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"

EVERY 1 MATTERS

PATIENTS RESULTS FINANCE PARTNERS STAFF

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

Part 2

Priorities for improvement and statements of assurance from the Board

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:

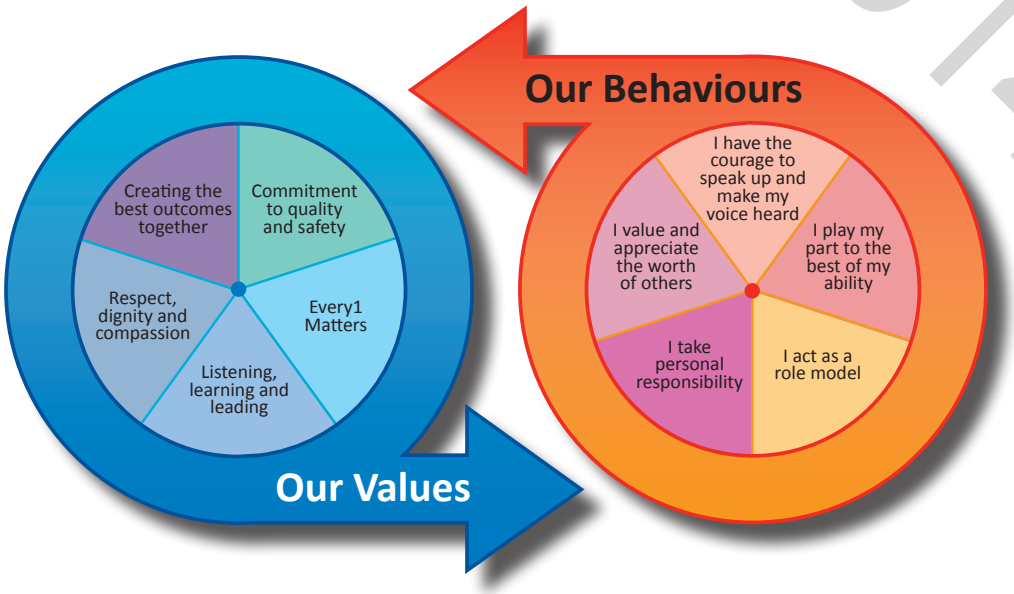
"To Deliver Excellence in Healthcare through Innovation and Collaboration"

The Trust will be a provider that:

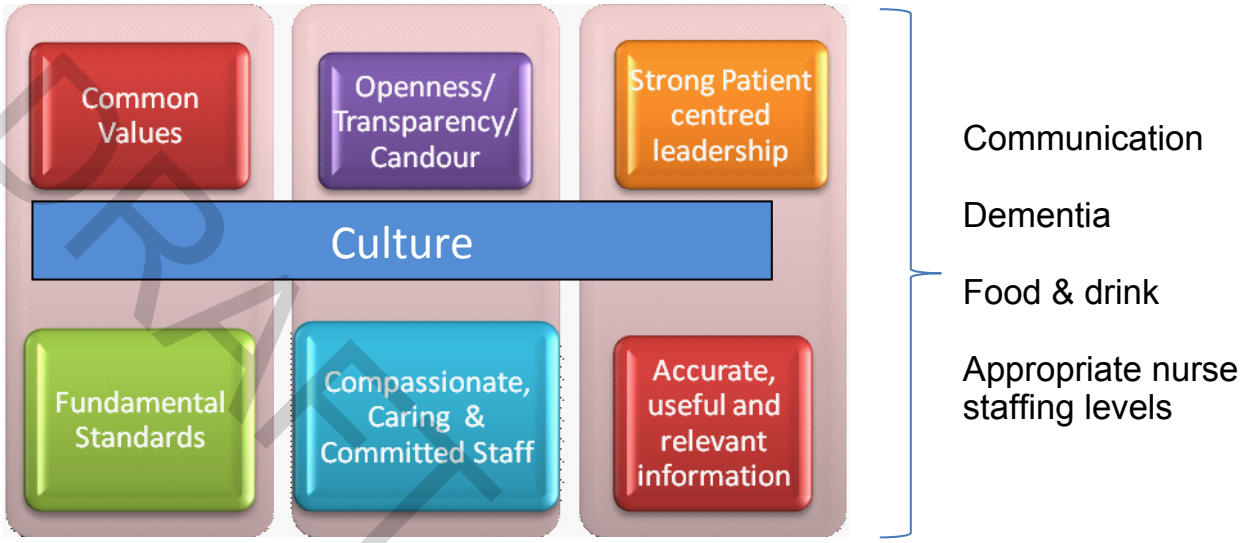
- Delivers high quality, safe, cost-effective and sustainable healthcare services
- Provides a working environment that is underpinned by values and behaviours
- Is committed to patient-centred care
- Treats patients and staff with dignity and respect.

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:



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."

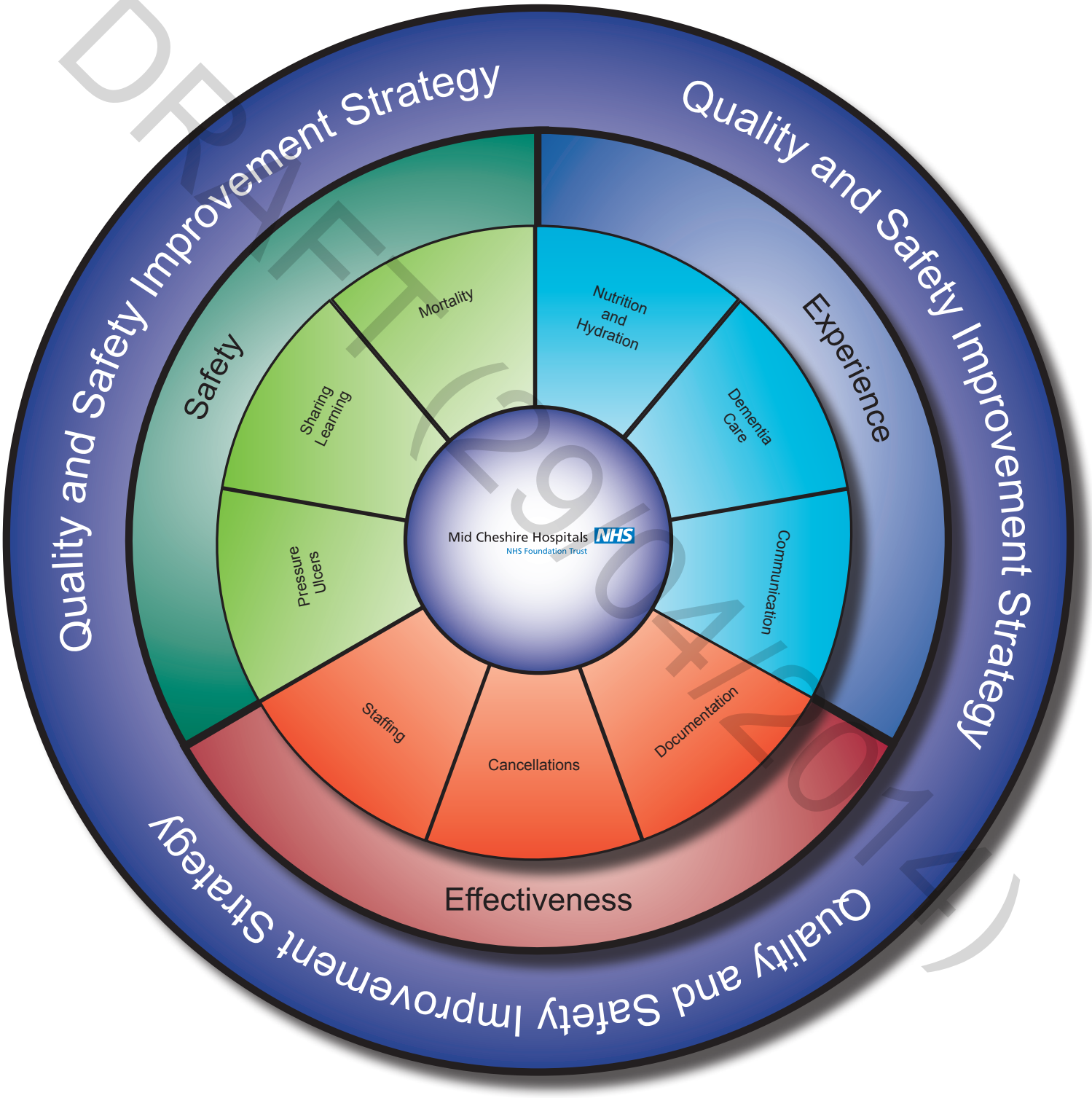
Patient Safety

- 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.

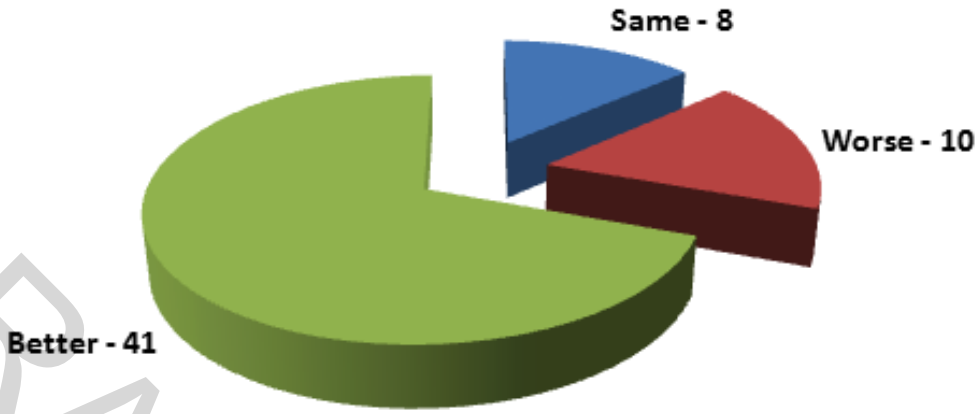
Responses were received from 442 patients which equates to a response rate of 54% of completed eligible returns.

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.

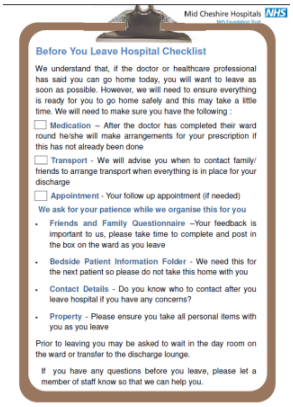
The Trust's overall score has improved by 2.2% since the last survey undertaken in 2012.

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



Areas identified for improvement

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


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.

- **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.

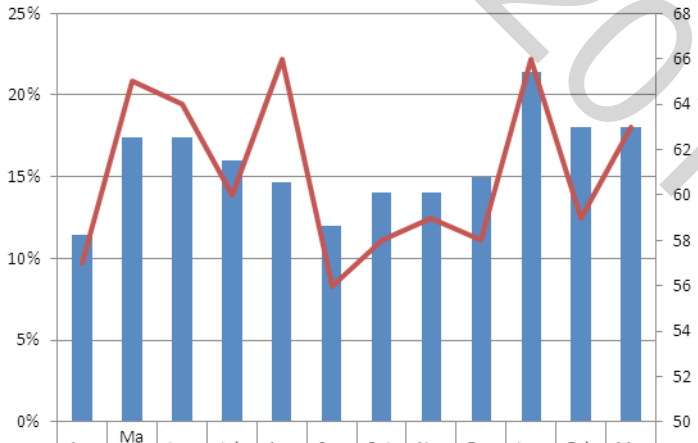
> From the first day the staff have been attentive, caring, and I have not waited for the toilet or medication. My only feedback is that beds should be ready for patient on day of operation and when you are being discharged, they should not be rushed out. All in all fantastic care.

> 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

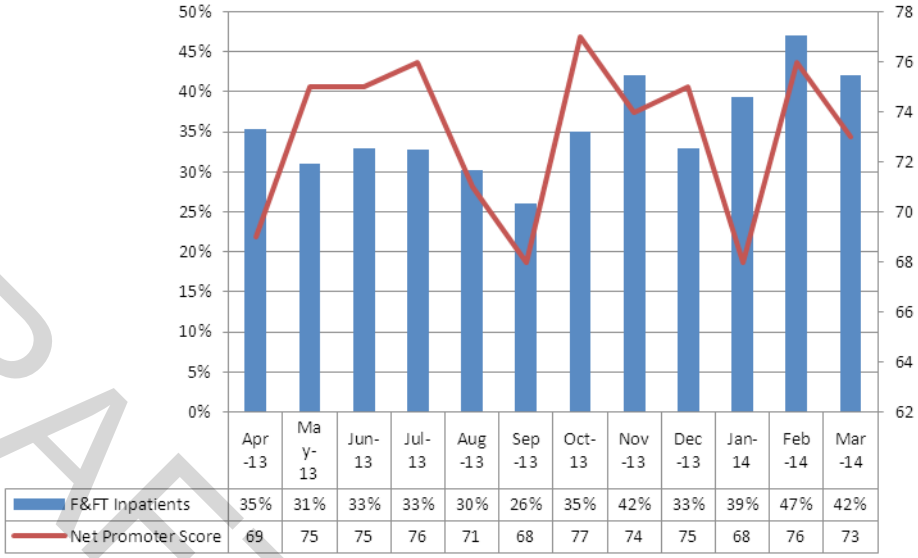
The following charts show the percentage response rate for patients and the Trust is delighted that the required national target specified as part of the CQUIN programme has been achieved. The charts also show the net promoter score results.

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



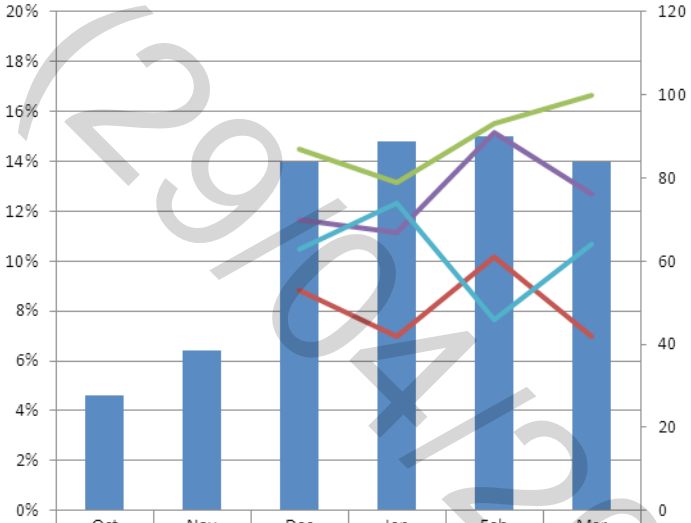
	Apr -13	May-13	Jun-13	Jul-13	Aug -13	Sep -13	Oct-13	Nov -13	Dec -13	Jan-14	Feb -14	Mar -14
F&FT A&E & Assessment Areas Response Rate	11%	17%	17%	16%	15%	12%	14%	14%	15%	21%	18%	18%
Net Promoter Score	57	65	64	60	66	56	58	59	58	66	59	63

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

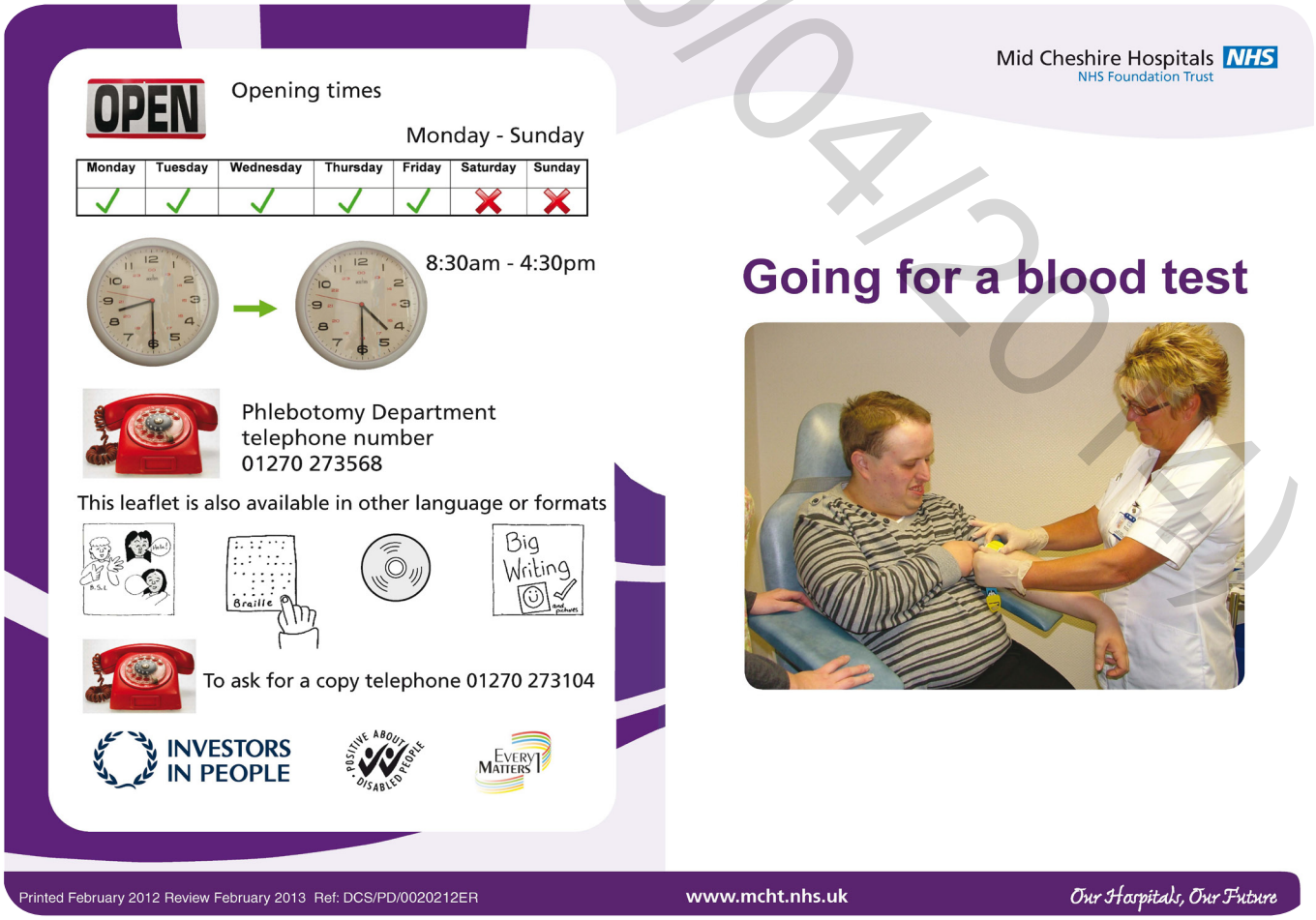
best manage patients in hospital with a learning disability.

- *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

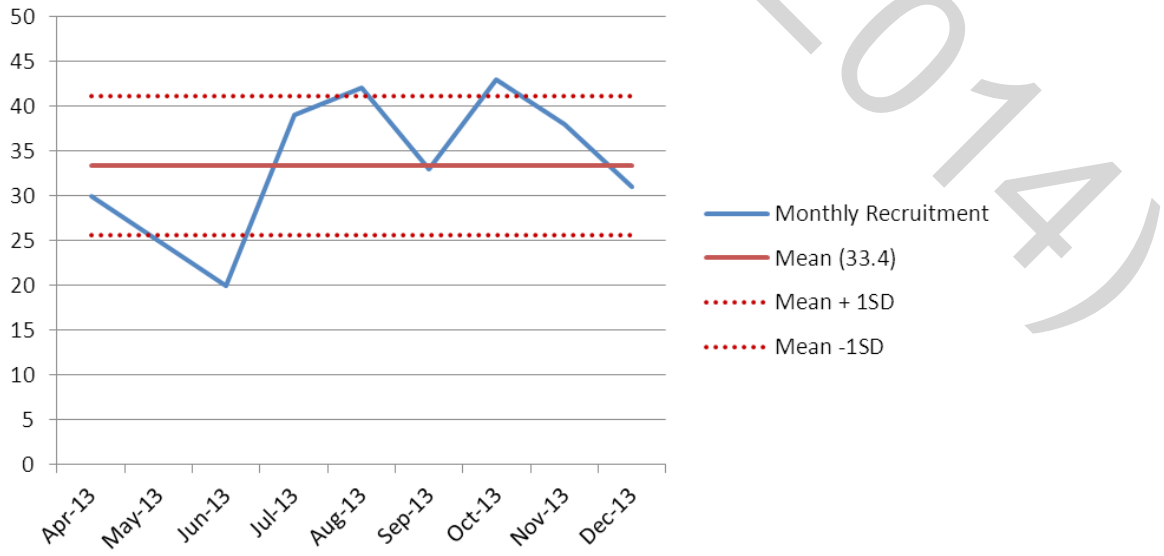
Local Audit	Actions taken / to be taken by the Trust
Audit of Obstetric Pre-Existing Diabetes	A diabetic care record for pregnant women with pre-existing diabetes has been implemented. Patient information leaflets have been developed in conjunction with the diabetes team which have been included in updated 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%	✓

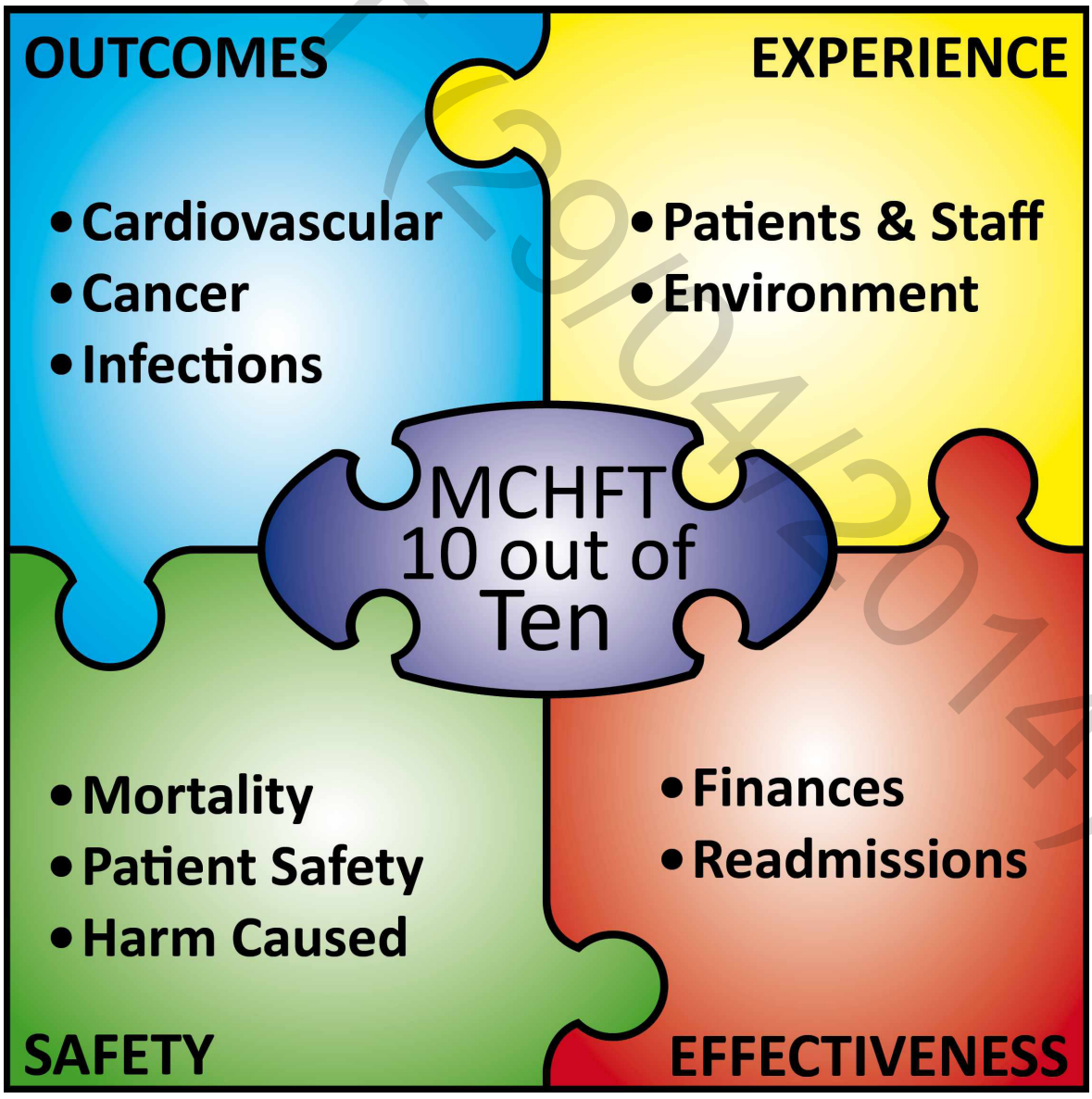
Part 3

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

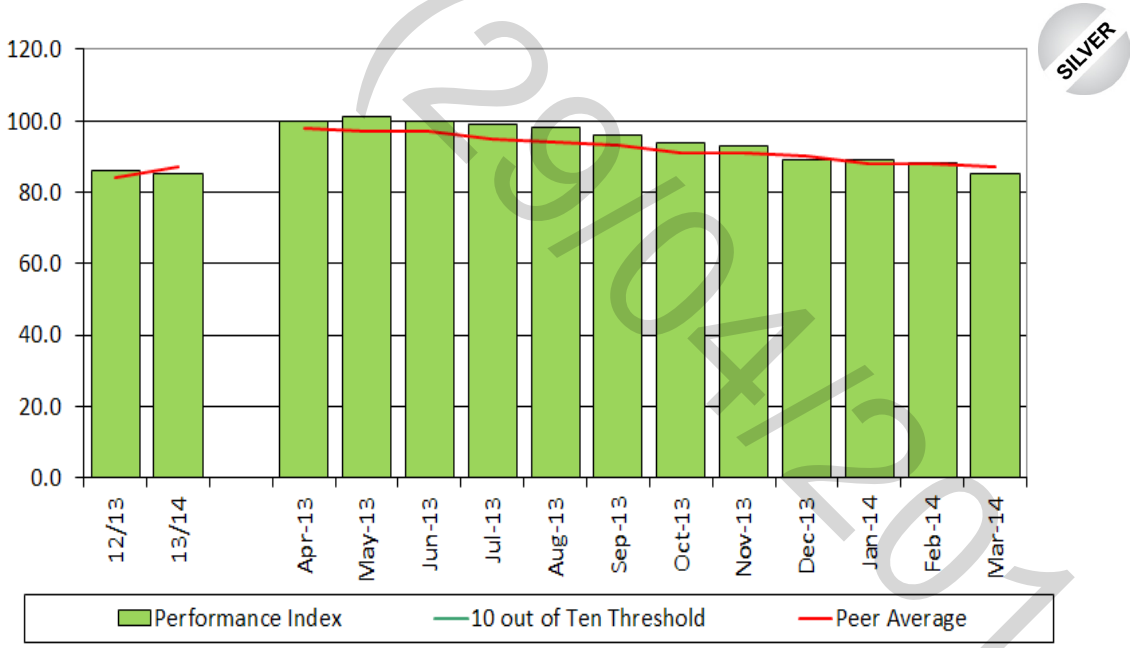
Priority 1: Mortality

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.

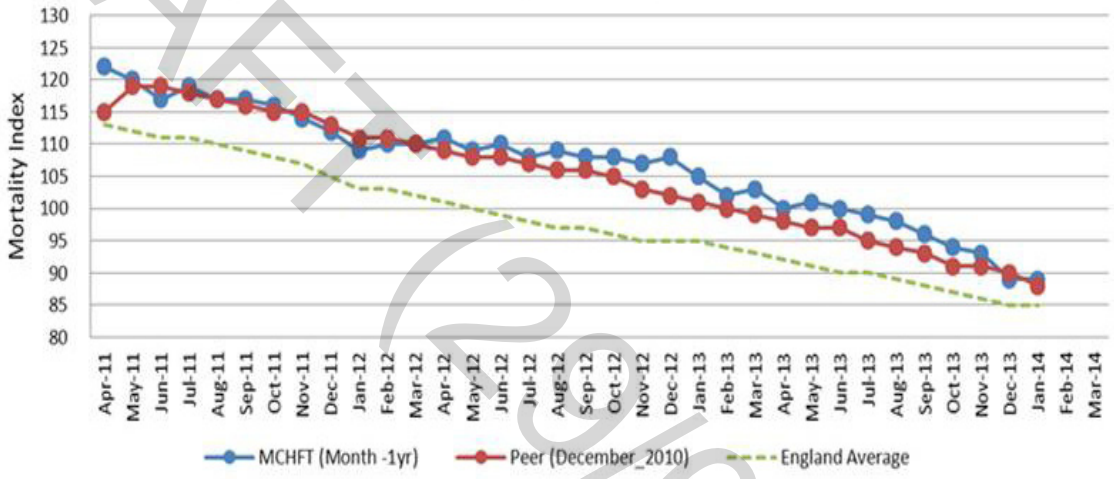
Work Programme to Improve Hospital Mortality Rates

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

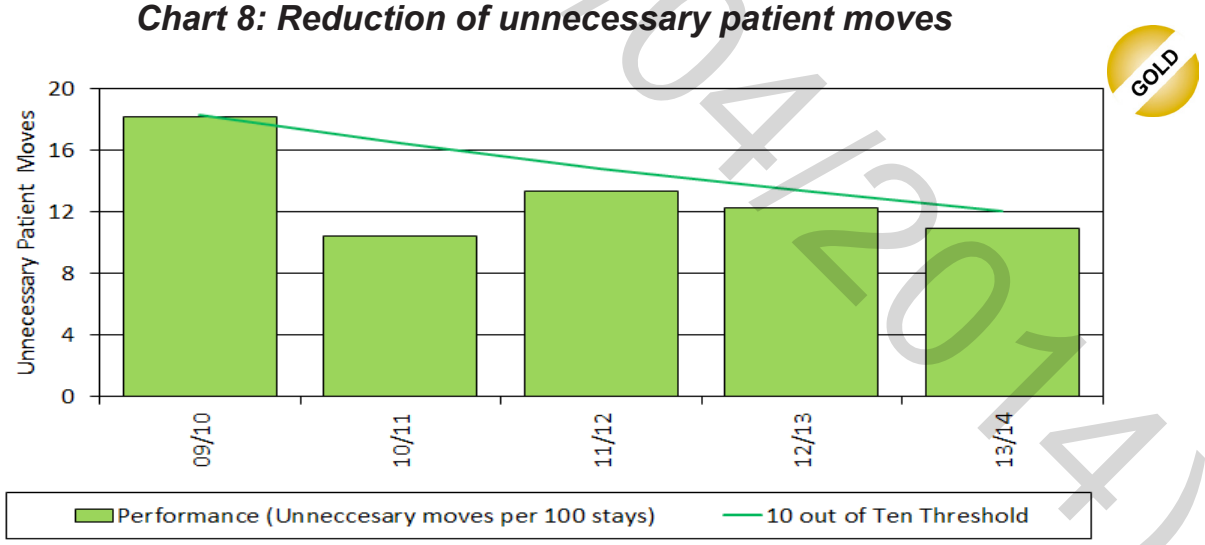
To monitor and reduce the number of unnecessary patient moves during a patient's stay in hospital

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

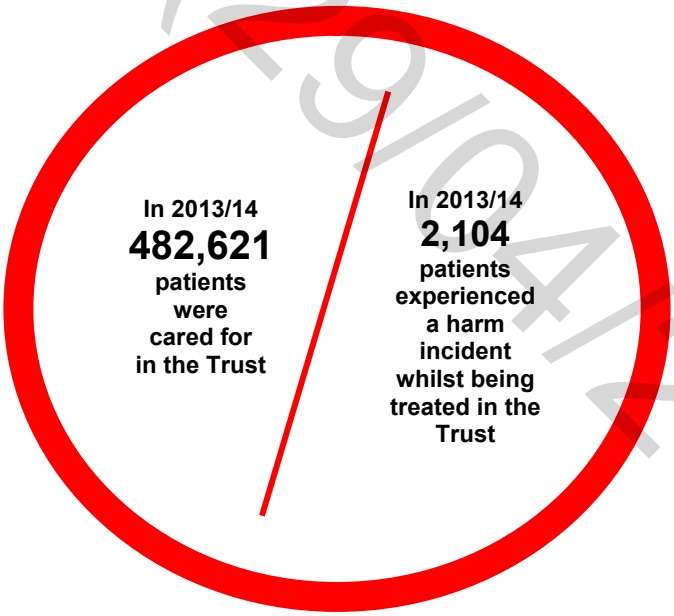
All patient safety incidents are reported within the Trust using the risk management system 'Safeguard Ulysses'. The Trust monitors patient safety incidents resulting in harm on a monthly basis through the Board performance report.

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



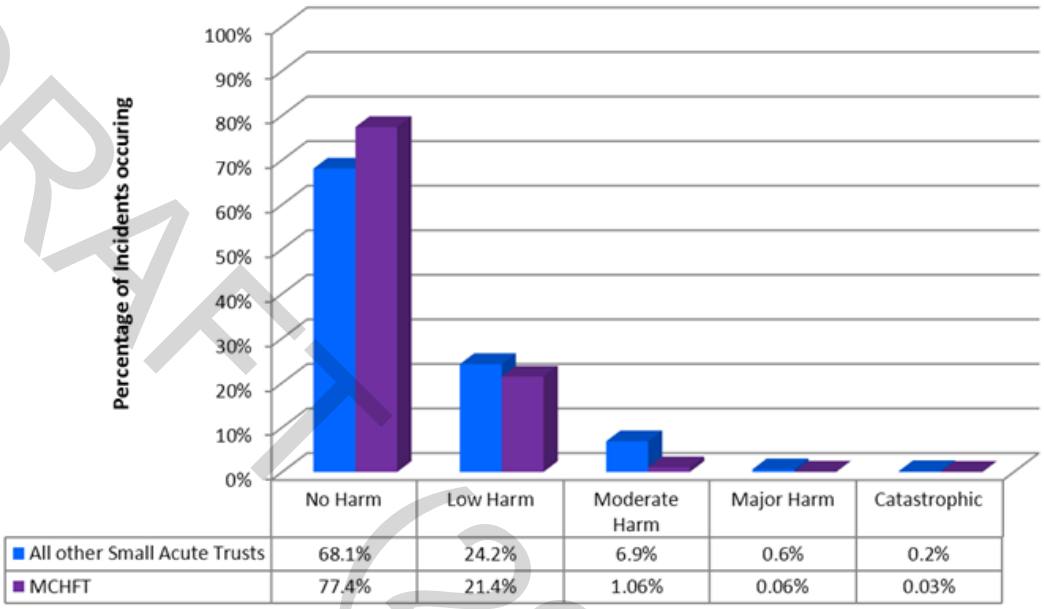
National Reporting and Learning System
The Trust reports all patient safety incidents to the National Reporting and Learning System (NRLS) on a weekly basis. The NRLS was established in 2003 and enables patient safety incident reports to be submitted from NHS organisations to a national database. This 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.

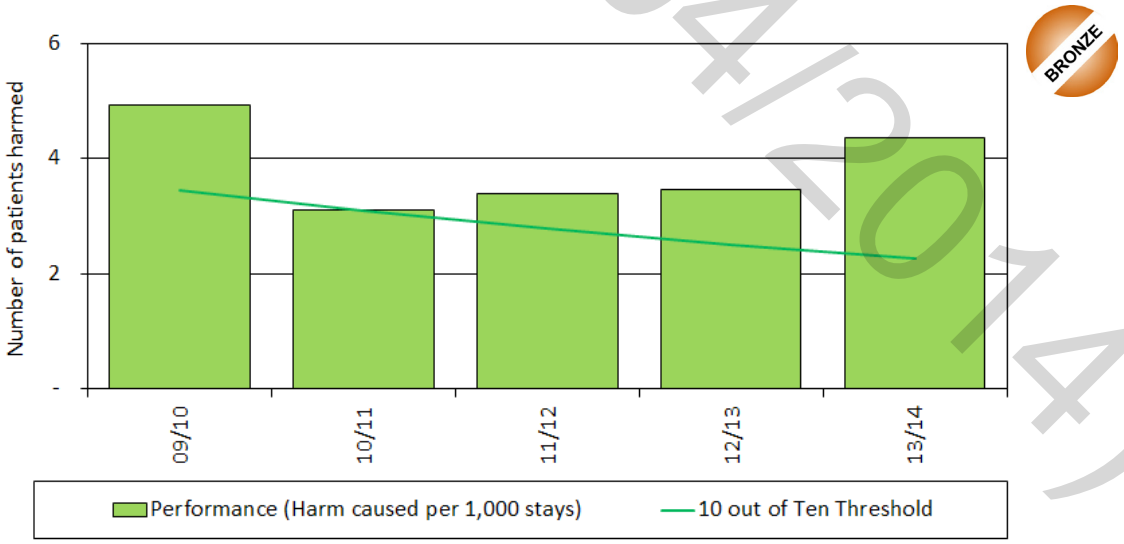
Chart 10: NRLS comparative data for October 2012 to March 2013



	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

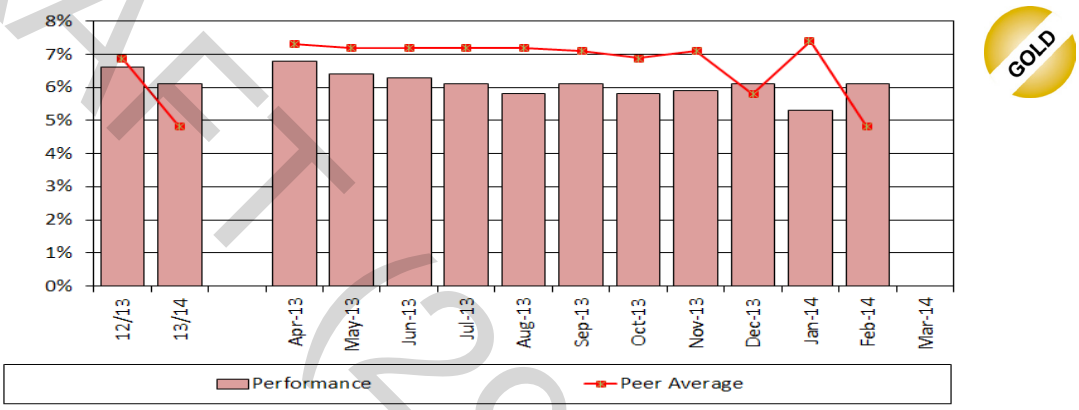


Chart 12 demonstrates that the number of emergency readmissions has fallen from 6.8% in April 2013 to 6.1% in February 2014 and, overall, the Trust's performance continues to be better than peer when compared against other acute Trusts in the North of England.

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.

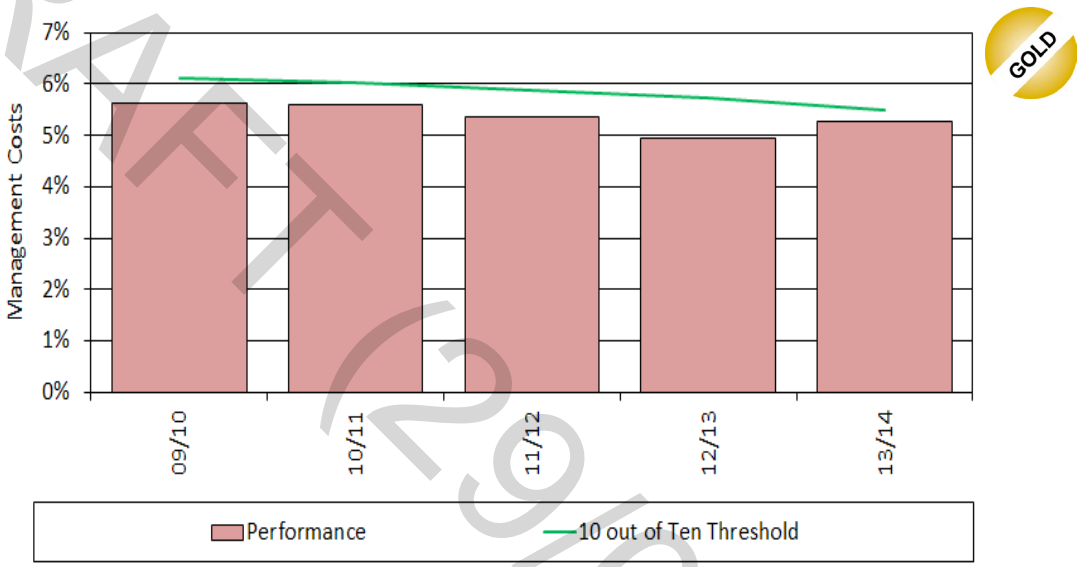
Effectiveness

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:

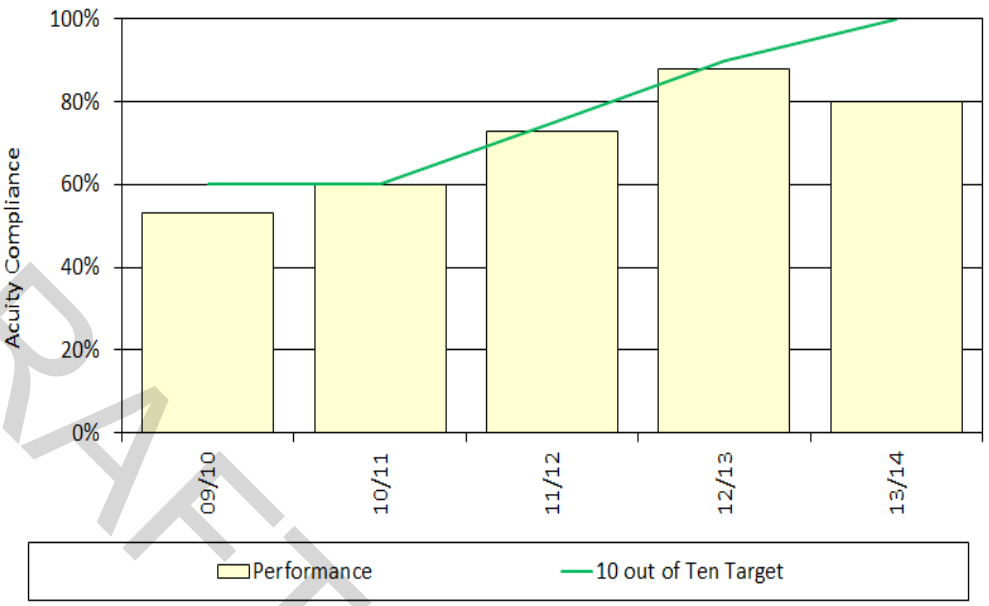
- Increasing complexity of patients
- Reduction in length of stay
- Increasing older population
- Increasing number of patients with dementia.

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.

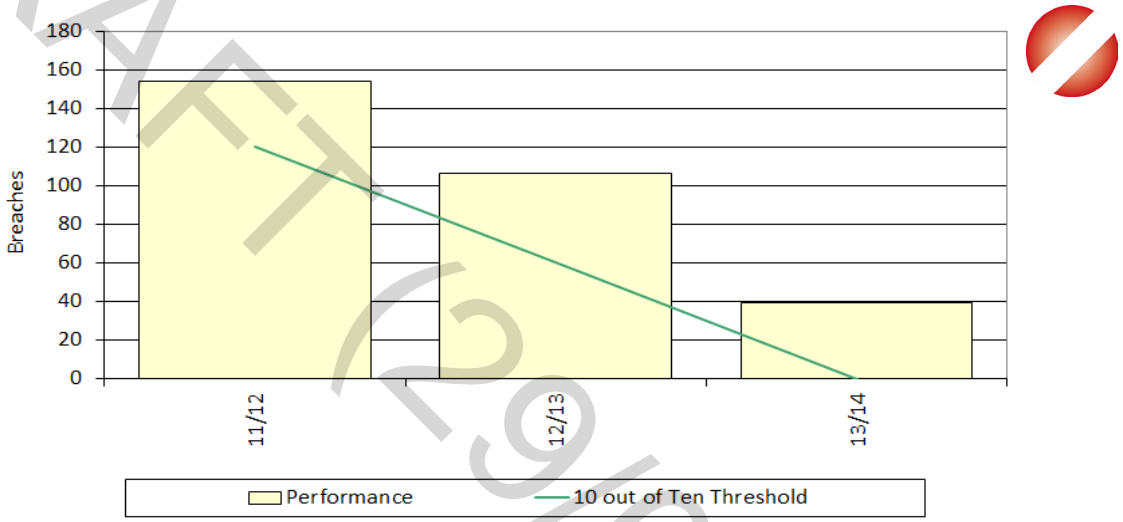
The Trust has recently opened a purpose-built Critical Care Unit, and the elimination of mixed sex accommodation was a key consideration in its build. The newly opened unit will

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)

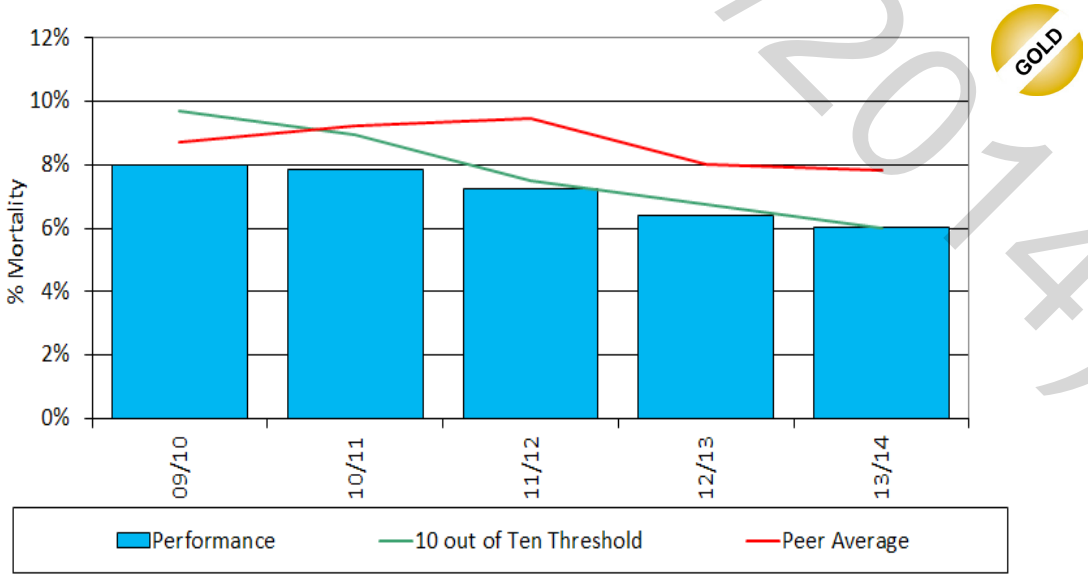
There were approximately 600 patients admitted in 2013/14 with a diagnosis of Acute Myocardial Infarction (AMI). Many of these patients were either taken directly to tertiary hospitals for treatment and intervention, or transferred after initial treatment at the Trust for further intervention. Patients 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.

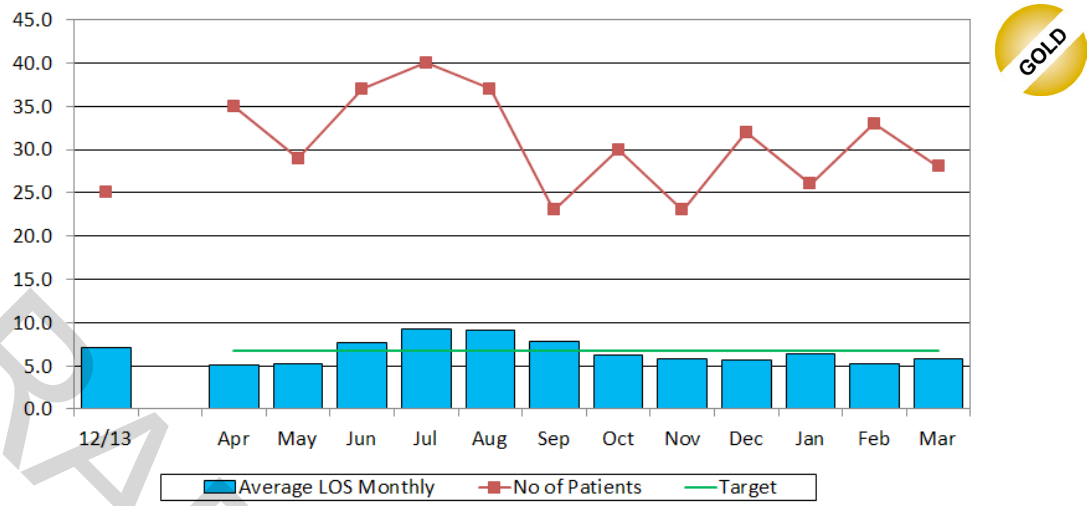
The Trust was one of the first Trusts in the Cancer Network to establish an acute oncology service and therefore there is very little peer data available with which to compare the Trust. The intention of the implementation of the acute oncology team is reduce the length of stay for patients admitted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

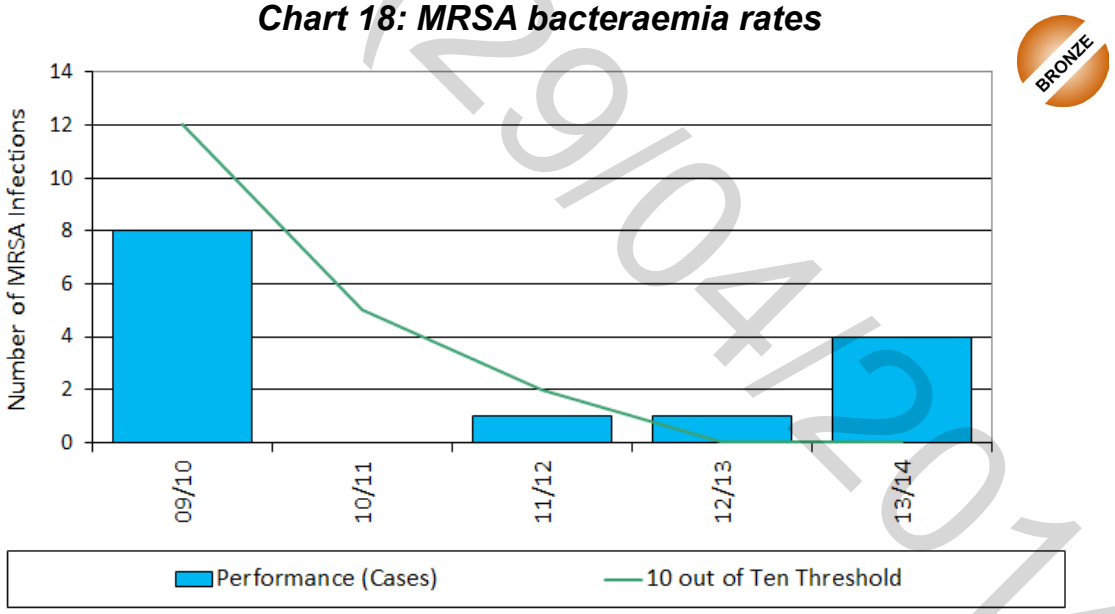
To reduce the rates of Healthcare Associated Infections (HCAI)

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.

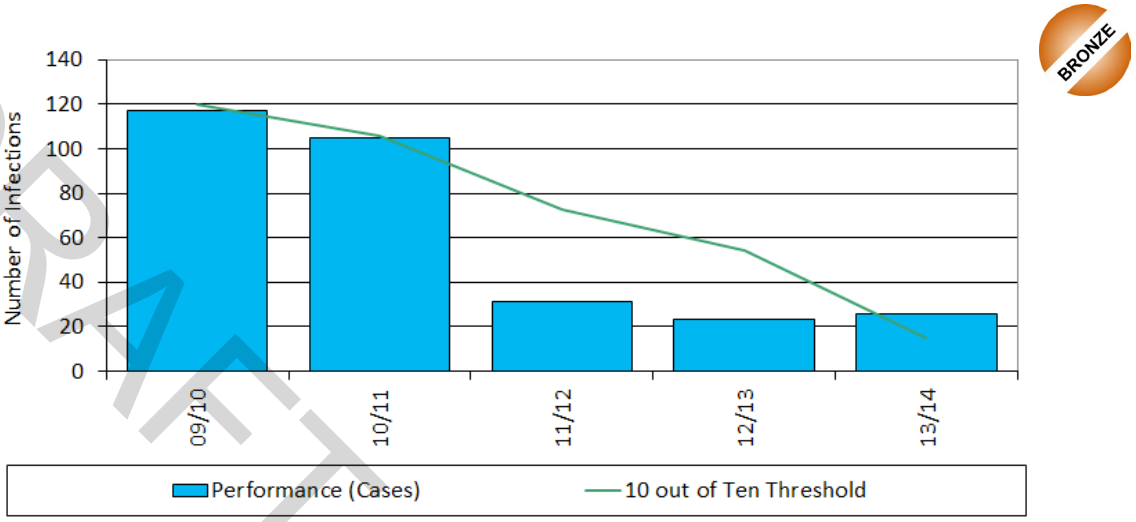


Chart 19: Clostridium difficile rates.

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.

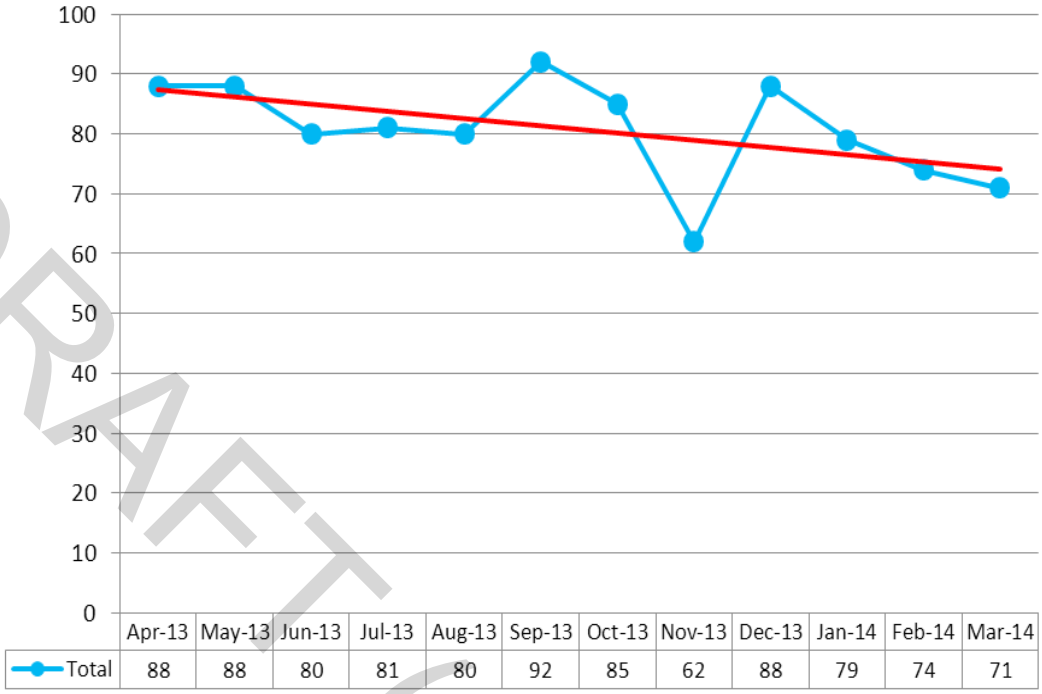
For people experiencing a fall, there may be many negative associations and perceptions, such as a sense of imminent loss of independence and risk of institutionalisation.

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?

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

_____
_____
_____
_____
_____

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Quality Account 2013/14