High Quality, Safe Healthcare
Quality People Sustainability

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Warrington and Halton Hospitals NHS Foundation Trust

Quality Account 2012-2013

Contents

NB: Please note that where this document states Quality Account it is referring to this Quality Report as required by Parliament. The Quality Report is also published on NHS Choices as the Quality Account under Department of Health guidance.

Our quality account

Quality is our number one priority. Our quality account sets out how we have performed against the targets we set last year and what we will achieve in the coming year.

Part 1. Statement of Quality from the Chief Executive

Warrington and Halton Hospitals NHS Foundation Trust is dedicated to the provision of high quality care and clinical excellence which puts the patient at the centre of everything we do. To achieve this we have established robust systems to ensure that we are accountable for continuously monitoring and improving the quality of our care and services.

Our highly skilled workforce is dedicated to pursuing the best outcomes for patients through review of service, service re-design and through delivery of patient focussed clinical care. As such we welcome this opportunity of demonstrating through our Quality Account (QA) to patients, their families, and the wider public the relentless focus that the Trust has on improving the quality of our services.

Importantly we believe that our staff, governors, members and patients are the eyes and ears of the organisation as such their views are constantly sought to ensure that we are focussing on the things that will make the most difference in supporting our overriding ethos of high quality care for all.

Importantly this QA also offers the Trust an opportunity to describe a range of quality initiatives which are central to our strategic framework supporting Quality, People, and Sustainability.

The Trust services the community across two sites. The Warrington Campus provides acute and emergency facilities including Accident & Emergency, intensive care, maternity, medicine, surgical services, paediatrics, outpatients and a full range of diagnostic and back up services. The Halton campus provides a range of diagnostic, intermediate care, antenatal and outpatient services including a minor injuries unit for local patients. More recently, the development of the Cheshire and Merseyside Treatment Centre at Halton General provides orthopaedic surgery for both sites and includes a radiology centre with facility for Magnetic Resonance Imaging MRI and Computerised Tomography CT scanning.

The Trust has a robust performance management framework and within year it has continued to monitor services across the three domains of quality being patient safety, clinical effectiveness and patient experience. Quality performance information is reviewed and discussed within our governance structures and reported on a monthly basis to the Trust Board.

This QA includes progress on our quality improvement priorities established for 2012/2013, these priorities have been identified through receiving regular feedback and regular engagement with staff, patients, the public, and commissioners of NHS services, scrutiny group and other

stakeholders. Progress on the planned improvements is reported through the Trust's assurance committees, via the Council of Governors and ultimately through to Trust Board.

The Trust can report significant improvements within the improvement priorities described during 2011/12 including:

Improved discharge is evidenced by the 2012 National Inpatient Survey which reported a 7% improvement relating to staff talking to patients about who to contact if they had fears after they had left hospital; a 7% improvement in relation to staff explaining the purpose of medications and a 5% improvement in patients being informed about medication side effects to watch for on going home.

The reporting period also shows a reduction in the amount of harm as detailed within our Quality Improvement and Patient Safety Strategy. Our threshold for falls resulting in moderate to catastrophic harm was 18 falls and by year end we had 16 moderate harm falls and 0 falls with catastrophic harm. The Trust can also report 18 hospital acquired Grade 3 pressure ulcers against an improvement target of less than 21 and an internal stretch target of <19. Infection rates have been reduced by 90% in five years to below the NHS average. For 2012/13, the Trust reported 1 case of hospital acquired MRSA bloodstream infection (against a threshold of 3) and 19 cases of hospital acquired Clostridium difficile infections (against a threshold of 40). (this is last year's and the year on year improvements are in the report.

The QA also shows achievement against targets and a range of prescribed mandatory information including compliance with national audits and confidential enquiries and information relating to research governance and data quality. 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 Trust is pleased to report that it achieved its 2012/2013 CQUIN targets.

The Trust continues to perform well across all activity namely, meeting the A&E four hour waits, fast access to diagnostics with over 90% of patients have their treatment within three months of seeing their GP. Importantly 95% of Halton General and 80% of Warrington Hospital patients would recommend us to friends and family.

The time from when a suspicion of cancer is raised is a particularly distressing and anxious time for both the patient and their family. The 62-day target intends to ensure that these patients are prioritised to receive the tests and procedures they need to confirm or eliminate cancer as quickly as possible, and if cancer is diagnosed to begin treatment as soon as possible. The target is to achieve 85% of patients diagnosed with cancer starting treatment within 62 days of urgent referral with a suspicion of cancer or referral through A&E. In 2012-2013, Warrington and Halton Hospitals NHS Foundation Trust met its National Targets and Minimum standards for patients urgently referred with a suspicion of cancer began treatment within 62 days of their referral.

Over the year feedback we received from our stakeholders included that we should focus our priorities for improvement in a number of quality areas that are measureable, and that we should also provide a focus on key areas that we can apply to all areas of the organisation. Feedback was

that this would enable better embedding of quality across services, and provide opportunity to benchmark and standardise service quality.

We are disappointed that we have not seen the improvement we intended in some areas, such as readmissions and mandatory training figures in all staff groups, this remains an area of focus and we aim to report a positive change in 2013/2014.

Through a programme of consultation, our quality priority areas for 2013/14 will be:

- Reduction in medication errors that are related to insulin
- Zero tolerance to hospital acquired MRSA bloodstream infections
- Reduction in catheter associated UTI's
- Commissioner priorities – targets are to be finalised
- Reduction in incidents that result in severe or catastrophic harm
- 62 day cancer access target
- Summary Hospital Mortality Indicators – reduction in Mortality Rates
- Pressure Ulcers – a sustained reduction.

Our key areas of focus will be to:

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

I would like to reiterate our dedication to working in partnership over the coming year as we work toward our goal: the delivery of safe, high quality and effective care to our patients, their families and carers.

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

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

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
29th May 2013

Part 2. Improvement Priorities & Statement of Assurance from Board

The Trust has, in consultation with our staff and governors, developed a strategic framework to improve the performance of the organisation called QPS - Quality, People, and Sustainability. This QPS framework enables us to continue to deliver good performance whilst striving to make year on year improvements.

We've identified three areas of real change for 2012/13 – tackling some of the challenges facing us

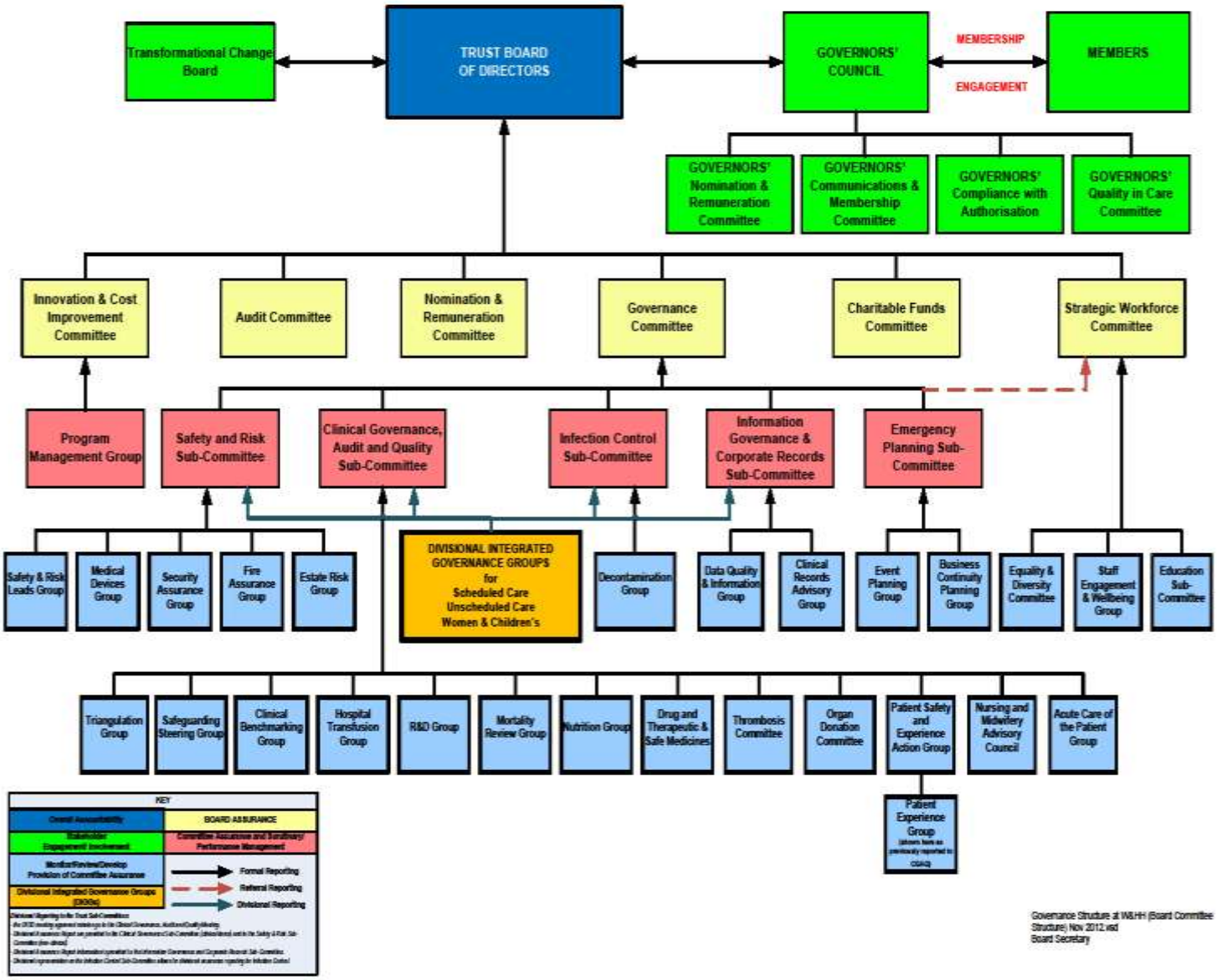
- **Reforming emergency care** - reducing pressure on our services. We've invested £1.4 million into A&E, redesigning the department, appointing extra staff and working on schemes to reduce demand.
- **Reforming elective care** – using our two sites effectively. We have developed the Cheshire and Merseyside Treatment Centre so we can move more planned work to Halton and focus on trauma at Warrington.
- **Reforming community services** – supporting patients. We focus on working more effectively in the community to reduce the requirement for people requiring admission into hospital, and getting them home safely and quickly.

We have developed a suite of performance indicators to provide assurance of its progress in developing patient safety, a quality patient experience and clinical effectiveness. The quality performance information is reviewed and discussed within our governance structures as shown below:

- Patient Safety and Experience Action Group
- Governors' Quality in Care Committee
- Meetings of the Board of Directors
- Meetings with the commissioners of the Trust's services

The Trust also undertakes joint working with both Warrington and Halton Clinical Commissioning Groups to identify and develop improvement opportunities.

Warrington & Halton Hospitals NHS Foundation Trust GOVERNANCE STRUCTURE



Governance Structure at W&HH (Board Committee Structure) Nov 2012.vsd
Board Secretary

2.1. Our Improvement Priorities

2.1.1. Improvement Priorities for 2012-13

In 2012/13, our improvement priorities were:

- Improve the way in which we plan and prepare patients for a safe discharge from hospital
    - Contact if patients had fears on leaving hospital
    - Details on side effects of medications taken home.
- Reduce the numbers of hospital acquired MRSA bloodstream infections.
- Reduce the amount of harm as detailed in our Quality Improvement and Patient Safety Strategy.
- Improve patient's experience based on the priorities included within the Patient Experience Strategy. Achieve an improvement in the priorities included within the Patient Experience Strategy (i.e. engagement and increasing the patient's voice in operating services).
- Commissioner priorities, including local and national CQUINs.

The Trust reported 1 case of hospital acquired MRSA bloodstream infection (against a threshold of 3) compared to 5 cases in 2011/12 and 19 cases of hospital acquired Clostridium difficile infections (against a threshold of 40) and against 38 cases for 2011/12.

The reporting period has also seen a reduction in the level of harm to our patients relating to both pressure ulcers and falls. Our threshold for falls was 18 falls that result in moderate to catastrophic harm, and by the end of the year we had 16 moderate harm falls. For 2011/12 we calculated that the Trust had 20 confirmed falls resulting in moderate to catastrophic harm.

Incidents severity levels

Incidents - severity levels and examples of descriptors		
Moderate	**Major**	**Catastrophic**
Moderate injury requiring professional intervention. **Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days.** **RIDDOR/agency reportable incident An event which impacts on a small number of patients.**	**Major injury leading to long-term incapacity/disability.** **Requiring time off work for >14 days Increase in length of hospital stay by >15 days.** **Mismanagement of patient care with long-term effects.**	**Incident leading to death.** **Multiple permanent injuries or irreversible health effects.** **An event which impacts on a large number of patients.**

We have reported 18 hospital acquired Grade 3 pressure ulcers against an improvement target of less than 21 and an internal stretch target of <19 compared to 21 cases for 2011/12

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

- Making Every Contact Counts (MECC) puts the prevention of health problems and disease at the heart of every NHS contact. The aim is to use each contact with a patient to offer appropriate brief advice on staying healthy.
- Patient Survey – measured by improvement in 5 survey questions whereby the Trust reported, via the 2012 National Inpatient Survey Report a 7% improvement relating to staff talking to patients about who to contact if they had fears after they had left hospital. We also saw a 7% improvement in relation to staff explaining the purpose of medications and a 5% improvement in patients being informed about medication side effects to watch for on going home.

Further detail on the compliance against the commissioner priorities can be found in sections 2.2.4 and 3.3.2 of this report.

The priorities identified within the Patient Experience Strategy for 2012/13 related to capturing views of patients through improved engagement. The Trust is committed to providing excellent care for all our patients. This means that not only will the care we provide be safe and effective, but that the patient experience of that care is the best it can be. It is essential that the Trust listens and acts upon all patient feedback, this comes from a variety of sources including compliments, comments, concerns, complaints, or via surveys we have undertaken ourselves. We have a duty then, once we have listened and understood, to focus on these experiences and make improvements based on patients own views and concerns.

This increased engagement has resulted in the Trust restructuring from September 2012, the Complaints and PALS Teams into a Patient Experience Team, with the specific remit of realigning a service to provide the best possible response to our patients concerns. Further information on this priority can be found in section 3.3.

2.1.2. Improvement Priorities for 2013 – 2014

The Trust Board, in partnership with staff and governors, has reviewed data relating to quality of care and have agreed that our improvement priorities for 2013/14 will include:

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

2.1.3. 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, scrutiny group and other stakeholders. Progress on the planned improvements will be reported through the Trust's assurance committees, via Council of Governors and ultimately through to Trust Board.

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

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 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.

2.1.4. Focus on Quality – Key issues

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

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

2.2. Statements of Assurance from the Board

During 2012-2013 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 2012-2013 represents 100% of the total income generated from the provision of relevant health services by the Warrington and Halton Hospitals NHS Foundation Trust for 2012-2013.

2.2.1. Data Quality

The data is reviewed through the Board's monthly review of the Quality Dashboard. The data reviewed covers three dimensions of quality – patient safety, clinical effectiveness and patient experience.

2.2.2. Participation in Clinical Audit and National Confidential Enquiries

During 2012/13 **34** national clinical audits and **4** national confidential enquiries covered relevant health services that Warrington and Halton Hospitals NHS Foundation Trust provides.

During 2012/13 Warrington and Halton Hospitals NHS Foundation Trust participated in **30 (88%)** national clinical audits and **4 (100%)** 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 2012/13 are as follows:-

National Clinical Audits

- Acute Coronary Syndrome or Acute Myocardial Infarction
- Adult community acquired pneumonia
- Adult Critical Care
- Bowel cancer
- Bronchiectasis
- Cardiac Arrest
- Cardiac Arrhythmia
- Carotid interventions
- Comparative audit of blood transfusion
- Diabetes (Paediatric)
- BTS - Emergency use of oxygen
- Epilepsy 12 (Childhood Epilepsy)
- Fever in children
- Fractured neck of femur
- Head and neck oncology
- Heart failure
- Hip fracture database
- Inflammatory bowel disease
- Lung cancer
- National joint registry
- Neonatal intensive and special care
- Non-invasive ventilation
- Oesophago-gastric cancer
- Paediatric asthma
- Paediatric pneumonia
- Pain Database
- Parkinson's disease
- Potential donor
- Renal colic
- Renal Registry
- Stroke National Audit Programme (combined)
- Vascular surgery (VSGBI Vascular Surgery Database)
- National Audit of Dementia

National Confidential Enquiries

- Alcohol Related Liver Disease
- Bariatric Surgery

- Cardiac Arrest Procedures
- Subarachnoid Haemorrhage

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 2012/13 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 2012/13

National Clinical Audits	Participated	Data collected 2012/13	% Cases submitted 2012/13
Acute Coronary Syndrome or Acute Myocardial Infarction	√	√	100%
Adult community acquired pneumonia	X	NA	NA
Adult Critical Care	√	√	Awaiting data
Bowel cancer	√	√	100%
Bronchiectasis	√	√	100% (37)
Cardiac Arrest	√	√	100%
Cardiac Arrhythmia	√	√	50% (38/76)
Carotid interventions	√	√	100% (46)
Comparative audit of blood transfusion	√	√	100% (30)
Diabetes (Paediatric)	√	√	Results not published
BTS - Emergency use of oxygen	√	√	100% (8)
Epilepsy 12 (Childhood Epilepsy)	√	√	100%
Fever in children	√	√	100%
Fractured neck of femur	√	√	100%
Head and neck oncology	√	√	29% (4/14)
Heart failure	√	√	100%
Hip fracture database	√	√	100% (382)

National Clinical Audits	Participated	Data collected 2012/13	% Cases submitted 2012/13
Inflammatory bowel disease	√	√	**Awaiting data**
Lung cancer	√	√	**100%**
National joint registry	√	√	**Awaiting data**
Neonatal intensive and special care	√	√	**100% (358)**
Non-invasive ventilation	√	√	**100% (27)**
Oesophago-gastric cancer	√	√	**64% (49/76)**
Paediatric asthma	**X**	**NA**	**NA**
Paediatric pneumonia	**X**	**NA**	**NA**
Pain Database	**X**	**NA**	**NA**
Parkinson's disease	√	√	**100%**
Potential donor	√	√	**100%**
Renal colic	√	√	**100%**
Renal Registry	√	√	**100%**
Stroke National Audit Programme (combined	√	√	**100%**
Vascular surgery (VSGBI Vascular Surgery Database)	√	√	**Awaiting data**
National Audit of Dementia	√	√	**100%**

National Confidential Enquiries	Participated	Data collected 2012/13	% Cases submitted 2012/13
Subarachnoid Haemorrhage	√	√	**100%**
Alcohol Related Liver Disease	√	√	**100%**
Bariatric Surgery	√	√	**100%**
Cardiac Arrest Procedures	√	√	**100%**

2.2.2.1. National Clinical Audits – reviewed

The reports of **10** national clinical audits were reviewed by the provider in 2012/13 and Warrington and Halton Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Audit	Actions for Improvements
National Neonatal Audit Project	Improve volume and quantity of data entered into Badger system on-going Staff awareness and training - posters Encourage all staff to use Badger Data entry guideline produced by NNAP Cross checking of data by data clerk in future Annual re-audit
Paediatric Pain College of Emergency Medicine (CEM) Standards	Raise awareness of CEM standards Highlight importance of good documentation Highlight importance of good pain management in children Re-evaluation of treatment crucial Feedback from staff Feedback from patients Re-audit
Consultant sign of Audit – CEM National Audit	Re-Audit Feb 2013
Vital signs CEM National Audit	Senior staff need to keep reminding juniors of importance of documenting vital signs and ensuring a FULL set of vital signs are done Safety briefings and posters to reinforce above Re-Audit
Renal Colic - CEM National Audit	Teaching session on pain assessment Reinforce use of Pathway Reinforce recording Renal Colic in audit section on AE card Compare results with National data once available and inform all staff
Head and Neck Cancer Network Group (CNG): 62 Day Pathway Audit	Re-Audit to be done prospectively by Cancer Network Meeting
National Audit of Inflammatory Bowel Disease	Take part in 4th National IBD Audit Bed manager to facilitate transfer of patients to Gastro wards. Care pathway for IBD

Audit	Actions for Improvements
National Diabetes in Pregnancy Audit	Reinstate planned/unplanned pregnancy onto audit sheet Raise issue early referrals and pre-conception care at GP and Practice Nurse forum meetings Midwifery diabetes update re importance early referrals Cardiac scan by end week 20 by anomaly scan being completed by medical obstetrician Ask if community pharmacists could do pre-conception medication review opportunistically. Consultant Diabetologist note to pharmacy lead.
National Comparative Audit of Blood Transfusion	Submit report to the Hospital Transfusion Committee and Clinical Governance (next meetings: Hospital Tranfusion Committee April 2013, CG report May 2013) Distribute finding to FY1's, FY2's, ST/SpR's and Consultants in the form of a "Bloody Matters" newsletter Recommendations to be presented to the Medical Consultants on Audit day.
British Society of UrogynaecologyNational Audit of Continence & Pelvic floor dysfunction surgery	Overall improvements in both Pelvic Organ Prolapse Quantification and quality of life are seen post treatment; Warrington results were consistent with National Data.

2.2.2.2. Participation in Local Clinical Audits

The reports of **207** local clinical audits were reviewed by the provider in 2012/13 and Warrington and Halton Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Local Clinical Audit – examples

Specialty	Title	Actions for improvements
Anaesthetic	**Chronic Pain Audit**	Cost savings Less inappropriate referrals to pain clinics Less inappropriate referrals to other secondary care teams Greater achievement in meeting 18 week targets Less GP consultations post PMP Potentially less need for repeat pain prescriptions post Pain Management Programmes.
Childrens Health	**Annual Meningitis Audit**	Maintain timely referrals from acute service Remind admin and audiology staff of prompt action to arrange Auditory Brain Stem Response if needed and to remind the hospital audiology staff of the 4 week deadline. Community staff (e.g. GP's RHV's and SHA's) remain aware of the importance of a timely audiological assessment. Annual audit

Specialty	Title	Actions for improvements
Childrens Health	**The Management of acute Asthma in Children**	Encourage Peak Flow measurements in acute asthma by communicating at handovers Reduce the X-ray investigations in children with uncomplicated asthma. Written care plans at discharge for children with asthma and wheeze
Emergency Care	**Head Injury Audit**	Ensure that a streaming nurse is present at the front end of the department as per the staffing plan and that all staff are aware of the streaming process and how to complete it Ensure all staff are aware of the pathways available for use and remind them to use them via e-mail
Emergency Care	**Sedation Audit**	Modifications to the Electronic Sedation Logbook To fast-track patients requiring sedation To undertake training in sedation for all professional groups. To include paediatric patients in the Electronic Sedation Logbook
Medical & Elderly Care	**Advancing Quality in acute Myocardial Infarction - Three years later**	Re-distribute referral criteria for Cardiac Specialist Nurses Monthly reviews of new measures Introduce secondary referral for any patient still requiring Left Ventricluar Systolic Dysfuntion assessment post discharge Seek support from pharmacy staff regarding standard secondary prescribing and Advancing Quality standards
Medical & Elderly Care	**Cardiac Arrests within 24 hours of admission to Urgent Care Centre**	Local agreed Do Not Attempt Cardio Pulmonary Resuscitation form Trust ceiling care form Trust Medical Emergency Team/ Trust escalation policy Revised Trust DNACPR leaflet If admitting doctor is considering DNACPR to escalate case to registrar grade or above Audit more of arrest calls for evidence of arrest
Orthopaedic	**Comparison of TKR with / without Tourniquet**	Change of Practice All Total Knee Replacements done without tourniquet
Pathology	**Transfusion sample labeling**	Submit report to Transfusion Team Meeting Submit report to Hospital Transfusion Committee and Clinical Governance Circulate 'Bloody Matters' to all wards for dissemination Present Findings to laboratory
Pathology	**Bladder Biopsies**	Three levels in every case Unstained sections in between (where needed) Consider using minimum dataset for bladder biopsy

		reporting Re-audit 2 years
Specialty	**Title**	**Actions for improvement**
Womens Health	**Diagnosis and management of ectopic pregnancy and pregnancy of unknown location**	Improve datix reports for ruptured ectopics and promote awareness of Early Pregnancy Assessment Unit referral criteria and pathways to GPs Need to adhere to protocol and follow the alogrithm HCG <5000 No pregnancy until after 3 months Follow up Human Chorionic Gonadatrophins until <20 Ultrasound scan FIRST, HCG if inconclusive Use HCG tracker board and UPDATE it! – may reduce no of HCGs being done before initiation of treatment Need to try and improve patient selection for managment to avoid requiring both medical and surgical management (although still better than 2008) Consider whether serum progesterone will change management before doing it Importance of re-scan if significant time has passed before giving methotrexate Encourage the use of datix for reporting ruptured ectopics and negative laparoscopies Re-audit

KEY:

CEM	College of Emergency Medicine
NNAP	National Neonatal Audit Project
AE	Emergency care
IBD	Inflammatory Bowel Disease
HTC	Hospital Transfusion Committee
CG	Clinical Governance
GP	General Practitioner
PN	Practice Nurse
FY1/FY2	Foundation Year 1 & 2
ST	Speciality Training
SpR	Registrar
BSUG	British Society of Urogynaecology
TKR	Total Knee Replacement
DNA CPR	Do Not Attempt CPR
AQ	Advancing Quality
EPAU	Early Pregnancy Assessment Unit
USS	Ultrasound Scan
MTX	Management
LVSD	Left Ventricular Systolic Dysfunction
ABR	Auditory Brainstem Response
HCG	Human Chorionic Gonadotropin

POPQ	Pelvic Organ Prolapse Quantification
RHV	Registered Health Visitor
PMP	Pain Management Programme

NB: Full details of the actions to be 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 2012/13 that were recruited during that period to participate in research approved by a research ethics committee was 1,830**.**

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 2012-2013 the Trust was involved in conducting 98 clinical research studies (a 3% increase on 2011/12**)** in research in oncology, surgery, stroke, reproductive health, cardiology, rheumatology, gastroenterology, ophthalmology, as well as paediatric and other studies.

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

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

Most of the research carried out by the Trust is funded by the NIHR. For 2012-2013 the Trust received £434,000 which funds nine research nurses to support Principal Investigators with recruitment and to assist with the management of NIHR studies ensuring that the study runs safely and in accordance with the approved protocol.

In 2012-2013 Warrington and Halton Hospitals NHS Foundation Trust also launched the Investigator Led Grant Awards Scheme and have awarded three projects to take place over the next 12 months which will provide a benefit to patients whilst also developing research investigators locally.

2.2.4. The CQUIN Framework

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

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

The locally agreed goals, which should be stretching and realistic, are discussed between Trust Board, commissioners and providers and included within contracts.

A proportion of Warrington and Halton Hospitals NHS Foundation Trust's income in 2012/13 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 2012/13 and for the following 12 month period are available online on the Monitor website.

The monetary total for the amount of income in 2012-2013, conditional upon achieving quality improvement and innovation goals, was £4.3m, with a monetary total for the associated payment in 2012/13 of £4.3m received. In 2011/12 the Trust received a monetary total for the associated CQUIN payment of £2,490,830.

The Trust achieved full compliance against all of the agreed CQUINS and received full payment. The Trust had the following CQUIN goals in 2012/13 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 2012/13

CQUIN	TITLE	MEASURE	WEIGHT	ACHIEVED CQUIN TARGET
National	Venous-thromboembolism (VTE) Risk Assessment - Reduce avoidable death, disability and chronic ill health from VTE.	90% of appropriate patients to be risk assessed	0.125	**YES**
National	Dementia	Dementia screening, risk assessment and referral.	0.125	**YES**
National	Patient Survey	Improvement in response to five inpatient survey	0.125	**YES**

		questions.		
National	Safety Thermometer	ST measures the percentage of patients who have experienced harm free care in relation to pressure ulcers; falls, UTI, VTE and catheter.	0.125	**YES**
Local	Advancing Quality – Application of quality requirements based on evidence and research to yield quality outcomes for:- • Pneumonia • Heart Failure • Acute Myocardial Infarction • Hip and Knee • Stroke • Patient Experience	Performance delivery for each condition demonstration annual improvement against the targets. Implementation of new quality targets.	1	**YES**
Local	Making Every Contact Counts (MECC) puts the prevention of health problems and disease at the heart of every NHS contact. The aim is to use each contact with a patient to offer appropriate brief advice on staying healthy.	Complete training of nursing staff to maximise the value of clinical contacts.	1	**YES**
TOTAL			**2.5**	

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 2012-2013.

Warrington and Halton Hospitals NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.
The Trust is registered to provide the following services:

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

The Care Quality Commission made two unannounced visits to Warrington Hospital in January and March 2013, to review systems, standards, audit and processes as part of the Regulated Activities for Quality and Safety. Both inspections were unannounced, one focussing on inpatient areas, and the second on pathology services. The full reports can be found at www.cqc.nhs.uk

Extract from the CQC inspection report from 23rd January 2013

How we carried out this inspection

We reviewed all the information we have gathered about Warrington Hospital, looked at the personal care or treatment records of people who use the service, carried out a visit on 23 January 2013 and observed how people were being cared for. We checked how people were cared for at each stage of their treatment and care, talked with people who use the service, talked with carers and / or family members and talked with staff. We talked with other regulators or the Department of Health. We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

What people told us and what we found

During our inspection we spoke with 18 people including patients, relatives and other visitors in various wards and departments. Most of the feedback we received was positive. We heard comments such as "the staff are brilliant, nothing is too much trouble for them"; "I give them 90%"; and “staff are marvellous” and "staff have been good."

Extract from CQC Inspection 20th March 2013 reported April 2013

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 20 March 2013, observed how people were being cared for and talked with people who use the service. We talked with staff, reviewed information we asked the provider to send to us and were accompanied by a specialist advisor.

What people told us and what we found

We spoke with professionals who frequently used the services of the microbiology laboratory and they said they were more than happy with the service that was provided.

They said that they were informed by the lab staff of the test results (as soon as these were available) to help plan the patient care pathway. They found lab staff approachable.

2.2.6. Trust Data Quality

Warrington and Halton Hospitals NHS Foundation Trust submitted records during 2012/13 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:

- **99.5%** for admitted patient care
- **99.7%** for outpatient care
- **98.3%** for accident and emergency care.

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

- **99.4%** for admitted patient care
- **99.6%** for outpatient care
- **100%** for accident and emergency care.

2.2.6.1. Information Governance

Warrington and Halton Hospitals NHS Foundation Trust's Information Governance Assessment overall score for 2012/13 was 67% and was graded red. However we are pleased to report an increase of 8% on the 2011/12 submission. The Trust's Information Governance arrangements were audited by the Mersey Internal Audit Agency during 2013 and were given a significant assurance rating.

Action plans are in place to work towards compliance against level 2 of the standards within the Information Governance Toolkit by March 2014. Areas requiring improvement include staff levels of Information Governance training and the implementation of an audit cycle for accuracy checks on service user data. Performance progress will be monitored by the IM&T Steering Committee which is a sub-committee of the Trust Board.

Warrington and Halton Hospitals NHS Foundation Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were 7%.

The sample was 270 finished consultant episodes (FCE) (equal to 225 Spells) across the following range of activities covered by the mandatory tariff. These results should not be extrapolated further than the actual sample audited.

	Spell Analysis			FCE Analysis		
Sample Areas	**Spells**	**HRG Error Rate/Spell**	**Spell Errors**	**FCEs**	**Coding Error Rate/FCE**	**FCE Errors**
Digestive Sytem	**67**	**6%**	**4.02**	**80**	**6%**	**4.56**
Cardiac Procedures	**40**	**7.50%**	**3.00**	**50**	**6.40%**	**3.20**
Stroke Admissions	**28**	**3.60%**	**1.01**	**50**	**3.20%**	**1.60**
Non Elective Short Stay Admisisons Through A&E	**90**	**6.70%**	**6.03**	**90**	**10.50%**	**9.45**
Total	**225**	**6.25%**	**14.06**	**270**	**6.97%**	**18.81**

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

- We are working towards compliance at the requisite level 2 standard across all the requirements contained within the Information Governance Toolkit in 2013/14.
- The trust continues to complete actions and recommend further improvements to Data Quality via the Trust's Data Quality and Management Steering Group.

2.3. Overview of Performance in 2012/13 against NHS Outcomes Framework

Set out in the table below are the quality indicators that trusts are required to report in their Quality Accounts.

Additionally, 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 same; and
- with those 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.

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

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

SHMI Coding

DATE PERIOD	TRUST	BANDING	HIGHEST	LOWEST	NATIONAL
October 2011 - September 2012	111.26	2	121	68	100
July 2011 - June 2012	109.51	2	125	71	100

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, where 1 = above average performance and 3 = below average performance.

Warrington and Halton Hospitals NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by introducing a new Clinical Effectiveness scrutiny system to monitor and evaluate healthcare intelligence designed to drive up quality and efficiency and improve patient experience.

The Trust has invested in a Clinical Effectiveness Manager role and in Healthcare Evaluation Data (HED); a clinically-led benchmarking system, to alert the Trust to areas of potential concern and to support clinical experts in more effective management of clinical performance. As part of these developments, the Trust is extending its mortality review processes to include a sample of all inpatient deaths (in addition to the categories of deaths already routinely reviewed) and to involve a wider range of clinical staff in this process.

Existing mortality review processes are being reviewed and a degree of standardisation introduced across the organisation to enable central coordination, more robust analysis of outcomes at an organisational level and action planning for improvement. Thorough case note reviews have been conducted following analysis of data on the HED system and where appropriate, action plans have been developed and have or are in the process of being implemented.

2.3.1b. The 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 2011 - September 2012	11.6%	18.8%	43.3%	0.2%
July 2011 - June 2012	9.1%	18.2%	46.3%	0.3%

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

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

Warrington and Halton Hospitals NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by introducing a new system and proposed appointment of a Clinical Effectiveness Manager to interrogate data and evaluate intelligence to improve palliative care coding in the Trust. The appointment of a Palliative care Consultant will support increased referrals to the specialist palliative care team.

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

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

		Groin hernia	Hip replacement	Knee replacement	Varicose vein
Year	**Level**	**Average health gain**	**Average health gain**	**Average health gain**	**Average health gain**
2010/11	Trust	0.055	0.382	0.299	*
2010/11	England	0.085	0.405	0.298	0.091
2010/11	Highest	0.156	0.503	0.407	0.155
2010/11	Lowest	-0.020	0.264	0.176	-0.007
2009/10	Trust	0.075	0.358	0.310	*
2009/10	England	0.082	0.411	0.294	0.094
2009/10	Highest	0.136	0.514	0.386	0.150
2009/10	Lowest	0.011	0.287	0.172	-0.002

NB: Only provisional data is available for 2012.

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

Warrington and Halton Hospitals NHS Foundation Trust considers that this data is as described for the following reason in that all PROMs data is collected, processed, analysed and reported by a number of organisations, including hospital trusts which perform PROMs procedures. The system established in 2009 currently covers four clinical 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 actions as described below to improve this average health gain score and so the quality of its services, by improving the performance management of each intervention to secure an improved health gain for these conditions.

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

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

- 0 to 14; and
- 15 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
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**

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

DATE PERIOD	TRUST	ENGLAND	HIGHEST	LOWEST
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**

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

Warrington and Halton Hospitals NHS Foundation Trust has taken the following actions to improve this rate and so the quality of its services, by holding monthly readmissions meetings with partners to review data and develop action plans to reduce the readmission rate.

2.3.4. Responsiveness to inpatients' personal needs based on five questions 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.

DATE PERIOD	TRUST	ENGLAND	HIGHEST	LOWEST
2010/2011	67.4	67.3	82.6	56.7
2011/2012	66.2	67.4	85	56.5

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 all 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.

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

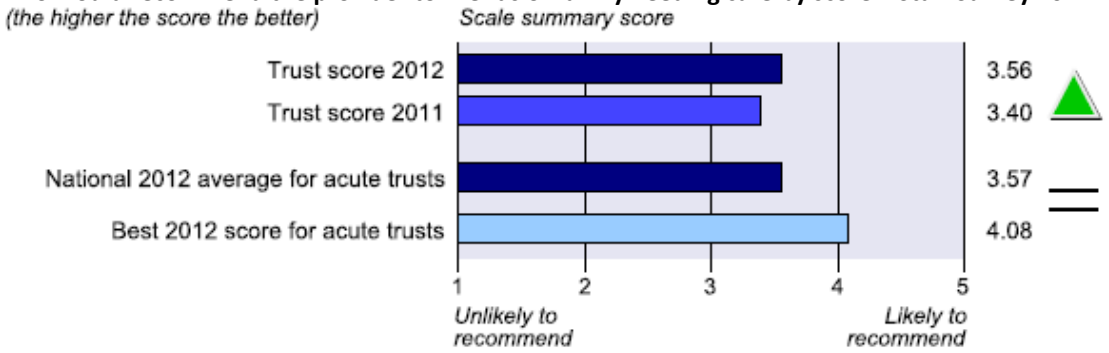
The data is made available to the Trust by the Health and Social Care Information Centre via the National NHS Staff Survey Coordination Centre with regard to the percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of 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
2011	57%	89%	33%	65%
2012	58%	69%	35%	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 2011.



Warrington and Halton Hospitals NHS Foundation Trust considers that this data is as described for the following reason, this report presents the findings of the 2012 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 44% response rate.

Warrington and Halton Hospitals NHS Foundation Trust has taken the following actions to improve this score and so the quality of its services, by improving staff engagement and health and wellbeing which has resulted in this element being one of three Key Findings where staff experiences have improved at the Trust since the 2011 survey.

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
2011/2012	Trust	95.6%	96.2%	95.4%	96.2%
	National Average	81%	88%	91%	93%

	Highest	***	***	100%	100%
	Lowest	***	***	32.4%	69.8%
2012/2013	Trust	95.4%	95.1%	94%	*93.9%
	National Average	93.4%	93.8%	94%	**
	Highest	100%	100%	100%	**
	Lowest	80.8%	80.9%	84.6%	**

** =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 quarterly review and monitoring by the Clinical Governance Committee.

Warrington and Halton Hospitals NHS Foundation Trust has taken the following actions to improve this percentage and so the quality of its services, by introducing a robust system of ward to board reporting which will facilitate real time review of data.

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
2010/2011	35.9	29.6
2011/2012	21	21.8

The Information Centre only provides average by Trust (not by highest and lowest) and 2012/13 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:

- Antimicrobial stewardship with regular audit and feedback on prescribing
- Improving hand hygiene (with soap and water when caring for patients with diarrhoea)
- Isolation of patients on suspicion of infectious diarrhoea rather than waiting for the result
- Continuous focus on improving the standards of environmental hygiene

- Training on the correct use of Personal protective equipment
- Use of polymerase chain reaction (PCR) testing to identify patients who are colonised with toxigenic Clostridium difficile
- Focus on advising patients (signage in toilets) to report loose stools
- Root Cause Analysis review to learn from hospital acquired cases

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 100 admissions

DATE	TRUST	TRUST NUMBER	MEDIAN	Lowest	Highest
October 2011 – March 2012	8.7	3402	6.7	2.21	10.54
April 2012 – September 2012	8.1	3257	6.7	3.11	14.44

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 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%
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

NB - The Trust has reported by actual number & percentage by highest/lowest rates please note these will not necessarily be the same trusts.

NB - *National = Severe Harm and Death combined. **Please see comments below.

Warrington and Halton Hospitals NHS Foundation Trust considers that this data is as described for the following reasons in that it downloads all incidents via DATIX to the National Reporting and Learning System within the agreed timescales. **It should be noted that the NRLS Report March 2013 (reporting period April 2012 – September 2012) shows inflated figures for severe harm. The records have now been re-uploaded to the NRLS so they are now up to date, and the CQC have been informed of the updated data. The NRLS are unable to amend the report published on the NRLS website but have inserted a caveat that: "Due to reporting problems from this organisation, the

number of incidents graded as resulting in severe harm may be inflated". The revised percentage for the reporting period is shown in the table above.

During the reporting period 1st April 2012 until 31st March 2013 the Trust reported 6, 827 patient safety incidents, 9incidents were categorised as severe harm (with a severity of 4 – major), 4 have been reported with a severity of 5 as catastrophic (death). The rate is reported as 0.19. Please note that 6 of these incidents are still subject to final approval and possible re-grading.

Warrington and Halton Hospitals NHS Foundation Trust has taken the following actions to improve this rate and so the quality of its services by actively encouraging incident reporting via the electronic system. According to the NRLS Reports the Trust has now moved from the bottom 25% of trusts to the top 25 trusts, as such incident reporting rates are high and the level of harm is below the national average providing a good indication of a strong safety culture within the Trust. Going forward our objective is to sustain these measures to maintain our level of reporting.

2.4. Information on the 62 day Cancer Access Target

The time from when a suspicion of cancer is raised is a particularly distressing and anxious time for both the patient and their family. The 62-day target intends to ensure that these patients are prioritised to receive the tests and procedures they need to confirm or eliminate cancer as quickly as possible, and if cancer is diagnosed to begin treatment as soon as possible.

The target is to achieve 85% of patients diagnosed with cancer starting treatment within 62 days of urgent referral with a suspicion of cancer or referral through A&E. In 2012-2013, Warrington and Halton Hospitals NHS Foundation Trust met its National Targets and Minimum standards for patients urgently referred with a suspicion of cancer began treatment within 62 days of their referral as below:

62 day Cancer Wait by percentage

	Jan-13	Feb-13	Mar-13	QTR-4	YTD
From Urgent GP Referral To Treatment - Open Exeter Position (Monitor)	90.41%	86.67%	85.25%	88.04%	**90.65%**
From Urgent GP Referral To Treatment - Reallocation Position (CQC/PCT)	90.41%	86.67%	85.25%	88.04%	**89.80%**

Quality Account Part 3 - Trust Overview of Quality

Patient Safety, Clinical Effectiveness & Patient Experience

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

To achieve this we recognise that safety, effectiveness and experience are key functions. Importantly, we must first ensure that patients are safe in our care. Our Quality Improvement and Patient Safety Strategy sets out the standards that we are committed to delivering consistently. In order to evaluate our success a host of indicators are measured; these indicators are monitored monthly and reported to the Trust Board on a regular basis. 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 is only available across two reporting years and more historical data has not been included.

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.

We are continually implementing quality improvement initiatives to further enhance the safety, effectiveness and experience outcomes for our patients. Within the year we have developed a new Patient Safety Experience Action Group and a Clinical Effectiveness Group to provide forums to lead, review and contribute to improved safe and effective patient care.

We have responded to the Francis Report which focussed on the events in another hospital. We want to ensure that we have taken the recommendations as an opportunity to carefully consider our own standards, and as a chance to learn lessons from a time when things went so very wrong for patients at another hospital. We want to be confident in the systems and measures that we have in place and are able through this report to tell patients why they can be confident in our care. The 290 recommendations of the Francis Report are being developed into an action plan for the Trust Board to review and monitor.

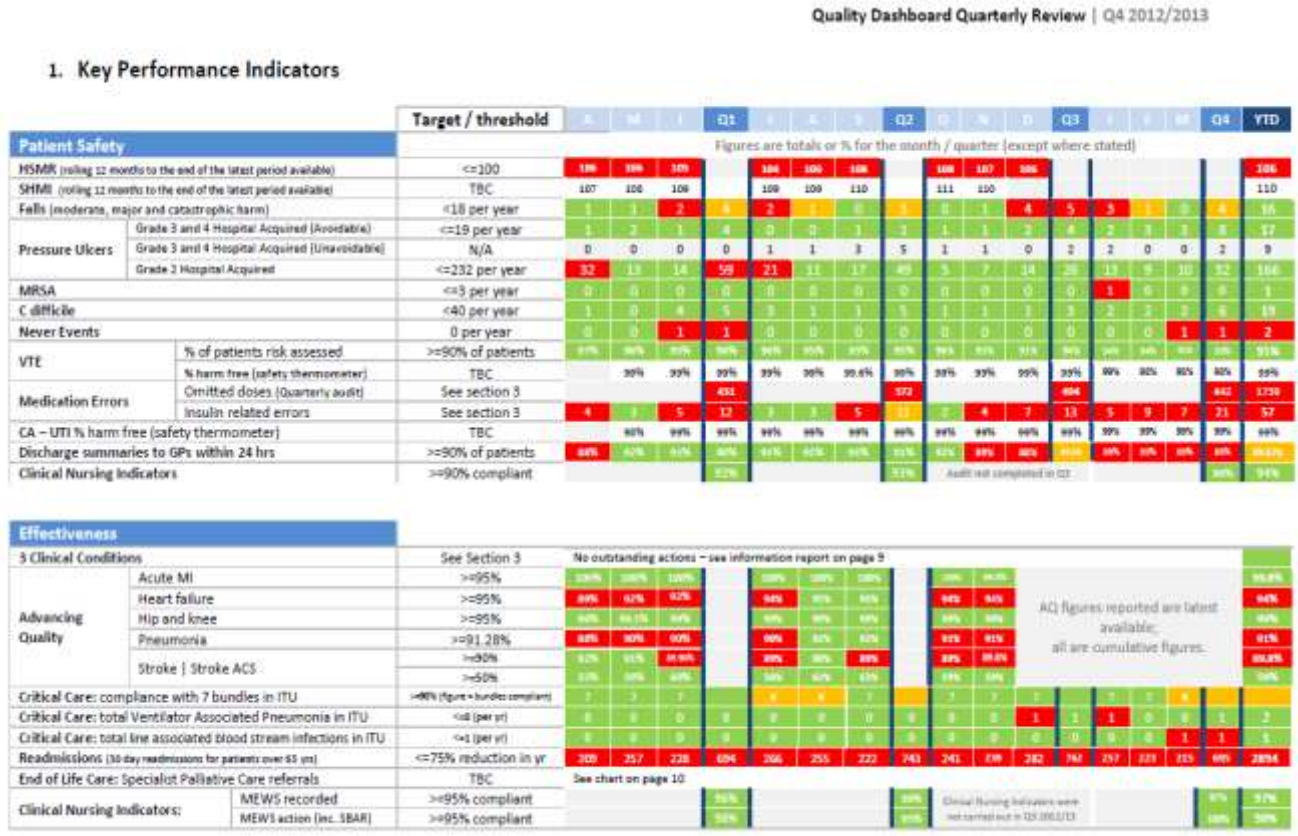
As a Trust, we define quality in three areas: safety, effectiveness and experience. This enables us to clearly define what we believe is important to our patients and public.

3.1. Patient Safety

Overview of the quality of care based on performance in 2012-2013 against indicators

Priorities for improving patient safety for 2012-2013 were set out in the Trusts' Quality Improvement and Patient Safety Strategy. Throughout the year, a dashboard of performance against each of the agreed targets for improvement has been presented to the Trust Board (and the wider committee groups) to provide assurance on progress and improvements made in the areas of patient safety, clinical effectiveness and patient experience.

Quality Dashboard 2012/13



Quality Dashboard Quarterly Review | Q4 2012/2013

1. Key Performance Indicators

		Target / threshold	Q1	Q2	Q3	Q4	YTD
Patient Safety			Figures are totals or % for the month / quarter (except where stated)				
HSMR (rolling 12 months to the end of the latest period available)		<=100	106	104	108		106
SHMI (rolling 12 months to the end of the latest period available)		TBC	109	109	110		110
Falls (moderate, major and catastrophic harm)		<18 per year	4	2	1	4	16
Pressure Ulcers	Grade 3 and 4 Hospital Acquired (Avoidable)	<=19 per year	4	0	1	2	7
	Grade 3 and 4 Hospital Acquired (Unavoidable)	N/A	0	1	1	0	2
	Grade 2 Hospital Acquired	<=232 per year	59	21	17	14	111
MRSA		<=3 per year	0	0	0	1	1
C difficile		<40 per year	5	3	1	3	12
Never Events		0 per year	1	0	0	1	2
VTE	% of patients risk assessed	>=90% of patients	94%	95%	95%	94%	95%
	% harm free (safety thermometer)	TBC	99%	99%	99%	99%	99%
Medication Errors	Omitted doses (Quarterly audit)	See section 3	451	572	404	442	1759
	Insulin related errors	See section 3	12	11	13	21	57
CA – UTI % harm free (safety thermometer)		TBC	99%	99%	99%	99%	99%
Discharge summaries to GPs within 24 hrs		>=90% of patients	80%	91%	88%	89%	87%
Clinical Nursing Indicators		>=90% compliant	92%	91%	Audit not completed in Q3	94%	94%
Effectiveness							
5 Clinical Conditions		See Section 3	No outstanding actions – see information report on page 9				
Advancing Quality	Acute MI	>=95%	100%	100%	100%		99.8%
	Heart failure	>=95%	93%	95%	94%		94%
	Hip and knee	>=95%	94%	95%	94%		94%
	Pneumonia	>=91.28%	90%	92%	91%		91%
	Stroke | Stroke ACS	>=90%	91%	89%	89%		89.8%
		>=60%	69%	65%	73%		70%
Critical Care: compliance with 7 bundles in ITU		>=80% (figure = bundles compliant)	7	7	7	7	
Critical Care: total Ventilator Associated Pneumonia in ITU		<=8 (per yr)	0	0	1	1	2
Critical Care: total line associated blood stream infections in ITU		<=1 (per yr)	0	0	0	1	1
Readmissions (30 day readmissions for patients over 65 yrs)		<=75% reduction in yr	209	255	282	215	2894
End of Life Care: Specialist Palliative Care referrals		TBC	See chart on page 10				
Clinical Nursing Indicators:	MEWS recorded	>=95% compliant	95%	95%	Clinical Nursing Indicators were not completed in Q3 2012/13	97%	97%
	MEWS action (inc. SBAR)	>=95% compliant	92%	95%		100%	96%

AQ figures reported are latest available; all are cumulative figures.

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

The information is collated from, whenever possible, sources which could be benchmarked with other organisations in order to indicate the Trust's performance in relation to others. The Trust has invested in a clinically-led benchmarking system called Healthcare Evaluation Data (HED) and uses this alongside Dr Foster to support this evaluation.

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. The Quality Improvement and Patient Safety Strategy and Patient Experience Strategy support the Trust's developments in quality.

The indicators selected for inclusion within this Quality Account have been determined after consultation and discussion with the Quality in Care Committee of the Council of Governors. It was agreed that the indicators that were a measurement of the priorities from the 2011-2012 report should feature in order to demonstrate continuous quality improvement.

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.

3.1.1. Discharge

In 2012/13 our goal was to improve the way in which we plan and prepare patients for a safe discharge from hospital. We particularly wanted to provide our patients with information on the following:

- ***Who they could contact if they had fears on leaving hospital***
- ***Details on side effects of medications taken home***

We have achieved our goals in both the above areas.

As part of our nursing care plan, we introduced a discharge plan to be commenced on admission that includes a multidisciplinary approach to a safe and effective discharge. The document acts as a tool to guide staff toward ensuring that all aspects of care that a patient will need are addressed in the planning stage. We also developed a Discharge Card to be given to patients when they are discharged to provide them with information on what to look out for on discharge and who to contact should this be required. In addition to this the Trust has piloted a scheme for all inpatients who are Halton registered patients or registered with a Halton GP.

This is a quality improvement project which aims to improve discharge and reduce readmissions whereby a nurse will contact patients within 24 hours of discharge to check that they are comfortable with their return home and to ensure that they do not have any issues or concerns. It any issues are identified the nurse will contact the relevant team and ensure that all actions take place and will feedback the responses to the patient. The nurse will ask a range of questions which include checking to see if the patient understands any side effects of medication.

We are pleased to report that we have had an overall improvement in our 2012 National Inpatient Survey relating to discharge information including medication at discharge. The National Inpatient Survey for 2012 has demonstrated a significant improvement in providing our patients with details of side effects of medication and we are proud to be above the national average in this area. In relation to our staff explaining the purposes of medication in a way that could be understood, we have demonstrated a 7% improvement and are above the national average. We have also demonstrated an overall 6% improvement in combined questions relating to whether patients felt

included in decision about their discharge from hospital. We are above the national average for patients who felt that 'yes, to some extent' they were involved in their discharge, however we remain slightly below the average for patients who felt 'yes, definitely' they were involved in decisions about their discharge, we hope to make further improvements in 2013-2014. These improvements will include expanding the quality improvement project for appropriate safe discharge to patients registered at Warrington Hospital. The Trust has identified two nurses who are currently receiving training in order to take this project forward.

3.1.2. Infection Control

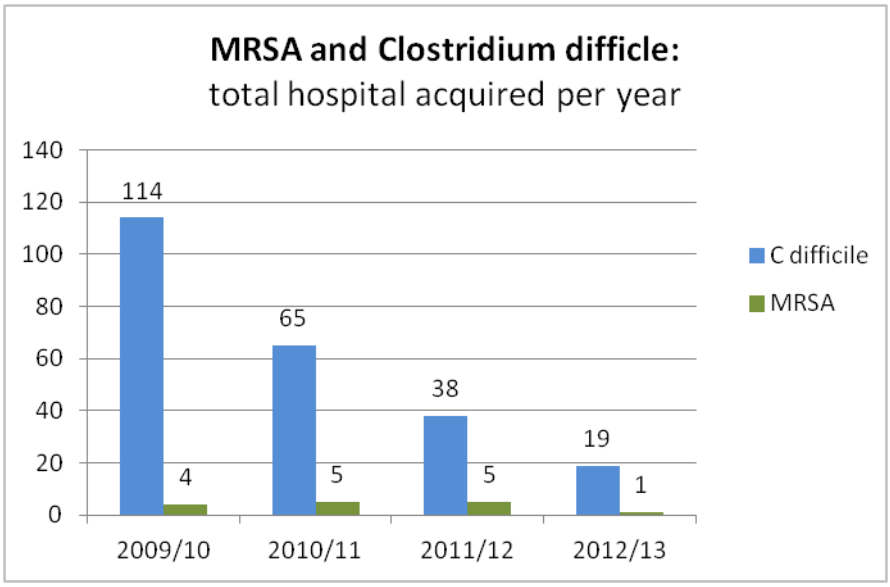
- ***In 2012/13 our goal was to have no more than 3 cases of MRSA bloodstream infections and 40 cases of Clostridium difficile acquired within the hospital***
- ***We achieved this goal***

We are extremely proud of our staff and the huge improvements we have made in the Trust performance with the infection prevention and control agenda. Our dedicated, highly skilled Infection Control team have focused on making improvements with:-

- Visual Infusion Phlebitis scores (VIP scores)
- Outbreak management
- Root cause analysis and learning from incidents
- Monitoring of antibiotic use

This has resulted in a year on year improvement and has enabled us to propose a highly ambitious 'zero' tolerance to MRSA bacteraemia as such the infection control trajectory for 2013/14 will be 0 cases for MRSA and 19 cases for Clostridium difficile (with an internal stretch target of 16). These improvements, in all aspects of Infection Control, ensure that we are providing the very best harm free care.

During 2012/13 the Trust reported the acquisition of 1 MRSA blood stream infection and 19 cases of Clostridium difficile within the hospital. We are very proud of our achievement of these goals.



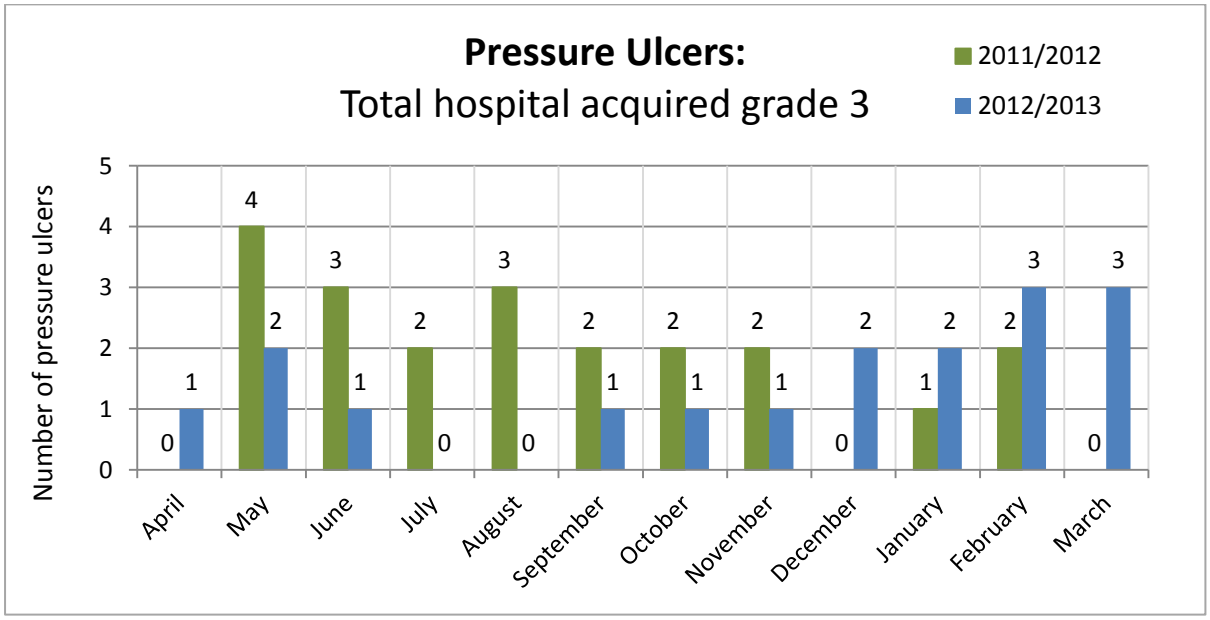
3.1.3. Pressure Ulcers

Pressure ulcers are miserable for patients, and can lead to pain, embarrassment and infection. As an organisation we aimed to reduce the numbers by grade.

- ***In 2012/13 our threshold for grade 3 & 4 pressure avoidable ulcers acquired within the hospital was 21 - in addition to this we set an internal stretch target of 19.***
- ***During the reporting period we have had 18 avoidable hospital acquired Grade 3 pressure ulcers and no Grade 4 pressure ulcers***

We have reported 18 grade 3 pressure ulcers against an improvement priority target of 21 and an internal stretch target of 19; importantly showing a reduction of 14% against 2011/12 figures.

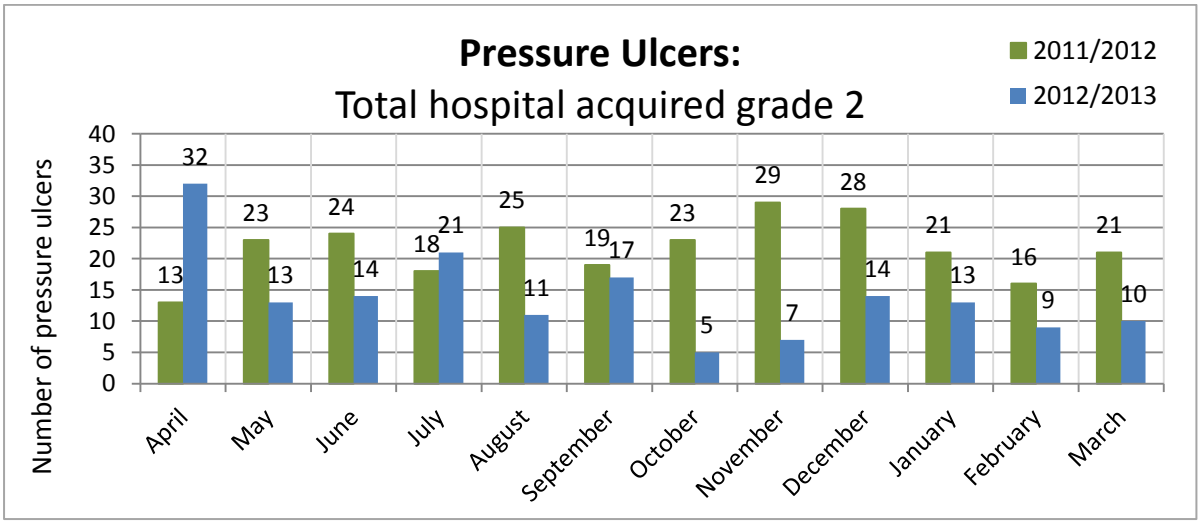
Pressure Ulcers – Grade 3



In 2012/13 we can report similar progress in relation to grade 2 pressure ulcers, in April 2012 the Trust revised a quality improvement project to further support the reduction of the number of Grade 2 pressure ulcers.

During 2012/13 we have reported 166 hospital acquired grade 2 pressure ulcers against a final threshold of 232 which shows a positive 36% reduction on 2011/2012 (260 grade 2) figures and significantly better than the internal target of 10% reduction for this period. The following graph demonstrates the continued reduction across the Trust.

Pressure Ulcers: hospital acquired Grade 2



Although this is still higher than we would want, it is below the trajectory that was agreed in that we had planned to reduce hospital acquired avoidable grade 2, 3 and 4 pressure ulcers by 10% and have achieved this target.

In 2013/14 we will strengthen the process by which our Grade 3 pressure ulcers are reviewed and provide greater transparency.

Although we are pleased with the reduction in pressure ulcers we want to further reduce grade 2, and to introduce a 'zero' tolerance for grade 3 and above.

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.

The Trust is also working with its partners in the local community to help identify ways of reducing the numbers of patients coming into hospital with pressure ulcers being acquired at home or in nursing homes.

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.

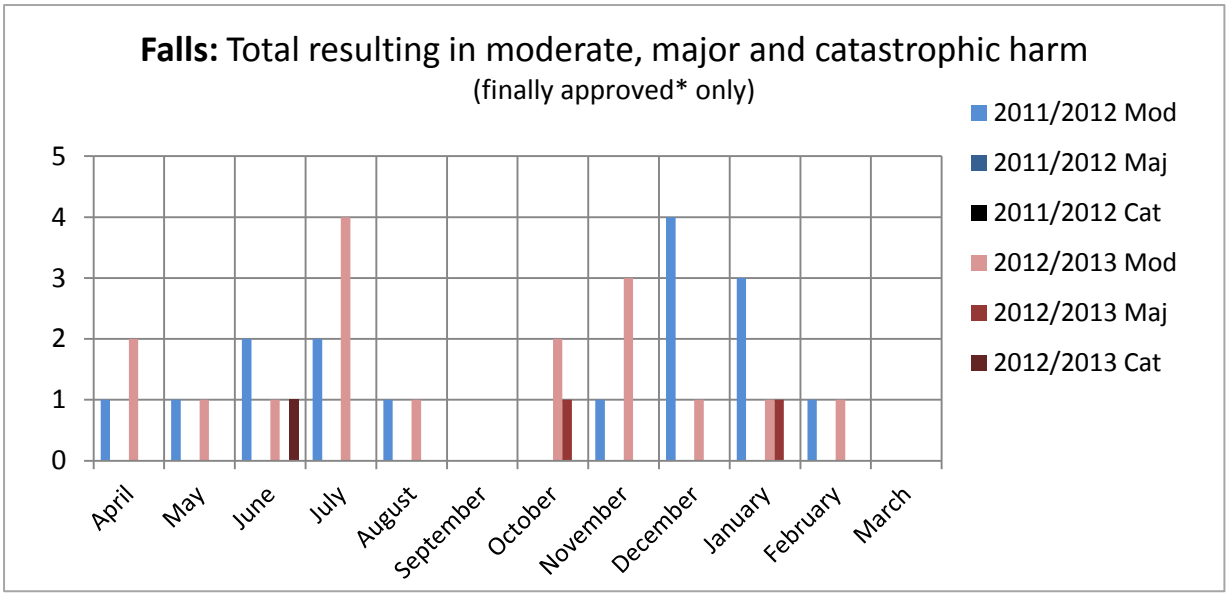
***** Not all pressure ulcers are avoidable; there are situations that render pressure ulcer development unavoidable, including hemodynamic instability that is worsened with physical movement and inability to maintain nutrition and hydration status and the presence of an advanced directive prohibiting 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.

3.1.4. Falls

- ***In 2012/13 our aim was to reduce the number of falls which cause moderate, major or catastrophic harm by 10%, to 18.***

For 2012/13 we have reported and finally approved* 16 falls that have resulted in moderate to catastrophic harm, which is an improvement above the proposed 10% trajectory on 2011/12 where we reported 20 approved falls resulting in moderate to catastrophic harm.

Falls by severity 2011/2012 - 2012/13



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

- Moderate Harm – an injury which may be a fracture, that isn't permanent but which has the ability to reduce mobility/movement

- Major Harm – an injury that results in either a fracture or an injury which contributes to long-term reduced movement/mobility
- Catastrophic Harm – an injury that causes or significantly contributes to the death of a patient or to such significant permanent injury as to be life changing.

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

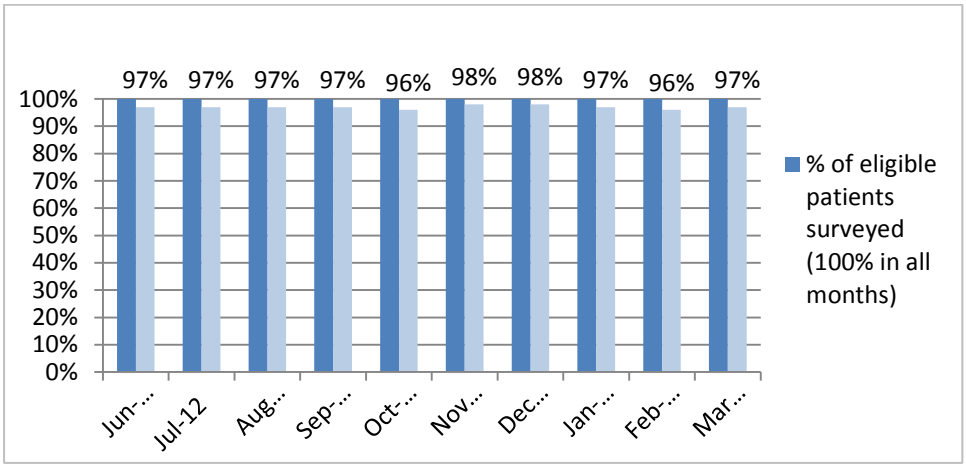
When patients fall (regardless of whether they experience harm or not), the incident is reported via the Datix system. This automatically informs a member of the senior nursing team who will visit the ward. A full review of processes and risk assessments required is then undertaken.

3.1.5. Safety Thermometer

The Trust has within year successfully implemented the national CQUIN for the NHS Safety Thermometer. The national CQUIN goal 2012/13 required all Trusts to undertake a monthly survey on one day of all appropriate patients, to collect data on four outcomes (pressure ulcers, falls, urinary tract infection (in patients with catheters) and new VTE (excluding CQUIN defined exclusions). The Safety Thermometer measures the percentage of patients who have experienced harm related to pressure ulcers, falls, catheters and UTI's and VTE.

The following graph demonstrates that the Trust has achieved the CQUIN by ensuring that 100% of patients were surveyed on a monthly basis from July 2012.

Safety Thermometer - completion



3.1.6. NPSA 'never events'

Two never events occurred during 2012/13, the first never event related to a patient receiving a intra vitreous injection into the right eye when it should have been placed in the first instance in the left eye followed by the right eye a week later. All actions relating to the recommendations have been completed. The second, never event, related to a wrong site pain injection, where a patient was given an injection for chronic pain relief into the wrong hip. The investigation reports show that no harm came to either patient and there would be no long-term complications as a result of this incident. The Trust explained everything to the patients in line with our 'Being Open' Policy.

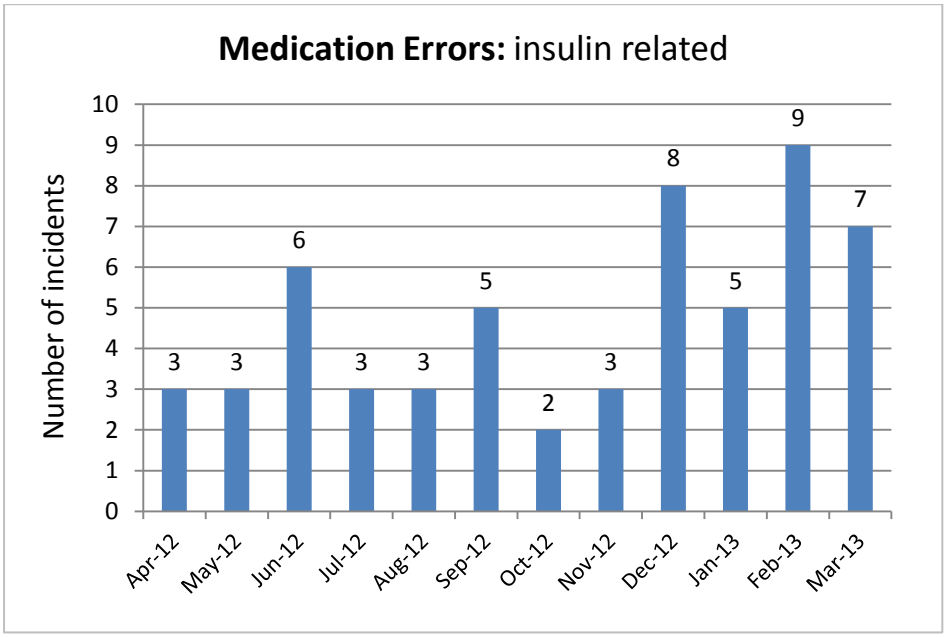
3.1.7. Omitted medicines and insulin associated errors

A quarterly Trust wide audit of omitted medicines has been carried out since April 2012; this is supporting the Trust in the identification of areas of concern and to enable targeted improvements to be made.

The chart below shows the number of insulin related errors reported on the Trust incident management system (Datix) in 2012 /2013. There have been two incidents finally approved as resulting in moderate harm, 2 further incidents have been categorised as resulting in moderate harm however these are still under review. The remaining incidents resulted in no or low harm. We did not meet the Trust internal target of 10% reduction in errors but during the year we did have improved reporting and a campaign to focus on allergy related incidents.

A reduction in the number of omitted medicines and errors associated with insulin medication are improvement priorities for the Trust for 2013/2014

Medication Errors: insulin related



3.2. Clinical Effectiveness

3.2.1. Hospital Standardised Mortality Review (HSMR)

We want to ensure that whilst delivering safe care we continue to give the best possible care to achieve the best outcomes for patients.

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

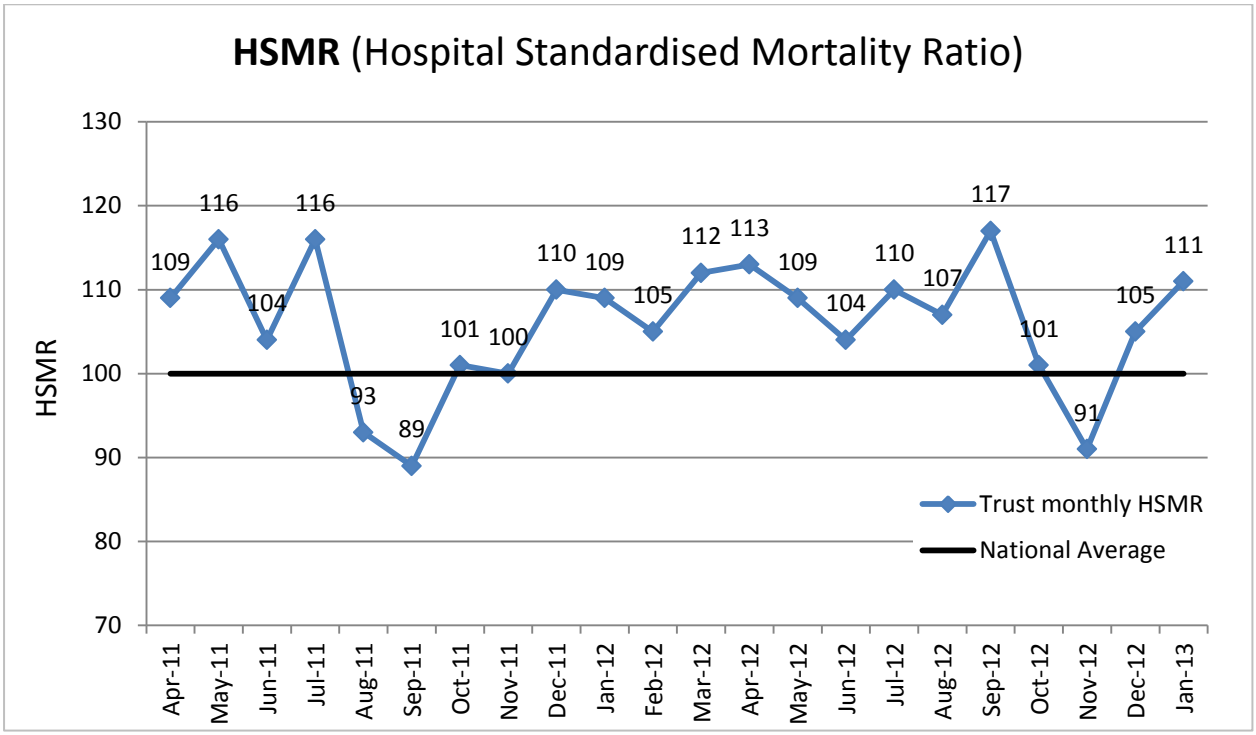
HSMR is an important indicator in alerting Trusts to potential issues that would adversely affect the quality of care provided.

Nationally the expected HSMR score for a trust such as Warrington and Halton NHS Foundation Trust is set at a score of 100. This figure does not represent deaths – it is a baseline number used to compare performance. A number below 100 indicates that the hospital has been able to show that there are now less than the expected numbers of deaths conversely a number above 100 would show a high than expected number of deaths for that diagnostic group of patients.

The Trust is committed developing a culture where clinical effectiveness is seen as integral to the day-to-day provision of clinical care. As such it has made a significant investment in ensuring that a Healthcare Evaluation Data (HED) system is in place supported by a Clinical Effectiveness Manager to review, prioritise, implement and monitor quality and patient safety indicators. A recent evaluation of data has resulted in the Trust looking into specific issues relating to:

- Urinary tract infections
- Chronic Obstructive Pulmonary Disease
- Vascular
- Specialist Palliative Care

Monthly HSMR.



NB – the HSMR score is accessed from the HED (Healthcare Evaluation Data) system and the information they use comes from the clinical coding of patient episodes within the trust.

The Medical Director and the Director of Nursing are in the process of identifying very clear paths of improvement which will include a focus upon the cleansing of our data as well as ensuring that clinical care provided to our patients is of a high quality.

3.2.2. Reducing harm to patients who are critically ill

Our sickest and most vulnerable patients are the ones treated within our Intensive Care Unit, and we have introduced and monitored a number of care bundles to ensure the best possible safe care is provided. The Trust focused on being compliant with a range of critical care bundles for a sample of patients which includes occurrence of Ventilator acquired pneumonia and of line associated blood stream infections.

- ***In 2011/12 our goal was to maintain this high level of compliance. We achieved 97% compliance for ventilator acquired pneumonia prevention and 100% for urinary catheter infection prevention – we achieved our goals.***
- ***Our plan for 2012/13 is to maintain this high standard.***

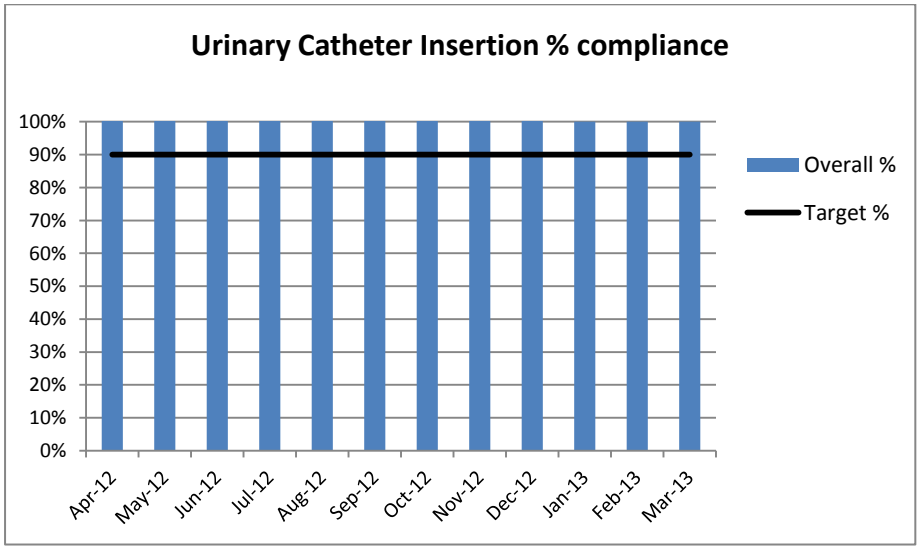
Every clinician has the potential to significantly reduce the risk of infection to their patients by ensuring that they consistently comply with evidence based practice and guidelines when they undertake a clinical procedure. The High Impact Interventions (HII) from the Department of Health 'Saving Lives' initiative are an evidence-based approach to key clinical procedures or care processes that can reduce the risk of infection if performed appropriately. They have been developed to provide a practical way of highlighting the critical elements of a particular procedure or care process (a care bundle), the key actions required and a means of demonstrating reliability. For any planned

clinical procedure, there are a number of critical components founded on a solid evidence base that must be undertaken correctly to reduce infection risk.

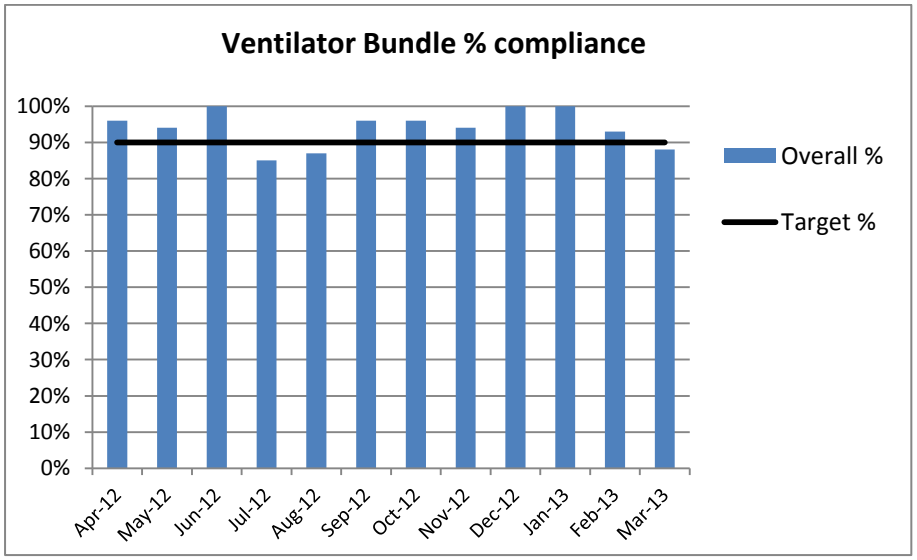
The following graphs provide an overview of compliance with all critical steps found within with two critical care bundles namely urinary catheter insertion and the ventilator-associated pneumonia (VAP) bundle. A ventilator 'care bundle' consists of four elements: head of bed elevation, sedation holding, deep vein thrombosis prophylaxis and gastric ulcer prophylaxis. Urinary catheter insertion determines that there are two sets of actions that are required for good practice, namely insertion and on-going care.

Regular auditing of the care bundle actions will support cycles of review and continuous improvement in care settings. The Trust has established a target of 90% compliance with the care bundle and our successful achievements is demonstrated in the following graphs:-

Urinary Catheter Insertion % compliance



Ventilator Bundle % compliance



The Trust has achieved the targets for the following High Impact Intervention critical care bundles achieving the following cumulative compliance rates for 2012/2013:

- Ventilator bundle compliance 94%
- Urinary catheter insertion bundle compliance 100%
- Urinary catheter on-going care bundle compliance 99%
- Peripheral cannula insertion compliance 99%
- Peripheral cannula on going care bundle compliance 96%
- CVC insertion compliance bundle 100%
- CVC on-going bundle compliance 100%

Acute and Critical Care of the patient

The Acute and Critical Care of the Patient Group meets monthly and is authorised by the Clinical Governance, Audit and Quality Sub Committee to explore, receive, review and progress Recommendations from National Guidance and High Level Enquires. National Guidance includes:

- National Confidential Enquires into Perioperative Death (NCEPOD)
- National Institute of Clinical Excellence (NICE)
- Patient Safety First Campaign – Safety Measures (PSF)

3.2.3. Implementation of national Dementia CQUIN

We have implemented tools for Dementia Screening and Dementia Risk Assessment and referrals for specialist diagnosis in mid-November 2012. We have achieved the target of over 90% of patients being assessed by Quarter 4 as per our contractual obligations.

- **In 2012-2013 we want to further improve the environment for our Dementia patients through our ForgetMeNot campaign.**

3.2.4. Compliance with regional targets set for Advancing Quality compliance with best practice

We work hard to ensure compliance with regional targets set for Advancing Quality compliance with best practice for patients with the following conditions. Performance is marginally below target (less than 1% in each case) for Pneumonia, Stroke compound score and Heart Failure. Cumulative compliance until the end November 2012 is:

- Acute Myocardial Infarction 99.82%
- Hip and knee replacement 99.30%
- Stroke compound score 89.80% (target >=90%) | Stroke Appropriate Care 59.11%
- Heart failure 94.34% (target >=95%)
- Pneumonia 91.05% (target >=91.28)

With targets stated where not achieved.

3.2.5. Stroke

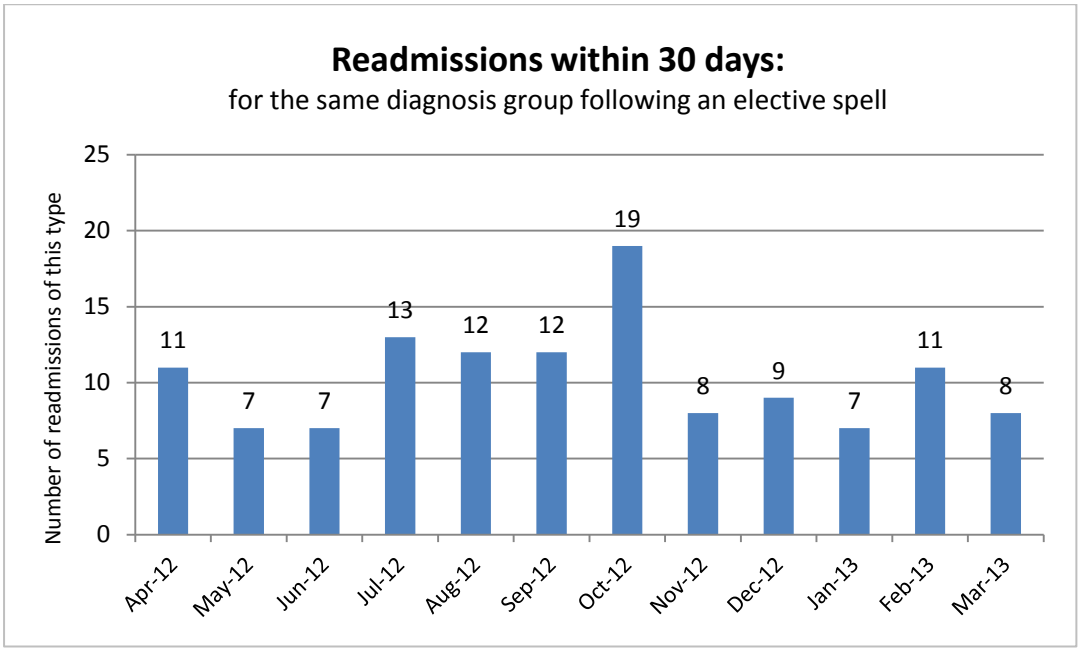
The trust has meets the standards of the National Sentinel Stroke Indicator with 90% of stroke patients treated on a Stroke Ward.

Our dedicated Stroke Ward has been inspected by the Care Quality Commission and our governors, the area evaluated well with good patient outcomes.

3.2.6. Reduction in readmissions

The Trust works toward reducing readmissions in accordance with National Requirements. Our cumulative year end position for the number of readmissions within 30 days for the same diagnosis group following an elective spell is 115.

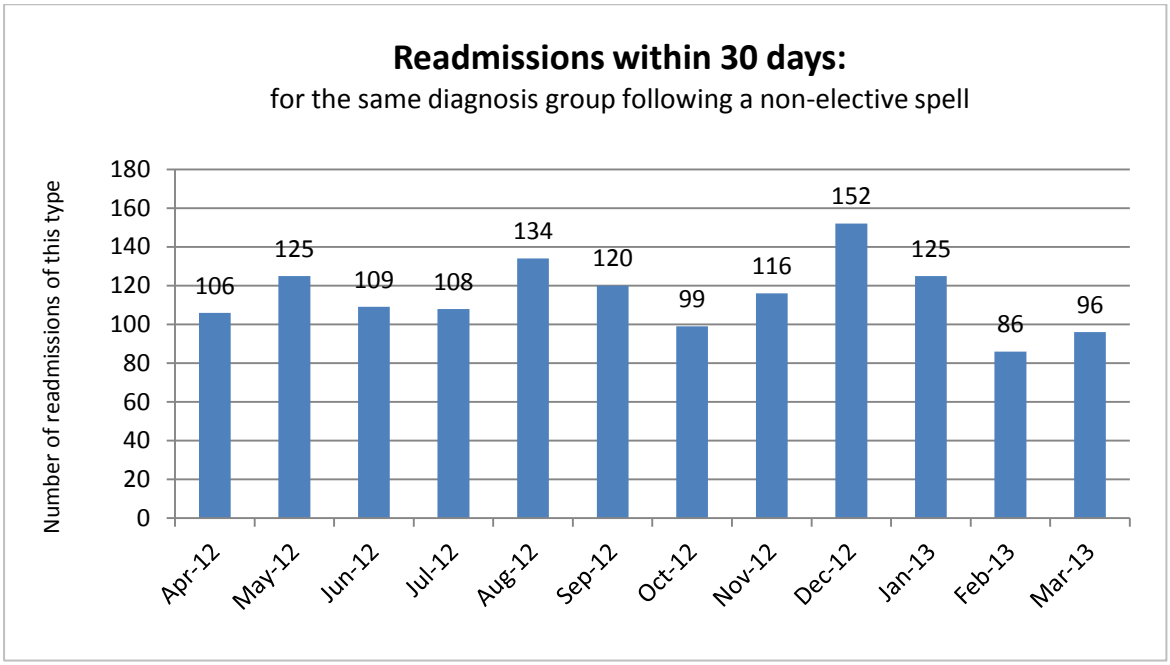
Readmission rates within 30 days following an elective spell



The cumulative position for readmissions within 30 days for the same diagnosis group following a non-elective spell at year end is above the threshold for that period. Unfortunately, we did not achieve the threshold by year end in that our current position at the end of March 2013 is 1268 against a threshold of 1094 for 2012/2013.

We have agreed a local CQUIN detailing work to be undertaken to have a positive effect on readmissions through effective discharge. We have planned to hold a multi-professional workshop to review discharge processes using lean methodology. Following this pathways will be identified aimed at supporting effective discharge and ultimately reducing levels of readmissions for the same diagnosis group.

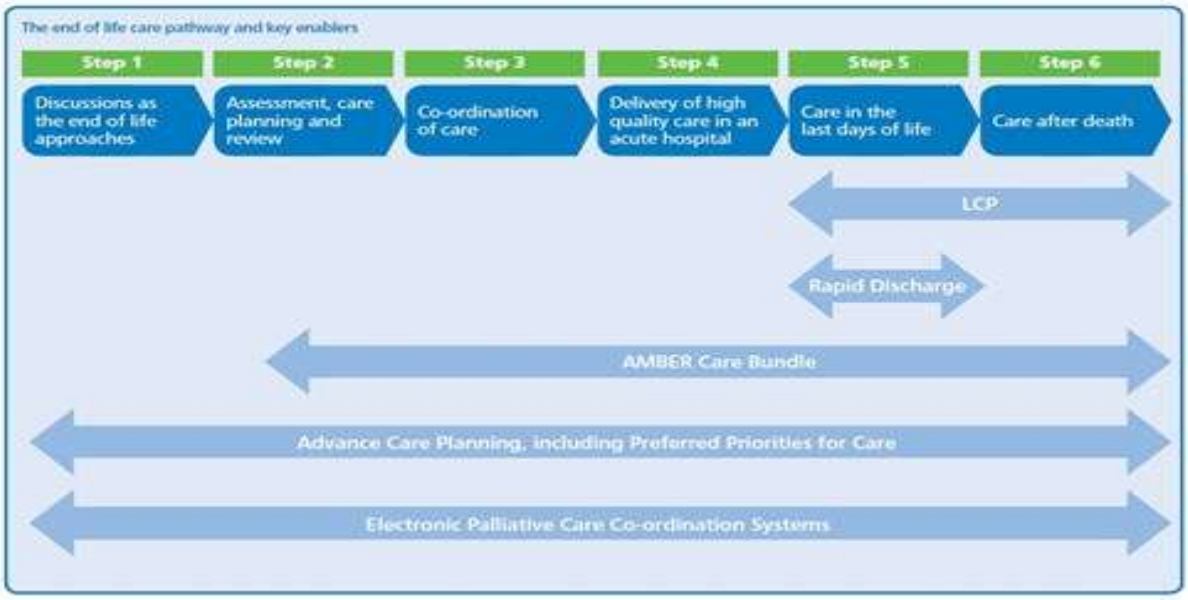
Readmission rates within 30 days following a non-elective spell



3.2.7. High Level Quality care at End of Life

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

- Advance Care Planning
- Electronic Palliative Care Coordinating Systems
- AMBER Care Bundle
- Rapid Discharge Home to Die Pathway
- Liverpool Care Pathway for the Dying patient.



Using the key enablers from the programme has benefitted the Trust in the following manner:

- Improving the quality of the individual patient experience and the quality of care
- Supporting the patient to die in the place of their choice
- Promoting the development of a skilled workforce with improved staff morale and retention
- Allowing more effective resource management by a reduction in inappropriate interventions
- Managing and reducing unplanned hospital admissions
- Reducing complaints and enhancing the reputation of the Trust.

Support has been obtained from the National team in benchmarking the Trust against other early implementers and this has enabled monitoring of the progress we are making.

Data is evidenced below in the reduction of bed days in the last year of life compared to the national average.

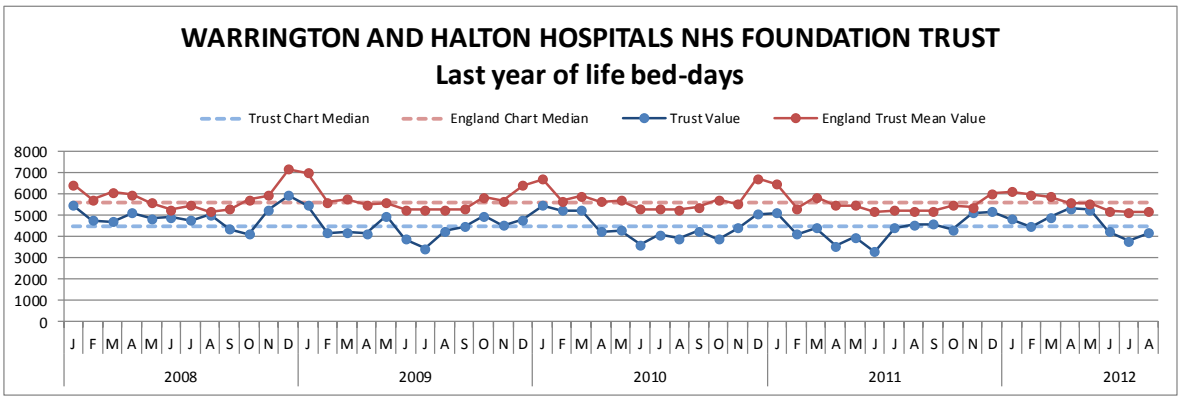
Data in support of the
Transform End of Life Care in Acute Hospitals Programme

National end of life care INTELLIGENCE NETWORK

The chart displays :

Trust Value	actual value of the measure each month for the Hospital Trust
Trust Chart Median	median value of all the monthly values for the Hospital Trust
England Trust Mean Value	monthly average value of the measure over all Acute Hospital Trust in England
England Chart Median	median of all the displayed monthly England Hospital Trust Means

Information included for people who were 18 years or older at the end of their life



Total hospital bed-days in last year of life admissions into the Hospital Trust by month of death (An admission and discharge onthe same day counts zero bed-days)

WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2008	5,466	4,750	4,686	5,099	4,851	4,895	4,755	5,012	4,325	4,106	5,240	5,924
2009	5,448	4,176	4,187	4,138	4,953	3,875	3,434	4,262	4,444	4,940	4,518	4,778
2010	5,450	5,204	5,218	4,226	4,295	3,622	4,081	3,894	4,257	3,873	4,394	5,038
2011	5,105	4,108	4,388	3,552	3,949	3,271	4,402	4,558	4,587	4,301	5,105	5,154
2012	4,801	4,466	4,885	5,298	5,237	4,218	3,782	4,164	No data	No data	No data	No data

Average for acute trusts in England

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2008	6,425.8	5,727.6	6,073.9	5,942.4	5,557.3	5,241.3	5,457.4	5,169.1	5,280.5	5,718.0	5,905.7	7,139.7
2009	6,973.0	5,599.2	5,737.2	5,494.5	5,581.2	5,248.9	5,259.4	5,240.0	5,269.8	5,845.4	5,661.4	6,379.6
2010	6,674.9	5,649.7	5,901.4	5,637.6	5,683.3	5,285.9	5,271.9	5,257.5	5,356.6	5,707.8	5,518.6	6,719.3
2011	6,435.9	5,315.7	5,823.2	5,449.2	5,451.0	5,156.4	5,205.0	5,185.9	5,190.4	5,442.7	5,354.7	6,013.0
2012	6,105.2	5,949.2	5,865.6	5,560.4	5,550.1	5,196.9	5,142.7	5,161.3	No Data	No Data	No Data	No Data

The continued implementation of two of the key enablers, the AMBER care bundle and the use of the Liverpool Care Pathway owe much to the tireless efforts of the two facilitators seconded to the team. 120 medical or nursing staff have received a brief 20-30 minute training on the use of the care bundle, with on-going support from the facilitator to enable roll out.

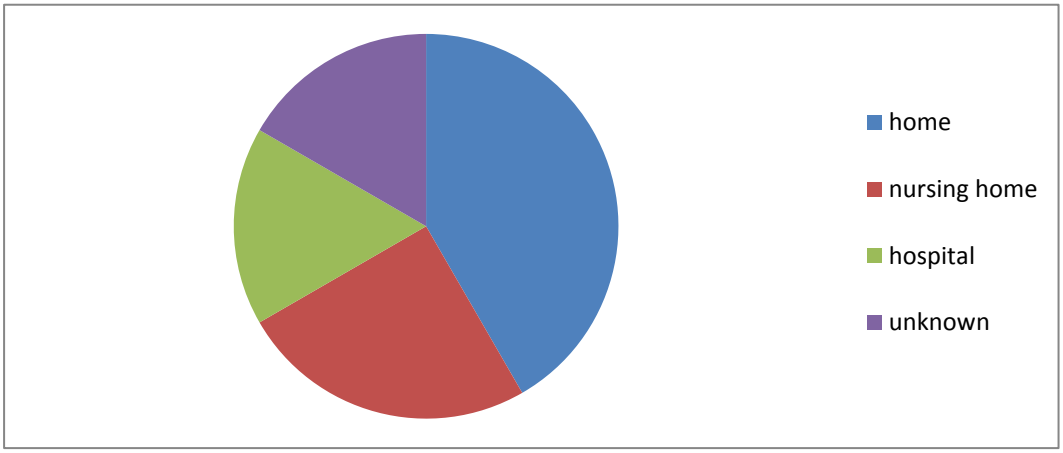
379 patients have had their care supported by an AMBER care bundle and 77% of those patients had their preferred place of care recorded. Only 3 patients discharged on an AMBER care bundle have been re-admitted and an AMBER discharge proforma is now being developed to inform clinicians in the CCG that care should be supported at home as per the patients wish and for re-admission to take place only if absolutely vital.

Wards using the AMBER care bundle

Wards	Using bundle unsupported	Using bundle supported	All deteriorating patients	Percentage of deteriorating patients
A1		Y		Y
A2		Y		Y
A3		Y		Y
A7	Y			Y
A8		Y		Y
B12	Y			Y
B14	Y			Y
B18		Y		Y
C22	Y			

Preferred Place of care

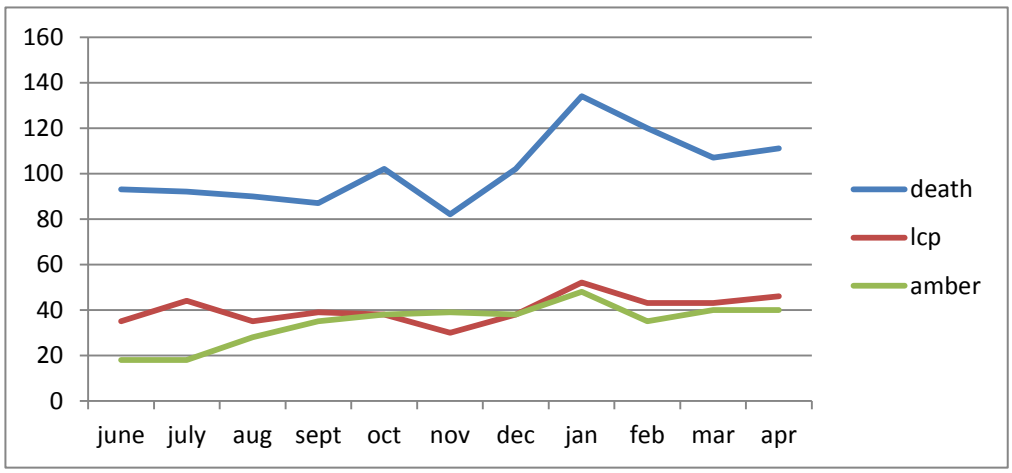
77% of patients who had care supported using the AMBER care bundle had Preferred Place of care recorded.



In spite of the recent adverse publicity around use of the Liverpool Care pathway, care of the patients in the final stages of their life has continued to be supported by this validated tool.

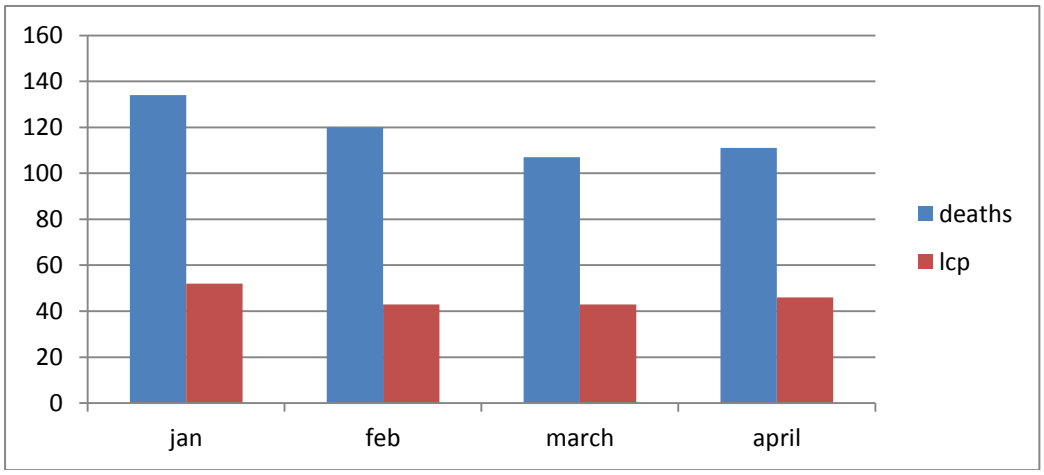
The use of the AMBER care bundle has led to an appropriate increase in the number of patients whose care is supported by the Liverpool Care Pathway (LCP), as the pathway identifies ceilings of care when further interventions would be either futile or inappropriate.

The number of hospital deaths and the use of the national evidence based tools ensuring quality care for patients

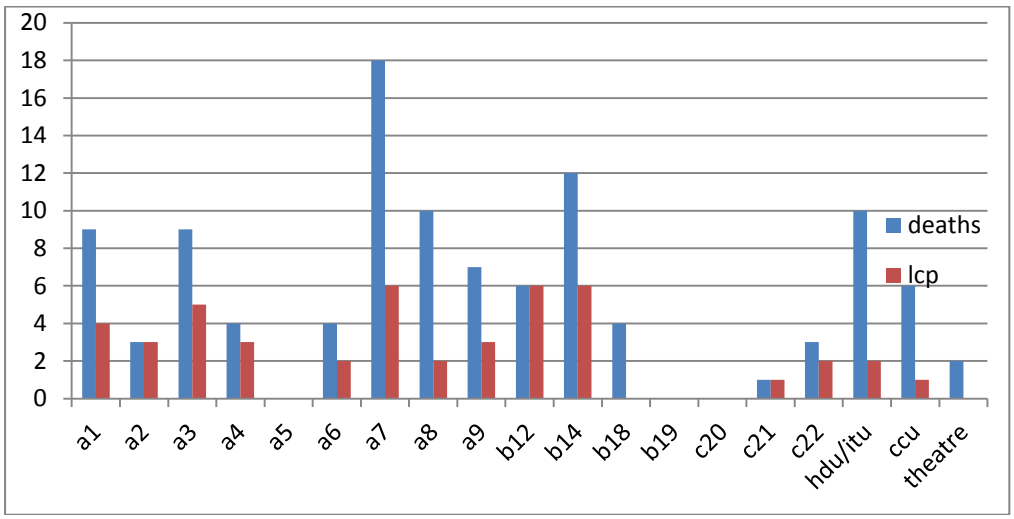


The Trust supports approx. 45% of expected deaths with the Liverpool Care pathway, which whilst slightly below the national average has shown a sustained increase over time.

Hospital deaths and the number of patients that had their care supported using the Liverpool care pathway.



Ward deaths and use of the Liverpool Care Pathway (data from month of April 2013)



3.3. Patient Experience

Quality would not be complete without looking at the second element; patient experience. The Trust is committed to providing excellent care for all our patients. This means that not only will the care we provide be safe and effective, but that the patient experience of that care is the best it can be. It is essential that experiences told to us in patient feedback are listed to and understood. This feedback could be via compliments, comments, concerns, complaints, or via surveys we have undertaken ourselves. We have a duty then, once we have listened and understood, to focus on these experiences and make improvements based on patients own views and concerns.

We have developed a new approach, which over the coming months will continue to support the Trust's priority to improve our patient's experience. The Patient Experience Team, has a specific remit of realigning a service to provide the best possible response to our patients concerns.

The Trust has invested in additional staff within the PALS section of the team to support this new approach of working collaboratively towards resolving complaints or concerns right from the outset. This is under the leadership of the Patient Experience Matron and the Associate Director of Nursing, (Corporate) who will lead the changes to developing a fully integrated Patient Experience Team.

The success of this new team will be measured via a range of outcomes:

- Successful implementation of a Patient Information Centre / Patient Experience 'Hotline'
- Improvement in number of formal complaints
- Improvement in the learning and analysis of themes and trends from complaints, evident by reports and to be followed through action planning and monitoring.
- Evidence of CQC compliance with regulations and outcomes
- Evidence of compliance with the recommendations of the Francis Report
- Improvements demonstrated in our In-patient Survey
- Good Healthwatch reports and external reviews

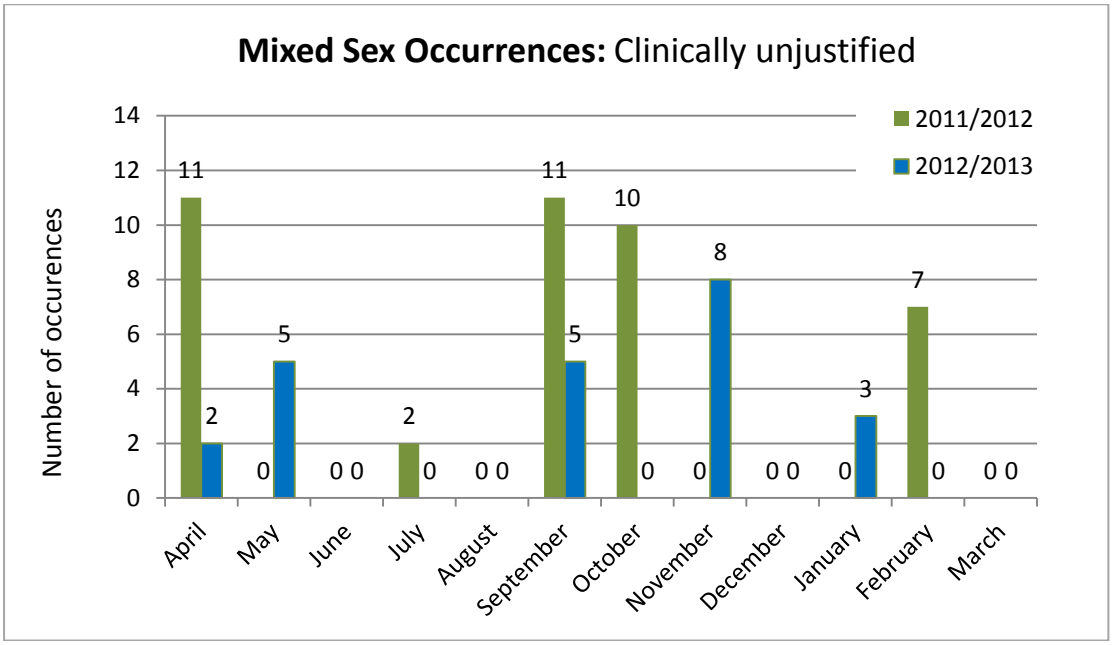
3.3.1. Eliminating Mixed Sex Accommodation

All providers of NHS funded care are expected to eliminate mixed-sex accommodation, except where it is in the overall best interest of the patient, in accordance with the definitions set out in the Professional Letter CNO/2010/3.

The Trust measures any occurrence of mixed sex accommodation by determining whether they are 'clinically justified' (i.e. "in the overall best interest of the patient" such as when both male and female patients are in the Intensive Care Unit) or 'non-clinically justified' (when male and female patients share either sleeping accommodation or bathrooms and toilets).

In 2011/12 the Trust had 41 breaches relating to mixed-sex accommodation and our target for 2012/13 was full compliance with no reported cases. However, whilst there have been 23 mixed sex occurrence breaches, which is a 44% reduction on 2011/12, no patients have shared sleeping accommodation on our acute wards. The Trust ensures 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.

Mixed Sex Occurrences



3.3.2. Patient Surveys - 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 2011-2012

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

Our National Inpatient Survey 2012 has shown a marginal improvement in the five questions to 66.7% from 66.2%.

In 2013/14 we have reviewed the results which show deterioration on the previous year and will focus on improving in these areas. We are currently exploring new ways of surveying our patients as our current methods are mainly paper based (following the end of a three year contract with Dr Foster's patient experience trackers), and more sophisticated methods will help us to respond in a more timely way to making improvements to patient experience. We have no areas of outstanding concern. It is important that the development of these methods supports data produced from the Friends & Family Test initiative, to provide more insight into satisfaction scores.

A 'You said, we did' initiative developed in Maternity Services has been used as an exemplar of good practice to providing real time patient feedback, this has been transferred to other Divisions and we are in the process of rolling this out across the trust. 'You said, we did' involves asking patients to give us their ideas, thoughts and suggestions about their experience of their visit to us. Immediate change can happen, or immediate explanation can be given to enhance the experience for patients.

We are pleased to see improvement on 2011 Staff Survey in relation to the response as to whether staff would recommend their hospital to patients. Patient Stories are collected in a variety of ways, written, filmed, taped. These have been shared with clinical services to help staff to appreciate the patient experience and reflect on the impact of their practice and care. Stories form an integral part of Board meetings, there have been 3 patient stories presented within year, engaging executive/non-executive directors in the patient's world.

3.3.3. Complaints and Compliments

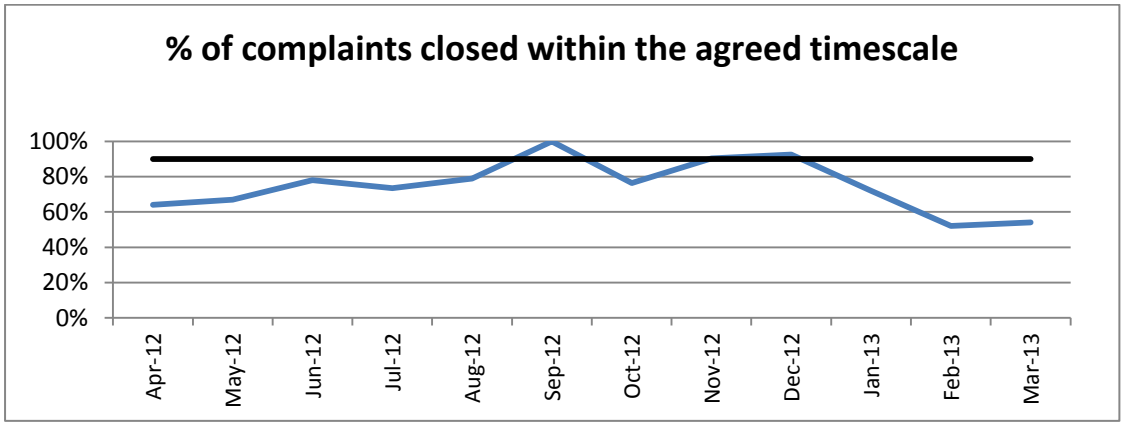
The complaints process is an important source of data and feedback for the trust in its plan to improve the patient experience. The priority for the forthcoming year is to build on the progress made during 2012-13. The Patient Relations Team continues to provide support and guidance for Divisions when dealing with complaints and the Patient Relations Manger attends regular meetings with key members of staff to discuss the handling of individual complaints.

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

Formal Complaints received by Trust 2010/11 – 2012/13

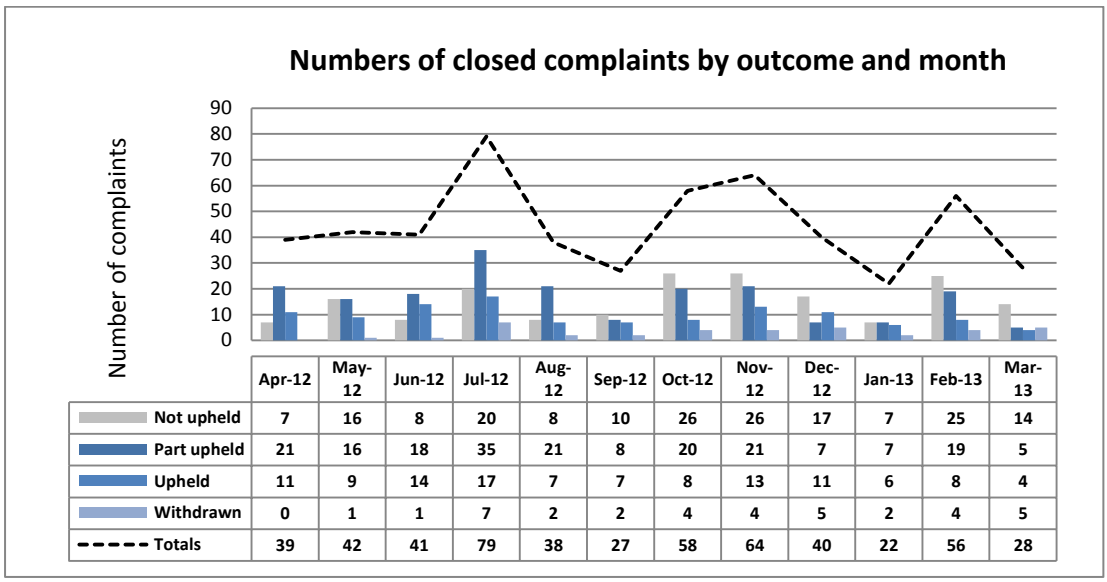
	2010/11	**2011/12**	**2012/13**
Total formal complaints received	491	505	593

Complaints closed within timescale



NB: Timeframe - Low to moderate = 15 days; Moderate = 30 days and High to extreme = 50 days

Complaints closed by outcome/month



	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
Not upheld	7	16	8	20	8	10	26	26	17	7	25	14
Part upheld	21	16	18	35	21	8	20	21	7	7	19	5
Upheld	11	9	14	17	7	7	8	13	11	6	8	4
Withdrawn	0	1	1	7	2	2	4	4	5	2	4	5
Totals	39	42	41	79	38	27	58	64	40	22	56	28

The majority of complaints are put into one of 5 categories in order for the Trust to identify the main themes; this enables us to decide what actions we need to prioritise to help us improve the service we provide to our patients.

Top 5 Complaints Subjects

	11/12 Q3	11/12 Q4	12/13 Q1	12/13 Q2	12/13 Q3	12/13 Q4
Care	63	126	129	125	84	67
Treatment	55	85	81	54	31	59
Waiting Times	25	40	34	41	24	41
Communication Problems	61	52	47	52	49	38
Attitude	33	37	40	39	32	28

The Trust believes that it is important that we respond to complaints within the agreed timescales and has therefore, from September 2012 invested additional resources into the Patient Relations Team to support this process. A review of the whole system for managing complaints has taken place with proposals for improvement being made since this time.

The Trust is committed to providing excellent care for all our patients. This means that not only will the care we provide be safe and effective, but that the patient experience of that care is the best it can be. It is essential that experiences told to us in patient feedback received are listened to and understood. This feedback could be via compliments, comments, concerns, complaints, or via surveys we have undertaken ourselves. We have a duty then, once we have listened and understood, to focus on these experiences and make improvements (lessons learned) based on patients own views and concerns.

The success of this new team will be measured via a range of outcomes:

- Successful implementation of a Patient Experience Hotline
- Improvement in number of formal complaints
- Improvement in the learning and analysis of themes and trends from complaints, evident by reports and to be followed through action planning and monitoring.
- Evidence of CQC compliance with regulations and outcomes
- Evidence of compliance with the recommendations of the Francis Report
- Improvements demonstrated in our In-patient Survey
- Good LINks reports and external reviews.

3.3.4. National Surveys Results 2012

The Trust's results in this year's survey, report that 79% of patients feel that they are always treated with dignity and respect whilst receiving care at Warrington and Halton Hospitals NHS Foundation Trust. This is an increase of 2% on the 2011 survey but remains 2% below the national average for all trusts. Our aim therefore is to continue to improve on this and make the experience of our patients even better in the next year.

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

The specific areas that we need to address are:

- Communication/interaction with doctors
- Ensuring patients have all the information about their condition and treatment that they need, including privacy for these type of discussions
- Continuing work on effective and timely discharge

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

During the summer of 2012, the Trust seconded a Matron to develop an improved approach to meeting patient's expectations at discharge from hospital. An improved set of documentation and patient information literature was developed and it is anticipated that this will improve patient's experience. Discharge cards, providing information for patients on who to contact if they have problems, have been rolled out to all areas. A pilot scheme, funded by Halton Clinical Commissioning Group, has introduced follow up phone calls by a registered nurse to identify safe discharges and to try to reduce readmission rates.

National A&E Survey 2012 identified some areas for improvement, some of which had been pre-empted by a departmental review of patient flow and service provision and a recruitment drive for medical and nursing staff. Specific areas are:

- Ambulance handover times
- Privacy in reception
- Better information and support of patients and family/carers
- Information provision for patients leaving A&E

3.4. Performance against key national priorities

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

Performance – Key National Priorities

Mar-13

Governance Risk Rating - (Monitor) 2012/13

Warrington and Halton Hospitals NHS
NHS Foundation Trust

All targets are QUARTERLY

Level One - National Targets		Target	Weighting	Apr-12	May-12	Jun-12	QTR-1	Jul-12	Aug-12	Sep-12	QTR-2	Oct-12	Nov-12	Dec-12	QTR-3	Jan-13	Feb-13	Mar-13	QTR-4
Clostridium Difficile	Hospital Acquired	40	1.0	1	0	4	5	3	1	1	5	1	1	1	3	2	2	2	6
	Total			1	3	7	11	5	6	4	15	5	5	2	12	5	4	5	14
MRSA Bacteraemia - (Hospital Acquired Target)		3	1.0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1
All Cancers:31-day wait for second or subsequent treatment	Surgery	>94%	1.0 (Failure for any of the 3 = failure against the overall target)	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	Anti Cancer Drug Treatments	>98%		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	Radiotherapy (not performed at this Trust)	>94%																	
All Cancers:62-day wait for First treatment	From Urgent GP Referral for Suspected Cancer (Open Exeter Position)	>85%	1.0 (Failure for either = failure against the overall target)	94.60%	92.00%	86.20%	91.18%	86.59%	88.00%	89.00%	90.15%	88.90%	95.10%	94.60%	90.29%	87.18%	87.84%	85.96%	87.44%
	From NHS Cancer Screening Service Referral	>90%		100.00%	98.00%	100.00%	98.60%	100.00%	98.00%	100.00%	99.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Referral to treatment waiting time	Admitted patients	90%	1.0	90.22%	92.37%	91.07%	91.29%	91.93%	91.38%	90.04%	91.14%	90.84%	91.10%	92.16%	91.30%	92.29%	90.52%	90.49%	91.11%
	Non-admitted patients	95%	1.0	97.78%	98.35%	97.58%	97.93%	97.01%	97.41%	97.12%	97.18%	97.21%	98.42%	98.26%	97.63%	97.62%	97.39%	98.03%	97.69%
	Incomplete Pathways	92%	1.0	92.30%	92.42%	92.35%	92.36%	92.61%	92.32%	92.67%	92.53%	92.76%	92.25%	92.31%	92.44%	92.22%	92.04%	92.19%	92.15%

Level Two - Minimum Standards		Target	Weighting	Apr-12	May-12	Jun-12	QTR-1	Jul-12	Aug-12	Sep-12	QTR-2	Oct-12	Nov-12	Dec-12	QTR-3	Jan-13	Feb-13	Mar-13	QTR-4
All Cancers: 31-Day Wait From Diagnosis To First Treatment		>96%	0.5	100.00%	100.00%	100.00%	100.00%	100.00%	98.00%	100.00%	99.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	99.00%	99.67%
Cancer: Two Week Wait From Referral To Date First Seen	Urgent Referrals (Cancer Suspected)	>93%	0.5 (Failure for either = failure against the overall target)	94.73%	96.00%	96.30%	95.81%	95.81%	95.10%	95.30%	95.30%	95.71%	93.75%	95.34%	95.50%	97.10%	98.20%	98.40%	98.40%
	Symptomatic Breast Patients (Cancer Not Initially Suspected)	>93%		94.10%	95.00%	95.80%	94.90%	95.00%	93.45%	90.20%	93.30%	93.01%	93.10%	96.8%	93.10%	95.50%	100.00%	98.4%	97.70%
A&E Clinical Quality	A&E Maximum waiting time of 4 hrs from arrival to admission/transfer/discharge	>=95%	1.0	95.22%	95.56%	95.69%	95.50%	95.22%	96.74%	93.29%	95.21%	92.16%	95.67%	97.61%	95.12%	94.80%	93.10%	97.81%	95.23%
Failure to comply with requirements regarding access to healthcare for people with a learning disability		N/A	0.5	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No

3.5. 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.

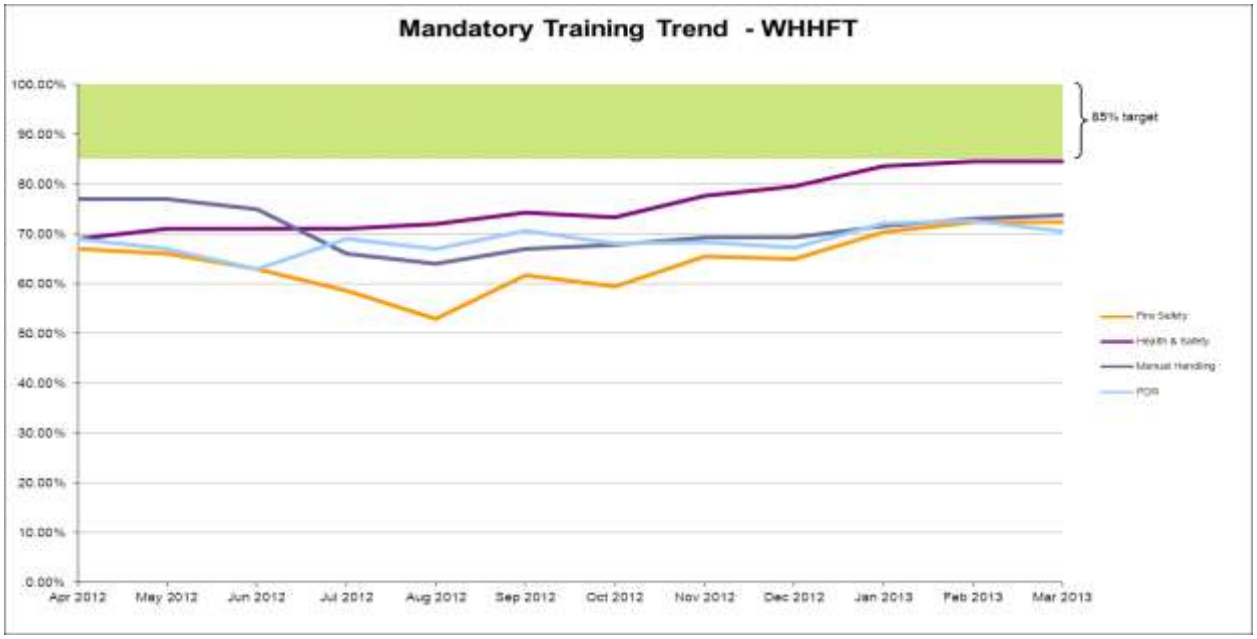
3.6. Training & Appraisal

Training and Appraisal Completion

	Target	**Year End Results**
Mandatory Training Health & Safety Fire Safety Manual Handling	 85% 85% 85%	 84.52% 72.47% 73.76%
Additional Fire Safety and Manual Handling sessions are in place to improve these figures.		
Staff Appraisal Non-medical Medical & Dental Consultants Medical & Dental (career grades) Medical & Dental – consultants and career grades (excluding junior doctors) Total = 172	 85% 100% 100% 100%	 70.49% 98% 93% 97%
As at 31.3.2013 **167 of 172 Consultants / Career Grade Doctors** had completed a 2012 Medical Appraisal. Of those 5 Doctors remaining **(3%):-** • 1 Doctor was on maternity leave and should not have been included in the total medical workforce figure • 3 Doctors have since completed their Medical Appraisals • 1 remaining Doctor is preparing his documentation for submission		

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.

Mandatory Training Attendance – Monthly



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

Version 10 of the Quality Report was submitted to the Clinical Commissioning Groups; Healthwatch and the Overview and Scrutiny Committees. Amendments and additional information inserted into the QR t since this version is as follows:-

Part 1 Statement of Quality from the Chief Executive - inserted

Part 2 Improvement Priorities & Statement of Assurance from Board:

- additional background information to introduction
- Patient Experience improvement priorities included
- Improvement priority relating to medicines to include only insulin related medications to diabetes care

2.2 Statements of Assurance from the Board

- Subcontracted services included
- Selection of local audits included in QR
- Clarified that the Trust has not participated in any special reviews or investigations by the CQC during the reporting period.
- Clinical coding results including error rates clarified (2.2.6.1)
- 62 day Cancer Access Target included

2.2.4 Inserted "CQUIN target achieved" to provide clarity

2.3 Overview of Performance in 2012/13 against NHS Outcomes Framework – data sets inserted

2.4.7 The rate of Patient Safety Incidents included

Part 3

- Patient Safety, Clinical Effectiveness & Patient Experience - Additional background information
- Improvement priorities – comparative data for 2011/12 inserted (graphs changed)
- Caveat inserted re "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 Trusts 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 is only available across two reporting years and more historical data has not been included."

- High Level Quality care at End of Life – section inserted.

3.3 Patient Experience - Introduction inserted

3.4 Performance against key national priorities – MONITOR table inserted.

3.6 Training and appraisal data inserted

4. Statement from the Halton Health Policy Performance Board and Statement from the Trust's Council of Governors' inserted

Appendix – Local Clinical Audits table removed

Statement of Directors Responsibilities inserted

2.2.4 Inserted "CQUIN target achieved" to provide clarity

2.5 The rate of Patient Safety Incidents included

Glossary of terms presented in table format for ease of reading

Quality Account 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

Many thanks for the opportunity to review the Quality Account for Warrington and Halton NHS Foundation Trust (2012-13). While we support the current direction of travel that the trust is taking we did hope to see in the account a stronger focus on some of the recommendations from Francis '2' and how you intend to implement them in the future.

An area of interest as commissioners of your services was the in the Improvement priorities with a notable reduction of the level of harm to patients particularly in the area of pressure ulcers and falls, with notable improvements in the reduction of grade 3 pressure ulcers. I would have liked to have seen some time-lines linked to the National Clinical Audits which have been reviewed this would provide further assurance on how the actions have influenced future care delivery.

I welcome the inclusion of your work in Clinical Research and Development and trust that this work will offer us a foundation on which to build on the findings of the research particularly in the area of stroke, cardiology cancer and gastroenterology which are areas of significant concern to us.

We believe that this account is clear and concise and identifies where future improvements can be made. The report is informative and offers a balanced view of the trust's performance of the reported period.

I congratulate you and your staff on all the hard work and commitment to improving the health and well-being of the local population and share your ethos of high quality for all

I hope that we will be able to work together in the future to further improve the safety, effectiveness and health experience of the local population.

Dr Sarah Baker
Chief Clinical Officer
Warrington Clinical Commissioning Group

4.2. Statement from Halton Clinical Commissioning Group

Many thanks to you and your team for sharing and presenting the Quality Account for 2012/2013 for Warrington and Halton Hospitals NHS Foundation Trust for review and comments and formally to NHS Halton Clinical Commissioning Group and the Local Authority on the 30th April 2013.

NHS Halton CCG would like to thank you for an informative Quality Account and would like to congratulate the organisation on its performance and success during 12/13. We look forward to working closely with you as coordinating commissioner during 2013/2014 and we wish you continued success during 2013/2014

Jan Snoddon
Chief Nurse
NHS Halton CCG

4.3. Statement from the Halton Health Policy Performance Board

HALTON
BOROUGH COUNCIL

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

Our Ref EST
If you telephone please ask for Emma Sutton-Thompson
Your ref
Date 10th May 2013
E-mail address Emma.Sutton-Thompson@halton.gov.uk

Dear Ms Pickup,

Warrington and Halton Hospitals NHS Foundation Trust Quality Accounts 2013

Further to receiving a copy of your draft Quality Accounts and the Joint Quality Accounts event held on 30th April that your colleagues Hannah Grey and Millie Bradshaw 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 2012/13 the Trust identified a number of priorities to be achieved during this year. The Board was pleased to note improvements in the following areas:

- How you plan and prepare patients for a safe discharge from hospital, in particular, who patients can contact if they have fears on leaving hospital and details on the side effects of medications taken home. The Board noted that a discharge plan has been introduced to be commenced on admission that includes a multi-disciplinary approach to a safe and effective discharge. The Trust have also developed a Discharge Card with contact details and information on what to look out for on discharge which is to be given to every patient on discharge.
- The overall improvement in the 2012 National Inpatient Survey report relating to both the areas above is excellent progress, especially in respect of the 7% improvement in providing your patients with details of side effects of medication and becoming above average nationally.
- To have no more than 3 cases of MRSA bloodstream infections and 40 cases of Clostridium difficile acquired within the hospital. The Trust has reported only 1 case of MRSA and 19 cases of Clostridium difficile which the Board are pleased to note.

- Reducing the number of grade 3 avoidable ulcers acquired within the hospital. The Board is pleased to note this number has reduced by 14% on the previous year, with 18 grade 3 ulcers being reported. The Board were also pleased to read that the Trust will be introducing a "zero" tolerance for grade 3 and above ulcers.
- Reducing the number of falls which cause moderate, major or catastrophic harm. The Trust has reported 16 falls causing moderate harm compared to 20 the previous year. The Board was pleased to note the new reporting system when a patient falls, whereby a member of the senior nursing team is automatically contacted via the Datix system and immediately visits the ward concerned.

Under Clinical Effectiveness the Board noted that the National Hospital Standardised Mortality Review (HSMR) score for a Trust such as Warrington and Halton NHS Foundation Trust is set at 100, although the actual figure for 2012 is reported as 106, intimating that there are more than expected numbers of deaths for this type of Trust. The Board are encouraged to read that this area is being focussed upon by the Medical Director and Director of Nursing to identify clear paths of improvement for the future.

Under Patient Experience the Board noted the slight improvement in some of the questions in your National Inpatient Survey 2012, in particular "Were you told who to contact if you were worried about your condition once your left hospital" from 64% in 2011 to 73% in 2012. The Board is pleased to read about the You Said, We Did initiative that is being rolled out across the Trust. This will be a useful tool to help gain valuable patient ideas, thoughts and suggestions.

The Board notes that complaints at the Trust have risen from 505 during 2011/12 to 593 during 2012/13.

In the National Survey Results 2012, the Board notes that 79% of patients feel that they are always treated with dignity and respect. This is an important area to aim for improvements. The Board are pleased to note that the Trust will be focussing on the following specific areas to improve:

- Communication/interaction with doctors
- Ensuring patients have all the information about their condition and treatment that they need, including privacy for these type of discussions
- Continuing work on effective and timely discharge.

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

Yours sincerely,

E L Sutton Thompson

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

4.4. Statement from Warrington LINk

Warrington LINk statement was requested but not received

4.5. Statement from the Halton LINk

Halton LINk thanks the Trust for the opportunity to comment on the Quality Account for the year 2012-13.

Members find it useful to have been able to work continuously with the Trust concerning the Quality Account report, through the LINk representative attending meetings such as the 'Quality in Care.' However, we are disappointed Healthwatch Halton will not have a representative sitting on the Governor's Council next year.

Through having a LINk representative on the Council of Governors and other committees such as the Communications & Membership and the Patients' Experience Group, we have been able to keep the LINk Board up to date on issues within the Trust. LINk members have also valued the opportunities to take part in the PEAT visits at the hospitals.

It is appreciated that improvements continue to have been made on the LINk's main concerns highlighted in last year's report i.e. patient experience and reduction in falls.

LINk members were also very pleased to note that hospital acquired infections such as MRSA and C. difficile have been reduced considerably.

Halton LINk has welcomed the progress on safe discharges this year and for 2013-14, members would welcome a plan to address delayed discharges.

We are pleased to note some improvement on targets for training and appraisal rates for staff, which has been one of our concerns over the past 2 years and we look forward to further improvements next year.

Members welcomed the Trust's list of priorities for the coming year, particularly the reduction of catheter associated UTIs. The inappropriate use of catheters can have a lasting effect on a person's dignity, especially frail elderly patients, after leaving hospital. Members were also pleased to note the proposed implementation of the developments of a culture within the organisation, where everyone will be aware of and help patients with dementia and the Trust's development of 'always events.'

We noted the improved format of the accounts. The report is clear and the data easy to understand including the Appendix- Local Clinical Audits Table, which is informative and simple to follow.

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

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

Statement from Warrington Health and Well Being Overview and Scrutiny Committee was requested but not received.

4.7. Statement from the Trust's Council of Governors

Supplied by Doreen Shotton Chair of Governors' Quality in Care Committee

Governors comment on the Quality Accounts on behalf of members of the Trust as well as patients and the public. They have reviewed the final Quality Accounts for 2012/2013 in their role of holding the Board to account and are pleased to say that they believe the Quality Accounts are a true reflection of the Trust's commitment to provide the best possible services and show good progress in improving patients' experience.

The Quality Accounts describe the Trusts' achievements well, show success in developments and are candid in acknowledging where mistakes have been made and improvements are needed. Governors believe that the accounts provide assurance that the Trust, through its framework of 'Quality People Sustainability'(QPS) is delivering safe high quality care for its patients.

Governors have been closely involved throughout the year in reviewing the Quality data in their Quality in Care committee and in seeing the way the Trust has put its improvements into practice through their unannounced observational visits to wards. Our response includes a report on these visits, which have been well worthwhile. They have been appreciated by staff and management and effective in prompting practical action and adding to maintaining high standards of safety and consistent delivery of quality of care

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

1) <u>Do the priorities reflect those of the local population?</u>

Governors think this is true. The emphasis on patient safety, which is very important to local people, as shown in patient surveys, is demonstrated in the impressive reduction in hospital acquired infections (MRSA and C. difficile), pressure ulcers and falls. The staff are to be congratulated on achieving reductions considerably beyond the targets set and continue to set further reduction targets to achieve zero tolerance in infection control. However insulin related medication errors did not achieve its target, although the majority resulted in no or low harm and measures have been put in place to address this. Many aspects of discharge from hospital have been improved and targets met, but, as patients report, waiting for medicines at discharge can be distressing. The governors look forward to the Trust's plans to improve this next year succeeding

2) <u>Are there any important issues missed in the Quality Accounts?</u>

Governors last year suggested that more attention could be paid to the development of interaction with members, patients and the public. This has not been measured, but there have been more opportunities for patients and governors to work with the Trust in focus groups, through surveys and open days and in contributing to planning for improved patient experience through the arrangement of Your Health Events and feedback through the Friends and Family test. It would be helpful if progress in this aspect could be reported in the Quality Accounts. It is pleasing to note that communication/interaction with doctors is one of several areas to be looked at in order to improve patient experience.

3) Has the Trust demonstrated that it has involved patients and the public in the production of the Quality Accounts?

This has been further developed during the year. Governors including representatives from LINks in Warrington and Halton through their Quality in Care Committee, have been regularly involved in discussing information in the Quality Dashboard and identifying areas of concern and, where appropriate, suggesting ways to improve. Patients have been encouraged to provide feedback on their experience and the Family and Friends Test has been introduced, where patients are asked if they would recommend using the Trust to their own family and friends.

Additionally, the governors' Quality in Care committee have included in their remit scrutiny of the Workforce Dashboard and a focus on the welfare of staff. Although there has been improvement in numbers receiving statutory training in manual handling, it still needs addressing as does the numbers receiving an annual appraisal. Governors believe personal development for staff is an essential part of the care the Trust shows for its staff as its most valuable asset and without its goodwill would be unable to deliver safe, high quality compassionate care to its patients. Governors feel that staff have achieved and surpassed many targets this year and are to be commended for that and encouraged to continue with the improvements and tackle shortcomings. The culture of openness and candour is important to patients and contributes to the Quality agenda. It is good to know that while needing to make considerable savings in the Cost Improvement Programme there has been no loss of quality due to reduced funding. The governors acknowledge and appreciate this, as demonstrated in coping with increased activity in A&E as well as elective surgery and dealing with increases in the number of frail elderly patients often suffering from dementia. Although there has been an increase in the number of complaints and the speed with which they are dealt, this is admitted and it is good that plans to improve this area are in hand

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

Governors think the format and section headings, as well as the relevant graphs are helpful. It is useful to have each topic showing achievement of targets and improvements agreed for next year, as well as an explanation of plans for the future. Not every aspect can be quantified, but where figures have been in included they are clear and percentages have been used appropriately. Governors are pleased with the presentation as well as the content and believe the Quality Accounts for this year are accurately documented and well expressed.

4.7.1. Report on Governor ward observation visits - Ward Inspections 2012/13

Our dedicated governors, occasionally accompanied by one of our two Non Executive Director recruits, have continued the programme of unannounced visits to wards at both Warrington and Halton hospitals.

The focus has been on wards specialising in elderly care. This included the long stay ward at Halton General Hospital where patients were awaiting accommodation in nursing homes. Some patients here were very insistent that they would prefer to stay in the hospital as the care there is so good and the staff excellent.

The teams have found that staff were mostly very welcoming, especially as the news spread of the positive effects of the visits. Members of the teams have been greeted in the hospital by ward managers who thanked them for their reporting of faulty equipment and worn out facilities which were replaced very shortly after the team's visits. One new team member was highly

amused to hear that an unusable bathroom which was being used as a storeroom was transformed into a wet room within days of the inspection.

Adverse criticism of old buzzers which were sometimes unreliable resulted in new buzzers being installed the following week instead of having to await their turn.

Staff in all wards have been praised highly for their dedication and care although on occasion the team felt that whilst the care could not be faulted it occasionally appeared not to be as compassionate as it might have been, in that staff attended to all the needs of the patients, but did not actually engage with them. However in some wards this compassion was in abundance.

Mealtimes were observed as improving, following the insistence that frail patients should be checked and re-checked to ensure they were in fact able to cope. As a result of the governors' comments that the red trays, which were supposed to indicate that someone needed feeding or extra care, were not being used, all meal trolleys now have a large notice about red trays and a message has gone round to all wards to use them and be vigilant.

Infection control has been carefully monitored and instances of lapses in hand hygiene and cleansing of equipment between patients brought to the notice of the ward managers. Doctors have been the most regular offenders by their recurrent non-observation of NHS clinical policy, of "bare below the elbows" and gelling between patients and bays. The occasional one still appearing in suit, tie and long- sleeved shirt and female doctors in long-sleeved tops with sleeves not rolled up.

On occasion, cleaning has not been as meticulous as it could be, with layers of dust above eye level and behind beds, baths and toilets and the occasional spill not removed immediately. But by and large wards are sparklingly clean with cleaners and housekeepers meticulous in their duties. Store rooms are also well-kept and tidy.

The governors' targets of reducing falls have been much in evidence as large red notices reading "Risk of Fall" are displayed above beds and more pressure cushions have been provided as a warning of patients who like to stand up and walk around and staff were instructed to regularly check on patients sitting in chairs as they tend to nod off and droop forwards and are at risk of falling.

Very few criticisms were reported from patients, mostly about noise at night and buzzers not being answered as quickly as they would have liked. Although the latter was excused by most patients as that the staff were busy at the time. Staff were requested to speak more quietly at night as the sound carries. Governors tested the response to buzzers on each visit.

Governors asked that staff should carefully check on patients who were transferred to their ward and who had special needs, as one patient with several special needs was very distressed that her incontinence was not attended to following transfer from another ward.. This was reported to the Matron and Director of Nursing.

During the visits, governors noted the number of patients with Dementia. In the long-stay ward there were three out of the six in one bay who sat and stared at the wall. As a result the governors have made suggestions and donated some items that can be used to help provide a welcome opportunity and focus attention on an activity thus avoiding agitation, boredom or anxiety. These items vary from wooden jig-saw puzzles to a small skittle game. In addition a

“Forget-Me-Not” club has been formed and rummage boxes are being filled with items which patients can relate to. It is also proposed that Dementia patients should wear a forget-me-not blue wrist band. There is a scheme to include members of the local Guide Association and friends to knit and sew muffs and blankets for patients to fiddle with whilst sitting. One patient commented that they needed to be able to tell the time so that they knew when the next meal was coming. The clock in her bay was not working. As a result of this, each bay is to have a working clock and a board on which is written the day and the date.

Patients have complained about being kept awake at night by dementia sufferers who awake as everyone else is going to sleep, and shout out for attention and wander around the ward. Some wards have dedicated bays staffed by specialist nurses to look after these patients.

The consultant who has been appointed to specialise in Elderly Care and Dementia gave a presentation on his work on the Dementia Strategy he is working on, to the Governors’ Council

Our last ward visit was to the Intensive Care Unit where the inspection team, although having the impression of being in the latest hi-tech submarine, with monitors and warning beeps sounding at the least movement of the patient, were deeply impressed with the ambience of the unit and the dedication and constant vigilance of the staff. The whole ward had an aura of calm efficiency. Every member of the team said they would be happy to be cared for in this unit and for members of their family to be cared for there.

We feel all staff are to be congratulated on maintaining the high level of care in the wards. Patients generally stated they would be happy for their friends and family to be cared for there.

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 2012/13;
- 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 2012 to June 2013
    - Papers relating to Quality reported to the Board over the period April 2012 to June 2013
    - Feedback from the commissioners dated 28/05/2013
    - Feedback from governors dated 01/05/2013
    - Feedback from Local Healthwatch organisations Halton LINk dated 15/05/2013
    - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 25/04/2013;
    - The 2012 national patient survey
    - The 2012 national staff survey
    - The Head of Internal Audit's annual opinion over the trust's control environment dated 29/04/2013
    - CQC quality and risk profiles for the reporting period published 01/04/2012 to 31/03/2012
- 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-nhsft.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

Mel Pickup
Chief Executive

Allan Massey
Chairman

29th May 2013

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

We have been engaged by the Council of Governors of Warrington 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 2013 (the 'Quality Report') and specified performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2013 in the Quality Report that have been subject to limited assurance consist of the following national priority indicators as mandated by Monitor:

1. Number of Clostridium difficile infections; and

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

We refer to these national priority indicators collectively as the "specified indicators".

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the assessment criteria referred to in the statement of directors' responsibilities of the Quality Report (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") 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;
- 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.

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

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

- Board minutes for the period April 2012 to the date of signing this limited assurance report (the period);
- Papers relating to Quality reported to the Board over the period April 2012 to the date of signing this limited assurance report;
- Feedback from the Commissioners Warrington Clinical Commissioning Group dated 27/05/2013 and Halton Clinical Commissioning Group dated 23/05/2013;

- Feedback from Governors;
- Feedback from local Healthwatch organisations, Halton Link dated 15/05/2013;
- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, included within the quarterly Governance Report, Governance Reports reviewed quarters 1-4 inclusive ;
- Feedback from other stakeholders involved in the sign-off of the Quality Report including Halton Health Policy Board dated 10/05/2013;
- The 2012 national patient survey and the 2012 national accident and emergency department survey;
- The 2012 national staff survey;
- Care Quality Commission quality and risk profiles dated 31/05/12, 30/06/12, 31/07/12, 30/09/12, 31/10/12, 30/11/12, 31/01/13, 28/02/13 and 31/03/13; and
- The Head of Internal Audit's annual opinion over the trust's control environment dated March 2012.

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

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

This report, including the conclusion, has been prepared solely for the 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 2013, 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:

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

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

Limitations

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

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

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

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

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that for the year ended 31 March 2013,

- The Quality Report does not incorporate the matters required to be reported on as specified in annex 2 to Chapter 7 of the FT ARM;
- The Quality Report is not consistent in all material respects with the documents specified above; and

the specified indicators have not been prepared in all material respects in accordance with the Criteria.

PricewaterhouseCoopers LLP Chartered Accountants
Manchester
29 May 2013

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.
Governance risk rating	MONITOR publish two risk ratings for each NHS foundation trust, on: Governance (rated red, amber-red, amber-green or green); and Finance (rated 1-5, where 1 represents the highest risk and 5 the lowest).
Governors	Governors form an integral part of the governance structure that exists in all NHS foundation trusts; they are the direct representatives of local community interests in foundation trusts
Healthwatch	Healthwatch is a body that enables the collective views of the people who use NHS and social care services to influence policy.
Healthcare evaluation data (HED)	Clinical benchmarking system to support clinical experts in more effective management of clinical performance.
Hospital episode statistics (HES)	is a database containing information about patients treated at NHS providers in England.
Hospital Standardised Mortality Review (HSMR)	is an indicator of healthcare quality that measures whether the death rate at a hospital is higher or lower than you would expect.

Information governance	ensures necessary safeguards for, and appropriate use of, patient and personal information.
Making every contact count (MECC)	is about using every opportunity to talk to individuals about improving their health and well being
Mandatory training	The Organisation has an obligation to meet its statutory and mandatory requirements to comply with requirements of external bodies e.g. Health & Safety Executive (HSE), training is provided to ensure that staff are competent in statutory and mandatory
Monitor	assess NHS trusts for foundation trust status and license foundation trusts to ensure they are well-led, in terms of both quality and finances
MRSA	Methicillin-resistant *Staphylococcus aureus* (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans.
National confidential enquiries (NCEPOD)	The purpose of NCEPOD is to assist in maintaining and improving standards of medical and surgical care for the benefit of the public by: reviewing the management of patients; undertaking confidential surveys and research; by maintaining and improving the quality of patient care; and by publishing and generally making available the results of such activities.
National inpatient survey	collects feedback on the experiences of over 64,500 people, who were admitted to an NHS hospital in 2012.
National institute for health and clinical excellence (NICE)	Is responsible for developing a series of national clinical guidelines to secure consistent, high quality, evidence based care for patients using the National Health Service.
National institute of health research (NIHR).	Organisation supporting the NHS.
National patient safety agency (NPSA)	leads and contributes to improved, safe patient care by informing, supporting and influencing organisations and people working in the health sector.
National reporting and learning system (NRLS)	is a central database of patient safety incident reports. Since the NRLS was set up in 2003, over four million incident reports have been submitted. All information submitted is analysed to identify hazards, risks and opportunities to continuously improve the safety of patient care
Never events	are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
NNHS outcomes framework	reflects the vision set out in the White Paper and contains a number of indicators selected to provide a balanced coverage of NHS activity. to act as a catalyst for driving up quality throughout the NHS by encouraging a change in culture and behaviour.
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	provide a means of gaining an insight into the way patients perceive their

Outcome Measures (PROMs)	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.
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).