Countess of Chester Hospital NHS Foundation Trust

Quality Account

2010 / 2011


Dimensions

Quality Account Contents

Summary Statement on Quality from the Chief Executive

Part One

2010-2011 has been a dynamic and exciting year for the Countess of Chester with the continued focus being upon transforming the organisation through the development of patient pathways with the patient central in their care.

We have acquired a community hospital with a predominant focus on rehabilitation which has enabled us to streamline services for the older person. We have reviewed our corporate objectives to ensure they are still fit for purpose. We were again awarded a place in the top 40 hospitals by CHKS, a leading healthcare intelligence provider.

Listening to the opinions of our patients and their relatives is core to putting the patients at the heart of everything we do. Engaging in constant dialogue helps us to identify areas for improvement that are important to our patients.

We have actively engaged with patients, service users, our membership and other stakeholders such as the Health and Wellbeing Select Panel of the Cheshire West and Chester Council and West Cheshire LINks.

We continue to have a proactive Board of Governors which continually engages with constituents to ensure that our direction is shaped in line with local needs. We also have many patient representatives engaged in Trust business and influencing the direction of service.

For the second year in succession, we have carried out hundreds of face to face interviews to understand the key priorities members of the public feel we should address.

Our transformational strategy, The Countess Way, has underpinned the reorganisation of the Trust from four divisions to three, Urgent Care, Planned Care and Diagnostics and Therapy Services. These three large divisions are supported by a number of corporate functions. This has allowed us to totally redesign the patient pathway to ensure we provide the most effective and efficient service with the best clinical outcomes for patients. The Countess Way encompasses three main workstreams. These are quality Improvement, transformational change and cost reduction.

2010-2011 saw the conclusion of our local Quality Improvement Programme which commenced in 2009. This programme was integral in progressing our new strategy for quality which was introduced in March 2010 to support our organisational transformation. This strategy sets clear direction for continuing our Quality Improvement Programme in line with The Countess Way and ensures transparency from ward to board with the development of a new governance process.

Following on from the success of delivering 2009-2010’s four Commissioning for Quality and Innovations (CQUIN’s) we achieved full recognition for the delivery of our eight new local CQUINs and the achievement of the stretch targets set within the Quality Schedule which is part of the contract we have with our commissioners of NHS care.

The past year has continued to see outstanding progress towards our 'zero tolerance' strategy to health care associated infection with sustained improvement and a reduction in MRSA bacteraemia cases.

We have again declared compliance with the elimination of mixed sex accommodation. Our action plan developed following our dignity audit, in partnership with Age UK, in March 2010 reflects the importance we place on care with dignity.

In line with national legislation we published our single equality scheme and continue to have active subgroups working on this agenda to ensure patients are treated fairly with respect and equality in a dignified way, making informed choices as is their right.

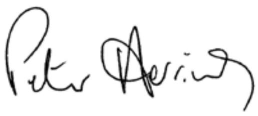
We continue to meet the requirements of our registration with the Care Quality Commission with the addition of Ellesmere Port Community Hospital as a new location.

We have also fulfilled our statutory obligations with regards to Safety Alerts/ National Patient Safety Agency reporting and national recommendations relating to best practice. Our safe practice in maternity services resulted in our successful achievement of National Litigation Standards Authority level 2. Our general assessment looking at safer care across the organisation as a whole will be carried out later in the year.

Our Board of Governors continues to bring great value to the organisation with a defined strategy to provide a healthy challenging presence to the Board.

The economic downturn continues to present us with a challenge and we recognise that delivering quality care as efficiently as possible is paramount to our continued success. We aim to ensure that this is achieved.

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



Peter Herring
Chief Executive

Statement of Directors' Responsibilities in Respect of Quality Accounts

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

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the Quality Report.

The Board is satisfied, to the best of its knowledge, that:

- The content of the Quality Account meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2010-2011
- 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 2010 – March 2011
✓ Papers relating to quality reported to the Board over the period April 2010 – March 2011
✓ The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated September 2010
✓ The 2010 Inpatient Survey: January 2011
✓ The 2010 National Staff Survey: Received March 2011
✓ The Head of Internal Audit's annual opinion of the Trust's control environment dated 31.03.11
✓ Care Quality Commission Quality and Risk Profiles received monthly and on occasion bimonthly in 2010 - 2011
✓ Feedback reports from NHS Western Cheshire
✓ Feedback reports from governors
✓ There were no reports received from the Overview and Scrutiny Committee or the Local Improvement network

- The Quality Report presents a balanced picture of the Countess of Chester NHS Hospital Foundation Trusts performance over 2010-2011
- The performance information reported in the Quality Account is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account and these controls are subject to review to confirm they are working effectively in practice
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Account has been prepared in accordance with Monitors annual reporting guidance as well as the standards to support data quality for the preparation of the Quality Account

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

By order of the Board

Sir Jim Sharples
Chairman
21 June 2011

Peter Herring
Chief Executive
21 June 2011

Independent Auditor's Report to the Board of Governors of Countess of Chester Hospital NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Board of Governors of Countess of Chester Hospital NHS Foundation Trust to perform an independent assurance engagement in respect of the content of Countess of Chester Hospital NHS Foundation Trust's Quality Report for the year ended 31 March 2011 (the 'Quality Report').

Scope and subject matter

We read the Quality Report and considered whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual, and considered the implications for our report if we become aware of any material omissions.

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual 2010/11 issued by the Independent Regulator of NHS Foundation Trusts ('Monitor').

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that the content of the Quality Report is not in accordance with the NHS Foundation Trust Annual Reporting Manual or is inconsistent with the documents.

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

- Board minutes for the period April 2010 to June 2011;
- Papers relating to quality reported to the Board over the period April 2010 to June 2011;
- Feedback from the commissioners dated 17/05/2011;
- Feedback from governors dated 19/05/2011;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated September 2010;
- The 2010 Inpatient Survey, January 2011;
- The 2010 National Staff Survey, March 2011;
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 31/03/2011; and
- Care Quality Commission Quality and Risk Profiles received monthly and on occasion bimonthly in 2010-2011

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

This report, including the conclusion, has been prepared solely for the Board of Governors of Countess of Chester Hospital NHS Foundation Trust as a body, to assist the Board of Governors in reporting Countess of Chester Hospital NHS Foundation Trust's quality agenda, performance and

Tim Cutler
KPMG LLP
Chartered Accountants
Manchester
21 June 2011

activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2011, to enable the Board of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the Quality Report.

To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of Governors as a body and Countess of Chester Hospital NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

- Making enquiries of management;
- Comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- Reading the documents.

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

Limitations

It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2011, the content of the Quality Report is not in accordance with the NHS Foundation Trust Annual Reporting Manual.


Women & Children's Building
MATERNITY EMERGENCIES
The Chester Childbirth Appeal
Shop & Café
Strictly No Parking
CHESTER CHILDBIRTH

Priorities for improvement in 2011/2012

The Trust has a significant number of quality and safety improvement initiatives planned for 2011-2012. The following information focuses on our key priorities as we move forward.

Part Two

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

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

Experience

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

Clinical Effectiveness

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

Safety

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

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

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

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

Experience

Aim	Monitored	Measured
To improve the patient experience relating to all points of contact prior to and within the hospital when accessing services: The is part of our Countess Way Programme	By The Countess Way Programme Board review of processes , action plans and improvements in the way patients are directed in how to access to services	By quality and delivery of outcomes and cost. By a reduction in complaints and incidents
To develop a children's comments card to seek the experience of children on an ongoing basis to inform paediatric therapy services improvement	By therapists action planning for improvements based on children's comments	By actions taken by the team in response to the comments
Implement real time patient experience surveys in outpatients	By the outpatient manager reviewing survey results and taking appropriate action	By survey response rates and an increase in the percentage of positive responses following action plan implementation

Effectiveness

Aim	Monitored	Measured
To improve communication on nutrition support decisions to primary care made following a review by the nutritional team	By the Nutritional Steering Group	By a programme of audit relating to letters being sent to the general practitioner regarding nutritional care delivered
To enable patients to be discharged by other health professionals in a more timely way	By the Heads of Nursing responsible for inpatient nursing care	By a programme of audit to assess improvements in discharge for patients
To introduce enhanced recovery for total Hysterectomy patients	By the Consultant lead and the team who will assess that all elements of the pathway are delivered and review the patient experience	By a programme of audit to assess improvement in Hysterectomy care and potential shorter hospital stays

Priorities for improvement in 2011/2012

Safety

Aim	Monitored	Measured
Implementation of early supported discharge for patients following a stroke	By the stroke team who will review the pathway and develop systems to support early discharge and monitor progress via an action plan	By a review of the system implemented and a potential reduction in the hospital stay of some patients following a stroke
To improve the care management of patients with dementia by the introduction of the 'This is me' document	By the identified ward manager ensuring that all patients with dementia have a document completed	By a programme of audit to review the outcome of this process
To ensure patients receive all prescribed medicine in a timely manner and waste is kept to a minimum	By the identified ward manager reviewing the safe administration of medicines and monitoring waste from the ward	By an ongoing reduction in medication administration incidents and a reduction in Trust wide waste relating to medicines not used

Whilst targeting the above areas we will continue to:

- Maintain high standards of infection prevention and control as detailed in the Health Act 2009
- Continue our planned programme of transformation driving down length of stay and improving administration processes to ensure high quality patient experience. We will be working with theatres to create greater efficiencies and we will be reducing cancellations and numbers of changes to appointments. We will also be working with our patients to reduce the numbers that 'do not attend' their appointments
- Utilise the Global Trigger Tool case note reviews monthly to monitor harm and disseminate learning and improvements in care
- Embed our 2010-2011 commissioning for quality and innovation (CQUIN) initiatives so they become business as usual, and work to implement the new CQUIN programme
- Meet the requirements of our quality contract with our commissioners
- Continue to develop our workforce to ensure they have the skills to deliver quality care in the most effective way.

Transfer of Contraceptive and Sexual Health services

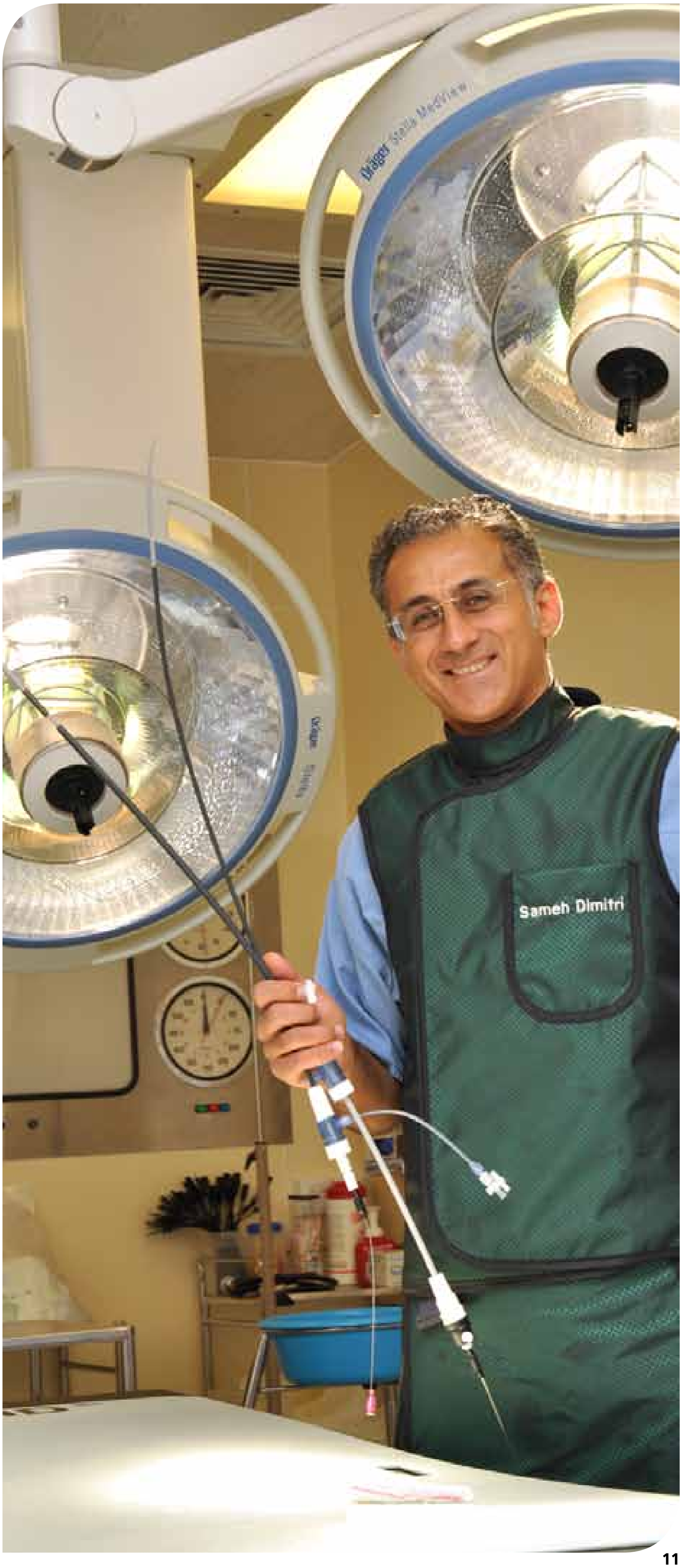
From April 1st 2011 the Trust will manage the above community services as part of its current regulated activities. There will be a strong focus in 2011-2012 in ensuring that this transition is seamless for patients and that the service is reviewed to ensure all necessary quality requirements are met.

Capacity and Capability

The Trust has implemented a new structure to support quality improvement in 2010-2011 which has resulted in the development of a central quality team. £250,000 was allocated in the budget for 2010-2011 as a commitment to quality improvement which included a number of new clinical posts and additional funding to support particular projects. Commitment for 2011-2012 includes the continuation of these posts on a permanent basis plus additional funds of £100,000 to support ongoing work.

Countess Quality Improvement Programme

This programme was successfully merged with our new quality strategy to ensure the improvements made continue to be built upon.



Review of services

During the reporting period the Countess of Chester Hospital NHS Foundation Trust provided and contracted 48 services. These are included in our statement of purpose.

The Countess of Chester Hospital NHS Foundation Trust has reviewed all the data available to them on the quality of care in the form of audits both local and national and there are a number of local mechanisms in place to ensure that data regarding quality of care is monitored and improved in all of our services as follows:

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

The income generated by the NHS services reviewed in 2010/2011 represents 93% of the total income generated from the provision of NHS services by the Countess of Chester Hospital NHS Foundation Trust for 2010-2011.

Participation in clinical audits

During 2010/2011, the Countess of Chester engaged in 34 national clinical audits including six national confidential enquiries.

There were several national and national confidential enquiries into patient outcome and death (NCEPOD) audits which were not relevant to the Trust and this equated to a participation rate of 78% national clinical audits and 88% national confidential enquiries from the Trust.

The national clinical audits and national confidential enquiries that the Countess of Chester Hospital NHS Foundation Trust was eligible for, and did participate in are as follows:

National Audits 2010/2011	Participation	Data collection completed	Rate of case ascertainment (%)
Feverish Children	✓	✓	100%
Renal Colic	✓	✓	100%
Vital signs	✓	✓	100%
Audit of Critical Care	✓	Ongoing	100%
Trauma Audit and Research Network (TARN)	✓	Ongoing	100%
Epilepsy in Children	✓	Ongoing	100%
Sentinel Stroke Audit	✓	✓	100%
National Audit of Dementia	✓	✓	100%
Heart Failure Audit	✓	✓	100%
Open Abdomen	✓	Ongoing	100%
National Comparative Audit of Blood Transfusion	✓	✓	100%
Myocardial Infarction National Audit Project (MINAP)	✓	Ongoing	100%
National Audit of Continence Care	✓	✗	50% organisational questionnaire submitted only
National Audit of Falls & Bone Health	✓	✓	100%
National Lung Cancer audit	✓	✓	100%
Familial Hypercholesterolaemia	✓	✓	100%
National Care of the Dying	✓	✓	100%
National Inflammatory Bowel Syndrome Audit	✓	✓	100%
National Elective Surgery Patient reported outcome measures (PROMS)	✓	Ongoing	Variable across 4 conditions
National Diabetes Audit	✓	Ongoing	100%
National Cervical Cancer Audit	✓	✓	100%
Obstetric Surveillance	✓	Ongoing	100%
National HIV in Pregnancy	✓	Ongoing	Not available
Head & Neck Oncology	✓	Ongoing	Not available
Bowel Cancer	✓	✓	100%
Oesophago-gastric cancer audit	✓	✓	100%
National Mastectomy & Breast Reconstruction Audit	✓	✓	100%
Heavy Menstrual Bleeding	✓	Ongoing	Not available

Review of services

Confidential Enquiry into Maternal & Child Health	Participation	Data collection completed	Rate of case ascertainment (%)
Perinatal Mortality	✓	✓	Audit started 1st March 2011. Audited every 3 yrs.
Head injury in Children	✓	✓	100%
Surgery in Children	✓	✓	100%

National Confidential Enquiry into Patient Outcome & Death	Participation	Data collection completed	Rate of case ascertainment (%)
Acute Kidney Injury	✓	✓	84%
Cardiac Arrest	✓	Ongoing	100%
Peri-operative Care	✓	✓	70%

The national audits and national confidential enquiries in which the Countess of Chester Hospital NHS Foundation Trust participated is the same list as above as we engaged in every audit that was eligible, and for which the data collection was completed during 2010/2011. They are in the list above alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases submitted to each audit or enquiry, where available.

The reports of 22 national clinical audits, including four National Confidential Enquiry reports were reviewed by the Trusts Quality Committee in 2010/2011 and disseminated to relevant multidisciplinary committees.

The Countess of Chester NHS Hospital Foundation Trust intends to take the following actions to improve the quality of the healthcare provided:

- Introduce changes to practice in dementia care relating to assessment and use of anti-psychotic medication
- Continue to improve stroke care by ensuring access to dedicated services in a timely manner and introducing early supported discharge
- Improve the assessment and management of patients with an acute kidney injury
- Carry out some local audit into the management of continence and action plan for improvements

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

The reports of more than 270 local clinical audits were reviewed by the provider in 2010/2011 and the Countess of Chester NHS Hospital Foundation Trust intends to take the following actions to improve the quality of the healthcare provided:

- To improve the prevention and management of falls by enhancement to the assessment process and the patient environment, particularly in our rehabilitation unit
- Maintain the safety of patients with a tracheostomy, on general wards, by ongoing local audit to ensure all care needs are met against a clear standard of care
- Improve antibiotic prescribing and management of infection by continued real time audit and the continuation of microbiologist led Clostridium Difficile ward rounds
- Improve fundamental nursing care via the implementation of a new system which reviews patient care across a range of indicators on every ward every month
- Reduce length of stay and improve the clinical outcome for patients through extended use of enhanced recovery programmes

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

Participation in clinical research

The number of patients receiving NHS services provided by the Countess of Chester Hospital NHS Foundation Trust in 2010/2011 that were recruited during that period to participate in researchapproved by a Research and Development Committee was 630.

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

1.5% of the Countess of Chester Hospital NHS Foundation Trust income in 2010/2011 was conditional on achieving quality improvement and innovation goals agreed between Countess of Chester Hospital NHS Foundation Trust and NHS Western Cheshire through the Commissioning for Quality and Innovation payment framework. In monetary terms, this equated to £1.7 million.

All CQUIN monies were earned for locally commissioned innovations, however the Trust was paid at 70% of the monies allocated to the national patient experience CQUIN, as whilst demonstrating improvements the stretch target set was not met. This equated to a loss of £66,443.

The CQUIN framework was agreed in partnership with the Primary Care Trust and involved close working with clinicians from both primary and secondary care. The schemes ranged from innovative service developments e.g. osteoporosis management, admission avoidance schemes reliant on cross boundary working and new care innovation e.g. advanced care planning, brief intervention work. Some of the schemes are discussed further in other areas of the report.

Further details of the agreed goals for 2010/2011 and for the following 12 month period are available on request from foundation.trustenquiries@coch.nhs.uk .

Care Quality Commission Registration (CQC)

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

The Care Quality Commission has not taken enforcement action against the Countess of Chester NHS Hospital Foundation Trust during 2010-2011.

The Countess of Chester NHS Hospital Foundation Trust is subject to periodic reviews by the Care Quality Commission. There were two reviews in 2010-11. The first was in conjunction with the Office for Standards in Education, Children's Services and Skills (Ofsted) and related to safeguarding children and was part of the Care Quality Commission commitment to inspecting safeguarding children, across the whole country over a three year period.

The review was across the health and social care economy and took place in November 2010. The Countess of Chester NHS Hospital Foundation Trust intends to take the following action to address the recommendations of the report:

» Ensure that all referrals to children's social care are appropriate via audit and partnership working
» Ensure robust pathways are in place for Common Assessment Framework cases
» Ensure that community paediatricians are appropriately trained and competent to complete initial health assessments on children in care
» Increase the importance of identification of children living with domestic abuse.

The last Care Quality Commission review was in the form of a randomly chosen unannounced inspection to observe patient dignity and nutrition. This took place in March 2011.

The Care Quality Commission's assessment of the Countess of Chester NHS Hospital Foundation Trust was extremely favourable and the Trust was found to be fully compliant with the essential standards observed.

The Countess of Chester NHS Hospital Foundation Trust has participated in one special review by the Care Quality Commission in 2010-2011 relating to stroke services. The Countess of Chester NHS Hospital Foundation Trust intends to work with the Primary care trust and emerging GP consortium to improve transfer home following a stroke and develop a process whereby patients can be discharged earlier and be supported in the community. These actions will be taken forward in 2011-2012.

Data quality

NHS and General Medical Practice Code validity:

The Countess of Chester Hospital NHS Foundation Trust submitted records during 2010/2011 to the Secondary Users Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was:

- 99.6% for admitted patient care
- 99.7% for out patient care
- 97.5% for accident and emergency care

and which included the patient's valid General Practitioner Registration code was:

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

(Latest available information April 2010 – January 2011)

Information Governance Toolkit Attainment levels:

The Countess of Chester Hospital NHS Foundation Trust Information Governance Assessment Report overall score for 2010/11 was 64% and was graded red.

We did not achieve a green status on the new key requirement for Information Governance Training. This is a requirement for 95% of the workforce to have received new training and to have completed an assessment. The Trust is in the process of taking the following action to address this:

- Implementation of a target to achieve the education standard of 95% by 30th June 2011
- Implementation of a training programme that provides e learning and a variety of other methods to ensure that all staff receive training and assessment.

Clinical Coding Error Rate:

The Countess of Chester Hospital NHS Foundation Trust was not subject to the payment by results clinical coding audit during the reporting period by the Audit Commission.

In December 2010 the Audit Commission reviewed the Trust's reference cost data for April 2009 to March 2010, instead of the usual payment by results coding audit. Reference costs are the average cost to the NHS of providing a defined service in a given financial year.

They support the production of the calculation and development of the national tariff. Trusts and PCTs also use the data to support local pricing and contract negotiations. The Audit Commission found that the Trusts reference cost submission in 2009/10 was materially accurate and the overall arrangements to support the submission of data were robust.

Written statement from our commissioner: NHS Western Cheshire

We are committed to commissioning high quality services from our providers and we make clear in our contract with this Trust the standards of care that we expect them to deliver.

We manage their performance through progress reports that demonstrate levels of compliance or areas of concern. It is through these arrangements that the accuracy of this Quality Account has been validated.

We commend the Trust for their open approach to the audit work they undertook in partnership with Age UK to explore how patients perceive the dignity of the care they receive. We look forward to seeing progress against the challenges identified by Age UK.

We are impressed with the systems that have been put in place at ward level to scrutinise nursing care standards. The results of these checks each month are visible on the wards and further reinforce the open culture of the Trust in its drive to improve care.

We are pleased to see the Trust commit to a continued focus on reducing the number of patients who have their dates of admission for surgery changed. We note that there has been some improvement but there is potential to do better and patient feedback shows this an area of high importance to them.

The Trust has an open culture of learning when things go wrong and this has been demonstrated through the investigation reports that we receive. We would have liked to see evidence in this Quality Account that the Trust Board continued to review service risks against recommendations made by the Francis Report into Mid Staffordshire Hospital Trust.

The Department of Health has set this Trust an objective in 2011-2012 of having no more than 42 cases of Clostridium difficile. NHS Western Cheshire recognises that this figure does not take into account all the cases attributed to this Trust during 2010-2011 so that this objective of 42 cases in this coming year will be extremely difficult to achieve and will represent an almost 50% reduction from the out turn figure of 2010-2011.

We acknowledge the hard work of the Trust in its "zero tolerance" approach and as such we except to see a further reduction of Clostridium difficile infections. In order to monitor the objective and the Trust's plans for continuous improvement, we have agreed a local stretch target for 2011-2012 of 53 cases which takes into account all the cases attributed to the Countess in 2010/11 and will demonstrate an improvement on the 2010-2011 out turn position.

The Trust has performed well against the goals set in the Commissioning for Quality and Innovation Schemes. The Trust are to be congratulated on achieving the national target of 90% of all adult inpatients having a Venous-Thromboembolism risk assessment a full 6 months ahead of the target delivery date. It would be of value to see some measures that reflect your management of rehabilitation and acute services in support of your statement that this streamlines services for older people.

We support the priorities that the Trust has identified for the forthcoming year and look forward to continuing to work in partnership with the Trust to assure the quality of services commissioned in 2011-2012.

Dr. Maureen Swanson
Medical Director
NHS Western Cheshire

Cathy Maddaford
Director of Patient Safety and Governance
NHS Western Cheshire

How we have delivered our priorities in 2010 - 2011

During this time we have worked to improve a number of measures across the three domains of quality.

Part Three

These were chosen with the following considerations:

- Our patient and public feedback based on engagement events driven by our Board of Governors.
- Views of commissioners and their stakeholders
- Results of our inpatient survey data taken on a month by month basis and from the annual inpatient survey
- Our staff via our transformation programme focus groups.

Patient experience

1. Dignity with Care and Compassion

Description of the issues and rationale for prioritising:

In 2010 the Trust worked in partnership with Age UK and commissioned some audit work looking at how the Trust measured up to the Dignity Challenge.

The National Dignity Challenge is a clear statement of what people can expect from a service which respects dignity. It is backed up by a series of 'dignity tests' that can be used by providers, commissioners and people who use services to see how their local services are performing.

High quality services that respect people's dignity should:

- Have a zero tolerance to all forms of abuse
- Support people with the same respect you would want for yourself or a member of your family
- Treat each person as an individual by offering a personalised service
- Enable people to maintain the maximum possible level of independence, choice and control
- Listen and support people to express their needs and wants
- Respect people's right to privacy
- Ensure people feel able to complain without retribution
- Engage with family members and carers as partners
- Assist people to maintain confidence and self esteem
- Act to alleviate people's loneliness and isolation.

Aim:

- To measure and report on progress towards delivery of the National Dignity Challenge
- To discover what the Trust is doing well and where there is room for improvement
- In particular to hear patient stories about the services we provide.
- To receive recommendations on how we can improve our services in terms of dignity and respect.

Results:

The audit concluded that the Trust has a 'Growing Dignity Profile Status', a score of three out of a possible five as follows:

- The Trust has a welcoming and open ambience, with initiatives such as meet and greet

volunteers contributing to this.
- » The hospital looks and smells clean with refurbishments making it look modern and attractive and giving a favourable impression
- » The Patient Advice and Liaison Service is visible and responsive and there is engagement with the public through a number of initiatives. Services rated highly across a range of externally validated measures with good food and a programme to introduce protected mealtimes. There are practical steps in place to preserve privacy and dignity such as curtain clips and 'do not disturb' signs and single sex accommodation and facilities.
- » The Trust is continuing to improve with a number of forums in place e.g. Equality and Diversity group and the working group on the 'care of the dying' pathway. There is an overall willingness to change and learn.

There are challenges in:

- » Meeting the needs of specialist groups e.g. Dementia and Parkinson's disease
- » Providing some individual information for patients about the hospital and services accessed
- » Evaluating the extent to which systems and services are person-centred. Some systems such as the discharge process requires improvement
- » Eliminating clutter and making more personal / private space for patients and relatives and their belongings
- » The lack of space around beds makes it hard to care for people who require manual handling without impacting on other patients nearby
- » More sensitive ways to measure patient experience

Current Status / Further planned improvements for 2011-2012:

There is an established group taking forward the Dignity with Care and Compassion action plan. The action plan is focussing on engagement with patients, gathering real time patient experience at ward level, formalising Dignity Champions to live our values and provide challenge at the point of care delivery. The action plan is received and monitored by the Board of Directors.

2. Changing the date of surgery

Description of the issues and rationale for prioritising:

Our work with our patients identified this as a key issue. This is also seen in our local and national inpatient survey data and when managing complaints. The Trust is committed to keeping this high on the agenda as it is an area of concern both in the experience of our patients and in the ability to manage capacity effectively.

Aim:

To reduce the number of times a patient's date is changed prior to their planned surgery and improve their experience.

Results:

The latest patient survey data has shown some improvement in this area but the Trust recognises there is still significant work to do. Local survey data can be viewed in the Quality metrics at the back of the report.

Current Status:

This year despite demonstrated work to address this, the number of influenza cases in the North West, from December 2010 and through January resulted in all inpatient elective surgery being cancelled for a number of weeks. This was regionally mandated by Gold Command as the North West influenza crisis progressed.

Planned care have reviewed and revised the process for monitoring the cancellation of elective procedures. A report is now generated to illustrate the times when a patient has had their operation date cancelled along with the reason for the change. The information is used as a benchmark for each specialty via a monthly monitoring tool to identify any problems so that actions can be taken to ensure continuous improvement.

The extent of emergency trauma work also impacts on elective work resulting in cancellations. Work is ongoing to expand capacity to meet both emergency and elective demand.

The latest patient survey data has shown some improvement in this area (see metrics at the back of this report) but the Trust recognises there is still significant work to do and has maintained this as an organisational risk.

Further planned improvements for 2011-2012:

- Work is still ongoing to relocate certain patient specialties to ensure that all capacity is utilised appropriately and beds are made available in the right place to accommodate both planned and urgent work
- We are currently recruiting an Orthopaedic surgeon to assist with trauma work.

3. Real time patient experience surveys in women's health

Description of the issues and rationale for prioritising:

If patients are not treated in a respectful and dignified way their experience tends to be poor. We decided to conduct real time surveys in women's health to measure this in conjunction with other improvements in care implemented in 2009-2010 and general aggregated data from complaints, incidents and surveys as follows:

- Being offered an opportunity to receive a copy of letters sent to general practitioners
- Being involved in care with good clear information
- Being treated with respect and dignity
- Waiting times

Aim:

To improve the patient experience within Women's Health Services relating to:

» Dignity and Respect
» Information
» Involvement.

Results:

Significant improvements were demonstrated across all areas of the survey data with feedback given regularly to staff who could then take recommendations forward.

Current Status / Further planned improvements for 2011-2012:

The survey will now continue to be used but less frequently. The same model is to be applied across general outpatients in the coming year.

Patient safety

1. Responding to acute patient illness and deterioration (RAPID Project)

Description of the issues and rationale for prioritising:

This project is a local initiative commenced by our Critical Care Outreach team in 2010 following recognition at national level that there was room to improve the safety of the acutely ill and deteriorating hospitalised patient.

This was reflected in our local findings from complaints and incident reports which has driven a clinical team from across the organisation to make improvements.

Within the trust there are three methods used to identify the acutely deteriorating ward based patient:

» Use of an early warning trigger
» Keeping a level of surveillance of high risk patients e.g. those stepped down from critical care
» Routine ward rounds by the team to identify patients who may be causing staff concern.

Experience has taught us that a combination of these methods is effective in identification and treatment of these patients. Out of hours care is being reviewed and the team are implementing straightforward standard operating procedures to assist clinical staff.

Aim:

» To identify patients at high risk of deterioration and increase safety by effective care, with increased calls to the outreach team and fewer emergency cardiac arrest calls
» Establish Standard Operating Procedures (SOP) to bridge the gap between guidelines and clinical practice
» Measure harm via clinical incident reporting with categories associated with the deteriorating patient and the use of the Global Trigger tool casenote review

Results:

Provisional data analysis demonstrates an overall fall in patient mortality year on year and risk adjusted mortality compares favourably with our peer group average. Our cardiac arrest calls have stabilised and are on average 19 per month. However, we are starting to look at true arrest data and this is much lower. Calls to the outreach team have steadily increased over the year and are sustained at consistently more than 108 per month. Our recording of patient's observations when making a referral has increased from 50% to 100% compliance.

The use of the global trigger tool has demonstrated a harm rate of 0-25 incidents per 1000 bed days from January to July 2010 with a median of 7. This is a low rate and on review of these events most relate to a length of stay longer than what would initially have been expected.

Current Status:

A number of Standard Operating Procedures are being developed ready for implementation. The project is continuing into 2011-2012.

Further planned improvements for 2011-2012:

- Further education events to maintain momentum
- Continuation of the global trigger tool analysis with regular organisational feedback.

2. Venous Thromboembolism management and prevention

Description of the issues and rationale for prioritising:

Venous Thromboembolism is a nationally recognised significant patient safety issue; however, nationally the outcome data on Venous Thromboembolism has been poor. Post mortem studies suggest that only 1-2 in every 10 fatal pulmonary emboli is diagnosed. While work is underway to improve reliability of outcome data, the process measure now in place of Venous Thromboembolism risk assessment has set an effective foundation for appropriate prevention. This gives the potential nationally to save thousands of lives each year.

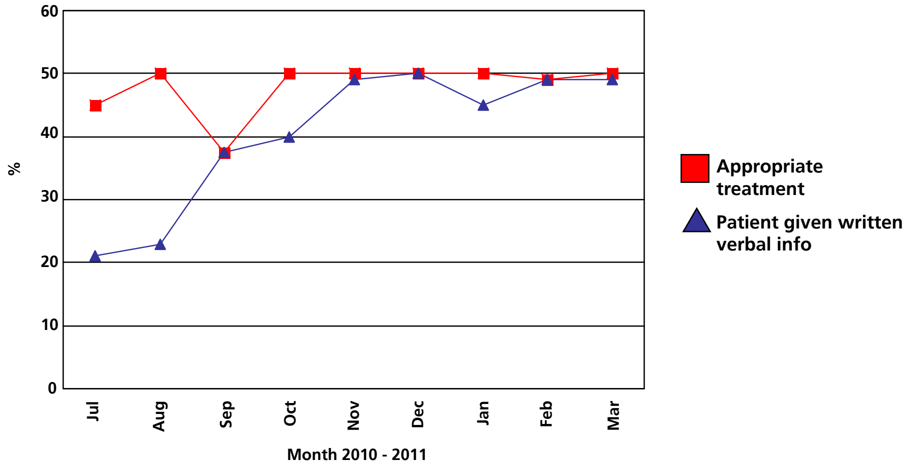
We became an exemplar site in January 2010 and have shared our work and experience with several Trusts across the country.

Aim:

- To ensure every patient receives the correct preventative treatment following assessment
- To ensure every patient admitted receives verbal and written information regarding the risk of Venous Thromboembolism

Results:

A monthly audit monitored the aims as follows:



Current Status:

Compliance remains high and the aims are being met.

Further planned improvements for 2011-2012:

» To review all cases of Venous Thromboembolism that occur following hospitalisation or recent hospitalisation to enable learning and improvements in care
» Continue monitoring via national commissioning requirements

3. Infection Prevention and Control

Description of the issues and rationale for prioritising:

Reduction of healthcare associated infection within health and social care is high on the national agenda with robust infection prevention and control practices being an essential contribution to patients receiving safe and effective care.

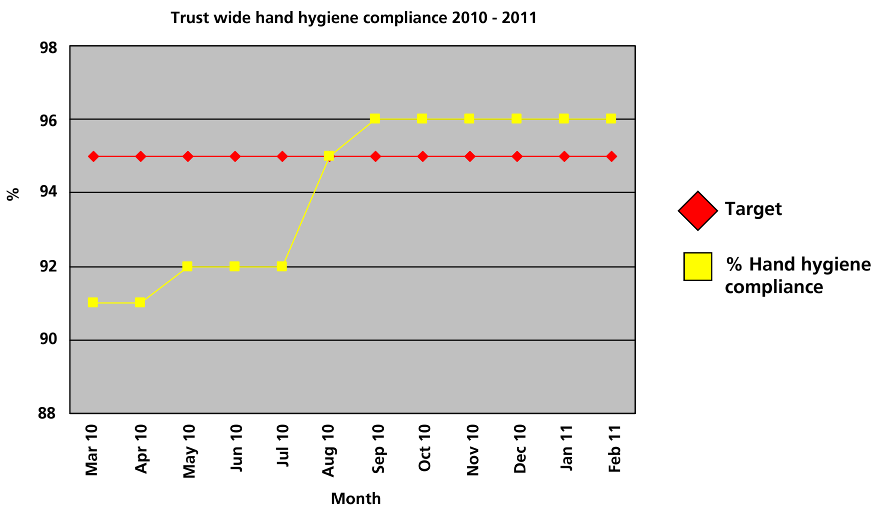
The Trust has adopted a zero tolerance approach to healthcare associated infections, with the aim being to achieve the 'irreducible' minimum. Reducing the number of healthcare associated infections within the organisation (or maintaining low numbers where further reduction may not be achieved) remains a high priority, as this also reduces morbidity and mortality. The consistent implementation of effective infection prevention and control is key to achieving this.

Aim:

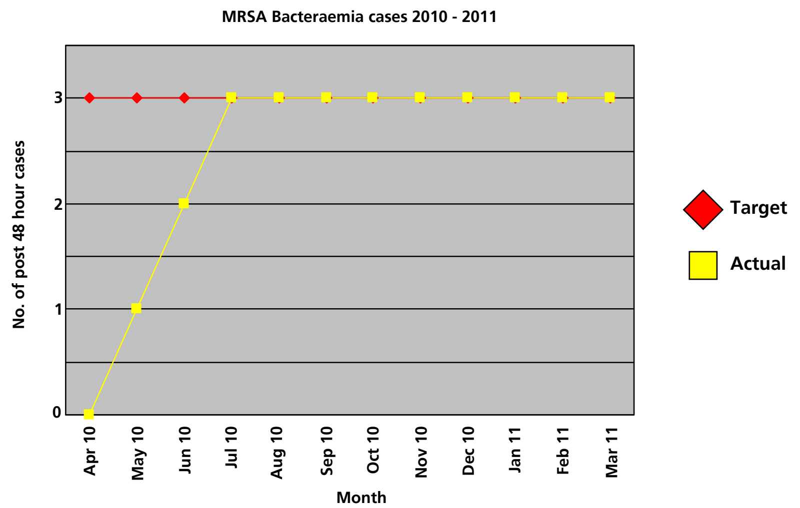
» To consistently maintain a 95% compliance or above with hand hygiene practices
» To consistently maintain a 95% compliance or above with MRSA screening requirements for both emergency and elective patient groups
» To have three or less MRSA bacteraemia cases within year
» To have 65 or less Clostridium difficile cases within year.

Results:

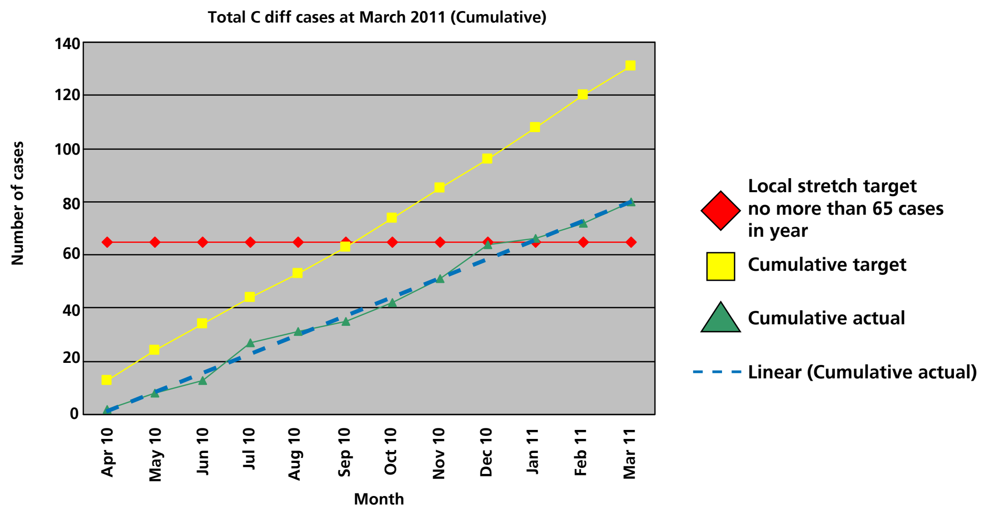
» Hand Hygiene compliance

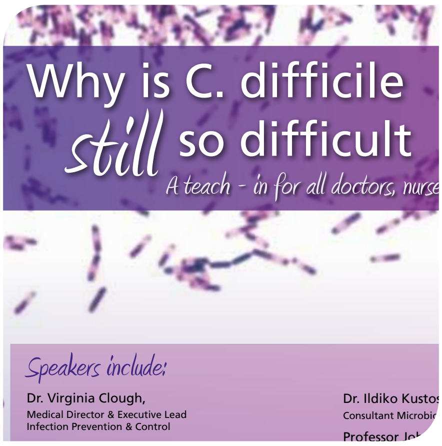


» MRSA Bacteraemia



» Clostridium difficile





A robust process to monitor MRSA screening compliance is in development.

Current Status:

- Hand hygiene compliance is consistently exceeding the required standard. However, this is not reflected within staff survey views regarding availability of hand hygiene facilities. Not withstanding the staff survey this perception is not reflected in our hand hygiene audits and is considered low risk
- MRSA bacteraemia achieved the set target for 2010-2011
- Clostridium difficile, while exceeding the local stretch target for 2010-2011, achieved the national target within year
- Compliance with MRSA screening requirements is improving as processes become embedded in routine practice.

Further planned improvements for 2011-2012:

- Continue training and education programmes for all staff groups, consistently re-enforcing the need to routinely maintain high standards of infection prevention and control
- Maintain the infection prevention and control audit and surveillance programmes, adding to these as the requirement or need is identified and ensuring compliance with national data collection
- Continue promoting best practice to reduce the number of Clostridium difficile cases via learning from root cause analysis and national evidence base
- Continue promoting best practice to reduce the number of MRSA bacteraemia cases via learning from root cause analysis and national evidence base
- To implement monitoring of Methicillin sensitive Staphylococcus Aureus and E. coli bloodstream infections
- Develop MRSA screening compliance dashboards, providing feedback to staff and driving improvement. Promotional campaign also in development.

Clinical effectiveness

1. Enhanced recovery

Description of the issues and rationale for prioritising:

There are nationally proven pathways for adults in orthopaedics, colorectal, urology, breast and gynaecology that demonstrate that by making small changes both before during and after an operation, patients can recover sooner. The introduction of this evidence based care can reduce the time spent in hospital.

Aim:

- Education and training for staff in the new pathway implementation
- Education for patients via the setting up of preoperative classes where they learn

about the surgery and how to optimise their own health both pre and post operatively
- Changes in practice e.g. relating to type of anaesthesia, type of post operative pain relief, earlier patient mobility post surgery, increased nutritional intake pre operatively and as soon after waking as possible.

Current status:

The Planned Care Division has established a multi-professional forum which currently meets on a monthly basis to review the implementation of the Enhanced Recovery Programme. Project work streams are well established with identified clinical leads. A baseline assessment on the nationally agreed essential elements of the enhanced recovery pathway for identified procedures has been undertaken.

There are five work streams which include Colorectal, Urology, Breast, Gynaecology and Orthopaedics. Gynaecology, breast and orthopaedics are now in early implementation with colorectal services refining their already established pathway. Urology is working towards implementation in 2011-2012.

Key individuals from specialty teams have attended the National and Regional Enhanced recovery events in order to share, network and benchmark with other organisations.

Further planned improvements for 2011/2012:

- The project will be taken forward as part of Commissioning for Quality and Innovation (CQUIN)
- The project's outcomes will be linked to a programme of audit and monitoring.

2. Advancing Quality

Description of the issues and rationale for prioritising:

The Trust has been part of the North West Advancing Quality programme for nearly 3 years. The programme supports the implementation of set pathways of care across the identified conditions of:

- Acute heart attack
- Heart failure
- Community acquired pneumonia
- Hip and Knee replacement
- Stroke care (new in August 2010).

Data is collected in retrospect to allow notes to be clinically coded.

Aim:

- To ensure patients receive the best practice indicated for their condition
- To promote timely recovery with good clinical outcomes.

Current status:

As the data is retrospective we are currently at Nov 2010. Excellent progress has been sustained across

3 of the pathways and the hip and knee pathway has improved significantly in 2010. Stroke is a new pathway with only 3 months of data currently available.

Results:

Data can be viewed in the Quality measures at the back of the report.

Further planned improvements for 2011/2012:

» The project will be taken forward as part of regional commissioning for Quality and Innovation (CQUIN).

3. Stroke care

Description of the issues and rationale for prioritising:

Stroke care is a high priority for the trust and was in our Quality Strategy in 2009-2011. The National Institute for Clinical Excellence has produced a new quality standard for Stroke 2010 and states that it ***'requires that stroke services should be commissioned from and coordinated across all relevant agencies to encompass the whole stroke care pathway. An integrated approach to provision of services is fundamental to the delivery of high-quality care to patients with stroke'***. The need for efficient and effective care acting fast is essential to the improved outcomes for patients following a stroke.

Aim:

To maximise effective stroke treatment and care for the population served by the Countess of Chester hospital in line with the most up to date research as well as Royal College of Physician and National Institute of Clinical Excellence guidelines. To reduce the burden of stroke on individuals affected by stroke, their carers and the community as a whole.

Current status:

During 2010 / 2011 the stroke unit has expanded from a six bedded 'Stroke Assessment Area' to a 21 bed Stroke Unit incorporating six hyper - acute beds. This has enabled the policy of direct admission from A&E to be implemented. Direct admission has improved the best practice care bundle compliance to approaching 90%.

In September 2010 the thrombolysis service was expanded from office hours to 24 / 7 availability by using both an increased senior doctor involvement and teleconferencing.

Further planned improvements for 2011/2012:

» To shorten A&E to stroke unit admission times allowing a further improvement in best practice care bundle compliance.
» To investigate the viability of an early supported discharge team.
» To stream line the stroke care pathway, joining up emergency care, acute and sub-acute treatment and rehabilitation to produce a seamless and ongoing service.


VIMED® 2000

Other quality improvements in 2010 - 2011

Delivering Same Sex Accommodation

The Trust has continued to work through the year completing capital work to improve the environment and has now declared compliance 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.

Risk Management

The Trust continues to report incidents via the National Patient Safety Agency National Reporting and Learning Service and continues to be in the top organisations (relating to medium sized district General Hospitals) reporting the highest number of incidents.

In general, the higher the rate of incidents, the stronger the reporting culture in that organisation. However, improvements can always be made and learning from our incidents is a key element of our Quality Strategy and Primary Care Trust quality contract.

'The Countess Way' 2010-11

The Countess Way Transformation Programme delivered reductions in length of stay, released time to care (wards), reduced costs through eliminating waste and reduced sickness absence across the hospital.

It also changed the shape of the organisation to better meet patient care needs and we also prepared our managers to be better leaders for the future.

Fractured Neck of Femur: Time to theatre

Further work has been undertaken with the introduction of best practice measures for those patients with a fragility hip fracture. Our aim has been to increase the number of patients who are medical optimised for theatre having their operation within 36 hours.

While making a good start at the beginning of the year this aim has been compromised by issues with capacity through the winter period previously mentioned in other parts of the report. A full action plan is in place and we hope to see improvements as we move into 2011-2012.

Data can be viewed in the Quality measures at the back of the report.

Cancer Peer review

The following cancer services at The Countess of Chester Hospital were reviewed in the 2010 2011 cycle of peer review:

- Breast Multidisciplinary Team
- Local Urology Multidisciplinary Team
- Local Skin Multidisciplinary Team
- Colorectal Multidisciplinary Team
- Local Gynaecology Multidisciplinary Team
- Local UGI Multidisciplinary Team

» Children's cancer services - Paediatric Oncology Shared Care Unit (POSCU) Level 1 and POSCU Multidisciplinary Team.

In addition the Countess of Chester Hospital together with the Primary Care Trust was involved with the Peer review of Locality Measures for:

» Head and Neck Cancers
» Complementary Therapies
» Colorectal
» Skin.

All teams selected were required to complete a self assessment of their service against nationally agreed measures and upload supporting evidence to the Cancer Quality Improvement Network System database.

Self assessments were internally validated by the Trust at individual panel meetings and reports published on the cancer database website within the required timescales.

Three teams Breast, local Skin and local Urology multidisciplinary teams were not internally validated having achieved earned autonomy on the basis of last year's review and this years self assessment.

No teams were selected for external visits in this cycle.

Of the multidisciplinary teams and locality measures reviewed there were no immediate risks or serious concerns identified. Action plans are in place to take forward recommended improvements in each speciality.

All of the multidisciplinary teams reviewed were able to demonstrate areas of good practice and number of key achievements including:

» **Colorectal** - A strong Enhanced Recovery Programme (ERP) in place for rectal and colon patients with the shortest hospital stays in the Network and further plans for development.

» **Gynaecology** - The development of an electronic referral system which automatically goes through to the multidisciplinary team coordinator and a nurse led holistic assessment clinic.

» **Lung** - Improvements in chest ultrasound Improved data collection with a new cancer data base now in place.

» **Children's cancer services** - Good working relationships enabling children with cancer to stay at home.

Nursing care measures

In 2010 the Trust implemented a system to assist ward and departmental managers to monitor care delivery at the bed side.

This provides them with clear standards to monitor both documentation and the care received by the patient and feed back directly to staff at the time of the audit. A monthly action plan is then produced which is discussed daily through the month at the ward safety briefings.

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

Currently overall Trust scores are good. Improvements continue to be made with regards to nutritional assessment, continence management and the discharge process.

Quality measures

Safety

Indicator	Method of monitoring/ Measure	08/09	09/10	10/11
Reduction in MRSA bacteraemia	Target: three post 48 hour cases	9	6	3
Reduction in Clostridium difficile	Target: 131 cases (Final data for 10-11 includes community hospital data from July 2010)	173	66	80
Trust-wide Hand Hygiene	Sustained improvement: compliance at greater than 95%	89%	92%	95%
The World Health Organisation safer surgery checklist	Sustained improvement: monthly audit average	Not collected	93%	96%

- Infection Control issues are discussed earlier in the report however we are extremely pleased with progress relating to MRSA bacteraemia cases year on year.
- Despite significant improvements in the numbers of Clostridium difficile cases, the continued reduction is a high priority.
- The Safer Surgery Checklist has been fully embedded with great success in 2010-2011 and will now be audited locally in 2011-2012.

Effectiveness

Indicator	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Optimisation of the care of patient with a Fractured neck of femur: % of medically optimised patients with a fractured neck of femur who go to theatre within 36 hours (refer to page 34)	93%	88%	94%	100%	74%	80%	87.5%	84%	64.3%	60%	69%	69%
Advancing Quality: The data displayed below is the trusts audited dated and may be subject to change following external audit and application of external weightings. Data available to Nov 2010 (refer to page 32)												
Hip and Knee. Threshold 93%	90.91	83.33	86.11	87.74	92.91	94.94	91.62	95.73				
Community Acquired Pneumonia Threshold 82%	80.54	87.76	82.76	76.92	82.93	92.42	84.62	93.16				
Heart Failure Threshold 80%	79.59	84.13	82.5	93.44	83.33	76.47	76.74	87.93				
Acute MI Threshold 98.5%	100	92.19	98.61	100	100	100	93.10	100				

- All of these quality indicators are discussed earlier in the report. Reduction in smoking in pregnancy was a key indicator last year. This is reported in the national performance table on page 40

Quality measures

Experience

Indicator	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
We asked the question 'Was your admission date changed by hospital?' The % displayed refers to the number of 'No' responses National average 72% (Local Data)	64%	72%	66%	64%	67%	71%	66%	76%	67%	61%	81%	71%

National patient experience survey Improvements **The % displayed refers to the number of 'yes' responses**	**08/09**	**09/10**	**10/11**
Were you given enough privacy when discussing your condition or treatment?	81.6%	81.4%	84.8%
Were you told who to contact if you were worried about your condition after you left hospital?	72.9%	72%	73.4%
Were you told about medication side effects to watch out for when you went home?	49.5%	44.9%	52.4%

» We have taken a different set of patient experience indicators to demonstrate progress in areas highlighted to us as a concern by service users. We are pleased to report that we made an improvement in the above identified areas of the inpatient survey as a response to National Commissioning for Quality and innovation (CQUIN). This was via a high profile action plan to address the issues and implementation of an information communication with patients at the point of discharge and the work of the Dignity steering group.

Performance against National Targets:

CQC Existing Commitments & National Priority Indicators

These were met at year end with the exception of cancelled operations. Our performance was severely affected by both winter/ trauma pressures and seasonal influenza from which we were unable to recover in year. This is also reflected in our patient experience results.

Target	Threshold	Monitoring period	Q1	Q2	Q3	Jan	Feb	Mar	Year
Infant health & inequalities: smoking during pregnancy	12% *tbc	2010 - 11	12.0%	9.0%	13.00%	12.00%	14.00%	12%	**11.8%**
Infant health & inequalities: breastfeeding initiation	66% *tbc	2010 - 11	70.7%	66.0%	70.0%	71.0%	68.0%	69%	**69.0%**
Access to GUM	100%	2010 - 11	100%	100%	100%	100%	100%	100%	**100%**
Data quality in ethnic group (NB HES runs 6 weeks in arrears)	>=85% *tbc	Apr - Dec 2010	98.71%	98.63%	100%	100%	n/a	n/a	**98.67%**
Maternity HES: Data quality (NB HES runs 6 weeks in arrears)	% *tbc	Apr - Dec 2010	100%	100%	100%	100%	n/a	n/a	**100%**
Delayed transfers of care		Apr - Dec 2010	24	34	16	3	0	0	**77**
Waiting times for Rapid Access Chest Pain Clinic	100%	2010 - 11	100%	100%	100%	100%	100%	100%	**100%**
Cancelled Operations - Part 1 - % Cancelled	<0.8%	2010 - 11	0.73%	0.80%	1.37%	1.30%	0.86%	0.72%	**1.00%**
Cancelled Operations - Part 2 - Treatment within 28 days	<=5% Breaches	2010 - 11	100%	100%	94%	100%	100%	100%	**100%**

Monitor Compliance Targets

The tables below demonstrate the remaining Monitor compliance framework against which we were assessed. All targets were met.

Target	Threshold	Monitoring period	Q1	Q2	Q3	Jan	Feb	Mar	Year
For admitted patients, max wait time of 18 weeks from point of referral to treatment	90%	Quarterly	91.65%	92.55%	89.94%	92.97%	88.60%	86.96%	91.01%
For non-admitted patients, max wait time of 18 weeks from point of referral to treatment	95%	Quarterly	98.70%	98.97%	98.87%	99.38%	99.40%	98.46%	98.89%
Data completeness assessment for admitted patients on 18 week RTT pathway	90-110%	Quarterly	99.93%	98.02%	96.37%	93.20%	96.40%	n/a	97.85%
Data completeness assessment for non admitted patients on 18 week RTT pathway	90-110%	Quarterly	97.67%	99.92%	106.3%	99.70%	101.5%	n/a	101.2%
For audiology patients, max wait time of 18 weeks from point of referral to treatment	95%	Quarterly	97.55%	96.45%	94.34%	100%	97%	100%	97.00%
Data completeness assessment for Audiology admitted patient on 18 week RTT pathway	80-120%	Quarterly	96.43%	84.23%	103.5%	118.7%	119.9%	114.2%	90.33%
Maximum wait time of four hours in A&E from arrival to admission, transfer or discharge	95%	Quarterly	97.5%	97.4%	96.2%	96.9%	97.60%	96.6%	97.1%
People suffering heart attack to receive thrombolysis within 60 minutes of call (*revision)	68%	Quarterly	n/a	n/a	n/a	n/a	n/a	n/a	92.00%

Performance against National Targets:

Cancer Performance (English + Welsh) 2010/10

Cancer Target	Wtg	Q1	Q2	Q3	Jan-11	Feb-11	Mar-10	Q4	Year end
14 Days (target 93%)	0.5	96.1%	96.0%	95.3%	93.9%	97.3%	95.1%	95.3%	95.8%
14 Days Breast Symptomatic (target 93%)*	0.5	97.8%	94.2%	91%	95.3%	94.5%	93.0%	96.4%	98.8%
31 Days - 1st Treatment (target 96%)	0.5	99.6%	98.8%	98.9%	96.2%	98.8%	97.3%	96.4%	98.8%
31 Days - subsequent SURGICAL (94%)	1.0	98.1%	98.3%	95.7%	66.7%	100.0%	100.0%	90.0%	96.6%
31 Day - subsequent NON SURGICAL (98%)	1.0	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
62 Days (target 85%)	1.0	90.4%	90.3%	83.1%	76.0%	93.3%	90.0%	87.0%	87.0%
Reallocated Breaches		1	4	5	1 in, 1 out				**10**
62 Days - screening (target 90%)	1.0	100.0%	100.0%	100.0%	100.0%	90.0%	100.0%	96.3%	95.0%
Number of Patients (Deminimus 20)		15	10	16	7	5	3	15	**56**
62 Days - upgrades (target TBC)	?	94.8%	94.7%	98.3%	95.5%	90.5%	100.0%	94.7%	95.6%
31 Days - rare (target 96%)		100.0%	100.0%		100.0%	100.0%			

These were met at year end despite seasonal pressures.

Written statements by other bodies

Part Four

Our Foundation Trust Board of Governors

Following the circulation of the CoCH Quality Account 10 - 11 draft to all governors I am happy to report that we will not be recommending any further additions or deletions and are happy for this to be translated into the final copy.

Michael I Hemmerdinger
Lead Governor

Local Involvement Networks (LINk)

No statement was received

Overview and Scrutiny Committee

No statement was received

Appendices

Appendix 1 - Glossary & Abbreviations

Term	Abbreviation	Description
Accident and Emergency	A&E or ED	The emergency department usually at a hospital
Advancing Quality	AQ	A programme which reward 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.
Care Quality Commission	CQC	The independent regulator of health and social care in England. It's aim is to make sure better care is provided for everyone, whether that's in hospital, in care homes, in people's own homes, or elsewhere. The CQC replaces the Healthcare Commission.
Clostridium Difficile	C-diff	A naturally occurring bacterium that does not cause any problems in healthy people. However, some antibiotics that are used to treat other health conditions can interfere with the balance of 'good' bacteria in the gut. When this happens, C-diff bacteria can multiply and cause symptoms such as diarrhoea and fever.
Commissioner		A person of body who buy services
Commissioning for Quality and Innovations	CQUINs	CQUIN is a payment framework developed to ensure that a proportion of a providers' income is determined by their work towards quality and innovation. The scheme was introduced in detail, from implementation to function, in High Quality Care For All to encourage organizations to see quality improvement and innovation as a motivator towards a better service for their patients.
Common Assessment Framework	CAF	An assessment undertaken on children with additional needs who may need multi agency support
Early Warning Score	EWS	This is a patient observations scoring system which detects deterioration dependent on e.g. the patients blood pressure/temperature and a number of other vital sign recordings. Clinical Staff have a series of actions to undertake if this early warning score identifies a problem or deterioration in a patient's condition.

Enhanced Recovery Programme	ERP	A pathway of care applied to a procedure relating to type of anaesthesia, type of post operative pain relief, earlier patient mobility post surgery, increased nutritional intake pre operatively and as soon after waking as possible, to reduce recovery time.
Healthcare Associated Infections	HCAI	A generic name to cover infections like MRSA and C-diff.
Hospital Episode Statistics	HES	This is the national statistical data warehouse for England of the care provided by NHS hospitals and for NHS hospital patients treated elsewhere. HES is the data source for a wide range of healthcare analysis for the NHS, government and many other organisations and individuals.
Global Trigger Tool		This is a tool that is used to review a patient medical record and establish whether any harm events occurred during the patient's care and treatment in hospital. From an analysis of a large number of records the hospital can measure its rate of harm and work towards reducing this.
Methicillin-Resistant Staphylococcus Aureus	MRSA	Staphylococcus aureus is a bacterium which is often found on the skin and in the nose of about 3 in 10 healthy people. An infection occurs when the bacterium enters the body through a break in the skin. A strain of this bacterium has become resistant to antibiotic treatment and this is often referred to as MRSA.
Monitor		This is the regulator of NHS Foundation Trusts. It is an independent body detached from central government and directly accountable to Parliament.
National Patient Survey		Co-ordinated by the Care Quality Commission, it gathers feedback from patients on different aspects of their experience of care they have recently received, across a variety of services/settings: Inpatients, Outpatients, Emergency care, Maternity care, Mental health services, primary care services and Ambulance services.

Appendix 1 - Glossary & Abbreviations

Patient Recorded Outcome Measures	PROMs	A programme in which patients complete a questionnaire on their health before and after their operation. The results of the two questionnaires can be compared to see if the operation has improved the health of the patient. Any improvement is measured from the patient's perspective as opposed to the clinicians.
Quality Account		This is a statutory annual report of quality which provides assurance to external bodies that the Trust Board has assessed quality across the totality of services and is driving continuous improvement.
Secondary Users Service		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.
Statement of Purpose		This is a care Quality Commission requirement of registration and described the aims and objectives of the service provider in carrying on the regulated activity. It describes the kinds of services provided for the purposes of the carrying on of the regulated activity and the range of service users' needs which those services are intended to meet.
Venous Thrombo-embolism	VTE	This is a blood clot developing when a person is in hospital and may not be as mobile as they are usually or following surgery. The blood clot itself is not usually life threatening, but if it comes loose it can be carried in your blood to another part of your body where it can cause problems – this is called a Venous Thromboembolism (VTE). If the clot travels to the lungs it is called a pulmonary embolus (PE) and it can be fatal. Even if a blood clot does not come loose, it can still cause long-term damage to your veins.