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Health and Wellbeing Scrutiny Committee

Agenda

Date:	**Thursday, 9th May, 2013**
Time:	**10.00 am**
Venue:	**Committee Suite 1,2 & 3, Westfields, Middlewich Road, Sandbach CW11 1HZ**

The agenda is divided into 2 parts. Part 1 is taken in the presence of the public and press. Part 2 items will be considered in the absence of the public and press for the reasons indicated on the agenda and at the foot of each report.

PART 1 – MATTERS TO BE CONSIDERED WITH THE PUBLIC AND PRESS PRESENT

1. **Apologies for Absence**

2. **Minutes of Previous meeting** (Pages 1 - 4)

   To approve the minutes of the meeting held on 4 April 2013

3. **Declarations of Interest**

   To provide an opportunity for Members and Officers to declare any disclosable pecuniary and non-pecuniary interests in any item on the agenda.

4. **Declaration of Party Whip**

   To provide an opportunity for Members to declare the existence of a party whip in relation to any item on the agenda

5. **Public Speaking Time/Open Session**

For any apologies or requests for further information, or to give notice of a question to be asked by a member of the public

Contact: James Morley
Tel: 01270 686468
E-Mail: james.morley@cheshireeast.gov.uk

A total period of 15 minutes is allocated for members of the public to make a statement(s) on any matter that falls within the remit of the Committee.

Individual members of the public may speak for up to 5 minutes, but the Chairman will decide how the period of time allocated for public speaking will be apportioned, where there are a number of speakers.

Note: in order for officers to undertake any background research, it would be helpful if members of the public notified the Scrutiny officer listed at the foot of the agenda at least one working day before the meeting with brief details of the matter to be covered.

6. **Mid Cheshire NHS Hospital Trust - Quality Accounts 2012/13** (Pages 5 - 84)

To examine the Quality Accounts for 2012/13 of the Mid Cheshire NHS Hospital Trust.

7. **East Cheshire NHS Trust - Quality Accounts 2012/13** (Pages 85 - 190)

To examine the first draft of the Quality Accounts for 2012/13 of the East Cheshire NHS Trust and provide comments to be included within the final draft.

8. **Work Programme** (Pages 191 - 196)

To review the current Work Programme (attached).

9. **Health and Wellbeing Board Update**

To receive an update on the Health and Wellbeing Board.

Agenda Item 2

CHESHIRE EAST COUNCIL

Minutes of a meeting of the **Health and Wellbeing Scrutiny Committee** held on Thursday, 4th April, 2013 at The Capesthorne Room - Town Hall, Macclesfield SK10 1EA

PRESENT

Councillor G Baxendale (Chairman)
Councillor A Harewood (Vice-Chairman)

Councillors R Domleo, D Hough, W Livesley, A Moran, J Saunders, F Keegan (as Substitute for Councillor J Weatherill) and L Jeuda (as Substitute for Councillor I Faseyi)

Apologies

Councillors J Weatherill and I Faseyi

OTHERS PRESENT

Councillor J Clowes – Portfolio Holder for Health and Adult Social Care
Councillor S Gardiner – Cabinet Support Member for Health and Adult Social Care
Fiona Field – South Cheshire Clinical Commissioning Group
Rebecca Patel – Eastern Cheshire Clinical Commissioning Group

OFFICERS PRESENT

Guy Kilminster – Head of Health Improvement
James Morley – Scrutiny Officer

111 MINUTES OF PREVIOUS MEETING

The minutes of the meeting on 7 March 2013 were approved as a correct record

112 DECLARATIONS OF INTEREST

There were no declarations of interest

113 DECLARATION OF PARTY WHIP

There were no declarations of party whip

114 PUBLIC SPEAKING TIME/OPEN SESSION

Ms Charlotte Peters Rock addressed the Committee regarding a recent decision by East Cheshire NHS Trust to permanently close Tatton Ward in Knutsford and suggested that closure of services had caused pressures on other NHS services resulting in issues of over subscription to beds in A&E and Acute Care. She suggested that the pressure on the care system and carers was having a knock

on effect on health services provided to the wider population of Cheshire East and asked the Committee what it would be doing to ameliorate the issue.

115 **CLINICAL COMMISSIONING GROUPS BRIEFING**

The Committee received a briefing on Clinical Commissioning Groups (CCGs). Fiona Field and Rebecca Patel attended the meeting to provide presentations on South Cheshire CCG and Eastern Cheshire CCG respectfully. Members asked questions and the following points were made:

- The Key focus of CCGs was the commissioning and monitoring of services that were centred on the needs of the patient and carer(s).

- General Practitioners (GPs) were members of CCGs to commission all services apart from their own. Primary Care from GPs was commissioned by NHS England and was an important part of health services.

- CCGs were responsible, along with the Council, for development of Cheshire East's Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing Strategy (JHWS).

- Eastern Cheshire CCG consisted of 23 GP Practices covering: Alderley Edge, Congleton, Holmes Chapel, Knutsford, Macclesfield, Poynton and Wilmslow. This area had a population of approximately 201,000 and a budget of £219million.

- South Cheshire CCG consisted of 18 GPs covering: Audlem, Alsager, Crewe, Middlewich, Nantwich and Sandbach. This area had a population of approximately 173,000 and a budget of £193million.

- Setting the budgets had been a complicated process of unpicking the PCTs budgets with funding being directed to a variety of different organisations. CCGs' budgets were mostly based on population but were also weighted based on the proportion of older people and the overall level of deprivation in the area.

- The key challenges for CCGs included reducing health inequalities and improving health outcomes for patients.

- CCG annual plans would set measurable targets based on desired health outcomes and would be focussed on making a difference to patients. The Committee would be able to scrutinise the plans and the performance of CCGs through the measureable targets. Local measures would be based on local priorities identified in the JHWS.

- Some residents living in south Cheshire used North Staffordshire Hospital rather than one of the hospitals in the Borough. The CCGs would try to ensure that they included figures for those residents

that use hospitals outside of the Borough in their performance outcomes.

- Issues like obesity were the responsibility of the Council through Public Health rather than CCGs. Demand Management was about prevention of ill health and reducing the need to go to hospital rather than reducing the number of cases that were dealt with.

The Committee discussed how it would scrutinise the performance of CCGs n future. It was suggested that expectations needed to be managed as it may take several years before significant improvements resulting from the introduction of CCGs would be visible. However there would be some indicators of performance at an earlier stage and the Committee would be able to examine these within twelve months. The Chairman suggested that representatives of the CCGs could attend a meeting in six months to inform the Committee about how the changes to commissioning had progressed and whether there were any inefficiencies in the new system.

RESOLVED:

(a) That the presentation be noted.

(b) That representatives of the CCGs be invited to attend a meeting in six months to update the Committee on progress within the new health arrangements.

116 **COMMITTEE PROTOCOL WITH THE SOUTH CHESHIRE CCG AND THE EASTERN CHESHIRE CCG**

The Committee considered a draft protocol with the Eastern Cheshire Clinical Commissioning Group and the South Cheshire Clinical Commissioning Group (CCGs) which was an updated version of an existing protocol between the previous Health and Adult Social Care Scrutiny Committee and the Central and Eastern Cheshire Primary Care Trust (PCT) which had taken account of the new National Health Service (NHS) arrangements brought about by the Health and Social Care Act 2012 which abolished PCTs and Strategic Health Authorities (SHAs), and introduced CCGs.

The Committee suggested some minor amendments to the protocol. Fiona Field of South Cheshire CCG suggested that the protocol needed amending to reflect that CCGs would not be responsible for commissioning of primary care services as PCTs had been because the General Practitioners (GPs) running the CCGs would not commission their own services. Ms Field offered to assist in amending the protocol and suggested that a protocol between the Committee, and the Cheshire & Merseyside Local Area Team (LAT) and NHS England to cover the commissioning of primary care services. It was also suggested that the Committee may need a protocol with Cheshire East Healthwatch.

RESOLVED:

(a) That the scrutiny officer, with support from officers of the Clinical Commissioning Groups (CCGs), be requested to amend the protocol to reflect that CCGs will not be responsible for

commissioning primary care services as the Primary Care Trust (PCT) had been.

(b) That the scrutiny officer investigate the need for a protocol with the Cheshire and Merseyside Local Area Team to cover the commissioning of primary care services.

(c) That with the following amendments be made to the protocol:
   a. Reference to Strategic Health Authorities be removed.
   b. Reference to Scrutiny Committee Spokesperson be replaced by Vice Chairman.
   c. In the sentence at 8.7 which reads "At level one, the committee would not become involved directly, but would assume that the Healthwatch is being consulted" that "assume" be replaced by "be notified".

117 HEALTH AND WELLBEING BOARD UPDATE

Councillor J Clowes gave an update on the Health and Wellbeing Board. The Board had official begun operating on 1 April 2013 and would hold its first public meeting on 30 April 2013. At its last meeting in shadow form the Board had received an update of Healthwatch. Healthwatch would be represented on the Board but a nomination had not yet been received. The terms of reference for the Board were being reviewed due to new regulations; Councillor Clowes stated that the new terms of reference would be shared with the Committee when available.

118 WORK PROGRAMME

The Committee discussed its work programme. At its next meeting the Committee was due to receive the quality accounts of East Cheshire NHS Trust and Mid Cheshire NHS Trust.

RESOLVED – That the work programme be noted.

119 CONSULTATIONS FROM CABINET

Councillor J Clowes informed the Committee that Cabinet had received the Dementia Task and Finish Scrutiny Report which had been endorsed by the Committee at its previous meeting and that the report would be referred to the Health and Adult Social Care Policy Development Group for consideration.

The meeting commenced at 10.00 am and concluded at 12.17 pm

Councillor G Baxendale (Chairman)

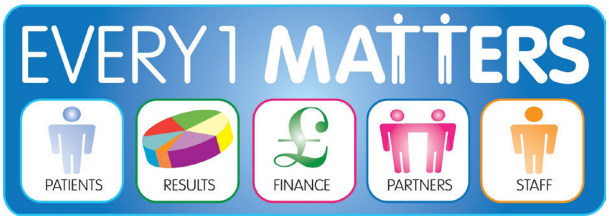
Mid Cheshire Hospitals NHS
NHS Foundation Trust

Quality Account 2012/13

Quality and Safety at Heart

Mid Cheshire Hospitals NHS Foundation Trust
Quality Account 2012/13

"Mid Cheshire Hospitals NHS Foundation Trust prides itself on the quality and safety of care it delivers to patients and carers"



Contents

Part 1
Statement on quality from the Chief Executive

I am pleased to present our fourth published Quality Account for the period of April 2012 to March 2013.

Mid Cheshire Hospitals NHS Foundation Trust is the organisation that runs Leighton Hospital, Crewe, Victoria Infirmary, Northwich and Elmhurst Intermediate Care Centre in Winsford.

2012 has continued to be a successful period for the Trust, with many significant achievements in quality, safety and experience. We are extremely proud to have continued our success within Infection Control having only one MRSA infection this year and seeing a further reduction in the number of cases of Clostridium difficile, placing us amongst the highest performers in the North West.

Another achievement has been the continued reduction in our mortality rates. We were awarded the CHKS national awards for the **Most Improved Hospital in 2012**, against 23 quality indicators (including mortality) and the CHKS **top 40 Trusts in the country**.

In December 2012, the Care Quality Commission (CQC) conducted an unannounced visit to a number of wards at Leighton Hospital to assess against 5 essential standards of care. The Trust received a very positive report that reflected the direct experiences of patients on our wards on that day. Most notable were the patient comments in relation to being treated with care and compassion.

There have been many areas where we have introduced new services/ new pathways to improve quality. One example is the introduction of an acute oncology service, being one of the first hospitals in the region to put this service in place. We have seen great benefits to patients who have been diagnosed with cancer and the care they receive when they have unplanned admissions to hospital.

This report also demonstrates that the Trust has a number of assurance mechanisms in place which demonstrate how we scrutinise the quality of the care that we deliver. Examples of these are the extensive audit program and the nursing acuity tool used to ensure correct staffing is in place.

I would like to take this opportunity to give a huge ‘thank you’ to all our staff for your efforts in 2012. I would also like to extend my appreciation to our Governors, Members, Patient Representatives and other Stakeholders who have helped shape our quality programme by taking time out to support and advise us.

I confirm that, to the best of my knowledge, the information presented in this document is accurate.

I hope you enjoy reading this Quality Account and find it of value. We are continually striving to improve our care and would therefore welcome any feedback you may have.

Tracy Bullock

Chief Executive
Mid Cheshire Hospitals
NHS Foundation Trust

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Throughout the document, there may be terminology that is not very familiar to readers. Where possible, the Trust has tried to write clearly in a user friendly way. However, some elements in the quality account are prescribed by the Department of Health or Monitor. To help readers, there is a glossary of terms at the back of the document in Appendix 1.

Part 2
Priorities for improvement and statements of assurance from the Board

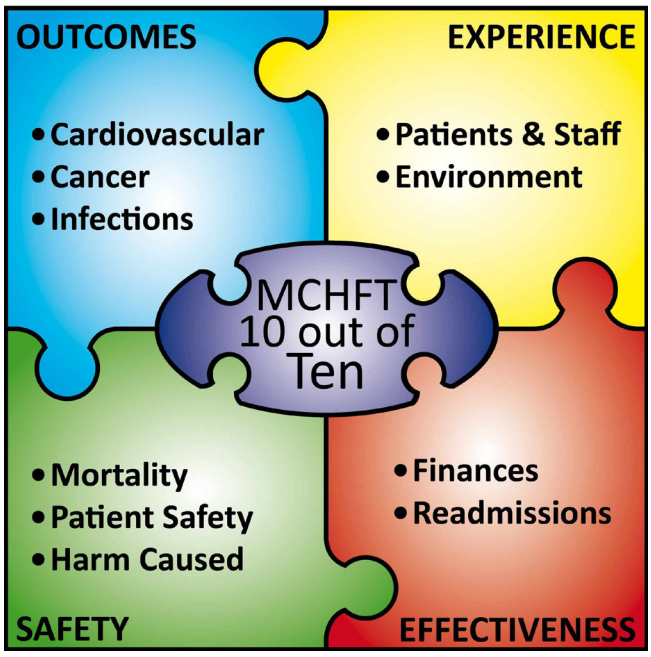
Quality, Effectiveness & Safety Committee (QuESt)

The Quality, Effectiveness and Safety Committee is responsible for providing information and assurances to the Board of Directors that the organisation is safely managing the quality of patient care, the effectiveness of quality interventions and patient safety.

During 2012/13, the Committee reviewed the 10 out of ten strategy indicators as stakeholder and public feedback had been that some of the indicators were causing confusion as they did not align to performance indicators and the outcomes framework. In considering this information, the Committee took this feedback on board and agreed to changes in two indicators: mortality and readmissions. The detail of the changes is explained in the relevant sections of the report.

Priorities for improvement in 2013/14

The Trust aims to be in the top 10% of all secondary care providers in England in ten agreed indicators of quality by 2014, selected through a public consultation process.



The quality consultation undertaken in January and February 2013 confirmed that these selected indicators remain a high priority to the local people.

These indicators are deliberately challenging as they are stretch targets designed to ensure the Trust drives improvement to the highest possible level, over and above nationally required targets.

Over the past year, it has been necessary to update the specific measures included within each indicator. This is explained within the summary of each indicator where this has taken place.

The following section provides an outline of each of the 10 out of ten indicators and how these are currently monitored and measured.

Progress against these targets during 2012/13 is described in part 3 of this report.

Safety

Mortality

To reduce the 12 month rolling Risk Adjusted Mortality Index (RAMI) by 10 points annually.

This indicator has been amended from 'to reduce mortality rates by 10 percentage points in patient groups where death is not expected.' The reason for this amendment is because this was of more significance to patients and the public.

Monitored:
A Trust mortality reduction group is well established and chaired by the Medical Director. This group reviews health records to identify areas for improvement in the quality of care provided by the Trust. Action plans are developed to address lessons learnt to ensure changes in practice are made. As the Trust monitors all mortality rates the overall intention is to reduce mortality for patient groups where death is not expected.

Measured:
The Trust uses CASPE Healthcare Knowledge Systems (CHKS) as the provider of comparative information and quality improvement services. This system provides information about mortality rates on a monthly basis.

Patient Safety

To monitor and reduce the number of unnecessary patient moves during a patient's stay in hospital.

Monitored:
The number of patient moves during each emergency admission is monitored using the Trust's information management system. The clinical divisions monitor this information on a monthly basis.

Measured:
All patient moves are measured through the Integrated Care System (ICS) which is the patient management system used by the Trust.

Harm Caused

To monitor and reduce the number of patients who experience avoidable harm by 10% annually.

Monitored:
The patient safety team reviews all patient safety incidents in order to identify lessons to learn and implement changes in practice. This is reported in the integrated governance monthly assurance report and is presented to various committees in the Trust's governance structure.

Measured:
The Trust's incident reporting system is used to determine the number of patients who suffer avoidable harm. All patient safety incidents are reported externally via the National Learning and Reporting System (NRLS). The NRLS send the Trust a report every six months on performance measured against other small acute Trusts.

Effectiveness

Readmissions

To reduce the number of patients who are readmitted to hospital within 30 days of discharge.

(This indicator has been amended from 'to reduce the number of patients who are readmitted to hospital within 7 days of discharge.' The reason for this amendment was to maintain consistency with national reporting requirements. It was identified that the use of the 7 day measure was causing confusion amongst members of the public and staff.)

Monitored:
The Trust monitors patients who have been readmitted as an emergency within 30 days.

Measured:
Readmissions to hospital within a 30 day period following discharge as an emergency admission are measured using ICS.

Finance

To reduce the percentage of the Trust's budget that is spent on management costs.

Monitored:
The percentage of non clinical spend is monitored by the Trust's finance department and compared with available benchmarking data to identify areas for improvement.

Measured:
Measurement is determined by taking the amount of actual expenditure outside of the clinical divisions and comparing this as a percentage of the total actual expenditure.

Experience

Patients & Staff

To ensure that the ratio of doctors & nurses to each inpatient bed is appropriate for delivering safe high quality patient care.

Monitored:
A nursing and midwifery acuity group has been established which is chaired by the Deputy Director of Nursing & Quality. This group meets bi-monthly and reports to the executive workforce committee.

Measured:
The nursing and midwifery acuity group reviews the results of the Safer Nursing Care (SNC) acuity / dependency monitoring tool which assesses the numbers of nursing staff required in adult inpatient wards. This process is undertaken at least every 6 months.

Similar tools for nurses and midwives working in other areas of the Trust are also being reviewed, implemented and evaluated.

The ratio of doctors has, in the previous 3 years, been an element of the 10 out of ten strategy. The data previously used to report this indicator is no longer available to the Trust. There has been extensive work undertaken to look at other information available to the Trust such as the 2011 census and consultant episodes of care. Unfortunately, this has proven not to be able to provide the information the Trust needs in a robust way to support this indicator. Therefore it is no longer possible to report against this metric.

Environment

To monitor and eliminate mixed sex accommodation for all patients admitted to the Trust (unless based on clinical need).

Monitored:
A delivering same sex accommodation (DSSA) group has been established which is chaired by the Deputy Director of Nursing & Quality. This group meets quarterly and reports to the Patient Experience Committee.

Measured:
The DSSA group reviews incident reports and patient feedback (via surveys and comments to the customer care team). It also evaluates progress against the Trust's self assessment toolkit and the delivering same sex accommodation improvement plan. The uptake of staff training relating to privacy and dignity is also reviewed.

Outcomes

Cardiovascular

To reduce the 30 day mortality rate in patients following Acute Myocardial Infarction (AMI).

Monitored:
The AMI mortality is monitored monthly by the emergency care division. The division's reducing mortality group reviews mortality and escalates issues when required to the Trust's hospital mortality reduction group. The division's performance report is also reviewed by the performance and finance committee.

Measured:
The data relating to mortality in AMI within 30 days is collated by the Trust using CHKS on a monthly basis. This rate is benchmarked against the Trust's peer organisations.

Cancer

To reduce acute admissions and length of stay in hospital following early complications of diagnosis and / or treatment of cancer.

Monitored:
The data for acute admissions and length of stay is monitored by the Cancer Network. The Trust's acute oncology team reports this data to the surgery and cancer divisional board.

Measured:
The acute oncology unit measures the reasons for acute admissions to ensure the preferred place of care for patients diagnosed with cancer is achieved.

Infections

To reduce the rates of Healthcare Associated Infections (HCAI).

Monitored:
MRSA and *Clostridium difficile* rates are monitored on a monthly basis and reported to the strategic infection control committee which is chaired by the Director of Nursing & Quality.

Measured:
The rates of MRSA and *Clostridium difficile* are measured and benchmarked nationally by the Health Protection Agency (HPA).

Statements of assurance from the Board

Review of services

During 2012/13 the Trust provided and / or subcontracted 39 relevant health services.

The Trust has reviewed all the data available to it on the quality of care in all of these services.

The income generated by the relevant health services reviewed in 2012/13 represents 100% of the total income generated from the provision of NHS services by the Trust for 2012/13.

Feedback from patients

National Patient survey results

To improve the quality of services that the NHS delivers, it is important to understand what patients think about their care and treatment. The Care Quality Commission use national surveys to find out about the experience of patients when receiving care and treatment from healthcare organisations.

National inpatient survey 2011/2012

Between October 2011 and January 2012, a questionnaire was sent to 850 adult inpatients who had been admitted to Leighton Hospital.

Responses were received from 454 patients which equates to a response rate of 53%.

The collated results of this survey show that the Trust performed about the same as other Trusts in all categories:

- The emergency department
- Waiting to get a bed on the ward
- The hospital and the ward
- Doctors
- Nurses
- Care and treatment
- Leaving hospital
- Overall views and experiences

The Trust achieved particularly high scores in relation to providing information about the patients' condition, providing enough privacy when they were examined in the A&E department, waiting times to get a bed on a ward and explaining how to take medication in a way that patients could understand.

Areas identified for improvements

- **Explaining medication side effects** - Pharmacists now review medicines available at ward levels to reduce the drugs that are dispensed from Pharmacy and liaise closely with patients to discuss their drugs as they do this.

- **Reducing call bell delays** - The Trust has started to introduce care rounds by nursing staff to identify any help patients need on a regular basis, therefore reducing the need for patients to call for assistance.
- **Improving asking patients for their views about the quality of care they have received** - Over 200 patients discharged from hospital were telephoned at home to ask their views about the care they received.
- **Reducing discharge delays and improving patient information about delays** - Patients are encouraged to use the discharge lounge when waiting to go home. This area is staffed by a qualified nurse who can ensure patients are kept informed about delays and proactively makes sure they are kept comfortable. Feedback from patients about the discharge lounge and its services has been very positive.

National inpatient survey 2012/2013

Between October 2012 and January 2013, a questionnaire was sent to 850 adult inpatients who had been admitted to Leighton Hospital. Responses were received from 444 patients which equates to a response rate of 52%.

The CQC will publish a benchmark report including results later in 2013.

Examples of comments made by patients in the national inpatient survey 2012

Patients commented on what was particularly good about their care:

"I always have great confidence in the competence of doctors. The nursing staff were also absolutely excellent. Nothing was too much trouble for them. They were focused, well-informed, energetic and constantly helpful. I particularly appreciated the frequency with which my blood sugars were monitored, even in the early hours of the morning. I am glad to have the opportunity of expressing my appreciation of them."

"The nursing staff were excellent, they were very attentive and caring."

"I was on two wards whilst in hospital and on both of these wards the nursing staff were exceptional in their care of patients and skills."

"Staff at all times were helpful and courteous. The hospital was very clean."

"The doctors were meticulous in their explanations and how and why they were following certain procedures."

"Everyone – paramedics/ambulance staff/doctors/nurses and all hospital staff were appropriately pleasant. I was always a person, not a number."

Areas for action for 2012/2013

1. Ensuring standards of cleanliness in rooms and wards are maintained.
2. Continue to monitor response times to call bells for patients and ensure staffing levels are correct based on the dependency needs for each ward.
3. Reduce unnecessary noise on wards at night.

National accident and emergency survey

During 2012, a questionnaire was sent to 850 people who had attended the accident and emergency department (A&E) during March 2012. Responses were received from 392 patients which equates to a response rate of 46%.

The collated results of this survey show that the Trust performed about the same as other Trusts in all categories:

- Travel by ambulance
- Reception and waiting
- Doctors and nurses
- Tests
- Hospital environment and facilities
- Leaving the A&E department
- Overall views on experience

✓ Overall the Trust achieved an improved set of results since the previous survey in 2008.
✓ The overall average score has increased from 72% to 76%.
✓ The Trust has improved by more than 5% or more on 8 questions.
✓ There have been no reductions by 5% or more in any question.
✓ The Trust scores around average (middle 60%) on most questions.

Patients made the following comments about their care:

"I have angina and was told I had done the right thing in going to A&E. At no time did I feel I had wasted their time (from doctors and nurses). I was well care for until my blood results were available. I was treated extremely well and have nothing but praise for the A&E department I attended".

"It would have been helpful to have an idea about timespans i.e. how long it may be before being called through. After an hour I was called through. I thought it was to see a doctor, but it was to see a nurse. It would be helpful to know how it all worked".

Areas for action for 2012/2013

- Ensure the plasma information screen is up kept up to date with details of current waiting times in the department.
- Provide information about waiting times at triage and/or reception.
- Provide information leaflets to explain processes within the A&E department.

Patient and public involvement programme

The Trust has an annual Patient and Public Involvement programme which includes a range of methods of seeking feedback from patients, carers and service users including patient satisfaction surveys.

In 2012/13, 34 local patient surveys were undertaken, 11 of which were conducted using a touch screen survey kiosk. The kiosk is an electronic, mobile device which allows patients and visitors to complete the surveys online. Once the feedback has been collated action plans are implemented to address any issues which have been identified from the survey.

The following information provides some examples of results of local patient surveys and improvements made from the results of four randomly selected surveys:

Patrick Murphy Unit (Gynaecology Clinic)
49 responses received via the kiosk.

Examples of responses received:
97% of patients felt their privacy was respected
93% of patients said they would recommend Leighton hospital to friends and family
84% of patients felt they received information that was easy to understand prior to their appointment.

Areas to action:
70% of patients were not offered an alternative private area
20% of patients did not receive any information prior to their appointment which was easy to understand.

Changes implemented following the survey:

- ✓ A new private room has been identified for patients who wish to speak in confidence with staff.
- ✓ Waiting times are now displayed and updated on a regular basis in the waiting area.

Confidentiality survey
95 responses received via the kiosk.

The following are the most recent examples of responses received:
95% of patients felt hospital staff respected the confidentiality.
95% of patients felt they could trust us as a hospital with their personal information.

Areas to action:
20% of patients did not feel adequately informed about how the hospital uses personal information.

Changes implemented following the survey:

- ✓ The introduction of the new "How we use your personal information" leaflet, copies now available in all areas.

A new style poster has been developed to ensure that feedback from surveys are displayed with clear actions highlighted as a result .

Macmillan Cancer Unit
92 responses received from a sample size of 100.

The following are the most recent examples of responses received:
100% of patients said staff treating them introduced themselves.
100% of patients felt staff listened carefully to what you had to say and their answers were informative and helpful'
100% of patients said the nurses gave them the opportunity to ask questions
98% of patients felt there was enough access to privacy if required
100% of patients felt the staff treated them treated them with respect

Areas to action:
Patients not always informed of clinic delays upon arrival to the unit.

Changes implemented following the survey:

- ✓ All patients/relatives are informed upon arrival of any clinic delays.

Nutrition survey
62 responses from a sample size of 75.

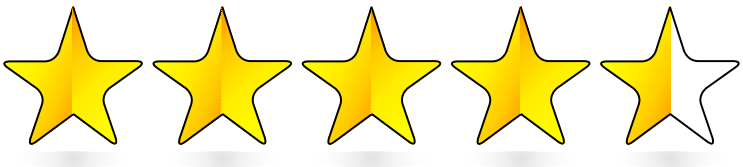
95% of patient said they were able to eat their meal without disturbance.
90% of patients felt their dignity was maintained during mealtimes.
90% of patients said they were offered regular drinks.

Areas to action:
87% of patients said they were not asked if they would like to eat their meal in the dayroom.
50% of patients were not offered the chance of washing their hands before their meal.
20% of patients said they were not offered condiments with their meal.

Changes implemented following the survey:
- ✓ Patients are now offered the use of the dayroom to eat their meals during their stay.
- ✓ All patients are now given hand wipes prior to their meals and offered condiments.

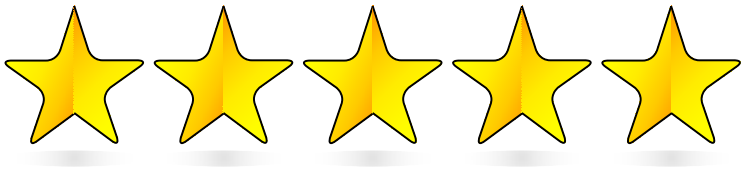
NHS Choices

Patients can comment about their experience on the NHS Choices website. There were a total of 76 new postings on the NHS Choices website in 2012/2013.



Leighton Hospital

Victoria Infirmary



As from December 2012, NHS Choices commenced using a star rating to assess NHS organisations. Leighton Hospital has achieved a star rating of 4.5 stars out of a maximum rating of 5 stars, whilst the Victoria Infirmary in Northwich has achieved 5 stars.

The Trust displays examples of positive postings on notice boards and actions any suggestions for improvement.

Examples of these include:

"The care I received in the Treatment Centre was considerate and efficient, staff were friendly and attentive"

"I have visited the Urology department on a number of occasions recently staff have always been friendly, courteous and efficient"

"From the moment I arrived until my departure staff treated me with courtesy, warmth and compassion in a very professional manner".

"Staff on ward 10 were fantastic, very attentive and made my stay a great deal easier".

"A service delivered by the Breast Care Unit with dignity, respect and compassion".

"I received efficient and effective treatment in the Accident and Emergency department".

"Staff in the Planned Investigations Unit were marvellous, they reassured and told me what they were doing and why".

Other patient and public involvement programme activities

Patient stories
Each month, the public board meeting is opened with a patient story. A patient story is where a patient, or carer, describes their experience of healthcare in their own words. The aim is to gain an understanding of what it is like to be a patient at the Trust, what was good and what could be improved. This is felt, by the organisation, to be an important way to set the tone of the meeting and ensure the Trust is grounded in the very essence of the patient experience.

Patient Register group meetings
The group consists of volunteers and members of the public who assist the Trust with various methods of involvement and is an opportunity for the Trust to share news of developments and to seek views form members. The meetings, held at local libraries, covered many topics which included presentations from the Eye Care Centre, the new Stroke Unit, Elmhurst Intermediate Care Centre, Pathology and the Infection, Prevention and Control Service.

Community talks
The Pathology Service Lead was invited to attend and talk to a community group. 2012 was National Pathology Year and an opportunity to increase public awareness and understanding. Pathology plays an important role in patient's diagnosis and treatment however, because much of the work is behind the scenes, many people are unaware of their vital contribution to medicine.

Readers' Panel
The panel has a total of 60 members and they have reviewed a total of 12 leaflets from April 2012 to March 2013. Leaflets included post operative information following surgery, Accident and Emergency information and parent information for babies who have MRSA and an easy read version of the Quality Accounts.

The panel submitted many suggestions including grammar changes and diagram or picture changes, overall the panel felt the leaflets were informative and the process supports staff in the development of patient information.

Patient Information
In 2012, the Trust introduced a patient information bedside folder. The folder includes information in relation to ward visiting times, car parking, and medication and discharge arrangements. The bedside folder was reviewed by the readers' panel, matrons, ward managers, executives and the infection control department, the folder is also available in other languages.

The Trust also has a number of leaflets now available in easy read version, all leaflets have been reviewed and approved by the Learning Disability Group. Leaflets include the following titles; Going for a blood test, Having a breast screening (x-ray), Having an ECG, Having an MRI Scan and Tell us what you think a patient feedback leaflet.

37 new patient information leaflets have been developed and an additional 36 have been reviewed either by the Patient Information Committee or Readers' Panel. 13 leaflets have been translated into other languages.

Review of complaints

The annual complaints report was produced and is available on the website via the Publication Scheme and the Customer Care pages - www.mcht.nhs.uk/customercare.

The Trust adheres to the Local Authority Social Services and National Health Service Complaints Regulations (England) 2009 and follows the Principles of Good Complaint Handling outlined by the Parliamentary and Health Service Ombudsman.

As part of the Trust's commitment to continuous improvement, a service review of the management of informal and formal complaints was undertaken in 2012. This has led to the development of a dedicated Customer Care Team who provide a single point of access for service users. This supports the single approach to dealing with complaints and provides flexibility to ensure complaints are dealt with effectively and that all feedback and lessons learned from complaints contribute to service improvement.

The Trust encourages feedback from service users on its complaint management processes and participates in the independent Patients Association Complaint Survey. The results of this survey help to identify any improvements that can be made to existing practice.

Some of the key themes of complaints received in 2012/13 involved communication, nursing care and delay in review/treatment and difficulties in parking, and are detailed opposite.

Communication – *issues raised in relation to lack of information for patients and relatives regarding treatment plans. Conflicting information given by different members of staff. Pathways/protocols not always explained properly.*

Actions taken:
- Communication skills workshops provided for staff.
- Communication & consultation skills training programme developed for medical staff.
- Dedicated "Nurse Co-ordinator" role introduced to wards to act as communication link for relatives.

Nursing Care – *issues raised regarding lack of nursing support with eating and drinking, making patients comfortable and assisting with toilet needs.*

Action taken:
- Care rounds are being introduced on a phased basis to check patients are comfortable and basic needs are met.

Delay in review/treatment – *some issues raised regarding wait times in the Emergency Department.*

Action taken:
- Patient assessment area (PAA) developed within the Emergency Department to aid patient flow and reduce wait times for patients for admission.

Car Parking – *issues raised regarding difficulty in finding a parking space during peak periods due to extensive building works across the hospital site.*

Actions taken:
- Reallocation of vacant employee parking areas to public / visitor parking. Intercom systems installed on entry and exit barriers linked directly to a Security Officer who can assist with locating a parking space. Reorganisation of security team working patterns to maximise the number of Security Officers on duty during peak periods.

The following table shows the number of complaints received, referrals to the Ombudsman and independent reviews over the past 3 years

Table 1: Overview of complaints received by the Trust

	2010/11	2011/12	2012/13
Number of complaints received	260	192	199
Number of independent reviews undertaken	1	0	0
Number of requests for review to the Ombudsman	3	10	5
Number accepted for review by the Ombudsman	0	3	4
Number upheld / partly upheld by the Ombudsman	0	1	2

Participation in clinical audits and research

The Trust is committed to embedding clinical audit throughout the organisation as a process for ensuring that healthcare provision is provided in line with best practice to optimise healthcare services. The process is facilitated through a clinical audit strategy (2010-13) that is managed through a central clinical audit function.

Both local and national clinical audit activity is instigated and led by clinicians with the support of the central clinical audit function.

National clinical audits

During 2012/13, there were 37 national clinical audits and no national confidential enquiries which covered the NHS services that the Trust provides. During the same period, the Trust participated in 70% of the national clinical audits in which it was eligible to participate.

The full list of national clinical audits can be seen in the following table which shows the clinical audits the Trust participated in and the percentage of cases submitted as required by the terms of reference for each clinical audit.

Table 2: National clinical audits participated in during 2012/13

National Clinical Audit	Participation	Data Submission
Adult community acquired pneumonia (British Thoracic Society)	Yes	100%
Adult critical care (Case Mix Programme – ICNARC CMP)	Yes	100%
National Joint Registry (NJR)	Yes	55%
Non-invasive ventilation - adults (British Thoracic Society)	Yes	In progress
Severe trauma (Trauma Audit & Research Network, TARN)	Yes	100%
National Comparative Audit of Blood Transfusion programme	Yes	100%
Potential donor audit (NHS Blood & Transplant)	Yes	Critical Care 100% Emergency Dept. 97.8%
Bowel cancer (National Bowel Cancer Audit Project)	Yes	100%
Head and neck oncology (Data for Head and Neck Oncology)	Yes	100%
Lung cancer (National Lung Cancer Audit)	Yes	100%
Oesophago-gastric cancer (National Audit for Oesphago-gastric Cancer)	Yes	100%
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Yes	100%
Heart failure	Yes	100%

National Clinical Audit	Participation	Data Submission
National Diabetes Inpatient Audit	Yes	100%
Diabetes (Paediatric)	Yes	100%
Pain database	Yes	44%
Carotid interventions audit	Yes	100%
Hip fracture database	Yes	95%
National audit of dementia	Yes	100%
Sentinel Stroke National Audit Programme (SSNAP)	Yes	100%
Elective surgery (National PROMs Programme)	Yes	80%
Epilepsy 12 audit (Childhood Epilepsy)	Yes	100%
Maternal, infant and newborn programme (MBRRACE-UK)	Yes	100%
Neonatal intensive and special care (NNAP)	Yes	100%
Paediatric asthma (British Thoracic Society)	Yes	100%
Paediatric pneumonia (British Thoracic Society)	Yes	Data collection in progress
Emergency use of oxygen (British Thoracic Society)	No	Consultant resource implications
Adult asthma (British Thoracic Society)	No	Consultant resource implications
Bronchiectasis (British Thoracic Society)	No	Consultant resource implications
Inflammatory bowel disease	No	Consultant resource implications
Renal colic (College of Emergency Medicine)	No	Availability of staff
Fractured neck of femur (College of Emergency Medicine)	No	Availability of staff
Paediatric fever (College of Emergency Medicine)	No	Availability of staff
Cardiac arrhythmia	No	Nurse specialist resource implications
National Cardiac Arrest Audit	No	Nurse specialist resource implications
Diabetes (Adult)	No	Data collection resource implications
Child health programme	No	New May 2012 – currently being reviewed

The reports of 17 national clinical audits were reviewed by the Trust in 2012/13. The table below highlights some of the actions taken to improve the quality of healthcare provided as a result of national clinical audits.

Table 3: Action taken following national clinical audit reports

National Audit	Actions Taken
Adult critical care (Case Mix Programme – ICNARC CMP)	A quarterly formal review of unexpected deaths has been instigated within the critical care unit.
National Joint Registry (NJR)	Compliant with standards to date but action is being progressed in relation to the patient's consent process to improve the Trust's submission rate.
Severe trauma (Trauma Audit & Research Network, TARN)	Good orthopaedic outcome measures were highlighted. Actions are now being undertaken to improve the numbers of patients seen by a Consultant in the emergency department and to reduce waiting times for CT scans and surgery.
National Comparative Audit of Blood Transfusion programme	Good compliance with labelling, adherence to policy and positive identification of patients. The Trust's transfusion policy is being updated to include revised processes for the handover of blood
Potential donor audit (NHS Blood & Transplant)	There has been a new appointment made to the chair of the organ donation committee. A new Trust policy for organ donation referral processes following completion of a risk assessment is being developed.
Lung cancer	A case of need has been prepared to support a second lung cancer specialist nurse and additional Consultant time. A respiratory service concept paper is being prepared and has been outlined in the emergency care division annual plan. Recording of patient information has improved in line with peer in the current dataset. The multi-disciplinary team structure is being reviewed to improve thoracic surgical presence.
Acute coronary syndrome or Acute myocardial infarction (MINAP)	There has been an improvement in compliance with prescribing patterns following the appointment of a permanent Consultant post.
Heart failure	There is a chronic heart failure protocol and specialist heart failure team in place to comply with the requirements for a multi disciplinary team clinical assessment of patients within 2 weeks of discharge.
Diabetes (Paediatric)	The percentage of patients with HbA1c (average plasma glucose concentration) <7.5% was the fourth highest in the country for compliance. Improvements in documentation have been implemented to address low compliance with key screening processes.
Pain database	There has been a change in the management of patients with epidural analgesia so that all patients with epidural analgesia are now cared for in the critical care unit. The acute pain team are developing updated pathways for the management of post-operative nausea and vomiting.
Hip fracture database	Multi-disciplinary team meetings have been implemented within the Unit in order to improve discharge arrangements for patients.
Sentinel Stroke National Audit Programme (SSNAP)	The thrombolysis service commenced in July 2012. The inpatient stroke services moved into a purpose built stroke unit in September 2012.

National Audit	Actions Taken
Elective surgery (National PROMs Programme)	Plans are being progressed to commence oral Apixiban for the prevention of deep vein thrombosis.
Epilepsy 12 audit (Childhood Epilepsy)	A paediatric epilepsy Nurse Specialist has been appointed and plans to appoint a paediatrician with an interest in epilepsy are currently under consideration.
Paediatric asthma (British Thoracic Society)	There has been a significant improvement in the documentation of assessments of inhaler technique and written discharge plans when compared to previous local audits.

Local clinical audits

The reports of 75 local clinical audits were reviewed by the Trust in 2012/13.

The table below highlights some examples of actions taken by the Trust as a result of local clinical audits to improve the quality of healthcare provided.

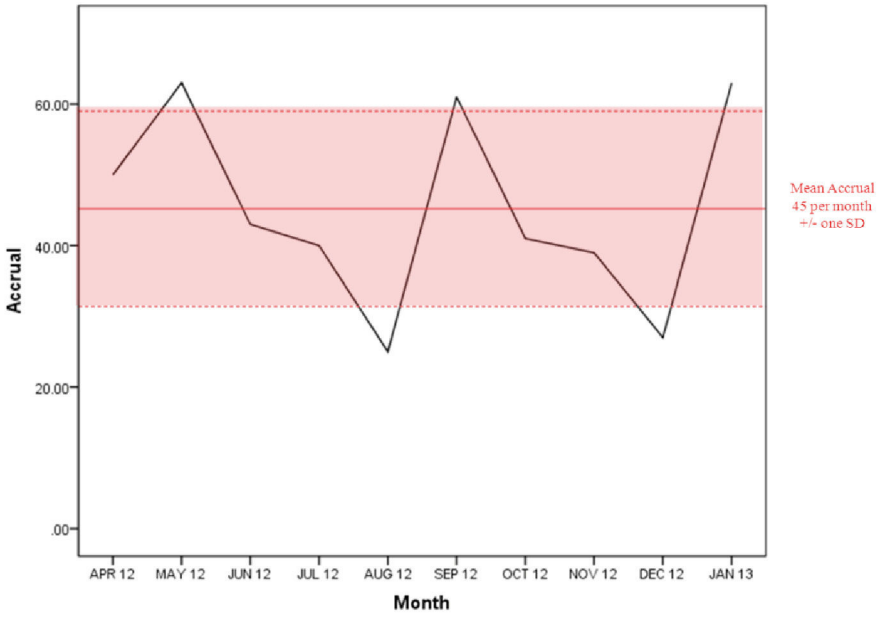
Table 4: Actions taken following local clinical audits

Local Audit	Actions Taken
Audit of Epidural Provisions within Labour Ward	A business case was presented to the Trust Board and subsequently anaesthetic cover has been increased on labour ward from 5 sessions per week to 10 sessions covering weekdays.
Re-audit of Latissimus Dorsi Flap (LDM) Reconstruction in MCHFT	The Trust VTE prophylaxis standards have been included in amended breast surgery protocols, including specific instructions around Enoxaparine, day-stay cases, in-patient cases and previous cases of VTE.
Audit of NICE CG124 Fractured Neck of Femur Patients on Orthopaedic Wards	A new pro-forma has been introduced for assessment and discharge to facilitate the mobilization and rehabilitation of patients who have undergone surgery for broken neck of femur. Plans are in place for a business case to be presented to the Clinical Commissioning Group for funding of a seven-day Physiotherapy service on the Orthopaedic wards.
Audit of Intra-Venous Urography (IVU)	Changes in practice have been agreed to stop using IVU series in favour of CT scanning where superior images are gained and improved diagnosis for treatment can be achieved.
Care of Babies with Prolonged Jaundice	A new Standard Operating Procedure and check list pathway detailing minimum tests required, in line with NICE guidelines, for prolonged jaundice cases has been introduced and now forms part of the clinical notes.

Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by the Trust between April 2012 and Jan 2013 that were recruited to participate in the National Institute of Health Research (NIHR) portfolio approved by a research ethics committee was 453.

The following chart shows the numbers of patients recruited to clinical trials over the past 10 months. There are, on average, 45 patients recruited each month.



Graph 1: Numbers of patients recruited to clinical trials

The Trust was involved in conducting 165 active clinical research studies during the reporting period including, but not limited to, the following areas:

- Cancer
- Cardiovascular
- Congenital Disorders
- Diabetes
- Eyes
- Generic Health Relevance and Cross Cutting Themes
- Infection
- Inflammatory and Immune System
- Injuries and Accidents
- Medicines for Children
- Musculoskeletal
- Oral and Gastrointestinal
- Primary Care
- Renal and Urogenital
- Reproductive Health and Childbirth
- Respiratory
- Skin
- Stroke

There are nine clinical research staff participating in research approved by a research ethics committee during the reporting period. Participation in clinical research demonstrates the Trust's commitment to improving the quality of care offered and contributing to wider health improvements. Clinical staff keep up to date with the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

The research and development team are constantly implementing change. The requirement for additional research opportunities for the local population was identified and, over the last year, partnerships have been developed with four local GP practices.

The Trust is now providing research at the primary /secondary care interface and, following feasibility assessments, NIHR studies have been implemented and successful recruitment has followed. This collaboration has sometimes proved challenging in a climate of constant change in the NHS but this has been overcome with good management support and exploring new ways of working.

Pictured above: Stephen O'Brien, MP for Eddisbury, meets with staff from the Trust's Clinical Research Department

Commissioning for Quality & Innovation framework (CQUIN)

A proportion (2.5%) of the Trust's income in 2012/13 was conditional upon achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Further details of the agreed goals for 2012/13 and for the following 12 month period are available online at:

www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275

The financial value of the 2012/13 CQUIN scheme for the Trust was £3,532,000.

For 2012/13, there were **national** CQUIN goals which focussed on the prevention of venous thrombo embolism (VTE), patient experience, dementia care and the NHS Safety Thermometer.

There were also **regional** goals which related to cancer staging, chemotherapy prescribing and advancing quality. The Trust and the local commissioners also agreed further **local** goals which are briefly described in the following table.

This table also shows the Trust's performance against each of the CQUIN goals. It can be seen that, of the 20 goals, the Trust achieved seventeen goals and has plans in place to address the three areas that were not achieved.

Full details of the CQUIN schedule and quarterly progress reports are available on the Trust's website under quality which can be accessed via the homepage at www.mcht.nhs.uk.

Key for Table 5 (opposite)

 = Achieved

 = Not Achieved

For goals 14 – 19, the Trust has anticipated the final results. The reporting period for the advancing quality programme does not close until August 2013.

Table 5: CQUIN results for 2012/13

Goal	Goal Name	Description of Goal	Achieved?
1	VTE prevention	Reduce avoidable death, disability and chronic ill health from VTE.	✓
2.	Patient Experience	Improve responsiveness to personal needs of patients.	✗
3.	Dementia Care	Improve awareness and diagnosis of dementia.	✗
4.	NHS Safety Thermometer	Improve collection of data in relation to pressure ulcers, falls, urinary tract infection and VTE	✓
5.	Cancer Staging Data	Increase number of patients' pre treatment data discussed and recorded at cancer MDT meetings	✓
6.	Chemotherapy Prescribing & Data Collection	Implementation of electronic prescribing of parenteral chemotherapy compatible with data collection using the systematic anti cancer therapy data set (SACT)	✓
7.	Prognostication & Advanced Care Planning	Implement prognostication of the last 12 months of life to ensure advanced care planning can take place.	✓
8.	Children and Young People Personal Diabetes Record	Develop and implement hand held records for children and young people with diabetes.	✓
9.	Children's Integrated Care Pathway	Develop and implement an integrated care pathway for children aged 0 - 2.5 years old who have complex physical or neurological conditions.	✓
10.	Co-ordinated Electronic Patient Records	Produce a strategy for a 5 year plan for hospital electronic patient records.	✓
11.	Implement Essence of Care Benchmarks	Implement the essence of care benchmarks as 'always events'	✓
12.	Medical Interventions and Medicines Management	Develop always events relating to medical interventions and medicine management.	✓
13.	Caring for Carers of Patients with Complex Needs	Document evidence of carers being actively involved where they wish to be involved, feel well informed and supported.	✓
14	AQ Acute Myocardial Infarction (AMI)	Implement the AQ care pathway for AMI	✓
15.	AQ Heart Failure	Implement the AQ care pathway for heart failure	✓
16.	AQ Hip and Knee Replacement	Implement the AQ care pathway for hip and knee replacement	✓
17.	AQ Stroke	Implement the AQ care pathway for stroke	✓
18.	AQ Patient Experience	All patients to complete an AQ PEMs survey	✓
19.	AQ Pneumonia	Implement the AQ care pathway for pneumonia	✗
20.	Integrated Neighbourhood Team	Participate in the development of an integrated neighbourhood team.	✓

Feedback from Care Quality Commission (CQC)

The Trust is required to register with the Care Quality Commission (CQC) and its current registration status is **unconditional** which means there are no conditions on its registration.

The Care Quality Commission has not taken enforcement action against the Trust during the period April 2012 to March 2013.

The Trust has participated in the following specials reviews and investigations by the Care Quality Commission during April 2012 to March 2013:

1. A targeted inspection programme for all acute NHS hospitals to assess services that provide the regulated activity of terminations of pregnancy. The focus of the visit was to assess the management of documentation that is used to certify the grounds under which a termination of pregnancy can lawfully take place. A random selection of medical records was checked by the CQC Inspectors who found that the Trust was compliant with the part of the regulation under review. No further action was required.

2. An annual unannounced inspection took place in December 2012 which reviewed the following outcomes for essential standards of quality and safety:
   - Outcome 1: Respecting and involving people who use services
   - Outcome 6: Cooperating with other providers
   - Outcome 7: Safeguarding people who use services from abuse
   - Outcome 9: Management of Medicines
   - Outcome 16: Assessing and measuring the quality of service provision

The Trust was found to be compliant in four of the five outcomes with minor concerns raised in relation to outcome 9: Management of Medicines.

In response to this, the Trust has developed an action plan to address the issues raised which will be monitored via the Trust governance processes.

The action plan included the dissemination of lessons learned posters and a list of critical medicines to all areas to raise staff awareness and remind them to report any incidents via the Trust's incident reporting system. Fortnightly audits to assess omissions and checking of controlled drugs has been commenced. A Trust-wide audit is proposed for the end of March 2013. Work is on-going on a new medication chart which will include standardised administration codes.

The report received from the CQC was very positive towards the services provided at the Trust. It included specific reference to the complimentary comments reported to the CQC Inspectors during their visit by patients regarding their care. Comments stated that staff were professional, caring and compassionate towards patients and respected their privacy and dignity.

Data quality assurance

NHS and General Practitioner registration code validity

The Trust submitted records during 2012/13 to the Secondary Uses service for inclusion in the Hospital Episodes 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:

99.9% for admitted patient care;
99.9% for outpatient care;
99.4% for accident and emergency care.

The percentage of records in the published data 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.

Information Governance toolkit attainment

The attainment levels assessed provide an overall measure of the quality of data systems, standards and processes within an organisation. The Trust's Information Governance assessment report overall score for 2012/13 was 72% and the Trust was graded "not satisfactory".

The reduction in score when compared with the 2011 – 2012 assessment can be attributed to the shift in focus from some lower priority requirements to Information Governance training. The Information Governance team supported the training of over 3,000 staff, students and volunteers over the course of the year. Additionally, a large number of policies required review during 2012/13. Those which were not reviewed in time for this submission are expected to be in place by the baseline submission in October 2013.

The Trust has a progressive Information Governance committee which meets quarterly and has an agenda specifically focused around the six sections of the toolkit. The outstanding requirements are highlighted at each committee and toolkit leads provide feedback on the progress of requirements.

Clinical Coding error rate

The Trust was subject to the payment by results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding were:

- Primary diagnoses incorrect: 6.7%
- Secondary diagnosis incorrect: 4.4%
- Primary procedures incorrect: 3.6%
- Secondary procedures incorrect: 8.8%

The Trust's performance in relation to the clinical coding error rate is better than the national average and has also improved in all areas when compared with the results from last year. The results shown should not be extrapolated further than the actual sample audited. A cross section of services was reviewed within this sample.

The Trust will be taking the following actions to improve data quality:

- Deliver the recommendations of the payment by results audit
- Continue to deliver required training for all accredited coders
- Recruit to the internal coding auditor position
- Continually review coding resources and performance

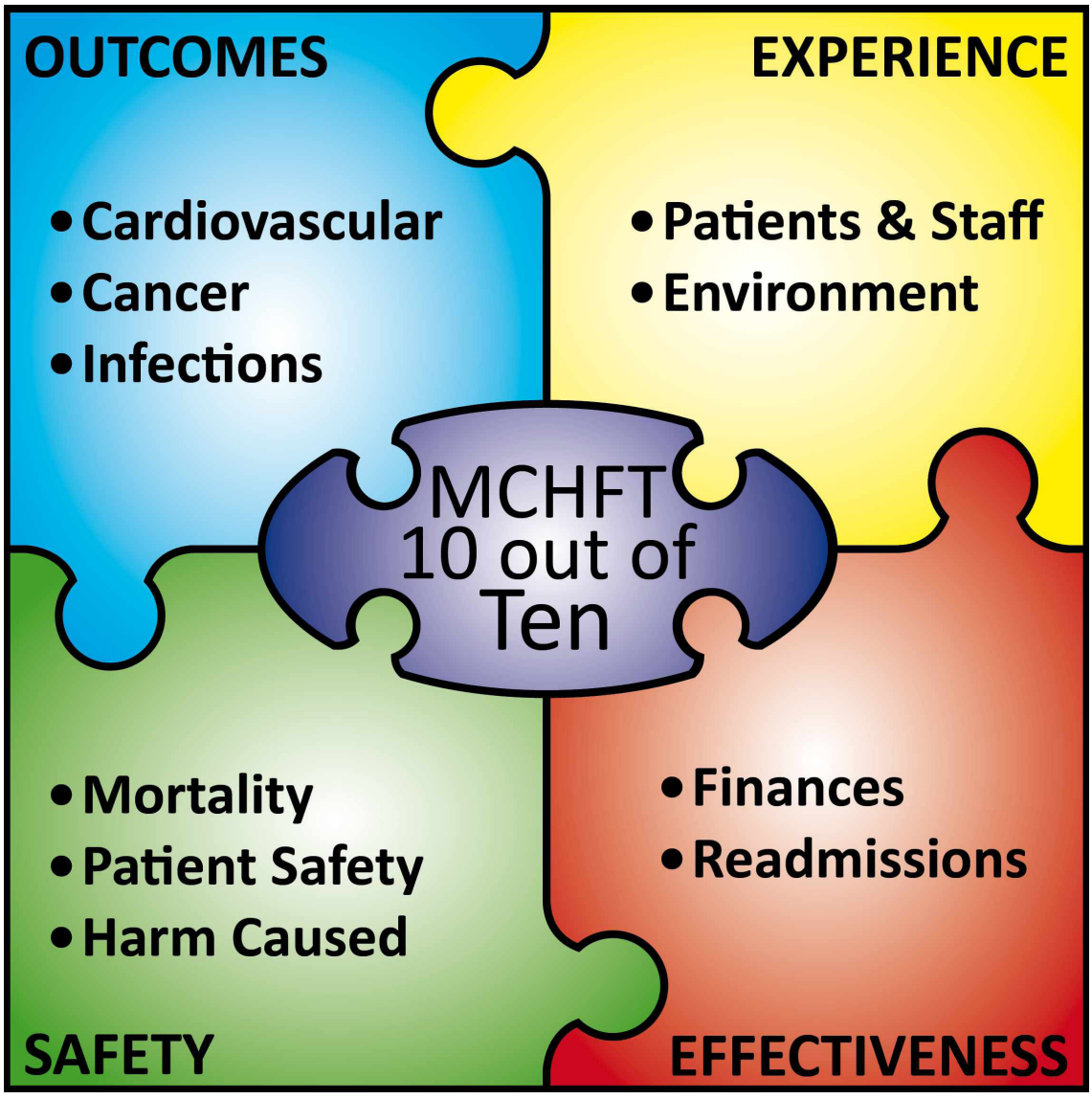
Part 3

Review of quality performance

This section of the Quality Account details progress against the Trust's 10 out of Ten strategy. It also describes the Trust's performance against areas of public interest or those recommended by other bodies such as Monitor and the Department of Health.

This review of quality performance has been detailed under the following domains of:

- Safety
- Effectiveness
- Experience
- Outcomes



Summary of overall progress

Achievement thresholds

As the Trust's 10 out of Ten quality indicators are stretch targets (over and above the national requirement), the achievement thresholds for the 2012/13 Quality Account have been set as Gold, Silver and Bronze.

Key

Achieved 10 out of Ten target (Top 10% of performing Trusts)

Performance in top 25% of performing Trusts or 10% away from 10 out of Ten threshold

Achieved better than peer or 25% away from 10 out of Ten threshold

Further work needed to achieve peer or better

Safety

Priority 1: Mortality – To reduce the 12 month rolling Risk Adjusted Mortality Index (RAMI) by 10 points annually

Priority 2: Patient safety - To monitor and reduce the number of unnecessary patient moves during a patient's stay in hospital

Priority 3: Harm caused- To monitor and reduce the number of patients who experience avoidable harm by 10% annually

Effectiveness

Priority 4: Readmissions – To reduce the number of patients who are readmitted to hospital within 30 days of discharge

Priority 5: Finance – To reduce the percentage of the Trust's budget that is spent on management costs

Experience

Priority 6: Patients & staff – To ensure that the ratio of doctors & nurses to each inpatient bed is appropriate for delivering safe high quality patient care

Priority 7: Environment - To monitor and eliminate mixed sex accommodation for all patients admitted to the Trust (unless based on clinical need)

Outcomes

Priority 8: Cardiovascular – To reduce the 30 day mortality rate in patients following Acute Myocardial Infarction (AMI)

Priority 9: Cancer – To reduce acute admissions and length of stay in hospital following early complications of diagnosis and / or treatment of cancer

Priority 10: Infections – To reduce the rates of Healthcare Associated Infections (HCAI)

- MRSA

- *Clostridium Difficile*

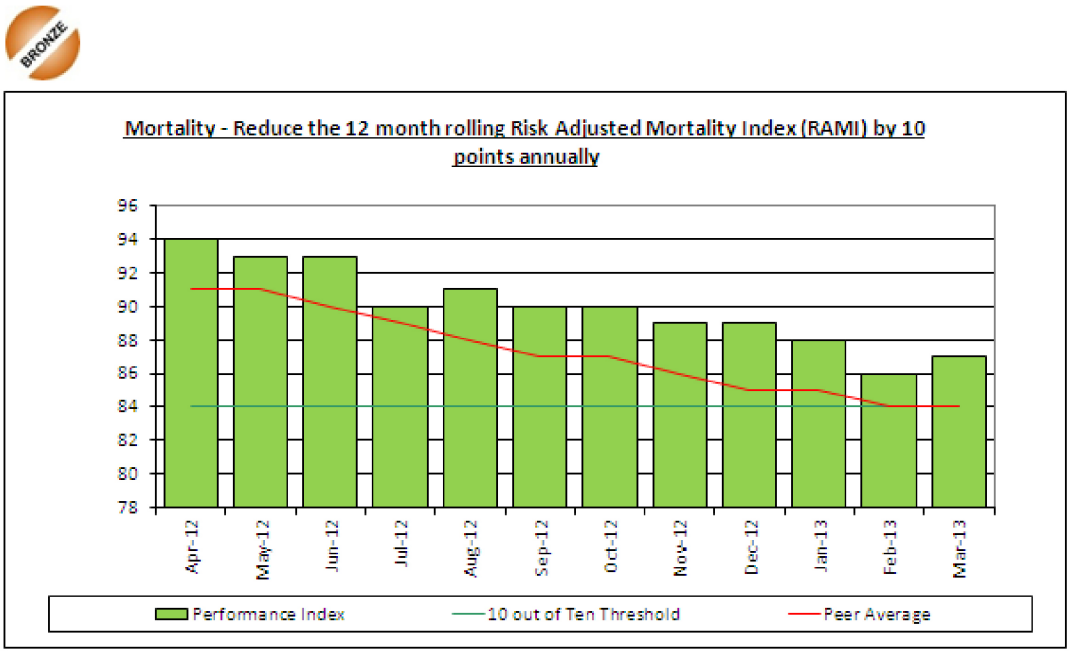
Safety

Priority 1: Mortality

To reduce the 12 month rolling Risk Adjusted Mortality Index (RAMI) by 10 points annually

In order to understand whether people are getting healthier or the Trust is getting safer, it is necessary to calculate the death rate. The crude death rate is the number of people who die in relation to the number of hospital admissions. The Risk Adjusted Mortality Index (RAMI) takes into account several factors including the relative risk of each patient's past medical history and existing conditions and displays this as an index. In general terms, the rationale for calculating death rates in hospital is so that they can be used as a measure of hospital quality.

Graph 2 shows the Trust's RAMI between April 2012 and March 2013 which demonstrates that the Trust's RAMI has reduced over the 12 month period.



Graph 2: RAMI between April 2012 and March 2013

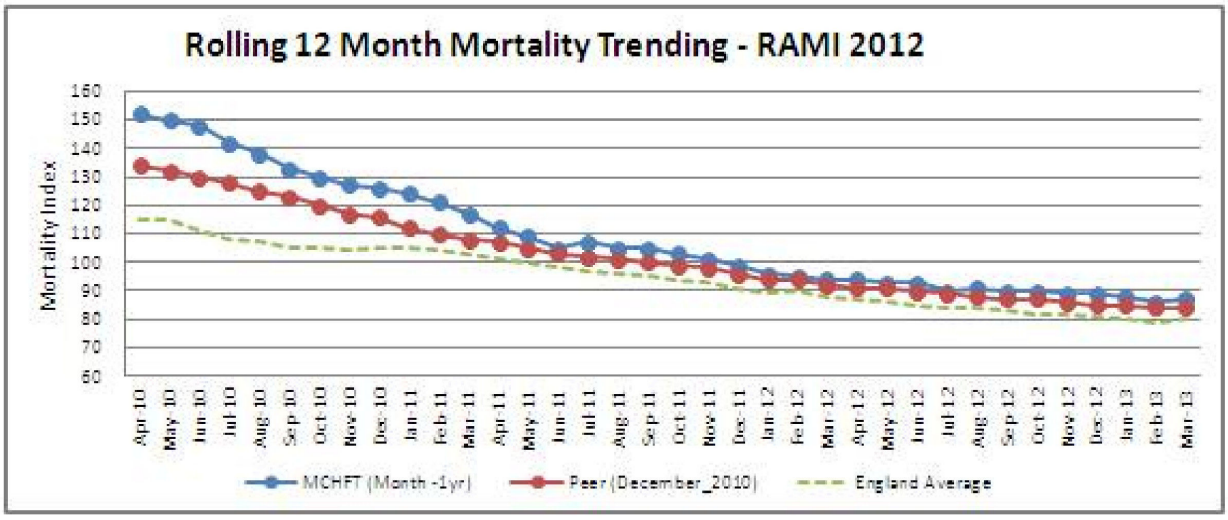
The Risk Adjusted Mortality Index (RAMI) developed by CHKS uses regression analysis to predict the expected probability of death for each patient based on the experience of the national norm for patients with similar characteristics:

- Age
- Sex
- Diagnosis
- Procedures
- Clinical grouping
- Admission type

CHKS is the provider of comparative information and quality improvement services for healthcare professionals. The Trust uses CHKS as its provider for mortality data.

Work Programme to Improve Hospital Mortality Rates
Since 2009, the Trust has monitored its mortality rate through the Hospital Reducing Mortality Group. Data from CHKS submitted to the Board of Directors each month has shown that the Trust's RAMI has fallen year on year, and is now at 87 compared to the peer of 84. This is demonstrated in graph 3 below.

The Hospital Reducing Mortality Group undertakes case note reviews to identify areas of good practice. It also asks the question 'could the Trust have done things better?' An action plan for improvement is developed and monitored via the Hospital Reducing Mortality Group. The clinical divisions also undertake case note reviews.



Graph 3: Rolling Monthly Mortality Trending

Safety

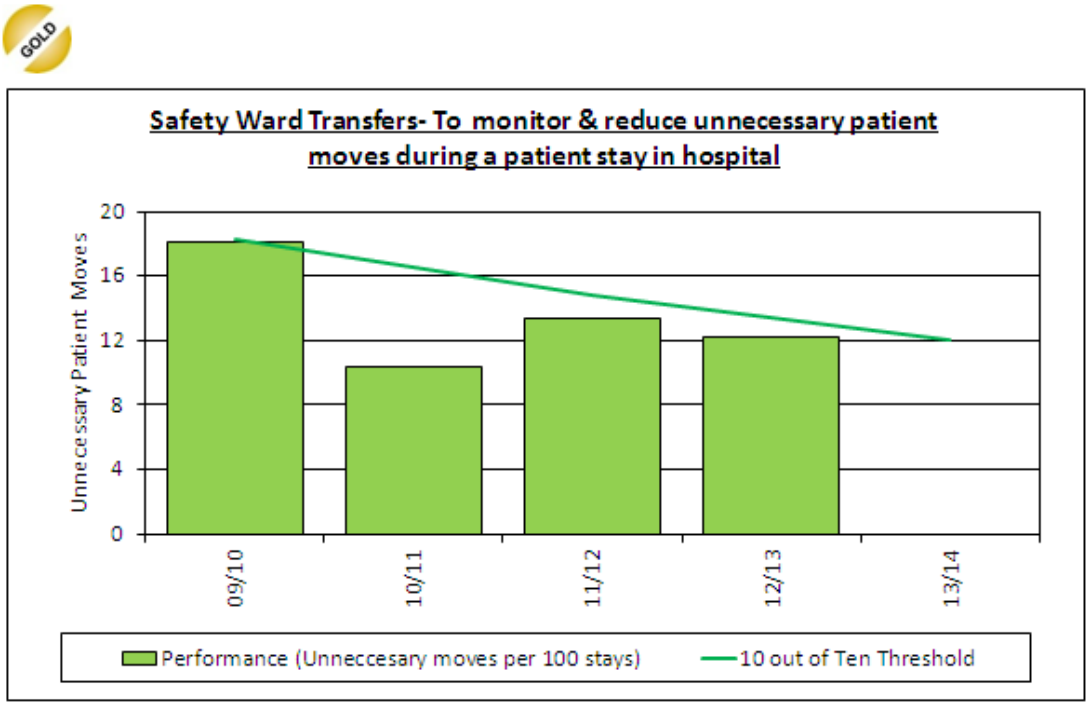
Priority 2: Patient safety

To monitor and reduce the number of unnecessary patient moves during a patient's stay in hospital

Patients appropriately move wards as part of their care pathway or if the patient's diagnosis has changed and their care transferred to another specialist. However, too many ward moves (for example to allow for the admission of acutely ill patients) can impact adversely on patient care and result in an increased length of stay in hospital. The documented goal for this priority is 'to reduce the number of times a patient is moved to another ward which is not connected with their care pathway'.

In 2010, following the launch of the Quality and Safety Improvement Strategy 2010-14, the Trust established a method of monitoring this quality indicator, which involved gathering performance data from 2009/10 in order to set a target for improvement. The target set is to achieve an annual 10% reduction from the starting point in 2009/10 for the remaining four years of the strategy.

Graph 4 shows the average number of unnecessary patient ward moves per 100 hospital stays since April 2009. The graph demonstrates that the Trust has consistently over-achieved against the target on an annual basis with an overall reduction of approximately 35% since the measure was introduced.



Graph 4: Unnecessary Patient Moves

The Trust intends to continue to reduce the number of unnecessary patient ward moves in 2013/14 by progressing the following actions:

- Ensuring that patients are admitted to the appropriate specialty and ward to care for their needs
- Monitoring and investigating the care of patients who have moved frequently during their hospital stay
- Ensuring that the bed configuration matches the demand for each specialty. This is being addressed through the Clinical Services Strategy and regular bed modelling reviews with the Divisional and Corporate teams
- Continuing to reduce the time patients spend in hospital and therefore reduce any circumstance of unnecessary ward moves
- Ensuring that reducing unnecessary ward moves is a personal objective of each member of the Patient Placement Team, who oversee ward moves within the hospital.
- Ensuring that patients who have a diagnosis of dementia are not moved to another ward, unless for clinical reasons. This action is audited regularly and the last audit showed the Trust achieved 100% for not moving patients with dementia unnecessarily.

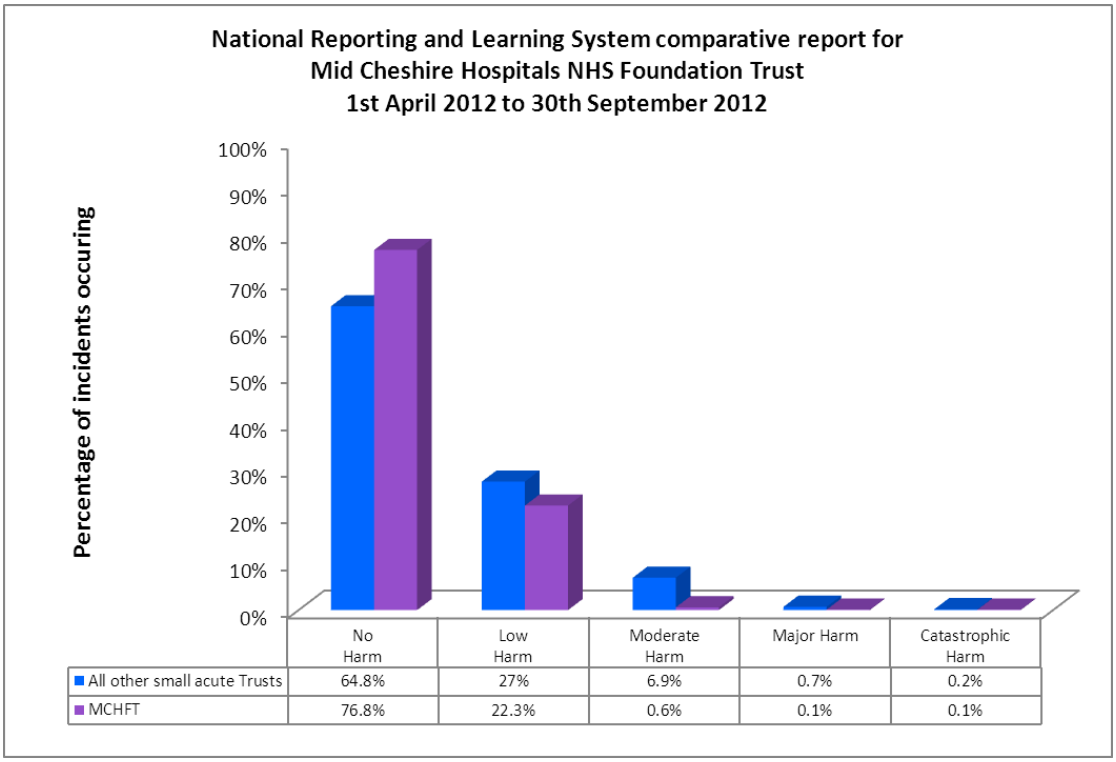
Safety

Priority 3: Harm caused

To monitor and reduce the number of patients who experience avoidable harm by 10% annually

All patient safety incidents are reported to the National Reporting and Learning System (NRLS) on a weekly basis. The NRLS produce a comparative report on a 6 monthly basis which compares the Trust with 30 similar sized acute Trusts. From June 2012, this data has been published on the NHS Commissioning Board's Website as they have now taken over the functions of the National Patient Safety Agency (NPSA). This will ensure that patient safety is at the heart of the NHS and builds on the learning and expertise developed by the NPSA.

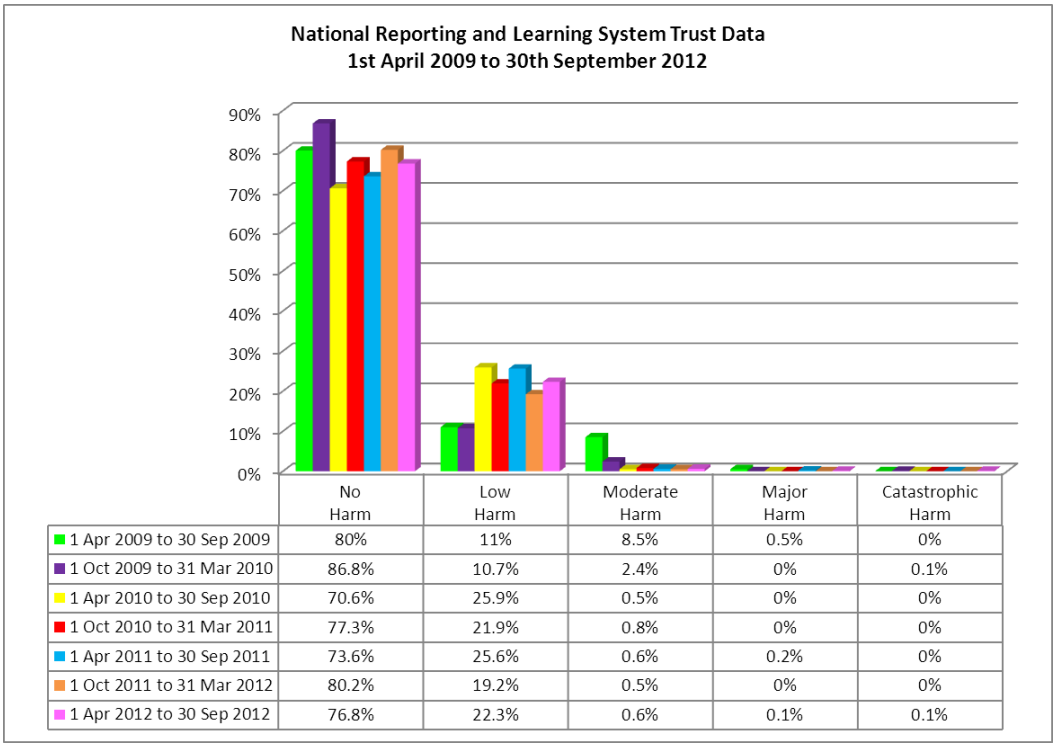
Graph 5 is the latest comparative reporting rate summary which provides an overview of incidents reported by the Trust to the NRLS between April 2012 and September 2012. This data is the latest available and was published in March 2013. The graph demonstrates that the Trust has a high number of reported no harm incidents and less harm incidents when compared to other acute Trusts of a similar size.



	No Harm	Low Harm	Moderate Harm	Major Harm	Catastrophic Harm
All other small acute Trusts	64.8%	27%	6.9%	0.7%	0.2%
MCHFT	76.8%	22.3%	0.6%	0.1%	0.1%

Graph 5: NRLS comparative data for April 2012 to September 2012

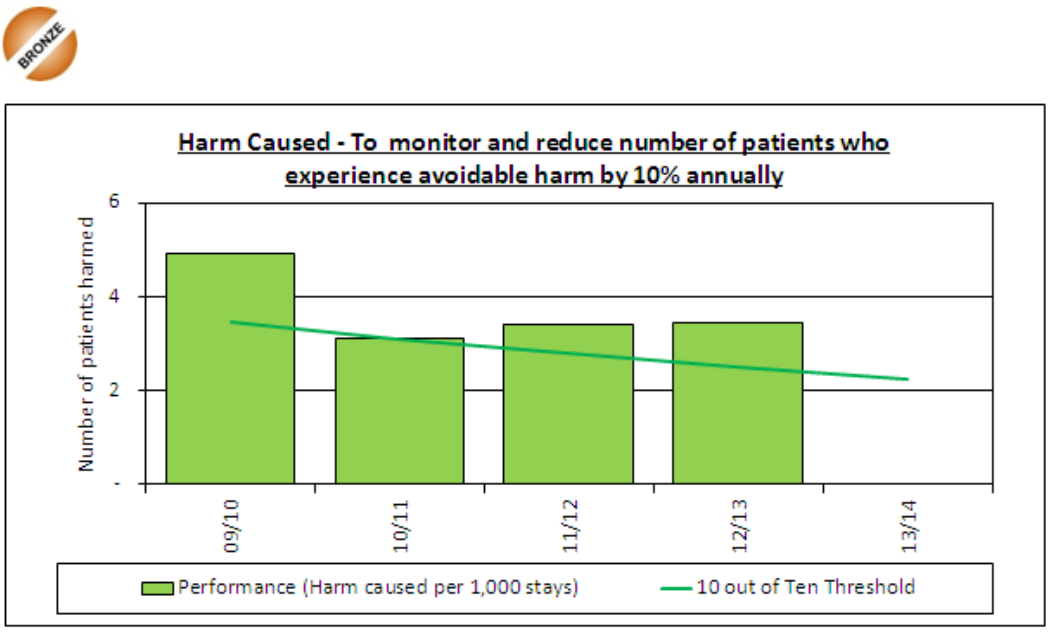
The reporting of no harm incidents is positive as it demonstrates that the Trust has a risk aware culture and that staff are open about reporting patient safety incidents.



	No Harm	Low Harm	Moderate Harm	Major Harm	Catastrophic Harm
1 Apr 2009 to 30 Sep 2009	80%	11%	8.5%	0.5%	0%
1 Oct 2009 to 31 Mar 2010	86.8%	10.7%	2.4%	0%	0.1%
1 Apr 2010 to 30 Sep 2010	70.6%	25.9%	0.5%	0%	0%
1 Oct 2010 to 31 Mar 2011	77.3%	21.9%	0.8%	0%	0%
1 Apr 2011 to 30 Sep 2011	73.6%	25.6%	0.6%	0.2%	0%
1 Oct 2011 to 31 Mar 2012	80.2%	19.2%	0.5%	0%	0%
1 Apr 2012 to 30 Sep 2012	76.8%	22.3%	0.6%	0.1%	0.1%

Graph 6: NRLS comparative data for the past 3 years

Graph 6 highlights the comparative data from the NRLS for the past 3 years. The graph demonstrates that the majority of incidents reported by the Trust resulted in no harm to patients and this has been consistent over the previous 3 years. The number of low, moderate and major harm incidents have all decreased in the period of October 2011 to March 2012 compared to the previous period of April 2011 to September 2011.



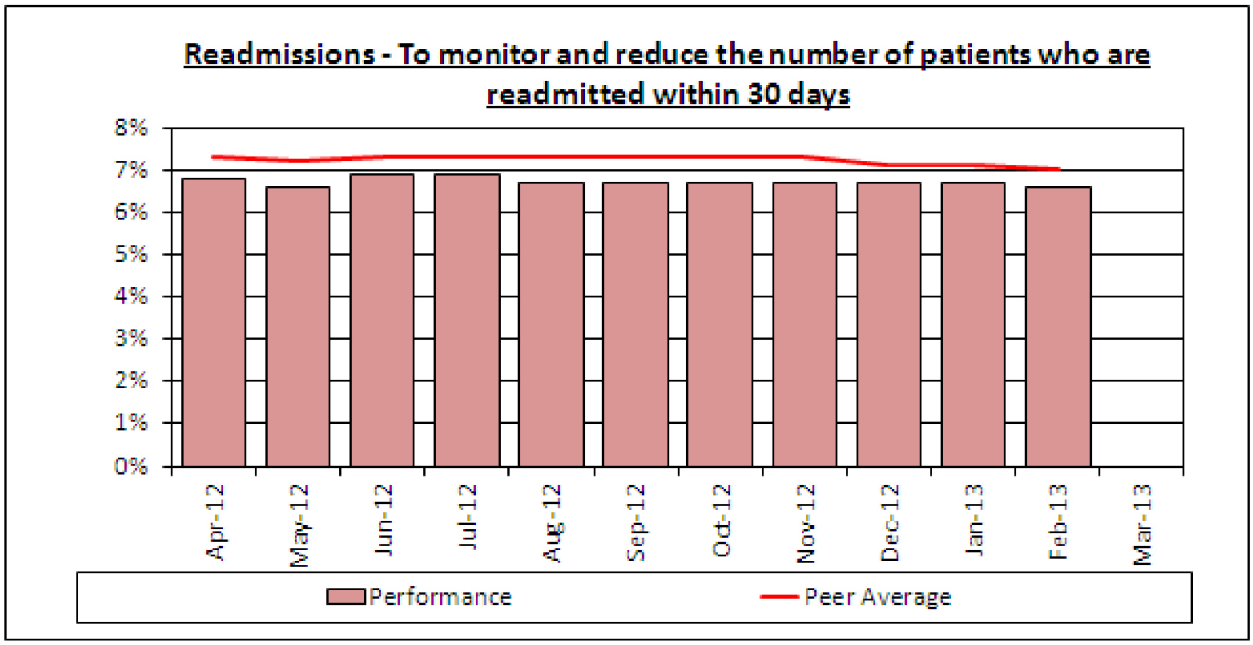
Graph 7: Avoidable harm caused

Graph 7 shows the Trust's performance against the 10 out of ten target to monitor and reduce the number of patients that experience avoidable harm by 10% annually. Although the Trust has not achieved this target, the number of patients that have experienced avoidable harm has remained the same during 2012/13 when compared to 2011/2012.

Effectiveness

Priority 4: Readmissions

To reduce the number of patients who are readmitted to hospital within 30 days of discharge



Graph 8: Reduction in number of patients readmitted within 30 days

To demonstrate effective discharge planning the Trust's priority is to reduce the number of patients readmitted to the hospital within 30 days of discharge. The graph above demonstrates that emergency readmissions within 30 days have reduced to 6.3% against a peer of average of 7.0%.

When the Trust's readmission rates are compared against the other acute Trusts in the North West of England, the Trust is in the top 10% of Trusts for the lowest readmission rates.

This success has been achieved through the daily monitoring of patients that are at high risk of readmission to ensure that a medical review is undertaken to assess each individual patient's wider health needs.

This review is followed up by a telephone call to the patient 72 hours following their discharge home by the integrated discharge team to ensure the continuing well being of the patient and to deal with any concerns that may have arisen.
Effective links with the relevant community teams have also been progressed to ensure the

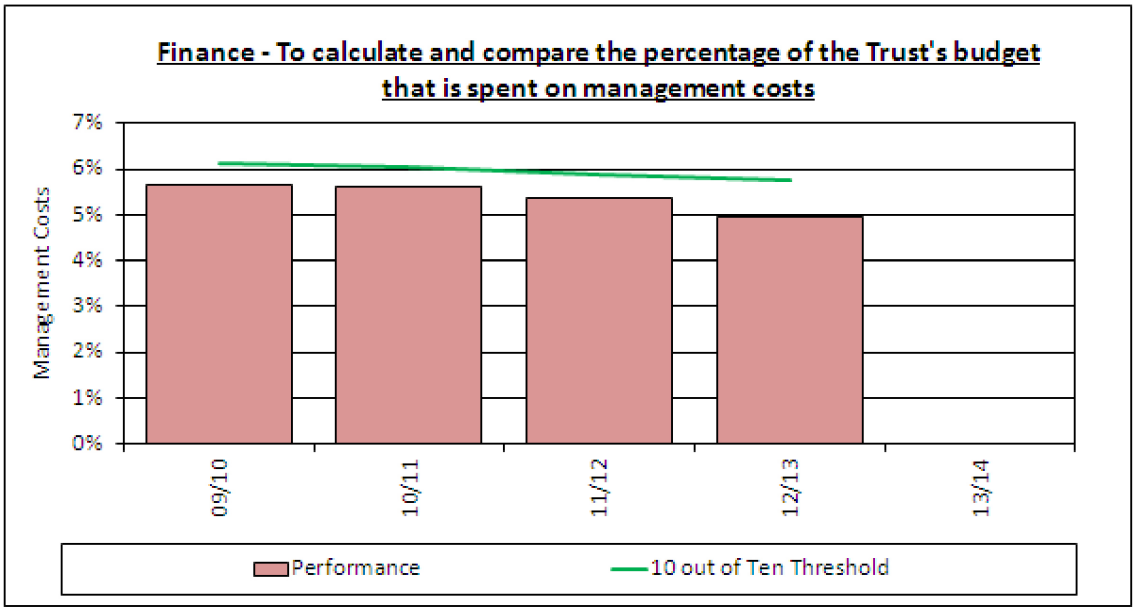
continuity of care within the community.

Further work for 2013/14 will include the continued development of partnership working with Clinical Commissioning Groups (CCGs) and other community teams to develop the use of a single patient passport for patients with long term conditions and specific health needs.

Effectiveness

Priority 5: Finance

To reduce the percentage of the Trust's budget that is spent on management costs



Graph 9: Trust's annual spend on management costs

On a quarterly basis, the Trust measures the percentage of income spent on management and this has continued to reduce through the year.

During 2012/13, the Trust has consistantly maintained a position lower than the target the Trust has set itself.

Experience

Priority 6: Patients & Staff

To ensure that the ratio of doctors & nurses to each inpatient bed is appropriate for delivering safe high quality patient care

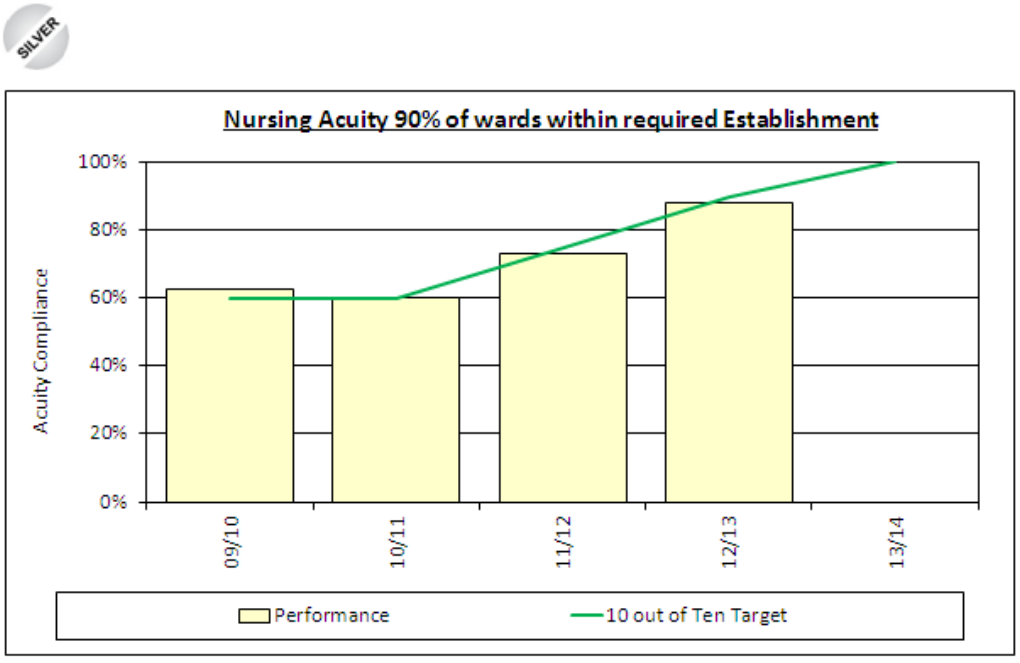
Nurses
Since 2008, the Trust has used the Safer Nursing Care Tool (SNCT), formerly known as the Association of UK University Hospitals Tool, to measure the acuity/dependency of adult inpatients to determine the required nurse staffing levels on its wards.

The acuity/dependency monitoring is undertaken at least every 6 months and the results are used to review staffing requirements and to adjust establishment budgets to meet the need of patients.

Information collated during 2012/13 has been reviewed by the Trust's Acuity group and escalated to the Executive Workforce Committee and the Executive Directors.

The aim for 2012/13 was that 90% of adult inpatient wards would be within range of their required establishment. The graph below shows that the Trust achieved 88% against the target of 90%.

Actions have been taken including the redeployment of staff from over established areas, the recruitment of qualified nurses from Ireland and Spain and the use of trained and unqualified bank staff employed by the Trust on a daily basis to ensure that the required staffing levels are met.



Graph 10: Nursing Acuity of Ward Areas

Doctors
The ratio of doctors has, in the previous 3 years, been an element of the 10 out of Ten strategy. The data previously used to report this indicator is no longer available to the Trust. There has been extensive work undertaken to look at other information available to the Trust such as the 2011 census and consultant episodes of care. Unfortunately, this has proven not to be able to provide the information the Trust needs in a robust way to support this indicator. Therefore it is no longer possible to report against this metric.

The Trust strives to provide safe, effective and compassionate care to all its patients and is committed to ensuring appropriate staffing levels for all healthcare professionals, including doctors.

Consequently, during 2012/13, the Trust has appointed additional Consultants in Paediatrics, Emergency Care and 3 posts in Anaesthetics. The Trust has also received support from the Mersey Deanery to appoint an additional training grade post in Acute Medicine.

The Trust's investment in additional Consultant posts will continue in 2013/14.

Experience

Priority 7: Environment

To monitor and eliminate mixed sex accommodation for all patients admitted to the Trust (unless based on clinical need)

On 1 April 2012, the Trust declared compliance in eliminating mixed-sex accommodation. The declaration of compliance has been published on the Trust's website and reads as follows:

"Mid Cheshire Hospitals NHS Foundation Trust is pleased to confirm that the Trust is compliant with the Government's requirement to eliminate mixed-sex accommodation, except when it is in the patient's overall best interest, or reflects their personal choice."

The Trust has the necessary facilities, resources and culture to ensure that patients who are admitted to its hospitals will only share the room where they sleep with members of the same sex, and same sex toilets and bathrooms will be close to their bed area.

Sharing with members of the opposite sex will only happen when clinically necessary (for example where patients need specialist equipment such as in Intensive Care, Coronary Care or the High Dependency Unit) or when patients actively choose to share (for instance the renal dialysis or chemotherapy unit).

If care should fall short of the required standard, the Trust will resolve it as quickly as possible and report it via the Trust Committee Structures to the Board of Directors and also to the local Commissioners.

The Trust has also set up an audit mechanism to make sure any reports are not misclassified and discusses the results of these audits at the Delivering Same Sex Accommodation (DSSA) Group.

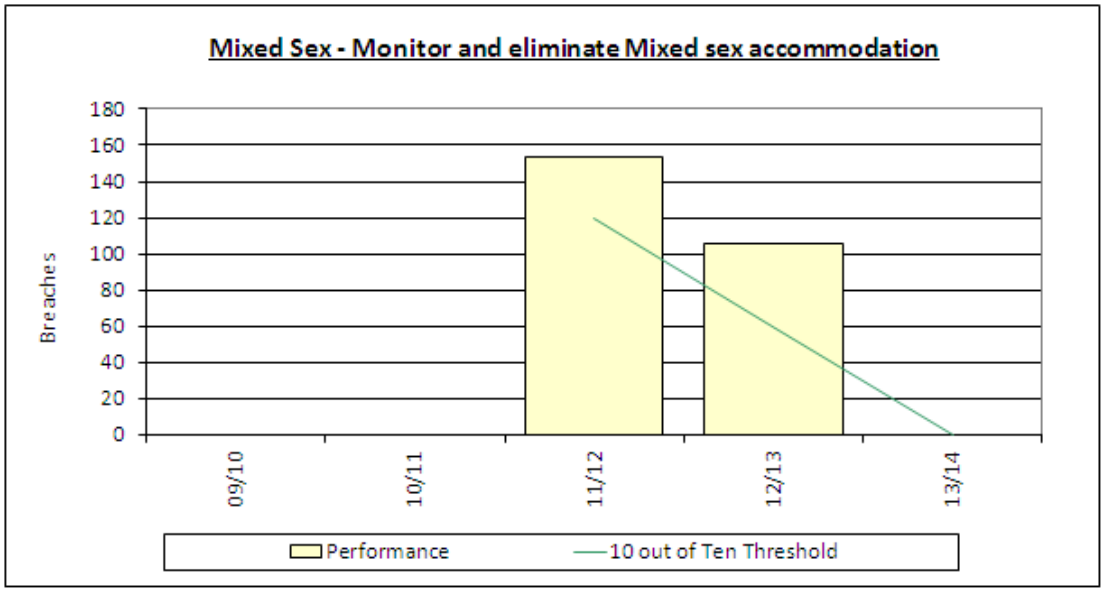
Patient feedback
Every month, volunteers assist the Trust asking patients about their experiences of same sex accommodation. The Trust is please to report that, over the past year, there have been no patient concerns raised as a result of mixed sex accommodation and all patients surveyed have never reported either sharing accommodation or washing/toilet facilities with patients of the opposite sex.

Changes made in practice
Previously, the Trust reported two areas where patients might receive care in an area that is not single sex. One of these was the Acute Stroke Bay and, earlier this year, the new stroke unit was opened with a purpose built acute stroke bay which has same sex accommodation. This means patients requiring acute care following a stroke are now cared for, during the whole of their stay, in high quality, safe, appropriate and same sex accommodation.

The other area where patients may receive care in a mixed sex environment is when they require clinical care in the intensive therapy unit/high dependency unit (ITU/HDU). There has been improved communication between staff working in these areas, bed managers and senior clinical staff to identify promptly when a patient is no longer likely to require ITU/HDU care. These patients are discussed at the twice daily bed meetings and plans made to move them to an appropriate ward when it is safe to do so. Unfortunately, there are occasions when this is not possible which leads to patients staying in ITU/HDU longer than they need and this is reported as a breach.

When these breaches occur, the staff always apologise to the patient and make every effort to address the situation as quickly and as safely as possible.

Graph 11 highlights the progress that has been made since last year. The numbers of breaches are reported monthly to the Trust Board, Commissioners and Health Authority.



Graph 11: Breaches within mixed sex accommodation

The development of the new theatre complex and critical care unit which is currently being built will negate mixed sex accommodation as the new unit has been designed with the resolution of this issue in mind. The new critical care facility is due to be opened in early 2014.

Outcomes

Priority 8: Cardiovascular

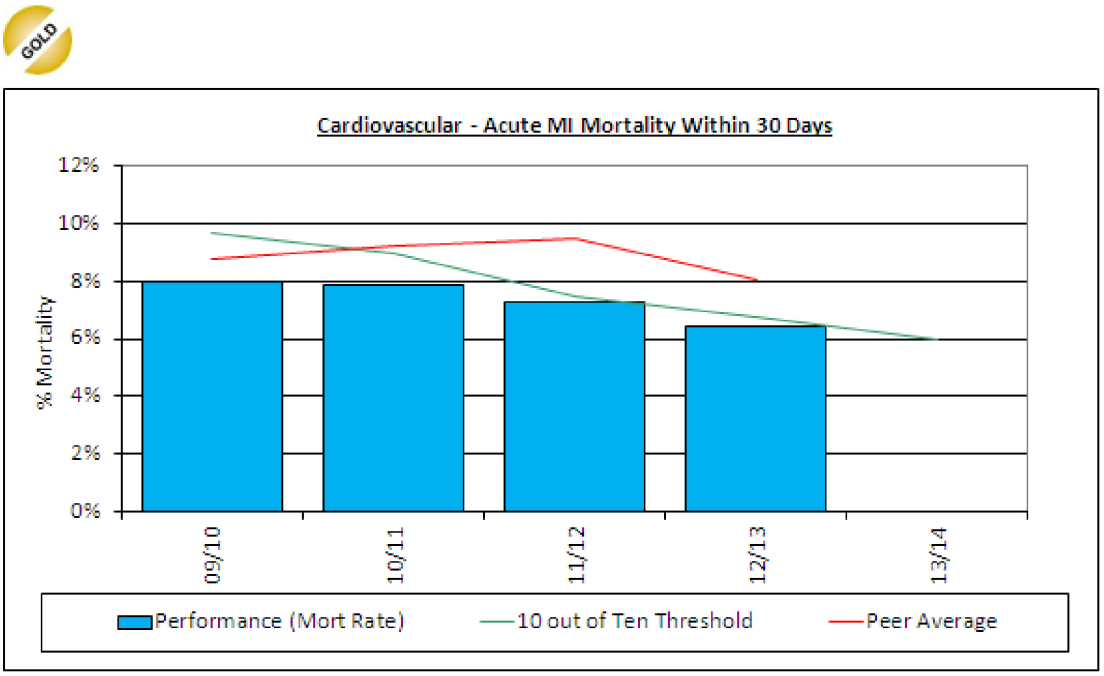
To reduce the 30 day mortality rate in patients following Acute Myocardial Infarction (AMI)

There were approximately 500 patients admitted in 2012/13 with a diagnosis of Acute Myocardial Infarction (AMI). Many of these patients were transferred to tertiary hospitals for further treatment and intervention. Patients were then either discharged home or transferred back to the Trust to continue their care.

For all patients who suffer an AMI, a return to an active and healthy lifestyle is positively encouraged with everyone being invited to join the cardiac rehabilitation programme. This programme is set out in 4 phases. Phase 1 is offered whilst the patient is still in hospital, phases 2 and 3 are offered following discharge and phase 4 is offered in partnership with Cheshire East Council and Age Concern Cheshire who fund exercise instructors for sessions held in Winsford and Sandbach.

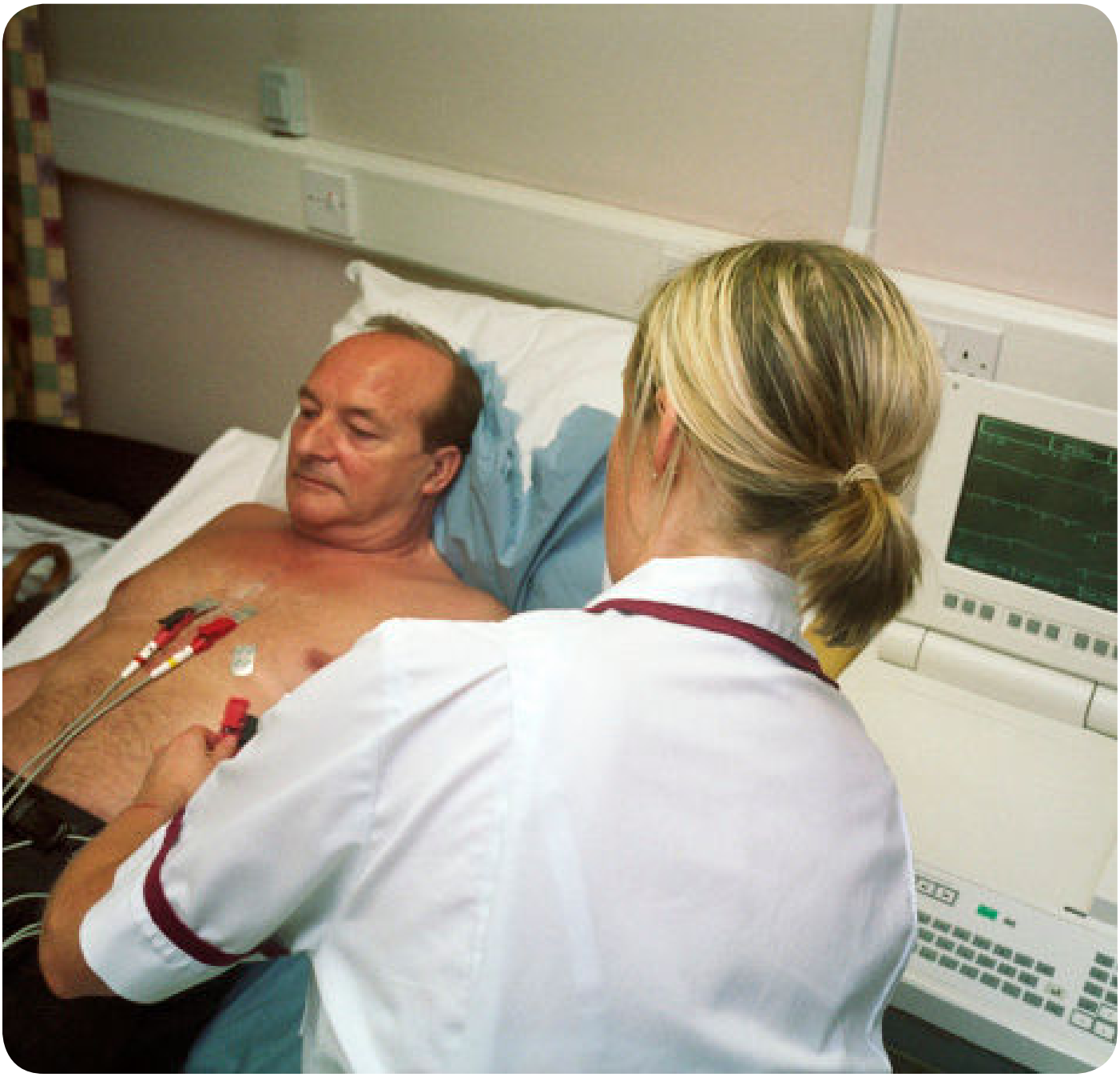
Cardiac rehabilitation aims to reduce patient mortality and morbidity and to provide support for both the patient and carer to enhance their quality of life. The chance of death following an AMI is significantly reduced when lifestyle modifications are made.

The Trust uses data from CHKS to monitor mortality within 30 days following AMI and it can be seen from the following graph that the Trust has achieved the target to reduce deaths following AMI during 2012/13.



Graph 12: Trust's performance in reducing acute MI mortality within 30 days

AMI is one of five clinical conditions that are monitored through the Advancing Quality (AQ) Programme. It has been chosen due to its high prevalence in North West England. The aim of this programme is to report on a set of clinically agreed measures to improve outcomes for patients. The Trust compliance with the Advancing Quality Programme for AMI care and treatment is currently 98.8% (CQUIN target is 95%).



Outcomes

Priority 9: Cancer

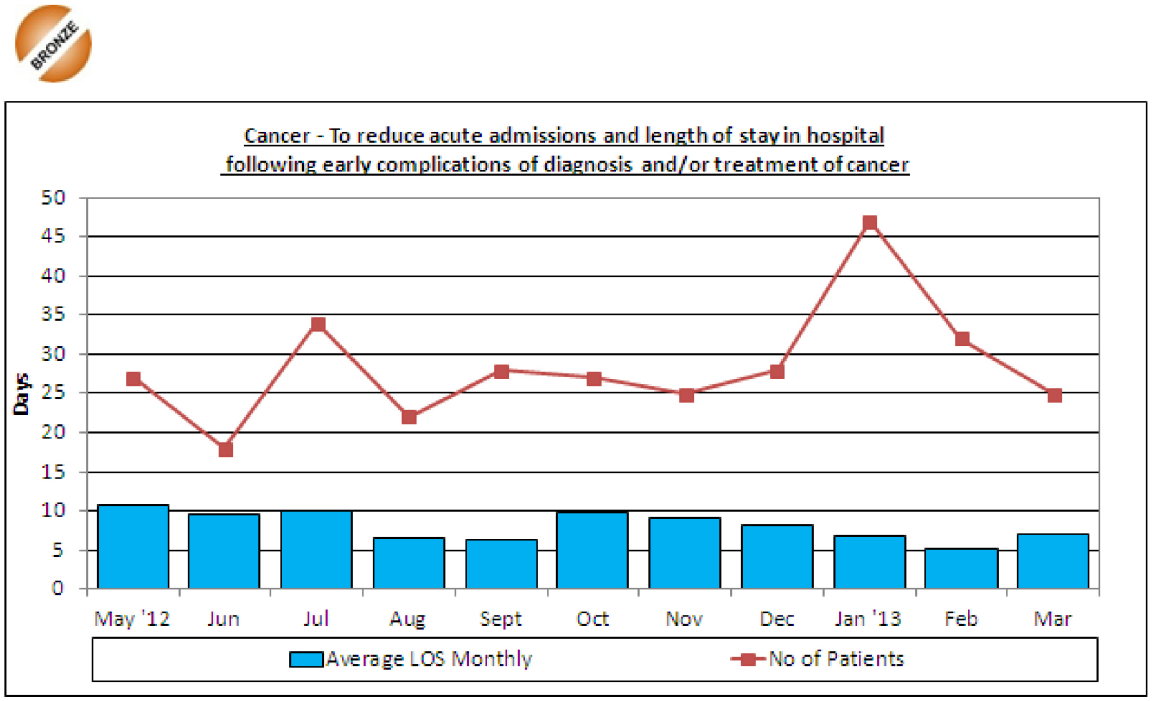
To reduce acute admissions and length of stay in hospital following early complications of diagnosis and / or treatment of cancer

The acute oncology team at the Trust was established in May 2012. The team consists of 2 Clinical Nurse Specialists and an multi disciplinary team co-ordinator.

MCHFT was one of the first Trusts in the Greater Manchester and Cheshire Cancer Network to establish an Acute Oncology Service and therefore there is very little peer data available to compare the Trust against. The intention of the implementation of the acute oncology team was to reduce the length of stay for patients admitted with complications of their cancer treatment or the cancer itself.

The introduction of a rapid alert system highlighting that a patient with a known cancer diagnosis has been admitted to A&E or into the hospital has meant that the acute oncology team can have a rapid intervention resulting in a reduction in length of stay. There is also improved patient experience as the acute oncology team know where that patient is up to on their cancer journey.

It can be seen in the data provided in graph 13 that the length of stay is decreasing steadily. The Cancer Network identified that there should be a reduction in length of stay of at least 1 day in the first 12 months, which has been achieved and exceeded by the team at MCHFT.



Graph 13: Average length of stay and numbers of acute admissions

Formal feedback from people who have used the service (patients, carers and staff) is due to take place in the summer of 2013, but initial informal feedback has shown that patients and their carers are benefitting from the service. The admitting medical teams report that they have benefitted in their decision making process with the specialist support of the acute oncology team ensuring that up to date clinical information and understanding is available from the tertiary cancer centre.

Outcomes

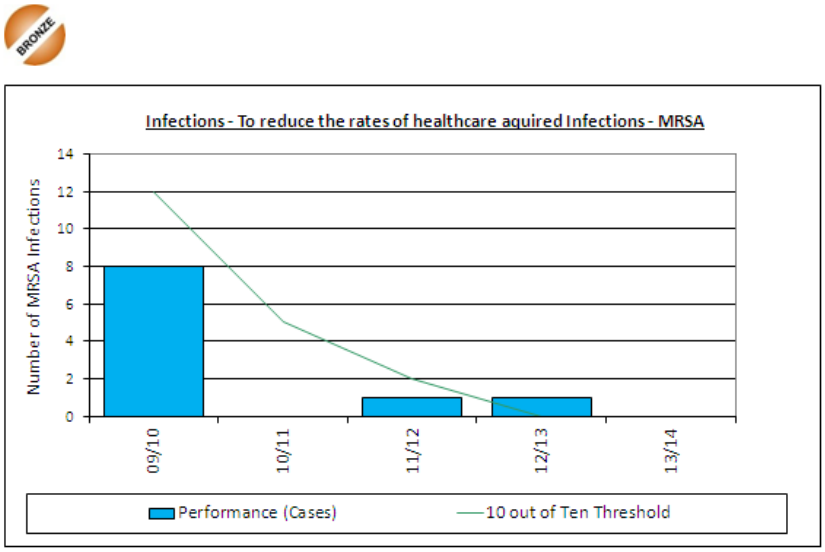
Priority 10: Infections

To reduce the rates of Healthcare Associated Infections (HCAI)

Planned Target Outcomes
To demonstrate an annual reduction in HCAI rates

MRSA bacteraemia	Target: 0	Actual 1	Not Achieved
Clostridium difficile	Target: < 54	Actual 23	Achieved

MRSA bacteraemia. The Trust has had one case of MRSA bacteraemia (blood stream infection) over the past twelve months, which means that the target of zero cases has not been achieved this year.

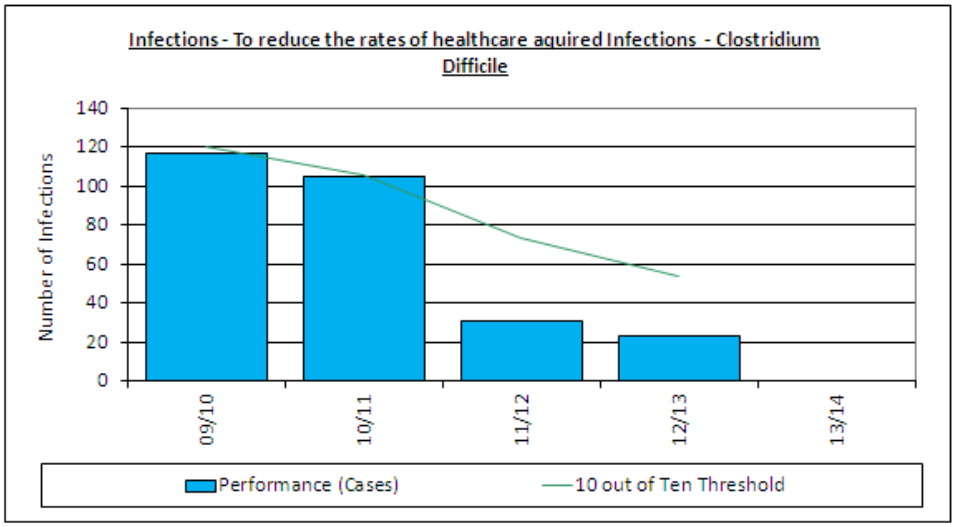


Graph 14: MRSA bacteraemia rates

Clostridium difficile - Rates of *Clostridium difficile* infection (CDI) Rates of *Clostridium difficile* infection (CDI) have continued to reduce over the last year and this is an on-going achievement for MCHFT.

The final CDI rate for the twelve month period stands at 23 cases, representing a 23% reduction from last year's reporting total for 2011/12 which was 30 cases.

This places the Trust amongst the top performing organisations in the North of England.



Graph 15: Clostridium difficile rates

Reduction Strategies
Effective infection prevention and control strategies target all types of HCAI and over the last year some of the infection prevention improvements have included:

- ✓ Cleaning standards have improved incrementally by 4% over the last 2 years
- ✓ The Trust now has a deep cleaning team that provides an additional 500 cleaning hours per month to perform a scheduled deep clean and ensure bed areas can be quickly prepared for the next patient
- ✓ Hand hygiene scores (compliance with hand hygiene practice) have improved over the last 2 years
- ✓ More staff have been trained in aseptic technique this year, which supports safe practice for patients with invasive devices or wounds
- ✓ Student Nurses on placement have received dedicated teaching time from the IPCS (Infection Prevention & Control Service)
- ✓ MCHFT has established a multi-disciplinary group looking at antibiotic stewardship; which supports the need to restrict certain antibiotics in specific patient groups and ensure careful and appropriate use of all antibiotics.

Next years' aim is to continue to drive up standards of clinical care by maintaining existing strategies and focus more on staff education within clinical areas.

Additionally, with recent changes in the delivery of healthcare, there is a need to consider how the Trust can further support patients on discharge if there is a risk of infection developing outside the hospital setting. Simple patient education and advisory leaflets may help to reduce any further treatment or readmissions that may be required due to infection.

Performance against quality indicators and targets

National quality targets

Table 9: National priority and performance standards

	2010-2011	2011-2012	2012-2013	Target	Achieved?
MRSA bacteraemias	8	1	1	0	✗
Clostridium Difficile infections	117	30	23	54	✓
Percentage of patient who wait 4 hours or less in A&E	98.1%	97.3%	95.04%	95%	✓
The percentage of Referral to Treatment (RTT) pathways within 18 weeks for completed admitted pathways	92.8%	91.1%	92.94%	90%	✓
The percentage of Referral to Treatment (RTT) pathways within 18 weeks for completed non-admitted pathways	97.6%	96.8%	96.96%	95%	✓
The percentage of Referral to Treatment (RTT) pathways within 18 weeks for incomplete pathways	N/A	N/A	95.6%	92%	✓
The percentage of patients waiting 6 weeks or more for a diagnostic test	N/A	N/A	0.87%	<1%	✓
Percentage of patients seen within two weeks of an urgent GP referral for suspected cancer	93.2%	95.4%	95.08%	93%	✓
Percentage of patients seen within two weeks of an urgent referral for breast symptoms where cancer was not initially suspected	N/A	94.6%	94.78%	93%	✓
Percentage of patients receiving first definite treatment for cancer within one month (31 days) of a cancer diagnosis	98.4%	99.6%	99.25%	96%	✓
Percentage of patients receiving subsequent treatment for cancer within 31 days where that treatment is surgery or anti-cancer drugs	100%	98.9%	100% 100%	98% surgery; 94% drugs	✓
Percentage of patients receiving first definite treatment for cancer within 62 days of an urgent GP referral for suspected cancer	85.6%	87.9%	89.71%	85%	✓
Percentage of patients receiving first definite treatment for cancer within 62 days of referral from an NHS Cancer Screening Service	N/A	92.9%	94.68%	90%	✓

✓ = Achieved ✗ = Not Achieved

National quality indicators

From 2012/13, all Trusts are required to report against a core set of indicators, for at least the last two reporting periods, using a standardised statement set out in the NHS (Quality Account) Amendment Regulations 2012. These regulations can be accessed through the following link - www.legislation.gov.uk/uksi/2012/3081/made

Where the data is made available by the Health and Social Care Information Centre, a comparison should be made of the numbers, percentages, values, scores or rates of the Trust's indicators with

a) the national average and
b) those Trusts with the highest and lowest figures.

The value and banding of the summary hospital-level mortality indicator (SHMI)

Date	Trust Performance	National Average	Highest Result	Lowest Result
July 2011 - June 2012	1.13 Higher than expected	1.00	1.25	0.71
October 2011 - September 2012	1.13 Higher than expected	1.00	1.13	0.89

The Trust is currently reviewing the data that feeds the SHMI reports and have enlisted the support of CHKS to do this. The Trust is also reviewing a selection of the SHMI categories to gain a greater understanding as to why some cases are being allocated to non-definitive categories such as:

- SHMI category 139 Malaise and fatigue;
- SHMI category 137 Nausea and vomiting;
- SHMI category 126 Open wounds of head, neck and trunk.

The Trust is also reviewing patients where their diagnosis is not recorded until after their second or third admission to hospital.

The Trust intends to take / has taken the following actions to improve this result, and therefore the quality of its service, by:

- Participating in the North West Mortality collaborative;
- Establishing a reducing mortality group which is chaired by the Medical Director;
- Establishing a reducing mortality group in the emergency care division;
- Reviewing case notes and developing action plans where appropriate.

The percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust

Date	Trust Performance	National Average	Highest Result	Lowest Result
July 2011 - June 2012	14.81%	18.6%	46.3%	0.3%
October 2011 - September 2012	15.27%	19.2%	43.3%	0.2%

This is an indicator designed to accompany the Summary Hospital-level Mortality Indicator (SHMI) and represents the percentage of deaths reported in the SHMI indicator where the patient received palliative care. The SHMI makes no adjustments for palliative care.

Using the same spell level data as the SHMI, this indicator presents the crude percentage rates of deaths that are coded with palliative care either in diagnosis or treatment specialty.

The Trust is below the national average for palliative care coded deaths which is a positive position to be in and reflects accurate coding practice.

The Trust's patient reported outcome measures scores (PROMS)

Date	Trust Performance	National Average	Highest Result	Lowest Result	Position Nationally
Groin Hernia Repair					
2011-2012	10.1	8.3	21.0	0	
2012-2013	9.2	9.1	31.03	0.14	Top 60%
Varicose Vein Surgery					
2011-2012	10.7	9.4	23.5	0	
2012-2013	8.2	9.3	27.2	0	Top 50%
Hip Replacement Surgery					
2011-2012	37.7	40.7	58.4	23.5	
2012-2013	49.9	43.7	69	0	Top 30%
Knee Replacement Surgery					
2011-2012	22.8	29.4	43.2	15.4	
2012-2013	52.7	31.2	52.7	0	Top performing Trust in country

The Trust intends to take / has taken the following actions to improve this result, and therefore the quality of its service, by:

- Working closely with patients undergoing surgery within the clinical focus groups to encourage their full participation in the completion of the PROMS questionnaires before surgery and six months following surgery;
- Using information leaflets which describe the process and value of the information collected through the use of the PROMS questionnaire.

The percentage of patients aged 0 to 14 readmitted to hospital within 28 days of being discharged

Date	Trust Performance	Peer Group Average
January 2011 - December 2011	9.3%	9.7%
January 2012 - December 2012	8.4%	10.3%

The Trust is pleased to report that it continues to be significantly below peer and considers that this is for the following reasons:

- More senior medical staff are available to review patients when they arrive and make prompt decisions with regard to treatment and follow up care;
- The development of more robust care pathways;
- Reclassification of some patients as assessments or ward attenders, rather than admissions, if not staying overnight.

The percentage of patients aged 15 or over readmitted to hospital within 28 days of being discharged

Date	Trust Performance	Peer Group Average
January 2011 - December 2011	7.0%	6.6%
January 2012 - December 2012	6.3%	6.3%

The data above shows a reduction in the percentage of readmissions for patients aged 15 or over, which has brought the Trust in line with its peer group. The Trust considers that this reduction is predominantly due to the following reasons:

- Introduction of a dedicated task and finish group to focus on readmissions;
- A daily review of patients who are readmitted or flagged as at high risk of readmission by the integrated discharge team;
- The integrated discharge team work closely with community teams, such as community matrons, alcohol liaison services and mental health, to support discharge;
- Introduction of ward-based pharmacy reviews of medications;
- Follow-up phone calls made by the integrated discharge team 48 hours post discharge.

The Trust intends to continue progressing the above actions to maintain improvement in this result and therefore the quality of its service.

The Trust's responsiveness to the personal needs of its patients

Date	Trust Performance	National Average	Highest Result	Lowest Result
2011	72.7	75.7	87.3	68.2
2012	73.5	75.6	87.8	67.4

This result is slightly lower than the national average. Comments from patients completing the national inpatient survey reflect the busy nature of the clinical environment, whilst highlighting that staff are very caring (more detail on the inpatient survey is included in part 2).

The Trust intends to take / has taken the following actions to improve this results, and therefore the quality of its service, by:

- Formally reviewing the staffing levels and skill mix on all inpatient wards every six months;
- Reviewing patient needs for staff requirements twice daily and making adjustments as required;
- Continuing the implementation of care rounds to respond proactively to patients' needs;
- Reviewing care pathways and implementing event-led discharge to avoid delays in patients waiting in hospital when they are medically fit to go home.

Staff employed by the Trust who would recommend the Trust as a provider of care to their family or friends (scores out of 5)

Date	Trust Performance	National Average	Highest Result	Lowest Result
2011 staff survey	3.52	3.50	4.05	2.84
2012 staff survey	3.59	3.57	4.08	2.90

This result is better than the national average. Staff frequently describe the Trust as a friendly place to work and, on the whole, they receive good support from their teams and line mangers.

The Trust intends to take / has taken the following actions to improve this result, and therefore the quality of its service, by:

- Presenting the results at key meetings and staff groups to agree which areas should be targeted for improvement. Currently, there is agreement that the Trust should focus on appraisals, involving staff in change, feedback on performance, health and well being and tacking violence;
- Meeting with senior divisional teams to discuss divisional reports;
- Undertaking further benchmarking of results with other Trusts and previous year's results.

The percentage of patients who were admitted to hospital who were risk assessed for Veneous thromboembolism (VTE)

Date	Trust Performance	National Average	Highest Result	Lowest Result
July 2012 - September 2012	96.3%	93.8%	100%	80.9%
October 2012 - December 2012	96.3%	94.1%	100%	84.6%

The Trust has consistently remained above the national average for the previous 2 reporting periods in relation to the percentage of admitted patients who were risk assessed for VTE.

The Trust has achieved the national CQUIN target of 90% in relation to VTE risk assessments for the past 2 years.

The Trust intends to take / has taken the following actions to improve this result, and therefore the quality of its service, by:

- Implementing the national guidance issued by the National Institute for Health and Clinical Excellence (NICE) relating to VTE risk assessment to ensure that all relevant patients are assessed on admission for their risk of developing a VTE. The VTE risk assessment has been included in the Trust's admission proformas to ensure this happens;
- Establishing a VTE Committee which reports into the integrated governance reporting structure. The group ensures that all national guidance is appropriately implemented and monitors the percentage of patients that are risk assessed on admission;
- Monitoring compliance monthly by the clinical divisions and quarterly by the Trust's VTE Committee.

The rate per utilised bed days of cases of Clostridium difficile infection reported within the Trust amongst patients aged 2 or over

Date	Trust Performance	National Average	Highest Result	Lowest Result
2010-2011	58.30	29.60	63.60	7.10
2011-2012	16.83	21.82	50.89	4.08
2012-2013	12.90	Not published	Not published	Not published

The above data shows a significant reduction in Clostridium difficile infections over the past three years and shows the Trust to be one of the best performing Trusts when compared to similar sized organisations. The Trust considers that this reduction is predominantly due to the following reasons:

- Limiting transfers within the Trust, particularly from viral diarrhoea and vomiting affected wards and close monitoring of symptomatic patients to ensure Clostridium difficile infection is not missed as a diagnosis;
- Providing additional cleaning resources to support the rapid response team to tackle infective areas (this has also increased cleaning scores and cleaning provision in other areas);
- Rolling out cholorine cleaning for all clinical areas and revised cleaning policy to ensure clinical equipment is effectively decontaminated;
- Greater reviews of antibiotic prescribing compliance and raised awareness within divisions

following antibiotic audits performed by consultant microbiologists;
- Case management of Clostridium difficile infection patients by the Infection Prevention and Control Service and ongoing review of all side rooms used for isolation purposes to ensure effective isolation practice and appropriate clinical management;
- Undertaking detailed root case analysis on all Clostridium difficile infection cases, to highlight all relevant risk factors and potential risks for transmission to others;
- Weekly Clostridium difficile infection clinical review group ensuring all aspects of patient management are assessed / actioned;
- Two ring-fenced beds on the gastroenterology ward to ensure appropriate case management for Clostridium difficile infections;
- Reviewing the process for mattress decontamination and tagging of equipment to monitor decontamination schedules.

The number of patient safety incidents reported within the Trust

Date	Trust Performance	National Average	Highest Result	Lowest Result
October 2011 to March 2012	2511	1782	3871	809
April 2012 to September 2012	2695	1812	4545	815

It is viewed nationally and by the Trust that being a high reporter of incidents is a positive position as it demonstrates a risk aware culture within the Trust and that staff are open about reporting patient safety incidents. The Trust reports more patient safety incidents than the national average and this has been consistent for both reporting periods. The majority of the incidents reported resulted in no harm to the patient which again demonstrates a risk aware culture within the Trust.

The Trust intends to take / has taken the following actions to improve this result, and therefore the quality of its service, by:
- Committing to a *Just Safety* culture which encourages staff to admit when an error occurs without fear of punitive measure;
- Providing training on incident reporting throughout the Trust. This training ensures that all staff in the Trust know how to report a patient safety incident and they also understand the importance of incident reporting. This training is on-going and is included on induction for all new staff.

The number and percentage of patient safety incidents reported within the Trust that resulted in severe harm or death

Date	Trust Performance	National Average	Highest Result	Lowest Result
October 2011 to March 2012	2	17	64	0
April 2012 to September 2012	6	16	69	2

The Trust considers that this data is as described for the following reasons:

- The above data demonstrates that, although the Trust is a high reporter of patient safety incidents, when the Trust's data for patient safety incidents which result in severe harm or death is compared with other organisations, the Trust is consistently below the national average. This is a very positive position for the Trust.

The Trust intends to take / has taken the following actions to improve this results, and therefore the quality of its service, by:

- Undertaking a full root cause analysis for all incidents which result in severe harm or death. A review meeting is held following the incident investigation which is always chaired by an Executive lead to ensure that lessons are learned and actions are implemented to prevent a reoccurrence;
- Reporting all incidents which result in severe harm death to the Board to ensure openness within the Trust;
- Promoting the Trust's being open policy, which ensures that if an incident occurs which results in severe harm or death, the patient and / or their family are informed and the lessons learned and actions from the incident are shared with them.

Local quality indicators

Reducing patient falls - Governors' choice of indicator

A fall is not a diagnosis and often reflects a multiplicity of risk factors with normal physiological ageing, de-conditioning from inactivity and superimposed acute and chronic disease. However, a fall is of direct clinical relevance to an individual, with a clear impact and all too often a negative outcome in terms of health and quality of life (Close, 2005).

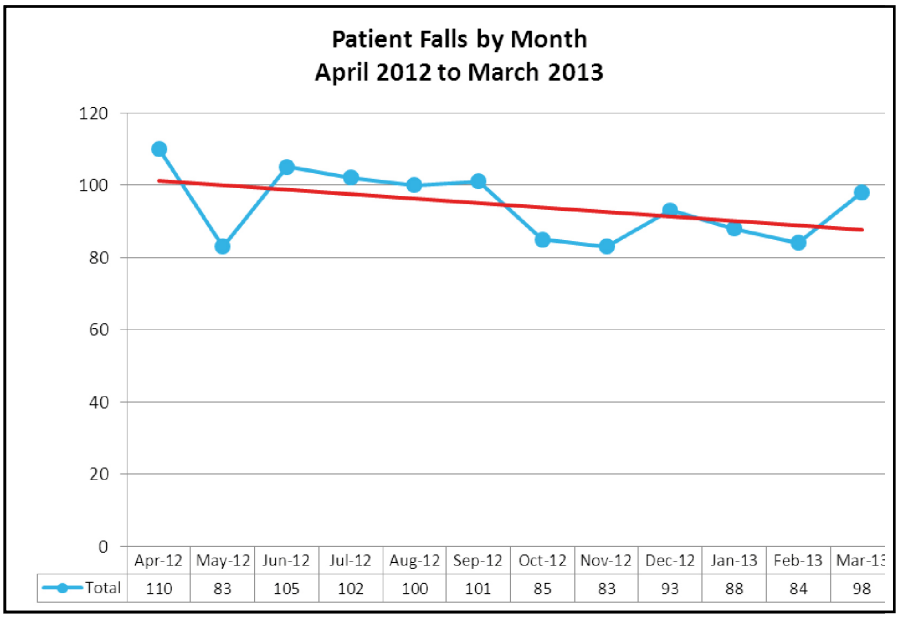
Falls are a considerable burden on patients, nurses and hospitals. Preventing falls from happening should be a priority in healthcare organisations. While the risk of falling cannot be eliminated, it can be significantly reduced through the implementation of an effective falls prevention programme (Oliver et al, 2009).

For people experiencing a fall, there may be many negative associations and perceptions, such as a sense of imminent loss of independence and risk of institutionalisation (Howland, Peterson & Levin, 1993).

There is a great deal of literature available in relation to patient falls that clearly demonstrates that patient falls in hospital are frequent occurrences. It is also known that patient falls in hospital can have a devastating effect on patients, their families and the nursing staff caring for the patient and that organisations as a whole also suffer in terms of reputation and financial loss.

Patient falls in hospital affect everyone involved in different ways. Despite patient falls prevention interventions being in place, patient falls remain the highest reported patient safety incident for the majority of Trusts, including MCHFT.

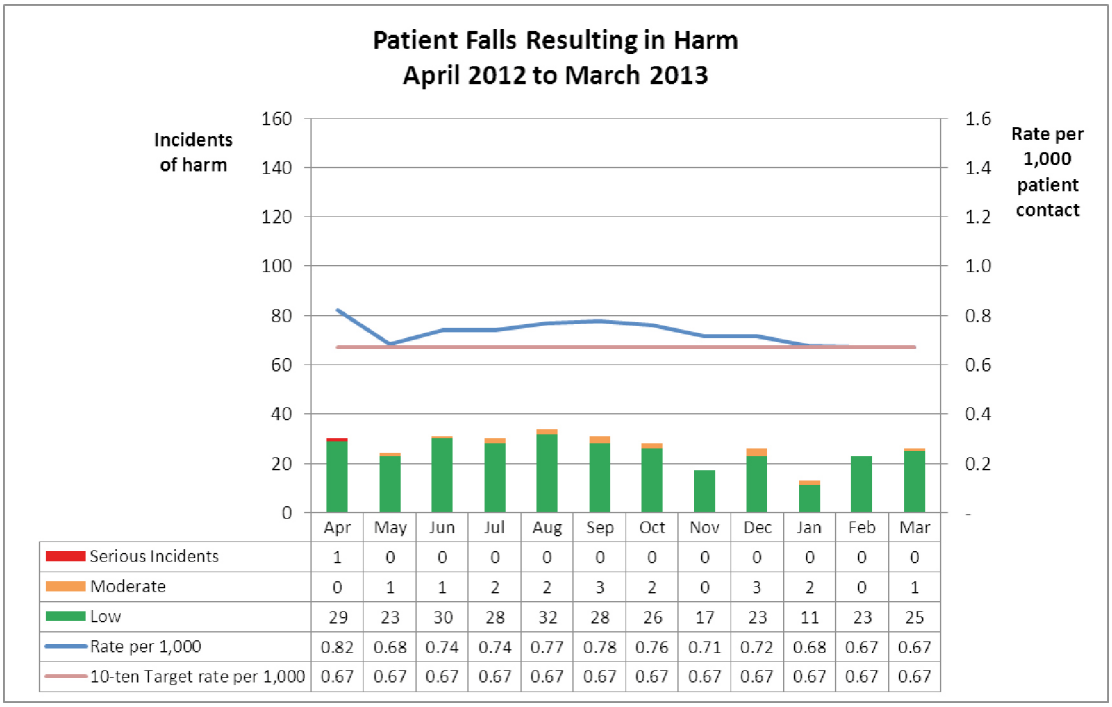
Graph 16 shows the number of patient falls at the Trust over a 12 month period between April 2012 and March 2013. The red line on the graph indicates that the overall number of falls has decreased over the last 12 months.



Graph 16: Patient Falls by Month

Work undertaken to reduce the number of patient falls and harm caused
The Trust has a patient falls prevention group which meets monthly. The group membership includes Clinicians, Nurses and Therapists and the group monitors all patients' falls on a monthly basis. A successful link nurse programme has been rolled out across the Trust to deliver education for staff on falls prevention and the Trust has been involved in number of national projects including Safety Express and FallSafe which have looked at reducing the harm from patient falls and fall prevention interventions.

Graph 17 highlights the patient falls that have resulted in harm between April 2012 and March 2013. The Trust set a target to reduce the harm from patient falls by 10% annually and this target is currently being achieved.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Serious Incidents	1	0	0	0	0	0	0	0	0	0	0	0
Moderate	0	1	1	2	2	3	2	0	3	2	0	1
Low	29	23	30	28	32	28	26	17	23	11	23	25
Rate per 1,000	0.82	0.68	0.74	0.74	0.77	0.78	0.76	0.71	0.72	0.68	0.67	0.67
10-ten Target rate per 1,000	0.67	0.67	0.67	0.67	0.67	0.67	0.67	0.67	0.67	0.67	0.67	0.67

Graph 17: Patient Falls Resulting in Harm

References
Close, J.(2005) "Prevention of falls - a time to translate evidence into practice", Age and Ageing, vol. 34, no. 2, pp. 98-100.

Oliver, D., Britton, M., Speed, P., Martin, F. C. & Hopper, A.H. 2009, "Development and evaluation of evidenced based assessment tool (STRATIFY) to predict which elderly inpatients will fall: case control and cohort studies", British Medical Journal, [Online], vol. 315, no. 7115, pp. 16.03.10. Available from: http://www.bmj.com/cgi/content/full/315/7115/1049. [16.03.10].

Howland, J., Peterson, E.W. & Levin, W.C. 1993, "Fear of falling among the community dwelling elderly", Aging health, vol. 5, no. ., pp. 229-243.

Incidents resulting in severe harm - mandated indicator

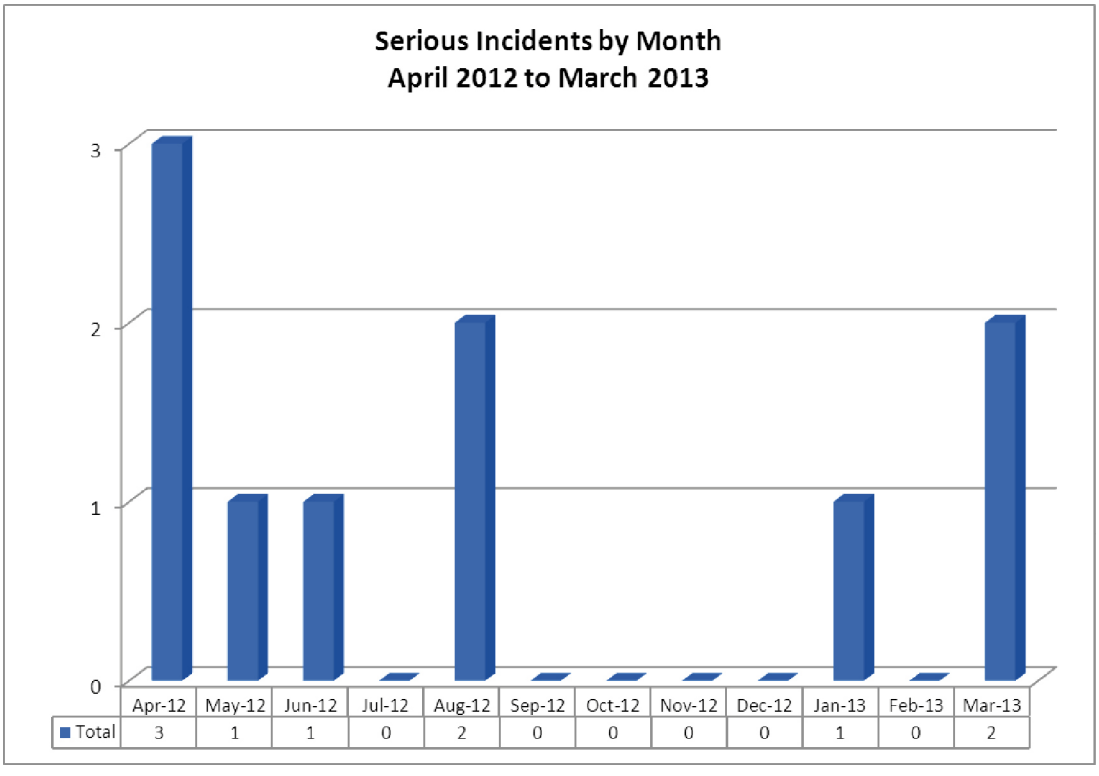
The Trust wants to deliver high quality, safe patient care. However, despite best efforts, human factors, systems and processes contribute to prevent this desire and patients are sometimes harmed unintentionally. The Trust is dedicated to reducing the avoidable harm caused to patients.

When harm is unintentionally caused, the Trust ensures that lessons are learned and that systems and processes are changed to prevent an incident from reoccurring. The Trust is committed to a Just Safety culture which encourages staff to acknowledge and report when an error occurs without fear of punitive measure.

When an incident which results in severe harm does occur, the incident is reported to the Trust Board, the local Clinical Commissioning Groups and the Strategic Executive Information System (StEIS) to ensure learning both locally within the Trust and across other healthcare providers.

A root cause analysis (RCA) is undertaken for all incidents resulting in severe harm to ensure that all contributory factors which led to the incident occurring are fully investigated and actions are implemented to prevent a reoccurrence. A review meeting is held following the investigation and this is led by an Executive Director. Following the review meeting, an action plan is developed, implemented and lessons learned are shared throughout the Trust.

Graph 18 shows the number of serious incidents reported within the Trust between April 2012 and March 2013 which resulted in severe harm. It can be seen that there has been a significant reduction in the past six months with only three serious incidents occurring between January and March 2013.



Graph 18: Serious incidents by month

Performance against local quality indicators

Indicator	2010-2011	2011-2012	2012-2013	Target	Achieved?
Cancelled operations (%)	1.19%	1.46%	1.32%	1.09%	✗
Cancelled operations – % breaching 28 day guarantee	6.8%	7.9%	15.83% *	5%	✗
Smoking during pregnancy	19.5%	18.3%	20.55%	< 15%	✗
Breastfeeding initiation rates	59.6%	62.8%	60.91%	65%	✗
Access to genito-urinary (GUM) clinics	99.9%	100%	100%	100%	✓
Falls risk assessments completed within 24 hours	96%	96%	96%	91%	✓
Pressure ulcer risk assessments completed within 24 hours	93%	95%	94%	91%	✓
Nutritional risk assessments completed within 24 hours	99%	97%	95%	91%	✓
% of patients who felt they were treated with dignity and respect	96%	100%	100%	100%	✓
% of patients who had not shared a sleeping area with the opposite sex	75%	100%	100%	100%	✓
% of patients who would recommend the hospital to family and friends	97%	87%	93%	No target	

✓ = Achieved ✗ = Not Achieved

* this equates to approximately 70 patients in 2012-2013.

Consultation on quality

Over the past 4 years, the Trust has consulted with the public, patients, staff and governors on its delivery of quality. Using the Trust's quality and safety strategy, the 10 out of Ten has been the focus for discussion and comment. These comments are then used to inform the annual Quality Account.

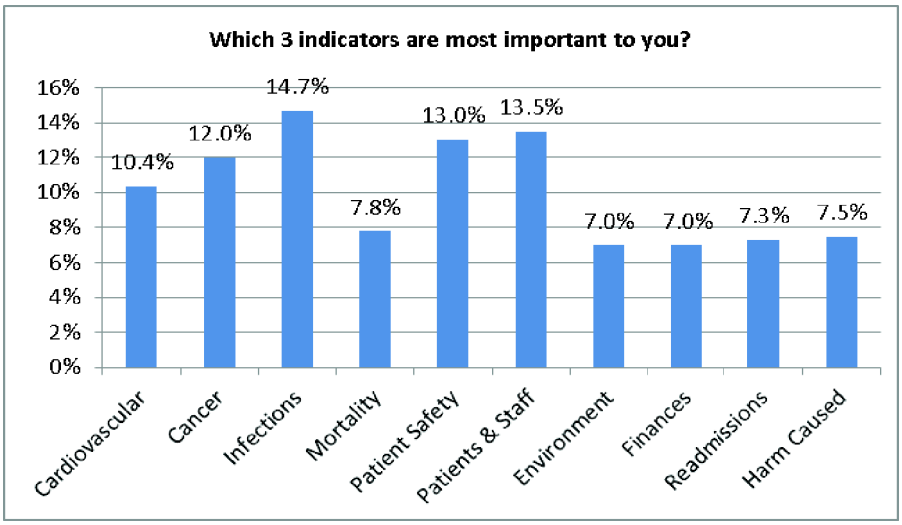
The 2012/13 Quality Account consultation was undertaken by staff and governors working together to meet with the public and patients at a variety of locations. Events at local supermarkets in Crewe, Sandbach, Winsford and Middlewich plus outpatient clinics in Crewe and Northwich generated 320 discussions and responses.

The aim of the consultation was to seek comments from the public regarding the Trust's 10 out of Ten priorities and to ensure the ten indicators are still considered essential markers of quality.

The results of the consultation showed that all the priorities are still considered important. Nobody suggested alternatives.

When asked to identify the most important priorities, reducing healthcare acquired infections was found to be the most important. The second most important priority was having the correct numbers of nurses and doctors closely followed by patient safety.

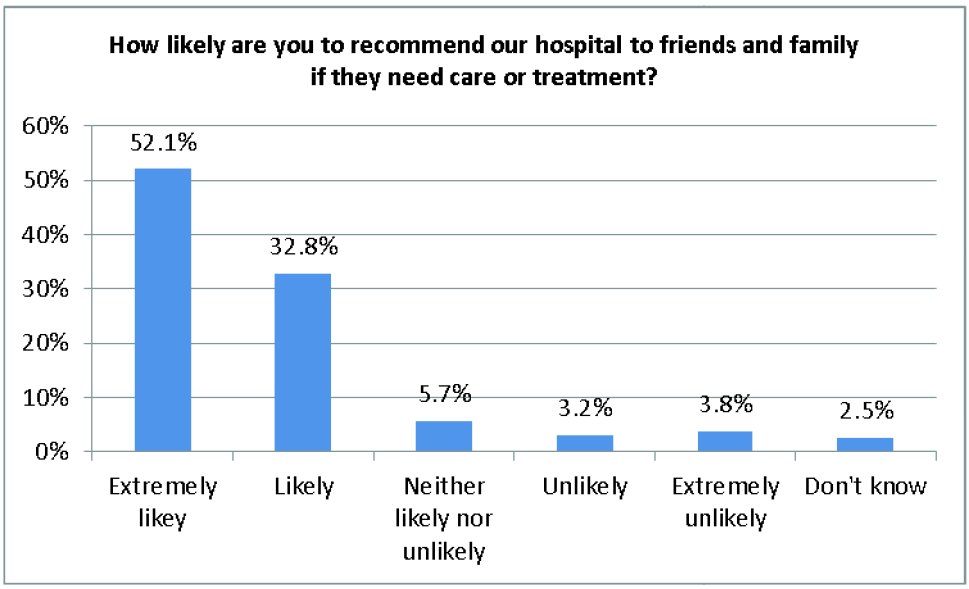
The following graph details the indicators that are considered most important by the 320 people included in the consultation.



Graph 19: Most important indicators identified during the consultation

The consultation process also asked the public and patients:
"How likely are you to recommend our hospital to friends and family if they need care or treatment?"

Responses to this were very positive with over half the people saying they would be extremely likely to recommend the hospital and its services.



Graph 20: Consultation response to question about how likely people were to recommend the hospital

Statements from external agencies

Cheshire East Healthwatch

Text goes here

East Cheshire Council Health and Wellbeing Scrutiny Committee

Text goes here

Governors

Text goes here

South Cheshire and Vale Royal Clinical Commissioning Groups

Text goes here

Statement of Directors' responsibilities in respect of the Quality Report

The Directors are required under the Health Act 2009 and the National Health Service Quality Accounts Regulations 2010 to prepare Quality Accounts for each financial year.

Monitor has also issued guidance to NHS Foundation Trust Boards on the form and content of annual Quality Accounts (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 Report meets the requirements set out in the *NHS Foundation Trust Annual Reporting Manual 2012 - 2013*

- 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 to March 2013
  - Papers relating to quality reported to the Board over the period April 2012 to March 2013
  - Feedback from the Commissioners dated ********
  - Feedback from Governors dated ********
  - Feedback from Local Healthwatch dated ********
  - Feedback from the Health and Wellbeing Scrutiny Committee dated ********
  - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated August 2012.
  - The 2012 national patient survey
  - The 2012 national staff survey
  - The Head of Internal Audit's annual opinion over the Trust's control environment dated ********
  - Care Quality Commission (CQC) quality and risk profiles dated February 2013

- The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over this period

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

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

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

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

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

By order of the Board, signed XX MONTH 2013,

John Moran
Chairman

Tracy Bullock
Chief Executive

Dr Paul Dodds
Medical Director and
Deputy Chief Executive

Denise Frodsham
Chief Operating Officer

Julie Smith
Director of Nursing
and Quality

Mark Oldham
Director of Finance

David Pitt
Director of Service Transformation
and Workforce

Dennis Dunn
Non-Executive Director

Dame Patricia Bacon
Non-Executive Director

John Barnes
Non-Executive Director

Mike Davis
Non-Executive Director

Ruth McNeil
Non-Executive Director

David Hopewell
Non-Executive Director

Appendices

Appendix 1 - Glossary and Abbreviations

Terms	Abbreviation	Description
Acute Myocardial Infarction	AMI	AMI is commonly known as a “heart attack” which results from the partial interruption of the blood supply to a part of the heart which can cause damage or death to the heart muscle.
Acute Trust		An acute Trust provides hospital services (not mental health hospital services, which are provided by a mental health trust).
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 – when compared to research which identifies what best care constitutes.
Board (of Trust)		The role of Trust’s board is to take corporate responsibility for the organisation’s strategies and actions. The chair and non-executive directors are lay people drawn from the local community and are accountable to the Secretary of State. The chief executive is responsible for ensuring that the board is empowered to govern the organisation and to deliver its objectives.
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 in hospital, in care homes, in people’s own homes, or elsewhere. The CQC replaced the Healthcare Commission.
C.A.S.P.E Healthcare Knowledge Systems	CHKS	An independent company which provides clinical data/ intelligence to allow NHS and independent sector organisations to benchmark their performance against each other.
Clinical Commissioning Group	CCG	This is the new GP led commissioning body who buy services from providers of care such as the hospital.
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.
Commissioner		A person or body who buy services.
Commissioning for Quality and Innovations	CQUIN	CQUIN is a payment framework developed to ensure that a proportion of a providers’ income is determined by their work towards quality and innovation.

Terms	Abbreviation	Description
Delivering Same Sex Accommodation	DSSA	DSSA was a national initiative launched in 2009 to eliminate mixed sex accommodation (EMSA) in hospital. There may be members of the opposite sex on a ward but they will not share the same sleeping area with members of the opposite sex unless this is required for clinical need, such as in the Intensive Care Unit.
Eliminating Mixed Sex Accommodation	EMSA	Please see description of Delivering Same Sex Accommodation.
Foundation Trust		A type of NHS Trust in England that has been created to devolve decision-making from central government control to local organisations and communities so they are more responsive to the needs and wishes of their local people. NHS Foundation Trusts have members drawn from patients, the public and staff and are governed by a board of governors comprising people elected from and by the membership base.
Healthcare Associated Infections	HCAI	A generic name to cover infections like MRSA and C-diff.
Health Protection Agency	HPA	The HPA was set up in 2003 to provide advice and information to protect the public in England from threats to health from infectious diseases and environmental hazards. In April 2013, the HPA will become part of Public Health England, a new executive agency of the Department of Health.
Health Service Ombudsman		The role of the Health Service Ombudsman is to provide a service to the public by undertaking independent investigations into complaints where the NHS in England have not acted properly or fairly or have provided a poor service.
Hospital Episode Statistics	HES	This is the national statistical data warehouse for England for 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.
Integrated Care System	ICS	The system used by the Trust to record patient activity.
Intensive Care National Audit and Research Centre: Case Mix Programme	ICNARC CMP	The ICNARC CMP is a high quality, clinical database holding over 18 years data relating to patient outcomes from adult, general critical care units in England, Wales and Northern Ireland.

Terms	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.
Mid Cheshire Hospitals NHS Foundation Trust	MCHFT	The organisation which runs Leighton Hospital, Crewe, Victoria Infirmary, Northwich and Elmhurst Intermediate Care Facility, Winsford
Mothers and Babies: reducing Risk through Audits and Confidential Enquiries across the UK	MBRRACE-UK	A new organisation appointed by the Healthcare Quality Improvement Programme to investigate maternal deaths, still births and infant deaths to support the delivery of safe, equitable, high quality, patient centred maternal, newborn and infant health services.
Monitor		This is the regulator of NHS Foundation Trusts. It is an independent body detached from central government and directly accountable to Parliament.
Myocardial Ischaemia National Audit Project	MINAP	MINAP is a national audit established in 1999 to enable hospitals to measure their performance against targets and improve the care of patients following a heart attack.
National Neonatal Audit Programme	NNAP	An audit programme established with the aim of informing good clinical practice in aspects of neonatal care by auditing national standards.
National Patient Surveys		Co-ordinated by the CQC, they gather feedback from patients on different aspects of their experience of care they have recently received, across a variety of services/settings: Inpatients, Outpatients, Emergency care, Maternity care, Mental Health services, Primary Care services and Ambulance services.
National Reporting and Learning System	NRLS	National database that allows learning from reported incidents. All Trusts upload their incident reporting data to this database on a weekly basis
Patient Experience Measures	PEMS	PEMS are used to measure the patient's view of their experience during the clinical episode, looking at how patients feel at an emotional and physical level.
Patient Reported 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.

Terms	Abbreviation	Description
Patient Safety Metrics		A number of measures which together can be used to assess how well a hospital keeps patients safe from harm whilst under their care.
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.
Re-admission Rates		A measure to compare hospitals which looks at the rate at which patients need to be readmitted to hospital after being discharged (leaving hospital).
Risk Adjusted Mortality Rates	RAMI	A measure to compare hospitals which looks at the actual number of deaths in a hospital compared to the expected number of deaths. The risk-adjustment is a method used to account for the impact of individual risk factors such as age, severity of illness(es) and other medical problems that can put some patients at greater risk of death than others.
Safer Nursing Care Tool	SNCT	The safer nursing care tool was launched in 2010 by the NHS Institute based on the work undertaken by the Association of UK University Hospitals (AUKUH). It is used to measure patient dependency/acuity to help determine nurse staffing levels on the wards.
Safety First		A report commissioned by Sir Liam Donaldson, Chief Medical Officer, to reconsider the organisational arrangements currently in place to ensure that patient safety is at the heart of the healthcare agenda. The report explicitly aimed to address issues raised by the National Audit Office in its report, A Safer Place for Patients, as well as to look at the NHS approach to patient safety more widely.
Secondary Users Service		This is the NHS data system for recording all NHS patient activity. It enables correct payments by commissioners for care provided by all provider services including acute trusts.
Sentinel Audit		A national audit that measures the care delivery provided for patients following the diagnosis of a stroke.
Sentinel Stroke National Audit Programme	SSNAP	SSNAP is a programme of work which aims to improve the quality of stroke care by auditing stroke services against evidence based standards.
Situation, Background, Assessment and Recommendation	SBAR	A national tool to standardise handover of care between clinicians
Stroke 90:10		An initiative, launched in North West England, which aims to significantly change frontline care practice for stroke patients in order to increase the number of stroke sufferers leaving hospital without serious disability.

Terms	Abbreviation	Description
Summary Hospital level Mortality Indicator	SHMI	SHMI is a hospital level indicator which measures whether mortality associated with hospitalisation was in line with expectations. The SHMI value is the ratio of observed deaths in a Trust over a period of time divided by the expected number given the characteristics of patients treated by that Trust Depending on the SHMI value, Trusts are banded between 1 and 3 to indicate whether their SHMI is low (3), average (2) or high (1) compared to other Trusts. SHMI is not an absolute measure of quality. However, it is a useful indicator for supporting organisations to ensure they properly understand their mortality rates across each and every service line they provide.
Systemic anti cancer therapy data set	SACT	The SACT collects clinical management information on patients undergoing chemotherapy in England.
Ten out of 10		The name of the Trust's strategic objective to improve quality by aiming for the Trust to be in the top 10 percent of hospitals nationally for the top ten indicators of Quality by 2014.
Venous Thrombo-Embolism	VTE	This is a blood clot which can develop when a person 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 the blood to another part of the body where it can cause problems – this is called a Venous Thromboembolism (VTE).

Appendix 2 - Feedback Form

We hope you have found this Quality Account useful.

To save costs, the report is available on our website and hard copies have been made available in waiting rooms or on request.

We would be grateful if you would take the time to complete this feedback form and return it to:

Clinical Quality and Outcomes Matron
Mid Cheshire Hospitals NHS Foundation Trust
Leighton Hospital
Middlewich Road
Crewe
Cheshire
CW1 4QJ

Email: quality.accounts@mcht.nhs.uk

How useful did you find this report?

Very useful □
Quite useful □
Not very useful □
Not useful at all □

Did you find the contents?

Too simplistic □
About right □
Too complicated □

Is the presentation of data clearly labelled?

Yes, completely □
Yes, to some extent □
No □

If no, what would have helped?

_____
_____
_____
_____
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Is there anything in this report you found particularly useful / not useful?

_____
_____
_____
_____
_____

East Cheshire NHS Trust

DRAFT IN CONFIDENCE

30/04/13

Quality Account 2012/13

Our Vision and Mission

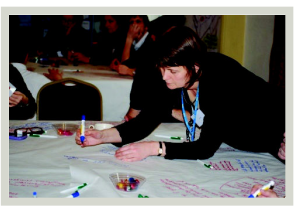
Quality is at the core of our mission and vision statements, and underpins our organisational values, strategic objectives and transformation plan. The Trust Board has agreed a Clinical Strategy that will build on existing strengths as the preferred provider of local, high quality and patient focussed healthcare.

Our mission

To provide high quality integrated and seamless services, as specified by Commissioners and delivered by highly motivated staff to our local population.

Our vision

East Cheshire NHS Trust will deliver the best care in the right place. This applies not only to the population of Cheshire, but also to our neighbouring areas including Stockport, High Peak and North Staffordshire.



Contents

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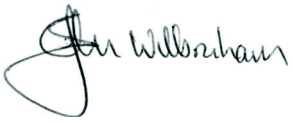
Foreword - Chairman

Lynn McGill,
Chairman

Chief Executive Statement



John Wilbraham, Chief Executive
April 2013

Directors statement

Why are we producing a Quality Account?

East Cheshire NHS Trust welcomes the opportunity to provide information on the quality of our services to patients, staff and members of the public. In this document we will demonstrate how well we are performing, taking into account the views of our patients, staff and members of the public, and comparing our performance with other NHS Trusts. All NHS Trusts are required to produce an annual Quality Account, which is also sometimes known as a Quality Report. We will use this information to help make decisions about our services and to identify areas for improvement.

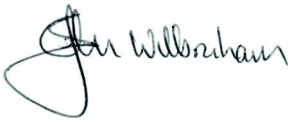
Respective responsibilities of Directors and auditors

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011).

In preparing the Quality Account, the Directors are required to take steps to satisfy themselves that:

- the Quality Account presents a balanced picture of the Trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance Included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review;
- the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account.



John Wilbraham, Chief Executive

Auditors letter

THIS YEARS LETTER TO BE UPDATED

Independent Auditor's Limited Assurance Report to the Directors of East Cheshire NHS Trust on the annual Quality Account

I am required by the Audit Commission to perform an independent assurance engagement in respect of East Cheshire NHS Trust's Quality Account for the year ended xx March 20xx ("the Quality Account") as part of my work under section 5(1)(e) of the Audit Commission Act 1998 (the Act). NHS Trusts are required by section 8 of the Health Act 2009 to publish a quality account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010 and the National Health Service (Quality Account) Amendment Regulations 2011 ("the Regulations"). I am required to consider whether the Quality Account includes the matters to be reported on as set out in the regulations.

My responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to my attention that causes me to believe that the Quality Account is not consistent with the requirements set out in the regulations. I read the Quality Account and conclude whether it is consistent with the requirements of the regulation and to consider the implications for my report if I become aware of any inconsistencies.

This report is made solely to the Board of Directors of East Cheshire NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 20xx.

Auditors letter

Assurance work performed

I conducted this limited assurance engagement under the terms of the Audit Commission Act 1998 and in accordance with the NHS Quality Accounts Auditor.

Guidance 20xx/xx issued by the Audit Commission on xx April 20xx. My limited assurance procedures included:

- Making enquiries of management;
- Comparing the content of the Quality Account to the requirements of the regulations.

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

Limitations

The scope of my assurance work did not include consideration of the accuracy of the reported indicators, the content of the Quality Account or the underlying data from which it is derived.

Non financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information. It is important to read the Quality Account in the context of the criteria set out in the regulations.

Conclusion

Based on the results of my procedures, nothing has come to my attention that causes me to believe that the Quality Account for the year ended xx March 20xx is not consistent with the requirements set out in the regulations.

Signature
Julian Farmer
Audit

Our values and objectives

Our values and objectives

We will:

• Treat each other with respect and dignity

This applies to all our interactions at an individual and organisational level, with all partners, patients, the public and carers, colleagues and other agencies. This is demonstrated by our seeking the views of staff, patients, and partners in the delivery of our services.

• Commit to quality of care;

Our Board Objective is to improve quality, safety and the patient experience. This is confirmed at every Board meeting in public by listening to the experience of patients and by the prominence of quality issues on the Board agenda.

• Show compassion;

By listening to staff and patients we are reminded daily that we are in the business of healthcare and that for a large proportion of our patients when they are in contact with us it is a particularly stressful time. We expect our staff to show compassion as part of their daily work.

• Improve lives;

Achieving our Board Objectives will ensure we achieve our Mission, by doing so we will improve the lives of our patients by preventing ill health, treating illness and alleviating pain.

• Work together for patients;

We promote team work within the organisation both within departments, across departments and Business Groups. In addition, our approach to health and social economy challenge is to align financial incentives and service improvement.

• Make everyone count.

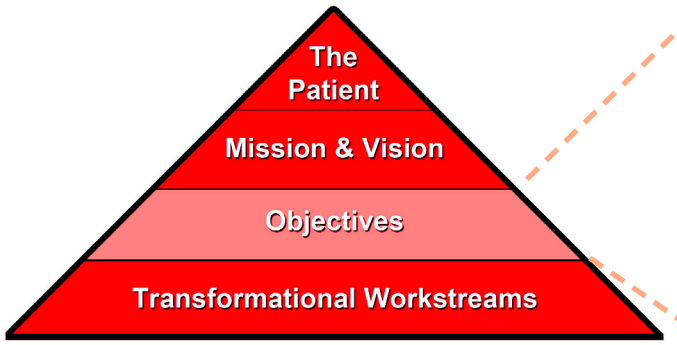
We are aware of the variation in health experience and outcome. Our approach is to treat all our customers equally by ensuring that the staff have the training to do so. As an employer we are committed to equality of employment and the benefit the oragnisation will gain.

East Cheshire NHS Trust is committed to ensuring that quality drives our clinical strategy and is at the core of everything we do.

Our values and objectives

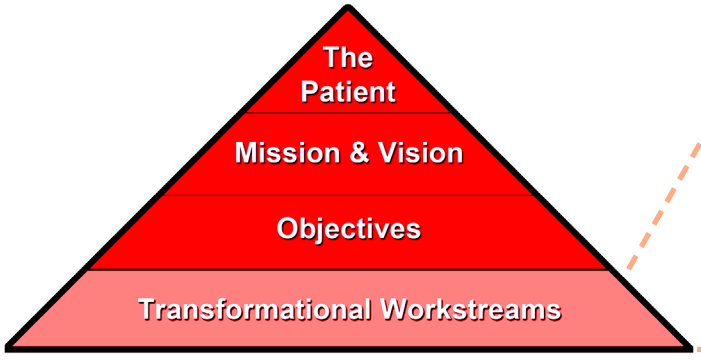
The Quality Strategy has been influenced by a range of drivers, the most significant of which are summarised below:

Our strategic objectives



- Continuously improve quality, safety and patient experience
- Supporting and developing staff to enable them to achieve their best
- Achieving financial sustainability
- Working with our partners to provide an integrated health service for our local population
- To contribute to the local community and being considerate to the environment
- Encouraging staff to be innovative when delivering and planning services

Transformational workstreams



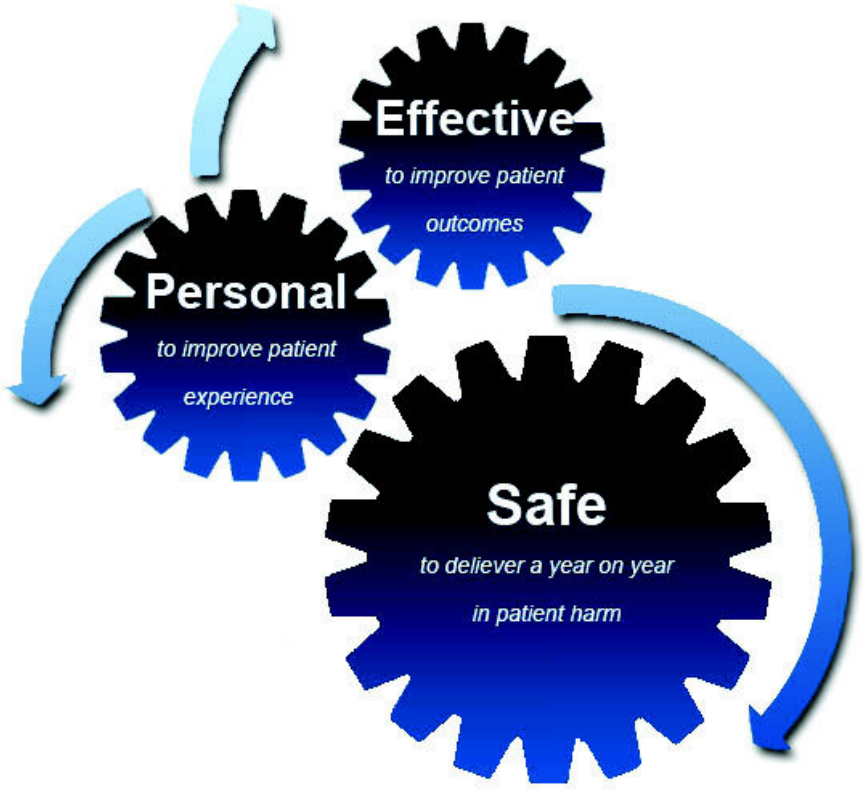
- Strengthening Operational Delivery
- Service Re-Design
- Organisational Development
- Cost Improvement Programme
- Governance and preparing for NHS Foundation Trust status
- Corporate and Social Responsibility


TRACY
SHUFFLEBOTTOM

The Quality Strategy 2012/15

The Quality Strategy ensures that quality is at the forefront of everything we do. The Trust is committed to improving quality and delivering safe, effective and personal care, with a culture of learning and continuous service improvement. The quality strategy indentifies the overarching priorities for improvement in community and acute settings, as depicted below.

ADDITIONAL INFORMATION TO BE ADDED



Influences on our quality strategy

Since the introduction of the Quality Strategy the Chief Nursing Officer for England has shared her vision for nurses, midwives and care givers. This is a strategy to support the development and delivery of compassionate and high quality care that achieves excellent health and well being outcomes. It builds on the existing NHS Constitution and details six values: Care, Compassion, Communication, Courage, Competency and Commitment

We have introduced a staff pledge that is at the heart of everything we do.

We will care with compassion, ensuring we communicate effectively, have the necessary competence to understand your health and social care needs and the courage to speak up for you. We will demonstrate our commitment by working together, combining our knowledge, skills and expertise to maximise opportunities for innovation and excellence.

Our quality priorities for 2013/14

Quality priorities

Using feedback from stakeholders and our commissioners, the Trust has identified quality priorities covering 2013/14, that will further improve safety, patient experience and clinical effectiveness. These quality priorities were established by reviewing feedback from our patients, staff, stakeholders and members of the public, to identify what we need to improve and to provide consistently high quality care, and to be able to measure success over the next year.

We will explain in this section how each quality priority for 2013/14 will be achieved.

Performance against the 2013/14 quality priorities will be monitored internally using the Trust's performance dashboard tool and progress will be reported monthly to the Trust Board.

Last year the Trust introduced the Safety Thermometer which is a tool for measuring patient safety developed by the NHS Information Centre. This was a point prevalence survey to measure, monitor and analyse the frequency of four specific patient harm areas:

1. Falls
2. Pressure Ulcers
3. Catheter Associated Urinary Tract Infections
4. Venous-thromboembolism

Progress to date is reported in (on page x)

A national initiative this year is the Family and Friends Test.

The Friends and Family Test

The NHS has introduced a Family and Friends Test for all Trusts as a way of gathering feedback about patients experience, helping to drive improvements in hospital services. Any patient aged over aged 16 who has had an overnight stay or has attended and been discharged from the Accident and Emergency Department will have the opportunity to feedback on one simple question relating to their experience. "How likely are you to recommend our ward / department to friends and family if they needed similar care or treatment?"

The results are public ally produced for patients comparisons. This information is available in the Trusts ward areas and on our website at www.eastcheshire.nhs.uk

Comments from patients from the Friends and Family Test include the following.

"The Staff were Super. Nothing was too much trouble for them. Always Smiling. Your hospital should be very proud of them.

Well all the staff very kind to me, took interest in me. In my eyes nothing could be improved at this present time.

THIS IS MY SECOND STAY ON THIS WARD. I WOULD DEFINITELY RECOMMEND IT TO OTHERS, BECAUSE OF THE HIGH LEVEL OF SUPPORT FOR BOTH PHYSICAL & EMOTIONAL NEEDS. I FELT COMFORTABLE & SAFE AT ALL TIMES DURING MY STAY & WAS ABLE TO DISCUSS ANY WORRIES I HAD. I WAS INCLUDED IN ANY DECISIONS ABOUT MY CARE.

The necessary treatment was given – not always as timely as required.
A disruptive patient ruined rest + sleep over several days + nights.
Empathy + compassion were not evident.
There was an overriding need to tick boxes, meet targets + fill forms, information to me was however limited.

COMMENTS BOXES TO BE DESIGNED

Our top priorities for 2013/14 (including CQUIN)

SAFE To reduce patient harm in hospital		
Priority	**Quality indicator**	**How we will achieve**
Safety Thermometer	To reduce by 30% the number of patients recorded as having a category 2-4 pressure ulcer (old or new) as measured using the NHS Safety Thermometer	• Monthly assessments will be undertaken • A trajectory for the year has been agreed to achieve planned reduction • Monthly completion of point prevelance study • Monthly assessment of data • Triangulation of data from other sources eg Datix and Root Cause Analysis report.
Clostridium difficile	To ensure compliance with the acute Clostridium difficile standard	• Monitoring of Clostridium difficile action plan • Root Cause Analysis of all incidences • Continue with operational audit programme.
Improve the assessment and management of the acutely unwell patient	Improve the assessment and management of the acutely unwell patient	• Review current process - update standard operating procedure • Review documentation • Review training in relation to Track and Trigger • Development/implementation of IT supporting the Trigger system • Independent competency • Established Health Care Assistant development programme • Review of critical care outreach service provision.

Our top priorities for 2013/14 (including CQUIN)

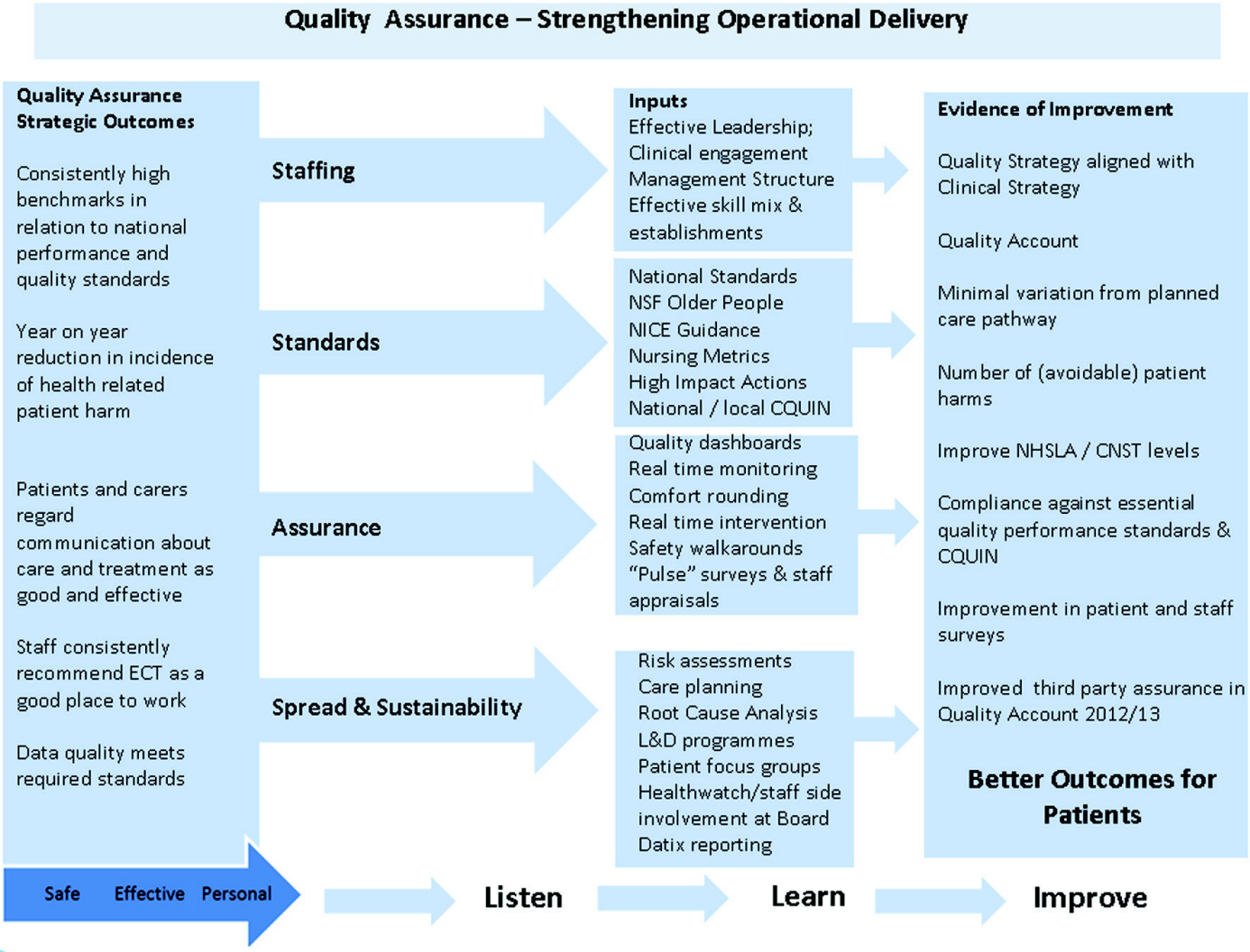
PERSONAL To provide a positive patient experience		
Priority	**Quality indicator**	**How we will achieve**
Friends and Family Test (FFT)	To improve the response rate on acute wards to 20%	• All patients will be given a survey form and information to explain what FFT is all about • Staff will encourage patients to complete the survey to support improvement in patient experience • Monthly information will be made available to patients and staff
Dementia Screening	To improve the diagnosis and referral of patients with dementia by screening eligible patients in line with national standards	• Effectively screen all non -elective patients over 75 years admitted to hospital • Patients with a positive screen will be referred back to their GP or an appropriate specialist for further support • Carers of patients with dementia will be surveyed to test if they feel supported.

Our top priorities for 2013/14 (including CQUIN)

EFFECTIVE To provide evidence based care		
Priority	**Quality indicator**	**How we will achieve**
The development and implementation of caring together neighbourhood teams	Development Caring together teams across all localities	• Establish health and social care teams in peer group locality areas • Implementing the pilot for risk profiling and aligning this to the neigbourhood teams in order to avoid admissions • Implementation of the self management programme for patients with identified long term conditions • Implementation of the care coordination role within the neigbourhood teams
Venous thromboembolism (VTE)	To ensure a minimum of 95% of patients have a risk assessment for VTE	• Ensure VTE risk assessments are carried out on all patients on admission • Effectively prescribe prophylaxis for all patients who are at high risk of developing VTE • Undertake a Root Cause Analysis on all patients with a hospital associated thrombosis.

How progress to achieve priorities will be monitored

The Trust has introduced a robust system of reporting to make sure that the Trust Board is given assurance about the quality of care it provides. There are many ways this will be carried out and the diagram below explains how the outcomes the Board requires are actioned by our staff. The actions below are measured to ensure that the standards are maintained and services are continually improved.



Statements of assurance

Statement of assurance

CONTENT TBC

Comissioning for Quality and Innovation (CQUIN)

The CQUIN framework was introduced in 2009 as a national framework that enables commissioners to reward quality achievements by linking income to improve improvement goals. During 2012/13 there were x national CQUIN's and x local CQUIN's.

CQUIN table to be re drawn.

2012/13 CQUINs

Acute	Achieved Yes / No
VTE Prevention	YES
NHS Safety Thermometer	YES
Care of Dementia	NO
Prognostication and Advanced care planning for End of Life	YES
Admission Prevention - % reduction in five agreed ACS conditions	YES
Patient experience: Personal needs	NO
Cancer staging (Reported Quarterly, 1 month in arrears) - Quarter 3 data	Achieved Quarter 1 - 3, Quarter 4 data not yet available
AQ: Acute Myocardial Infarction (composite score) December 2012 data	YES
AQ: Heart Failure (composite score) December 2012 data	NO
AQ: Elective Hip & Knee Surgery (composite score) December 2012 data	YES
AQ: Elective Knee Surgery (composite score) December data	YES
AQ: Pneumonia (composite score) December 2012 data	YES
AQ: Stroke (composite score) December 2012 data	YES
AQ: Patient Experience % survey response rate - February data	YES
Cancelled Operations - All cancelled as % of all electives Payment is based on year end performance.	NO
Urgent Care Information	YES

Community	Achieved Yes / No
Community: Integration of patient services	YES
Community: NHS Safety Thermometer	YES
Community: Management of patients with low back pain	YES
Community: Falls prevention	YES

Care Quality Commission (CQC)

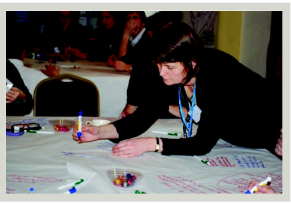
Registration under the Health and Social Care Act 2008 (Regulated Activity) Regulations 2009 and the Care Quality Commission (Registration) Regulations 2009

All NHS health care providers are required by law to register with the Care Quality Commission and declare compliance against 28 regulations. 16 regulations relate to quality and safety of care received by patients.

During 2012/13, East Cheshire NHS Trust has successfully maintained registration with the Care Quality Commission with no conditions.

However, following an inspection in February 2013, the Trust was found to be non-compliant in relation to three outcomes areas, including staffing levels, supporting workers and care and welfare of people who use services. An action plan to achieve full compliance has been put in place with the aim to achieve full compliance by May 2013.

All other outcomes inspected were fully compliant.



Relevance of data quality and action to improve data quality

The Trust's Data Quality Policy states that all staff have responsibilities for ensuring the quality of data meets required standards. Systems are in place to identify when data quality errors occur enabling the Trust to address the errors promptly. Overall data quality is reported monthly to the Trust Board. The Trust's overall data quality scores are better than the national average.

Secondary Uses Service

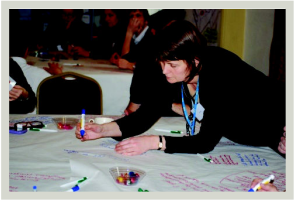
For 2012/13 (Apr-Jan), the average validity for the data items monitored in the Secondary Uses Service (SUS) Data Quality Dashboard is **96.6%** against a National score of 96.1%.

NHS number being present

Specifically, for a valid NHS number being present in the data the scores are above the National average: Admitted patient care at **99.3%** against 99.1%. Outpatients showing **99.8%** against 99.3% and A and E significantly above the national average of 94.9% at **98.0%**

Valid Healthcare Resource Group

For a valid Healthcare Resource Group version 4 code the scores are at **100%** for the following data sets for the Trust: Admitted Patient Care, Outpatients and Accident and Emergency. These are against National averages of 98.5%, 99.3% and 96.8% respectively.



Clinical coding translates the medical terminology written by clinicians to describe the patients' diagnosis and treatment into standard, recognised codes. The accuracy of this coding is a fundamental indicator of the accuracy of the patient records. There is a robust internal clinical coding audit and training programme which was developed in 2011/12. The Trust has a Connecting for Health (CFH) accredited auditor and trainer in post. Coding is carried out using the full patient case note supplemented by electronic systems such as histopathology and radiology which is considered best practice.

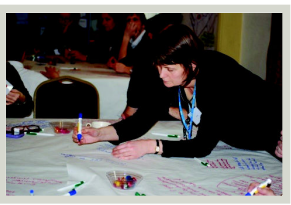
Information Governance Toolkit

As part of the Department of Health commitment to ensure the highest standards of information governance, it has developed an Information Governance Assurance Framework supported by the Information Governance Toolkit (IG Toolkit). The IG Toolkit is a self-assessment and reporting tool that organisations must use to assess local performance in line with Department of Health requirements. The Connecting for Health guidance states that all NHS organisations need to demonstrate compliance with all IG Toolkit requirements through achievement of at least Level 2 attainment and should be achieving Level 2 against all the requirements by 31st March 2013. The Trust submitted evidence in March 2013, confirming level 2 compliance against all the requirements.

Clinical Coding – Payment By Results (PBR)

Information not yet available

Will be available in final account



Patient and staff feedback

Patient feedback

We take the views of our patients, carers and staff very seriously. There are a number of different methods we use to collect data on patient and staff satisfaction, such as surveys, patient stories and patient experience groups, all of which provide us with vital information on how to improve the quality of our care. Below is a selection of feedback and results from our Patient Reference Group and the National Surveys that were conducted in 2012/13.

Patient Experience Reference Groups

As part of our ongoing commitment to quality improvements we hold Patient Reference Groups to increase our patients' involvement in the decisions we make. Two meetings of this group have been held in the past year, in May and November 2012.

At the first of these groups, progress with the projects implemented previously as a result of the Patient Reference Group's suggestions were reviewed. Positive comments were made by attendees on the speed of actions following the discussions and the suggestions made.

'The strength of the group lies in it not being restricted – people can say what they think without progress being held up by bureaucracy.'

In November 2012 discussion focused on the new Friends and Family Test and discharge arrangements. The groups reviewed and commented on the FFT proposal. Emerging themes were:

- Enhancing patient engagement and support of the Trust
- Staff mechanisms
- Timeliness of the question
- Management of cultural diversities.

National Adult Inpatient Survey 2012

East Cheshire NHS Trust was reviewed by 413 patients out of a sample of 805 patients who had been treated as an inpatient at the Trust during summer 2012.

Overall, the Trust was classed as performing in line with other Trusts for the majority of areas.

The areas where the Trust's performance was most improved include:

- Patients being asked to give their views on the quality of their care
- Doctors / nurses giving families all the information needed to help care for patient following discharge
- Following an operation or procedure patients receiving an explanation they could understand as to how things had gone
- Provision of same sex bathroom facilities
- Receiving copies of letters sent between hospital doctors and family GP
- Patients receiving enough help to eat their meals.

The Trust was classed as performing 'worse than other Trusts' in three areas:

- Enough information given to patients about their condition
- Side effects of medication being explained
- Patients knowing who to contact if worried about their condition after discharge.

A full action plan will be developed to help improve performance in these areas during 2012/13

National Emergency Department Survey 2012

The Trust was reviewed by 399 patients out of a random sample of 820 patients that were seen in the department between January and March 2012.

The Trust was in the top 20% of Trusts for 4 out of a possible 37 areas including:

- Staff telling patients about medication side effects to watch out for
- Staff telling patients when they could resume usual activities, such as when to go back to work or drive a car
- Staff telling patients about what danger signals regarding their illness or treatment to watch for after they went home
- Posters or leaflets displayed explaining how to complain about the care received

The Trust was not in the lowest 20% of Trusts for any area.

Areas where the Trust performance was most improved include:

- Being given enough privacy when discussing thier condition with the receptionist
- Initial wait to speak to a doctor / nurse
- Cleanliness of A&E department and Trust toilets
- Staff telling patients about medication side effects to watch out for, resume usual activities and danger signals regarding their illness on their return home

Following the survey an action plan has been developed to further improve patients' experience of the department and improvements have already been made in; ambulance to A&E turn around, reception privacy and alternative private discussion areas, dedicated triage service to reduce waiting times and a dedicated Emergency Nurse Practitioner for minor injuries. A dedicated nurse call bell system has been installed and deep clean programs are in place.

Local Feedback

A full programme of patient feedback work has been carried out across all areas of the Trust covering a range of different subjects including audiology, breast screening, breast surgery, breast feeding, cardio respiratory department, carers focus group, children's ward, coeliac disease, complaints service, dermatology, endoscopy and treatment unit, home intravenous therapy service (HITS), intensive care, maternity services, renal department, occupational therapy, paediatric diabetes, physiotherapy, special schools (inc. paediatric therapies) and supervision of midwives.

Specific examples of local feedback include:

Realtime feedback in the renal unit – patients in the renal unit were asked to complete a short survey on a touch-screen computer. This allowed the results to be collated and analysed on the same day and then fed back to the unit so that any action needed could be taken straight away.

Carers Focus Group – relatives / carers of patients on the Langley Unit were invited to a focus group to discuss the unit and how to improve the service offered.

- Overall carers were very happy with the care and attention that they and their relatives were receiving
- Overall carers rated the Langley Unit very highly and complimented the nurses extremely well
- Carers would like to see more physiotherapy for their relatives as currently the physiotherapists do not work at weekends (although rehab assistants are available).

Improvements made following the group include:

- Patients felt they received support if they were grouped with other patients that had similar conditions so now every effort is made to group patients this way
- Patients felt they would like more activities so the unit now has a weekly exercise group and a weekly bingo session.

Home Intravenous Therapy Service (HITS)

A paper based questionnaire was handed out to patients of the HITS service and returned to the Trust in a pre-paid envelope. The results highlighted that:

- All patients felt the staff treated them with kindness and compassion, dignity and respect and honesty and understanding
- 100% stated that they received an explanation as to the reason for their treatment
- 95% of patients said that staff definitely discussed their diagnosis, treatment and outcomes with them
- All patients said that the staff listened to their views and felt that the staff knew them as an individual
- All patients felt they had enough information in relation to their intravenous line and did not feel lacking in any information.

Comments in relation to the HITS team included:

"The nurses were very kind and understanding. They considered all my medical needs, and answered any questions. It is an excellent service."

"I really liked the care, respect and compassion shown by all of the staff."

"Being treated at home made me feel more relaxed and able to get on with life."

2011/12 Cancer Patient Experience Survey

The Trust was reviewed by 139 patients out of an eligible sample of 214 patients giving an overall response rate of 70%. All patients had a primary diagnosis of cancer and had been admitted to the Trust as either a day patient or an inpatient between 1st September 2011 and 30th November 2011.

The Trust was in the **top 20%** of Trusts for 21 areas including:

- Being given easy to understand written information about diagnostic tests
- Finding it easy to contact their Clinical Nurse Specialist
- The Clinical Nurse Specialist listening carefully to the patient
- Receiving answers they could understand from the Clinical Nurse Specialist
- Being told they were eligible for free prescriptions
- Admission dates not being changed by the hospital
- Being given written information about any operations

Following the survey there have been several improvements made including:

- A weekly financial support clinic has been set up to offer advice and information for patients. This is proving to be a very well utilised and helpful service.
- A new patient information leaflet has been developed to help support patients undergoing treatment for colorectal cancer.
- There is a project underway to look at the Trust practice around written assessments and care plans.

Cheshire East Local Involvement Network (LINK)

The Trust has received 13 'Enter and View' site visits from the Cheshire East Local Involvement Network over the past year to the following areas:

- Visits to wards 1, 5, 6, 7, Audiology and the Langley Unit (Ward 10) and two visits to ward 4
- Three visits to the paediatric unit and one to the Maternity Unit
- A visit to Knutsford District and Community Hospital during the consultation about the Tatton Ward closure.

There has been a significant amount of positive feedback following the visits, in particular around the following areas:

- Clean and bright environment and regular hand washing by staff
- Staff were helpful, courteous and polite and patients were appreciative of their care, feeling involved and informed
- On the Paediatric Unit, the therapy service was found to be impressive, along with the community play service enabling children to be treated at home
- All patients were appreciative of the facilities at Knutsford District and Community Hospital. There was little anxiety about the closure of Tatton Ward, and where there were queries, the issues around the building being 'fit for purpose' were discussed
- On the Maternity Unit, the team noted the availability of bariatric facilities, ergonomic chairs and signing provision, along with the private areas available.

The Director of Nursing Performance and Quality has responded to all 'Enter and View' reports providing further information where requested, acknowledging any improvements suggested and confirming any action to be taken. Service improvements as a result of these visits include improved home assessment visit timings, discharge arrangements, engagement between nurses and relatives/carers, nutritional improvement and meal time encouragement and support, Audiology reception facilities and improve patient information leaflets.

Cheshire West and Chester Local Involvement Network

The Trust has also had feedback from Cheshire West and Chester Local Involvement Network regarding the Out of Hours consultation concerning Northwich Royal Infirmary and Leighton Hospital, Crewe. As a result of the feedback received during the consultation and from the LINk, the plans to transfer some of the GP hours from Northwich to Leighton were put on hold.

Healthwatch

Local Involvement Networks (LINks) ceased to exist on 31st March 2013. The Trust would like to thank the LINks for their valuable contribution and the service improvements we have made as a result.

As from April 1st 2013, councils across England have been asked by the Government to set up a new organisation in their local area known as Healthwatch. This will act as the new local consumer champion for Health and Social Care. Its main role will be to:

- Provide information and advice to the public on Health and Social Care services
- To monitor and listen to the views of the public on Health and Social Care services
- To influence the way Health and Social Care services are provided in the future.

Healthwatch Cheshire East is currently recruiting members and will be fully functional around May/June 2013, for this reason, Healthwatch Cheshire East is not in a position to offer comment on this year's Quality Account.

YOUR VOICE : Listening into Action

The YOUR VOICE; Listening into Action Campaign was launched across the Trust on 8th October 2012. The purpose of the campaign is to increase staff engagement across the organisation by listening to staff, focussing on action (at a pace); developing sustainable solutions with staff; and building belief in the organisation and its ambition.

During October and November the campaign launched a pulse survey consisting of 10 questions to ascertain how engaged and valued staff were feeling right now. A total of 1411 staff (representing 40% of our workforce) completed the survey demonstrating a strong commitment to helping identify areas where staff engagement can be improved.

As part of the campaign five 'Staff Conversations' have been facilitated. These listening events have been very successful in bringing staff together to discuss what matters to them, what gets in their way, and how these issues can be overcome in order to make sustainable improvements for both staff and our patients.

We have captured over 2500 comments which have been used to identify some 'quick wins' to help make rapid improvements. Enabling our people schemes' are focussed corporate wide schemes that will benefit both patients and staff and we have launched '10 pioneering teams' which are dedicated projects within teams and departments to remove obstacles to support staff to do their jobs more easily.

YOUR VOICE
East Cheshire NHS
NHS Trust
Listening into Action

Staff survey information

The East Cheshire NHS Trust (ECNHST) staff survey was conducted between September 2012 and December 2012. 355 staff at ECNHST took part in the survey. The results are a snapshot of how staff felt at this time.

The results of the survey are presented into 28 key findings. Our results are compared to other acute Trusts in England, and to the Trust's performance in the 2011 survey. The findings are arranged under six headings, four pledges from the NHS Constitution, plus two additional themes. These are in the outlined in the table below.

Pledge 1	To provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities
Pledge 2	To provide all staff with personal development, access to appropriate training for their jobs and line management support to succeed
Pledge 3	To provide support and opportunities for staff to maintain their health well-being and safety
Pledge 4	To engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families
Additional 1	Staff satisfaction
Additional 2	Equality and diversity

Table to be re-designed

Changes since 2011 Survey:

The largest change in the survey since 2011 is evident in staff experience. Job satisfaction, and equality and diversity training, have shown most improvement. 16 factors have had no change since last year. Three measures are showing a reduced performance.

The Trust will be using the survey findings to shape our plans for the future. The Trust is pro-active in responding to our staff needs, and has already implemented a new a new staff engagement campaign- Your Voice...Listening Into Action (see Page 37) and a new health and wellbeing strategy.

A new Health and wellbeing strategy was launched November 2012. This strategy focuses on 3 main areas: mental health and well-being at work, physical wellbeing at work, and weight management and healthy lifestyle.

The strategy is designed to reduce stress in the workplace, reduce accidents, and assist our workforce in delivering healthier lives through our public authority deal pledges.

Both the Your Voice campaign, and the new health & wellbeing strategy were not fully implemented at the time of the 2012 staff survey; however it is expected that the benefits realisation of both these initiatives will be evidenced in the 2013 staff survey results.

Quality Performance in 2012/13

Our Achievements

Reduced the number of health acquired pressure ulcers at grades 3 and 4 by 10% from the 2011/12 baseline figure of 40.
Reduced the number of catheter associated urinary tract infections from the initial baseline assessment in Q1 by 10%, measured by the safety thermometer.
Rolled out the use of the Safety Thermometer as a safety monitoring tool Trust wide from April 2012.
Ensured a minimum of 90% of patients have a risk assessment for Venous thromboembolism. (except heart failure)
Successfully achieved the North West benchmarks for the Advancing Quality clinical care bundles.
Developed an infrastructure to support the clinical management of integrated care of patients with long term conditions.
MRSA in the acute setting had only one recorded case this year
Cancer targets achieved across all standards
18 weeks targets achieved across all three standards

Safe

To reduce the number of falls that cause harm from the baseline 2.8 per 1,000 bed days 2011/12 figure to 2.5 per 1,000 bed days.

How much: From 2011/12 baseline of 2.8 per 1,000 bed days to 2.5 per 1,000 bed days.

By when: March 2013

Progress: < Underachieved - Factors which have impacted on falls this year:

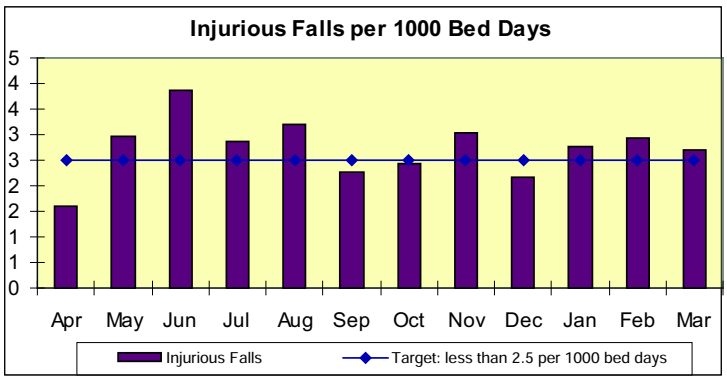
- Increased/Improved reporting on falls incidents
- Increase in the number of patients with multiple co-morbidities increasing the risk of falling.

Outcome:

- Injurious falls target achieved for four (out of nine) months of data
- Percentage of Injurious falls in comparison to 2011/12 are lower for six out of nine months of data

2012/13	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Injurious falls	1.6	3.0	3.9	2.9	3.2	2.3	2.4	3.0	2.2	2.8	2.9	2.7

2012/13



Improvements achieved

- Improved reporting
- Introduced falls awareness training onto Clinical Statutory and Mandatory Training
- Development and implementation of an integrated falls policy
- Developed an agreed model for undertaking falls risk assessment and supporting generic management plan for use in community settings, to reduce, to identify and target people at risk of falls in their own homes and prevent falls in the community through addressing contributing factors e.g. environmental
- Identified a network of 'Falls Champions' across hospital and community settings who will champion the cause of falls prevention, and to advocate, support and ensure the implementation and follow through of falls prevention initiatives
- Review of falls prevention programmes and education materials available within all health and social care organisations
- A revision and restructure of falls groups to provide an integrated approach to falls management/ prevention and clear monitoring and accountability for falls work across bed and home based services
- Pilot Project/scoping exercise undertaken in the South and Vale Royal area with the North West Ambulance Service, to look at pathways to reduce avoidable hospital admission for patients who have fallen, by providing direct referral route to Intermediate Care Services.

Future improvements

- Revision of falls risk identification for inpatients through the use of 'wristband identification' for inpatients
- Establishment of a training programme and implementation plan for the community based Falls Risk Assessment and management plan
- Ongoing work/analysis to provide relevant and timely staff training around falls prevention and management
- Alignment and development of falls prevention educational materials for patients/carers
- Review current audit tools to ensure that best information/intelligence is gathered and identify and communicate lessons learnt when patients have fallen in the hospital setting.

Safe

To reduce the number of health acquired pressure ulcers at grades 3 and 4 by 10% from the 2011/12 baseline figure of 40

How much: By 10% from the 2011/12 baseline figure of 40.

By when: March 2013

Progress: ✓ Target achieved

Outcome:

TABLE TO DEMONSTRATE ACHIEVEMENT TO BE INSERTED

Improvements achieved

- Robust system for reporting and checking accuracy of staging of pressure ulcer
- Link nurse system established to target ward performance
- New pressure ulcer prevention and management guidelines in operation
- Robust process of action learning from Root Cause Analysis for all stage three & four pressure ulcers that are health acquired
- Patient/carer friendly information leaflets to promote the importance of pressure ulcer prevention for clients at risk
- A training programme commenced with social services to target independent carer organisations out in the community on pressure ulcer prevention
- Consistent documentation for pressure ulcer prevention and management across the Trust
- Dressing formulary updated to ensure up to date products in use, in line with pressure ulcer prevention and management guidelines (NICE)
- Firm accurate baseline of pressure ulcers established within the Trust.

Future improvements

- To further embed governance and accountability into Link Nurse role
- To further analyse data to ensure prevention is targeted at key areas
- To revaluate the health acquired pressure ulcers, particularly in the community, to measure against set criteria of what is preventable and what is not
- To continue work with maternity and paediatrics to ensure risk assessment and prevention is targeted to working area.

Safe

To reduce the number of catheter associated urinary tract infections from the initial baseline assessment of 2.5 by 10%, measured by the safety thermometer.

By when: March 2013

Progress: ✓ Target achieved

Outcome:

TABLE TO DEMONSTRATE ACHIEVEMENT TO BE INSERTED

Improvements achieved

- Introduced safety thermometer points prevelance survey
- Reviewed catheter care plan
- National Houdini project pilot on control ward and actual ward re: compliance with saving lives
- Improved infection control data regarding catheter care

Future improvements

- Ongoing use of safety thermometer to continuously assess and improve catheter and UTI measurements. Re-visit, agree and clarify baseline and reduction percentage
- Undertake a review of the infection control team to incorporate a lead staff member to drive quality improvement and practice around catheter care
- Develop staff training program
- Produce an annual plan re: Houdini roll out
- Monitor and audit compliance against saving lives and implement changes to practice as required.

Safe

To roll out the use of the Safety Thermometer as a safety monitoring tool Trust wide from April 2012

By when: March 2013

Progress: ✓ Target achieved

Outcome:

TABLE TO DEMONSTRATE ACHIEVEMENT TO BE INSERTED

Improvements achieved

- Implementation of integrated and coordinated collection/point prevalence score on pre-identified dates
- Compliance with national reporting requirements with regards to the submission of NHS Safety Thermometer data
- Establishment of a data baseline against which we can track improvements or deterioration
- Preparation and development of local data collection through development of local database to be used in conjunction with national submission requirements, to enable trend data and drilling down to well performing and/or problem areas
- Showing overall compliance, type of harm by each category and percentage of harm free care
- Breakdown of community and acute data, acute by ward area and harm and community by locality and harm to enable analysis of specific data at local level e.g. pressure ulcers, falls etc.

Future improvements

- Ensure that data consistency is maintained and continue to embed the NHS Safety Thermometer in our patient safety culture
- Ensure that operational definitions are applied consistently, not only at a local level, but also a national level
- Work with commissioners to identify and set improvement goals – likely to be focused on improvement in pressure
- To work with the national Safety Thermometer leads and Tissue Viability Network to further develop, standardise and understand the data generated with regards to tissue viability and pressure ulcer prevalence - e.g. with particular clarification/consideration given to capturing un-gradable pressure ulcer incidences
- Develop mechanisms for sharing and cascading database/Safety Thermometer performance information with teams to enable understanding of individual team performance/contribution.

Effective

To ensure a minimum of 90% of patients have a risk assessment for Venous thromboembolism

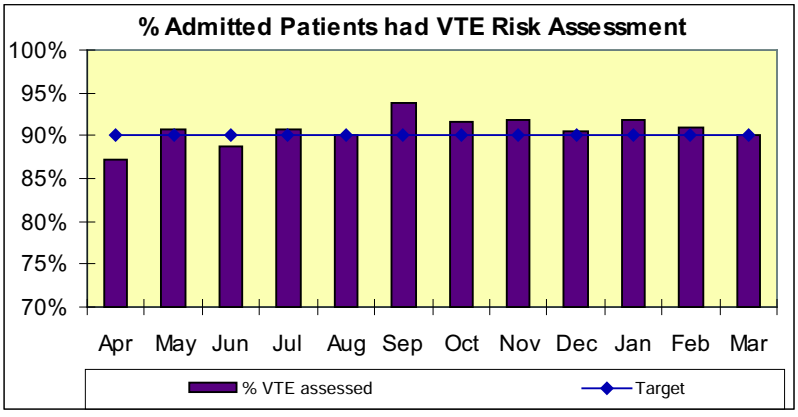
By when: March 2013

Progress: ✓ Target achieved

Outcome:

VTE prevention, reduce avoidable death, disability and chronic ill health from Venous thromboembolism

%	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
12/13 Plan	90	90	90	90	90	90	90	90	90	90	90	90
12/13 Actual	87.3	90.8	88.8	90.8	90.1	93.9	91.6	91.8	90.4	91.8	91.0	90.1



Improvements achieved

- Audit process embedded on wards and departments
- Improved competence monitoring

Future improvements

- Ongoing education of medical and nursing staff
- Training for all staff on electronic recording system
- Venous thromboembolism policy to be reviewed to include Deep Vein Thrombosis and Pulmonary Embolism guidelines on one document
- Daily auditing within wards to ensure non compliance is manage at the earliest opportunity
- Systems and processes for data collection and input and neccessary improvements are being taken and reviewed via the Venous thromboembolism steering group
- Work has commenced to ensure CQUIN target for 2013/14.

Effective

To successfully achieve the North West benchmarks for the Advancing Quality clinical care bundles.

We participate in:

Acute Myocardial Infarction AMI, Heart Failure, Hip & Knee, Pneumonia and Stroke. We currently do not participate in Dementia and First Episode Psychoses that were introduced more recently.

By when: March 2013

Progress:

✓ Target achieved - in AMI, Hip & Knee, Pneumonia and Stroke.

Outcome:

Below is a breakdown of each clinical focus areas and the Trust's results for the individual measures. The red lines on the green bar show the minimum and maximum score achieved in the region.

NEW TABLE TO BE ADDED

Improvements achieved

- To date, the clinical focus groups, Hip & Knee and Stroke demonstrate improvement in overall composite quality scores from the previous year (April 2011-March 2012)

- Hip and Knee currently resides in 5th place in terms of the performance ranking AQ table whereas Stroke is currently ranked in 3rd place.

- An improved stroke database and lean events have secured

Future improvements

- Review membership of sub-groups in particular Heart Failure and enlist more champions re: Advancing Quality (AQ)
- Strengthen clinical engagement in order to improve and sustain Heart Failure standards
- AQ lead to attend programme lead meetings in order to receive regular appraisal of AQ programme and share best practise
- Undertake regular audit of clinical documentation. Review and amend as required.
- Secure workforce resource for AQ data collection recurrently
- Monitor AQ performance via the Acute Business Group's balanced scorecard and via Quality Account Dashboard
- Monitor action plan to ensure target achievement.

Effective

To develop an infrastructure to support the clinical management of integrated care of patients with long term conditions.

By when: March 2013

Progress: ✓ Target achieved

Outcome:

The neighbourhood teams are made up of groups of health and social care professionals. Health services work alongside social services and generalists work alongside specialists to deliver proactive, personalised coordinated care for patient's over 65 with a Long Term Condition.

Patient and carers will have an input to the decisions about their own care and support in enabling them to self-care–'no decision about me without me'

Who are the Neighbourhood Teams?

Using the learning from the Knutsford early implementer site the professionals identified to work in the neighbourhood team are GPs, Community Matrons, District Nurses, Physio's, OT's, Social Workers and Community Psychiatric Nurses. In the future, health trainers provided by Age UK and Psychological Wellbeing Workers will be introduced to the team.

How do these Neighbourhood Teams work?

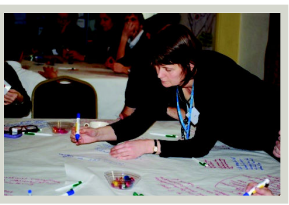
National Evidence (Department of Health) shows one of the most effective models to improve quality of care to patients, is by the professionals working in a Neighbourhood Team case managing patients together, such as the model used in North East Outer London. Fortnightly clinical team meetings are held in clusters of practices to discuss and agree case management plans for identified patients.

Improvements achieved

- Closer collaboration across organisations and professions aligned to integrated teams e.g Knutsford, Winsford, Rope Green teams in preparation for care coordination
- Information sharing agreement and privacy impact assessments completed
- Further roll out of patient passports and use of assistive technology.

Future improvements

- Continued roll-out of neighbourhood/ extended practice teams across all Clinical Commissioning Groups
- Development of care coordination within integrated teams
- Establishment of health coaches role and dementia champions
- Further expansion of telehealth
- Development of Risk Profiling and Multi Disciplinary team meetings.



Effective

To improve the diagnosis and referral of patients with dementia by screening eligible patients in line with national standards.

By when: March 2013

Progress: < Underachieved

Outcomes:

- The electronic recording system was delayed due to technical reasons
- Quarter four has seen a 6% increase in medical admissions

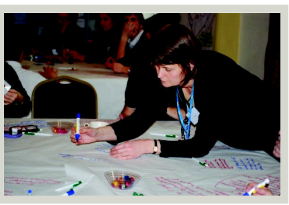
Improvements achieved

- Nursing documentation reviewed and amended to include dementia screening assessment
- Acute confusion pathway developed and piloted
- IT software updated to capture data collection
- Chief Executive signed up to commit to becoming a dementia friendly hospital
- The Kings Fund Environmental Assessment Tool has been adopted and an assessment undertaken in clinical areas.
- Submission to Department of Health re: Dementia funding advanced to second stage
- Dignity workbook for staff developed and implemented.

Future improvements

Second stage bid submitted to secure national monies re creating dementia friendly environment

- Review and re-launch acute Confusional Pathway
- Utilise Admiral nurse to facilitate training prior to re-launch of pathway
- Audit compliance of pathway
- Undertake a training needs analysis for staff working within acute care of the elderly
- Consider Registered Mental Nurse modules
- Review membership of dementia steering group
- Establish operational dementia steering group and Terms of Reference
- In conjunction with comissioners and social care, explore the development of local dementia strategy
- Explore the development of dementia nurse specialist role
- Monitor patient experience reports and improve in categories relating to dignity and care from previous year's baseline
- Develop stronger partnership and recruitment with the volunteers sector
- Develop elearning opportunities in dementia care for staff.



Effective

To reduce the number of cancelled operations.

How much: By 2% from 2011/12 baseline figure of 7.54% to 5.5%

By when: March 2013

Progress: < Underachieved

Outcome:

Pressure of emergency activity on surgical bed stock.

Despite not achieving the required standard, the level of cancellations in 2012/13 has improved on the previous year.

2012/13

Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	Overall year end
13.3%	**6.5%**	**7.6%**	**8.0%**	**6.1%**	**8.2%**	**5.5%**	**6.5%**	**5.9%**	**13.1%**	**15.8%**	10.3%	8.7%

NEW BAR CHART TO BE ADDED

Improvements achieved

- Introduction of the Surgical Admissions Lounge
- Development of a short stay area for orthopaedic and surgical electives
- Increase in day case rates for surgery
- Centralised booking team established for all elective specialties
- Development of National Confidential Enquiry into Patient Outcome and Death list to ensure emergency cases do not result in cancellation of non urgent elective work
- Spaces reserved for Cancer patients on specific consultants lists.

Future improvements

- Flexible job plans for newly appointed surgeons in some specialties to facilitate utilisation of dropped lists
- Establishment of Key Performance Indicators for monthly reporting at Theatre utilisation group
- Development of an orthopaedic waiting lounge
- Further increase in daycase rates for orthopaedics, breast surgery and general surgery
- Explore options for development of electronic bed booking system.

Effective

To improve the timeliness of initial clinical assessment of patients attending A&E by ambulance from 84.6% to 95% in less than 15 minutes.

By when: March 2013

Progress: < Underachieved

Outcome:

- High levels of pressure within the A&E departments due to medical assement areas being used as in patient capasity.
- increased departmnental pressures due to multiple ambulance arrivals at one time.

	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
12/13 Plan	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
12/13 Actual	**86.8%**	**90.6%**	**87.9%**	**87.7%**	**87.5%**	**91.2%**	**92.0%**	**92.9%**	**90.0%**	**89.9%**	**85.8%**	91.0%

New bar chart

Improvements achieved

- Improved compliance with Ambulance Capacity Management System
- Agreed participation in the Ambulance Service “Rapid Handover” procedures
- Ambulance Triage system in Emergency Department (ED) managed by Band 7 Shift Leader to ensure timely and effective handover from Ambulance to ED.

Future improvements

- Implementation of North West Ambulance rapid hand over system to develop purpose built Ambulance “Drop off” Bays to expedite ambulance handover and turnaround
- Nursing workforce review underway to consider the nursing requirements across the department, including the provision of Triage.

Performance against national targets 2012/13

2012/13 Target	Monitor Standards	In Month Target	In Month Performance	Quarter 4 Performance	YTD Performance	Level of Risk
95%	A&E: Maximum waiting time of 4 hours in A&E	>=95%	90.26%	88.23%	93.88%	High
No more than 1	Hospital MRSA bacteraemia year on year reduction versus trajectory for the year	0	0	0	1	High
No more than 10	Community MRSA bacteraemia year on year reduction versus trajectory for the year	1 or less	0	1	5	Moderate
No more than 24	Hospital Acquired CDifficile (Year Target)*	2 or less	0	2	29	Significant
No more than 90	Community Acquired CDifficile (Year Target)	7 or less	6	15	68	Moderate
>=93%	2 Weeks maximum wait from urgent referral for suspected cancer	>=93%	99.3%	98.4%	98.2%	Low
>=93%	2 Weeks maximum wait from referral for breast symptoms	>=93%	96.8%	97.1%	97.5%	Low
>=94%	31 days maximum from decision to treat to subsequent treatment - Surgery	>=94%	100.0%	100.0%	100.0%	Low
>=98%	31 days maximum from decision to treat to subsequent treatment - Drugs	>=98%	100.0%	100.0%	100.0%	Low
>=96%	31 day wait from cancer diagnosis to treatment	>=96%	100.0%	100.0%	100.0%	Low
>=85%	62 day maximum wait from urgent referral to treatment of all cancers (including patients treated at a tertiary centre)	>=85%	83.8%	89.1%	90.7%	Low
>=90%	62 days maximum from screening referral to treatment (including patients treated at a tertiary centre)	>=90%	100.0%	100.0%	99.0%	Low
>=90%	18 week Referral to Treatment - Admitted Patients - 90% within 18 weeks	>=90%	90.0%	90.8%	91.2%	Moderate
>=95%	18 week maximum wait - Non-Admitted Patients - 95% within 18 weeks (including community)	>=95%	97.8%	98.0%	98.2%	Low
>=92%	18 week maximum wait - Incomplete - 92% within 18 weeks	>=92%	92.1%	92.7%	93.1%	Low
>50%	Data completeness (Community)	>50%	Community system being implemented. Compliance by April 2014			Low

2012/13 Target	Other National Standards	In Month Target	In Month Performance	Quarter 4 Performance	YTD Performance	Level of Risk
0	18 week maximum wait - Delivery in all specialties - number of specialties failing as total in Admitted, Non-Admitted and Incomplete results	0	15			Moderate
>=99%	Diagnostic test waiting time	>=99%	99.2%	99.2%	97.6%	Significant
<3.5%	Delayed Transfers of Care	<3.5%	4.6%	5.3%	5.0%	High
0	Mixed Sex Accommodation breaches	0	0	0	0	Low
>=90%	VTE risk assessment	>=90%	90.09%	90.97%	90.70%	Low

* Hospital Acquired CDiff (Year Target) A revised annual target of 42 was agreed with Commissioners (Contract Variation)

TABLE TO BE RE-DRAWN

Core Indicators 2012/13

Data Requirement	Data Average	National Average	East Cheshire NHS Trust considers that this data is as described for the following reasons	East Cheshire NHS Trust has taken the following actions to improve this score and so improve its quality of services by:
SHMI 1. The SHMI value and SHMI banding for the trust;	Oct 2011 - Sep 2012 0.9862 Band 2 - As Expected July 2011 - June 2012 1.0079 Band 2 April 2011 - March 2012 1.0029 Band 2 Jan 2011 - Dec 2011 1.0176 Band 2 Oct 2010 - Sep 2011 1.0111 Band 2	Oct 2011 - Sept 2012 = 1.0 10 Trusts Higher than Expected 18 Lower than Expected	The Trust now performs within the expected range for this indicator. Improvements have been made due to focus work by the Trust Mortality Group. This is in line with our Trust TDA submission	The Trust holds a monthly Mortality Meeting where low risk deaths are reviewed and Mortality figures scruitinised. The meeting has recently developed a process to enable the effective review of every avoidable death.
2. The percentage of patients admitted to a hospital within the trust whose treatment induded palliative care; and	Oct 2011 - Sep 2012 1.0% July 2011 - June 2012 0.9% April 2011 - March 2012 0.8% Jan 2011 - Dec 2011 0.6% Oct 2010 - Sep 2011 0.4%	Oct 2011 - Sep 2012 1.0% July 2011 - June 2012 1.0% April 2011 - March 2012 1.0% Jan 2011 - Dec 2011 1.0% Oct 2010 - Sep 2011 0.9%	The Trust now performs within the expected range for this indicator. Improvements have been made due to focus work by the Trust Mortality Group. This is in line with our Trust TDA submission	The Trust holds a monthly Mortality Meeting where low risk deaths are reviewed and Mortality figures scruitinised. The meeting has recently developed a process to enable the effective review of every avoidable death.
3. The percentage of patients admitted to a hospital within the trust whose deaths were induded in the SHMI and whose treatment included palliative care.	Oct 2011 - Sep 2012 15.0% July 2011 - June 2012 14.0% April 2011 - March 2012 13.4% Jan 2011 - Dec 2011 10.2% Oct 2010 - Sep 2011 7.1%	Oct 2011 - Sep 2012 18.9% July 2011 - June 2012 18.4% April 2011 - March 2012 17.9% Jan 2011 - Dec 2011 17.2% Oct 2010 - Sep 2011 16.4%	The Trust now performs within the expected range for this indicator. Improvements have been made due to focus work by the Trust Mortality Group. This is in line with our Trust TDA submission	The Trust holds a monthly Mortality Meeting where low risk deaths are reviewed and Mortality figures scruitinised. The meeting has recently developed a process to enable the effective review of every avoidable death.
PROMS score Groin Hernia VV Hip Replacement Knee Replacement	No modelled scores have been provided for these records due to the unreliability of the statistical models when presented with a small number of results. East Cheshire has low volumes of activity in this area and so no scores are available.		Results are unable to show health gain as numbers are so small and are therefore not induded.	Improve patient participation by active encouragement by clinical staff. Development of reminder system for responses. Improve circulation and review of outcomes by clinical teams
Readmissions The percentage of patients of all ages and genders who were readmitted to hospital within the trust within 28 days of being discharged	11.63%	11.42%	Age and co-morbidity of patients above national average	All readmissions are reviewed by clinical teams to identify learning. Development of an electronic alert system for high intensity service users. Development of a pathway to support patients with alcohol related conditions to prevent the need for an acute admission.Patient Journey coordinators to continue to develop role and support ward staff in effective discharge planning. Expansion of nurse specialist cardiology team using an integrated approach with community teams to manage patients with long term cardiac conditions. Development of ACS pathway assessment area.

				pathway assessment area.
Responsiveness to inpatients' needs The score, based on the CQC national inpatient survey, for responsiveness to patients' needs	Overall score: 62.8 Q1. Involvement in decisions about treatment/care: 72 2. Hospital staff being available to talk about worries/concerns: 53.6 3. Privacy when discussing condition/treatment: 83.9 4. Being informed about side effects of medication: 36.6 5. Being informed about who to contact if worried about condition after leaving hospital: 68.2	National Score ??	Operational pressures including increased patient dependency and throughput has challenged the workforce.	Develop an action plan involving all relevant areas. Regular monitoring of performance which will be scrutinised at Business Unit Safety, Quality and Standards committees, trends identified and corrective actions agreed. This will be documented in the minutes of these meetings and forwarded to the Patient Experience Group who will oversee progress.
The percentage of staff who responded to the NHS staff survey that they agree or strongly agree that if a friend or relative needed treatment, they would be happy with the standard of care provided by the trust	60%	Average for acute trusts = 60%	The Trust has undergone a number of organisational restructures, which have impacted on staff morale across all areas. The Trust is working towards Foundation Trust status. Operational pressures induding patient dependency and throughput has challenged the workforce.	Your Voice:Listening into Action has been implemented in the Trust to further engage with staff, listening and responding to ideas for improvement. There has been an increase in acute ward nursing establishment to improve the baseline staffing levels. The application for FT status continues. The achievement of quality standards continues.
VTE The percentage of admitted patients who were risk-assessed for VTE	Apr 2012 87.3% May 2012 90.8% June 2012 88.8% Q1 2012 89.1% July 2012 90.8% Aug 2012 90.1% Sep 2012 93.9% Q2 91.6%	Apr 2012 93.4% May 2012 93.6% June 2012 93.3% Q1 2012 93.4% July 2012 93.9% Aug 2012 93.9% Sep 2012 94.0% Q2 93.9%	The Trust performs to the required standard.	On-going education of medical and nursing staff. On-going training on electronic system. VTE policy to be reviewed to indude DVT and PE guidelines in one document. Daily auditing within wards to ensure non compliance is managed at earliest opportunity.
CDiff rate The rate of C. difficile infections per 100,000 bed days amongst patients aged two years and over apportioned to the trust	April 2011 - March 2012 24.4 C. difficile infections per 100,000 bed days amongst patients aged two years and over	April 2011 - March 2012 21.8 C. difficile infections per 100,000 bed days amongst patients aged two years and over	Issues in Q1 and Q2 . New consultant Microbiologist commenced in post following gap in service after requirement of previous post holder. Action plan implemented. Evidence that the situation was brought back in control.	Continue with established MDT antibiotic ward rounds. Infection prevention and control team (nursing and medical) to work with CCG and GP's in reviewing antibiotic prescribing and overall management of patients with Long Term Condition that have potential to develop CDiff. Continue to develop CDiff management training . Continue with Root Cause Analysis review of all identified cases. Development of actions plans where required to be monitored within the clinical business group.
Reported patient safety incidents The rate of patient safety incidents they have reported per 100 admissions The proportion of patient safety incidents they have reported that resulted in severe harm or death.	10.51 incidents per 100 admissions Apr 2012-Sep 2012 0.3% resulting in severe harm or death (4 incidents resulting in severe harm, 2 resulting in death)	National average / total not given For all small acute trusts Apr-Sep 2012: Rate per 1000 admissions not given 0.9% resulting in severe harm or death	The web based incident reporting system is used to capture incidents and is available to all staff via PCs The patient harm field is mandatory on the incident reporting form All clinical incidents are reviewed by the Risk Management Team Training and communication takes place There is ownership for all incidents The Trust has a high level Executive lead group which considers all serious incidents	On-going training and education of Trust staff on incident reporting. The Trust is moving to Business Group specific reporting within the quarterly report to monitor reporting levels and trends The Trust is promoting the Duty of Candour across the organisation and have a "being open" policy Manchester Patient Safety Framework tool rolled out to Clinical Business Groups sub committees

Examples of best practice

Initiative	
Trust wide standardisation of intravenous practices, through competency based training and assessment programme. Ongoing assessment of competencies and knowledge to maintain standards across health economy.	
Aims	**Benefits**
All staff complete an evidence based workbook. The workbook starts at a basic level and build in complexity to appeal to staff with different levels of knowledge. Staff attend an intravenous study day with the workbook. Day consists of theoretical and practical participation Staff undergo competency assessment in clinical practice at least 3 times per skill. Competencies signed off and at level 1-4 using KSF outcomes to use at appraisal. Certificate issued and a date is set for an annual assessment. To maintain competencies. A key element of this is that staff learn best practice standards - maintain those standards and involve their patients in the process	• Educated workforce • Staff developed and feel values • Standardisation • Best practice cascaded • Safe and efficient services • Identifies and rectifies poor practice • Improved quality • Infection risk decreases • Enhanced patient experience • Reduced length of stay • Raises the profile of intravenous services within the trust • Encourages integration • Empowered and educated patients.

Examples of best practice

Initiative	
In September 2012, the Trust implemented a pilot Advanced Level 3 Apprenticeship in Health and Social Care.	
Aims	**Benefits**
The overall aim of the programme is to nurture home grown talent and facilitate local young people to work and have a career in the NHS. Working in partnership with Macclesfield College the scheme provides local young people with the opportunity to work as Health Care Assistants on the nurse bank whilst developing their skills and knowledge in health care. The apprentices work 30 hours a week in the Trust and attend college for 1 day a week. The Professional Practice Team supports the skills development of the apprentices in practice and designed a clinical placement programme to ensure that the apprentices experience care delivery in a range of clinical areas including medicine, surgery, orthopaedics, intermediate care and the community. Assessment of competency in practice is provided as part of the partnership agreement with Macclesfield College.	• The scheme provides a real opportunity for local students from our community to gain work experience and contribute to care that we deliver at the Trust. • The apprentices are supported by the Professional Practice Team and the Trust's ward staff to gain skills and competencies to deliver high quality care. The students also have access the Trust's state of the art simulation facilities where they can learn to deliver quality care in a safe realistic environment. • On completion of the Diploma the apprentices may have the option to either move on to a Foundation degree Trainee Assistant Practitioner programme, or enter Professional training.

Initiative
The home intravenous therapy service (HITS) was launched in 2012 driven by ECT strategic objectives and national agenda such as QIPP. Organisations are now required to manage patient throughout more effectively. HITS has a rare opportunity to promote cost effectiveness and improve quality of care. This is achieved by expediting discharge of patients no longer requiring hospital admission and where appropriate avoid admission all together.

Aim	Benefits
The HITS has been designed specifically to benefit a wide range of patients. Service pathways have been designed so that future patients will be considered, regardless of the condition. If the patient can safely undergo their intravenous therapy at home or in the community we will develop pathways to facilitate this. The service is split into two elements. Outpatient antibiotic therapy (OPAT) and speciality pathways, such as cardiology, alcohol detox, respiratory etc. The OPAT service is supported by district nursing teams who have worked hard through 2012 to achieve competence in IV antibiotic reconstitution and administration. The team has undergone competency assessment and has access to continually expanding educational resources. As a result we no longer have drugs supplied by a private provider. The Trust is working on admission avoidance pathways with GP's. This will benefit our over crowded A&E department and will allow for resources to be diverted to more appropriate areas.	• Educated Workforce • Enables best care at the right place • High Quality Service • Reduction hospital acquired infection • Promotes cost efficiency • Collaborative working • Integrated approach • Promotes efficiency in bed stock • Reduces waiting times for orthopaedics procedures • Reduces A&E activity

Examples of best practice

Initiative	
The introduction of Staff Training on 1 April 2013. In line with the National Core Skills Framework staff will complete their core statutory and mandatory training electronically.	
Aim	**Benefits**
From 2 April, 2013 staff will complete their Core Statutory and Mandatory training electronically through an e-learning programme, rather than via face-to-face delivery. The refresher period will also change to every three years rather than annually. There will still be a very limited number of places on the face-to-face programme reserved for staff who are unable to complete the modules online. Electronic Statutory and Mandatory Training (estat and Mand) is based on the modules developed for the National Core Skills Framework. The modules meet all the legislative and best practice guidelines required for statutory and mandatory training.	• Reduced time scales • The whole programme can be completed in approximately two hours saving time for staff • Cost effectiveness • The need for travel, a network of trainers and the general overheads of training can be reduced significantly. All national NHS e-learning is provided to the NHS free of charge • Accessibility • All materials can be made available online. This means there are no waiting lists, learning can be undertaken close to the time of need and the programme completed flexibly to fit in with the needs of staff.

Examples of best practice

Initiative	
The Resuscitation Council (UK) state that all clinical services must ensure tht their staff have immediate access to appropiate resuscitation euipment and drugs to facilitate rapid resuscitation of the patient in cardiopulmonary arrest. Standardisation of such equipment throughout an organisation is recommended.	
Aim	**Benefits**
Standardisation of the Crash Trolleys, and the layout of the equipment stored within - has the potential to improve the outcome following in-hospital cardiopulmonary arrest and reduce anxiety levels when staff respond to medical emergencies.	• Standardised equipment improves quality, safety and the patient experience by ensuring resuscitation equipment is readily available and fit for purpose • Consequently this benefits both patients and staff alike.

Initiative	
The Trust has invested in the reconfiguration of the discharge team and the establishment of the Patient Journey project which supports the overall Patient Flow programme for East Cheshire NHS Trust.	
Aim	**Benefits**
The aim of the reconfiguration and project is to strengthen the management of the discharge process by supporting ward based staff and moving from a 5 day service to a 7 day service in order to reduce the % of delayed transfers of care from the Trust to < 3.5% of inpatient bed stock. This will be achieved by:	• Provision of a 7 day service which will support increased discharges at the weekend • Early identification of patients requiring assisted discharge planning (providing assurances that the Trust is meeting it's legal obligations regarding pre-discharge assessments and entitlements to all patients) • Robust management of delays associated with 'Patient Choice' issues by improved and timely communication between Trust staff and it's patients and their carers (reduced patient/carer complaints re: discharge management) • Improved compliance with Trust policy through on-going education and training of Trust staff • Provision of a consistent monthly reporting process.

Initiative	
District Nursing-Pressure Sore Prevention.	
Aim	**Benefits**
To raise the profile of good pressure area care with effective and nursing assessments. All staff to be aware of their personal roles and responsibilities. Focus upon evaluation and treatment of nutritionally compromised patients.	• "At risk" patients were identified and a series of audits were undertaken to ensure the correct measures, care plans and risk assessments were carried out and were reviewed. • Morale has been improved as the team feel they are taking a proactive part in effective management of pressure ulcers. • Improvements in overall health and nutrition of patients on case load is beginning to be apparent.

Examples of best practice

Initiative	
A review of the nurses establishment across the acute wards	
Aim	**Benefits**
Work was undertaken to access the level of patient dependency in relation to the nurse establishment on the acute wards Benchmarking using a selection of nursing models was undertaken and was triangulated to agree the revised model A business case was developed and taken to Trust Board. Trust Board agreed aditional resources - £880k to support the improve staffing levels	• Nurse to patient ratio improved to six/seven patients to a qualified health care assistant • Improve nursing capcity to support patients and give quality care • Reduced levels of temporary staffing • Better continuity of care • Staff are aware of and are better able to work to the Trusts policies and procedures • improved staff moral.

Initiative	
Implement a community matron alert system.	
Aim	**Benefits**
To inform community matrons when a patient on their case load has attended A&E or has been admitted	• Matrons informed in real time regarding patients on their case load. • Improved communication • More effective management of patients supporting discharge at earliest opportunity

Initiative	
Implementation of tele health by community matrons	
Aim	**Benefits**
To allow community matrons to monitor patients with long term conditions remotely	• Patients can have vital reading such as blood pressure temperature pulse and oxygen saturation recorded within their own home. • Allows early intervention • Allows matrons to prioritise their work load • Reduces the requirement of home visits and patients attend GP practise.

East Cheshire NHS Trust teams shortlisted for national awards

The respiratory and cardiac teams at East Cheshire NHS Trust have been shortlisted for the Care Integration Awards, thanks to the excellent integrated services they provide.

The scheme's success has also been recognised by other healthcare professionals including the School of Nursing and by other Trusts, which are looking to adopt this model of care.

Kath Senior, Director of Nursing, said:

"It's great that the excellent work these teams are doing on behalf of the Trust has been recognised.

"By providing integrated services of this nature we can make a really positive difference to the patient experience, effectively supporting them and enabling them to adjust more easily to living back at home and managing their own conditions.

East Cheshire NHS Trust named NHS patient feedback challenge winner

East Cheshire NHS Trust was one of nine ambitious organisations leading patient experience projects to spread their innovative practices to other areas of the NHS, after being selected as winners of the NHS Patient Feedback Challenge. The project, entitled Patient & Family Echo, was a joint application by the Trust and Clever Together, a leading change and transformation agency.

They have been awarded £150,000 to spread the Patient & Family Echo process to health and social care organisations across the nation. Patient & Family Echo is a patient experience improvement tool that engages and empowers staff to 'echo' the voice, experience and needs of patients and families into their organisation. It aims to create organisations that value, listen and respond to feedback in order to continuously improve patient experience.

Audit participation

Participation in clinical audits 2012/2013

During 2012-13, 34 national clinical audits and four (NCEPODs) national confidential enquiries covered NHS services that East Cheshire NHS Trust provides.

During that period East Cheshire NHS Trust participated in 27/34 (79%) of the national clinical audits and 4/4 (100%) (NCEPODS) of the national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that East Cheshire NHS Trust participated in, and for which data collection was completed during 2012-13, are listed below, alongside the number of cases submitted to each audit or enquiry, as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Clinical Audit	Participation	Data collection 2012/13	% cases submitted in 2012/13	Patient recruited 2012/13
Neonatal intensive and special care (NNAP)	✓	✓	100%	166 admissions
Paediatric Pneumonia (BTS)	✓	✓	100%	40
Paediatric Asthma (BTS)	✓	✓	100%	23 cases submitted
Pain database	X	X	N/A	N/A
Epilepsy 12 (Childhood Epilepsy)	✓	✓	Data input commenced 01/03/13	N/A
Paediatric Intensive Care (PICAnet)	✓	✓	100%	12
Paediatric Cardiac surgery	N/A	N/A	N/A	N/A
Adult Cardiac surgery	N/A	N/A	N/A	N/A
Emergency use of oxygen (BTS)	✓	✓	100%	11 cases submitted
Adult community acquired pneumonia (BTS)	X	X	N/A	N/A

Audit participation

National Clinical Audit	Participation	Data collection 2012/13	% cases submitted in 2012/13	Patient recruited 2012/13
Non invasive ventilation – adults (BTS)	X	X	N/A	Not enough cases submitted
Cardiothoracic transplant	N/A	N/A	N/A	N/A
Cardiac arrest	X	X	N/A	N/A
Comparative audit of medical blood transfusion	✓	✓	100%	40
Adult critical care (ICNARC)	✓	✓	100%	410
Potential donor audit	✓	✓	TBC	TBC
Fever in children	✓	✓	100%	50
Diabetes (adults ANDA)	X	X	N/A	N/A
Diabetes (paediatric PNDA)	✓	✓	100%	95
Fractured neck of femur	✓	✓	100%	50
Parkinson's disease	X	X	N/A	N/A
Adult asthma (BTS)	✓	✓	100%	13
Bronchiectasis (BTS)	X	X	N/A	Not enough cases submitted
NJR hip knee and ankle replacements	✓	✓	TBC	TBC
Health promotion in Hospitals (NHPHA)	N/A	N/A	N/A	N/A
Inflammatory bowel disease (IBD)	✓		N/A	N/A
Suicide and homicide in mental health (NCISH)	N/A	N/A	N/A	N/A
Vascular surgery (VSGBI Vascular Surgery Database)	N/A	N/A	Data for East Cheshire NHS Trust patients included in patient data submitted by UHSM	Data for East Cheshire NHS Trust patients included in patient data submitted by UHSM
Carotid interventions	N/A	N/A	Data for East Cheshire NHS Trust patients included in patient data submitted by UHSM	Data for East Cheshire NHS Trust patients included in patient data submitted by UHSM
MINAP	✓	✓	Ongoing	Data completion date end of May 2013

Audit participation

National Clinical Audit	Participation	Data collection 2012/13	% cases submitted in 2012/13	Patient recruited 2012/13
Heart failure	✓	✓	Ongoing	Data inputting until end of May 2013
SINAP	✓	✓	100%	320
Cardiac arrhythmia	N/A	N/A	N/A	N/A
Renal replacement therapy (renal registry)	✓	✓		
Renal transplantation	N/A	N/A	N/A	N/A
Lung cancer	✓	✓	TBC	TBC
Bowel cancer	✓	✓	TBC	TBC
Head and Neck Oncology	✓	✓	TBC	TBC
Oesophago-gastric cancer	✓	✓	TBC	TBC
National Hip fracture database	✓	✓	100%	227
TARN	✓	✓	TBC	TBC
Renal Colic	✓	✓	100%	10
Prescribing Observatory for Mental Health (POMH-UK)	N/A	N/A	N/A	N/A
Psychological therapies	N/A	N/A	N/A	N/A
Pulmonary Hypertension	N/A	N/A	N/A	N/A
National Audit of Dementia (NAD)	✓	✓	100%	40
Coronary Angioplasty	N/A	N/A	N/A	N/A

Audit participation

Confidential Enquiries	Participation	Data collection 2012/13	% cases submitted in 2012/13
Asthma Deaths (NRAD)	✓	✓	100%
Child Health (CHR-UK)	✓	2	100%
Maternal Infant and Perinatal	✓	✓	100%
National Confidential Enquiry into Patient outcome and Death (NCEPOD) Subarachnoid Haemorrhage	N/A	N/A	N/A
National Confidential Enquiry into Patient outcome and Death (NCEPOD) Alcohol Related Liver Disease	✓	Organisational questionnaire returned Jan 2013	No patient data submitted
National Confidential Enquiry into Patient outcome and Death (NCEPOD) Bariatric Surgery	N/A	N/A	No patient data submitted as ECT does not undertake Bariatric Surgery
National Confidential Enquiry into Patient outcome and Death (NCEPOD) Cardiac Arrest Procedures	✓	✓	100%
Suicide and homicide in mental health (NCISH)	N/A	N/A	N/A
Elective Surgery (National PROMs Programme)	✓	✓	Average participation rate provisional data for Oct 2012 to Jan 2013 = 63%

National Clinical Audits 2012/13

The reports of 5 National Audits were reviewed by the provider and East Cheshire NHS Trust intends to take the following actions to improve the quality of healthcare provided:

National audit	Actions and progress
British Thoracic Society Adult Asthma Audit 2011	The British Thoracic Society Adult Asthma audit was carried out between 1st September 2011 to 31st October 2011 and data on 16 patients was submitted by East Cheshire NHS Trust. Recommendations from the audit: 1. Recording inhaler technique reviews 2. Advice regarding visit with GP within a week of discharge 3. Hospital follow-up appointments within 4 weeks 4. Written management plans.
Newborn Hearing Screening: Parent Satisfaction Audit 2012	The NHSP National Quality Standard to do with coverage and timeliness specifies that 95% of all babies should have completed the screen process by the 28th day of life and this Standard is regularly achieved at Macclesfield. Around 80% of babies born at Macclesfield District Hospital are screened as inpatients. Home births, babies born at other hospitals and babies requiring a further screen are seen as outpatients in a screening clinic which runs once a week in Children's Outpatients. This is the fifth Macclesfield NHSP Parent Satisfaction Audit since the Macclesfield Newborn Hearing Screening Programme (NHSP) began in February 2004 as part of Phase 3 of a national five phase rollout. The overall aim is to provide evidence to the NHSP Quality Assurance team of parental satisfaction in the Newborn Hearing Service as delivered at Macclesfield, also to highlight any areas for improvement and to track changes in these areas over a period of time. In the main, the results replicate those given in previous audits, underlining the consistent and ongoing high standards of performance demonstrated by the Screening Team and also their excellent skills, knowledge, approachability and competence as perceived by the parents surveyed. Ongoing problems with the ordering and supply of the PCHR (Red Book) which were substantial in 2009 and 2010 now seem to have been resolved with adequate stocks and no restrictions to ordering. Although the number of respondents noting that the checklist had been pointed out to them has risen to 68% in 2012, from 59% in 2010, this will be highlighted to the Screeners for further emphasis and their Screener Dialogue will be monitored during practical observations.

National audit	Actions and progress
National Diabetes In-Patient Audit Results	This is a rolling National annual audit looking at data from 2009 to 2011, with audit week in September each year. This audit was carried out as a one day snapshot audit during audit week. Data on 49 patients was submitted by East Cheshire NHS Trust. Benchmarking data is available from 2010. Recommendations from the audit: 1. “Think glucose” implementation to raise awareness of in-patient diabetes a. Referral guidelines to diabetes team. 2. Insulin prescription chart to tie in with a. Diabetic Ketoacidosis Pathway b. Hypoglycaemia pathway c. Peri-operative pathway d. Intra-partum care pathway e. Self-administration policy for insulin (in line with NPSA insulin alert) and decision tree for assessment f. Insulin passports. 3. More importantly - to reduce insulin prescription errors & management errors. 4. To comply with NPSA insulin alert by the end of August. 5. To reconsider the support of in-patient diabetes specialist nurses 6. Rolling training programme for a. Junior doctors b. Ward based staff. Further discussion during the audit presentation highlighted a general consensus, that Macclesfield District Hospital should have an in-patient diabetes nurse support and this is to be liaised within the restructure of the community business group.

The reports of two Confidential Enquiries were reviewed by the Board and East Cheshire NHS Trust intends to take the following actions to improve the quality of healthcare provided. (We have taken into account the development of responsibilities to other Trust committees/groups and included actions informed by those bodies.)

Group or forum	National audit reviewed	Actions and progress
CARE Group (Clinical Audit Research and Effectiveness Group) monthly meetings. *National Audit scorecard reviewed by this group on a monthly basis and Business Unit audit scorecards reviewed by this group on a quarterly basis.*	Review of Cardiac Arrests 2011 (referring to NCEPOD – Cardiac Arrest Procedures Study 2010, "A Time to Intervene Report") reviewed 09.07.12	Audit report published March 2012 based on a Review of Cardiac Arrests 2011. Key recommendation from this audit was Clinicians at East Cheshire NHS Trust must comply with the CPR & DNACPR Policies to avoid undignified CPR attempts during the dying process. CARE added support to East Cheshire NHS Trust, via Resuscitation Committee, to comply with the 5 principal recommendations from NCEPOD 'Time to Intervene?' Report (June 2012).
	NCEPOD "A Mixed Bag", an enquiry into the care of hospital patients receiving parenteral nutrition (2010) reviewed 09.07.12	An audit was conducted in line with NCEPOD - A Mixed Bag. The Nutrition Support Team has improved the management of Parenteral Nutrition in the hospital in respect of issues such as line care and monitoring. Implementation of the Parenteral Policy and the Request for Parenteral Nutrition pro-forma has been key to assessing suitability of patients for Parenteral Nutrition and its safe and effective use.

The reports of 58 @ 19/03/13 local clinical audits were reviewed by the provider in 2012-13 and East Cheshire NHS Trust intends to take the following actions to improve the quality of healthcare provided. (We have taken into account the development of responsibilities to other Trust committees/groups and included actions informed by those bodies)

Group or forum	Local audits reviewed	Actions and Outcomes
CARE Group (Clinical Audit, Research and Effectiveness Group). Monthly meetings. *Business Unit Audit scorecards are reviewed by this group on a quarterly basis*	Looked after children (NICE)	CARE Group acknowledged the extent this public health guidance highlighted the importance of collaborative working and good practice.
	Glaucoma (NICE)	CARE acknowledged this presentation as an example of good audit practice for improving patient care in an outpatient setting. Actions from audit – tailored management plan to be agreed between doctor and patient. Patient survey to be conducted to monitor quality of service.
	Medicines Adherence (NICE)	CARE Group acknowledged the ongoing improvements shown from the results of this audit and processes in place to progress further. Audit results were disseminated at Business Unit Safety Quality Standard (SQS) and Audit meetings.

National Clinical Audits 2012/13

Group or forum	Local audits reviewed	Actions and Outcomes
CARE Group (Clinical Audit, Research and Effectiveness Group). Monthly meetings.	Specialist Neonatal Care (NICE Quality Standard)	Original audit of the self assessment checklist highlighted the provision of Specialist Neonatal Speech & Language Therapy was not met. Deputy Speech & Language Manager progressed this status to partial compliance as trained Speech & Language Neonatal care is now available. CARE acknowledged this as an example of good practice, added support to a business case for additional resources and requested this be added to risk register.
	Lung Cancer (NICE Quality Standard)	CARE acknowledged this as an excellent example of good practice and collaborative approach with relevant agencies, to improve lung cancer service to East Cheshire NHS Trust patients. Radiology service was highlighted as integral to the efficient service provided. CARE supports all opportunities to continue to 'fly the flag' with GP's and Primary Care.
	Infection Control (NICE)	CARE Group were informed that Statutory & Mandatory training covered the core elements of Infection Control. Since the formation of the integrated Trust this training has been rolled out to include those working in the community arm of the Trust.
	Bacterial Meningitis & Meningococcal Septicaemia in Children & Young People (NICE)	Quality standard self assessment checklist audited and presented at CARE Group. Three statements identified as being non-compliant with a timescale of one month given to meet compliance. Actions completed against all three statements within one month and compliance status updated to full compliance.

Group or forum	Local audits reviewed	Actions and Outcomes
CARE Group (Clinical Audit, Research and Effectiveness Group). Monthly meetings.	Patient Experience in Adult NHS Services (NICE Quality Standard)	Quality standard was presented at CARE Group, illustrating evidence of the individual compliance status against the 14 statements. The group noted that 'Statement 8 - Patients are made aware they can ask for a second opinion' provides a challenge as it is difficult to obtain evidence and to find suitable ways on implementing this. CARE Group agreed that further discussion to take place with Clinical Commissioning Group (CCG), as to whether this should be a high level approach instigated by CCG across all their organisations.
Acute Care Business Group monthly audit meetings.	**Medical Specialties:** Clinical Assessment in Stroke	The aim of the audit was to assess the completeness of neurological examination & use of the stroke pro-forma in patients admitted with a possible stroke diagnosis. The quality of the initial assessment has the potential to have significant impact on patient care and diagnosis particularly in stroke patients with the advent of thrombolysis. The conclusion was that we are falling short in our initial assessment of stroke patients and / or our documentation in relation to this. Recommendations with an implementation date of March 2013: 1. Full neurological assessment for patients admitted with a neurological problem 2. Clear documentation of reasons why parts of assessment not done if unable to do so 3. Neurological teaching sessions for Junior Doctors.

Group or forum	Local audits reviewed	Actions and Outcomes
Acute Care Business Unit monthly audit meetings.	**Orthopaedic Surgery –** Venous thromboembolism Prophylaxis in Orthopaedic In-Patients (NICE)	In line with NICE guidelines to reduce the number of VTEs, all hospitalised patients must have a risk assessment to prevent potentially fatal venous thrombo-ebolisms. The aims of the audit: 1. Ensure all patients have Venous thrombo-embolism Prophylaxis (VTEP) 2. Ensure all patients have mechanical VTEP unless contraindicated 3. Ensure all patients who have pharmacological intervention receive the correct drug, with the correct dose, at the correct time and for the correct duration The recommendations and actions from the audit: 1. Education of all doctors regarding the importance of filling out VTE risk assessments at admission, 24 hourly and weekly. 2. To ensure all forms are filled in correctly, and duration of treatment is included in the drug chart. 3. To re-audit with a larger sample size. 4. Review the benefits of carrying out a weekly risk assessment on orthopaedic inpatients (as per NICE guidelines).

Group or forum	Local audits reviewed	Actions and Outcomes
Acute Care Business Unit monthly audit meetings.	**Urgent Care** Management of Deliberate Self-Harm in A & E	The audit was conducted to compare our practise to national standards set by Royal College of Psychiatry with the objective to educate or to formulate a pro-forma to improve management of deliberate self harm (DSH) at MDGH. We retrospectively audited 15 patients from January to March 2012 who attended Emergency Department with DSH. Recommendations from the audit included; production of an assessment pro-forma, teaching all Health Professionals & Junior Doctors on Induction day and to re-audit in 6 months.
	General Surgery Cholecystectomy – Readmissions & Complications	The audit was conducted against the British Association of Day Case Surgery with the objective being, to increase the proportion of laparoscopic cholecystectomies done as day cases within the Trust, as this would have beneficial cost implications. The audit aimed to find and address the factors that led to an overnight or prolonged stay. The recommendations from the audit included; to default laparoscopic cholecystectomies to day case, unless social or surgical reasons, to conduct Post-op review at the end of list/day and to carry out telephone assessments on discharge as this would reduce readmission rates.

Group or forum	Local audits reviewed	Actions and Outcomes
Acute Care Business Unit monthly audit meetings.	**Clinical Services** Hand Hygiene in Clinical Environments in Radiology (NICE)	Hand hygiene is one of the most important procedures for preventing the spread of infection. Local Trust policies & NICE Guidance mandate good hand hygiene measures. 1 in 9 patients acquire HAI (Hand Hygiene Infection) which results in increased length of stay and further care and treatment is an adverse outcome for the patient. At 97% compliance all Radiology areas fell well within the targets set by the Trust, with no single month falling below the target. Recommendations from the audit included; - Clean jewellery well - Minimum of 30 seconds is recommended hand washing time - Ongoing re-audit to ensure compliance at all times (particularly summer time when rise in Methicillin-resistant Staphylococcus aureus and Clostridium difficile).
	Breast Surgery Lipomodelling Audit, (Dec 12)	Awaiting report/presentation to enable info to be extracted and added in.

Group or forum	Local audits reviewed	Actions and Outcomes
Families & Wellbeing Unit monthly audit meetings including Maternity & Women's audit meetings. All of the audits have actions plans for development or have achieved the standards of care.	**Midwifery** Decision to delivery time interval for grade 1 & 11 caesarean section	It is of utmost importance for the mother and fetus wellbeing, that the emergency caesarian sections grade 1 and 2 are performed within specific time limits. The aim was to audit the time from decision to delivery for grade 1 and 2 emergency caesarean sections in order to optimise clinical outcomes. In addition, to audit the adequacy of documentation in the patient notes according to the hospital policy. Greater than 95% concordance was set as the standard. Recommendations and actions from the audit: 1. To focus on documentation of decision and consultant involvement, by clinician involved in making the decision. 2. Maintain the high standards of practice of grade 1 and 2 caesarean sections. 3. Education of Senior clinician involved in the decision process regarding the need for better documentation in cases of emergency caesarian sections.

Group or forum	Local audits reviewed	Actions and Outcomes
Families & Wellbeing Unit monthly audit meetings including Maternity & Women's audit meetings.	**Childrens Services** Insertion & Management of Nasogastric Tubes in Paediatric Unit	The nasogastric tube care plan used on the Children's Ward at Macclesfield District General Hospital, was updated in June 2011 to reflect the recommendations of both NPSA & NICE. The aim of this audit was to assess whether patients on the Paediatric unit who require nutritional input, or other carers requiring the use of a Nasogastric tube are receiving quality, safe & effective care based on local & national guidelines. Several recommendations were made to improve patient care including: 1. Medical staff to document a full assessment and rationale for using a nasograstric tube. 2. All staff to be assessed for competency in use of nasogastric tube and to be introduced as a standard for all new starters to the ward. The findings of the audit have been shared with the Special Care Baby Unit Advanced Neonatal Nurse Practitioner and the actions to date are in line with the implementation dates set.
	Dietetics Weight Management Audit – NICE	Recommendations from the audit included ways in which to improve data collection of outcome measures and further assist patients in weight reduction within constraints of current weight management team. The team have actioned the recommendations, which included additional training for staff, trialling a drop in weigh session and working closely with IT analyst to ensure accurate coding of patient data. The implementation of these recommendations has led to improvements in service and patient care.

Group or forum	Local audits reviewed	Actions and Outcomes
Community Service Business Unit bi-monthly audit meetings. All of the audits have actions plans for development or have achieved the standards of care.	**Community East Locality** Audit of Giant Cell Arteritis (GCA) against BSR guidelines	Two actions that have been implemented following the audit: 1. Education for FY1 and FY2s on GCA as part of their annual teaching programme – implemented October 2012. 2. GCA investigation and management protocol on the East Cheshire NHS Trust intranet site – Clinical Guideline Intranet micro-site implemented February 2013.
	Community South & Vale Royal Locality Occupational Therapy Service Audit against National Occupational Therapy Standards	This audit assessed nine areas; - Accountability - Service users Best Interests - Consent - Practise and Progress - Competence - Record Keeping - Collaborative Working - Effective Communication - Management. An action plan was compiled to address any low compliance areas and this will be re-audited annually.

Families & Wellbeing Business Group

The National Confidential Enquiry into Maternal and Child Health (CEMACH) produced a report into why Children Die (2007). This report concluded that up to two thirds of childhood deaths may be preventable. A key finding was that prompt recognition of deterioration of a child's illness was paramount in preventing a child's death.

The recommendation from this report is that all areas that care for paediatrics in hospital should have a 'standardised and rational monitoring system for children developing critical illness - an early warning score'.

In 2009 the children's ward at Macclesfield District Hospital introduced a paediatric early warning scoring tool (PEWS). Despite extensive staff training and encouragement several clinical audits showed very poor results, mainly focused on poor compliance in recording by the nursing staff and a negative view of its use by both medical and nursing staff.

A working group was formulated and a peer review was undertaken of the current tool and, following very negative feedback from Partners in Paediatrics forum (PIP), combined with the poor audit results prompted a radical redesign of the tool to age specific charts, which other hospitals found more user friendly. The new tool introduced had been adapted from tools available on the NHS Institute for Innovation and Improvement. This new tool was launched in February 2012 and all medical and nursing staff had extensive training and teaching and competency booklets were distributed.

Following an audit in May 2012, and a comparison with previous audits, there had been improvements in the recording of the early warning score, thereby improving the quality of care provided to children. However, the audit report did still highlight that further improvement could be achieved once the new tool is embedded.

Community Services Business Group - GP Out of Hours Service

Trial additional shifts in GP Out of Hours services to cope with potential extra demand.

The aim of bringing in additional GP time was to enable A&E to refer more primary care patients to the GP Out Of Hours Service, and release A&E pressures. This was due to an increase in A&E clinical incidents reported, which could be seen by the GPOOH/New Service. Examples of these incidents arose from:

- Incorrect use of the A&E Department by patients
- Staffing pressures – 1 GP on A&E Saturday/Sunday nights
- Bed and ward pressures - sending to A&E when ward full
- Increased demand due to population rise and language barriers / patient education.

Additional commissioned shifts were piloted between 1st June 2012 and 31st July, 2012, every Saturday and Sunday from 6pm until 12pm.

A&E felt that the additional commissioning shifts were beneficial and well received – increasing their capacity. The impact was measured by the number of appointments required, shorter waiting times to be seen at base and shorter waiting times for home visits. Demand has not decreased; however, it has remained constant.

Service GPs on Saturday and Sunday afternoons and evenings, stated that the additional shifts were significantly beneficial, as it reduced pressure on them and it meant they could accept more patients and support A&E in a more flexible way. The service Triage Team noticed improvement in relationships between the A&E Triage and the service, due to the additional GP cover. It did mean that post 10pm there were two Doctors on duty giving more flexibility in the event of home visits and any sudden increase in demand.

These additional shifts meant the service could offer a better, more robust service to our patients, and additional support to A&E, and thus a safer transfer and handover of patients.

Adult Physiotherapy Service

There has been a rolling program of training staff in the use of the STarT BACK Tool since its introduction as part of the IMPaCT Research Study with Keele University in 2008. The Back Pain Specialists, who have been responsible for the training, undertook a service wide audit in June 2012 which identified that 91.37% of staff had received training in the use of the tool.

The Back Pain Specialists have manually audited the use of the tool (April – July 2012) and patient outcomes.

Results showed 942 patients with low back pain were assessed, of these 824 patients were assessed with the STarT BACK tool. Overall 75% of patients had a positive outcome (problems resolved/resolving/ goals near achievement – Modified Goal Achievement Score (MGAS).

Care Home Learning and Development Team

Background

One of the roles of the team is to deliver training and support to Registered Nurses within the 32 Nursing Homes in the East Cheshire area, to enable them to administer subcutaneous fluids. This means residents can be treated for dehydration within the home thus providing quality care for the resident and avoiding hospital admission. The aim was to quantify the potential number of bed days saved by the use of subcutaneous fluids within nursing homes.

Progress

Data collected from April 2012-February 2013 shows that subcutaneous fluids were administered to 94 patients over 730 days (although not all homes responded to the data requests). At an estimated cost of £260** per bed day, this equates to a potential saving of £189800 during the 11 month period. The service thus supports the Trust objectives of improving the patient experience, achieving financial sustainability and working with partners to provide integrated and innovative services.

Actions

-To examine the data by individual home to identify nursing homes that have not returned data. This will enable us to raise awareness of the procedure within those homes.

-To use the data to evaluate whether the service will be rolled out to the Central Cheshire nursing homes.

** Bed cost sourced from the In Patient Services Manager at MDGH.

Acute Care Business Group

The Department of Elderly Care Medicine participated in the North West Regional Falls Audit (which was the final cycle of four over an eight year period) by conducting a retrospective case note review. Participation in this audit provided an opportunity to benchmark and collaborate services to fit in with National standards.

The aims and objectives of the audit:

- To evaluate if patients with falls are managed appropriately
- To assess if the Trust are using the falls risk assessment tool properly
- To determine if falls interventions are undertaken robustly
- To ascertain if the Trust are compliant with the national guidance
- To ascertain if the Trust are showing continued improvement with the best available research.

One of the aims from this audit was to improve assessment processes and care planning and this was achieved in the majority of cases, with marked improvement from the 2009 audit. The results highlighted other areas of good practice with improvements made on the 2009 audit:

- As a reflection of more frequent assessments, up to two thirds were identified at risk for falls
- Medications reviewed and changed more by clinicians
- More falls and ward transfers identified
- More additional assessments (moving and handling, continence, bedrail, alternative bed).

Areas for improvement were also highlighted in the audit including staff training for falls awareness and a re-audit is planned to monitor these areas.

Participation in clinical research demonstrates the Trust's commitment to improving the quality of care offered and making a contribution to wider health improvement.

Our clinical staff stay abreast of the latest treatment possibilities and active participation in research leads to successful patient outcomes.

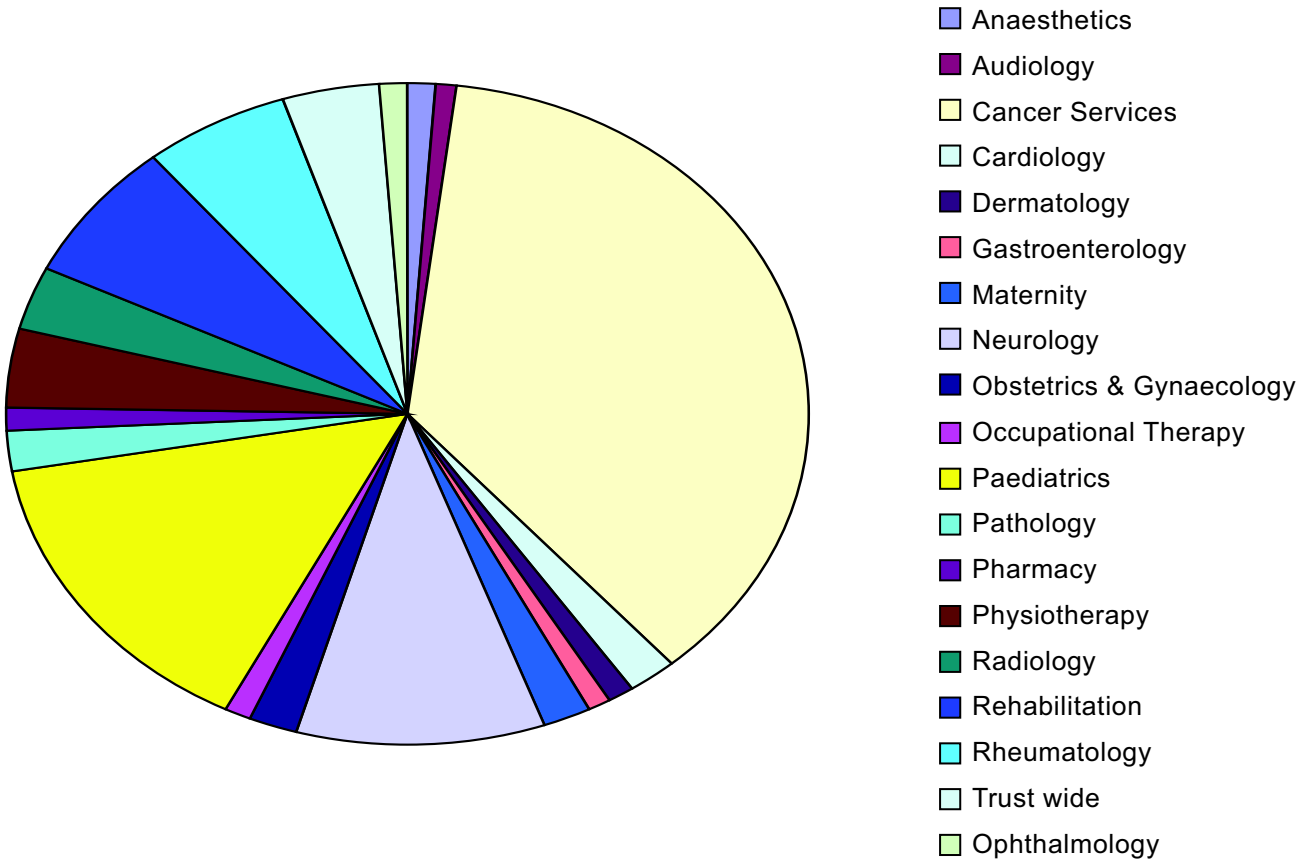
Whilst maintaining the studies and following up participants recruited in previous years, a further 27 studies have been opened and 379 participants were recruited in 2012-13. A further nine studies are awaiting approval by East Cheshire NHS Trust research staff for research that has been approved by the ethics committee.

The figure above refers to patients recruited into National Institute of Health Research (NIHR) approved studies. We have also recruited staff and patients into other research studies, including clinical trials conducted with external companies.

The Trust is currently involved in 101 active clinical research studies covering 19 medical specialities, which are:

Areas of Clinical Research	
Anaesthetics	Paediatrics
Audiology	Pathology
Cancer Services	Pharmacy
Cardiology	Physiotherapy
Dermatology	Radiology
Gastroenterology	Rehabilitation
Maternity	Rheumatology
Neurology	Trust wide
Obstetrics & Gynaecology	Ophthalmology
Occupational Therapy	

Distribution of action studies across The Trust



As can be seen in the chart above Cancer services make up a large part of our portfolio which mirrors the situation nationally. The Cancer Unit runs a number of trials across a range of disease groups.

Written statements from other bodies

Glossary

Term	Explanation
ANTT	Aseptic Non - Touch Technique
BTS	British Thoracic Society
CARE	Clinical Audit Research and Effective
CEMACH	Confidential Enquiries into Maternal and Child Health
CEM	College of Emergency Medicine
CDiff	Clostridium Difficile
CQC	Care Quality Commission
CNST	Clinical Negligence Scheme for Trusts
COPD	Chronic obstructive pulmonary disease
CQUIN	Comissioning for Quality And Innovation
CSBU	Community Services Business Unit
CSLN	Cumbria and Lancashire Stroke Network
CXR	Chest XRay
DNAR	Do Not Attempt Resuscitation
HSMR	Hospital Standardised Mortality Ratio
ICNARC	Intensive Care National Audit And Research Centre
MBU	Medical Business Unit
MDGH	Macclesfield District General Hospital
MRSA	Methicillin-resistant Staphylococcus aureus

TO BE UPDATED

MINAP	Myocardial Ischaemia National Audit Project
NRAS	National Rheumatoid Arthritis Society
NHSLA	NHS Litigation Authority
NICE	National Institute of Clinical Excellence
NIHR	National Institue of Health Research
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NNAP	National Neonatal Audit Programme
NPSA	National Patient Safety Agency
PAS	Patient Administration System
PROMS	Patient Reported Outcome Measures
RCP	Royal College of Physicians
RA	Rheumatoid arthritis
RAMI	Risk Adjusted Mortality Index
SBAR	Situation Background Assessment Recommendation
SINAP	Stroke Improvement National Audit Progr\mme
SQS	Safety, Quality Standards
TARN	Trauma Audit and Research Networks
VTE	Venous Thromboembolism
VSGBI	Vascular Society of Great Britain and Ireland

Feedback Form

We hope that you have found this Quality Account interesting and helpful.

This report is available n our website. Hard copies can be made available on request.

We would be grateful if you would take the time to complete this feedback forma and return in to:

The Engagement Office
East Cheshire NHS Trust
Victoria Road, Macclesfield, Cheshire, SK10 3BL

Email: ecn-tr.Yourvoice@nhs.net

How useful did you find this report?

Very useful ☐
Quite useful ☐
Not very useful at all ☐

Did you find the contents?

Too simplistic ☐
About right ☐
Too complicated ☐

Is the presentation of data clearly labelled?

Yes, completely ☐
Yes, to some extent ☐
No ☐

If no, what would have helped?

.....

Is there anything in this Account that you found particularly interesting and helpful?

.....

Thank you for your time.

Copies of this report, including different formats, are available from the Communications and Engagement Department.
Telephone: 01625 661184

It is also available online at www.eastcheshire.nhs.uk

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CHESHIRE EAST COUNCIL

REPORT TO: Health and Wellbeing Scrutiny Committee

Date of Meeting: 9 May 2013
Report of: Interim Borough Solicitor
Subject/Title: Work Programme update

1.0 Report Summary

1.1 To review items in the 2012/13 Work Programme, to consider the efficacy of existing items listed in the schedule attached, together with any other items suggested by Committee Members.

2.0 Recommendations

2.1 That the work programme be received and noted.

3.0 Reasons for Recommendations

3.1 It is good practice to agree and review the Work Programme to enable effective management of the Committee's business.

4.0 Wards Affected

4.1 All

5.0 Local Ward Members

5.1 Not applicable.

6.0 Policy Implications

6.1 Not known at this stage.

7.0 Financial Implications for Transition Costs

7.1 None identified at the moment.

8.0 Legal Implications (Authorised by the Borough Solicitor)

8.1 None.

9.0 Risk Management

9.1 There are no identifiable risks.

10.0 Background and Options

10.1 In reviewing the work programme, Members must pay close attention to the Corporate Plan and Sustainable Communities Strategy.

10.2 The schedule attached, has been updated in line with the Committees recommendations on 4 April 2013. Following this meeting the document will be updated so that all the appropriate targets will be included within the schedule.

10.3 In reviewing the work programme, Members must have regard to the general criteria which should be applied to all potential items, including Task and Finish reviews, when considering whether any Scrutiny activity is appropriate. Matters should be assessed against the following criteria:

- Does the issue fall within a corporate priority
- Is the issue of key interest to the public
- Does the matter relate to a poor or declining performing service for which there is no obvious explanation
- Is there a pattern of budgetary overspends
- Is it a matter raised by external audit management letters and or audit reports?
- Is there a high level of dissatisfaction with the service

10.4 If during the assessment process any of the following emerge, then the topic should be rejected:

- The topic is already being addressed elsewhere
- The matter is subjudice
- Scrutiny cannot add value or is unlikely to be able to conclude an investigation within the specified timescale

11.0 *Access to Information*

The background papers relating to this report can be inspected by contacting the report writer:

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Email: james.morley@cheshireeast.gov.uk

HEALTH AND WELLBEING SCRUTINY COMMITTEE – WORK PROGRAMME

Last Updated – 1 May 2013

Issue	Description/ Comments	Suggested by	Portfolio Holder	Current position	Next Key Date
Health and Wellbeing Board (HWBB)	Development of new arrangements	Standard Item	Health and Adult	HWBB - Update on progress at each meeting.	1 May 2013 agenda deadline 9 May 2013 meeting.
Quality Accounts:	NHS Providers publish Quality Accounts on a yearly basis and are required to give Scrutiny the opportunity to comment.	Committee	Health and Adults	Mid Cheshire and East Cheshire Hospital Trusts to provide quality accounts at public meeting	1 May 2013 agenda deadline 9 May 2013 meeting
Quality Accounts	NHS Providers publish Quality Accounts on a yearly basis and are required to give Scrutiny the opportunity to comment.	Committee	Health and Adults	Cheshire and Wirral Partnership and Clatterbridge Cancer Centre Quality Accounts will be available for review in June	Potential items for future meeting. June – July 2013
Ageing Well Programme	To receive a one year update on the performance of the programme	Chairman	Health and Adults	Scrutinise Performance of the Programme at a public meeting	June

HEALTH AND WELLBEING SCRUTINY COMMITTEE – WORK PROGRAMME

Last Updated – 1 May 2013

Scrutiny Protocol with CCGs	To approve the proposed protocol	Scrutiny Team	Health and Adults	Scrutiny Team to review protocol with CCG representatives	Meeting TBA
Annual Public Health Report	To receive a presentation on the Annual Public Health report and assess whether any issues should be a focus for Scrutiny	Committee	Health and Adults	Presentation to Committee when ready	Deferred until TBC
Joint Health and Wellbeing Strategy		Committee	Health and Adults	Report to Committee in July 2012; update to 1:1 after engagement process	On-going
NHS Health Checks	Centre for Public Scrutiny are offering support to 5 local authorities to conduct a review of NHS Health Checks.	Scrutiny Team	Health and Adults	Cheshire East has expressed interest in the scheme. If selected a Task and Finish Review will be commissioned.	TBC
New 111 call system	To inform members of the new call system.	Committee	Health and Adult	Officers to arrange for information to be communicated to members via email.	Information to be provided when available
Mental Health Scrutiny	Need to establish how scrutiny of CWP and mental health services will take place without Joint Scrutiny Cttee	Chairman	Health and Adults	Chairman and Portfolio Holder to discuss.	TBC

NWAS Communities Strategy Performance	To examine and offer comments on NWAS performance	Committee	Health and Adults	Receive performance reports every six months. Where at meeting on via email to members	TBC
Safeguarding Peer Review	Chairman to liaise with Corporate Scrutiny Chairman regarding future monitoring of item.	Corporate Scrutiny Committee	Health and Adults /Children and Families	Update to be provided when available	Unknown

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