Quality Accounts
2014-2015
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If you require any further information about the 2014/15 Quality Accounts please contact: The Quality Improvement Team on 0161 206 8168 or email Debbie Carr at Debbie.Carr@srft.nhs.uk
Achievements in quality

Over 8 years we have achieved:

- **10%** in the best nationally we have continued to maintain our position for risk adjusted mortality
- **Zero** avoidable MRSA bloodstream infections for the past 40 months
- **83%** reduction in *Clostridium difficile* infections
- **79%** reduction in grade 2 pressure ulcers

**2014/15 achievements:**

- Rated “Outstanding” by the Care Quality Commission (CQC)
- Rated in the Top 3 best Trust nationally in the NHS Staff Survey 2014
- 97% of district nursing patients and 97.8% of hospital patients receive harm free care (as measured by the safety thermometer)
- 59% reduction grade 2 pressure ulcers compared to last year
- 320 days without a Hospital Acquired grade 3 or 4 pressure ulcer
- 95% compliance with Salford Royal’s Dementia & Delirium Care Bundle
- 96% compliance with correct antibiotic prescribing procedures to help prevent *Clostridium difficile*
- 90% of Salford Royal patients rate their care as excellent or very good
- 100% of patients having an accurate prescription on EAU when the pharmacists use the ‘on hold’ function on the electronic patient record
- 94% of registered nurse shifts fully staffed
- Over 220 days without a serious untoward incident in theatres
- 18% reduction in the percentage of patients catheterised in the hospital
- 17% reduction in the number of catheterised patients per month in the community
Some 2014/15 achievements

**Janice McGrory**
Awarded ‘Best Dementia Nurse Specialist/Dementia Lead’ at the National Dementia Care Awards 2014

**Debra Dooley**
Lead Nurse in Adult Community Services, has been given the prestigious title of Queens Nurse (QN)

**Sandra Smith**
Has become one of the first group of health visitors in England to become a Fellow of the Institute of Health Visiting

**Sir David Dalton**
Chief Executive has been awarded with an Honorary Doctorate in science from Salford University

**Salford Royal**
Is named as one of the Top 10 best places to work in healthcare by the Health Service Journal

**Elaine Inglesby-Burke**
Is named on the inaugural Nursing Times Leaders List 2014

**Maxine Power**
Appointed Honorary Professor in the College of Health and Social Care at the University of Salford

**Health Education success:**
Stacey Barnes has been awarded North West Apprentice of the Year in Health and Social Care and Phylis Ziswa received the award for First Steps into Employment in Health and Social Care at an awards ceremony hosted by Health Education North West 2014

**Salford Together Partnership**
Awarded special ‘vanguard’ status - pioneering joined-up care to create significant health improvements for Salford residents

**Salford Royal’s Twitter account**
Was ranked 15th in the top 50 of NHS tweeters from all NHS organisations across the country

**New Renal Unit opens in Oldham**
Dialysis patients now receive treatment closer to home after a state-of-the-art Renal Unit opens in Oldham in April 2014

**Salford specialist renal clinic for young adults with chronic kidney disease (CKD)**
Won the Managing Long-Term Conditions category in the Health Service Journal Patient Safety and Care Awards 2014

**Salford Royal**
Appointed Honorary Professor in the College of Health and Social Care at the University of Salford

**Dr Ibi Erekosima**
Appointed as International Society of Nephrology Educational Ambassador

**Dr Ibi Erekosima**
Presented with the Meritorious Award by the College of Podiatry in recognition of his work in the field of diabetes-related foot disease

**Baby Friendly Award for Salford**
Salford Royal NHS Foundation Trust’s children’s services Health Visiting team and Salford City Council’s Children’s Centres have been awarded the prestigious Baby Friendly Award by UNICEF (United Nation’s Children Fund)

**Salford Royal**
Has recruited more than 2,500 members of the local community to get involved in research

**Sir David Dalton**
Named as top Chief Executive for 2015 by the Health Service Journal

**Citizen Scientist Project**
Has recruited more than 2,500 members of the local community to get involved in research

**Dr Paul Chadwick**
For innovations in dementia care from Royal College of Nursing

**Launch of new partnership for Manchester Orthopaedic Centre**
Salford’s Orthopaedic patients will now receive their surgery at an off-site specialist centre based at Trafford General Hospital as a result of a joint partnership between Salford Royal and Central Manchester University Hospitals NHS Foundation Trust

**Stacey Barnes**
Awarded North West Apprentice of the Year in Health and Social Care and Phylis Ziswa received the award for First Steps into Employment in Health and Social Care at an awards ceremony hosted by Health Education North West 2014

**1st Prize**
For innovations in dementia care from Royal College of Nursing
Statement on Quality from the Chief Executive

safe • clean • personal
2014/15 was another eventful and successful year for Salford Royal. We received an “outstanding” rating from the Care Quality Commission (CQC) following our inspection in January 2015, making us only the second Trust in the country to be awarded this status, the first Trust in the North of England and the first Trust with integrated hospital and community services in the country to be awarded this status.

A team of 54 inspectors, including doctors, nurses and trained members of the public visited the organisation and examined a range of Salford Royal’s services within both the hospital and community settings. Additionally, inspectors spoke to staff, patients and visitors during focus groups, interviews and listening events, leaving no stone unturned. We are extremely proud of our outstanding rating and know that it results from the care, compassion and skills of all staff, whatever their role and wherever they work.

The CQC was looking for evidence of whether services are safe, effective, caring, responsive and well-led. The inspectors’ overall rating of “outstanding” for Salford Royal is made up of a rating of “outstanding” for hospital services and “good” for community services.

Additionally, several areas across both the hospital and community services were praised as being “outstanding”. These were urgent and emergency services, medical care, end of life care, community health services for adults and end of life care in the community.

In its formal report on Salford Royal’s inspection, the CQC drew out an extensive list of outstanding practice, including:

- The Trust’s use of its Nursing Assessment and Accreditation System (NAAS) to provide real transparency to patients on key clinical performance indicators and measures - and the roll out of a sister system, the Community Assessment and Accreditation System (CAAS) in the community;
- The way members of staff talk positively about ensuring patients receive safe, clean and personal care every time;
- The system of daily safety huddles and systems of information flow between staff on different shifts;
- The Emergency Village’s approach to working with partners to provide integrated care for patients;
- The Trust’s ongoing focus on its Quality Improvement work to create safer care for patients, including a reduction in pressure ulcers;
- The Care Homes Medical Practice, a satellite GP service for care home residents;
- Care for patients with dementia;
- The leadership at Board level was recognised by staff as inspiring and providing a clear vision.

This rating gives real confidence to people that our services are not only amongst the best in the country - but is an important milestone in our journey to becoming the safest NHS organisation in the country. We are thankful for the efforts of all of our staff in helping us to achieve this rating.
Also in 2015, we launched our third Quality Improvement Strategy which builds on our ambition to be the safest organisation in the NHS. We will accomplish this by putting the needs of our patients, their families and carers, first and will support this through attainment of 5 clear aims:

1. No preventable deaths
2. Continuously seek out and reduce patient harm
3. Achieve the highest level of reliability for clinical care
4. Deliver what matters most: work in partnerships with patients, carers and families to meet all their needs and better their lives
5. Deliver innovative and integrated care close to home which supports and improves health, wellbeing and independent living

Our third QI strategy builds on the work which began in 2007. The strategy remains ambitious and challenging and enables the Board to commit to supporting staff to make the necessary continued improvements. The Board also continues with its promise: to assure safe staffing levels at all times. We recognise too that Salford Royal’s ambition must remain affordable and we believe that better care can be delivered at a lower cost. Making explicit this link between quality improvement and cost improvement is vital to our continued success.

I am delighted that we are already making excellent progress with lower mortality rates, fewer incidents of patient harm and ever increasing levels of patient satisfaction. In February 2015, we were pleased to find that our staff satisfaction levels remain some of the best in the country; for four consecutive years we have been rated in the top three in the country for overall staff engagement in the NHS Staff Survey 2014. The evidence is strong and intuitive: that staff who enjoy working and have high morale will provide better care.

I am pleased to confirm that the Board of Directors has reviewed the 2014/15 Quality Accounts and confirm that it is a true and fair reflection of our performance. We hope that this Quality Accounts provides you with a clear picture of how important quality improvement, patient safety and patient and carer experience are to us at Salford Royal.

Finally, I’d like to extend a warm thank you to all the staff at Salford Royal who work tirelessly every day to better the lives of patients and the community we serve. It is their contribution which makes us who we are - an Outstanding Trust.

Sir David Dalton
May 2015
Chief Executive
Salford Royal NHS Foundation Trust
Salford Royal is an “outstanding” Trust

We are extremely proud that Salford Royal have been awarded an overall rating of “outstanding” by the Care Quality Commission (CQC), we are only the second Trust in the country to earn the top rating by the health and social care regulator, the first in the North of England and the first Trust with integrated hospital and community services.

The inspectors’ overall rating of “outstanding” for Salford Royal is made up of a rating of “outstanding” for hospital services and “good” for community services.

During January 2015, a team of CQC inspectors spent time in our hospital and community services, looking for evidence of whether our services are safe, effective, caring, responsive and well-led. At Salford Royal they found safety and effectiveness to be “good” and care, responsiveness and leadership to be “outstanding”.

Additionally, several areas across both the hospital and community services were praised as being “outstanding”. These were urgent and emergency services, medical care, end of life care, community health services for adults and end of life care in the community.

The CQC drew out an extensive list of outstanding practice, which included the following:

- Salford’s Nursing Assessment and Accreditation System (NAAS) which provides real transparency to patients on key clinical performance indicators and measures - and the roll out of a sister system, the Community Assessment and Accreditation System (CAAS) in the community
- The way members of staff talk positively about ensuring patients receive safe, clean and personal care every time
- The system of daily safety huddles and systems of information flow between staff on different shifts
- The Emergency Village’s approach to working with partners to provide integrated care for patients
- The Trust’s ongoing focus on its Quality Improvement work to create safer care for patients, including a reduction in pressure ulcers
- The Care Homes Medical Practice, a satellite GP service for care home residents
- Care for patients with dementia
- The leadership at Board level was recognised by staff as inspiring and providing a clear vision

Sir David Dalton
Chief Executive

We are absolutely delighted to achieve the rating of outstanding; this rating is so thoroughly well-deserved by the remarkable people who work for Salford Royal across our hospital and community services. This rating gives real confidence to our patients and visitors that our services are not only amongst the best in the country - but is an important milestone in our journey to becoming the safest NHS organisation in the country.

The CQC inspection did highlight some areas for improvement. These have either already been addressed or plans are in place to do so.
Our aims

Improving all aspects of quality is our primary focus at Salford Royal, and we have had a clear Quality Improvement Strategy in place since 2008. The most recent edition of Salford Royal’s Quality Improvement Strategy (2015-2018) can be found on page 74 of the Quality Accounts. The following provides a brief summary of progress against aims outlined in the previous strategy (2011-2014).

Reducing mortality
Salford Royal has achieved and continued to maintain a position of top 10% of NHS Trusts for risk adjusted mortality.

Reducing harm
Harm is suboptimal care which reaches the patient either because of something we shouldn’t have done or something we didn’t do that we should have done. We have undertaken targeted work to reduce harm to our patients:

Over eight years we have achieved:

97% of district nursing patients and 97.8% of hospital patients receive harm-free care (as measured by the safety thermometer)

90% of Salford Royal patients rate their care as EXCELLENT or VERY GOOD

The views of our patients and staff are very important to us and receive feedback through a number of methods, including surveys, patient and staff stories and patient experience trackers, all of which provide us with vital information on how to improve.

Improving reliability
At Salford Royal we are using the principles of reliability science to maintain high performance, improve care where needed and improve processes in the following areas:

- Community-acquired pneumonia
- Heart failure
- Hip and knee replacement
- Myocardial infarction (heart attack)
- Stroke
- Intentional Rounding

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<td>Heart failure</td>
<td>On plan</td>
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<td>Hip and knee replacement</td>
<td>On plan</td>
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<td>Myocardial infarction (heart attack)</td>
<td>On plan</td>
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<td>Stroke</td>
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<td>Intentional Rounding</td>
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A review of Quality Improvement projects 2014/15

Below is a list of quality initiatives in progress and their current status. Each project is explained in the individual project pages.

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<th>Target Achieved / On Plan</th>
<th>Close to Target</th>
<th>Behind Plan</th>
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<th>Close to Target</th>
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The safety of our patients is of huge priority to us. To help us monitor the safety of our patients we use a Department of Health tool called the Safety Thermometer. We use this tool each month to audit the care given to our patients both in the hospital and in the community. Doing this helps us to understand how well we are doing and highlights areas for further improvement.

The Safety Thermometer records how many of our patients suffer from four types of harm:

- Pressure ulcers
- Falls
- Urinary tract infections in patients who are catheterised (CA-UTI)
- Blood clots (VTE)

Each of these harms measured by the Safety Thermometer are then looked at in a more in depth way by dedicated project teams; their work on improvement can be seen in the coming pages.

As well as the work undertaken by the dedicated project teams we have introduced a Patient Safety Briefing* in the format of a film. This film is shown to patients and it gives them a series of simple steps they can take to help keep them safe, whilst they are staying in hospital. This includes tips on how to avoid a fall, pressure ulcer, infection or ensuring personal information is correct and up to date.

*Data source: Safety Thermometer

*As measured by the Safety Thermometer

*The Patient Safety Briefing was developed by Haelo which is an innovation centre based at Salford Royal.
Harm free care - Community

97% of District Nursing patients receiving harm free care*

District nurses use a tool called the Safety Thermometer every month to audit patient care, in order to understand how we are performing and highlight areas for further improvement.

The Safety Thermometer records how many of our patients suffer from four types of harm:

- Pressure ulcers
- Falls
- Urinary tract infections in patients who are catheterised (CA-UTI)
- Blood clots (VTE)

The most common harm we see in the district nursing caseload is the development of pressure ulcers. Last year we set an aim to reduce all pressure ulcers on the caseload by 50%, we did not achieve this. Reducing the number of pressure ulcers developing in patients on the district nurse caseload can be very challenging. We have patients on the caseload who will have a district nurse visit once a month, providing us with a small window to work with the patient to reduce the risk of acquiring a pressure ulcer.

We continue to work to reduce pressure ulcers in the community having developed a clear plan for improvement, adapting the tools and techniques we have seen prevent pressure ulcers in the hospital, including regular changing of a patient’s position and better use of use of pressure relieving devices.
Pressure ulcers - Community

What: To reduce pressure ulcers developing on the district nursing caseload
How much: 50% reduction in grade 3 and 4 pressure ulcers
By when: 31 March 2015
Outcome: Close to target, 49% reduction in grade 3 and 4 pressure ulcers

Improvements achieved
- A package of changes aimed at preventing pressure ulcers in community settings is being rolled out
- Daily reporting of skin changes discussed at team safety meeting
- Patient log of all patients with skin changes, agreed action and review plan
- Use of photography via i-Pads so that skin changes can be discussed with senior nurses who can advise on treatment and management
- Standard process for pressure ulcer prevention and management developed
- E-learning package developed and rolled out
- Joint safety huddles with tissue viability team

Further improvements identified
- Introduce patient information boards into District Nurse teams so that they can monitor progress
- Roll out pressure ulcer calendar to measure days free of grade 3 and 4 pressure ulcers at team level
- Implement regular education sessions by tissue viability service
- Review and update documentation and wound care plans in the community
Pressure ulcers - Acute

59% reduction in grade 2 pressure ulcers in 2014/15
We have only had 1 grade 3 or 4 pressure ulcer in the last year

Pressure ulcers can develop when a large amount of pressure is applied to an area of skin over a short period of time. They can also occur when less pressure is applied over a longer period of time. The extra pressure disrupts the flow of blood through the skin. Without a blood supply, the affected skin becomes starved of oxygen and nutrients, and begins to break down, leading to an ulcer forming.

Pressure ulcers tend to affect people with health conditions that make it difficult to move, especially those confined to lying in a bed or sitting for prolonged periods of time. Pressure ulcers can range in severity from patches of dis-coloured skin to open wounds that expose the underlying bone or muscle (Information taken from the NHS Choices website).

Pressure ulcers can be prevented by ensuring patients are kept mobile, regularly changing positions whenever possible. At the Trust we have a wide range of pressure relieving equipment, including cushions, mattresses and boots.

What:  To reduce healthcare acquired pressure ulcers across the hospital
How much: 50% reduction in hospital acquired grade 2 pressure ulcers
Elimination of grade 3 and 4 pressure ulcers
By when:  April 2015
Outcome:  Grade 2 pressure ulcers: 59% reduction
We have had one grade 4 hospital acquired pressure ulcer
Progress:  Grade 2: Target achieved
           Grade 3 and 4: Close to target
 Improvements achieved

- The root cause analysis of hospital acquired pressure ulcers is fed back to senior nursing staff at the Pressure Ulcer Steering Group to share any learning
- All areas of the patient journey feed into our Root Cause analysis to identify all opportunities we had to prevent a pressure ulcer occurring
- Focused training from the Tissue Viability Nurses with wards where pressure ulcers have been a problem
- We are using softer oxygen masks and sponge covering for tubes that may come into contact with vulnerable areas

Further improvements identified

- Action plans in place across all divisions to ensure the reduction in pressure ulcers and learning continues
- Work ongoing with our Theatres team to evaluate equipment used to prevent pressure ulcers developing in Theatre during lengthy procedures
2 Reduction in patient falls

Patient falls are one of the leading causes of incidents in hospital. A patient fall can lead to injury and prolonged hospital stays. Falls can also have a long term psychological effect on patients. A fall can lead to a loss in confidence and fears of falling again, which leads to a loss in independence.

What: Reduce the number of patient falls in hospital
How much: 10% reduction in overall falls rate; 5% reduction in falls with harm rate
By when: April 2015
Outcome: No change in falls rate
Progress: Behind plan

Improvements achieved
- Teams have made the following interventions to reduce the risk of patient falls in the bathroom: these include:
  - Patient and staff information posters
  - Tagging system - staying with the patient and ensuring someone is “tagged in” to monitor the patient if the original member of staff is called away (see picture)
  - “Lav Bags” a pre-packed bag with items that may be required while a patient is in the bathroom which will be taken to the bathroom and reduce the need for a patient to be left alone
  - Testing of falls prevention equipment eg. non-slip socks, non-slip anti embolism stockings, bed sensors
  - Patients ‘behind the bed boards’ will include patient transfer status so all staff know how to safely mobilise all patients

Further improvements identified
- Where possible we ensure patients have chairs of a suitable height to prevent them slipping down the chair
- We have tested a number of changes around the patient environment and ensuring it remains hazard free and that all walking aids are accessible
Community reduction in falls

What: To reduce inpatient falls within a community setting
How much: 5% reduction in falls with a 10% reduction in falls with major and catastrophic harm
By when: April 2015
Outcome: No change - behind plan

Improvements achieved
- Telecare trial and provision of eight Passive Infrared Detectors (PIRS) from Salford telecare at no cost
- A post falls list on steps to take and document following a fall
- Teach back can be effective for patients
- Red socks (anti-slip) prevent falls and increase patient and staff confidence
- Falls prevention groups have led to standardised assessments
- Education has been provided to patients who as a result understand their personal risk factors
- Post falls bundle is being trialled but when used it has so far shown to aid identification of risk and preventative measures to take
- Toilet tagging reduced falls in bathrooms
- Moving and handling equipment review and obtaining new equipment where required

Further improvements identified
- Lee and Stokic, 2008 and Forrest et al 2012 trialled (Functional Independence Measure) FIM as outcome measure for measuring falls risk on rehab unit with positive outcomes, will be trialled at Heartly Green
- Increased continence assessments
- Postural BP routinely taken with appropriate patients
- We will reliably ask if patients need the toilet during intentional rounding when they are awake and whether they are warm enough at night
- ‘Call don’t fall’ signs, included in admission pack and at foot of bed
- Medication reviews for every falls patient
- A range of materials found on Patient Safety First will be trialled
Catheter associated Urinary Tract Infections (CaUTI)

This year to date we have achieved an **18%** reduction in the percentage of patients catheterised in the hospital and the Community have reduced the number of catheterised patients per month by **17%** in 2014/15.

The most common hospital acquired infection is urinary tract infection and many of these (around 80%) are linked to the patient having a catheter. In addition, many patients being cared for in the community have catheters when discharged from hospital or have long term catheters.

The risk of acquiring infection has been estimated as 5% for each day a patient has a catheter in situ. The longer you have a catheter the higher the risk of infection (*Australian Government 2004*).

We aim to reduce infection by:

- Reducing the number of inappropriate catheters inserted in patients
- Reduce the time catheter remain in the bladder
- Ensure where catheters are required they are inserted and cared for appropriately

<table>
<thead>
<tr>
<th>What:</th>
<th>To reduce Catheter Urinary Tract Infections</th>
</tr>
</thead>
<tbody>
<tr>
<td>By when:</td>
<td>April 2015</td>
</tr>
<tr>
<td><strong>Outcome:</strong></td>
<td>18% reduction in the percentage of patients catheterised in the hospital</td>
</tr>
<tr>
<td></td>
<td>17% reduction in patients with catheters in the community</td>
</tr>
<tr>
<td>Progress:</td>
<td>On plan</td>
</tr>
</tbody>
</table>

**Improvements achieved**

We have agreed the explicit criteria for catheterisation “**TRAPP**” which is used by our nurses and doctors to ensure that catheters are only inserted for appropriate reasons.

**Acutely unwell**

Currently requiring level 2 or 3 care **OR** if a senior decision maker specifically mentions the need for a catheter clearly in the notes

**Patient preference**

For end of life patients who prefer a catheter to ease distress (must be discussed with patient and documented)

**Peri-op**

Maximum 24 hours after surgery

**Other**

Prolonged immobilisation due to spinal fractures or trauma. Urological indications including intra-bladder treatments, bladder diagnostic tests and visible haematuria
Training has been provided to enable staff to audit the number of inappropriate catheters.

The use of the TRAPP tool is now providing the Trust with regular data on the numbers of inappropriate catheters which will be used to support the improvement work.

Community teams have developed a TWOC (Trial without Catheter) of the week award for the District Nursing Team with the most successful numbers of catheter removals.

All hospital wards and community teams have been part of two learning sessions with nursing staff representing all teams.

The number of catheters in the community has fallen from an average of 294 in 2013/14 to 258.91 in 2014/15.

**Further improvements identified**

- The data on inappropriate catheters will drive future improvement work.
- Wards and community teams will be looking at testing:
  - Formal consent from patients prior to catheterisation.
  - Locking catheters away from the main stock area.
  - Prescriptions required for catheterisation.
  - A step by step Nurse Led Removal Tool.
- We will run further Trust wide learning sessions over the next 12 months.
Venous thromboembolism (VTE) is a term that covers both deep vein thrombosis and its possible consequence: pulmonary embolism (PE). A deep vein thrombosis (DVT) is a blood clot that develops in the deep veins of the leg. If the blood clot becomes mobile in the bloodstream it can travel to the lungs and cause a blockage (PE) that could lead to death.

Salford Royal regards any clot as hospital associated if it occurs during an admission or within 90 days of a hospital stay. The risk of hospital-acquired VTE can be greatly reduced by risk assessing patients on admission to hospital and taking appropriate action to prevent a VTE from occurring. Where clots happen the assessment, prescription and administration of appropriate medication is assessed to see if this was all done correctly.

96% of patients have VTE risk assessment completed

Venous thromboembolism (VTE) is a term that covers both deep vein thrombosis and its possible consequence: pulmonary embolism (PE). A deep vein thrombosis (DVT) is a blood clot that develops in the deep veins of the leg. If the blood clot becomes mobile in the bloodstream it can travel to the lungs and cause a blockage (PE) that could lead to death.

What:
1) To assess all patients admitted to hospital for their risk of developing VTE
2) To improve root cause analysis (RCA) completion after episodes of VTE are identified

How much:
1) 95% of patients risk assessed
2) Maintain process of root cause analysis of cases

By when: Ongoing

Outcome:
1) 96% risk assessment
2) 100% RCA completed (Q3 to date)

Progress:
1) Achieved
2) On target

Improvements achieved:

- 70% of reviewed cases identified care where all aspects of assessment and prevention had been carried out perfectly
- Sustained process of risk assessment for patients on admissions to hospital
- A root cause analysis process to review all cases where clots occur now embedded with action planning around any risk identified
- The root cause analysis process has led to the introduction of compression devices for use in Acute Stroke care
- Ongoing induction and training for Junior Doctors new to the Trust

Further improvements identified:

- Investigate cases where not all aspects of the assessment and prevention were done correctly, pulling themes together to make improvements
- Utilise the Electronic Patient Record to produce a new risk assessment which automatically identifies changes in the patient condition to improve prevention and prescribing
- Automate the VTE identification process to increase the time available for improving care where preventable cases are found
Enhancing the hospital experience for our patients whilst continuing to manage increased emergency demand

The Patient Flow Programme forms part of the Salford Royal’s wider Productivity and Efficiency work and aims to enhance patient experience, whilst effectively managing our increasing demand within existing resources.

**Aim:** To be determined  
**Progress:** Commencing Spring 2015

**Plans for improvement**

A key component of the programme has been to establish a Corporate Patient Flow Team bringing together the Patient Pathway Managers, Bed Managers, ward co-ordinators and the hospital Social Work team.

The key goals of the programme are to:

- Review current pathways and processes to identify opportunities for improvement
- Develop capacity management skills across the organisation to ensure optimum utilisation of resources and improve the flow of patients through the healthcare system
- Review patient flow across local healthcare system, bringing together different models of care, improvements in community services and using hospital services differently
- Continue use and development of the Electronic Patient Record to support patient flow

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*Improving Patient Flow*  
The Health Foundation, April 2013

The term ‘flow’ describes the progressive movement of people, equipment and information through a sequence of processes. In healthcare, the term generally denotes the flow of patients between staff, departments and organisations along a pathway of care. Flow is not about the what of clinical care decisions, but about the how, where, when and who of care provision. How services are accessed, when and where assessment and treatment is available, and who it is provided by, can have as significant an impact on the quality of care as the actual clinical care received.
The programme consists of five key workstreams, a summary of which is provided below:

**Delayed transfers of care**
- Review of Community IV Service
- Greater Manchester Repatriation of services and Neuro Rehabilitation
- Review of Continuing Healthcare for adult patients
- Review of Intermediate Care Services
- Implementation of a Family-Carer Choice Policy

**Review critical care capacity**
- Development of a step-down forcing function - to enable patients to move from critical care when fit to do so

**Reduction in readmissions**
- Telephone follow-up of patients after discharge from hospital
- Expansion of Electronic Patient Record to community services

**Reduction in length of stay**
- Increasing morning discharges from hospital
- Automated medications dispensing on wards
- Reduction the time spent in hospital for non-emergency surgical, urological, trauma and orthopaedic patients
- Electronic Patient Flow System embedded across the organisation
- Introduction of Nurse-led discharges
- Development of a “virtual ward” within the Salford Health Care Division
- Increasing the number of patients who stay as a day case (non-emergency patients who stay in hospital less than 24 hours)

**Admission avoidance**
- Telephone follow-up of patients after discharge from hospital
- Reviewing alternatives to patient transport schemes
Safer staffing levels

94% of registered nurse shifts fully staffed

All wards are staffed to a ratio of at least:

1 registered nurse to 8 patients

while many exceed this number

The Francis Report (2013) pointed to the issues of safe staffing levels in nursing being a significant factor in the scandal of poor care and compassion shown in parts of the Mid-Staffordshire hospital.

In 2012 Salford Royal made a commitment to work to safe staffing levels and be open and transparent about the staffing levels on our wards.

Staffing levels are recorded every day by all wards in the hospital and displayed at the entrance to our wards. The staffing level boards are one of the first things visitors see when they come on to the ward and provide them with details of the shift co-ordinator, the numbers of qualified and unqualified nurses the ward should have for each shift, and the numbers they actually do have. The aim is to share staffing levels with our patients, families and staff in an open and transparent way, and to provide reassurance that the organisation is taking nursing staffing seriously, giving patients and families a greater sense of safety.

The Trust has a dual approach to setting safe staffing levels. Based on available evidence, the Trust has taken the decision to adopt a standard whereby the available nurse to patient ratio never exceeds one registered nurse per eight patients (inpatient beds), and that both the shift coordinator and ward manager function in a supervisory capacity.

All wards are now established to fulfil these staffing requirements. We are also collecting data on safe staffing in the community.

To take this a step further the Trust is using a tool that helps us measure how sick our patients are. This helps us to fully understand what the most appropriate staffing levels are for our wards by taking into account the types of patients and their needs.

*This ratio does not include trainee nurses or healthcare assistants, but only fully-qualified nurses*
Acute Kidney Injury (AKI) means your kidneys have suddenly stopped working as well as they were, some people used to call this acute renal failure.

AKI normally happens as a complication of another serious illness. AKI can be caused by stress on your kidneys due to a variety of reasons but includes infection, severe dehydration or some medications.

One in five people admitted to hospital in the UK each year as an emergency have AKI (Wang et al 2012).

In the UK up to 100,000 deaths in hospitals are associated with AKI and it is estimated that up to 30% could be prevented with the right care and treatment (NCEPOD 2009).

In September 2014 Salford Royal launched a new quality improvement project to improve the prevention, recognition and treatment of AKI across the organisation.

**What:** To reduce the number of patients that develop Acute Kidney Injury

**How much:** 10% reduction in Acute Kidney Injury

**By when:** December 2016

**Outcome:** In progress

**Progress:** On plan

![Graph showing count of patients with AKI alert over time](image)
Improvements achieved

- Patient Information leaflet available on our wards to help support patients in their knowledge of AKI
- The implementation of a national algorithm in our Electronic Patient Record. The algorithm identifies potential cases of AKI from laboratory results in real time and produces a test result advising clinicians of the severity of the AKI
- Training to our nurses and doctors about AKI and the best way to identify and treat patients at risk or who have developed AKI

Further improvements identified

- Trust wide online and face to face training to our nurses, doctors and pharmacists
- Using the Electronic Patient Record to risk assess patients for AKI and to assist clinicians to deliver the best care for AKI
- Working with our GP colleagues in the community to support ‘sick day’ education with patients. Sick days are days when patients should temporarily stop certain drugs during illnesses that can result in dehydration
Salford Royal continuously strives to be the safest organisation in the NHS. One of our primary drivers is to educate staff with quality improvement skills. While we offer a variety of Quality Improvement courses the Clinical Quality Academy is the most detailed programme. This programme is run annually, usually accepting 10 teams who spend 10 months learning improvement science whilst working on an improvement project in their area. Since the beginning of the programme 45 teams have completed the academy representing 193 staff.

**What:** To educate and train a group of senior leaders and clinical staff in quality improvement methods to build system wide improvement capability

**By when:** Annual programme

**Progress:** On plan

**Improvements achieved**

- Continued programme now in its 6th year
- Multidisciplinary teams across all divisions have been recruited
- Achieved cross organisational working (team members went onto continuing improvement in other hospitals)
- CQA projects have been published in journals and accepted as posters at international conferences
- The table on the right shows the number of different staff groups who have been involved in CQA

<table>
<thead>
<tr>
<th>Consultants</th>
<th>67</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Practitioner</td>
<td>1</td>
</tr>
<tr>
<td>Medical trainees</td>
<td>8</td>
</tr>
<tr>
<td>Specialist nurses / advanced practitioners</td>
<td>30</td>
</tr>
<tr>
<td>Lead nurses / ADNS / Matron</td>
<td>13</td>
</tr>
<tr>
<td>Ward / Community / Theatre nurses</td>
<td>30</td>
</tr>
<tr>
<td>Support Workers</td>
<td>1</td>
</tr>
<tr>
<td>Allied healthcare professionals</td>
<td>12</td>
</tr>
<tr>
<td>Non-clinical</td>
<td>31</td>
</tr>
</tbody>
</table>
Intestinal Failure Unit (Ward H8)

The Intestinal Failure Unit, one of only two national units serving patients with intestinal failure, carried out a project to reduce waste involving nurses, doctors, pharmacists, dieticians and patients.

The team became aware artificial parenteral nutrition (PN) feed was being wasted prior to being used for patients (parenteral nutrition is a way of feeding patients intravenously - directly into the vein, who have problems with their gastrointestinal tract). This was costly and in many cases preventable. Wastage of PN can be due to sudden changes in clinical condition of the patient, loss of venous access or for organisational reasons.

Through the support of the CQA program, data collection systems were created to identify and understand PN waste using statistical process control (SPC) charts. Following this a pattern of typical wastage appeared and helped determine the primary and secondary drivers used in a driver diagram, which enabled the team to articulate the aim of achieving a 10% reduction in PN waste by October 2014.

Regular team meetings were used to drive and develop quality improvement methodologies. Changes and effects were determined using plan, do, study, act (PDSA) cycles that were run concurrently using multiple strategies to reduce wastage including: Raised team awareness, highlighting the problem and querying as a handover question. Re-labelling bags unused still within expiry date, splitting fridge storage into days of the week so bags are quickly re-labelled to the next available day. In addition changing to standard bags during weaning processes, rotating stock bags, following a bag from fridge to patient, enhanced coordination and discharge processes.

PDSA strategies reduced waste by 39% exceeding the initial target of 10% in nine months. Enhanced team communication resulted in reinforced coordination of discharge planning.

The project highlighted PDSA cycles bring rapid opportunities for change using low cost ideas. A good driver diagram; robust data collection, PDSA cycles and proactive team work produce rapid and effective results.
Endoscopy unit - using quality improvement to improve endoscopy utilisation and flow

The Endoscopy Unit faced a number of challenges regarding capacity and so they applied for the Clinical Quality Academy to equip the team with the quality improvement methods to look at increasing the utilisation of existing capacity whilst ensuring patients are seen in a timely manner appropriate to their clinical needs and by appropriately trained staff.

The classroom based knowledge was put into practice and the team used weekly meetings to review data, diagnose the problems and develop, test and review change for improvement.

The team tried a number of changes, with the following results:

Inpatient triage:
- Positive patient and ward staff feedback
- Poor quality bowel prep reduced by 20%
- Less inpatient cancellations on the day
- Better unit flow

Telephone outpatients:
- Positive patient feedback
- 33% reduction in DNAs
- Poor quality bowel prep reduced by 20%
- 52% reduction in cancellations on the day

Session flow champion reduced sessions that started late by 25%.

Testing change is the best way to try things prior to implementation as it helps you to engage sceptics, but also allows you to see what the real problems are. Data is integral to informing improvement, it also helps to dispel myths.
Ensuring trainee doctors have the skills to undertake quality improvement work is a vital part of capability building.

What: Deliver an integrated patient safety programme to trainee doctors

By when: Annual programme

Progress: On plan

Established by a group of junior doctors the TICkLE group harnesses the skills and enthusiasm of doctors in training and equips them with the skills they need to lead improvement and safety initiative, by working with quality improvement projects as part of the regular training.

Improvements achieved

- Integration of Quality Improvement and Patient Safety teaching into the “Lessons Learnt” programme for Foundation Trainees
- Deliver a rolling programme of sessions on quality improvement, measurement and reliability in healthcare
- Link training sessions to clinical scenarios relevant to the trainees
- Identify improvement projects in areas of interest and facilitate trainees involvement in these
- Trainees involved in Sepsis and Catheter UTI improvement work
- Presented at the International Quality and Safety Forum 2014
- Presented to the National Foundation Training Program about patient safety training opportunities in Salford
- Use of monthly Grand Round session to focus on patient safety issues

Further improvements identified

- Link trainees to national audits - either to undertake an audit or to develop an improvement project based on audit results
- Develop a “menu” of topics (based on NICE guidelines and quality standards) where trainees can identify a topic of interest
Clinical Microsystems coaching works on the principal that all staff have two jobs, one to deliver care and two to improve how that care is delivered. Now an established programme, the Clinical Microsystems approach supports teams to lead and manage their own improvement work with focussed coaching in quality improvement methodology to ultimately build Trust wide improvement capability. This programme differs from other Quality Improvement projects and collaboratives through its pace and structure, and as the multi-disciplinary team have highlighted areas for improvement themselves they are more likely to have ownership and sustain the improvements made.

What: A structured six month coaching programme working with teams on a weekly basis on areas highlighted by them, whilst spreading Trust wide improvement capabilities

By when: Annual programme

Progress: On plan

Improvements achieved

- 21 teams have successfully completed the programme since it started in 2013, exposing a large number of staff to a wide range of improvement tools and techniques.
- Many teams have seen significant improvements in their area of work, some examples of this can be seen below.
- Teams are engaged and empowered to develop their own ideas for improvement and continue to meet once formal coaching has ended.
- Teams participating in Wave 3 (2014/15) are:

<table>
<thead>
<tr>
<th>Wave 3 teams and project focus:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Dietetics Outpatient Clinics</td>
</tr>
<tr>
<td>Pharmacy</td>
</tr>
<tr>
<td>Medical Investigation Units - Improvement in infusion process</td>
</tr>
<tr>
<td>C2 - Improvements in ward based processes</td>
</tr>
<tr>
<td>Stroke - Improving the Transient Ischaemic Attack (TIA) Service</td>
</tr>
<tr>
<td>Community Speech and Language Therapy Service</td>
</tr>
<tr>
<td>Podiatry - Home visit service</td>
</tr>
</tbody>
</table>
Reflections on Clinical Microsystems coaching

Laura O’Shea  
AHP Lead for Adult Speech and Language Therapy

I feel the outcomes of this programme have been more far reaching than I ever expected. From a management perspective I have felt empowered; reflecting on the start of the programme where the team were anxious about putting themselves out of their comfort zone to the end of the programme where everyone was contributing and taking it in turns to lead discussion without a second thought. It has changed how I approach change and have no issues in using the quality improvement methodology learnt over the programme, it’s really become second nature.

Jane Redshaw  
Senior Specialist Nurse, Transplantation

The QI Microsystems coaching has allowed the chance to pause from “firefighting” and stop and challenge what we are actually doing. We now realise that rushing through what we thought was the best way to manage increasing waiting lists wasn’t the most effective or efficient way to do this.

Having a structured way of evaluating the service has allowed us to change systems and ensure the team is working as efficiently and effectively as possible. Without this support we would never have made the time to stop and challenge our way of working because we were too busy doing! It’s amazing how much you can achieve in an hour when everyone is so focussed.

The facilitation has encouraged all team members to be involved which I believe has promoted shared ownership and responsibility and ultimately successful change. I feel as a group we have changed our way of thinking. We appear to be constantly challenging whether certain steps are necessary rather than accepting the status quo and making sure we can demonstrate that the change is effective.
As a ward based MDT (multi-disciplinary team) we have weekly meetings to identify ward based issues and areas for improvement.

The meetings are attended by nurses, doctors and therapists and having a varied MDT presence encourages open discussions, debate and collaboration across the whole team. This in turn has encouraged and reinforced changes in practice at ward level as any changes are driven from all angles. We also invite “guests” to attend the meetings such as the volunteers coordinator and the speech and language team, giving us the opportunity to use other specialist knowledge to create networks when trying to make improvements.

We have worked on several areas over the past 12 months, some examples of this are as follows:

The “Ban the beaker” initiative discouraged the universal use of beakers for all patients, unless they had just cause to use them. This initiative was driven forward by the Housekeeper and the ward volunteers. We sought patient and carer feedback throughout and it also led to the current practice of using bold coloured crockery for patients with cognitive impairment.

We also looked at how we could reduce patient falls and moved the storage of zimmer frames to within the reach of patients at the end of the bed as opposed to stacking them together in the middle of the bay, which had been historical practice.

This test of change was driven by the Physiotherapists, Occupational Therapists and the Care Support Worker and this new practice is now fully embedded on the ward.

There are many examples of how using a full MDT approach has made changing culture and ward practices that bit easier. Having the medical team engaged and involved from the start, ensured that they had a personal interest in all ward issues and have got involved with all the initiatives thus far. Having structure to the meetings, together with QI team facilitation has ensured we keep focussed, data is available and that the momentum of establishing a culture of continuous improvement is maintained. The process has also provided us with the opportunity to share our learning, not only at ward level, but also with other ward teams and the executives. This has further reinforced the positive culture of change on the ward and has given staff the opportunity to shine.
Consultant Fellowship Programme in Quality Improvement

Salford Royal continues to expand the numbers of doctors actively engaging with and leading Quality Improvement (QI) Projects across the Trust.

Having more senior doctors driving improvement projects is a key driver towards Salford Royal improving care. The fellowship course aims to give skills to a group of doctors such that they are sufficiently knowledgeable and experienced to be able to lead Trust-level QI projects in the future and be available to help teach QI knowledge and skills within and beyond Salford Royal.

Aims:
1. Ensure attendees/fellows can successfully develop, lead and manage a Trust-level QI project
2. As part of a wider faculty, teach QI knowledge and skills

What:
Run a ‘pilot fellowship’ lasting one year, incorporating one to one QI support, alongside 10 days of small group teaching with clear objectives. Each fellow should be involved with two QI projects, one being Trust-level

By when: Final presentation and debrief in June 2015

Outcome: In progress
Progress: On plan

In September 2014, a year-long pilot was commenced with five doctors from various medical and surgical disciplines. These ‘fellows’ all had prior QI training and experience of being involved in projects.

Each doctor was asked to lead two QI projects, at least one of which had to be a Trust-level priority. One to one support was provided and there was an accompanying 10 day detailed training package focussing on measurement for improvement, alongside leadership and relevant management skills to support their further development.

Examples of projects the fellows are working on are as follows:
- Establishing a departmental level Quality and Safety dashboard
- Qualitative audit of “5 Steps to Safer Surgery” within theatres
- Structured ward round within General Surgery
- Intensive Care Unit handover
As a Specialty Trainee in Intensive Care, the Quality Improvement Fellowship Programme has provided an excellent opportunity to lead a quality improvement project from start-to-finish with supervision from the QI department. I have learnt a lot from the various speakers that have discussed a wide variety of topics ranging from the history of quality improvement, the role of QI in the evolution of Salford Royal to how to perform an inspection and run a meeting effectively.

I have learnt a lot from the other fellows about how to set-up and run a project as well as tips on how to deal with problems that crop-up during implementation of change. I have enjoyed learning about the working lives of colleagues in different specialties and it has made me appreciate others perspectives a lot more.

I feel much more confident in running a QI project and offering guidance to other colleagues through attending this programme. I feel that my ability to select appropriate tools and chart data have improved immeasurably!

The fellowship has been an excellent opportunity to develop a deeper knowledge of QI theory and a broader tool-kit with which to approach projects. The small group structure facilitates interaction and discussion. More broadly the seminars have covered a range of topics including hospital inspections, human factors and medical leadership that have extended my understanding of how healthcare functions. I would recommend the fellowship to any consultant looking to develop QI interest.
A proportion of patients discharged from hospital are readmitted as an emergency within 30 days. Although not always avoidable, there are things we can do to help prevent readmissions. For example, identifying patients who are more likely to re-attend, explaining medication instructions in a manner the patient understands, following up patients once they have left hospital or providing a telephone helpline for patients to discuss any worries they may have.

**What:** Reduce the number of patients who are readmitted as an emergency within 30 days of discharge from hospital

**How much:** NHS Salford CCG and Salford Royal have an agreement regarding reduction in readmissions in that if 2014/15 readmission rate is:

- a) Below 9.79% - no financial penalty will be applied
- b) Between 9.79% and 11.1%, - a penalty of £500,000 will be applied*
- c) Above 11.1% - a penalty of £1,000,000 will be applied*

**By when:** Ongoing

**Outcome:** In progress (readmissions rate 10.4% year to date 2014/15)

**Progress:**
- a) Readmission rate below 9.79% - Behind plan
- b) Readmission rate between 9.79% and 11.1% - On plan
- c) Readmission rate above 11.1% - On plan to avoid this penalty
A Trust-wide improvement collaborative established in 2013 brought together staff from wards, departments and across the community to solve this problem. Although we have tested and put in place many interventions, we did not achieve the original aim of 5% reduction by July 2014. However, there have been some local examples where change ideas have reduced readmissions for a specific group of patients.

We recognise that reducing readmissions is an incredibly complex long term project and we will continue to work on making improvements in this area. Reduction of readmissions is one of the five primary workstreams of the Patient Flow Programme (see page 21).

**Improvements achieved**

- Telephone helpline for patients with wound related queries after discharge
- Identification of re-attending patients for early review and admission avoidance
- Extension of visiting hours on wards to allow patients, families and carers to become more involved in their plan of care and treatment following discharge
- Telephone follow ups tested for patients after discharge
- Community Nurse Review for ‘at risk’ patients with alcohol liver disease
- Teach-back - clearly explaining information and making sure patients feel confident in how we have explained this and have understood the information

- Readmission avoidance via alternative access routes - dedicated services set-up to review appropriate patients after discharge to avoid readmission e.g. Renal Assessment Service and Surgical Neurosciences Readmission Clinic - see case study below
- Improved patient information to help patients to understand their illness and medications
- Ensuring patients get the right nutrition and sleep on wards in order to ensure that they are fit for discharge

**Further improvements identified**

- Test the improvements achieved across a wider section of the hospital and community and implement successful interventions
- Improved handovers between care providers in the hospital and community giving details about their patients to prevent patients from being readmitted

**Readmissions case study**

The Surgical Neurosciences Readmission Clinic was set up to reduce unnecessary attendance at both GP and A&E and subsequent readmission to hospital. The service is open to all patients discharged from Neurosurgery and allows patients prompt access to assessment and review by a senior medical clinician when they are experiencing any problems or issues following discharge.

Patient feedback, a record of clinic attendance and outcome of the appointment is reviewed monthly for continuous learning.

* Agreement with NHS Salford CCG and Salford Royal only, other commissioners readmission policy differ. Policy based on 2012/13 audit of avoidable emergency readmissions and uses data from PBR report, exclusions apply. The monetary value of any applicable financial penalties will be reinvested into community services to assist with admission avoidance.*
Collaboration in kidney replacement therapies

The Collaborative in kidney replacement therapies is an improvement project which began in April 2010 to improve care of renal patients in the Salford Renal Network. Phases one and two used a modified Institute for Healthcare Improvement Breakthrough Series Collaborative model to improve the achievement of clinical targets in dialysis patients in the network. The collaborative teams significantly reduced infection rates, a success which has been sustained for over a year.

For phase three we brought together stakeholders, experts and patients to discuss audit data and the findings from surveys of staff and patients. Two clear themes emerged as targets for improvement:

1. Staff culture and satisfaction (which has been demonstrated in NHS research to correlate to patient outcomes) and
2. The experience patients have of living with kidney failure

### Staff culture and satisfaction

**What:** For dialysis staff to feel highly valued, supported and that they are working in a positive team environment, as evidenced by improvement in the staff engagement score on the NHS staff survey to the best in the UK by March 2015

**How:**
- Strong supportive leadership with a culture that nourishes and improves staff
- Learning and development - effective appraisals and personal learning plans
- Improve teamwork and communication
- Improve staffing and sickness absence

**Outcome:**
- Leadership coaching for managers programme
- New training opportunities for staff - pioneering “microteaching” on the shop floor
- Multi-media learning tools - videos, presentations, case studies
- Improved communication via newsletters, coffee sessions with senior managers
- Morale-building activities such as staff and family days out
- Improving working processes and reorganisation of roles
- Training in people management for staff with leadership responsibilities

**Progress:** On plan
Patient experience

What: 90% of patients rating their care as good or excellent by November 2015

How:
- Improve communication between staff and patients
- Use technology and multimedia to give patients information they need in the way they want
- Peer support, mentoring and coaching
- Shared decision-making and self-care training to empower patients
- Create a positive, comfortable and welcoming environment for patients

Outcome:
- Newsletters, videos and articles about kidney disease written by and for patients
- Kidney patients trained as mentors and peer supporters
- Testing kidney patients using online an “expert patient programme”
- Development of a network of skilled volunteers
- Improved communication in outpatient settings
- Trips and community/family days to improve psychosocial wellbeing
- Increased self-care and self-management tools for patients
- Improvements to travel arrangements for dialysis patients

Progress: On plan
of patients having an accurate prescription on EAU when the pharmacists use the ‘on hold’ function on the Electronic Patient Record

Salford Royal has been selected by the Health Foundation to participate in a pilot project to lead the way on reliable prescribing systems.

Medication errors at Salford Royal rarely cause harm to patients because our systems are designed to stop this from happening. However, medication errors that have the potential to cause harm do occur. We aim to design a system which removes the potential for harm and delivers a reliable medication process to patients. This is from the point of prescribing, through dispensing and finally in the administration of the medicine to the patient.

What: Reduce medication errors during prescription, dispensing and administration of medicines

How much: 50% decrease in errors relating to the prescribing, dispensing and administration of medicines

By when: February 2016

Outcome: In progress

Progress: On plan

Improvements achieved

- An e-learning package for high risk medicines extended to nurses, pharmacists and non-medical prescribers. A further package released regarding controlled drugs for all nurses on 15 March 2015
- A pharmacist has been appointed to review patients admitted to the Surgical Admissions Lounge to increase the number of patients who have their medicines prescribed correctly before going to theatre
- On the Renal and Intestinal Failure Units patients are able to be referred to the Pharmacy team to ask any questions they may have about their medicines
Improvements achieved continued

On the Electronic Patient Record, new tools have been introduced for doctors to help them prescribe the correct antibiotics and help patients to receive these antibiotics more quickly. The following interventions have been implemented on EAU:

- All EAU pharmacists regularly use the ‘on-hold’ function to provide accurate information to prescribing doctors to streamline the prescribing process.
- One of the pharmacists on EAU is a non medical prescriber so is working with medical staff to ensure all patients are on the correct medicines.
- An additional Pharmacist is in place to provide support to the Ambulatory Assessment Area to complete medicines reconciliations (a process to ensure medicines prescribed on admission correspond to those taken before admission) now in post.
- Improved communication between Pharmacists and the ward team at the daily safety huddle which the pharmacist attends each day.
- Pharmacy staff now have a daily huddle on EAU to improve communication between the team.
- A project on EAU has been completed to ensure that GPs have an accurate list of all the medicines stopped and started during a patient’s admission.

Further improvements identified

- After the pilot project in 2014, the patient Information Helpline will be rolled out to all ward areas in 2015. The aim of the helpline is to help improve a patient’s understanding of their medicines.
- To undertake a pilot of an automated drug cupboard on a medical ward at Salford Royal, including an electronic controlled drug cupboard. This should reduce the number of drug administration errors.
- Salford Royal is undertaking a joint project with Manchester University and Salford Clinical Commissioning group utilising decision support software in primary care. This brings together a hospital pharmacist and GP practice based pharmacists to improve prescribing and reduce the number of potentially avoidable adverse incidents regarding medicines.
- Salford Royal was awarded money for the 2nd stage of the Health Foundation Safer Clinical Systems Project. The areas to be addressed in the next stage are:
  - To increase the accuracy of prescribed medicines during weekends on EAU.
  - To have more Pharmacy staff working on EAU at weekends and bank holidays.
  - To extend the pharmacy service to 9pm so patients receive their medicines more promptly.
The Salford Integrated Care Programme

Salford’s Integrated Care Programme (ICP) aims to improve the health care system for those people aged 65 years or older and is being delivered in partnership with Salford City Council, NHS Salford Clinical Commissioning Group, Salford Royal NHS Foundation Trust and Greater Manchester West Mental Health NHS Foundation Trust.

A fictional character, ‘Sally Ford’ was created to better illustrate how three, inter-related work streams - Local Community Assets, Centre of Contact and Multi-Disciplinary Groups - come together to ensure that the person remains at the centre of the care system.

To complement the three original work streams opposite, we have since added new ones, including:

› Continuing to develop a set of care standards for care homes and supported living to provide broader support for to those in supported living accommodation.

A housing work stream has been established to work with colleagues in social housing - and also with the Fire and Rescue Service - enabling better access to those in privately-owned and rented homes.

› March 2015 saw the inaugural meeting of the out-of-hours work stream; aimed at identifying the changes needed across current services so to ensure a broader offer of care and support to Salford residents during times of the day when community services are closed.

› Salford Royal working with Age UK was one of five national Malnutrition Task Force pilot areas and links directly into the ICP, which - in recognition of the initiative’s impact to date - will continue to support this important area.

Furthermore, there is more work ongoing that shall enable us to deliver the programme across Salford. This includes:

› Using a summary shared care integrated record, hosted in Salford Royal’s own EPR system and accessed by community staff, GPs and mental health practitioners

› Establishing care co-ordinators, responsible for co-ordinating care for those with more complex needs. They support the MDGs in planning and are the main point-of-contact for patients and carers.
All of the ICP work is underpinned by a set of standards, which were developed and agreed by residents in Salford when asked to consider what older people should expect from the city as a whole, the health and social care services, and also standards by which they can live by to keep them healthy and independent for as long as possible.

These standards are:

**You should** do all you can to stay independent, healthy and secure by:

- Being motivated to look after yourself and motivating others to look after themselves
- Being respected and having respect for others
- Being treated as an individual person with dignity and:

**You want** to be valued as a person to and enabled to stay independent by:

- Taking part in activities which enable you to be happy and contented
- Taking an active role in decisions about yourself to enable you to live their life as you choose
- Taking up opportunities to access support and services which will help you to have a good quality of life

**You should expect to** be kept informed and up to date on what is happening locally so you know how to access information, advice and guidance on:

- Access to emotional well being
- Access to medication
- Access to emergency support
- Access to housing which meets their needs

Within the ICP, we are hoping to achieve the following objectives by 2020:

1. Reducing Emergency admissions and re-admissions
2. Reducing permanent admissions to residential and nursing homes
3. Improving quality of life for users and carers
4. Increasing the proportion of older people that feel supported to manage their own conditions
5. Increasing satisfaction with care and support provided to older people
6. Increasing flu vaccine uptake
7. Increasing proportion of older people that die in their preferred place
8. Increasing rates of early dementia diagnosis (a better Care Fund requirement)

**Further improvements identified**

- Redesign to strengthen care and support across seven-day working
- Awareness raising and engagement with older people, staff and other stakeholders
- Further monitoring and review of our 2020 programme objectives

During 2014/15, the programme has gained impetus in its implementation of its delivery model. This culminated in the historic agreement amongst the partners to create an Integrated Care Organisation (ICO) in order to develop better person-centred care.

Together, with our partners, we will explore the benefits of creating an ICO to further our shared vision of delivering integrated care which will cover the entire adult population. The ICO will be subject to future business case process and approval. Under the New Models of Care programme, Salford has been awarded Vanguard status for Primary and Acute Care Systems which will further support this work.
Sepsis: improved recognition and documentation of patients with sepsis

During Sepsis Nurse Testing we have seen the average time to antibiotics fall to under 48 minutes in the Emergency Department.

Sepsis claims **37,000** lives annually in the UK and costs the NHS an estimated **£2.5 billion**.

Early intervention with the Sepsis 6 bundle certainly saves lives, but has also been shown to reduce the length of hospital stay and the need for Critical Care admissions.

Evidence shows that addressing an organisation’s response to sepsis will save an extra 100 lives per year for a typical medium-sized District General Hospital, and £1.25 million annually; just by getting the basics right.

Once sepsis is recognised, prompt assessment and implementation of the Sepsis 6 can save lives - **if antibiotics are given within the first hour, mortality is reduced by 8%**.

**What:** Reduce death from Sepsis by ensuring patients with Sepsis receive antibiotics within 1 hour

**How much:** 95% of patients to receive antibiotics in 1 hour

**By when:** December 2015

**Outcome:** In progress

**Progress:** On plan

**Improvements achieved**

- We are testing a Sepsis Nurse in four pilot areas across the Trust
- The nurse will ensure the Sepsis 6 bundle is administered in a timely fashion and we capture the time the elements have been delivered
- As part of World Sepsis Day we carried out Sepsis simulation training across the majority of the hospital wards
Further improvements identified

- An education programme is in development with the use of a simulation exercise to evaluate the recognition and treatment of Sepsis.
- Pilot wards are mapping the journey of a patient with Sepsis from recognition to treatment, to identify where improvement work may improve our performance.
- We need to improve the number of staff trained in providing the Sepsis Competencies e.g. IV Therapy.

The above chart shows the average time to administer antibiotics to patients with sepsis. This chart shows that when the Sepsis Nurse is active in A&E the average time of arrival to antibiotics is 47.97 minutes.
### Over 2 years
without a serious incident in Theatres within the Division of Surgery

<table>
<thead>
<tr>
<th>What:</th>
<th>To achieve a culture of safety within Theatres and reduce the number of serious incidents in Theatres</th>
</tr>
</thead>
<tbody>
<tr>
<td>How much:</td>
<td>Zero serious untoward incidents in Theatres</td>
</tr>
<tr>
<td>By when:</td>
<td>March 2015</td>
</tr>
</tbody>
</table>
| Outcome: | 1) Achieved 789 days without a serious incident in Surgical Division Theatres  
2) Achieved 226 days without a serious incident in Neurosurgical Division Theatres |
| Progress: | Surgical Division - Target achieved  
Neurosurgical Division - Behind plan |

We continue to work towards embedding a culture of safety within our theatres. This means we want our staff to feel able to speak out about, and are enabled to solve, any problems they encounter which might have a negative impact on patient safety. As a direct impact of changing culture, we are aiming to reduce the number of serious untoward incidents (SUI) which occur within theatres.

We would like our theatres to become the safest within the NHS. The key measurable aims are to:

1. Have zero Serious Untoward Incidents
2. Achieve 100% compliance with the five steps to safer surgery
3. Improve theatre culture, as measured by the Safety Attitudes Questionnaire

Within the past year we have expanded the scope of our Theatre Improvement Programme to include operational issues and the way we organise and plan activity in our operating theatres.
**Improvements achieved**

- Tested a qualitative audit of the five steps to Safer Surgery
- Launched a more comprehensive theatre improvement programme based on the recommendations of frontline staff

**Further improvements identified**

- Implement quantitative audit of the 5 steps to safer surgery
- Implement our Theatre Improvement Programme, which is based on the NHS Institute for Innovation and Improvement’s Productive Operating Theatre Programme. A Steering Group chaired by an Executive Director will meet monthly to guide the work, which is based around four improvement themes as detailed below:

  **The Programme**
  
  focusses on the following key areas, and we will work with pilot teams from each of our Theatre specialties in sequence to embed the work.

  A series of additional measures are currently being agreed to enable us to gauge the success of the programme.

**Session Start-up**

Will help teams identify what is required to standardise the processes and make that standard repeatable, thereby eliminating duplication and delays by ensuring each task has been actioned at the right time.

**Patient Preparation**

Will focus on managing preparation of patients for surgery, focusing on the information and activities required in the theatre suite to ‘pull’ the patient for surgery, efficiently and without delay.

**Patient Turnaround**

Covers the process of managing the transition between patients in the theatre.

**Handover**

Will help teams focus on the safe and efficient transferral of patients from one function to another.

**Consumables & Equipment**

Helps plan the levels and timing of top-ups, including stock usage requirements, stock levels, storage and replenishment systems for surgical kit and consumables.

**Recovery**

Managing the patient’s recovery process, focusing on information flows, tasks and activities required to transfer the patient into recovery and out of the theatre suite, efficiently and without delay.

**Team-working**

This module focuses on enhancing multidisciplinary team working within operating theatres, training human factors helps teams understand the importance of, and introduce techniques to, improve communication using tools such as brief, debrief and time out.

**Scheduling**

Looking at the essentials of the scheduling process through fresh eyes involving the whole team in:

- Improving the flow of information
- Ensuring each process is performed in a timely manner
- Reducing errors / delays
- Eliminating unnecessary duplication and maximising the effectiveness of the processes

**Knowing How we are Doing**

Developing measures to help your theatre teams understand how you are doing against the overall objectives of the programme. This module will promote the use of facts and data to drive continuous improvement and promote ways to resolve issues in a team environment.

**Well Organised Theatre**

Will help teams organise their workplace to better support the processes being carried out in theatres, simplifying your workplace and reducing waste by having everything in the right place, at the right time, ready to go.

**Operational Status at a Glance**

A visual management tool that will support individual theatres and the whole theatre suite to demonstrate ‘real time’ performance enabling staff to pro-actively manage and mitigate any quality, safety or operational risks as they arise.
Executive WalkRounds

**86 visits conducted this year**

Executive Safety WalkRounds started in February 2009 and have evolved into Work-Withs where Executives work alongside or shadow frontline staff to better understand the challenges of delivering safe, clean, and personal care.

The Work-Withs process involves Executives visiting clinical areas and talking to staff and patients in an attempt to gain a deeper understanding of local patient safety concerns and the challenges faced by the frontline team.

### The goals:

1. To increase awareness of safety issues among all staff
2. To make safety a priority for senior leaders by allowing them to spend dedicated time with frontline staff discussing patient safety issues
3. To highlight patient experience and satisfaction
4. To promote a safety culture

### Progress:

- On plan

**Improvements achieved**

- 86 areas have been visited since April 2014
- Work-Withs are now booked directly through Clinical Directors to enhance engagement with medical staff (Clinical Directors are able to connect the Executives with the activities of doctors in clinical areas)
- Community areas, including Children’s Services are now fully incorporated into the Work-Withs schedule

**Further improvements identified**

- Continuous review of the format of the Work-Withs to ensure that patient safety is maintained as a priority
Outpatient improvement

The Outpatients Department at Salford Royal has clinics across a range of specialties, providing services to over 300,000 patients every year.

What: To deliver an outpatient experience that is patient centred, efficient and innovative
By when: Ongoing as part of the Outpatient Improvement Strategy
Outcome: Achievements against 2014/15 objectives
Progress: On plan

We will deliver an outpatient experience that is:

- Patient centred
- Efficient
- Innovative

Tool for delivery:
- Teamwork & communication
- Lean methodology
- Technology solutions
- Department redesign

Expected standards:
- Pathway redesign
- Customer services training
- Communication
- Reducing unnecessary attendance
- 7-day working

Values:
- Patient & customer focus
- Respect
- Continuous improvement
- Accountability

Sustainability:
- Leadership
- Continuous focus on patient experience
- Exploring & developing new ways of working

We want to be the best outpatient department in the NHS:
- Patient centred
- Efficient
- Innovative
We aim to deliver an efficient outpatient service with minimal patient waits underpinned by the best possible care.

**Patient centred**

We want to provide our patients and their carers with the best possible experience whilst they are using our services. We know that providing patients with clear information and an efficient appointment leads to improved experience and helps reduce anxiety.

We have reviewed all outpatient information and letters to ensure information is clear and consistent. We have also completed analysis to identify causes of delays in clinic. We will continue this work to ensure patients are seen smoothly and on time.

**Efficient**

We are continuing our work to reduce the number of patients who did not attend (DNA). A phone text service has been rolled out to outpatient (and inpatient) areas. We have also developed mechanisms to identify patients who DNA on a number of occasions, this allows us to ensure patients are appropriately managed and supported.

**Innovative**

We have implemented a number of technology linked improvements in outpatients, including interactive text services allowing patients to rebook or cancel their appointments via mobile phone.

We have submitted an innovation bid to Salford CCG to pilot a new Teledermatology service for Salford based medical practices. Teledermatology allows GPs to send in images of skin conditions which can be rapidly interpreted by a dermatologist and advice given within a number of days. The service also supports GP education and knowledge of dermatological conditions.

**Improvements achieved**

- Sustained improvement in did not attend (DNA) rates
- Patient text service for appointment reminders and appointment rebooking
- Review of all patient communications - improving clarity and instruction
- 95% of patients reporting the care they received in outpatients as excellent or very good

**Further improvements identified**

- Patient waiting times in outpatients
- Clinic space utilisation
- Pilot of a Teledermatology service for Salford medical practices
Lessons learned

Hospitals and healthcare organisations are very complex and busy, sometimes despite the hard work and best intentions of the staff incidents can occur. Such incidents can range from the serious to the very minor, sometimes they can even cause harm to patients.

When incidents occur the teams in the Trust spend time investigating them, trying to understand what caused them and putting in place action plans to ensure that they do not happen again. Often these action plans are successful, sometimes less so. Sometimes repeat incidents can occur in other parts of the organisation because the learning from the incident last time it happened wasn’t communicated as well as it should have been.

Salford Royal has, over the course of the last year worked with two other organisations (Royal Devon and Exeter and Sheffield Teaching Hospitals) on improving learning from incidents.

Improvements achieved

› The testing of a system that categorises the causes of incidents so that these causes can be measured over time (often different types of incidents have the same causes which is why it is useful to measure how frequently these causes occur)
› The testing of a lessons learned newsletter to share across the divisions - with the purpose of helping wards and departments learn from incidents that could happen in their areas
› Serious incidents have been shared across the three organisations working together so that we can share the lessons from the different incidents. All shared incidents were anonymised before sharing between Trusts
› Our teams have been trained on reviewing incidents so that they are better able to understand the causes of them

Further Improvements Identified

› Further development of the lessons learned newsletter so it can be published to all areas of the Trust
› Monitoring occurrence of different causes of incidents across the different areas of the Trust so that we can better understand trends and themes
Salford Royal NHS Foundation Trust recognises that in order to achieve our ambitious aims, we’ll also need to collaborate with external partners. Our partners include:

**Salford Royal** is one of 16 member Foundation Trusts in the first member-convened network who wish to focus relentlessly on improving quality and safety. NHS QUEST members work together, share challenges and design innovative solutions to provide the best care possible for patients. NHS QUEST organise their work under four primary drivers; leadership, improvement programmes, measurement and building capability. Members are an action-orientated, ambitious and committed network and it is an ambition to extend their membership to a maximum of 20 organisations over the coming year.

**Haelo** is an innovation and improvement science centre, based in Salford and owned by Salford partners:
- Salford Royal NHS Foundation Trust
- NHS Salford Clinical Commissioning Group
- University of Salford

Haelo also has a strong and evolving partnership with Salford City Council, Salford Public Health and Greater Manchester West Mental Health Services. The primary purpose of Haelo is to identify, adopt and spread innovation and best practice for population health benefit, focusing on improving outcomes to address inequalities and optimise public resource.

**Making Safety Visible Programme**

The Trust is actively involved in the Making Safety Visible Programme, providing opportunity for the Trust and key partners to develop an improved understanding of measuring and monitoring patient safety across Salford’s whole health and social care economy. The Trust is working closely with Salford Clinical Commissioning Group and Social Care colleagues to build a safety surveillance system that provides reliable data on which Boards can base informed decisions.

**Salford Royal site visits**

In addition to these formal partnerships, the Trust hosts six monthly external site visits which are open to attendees from across the NHS in Great Britain and also welcome International visitors. The days provide an opportunity for Salford Royal to share its Quality Improvement journey with colleagues whilst also learning from others and establishing important networks which will support improvements going forward.
0

MRSA blood stream infections in 2 years

What: To sustain zero MRSA blood stream infections
How much: Target for 2014/15 was zero avoidable MRSA bloodstream infections
By when: April 2015
Outcome: 0 avoidable MRSA bloodstream infections
Progress: Target achieved

Improvements achieved

- We have achieved over two years without an avoidable MRSA bloodstream infection
- Expansion of the Intravenous (IV) service to ensure best practice for placement and management of IV devices
- We have treated patients at high risk of infection in the community to minimise their risk of developing MRSA
- Sustained compliance with hand hygiene practices to minimise infections
- Sustained compliance with Aseptic non-touch technique to minimise infections

Further improvements identified

- Continue to maintain standards implemented in order to sustain improvements achieved
- Working across the community to have a whole system approach to the reduction of MRSA
Clostridium difficile (C-diff)

96% compliance with correct antibiotic prescribing procedures

Clostridium difficile is a common bacterium that is harmlessly in the bowel of 3% of healthy adults and up to 30% of elderly patients. Antibiotics disturb the balance of bacteria in the bowel and Clostridium difficile can then multiply rapidly and produce toxins which cause diarrhoea and illness.

What: To reduce the incidence of avoidable Clostridium difficile
How much: Target for 2014/15 was 21 avoidable cases of Clostridium difficile
By when: April 2015
Outcome: 19 cases of avoidable Clostridium difficile
Progress: Target achieved

Improvements achieved
- 83% reduction in Clostridium difficile cases over eight years
- 96% compliance with correct antibiotic prescribing procedures
- Enhanced working across the health economy for a whole system approach to reducing Clostridium difficile infections

Further improvements identified
- Sustained compliance with antibiotic prescribing
- A continued focus on reducing all health care associated infections to minimise use of antibiotics and therefore further reduce the risk of Clostridium difficile infections
- Sustain a blood culture contamination rate below 3%
Fundamentals of nursing

Striving to provide Safe, Clean and Personal care every time

Measuring the quality of nursing care delivered by individuals and teams is not easy. We have had a performance framework based on the Trust’s Safe, Clean and Personal approach to service delivery, which incorporates Essence of Care standards and key clinical indicators. This has been widely used at the Trust in the acute hospital for a number of years; this system is known as the Nursing Assessment and Accreditation System (NAAS). This performance assessment framework supports the process of assurance across the organisation and assists in meeting the requirements of our regulators.

The Nursing Assessment and Accreditation System (NAAS) is used to monitor nursing care through a range of standards. The system involves, not just nurses but the whole team and puts patient care at the centre. It highlights best practice which is shared throughout the organisation and identifies areas for improvement.

The NAAS works at various levels:
› Patients - receive safe, clean and personal care every time
› Ward teams - ownership providing healthy competition between wards
› Divisions - can assess nursing care in their areas
› Trust Executive - demonstrates the quality of nursing care in the whole organisation

Salford Royal focuses on patients and outcomes instead of more traditional performance assessments and staff have embraced this process because they see it as fundamental to achieving excellent quality care for patients.

For a ward to achieve SCAPE status the must, as a minimum, have maintained level 2 NAAS (green) for 24 months (3 consecutive assessments).
All services assessed are required to have an action plan which is signed off by the Assistant Director of Nursing for community services.

Community teams have engaged very positively with the CAAS process and there are now only a handful of community teams yet to receive an assessment. A successful aspect of the CAAS process in the past 12 months has been the assessment of several non-nursing community teams. The process has been applied to Allied Health Professional (AHP) teams such as Adult Speech and Language, Podiatry and the Community Neurological Rehabilitation Team as well as Paediatric AHP teams such as Occupational Therapy and Physiotherapy teams. This has allowed these teams to demonstrate the valuable work they provide to the patient pathway, as well as ensure they are providing a safe and effective service.

Community Assessment and Accreditation System (CAAS)

Taking the learning from NAAS, over the last couple of years we have developed a Community Assessment and Accreditation System (CAAS) which is being rolled out to all community based services. Each question in the CAAS is linked to the 6Cs of compassionate care; whilst providing evidence for the Care Quality Commission’s core standards.

Care, Compassion, Competence, Communication, Courage and Commitment
Patient feedback
The friends and family test

The NHS friends and family test is an important opportunity for us to gain feedback on the services that we provide. Patients are given the opportunity to give feedback by answering a simple question about their experience. “How likely are you to recommend our ward to friends and family if they needed similar care or treatment?” Patients are invited to respond by returning a postcard, by phone, text message or using the Salford Royal website.

From April 2013 to January 2015 the Trust’s mean score has steadily increased and is currently 92.86% with response rates over the past 12 months for inpatients at 37.62%. Whilst the Trust is currently exceeding the minimum response rate requirement set, further work is required to ensure ongoing improvement to meet future increases required.

The information provided by the friends and family test allows us to understand both our strengths and weaknesses and to devise action plans to improve quality care and service delivery. Regular monitoring of this information is vital to ensure timely responses in making improvements. Therefore, Ward Managers and Matrons provide monthly forums to discuss results and enable shared learning to support each other to make improvements.

The next 12 months will see all identified community teams and services (of which there are 46) receive a CAAS assessment with the process for SCAPE developed for community teams.

Inpatient survey

In addition to the friends and family test, we spend a lot of time collecting and responding to information we receive about our services from our patients and staff. In order to find out what our patients think, we are one of 78 organisations that take part in the annual Picker Survey. Below are some of the results and findings from the Picker Survey.

Salford Royal performs better than average on: 35 questions!

Salford Royal performs better than last year on: 2 questions!
2 Community Paediatric Service

Improving HbA1c in children and young people (CYP) with Type 1 diabetes under 19 years old.

HbA1c is a measure of blood glucose (sugar) and is important to monitor in patients with diabetes. The unit to measure the HbA1c is known as mmol/mol.

The recommended HbA1c level for children with diabetes is generally less than 58mmol/mol (7.5%) but targets are individual (Diabetes UK).

The National Diabetes Paediatric Audit 2012/13 reported that nationally only 15.8% of children and young people with Type 1 diabetes had an HbA1c within the optimal range of under 58mmol/mol. In addition 58.4% of CYP had an HbA1c between 58-80mmol/mol. Over 25% of children nationally have an HbA1c over 80mmol/mol.

The figures in Salford are better than the national average with 17.5% achieving an HbA1c below 58mmol/l. The number between 58-80mmol/mol was 59.5%. The number with an HbA1c above 80mmol/mol was 23%.

We therefore set the following aims, that by April:

- To increase by 5% (to 22.5%) the percentage of children and young people (CYP) with an HbA1c under 58mmol/mol
- Reduce by 5% (to 18%) those with an HbA1c above 80mmol/mol

Outcome:

By the end of January 2015:
- Percentage of HbA1c under 58mmol/l = 23%
- Percentage of HbA1c above 80mmol/mol = 20%

Progress:

- 5% increase in the number of CYP with an HbA1c below 58mmol/mol - Target achieved
- 5% reduction in those with an HbA1c above 80mmol/mol - Behind plan

Further information

- At the start of the project the focus was to reduce the number of CYP with an HbA1c above 80mmol/mol as this group are significantly more at risk of hospital admission and developing the long term problems associated with diabetes. However, despite increased interventions there has been little consistent improvement in individual HbA1c

Further improvements identified

- The focus of the project is now on increasing the number of CYP with an HbA1c below 58mmol/l
- Currently 18% of CYP have an HbA1c between 58-62mmol/mol. Improving HbA1c in this group will lead to a rise in the number below 58mmol/mol

As part of the project we have developed a quality initiative to identify how each individual in the Paediatric Diabetes Service is performing. This includes the following information:

- Current HbA1c
- Insulin regime e.g. multiple injections, Insulin pump etc
- Type of blood glucose meter
- Psychology intervention

This information is displayed on an anonymised white board so that the team can identify individual CYP who need specific interventions to improve HbA1c. This is updated every week and the team can see at a glance where interventions need to be focussed.
In January 2013 Salford Royal launched an ambitious project aimed at improving Patient, Family and Carer Experience and making it the best organisation in the NHS. This project is part of our wider Patient Experience Strategy which aims to ensure we deliver what matters most to our patients.

Since the project started more than 30 teams from across the organisation have participated in eight learning sessions to share best practice and learn from our patients and other experts in improving patient experience.

Underpinning the improvement work is the delivery of the Trust ‘Always Events’ which patients should expect are embedded in the care we provide.

What: To be in the top 20% for patient satisfaction in the NHS
90% of patients to rate their care as excellent or very good

By when: Ongoing

Outcome: Top 20% for patient satisfaction

Progress: Target achieved
Improvements achieved

The Patient, Family and Carer Experience Change Package was launched in October 2014. The Change Package includes six key areas within which our teams test new ways to improve experience:

1. **Written bedside communication**
   This includes teams offering diaries to patients to capture their thoughts, reflections and any questions they would like to ask their Doctors.

2. **Capturing, displaying and acting on patient feedback data**
   This includes ways of sharing patient feedback with the whole ward team and developing changes based directly on the formal and informal feedback we receive from our patients.

3. **Enriching what matters most conversations**
   This includes ways to get to know our patients’ preferences in more detail.

4. **Creating a home from home environment**
   This includes ways of making our patients’ stay in hospital more comfortable including reducing noise at nights.

5. **Different ways to provide information to patients and their families**
   This change area is all about improving communication using different methods such as videos.

6. **Improved patient and family access to the staff that look after them**
   This includes wards extending opening hours.

Further improvements identified

▷ Embed the Change Package throughout the organisation
▷ Continue to develop and refine the Change Package through testing new ways to improve our patient experience
▷ Focus on community teams to understand how we can improve patient experience amongst different teams

Please note we are working on increasing the responses to the community patient survey to ensure that it is representative of the services that are provided.
The views of our patients and staff are very important to us. We spend a lot of time collecting and responding to information we receive about our services from our patients and staff. We receive feedback through a number of methods, including surveys, patient stories and patient experience surveys taken at the point of discharge, all of which provide us with vital information on how to improve. This page details a selection of results from our Patient Experience Surveys and the National Surveys that were conducted in 2014.

**What:** To continually improve patient and staff satisfaction

**By when:** On-going

**Progress:** On plan

As well as our Patient, Family and Carer Experience Collaborative we spend a lot of time understanding what our patients tell us about their time in our Trust.

In order to find out what our patients think, we are one of 78 organisations that take part in the annual Picker Survey.

Here are some of the results and findings from the Picker Survey:

- **Salford Royal performed better than average on 35 questions**
- **Surgery - told how to expect to feel after operation or procedure**
- **Discharged - was not delayed**
- **Having confidence and trust in doctors and nurses treating**
- **A&E - given enough privacy when being examined or treated**

Salford Royal performed better than last year on 2 questions:

Areas of significantly better than average performance for Salford Royal:

Areas of significant year on year improvement for Salford Royal:
What our staff said:

The 2014 staff survey was undertaken between October and December 2014 with the results being published by NHS England on 24 February 2015.

For the first time this year staff had the opportunity to complete the survey online with 810 eligible staff invited to do so. 450 members of staff completed the survey, a response rate of 56% which is amongst the top 20% of response rates in the country.

We are really proud of maintaining our position in the top 20% of Trusts for staff engagement with Salford Royal currently sitting in 2nd place for all acute Trusts. This year we also entered the Times Top 100 Best Not-For-Profit Organisations to Work For and were listed as “one to watch”.

NHS England identified 29 key findings, clustered under the four staff pledges listed in the NHS Constitution. These are to:

1. Provide staff with clear roles and responsibilities and rewarding jobs
2. Provide all staff with personal development, access to appropriate training for their jobs and line management support to succeed
3. Provide support and opportunities for staff to maintain their health, well-being and safety
4. Engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services

Compared with other acute Trusts (n=138), Salford Royal NHS Foundation Trust ranked, in the 29 key findings, as follows:

- Best 20% in 19 (20 in 2013)
- Above average in 4 (6 in 2013)
- Average in 6 (2 in 2013)
- Below average in 0
- Worst 20% in 0
Experience of Staff as Patients’

In 2014, while considering the different sources of patient information we realised that we were missing a valuable source of information. That source of information was those who work at our Trust who have also been patients.

Many of our staff live locally, and as a result when they have healthcare needs it is the services of Salford Royal that they use.

We also felt that there was great value in the feedback of the staff as they are more aware of the Trust’s expectation for care and how we believe our patients should be treated, making them an excellent “mystery shopper”. They have the knowledge of what “good” is and therefore can identify when expectations are not met and advise ways to rectify issues that have been identified.

It was agreed that the interviews with staff would be informal and we would listen to their story and whatever they wished to talk about, but, we had a minimum amount of information that we wanted to get. This followed four areas (which are used by the CQC when they undertake inspections) which we asked the individual to give marks out of 10 for:

- Safe (How safe did you feel throughout your journey?)
- Effective (Did the care we provided provide you with the desired result?)
- Responsiveness (Did you receive treatment in a timely manner with an efficient use of resources?)
- Caring (During your stay in the hospital did you feel cared for or was the treatment centred on your illness/condition with little regard to you as a person?)

We also ask if there was anything that they as members of staff had to do to influence their care, which a patient who wasn’t a member of staff would be unable to do.

The feedback we have had so far has been overwhelmingly positive with some areas for improvement identified.

In the four domains that we chose from the CQC inspection the average mark out of 10 was:

- Safe 8.16
- Responsiveness 7.56
- Efficient 8.03
- Caring 8.34

The recurring themes for improvement that the interviews identified are, scheduling/administrative errors, taking home medication delays and preparing for discharge. This has highlighted where improvements are required in the patient journey.
Salford Royal set up a specialist renal clinic in 2014 for young adults with chronic kidney disease (CKD) and managed to win a prestigious national award within the Managing Long-Term Conditions category of the Health Service Journal Patient Safety and Care Awards.

The clinic was set up because of concern about poor outcomes for many patients aged 16-30 with CKD and because patients often asked ‘why do I never see other young people like me?’ At worst, issues included premature deaths and transplant losses. In addition, there were many problems around patients not taking their medication, missing appointments and having long hospital stays, as well as feeling cut off from their peer groups.

The one-stop clinic was designed around feedback from 36 young patients and provides personalised care from medical staff and also from advisers offering counselling, career and benefits information.

Patients have been able to get involved in mentoring and expert patient programmes and there has been a buddying scheme launched where existing patients team up with new inpatients who have kidney failure or are struggling to cope with their kidney disease.

The multi-disciplinary approach means those who attend the clinic can access help with all sorts of problems, which are often bigger priorities for patients and directly impact on their renal health and wellbeing - such as arranging help with transport costs so a patient could attend college and hospital appointments.

There has been the establishment of a young adult network group so patients aged 16-30 can meet up socially and support each other. Young patients also have their own section on the Greater Manchester Kidney Information Network website and there is also a dedicated Facebook page.

"The ‘relationship-centred’ personalised care where patients feel they’re being treated as a person, not just a kidney, and the extra information and peer support from the clinic have improved patients’ confidence and morale. We are seeing better medication compliance, more patient empowerment and fewer complications."

Dr Tina Chrysochou
Consultant - Renal Young Adult Service
The term dementia describes a set of symptoms which include loss of memory, mood changes and problems with communication and reasoning. These symptoms occur when the brain is damaged by certain diseases, including Alzheimer’s disease and damage caused by a series of small strokes. It is progressive, which means the symptoms will gradually get worse.

Delirium is a common clinical syndrome characterised by disturbed consciousness, cognitive function or perception, which can develop suddenly, and can come and go.

While delirium and dementia are different conditions, patients with dementia are at increased risk of delirium and many have both conditions. It can sometimes be difficult to differentiate between delirium and dementia and there is some overlap in terms of idealised care for patients who have dementia and/or delirium.

The Dementia and Delirium Quality Improvement Collaborative supported the development of a bundle of care by Clinicians at Salford Royal.

The elements of the bundle are detailed below:
1. Discharge planning started within 24 hours
2. Weight assessment completed and appropriate management in place
3. Intentional Rounding completed to protocol
4. If antipsychotics prescribed at Salford Royal then there is a clear rationale documented
5. Sensory impairment assessment and correction completed
Improvements achieved

- The change package was introduced Trust wide in May 2014 with an expectation of achieving 95% compliance with the bundle of care by September 2014. Regular audits were completed and we sustained compliance of between 93-95%. Rolling audit ended with the end of the dementia and delirium collaborative.
- The guideline for diagnosis and management of delirium has been ratified and circulated to clinical staff.
- The ‘day room’ areas in Ageing and Complex medicine have been redesigned providing a comfortable and more homely environment.
- Dementia courtyard officially opened.
- Development of a Dementia Membership Engagement Group.
- Received 1st prize for innovations in dementia care from the Royal College of Nursing.
- Dementia team received the Improving Person Centred Care award at the Trust Awards.
- Lead nurse received an award for best dementia lead at the National Dementia Care Awards.
- Volunteers identified to work specifically with people diagnosed with dementia.

Further improvements identified

- Embed Change Package and continue to audit performance. Future measurement will be a snapshot audit by the dementia team.
- Implementation of a dementia pathway to guide care through Trust services.
- Achieve 95% compliance with National Dementia Audit Standards 2016.
- Implementation of the Triangle of Care Trust wide.
- To measure and increase reliability to an expanded bundle which includes:
  1. All patients will be screened for Dementia and the dementia assessment process will be completed in full for all patients over 65 years of age who identify memory difficulties.
  2. Dementia and Delirium Diagnosis will be added to/confirmed in the Health Issues section of the Electronic Patient Record.
  3. Patients with a Cognitive Impairment will be provided with a blue identity band.
  4. Patients with a Cognitive Impairment will have a butterfly symbol on the bed boards.
  5. A hospital passport will be provided and completed during admission and stored at the bedside, scanned into the electronic patient record and given to the patient at discharge.
  6. The Confusion Assessment Method (CAM) will be used to assess acute confusion.
  7. New diagnosis or need for further assessment will be recorded in the discharge summary.
  8. People living with dementia and their carers will be offered the opportunity to complete the experience questionnaire.
End of Life Care has been rated “outstanding” across the Trust by the Care Quality Commission

NHS Improving Quality
September 2014

Advance care planning is a process of discussion between you, your partner, family or friends and depending on your individual circumstances at the time, those who may provide care for you, for example nurses, doctors, care home manager or social worker.

During this discussion you may choose to express some views, preferences and wishes about your future care so that these can be taken into account by those caring for you if you were unable to make your own decisions at some point in the future. This process will enable you to communicate your wishes to all involved in your care.

Advance care planning is an entirely voluntary process and no one is under any pressure to take any of the above steps.

The Trust uses our version of the Electronic Palliative Care Co-ordination System (EPaCCS) to support patient and carer involvement in planning for their future care (advance care planning).

EPaCCS shares information such as important goals, preferences for place of care and death, advance decisions to refuse treatment and lasting power of attorney electronically with hospital Teams, GPs (including Out of Hours), District Nurses (including Out of Hours), St Ann’s Hospice and the North West Ambulance Service.

From April 2014 to January 2015 of 411 people (across hospital and community) who had an advance care plan recorded in EPaCCS, 369 died in their place of choice (90%).
Improvements achieved:

Advance care planning and end of life care improvement initiatives for 2014/15 include:

**Advance care planning in the hospital**

- **What:** To increase the numbers of medical and nursing staff in the hospital setting with the skills and confidence to have advance care planning conversations with patients and carers using EPaCCS to capture and record this
- **How much:** 28 staff (14 doctors and 14 nurses) across 7 wards
- **By when:** End of March 2015
- **Outcome:** All identified staff took part in advance care planning conversations with patients to find out what they wanted for their future care - and gained permission to record this in EPaCCS so it could be shared with their GP and other professionals involved in their care
- **Progress:** Target achieved

**Advance care planning in the community**

- **What:** To develop a system of best practice in advance care planning communication with GPs in Primary Care and the community - using the ‘Palliative Care Meeting Checklist’ by District Nurses (ensuring that advance care planning information from EPaCCS directly influences the care offered to patients and carers - both in and out of hours)
- **How much:** The number of Primary Care (GP) Palliative Care meetings that were held over each 3 months of 2014/15 - where the District Nurse completed the ‘Palliative Care Meeting Checklist’ populated with EPaCCS Advance Care Planning information (target 85%)
- **By when:** End of March 2015
- **Outcome:** For quarter 3 of 2014/15 (October - December 2014) achievement was 100%
- **Progress:** On plan
Further improvements achieved:

- Implementation of the ‘Principles of Care and Support for the Adult Dying Patient’
- Formation of the Executive End of Life Care Task Group - with clear work aimed at improving key areas of patient and carer experience of end of life care
- Development and testing of reliable systems for delivering and measuring high quality end of life care incorporating national guidance
- Development and testing of a comprehensive education and training programme to actively support the achievement of a competent workforce
- Rapid Discharge - for those people dying in hospital who wished to die at home - between April and December 2014 - 25 of 25 people (100%) were successfully discharged with maximum support to do this - all within 24 hours of making the request (with the carer making the request if the patient was unable)
Death and dying is very difficult to deal with, even for staff who work in healthcare, but, helping patients and their families at their time of greatest need is hugely important us.

To do this we must ensure that patients and their families are able to easily access all of the services on offer supporting them in times of acute grief. During this difficult time there are many choices available. Patients and their families appreciate being given help to understand those choices.

The Royal’s Alliance Bereavement Service is a nurse led innovation transforming practice across three large acute Hospital Trusts including Salford Royal, with the purpose of providing excellent end of life care for all. The pioneering work has dramatically improved practice and successfully promoted patient choice and dignity in bereavement. This has brought together all multidisciplinary team members from porters to consultants and coroners to achieve excellence in care, delivered with care and compassion whilst helping to raise the profile both locally and nationally.

This work has developed and driven an inclusive package of care for patients and their relatives, irrespective of place of death. Initially starting in a single Trust, this service innovation has been replicated across a further two Hospital Trusts successfully resulting in close partnership working and innovation. Due to its success in reliability and transferability the model is now being seen as a model of ‘best practice’ with the Alliance lead regularly invited to deliver presentations about these ambitious and innovative developments.

The Alliance has transformed bereavement care and support and is far reaching in its impact.

Patients and family experiences are central to the bereavement service and we constantly strive for further improvements.
**Improvements achieved**

- Integration of agencies outside of the NHS including Greater Manchester Police, HM Coroner for Manchester West and the Registrar Offices
- Dignity in death symbol used throughout the organisation easily recognisable and a reminder of excellence in practice
- Nurse verification of death policy
- Reduction in times from patient death to arrival in the mortuary
- Organ and tissue donation referral/rate continues to improve

**Further improvements identified**

- Sharing of ideas and best practice across Salford resulting in high quality end of life care regardless of location and whether death is expected
- Bereavement study days allowing staff to develop their knowledge in bereavement care
- Understand satisfaction with end of life care through questionnaires and monitoring of complaints
- Simulation training for organ donation, verification of death and breaking bad news
- Bereavement support group established
- Annual donor support group
- Annual memorial service now including children of any age
- Electronic records established for care after death, verification of death and rapid discharge
- Quality improvement initiative to support 23 Trusts throughout the UK and internationally
- Bereavement website updated to incorporate all necessary information in relation to dying, death and bereavement available for hospital and community staff
- Innovations money granted and utilised for bereavement trainer for children and families. Training of health professionals in contact with children commenced
- We have developed comfort packs for families involving partnerships with a local school for children with learning disabilities and the kind support of ASDA supermarket
Using volunteers to enhance patient experience

Volunteers are a firm part of the staff community at Salford Royal with over 340 currently supporting our patients, visitors and staff. Volunteers enable the Trust to explore new ways of working and to improve the experiences of people that use our services. As well as continuing to recruit new volunteers from the local area, and the avenues this can provide to those seeking future employment or a new social outlet, there have been a number of key developments in 2014/15:

The meet and greet service
Following feedback from the Trust’s Service User Forum, developed by the Inclusion and Equality Team, we identified the need to improve assistance for patients that may face barriers or have worries about attending appointments at the Trust; this could be due to a sensory or physical impairment, cognitive issues or possibly just feeling anxious and in need of a little support on the day.

We developed a network of specially trained volunteers who can be pre-booked to meet visitors as soon as they arrive on site, guide them to their appointment and even wait with them if required.

Following appointments the volunteers will guide patients back to their point of departure (vehicle or discharge lounge) and ensure that they are safely on their way.

The volunteers have access to a fleet of mobility scooters and when not supporting booked appointments they are able to support members of the public in navigating the main hospital site.

NHS Salford have also funded a Project Officer for 12 month to co-ordinate and develop the scheme.

Feedback from people who have used the service has been very positive so far and the Trust is hoping to expand the services provided in the near future.
Young adult renal mentors
For many young adults who are living with a kidney disorder the transition from paediatric to adult care can be a difficult process. Salford Royal’s Young Adult Renal Clinic was set up in order to provide a dedicated service designed around the needs of people in this age group and was the recipient of the Health Service Journal award for Managing Long-Term Conditions.

A new addition to the service is the introduction of Young Adult Mentors, these volunteers are all people who have suffered a variety of kidney disorders and have a wealth of experience relating to living with these types of conditions. As well as being present on the days the clinic operates the mentors are also sometimes paired with patients who are going through a difficult time and provide peer support from a perspective that is different and sometimes more informed than even our own staff.

The mentors have provided a wealth of resources to the Trust including hosting recruitment workshops and designing an event to promote diet options for renal patients.

Volunteer recruitment
Our volunteers provide an invaluable service to our organisation and the patients and visitors we serve. Volunteers can fulfil a variety of rewarding roles, some of which include:

- Patient Support Volunteers
- Head Strong Volunteers
- Volunteer Cancer Drivers Scheme
- Multiple Sclerosis Society Volunteers

We are always looking for new volunteers to join our community here at Salford Royal.

If you are interested in becoming a volunteer, please email: volunteer@srft.nhs.uk

or phone: 0161 206 8942

you can also find more information by visiting: www.srft.nhs.uk/volunteer
Our plans for the future
Our Quality Improvement Strategy (2015-2018) sets the ambitious aim to be the safest organisation within the NHS. This third edition of the strategy was developed building on the successful work from the two previous strategies and took into account the recommendations of the Francis Report and Berwick Review.

Staff views and suggestions were sought on how to move Salford Royal’s vision forward towards being the safest Trust in the NHS, in addition to patient, family and carer feedback and governance intelligence sources such as complaints and incident reports.

This gave us the direction for the Quality Improvement Strategy 2015-2018. An explanation of the aims and the work programmes required to achieve these aims are set out below.

**Our aims**
We aim to be the safest organisation in the NHS as well as the first choice care provider for our patients.

**Key aims**
- No preventable deaths
- Continuously seek out and reduce patient harm
- Achieve the highest level of reliability for clinical care
- Deliver what matters most: work in partnership with patients, carers and families to meet all their needs and better their lives
- Deliver innovative and integrated care close to home which support and improve health, wellbeing and independent living

**AIM**

**No preventable deaths**

**As measured by:**
- Maintaining position in top 10% of NHS organisations with the lowest risk adjusted mortality
- Serious untoward incidents that results in patient death
- Mortality reviews
- Dr Foster mortality alerts

The number of preventable deaths in the NHS remains uncertain, however, through our mortality reviews we carry out on all patients who die whilst in our care at Salford, it is certain that not all our patients receive all ideal aspects of care in a timely manner. Conducting these mortality reviews allows us to learn from patient journeys in our Trust and where appropriate, make improvements to the care we give.
Despite the extraordinary hard work of healthcare professionals patients are harmed in healthcare every day. Harm can be defined as “unintended physical or emotional injury resulting from, or contributed to by clinical care (including the absence of indicated treatment or best practice) that required additional monitoring, treatment or extended length of time under the care of a clinician”.

We will continue our relentless focus on reducing harm by working on strengthening our Trust wide and local learning systems and building capability in our staff to recognise and prevent harm in addition to addressing a suite of projects on specific harms.

It is widely acknowledged that aspects of health care do not perform as well as they should, often our systems are not designed to reliably deliver all aspects of evidence based care to every patient, every time. Over the next three years, we will seek out and reduce our variation in service delivery. Additionally, we will put specific focus on the pathways indicated above so that all patients receive the same high quality care seven days a week.
We are aiming to shift the focus of our relationships with patients from “what’s the matter?” to “what matters most to you?” We will use this shift in focus to drive our improvement and service redesign. Furthermore, we have detailed a series of ‘Always Events’ that all of our patients should expect we deliver. We will continue to work on delivering these ‘Always Events’ to every patient at every interaction.

Community based teams such as District Nurses, Allied Health Professionals and intermediate care teams provide high quality compassionate care closer to or in a patient’s home. It is important that in and out of hospital care feels seamless for patients and is of a consistent high quality. Over the next three years, we will work with our community based staff to address their unique improvement ambitions including improving coordination of care and person centredness.

The Quality Improvement Strategy 2015-2018 outlines a number of projects which we will be focussing on in the coming years. We would however, like to highlight the following project as key priorities for 2015/16:

**Patient flow**

It is recognised a significant number of our patients remain in a hospital or intermediate care bed when they could reasonably and safely be in a more appropriate place of care. The Patient Flow Programme aims to enhance patient experience, whilst effectively managing our increasing demand within existing resources.

This year we will focus on testing interventions to help in:

- Reducing delays in the transfers of care across service providers
- Reducing the length of stay
- Reviewing critical care capacity
- Reducing readmissions to hospital
- Avoiding unnecessary admissions

**Theatre improvement**

Theatre remains a key improvement area for the Trust and we are continuing to work towards embedding a culture of safety within our theatres. Based on staff feedback we will widen the scope of our improvement activities to include operational issues and the way we organise and plan activity in our operating theatres. We will initially work with theatres teams from General Surgery and Neurosurgery to test and embed ideas for improvement prior to spreading to the whole of theatres. In addition, work to quantitatively measure the WHO checklist will continue and improvement will focus on the quality of the implementation.

**Acute Kidney Injury (AKI)**

One in five people admitted to hospital in the UK each year as an emergency have Acute Kidney Injury (AKI) (Wang et al 2012). In the UK up to 100,000 deaths in hospitals are associated with AKI and it is estimated that up to 30% could be prevented with the right care and treatment (NCEPOD 2009). We know that by improving the prevention, recognition and treatment of AKI across the organisation then we can make a huge impact on the number of patients developing AKI and so in the coming year we aim to test interventions that will help to reduce the number of patients that develop Acute Kidney Injury.

**Measurement, monitoring and reporting**

All our improvement projects follow a structure which monitors and measures performance and progress is reported to the Executive Quality and Safety Committee, chaired by the Executive Nurse Director.
Review of services

During 2014/15, Salford Royal NHS Foundation Trust provided and/or sub-contracted 16 relevant health services.

Salford Royal NHS Foundation Trust has reviewed all the data available to them on the quality of care in 100% of these relevant health services.

The income generated by the relevant health services reviewed in 2014/15 represents 100% of the total income generated from the provision of relevant health services by Salford Royal NHS Foundation Trust for 2014/15.

Participation in clinical audits

During 2014/15, 30 national clinical audits and two national confidential enquiries covered relevant health services that Salford Royal NHS Foundation Trust provides.

During that period Salford Royal NHS Foundation Trust participated in 90% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

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

Table 1: National clinical audits

<table>
<thead>
<tr>
<th>Long Term Conditions</th>
<th>Heart</th>
<th>Cancer</th>
<th>Older People</th>
<th>Trauma</th>
<th>Mental Health</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Diabetes Audit (Adults)</td>
<td>National Audit of Acute Myocardial Infarction (MINAP)</td>
<td>National Bowel Cancer Audit (NBOCAP)</td>
<td>National Hip Fracture Database</td>
<td>UK Trauma Audit and Research Network (UKTARN)</td>
<td>National CEM Audit of Mental Health Care in Emergency Departments</td>
<td>National PROMS - knee replacement, varicose vein and groin hernia surgery</td>
</tr>
<tr>
<td>National Diabetes Paediatrics (NPDA)</td>
<td>National Cardiac Rhythm Management Audit (CRM)</td>
<td>National Head and Neck Cancer Audit (DAHNO)</td>
<td>National CEM Audit of Older People Care in Emergency Departments</td>
<td>National CEM Audit of Mental Health Care in Emergency Departments</td>
<td>National Lung Cancer Audit</td>
<td>National Intermediate Care Audit</td>
</tr>
<tr>
<td>National Audit Programme: Pulmonary Rehabilitation Audit</td>
<td>National Heart Failure Audit</td>
<td>National Oesophageal Cancer Audit (NOCGA)</td>
<td>National Stroke Audit Programme (SSNAP)</td>
<td>National Prostate Cancer Audit (NPCA)</td>
<td>National Renal Registry</td>
<td>Adherence to British Society for Clinical Neurophysiology (BSCN) and Association of Neurophysiological Scientists (ANS) Standards for Ulnar Neuropathy at Elbow (UNE) testing</td>
</tr>
<tr>
<td>National Rheumatoid and Early Inflammatory Arthritis Audit</td>
<td>National Cardiac Arrest Audit</td>
<td>National Prostate Cancer Audit (NPCA)</td>
<td>SSNAP Organisational Audit</td>
<td>National Renal Registry</td>
<td>Other</td>
<td>National BTS Audit of Pleural Procedures</td>
</tr>
</tbody>
</table>
The national clinical audits and national confidential enquiries that Salford Royal NHS Foundation Trust participated in, and for which data collection was completed during 2014/15, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

### Table 2: NCEPOD confidential enquiries

<table>
<thead>
<tr>
<th>Title</th>
<th>Eligible</th>
<th>Participated</th>
<th>% Submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCEPOD - Gastrointestinal Haemorrhage Study</td>
<td>NO</td>
<td>Not Applicable to Salford Royal Services</td>
<td></td>
</tr>
<tr>
<td>NCEPOD - Sepsis Study</td>
<td>NOT</td>
<td>Not Applicable to Salford Royal Services</td>
<td></td>
</tr>
</tbody>
</table>

### Table 3: National clinical audit projects participants

<table>
<thead>
<tr>
<th>Title</th>
<th>Eligible</th>
<th>Participated</th>
<th>% Submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Women's &amp; Children's Health</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)</td>
<td>NO</td>
<td>Not Applicable to Salford Royal Services</td>
<td></td>
</tr>
<tr>
<td>Paediatric Intensive Care (PICAnet)</td>
<td>NO</td>
<td>Not Applicable to Salford Royal Services</td>
<td></td>
</tr>
<tr>
<td>Neonatal intensive and special care (NNAO)</td>
<td>NO</td>
<td>Not Applicable to Salford Royal Services</td>
<td></td>
</tr>
<tr>
<td><strong>Children</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Congenital Heart Disease (Paediatric cardiac surgery) (CHD)</td>
<td>NO</td>
<td>Not Applicable to Salford Royal Services</td>
<td></td>
</tr>
<tr>
<td>Epilepsy 12 Audit (Childhood Epilepsy)</td>
<td>✓</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>National CEM Audit of Initial Management of the fitting child in Emergency Departments</td>
<td>✓</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Acute Care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intensive Care National Audit &amp; Research Centre - Case Mix Programme (ICNARC)</td>
<td>✓</td>
<td>✓</td>
<td>Ongoing</td>
</tr>
<tr>
<td>National Emergency Laparotomy Audit (NELA)</td>
<td>✓</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>National BTS Adult Community Acquired Pneumonia Audit</td>
<td>✓</td>
<td></td>
<td>Did not participate in the current year</td>
</tr>
<tr>
<td>National Joint Registry (NJR)</td>
<td>✓</td>
<td>✓</td>
<td>Ongoing</td>
</tr>
<tr>
<td>National BTS Audit of Pleural Procedures</td>
<td>✓</td>
<td>✓</td>
<td>Ongoing</td>
</tr>
<tr>
<td><strong>Long Term Conditions</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Diabetes Audit (Adults)</td>
<td>✓</td>
<td>✓</td>
<td>Ongoing</td>
</tr>
<tr>
<td>National Diabetes Paediatrics (NPDA)</td>
<td>✓</td>
<td>✓</td>
<td>Ongoing</td>
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<tr>
<td>National Audit Programme: Pulmonary Rehabilitation Audit</td>
<td>✓</td>
<td>✓</td>
<td>Ongoing</td>
</tr>
<tr>
<td>National Renal Registry</td>
<td>✓</td>
<td>✓</td>
<td>Ongoing</td>
</tr>
<tr>
<td>National Rheumatoid and Early Inflammatory Arthritis Audit</td>
<td>✓</td>
<td>✓</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Title</td>
<td>Eligible</td>
<td>Participated</td>
<td>% Submitted</td>
</tr>
<tr>
<td>---------------------------------------------------------------------</td>
<td>----------</td>
<td>--------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Heart</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Audit of Acute Myocardial Infarction (MINAP)</td>
<td>✔️</td>
<td>✔️</td>
<td>Ongoing</td>
</tr>
<tr>
<td>National Cardiac Rhythm Management Audit (CRM)</td>
<td>✔️</td>
<td>✔️</td>
<td>100%</td>
</tr>
<tr>
<td>National Heart Failure Audit</td>
<td>✔️</td>
<td>✔️</td>
<td>Ongoing</td>
</tr>
<tr>
<td>National Cardiac Arrest Audit</td>
<td>✔️</td>
<td>Did not participate in the current year</td>
<td></td>
</tr>
<tr>
<td>National Vascular Registry</td>
<td>NO</td>
<td>Not Applicable to Salford Royal Services</td>
<td></td>
</tr>
<tr>
<td>Coronary Angioplasty</td>
<td>NO</td>
<td>Not Applicable to Salford Royal Services</td>
<td></td>
</tr>
<tr>
<td>National Adult Cardiac Surgery Audit</td>
<td>NO</td>
<td>Not Applicable to Salford Royal Services</td>
<td></td>
</tr>
<tr>
<td>Pulmonary Hypertension Audit</td>
<td>NO</td>
<td>Not Applicable to Salford Royal Services</td>
<td></td>
</tr>
<tr>
<td>National Bowel Cancer Audit (NBOCAP)</td>
<td>✔️</td>
<td>✔️</td>
<td>100%</td>
</tr>
<tr>
<td>National Head and Neck Cancer Audit (DAHNO)</td>
<td>✔️</td>
<td>✔️</td>
<td>100%</td>
</tr>
<tr>
<td>National Lung Cancer Audit</td>
<td>✔️</td>
<td>✔️</td>
<td>100%</td>
</tr>
<tr>
<td>National Oesophageal Cancer Audit (NOCGA)</td>
<td>✔️</td>
<td>✔️</td>
<td>100%</td>
</tr>
<tr>
<td>National Prostate Cancer Audit (NPCA)</td>
<td>✔️</td>
<td>✔️</td>
<td>100%</td>
</tr>
<tr>
<td>Older People</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Hip Fracture Database</td>
<td>✔️</td>
<td>✔️</td>
<td>Ongoing</td>
</tr>
<tr>
<td>National CEM Audit of Older People Care in Emergency Departments</td>
<td>✔️</td>
<td>✔️</td>
<td>100%</td>
</tr>
<tr>
<td>National Stroke Audit Programme (SSNAP)</td>
<td>✔️</td>
<td>✔️</td>
<td>Ongoing</td>
</tr>
<tr>
<td>SSNAP Organisational Audit</td>
<td>✔️</td>
<td>✔️</td>
<td>100%</td>
</tr>
<tr>
<td>Trauma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UK Trauma Audit and Research Network (UKTARN)</td>
<td>✔️</td>
<td>✔️</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Comparative Audit of Blood Transfusion - Audit of transfusion in children and adults with Sickle Cell Disease</td>
<td>NO</td>
<td>Not Applicable to Salford Royal Services</td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National CEM Audit of Mental Health Care in Emergency Departments</td>
<td>✔️</td>
<td>✔️</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Mental health clinical outcome review programme. National Confidential Inquiry into Suicide and Homicide for people with Mental illness (NCISH)</td>
<td>NO</td>
<td>Not Applicable to Salford Royal Services</td>
<td></td>
</tr>
<tr>
<td>Prescribing Observatory for Mental Health</td>
<td>NO</td>
<td>Not Applicable to Salford Royal Services</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National PROMS – knee replacement, varicose vein and groin hernia surgery</td>
<td>✔️</td>
<td>✔️</td>
<td>Ongoing</td>
</tr>
<tr>
<td>National Intermediate Care Audit</td>
<td>✔️</td>
<td>✔️</td>
<td>92%</td>
</tr>
<tr>
<td>Adherence to British Society for Clinical Neurophysiology (BSCN) and Association of Neurophysiological Scientists (ANS) Standards for Ulnar Neuropathy at Elbow (UNE) testing</td>
<td>✔️</td>
<td>Did not participate</td>
<td></td>
</tr>
</tbody>
</table>
The reports of 30 national clinical audits were reviewed by the provider in 2014/15 and Salford Royal NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided [See Appendix A].

The reports of 50 local clinical audits were reviewed by the Trust in 2014/15. Salford Royal NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided. (See Appendix B)

The table in Appendix B includes examples of local audits reported in 2014/15. Further actions planned and undertaken in response to the audit findings will be detailed in the Trust’s 2014/15 Clinical Audit Annual Report.

### Participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by Salford Royal NHS Foundation Trust in 2014/15 that were recruited during that period to participate in research approved by a research ethics committee was 7,500.

### Goals agreed with commissioners: use of the CQUIN payment framework

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

For 2014/15 the baseline value of the CQUIN was 2.5% of the contract value £7.2m. If the agreed milestones were not achieved during the year or the outturn contract value was lower than the baseline contract, then a proportion of CQUIN monies would be withheld.

For 2014/15, Salford Royal has received sign-off to date that the milestones relating to quarters 1-3 of 2014/15 have been delivered with the exception of the admissions avoidance CQUIN (partially achieved in quarter 2) and the 7 day working - general surgery CQUIN (discussions are continuing with the CCG regarding this CQUIN). The Trust is awaiting confirmation in respect of quarter 4. The quarter 4 performance will be shared with commissioners at the end of April but confirmation is not expected from commissioners until the end of May.

Further details of the agreed goals for 2014/15 and for the following 12 month period are available on request via joanne.entwistle@srft.nhs.uk

For 2013/14 the Trust achieved 100% of its CQUIN goals. The baseline value for CQUIN was £7.8m. However, as the Trust exceeded its activity / income targets for 2013/14 (and CQUIN reflects 2.5% of the actual value delivered) the actual income recovered from CQUIN in 2013/14 will be more than £7.8m.

---

### Table 4: NCEPOD Confidential Enquiries projects participation

<table>
<thead>
<tr>
<th>Title</th>
<th>Eligible</th>
<th>Participated</th>
<th>% Submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCEPOD - Gastrointestinal Haemorrhage Study</td>
<td>✔️</td>
<td>✔️</td>
<td>88% + Organisational Tool</td>
</tr>
<tr>
<td>NCEPOD - Sepsis Study</td>
<td>✔️</td>
<td>✔️</td>
<td>80% + Organisational Tool</td>
</tr>
</tbody>
</table>
Relevance of data quality and action to improve data quality

It is well known that good quality information underpins the effective delivery of improvements to the quality of patient care. Improving data quality will therefore improve patient care and improve value for money. High quality information means better patient care and patient safety.

High quality information is:

- Accurate
- Up to date
- Free from duplication (for example, where two or more different records exist for the same patient)

Salford Royal NHS Foundation Trust will be taking the following actions to improve data quality:

- Daily validation to improve ethnicity recording for acute and community activity
- Daily validation of new registrations to reduce the number of duplicate registrations
- Weekly submissions to demographic batch service to trace records against the National Spine portal to ensure accurate data
- Daily monitoring of day case activity and regular attenders to improve live ADT
- Ward audits and monitoring of 11pm to 6am discharges to improve ADT
- Auditing of all returned patient related correspondence to the Trust to ensure correct demographic data is held
- Daily review of outpatient activity to ensure attendance outcome is recorded timely and to ensure patients who did not attend (DNA) have correct postal addresses in comparison to National Spine portal
- Daily review of outpatient activity to ensure attendance outcome is recorded in a timely manner
- Review of outpatients who did not attend their appointments to ensure correct postal addresses in comparison to national portal (not currently daily, piloting a plan to use batch tracing to speed up this process)
- Monitoring of undelivered and ‘invalid address’ correspondence reported by the Trust mail handler
- Daily review of rejected GP correspondence sent via electronic document transfer (to ensure correct GP registration in comparison to national portal)
- Daily review of any inpatient, outpatient and A&E activity that has not undergone automatic contract allocation
- Weekly enhanced death reports from National Spine portal to ensure out of hospital deaths are recorded on the Trust’s Patient Administration System (PAS)
- Monitoring responses to email and telephone queries to support the delivery of an efficient service
NHS number of General Medical Practice code validity
Salford Royal NHS Foundation 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
  - 98.9% for Accident and Emergency care

- Which included the patient’s valid General Medical Practice Code was:
  - 99.9% for admitted patient care;
  - 99.7% for outpatient care; and
  - 99.9% for Accident and Emergency care

Clinical coding error rate
Salford Royal NHS Foundation Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

- Primary Diagnoses Incorrect: 4.5%
- Secondary Diagnoses Incorrect: 5.9%
- Primary Procedures Incorrect: 5.9%
- Secondary Procedures Incorrect: 17.4%

The two focus areas of the audit were HRG (healthcare resource group) HC spinal surgery and disorders and LA renal procedures and disorders.

The clinical coding results should not be extrapolated further than the actual sample size audit.

Information governance toolkit attainment level
The IG Toolkit is an online system which allows NHS organisations and partners to assess themselves against Department of Health Information Governance policies and standards. It is fundamental to access the NHS N3 network and to promote safe data sharing. It also allows members of the public to view participating organisations’ IG Toolkit assessments.

Salford Royal NHS Foundation Trust Information Governance Assessment Report score overall score for 2014/15 was 91% and was graded Green.
What Others Say About Salford Royal NHS Foundation Trust:

Statement from the Care Quality Commission

Salford Royal NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is “registered without conditions”.

Salford Royal NHS Foundation Trust has the following conditions on registration - none.

The Care Quality Commission has not taken enforcement action against Salford Royal NHS Foundation Trust during 2014/15.

Salford Royal NHS Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2014/15:

The Care Quality Commission’s (CQC) thematic review of Mental Health Crisis began in late in 2013 with the objective of exploring the experiences and outcomes of care for people experiencing a mental health crisis. This was described as an important piece of work that will improve CQC’s understanding of an area that is at the centre of current debate around differences in the provision and the quality of care received by those with urgent physical health needs compared with those experiencing a mental health crisis.

The review concluded with the following findings:

- People in Salford presenting at Accident and Emergency in a mental health crisis receive a good service
- People in the community who have a mental health crisis receive a good service from specialist mental health services
- There is strong evidence of good internal working within Greater Manchester West (GMW) and Salford Royal NHS Foundation Trust and of good joint working between all of the agencies including the Police
- There is a seamless pathway from patients in mental health crisis entering Accident and Emergency to the point of discharge
- There is clear evidence of safe handover between Accident and Emergency, the psychiatric liaison team and the home based treatment team

Salford Royal NHS Foundation Trust intends to take the following action to address the conclusions or requirements reported by the CQC - none required.

Salford Royal NHS Foundation Trust has made the following progress by 31 March 2015 in taking such action - none applicable.

The most recent CQC inspection took place in January 2015, where the Trust received an overall rating of “outstanding”. More information on this inspection can be found on page 8 of the Quality Accounts.
Review of quality performance

safe • clean • personal
Salford Royal aims to meet all national targets and priorities. We have provided an overview of the national targets and minimum standards including those set out within Monitor’s Compliance Framework below. Further indicators of performance can be found in section 4 of the Quality Accounts.

### Performance against National Targets and Regulatory Requirements 2014/15

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Control</td>
<td>Number of <em>clostridium difficile</em> cases</td>
<td>21</td>
<td>19</td>
<td>18</td>
<td>47</td>
<td>58</td>
</tr>
<tr>
<td></td>
<td>Number of MRSA blood stream infection cases</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Access to Cancer Services</td>
<td>% of cancer patients waiting a maximum of 31 days from diagnosis to first definitive treatment</td>
<td>96%</td>
<td>97.0%</td>
<td>98.2%</td>
<td>98.9%</td>
<td>98.4%</td>
</tr>
<tr>
<td></td>
<td>% of cancer patients waiting a maximum of 31 days for subsequent treatment (anti-cancer drugs)</td>
<td>98%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>% of cancer patients waiting a maximum of 31 days for subsequent treatment (surgery)</td>
<td>94%</td>
<td>96.5%</td>
<td>98.3%</td>
<td>99.4%</td>
<td>97.8%</td>
</tr>
<tr>
<td></td>
<td>% of cancer patients waiting a maximum of 31 days for subsequent treatment (radiotherapy)</td>
<td>94%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>% of cancer patients waiting a maximum of 31 days for subsequent treatment (surgery)</td>
<td>85%</td>
<td>86.2%</td>
<td>86.8%</td>
<td>88.7%</td>
<td>89.6%</td>
</tr>
<tr>
<td></td>
<td>% of cancer patients waiting a maximum of 2 months from the consultant screening service referral to treatment</td>
<td>90%</td>
<td>82.6%</td>
<td>96.4%</td>
<td>85.2%</td>
<td>92.6%</td>
</tr>
<tr>
<td></td>
<td>% of cancer patients waiting a maximum of 2 months from urgent GP referral to treatment</td>
<td>93%</td>
<td>96.0%</td>
<td>97.9%</td>
<td>98.4%</td>
<td>98.6%</td>
</tr>
<tr>
<td></td>
<td>% of cancer patients waiting a maximum of 2 weeks from urgent GP referral to date first seen</td>
<td>93%</td>
<td>96.2%</td>
<td>95.6%</td>
<td>97.5%</td>
<td>95.5%</td>
</tr>
<tr>
<td></td>
<td>% of symptomatic breast patients (cancer not initially suspected) waiting a maximum of 2 weeks from urgent GP referral to date first seen</td>
<td>90%</td>
<td>86.99%</td>
<td>93.0%</td>
<td>94.5%</td>
<td>90.34%</td>
</tr>
<tr>
<td>Access to Treatment</td>
<td>18 weeks Referral to Treatment - admitted patients</td>
<td>90%</td>
<td>86.99%</td>
<td>93.0%</td>
<td>94.5%</td>
<td>90.34%</td>
</tr>
<tr>
<td></td>
<td>18 weeks Referral to Treatment - non-admitted patients</td>
<td>95%</td>
<td>92.80%</td>
<td>96.2%</td>
<td>96.79%</td>
<td>95.48%</td>
</tr>
<tr>
<td></td>
<td>18 weeks Referral to Treatment - patients on an incomplete pathway</td>
<td>92%</td>
<td>94.27%</td>
<td>95.1%</td>
<td>96.4%</td>
<td>N/A</td>
</tr>
<tr>
<td>Access to A&amp;E</td>
<td>% of patients waiting a maximum of 4 hours in A&amp;E from arrival to admission, transfer or discharge</td>
<td>95%</td>
<td>95.01%</td>
<td>95.9%</td>
<td>95.46%</td>
<td>98.86%</td>
</tr>
<tr>
<td>Access to patients with a learning disability</td>
<td>The Trust provides self-certification that it meets the requirements to provide access to healthcare for patients with a learning disability</td>
<td>N/A</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Cancelled operations</td>
<td>% of in-patients whose operations were cancelled by the hospital for non-clinical reasons on day of or after admission to hospital</td>
<td>0%</td>
<td>0.66%</td>
<td>0.56%</td>
<td>0.52%</td>
<td>0.53%</td>
</tr>
<tr>
<td>Cancelled operations not treated within 28 days</td>
<td>% of those patients whose operations were cancelled by the hospital for non-clinical reasons on day of or after admission to hospital, and were not treated within 28 days</td>
<td>0%</td>
<td>3.44%</td>
<td>0.78%</td>
<td>0.89%</td>
<td>3.54%</td>
</tr>
</tbody>
</table>
The NHS outcomes framework 2014/15 indicators

The NHS Outcomes Framework 2014/15 sets out high level national outcomes which the NHS should be aiming to improve. The Framework provides indicators which have been chosen to measure these outcomes. An overview of the indicators is provided in the table. It is important to note that whilst these indicators must be included in the Quality Accounts the most recent national data available for the reporting period is not always for the most recent financial year. Where this is the case the time period used is noted underneath the indicator description. It is also not always possible to provide the national average and best and worst performers for some indicators due to the way the data is provided.

<table>
<thead>
<tr>
<th>Domain</th>
<th>Indicator</th>
<th>2014/15</th>
<th>National Average</th>
<th>Where Applicable - Best Performer</th>
<th>Where Applicable - Worst Performer</th>
<th>Trust Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventing people from dying prematurely</td>
<td>SHMI value and banding (July 2013 - June 2014)</td>
<td>SHMI value = 0.971 Band 2 as expected</td>
<td>1 Band 2 as expected</td>
<td></td>
<td></td>
<td>The Salford Royal NHS Foundation Trust considers that this data is as described for the following reasons. Mortality reduction has been a constant focus for the Trust over the course of successive Quality Improvement Strategies.</td>
</tr>
<tr>
<td>Enhancing quality of life for people with long-term conditions</td>
<td>% patients deaths with palliative care coded at either diagnosis or specialty level for (July 2013 - June 2014 taken from Dr Foster Mortality Comparator)</td>
<td>49% 24% N/A N/A</td>
<td>The Whittington Hospital SHMI Value = 0.541 Band 1 better than expected</td>
<td>Medway NHS Foundation Trust SHMI Value = 1.198 Band 3 worse than expected</td>
<td>The Salford Royal NHS Foundation Trust considers that this data is as described for the following reasons. The Trust has a very well established Palliative Care Team, who provide in reach to all areas of the hospital. The Salford Royal NHS Foundation Trust continues to take the actions highlighted in this Quality Account to improve this percentage and so the quality of its services, by continuing to place the upmost importance on high quality palliative care for our patients.</td>
<td></td>
</tr>
<tr>
<td>Helping people recover from episodes of ill health or following injury</td>
<td>Patient reported outcome scores for groin hernia surgery (April 13 - March 2014 - most recent full year of data available)</td>
<td>0.08 0.085 N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>The Salford Royal NHS Foundation Trust considers that this data is as described for the following reasons. The Trust has undertaken a significant amount of work in the area of Theatres Improvement. The Salford Royal NHS Foundation Trust continues to take the following actions to improve this outcome and so the quality of its services, by developing a significant amount of work in the area of theatre improvement, this in the form of a Theatres Improvement Project which is developing work in a number of areas which are in the projects section of this Quality Account.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Patient reported outcome scores for varicose vein surgery (April 13 - March 2014 - most recent full year of data available)</td>
<td>N/A N/A N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>This procedure is not carried out at the Trust.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Patient reported outcome scores for hip replacement surgery (April 13 - March 2014 - most recent full year of data available)</td>
<td>0.421 0.436 N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>The Salford Royal NHS Foundation Trust considers that this data is as described for the following reasons. The Trust has undertaken a significant amount of work in the area of Theatres Improvement. The Salford Royal NHS Foundation Trust continues to take the following actions to improve this outcome and so the quality of its services, by developing a significant amount of work in the area of theatre improvement, this in the form of a Theatres Improvement Project which is developing work in a number of areas which are in the projects section of this Quality Account.</td>
<td></td>
</tr>
<tr>
<td>--------</td>
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<td>------------------</td>
<td>-----------------------------------</td>
<td>-----------------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Helping people recover from episodes of ill health or following injury continued</td>
<td>Patient reported outcome scores for knee replacement surgery (April 13 - March 2014 - most recent full year of data available)</td>
<td>0.311</td>
<td>0.323</td>
<td>N/A</td>
<td>N/A</td>
<td>Trust considers that this data is as described for the following reasons. The Trust has undertaken a significant amount of work in the area of Theatre Improvement. The Salford Royal NHS Foundation Trust continues to take the following actions to improve this outcome and so the quality of its services, by developing a significant amount of work in the area of theatre improvement, this in the form of a Theatres Improvement Project which is developing work in a number of areas which are in the projects section of this Quality Account.</td>
</tr>
<tr>
<td>28 day readmission rate for patients aged 0-15</td>
<td></td>
<td>The data made available to Trusts for reporting has not been updated since last year's Quality Account. However, please see the readmissions page in this Quality Account for further details on the Trust's work on readmissions.</td>
<td>8.8%</td>
<td>9.1%</td>
<td>10.18%</td>
<td></td>
</tr>
<tr>
<td>28 day readmission rate for patients aged 16 or over</td>
<td></td>
<td>The data made available to Trusts for reporting has not been updated since last year's Quality Account. However, please see the readmissions page in this Quality Account for further details on the Trust's work on readmissions.</td>
<td>12.27%</td>
<td>11.87%</td>
<td>11.84%</td>
<td></td>
</tr>
<tr>
<td>Ensuring that people have a positive experience of care</td>
<td>Responsiveness to inpatients' personal needs: CQC national inpatient survey score (2013-2014 data)</td>
<td>74.5%</td>
<td>68.7%</td>
<td>N/A</td>
<td>N/A</td>
<td>The Salford Royal NHS Foundation Trust considers that this data is as described for the following reasons. The Trust has undertaken a Patient Family and Carer Experience Collaborative which was started in January 2013 and aims to improve all elements of experience. The Salford Royal NHS Foundation Trust continues to take the following actions to improve this outcome and so the quality of its services, by continuing to deliver a Patient, Family and Carer Experience Collaborative and other work streams aimed at delivering what matters most to our patients.</td>
</tr>
<tr>
<td></td>
<td>Percentage of staff who would recommend the provider to friends or family needing care 2014 Staff Survey</td>
<td>87%</td>
<td>67%</td>
<td>Frimley Park Hospital NHS Foundation Trust (89%)</td>
<td>Royal Cornwall Hospitals NHS Trust (38%)</td>
<td>The Salford Royal NHS Foundation Trust considers that this data is as described for the following reasons. The Salford Royal NHS Foundation Trust continues to take the following actions to improve this outcome and so the quality of its services, by continuing to deliver a Patient, Family and Carer Experience Collaborative and other work streams aimed at delivering what matters most to our patients.</td>
</tr>
<tr>
<td>Treating and caring for people in a safe environment and protecting them from avoidable harm</td>
<td>% of admitted patients risk-assessed for Venous Thromboembolism (April - December 2014)</td>
<td>96%</td>
<td>96%</td>
<td>N/A</td>
<td>N/A</td>
<td>The Salford Royal NHS Foundation Trust considers that this data is as described for the following reasons. The Trust reviews all cases of hospital acquired Venous Thromboembolism to ensure that all elements of best practice are adhered to. The Salford Royal NHS Foundation Trust continues to take the following actions to improve this outcome and so the quality of its services, by developing systems to ensure that patients receive risk assessments for venous thromboembolism. Monthly Safety Thermometer walk rounds highlight the importance of timely risk assessments in the prevention of blood clots.</td>
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</tr>
<tr>
<td>Treating and caring for people in a safe environment and protecting them from avoidable harm continued</td>
<td>Rate of C.Difficile per 100,000 bed days (2013/2014) For up to date data on the most recent financial year performance please see the specific C.Difficile page within the Quality Accounts</td>
<td>8</td>
<td>14.7</td>
<td>Homerton University Hospital (18 Trust appointed cases)</td>
<td>University College London Hospitals (2 Trust appointed cases)</td>
<td>The Salford Royal NHS Foundation Trust considers that this data is as described for the following reasons. Infection control remains one of the Trust’s highest priorities with all cases of Hospital Acquired C.Difficile reviewed and opportunities for learning are shared. The Salford Royal NHS Foundation Trust continues to take the following actions to improve this outcome and so the quality of its services, by placing infection control as the highest priorities and ensuring that all staff are fully compliant with mandatory training for antiseptic non-touch technique.</td>
</tr>
<tr>
<td></td>
<td>Rate of patient safety incidents per 100 admissions (Oct 13 - Mar-14) *High Reporters should be shown as better</td>
<td>9.9</td>
<td>9.9</td>
<td>Lewisham and Greenwich NHS Trust (count of incidents 3685)</td>
<td>Dorset County Hospital NHS Foundation Trust (16.8)</td>
<td>The Salford Royal NHS Foundation Trust considers that this data is as described for the following reasons. The Trust continues to promote a culture of open and honest reporting and endorsing a fair blame culture. The Salford Royal NHS Foundation Trust continues to take the following actions to improve this outcome and so the quality of its services, by encouraging a culture of voluntary reporting and endorsing a fair blame culture.</td>
</tr>
<tr>
<td></td>
<td>Rate of patient safety incidents per 100 admissions that resulted in severe harm or death (Oct 13 - Mar 14) *High Reporters should be shown as better</td>
<td>0.05</td>
<td>0.05</td>
<td>Isle of Wight NHS Trust (count of incidents = 17)</td>
<td>Dorset County Hospital NHS Foundation Trust (0.37)</td>
<td>The Salford Royal NHS Foundation Trust considers that this data is as described for the following reasons. The Trust continues to promote a culture of open and honest reporting and endorsing a fair blame culture. The Salford Royal NHS Foundation Trust continues to take the following actions to improve this outcome and so the quality of its services, by encouraging a culture of voluntary reporting and endorsing a fair blame culture.</td>
</tr>
<tr>
<td>Ensuring that people have a positive experience of care</td>
<td>Inpatient Friends and Family Test (February 2015 Data)</td>
<td>94%</td>
<td>95%</td>
<td>Royal Berkshire NHS Foundation Trust (99%)</td>
<td>Medway NHS Foundation Trust (82%)</td>
<td>The Salford Royal NHS Foundation Trust considers that this data is as described for the following reasons. The Trust continues to promote a culture of open and honest reporting and endorsing a fair blame culture. The Salford Royal NHS Foundation Trust continues to take the following actions to improve this outcome and so the quality of its services, by continuing to deliver a Patient, Family and Carer Experience Collaborative and other work streams aimed at delivering what matters most to our patients.</td>
</tr>
<tr>
<td></td>
<td>Accident and Emergency Friends and Family Test (February 2015 Data)</td>
<td>91%</td>
<td>88%</td>
<td>Wirral University Teaching Hospital NHS Foundation Trust (98%)</td>
<td>North Middlesex University Hospital NHS Trust (53%)</td>
<td>The Salford Royal NHS Foundation Trust considers that this data is as described for the following reasons. The Trust has undertaken a Patient Family and Carer Experience Collaborative which was started in January 2013 and aims to improve all elements of experience. The Salford Royal NHS Foundation Trust continues to take the following actions to improve this outcome and so the quality of its services, by continuing to deliver a Patient, Family and Carer Experience Collaborative and other work streams aimed at delivering what matters most to our patients.</td>
</tr>
</tbody>
</table>

Data comes from the NHS Information Centre Portal

*Data used compares only Trusts that are in the Small Acute, Medium Acute, Large Acute and Acute Teaching categories of hospital
Domain: preventing people from dying prematurely

The Standardised Hospital Level Mortality Indicator (SHMI) is a measure of mortality developed by the Department of Health, which compares our actual number of deaths with our predicted number of deaths. Each hospital is placed into a band based upon their SHMI; Salford Royal is in band 2 which is ‘as expected’.

Domain: helping people to recover from episodes of ill health or following injury.

Patient reported outcome scores

A patient reported outcome measure is a series of questions that patients are asked in order to gauge their views on their own health. In the examples of groin hernia, knee replacement, hip replacement and varicose vein surgery, patients are asked to score their health before and after surgery. We are then able to understand whether patients see a ‘health gain’ following surgery.

The data provided gives the average difference between the first score (pre-surgery) and second score (post-surgery) that patients give themselves. In all procedures where data is available there are improvements in the average score. However, it is important to note that the sample size for all patient reported outcome scores is very small which may impact upon the meaningfulness of the data, this is rectified when the full year data is provided.

Domain: ensuring that people have a positive experience of care

Responsiveness to inpatients’ personal needs

This indicator provides a measure of quality, based on the Care Quality Commission’s National Inpatient Survey. The score is calculated by averaging the answers to five questions in the inpatient survey. The highest score achievable is 100%.

Salford Royal launched a Patient Experience Strategy in January 2013, which provides a structure for all work streams fitting under this heading.

Salford Royal is proud that the number of staff members who would recommend us to friends and family needing treatments is higher than the national average.

Domain: Treating and caring for people in a safe environment and protecting them from avoidable harm

Risk assessing inpatients for venous thromboembolism (VTE) is important in reducing hospital acquired VTE. Salford Royal has worked hard to ensure that not only are our patients risk assessed promptly but that any prophylaxis is given reliably.

Domain: Treating and caring for people in a safe environment and protecting them from avoidable harm

Patient safety incidents are reported to NHS England. The rate of patient safety incidents per 100 admissions reported by Salford Royal is 9.9. Organisations that report more incidents usually have a better and more effective safety culture. We believe you cannot learn and improve if you do not know what the problems are. Salford Royal will continue to encourage a culture of open reporting in order to learn and improve.
# Performance against Trust selected metrics

The measures in the table below have been provided as the Trust believes that they are important to track. They are frequently areas that fit into the main aims of the Trust’s ongoing Quality Improvement Strategy and the Trust wishes to continue to make them available in the Quality Account.

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<tbody>
<tr>
<td>Hospital Standardised Mortality Rate* (Calculated using annual benchmark)</td>
<td>82.4</td>
<td>82.23</td>
<td>79.38</td>
<td>77.08</td>
<td>81.32</td>
<td>82.29</td>
<td>81.29</td>
</tr>
<tr>
<td>Stroke Mortality Rates (Acute Cerebral Vascular Disease)*</td>
<td>108.03</td>
<td>102.91</td>
<td>104.16</td>
<td>111.5</td>
<td>109.17</td>
<td>103.47</td>
<td>95.15</td>
</tr>
<tr>
<td>Cardiac arrests outside critical care units per 1,000 admissions</td>
<td>0.48</td>
<td>0.49</td>
<td>0.52</td>
<td>0.40</td>
<td>0.49</td>
<td>0.66</td>
<td>0.91</td>
</tr>
<tr>
<td>Orthopaedic Surgical Site Infections (inpatients &amp; readmissions, includes procedures Hip Replacement, Knee Replacement, Reduction of Long Bone Fracture, Repair of Neck of Femur)</td>
<td>2.34% (up to Dec 2014)</td>
<td>3.0%</td>
<td>3.37%</td>
<td>2.6%</td>
<td>3.14%</td>
<td>N/A</td>
<td>N/A</td>
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<tbody>
<tr>
<td>Advancing Quality Composite Quality Score for Acute Myocardial Infarction**</td>
<td>98.3%</td>
<td>96.54%</td>
<td>97.95%</td>
<td>95%</td>
<td>97.42%</td>
<td>96.80%</td>
<td>95.56%</td>
</tr>
<tr>
<td>Advancing Quality Appropriate Care Score for Acute Myocardial Infarction</td>
<td>92.53%</td>
<td>89.1%</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Advancing Quality Composite Quality Score for Hip and Knee Surgery**</td>
<td>98.65%</td>
<td>84.86%</td>
<td>99.04%</td>
<td>98.59%</td>
<td>97.65%</td>
<td>97.98%</td>
<td>79.54%</td>
</tr>
<tr>
<td>Advancing Quality Appropriate Quality Score for Hip and Knee Surgery**</td>
<td>94.62%</td>
<td>84.68%</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Advancing Quality Composite Quality Score for Congestive Heart Failure**</td>
<td>94.61%</td>
<td>83.11%</td>
<td>83.22%</td>
<td>82.38%</td>
<td>85.62%</td>
<td>73.91%</td>
<td>59.29%</td>
</tr>
<tr>
<td>Advancing Quality Appropriate Quality Score for Congestive Heart Failure**</td>
<td>85.64%</td>
<td>61.22%</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Advancing Quality Composite Quality Score for Pneumonia**</td>
<td>92.11%</td>
<td>89.42%</td>
<td>90.37%</td>
<td>83.38%</td>
<td>74.42%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Advancing Quality Appropriate Quality Score for Pneumonia**</td>
<td>76.64%</td>
<td>74.88%</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Advancing Quality Composite Quality Score for Stroke**</td>
<td>96.98%</td>
<td>91.9%</td>
<td>97.88%</td>
<td>96.02%</td>
<td>97.37%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Advancing Quality Appropriate Quality Score for Stroke**</td>
<td>86.63%</td>
<td>92.56%</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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</thead>
<tbody>
<tr>
<td>% of adult in-patients who felt they were treated with respect and dignity***</td>
<td>85%</td>
<td>88%</td>
<td>82%</td>
<td>85%</td>
<td>81%</td>
<td>86%</td>
<td>85%</td>
</tr>
<tr>
<td>% of adult in-patients who had confidence in the Trust doctors treating them***</td>
<td>89%</td>
<td>88%</td>
<td>84%</td>
<td>84%</td>
<td>81%</td>
<td>85%</td>
<td>87%</td>
</tr>
<tr>
<td>% of in-patients whose operations were cancelled by the hospital for non-clinical reasons on day of or after admission to hospital</td>
<td>0.66%</td>
<td>0.56%</td>
<td>0.52%</td>
<td>0.53%</td>
<td>0.63%</td>
<td>0.64%</td>
<td>0.54%</td>
</tr>
<tr>
<td>% of those patients whose operations were cancelled by the hospital for non-clinical reasons on day of or after admission to hospital, and were not treated within 28 days</td>
<td>3.44%</td>
<td>0.78%</td>
<td>0.89%</td>
<td>3.54%</td>
<td>3.9%</td>
<td>2.7%</td>
<td>2.4%</td>
</tr>
<tr>
<td>Count of patients who waited greater than 52 weeks for treatment</td>
<td>20</td>
<td>11</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>GP Out of Hours - Time from case active to definitive telephone clinical assessment. Urgent calls within 20 minutes****</td>
<td>100%</td>
<td>98.23%</td>
<td>96.38%</td>
<td>97.28%</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>GP Out of Hours - Time from case active to definitive telephone clinical assessment. Non-urgent calls within 60 minutes****</td>
<td>96.53%</td>
<td>98.06%</td>
<td>96.26%</td>
<td>97.14%</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

* Following recalculation of Dr Foster data, Dr Foster will not be the same as that reported in the 2013/14 Quality Accounts due to the re-basing of data.
** Data covers the period April 2014 - December 2014 as there is a time delay in the data reporting system.
*** Indicates data taken from the Inpatient Survey 2014.
**** Data from Adastra system.
Through the analysis of reports of safety incidents, and safety information from other sources, NHS England develops advice for the NHS that can help to ensure the safety of patients, visitors and staff. As advice becomes available, NHS England issues alerts on potential and identified risks to safety.

At Salford Royal, these alerts are coordinated and monitored by the governance team who work with clinicians and managers in the appropriate areas to confirm compliance or to form an action plan to monitor compliance against it.

Salford Royal is fully compliant with all alerts for which compliance deadlines have passed. The following table shows those alerts issued by NHS England during 2014/15, and progress against them.

<table>
<thead>
<tr>
<th>Reference</th>
<th>Alert Title</th>
<th>Issue Date</th>
<th>Response</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS/PSA/W/2015/001</td>
<td>Harm from using Low Molecular Weight Heparins when contraindicated</td>
<td>19/01/2015</td>
<td>Alert disseminated to all clinical divisions. The Trust Medicines Safety Group have discussed the alert and decided on an appropriate course of action.</td>
<td>02/03/2015</td>
</tr>
<tr>
<td>NHS/PSA/W/2014/18</td>
<td>Risk of death and serious harm from accidental ingestion of potassium permanganate preparations</td>
<td>22/12/2014</td>
<td>Alert disseminated to all clinical divisions an confirmation received the information has been reviewed and assurance of compliance provided by relevant teams.</td>
<td>22/01/2015</td>
</tr>
<tr>
<td>NHS/PSA/W/2014/017</td>
<td>Risk of death and serious harm from delays in recognising and treating ingestion of button batteries</td>
<td>19/12/2014</td>
<td>Alert disseminated to all clinical divisions an confirmation received the information has been reviewed and assurance of compliance provided by relevant teams including the Emergency Department and PANDA.</td>
<td>19/01/2015</td>
</tr>
<tr>
<td>NHS/PSA//2014/016R</td>
<td>Risk of distress and death from inappropriate doses of naloxone in patients on long-term opioid/opiate...</td>
<td>20/11/2014</td>
<td>Alert disseminated to all Clinical Directors and confirmation received the information has been reviewed and assurance of compliance provided by relevant teams.</td>
<td>22/12/2014</td>
</tr>
<tr>
<td>NHS/PSA/R/2014/015</td>
<td>Resources to support the prompt recognition of sepsis and the rapid initiation of treatment</td>
<td>02/09/2014</td>
<td>An assurance document has been provided by the Sepsis Steering Group. An ongoing piece of Improvement work in progress across the Trust with every ward to be engaged as part of this work.</td>
<td>31/10/2014</td>
</tr>
<tr>
<td>NHS/PSA/W/2014/014</td>
<td>Risks arising from breakdown and failure to act on communication during handover at the time of disc...</td>
<td>29/08/2014</td>
<td>Alert disseminated to the Trust Discharge Meeting, confirmation received discussions have been had and relevant action taken.</td>
<td>13/10/2014</td>
</tr>
<tr>
<td>NHS/PSA/W/2014/013</td>
<td>Risk of inadvertently cutting in-line (or closed) suction catheters</td>
<td>17/07/2014</td>
<td>Alert disseminated to all clinical divisions for information. Confirmation received the information has been reviewed and assurance of compliance provided by Critical Care.</td>
<td>14/08/2014</td>
</tr>
<tr>
<td>NHS/PSA/W/2014/012</td>
<td>Risk of harm relating to interpretation and action on PCR results in pregnant women</td>
<td>23/06/2014</td>
<td>Alert disseminated to Pathology for review. Assurance received that the alert has been discussed at both Salford and Wigan and appropriate actions taken.</td>
<td>31/07/2014</td>
</tr>
<tr>
<td>NHS/PSA/D/2014/010</td>
<td>Standardising the early identification of Acute Kidney Injury</td>
<td>09/06/2014</td>
<td>Confirmation received from Pathology that the Trust had already purchased software to ensure compliance with the alert.</td>
<td>09/03/2015</td>
</tr>
<tr>
<td>NHS/PSA/W/2014/009</td>
<td>Risk of using vacuum and suction drains when not clinically indicated</td>
<td>06/06/2014</td>
<td>Alert disseminated to surgical governance and confirmation received the information has been reviewed and assurance of compliance provided by relevant teams.</td>
<td>04/07/2014</td>
</tr>
<tr>
<td>NHS/PSA/W/2014/008</td>
<td>Residual anaesthetic drugs in cannulae and intravenous lines</td>
<td>14/04/2014</td>
<td>Alert disseminated to all clinical divisions an confirmation received the information has been reviewed and assurance of compliance provided by relevant teams.</td>
<td>13/05/2014</td>
</tr>
<tr>
<td>NHS/PSA/W/2014/007</td>
<td>Minimising risks of omitted and delayed medicines for patients receiving homecare services</td>
<td>10/04/2014</td>
<td>Alert disseminated to all clinical divisions an confirmation received the information has been reviewed and assurance of compliance provided by relevant teams. The Trust incident management system has been amended to allow incidents concerning homecare medicines to be reported and identified easily.</td>
<td>09/05/2014</td>
</tr>
</tbody>
</table>
Never events

Never Events are described by NHS England as serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

Each Never Event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a Never Event. Never Events include incidents such as:

- Wrong site surgery
- Retained instrument post operation
- Wrong route administration of chemotherapy

Nationally between April 2014 and February 2015 there were 271 Never Events, in the same period Salford Royal had 2 Never Events. The details of the Salford Royal Never Events are in the table below together with the key findings from the review of the events and the actions taken to prevent future recurrence.

<table>
<thead>
<tr>
<th>Never Event</th>
<th>Description</th>
<th>Key Findings from Root Cause Analysis</th>
<th>Actions to Prevent Recurrence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wrong site surgery</td>
<td>Extraction of the wrong tooth in a Community Dental Clinic</td>
<td><strong>Issues Identified</strong>&lt;br&gt;1. Identification of the tooth to be removed was not confirmed by the student&lt;br&gt;2. The correct tooth was not confirmed by the tutor once the student had applied the forceps&lt;br&gt;&lt;br&gt;<strong>Incidental Issues</strong>&lt;br&gt;1. Incomplete consent process.&lt;br&gt;2. Concerns raised over the manoeuvrability of the lighting in the dental surgery&lt;br&gt;&lt;br&gt;<strong>Potential Root Causes</strong>&lt;br&gt;1. Gaps in the process for identification of the correct tooth to be removed&lt;br&gt;2. Incomplete consent process&lt;br&gt;3. Concerns raised over the manoeuvrability of the lighting in the dental surgery</td>
<td>Actions Identified:&lt;br&gt;1. Introduction of tooth marking&lt;br&gt;2. The consent and documentation process in the Community Dental Service extended to capture students and potential for incorrect tooth removal&lt;br&gt;3. Replacement of the lighting concerned</td>
</tr>
</tbody>
</table>

Wrong level spinal surgery | Wrong site surgery | At the time of completing this report, the investigation was still ongoing, due for completion 27/05/2015 |  |
How we keep everyone informed

We now have more than 7,600 followers on Twitter who follow the @SalfordRoyalNHS feed to keep up to date with Trust news and events, provide feedback on our services and much more. We were pleased to find out in December 2014 that our account was ranked 15th in the top 50 of NHS tweeters from all NHS organisations across the country. Rankings were reached based on the number of followers and the number of tweets from our account. Twitter is also a useful way of sharing messages with colleagues across Salford Royal, for example encouraging our staff to take up flu vaccinations.

Other methods of reaching our staff include the intranet, the fortnightly e-bulletin SiREN and screensavers. Screensavers are particularly useful in sharing patient safety messages, for example, information about sepsis or pressure ulcers.

Salford Royal continues to celebrate the successes and achievements of the organisation and its staff on the Trust’s weekly page in the local paper, the Manchester Weekly News. Coverage in the local paper proved to be particularly beneficial during nominations for the annual Staff Awards when a new Patient’s Star category was introduced. Publicity in the paper ensured we received a wealth of nominations from readers who wanted to put forward a member of staff or a team for a Staff Award because they had gone the extra mile.

The organisation has achieved lots of positive regional and national media coverage during the past 12 months, such as the opening of a satellite renal unit in Oldham, a new dementia courtyard on the hospital site and the Health Service Journal named the Trust as one of the Top 10 best places to work in healthcare.

Our Foundation Trust members also like to keep up to date with the latest news from Salford Royal and we publish The Loop magazine twice a year, which is distributed to more than 22,000 people and includes information about events and meetings they can get involved in.

The Membership Team has helped co-ordinate a number of engagement projects in the past 12 months including a survey looking into patient experience in A&E and they also recruited a team of Youth Health Ambassadors to give the Trust feedback on how healthcare services for young people can be improved.
CCG Statement for 2014/15 Quality Accounts

NHS Salford Clinical Commissioning Group (CCG) welcomes the opportunity to comment on the 2014/15 Quality Accounts for Salford Royal NHS Foundation Trust.

We have been working closely with the Trust during the year, gaining assurance of the delivery of safe and effective services. A range of indicators in relation to quality, safety and performance is presented and discussed at regular meetings between the Trust and the CCG. We are pleased to see that the information presented within the Quality Accounts is consistent with information supplied to the commissioners throughout the year.

Review of regulatory inspections form part of our quality assurance processes and we commend the Trust on the excellent feedback from the CQC inspection undertaken during the year. The CQC rating of outstanding is a huge achievement and reflects the emphasis that the Trust places on delivering safe and effective services. The importance of this independent view on the quality of service provision is helpful in providing additional assurance to our direct discussions and observations.

Members of the CCG Governing Body have undertaken commissioner-led walk arounds during the year and the feedback from the CQC resonates with our own observations in terms of effective leadership, the values and behaviour of staff and their commitment to patient safety.

We acknowledge the increased emphasis on quality improvement initiatives within community services and the evidence provided on their achievements during 2014/15. This was something that we had asked to be included as part of our feedback last year and welcome the opportunity to receive information on the full range of services provided by the organisation.

The emphasis placed upon safety through the harm reduction and prevention programmes undertaken by the organisation is clearly evidenced within this document. The Trust’s commitment to improving scrutiny on safety issues and safety improvement is evident in their involvement with the Making Safety Visible Programme; we fully support and endorse these important elements that contribute to high quality healthcare for our patients.

The focus on listening to the feedback of people using services and improving patient experience is evident in the initiatives outlined. The information provided on the Patient, Family and Carer Experience Collaborative highlights how the organisation has made direct improvements as a result of this feedback. We are keen to see the work that has been undertaken within the hospital environment adapted for use within a community setting and look forward to information being provided in next year’s accounts.

The link between the provision of high quality care and staffing levels is clearly demonstrated within the document. The Trusts’ commitment to safe staffing and the work undertaken during the year to share information with patients and the public is to be commended. We would be keen to see the work completed on nurse staffing ratio’s within a ward environment be extended to community nursing and other staff groups, to provide additional assurance in this area.

The document includes a range of areas where NHS Salford CCG has been working in conjunction with the Trust to support quality improvement. This is evidenced within the Integrated Care Programme, through innovation projects and on the Making Safety Visible Programme. It reflects our commitment to continued scrutiny of quality and performance against agreed metrics and collaboration on quality and safety improvement. We are pleased to endorse these Quality Accounts for 2014/15 and look forward to continued partnership working on driving improvements in safety and quality for the benefit of our population.

Alan Campbell
Chief Accountable Officer
NHS Salford Clinical Commissioning Group
Healthwatch Salford

Healthwatch Salford is a consumer champion for health and social care. We listen to the views and experiences of local people and use this information to influence health and social care services. We aim to work as a critical friend, offering constructive feedback to services based on the voices of local people.

Over the past year, Healthwatch Salford has continued to maintain its good relationships with Salford Royal Foundation Trust and a stronger approach to joint working has been developed through the Engagement Leads group. This helps us to learn more about how Salford Royal is engaging and working with the people using their services.

Healthwatch Salford would like to congratulate Salford Royal on its rating of ‘Outstanding’ in the recent CQC inspection. This is truly a great achievement and reflects a great deal of hard work and dedication. As part of the inspection process, Healthwatch Salford was able to provide independently gathered comments and experiences of local people to the Care Quality Commission (CQC) to ensure that their experiences were accurately reflected in the inspection.

We understand that delivering safe, clean, personal care can be a difficult task, and we would like to recognise the positive outcomes achieved by Salford Royal in 2014-15. Healthwatch Salford looks forward to continued partnership working with Salford Royal, highlighting challenges and ensuring that local people’s voices influence improvements in service delivery.

Clare Mayo
Chief Officer
Healthwatch Salford

Health and Adults Scrutiny Panel

As Chair of the new Health and Adults Scrutiny Panel, I am delighted to comment on the Quality Account for the Salford Royal Foundation Trust.

Once again the Trust has made outstanding achievements and improvements. I make these comments in support of the excellent results arising from the recent CQC inspection.

The dedication and pride shown by the Trust staff and the way that service is valued by patients is a credit to the Board and the organisation as a whole.

Salford, as a city, is proud to have the Trust serving its people. We, as a scrutiny panel, are looking forward to the coming year and will endeavour to work with the Trust to deliver their ambitious targets.

Councillor Margaret Morris
Chair of the Health and Adults Scrutiny Panel
Salford City Council
Statement of Directors’ responsibilities in respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS Foundation Trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that 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 May 2015
  - Feedback from local Healthwatch organisations dated April 2015
  - Feedback from Health and Adults Scrutiny Panel dated April 2015
  - The Trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 dated June 2014
  - The latest national patient survey 2014
  - The latest national staff survey 2014
  - The Head of Internal Audit’s annual opinion over the Trust’s control environment dated May 2015
  - CQC Intelligent Monitoring Report dated March 2015

The Quality Report presents a balanced picture of the NHS Foundation Trust’s performance over the period covered

The performance information reported in the Quality Report is reliable and accurate

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

The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review

The Quality Report has been prepared in accordance with Monitor’s annual reporting guidance (which incorporates the Quality Accounts Regulations) published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual)

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

28 May 2015
Date
Chairman

28 May 2015
Date
Chief Executive
We have been engaged by the Board of Directors and Council of Governors of Salford Royal NHS Foundation Trust to perform an independent limited assurance engagement in respect of Salford Royal NHS Foundation Trust’s Quality Report for the year ended 31 March 2015 (the ‘Quality Report’) and certain performance indicators contained therein.

Scope and subject matter
The indicators for the year ended 31 March 2015 subject to limited assurance consist of the national priority indicators 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 Monitor’s ‘Detailed guidance for external assurance on quality reports 2014/15’; 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 2014/15’.

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:

- Board minutes for the period 1 April 2014 to 30 March 2015;
- Papers relating to quality reported to the board over the period 1 April 2014 to 27 April 2015;
- Feedback from Commissioners, dated May 2015;
- Feedback from Governors, dated May 2015;
- Feedback from local Healthwatch organisations, dated May 2015;
- Feedback from Salford City Council Health and Adults Scrutiny Panel, dated May 2015;
- The Trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 5 June 2014;
- The national patient survey, dated February 2015;
- The national staff survey, dated 2014;
- Care Quality Commission Intelligent Monitoring Report, dated March 2015; and
- The Head of Internal Audit’s annual opinion over the Trust’s control environment, dated March 2015.

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

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.
This report, including the conclusion, has been prepared solely for the Council of Governors of Salford Royal NHS Foundation Trust as a body and the Board of Directors of the Trust as a body, to assist the Board of Directors and Council of Governors in reporting Salford Royal 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 Board of Directors and 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 Board of Directors as a body, the Council of Governors as a body and Salford Royal NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed
We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (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;
- Analytical procedures;
- 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 governance over quality or non-mandated indicators, which have been determined locally by Salford Royal NHS Foundation Trust.

Conclusion
Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 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 above; and
- The indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the ‘NHS Foundation Trust Annual Reporting Manual’.

Grant Thornton UK LLP
4 Hardman Square, Spinningfields, Manchester, M3 3EB

Date: 28 May 2015
Appendices
### National Clinical Audit: actions to improve quality

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<th>Audit Title</th>
<th>Outcome</th>
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| **Epilepsy 12 Audit (Childhood Epilepsy)** | The audit reports against 12 performance indicators that measure care over 12 months. Units are defined as a negative outlier if they are below two standard deviations from the UK value and a positive outlier if they are higher than two standard deviations from the UK value.
- The Trust was reported as, not an outlier, for 11 of the 12 performance indicators and a positive outlier for 1 of the performance indicators.
- The Trust continues to work towards meeting and improving upon its performance in relation to the Epilepsy 12 standards.
- The audit also measured patient satisfaction with the service. In our unit 23 (96%) of those who answered the question indicated yes to: ‘Overall, are you satisfied with the care you receive from the epilepsy service?’ compared to 88% across the UK. |
| **National CEM Audit of Management of Moderate or Severe Asthma in Children in Emergency Departments** | The national report was received by the Trust in February 2015, the clinical team are in the process of reviewing the audit results and will then develop an action plan to address any areas requiring improvement. |
| **Intensive Care National Audit & Research Centre - Case Mix Programme (ICNARC)** | The Trust’s ITU has participated in the CMP for level 3 beds since 1997. On 31 March 2014 the Trust re-registered with ICNARC as CCU and MHDU as separate units and submits data for all level 2 and level 3 beds (this includes ICU, NHDU, SHDU, and MHDU).
- Data from ICNARC is regularly discussed at a number of meetings including the Critical Care Management Group and the Critical Care Strategic Group.
- There are currently actions in progress to improve quality of documentation, patient flow, delayed admission, and organ support activity log.
- The Team are investigating data around delayed discharges from Critical Care in an attempt to understand where the issues are and will then go on to develop and action plan. This fits into the new Trust-wide patient flow workstream. |
| **National Emergency Laparotomy Audit (NELA)** | The audit lead has reviewed the national organisational audit report and identified the following areas for action.
- Surgeons to ensure recording of time of first assessment and decision to operate in EPR
- Availability of theatres for acute laparotomies after 5pm
- Minimise time to theatre once decision to operate has been made
- Early recognition of signs of sepsis and implementing the sepsis bundle
- Improve access to ICU and SHDU beds
- Early transfer of patients needing a laparotomy when referred from outlying wards to a surgical bed or SHDU/ICU as is deemed appropriate
- Training of juniors to recognise acute surgical problems needing a laparotomy and timely involvement of a consultant surgeon
- Improve access to opinion from a consultant Radiologist and availability of Interventional Radiology
- These recommendations will be discussed in further detail at the appropriate clinical governance/consultants meetings and in liaison with managers before an action plan is developed. |
| **National Joint Registry (NJR)** | The Trust continues to work towards improving the completeness of its NJR submission and has identified a new consultant lead for the project.
- During 2015 the orthopaedic team will be participating in a pilot data quality audit working with other Trusts in the region. The audit will review; data completeness, data validation and data quality.
- The audit findings will support the development of an improved data collection, submission and validation process. This would result in the achievement of a higher compliance to BPT (best practice tariff) and therefore higher remuneration to the department and Trust
- The possibility of an electronic solution for data submission will also be explored during 2015. |
| **CEM Severe Sepsis and Septic Shock** | Overall Trust results were very good compared to the national average and showed an improvement from the 2011 audit. However, the team is still working towards improving on a number of areas.
- An action plan for the audit has been developed and is been taken forward as part of the Trust Sepsis Collaborative Project. Further details are available on page 43. |
| **CEM Paracetamol Overdose** | The audit showed treatment overall was in accordance with MHRA guidance, with only 3 cases partially deviating without serious omissions.
- The team will work to improve time to Parvolex being prescribed and administered by promoting the use of existing proforma and prescription sheet.
- FY2 teaching regarding overdose and poisoning is ongoing. |
### Audit Title

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| National Diabetes Audit (Adults)                | Audit results are reviewed annually (most recently in February 2015) by a multidisciplinary, cross organisational (Salford Royal, NHS Salford CCG) patient and professional group (Salford Diabetes Care). Priorities for action are agreed and then progressed through the following year with bi-monthly reviews by SDC. The overall priorities for 2015 are:  
  - Practice Improvement (reduced variation in both care processes and treatment target achievements)  
  - Patient Education: converting more offers into attendances  
  - Foot care: improved surveillance rates, benchmarked ulcer healing and fewer shorter admissions  
  - Patient View: rolled out to support the routine annual review and care planning processes. The group felt that this would be helpful but that alternative systems would be needed for the older age group  
  - Services for younger people: focussed development including probably greater deployment of pumps and continued focus on reducing the number of / making modest improvements in the patients with Haemoglobin A1c >80mmol/mol  
  - Reduced impact of cardiovascular disease (incidence/admissions/outcome) i.e. an extension of the previous focus on heart failure prevention  
  - Healthy Cities Initiative. The focus on diabetes prevention is clearly the big hope for containing the steadily increasing burden of diabetes |
| National In-patient Diabetes Audit              | The Trust has an inpatient steering group that meets monthly and the results of the national diabetes audits are reviewed and actioned by the group. The findings of this snap shot audit of inpatient care (NaDIA) have resulted in the following local actions:  
  - Ward staff education programmes  
  - Work to improve understanding and consistent use of VR1I charts; an EPR solution which should be more reliable has been developed but not yet implemented  
  - Local CEA's of episodes of severe hypoglycaemia and hyperglycaemia including participation in the national Diabetes Morbidity and Mortality review  
  - Working with Pathology to get remote monitoring of bedside Blood Glucose made accessible to the Inpatient DSNs (implementation expected in Spring 2015) |
| National Diabetes Paediatrics (NPDA)            | Results of the NPDA have been reviewed by the paediatric diabetes team and by SDC. In respect of glucose control Salford has the best performance in GM. The focus of the action plan is to reduce the number of / making modest improvements in the patients with Haemoglobin A1c >80mmol/mol. |
| National Pregnancy in Diabetes                  | The results of the audit have been discussed locally and at the Regional Annual Diabetes in Pregnancy workshop. The focus of the action plan will be on new systems to increased effective pre-pregnancy planning and reducing neonatal admissions. |
| Inflammatory Bowel Disease (IBD)               | The results of the audit have been reviewed by the clinical team. An electronic referral to the IBD team to enable support to improve compliance with VTE, stool samples and referral to other member’s of the MDT is in development. |
| National COPD Audit                              | The national report was received by the Trust in February 2015, the clinical team are in the process of reviewing the audit results and national recommendations. They will then develop an action plan to address any areas requiring improvement. |
| National Renal Registry                          | The Trust submits the mandatory data fields to the Registry on a quarterly basis. Data is electronically pulled and transferred from the Trust Patient Record. The Clinical Team feels that there may be inaccuracies in the electronic data submission and local audits have shown better results in relation to haemoglobin, phosphates and vascular access. The aim for 2015/16 is for the clinical team to work with the EPR Team in order to improve the quality of the data submission and work towards collecting the additional data fields as well as the mandatory ones. |
| The National Review of Asthma Deaths (NRAD)     | The Trust has received the national report. The results are due to be discussed through the relevant Governance structure and. If required, an action plan will be produced in order to address any specific areas of concern. |
| National Audit of Acute Myocardial Infarction (MINAP) | The National report was published in late December 2014. Initial review shows that the Trust results compare well against the England average figures. In particular:  
  - 94.3% of patients received all secondary prevention medications for which they were eligible (England 87.9%)  
  - 95.6% of nSTEMI patients were referred for or had angiography during admission (England 78%)  
  - 97.3% of nSTEMI patients were referred for or had angiography during admission including angiography planned after discharge (England 80.3%)  
  The audit results are due to be discussed through the relevant Governance structure and, if required, an action plan will be produced in order to address any specific areas of concern. |
### National Cardiac Rhythm Management Audit (CRM)

The national audit report was made available for validation in October 2014. The Clinical Lead worked with the Clinical Audit Team to ensure that all procedures were submitted by the new deadline. Work is being undertaken by the Trust EPR Team to develop an electronic structured note which will allow for a more efficient and accurate data submission process.

### National Heart Failure Audit

There is a well-established integrated heart failure (HF) service serving Salford Royal and Salford Community, including: Inpatient service, rapid access HF clinics, nurse-led out-patient clinics (in hospital & the community), telephone clinics and home visits.

The majority of patients are admitted to Cardiology ward or Aging & Complex Medicine (ACM).

The HF team are pro-active in identifying patients admitted with HF. They receive automatic e-mail alerts for patients admitted with a known diagnosis of HF, known to HF service, with a Health Issue of HF put on EPR or an echo demonstrating LVSD they also visit EAU 5 days a week. Specialist HF nurses will see patients irrespective of admitting ward.

The hospital operates an active ‘out-reach’ service to ensure that patients are seen by appropriate health professionals and ensures that patients with multiple co-morbidities receive the best care (often ACM). This has recently been proposed as a model of care by the recent NICE guidelines for Acute Heart Failure.

HF patients not on a cardiology ward will be seen by Cardiologist if:
- Referred by responsible consultant
- Identified by HF nurse as requiring specialist input

Echocardiograms are requested on patients who have not had a previous abnormal echo, to be performed in hospital or within 2 weeks of discharge for short stay patients.

### National Bowel Cancer Audit (NBOCAP)

The 2014 report (based on 2010 to 2013 data) showed reassuring outcome data for the Trust and individual surgeon level mortality rates. Local action plans have been developed with the key focus on:
- Continued development of Minimally Invasive Techniques
- Patient Self-care and Enhanced Recovery after Surgery

The Clinical Audit, Cancer Services and Clinical Specialty Teams are working together to develop and improve the data collection and validation process for the audit.

### National Head and Neck Cancer Audit (DAHNO)

The Clinical Audit, Cancer Services and Clinical Specialty Teams are working together to develop and improve the data collection and validation process for the audit.

### National Lung Cancer Audit

The National Lung Cancer Audit identified low rates of chemotherapy treatment for small cell carcinoma at Bolton, Wigan and Salford.

In order to understand why this has occurred, a sector MDT audit has been set up to review current practice and to then understand the published figures. The aim is to improve chemotherapy rates.

### National Oesophageal Cancer Audit (NOCGA)

The 2014 audit report demonstrates excellent post-operative outcomes for Oesophageal cancer patients at Salford Royal with a 30 and 90 day mortality at 1.3% and 3.1% respectively against a national rate of 2.4% and 4.4%. Local action plans have been developed with the key focus on:
- Continued development of Minimally Invasive Techniques - including endoscopic resection of early stage disease
- Patient Self-care and Enhanced Recovery after Surgery
- Improved recording of TNM staging at the MDT

Salford Royal NHS Foundation Trust is also the only UK centre to participate in a European surgical trial.

In addition the Clinical Audit, Cancer Services and Clinical Specialty Teams are working together to develop and improve the data collection and validation process for the audit. We have been successful in developing audit links with other local Trusts which has helped to improve the quality and completeness of our data submission for patients who are referred to us for only part of their patient pathway.

### National Prostate Cancer Audit (NPCA)

National Prostate Cancer Audit (NPCA) has been collecting prospective data on the diagnosis, management and treatment of patients with a new diagnosis of prostate cancer since 01/04/2014.

Data is submitted on a monthly basis and the Clinical Audit, Cancer Services and Clinical Specialty Teams are working together to develop and improve the data collection and validation process for the audit.

The First Year Annual Report was published in November 2014. The second year report is planned for publication in October 2015, which will describe the findings from the first year of the prospective audit.

Following publication of this report the team will discuss the findings at the regular educational SMDT meeting and identify areas for further audit, good practice and quality improvement.
<table>
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<tr>
<th>Audit Title</th>
<th>Outcome</th>
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<tbody>
<tr>
<td>National Hip Fracture Database</td>
<td>The orthogeriatric team have contributed to the quality focus for hip fracture care within the Trust since 2012. As a result the report of the National Hip Fracture Database has shown improvements in our local practice between 2013 and 2014. In the “Blue Book” six standards there have been improvements in all areas or minimal change consistent with stability. In the Best Practice Tariff goals the orthogeriatric delivered components show high levels of compliance above a minimum standard of 85%. In 2015 we aim to maintain and improve on our achievements so far and the orthogeriatric team will engage with surgical and anaesthetic colleagues to improve our Best Practice Tariff compliance.</td>
</tr>
<tr>
<td>National Stroke Audit Programme (SSNAP)</td>
<td>National audit findings published in 2014 highlighted the following areas of concern: Domain 5 - Occupational therapy, Domain 6 - Physiotherapy, Domain 7 - Speech and Language therapy and Domain 8 - MDT working. The Team has been working hard to implement actions to address these issues and performance has improved within these areas over the last 12 months. The key changes in 2014 being 7-day working for Occupational Therapy and Physiotherapy staff (which has positively impacted on domains 5, 6 &amp; 8) and then for Speech and Language Therapy staff (which has positively impacted on domains 7 &amp; 8). We are aiming to continue to improve and there are expected impacts from stroke service reconfiguration which is scheduled for March 2015. The first full quarter of audit data within which we will expect this to impact will be Q1, 2015-16.</td>
</tr>
<tr>
<td>SSNAP Organisational Audit</td>
<td>Early Support Discharge (ESD) team composition and service delivery has been reviewed and recommendations made by Therapy Lead, GP and commissioner - ESD business case in submission with commissioners. Access to podiatry services was identified as being more than five days. This has been addressed and access is now within five days. Staffing levels - plans are in place for staff expansion in line with service expansion in 2015. A Stroke Strategy Board has been set up with regular meetings including Trust Board Membership. Additionally there is Trust Board representation at Stroke Implementation Board. Psychology to be included in future meetings, Social Worker/Dietetics attend as appropriate with responsive access to each of these services. A Stroke user group has been recommenced, led by Stroke Nurse Consultant.</td>
</tr>
<tr>
<td>UK Trauma Audit and Research Network (UKTARN)</td>
<td>The Trust has performed well above national average in 8 of the 12 TARN indicators. The results are regularly discussed at the Major Trauma Operational meetings and recommendations and action plans are in place so that practice can be improved where required.</td>
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<tr>
<td>National Audit of Seizure Management</td>
<td>Overall, the Trust’s performance on the indicators of overall quality of care is better than national average. However, there are areas identified for improvement. The main area of development identified was rapid access to first seizure services. We have a clinic at Salford Royal, but providing appointments within the 2 week period stipulated has been difficult. The team is working with the Strategic Clinical network to set up rapid access triage clinics to reduce the number of inappropriate referrals which will lead to better access for patients who need it. The Trust is also implementing an ongoing programme of education for junior doctors in the emergency department to ensure standards are maintained.</td>
</tr>
<tr>
<td>National Intermediate Care Audit</td>
<td>The national audit report has been received by the Trust and is currently being reviewed to identify opportunities for improvement. Following this a local action plan will be developed.</td>
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</table>
| National Care of the Dying                      | The Trust has been working towards implementation of a robust action plan in relation to the care of the dying patient. This includes:  
- An extensive end of life care education programme is in place and accessible to all social and healthcare professionals across Salford  
- The Trust has identified a non-executive director to represent end of life care at board level and established an End of Life Care Steering Group  
- Recognition of dying is covered at length in the monthly Transforming end of life care, discussions in last days of life simulation programme and the bi-annual intermediate programme  
- “5 Priorities” are displayed in all wards. Explanation given in clinical areas and is included in the formal training programme  
- Established weekly electronic notifications regarding the use of the end of life care plan. Analysis undertaken at divisional directorate and ward level  
- End of Life Care medication algorithms revised and accessible on the intranet along with prescribing bundles for Rapid Discharge and end of life care plan  
- Analysis of Trust deaths found that the ceiling of care/ DNACPR status was complete in 93% (April 2014) with an increase to 96% (October 2014)  
- Appointment of a Bereavement Specialist Nurse in the clinical setting to advise and support staff and bereaved relatives/carers |
### Local Clinical Audit: actions to improve quality

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<th>Audit Title</th>
<th>Actions Planned/Undertaken</th>
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<tr>
<td>Chronic Obstructive Pulmonary Disease (COPD) discharges re-audit</td>
<td>The audit results showed a clear improvement since the original audit and the introduction of the Respiratory Review Bundle in summer 2012. e.g. More patients have an action plan, rescue medication and timely follow-up. However, there are areas that require further improvement and the team have been working on the implementation of the following actions: The COPD Respiratory Team is alerted by email for every COPD admission. This is to ensure that the patient will receive a respiratory review while an inpatient. The Respiratory Team will then address health issues/ risk factors specific for COPD patients that include the risk of O2 toxicity. Smoking cessation advice will be offered by the Respiratory Team who can allocate more time and are trained in providing smoking cessation advice. To improve the coding of COPD diagnosis so that the appropriate email alert can be generated for the Respiratory Team. To finalise the Oxygen alert card policy and submit it to CG meeting for approval. After Clinical Governors meeting the policy can be publicised on the Trust Intranet.</td>
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| Hand and Finger Injuries in Adults (Emergency Department Management)       | There is ongoing work in the ED to improve pain management, including work around staffing levels, triage and initial assessment, PGD development, and education of new staff. Once the electronic patient notes (ED Clinical Assessment on EPR) have been well established, condition-specific proformas will be developed, with prompts for important positive and negative findings, e.g.:  
- Dominance  
- Mechanism of injury  
- Tendon or nerve injury  

The findings of the audit are broken down to ward level in order to identify specific areas requiring action. The data allows us to identify any issues that exist regarding ward infrastructure, eg broken locks that may be preventing compliance with the required standards and these can be acted upon in real time. |
| Safe Storage of Medicines at Ward Level                                    | The findings of the audit resulted in the following actions being planned / implemented:  
- Staff are required to read and sign the Salford Royal lone working policy and local procedure annually  
- All community staff are supplied with Sky Guard devices and this will to be added to the local dietetic lone working procedure  
- All staff to familiarise themselves with the Sky Guard device using the instruction manuals that are available  
- All referrals to be screened and safety questions to be asked prior to any joint visits  
- The red sticker system to be used to identify when a joint visit is required  
- A buddy system to be in place at all times  

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The findings of the audit resulted in the following actions being planned / implemented:  
- Staff are required to read and sign the Salford Royal lone working policy and local procedure annually  
- All community staff are supplied with Sky Guard devices and this will to be added to the local dietetic lone working procedure  
- All staff to familiarise themselves with the Sky Guard device using the instruction manuals that are available  
- All referrals to be screened and safety questions to be asked prior to any joint visits  
- The red sticker system to be used to identify when a joint visit is required  
- A buddy system to be in place at all times  

The Infection Control Team undertakes a rolling programme of ward and community area infection control audits. Wards/areas are audited annually and individual reports are returned to the ward manager / lead manager for action. Reports highlight areas of concern which require improvement. Wards/areas are required to produce an action plan to address any issues of concern and submit these to the IC Team. Wards/areas are RAG Rated as Green, Amber or Red. Any areas receiving a Red Rating is followed up within one week, any area receiving an Amber Rating with 6 months to ensure improvements have been made. |
<table>
<thead>
<tr>
<th>Audit Title</th>
<th>Actions Planned/Undertaken</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit and re-audit of paracetamol prescribing in surgical patients weighing &lt;50kg</td>
<td>Following the initial audit:&lt;br&gt;› An alert was created within EPR to display the weight based guidelines for safe paracetamol prescribing&lt;br&gt;› An awareness campaign was created for junior doctors to improve the safety of paracetamol prescribing&lt;br&gt;The re-audit showed a significant reduction in prescribing errors of paracetamol in this patient population.</td>
</tr>
<tr>
<td>Appropriate testing of female patients of reproductive age on ICU</td>
<td>Following the audit:&lt;br&gt;Posters have been developed detailing the results of the audit and the key checks that should be made in relation to this patient group. These posters have been displayed within the clinical area to remind all staff of the guidance.&lt;br&gt;Stickers have also been developed to attach to the patient notes which prompt these checks to be made. This is an interim measure and the audit team are liaising with the Trust’s EPR team to develop an electronic solution linked to the patient record.</td>
</tr>
<tr>
<td>Management of Cholecystostomy Tubes</td>
<td>The audit has been presented back to the clinical team to raise awareness.&lt;br&gt;A Policy has been agreed at Directorate Clinical Governance and is in the process of being uploaded onto the Trust Document Management Site.&lt;br&gt;The audit results have been accepted to be displayed as a poster presentation at the Association of Surgeons of Great Britain and Ireland (ASGBI) in April 2015.</td>
</tr>
<tr>
<td>Orthopaedic Admission Clerking Audit</td>
<td>Following the initial audit a structured clerking template based on the RCP example template was introduced.&lt;br&gt;A re-audit was then undertaken to measure any improvements made as a results of the new document.&lt;br&gt;Further work is ongoing to improve the use of the new document and look into the possibility of this being put onto the EPR system.</td>
</tr>
<tr>
<td>Audit of BP monitoring and management in Acute ICH patients</td>
<td>Following presentation of the audit findings the following actions were agreed:&lt;br&gt;› Update Trust protocol for the management of acute hypertension after intracerebral haemorrhage - Review existing protocol in collaboration with ASU medical and nursing team&lt;br&gt;› Explore means of improving compliance with BP protocol on ASU - liaising with the QI Team&lt;br&gt;› Improve induction for new medical and nursing staff to include awareness of ICH BP protocol</td>
</tr>
<tr>
<td>Diagnosis and Management of Pneumonia in Acute Stroke: Audit of Adherence to Trust Antibiotic Policy</td>
<td>Following presentation of the audit findings the following actions were agreed:&lt;br&gt;› Development of a policy for the monitoring and management of fever in the setting of acute stroke care and make this available on the Trust Document Management System&lt;br&gt;› Implement daily WR-based review of antibiotic stewardship with respect to treatment of pneumonia&lt;br&gt;› Re-audit 2015</td>
</tr>
<tr>
<td>Infection Control – Blood Cultures Audit (monthly on-going)</td>
<td>The aim of the audit is to measure compliance with the local Trust policy; Blood Culture Sampling in Adults. The audit focus is on whether:&lt;br&gt;› The name of the member of staff on the pathology form is the same name as the member of staff taking the blood&lt;br&gt;› The blood culture sticker is attached to the form with questions completed and signed by the same person taking the blood&lt;br&gt;› The person taking the blood has current status on to the Blood Culture Sampling Competency Register&lt;br&gt;All non-adherence to the above is followed up by the Infection Control Team.</td>
</tr>
</tbody>
</table>
## Appendix C

### Goals agreed with commissioners: commissioning for Quality and Innovation Payment Framework (CQUIN)

<table>
<thead>
<tr>
<th>Indicator Number</th>
<th>Indicator Name</th>
<th>Comment</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>National - Friends and family test: Implementation of Staff Test</td>
<td>Implementation of staff FFT as per guidance, according to the national timetable</td>
<td>£119,671</td>
</tr>
<tr>
<td>1.2</td>
<td>National - Early implementation</td>
<td>Implementation of the Family and Friends Test in Community Services</td>
<td>£119,672</td>
</tr>
</tbody>
</table>
| 1.3              | National - Response rates in A&E and inpatient                               | “A response rate for Q4 that is at least 20% for A&E services and at least 30% for inpatient services  
A response rate for Q4 that is at least 20% for A&E services and at least 30% for inpatient services” | £119,671    |
| 1.4              | National - Response rates in inpatient                                       | A response rate of 40% (or more) for the month of March 2015                                                                                                                                          | £119,672    |
| 2a               | National - NHS Safety Thermometer : Improvement Goal Specification            | Reduction in inappropriate catheter days                                                                                                                                                              | £478,285    |
| 3a               | National - Dementia : Find, Assess, Investigate and Refer (FAIR)            | “Achieve 90% per quarter for:  
1) Number of patients >75 admitted as an emergency who are reported as having a known diagnosis of dementia or clinical diagnosis of delirium, or who have been asked the dementia case finding question, excluding those for whom the case finding question can not be completed for clinical reasons (e.g. coma)  
2) Number of above patients reported as having had a diagnostic assessment including investigations  
3) Number of above patients referred for further diagnostic advice in line with local pathways agreed with commissioners” | £159,294    |
<p>| 3b               | National - Dementia : Clinical leadership                                     | Confirmation of a named lead clinician for dementia and delivery of the planned training programme has been undertaken                                                                                | £159,295    |
| 3c               | National - Dementia : Supporting Carers                                      | A monthly patient experience survey of carers of people with dementia to test whether they feel supported and report the results to the Board                                                                 | £159,295    |
| 4                | GM - Use of change methodology to improve Patient Safety                     | To use change improvement methodology to improve and sustain change in relation to a Lessons Learned Theme identified and agreed from areas such as serious incidents, claims, complaints or serious case reviews | £191,759    |
| 5                | GM - Ambulatory Care                                                          | “To reduce emergency admissions for agreed local cohort of patients. Acute and community services to work collaboratively i.e. right care, right time, right place to achieve this and ensure that the pathways involving different providers and different care locations are made seamless” | £191,759    |
| 6.1              | GM - Clinical Effectiveness Acute                                              | Improve care of the deteriorating patient in the acute hospital setting by developing a tool to identify the deteriorating patient                                                                      | £95,880     |
| 6.2              | GM - Clinical Effectiveness Community                                          | Improve care of the deteriorating patient in the community by developing a tool to identify the deteriorating patient in the community setting                                                   | £95,879     |
| 7                | GM - Improving Learning Disability Patient User Experiences and Support       | Benchmarking each organisation using the Hospital SAF and agreement with local commissioners of a comprehensive local priorities work plan that Improves Access and Reduces Inequalities for people with learning disabilities | £191,759    |</p>
<table>
<thead>
<tr>
<th>Indicator Number</th>
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<th>Comment</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>Local - Seven Day Working A&amp;E</td>
<td>Development of a measurement for Seven Day Working Standards for Admitted patients under Acute Medicine and A&amp;E</td>
<td>£191,759</td>
</tr>
<tr>
<td>9</td>
<td>Local - Seven Day Working General Surgery</td>
<td>Development of a measurement for Seven Day Working Standards for surgical emergencies presenting in A&amp;E</td>
<td>£191,759</td>
</tr>
<tr>
<td>10</td>
<td>Local - Admission Avoidance</td>
<td>To test new new service models that provide general surgical input into unscheduled care pathways without the need for hospital admission</td>
<td>£191,759</td>
</tr>
<tr>
<td>11</td>
<td>Local - Communications</td>
<td>To continue to improve the quality of clinical information communicated between secondary and primary care clinicians to ensure that patients receive quality, continuity of and seamless care</td>
<td>£191,759</td>
</tr>
<tr>
<td>12a</td>
<td>Local - EOL Care Acute</td>
<td>Selected medical and nursing staff will have the skills and confidence to use EPaCCS within Salford Royal. This will include Haematology for the Division of Clinical Support Services &amp; Tertiary Medicine and 2 wards for each of the remaining 3 divisions, including surgery and neurosciences (total of 7 wards and 28 staff)</td>
<td>£191,759</td>
</tr>
<tr>
<td>12b</td>
<td>Local - EOL Care Community</td>
<td>A system of best practice Advance Care Planning communication is established with the use of the ‘Palliative Care Meeting Checklist’ by District Nurses</td>
<td>£191,759</td>
</tr>
</tbody>
</table>
| 13               | Local - Paediatric Care Pathway      | “There are two linked themes to the indicator:  
> Sustain improvement in Asthma management and,  
> Design and implement a whole system pathway for constipation, in line with NICE guidance. Monitor compliance with pathway. Achieve a target proportion of eligible children following the pathway” | £191,759    |
| 14               | Local - MDT Children                | “There are two linked themes to this indicator:  
> Continue to hold and refine CDF meetings  
> Design and implement a systematic child health profiling strategy conforming to British Association of Community Child Health informatics guidance. Data will be collected and held on Salford Royal PAS systems” | £191,759    |
<p>| 15               | Local - Medicines Thermometer        | To use the medicines safety thermometer to identify the degree of harm from specified critical medicines. To continue collecting data using step 1 and 2 and to trial step 3 and 4 | £445,965    |
| 16               | Local - Medicines Reconciliation     | To improve the standards at discharge and ensure reconciliation of medicines, improving care for patients through clinical safety | £191,759    |
| 17               | Local - Self Care Fracture Clinic    | Modernisation of Salford Royal fracture clinic including introduction of 5 self care pathways and GP direct access to the clinic | £191,759    |
| 18               | Local - COPD                         | To develop a COPD Integrated Care Bundle. The bundle is for patients admitted with a primary diagnosis of an acute COPD exacerbation (ICD10 J44.1) initially on wards H2 and L6 &amp; followed-up by the COPD Assessment and Support Team (CAST). It should be personalised to the individual, simple to use, have the power to alter clinical behaviour and achieve sustainable improvement | £191,759    |</p>
<table>
<thead>
<tr>
<th>Indicator Number</th>
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<th>Comment</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>19</td>
<td>Quality Dashboard - adult critical care, neurosurgery, complex spinal surgery, specialised orthopaedics and specialised pain</td>
<td>Submit quarterly data against all the required dashboards in line with the dashboards reporting arrangements</td>
<td>£317,758</td>
</tr>
<tr>
<td>20</td>
<td>Highly specialised services clinical outcome collaborative workshop and provider report</td>
<td>Providers of Highly specialised services will hold a clinical outcome collaborative audit workshop and produce a single Provider report</td>
<td>£317,758</td>
</tr>
<tr>
<td>21</td>
<td>Trauma adult critical care - rehab prescriptions</td>
<td>Develop systems to review and increase the effectiveness of rehabilitation following admission to critical care and on discharge</td>
<td>£492,524</td>
</tr>
<tr>
<td>22</td>
<td>HIV GP registration</td>
<td>“90% of patients with HIV to agree that their status is disclosed to their GP. At least annual communication with the GP including medications prescribed, information on potential drug interactions and other health conditions with monitoring and treatment needs”</td>
<td>£333,646</td>
</tr>
<tr>
<td>23</td>
<td>Cancer and blood - patient held self care plans</td>
<td>Encourage the use of patient held records by provider services</td>
<td>£333,646</td>
</tr>
<tr>
<td>24</td>
<td>Renal Dialysis - Shared Haemodialysis care</td>
<td>To encourage patient involvement in elements of the tasks of in centre haemodialysis</td>
<td>£492,524</td>
</tr>
<tr>
<td>25</td>
<td>Health inequalities - health visiting and diabetic retinopathy</td>
<td>Provide an assessment of access and coverage for vulnerable and deprived groups</td>
<td>£94,311</td>
</tr>
<tr>
<td>26</td>
<td>Dental - friends and family test - early implementation</td>
<td>Early implementation of dental Family and Friends Test. To improve patient experience and to gain timely feedback about their experience</td>
<td>£18,205</td>
</tr>
<tr>
<td>27</td>
<td>Dental - consistent clinical coding</td>
<td>Implementation of consistent coding</td>
<td>£16,684</td>
</tr>
<tr>
<td>28</td>
<td>Alcohol</td>
<td>Progress with action plan milestones to reduce alcohol abuse</td>
<td>£20,846</td>
</tr>
<tr>
<td>29</td>
<td>Sexual Health - No talk testing</td>
<td>Exploring the concept of “no talk testing” service</td>
<td>£41,693</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td></td>
<td><strong>£7,236,800</strong></td>
</tr>
</tbody>
</table>
### Glossary of definitions

<table>
<thead>
<tr>
<th>Term</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAA</td>
<td>Ambulatory Assessment Area.</td>
</tr>
<tr>
<td>Administering</td>
<td>The act of giving the medicine to the patient, usually by a nurse.</td>
</tr>
<tr>
<td>Advance Care Plan</td>
<td>A written statement of wishes or preferences relating to their patient care at the end of life.</td>
</tr>
<tr>
<td>ADNS</td>
<td>Assistant Director of Nursing Services. A job role in the hospital relating to nursing management.</td>
</tr>
<tr>
<td>Always Events</td>
<td>What patients should always receive when they use our services.</td>
</tr>
<tr>
<td>Arthroplasty</td>
<td>Arthroplasty is a surgical procedure to restore the integrity and function of a joint. A joint can be restored by resurfacing the bones.</td>
</tr>
<tr>
<td>Aseptic</td>
<td>If something is aseptic it is sterile, sanitised, or otherwise clean of infectious organisms.</td>
</tr>
<tr>
<td>Bay tagging</td>
<td>Practice where there is a member of staff in patient bay areas at all times.</td>
</tr>
<tr>
<td>Bacteraemia</td>
<td>The presence of bacteria in the blood.</td>
</tr>
<tr>
<td>Berwick Report</td>
<td>Review of the Francis Report to give recommendations on how the NHS should improve patient safety continually and forever reduce patient harm by embracing wholeheartedly an ethic of learning.</td>
</tr>
<tr>
<td>Cardiovascular care</td>
<td>Relates to the heart and blood vessels.</td>
</tr>
<tr>
<td>Care bundle</td>
<td>A group of interventions which are proven to treat a particular condition.</td>
</tr>
<tr>
<td>Care partner</td>
<td>A patient's relative, carer of friend who knows them well, who works with healthcare professionals to help us deliver the best care to our patients.</td>
</tr>
<tr>
<td>Care provider</td>
<td>An organisation that cares for patients. There are many examples some of which are a hospital, doctors surgery or care home.</td>
</tr>
<tr>
<td>Catheter</td>
<td>Catheters are medical devices that can be inserted in the body to treat diseases or perform a surgical procedure. Catheters are used for many reasons, for example, draining urine and in the process of haemodialysis.</td>
</tr>
<tr>
<td>Catheter associated urinary tract infection</td>
<td>An infection which it is believed has been caused by a urinary catheter.</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group responsible for most healthcare services available within a specific geographical area.</td>
</tr>
<tr>
<td>CfH</td>
<td>NHS Connecting for Health (NHS CFH) is part of the Department of Health Informatics Directorate.</td>
</tr>
<tr>
<td>Change Package</td>
<td>A group of changes or interventions developed to help tackle a particular problem.</td>
</tr>
<tr>
<td>Clinical</td>
<td>Relating to the care environment.</td>
</tr>
<tr>
<td>Clinical Microsystems Coaching</td>
<td>The Clinical Microsystems approach was developed at the Dartmouth Hitchcock Medical Centre in the US. The Clinical Microsystems approach involves supporting teams to lead and manage their improvement work by focusing on the needs of their [patients] and strengthening their organisational links to enhance their competencies in meeting these. Teams are supported in identifying and addressing areas for improvement through the use of a framework [for data collection] and a set of specific [improvement] tools and techniques (Nelson et al 2007).</td>
</tr>
<tr>
<td>Clostridium difficile</td>
<td>A type of infection.</td>
</tr>
<tr>
<td>Collaborative</td>
<td>Working together towards a shared purpose.</td>
</tr>
<tr>
<td>Collated COMFE</td>
<td>Comfortable, Observe, Move &amp; Mobilise, Food and Fluids, Elimination. This is a form of intentional rounding in the community.</td>
</tr>
<tr>
<td>Condition</td>
<td>An illness or disease which a patient is suffering from.</td>
</tr>
<tr>
<td>Continuing Healthcare</td>
<td>NHS continuing healthcare is the name given to a package of care that is arranged and funded by the NHS for individuals who are not in hospital but have complex ongoing healthcare needs.</td>
</tr>
<tr>
<td>Control Charts</td>
<td>Control charts, also known as Shewhart charts or process control charts (SPC Charts), are graphs used to determine whether or not a process is stable. This is helpful in monitoring performance and monitoring improvement work. If there is an active improvement effort going on, these tools can also be used to determine if an improvement has indeed been made.</td>
</tr>
<tr>
<td>COPD</td>
<td>Chronic obstructive pulmonary disease. The name for a collection of lung diseases including chronic bronchitis, emphysema and chronic obstructive airways disease.</td>
</tr>
<tr>
<td>Core Values</td>
<td>A group of ideals which the Trust believes all staff should exhibit.</td>
</tr>
<tr>
<td>CQC</td>
<td>Care Quality Commission - The independent regulator of all health and social care services in England.</td>
</tr>
<tr>
<td>CQUIN</td>
<td>Commissioning for Quality and Innovation. This is a system introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of care.</td>
</tr>
<tr>
<td>CURB-65</td>
<td>CURB-65 is a clinical prediction rule that has been validated for predicting mortality in community-acquired pneumonia and infection of any site. The CURB-65 is based on the earlier CURB score and is recommended by the British Thoracic Society for the assessment of severity of pneumonia.</td>
</tr>
<tr>
<td>Term</td>
<td>Explanation</td>
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</tr>
<tr>
<td>Deep Vein Thrombosis</td>
<td>A blood clot occurring in the deep veins of the leg.</td>
</tr>
<tr>
<td>Dispensing</td>
<td>The provision of medications by the pharmacy.</td>
</tr>
<tr>
<td>EAU</td>
<td>Emergency Assessment Unit.</td>
</tr>
<tr>
<td>Electronic patient record</td>
<td>A software programme which is used to enter information about a patient which is accessible by members of staff at the Trust.</td>
</tr>
<tr>
<td>Embed</td>
<td>Put in place.</td>
</tr>
<tr>
<td>Emergency village</td>
<td>A ward of the hospital which receives different types of patients into the hospital for example from the emergency department.</td>
</tr>
<tr>
<td>Episodes</td>
<td>An interval of healthcare provided.</td>
</tr>
<tr>
<td>Executive Safety WalkRounds</td>
<td>A visit to wards and departments by members of the Executive Team where members of staff can discuss concerns relating to patient safety.</td>
</tr>
<tr>
<td>Executive Team</td>
<td>The most senior managers in the Trust consisting of the Chief Executive, the Deputy Chief Executive, the Executive Medical Director, the Executive Nurse, Executive Director of Organisational Development and Corporate Affairs, Finance Director and the Executive Director of Service Strategy and Development.</td>
</tr>
<tr>
<td>FCE = finished consultant episode</td>
<td>The total time a patient spends under the care of an individual consultant.</td>
</tr>
<tr>
<td>Francis Report</td>
<td>Report led by Robert Francis QC, of the Mid Staffordshire NHS Foundation Trust Public Inquiry. The report highlighted areas of concerns relating to patient safety to aid organisational learning.</td>
</tr>
<tr>
<td>Geriatricians</td>
<td>Doctors who specialise in working with older people.</td>
</tr>
<tr>
<td>Grand Round</td>
<td>A teaching session which forms part of the medical education of junior doctors.</td>
</tr>
<tr>
<td>Haemodialysis</td>
<td>A process where blood taken from the body to be cleaned in a filter known as a dialyser.</td>
</tr>
<tr>
<td>Haemodialysis catheter-related bacteraemia</td>
<td>A blood stream infection caused by catheters inserted into the body which are required for patients requiring haemodialysis.</td>
</tr>
<tr>
<td>Haemoglobin</td>
<td>A part of red blood cells. Its function is to carry the oxygen from your lungs to your tissues.</td>
</tr>
<tr>
<td>Harm</td>
<td>An unwanted outcome of care intended to treat a patient.</td>
</tr>
<tr>
<td>HELP</td>
<td>Hospital Empowering Loved-ones and Patients.</td>
</tr>
<tr>
<td>Hippocratic Oath</td>
<td>The Hippocratic oath is a long-standing tradition in medicine. Named after the Greek physician Hippocrates, the written oath was intended to act as a guideline for those entering the medical profession.</td>
</tr>
<tr>
<td>HSMR</td>
<td>Hospital Standardised Mortality Ratio. A system which compares expected mortality of patients to actual mortality.</td>
</tr>
<tr>
<td>Huddle</td>
<td>A brief meeting often at the start and finish of shifts in care areas.</td>
</tr>
<tr>
<td>IHI</td>
<td>The Institute for Healthcare Improvement. The mission of IHI is to improve healthcare.</td>
</tr>
<tr>
<td>Information intensive consultations</td>
<td>Appointments that include a large amount of information for patients often from different sources such as the internet and electronic patient records</td>
</tr>
<tr>
<td>Intervention</td>
<td>A treatment which is intended to improve a patient’s condition.</td>
</tr>
<tr>
<td>Intentional rounding</td>
<td>A structured process where nursing staff carry out regular checks with individual patients at set intervals, typically hourly.</td>
</tr>
<tr>
<td>Intermediate care units</td>
<td>Units which patients go to when they no longer require the acute care of the hospital but are not yet ready to go home.</td>
</tr>
<tr>
<td>IV</td>
<td>Intravenous. Means within a vein but often seen in the context of giving medications which means administered directly into the vein.</td>
</tr>
<tr>
<td>IV diuretic treatment</td>
<td>Diuretics, also called water-pills, are a class of medications used to treat high blood pressure, heart failure and other diseases that cause fluid build-up in the body.</td>
</tr>
<tr>
<td>Just culture</td>
<td>A culture which understands that poorly designed systems are most commonly the cause of adverse events rather than individuals.</td>
</tr>
<tr>
<td>Lean Methodology</td>
<td>Lean methodology is an approach to improve flow and eliminate waste that was developed by Toyota. Lean is about getting the right things to the right place, at the right time, in the right quantities, while minimising waste and being flexible and open to change.</td>
</tr>
<tr>
<td>Liverpool Care Pathway</td>
<td>The Liverpool Care Pathway for the Dying Patient (LCP) is a UK care pathway covering palliative care options for patients in the final days or hours of life.</td>
</tr>
<tr>
<td>Locum</td>
<td>A temporary member of staff who fills in when Trust staff aren’t available, usually a doctor (locum doctor) or nurse (locum nurse).</td>
</tr>
<tr>
<td>Lumbar puncture</td>
<td>A procedure that takes fluid from the spine in the lower back through a hollow needle, usually done for diagnostic purposes.</td>
</tr>
<tr>
<td>Managed Booking</td>
<td>Outpatient appointment booking system where follow-up appointments are booked no more than six weeks in advance.</td>
</tr>
<tr>
<td>Medicines reconciliations</td>
<td>A process to ensure medicines prescribed on admission correspond to those taken before admission.</td>
</tr>
<tr>
<td>Term</td>
<td>Explanation</td>
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<td>-----------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Model for Improvement</td>
<td>The Model for Improvement is a quality improvement tool which asks three questions: 1) What are we trying to accomplish? 2) How will we know that a change is an improvement? 3) What changes can we make that will result in improvement? These three questions, coupled with the Plan, Do, Study, Act method of testing change form the Model for Improvement. Source: Associates for Process Improvement.</td>
</tr>
<tr>
<td>Monitor</td>
<td>Monitor was established in 2004 and authorises and regulates NHS Foundation Trusts. Monitor works to ensure that Foundation Trusts comply with the conditions they signed up to and that they are well led and financially robust.</td>
</tr>
<tr>
<td>Morbidity</td>
<td>Morbidity comes from the word morbid, which means “of or relating to disease”.</td>
</tr>
<tr>
<td>Mortality</td>
<td>Mortality relates to death. In health care mortality rates means death rate.</td>
</tr>
<tr>
<td>MRSA blood stream infection</td>
<td>Methicillin-resistant Staphylococcus Aureus (MRSA) is a type of blood stream infection.</td>
</tr>
<tr>
<td>Multidisciplinary</td>
<td>Consisting of members of staff from different professional groups.</td>
</tr>
<tr>
<td>Never Event</td>
<td>Never Events are patient safety incidents that are preventable and should not occur because: 1) There is guidance that explains what the care or treatment should be; 2) There is guidance to explain how risks and harm can be prevented; 3) There has been adequate notice and support to put systems in place to prevent them from happening</td>
</tr>
<tr>
<td>NHS Quest</td>
<td>NHS QUEST is a network for Foundation Trusts who wish to focus relentlessly on improving quality and safety.</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute of Clinical Excellence. An independent organisation that provides national guidance and standards on the promotion of good health and the prevention and treatment of ill health.</td>
</tr>
<tr>
<td>Non-statutory</td>
<td>Not required by law.</td>
</tr>
<tr>
<td>Nursing Assessment and Accreditation System (NAAS)</td>
<td>The Nursing Assessment and Accreditation System is quality and performance assessment framework used to monitor nursing standards throughout the organisation.</td>
</tr>
<tr>
<td>Open (flexible) visiting hours</td>
<td>Visiting hours extended beyond traditional set times to allow carer and relatives to visit patients at more convenient times.</td>
</tr>
<tr>
<td>Patient Experience Trackers</td>
<td>Hand held device that is used to record patient feedback.</td>
</tr>
<tr>
<td>Patient portals</td>
<td>Patient Portals are healthcare-related online applications that allow patients to interact and communicate with their healthcare providers.</td>
</tr>
<tr>
<td>P-D-S-A</td>
<td>Plan, Do, Study, Act. A test of change methodology within Quality Improvement which is used to try something out for a short period of time. Tests of change help us to understand whether the things that we think will make something better will work in practice.</td>
</tr>
<tr>
<td>Peritoneal dialysis</td>
<td>Peritoneal dialysis is one of the two types of dialysis (removal of waste and excess water from the blood) that is used to treat people with kidney failure. In PD, the process of dialysis takes place inside the body. The abdomen has a lining called the peritoneal membrane, which can be used as a filter to remove excess waste and water.</td>
</tr>
<tr>
<td>Peritonitis</td>
<td>Peritonitis is an inflammation of the peritoneum, the thin tissue that lines the inner wall of the abdomen and covers most of the abdominal organs.</td>
</tr>
<tr>
<td>Phosphate</td>
<td>Phosphate is a mineral in the body, and together with calcium makes up most of our bones.</td>
</tr>
<tr>
<td>Pilot ward / area</td>
<td>A ward / area involved in the initial testing period of a project.</td>
</tr>
<tr>
<td>Piloting / Piloted</td>
<td>Testing / tested.</td>
</tr>
<tr>
<td>Prescriber</td>
<td>Someone who writes prescriptions for medicines for patients.</td>
</tr>
<tr>
<td>Prescribing</td>
<td>The act of deciding which medicines a patient needs, usually by a doctor.</td>
</tr>
<tr>
<td>Prophylaxis</td>
<td>Preventative medicine or care.</td>
</tr>
<tr>
<td>Psychological safety</td>
<td>The perception of being able to speak up without fear of reprisal from others.</td>
</tr>
<tr>
<td>Pulmonary embolism (PE)</td>
<td>A blood clot which has become lodged in the lungs.</td>
</tr>
<tr>
<td>Quality Improvement</td>
<td>is a formal approach to the analysis of performance and systematic efforts to improve it; combining the efforts of healthcare professionals, patients and their families to make the changes that will lead to better patient outcomes (health), better system performance (care) and better professional development (learning)</td>
</tr>
<tr>
<td>Quality Improvement Strategy</td>
<td>A document which outlines the aims and objectives of the Trust relating to patient safety and improving quality.</td>
</tr>
<tr>
<td>Readmission</td>
<td>Where a patient is admitted to the hospital after an initial period of treatment.</td>
</tr>
<tr>
<td>Readmission - Relative Risk</td>
<td>This data focusses on the probability of a readmission occurring and how it is comparable to the national average. NHS average is an relative risk outcome of 100</td>
</tr>
<tr>
<td>Term</td>
<td>Explanation</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Readmission - PBR</td>
<td>Measures readmissions in another way, excluding certain groups of patients who are more likely to readmit due to their long-term condition e.g. cancer patients and renal dialysis patients. Financial penalties are not attributable to the Trust if these patients are readmitted to hospital. Therefore the PBR readmission rate excludes these groups of patients.</td>
</tr>
<tr>
<td>Readmission Rate</td>
<td></td>
</tr>
<tr>
<td>Relationship based care</td>
<td>A patient centred model of communication that encourages patient involvement and two-way communication.</td>
</tr>
<tr>
<td>Reliability science</td>
<td>The science relating to ensuring that all processes and procedures perform their intended function.</td>
</tr>
<tr>
<td>Root Cause Analysis (RCA)</td>
<td>A method of problem solving that tries to identify the root causes of issues and why they are happening.</td>
</tr>
<tr>
<td>Run Charts</td>
<td>Run charts are graphs used to display data for quality improvement purposes. Run charts are easier for teams to work with than control charts, although they may be less statistically sensitive. Run charts are helpful in monitoring performance and monitoring improvement work. If there is an active improvement effort going on, these tools can also be used to determine if an improvement has indeed been made.</td>
</tr>
<tr>
<td>Safety Thermometer</td>
<td>A point of care survey which is used to record the occurrence of four types of harm (pressure ulcers, falls, catheter associated urinary tract infection and venous thromboembolism).</td>
</tr>
<tr>
<td>SCAPE</td>
<td>Safe, Clean and Personal Everytime.</td>
</tr>
<tr>
<td>Scoping Phase</td>
<td>The scoping phase of a project relates to introductory work which is required in order to make the project a success in the future. This may include collection and review of data, research of best practice and world class performance, building a team to direct the project, early work with pilot teams.</td>
</tr>
<tr>
<td>Self-testing</td>
<td>Tests which patients are able to perform for themselves, for example taking blood sugar readings.</td>
</tr>
<tr>
<td>Shared decision making</td>
<td>A method of actively involving patients in decisions about their treatment.</td>
</tr>
<tr>
<td>Shear</td>
<td>Shear is a cause of pressure ulcers and is caused by bones moving against soft tissue.</td>
</tr>
<tr>
<td>SHMI</td>
<td>Standardised Hospital Mortality Index. A system which compares expected mortality of patients to actual mortality (similar to HSMR).</td>
</tr>
<tr>
<td>Specialising</td>
<td>Certain patients may require one on one nursing care within the ward setting. This may be due to the patient being at high risk of falls, due to confusion or for some other reason. When this one on one care is required it is known as specialising.</td>
</tr>
<tr>
<td>Steering Group</td>
<td>A group of people who are involved in the management of a piece of work or a project.</td>
</tr>
<tr>
<td>Step-down</td>
<td>The transition from one level of care from one ward to another ward. For example, from critical care to regular inpatient ward.</td>
</tr>
<tr>
<td>Teach-back</td>
<td>This is a technique that helps us to understand how well we have delivered important information to our patients about their condition or medications.</td>
</tr>
<tr>
<td>Telehealth</td>
<td>The delivery of health-related services and information via telecommunications technologies.</td>
</tr>
<tr>
<td>Telehealth kit</td>
<td>The equipment needed to deliver health-related services and information via telecommunications technologies.</td>
</tr>
<tr>
<td>Telemedicine</td>
<td>The application of clinical medicine where medical information is transferred through the phone or the Internet and sometimes other networks for the purpose of consulting, and sometimes remote medical procedures or examinations.</td>
</tr>
<tr>
<td>Test of Change</td>
<td>A small test used in Quality Improvement which is used to try something out for a short period of time. Tests of change help us to understand whether the things that we think will make something better will work in practice.</td>
</tr>
<tr>
<td>The Picker Institute</td>
<td>The Picker Institute is a not-for-profit organisation that works to improve patient care. The Picker Institute organise surveys throughout healthcare including the Department of Health, NHS Trusts and Boards, hospitals and voluntary organisations.</td>
</tr>
<tr>
<td>The Trust</td>
<td>Salford Royal NHS Foundation Trust. A Foundation Trust is part of the National Health Service in England and has to meet national targets and standards. NHS Foundation Trust status also gives us greater freedom from central Government control and new financial flexibility.</td>
</tr>
<tr>
<td>Thrombolysis</td>
<td>This is the breakdown of blood clots by the injection of specific medicine.</td>
</tr>
<tr>
<td>TICLE</td>
<td>Trainees Improving Care through Leadership and Education (TICLE) .</td>
</tr>
<tr>
<td>Two Week Wait</td>
<td>Two week maximum wait from urgent GP referral to first outpatient appointment for all urgent suspected cancers.</td>
</tr>
<tr>
<td>Urea reduction ratio</td>
<td>Reduction in urea (waste product in urine) as a result of dialysis.</td>
</tr>
<tr>
<td>Urinary Catheter</td>
<td>A device which is placed into a patient’s bladder for the purpose of draining urine.</td>
</tr>
<tr>
<td>Venous Thromboembolism (VTE)</td>
<td>A blood clot forming within a vein.</td>
</tr>
<tr>
<td>Vertically integrated</td>
<td>The integration of areas of work that have one common user. In the case of Salford the acute hospital and community services have been integrated in order to improve the care given to patients.</td>
</tr>
<tr>
<td>Virtual Ward</td>
<td>The Virtual Ward is similar to a ward in a hospital in that it has a structure of both clinical and administrative staff that coordinates and provides direct care to patients. The main difference is that the actual ward does not physically exist to house all the patients in one location, the care is provided in the individual patient’s own home.</td>
</tr>
</tbody>
</table>
Salford Royal NHS Foundation Trust
University Teaching Trust

Safe • Clean • Personal

Salford Royal NHS Foundation Trust
Stott Lane
Salford, M6 8HD

0161 789 7373
0161 206 4809
foundation@srft.nhs.uk
www.srft.nhs.uk
@salfordroyalnhs

Issue Number: One.
Review Date: 2016

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