

QUALITY ACCOUNT 2015/16

CONTENTS

PART ONE 04

Summary statement on Quality from the Chief Executive	04
Statement of Directors' responsibilities in respect of Quality Report	07

PART TWO 08

Priorities for Improvement in 2016/17	08
- Safety	08
- Experience	08
- Clinical Effectiveness	08
- Capacity and Capability	08
Review of Services	11
- Participation in Clinical Research	11
- Research Activity	12
Centre For Integrated Healthcare Science	12
- Participation in Clinical Audits	12
- Goals agreed with our commissioners via the Commissioning for Quality and Innovation Framework (CQUIN)	15
- Care Quality Commission Registration (CQC)	16
- Data Quality	16
West Cheshire Clinical Commissioning Group Commentary	19

PART THREE 20

How we have delivered our priorities in 2015/2016	20
- Patient Experience	20
- Effectiveness	20
- Safety	22
Other Quality Improvements in 2015/2016	25
Working in Partnership: What our Governors have said	25
- Infection Prevention and Control	26
- Risk Management	30

- Safeguarding 34
- Equality, Diversity and Human Rights 36
- Cancer Peer Review 37
- Trauma Peer Review 38
- National Cancer Patient Experience Survey (NCPES) 38
- Transparency – ‘How are we doing?’ 38
- Advancing Quality Report 39
- Patient Surveys 40
- Maternity Survey 41
- Friends and Family Test 2015-2016 42
- Staff Survey 42
- Managing and Responding to External Recommendations 43
- Summary Hospital Mortality Indicator (SHMI) 44
- Patient Reported Outcome Measures (PROM) 44
- Quality Measures 46**
- Effectiveness 46
- Advancing Quality 46
- Responsiveness 47
- Monitor Compliance Targets 47

PART FOUR 50

- Written Statement from Other Bodies 50**
- Governors’ Quality Account Statement 50
- Healthwatch Cheshire West 51
- Advancing Quality Measures 53
- Patient Recorded Outcome Measures 56

APPENDIX 58

- Appendix 1 – Glossary & Abbreviations 58**

INDEPENDENT AUDITOR’S REPORT 62

PART ONE

SUMMARY STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

At this time every year, Foundation Trust hospitals across the country publish their Quality Accounts to provide assurances to their local population, patients and partner organisations about the delivery and standards of care that can be expected.

Our vision is to deliver care locally that makes our staff and our community proud by being safe, kind and effective in everything that we do.

As Chief Executive, I am incredibly proud of what we have achieved and we aim to do even better in the months ahead.

I hope that you find this Quality Account useful as it describes our achievements to date and our plans for the future. We know that great staff experiences at The Countess lead to great patient experiences.

A series of major service developments and achievements have come to fruition this year, energising our optimism and ambition for the future. These include:

- Taking responsibility for running a new Primary Care Unit that eases pressures by triaging patients arriving in Accident & Emergency who have minor illnesses or ailments
- Welcoming #hellomynameis campaign founder Kate Granger MBE to the Trust to meet with nursing and medical staff supporting her campaign to get basic introductions right for patients
- Launching a new Discharge to Assess service at Ellesmere Port Hospital, to provide frail patients with recuperation supported by nurses, therapists and social care
- Supporting a national educational project for the British Association of Day Case Surgery with film crews working with Countess surgeons and anaesthetists in our Jubilee Day Centre
- Holding an official opening ceremony to celebrate having a new state-of-the-art CT scanner in Radiology that takes high quality images to support faster diagnostics
- Running a range of community events to secure feedback on services, offer career advice to local secondary school children about NHS opportunities, raise awareness of diabetes and help older people get advice on keeping warm over winter
- Achieving the top rating in our stroke audit and going on to win a regional award for innovation in stroke services
- Starting interactive ‘Show Me the Money’ sessions, led by our finance team to raise awareness about how the NHS is funded
- Showcasing pioneering work linking audits to incident reporting at national healthcare patient safety forums
- Supporting North West Ambulance’s #findthedefib campaign to highlight availability of equipment in public areas, in order to support resuscitation
- Partnering with the British Red Cross for a new discharge service to help patients get home safely and more quickly from hospital
- Launching an on-line booking service for phlebotomy appointments
- Starting the New Year by providing a range of new fitness initiatives to support staff wellbeing and resilience in work – ranging from fitness classes to mindfulness sessions
- The opening of innovation space at Bache Hall, as part of a new partnership with the University of Chester

- Unveiling a new memorial feature, to raise awareness and pay tribute to the significance of organ donation here at The Countess
- Piloting new models of GP assessment and elderly medicine consultants based in A&E to ease pressures with patient flow and demands for beds

Disappointingly, this year we have had two “never” events. It is clear from the reviews that lessons need to be learned, and these have been reinforced within teams. We will continue to monitor the action that we have in place supported by the campaign work from ‘Sign up to Safety’. This is a campaign that the Trust has joined to support the reduction of patient harm.

A part of ensuring the safety of our patients and staff is our flu vaccine campaign. This year, we had a total of 74.1% of frontline healthcare workers vaccinated in the flu campaign, again placing the Trust among the highest performing in the country. National staff survey results show 74% of staff at The Countess agree that if a relative or friend needed treatment they would be happy with the standard of care provided by this organisation, compared with the national average of 70%.

Over the last year, a wide range of other award accolades have been bestowed on high performing clinical teams and role models within the Trust including:

- The hospital being shortlisted as Trust of the Year in the ‘National Patient Safety Awards 2015’
- Stroke care services winning the ‘Most Innovative NHS Team’ category at the North West Coast Research and Innovation Awards 2015
- Human Resources and Organisational Development being highly commended in the ‘Chartered Institute of Professional Development People Management Awards 2015’
- The hospital procurement team being shortlisted in the HSJ ‘Value in Healthcare Awards for Value and Improvement in Procurement’
- The Countess ‘Care of the Elderly’ project securing the most community votes and winning £25,000 from Aviva for investment in dementia services
- Lead Tissue Viability Nurse Specialist Carolynne Sinclair being shortlisted for her collaborative approach to wound care product selection at the ‘North West Excellence in Supply’ Awards
- Senior Buyer for the Trust, Caroline Phelan being nominated for the ‘NHS Procurement Rising Star’ award at the North West Excellence in Supply Awards
- Catering leads Craig Hough and Sue Miller were shortlisted for the ‘National Cost Sector Catering Awards 2016’
- Procurement winning the GO ‘Excellence in Public Procurement Awards 2016’
- Feedback and understanding in the quality of services provided, has prompted involvement in a range of initiatives to foster a culture of transparency and inclusivity
- Board meetings are carried out to understand partnership perspectives. This can be through patient stories, staff stories and discussions on topical issues, e.g. quality in maternity services, support for carers, complexity of appointment booking systems



- Staff, union partners, and governors supporting a programme of independent walkabouts where staff can provide an insight into working for the Trust and highlight any patient / staff safety concerns and showcase their achievements
- Governors participating in 'sit and see' observational visits to the ward
- Our hospital is the only NHS provider in the country to achieve the Navajo Charter Mark, measuring how sensitive and inclusive an organisation is in looking after patients, carers and staff who identify as Lesbian, Gay, Bisexual, or Transgender (LGBT).

There have also been challenges at times, and I know staff have often gone the extra mile to make sure our patients receive the quality care they deserve. Whilst there are things we could and will improve on, I remain humbled by the many letters of thanks that are sent to me about the care that has been given to our patients.

Many of our staff are named by families wanting to thank them for the care we have delivered. This year, we have ensured that the staff awards recognise the positive feedback at our regular award ceremonies.

“
Whilst there are things we could and will improve on, I remain humbled by the many letters of thanks that are sent to me about the care that has been given to our patients.
 ”

The latter part of this year has seen the hospital support the work of the Department of Health's efficiency programme. We were a key contributor to the Carter report. The report outlined areas for change and the Trust is launching its aim supported by a number of work streams to become the 'Model Hospital' and this will be a blueprint for other organisations to follow.

With the current financial constraints, I don't underestimate the challenges ahead but supported by our 'Model Hospital', I am confident in the staff and that we can deliver on these.

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



On behalf of

Tony Chambers
 Chief Executive

24th May 2016



STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF QUALITY ACCOUNTS

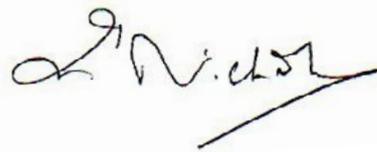
The directors are required under the Health Act 2009 and the National Health Service Quality Accounts Regulations to prepare quality accounts for each financial year.

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 report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements as set out in the NHS Foundation Trust Annual Reporting Manual 2014/15;
- the content of the quality report is not inconsistent with internal and external sources of information including:
 - Board minutes and papers for the period April 2015 to March 2016
 - Papers relating to 'quality' reported to the Board over the period April 2015 to March 2016
 - Feedback from West Cheshire Clinical Commissioning Group (CCG) May 2016
 - Feedback from Council of Governors dated April 2016
 - Feedback from Healthwatch Cheshire West dated May 2016
 - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, 2015
 - The 2015 national patient survey
 - The 2015 national staff survey, received January 2016
 - The head of internal audit's annual opinion over the Trust's control environment dated for the period of 2014/15
 - CQC Intelligent Monitoring, December 2015:
 - The quality report presents a balanced picture of the NHS Foundation Trust's performance over the period covered

- The performance information in the quality report is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review
- The quality report 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 report
- The Directors confirm to the best of their knowledge and belief that they have complied with the above requirements in preparing the quality report
- By order of the Board



Sir Duncan Nichol CBE Chairman



On behalf of

Tony Chambers Chief Executive

24th May 2016

PART TWO

PRIORITIES FOR IMPROVEMENT IN 2016/2017

Work we have undertaken in the previous year continues to support the Trust's 2014-2017 Quality Improvement Strategy which is reflected in the Trust's annual plan. The following information focuses on our key priorities for the next year.

The Trust remains committed to improving patient safety, quality and outcomes. Our choices and those of the local population we serve are reflected in our priorities going forward.

In February, our hospital and the services it provides underwent its full CQC (Care Quality Commission) inspection. It is too early to have the full result but we would expect it to reflect the current high level of assurance of band 5 rating that the CQC gave us in 2015.

The Trust embraced the visit from the CQC and it gave us a real opportunity to showcase the safe, kind and effective care we believe that we deliver.

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

> SAFETY (#SAFE)

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

> EXPERIENCE (#KIND)

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

> CLINICAL EFFECTIVENESS (#EFFECTIVE)

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

> CAPACITY AND CAPABILITY

The 'Patient Safety Team' is providing a strong corporate approach in facilitating quality and safety initiatives and it monitors the organisation's progress. The team has led on a number of areas of work and supports a truly patient-centred safety focus at work.

Throughout the document you may see terminology that you are not familiar with. To help you, we have included a glossary of terms at the back of the document in Appendix 1.

Safety (#Safe)

Aim	Rationale	Monitored	Measured
Improve patient dietary instructions for OGD	Improve patient concordance with advice	Divisional Board	Reducing the number of cancellations
Reduce the risk of hospital admission by performing cystoscopy in the outpatient setting	Improve patient safety	Divisional Board	Monitor numbers in the outpatient setting
Commence 'pre assessment' clinics for certain radiological examinations	Improve patient compliance and safety	Divisional Board	Reduce the number of wasted slots

Experience- (#Kind)

Aim	Rationale	Monitored	Measured
Using the governors to establish a peer review process to review complaint responses	To ensure that responses are empathetic and responsive to patient concerns	Patient Experience Operational Group	By the return rate
Attend a number of established service users support groups	Gain a better understanding of the views of our service users	Patient Experience Operational Group	Obtain feedback and factor into proposed service developments
Review the carer strategy measures	To ensure the strategy is effective	Patient Experience Operational Group	Satisfaction audit

Effectiveness- (#Effective)

Aim	Rationale	Monitored	Measured
Increase effectiveness of the model of discharge to assess (D2A)	Ensure that patients spend only the minimum amount of time in acute hospital care	Divisional Board	The number of patients who return to their usual place of residence
Trial partial booking in colposcopy	To support patient choice.	Divisional Board	Evidence of service improvement to reduce the 'Did not attend' rates

Whilst focusing 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 2014-2015 Commissioning for Quality and Innovation (CQUIN) initiatives so they become 'business as usual', and work to implement the new CQUIN programme to support the integrated model of care across West Cheshire
- 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 and caring way
- Continue with our programme of development relating to new initiatives
- Focus on the 'Model Hospital' changes



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, targets and 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

Income generated by the NHS services in 2015/2016 represents 94.8% of the total income generated from the provision of NHS services by the Countess of Chester Hospital NHS Foundation Trust for 2016/2017.

> PARTICIPATION IN CLINICAL RESEARCH

The Countess of Chester Hospital NHS Foundation Trust is part of the North West Coast Clinical Research Network (NWC CRN) which funds NHS research activity in the hospital. A small proportion of commercial research is also undertaken.

The Research and Innovation department successfully delivers research in the following clinical specialties:

- Ageing
- Anaesthesia
- Cancer
- Cardiovascular disease
- Children
- Critical care
- Dermatology
- Diabetes
- Gastroenterology
- Haematology
- Mental health
- Microbiology
- Musculoskeletal disorders
- Renal disorders
- Reproductive health & childbirth
- Respiratory disorders
- Stroke
- Surgery

> RESEARCH ACTIVITY

The number of patients receiving NHS services provided or sub-contracted by the Countess of Chester Hospital 2015/16 that were recruited during that period to participate in research - approved by a research ethics committee was 704.

In this coming year, we expect to recruit around 800 patients onto research studies, a small reduction from the previous year. This is due to the increasing complexity of the studies and the more stringent requirements that are asked for by the study sponsors. Many thousands of patients each year are screened by our clinical staff, of which only a small proportion are actually recruited successfully.

> CENTRE FOR INTEGRATED HEALTHCARE SCIENCE

The Trust is working closely with the University of Chester and has created the Centre for Integrated Healthcare Science, based at Bache Hall in Chester. Our objective is to bring together clinical research, innovation, and initially postgraduate medical education – together in one place, for the benefit of our patients and local population. We will work closely with other local healthcare partners, including Cheshire and Wirral Partnership NHS Foundation Trust and Wirral University Hospitals NHS Foundation Trust, from a research perspective. We are supported in our aims by the North West Coast Clinical Research Network, and the North West Coast Academic Health Science Network in innovation.

> PARTICIPATION IN CLINICAL AUDITS

During 2015/16, The Countess of Chester Hospital NHS Foundation Trust engaged in 35 national clinical audits including three National Confidential Enquiries into Patient Outcome and Death (NCEPOD).

This equates to participation in 92% of relevant national clinical audits and 100% of national confidential enquiries. 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 2015/16 are listed on the following page, 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 2015/16	Participation	Data collection completed	Rate of case ascertainment
Trauma Audit & Research Network	Yes	Rolling	100%
Audit of Critical Care (ICNARC)	Yes	Rolling	Not available
National Diabetes Audit	Yes	Yes	100%
National Foot Care Audit	Yes	Yes	Not available
National Diabetes Inpatient Audit	Yes	Yes	Not available
National Pregnancy in Diabetes Audit	Yes	Yes	Not available
National Elective Surgery Patient Reported Outcome Measures (PROMs)	Yes	Rolling	Variable across four conditions
Myocardial Infarction National Audit Project (MINAP)	Yes	Rolling	99.7% - (Un-validated)
National Emergency Laparotomy Audit	Yes	Rolling	100%
College of Emergency Medicine : Vital signs	Yes	Yes	100%
College of Emergency Medicine: Procedural sedation	Yes	Yes	100%
College of Emergency Medicine: VTE in patients with lower limb mobilisation	Yes	Yes	100%
National Ophthalmology Audit	No	NA	NA
Neonatal Intensive and Special Care (NNAP)	Yes	Yes	Not available
Sentinel Stroke National Audit Programme (SSNAP)	Yes	Yes	>90%
British Association of Urological Surgeons: Nephrectomy Audit	Yes	Yes	Not available
British Association of Urological Surgeons: Percutaneous Nephrolithotomy	Yes	Yes	Not available
UK IBD Audit	Yes	Yes	Not available
National Comparative Audit of Blood Transfusion: Blood Management in Scheduled Surgery	Yes	Yes	Not available
Cardiac arrhythmia	Yes	Rolling	Not available
National Vascular Registry	Yes	Rolling	66%
Hip, knee and ankle replacements (National Joint Registry)	Yes	Rolling	Not available

National Audits 2015/16	Participation	Data collection completed	Rate of case ascertainment
Lung Cancer	Yes	Rolling	100%
Bowel Cancer	Yes	Rolling	87%
Oesophago-gastric Cancer	Yes	Rolling	61-70%
National COPD Audit	Yes	Yes	Not available
Rheumatoid and Early Inflammatory Arthritis	Yes	On-going until 2017	Not available
Falls and Fragility Fractures Audit Programme	Yes	Rolling	100% (NAIF)
MBRRACE	Yes	Rolling	Not available
Heart Failure	Yes	Rolling	100%
Renal Registry	Yes	Rolling	Not available
Child Health Reviews	Yes	Rolling	Not available
Prostate Cancer	Yes	Rolling	76%
National Paediatric Diabetes Audit	Yes	Yes	Not available
BTS Paediatric Pneumonia	No	NA	NA
BTS Adult Asthma	No	NA	NA
NCEPOD: Acute Pancreatitis	Yes	Yes	100%
NCEPOD: Non-invasive ventilation	Yes	In progress	NA
NCEPOD: Physical and mental health care of mental health patients in acute hospitals	Yes	Yes	100%

The reports of 37 national clinical audits, including 2 NCEPODs were reviewed by the Trust in 2015-16 and the Trust intends to take actions to improve the quality of healthcare provided including in the following areas:

- Cardiology
- Stroke
- A&E
- Transfusion
- Vascular surgery
- Diabetes
- Obstetrics
- Neonatology
- Elderly medicine

The reports of more than 80 local clinical audits were reviewed by the Trust in 2015/16. The Trust intends to take the following actions to improve the quality of healthcare provided, this includes:

- Development of training workshops for nursing students in the care of Parkinson's Disease patients
- Aim to develop a specific clinic for Atrial Fibrillation/DC cardioversion patients
- Establishment of new drop-in clinic for blood pressure monitoring for renal patients
- Development of new major amputation pathway

The above is not an exhaustive list of actions taken.

> GOALS AGREED WITH OUR COMMISSIONERS VIA THE COMMISSIONING FOR QUALITY AND INNOVATION FRAMEWORK (CQUIN)

In 2015/16 year to date, the Trust has achieved two of the local CQUINs fully, and the rest were partially achieved. The Trust achieved one of the national CQUINs fully and partially achieved the other two. Year to date it has achieved all the Specialist Commissioning CQUINs.

As usual, the CQUIN framework was agreed in partnership with the Clinical Commissioning Group (CCG) 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.

Disappointingly, and despite the best efforts of the clinical teams this year, CQUIN has been a real challenge in a number of areas. The increase in the number of patients who have been delayed in hospital, despite being medically well enough to go has led to an increasing length of stays in the areas agreed. This measure was one of a number of indicators that the hospital was using to measure its success rate.

The local and national schemes are described below with the achievements to date.

CQUIN	Outcome	Achieved
Emergency Care Intensive Support Team (ECIST)	To implement the ECIST action plan.	Yes
The longer term need of people in an acute phase of care is determined quickly and arrangements made for their ongoing needs	To devise a system that will ensure rapid assessment of patients during the 72 hour acute phase of admission to the Frailty Unit	Yes
Patients will be cared for in the most appropriate setting for their needs, with a focus on bringing care out of the hospital setting and closer to home.	Work with all partners to develop a joint plan to support implementation of a shared approach to minimise length of stay in hospital and increasing support outside of the hospital setting within the Emerald Unit.	No
Providers see 'incidents' as opportunities to learn and improve the quality of care for patients	To work with partners in undertaking peer reviews of selected incidents, to identify learning and implement improvements based on these.	Yes
Dementia and Delirium (NATIONAL)	To incentivise the identification of patients with dementia and delirium, alone and in combination alongside their medical conditions, to prompt appropriate referral and follow up after they leave hospital and to ensure that hospitals deliver high quality care to people with dementia and support their carers.	Yes
Urgent and Emergency Care Menu	Reducing the proportion of avoidable emergency admissions to hospital	Partial
Urgent and Emergency Care Menu	To improve recording of diagnosis rates in A&E and a reduction in the rate of mental health re-attendances at A&E	Partial
Acute Kidney Injury (AKI)	To improve the follow up and recovery of individuals who have sustained AKI, reducing risks of readmission, re-establishing medication for other long-term conditions and improving follow up of episodes of AKI which is associated with increased cardiovascular risk in the long- term.	Partial

A proportion of the Trusts income in 2015/16 was conditional on achieving quality improvement and innovation (CQUIN) goals agreed between us and our commissioner and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2015/16 and for the following 12 month period are available electronically at www.coch.nhs.uk

In 2015/16, the Trust achieved £2,825,357 of the £3,200,000 available for its CQUIN goals achievement

> CARE QUALITY COMMISSION REGISTRATION (CQC)

The Trust is required to register with the Care Quality Commission (CQC), and currently it is 'registered', with no conditions attached to registration.

The CQC has not taken enforcement action against the Trust during 2015/16.

This year, the CQC has assessed the hospital using its 'Intelligent Monitoring' tool. The model measures a number of different indicators that give an overall band from 1-6.

The Trust has been placed in Band 5 in October 2016, demonstrating a high area of compliance and assurance.

Our hospital was not required to participate in any special reviews by the CQC in 2014/2015.

The hospital has recently had its full inspection; however the report could take just over 50 days to be returned to the hospital. Once the report is agreed, the hospital will ensure that it is published in full on its website for full public viewing.

> DATA QUALITY

During 2015/16, The Countess of Chester Hospital NHS Foundation Trust submitted data to the Secondary Uses Service (SUS) for inclusion in the nationally published hospital episode statistics.

Based on the data submitted, the SUS Data Quality Dashboard reported at month nine that:

- The percentage of records which included a valid NHS number was:
 - 99.8% for admitted patient care;
 - 99.8% for outpatient care;
 - 98.4% for accident and emergency care
- The percentage of records which included a valid general practice code was:
 - 99.9% for admitted patient care;
 - 100% for outpatient care;
 - 99.9% for accident and emergency care

The following actions were undertaken during the period to improve overall Trust data quality:

- All administrative and clerical staff involved in the operational management of patients waiting to be seen, undertook a detailed programme of training relating to the key aspects of operational patient administration, helping to improve knowledge and data quality;
- The Healthcare Evaluation Data (HED) clinical benchmarking tool is now being utilised to identify variation in clinical performance. Identified variations can sometimes relate to issues of data quality; when identified, these are addressed accordingly;
- A new weekly process for the updating of deceased patients on the Trust Electronic Patient Record system using the national Demographic Batch Service (DBS) has been implemented. This has enabled weekly updates to all patients on the Master Patient Index (MPI) improving the quality of the indices;
- The new Performance Information System has been implemented enabling the development and implementation of several operational dashboards. These dashboards are assisting in the real-time identification and rectification of some aspects of poor data quality in theatres and the emergency department.
- The Operational Data Quality Group is established to oversee key aspects of data quality. Reporting bi-annually to the Trust Informatics Board, the group monitors, analyses and addresses issues in relation to data quality, escalating issues as appropriate, and ensuring that there is demonstrable year on year improvement.

The Trust was independently audited by Price Waterhouse Coopers (PWC) on behalf of Monitor early in 2016, as part of the reference cost assurance audit programme, to assess the Trust Payment by Results (PBR) process. The audit included a review of how data is processed, managed and validated for accuracy and consistency by Trust operational and Business Intelligence services. It also assessed how the Trust involves clinicians in the review and validation of data collected and reported. The results of this audit are still pending.

Clinical Coding Error Rate

The Trust was not required to undertake a Payment by Results clinical coding audit during 2015/16 by the Audit Commission.

The most recent independent Clinical Coding audit was undertaken by Mersey Internal Audit Agency (MIAA) in September 2015. This annual audit is a mandatory requirement of the Information Governance Toolkit (IGT). The audit checks the accuracy of clinical coding across all specialities, based on a randomised sample of 200 finished consultant episodes. The results of this year's audit provided 'Significant Assurance' and confirmed coding accuracy of over 92% for both the primary diagnoses and primary procedures. This level of accuracy has allowed the Trust to self-assess having achieved IGT Level 2 compliance in 2015/16 for clinical coding accuracy.



Mandated Indicators

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	44
Care of patients with a suspected ST elevation Acute Myocardial Infarction(Heart Attack)	These patients receive care at the regional centre at Liverpool Heart and Chest Hospital Other heart attack data	46
Care of patients with a suspected stroke	% of patients with appropriate care received	13
Patient reported outcome measures (PROMs) following: Groin hernia Varicose vein surgery Hip and knee replacement	Trust data regarding PROMs	44
Readmission to hospital within 28 days of discharge	% patients who are readmitted as an emergency within 28 days of discharge	46
Staff survey	% of staff who would recommend the organisation as a place of work or to receive treatment	42
Clostridium Difficile	Rate per 100,000 bed days among patients aged 2 or over	28
Patient Safety Incidents	Number of reported per 100 admissions that caused severe harm or death	30

WEST CHESHIRE CLINICAL COMMISSIONING GROUP COMMENTARY

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 regular 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.

The Trust is commended on the achievements in delivering high quality stroke care evidenced through achieving excellence levels of compliance when audited against best practice.

The Trust has not performed well against peers in the Advancing Quality scheme in a number of pathways and, based on information to January 2016, are unlikely to achieve most of the targets set. This is despite providing reassurance in 2014-15 that we would see sustained improvements this year.

We are pleased to note the progress in delivering an improved frailty pathway both within and outside of the hospital, and recognise your ongoing commitment to the partnership working that strengthens the success of this work.

We shared with you a number of concerns reported by GPs about delays in them receiving timely radiology reports. We acknowledge through the introduction of routine sharing of performance levels we now have a clearer understanding of the challenges to improving this. In recognition of the importance of timely reports following investigations to GPs and patients we anticipate that your plans in 2015-16 to remedy this will deliver improvements.

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 was evident in the post infection reviews into the cases of avoidable MRSA. These reviews are positive examples of your efforts to learn from incidents, along with the processes in the Trust for sharing learning.

We are pleased to see the elimination of the variation between overall mortality ratios and weekend mortality ratios.

It is of concern that you have had 2 Never Events and that opportunities to embed learning from previous Never Events and Serious Incidents in 2014-15 may not have been implemented successfully in all departments who undertake invasive procedures. Of significant assurance though going forward is the major piece of work done across all areas of the hospital undertaking invasive procedures to map performance against new national safety standards for invasive procedures.

The leadership and standard of service delivery across children and adult safeguarding has consistently been regarded as positive by partners.

The Trust’s efforts to increase patient feedback and better understand the experience of people accessing the Trust’s services, is noted and welcomed. During the year we raised concerns about the comparatively low return rate of Friends and Family Test Surveys and as a consequence of your decision to invest in a text system the return rate improved significantly in outpatients. We look forward to seeing this rate increase during 2016-17 across all the service lines.

We support the priorities that the Trust has identified for the forthcoming year and look forward to continuing to work in partnership with you to assure the quality of services commissioned in 2016-17.

May 2016

PART THREE

HOW WE HAVE DELIVERED OUR PRIORITIES IN 2015/16

> PATIENT EXPERIENCE

How have we improved our patients' experience?

We wanted to:

Improve the patient experience by holding a patient/service user engagement event(s)

The hospital has held three engagement events this year. Although they were not well attended, it proved a useful experience to engage with the public. The Deputy Director of Nursing and then Hospital Governor also attended a General Practice Patient Participation Group. This was a very interactive session and although there were many positive experiences for our patients, there are a number of areas we need to improve on and these have been shared with the relevant teams.

Reflect the public voice in recruitment of identified 'other' staff groups

This has been more of a challenge to achieve. Areas in the hospital have been reminded, where appropriate to involve a governor in the recruitment selection.

Improve family and patient experience by the use of patient experience volunteers

The hospital trained a very small group of volunteers to support obtaining feedback from our patients. Volunteers have also been involved in the 'My Life' project which involves using local history and pictures on an electronic board.

> EFFECTIVENESS

The Ambulatory Care Unit continues to operate six days per week – we have trialled the unit being open on a Sunday. However, the throughput has not been sufficient to justify the resource.

We have extended pathways to include numbers of clinical pathways of good clinical practice which support the patient's wishes of being treated in a day care setting.

In November 2015, we launched a GP to Clinician call system to allow a GP ringing Single Point of Access for a potential medical admission the opportunity to discuss the patient with an acute physician.

During November 2015 and January 2016, 614 calls were taken and signposted as below:

Location	Number of calls/patients
GP Assessment Unit (Ward 46)	133
Ambulatory Care Unit	158
Emergency Medicine	267
Hospital@Home	9
Surgical Referral	13
GP to monitor	18
Other (access to other service/outpatients)	22

In February 2016, we relocated the unit and are now developing an extended GP admissions unit on Ward 46 for 2016/17.



Pilot the option to an identified group of patients of a Skype clinic follow up consultation

Historically, the Colorectal Clinical Nurse Specialist Team have followed up their enhanced recovery patients with a telephone consultation post discharge. However, to move forward with the times and offer our patients an alternative/ interactive method of communication, it was suggested we could use Skype.

In November 2014, we carried out a pilot for six months which proved to be an overwhelming success with the patients who chose to enter the pilot. As with anything, there were a few teething problems but this was mainly due to poor internet connections.

Following the pilot, we have now integrated this method of consultation into our routine post-operative follow up. All colorectal patients (elective) are offered the option of follow up via Skype or telephone at pre-assessment and given information about Skype at that time. All emergency colorectal admissions are spoken to prior to discharge about what form of follow up they would like.

In September 2015, we have up to three Skype clinics – Monday afternoon, Wednesday morning and Friday morning. Currently, they are two hour clinics with half an hour allocated slots. The Wednesday clinic also acts as an emergency stoma Skype clinic for patients that have any problems or were discharged on the Monday afternoon/Tuesday morning.

The introduction of Skype has worked well for our patients as a specialised area and has been a success in the following ways:

- It has reduced the number of home visits carried out by the stoma care team, and in some cases it has removed the need for a district nurse visit
- It has reduced our patients needing to attend hospital for wound reviews
- It has facilitated patients who have wished to recuperate with relatives who are not local, and who have been able to more freely, knowing they will have a face to face interaction

Although all verbal feedback has been excellent from the patient and their relatives, we are currently running an audit to officially record its impact/effectiveness.

What does the future hold?

There are endless possibilities for the colorectal/stoma care department to develop the use of Skype consultations which is very exciting for us as specialist nurses and the patients.

We have recently received a donation from one of our patients, which has enabled us to purchase five tablet devices that will belong to the department. This will allow us to provide patients with no access to a computer at home with a tablet, enabling them to use Skype and for those patients that do not have internet will be able to access Skype.

> SAFETY

To reduce unnecessary frail elderly admissions

Our frailty service – now known as Community Healthy Ageing Team are based in Ellesmere Port hospital.

The team receives referrals from GPs, Community Care Teams and other health professionals. It offers a comprehensive assessment in conjunction with a full multi-disciplinary team (MDT) and wellbeing coordinator from Age UK. It also has a clinic at Tarporley hospital and provides home visits across West Cheshire. The team works closely with each practice and the Community Care Team, supporting them in regards to the older person's needs and wherever possible allowing them to stay at home. The Centre for Healthy Ageing also provides a falls clinic, low level exercise classes, movement disorder clinic and access to a wellbeing co-ordinator.

In July 2015, the hospital developed an Acute Frailty Ward which has twice daily consultant ward rounds and daily MDT providing a patient centred and targeted approach towards discharge. This is led by the care of the Elderly Consultant Team and they identify appropriate patients from Emergency Medicine and Acute Medicine daily to be accepted onto our frailty ward. The MDT consists of medical, nursing, pharmacy, therapies and discharge staff all working together to achieve the best outcome for each patient and family.



“
In July 2015, we launched a Discharge to Assess (D2A) project providing alternative locations (outside of the acute hospital site) for patients’ on-going assessment needs.
”

To improve patient safety in Interventional Radiology (IR)

It was decided in early 2015, to appoint a Radiology Patient Safety Lead who would report to the Radiology Department and the Head of Risk and Patient Safety.

Below is a table which shows the increase of the numbers reported.

Radiology Incidents

2013	2014	2015
201	242	404

The 2015 figures show almost a 100% increase in reporting. This increase was anticipated, as this now demonstrates a positive reporting culture of the Radiology Department. Through the Radiology Patient Safety Lead, the Radiology Department can obtain more direct feedback relating to specific incidents. Going forward, the themes and trends from the reported incidents will be monitored and actioned ensuring a robust patient safety culture.

Radiology reporting

In March 2016, the Trust invested in a new PACS system supplied by Carestream. This system will provide the Radiology Department with an improvement in reporting efficiency which will reduce the turnaround time for reports following investigations. In addition, the Trust has commenced monthly monitoring KPIs for GP reporting turnaround times and is committed to delivering a significant improvement in report turnaround in 2016/17.



OTHER QUALITY IMPROVEMENTS IN 2015/16

> WORKING IN PARTNERSHIP: WHAT OUR GOVERNORS HAVE SAID

The Council of Governors is pleased to be an integral and significant partner in the Trust. The governors' 'Quality Forum', is an open group for all governors that meets regularly and receives updates from senior members of staff, members of the Board and executive team and others. This includes the Deputy Director of Nursing who updates on quality and safety at almost every meeting. Presentations are frequently given and governors are robust in questioning and commenting on the content and plans. The Council of Governors very much appreciates that there is clear openness in the sharing of information with them.

Governors have many opportunities to participate in committees and working groups in the Trust. These include the Disability and Equality Group, the Race, Religion and Belief Group, the Organ Donation Committee which is chaired by a governor, the Wayfinding workgroup, Stop Smoking working group, the Medical Devices Group and many others.

One governor attends the Quality, Safety and Patient Experience Committee and is now preparing to take the feedback received by governors and explore ways of responding to patients and the public about those concerns and inform them of any action taken. Governors continue to make unannounced visits to wards and public areas of the Trust for 'sit and see' visits. Feedback from these is also acted upon.

The Trust had its first full Care Quality Commission inspection during the year and governors were regularly informed and participated in preparations for this visit. A group of governors met with the inspectors and was enthusiastic about the Trust and role that the Council of Governors has in the Trust.

Governors understand and support the need for a more integrated approach to health and social care and try to promote this by attending other community groups and by participating in events. They attend their Patient Participation Groups, the Health and Well Being Board meetings, Healthwatch, the Clinical Commissioning Group meetings, as well as local patient support groups, such as the Heart Support Group.

The Council of Governors is a strong team of representatives with a variety of skills and experience and they much appreciate the opportunity to contribute to the Quality Account. They are proud of their hospital and will continue to work to ensure it provides good safe and effective care in a kind way.

Our chosen indicator to be audited for the Trust was Myocardial Infarction National Audit Program (MINAP). The Trust compliance for data completeness and accuracy in 2015/16 is 99.7% compared to 94.6% in 2014/15 according to the University College London (UCL), who reports on the data reporting. Although un-validated, the 2015/16 position has demonstrated good compliance.



> INFECTION PREVENTION AND CONTROL

Description of the issues and rationale for prioritising

Ensuring that avoidable healthcare associated infections do not occur is an essential aspect of quality healthcare provision, with robust infection prevention and control practices being a key contribution to patients receiving safe and effective care.

Reducing the number of healthcare associated infections identified within the organisation remains a high priority, maintaining the focus on risk reduction to patients, visitors and staff. The routine implementation of effective infection prevention and control measures within daily practice is essential to achieving this aim, and must include robust systems to monitor, evaluate and to improve when identified as necessary.

Antimicrobial stewardship is also a national and international priority ensuring that access to working antimicrobials is sustainable into the future. This places an even greater focus on infection prevention as resistance to the drugs that we use to treat infections increases, rendering them ineffective.

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 from 'board to ward', and with the focus remaining on risk assessment and risk reduction strategies.

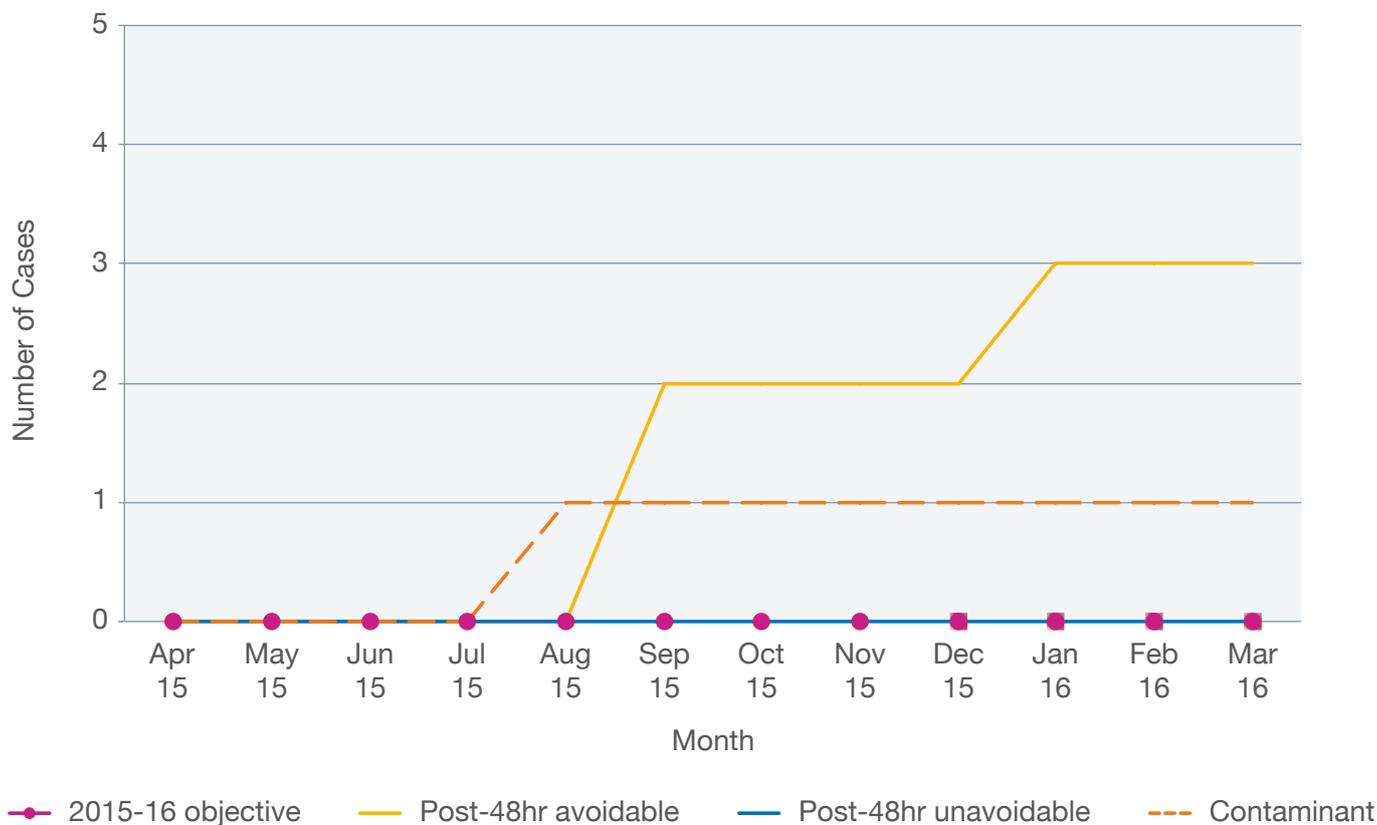
Objectives for 2016-17:

- To have zero preventable MRSA bacteraemia cases within the year
- To have 24 or fewer cases of clostridium difficile infection within the year
- To enhance focus on antimicrobial stewardship strategies, incorporating the 'Start Smart Then Focus' approach
- 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 maintain local surveillance systems, including those for antimicrobial resistant organisms, and maintain all mandatory surveillance requirements as part of national surveillance programmes

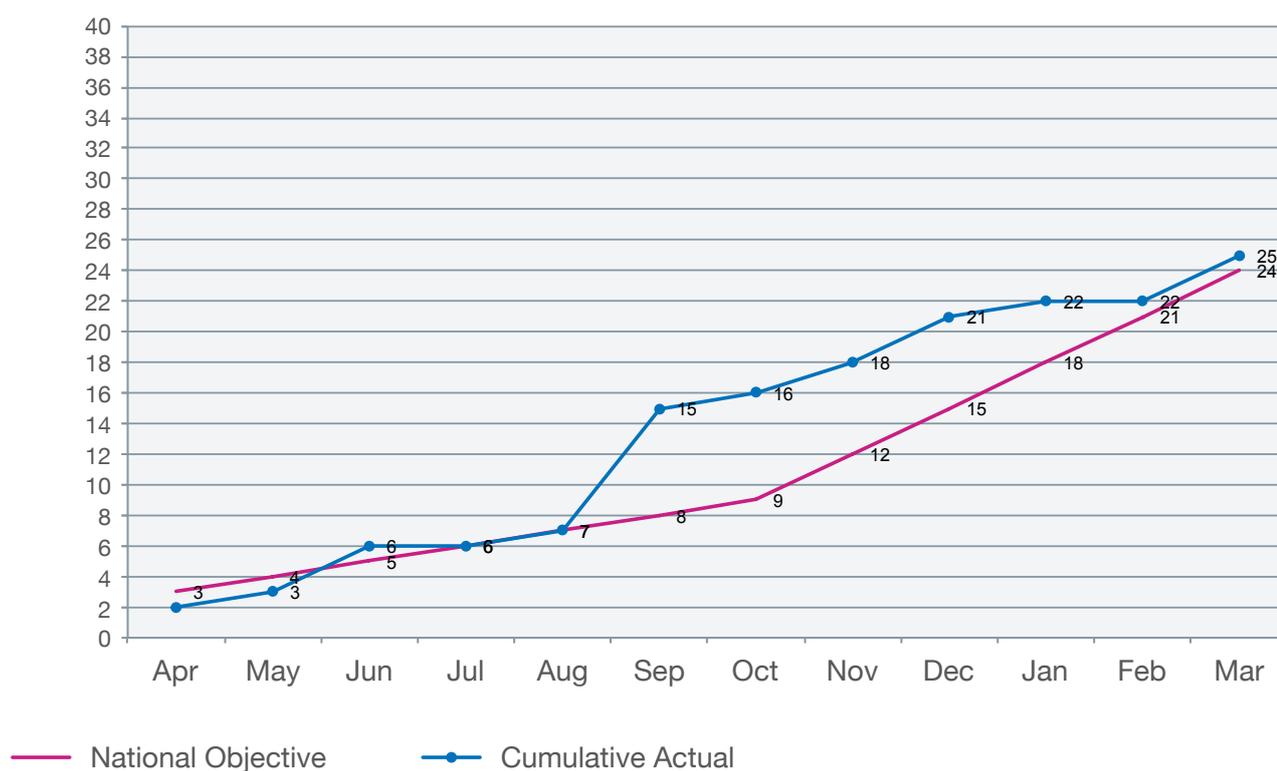
2015-16 results:

- 25 cases of clostridium difficile infection reported (set against a trajectory of no more than 24 cases within the year). This is a reduction from the 29 cases reported in the previous year (2014-15).
- 3 avoidable cases of MRSA bacteraemia identified, against the objective of zero avoidable MRSA bacteraemia within the year.
- Success in maintaining average hand hygiene compliance above the 95% minimum compliance level for the year (Average compliance score for the year calculated at 96%).
- Strengthened focus on improving compliance with MRSA screening requirements for emergency and elective admissions – local surveillance systems continue to demonstrate a downward trend in MRSA identified within the organisation.
- Success in maintaining an 'unconditional' registration status with the CQC.

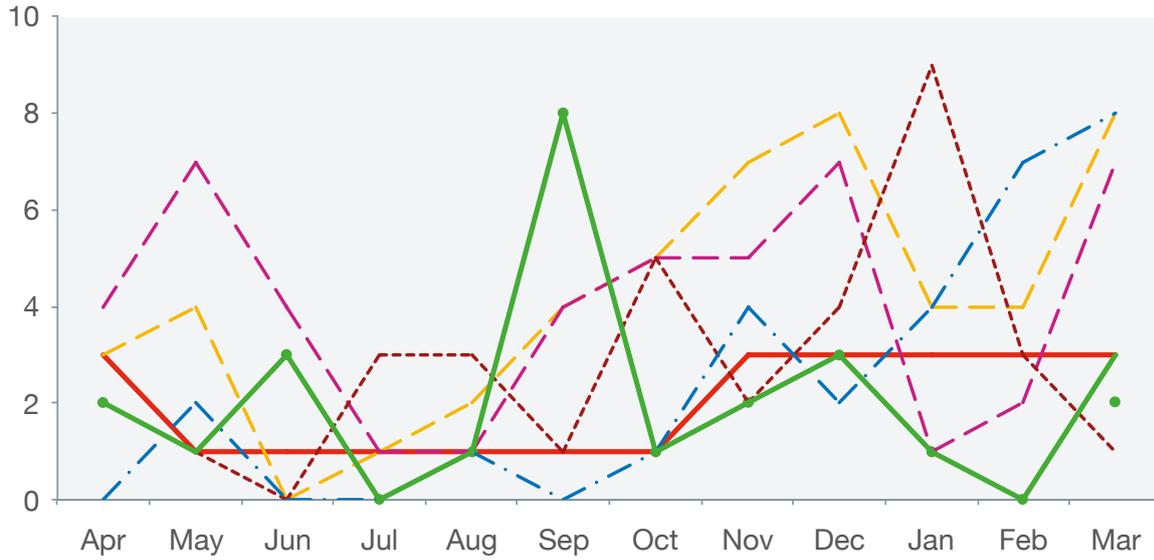
MRSA Bacteraemia 2015-16



Total Clostridium Difficile Cases 2015/16 (cumulative)



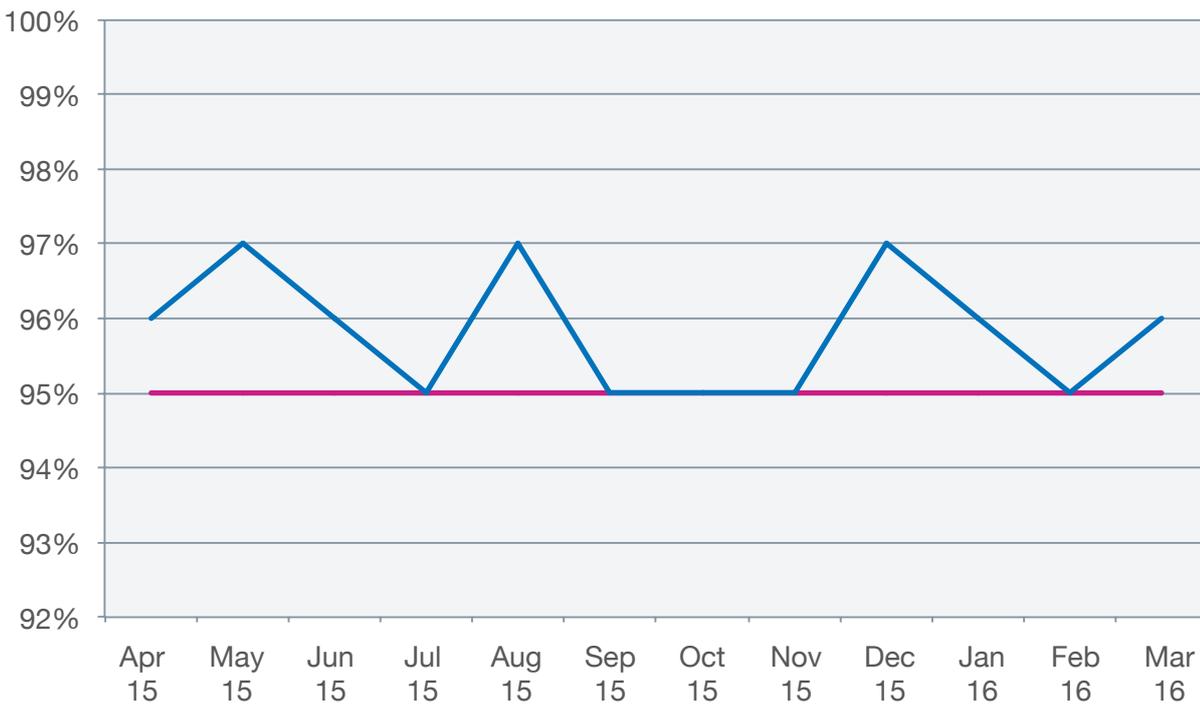
Clostridium Difficile Comparison Data 2011-16



--- 2011-12 Actual - - - 2012-13 Actual - - - 2013-14 Actual - . - . 2014-15 Actual ● 2015-16 Actual

Clostridium difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period' - 25 cases equate to 12.24 per 100,000 bed days.

Hand Hygiene Compliance Data 2015-16



— Objective % — Compliance %

Planned Focus for 2016-2017:

- The corporate infection prevention and control assurance framework, incorporating national changes to the Health and Social Care Act (2008): Code of Practice on the Prevention and Control of Infections and Related Guidance; ensuring that this continues to support all related activity, including healthcare associated infection registration requirements.
- Maintain systems of 'alert organism' review to ensure that colonised patients or those with associated infections are treated promptly and appropriately to their benefit and for wider public health within the patient population.
- Maintain new and established systems for promoting best practice to reduce the number of clostridium difficile infections via learning from root cause analyses and national evidence base.
- Strengthen antimicrobial stewardship across the organisation, ensuring appropriate antimicrobial use and risk reduction associated with antimicrobial resistance, utilising the information and resources provided by the 'Start Smart Then Focus' approach.
- Maintain new and established systems for promoting best practice to reduce the number of MRSA bacteraemia cases via learning from root cause analyses and national evidence base.
- Maintain established levels of cleanliness, both within the environment and for equipment, ensuring compliance with national cleaning frequencies and working collaboratively with facilities.
- Maintain the infection prevention and control audit 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. Utilise local surveillance to promptly identify outbreaks or periods of increased infection incidence, including but not exclusive of clostridium difficile, MRSA, plus other multidrug resistant organisms.
- Maintain training and education programmes for all staff groups, consistently reinforcing the routine implementation of infection prevention and control standards and antimicrobial stewardship for all patients, all of the time.
- Maintain systems of information dissemination to ensure that the workforce remains informed and engaged on performance against agreed objectives for healthcare associated infection reduction, adapting these as circumstances dictate.
- Ensure that the healthcare environment is fit for purpose, working collaboratively with estates and facilities.
- Continually assess any new developments in infection prevention and control (regionally, nationally or internationally) to inform and improve on practice.
- Maintain a system of policy development and review in conjunction with revised or emerging evidence-base.
- Ensure that healthcare workers remain adequately protected from infection risks within the workplace and do not as individuals pose an infection risk to others.
- Maintain systems to provide accurate healthcare associated infection information for patients, visitors and other healthcare providers to minimise risks associated with the transmission of infection, working collaboratively with healthcare providers.

> RISK MANAGEMENT

The Trust's risk management strategy provides a framework for managing risk across the organisation. The roles and responsibilities of all staff in relation to the identification and management of risk are identified in this and other related policies, e.g. Incident Reporting.

The strategy sets out the role of the Board of Directors and standing committees, including the Corporate Directors Group which is chaired by the Chief Executive and has delegated responsibility for overseeing and monitoring the risk management and assurance framework process. The group draws assurance from the Quality, Safety and Patient Experience Committee (QSPEC) and other underpinning committees.

To support listening to staff, the Trust has a number of formal and informal systems including a programme of Executive 'walk-rounds', the use of safety briefings and "huddles", Executive presence within the induction process for all new starters and the roll-out of the 'Speak out Safely' campaign.

The risk management strategy and supporting procedures set out the key responsibilities for managing risk within the organisation, including ways in which the risk is identified, evaluated and controlled. The continued use of the Health and Safety Executive's "five steps to risk assessment" model ensures that a consistent approach is applied to assessing and responding to clinical and non-clinical risks and incidents. Further progress has been made over the past year to strengthen the Trust's risk management systems and processes. This involves the recording of risks locally onto departmental/ward risk registers.

Staff are trained and equipped to manage risk in a way appropriate to their authority and duties. All new staff receive an overview of the Trust's risk management processes as part of the corporate induction programme, supplemented by local induction and organised by line managers. Further education is provided with cyclical mandatory training undertaken by both clinical and non-clinical staff; the risk content for this programme was updated in 2015. The training needs of staff are identified through annual performance and development appraisals.

The Trust's robust risk management processes were recognised during 2015/16 when shortlisted in the 'Trust of the Year' category at the national Patient Safety Awards.

Although not a winner on this occasion, the shortlisting was an opportunity to demonstrate how the Trust has embedded risk and safety processes as part of the culture of the organisation and making it 'everybody's business.'

Risk management is well embedded in the organisation in a variety of ways:

- The Trust receives assurance from the National Reporting and Learning System on reporting performance.
- The Trust has an established process for learning from past harms and the review of incidents of concern, such as where a theme is evident or where serious harm has (or could have) occurred. This is supported by the electronic risk management system, which enables the linking of incidents for thematic review and also learning from complaints, claims and HM Coroner's Inquests.

The Executive Serious Incident Panel, chaired by the Director of Nursing and Quality meets each week to review any incident in which a patient has sustained a moderate harm or greater, or incidents where a trend is evident. Agreement is reached regarding the level of investigation and in line with the Serious Incident Framework. These are reported externally to StEIS (the National Framework for Reporting and Learning from Serious Incidents requiring Investigation). These incidents, the quality of the review and report, and its subsequent action plan, are monitored internally via a monthly report to the QSPEC and via the monthly CCG Serious Incident Meeting.

During 2015/16, the Trust reported 70 incidents to the Clinical Commissioning Group (CCG) and NHS England – this equates to 0.6% of all incidents reported within the Trust in year (n=12374)

2015/16 Serious Incidents for Quality Account

Incident Category	StEIS Incident Type	Total Number of Incidents
Pressure Ulcers	Hospital Acquired Grade 3 Pressure Ulcer	5
	Hospital Acquired Deterioration of Existing Pressure Ulcer to Grade 3	12
	Hospital Acquired Grade 4 Pressure Ulcer	2
	Hospital Acquired Deterioration of Existing Pressure Ulcer to Grade 4	2
		21
Infection Control	CDI and Healthcare Acquired Infections	5
	MRSA Bacteraemia	3
		8
Serious Incidents	Surgical Incident	4
	Wrong Site Surgery (Never Event)	1
	Unexpected Admission to Neonatal Intensive Care Unit	1
	Maternity/Obstetric Incident: Mother Only Retained tampon post procedure (Never Event)	1
	Diagnostic Incident	8
	Medication Incident	4
	Treatment Delay	6
	Medical Device/Disposable Incident	2
	Slips, Trips & Falls Incident	4
	Suboptimal Care of Deteriorating Patient Regulation 28	1
	Maternity/Obstetric Incident: Mother & Baby	1
	Failure to Obtain Bed for Child	1
	Adverse Media Incident	2
	Abuse/Allegation of Abuse by Staff	2
	Maternity/Obstetric Incident: Baby Only	2
Confidential Information Leak	1	
		41
Total		70

* To note: that NHSE have agreed to 'declassify' the 12 hour ED breaches due to no harm but they are included in these figures as they have not yet been removed from our StEIS records

* To note: StEIS was updated with the SI Framework and criteria on 19th May 2015 so some of the incident categories look different from previous years

There were two 'never events' reported during this period, one 'wrong site surgery' and one 'retained foreign product post-procedure'.

Significant progress has been made in the year to further develop a whole theatre team approach to safety and full engagement with the WHO Safer Surgery checklist – with particular focus upon the pre-briefing stage. This has been reiterated via the launch of the National Safety Standards for Invasive Procedures (NatSSIPs), following which a scoping exercise of the Trust was undertaken.

Misidentification remains the theme across a number of incidents which triggered patient safety reviews. These clinical risks feature within the Trust's Sign up to Safety Improvement Plans and will continue to be a focus going forward.

How do we learn?

The hospital teams learn from good practice through a range of mechanisms including clinical supervision, reflective practice, individual and peer reviews, performance management, continuing professional development, clinical audit and the application of evidence based practice. In addition, we conduct triangulation of risks and provide further bespoke training where necessary.

The High Quality Care Costs Less work streams provide further opportunity to identify, share and learn from good practice. Lessons learned and good practice is shared throughout the Trust via mechanisms such as the QSPEC, the Operational Delivery Committee and the monthly 'Safe, Kind and Effective' bulletins.

The hospital's intranet - which our staff have access to, has been refreshed and includes a section dedicated to risk and patient safety issues. In addition, lessons learned are fed back through various team meetings and other learning opportunities.

The QSPEC as a sub-committee of the Board have provided assurance that the Trust is compliant with key recommendations from national reports and inquiries. The Committee also monitors the progress of any high risk clinical issues and serious incident action plans (including 'never events').

The Head of Risk and Patient Safety provides a monthly assurance report to the Quality, Safety and Patient Experience Committee outlining the Trust's current performance in relation to serious incident investigations, associated action plans and learning. Escalation of risk is managed via the Corporate Directors Group, where the Executive Risk Register is received and challenged.

Clinical audit is monitored on a monthly basis with the current audit programme sent to specialties for their review. Divisional reports are also received providing updates of quarterly activity. National audit activity is monitored through the Clinical Improvement and Assurance Committee.

The Clinical Improvement and Assurance Manager has introduced a bespoke module within the Trust's risk management system which supports the integration of incidents, claims and complaints within our audit programme. This work has received national interest, and was presented at the national Patient First Congress in November 2015.

How we are implementing the duty of candour

The Trust has taken the duty of candour legislation seriously. All staff receives information at induction, supported by a leaflet through the induction process and duty of candour is discussed during the welcome event and all mandatory training sessions. There is an information section dedicated to duty of candour guidance and case studies on the Trust's intranet pages.

In February 2015 a duty of candour paper was presented to the QSPEC by Alison Kelly, Director of Nursing & Quality, giving an overview, assessment and recommendations on the guidance. Our policy for investigating incidents has had its section on 'being open' reviewed and now includes a robust detailed section on duty of candour.

Our Patient Safety Improvement Plan

The Trust's Quality Improvement Strategy 2014-17 outlines the commitment to delivering consistently safe care, taking action to reduce harm to patients in our care, and moving from 'good to great' in our goal to achieve excellence in all we do. By participating in NHS England's Sign Up to Safety initiative, and the overarching goal of reducing avoidable harm, the Trust has developed a Safety Improvement Plan – the basis of which is the analysis of our local incident and claims data.

This analysis has identified six safety work streams that, it is expected, will significantly reduce harm, these are:

- **Safety work stream 1:**
Improve team effectiveness and safety culture in the operating theatres.
- **Safety work stream 2:**
Reduce the number of moisture lesions and grade two pressure ulcers within the organisation, with focus upon medical device associated pressure ulcers.
- **Safety work stream 3:**
Develop a robust system to identify babies at risk of IUGR, enabling robust monitoring of foetal growth and a reduction in harm/stillbirth rate.
- **Safety work stream 4:**
Work across the health community to improve the management of patients with sepsis pre-hospital and on admission.
- **Safety work stream 5:**
Improve safety in the requests for radiological investigations.
- **Safety work stream 6:**
Reduce the number of patient falls resulting in serious harm

The Safety Improvement Plan is aimed at improving the health outcomes and effectiveness of our care. It aims to reduce avoidable harm, thereby improving the patient experience. Further development of the Trust's 'safety culture' is essential so that the delivery of safe and evidenced-based care becomes embedded in the day-to-day practices of all Trust staff. In January 2015, the Trust applied for consideration of an NHS Litigation Authority (NHSLA) incentive payment - a financial reimbursement of up to 10% of the Trust's NHSLA annual contribution. The Trust was unsuccessful in achieving the required pass mark and it should be noted that of the 249 bids submitted in total for the incentivised payment, only 67 were successful.



> SAFEGUARDING

Safeguarding Children & Identifying and Supporting Victims of Domestic Abuse

Our safeguarding responsibilities are a top priority for the Trust and this is overseen by our Director of Nursing as the Executive Lead for Safeguarding and Chair of the hospital Safeguarding Strategy Board. Our dedicated and experienced team leads on ensuring a timely and appropriate response to safeguarding children's and domestic abuse issues in all areas across the Trust.

Our Safeguarding Children and Domestic Abuse processes are embedded in training and clinical supervision.

During 2015/16:

- The Safeguarding Children and Domestic Abuse Team has received and ensured an appropriate response to 532 Safeguarding Children Notifications from across the Trust.
- The team has dealt with and supervised midwives in 191 safeguarding children cases involving unborn children.
- This has included 288 referrals to children's social care. This has taken place because of concerns about a potential risk of significant harm to children and young people, including unborn children.

Quality Standard QS116 February 2016

In all safeguarding children's and domestic abuse cases identified, there will always be a multi-agency approach to ensuring all information available is collated and included in our initial action planning. This will include working with our health colleagues in other agencies, police, and children's social care and early support services.

This year we have undergone the following reviews:

- Local Safeguarding Children's Board Section 11 (2004 Children's Act) audit of compliance with excellent outcomes.
- Care Quality Commission inspection - Verbal comments from the inspection regarding our safeguarding children and domestic abuse processes were extremely positive.

The Safeguarding Children and Domestic Abuse Team look forward to the year ahead and remain absolutely committed to ensuring the appropriate and timely response to all Safeguarding Children and Domestic Abuse issues that arise across the Trust. This includes an ongoing and increased focus on issues such as Child Sexual Exploitation and Female Genital Mutilation (FGM).

Adults

The Adult Safeguarding and Learning Disability Coordinator has been a great asset during the year having built on the awareness raised previously, and increasing training compliance. We have supported our commissioners in safeguarding which has really ensured a whole area approach.

With the Government strategy regarding PREVENT, the coordinator will be pivotal in ensuring the training and delivery of the strategy.

We know there is still work to do to ensure that adult safeguarding continues to be recognised as a priority by all staff and responded to appropriately. During the year, the hospital has launched points of contact and named leads for adult safeguarding.

We are confident that we are making real progress to keep our patients safe.



> EQUALITY, DIVERSITY AND HUMAN RIGHTS

We now have a well-developed equality governance framework, which includes patients and third sector organisations, from across the full range of protected characteristics.

There are inclusion and engagement activities with protected groups, for example, disabled people, who are a key element to effective equality governance.

This is supported by our Equality, Diversity and Human Rights Strategy Group and the equality sub groups that report into it.

The following achievements in 2015-2016 are a consequence of our transparent, inclusive and engaging equality, diversity and human rights agenda.

We are proud to say we have:

- Attained a very high equality performance rating in the NHS equality delivery system 2 assessment, with 15 out of 18 individual outcomes being rated as “Achieving” and the remaining three outcomes being rated as “Excelling”.
- We launched our inaugural carer’s strategy to better involve carers in care and include them in the planning and review of care delivery and services

- Continued partnership working with agencies, co-facilitating health and wellbeing forums with a range of seldom heard protected groups, in order to obtain stakeholder feedback on services and health needs
- Retained the Navajo LGBTI charter mark for our policies, services and engagement with people who identify as lesbian, gay, bisexual, transgender and intersexed
- Introduced a reasonable adjustments flagging system to support patients with learning disabilities or who lack mental capacity
- Retained the “Two Ticks”:
 - Positive about disabled people accreditation for our commitment to staff that has a disability and engagement with disability groups
 - Received the annual national NHS ‘Leadership Academy Award’ for inclusive leadership for continued equality performance and developing a culture that promotes and sustains equality and human rights.
- Published our inaugural Workforce Race Equality Standard (WRES) submission



Going forward, the hospital will continue with its engagement and collaboration with stakeholder groups representing the protected characteristics.



> CANCER PEER REVIEW

The quality surveillance programme, formerly known as the National Peer Review Programme (NCPRP) is the quality assurance process for the NHS with a focus on cancer services. The programme continued into 2015 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 teams were required to undergo internal validation of their self-assessment (SAIV) by the Trust: Local Upper GI, Lung, Breast, Head and Neck, Acute Oncology, Cancer of Unknown Primary (CUP), Local Urology and Local Skin MDTs. In addition, the haematology service was subject to an external visit, although this was held at Wirral University Hospital Trust which hosts the MDT.

All of the teams were able to demonstrate areas of good clinical practice and a whole team approach was seen in many sites. Outcomes were comparable with or better than national averages. No immediate risks or serious concerns were raised, although some concerns were highlighted which have been incorporated into the individual teams' work programmes as areas to be addressed in the next twelve months.

There were some shared concerns which arose from the joint assurance meetings. One of these was around the attendance of core team

members at MDT meetings. However, this remains attributable in part to a change in the measure and the accurate recording of attendance at MDT meetings to comply with requirements, in addition to staff recruitment. There is still a challenge around oncology cover at some MDT meetings due to oncologist availability from Clatterbridge Cancer Centre (CCC).

The outcome of the external visit to the haematology team concluded that the reviewers were in agreement with the team self-assessment and good practice was recognised. However, concerns were raised around oncology cover and lack of uptake to the regional diagnostic service, which have been responded to.

There are still some outstanding actions from previous peer review visits including the lack of electronic prescribing for intravenous chemotherapy. The Trust is looking to link with the system currently being developed at CCC. There is also a planned external visit to the Cancer of Unknown Primary team in February 2016, although the MDT meeting for this is hosted at CCC.

We are currently awaiting confirmation from the Quality Surveillance Team as to how the programme will develop in the future as further national changes are planned. Until such information is received, the Trust will continue with the current programme as is considered best practice.



> TRAUMA PEER REVIEW

The hospital has been authorised as a Trauma Unit (TU) since 2012 and it forms an integral part of the Cheshire and Merseyside major trauma network. The Countess of Chester Hospital Trauma Unit stabilises major trauma patients prior to a transfer to the Major Trauma Centre Collaboration (MCCT). It also provides assessment and treatment of trauma patients with less severe and complex, but still serious injuries. Our hospital underwent a peer trauma review in 2015.

There were several areas of notable practice; examples including dedicated paediatric orthopaedic surgeons and anaesthetists on-site. Trauma simulation training conducted in the emergency department, empowered nurses to activate trauma teams which subsequently led to an increase in trauma call activation.

There was a good accreditation of trauma data at 96.9%. The reviewers commended the team for their ability to offer interventional radiology for trauma patients through the Trust hosting the South Mersey arterial service.

The team highlighted areas for the hospital to improve. Examples include the need for a Trauma Nurse Coordinator and improvement in the administration of Tranexamic Acid to trauma patients within three hours.

A Trauma Nurse Coordinator came into post in April of 2015. Over the last year, this role has helped to improve the system for patients repatriated from the MCCT with a 48 hour time frame. A multidisciplinary team approach has also been established for all repatriated trauma patients to rapidly identify and plan for their rehabilitation needs.

There has been an improvement of the accreditation data for TARN from 96.9% to 98.9% with a significant change reflected in the TARN Dashboard compliance data. Further action plans and operational policies are being developed to ensure the areas highlighted are improved.

> NATIONAL CANCER PATIENT EXPERIENCE SURVEY (NCPES)

There was no NCPES for 2015 with results from the 2014 survey only being available in August 2014.

At this current time, surveys are being sent out for the 2015/16 survey in which the Trust is participating. Throughout 2015, we continued

to work on previously identified actions around support and information for cancer patients.

The Countess of Chester Hospital has been part of the Macmillan Cancer Support eHNA pilot. This is built on a holistic needs assessment and provides an electronic form of the assessment using an iPad, with the aim of identifying patients' main concerns and enabling them to access the appropriate support. At the end of 2015, five sites were live with eHNA with a further three sites planning on going live early 2016.

In addition, local surveys have also been undertaken to ensure we are working to improve the experience of patients with a cancer diagnosis seen at the Countess of Chester Hospital.

> TRANSPARENCY – 'HOW ARE WE DOING?'

We are developing the 'How are we doing' web page. This year, the information displayed on the public website has grown.

We will continue to be transparent and publish as much information as possible.

Each month, we continue to publish the following information on our website:

- Pressure ulcers
- Falls whilst in hospital
- Nurse staffing levels
- Nurse staffing reviews
- Nurse strategy updates
- Advancing Quality indicators for conditions such as heart failure and heart attacks
- Patient satisfaction scores from 'Friends and Family'
- Patient experience report

We believe that this will help assure the public of the continual work and commitment to deliver high quality and safe patient care.

During the year, we have relaunched our nursing care metrics following a complete senior nurse review. Our compliance currently stands at over 90%.

Our senior nursing team has continued to be out and about on the wards and departments, monitoring patient care in real time.

> 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 over seven years for a number of conditions.

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
- Chronic Obstructive Pulmonary Disease (COPD)
- Diabetes
- Hip fracture
- Acute kidney injury
- Sepsis
- Alcohol related liver disease

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

Disappointingly the Advancing Quality (AQ) regional CQUINS have continued to underperform despite the Trust having a plan to improve. Work is ongoing to support these pathways and they will be continually monitored.

Current status:

The Advancing Quality data is retrospective. We are currently verified up to January. We have continued to find these areas a challenge to achieve and are not likely to achieve any of these fully. However, some of the changes put in place this year will support the ongoing effort to improve.



> PATIENT SURVEYS

In Patient 2015

This survey has highlighted the many positive aspects of the patient experience:

- Overall: 87% rated care 7+ out of 10.
- Overall: treated with respect and dignity - 82%.
- Doctors: always had confidence and trust - 80%.
- Hospital: room or ward was very/fairly clean - 96%.
- Hospital: toilets and bathrooms were very/fairly clean - 95%.
- Care: always enough privacy when being examined or treated - 91%.

2014 Results

Overall: 84% rated care 7+ out of 10.

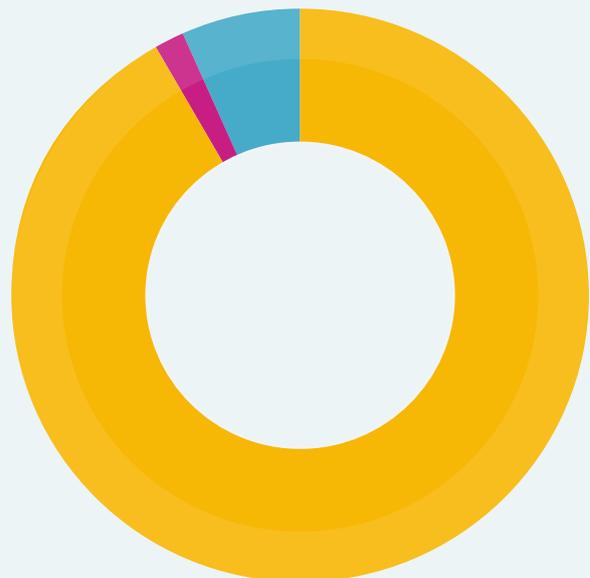
- Overall: treated with respect and dignity - 81%.
- Doctors: always had confidence and trust - 81%.
- Hospital: room or ward was very/fairly clean - 97%.
- Hospital: toilets and bathrooms were very/fairly clean - 96%.
- Care: always enough privacy when being examined or treated - 90%.

Have we improved since the 2014 survey?

A total of 62 questions were used in both the 2014 and 2015 surveys.

Compared to the 2014 survey, your Trust is:

- Significantly BETTER on 4 questions
- Significantly WORSE on 1 question
- The scores show no significant difference on 57 questions



Most of our patients are highly appreciative of the care they receive. However, it is evident that there is also room for improving the patient experience. Actions will be agreed to support improvements and these will be monitored via the Patient Experience Operational Group (PEOG)

> MATERNITY SURVEY

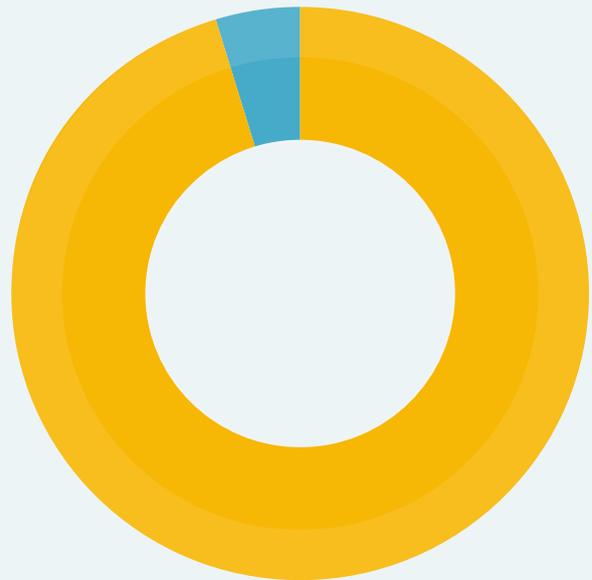
In 2014, the hospital participated in the national maternity survey. The results are displayed below. The maternity service has a number of actions they are progressing to continually improve the service it provides to women.

Have we improved since the 2013 survey?

A total of 44 questions were used in both the 2013 and 2015 surveys.

Compared to the 2013 survey, our Trust is:

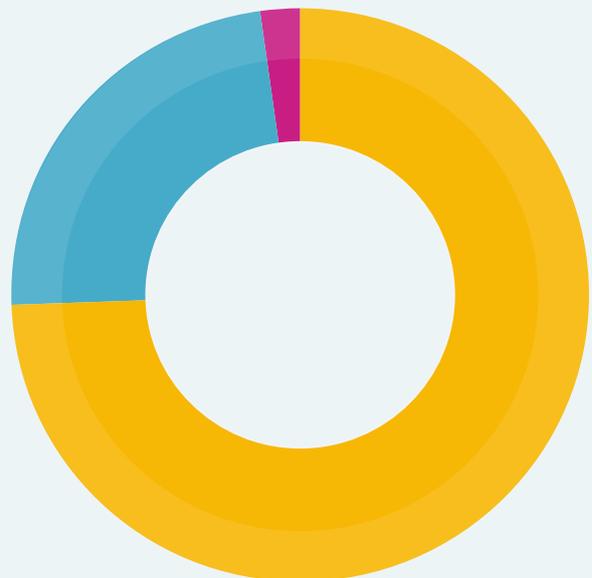
- Significantly BETTER on 2 questions
- Significantly WORSE on 0 question
- The scores show no significant difference on 42 questions



How do we compare to other Trusts?

The survey showed that our Trust is:

- Significantly BETTER on 12 questions
- Significantly WORSE on 1 question
- The scores show no significant difference on 38 questions



> FRIENDS AND FAMILY TEST 2015-2016

The Friends and Family Test (FFT) has been implemented in all adult inpatient areas at the Trust, as well as outpatient areas and, more recently, our children's ward.

At the end of 2015, the hospital changed the company that supports the implementation. As a result of this change, we have seen a significant increase in response rates, particularly from patients who have attended our outpatient clinics. We not only receive feedback by text message and cards but also from interactive voice messaging (IVM).

Results so far have been hugely positive. Last year, in our outpatient department we received very few responses (68). Following the launch in January 2016, we have received 17,349 responses based on the 56,458 surveys sent (giving a response rate of 28.3%). 11,359 responses have been received by text, 5,466 by IVM and 524 via postcard. 91% of our patients who responded would recommend the treatment they receive to friends and family.

Having such detailed information will enable us to examine the areas that need to be improved.

> STAFF SURVEY

One of the ways that we monitor staff engagement is through the national NHS staff survey which is conducted each year by the Trust, the results of which are used by the Care Quality Commission (CQC), our Commissioners and others to assess our performance.

In partnership with our Trade Union colleagues, operational colleagues and medical representatives, with governance from the People and Organisational Development committee, the hospital developed an action plan to address areas of concern. Our results are published nationally on the website.

In addition to this, we also monitor the feelings of our staff via the National Staff Friends and Family Test. For the fifth year running, we surveyed all of our staff rather than a random sample, as we believe it is important to give all our staff the opportunity to comment. Our response rate for 2015 was 40% (a reduction of 1% on 2014) and was slightly below average (40%), although we received almost 1500 responses. In part, this may be down to the increased requirements for us to additionally survey staff through the Staff Friends and Family Test and other local surveys to test the temperature throughout the organization.

Of the 32 key findings:-

- 4 (compared against 11 in 2014) have shown improvement since 2014
- 17 (compared against 1 in 2014) have remained the same
- 1 (compared against 15 in 2014) has deteriorated
- 10 (compared against 2 in 2014) cannot be compared due to changes in the questions.



Response rate 2015 compared with 2014

	2014		2015		Change
	Trust	National Average	Trust	National Average	
Response Rate	41%	42%	40%	41%	-1%

Areas of Improvement and positive findings indicated in the best 20% of Acute Trusts

Areas where staff experience has worsened compared to 2014

Future priorities

An initial summary plan has been developed with clear responsibilities, suggested executive leads and timescales put in place. The People and Organisational Development Committee will oversee the progress of the action plan, with the nominated leads personally reporting into the Committee on a regular basis.

The results of the survey and the progress we intend to make during 16/17 will be an integral element of our work around the 'Model Hospital' and will support us in measuring our progress on our cultural journey.

Quarterly Friends and Family

Each quarter, the Trust also actively offers all staff the opportunity to participate in a survey asking the following question:

Would you recommend the Trust to your friends and family?

Staff F and F 2015/16	Countess Q1	Countess Q2	National Average	Lowest Scoring	Highest Scoring
Results %	77%	88%	78.9%	48%	100%
				Mental Health Trust	Amb Trust

> MANAGING AND RESPONDING TO EXTERNAL RECOMMENDATIONS

During 2015/16, the Trust received, monitored and took action on a number of external reviews to ascertain whether there were any 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.

In all cases, there are robust systems to receive and acknowledge these recommendations, conduct an analysis, 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 SHMI values published in the last year are:

Year	COCH SHMI	ALL Trust Average	Best Trust	Worst Trust
Oct 14-Sep 15	1.04	1.03	0.69	1.26
Jul 14-Jun 15	1.06	0.96	0.69	1.24
Apr 14-Mar 15	1.05			
Jan 14-Dec 14	1.10			

Note: These values were all within the “as expected” range.

The most recent available Hospital Standardised Mortality Ratios (HSMR) is for the period January – December 2015 and is 95.81. Within this, the HSMR for weekday admissions was 96.42 and for weekend admissions 93.81. Therefore, we have successfully eradicated the gap that saw weekend admission mortality, as evidenced by HSMR, being significantly worse than that for weekday admissions.

It was reported in the Quality Accounts 2014/15, that the Trust had been required to compile a response to the CQC following notification of a mortality outlier alert for ‘epilepsy, convulsions’.

> PROMS – PATIENT REPORTED OUTCOME MEASURES

Patients receive a questionnaire before and after their operation asking about their health and quality of life. The results are compared against each other to see if there is an improvement, or not, post-operation. There are three ways of measuring:

- EQ-VAS - patients use a visual scale to record their health
- EQ-5D –patients have a choice of statements to choose one that best describes their health at the time.
- Oxford Hip/Knee and Aberdeen varicose vein – condition specific questions e.g. asking about joint pain, varicose vein skin related conditions and interference with social and domestic activities.

Hip replacement 15/16	EQ-VAS	EQ-5D Index	Oxford hip Score
Increase	60	88.9	100
Same	20	11.1	0
Decrease	20	0	0

Knee replacement 15/16	EQ-VAS	EQ-5D Index	Oxford hip Score
Increase	80	80	80
Same	0	0	0
Decrease	20	20	20

Varicose Vein 15/16	EQ-VAS	EQ-5D Index	Aberdeen VV Question
Increase	50	80	66.7
Same	16.7	20	0
Decrease	33.3	0	33.3

Groin Hernia 15/16	EQ-VAS	EQ-5D Index
Increase	40.7	61.5
Same	18.5	26.9
Decrease	40.7	11.5



QUALITY MEASURES

> EFFECTIVENESS

Age	readmissions within 28 days	Admissions	%
0-15	563	5268	10.69
16+	2630	48145	5.46
Total	3193	53413	5.98

> ADVANCING QUALITY

Indicator	Threshold	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Hip & Knee	92.7%	70.0%	86.0%	61.0%	72.0%	92.0%	91.0%	88.0%	78.3%	Not available
Community Acquired Pneumonia	75.1%	64.0%	63.0%	80.0%	80.0%	72.0%	78.0%	61.0%	51.0%	61.7%
Heart Failure	79.3%	59.0%	55.0%	84.0%	93.0%	80.0%	82.0%	60.0%	69.0%	80.0%
Acute MI	94.2%	65.0%	100.0%	87.0%	94.0%	94.0%	86.0%	92.0%	100.0%	93.3%
COPD	50.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Fractured Neck of Femur	50.0%	12.0%	6.0%	16.0%	14.0%	26.0%	21.0%	0.0%	7.0%	4.5%
Sepsis	50.0%	29.0%	36.0%	37.0%	37.0%	46.0%	26.0%	29.0%	25.0%	28.6%
AKI	50.0%	X	X	5.0%	0.0%	8.0%	0.0%	0.0%	10.0%	0.0%
Diabetes	50.0%	11.0%	10.0%	0.0%	15.0%	0.0%	0.0%	29.0%	0.0%	28.6%
Alcohol Related Liver Disease	50.0%	25.0%	20.0%	33.0%	25.0%	17.0%	43.0%	17.0%	33.0%	Not available

Note: the following data is the Trust's audited data and may be subject to change

> RESPONSIVENESS

The Trust is mandated to report its responsiveness to patient's needs. The information is made up of patient responses to five questions asked in the inpatient survey.

Year 2013/14	Countess of Chester Hospital	Average from 211 Trusts	Worst	Best
Responsiveness %	69.2%	68.4%	58.8%	79.2%

Note: We are awaiting the next results

> MONITOR COMPLIANCE TARGETS

RAG		Target	Actual	Comments
Infection Control Targets				
R	Clostridium Difficile	24	25	
R	MRSA	0	3	
Waiting Times				
R	% RTT incomplete Pathway	92%	90.2% Last 6 months	91.7% Full year 15/16
R	Total time in A&E	95%	89.18%	
Cancer Targets				
G	14 days –all cancers	93%	96.67%	
G	14 days-breast symptomatic	93%	95.40%	
G	31 day – decision to treat to treatment	96%	99.30%	
G	31 days –subsequent surgical treatment	94%	97.16%	
G	31 days - subsequent non-surgical treatment	98%	100%	
R	62 days – first treatment from urgent GP referral	85%	81.58%	
G	62 days –first treatment from screening referral	90%	98.65%	
G	Monitor Governance rating			

Note: Cancer figures may change as the March figure is still un-validated



This has been a very challenging year for the hospital in maintaining the emergency standards access measure of 4 hours. Whilst performance has been achieved within the summer months (Quarter 2), the last six months of the year have proven extremely difficult to achieve the 95% standard. The Trust has continued to work in partnership with other health and social care organisations to support the performance of the emergency department and the timely discharge of patients into the appropriate health and social care setting.

The performance to meet the 18 week waiting time (incomplete pathway) standard has been a challenge over the later months of the year, due to emergency pressures and increasing demand on elective services as well as the industrial action by the junior doctors. The Trust Access Policy provides the operational framework for the management of patients who are waiting for elective treatment. The Trust continues to produce routine elective waiting time data (both inpatient and outpatient), which is subject to review and analysis in-line with good standards of corporate governance.

Within the final quarter of 2014/15, the Quality Account's audit identified two issues:

- 1 A requirement to retain monthly validated Patient Target Lists, which was actioned with immediate effect;
- 2 An issue of interpretation relating to 18 week 'clock pauses' which after further clarification was actioned and reflected in the management of the 18 week standard. The Trust has clarified the RTT incomplete pathway following the audit, which had demonstrated some erroneously reported 'pauses' in the pathway. Therefore, there are two figures reported:-
 - The current one is the last 6 months of data 2015/16.
 - The comment and percentage alongside is the full year end position, following the problem not being rectified to a satisfactory conclusion for the first 6 months of 2015/16 from the pathway as the solution and training to enable this is a permanent happened in the first 6 months of this year.

Individual staff, who were involved with the collection and recording of this data have been made aware of their responsibilities and receive annual mandatory training.

The Trust continued to achieve all cancer standards except for the 62 day standard which, although this has improved remains a priority. To improve the performance, a significant amount of work and investment has been placed into the service and while the standard continues to be difficult, the number of patients waiting over 62 days has continued to reduce.

The Trust has maintained performance with regard to clostridium difficile. Against a target of 24 cases for the year, the Trust ended the year with 25. The Trust reported 3 cases of MRSA for the year and continues to work towards a target of no cases for the upcoming year.

PART FOUR

WRITTEN STATEMENTS BY OTHER BODIES

> GOVERNORS' QUALITY ACCOUNT STATEMENT

Governors continue to monitor the quality of safety and effectiveness of the patient and staff experience at the Trust. They value the openness and quality of the information and presentations from the executive team and take every opportunity to challenge and question the Board of Directors.

During the last year the Trust has faced many challenges, with increasing numbers of sick and frail patients presenting at the hospital, delays in discharge of 'medically optimised' patients and financial constraints, in common with the rest of the country. Governors have been kept informed throughout and are pleased with the success of the Ambulatory Care Unit and the further developments to extend the GP involvement with hospital clinicians to help reduce the number of admissions.

The establishment of the Centre for Healthy Ageing based at Ellesmere Port hospital is also acknowledged as a welcome development to improve safety and reduce the length of stay and need for admission of frail elderly patients.

Governors have also taken a particular interest in gathering feedback from the experience of patients and are pleased to note the considerable increase in responses to the 'Friends and Family' test. It was disappointing that the engagement events were not well attended but the input from the Deputy Director of Nursing is valued and it is pleasing that these events will continue with lessons learnt for the future.

The plan to establish a peer review process to review responses to complaints to ensure that these are empathic and responsive to the concerns of patients is a very welcome one with which governors will be pleased to be involved.

Governors are hugely impressed by the good will and hard work put in by every member of staff at the Trust and are delighted with the developments in occupational health, fitness classes and initiatives to support staff wellbeing. The Carers' Strategy which has been developed to involve carers in the delivery of care is important, particularly as it is an opportunity to identify and support members of staff who are also carers. It is to be hoped that the outcomes of these developments will be reflected in the numbers and responses to the staff survey in future.

It was disappointing that there have been two 'never' events during the year; governors have noted that these have been thoroughly reviewed and lessons learned and monitored. When there are so many pressures on staff who are often 'going the extra mile' it is important that safety is not compromised and governors will continue to note and challenge signs such as staff sickness and turnover.

The Quality Account highlights the wide range of achievements of the Trust and governors congratulate those awarded for success and hard work.

These are challenging times throughout the NHS and governors are grateful for the opportunity to review and comment on the Quality Account; they will continue to monitor the experiences of patients to improve and ensure that they receive safe, kind and effective care.



healthwatch

Cheshire West

Response to Quality Accounts Document – Countess of Chester Hospital (COCH)

Healthwatch Cheshire West (HWCW) values the opportunity to comment on these quality accounts. COCH continues to be the main hospital Trust supporting residents of Chester, Rural Cheshire and Ellesmere Port.

In regard to the document Healthwatch Cheshire West would like to make the following comments:

- We feel that the executive summaries at the beginning of the document form a useful précis, however, we feel that where possible hyperlinks could be added so that those individuals reading electronically are able to follow up award nominations etc. In addition we feel that more explanation should be given to certain phrases e.g. ‘never event.’ What is it? What lessons are to be learned?
- In relation to award nominations, where appropriate, we feel individuals should be given credit. e.g. *Craig Hough/Sue Miller (Catering Award Nomination)*.
- HWCW endorses the priorities for improvement section and in particular the matrix explanation following; although we feel a separate “timescale” column would give greater strength to the information as presented.
- **Clinical Audits** – We note the significant number of these detailed; however, no detail is given to the reader as to if this is a good thing or bad thing for those service users using the hospital?
- We would like to see a brief summary on how this work benefits patient outcomes and feel the bullet points of planned actions need greater detail – perhaps something similar to the tables used in the ‘priorities for improvement’ section of the document.
- **Commissioners’ goals (CQUIN)**
 - HWCW are pleased to see that some of these goals have been achieved in full. In particular we would congratulate the Trust on its achievements on identification dementia/delirium.

- In relation to those targets that have only been partially achieved. We feel that this document should include a little more information - to indicate to the reader any barriers that have prevented achievement. e.g. *Resources and plans/actions put in place to improve this performance.*
- In relation to the ‘appropriate setting for need’ target HWCW feel that greater explanation is required. We note comments in relation to the above missed targets but in relation to future goals, feel that more information could be included here; to inform the reader of specific plans and actions to improve performance and additional information on what the challenges are and; What specifically has caused patients to be ‘delayed in hospital’ over the period?
- **From the delivery of priorities section:**
 - We feel that the Skype system used for some of the clinics is a good idea and something that could be expanded and developed further.
 - We feel that this section is comprehensive and detailed but in places hard to read with some of the graphs hard to understand (even when enlarged using the computer). Some sections have a clear summary at the beginning of each section (good) others not so much. We hope this may be edited prior to publication.
- **Patient surveys:**
 - HWCW expresses some concern over wording choices in relation to surveys. How can toilets or wards be fairly/very clean? We feel that they are clean or not and that the term ‘fairly clean’ is unacceptable.

Healthwatch Cheshire West feels that overall the document is positive, well produced and gives a good and fair account of service. However, in order to encourage more people to view its contents, we would like to see less technical language used in future; or if this cannot be avoided, due to subject matter; a simple summary at end or beginning of each section and an appendix of technical words and abbreviations used.

In addition, in order to give a broader picture of work at the hospital and so set its place in the community, we would like to see some reference to other hospital related goings-on including building improvements and community activity, e.g. *detail on the £25,000 Aviva Award November 2015.*

We note the comments from Healthwatch and have made some changes. However, some of the text and indicator presentations are nationally mandated so therefore we are unable to change the format. In light of the comments made, we have also reviewed the glossary of terms.

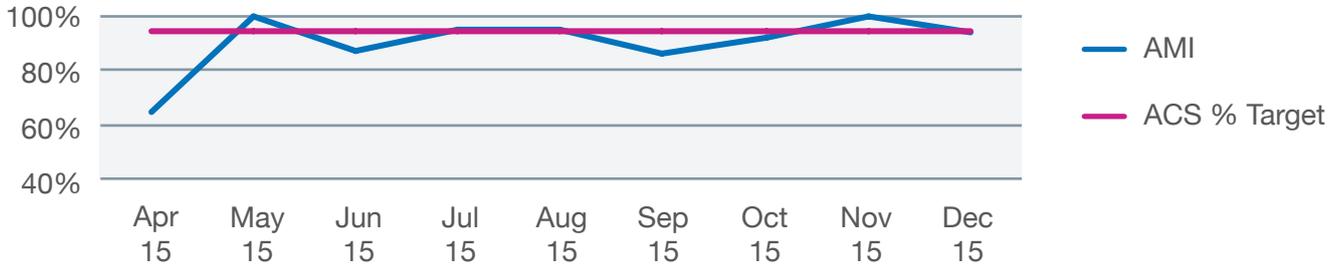
Countess of Chester Hospital NHS Foundation Trust

May 2016

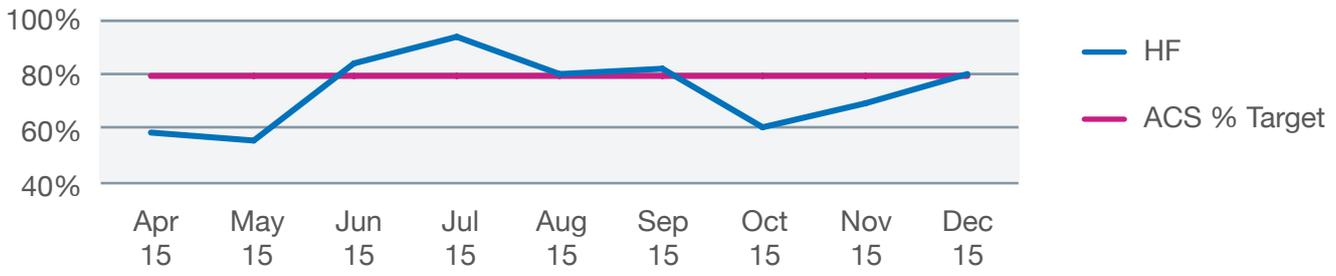


> ADVANCING QUALITY MEASURES

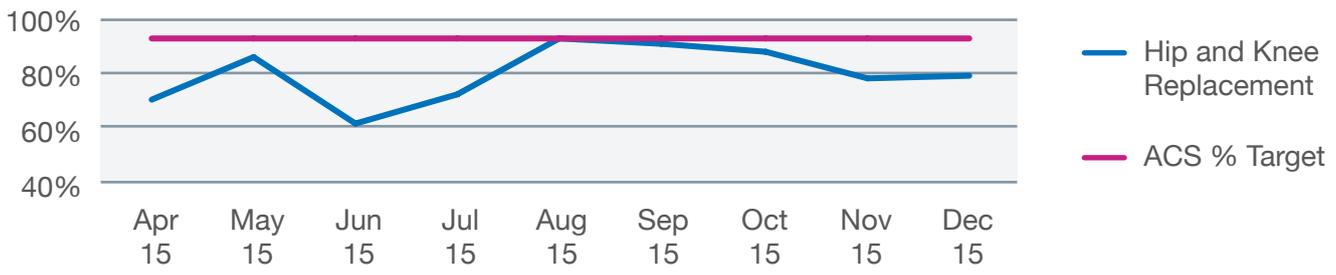
AMI



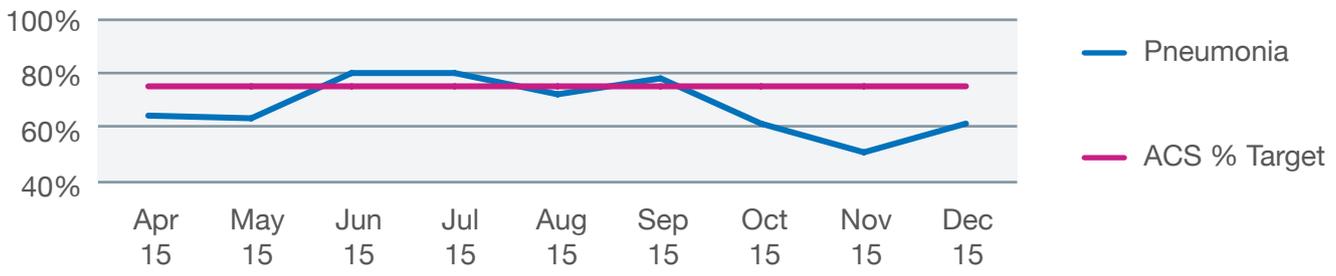
Heart Failure



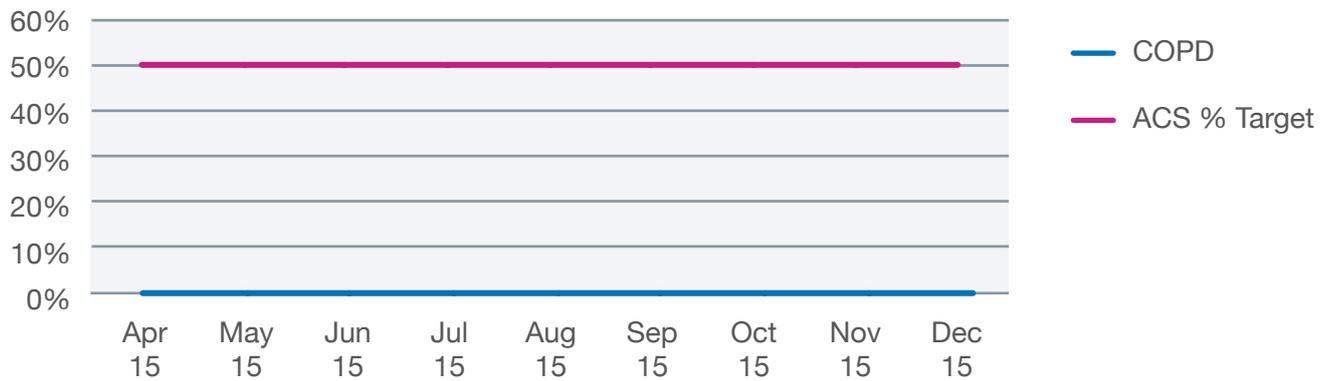
Hip and Knee



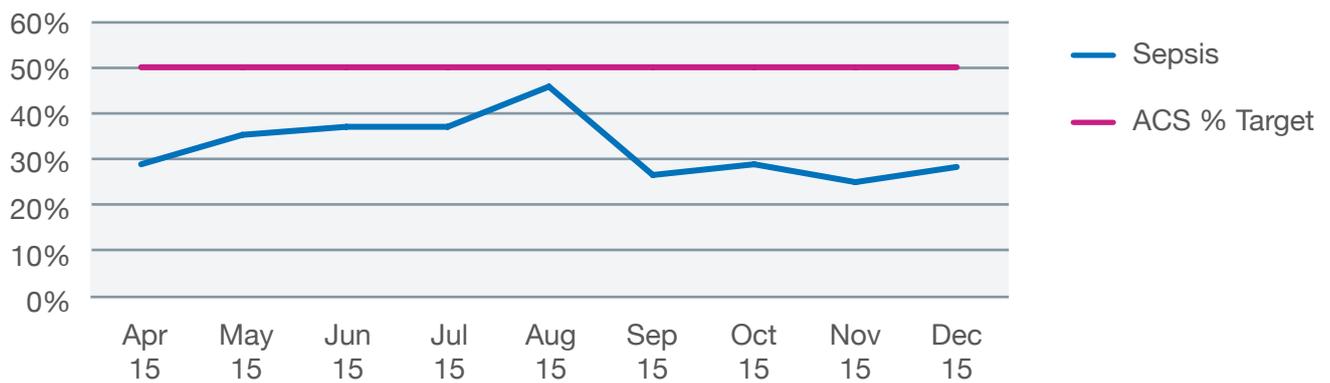
Pneumonia



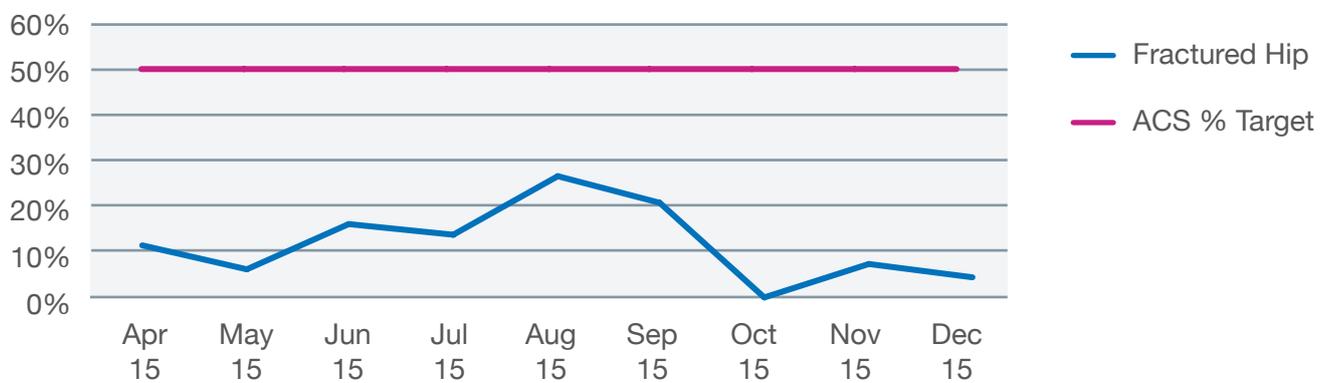
COPD



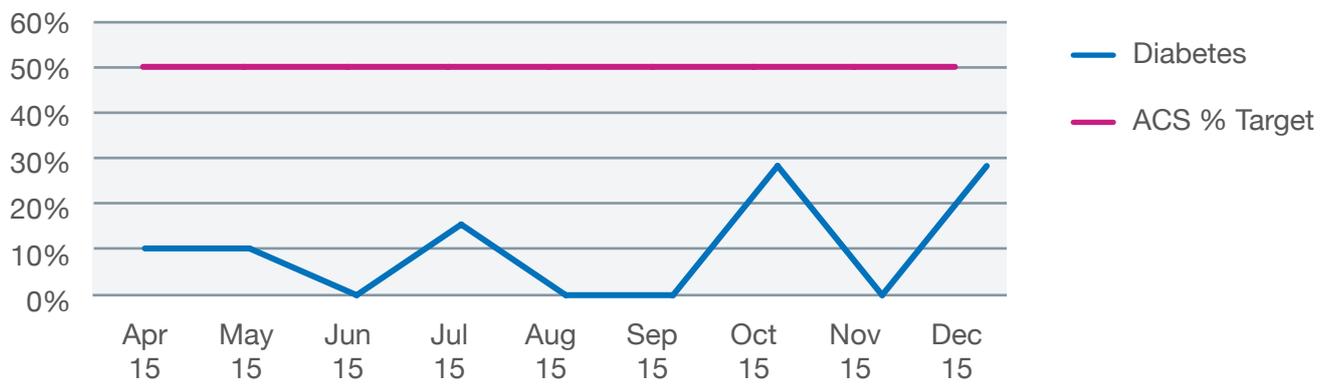
Sepsis



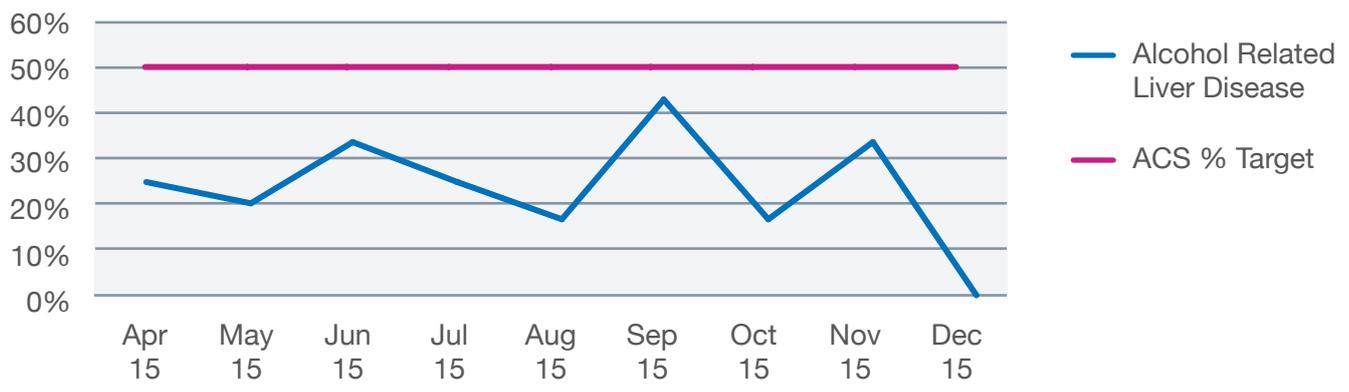
Fractured Hip



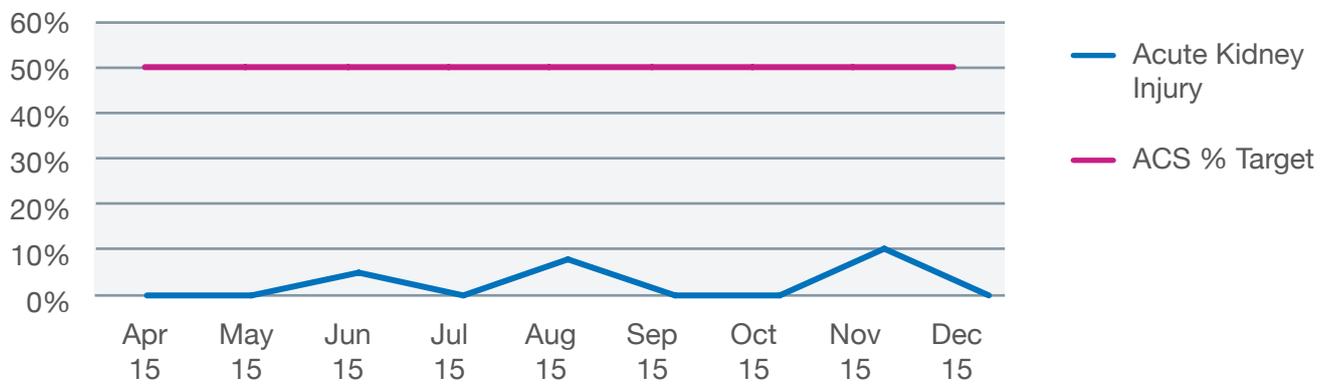
Diabetes



Alcohol Related Liver Disease



Acute Kidney Injury

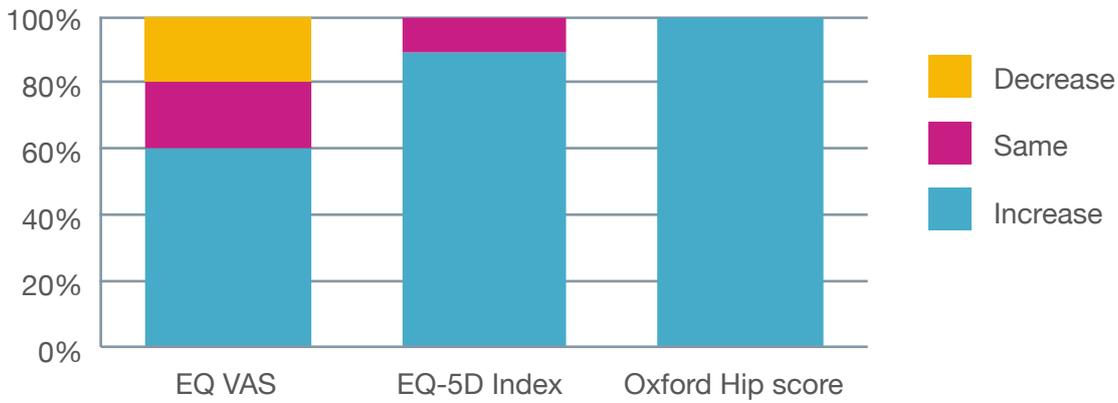


> PATIENT RECORDED OUTCOME MEASURES

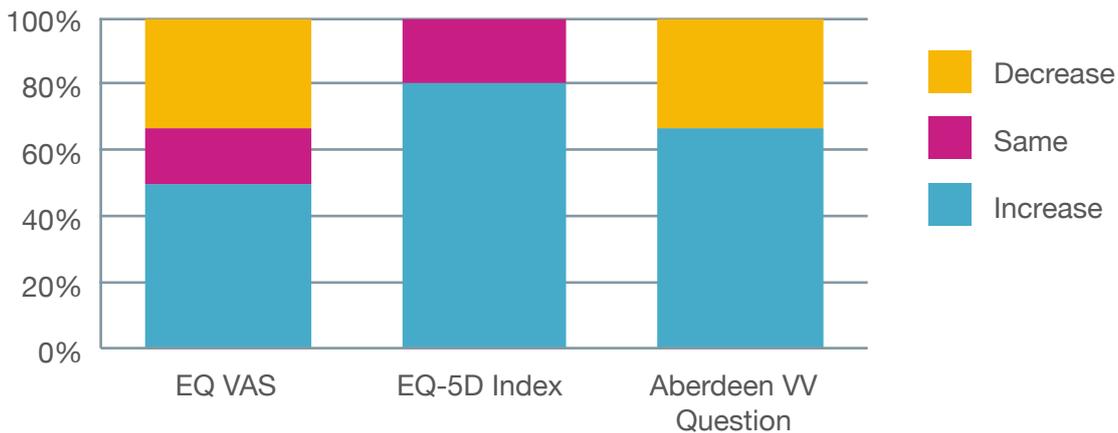
Knee Replacement



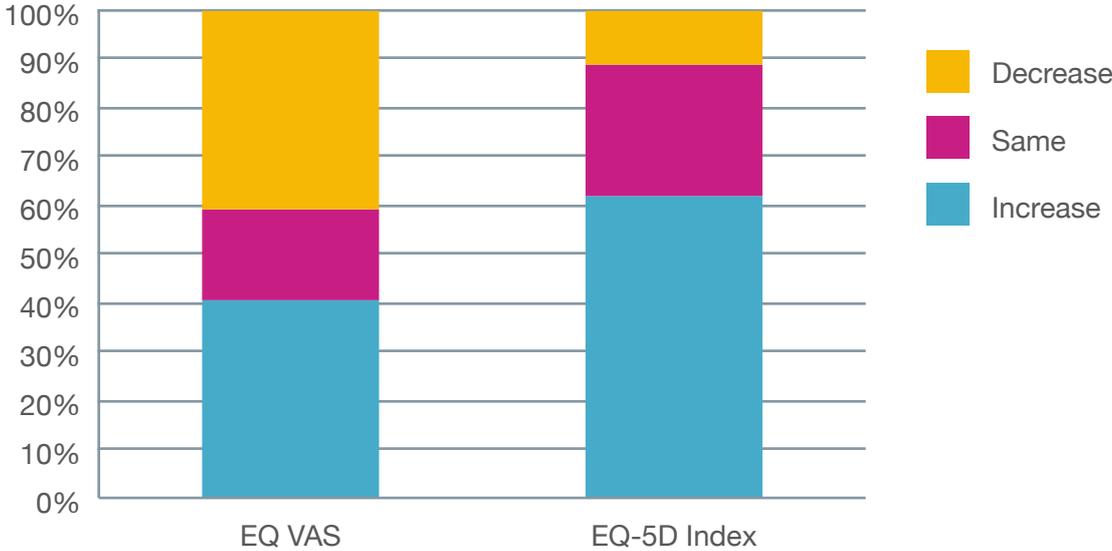
Hip Replacement



Varicose Vein



Groin Hernia



APPENDIX

APPENDIX 1 - GLOSSARY & ABBREVIATIONS

Term	Abbreviation	Description
Accident and Emergency	A&E or ED	The Emergency Department, usually at a hospital.
Acute Oncology	AO	Refers to the management of the unexpected care needs of the patient with cancer, including emergency situations and the acutely unwell patient
Advancing Quality	AQ	A programme which rewards hospitals to improve care on a number of key areas – heart attacks, pneumonia, hip and knee replacements, heart failure and heart bypass surgery – when compared to research which identifies what best care constitutes.
Anti-microbial stewardship		Refers to a set of coordinated strategies to improve the use of antimicrobial medications with the goal of enhancing patient health outcomes, reducing resistance to antibiotics, and decreasing unnecessary costs.
Bacteraemia		The presence of bacteria in the blood
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.
Cardiac Arrhythmia	CA	Also known as cardiac dysrhythmia or irregular heartbeat, is a group of conditions in which the heartbeat is irregular, too fast, or too slow
Care Quality Commission	CQC	The independent regulator of health and social care in England. It's aim is to make sure better care is provided for everyone, whether that's 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.
Colorectal		Relating to or affecting the colon and the rectum.

Term	Abbreviation	Description
Colposcopy		A colposcopy is a procedure to find out whether there are abnormal cells on or in a woman's cervix or vagina
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 organizations 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.
COPD		Chronic obstructive pulmonary disease is the name for a collection of lung diseases
Cystoscopy		This is a medical procedure used to examine the inside of the bladder using an instrument called a cystoscope
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 returning 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.
Gastroenterology		This deals with disorders of the stomach and intestines
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.
Haematology		This is a specialty covering the diagnosis and treatment of blood disorders
Healthcare Associated Infections	HCAI	A generic name to cover infections like MRSA and C-diff.

Term	Abbreviation	Description
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.
Intrauterine growth restriction	IUGR	Refers to a condition in which an unborn baby is smaller than it should be because it is not growing at a normal rate inside the womb
Laparoscopy		Otherwise known as keyhole surgery, is a medical procedure used to examine the interior of the abdominal or pelvic cavities.
Laparotomy		This is any major surgical procedure that involves opening the abdomen
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.
Myocardial Infarction	MI	Known medically as a heart attack
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.
Nephrectomy		Nephrectomy (nephro = kidney, ectomy = removal) is the surgical removal of a kidney
Neonatology		This is a subspecialty of paediatrics that consists of the medical care of new-born infants, especially the ill or premature new-born infant
Never Events		These are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
Obstetrics		Concerned with childbirth and midwifery.

Term	Abbreviation	Description
Oesophago-gastro-duodenoscopy	OGD	Known more simply as a gastroscopy or endoscopy. This is an examination of your oesophagus, stomach and the first part of your small bowel called the duodenum.
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.
Percutaneous Nephrolithotomy	PCNL	This is a procedure to remove a kidney stone or stones.
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		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.
Sepsis		Also referred to as blood poisoning or septicaemia, this is a potentially life-threatening condition, triggered by an infection or injury
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		This is a care Quality Commission requirement of registration and described 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.
Stoma		A stoma is an opening on the front of your abdomen (tummy) which is made using surgery. It diverts your faeces or urine into a pouch (bag) on the outside of your body
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 2016 (the 'Quality Report') and certain performance indicators contained therein.

> SCOPE AND SUBJECT MATTER

The indicators for the year ended 31 March 2016 subject to limited assurance consist of the following two national priority indicators (the indicators):

- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period; and
- A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge.

> 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 and supporting guidance 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 and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Detailed Guidance for External Assurance on Quality Reports 2015/16 ('the Guidance'); and

- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and supporting guidance and the six dimensions of data quality set out in the Guidance.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and supporting guidance 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 and papers for the period April 2015 to 24 May 2016;
- papers relating to quality reported to the board over the period April 2015 to 24 May 2016;
- feedback from commissioners May 2016;
- feedback from governors May 2016;
- feedback from local Healthwatch organisations dated May 2016;
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the latest national patient survey dated May 2015;
- the latest national staff survey received February 2016;
- the 2015/16 Head of Internal Audit's annual opinion over the Trust's control environment dated April 2016; and

- the latest CQC Intelligent Monitoring Report dated May 2015.

Feedback from Overview and Scrutiny Committee was requested on 13 May 2016 but not received.

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 the NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2016, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Countess of Chester Hospital NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

➤ ASSURANCE WORK PERFORMED

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

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicator;
- making enquiries of management;
- testing key management controls;

- limited testing, on a selective basis, of the data used to calculate the indicators back to supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual and supporting guidance to the categories reported in the Quality Report; and
- reading the documents.

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

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

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance.

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was determined locally by Countess of Chester Hospital NHS Foundation Trust.

> BASIS FOR QUALIFIED CONCLUSION

As set out on page 47 of the Trust's Quality Report, the Trust currently has concerns with accuracy of the "percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period" data presented in its Quality Report. For the first six months of the financial year (April 2015 to September 2015), clock pauses were erroneously included within the data for this indicator, which is not compliant with the Guidance. Whilst for the second six months of the year (October 2015 to March 2016) clock pauses were correctly excluded, the Guidance requires that the figure included in the Quality Report is a twelve-month arithmetic average.

As a result of these issues, we are unable to conclude that nothing has come to our attention that causes us to believe that the "percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period" indicator for the year ended 31 March 2016 has been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and supporting guidance and the six dimensions of data quality set out in the Guidance.

> QUALIFIED CONCLUSION

Based on the results of our procedures, except for the effects of the matters described in the 'Basis for qualified conclusion' section above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2016:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance; and
- the indicator in the Quality Report subject to limited assurance has not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and supporting guidance and the six dimensions of data quality set out in the Guidance.



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26 May 2016



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