communities Directorate
Runcorn Town Hall, Heath Road, Runcorn, Cheshire WA7 5TD
Tel: 0151 907 8300



4.4 Statement from HealthWatch Warrington

The trust requested a formal Statement from Warrington HealthWatch on the 17th April 2015 but was not submitted to the trust.

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

The trust requested a formal Statement from Warrington Health and Well Being Overview and Scrutiny Committee on the 17th April 2015 but this was not submitted to the trust.

4.6 Statement from the Halton HealthWatch

Healthwatch Halton's Statement for the Quality Account of Warrington & Halton Hospitals NHS Foundation Trust 2014-15

Healthwatch Halton thanks the Trust for the opportunity to comment on the Quality Account for the year 2014-15.

It is a comprehensive and detailed report but, as mentioned last year, Healthwatch Halton would appreciate a succinct executive summary, with clear statements of future priorities and a simple 'Met' or Partially Met' rating system for last year's priorities, as the document is too complex to identify the facts easily. We would also welcome the use of figures as well as percentages for a lot of the data and more use of graphs to illustrate progress. We appreciate the Glossary Appendix which fully explains the clinical and abbreviated health terms.

The Quality Dashboard chart we feel, is difficult to follow and the detail contained is complex and not easy for the public to understand.

Members were pleased to note that improvements in hospital acquired infections have been maintained and we welcome the continued management of pressure ulcers. However, although there was a reduction in 'all falls' it was disappointing to note an increase in moderate to catastrophic falls, but we welcome the Trust's commitment to addressing this issue by including it in next year's priorities.

We welcome the ward-led initiative to reduce falls, such as 'bay tagging' and the innovative campaign to improve patient hydration with a simple yet effective "Hello, my name is… would you like a drink?" is to be applauded.

The Trust is to be commended on the 'Forget-me-not' dementia ward, which is an excellent facility for patients and we applaud the use of dementia champions and the on-going dementia training for staff.

We noted the visit by CQC in January 2015 and await their report with interest.

Healthwatch members have valued the opportunities to take part in the PLACE visits at the hospitals.

We recognise the efforts of the Trust to engage with key stakeholders during the past year and we appreciate that feedback from a variety of sources informed the priority choices for 2015-16. Improving quality of care at the End of Life has been a key priority for Healthwatch Halton and we are pleased to see it will be one of your improvement priorities next year.

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

4.7 Statement from the Trust's Council of Governors 2014/2015

As in previous years, comments are based around the four main questions, which patients may wish to be answered.

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

Governors think this is true. We support the emphasis on patient safety, patient experience and clinical effectiveness documented throughout the Quality Report. Patients, their relatives, carers and the hospital's key stakeholders have all identified these as three areas of paramount importance. Due to the dedication, commitment and hard work of staff, our hospitals continue to enjoy an excellent reputation within our communities. Each year targets are agreed with the hospital's Governors; and staff should be congratulated for continuing to achieve many of the improvement targets.

The Quality Report highlights the Trust's continued focus in reducing the risk of patients acquiring a pressure ulcer and we are pleased to see that it has achieved a 42.9% reduction in grade 2 pressure ulcers during 2014/2015. The Accident and Emergency department national target for seeing 95% or more patients within four hours was not achieved over the year. The Governors recognise that the national position on delivery of the A&E target was much the same with only a small proportion of Foundation Trusts achieving the national target. The Governors also recognise that the problems encountered in A&E were systemic and that issues associated with discharge of patients to intermediate care facilities exacerbated the position. The care and treatment of patients who experience dementia is outstanding. The targets have been exceeded for treating people who have had a heart attack, hip or knee surgery.

The Summary Hospital Level Mortality Indicator (SHMI) and Hospital Standardised Mortality Rates (HSMR) rose slightly in the latter half of the year and failed to meet their year-end target. The Governors recognise that the Trust has reviewed this and received assurance that the Trust would be effective in reducing the rates through a better integration of central and local processes and promotion of trust wide learning and improvement. The Governors recognise the commitment and drive amongst all staff in the Trust to further improve patient care and patient safety and look to a significant improvement in the 2015/2016 mortality rate.

The likelihood of acquiring a hospital infection has reduced significantly during the last five years. The Governors were disappointed to see that the Trust has not reduced the cases of MRSA and C. difficile during 2014/2015. Every effort is made to ensure these infections are not passed from one patient to another. Governors also appreciate this is a problem for most Trusts in the North West. The Governors have received assurance throughout the year that each case was investigated. The Governors further recognise that a number of cases of C. difficile were challenged with Warrington CCG as the Trust felt they were not hospital acquired infections. All challenges had been rejected by the CCG despite the Trust management having put forward strong cases. The Governors recognise that going forward a new process of review is to be implemented that will have greater involvement of the CCG in reviewing cases.

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

Q2 Are there any important issues missed in the Quality Report?

The Governors believe most significant issues have been addressed. The Quality Report is very detailed and thorough and assists them in holding the Board to account. It provides comprehensive

information detailing patients' views of the care and treatment they have received. More data has become available during 2014/2015 to enable Governors to monitor patient and staff experiences in the Trust. The Friends and Family Test was introduced in April 2013 and continues to provide useful data. The CQUIN Inpatient Survey shows year on year improvements in the positive comments the Trust receives and the Governors are pleased to note the improvement in poor performing indicators identified as an improvement priority for this year. The staff survey shows that the percentage of staff who would recommend the Trust to friends and family increased in the last year.

The Trust prioritised complaints as an area where improvements were required and whilst this year has recorded an increase in the number of complaints, the Governors are pleased to note that the Trust is achieving its contractual target in responding to >=94% complaints within agreed timescales. There is further work to do and Governors are pleased to note that the development and implementation of the Patient Experience Strategy has again been included in the Trust's priorities for 2015/2016.

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

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

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

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

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

Outpatient services are provided at both hospital sites and for most patients it is their first contact with the Trust. Governors have surveyed former outpatients to better understand their priorities in the services provided. Their comments have been passed on to the Trust for consideration. Carers play a crucial role in supporting many patients during their time in hospital and after they leave. Governors have worked with unpaid carers, hospital staff and local Carers' Centres to develop a Carer Strategy for the Trust. During the last year Governors have supported measures to improve member, patient and staff feedback and encouraged the Trust to take action on what they have to say about services and the way they are delivered.

The Quality Report shows the Trust is in the process of implementing innovations around delivery of recruitment and training. This is to be welcomed. Governors are aware that the rates for staff receiving mandatory training, in particular, fire safety and manual handling, need to increase. The Governors continue to seek improvement in the number of staff receiving an annual appraisal during the forthcoming year and felt assured that this will continue with the appointment of the new Director of Human Resources and Organisational Development. Governors believe the Trust's staff are its most valuable asset and without their commitment and continual personal development it would not be able to deliver safe, high quality, compassionate care to its patients.

Q4 Is the Quality Report clearly presented for patients and the public?

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

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

4.7.1. Report on Governor ward observation visits - Ward Observation Visits 2014/2015

Background and the way in which ward observations are conducted

Governor led ward observation visits began in October 2011, having been initiated by the then Lead Governor in consultation with the Director of Nursing. This has led to an overall broadening of the role of the Governors in this Trust. One of the Governors takes responsibility for organising the visits together with two to four other Governors. A timetable for monthly ward observation visits is published at the start of each year, but the visits themselves are unannounced. A report of the findings is then issued to the board and the Care Quality Commission (CQC). To date there have been 34 ward observation visits.

The visits are designed to provide assurance to the Trust's Governors that the best possible standard of medical and nursing care is provided to patients in our hospitals. The checklist was originally developed by the CQC and has been modified and improved over time. This acts as a guide in assisting the Governors to assess the standard of care being provided.

At the start of the visit a check is made of the display boards outside the wards. These contain important information about whether any patients on the ward have recently had a fall, experienced a pressure ulcer, whether there has been a delayed discharge and what the level of staff sickness is on the ward was.

Patients

Patient care should be of the highest standard. The Governors always ask the patients about their views of the health care they are provided with. They ask patients about the food they are given and the noise levels on the wards during the day and at night. They ask about the nursing and medical care they receive and whether they are satisfied with how they are being treated.

The majority of patients that the Governors speak to praise the nursing care very highly and comment on their level of commitment and how hard everybody works. Doctors and other health professionals are also highly praised for their attention to detail and sensitive approach to dealing with the patients in their care. Patients and their visitors generally feel they have received information about their condition and the treatment they were being given.

Staff

During the visits the Governors talk to various members of staff on the wards about their roles. This has been very informative and has helped in the understanding of how the wards are managed and the pressures that staff may experience. Leadership on the wards is crucial and Governors are pleased to report they have seen many examples of outstanding teamwork.

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

Governors note items of equipment that may be missing/faulty or changes that would improve patient care or the appearance of the ward. Their views are always included in the Governor's report and in many instances this has led to the staff suggestions being implemented and the improvements being made.

Infection Control

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

Historically, areas of concern that the Governors reported have included some doctors wearing long sleeve garments, patients not being asked if they wanted to go to the toilet or being offered hand wipes prior to a meal being served. These occurrences have not been observed during the past year.

Cleaning

Cleanliness has improved drastically over the years to the point at which a spotless ward is now the norm. A check is always made on the cleanliness of the patient toilet areas, bathrooms and the length of the emergency cords. At no time, in the last year, have they voiced concern about the standard of cleaning. All the wards have dedicated domestic staff. They work tirelessly to maintain a high level of cleanliness. The bathrooms, toilets, floors and all patient areas have been perfectly clean. Spillages are promptly cleaned up and the floors around patient's beds clear of trip hazards or fallen items.

Privacy and Dignity

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

Medication

If the visit coincides with the administration of medication the governors will observe and report. Many beds now have a locked medicine cupboard and Governors observe if checks are made on the identity of the patient before medicines are administered. Governors have not observed any practices in the administration of medicine that have caused concern.

Food

Most patients were found to have been satisfied with the food provided. Occasionally the food ordered in the morning is not what some patients wanted for lunch. Every effort was made to accommodate the patient's wishes and find an alternative. Red trays are provided to indicate that a patient could not feed themselves and required assistance.

Many patients were coaxed and encouraged to eat and drink. Health care assistants and nursing support were always on hand to offer assistance where it was required. Many staff used this interaction as an opportunity to talk to the patients, sometimes about their family situation or their hobbies. In these situations the Governors have seen considerable care, attention and compassion being provided to patients.

Moving Forward

Discussions have recently been held with the Director and Deputy Director of Nursing as how the visits might be improved. Since the visits inception the concentration has been largely on the more general type of wards. In doing so the Governors have come to realise that many areas of Warrington and Halton are being omitted. It is therefore intended that the scope of visits be expanded to include departments such as AED, Outpatients, MRI etc. During these discussions it was suggested that the Governors might benefit from some of the practices already in use at WHH. These include The 15 Step Challenge and staff shadowing. It is intended to examine these in detail with a view to making them more appropriate to the Governor's requirements.

Conclusion

The ward observation visits have become an important part of the role of a Governor. They are designed to provide the Trust's Governors with an assurance that patients from Warrington and Halton are being provided with the best possible care. In publishing this report Governors are able to assure the Trust's members, staff and their patients that they believe this to be the case. The Governor visits to the wards have helped them to understand how they are managed and the roles of various staff. It demonstrates to the many patients and staff that their Trust's Governors not only attend committees but want to see and hear for themselves what it is like to be a patient in Warrington Hospital and Halton Hospital.

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

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

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

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2014/2015 and supporting guidance;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes for the period April 2014 to March 2015 (the period);
    - Papers relating to quality report reported to the Board over the period April 2014 to March 2015; date of statement
    - Feedback from the Commissioners, Warrington Clinical Commissioning Group dated 26/05/2015 and Halton Clinical Commissioning Group dated 26/05/2015;
    - Feedback from Governors dated 07/05/2015.
    - Feedback from local Healthwatch organisations, Healthwatch Halton dated 15/05/2015
    - Feedback from Overview and Scrutiny Committee Halton Borough Council Health Policy and Performance Board dated 20/05/2015
    - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 (Complaints: Patient Experience Annual Report – 2014/15), dated 27/05/2015;
    - The 2014 national inpatient survey;
    - The 2014 national staff survey;
    - CQC Intelligence Monitoring Report dated December 2014; and
    - The Head of Internal Audit's annual opinion over the trust's control environment dated March 2015.

- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;

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

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

By order of the Board
NB: sign and date in any colour ink except black

Mel Pickup Chief Executive	**Steve McGuirk** Chairman

28th May 2015

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

We have been engaged by the Council of Governors of Warrington 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 for the year ended 31 March 2015 (the 'Quality Report') and specified performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2015 subject to limited assurance (the "specified indicators"); marked with the symbol Ⓐ in the Quality Report, consist of the following national priority indicators as mandated by Monitor:

Specified Indicators	***Specified indicators criteria*** (section where criteria can be found)
Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways	3.13
Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers	3.13

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the specified indicators criteria referred to on pages of the Quality Report as listed above (the "Criteria"). The Directors are also responsible for the conformity of their Criteria with the assessment criteria set out in the NHS Foundation Trust Annual Reporting Manual ("FT ARM") and the "Detailed requirements for quality reports 2014/15" issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

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

The Quality Report does not incorporate the matters required to be reported on as specified in Annex 2 to Chapter 7 of the FT ARM and the "Detailed requirements for quality reports 2014/15";

The Quality Report is not consistent in all material respects with the sources specified below; and

- The specified indicators have not been prepared in all material respects in accordance with the Criteria and the six dimensions of data quality set out in the "2014/15 Detailed guidance for external assurance on quality reports".

We read the Quality Report and consider whether it addresses the content requirements of the FT ARM and the "Detailed requirements for quality reports 2014/15; and consider the implications for our report if we become aware of any material omissions.

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

- Board minutes for the period April 2014 to March 2015 (the period);
- Papers relating to quality report reported to the Board over the period April 2014 to March 2015;
- Feedback from the Commissioners, Warrington Clinical Commissioning Group dated 26/05/2015 and Halton Clinical Commissioning Group dated 26/05/2015;
- Feedback from Governors received 07/05/2015;
- Feedback from Local Healthwatch organisation, Healthwatch Halton dated 15/05/2015;
- Feedback from Overview and Scrutiny Committee, Halton Borough Council Health Policy and Performance Board dated 20/05/2015;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 (Complaints: Patient Experience Annual Report – 2014/15), dated 27/05/2015;
- The 2014 national inpatient survey;
- The 2014 national staff survey;
- Care Quality Commission Intelligent Monitoring Reports dated December 2014; and
- The Head of Internal Audit's annual opinion over the Trust's control environment dated March 2015.

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

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

This report, including the conclusion, has been prepared solely for the Council of Governors of Warrington and Halton Hospitals NHS Foundation Trust as a body, to assist the Council of Governors 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 2015, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Warrington 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:

- reviewing the content of the Quality Report against the requirements of the FT ARM and "Detailed requirements for quality reports 2014/15";
- reviewing the Quality Report for consistency against the documents specified above;
- obtaining an understanding of the design and operation of the controls in place in relation to the collation and reporting of the specified indicators, including controls over third party information (if applicable) and performing walkthroughs to confirm our understanding;
- based on our understanding, assessing the risks that the performance against the specified indicators may be materially misstated and determining the nature, timing and extent of further procedures;
- making enquiries of relevant management, personnel and, where relevant, third parties;
- considering significant judgements made by the NHS Foundation Trust in preparation of the specified indicators;
- performing limited testing, on a selective basis of evidence supporting the reported performance indicators, and assessing the related disclosures; and
- reading 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 but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the assessment criteria set out in the FT ARM the "Detailed requirements for quality reports 2014/15 and the Criteria referred to above.

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

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

Basis for Adverse Conclusion – Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways

The Trust is required to report to Monitor, on a monthly basis, the percentage of patients on an 18 week incomplete pathway who are still within the 18 week target. For four patients in a sample of 26 tested, we found errors in the way these had been reported which resulted in incorrect inclusion or exclusion from one or more monthly reports. A further two patients were found to be reported as non-breaches in a number of the monthly reports, when they actually should have been reported as having breached the 18 week target. We also found one patient where there was a discrepancy in the clock start date, although this did not impact on the months in which they were reported.

Conclusion (including adverse conclusion on percentage of incomplete pathways within 18 weeks for patients on incomplete pathways)

In our opinion, because of the significance of the matters described in the Basis for Adverse Conclusion paragraph, the Percentage of incomplete pathways with 18 weeks for patients on incomplete pathways indicator has not been prepared in all material respects in accordance with the criteria.

Based on the results of our procedures, nothing has come to our attention that causes us to believe that for the year ended 31 March 2015,

- The Quality Report does not incorporate the matters required to be reported on as specified in Annex 2 to Chapter 7 of the FT ARM and the "Detailed requirements for quality reports 2014/15";
- The Quality Report is not consistent in all material respects with the documents specified above; and
- the "Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers" indicator has not been prepared in all material respects in accordance with the Criteria and the six dimensions of data quality set out in the "Detailed guidance for external assurance on quality reports 2014/15".

PricewaterhouseCoopers LLP

Manchester

28/05/15

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

Appendix

Glossary

Appraisal	method by which the job performance of an employee is evaluated
Bariatric surgery	(weight loss surgery) includes a variety of procedures performed on people who are obese.
Care quality commission (CQC)	Independent regulator of all health and social care services in England. They inspect these services to make sure that care provided by them meets national standards of quality and safety.
Clinical audit	is a process that has been defined as "a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change.
Clinical commissioning group (CCCG)	Clinical commissioning groups (CCGs) are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England.
Clostridium difficile (C diff)	**A *Clostridium difficile* infection (CDI) is a type of bacterial infection that can affect the digestive system. It most commonly affects people who are staying in hospital.** (CMCLRN) Cheshire and Merseyside Comprehensive Local Research Network
Commissioning for Quality and Innovation (CQUIN)	This is a system introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of care.
Dr Foster	is a provider of healthcare information and benchmarking solutions to enable healthcare organisations to benchmark and monitor performance against key indicators of quality and efficiency.
Friends and Family test (FFT)	Since April 2013, the following FFT question has been asked in all NHS Inpatient and A&E departments across England and, from October 2013, all providers of NHS funded maternity services have also been asking women the same question at different points throughout their care : **"How likely are you to recommend our [ward/A&E department/maternity service] to friends and family if they needed similar care or treatment?"**
Governance risk rating	MONITOR **publish two risk ratings for each NHS foundation trust, on:** Governance (rated red, amber-red, amber-green or green); and Finance (rated 1-5, where 1 represents the highest risk and 5 the lowest).
Governors	Governors form an integral part of the governance structure that exists in all NHS foundation trusts; they are the direct representatives of local community interests in foundation trusts
Healthwatch	Healthwatch is a body that enables the collective views of the people who use NHS and social care services to influence policy.
Healthcare evaluation data (HED)	Clinical benchmarking system to support clinical experts in more effective management of clinical performance.

Hospital episode statistics (HES)	is a database containing information about patients treated at NHS providers in England.
Hospital Standardised Mortality Review (HSMR)	is an indicator of healthcare quality that measures whether the death rate at a hospital is higher or lower than you would expect.
Information governance	ensures necessary safeguards for, and appropriate use of, patient and personal information.
Mandatory training	The Organisation has an obligation to meet its statutory and mandatory requirements to comply with requirements of external bodies e.g. Health & Safety Executive (HSE), training is provided to ensure that staff are competent in statutory and mandatory
Monitor	assess NHS trusts for foundation trust status and license foundation trusts to ensure they are well-led, in terms of both quality and finances
MRSA	Methicillin-resistant *Staphylococcus aureus* (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans.
National confidential enquiries (NCEPOD)	The purpose of NCEPOD is to assist in maintaining and improving standards of medical and surgical care for the benefit of the public by: reviewing the management of patients; undertaking confidential surveys and research; by maintaining and improving the quality of patient care; and by publishing and generally making available the results of such activities.
National inpatient survey	collects feedback on the experiences of over 64,500 people, who were admitted to an NHS hospital in 2012.
National institute for health and clinical excellence (NICE)	Is responsible for developing a series of national clinical guidelines to secure consistent, high quality, evidence based care for patients using the National Health Service.
National institute of health research (NIHR).	Organisation supporting the NHS.
National patient safety agency (NPSA)	leads and contributes to improved, safe patient care by informing, supporting and influencing organisations and people working in the health sector.
National reporting and learning system (NRLS)	is a central database of patient safety incident reports. Since the NRLS was set up in 2003, over four million incident reports have been submitted. All information submitted is analysed to identify hazards, risks and opportunities to continuously improve the safety of patient care
Never events	are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
NNHS outcomes framework	reflects the vision set out in the White Paper and contains a number of indicators selected to provide a balanced coverage of NHS activity. to act as a catalyst for driving up quality throughout the NHS by encouraging a change in culture and behaviour.
Open and Honest	North of England Trusts produce and publish monthly reports on key areas of healthcare quality.

Palliative care	focuses on the relief of pain and other symptoms and problems experienced in serious illness. The goal of palliative care is to improve quality of life, by increasing comfort, promoting dignity and providing a support system to the person who is ill and those close to them.
Patient Reported Outcome Measures (PROMs)	provide a means of gaining an insight into the way patients perceive their health and the impact that treatments or adjustments to lifestyle have on their quality of life
Payment by results (PBR)	provide a transparent, rules-based system for paying trusts. It will reward efficiency, support patient choice and diversity and encourage activity for sustainable waiting time reductions. Payment will be linked to activity and adjusted for casemix.
Riddor	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995
Secondary users services (SUS)	The Secondary Uses Service is the single, comprehensive repository for healthcare data which enables a range of reporting and analyses to support the NHS in the delivery of healthcare services
Safety thermometer	is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care.
Subarachnoid haemorrhage (SAH)	Subarachnoid haemorrhage is a leakage of blood beneath the arachnoid membrane of the brain, from a major blood vessel. It affects a person suddenly and usually without any prior warning.
Summary hospital-level indicator (SHMI)	reports mortality at trust level across the NHS in England using standard and transparent methodology.
Urinary tract infection (UTI)	is an infection that affects part of the urinary tract
Venous thromboembolism (VTE)	A venous thrombosis or phlebothrombosis is a blood clot (thrombus) that forms within a vein. A classical venous thrombosis is deep vein thrombosis (DVT), which can break off (embolize), and become a life-threatening pulmonary embolism (PE).

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