Wrightington, Wigan and Leigh
NHS Foundation Trust

Quality Accounts 1 April 2015 – 31 March 2016

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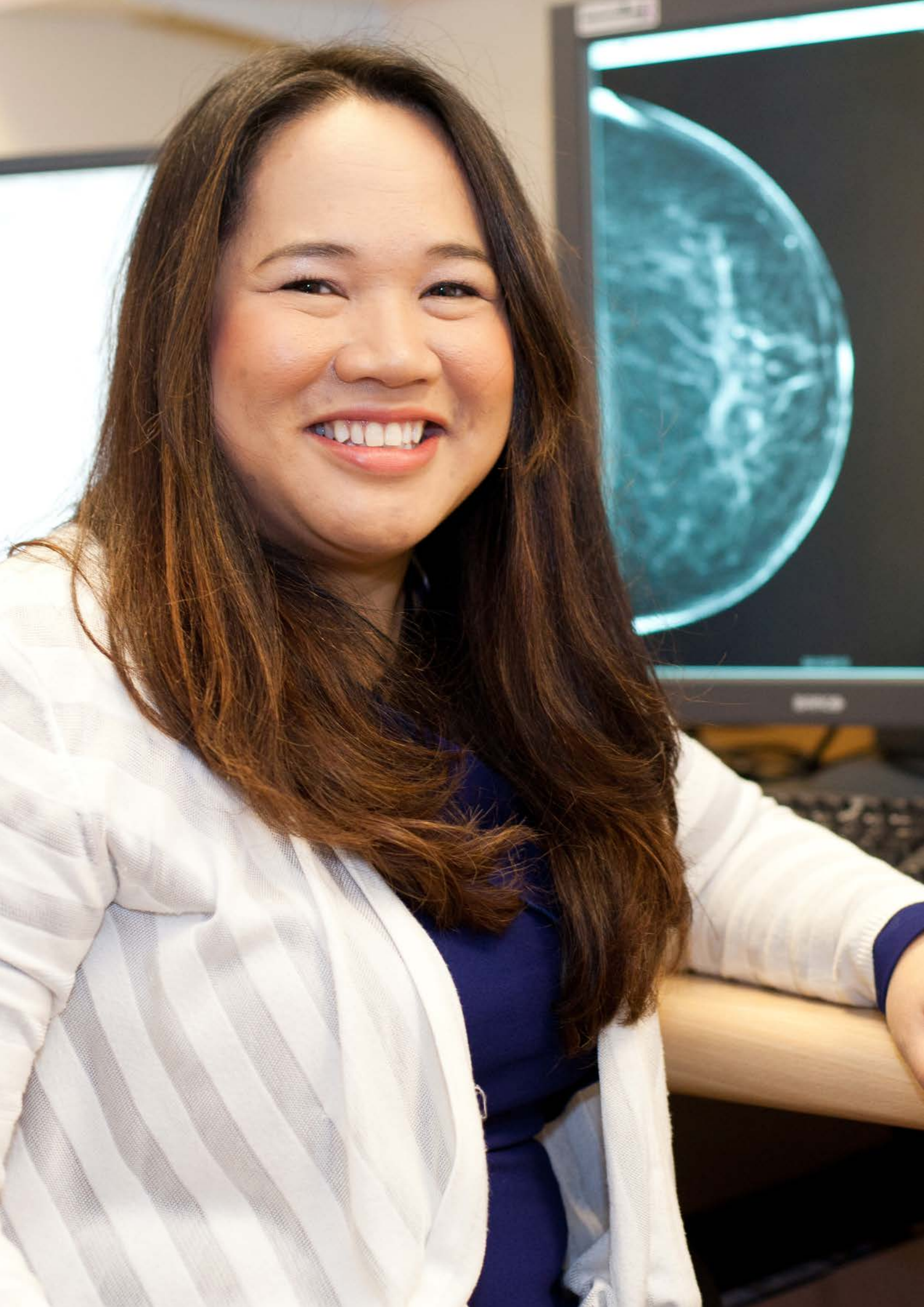


What is a Quality Account?

All providers of NHS Services in England are required to produce an Annual Quality Account. The purpose of a Quality Account is to inform the public about the quality of services delivered by the Trust. Quality Accounts enable NHS Trusts to demonstrate commitment to continuous, evidence based quality improvement and to explain progress to the public. This is the Trust's sixth Quality Accounts.

Part 1:

Statement from the Chief Executive

Welcome to our eighth Quality Account. This is a critically important document for us as it was eight years ago that we chose to pursue Quality as the overarching strategy for our services. We use the Darzi definition of Quality – Safe, Effective and Caring – as the basis of our corporate and divisional plans and as the basis for measuring and reporting on our progress in reducing avoidable harm and improving quality.

Welcome to our eighth Quality Account. This is a critically important document for us as it was eight years ago that we chose to pursue Quality as the overarching strategy for our services. We use the Darzi definition of Quality – Safe, Effective and Caring – as the basis of our corporate and divisional plans and as the basis for measuring and reporting on our progress in reducing avoidable harm and improving quality. This is also the fifth year that we have used the WWL Wheel as a simple, visual reminder to strengthen awareness of 'Safe, Effective and Caring' and of our quality strategy amongst staff. We continue to actively participate as a member of NHS QUEST; (a network for Foundation Trusts' who wish to focus on improving quality and safety) working collaboratively with other member organisations to reduce deaths in hospital as well as continuing to reduce readmissions and deliver harm-free care.

As with previous Quality Accounts, we have given considerable priority to collecting and reporting facts and data to monitor our progress. 2015/16 was another year in which we have continued to make good progress at all levels, ranging from nationally published measures, such as infection rates, to our monthly report on avoidable serious harms.

On infection control for the first time we had no cases of Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia infection compared to one in each of the two previous years, and just 12 cases of Clostridium *difficile* compared to 25 the previous year. We also recorded 5 cases of Methicillin-Susceptible Staphylococcus Aureus (MSSA) and 14 E Coli bacteraemia compared to 9 and 17 respectively in 2013/14 and 2014/15.

Another key quality measure is Hospital Standardised Mortality Ratio (HSMR) and we continue to see year-on-year improvement. The most up to date HSMR figure for 2015/16 is 92.3 to February 2016 and we are very proud of this further reduction. To corroborate the data provided by Dr Foster, over the last eight years our absolute numbers of deaths in hospital has gone down from 1,561 in 2007/08 to 1115 in 2015/16, a fall of 29 per cent that can principally be explained by improved quality of care and reduced instances of harm.

This report contains many more facts and figures and I encourage you to study the range of quality initiatives and measures that are in place to improve quality and reduce avoidable harm. Here are some headlines:

Safe

- We had 19 serious and moderate falls in hospital, compared to 11 the previous year
- There were no Central Line infections, the same as the previous year
- There have been no incidents that have met the criteria for a Never Event in 2015/16
- There was one case of Ventilator Associated Pneumonia compared to zero in 2014/15

Effective

- We invested £15.1m in new buildings, our new Hospital Information System and new equipment
- We successfully achieved all the national targets except for four hour waits in A&E which we achieved for the whole year but failed in the last two quarters

Caring

- In the national patient survey we performed significantly better on eight questions and only significantly worse in one compared to the previous year. We were also significantly better than other Trusts on 24 questions and only significantly worse on one.
- In the annual Patient Led Assessments of the Care Environment (PLACE) survey we were the cleanest hospital in the NHS for the second year in a row and our overall scores were the fifth best in the NHS
- Our national staff survey showed that 84% of staff say that "care of patients is my organisation's top priority" compared to 79% the previous year. The average for the NHS is 75%.
- It also showed that 78% of staff would "recommend my organisation as a place to work" compared to 77% who felt this the previous year. The average for the NHS is 61%.
- This year we grew the number of Quality Champions to 288, each being trained in techniques of quality improvement before taking on leadership of 61 tasks or projects

From the 9th to 11th December 2015, a team of Care Quality Commission (CQC) inspectors visited our hospitals reviewing the services we provide and speaking to patients, visitors, carers and staff. This was followed by an unannounced visit on the 21st December 2015. The Trust welcomed this inspection as an opportunity to showcase the work undertaken by the Trust and the support provided by our patients and staff. At the time of writing, the report has not been published.

Some of the achievements from 2015/16 are outlined above, but we also acknowledge that things often go wrong, sometimes seriously wrong in the NHSand we record some of these below.

The Trust reported 22 serious incidents in 2015/16, in comparison with 30 in 2014/15 and 33 in 2013/14. The Trust received 362 formal complaints in 2015/16. This was a reduction of 4% in comparison with 2014/15.

We have one of the best A&E departments in the country and for the year to Christmas 2015 it was the best performing department in Greater Manchester and 7th in the whole country. However, we had a very difficult winter when our system became overwhelmed for many weeks and our third and fourth quarter performance dipped to 94.0% and 92.38% respectively for the 4-hour standard. We apologise to patients who experienced extensive waiting at that time. However across the year we did achieve the standard and were the only Trust in Greater Manchester to achieve the 95% standard overall with an annual figure of 95.08%. We were also the only acute Trust in the whole of the North of England to achieve this.

We won two awards for Best Performing Trust for acute Myocardial Infarction (MI) and Heart Failure at the Advancing Quality Awards. Although the Trust no longer participates in the Advancing Quality Initiative we continue to measure a bundle of quality indicators for Heart Attack, Heart Failure, Hip Replacement, Knee Replacement, Pneumonia and Stroke.

Over the years that we have been publishing Quality Accounts, we have aimed to build a strong safety culture all the way from the Board to the level of our front line staff who deal directly with patients. We want strong leaders and managers at every level in the organisation, who are committed to quality and safety and who promote a strong and vibrant energy and sense of belonging. Culture is one of the hardest things to change and also one of the most difficult to measure but three of our programmes – Harm-Free Wards, Quality Champions and Always Events, seem to be making a clear and noticeable difference. It is pleasing to note that we won 5 national and regional awards. My congratulations go to the teams in the Pathology, Maternity, Catering, Finance and Research and Development Departments.

2015/16 was a hugely successful year for certain departments at WWL. A number of individuals and departments were honoured with awards in recognition of their outstanding work. It started in June 2015, when Olwen Winstanley, from Voluntary Services, picked up a Lifetime Achievement at the Our Stars Awards event. Next, in July 2015, the Catering department were recipients of the Sandra Heyes Memorial Award at the Hospital Caterers Association (North West) awards. September saw Pathology at Wigan and Salford (PAWS) honoured with a Value and Improvement in Pathology award at the Health Service Journal (HSJ) Value in Healthcare Awards.

On to November 2015, and Dr Chandra Chattopadhyay received a Lifetime Achievement Award, for our Research Department, at the Greater Manchester Clinical Research Awards. The Finance Department also won a prize at the Healthcare Financial Management Association Awards in the same month.

December 2015 saw three of our Quality Champions awarded Advancing Quality Awards, courtesy of AQuA (Advancing Quality Alliance). They were presented with their awards at a Quality Champions Committee meeting on Friday 26 February 2016, having not been able to attend the original ceremony. Two of our consultants were also recipients of Clinical Excellence Awards in January 2016; Professor Nirmal Kumar received a Silver Award, while Mr Martyn Porter attained a Gold Award.

Moving into February 2016, Dr Chandra Chattopadhyay was honoured again, this time by the BMA. They held an event to recognise the contribution of Principle Investigators. Dr Chattopadhyay was recognised in the "Consistently delivers to time and target", in what was another coup for the Research and Development department.

In March 2016, our Maternity Team won a national Friends and Family Test Award in the "Friends and Family Champion" category. The team were honoured at an event in Leeds by NHS England for their creative and innovative approach to implementing the scheme.

In making this statement I can confirm that, to the best of my knowledge, the information contained in this Quality Account is accurate.

Andrew Foster
Chief Executive

Part 2:

Priorities for Improvement and Statements of Assurances from the Board

Part 2.1: Priorities for Improvement in 2016/17

This is the 'look forward' section of the Trust's Quality Account. In April 2014 the Trust launched a Quality Strategy 2014/17 with goals for improvement over the next three years. Sign Up to Safety was also launched in 2014. Outlined below are the three year quality goals, information about the Trust's Sign up to Safety Improvement Plan and the improvements that the Trust plans to undertake over the next three years.

Quality Strategy 2014/17

The purpose of the Trust's Quality Strategy 2014/17 is to support the achievement of the Trust's overarching strategy to be safe, effective and caring, and the three year corporate objectives for 2014/17 agreed by the Trust Board.

The Quality Strategy 2014/17 outlines a number of quality goals for improvement over a three year period. These goals were identified in consultation with internal and external stakeholders. These quality goals reflect the Trust's corporate objectives and vision to be in the top 10% of everything we do. The Quality Strategy goals for 2014/17 are:

Safe

- To reduce avoidable harms
  The Trust aims to move progressively towards zero avoidable harms in hospital over the next three years.
- To reduce mortality
  The Trust aims to reach a Hospital-Standardised Mortality Ratio (HSMR) of 83 by 2017 and a Summary Hospital-Level Mortality Indicator (SHMI) of no more than 100 over the next three years.

Effective

- To improve patient clinical outcomes for planned treatments
  The Trust aims to be in the top 10% of Trusts for Patient Reported Outcome Measures (PROMS) and Advancing Quality Scores, indicators of positive patient experience.
- To improve the recognition of and response to the acutely unwell patient
  The Trust identifies specific areas of concern annually and includes these priorities in the Quality Account.
- To improve nutrition management
  The Trust identifies specific areas of concern annually and includes these priorities in the Quality Account.
- To improve discharge arrangements for patients
  The Trust identifies specific areas of concern annually and includes these priorities in the Quality Account.

Caring

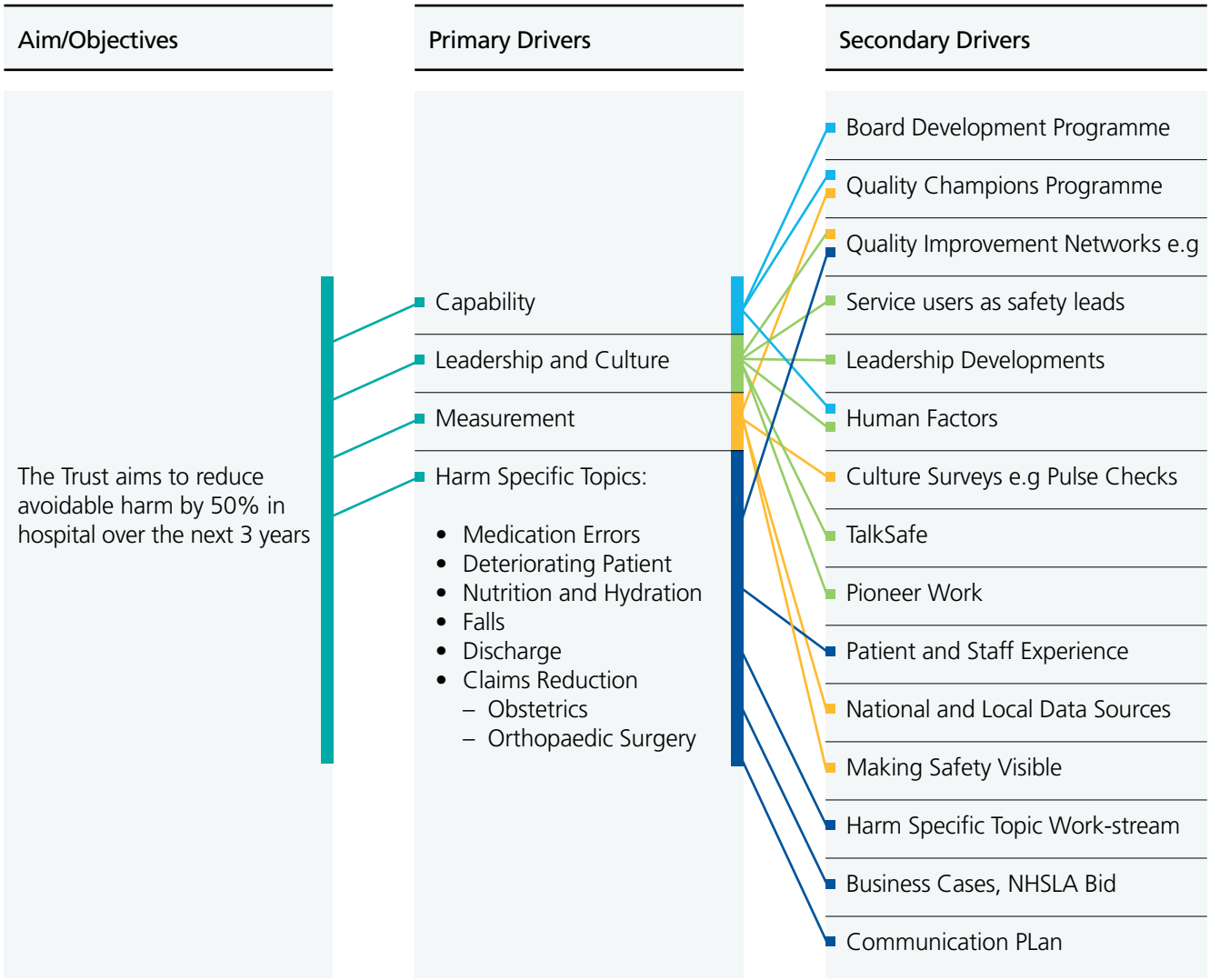
- To be recognised as the most caring Trust in the country by 2017
  The Trust aims to be in the top 10% of similar Trusts for patient opinion surveys. The Trust will also identify specific areas of concern identified by patient feedback for annual improvement and include these priorities in the Quality Account.

Participation in the National Sign Up to Safety Campaign

The aim of the National Sign Up to Safety Campaign is to deliver harm-free care for every patient, every time, everywhere. The campaign champions openness and honesty, and supports everyone to improve the safety of patients. The campaign has a three year objective to reduce avoidable harms by 50% and save 6000 lives over three years.

The Trust 'signed up to safety' in August 2014, committing to the development of an improvement plan which was submitted in January 2015. The Trust's improvement plan builds on the Trust's Quality Strategy 2014/17 and brings together existing quality and safety initiatives that are underway.

The diagram below summarises the Trust's Sign up to Safety Improvement Plan. Detail regarding a number of the initiatives included in the plan is described in this Quality Account.



Quality Priorities for 2016/17

The Trust's safe, effective and caring strategy is the basis for our corporate and divisional plans and the basis for measuring and reporting on the Trust's progress in reducing avoidable harm and improving quality. The Trust has experienced local successes and challenges in achieving the Trust's safe, effective and caring strategy over the previous year which are outlined throughout this quality account.

The Trust has agreed a number of annual priorities for 2015/16 which support the Trust's Quality Strategy 2014/17, Sign Up to Safety Improvement Plan, and considers some of the Trust's challenges. The annual priorities were agreed following consultation with staff and stakeholders including Governors.

The quality priorities, the rationale for their selection and how the Trust plans to monitor and report progress are outlined below. All quality priorities have a timescale for achievement by the 31st March 2017 and progress to achieve them is monitored by the Quality and Safety Committee.

Safe

Priority 1:	To reach an HSMR (Hospital-Standardised Mortality Ratio) of no more than 85 before rebasing and SHMI (Summary Hospital-Level Mortality Indicator) of no more than 100
Rationale:	This was a quality priority for the Trust in 2015/16 and remains a priority for 2016/17. HSMR year to to February 2016 (data is three months behind) is 92.3 and within expected range when benchmarked against other organisations. The latest SHMI data is 111.45 (October 2014 - September 2015). The Trust is considered an outlier (has a worse performance for SHMI when compared to other acute Trusts in Greater Manchester.
Monitoring:	The Trust Board and Quality and Safety Committee regularly review HSMR and SHMI data provided by Dr Foster Intelligence, a provider of healthcare information monitoring the performance of the NHS. The data is monitored in the Monthly Trust Board Performance Report and Quarterly Safe Effective Caring (SEC) Report.
Reporting:	Trust Board; Quality and Safety Committee; Monthly Team Brief

Priority 2:	To reduce the numbers of falls by 10%
Rationale:	The Trust did not achieve the ambitious target to reduce falls by 10% by the end of 2015/16. Falls continues to be a focus for improvement. A local Commissioning for Quality and Innovation (CQUIN) scheme for 2016/17 relates to falls and the work planned should contribute to a decrease in the numbers of falls by the end of March 2017. This work will focus on patients who sustain multiple falls, people living with dementia and communication with GP's. Further initiatives underway include the provision of ward level data and establishment of Volunteer Patient Companions.
Monitoring:	The Harm Free Care Board is responsible for monitoring the work undertaken by the Falls Improvement Group and progress to reduce the number of falls. The number of falls is measured by the incidents reported to the Trusts risk management system (Datix) and reported in the monthly Trust Board Performance Reports.
Reporting:	Trust Board; Harm Free Care Board

Priority 3:	**To complete a venous thromboembolism (VTE) risk assessment for 95% of patients admitted to hospital**
Rationale:	This has been identified as a priority by the Trust and Wigan Borough Clinical Commissioning Group to act on measures put in place to reduce the risk of venous thromboembolism (VTE) in hospitalised patients
Monitoring:	The Thrombosis Committee is responsible for monitoring compliance to achieve the priority and audit results. The audit excludes patients who have an exempt code listed on their records, such as those attending for a day case procedure, or those admitted for only a few hours before being discharged.
Reporting:	Trust Board, Thrombosis Committee

Effective

Priority 1:	To create a comprehensive register for all Trusts electronic information assets with details of the name and role of the responsible individual.
Rationale:	This was a priority for the Trust in 2015/16 and further work during 2016/17 is required. A simplified Information Asset Owner (IAO) approach has been established. An update was presented to the Audit Committee in February 2016 and it was agreed that further work was required to achieve this priority.
Monitoring:	Monthly reports to the Trust's Senior Information Risk Owner (SIRO).
Reporting:	Audit Committee; Caldicott Committee; Appropriate information is reported in the Information Governance annual return.

Priority 2:	To achieve a 50% reduction in delays in discharges
Rationale:	The Trust Board has selected this as a corporate objective for 2016/17. Discharge remains a priority for the Trust. Improving discharge for patients is a Quality Strategy goal for 2014/17.
Monitoring:	This priority will be monitored monthly on the Board Assurance Framework. [Measurement currently being developed by Business Intelligence].
Reporting:	Trust Board; Quality and Safety Committee

Priority 3:	To achieve 95% of patients who have the correct anti-coagulation treatment prescribed and administered at the correct time, 24 hours after admission.
Rationale:	Anticoagulation is a high risk medication that can result in patient harm if not administered correctly. The Trust has had a number of incidents related to anticoagulation.
Monitoring:	The monitoring of this priority will be undertaken as part of the Trust's participation in the NHS QUEST 'Clinical Community' that has been established to improve anticoagulation management. NHS QUEST is a network for Foundation Trusts who wish to focus on improving quality and safety.
Reporting:	Trust Board, Medicine Safety Committee

Priority 4:	To achieve 100% compliance with the identification of a deteriorating patient, appropriate frequency of observations and escalation of the deteriorating patient.
Rationale:	Early recognition of the deteriorating patient improves patient's morbidity and mortality and allows appropriate treatment to commence in a timely manner.
Monitoring:	The Critical Care Outreach Team (CCOT) undertakes monthly audits of compliance. In February 2016, the audit results demonstrated that completion of the Modified Early Warning Score (MEWS) algorithm was 94%, however completion of observations was 62%.
Reporting:	Trust Board; Harm Free Care Board

Priority 5:	To recruit a further 100 clinical staff as dementia champions achieve 25% of appropriate clinical staff are trained dementia champions
Rationale:	In Greater Manchester there are circa 31,000 patient living with dementia, over 3,500 of those are in the NHS Wigan Borough CCG area. These are an important patient population and we need champions to help manage them effectively. A local Commissioning for Quality and Innovation (CQUIN) scheme for 2016/17 relates to dementia. Currently, the Trust has 250 dementia champions and aims to have 350 by the end of March 2017.
Monitoring:	Progress towards this priority will be provided bi-monthly to the dementia Strategy Group.
Reporting:	Trust Board; Dementia Strategy Group

Caring

Priority 1:	To achieve 90% of patients reporting that they were involved as much as they wanted to be in decisions about discharge from hospital.
Rationale:	The Trust score for patients reporting that they are involved as much as they wanted to be in decisions about their discharge home is 63.6% year to March 2016. There has been steady improvement in this score since April 2015. The Trust held a Discharge Improvement Event in November 2015 with Picker Institute Europe. The Discharge Improvement Group is responsible for implementation of the actions. New admission/discharge wallets are being developed to reinforce information to patients, families and carers regarding discharge. The Trust aims to achieve its target of 90% by the end of 2016/17.
Monitoring:	Real Time Patient Surveys are undertaken monthly by lay auditors. The results are reported in the Trust Board Performance Report.
Reporting:	Trust Board.

Priority 2:	To achieve 90% of patients reporting that they were aware of which doctor or consultant was treating them
Rationale:	The Trust score for patients reporting that they are aware of which doctor or consultant is treating them is 84.2% year to March 2016. The score has improved over the last four months following the amendment of the question to include doctor or consultant. Patients have responded more positively to 'doctor'. The Trust aims to achieve its target of 90% by the end of 2016/17.
Monitoring:	Real Time Patient Surveys are undertaken monthly by lay auditors. The results are reported in the Trust Board Performance Report.
Reporting:	Trust Board.

Priority 3:	To achieve an improved benchmarked position for patients reporting that they have been bothered by noise at night.
Rationale:	The 2015 National Patient Survey results indicated that the Trust scored worse than other Trusts for patients reporting that they were bothered by noise at night. Goodnight 'Always Events' where introduced in late 2015 to reduce unnecessary noise at night and promote a good nights sleep for patients.
Monitoring:	A bi-weekly 'Good Night Always Event' audit is undertaken by Volunteers by way of a random sample of patients.
Reporting:	Trust Board, Quality and Safety Committee

Priority 4:	**To achieve 100% of notifiable patient safety incidents triggering Duty of Candour requirements acknowledged to relevant person (informing them that the incident has occurred or is suspected to have occurred) within 10 working days of the incident being reported.**
Rationale:	The Trust Board has selected this as a corporate objective for 2016/17. A culture of openness is essential to improve patient safety, experience and service quality. The Trust is aiming to ensure that the responsibilities outlined in strategy regulations for Duty of Candour are undertaken, enhanced and monitored at a senior level within the organisation. Implementation of Duty of Candour has been a priority since the introduction of the regulation in November 2014. The Trust has held a number of training sessions for staff, developed a 'resource page' on the Trust intranet and produced a video providing clarity on the requirements to meet the regulations.
Monitoring:	Monthly compliance reporting from the incident reporting system (Datix) for incidents triggering Duty of Candour requirements. This priority will be monitored monthly on the Board Assurance Framework.
Reporting:	Trust Board, Quality and Safety Committee, Divisional Quality Executive Committees

Part 2.2:

Statements of Assurances from the Board

Wrightington, Wigan and Leigh NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

Review of Services

During 2015/16 the Trust provided and/or sub-contracted 67 relevant health services as defined in the Trust's Terms of Authorisation as a Foundation Trust.

The Trust has reviewed all the data available to them on quality of care in all 67 of these relevant health services.

The income generated by the relevant health services reviewed in 2015/16 represents 89.3% of the total income generated from the provision of relevant health services by the Trust for 2015/16.

Trusts are required to include this statement in their Quality Account to demonstrate that the Trust has considered the quality of care across all the services delivered across WWL for inclusion in this Quality Account, rather than focusing on just one or two areas.

Participation in Clinical Audits

During 2015/16, there were 20 National Clinical Audits and 4 National Confidential Enquiries covered relevant health services that the Trust provides.

During that period the Trust participated in 90% National Clinical Audits and 100% National Confidential Enquiries of the National Clinical Audits and National Confidential Enquiries which it was eligible to participate in. In addition the Trust participated in a further 10 National Audits (Non-NCAPOP) recommended by HQIP.

The National Clinical Audits and National Confidential enquiries that the Trust was eligible to participate in during 2015/16 are listed in Appendix A.

The National Clinical Audits and National Confidential Enquiries that the Trust participated in, and for which data collection was completed during 2015/16, are listed in Appendix A, 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 the audit or enquiry.

To date, the reports of 10 National Clinical Audits were reviewed by the provider in the period 1 April 2015 to 31 March 2016, and WWL intends to take/has taken the following actions to improve the quality of healthcare provided.

Audit	Trust Actions
National Confidential Enquiry into Patient Outcome and Death (NCEPOD): Gastrointestinal Haemorrhage Study	The Gastrointestinal on-call service is currently under review for improvement.
Mental Health in Emergency Departments	A Senior House Officer (SHO) Teaching programme has been established and Accident and Emergency (A&E) staff now provide training on the patient information system used in A&E on induction.
Sepsis Study	An audit of the Systematic Inflammatory Response Syndrome (SIRS) criteria is to be undertaken. Blood culture training has been completed.
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE)	Cases will continue to be reviewed. An audit has been planned for March 2016

Audit	Trust Actions
National Cardiac Arrest Audit	Reports are distributed to all Trust staff and periodic updates are given at audit meetings outlining areas for improvement
National Enquiry Laparotomy Audit (NELA)	No actions were agreed
National Joint Registry	Regular updates are provided at Audit meetings where areas for improvement are highlighted. The Trust was over 95% compliant this year
Rheumatoid Arthritis	Actions to be identified following discussion at the next Rheumatology Audit Meeting.
National Hip Fracture Database	Actions have not been identified as the Trust is performing well.
National Cardiac Arrest Audit (NCAA)	Actions to be identified following discussion at the next Resuscitation Committee in June 2016.

The reports of 205 local clinical audits were reviewed by the provider in 2015/16. A selection of these audits is outlined below and the Trust has taken, or intends to take, the following actions to improve the quality of healthcare provided:

Audit	Trust Actions
Re-audit of Mental Health (Accident and Emergency	Learning has been integrated into Senior House Officer (SHO) teaching and Accident and Emergency staff induction. Actions related to improved record keeping.
Re-audit Asthma in Children	A revised pathway for children with asthma is in place and staff training has been incorporated into induction
Child protection/ Safeguarding Children Awareness	A monthly safeguarding bulletin is distributed to staff highlighting learning from safeguarding incidents. Child Protection training packages are under review for levels 1, 2 and 3. The Safeguarding Team are undertaking drop in visits to a number of services including the Neonatal Unit.
Two-year development outcome for neonates born at less than 30 weeks gestation and neonates with Hypoxic-Ischemic Encephalopathy (HIE)	An Aetiology Clinic at Thomas Linacre Centre, the Trust's outpatient location, has been established to ensure that tests and investigations can take place in an appropriate setting with nursing support.
Patients with diabetes receiving foot examinations within 24 hours of admission	The Diabetes Specialist Nurse has introduced a new pathway to ensure patients receive foot examinations within 24 hours of admission. 'Putting feet first' posters have been circulated to wards.
Re-audit of the identification of scaphoid injury	A new protocol for the identification of scaphoid fractures was introduced. Awareness of this protocol is raised in clinics, triage, radiology and for new doctors. There have not been complications or missed injuries since introduction of protocol.
Transient Ischaemic Attack (TIA) clinic re-audit	Following introduction of NICE guidelines the audit demonstrated a need for introduction of a TIA clinic. The service was introduced and vast improvements were demonstrated.
Re-audit of accuracy of hand management	An initial audit demonstrated a low incidence of compliance. A pathway was introduced and vast improvement was achieved. 100% hand injuries were reviewed within the Trust and 100% met standard.

Audit	Trust Actions
The safe management of children with sleep related breathing disorder (SRBD)	An initial audit against national best practice guidelines demonstrated inconsistencies in the management of children with SRBD. A teaching package was developed and delivered to clinicians and local protocols were introduced. A re-audit highlighted improvements in several key domains.
An audit of the non-specific venous thromboembolism (VTE) policy and consequential implementation of thyroidectomy specific VTE policy	An initial audit highlighted increased risk to patients regarding the Trust-wide non-specific VTE risk assessment policy. A risk stratified thyroidectomy-specific policy was introduced. Rapid cycle audits undertaken demonstrated a reduction of the post-operative haematoma to 0% (previously 9%) with no increased incidence of VTE.
Implementing a "one stop" Consultant led ultrasound fine needle aspiration service for Thyroid lumps	The Trust has introduced a 'Bethseda system' for reporting Thyroid Fine Needle Aspiration (FNA). This has provided a more methodical and standardised approach. It has provided increased diagnostic accuracy and streamlined patient flow allowing for a reduction in time taken for formulation of a management plan.
Introduction of 7 day Physiotherapy service re-audit	Following an initial audit a 7 day physiotherapy service was introduced to accommodate weekend discharges. Average length of stay has decreased. The service ensures consistency and continuity of care providing patients with the opportunity to meet goals regardless of their day of surgery.
Ectopic Pregnancy	Following poor results a database was developed by the Trusts Information Technology team. Results were disseminated to all relevant staff including a pathway for Accident and Emergency. A re-audit demonstrated excellent compliance
Modified Early Obstetric Warning System (MEOWS) chart audit	Guidelines have been amended to remind staff to clearly record respiratory rate. Frequency of timing of observations have been agreed and staff training is provided annually.

Audit Actions are monitored at monthly audit meetings as well as at Divisional Quality Executive meetings. Actions are signed off as complete (on the audit database) when feedback is provided back to the audit department by those responsible for implementing the actions.

National clinical audits are primarily funded by the Department of Health and commissioned by the Healthcare Quality Improvement Partnership (HQIP) which manages the National Clinical Audit and Patients Outcome Programme (NCAPOP). Although national clinical audits are not mandatory, organisations are strongly encouraged to participate in those that relate to the services they deliver. It is mandatory to publish participation in national clinical audits in a Trust's Quality Account. A high level of participation provides a level of assurance that quality is taken seriously by the Trust and that participation is a requirement for clinical teams and individual clinicians as a means of monitoring and improving their practice. Local clinical audit is also important in measuring and benchmarking clinical practice against agreed standards of good professional practice.

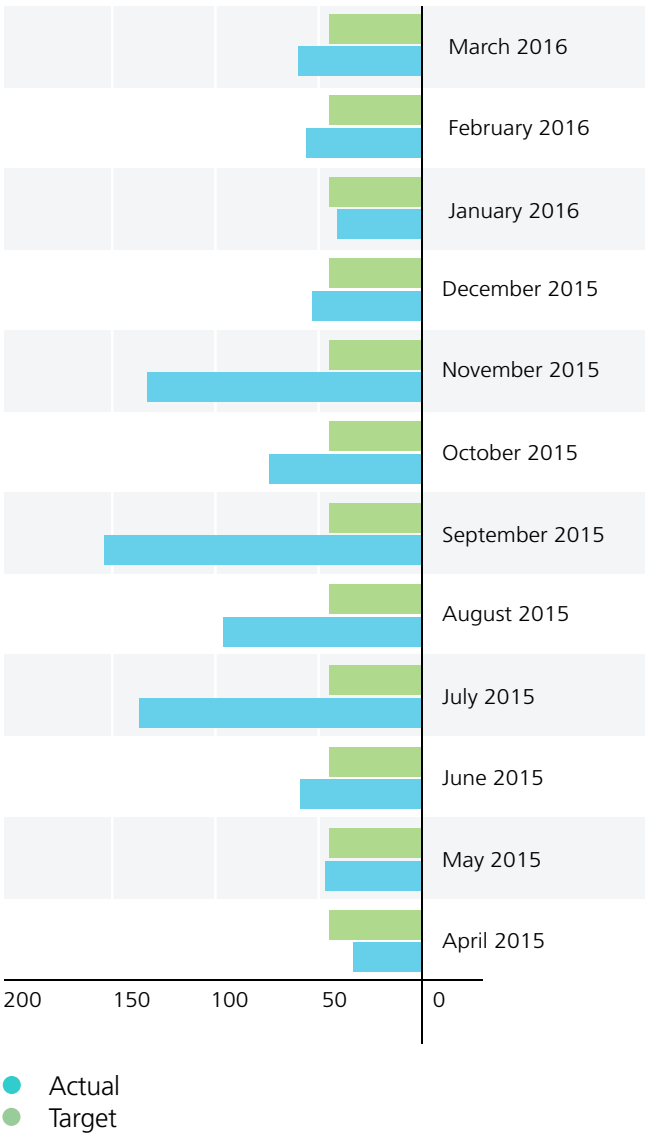
Research

Participation in Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by the Trust in 2015/16 who were recruited during this period to participate in research (approved by a research ethics committee registered and adopted onto the 'National Institute for Health Research (NIHR) Portfolio') was 943; an average of 78 patients per month.

Patient Recruitment 2015/16

The following chart illustrates target recruitment versus actual recruitment to research studies in 2015/16.



Participation in clinical research demonstrates the Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff are continually updated about the latest treatments. Active participation in research leads to improved patient outcomes.

The Trust was involved in conducting 120 clinical research studies in a variety of specialities during the year 2015/16.

The improvement in patient health outcomes demonstrates that a commitment to clinical research leads to better outcomes for patients. An example of this has been our growing involvement in research associated with infertility. The new fertility centre at Wrightington Hospital is attracting significant interest from both patients and innovators.

The Trust's five-year research strategy aims to include all clinical staff in research. Each year the Research Department has identified a clinical area for promoting and supporting research. This has proved successful and areas of interest have greatly increased with strong recruitment in the following clinical specialities:

Rheumatology; Cardiology; Diabetes; Surgery; Stroke; Paediatrics; Obstetrics; Cancer; Ear Nose and Throat (ENT); Gastroenterology; Dermatology; Musculo-skeletal and Infection Control; Infertility; Opthalmology.

Training and Development opportunities are provided by the Research Department to support staff in conducting quality research studies in a safe and effective manner. All staff who support research activity within the Trust are trained in Good Clinical Practice (GCP) which is an international quality standard transposed into legally required regulations for clinical trials involving human subjects.

Publications have resulted from both our engagement in NIHR Portfolio research and Trust supported research, which has secured Ethical Approval.

It is important that we continue to support both pilot studies in preparation for larger research projects and smaller research studies which do not qualify for adoption onto the NIHR Portfolio because they do not require access to a funding stream. This shows our commitment to transparency and our strong desire to improve patient outcomes and experience across the NHS.

The clinical research team supports all clinical teams conducting research studies, ensuring the safe care of patients and adherence to the European Directive, Good Clinical Practice guidelines and data collection standards.

As a result of this expert support, the larger clinical community within the Trust is in a position to conduct a wide variety of clinical research which will ultimately provide better access to research for our patients.

Research is a core part of the NHS, enabling the NHS to improve the current and future health of the people it serves. 'Clinical research' refers to research that has received a favourable opinion from a Research Ethics Committee within the National Research Ethics Service (NRES). Trusts must keep a local record of research projects.

Use of the Commissioning for Quality and Innovation (CQUIN) Payment Framework

A proportion of the Trust's income for 2015/16 was conditional upon achieving quality improvement and innovation goals agreed between Wrightington, Wigan and Leigh NHS Foundation Trust and any person or body with whom they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework. In 2015/16 the Trust achieved £5,455,008 in CQUIN funding representing 99% of the total available which is a small increase on 2014/15 when £5,450,641 was achieved.

The Trust CQUIN schemes for 2015/16 covered the following areas

1. National Schemes

a. Acute Kidney Injury (AKI) – content of discharge summary documentation
b. Sepsis – improvements in screening and antibiotic administration in A&E
c. Dementia – improvements in care for patients and their carers
d. Avoidable admissions – reduction in these admissions
e. Coding of mental health related attendance at accident and emergency

2. Greater Manchester Scheme

a. Information Management and Technology (IM & T) – roll out of integrated care records

3. Local Schemes

a. Sepsis training for primary care – delivery of sessions
b. Maternity safety thermometer – improvements in care
c. Discharge summary content improvement – quality improvements
d. New Trust Health Information System – roll out of programme
e. Mortality improvements – compliance with audit of governance surrounding mortality

The Trust has faced a number of challenges in the delivery of CQUIN in 2015/16, in particular in relation to the national sepsis screening and antibiotic administration scheme. However, despite this, there has been a significant improvement, particularly in relation to

antibiotic administration within one hour, improving from 6% in July 2015 rising to 92 compliance by March 2016. This represents a major improvement in patient care. The AKI scheme regarding inclusion of key data in discharge summaries has been challenging, as the current systems do not support electronic transfer of this information. It has therefore been dependant on individual clinicians including the information which may not always have been clinically relevant, for example, where the AKI is completely resolved before discharge.

As well as the sepsis improvements outlined in this section, the Trust achieved a reduction in admissions for ambulatory care-sensitive conditions, linked to work done to reduce readmissions for these patients. In addition Wigan Borough Clinical Commissioning Group has been particularly impressed with the work undertaken to improve the governance structure for mortality and the process for investigating alerts. The Trust continues to perform well in relation to the areas captured by the maternity safety thermometer. The main CQUIN schemes for 2015/16 will roll forward to become key performance indicators in 2016/17 to ensure sustained performance and improvement.

In addition to the national CQUIN schemes for 2016/17, local schemes will focus on the following areas:

- Discharge documentation and process
- Nutrition and hydration
- Falls
- Paediatric diabetes
- Promoting Healthy Lifestyle

An estimated income of £5,000,000 is conditional upon achieving the quality improvement and innovation goals in 2016/17.

The CQUIN payment framework aims to embed quality at the heart of Commissioner-Provider discussions and indicates that the Trust is actively engaged in quality improvements with our Commissioners. Achievement of the CQUIN quality goals impacts on income received by the Trust.

What others say about WWL

Statements from the Care Quality Commission (CQC)

The Trust is required to register with the Care Quality Commission; its current registration status, at the end of 2015/16, is registration without compliance conditions.

The Care Quality Commission (CQC) has not taken enforcement action against the Trust during 2015/16.

The Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

In May 2015 the Trust received the final CQC Intelligent Monitoring Report outlined the following risks:

Risk Level	Indicator
Elevated Risk	Never Events Incidence
Elevated Risk	SSNAP Domain 2: Overall team-centred rating score for key stroke unit indicator
Elevated Risk	Emergency readmissions with an overnight stay following an emergency admission (Nov12/ Oct13)
Elevated Risk	In-Hospital Mortality - Infectious Disease
Risk	In-hospital mortality - Vascular Conditions and Procedures

The CQC Intelligent Monitoring Tool was utilised by compliance inspectors to identify areas of care that require further investigation and assisted them to determine their programme of inspection. The Trust implemented actions to address the above risks. The CQC has ceased the publication of Intelligent Monitoring Reports for acute Trusts.

The CQC has an inspection programme for all hospital Trusts in England. From the 9th to 11th December 2015 a team of CQC inspectors visited our hospitals, speaking to patients, families, carers and staff and they reviewed the services provided by the Trust. This was followed by an unannounced visit on Monday 21st December 2015.

The Trust welcomed this inspection as an opportunity to showcase the excellent work undertaken by the Trust, the support provided to our patients and staff and the improvements made since our last inspections in 2013. It was also an opportunity to demonstrate our awareness of our risks and the plans in place to address them. We were also able to demonstrate how we gain feedback from our patients and staff, and how the Trust learns and continuously improves to provide safe, effective and caring treatment and support to our patients and their families or carers.

The CQC review key lines of enquiry (KLOEs) under 5 domains:

Safe
Are people protected from abuse and avoidable harm?

Effective
Do people's care, treatment and support achieve good outcomes, promote a good quality of life and is this based on the best available evidence?

Caring
Do staff involve and treat people with compassion, kindness, dignity and respect?

Responsive
Are services organised so that they meet people's needs?

Well-led
Do the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promote an open and fair culture?

The CQC will rate every domain (safe, effective, caring, responsive and well-led) for every core service and provide an overall rating for each core service. The CQC will also rate every domain for the Trust as a whole and provide an overall Trust rating. The ratings are as follows:

- Outstanding
- Good
- Requires Improvement
- Inadequate

At the time of writing the CQC findings have not been published.

All NHS Trusts are required to register with the Care Quality Commission. The CQC undertakes checks to ensure that Trusts are meeting the Fundamental Standards for Quality and Safety. If the CQC has concerns that providers are non-compliant, there are a wide range of enforcement powers that it can utilise, which include issuing a warning notice and suspending or cancelling registration.

NHS Number and General Medical Practice Code Validity

The Trust submitted records during 2015/16 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 patients' valid NHS number was:
- 99.9% for admitted patient care;
- 99.9% for outpatient care; and
- 99.2% for accident and emergency care.

which included the patients' valid General Medical Practice Code was:
- 100% for admitted patient care;
- 100% for outpatient care; and
- 100% for accident and emergency care.

The patient NHS number is the key identifier for patient records. Accurate recording of the patient's General Medical Practice Code (Patient Registration) is essential to enable the transfer of clinical information about the patient from a Trust to the patient's General Practitioner (GP).

Information Governance Toolkit Attainment Levels

The Trust's Information Governance Assessment Report overall score for 2015/16 was 81% and was graded a satisfactory submission.

Information Governance ensures necessary safeguards for, and appropriate use of, patient and personal information. The Information Governance Toolkit is a performance tool produced by the Department of Health (DH) and now hosted by the Health and Social Care Information Centre (HSCIC). It draws together the legal rules and central guidance related to Information Governance and presents them in one place as a set of information governance requirements.

Clinical Coding Error Rate

The Trust was not subject to a Payment by Results clinical coding audit during 2015/16 by the Audit Commission. However it did commission an audit undertaken by Clinical Classifications Service approved Clinical Coding Auditors from Blackpool Teaching Hospitals NHS Foundation Trust, to provide external assurance of its coding quality. The error rates reported in this audit for that period for diagnoses and treatment coding (clinical coding) were:

- Primary Diagnoses incorrect 1.00%
- Secondary Diagnoses incorrect 4.04%
- Primary Procedures Incorrect 3.82%
- Secondary Procedures Incorrect 2.98%

The results relate to a random audit sample of 200 Consultant Episodes from July to September 2015 and should not be extrapolated further than the actual sample audited. In accordance with Information Governance Toolkit standards for criteria 510 this has resulted in a level 3 achievement which is the highest rating available. The report commended the Trust for its commitment to clinical coding in terms of clinical coding training, clinical engagement and accuracy levels.

Clinical coding translates the medical terminology written by clinicians to describe a patient's diagnosis and treatment into standard recognised codes. The accuracy of this coding is a fundamental indicator of the accuracy of patient records.

Statement on relevance of Data Quality and your actions to improve your Data Quality

The Trust will be taking the following actions to improve data quality:

The Trust has a Data Quality Committee with responsibilities for ensuring that data standards are achieved and maintained. The annual data quality audit plan rates information audited using the data quality kite mark which is measured on accuracy, source, timeliness and validity. Recommendations are provided and associated action plans where findings show that data quality could be improved.

The Data Quality Committee also has responsibilities for reviewing the data submitted as part of the Quality Accounts ensuring that the data has been submitted by responsible data owners, the data source is credible and the data quality is accurate.

The Trust will be taking the following actions to focus on improving data quality in 2016/17:

- Recruitment of administration posts to ensure 'out of hours' patient admissions are recorded in real time and not retrospectively by ward clerks.
- Review all activities being undertaking to provide clinical care and ensure these are recorded electronically as well as in paper notes.
- Monitoring the conversion of paper data collection methods to electronic methods with the implementation of the new electronic Health Information System to ensure data quality is maintained and where possible improved.

Good quality information underpins the effective delivery of patient care and is essential if improvements in quality of care are to be made. The Trust Board is required to sign a 'Statement of Directors' Responsibilities in respect of the Quality Report, part of which is to confirm that data underpinning the measures of performance reported in the Quality Report is robust and reliable, that the data conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review.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Part 2.3:

Reporting Against Core Indicators

The Trust is required to report performance against a core set of indicators using data made available to the Trust by the Health and Social Care Information Centre (HSCIC).

For each indicator, the number, percentage, value, score or rate (as applicable) for at least the last two reporting periods, is presented in the table below. In addition, where the required data is made available by the HSCIC, a comparison is made of the numbers, percentages, values, scores or rates of each of the NHS Trusts indicators with:

a) National average for the same, and;
b) Those NHS Trusts with highest and lowest for the same.

Indicator		Reporting Periods	Trust Perform-ance	National Average	Benchmarking
Mortality	(a) The value and banding of the summary hospital-level mortality indicator ("SHMI") for the Trust for the reporting period; and	April 2014 - March 2015	Value: 1.126, Banding: 1	Value: 1.002	Best: The Whittington Hospital NHS Trust (RKE): Value:0.67, Banding: 3
					Worst: North Tees and Hartlepool NHS Foundation Trust (RVW) : Value: 1.21 , Banding: 1
		October 2014 - September 2015	Value: 1.115, Banding : 1	Value: 1.004	Best: The Whittington Hospital NHS Trust (RKE): Value:0.652 , Banding: 3
					Worst: North Tees and Hartlepool NHS Foundation Trust (RVW) : Value: 1.177 , Banding: 1
	(b) The percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust for the reporting period.	April 2014 - March 2015	28.9%	25.7%	Best: The Whittington Hospital NHS Trust (RKE) : Value:0%
					Worst: Imperial College Healthcare NHS Trust (RYJ) : Value: 50.85%
		October 2014 - September 2015	28.6%	26.6%	Best: The Whittington Hospital NHS Trust (RKE) : Value:0.19%
					Worst: Imperial College Healthcare NHS Trust (RYJ) : Value: 53.5%

Assurance Statement

The Trust considers that this data is as described for the following reasons:

Hospital Standardised Mortality Ratio (HSMR) results for the year within expected range. SHMI results do not benchmark as well. The difference between the two indicators is predominantly due to the effect of deaths out of hospital. Work to understand the deaths out of hospital has not identified areas of poor care or obvious areas for improvement. The work continues to seek out areas for development. The Trust's weekly deaths audit seeks to convert statistics into real cases and real areas for improvement. This has successfully led to clinical improvements throughout the last eight years. The work also allows us to understand our "potentially preventable death rate" which for the year was 3.4%. This is close to the levels quoted by Hogan in the Preventable Incidents, Survival and Mortality (PRISM) 2 study and more recently shared by NHS England as an aspirational process for understanding improvement that could be made in mortality.

The Trust intends to take the following actions to improve these indicators and, thereby, the quality of its services, by:

Continuing the work of looking at real cases and provide learning from these. The work is shared widely on a week by week basis and summarised annually. Issues are identified and work plans agreed for improvement.

Indicator		Reporting Periods	Trust Perform-ance	National Average	Benchmarking
Patient Reported Outcome Measures Scores (PROMs)	The Trust's patient reported outcome measures scores during the reporting period for - i) groin hernia surgery;	April 2013 - March 2014	0.099	0.085	Best: BMI - The Foscote Hospital (NVC11): Value:0.14
					Worst: North Downs Hospital (NT415) : Value: 0.008
		April 2014 - March 2015 (Provisional)	0.074	0.083	Best: Poole Hospital NHS Foundation Trust (RD3): Value: 1.54
					Worst: Lewisham and Greenwich NHS Trust (RJ2): Value: -1.94
	i) varicose vein surgery;	April 2013 - March 2014	n/a	0.093	Best: Wye Valley Nhs Trust (RLQ) : Value: 0.15
					Worst: Imperial College Healthcare NHS Trust (RYJ) : Value: 0.23
		April 2014 - March 2015 (Provisional)	n/a	0.094	Best: Buckinghamshire Healthcare NHS Trust (RXQ): Value: 0.15
					Worst: St George's University Hospitals Nhs Foundation Trust (RJ7) : Value: -0.002
	ii) hip replacement surgery;	April 2013 - March 2014	0.441	0.436	Best: BMI - The Park Hospital (NT427): Value: 0.54
					Worst: Homerton University Hospital NHS Foundation Trust (RQX): Value: 0.31
		April 2014 - March 2015 (Provisional)	0.453	0.436	Best: SPIRE CLARE PARK HOSPITAL (NT345): Value: 0.52
					Worst: WALSALL HEALTHCARE NHS TRUST (RBK) : Value: 0.33

Indicator		Reporting Periods	Trust Perform-ance	National Average	Benchmarking
Patient Reported Outcome Measures Scores (PROMs) cont.	iii) knee replacement surgery	April 2013 - March 2014	0.302	0.323	Best: Nuffield Health, Cambridge Hospital (NT209) : Value: 0.42
					Worst: Homerton University Hospital NHS Foundation Trust (RQX): Value: 0.21
		April 2014 - March 2015 (Provisional)	0.300	0.310	Best: Nuffield Health, Cambridge Hospital (NT209) : Value: 0.42
					Worst: South Tyneside NHS Foundation Trust (RE9) : Value: 0.204

Assurance Statement

The Trust considers that this data is as described for the following reasons:

The data is validated and published by Patient Related Outcome Measures (PROM's); and is accessible via the Health and Social Care Information Centre (HSCIC).

The Trust has taken the following actions to improve this indicator and, thereby the quality of its services, by:

The data collection process within the pre-operative assessment clinics has been realigned to increase participation rates.

Indicator		Reporting Periods	Trust Perform-ance	National Average	Benchmarking
Hospital Readmission	The percentage of patients 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: aged 0-15	April 2010 - March 2011	7.73	10.31	Best: Epsom & St Helier University Hospitals NHS Trust (RVR): 6.41
					Worst: Royal Wolverhampton Hospitals NHS Trust (RL4): 14.11
		April 2011 - March 2012	7.95	10.23	Best: Epsom & St Helier University Hospitals NHS Trust (RVR): 6.4
					Worst: Royal Wolverhampton Hospitals NHS Trust (RL4): 14.94
	The percentage of patients 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: aged 16 or over	April 2010 - March 2011	12.71	11.55	Best: Shrewsbury and Telford Hospital NHS Trust (RXW): 9.20
					Worst: Heart of England NHS Foundation Trust (RR1): 14.06
		April 2011 - March 2012	12.40	11.56	Best: Norfolk and Norwich University Hospital NHS Foundation Trust (RM1): 9:34
					Worst: Epsom & St Helier University Hospitals NHS Trust (RVR): 13.80

Assurance Statement

The Trust considers that this data is as described for the following reasons:

Due to the high profile of readmissions and the potential high cost penalties associated with not achieving the targets, analysis of data, implementation of improvements and development of an electronic application has ensured that the Trust has undertaken a comprehensive and robust response. This represents the latest available data from the Health and Social Care Information Centre (HSCIC).

The Trust has taken the following actions to improve this indicator and so the quality of services by:

A project group, led by the Team Leader of the Access to Community Services Team acting as project manager, has implemented a number of initiatives which, together, aim to reduce the overall number of readmissions. Work to focus on high re-attending patients is a priority, to understand the reasons for readmission and development of care plans, which could redirect patients to more appropriate community services.

Hospital readmissions within 28 days of being discharged from hospital for all age groups (excluding private patients and well babies) for 2014/15 was 6.3%. For 2015/16 it is 6.1%.

Indicator		Reporting Periods	Trust Perform-ance	National Average	Benchmarking
Responsive-ness to Personal Needs	The Trust's responsiveness to the personal needs of its patients during the reporting period	National Inpatient Survey 2013-14	75.50%	76.90%	Best: The Royal Marsden NHS Foundation Trust (RPY): 87%
					Worst: Croydon Health Services NHS Trust (RJ6): 67.1%
		National Inpatient Survey 2014-15	66.90%	68.90%	Best: The Royal Marsden NHS Foundation Trust (RPY) : Value: 86.1%
					Worst: Croydon Health Services NHS Trust (RJ6): Value: 59.1%

Assurance Statement

The Trust considers that this data is as described for the following reasons:

The Trust has performed slightly below national average for patients reporting that their personal needs are responded to.

The Trust has taken the following actions to improve this score to the quality of its services by:

The Trust continues to respond to the National Survey by making improvements in patient care based on the results. There have been a number of improvements made during the last 12 months including some detailed work around patient discharge: Ensuring on admission that patients receive an Expected Date of Discharge, Discharge Coordinators will provide support and advice during Consultant ward rounds. All patients will be aware of the consultant who is providing their treatment and care. The introduction this year of the Welcome Packs, which will include information on both the Discharge process and all services at Discharge, will be provided to every patient on admission. There will be continued focused work ensuring that the Always Events and the Goodnight Always Events continue to be embedded and provided reinforcement across the organisation.

Indicator		Reporting Periods	Trust Perform-ance	National Average	Benchmarking
Friends and Family Test (Staff)	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.	National NHS Staff Survey 2014	78.00%	65.00%	Best: Frimley Park Hospital NHS Foundation Trust (RDU):89%
					Worst: Royal Cornwall Hospitals NHS Trust (REF): 38%
		National NHS Staff Survey 2015	79.00%	69.00%	Best: Northumbria Healthcare NHS Foundation Trust (RTF) : Value: 85%
					Worst: Isle of Wight NHS Trust (acute sector) (R1F1) : Value: 46%

Assurance Statement

The Trust considers that this data is as described for the following reasons:

The Trust has performed better than the national average for staff recommending the Trust as a place to friends and family as a place to be treated. The Trust has also scored above average for staff recommending the Trust as a place to work, and is the highest performing in the North West Sector for this measure.

The Trust has been able to sustain this position by regularly acting on staff feedback. The Trust distributes it's own staff engagement pulse survey which is issued to a quarter of staff every quarter of the year.

The quarterly pulse survey has been of significant value to WWL over the last two years. It has enabled the Trust to act quickly on the issues identified, ensuring that we are always aware of trends and new issues. Many Trusts do not have access to this type of staff feedback and rely solely on the annual National staff survey. The quarterly pulse surveys and associated actions have been integral to shaping the organisational culture.

The results of the quarterly pulse survey indicate that the improvements in staff engagement seen in 2015 can be linked in particular to staff feeling trusted and empowered in their workplace, supportive working relationships with managers and colleagues, clear, open and honest communications and an increase in staff feeling valued/recognised.

The Trust intends to take the following actions to improve this percentage and, so the quality of its services, by:

The pulse survey identifies that engagement has continued to improve throughout the year, whilst energy levels amongst staff have only fractionally improved. There has been some investment in health and well-being initiatives with the aim of improving energy levels (resilience training, mindfulness, on site therapies).

But to ensure that the Trust is able to sustain high levels of engagement into 2016, further analysis of the risk of staff burnout and investment in health and well-being interventions are also required. Further investment in enhanced staff engagement interventions are also in the pipeline, including a staff phone "app", enhanced reward and recognition schemes, sporting events, targeted listening events and continuation of the pioneer teams programme.

Indicator		Reporting Periods	Trust Perform-ance	National Average	Benchmarking
Venus Thromboe-mbolism	The percentage of patients who were admitted to hospital and who were risk assessed for Venous Thromboembolism during the reporting period.	October 2014 - December 2014	96.00%	96.00%	Best: Bridgewater Community Healthcare NHS Trust (RY2), Queen Victoria Hospital NHS Foundation Trust(Rpc), Royal National Hospital For Rheumatic Diseases NHS Foundation Trust(RBB), South Essex Partnership University NHS Foundation Trust(RWN), The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust(RL1), Blackpool Teaching Hospitals NHS Foundation Trust(RXL), Basildon and Thurrock University Hospitals NHS Foundation Trust (RDD), Derbyshire Community Health Services NHS Trust(RY8), Royal National Orthopaedic Hospital NHS Trust(RAN) : 100%
					Worst: Cambridge University Hospitals NHS Foundation Trust (RGT): 81%
		October - December 2015	98.60%	95.50%	Best: The Robert Jones And Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RL1), Bridgewater Community Healthcare NHS Trust (RY2), Royal National Orthopaedic Hospital NHS Trust (RAN), South Essex Partnership University NHS Foundation Trust (RWN): Value: 100%
					Worst: Hull And East Yorkshire Hospitals NHSTrust (RWA) : Value: 78.5%

Assurance Statement

The Trust considers that this data is as described for the following reasons:

Compliance data is reported on by clinical audit and discrepancies investigated. Increased resources have been used to improve staff training and data collection.

The Trust has taken the following actions to improve this percentage and so the quality of its services by:

Root cause analysis is undertaken for all patients who develop a Venous Thromboembolism whilst in hospital. Review of patients who are not VTE assessed also takes place to understand the reasons for this and lessons to be learnt.

Indicator		Reporting Periods	Trust Perform-ance	National Average	Benchmarking
Clostridium *difficile* (C. *difficile*)	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.	April 2013 - March 2014	21.4	14.7	Best: Birmingham Women's (RLU), Moorfields Eye Hospital (RP6), Royal National Hospital for Rheumatic Diseases (RBB); 0.00
					Worst: University College London Hospitals (RRV): 37.1
		April 2014 - March 2015	16.3	15.1	Best: Alder Hey Children's (RBS), Birmingham Children's Hospital (RQ3), Birmingham Women's (RLU), Moorfields Eye Hospital (RP6): 0.00
					Worst: The Royal Marsden (RPY):62.2

Assurance Statement

The Trust considers that this data is as described for the following reasons:

The data describes an improved rate per 100,000 bed days of C.*difficile* infection which has continued to improve year on year. The Trust has worked hard, not only to reduce individual C.*difficile* cases, but also to increase operational throughput capacity. These two processes in conjunction have reduced C.*difficile* rates per 100,000 bed days.

The Trust intends to take the following actions to improve this rate and thereby the quality of services by:

Continuing efforts to improve its C.*difficile* rate per 100,000 bed days by working with admission, operational and discharge Coordinators, to improve data collection and prevent health care associated infection. Continue working with other organisations on reducing C. *difficile* as a Total Health economy.

Indicator		Reporting Periods	Trust Perform-ance	National Average	Benchmarking
Patient Safety Incidents	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.	April 2014-September 2014	2664 Incidents Reported (Rate per 1000 Bed Days 35.11) / 19 Serious Incidents (0.7%)	587,483 Incidents Reported / 2851 Serious Incidents (0.5%)	Best: Doncaster & Bassetlaw Hospitals NHS Foundation Trust (RP5): Incidents Reported 35 (Rate per 1000 bed days 0.24) / 29 Serious Incidents (82.9%)
					Worst: Northern Devon Healthcare NHS Foundation Trust (RBZ) Incidents Reported 3795 (Rate per 1000 bed days 74.96) / 55 Serious Incidents (1.4%)
		October 2014 - March 2015	3153 Incidents Reported (Rate per 1000 Bed Days 41.3) / 11 Serious Incidents (0.35%)	621,776 Incidents Reported / 3089 Serious Incidents (0.5%)	Best: Poole Hospital NHS Foundation Trust (RD3): Incidents Reported 4377 (Rate per 1000 bed days 46.9) / 2 Serious Incidents (0.046%)
					Worst: South Warwickshire NHS Foundation Trust (RJC) : Incidents Reported 2464 (Rate per 1000 bed days 29.5) / 128 Serious Incidents (5.19%)

Assurance Statement

The Trust considers that this data is as described for the following reasons:

The Trust has strived to improve its benchmarked position by communicating the importance of incident reporting and the understanding of barriers to reporting incidents and near misses.

The Trust's overall national position is 37th out of 137 Acute non specialist Trusts based on reporting rates per 1000 bed days (41.3%). This places the Trust in the top 25% of Trusts submitting to NRLS. Last year the Trust was in the bottom 10%. The Trust is 4th out of 8 Greater Manchester Acute Trusts. Last year the Trust was the worst performing Trust in Greater Manchester. The Trust has submitted in 6 out of 6 reporting months, the first time this has been achieved.

The Trust intends to take the following actions to improve these indicators:

An area for improvement that has been identified is the number of days from the incident being reported locally to its submission to NRLS. The Trust has taken action to ensure that incidents are submitted at least weekly and most weeks on a daily basis.

Part 3:

Other Information

Part 3.1:
Review of Quality Performance

This section of the Quality Account provides information on the Trust's quality performance during 2015/16. Performance against the priorities identified in the Trust's previous quality account and performance against the relevant indicators and performance thresholds set out in Monitor's Risk Assessment Framework are outlined. The Trust has a number of initiatives which contribute to strengthening quality governance systems. An update on progress to embed these initiatives is also included in this section.

Performance against priorities identified for improvement in 2015/16

The Trust agreed a number of priorities for improvement in 2015/16 published in last year's Quality Account. These were selected following the development of the Trust's Quality Strategy in conjunction with internal and external stakeholders.

Safe

Priority 1	To reduce the number of falls by 10%
Where we were in 2014/15	The Trust was consistently achieving over 98% of harm-free care in hospital measured by the safety thermometer. In 2014/15 the Trust had significantly reduced harm from falls but has agreed to focus on reduction in the number of falls. Falls is one of the harm specific focuses in the Trust's Sign Up to Safety Improvement plan. The number of falls per 1000 bed days at the end of 2014/15 was 5.8.
Where we are at the end of 2015/16	The Trust did not achieve the ambitious target to reduce falls by 10% by the end of 2015/16. However, a number of actions were commenced which the Trust hopes will contribute to a decrease in the number of falls in 2016/17. The Falls Improvement Group was established in 2015 with the specific aim of reducing the number of falls for inpatients. The group is multi-professional and has a number of work-streams reporting to it including redesign of documentation, interventions and post fall investigations, to ensure that we have gained all the learning possible from these events. The Trust utilised a secondment to the post of Falls Lead for nine months to accelerate the rate of change and to facilitate a detailed understanding of the areas of improvement needed. The Trust has also been working with NHS QUEST a network for Foundation Trusts who wish to focus on improving quality and safety as part of a 'Falls Clinical Community'.

Priority 2	To implement the medicines safety thermometer in all relevant areas
Where we were in 2014/15	The Medicine's Safety Thermometer was embedded on the 10 pilot wards. There were technical challenges with implementing the Medicine's Safety Thermometer to all relevant inpatient areas: These challenges were resolved. 'Haelo', an Innovation and Improvement Science Centre, based in Salford and owned by Salford partners, including Salford NHS Foundation Trust, led the pilot. 'Haelo' was in discussion with the Trust regarding how to integrate the Point Prevalence Medicine's Audit that is undertaken on all wards each week by pharmacy, to reduce duplication of data collection. The Point Prevalence Survey is a robust method of data collection and has been used successfully to demonstrate improvement in Medicine's Management Practice.
Where we are at the end of 2015/16	Unfortunately the option to combine the Point Prevalence Survey with the Medicines Safety Thermometer has not been possible, as this would have 'skewed' national data. The Trust was committed to rolling the Safety Thermometer out to all relevant inpatient areas; however, it has become evident that the Medicine Safety Thermometer is not being mandated nationally. The Trust has agreed to continue with the internal Point Prevalence Surveys and undertake work to further develop the process to complete them. This should be of greater benefit to the Trust.

Priority 3	To reach a Hospital Standardised Mortality Ratio (HSMR) of no more than 85 before rebasing and Summary Hospital level Mortality Indicator (SHMI) of no more than 100.
Where we were in 2014/15	The data published in the Trusts Quality Account at the end of 2014/15 demonstrated that the Trusts HSMR up to December 2014 was 96.6 and SHMI from July 2013 to June 2014 was 109.3.
Where we are at the end of 2015/16	HSMR year to February 2016 (data is three months behind) is 92.3 and within expected range when benchmarked against other organisations. The latest SHMI data is 111.45 (October 2014 - September 2015). The Trust is considered an outlier for SHMI when compared to other acute Trusts in Greater Manchester. The deaths review process continues with resulting actions and circulations. Reviews of areas of increased mortality have been completed. Further reviews will be undertaken as appropriate. Statistician support from Salford University has been sought and an initial review of mortality methodology has been completed.

Effective

Priority 1	To undertake an investigation following all cardiac arrests from admission to event to identify areas for learning.
Where we were in 2014/15	The Trust contributed to the NHS QUEST project to support the Foundation Trust in providing evidence of best practice to improve management of the deteriorating patient, improving outcomes, including Sign Up to Safety, human factors and dedicated training work streams.
Where we are at the end of 2015/16	This priority has been achieved. All cardiac arrests are investigated and the reviews form part of the weekly mortality reviews. Learning is shared with the clinicians and nursing teams relevant to where the cardiac arrests have occurred. All patients that suffer a cardiac arrest at the Royal Albert Edward Infirmary site are reported to the National Cardiac Arrest Audit database by the Resuscitation Training Officers. This is a comparative audit of 171 hospitals. A local audit of all arrests at the Trust is performed annually by the Resuscitation Training Officers. This audit is reported to the individual clinical teams for evaluation and improvement if so required.

Priority 2	To achieve 95% of patients weighed on admission
Where we were in 2014/15	Audit data (September 2014) demonstrated that 70% of patients were being weighed on admission. Nutritional management is one of the Trust's harm specific focuses in the Sign Up to Safety Improvement Plan.
Where we are at the end of 2015/16	While this priority has not been achieved significant progress has been made during 2015/16. The nutrition and hydration improvement group was convened in June 2015 with the specific aims of improving patients' nutrition and hydration and ensuring that patients had access to nutrition and hydration appropriate to their needs. The focus has been on establishing a baseline weight for patients to ensure that patients do not suffer from any unintended weight loss. In April 2015, 93% of inpatients across the trust were weighed; this figure had slightly decreased by September 2015 to 91.5%. This was a significant improvement in comparison with 12 months previously, when 70% of patients were weighed on admission.

Priority 3	To review patient discharges that are planned to occur after 8p.m. to ensure it is safe and appropriate for the patient to be discharged
Where we were in 2014/15	A proforma was introduced for completion for discharges after 9pm prior to the patients' discharge to review the following: Confirmation of agreement from patients and relatives or carers; Time confirmed for transport arrangements; Destination of patient being discharged. If 'home', confirmation of adequate provisions such as food and heating. If nursing or residential home, confirmation of acceptance after 8pm; Confirmation that the patient is adequately dressed; Confirmation that the patient has had food/drink/relevant medicines before discharge.
Where we are at the end of 2015/16	This priority has been achieved. A dedicated EPR pathway captures all discharges after 8pm from all wards and provides evidence that a safe and effective discharge has been completed for the patient, the patient's relatives/ carers and care facilities. An audit of the proforma introduced in 2014/15 has enabled a review of post-8pm discharges to be completed by the Discharge Improvement Group. A local CQUIN related to discharge will ensure that the proforma continues to be audited in 2016/17 and issues identified are addressed.

Priority 4	To complete 10 'Dementia Friendly' ward environments in 2015/16
Where we were in 2014/15	The inclusion of a priority related to the care of patients living with Dementia was proposed at the Trust's Quality and Safety Committee and by stakeholders at an event in February 2015. To complement the Trust's Dementia Strategy, a Dementia Friendly Design Group was developed with representation from Nursing, Governors, Dementia Champions, Communications and Estates and Facilities. The Design Strategy incorporates a range of features incorporated into ward areas during annual deep clean works programme.
Where we are at the end of 2015/16	This priority has been achieved. All inpatient wards at the Royal Albert Edward Infirmary (RAEI) have been redecorated as part of the annual deep clean using the principles set out in the Trust's Dementia Strategy with predominantly white with feature walls using Trust Corporate Colours and light grey skirtings, frames and architraves. Bedside lockers have been changed to a complimentary white/ grey and all cubicle curtains have been changed to grey. New clocks, signage and contrasting toilet seats are also in the process of being installed. The Trust anticipates completing these elements of the works in the first quarter of 2016/17. The new Wrightington Phase 1 development has also been designed to incorporate the design features identified in the strategy.

Effective cont.

Priority 5	To create a comprehensive register of all of the Trust's electronic information assets with details of the name and role of the responsible individual
Where we were in 2014/15	The Trust is required to submit a self-assessment against the requirements of the 'Information Governance Toolkit', an online system which enables NHS organisations and Partners to assess themselves against the Department of Health Information Governance policies and standards. One of the requirements is that 'there is an information asset register that includes all assets that comprise or hold personal data, with a clearly identified accountable individual'. The Trust had an information asset register, but it required a significant review.
Where we are at the end of 2015/16	A simplified Information Asset Owner (IAO) approach has been agreed with the Director of IM&T. The Information Governance Department received a mixed response from initial IAO's approached. An update was presented to the Audit Committee in February 2016. There has been agreement to delay this project pending HIS implementation, but achieving this priority will remain a focus in 2016/17.

Caring

Priority 1	To be in the top 10% of Trusts for the Friends and Family Test
Where we were in 2014/15	In 2014/2015 the Trust was in the top 10% of Trusts nationally being 7th out of 136 Acute Trusts (97%).
Where we are at the end of 2015/16	The Trust agreed this as a Corporate Objective for 2015/16. The Trust has achieved this priority to be in the top 10% of Trusts nationally for the Friends and Family Test (percentage recommended) being 3rd out of 139 Acute Trusts (98%) (Between April 2015 – February 2016 – full years data is not available yet)

Priority 2	To achieve 90% of patients reporting that they were involved as much as they wanted to be in decisions about discharge from hospital
Where we were in 2014/15	During 2014/15, the Trust achieved a year-end score of 58.66% in the question 'Were you involved as much as you wanted to be in your discharge from hospital?'
Where we are at the end of 2015/16	This priority has not been achieved. During 2015/16 the Trust achieved a score of 76.67% (Jan 2016). The Trust year-end score for patients reporting that they are involved as much as they want to be in decisions about their discharge home is 63.6%. A discharge improvement event led by the Trust and Picker Institute Europe was held on the 19th November 2015. The top themes highlighted in the report following the event were resources, timings and communication. A detailed action plan has been developed and presented to the Discharge Quality Improvement Committee. New discharge wallets are being developed. A patient discharge checklist and flowchart informing patients of the discharge process are being launched. The Trust has not yet achieved a total score of 90% at year end.

Caring cont.

Priority 3	To achieve 90% of patients reporting that they were aware of which Consultant was treating them
Where we were in 2014/15	In 2014/15 77.2% of patients responding to the real-time patient experience surveys reported that they knew which Consultant was currently treating them.
Where we are at the end of 2015/16	This priority has not been achieved. The year to date Trust score for patients reporting that they are aware of which Doctor or Consultant is treating them is 84.2%. The score has improved over the last four months following the amendment of the question to include Doctor and Consultant. Patients have responded more positively to the word 'Doctor' rather than Consultant. The Trust has not yet achieved a total score of 90% at year end.


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Performance against the relevant indicators and performance thresholds set out in Monitor's Risk Assessment Framework

The Trust selected a number of key indicators monitored under its strategy to be safe, effective and caring for the last three years and reported to the Trust Board within the monthly performance reports. These indicators include those set out in Monitor's Risk Assessment Framework.

Monitor's Risk Assessment Framework replaced the Compliance Framework in October 2013 and sets out Monitor's approach to overseeing NHS Foundation Trusts' compliance with the governance and continuity of service requirements of the Foundation Trust licence.

Safe

Infection Control

Indicator	2013/14	2014/15	2015/16
Clostridium *Difficile* (C.*Difficile*)	32 (-6)	25	12
Threshold	25	32	19
Methicillin-resistant Staphylococcus aureus (MRSA) Bacteraemia	1	1	0
Threshold	0	0	0

C.*difficile*

The Trust's trajectory for C.*difficile* was agreed by the Department of Health at 19. It was thought that 19 would be a challenging trajectory to achieve. However, the Trust has continued to undertake individual Root Cause Analysis (RCA) reviews collaboratively with the CCG. The purpose of the individual reviews are to ascertain if any lapse/lessons in provision of care could be identified to protect other patients. The reviews of the C.*difficile* cases identified 4 Lapses in Care: 1 lack of Isolation, 1 Insufficient monitoring of Bristol stool chart, 1 prescribing antibiotic therapy outside policy, 1 cross-transmission. Each individual lapse in care was addressed with the relevant team and cross divisional learning was shared to prevent reoccurrence.

MRSA Bacteraemia

The Trust has not had an MRSA Bacteraemia arising during inpatient care during 2015/16. At year end the Trust had had 542 MRSA free days and hopes to continue this.

Data Source: National Health Protection Agency data collection, as governed by standard national definitions.

Key

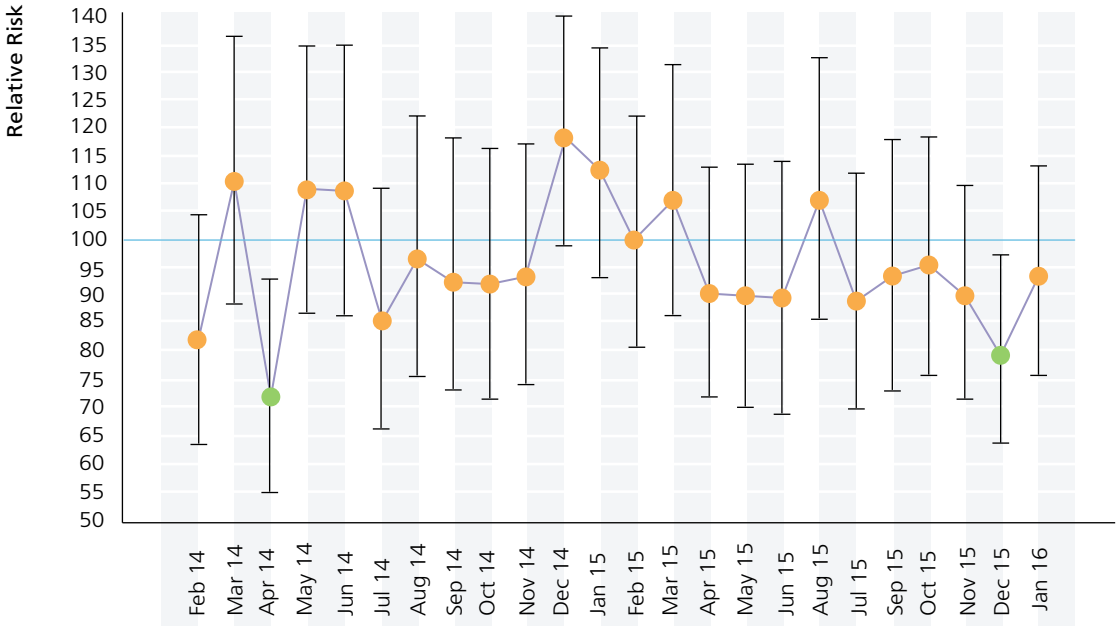
- Performing on or above target
- Performing below trajectory; robust recovery plan required
- Failed target or significant risk of failure

- Improved position
- Worsening position
- Steady position

Hospital Standardised Mortality Ratios (HSMR)

Hospital Standardised Mortality Ratios (HSMR) is a statistical way of comparing mortality ratios between hospitals. In order to compare hospitals in different areas with different populations and varying speciality work, the methodology looks at how many people are expected to die in hospital due to their condition and then compares this figure against how many people actually die.

Data Source: Dr Foster Intelligence sourced from national commissioning datasets as governed by standard national definitions.



High relative risk
Low relative risk
Expected range

National benchmark
Confidence Intervals

Safe cont.

Never Event

Indicator	2013/14	2014/15	2015/16
Number of Incidents Reported as Never Events	2	6	0
Threshold	0	0	0

The Trust has not had an incident meeting the 'Never Event' criteria outlined in the Never Events Policy and Framework (NHS England, March 2015) since March 2015.

Data Source: Datix Risk Management System. 'Never Events' are governed by standard national definitions.

Human Resources

Indicator	2013/14	2014/15	2015/16
Temporary Staffing	A	B	C
Threshold	N/A	N/A	N/A

A - £12,300,719
B - £14,178,009
C - £14,626,255

Spend on Temporary Staffing year to date (April 2015 to March 2016) is £14,626k and in month spend has increased slightly from £1,281k in February 2016 to £1,322k in March 2016.

Agency spend continues to be a hot spot and in Month 12 this accounts for £717k (54%) of spend and the second highest area is NHS Professionals (NHSP) at £261k (20%) of spend. NHSP recruits and supplies temporary nurses. We use framework agencies, which ensure the best possible value for money, for all other agency workers. The main challenges in relation to temporary staffing expenditure relate to hard to fill posts, aligned to national trends. This is most notable for medical staff in Emergency Medicine, Elderly Medicine, Dermatology and Urology and in nursing areas, the main challenges are for RSCN paediatric nurses and theatre staff.

Temporary spend continues to be a key focus for the Trust and various strategies are being deployed to support the management of temporary spend. These strategies include but are not limited to the implementation of Agency price caps (with a limited number of interim exception areas), participation in the Agency Partnership programme and the development of additional measures to recruit and retain skilled staff within the workforce.

Data source: Trust Oracle Ledger

Key

- Performing on or above target
- Performing below trajectory; robust recovery plan required
- Failed target or significant risk of failure

- Improved position
- Worsening position
- Steady position

Effective

A&E

Indicator	2013/14	2014/15	2015/16
Total time in A&E: Less than 4hrs	95.68%	94.7%	95.08%
Threshold - Monitor	95%	95%	95%

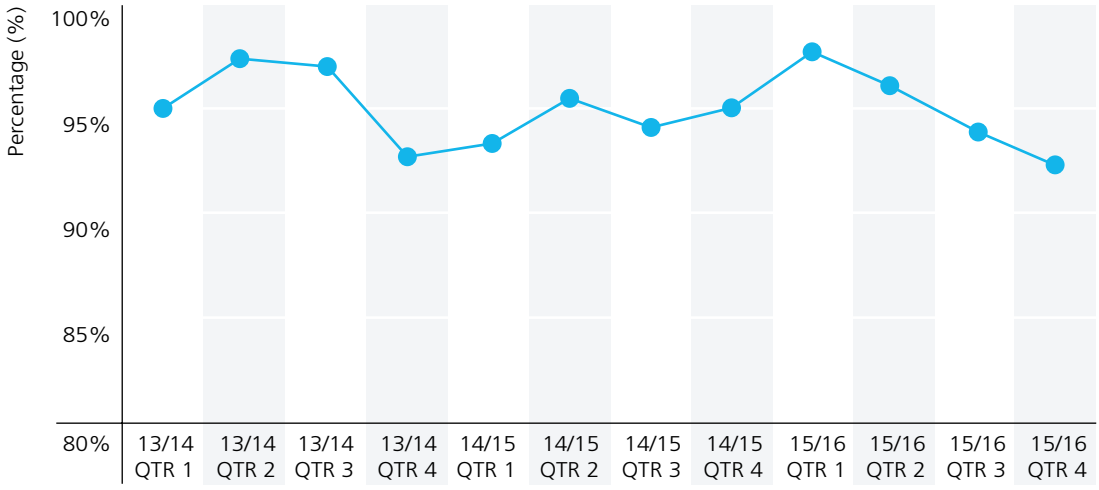
The data above represents the Trust position as at the year end.

The Trust performed remarkably well during the first quarter of the year, achieving the 4 hour standard every month and ended Quarter 1 on 97.73%. This was the best result in Greater Manchester. Quarter 2 was also achieved, with the Trust achieving 96.31%, as August was below the standard, at 94.07%. The Trust was again the highest performing Trust in Greater Manchester in Quarter 2. October was the only month in Quarter 3 when the Trust achieved the 4 hour standard and as a consequence failed Quarter 3, achieving 93.64%. This was still the best performance in Greater Manchester and for the 9 months to 31st December 2015 the Trust was the 7th best performer nationally.

The Trust achieved 92.38% in Quarter 4 but achieved above 95% for the year ended 31st March 2016. The Trust was the only Trust in Greater Manchester to achieve the 95% standard overall with an annual figure of 95.08%. We were also the only acute Trust in the whole of the North of England to achieve this.

Data Source: Management Systems Services (MSS) System, as governed by national standard definitions

A&E Attendances seen within 4 hours



Effective cont.

Cancer Waits

Indicator	2013/14	2014/15	2015/16
Cancer 62-Day Waits for first treatment - from urgent GP referral			
After repatriation	90.33%	91.25%	88.85%
Before repatriation	91.75%	92.13%	91.3%
Threshold	85%	85%	85%
Cancer 62-Day Waits for first treatment - from NHS Cancer Screening Service Referral			
After repatriation	99.46%	99.54%	97.25
Before repatriation	99.20%	99.54%	97.01%
Threshold	90%	90%	90%
Cancer 31-Day Wait for second or subsequent treatment – surgery	100%	100%	100%
Threshold	94%	94%	94%

Indicator	2013/14	2014/15	2015/16
Cancer 31-Day Wait for second or subsequent treatment – drug treatments	99.68%	100%	100%
Threshold	98%	98%	98%
Cancer 31-Day Wait from diagnosis to treatment	99.70%	99.03%	99.08%
Threshold	96%	96%	96%
Cancer 2-week – all cancers	98.66%	98.28%	98.14%
Threshold	93%	93%	93%
Cancer 2-week – breast symptoms	96.44%	95.66%	96.67%
Threshold	93%	93%	93%

"After repatriation" are Greater Manchester agreed figures. "Before repatriation" are nationally reported figures. Greater Manchester has an integrated cancer system. A breach re-allocation policy has been agreed by all Trusts. When a breach has occurred and the pathway has involved more than one Trust, rather than sharing the breach, the whole breach can been re-allocated to one Trust if the agreed timescales for transfer or treatment have not been met.

The Trust has continued to achieve all performance indicators for cancer care for 2015/16 despite being a very challenging year for Cancer Services nationally. During 2015 NHS England set up a tripartite to tackle the decrease in performance against the 62-day target from referral to treatment at national level. Trusts are now required to report performance against the 62 day standard on each cancer site, e.g. breast, lung, colorectal etc. Since September 2015 we have reported this data in the Trust's monthly published Performance Report. We have implemented improvement plans for those cancer sites that have struggled to achieve the 85% target, mainly due to the complexity of the disease, and we hope to see improvements as we go into 2016/17. The Trust continues to work closely with partner organisations in Greater Manchester and the Manchester Cancer Pathway Boards to further enhance the transition for patients being treated at specialist centres and is working collaboratively to improve the patient experience.

Data Source: National Open Exeter System, as governed by standard national definitions.

Key

- Performing on or above target
- Performing below trajectory; robust recovery plan required
- Failed target or significant risk of failure

- Improved position
- Worsening position
- Steady position

Effective cont.

Referral to Treatment (RTT)

Indicator	2013/14	2014/15	2015/16
Referral to treatment time, 18 weeks in aggregate, admitted patients	91.37%	92.7%	Q1-Q2 93.3% Q3-Q4 91.4%**
Threshold	90%	90%	90%
Referral to treatment time, 18 weeks in aggregate, non-admitted patients.	97.71%	98.0%	98.3%
Threshold	95%	95%	95%
Referral to treatment time, 18 weeks in aggregate, incomplete pathways	94.21%	97.1%	96.9%
Threshold	92%	92%	92%

The Referral to Treatment (RTT) targets are the minimum standards Trusts are expected to provide for patients referred to the Trust on an 18-week pathway. There are five specific specialities experiencing either an increase in referrals or a reduction in capacity. There specialities are monitored closely on a performance dashboard and by operational groups. Overall, WWL continues to exceed national standards.
** Q1-Q2 adjusted position, Q3-Q4 unadjusted position due to definitional changes with effect from 1st October 2015

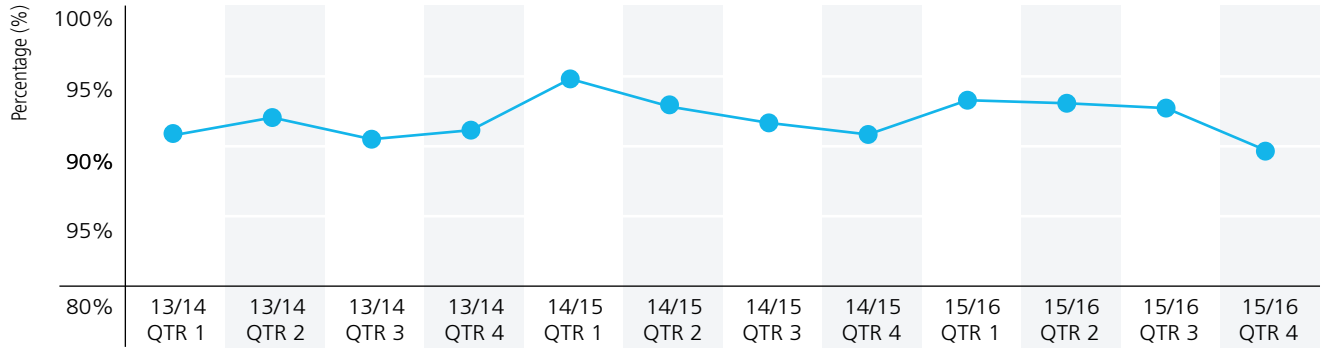
Data Source: Patient Administration System (PAS), as governed by standard national definitions.

Key

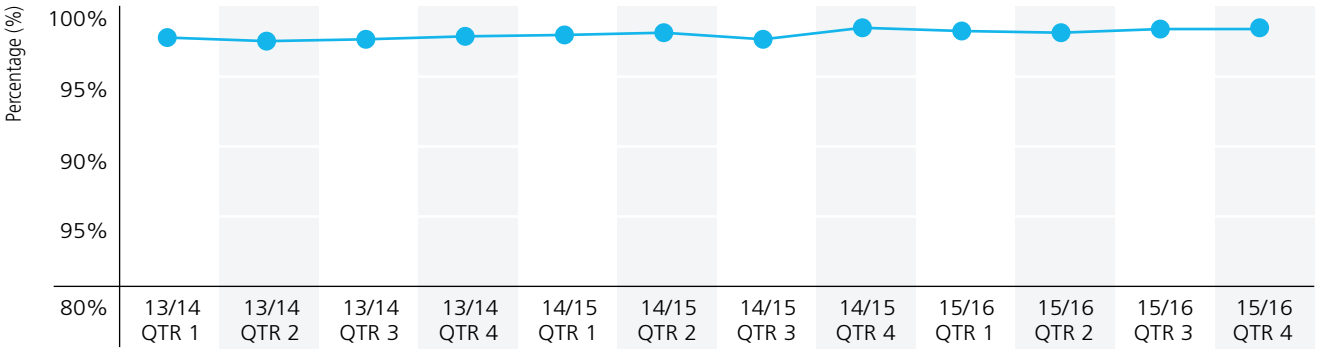
- Performing on or above target
- Performing below trajectory; robust recovery plan required
- Failed target or significant risk of failure

- Improved position
- Worsening position
- Steady position

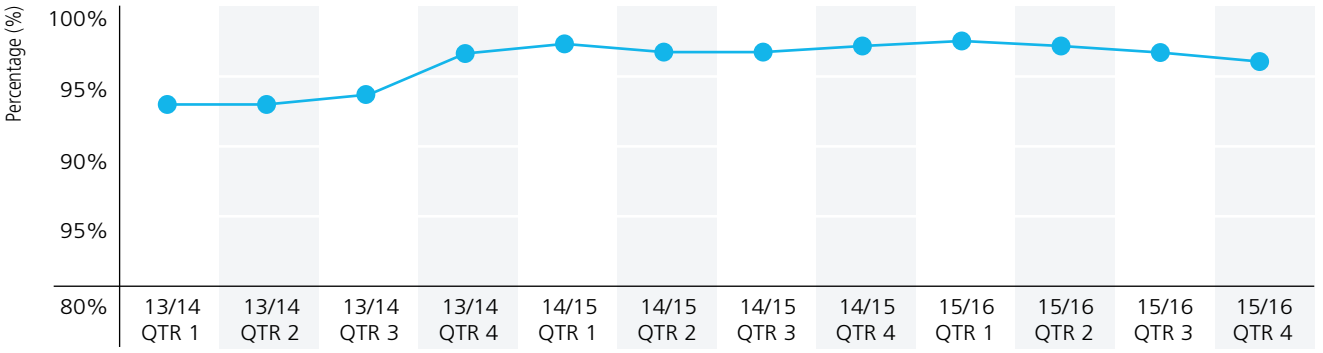
Admitted



Non Admitted



Incomplete



Effective cont.

Access to Healthcare for People with a Learning Disability

Indicator	2013/14	2014/15	2015/16
Compliance with requirements regarding access to healthcare for people with a learning difficulty	Achieved	Achieved	Achieved

Accessible information is available for patients with learning disabilities, their family and carers, around treatment options; complaints procedures, appointments, all of the above are available on a bespoke patient need; we also use the national documentation available eg, MacMillan: Breast Screening, Bowel Screening.
The Trust continues to work in partnership with the Hospital Liaison Nurse to ensure any reasonable adjustments required are in place. Learning Disability awareness is included in Trust induction of which all new staff to the organisation attend, and is delivered in partnership with the hospital LD Liaison Team and the Trust Safeguarding Team. In addition, bespoke awareness training continues to be delivered to key staff e.g. Reception Staff in outpatients departments.

Community Care

Indicator	2013/14	2014/15	2015/16
Community care – referral to treatment information completeness	66.68%	66.69%	67.1%
Threshold	50%	50%	50%
Community care-referral information completeness	93.06%	95.57%	95.1%
Threshold	50%	50%	50%
Community care – activity information completeness	99.07%	97.91%	97.8%
Threshold	50%	50%	50%

The data above represents the Trust's year end position. The Trust has continued to consistently perform above the threshold for these indicators for the past three years.

Data Source: Electronic Patient Record (EPR) system, as governed by standard national definitions.

Key

- Performing on or above target
- Performing below trajectory; robust recovery plan required
- Failed target or significant risk of failure

- Improved position
- Worsening position
- Steady position

Caring

Financial Sustainability Risk Rating (FSRR)

Indicator	2013/14	2014/15	2015/16
Financial Risk Rating (FRR)	4	N/A	N/A
Threshold	3	3	3
Continuity of Services Risk Rating (CSR)	4	3	N/A
Financial Sustainability Risk Rating (FSRR)	N/A	N/A	1

Monitor exercises a range of powers granted by Parliament which include setting and enforcing a framework of rules which is implemented, in part, through issuing licences to NHS-funded providers. This licence stipulates the specific conditions that the NHS provider must meet to continue to operate including those in respect of the continuity of services ratio. The purpose of this measure is to identify any significant risks to the financial sustainability of the Foundation Trust which would endanger the delivery of key services.

Data source: Figures from the Trust Oracle General Ledger, subject to Monitors calculation methodology as governed by standard national definitions.

Selected Real Time Feedback Indicators

Indicator	2013/14	2014/15	2015/16
Feedback scores – Real Time Patient Survey	85.06%	92.39%	92.49 ●
Threshold	90%	90%	90%
Feedback scores – Real Time Patient Survey – Pain Control	93.7%	93.5%	96.00 ●
Threshold	90%	90%	90%
Feedback scores – Real Time Patient Survey – Worries and Fears	87.5%	90.5%	92.75 ●
Threshold	90%	90%	90%

● As at March 2016

During 2015/16 the average score for the Real Time Survey is 92.49% (as at March 2016) which has shown a slight increase on the average score for 2014/15.

There has been slight increase in the pain control question during 2015/16. This is due to having maintained training for staff in pain control.

There has been slight improvement in the score for the Worries and Fears question. The Trust continues to maintain the hourly rounding on the wards.

Data Source: Real Time Patient Experience Surveys as at March 2016.

Complaints, Patient Advice and Liaison Service and the Ombudsman

Patient Relations and Patient Advice and Liaison Service (PALS) is dedicated to enhancing the patient, carer and relative's experience. The Trust welcomes complaints and concerns to ensure that continuous improvement to Trust services take place and to improve experience through lessons learned.

The department continues to work closely with the Divisions to promote a positive patient experience and to actively encourage a speedy response to concerns that are received through the different media, including letter, e-mail, telephone or personal caller through the PALS element of the department, providing resolution in real time.

All complaints and concerns are shared at the Trust's Executive Scrutiny Committee which is held on a weekly basis. The more complex and serious complaints are reviewed and discussed in detail. These meetings also provide the opportunity to triangulate information with incidents, possible claims and inquests.

Statistical information in respect of complaints and concerns is collected and monitored to identify trends. The Trust continues to share its statistical information from formal complaints nationally named (KO41a), now required on a quarterly basis.

The Trust views the receipt of complaints positively to learn and reflect on the work undertaken and to make the appropriate improvements. The following outlines actions taken and lessons learned from a sample of complaints received.

Complaint	Actions Taken and Lessons Learned
Communication	
Staff were unaware of a patient's arrival in the department and therefore the patient was left waiting in the cold and wearing only a gown.	All staff to check the reception area if there is any indication that the patient may not have attended. All staff have been individually contacted by e-mail as a reminder of this and this issue has also been discussed at the daily com cell for the department.
Medication Error	
Patient received medication that was not compliant with the current medication which led to the patient having a setback in treatment.	This complaint has been discussed with the Doctor concerned who has reflected on the error. The doctor has provided a statement to the Consultant in charge of care.
Equipment Failure	
Patient fell from the operating chair.	Patients are supervised when being seated on the operating chair. Staff to attend formal teaching sessions regarding seating positions. A standard operating procedure is in development and poster communication will be displayed in the Anaesthetic room.
Aspects of clinical care	
There was a delay in biopsy results being provided for treatment plan to commence.	The Cellular Pathology Department are to review their processes for the tracking of samples.

Complaint	Actions Taken and Lessons Learned
Attitude of staff	
Review of the complaints received regarding attitude.	Individual members of staff have been interviewed on their attitude and approach when communicating. Staff have also been provided with information and recommendations to attend the various Trust training programmes, including enhanced communication awareness sessions.
Admissions	
Complex Orthopaedic patients enduring delays in receiving a date to undergo their procedures at the RAEI site.	The Divisions of Specialist Services and Surgery are working together to ensure that these patients are not disadvantaged due to their complex needs.

Improvement Plans as a result of complaints referred to the Parliamentary Health Service Ombudsman

The role of the Parliamentary and Health Services Ombudsman (PHSO) is to provide a service to the public by undertaking independent investigations into complaints that government departments, a range of other public bodies in the UK, and the NHS in England, have not acted properly or fairly or have provided a poor service.

The aim of the PHSO is to provide an independent high quality complaint handling service that rights individual wrongs, drives improvement in public service and informs public policy.

During 2015/16 the PHSO requested information regarding 13 complaints. 2 were partially upheld; 2 were not upheld; 1 is in draft form at present; 6 have investigations underway and 2 are requests for records at the time of writing. These cases relate to (years) 2013/14/15.

The Trust is currently monitoring 1 Action Plan.

Patient Experience

The Trust has continued to achieve excellent scores for cleanliness throughout the hospital, placing us in the top 20% of all Trusts in this area of assessment in the National Inpatient surveys 2014/15.

The Patient and Public Engagement Team continues to obtain feedback from inpatients using the Real Time Patient Experience Survey. The surveys are undertaken by our hospital volunteers and Governors. The results are presented to the Board every month to monitor the corporate objective of over 90% of a positive patient experience. As a result of this monitoring, significant improvement has been identified in patients being involved as much as they have wished in decisions about their care and treatment. Results of the outcome of the real times surveys can be viewed in the patient engagement section of the Trust's annual report.

Patient and Public Engagement

Patients, Carers and Governors attended an event to assist with redesigning of Outpatient Services. They spoke about their experiences, drawing out the positive and the negative elements of their care, with a view to bringing about changes that will lead to the establishment of a gold standard patient experience. Initiatives implemented in response to feedback include improved Shared Decision Making across all sites. This will ensure that patients are involved in decisions about their care and treatment with more information and awareness on the patient pagers available for patients and relatives.

The Trust held a Discharge Improvement Workshop in partnership with Picker Institute Europe for patients and staff. Patients and staff spoke about their experiences and set short, long and medium term goals for improvement. Initiatives implemented in response to the feedback are a discharge wallet, a patient discharge checklist and a ward based pharmacy discharge service.

A patient and public engagement campaign on Shared Decision Making 'Ask 3 Questions' was very successful, engaging with over 180,000 patients, public and staff through various touch points. The campaign informed and empowered patients to be involved in decisions about their care and treatment.

The Trust also values the contribution of lay representatives who attend the Divisional Quality Executive Committees, Quality Champion Committee, Discharge Improvement Committee, Children's Clinical Cabinet and Patient Led Assessments of the Care Environoment (PLACE) , to provide the patients' perspective.

The Trust has a Patient and Public Engagement Committee whose remit is to ensure that patient and public engagement remains integral to the Trust. The Committee is chaired by the Lead Governor with representation from Governors and key local stakeholder agencies.

In addition to continuing with all the initiatives and activities described, achieving a positive patient experience remains a key priority for the Trust. The Trust will continue the engagement campaign on Shared Decision Making 'Ask 3 Questions'. This will inform and empower patients to be involved in decision about their care and treatment.

Healthwatch undertook announced visits. The visits to the Royal Albert Edward Infirmary were announced and planned over a two week period. They were prompted by recent press and television coverage of the success the Trust was having, not only in winning awards, both nationally and regionally, but also achieving the Accident and Emergency standard of less than 4 hour waiting times, more than any other hospital in the Northwest. Healthwatch Wigan, whilst feeling very proud of its local Trust, wondered what WWL were doing differently to other Trusts and maybe more importantly what had the Trust done in the past few years to bring about such a dramatic improvement in the standard of care being delivered. The Enter and View team agreed that they would like to make several visits to RAEI to view not only the Emergency Care Unit but also the discharge procedures and facilities. Some initiatives implemented following the visit were: individual place mats ordered for inpatients depicting staff uniforms, continuing to promote the Always Events and also ward-based Pharmacists on assessment units.

The CCG, Healthwatch, local voluntary groups such as Think Ahead, and the Local Authority worked in partnership with the Trust and Picker Institute Europe on improving discharge.

A Cancer Services Awareness Raising event on prevention and detection of cancer also took place in partnership with the Local Authority Public Health and Healthwatch.

Part 3.2:

Quality Initiatives

The Trust has introduced a number of initiatives to strengthen quality governance systems and improve the care, treatment and support provided to patients across the organisation. A summary of progress during 2015/16 is outlined opposite.

Staff Engagement the WWL Way

NHS England has requested that Trusts highlight the results of two indicators in the 2015 National Staff Survey which are as follows:

Key Finding 26 (percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months):

21% of staff reported experiencing harassment, bullying or abuse from staff in last 12 months. There was a 4% increase in this score since 2014, but this was not statistically significant. WWL scored significantly better than the national average of 26%. The Trust plans to continue its work on supporting staff with safe avenues to raise concerns via the revised Raising Concerns policy and the new Freedom to Speak Up Guardian.

Key Finding 21 (percentage of staff believing that the Trust provides equal opportunities for career progression or promotion):

91% of staff reported believing that the organisation provides equal opportunities for career progression or promotion. There was a 2% decrease in this score since 2014, but this was not statistically significant. WWL scored significantly better than the national average of 87%. WWL will launch its new talent management programme in 2016, which will provide all staff with the equal opportunities to find their own developmental career progression route within the organisation.

At Trust wide level, WWL has significantly improved on a number of engagement measures over the last 12 months, including improved staff recognition, as a result of the successful "Going the Extra Mile" staff recognition scheme. We have continued to sustain the position of being in the top 10% of NHS Trusts for staff recommending us as a place to work and are viewed as forward thinkers for staff engagement within the NHS. As a result the Trust is sharing their in-house developed staff engagement pathway model with external organisations, under the label "Go Engage," which includes a licence to an online platform that surveys staff and statistically analyses data for trends and hot spots. This is providing even more organisations with a measurable framework to rapidly and continually diagnose and understand the cause and effect of staff engagement.

This year we have continued to engage staff at local levels within their teams, through our staff engagement 'Pioneer Teams' programme. Forty teams have been through the programme which features a comprehensive staff engagement diagnostic survey and a staff engagement toolkit. Teams that have taken part on the programme have, on average, made a 7% improvement in their staff engagement scores, with some improving as much as 25%.

We have acted upon pulse survey data associated with staff energy levels by taking a pro-active approach with staff health and wellbeing, in order to create a positive and healthy working environment. We have continued to offer resilience training to staff and, for the first time trained our new foundation doctors to support them with the challenges of their new role. We continue to take a pro-active approach by centring on prevention and the reduction of sickness absence. This has included onsite therapies and massage for staff during winter pressures and the recruitment of a Mindfulness Practitioner.

We will continue to build on our work by actively sustaining positive staff engagement, and importantly, focusing on staff health and wellbeing. We believe that continuing with this approach will be beneficial for our staff's future health, and that these measures will contribute to a reduction in sickness absence, reduced agency costs, and improve the quality of care provided to our patients.

Continued Recruitment and Development of the Quality Faculty

The Trust's Quality Faculty has continued to grow during 2015/16 and there are now approximately 320 Quality Champions representing a wide range of disciplines and departments, working on approximately 103 improvement projects.

All Quality Champions who complete the training programme and commence an improvement project are awarded a bronze badge. Silver and gold badges are awarded to those Champions who sustain their improvements and disseminate them to other organisations. In 2015, 20 silver and 4 gold awards were awarded.

Three courses of training in quality improvement methods have been delivered during 2015/16 and approximately 80 Quality Champions have attended these. Several other NHS organisations have shown interest in The Quality Champions' programme including University of Morecambe Bay NHS Foundation Trust and The Royal Free Hospital. The Heart of England NHS Foundation Trust have taken the programme in its entirety and have been coached and supported to deliver it within

their own organisation. They have recently had their first successful graduates from the programme.

During 2015/16 we have begun to involve other disciplines in the programme including the Programme Management Office, Clinical Audit Team and Finance. By involving these departments it will allow the participants a wider palette of methodologies to choose from and provide robust data and evidence for their improvement projects. Finance will provide the evidence for financial gain as well as an improvement in the quality and safety of care.

Plans are in place to continue to sustain and build the Quality Faculty in 2016/17 by offering a broader range of training programmes with the aim of involving more junior staff, particularly junior doctors. Junior doctor involvement has always been difficult due to the time commitment and we are looking to utilise a mentor system whereby we pair a junior doctor with a Consultant to provide support to them.

Implementing Recommendations from the Francis Report

Throughout 2012 and 2013 a series of reports were published following findings of reviews undertaken in response to serious lapses in care resulting in significant harm to patients and reputational damage to individual hospitals and NHS Trusts. The reports raised significant concerns relating to the voice of the patient and carers, organisational cultures, patient safety and care and compassion and also highlighted the requirement for fundamental change in the oversight, scrutiny and accountability across providers and regulators of care.

The Trust's Quality and Safety Committee received an update during 2015/16 in relation to the Trust's self-assessment of compliance with the Francis, Berwick and Keogh reports. This was subsequently considered by the Trust Board and published on the Trust's website. The report provided Significant Assurance of progress with the themes identified.

Leadership Quality and Safety Rounds

During 2015/16 six leadership safety rounds took place. Executive and Non-Executive members of the Trust Board and Trust Governors visited wards and departments and held conversations with groups of staff about patient safety using an "appreciative inquiry" approach. Areas visited included, Standish Ward, Medical Assessment Unit and Rainbow Ward at the Royal Albert Edward Infirmary, the Endoscopy Unit and Wards 2 and 3 at Leigh Infirmary and Ward 5 at Wrightington Hospital. 26 staff participated in the visits in total. In all, 29 safety rounds have taken place using this approach since 2012, involving many different disciplines across four Trust sites. A training programme for Governors, Non Executive Directors and Executive Directors has been developed and delivered. During 2016/17 a further 12 visits are planned.

Internal Compliance Review

Since December 2013 the Trust has undertaken twice-yearly internal inspections, the most recent occurring in June 2015. These inspections have occurred at RAEI, Wrightington Hospital, Leigh Infirmary and the Thomas Linacre Centre. They have evolved over time and involve an extensive and enthusiastic team of inspectors representing a wide spectrum of staff groups within the organisation. The June 2015 inspection was the largest since the inspections began. The CCG has participated in every inspection.

The June 2015 inspection took place on a Friday and Saturday and focused upon Care at the Weekends, Surgical Pathways, Consent, Do Not Attempt Cardiopulmonary Resuscitation (DNACPR), Deprivation of Liberty Safeguards (DoLS), Patient Information, Staff Satisfaction, Confidentiality and Communication of Information. The Trust was delighted to be joined by Morecambe Bay University Hospitals NHS Foundation Trust to provide input from another NHS Trust.

Following the June 2015 Inspection a comprehensive improvement plan has been developed to address the '10 things to improve' and other elements highlighted in the inspection report. This plan was approved at the Quality and Safety Committee in October 2015 with updates presented thereafter.

10 things to celebrate

1. Consent
2. Comms Cells (Person to person communication)
3. Happy Staff
4. Happy Patients
5. Well supported Staff
6. Positive relationships with seniors

7. DNACPR communication
8. Staff feel empowered to challenge
9. Band 2 and FY1 understanding DoLS
10. EPR Doctor at weekends

10 things to improve

1. Management and training of DoLS
2. Mental Capacity Act training
3. Surgical outliers and flow
4. Surgeon responsiveness
5. Slow discharge at weekends
6. Corporate communication (5 point communication files) and visibility of Executive Directors
7. Communication between theatre and ward teams
8. Patient information
9. DNACPR documentation
10. Drug management for surgical admissions

Compliance Self Assessments

Additionally, we implemented a way of reviewing compliance with the CQC's Key Lines of Enquiry (KLOE) at ward and departmental level. There was a real opportunity to delve much deeper into the actual wards and departments and to ask the key individuals in those teams to provide self-assessments of their own areas. The assessments were then signed off by Sponsors. We aimed the assessments at highlighting any areas for improvement and capturing actions required to improve compliance, as well as highlighting areas which were good and outstanding.

Our CQC Assure system was set up with an "accountability owner" for each ward/department who was responsible for the self-assessment of the ward/department against the Key Lines of Enquiry.

The individual KLOE ratings given by each ward and department were aggregated into ward, department, divisional and trust-wide compliance tables and can be displayed in various dashboards and reports.

Within an 8-12 week period, our staff completed 71 sets of clinical review, which comprised of the 5 KLOE, totalling an impressive 355 self-assessments.

How have we done it?

The self-assessments undertaken by ward and departmental managers were linked within the system to the appropriate directorates, divisions, hospital sites and eight core services. The self-assessments required the key staff to make the same judgements used by the CQC in relation to individual areas. Staff found the system quite intuitive and, in the main, only required short, group training sessions within which they were provided with a hand-out with screenshots. We experienced really great buy-in from our staff, including ward and departmental Managers, Matrons, Governance colleagues, Heads of Nursing and Executives.

How has it improved the safety of our patients?

Francis, Keogh and Berwick reviews illustrated the need for strong patient-focused leadership and accurate and useful information, and the need for leaders to fully understand improvements which can be made to patient safety, engage and empower our staff to develop and grow through their ability, through providing opportunities, to make improvements to systems and processes within their working practice and environment.

The ward and departmental self-assessments helped us with this and enabled a wide range of staff to consider and self-assess their areas against the KLOE in advance of the CQC Inspection. This provided invaluable preparation, organisational insight and a mechanism to capture actions identified to improve areas, as necessary or appropriate. We were also able to recognise the many areas of outstanding and good compliance across the organisation.

Always Events

The Always Events are the Trust's commitment to improving the delivery of patient and family centred care. The first 10 Always Events were launched in January 2014.

The Always Events are embedded within our Safe, Effective, Caring culture. The regular weekly snap shot audits and the quarterly whole hospital site audits have continued to demonstrate stability and improvement.

As a result of feedback from our most recent Picker Survey we have introduced 10 new "Good Night" Always Events which will address the noise at night issues identified by the survey. These too are now audited weekly and there has already been a steady improvement.

Always Events work for our staff, they know why we have them and what they mean. They have proved to be a great tool for contributing towards safe, effective care.

The HELPline

HELPline continues to be offered to current inpatients and their families as a way of escalating and addressing concerns that they feel are not being appropriately addressed at ward level. HELPline provides direct access to the Matron on call or Site Co-ordinators; it is not intended as a way to bypass communication with ward staff, but rather to supplement it. Since March 2015 HELPline has received 53 calls in total. Work is currently underway with the PALs department to be able to collate themes and trends of calls received and therefore further improve services offered to patients.

Commissioner Quality Visits

NHS Wigan Borough Clinical Commissioning Group (CCG) has undertaken two unannounced Commissioner Quality Visits in 2015/16 to determine the experiences and views of the patients, relatives, carers and staff on the services provided on Taylor Ward, Leigh Infirmary in August 2015 and Maternity Services, Royal Albert Edward Infirmary in November 2015.

The Commissioner's reports following their visits are reviewed by the Trust's Quality and Safety Committee. Agreed actions are monitored by Commissioners at the Joint Quality Safety and Safeguarding Committee attended by representatives from the Trust and the CCG.

The Trust welcomes the unannounced visits by the CCG and the collaborative approach taken by the CCG to improve patient and staff experience.

TalkSafe

TalkSafe is a programme that is focused on changing the safety culture of an organisation through structured conversations. TalkSafe has a 20 year proven history within the aviation, chemical engineering and engineering sectors.

Conversations focus on safety, both safe and unsafe practice, and the potential consequences of these actions. TalkSafe uses a coaching style focused on behaviour, actions and consequences. It is designed to act at the level prior to incidents or near misses, and focuses on organisational and system factors in addition to individual behaviours. The programme is a gateway to human factors and is focused at all levels of staff.

TalkSafe was introduced into WWL in October 2014. MAU and Lowton Wards were chosen as the pilot areas. The programme has trained over 80 staff in awareness and 32 TalkSafe champions,

A number of resources have been developed to support champions in their roles, including technology solutions as well as one to one support for champions.

There is evidence on MAU and Lowton that the safety culture is changing and that there is a reduction in moderate/severe harm incidents and an increase in no/low harm incidents, indicative of a more mature safety culture.

The programme has taken off in places that were not included in the pilot areas: Pharmacy, the Critical Care Outreach Team and various specialist nurses and other staff groups. The movement is towards a social movement as people are now approaching me asking if they can be a champion or if their area can be the next development area.

Maternity and Theatres at RAEI and Wrightington are the next areas that are undertaking the programme. Pharmacy has trained the majority of its staff to become champions. These programmes will look different than those on MAU and Lowton Ward as the resources are now developed and there has been much more preparatory work to provide a good foundation from which to work to being proactive rather than reactive. Champions aware of the commitment as a role description outlining the commitment required has been developed by the champions themselves. An awareness podcast has been developed to replace the awareness training allowing more time to focus the champions' training.


CONGRATS!

Appendix A

National Clinical Audits and National Confidential Enquiries

National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Eligible to participate Y/N	Participated	Number eligible	Actual submissions
Acute pancreatitis	Yes	Yes	5	80%
Sepsis	Yes	Yes	4	75%
Mental Health in General Hospitals	Yes	Yes	2	40%
Gastrointestinal haemorrhage	Yes	Yes	6	50%

National Audits (NCAPOP – n =)	Eligible to participate Y/N	Participated	Number eligible	Actual submissions %
Acute coronary syndrome (MINAP)	Yes	Yes	10	100%
Cardiac rhythm management (CRM)	Yes	Yes	Data submission deadline 30/06/16	
Coronary angioplasty/PCI	Yes	Yes	Data submission deadline 01/06/16	
Bowel Cancer	Yes	Yes	All Cancer audits reported by Oncology Department Services	
Head & neck cancer	Yes	Yes		
Lung cancer	Yes	Yes		
National prostate cancer	Yes	Yes		
Oesophago-gastric cancer (NAOGC)	Yes	Yes		
Child health clinical outcome programme	Yes	Yes	Data Collection Feb/March 2016	
Diabetes (Adult) (NADIA)	Yes	Yes	61	100%
Diabetes (Paediatric) NPDA	Yes	Yes	Data collection until end March 2016	
Falls & Fragility Fractures (FFAP)	Yes	Yes	30	100%
Inflammatory bowel disease (IBD)	Yes	No	Awaiting database for data collection	
Maternal, newborn & infant clinical outcome programme (MBRRACE)	Yes	Yes	15	100%
National emergency laparotomy audit (NELA)	Yes	Yes	149	97.3%
National joint registry	Yes	Yes	2932	100%
National ophthalmology audit	Yes	No	Problems with data entered at Post-op so no submissions to date	
Neonatal Intensive Care (NNAP)	Yes	Yes	326	100%
Rheumatoid & early inflammatory arthritis	Yes	Yes	13	100%
Sentinel stroke National audit programme	Yes	Yes	312	99% (to date)

Non-NCAPOP	Eligible to participate Y/N	Participated	Number eligible	Actual Audit Submissions %
Adult asthma	Yes	No	Insufficient resources in department	
Case mix programme (ICNARC)	Yes	Yes	809	100%
National elective surgery PROMS	Yes	Yes	Reported in core indicators section	
Emergency use of oxygen	Yes	Yes	30	100%

Non-NCAPOP cont.	Eligible to participate Y/N	Participated	Number eligible	Actual Audit submissions %
Trauma audit research network (TARN)	Yes	Yes	2015 – 198 2016 – 39	56.4 – 61.9 36.8 – 40.4
Emergency use of oxygen	Yes	Yes	30	100%
National cardiac arrest Audit (NCAA)	Yes	Yes	83	100%
National comparative audit of blood transfusion programme	Yes	Yes	22	100%
Paediatric Asthma	Yes	Yes	32	100%
National Heart Failure audit	Yes	Yes	Data submission deadline 01/06/16	
UK Parkinson's Audit	Yes	Yes	42	100%
Vital signs in children (care in emergency department)	Yes	Yes	50	100%
VTE risk in lower limb immobilization (care in emergency department)	Yes	Yes	50	100%

Note: The figures above represent the information provided to the Clinical Audit Department by the relevant audit leads/departments. Data collection for some of the audits extends beyond the date of this report therefore the figures contained within the report may not correspond with the actual validated figures published in the final audit reports.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faxitron


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NHS
Sola Akinbami
Senior Assistant Tech. Officer

Annex

Annex A:

Statements from Healthwatch, Overview and Scrutiny Committee and Clinical Commissioning Group

This section outlines the comments received from stakeholders on this Quality Account prior to publication.

Healthwatch

We would like to thank the Trust for inviting Healthwatch Wigan to respond to the draft Quality Accounts report.

We congratulate the Trust for many of the achievements outlined in the report; including improvements in infection control, leading to reduction in cases of MRSA, C-Diff.

Healthwatch volunteers support the Trust's work in PLACE surveys and we are pleased to see that the hospital was declared to be the cleanest in the NHS – this is something that our volunteers recognise as well. We are also pleased to see that there have been no so called 'Never Events' during this period.

Much of this success can be traced back to the Trusts decision to pursue Quality as an overriding strategy for all services and we commend them for this vision.

We are pleased to see that the Trust accepted some of our suggestions from last year's Quality report – for example that Trust Board meetings should have a focus on both favourable and critical patient stories at each meeting. We know from our attendance at these meetings that such stories help the Board in undertaking their role.

Healthwatch Wigan decided to look into the Trusts' activities to cope with and respond to the extra pressures during the winter and in early 2015, our Enter and View team made 6 visits to Trust sites A&E (major injuries, minor injuries and ambulatory assessment), clinical decisions ward, medical admissions unit and discharge ward. The subsequent report highlighted the many good things we observed during these visits.

Our report recognised significant achievements and good practice within the winter resilience program. It also included a number of recommendations based on the observations of E&V volunteers and their discussions with patients and carers at the hospital, in particular, recommendations for the improvement of discharge processes. The report was welcomed by WWL and we are grateful that it featured prominently in the Members magazine and that the Trust produced an action plan to implement many of the recommendations. We were pleased to be invited to join the Discharge Improvement Committee and have continued to provide lay perspective contributing to subsequent improvements in performance. We fully endorsed WWL's commitments to achieve a 50% reduction in delays in discharge, and to improve the number of patients who feel they were involved in decisions about their discharge – which is something Healthwatch Wigan have called for in the past two years.

In May 2015, Healthwatch Wigan began to offer support to individuals who need to make a complaint about NHS services. This work has brought us into closer contact with the PALS services, Complaints Department and PHS Ombudsman. Whilst recognising much of the good work contained within the Quality Account we are keen to work with the Trust to continue to make further improvements in this area – to always welcome complaints and comments as a source of useful feedback from which to learn and to make sure that actions promised within the process are applied throughout the Trust.

As last year, we heartily endorse the Trust's aim to be in the top 10% of Trusts across a range of key measures.

We welcome the increasing focus of the Trust in being dementia friendly. This is something that will become increasingly important to all hospitals and to all who work in the NHS and Social Care. We wish the Trust well in its targets to increase the number of Dementia Champions across its workforce and to make improvements to the ward environment to be more dementia friendly. Moving forwards – looking into plans for closer cooperation between hospitals through schemes such as Healthier Together, GM Devolution and NHS Vanguard; the Trust should pay more attention to the outcomes of patients who are cared for and treated across the wider health and care economy.

We look forward to seeing the CQC report when finally published and working with the Trust on the actions to address any recommendations.

Healthwatch Wigan looks forward to working with Wrightington, Wigan and Leigh NHS Foundation Trust in ensuring that local people, from all backgrounds, get the very best out of services delivered locally.

Dave Nunns
Chief Executive - Healthwatch Wigan

Wigan Borough Clinical Commissioning Group (CCG)

Wigan Borough Clinical Commissioning Group (the CCG) appreciates the opportunity to comment on the 2015/2016 Quality Account for Wrightington, Wigan and Leigh NHS Foundation Trust.

Notable successes for the Trust in 2015/2016 include:

- Participation in the national Sign up to Safety campaign
- The Quality Champions programme
- Achievement of the 4 hour wait target in A&E across the year
- Zero reported cases of Methicillin Resistant Staphylococcus Aureus
- A 48% reduction in the number of cases of Clostridium *difficile*
- A reduction in the number of Never Events to zero

In respect of the 2015/2016 quality priorities the CCG notes not all objectives were achieved, however good progress was made in a number of areas including improvements to the discharge process, the creation of dementia friendly ward environments and the investigation of all cardiac arrests to identify learning.

For 2016/2017 the CCG welcomes the focus on reducing mortality rates and the goal of achieving a Hospital Standardised Mortality Ratio of 85 and a Summary Hospital Level Mortality Indicator of 100. A renewed focus on venous thromboembolism prevention, falls prevention and early recognition of the deteriorating patient is also appreciated.

The CCG looks forward to seeing further quality improvements during 2016/2017 through the implementation of the new integrated Health Information System.

The CCG will continue to work with the Trust during the coming year to build on the progress made and to provide support to initiatives that will improve the quality of care and outcomes for the resident population of the Wigan Borough.

Dr Tim Dalton
Chairman, Wigan Borough Clinical Commissioning Group

Overview and Scrutiny Committee

Comments were sought from Overview and Scrutiny Committee, but none were received.

Annex B:

Statement of Directors' Responsibilities in respect of the Quality Report

The Directors of Wrightington, Wigan and Leigh NHS Foundation Trust (WWL) are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 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 the NHS 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 2015/16 and supporting guidance;
- 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 2015 to March 2016
  - Papers relating to Quality reported to the Board over the period April 2015 to March 2016
  - Feedback from Commissioners dated 10 May 2016
  - Feedback from Governors dated 16 May 2016
  - Feedback from local Healthwatch dated 23 May 2016
  - Feedback from Overview and Scrutiny Committee (not received)
  - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations, dated 2014/2015.
  - The National Patient Survey 2015
  - The National Staff Survey 2015
  - The Head of Internal Audit's annual opinion over the Trust's control environment dated 2015/16
  - Care Quality Commission (CQC) Intelligent Monitoring Report dated May 2015.
- The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered;
- The performance information reported in the Quality Account 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.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor.gov.uk/annualreportingmanual)

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

By order of the Board

Robert Armstrong
Chairman

25 May 2016

Andrew Foster
Chief Executive

25 May 2016

Annex C:

How to provide feedback on the account

Feedback on the content of this report and suggestions for the content of future reports can be provided by calling the Foundation Trust Freephone Number 0800 073 1477 or by emailing: foundationstrust@wwl.nhs.uk


Mercury

Annex D:

External Auditors Limited Assurance Report

Independent auditor's report to the Council of Governors of Wrightington, Wigan and Leigh NHS Foundation Trust on the quality report

We have been engaged by the Council of Governors of Wrightington, Wigan and Leigh NHS Foundation Trust to perform an independent assurance engagement in respect of Wrightington, Wigan and Leigh NHS Foundation Trust's quality report for the year ended 31 March 2016 (the 'Quality Report') and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the Council of Governors of Wrightington, Wigan and Leigh NHS Foundation Trust as a body, to assist the Council of Governors in reporting Wrightington, Wigan and Leigh 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 2016, 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 Wrightington, Wigan and Leigh NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter
The indicators for the year ended 31 March 2016 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period; and
- Percentage of patients with a total discharge time in A&E of 4 hours or less from arrival to admission, transfer or discharge.

We refer to these national priority indicators collectively as the '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 criteria set out in the 'NHS foundation trust annual reporting manual' issued by 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 is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual';
- the quality report is not consistent in all material respects with the sources specified in section 2.1 of the Monitor 2015/16 Detailed guidance for external assurance on quality reports; and
- the indicators in the quality report identified as having been the subject of limited assurance in the quality report are not reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual' and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports'.

We read the quality report and consider whether it addresses the content requirements of the '*NHS foundation trust annual reporting manual,* 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 documents listed below:

- board minutes for the period April 2015 to March 2016;
- papers relating to quality reported to the Board over the period April 2015 to March 2016;
- feedback from Commissioners, dated May 2016;
- feedback from local Healthwatch organisations, dated 23 May 2016;
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS complaints regulations, dated 2014/15;
- the latest national patient survey;
- the latest national staff survey;
- Care Quality Commission Intelligent Monitoring Report dated May 2015; and
- the Head of Internal Audit's annual opinion over the Trust's control environment, dated April 2016.

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.

Assurance work performed
We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). 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;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the 'NHS foundation trust annual reporting manual' to the categories reported in the quality report; and
- reading the documents.

A limited assurance engagement is smaller 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 affect 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 of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual'.

The scope of our assurance work has not included testing of indicators other than the two selected mandated indicators, or consideration of quality governance.

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 2016:

- the quality report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the quality report is not consistent in all material respects with the sources specified above; and
- the indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual.

Deloitte LLP

Chartered Accountants
Leeds
26 May 2016

Annex E:

Glossary of Terms

Acute
Having or experiencing a rapid onset of short but severe pain or illness.

Acute care
Necessary treatment, usually in hospital, for only a short period of time in which a patient is treated for a brief but severe episode of illness, injury or recovery from surgery.

Annual Governance Statement
This is a key feature of the organisation's annual report and accounts. It demonstrates publicly the management and control of resources and the extent to which the Trust complies with its own governance requirements, including how we have monitored and evaluated the effectiveness of our governance arrangements. It is intended to bring together into one place in the annual report all disclosures relating to governance, risk and control.

Arterial
This is of or relating to an artery or arteries.

Assisted Conception
Assisted conception means using reproductive technology to increase the chances of pregnancy.

Better Care Better Value
The Better Care, Better Value indicators reveal the potential to make significant cash or resource savings whilst improving quality.

Cardiology
The medical study of the structure, function, and disorders of the heart.

Care Quality Commission (CQC)
The independent regulator of health and social care in England. The CQC make sure health and social care services provide people with safe, effective, compassionate, high quality care and encourage services to improve.

Chemical Pathology
Chemical Pathology is the branch of pathology dealing with the biochemical basis of disease and the use of biochemical tests for screening, diagnosis, prognosis and management.

Chemotherapy
This is the treatment of disease by the use of chemical substances, especially the treatment of cancer by cytotoxic and other drugs.

CIP (Cost Improvement Programme)
These are a vital part of NHS Trust finances to deliver savings and reduce costs.

Clinical Commissioning Group (CCG)
Clinical Commissioning Groups (CCGs) were created following the Health and Social Care Act in 2012, and replaced Primary Care Trusts on the 1st April 2013. CCGs are clinically-led statutory NHS Bodies responsible for the planning and commissioning of healthcare services for their local area.

Clostridium *difficile* (C diff / CDT)
A bacterium that is recognised as the major cause of antibiotic associated colitis and diarrhoea. Mostly affects elderly patients with other underlying diseases.

Colorectal
This is relating to or affecting the colon and the rectum.

Council of Governors
There are three types of Governors: public, staff and partner. The main role of the Governors is to represent the communities the Trust serves and our stakeholders and to champion the Trust and its services. The Council of Governors do not "run" the Trust or get involved in operational issues: that is the job of the Trust Board. It has however, a key role in advising the Board and ultimately holding the Board to account for the decisions it makes.

CPE (Carbapenemase Producing Enterobacteriaceae)
Carbapenem-resistant enterobacteriaceae (CRE) or Carbapenemase-producing Enterobacteriaceae (CPE), are gram-negative bacteria that are nearly resistant to the carbapenem class of antibiotics, considered the "drug of last resort" for such infections. Enterobacteriaceae are common commensals and infectious agents

CQUIN
The Commissioning for Quality and Innovation Payment Framework enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals.

Dermatology
This is the branch of medicine concerned with the diagnosis and treatment of skin disorders.

Diabetes
This is a metabolic disease in which the body's inability to produce any or enough insulin causes elevated levels of glucose in the blood.

Freedom of Information (FOI)
The Freedom of Information Act deals with access to official information and gives individuals or organisations the right to request information from any public authority.

Friends and Family Test
The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. It asks people if they would recommend the services they have used and offers a range of responses

Greater Manchester Devolution
Devolution is the transfer of certain powers and responsibilities from national government to a particular geographical region i.e. Greater Manchester.

Gynaecology
This is the branch of physiology and medicine that deals with the functions and diseases specific to women and girls, especially those affecting the reproductive system.

Health and Social Care Information Centre (HSCIC)
The national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care.

Healthier Together
Healthier Together has been looking at how patients will receive health and care in the future. The Healthier Together programme is a key part of the wider programme for health and social care reform across Greater Manchester. Clinically led by health and social care professionals, the programme aims to provide the best health and care for the people of Greater Manchester.

Healthwatch
Healthwatch is the independent consumer champion that gathers and represents the views of the public about health and social care services in England.

Hospital Standardised Mortality Ratio (HSMR)
This is an important measure that can help support efforts to improve patient safety and quality of care in hospitals. The HSMR compares the actual number of deaths in a hospital with the average patient experience, after adjusting for several factors that may affect in-hospital mortality rates, such as the age, sex, diagnoses and admission status of patients. The ratio provides a starting point to assess mortality rates and identify areas for improvement, which may help to reduce hospital deaths from adverse events.

HSJ
This is Health Service Journal, a national health care publication.

Hyperemesis
This is severe or prolonged vomiting.

IM&T
Information Management and Technology.

Information Governance
Information Governance is a framework for handling information in a confidential and secure manner to appropriate ethical and quality standards.

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Information Technology (IT)
The development, installation and implementation of computer systems and applications.

JAG
The JAG Accreditation Scheme is a patient centred and workforce focused scheme based on the principle of independent assessment against recognised standards. The scheme was developed for all endoscopy services and providers across the UK in the NHS and Independent Sector.

Laparoscopy
Laparoscopy is a surgery that uses a thin, lighted tube put through a cut (incision) in the belly to look at the abdominal organs or the female pelvic organs. Laparoscopy is used to find problems such as cysts, adhesions, fibroids, and infection. Tissue samples can be taken for biopsy through the tube (laparoscope).

LEAN
Lean is an improvement approach to improve flow and eliminate waste that was developed by Toyota. Lean is basically about getting the right things to the right place, at the right time, in the right quantities, while minimising waste and being flexible and open to change.

Legionella
This is the bacterium which causes legionnaires' disease, flourishing in air conditioning and central heating systems.

League of Friends
A voluntary organisation which supports the work of the hospitals in the Trust. The League of Friends is able to provide much needed equipment and comforts for the benefit of patients and staff through the income raised by the work of volunteers.

LUSCS
This is a lower uterine segment caesarean section.

Magnetic Resonance Scanning
This is a medical imaging technique used in radiology to image the anatomy and the physiological processes of the body in both health and disease.

Max Fax
Oral and Maxillofacial Surgery is a specialty that deals with conditions affecting the head and neck.

Mch
The Master of Surgery (Latin: Magister Chirurgiae) is an advanced qualification in surgery.

MDT (Multi-Disciplinary Team)
This is a meeting of a group of professionals from one or more clinical disciplines who together make decisions regarding recommended treatment of individual patients.

Monitor
Monitor is the independent regulator of NHS Foundation Trusts. The organisation was established in January 2004 to authorise and regulate NHS Foundation Trusts. It is independent of central government and directly accountable to Parliament.

There are three main strands to Monitor's work:

- Determining whether NHS Trusts are ready to become NHS Foundation Trusts
- Ensuring that NHS Foundation Trusts comply with the conditions they signed up to and that they are well-led and financially robust
- Supporting NHS Foundation Trust development

Methicillin-resistant Staphylococcus aureus (MRSA)
Staphylococcus aureus (SA) is a common type of bacteria that live harmlessly, as a colonisation, in the nose or on the skin of around 25-30% of people. It is important to remember that MRSA rarely causes problems for fit and healthy people. Many people carry MRSA without knowing it and never experience any ill effects. (These people are said to be colonised with MRSA rather than being infected with it).

In most cases, MRSA only poses a threat when it has the opportunity to get inside the body and cause an infection; this is called a bacteraemia.

MEWS
The modified early warning score (MEWS) is a simple guide used by hospital nursing & medical staff to quickly determine the degree of illness of a patient.

Medicines Safety Thermometer
The medicines safety thermometer is a measurement tool for improvement that focuses on medicine reconciliation, allergy status, medication omission and identifying harm from high risk medicines.

National Reporting and Learning System (NRLS)
The NRLS is a central database of patient safety incident reports.

NHS Foundation Trusts
NHS Foundation Trusts are a key part of the reform programme in the NHS. They are autonomous organisations, free from central Government control. They decide how to improve their services and can retain any surpluses they generate or borrow money to support these investments. They establish strong connections with their local communities; local people can become members and governors. These freedoms mean NHS Foundation Trusts can better shape their healthcare services around local needs and priorities. NHS Foundation Trusts remain providers of healthcare according to core NHS principles: free care, based on need and not ability to pay.

North West Sector Solution
A collaborative approach taken by WWL NHS FT, Salford Royal NHS FT and Bolton NH FT to meet the requirements set out by the Healthier Together programme.

Obstetrics
This is the branch of medicine and surgery concerned with childbirth and the care of women giving birth.

Oncology
This is the study and treatment of tumours.

Ophthalmology
This is the branch of medicine concerned with the study and treatment of disorders and diseases of the eye.

Orthopaedics
The diagnosis and treatment, including surgery, of diseases and disorders of the Musculo-skeletal system, including bones, joints, tendons, ligaments, muscles and nerves.

Paediatrics
This is the branch of medicine dealing with children and their diseases.

PAWS
This stands for Pathology at Wigan and Salford, a joint service between the two Trusts.

PCR (Polymerase Chain Reaction)
The polymerase chain reaction (PCR) is a technology in molecular biology used to amplify a single copy or a few copies of a piece of DNA across several orders of magnitude, generating thousands to millions of copies of a particular DNA sequence

Performance Development Reviews (PDR)
The purpose of a PDR is to review periodically the work, development needs and career aspirations of members of staff in relation to the requirements of their department and the Trust's plans and to take appropriate steps to realise their potential. It facilitates communication, clarity of tasks and responsibilities, recognition of achievements, motivation, training and development to the mutual benefit of employer and employees.

PLACE Assessments
Patient-led Assessments of the Care Environment (PLACE) assessments are undertaken by teams of NHS and private/independent healthcare providers, and include at least 50 percent members of the public. They focus on the environment in which care is provided, as well as supporting non-clinical services such as cleanliness, food, hydration, and the extent to which the provision of care with privacy and dignity is supported.

Pseudomonas
This is a bacterium of a genus that occurs in soil and detritus, including a number that are pathogens of plants or animals.

Radiology
This is the medical speciality that uses radioactive substances in the diagnosis and treatment of disease, especially the use of X-rays.

RCOG
This is the Royal College of Obstetricians and Gynaecologists.

Rheumatology
This is the study of rheumatism, arthritis, and other disorders of the joints, muscles, and ligaments.

Secondary Care
The term secondary care is a service provided by medical specialists who generally do not have first contact with patients, for example, cardiologists, urologists and dermatologists.

Seven Day Services
This is an initiative to make routine hospital services available 7 days a week.

SPR (Specialist Registrar)
A Specialist Registrar or SpR is a doctor who is receiving advanced training in a specialist field of medicine in order eventually to become a consultant.

Summary Hospital-level Mortality Indicator (SHMI)
SHMI is a hospital-level indicator which reports mortality at trust level across the NHS in England using standard and transparent methodology. This indicator is being produced and published quarterly by the Health and Social Care Information Centre.

Ultrasound
This is sound or other vibrations having an ultrasonic frequency, particularly as used in medical imaging.

Urology
The branch of medicine concerned with the study of the anatomy, physiology, and pathology of the urinary tract, with the care of the urinary tract of men and women, and with the care of the male genital tract.

Vascular
This is relating to, affecting, or consisting of a vessel or vessels, especially those that carry blood.

Venous thromboembolism (VTE)
This is the formation of blood clots in the vein. When a clot forms in a deep vein, usually in the leg, it is called a deep vein thrombosis or DVT. If that clot breaks loose and travels to the lungs, it is called a pulmonary embolism or PE.

WWL Wheel
The Strategic framework for the Trust is represented by the WWL wheel, there are 7 strategic aims that are underpinned by the 6 core values contained in the NHS Constitution. Patients are at the centre of the wheel as they are at the heart of everything we do.

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