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Health and Wellbeing Scrutiny Committee

Agenda

Date:	**Thursday, 8th May, 2014**
Time:	**10.00 am**
Venue:	**Council Chamber - Town Hall, Macclesfield, SK10 1EA**

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 13 March 2014

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. **Eastern Cheshire NHS Trust - Quality Account 2013/14** (Pages 5 - 100)

To examine the draft Quality Account 2013/14 of Eastern Cheshire NHS Trust and provide comments to be submitted to the Trust for consideration and inclusion in the final Quality Account.

7. **Mid Cheshire Hospitals NHS Foundation Trust - Quality Account 2013/14** (Pages 101 - 186)

To examine the draft Quality Account 2013/14 of Mid Cheshire Hospitals NHS Foundation Trust and provide comments to be submitted to the Trust for consideration and inclusion in the final Quality Account.

8. **Eastern Cheshire CCG - Caring Together Programme** (Pages 187 - 206)

To consider the draft Caring Together care models and submit views to Eastern Cheshire CCG

9. **Work Programme** (Pages 207 - 210)

To review the current Work Programme (attached).

Agenda Item 2

CHESHIRE EAST COUNCIL

Minutes of a meeting of the **Health and Wellbeing Scrutiny Committee** held on Thursday, 13th March, 2014 at Committee Suite 1,2 & 3, Westfields, Middlewich Road, Sandbach CW11 1HZ

PRESENT

Councillor H Gaddum (Chairman)

Councillors R Domleo, I Faseyi, D Hough, W Livesley, J Saunders, O Hunter and M Sherratt

Apologies

Councillors L Jeuda, A Moran and M J Weatherill

ALSO PRESENT

Councillor J Clowes – Cabinet Member for Health and Adult Social Care
Jo Vitta – South Cheshire Clinical Commissioning Group
Matthew Cunningham – Eastern Cheshire Clinical Commissioning Group
Sam Nicol – Eastern Cheshire Clinical Commissioning Group

OFFICERS PRESENT

Lorraine Butcher – Strategic Director of Commissioning
Guy Kilminster – Head of Health Improvement
James Morley – Scrutiny Officer

185 **MINUTES OF PREVIOUS MEETING**

RESOLVED – That the minutes of the meeting held on 13 February 2014 be approved as a correct record and signed by the Chairman.

186 **DECLARATIONS OF INTEREST**

There were no declarations of interest

187 **DECLARATION OF PARTY WHIP**

There were no declarations of Party Whip

188 **PUBLIC SPEAKING TIME/OPEN SESSION**

Mr Stefan Pyra, representing South Cheshire Patient Participation Group (SCPPG), informed the Group about an issue that had been raised regarding prescribing exercise as a form of treatment. SCPPG had received complaints that patients in Alsager were no longer able to receive subsidised access to leisure services at the local leisure centre through prescriptions from their GP. Funding for exercise on prescription had previously been provided by the Primary Care

Trust (PCT) and SCPPG believed that the funding was a Council function and suggested that the funding should be reinstated as the exercise programme was useful in reducing the effects of a variety of conditions and therefore reduced visits to hospital or accident and emergency services.

The Chairman asked the Cabinet Member for Health and Adult Services if she was able to address the questions raised by Mr Pyra. The Cabinet Member explained that as the subsidised exercise programme was prescribed by GPs for therapeutic purposes it was not the responsibility of the Council or Public Health to fund such an initiative. There seemed to have been an oversight during the transition from the PCT which resulted in the lack of funding. There was currently a pilot scheme taking place in Crewe which was hoped would provide evidence to GPs and the CCGs that providing funding to allow exercise on prescription was worthwhile by providing long term health benefits. The Cabinet Member also clarified that this issue did not impact on exercise as part of cardiac rehabilitation which was separate from exercise on prescription.

The Committee suggested that the Council needed to ensure there was better communication with the public on matters such as these. It was also suggested that the Council should encourage the CCGs to commission exercise programmes for patients, whilst ensuring that adequate services were available in Council leisure centres to do so.

189 CARING TOGETHER: THE CASE FOR CHANGE

Sam Nicol, Programme Director for Caring Together, gave a presentation about Eastern Cheshire CCG's Caring Together Programme. The aim of the Caring Together Programme was to design the most effective system for sustainable quality care.

To design a new system to meet the challenges in providing health and social care services to the community, Eastern Cheshire CCG wanted to engage patients, public and other stakeholders. This was because the CCG wished to design the system around the people involved and their needs. The CCG sought the Committee's assistance in promoting the Caring Together initiative to the Eastern Cheshire community and encourage people to contribute to the consultation.

The results of the consultation would be available in May 2014. It was suggested that they be presented to the Committee with viable options for the new system to allow the Committee to comment and make recommendations about the preferred option.

RESOLVED – That Eastern Cheshire CCG be requested to provide a report on the result of the Caring Together case for change consultation and the options for service development at the Committee's meeting in May.

190 UPDATES FROM CCGS AND NHS ENGLAND

Jo Vitta, South Cheshire Clinical Commissioning Group (CCG), and Matthew Cunningham, Eastern Cheshire CCG, provided brief updates on the progress made by the CCGs since they began operating in April 2013 and the challenges that they would be facing in the near future.

Jo made the following points on the progress of South Cheshire CCG:

- The CCG was making good progress with Connecting Care, which had similar themes to Eastern Cheshire Caring Together programme.
- The CCG had a lay member on the Board who was responsible for public engagement.
- The CCGs five year strategy and two year plan were near completion and would be available to look at soon.
- The CCG was meeting the challenge of working with less capacity and resources than the previous PCT.
- There had been more collaboration of commissioning with partners, including the Council, than ever before and this would continue in the future.

The challenges for the future faced by South Cheshire CCG included:

- Increasing the quality of services provided with fewer resources.
- The growing number of people living longer into old age and young people with disabilities surviving into adulthood increase the demand for services.
- Managing the growing complexity of health needs.

Matthew reiterated many of the points made by Jo as Eastern Cheshire had gone through similar structural and governance changes during the transition from the PCT. Much of the work of the CCG was focused on the Caring Together programme which the Committee had considered in the previous item. The challenges Eastern Cheshire CCG faced in the future included:

- Difficulties caused by the funding formulae and financial challenge of £50M deficit
- Geographical influences, i.e. proximity to Greater Manchester and the requirement to build relationships with them to serve patients effectively

Kirsty McBride, NHS England, sent apologies for not being able to attend the meeting but had sent a note to update the Committee on NHS England's future challenges. NHS England was prioritising its specialised commissioning; its aim was to create more national specialised centres for treatments that were rarely carried out on a local basis. It was hoped that outcomes for patients with rare conditions or specialised needs would be improved if there were fewer centres providing services more often to more people.

RESOLVED – That the updates be noted.

191 **WORK PROGRAMME**

The Committee considered its new work programme document and developed ideas for possible future items. The following topics were suggested:

- Winter planning
- Caring Together
- CCG two year plans
- Travel plans (patients, family and friends travelling to health services)

- NHS Trust Quality Accounts
- Shifting services from hospitals to communities
- Quality of health and care services
- Integration and connecting budgets for health and social care
- Early Intervention and Prevention of illness and deterioration

RESOLVED – That the work programme be updated to include the items discussed.

The meeting commenced at 10.00 am and concluded at 11.50 am

Councillor H Gaddum (Chairman)

East Cheshire NHS Trust

Quality Account

2013/14

The best care, in the right place

Year at a glance

This year has delivered some excellent achievements. The rewards, accolades and achievements we receive are a result of the hard work and dedication our staff put in throughout the year, to be the best at delivering patient care in the region.

April 2013

Integrated community and acute teams shortlisted for national awards

May 2013

Trust named CHKS Top 40 for third time in a row

June 2013

Innovative text service for young people launched by school nurses

October 2013

CNST Level 3 - top safety accreditation for maternity services

November 2013

Ward 9, winners of the patient choice award for quality of care

December 2013

Dr Foster online - trust performing "as expected" for mortality rates

Cancer patients receiving some of the best care and support in England

Cancer patients were assured they were receiving some of the best care and support in England when the trust came second in a league table measuring patient experience.

July 2013

Trust secures funding to improve quality of care for dementia patients

August 2013

Family and Friends Test launched for patients

September 2013

Trust placed in second-safest banding (band 5) by Care Quality Commission (CQC)

January 2014

Recognised as regional leaders to improve end of life quality of care

February 2014

New service to improve lung cancer diagnosis and treatment launched

March 2014

Macclesfield Hospital stroke co-ordinator nominated for top award

Our quality account describes our key achievements for 2013/14 and sets our priorities for the year ahead. We have made excellent progress in the past year in strengthening the quality of our acute and community services, and there is still more we can do. Our aim is to provide the best care in the right place for all of our patients, all of the time.

Kath Senior, Director of Nursing, Performance & Quality

Quality assurance monitoring 2012/15

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 generated by our staff.

Board Objectives

1. PATIENTS - Provide the best services to our population through improvements to safety, productivity and patient experience

2. PEOPLE - Empower, develop and value staff in providing innovative patient-focused care

3. PARTNERSHIPS - Actively develop sustainable services through effective partnerships

4. RESOURCES - Effectively provide services that are sustainable both now and in the future

Strategic Outcomes

1. Delivery of care services that are as clinically safe and effective as possible with a year on year reduction in health related harm

2. Delivery of care in a manner whereby patients are treated with compassion, dignity and respect with patients and carers consistently; rating the trust as good or excellent in relation to communication about care and treatment

3. Delivery of evidence based pathways of care, supported by an attitude and culture within the organisation whereby everyone is striving for excellence and continuous quality improvement in all that they do

Evidence of Improvement

1. Quality Account

2. Minimal variation from planned care pathway

3. Number of (avoidable) patient harms

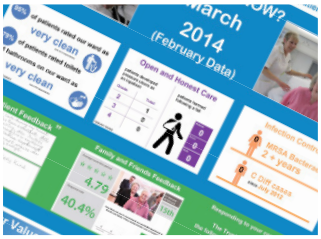
4. Compliance against essential quality performance standards and CQUIN

5. Improvement in patient and staff surveys

6. Improved third party assurance in Quality Account 2012/13

7. Improved Quality Governance

Leadership	Quality Governance	Patient & Family Involvement	Training & Development	Measure for Improvement
Restructure of clinical and management leadership Further embed nursing & Allied Health Professional (AHP) strategy and 6 Cs	Risk management Datix reporting Root cause analysis SQS committees Risk registers Rapid Assessment of Disease Activity in Rheumatology (RADAR)	Real-time monitoring Patient stories Patient/carer focus groups Learning from complaints and incidents Family and Friends Test (FFT) and other patient surveys	Revalidation Staff appraisal Role-specific training Statutory & mandatory training Competency framework AWARE	Data quality Annual quality accounts Quality dashboards CQC quality rating



Our quality promise

A focus on safety and quality has always been central to everything we do at East Cheshire NHS Trust. However, the publication of the Robert Francis QC report, the Don Berwick report and the report of Professor Sir Bruce Keogh further heightened our pledge to provide quality care in a compassionate and dignified way.

Even before the publication of the last year's high-profile reports into patient safety the trust took action to improve quality measures before taking into account the report's full recommendations. A single trust-wide action plan which embraces our community and acute services is now in place to embed improvement through one single mechanism.

The trust is dedicated to the delivery of:

• Care services which are as clinically safe and as effective as possible with a year-on-year reduction in health-related harm

• Care in a manner whereby patients are treated with compassion, dignity and respect

• Evidence-based pathways of care, supported by values-based attitudes and a culture within the organisation where everyone is striving for excellence and continuous quality improvement in all that they do.

We have a significant opportunity as a provider of both community and hospital services to provide seamless care benefiting the patients we serve. This gives us opportunities to shape services innovatively across care pathways that are not always available to other providers. We work with and support our clinical leaders to forge closer relationships with GPs and clinicians from other partner organisations for the benefit of all our patients. We want to embrace opportunities to extend our reach into the community and primary care so that only those who really need to, go to hospital.

The trust is a formal member of the Caring Together programme, a framework for integrated health and social care in eastern Cheshire, led by Eastern Cheshire Clinical Commissioning Group (ECCCG). Caring Together seeks to address the local health and social care challenges that we face in providing the future needs of our population across self care, primary care, community care and acute and specialist services.

The South Cheshire and Vale Royal CCGs are working together on a similar, Connecting Care programme for whole-system transformation with partners, including the trust. This programme is also seeking to create integrated care systems that improve care outcomes and make best use of care resources.

Contents

Throughout this document you will see quotation boxes like this:
These feature genuine comments about our services made by patients and their families.

Foreword

East Cheshire NHS Trust is totally committed to improving quality and delivering safe, effective, personal care with dignity and compassion. This has never been more important at a time when we are seeing a greater number of older patients cross our threshold, often with complex health needs.

Our vision is to deliver the best care in the right place, be this at home, in the community or in hospital - an approach wholly aligned with our commissioners. We have moved markedly in developing 'wrap around' patient services and on the following pages, you will see examples of how we continue to shift care safely, supporting services that aim to keep patients out of hospital when it is clinically safe to do so.

Over the last twelve months, the trust has focused on ensuring that quality improvements are in place, informed through patient stories at public trust board meetings. Recent years have seen the publication of a series of key reports, including Francis, Berwick, Keogh, Cavendish and Clwyd-Hart, so we have consolidated their recommendations and delivered them coherently through one of the trust's six overarching programmes of work - Strengthening Operational Delivery, demonstrating that we are applying NHS lessons learned elsewhere, so ensuring consistently safe, high-quality care.

Delivering improvements when resources are under pressure, we must spend wisely to benefit patients. To that end, we have invested in innovative technologies that support our workforce at the front line, enabling our staff to spend more time with patients.

Strong team work is a key factor of all achievements. By working in different ways, united by common values, we are making sure we deliver the right care first time, every time. We are actively listening to patient feedback, which has been overwhelmingly positive. However, we can always improve and we take learning from complaints and incidents, which have high levels of openness and reporting, to inform improved practice, which is reflective of how we act on and deliver our Duty of Candour. I am delighted that we have been accredited with CNST level 3, the highest level of regulatory assurance for maternity services and recognised as a provider of high-quality, low-risk service provision as measured by the Care Quality Commission, positioned at risk level 5, where 1 is poor/high risk and 6 is excellent/low risk. In addition, this year cancer patients were assured they were receiving some of the best care and support in England when the trust came second in a Macmillan Cancer Support league table measuring patient experience.

We are also actively listening to what our staff tell us about how we provide care. By empowering staff to share and act on the big and little ideas through the Your Voice – Listening into Action programme, we are all taking steps to transform services locally, as shown when we were recognised as the first autism-friendly hospital in England by the National Autistic Society.

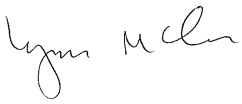
Working more frequently with partners is an increasing theme in how we deliver high-quality care. In the coming year, this will become more evident through Caring Together in the East of Cheshire, Connecting Care in South Cheshire and Vale Royal and the impact of Healthier Together, a Greater Manchester commissioning initiative that we are embracing, alongside our South Sector Partnership trusts. As we deliver services, we will ensure we do things once across our health economy, avoiding duplication. Examples include the locality teams where primary, secondary and social care partners identify patients more likely to be at risk to better manage their care; the discharge teams, where health and social care partners coordinate care for a seamless transition between services.

The trust's Quality Account summarises our continued drive to improve quality and safety, demonstrating much to celebrate, although we remain focused on the challenges ahead. Delivering accessible care across

patient pathways, organisations and with partners to achieve great patient outcomes and experiences through sustainable services is a high priority for the trust over the next three years.

This year's Quality Account is written at the end of the first year of consolidation following significant healthcare system changes. This trust is clear that quality is the overriding hallmark of successful patient care and experience. I would like to take this opportunity to thank every member of staff, each of whom have worked tirelessly, contributing to this year's achievements and for your unwavering commitment to safe, compassionate and personal care delivered in the right place.

Thank you.



Lynn McGill
Chairman

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Chief executive's statement

Any questions I had were answered fully. All the people involved in the procedure inspired confidence

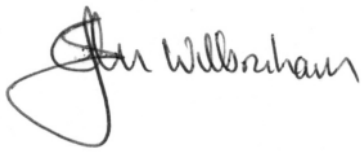
Chief executive's statement

Consistent delivery of quality in the care we provide is high on the agenda both of the patients we serve and the staff who provide services. Patients' expectations are rising, as they should, and it is important that we seek to exceed their expectations each time we touch their lives.

The board hear first-hand at our meetings the impact our staff have on the lives of patients to ensure we remain grounded in the purpose of our organisation to deliver the best care in the right place, providing sustainable, safe, effective and personalised care of which we can all be proud.

This quality account documents the achievements of our staff in providing high-quality care, as well as showing where we have innovated to improve the services we deliver. This account is the product of input from our staff and other partners and is not only a review of the 2013/14 year but also a commitment to the continued focus on quality improvement at the trust.

I hope the document demonstrates to you talent of our staff and their true dedication to the provision of high-quality services when you need them.



John Wilbraham
Chief executive

Director's 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;

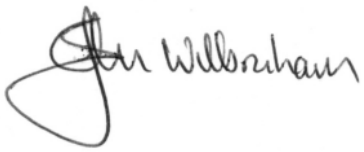
• the performance information reported in the Quality Account is reliable and accurate;

• 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

Auditor's letter

***Insert text - auditor's letter – to be updated on receipt ***

INDEPENDENT AUDITORS' LIMITED ASSURANCE REPORT TO THE DIRECTORS OF EAST CHESHIRE NHS TRUST ON THE ANNUAL QUALITY ACCOUNT

We are required by the Audit Commission to perform an independent limited assurance engagement in respect of East Cheshire NHS Trust's Quality Account for the year ended 31 March 2013 ('the Quality Account') and certain performance indicators contained therein as part of our 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, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ('the Regulations').
Scope and subject matter

The indicators for the year ended 31 March 2013 subject to limited assurance consist of the following indicators:

We have agreed VTE and F&F

• percentage of patient safety incidents that resulted in severe harm or death; and

• the number and rate of clostridium difficile infections for patients aged two or more on the date the specimen was taken. We refer to these two indicators collectively as 'the indicators'.

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 Regulations). 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; and

• 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.

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

• the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;

• the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2012/13 issued by the Audit Commission on 25 March 2013 ('the Guidance'); and

• the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and to consider the implications for our report if we become aware of any material omissions.

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

• Board minutes for the period April 2012 to June 2013;

• papers relating to the Quality Account reported to the Board over the period April 2012 to June 2013;

• feedback from the Commissioners dated May 2013;

• feedback from Local Healthwatch dated May 2013;

• the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated 7 May 2013;

• feedback from Cheshire East Council Health and Wellbeing Scrutiny Committee dated May 2013;

• the latest national patient surveys;

• the 2012 national staff survey;

• the Head of Internal Audit's annual opinion over the trust's control environment dated April 2013;

• the annual governance statement dated 6 June 2013;

• Nine Care Quality Commission quality and risk profiles published monthly between May 2012 and March 2013; and

• the results of the Payment by Results coding review dated 22 May 2013.

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

This report, including the conclusion, 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 2010.

We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and East Cheshire NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement under the terms of the Audit Commission Act 1998 and in accordance with the Guidance. Our limited assurance procedures included:

• evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;

• making enquiries of management;

• testing key management controls;

• analytical procedures;

• limited testing, on a selective basis, of the data used to calculate the indicators back to supporting documentation;

• comparing the content of the Quality Account to the requirements of the Regulations; and

• reading the documents.

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

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

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability.

The precision of different measurement techniques may also vary. Furthermore. The nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by East Cheshire NHS Trust. Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2013:

• the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;

• the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and

• the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

Julian Farmer
Senior Statutory Auditor, for and on behalf of Grant Thornton UK LLP

The quality strategy

I appreciate the speed of which I was seen from the doctors to the clinic at a time to suit my job

The quality strategy 2014/15

The trust is committed to ensuring that quality drives our clinical strategy and is at the core of everything we do.

The trust's clinical strategy aims to ensure that we deliver the best care in the right place for the healthcare needs of patients. This will support patient care away from hospital into more appropriate clinical care settings. It is important that this shift and change in service delivery supports quality improvements in patient care and experience.

For East Cheshire NHS Trust, quality is therefore about three things:

1. Designing and delivering care services that are as clinically safe and effective as possible

2. Delivering care in a manner whereby patients are treated equally, with compassion, dignity and respect in a clean and pleasant environment personal to each individual

3. Developing an attitude and culture within our entire organisation whereby everyone is constantly striving for excellence and continuous quality improvement in all that they do

Equally important to patients is their whole experience of services provided by the trust: from their care during a hospital appointment or inpatient stay or at home from a district nurse; whether they could park easily at a hospital site to our communication with them and whether staff were helpful and respectful. Developing an attitude and culture within our entire organisation whereby everyone is constantly striving for excellence and continuous quality improvement in all that they do is crucial.

Our quality will be supported by:

- ensuring required standards are achieved

- investigating and taking action on substandard performance

- planning and driving continuous improvement

- identifying sharing and ensuring delivery of best practice, and

- identifying and managing risk to quality of care.

Our focus is on helping people to stay healthy and independent by providing support and services that prevent ill health and maintain quality of life. This approach of prevention and early intervention of low-level support will help people to maintain control of their lives and decrease their dependency on care services.

However, there will continue to be increasing numbers of people who need care services as they grow older and these services need to offer patient choice wherever possible, and maintain dignity and respect. Many services, including re-enablement and intermediate care, provide short-term intensive support at times of crisis to enable people to return to independence in their daily lives. The trust intends to be the provider of excellence for specialist services for older people in community or hospital care settings.

The trust will continue to actively pursue full integration and transformation of clinical pathways, working proactively and collaboratively to expand our opportunities of working with others. The aim is to provide out-of-hospital care where appropriate, designing and improving services that build on work already happening in the community, working closely with GPs to achieve this.

The trust's board is made aware of potential risks to quality through the Board Assurance Framework. Trust boards are accountable for ensuring that patients continue to receive high-quality healthcare. Placing quality at the heart of an organisation is widely believed to improve patient outcomes while being a more cost-effective way to deliver modern healthcare. For example, by putting systems in place to prevent the occurrence of methicillin resistant staphylococcus aureus (MRSA) infections or pressure ulcers, you minimise the cost of treating them. The trust has placed quality as a key corporate objective and has ensured, through the application of the NHS knowledge and skills framework, that all staff have this as a key personal objective.

Our aim is to provide a quality of healthcare we would want for ourselves, our families and our friends.

The quality strategy describes how we will improve the safety and effectiveness of care while continuing to develop our patient focus. Our aim is to ensure that all clinical care provided is appropriately measured for its safety, effectiveness and patient experience, where we can increasingly measure the ultimate outcomes of care, and where information on quality is acted upon rapidly and effectively to ensure continual improvement.

The full quality strategy can be found on our website at: www.eastcheshire.nhs.uk

Our staff commitment to quality

East Cheshire NHS Staff pledge

"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."

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 compassionate and high quality care that achieves excellent health and wellbeing outcomes. It builds on the existing NHS Constitution and details six values: Care, Compassion, Communication, Courage, Competency and Commitment.

Our patients' opinions

Our patients' opinions are not just important to us as an organisation - patient opinion is a vital tool to help us understand the impact of our actions both to reward and praise staff in the delivery of quality care and to assist us in improving the quality of our service.

The Friends and Family Test - patients

In 2013, the NHS introduced a Family and Friends test for all trusts as a way of gathering feedback about patient's experience, helping to drive improvements in hospital services. Any patient aged over aged 16 who has had an overnight stay, received maternity care or has attended and been discharged from the accident and emergency department has 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?"

For patients under 16, we have a young person's online survey, developed in conjunction with children, that can be completed on any digital device including iPads and a paper-based survey that is always available on the ward and in outpatient clinics. A further age-appropriate way of capturing feedback is done using a 'washing line'. This involves patients writing on pictures of clothing: good comments go on t-shirts and bad comments go on a pair of pants. These are then pegged out on a mocked-up washing line for all to see.

We have also carried out a feedback exercise at Knutsford High School in relation to the young person's sexual health clinic. This was run in conjunction with the school nursing team. A questionnaire and a link to an online survey were distributed through the pupil's book bags. The aim of this was to promote the clinic location and times of the service.

The results of the Family and Friends test are publicly produced for patients' comparisons. This information is available in the trust's ward areas and on our website at www.eastcheshire.nhs.uk. Full details of how the trust has used this test as a 2013/14 priority and its outcomes can be found on page 40.

During 2014 the Family and Friends test for patients will also be extended to cover day cases and outpatients.

The Friends and Family Test - staff

During 2014 we will start to collect feedback from staff as the Family and Friends test is launched for staff to take part in. The results of this feedback will be published the trust website at www.eastcheshire.nhs.uk

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Our quality action plan

Efficient, friendly manner, pleasant, comfortable and clean surroundings

Our quality action plan 2013/14

The aims of the Quality action plan for 2013/14 were centred around three quality areas:

• To deliver a year-on-year reduction in avoidable patient harm within a health care setting

• To continuously improve patient outcomes through early identification and appropriate management

• To continuously improve the experience of patients using our services.

Over the past 12 months, the trust monitored its quality standards through various methods, such as:

• Positioning against peer/national benchmarks

• Clinical audits

• External assurance – Care Quality Commission, Clinical Negligence Scheme for trusts, Healthwatch, deanery visits, NW audit

• Patient feedback

Specific details on each of our priorities can be seen below. In summary:

Year-on-year reduction in patient harm

The trust has achieved in the following areas:

• Reduction in injurious falls

• Reduction in grade 3 & 4 pressure ulcers

• Reduced medication errors

• Fewer cancelled operations

• Reduction in confirmed cases of C Difficile

• Acute stroke indicators against Advancing Quality standards. Placed in top five hospitals for stroke care in the North West.

• Reduced mortality – Risk Adjusted Mortality Index (RAMI) and the Summary Hospital-level Mortality Indicator (SHMI)

• Safety thermometer

Unfortunately, the trust had one case of MRSA bacteraemia confirmed during the year, against a target of zero. As part of the post-infection review process it was identified that the MRSA blood stream infection was unavoidable. However there has been learning from this which has included a review of the MRSA screening process.

The trust also reported three blood steam contaminants during the year. MRSA blood stream (BSI) contaminants relate to blood cultures which are MRSA positive but the patient does not have MRSA bacteraemia. This can be due to contamination when the sample was taken. No patient harm occurred as a result of these contaminants. However it is important to reduce the risk of further contaminants and a review of blood culture sampling has taken place. Training for practitioners has been strengthened and the creation of blood culture packs will further improve documentation of the procedure in patients' notes. The trust has an ongoing focus to ensure appropriate clinical management of invasive lines. This is being driven by the Home Intravenous Therapy Service (HITS) team, infection control and practice educators.

Improve clinical outcomes

The trust has achieved in the following areas:

• 95% venous thromboembolism (VTE) assessment on admission

• Alcohol intervention and advice

• Improving inhaler technique

• Mortality reviews - for every patient the trust reviews the entire episode of care prior to death

• Management of the acutely unwell patient

• Improvements in dementia screening

• Caring Together – development of neighbourhood teams

• Roll out of EMIS web – secure, patient record data systems which save time and money for primary and secondary healthcare providers and help improve the patient experience

• Falls prevention.

The trust was less successful in achieving targets of completing outpatient clinical correspondence with GPs within 14 days and Advancing Quality standards (as set by the Advancing Quality Alliance) in the treatment of heart failure and myocardial infarction.

Improve patient experience

The trust has achieved in the following areas:

• Annual audit programme

• End-of-life care and associated staff training

• Friends and Family test – inpatients and emergency department

• Roll out of Friends and Family test to maternity

• Reduced number of complaints relating to communication

• Key performance standards include:

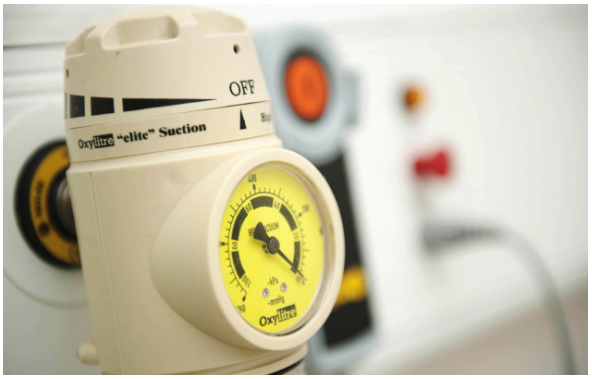
– Emergency department four-hour target, 18 weeks referral to treatment (RTT), 62-day cancer wait, same sex accommodation (SSA) breaches, diagnostic waiting times.

Safeguarding

The trust has over-achieved against the agreed trajectory for level one safeguarding training. This is not the case for levels two and three which are role specific. An action plan has been agreed with commissioners to deliver a significantly improved position by the end of quarter one.

The trust is pleased to report that following an unannounced CQC inspection earlier in the year, staff were able to demonstrate compliance with the expected safeguarding standards. Ongoing monitoring takes place via audits including internal peer reviews, led by the governance team and involving multidisciplinary staff.

The trust is currently implementing recommendations from the recently published intercollegiate document - Safeguarding children and young people: roles and competences for health care staff (third edition).



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Our achievements

The compassion, diligence and total perseverance of staff to provide long-term care is clear

Quality performance 2013/14

Each year all trusts are performance monitored on a range of high level, national performance standards.

East Cheshire NHS Trust's performance against the 2013/14 standards is tabled below. The equivalent performance in 2012/13 is also included, and where the 2013/14 standards did not apply, this has been noted.

2013/14 Target	Monitor Standards	In Month Target	2013/14 Performance	2012/13 Performance
95%	A&E: Maximum waiting time of 4 hours in A&E (calendar month)	>=95%	**95.49%**	93.88%
0 (2012/13 Target = 1)	Hospital MRSA bacteraemia year on year reduction versus trajectory for the year	0	1	1
No more than 24	Hospital Acquired CDifficile (Year Target)	2 or less	**14**	29
>=93%	2 Weeks maximum wait from urgent referral for suspected cancer	>=93%	**97.7%**	98.2%
>=93%	2 Weeks maximum wait from referral for breast symptoms	>=93%	**95.7%**	97.5%
>=94%	31 days maximum from decision to treat to subsequent treatment - Surgery	>=94%	**100.0%**	100.0%
>=98%	31 days maximum from decision to treat to subsequent treatment - Drugs	>=98%	**100.0%**	100.0%
>=96%	31 day wait from cancer diagnosis to treatment	>=96%	**99.5%**	100.0%
>=85%	62 day maximum wait from urgent refferal to treatment of all cancers (including patients treated at a tertiary centre)	>=85%	**87.7%**	90.7%
>=90%	62 days maximum from screening referral to treatment (including patients treated at a tertiary centre)	>=90%	**95.2%**	99.0%
>=90%	18 week Referral to Treatment - Admitted Patients - 90% within 18 weeks	>=90%	89.6%	91.2%
>=95%	18 week maximum wait - Non-Admitted Patients - 95% within 18 weeks (including community)	>=95%	**96.5%**	98.2%
>=92%	18 week maximum wait - Incomplete - 92% within 18 weeks (UNADJUSTED)	>=92%	**93.6%**	93.1%
>=99%	Diagnostic test waiting time	0%	**99.2%**	97.6%
<3.5%	Delayed transfers of care	<3.5%	5.2%	5.0%
0	Mixed Sex Accommodation breaches (Per 1000 FCE's)	0	0.06	0
>=95%	VTE Prevention - risk assessment	>=95%	**95.00%**	90.70%

Commissioning 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 2013/14 ten acute and two community goals were achieved.

Over the next 12 months, the continued achievement of the agreed goals will be undertaken through the Commissioners Quality Service Review Group. Where achievement is labelled as 'NO' in the table below, an explanation of why and plans to improve these areas are detailed in our review of quality performance starting on page 30.

Community	Achieved
NHS Safety Thermometer	tbc
Long-term conditions	✓
Falls	tbc
Self-care	✓

Acute	Achieved
Family and Friends Test	✓
NHS Safety Thermometer	tbc
Dementia	✓
Venous thombolysis	✓
Long-term conditions	✓
Alcohol	✓
Falls	tbc
Improving inhaler tech	✓
Advanced care planning EOL	✓
Advancing quality - Pneumonia	✓
NIC - Improved access to breast milk in pre-term infants	✓
NIC - Retinopathy of pre-maturity screening	✓

Safety thermometer

The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care.

Target

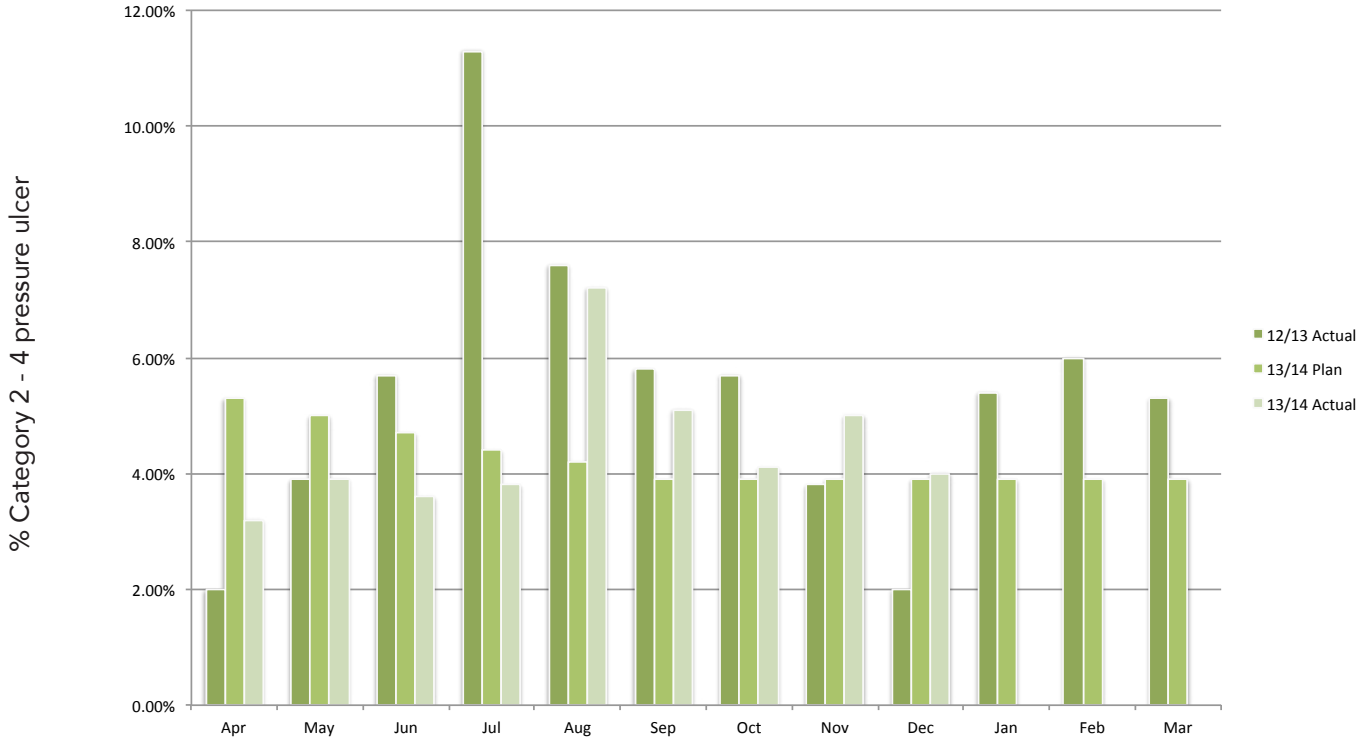
The trust committed to reducing by 30% the number of patients recorded as having a category 2-4 pressure ulcer (old or new) as measured using the NHS Safety Thermometer. The baseline is the median of August 2013 to January 2014 - 5.55%.

Payment to the trust in achieving this quality measure is triggered on achieving more than 95% of the agreed improvement goal between April and September 2013 followed by maintenance of that goal between October 2013 and March 2014.

An improvement goal of 30% was agreed.

After an initial positive start with the target achieved from April to July, there were fluctuations in achievements and the overall required percentage was not met.

Important note: Safety thermometer measures all pressure ulcers grades 1-4, which may have developed prior to care at the trust. In addition, it does not consider avoidable or unavoidable incidences which would more accurately reflect the true performance.



Achievements:

• Development of competency assessment in pressure area care for registered and unregistered staff (as part of the competency framework development work).

• Initial identification and training of link nurses.

• Development of staff e-learning package for pressure ulcer prevention, assessment and management – implementation planned for early April 2014.

Improvements:

• Work underway to undertake mini root cause analysis (RCA) on all stage 2 pressure ulcers reported as part of the transparency project development.

• Tissue viability involvement in all root cause analysis of stage 3 and 4 pressure ulcers - this enabled the trust to collate and consider trend analysis and root cause across the organisation. This in turn allows the accurate identification of the incidence in terms of pressure ulcers that are classed as avoidable and unavoidable.

• Development and implementation of bespoke templates within the incident reporting system to improve data quality, trend analysis and learning.

• Targeted training to areas of highest incidence delivered to highest reporting acute ward and community nursing team areas.

Clostridium Difficile

A clostridium difficile infection (CDI) is a type of bacterial infection that can affect the digestive system. It most commonly affects people who are staying in hospital.

Target

The trust committed to ensure compliance with the acute CDI maximum of 24. The trust had 15 cases.

Antibiotic stewardship continues to be a primary focus in reducing rates of CDI. Antibiotics are very important for the management of infections. Non-prudent use of antibiotics will lead to antibiotic resistance, thereby making them ineffective and increasing the chances of CDI infection. It is essential that we restrict the use of antibiotics for genuine infections for a dedicated length of time and at the right dose.

This control has contributed to a month-on-month reduction of cases.

As always, the best place to get care, fantastic high morale staff Very clean, very friendly

Achievements:

Following each individual case review, robust action plans are implemented to ensure lessons learnt can be used to focus changes in clinical practice. During 2013/14 the infection control team has implemented a process of home visits for patients who are identified as having CDI following discharge from hospital or after a GP sample - this is in addition to the infection prevention visits undertaken for inpatients.

These visits are intended to support the patient in understanding what CDI is and any actions they need to take on a day-to-day basis to manage their symptoms. In addition, the infection control nurses work with clinical areas to promote hand hygiene across multi-disciplinary teams. This is evaluated by routine audits and will be further strengthened by teaching sessions in clinical areas.

Improvements:

Continual monitoring of cleanliness standards is ongoing, in line with the trust's commitment to improving the quality of the patient's journey.

Management of acutely unwell patients

Improving the management of patients on our wards who require high levels of care.

Target

The trust aimed to improve the assessment and management of the acutely unwell patient in the following ways:

- Review current processes and update the standard operating procedure
- Review documentation
- Review training in relation to Track and Trigger and implement relevant IT to support the Trigger system
- Establish a health care assistant (HCA) development programme
- Review the critical care outreach service provision.

Excellent care, all staff very caring - clean, tidy and very professional

Achievements:

• 100% statutory and mandatory training delivered, including maternity

• Uploaded Minimum Standards policy onto the trust intranet

• All documentation reviewed

• Delivered fluid balance training trust-wide to all disciplines and promoted new fluid balance charts

• Developed sepsis care bundle and sepsis training trust-wide

• The critical care outreach service has been supported with increased staff hours.

• A trust-wide consultation forum has been developed with the executive team which included key stakeholders and service users. This has since set the standards to improve the care delivered to acutely unwell patients.

• An audit is now carried out twice yearly to monitor performance.

• Healthcare assistant training - the 'Aware' programme began in October 2013. So far, 66 healthcare assistants have completed the training.

Improvements:

• Planned improvement in the next 12 months will allow electronic vital sign recording to be implemented in acute ward areas to improve the recognition and response to acutely ill adult patients.

• Planned development of further HCA training in 2013/14

Caring Together – neighbourhood teams

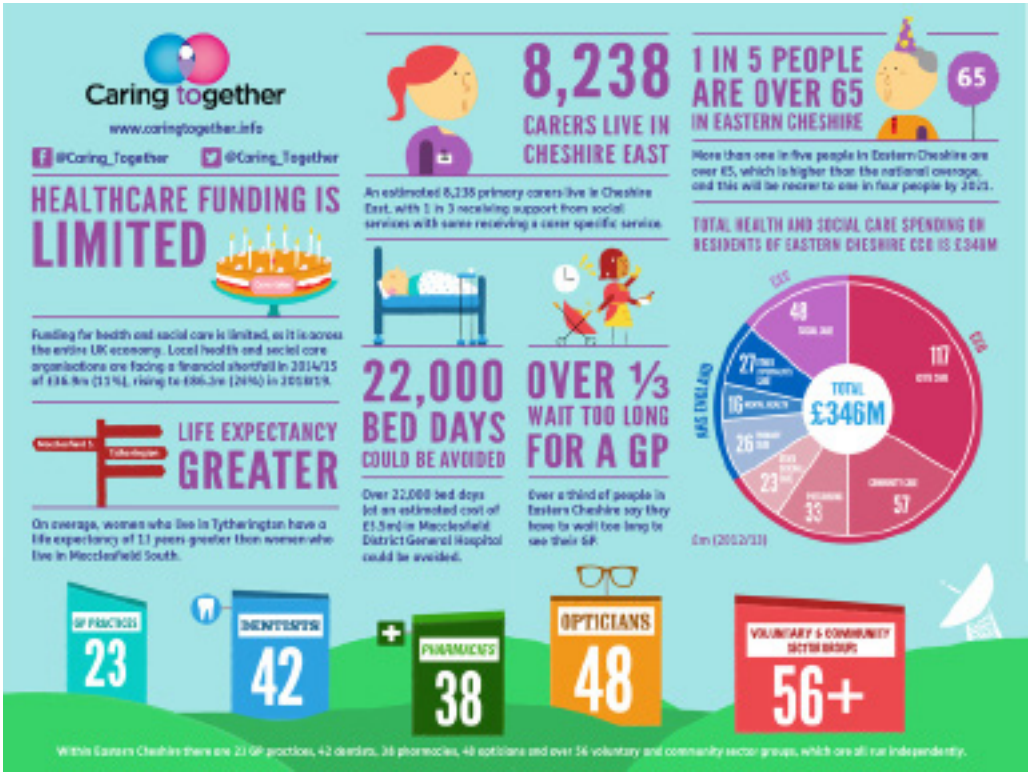
We believe that our patient's should sit at the heart of a pro-active care system. Caring Together is an alliance of all area's of health and social care working together to create a joined up service across eastern Cheshire.

Target

National policy and best-practice documents promote integrated care models as effective approaches to providing the best care for vulnerable people with complex long-term conditions. The aim for the trust in 2013/14 was to extend integrated working as demonstrated in neighbourhood teams.

Patients identified for care coordination are often frail, older people with multiple teams involved in their care. Currently, this can be fragmented with duplication and sometimes gaps in provision. The neighbourhood teams will involve patients and their carers in the planning of care and making of key decisions, ensuring care is centred on the patients' needs.

The local response has been to establish neighbourhood teams and extended practice teams, which are made up of health and social care professionals who work alongside each other to deliver proactive and coordinated care for patients with long-term conditions. Priorities include admission avoidance, early help and self-management.



Achievements:

During 2013/14, teams were established across five areas in East Cheshire and 11 in South and Vale Royal. The teams are developing effective processes which mean that patient care can be tailored to individual needs and is joined-up across all the professionals involved, including GPs, community nurses, therapists, mental health workers and social workers.

A new role introduced to the team in the last year is that of the wellbeing coordinator, whose role is to help people understand and manage their care and guide people to services and interventions which can improve their health and wellbeing. Wellbeing coordinators are currently working in Macclesfield, Knutsford, Congleton, Winsford and Crewe.

Improvements:

The established teams meet on a regular basis with a clinical focus to discuss and review patient needs. Separate implementation meetings are also held for all organisations and professional groups to attend and contribute to the shaping of the teams as they develop and evolve.

This includes building links with other services that can contribute to effective processes, such as the hospital discharge team, which can help to identify patients at high risk of admission who would benefit from proactive, coordinated community care.

In future, the teams will further develop the use of technology (remote blood pressure monitoring, for example) and discuss self-management strategies with patients.

Continuing to build links with teams across acute, primary, community and social care, and embedding robust processes, will be the focus of 2014/15, along with setting up teams in the remaining localities.

Venous thromboembolism (VTE)

When a blood clot breaks loose and travels in the blood, this is called a Venous thromboembolism (VTE)

Target

The trust aimed to ensure that a minimum of 95% of patients have a VTE risk assessment completed on admission, and that 95% of incidences of hospital-acquired VTE have a root-cause analysis completed by March 2014.

VTE risk assessment completed on admission (%)

April	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
91.9%	93.3	94.6	92.0	91.5	92.8	94.4	94.8	98.2	99.1	98.8	98.3

VTE hospital-acquired root - cause analysis

	April	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
No. VTE cases	0	1	3	1	1	2	1	1	1	0	2	
No. RCA under-taken	0	1	3	1	1	2	1	1	1	0	2	
% RCA under-taken	100	100	100	100	100	100	100	100	100	-	100	

Achievements:

• During 2013/14, the trust moved to an electronic system directly linked with the patient admission system (PAS) for recording the completion of VTE assessments.

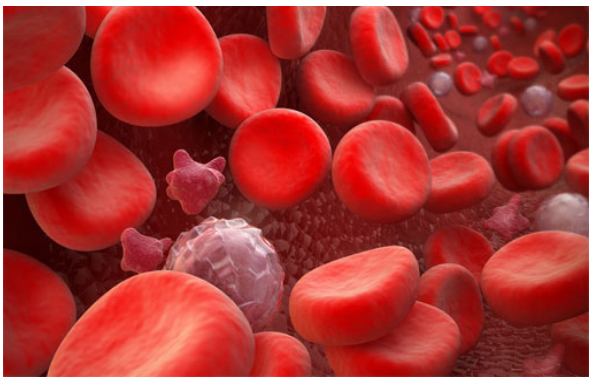
• The target has been consistently achieved since December 2014

• A process for root-cause analysis with hospital-acquired VTE was developed. Incidences of VTE are investigated by the patient's named consultant, reports are fed back to the VTE group for approval, comment and recommendation and then presented at the appropriate speciality Safety and Quality Standards Committee (SQS) and clinical audits meetings for shared learning

• An e-learning package for trained staff has been agreed.

Improvements:

• Work continues to ensure that all patients are assessed within the agreed timescales.



Friends and Family Test

The NHS Friends and Family Test is an important opportunity for you to provide feedback on the care and treatment you receive and to improve services.

Target

The trust target was to increase the response rate from acute wards patients to 20%, and emergency department patients to 15%, by March 2014. This has been achieved.

The Friends and Family Test (FFT) was introduced as a way of gathering feedback from patients about their experience of the NHS. Any patient over the age of 16 who has had an overnight stay or attended the Emergency Department is asked one question:

How likely are you to recommend our ward/department to your friends and family if they needed similar care or treatment?

A paper, text message or online survey is completed, giving feedback. These are our results for 2013/14

	April	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
% Response (Inpatients)	17.4	20.4	28.5	22.0	18.8	48.8	39.2	30.8	34.1	33.4	33.3	26.1
% Response (Emergency Dept)	8.0	25.0	28.5	21.6	24.9	24.7	20.4	24.1	21.3	23.0	20.7	21.1
% Response (Maternity / Overall)*	-	-	-	-	-	-	5.5	16.4	28.4	61.9	52.1	28.1

*Monitoring only introduced in Oct 2013.

Achievements:

• Full roll out to all inpatient areas undertaken from April 2013.

• Significant improvement in response rates through the year.

• The FFT results are displayed at the entrance to each ward. Themes are identified from the free text feedback by each ward manager and actions take on any identified areas of concern.

The top three positive themes identified across the trust are:

1. Friendly professional, polite and helpful staff
2. Excellent first-class care and
3. Staff were reassuring and answered questions.

The top themes for improvement are:

1. Lack and cost of TVs
2. Food - in particular the evening meal /supper menu, and
3. Noise – especially at night.

Action plans are in place to address areas for improvement and due to the success of the roll-out, the trust has shared its experiences with other organisations.

Improvements:

• Ongoing work to improve the response rate and use the information to improve the patient experience.

• Roll-out to the emergency department has also been successful and this has moved to a text message system, which has been well received.

• Roll-out to maternity commenced in October 2013.

• Roll-out to staff will commence in April 2014.

• Work continues to improve the overall 'net promoter' score.

• Roll-out to day cases and outpatients by October 2014

Dementia

Dementia is a syndrome (a group of related symptoms) associated with an ongoing decline of the brain and its abilities.

Target

The trust aim for 2013/14 was to improve the diagnosis and referral of patients with dementia by screening eligible patients in line with national standards. This has been achieved by effectively screening all non-elective patients aged 75 years and over who are admitted to hospital, and referring patients with a positive screen back to their GP or an appropriate specialist for further support. Carers with dementia will be surveyed to see if they feel supported. In addition, the views of carers caring for people with dementia were also sought.

Ward 9 is the best and made our experience of the hospital system rosy - lovely ward and great staff

Achievements:

• Following the successful submission of a two-stage application process in August 2013, the trust was awarded £326,000 to improve the environment of care for people with dementia. The funding enabled the construction of a new conservatory and garden, a new communal seating area, improved décor, lighting, flooring and signage and interactive digital artwork

• Ward 9 received the 'Team of the Month' award October 2013.

• Ward 9 received 'Team of the Year' at the trust's annual award ceremony in November 2013.

• The trust achieved the dementia Commissioning for Quality and Innovation (CQUIN) key quality indicators.

• The trust commissioned three two-day courses in partnership with the University of Chester. The course content was tailor-made to ensure that our learning outcomes were met, which underpinned increasing inter-disciplinary knowledge and skill sets.

Improvements:

• An assessment of the Ward 9 environment was undertaken in April 2013 using The King's Fund Enhancing the Healing Environment (EHE) assessment tools. This supported and informed the proposed project plans for refurbishment.

• A '15 steps challenge' assessment was undertaken as part of the 'productive ward' series. The toolkit enables teams to collate first impressions of a ward area from a patients perspective and tests the 'confidence in care' concept.

• A detailed project plan has been developed to ensure that proposals outlined in the original bid for the funding are delivered within the specified timescale and within budget.

• A key stakeholders event held in December 2013 provided an opportunity for potential providers, professional, voluntary groups and members of the general public to obtain public engagement on the dementia initiatives.

• A dementia operational group was established and now meets monthly to drive service improvements, increase dementia awareness and training among staff and promote wider engagement with a view to implementing the Department of Health's national dementia strategy, 'Living well with dementia'.

A patient story

Neighbourhood team meeting: Mrs F was on the list of patients at high risk of re-admission in the next year.

Her GP would not have referred the patient to the community matron service as this patient was not identified as being in need of advanced nursing and case management, although she did have long-term conditions.

The case was discussed at the neighbourhood team meeting. A group of professionals developing the care co-ordination model decided to assess this lady and learn from the case, to see if the risk monitoring systems in use were identifying appropriate patients.

Initially, the community matron was identified as the most appropriate care coordinator as her main condition was chronic obstructive pulmonary disease (COPD), with previous admissions for type 2 respiratory failure.

Initial assessment involved the community matron and the outreach pharmacist. The patient was, at that point, under the care of the integrated respiratory team for her COPD. The community matrons took over her care.
A number of issues were identified, including her inability to use her inhalers correctly. These were changed to nebulisers immediately. Nebulisers are only prescribed after careful assessment and are used to deliver medication in the most appropriate way for patients when inhalers are not felt appropriate.

It was also apparent that the patient had been inappropriately adjusting her oxygen supply, which exacerbated her condition. A control mechanism which prevents over-use of oxygen was then fitted to the patient's oxygen supply.

Within the next three weeks of assessments, the community matrons identified that Mrs F was in the palliative phase (final stages of life) of the disease, which had not until this point been identified. The family were becoming very anxious. Had the community matron team not been involved, this lady may have been admitted to hospital as often families feel unable to cope with a loved one's deterioration. In this case, they had not been prepared for the terminal stage.

Mrs F expressed that her preferred place of care was her home and her family supported this. The community matrons facilitated this choice and Mrs F passed away very peacefully at home, five weeks after the first discussions at the neighbourhood team meeting.

87% of patients who express a preferred place of care in which to die achieved this wish.

Data quality

Confidentiality when checking in.....could be improved

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Data quality 2013/14

Care Quality Commission

East Cheshire NHS Trust is required to register with the Care Quality Commission (CQC) and its current registration status is that all standards are being met. The CQC has not taken enforcement action against East Cheshire NHS Trust during 2013/14.

The CQC, which regulates the care offered by the NHS and inspects trusts on an annual basis, conducted an in-depth inspection of the hospital in August 2013 – rating it against five standards. The report noted the hospital met all the required standards it was inspected against and also highlighted many positive comments from patients and their families.

During 2013/14 the trust has provided the following regulated activities, as defined by the Care Quality Commission.

- Dementia
- Diagnostic and/or screening services
- Family planning services
- Maternity and midwifery services
- Nursing care
- Personal care
- Services for everyone
- Surgical procedures
- Termination of pregnancy
- Treatment of disease, disorder or injury
- Caring for children (0 - 18yrs)
- Caring for adults under 65 yrs
- Caring for adults over 65 yrs

East Cheshire NHS Trust systematically and continuously reviews data related to the quality of its services. The trust uses its integrated quality, safety and performance scorecard to demonstrate this.

Reports to the trust's board and sub-committees, Clinical Management Board, Safety Quality and Standards Committee and the performance management framework all include data and information relating to our quality of services. The trust has reviewed all the data available on the quality of care in all of these NHS services.

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. The Secondary Uses Service dashboard is continually monitored.

Areas for improvement are identified and quality errors, such as invalid NHS numbers, are rectified. Overall, data quality is reported monthly to the trust board. The trust's overall data quality scores are better than the national average.

Data quality

Under figures for April 2013 to October 2014, the Secondary Uses Service Data Quality Dashboard was at 93.9%, against 95.9% nationally.

Meanwhile, for a valid NHS number being present in the data, the scores are above the national average. Admitted patient care was at 99.6% against 99.1%, outpatients was showing 99.8% against 99.3%, and accident and emergency was significantly above the national average of 95.7%, at 98.3%.

For a valid Healthcare Resource Group version 4 code, the scores are 100% for the trust against national scores of admitted patient care at 98.6%, outpatients at 99.2% and accident and emergency at 96.8%.

Clinical coding

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 2014. The trust submitted evidence in March 2014, confirming Level 2 compliance against all the requirements. The trust's overall score was 67% or 'green' according to the IGT grading system.

Clinical coding – Payment By Results (PBR)

No PBR audit was carried out in the year 2013/14.

Review of Services

During 2013/14 East Cheshire NHS Trust provided and/or sub-contracted 13 NHS services.

The Trust has reviewed all the data available to them on the quality of care in 100% of these NHS services.

The income generated by the NHS services reviewed in 2012/13 represents 100% per cent of the total income generated from the provision of NHS services by East Cheshire NHS Trust for 2013/14

Patient and staff feedback

Patient and staff feedback

CQC – National Maternity Survey 2013

The trust was reviewed by 151 women out of a sample of 266 who had given birth at the trust during January and February 2013.

The survey looked at experiences under categories of 'antenatal care', 'labour and birth', 'postnatal care' and 'infant feeding support'. As mothers could have received 'antenatal care', 'postnatal care' and 'infant feeding support' at a trust or location different to where they gave birth, the CQC would only publish benchmarked data for the 'labour and birth' sections of the questionnaire.

Overall, the trust was classed as performing in line with other trusts for all criteria included within the 'labour and birth' section of the survey.

An action plan has been developed to further improve mothers' experience of labour and birth at the trust. Improvements have already been made in relation to the explanations and information given following the birth via dedicated support workers on the ward and an opportunity to discuss the birth prior to discharge.

There is also ongoing work to develop an advanced recovery programme for women undergoing an elective caesarean section. This will enable the length of stay in hospital to be reduced, so that women are able to return home with their baby sooner following the birth.

East Cheshire NHS Trust was able to identify where respondents had received 'antenatal care', 'postnatal care' and 'infant feeding support' from its services. Due to this it was also possible to benchmark against other trusts that were also able to make these identifications for the remainder of the survey.

When looking at the survey overall the trust was classed as performing in line with other trusts for the majority of criteria. The trust was classed as performing better than other trust in three areas:

- Having a choice of where antenatal appointments took place

- Having a contact number for a midwife/midwifery team once at home following the birth.

- Mothers being asked how they felt emotionally once at home following the birth

Areas of focus for improvement in 2014/15 are:

- Mothers being told they would need to arrange a postnatal health check with their GP

- Consistent advice given by health professionals in relation to baby feeding

- Mothers being offered advice/information in relation to contraception.

The maternity care I received was second to none. The staff are very conscientious and professional, and I had great faith in them. So much so I recommended other expectant mothers to go there.

The 2012/13 National Cancer Patient Experience Survey

The trust was in the top 20% of trusts for 47 areas out of a possible 62 in the survey, which was commissioned by NHS England.

212 patients who received cancer treatment at the trust during a set time period were asked to rate the care they received. A total of 131 patients completed the survey giving a response rate of 68%.

East Cheshire NHS Trust was ranked second out of 155 trusts nationally on patient experience.

There were three areas where the trust scored as the highest or joint-highest in the country:

- Patients overall rating of care as excellent/very good (96%)

- Patient received understandable answers to important questions all/most of the time from hospital doctors (95%)

- Patients thought they were seen as soon as necessary (prior to diagnosis) (95%).

In addition, the areas where the trust saw the largest improvements in its scores were:

- Hospital staff giving information on financial help

- Patients definitely involved in decisions about care and treatment

- Patients being told they could bring a friend when they are first told they have cancer

- Patient received understandable answers to important questions all/most of the time from hospital doctors

- Staff completely explained what would be done during any tests

The trust was in the lowest scoring 20% of trusts for two areas:

- Possible side effects of treatment explained in an understandable way

- Patient taking part in cancer research.

An action plan has been developed to ensure that possible side-effects of treatment are fully explained and a review of the patient information provided has been undertaken. Work is already underway to further promote clinical trials within the trust (for example, through our 'Health Matters' public lectures and posters in the Cancer Resource Centre) and recruitment is now well ahead of plan.

There were some occasions when I felt that the Doctor treating me did not explain enough...though I didn't doubt his intention to care for me (there) seemed to be a lack of communication skills.

The CQC National Adult Inpatient Survey 2013

East Cheshire NHS Trust was reviewed by 425 patients (out of a sample of 809 patients) who had been treated as an inpatient at the trust during summer 2013.

Overall, the trust was classed as performing in line with other trusts for the majority of areas. It was classed as performing better than other trusts in relation to hospital staff discussing whether patients would need any further health or social care services after leaving hospital.

The trust showed an improvement in its scores for 33 areas. The areas where the trust's performance was most improved include:

- Length of time waiting to get to bed on a ward
- Enough information given about condition while on the ward
- Side-effects of medication being fully explained
- Being told who to contact if worried following discharge
- Having enough nurses on duty.

The trust was classed as performing 'worse than other trusts' for patients being offered a choice of food and changes to the patient menu have already been implemented. Other areas highlighted for improvement include:

- Patient receiving enough help to eat meals
- Patients experiencing a delay when waiting to be discharged.

Quarterly audits – inpatients

The trust is committed to regular patient feedback, demonstrated by quarterly audits across all inpatient areas.

These audits look at key areas including the patient's experience of the ward environment, views on care and treatment, preparations for discharge and overall views on the level of service and care received.

During 2013/14:

- 98% of patients said they were made to feel welcome on arrival at the ward
- 87% of patients rated the cleanliness of the ward as 'very clean'
- 85% of patients 'always' had enough privacy when discussing their condition/treatment
- 93% 'always' had enough privacy when being examined or treated
- 96% of patients said they were 'always' treated with dignity and respect
- 91% of patients said they were 'definitely' treated with care and compassion
- 73% of patients rated the overall level of care as 'excellent' and 24% rated it as 'good'.

I couldn't have been more impressed with the compassion and care shown by the staff - watching them deal with an elderly lady brought me to tears - the compassion shown to her was amazing.

Quarterly audits – outpatients

Along with the trust's participation in the quarterly inpatient survey, the trust also conducts a quarterly audit across outpatient areas. This audit covers the patient's experience of the department, the care and treatment received, leaving the department and overall views on care and service received.

During 2013/14:

• 95% of patients felt welcome on arrival at the department

• 80% of patients rated the cleanliness of the department as 'very clean'

• 86% of patients 'definitely' felt involved in decisions about care and treatment

• 96% of patients 'always' had enough privacy when discussing treatment and 99% 'always' had enough privacy when being examined

• 99% of patients said they were 'always' treated with dignity and respect and 97% said they were 'definitely' treated with care and compassion

• 81% of patients rated the overall level of care as 'excellent', with all remaining respondents rating it as 'good'.

Dementia Commissioning for Quality and Innovation (CQUIN) system

One element of the dementia Commissioning for Quality and Innovation (CQUIN) system is the requirement for the trust to undertake monthly feedback among carers of people with dementia.

A short questionnaire has been developed to gauge how well relatives and carers feel staff understand dementia, how involved they feel in their relatives care and to measure awareness of patient passports.

Overall:

• 91% of respondents felt their relative 'definitely' had enough privacy when being examined or treated

• 91% of respondents felt their relative had 'definitely' being treated with dignity and respect

• 71% of respondents felt that the staff involved in their relatives care 'definitely' knew how to care for someone with dementia

• 58% of respondents said that they 'definitely' felt involved in their relatives care with a further 34% saying they felt involved 'to some extent'

• 54% of patients who did not have a patient passport on arrival at hospital were subsequently given one following admission.

Discharge arrangement could be made clearer, in plenty time, before it is due to happen.

Intermediate care services

Intermediate care services took part in a national benchmarking survey, which also included an audit in relation to patient experience.

The feedback was very positive - the key themes were that the staff were very caring and involved them in the decisions around their care.

Eastern Cheshire intermediate care services

As part of ongoing service improvement, Langley and Aston intermediate care units (at Macclesfield and Congleton hospitals respectively) are involved in a project to attain the National Quality Mark for Elder-Friendly Hospital Wards.

Among other things, this consisted of data collection over a three-month period from February 2013 to May 2013. The aim of the process is to help individual services understand their performance, identify areas of achievement and improvement and provide a basis for action planning. This is an ongoing, year-long project.

The data from the Langley Unit showed that patients had a positive experience, both with the attitude and care from the staff. The staff worked hard and the environment was clean. Patient comments stated that they found the staff friendly and courteous at all times.

Community patient feedback results show that of responses received, 100% regarded their care as 'good' or 'excellent'.

South Cheshire and Vale Royal patient feedback programme

There is a planned annual programme of patient feedback across acute and community areas of the trust. Below are the results of two large scale surveys across community areas, both of which were rated highly by our patients.

Podiatry

- 95% of respondents 'always' treated with kindness and compassion
- 96% 'always' treated with dignity and respect
- 96% 'always' had enough privacy when being treated
- 95% said that staff 'definitely' discussed their diagnosis and treatment plan
- 100% said they felt treated as an individual.

Outpatient physiotherapy

- 96% of respondents 'always' treated with kindness and compassion
- 97% 'always' treated with dignity and respect
- 95% 'always' had enough privacy when being treated
- 92% said that staff 'definitely' discussed their diagnosis and treatment plan
- 98% said they felt treated as an individual.

All the team were caring, helpful and pleasant and made me feel valued - and more to the point, made my feet more comfortable than I have been for years.

Podiatry and physiotherapy surveys

The podiatry and physiotherapy patient surveys were carried out across all localities and as such the action plans for these areas cross boundaries and are not specific to South Cheshire and Vale Royal but will impact on this area.

The actions are summarised below:

Podiatry

• Patients can now book appointments through the therapy booking centre

• All staff are reminded to introduce themselves and explain their role

• Patient centred action planning is now in place to further involve patients in their treatment

• Customer care skills training for staff is in place.

Physiotherapy

• Consent for students to be present during treatment is formally requested and documented

• Patients are made aware they have the right to ask for a second opinion in relation to their treatment

• Further development of a pilot study to allow patients to self-refer into the service without the need to see their GP as the first point of contact.

Your Voice; Listening into Action

During 2013 our Your Voice; Listening into Action (LiA) programme has continued to gather momentum and energy across the organisation. The programme is currently supporting 26 improvement projects covering a range of teams, services and departments including community matrons, pharmacy, patient discharge, pre-operative assessment unit, community dental services,

During the year, our engagement work has facilitated over 50 staff conversations on a range of topics and challenges that matter the most to staff including communications, the Francis Report, information technology, reward and recognition, patient discharge, recruitment and selection and our values and behaviours.

A new online conversation tool called 'Your Voice Online' was launched, enabling whole workforce participation in staff conversations.

Over the last 12 months we have seen some fantastic results and wider recognition of the benefits of our staff engagement programme.

One example is our 'Safety in Numbers' project led by nurse consultant Heather Cooper. The project has focussed on exploring IT interventions and solutions to support the recording and tracking of patient observations, improving quality and safety standards.

Through this work, Heather has engaged with a wide range of staff and key stakeholders to identify the trust's requirements for the future. This work has been instrumental in informing and strengthening a bid to the Department of Health's Nursing Technology Fund.

Building on the work and successes during Listening into Action's first year, the focus in future will be to support clinical change. In particular:

• The quality and safety of patient care (what we do for our patients)

• Enhancing the patient experience (how we do what we do for our patients)

• Enabling our front-line teams (supporting who delivers the service with what they need).

Staff health and wellbeing

East Cheshire NHS Trust is fully committed to the health and wellbeing of its employees. We want to do as much as we can to enable our employees to be at their best, be energised, motivated and committed to their work.

Employee wellbeing relates to all aspects of your working life, from the quality and safety of your physical environment, to how you feel about your work. The aim of any employee wellbeing strategy is to make sure employees are safe, healthy, happy, and engaged at work and should encompass the following key areas:

• Better physical and mental health - an environment that promotes healthy behaviours

• Better work – a happy and engaging work environment

• Better relationships – good communications and social connections

• Better specialist support – interventions to manage health and wellbeing.

Wellbeing initiatives for 2013/14 included, weight loss, pilates, membership of the trust choir and complimentary therapies.

Staff survey information

The staff survey was conducted between September 2013 and December 2013. 339 staff took part.

The survey results are presented into 28 key findings and results are compared to other acute trusts in England.

The survey asks staff a how they felt at the time under six categories:

1. Personal Development
2. Job role
3. Managers
4. Organisation
5. Health, wellbeing and safety at work
6. Background information

Results compared with other acute trusts

Out of 28 key factors, comparing East Cheshire NHS Trust to other trusts, 10 factors scored better than average, with seven of these placing us in the top 20% of all acute trusts.

Seven factors were scored as average, and 11 factors were scored below average. Work has commenced to improve these areas using the Your Voice - Listening Into Action approach.

Changes since 2012 survey

Since 2012, we have seen an increase in the number of staff reporting good communication between senior management and staff.

Over the last 12 months the trust has worked hard to improve communication, for example by introducing the chief executive's monthly podcast, holding senior leaders' forums at a variety of locations and introducing a chief executive email alert to communicate key messages across the organisation.

However, it has been recognised that further work still needs to take place and this has been identified as a Listening into Action priority area for 2014/2015.

One of the factors which has seen a significant improvement is the number of staff who have received health and safety training within the last 12 months. This score places us in the top 20% of acute trusts. There are 26 factors that have had no change since last year.

The trust will be proactively responding to the staff survey feedback and will be using the Your Voice - Listening into Action approach to engage with staff, discuss the findings and harness ideas and suggestions as to how the trust can make sustainable improvements.

Core indicators

Core Indicators 2013/14

All trusts are required to include their performance against nationally-selected quality indicators. In addition, the national performance average is required to be included. East Cheshire NHS Trust's performance against the selected national quality indicators is presented below.

Quality Indicator	East Cheshire NHS Trust (ECT) Data	Comparison against worst/best performing trust and 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:
Preventing people from dying prematurely. Summary Hospital-Level Mortality Indicator (SHMI):				
A: SHMI value and banding July 2012 - June 2013	1.0305 (band 2 – as expected)	9 trusts higher than expected 17 trusts lower than expected 115 trusts as expected Lowest = 0.959 Highest = 1.1563 Average = 0.996	The trust performs within the expected range for this indicator. This is in line with the trust TDA submission	The trust holds a monthly Mortality Meeting where low risk deaths are reviewed and mortality figures scrutinised to enable the effective review of every avoidable death.
B: Percentage of admitted patients whose treatment included palliative care July 2012 - June 2013	0.9%	National average = 1.14%		
C: Percentage of admitted patients whose deaths were included in the SHMI and whose treatment included palliative care (context indicator). July 2012 - June 2013	14%	National average = 20.3%		

Quality Indicator	East Cheshire NHS Trust (ECT) Data	Comparison against worst/best performing trust and 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:
Helping people to recover from episodes of ill-health or following injury. Patient reported outcome scores for:				
i) groin hernia surgery	EQ5D Index: 0.087	England: EQ5D Index: 0.86	Health gain is marginally better than the England average	
ii,iii,iv) varicose vein surgery, hip replacement surgery, knee replacement surgery (primary)			Results are unable to show health gain as numbers are so small and therefore not included	
Helping people to recover from episodes of ill-health or following injury. Emergency re-admissions to hospital within 28 days of discharge:				
i) 0-15 years of age (% of discharge)	ECT: 10.77 (2011/12) 11.70 (2010/11) 10.92 (2009/10) No further annual data available	England: 10.01 (2011/12) 10.01 (2010/11) 10.01 (2009/10) CECPCT (prior to CCG): 9.98 (2011/12) 11.92 (2010/11) 11.69 (2009/10)	Age and co-morbidity of patients above national average	All readmissions are reviewed by clinical teams to identify learning. Implemented an electronic alert system for high-intensity service users. Implemented a pathway to support patients with alcohol related conditions to prevent the need for an acute admission. Implemented a number of ambulatory care pathways to prevent the need for acute admissions. Work continues to expand this initiative which includes a pilot scheme, working as an integrated health economy to manage patient discharge. Expansion of Home Intravenous Therapy Service
i) 16-74 Years (% of discharge)	ECT: 10.01 (2011/12) 10.68 (2010/11) 9.94 (2009/10) No further annual data available	England: 10.14 (2011/12) 10.09 (2010/11) 9.92 (2009/10) CECPCT (prior to CCG): 9.40 (2011/12) 10.79 (2010/11) 10.06 (2009/10)		
i) 75+ Years (% of discharge)	ECT: 13.85(2011/12) 14.90 (2010/11) 14.29 (2009/10) No further annual data available	England: 15.29 (2011/12) 15.35 (2010/11) 14.86 (2009/10) CECPCT (prior to CCG): 14.40 (2011/12) 15.74 (2010/11) 15.03 (2009/10)		

Quality Indicator	East Cheshire NHS Trust (ECT) Data	Comparison against worst/best performing trust and 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:
Helping people to recover from episodes of ill-health or following injury. Emergency readmissions to hospital within 28 days of discharge:				
Ensuring that people have a positive experience of care Responsiveness to inpatients' personal needs. Average weighted score of 5 questions.	ECT: No data available for 2014 62.8 (2012/13) 66.2 (2011/12) 67.3 (2010/11) 66.5 (2009/10)	England: 68.1 (2012/13) 67.4 (2011/12) 67.3 (2010/11) 66.7 (2009/10) Worst - 57.4 (2012/13) Best - 84.4 (2012/13)	Missing	Missing
Ensuring that people have a positive experience of care Percentage of staff who would recommend the provider to friends or family needing care.	ECT: Januray 2014 66% February 2014 64% 61% (2013)	England: 65.0% (ALL ORGANI-SATIONS - 2013) 67.0% (ALL ACUTE TRUSTS - 2013) Worst = 40.0% Best = 89.0% January 2014 65% Worst = 4% Best = 100% February 2014 64% Worst = 4% Best = 100%	The trust in response to the changing NHS environment has reviewed its strategic direction for sustainability and has become involved in new ways of working with health and social care organisations in the locality. Organisational change has impacted on staff across all areas of the trust.	Your Voice:Listening into Action continues to engage staff and further encourage feedback and ideas. The achievement of quality standards continues.
Treating and caring for people in a safe environment and protecting them from avoidable harm. Percentage of admitted patients risk-assessed for venous thromboembolism.	ECT: Oct-12 91.5% Nov-12 91.8% Dec-12 90.4% Q3 (2012-13) 91.3% Jan-13 91.8% Feb-13 91.0% Mar-13 90.1% Q4 (2012-13) 91.0% Apr-13 92.0% May-13 93.3% Jun-13 94.6% Q1 (2013-14) 93.3% Jul-13 93.5% Aug-13 95.3% Sep-13 92.9% Q2 (2013-14) 93.8% Oct-13 94.4% Nov-13 94.4% Dec-13 98.5% Q3 (2013-14) 95.7%	England: Oct-12 94.3% Nov-12 94.4% Dec-12 93.8% Q3 (2012-13) 94.2% Jan-13 94.4% Feb-13 94.2% Mar-13 94.3% Q4 (2012-13) 94.3% Apr-13 95.1% May-13 95.5% Jun-13 95.7% Q1 (2013-14) 95.5% Jul-13 96.0% Aug-13 95.7% Sep-13 95.6% Q2 (2013-14) 95.7% Oct-13 95.9% Nov-13 96.0% Dec-13 95.6% Q3 (2013-14) 95.8%	The trust performs to required standard	On going education of medical and nursing staff, including development of e learning package Implementation of RCA for all hospital acquired VTE Daily monitoring within wards to ensure compliance Implementation of revised electronic reporting system.

Quality Indicator	East Cheshire NHS Trust (ECT) Data	Comparison against worst/best performing trust and 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:
Helping people to recover from episodes of ill-health or following injury. Emergency readmissions to hospital within 28 days of discharge:				
Treating and caring for people in a safe environment and protecting them from avoidable harm. Rate of C Difficile.	ECT: April 2012 March 2013 23.1 C.Difficile infections per 100,000 bed days amongst patients aged two years and over.	England: April 2012 - March 2013 17.3 C.Difficile infections per 100,000 bed days for specimens taken from patients aged 2 years and over. Worst 30.8 Best 0.0	The trust performs to required standard	Implementation of individual case reviews for all positive patients both on the wards and in the community. Implementation of home visits for patients following discharge from hospital. On going audit. On going education of medical and nursing staff. Appointment of additional antibiotic. Pharmacist hours.
Treating and caring for people in a safe environment and protecting them from avoidable harm. Rate of patient safety incidents and percentage resulting in severe harm or death.	• Reported patient safety incidents • The rate of patient safety incidents reported per 100 admissions • The proportion of patient safety incidents reported that resulted in severe harm or death. Oct 12 - Mar 13 10.9 incidents per 100 admissions 0.2 % resulting in severe harm of death 4 incidents resulting in severe harm 1 incident resulting in death. Apr 13- Sept 13 13.8 incidents per 100 admissions 0.12% resulting in severe harm or death (3 incidents resulting in severe harm, 0 resulting in death)	Overall for small acute trusts 7.7 Incidents per 100 admissions 0.8% resulting in severe harm or death Worst 17.5 incidents per 100 admissions (small acute trusts) 0.9% resulting in severe harm or death, 39 incidents resulting in severe harm, 0 resulting in death. Best 4.1 Incidents per 100 admissions (small acute trusts), 1.0% resulting in severe harm or death. 5 incidents resulting in severe harm, 4 in death.	A 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 as all team leaders and managers are assigned incidents to investigate. The trust has a high level executive lead group which considers all serious incidents. All patient safety incidents which resulted in serious harm or death are verified by the clinical risk manager prior to upload.	On-going training and education of trust staff on incident reporting. Monthly and quarterly reporting has been amended to be business group specific, allowing reporting levels and trends to be monitored. Incident data available for each service area throughout the trust which can be used to provide feedback to individual teams.

Examples of best practice 2013/14

End-of-life care

Aim:

To co-ordinate and manage palliative and end-of-life care for patients at home.

Benefits:

• Patients enabled to die in their Preferred Place of Care (PPC)

• End-of-life care is provided in a coordinated way

• 87% of patients who expressed a PPC achieved this

• 24/7 support from qualified staff

• Maintains respect and dignity in home environment

• Carer and family support

• Respects person's wishes and personal needs at last stages of their life.

National Quality Mark project for Elder-Friendly Hospital Wards in Aston and Langley units.

Aim:

To help individual services understand their performance, identify areas of achievement and improvement and provide a basis for action planning.

Benefits:

• Langley Unit showed that patients had a positive experience both with the attitude and care from the staff. The staff worked hard and the environment was clean.

• Patient comments stated that they found the staff friendly and courteous at all times

• Community patient feedback results show that of responses received 100% regarded their care as good or excellent.

AQUA project in intermediate care to improve frail elderly pathway

Aim:

To improve the safety of patients on discharge and ensuring patients are actively involved in the decision making in relation to their rehabilitation.

Benefits:

• Strengthening care coordination with patients

• Improved staff morale by focusing directly on patient pathway

• Reduction in length of stay

• Closer monitoring and support to patients.

Open 2 autism

Aim:

To increase the awareness of autism for all healthcare staff to improve the patient experience

Benefits:

• East Cheshire NHS Trusts project, 'Open 2 autism' was the winner of the NHS North West Leadership Award for Patient Inclusivity

• The trust is the first in the UK to be recognised by the National Autistic Society thanks to its pioneering work with autistic patients

• 'Open 2 Autism' is a groundbreaking project which aims to improve autism awareness and help healthcare staff develop their understanding of the condition so they can support and make reasonable adjustments for people with autism coming into their clinical area

• The trust is working with the National Autistic Society to gain their access accreditation award (to be confirmed in May 2014)

• The project will allow us to break down barriers and enable staff to make positive changes to improve the healthcare we offer to our patients.

Reducing healthcare-associated infections

Aim:

As part of its ongoing commitment to reducing healthcare-associated infection, NHS England implemented a zero-tolerance approach for MRSA blood stream infections (MRSA BSI).

Benefits:

• Changed the way MRSA BSI is reported. Dependent on the outcome of the review process, they are attributed to either the acute trust or the appropriate Clinical Commissioning Group. This joint approach enables a health economy approach to improve patient outcomes.

• For the period 2013-14, the trust had one identified case of MRSA BSI. This was subject to an internal review identifying lessons learnt. This information was then shared across the organisation and used to improve the quality of patient care.

Home intravenous therapy service

Aim:

To allow patients to be treated at home with home intravenous therapy so that a hospital admission can be avoided or a stay in hospital shortened.

Benefits:

• HITS specialist cardiology pathway developed in 2013 to enable patients to receive all appropriate intravenous therapy treatment at home. This reduces the risk of hospital-acquired infections.

• Palliative cardiac patients required frequent hospital admissions (average 11 days)

• End-of-life patients' wishes to die at home. An annual audit of 250 patient deaths showed 78% achieved their preferred place of care at the end of life.

• Generates cost efficiency with 50% saving when compared with acute admission

• 500 bed days saved April to Sept 2013.

Acute Assessment Pilot

Aim:

The Acute Assessment Pilot is a large-scale transformational programme designed to change the management of patients who require emergency health care via the introduction of ambulatory care. For patients this means not being admitted to hospital where this is not clinically indicated.

Benefits:

• Dedicated assessment and treatment area to provide an alternative to hospital admission

• Rapid access to diagnostics equivalent to the response times for patients in the emergency department

• Facilitating admission only as a clinical choice for patients with an underlying life- threatening illness or need for surgery is essential and requires a change in cultural behaviours, particularly on the part of medical staff, i.e. admission is not the default position

• Responsive multi-disciplinary community support to manage onward care

• Where applicable - access to a comprehensive geriatric assessment via a pilot to support interface between the acute admission areas, ambulatory care clinic, emergency department, medical admission unit and community services.

• Clear pathways to enable patients with an identified ambulatory care condition or frail elderly patients with multiple needs, to be assessed and discharged with support within a community setting in a timely manner.

Audit participation

Excellent, pleasant staff and very good results

Audit Participation

Participations in clinical audits 2013/14

During 2013-14, 31 national clinical audits and three National Confidential Enquiries into Patient Outcome and Death (NCEPOD) requests covered NHS services that East Cheshire NHS Trust provides.

During that period, the trust participated in 31 of the national clinical audits and three out of the three (or 100% of the) NCEPODs which it was eligible to participate in.

The national clinical audits and NCEPODs that East Cheshire NHS Trust participated in, and for which data collection was completed during 2013/14, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Audit	Participation	Data collection 2013/14	Patient recruited 2013/14	% cases submitted in 2013/14
Neonatal intensive and special care (NNAP)	Y	Y	135 admissions	100%
Paediatric Asthma (BTS)	Y	Y	7	100%
Epilepsy 12 (Childhood Epilepsy)	Y	Y	6	100%
Paediatric Intensive Care (PICAnet)	Y	Y	16	100%
Paediatric Bronchiectasis	N	N	Minimum number of cases not met	N/A
Diabetes (Paediatric)	Y	Y	96	100%
Moderate or severe asthma in children (care provided in emergency departments)	Y	Y	31	97%
Paracetamol overdose (care provided in emergency departments)	Y	Y	50	100%
Severe sepsis & septic shock	Y	Y	33	100%
Emergency use of oxygen (BTS)	Y	Y	33	100%
Chronic Obstructive Pulmonary Disease	Y	Y	Data collection February to May 2014	Data collection February to May 2014

National Audit	Participation	Data collection 2013/14	Patient recruited 2013/14	% cases submitted in 2013/14
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Y	Y	Ongoing	Data completion date end May 2014
Heart failure	Y	Y	Ongoing	Data completion date end May 2014
Comparative audit of blood transfusion	Y	Y	15	100%
Adult critical care (ICNARC)	Y	Y	444	100%
Rheumatoid & early inflammatory arthritis	Y	Y	Data collection commenced 1st February 2014	Data collection commenced 1st February 2014
Emergency laparotomy	Y	On-line data entry commenced 07/01/2014	Organisational audit submitted August 2013	Two year data collection period commenced December 2013
National Joint Registry	Y	Y	360	100%
Falls & Fragility Fractures Audit Programme, includes National Hip Fracture Database	Y	Y	242	100%
Inflammatory bowel disease (IBD)	Y	Y	14	100%
National audit of seizure management (NASH)	Y	Y	50 patients	100%
Stroke National Audit Programme SSNAP (combined Sentinel & SINAP)	Y	Y	267	100%
Renal replacement therapy (renal registry)	Y	Y	56	100%
Lung cancer	Y	Y	120	111%
Bowel cancer	Y	Y	152	Upload deadline October 2014, so improvements expected in amount and quality of data
Head & neck oncology	Y	Y	5	End date 31st October 2014

National Audit	Participation	Data collection 2013/14	Patient recruited 2013/14	% cases submitted in 2013/14
Oesophago-gastric cancer	Y	Y	42	Upload deadline October 2014, so improvements expected in amount and quality of data
Elective surgery (national PROMS programme) Includes groin hernia, hip replacement & knee replacement	Y Y	Y Y	Pre-operative questionnaires completed 547 Post-operative questionnaires returned 374	Response rate 76.3% Response rate 72.5%
Cardiac arrest	N	N	N/A - Extensive quality data provided through local audit	N/A
Diabetes (adults ANDA) includes National Diabetes Inpatient Audit (NaDIA)	Y - Participated in NaDIA September 2013	Y	43 Bedside Audit Questionnaires 30 Patient Experience Questionnaires	100%
TARN	Y	Y	77 cases submitted @ 31/03/14 - data input ongoing	Continuous data input
Congenital heart disease (paediatric cardiac surgery)	N/A	N/A	N/A	N/A
Adult cardiac surgery	N/A	N/A	N/A	N/A
Pulmonary hypertension	N/A	N/A	N/A	N/A
Cardiac arrhythmia	N/A	N/A	N/A	N/A
National Vascular Registry, including CIA and elements of NVD	N/A	N/A	Data for East Cheshire NHS Trust patients included in patient data submitted by UHSM	
Prescribing Observatory for Mental Health (POMH-UK)	N/A	N/A	N/A	N/A
National audit of schizophrenia	N/A	N/A	N/A	N/A
Coronary angioplasty	N/A	N/A	N/A	N/A
Prostrate cancer	HQIP stated no data collection 13/14			
National Audit of Dementia (NAD)	HQIP stated no data collection 13/14			

Participations in confidential enquiries 2013/14

Confidential Enquiries	Participation	Data Collection	% cases submitted
Child Health (CHR-UK)	N	N	No relevant cases / patient in status reported
Maternal Infant and Perinatal (previously Perinatal Mortality)	Y	Y	100% (7/7)
National Confidential Enquiry into Patient outcome and Death (NCEPOD) Subarachnoid Haemorrhage	Y	Y	1 qualified case during data collection period
National Confidential Enquiry into Patient outcome and Death (NCEPOD) Tracheostomy Study	Y	Y	5 qualified cases during data collection period
National Confidential Enquiry into Patient outcome and Death (NCEPOD) Lower Limb Amputation Study	Y	Organisational questionnaire completed and returned October 2013. This covered the rehabilitation of patients following lower limb amputation	No qualifying amputations for the data collection period
National Confidential Enquiry into Patient outcome and Death (NCEPOD) Gastrointestinal Bleeding Study	Y	Organisational questionnaire completed and returned January 2013	No patient data submitted
National Confidential Enquiry into Suicide and Homicide for people with mental illness (NCISH)	N/A	N/A	N/A

National clinical audits 2013/14

The reports of six 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
Acute Care The National Stroke Audit 2012 results were presented and discussed at the medicine audit meeting in May 2013. The audit has two sections: 1. Organisational component (bi-yearly) 2. Clinical section, (previously bi annually for 60 patients) now reported for ALL stroke patients via SSNAP.	The audit measured stroke services as at 2nd July 2012 covering eight domains. The audit enables stroke services to be compared with national standards outlined in: • The fourth edition of the National Clinical Guideline for Stroke (ICWP 2012) • The NICE Quality Standards for Stroke (2010) • The National Institute for Health and Clinical Excellence Stroke Clinical Guideline (2008) • The National Stroke Strategy 2007 East Cheshire NHS Trust strengths were reported as: • Strong inpatient multi-disciplinary team working • Thrombolysis-trained staff • 6/7 acute unit criteria filled • Involvement in research and patient/carer views are sought.
Families & Wellbeing BTS National Paediatric Asthma 2013 results were presented and discussed at the paediatric audit meeting in February 2014. Audit criteria • Children (aged over 12 months) who had been admitted to the paediatric unit during the month of November 2013 with wheezing/asthma Audit standard • BTS/SIGN: British Guideline on the Management of Asthma	Of the criteria set - seven patients were eligible for participation in the audit on which the data is based. Conclusions from the audit reported that admission clerking is good. However there are lessons to be learnt in respect of the use of the discharge summary. As at 31st January 2014 none of the seven patients audited had been re-admitted. Actions from the audit: • Increased use of asthma pro-forma • Review BTS guidelines when discharging asthma patients • Review whether GP follow-up is required.

National Audit	Actions and progress
Community National Patient Safety Alert (NPSA) treatment dose - Low Molecular Weight Heparins (LMWH)audit. An audit was carried out across all wards at Macclesfield District General Hospital over a two-week period in February 2014 by the pharmacy team. This audit reviewed the current trust prescribing practice for treatment dose LMWH to ascertain if the trust is complaint with NPSA recommendations.	The results of this audit highlight that, in the duration of the data collection, for the majority of patients treated with LMWH, the trust is compliant with NPSA RRR014 recommendations. Actions from the audit : • Ensure accurate patient weight are recorded on the front of all inpatients charts for a patient's prescribed treatment doses of LMWH • Ensure that the urea and electrolyte levels are reviewed within 24 hours of admission and documented in the patient's notes. This provides evidence that the prescriber has considered the patient's renal function when prescribing appropriate treatment doses of LMWH • Ensure that prescribers are familiar with the trust venous thromboembolism (VTE) policy (this policy covers both prophylactic and treatment doses of low molecular weight heparins) • Ensure any prescriber involved in a prescribing error for LMWH completes the venous thromboembolism (VTE) e-learning module • Following this audit, an F1 training session on the NPSA LMWH alert has been included in the F1 annual training plan as this was recorded as a high priority.

The report of one Confidential Enquiry Into Patient Outcome and Death was reviewed by East Cheshire NHS Trust's board and as a result, the trust is taking the following action to improve the quality of healthcare provided: (We have taken into account the devolvement of responsibilities to other trust committees and 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 group audit scorecards reviewed by this group on a quarterly basis.	NCEPOD "Knowing the Risk" (A review of the peri-operative care of surgical patients) Reviewed 08.04.13	The audit reviewed the peri-operative care of 'high-risk' surgical inpatients. The group discussed the definition of 'high-risk'. High-risk is determined following assessment of an individual patient's requirement. CARE Group suggested a future audit may include the peri-operative care of fracture neck of femur patients.

The reports of 94 local clinical audits were reviewed by the provider in 2013-14 and the trust intends to take the following actions to improve the quality of healthcare provided. (We have taken into account the devolvement 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 group audit scorecards are reviewed by this group on a quarterly basis	Clinical Records Management audit and re-audit	Aim of the audit: • CARE Group reviewed the results of the 2012 round of the Clinical Records Management audit and agreed to carry out a re-audit in June 2013 for those specialties that had not achieved 75% compliance. Results: • Following the re-audit, CARE Group agreed to set up a working group to review the audit tools and align the processes in readiness for the next full round of the audit. • Revised audit tools were piloted and are now in use. Results will be reported back via the business group audit leads to SQS. Actions: • An action plan, with timescales for implementation, will be agreed. Any outstanding actions will be raised via the CARE Group quarterly reports to trust SQS Committee.
Departmental audit meetings All of the audits have actions plans for development or have achieved the standards of care. Acute Care Business Group monthly audit meetings	Antibiotic ward round data July 2012 - June 2013	Aims of the audit: • To assure compliance of antibiotic prescribing with the trust policy • Are key performance indicators (KPIs) met? Results: • Appropriate choice of antibiotic. Target >90% - achieved 96% (achieved) • Antibiotic courses have no avoidable missed dose. Target >90% - achieved 92% (achieved) • Prescriber indication on drug chart. Target 100% - achieved 68% • Prescriber on stop or review. Target 100% - achieved 66% Actions: • Prescribe all initial doses of antibiotics as a STAT (single dose) dose, with time for administration • Inform nursing staff so antibiotics can be given promptly • A re-audit of ward rounds will be carried out to ensure continual improvements are made.

Group or forum	Local audits reviewed	Actions and Outcomes
Departmental audit meetings (cont)	Neurological assessment in stroke (re-audit)	Aims of the audit: • To appraise the actions from the initial audit (September 2012) • To establish the improvement to the quality of service for stroke patients • To review the completeness of neurological examination in patients. 38 case notes were randomly selected to include in the audit. Results: • Compared to the initial audit data, the re-audit showed a vast improvement in the completeness of the neurological assessment in patients admitted to the Acute Stroke Unit (ASU) with an increase from 33% to 87%. Actions: • The teaching session on neurological examination and documentation becomes part of the regular foundation teaching programme. This will ensure continual improvement in the service we provide to patients, while supporting and developing staff to enable them to achieve their best.
	Central and Eastern Cheshire locality integrated care pathway for the dying (adult) audit	Aims of the audit: • To determine if the Integrated Care Pathway (ICP) for the dying (adult) was being appropriately and effectively applied across different care settings within central & eastern Cheshire. (The audit proved to be a timely review of compliance with the Version 12 Liverpool Care Pathway (LCP) that, at the time of the audit, had been in place for almost two years). Results: • The results of the audit demonstrated that the local ICP/LCP was being largely applied for the length of time for which it was intended (up to 72 hours before death) and that 70% (n-65) of all deaths audited died within 72 hours of pathway commencement. • For the remaining 30% (n-28) of patients there was evidence within 46% (n-13) of pathways that the appropriateness of continuing the pathway for more than 72 hours had been reviewed by the team caring for the patient. • In 65% of cases the pathway was used with patients who had a non-cancer diagnosis and the challenges of diagnosing dying within different disease groups has been highlighted within the LCP review.

Group or forum	Local audits reviewed	Actions and Outcomes
		Actions: • This cross-locality audit listed twelve recommendations, from which an action plan has been devised identifying clinical leads and implementation dates for each action. • Examples of recommendations included communication, training and documentation.
	Review of Cardiac Arrests 2012 Healthcare institutions have an obligation to provide an effective resuscitation service, failure to provide an effective service is a failure of a duty of care.	Aims of the audit: • The aim of the review of cardiac arrests audit undertaken between January 1st and December 31st 2012 was to ensure that a high quality resuscitation service is provided for patients within the trust and improve adherence with the trust Cardiopulmonary Resuscitation Policy. Results: • The 2012 results indicated a 96.2% compliance rate with the Cardiac Arrest Team Activity (CATA) pro-forma return during 2012. • The compliance percentage for 2011 was 75.1%, for 2010 the figure was 65.2% and for 2009 35.4%. • The steady increase in compliance, year on year, indicates effective communication/education regarding the requirement for CATA pro-forma completion.
Trauma & orthopaedics	Early results of Xiapex injections & patient satisfaction audit Dupuytren's disease is a common condition affecting a significant proportion of the population within the UK. It can result in severe functional limitations of hand function. Injectable collagenase Clostridium histolyticum (CHC) is a new non-surgical treatment option which has been shown to have significant effects on joint contractures.	Aims of the audit: • To assess the use of injectable CHC within a district general hospital setting and evaluate patient satisfaction. • Prospective data was collected on all patients with Dupuytrens disease, over a six month period, where surgical options were being considered. • Patients were seen in outpatient clinic by a consultant upper limb orthopaedic surgeon and, if inclusion criteria were met, they were offered injectable collagenase as part of their treatment options. Results: • The current results of the use of CHC are encouraging and it is a very useful option in the treatment of Dupuytren's contractures. • East Cheshire NHS Trust usage and results for Xiapex as the first-line treatment of symptomatic Dupuytren's contractures are in keeping with results from large centres.

Group or forum	Local audits reviewed	Actions and Outcomes
		Actions: • As CHC is a non-surgical procedure, patients who are high-risk surgical candidates due to medical co-morbidities, are offered CHC as an alternative treatment. • The increased risk of significant peri-operative complications with revision surgery makes the concept of a minimally-invasive procedure appealing.
Breast surgery	Patients with breast cancer under 35 audit. Breast cancer in patients under 35 is rare but is serious and might be aggressive.	Aims of the audit: • To ensure practice is in line with NICE guideline CG80 (early and locally advanced breast cancer) and to evaluate how the early detection of breast cancer may improve survival rate. • The audit was conducted retrospectively on 648 patients aged under 35 years old presenting to the low-risk group clinic, during the period April 2010 to July 2013. Results: • Incidence of breast cancer under 35 remains very low • Majority of patients have benign breast changes / benign lumps like fibroadenoma • All patients diagnosed with breast cancer were over 28 year old • Management for breast cancer under 35 was carried as per standard protocol. Actions: • Continue the same screening and treatment plane • Advise females to contact GP for any breast lump or axillary lump • Repeat retrospective audit to follow up the patients with cancer to discover the outcome and survival rate.
Families & Wellbeing Business Group monthly audit meetings including Maternity & Women's audit meetings	Midwifery CNST Standard 3.1 Severe Pre-eclampsia The incidence of eclampsia and its complications have decreased significantly in the United Kingdom since 1992, following the introduction of management guidelines for eclampsia and pre-eclampsia. However, eclampsia remains the second most common cause of direct deaths.	Aims of the audit: • To ensure the maternity service has approved documentation for the management of severe pre-eclampsia that is implemented and monitored. • To demonstrate that current practice regarding documentation is in line with the unit guidelines (severe pre-eclampsia and eclampsia). • To identify where changes are needed to improve practice. • To identify and disseminate good practice. Results: • The results of this audit measured 100% compliance and all three objectives were met.

Group or forum	Local audits reviewed	Actions and Outcomes
	Paediatrics Urinary tract infection in children under 16 audit	Aims of the audit: • To evaluate the management of urinary tract infections (UTIs) measured against the NICE quality standards for UTI in infants, children and young people under 16 (associated NICE guidance – CG54 UTI in children) Four standards were audited: 1. Evidence of a urine sample collected within 24 hours in children presenting with fever of 38 degrees 2. Evidence of risk factors for UTI and serious underlying pathology recorded as part of their history and examination 3. Evidence of positive urine results differentiated between E.Coli and non-E. Coli organisms 4. Evidence of information being given about how to recognise infection and to seek medical advice straight away Results: • The audit results showed 100% adherence to quality standards 1, 2 and 3 and partial compliance with standard 4. Actions: • Use a clerking checklist/pathway to ensure all necessary questions are covered. • Ensure the current information leaflets are utilised to give information to parents on discharge, with clear documentation in the notes. As a result of implementing the actions, the quality of patient care will be improved.
	Eastern Cheshire Sexual Health Service Ensuring that the safeguarding documentation standards for our patients are met	Aim of the audit: • To measure compliance with the safeguarding and Fraser Guideline documentation standards for all clients under the age of 16. • The audit was conducted on a sample of 108 patients covering the three month period 1st October to 31st December 2012. Results: • The results show that documentation standards need to be improved with 31% not meeting the standard.

Group or forum	Local audits reviewed	Actions and Outcomes
		Actions: • Clear instructions need to be incorporated in the Lilie user's manual and clinical guidelines to ensure that all members of staff are following the same process. • All staff should receive update training on the completion of appropriate templates and documentation. • Reception staff need to be trained to ensure that all male patients, when given out condoms, must be booked in to see a health care professional at each consultation. • The combined contraception template on the patient management system needs to include the same drop-down menu as the other templates. Implementation of these recommendations will ensure staff will be supported and developed, to enable them to achieve their best, ensuring continual improvement in the service they provide.
	Dental Dental Audit outcome and subsequent upgrade of non-compliant facilities	Aim of the audit: • This was a re-audit due to concerns of non-compliance highlighted in previous audits. Result: • The result of the dental audit at Victoria Infirmary, Northwich highlighted the compliance failure in the premises and facilities at the centre. • The facility required a large scale program of modernisation and installation of modern up-to-date decontamination equipment. • This required a full risk assessment and board approval from both East Cheshire NHS Trust and Mid Cheshire Hospitals NHS Foundation Trust (MCHFT) to finance the project. Action: • A refurbishment has taken place in collaboration with MCHFT, this includes a newly-created dedicated decontamination facility, now separate from the clinical environment.

Group or forum	Local audits reviewed	Actions and Outcomes
		• New modern equipment has been installed, with the ability to log and closely monitor all activity and maintain an assurance of effective instrument processing. • Patients can now be assured that effective processing of reusable instruments and a reliable infection control and logging system is in place for patient safety.
Community Service Business Group bi-monthly audit meetings Eastern Cheshire	Dermatology Cancer Services Peer Review Audit - Timeliness of Notification of Diagnosis to GP - Skin Cancer. Annual audit undertaken by dermatology specialist nurse - July 2013.	Aims of the audit: • To determine compliance against the following criteria: • GPs should be notified of a patient's diagnosis within 24 working hours or 48 hours if over a weekend. Action: • All dermatology consultants are required to indicate on ALL GP correspondence where a patient has been informed of a cancer diagnosis. Secretaries are then required to prioritise this correspondence. Results: • The results showed that 81% of GPs received notification of a patient's diagnosis either before or within 24 hrs (compared to 56% in 2012).

Participation in clinical research

Participation in clinical research

Participation in clinical research demonstrates the trust's ambition to improve the quality of care offered and make 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.

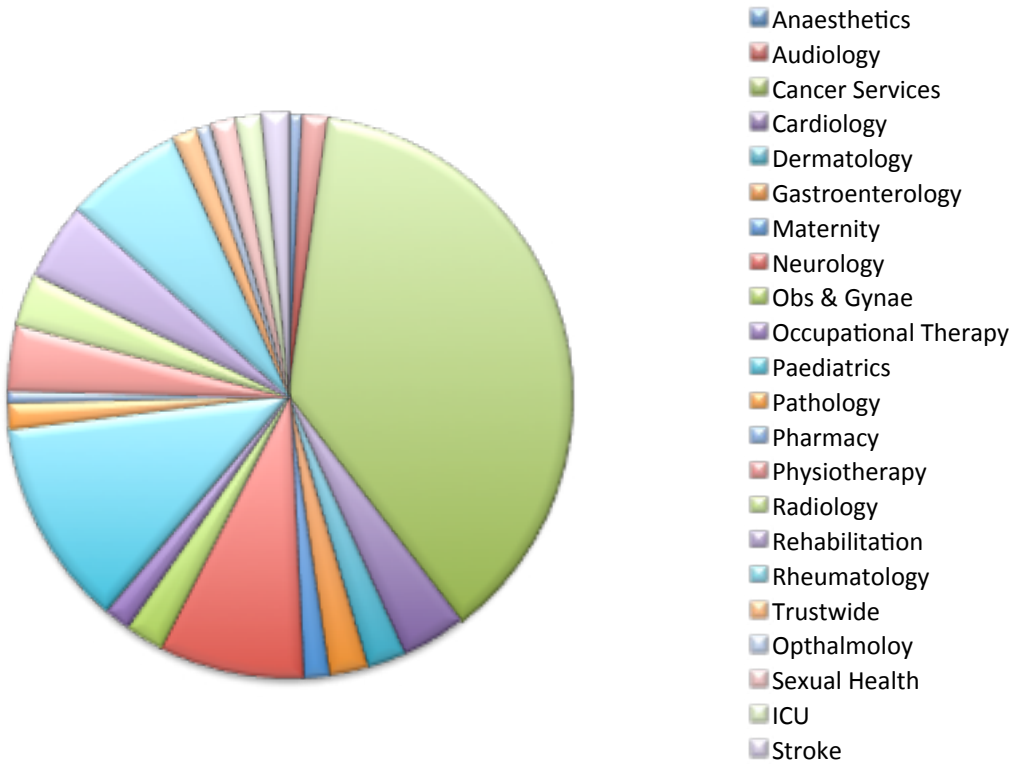
While maintaining the studies and following up participants recruited in previous years, a further 33 studies have been opened and 1331 participants were recruited in 2013-14. A further seven studies are awaiting approval by East Cheshire NHS Trust research staff for research that has been approved by the ethics committee.

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

The trust is currently involved in 134 active clinical research studies, of which 112 are portfolio studies covering 21 medical specialities.

As can be seen in the chart below, 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.

Distribution of active studies across the trust and areas of clinical research



Audit examples of good practice

Community Services Business Group

Re-audit of NICE Clinical Guidance CG88 - The early management of persistent non-specific low back pain within the Adult Physiotherapy Service.

The aim of the re-audit was to demonstrate the compliance of current physiotherapy practice within East Cheshire NHS Trust (Community Business Unit), to the guideline CG88 issued by the National Institute for Health and Care Excellence (NICE) in May 2009.

The objectives set were to establish whether patients receive treatments as specified by the NICE guideline as follows:

- Advice on self-management
- Structured exercise
- Manual therapy
- Acupuncture
- Psychosocial management, if not responding to above treatments or identified as "at risk" of poor outcome.

One hundred patients were audited during September 2012 to January 2013 from across all of the adult community physiotherapy bases (Community Business unit) within East Cheshire NHS Trust. Of the 100 patients audited, 70% were female and 30% male. Their age ranged from 19 to 75 years old, with the highest proportion of patients being in the 30 – 50 year age range (40%).

The audit concluded all patients audited during the period were managed appropriately in line with NICE Guideline CG88.

A planned re-audit in two years will ensure continuation of high quality care for patients and sustainability of compliance with NICE guideline CG88.

Families & Wellbeing Business Group

1. East Cheshire NHS Trust Maternity Services achieved CNST level 3 in September 2013, with the completion of 50/50 standards at the highest level. To achieve the level 3 accreditation, the maternity services conducted a series of 50 clinical audits (throughout 2012-13), which were measured against the 5 CNST standards (each standard contained 10 criteria). The clinical effectiveness department worked in cohesion with maternity services to provide consistency and support the assurance process. The achievement of CNST level 3 demonstrates excellence in quality of care and reduces the financial premium paid to the NHSLA.

2. Joint working between paediatric speech and language therapy and local councils/schools.

Partnership agreements have been put in place with Cheshire West and Chester and Cheshire East councils covering the commissioning of paediatric speech and language therapy in early years settings, in mainstream and special schools in areas of high depravation.

We are continuing to commission with individual schools or clusters of schools and engaging with new schools to look at future commissioning.

Acute Care Business Group

NICE guidelines recommend the use of antibiotic prophylaxis for large bowel surgery. Surgical site infection is a type of healthcare- associated infection in which a wound infection occurs after an invasive surgical procedure.

The aim of this audit was to look at surgical site infections (SSI) and the appropriate use of antibiotic prophylaxis in large bowel surgery. A UK study in 2000 showed the consequence of a healthcare associated infection resulted in an average additional stay of 6.5 days and a cost of £3,246.

The audit was carried out on a retrospective basis and data was collected on 42 patients with surgical site infections between October 2011 and June 2013.

Results of the audit show that 33% of patients had a delay in their discharge and 21% of patients were re-admitted due to infection. The results show we are partially compliant with the requirement of giving antibiotic prophylaxis for all large bowel surgery.

As a result of this audit actions identified included:-

• Education of surgical staff on the importance of antimicrobial prophylaxis with development of a training session

• Update the current antimicrobial prophylaxis guidelines based on local antibiotic sensitivity patterns and latest evidence base

• Undertake root cause analysis (RCA) on delayed discharges and readmissions with SSI

• Develop a workshop which focuses on improving documentation skills and awareness on the importance of SSI

Outcomes from the implementation of these actions include improvements in quality of patient care along with a reduction in delays in discharge and re-admission rate.

Our quality priorities for 2014/15

I felt I didn't recieve much information when I was transferred from one ward to another

Our quality priorities for 2014/15

Priority	Indicator	How will we achieve
Patient experience		
Friends and Family Test (FFT) Continue to develop the FFT survey process for both patients and staff.	• To implement the staff FFT survey • To increase or maintain response rate in inpatient and emergency department surveys • To reduce the number of negative response rates for the FFT survey • To implement the FFT survey in day case and outpatient areas by October 2014	• Work with an agreed supplier in order to deliver the survey every quarter, engaging staff through communications and staff-side support. • Work to continue to increase response rates across all areas, developing a range of options to collect survey responses • Ward/department managers will continue to review feedback and identify themes and actions for improvement in each ward area. • Surveys will be implemented within the required timeframe
'Always event' To ensure that specific actions in relation to safe discharge always happen.	• To improve the patient experience • To improve compliance with post-discharge instructions • Reduce the need for readmission into hospital.	• The minimum 'always events' to take place at discharge will be implemented. • This will be supported by the patient journey coordinators. • A post-discharge phone call to patients will be made to monitor progress and compliance, increase patient engagement and improve their experience of the trust.
Outpatients • To improve the process for managing outpatient appointments • To improve communication and the overall experience of patients attending outpatient clinics	• To reduce the volume of clinics cancelled resulting in patients appointments having to be re scheduled • Establish alternative process for managing the follow up process for outpatients • To reduce the number of PALS contacts/complaints relating to the cancellation of clinics and delays in clinic	• Monitor and improve the timeliness of communication in relation to requests to reduce/cancel clinics by clinicians • Investigate and implement alternative process to manage follow-up appointments • Establish customer care/ communication programme for staff.

Priority	Indicator	How will we achieve
Clinical effectiveness - improving clinical outcomes		
Dementia To ensure patients are appropriately assessed, investigated and referred on to appropriate services.	• To improve the diagnosis and referral of patients with dementia and/or delirium by screening eligible patients in line with national requirements.	• All non-elective patients aged over 75 years admitted to hospital will be asked the screening questions. • Patients with a positive screen to be referred back to their GP or specialist for further support and or treatment. • Carers of patients with dementia to be surveyed to establish if they feel supported. • A newly-refurbished 'dementia environment' elderly care ward will be completed in April 2014
Proactive care for patients with long-term conditions	• To support improved management of patients with long-term conditions to be managed within a community care setting	• To implement a tool that assesses patient's and their future probability of readmission with follow-up care coordination in the community. • To continue to develop the health and social care teams in locality areas. • To undertake further work with patients with a long-term condition to help them better self-manage their condition. • To continue to support the care coordination of patients within the neighbourhood teams.
Patient safety - reduction in patient harm		
Reduction in pressure ulcers	• To reduce the total number of newly-acquired pressure ulcers on caseload/during hospital stay by 25%.	• Use evidence-based practice to support the prevention, identification and treatment of pressure ulcers.

Priority	Indicator	How will we achieve
Reduction in pressure ulcers	• To develop a training package to support staff in their management of pressure care.	• Improve the recording of pressure area information and visual assessment by the use of digital cameras. • Undertake a planned staff training programme across acute and community areas. • Work with patients and carers to ensure a better understanding of prevention and treatment.
Transparency project	• To implement the transparency project – 'Open and Honest Care' Report on the following metrics for publication on a monthly basis:- • Safety Thermometer • Friends and Family Test (FFT) • Healthcare-acquired infections (MRSA/CDIFF) • Pressure ulcers Grade 2-4 acquired while in hospital • Falls sustained while in hospital where moderate/severe/fatal harm occurred • Patient experience survey • Staff experience survey • A patient story (quarterly) • An improvement story (quarterly) Overall aims are to: • Reduce the incidence of pressure ulcers acquired in hospital. • Reduce the incidence of moderate/severe falls sustained in hospital. • Triangulate data from patient and staff surveys where harm has occurred to elicit themes and trends.	• Establish a steering group to monitor and progress implementation of transparency 'Open and Honest' care project. • Work with key stakeholders to facilitate data collection, analysis and communication strategies. • Engage frontline clinical staff with the project in order to seek improvements and actions required inclusive of resource implications and identifying preventative measures. • The communication team will provide monthly 'Did you know?' boards following quality assurance checks. • The engagement department will support with the analysis of patient and staff experience surveys. • Attend NHS England meetings to keep abreast of new metrics for consideration e.g. publishing of staffing levels.

Statement's of assurance

I cannot speak highly enough regarding the staff and the speed at which I was attended to

Statements of assurance

A proportion of the income received at East Cheshire NHS Trust in 2013/14 was conditional on achieving quality improvements and innovation goals agreed between the trust and its commissioners.

The goals agreed can be found at www.institute.nhs.uk or through the trust website at www.eastcheshire.nhs.uk.

East Cheshire NHS Trust has reviewed all of the data on the quality of care in 2013/14 and the reports, achievements and improvements planned can be seen throughout this report.

East Cheshire NHS Trust is required to register with the Care Quality Commission (CQC). This report can be found at www.cqc.org and during 2013/14 successfully maintained registration with no conditions.

A number of third party organisations have also had the opportunity to comment on the trust's Quality Account this year. The reports of Eastern Cheshire Clinical Commissioning Group, the local council's overview and scrutiny committee and Healthwatch can all be found on the following pages.

The Audit Commission have also reviewed the data quality reported in all areas of the Quality Account.

Eastern Cheshire Clinical Commissioning Group

South Cheshire Clinical Commissioning Group

Vale Royal Clinical Commissioning Group

Healthwatch Cheshire East

Cheshire East Council
Health and Wellbeing Scrutiny Committee

Glossary

Term	Explanation
A+E	Accident and Emergency
ACS	Acute Coronary Syndrome
AQ	Advancing Quality
AMi	Acute Myocardial Infarction
CARE	Clinical Audit Research and Effective
CCG	Clinical Commissioning Group
CFH	Connecting for Health
CHKS	Caspe Healthcare Knowledge Systems
CDiff	Clostridium Difficile
CQC	Care Quality Commission
CNST	Clinical Negligence Scheme for Trusts
CPR	Cardiopulmonary resuscitation
CQUIN	Commissioning for Quality And Innovation
DNACPR	Do Not Attempt Cardiopulmonary Resuscitation
DVT	Deep Vein Thrombosis
ECT	East Cheshire NHS Trust
ECNHST	East Cheshire NHS Trust
ED	Emergency Department
GP OOH	GP Out of Hours Service
FFT	Friends and Family Test
FT	Foundation Trust
GP	General Practitioner
HITS	Home Intravenous Therapy Team

IV	Intravenous
LINkS	Local Involvement Networks
L+D	Learning and Development
MDGH	Macclesfield District General Hospital
MDT	Multi-Disciplinary Team
MRSA	Methicillin-Resistant Staphylococcus Aureus
MINAP	Myocardial Ischaemia National Audit Project
NHS	National Health Service
NHSLA	NHS Litigation Authority
NSF	National Service Framework
NHSP	Newborn Hearing Screening Programme
NICE	National Institute of Clinical Excellence
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
OT	Occupational Therapist
PE	Pulmonary Embolism
PBR	Payment by Results
PROMS	Patient-Reported Outcome Measures
QIPP	Quality, Innovation, Productivity and Prevention
RCA	Root Cause Analysis
SHMI	Summary Hospital-level Mortality Indicator
SUS	Secondary Uses Service
SQS	Safety, Quality Standards
TARN	Trauma Audit and Research Networks
TDA	Trust Development Authority
UTI	Urinary Tract Infection
VTE	Venous Thromboembolism
VV	Varicose veins

If you would like more information about any of the details in this document, please contact us at:

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Quality Account
2013/14

Designed and printed by East Cheshire NHS Trust

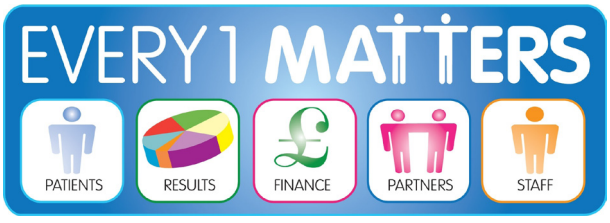
Mid Cheshire Hospitals NHS
NHS Foundation Trust

Quality Account 2013/14

Quality and Safety at Heart

Mid Cheshire Hospitals NHS Foundation Trust
Quality Account 2013/14

"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

Hello and welcome, I am pleased to present our fifth published Quality Account for the period of April 2013 to March 2014.

I am sure you will agree that the report demonstrates that 2013/14 has been a period of continued improvement for the Trust, with many significant achievements in quality, safety and experience. Although, it has not been without its challenges and disappointments.

The Francis report published in February 2013 rightly brought about significant learning to the forefront for the NHS. The Trust viewed this as not the end of a public enquiry but the beginning of something much larger, a conversation for both the public and the professionals to take part in as owners and guardians of our hospitals services. Extensive listening events and conversations with staff and public were held during 2013 and what we heard during these conversations helped shape and focused our new Quality Improvement Strategy for 2014 to 2016.

This Quality Account demonstrates delivery beyond the expected national standards and improved quality, safety and experience for our patients and staff through delivery of the final year of our current 5 year Quality Strategy, 10 out of Ten.

Alongside this we have delivered additional quality improvements such as reducing pressure ulcers, reducing readmissions and cancellations amongst others.

We value and seek extensive feedback from patients through a range of sources, such as national and local surveys, the Friends and Family test, NHS choices; and all show improvements in the care and service we offer whilst providing us with the valuable feedback which we will use to continue our improvement journey.

There have also been significant challenges during 2013/14; we continue to prioritise reducing our mortality rate and are confident we are taking all appropriate actions to do so. Over the last 2/3 years the Trust achieved exceptionally low rates of infection, however, sustaining this has been challenging during 2013/14. Whilst levels of infections remained low and we performed very well nationally in this area, we had more cdifficile and MRSA than in the previous year. As a result, significant work is underway to ensure we regain our position as one of the top performers in the country.

Finally, I want to take this opportunity to thank our staff, they do an incredible job, sometimes in very difficult circumstances and always with the patient in mind. 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 am pleased to confirm that the Board of Directors has reviewed the 2013/14 Quality Account and confirm that it is a true and fair reflection of our performance.

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 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
tracy.bullock@mcht.nhs.uk

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

Priorities for improvement in 2014/15

During 2013/14, the Trust conducted an extensive engagement programme based on the key themes from the Francis Inquiry into the failings at Mid Staffordshire Hospital NHS Foundation Trust. This consultation exercise has informed MCHFT's new Quality and Safety Improvement strategy that will run from 2014 to 2016 inclusively.

The overall purpose of the new strategy is to support the delivery of the organisation's vision and mission:

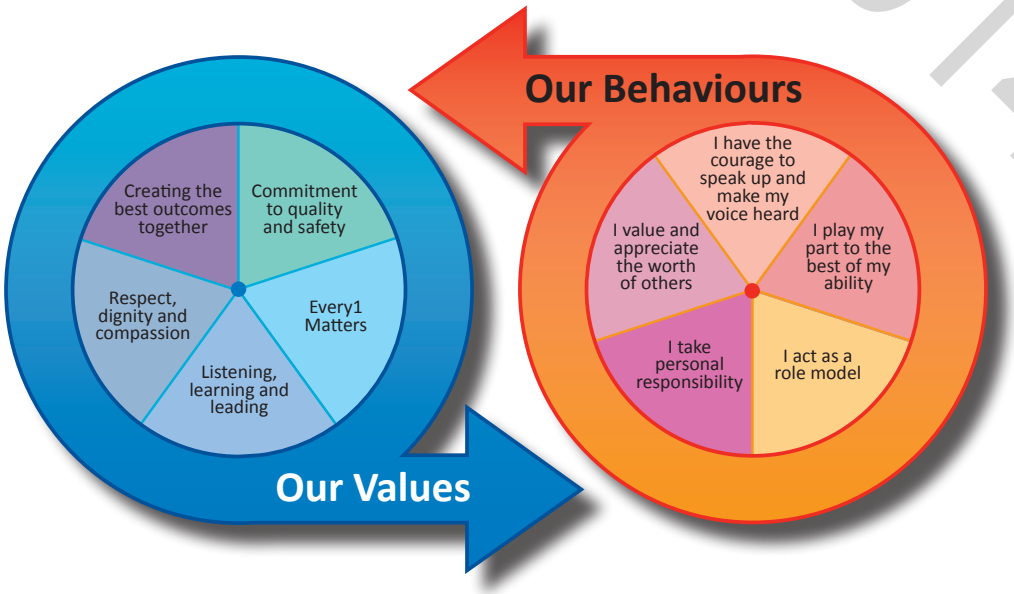
"To Deliver Excellence in Healthcare through Innovation and Collaboration"

The Trust will be a provider that:

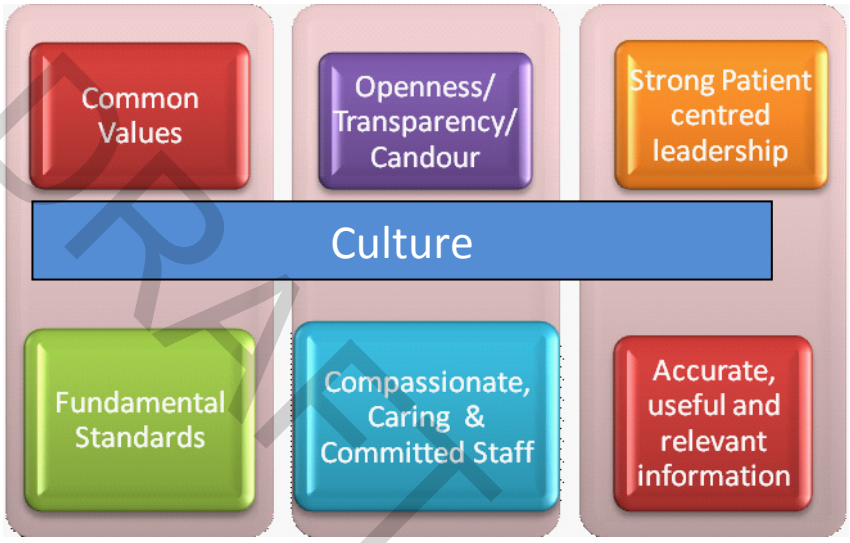
- Delivers high quality, safe, cost-effective and sustainable healthcare services
- Provides a working environment that is underpinned by values and behaviours
- Is committed to patient-centred care
- Treats patients and staff with dignity and respect.

The strategy links closely with other key strategies such as the Clinical Services strategy and the Organisational Development strategy. It is when these work hand in hand that collectively the Trust can deliver the vision and mission of the organisation.

The values and behaviours developed with the Trust's staff underpin the delivery and success of the strategy. The Trust recruits and nurtures its staff so that these values and behaviours are observed at all times from all staff.



The strategy is based on what the people of Vale Royal, South Cheshire and the surrounding areas told the Trust they wanted from their hospitals in addition to national priorities and contributions from Governors and staff. The public told the Trust they wanted a strong focus on:



Communication

Dementia

Food & drink

Appropriate nurse staffing levels

In addition, staff, Governors and other stakeholders told the Trust they wanted the following areas to be included:

- Improving staffing levels
- Reducing cancelled appointments
- Improving paperwork and reducing duplication
- Reducing pressure ulcers.

The subsequent development of the Quality and Safety Improvement strategy has allowed the Trust to focus its key areas of improvement under the three domains of quality as determined by the Health and Social Care Act 2012. The strategy is ambitious but achievable.

Patient Experience

- Improving nutrition and hydration for patients
  "The Trust will continue to provide an environment that promotes healthy nutrition and is tailored to individual patient need."

- Supporting patients with dementia and their carers
  "The Trust will support patients who have concerns about their memory and will work with patients who have dementia and their carers to promote a positive experience whilst in hospital."

- Improving communication
  "The Trust will ensure that staff improve their understanding of patients and their care needs. The Trust will use this knowledge to communicate effectively with patients and involve them in their care."

Clinical Effectiveness

- Improving documentation and reducing duplication
  "The Trust will review and improve its paper documentation so that it is relevant, adds value to care and avoids duplication."

- Reducing cancellations
  "The Trust will reduce the number of hospital initiated outpatient clinic cancellations by 20% by 2016."

- Improving staffing levels and skill mix
  "The Trust will ensure it has levels of staffing and skill mix that meet the needs of its patients."

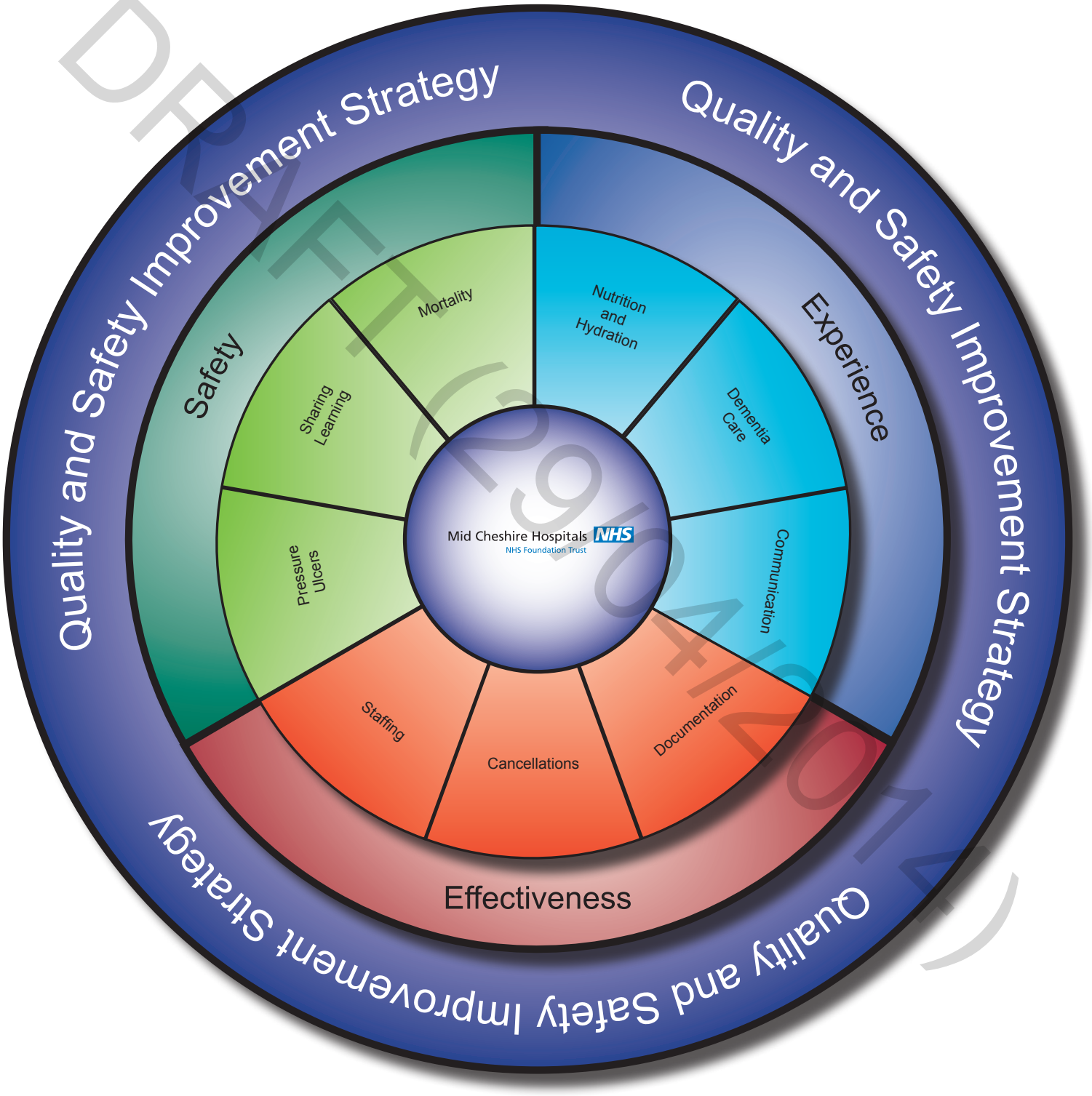
Patient Safety

- Reducing pressure ulcers
  "The Trust will eliminate avoidable hospital acquired pressure ulcers by 2016."

- Sharing learning from feedback and incidents
  "All clinical staff will work together to respond to feedback from patients and carers and to learn from incidents that occur. The Trust will then ensure it responds to such learning and embed this into practice."

- Reducing mortality rates
  "The Trust will reduce its mortality rates each quarter so that they reach expected levels as measured by the Summary Hospital-Level Mortality Indicator (SHMI)."

The logo for the Trust's Quality and Safety Improvement strategy is shown below. This will be used to promote Trust-wide awareness of the strategy and has replaced the 10 out of Ten strategy on which the Trust has focussed its quality priorities for the past five years. Progress against the final year (2013/14) of the 10 out of Ten targets is described in Part 3 of this report.



Monitoring and reporting of the Quality and Safety Improvement Strategy

Each element of the strategy will have a responsible lead who will report progress bi monthly to the Quality, Effectiveness and Safety Committee (QuESt).

QuESt is responsible for providing information and assurances to the Board of Directors that the Trust is safely managing the quality of patient care, the effectiveness of quality interventions and patient safety. These elements of the strategy will have objectives that will require both qualitative and quantitative evidence of achievement.

QuESt will review the key areas of improvement at its meetings to ensure progress is being made in relation to the aims and keys areas for achievement.

In addition, progress of the key areas of improvement will also be reported in the annual Quality Account. This report will be made available to the public on the Trust's website and NHS Choices and will also be included in the Trust's Annual Report and Accounts.

Statements of assurance from the Board

Review of services

During 2013/14 the Trust provided and / or sub-contracted 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 2013/14 represents 100% of the total income generated from the provision of NHS services by the Trust for 2013/14.

Feedback from patients

National Patient Surveys

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 2013/2014

Between October 2013 and January 2014, a questionnaire was sent to 850 adult inpatients who had been admitted to Leighton Hospital.

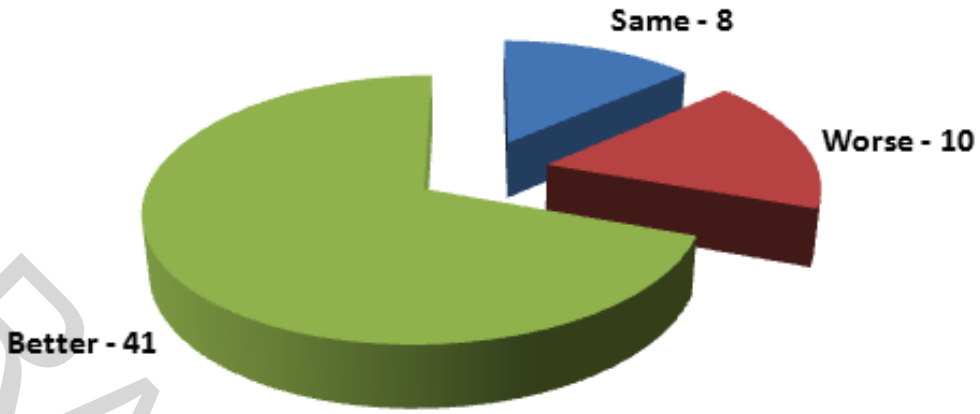
Responses were received from 442 patients which equates to a response rate of 54% of completed eligible returns.

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

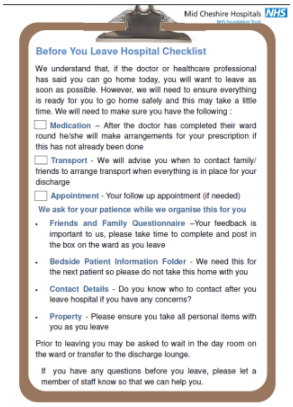
- The emergency department
- Waiting to get a bed on the ward
- The hospital and the ward
- Doctors
- Nurses
- Care and treatment
- Leaving hospital
- Overall views and experiences.

The Trust's overall score has improved by 2.2% since the last survey undertaken in 2012.

Chart 1: Comparison of responses from 2013 national inpatient survey (when compared with results from the 2012 survey)



Areas identified for improvement


Mid Cheshire Hospitals NHS

Before You Leave Hospital Checklist

We understand that, if the doctor or healthcare professional has said you can go home today, you will want to leave as soon as possible. However, we will need to ensure everything is ready for you to go home safely and this may take a little time. We will need to make sure you have the following :

- Medication – After the doctor has completed their ward round he/she will make arrangements for your prescription if this has not already been done
- Transport - We will advise you when to contact family/ friends to arrange transport when everything is in place for your discharge
- Appointment - Your follow up appointment (if needed)

We ask for your patience while we organise this for you

- Friends and Family Questionnaire –Your feedback is important to us, please take time to complete and post in the box on the ward as you leave
- Bedside Patient Information Folder - We need this for the next patient so please do not take this home with you
- Contact Details - Do you know who to contact after you leave hospital if you have any concerns?
- Property - Please ensure you take all personal items with you as you leave

Prior to leaving you may be asked to wait in the day room on the ward or transfer to the discharge lounge.

If you have any questions before you leave, please let a member of staff know so that we can help you.

- **Communication** - a “before you leave hospital checklist” has been developed to explain to patients what needs to happen to ensure they go home safely.

- **Noise at night** - a ‘quiet protocol’ is being developed to reduce unnecessary noise at night. A good night’s sleep is important for every patients’ recovery. The ‘quiet protocol’ will be active from 11pm to 6am every night where staff will work hard to keep noise levels to a minimum.

Patients also commented on what was particularly good about their care:

> A very good atmosphere on the ward created by the medical staff, who were caring and professional and clearly loved working as a team on 'their' ward.

> I was in hospital for one day and night and was impressed by care administered to all patients on the ward. The food was delicious and added to a patients’ recovery.

> I would like to say that the healthcare assistants were very helpful and kind to me. Also, I would like to say that all the staff were superb.

> The care received during my hospital visit was excellent from Accident and Emergency through to my admittance to a ward. There was nothing to fault during my whole stay, the food and choice was also excellent.

> The surgeon was pleasant, informative and spoke to me as an equal. I knew she was very busy but she didn’t rush me at all.

National Maternity Survey 2013

During 2013, a questionnaire was sent to 300 women who had experienced the Trust's maternity services. The Trust achieved a 51% response rate, with 152 completed surveys returned.

The Trust scored better than other Trusts for one question: Being given appropriate advice and support at the start of labour.

The Trust also scored better than other Trusts on one section of questions in the survey: Labour and Birth.

The Trust performed about the same as other Trusts in all other categories and questions.

Women also commented on what was particularly good about their care:

> I was very pleased with all of the care I had throughout all of my pregnancies and deliveries in this area. I always felt safe and happy with how I was treated. Thanks.

> The new maternity unit with pools/balls/bean bags was excellent. Once in room (after assessment) the care from my midwives was outstanding.

> Both my community midwife and the midwife whilst I was in labour were exceptional. I did come into contact with other midwives but my main midwife was fabulous.

In addition to the survey results, a significant programme of work is in place to improve breast feeding initiation rates. This has already delivered an increased rate and the maternity unit has also achieved Level Two Baby Friendly accreditation.

Local patient surveys

The Trust has an annual patient and public involvement programme which includes a variety of methods for patient involvement, such as local patient surveys.

In 2013/14, 41 local surveys were undertaken. Once feedback has been collated from these surveys, action plans are developed to address any issues identified from the results. These action plans are then monitored by the Action Group for Patient Experience.

A sample of the results from randomly selected surveys are highlighted below:

Early Pregnancy Assessment Unit

43 responses were received from a sample size of 97.

The results showed that:

- 91% said the waiting time was appropriate
- 100% said they were told what to expect at the appointment
- 97% said the care they received in the scan room was delivered in a sensitive manner
- 100% said that the sonographer explained things in a way they could understand
- 97% were treated with privacy and dignity
- 100% rated the care as very good or excellent.

Key issues included:

- Patients felt signage could be clearer
- GPs did not always make patients aware of the referral criteria
- Patients were not always advised to take a seat in the dayroom.

Changes implemented following the survey:

- Patients now receive a telephone call to talk about their referral and where the unit is situated
- GPs have received verbal explanations of the referral criteria
- A sign has been introduced to advise patients upon arrival to take a seat in the day room.

Pharmacy Survey

128 responses were received via a touch screen survey kiosk. The kiosk is an electronic, mobile device which allows patients and visitors to complete surveys online.

The results showed that:

- 94% of patients said pharmacy staff were approachable
- 95% of patients found the information included in their medication helpful
- 95% of patients said they were treated with privacy and dignity when they visited the pharmacy department.

Key issues included:

- Lack of signage to the pharmacy department
- Patients not always informed of any delays upon arrival to pharmacy
- Lack of privacy when patients were having conversations with the pharmacist in the waiting area.

Changes implemented following the survey:
- New signage has been installed for the pharmacy department from both outpatients and the main entrance
- Patients are advised of any delays as soon as they arrive in the pharmacy department
- A new counselling room has been made available for patients to have confidential conversations.

Infection Control Survey
57 responses were received from a sample size of 75.

The results showed that:
- 96% of patients said the environment of the ward was clean, fresh and pleasant
- 100% of patients said the showers were clean and tidy and always ready to use
- 97% of patients said the alcohol hand rubs were readily available
- 98% of patients said the overall appearance of the ward was tidy and uncluttered.

Key issues included:
- Infection control leaflets were not always available for patients and relatives
- Infection control posters were not displayed on all wards
- Hand washing wipes were not always offered to patients before and after meals.

Changes implemented following the survey:
- Leaflets are readily available on all wards and posters are displayed in all areas to raise the importance of infection control for visitors and patients
- Patient meals are now accompanied with single use hand wipes.

Friends and Family Test: Patient Element

The NHS Friends and Family Test is a nationwide initiative to gain feedback from patients about the care and treatment they receive in hospital. Patients are asked whether they would recommend NHS services to their friends and family if they needed similar care or treatment. This is believed to be an important indicator of the quality of care they have received.

The Friends and Family Test is completed on the adult wards, the emergency department, assessment areas and maternity services. Every patient that receives treatment in those areas can give feedback about the quality of care they have received.

Responses are anonymous and patients are asked to complete a survey card which can be handed to a member of staff or posted into a confidential post box. Patients attending the emergency department can choose to complete the survey on a touch screen kiosk, which has a multi-language option.

In October 2013, the Friends and Family Test commenced in Maternity using SMS text messages at four points across the care pathway: antenatal, labour ward, postnatal ward and postnatal community.

How are the results calculated?
The results of the Friends and Family Test are calculated and reported in a consistent and transparent way using the net promoter score (NPS). The overall result can range from 0 to

100 and is calculated by the number of respondents who are extremely likely to recommend the service minus those who are neither likely, unlikely or extremely unlikely to recommend the service.

Patients are invited to comment on the reason for the answer they give. Comments have included:

> My reason is the total and efficient willingness and care given to me when I needed it plus their friendliness and interest and I mean medical, household and any other staff - my sincere thanks to all.

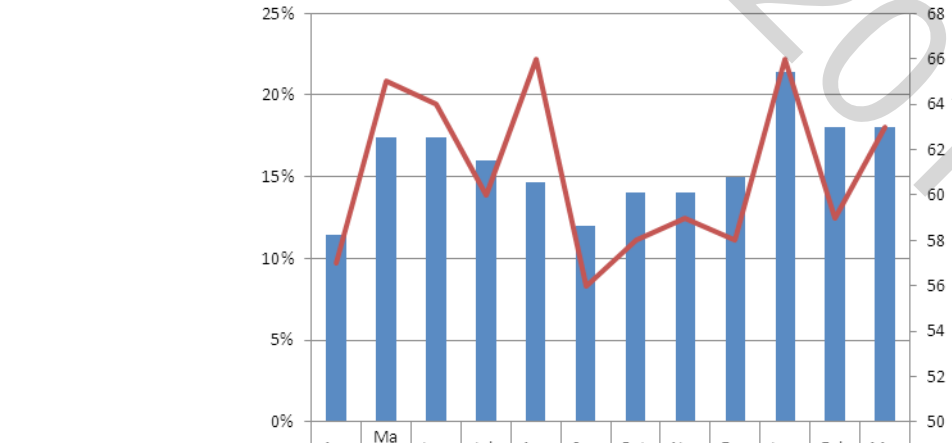
> From the first day the staff have been attentive, caring, and I have not waited for the toilet or medication. My only feedback is that beds should be ready for patient on day of operation and when you are being discharged, they should not be rushed out. All in all fantastic care.

> I felt that I was given a level of care and respect that made me feel I wasn't just 'a number' on a very busy and multi-disciplined surgical ward. The nurses who cared for me demonstrated a good knowledge of my procedure and always encouraged me to ask for any additional help or support if I required it.

Trust Results

The following charts show the percentage response rate for patients and the Trust is delighted that the required national target specified as part of the CQUIN programme has been achieved. The charts also show the net promoter score results.

Chart 2: Friends and Family Test results from the Emergency Department (A&E) and the Assessment Areas

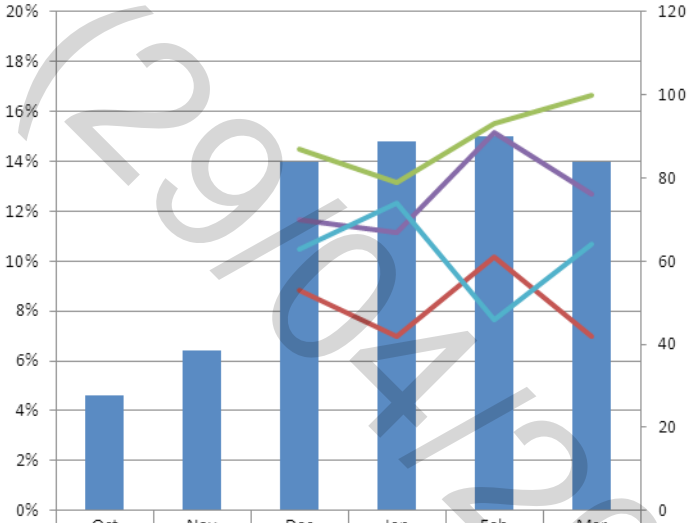


	Apr -13	May-13	Jun-13	Jul-13	Aug -13	Sep -13	Oct-13	Nov -13	Dec -13	Jan-14	Feb -14	Mar -14
F&FT A&E & Assessment Areas Response Rate	11%	17%	17%	16%	15%	12%	14%	14%	15%	21%	18%	18%
Net Promoter Score	57	65	64	60	66	56	58	59	58	66	59	63

Chart 3: Friends and Family test results from the inpatient wards

	Apr -13	May-13	Jun-13	Jul-13	Aug -13	Sep -13	Oct-13	Nov -13	Dec -13	Jan-14	Feb -14	Mar -14
F&FT Inpatients	35%	31%	33%	33%	30%	26%	35%	42%	33%	39%	47%	42%
Net Promoter Score	69	75	75	76	71	68	77	74	75	68	76	73

Chart 4: Friends and Family test results from maternity services



	Oct	Nov	Dec	Jan	Feb	Mar
F&FT Response Rate	5%	6%	14%	15%	15%	14%
Net Promoter Score - Ante Natal			53	42	61	42
Net Promoter Score - Labour Ward			87	79	93	100
Net Promoter Score - Maternity Ward			70	67	91	76
Net Promoter Score - Community			63	74	46	64

Posters are displayed in the emergency department, assessment areas, the wards and maternity unit to promote the score achieved and to highlight patient comments.

What could be improved?

The Trust is carefully monitoring comments from patients if they indicate they are unlikely to recommend our services to understand where improvements can be made. Nearly 10,000 responses have been received to the Friends and Family test, with 94% of patients indicating that they are likely or extremely likely to recommend services or treatment to their family or friends.

Examples of actions taken so far have been a change in the hospital menu to include soup as a lunch time option, reducing unnecessary noise at night and offering ear plugs to help patients sleep.

The Friends and Family results are published on the NHS Choices website:
www.nhs.uk/Services/hospitals/Overview/DefaultView.aspx?id=505
www.nhs.uk/Services/hospitals/Services/Service/DefaultView.aspx?id=208744

NHS Choices

Patients can comment about their experience on the NHS Choices website. There were a total of 130 new postings on the NHS Choices website in 2013/14. Proportionally, the Trust receives more postings than most other Acute hospitals in the country. Leighton Hospital is currently achieving a star rating of 4.5 stars out of a maximum rating of 5 stars and the Victoria Infirmary in Northwich is achieving the maximum 5 stars.

Leighton Hospital

Victoria Infirmary

The Trust displays examples of postings on notice boards and takes action following any suggestions for improvement.

Examples of comments posted on NHS Choices include:

> Staff in the Macmillan Unit were polite, friendly, helpful, caring and they knew exactly what I needed.

> I gave birth to a lovely baby boy thanks to a lovely midwife and doctor.

> The eye care clinic is highly professional and I would certainly recommend the unit to anyone who needs to be treated here.

> Staff were first class, the treatment and attention I received was outstanding at the minor injuries unit at Victoria Infirmary Northwich.

> The care given to me on ward 12 was fantastic. Thank you all very much.

> The team who dealt with me in the Urology department were first class professional; they treated me with dignity and patience.

> I have been and continue to be impressed by the care which I received in the Dermatology clinic.

> All the staff were fantastic and I am seriously considering a change in career to join them.

Other patient and public involvement programme activities

Patient register group meetings
These meetings are held at local libraries. 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 seek views from members. This year, the meetings covered many topics, including presentations about the new theatre rebuild project, the enhanced recovery programme and the neonatal unit project.

Readers' panel
The panel has increased its membership by 17 over the past year and now has 77 members. The panel has reviewed a total of 17 leaflets including information about eye care, attending the fertility clinic and the paediatric audiology service.

The panel has submitted many suggestions including grammatical changes and diagram or picture changes. Overall, feedback about the information reviewed has been that the leaflets are enlightening and will be very helpful to patients.

Patient information committee
Membership of the committee has recently been expanded and now includes three patient representatives, staff from orthopaedic outpatients, the emergency department, the treatment centre, information governance, the Macmillan unit, pharmacy and the maternity unit. In 2013, the committee reviewed and approved 23 local patient information leaflets.

In 2012, the Trust introduced a patient information bedside folder. The folder has subsequently been revised and includes information in relation to visiting times, staff uniforms, discharge information, a sample of the new inpatient menu and a 'your views count' section. The folder is also available in Polish.

All wards have been restocked with the updated version of the folder, along with the maternity and neonatal bedside folders which have also been recently updated.

Over the last 12 months the Trust has increased the number of leaflets available in easy read version, including caring for your plaster cast and having a blood test.

Patient stories
The Board of Directors' meetings continue to start with a patient story which is presented as a video clip, audio account or letter. The story relays the very real and personal experiences of an individual who has been a patient or carer at the Trust. A theme has emerged this year, highlighting the value of ensuring the carer's voice is heard. The patient's story is always shared with the relevant team, ward or department and examples are included in customer care training.

The stories are a combination of positive and negative experiences which ensure that the Trust's agenda is grounded in the value of listening to and learning from the experience of patients and carers.

Planning the delivery of services
Whether through direct consultation or through the provision of information the Trust continued to directly involve service users (or their representatives) in planning both the provision of new services and changes to existing services.

The Ophthalmology department have set up a support group for patients who have glaucoma and their friends / family. Feedback from attendees to date has been excellent and has allowed the Trust to discuss plans to undertake diagnostic tests at glaucoma clinics by senior ophthalmic technicians, which will improve the quality of tests being undertaken and reduce appointment times.

Similar support group meetings have taken place with people who have had a stroke and people who have head and neck cancer to discuss how services can be redesigned to improve experiences of patients.

During 2013/14, the Trust has been an active member of the local area partnership which has resulted in links being developed to support health and wellbeing of the local community. The Trust has also continued to work with its youth committee to increase the involvement of young people across the Trust and ensure their feedback is included in service redesign.

Customer care team
The role of the customer care team is to provide on-the-spot advice, information and support for patients and relatives if they wish to raise concerns. The team can also support patients when dealing with issues about NHS care and provide advice and information about local health services. The customer care team aims to respond to patients' concerns and issues on time and effectively, irrespective of whether they have been raised as an informal concern or a formal complaint. The majority of concerns can usually be resolved swiftly by staff who care for patients. However, sometimes patients or a family member may want to talk to someone who is not involved in their care and the customer care team are then able to help.

A new 'Tell us what you think' poster has been developed and displayed across the Trust. It provides information on how to contact the team and reinterates that the Trust welcomes feedback in relation to concerns, complaints, advice, information, suggestions and compliments.

Compliments

2,112 formal compliments were received by the Trust during 2013/14 which expressed thanks from patients and families about the care received. This is a significant increase compared with previous years. All compliments are shared with the relevant teams who are mentioned.

Table 1: Overview of compliments received by the Trust

	2011/12	2012/13	2013/14
Number of compliments received	495	644	2,112

Review of Complaints

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.

It is recognised that the NHS landscape, in terms of legal and statutory duties in handling complaints, is undergoing a fundamental change of culture in response to the Francis Report (2013) and the Ann Clwyd and Professor Hart review of complaint handling within the NHS (2013). As part of the Trust's commitment to continuous improvement, the complaints policy is being reviewed to ensure that the recommendations identified are incorporated into the effective and compassionate management of complaints.

The Trust is committed to providing an accessible, fair and efficient service for patients and service users who wish to express their concerns or make a complaint with regard to the care, treatment or services provided by the Trust.

The Trust recognises the importance of having a robust and flexible process for the management of complaints to ensure complainants receive a timely and person-centred response to the issues they have raised.

The complaints review panel is chaired by a Non Executive Director and has membership which includes the Director of Nursing, a Governor and Patient Representative. The panel reviews individual cases of closed complaints and follows best practice as recommended by the Patient's Association in monitoring progress against action plans and undertaking detailed reviews.

A poster has been introduced and shared with staff to illustrate improvements that have been made as a result of feedback from patients or their carers. An example is included overleaf.

The following table shows the number of complaints received by the Trust and referrals to the Ombudsman over the past three years.

Table 2: Overview of complaints received by the Trust

	2011/12	2012/13	2013/14
Number of complaints received	192	199	228
Number of requests for review by Ombudsman	10	5	3
Number accepted for review by Ombudsman	3	4	1
Number upheld/partially upheld by Ombudsman	1	2	2

Proportionally, the Trust receives fewer complaints than in England and in the North West, and is in the upper quartile in terms of this performance.

Learning disability access

Healthcare for All (DH 2008) identifies six criteria for meeting the needs of people with a learning disability which should be met by all NHS Foundation Trusts. The Trust is pleased to declare that it meets all six criteria as described below.

- *Does the NHS Foundation Trust have a mechanism in place to identify and flag patients with learning disabilities and protocols that ensure pathways of care are reasonably adjusted to meet the health needs of these patients?*

The Trust has a flagging system in place for people with a learning disability coming into the Trust. Patients can then be identified as needing specialist support at the earliest opportunity. The list is kept updated through collaboration with the Trust's community colleagues. There is also a system to flag patients who have a specialist care plan in place which highlights individual needs and documents reasonable adjustments that will need to be made for this person. A reasonable adjustment care plan/risk assessment is also available for staff to use, which is particularly helpful in a pre-operative meeting.

- *Does the NHS Foundation Trust provide readily available and comprehensible information to patients with learning disabilities about the following criteria: Treatment options, complaints procedures and appointments?*

A great deal of work has been done at the Trust in respect of easy read literature. The Trust has its own picture pathways in place which uses service users from a local drama group (all with a learning disability) taking part in the process. This work is ongoing and staff are currently working on the emergency department pathway. Trust staff have worked with breast screening to arrange for easy read appointment letters to be sent out to appropriate patients and also with pharmacy to devise easy read medication information leaflets.

- *Does the NHS Foundation Trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities?*

The Trust has a Dignity Matron in post who works directly with parents and carers to support them whilst their relatives are in hospital. This may include arranging open visiting, staying with the patient and obtaining meals from the hospital. Support also includes emotional support and working collaboratively to get the best outcomes for both patient and carer. Home visits are undertaken and reasonable adjustments discussed with carers to ensure the admission to hospital goes as smoothly as possible.

- *Does the NHS Foundation Trust have protocols in place to routinely include training on providing healthcare to patients with learning disabilities for all staff?*

Awareness training forms part of the three-day Healthcare Assistant Development Programme. The Trust has also introduced Autism awareness as part of the Trust's training schedule. Adult Safeguarding training is now mandatory, includes case studies, covers the five principles of the Mental Capacity Act (MCA) and best interest decision making. Ad hoc learning disability training takes place on a regular basis and training and education is a standing agenda item for discussion at the learning disability development group. There are also staff electronic prompts and guidelines on the Trust's intranet advising staff on how to

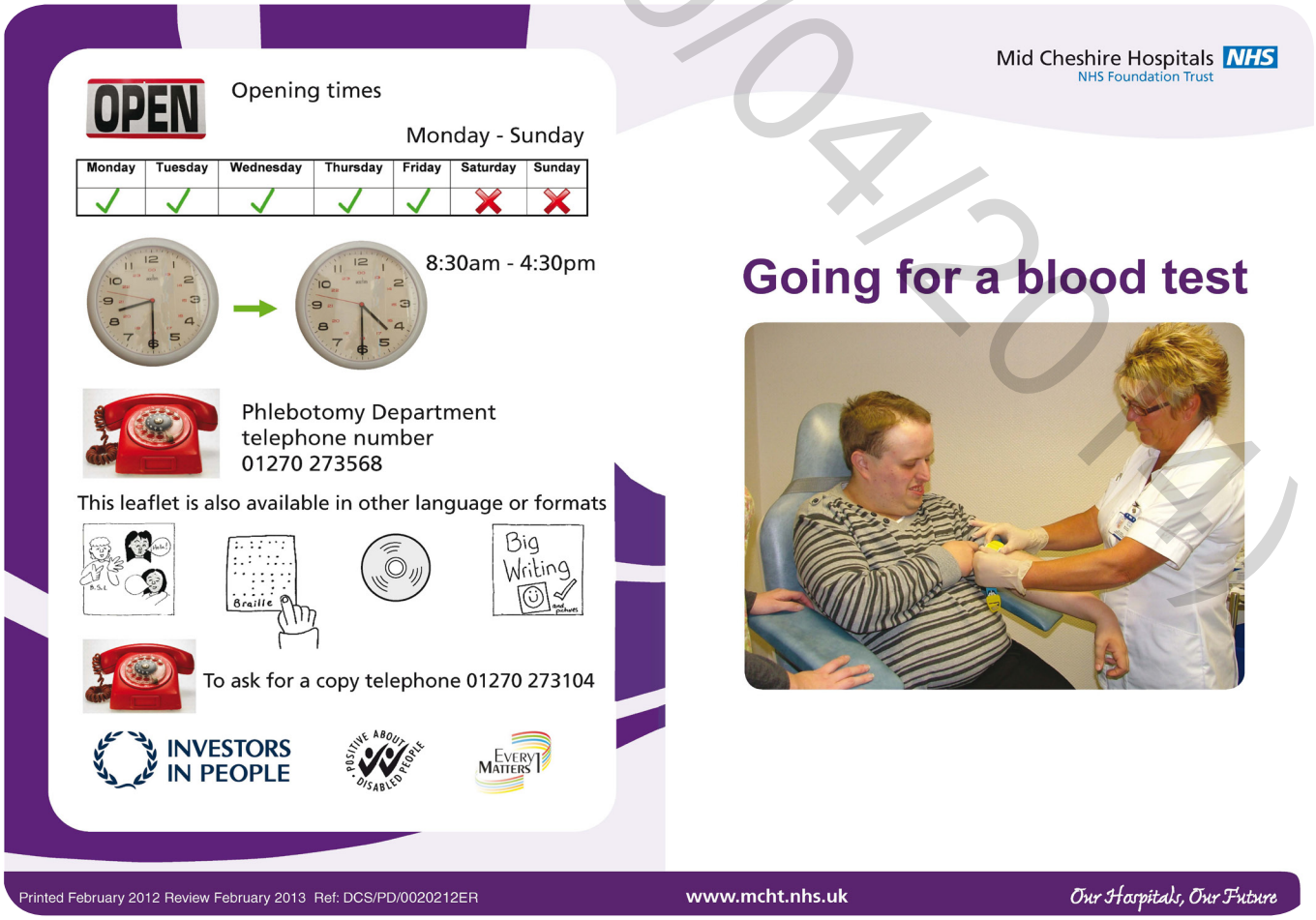
best manage patients in hospital with a learning disability.

- *Does the NHS Foundation Trust have protocols in place to encourage representation of people with learning disabilities and their family carers?*

The Trust has a learning disability development group that has carers as part of the membership. Service users and carers are utilised in the staff training programme and staff actively seek feedback from patients and carers from their stay in hospital. The Trust asked service users what particular investigations worried them most in hospital, and these were the first picture pathways that were undertaken. The Trust is also in the final stages of building its own Changing Places facility (modified toilet and changing facilities) in the hospital, and this has been undertaken through collaboration with patients and carers.

- *Does the NHS Foundation Trust have protocols in place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public boards?*

The Trust audits the use of hospital passports for people with a learning disability and has also audited the use of the MCA and 'do not resuscitate' orders for patients. These will be repeated this year as part of the safeguarding audit programme. Staff are also working collaboratively with patient safety and the community learning disability teams to investigate all patients who die in the hospital who have a learning disability to share good practice and learn lessons.



Participation in clinical audits and research

Clinical audit evaluates the quality of care provided against evidence-based standards and is a key component of clinical governance and quality improvement. The Trust produces an annual forward plan for clinical audit which incorporates both national and local projects. Progress against the forward plan is reviewed by the clinical audit committee on a quarterly basis.

National clinical audits

During 2013/14, 32 national clinical audits and two national confidential enquiries covered NHS services that the Trust provides.

During the same period, the Trust participated in 84% of the national clinical audits and 100% of the national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the Trust was eligible for and actually participated in during 2013/14 can be seen in Tables 3 and 4. These tables also show the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Table 3: National clinical audit participation 2013/14

National Clinical Audit / Programme	Participation	% Data Submission
Adult critical care (Case Mix Programme – ICNARC CMP)	Yes	100%
Emergency Use of Oxygen (British Thoracic Society)	Yes	100%
National Emergency Laparotomy Audit (NELA)	Yes	Data collection in progress
National Joint Registry (NJR)	Yes	98% consent
Paracetamol Overdose (care provided in emergency departments – CEM)	Yes	Data collection in progress
Severe Sepsis and Septic Shock (care provided in emergency departments – CEM)	Yes	Data collection in progress
Severe trauma (Trauma Audit & Research Network, TARN)	Yes	Currently 70%
Bowel cancer (NBOCAP)	Yes	88%
Head and neck oncology (DAHNO)	Yes	100%
Lung cancer (NLCA)	Yes	95%
Oesophago-gastric cancer (NAOGC)	Yes	80%
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Yes	100%
National Heart Failure (HF)	Yes	46%
National Diabetes Inpatient Audit (NADIA)	Yes	100%
Diabetes (Paediatric) (NPDA)	Yes	100%

National Clinical Audit / Programme	Participation	% Data Submission
Inflammatory bowel disease (IBD)	Yes	Registered late 17 cases*
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	Yes	Data collection in progress
Rheumatoid and early inflammatory arthritis	Yes	Data collection in progress
FFFAP: National Hip Fracture Database	Yes	95% (2012/13)
Sentinel Stroke National Audit Programme (SSNAP)	Yes	100%
Elective surgery (National PROMs Programme)	Yes	82%
Child health clinical outcome review programme (CHR-UK)	Yes	100%
Epilepsy 12 audit (Childhood Epilepsy)	Yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Yes	100%
Moderate or severe asthma in children (care provided in emergency departments – CEM)	Yes	Data collection in progress
Neonatal intensive and special care (NNAP)	Yes	100%
National Comparative Audit of Blood Transfusion programme: Patient Information and Consent	Yes	Data collection in progress
NCEPOD Lower Limb Amputation	Yes	100%
NCEPOD Tracheostomy Care Study	Yes	100%

* Registered for the project in the last submission month

Table 4: National clinical audit non-participation 2013/14

National Clinical Audit / Programme	Participation	Reason
National Comparative Audit of Blood Transfusion programme: Use of Anti-D	No	Maternity Unit resource implications – preparing for NHSLA Level 3 assessment
National Audit of Seizures in Hospitals (NASH)	No	The Emergency Department saw no benefit from the first round audit
National Cardiac Arrest Audit (NCAA)	No	Nurse specialist resource implications
Diabetes (Adult) ND(A)	No	Consultant and data collection resource implications
Paediatric asthma	No	Consultant and data collection resource implications

The reports of 20 national clinical audits were reviewed by the Trust in 2013/14. Table 5 details the actions taken / to be taken to improve the quality of healthcare provided as a result of national clinical audits.

Table 5: National clinical audit participation 2013/14 – actions taken

National Clinical Audit / Programme	Actions taken / to be taken by the Trust
Adult critical care (Case Mix Programme – ICNARC CMP)	A formal review of unexpected deaths continues to take place within the Trust. There are plans in place to increase ITU capacity as part of new theatre build project.
Emergency Use of Oxygen (British Thoracic Society)	Continued guidance and education for doctors and nurses in relation to routine prescribing, recording and titration of oxygen is taking place following the introduction of new pre-printed prescription charts.
Severe trauma (Trauma Audit & Research Network, TARN)	Continuing improvements in times to CT scan and the number of patients being seen by a consultant, especially when the trauma team has been activated.
Bowel cancer (NBOCAP)	Continued education of ward nurses to optimise compliance with enhanced recovery pathways and reduce inpatient length of stay and outcomes. Further local understanding of data handling to improve data collection and submission.
Head and neck oncology (DAHNO)	Work is underway to define and agree submission routes/data capture in key fields and ensure the link between the Trust and Aintree Hospital allows improved representation of local data. Plans to agree a protocol for capturing pre-treatment. A pathway is under review to include pre-treatment speech and swallowing assessment.
Lung cancer (NLCA)	A business case has been supported by the Trust to increase investment in the clinical workforce that supports inpatient care in respiratory medicine.
Oesophago-gastric cancer (NAOGC)	Real time MDT data capture and ongoing work to improve data completeness is in progress. Exploration of video links to improve co-ordination with specialist MDT and further support for CNS is being taken forwards.
Acute coronary syndrome or Acute myocardial infarction (MINAP)	A quarterly review of local data compared to national results has been circulated to stakeholders which shows marked improvement in revascularisation rates and primary PCI following the implementation of the UHNS primary PCI pathway for STEMI.
National Heart Failure (HF)	A target of 70% has been set for 2014/15 for data submission. An inpatient heart failure pathway has been approved for implementation.
National Diabetes Inpatient Audit (NADIA)	New referral pathways have been implemented and changes made to the admission care bundle together with increased centralisation and specialist management of diabetes related admissions.
Diabetes (Paediatric) (NPDA)	There is evidence of high quality care in the Trust compared to peer, therefore current quality improvement strategies will be continued.

National Clinical Audit / Programme	Actions taken / to be taken by the Trust
FFFAP: National Hip Fracture Database	Work continues to recruit an ortho-geriatrian.
Sentinel Stroke National Audit Programme (SSNAP)	The stroke thrombolysis service has now increased its hours to Monday to Friday 09.00-21.00 with full support from the stroke specialist nurse.
Elective surgery (National PROMs Programme)	A PROMS (Patient Reported Outcome Measures) database has been created to enable a full case note review of patients who have reported a negative health impact post-surgery or no change to health post-surgery.
Child health clinical outcome review programme (CHR-UK)	A peer review mechanism is under consideration and an epilepsy passport is under development.
Epilepsy 12 audit (Childhood Epilepsy)	The paediatric epilepsy nurse specialist has been in post since March 2013. The next stage of audit has just commenced with the collection of patient/carer questionnaires.
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Evidence of a decreased stillbirth rate following implementation of standardised documentation and customised GROW charts, supplemented with improved training for recording and plotting of charts.
Neonatal intensive and special care (NNAP)	Issues with low admission temperatures and promptness of measurement have been addressed through local audit and improvements have been made. A system has been implemented to identify patients due for 2 year follow-up so data can be completed in clinic to address data collection issue.
NCEPOD Alcohol Related Liver Disease (Measuring the Units)	Alcohol liaison service on site at Leighton Hospital and a comprehensive assessment tool with associated care pathway is in place. Provision of a safe environment for patients undergoing detoxification with a protocol for managing violence and aggression in these patients is also in place.

Three College of Emergency Medicine reports for 2013/14 were delayed by the College due to online technical issues with data submission:

- Paracetamol Overdose (care provided in emergency departments – CEM)
- Severe Sepsis and Septic Shock (care provided in emergency departments – CEM)
- Moderate or severe asthma in children (care provided in emergency departments – CEM)

Local clinical audits

The reports of 161 local clinical audits were reviewed by the Trust in 2013/14. 32% of these audits were re-audits and 29% were related to successfully demonstrating compliance with the Level 3 requirements of the Clinical Negligence Scheme for Trusts (CNST) Maternity Clinical Risk Management Standards 2013/14.

Table 6 highlights some examples of the actions taken / to be taken by the Trust as a result of local clinical audits to improve the quality of healthcare provided.

Table 6: Examples of actions taken following local clinical audits

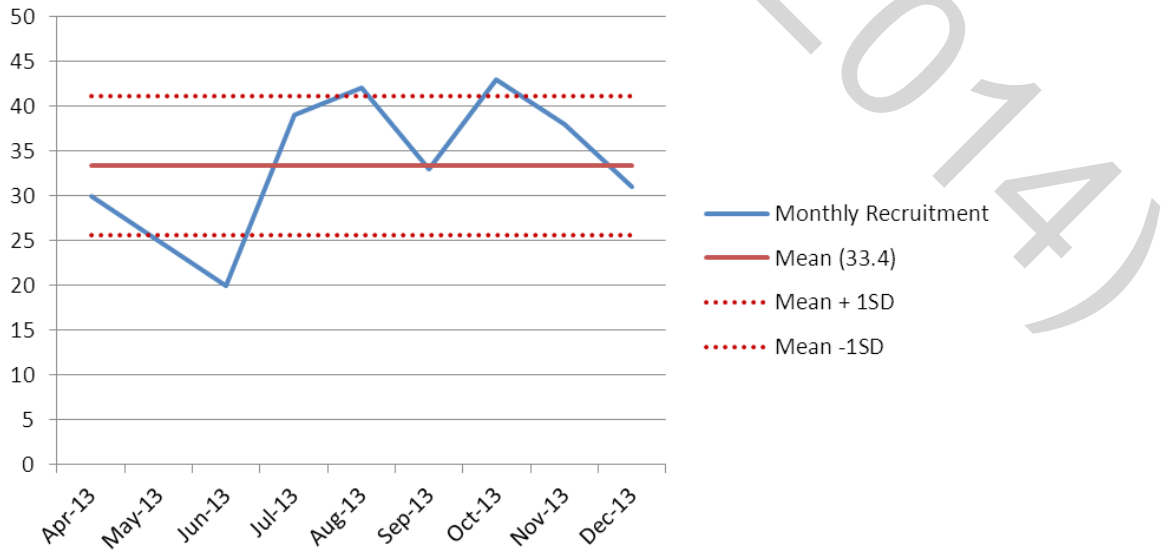
Local Audit	Actions taken / to be taken by the Trust
Audit of Obstetric Pre-Existing Diabetes	A diabetic care record for pregnant women with pre-existing diabetes has been implemented. Patient information leaflets have been developed in conjunction with the diabetes team which have been included in updated clinical guidelines and staff awareness sessions.
Audit of Pre and Post Oncoplastic Breast Reconstruction	Cameras and consent forms are now available in all breast clinics and the cancer centre. The multi-disciplinary team has had training and are proficient in photography standards. A secure online database has been developed to store the data in line with governance requirements.
Re-Audit Of Management Of Upper GI Bleeding	A new integrated care pathway pro-forma incorporating NICE guidelines and Rockall scoring system for patients presenting with Upper GI bleeding has been implemented. This includes assessment and documentation of the pre-endoscopy Rockall score.
Audit of the Efficacy of Saebo Upper Limb Splints for use with Stroke Patients	Clinical criteria have been established for the suitability of Stroke patients who will benefit from Saebo Flex and Saebo Stretch splints as part of their rehabilitation. All static Physiotherapists and Occupational Therapists working on the Stroke Unit have been trained to assess, fit and use the technology in accordance with the criteria.

Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by the Trust between April 2013 and December 2013 that were recruited to participate in research approved by a research ethics committee was 304.

The chart below shows the numbers of patients recruited to clinical trials over the past nine months. There were, on average, 33 patients recruited each month.

Chart 5: Numbers of patients recruited to clinical trials



There are ten 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.

During 2013/14, the research department has increased the number of ways in which patients can be made aware of research in the hospital. This has been achieved through posters, leaflets, information on screens and via the 'research' tab on the Trust's internet site.

The Trust was involved in conducting 128 active clinical research studies during the reporting period including, but not limited to, the following areas:

- Cancer
- Cardiovascular
- Congenital Disorders
- Diabetes
- Eyes
- Ears
- 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

Commissioning for Quality & Innovation framework (CQUIN)

A proportion (2.5%) of the Trust's income in 2013/14 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 2013/14 and for the following 12 month period are available online at www.mcht.nhs.uk/quality.

The financial value of the 2013/14 CQUIN scheme for the Trust was £3,725,482.

For 2013/14, there were four national CQUIN goals which focussed on the NHS Safety Thermometer, Dementia Care, Venous thrombo embolism (VTE) and the Friends and Family Test.

The Trust and the Clinical Commissioning Groups (CCGs) for Vale Royal and South Cheshire agreed a further 16 goals. The North West Specialised Commissioning Group (SCG) negotiated two goals in relation to the neonatal services provided at the Trust.

Table 8 briefly describes the goals included in this year's CQUIN and the Trust's performance against each of the CQUIN goals. It can be seen that, of the 22 goals, the Trust has achieved, or has plans to achieve, all CQUIN goals apart from implementation of the Advancing Quality (AQ) care pathway for hip and knee replacement. Actions are in place to improve the Trust's position against this element of the CQUIN.

For the Advancing Quality goals (5 – 9), the Trust has anticipated the final results. The reporting period for the advancing quality programme does not close until August 2014.

Key for Table 7 (overleaf)

Achieved 

Off track but recoverable
(applies only to advancing quality CQUIN where data is delayed by 4 months) 

Not Achieved 

Table 7: CQUIN results for 2013/14

Goal	Goal Name	Description of Goal	Status
1	NHS Safety Thermometer	To collect data in relation to pressure ulcers, falls, urinary tract infection and VTE	✓
2	Dementia		
	Part 1: Assess and refer	The proportion of patients aged 75 and over to whom the case finding question is applied following emergency admission; the proportion of those identified as potentially having dementia who are appropriately assessed and the number referred on to GP services.	✓
	Part 2: Training	Named lead clinician for dementia and appropriate training for staff.	✓
	Part 3: Supporting carers	Ensuring carers feel supported.	✓
3	Venous Thrombo-embolism (VTE)		
	Part 1: Risk assessment	% of all adult inpatients who have had a VTE risk assessment on admission to hospital.	✓
	Part 2: Root cause analysis	The number of root cause analyses carried out on cases of hospital associated thrombosis.	✓
4	Friends and Family Test		
	Part 1: phased expansion	Roll out the friends and family test to maternity services.	✓
	Part 2: response rate and improvement	Increased response rate.	✓
	Part 3: improvement on staff survey results	Improved performance on the staff friends and family test.	✓
5	Advancing Quality (AQ): Acute Myocardial Infarction	Implement the AQ care pathway for Acute Myocardial Infarction	✓
6	Advancing Quality (AQ): Heart Failure	Implement the AQ care pathway for Heart Failure	☹
7	Advancing Quality (AQ): Hip and Knee Replacement	Implement the AQ care pathway for Hip and Knee Replacement	⊗
8	Advancing Quality (AQ): Pneumonia	Implement the AQ care pathway for Pneumonia	☹
9	Advancing Quality: Stroke	Implement the AQ care pathway for Stroke	☹
10	Co-ordinated electronic patient records (EPR)	Implement a rolling 5 year plan with involvement from the CCGs to put in place hospital electronic patient records.	✓

Goal	Goal Name	Description of Goal	Status
11	Alcohol assessment	Implementation of a systematic assessment of alcohol consumption, provision of support and communication with primary care on discharge.	✓
12	Readmissions	Work with Commissioners to implement an action plan to reduce readmissions within 30 days of discharge.	✓
13	Cancellations	Reduce cancellations for elective surgery and outpatients appointments.	✓
14	Patient/carer focus groups	Work with Commissioners and three patient focus groups to develop service specifications and quality dashboards.	
		Glaucoma	✓
		Head and Neck Cancer	✓
		Stroke	✓
15	Staff Engagement		
	Part 1: Care rounds	Implementation of care rounds.	✓
	Part 2: Staff focus groups	Undertake three staff focus groups (glaucoma, head and neck cancers and stroke) to inform service specification and quality dashboards.	
		Glaucoma	✓
		Head and Neck Cancer	✓
		Stroke	✓
	Part 3: Shared decision making in outpatient services	Measure and evaluate shared decision making in outpatients using the following services:	
		Cardiac rehabilitation	✓
		Women on the high risk antenatal pathway	✓
		Acne services	✓
16	Pressure ulcers:		
	Part 1: Training	Increase the number of eligible clinical staff in post who have attended training for pressure ulcer prevention, assessment and management.	✓

Goal	Goal Name	Description of Goal	Status
	Part 2: Assessment and management	Ensure all patients receive an initial risk assessment on admission and appropriate plan of care. Reduce the incidence of preventable hospital acquired pressure ulcers by 10%.	✓
17	Prognostication and advance care planning	Identify and support patients in their last 12 months of life.	✓
18	Medicines management	Reduce harm from omitted and delayed medicines in hospital.	✓
19	Improving inhaler technique	Measure and improve inhaler technique for inpatients.	✓
20	Advice line for GPs	Provide dedicated time where consultants are available on a regular basis to discuss patients' management with GPs.	✓
21	Retinopathy screening	Achieve 95% screening rate for retinopathy of prematurity (RoP).	✓
22	Total parenteral nutrition administration	Timely administration of total parenteral nutrition (TPN) for preterm infants.	✓

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 2013 to March 2014.

The Trust has participated in the following reviews or investigations by the CQC during April 2013 to March 2014. Where required, actions taken by the Trust to address the conclusions or requirements by the CQC are described.

1. An unannounced inspection took place on 10 October 2013, which reviewed management of medicines (outcome 9) following minor concerns raised during the annual unannounced inspection in December 2012. The Trust was found to have made significant improvement, but the CQC felt that action was needed in relation to medication omissions. The Trust has developed an action plan to address the issues raised which has been monitored via the Trust's governance processes. The action plan included weekly ward audits to assess medication omissions which were reviewed via the divisional governance committees and monitored at the Trust's operational integrated governance committee. The requested evidence has been submitted and the Trust was reinspected against the standard on 5 March 2014 and the updated outcome from the CQC is awaited.

2. In January 2014, the CQC/Ofsted conducted a review of safeguarding arrangements with health providers of children and services for looked after children, young people and their families who receive services within the boundaries of Cheshire West and Chester. The combined report for health providers within the locality was overall positive and a joint action plan is in place.

3. The Trust received its unannounced annual inspection on 4 and 5 February 2014. This was a dementia-themed inspection. The outcomes inspected were:

Outcome 4:	Care and welfare of people who use services
Outcome 6:	Cooperating with providers
Outcome 14:	Supporting workers
Outcome 16:	Assessing and monitoring the quality of service provision.

Routine evidence requested by the CQC in relation to their inspection has been submitted. The final report is due to be published in May 2014.

In line with the new inspection approach by the CQC, the quality and risk profiles have been replaced with a new model: the Intelligent Monitoring report. This report is based on a number of statistical tests which are used to determine the thresholds of "risk" and "elevated risk" for each indicator. This information is released on every provider Trust on a quarterly basis. All Trusts have been categorised into one of six summary bands, with Band 1 representing highest risk and Band 6 the lowest risk. The Trust has been assigned Band 2.

Data Quality Assurance

NHS and General Practitioner registration code validity

The Trust submitted records during 2013/14 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:

- 99.8% 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 2013/14 has increased from 72% to 78%.

There are 45 requirements in total within the toolkit. To be graded 'satisfactory', each requirement must be at level 2 or above. The Trust submission in 2013/14 showed 42 requirements are satisfactory, which is an increase from the 34 requirements submitted last year. However, the Trust remains graded as "not satisfactory" (status: red).

A Trust-wide information asset and sharing review was concluded in March 2014. The purpose of this review was to ascertain what information assets are held by the Trust and with whom information is being shared externally. This was a large piece of work which was linked to several requirements within the toolkit. Information Governance is continuing to conduct a project to renew all sharing agreements in place with third parties.

The Information Governance team supported the training of 3,781 staff, students and volunteers over the course of 2013/14 compared with 3,496 during the previous year. This is the first time the Trust has achieved the toolkit requirement of at least 95% of individuals being trained in information governance.

There have also been new policies and procedures developed within Information Governance during 2013/14, including a social media policy.

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

In 2012/13, the Trust was one of the top performing Trusts in the payment by results clinical coding audit undertaken by the Audit Commission. This meant that the Trust did not require an external audit during 2013/14. However, an internal audit was undertaken and the error rates reported for diagnoses and treatment coding (clinical coding) were:

- Primary diagnoses incorrect: 9.5%
- Secondary diagnosis incorrect: 6.10%
- Primary procedures incorrect: 6.4%
- Secondary procedures incorrect: 8.2%

The Trust remains very pleased with these results. Please note that 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 internal audit
- Continue to deliver required training for all accredited coders
- Continually review coding resources and performance.

Performance against quality indicators and targets

National quality targets

Table 8: National priority and performance standards

	2011-2012	2012-2013	2013-2014	Target	Achieved?
MRSA bacteraemias	1	1	4	0	✗
Clostridium difficile infections	30	23	26	15	✗
Percentage of patient who wait 4 hours or less in A&E	97.3%	95.04%	95.38%	95%	✓
The percentage of Referral to Treatment (RTT) pathways within 18 weeks for completed admitted pathways	91.1%	92.94%	91.39%	90%	✓
The percentage of Referral to Treatment (RTT) pathways within 18 weeks for completed non-admitted pathways	96.8%	96.96%	95.89%	95%	✓
The percentage of Referral to Treatment (RTT) pathways within 18 weeks for incomplete pathways	N/A	95.6%	95.08%	92%	✓
The percentage of patients waiting 6 weeks or more for a diagnostic test	N/A	0.87%	0.49%	<1%	✓
Percentage of patients seen within two weeks of an urgent GP referral for suspected cancer	95.4%	95.08%	95.56%	93%	✓
Percentage of patients seen within two weeks of an urgent referral for breast symptoms where cancer was not initially suspected	94.6%	94.78%	95.39%	93%	✓
Percentage of patients receiving first definite treatment for cancer within one month (31 days) of a cancer diagnosis	99.6%	99.25%	99.59%	96%	✓
Percentage of patients receiving subsequent treatment for cancer within 31 days where that treatment is surgery or anti-cancer drugs	98.9%	100% 100%	99.3% 100%	94% surgery 98% drugs	✓
Percentage of patients receiving first definite treatment for cancer within 62 days of an urgent GP referral for suspected cancer	87.9%	89.71%	90.82%	85%	✓
Percentage of patients receiving first definite treatment for cancer within 62 days of referral from an NHS Cancer Screening Service	92.9%	94.68%	94.84%	90%	✓

National Quality Indicators

Since 2012/13, all Trusts have been required to report performance against a core set of indicators using data made available to the Trust by the Health and Social Care Information Centre (HSCIC).

For each indicator, the number / percentage / value / score or rate (as applicable) for at least the last two reporting periods should be presented in a table. In addition, where the data is made available by the HSCIC, 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.

Table 9: The value and banding of the Summary Hospital-level Mortality Indicator (SHMI)

Date	Trust Performance	National Average	95% Upper Limit	95% Lower Limit
October 2011 - September 2012	1.13 Higher than expected	1.00	1.13	0.89
January 2012 – December 2012	1.16 Higher than expected	1.00	1.12	0.89
April 2012 – March 2013	1.16 Higher than expected	1.00	1.13	0.89
July 2012 – June 2013	1.15 Higher than expected	1.00	1.13	0.89

The Summary Hospital-level Mortality Indicator (SHMI) is one of the nationally-recognised measure of mortality used within the NHS. The Trust uses SHMI alongside the Risk Adjusted Mortality Index (RAMI) to assess its performance in this area of quality and safety.

The Trust has been working with the Health and Social Care Information Centre and the local Clinical Commissioning Groups to understand the Trust's SHMI data so that key areas for further work can be prioritised. SHMI is one of

One factor which has impacted on the Trust's SHMI is the classification of admissions lasting less than 12 hours as assessments. Removing these low risk patients from the SHMI calculations caused the value to spike into the 'higher than expected' category. As a result, the Trust will be returning to national guidance as of 1 April 2014 and will be classifying these short-stays as admissions. This change should cause the Trust's SHMI to return to the more-accurate category of 'as expected' within 6-12 months.

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

- A series of inter-related projects to reduce the Trust's mortality rates which are currently in progress under the primary drivers of:
  - **R**eliable clinical care
  - **E**ffective clinical care
  - **M**edical documentation, clinical coding and data consistency

End of life care
Leadership

- The Trust invited the Advancing Quality Alliance (AQuA) to undertake a thorough review of the Trust's mortality rates and this was concluded in March 2014. The internal recommendations from the report are being incorporated into the Trust's mortality action plan
- A driver diagram and gap analysis which has been developed to review the current position and develop areas for further work with regards to mortality
- A weekly mortality case note review group which is led by the Lead Consultant for Patient Safety has been established where themes are identified and areas for further work are developed with the Hospital Mortality Reduction Group.

Table 10: 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
October 2011 - September 2012	15.27%	19.0%	43.0%	0%
January 2012 – December 2012	15.67%	19.47%	42.7%	1.0%
April 2012 – March 2013	16.43%	20.38%	44.0%	1.0%
July 2012 – June 2013	14.86%	20.65%	44.1%	0%

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

- Reviewing medical documentation, clinical coding and data consistency as part of a series of inter-related projects to reduce the Trust's mortality rates.

Table 11: 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%
2013-2014	7.5	8.5	23.8	-14.4	Top 65%
Varicose Vein Surgery					
2011-2012	10.7	9.4	23.5	0	
2012-2013	8.2	9.3	27.2	0	Top 50%
2013-2014	NA	10	31.1	-4.33	NA
Hip Replacement Surgery					
2011-2012	37.7	40.7	58.4	23.5	
2012-2013	49.9	43.7	69	0	Top 30%
2013-2014	46.8	43.8	72.4	20.4	Top 35%
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
2013-2014	41	34	61.4	14.4	Top 20%

The Trust considers that these results are as described for the following reasons:

- The numbers of patients undergoing varicose vein surgery at the Trust are minimal.

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

- Continuing to work 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
- Continuing to use information leaflets which describe the process and value of the information collected through the use of the PROMS questionnaire
- Undertaking case note reviews for patients who undergo groin hernia surgery to identify opportunities to improve practice.

Table 12: The percentage of patients aged 0 to 15 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%
January 2013 - December 2013	8.8%	10.6%

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

- There is an open access process in place which allows the Paediatricians to discharge children and offer 'open' access for a limited time dependent on the child's diagnosis and where they are on the clinical pathway.
- In June 2011 – April 2014 all paediatric admissions with a stay of less than 12 hours were revalidated and, dependent on their clinical interventions, some were reclassified as an assessment.
- The Child and Young Persons Home Care Team (speciality focused) work in conjunction with the Child and Adolescent unit and take referrals for children who are discharged and may require follow up at home. This service may prevent the need for children to be readmitted
- The reclassification of zero-day length of stay patients (those admitted for less than 12 hours) from admissions to assessments reduced re-admission rates. However, from 1 April 2014, those patients classed as assessment cases will be reclassified as admissions.

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

- Consultant paediatricians carrying out daily ward rounds seven days a week who are able to review all patients, make prompt clinical decisions and plan and co-ordinate their follow up care with the multi-disciplinary team
- The Trust is currently looking at the feasibility of introducing a nurse led 'hospital at home' service which would also support admission avoidance and reduce the need for readmissions (acute focused)
- In the last 6 months the Trust has introduced rapid access slots in Consultant clinics. The aim is to provide an alternative pathway for suitably identified children who would normally be seen as assessments or ward attender
- Introducing, in January 2014, a dedicated Advice and Guidance Service for GPs to request advice on the management of Paediatric patients. The aim of this pilot is to support GP colleagues and offer an alternative to acute admission or outpatient referral for specialist advice.

Table 13: The percentage of patients aged 16 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%
January 2013 - December 2013	5.9%	6.7%

The Trust is pleased to report that its readmission results continue to improve and that it is now significantly below peer and considers that this is for the following reasons:

- There has been focussed work on four specialities undertaken by the clinical divisions. They have reviewed readmissions for patients who have respiratory conditions, cardiac conditions, urology conditions or who have undergone breast surgery. Dedicated matrons have supported this work and implemented specific action plans to identify any issues identified
- Partnership working with a number of nursing homes within the local area, which includes joint planning for the patient's discharge back to the home.

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

- Continuing to progress collaborative working with community services
- Extending the work with nursing homes to support them in caring for their patients
- Embedding the use of patient passports for those patients with long term conditions.

Table 14: 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
2013	75.9	76.9	Not published	Not published

The Trust considers that these results are as described for the following reasons:

- The result is slightly lower than the national average. The Trust has demonstrated an improvement compared with last year's results and has increased scores in every section of the Trust's responsiveness to the personal needs of its patients:
    - Access and Waiting
    - Safe, high quality, co-ordinated care
    - Better information, more choice
    - Building closer relationships
    - Clean, comfortable, friendly place to be.

Comments from patients completing the national inpatient survey reflect positive feedback following the implementation of care rounds. The highest number of comments made by patients relate to "kind and caring staff."

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

- Increasing nursing staffing levels and reviewing the skill mix on inpatient wards every six months
- Fully implementing care rounds to respond proactively to patients' needs
- Implementing a "quiet protocol" to reduce unnecessary noise at night
- Improving communication for patients when leaving hospital and fully implement a 'before you leave' checklist which fully explains what happens on the day of discharge.

Table 15: 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
2013 staff survey	3.79	3.68	4.25	3.05

The Trust is delighted to report that these results are above the national average and considers that these results are as described for the following reasons:

- Over the last year there has been a lot of focus and communication with staff about how important all staff are in improving the quality of care and services we provide
- The Trust's appraisal system has been redesigned to look at values and behaviours
- Engagement sessions with the Trust's Chief Executive have taken place which have had quality and patient experience at the heart of those discussions
- The Chief Executive delivers weekly briefs which focus on the patient safety and quality agenda
- Patient stories are told at Board meetings each month – to ensure that patients are at the heart of all decisions being made by the Board
- All internal leadership programmes include a focus on patients – and have had patients come and deliver presentations to participants about their experiences at the Trust
- Patients are on the Trust's judging panels for the Celebration of Achievement evening. Their perspective on what matters has been valued and we have added a Patient Choice category for nominations
- Staff focus groups run twice a year to ascertain their views and they are asked if they would they recommend the Trust as a place to receive treatment and any negative responses are discussed.

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

- Focussing on specific areas for improvement based on the national staff survey results. In particular, improving team working and communication, reducing violence and discrimination towards staff and improving the health and wellbeing of staff
- Renewing the Trust's focus on the Employee Support Advisor (ESA) service, which can support staff if they are experiencing difficulties at work, as well promoting the staff support helpline.

Table 16: The percentage of patients who were admitted to hospital who were risk assessed for venous thromboembolism (VTE)

Date	Trust Performance	National Average	Highest Result	Lowest Result
July 2013 - September 2013	97.18%	95.74%	100%	81.70%
October 2013 – December 2013	96.8%	95.8%	100%	77.7%

The Trust is pleased to report that these results are above the national average and considers that this data is as described for the following reasons:

- Patients are risk assessed for VTE on admission to the Trust. The VTE risk assessment has been included in the Trust's admission proformas to ensure that all appropriate patients have a risk assessment undertaken
- The Trust has 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. Compliance is also monitored monthly by the clinical divisions
- The Trust has consistently remained above the national average for the previous two reporting periods in relation to the percentage of admitted patients who were risk assessed for VTE.

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 Trust has achieved the national CQUIN in relation to VTE risk assessment for the past three years. The VTE CQUIN target was 95% in 2013/2014.

Table 17: The rate per 100,000 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	58.3	29.6	63.6	7.1
2011-2012	16.83	21.82	50.89	4.08
2012-2013	12.9	17.3	30.8	0
2013-2014	14.6	Not published	Not published	Not published

The Trust considers this slight increase in performance is due the marginal increase in case numbers from 23 to 26 cases.

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

- Continuing use of chlorine for cleaning
- 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 on-going review of all side rooms used for isolation purposes to ensure effective isolation practice and appropriate clinical management
- Undertaking detailed root cause 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
- A review of performance against all other Foundation Trusts to identify any learning.

Table 18: The number of patient safety incidents reported within the Trust

Date	Trust Performance	National Average	Highest Result	Lowest Result
October 2011 - March 2012	2511	1782	3871	809
April 2012 - September 2012	2695	1812	4545	815
October 2012 – March 2013	3015	1964	4517	924

The above data demonstrates that the Trust reports more patient safety incidents than the national average and this has been consistent for all reporting periods.

Nationally, it is viewed that being a high reporter of incidents is a positive position as it demonstrates a risk aware culture within the Trust and highlights that staff are not afraid to report patient safety incidents. The majority of the incidents reported resulted in no harm to the patient, which again demonstrates a positive 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:

- The Trust's commitment to a *Just Safety* culture which encourages staff to acknowledge when an error occurs without fear of punitive measure
- Training about incident reporting for all staff 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.

Table 19: 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 - March 2012	2	17	64	0
April 2012 - September 2012	6	16	69	2
October 2012 - March 2013	3	16	56	1

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

The Trust had four 'Never Events' (serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented) during 2013/14. One was a drug error and three were related to retained swabs. None of the patients concerned came to harm as a result of the Never Events, although one patient had to go to Theatre for the removal of the swab. All patients involved were fully briefed on the incident.

The Trust intends to take / has taken the following actions to improve this result, 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 recurrence
- Reporting all incidents which result in severe harm or death to the Board to ensure openness within the Trust
- Implementing 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 root cause analysis are shared with them in line with the Duty of Candour.

Performance against local quality indicators

Table 20: Performance against local quality indicators

Indicator	2011-2012	2012-2013	2013-2014	Target	Achieved?
Cancelled operations (%)	1.46%	1.32%	0.83%	1.09%	✓
Cancelled operations – % breaching 28 day guarantee	7.9%	15.83%	16.06%	5%	✗
Smoking during pregnancy	18.3%	20.55%	17.34%	< 15%	✗
Breastfeeding initiation rates	62.8%	60.91%	66.96%	65%	✓
Access to genito-urinary (GUM) clinics	100%	100%	100%	100%	✓
Falls risk assessments completed	96%	96%	98%	90%	✓
Pressure ulcer risk assessments completed	95%	94%	99%	90%	✓
Nutritional risk assessments completed	97%	95%	90%	90%	✓
% of patients who felt they were treated with dignity and respect	100%	100%	100%	100%	✓
% of patients who had not shared a sleeping area with the opposite sex	100%	100%	100%	100%	✓

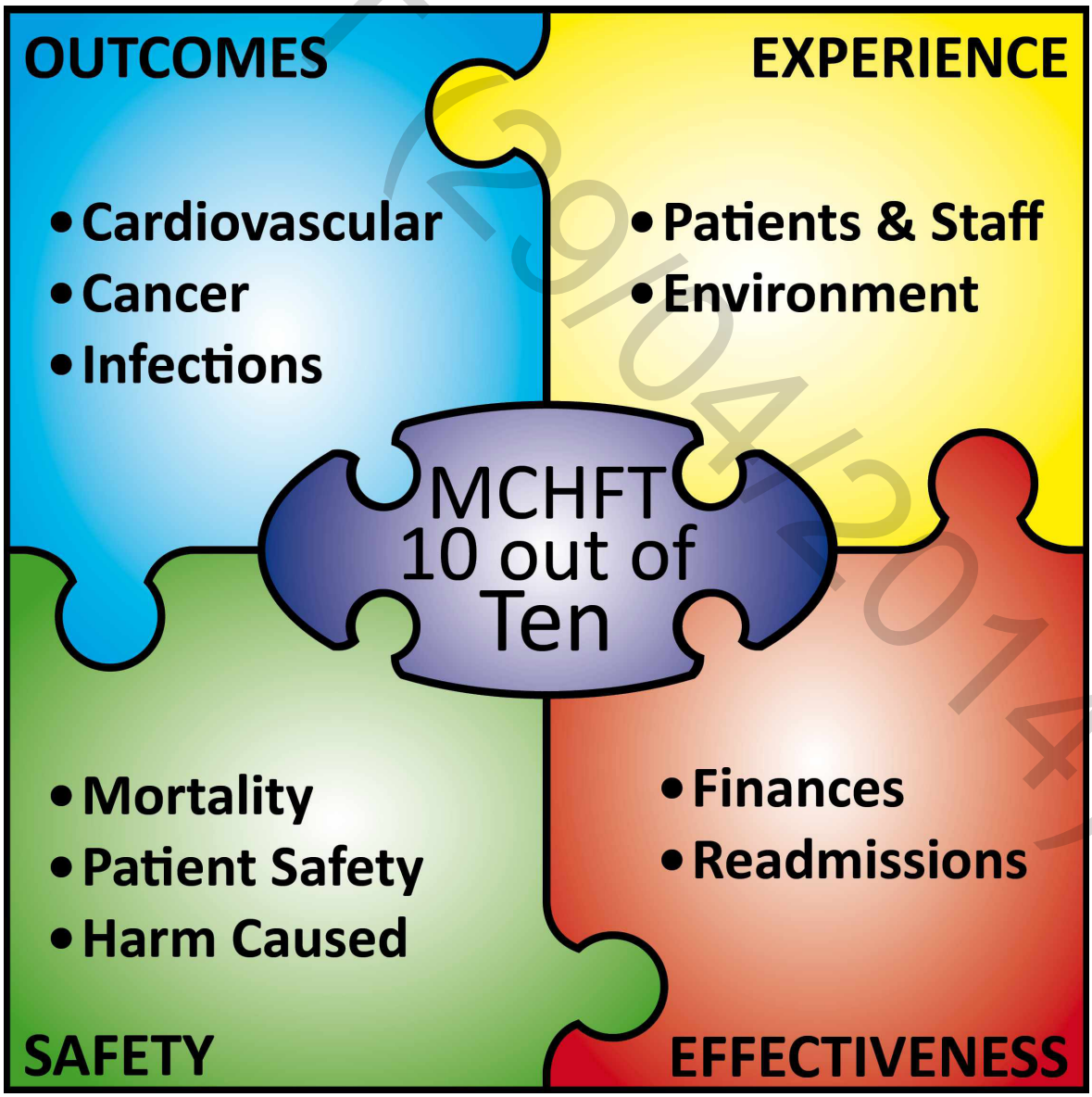
Part 3

Review of quality performance

This section of the Quality Account details progress against the final year of the Trust's five year 10 out of Ten strategy plus the Governors' choice of indicator.

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 2013/134 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

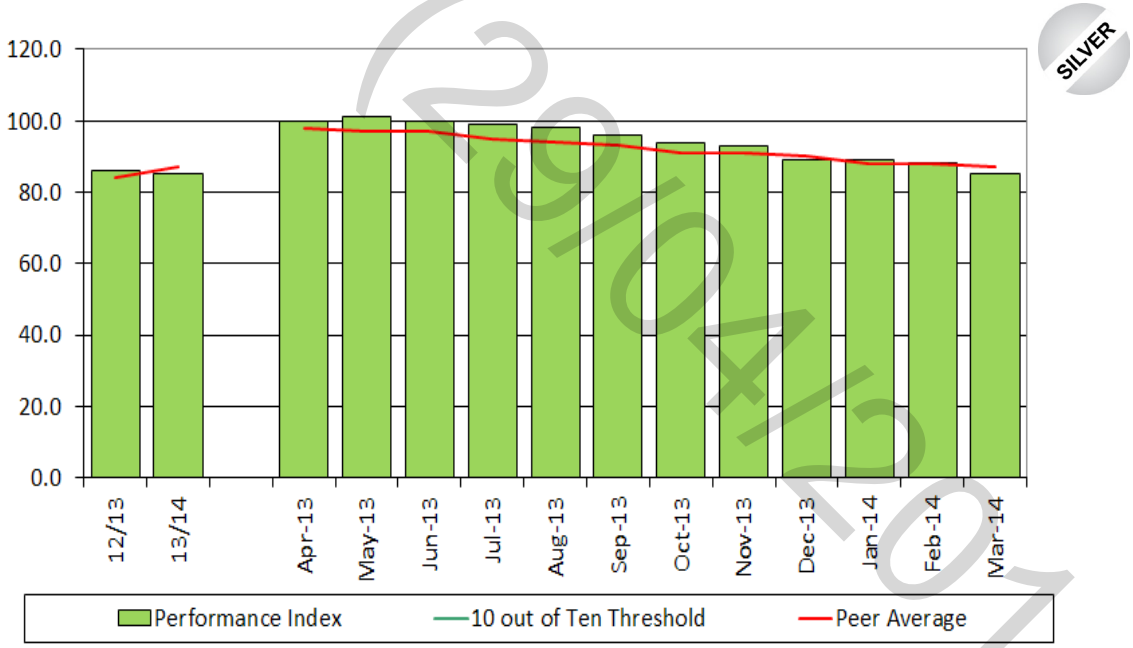
Priority 1: Mortality

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 our 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 conditions and displays this as an index. In general terms, the rationale for calculating death rates in hospital is so they can be used as a measure of hospital quality.

Chart 6 shows the Trust's RAMI over the 12 month period between April 2013 and March 2014. The Trust has achieved its target to reduce its RAMI by 10 points in 2013/14. The RAMI has reduced from 100 to 89.

Chart 6: Reduction in Risk Adjusted Mortality Index



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

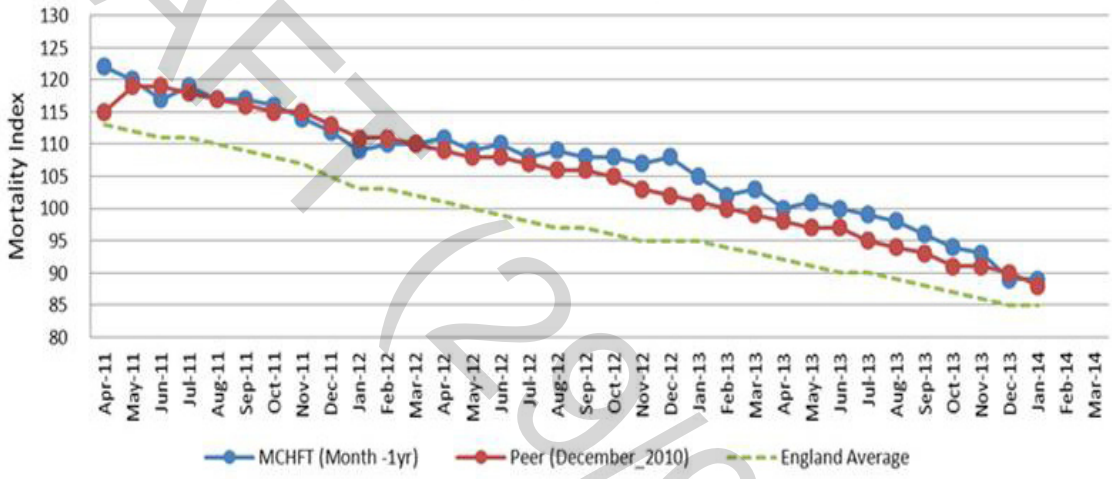
Work Programme to Improve Hospital Mortality Rates

Since 2009, the Trust has monitored the mortality rate through the Hospital Mortality Reduction Group. Data from CHKS submitted to the Board of Directors each month has shown that the Trust's RAMI has fallen year on year.

In January 2014, the Trust's RAMI was 89 compared with a peer result of 88 and an England average of 85. This is demonstrated in Chart 7. The results for February and March 2014 will be confirmed later in the year.

Chart 7: Reduction in rolling 12 month mortality trending and comparison with peer and the England average

(Source: Information Services 2014)



As mentioned on page 39, the Trust measures mortality using RAMI as well as the Summary Hospital-level Mortality Indicator (SHMI). The data provided in this report shows the Trust's SHMI as being 'higher than expected' - as a result, reducing mortality will remain as one of the Trust's key priorities, and a rigorous plan of work is underway in this regard.

The work to reduce the Trust's mortality rates is being led by the Medical Director through the Hospital Mortality Reduction Group. This group reports directly to the Quality, Experience and Safety Committee (QuESt), a Board subcommittee chaired by the Chief Executive. A series of inter-related projects to reduce the Trust's mortality rates are currently in progress under the primary drivers of:

- **R**eliable clinical care
- **E**ffective clinical care
- **M**edical documentation, clinical coding and data consistency
- **E**nd of life care
- **L**eadership.

A driver diagram and gap analysis has been developed to review the current position and develop areas for further work with regards to mortality. The action plan is reviewed monthly by the Hospital Mortality Reduction Group.

The Trust invited the Advancing Quality Alliance (AQuA) to undertake an in-depth review of the Trust's mortality rates in January 2014. The review was concluded in March 2014 and the internal recommendations are being incorporated into the Trust's mortality action plan.

The Trust has established a weekly mortality case note review group led by the Lead Consultant for Patient Safety. This involves a team of consultants reviewing all deaths that have occurred that week, followed by a more detailed review of all deaths where clinical care could have been more appropriate. This information is then collated at the Hospital Mortality Reduction Group in order to identify themes and areas for further work. Clinicians are also informed of any concerns or issues that have been identified.

Safety

Priority 2: Patient safety

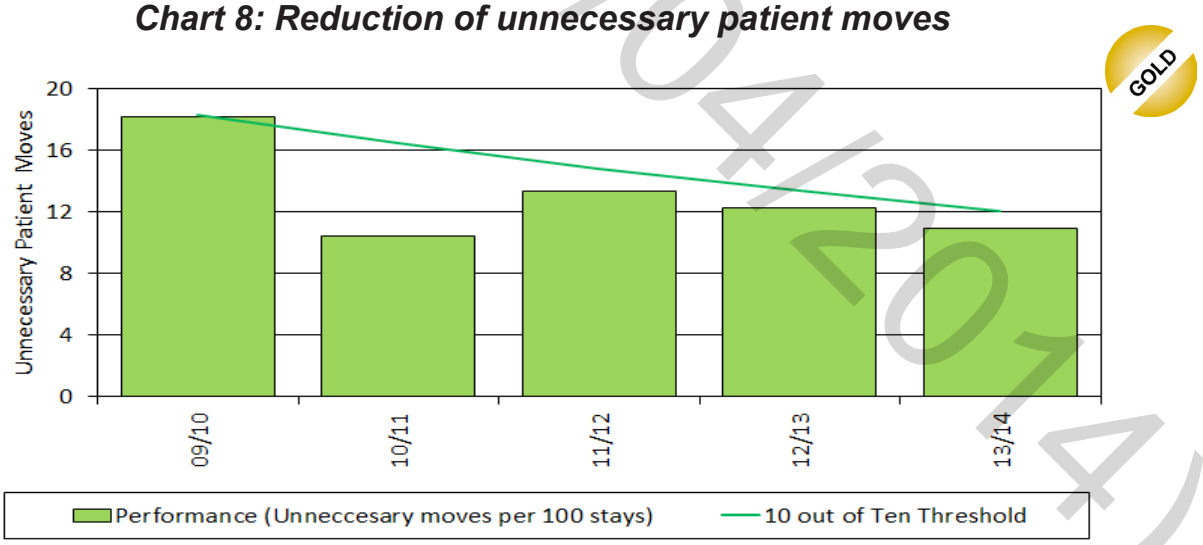
To monitor and reduce the number of unnecessary patient moves during a patient's stay in hospital

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. This has been particularly demonstrated for frail elderly patients and / or patients suffering from dementia. 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.

Chart 8 shows the average number of unnecessary patient ward moves per 100 hospital stays since April 2009. The chart demonstrates that the Trust has consistently over-achieved against the target on an annual basis, with an overall reduction of approximately 44% since the measure was introduced.

Chart 8: Reduction of unnecessary patient moves



The Trust intends to continue to reduce the number of unnecessary patient ward moves in 2014/15 by progressing the following actions:

- Ensuring that patients are admitted to the appropriate specialty and ward to care for their needs
- 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. This is a particular focus in the Emergency Care Division
- 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 did not unnecessarily move any patients with dementia
- Working to minimise the 'night-time' movement of patients between wards, excluding patient transfers from the admissions unit to the appropriate ward.

Safety

Priority 3: Harm caused

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

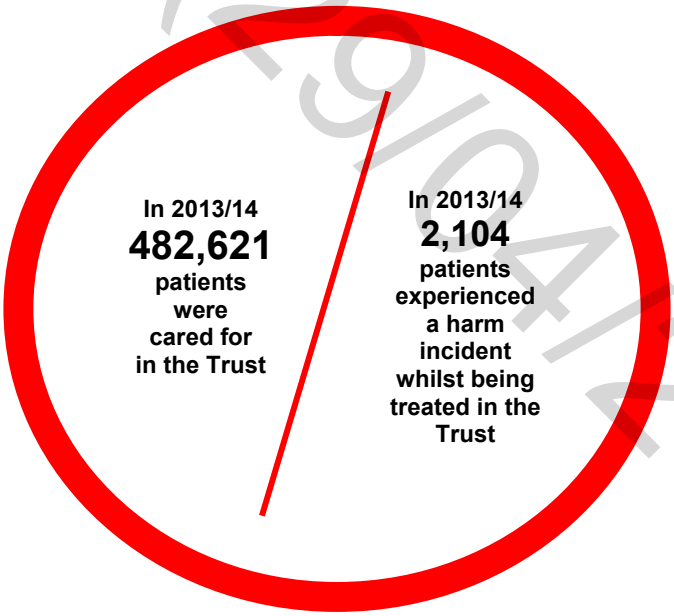
All patient safety incidents are reported within the Trust using the risk management system 'Safeguard Ulysses'. The Trust monitors patient safety incidents resulting in harm on a monthly basis through the Board performance report.

The Trust has a work stream for each of the top three reported incidents which are patient falls, hospital acquired pressure ulcers and safer medication. These work streams are each progressing towards reducing the number of incidents resulting in harm by 10%.

A 10% reduction in hospital acquired pressure ulcers was achieved in 2013/2014, but not for harm caused by patient falls or medication incidents.

Chart 9 shows the number of people cared for in the Trust during the last year and highlights that less than 0.5% of patients experienced harm during their treatment.

Chart 9: Avoidable harm caused



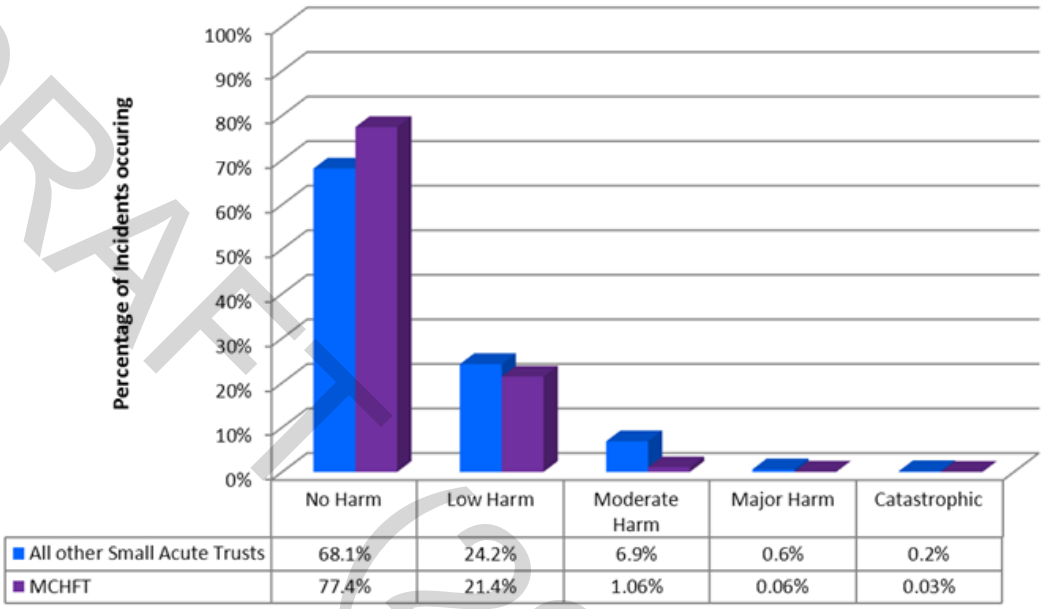
National Reporting and Learning System
The Trust reports all patient safety incidents to the National Reporting and Learning System (NRLS) on a weekly basis. The NRLS was established in 2003 and enables patient safety incident reports to be submitted from NHS organisations to a national database. This data is then analysed to identify hazards, risks and opportunities to improve the safety of patient care.

The NRLS produce a comparative report on a six-monthly basis comparing similar sized acute Trusts. The most recent report was published in September 2013 and provides an overview of incidents reported by the Trusts to the NRLS between October 2012 and March 2013. This information is shown in Chart 10 which demonstrates that the Trust has a higher

number of reported no harm incidents and fewer harm incidents when compared to other acute Trusts of a similar size.

The reporting of no harm incidents is seen as positive as it demonstrates that the Trust has a risk aware culture and that staff are not afraid to report patient safety incidents.

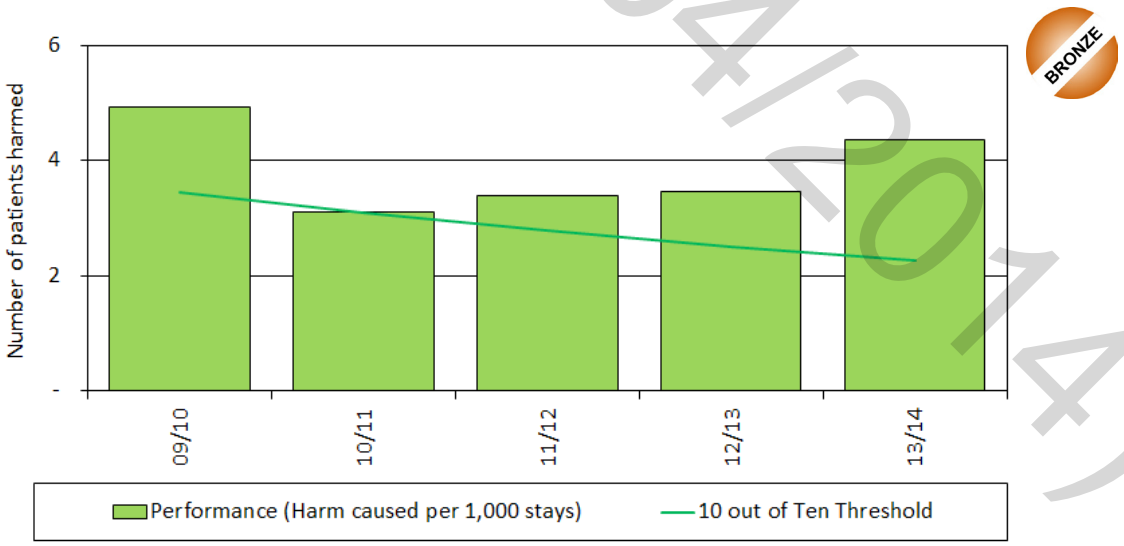
Chart 10: NRLS comparative data for October 2012 to March 2013



	No Harm	Low Harm	Moderate Harm	Major Harm	Catastrophic
All other Small Acute Trusts	68.1%	24.2%	6.9%	0.6%	0.2%
MCHFT	77.4%	21.4%	1.06%	0.06%	0.03%

Unfortunately, the Trust has not achieved the stretch target of an on-going year on year 10% reduction in the number of patients that experienced an avoidable harm in 2013/14.

Chart 11: Trend of avoidable harm caused since 2009/10



Effectiveness

Priority 4: Readmissions

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

The impact of effective discharge planning on the Trust's priority to reduce the number of patients readmitted to the hospital within 30 days has continued to demonstrate an ongoing reduction.

Chart 12: Reduction in numbers of patients readmitted within 30 days

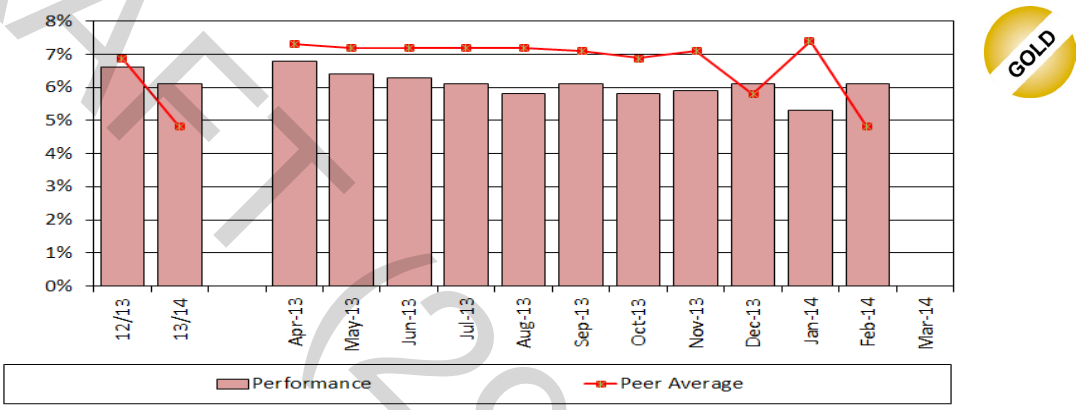


Chart 12 demonstrates that the number of emergency readmissions has fallen from 6.8% in April 2013 to 6.1% in February 2014 and, overall, the Trust's performance continues to be better than peer when compared against other acute Trusts in the North of England.

This ongoing improvement has been achieved through the continual daily monitoring of patients that are at high risk of readmission to ensure that the discharge planning meets their wider health needs.

There has been improved collaborative working with community services to ensure that patients have access to appropriate services for ongoing support together with the introduction of a patient passport for patients with complex long term conditions and specific health needs.

There has been specific work undertaken to support elderly patients admitted from nursing homes which has involved partnership working with 27 nursing homes within the local areas. This involves daily communication with the homes during the patient's stay, joint planning for discharge and a follow up phone call post discharge to the nursing home to ensure the continued wellbeing of the patient.

Further work for 2014/15 will focus on extending the work with nursing homes to support our elderly patients and embedding the use of patient passports for those patients with long term conditions.

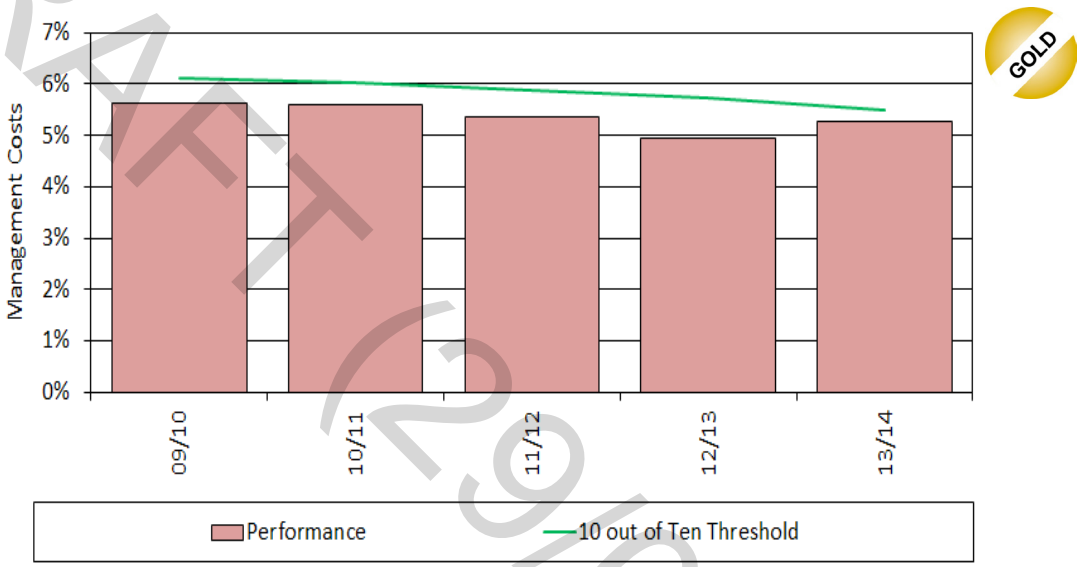
Effectiveness

Priority 5: Finance

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

On a quarterly basis, the Trust measures the percentage of income spent on management costs.

Chart 13: Trust's annual spend on management costs



During 2013/14, the Trust has continued to maintain a position lower than the target the Trust 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 individual adult inpatients to determine the required nurse staffing levels on its wards. This is the nationally recognised tool.

The acuity/dependency monitoring is undertaken Trust-wide every 6 months and the results are used to review staffing requirements and to adjust establishment budgets to meet the need of patients. Some wards within the Trust use this information on a daily basis to manage their variable acuity and staffing to best effect.

The acuity data is the closest indicator we have of the staffing needs of our patients at a point in time. The data over the past three years has demonstrated a continual increase in the level of acuity / dependency of patients across the wards. The results of the SNCT from January 2014 show an incremental improvement in staffing levels across all areas and a continued rise in the level of acuity / dependency. This continual rise in acuity/dependency is to a number of factors:

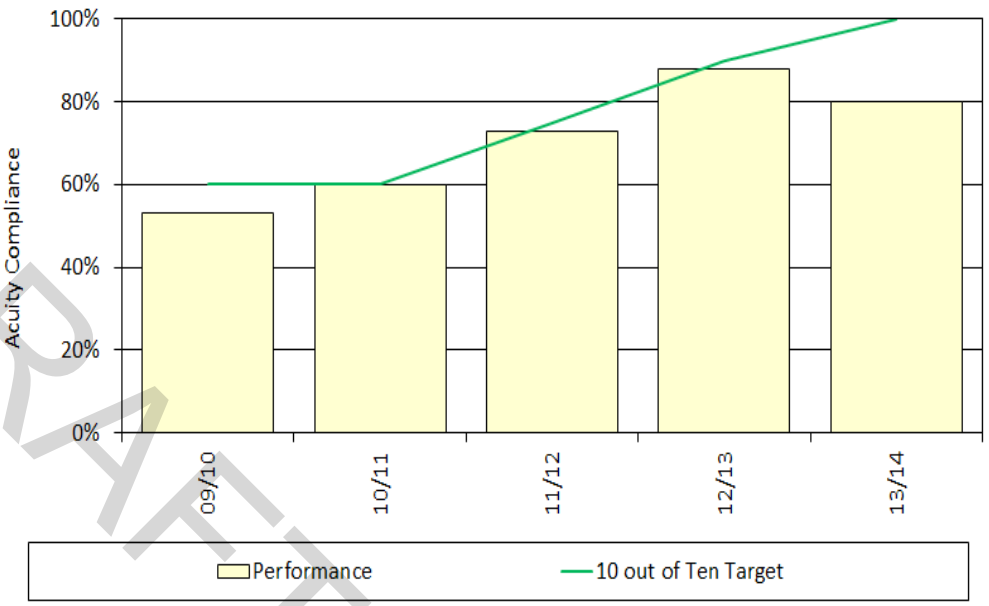
- Increasing complexity of patients
- Reduction in length of stay
- Increasing older population
- Increasing number of patients with dementia.

During 2013/14, the Trust invested approximately £980,000 in additional ward based nursing staff within the emergency care division which led to the recruitment of an additional 26 whole time equivalent nursing staff. Despite continual investment and robust recruitment plans the acuity and dependency continues to increase.

Information collated during 2013/14 has been reviewed by the Trust's Acuity group and escalated to the Divisional Boards, Workforce Assurance Committee and Board of Directors.

The aim for 2013/14 was that 100% of adult inpatient wards would be within range of their required establishment. Chart 14 shows that the Trust achieved 80% against the target of 100%.

Chart 14: Nursing acuity compliance for ward areas



Actions to address this shortfall have been taken which include the redeployment of staff from over established areas, robust and active recruitment plans including overseas recruitment and close working with the University of Chester to recruit the newly qualified nurses. The Trust also makes daily use of its trained and unqualified bank staff to ensure that the required staffing levels are met.

Planning for longer term recruitment has seen the Trust resume the secondment process for healthcare assistants to undertake their nurse training at the University of Chester. In March 2014, two Healthcare Assistants commenced their training and the Trust has been provided with five places for March 2015 (four general nurse training positions and one for a mental health post). In addition, the Trust held a joint recruitment event with the University of Chester to provide on-site information about the facilities both organisations have to offer prospective students. The event was extremely well attended and feedback was very positive. A further event will take place later in 2014.

Doctors

The ratio of doctors has, in the previous three 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 2013/14, the Trust has appointed additional Consultants in Cardiology, Sexual Health, Acute Medicine, Colorectal Surgery, Paediatrics and Ear, Nose and Throat (ENT).

The Trust has also received support from the Mersey Deanery to appoint an additional training grade post in Breast Surgery and three Foundation Trainees (Junior Doctors).

The Trust's investment in additional Consultant posts will continue in 2014/15.

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 2013, the Trust declared compliance in eliminating mixed-sex accommodation (EMSA). 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.

Over the past year the Trust has maintained the elimination of mixed sex accommodation on all wards and departments. The only area where patients might receive care in a mixed-sex environment was within the critical care areas of intensive care and high dependency.

Robust processes are in place to ensure the breaches in these areas are kept to an absolute minimum. The critical care staff work closely with the patient placement team to prioritise patients who could breach mixed-sex accommodation and plans are immediately put in place to move these patients into same-sex accommodation as a matter of priority.

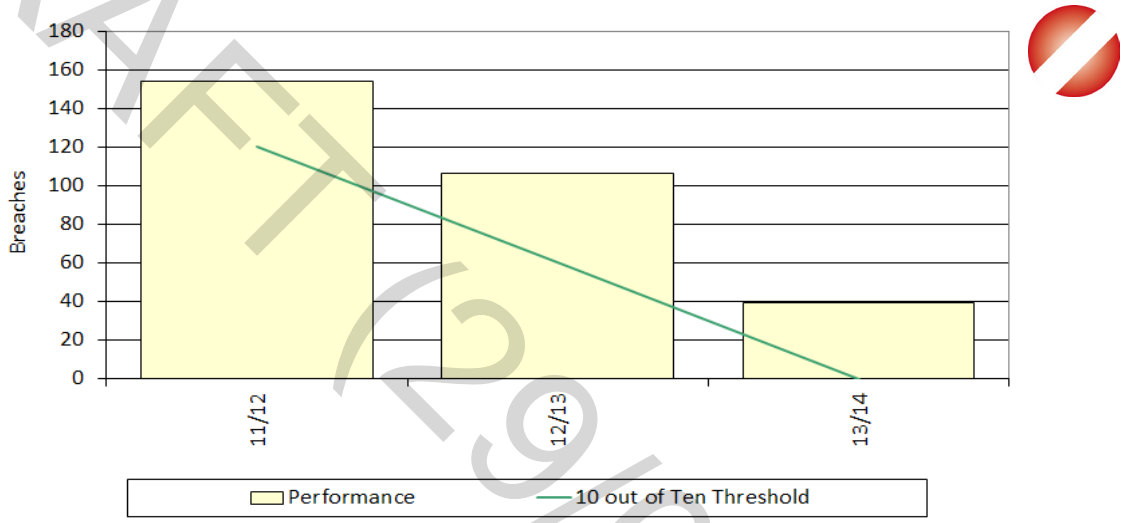
The Trust has recently opened a purpose-built Critical Care Unit, and the elimination of mixed sex accommodation was a key consideration in its build. The newly opened unit will

mean patients will no longer breach mixed sex accommodation standards and from April 2014 the Trust will not have any further breaches.

Trust volunteers have continued to ask patients on a monthly basis about their experience of mixed-sex accommodation and The Trust continues to report that there have been no patient concerns raised as a result of mixed sex accommodation and none of the patients surveyed reported either sharing accommodation or washing/toilet facilities with patients of the opposite sex.

Chart 15 highlights the significant progress that has been made since last year. The numbers of breaches are reported monthly to the Trust Board and Commissioners.

Chart 15: Reduction in breaches within mixed sex accommodation



Outcomes

Priority 8: Cardiovascular

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

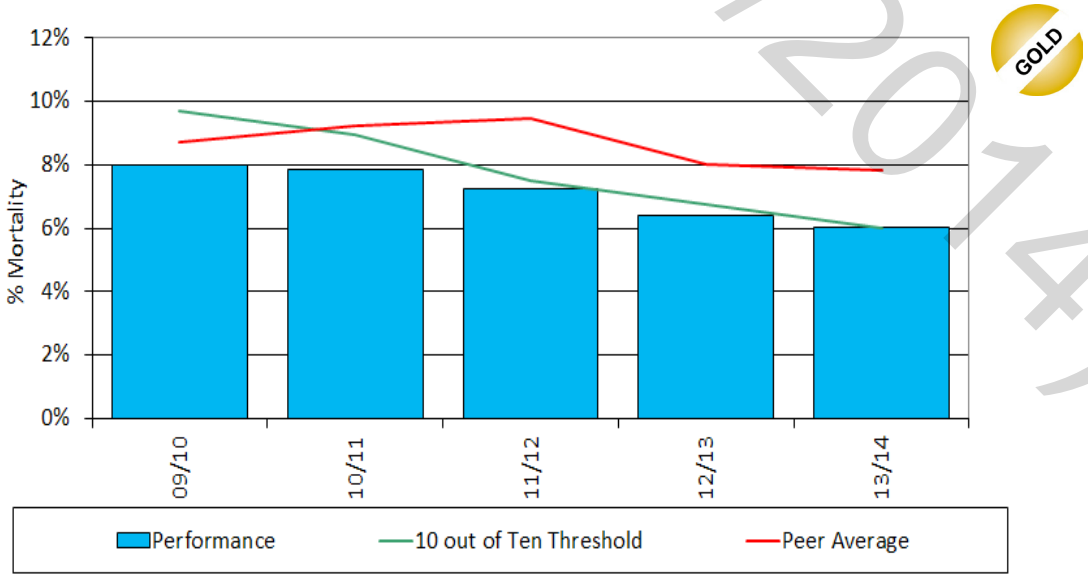
There were approximately 600 patients admitted in 2013/14 with a diagnosis of Acute Myocardial Infarction (AMI). Many of these patients were either taken directly to tertiary hospitals for treatment and intervention, or transferred after initial treatment at the Trust for further intervention. Patients that were taken directly to tertiary centres were treated within the catheter laboratory via stent therapy. 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 four phases. Phase One is offered whilst the patient is still in hospital, Phases Two and Three are offered following discharge and Phase Four 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 has supported the reduction in patient mortality and morbidity and provides 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 Chart 16 that the Trust has achieved the target to reduce further deaths following AMI during 2013/14. In addition, the Trust remains significantly below the peer average.

Chart 16: Reducing Acute Myocardial Infarction mortality within 30 days



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 two clinical nurse specialists and a multi-disciplinary team coordinator.

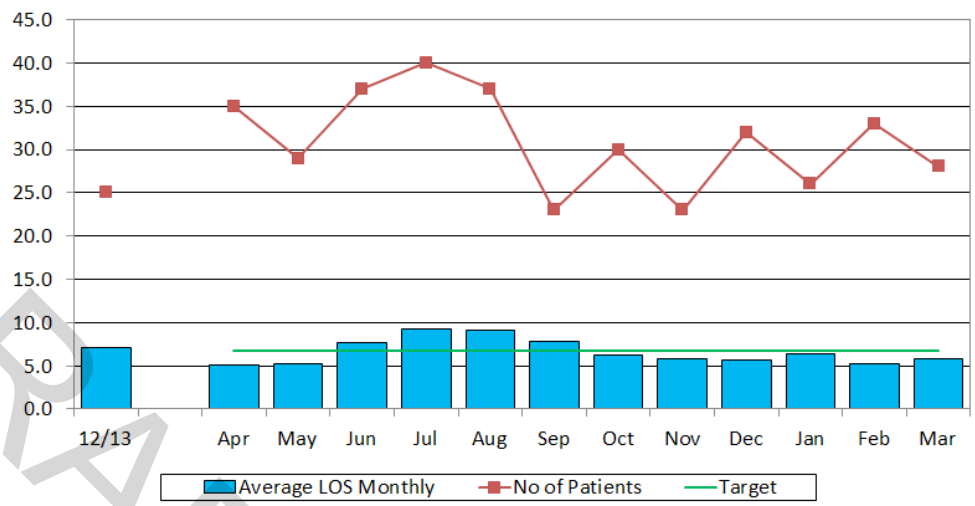
The Trust was one of the first Trusts in the Cancer Network to establish an acute oncology service and therefore there is very little peer data available with which to compare the Trust. The intention of the implementation of the acute oncology team is reduce the length of stay for patients admitted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

The introduction of the rapid alert system highlighting that a patient with a known cancer diagnosis has been admitted to the Emergency Department or into hospital has meant that the acute oncology team can rapidly intervene resulting in an improved patient experience and a reduction in length of stay.

The acute oncology team have worked in collaboration with the emergency department physicians during 2013 /14 to educate front line staff about the one-hour “door to needle time” for patients undergoing chemotherapy who present with signs and symptoms of neutropenic sepsis. Treating these patients with intravenous antibiotics within one-hour of presentation at the emergency department can significantly improve mortality rates and also reduce any subsequent length of stay in hospital.

It can be seen in the data provided in Chart 17 that the length of stay has decreased since the implementation of the acute oncology team in 2012, so that the stretch 10 out of Ten target has been achieved. In addition, the number of patients staying 10 days or longer has decreased steadily during 2013/14.

Chart 17: The average length of stay and numbers of acute admissions



The acute oncology team saw a total of 373 patients in 2013/14, whilst an additional 113 patients avoided admission to hospital through appropriate intervention by the team.

The admitting medical teams report that they value the input of the acute oncology team to support the decision making process at ward level. The acute oncology team also ensure that up-to-date clinical information is available from the tertiary cancer centres so that patients benefit from the right treatment at the right time.

Outcomes

Priority 10: Infections

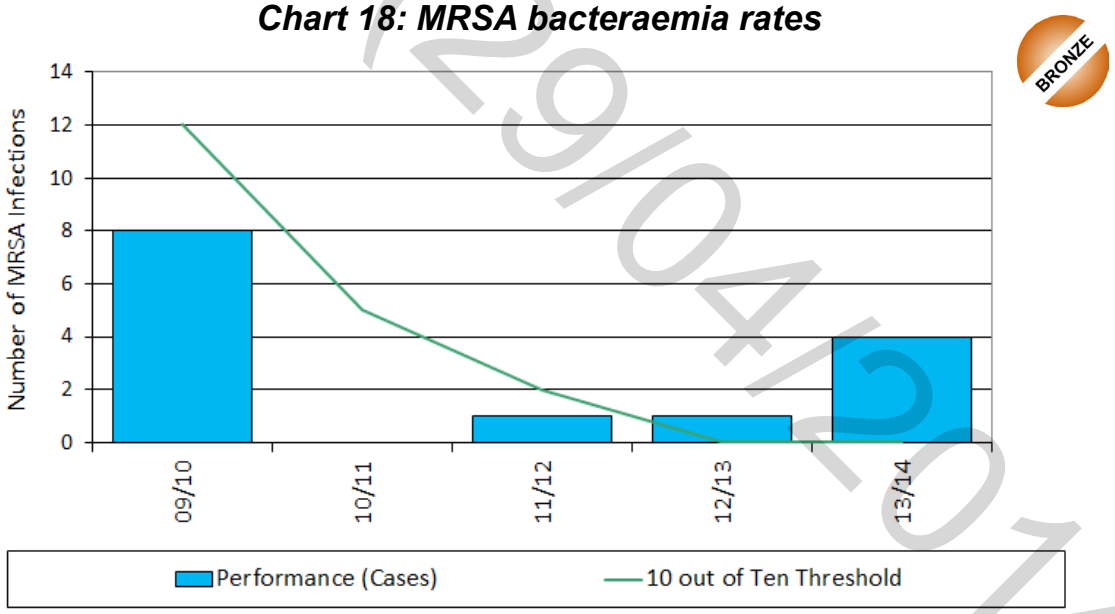
To reduce the rates of Healthcare Associated Infections (HCAI)

Planned Target Outcomes
To demonstrate an annual reduction in HCAI rates

MRSA bacteraemia	Target: 0	Actual 4	Not Achieved
Clostridium difficile	Target: <15	Actual 26	Not Achieved

MRSA bacteraemia
The Trust has had four cases 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. However, the Trust still achieved better than peer, hence its bronze rating in this report.

Chart 18: MRSA bacteraemia rates



Clostridium difficile

Rates of *Clostridium difficile* infection (CDI) have increased this year by three cases (23 last year against 26 this year) which means that the target of less than 15 cases has not been achieved this year. However, similarly to MRSA bacteraemia performance, the Trust still achieved better than peer, hence the bronze rating in this report.

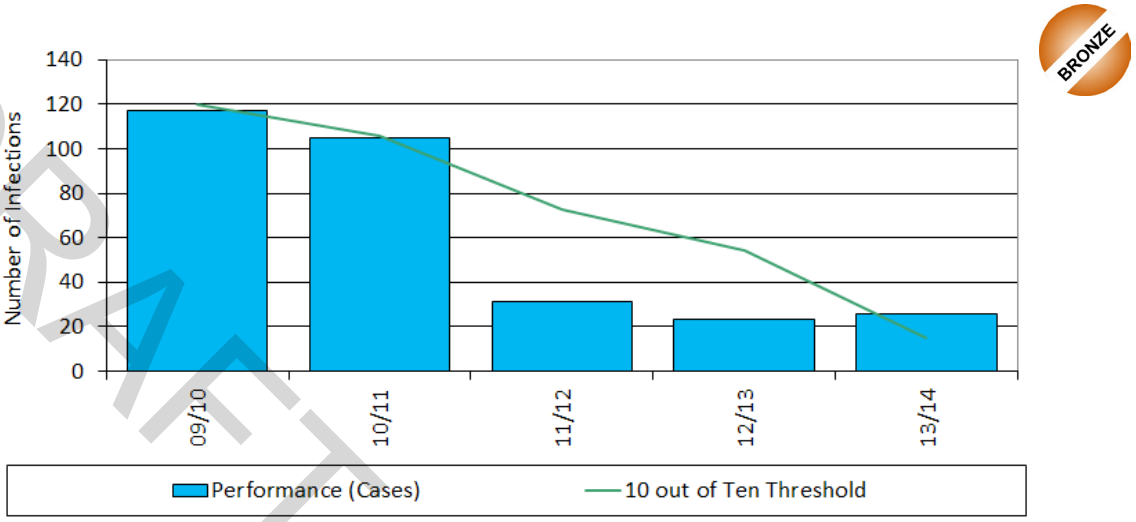


Chart 19: Clostridium difficile rates.

Infection Prevention Strategies

Cases of CDI are allocated to either the hospital or the community in terms of infection source as determined by the sampling date. Out of the 26 cases reported in 2013/14, six of these could have been attributed to the community rather than the Trust due to the sampling date/time. Therefore, one of the prevention strategies to be employed in 2014/15 will focus on accurate sampling processes and staff education.

Additionally, the infection prevention and control team will implement the following infection prevention strategies:

- Increased frequency of the Strategic Infection Control Committee (SICC) to ensure corporate engagement and divisional ownership for HCAI prevention strategies
- A re-launch of basic infection prevention measures within wards and departments to ensure clinical staff understand the risks associated with HCAI's and continue to implement proactive preventative strategies
- Development of ward metrics for HCAI cases with the inclusion of an assurance framework to closely monitor infection rates and progress with remedial actions
- Increased frequency of Matron/Infection Control walkabouts (or ward rounds) to ensure the clinical environment remains optimal for the delivery of safe, clean care
- Development of training programmes and type of training delivered to ensure all relevant staff are equipped to safely manage patients with an infection or those at risk of developing an infection
- Review of environmental hygiene performance and campaigns for "clean-ups" and "declutters" within ward and department areas.

Governors' choice of indicator - reducing patient falls

The majority of hospital beds in the developed nations are occupied by older people, many of whom have been admitted because of mobility problems, falls, or injury from falls. With an aging population and projected increases in the number of people surviving with functional impairment, cognitive impairment, or multiple long-term conditions, these trends are likely to continue. This means fall prevention is an increasing risk management challenge for hospitals and a real threat to patient safety.

Falls are a considerable burden for patients, healthcare workers and hospitals. Preventing falls from happening must 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.

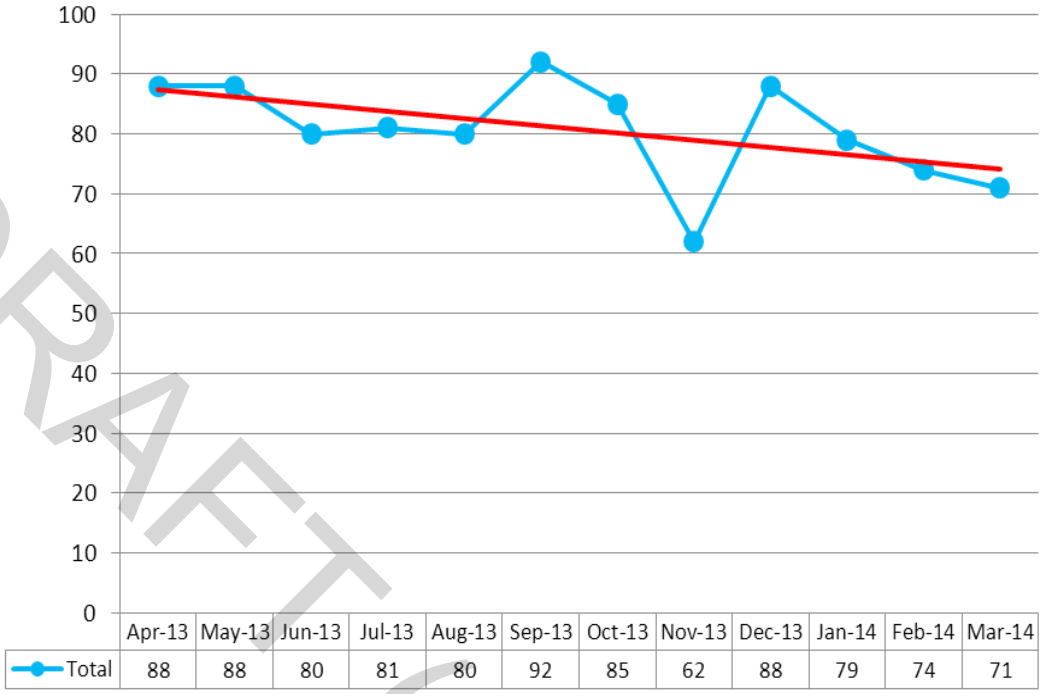
For people experiencing a fall, there may be many negative associations and perceptions, such as a sense of imminent loss of independence and risk of institutionalisation.

The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and mortality. Falling also affects family members and the carers of people who fall.

Falls are estimated to cost the NHS more than £2.3 billion a year. Therefore, falling has potentially a significant impact on quality of life, health and healthcare costs.

Chart 20 shows the number of patient falls in the Trust over a 12 month period between April 2013 and March 2014. The red line on the graph indicates that the overall number of falls has decreased over the last 12 months. This represents a 15% reduction.

Chart 20: Overall reduction in patient falls (April 2013 to March 2014)



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Total	88	88	80	81	80	92	85	62	88	79	74	71

Work undertaken to reduce the number of patient falls and harm caused
The Trust has a patient falls prevention group which meets on a six weekly basis. The group membership includes clinicians, nurses, pharmacists, therapists and divisional risk and governance managers. The group reviews all patients' falls at each meeting.

A successful link nurse programme has been rolled out across the Trust to deliver education for staff on falls prevention.

The Trust continues to be involved in a number of national projects including Safety Express and FallSafe, both of which aim to reduce the harm from patient falls. The Trust has also undertaken a thorough documentation review to ensure compliance with the latest NICE Guidelines (the assessment and prevention of falls in older people - CG161).

Statements from external agencies

South Cheshire and Vale Royal Clinical Commissioning Groups

Text

Cheshire, Warrington and Wirral Area Team

TO BE INSERTED

Healthwatch Cheshire East

TO BE INSERTED

Cheshire East Council Health and Wellbeing Scrutiny Committee

TO BE INSERTED

Governors

TO BE INSERTED

Statement of Directors' responsibilities in respect of the Quality Report

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

Monitor has also issued guidance to NHS Foundation Trust Boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Trust Boards should put in place to support the data quality for the preparation of the quality report.

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

- The content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2013/14

- 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 2013 to March 2014
    - Papers relating to quality reported to the Board over the period April 2013 to March 2014
    - Feedback from the Commissioners dated xx May 2014
    - Feedback from Local Healthwatch dated xx May 2014
    - Feedback from the Health and Wellbeing Scrutiny Committee dated xx May 2014
    - Feedback from Governors dated xx May 2014
    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated xxxxxx 2013.
    - The 2013 national patient survey
    - The 2013 national staff survey
    - The Head of Internal Audit's annual opinion over the Trust's control environment dated xx May 2014
    - Care Quality Commission (CQC) quality and risk profiles dated July 2013.

- The quality report presents a balanced picture of the 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.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the Board, signed 27 May 2014

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.
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 GP-led commissioning body who buy services from providers of care such as the Trust.
Clostridium Difficile	C-diff	A naturally occurring bacterium that does not cause any problems in healthy people. However, some antibiotics that are used to treat other health conditions can interfere with the balance of 'good' bacteria in the gut. When this happens, C-diff bacteria can multiply and cause symptoms such as diarrhoea and fever.
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		An 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	I C N A R C 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.
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.

Terms	Abbreviation	Description
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.
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).

Terms	Abbreviation	Description
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.
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).
10 out of Ten		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.

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?

_____
_____
_____
_____
_____

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

_____
_____
_____
_____
_____

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Quality Account 2013/14

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Caring Together Update
Care Models

Health and Scrutiny Committee

7th May 2014

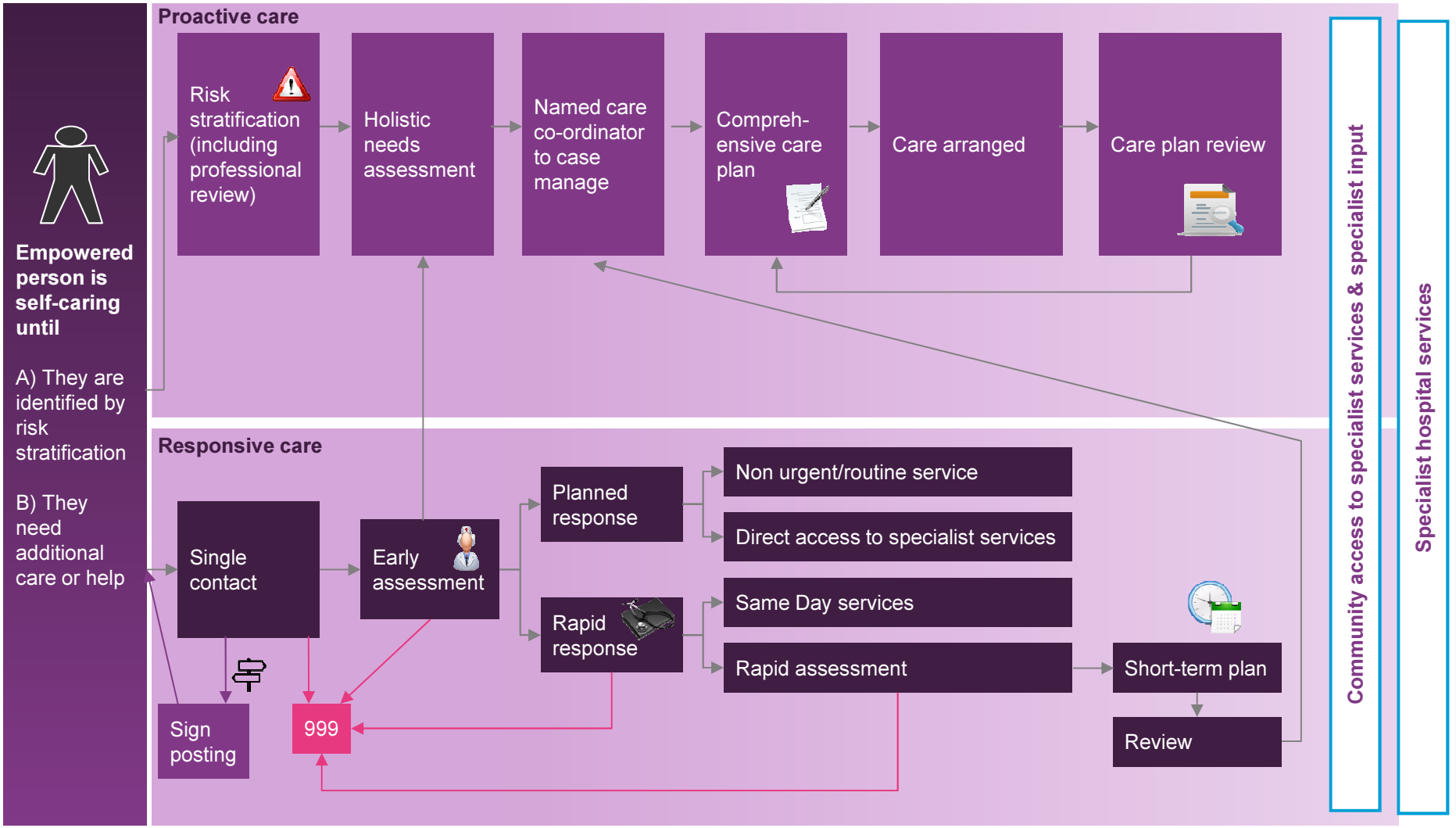
Integrating Care in Eastern Cheshire

Objectives for our discussion

- Discuss draft Caring Together care models
- Review the detail of the care model components

The Caring Together care model

DRAFT MODEL



Enablers				
• Single patient record • Directory of services • Online prescription service	• Joint assessment tool • Risk stratification tool	• Joint/personal commissioning • Contractual levers	• Electronic ordering technology	• Access to specialist opinion/diagnostics • Online patient resources

The design groups agreed on care model components for Caring Together (1/3)

ACUTE COMPONENTS TO BE ADDED

Whole system approach	**Single contact point (including early assessment)**	• People have a single point of contact with the system that makes things easy and convenient. This contact directs them to the correct service to best meet their needs. • Early assessment by a senior clinician to make sure that people receive an appropriate response as soon as possible. 24/7 response.
	Self care, self management support, and signposting	• Where possible, support to people to provide self care including the use of web-based resources. people are enabled to self care with person education and public health programmes. • Appropriate signposting to support people to self care, for example, to community pharmacists or the voluntary sector. Potential integration with other Cheshire East Council services. Directory of services available to professionals and people.
	Direct access to specialist services	• Direct booking to specialist services such as physiotherapy, hospital-based diagnostics, etc where a referral or A&E attendance is required. This will reduce appointments/A&E attendances and speed up diagnosis and treatment.
	Non-urgent/routine services	• Direct booking for non-urgent and routine community services at a time and location to suit the person (8-8 access to GP routine appointments).
	Same day service	• Access to urgent care for minor injuries at a place and time to suit the person – the aim to see and treat all people. Includes a GP-led urgent care centre that may be standalone or part of an A&E.
	Named GP	• People with specific conditions (long term conditions, cancer, end of life, mental health) to have a 'named GP' who will be their regular GP with additional appointment time allowed for discussion and disease management.
	Risk stratification	• Risk stratifying the population through the use of a predictive tool supported by clinical/social care review by the GP and/or multi-disciplinary team. To identify the top 20% most 'at risk' people for pro-active management.

The design groups agreed on care model components for Caring Together (2/3)

ACUTE COMPONENTS TO BE ADDED

Whole system approach	**Needs assessment**	• Conduct single assessment focused on people's lifestyle, goals and care needs using a joint assessment tool. Home assessment for those at the highest risk/needs, assessment outside the home (e.g. in GP practice) where appropriate. Identify care co-ordinator from within multi-disciplinary team, if required. To include advanced EOL discussion and plan.
	Care planning	• Jointly create a care plan with person for care needed to include goals, required interventions, provider details, and information on who to contact in case of change or crisis. This should also trigger a request for specific services e.g. falls assessment. Complexity of the plan matched to person needs – may be simply a crisis plan.
	Care coordination	• Match resources to assessed need. Support to ensure person is following the care plan, that care required for a person takes place and that a person is able to secure any appointments required and is actually attending them when needed
	Rapid assessment with short term plans and short term care	• Provide an alternative to unnecessary acute and care home admissions by responding to person's need in situations of crisis and ensuring that the relevant providers are able to put in care packages quickly to support the person at home. Requires joint commissioning/personal budgets and access to specialist opinion and diagnostics.
	Specialist input in the community	• Ensure specialists are able to provide support in the community for GPs or to provide input for people. Where people are appropriately seen in specialist services, contact to be maintained with the community team and person to be discharged back into the same team.
	Discharge support	• Ensure discharge planning starts from day 1, that people are assessed regularly during their stay, and that all required care packages are in place for when the person returns home. This will also aim to ensure that post-acute care can happen at home as much as possible, e.g. rehabilitation, or within alternative housing options and that it can be put in place in time for a person's discharge

The design groups agreed on care model components for Caring Together (3/3)

ACUTE COMPONENTS TO BE ADDED

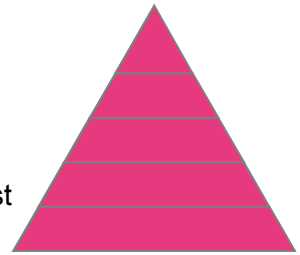
Whole system approach	Cultural transformation	• Communication campaign to inform and interact with the public about how to become an empowered person, including information, tips, suggestions and dialogue through social media tools. This requires the development of online resources such as a website that will signpost people to the right information and guide them through the system
	Workforce preparation	• Preparation of the workforce to interact with or promote becoming an empowered person. This will be done by adjusting the work description of the care professionals to incorporate best practices to interact with/promote empowered people and by organizing “Empowered development teams” that will gather care professionals with people to train them and discuss how to achieve the “Empowered people” quality standards
	Community centres participation	• Leveraging the existing community centres, support and investment in existing programmes such as healthy eating services, stop smoking services, stop drinking services and other relevant initiatives to empower people.

Single point of contact: Component Overview

PRELIMINARY

Relevant population

- Everyone in the population will use the same single point of contact for services and be directed to the most appropriate place



Total people **~201,000**

Description

- The single point of contact number would be a call centre that would help direct people to the most appropriate place of care for calls that do not require 999
- Triage would happen immediately by a care professional on the phone, who would be able to schedule appointments, make referrals, and re-direct calls to the most appropriate setting
- Single point of contact would be in operation 24/7 to help direct people to the most appropriate place for their care, and to help avoid hospital admissions

Key design features

Provider view

Staff training and education about services available and appropriate triage locations and services to ensure that single point of access is staffed effectively

→

Single point of contact telephone number is monitored by a nurse or clinician and triage is done immediately for people who call in

person view

Person has a crisis or urgent need that does not require 999

Person has a care need and would like to talk to a professional

→

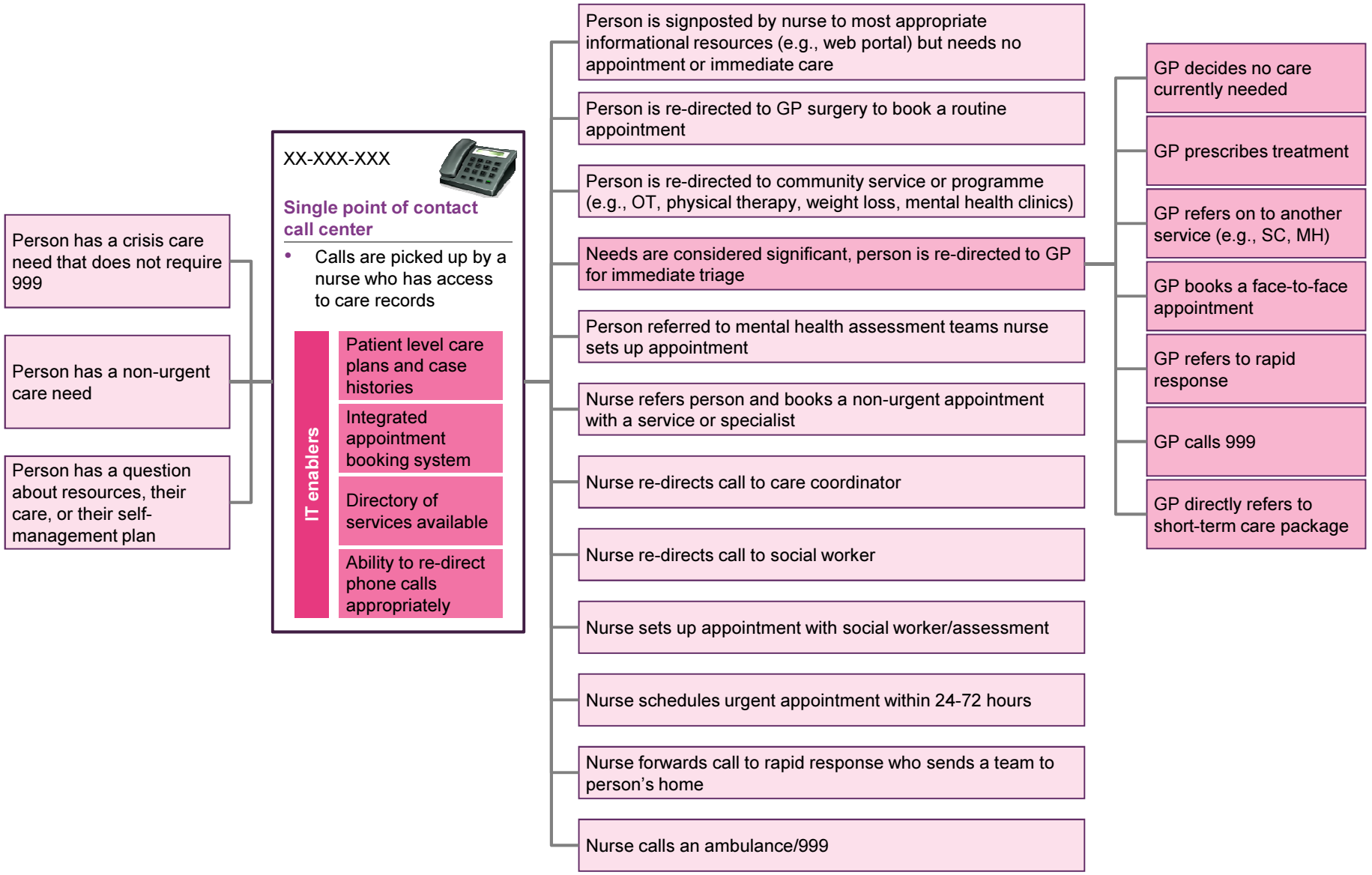
Person telephones single point of contact where their call is picked up by a nurse or similar care professional. Nurse has access to integrated patient record and history quickly through IT platform.

→

Person is triaged by either a nurse or a clinician on the phone and directed to the most appropriate setting of care for their needs

Single point of contact: Detailed component flow

DRAFT – PRELIMINARY

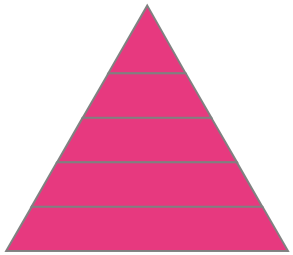


Risk Stratification: Component Overview

PRELIMINARY

Relevant population

- All people will be risk stratified to identify those at high risk of admission or predicted cost of care



Total people ~201,000

Description

- Providers will run the risk stratification software at least once a month to come up with the list of people who are at high risk of admission
- Stratification will either need to have social care input or be a joint risk stratification tool across health and social care (ultimate goal)
- GPs will usually be the ones to review the lists of high risk people and ensure that services are targeted to the correct people
- A flagging system will be in place for further review by social care or by mental health services if needed

Key design features

Provider view

Single analyst who is dedicated to risk stratification runs the software across the patch

→ **Flagging system** in place to identify people who will need review by other professionals (e.g., person lives alone, is a carer, or has specific conditions)

→ **Social care** or **mental health** workers review list **along with GPs** to ensure that appropriate people are identified

→ **GPs or MDTs review the list** each quarter to ensure that it is up to date and is capturing any new high risk people

person view

Person-level health and social care data is collected and fed into the risk stratification tool

→ 

All people are risk stratified

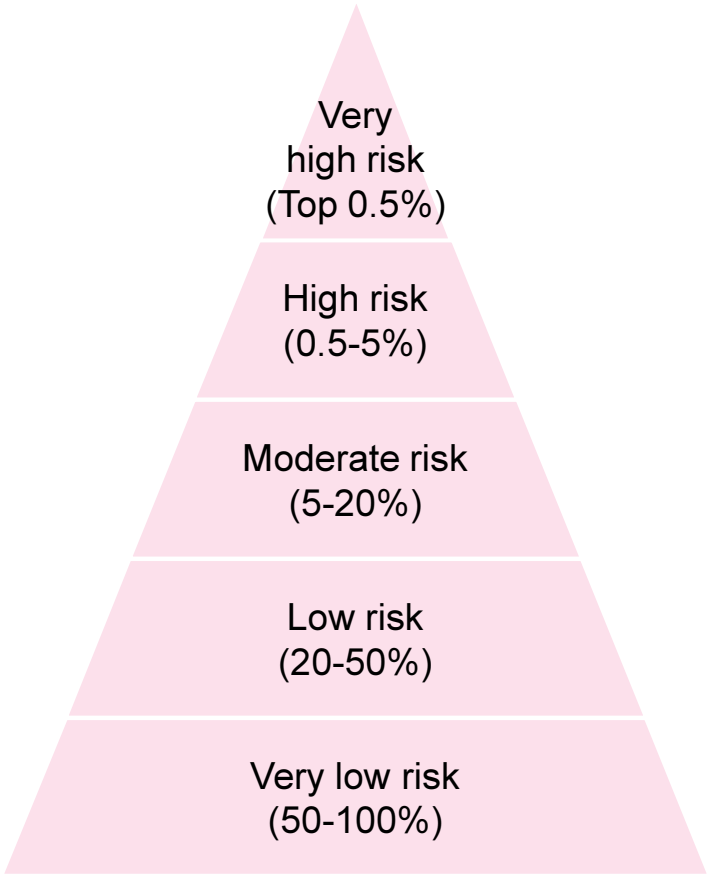
→
- People who are high risk (top 20%) will receive intensified assessment, care coordination/MDTs
- Lower risk groups will be empowered to self care

→ People will be informed when their risk status is being reviewed by a clinician or by their care coordinator, and will be kept up to date on changes in their care as a result

Risk Stratification: Understanding the risk of emergency admission in the population

- Risk stratification uses either the CPM model or a newly developed tool to predict the risk of emergency admission in the next 12 months or to predict overall care costs or vulnerability
- These models are predictive, which means they can be used to understand likely events in the future
- CPM is already being used in Eastern Cheshire to understand which people are high risk
- Risk factors include current conditions, age, other demographic factors and past history of admission
- **Review will be necessary by care professionals to add the richness needed to truly understand people on an individual basis**

CPM predicts risk of an emergency admission in next 12 months

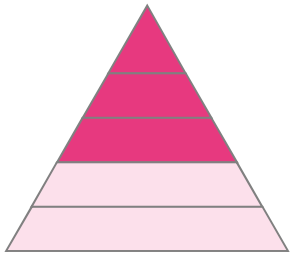


Needs assessment: Component Overview

PRELIMINARY

Relevant population

- Holistic needs assessments will be offered to anyone in the top 20% of risk



Total people **~40,000**

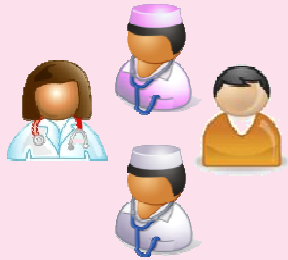
Description

- Holistic needs assessments will be joint assessments of physical, biological, and social care needs by the appropriate professional in the right setting. This setting may be a GP practice, a community center, or, for high risk people, may be the person's home
- These assessments will be enable the identification of who the most appropriate care coordinator will be, and should be carried out by anyone who is trained to do them (e.g., nurses, GPs, physios, social care workers, mental health professionals)
- Trainings will give care professionals a core ability to assess needs in a person-centred way across the different types of care, and will provide protocols on when to flag for further assessment by an appropriate professional

Key design features

Provider view

Professionals receive 5 days of training on how to conduct holistic assessments across disciplines



Most appropriate care professional carries out needs assessment either in the home or the most appropriate setting

person view

Person is risk stratified and assessed

Person is assessed in the **most appropriate setting by the most appropriate professional**. This may be the next person to visit them, the GP, or a district nurse, and should be decided based on the risk strata and other knowledge of the person.

Assessor decides if **additional professionals should be pulled in** for further assessment (e.g, social care, mental health) based on a list of criteria.

Person is assigned the **most appropriate care coordinator**. This could be a GP, social worker, community nurse, mental health etc.

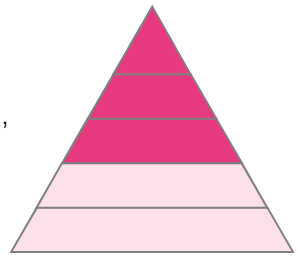
Care Planning: Component Overview

PRELIMINARY

Further detailed on following pages

Relevant population

- Care planning will happen at different levels for the top three risk strata (e.g., top 20% of the population)



Total people **~40,000**

Description

- "I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve outcomes important to me." –National Voices
- A care plan is a document owned by the person that will help them plan their care. It should be created with the individual's GP, their carer, and any other relevant care professionals.
- Care planning is the process of holistically assessing care needs, creating a care plan, and then reviewing the plan regularly with the person and the correct professionals.
- Care plans should be put in place for anyone who has a long term condition or complex needs

Key design features

Provider view

Care coordinator identified/assigned after risk stratification.

Very high risk	***Comprehensive care plan*** created and discussed by MDT and with carer/person	Care plan is reviewed after a change in status or quarterly by MDT
High risk	***Comprehensive care plan*** created with care coordinator and GP	Care plan is reviewed annually or after a change in status by GP
Moderate risk	***Light touch crisis plan*** is created with care coordinator if needed	Crisis plan is reviewed if there is a change in status by the care coordinator

person view

Person is risk stratified and assessed

Person is assigned the **most appropriate care coordinator**. This could be a GP, social care worker, community nurse, mental health worker, etc.

Very high risk	Care plan includes information about home situation, clinical history, family situation, etc.
High risk	Care plan includes clinical history and relevant personal details
Moderate risk	Crisis plan includes a light touch plan of who to contact in a crisis event and where to go

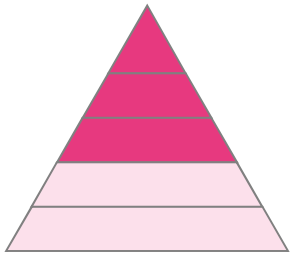
Care Coordination: Component Overview

PRELIMINARY

Further detailed on following pages

Relevant population

- Care coordination of different levels of intensity will be provided to all moderate to very high risk people (e.g., 20% of population)



Total people **~40,000**

Description

- Care coordination is personally tailored support from a named care worker to empower a person to self manage their health and wellbeing and to join up their care
- Care coordination will provide navigation for people between the different care professionals and organisations. Care coordinators will help people schedule appointments, ensuring home visits are happening appropriately, liaising with different care professionals, and providing proactive check-ups on people who need intensive managing.
- Care coordination will look different for different types of people. For example, the most high risk people may have a GP to coordinate their care, while a moderate risk person may have a very light touch coordination service from a well-being coordinator.

Key design features

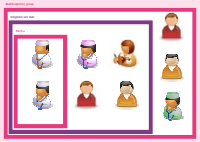
Provider view

Care coordinator identified/assigned after risk stratification/assessment. Coordinator is most appropriate for person.

Care coordinators go through 5 day training on how to be a coordinator

Coordinators have access to integrated IT system with single record

Care coordinators assess holistic person needs and create joint care plan



Care coordinators liaise with MDTs, discharge coordinators and rapid response teams to provide the best care. They also proactively check-in with person and carers at regular intervals.

person view

Person is risk stratified and assessed

Person is assigned the **most appropriate care coordinator**. This could be a GP, social care worker, community nurse, mental health worker, etc.

People get regular calls from their care coordinator

Care coordinator helps people after they've been discharged

Coordinators help set up appointments and referrals

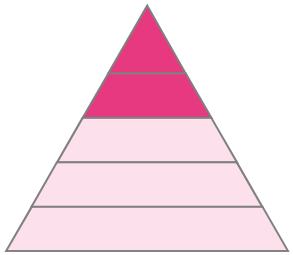
People are able to **form a lasting relationship with their care coordinators**. As a result, they don't need to repeat their history to different professionals or go through the confusion of navigating the system on their own. They are also proactively cared for.

MDTs: Component Overview

PRELIMINARY

Relevant population

- MDTs would cover and review all very high risk and high risk people (e.g., top 5% of people)



Total people **~10,000**

Description

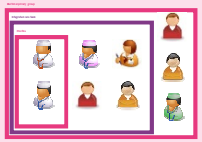
- Multi-disciplinary teams will form the core of new models of care. These teams should bring together all of the relevant care professionals, volunteers, and other partners who provide care for a given individual.
- The professionals included will effectively look after the physical, mental and social care and support needs of the individuals it covers. The vital part of an MDT is to facilitate conversations and referrals amongst care professionals. Effective discussion should result in a balanced care plan and care process that is supportive of an individual's whole needs.

Key design features

Provider view

Integrated informatics system across the MDT

Risk stratification identifies high risk and very high risk people for discussion at MDT



MDTs meet **twice a month for 2 hours**. In these meetings, they:
1. Review complex cases and acute admissions
2. Refer individuals to relevant services directly
3. Provide advice and opinions across disciplines

Care coordinators feedback outcomes of meetings to people, carers, other care professionals

person view

Person is risk stratified and assessed

Assigned care coordinator explains to person that they will have their case discussed at the MDT

Any ***change in status*** is reviewed by the MDT, including admissions, development of new conditions, and change in household status. Care plan is also regularly reviewed for very high risk individuals by the MDT.

Care coordinator lets person and carer know of ***any changes in care plan as a result of review***. In addition, ***direct referrals*** that come out of the MDT meetings are communicated with the person, and MDT discusses how the person can be empowered to self care.

MDTs: Multi-disciplinary teams will include input from a wide range of care professionals

Multidisciplinary group

Integrated care team

Practice

GP

Practice Nurse

District Nurse

Social Care Representative

Community Matron

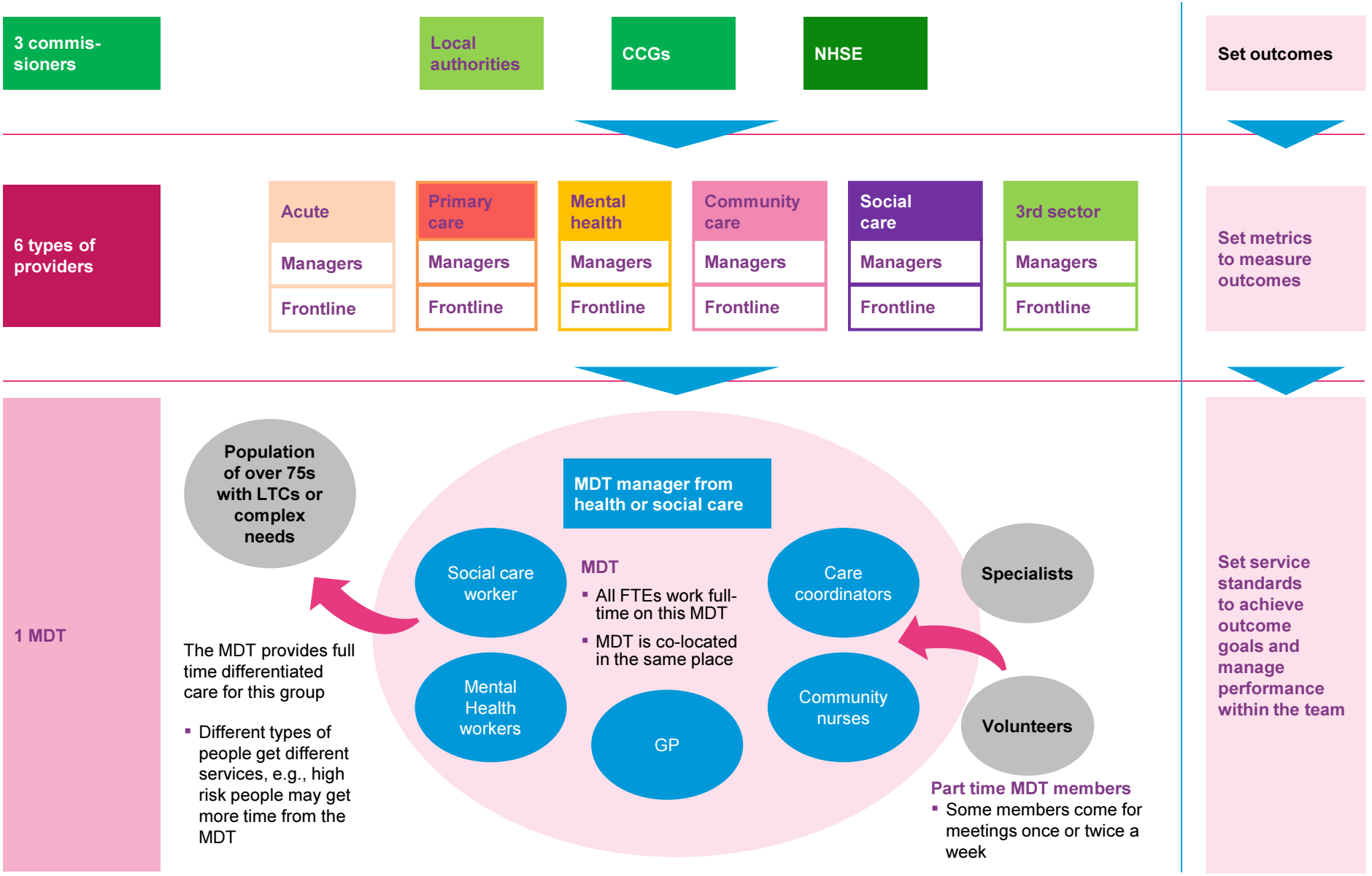
Community Mental Health Representative

Social Care Specialist

Mental Health Specialist

Community geriatricians and other specialists

MDTs: The operating model for MDTs will provide differentiated care

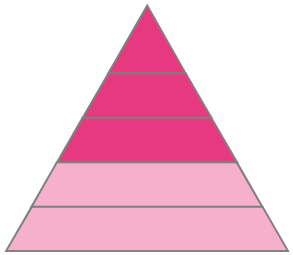


Specialist input in the community: Component Overview

PRELIMINARY

Relevant population

- Access to specialists in the community will target the top 20% of risky people, but some clinics may be open to everyone



Total people **~40,000 – 201,000**

Description

- Specialist input into the community will help join up clinical care across primary and secondary and aim to cut down on unnecessary appointments and hospital attendances
- Three part approach to specialist input in the community:
  - Email and phone liaison that GPs and MDTs can use to gain specialist opinions on complex cases
  - Specialist presence on select MDTs (e.g., diabetes specialist comes to MDT once a quarter to review diabetes cases)
  - Open clinics for specialists to see people deemed to be high risk by MDTs

Key design features

Provider view

Phone and email liaison – GPs email or phone for rapid response about complex people

Different types of specialists put time to input into the community in three major ways (includes diabetes, cardio, etc.)

Presence on MDTs- Once a month each MDT will have a rotating specialist who joins for 1-2 hours

Occasional clinics- Specialists give clinics for those who need time according to MDT

person view

Person is risk stratified and assessed

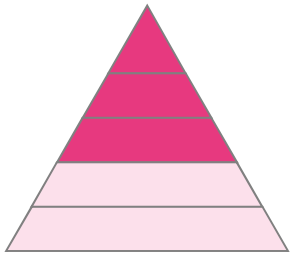
People are able to access specialist opinions and services in the community, rather than having to go for an outperson appointment

Rapid response and short term care: Component Overview

PRELIMINARY

Relevant population

- Rapid response will be available to people in the top three risk strata (top 20%)



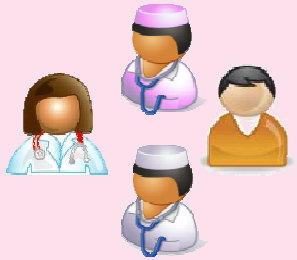
Total people **~40,000**

Description

- Rapid response will be a service within the single point of contact service to respond to crises in a way that will support more people to stay in their homes/communities
- Provide a 24/7 single point of access and a rapid response
- Provide a rapid response within a short timeframe (maximum of 3 hours)
- Ensure coordinated response across health and social care to provide the most adequate intervention and ensure person is able to remain safely at home
- Put in place short term care packages in peoples' homes

Key design features

Provider view



Rapid response team **sits at the hub or is on-call 24/7** to respond to urgent calls that do not require an ambulance

→ Team is dispatched to person homes when they are needed

→

Liaises with care coordinator after a rapid response to discuss the care plan and any short term care

person view

Person calls **single point of contact** with urgent sickness that they thought did not require 999

→

- No care needed; signposting and self-care
- Phone liaison needed for appointment scheduling or triage
- Rapid response needed
- Ambulance needed

→ **Rapid response team** comprising a GP, community nurse or community matron, and social care worker **arrive at the person's home within 3 hours**

→ **Response team assesses person in their home**

→

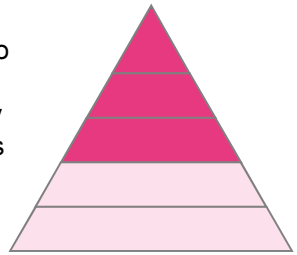
- Person transported to hospital by team
- Ambulance needed
- Person stays at home- no extra care
- Person at home – extra care arranged

Discharge Support: Component Overview

PRELIMINARY

Relevant population

- Target population is all people admitted to an acute centre, which would typically be in the top 3 bands of the pyramid



Total people **~40,000**

Description

- Provide discharge coordination for people 7 days a week, to start at the front end with A&E/AMU attendances flagged for discharge coordinators
- Ensure coordination across health and social care to provide the most adequate intervention and ensure person is able to return safely to home
- Provide target discharge date from day 1 of admission
- Monitor quality of work of various discharge coordinators through establishment of team leadership

Key design features

Provider view

Supportive IT systems will notify discharge coordinators of high risk person admissions

Electronic care plans will allow discharge coordinators to understand case histories

Discharge coordinators will be embedded in the ***hospitals*** and have ***lists of high risk people*** and their designated care coordinators

person view

person admitted to hospital

Discharge coordinator will contact care coordinator, understand case history, and liaise with family within 1 day of admittance

Discharge coordinator will discuss options for return home with clinicians, set a goal date, and arrange any short term care

Discharge coordinator will liaise with care coordinator to set up follow-up appointments and ensure a smooth transition home

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Health and Wellbeing Scrutiny Committee Work Programme – 23 April 2014

Topic	Description /Comments	Responsible Organisation /Officer	Suggested by	Corporate Priority	Current Position (G/A/R)	Next Key Date
Eastern Cheshire Quality Account 2013/14	To consider and comment on the Quality Accounts	Eastern Cheshire NHS Trust/ Fiona Doorey	Eastern Cheshire NHS Trust	Outcome 5 – People live well and for longer	Deferred from 3 April meeting due to insufficient information available. Now expected to receive the Trust's Quality Accounts at the 8 May meeting	Receive documents by Agenda deadline 30 April
Mid Cheshire Quality Account 2013/14	To consider and comment on the Quality Accounts	Mid Cheshire NHS Trust/ Jayne Hartley	Committee	Outcome 5 – People live well and for longer	On target to receive the Trust's Quality Account at the 8 May meeting	Receive documents by Agenda deadline 30 April
Caring Together Programme	To consider the case for change for the Programme and provide comments about potential changes	Eastern Cheshire CCG/ Sam Nicol	Chairman	Outcome 5 - People live well and for longer	On target to receive a report about the consultation feedback and options for service change 8 May meeting	Receive documents by Agenda deadline 30 April
North West Ambulance Service Quality Accounts 13/14	To consider and comment on the Quality Accounts	North West Ambulance Service/ Tim Butler	Committee	Outcome 5 - People live well and for longer	On target to receive the Quality Accounts at the 12 June meeting	Receive documents by Agenda deadline 4 June
CWP Quality Accounts 13/14	To consider and comment on the Quality Accounts	Cheshire and Wirral Partnership/ Audrey Jones	Committee	Outcome 5 - People live well and for longer	Waiting to confirm attendance at 12 June meeting	If confirmed, receive documents by Agenda deadline 4 June
Winter Wellbeing	To Review of Winter	Council, Eastern	Committee	Outcome 5 -	On target to receive	Receive

Health and Wellbeing Scrutiny Committee Work Programme – 23 April 2014

	Planning 2013 – encompassing the CCG's Winter Planning and the multi-agency Winter Wellbeing activities 2014.	CCG, South CCG/ Guy Kilminster		People live well and for longer	reports on Winter Wellbeing at the 12 June meeting	documents by Agenda deadline 4 June

Possible Items to Monitor or consider at future Meetings

- Connecting Care Programme – South Cheshire CCG
- CCG two year plans
- Family Nurse Partnership
- Future of local hospitals
- Rape and Sexual Abuse Support Centre Annual Report
- Impact of Social Landlords on Health and Wellbeing
- Better Care Fund
- Public Health Services
- Mental Health
- Health and Wellbeing Strategy
- NHS England – Specialist Commissioning
- Health Impact Assessments for the Local Plan
- Travel plans (i.e. patients, family and friends travelling to health services)
- Shifting services from hospitals to communities
- Quality of health and care services
- Integration and connecting budgets for health and social care
- Early Intervention and Prevention of illness and deterioration

Dates of Future Committee Meetings

8 May, 12 June, 10 July, 11 September, 9 October, 6 November, 4 December, 8 January 2015, 5 February 2015, 5 March 2015, 2 April 2015

Dates of Future Cabinet Meetings

29 April, 27 May, 1 July, 22 July, 16 September, 14 October, 11 November, 9 December, 6 January 2015, 3 February 2015, 3 March 2015, 31 March 2015, 28 April 2015

Wednesday, 26 March 2014

Health and Wellbeing Scrutiny Committee Work Programme – 23 April 2014

Dates of Future Health and Wellbeing Board Meetings
29 May, 29 July, 23 September, 18 November, 27 January 2015, 24 March 2015

Dates of Future Council Meetings
14 May, 17 July, 16 October, 11 December, 26 February 2015, 20 May 2015

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