Wrightington Wigan and Leigh NHS Foundation Trust

Quality Accounts 1 April 2014 – 31 March 2015

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Presented to Parliament pursuant to Schedule 7, paragraph 25(4) of the National Health Service Act 2006

Contents

Welcome to our seventh Quality Account. This document is crucial to Wrightington, Wigan and Leigh NHS Foundation Trust (WWL) as our entire strategy is centred on Quality.

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.

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As with previous Quality Accounts, we have given considerable priority to collecting and reporting facts and data to monitor our progress, and 2014/15 was another year in which we have continued to make good progress at all levels.

Part 1.

Statement from the Chief Executive.

Our vision is to be in the top 10% of everything we do, with a strategy of Safe, Effective and Caring healthcare delivery to achieve this, which is in fact the Darzi definition of quality.

Part 1. Statement from the Chief Executive

Welcome to our seventh Quality Account. This document is crucial to Wrightington, Wigan and Leigh NHS Foundation Trust (WWL) as our entire strategy is centred on Quality.

Our vision is to be in the top 10% of everything we do, with a strategy of Safe, Effective and Caring healthcare delivery to achieve this, which is in fact the Darzi definition of quality. The values and objectives are captured within the now fully organisationally and culturally embedded 'WWL Wheel', and this gives a visual and concise representation of the values based organisation we strive to be.

As an active member of NHS Quest we continue our quest to collaboratively eliminate avoidable harm and drive best practice.

We have had a successful year, culminating in the award of the Health Service Journal (HSJ) Patient Safety award for our nationally recognised Quality Champions project (this in addition to HSJ Awards for Improving Environmental and Social Responsibility and the prestigious Provider Trust of the Year). However, we remain a far from perfect organisation, and our aim is open candour for staff and patients to tell us where we may be going wrong or can do better in order to continue our improving quality trajectory, to become the benchmark for Quality within the NHS and beyond.

As with previous Quality Accounts, we have given considerable priority to collecting and reporting facts and data to monitor our progress. 2014/15 was another year in which we have continued to make good progress at all levels, ranging from nationally published measures such as infection rates down to our monthly report on avoidable serious harms.

On infection control, our number of post 48 hour Methicillin Resistant Staphylococcus Aureus (MRSA) at year end was 1. We also recorded 9 cases of Methicillin Sensitive Staphylococcus Aureus (MSSA) and 17 Ecoli bacteraemia compared to 3 and 25 respectively in 2013/14. The Trust reported 25 cases of Clostridium Difficile against its threshold of 32.

Another key quality measure is Hospital Standardised Mortality Ratio (HSMR). The latest data up to December 2014 reports the Trust HSMR as 96.6. According to Dr Foster, there were 23 less deaths recorded in the Trust's hospitals than were statistically expected over the last 8 months.

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 highlights:

Safe

- We had 11 serious falls in hospital, compared to 26 the previous year.
- There were 0 cases of Ventilator Associated Pneumonia.
- There were no 0 Central Line infections, compared to 1 in the previous year.

Effective

- In year we achieved our performance targets and a Continuity of Services Risk Rating (CSR) of 3.
- We successfully achieved all the national targets for waiting times.

Caring

- Overall 85% of patients taking part in the national survey rated the care delivered by WWL 7+ out of 10, which is an improvement of 5% when compared to the 2013 survey.
- The national patient survey showed that 99% of patients felt that our wards and departments are clean. 96% rated the bathrooms and toilets as clean, which was a 2% improvement on the 2013 score.
- Our national staff survey showed that 80% of staff say that 'care of patients is my organisation's top priority' compared to 71% the previous year.
- It also showed that 78% of staff would 'recommend my organisation as a place to work' compared to 66% who felt this the previous year.
- This year we increased the number of Quality Champions to 259, each being trained in techniques of quality improvement and then taking on leadership of 69 tasks or projects.

The improvements and successes that have happened during 2014/15 do not dilute the fact that the organisation continues to require improvement and recognises that no avoidable patient harm is acceptable. Failures have arisen during the year which have been investigated with the key to embedding the lessons learnt.

The Trust has reported 6 incidents as 'never events' during 2014/15. The incidents were escalated rapidly and reported to Wigan Clinical Commissioning Group, Care Quality Commission and Monitor. Comprehensive Root Cause Analysis investigations were undertaken and action plans have been implemented. One incident remains under investigation. The Trust Board commissioned an external review by Professor Brian Toft OBE, an eminent name in safety. We are implementing a number of actions to address the recommendations in his report.

WWL had four visits from the Care Quality Commission (CQC), between November 2012 and September 2013, three of them unannounced. The first two visits discovered some failings in our medicines management procedures in parts of the hospital. This galvanised a major focused response to tackle the shortcomings that had been found. The final two CQC visits found no further problems and confirmed that we had resolved the earlier issues. The Trust has not been visited by the CQC during 2014/15; however, Wigan Borough Clinical Commissioning Group has undertaken a series of quality visits. Details of these visits are outlined in the Quality Account.

We have one of the best Accident and Emergency departments in the country and for the year to Christmas it was the best performing department in Greater Manchester and second in the whole North West. However, we had a very difficult start to 2015 when our system became overwhelmed for a few weeks and our first quarter performance dipped for the 4-hour standard. We apologise to patients who experienced extensive waiting at that time. However we slowly improved in February and March and were one of just three Trusts in Greater Manchester to achieve the 95% target for Quarter 4.

Like all Trusts in the former NHS North West area, we participate in the Advancing Quality initiative which measures a bundle of quality indicators for Heart Attack, Heart Failure, Hip Replacement, Knee Replacement, Pneumonia and Stroke. We were pleased to score very highly in all of these measures and we won an award for Best Performing Trust at the Advancing Quality Awards. Results from the national staff survey have shown another significant improvement and more details are in the Annual Report.

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. At every level in the organisation, we want strong leaders and managers, 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 'The WWL Way' seem to be making a clear and noticeable difference. It is pleasing to note that we won ten national and regional awards and my congratulations go to the teams in cardiology, respiratory medicine, stroke care, hip and knee replacement, catering, estates, facilities, finance, Human Resources and Midwifery.

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

Rob Forster
Acting Chief Executive


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Part 2.

Priorities for Improvement and Statements of Assurances from the Board.

Part 2.1. Priorities for Improvement in 2015/16

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 year.

The rationale for why these annual improvements have been chosen and how progress will be monitored and reported is described.

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 the 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 outcomes.
- **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

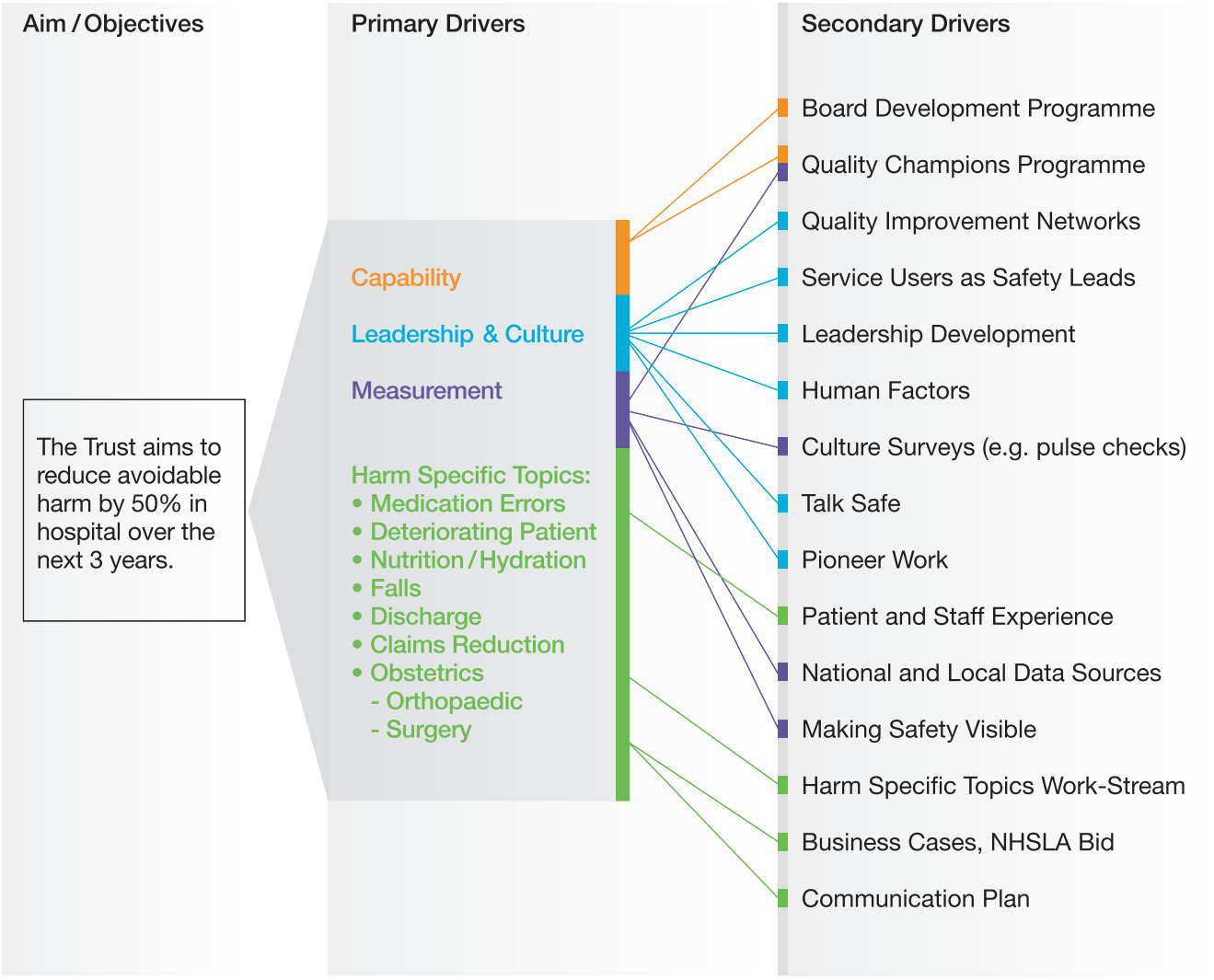
- **To be recognised as the most caring Trust in the country by 2017**
  The Trust aims to be in the top 10% of similar Trusts for patient opinion surveys. The Trust will also identify specific areas of concerns identified by patient feedback for annual improvement and include these priorities in the 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 harm by 50% and save 6000 lives over the 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 about a number of the initiatives included in the plan is described in this Quality Account.



Quality Priorities for 2015/16

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 to 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 quality 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 quality priorities, the rationale for their selection and how the Trust plans to monitor and report progress are outlined opposite:

Safe

Priority 1	To reduce the number of falls by 10%.
Rationale	The Trust is consistently achieving over 98% of harm free care in hospital measured by the safety thermometer. The Trust has 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.
Monitoring	The Harm Free Care Board is responsible for monitoring progress to reduce the number of falls.
Reporting	Harm Free Care Board Trust Board: Monthly Performance Report.

Priority 2	To implement the medicines safety thermometer in all relevant areas.
Rationale	There have been challenges preventing the implementation of the medicines safety thermometer in 2014/15; however, the Trust is committed to continue this rollout and integrate the medicine safety audits undertaken by the Pharmacy Department. Reducing medicine errors is one of the Trust's harm specific focuses in the Sign Up to Safety Improvement Plan.
Monitoring	The Harm Free Care Board is responsible for monitoring implementation progress to roll out the medicines safety thermometer to all relevant inpatient areas.
Reporting	Harm Free Care Board. Medicines Management Strategy Board.

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.
Rationale	The latest data available demonstrates that the Trust's HSMR up to December 2014 is 96.6 and a SHMI from July 2013 to June 2014 is 109.3. In April 2014 the Trust committed to achieving an HSMR of 83 and a SHMI of 100 within three years. A focus for 2015/16 will be to improve SHMI for weekend admissions. For some time there has been an understanding that services in the NHS are less good at the weekend and there have been various reports about this. Lower staffing levels and fewer services being available are evident to anyone who walks through a hospital or visits a General Practitioner (GP) during the course of a weekend. Higher mortality (death) rates over the course of a weekend have been linked with this. The NHS has committed to moving to 7-day working. This is a long term plan. The Trust has increased the numbers of doctors and services available at the weekend. The commitment to changing how healthcare is provided at weekends remains clear but the Trust aims to move to a 7-day service.
Monitoring	The Trust regularly reviews HSMR and SHMI data provided by Dr Foster Intelligence, a provider of healthcare information monitoring the performance of the NHS. The Trust undertakes a weekly review of all deaths and circulates the findings to clinicians and managers.
Reporting	Trust Board: Monthly Board Performance Report. Monthly Team Brief.

Quality Priorities for 2015/16 cont

Effective

Priority 1	To undertake an investigation following all cardiac arrests from admission to event to identify areas for learning.
Rationale	A significant amount of work has been undertaken during 2014/15 but there is more to do and the Trust's work with NHS Quest, a quality improvement network for Foundation Trusts, continues. Management of the deteriorating patient is on the Trust's harm specific focuses in the Sign Up to Safety Improvement Plan. It was also highlighted as a theme in the Trust's annual summary of deaths occurring in hospital.
Monitoring	The Trust is participating in an NHS QUEST project. NHS QUEST support Foundation Trusts to find the ways of improving so that they can provide the best care possible for their patients. Milestones and targets to demonstrate improvement will be established as part of the NHS QUEST project.
Reporting	Deteriorating Patient Group.

Priority 2	To achieve 95% of patients weighed on admission.
Rationale	The latest 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.
Monitoring	Clinical Audits will be undertaken to monitor the progress to achieve this.
Reporting	Nutrition Group.

Priority 3	To review patient discharges that are planned to occur after 8pm to ensure it is safe and appropriate for the patient to be discharged.
Rationale	Discharge is one of the Trust's specific focuses in the Sign Up to Safety Improvement Plan. It is also a theme from incidents, complaints and the Trust's internal inspections. External stakeholders have requested that this remains a focus for the Trust in 2015/16.
Monitoring	A proforma will be completed for discharges after 8p.m. prior to the patient's discharge to review the following: • Confirmation of agreement from patient 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 adequately dressed? • Confirmation the patient has had food/drink/relevant medications before discharge.
Reporting	Discharge Improvement Group.

Priority 4	To complete 10 'Dementia Friendly' ward environments in 2015/16.
Rationale	The inclusion of a priority related to the care of patients with Dementia as proposed at the Trust's Quality and Safety Committee and by stakeholders at an engagement event in February 2015. The Trust's Dementia Strategy was approved by the Trust Board in 2014. To compliment this strategy the Trust has developed a Dementia Friendly Design Strategy in conjunction with the Dementia Strategy Group with includes representatives from Nursing, Governors, Dementia Champions, Communications and Estates and Facilities. The Design Strategy incorporates a range of features which will be incorporated into all of the Trusts inpatient ward areas over the course of the next two years during our annual deep clean programme of works. There are 24 ward areas in total and the Trust plans to complete 10 of these in 2015/16 and the remainder by the end of 2016/17.
Monitoring	Estates and Facilities Reports to the Dementia Strategy Group.
Reporting	Dementia Strategy Group.

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.
Rationale	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 has an information asset register but it requires a significant review.
Monitoring	Monthly report to the Trust's Senior Information Risk Owner (SIRO). Monthly reports to Information Management and Technology (IM&T) Deep Dive.
Reporting	Bi-monthly reports to the Information Governance Committee. Appropriate information to be included in the Information Governance annual return.

Quality Priorities for 2015/16 cont

Caring

Priority 1	To be in the top 10% of Trusts for the Friends and Family Test.
Rationale	This is a corporate objective for 2015/16. The Family and Friends Test initiative was launched in April 2013. The NHS Friends and Family Test asks patients how likely they are to recommend the Trust to friends and family if they needed similar care and treatment. Responses can be collated to produce an overall quality score for Inpatients, Accident and Emergency, and Maternity. External stakeholders have requested that this quality score must be reported with response rates. We have achieved an overall quality score of 97% and also addressed any issues raised to improve the patient experience. Friends and Family Champions support and promote the friends and family cards with patients. The Trust response rates at the end of 2015 were Accident and Emergency 31.76% against a target of 20% and for inpatients 40.63% against a target of 40%.
Monitoring	Performance Report.
Reporting	Trust Board.

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.
Rationale	Patients responding to the Trust's real time patient experience surveys are reporting that they do not always feel involved in decisions about their discharge. In 2014/15 58.7% of patients responding to real time patient experience surveys' reported that they were involved in decisions about their discharge. Improving this experience for patients is a priority for 2015/16.
Monitoring	Real Time Patient Experience Survey; Corporate Clinical Audit Programme 2015/16: Always Event audit undertaken by Lay Auditors.
Reporting	Trust Board: Monthly Performance Report. Engagement Committee.

Priority 3	To achieve 90% of patients reporting that they were aware of which consultant was treating them.
Rationale	Patients responding to the Trust's real time patient experience surveys are reporting that they do not always know who is responsible for their care and treatment. 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. A new welcome pack is being developed for 2015/16 which will include a prompt card giving the name of the Consultant who is responsible for the patient's care.
Monitoring	Real Time Patient Experience Surveys; Corporate Clinical Audit Programme 2015/16: Always Event audit undertaken by Lay Auditors.
Reporting	Trust Board: Monthly Performance Report. Engagement Committee.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Part 2.2.

Statement of Assurances from the Board

The Trust is required to include Statements of Assurances from the Trust Board which are nationally requested to give information to the public. These statements are common across all NHS Quality Accounts.

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Review of Services

During 2014/15 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 2014/15 represents 92% of the total income generated from the provision of relevant health services by the Trust for 2014/15.

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 2014/15, there were 22 National Clinical Audits and 4 National Confidential Enquiries covered relevant health services that the Trust provides. In addition the Trust participated in a further 9 National Audits (Non-NCAPOP) recommended by HQIP.

During that period the Trust participated in 95% National Clinical Audits and 100% National Confidential Enquiries of the National Clinical Audits and National Confidential Enquiries which it was eligible to participate in.

The National Clinical Audits and National Confidential enquiries that the Trust was eligible to participate in during 2014/15 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 2014/15 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.

The reports of 12 of National Clinical Audits were reviewed by the provider in 2014/15 and the Trust intends to take the following actions (see overleaf) to improve the quality of healthcare provided:

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.

Participation in Clinical Audits cont

Clinical Audit	Trust Actions
National Tracheostomy Study	Actions to be agreed.
Lower Limb Amputation	Actions to be agreed.
National Chronic Obstructive Pulmonary Disease (COPD) (Organisational)	The Trust is performing well with the exception of one or two areas where improvements are required. The Respiratory unit is reviewing the actions required to work towards the implementation of a 7 day service.
Prostate Cancer	The report has been reviewed at the Cancer Clinical Conference. Plans are in place to increase amount of data collected to be reviewed monthly.
National Pleural Procedures	The report has been presented at the Medicine Audit Meeting. Results highlighted good practice and areas for improvement. A plural procedure checklist is being developed. Ongoing teaching for trainee doctors and nursing staff on chest drain management is in place.
National Emergency Laparotomy Audit (NELA) (Organisational Questionnaire report)	There are plans to participate in further study reviewing enhanced peri-operative care for high risk patients (EPOCH). An 'emergency laparotomy boarding card' is in development.
National Inflammatory Bowel Disease (IBD) audit	Actions to be agreed.
The Falls and Fragility Fracture Audit Programme (FFFAP)	An information leaflet for patients is in development. The call bells will be replaced to ensure they are within patient reach following each consultation. Trust policy will be reviewed to include a Delirium assessment.
National Neonatal Audit Programme (NNAP)	Changes have been implemented in retinopathy of screening to introduce a revised process for capturing eligible babies with assistance from the Outreach Team. Discussions take place with the Obstetric Team regarding reaching standards for giving antenatal steroids. There are also improvements planned in relation to improving documentation.
National Paediatric Diabetes Audit	The Trust is reviewing the recording of eye screening results and improved recording of foot examination from clinic letters.
National Joint Registry (NJR)	Awareness sessions have been held in speciality audit meetings which have led to further improvements in the completion of NJR forms by clinicians.
Paediatric Asthma	The Trust now delivers a paediatric asthma clinic and an enhanced paediatric nurse led clinic at a designated General Practitioner (GP) Practice. Educational leaflets have been produced which include Asthma Management Plan; Respiratory/Asthma Control Test for Children; How to use blue Aero chamber with mouthpiece and pressured meter dose inhaler; How to use spacer with mouthpiece and pressured meter dose inhaler.

The reports of 263 local clinical audits were reviewed by the provider in 2014/15. 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:

Clinical Audit	Trust Actions
Injuries in Non-Mobile Children	An 'Injuries in Non-Mobile Children Policy' was developed following two serious case reviews (SCR). The Trust undertook an audit of the proforma and implemented amendments to improve its use .
Head Injury for Patients taking Warfarin	Head injury can be a common presentation for patients in Accident and Emergency. Head injury for patients taking warfarin/anticoagulants is can result in a poor outcome. An audit was undertaken to discover whether or not appropriate procedures were delivered and compliant with NICE guidelines. A pro-forma has been introduced for head injury and patient discharge.
Nasogastric Tube Safety	The National Patient Safety Agency (NPSA) reviewed reports of 21 deaths and 79 cases of harm due to feeding into lungs through misplaced nasogastric tubes from September 2005 to March 2010. The primary factor leading to harm was misinterpretation of x-rays. An audit has been undertaken to assess performance on adherence to nasogastric tube safety standards and guidelines. Staff have been encouraged to complete an e-learning module on nasogastric tube x-ray interpretation. Handbooks for trainee doctors including local guidelines on correct placement of nasogastric tubes have been developed. An annual teaching session on correct placement of nasogastric tubes has been included into the FY1/FY2 teaching schedule.
Urinary Catheter Passport Audit	The Urinary Catheter Passport was devised by the Catheter Care Group approximately 18 months ago to improve the documentation for WWL patients with an indwelling catheter. The aim of the passport was to provide the patients with a "Patient Held" document that provided written information on catheter care. This ensures an accurate record can be kept that includes the reason why the catheter was inserted and the plan for when it is to be removed. Staff have been asked to ensure patients are informed to bring their passport to each catheter change. Catheter care e-learning module will emphasise the importance of the passport in the update.
Management of Decompensated Cirrhosis	Over the last 20 years there has been an increase in Chronic Liver Disease (Alcohol/Obesity/Hepatitis B and C), an increase in hospital admissions with complications of liver disease and high mortality rate and cause of premature death. An 2013 NCEPOD report highlighted concerns about suboptimal care of patients in hospital with cirrhosis. Less than half of the patients who died from Alcohol Related Liver Disease received 'good care'. Avoidable deaths were identified. A care bundle for liver patients is now available to staff on the Trust's intranet. It will be publicised to all trainee doctors (via teaching at induction) and senior medical colleagues on the Medical Assessment Unit.

Participation in Clinical Audits cont

Local Clinical Audits cont

Clinical Audit	Trust Actions
Re-admission after Fractured Neck of Femur	The purpose of this audit was to evaluate the reasons for re-admissions following fractured neck of femur and to plan further action to prevent future re-admissions. A new pathway has been introduced and which will be re-audited.
Re-audit of Faecal Specimen Transit Times	A baseline audit was undertaken due to transport delays that were highlighted by the Coroner at two Coroners inquests. Failure to deliver specimens to the laboratory reception was a contributory factor, particularly at weekends and bank holidays. There has been awareness and further education for all staff in relation to delivery of samples in timely fashion. A specimen's log book was instituted at the laboratory reception. Ongoing rapid cycle audits are undertaken demonstrating that there has been a significant fall in rates of delayed samples.
Local Implementation of Sonographic Classification for Thyroid Cancer	An audit was undertaken to assess Trust's performance against British Thyroid Association (BTA) guidelines. Following implementation of a standard reporting proforma (after 1st cycle) improvements were shown to be significant in improving compliance with reporting of U-classification, Lymphadenopathy and nodule composition as well as marginal improvements in most other BTA guidance.
Safe Handover Saves Lives – A Quality Improvement Rapid Cycle Change Model of Audit	Safe handover is an essential pre-requisite for good patient care. Changing patterns of work and full shift rotas have become standard. There is greater cross-over between specialties including both resident and non-resident staff. Improvements include Surgical Division handover shared drive generated with real time updating; access to all doctors of all grades in Ear Nose and Throat (ENT), Urology, Vascular and General Surgery; a designated time and place for handover and education on induction for trainees. Actions taken have shown a vast improvement in the quality of handover.
World Health Organisation (WHO) Surgical Checklist	The WHO surgical checklist must be completed for every patient undergoing a procedure in theatre. Following an audit the electronic completion of the checklist was introduced which has led to a 100% completion rate.

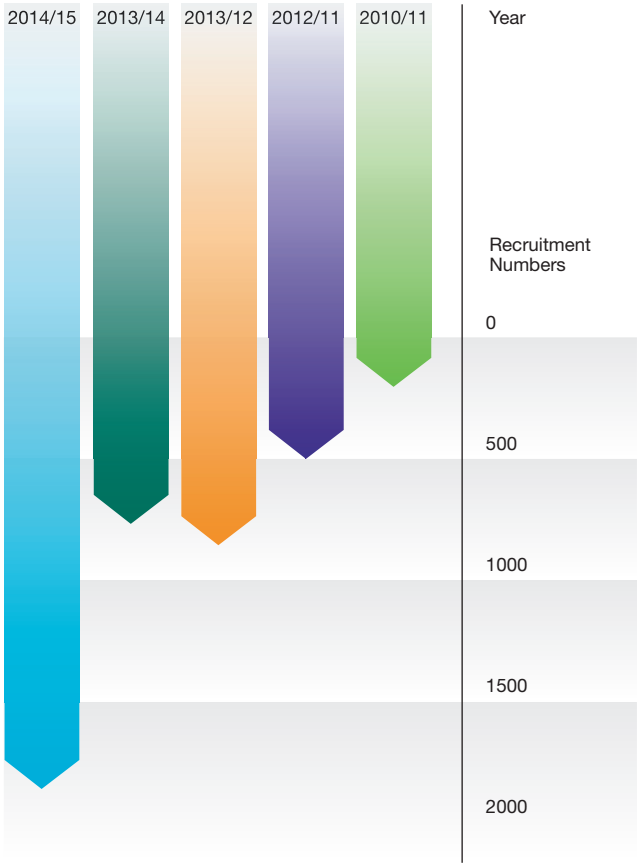
Audit Actions are monitored at monthly audit meetings as well as at Divisional Quality Executive meetings. Actions are signed off as complete (on the audit database) when feedback is relayed back to the audit department by those responsible for implementing the actions.

Research

Participation in Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by the Trust in the 2014/15 that were recruited during that period to participate in research approved by a research ethics committee registered and adopted onto the 'National Institute for Health Research (NIHR) Portfolio' was 2054 an average of 171 patients per month. The graph below demonstrates actual recruitment to research trials over a 5 year period. The Trust has once again exceeded the recruitment target of 480 set by the NIHR for 2014/15.

Comparison of research recruitment to research trials 2010/2015



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.

Research cont

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 keep themselves updated about the latest treatment possibilities and active participation in research leads to successful patient outcomes.

The Trust was involved in conducting 189 clinical research studies in a variety of specialities during the year 2014/15. Our engagement with clinical research demonstrates commitment to rigorous investigation and offering the latest medical treatments and techniques.

The improvement in patient health outcomes in the Trust demonstrates that a commitment to clinical research leads to better outcomes for patients. An exercise in collaboration with Oxford University has taken place to help us understand how meningococcal disease is carried amongst teenagers. Teenagers are at increased risk of meningococcal disease and although the disease can be serious the germ itself is carried in the back of the throat without causing any symptoms in about one in five teenagers. The research will allow us to understand how vaccines can protect people against this disease.

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

This year the Trust has identified Elderly Care and Dementia as an area of interest to further develop its research portfolio.

Training and Development opportunities are provided by the Research Department to support staff in conducting quality research studies in a safe and effective manner.

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.

Goals Agreed With Commissioners

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

A proportion of the Trust's income for 2014/15 was conditional upon achieving quality improvement and innovation goals agreed between Wrightington Wigan and Leigh NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

In 2014/15 the Trust received 445,450,641 in CQUIN funding representing 98.56% of the total available which equates £5,530,008.

The main areas covered by the 2014/15 scheme were:

- The National Friends and Family Test
- Care for patients with dementia and their carers
- Reduction in pressure ulcers
- Reduction in admissions for Chronic Obstructive Pulmonary Disease (COPD)
- Improvements in care for patients with Acute Kidney Injury (AKI)
- Improvements in care for deteriorating patients
- Improvements in care for patients with learning disabilities
- Seven day working
- The new hospital information system

There were also two other schemes for services commissioned by NHS England:

- Review of data collection for screening services (Breast Screening and Diabetic Eye Screening)
- Participation in multidisciplinary team (MDT) arrangements for specialist orthopaedics

With the exception of the national schemes which focused on specific areas (items 1 and 2 in the list above) and scheme 7 which was very specific the CQUINS were designed to reflect areas of priority by the Commissioners (Wigan Borough CCG) and the Trust.

The schemes were also designed (where possible) to promote collaborative working with other providers; the pressure ulcer scheme was particularly effective at this and a multi-disciplinary approach is now taken with the Trust supporting community providers and nursing homes to reduce incidence of pressure ulcers.

A number of the 2014/15 schemes performed particularly well; these included:

- Friends and family test where not only did the Trust achieve all the response rate targets, but also received consistently positive outcomes.
- The dementia scheme which covers both care of patients with dementia but also their carers
- The pressure ulcer reduction scheme
- An improvement in care for patients with acute kidney injury (and prevention)

A number of the schemes will continue during 2015/16 although they will transfer to key performance indicators.

The 2015/16 schemes will cover the following areas:

- Dementia care and training
- Acute kidney injury care
- Sepsis care
- Unscheduled care admission information
- Mortality improvements
- Discharge summary improvements

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 (CQC) and its current registration status, at the end of 2014/15, is registration without compliance conditions.

The Care Quality Commission has not taken enforcement action against the Trust during 2014/15.

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

The Trust's CQC Intelligent Monitoring Report in December 2014 outlined the following risks:

Risk Level	Indicator
Elevated	Never Events Incidence
Elevated	Potential under-reporting of patient safety incidents.
Elevated	In-Hospital Mortality – Vascular conditions and procedures.
Elevated	SSNAP Domain 2: Overall team-centred rating score for key stroke unit indicator.
Elevated	Emergency readmissions with an overnight stay following an emergency admission (November 12 – October 13).

The CQC Intelligent Monitoring Tool is utilised by compliance inspectors to identify areas of care that require further investigation and assists them to determine their programme of inspection. The Trust has implemented actions to address the above risks.

All NHS Trusts are required to register with the Care Quality Commission. The CQC undertakes checks to ensure that Trusts are meeting the Essential 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 2014/15 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

Which included the patient's valid NHS number was:

- 99.8% for admitted patient care;
- 99.9% for outpatient care; and
- 99.0% for accident and emergency care.

Which included the patient's 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.

Information Governance Toolkit Attainment Levels

The Trust's Information Governance Assessment Report overall score for 2014/15 was 87% and was graded a satisfactory submission.

Clinical Coding Error Rate

The Trust was not subject to a Payment by Results clinical coding audit during 2014/15 by the Audit Commission. However the Trust did undertake an Internal Audit for the purpose of the Information Governance Toolkit, the error rates reported for that period for diagnoses and treatment coding (clinical coding) were:

- Primary Diagnosis incorrect 3.5%
- Secondary Diagnoses incorrect 1.88%
- Primary Procedures Incorrect 3%
- Secondary Procedures Incorrect 5.93%

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 maintained and it governs the audit plan to ensure data is accurate, complete and is obtained from a reliable source. The data quality audits recommend a data quality kite mark rating which provides assurance in terms of accuracy of information. 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 to ensure that the data has been submitted by responsible data owners, that the data source is credible and that the data quality is accurate.

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 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.

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, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review.

Part 2.3.

Reporting Against Core Indicators

Since 2012/13 NHS Foundation Trusts have been 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).

Part 2.3. Reporting against core indicators

Since 2012/13 NHS Foundation Trusts have been 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 indictor the number, percentage, value, score or rate (as applicable) for at least the last two reporting periods is presented in the table overleaf.

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.

Reporting against core indicators cont

Mortality

Indicator	Reporting Periods	Trust Performance	National Average	Benchmarking
(a) The value and banding of the summary hospital-level mortality indicator ("SHMI") for the Trust for the reporting period; and	April 2013 to March 2014	Value 1.0770 Banding 2	Value 1.0001	Best: The Whittington Hospital NHS Foundation Trust (RKE): Value 0.5390 Banding 3 Worst: Blackpool Teaching Hospitals NHS Foundation Trust (RXL): Value 1.1970 Banding 1
	July 2013 to June 2014	Value 1.0932 Banding 2	Value 0.9983	Best: The Whittington Hospital NHS Foundation Trust (RKE): Value: 0.5407 Banding 3 Worst: Medway NHS Foundation Trust (RPA): Value 1.1982 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 2013 to March 2014	23.2%	23.6	Best: The Whittington Hospital NHS Foundation Trust (RKE): 0% Worst: Salford Hospitals NHS Foundation Trust (RM3): 48.5%
	July 2013 to June 2014	25.0%	24.6%	Best: The Whittington Hospitals NHS Foundation Trust (RKE): 0% Worst: Salford Hospitals NHS Foundation Trust (RM3): 29.00%

Assurance Statement

The Trust considers that this data is as described for the following reasons: The mortality data for the Trust benchmarks less positively for SHMI than HSMR. The Trust intends to take the following actions to improve these indicators and, so the quality of its services, by:

The Trust continually strives to improve mortality relates and this is reflected by the inclusion to improve mortality in the Trust's quality priorities for 2015/6 outlined in part 2.1 of the Quality Account.

Reporting against core indicators cont

Patient Reported Outcome Measures Scores

Indicator	Reporting Periods	Trust Performance	National Average	Benchmarking
The Trust's patient reported outcome measures scores during the reporting period for (i) groin hernia surgery.	April 2012 to March 2013	0.054	0.085	Best: BMI – The Foscote Hospital (NT415): 0.157 Worst: Boston West Hospital (NVC27): 0.015
	April 2013 to April 2014	0.100	0.085	Best: The Foscote Hospital (NT415): 0.139 Worst: North Downs Hospital (NVC11): 0.008
The Trust's patient reported outcome measures scores during the reporting period for (ii) varicose vein surgery.	April 2012 to March 2013	n/a	0.093	Best: Doncaster & Bassetlaw Hospitals NHS Foundation Trust (RP5): 0.175 Worst: The Kings College Hospital NHS Foundation Trust (RJZ): 0.023
	April 2013 to April 2014	n/a	0.093	Best: Wye Valley NHS (RLQ): 0.15 Worst: Imperial College Healthcare NHS Trust (RYJ): 0.02

Patient Reported Outcome Measures Scores cont

Indicator	Reporting Periods	Trust Performance	National Average	Benchmarking
The Trust's patient reported outcome measures scores during the reporting period for (iii) hip replacement surgery.	April 2012 to March 2013	0.440	0.438	Best: Oaks Hospital (NVC13): 0.543 Worst: The Whittington Hospital NHS Foundation Trust (RKE): 0.319
	April 2013 to April 2014	0.439	0.436	Best: BMI – The Park Hospital (NT427): 0.545 Worst: Royal Liverpool and Broadgreen University Hospitals NHS Trust (RQ6): 0.342
The Trust's patient reported outcome measures scores during the reporting period for (iv) knee replacement surgery.	April 2012 to March 2013	0.319	0.319	Best: Spire Fylde Coast Hospital (NT347): 0.409 Worst: West Middlesex University Hospital NHS Trust (RFW): 0.195
	April 2013 to April 2014	0.309	0.323	Best: Nuffield Health, Cambridge Hospital (NT209): 0.416 Worst: Homerton University Hospital NHS Foundation Trust (RQX): 0.215

Assurance Statement

The Trust considers that this data is as described for the following reason: 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, so the quality of its services, by: The data collection process within the pre-operative assessment clinics has been realigned to increase participation rates.

Hospital Readmission

Indicator	Reporting Periods	Trust Performance	National Average	Benchmarking
The percentage of patients readmitted to a hospital which forms part of the trust within 28 days of being discharged from hospital which forms part of the Trust during the reporting period: aged 0-15.	April 2010 to 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 to April 2012	7.95	10.23	Best: Epsom & St Helier University Hospitals NHS Trust (RVR): 6.4 Worst: Royal Wolverhampton Hospitals NHS Trust (RL4): 14.95
The percentage of patients readmitted to a hospital which forms part of the trust within 28 days of being discharged from hospital which forms part of the Trust during the reporting period: aged 16 or over.	April 2010 to 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 to April 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 numerous 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 other 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 2013/14 was 6.51%. For 2014/15 it is 6.49%.

Responsiveness to Personal Needs

Indicator	Reporting Periods	Trust Performance	National Average	Benchmarking
The Trust's responsiveness to the personal needs of its patients during the reporting period.	National Inpatient Survey 2012-2013	75.9	76.5	Best: Queen Victoria Hospital NHS Foundation Trust (RPC): 88.2 Worst: Croydon Health Services NHS Trust (RJ6): 68.0
	National Inpatient Survey 2013-2014	75.5	76.9	Best: The Royal Marsden NHS Foundation Trust (RPY): 87 Worst: Croydon Health Services NHS Trust (RJ6): 67.1

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: White boards behind the patients beds with information regarding 'Expected date of Discharge' and the name of the consultant treating them; new patient admission packs are being trialled and the Always Events in particular are continuing to be embedded across the organisation.

Friends and Family Test (Staff)

Indicator	Reporting Periods	Trust Performance	National Average	Benchmarking
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 2013	64.91%	64.50%	Best: Salford Royal NHS Foundation Trust (RM3): 88.51% Worst: Mid Yorkshire Hospitals NHS Trust (RXF): 39.57%
	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%

Assurance Statement

The Trust considers that this data is as described for the following reasons: In the 2014 Staff Survey 78% of staff would recommend the Trust as a provider of care to their friends and family. This places the Trust significantly above average compared with other Acute Trusts (65%). We have also seen an improvement from the 2013 results when we scored 64.91%.

The Trust intends to take the following actions to improve this percentage and, so the quality of its services, by: The Trust welcomes this positive feedback from staff and we hope to see further improvements in our 2015 score through our ongoing staff engagement programme outlined in the ‘Quality Initiatives’ section.

Venus Thomboembolism

Indicator	Reporting Periods	Trust Performance	National Average	Benchmarking
The percentage of patients who were admitted to hospital and who were risk assessed for venus thromboembolism during the reporting period.	October 2013 – December 2013	96.75%	95.77%	Best: Bridgewater Community Healthcare NHS Foundation Trust (RY2), Queen Victoria Hospital NHS Foundation Trust (RPC), Royal National Hospital for Rheumatic Diseases NHS Foundation Trust (RBB) and South Essex Partnership University NHS Foundation Trust (RWN): 100% Worst: North Cumbria University Hospitals NHS Trust (RNL): 77.70%

Venus Thomboembolism cont

Indicator	Reporting Periods	Trust Performance	National Average	Benchmarking
The percentage of patients who were admitted to hospital and who were risk assessed for venus thromboembolism during the reporting period.	October 2014 – December 2014	96.00%	96.00%	Best: 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%

Assurance Statement

The Trust considers that this data is as described for the following reasons: The Trust has performed in line with the national average. The Trust has taken the following actions to improve this percentage and so the quality of its services by: improving the reporting processes to evidence completion of a risk assessment. Root Cause Analysis is undertaken for all patients who develop a Venus Thomboembolism in hospital.

Clostridium Difficile (C. Difficile)

Indicator	Reporting Periods	Trust Performance	National Average	Benchmarking
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 2012 – March 2013	23.4	17.3	Best: Alder Hey Children's (RBS), Birmingham Women's (RLU), Liverpool Women's (REP), Moorfields Eye Hospital (RP6) & Queen Victoria Hospital (RPC): 0.00 Worst: North Tees & Hartlepool (RVW): 30.8
	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

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 to not only 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 so the quality of services by: The Trust will continue efforts to coordinate appropriate patient discharge and continued operational throughput to prevent to prevent healthcare acquired infection such as C.Difficile.

Patient Safety Incidents

Indicator	Reporting Periods	Trust Performance	National Average	Benchmarking
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.	Oct 2013 – March 2014	Incidents Reported 1048 (Rate per 1000 Bed days 13.8) / 22 Serious Incidents (2%)	550,463 Incidents Reported / 2978 Serious Incidents (0.5%)	Best: Dorset County Hospitals NHS Foundation Trust (RBD): 301 Incidents Reported (Rate per 1000 bed days 5.8) / 0 Serious Incidents (0%) Worst: Lewisham and Greenwich NHS Trust (RJ2): 4915 Incidents Reported (Rate per 1000 bed days 31.5) / 17 Serious Incidents (0.3%)
	April 2014 – Sept 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 Health-care NHS Foundation Trust (RBZ) Incidents Reported 3795 (Rate per 1000 bed days 74.96)/55 Serious Incidents (1.4%)

Assurance Statement

The Trust considers that this data is as described for the following reasons: During 2014-15 the Trust had a Care Quality Commission elevated red risk for the 'potential under-reporting of patient safety incidents' reported to the National Learning and Reporting System. The Trust has had a reasonably low rate of incidents resulting in severe harm or death, however, it has recognised that actions were required to increase reporting rates for patient safety incidents. These actions taken have reflected in the improvement in number of incidents reported per 100 bed days from 13.8 for October 2013 - March 2014 to 35.11 for April 2014 to September 2014.

The Trust intends to take the following actions to improve these indicators: Despite the relatively low rate of incidents resulting in severe harm or death, the Trust strives to continue to improve the Trust's benchmarked position by communicating the importance of incident reporting and understanding barriers to reporting incidents and near misses.

The Trust has reviewed the process for uploading incidents to the National Reporting and Learning System and visited Stockport NHS Foundation Trust who benchmark well against other NHS Organisations.

Part 3.

Other Information

Part 3.1. Review of Quality Performance

The Trust had a successful year at the Health Service Journal (HSJ) awards winning a Patient Safety Award for our nationally recognised Quality Champions project in addition to the HJS awards for Improving Environmental and Social Responsibility and the prestigious Provider Trust of the Year.

This section of the Quality Account provides information on the Trust's quality performance during 2014/15. Performance against the priorities identified in the Trust's previous quality account and performance against the relevant indicators and performance thresholds set out in Monitors Risk Assessment Framework are outlined. The Trust has introduced a number of initiatives to strengthen quality governance systems. An update on progress to embed these initiatives is also included in this section.

Performance against priorities identified for improvement in 2014/15

The Trust agreed a number of priorities for improvement in 2014/15 that were 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 attain and maintain 98% of inpatients experiencing harm free care in hospital.
Where we were in 2013/14	95% of our patients did not experience harm in hospital (new harms) from falls, blood clots, pressure ulcers or urine infections (for patients with a urinary catheter in place). The Trust aim for 2014/15 was to move towards 98% of patients experiencing harm free care in hospital.
Where we are at the end of 2014/15	The Trust has sustained 98% harm free care. The median is 99.32% of patients experiencing harm free care whilst an inpatient.

Priority 2	To reach an HSMR (Hospital Standardised Mortality Ratio) of no more than 87 before rebasing and Summary Hospital-Level Mortality Indicator (SHMI) of no more than 100.
Where we were in 2013/14	Data for the calendar year 2013 for HSMR was 100.58. SHMI for time period was 110.92.
Where we are at the end of 2014/15	The latest data available demonstrates that the Trust's HSMR up to December 2014 is 96.6 and SHMI from July 2013 to June 2014 is 109.3. During the year there were some alterations in HSMR calculation with Dr Foster moving from HIS (Health Information Statistics) data to HES (Hospital Episode Statistics) data. This was widely trialled but had little practical effect. Despite 23 less deaths recorded in the Trust's hospitals than were statistically expected over the last 8 months SHMI is at a disappointing 109.3. SHMI data is behind the HSMR data and the actual deaths with regards to time period.

Priority 3	To implement the medicines safety thermometer to all relevant inpatient areas.
Where we were in 2013/14	A pilot of the Medicines Safety Thermometer had commenced on ten wards and the Trust planned to roll this out across the Trust during 2014/15.
Where we are at the end of 2014/15	The Medicines Safety Thermometer is now embedded on the 10 pilot wards. There have been technical challenges with implementing the Medicines Safety Thermometer to all relevant inpatient areas. These challenged have now been resolved. 'Haelo', an Innovation and Improvement Science Centre, based in Salford and owned by Salford partners, including Salford NHS Foundation Trust have led the pilot. 'Haelo' are in discussion with the Trust regarding how to integrate the point prevalence medicines 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 data collection and has been used successfully to demonstrate improvement in medicines management practice.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Effective

Priority 1	To improve the management of the deteriorating patient with a focus on sepsis and cardiac arrest.
Where we were in 2013/14	A group of staff had been identified to work with NHS Quest on the deteriorating patients work stream. On-call handover work had commenced with the Critical Care Outreach Team (CCOT), a consultant lead and junior doctors. A new Modified Early Warning System (MEWS) chart was introduced and fluid input/output booklets had been embedded in practice. High flow oxygen machines for ward use, led and supported by CCOT were introduced. A Commissioning for Innovation and Improvement target (CQUIN) for Sepsis training was achieved.
Where we are at the end of 2014/15	Following the NHS Quest Launch event Cardiac Arrest data was reviewed using coding to establish our cardiac arrest baseline. This was cross referenced with the resuscitation data and fed back at the Trust's inaugural Quest meeting. From this three wards were identified to roll out NHS Quest improvement work. If successful, this work will be rolled out Trust wide. A further ward has since been added. The focus of our work has included huddles, handover, sick patient alerts (on white boards) and effective ward round/patient review On-call Medical Handover has improved immensely. The Consultant of the day leads the handover from night staff to day staff with the on-coming Registrar. All members of the team are to attend the meeting, including the Critical Care Outreach Team (CCOT) and bed managers. Cardiac arrest team roles are allocated so everyone is aware of their station at the arrest. An attendance and allocation list is kept and the consultants ensure the juniors attend. Duties are allocated and concerns are managed. A poster with improvement data has been submitted and accepted at the National Acute Care Physician Conference.CCOT continue to collect attendance records. Langtree Ward has changed handover to include MEWS scores on handover, therefore identifying the sickest patients requiring action. Lowton ward has commenced whiteboard huddles at various intervals over the day to identify and update on the sickest patients and action any outstanding tasks. Aspull Ward is initiating set ward rounds to allow better attendance by shift leader and improve communication and patient flow. On Shevington Ward work was initiated by a Trainee Doctor in relation to a 'job book' to improve communication and track actions. This 'job book' documented any procedures, investigation, referrals etc. that needed following up. Following a change in placement this initiative will be re- launched.

Where we are at the end of 2014/15	Compliance with MEWS requirements is audited monthly. This is a spot audit of 10 patients. 489 staff have received acute illness management training which includes MEWS, Sepsis and Competency Observations (Cobs) up to end of December 2014. Additionally 149 staff have been trained in Acute Kidney Injury. A Sepsis Nurse is in post and focusing on early recognition and management. This nurse audits compliance with screening requirements and adherence to Sepsis 6. Bespoke sepsis sessions are provided to raise awareness. Accident and Emergency have identified one of the Advanced Practitioners to take the sepsis pathway forward. It has been agreed at the Trust meeting to undertake a rapid review following all cardiac arrests from admission to event to identify areas for learning.
Priority 2	To prevent unacceptable levels of unplanned weight loss for inpatients
Where we were in 2013/14	A recurrent theme from incidents, complaints and claims has been unplanned weight loss in hospital. It was decided to implement a strategy to increase staff's awareness of unintended weight loss. Audits identified that patients are not weighed consistently on admission and during their admission. The aim was to ensure that 95% of patients are weighed on admission; this will allow us to understand whether the patient has suffered any weight loss whilst an inpatient.
Where we are at the end of 2014/15	Audits in July 2013 and November 2013 demonstrated just over 50% compliance with the weighing of patients on admission. A further audit in September 2014 in the Division of Medicine demonstrates improvement from 50% to 70% compliance with weighing patients on admission. Staff education was identified as a theme for improving nutrition and hydration for inpatients. A staff Development Day held in May 2014 included 'The Hidden Harm' presentation - unintentional significant weight loss presentation, workshop and lunchtime stall. Themes and barriers were identified at this event and these have been actioned in the appropriate divisions and departments. Further nutrition and hydration study days have been well attended. 230 staff across the organisation have attended the study days across different disciplines. Snacks are available at all times on the wards, finger foods have been implemented on Standish Ward to encourage patients with dementia to eat. Always Events promote that food and drinks are available and hourly rounding checks ensure that patients are comfortable and their needs are addressed including nutrition and hydration. Work is continuing in achieving 95% of patients being weighed on admission. There have been difficulties with weighing patients who are immobile as they require a weighing bed and there is not always a weighing bed available. As beds are replaced more weighing beds are being purchased. All wards have now got appropriate scales to weigh patients. The nutrition and hydration group are addressing the issues preventing patients being weighed 95% of the time on admission.

Effective cont

Priority 3	100% of patients to receive an expected date of discharge.
Where we were in 2013/14	In November 2013 a baseline audit was undertaken prior to the introduction of the Trust's Always Events. 45% of patients reported that they had received an expected date of discharge. 48% of staff reported that they had provided the patient with an expected date of discharge. This priority excludes patients receiving day surgery procedures.
Where we are at the end of 2014/15	An Always Events Audit Report in September 2014 outlined that an average of 61% of patients over 17 weeks stated that they had been given an expected date of discharge. An average of 85% of staff over 11 weeks stated that they informed patients on admission what their expected date of discharge is and what it means. The Trust purchased new quality boards for all wards. From the 29th September 2014 the new Matron check list commenced which incorporates confirmation of expected date of discharge for all patients. An Always Audit Report in February 2015 outlined an average of 73.16 of patients over 9 weeks stated that they had been given an expected date of discharge. An average of 94% of staff over 9 weeks stated that they informed patients on admission what their expected date of discharge is and what it means. The last weekly audit undertaken demonstrated 100% for patients and staff.

Priority 4	To improve patient clinical outcomes for planned treatments
Where we were in 2013/14	All NHS patients having hip or knee replacements, varicose vein surgery, or groin hernia surgery are invited to fill in PROMs (Patient Reported Outcome Measures) questionnaires. Patients are asked about their health and quality of life before they have an operation, and about their health and the effectiveness of the operation afterwards. This helps the Trust to measure and improve the quality of its care. The participation rate of completed PROMs questionnaires in the preoperative assessment clinic for patients listed for a hip replacement was 81%. For patients who were listed for a knee replacement, the participation rate for completed PROMs questionnaires was 84%. There is only data available for quarters 3 and 4 for the participation rate of patients completing a groin hernia PROMs questionnaire in the pre-operative assessment clinic. The participation rate was 69%. Advancing Quality aims to give patients a better experience of the NHS by making sure every patient admitted to a North West hospital is given the same high standard of care. The Trust aims to be in the top 10% for PROMs and Advancing Quality Scores. Advancing Quality works with clinicians to provide NHS Trusts with a set of quality standards which define and measure good clinical practice. Compliance against those standards is measured. The Trust participation focuses on the following areas: heart attack, heart failure, hip and knee surgery, pneumonia and stroke

Where we are at the end of 2014/15	From April 2014 to January 2015 the participation rate of completed PROMs questionnaires in the preoperative assessment clinic for patients listed for a hip replacement is 93% (81% in 2013-14). For patients who were listed for a knee replacement, the participation rate for completed PROMs questionnaires is 93% (84% in 2013/14). The participation of patients completing the groin hernia repair PROMs questionnaire rate is 73% (69% in 2013-14). The participation rate of completed PROMs questionnaires in the preoperative assessment clinic for patients listed for a hip replacement is 93%. Patients who were listed for a knee replacement, the participation rate for completed PROMs questionnaires is 93%. The participation of patients completing the groin hernia repair PROMs questionnaire rate is 73%. There are 22 Acute Trusts participating in AQ. Last year we won awards for being first in Heart Failure, and third in Acute Myocardial Infarction (AMI) and Pneumonia. Although pneumonia is below threshold, due to calculations undertaken by AQ, this threshold calculated by AQ is higher than that of all other Trusts. The 'Appropriate Care Score' for pneumonia in December 2014 was 93.33%. Hip and knee continues to perform well against threshold. AQ was the driver behind the promotion of smoking cessation in the medical divisions. Ascertaining smoking status and offering help is now an increasing part of the admission process. This is reflected in an increasing number of referrals to the smoking cessation team.

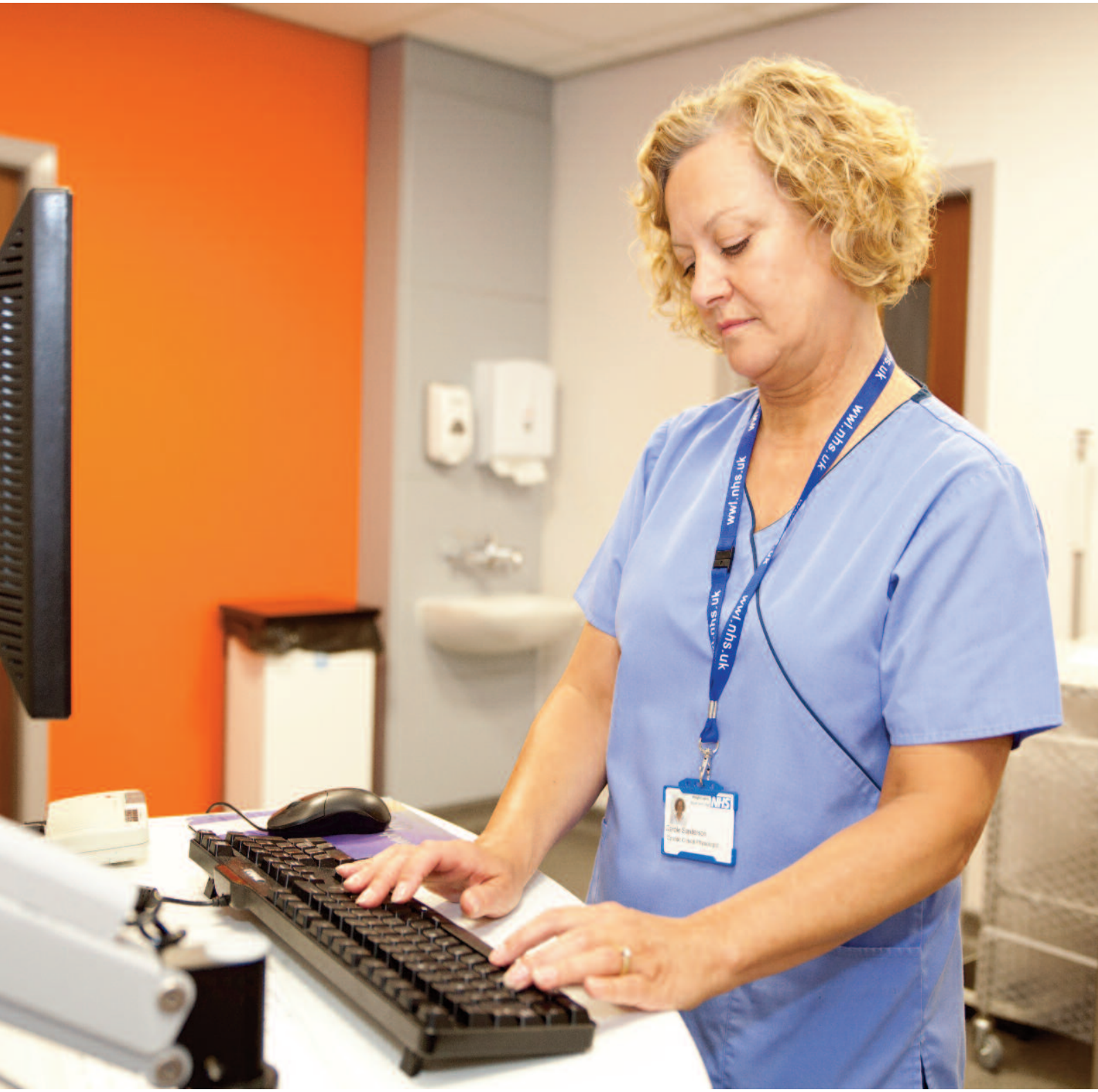
Where we are at the end of 2014/15	Stroke performance should improve over the coming months as more patients are taken directly to Manchester by ambulance. Admission to a stroke unit within four hours is a significant challenge. The last external audit was in February 2015. The Trust awaits the written report, but the verbal feedback was positive. There were no major discrepancies in data quality, just two minor ones for stroke and one for hip and knee.

Caring

Priority 1	To be in the top 10% of Trusts for patient opinion surveys
Where we were in 2013/14	The Trust Board aimed for the Trust to be recognised as the most caring Trust in the country. Patient feedback is a crucial indicator of whether the Trust is progressing towards achieving this. The Trust did not report on whether it had been successful in achieving the top 10% of Trusts for patient feedback.
Where we are at the end of 2014/15	The Care Quality Commission (CQC) National Survey 2013 results published on the CQC website in April 2014 demonstrated that overall view of inpatient services (patients feeling they had a good experience) was rated as 8/10 and the highest scoring trust received a score of 9/10. The Trust is rated 'average' against all other trusts and not in the top 20%. Overall views and experiences including respect and dignity, views on quality of care, overall view of inpatient services and provision of complaints information scored 5.3/10 again rated as 'average'. The Accident and Emergency Department scored 9/10 rated as 'above average'. The CQC National Survey 2014 results are due for publication shortly. The Trust performs well for the Friends and Family Test Quality Score but not so well for response rate. The Trust commissioned Picker Institute Europe to undertake the 2014 national Inpatient Survey. In February 2015 Picker published a report comparing the results of 78 Trusts who commissioned the organisation to undertake the inpatient survey. The report highlighted that 85% of patients rated our care 7+ out of 10 compared to 80% in 2013 and 78% in 2012. The Inpatient Survey 2014 results are due to be published on the Care Quality Commission website on the 21st May 2015.

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 2013/14	Patients responding to the Trust's real time patient surveys were reporting that they do not always feel involved in decisions about their discharge. In 2013/14 57.4% of patients responding to real time patient experience surveys, reported that they were involved in decisions about their discharge.
Where we are at the end of 2014/15	In 2014/15 on average 58.7% of patients responding to real time patient experience survey, reported that they were involved as much as they wanted to be in decisions about their discharge. This remains a priority for the Trust to address in 2015/16.

Priority 3	To achieve 90% of patients reporting that they were aware of which consultant was treating them.
Where we were in 2013/14	Patients responding to the Trust's real time patient surveys were reporting that they do not always know who is responsible for their care and treatment. From August 2013 to March 2014 74.6% of patients responding to real time patient experience surveys reported that they knew which consultant was currently treating them.
Where we are at the end of 2014/15	During the year 2014/15, on average 77.15% of patients reported that they were aware if which consultant was treating them. We have seen a steady improvement in this score achieved in 2014/15 as a result of the focus of the "Always Events".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Performance against the relevant indicators and performance thresholds set out in Monitor's Risk Assessment Framework

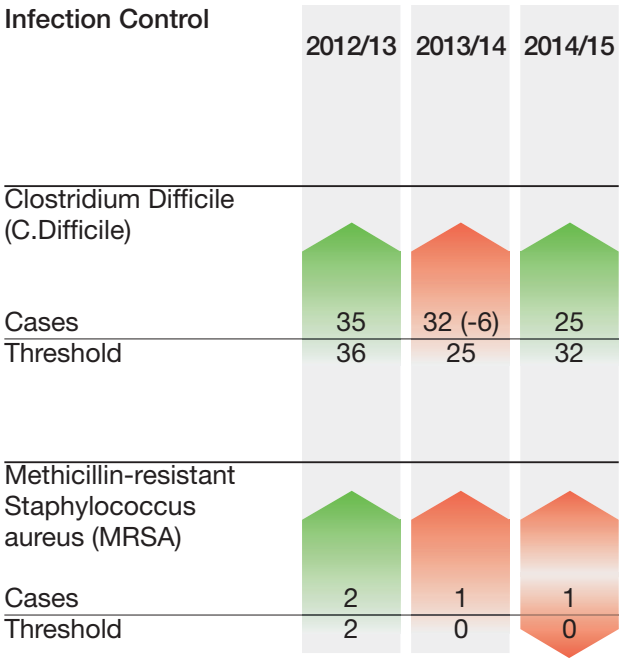
The Trust selected a number of key indicators monitored under its strategy to be safe, effective and caring for the last three years and reported to the Trust Board within the monthly performance reports. These indicators include those set out in Monitor's Risk Assessment Framework.

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

The Trust trajectory for C.Difficile 2014/15 was agreed by the Department of Health at 32. To date the Trust has identified 25 cases of C.Difficile Infection. A Total Health Economy Root Cause Analysis (RCA) was performed for each individual case of C.Difficile Infection to identify any learning that may prevent any future infections. Following the individual RCA investigations, three lapses in care were identified which needed remedial action. One related to prompt isolation, one related to the prescription of an antibiotic course of medication that was not on the formulary and one was due to an asymptomatic carrier. The Trust has introduced corrective measure to address the lapses in care of which are within Trust control.

MRSA: The Trust has identified one MRSA bacteraemia post-48 hours from admission. This was classed as unavoidable, due to the nature of the patient's condition. The CCG reassigned one further case of MRSA bacteraemia as community contributable due to the infection incubation period.

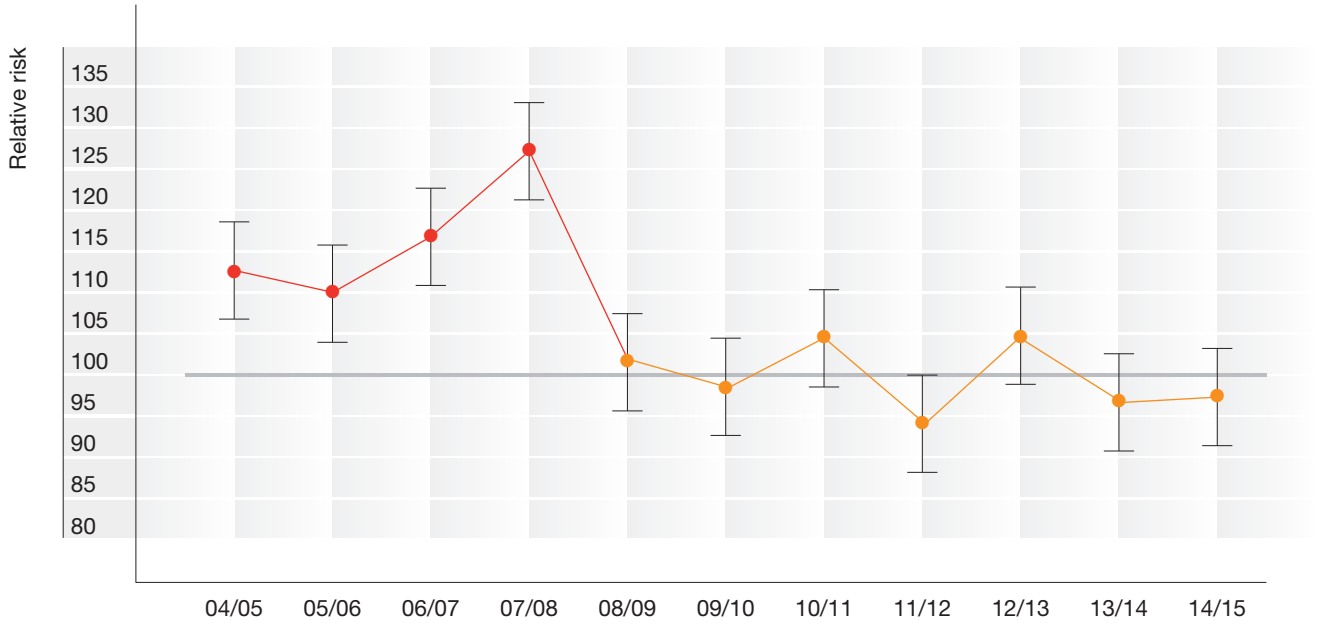


Data Source:
National Health Protection Agency data collection, as governed by standard national definitions.

- On or above target
- Below trajectory; robust recovery plan required
- Failed target or significant risk of failure

- Improved position
- Worsening position
- Steady position

Hospital Standardised Mortality Ratios (HSMR)



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

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 actively die.

- high relative risk
- low relative risk
- expected range
- national benchmark
- confindence intervals

Never Events

There have been 6 incidents reported as never events during 2014/15. The incidents were escalated rapidly and reported to Wigan Clinical Commissioning Group, Care Quality Commission and Monitor. Comprehensive Root Cause Analysis investigations were undertaken and action plans have been implemented. One incident remains under investigation. The six incidents reported as Never Events during 2014/15 related to retained foreign objects and wrong site surgery.

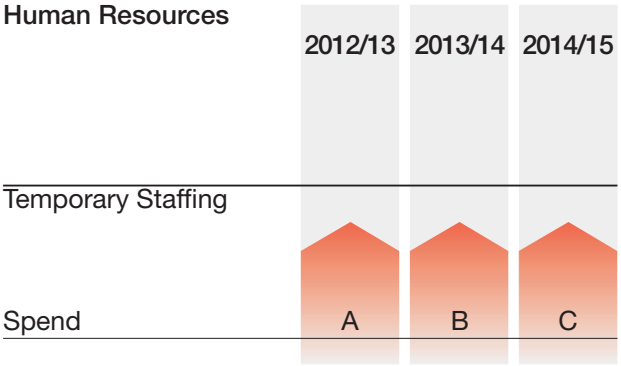
The Trust Board commissioned an external review of five of the incidents reported as never events that have occurred at the Trust since 2012. This review was undertaken by Professor Brian Toft, OBE, BA (Hons), Dip Comp Sci (Cantab), LLM, PhD, ICDDS Dipl, FIIRSM, Hon FICPEM, FRSA; Principal, Risk Partnerships; Professor Emeritus of Patient Safety Coventry University; Professor of Patient Safety Brighton and Sussex Medical School.

Professor Brian Toft's Executive Summary was as follows:

> The starting point for the Trust and Reviewer is that patient safety is paramount. As a result, as issues have come to light during the review the Trust have started to put in place the necessary processes to support the recommendations made by the author of this report.
>
> Five patients who attended Wrightington, Wigan and Leigh NHS Foundation Trust (Trust) for their health-care needs between 19th December 2012 and 29th August 2014 unintentionally suffered serious adverse incidents (SUI) later classified by the Trust as 'Never Events'. Although remedial actions were taken quickly following each of the 'Never Events' it became a matter of concern to the senior management of the Trust that such serious untoward incidents had continued to occur. Therefore Dr Umesh Prabhu, Medical Director of the Trust, decided to commission this External Review of the Root Cause Analysis Investigation Reports produced following those SUI's to ascertain if any additional lessons might be drawn.
>
> For an SUI to be characterised as a 'Never Event' national guidance or national safety recommendations must have been published, which if implemented, would have prevented the serious adverse incident from taking place. Or, putting it another way, a serious untoward incident can only be classed as a 'Never Event' where the national guidance or safety recommendations issued have not been implemented by Trust concerned and that is the reason for the SUI occurring.
>
> Therefore as no national guidance or safety recommendations have been published with respect to the circumstances surrounding two of the SUI's at the Trust they should not have been classified as 'Never Events.
>
> While the circumstances surrounding a third SUI were misinterpreted by the investigators as meeting the criteria and definition of a 'Never Event' when they did not. Hence only two of the five SUI's which occurred at the Trust should have been categorised as 'Never Events'.
>
> In addition, this External Review has not found any evidence to suggest that a patient safety problem exists within the Trusts Operating Theatre complexes. However, where there appears to be room for improvement recommendations have been in those respects. Recommendations have also been formulated for consideration by NHS England.
>
> Finally it should be noted that Systems Theory and human fallibility predict that in an open sociotechnical system, such as healthcare, regardless of what precautions are taken there is always the possibility that a serious untoward incident could occur. Thus, when implemented, the recommendations made in this report, will help to reduce the risk of patients experiencing serious untoward incidents. However, what they cannot do is guarantee that such events will not recur.
>
> The Trust is implementing a number of actions to address the recommendations outlined in Professor Toft's report. These actions include the revision of the Trust's Surgical Count Policy and a review of the training provided to staff undertaking investigations.

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

Human Resources



A - £12,190,316
B - £12,300,719
C - £14,178,009

Spend on temporary staff in 2014/15 was £14,178,009 which is £1,877,290 over the prior year. During 2014/15 the highest Divisional spend was within Medicine at £5,217,098 followed by Surgery at £3,370,771; Specialist Services at £3,237,741; Estates and Facilities at £978,978; and Joint Services at £597,570. The corporate areas accounted for the balance.

Agency was the highest category of spend during 2014/15 at £8,740,477 followed by Bank NHSP at £2,763,276; Overtime at £1,452,266; Zero Hours at £635,641; and Locum at £351,153. The balance was made up of internal bank and cost per case.

After being relatively stable for two years, temporary spend has increased significantly. The largest increase was in Medicine Division at £1,598,094. The Trust received winter funding to implement additional initiatives over the period from October 2014 to March 2015. The funding was given at short notice and necessitated the hiring of temporary staff. The funding level for 15/16 has been requested at the start of the year to enable better planning.

Data Source:
Trust Oracle General Ledger, governed by standard national

- high relative risk
- low relative risk
- expected range
- national benchmark
- confindence intervals

Effective

2014 commenced with an unusually long period of severe patient flow pressures which extended well into Quarter 1 of 2014/15.

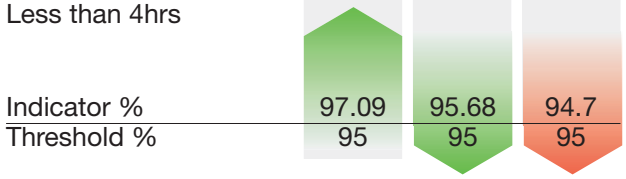
June was the only month in Quarter 1 of 2014/15 when the 95% 4 hour wait target was achieved. Consequently the Trust failed the Monitor target for this quarter. Throughout the summer period the Trust improved significantly, achieving the Quarter 2 Monitor 95% target at 95.82% and by November 2014 was the highest performing Trust in Greater Manchester.

Nationally however, major Accident and Emergency pressures impacted on all Trusts in December 2014 resulting in the Trust failing the Monitor target in Quarter 3 achieving 93.76%. Despite an improved performance during January 2015, the Trust was still not achieving the 95% target. The Trust's Quarter 4 performance at the end of March 2015 was 95.77%

Data below represents the Trust's year end position

A&E

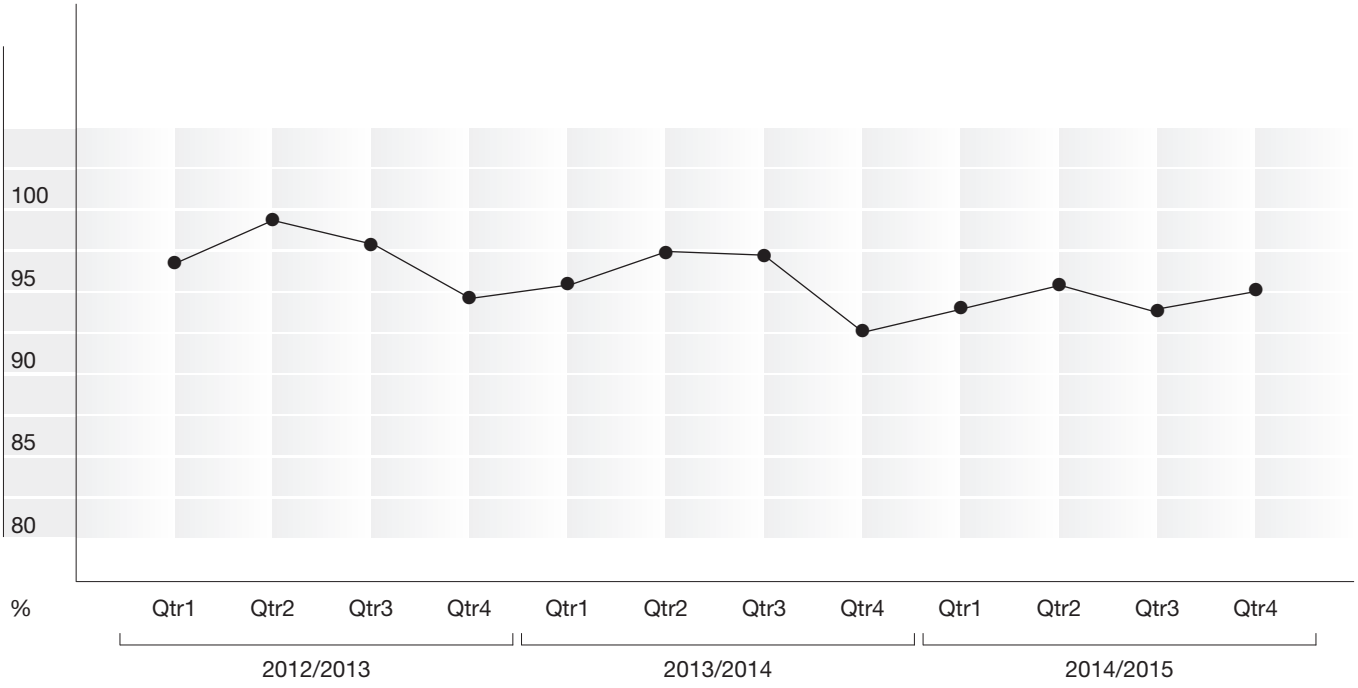
	2012/13	2013/14	2014/15
Total time in A&E: Less than 4hrs			
Indicator %	97.09	95.68	94.7
Threshold %	95	95	95



- On or above target
- Below trajectory; robust recovery plan required
- Failed target or significant risk of failure

- Improved position
- Worsening position
- Steady position

A&E - Total time in A&E: Less than 4 hour
From Performance report



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

Cancer Waits

	2012/13	2013/14	2014/15
62 Day Waits for first treatment from urgent GP referral			
After repatriation %	91.70	90.33	91.25
Before repatriation %	92.23	91.75	92.13
Threshold %	85	85	85
62 Day Waits for first treatment from NHS Cancer Screening Service Referral			
After repatriation %	97.91	99.46	99.54
Before repatriation %	99.65	99.20	99.54
Threshold %	90	90	90
31 Day Wait for second or subsequent treatment – surgery			
%	100	100	100
Threshold %	94	94	94
31 Day Wait for second or subsequent treatment – drug			
%	100	99.68	100
Threshold %	98	98	98
31 Day Wait from diagnosis to treatment			
%	98.77	99.70	99.03
Threshold %	98	98	98

	2012/13	2013/14	2014/15
Cancer 2 week – all cancers			
%	98.76	98.66	98.28
Threshold %	93	93	93
Cancer 2 week - breast symptoms			
%	96.24	96.44	95.66
Threshold %	93	93	93

The data above represents the Trusts year end position.

- On or above target
- Below trajectory; robust recovery plan required
- Failed target or significant risk of failure

- Improved position
- Worsening position
- Steady position

After repatriation are Greater Manchester agreed figures. Before repatriation are nationally reported figures.

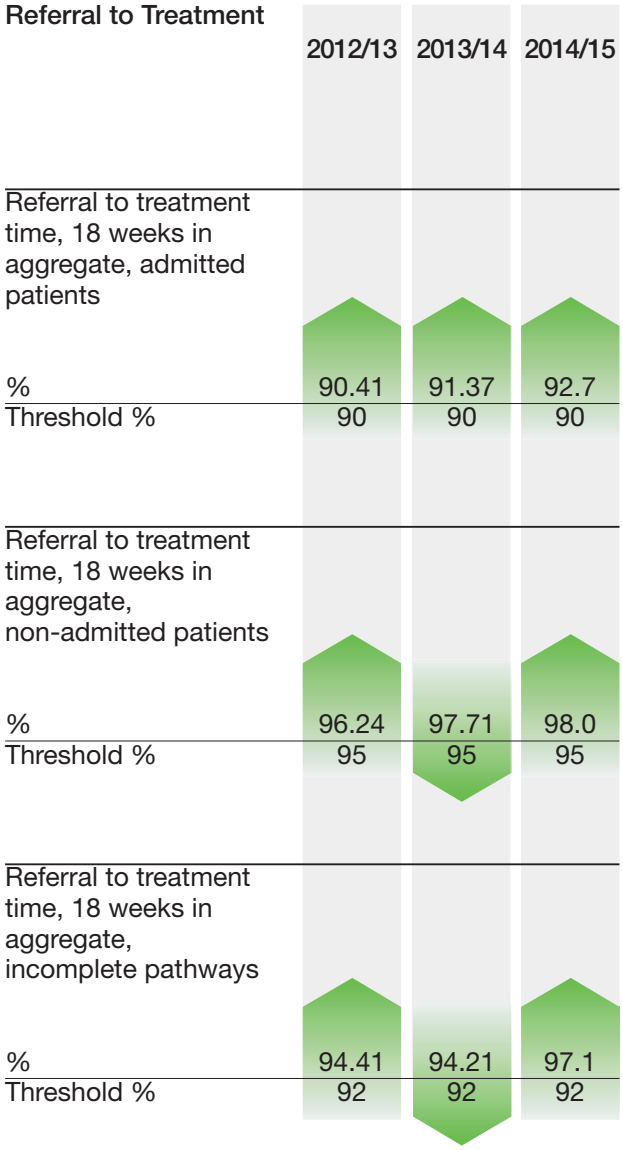
Greater Manchester has an integrated cancer system. A breach re-allocation policy has been agreed by all Trusts. When a breach has occurred and the pathway has involved more than one Trust, rather than sharing the breach, the whole breach can been re-allocated to one Trust if the agreed timescales for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

The Trust has continued to achieve all performance indicators for cancer care throughout 2014/15 despite being a very challenging year for Cancer Services nationally. In January 2015 the Trust's new Cancer Care Suite opened delivering chemotherapy under the Christie @ Wigan brand. The aim is to provide more treatments closer to home for Wigan patients.

The Trust continues to work closely with partner organisations in Greater Manchester and the Manchester Cancer pathway boards. There are twenty different pathway boards all working on different disease sites, for example, breast cancer, lung cancer and colorectal cancer. The Trust has clinical representation from consultants and specialist cancer nurses on all the pathway boards to further enhance the transition for patients being treated at specialist centres and working collaboratively to improve the patient experience.

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

Referral to Treatment



- On or above target
- Below trajectory; robust recovery plan required
- Failed target or significant risk of failure

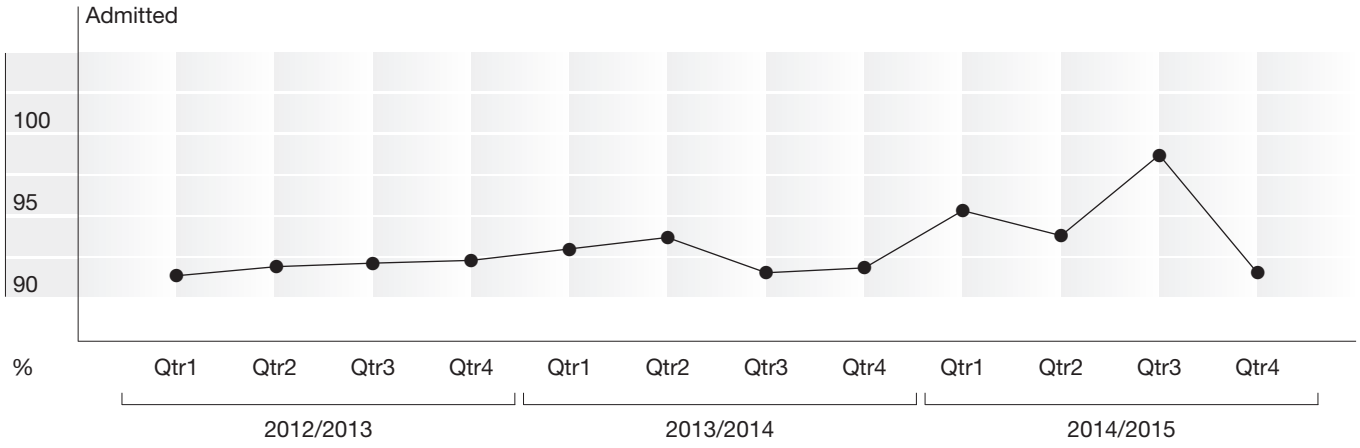
- Improved position
- Worsening position
- Steady position

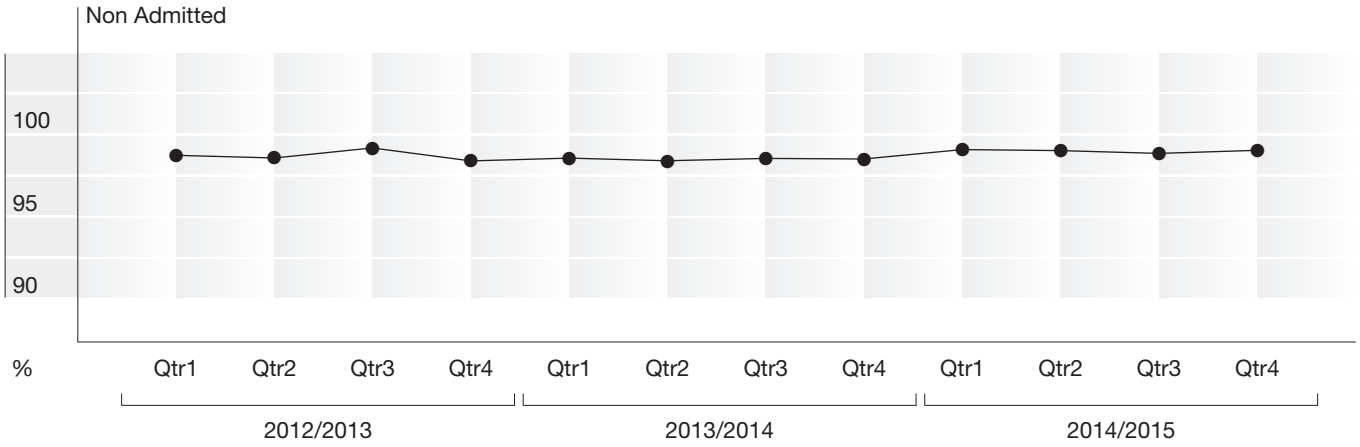
The data above represents the Trusts year end position.

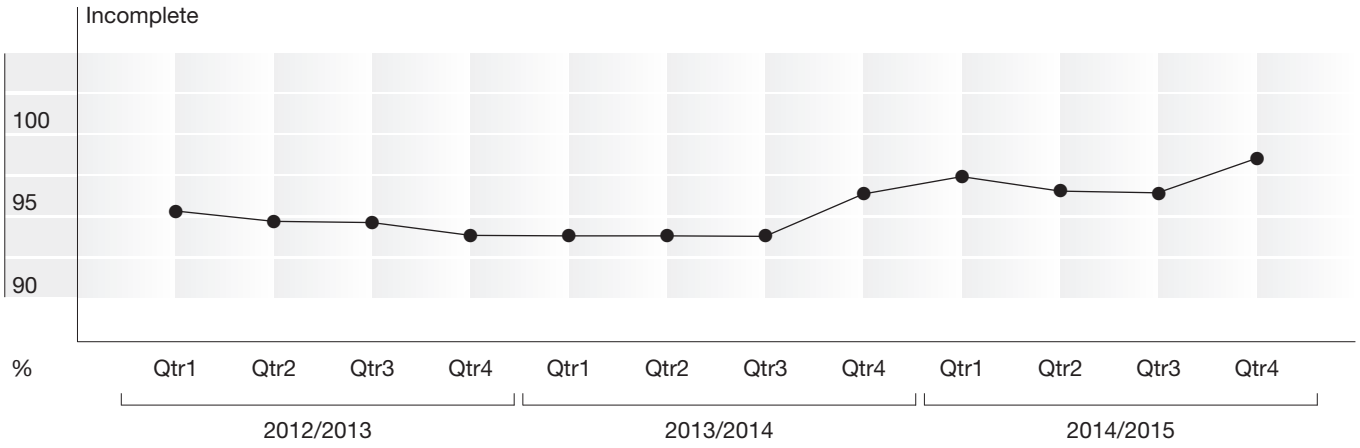
The Referral to Treatment (RTT) targets are the minimum standards Trusts are expected to provide for patients referred to the Trust on an 18 week pathway. There are five specific specialties experiencing either an increase in referrals or a reduction in capacity. These specialties are monitored closely on a performance dashboard and by operational groups. Overall WWL continues to improve its performance against all three indicators and exceed national standards.

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

Referral to Treatment (RTT)







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

Access to healthcare for people with a learning disability

	2012/13	2013/14	2014/15
Compliance with requirements regarding access to healthcare for people with a learning difficulty			
Achieved	Yes	Yes	Yes

The Trust is compliant with requirements regarding access to Healthcare for people with a Learning Disability. The Trust is represented on Wigan Learning Disability Partnership Board and is actively involved in the Health sub group of this board, and works in close collaboration with its partners within the community. Orientation tours of Thomas Linacre Outpatient Department for people with a learning disability commenced in April 2014

Community Care

	2012/13	2013/14	2014/15
Referral to treatment information completeness			
%	66.73	66.68	66.69
Threshold %	50	50	50
Referral information completeness			
%	88.33	93.06	95.57
Threshold %	50	50	50
Activity information completeness			
%	98.05	99.07	97.91
Threshold %	50	50	50

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

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

- On or above target
- Below trajectory; robust recovery plan required
- Failed target or significant risk of failure

- Improved position
- Worsening position
- Steady position

Financial Risk Rating and Continuity of Services Risk Rating (CSR)

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.

The ratio assesses two common measures of financial robustness: liquidity and capital servicing capacity. The Trust achieved a ratio of 3 during the year ended 2014/15. This ratio is calculated using the Monitor's pre-defined methodology and all figures used to calculate the ratio are derived from the Trust Annual Accounts.

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

Caring

The results for patients responding that they think hospital staff did everything they could to help control their pain are similar in 2014/15 to 2013/14. This may be due to having maintained training for staff on pain control. There has been continued improvement in patients informing the Trust that they find someone to talk to about their worries and fears. This could be due to hourly rounding on the wards continuing.

Selected Real Time Feedback Indicators

	2012/13	2013/14	2014/15
Real Time Patient Survey			
Feedback scores	96.17	85.06	92.39
Threshold %	90	90	90
Real Time Patient Survey – Pain Control			
Feedback scores	94.68	93.7	93.5
Threshold %	90	90	90
Real Time Patient Survey – Worries/Fears			
Feedback scores	90.33	87.5	90.5
Threshold >90%	50	50	50

Data source:
Real Time Patient Survey Data, questions consistent with NHS National Patient Survey.

Selected Complaints

	2012/13	2013/14	2014/15
Complaints 'Attitudes of Staff'			
Feedback scores	46	38	24
Threshold	0	0	0

Data Source: Datix Risk Management System, consistent with standard national definitions.

The Caring for Customers programme was launched last year. It is designed for both clinical and non-clinical staff and supersedes the Impact Programme.
The new programme offers learning from case studies of patient care experience both locally and nationally, to help Trust staff optimise their customer practice.

The new course content includes:

- A review of WWL Trust values and how enacting them helps provide benefits to patient care.
- Reflection on the Robert Francis Report and a review of the learning points and overall themes relating to the poor care at Mid-Staffordshire Trust.
- Patient comments and observations from the Trust internal inspections are discussed.
- The WWL Empathy and Bereavement Video assists staff to reflect on providing compassionate care.
- The Trust Always Events are discussed.
- A board game is played, which allows staff to discuss customer care in clinical situations and determine appropriate actions to deal with them.

The feedback for the new course has been extremely positive.

- On or above target
- Below trajectory; robust recovery plan required
- Failed target or significant risk of failure

- Improved position
- Worsening position
- Steady position

Complaints, Patient Advice and Liaison Service and the Ombudsman

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

The Department continues to work closely with clinical services 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.

Complex and serious complaints are escalated to the Trust's Executive Scrutiny Committee held on a weekly basis. This ensures prompt decision making regarding the progression of these complaints and, where appropriate, instigation of investigations through the Root Cause Analysis process. These meetings also provide the opportunity to triangulate information with previous incidents and possible claims.

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 (KO41) which includes information on Subject of complaint, and the Services Area (in-patient; out-patient; A&E and Maternity). It is imperative that complaints are used positively to learn and reflect on how we work and to make the appropriate improvements.

This table outlines actions taken and lessons learned from a sample of complaints received:

Complaint	Actions Taken and Lessons Learned
0514-8936 Delay in Diagnosis	This case was discussed and is used at a teaching session for junior doctors. The session now includes why the doctors should look for a blood clot in thigh and calves as a differential diagnosis for patients presenting with leg and knee pains.
0414-8862 Concerns about management of care	Following the identification of a delay in pain relief at triage, there is now Patient Group Directive (PGD) training for triage nurses in progress. In the interim, until the staff are fully compliant, all staff have been reminded that they should escalate to a doctor to ensure that patients do not wait unnecessarily for pain relief.
0414-8885 Delay before receiving treatment/ Commun-ication	Following a problem with a District Nurse referral during a Bank Holiday an information document has been produced to ensure ward staff are aware of the process of making referral to the District Nurses during a bank holiday. This has also been discussed at ward level and the information document has been added to wards 5 Point Communication folder.

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

The role of the Parliamentary and Health Service 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 2014/15 the PHSO requested information regarding 13 complaints. Four were not upheld; three have investigations underway and six are requests for records at this time. One case relates to 2011 and nine of the cases relate to 2013. The Trust is currently monitoring 1 improvement plan arising from a complaint that was partially upheld by the PHSO.

Patient Experience

The Trust has continually achieved 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 2013/14

The Patient and Public Engagement Team continue 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 we have seen significant improvement in patients being involved as much as they have wanted in decisions about their care and treatment. Results of the outcome of the real times surveys can be found in the patient engagement section of the Trust's Annual Report.

Patient and Public Engagement

Patients, Carers and Governors attended an event to help redesign Cataract Services. Patients, Carers and Governors spoke about their experience, 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 communication in the patient information leaflets and improved information on the patient white-boards regarding which member of staff is assigned to their care.

We also value the contribution of lay representatives who attend the Divisional Quality Executive Committees, Quality Champions Committee, Discharge Improvement Committee, and PLACE assessment, 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.

Looking forward

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

Consultation with Local Groups and Partnerships

The Trust continues to work in partnership with our local partners. A Youth Event in partnership with the Wigan Youth Zone, Wigan Borough and Wigan Clinical Commissioning Group took place in July, to raise awareness amongst young people about the range of support for young carers, careers, health and inclusion and diversity with young people. The intended outcome from the event was to support young people to achieve an insight to the wide variety of job roles in the NHS and how "everyone is unique" when it comes to equality and diversity.

Other projects during the year include:

- Engagement with the local Leigh Asylum Seekers and Refuges (LASARs) to ask them what their experiences were like when accessing and using the hospital services. The members of the public we engaged with were from countries such as India, China, Republic of the Congo and Bangladesh. Everyone said they received a positive experience of using the hospital services.

- Engagement with our local Gypsies and Travellers to find out what their experiences were like when accessing and using the hospital services. The members of the public we engaged with made us very welcome on the camp. Everyone we spoke to said that they received a very positive experience when using the services of the hospital.

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.

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 2014/15 is outlined below.

Staff Engagement the WWL Way

In June 2014 the Trust won first prize in the Healthcare People Management Association's "Appreciate Champion" Award for the work achieved in Staff Engagement. In addition, they also won the overall winner award.

'The WWL Way', the Hospital Trust's pioneering staff engagement partnership approach has gone from strength to strength over the last 12 months, achieving real improvements in culture, staff engagement and performance. The Trust's staff engagement pathway model, developed in-house, has assisted both the organisation and individual teams with a measurable framework to continually diagnose and understand the cause and effect of staff engagement. As a result, teams have on average improved levels of engagement by 7% and as much as 25% over 6 months. WWL now ranks 4th out of 138 Acute Trusts on the overall engagement score for the National Staff Survey 2014, and has outperformed other NHS Trusts on over 90% of measures. WWL has been recognised as a Trust demonstrating best practice in staff engagement and are beginning to collaborate with other NHS organisations to share their learning.

The Trust aims to continue to build upon and innovate staff engagement, strengthening its links with Health and Well-Being initiatives. There were several Trust-wide staff engagement events scheduled throughout 2014 including staff feedback video pods, a summer sporting event, listening events, amongst others. In addition, the Staff Engagement Pioneer Teams 26 week Programme continues into cohort 3 and 4 for 2015, enabling even more teams to apply the "WWL Way" staff engagement toolkit and embed staff engagement locally and self-sufficiently.

Continued Recruitment and Development of the Quality Faculty

The Trust's Quality Faculty has continued to grow during 2014/15 and there are now approximately 259 Quality Champions representing a wide range of disciplines and departments, working on approximately 69 live improvement projects.

Two courses of training in quality improvement methods have been delivered during 2014 and approximately 60 Quality Champions have attended these. 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 2014, 13 silver and 1 gold awards were made.

The Quality Champions' programme has received national recognition and was successful in winning the Health Service Journal Award for Patient Safety in 2014. Plans are in place to continue to sustain and build the Quality Faculty in 2015/16 by offering a broader range of training programmes with the aim of involving more junior staff.

Implementing Recommendations from the Francis Report

In September 2014 the Trust published its annual progress update in response to the recommendations outlined in the Francis Report. This can be located on the Trust's website. The Trust undertook a comprehensive review of the recommendations from reports by Francis, Keogh and Berwick. The Trust also commissioned an Internal Audit by Mersey Internal Audit Agency to review the Trust's response to those three national reports, which provided a conclusion of 'significant assurance'.

Leadership Quality and Safety Rounds

During 2014 four leadership safety rounds took place whereby 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 the Neonatal Unit, the Catering department, Acute Stroke Unit, Swinley Ward. 24 staff participated in the visits in total. In all, 23 safety rounds have taken place using this approach since 2012, involving many different disciplines across four Trust sites. A review of the Leadership Quality and Safety Rounds is due to commence in 2015.


Carl Zeiss

Internal Compliance Review

The Trust aims proactively to identify and address any concerns about the quality of care provided to patients.

In 2013-14 the Trust introduced twice-yearly internal inspections to check that standards are being met throughout the organisation. In order to do this an inspection team was developed and included doctors, nurses, therapists, patients, commissioners, external professionals and lay representatives. During the inspections the teams identify areas of good practice and areas where improvements can be made. This information is shared with individual teams and all staff within the Trust. Improvement plans are developed. The Trust's third inspection was held in December 2014 and included a team undertaking a night visit. The findings from the review, particularly regarding patient and staff feedback, were predominantly positive.

Areas for improvement included discharge arrangements and clinic start times. The Trust values the internal inspections and strives to improve the process. The next internal inspection is scheduled for June 2015 and the Trust is exploring the possibility of partnering another organisation to undertake peer review.

Always Events

The Always Events are the Trust's commitment to improving the delivery of patient and family centred care. The 10 Always Event were officially launched in the Trust on 8th January 2014. Since the launch in January 2014, detailed monitoring, recording and tracking of progress has been undertaken.

Every week, 20 patients and 20 members of staff are audited against the 10 Always Events. This produces a heat map which is presented monthly at a number of appropriate forums.

Every quarter, 400 staff (10%) are audited and every patient who is in a bed or chair at any Trust site and who is able to have the conversation, is audited over a two week period. The quarterly audits are undertaken by a team of WWL's clinical lay auditors.

The 10 Always Events are also included in the monthly Ward to Board Quality Indicator Audit and the results are displayed on the quality boards at the entrance to every ward. Both audits produce real time feedback to ward managers and other staff.

There is also direct feedback to the Deputy Director of Nursing who then provides the information to the Heads of Nursing for appropriate action.

The results of the Always Events audits are presented to the Engagement Committee, Heads of Nursing Meeting and the Discharge Improvement Committee. When the baseline audit was undertaken prior to the launch of the Always Events in December 2013, the scores varied from 20 percent to 60 percent of patients and staff reporting that the 10 Always Events always happen. The weekly audits are now clearly demonstrating 90 – 100 percent for all the questions. This gives a clear indication that the Always Events are being embedded into the organisation.

The HELP Line

The Trust recognises that effective communication between patients, relatives and healthcare professionals is of the utmost importance during a stay in hospital. In particular, when a patient becomes acutely unwell, it is vital that the concerns and opinions of the loved ones and carers are listened to and acted upon accordingly. It is clear from some of our investigations into clinical events that there are occasions when these concerns have not been listened to by the ward teams resulting in significant clinical issues for the patients.

The HELP line has been set up using a mobile phone that is carried by the Matron on-call or by the site co-ordinator out of hours. The contact number is a landline number that is diverted to the mobile phone 24/7. Relatives and patients who feel they are not being listened to or are not having their issues addressed at ward level can ring this number and escalate to an appropriate senior colleague.

The HELP line is available to current inpatients and their families only; on discharge any concerns that the families have are escalated via the Patient Relations/ PALS Service.

The number of calls received in 2014 was 33 with a further 21 up until the end of March 2015.

The HELP Line is available to inpatients and their families.

Some of the Trust Quality Champions

The Quality Champions' programme has received national recognition and was successful in winning the Health Service Journal Award for Patient Safety in 2014.

Two courses of training in quality improvement methods have been delivered during 2014 and approximately 60 Quality Champions have attended these.

Training to be a Quality Champion

Training to be a Quality Champion

Commissioner Quality Visits

NHS Wigan Borough Clinical Commissioning Group (CCG) has undertaken two Commissioner Quality Visits in 2014/15. An announced visit to Wrightington Hospital took place in January 2015.

The focus of the visit was to review the Estates Management Systems, to undertake a walk-round speaking to staff and patients and to review the environment and facilities at ward level. In February 2014 the CCG undertook an unannounced night visit to Accident and Emergency and the Clinical Decisions Ward at the Royal Albert Edward Infirmary.

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 these visits 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.

The 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.

At the Trust the programme is being piloted on MAU and Lowton assessment areas. A number of staff working within these areas have been trained to be 'TalkSafe Champions'. The champions have the conversations with other members of staff and discuss their behaviour and the potential consequences of that behaviour and obtain a commitment to change 'unsafe' behaviour. The success will be measured through a shift in the baseline cultural survey, an increase in no harm and near miss incident reporting and a decrease in incidents causing harm. If the programme is successful in these areas there is an appetite to roll it out further into the organisation.


www.nhs.uk

Appendix A

These figures 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 figures published in the final audit reports.

National Confidential Enquiry into Patient outcome and Death (NCEPOD)
Lower Limb Amputation
Gastrointestinal Haemorrhage Study
Sepsis (study still open)
Tracheostomy Care

National Audits (NCAPOP – n =)
Emergency Laparotomy (NELA)
National Joint Registry
Bowel Cancer (NBOCAP)
Head and Neck Cancer (DAHNO)
Lung Cancer (NLCA)
Oesophago-gastric Cancer (NAOGC)
Prostate Cancer
Acute Coronary Syndrome (MINAP)
Cardiac Rhythm Management (CRM)
Coronary Angioplasty/National Audit of PCI
National Heart Failure Audit
National Vascular Registry
Diabetes (Adult)
Diabetes (Paediatric)
Inflammatory Bowel Disease (IBD)
Rheumatoid and Early Inflammatory Arthritis
Falls and Fragility Fractures Audit Programme (FFFAP)
National Audit of Dementia
Sentinel Stroke (SSNAP)
Epilepsy 12 Audit (Childhood Epilepsy)
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE)
Neonatal Intensive and Special Care (NNAP)

National Audits (Other HQIP) for which data has been submitted
Adult Community Acquired Pneumonia
Severe Trauma (TARN)
Pleural Procedure
National Cardiac Arrest Audit
Adult Critical Care (case mix programme – ICNARC)
National Chronic Obstructive Pulmonary Disease (COPD)
Fitting Child (care in emergency departments)
Mental Health (care in emergency departments)
Older People (care in emergency departments)

Eligible to participate Y/N	Participated	Number eligible	Actual submissions %
Yes	Yes	6	5 (84%)
Yes	Yes	6	3 (50%)
Yes	Yes	5	4 (80%)
Yes	Yes	2	2 (100%)

Eligible	Participated	Number eligible	Actual submissions %
Yes	Yes	123	100%
Yes	Yes	3032	100%
Yes	Yes		
Yes	Yes		
Yes	Yes	Reported by	
Yes	Yes	Cancer Services	
Yes	Yes	Department	
Yes	Yes		
Yes	Yes	10	100%
Yes	Yes	Validation of data June 2015	
Yes	Yes	Validation of data June 2015	
Yes	Yes	Awaiting Information	
Yes	Yes	60 (AAA) 119 (CEA)	Awaiting figures
Yes	Yes	Data collection until 31 March	
Yes	Yes	Data collection commences May 2015	
Yes	Audit of service provision only		
Yes	Yes	Prospective data collection – 9 fully completed entries submitted (awaiting further update)	
Yes	Yes	16 (Pilot)	100%
Yes	Yes	Begins April 2015	
Yes	Yes	288	259 (90%) (to 31/12/14) – Q4 data to be submitted 27/4/15
Yes	Partial	Organisational data submitted. Clinical data not collected due to staff changes	
Yes	Yes	13	100%
Yes	Yes	311 episodes 288 distinct babies	100%

Eligible	Participated	Number eligible	Actual Submissions %
Yes	Yes	Data collection underway – deadline for submission May 2015	
Yes	Yes	152 cases submitted	100%
Yes	Yes	6	100%
Yes	Yes	Data available end of May 2015	100%
Yes	Yes	11	100%
Yes	Yes	152	39%
Yes	Yes	50	100%
Yes	Yes	50	100%
Yes	Yes	100	100%

80 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 welcome the many initiatives outlined in the report and the Trust's success in gaining several prestigious awards during the past year.

Our comments below should be read in that context.

1. We would be wary (reference the acting CEO's introduction) of describing the A&E department as 'one of the best in the country' - the measures used are at best limited and at worst misleading. The Trust should be satisfied that it is achieving the targets against which it is measured.
2. We would be wary of using the flawed Friends and Family test as a benchmark. It may be useful but the national patient survey is a much better measure of what patients really think.
3. We have mentioned on several occasions that the Trust Board should hear one favourable and one critical patient story each month. Your Medical Director agrees with us. We hope that this will soon be put into effect.
4. It is clear that the Trust still needs to do more to improve the discharge experience (though we were pleased to note the steps taken to reduce discharges after 8pm)
5. Services provided to vulnerable patients including those with dementia.
6. We were pleased to note the increase in take up of PROMS scoring, referrals to smoking cessation services and steps being taken to prevent unplanned weight loss.
7. Finally, we heartily endorse the Trust's aim to be in the top 10% of Trusts across a range of key measures.

We look forward to discussing the quality accounts with the Trust and other stakeholders in due course.

HealthWatch have requested further information on the following:

1. The business model for the IVF centre as it presumes the CCG paying for up to three cycles when the CCG is only committed to paying for up to two.
2. Progress regarding end to end pathways in the community including multi-disciplinary intermediate care services led by the Trust.
3. Improving outcomes for acute service patients returning to Wigan from other Trusts (especially in the light of NW sector proposals for Healthier Together).

Annex A. Statements from HealthWatch, Overview and Scrutiny Committee and Clinical Commissioning Group cont

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

Clinical Commissioning Group

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

The CCG welcomes and recognises the progress the Trust has made in respect of the 2014/2015 quality priorities. Notable successes have included an increase in the percentage of patients experiencing Harm Free Care (up from 95% to 98%) and an increase in the percentage of patients who receive an expected date of discharge on admission (up from 45% to 100%). The Trust has also participated in the NHS Quest work stream and has appointed a dedicated Sepsis Nurse; this will provide a renewed focus on early detection and treatment of Sepsis. However the CCG recognises that a number of priorities have not been achieved for example; the target of 95% of all patients being weighed on admission. There was also no significant increase in the numbers of patients having been involved 'as much as they would want to be in decisions about their discharge from hospital'. The CCG would like to see a renewed focus on the areas were improvements were not achieved in the 2015/2016 quality priorities.

During 2014/2015 the Trust participated in 95% of the National Clinical Audits and 100% of National Confidential Enquires that it was eligible to participate in. The CCG is pleased to see that the actions the Trust has taken as a direct result of these audits have been reported in the Quality Account. The CCG would like the Trust to continue to improve on this work and the level of compliance in 2015/2016.

The CCG is once again supportive of the engagement model used with Commissioners, Governors and Healthwatch in the development of the quality priorities for 2015/2016 and wholly supports the goals and the improvements that the Trust plans to undertake over the next year.

The CCG would like the Trust to particularly focus on a reduction in overall and weekend Summary Hospital Mortality Index (SHMI), discharge processes to ensure they are both safe and appropriate and the implementation of the recommendations made in the independent review of Never Events.

In order to support the Trust to deliver safe, effective and caring healthcare the CCG will work with the Trust, utilising Commissioning for Quality and Innovation (CQUIN) Schemes during 2015/2016, to incentivise further quality improvements in Sepsis Management, Mortality, Discharge Communication and Maternity Care locally.

The CCG looks forward to continuing 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
May 2015

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 2014/15 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 2014 to May 2015
- Papers relating to Quality reported to the Board over the period April 2014 to May 2015
- Feedback from commissioners dated May 2015
- Feedback from governors dated 03/05/2015
- Feedback from Local Healthwatch dated 20/05/2015
- Feedback from Overview and Scrutiny Committee None received
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations, dated 06/05/2015
- The national patient survey 2013
- The national staff survey 2014
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 2014/15
- Care Quality Commission (CQC) Intelligent Monitoring Report dated July 2014 and December 2014

- 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 ;

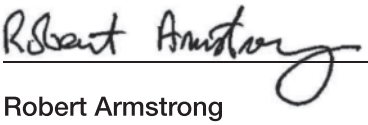
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report and these controls are subject to review to confirm that they are working effectively in practice;

- 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/annualreporting-manual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor.gov.uk/annualreporting-manual

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
May 2015

Rob Forster
Acting Chief Executive
May 2015

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

Annex D. External Auditors Limited Assurance Report

2014/15 limited assurance report on the content of the quality reports and mandated performance indicators

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 2015 (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 2015, to enable the council of governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and 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 2015 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
- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.

We refer to these national priority indicators collectively as the '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 the guidance; 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 2014 to March 2015;
- papers relating to quality reported to the board over the period April 2014 to March 2015;
- feedback from Commissioners, dated May 2015;
- feedback from local Healthwatch organisations, dated May 2015;
- the Trust's 2013/14 annual complaints report;
- the 2014 national patient surveys relating to children's inpatients and day cases and cancer patients;
- the 2014 national staff survey;
- Care Quality Commission Intelligent Monitoring Report dated December 2014;and
- the Head of Internal Audit's annual opinion over the trust's control environment dated 05/05/2015

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

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

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;

Annex D. External Auditors Limited Assurance Report cont

- 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.

Basis for qualified conclusion
The annualised 18 week referral to treatment indicator is calculated as an average based on the percentage of incomplete pathways which are incomplete at each month end, where the patient has been waiting less than the 18 week target. We have tested a sample of pathways which were listed as incomplete at a month end, selected on both a random and risk focussed basis.

We found that within our sample a number of patient records had not been appropriately included or excluded from the calculations supporting the monthly RTT incomplete pathway metric.

As a result of the issues identified, we have concluded that there are errors in the calculation of the "maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway" indicator for the year ended 31 March 2015. We are unable to quantify the effect of these errors on the reported indicator.

Qualified conclusion

Based on the results of our procedures, except for the matters set out in the basis for qualified conclusion paragraph above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2015:

- 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 the respective responsibilities of the directors and auditors section of this limited assurance report; 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

Deloitte LLP
Chartered Accountants
Newcastle Upon Tyne
28 May 2015

90 Glossary of Terms

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.

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.

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)
A bacterium that is recognised as the major cause of antibiotic associated colitis and diarrhoea. Mostly affects elderly patients with other underlying diseases.

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 as that is the job of the Trust Board. However, it has a key role in advising the Board and ultimately holding the Board to account for the decisions it makes.

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.

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.

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.

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.

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

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

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.

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.

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.


ENTRANCE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