Countess of Chester Hospital NHS
NHS Foundation Trust

Annual Report and Accounts

2013/2014

Countess of Chester Hospital
NHS Foundation Trust

Countess of Chester Hospital NHS Foundation Trust

Quality Account

2013/2014

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Part One

Summary Statement on Quality from the Chief Executive

The Countess of Chester Hospitals NHS Foundation Trust aims to be one of the best and safest organisations within the NHS. This means that patient safety and experience are at the very core of everything that we do. As Chief Executive I am incredibly proud of what we have achieved and we aim to do even better. I hope that you find this Quality Account useful as it describes our achievements to date and our plans for the future.

We are committed to moving from delivering 'good' experiences, to consistently delivering 'great' experiences, for all patients and their friends and families when they receive care here at the Countess. Going from 'Good to Great' is our commitment to continual year-on-year improvement.

Being 'great' is our ambition to be 10 times better. It's simply saying that if we can provide great care experiences to one person then why not for ten; if we can do it for ten, then why not a hundred; and if we can for a hundred then why not a thousand?

We are focussed on the staff experience too. Our team at the Countess is very special and is committed to providing care at its best to every patient, every time. We believe that when people enjoy their work and have pride in it, they will provide the best patient experiences. We are delighted that this year we are amongst the highest staff satisfaction scores in the NHS. Our patients also agree - with 90% of patients stating that they would recommend the Countess hospitals to their family and friends.

In December 2013 we launched our Nursing and Midwifery Strategy 2014 and beyond. The strategy is underpinned by what we believe are the 3 main principles of our patients' journey: Quality, Safety and Patient Experience. These principles are underpinned by the national nursing strategy of the 6Cs: *Care, Compassion, Competence, Communication, Courage and Commitment*.

Over the last year the NHS has not only received the Public Inquiry report into the failings in Mid Staffordshire Hospital and the government response to it, but also a succession of subsequent reports and reviews. These include Don Berwick's review into patient safety, Sir Bruce Keogh's mortality review, Ann Clwyd and Professor Tricia Hart's review into NHS complaints procedures and Camilla Cavendish's healthcare assistants review. We have reviewed each of these reports and reported findings to our Board; however, we are only just beginning to implement changes at a local level.

A consistent theme from all these review and reports relates to the need to improve organisational culture in Trusts, through greater openness, transparency and candour. Whilst we recognise that genuine culture change is a slow process and that some staff may still not feel comfortable in raising concerns, we have, with support from our staff side partners launched a process called 'Speak out Safely'.

The Speak out Safely (SOS) campaign aims to encourage NHS organisations and independent healthcare providers to develop cultures that are honest and transparent, to actively encourage staff to raise the alarm when they see poor practice, and to protect them when they do so.

The Countess has an outstanding record of success and there is much to be proud of and in 2013/14 we saw another busy year for the Trust with a period of significant improvement. Below are just some of the highlights:

- Moved our High Dependency and Critical Care Units into a brand new Intensive Care Unit with 100% single rooms.
- Advancing Quality Award – Most improved Trust over the past 5 years.
- Complete refresh of our mortality review process and reduction in both HSMR and SHMI.
- New equipment investments including a second MRI scanner.
- Review of our ward nursing numbers resulting in over £1m of new money to employ more nurses.
- Step change in our Infection Control performance with zero MRSA bacteraemia and the lowest number of Clostridium Difficile infections that the Trust has ever reported, 34 in total.
- In December 2013 we trained and signed up our 1000th Dementia Friend – this number continues to grow.
- Support to Healthwatch with their visiting programme.
- National recognition for our 'Research Matters' initiative to encourage patient involvement in research and local clinical trials.

Our Council of Governors continues to be proactive and we have a healthy Trust membership to which we continue to recruit. During the year we strengthened these links further with a newly established Governors Quality Forum. The forum provides real Governor involvement in vision and strategy development, allows open discussion and challenge and has developed and managed the 'Governor Clinical Visit' programme.


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STEP UP

Our Quality Strategy has been refreshed this year and was presented to the Board at its meeting in May 2014. We continue to deliver our services in line with our Quality Strategy and in addition to our core services; the Trust has expanded its existing portfolio of specialist services with the development of the South Mersey Arterial Surgery (SMART) Centre for Vascular patients at the Countess of Chester covering the populations of West Cheshire, Deeside, Wirral and Warrington. This also includes provision of integrated Interventional Radiology services across the three sites.

We continue to play a lead role in the development of an integrated care system that is professionally led and publicly accountable, driven by quality, partnership working and empowering for patients and staff. Our focus is on our patients - the frail elderly, those with long term conditions, those with dementia, and supporting the services to support them - out of hours, care closer to home in the community, and working with our partners as part of the Cheshire Altogether Better Programme.

The West Cheshire health economy has unified its thinking into the development of a system wide approach to improving and integrating care. Developed by senior clinicians from across the system 'The West Cheshire Way' describes the principles and approach that the health and care system is adopting to improve care for patients. It involves our Trust working closely with our partners.

In my view we have to see this time of change as an opportunity to "think differently" and to make fundamental changes to the way we organise services. If we end up in five years' time with more patients cared for at home, or near where they live; if we achieve a service where the NHS, social services, and the voluntary sector are consistently working closely with families and patients to help them remain within their communities; then we will have made lives better for thousands of people. If we provide emergency, urgent and specialist care quickly, efficiently and more safely in a smaller better organised hospital; if patient outcomes are the best possible; then we will have improved on what we are doing now.

To my knowledge I declare that the information within this document is a true and accurate reflection of the quality of care delivered the Countess of Chester Hospital NHS Foundation Trust.

Tony Chambers
Chief Executive

Statement of Directors' Responsibilities in Respect of Quality Accounts

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 data quality for the preparation of the quality account.

In preparing the quality account, Directors are required to take steps to satisfy themselves that:

- the content of the quality account meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2013/14;
- the content of the quality account is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2013 to June 2014
    - papers relating to Quality reported to the Board over the period April 2013 to June 2014
    - feedback from West Cheshire Clinical Commissioning Group (CCG) dated 12th May 2014
    - feedback from Council of Governors dated 12th May 2014
    - feedback from Healthwatch Cheshire West dated 9th May 2014
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated July 2013
    - The 2013 national patient survey received January 2014
    - The 2013 national staff survey received February 2014
    - the head of internal audit's annual opinion over the Trust's control environment dated for the period of 2013/14
    - CQC quality and risk profiles dated March 2014:
- the quality account presents a balanced picture of the NHS Foundation Trust's performance over the period covered;
- the performance information in the quality account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance in the quality account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- the quality account has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts Regulations) as well as the standards to support data quality for the preparation of the quality account.
- The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality account.
- By order of the Board

Chief Executive  ***Chairman*** 

Part Two

Priorities for improvement in 2014/15

Building on the work undertaken in the previous year the Trust has a significant number of quality and safety improvement initiatives planned for 2014-2015. These are underpinned by our new Quality Improvement Strategy which is reflected in the Trust's annual plan. The following information focuses on our key priorities for the next year.

We continue to make our choices based on a wide-ranging and rigorous review of our quality and safety performance, fully informed by feedback from patient, staff and public involvement events; information taken from our patient survey responses both nationally and locally; complaints themes: and concerns raised by Commissioners following feedback received from colleagues in Primary Care. This year we will also ensure that we reflect the common themes set out in a number of reports published in the post-Francis era:

- Review into the Quality of Care and Treatment provided by 14 Hospital Trusts in England, led by Professor Sir Bruce Keogh, the NHS Medical Director in NHS England (report published 16 July 2013)

- The Cavendish Review: An Independent Review into Healthcare Assistants and Support Workers in the NHS and Social Care Settings, by Camilla Cavendish (published 10 July 2013)

- A Promise to Learn – A Commitment to Act: Improving the Safety of Patients in England, by Professor Don Berwick (published 6 August 2013)

- A Review of the NHS Hospitals Complaints System: Putting Patients Back in the Picture by Rt Hon Ann Clwyd MP and Professor Tricia Hart (published 28 October 2013)

- Challenging Bureaucracy, led by the NHS Confederation (19 November 2013)

- The report by the Children and Young People's Health Outcomes Forum, co-chaired by Professor Ian Lewis and Christine Lenehan (October 2013).

- The Government produced an initial response in March 2013 to the Francis Inquiry and on the 19th November 2013 it published its full response to the Francis Inquiry; 'Hard Truths – the journey to putting patients first'.

Following consultation with the public the CQC has changed its inspection regime. On its inspection visits to the Trust it will look for evidence to judge services against the national standards that the public can expect when receiving health or social care. The CQC will expect the Trust to be able to demonstrate that its services and the delivery of care it provides is:

- Safe;
- Effective;
- Caring;
- Well led;
- Responsive to people's needs.

After taking into account all of the above our key priorities have been chosen to reflect the three domains of quality defined as follows:

Experience

Improving the experience as described by 'you', our patient, when using the service for any reason.

Clinical Effectiveness

Improving the outcome of any assessment, treatment and care you receive in order to optimise health and wellbeing at all stages of illness

Safety

- Improving and increasing the safety of any care or service provided

All of our aims across each of the domains of quality will be reported as follows

- To our Board of Directors through our meeting channels from ward to Board and through our monthly Quality Performance reporting arrangements
- To the Board of Governors at regular workshop events
- To our Commissioners through our joint quality and performance contract meetings

Throughout the document you may see terminology that you are not familiar with. Where possible we have tried to write clearly in a reader friendly way, however, some elements are prescribed to us by the Department of Health. To help you, we have included a glossary of terms at the back of the document in Appendix 1 (page 62).

Experience

Aim	Rationale	Monitored	Measured
To improve the patient experience by caring for a patient in their own home	Improve patient experience by expansion of Early Supported Discharge	Quality Safety and Patient Experience Committee Divisions	Number of patients maintained at home with the service
To reflect the public voice in recruitment of identified staff groups e.g. Nursing	Have Governor involvement in the recruitment process in the staffing groups identified	Human Resource and Organisational Delivery Committees	Groups of staff who have had Governor involvement at recruitment
To Increase women's choice of labour options by optimising the number of women who deliver in the midwife led birthing unit'	To improve women's choice of labour options	Quality Safety and Patient Experience Committee Divisions	Patient Satisfaction
To Improve family and patient experience by the use of bedside diaries	Patient Diary in ITU and improving relatives experience	Quality Safety and Patient Experience Committee Divisions	Family and Patient satisfaction

Effectiveness

Aim	Rationale	Monitored	Measured
To increase effectiveness of patient pathways via Ambulatory care	Ensure that the Ambulatory care pathways are effectively used to enabling optimal care for patients	Operational Delivery Committee and Quality Safety and Patient Experience Committee Divisions	The number of patients not admitted using a recognised patient pathway Patient feedback
To improve patient experience by patients no longer going 'outside' for their MRI scan	Use of new MRI Many of our patients had to go outside to have their scans on the mobile van and now have a much better experience on the new static scanner	Quality Safety and Patient Experience Committee Divisional Board	Patient satisfaction

Safety

Aim	Rationale	Monitored	Measured
To reduce time on ventilation of neonates by reducing the risk of infection due to the temperature control and safer patient care	Use of new Neonatal respirator as this now has thermal neutral environment which is crucial to maintain the temperature of the Neonate and has an integrated ventilator support if required.	Divisional Board	By the number of infections
To reduce unnecessary hospital admission in the frail elderly population	It is well evidenced that the frail elderly will often not fare as well in acute hospital settings. Investment in acute medicine & care of the elderly consultants has enabled the hospital to investigate alternative ways of working	Divisional Board Quality Safety and Patient Experience Committee	Numbers of patients discharged back to home or other setting as an alternative to home Patient satisfaction
To reduce the number of young patients who are exposed to a high dose of radiation	Examination of small bowel via MRI is to be used as a method of diagnostics as an alternative to Barium studies.	Divisional Board Quality Safety and Patient Experience Committee	Number and the dose received

While focussing on the above areas, we will also continue to:

- Maintain high standards of infection prevention and control as detailed in the Health Act 2009;
- Embed our 2013-2014 Commissioning for Quality and Innovation (CQUIN) initiatives so they become 'business as usual', and work to support the new CQUIN programme;
- Meet the requirements of our Quality Contract with our Commissioners both local and specialist ;
- Continue to develop our workforce to ensure they have the right skills and values to deliver quality care in the most effective caring way;
- Continue with our programme of development relating to new initiatives;

Capacity and Capability

The Trust has continued to develop its central Quality Team and this now focusses strongly on patient safety. Supported by the Service Improvement Team this provides a corporate approach to quality initiatives and monitors the organisation's progress. Commitment to 2014-2015 includes the continued provision of the Team with a focused approach of quality, supported by funds of £100,000 to enable ongoing quality improvement work.

Working in Partnership with our Council of Governors

Our Quality Forum for our Governors is now very well established and has been a very valuable resource. The forum has received information on a regular basis regarding the progress of the organisation as follows:

- Regular updates regarding the Quality contract and the Trust priorities
- Updates regarding the strategic direction of travel
- Information regarding serious untoward incidents and the actions for improvement
- Liaison with the CQC regarding their role
- Developed unannounced visits to wards and departments using the '15 Steps Toolkit'.

The Governors have provided valuable information back to the organisation regarding a number of issues/concerns as follows:

- Information regarding concerns raised by the membership of the FT
- General feedback from engagement events with the local public held in a range of external places to include town centres and supermarkets
- Information from their ward and department observational and interactive visits
- Internal stands within the hospital.

There has also been involvement of the local CQC Inspector as well our own clinicians in the Governors forums. The Trust hosted the North West Governors forum in November 2013. The theme was centred on patient safety and involved a number of speakers including Suzette Woodward Director of Safety, Learning and People at the NHSLA. The day was attended by over 80 people from across the region from both the Mental Health and the Acute Trust

Sector. This was an extremely successful event receiving excellent feedback from other Trust Governors. Our Governors continue to be involved in the Patient Led Assessment of the Care Environment Teams (PLACE) and are also involved in a number of forums associated with the delivery of quality care.

We will be working with our Governors to support the CQC inspection process as part of the public voice.

The Governors will continue to support the organisation by having involvement in the 2014-15 local Quality Account priorities. Our Governors will also this year become involved in staff recruitment with a particular focus on the recruitment of nurses.

Review of services

During the reporting period the Countess of Chester Hospital NHS Foundation Trust provided and contracted 49 services. These are included in our statement of purpose. The Countess of Chester Hospital NHS Foundation Trust has reviewed all the data available on the quality of care in the form of audits both local and national and there are a number of local mechanisms in place to ensure that data regarding quality of care is monitored and improved in all of our services as follows:

- Service dimensions such as population demographics, trading account position and whether or not the service is core.
- Service delivery which looks at aspects relating to meeting performance standards and targets, quality standards.
- Service design which reviews where the service is located e.g. central or community.
- Service development which explores planned changes to services over the next five years.
- Service decisions which considers, based on the above, if the Trust is best placed to deliver the service in its current form.

The income generated by the NHS services reviewed in 2013/2014 represents 93% of the total income generated from the provision of NHS services by the Countess of Chester Hospital NHS Foundation Trust for 2013-2014.

Participation in clinical research

Since the introduction of the NHS Operating Framework (2008/09) the Countess of Chester Hospital NHS Foundation Trust has greatly increased recruitment to trials. In 2008/09 recruitment stood at 178 and by 2012/13 the figure increased to 972. Our total recruitment for the period April 2013 – March 2014 was **1263**.

Considerable improvement and progress has been achieved in integrating research into clinical service in the Trust and we continually endeavour to drive this forward through highly motivated research teams, comprising both keen research clinicians and very capable research nurses.

As a result of continued successful recruitment of participants to trials the Research & Innovation Department were selected by the National Institute of Health Research (NIHR) to be the first Trust nationally to undertake a research engagement project entitled "**Research Matters**". The primary aims of the project were as follows:

- To develop and increase successful `Engagement` with all Trust stakeholders
- To promote a wider awareness of research
- To provide a platform to discuss and explore the benefits of research
- To meet a key performance indicator of the Clinical Research network (CRN) and high level objective number 1 (2012-2015) by doubling the number of participants recruited into NIHR CRN portfolio studies.

Specialties actively engaged in research trials at the Trust are:

- Critical Care
- Diabetes
- Dermatology
- Gastroenterology
- Haematology
- Oncology
- Obstetrics & Gynaecology
- Paediatrics
- Respiratory
- Rheumatology
- Stroke
- Sexual Health
- Surgical
- Renal
- Cardiology
- Vascular

Participation in clinical audits

During 2013-14, The Countess of Chester NHS Hospital Foundation Trust engaged in 32 national clinical audits including 2 National Confidential Patient Outcome and Death (NCEPOD) enquiries

There were two NCEPOD audits which were not relevant to the Trust and this equated to a participation rate of 97% in relevant national clinical audits and 100% national confidential enquiries from the Trust.

The national clinical audits and national confidential enquiries that the Countess of Chester Hospital NHS Foundation Trust was eligible to participate in and for which data collection was completed during 2013-14 are listed below, alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry:

National Audits 2012/13	Participation	Data collection completed	Rate of case ascertainment (%)
Trauma Audit and Research Network (TARN)	Yes	Rolling	63.2%
National Audit of Seizure Management (NASH 2)	Yes	Yes	100%
Head and Neck Oncology	Yes	Rolling	Below 80% (but COCH cases submitted via Aintree)
Audit of Critical Care (ICNARC)	Yes	Rolling	Not available

National Audits 2012/13	Participation	Data collection completed	Rate of case ascertainment (%)
Epilepsy in Children (Epilepsy12)	Yes	Rolling	Not available
National Diabetes Inpatient Audit & National Diabetes Audit	Yes	Yes	100%
National Elective Surgery Patient reported Outcome Measures (PROMS)	Yes	Rolling	Variable across 4 conditions
Myocardial Infarction National Audit Project (MINAP)	Yes	Rolling	Not available
National Emergency Laparotomy Audit	Yes	Ongoing Until 2015	Not available
Sentinel Stroke National Audit Project	Yes	Rolling	Less than 60%
College of Emergency Medicine: Paracetamol Overdose	Yes	Yes	Not available
College of Emergency Medicine: Severe sepsis and septic shock	Yes	Yes	Not available
College of Emergency Medicine: Moderate or severe asthma in children	Yes	Yes	Not available
Neonatal intensive and special care (NNAP)	Yes	Yes	100%
UK IBD Audit (Round 4)	Yes	Yes	Not available
National Comparative Audit of Blood Transfusion Programme	Yes	Yes	100%
Cardiac arrhythmia	Yes	Rolling	100%
National Vascular Registry	Yes	Rolling	Not available
Hip, knee and ankle replacements (National Joint Registry)	Yes	Rolling	80%
Lung cancer	Yes	Rolling	100%
Bowel cancer	Yes	Rolling	98%
Oesophago-gastric cancer	Yes	Rolling	20 - 40%
National COPD Audit	Yes	Rolling	Not available
Rheumatoid and Early Inflammatory Arthritis	Yes	Ongoing Until 2017	Not available
Falls and Fragility Fractures Audit Programme	Yes	Rolling	100%
MBRRACE	Yes	Rolling	Not available
Paediatric asthma	No	NA	NA
Heart failure audit	Yes	Rolling	82.6%
Renal registry	Yes	Rolling	Not available

National Audits 2012/13	Participation	Data collection completed	Rate of case ascertainment (%)
Child Health Reviews – epilepsy in children	Yes	Rolling	100%
National Paediatric Diabetes audit	Yes	Rolling	Not available
Paediatric bronchiectasis	No	NA	NA
Emergency Use of Oxygen	No	NA	NA

National Confidential Enquiry into Patient Outcome & Death	Participation	Data collection completed	Rate of case ascertainment (%)
Tracheostomy	Yes	Yes	70%
Lower Limb Amputations	Yes	Yes	100%

The reports of 7 National clinical audits, including one NCEPOD report were reviewed by the Trust in 2013/2014 and the Countess of Chester Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided in the following areas:

- Child Health Review
- Head and Neck Oncology
- Paediatric Diabetes
- Bowel Cancer
- Neonatal Intensive and Special Care
- National Joint Registry.

NCEPOD: Measuring the Units which is also supported by an action plan

The reports of more than 75 local clinical audits were reviewed by the Trust in 2013-14. The Trust intends to take the following actions to improve the quality of healthcare provided:

- To make the documentation of falls clinic referrals in A&E a simpler process
- Physiotherapy classes for musculoskeletal patients established to enable more 1:1 contact
- Trust's Stroke guidelines revised to provide improved information on cardiac monitoring of stroke patients
- Additional A&E consultant now on duty at weekends to help reduce weekend waiting times
- Improve signage in Eye Clinic
- Standard Operating Procedure for bladder care of gynaecological patients to be developed
- Colorectal patients admitted on day of surgery to help reduce patient length of stay and experience.

The above is not an exhaustive list of actions taken.


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Goals agreed with our commissioners via the Commissioning for Quality and Innovation framework (CQUIN)

In 2013-2014 the Trust achieved all 11 of the local CQUINs and partially achieved the national Safety Thermometer CQUIN.

As usual the CQUIN framework was agreed in partnership with the Clinical Commissioning Group and involved close working with clinicians from both primary and secondary care. This has supported the start of the integration of services to support the patient pathway.

The schemes are described below with the achievements to date.

CQUIN Title and description	Achieved Y/N partially
Ageing Well: Admission/Discharge pathway Work with community teams, primary care, local authority to monitor admissions and ensure appropriate communication	Y
Advanced Community Respiratory Service To provide a community based advanced care service for COPD	Y
Long Term Conditions Work with external partners to develop and deliver patient education programmes for people with a long term condition	Y
Colorectal Cancer To improve the discharge and planning and follow up of cancer patients after the acute treatment phase	Y
Cancer: Waiting Times Cancer waiting times standard – Cheshire & Merseyside Model	Y
Real Time Patient Experience Inpatients given opportunity to provide real time feedback on their satisfaction with care provision	Y
Out Patient Shared Decision Making Enhancing the use of decision making tools to enable shared decision making and a philosophy of shared informed care in outpatient settings	Y
Mental Health in Acute Setting Work with Cheshire & Wirral Partnership to develop multi-disciplinary pathways of care within the hospital setting to support patients' mental health needs.	Y
Discharge Care Bundle for Heart Disease Use of a care bundle at the point of discharge for patients with heart disease to promote self- care opportunities and supportive discharge	Y
Normalising Birth Develop and implement a midwifery led care pathway that reaches out into the community. Pathway will have an element of triage to manage women's concerns/need for information	Y
Transition children's to Adult services Transition from children's to adult services: Timely planning and intervention	Y

We were pleased to achieve the National Venous Thromboembolism assessment CQUIN, Dementia CQUIN and the Friends and Family CQUIN but were disappointed to have only partially achieved the Safety Thermometer CQUIN. Work will continue in the coming year to continuously improve the position.

2% of the Countess of Chester Hospital NHS Foundation Trust income in 2013/2014 is conditional on achieving quality improvement and innovation goals agreed between Countess of Chester Hospital NHS Foundation Trust and West Cheshire Clinical Commissioning Group (CCG) through the Commissioning for Quality and Innovation (CQUIN) payment framework. In monetary terms, this equates to £3,050,725.

Further details of the agreed goals for 2013/2014 and for the following 12 month period are available on request from foundation.trustenquiries@nhs.net

Care Quality Commission Registration (CQC)

The Countess of Chester Hospital NHS Foundation Trust is required to register with the Care Quality Commission and its current status is 'registered' with no conditions attached to registration.

In year the CQC have changed the way it measures its Quality Risk Profile (QRP) of Acute Hospitals to a different model called 'Intelligent Monitoring'. The model measures a number of different indicators that give an overall band. The Bands are 1-6 and the Trust was placed in Band 5 in March 2014 achieving high compliance.

The organisation has taken part in a whole health economy review of its safeguarding children's service. The organisation received positive feedback on the day and is involved in implementing actions as part of a whole health economy action plan with other health and social care partners.

The Care Quality Commission has not taken enforcement action against the Countess of Chester NHS Hospital Foundation Trust during 2013-2014. 2 minor areas of non-compliance following an inspection at the Ellesmere Port rehabilitation Site in 2012 -2013 were subject to a further inspection and found to be compliant.

The Countess of Chester NHS Hospital Foundation Trust was not required to participate in any special reviews by the Care Quality Commission in 2013-2014.

Data Quality

NHS and General Medical Practice Code validity:

The Countess of Chester Hospital NHS Foundation Trust submitted records during 2013/2014 to the Secondary Users 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
- 99.0% for accident and emergency care

And which included the patient's valid General Practitioner Registration code was:

- 99.9% for admitted patient care
- 100% for outpatient care
- 99.9% for accident and emergency care

Based on SUS Data Quality dashboard (month 9).

Data Quality Assurance

Information Governance Toolkit Attainment levels:

Information governance and information risks are managed and controlled via the Information Governance toolkit submissions. The Trust's Information Governance assessment report overall score for 2013/14 was 65% and graded 'unsatisfactory'. This is disappointing, however throughout 2013/14 we have continued to develop and strengthen the Information Governance reporting structure and culture within the Trust, with the implementation of a more robust framework and appointment to key governance roles including most recently the Trust's Senior Information Risk Owner (SIRO) who is the Director of Nursing and Quality.

Together the Trust's SIRO and Caldicott Guardian (the Medical Director) supported by the Information Governance and Calidcott Panels, oversee the compliance with and progress against the toolkit and Information Governance agenda.

An Information Governance Manager is in post to support the SIRO, and in 2014/15 the Trust will be undertaking a risk based approach to the toolkit requirements and implementing appropriate action plans to ensure improvement of currently unsatisfactory areas with a priority focus to improve the Trust's current information asset register and associated framework.

Clinical Coding Error Rate

In 2013/14 the Countess of Chester Hospital NHS Foundation Trust took the following actions to improve data quality:

- External audit undertaken and an action plan developed which is being monitored by the Data Quality Management Group, Informatics Board and Operational Delivery Committee.
- An in-depth training programme has been delivered to administrative and clerical staff who are involved in the operational management of patients waiting to be seen.

The Trust's most recent external review of clinical coding covered 205 finished consultant episodes. The audit found coding accuracy of over 90% for both the primary diagnoses and primary procedures. This level of accuracy means that the Trust has achieved level 3 (the highest) in the Information Governance toolkit score for clinical coding. The overall finding of the report was one of "significant assurance". The audit was limited to the number above and that the results should not be extrapolated further than the actual sample audited. It was performed on a randomized sample across specialties.

The Countess of Chester Hospital NHS Foundation Trust will be taking the following actions to improve data quality for 2014/15:

- Annual refresher training
- Continue to deliver and monitor and will take remedial action as required any issues in the Operational Data Quality Group – utilising the information from its own dashboard as well as external reviews and recommendations
- Develop a training plan for other clinicians within the Trust to be delivered during 2014/15.
- include data quality refresher training for other staff groups.

New Mandated Indicators

The Countess of Chester Hospital NHS FT was already reporting on the majority of these. For ease of the reader the table below lists the indicators and some results or the page on which the report can be found.

Subject	Indicator	Page Number
Mortality	Summary Hospital level mortality indicator (SHMI) and the % of patient deaths with a palliative care coded at diagnosis or speciality level	51
Care of patients with a suspected ST Elevation Acute Myocardial Infarction	These patients receive care at the regional centre at Liverpool Heart and Chest Other Heart attack pathway data	57
Care of patients with a suspected stroke	% of patients with appropriate care received	57
Patient reported outcome measures (PROMs) following - • Groin Hernia • Varicose Vein surgery • Hip and Knee replacement	Trust data regarding PROMs	57
Readmission to hospital within 28 days of discharge	Patients aged 0-14 years Patients aged 15 years and over	55
Staff survey	% of staff who would recommend the organisation as a place of work or to receive treatment	55
Venous Thromboembolism Assessment	% of patients who received a risk assessment	54
Clostridium Difficile	Rate per 100,000 bed days amongst patients aged 2 or over	54
Patient safety Incidents	Number reported per 100 admissions that caused severe harm or death	54

Written statement from our Commissioner: West Cheshire CCG

We are committed to commissioning high quality services from our providers and we make it clear in our contract with this Trust the standards of care that we expect them to deliver. We manage their performance through progress reports that demonstrate levels of compliance or areas of concern. It is through these arrangements that the accuracy of this Quality Account has been validated.

We commend the Trust for its focus on hearing the patients' voice and using bed-side technology to capture real time patient experience. There is evidence that insight from patient feedback has led to improvements in care. We understand that this is an area of sustained effort as the Trust responds to national requirements to show openness and transparency in improving standards of care.

The Trust has performed well against the majority of the goals in the Commissioning for Quality and Innovation Schemes. We note the increased number of pressure ulcers reported and support the Trust in acknowledging that this is due to improvements in how these are reported publically. We expect this number will decrease in the year ahead as a number of your priorities for delivery in 2014-15 impact on direct care. We are particularly keen to see the impact of workforce plans for ward managers to become supernumerary and remedial actions to address staffing pressures reported in areas such as the emergency department at busy times. We anticipate that these changes should result in an improvement on the current 80% of staff who reported in the national staff survey that they were satisfied with the quality of their work and the patient care they were able to deliver.

We note there is no reference to the findings from the service review processes that you have been undertaking. These in-depth reviews will have identified areas for improvement and we would have welcomed seeing some of these reflected in your priorities for the forthcoming year. We have shared with you a number of concerns reported by GPs about the effectiveness of processes used to track patients through hospital systems and you committed to resolving this. We expect to see the changes you have put in place deliver on-going improvements. Lack of timely outpatient information to GPs about their patients has been a challenge for some specialities and we acknowledge the effort you are directing towards remedying this.

We are pleased to see the improvements in year in your performance levels to deliver national and regional targets in stroke care but recognise that your integrated team has more work to do. We acknowledge the hard work of the Trust in its "zero tolerance" approach to healthcare associated infections and support the Trusts determination to maintain robust infection prevention and control practices. Failure to comply with this good practice should not go unchallenged. We note the progress in implementing a systematic approach to reviewing all in hospital deaths and support the Trust's view of the need to make progress in expanding end of life choices outside of hospital. We expect to see the variation between overall mortality ratios and weekend mortality ratios decrease as your plans for 7 day working expand at pace over the forthcoming 12 months.

We support the priorities that the Trust has identified for the forthcoming year and look forward to continuing to work in partnership with the Trust to assure the quality of services commissioned in 2014-15.

Part Three

How we have delivered our priorities in 2013/14

During this time we have worked to improve a number of measures across the three domains of quality.

These were chosen with the following considerations:

- Our patient and public feedback from engagement events held by our Board of Governors.
- Views of Commissioners and their stakeholders from various methods of feedback and our jointly agreed quality priorities
- Results of our inpatient survey data taken on a month by month basis and from the annual inpatient survey.

To improve the patient experience via Council of Governors engagement events with the membership and wider public regarding care delivery and service at the Trust with a particular focus on communication and information. To gain some real time experience data from patients on a cancer pathway

The Communication and Membership sub-group has met with Trust staff every 6-8 weeks throughout the year to discuss priorities and plan events which were then taken back to the Governors for their approval.

Items which have regularly been on the agenda are as follows:

- Countess Matters - This is the Governors principle tool for communication with the membership. By referral to past editions, effectiveness of this effort can be judged.

- Membership Form Changes - The form has been reviewed and changed. Although the changes are positive further work is needed.

- Membership now has an "on the corridor" approach. In the early days of the Trust, we had high levels of hospital acquired infections and other challenges. Being "on the corridor" was not a good place to be! Today it has all changed. The public love their hospital and are appreciative and supportive of it.

In addition to recruiting members, our Governors also ask the public they meet to fill in Quality Survey Forms.

If on occasion they pick up on a problem, it is dealt with immediately. The Governors support learning from these problems and take them back to the Board where changes can be made to improve the patient experience.

A good example of this is the provision of fixed "Rest Seating", placed at intervals along both corridors. While recruiting in the corridor, it was noticed the difficulties many patients experienced with the distance to walk to different departments and the "Rest Spots" are now well used and appreciated.

Road Shows - In the last 12 months Governors have continued to plan and attend Road Shows – six events this year to date. These have been held in each area of the hospital's catchment area. Our venues have been in a number of places for example:

- Supermarkets
- Car Boot events
- Churches
- Hospital Reception

At these Road Shows, the Governors recruit Trust members but more importantly, they ask about hospital experiences and whether they would recommend the Trust to Family and Friends. On occasion, they do come across someone who has had a not so good experience and this gives them the opportunity to get details and hopefully redress the balance. It also gives the Trust a learning opportunity to make sure that "the problem" doesn't happen again.

We have been delighted to have one or two Non-Executive Directors join us at the Road Shows recently.

Governor Drop In Sessions - When recruiting members we talk about the opportunity for involvement in the Trust and for election to Governorship of the Trust. Prior to the Governor Elections in 2013, we held a drop in for all members interested in standing for election. Several Governors met with these interested members in June 2013 and talked to them about "Our Job" and what is involved. It was a successful meeting and all interested parties were supplied with the necessary Election Pack.

Governor Stand at the AGM - There was Governor representation amongst the stands at the AGM to enable the public present to find out more about involvement in the Trust as a Member and Governor.

Other Governor Involvement - Certain Governors have also been involved in the following:

- 2014 Equality Delivery System Assessment.
- Patient Led Assessment of the Care Environment process - Ellesmere Port Hospital/ COCH
- Disability Equality Group
- Diversity Equality Group
- Equality Local Champions Forum
- Culture, Faith & Belief Equality Group
- Age, Equality & Adult Safeguarding sub-group.

Governors Quality Forum Meeting - These meetings are held every 3 weeks when information is exchanged between Governors and Board Members. Governors have the opportunity to ask questions about information received and also pass on concerns that they have picked up on in their contact with patients and the general public.

Ward and Department Visits - These have been ongoing throughout the year. These have proved most useful and link in with our Quality Forum Meetings. Feedback is given to staff using the 15 Steps Toolkit.

To assess the outcomes for patients from the introduction of care and comfort workers in the Planned Care Division

The introduction of the care and comfort assistant role is enhancing the delivery of individualised, compassionate care in a culture that promotes well-being and comfort. It has revealed practice and behaviours characterized by: engagement, holism, listening, presence, kindness, patience, evidence, respect, energy, empowerment, professionalism and collaboration.

Not only has the role been embraced by patients on the three pilot wards but crucially it has received the endorsement of registered and non-registered nursing staff. Evaluation of this aspect of the audit revealed that although initially staff were dubious of the role they have come to appreciate the important contribution it makes to the delivery of high quality care.

Patients have said *"The two lady Care and Comfort assistants were excellent" and "the care and comfort assistants are a brilliant idea especially for patients who do not have family or friends living close by".*

One of the assistants said "I value the contact with patients and seeing the small but important difference that this new role can make to them is highly rewarding. In my experience all the staff on the ward demonstrates, to a high degree, the value of applying the 6Cs and I feel that the overall patient care experience has benefitted by the addition of our role." A full evaluation of the pilot will be completed by the end of June 2014. The results of this will then be planned into the ongoing staffing reviews at ward level.

Make key improvements to the environment for patients with dementia

Environment

Following an audit of our ward environments using the Kings Fund's 'Enhancing the Healing Environment' audit tool and visits to other hospitals, progress has been made to make wards at the Countess dementia-friendly.

Changes to the colour scheme, signage and lighting on ward 34 and ward 43 as a result of the audit have informed how wards will be redecorated in the future and have now been incorporated into a rolling programme, including:

- Standardised bathroom signage
- Use of evidence based 'colour blocking' on identified wards
- Enhanced colour co-ordinated rooms on wards
- Installation of colour co-ordinated handrails
- Installation of dementia friendly time and date clocks
- Colour co-ordinated toilet seats.

It has now been agreed that any ward upgrades will incorporate the changes that will lead to an overall dementia friendly environment.

To provide additional assurance to the Board of Directors that clinical care meets the required CQC standards of Quality and Safety

A new Board Assurance Framework was developed during 2013/14. This framework details our strategic objectives outlining the key risks to achieving those objectives. The controls and assurances in respect of strategic risks are reviewed by the Board of Directors on a quarterly basis. In respect of CQC compliance, the Board Assurance Framework details a number of actions to mitigate the risks of non-compliance.

To optimise the health outcomes of patients who have suffered a stroke

During the previous year we have merged the acute and rehabilitation stroke units. The combined Stroke Unit is now on a single site at the Countess of Chester Hospital and treats patients through their whole inpatient stay.

Combining the units has had a number of benefits for patients and recovery outcomes:

- All patients are reviewed by a stroke specialist medical consultant daily
- There is no transfer to a different ward, meaning that patients can build up a longer lasting rapport with all staff on the unit
- Patients do not need to travel back to the acute site if they become unwell or need further investigations
- We can concentrate nursing and therapy stroke specialist expertise on one ward
- We can offer more therapy to patients
- We are able to work with the Stroke Association more effectively supporting patients and families post stroke.

We have been able to develop the Stroke Early Supported Discharge Team allowing patients to be discharged from hospital earlier, but still receive the rehabilitation they need in their own homes.

The introduction of the 7 day working in MRI has enabled the Trust to have faster turnaround at the weekend. It supports the 7 day working concept of safer patient care

This has been successfully introduced and has enabled the Trust to support the access to services 7 days a week. MRI scans are now available if clinically required the 7 days this enables inpatients to be scanned in a timely manner and will enable clinicians to make earlier decisions on patient management.

The initiative started with 3 hour radiologist reporting sessions on Saturday and Sunday and this has now been extended to 5 hour sessions. The data below shows this year there has been a 60% increase in the number of MRI scans performed and reported over the weekend compared to 2012/13.

A similar impact has been shown for CT examinations. The 7 day working service means in-patients now have full access to radiology every day which now includes reporting. The impact for Radiology is that all patients receive a faster service and have benefitted from this initiative, and the beginning of the week doesn't start with a backlog from the weekend. Therefore all patients have benefited from this initiative.

To provide alternatives to in-patient admission for paediatrics through clinical streaming in A&E and utilisation of paediatric hospital at home

Children's Hospital at Home (H@H) was launched to provide ongoing nursing care for children with acute and chronic conditions within the confines of their own home. This concept had been a vision of the children's team for over 15 years and eventually it has now become a reality.


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ALERT
Fluid Flow to Patient

The main objectives of Children's Hospital at Home are:

- to reduce the length of stay for children in hospital
- prevent inappropriate admission of those children whose care following assessment could be safely provided at home without the need for admission.

Benefits from this service include the in-patient capacity less pressured within paediatrics. Some of these visits would have been to the child's nursery, school or homes depending on the need of the individual child and their condition.

The Team has encouraged families to maintain their normal lifestyle and if children are well enough to still attend school with Educations agreement, for care and interventions such as Intra-Venous Antibiotics to be given at school. This has been very well accepted by our local education partners and when carried out at break times has not caused any disruption to the classroom situation.

Each family have been asked to complete satisfaction questionnaires and the feedback has been very positive from both children and their families with quotes such as:

'Much better approach than prolonged stays in hospital'
'Having support at home has been invaluable'
'Very pleased with such high levels of care'
'Very professional, helpful and understanding'
'Brilliant new initiative'
'Much happier to be treated in her own home'

The service is now set to go into its next phase.

To carry out a full and concise review of all aspects of falls management and make a targeted reduction in the numbers and level of harm across the 5 highest falls areas identified

During 2013-14, patient slips, trips and falls incidents continued to dominate the clinical incident reports for adult wards. For the period 01/04/13 to 31/03/14, there were 1202 falls incidents reported with the 5 highest falls areas accounting for 35% of these (423 incidents).

The highest reporting areas were primarily wards with an Elderly Medicine or Rehabilitative patient group. This is perhaps understandable due to the clinical complexities of these patients, and higher incidence of temporary and permanent cognitive impairment which contributes to an increased risk of patient falls.

During 2013-14, a member of the Risk & Patient Safety Team has led the daily review of all patient slips, trips and falls incidents. Grass roots education has been supplemented by changes within the Trust's computerised care plans falls assessment screens to encourage

nursing staff to think more widely about the use of falls prevention measures and fit them to the individual needs of patients at risk. In particular, and learning from previous incidents, the Trust policy and practice has reiterated the need for caution where patients are at increased risk due to the use of long-term Warfarin therapy. The use of the Safety Cross (which is a visual display) and Safety Briefings at ward level continues to highlight when incidents have occurred and enables local review by the nursing team.

Ward	2012-13 Data	2013-14 Data	% Change in year
Ward 34/Priory	97	128	+32%
Ward 33/Trinity	89	96	+8%
Emerald Ward	81	50	-38%
Ward 48/Northgate	79	40	*
Ruby Ward	77	58	-25%

*2013-14 data for Ward 48/Northgate is based upon 5 months as ward closed August 2013

Although not all the wards identified have seen a reduction of falls, the Trust as whole has seen a reduction by 10% year to date.

Further Plans 2014-15

The Trust policy has been reviewed and the process for risk assessment simplified. Once approved via consultation, this will be disseminated alongside an awareness programme and competency framework specifically around identifying risk and selection of appropriate falls prevention measures. Focus will continue within the higher risk areas identified which remains Elderly Medicine or Rehabilitative environments.

Self-administration of medicine for suitable patients on a rehabilitation pathway

As the principle underpinning self-administration on Sapphire Ward was to help prepare patients to manage their own medications safely on discharge, the process was amended and embedded within each patient's rehabilitation assessments. This increased the numbers of patients participating in self-administration of medicines, although it is noted that a number of patients who met the criteria have declined to participate.

19% of patients assessed met the criteria for self-administration of medicines. The criteria are strict and ensure that only patients who physically dispense their own medications each time are included. This excludes patients from care settings where a carer undertakes this, or where 'blister packs' are in use.

Patients are also excluded if their level of manual dexterity is limited (such as restricted due to recent surgery) or if there is cognitive impairment (permanent or temporary) – although staff will reassess the patient during their hospital stay to determine if the patient has become suitable for self-administration of medicines.

14% of patients assessed have participated in self-administration of medicines. For these patients, it has been a positive experience and the general feedback is that it develops patient confidence prior to discharge – often these patients have been in hospital (both acute and rehabilitative) for several weeks and they express anxiety about coping on discharge. By participating in self-administration of medicines, the patients become familiar once more with the medication regimes and take some control back over their care which helps prepare them for home.

It is expected that the multidisciplinary teams on the 4 wards at Ellesmere Port Hospital will continue to assess patients for self-administration of medicines. During 2014-15, it is planned to roll-out further to several acute wards at the Trust – primarily Elderly Medicine wards (Wards 34 and 43) and to elective Surgical wards (Wards 52 and 53).

Maternity Assessment processes

During the period April 2013 to February 2014 we are pleased to be able to report that there have been no serious incidents relating to the Assessment area in Labour Ward.

We believe that the actions taken to reduce incidents within this area of Midwifery practice during April-August 2013 have been effective, with the following actions being undertaken:

- Reviewing and agreeing the guidance for staff about the assessment SOP handover of patient by reception staff produced & implemented
- Clarity of the shift leader role
- Installation of a visible system which displays all relevant information for staff to use
- Shift leader/staff handover reviewed
- Maternity Appendix to Trust Bed Management Policy updated
- Review and changes to the Telephone Assessment form
- Meetings with Shift leaders to discuss issues/horizon scan/plan for changes/ensure shift leaders able to lead effectively
- The allocation for approximately 80% of shifts of a senior and experienced midwife to run and coordinate the assessment area.
- Record keeping audit
- Relocation of women being admitted for induction to a maternity ward
- All of the above communicated with all staff to ensure compliance.

A number of additional actions taken to support the reduction of incidents within the area of Midwifery practice during August 2013-February 2014 were:-

- External review of Maternity Services commissioned by Director of Nursing & Quality which demonstrated no significant safety concerns, however a number of recommendations were identified regarding culture and team work, service improvement, workforce and education. In respect of these, a detailed action plan has been developed and is monitored via the Quality, Safety & Patient Experience Committee.

- Actions as part of the Maternity Network 'New Beginnings' being operationalised i.e. change to guidelines reducing numbers for Induction of Labour (IOL) thus improving capacity related issues.
- Phase one of Birthing Unit operationalised
- Ongoing monthly audit of Maternity health records against recognised national standards 2013/14
- Communication to staff
- Service user engagement feedback events coordinated by Supervisors of Midwives & CCG patient Engagement Lead.

On-going work February 2014 onwards:

- Phase two – completion of a two room Midwifery Led Birthing Unit.
- Phase three - increase in bed capacity within Obstetric day unit to facilitate movement of non-labouring women from Labour ward in conjunction with staffing review.
- Staffing review using recommendations from external review to address shortfall identified.
- Communication to staff via email & Safety Brief re above planned actions.

Quality improvement initiatives in 2013/14

Infection Prevention and Control

Description of the issues and rationale for prioritising:

Infection prevention and control remains a constant challenge within healthcare provision and ensuring that we have robust systems and processes embedded within the organisation is an essential part of delivering safe, high quality care. The Chief Medical Officer has highlighted that antimicrobial resistance is a real threat, with an even greater focus on infection prevention as resistance to the drugs that we use to treat infections increases, rendering them ineffective. The development of new antimicrobials has also dramatically slowed down, so we need to ensure prudent use of the drugs available to us.

The Trust plans to maintain the intensity of both infection prevention and control and antimicrobial stewardship at all levels of the organisation, sustaining our 'zero tolerance' approach to preventable infection. The focus will remain on risk reduction strategies, with the routine implementation of effective infection prevention and control measures within daily practice being essential to achieving this aim.

To ensure that high quality care is delivered in a safe and appropriate environment, it is essential that risk reduction strategies include robust systems to monitor and evaluate the systems and processes aimed at reducing risks associated with healthcare associated infection. These must also include strategies to disseminate any lessons learned in real time, plus those changes to existing practice that are identified as a result.

Aim:

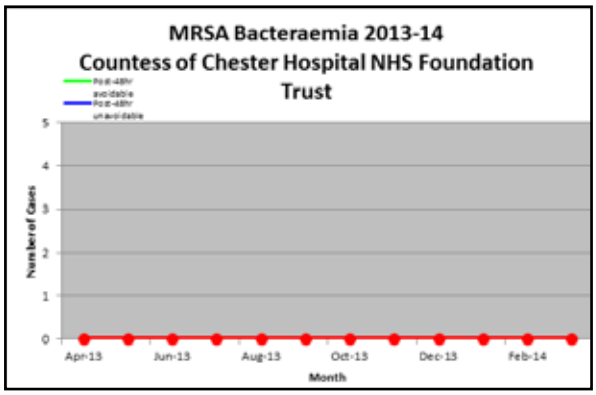
- To have zero preventable MRSA bacteraemia cases within year
- To have 30 or less cases of Clostridium difficile infection within year
- To consistently maintain 95% compliance or above with hand hygiene practices
- To consistently achieve 95% compliance or above with MRSA screening requirements for emergency and elective admissions
- To progress with antimicrobial stewardship strategies, ensuring prudent use of all antimicrobials
- To maintain local surveillance systems, including those for antimicrobial resistant organisms, and maintain all mandatory surveillance requirements as part of national surveillance programmes

2013-14 Results:

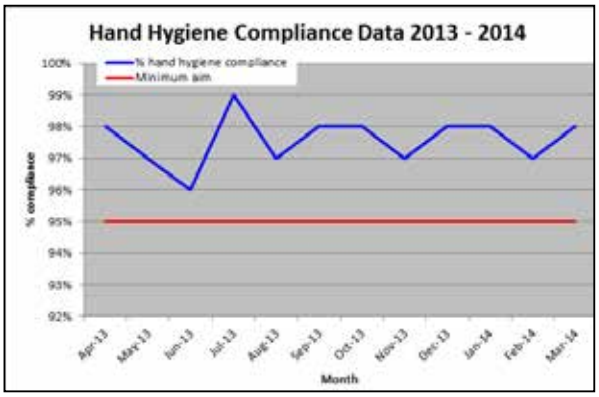
- Success in achieving the MRSA bacteraemia objective - set at zero preventable MRSA bacteraemia within year. Zero Trust apportioned MRSA bacteraemia reported within year.
- Success in achieving the Clostridium difficile infection objective - set at no more than 36 cases within year. 34 cases of Clostridium difficile infection reported within year.
- Success in maintaining hand hygiene compliance above the 95% minimum compliance level throughout 2013-14.
- Success in maintaining an 'unconditional' registration status with the Care Quality Commission.

- Improved compliance with MRSA screening requirements for emergency and elective admissions during 2013-14.

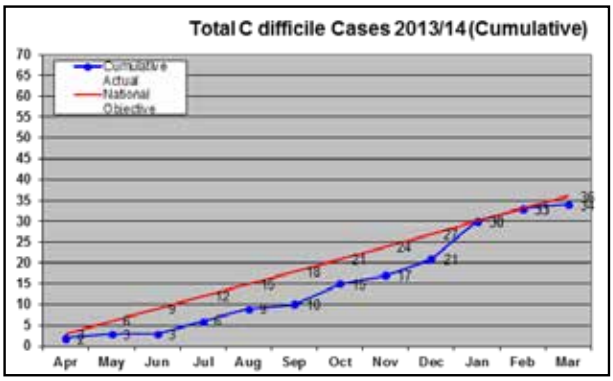
- **MRSA Bacteraemia**

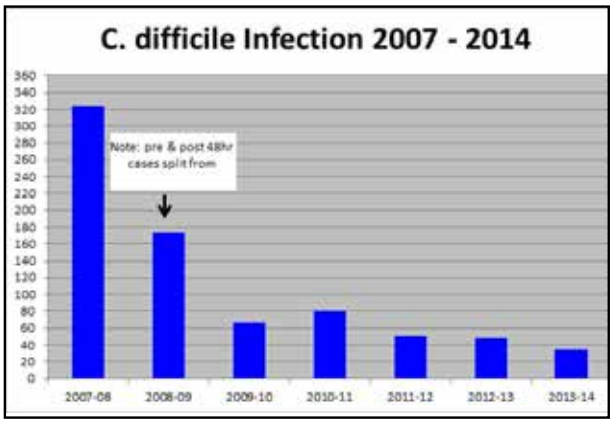


- **Hand Hygiene Compliance**



- **Closrtidium difficile infection**





The C-Diff per 100,000 bed days rate is 15.1 for Apr 13 to Mar 14. This compares favourably to the national rate of 17.3

Planned Focus for 2014-2015:
To maintain, regularly review and further develop as necessary:

- The corporate infection prevention and control assurance framework, ensuring that this continues to support all infection prevention and control related activity.

- Systems of 'alert organism' review to ensure that colonised individuals or those with associated infection are managed promptly and appropriately, both to their benefit and the benefit of the wider population; ensuring that relevant information about healthcare associated infection is communicated promptly to other healthcare providers.

- Systems for promoting best practice to reduce the number of Clostridium difficile and MRSA bacteraemia infections via learning from root cause analysis and national evidence base, regularly reviewing any associated improvement strategies.

- Antibiotic stewardship across the organisation, promoting prudent use of all antimicrobials.

- Cleanliness, both within the environment and for equipment, ensuring compliance with national cleaning frequencies, whilst ensuring that the environment remains fit for purpose.

- Infection prevention and control audit (including hand hygiene) and surveillance programmes (including surgical site infection surveillance), adding to these as the need is identified and ensuring compliance with national mandatory surveillance programmes and data reporting.

- Systems to utilise local surveillance data, promptly identifying outbreaks or periods of increased healthcare associated infection incidence, including but not exclusive of C. difficile plus antimicrobial resistant organisms i.e. Vancomycin Resistant Enterococcus (VRE), carbapenemase-producing Enterobacteriaceae (CPE), extended-spectrum beta-lactamase producing organisms (ESBL).

- Training and education programmes for all staff groups, consistently re-enforcing the routine implementation of infection prevention and control standards and antimicrobial stewardship for all patients, all of the time.

- Systems of information dissemination to ensure that the workforce remains informed and engaged on performance against agreed aims for healthcare associated infection reduction, adapting these as circumstances dictate.

- Processes to identify and assess new developments in infection prevention and control (regionally, nationally or internationally) to inform and improve on practice.

- Systems for policy development and review in conjunction with new or emerging evidence-base.

- Systems for ensuring that healthcare workers are adequately protected from infection risks within the workplace and do not as individuals pose an infection risk to others.

- The provision of healthcare associated infection information for patients, visitors and other healthcare providers to minimise risks associated with the transmission of infection.

Risk Management

National Reporting & Learning System (NRLS)

In line with national recommendations the Trust has continued to report all its clinical incidents to the National Patient Safety Agency (NPSA) – National Reporting & Learning System (NRLS). The Trust is measured against other similar medium acute Trusts regionally.

Previously the Trust had fluctuated between the highest 25% reporters to the middle 50% reported, however the last published NPSA data covered the period October 2012 to March 2013 and the Trust was illustrated as having fallen into the lower 25% of reporters. This position has been reviewed internally and while the number of incidents reported to NRLS by the Trust has decreased, the number of incidents reported within the Trust remained similar to previous reporting periods suggesting a process issue regarding exporting the data to the NPSA. This internal process has been improved and we expect to see a significant improvement in the Trust's position in the next NPSA data report which is expected to be released in April 2014.

In year the process of Serious Incident (SI) management has changed within the Trust. The introduction of a weekly SI panel chaired by the Medical Director or the Director of Nursing and Quality has enabled the full triangulation of incidents from a clinical and legal perspective. This has ensured full objectivity and that the duty of candour is followed at a really early stage. Divisional input has often been required and this now ensures that full engagement is happening at all levels.

During the period 1/4/2013 to 11/3/2014 the Trust has reported 41 incidents on the Department of Health electronic Strategic Executive Information System (StEIS) for serious untoward incident reporting. These are listed in the table below:

Category	Sub Category	Total
Pressure ulcers	Pressure ulcers Grade 3	20
	Pressure ulcers Grade 4	5
Subtotal		25
Information Governance	Confidential Information Loss	1
Sub Total		1
Infection Control	C.diff & Healthcare Acquired Infections	3
	Ward Closure	1
Sub Total		4
Level 2 Incidents	Drug Incident	2
	Unexpected admission to NICU (neonatal intensive care unit)	1
	Delayed diagnosis	3
	Other	2
	Sub-optimal care of the deteriorating patient	1
	Unexpected Death (general)	2
Sub Total		11
Total		41

When compared to the incident data reported on StEIS in 2012/13 the following conclusions can be reached:

- There is an increase in the number of pressure ulcers reported on StEIS (10 reported in 2012/13); however the process for identifying pressure ulcer incidents which require reporting has been improved within the Trust during this time period.
- The number of infection control incidents reported shows a significant decrease from 17 in 2012/13 to 4 in 2013/14.
- There have been no 'Never Events' reported during this time period (3 were reported in 2012/13).

All of the incidents reported are monitored throughout the process from the initial report, through to the completion of the investigation report and on to the completion of the action plan by the Clinical Commissioning Group (CCG) and the relevant Trust committees which include the Quality, Safety and Patient Experience Committee and the appropriate Divisional Governance Forums. In addition, lessons learned are shared when appropriate with nursing teams at the monthly Ward Managers meeting and through Safety Briefings. Medical staff have shared lessons learned by presenting findings of appropriate incident reviews during educational sessions such as the rolling half day programmes and during mortality meetings.

Safer Nurse Staffing

During 2013/14 a detailed review was undertaken across all ward areas to establish the baseline staffing levels. It was identified that there were some deficiencies which in some areas required immediate action, other actions have taken place in a phased approach. It is positive to note that nearly £1 million pounds has been invested in the nursing workforce to ensure we have the right resources to deliver the high standards of care to our patients. We have reviewed the need to have our ward managers supervisory and from April 2014 we will progress this in addition to supporting other staffing in clinical areas such as the Emergency Department and Intensive Care. In addition we will ensure we deliver the requirements of the National Quality Board paper 'Ensuring that we have the right people, with the right skills, in the right place, at the right time: Nursing, Midwifery & Care Staffing' in articulating our staffing levels to Board members and the public.

Safeguarding

Children

In the last year to date our Safeguarding Children/Domestic Abuse Team have received and dealt with over 600 safeguarding children written notifications from our staff with over 200 referrals in relation to safeguarding children issues being referred to children's social care.

We have continued to work in partnership our Local Safeguarding Children's Board and at the newly formed Child Sexual Exploitation (CSE) operational group. Internally we have worked hard to maintain a high quality of safeguarding children's training for staff and we update these sessions every year to ensure staff are getting the very latest information.

We have undergone our CQC Safeguarding Children's Inspection with an excellent outcome. Patients and families spoken to by the CQC rated the support provided by the paediatric staff at the Countess of Chester Hospital as excellent. Praising the work of the clinical assessment unit at the Countess of Chester Hospital one said "We were there for 5 hours and were really well looked after. The baby was examined thoroughly on 3 occasions during this period, and they even brought me tea and a sandwich."

There are as always areas to address and improve but overall the inspection was very reassuring. In a separate piece of work we have secured a 12 month secondment into the team of an Independent Domestic Violence Advocate (IDVA) from Cheshire West and Chester Council. We believe this is a fantastic opportunity to improve the good practices we already have in place surrounding domestic abuse and we are already seeing the huge benefits of this secondment for our patients and staff alike.

Adults

In October 2013 the Trust recruited to the new post of Adult Safeguarding and Learning Disability Coordinator leading to a review of the Trust's position in relation to meeting Adult Safeguarding requirements. This review was captured in a Safeguarding Adult Strategy that identified the key actions outstanding in a three year action plan. This action plan is intended to develop as the Trust explores its approach to safeguarding over the next three

years with an intended wide scale review in 2016 to identify overall progress and next steps. To date the following actions have been addressed in line with the action plan:

- Development and Implementation of a PREVENT Policy
- Implementation of a PREVENT Training strategy
- Revision of Adult Safeguarding Policy and associated Operating Procedures
- Development of an electronic based referral for Safeguarding forms, including Deprivation of Liberty, Mental Capacity Act and Best Interest Process, IMCA referral and Adult Safeguarding referral forms
- Development of a Training Competency Framework for Adult Safeguarding
- Development of an Adult Safeguarding Training Strategy
- Revision of existing Adult safeguarding training packages to meet the new competency framework
- Piloting of the revised training packages
- Introduction of Adult safeguarding noticeboards throughout the Trust
- Introduction of a revised Learning Disability Health Passport
- Consultation with patients with Learning Disabilities and their carers to identify actions required to improve our response to a vulnerable patient group
- Development of a draft Learning Disability action plan
- Development of an annual audit plan to monitor and scrutinise practice to ensure it is in line with legal and contract based requirements alongside identifying any learning that can be shared across the Trust to improve practice
- Links into a range of partner agency forums, including the LSAB Learning & development and Quality and Performance sub group, the local Learning Disability Partnership Board, the Channel Coordinator, and a range of local carer and patient forums

The purpose of the above actions has ensured the Trust has a robust adult safeguarding process in place that staff are equipped to participate in and that can be effectively monitored and audited. The actions currently still in development for this period include:

- Launch of an intranet based directory for staff to use to signpost patients for early support
- Reference materials relating to responding to disclosures of abuse and confidentiality issues
- Communication action plan to ensure awareness of various related safeguarding issues such as forced marriage are regularly promoted to staff
- Revision of the Intranet site to ensure easy read leaflets for patients and carers are accessible regarding reporting concerns
- Development of an Information Sharing protocol to offer staff clarity on what and how to share information with other agencies.

Equality and Diversity

For over two and a half years, we have developed and built upon our equality governance framework, which includes patients and 3rd sector organisations, from across the full range of protected characteristics. Inclusion and engagement activities with protected groups e.g. disabled people is a key element to equality governance. This is supported by our Equality Diversity and Human Rights Strategy Group and the equality sub groups that report into it. The revised engagement plan for 2013-2014 had the following objectives:

- Build up the Trust's engagement with protected groups, in particular, those who are seldom heard or engage with services
- Recruit a wider stakeholder membership in the Trust equality groups
- Progress the involvement of protected groups who are already established within the equality governance framework, to shape progress and equality objectives, including the establishment of Chairperson roles from external stakeholder groups
- Work with the multi-agency CWaC steering group, to set out joint engagement activities including a programme of predetermined health and wellbeing forums across the protected characteristics.

As a consequence of its inclusion and engagement activity, the Trust works closely with a number of organisations with regard to a range of actions, functions and resources:

The Trust will continue with its engagement and collaboration with stakeholder groups representing the protected characteristics and will co-facilitate multi-agency health and wellbeing forums as part of this programme in 2014 to 2015.

Cancer Peer review

The National Cancer Peer Review Programme is the cancer quality assurance process for cancer services. This programme continued into 2013/14 with the cancer multi-disciplinary teams (MDTs) at the Countess of Chester Hospital being required to self-assess the compliance of their service against nationally agreed measures. The following cancer teams were all required to self-assess their service in 2013/14:

- Local Gynaecology;
- Breast;
- Lung;
- Local Urology;
- Local Skin;
- Colorectal;
- Upper Gastro-intestinal(UGI);
- Haematology;
- Chemotherapy services;
- Brain and Central Nervous System,
- Sarcoma;
- Acute Oncology ;
- Cancer of Unknown Primary (CUP);
- Head and neck

Of these services, the self-assessments for Haematology, Acute Oncology, CUP, Breast, Lung and Head and Neck cancers were internally validated by the Trust at individual panel meetings, with the reports of these meetings being published on the Cancer Quality Improvement Network Systems database. All of these teams were able to demonstrate areas of good practice and no immediate risks or serious concerns were raised although some concerns were highlighted which have been incorporated in to the individual teams work programme as areas to be addressed in the next 12 months and put in a Trust action plan. Following external validation of these reports the regional NHS Improving Quality (NHSIQ) review team is planning an external visit to the Breast Cancer MDT in June 2014.

Two services were selected for an external visit by the NHSIQ team for 2013/14. These were Local Upper Gastro-intestinal and local Skin multi-disciplinary teams. Reports for both teams were positive with no immediate risks or serious concerns being raised.

Work continues on the action outstanding from the peer review visit of 2012/13 which involves the development of an electronic prescribing system for chemotherapy. Work is in progress to resolve this with regular updates being sent to the regional NHSIQ team. Other actions resulting from this visit have been completed although the Trust is experiencing difficulty recruiting to the Acute Oncology Support Nurse post.

The Trust is in preparation for the 2014/15 reviews. The process for peer review is once again under review with a revised process for forthcoming reviews which will not be fully operational until 2015/16.

National Cancer Patient Experience Survey

Once again the Countess of Chester Hospital participated in the National Cancer Patient Experience Survey (NCPES). 386 surveys were sent out to patients who had been seen in the Trust either as a day case or inpatient and discharged between 1st September 2012 and 30th November 2012. 218 were returned giving a response rate of 61%.

As in previous years the Trust was benchmarked against other Trusts as either appearing in the lowest 20% responses or the highest 20% of responses.

Positive responses were around patients being told sensitively they had cancer, patient choice and access to a Clinical Nurse Specialist (CNS) and the Trust reported a significant increase in the number of patients responding that they had received information about free prescriptions. Responses benchmarked in the lowest 20% formed the basis of an action plan being monitored by the Trust. These were largely around the provision of information with financial information and support groups being of particular note.

The Trust is participating in the 2013/14 NCPES .

Stroke Peer Review

The Peer Teams visited our Trust's Stroke services this year. he visit was undertaken as part of a series of peer support visits conducted by the Cheshire and Merseyside Strategic Clinical Networks.

The report back stated that the *"Stroke Team is clearly well-motivated and enthusiastic, with a strong desire to develop, improve and extend the range of services provided. This strong commitment and ambition needs to be harnessed by the Trust, to aid the strategic, integrated development of stroke services, in partnership with Clinical Commissioning Groups"*.

It went on to say the current reconfiguration of services is clearly work in progress and the expected benefits in terms of efficiency, access and improved performance needs a longer unit gestation time before they are fully realised. The depth of the service is developing with strong leadership evident in the different components on the multi-disciplinary team, all determined to work towards the common goal of improved stroke care. The current availability of a pool of experienced personnel allows for potentially exciting and crucial developments of new roles which will certainly enhance the service. The demonstrable benefits of Early Supported Discharge (ESD) need to be harnessed in sound financial investment to enable the continuing development of comprehensive stroke care.

The team recommended a number of actions including:

- Review the pathway
- Explore the development of psychology provision
- Further integration with community and social services

- Skill up staff to support the stroke co-ordinator
- Review data collection

These will be explored and progressed as needed in year. The visiting team went on to say they were very impressed with the dedication, enthusiasm and commitment of the stroke team.

Nursing Care Measures

In 2013- 2014 the Trust continued with its process of nursing care audits and also ensured the care and comfort rounding has become embedded.

This process has provided managers and senior nurses with assurance that patient care is monitored and any remedial action taken is as required. The audit is visible at ward level to both patients and the public as is the action planning for improvement.

Below is a table of the Trust scores over the last 7 months of 2013-2014 and a final compliance of over 90% with each care bundle.

	Sep 2013	Oct 2013	Nov 2013	Dec 2013	Jan 2014	Feb 2014	Mar 2014
Medication storage and custody	99% ↑	98% ↓	99% ↑	99% →	99% →	100% ↑	99% ↓
Infection control & privacy & dignity	100% ↑	100% →	100% →	99% ↓	99% →	100% ↑	99% ↓
Patient observations	96% ↑	97% ↑	98% ↑	90% ↓	95% ↑	97% ↑	97% →
Pain management	99% ↑	99% →	99% →	99% →	99% →	100% ↑	99% ↓
Tissue viability	97% ↑	98% ↑	97% ↓	94% ↓	97% ↑	98% ↑	96% ↓
Nutritional assessment	96% ↑	93% ↓	98% ↑	100% ↑	96% ↓	94% ↓	96% ↑
Falls assessment	98% ↑	99% ↑	99% →	97% ↓	100% ↑	99% ↓	100% ↑
Continence assessment	97% ↑	99% ↑	93% ↓	92% ↓	99% ↑	96% ↓	98% ↑
Management of Urinary Catheters	94% ↑	95% ↑	94% ↓	100% ↑	95% ↓	82% ↓	91% ↑
Discharge	97% ↑	95% ↓	97% ↑	98% ↑	95% ↓	94% ↓	96% ↑
Total	98% ↑	98% →	98% →	97% ↓	98% ↑	98% →	98% →

Work is underway with the ward managers to review the suite of indicators that are currently in use. The refreshing of these will form part of the agreed nursing key performance indicators in 14/15 and will support the justification of the investment into the nursing budget.

Focus on Pressure Ulcer Management

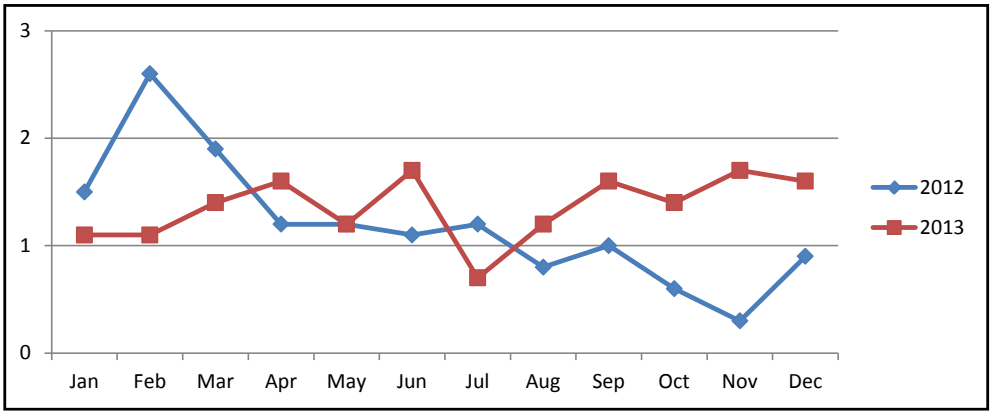
In 2013-2014 the Trust has continued to maintain the profile of pressure ulcer management by ensuring all patient data is validated and all pressure ulcers are monitored both locally and strategically by the senior nursing team.

The whole process in year has been reviewed and significant work has taken place to ensure the robustness of the data.

A significant piece of work has taken place in year to ensure that the process around pressure ulcer prevention and detection is robust. This has seen an increase of correct and accurate reporting of pressure ulcers and therefore has seen an increase in the overall Trust number. The Trust is now confident that the data is correct and staff education has taken place to facilitate an expected reduction.

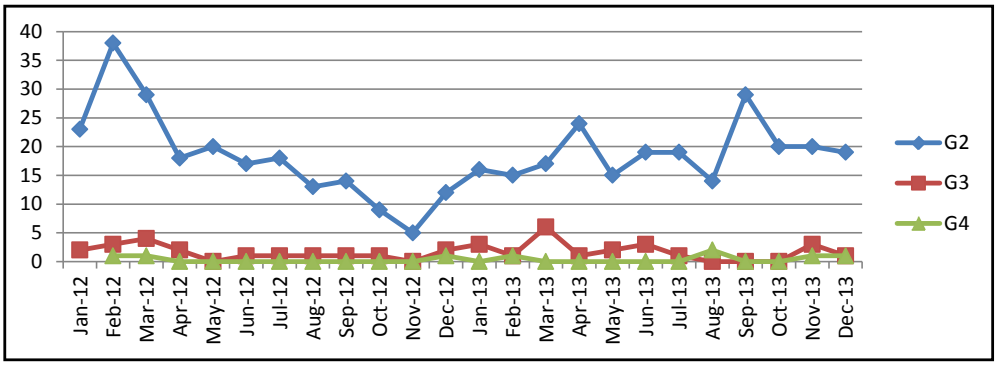
This culminated with the launch of the new process on NHS Change Day in March 2014. Our pledge was to support the reduction of patient harm by reducing hospital acquired pressure ulcers.

The incident rate of grade 2-4 hospital acquired pressure sores per 1000 bed days / year



When reviewing the data by pressure ulcer grade (see graph below), it can be identified that in general the number of grade 2 pressure ulcers reported has increased, while the grade 3 and 4 pressure ulcers generally remain at a low level.

Grade 2, 3 and 4 pressure ulcers by grade and month/year



All grade 3 and 4 pressure ulcers undergo an full review by the ward manager, matron, tissue viability team, and any other relevant staff to identify lessons learned which are then addressed through an action plan and the case review is presented to the Director of Nursing and Quality for assurance.

Quarterly reports are received by the Quality, Safety and Patient Experience Committee regarding pressure ulcers and this report is also shared with the Clinical Commissioning Group as assurance.

Advancing Quality Report

Aim:

- To ensure patients receive the best practice indicated for their condition
- To promote timely recovery with good clinical outcomes

Description of the issues and rationale for prioritising:

The Trust has been part of the North West Advancing Quality programme for six years. The programme supports the implementation of set pathways of care across the identified conditions of:

- Acute heart attack
- Heart failure
- Community acquired pneumonia
- Hip and knee replacement
- Stroke care

Data is collected in retrospect to allow notes to be clinically coded first and then matched to the above condition related pathways.

In 2014/15 new Focus Groups are to be included:

- Chronic Obstructive Pulmonary Disease
- Diabetes
- Hip fracture
- Acute Kidney injury
- Sepsis
- Alcohol related liver disease.

Current status:
As the data is retrospective we are currently verified up to November 2013. This is the first year we have been measured by the number of patients who received all the care they were eligible for in the time frames set by AQuA (previous scoring looked at number of measures achieved). This is a harder measure to achieve but is welcomed as it demonstrates more clearly the level of patient safety.

All current focus areas have shown an increase in achieved measures since April 2013 and are accomplishing above target for the 8 month year-to-date score.

- Heart attack pathway – this has shown an improvement from the beginning of the year and reached 100% in November.
- Heart Failure – new measures this year provided more of a challenge and action plans have been successful in improving compliance.
- Hip and Knee – this focus group experienced changes to existing measures (reduction in time frames) and additional measures this year requiring us to embed new guidelines.
- Pneumonia – this focus group although above target remains a challenge for significant improvement and requires further work.
- Stroke – With closer attention to the patient clinical pathway this group has shown an improvement overall and work is ongoing with the team to sustain the improvement

The Trust was pleased to have been awarded the 'Most Improved Trust Years 1-5' at the Advancing Quality awards this year. We are very proud of this North West award and hope to maintain our successes.

Graphed Results:
Data can be viewed in the Quality measures at the back of the report on page 57.

Further planned improvements for 2014/2015
The project will continue as part of the region's commissioning for Quality and Innovation (CQUIN). It will be measured differently this year with targets based upon the number of patients receiving all elements of care across the pathway.

Patient surveys

Inpatient 2013
This survey has highlighted the many positive aspects of the patient experience.
A total of 850 patients from our Trust were sent a questionnaire. 828 were eligible for the survey, of which 361 returned a completed questionnaire, giving a response rate of 44%. The response rate for our Inpatient survey in 2012 was 50%.

Overall: 81% rated care 7+ out of 10.

- Overall: treated with respect and dignity 80%.
- Doctors: always had confidence and trust 81%.
- Hospital: room or ward was very/fairly clean 96%.
- Hospital: toilets and bathrooms were very/fairly clean 93%.
- Care: always enough privacy when being examined or treated 89%.

Most patients are highly appreciative of the care they receive. However, it is evident that there is also room for improving the patient experience.

Friends and Family Test 2013 – 2014
The Friends and Family Test (FFT) has been successfully implemented in three areas at the Trust - Inpatients, Emergency Department (ED) and Maternity.

The measurement of 'likely to recommend' has proven invaluable to the Trust with the average percentage for the Trust as a whole being 87.7%.

Likely to recommend stats by department:

Department	Average 'Likely to recommend' percentage
Inpatients	90.7%
Accident and Emergency	85.3%
Maternity	86%

Response rates have identified that certain departments have fully embraced the FFT and are comfortable in the communication of what it means to patients and the improvements it can help the Trust make.

Nationally, the response rate percentage set by NHS England is 15%. Currently we are achieving a Trust wide response rate of 22.3%

Response rates by department:

Department	Average 'Likely to recommend' percentage
Inpatients	40%
Accident and Emergency	19%
Maternity	10%

For a National Comparative data and detail please see page 56.

Following full analysis of the response rates, it is evident there are areas which have room for improvement when it comes to introducing patients to the survey and conveying its importance. Improvements in the visibility of the FFT in the ED area have and will continue to be made. In the four 'touch points' (this is where maternity patients can be faced with completing the survey) - two areas which are based within the community setting are also proving a challenge. Encouragement from the Senior Midwives is helping to engage Midwives with the importance of FFT feedback. Their feedback on why they found it difficult to obtain the information resulted in the method used being changed, which has already seen an improvement in recent response rates.

We are embracing the use of Friends and Family Test and its results. In the future the FFT survey will be rolled out across Outpatients and Paediatrics and this will be complemented by the introduction of the Staff Friends and Family Test as per national guidelines.

Managing and Responding to External Recommendations

During 2013-2014, the Trust's Quality, Safety and Patient Experience Committee received, monitored and took action on a number of external reviews to ensure there were no implications for the Trust. These reviews were in the form of National Confidential Enquiries into Patient Outcomes and Death (NCEPOD), or investigation reports into events in other Trusts or healthcare providers. (Examples of these can be seen on page 15)

In all cases there are robust systems to receive and acknowledge these recommendations, conduct an analysis and identify any gaps and initiate relevant action plans. This system is subject to a programme of audit to provide assurance.

Summary Hospital Mortality Indicator (SHMI)

The most recent SHMI published by the HSCIC, for the period October 12 – September 13, was 1.06, a small decrease, 0.03, on the previous period and remaining within the "as expected" range which equates to a Banding of 2. The overall HSMR, as reported by NHS North of England, has become consistently as, or below, expected. The HSMR for weekend admissions has been consistently higher; however, there have been no failures of care or treatment identified by the mortality review process (see below) for patients admitted at the weekend.

The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period of October 2012 to September 2013 was 23.12%

We are investigating the factors that influence mortality ratios e.g. the use of signs and symptoms and the influence of numbers of FCEs and particularly the differences between weekday and weekend. This work is already resulting in a reduction of the coding of signs and symptoms.

The Trust formed a Mortality Review Group (MRG) in 2013/14. The purpose of this group is to review every in-hospital death at the Trust, to identify any areas of poor practice and any areas of failure that might have contributed to death, and to learn from these and change practice to avoid repeat.

Initially 5 teams were formed, comprising a Consultant and a Senior Nurse, including the Medical Director and the Director of Nursing and Quality; a further 3 teams have been subsequently added in the latter part of this year.

The review process was based on the 3x2 matrix tool developed by the NHS Modernisation Agency (A Matter of Life and Death; improving hospital mortality rates and end of life care. NHS Modernisation Agency. 2004) as used by the Medical Director for an initial retrospective audit of deaths in January 2013.

In year the process has evolved; it became apparent that whilst the matrix tool was a good starting point, it did not specifically address many of the issues arising from mortality ratios or from our own early reviews. The tool has, therefore been revised so that it will also allow easier, and quicker, review of the results but also comprehensively covers the areas of concern. It is envisaged that this process will continue to evolve. To date we have not identified any cases where there has been a failure of care that has contributed to the death of a patient. The major finding to date has been the need to develop palliative care and end of life strategy across the whole West Cheshire health economy.

Patient Reported Outcome Measures (PROMs)

April 2012 to March 2013

Knee Replacement	EQ-5D Index Lifestyle	EQ VAS Health	Condition Specific	Comments	National score - % patients showing an improvement
Patients with a better outcome	80% (79%)	52.1% (46%)	87.2% (91%)	Improvement seen in lifestyle and health scores. Knee replacement specific questions show a slight increase in patients reporting worse outcome - this could be due to reduced number of procedures being performed.	EQ-5D 79.7% EQ-VAS 54.6% Condition specific 92.3%
Patients with no change	6.7% (12%)	13.7% (11%)	2.3% (1%)		
Patients with a worse outcome	13.3% (14%)	34.2% (43%)	10.5% (8%)		

11/12 Information in brackets

Varicose vein	EQ-5D Index Lifestyle	EQ VAS Health	Condition Specific	Comments	National score - % patients showing an improvement
Patients with a better outcome	40% (30%)	33.3% (35%)	66.7% (79%)	Continued decrease in patients undergoing this procedure with overall numbers low.	EQ-5D 52.8% EQ-VAS 41.1% Condition specific 83.0%
Patients with no change	33.3% (47%)	0% (19%)	0% (0%)		
Patients with a worse outcome	26.7% (22%)	66.7% (46%)	33.3% (21%)		

11/12 Information in brackets

Groin Hernia	EQ-5D Index Lifestyle	EQ VAS Health	Condition Specific	Comments	National score - % patients showing an improvement
Patients with a better outcome	45.7% (60%)	40.3% (42%)	NA	Increase in number of patients reporting no change or worsening post operation.	EQ-5D 49.3% EQ-VAS 37.4%
Patients with no change	35.1% (24%)	18.8% (15%)	NA		
Patients with a worse outcome	19.2% (16%)	40.9% (42%)	NA		

11/12 Information in brackets

Quality measures

The Trust has seen an increase in the rate of patient safety incidents reported per 100 admissions to 9.7 – this is reflective on an increase in incident reporting trust-wide and follows a change in direction taken by the Trust in ensuring that harms identified through other routes (such as the safety thermometer and mortality and morbidity reviews) are also reported as incidents. Understandably then, the Trust has seen a slight increase in the percentage of patient safety incidents resulting in severe harm 0.5%. Overall, the work undertaken in 2013/14 has ensured an increased focus upon improving the rate of incident reporting across the Trust; further work is planned for 2014/15 with regard to feedback of lessons learnt in order to maintain the Trust's position as a high reporter of incidents with low level of harm.

Indicator	Method of monitoring / Measure	11/12	12/13	13/14
Reduction in MRSA bacteraemia	Target: 1 post 48 hour cases	2	3	0
Reduction in Clostridium difficile	Target: National 36 cases	50	48	34
Trust-wide Hand Hygiene	Sustained improvement: compliance at greater than 95%	95.5%	97%	Average score for the year 98%
VTE assessment (12/13 data final 6 months)	Sustained improvement: Compliance at 90% or above	93.2%	93.23%	Year end 97.2%
Incident data: Latest data available at time of report		April 2011 - September 2011	April 2012 - September 2012	April 13 - September 2013
Rate of patient safety incidents per 100 admissions	National patient safety agency report	6.8	6	9.7
% of patient safety incidents resulting in severe harm or death	National patient safety agency report	0.1%	0.4%	0.5%

Indicator	Year to date	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Emergency readmissions to hospital within 28 days of discharge **Average 11-12 is 5.73% Average 12-13 is 5.50% Average 13-14 is 5.20% (to date end of Feb)**													
Optimisation of the care of patient with a Fractured neck of femur: % of medically optimised patients with a fractured neck of femur who go to theatre within 36 hours **Average 11-12 83% Average 12-13 89% Average 13-14 93%**	93%	93%	100%	75%	100%	95%	92%	96%	82%	90%	100%	95%	96%

Advancing Quality:

The data displayed below is the Trust's audited data and may be subject to change following external audit and application of external weightings. Data available to December 13 (refer to page 47 for full summary).

Hip and Knee. Threshold 82.02%		84.21	81.48	90.32	75.00	85.19	95.83	90.63	88.89	86.96			
Community Acquired Pneumonia Threshold 61.07%		66.07	73.91	74.00	76.00	77.14	71.70	63.83	58.54	82.35			
Heart Failure Threshold 68.25%		56.00	54.17	76.92	76.19	73.33	73.90	77.27	80.95	92.00			
Acute MI Threshold 79.87%		94.74	58.52	73.30	72.22	76.92	86.96	93.75	100	68.75			
Stroke Care Threshold 50%		32.00	29.17	75.00	41.94	65.22	81.48	64.00	57.89	67.86			
Staff survey													
Percentage of staff who would recommend the Trust as a place of work or to receive treatment *		70.4% (3.52 out of 5)			73% (3.65 out of 5)			75.4% (3.77 out of 5)			(3.78 out of 5)		

* Questionnaires were sent to all 3404 staff eligible to receive the survey. This includes only staff employed directly by the Trust (i.e. excluding staff working for external contractors). It excludes bank staff unless they are also employed directly elsewhere in the Trust.

Comparative Friends and Family Test data

FFT test scores	Apr - 13	May - 13	Jun - 13	Jul - 13	Aug - 13	Sep - 13	Oct - 13	Nov - 13	Dec - 13	Jan - 14	Feb - 14	Mar - 14
COCH IP	84	74	79	79	78	83	82	76	77	80	83	82
England IP	70	70	71	71	71	71	71	72	71	72	72	72
COCH AED	72	72	77	53	69	53	55	57	57	49	48	64
England AED	49	55	54	54	56	53	56	56	57	57	55	54
COCH combined	-	-	78	64	73	61	67	68	69	66	64	-
England combined	-	-	63	63	64	62	64	65	64	64	63	63

FFT response rates %	Apr - 13	May - 13	Jun - 13	Jul - 13	Aug - 13	Sep - 13	Oct - 13	Nov - 13	Dec - 13	Jan - 14	Feb - 14	Mar - 14
COCH IP	24.0	27.6	44.4	38.2	44.9	41.0	36.0	30.0	47.1	38.9	34.6	31.8
England IP	21.5	24.0	27.0	27.9	28.8	29.4	30.9	31.1	28.5	31.0	34.0	34.8
COCH AED	0.8	2.2	17.1	17.5	21.9	38.8	14.9	19.5	13.4	12.6	15.9	18.3
England AED	5.7	7.6	10.3	10.4	11.3	13.2	13.9	15.2	15.3	17.4	18.6	18.5
COCH combined	-	-	23.8	23.2	28.1	39.3	20.3	23.8	23.3	20.8	21.4	22.3
England combined	-	-	15.7	15.9	16.9	18.4	19.6	20.6	19.7	22.0	23.8	23.7

Monitor Compliance Targets

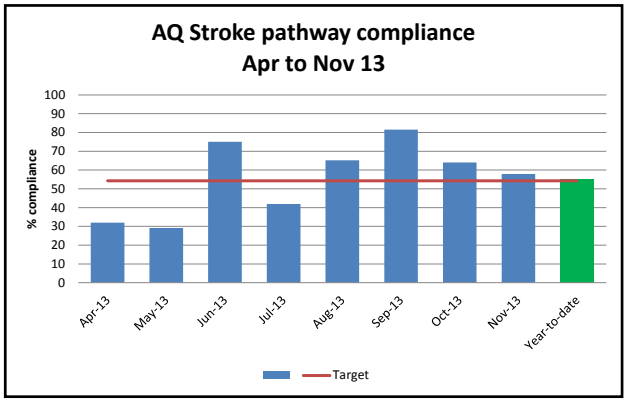
The Trust is pleased to have come under its target of no more than 36 C.difficile in year by two cases ending the year at 34. This is a real testament to its ongoing focus on infection prevention control. The target is more challenging this year and is set at no more than 30 cases. The Trust has an ongoing strategy to support this reduction and we will monitor very closely its effectiveness. This year the Trust has had no MRSA bacteraemia cases in fact it is now well over 400 days since its last case. This is a significant achievement and has been realised with clinical and continued ongoing focus of its staff.

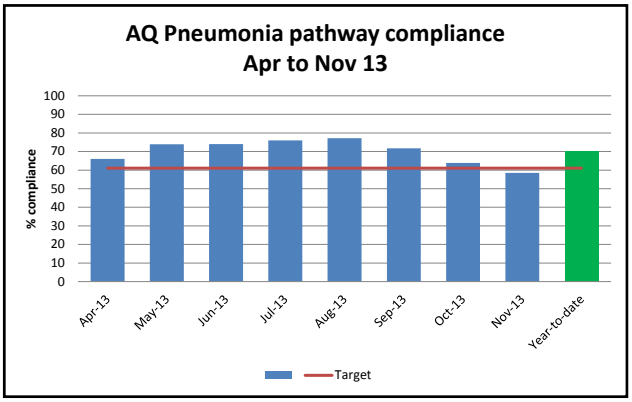
The Trust is working in partnership with other health and social care organisations to support the performance of the Emergency Department. It has in year started the Ambulatory Care Unit and admission diversion option as well as other schemes for example Early Supported Discharge (ESD).These initiates have had a positive impact on the patient care pathway and supporting the performance of the ED target. The coming year will see the Trust launch its frailty pathway to support our elderly frail patients to be cared for in a setting which is most appropriate to meet their needs.

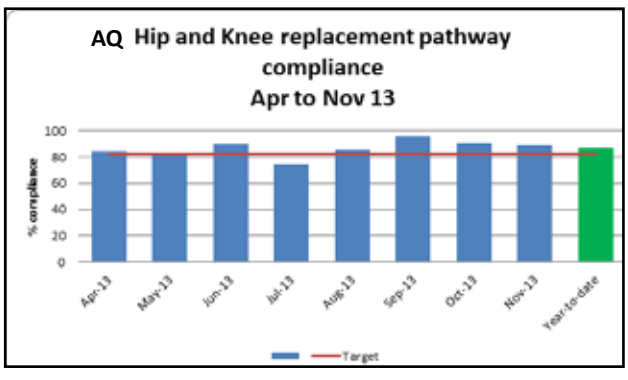
The cancer target has been particularly challenging this year. The cumulative year-end position is disappointing. We have now completed a number of pieces of work to ensure we see a reduction of the breaches of the target. This work is still ongoing but we are confident the position will improve. Cancer performance continues to be a real focus of the Board and we are fully engaged with our community colleagues to ensure the focus remains on the pathway.

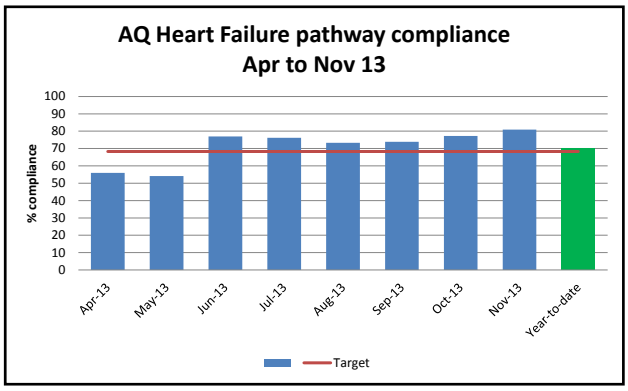
Infection Control Targets	Target	Actual	Comments
Clostridium Difficile	36	34	
MRSA	0	0	
Waiting Time Targets	**Target**	**Total**	
% RTT treated admitted patients	90%	95.1%	
% RTT treated non-admitted patients	95%	99.8%	
% RTT incomplete pathway	92%	94.9%	
Total time in A&E	95%	95.67%	Monitor year - 01/01/2013 - 30/03/2014
Cancer Targets	**Target**	**Total**	
14 days - all cancers	93%	98%	
14 days - breast symptomatic	93%		
31 days - subsequent surgical treatment	94%	97.5%	
31 days - subsequent non-surgical treatment	98%	100%	
62 days - first treatment from urgent GP referral	85%	83.9%	
62 days - first treatment from screening referral	90%	96.2%	
Monitor Governance Rating			

Advancing Quality Measures

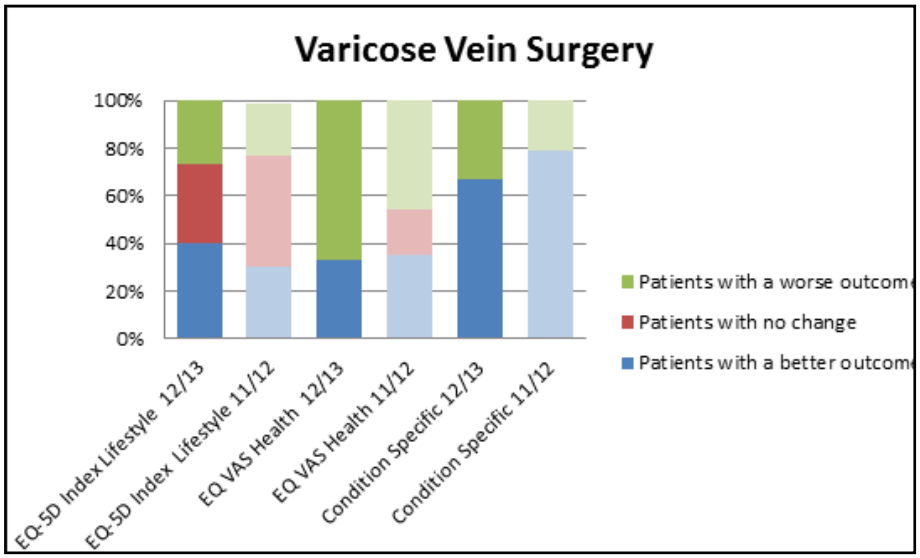


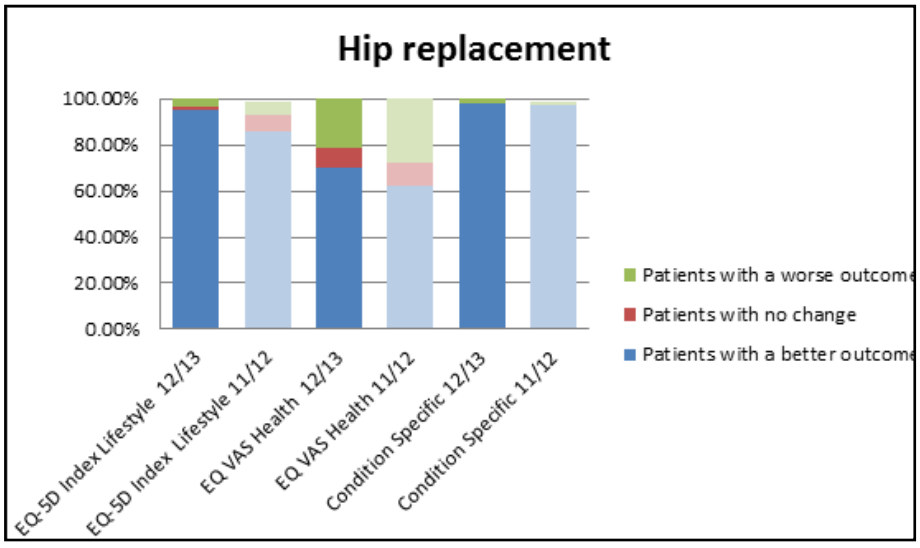


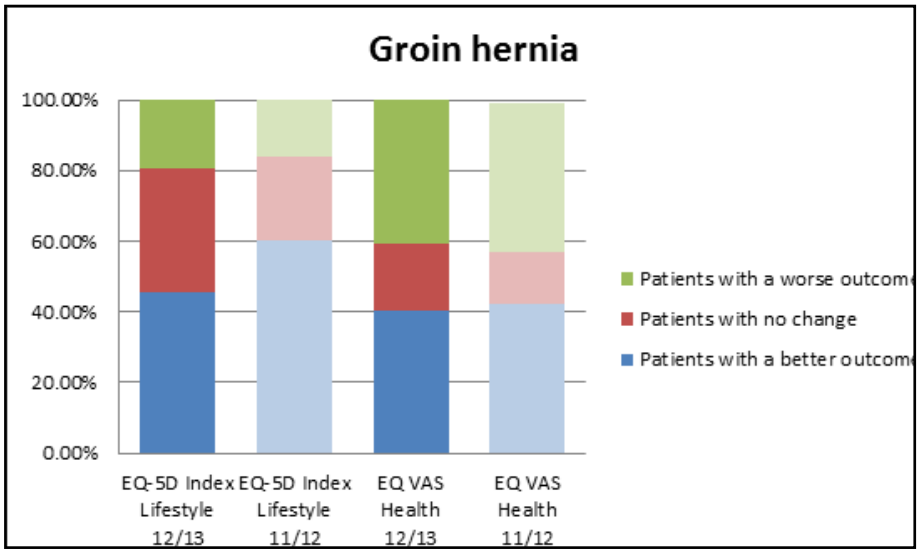




PROMS


Varicose Vein Surgery
100%
80%
60%
40%
20%
0%
EQ-5D Index Lifestyle 12/13
EQ-5D Index Lifestyle 11/12
EQ VAS Health 12/13
EQ VAS Health 11/12
Condition Specific 12/13
Condition Specific 11/12
Patients with a worse outcome
Patients with no change
Patients with a better outcome


Hip replacement
100.00%
80.00%
60.00%
40.00%
20.00%
0.00%
EQ-5D Index Lifestyle 12/13
EQ-5D Index Lifestyle 11/12
EQ VAS Health 12/13
EQ VAS Health 11/12
Condition Specific 12/13
Condition Specific 11/12
Patients with a worse outcome
Patients with no change
Patients with a better outcome


Groin hernia
100.00%
80.00%
60.00%
40.00%
20.00%
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EQ-5D Index Lifestyle 12/13
EQ-5D Index Lifestyle 11/12
EQ VAS Health 12/13
EQ VAS Health 11/12
Patients with a worse outcome
Patients with no change
Patients with a better outcome

Part Four

Written Statements by Other Bodies

Our Foundation Trust Council of Governors

Governors attend Board of Directors meetings, regular Council of Governors meetings, where Directors present compliance and quality data, and financial information, and joint workshops where strategic plans are discussed. Governors continue to request and receive regular presentations on relevant issues. We consider ourselves well informed and able to validate the accuracy of the Quality Account.

The Council of Governors are proud of the Trust's achievements in 2013/14 including –

- Achieving the C Diff and MRSA targets
- No 'Never Events'
- Becoming the regional vascular centre for South Mersey
- Completing the new building, including the impressive Intensive Care unit, on time and under-budget
- Training over 1000 Dementia Friends and improving the environment for patients with dementia
- Providing flu jabs for significant numbers of staff
- Success of Ambulatory care and Paediatric Hospital@Home
- Implementation of Real-time patient feedback for in-patients
- Successful assessment of the Equality Delivery System
- Hosting the North West Governors forum

The Council of Governors support the Trust's priorities for 2014/15 and will continue to work closely with the Non-Executive Directors to achieve these. The Governors also fully support the Trust's aim to work closely with local partners in the West Cheshire Way. We also support the Trust's vision to deliver high quality care, 'Going from Good to Great' and the 5-year strategic plan. The Governors' Quality forum will continue to monitor the quality of care delivered by the trust through our 'clinical area visit programme' using the 15-steps Toolkit and support the Trust's positive engagement with Healthwatch inspections.

The Council of Governors support the Trust's response to the Francis report including the Nursing and Midwifery Strategy, joining the 'Speak Out Safely' campaign, increased nurse recruitment following the Nursing Review, the action plan implemented following the external review of Maternity Services, Board member 'walkabouts' and Leadership Briefings, and the appointment of a Non-Executive Director as Chair of the Quality, Safety and Patient Experience committee. We also look forward to governor involvement in the implementation of recruiting nurses to 'values and behaviours'.

The outcomes from the Quality Account also indicate areas where improvements must be made in 2014/15 including pressure ulcers, which are part of the National Safety Thermometer CQUIN, and the 62-day cancer target. The Council of Governors will also closely monitor issues with end-of-life strategy raised by the mortality review process, the staff response to the Family and Friends test and ED performance.

Governors will continue to engage proactively with members and the public at regular community-based events. We look forward to another successful year working closely with the Trust to ensure that the feedback received from patients, carers, members and the public is built into the forward plans of the Trust.

The Quality Account is representative of the achievements and progress made to date and provides a good foundation for further improvement, actively monitored, promoted and informed by the Council of Governors. We would like to thank the Board of Directors for their openness in sharing information, listening to feedback and positive engagement in joint working with us.

Healthwatch Cheshire West

A draft copy of the Quality Account for the Countess of Chester Hospital NHS Foundation Trust was received by Healthwatch Cheshire West on the 17th April 2014 in line with the NHS Quality Account regulations 2010. Healthwatch Cheshire West was also invited to attend a Quality Account Presentation Day by the NHS England Area Team on 2nd May 2014, to receive the presentation of the draft Quality Account for the Countess of Chester Hospital NHS Foundation Trust for 2013-2014.

The presentation day allowed the opportunity for Healthwatch Cheshire West to comment on the Quality Account in draft format and interact with Trust representatives in a meaningful and positive way. Healthwatch Cheshire West was pleased to see that the Trust took on board the feedback received from Healthwatch Cheshire West and wider stakeholders at the presentation day in developing its Quality Account.

Strong links and excellent involvement/engagement has been developed between Healthwatch Cheshire West as the new statutory, independent consumer champion for health and social care in Cheshire West and Chester and quality leads at the Countess of Chester Hospital NHS Foundation Trust during 2013/14. Healthwatch Cheshire West has also been invited to attend meetings of the Quality Forum to develop intelligence sharing capability in relation to patient experience/quality data that we collect regarding the Trust.

Based on the views of patients received by Healthwatch Cheshire West regarding the Countess of Chester Hospital NHS Foundation Trust, and other information that we have access to (for example via our Enter and View activity and published reports) there are no surprises in the Quality Account, which is a fair reflection of the full range of services offered.

Healthwatch Cheshire West is particularly impressed with the Trust's genuine and explicit commitment to equality and diversity and the level of inclusion and engagement activities with protected groups, led by Joe O'Grady, Equality and Diversity Manger. Healthwatch Cheshire West feels that it is important that efforts continue to address staffing levels at the Countess of Chester Hospital NHS Foundation Trust to ensure a safe and high quality 7 day service for patients and the public. The presentation of the Quality Account is generally good, although a greater balance between explicitly identifying and addressing the challenges and 'celebrating the good' could be achieved.

Healthwatch Cheshire West would also like to see greater consideration of alternative formats and more innovative ways to bring the information contained within the Quality Account to life for patients and the public in the future. To this end we happily offer our expertise in this area in relation to future publications.

Healthwatch Cheshire West looks forward to receiving regular updates from the Trust on progress with the implementation of the Quality Account and the impact on patient care throughout 2014/15.

Health and Wellbeing Scrutiny Committee

The Health and Wellbeing Scrutiny Committee welcomes the achievements of the Trust in 2013/14 especially with regard to infection prevention and control and the work it is doing on the management of dementia. The priorities for improvements and the introduction of 7 day MRI scanning were also welcomed.

Post discharge care and alternatives to in patient admission for children through clinical streaming in A&E and utilisation of paediatric hospital at home should help improve care and reduce the pressures on hospital services.

Although there has been a ten per cent reduction in falls overall, as the Trust recognises, there is still a need for improvement in certain areas and the Committee hopes that the proposed fall reduction measures will be successful. The report also identifies that although most patients are highly appreciative of the care they receive the patient experience could be improved further.

A member of the Committee visited the A and E department and met with staff last year and was encouraged by an additional consultant being on duty at weekends to help reduce weekend waiting times.

Appendices

Appendix 1 - Glossary & Abbreviations

Term	Abbreviation	Description
Accident and Emergency	A&E or ED	The Emergency Department usually at a hospital.
Advancing Quality	AQ	A programme which rewards hospitals which improve care in a number of key areas – heart attacks, pneumonia, hip and knee replacements, heart failure and heart bypass surgery, stroke– when compared to research which identifies what best care constitutes.
Birthing Unit	BU	The Birthing Unit has a focus on normality, provides a relaxed environment to support women's choices and improve outcomes for low risk women.
Care Quality Commission	CQC	The independent regulator of health and social care in England. Its aim is to make sure better care is provided for everyone, whether that is in hospital, in care homes, in people's own homes, or elsewhere. The CQC replaces the Healthcare Commission.
Clostridium difficile	C-diff	A naturally occurring bacterium that does not cause any problems in healthy people. However, some antibiotics that are used to treat other health conditions can interfere with the balance of 'good' bacteria in the gut. When this happens, C-diff bacteria can multiply and cause symptoms such as diarrhoea and fever.
Clinical Commissioning Group	CCG	This is the new GP led commissioning body who buys services from providers of care such as the hospital.
Commissioner		A person or body who buy services.
Commissioning for Quality and Innovations	CQUINs	CQUIN is a payment framework developed to ensure that a proportion of a providers' income is determined by their work towards quality and innovation. The scheme was introduced in detail, from implementation to function, in High Quality Care For All to encourage organisations to see quality improvement and innovation as a motivator towards a better service for their patients.
Criteria Led Discharge	CLD	This is a system by which the Doctor clearly defines the care that needs to be met / treatment delivered or results parameters to be achieved before the nurse can discharge the patient home.
Clinical Research Network	CRN	The NIHR Clinical Research Network (CRN) makes it possible for all patients and healthcare professionals across England to participate in relevant clinical trials.
Early Supported Discharge	ESD	This process is about putting additional care into the community setting to enable patients to spend a shorter time in hospital and where possible return to their original place of residence
Enhanced Recovery Programme	ERP	A pathway of care applied to a procedure relating to type of anaesthesia, type of post operative pain relief, earlier patient mobility post surgery, increased nutritional intake pre operatively and as soon after waking as possible, to reduce recovery time.
Healthcare Associated Infections	HCAI	A generic name to cover infections like MRSA and C-diff.
Hospital Episode Statistics	HES	This is the national statistical data warehouse for England of the care provided by NHS hospitals and for NHS hospital patients treated elsewhere. HES are the data source for a wide range of healthcare analysis for the NHS, government and many other organisations and individuals.

Term	Abbreviation	Description
Global Trigger Tool		This is a tool that is used to review a patient medical record and establish whether any harm events occurred during the patient's care and treatment in hospital. From an analysis of a large number of records the hospital can measure its rate of harm and work towards reducing this.
Methicillin-Resistant Staphylococcus Aureus	MRSA	Staphylococcus aureus is a bacterium which is often found on the skin and in the nose of about 3 in 10 healthy people. An infection occurs when the bacterium enters the body through a break in the skin. A strain of this bacterium has become resistant to antibiotic treatment and this is often referred to as MRSA.
Monitor		This is the regulator of NHS Foundation Trusts. It is an independent body detached from central government and directly accountable to Parliament.
National Patient Survey		Co-ordinated by the Care Quality Commission, it gathers feedback from patients on different aspects of their experience of care they have recently received, across a variety of services/settings: Inpatients, Outpatients, Emergency care, Maternity care, Mental health services, primary care services and Ambulance services.
National Reporting & Learning Service	NRLS	This is the National Reporting and Learning Service which collates incident data from all organisations nationally and allows trends to be identified.
Patient Recorded Outcome Measures	PROMs	A programme in which patients complete a questionnaire on their health before and after their operation. The results of the two questionnaires can be compared to see if the operation has improved the health of the patient. Any improvement is measured from the patient's perspective as opposed to the clinicians.
Quality Account		This is a statutory annual report of quality which provides assurance to external bodies that the Trust Board has assessed quality across the totality of services and is driving continuous improvement.
Safety Brief		This is a tool of communication used by clinical staff at ward level to ensure risks are handed over
Secondary Users Service	SUS	This is the NHS data system for recording all NHS patient activity. It enables correct payments by Commissioners, for care provided by all provider services including acute trusts.
Service Level Agreement	SLA	This is a local contract between services external to the Trust to deliver shared or part of the patient pathway.
Statement of Purpose	SoP	This is a Care Quality Commission requirement of registration and describes the aims and objectives of the service provider in carrying on the regulated activity. It describes the kinds of services provided for the purposes of the carrying on of the regulated activity and the range of service users' needs which those services are intended to meet.
Venous Thrombo-embolism	VTE	This is a blood clot developing when a person is in hospital and may not be as mobile as they are usually or following surgery. The blood clot itself is not usually life threatening, but if it comes loose it can be carried in your blood to another part of your body where it can cause problems – this is called a Venous Thromboembolism (VTE). If the clot travels to the lungs it is called a pulmonary embolus (PE) and it can be fatal. Even if a blood clot does not come loose, it can still cause long-term damage to your veins.
6Cs		Care, Compassion, Competence, Communication, Courage and Commitment

Independent Auditor's Report to the Council of Governors of Countess of Chester Hospital NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of Countess of Chester Hospital NHS Foundation Trust to perform an independent assurance engagement in respect of Countess of Chester Hospital NHS Foundation Trust's Quality Report for the year ended 31 March 2014 (the "Quality Report") and considered certain performance indicators contained therein.

Scope and subject matter
The indicators for the year ended 31 March 2014 subject to limited assurance consist of two of the three national priority indicators as mandated by Monitor:

For acute NHS foundation trusts:

- Clostridium Difficile – all cases of Clostridium Difficile positive diarrhoea in patients aged two years or over that are attributed to the Trust; and
- 62 Day cancer waits – the percentage of patients treated within 62 days of referral from GP.

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

Respective responsibilities of the Directors and auditors
The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources - specified in the Detailed Guidance for External Assurance on Quality Reports; and.
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Guidance for External Assurance on Quality Reports.

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

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

- Board minutes for the period April 2013 to May 2014;
- Papers relating to Quality reported to the Board over the period April 2013 to May 2014; - Feedback from the Commissioners dated May 2014;
- Feedback from local Healthwatch organisations dated May 2014;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- The 2013/14 national patient survey;
- The 2013/14 national staff survey;
- Care Quality Commission quality and risk profiles/intelligent monitoring reports 2013/14; and
- The 2013/14 Head of Internal Audit's annual opinion over the Trust's control environment.

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 Countess of Chester Hospital NHS Foundation Trust as a body, to assist the Council of Governors in reporting Countess of Chester Hospital 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 2014, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Countess of Chester Hospital NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators.
- Making enquiries of management.
- Testing key management controls.

- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation.
- Comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report.
- 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 impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the 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 Countess of Chester Hospital 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 2014:

- 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.

KPMG LLP,
Statutory Auditor
St James' Square, Manchester, M2 6DS. 19 May 2014.

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