Countess of Chester Hospital NHS Foundation Trust

Quality Account

2012/2013

Quality Account

2012/13

Contents

Part One

Summary Statement on Quality from the Chief Executive

The Countess has an outstanding record of success and there is much to be proud of and in 2012/13 we saw another busy and challenging year for the Trust and a period of significant change. The Trust said goodbye to my predecessor Peter Herring who led this remarkable organisation for 12 years together with Sir Jim Sharples the previous Chairman who retired after a long term of office. We also said goodbye to the Director of Nursing and Quality, Gaynor Hales and have seen other changes in our Non-Executives.

In late 2012 I took up post as the new Chief Executive and joined our newly appointed Chairman, Sir Duncan Nichol and together we have worked with our partners within the Clinical Commissioning Group (CCG) to describe the future shape of healthcare moving forward into 2013/14.

The Countess of Chester Hospital NHS FT has had another successful year. Below are just some of the highlights:

- The new Cardio, Respiratory and Vascular Department was opened by Beth Tweddle.
- We were accredited with Trauma Unit Status.
- We achieved the highest NHS Litigation Authority standards in both Maternity and Acute Services demonstrating our excellent commitment to patient care and safety.
- We became a Healthcare Financial Management Association Efficiency Award Winner 2012 for our Microbiology project.
- Our Emergency Department was reported to be among the best performers in the country in a national patient survey.
- We achieved significant quality improvements – in pressure sore reductions, infection control and dementia care.
- We launched our most ambitious fundraising appeal yet - the Babygrow Appeal which supports an improved Neonatal care facility.

The Trust hosted two Care Quality Commission (CQC) inspections during 2012/13 at both the Ellesmere Port site and the Countess site. At both sites inspectors spoke with patients, relatives and ward staff. Patients and relatives reported how they were treated with respect, consulted about their care and treatment and how they are provided with the information needed to make informed decisions regarding their care. We welcomed the feedback from the visits and actions are now complete to address two areas of minor concern relating to self-administration of medicines and record keeping at Ellesmere Port Hospital. Full inspection reports are available on the Trust website and also the CQC website.

During February 2013 the Trust celebrated National Dignity Action Day with a number of events involving patients, public and staff and our Nursing cadets from West Cheshire College.

We actively engage with patients, service users, our membership and other stakeholders. West Cheshire Local Improvement Networks (LINks) and Flintshire Health Board have again conducted 'Enter and View' visits during the year, which resulted in positive feedback about the dignified care our patients receive. The groups noted that the discharge lounge was not always 'patient friendly' and we have held a discharge focus group with patients and set up a discharge group to explore how we can improve discharge on the day. We continue to work with the voluntary sector particularly with a regard to the care of older people. Engagement with groups like the Alzheimer's Society and the Parkinson's Society has continued to demonstrate better outcomes for patients who are affected by these conditions.

Our Council of Governors continues to be proactive and we have a healthy Trust membership to which we continue to recruit. During the year we strengthened these links further with a newly established Quality Forum. This forum has enabled our Governors to have a true involvement in the organisation's direction, has enabled particular issues to be discussed and challenged with clinician support and has developed and managed the Governor Clinical area visits programme.

We have continued to deliver our services in line with our Quality Strategy, which in light of the new Board members, will be refreshed in 2013/14. We continue to review our services and have been successful in being awarded the Vascular Service for all patients south of the river Mersey. This service will be up and running later this year. We were also awarded the contract for a new Bariatric Surgery service which commenced in April 2012. A review of our administration systems has progressed and a full skill mix consultation is now being progressed, with a plan to improve technology to further improve these services.

The Francis Report detailing the shocking lapses of care at Mid Staffordshire NHS Foundation Trust was published in February 2013. This report has serious implications for the whole of the NHS and there are important lessons to be learnt. This Trust believes that no hospital should rest on its laurels and despite the achievements described above, has instigated a review of its services against the recommendations made in the Francis Report. Any areas identified as needing improvement


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will be acted upon during 2013, in an effort to continually improve and provide the best possible care for our patients.

Quality drives the Board agenda and strategy and ensures that the priorities agreed are focused on delivering high standards of care to our patients. The Board's members are relatively new and as such have a fresh outlook on the quality agenda going forward. The newly developed Quality & Safety Committee is responsible for ensuring all quality, safety and patient experience topics are discussed and challenged. This Committee is chaired by a Non-Executive Director supported by the Director of Nursing & Quality and Medical Director. Divisional representatives sit on this Committee, and there is a two-way mechanism of feeding issues and best practice from Divisions to the Board. All significant risks associated with quality, safety and patient experience will be articulated and monitored by the Quality & Safety Committee. A development programme is in place to support new members of the Board and recognises that the quality agenda is a key topic area in this programme. The Director of Nursing & Quality and Medical Director have commenced clinical walkabouts, Non-Executive Directors will join these walkabouts in the near future. The new Chairman is very visible in the organisation.

In 2012/13 the Trust had twelve local Commissioning for Quality and Innovations (CQUINs) to achieve, agreed with our Clinical Commissioning Group. We look to achieve full recognition for the delivery of ten and partial achievement of two where some indicators were partially met. We are very keen to have timely feedback on our services and the experience of care delivered within the Trust. The Friends and Family Test has been operating since February with some positive results so far; that said we are disappointed not to have achieved the National Patient Experience CQUIN this year despite making a 4% improvement in the areas reviewed.

We remain committed to our Equality Scheme, and we have active subgroups working on this agenda to make sure our patients are treated fairly, with respect and equality in a dignified way and who can make informed choices, as is their right. Our Equality Delivery System has been assessed through external consultation. I am pleased to report that our status was judged to be one of 'achieving' with further areas moving positively from the developing stage.

This is a really interesting time for the Trust. After years of growth, the NHS is now facing its biggest ever financial challenge. Our demographics are challenging too, with the number of people over the age of 75 due to double over the next 25 years. Meeting our local population's needs, particularly diseases associated with increasing frailty, will require the health and social care services to truly work together and overcome professional and organisational boundaries that too often have made this difficult. To achieve this we must work hand-in-hand and build upon our relationships and collaborative work with local partners.

In my view we have to see this situation as an opportunity. It is an opportunity to "think differently" and to make fundamental changes to

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

It will be no great surprise to anyone that we have a significant financial challenge in the coming year. This is a very harsh reality however; we know we have to do our best for our communities and patients within these resources. There are very few areas of healthcare that we can stop without either unacceptable consequences for patients or a financial impact on a different part of the health service or an impact in the future. Therefore if we are to live within the resources available to us we need to focus not so much on the money itself but on changing what we do and how we do it from what we have now to a truly integrated approach. The guiding principles for this are -

- The patient voice must be at the heart of all provision.
- Consultant opinion is an essential component of effective integrated services.
- The delivery of integrated services will rest primarily on extended roles for Nurses and Allied Health Professionals (AHPs).
- Integrated services must incorporate social care.
- Future integrated services should bring together the full range of primary care.

Together with our partners within the Clinical Commissioning Group (CCG) we are using these to help guide and describe the future shape for Integrated Care at its Best in West Cheshire and these will form the basis for our plans going forwards.

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

Tony Chambers
Chief Executive

Statement of Directors' Responsibilities in Respect of Quality Accounts

The Directors are required under the Health Act 2009 and the National Health Service Quality Accounts Regulations to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS Foundation Trust Boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that Foundation Trust Boards should put in place to support the data quality for the preparation of the Quality Report.

In preparing the Quality Report, Directors are required to take steps to satisfy themselves that –

- The content of the Quality Account meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2012/13.

- 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 2012 – March 2013
    - Papers relating to quality reported to the Board over the period April 2012 – June 2013
    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated July 2012
    - The 2012 Inpatient Survey: January 2013
    - The 2012 National Staff Survey: Received February 2013
    - The Head of Internal Audit's annual opinion of the Trust's control environment dated 31.03.13
    - Care Quality Commission Quality and Risk Profiles received monthly and on occasion bimonthly in 2012/13
    - Feedback reports from Western Cheshire Clinical Commissioning Group (CCG)
    - Feedback reports from Countess of Chester Hospital NHS Foundation Trust Governors
    - Feedback reports from the Local Improvement Networks (LINks)

- The Quality Report presents a balanced picture of the Countess of Chester Hospital NHS Foundation Trust's performance over 2012/13.
- The performance information reported in the Quality Account is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account and these controls are subject to review to confirm they are working effectively in practice.
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Account has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations -published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/ annualreportingmanual).

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

By order of the Board

Chief Executive

Chairman

Part Two

Priorities for improvement in 2013/14

The Trust has a significant number of quality and safety improvement initiatives planned for 2013/14 agreed by the Board and in the Trust's Annual Plan. The following information focuses on our key priorities as we move forward.

We have made our choices based on our patient, staff and public involvement events; information taken from our patient survey responses both nationally and locally; complaints themes and concerns raised by Commissioners following feedback received form colleagues in Primary Care.

Our key priorities have been chosen to reflect the three domains of quality defined as follows -

Experience

This is about improving the experience as described by 'you' our patient when using the service for any reason.

Clinical Effectiveness

This is about improving the outcome of any assessment, treatment and care you receive in order to optimise health and wellbeing at all stages of illness.

Safety

This is about improving and increasing the safety of any care or service provided.

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

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

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

Experience

Aim	Rationale	Monitored	Measured
To improve the patient experience via Council of Governors engagement events with the membership and wider public regarding care delivery and service at the Trust with a particular focus on communication and information	Communication and information is a key issue in many complaints incidents and Governor concerns	Via the Governor Quality Forum and the Quality and Safety Committee	At least 6 events a year to be held Outcome reports from each received, discussed and actioned by the Quality and Safety Committee
To assess the outcomes for patients from the introduction of care and comfort workers in planned care	This role is a pilot in 2013/14 to support the care and comfort of patients receiving inpatient care	Via the Planned Care Divisional Board and the Quality and Safety Committee	Roles to be evaluated through a series of patient engagement / surveying and use of Friends and Family test information
Make key improvements to the environment for patients with dementia	Make key improvements to the environment for patients with dementia	xVia the Quality and Safety Committee	At least three environmental improvements will be made in 2013/14 and described in detail within next year's account

Effectiveness

Aim	Rationale	Monitored	Measured
To provide additional assurance to the Board of Directors that clinical care meets the required CQC standards of Quality and Safety	To support the inspection process and provide a range of robust assurance methods regarding the quality of care provided	Via the Governor Quality Forum and the Quality and Safety Committee	All ward areas and clinical Departments to receive one clinical assessment visit per annum. 2 visits per year should be unannounced enter and view
To optimise the health outcomes of patients who have suffered a stroke	Merging the acute and rehabilitation elements of the stroke pathway will optimise the health outcomes of this patient group	Via Divisional Board for Urgent Care and the Quality and Safety Committee	Whole pathway within a dedicated one site unit with good outcomes regarding discharge to original place of residence
To introduce seven day working in Radiology	To remove delays in the patient pathway	Via Radiology Directorate Board and the Quality and Safety Committee	Reduced turnaround times for inpatients, particularly those requiring Magnetic Resonance Imaging (MRI).
To provide alternatives to inpatient admission for paediatrics through clinical streaming in A&E and utilisation of paediatric hospital at home	Children thrive in the home environment where family life and normal routines can be maintained	Via paediatric speciality meetings and the Urgent Care Strategy Group	Outcome report to be received at 6 months Targeted reduction in paediatric admissions

Safety

Aim	Rationale	Monitored	Measured
To carry out a full and concise review of all aspects of falls management and make a targeted reduction in the numbers and level of harm across the 5 highest falls areas identified	The Trust has worked hard to reduce falls and the harm associated with them, however patients are still falling with some cases of severe harm	Via the Quality and Safety Committee	Target reduction to be in place at end of Quarter 2 Year-end reduction
Self-administration of medicine for suitable patients on a rehabilitation pathway	This is a CQC requirement which has commenced but needs expansion and evaluation through 2013/14	Via the Governor Quality Forum and the Quality and Safety Committee	Number of patients on the pathway and positive outcomes
Maternity Assessment processes	The Trust has seen an increase in serious incidents relating to processes on arrival at the labour suite, not meeting mothers' requirements	Via the Planned Care Divisional Board and the Quality and Safety Committee	Robust systems in operation Reduction in incidents relating to assessment processes
Reducing harm, variation and waste regarding patient pathways	The Trust has seen an increase in the complexity of patients admitted via the Emergency Department	Via Operational Delivery Committee - progress against the implementation of clinical streaming, Early Supported Discharge processes, and ambulatory care. Progress in working towards an integrated health system	Reduction in harm Increase in timely, safe discharges Information and performance data systems to support the above projects

While targeting the above areas, we will continue to -

- Maintain high standards of infection prevention and control as detailed in the Health Act 2009.
- Embed our 2012/13 Commissioning for Quality and Innovation (CQUIN) initiatives so they become 'business as usual', and work to implement the new CQUIN programme.
- Meet the requirements of our Quality Contract with our Commissioners.
- Continue to develop our workforce to ensure they have the skills to deliver quality care in the most effective way.
- Continue with our programme of development relating to new initiatives.

Capacity and Capability

The Trust has a central Quality Team, which provides a corporate approach to quality initiatives and monitors the organisation's progress. Commitment to 2013/14 includes the continued provision of the Team and additional funds of £100,000 to support ongoing quality improvement work.

Working in Partnership with our Council of Governors

Our Quality Forum for our Governors was established early last year and is now an embedded Forum within the organisation. The Forum is also attended by our Non-Executive Directors.

The Forum has received information regarding the progress of the organisation as follows -

- Regular updates regarding the Quality contract and Trust priorities.
- Updates regarding the strategic direction of travel.
- Information regarding serious untoward incidents and the actions for improvement.
- Liaison with the CQC regarding their role.

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

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

There has also been lively debate with clinician involvement regarding clinical pathways e.g. End of Life care and Dementia care.

Our Governors continue to be involved in the now new Patient Led Assessment of the Care Environment teams (PLACE) and are also involved in a number of forums associated with the delivery of quality care.

In 2012/13 two of the local quality priorities for the organisation involved our Governors role.

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 to it on the quality of care in the form of audits both local and national and there are a number of local mechanisms in place to ensure that data regarding quality of care is monitored and improved in all of our services as follows -

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

The income generated by the NHS services reviewed in 2012/13 represents 93% of the total income generated from the provision of NHS services by the Countess of Chester Hospital NHS Foundation Trust for 2012/13.

There are robust arrangements at Divisional and Organisational level to monitor and review clinical performance via Divisional Governance Committee structures and through the Trust's Quality & Safety Committee. As part of these governance processes the Trust undertakes both local and national audits on the delivery of clinical services.

Throughout 2013/14 the Trust will commence detailed reviews of clinical services to formulate a strategic assessment of each clinical area. To support this work and to co-ordinate and facilitate the delivery of projects across the organisation the Trust established a Programme Management Office (PMO) in February 2013. The PMO will work with the Divisions to review clinical services from an operational, clinical and financial perspective. These reviews will ensure that each service is viable across each of these key areas and that the clinical services meet the needs of the local population.

Participation in clinical research

The number of patients receiving NHS services provided by the Countess of Chester Hospital NHS Foundation Trust in 2012/13 that were recruited during that period to participate in research approved by a Research and Development Committee was 935. Examples include –

- Stroke – TICH-2 – Checking the efficacy of a blood clotting agent in patients who have had a brain haemorrhage.
- Paediatrics – WAIT – Parent initiated intermittent treatment for pre-school wheeze.
- Haematology – MYELOMA XI – Assessing first line treatment for newly diagnosed blood cancer patients.

Participation in clinical audits

During 2012/13, The Countess of Chester Hospital NHS Foundation Trust engaged in 49 national clinical audits including 3 National Confidential Enquiries (NCEPOD).

There were several national audits and National Confidential Enquiries into Patient Outcome and Death (NCEPOD) audits which were not relevant to the Trust and this equated to a participation rate of 71% in relevant national clinical audits and 100% national confidential enquiries from the Trust.

The national clinical audits and National Confidential Enquiries that the Countess of Chester Hospital NHS Foundation Trust was eligible for, and did participate in includes:

National Audits 2012/13	Participation	Data collection completed	Rate of case ascertainment (%)
National Diabetes Audit	Yes	Yes	100%
Trauma Audit and Research Network (TARN)	Yes	Ongoing	Not available
National Audit of Dementia	Yes	Yes	100%
Head and Neck Oncology	Yes	Ongoing	Not available
Audit of Critical Care	Yes	Ongoing	100%
Epilepsy in Children (Epilepsy12)	Yes	Ongoing	100%
National Diabetes Inpatient Audit	Yes	Yes	100%
National Elective Surgery Patient reported Outcome Measures (PROMS)	Yes	Ongoing	Variable across 4 conditions
Myocardial Infarction National Audit Project (MINAP)	Yes	Ongoing	100%
Obstetric Surveillance	Yes	Ongoing	100%
Sentinel Stroke National Audit Project	Yes	Yes	Not available
National Review of Asthma deaths	Yes	Yes	100%
Neonatal intensive and special care	Yes	Yes	100%
UK IBD Audit (Round 4)	Yes	Ongoing	Not available
BHIVA audit of HIV patients not in care	Yes	Yes	Not available
Heavy Menstrual Bleeding	Yes	Ongoing	Not available

National Endometriosis Centre audit	Yes	Ongoing	Not available
Hip, knee and ankle replacements (National Joint Registry)	Yes	Ongoing	100%
Lung cancer	Yes	Yes	100%
Bowel cancer	Yes	Yes	Not available
Oesophago-gastric cancer	Yes	Yes	Not available
National Pregnancy in Diabetes audit	Yes	Ongoing	Not available
Treatment regimens for HIV patients	Yes	Yes	100%
NHSBT UK Transplant Registry - Renal	Yes	Yes	Not available
Carotid interventions audit	Yes	Yes	93%
Blood component transfusion in patients with liver cirrhosis	Yes	Ongoing	Not available
Heart failure audit	Yes	Yes	100%
Renal registry	Yes	Yes	Not available
Child Health Reviews – epilepsy in children	Yes	Yes	Not available
Consultant sign off	Yes	Yes	100%
Renal colic audit	Yes	Yes	100%
Fractured neck of femur audit	Yes	Yes	100%
Feverish children audit	Yes	Yes	100%
Sloane DCIS/LCIS and atypical hyperplasia audit	Yes	Ongoing	Not available
Breast cancer outcome measures	Yes	Ongoing	100%
Screen-detected breast cancers	Yes	Ongoing	Not available
Invasive cervical cancer	Yes	Ongoing	Not available
National Paediatric Diabetes audit	Yes	Yes	100%
Facing the Future: Audit of acute paediatric units	Yes	Yes	100%
Prevention of surgical site infections	Yes	Yes	100%
Accidental awareness during general anaesthesia	Yes	Ongoing	Not available
National Comparative Audit of Transfusion	Yes	Yes	Not available
Bronchiectasis	Yes	Yes	Not available
COPD Discharge	Yes	Yes	100%
Emergency Oxygen	Yes	Yes	Not available
National Pain Audit	Yes	Yes	Not available

National Confidential Enquiry into Patient Outcome & Death	Participation	Data collection completed	Rate of case ascertainment (%)
Alcohol Related Liver Disease	Yes	Yes	100%
Subarachnoid Haemorrhage	Yes	Yes	100%
Tracheostomy	Yes	In progress	Organisational level questionnaire submitted; data collection in progress

The National Confidential Enquiries in which the Countess of Chester Hospital NHS Foundation Trust participated is the same list as above as we engaged in every audit that was eligible, and for which the data collection was completed during 2012/13. They are in the list above alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases submitted to each audit or enquiry, where available.

The reports of 11 National clinical audits, including three National Confidential Enquiry reports were reviewed by the Trust's Quality Committee in 2012/13.

The Trust also undertook 99 audits for the purposes of assessment for NHSLA Level 3, as well as a programme of audit for assessment for CNST Level 3.

Actions taken by the Countess of Chester Hospital NHS Foundation Trust to improve the quality of the healthcare provided include ensuring that CPR status is recorded and documented for all acute admissions through the electronic nursing records and the commencement of a Paediatric Epilepsy clinic.

This is not an exhaustive list of improvements but provides examples of ongoing actions.

The reports of more than 80 local clinical audits which are completed and reported on were reviewed by the provider in 2012/13 and the Countess of Chester Hospital NHS Foundation Trust intends to take the following actions to improve the quality of the healthcare provided -

- Re-developed the Trust guidelines for the care of paediatric patients with osteomyelitis.
- Action being taken locally to improve documentation to enable better standards of clinical coding.
- Action and ongoing training being taken to improve junior doctors' awareness of the paediatric safeguarding documentation.
- The establishment of a healthy eating group for pregnant women.


WARNING DO NOT FILL

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

This section is still wrong on the quality account on page 18 – it should be this:

2.5% of the Countess of Chester Hospital NHS Foundation Trust income in 2012/13 was conditional on achieving quality improvement and innovation goals agreed between Countess of Chester Hospital NHS Foundation Trust and NHS Western Cheshire Clinical Commissioning Group (CCG) through the Commissioning for Quality and Innovation (CQUIN) payment framework. In monetary terms, this equated to £3,512,802.

In 2012/13 the Trust achieved 6 of the local CQUINs and partial achievement of two and non-payment for the National Patient Experience CQUIN. This achieved £3,297,758 in monetary terms.

The CQUIN framework was agreed in partnership with the Clinical Commissioning Group and involved close working with clinicians from both primary and secondary care. The schemes are described below with the achievements to date.

CQUIN Title and description	Achieved Y/N partially
Inpatient Diabetes care To improve the outcomes of inpatients with diabetes admitted to all wards through early detection of foot problems and self-care pathways	Y
Improving parents' experience of midwifery services Using focus groups to understand how midwifery services can be developed	Y
Improving children's experience in acute services Using real time data from children to improve their experience of services they access	Y
Appropriate Care for Patients with a Learning Disability Implement the 'Getting it Right Charter' to ensure that people with learning disabilities accessing acute care have their needs managed appropriately.	Y
Urgent GP Access to Secondary Care Opinion Use a system of access to urgent clinic slots to avert an unplanned episode	Partially. Not all letters following a clinic appointment were received by the GP in a timely manner
Screening and interventions for alcohol use To identify patients at risk from an alcohol related problem and then direct to the appropriate pathway	Y
Improving care for inpatients with dementia Improving the outcomes of inpatients with dementia through the use of specialist support and early intervention, to reduce admissions and length of stay	Y
Shared Decision Making in chosen care pathways Use of national patient decision aids for localised prostatic cancer and Amniocentesis/ CVS to reduce unwarranted variation in terms of treatment options chosen and service utilisation and improved adherence to treatment recommendations	Y
Shared Decision Making in general Outpatient clinics Use of a simple tool to prompt patients to feel empowered to ask questions and feel more involved in their care and their ability to make informed choices based on the ethos 'No decision about me without me'	Y
Chronic Obstructive Pulmonary Disorder discharge care bundle The use of a care bundle at the point of discharge for COPD patients to promote self-care opportunities and supportive discharge.	Partially. Not all letters following a clinic appointment were received by the GP in a timely manner
Care and comfort interventions for inpatients Creating an optimal patient experience through the use of a care bundle to focus on care, comfort, dignity and compassion.	Y
Paediatric Continence Develop Specialist Paediatric Continence Nurse role to enable further reach in to community setting.	Y

We were pleased to achieve the National Venous Thromboembolism assessment CQUIN and the new Dementia CQUIN but were disappointed not to have achieved the National Patient Experience CQUIN but did achieve a 4% improvement on last year's scores.

Care Quality Commission Registration (CQC)

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

The Care Quality Commission has not taken enforcement action against the Countess of Chester Hospital NHS Foundation Trust during 2012/13 however the organisation had 2 minor areas of non-compliance following an inspection at the Ellesmere Port Hospital rehabilitation site.

The Countess of Chester Hospital NHS Foundation Trust is subject to periodic reviews by the Care Quality Commission. The Trust was subject to two periodic reviews in 2012/13, which took place in November 2012 at the Ellesmere Port site and in February 2013 at the Countess site. The reviews looked at respecting and involving people who use services, care and welfare of people who use services, staffing, medicines management, safeguarding and records. The Care Quality Commission reports, following both visits, were extremely positive. The Countess of Chester Site had no conditions applied. The Ellesmere Port site had two minor non-compliances relating to self-administration of medicines and health records management. An action plan has now been completed regarding the non-compliance.

The Countess of Chester Hospital NHS Foundation Trust was not required to participate in any special reviews by the Care Quality Commission in 2012/13.

Data Quality

Data Quality Assurance:

The Trust has rigorous data quality assurance processes. The operational Data Quality Group meets on a bi-monthly basis and is well attended by all areas of the Trust. The group focuses on standard data quality issues such as NHS number and GP completeness as well as specific data quality issues such as overseas visitors, and other topical areas. A data quality report is produced on a monthly basis and this is presented at the meeting. This meeting reports through to the Quality and Safety Committee where significant issues are raised and actioned. In addition to this, relevant items are also discussed at the Trust's Health Informatics and Governance Board. The Trust's commissioners also provide the Trust with data quality reports which are actioned as part of the commissioning process. In 2012/13 the Countess of Chester Hospital NHS Foundation Trust took the following actions to improve data quality –

- To ensure that any significant data quality issues are visible within the Integrated Performance Report received by the Board of Directors.
- Any remedial action will be clearly defined and monitored by the Quality and Safety Committee.

NHS and General Medical Practice Code validity:

The Countess of Chester Hospital NHS Foundation Trust submitted records during 2012/13 to the Secondary Users Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was -

- 99.8% for admitted patient care
- 99.9% for outpatient care
- 98.7% for accident and emergency care.

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

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

Based on SUS Data Quality dashboard (month 10).

Information Governance Toolkit Attainment levels:

The Countess of Chester Hospital NHS Foundation Trust's score for 2012/13 Information Governance compliance is assessed using the Information Governance Toolkit and was 73%, graded satisfactory, which is a significant improvement for the Trust.

The Information Governance team will continue working towards and strengthening the Trust's position in specific key areas with a focus on further auditing and improving the Trust's current information asset register and associated framework.

Clinical Coding Error Rate:

The Trust was audited by the Audit Commission in January 2013. The clinical coding of 180 patient episodes was audited as well as key data quality indicators. The Trust has received a draft summary of the audit findings but a report is yet to be received.

The error rate for the coding of the primary diagnosis code was 7.7%- this compares very favourably to a national error rate last year of around 12%. The error rate for primary procedure coding was 6.9% - again comparable to a national average error rate last year of 10%. The audit of the extended data set (including age on admission, admission method, sex and length of stay) found no errors in these data items.

The results should not be extrapolated further than the actual sample audited which was a selection of episodes. 80 episodes were audited from digestive systems, 50 from cardiac procedures and 50 from stroke admissions/gynaecology. The other 100 were a random sample from across the Trust.

New Mandated Indicators

A number of new indicators have been mandated by the NHS Quality Account Regulation Amendments 2013. The Countess of Chester Hospital NHS Foundation Trust was already reporting on the majority of these. For ease of the reader the table below lists the indicators and some results or the page on which the report can be found.

Subject	Indicator	Page Number
Mortality	Summary Hospital level mortality indicator (SHMI) and the % of patient deaths with a palliative care coded at diagnosis or speciality level	Page 46
Care of patients with a suspected ST Elevation Acute Myocardial Infarction	These patients receive care at the regional centre at Liverpool Heart and Chest Other Heart attack pathway data	NA Page 51
Care of patients with a suspected stroke	% of patients with appropriate care received	Page 51
Patient reported outcome measures (PROMs) following - • Groin Hernia • Varicose Vein surgery • Hip and Knee replacement	Trust data regarding PROMs	Page 49
Readmission to hospital within 28 days of discharge	Patients aged 0-14 years Patients aged 15 years and over	Page 51
Staff survey	% of staff who would recommend the organisation as a place of work or to receive treatment	Page 53
Venous Thromboembolism Assessment	% of patients who received a risk assessment	Page 50
Clostridium Difficile	Rate per 100,000 bed days amongst patients aged 2 or over	To commence from 2013/14
Patient safety Incidents	Number of reported per 100 admissions that caused severe harm or death	Page 50

Written statement from our Commissioner: West Cheshire CCG

As a new commissioning organisation we have continued on the path of our predecessor organisation, Western Cheshire Primary Care Trust, in our commitment to commission high quality services for our population. Our contract with this Trust for 2012-13 detailed the level and standard of care expected. We managed their performance through progress reports that demonstrated levels of compliance or areas of concern. It is through these arrangements that the accuracy of this Quality Account has been validated.

We commend the Trust for achieving NHS Litigation Authority standards in both Maternity and Acute Services and note the positive reports from the 2 unannounced Care Quality Commission visits.

The Trust has performed well against the majority of the goals in the Commissioning for Quality and Innovation Schemes. However, it is of concern that the Trust did not achieve the expected level of performance against the national inpatient experience measures. There was an improvement on last year's performance but there is clearly a need to improve further. We welcome the focus on improving the inpatients experience on the day of discharge and want to see effort directed at managing the timeliness of medicines at the point of discharge. Lack of timely discharge information to GPs about their patients was also an area of non-achievement that we expect to see improved in 2013-14.

It is of significant concern that there have been 3 Never Events all linked to providing the wrong procedures to patients. We recognise that the Trust has responded to this by focusing on compliance with patient identification processes prior to ordering or conducting any procedures. We are pleased that the Trust has instigated a review of its services against the recommendations made in the Francis Report. We anticipate that improvements in practice will be identified and that this will lead to higher quality care for our patients and reduce the incidence of avoidable harm incidents. This will build on the good work already done to successfully reduce the incidence of pressure ulcers.

We recognise the high level of achievement in patient satisfaction from the national patient survey about emergency departments. We acknowledge the hard work of the Trust in its "zero tolerance" approach to healthcare associated infections and support the Trusts determination to maintain robust infection prevention and control practices. Failure to comply with this good practice should not go unchallenged.

We are aware that the Trust has been reported as an outlier on one of the mortality measures and that a new system to review all in hospital deaths is being established. We will be monitoring this closely.
We welcome the inclusion in next year's priorities work that builds on learning from serious incidents about processes on arrival at the labour suite, not meeting mothers' requirements. This emphasis on learning reinforces the drive to improve care through an open culture.

We support the priorities that the Trust has identified for the forthcoming year and look forward to continuing to work in partnership with the Trust to assure the quality of services commissioned in 2013-14.

Part Three

How we have delivered our priorities in 2012/13

During this time we have worked to improve a number of measures across the three domains of quality. These were chosen with the following considerations -

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

Patient experience

1. To gain some real time experience data from patients on a cancer pathway

Description of the issues and rational for prioritising -
By collecting information regarding the experiences of cancer patients in individual specialties, those teams can utilise the information gained to make improvements to services and the outcomes for those living with cancer.

Results -
Data has been collected across a variety of cancer pathways across the year with a positive response and a number of actions in progress. Pathways involved in this local work are -

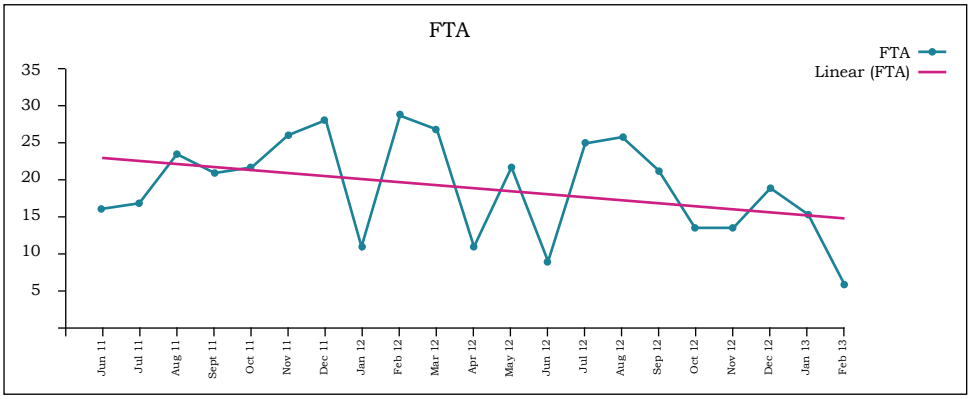
- Breast care, experience of the 23hr enhanced pathway now in second wave and Lymphoedema care exercise programme, both well evaluated by patients.
- Macmillan support centre evaluation of the living after treatment programme evaluated well with some key practical action points from participants. Also working with Chester University using focus groups, first groups have been held.
- Macmillan support and information centre survey of patients and users currently being undertaken.
- Gynaecology, local patient experience survey, good evaluation, now strengthening links between patients and key workers as this was raised as a concern.
- Upper GI, very positive results of local patient experience survey. Waiting times were raised as an issue, bleep system now in place.
- Further work ongoing in acute oncology, lung and skin.
- Specialist palliative care team conducted a survey throughout the year. The numbers have been low but overall the results were positive particularly in the key areas of information giving and patients and carers being aware of whom their key worker was. The Specialist Palliative Care Team (SPCT) also took the opportunity to survey how helpful the Palliative Care Information Booklet/Diary is to patients and carers. The booklet enables the SPCT to give patients and carers a written record of their visit for example detailing information regarding medication changes, date of next visit contact numbers etc. and was reported to be of use to patients and carers.

Current Status/Further Improvements for 2013/14 -
Staff in specialties will be continuing to work with patients and their families to make improvements to their experience.

2. To work with patients to understand why people Fail To Attend (FTA) on the day of their operation and as a result to reduce the numbers of people who fail to attend

Description of the issues and rationale for prioritising -
Failure to attend an appointment results in a number of events which often puts delay in the system for the patient who doesn't attend and a number of other patients being delayed as people are placed back in the system at another time. There are also a number of administrative steps involved in this process with staff reworking and wasting resources.

Results -



The graph above clearly demonstrates that FTAs are on the decrease. In February we saw our lowest amount of FTAs since data collection commenced, only six patients. Looking closely at the figures, since April last year, spikes in activity occurred in key seasonal times – July/August and December.

Current Status / Further planned improvements for 2013/14 -
The following have all been implemented in the past year to address FTA issues -

- Poster campaign in all outpatient areas.
- A patient information leaflet has been designed and is given to all patients who attend pre-operative assessment.
- The pre-assessment staff go through this information with every patient reiterating the importance of timely cancellations/attendance
- The TXT reminder service has now been successfully implemented (October 2012).

We will continue to drive improvements within the teams to further improve FTAs and also working with our commissioning colleagues and GPs in the community we hope to maintain these low figures in the future.

3. To gain patient experiences from patients in a protected characteristics group (Equality Act 2010)

Aim -
To improve the real time patient experience within Outpatient services relating to -

- Dignity and Respect
- Information
- Involvement

Description of the issues and rationale for prioritising -
If patients are not treated in a respectful and dignified way their experience tends to be poor. We are particularly aware that patients in a protected characteristics/minority group may be more vulnerable. We utilised our Equality Delivery assessment as an opportunity to work with a number of groups to see how care could be improved within the Trust.

Results -
The Trust has engaged with a number of groups from all protected characteristics with the following outcomes -

- The Trust has met with University of Chester Lesbian Gay Bisexual and Trans (LGBT) student forum and Cheshire West and Chester Council Staff LGBT forum and has established partner membership in Encompass LGBT North Wales and Cheshire West. We are also working with TransForum and Unique TG in reviewing polices and guidance for gender reassignment.
- The Trust has worked with the Deafness Support Network (DSN) on health awareness and equality rights for deaf people.
- The Trust has met with Irish Traveller Women through joint working with Irish Community Care Merseyside and Cheshire West and Chester Council (CWaC).
- The Trust is working with local faith organisations to facilitate health awareness raising for vulnerable groups such as older people and BME communities.

Current Status/Further planned improvements for 2013/14 -
A number of Health & Wellbeing Forums have been facilitated during the year 2012/13 for Disability groups, Deaf/Hearing impaired people, Pregnancy & Maternity and Lesbian Gay Bisexual and Trans, these resulting as a direct consequence of the steering group collaboration and individual engagement work from the hospital with protected groups.
A Health & Wellbeing Forum for Irish Traveller Women is set for 2013 in Ellesmere Port. The Trust has collaborated with 3rd sector partners to co-facilitate National Patient Dignity Day, International Day against Homophobia (IDAHO), World AIDS day events, One World Religion Day, Compassion in Health Care seminar for Inter Faith, and International Disabled Peoples' Day. This work will be ongoing as part of our Equality delivery system.

Patient safety

1. To roll out the 'This is me' document to all wards caring for dementia patients and to link this to the use of the 'Forget me not sign'

Description of the issues and rationale for prioritising -
A crucial yet obvious first step in helping people with dementia is in actually identifying them wherever or whenever they come into contact with health care and social services. This of course relies upon cross-organisational working and information-sharing which is often problematic or inefficient. Early identification in hospitals is essential to effective care planning with improved outcomes for patients. Dementia is a significant challenge for the NHS - 25% of beds are occupied by people with dementia, their length of stay is longer than people without dementia and they often receive suboptimal care. By liaising with the patient and their family the 'This is me' document can build up a picture of the person that enables appropriate care and significant improvements to their experience and safety.

Results -
Over the year we have achieved more than 95% compliance in completion of a 'This is Me' document for patients identified with dementia.

Current Status/Further planned improvements for 2013/14 -
This has been a really positive initiative in 2012/13 and patients and families have felt a real benefit from having this in place. The 'forget me not' symbol is also now widely recognised after a period of bedding in. This will be subject to on-going audit in 2013/14 looking at qualitative measures to analyse the difference this has made to patients, their families and the staff looking after them.

2. To reduce urinary catheter related infections

Description of the issues and rationale for prioritising -
Urine infections relating to a catheter insertion are deemed to be a harm to patients which is largely avoidable. Therefore as an organisation it was important to know the number of catheter related infections, be alerted to any trends and ensure that the correct education of staff is in place to avoid inappropriate insertion and poor management. This is also a key element of the national CQUIN data collection regarding patient harm.

Results -
15 Catheter related urinary tract infections (CAUTI) were recorded June 2012 – January 2013 from the total patient population surveyed (3693), with no trends identified following data review.

Further planned improvements for 2013/14 -
Project work is progressing, looking at how to further strengthen decision making processes around the requirement to insert urinary catheters and to ensure removal at the earliest opportunity. Data collection will continue for 2013/14 and will enable comparison with 2012/13 data to measure improvement.


Dignity is....
Making time for patients.
Dignity
Valuing pat
individual ne

3. To improve discharge communication across the organisation to improve discharge processes

Description of the issues and rationale for prioritising -
The organisation had received a number of complaints, incidents had been reported and patients themselves had expressed concerns verbally regarding the process of discharge particularly on the day they were leaving the hospital. A group has looked at this process and a pilot was implemented with staff improving the information given on discharge and a follow up phone call to address any concerns was also introduced.

Results -
We achieved a 4% improvement in our national patient experience results in this area, with significant improvement noted in the standard of written information given to patients on leaving hospital and the potential side effects of any medication given.

Current Status/Further planned improvements for 2013/14 -
A task and finish group has commenced and taken an initial review of the discharge process on the day and how this can be improved. We also held a focus group inviting patients back to talk to us about their discharge experiences. Key themes were a 'disconnect' between information given and actual events in the hospital, lack of communication regarding some aspects of the discharge process; information could be more tailored to individual needs. Good practice centred on check-up phone calls from staff post discharge, joint schools, discharge sheet with information on. The group will be looking at further improving information and communication and medication issues on the day of discharge.

Clinical effectiveness

1. To achieve 90% compliance across all aspects of enhanced recovery for identified urology patients

Description of the issues and rationale for prioritising -
There are nationally proven pathways for adults in a range of surgical conditions of which urology is one. The Trust successfully rolled out the enhanced recovery pathways in a number of conditions in 2011/12. Urology services were later in the implementation phase and the systems were embedded in 2012/13. This national best practice supports the delivery of evidence based care which is evidenced as reducing length of stay and produces cost benefit.

Results -
Over 90% compliance now achieved.

Current status / Further planned improvements for 2013/14 -
The plan for 2013/14 is to further evaluate the pathways already within the Enhanced Recovery programme and to further identify other specialties where this methodology can be applied.

2. To Introduce the 'get it on time' principles for patients with Parkinson's Disease

Description of the issues and rationale for prioritising -
This has been introduced in all three Care of the Elderly wards and the wards at Ellesmere Port hospital looking after older people. The aim is to ensure that there are mechanisms in place for patients suffering Parkinson's disease to get their medication at the right time. This improves all aspects of the management of the disease and is crucial to patient wellbeing.

Results -
This continues to roll out across all the hospital wards.

Current status/Further planned improvements for 2013/14 -
We are extending this to the trauma orthopaedic ward and will be looking to link this to patients managing their own medications whilst in a rehabilitation setting. On other general wards the principles are place for individual patients' needs. We continue to work with the Parkinson's Society and have a study day planned in May to further strengthen knowledge regarding this disabling disease.

3. To Introduce changes to the bowel cancer screening pathway to shorten the pathway and to improve the quality of the patient's experience

Description of the issues and rationale for prioritising -
To realign this pathway with the work of other organisations to ensure that patients only have the required colonoscopy diagnostic examination, rather than a series of diagnostics with the same end point. This pathway is shorter and will improve the overall quality and experience for patients and add efficiency to the system for more patients.

Results -
None available as yet.

Current status/Further planned improvements for 2013/14 -
Business case ready for presentation and the following steps have been taken:

- Additional endoscopy capacity has been identified to accommodate future changes (trainee endoscopist now qualified as of March 2013).
- New endoscopy facility programmed for completion by March 2014.
- Equipment requirements in place to start from May 2013.
- Additional nurse led clinics identified to support change to future practice.

The implementation phase will be in early 2013/14.

Quality improvement initiatives in 2012/13

Infection Prevention and Control

Aim -

- To have no more than 1 preventable MRSA bacteraemia case within year.
- To have 42 or less Clostridium difficile cases within year.
- To consistently maintain 95% compliance or above with hand hygiene practices.
- To consistently achieve 95% compliance or above with MRSA screening requirements for emergency and elective admissions.
- To maintain local surveillance systems, including antimicrobial resistant organisms, and maintain all mandatory surveillance requirements as part of national surveillance programmes.

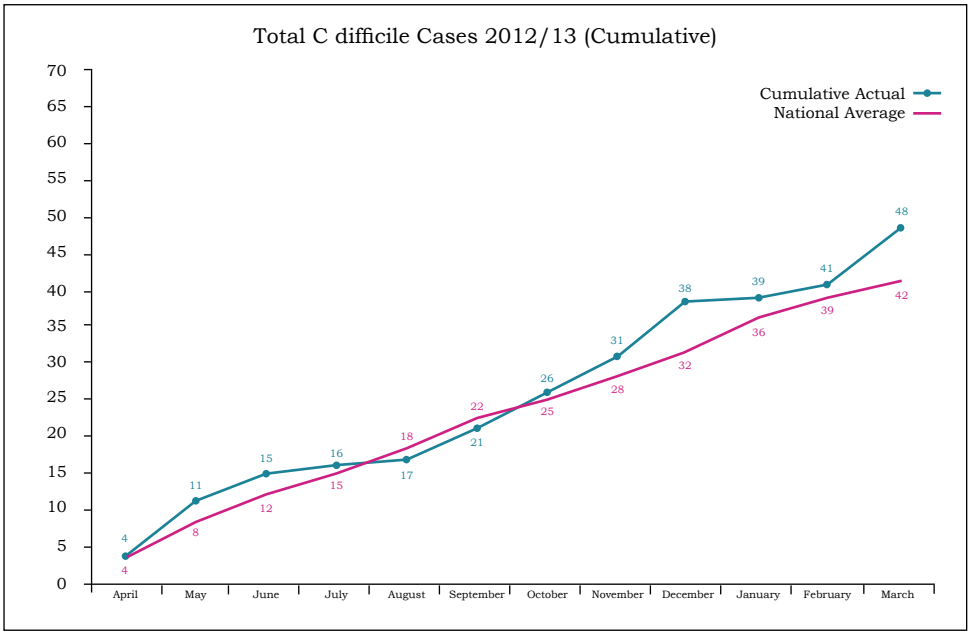
Description of the issues and rationale for prioritising -
Ensuring that preventable Healthcare Associated Infections do not occur is an essential aspect of quality healthcare provision, with robust infection prevention and control practices being an essential contribution to patients receiving safe and effective care. This remains a key priority at a national level, with emerging and increasing levels of antimicrobial resistance being recently highlighted on the national agenda by the Chief Medical Officer.

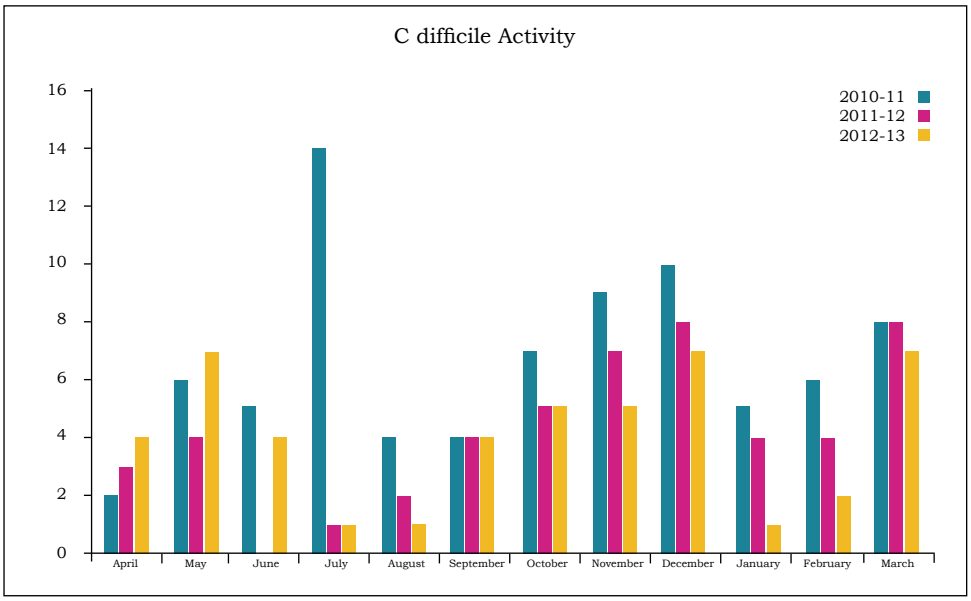
The Trust maintains an established zero tolerance approach to preventable Healthcare Associated Infections. Reducing the number of Healthcare Associated Infections identified within the organisation is a high priority, maintaining the focus on risk reduction. The routine implementation of effective infection 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.

2012/13 Results -

- MRSA bacteraemia objective set at no more than 1 case within year – 3 MRSA bacteraemia were reported during 2012/13 exceeding our objective, although a period of 500 days between bacteraemia was recorded.
- Clostridium difficile infection objective set at no more than 42 cases within year – 48 infections were reported during 2012/13 exceeding our objective, although a 4% reduction from 2011/12 was achieved.
- Success in maintaining hand hygiene compliance above the 95% minimum compliance level throughout 2012/13.
- Compliance with MRSA screening requirements for emergency and elective admissions identifies an improving trend throughout 2012/13.
- An 'unconditional' registration status with the Care Quality Commission has been successfully maintained.

Clostridium difficile
The graphs below demonstrate the in-year performance regarding Clostridium difficile cases and comparison data from 2010 to date.





Hand Hygiene Compliance

Actions to promote hand hygiene, ensuring that improving and sustaining compliance with evidence-based best practice remains core to the infection prevention and control assurance framework, including -

- Hand hygiene policy is available to all staff via SharePoint and incorporates evidence based best practice.
- Hand hygiene training and education is embedded within all Trust induction, local induction and mandatory training programmes, including all clinical and non-clinical staff groups. Staff are encouraged to challenge colleagues if non-compliance is observed.
- In support of hand hygiene training and education programmes, there is an established rolling programme of ward/department based

training utilising UV light box technology, to act as a visual learning aid.

- Hand hygiene compliance monitoring is undertaken across all clinical areas to provide monthly compliance data on performance. This is disseminated to all clinical staff to raise awareness on a monthly basis, via the Executive Team.
- Systems have been developed to support areas that have lower levels of hand hygiene compliance on an individual basis until compliance is seen to improve. This may involve wards/departments, groups of staff or individuals.
- Hand hygiene facilities and compliance are also monitored via the infection prevention and control rolling programme of audit, plus

inclusion within high impact intervention monitoring for key clinical practices, with results disseminated through established routes.

- Hand hygiene awareness posters are clearly displayed in all clinical areas as a reminder to staff. A hand hygiene poster competition has recently been undertaken within local schools to raise hand hygiene awareness and refresh awareness posters throughout the organisation – roll-out of new posters is in progress.
- Hand hygiene technique reminders have recently been added to all hand hygiene product dispensers i.e. soap and hand rub dispensers, as an aide memoire for staff.
- Information leaflets on a number of alert organisms for staff, patients and visitors are widely available, with all including sections on the importance of hand hygiene. There is also a patient/visitor specific leaflet identifying their involvement in infection prevention and control containing clear guidance on hand hygiene.

Planned improvements for 2013/14 -

- Maintain established infection prevention and control assurance frameworks.
- Maintain established systems for promoting best practice to ensure that preventable MRSA bacteraemia do not occur through introduction of the national post infection review tool for MRSA bacteraemia and associated learning.
- Maintain established systems for promoting best practice to reduce the number of Clostridium difficile cases via shared learning from root cause analysis and national evidence base, building on the 2012/13 C. difficile Improvement Strategy.
- Maintain local audit and surveillance systems, including those for antimicrobial resistant organisms, ensuring compliance with all mandatory surveillance requirements as part of the national healthcare associated infection surveillance programme.
- Maintain training and education programmes for all staff groups, consistently re-enforcing the need to routinely maintain high standards of infection prevention and control to ensure that patients receive safe and effective care at all times.
- Improve on existing systems of collaborative working with partners within primary care; identifying and improving knowledge and understanding of existing or emerging antimicrobial resistance and significant infections, through shared learning and strengthened communication.

Risk Management

In line with national recommendations the Trust has continued to report all its clinical incidents to the National Patient Safety Agency (NPSA) - National Reporting and Learning System (NRLS). The Trust is measured against other similar medium acute Trusts regionally. The Trust has fluctuated between the highest 25% reporters to middle 50% reporters over the past 12 months reports which cover reporting for the periods April 2011 to Sept 2012. The process that the Trust has adopted to ensure timely reporting has been established.

During the period April 2012 to April 2013 the Trust has reported 42 incidents on to the Department of Health electronic Strategic Executive Information System (STEIS) for serious untoward incident reporting. These are listed in the table below.

Category	Sub Category	Total
Downgraded to Level 1	Radiology/Scanning Incident	1
Subtotal		1
Infection Control	MRSA Bacteraemia (Post 48 hrs)	3
	MRSA Bacteraemia (Pre 48 hrs)	2
	C. Diff & Health Care Aquired Infections	12
Sub Total		17
Information Governance	Confidential Information Loss	1
Sub Total		1
HR Investigation (No Patient harm therefore no NPSA Investigations carried out)	Adverse media coverage or public concern about the organisation or the wider NHS	2
Sub Total		2
Pressure Ulcers	Pressure ulcer Grade 4	2
	Pressure ulcer Grade 3	3
	Pressure ulcer - (Grade 3 or 4)	5
Sub Total		10
Never Events	Wrong site surgery	1
	Radiology/Scanning incident (Misidentification)	1
	Other (Wrong Implant)	1
Sub Total		3
Level 2 Incidents	Drug Incident	2
	Maternity Services - Unexpected admission to NICU (neonatal intensive care unit)	2
	Slips/Trips/Falls	2
	Sub-optimal care of the deteriorating patient	1
	Unexpected Death (general)	1
Sub Total		8
Total		42

Due to the judgmental nature of this indicator it is difficult to be certain that all incidents are identified and reported and that all incidents are classified consistently within the organisation and nationally. One individuals view of what constitutes severe harm can differ from another's substantially. As a Trust we work very hard to ensure all our staff are aware of and comply with internal policies on incident reporting and standardisation in clinical judgements.

All of the incidents are monitored by the Clinical Commissioning Group (CCG) and reviewed by the relevant Trust committees which include the Level 2 and Never Events incidents which are discussed at Quality Committee.

The incidents are reported back to the Divisions through the Quality and Safety Committee and Divisional Governance forums. In addition lessons learnt are shared with nursing teams at the monthly Ward Managers meeting and through daily Safety Briefings. Medical staff have presented findings of the wrong implant and the wrong site surgery at whole hospital rolling half days as well as regular specialty Morbidity and Mortality review meetings.

Much work has been done to ensure that the World Health Organisation Safer Surgery Check list is embedded in practice. A new audit process to observe compliance has been developed and will be rolled out in April 2013.

In December 2012 the Trust was assessed against the Level 3 compliance for Clinical Negligence Scheme for Trusts (CNST), scoring 49/50. These standards measure the level of risk management within maternity services. In February 2013 the Trust was assessed against the Level 3 compliance for the NHS Litigation Authority (NHSLA), scoring 49/50. These standards measure the level of risk management throughout the whole organisation.

During both assessments the assessors noted the robust risk and governance process that were in place and commended the Trust. Both assessments demonstrate a culture of high standards of safety for our patients and strong organisational governance.

The NHSLA assessors reported the following -

> *'The Countess of Chester Hospital NHS Foundation Trust is to be congratulated at achieving Level 3 of the NHSLA Risk Management Standards for NHS Trusts Providing Acute Services 2012/13 with a score of 49 out of 50'.*
>
> *'There were high levels of engagement from staff during the assessment and it was evident that there is widespread commitment throughout the organisation in relation to the implementation of the standards and the management of risk generally'.*
>
> *'The organisation demonstrated an extremely thorough and well executed approach, both in terms of risk management and the assessment process, resulting in a well-deserved Level 3 award'.*

Report of the QA visit to Chester Breast Screening Programme

Each NHS region has a Quality Assurance Director for Breast Screening and a Quality Assurance Reference Centre. Each Regional Quality Assurance Director is supported by a Regional Quality Assurance Team which includes a professional coordinator from each of the professions which contribute to the breast screening programme (radiology, radiography, pathology, surgery, breast care nursing, administration and medical physics). There is a programme of regular (three-year cycle)

quality assurance visits to breast screening units. These provide a means of assessing the performance of the breast screening programme and of professional competence within the programme. Recent high profile clinical incidents at regional and national level have increased the degree of scrutiny applied and the strength of subsequent recommendations.

The overarching theme of the November 2012 visit was the CoCH Breast Screening programme was delivering a high quality cost effective service but that it was too small with particular vulnerabilities around breast radiographer availability.

Action planning and progress
The recommendations have been converted into an action plan for resolution however two of the recommendations were for immediate attention –

- NHSBSP trained consultant radiology input is required at arbitration and consensus meetings.
- The Trust should liaise with Commissioners and an adjacent screening programme in order to implement joint MDT working and work towards full merger to form a single screening programme.

The unit has secured consultant input into arbitration and consensus from the Nightingale Centre (Manchester) while the CoCH substantive consultant completes the required training.

Public Health England is the interim Commissioner of the breast screening programme until this responsibility moves to the NHSCB Area Team responsible for Specialist Commissioning and they are coordinating the work to define design and implement a merger of the MDT and screening programme.

Cancer Peer review

The National Cancer Peer Review Programme is the cancer quality assurance process for cancer services. This programme continued into 2012/13 with the cancer multi-disciplinary teams (MDTs) at the Countess of Chester Hospital NHS Foundation Trust being required to self-assess the compliance of their service against nationally agreed measures. This self-assessment together with supporting evidence is uploaded to the Cancer Quality Improvement Network System (CQuINS) database.

The following teams were all required to self-assess only their service in 2012/13 – local Gynaecology, Breast, Lung, Local Urology, Oncology Pharmacy services, Brain and Central Nervous System, Sarcoma, Paediatric Oncology Shared Care Unit (POSCU) and Head and Neck Locality.

In addition to self-assessment, the Colorectal MDT, Local Upper GI MDT and Skin cancer MDT were subject to internal validation by the Trust at individual panel meetings, with the reports of these meetings being published on the CQuINS database.

Two services, the Chemotherapy services MDT and the Acute Oncology (AO) service were selected for an external visit by the Zonal Peer review team. These visits took place on January 9th 2013. Many areas of good practice were highlighted; however, serious concerns were raised by the external team for both services.

Acute Oncology Services

- There is no patient flagging system in place meaning that patients being admitted to the Trust with complications of cancer or its treatment may experience significant delay in their assessment and management. Reviewers were not assured there is a clear plan to resolve this issue within a reasonable timescale.
- The service is only supported by a single handed part time Acute Oncology nurse with no cover arrangements in place. As a consequence during periods of leave patients may receive an inadequate and inequitable service.
- The reviewers were not assured that the network agreed Metastatic Spinal Cord Compression (MSCC) pathway is complied with. As a consequence it was unclear if patients experience delays in receiving treatment.

Chemotherapy Services

- An electronic prescribing system has not been implemented within the Trust for Chemotherapy and with no definitive timescales in place. Furthermore oral chemotherapy prescriptions continue to be handwritten. The National Chemotherapy Advisory Group (NCAG 2009) highlighted the benefits of validated electronic prescribing systems in promoting patient safety.
- No formal assessment of patients is undertaken prior to the dispensing of oral chemotherapy. Furthermore there is no evidence of the prescribed oral chemotherapy within the patient's case notes as this information is stored within pharmacy only.

Action plans and timescales are being developed for these issues with the concerns relating to oral chemotherapy already being resolved. Concerns raised at the 2011/12 review have also been resolved.

The 2013/14 Cancer Peer Review cycle is now underway. Teams have been notified of the programme for the year.

Nursing care measures

In 2012/13 the Trust continued with its process of nursing care audits and also added a system of care and comfort rounding as part of the CQUIN framework. The comfort rounds ensure that there is regular patient contact throughout the day and patients' needs are met from ensuring the call bell is reachable, to checking skin and supporting eating and drinking.

The audits are carried out bi-monthly with the exception of areas where the standard falls below 90% consecutively. In these cases the ward managers continue to audit monthly hence data being displayed monthly.

The audits continue to provide the ward manager with clear standards to monitor both documentation and the care received by the patient and feed back directly to staff at the time of the audit. An action plan is then produced which is discussed daily through the ward Safety Briefings.

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

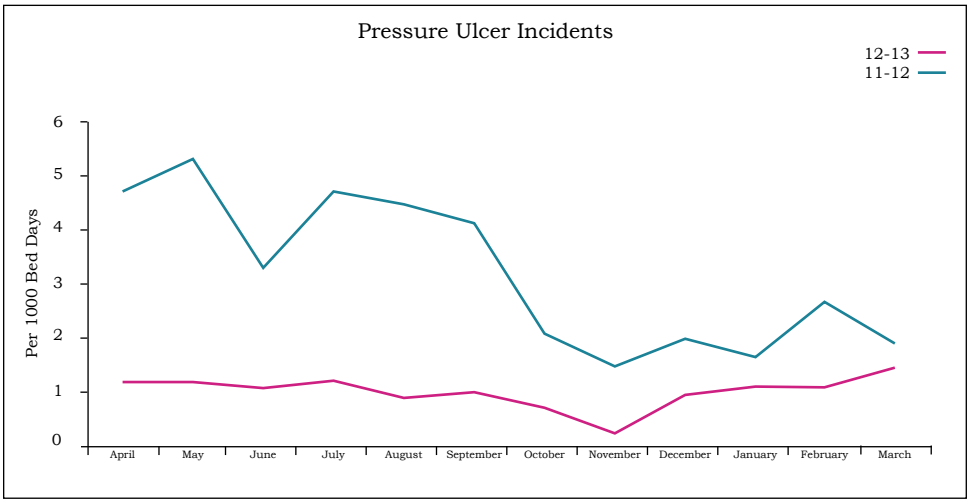
Below is a table of the Trust scores over the last 6 months of 2012/13 and a final compliance of over 90% with each care bundle.

	Oct 2012	Nov 2012	Dec 2012	Jan 2013	Feb 2013	Mar 2013
Medication storage and custody	97% ↑	99% ↑	96% ↓	99% ↑	99% ■	98% ↓
Infection control & privacy & dignity	100% ↑	99% ↓	100% ↑	99% ↓	93% ↓	99% ↑
Patient observations	95% ↑	95% ■	92% ↓	96% ↑	95% ↓	95% ■
Pain management	100% ↑	99% ↓	98% ↓	99% ↑	94% ↓	98% ↑
Tissue viability	99% ↑	98% ↓	89% ↓	96% ↑	93% ↓	94% ↑
Nutritional assessment	99% ↑	97% ↓	95% ↓	96% ↑	90% ↓	94% ↑
Falls assessment	100% ↑	99% ↓	90% ↓	99% ↑	98% ↓	98% ■
Continence assessment	100% ↑	99% ↓	99% ■	95% ↓	86% ↓	96% ↑
Management of Urinary Catheters	98% ↑	95% ↓	98% ↑	87% ↓	80% ↓	92% ↑
Discharge	97% ↑	96% ↓	96% ■	96% ■	86% ↓	94% ↑
Total	98% ↑	98% ■	95% ↓	97% ↑	94% ↓	96% ↑

Focus on Pressure Ulcer Management

In 2012/13 the Trust continued to maintain the profile of pressure ulcer management by ensuring all patient data is validated and all pressure ulcers are monitored both locally and strategically by the senior nursing team.

Over the year, we have successfully reduced and maintained the incidence of pressure ulcers per 1000 bed days -



We continue to have some pressure ulcers at grade 3 and very occasional at grade 4. Every one of these is subject to a review and where there is learning this is shared with nursing staff across the organisation. Where we observe that the care given did not adequately reduce the risk we report this as a serious untoward incident as can be seen in other areas of the report. Any incident such as this has a full action plan to improve. All pressure ulcers are discussed with the patient concerned wherever possible and with their family or carers.

Transfer of Community Contraceptive and Sexual Health services: Two years on

The Community Contraceptive and Sexual Health services (CCASH) team transferred to Countess of Chester Hospital NHS Foundation Trust under Transforming Community Services on April 1st 2011.

Current Position -
The Integrated Sexual Health Steering group meets bi-monthly and continues working towards a fully integrated service. Membership includes the Commissioner and Lead GP for Sexual Health, Clinicians, and IM&T representatives.

Phase 1 implementation -
Phase 1 implemented (still working with IM&T on some connectivity issues).

Phases 2 to 4 implementation -
Connectivity in Community sexual health services remains an issue on our Risk Register - IM&T working externally to address this interface with a number of partners. Electronic patient record templates now designed for the integrated service to be progressed and training to be cascaded.

Further developments -

- Sub groups continue to work on integrated treatment pathways; these are ratified at speciality meetings and then transferred onto the Trust's policy database.
- A Nursing and Administration model has been developed to enable delivery of a fully integrated service and will go to Consultation May/ June 2013. We currently have 7 nurses who are already working as integrated practitioners using Patient Group Directives to examine and treat sexually transmitted infections as appropriate. An eighth nurse is currently undergoing training.
- Reduction of teenage pregnancies achieved (see data blow).
- A restructure will facilitate Information/ IT Co-ordinator for the integrated service to ensure good data quality and management of the sexual health stand-alone system.
- Web based booking system identified for single point of access, fit for 21st Century service. Paper going to Divisional Board (23/04/13) for support to implement from internal cost savings and income.
- Pharmacy services are now provided by the Countess of Chester Hospital NHS Foundation Trust and are working well.
- Work continues with Commissioners regarding the development of the National Sexual Health tariff.
- West Cheshire College service working well and has been extended to all Young People under 25 years in accordance with service specification.
- The Young Persons Outreach nurse role (currently 15 hours) is successfully delivering a service to the more vulnerable and hard to reach young people.
- Working to re-site some services in the new Northgate development which will support easier access.
- A review of the service against the recently published DOH paper "A Framework for Sexual Health improvement in England" (March 2013) is in progress.

Below is a summary of the data released last month - there has been some fantastic progress both nationally and in Cheshire West and Chester that the service has contributed to.

2011 data for Cheshire West and Chester shows -

- The under 18 conception rate was 25.8 per 1000 females aged 15-17, a fall of 27.5% from 2010. The reduction from the baseline year of the Teenage Pregnancy Strategy is now 31%.
- The under 16 conception rate was 5.3 per 1000 females aged 13-15, a fall of 17% from 2010.
- Numbers of conceptions also declined: from 207 in 2010 to 146 in under 18s, a fall of 29%; and from 37 to 30 in under 16s, a fall of 19%.
- Abortion proportions have also fallen: for < 18 conceptions 43.2% led to an abortion, compared with 50.2% in 2010; for < 16s, 60% of conceptions led to an abortion, compared with 64.9% in 2010.

2011 data for England shows -

- The under 18 conception rate was 30.7 per 1000 females aged 15-17, a fall of 10.2% from 2010. The reduction from the baseline year of the Teenage Pregnancy Strategy is now 34%.
- The under 16 conception rate was 6.1 per 1000 females aged 13-15, a fall of 9% from 2010. The reduction from the baseline year is now 29%.
- Numbers of conceptions also declined: from 32,600 to 29,200 in under 18s, a fall of 10.4%; and from 6,300 to 5,700 in under 16s, a fall of 9.5%.
- Abortion proportions remained stable: for <18 conceptions 49.3% led to an abortion, compared with 50.3% in 2010; for under 16s, 60.5% of conceptions led to an abortion, compared with 62.8% in 2010.

The challenge now is to sustain the amazing reductions we have achieved and to share the learning.

The Integrated Contraception and Sexual Health Group will continue to drive the changes to ensure a fully integrated service; the success of the future model depends on robust IT systems, good data quality and good training.

It is through embedding the culture and values of the Trust and a definite "can do" attitude of all involved that will ensure this is achieved and allow the service to evolve in line with national and local guidance.

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 nearly five years. The programme supports the implementation of set pathways of care across the identified conditions of:

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

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

Current status -
As the data is retrospective, we are currently reporting data up to November 2012. Excellent progress has been sustained across the heart attack pathway and the hip and knee replacement pathway has improved significantly in 2012/13 and is now sustaining the target set. The heart failure pathway presented a challenge when the target stretched however this pathway has been met for the last three months following a robust action plan implementation. The stroke pathway is now embedded and has reached the standard of 90% compliance on occasion with over 50% of patients receiving all aspects of the care pathway every month except on one occasion.

The Community acquired pneumonia pathway remains the biggest challenge and this year has been allocated to a new lead in Urgent care. The action plan in place has begun to sustain some noticeable improvement.

Results -
Data can be viewed in the Quality measures on page 51 .

Further planned improvements for 2013/14 -
The project will continue as part of the Region's Commissioning for Quality and Innovation (CQUIN). It will be measured differently this year with targets based upon the number of patients receiving all elements of care across the pathway.

Managing and Responding to External Recommendations

During 2012/13, the Trust's Quality Committee received, monitored and took action on a number of external reviews to ensure there were no implications for the Trust. These reviews were in the form of National Confidential Enquiries into Patient Outcomes and Death (NCEPOD), or investigation reports into events in other Trusts or healthcare providers. Examples of these have been the latest Mid-Staffordshire Independent inquiry, The Morecambe Bay report, the Saville investigation and the Winterbourne View report.

In all cases there are robust systems to receive and acknowledge these recommendations, conduct an analysis and identify any gaps and initiate relevant action plans. The Committee continues to monitor the Trust action plans for a minimum of 12 months when outstanding risks, if any, are placed on the appropriate risk register. This system is subject to a programme of audit as part of the NHS Litigation Authority compliance standards.

Summary Hospital Mortality Indicator (SHMI)

Risk assessed mortality is an important measure and the Board must have confidence in its measuring and reporting as evidenced by the Francis report. A Mortality Review Group is being instituted (commencing June 2013) to review all in-hospital deaths in a timely fashion. The Medical Director and Director of Nursing and Quality will lead the group which will include other senior medical and nursing staff, coders and IT staff. The purpose of this group will be to assure that there are no concerns regarding the safety or quality of care and that we optimise the recording of clinical data. A report from the Group will be a standing item on the Board agenda. In addition, lessons learnt from review will be disseminated down to Divisions and specialties.

- SHMI is published every three months and the values for the Countess of Chester Hospital NHS Foundation Trust are as follows -

1.09	*July 2011 – June 2012*
1.12	*October 2011 – September 2012*

- Percentage of patient deaths with palliative care coded at either diagnosis or specialty level;

14.07%	*July 2011 – June 2012*
15.03%	*October 2011 – September 2012*

SHMI values have remained within "expected" range however there remains an over-representation of symptoms and signs that disproportionately affect SHMI. Also, some diagnostic categories will be

influenced by SHMI including deaths out of hospital within 30 days of admission which accounts for approximately 25% of deaths included. A new history sheet is being piloted to address the diagnostic issues.

Despite SHMI remaining acceptable and having a reliably low crude mortality, the Trust has been reported as an outlier on HSMR and because of this, and having risk assessed scores consistently at the upper end of the expected range, mortality at the Trust needs reviewing.

It is proposed that there will be two strands to this review -

1. An audit using the NHS Modernisation Agency's 3x2 Matrix Tool (2004) will review 50-60 consecutive deaths that occurred in the Trust in January 2013. This has two components, an initial sweep and classification depending on whether admission was for terminal care or not, and whether admission was for ward care or critical care. A second, more detailed, review then looks at the various groups for relevant safety and quality issues. This audit has already commenced.

2. A Mortality Review Group will be instituted to review all in-hospital deaths in a timely fashion. Advice is being sought from those Trusts who already have such a group regarding the constitution and effectiveness of such a group. Terms of Reference will then be developed for the Countess. It is envisaged that the Medical Director and Director of Nursing & Quality will run the group and that other senior medical and nursing staff, coders and IT staff will be involved.

The purpose of this group will be to assure that there are no concerns regarding the quality and safety of care and that we optimise the recording of clinical data and coding. It will also allow us to better interrogate data relating to diagnoses. It is envisaged that the group will be convened and meet at the beginning of May with a view to commencing review of cases at the beginning of June 2013.

Patient Reported Outcome Measures (PROMs)

The Trust has been involved in this programme since 2009 although earlier data has been collected in orthopaedic care. The process is run nationally and requires the Trust to invite patients to complete a questionnaire prior to their surgery and currently involves four types of surgery as follows -

- Hip replacement
- Knee replacement
- Groin hernia repair
- Varicose vein surgery

After a defined period post-surgery the patient receives another questionnaire, a comparison of which is taken with the pre questionnaire to see if the surgery had a positive outcome. The data shown is for 2010/11 and 2011/12.

The system is quite complex involving a combination of the following tools dependent on the operation.

Questionnaire Name	What it looks at
Lifestyle (EQ-5D Index)	Mobility, Self-care, Usual activities e.g. work, study, housework, Pain/ discomfort, Anxiety/depression
Health (EQ-VAS)	Patients are asked to rate their health state by marking the scale at the relevant point, with zero being worst and 100 being the best state.
Condition specific Varicose Vein Questionnaire (AVVQ)	Comprises of 13 questions related to key aspects of the problems associated with varicose veins.
Oxford Hip Score (OHS) and Oxford Knee Score (OKS) questionnaires	Joint specific comprising of 12 multiple choice questions relating to the patients experience of pain, ease of joint movement and ease of undertaking normal domestic activities.

The clinical teams concerned are reviewing their data and can do so at a patient level to enable learning and sharing of good practice.

Please note -

- The results below have been rounded for ease of reading.
- Some results may be subject to change as questionnaires are returned by patients at different intervals.
- A full report is available on request.

Results –

Hip Replacement PROMS 2011/12 (2010/11 comparison data in brackets)				
	Lifestyle	Health	Condition specific	Comments
Patients with a better outcome	86% (92%)	62% (60%)	97% (97%)	There is sustained improvement relating to surgery specific questions. With some decreased responses to the lifestyle aspect which could be due to other reasons
Patients with no change	7% (0%)	8% (10%)	0% (3%)	
Patients with a worse outcome	6% (0%)	29% (21%)	2% (0%)	

Knee replacement PROMS (2010/11 comparison data in brackets)				
	Lifestyle	Health	Condition specific	Comments
Patients with a better outcome	79% (74%)	46% (51%)	91% (91%)	The specific questionaire remains positive with high numbers reporting a sustained improvement. A decrease in overall health outcomes is observed over the 2 years. This could be due to other health reasons.
Patients with no change	12% (10%)	11% (7%)	1% (0%)	
Patients with a worse outcome	14% (10%)	43% (42%)	8% (0%)	

Varicose Vein surgery PROMS (2010/11 comparison data in brackets)				
	Lifestyle	Health	Condition specific	Comments
Patients with a better outcome	30% (53%)	35% (0%)	79% (86%)	There are continued good outcomes relating to the surgery specific questionaire. The lifestyle questionaire has worsened but could be due to other health reasons and a continued decrease in patients undergoing this procedure with overall low numbers.
Patients with no change	47% (0%)	19% (0%)	0% (0%)	
Patients with a worse outcome	22% (0%)	46% (46%)	21% (0%)	

Groin Hernia Repair surgery PROMS (2010/11 comparison data in brackets)				
	Lifestyle	Health	Condition specific	Comments
Patients with a better outcome	60% (49%)	42% (40%)	NA	More patients reported improved outcomes in 11-12, however a large percentage aslo reported worsening outcomes following surgery. This could be due to another health condition.
Patients with no change	24% (27%)	15% (18%)	NA	
Patients with a worse outcome	16% (24%)	42% (42%)	NA	

Quality measures

We have made significant progress across the safety, effectiveness and patient experience domains. We are proud that we achieved a reduction in Clostridium difficile cases but acknowledge we can do better and this, in addition to maintaining the focus on MRSA, will continue in 2013/14. We have seen an increase in compliance within the last quarter of optimising the care a patient has with a fractured neck of femur and we will strive to maintain this in the coming year. The Advancing Quality programme has seen a gradual improvement - this has come as a result of further clinical engagement and focussed work on these specific areas to ensure our patients have the best possible pathways of care. It is positive to note our improvements across the five 'Patient Experience Survey' questions as illustrated below. Significant focus has taken place during 2012/13 on ensuring these key areas are improved, however it is disappointing that collectively we didn't achieve our national target score. 2013/14 will see the development of a wider patient experience agenda. We value the feedback we gain from our patients and we plan to further focus on the learning from what our patients are saying in order to improve standards and services.

Safety

Indicator	Method of monitoring / Measure	08/09	09/10	10/11	11/12	12/13
Reduction in MRSA bacteraemia	Target: 1 post 48 hour cases	9	6	3	2	3
Reduction in Clostridium difficile	Target: National 42 cases	173	66	80	50	48
Trust-wide Hand Hygiene	Sustained improvement: compliance at greater than 95%	89%	92%	96%	95.5%	97%
VTE assessment (10/11 data final 6 months)	Sustained improvement: Compliance at 90% or above	No data	No data	92.7%	93.2%	93.23%
Incident data: Latest data available at time of report			October 2010-March 2011		April 2011-September 2011	April 12-September 2012
Rate of patient safety incidents per 100 admissions	National patient safety agency report		7.9		6.8	6
% of patient safety incidents resulting in severe harm or death	National patient safety agency report		0%		0.1%	0.4%

Effectiveness

Indicator		09/10	10/11	11/12	12/13
Emergency readmissions to hospital within 28 days of discharge. Average Trust figure for 2011/12 is 5.73% Average Trust figure for 2012/13 is 5.50% *This indicator has been changed to meet with mandated requirements and is taken from national data*	0—14 years	10.34%	9.70%	NA	NA
	15 years and over	10.68%	10.69%	NA	NA

Indicator	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Optimisation of the care of patient with a Fractured neck of femur: % of medically optimised patients with a fractured neck of femur who go to theatre within 36 hours Average 2011/12 83% Average 2012/13 89%	96%	89%	92%	87%	80%	100%	80%	79%	83%	100%	100%	
Advancing Quality: **The data displayed below is the Trust's audited data and may be subject to change following external audit and application of external weightings. Data available to Nov 12 (refer to page 36 for full summary)**												
Hip and Knee. Threshold 95%	92.95	95.95	96.77	98.31	95.28	98.34	100	98.38				
Community Acquired Pneumonia Threshold 85.96%	80.6	84.75	78.37	79.39	82.38	78.74	84.98	85.65				
Heart Failure Threshold 90.29%	90	80.28	73.91	87.27	84.21	94.12	93.88	90.77				
Acute MI Threshold 95%	100	100	97.5	100	96.49	92.63	100	96.43				
Stroke care 90% average and over 50% receiving all elements of the correct care	86.4	81.98	90.38	85.55	90.34	90.83	86.21	88.31				
	58.62	42.86	52.63	55.17	62.50	69.23	54.17	54.05				


NHS
Diabetes Essentials
A group education session for people with diabetes
Eating well with Type 2 diabetes

Experience

Indicator			10/11	11/12	12/13
We asked the question 'Was your admission date changed by hospital?* *The % displayed refers to the average number of 'No' responses in local surveying*	NA	NA	64%	74%	76%
National patient experience survey Improvements The % displayed refers to the number of 'yes' responses #	08/09	09/10	10/11	11/12	12/13
Were you given enough privacy when discussing your condition or treatment?	81.6%	81.4%	84.8%	83.2%	81.9%
Were you told who to contact if you were worried about your condition after you left hospital?	72.9%	72%	73.4%	70.9%	76.9%
Were you told about medication side effects to watch out for when you went home?	49.5%	44.9%	52.4%	42.3%	54.3%
Did you find someone to talk to about worries and fears?	63.3%	61.6%	60%	56.5%	66.4%
Were you as involved as you wanted to be in decisions about your care and treatment?	74.4%	72.8%	72.5%	69%	71%
Staff Survey					
Percentage of staff who would recommend the Trust as a place of work or to receive treatment			70.4% (3.52 out of 5)	73% (3.65 out of 5)	75.4% (3.77 out of 5)

**Progress has been sustained in changing the date of patients' admission. We also made a significant improvement in the National inpatient survey for this question; however, there is still much work to do in this area.*

 # We are pleased to report a 4% improvement across the 5 CQUIN patient experience questions.

Monitor Compliance Targets

Areas where compliance has been challenging -

The Trust has had particular areas of challenge in maintaining Monitor Compliance and national target achievement –

- C.difficile - full year target of 42 cases.
- Cancer 62 day – three consecutive quarters.
- Emergency Department (ED) overall 95% four hour access target for Q4.

C.difficile – the trajectory for the year 2012/13 was closely mapped to performance in previous years as levels of C.difficile can be associated with seasonal peaks in non-elective activity and incidences of norovirus. During the first two quarters of the year the trajectory was largely on plan. Despite prolonged periods of high non-elective activity incidences of C.difficile remained well contained. Root cause analysis of confirmed cases categorised all cases as unavoidable until late September when the first avoidable cases were recorded. The trajectory then deteriorated through November and December due to higher incidences of patients vulnerable to C.difficile combined with avoidable cases. The avoidable cases where linked to patients on specific treatment regimens whereby the specific testing regime used was inappropriate.

The 2012/13 C.difficile target was one of the key priorities of the organisation and the number one priority for the Trust Infection Prevention & Control arrangements. As such the progress has been tracked closely by the Trust Board as have the Improvement Strategies such as the Acute Medical Unit (AMU) Antibiotic Stewardship pilot tested in February 2013.

The Trust has recorded 48 cases of C.difficile this reporting year with a target of 36 for the year 2013/14. The Trust has been able to demonstrate a reduction in the ratio of C.difficile cases to patient bed days. If we had maintained the same ratio as in 2011/12 there would have been 51 cases.

We are confident that the full range of strategies we have developed across education, cleanliness, antibiotic stewardship, audit and microbiological testing will allow the Trust to achieve this target.

Cancer 62 day target – due to the multiple causes of variation that can occur within cancer pathways the Trust has decided to carry out a root and branch review of our cancer services. This has involved both our local audit service and the national cancer Intensive Support Team (IST) as well as the newly formed cancer strategy group hosted by the CCG.

This review will include the assessment of the efficiency of the patient pathways within priority tumour groups with a view to achieving the first diagnostic test by day seven of the relevant patient pathway.

Cancer performance is discussed at every Trust Board and in February the Board hosted a wider debate involving members of the responsible management team.

It is accepted that due to the small numbers of patients that are required to breach before the compliance target is failed that every single cancer patient will be micromanaged through their pathway by an enhanced group of cancer trackers and that a robust escalation mechanism is embedded to ensure that barriers and bottlenecks can be removed.

Emergency Department 95% - performance was maintained throughout the first three quarters of the year with a small dip experienced in October. From February the performance has been compromised by two factors. One is that at times the volume of patients presenting at particular times of the day has outstripped the medical capacity of the Emergency Department, secondly the level of delayed discharges into the community has increased compromising the non-elective patient flow.

The Trust has engaged with its partners in the health economy to redesign parts of the non-elective care system and we have already introduced clinical streaming and Paediatric 'Hospital @ Home' as part of our transition to different types of service delivery. In the first quarter of 2013/14 we will develop an ambulatory care area in an effort to improve patient experience and relieve some pressure on the ED department.

As the reasons for the slippage in ED performance are reasonably clear we are confident in returning to sustainable performance in 2013. The table below demonstrates our 2012/13 performance against Monitor's

Infection Control Targets	Target	Actual
Clostridium Difficile	42	48
MRSA – (deminimus of 6 cases per year)	1	3
Waiting Time Targets	**Target**	**Total**
RTT, 95th percentile, admitted patients	90%	96.8%
RTT, 95th percentile, non-admitted patients	95%	99.6%
RTT, Incomplete Pathway	92%	96.2%
Total time in A&E *	5%<4hrs	95.8%
Cancer Targets	**Target**	**Total**
14 days - all cancers	93%	95.6%
14 days - breast symptomatic	93%	97.5%
31 days - diagnosis to first treatment	96%	99.0%
31 days - subsequent surgical treatment	94%	99.0%
31 days - subsequent non-surgical treatment	98%	100.0%
62 days - first treatment from urgent GP referral	85%	83.9%
62 days - first treatment from screening referral	90%	98.3%
Monitor Governance Rating (Quarter 4)		Amber/Red

Notes –
** Quarter 4 performance at 94.5%*

Part Four

Written Statements by Other Bodies

Our Foundation Trust Council of Governors

This statement is provided by the Council of Governors in response to the Trust Quality Account.

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

The Council of Governors are proud of the Trust's achievements in 2012/13 including -

- the CQC inspections at Ellesmere Port and the Countess of Chester Hospitals
- NHSLA level 3 compliance for Acute services
- CNST Level 3 compliance for Maternity services
- its continued commitment to dementia care
- the active engagement of sub-groups to the Equality Delivery Scheme
- the delivery of locally agreed CQUINs
- the Staff Survey indicators

The Council of Governors support the Trust's priorities for 2013/14 and we are looking forward to working more closely with the Non-Executive Directors and the Quality & Safety committee to achieve these. The Governors will support the delivery of two key objectives in the areas of patient experience and clinical effectiveness through patient and public engagement.

Following recent joint workshops, the Governors also fully support the Trust's aim to improve collaborative working with local partners thereby providing more integrated care for our community and patients.

The Governors' Quality Forum will continue to monitor the quality of care delivered by the Trust through our 'clinical area visit program' and will develop a standardised approach to reporting so that actions made in response to observations are reported back to the Forum.

Governors will also continue to engage proactively with members and the public at regular community-based events. We will use these opportunities to seek views on patient experience and perception and will communicate these to the Trust. We will seek improvements to services based on our feedback and will agree the mechanisms to actively monitor progress; the results of this strategy will be communicated to members and the public at future engagement events and through the Trust magazine 'Countess Matters'.

The outcomes from the Quality Account also indicate areas where improvements must be made in 2013/14 including never events, serious untoward incidents, clostridium difficile infection rates and the National Patient Experience CQUIN.

The Council of Governors will also closely monitor the Nursing Care audits, risk-assessed mortality indicators and the Trust's response to the Francis report.

In conclusion, the Council of Governors undertakes its role in assuring and promoting quality robustly through interactions with the Board of Directors, patients, members and other stakeholders. The quality account is representative of the achievements and progress made to date and provides a good foundation for greater improvement, actively monitored, promoted and informed by the Council of Governors. The Council of Governors would like to thank the Board of Directors for their openness in sharing information, listening to feedback and positive engagement in joint working with us.

Local Involvement Networks (LINk)

None received

Health and Wellbeing Scrutiny Committee

None received

Appendices

Appendix 1 - Glossary & Abbreviations

Term	Abbreviation	Description
Accident and Emergency	A&E or ED	The Emergency Department usually at a hospital.
Advancing Quality	AQ	A programme which rewards hospitals which improve care in a number of key areas – heart attacks, pneumonia, hip and knee replacements, heart failure and heart bypass surgery, stroke– when compared to research which identifies what best care constitutes.
Care Quality Commission	CQC	The independent regulator of health and social care in England. Its aim is to make sure better care is provided for everyone, whether that is in hospital, in care homes, in people's own homes, or elsewhere. The CQC replaces the Healthcare Commission.
CHKS		CHKS is a leading provider of healthcare intelligence and quality improvement services whose services are used within the Trust.
Clostridium difficile	C-diff	A naturally occurring bacterium that does not cause any problems in healthy people. However, some antibiotics that are used to treat other health conditions can interfere with the balance of 'good' bacteria in the gut. When this happens, C-diff bacteria can multiply and cause symptoms such as diarrhoea and fever.
Clinical Commissioning Group	CCG	This is the new GP led commissioning body who buys services from providers of care such as the hospital.
Commissioner		A person or body who buys services within the NHS or from private sector providers.
Commissioning for Quality and Innovations	CQUINs	CQUIN is a payment framework developed to ensure that a proportion of a providers' income is determined by their work towards quality and innovation. The scheme was introduced in detail, from implementation to function, in High Quality Care For All to encourage organisations to see quality improvement and innovation as a motivator towards a better service for their patients.
Enhanced Recovery Programme	ERP	A pathway of care applied to a procedure relating to type of anaesthesia, type of post operative pain relief, earlier patient mobility post surgery, increased nutritional intake pre operatively and as soon after waking as possible, to reduce recovery time.
Healthcare Associated Infections	HCAI	A generic name to cover infections like MRSA and C-diff.
Hospital Episode Statistics	HES	This is the national statistical data warehouse for England of the care provided by NHS hospitals and for NHS hospital patients treated elsewhere. HES is the data source for a wide range of healthcare analysis for the NHS, government and many other organisations and individuals.

Term	Abbreviation	Description
Methicillin-Resistant Staphylococcus Aureus	MRSA	Staphylococcus aureus is a bacterium which is often found on the skin and in the nose of about 3 in 10 healthy people. An infection occurs when the bacterium enters the body through a break in the skin. A strain of this bacterium has become resistant to antibiotic treatment and this is often referred to as MRSA.
Monitor		This is the regulator of NHS Foundation Trusts. It is an independent body detached from central government and directly accountable to Parliament.
National Patient Survey		Co-ordinated by the Care Quality Commission, it gathers feedback from patients on different aspects of their experience of care they have recently received, across a variety of services/settings: Inpatients, Outpatients, Emergency care, Maternity care, Mental health services, primary care services and Ambulance services.
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.
Patient Led Assessment of the Care Environment	PLACE	This is the new organisation that inspects the Trust's care environment for patients including privacy and dignity, cleanliness and food provision.
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.
Secondary Users Service	SUS	This is the NHS data system for recording all NHS patient activity. It enables correct payments by Commissioners, for care provided by all provider services including acute trusts.
Service Level Agreement	SLA	This is a local contract between services external to the Trust to deliver shared or part of the patient pathway.
Statement of Purpose	SoP	This is a Care Quality Commission requirement of registration and describes the aims and objectives of the service provider in carrying on the regulated activity. It describes the kinds of services provided for the purposes of the carrying on of the regulated activity and the range of service users' needs which those services are intended to meet.
Venous Thrombo-embolism	VTE	This is a blood clot developing when a person is in hospital and may not be as mobile as they are usually or following surgery. The blood clot itself is not usually life threatening, but if it comes loose it can be carried in your blood to another part of your body where it can cause problems – this is called a Venous Thromboembolism (VTE). If the clot travels to the lungs it is called a pulmonary embolus (PE) and it can be fatal. Even if a blood clot does not come loose, it can still cause long-term damage to your veins.