Warrington and Halton Hospitals
NHS Foundation Trust

Quality Account 2010-11

Our Quality Report

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Our quality report

Part 1: Statement on quality from Chief Executive

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

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

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

In order to ensure that we meet these objectives, the trust has, over the past year, developed a set of quality metrics that enables us to demonstrate how we are performing and, most importantly, how we can strive to be the best. These metrics are part of a Quality Dashboard that is produced monthly and discussed across the different forums of the trust. Importantly, the transparency of this approach means that we can identify the impact any changes to practice have made to patients' safety, experience or the clinical effectiveness of the care we provide.

By ensuring that clinicians are at the forefront of developing these initiatives, we can maintain our commitment to develop services as well as ensuring accountability from the people who provide care. To this effect, the trust has continued to develop the process taken by the Leading Improvement in Patient Safety programme (LIPS) which was commenced in September 2009. LIPS has been the method in which they majority of patient safety improvements have been implemented.
Our participation with the North West Advancing Quality Programme has demonstrated our excellent performance in ensuring that patients get the right treatment at the right time.

During 2010, the Foundation Trust Governors established a Quality Committee of the Governors' Council. Led and chaired by a Governor, this group provides scrutiny to the whole process and is able to challenge the performance of the trust on its performance of the Quality Dashboard. This approach of a 'critical friend' has provided a valued additional tier of monitoring.

The trust has a robust performance management framework and engages in contract performance meetings with our commissioners.

The Board of Directors ensure that it too is provided with satisfactory evidence of the trust's performance. Quality is a standing item on the Board agenda – receiving the Quality Dashboards and other quality specific papers to embed the issues of safety, experience and quality at the heart of their discussions.

In order to ensure that colleagues can test the information that is being provided to them; Safety and Quality Walkabouts are scheduled into the monthly calendar. The Board are able to visit services first hand, talk to staff and patients to see that the information they receive is indeed, being practised and understood.

The senior nursing team perform a similar function in their Clinical Walkabouts that provide confidence that clinical standards are being maintained across the Trust.

2011/12 will see the introduction of Governor visits to our wards and departments, providing another perspective on the services we provide.

We have seen some significant achievements across the trust in the last year which are outlined in more detail in this report:

- a reduction in the number of hospital acquired Clostridium difficile cases by 44%
- a reduction in the number of cardiac arrests of 23%
- a reduction of our HSMR (mortality rates) to 90.2 against the national standard of 100 (where a lower score is better)
- compliance with a range of improvement packages to maintain safety and clinical effectiveness
- patient feedback giving a high rating for being treated with dignity
- 97% of patients rating their care as "good" to "excellent".

However, we know that we need to continue this improvement work and look at ways in which we can provide better care to patients (particularly in relation to falls and the development of pressure ulcers). The improvement of patient care will remain our top priority. As too will the further development of the structures and processes within the trust for ensuring effective monitoring.

In conclusion, this Quality Account will demonstrate that we have made positive strides in improving the care and services we deliver and that our determination remains strong to further that improvement.

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

Mel Pickup
Chief Executive
1st June 2011

Part 2: Priorities for improvement

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

This Dashboard is reviewed and discussed at:

- The Quality Improvement Committee (a sub-committee of the Board, established in 2010-2011)
- Nursing and Midwifery Advisory Council (the trust's senior nursing committee)
- Governors' Council Quality Committee (established 2010-2011)
- Meetings of the Board of Directors.

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

Our improvement priorities for 2011/12 will include:

- Achievement of the infection control standards set for the trust (no more that 4 MRSA blood stream infections and no more than 54 clostridium difficile cases to be acquired within the trust)
- A reduction in the number of falls within the trust which result in moderate to severe harm by 10%
- A reduction in hospital acquired pressure ulcers (grade 3 and 4) to no more than 29 within the year.

The approach for achieving these priorities will include:

- Developing Quality Improvement project teams to develop 'change packages' to address the specific issues
- Continued involvement with the Advancing Quality and LIPS programmes
- Develop measurements that are discussed with local teams in order to fully engage them with the projects
- Senior colleagues to 'adopt' a ward in order to demonstrate organisational commitment to achieving the targets
- Uphold a no compromise attitude to issues/practices which do not provide safe and effective care
- Receive more immediate feedback from patients regarding the care that they receive.

Targets for other safety, experience and effectiveness projects are contained within the main body of the Quality Account.

Statements of assurance from the Board

During 2010-2011 the Warrington and Halton Hospitals NHS Foundation Trust provided and/or sub-contracted seven NHS services as defined by the Care Quality Commission. These are:

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

The trust has reviewed all the data available to them on the quality of care in all seven of these NHS services. The income generated by these services makes up 100% of the total income generated from the provision of NHS services by the trust in 2010-2011.

Audit and Research

During 2010-2011 107 national clinical audits and four national confidential enquiries covered NHS services that the trust provides. The trust participated in 86% of national clinical audits and 75% of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

National Audits

The national clinical audits and national confidential enquiries that Warrington and Halton NHS Foundation Trust was eligible to participate in during 2010-2011 are as follows:

- NDA: National Diabetes Audit
- ICNARC CMPD: Adult Critical Care
- ICNACNCAA: Cardiac Arrest
- National Elective Surgery PROMs: Four Operations
- National Vascular Database: Peripheral Vascular Surgery
- CEMACH: Perinatal Mortality
- NLCA: Lung Cancer
- MINAP (including ambulance care): Acute Myocardial Infarction (AMI) & other Acute Coronary Syndromes (ACS)
- Heart Failure Audit
- NHFD: Hip Fracture
- TARN: Severe Trauma
- National Childhood Epilepsy Audit (Epilepsy 12)
- National Audit of Heavy Menstrual Bleeding
- SINAP: Acute Stroke
- National Sentinal Stoke Audit
- National Audit of Dementia
- National Falls & Bone Health Audit
- National Clinical Audit of Management of Familiar Hypercholesterolemia
- National Comparative Audit of Blood Transfusion: O Negative Blood Use
- National Comparative Audit of Blood Transfusion: Platelets
- British Thoracic Society: Paediatric Asthma
- College of Emergency Medicine: Paediatric Fever
- College of Emergency Medicine: Vital Signs in Majors
- College of Emergency Medicine: Renal Colic
- National Inflammatory Bowel Disease: Ulcerative Colitis & Crohn’s Disease
- SINAP: Acute Stroke

National Confidential Enquires

NCEPOD (National Confidential Enquiry into Patient Outcome and Death) aims to review medical clinical practice and to make recommendations to improve the quality of the delivery of care. This is done by undertaking confidential surveys covering many different aspects of medical care and making recommendations for clinicians and management to implement.

- Parenteral Nutrition
- Surgery in the Elderly
- Cardiac Arrest Procedures
- Peri-Operative Care

A full list of all audits and national confidential enquiries in which the trust participated during 2010-2011 is included in Appendix 1 of this report.

The national confidential enquiries that the trust participated in, and for which data collection was completed during 2010-2011, 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.

- Parenteral Nutrition – 100%
- Surgery in the Elderly – 100%
- Cardiac Arrest Procedures – 100%
- Peri-Operative Care – 0% - did not complete data within the required time period.

The reports of national clinical audits were reviewed by the provider (trust) in 2010-2011 and the trust intends to take actions to improve the quality of healthcare provided. Appendix 1 of this report gives examples of actions taken of both national and local audits.

Information on participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by Warrington & Halton Hospitals NHS Foundation Trust in 2010-2011 who were recruited to participate in research approved by a Research Ethics Committee was 1,859. This includes National Institute for Health Research (NIHR) portfolio studies as well as non portfolio studies.

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

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

In 2010-2011 the trust was involved in conducting 90 clinical research studies (55% increase on 2009-2010) mainly in Cancer, Stroke, Paediatrics, Reproductive Health, Rheumatology, Critical Care, Cardiovascular, Diabetes, Musculoskeletal, Ophthalmology, Oral and Gastrointestinal.

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

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

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

Most of the research carried out is funded by the NIHR. For 2010-2011 the trust received £421,082. We fund eight research nurses to support principal Investigators with recruitment and assist with the management of NIHR studies ensuring that the study runs safely and in accordance with the approved protocol.

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

Information on the use of the CQUIN framework

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

The aim of the CQUIN payment framework is to support a cultural shift by embedding quality improvement and innovation as part of the commissioner-provider discussion. The framework is intended to ensure contracts with providers include clear and agreed plans for achieving higher levels of quality by allowing the commissioners to link a specific modest proportion of providers' contract income to the achievement of locally agreed goals.

The locally agreed goals, which should be stretching and realistic, are discussed between co-ordinating commissioners and providers and included as part of contracts.

A proportion of trust income in 2010-2011 was conditional upon achieving quality improvement and innovation goals agreed between the trust and any person or body we entered into a contract, agreement or arrangement with for the provision of NHS services, through the CQUIN payment framework.

Further details of the agreed goals for 2010-2011 and for the following 12 month period are available online at the Monitor website - **www.monitornhsft.gov.uk**

Monetary total for the amount of income in 2010-2011, conditional upon achieving quality improvement and innovation goals, was £2,569,699, with a monetary total for the associated payment in 2010/11 of £2,545,969 received.

For purposes of clarity, a description of the national, regional and local CQUIN is illustrated on the following page with the identified targets and achievement status.

The Commissioning for Quality and Innovation (CQUIN)

		Targets	Achieved	
National	VTE	Baseline Reported	Baseline Reported 35.02%	
		90% Achieved in (Nov, Dec, Jan)	Nov = 94.41, Dec = 95.33 Jan = 96.16	Target fully achieved
	Patient Experience	70.9 (max) (09/10 performance 62.9%)	66.9	Trust improved performance by 4% from 62.9 % in 9/10.
Regional	AQ AMI	95% (cumulative)	99.43 cumulative to Dec 10	Latest position available is to December 2010. On target
	AQ Hip & Knee	93.25% (cumulative)	96.60 cumulative to Dec 10	Latest position available is to December 2010. On target
	AQ Heart Failure	76.42% (cumulative)	90.26 cumulative to Dec 10	Latest position available is to December 2010. On target
	AQ Pneumonia	85.11% (cumulative)	86.03 cumulative to Dec 10	Latest position available is to December 2010. On target
	AQ - PEMS	10%	21.8%	
		Pilot new system	Pilot implemented	Target fully achieved
	AQ - Stroke	Composite 90% Oct	89.34% cumulative to October to Dec 10	As at December the trust were marginally below target for the composite indicator but on target for the care bundle target
		Care Bundle 50% Oct	56.25%	
	TARN	Accreditation Clinical 97% Accreditation Demographics 97% Completeness 97%	Level 3 on target	Based on the December 2010 position the Trust are on target to achieve the Level 3 requirements
Local	CRAB	System/Baseline	Baseline reported	Achieved
		Trajectories	Trajectories reported	
	COPD	Complete TOR	Reported and agreed	Target requirements fully achieved
		Completion of Audit	Audit Complete and agreed	
	Medicine Management	1 Statins = 60% Q2, 3, 4	Fully achieved	Fully achieved
		2 Proton Pump Inhibitors =70% Q2, 3, 4	Fully achieved	Fully achieved
		3 ACE Inhibitors = 60% Q2, 3, 4	Fully achieved	Fully achieved
		4 Black Light = 0% Q1 - 4	Fully achieved	Fully achieved
		5 Clopidogrel = Q4 90% GP Notified	Fully achieved	Fully achieved
		6 Atorvastatin = Q4 90% GP Notified	Fully achieved	Fully achieved
		7 Anti TNF = 100% audited	Fully achieved	Fully achieved

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

Warrington and Halton NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is registered for the following regulated activity:

- 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 have no conditions on its registration.

The Care Quality Commission has not taken enforcement action against Warrington and Halton Hospitals NHS Foundation Trust during 2010-2011.

The trust has participated in a special inspection by the Care Quality Commission during April 2010 – March 2011. An unannounced response inspection was made in August 2010 following an incident within the Emergency Medical Unit (EMU) earlier in 2010.

Following the incident (which was reported via the Strategic Executive Information System (STEIS)) an action plan was developed to improve practice and services.

The action plan included issues to address:

- Safe standards of practice within EMU
- Provision of services for patients admitted to hospital by their General Practitioner
- Competencies required for nursing teams in the provision of care within an acute assessment setting.

The action plan is now complete. The visit from the CQC did not result in any restrictions to the provision of services/ practices within the trust.

Information on the quality of data

Warrington and Halton NHS Foundation Trust submitted records during 2010/11 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:

- Which included the patient's valid NHS Number was: 99.73% for admitted patient care; 99.85% for outpatient care; and 98.89% for accident and emergency care.
- Which included the patient's valid General Practitioner Registration Code was: 99.57% for admitted patient care; 99.79% for outpatient care; and 99.09% for accident and emergency care.

Information Governance (against the Information Governance Toolkit level 2)

The trust's Information Governance Assessment Report overall score for 2010/11 was 40% and was graded: Not Satisfactory .

We will be taking the following actions to improve data quality:

- Setting up a new Information Governance and Corporate Record Sub-Committee (chaired by the Director of Organisational Development and Governance and attended by Executive Directors) where we address issues relating to:
  - o Data Quality
  - o SUS Dashboards
  - o Information Governance
  - o Data items
- Putting in place a plan of action to achieve compliance with level 2 of the Information Governance Toolkit during 2011/12.

The trust was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission.

Part 3: Patient Safety, Clinical effectiveness & Patient Experience

In April 2010, the former Director of Nursing proposed that a 'dashboard' be presented to the trust board (and the wider committee groups) to provide assurance on:

- patient safety
- clinical effectiveness
- patient experience

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

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

The overall purpose of this information is to inform the organisation of its effectiveness and performance and to lead it in a direction of improvement by indicating specific issues/areas that need to be developed.

3.1 Patient safety

3.1.2 Infection Control

"We said that in 2010/11 we would have no more than 4 MRSA bloodstream infections and 116 cases of Clostridium difficile acquired within the hospital.

We had 5 cases of MRSA bloodstream infections and 65 cases of Clostridium difficile acquired within the hospital in the year.

Our plan for 2011/12 is to have no more than 4 cases MRSA bloodstream infections and 54 cases of Clostridium difficile acquired within the hospital"

Reducing healthcare associated infections remains a national priority for the NHS and for the trust in the delivery of its services.

Over the last twelve months the trust has maintained the low incidence of MRSA bloodstream infections and significantly reduced cases of Clostridium difficile. The following table provide an overview of these hospital acquired infections over the last three years.

Healthcare Associated Infections	Hospital Acquired Cases		
	2008/2009	2009/2010	2010/2011
MRSA bloodstream infection	8	4	5
Clostridium difficile	116	114	65

The targets set for reduction in 2010/11 were for the trust to have no more than four cases of MRSA bloodstream infections and so it was disappointing that there was one more hospital acquired case than had been anticipated.

MRSA screening remains in place for all elective (planned) and non-elective (emergency) patients and there is monitoring of the safe management of in-dwelling intravenous devices.

However, greater success is demonstrated in that the trust had 65 cases of Clostridium difficile in 2010/11 against a target of no more than 116. This is a considerable achievement and is testament to the seriousness that the trust places against infection prevention and control.

This success is a result in the strengthened practices the clinical staff employ whilst caring for patients; specifically in the prescription and monitoring of antibiotics (changes to the antibiotic formulary) and the introduction of new antibiotics with a lower reported association with Clostridium difficile.

The trust has antimicrobial ward rounds and has revitalised the 'Antimicrobial Steering Group' making it a much more effective forum.

Audit of appropriate antibiotic prescribing (84% compliance demonstrated) is carried out each quarter with the additional provision of additional audits of antibiotic prescribing where an increase in cases of Clostridium difficile have been identified.

Clostridium difficile training is provided to enable staff to identify and manage patients who develop symptoms to ensure they are isolated and tested immediately and prescribing training for junior doctors is also provided.

The trust is able to demonstrate compliance of good hand hygiene via weekly audits. Average monthly scores are reported to be between 94 – 98%.

The hospital environment has been reported as good by the PEAT (Patient Environment Action Teams) when inspections were carried out in February 2011. This team includes members of the local LINk organisations.

Infection Control Targets 2011-2012

The national MRSA and Clostridium difficile objectives have been set. The trust's targets for the next financial year are that we will have no more than:

- 4 cases of hospital acquired MRSA bacteraemia
- 54 cases of hospital acquired Clostridium difficile.

Future plans to control infection

The trust is committed to reducing infection risks. Additional activity is being undertaken to ensure the incidence of MRSA bloodstream infections remain low. This will include a re-launch of ANTT (aseptic non-touch technique). This is a nationally recognised approach for accessing intravenous devices to give fluid therapy and drugs.

In January 2011 the trust began reporting cases of meticillin-sensitive bloodstream infections. Hospital acquired cases will be investigated to identify how care improvements can be made.

The trust will continue the work on antibiotic prescribing. A target of 90% prescribing compliance has been set. A reformatted prescription chart is being introduced which will prompt medical staff to monitor the method of giving antibiotics and the length of time antibiotics are prescribed.

The trust will participate in the regional initiative to provide patients with an information card that they can use to inform medical personnel they have had a Clostridium difficile infection and that advice should be sought before prescribing antibiotics. In addition we are aiming to provide timely discharge information to GPs when healthcare associated infections have been identified.

3.1.3 Pressure Ulcers

"We said that in 2010/11 we would have no more than 35 grade 3 & 4 hospital acquired pressure ulcers.

We had 41 cases of grade 3 & 4 hospital acquired pressure ulcers.

Our plan for 2011/12 is to have no more than 29 grade 3 & 4 hospital acquired pressure ulcers"

Reducing the incidence of hospital acquired pressure ulcers (grade 3 and 4) was identified as an important challenge for the trust. During 2010/11, the organisation set itself a target of reduction of 10% of the previous year's total of 39.

Disappointingly, this was not achieved and at the end of March 2011, the trust reported that in the year 2010/11 there had been 38 grade 3 pressure ulcers and 3 grade 4 pressure ulcers acquired in the hospital.

This will remain a significant priority for the trust and is the focus of improvement activity. A package of measures to reduce the incidence of hospital acquired pressure ulcers to 29 (or less) has been introduced.

3.1.4 **Venous Thromboprophylaxis (VTE)**

"We said that in 2010/11 we would achieve a compliance rate of 90% or more for patients being assessed for VTE

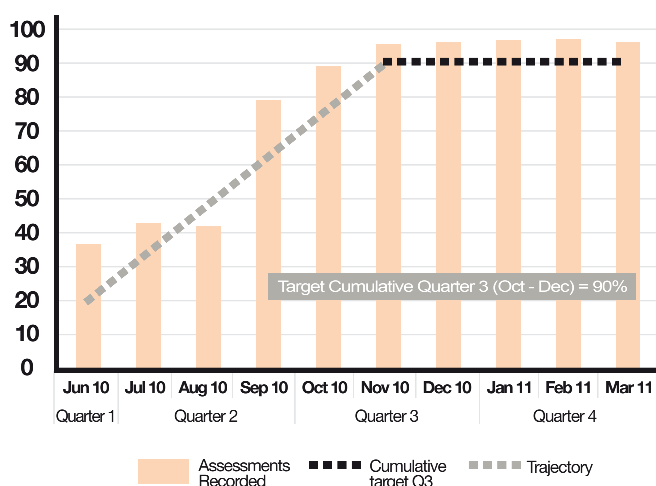
We achieved a compliance rate of 95.51%.

Our aim for 2011/12 is to continue to maintain the compliance rate of over 90%"

In 2010 we set out to improve the assessment, prescribing and administration of treatments to prevent patients from developing deep vein thrombosis. This serious issue was taken up as a national priority and incorporated it as part of the CQUIN targets. We were charged with a compliance target of 90% of patients being assessed by November 2010.

We are pleased to be able to report that we achieved that target and that the result for March 2011 was a compliance rating of 95.51%.

Venous Thromboprophylaxis (VTE)
% of patients being assessed



3.1.5 **Falls**

"We said that in 2010-2011 we would have no more than 50 incidents of a fall which caused moderate to severe harm.

We had 55 incidents of these falls within the year.

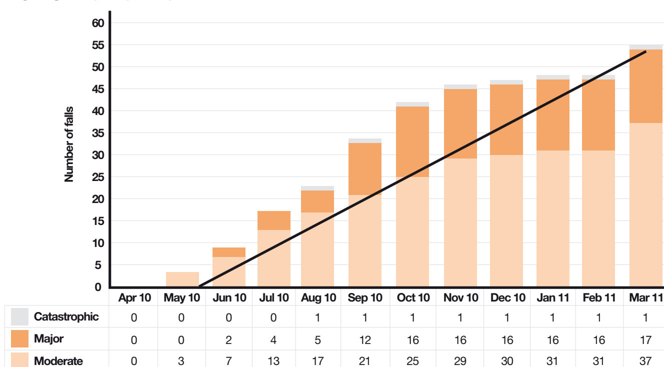
In 2011-2012 we will plan to achieve a target of having no more than 50 of these incidents"

In the period of 2010-2011, the trust set a trajectory to reduce the number of falls that caused moderate, major or severe harm to patients by 10% from the previous year's total number of 54 cases.

At the end of 2010-2011 the trust reported 55 cases of falls that caused this level of harm. The trust is disappointed that it did not achieve its target and has set about developing a series of measures to improve on this standard. The target to reduce this by 10% remains an objective for 2011-2012. This includes:

- A revised risk assessment process
- Increased training provision for staff in the care and management of patients who are identified as being at risk of falling
- A development of local quality improvement processes aimed at identifying a package of change to practice that will be rolled out across the whole of the trust.

Cumulative moderate, major and catastrophic falls 2010-2011



	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11
Catastrophic	0	0	0	0	1	1	1	1	1	1	1	1
Major	0	0	2	4	5	12	16	16	16	16	16	17
Moderate	0	3	7	13	17	21	25	29	30	31	31	37

Falls: Threshold is 55 total in the year

3.1.6 **Clinical Effectiveness**

Hospital Standardised Mortality Review (HSMR)

The HSMR scoring system works by taking a hospital's crude mortality rate (actual deaths) and adjusting it for a wide variety of factors such as population size, age profile, level of poverty, range of treatments and operations provided etc.

By taking these facts into account for each hospital, it is possible to calculate two scores – the mortality rate that which would be expected for NHS hospitals of a particular type and the observed rate for an individual hospital within that group. HSMR is an important indicator in alerting Trust's to potential issues that would adversely affect the quality of care provided.

Nationally the expected HSMR score for a trust such as Warrington and Halton NHS Foundation Trust is set at a score of 100. This figure does not represent deaths – it is just a baseline number used to compare performance. A number below 100 indicates that a hospital has less than the expected number of deaths.

This is a positive result for the trust and demonstrates that the improvement work implemented by our staff is having a positive effect on patient's outcomes.

	Warrington and Halton Hospitals NHS Foundation Trust HSMR score
February 2010	92.5
February 2011 (latest results)	90.2

Reducing harm to critically ill patients

"We said that in 2010-2011 we would have a compliance rate of at least 90% for bundles of care to prevent ventilator acquired pneumonia and urinary catheter infection

We achieved a compliance of 95% for ventilator acquired pneumonia prevention and 100% for urinary catheter infection prevention.

Our plan for 2011-2012 is to maintain this high level of compliance"

In last year's Quality Accounts we set out our intention to reduce harm to critically ill patients in relation to:

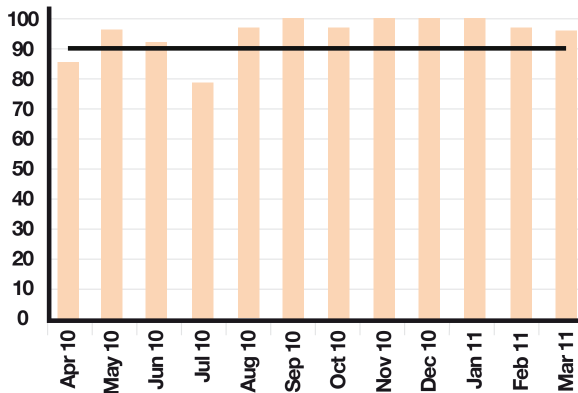
- Reducing ventilator acquired pneumonia (VAP)
- Reducing urinary associated catheter infections
- Reducing blood stream infections (as part of the 'Matching Michigan' study).

To achieve these goals, we introduced care bundles (packages of 'best practice'). Compliance against the implementation of these bundles is audited and we are able to demonstrate a reduction in the associated infections.

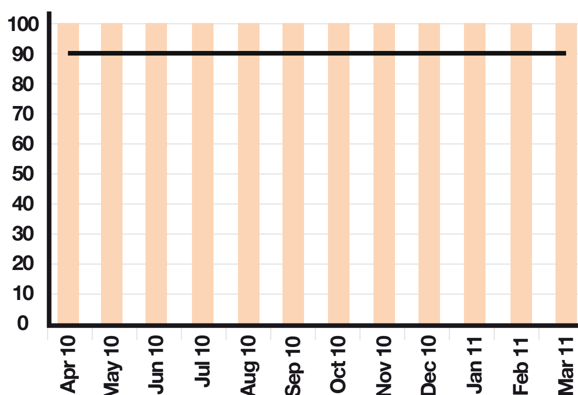
We set a trajectory of compliance of 90% for compliance against the implementation of care bundles for VAP and the insertion of urinary catheters.

Our successful achievement for these is demonstrated in the following graphs:

% of Ventilator or Bundles completed



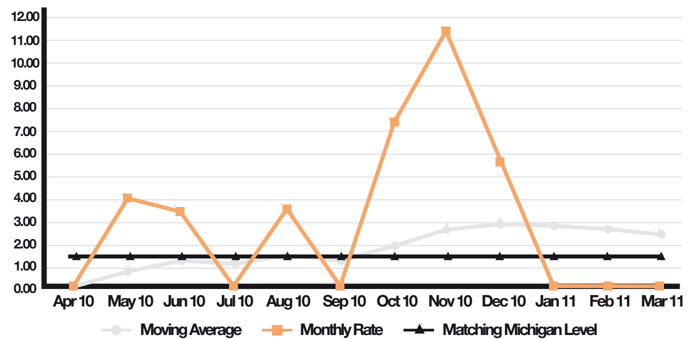
% of care bundles completed for urinary catheter insertion



—— = target

The graph below (courtesy of the Matching Michigan National Study) demonstrates our line infection rate per 1000 catheter days. This highlights a cluster of 8 infections over a 3 month period in October to December 2010 which significantly reduced our compliance with 'Matching Michigan'.

However, no further infections were reported in January 2011 – March 2011 which is beginning to affect our moving target positively.



Improving the care of the deteriorating patient

"Our aim for 2010-2011 was to reduce cardiac arrests by 5%

We achieved a reduction of 23%

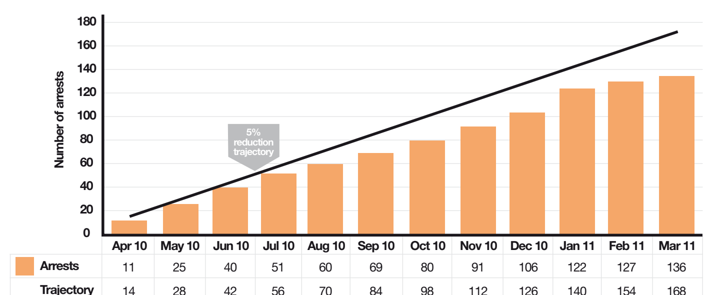
Our plan for 2011-2012 is to reduce this further by another 5%"

This aims to reduce the number of cardiac arrests of hospital patients other than those in the accident and emergency department, theatre department and the critical care areas.

In 2010-2011, we established our baseline for cardiac arrest and set a 5% reduction trajectory. As a result of the actions the trust has taken (improving the Modified Early Warning Score system and improved training of our staff) the trust has reduced the number of cardiac arrests by 23%.

The trust aims to build on this success and look at further ways of reducing cardiac arrests.

Total cardiac arrests (cumulative)



	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11
Arrests	11	25	40	51	60	69	80	91	106	122	127	136
Trajectory	14	28	42	56	70	84	98	112	126	140	154	168

Ensuring Safer Surgery

"Our aim for 2010-2011 was to achieve a 90% compliance in completing the 'safer surgery checklist'

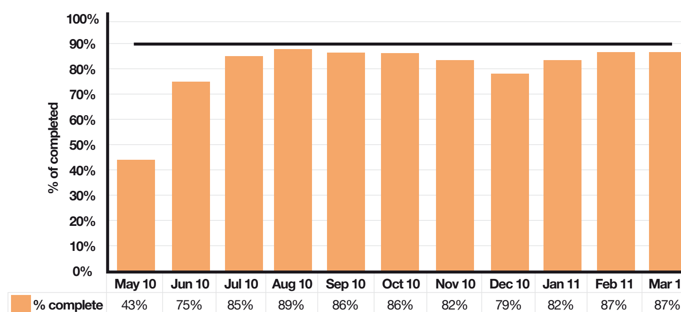
We achieved a compliance rate of 87%

Our plan for 2011-2012 is to achieve and maintain a compliance rate of 90%"

Last year's Quality Account stated the trust's intentions to adopt the principals of the 'Safer Surgery Checklist' (The goal of which is to improve the safety of surgical care around the world by ensuring adherence to proven standards of care. This is derived from a World Health Organisation initiative that has been shown to improve compliance with standards and decreased complications from surgery).

A baseline audit of compliance in May 2010 demonstrated a compliance of 43%. This has now increased to 87% at the end of March 2011, which is slightly below our target of 90%.

% of Safer Surgery Checklists completed



= target

The trust aims to achieve this target of 90% compliance in 2011/12 by providing further education to colleagues. There will then follow the important step change to ensure 100% compliance. This remains one of the trust's key objectives for the coming year.

Advancing Quality (AQ)

Advancing Quality aims to save lives and promote better quality patient care. It is based on a series of quality standards when treating patients for five common conditions/procedures (and a measure of patient experience):

- Acute myocardial infarction (heart attacks)
- Pneumonia
- Heart failure
- Hip and knee replacements
- Stroke

Pathway	Target	2009/10	2010/11
Acute myocardial infarction	95% (cumulative)	99.43 cumulative to Dec 2010	Latest position available is to December 2010. On target
Hip and knee replacements	93.25% (cumulative)	96.60% cumulative to Dec 2010	Latest position available is to December 2010. On target
Heart failure	76.42% (cumulative)	90.26% cumulative to Dec 2010	Latest position available is to December 2010. On target
Pneumonia	85.11% (cumulative)	86.03% cumulative to Dec 2010	Latest position available is to December 2010. On target
Stroke	Composite 90% Oct Care Bundle 50% Oct	89.34% cumulative to October to Dec 10. 56.25%	As at December the trust were marginally below target for the composite indicator but on target for the care bundle target
Patient Experience Measures (PEMS)	10% Pilot new system	21.8% Pilot implemented	Target fully achieved

NB – AQ data is produced some months after the end of each quarter and so information is only available for quarters 1 – 3 in 2010/11

3.2 **Patient Experience**

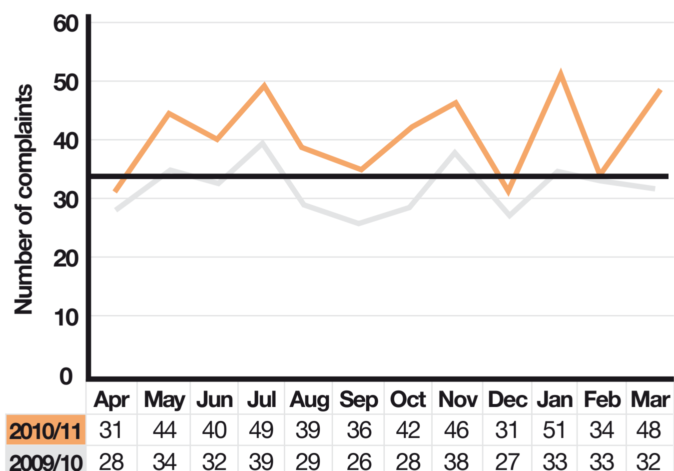
3.2.1 **Complaints**

The complaints process is an important source of data and feedback for the trust in its plan to improve the patient experience. The priority for the forthcoming year is to build on the progress made during 2010-2011. The patient relations team continues to provide support and guidance for Divisions when dealing with complaints and the patient relations manager attends regular meetings with key members of staff to discuss the handling of individual complaints.

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

In line with Care Quality Commission guidance we have encouraged more patients to make comments about their experience of services. This is an area in which we have improved our score as demonstrated in the National inpatient Survey around awareness of how to raise concerns. This has led to a rise in complaints this year which is part of a national trend in the NHS.

Complaints received



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2010/11	31	44	40	49	39	36	42	46	31	51	34	48
2009/10	28	34	32	39	29	26	28	38	27	33	33	32

Average no. of complaints received each month based on 2008/2009 and 2009/2010 data

	2009/2010	2010/2011
Total formal complaints received	379	491

Formal complaints - top five subjects 2010-11

	2010/2011
All aspects of clinical treatment	267
Appointments, delay/cancellation (outpatient)	59
Communication/information to patients (written and oral)	36
Patients property and expenses	20
Admissions, discharge and transfer arrangements	10

As a result of learning lessons about our services from feedback identified within complaints, the Trust has taken steps to ensure that patients have a much improved experience. Some of the actions taken have been the reinforcement of our current practice (for example, compliance with discharge planning pathways, infection control practice and the safe storage of patients' property) whilst other actions have required us to implement new approaches to how we provide care (for example, producing new patient information, providing additional training to our staff and changing some of the facilities/ ward environments).

3.2.2 **PALS**

The Patient Advice & Liaison Service (PALS) is an informal but valuable way of gaining patient feedback. PALS plays a significant and important role in the patient and public experience within the trust in dealing with concerns at the first level to help resolve issues before these escalate into formal complaints.

PALS contacts have increased in numbers in the past 2 years

	2009/2010	2010/2011
Total PALS contacts	920	1,253
Number of PALS contacts escalated to formal complaints	15	42

PALS contacts (by top five subjects 2010-11)

	2010/2011
Waiting times for an appointment	70
Support & advice	64
Communication problems with family	57
Waiting times for an operation	52
Staff attitude	48

3.2.3 **Compliments**

Although no figures for compliments received have been recorded in previous years it should be noted that from May 2010 (when compliment records began) to April 2011 the trust received 460 formal complaints, but received 2,125 compliments in the same period. These numbers do not reflect the many cards and letters sent direct to the wards and departments which are not forwarded for inclusion in the Divisional reports.

3.2.4 **National Inpatient Survey 2010**

The National Inpatient Survey 2010 has demonstrated that the improvement work the trust has implemented over the past year has had a significant effect on patient experience.

In the majority of issues that the survey addressed (admission to hospital, the ward patients stayed on, cleanliness, food, care and treatment provided, involvement in decisions, being treated with dignity and respect and discharge from hospital) the trust has made improvements in its scores.

This is a good result for the trust and it means that patients feel that they are receiving a much more improved experience at the time they spend under our care.

Overall, patients said that:

- They were treated with dignity and respect whilst in hospital (99% rated this as always or sometimes)
- They felt that the doctors and nurses worked well - excellently together (97%)
- They would rate the care they received as "good" to "excellent" (97%).

There are issues that we need to continue to improve upon and these will be the focus of our work over the next 12 months. These include:

- Responding to patients when they have used their call bell
- Improved ways of communication with patients about their care
- Reducing the delay in the process of discharge from hospital.

Evidence of achievement against these priorities will be demonstrated in the next National Patient Survey.

3.2.5 **Training & Appraisal**

	Target	Year End Results
Mandatory Training Health & Safety	85%	88%
Fire Safety	85%	61%
Manual Handling	85%	70%
Fire Safety - Over 100 additional refresher sessions have been agreed with the training department, and these are being organised.		
Staff Appraisal Non-medical	85%	83%
Medical & Dental Consultants	85%	59%
Medical & Dental (career grades)	85%	37%
Medical & Dental – consultants and career grades (excluding junior doctors)	85%	52%
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.		

An overview of performance in 2010/11 against the key national priorities from the Department of Health's Operating Framework

Level One - National Targets		Target	Weighting	Apr 10	May 10	Jun 10	QTR 1	Jul 10	Aug 10	Sep 10	QTR 2	Oct 10	Nov 10	Dec 10	QTR 3	Jan 11	Feb 11	Mar 11	QTR 4
Clostridium Difficile	Hospital Acquired (Target 116 per Year)	116	1	7	5	4	16	7	4	7	18	3	7	5	15	8	3	5	16
	Total (? Per Year)			8	8	7	23	9	7	9	25	5	10	7	22	10	5	7	22
MRSA Bacteraemia - (Hospital Acquired Target)		6	1	0	0	0	0	1	0	2	3	0	1	0	1	0	1	0	1
All Cancers: 31 - day wait for second or subsequent treatment	Surgery	94%	1	97.00%	100.00%	100.00%	99.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	Anti Cancer Drug Treatments	98%		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	Radiotherapy (From 01 Jan 2011)	94%		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
All Cancers: 62 - day wait for First treatment	From Urgent GP Referral To Treatment (Open Exeter Position)	85%	1	93.24%	76.67%	83.58%	85.07%	79.45%	83.87%	95.00%	86.18%	95.00%	81.00%	83.00%	85.29%	85.00%	86.96%	96.30%	89.57%
	From Consultant Screening Service Referral	90%		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Level Two - Minimum Standards		Target	Weighting	Apr 10	May 10	Jun 10	QTR 1	Jul 10	Aug 10	Sep 10	QTR 2	Oct 10	Nov 10	Dec 10	QTR 3	Jan 11	Feb 11	Mar 11	QTR 4
All Cancers: 31-Day Wait From Diagnosis To First Treatment		96%	0.5	98.00%	97.00%	100.00%	97.00%	100.00%	92.90%	98.00%	97.00%	95.90%	100.00%	100.00%	98.40%	96.7%	100.00%	100.00%	98.37%
Cancer: Two Week Wait From Referral To Date First Seen	All Cancers	93%	0.5	98.00%	98.00%	96.00%	98.00%	97.40%	97.80%	96.00%	97.00%	95.70%	97.40%	94.80%	96.80%	98.64%	97.27%	96.80%	97.50%
	Symptomatic Breast Patients (Cancer Not Initially Suspected)	93%		97.00%	95.00%	97.0%	96.00%	95.07%	97.80%	96.0%	96.00%	97.50%	95.90%	93.90%	95.80%	96.69%	96.58%	97.40%	97.30%
Screening of all elective patients for MRSA		100%	0.5	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available
% A&E and MIU throughput within 4 hours (hospital only)		95%	0.5	98.00%	98.55%	98.06%	98.21%	97.11%	96.77%	95.99%	96.63%	96.40%	95.98%	94.94%	95.77%	94.19%	95.05%	94.12%	94.42%
% A&E and MIU throughput within 4 hours (including 25% walk in with 308 added back in per week) = BASIS FOR COMPLIANCE ASSESSMENT		95%		98.55%	98.88%	98.48%	98.64%	97.89%	97.51%	96.91%	97.45%	97.39%	96.92%	96.22%	96.85%	95.50%	96.27%	95.43%	95.71%
% of patients thrombolysed within 60 minutes	Percentage	68%	0.5	100.00%	75.00%	From 1st June 2010 all eligible patients for Thrombolysis will be transferred to LHCH for Primary PCI and therefore these patients will not be thrombolysed and the collection of door and call to needle times will be obsolete. LHCH will be responsible for collecting data on call to balloon time with the target being 150minutes. If the patient self presents at Warrington Hospital is brought here by ambulance for further assessment or suffers an ST elevation MI as an in patient the times needed by LHCH will be documented on the transfer forms which are sent with the patient.													
	Number of patients eligible to be thrombolised			0	4														

All Acute and Mental Health Foundation Trusts	Target	Weighting	Apr 10	May 10	Jun 10	QTR 1	Jul 10	Aug 10	Sep 10	QTR 2	Oct 10	Nov 10	Dec 10	QTR 3	Jan 11	Feb 11	Mar 11	QTR 4	YTD
Self -Certification against compliance with requirements regarding access to healthcare for people with learning disability (Annual target)	N/A	0.5																	
Moderate CQC concerns regarding the safety of healthcare provision	N/A	1.0	No	No	No	No	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Major CQC concerns regarding the safety of healthcare provision	N/A	2.0	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	
Failure to rectify a compliance or restrictive condition(s) by the date set by CQC within the condition(s) (or as subsequently amended with the CQC's agreement)	N/A	4.0	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	
Registration conditions imposed by Care Quality Commission	N/A		No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	
Restrictive registration conditions imposed by Care Quality Commission	N/A		No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	

Overall Governance Risk Rating	Apr 10	May 10	Jun 10	QTR 1	Jul 10	Aug 10	Sep 10	QTR 2	Oct 10	Nov 10	Dec 10	QTR 3	Jan 11	Feb 11	Mar 11	QTR 4
Overall Governance Risk Rating Total Points 0 - 0.9 (Green, 1 - 1.9, Amber-Green, 2 - 2.9, Amber-Red, 3 or above Red)	0.0	0.0	0.0	0.0	0.0	0.5	1.0	1.0	1.5	2.0	2.0	1.0	1.0	1.0	1.0	1.0

Part 4: Statements from primary care trusts, Local Involvement Networks and Overview and Scrutiny Committees

4.1 Statement from the Halton LINk:

“Members welcomed the trust’s commitment to share the report widely and to seek the views of the Halton LINk and they appreciated the opportunity to be able to give feedback. Halton LINk is pleased to note the improvement shown in the quality of care within the report, especially with respect to infection control, mortality rates and some clinical outcomes. However, the statistics regarding falls and pressure ulcers are disappointing, although it is good to see that action plans have been put in place to address these issues. Additionally, the training and appraisal rates for staff, especially consultants are disappointing and it is hoped this will improve in the future.

“The Halton LINk would have liked to have had more detailed information about discharge processes and to have actual figures as well as percentages wherever possible. The lay-out and presentation of the information is clear and helpful for patients and the public and the Halton LINk appreciates the explanation for future plans for each section.

“Halton LINk members have been keen to have been involved with the trust throughout the year through groups such as the Patient Experience Group and the Patient Communication Group and the PEAT inspections. They are particularly pleased that a Halton LINk representative, as well as a Warrington LINk representative, is now sitting on the Governors’ Council. It would be useful if there could be a mid-term consultation with the LINk regarding Quality Accounts and we would appreciate this next year.”

4.2 Statement from the Halton Overview and Scrutiny Committee/Health Policy Performance Board:

“Positive improvements noted in the quality of care provided within the trust; this is evidenced within the document, in relation to MRSA, C Difficile rates and the overall HSMR. Although the target for the number of MRSA infections, pressure ulcers and falls were not achieved- the overall direction of improvement is evidenced.

“The report evidences a number of improvement action plans, which are being implemented- with a proactive approach to addressing issues raised. The National patient survey demonstrated excellent outcomes, however areas for improvement have been identified and plans in place to improve further. Partnership working with the trust and local authorities is good, and demonstrating improved outcomes for patients and carers- in particular on hospital discharges, intermediate care and the dignity agenda-this could be reflected in the report.

“It is good to see further improvements in quality of patient care recognised as a priority within the trust; including a reduction in the number of falls and pressure ulcers.”

4.3 Statement from Warrington LINk

"The LINk agrees with the main priorities set out in the Quality Accounts, but would like to see more work and improvements in working with Vulnerable Adults. The LINk would encourage the trust to continue its work round the assessment and monitoring of Vulnerable Adults, including feeding and nutrition.

"Warrington and Halton Hospitals NHS Foundation Trust has an effective open working relationship with the Warrington LINk. A LINk member is a Governor of the Trust representing the LINk. LINk members sit on the following groups:

- Patient Experience Group
- Blood Transfusion Committee
- Patient Communications Group
- PEAT Inspection
- Governors' Committees
- Staff and Patient Care Committee
- Governor Council Meetings
- Governors Only Meetings

"LINk members also attend other meetings as and when required, such as Quality Accounts and training. The LINk manager and the LINk 'health champion' for Acute Care are invited to attend bi monthly meetings with staff and Halton LINk to discuss LINk work, comments that have been received and best practice.

"The LINk has an effective working relationship with many staff within the Trust. Any comments that are received regarding the Trust are sent monthly and a full response is always provided by the Trust, in a timely fashion.

"Over the past year the LINk have conducted visits to B14, EMU wards, A6 and the new short stay/ discharge lounge at Warrington Hospital. The visits are always arranged effectively with the quality matron and all staff have been helpful. Recommendations from the visits are always responded to. The two main outcomes this year have been the successful Business Cases for 24 hour Thrombolysis and the improvements of the bathing facilities on B14, both of which the LINk highlighted and recommended. The LINk has also been involved in the PEAT visits, with a member attending the visits at both Warrington and Halton Hospital and through these have highlighted the need for improvements in bathing facilities in both Daresbury Wing and the Children's Ward.

"Through comments and issues raised with the LINk, a piece of work regarding the Psychiatric Liaison Services (PLS) in Warrington A&E was undertaken. This work is ongoing, below are the recommendations from the report. The Trust is working with LINk to improve the service. There is a commitment by the Trust to secure funding and to improve the service.

"The funding for the service needs to be secured as soon as possible, with the possibility of joint funding

- Mental Health training to be given to all A&E staff, including reception staff. Contact details for some basic Mental Health training, provided by NHS Warrington, has been passed to the Mental Health Liaison Nurse.
- More awareness of the service and especially awareness of the use of the on call Psychologist Consultant after midnight to all staff
- More information available at A&E i.e. coping with stress etc
- To ensure that appropriate, up to date information is given to all patients that are discharged
- Improved communication between Warrington and Halton Hospitals NHS Foundation Trust staff and the staff who work in the Mental Health Liaison Team
- If there is to be a relocation of the service , we would strongly recommend that consultation with staff and service users takes place
- If the service is not relocated, the appropriateness of the current assessment room should be considered, again with consultation with staff

"The Trust has now put an action plan in place, which addresses all the recommendations and continues to work with the LINk to improve the service. "

4.4 Statement from the trust's Governors' Council

Governors have reviewed carefully all sections of the draft Quality Accounts for 2010/2011 in their role as having responsibility for holding the Trust Board to account on behalf of the members, patients and the public. They commented to the Trust on the presentation and suggested ways in which the text may be made clearly understandable for patients and the public. Overall governors consider the Trust's Quality Accounts to be helpful in explaining the Trust's achievements, improvements and its priorities for the future and they recommend reading it. Governors considered their comments related to four main questions.

Do the priorities reflect those of the local population?

We believe this to be the case as evidenced by the largely positive results of the inpatient survey. Governors note that the patient experience has improved, although it is acknowledged that there are still issues to be addressed, such as timely response to the call bell, better communication with patients and reducing delays in the discharge processes. Also the report that complaints and concerns are taken seriously with action plans arising from them is welcomed as are the many compliments received. It is good that the priorities are not only outlined

at the beginning, but also in every section. The governors noted that even though all the targets for infection control were not achieved, there has been much improvement in this area. However there was disappointment that falls are still a problem, as is the incidence of pressure ulcers. It was appreciated that these issues are a high priority for improvement, with which, governors believe, patients would concur.

Are there any important issues missed in the Quality Accounts?

Governors feel the accounts are comprehensive, but suggest that some further attention could be paid to the known aspirations of patients and the development of interaction with members, patients and the public.
Has the Trust demonstrated that it has involved patients and the public in the production of the Quality Accounts? This has been done to some extent and is developing. Governors which include elected public and staff governors and appointed partner governors, through their Quality Committee, established in November 2010, have been involved in discussing quality information arising in monthly quality statistics for part of the year. LINk Governor representatives from both Halton and Warrington, who represent the public, have contributed to these discussions. LINk and patient representatives have sat on the Trust's Patient Experience and Communication Committees. Next year it is planned to develop this involvement by establishing a formal time table for regular consultation with the Governor's Quality Committee, who represent members, patients and the public.

Is the Quality Account clearly presented for patients and the public?

As stated above, Governors believe the format and section headings, where each topic shows what targets were set, to what extent they have been achieved and what plans there are for improvement is clear and understandable. The definition of acronyms is useful as is the arrangement of the appendices separated from the main text. It is hoped that patients and the public find this easy to read.

4.5 Statement from Warrington Health Consortium

"The overall content of the account was good however while the inpatient survey highlighted that the 'Patient Experience' has improved there are still a number of issues which appear unresolved,

- Poor communication between patients and staff appears to delay the patients discharge resulting in longer inappropriate stays in acute beds.
- Infection control targets not being met although there appear improvements in place to address these concerns.
- Falls – while there is a robust plan in place to monitor the numbers it appears that this is still an area where further work is necessary.
- Pressure Ulcers – the importance of ensuring patients skin integrity should be an essential component of the nursing process for all patients on admission.
- Poor response to call bells. This can be extremely distressing particularly for elderly and frail patients.

"A welcome aspect of the report is around the area of complaints and concerns which are clearly being taken seriously with a strong focus on the implementation of action plans to ensure that patient care and safety is improved upon quickly. However, a breakdown of the most common areas for complaint and the response of the trust to these areas would have enhanced the account.

"A further area which could have been included and in light of recent damming reports was a stronger focus on elderly care provision might have proved advantageous for assurance purposes.

"The inclusion of the low training and lack of staff appraisals was a further area of concern which raises the issue of 'safe' practice amongst the practitioners who are responsible for the delivery of patient care which the trust are ultimately responsible for.
"In conclusion while the report is concise there appeared a lack of attention to detail in the ensuring that the patient's needs are at the very centre of care delivery. While there have been improvements in reporting and the inclusion of elected public and staff as partner governors there doesn't appear to be a strong focus on improving the interface between the trust and the public."

John Wharton, Quality Lead
Warrington Health Consortium

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

"The following comments are provided on behalf of Warrington Borough Council's Health and Well-Being Overview and Scrutiny Committee (OSC). Due to the nature of the request and the timescales involved, which unfortunately did not coincide with the Committee's scheduled meetings, it has not been possible to submit the Quality Accounts 2010-2011 to a formal meeting of the Health and Well-Being Overview and Scrutiny Committee. However, the draft Accounts have been considered by the newly elected Chair of the Committee for 2011-2012 and the previous Chair for 2010-2011.

"The Quality Accounts provide a useful précis of the Trust's objectives for the delivery of key services, its performance in relation to targets for 2010-2011 and

improvement priorities for 2011-2012. We note the on-going strengthening of performance management structures and development of robust procedures to test the quality of information gathered. It is pleasing to see the significant achievements highlighted in the report and an acknowledgement of where the Trust needs to do better, including the steps being taken to achieve those improvements. It is somewhat disappointing to see an increase in the number of complaints received by the Trust in 2010/11, but we feel that the Trust is well placed to learn from patients' feedback. The high number of formal compliments received is a real positive and the value of informal feedback through the sentiments expressed in cards and letters should not be underestimated.

"The Trust has worked constructively with the OSC during 2010-2011. It has provided information which has led to the development of recommendations about hospital discharges. It has also actively participated in a joint report drafted by Warrington LINk and the Warrington Mental Health Forum on the A&E Mental Health Liaison Service, which was subsequently endorsed by the OSC. The Committee has also received regular updates from Warrington LINk about site visits to facilities operated by the Trust, which demonstrates the Trust's willingness to engage with interested groups. In November 2010, the Committee noted the good relationship that had been established between the Trust and Warrington LINk. The Trust has also raised with the Committee the potential impact of a review of Vascular Services in Cheshire and Merseyside, which is being led by Knowsley PCT. The Committee will maintain a watching brief in relation to these developments and will consider carefully any views expressed by the Trust.

"The Committee will continue to develop its relationship with the Trust to ensure accountability to the public for the services provided to Warrington residents. We look forward to working closely with the Trust about key issues in 2011/12 and to monitoring progress on its identified improvement priorities."

Cllr Tony Higgins
Chair Health and Well-Being OSC (2011-2012)

Cllr Wendy Johnson
Chair Health and Well-Being OSC (2010-2011)

Part 5: Statement of Directors' responsibilities in respect of the quality report

The directors' are required under the Health Act 2009, National Health Service (Quality Accounts) Regulations 2010 and National Health Service (Quality Account) Amendment Regulation 2011 to prepare Quality Accounts for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (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 2010-2011
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
- Board minutes and papers for the period April 2010 to June 2011
- Papers relating to Quality reported to the Board over the period April 2010 to June 2011
- Feedback from the commissioners dated 03/06/2011
- Feedback from governors dated 03/06/2011
- Feedback from Halton LINk dated 03/06/2011
- Feedback from Warrington LINk dated 02/06/2011

- Feedback from Halton Overview and Scrutiny Committee/Health Policy Performance Board 02/06/2011
- Feedback from the Warrington Health and Well Being Overview and Scrutiny Committee dated 06/06/2011
- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated April 2011 (CLIPS Report);
- The [latest] national patient survey (2010)
- The [latest] national staff survey (2010)
- The Head of Internal Audit's annual opinion over the trust's control environment dated April 2011.
- CQC quality and risk profiles dated March 2011.

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

- The Quality Accounts presents a balanced picture of the trust's performance over the period covered;
- The performance information reported in the Quality Account is reliable and accurate;
- The proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, 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 account is robust and reliable, confirms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Account has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at: www.monitornhsft.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

Allan Massey
Chairman
1st June 2011

Mel Pickup
Chief Executive
1st June 2011

Part 6: Independent Assurance Report

to the Governors' Council of Warrington and Halton Hospitals NHS Foundation Trust on the Annual Quality Report

I have been engaged by the Governors' Council of Warrington and Halton Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of the content of Warrington and Halton Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2011 (the 'Quality Report').

Scope and subject matter

I read the Quality Report and considered whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual, and consider the implications for my report if I become aware of any material omissions.

Respective responsibilities of the Directors and auditor

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual 2010/11 issued by the Independent Regulator of NHS Foundation Trusts ('Monitor').

My responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to my attention that causes me to believe that the content of the Quality Report is not in accordance with the NHS Foundation Trust Annual Reporting Manual or is inconsistent with the documents.

I read the other information contained in the Quality Report and considered whether it is materially inconsistent with:

- Board minutes for the period April 2010 to May 2011;
- papers relating to Quality reported to the Board over the period April 2010 to May 2011;
- feedback from the Commissioners dated 6 June 2010;
- feedback from the Lead Governor dated 2 June 2011;
- feedback from LINKS dated 2 and 3 June 2011;
- the Trust's annual complaints report;
- the 2010 national patient survey;
- the 2010 national staff survey;
- the draft Head of Internal Audit's annual opinion over the trust's control environment March 2011; and
- Care Quality Commission quality and risk profiles dated September 2010, October 2010, November 2010, December 2010, February 2011 and March 2011.

I considered the implications for my report if I became aware of any apparent misstatements or material inconsistencies with those documents (collectively, the 'documents'). My responsibilities do not extend to any other information.

This report, including the conclusion, has been prepared solely for the Governors' Council of Warrington and Halton Hospitals NHS Foundation Trust as a body, to assist the Governors' Council in reporting Warrington and Halton Hospitals' NHS Foundation Trust's quality agenda, performance and activities. I permit the disclosure of this report within the Annual Report for the year ended 31 March 2011, to enable the Governors' Council to demonstrate it has discharged its governance responsibilities by commissioning an independent assurance report in connection with the Quality Report. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the Governors' Council as a body and Warrington and Halton Hospitals NHS Foundation Trust for my work or this report save where terms are expressly agreed and with my prior consent in writing.

Assurance work performed

I conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). My limited assurance procedures included:

- making enquiries of management;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents listed previously.

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

It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

Conclusion

Based on the results of my procedures, nothing has come to my attention that causes me to believe that, for the year ended 31 March 2011, the content of the Quality Report is not in accordance with the NHS Foundation Trust Annual Reporting Manual.

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23rd June 2011

Quality report appendix

a) Details of clinical audits and national confidential enquiries participated in by the trust 2010-2011

The national clinical audits and national confidential enquiries that the trust participated in during 2010-2011 are shown on the following page.

Topic	National
Advancing Quality Results	National
Fracture neck of femur - CEM	CEM Standards
Urinary Retention Audit - CEM	CEM Standards
Obstetric Haemorrhage	CEMACH
Obesity in pregnancy	College
Colposcopy	National
Acute GI Bleed in ACS Patients	National
Ambulatory Oxygen service	National
Inpatient Diabetes care audit in Acute Medical Ward	National
Lung cancer in patients under 50 NLCA	National
BSR guidelines for the commencement & follow up of Biological Therapy in Ankylosing spondylitis Nov 2009	National
Cataract Surgery and complications	National
Caesarean section wound audit 2009	National
AQ Results 2008 - 2009	National
Matching Michigan	National
Massive Blood Transfusion	National
Management of massive blood loss for 2009	National
Pneumothorax Audit	National
Compliance in 2 week referral for suspected head and neck cancer	National
Cutaneous Squamous cell Carcinoma reports - compliance with National minimum dataset	National
AQ Standards for Pneumonia	National
Surgical Check list	National
Audiology Audit	National
Diabetic Retinopathy	National
Vaginal delivery swab count	National
Cardiac Arrest Audit	National
Out of Hospital Cardiac Arrests presenting to the Emergency Department	National
Perioperative Management of Diabetes	National
National Heavy Menstrual Bleeding Audit	National
Peri-operative Normothermia	National
Glaucoma Surgery Audit	National
AQ Results 1st / 2nd Year	National
GP compliance of rapid Access Neck Lump Clinic	National
Chest pain management mapping the journey	National/Local
Audit of sedation practice A&E department	National/Local
Audit of Use of Beriplex / FFTP in Reversal of Anti-Coagulation with Warfarin	National/Local
Peri-operative Anaesthetic morbidity review	NCEPOD
Adherence to the recommendations of the 2004 NCEPOD report	NCEPOD
Anaesthetic & OPD staffing Audit	NHSLA/CNST
Consultant Obstetrician Staffing Audit	NHSLA/CNST
Documentation Audit x6	NHSLA/CNST
Health records	NHSLA/CNST
CNST	NHSLA/CNST
Doctor's handover	NHSLA/CNST
Thromboprophylaxis implementation of National VTE assessment form	NICE
Laparoscopic vs. open repairs of groin hernias	NICE
Bladder care in Obstetrics	NICE
Warrington Hospital use of Exanatide Management of Type 2 Diabetes vs. NICE Standards	NICE
Exanatide in management of type 2 diabetes vs. NICE standards	NICE
CPAP Audit 2007 – 2009	NICE

Topic	National
Foetal Blood sampling	NICE
Novasure Audit	NICE
Shoulder Dystocia	NICE
TVT The procedure	NICE
Rivaroxban for TVT prophylaxis	NICE
Severely ill pregnant women	NICE
NICE treatment of Ankylosing Spondylitis with Anti TNF	NICE
Treatment of Menorrhagia with TAH	NICE
Electronic Foetal Monitoring	NICE
NICE Ankylosing Spondylitis	NICE
NICE Guidance on Biologics in RA	NICE
Primip C Section	NICE
Head Injury Audit	NICE
Rheumatoid Arthritis Care & NICE Guidance	NICE
Outcomes of Forminal Epidural steroid Injections (FESI)	NICE
1st Metatarsal Osteotomy	NICE
Timing of antibiotic administration BTS Guidelines	National
Re-Admissions	Regional
Audit of use of Immunohistochemistry in Pleural biopsies	Royal College
Re-Audit of Quality of reporting and lymph mode yield in colorectal surgery	Royal College
Cytological Accuracy of Thyroid FNAs	Royal College
External Cephalic Version	Royal College
Vital Signs National Audit 2010 – 2011	CEM Standards
Quality Review	NHSLA/CNST
Nursing Majors / Minors Documentation	NHSLA/CNST
ENP Documentation Audit	NHSLA/CNST
Documentation Audits - Receptionist - Halton	NHSLA/CNST
Epididymo Orchitis	National
COPD	National
Safeguarding Audit	National
VBAC Audit	National
Tonsillectomy & adenoidectomy - do we make a difference	National
Thromboprophylaxis	National
GI Bleeds	National
TARN Audit	National
Perineal Trauma	National/Local
Cardiac Arrest	NCEPOD
Elective and Emergency Surgery	NCEPOD
Operative Vaginal Delivery	NHSLA/CNST
Neonatal Resuscitation	NHSLA/CNST
Maternal Screening	NHSLA/CNST
Use of Infliximab in IBD patients	NICE
Foetal blood Sampling	NICE
Temperature monitoring in Maternity	NICE
Middle Ear Effusion Audit	NICE
NICE Guidelines on Surgical Treatment of OME	NICE
Fever in Children Audit	NICE
Tonsillectomy - Re-Audit	National - re-audit
Current practice of duodenal biopsy	Royal College
Amniocentesis	Royal College
Renal Colic	Royal College
Telephoning Critically Abnormal Results	Royal College

b) Examples of actions taken following completion of national clinical audits 2010-2011

Examples of actions taken following completion of clinical audit:

Audit	Actions
Renal Colic	Renal Colic Pathway to be approved
	Complete full data collection for CEM Audit
	Present findings to surgical meeting
Caesarean Sections	Additional fields on Operative Summary
	Weekly reports taken from Meditech
	Discussed at monthly Incident Report Meetings
	Operative delivery summary to be completed by all doctors
	Alerts on Meditech
	Incident forms must be completed for both red and amber non-compliance
Vital Signs	Trust-wide letter regarding which EWS are being used
	Feedback results to all staff and complement those who have done well
	Carry out internal audit
	Re-audit
Upper GI Bleed	Introduce GI bleed pathway
	Liaise with IT to improve data capture
	Re-audit
AQ results	AMI - to continue
	Pneumonia - Record smoking advice - Record blood culture time - Give antibiotics stat - Refer to new antibiotic guidelines - Refer all eligible patients - Future electronic orders to incorporate time of venous blood sampling
	Heart failure - Review old Echo / request Echo - Refer all eligible patients - Local HF booklet (in approval process)
	PEMS - Limited start on A1/A2/A3/CCU/A7/A8/A9/ Daresbury - Agree responsibilities with nursing management

c) Examples of actions taken following completion of local clinical audits 2010-2011

The reports of local clinical audits were reviewed by the provider (trust) in 2010-2011 and Warrington and Halton Hospitals NHS Foundation Trust intends to take actions to improve the quality of healthcare provided (examples for illustrative purposes).

Children's Health Audit Recommendations	
Documentation	**Actions**
	All pages to be labelled with patient name and DOB/Unit number by whoever starts the page
	Doctors to have access and training on how to print patient labels from Meditech
	All signatures to be identified by printing name underneath
Eczema Annual report	**Actions**
	Improving knowledge of education staff in schools with children with eczema. To attend some schools that are having problems with children with eczema
	To continue to improve dermatology knowledge
	Continue to support The National Eczema Society, by being a volunteer. Supporting National Eczema week with display boards in COPD and the ward.
	To increase community staff awareness of eczema nurse led clinic.
	To be involved with and provide mentorship for new student nurses.
	To continue nurse led clinics
	The trust does not directly provide dermatology services but when it is a secondary condition we ensure that the correct care and treatment is prescribed.
Medical reports for children for whom there are safeguarding concerns	**Recommendations**
	Improve the content of our Medical reports
	Produce a template / checklist that is locally agreed
	Encourage discussion between trainees & consultants re
	Interpretation & opinion
	Reduce the time taken to issue the report, local target of 48 hours
	Compare our findings with audit of medical reports produced by Community colleagues
	Re-audit after changes implemented.

Emergency Medicine	
Sedation Practice	**Recommendations**
	Continue to use sedation log to facilitate audit (electronic)
	Continue to use pathway to improve documentation
	"Fast track" patients likely to need sedation
	Standardise post procedural observation
	Training in giving sedation: - Other procedures e.g. chest drain - Other agents e.g. propofol - Nursing expectations (simulation)

Surgery	
Quality of reporting & Lymph node yield in Colorectal Resection specimens	**Recommendations**
	Target - To achieve a 100% compliance in completing the dataset
	Use of the new dataset will help us target both the aims of completing a proforma and reporting the core data items
	If LN harvest <12 - individual pathologist to return to the specimen (where relevant) for more LN
	Re-audit in 1 year
	Present the data in a surgical audit meeting

ENT	
SLT voice caseload	**Actions**
	Adjust SLT leaflet (sent out with opt-in letter) to include voice deterioration with stress / anxiety
	Increasing requirement to obtain patient feedback
	Warrington will start to collect feedback Halton will update current feedback form used
	Consider adjusting opt-in process
	Telephone contact prior to d/c if patients do not opt-in
	Copy of d/c letter to patient
	ENT giving SLT leaflet with contact details at the point of referral
	ENT- ensure patients understand the specific reason for referral e.g. post surgery nodules (reason = prevention) MDT /stress (reason = improve voice use) reflux (reason = support lifestyle change/vocal hygiene)
	Clearer CNA / DNA protocols to be considered
	Taking into consideration most optimal timing of intervention

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