Public Document Pack

Health and Adult Social Care Scrutiny Committee

Agenda

Date:	**Thursday, 29th April, 2010**
Time:	**10.30 am**
Venue:	**West Committee Room - Municipal Buildings, Earle Street, Crewe, CW1 2BJ**

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

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

1. **Apologies for Absence**

2. **Declaration of Interests/Party Whip**

   To provide an opportunity for Members and Officers to declare any personal and/or prejudicial interests or members to declare the existence of a party whip in relation to any item on the agenda.

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

Please contact	Denise French on 01270 686464
E-Mail:	denise.french@cheshireeast.gov.uk with any apologies or requests for further information or to give notice of a question to be asked by a member of the public

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

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

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

4. **Minutes of Previous meeting** (Pages 1 - 6)

To approve the minutes of the meeting of the Committee held on 10 March 2010.

5. **Mid Cheshire Hospitals NHS Foundation Trust - Quality Account** (Pages 7 - 66)

In *High Quality Care for All,* published in June 2008, Ministers set out the Government's vision for putting quality at the heart of everything the NHS does. A key component of the new Quality Framework was a requirement for all providers of NHS services to publish Quality Accounts – aimed at improving public accountability and engaging NHS Boards in understanding and improving quality in their organisations.

Both the Scrutiny Committee and the Local Involvement Network (LINk) have an important role in developing these Accounts through being given the opportunity to see and comment on the draft account prior to publication.

The draft Quality Account from Mid Cheshire Hospitals NHS Foundation Trust is attached for the Committee's consideration and comment. The document is currently undergoing a 30 day consultation period prior to publication of the final Quality Account document in June 2010.

Tracy Bullock, Deputy Chief Executive/Director of Nursing and Elizabeth Kanwar, Quality and Clinical Outcomes Project Manager, will attend the meeting to address the Committee and answer any questions. Tracy Bullock will also give a brief outline of the work undertaken over the past year in relation to the Healthcheck process and the process for registration with the Care Quality Commission.

Agenda Item 4

CHESHIRE EAST COUNCIL

Minutes of a meeting of the **Health and Adult Social Care Scrutiny Committee**
held on Wednesday, 10th March, 2010 at Committee Suite 1,2 & 3, Westfields, Middlewich Road, Sandbach CW11 1HZ

PRESENT

Councillor Rachel Bailey (Chairman)
Councillor G Baxendale (Vice-Chairman)

Councillors S Bentley, S Furlong, S Jones, W Livesley, A Moran, J Wray, C Andrew, C Beard, A Martin and C Tomlinson

Apologies

Councillors D Flude

14 **ALSO PRESENT**

Councillor R Domleo, Portfolio Holder for Adult Services
Councillor A Knowles, Portfolio Holder for Health and Well-being
Councillor A Thwaite, Substitute Member
Councillor O Hunter, Cabinet Support Member

15 **DECLARATION OF INTERESTS/PARTY WHIP**

There were no declarations of interest made.

16 **PUBLIC SPEAKING TIME/OPEN SESSION**

There were no members of the public present who wished to address the Committee.

17 **MINUTES OF PREVIOUS MEETING**

RESOLVED: That the minutes of the meetings of the Committee held on 13 January and 12 February be approved as a correct record.

18 **CARE QUALITY COMMISSION**

The Committee was briefed on the Care Quality Commission by Deborah Westhead and Hayley Moore.

Members were advised that the main aim of the CQC was to “Make sure people get better care” and this was facilitated by:

- Driving improvement;
- Putting people first and championing their rights;
- Acting swiftly to remedy bad practice;

- Gathering and using knowledge and work with others.

There was now a requirement for providers of health and social care to register with the CQC - NHS providers were required to register by April 2010, adult social care and independent healthcare providers by October 2010 and primary medical and dental services and others from 2011. CQC had been given stronger enforcement powers including the power to fine, suspend or ultimately close a service.

The CQC would undertake periodic reviews to assess the performance of organisations that commissioned and provided care and make sure they worked together better, would undertake special reviews of specific services or pathways of care or themes and also contribute information on care services to guide Comprehensive Area Assessments.

The key driver for change was to focus on how health and adult social care commissioners worked together to make care better for people.

A CQC assessment would replace the Annual Healthcheck for commissioner PCTs. The CQC would report on the PCT's performance against a number of commitments indicators and national priorities that were part of the Vital Signs framework as well as reporting on various scores the PCT received under other assessment processes such as World Class Commissioning.

Adult Social Care departments would receive an aggregated grade from the CQC based on outcomes for people who use services, CQC would report on the two domains covering leadership, commissioning and use of resources and score each Council in relation to the quality of regulated services it commissioned. A self assessment would be completed and to score "performing excellently" 4 out of the 7 outcomes must be judged as performing excellently with Outcome 7 "Maintaining Personal Dignity and Respect" judged as performing well.

The timescale meant that in September 2010 the CQC would share the grades/ratings from commissioner assessments with PCTs and Councils. Then in late November/December 2010 the CQC would publish adult social care grades and PCT ratings together as a single publication focusing on commissioners and around the same time the Comprehensive Area Assessment of commissioners would also be published.

The CQC was committed to listening and working with people and published Voices into Action to show how people's views would feed into its work. People would be involved in decision making, assessments, reviews and studies, surveys, as "Experts by Experience" and through bodies such as Scrutiny Committees and Local Involvement Networks.

The CQC would not need a commentary to be submitted about core standards for the NHS but had adopted a more flexible system that allowed information to be sent at any time via a form on the website, such information would be used as part of monitoring services. Any urgent concerns could be raised if local solutions could not be found.

Members of the Committee were then given the opportunity to ask questions and make points as follows:

- What reassurances could be given that inspection services would be effective? In response, D Westhead explained that the CQC had new powers, would seek views from a wide variety of groups including service users and carers, would conduct visits to all types of sites;
- Was there a role for Members in contributing to the Council's Self Assessment? The committee was advised that the Self Assessment for Cheshire East Adult Social Care service had been submitted but part of the budget consultation process had included Members challenging officers about performance. There was also a quarterly performance meeting attended by the Portfolio Holder and a representative of Overview and Scrutiny could attend these meetings too;
- It was possible to get lists of providers from the Third Sector but how could safeguards be built into this? In response, the Committee was advised that any detail about providers could be found by looking on the CQC website;
- Whether patients were asked how they liked to be addressed? It was explained that case notes should indicate this and monitoring this was a role that could be undertaken by the Local Involvement Network;
- What did the power to suspend services mean in practice? The Committee was advised that this was a new power but risks arising from suspending a service would be high, there may be a case for suspending a specific service but it was unlikely that a whole hospital would be suspended. It was vital that CQC were satisfied that services were safe. The ultimate sanction was to deregulate and close a service.

RESOLVED: That the presentation be noted and the Care Quality Commission be invited back to a meeting in the autumn 2010.

19 CHESHIRE EAST COMMUNITY HEALTH

Audrey Fitzpatrick, Director of Nursing and Quality and Deputy Managing Director, Cheshire East Community Health, briefed the Committee on the role of Cheshire East Community Health (CECH). CECH was the provider of community services to Central and Eastern Cheshire PCT and was formally launched on 30 June 2008.

CECH served a population of 460,000 and had a budget of £56m. It provided 26 Core Services which could be broken down into 83 sub specialities. Services were mainly commissioned by the PCT but also by three Practice Based Commissioning Consortia. The mission statement of CECH was "To deliver a positive patient experience through what we do and how we do it". CECH had various strategic objectives including establishing strong and effective partnerships with the community to ensure that patients, clients and carers experienced high quality and seamless care and support, to increase the accessibility and equity of high quality healthcare to the community and develop the use of technology to improve the delivery of quality based care.

A programme to transform Community Services had been launched on 13 January 2009 to transform delivery, ensure a patient centred approach focused on quality and outcomes and transactional change looking at costs, contracts, performance management and value for money.

CECH had made an interim declaration on healthcare and applied for registration which would come into effect in April 2010. The activities CECH was to be regulated for were urgent care services and treatment of disease, disorder or injury.

Members of the Committee were then given the opportunity to ask questions/raise issues as follows:

- How were cross boundary issues dealt with? In response the Committee was advised that there was work underway looking at out of area services, a patient registered with a PCT GP would be looked after by a PCT District Nurse and the focus would be on the patient;
- The role of the Urgent Care Centre was discussed and the Committee was advised that every PCT was required to have one such centre in its patch, in Central and Eastern Cheshire an Urgent Care Centre was situated at Mid Cheshire Hospital Trust site at Leighton Hospital and enabled patients to see a GP for urgent care. They were particularly effective in urban city centres where they were popular with full time employees and young people etc.

RESOLVED: That the report be noted and the role of the Urgent Care Centre be discussed at the mid point meeting.

20 SOCIAL CARE REDESIGN

Phil Lloyd briefed the Committee on the current position with Social Care Redesign. He reported that many people were now receiving direct payments and during the recent severe weather conditions all care arrangements had been maintained.

Provider services in Adult Social Care had been renamed as Care Force and developed as a separate entity. The focus was on reablement to increase independence in the longer term for people with complex conditions.

A Safeguarding Board had been established and a Chairman appointed.

There was an increasing move towards co-location of services and Local Independent Living Teams were being established.

An increasing area of work was with people with dementia and specific staff training was underway.

There was investment in IT infrastructure and an area for development was to work on preventative services.

The number of personal budgets had increased by 190% (although this was from a low base).

If any local Councils wanted to have a briefing on the Redesign officers would be happy to facilitate this.

A manager was currently considering how the Council would implement the National Dementia Strategy and this would include looking at the role of carers.

RESOLVED: that the update be noted and a briefing on implementing the National Dementia Strategy be made to the mid point meeting.

21 NORTH WEST AMBULANCE SERVICE

The Committee consider an update report from the North West Ambulance Service (NWAS) on progress with community and co-responder schemes.

A Community First Responders (CFR) regional forum was established in February 2009 to ensure full engagement was undertaken with CFR representatives across the North West region. A newsletter for CFRs had been introduced as part of various methods aimed at improving communication between NWAS and CFRs.

A local group had been established in Cheshire chaired by the Chief Executive of the Central and Eastern Cheshire Primary Care Trust (PCT). A co-responder scheme had been launched in conjunction with Cheshire Fire and Rescue.

An additional ambulance resource was to be deployed to serve the Nantwich area and its impact would be monitored closely. The individual CFR who had previously operated on blue lights in Nantwich had now had the blue light restored in recognition of the unique and special skill he brought to his role as a Nantwich CFR.

The NWAS had also developed a Chain of Survival strategy with 4 objectives:

- Improve public awareness of how and when to access emergency care;
- Increase the number of people in the North West able to provide basic emergency life support, including the use of an automated external defibrillator;
- Increase the availability of emergency medical equipment and in particular automated external defibrillators, for use in emergency situations;
- Increase the availability of advanced life support trained responders able to provide support to emergency ambulance crews.

The work would be overseen by a complementary resources steering group on which the Cheshire Association of Local Councils was represented. NWAS anticipated that Cheshire villages and small towns would develop Public Access Defibrillation and CFR schemes and this would be supported by a Cheshire Steering Group.

The new CFR scheme was soon to begin Crewe with four fully trained CFRs.

Members noted that in some cases local Councils purchased defibrillation equipment but felt that maintenance and battery replacement should be a role for NWAS. Members also felt that further information was needed on response times in Cheshire East and how these compared to other parts of the North West.

RESOLVED: that:

(a) the update report on the Community First Responders Scheme and Co-Responders be noted; and

(b) a further report be requested from the North West Ambulance Service on response times and standards of service.

22 **CENTRE FOR PUBLIC SCRUTINY PILOT PROJECT**

The Committee considered a report of the Borough Solicitor on the current position with the Centre for Public Scrutiny (CfPS) Pilot Project.

Cheshire East Council had successfully submitted a joint bid with Cheshire West and Chester Council to be a Scrutiny Development Area which would involve raising the profile of overview and scrutiny as a tool to promote community well-being and help councils and partners address health inequalities.

The initial work was to undertake a detailed mapping exercise to try to identify a clear picture of health inequalities and from that identify areas to undertake specific scrutiny work.

It was proposed that a joint Scrutiny Panel be established with Cheshire West and Chester Council to guide the work of the project.

RESOLVED: That:

(a) the progress made to date on the Pilot Project be noted;

(b) the initial work and proposed direction of the Project be endorsed; and

(c) 5 Members be appointed from this Council to the Joint Scrutiny Panel as follows – Councillors C Andrew, D Flude, S Jones, B Livesley and A Moran.

The meeting commenced at 10.00 am and concluded at 12.25 pm

Councillor Rachel Bailey (Chairman)

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Our Ref:

31st March 2010

Dear Sir / Madam

In *High Quality Care for All,* published in June 2008, Ministers set out the Government's vision for putting quality at the heart of everything the NHS does. A key component of the new Quality Framework was a requirement for all providers of NHS services to publish Quality Accounts.
The aim of the Quality Account is to improve public accountability and to engage Boards in understanding and improving quality in their organisations.

It is recognised that the Primary Care Trust, Local Involvement Networks (LINk) and Overview & Scrutiny Committees (OSC) have important roles in the development of these accounts and maximising their success.

Mid Cheshire Hospitals NHS Foundation Trust is delighted to send you a copy of our draft Quality Account for 2009/10 for your comments. Some of the data for the report will not be available until later in April / May but we hope this will not detract from the overall content.

The consultation period for this is 30 days and we would hope to receive your comments by April 30th 2010.

With sincere thanks

Best wishes

T Bullock

Tracy Bullock
Deputy Chief Executive / Director of Nursing

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Mid Cheshire Hospitals NHS
NHS Foundation Trust

Quality Account 2009/10

Quality and safety at heart
Mid Cheshire Hospitals NHS Foundation Trust
Quality Account 2009/10

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

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Quality Account 2009/10

Part 1

Summary Statement on Quality from the Chief Executive

Mid Cheshire Hospitals NHS Foundation Trust (the Trust) is proud to present its first published annual Quality Account for the period of April 2009 to March 2010. Last year the Trust published a Quality Report which outlined the quality areas that would be measured in 2009/10 and how it would take forward its aspiration to be a World Class Provider through the implementation of the five year '10 out of Ten' quality strategy. The aim of this strategy is to identify the Trust's top 10 quality indicators and to establish the measurements that will be used to monitor effectiveness against these.

Following consultation the Trust has agreed the following definition of Quality:

Effective and efficient delivery, a positive experience by both service users and staff; the best possible clinical and patient outcomes.

In addition to the above, the Trust recognises the reduction of avoidable harm as a key imperative.

Values

- *Commitment to quality and safety*
- *Respect, dignity and compassion*
- *Listening, learning and leading*
- *Creating the best outcomes together*
- *Every1Matters*

Behaviours

- *I will act as a role model*
- *I will take personal responsibility*
- *I will have the courage to speak up and make my voice heard*
- *I will value and appreciate the worth of others*
- *I will play my part to the best of my ability*

The Quality Account for 2009/10 will illustrate progress over the preceding year and will reaffirm the commitment of the Board of Directors to quality and set priorities for the forthcoming year. Page 51 demonstrates the extent of consultation and collaboration which has been undertaken to incorporate the views of stakeholders, public and staff in producing this final account.

Mid Cheshire Hospitals NHS Foundation Trust strives to deliver the best possible quality of care to users and carers whilst continually recognising potential areas to further improve both the quality and safety of services it provides. In December 2008, the Board formally acknowledged its accountability for the delivery of high quality care through the agreement of a five year quality strategy. To date, delivery against the commitments for year one has been achieved which includes the collaborative development of the top 10 indicators and the metrics that will be used to measure success against these. In restating its accountability in 2009, the Board sees quality and safety as being fundamentally aligned and views the quality strategy as complementary to the integrated governance strategy and infrastructure. This alignment was further endorsed when the Trust joined the Patient Safety First Campaign and the Leading in Patient Safety Programme (LIPS) in 2009.

In recognition of the priority given to quality and safety, the Trust Board has established an Executive Committee known as QuESt (Quality, Effectiveness and Safety). This committee meets bi-monthly, reports to the Board of Directors and is chaired by the Chief Executive. The terms of reference and membership were ratified at the January 2010 Board and the inaugural meeting took place in March 2010. The committee is responsible for providing information and assurances to the Board of Directors that it is safely managing the quality of patient care, effectiveness of quality interventions, investments and patient safety.

Statement of Directors' Responsibilities in Respect of Quality Accounts.

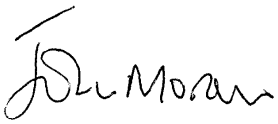
The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year.

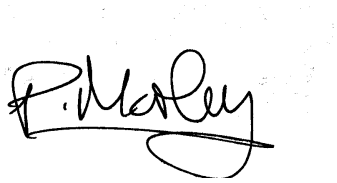
In preparing these accounts, Directors are required to take steps to satisfy themselves that:

- The Quality Account present a balanced picture of the NHS Foundation Trust's performance over the period covered;
- The performance information reported in the Quality Account is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data, quality standards and prescribed definitions, and is subject to appropriate scrutiny and review;
- The Quality Account has been prepared in accordance with relevant requirements and guidance issued by Monitor.

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

By order of the Board





John Moran
Chairman

Phil Morley
Chief Executive

Part 2
Priorities for improvement in 2010/11

The Trust has a significant number of quality and safety improvement initiatives underway, which have been distilled into a number of key priorities for 2010/11. These are largely focused on the implementation of year two of the quality and safety strategy.

In year one, the top ten indicators were agreed. Year two will determine baseline assessments against each indicator to establish the Trust's current performance. Where baseline or benchmarking data is currently available, stretch targets will be agreed for the next four years. Below is an outline of the top ten indicators and a summary of how progress will be monitored, measured and reported.

Outcomes

Cardiovascular

Aim:	To reduce mortality rates in patients who suffer an Acute Myocardial Infarction (AMI) within a 30 day period
Monitored:	Data relating to mortality in AMI within 30 days is not routinely collected by the Trust. Processes are currently being implemented to allow for this monitoring and benchmarking against peer organisations.
Measured:	The Trust is currently working with Dr. Foster, a performance benchmarking tool, to measure Acute Myocardial Infarction mortality.
Reported:	Acute Myocardial Infarction mortality within 30 days will be reported to the Quality, Effectiveness & Safety Committee (QuESt).

Cancer

Aim: To improve survival rates for patients diagnosed with cancer.

Monitored: The survival rates for patients diagnosed with cancer will be monitored annually.

Measured: The survival rates for patients diagnosed with cancer will be measured by the Public Health team at the Primary Care Trust and the North West Cancer Intelligence Service.

Reported: Survival rates for patients diagnosed with cancer will be reported to the Quality, Effectiveness & Safety Committee (QuESt).

Infections

Aim: To reduce the rates of healthcare acquired infections:
MRSA – zero blood steam bacteraemias
Clostridium Difficile – to perform better than the nationally agreed target of 106.
Urinary tract infection – to develop a monitoring mechanism and establish a benchmark during 2010/11

Monitored: MRSA & Clostridium Difficile are monitored on a monthly basis. The Trust is currently developing a methodology of collecting appropriate information.

Measured: The rates of MRSA and Clostridium Difficile are measured and benchmarked nationally by the Health Protection Agency (HPA). There is currently no nationally recognised measure for urinary tract infections; therefore the Trust will devise a mechanism internally.

Reported: The monitoring and reduction of all hospital acquired infections will be reported to the Quality, Effectiveness & Safety Committee (QuESt).

Safety

Mortality

Aim: To reduce mortality rates by 10% in patient groups where death is not expected.

Monitored: A Hospital Mortality Reduction Group has been established which is chaired by the Medical Director. This group reviews health records in order to identify areas for improvement in the quality of care we provide. Action plans are then developed in order to address the lessons learnt to ensure changes in practice are made. This group meets on a bi-monthly basis.

Measured: The hospital uses CHKS Risk Adjusted Mortality Index 10 which is a national healthcare benchmarking system. This system provides monthly information in order that the trust can closely monitor mortality rates with the aim of seeing a 10% reduction in 2010/2011.

Reported: The Hospital Mortality Reduction Group meets on a bi-monthly basis and reports to the Quality, Effectiveness & Safety Committee (QuESt).

Patient Safety

Aim: To monitor and reduce the number of consultant episodes (unnecessary patient moves) during each patient admission

Monitored: The episodes will be monitored through ISOFT which is a patient management system used at the Trust.

Measured: The number of consultant episodes during each non-elective admission will be measured using the Management Information System at the Trust.

Reported: The monitoring and reduction in the number of consultant episodes during each patient admission will be reported to the Quality, Effectiveness & Safety Committee (QuESt).

Harm Caused

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

Monitored: The patient safety team review all of the patient safety incidents in order to identify lessons to learn and changes in practice. This is reported in the Integrated Governance quarterly assurance report.

Measured: The Trust's incident reporting system is used to determine the number of patients who suffer avoidable harm. In addition to the learning from the national Leading in Patient Safety programme the Trust has commenced a process of reviewing health records to determine if any avoidable harm was caused using the Global Trigger Tool.

Reported: All serious patient safety incidents and actions taken/planned are reported to the Trust Board by the Medical Director. All patient safety incidents are reported in the Integrated Governance quarterly assurance report which includes lessons to learn and changes in practice. This is discussed at the Operational Integrated Governance Committee which has representation from all of the divisions. Patient safety incidents will also be reported to the Quality, Effectiveness & Safety Committee (QuESt)

Experience

Environment

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

Monitored: A Delivering Same Sex Accommodation (DSSA) group has been established which is chaired by the Deputy Chief Executive/Director of Nursing. This group meets bi-monthly and reports to the Patient Experience and Quality Committee.

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

Reported: The outcomes from DSSA group will be reported to the Quality, Effectiveness and Safety Committee (QuEST). Outcomes will also be reported to the Central & Eastern Cheshire Primary Care Trust (CECPCT) Contract Monitoring Committee.

Patients & Staff

Aim: To monitor and revise the ratio of doctors and nurses to each inpatient bed within the trust.

Monitored: An acuity group has been established which is chaired by the Deputy Chief Executive/Director of Nursing. This group meets bi-monthly and submits reports every 6 months to the Trust Board.

Measured: The acuity group reviews the results of the Association of University Hospitals (AUKUH) acuity/dependency monitoring tool which is used to assess the numbers of nursing staff required in adult inpatient wards. The monitoring process is undertaken every 6 months. Similar tools for nurses and midwives working in other areas of the trust and for medical staff will be reviewed, evaluated and implemented.

Reported: The outcomes from the acuity group will be reported to the Quality, Effectiveness and Safety Committee (QuEST).

Effectiveness

Finance

Aim: To measure the percentage of the Trust budget that is spent directly on patient care

Monitored: The Finance Team are currently developing a methodology to enable the measurement of the Trust budget spent directly on patient care.

Measured: The percentage of the Trust budget spent directly on patient care will be measured by the Finance Team, providing historic data against which the Trust can benchmark its future performance

Reported: The percentage of Trust budget spent directly on patient care will be reported to the Quality, Effectiveness and Safety Committee (QuEST).

Readmissions

Aim: To monitor and investigate all patients who are readmitted to hospital within 7 days of discharge.

Monitored: Readmission to hospital within a 7 day period as an emergency will be monitored on a monthly basis.

Measured: Readmission rates have previously been monitored on a monthly basis for patients who were readmitted as an emergency. Processes are currently being put in place to monitor readmissions within a 7 day period.

Reported: The results of the monitoring and investigating patients who are readmitted to hospital within 7 days will be reported to the Quality, Effectiveness & Safety Committee (QuESt). In addition to this, readmission rates are also reported to CECPCT for patients readmissions within 14 days.

The priorities for 2010/11 were arrived at through a number of mechanisms:-

- Those outlined in the 10 out of Ten strategy
- Those mandated or suggested by Monitor and the Department of Health
- Those identified in the Quality Report published for 2008/09

The views of relevant stakeholders, public and staff were taken into account when deciding the areas for inclusion.
The extent of this consultation is illustrated on Page 51, Consultation on Quality.

Review of Services

During 2009/10, the Trust provided and or sub-contracted [n] NHS services.

The Trust has reviewed all the data available to the Trust on the quality of care in [n] of these NHS services.

The income generated by the NHS services reviewed in 2009/10 represents [n] per cent of the total income generated from the provision of NHS services by the Trust for 2009/10.

The review of services takes place through the development of the annual clinical service strategy which reviews all services in respect of:

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

Participation in Clinical Audits

Clinical audit

During 2009/10, 32 national clinical audits and 6 national confidential enquiries covered NHS services that the Trust provides.

During the same period, the Trust participated in 78% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries in which it was eligible to participate.

The national clinical audits and national confidential enquiries that the Trust was eligible to participate in during 2009/10 is dependent on the audit project methodology, and are listed below. The number of cases submitted to each audit or enquiry is also presented as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Figure 1: Submission rates for national clinical audits and national confidential enquiries

Audit	Submission Rates - %
Continuous Data Collection	
NNAP: Neonatal Care	100
NDA: National Diabetes Audit: Paediatric	100
ICNARC CMPD: Adult Critical Care Units	100
National Elective Surgery PROMs: Four Operations	96
CMACE: Perinatal Mortality	100
NJR: Hip and Knee Replacements	77
NBOCAP: Bowel Cancer	44
MINAP (inc Ambulance Care): AMI and Other ACS	99
Heart Failure Audit	12
NHFD: Hip Fracture	Not known
TARN: Severe Trauma	64
Intermittent/One-Off Samples	
National Sentinel Stroke Audit	100
National Audit of Dementia: Dementia Care	In progress
National Falls and Bone Health Audit	100
National Comparative Audit of Blood Transfusion: Changing Topics	Not known
College of Emergency Medicine: Pain in Children	100
College of Emergency Medicine: Asthma	100
College of Emergency Medicine: Fractured Neck of Femur	100
National Mastectomy and Breast Reconstruction Audit	99
National Carotid Endarterectomy Audit	In progress
ASIG You're Welcome and NICE PH3 Guidelines Implementation Survey	100
BHIVA Survey of Paediatric Aspects of Adult HIV Care	100
BASHH Audit on the Management of PID in GUM Clinics 2009	100
Cervical Cytology Screening Practice in UK GUM Clinics	100
BHIVA Clinical Audit of HIV and Hepatitis B/C Co-infection	100

National Confidential Enquiries	
NCEPOD: Elective and Emergency Surgery in the Elderly	In progress
NCEPOD: Perioperative Care Study	In progress
NCEPOD: Parenteral Nutrition	46
NECPOD: Surgery in Children	In progress
NCEPOD: Deaths in Acute Hospitals (Caring to the End)	61
NCEPOD: Acute Kidney Injury: Adding Insult to Injury	50

* Submission rates are as accurate as current information allows, as eligible submission figures are not always available.

Reports for the audits listed have been reviewed by the Trust in the appropriate audit period. Continued improvement initiatives are monitored by the relevant clinical divisions

The reports of 61 local clinical audits were reviewed by the Trust in 2009/10. For details of clinical audit action plans please contact the Clinical Audit & Effectiveness office.

Research and Innovation

Participation in clinical research

Research is a core part of the NHS, enabling the NHS to improve the current and future health of the people it serves. The trust works in partnership with research networks across the North West including the Greater Manchester and Cheshire Cancer Research Network and Cheshire and Merseyside Local Research Network.

The number of patients receiving NHS services provided or subcontracted by the Trust in 2009/10, that were recruited during that period to participate in research approved by a research ethics committee was 321.

CQUIN: Commissioning for Quality & Innovation framework

A proportion of the Trust's contracted income in 2009/10 was conditional upon achieving quality improvement and innovation goals agreed between the Trust and its commissioners through the CQUIN payment framework. Further details of the 2009/10 agreed goals and new goals agreed for 2010/11 is available on request from the Deputy Director of Quality and Performance.

Two of the agreed CQUINs related to the development of an alcohol pathway within the Trust and improving the discharge arrangements for patients leaving hospital.

The development of the **alcohol pathway** aims to ensure that patients treated within the trust with alcohol related conditions are appropriately assessed and referred to alcohol support services. In this way the local health services can support individuals who want to address their alcohol issues as well as treating them for the consequence of these issues. The alcohol CQUIN monitors the Trust in agreeing the pathway between professionals, training staff in the use of the pathway and then delivering the screening, advice and initial interventions detailed within the pathway. The Trust is on track to have successfully implemented the alcohol pathway by the end of 2009/10.

The improvement of **discharge arrangements** is aimed at patients with particularly complex needs who require a number of different organisations to help meet these needs after they leave hospital. These improvements should reduce the unnecessary time patients stay in hospital and better plan for their care after they leave hospital. The discharge CQUIN monitors the Trust on the time it takes to complete the necessary assessment information, making better use of technology to communicate assessments between care organisations and ensure that patients who apply for continuing health care funding have all the appropriate information and support whilst doing this. The Trust is on track to have successfully improved the discharge arrangements by the end of 2009/10.

The monetary total for the amount of income in 2009/10 conditional upon achieving quality improvement and innovation goals was £686,000. The associated payment in 2009/10 remained at £686,000 as the payment for achieving quality was fixed by CECPCT.

What others say about the Trust

External visits for the current year have included:

Delivering Same Sex Accommodation Peer Review

A report was submitted to the Operational Integrated Governance Committee following this visit by the Strategic Health Authority, Primary Care Trust and Department of Health in October 2009. There was very positive feedback about the innovative way the trust had utilised the funding to meet this requirement, including the secondment post of Privacy and Dignity Matron and the signage which has been developed for ward areas. An action plan has been completed following this visit and this is being monitored by the National Service Framework for Older People Steering Group.

Environmental Quality Mark

The Macmillan cancer centre which opened in May 2008 was assessed against the requirements for the *Macmillan Environmental Quality Mark* in December 2009. The Trust is very pleased to advise that the centre was presented with the award in January 2010.

Patient Safety First Campaign

The Trust has signed up to the Patient Safety First Campaign and has at its heart a vision of an NHS with no avoidable death and no avoidable harm. This certificate demonstrates the Trust's progress and commitment to the campaign.

Care Quality Commission Registration

The Care Quality Commission (CQC) is the independent regulator of health and social care in England. Each year they give a rating to every NHS Trust in England to show how it performed over the last year.

Figure 2 - CQC Ratings for the Trust

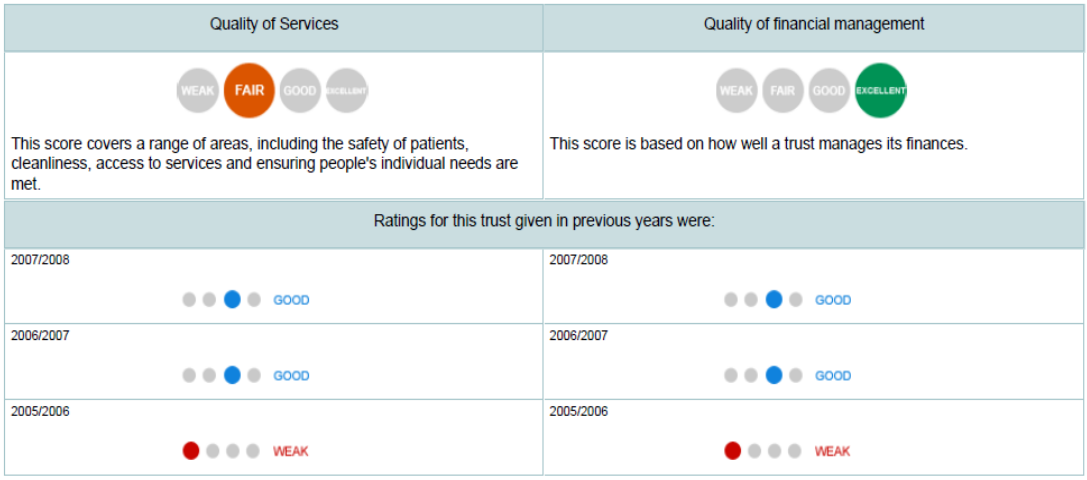


Figure 3 - CQC Assessments results

	Score
Safety and cleanliness	**13**/14
Waiting to be seen	**9**/12
Standard of care	**7**/8
Dignity and respect	**9**/9
Keeping the public healthy	**4**/5
Good management	**16**/18

The overall rating is made up of a range of assessments carried out throughout the year. The CQC examines how well the Trust has performed against the targets and the standards the government has set for the NHS.

The Trust is required to register with the CQC and its current status is:-

- Registered without conditions in relation to the Hygiene Code
- General registration not yet announced.

The most recent review carried out by the CQC was an unannounced inspection in relation to the Hygiene Code. The review took place on February 10th 2010 and the following conclusions were made:-

Of the 17 measures reviewed there were no areas of concern with regard to 15 measures. With the remaining two measures, areas requiring improvement were identified.

In view of this, the Trust has developed an action plan to address the areas requiring improvement. The action plan will be monitored by the Strategic Infection Control Committee to ensure that timescales are met.

The Trust has not been invited to take part in the any special reviews by the CQC during the reporting period.

Data Quality

NHS & General Medical Practice Code Validity:

The Trust submitted records during 2009/10 to the Secondary Uses 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:

Xx% for admitted patient care

Xx% for outpatient care

Xx% for accident and emergency care".

The percentage of records in the published data which included the patient's valid General Medical Practice Code was:

Xx% for admitted patient care;

Xx% for outpatient care;

Xx% for accident and emergency care."

Information Governance Toolkit Attainment Levels:

The Trust's score for 2008-2009 (results for 09/10 will be made available w/c 29th March) for Information Quality and Records Management, assessed using the Information Governance Toolkit was 74.6%.

Clinical Coding Error Rate

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

- Primary Diagnoses Incorrect 9.3%
- Secondary Diagnosis Incorrect 9.8%
- Primary Procedures Incorrect 5.4%
- Secondary Procedures Incorrect 2.3%

Part 3

Review of Quality Performance

The 2009/10 Quality Account specifically details progress against 2008/09 key priorities. It then progresses to review performance against areas of public interest or those recommended by other bodies such as Monitor and the Department of Health. These have been detailed under the headings of:

- Patient Safety
- Clinical Effectiveness
- Patient Experience

Progress against 2008/09 Key Priorities

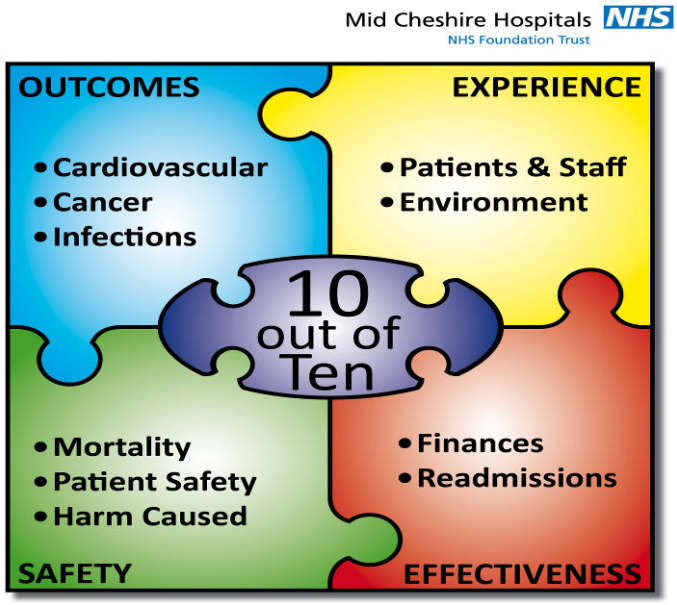
1. 10 out of Ten

The Trust aims to be in the top 10% of all secondary care providers in England in ten agreed indicators of quality by 2014. Year one of the 10 out of Ten strategy successfully achieved the following objectives:

a. Identify the trust's top 10 quality indicators
b. Divisional boards to agree their top 10 priorities
c. Each department to develop their top 10 priorities
d. Individual objective setting and appraisals to be commenced

Following an extensive consultation programme, the 10 out of Ten key indicators were agreed.

Figure 4 - Top 10 Priorities



For each of the above indicators, a series of metrics have been agreed or are under construction where baseline data is not available. Reporting against these indicators will formally take place in next year's Quality Account.

2. Quality Matters

The Quality Matters project is a three year programme using "Lean" methodology to review trust wide services aimed at:

- Improving patient care
- Improving staff morale
- Improving efficiency

A pilot phase commenced in 2008/09 to test the processes and patient pathways in Ophthalmology and Obstetrics. The changes made created "one stop" templates for patients with glaucoma and improved efficiency of services for ante-natal patients. Alongside this, the Trust rolled out the 'Productive Ward' series and introduced a number of modules which have demonstrated the release of nursing time to provide direct care for our patients.

2009/10 saw the commencement of year 2 of the project where the emergency care pathway, theatre efficiency and gynaecology outpatients were selected for review with the intention to:

- Maximise the utilisation of theatres;
- Improve the process flow through Accident & Emergency and the Emergency Admissions Unit;
- Improve the productivity within specific care pathways;
- Improve the patient experience;
- Reduce readmission rates;
- Improve the Care Quality Commission ratings on quality and finance;
- Improve staff experience through improving morale in the trust;
- Reduce serious untoward incidents
- Reduce complaints
- Release £1.8 million for reinvestment in patient services.

This year has seen the assessment and redesign of processes leading towards the implementation of outcomes which are expected to see results from April 2010 onwards.

3. Coaching for Quality and Organisational Development

In 2009/10 a coaching for quality framework was agreed, setting out how the trust would introduce a coaching culture. The two main elements of the framework were:

- Developing, leading and managing in a coaching style
- Developing in-house trained coaches.

Through a tendering exercise I-Coach were successfully selected to work with the trust, and training began during the first part of 2010.

The coaching for quality framework was developed as part of the overall approach to leadership and management development. September 2009 saw the completion of the first cohort of a newly developed two-stage management and leadership development programme. The programme consisted of a professional review process which demonstrated positive improvement outcomes. The second cohort commenced in September 2009.

Senior management development has taken place using a number of psychometric tools to support the development of team working, managing change, difficult situations and effective communication. In addition, Divisional Board members have had time with the executive team as part of a strategic team development process. The purpose of this is to work with divisions on current issues and support the development of sustainable solutions.

4. Clinical Pathway Action Groups:

Three Consultant led groups were identified to review and establish improvements to pathways or practice within specified areas. These were:

a. Elective care
This clinical pathway action group succeeded in establishing pathways for elective total knee replacement and hip replacement. Due to the success of these pathways, work is underway to review the pathway for rectal bleeding. To date this has resulted in reviewing and extending the practice of nurse endoscopists, revision of the referral pathway and additional clinical capacity for endoscopy sessions. Patient satisfaction is being monitored and has to date been very positive.

b. Primary and Community care – Chronic Obstructive Pulmonary Disease (COPD)
Through this clinical pathway action group, a new service will be launched on 1 April 2010, which integrates health care professionals into a single, 7 day service for COPD management, covering Primary and Secondary Care. The business case has been agreed between the East Cheshire NHS Hospitals, MCHFT and CECPCT and a pathway completed. The COPD Guidance Document is already in use.

c. Planned and end of life care
This clinical pathway action group was established to develop and improve the trust's performance in relation to the management of patients nearing their end of life. A baseline assessment was undertaken to establish compliance against recently published guidelines (End of Life Strategy, DH 086277). Following this an action plan was developed to address:

- Development and delivery of End of Life awareness / training sessions to medical and nursing staff
- Performance monitoring the use of the 'End of Life Care of the Dying' Pathway and benchmarking against external data.
- Development of proposals for specific palliative care beds as part of the Primary Care Trust's intermediate bed based services commissioning plans

The outcomes of the project have shown significant improvement in the performance of the trust against these objectives. This was re-audited in February 2010 to ensure continuous improvement is maintained.

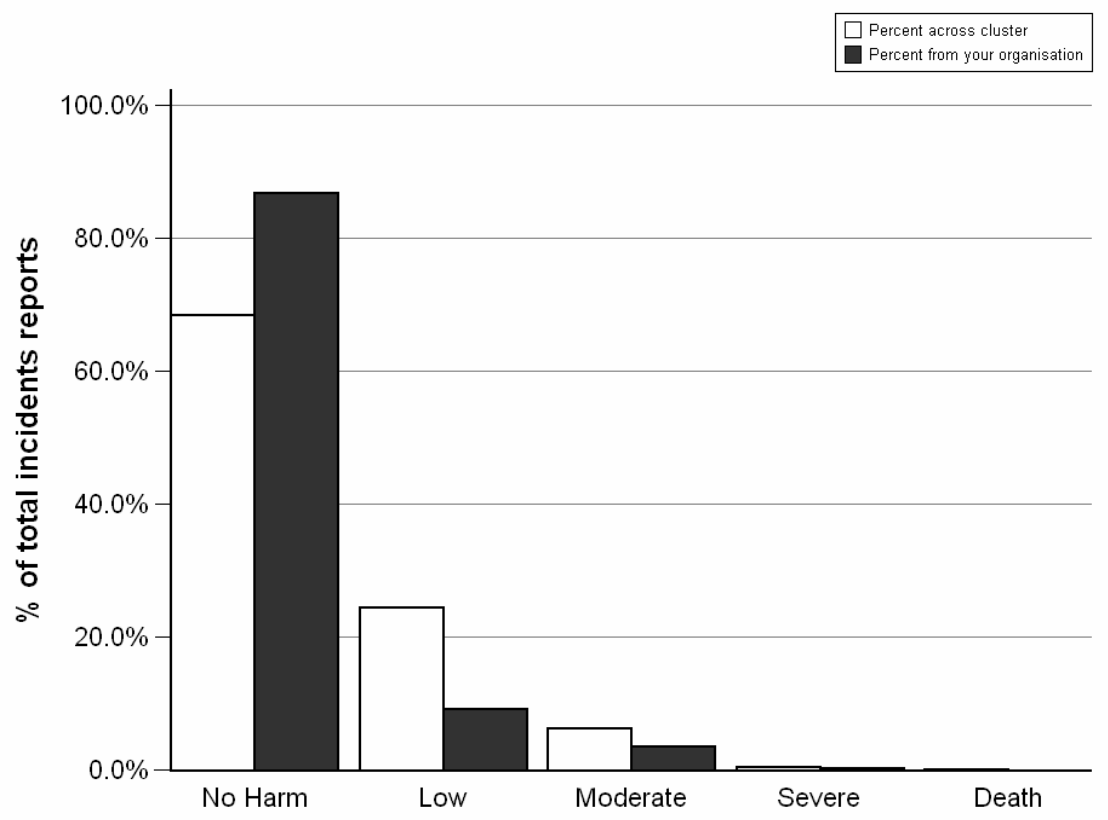
Patient Safety

Priority 1: Reduce avoidable harm

Why?: *'Almost 4,000 NHS patients in England died as a result of "safety incidents," while a further 7,500 suffered severe harm' according to figures released in 2009 by the National Patient Safety Agency (NPSA).*

All patient safety incidents at the Trust are reported to the National Patient Safety Agency (NPSA). The NPSA provide the Trust with feedback on this information and provide comparisons with similar sized organisations.

Graph 1: Comparison data of patient harm



Graph 1 shows how the Trust compares with other organisations in the cluster with regard to degree of harm incurred by patients in the incidents reported during the period 1st April to 31st September 2009. This is the most current data available from the NPSA.

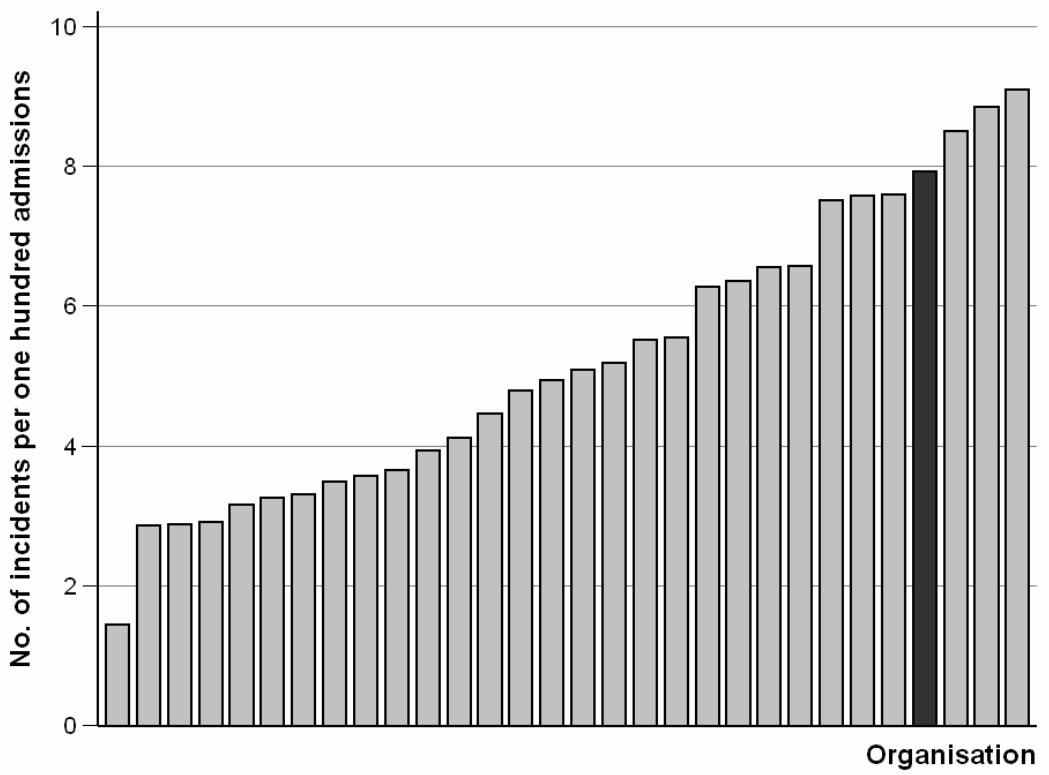
In comparison to previous data the Trust is maintaining a reduction in harm caused to patients. The majority of patient safety incidents resulted in no or minor avoidable harm to patients. Going forward the Trust aims to set targets and timescales to further reduce avoidable harm caused to patients.

Patient Safety

Priority 2: Maintain the Trust's Safety Culture

Why?: *The National Patient Safety Agency (2009) has emphasised that Trusts with the highest level of reported incidents tend to be the safest, because staff are encouraged to report incidents openly and learn from them.*

Graph 2 - Rate of Reported Patient Safety Incidents per 100 Admissions within Trust Cluster Group during April 2009 - September 2009



Graph 2 shows the rates of reported patient safety incidents per 100 admissions in the organisations in the Trust's cluster group (small district general hospital) during the period 1st April to 31st September 2009. The highlighted bar represents Mid Cheshire Hospitals NHS Foundation Trust. This is the most current data available from the NPSA.

For the past three years the Trust has remained in the top centile of reporters compared with other organisations within the cluster. The Trust has a high reporting culture which has been demonstrated in the NPSA reports for three years consecutively. The Trust aims to increase the reporting of incidents and near misses by 1% year on year.

Medication incidents

The Trust has been recognised by the NPSA as under reporting medication incidents; therefore additional resources have been put into an additional reporting system within pharmacy. Early indications are that this is proving successful as there is an increase in reporting. The Trust aims to see a 10% increase in medication near miss and minor incident reporting next year and a Safer Medicines Practice Group has been established to analyse the information and identify lessons to learn and changes in practice. Additionally the Trust will take forward the Medicines Management Module from the Productive Ward project.

Patient Safety

Priority 3: Implement National Patient Safety Initiatives

Why?: *To develop the capacity and capability in the trust to eliminate avoidable harm to patients (NHS Institute for Innovation and Improvement 2009).*

Patient Safety First Campaign

The Trust has signed up to the Patient Safety First Campaign which is led by a Senior Consultant and the Patient Safety Lead. The *Patient Safety First Campaign* has at its heart a vision of an NHS with No Avoidable Death and No Avoidable Harm (Patient Safety First Campaign 2009). The Trust has committed to making progress in relation to the following interventions:

Deterioration

Aim:
To reduce in-hospital cardiac arrests and mortality rates through earlier recognition and treatment of a patient who is deteriorating.

Progress:

- A gap analysis has been undertaken against the six key areas relating to patient deterioration.
- The Trust has effectively developed and implemented an Early Warning System specifically for maternity patients.
- A task and finish group has been established to introduce SBAR to the Trust which is a tool to standardise handover of care between clinicians.
- A mortality reduction group has been established, which is led by the Medical Director.
- A systematic audit of inpatient deaths has been established.
- Links have been strengthened between clinical coders and consultants.

Leadership

Aim:
To ensure a leadership culture at Trust Board level which promotes quality and patient safety and provides an environment where continuous improvement in harm reduction becomes routine throughout the organisation.

Progress:

- Nurses are involved in the programme with representation from all clinical divisions.
- The Trust has developed courses for *Becoming a Manager* and *Managers Moving On* which focus on leadership and professional development.
- Senior Nurse Managers (which includes the Deputy Chief Executive/ Director of Nursing) with a current clinical qualification, spend 1 day per month working in clinical areas and write a reflective piece identifying good practice and areas for improvement.
- The Chief Executive visits one patient each morning to discuss their experiences whilst under our care. The information gained from the patients is discussed with board members on a regular basis, whilst ensuring anonymity and patient confidentiality at all times.

Pre op care

Aim:
To improve care for patients undergoing elective surgical procedures in the hospital setting.

Progress:

- The World Health Organisation (WHO) *Safe Surgical Safety Checklist* was rolled out to all theatres by March 2010.
- Pre surgery briefs are being held as part of the WHO safe surgery checklist in order to ensure that everyone involved in the surgery is aware of what they should be doing and that all the equipment required is readily at hand.

NHS Institute of Innovation & Improvement

Leading in Patient Safety Programme (LIPS)

Safer Care

The Trust has signed up to the Leading in Patient Safety programme which aims to develop the capacity and capability to eliminate avoidable harm to patients. This programme involves trust board members, senior clinicians and senior managers from across the organisation.
Actions from this include:

- The patient safety team undertake patient safety 'walkarounds' discussing patients with clinicians, identifying changes in practice and promoting incident & near miss reporting.
- Use of the Global Trigger Tool which helps to randomly select health records and review them for harmful events and make appropriate changes.
- Changes in the way the Trust presents its information to provide a clearer picture of improvement or identifying areas for action.

Clinical Effectiveness

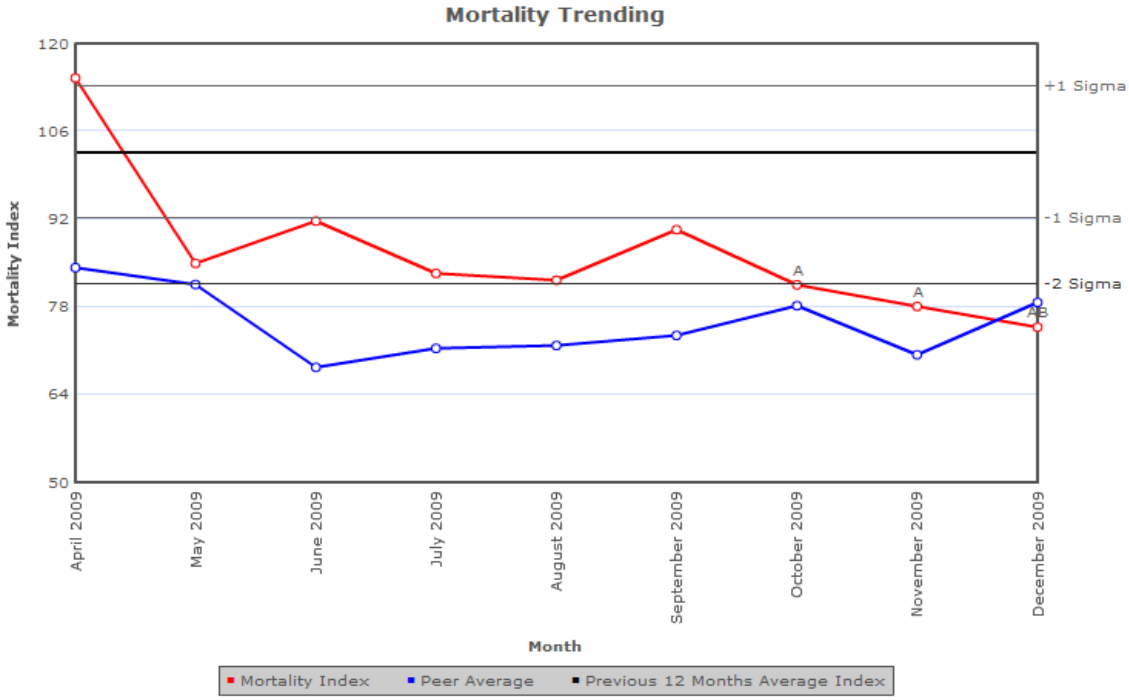
Priority 1: Saving lives – Reducing Mortality Rates

Why ?: *To improve outcomes for our patients and reduce the Trusts Hospital Standardised Mortality Rates (HSMR)*

Reduction in mortality

A Trust Mortality Reduction Group has been established which reviews patient's records and collates information to highlight lessons to learn and agree changes in practice. Changes made will be reported in the 2010-2011 Quality Accounts.

Graph 3: – Mortality Trending



This chart demonstrates a reduction in mortality with the Trust being below peer by December 2009

Clinical Effectiveness

Priority 2: Implement the most Clinically Effective Care – Advancing Quality Programme

Why?: *To enhance standards of patient care and management, to improve clinical outcomes and overall patient experience for the four clinical conditions included in the advancing quality programme.*

The Trust was selected as a pilot organisation for the implementation of the Regional Advancing Quality programme in 2007. The aim of this project is to record and report on agreed clinical measures and improve outcomes for patients with the following clinical conditions.

- ⇨ Acute Myocardial Infarction
- ⇨ Heart Failure
- ⇨ Hip & Knee Replacement Surgery
- ⇨ Community Acquired Pneumonia

Data is entered retrospectively and based on discharge diagnosis. Advancing Quality is a pilot project so therefore there is no historic data

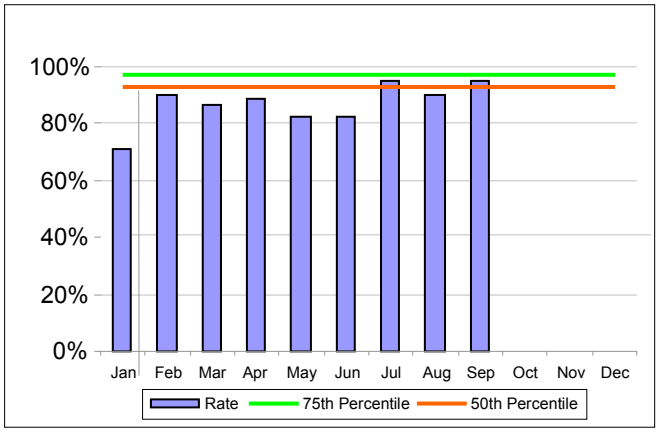
The red line on the following charts overleaf shows the top 50% of the Northwest trusts and the green line shows the top 25% of the Northwest trusts.

The Trust consistently achieves above these lines then the trust will be rewarded financially for the high standard of care provided.

Interventions for all patients admitted with Acute Myocardial Infarction.

- Aspirin administered within the first 24 hours of admission.
- Thrombolytic treatment (if clinically indicated)
- Smoking cessation advice given
- Discharge medications provided

Graph 4: - Acute Myocardial Infarction - Composite Scores

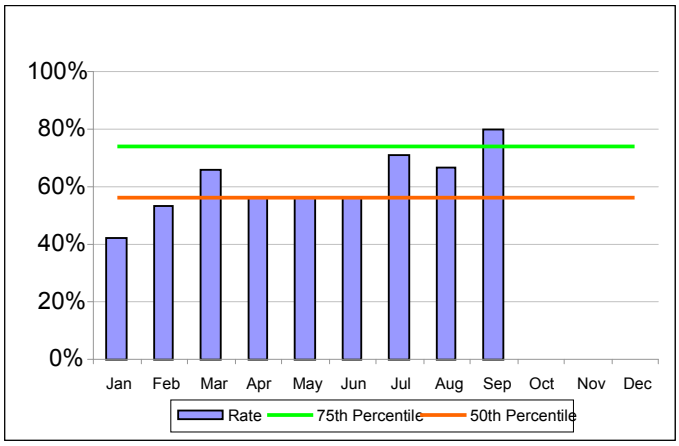


The chart demonstrates that the delivery of these interventions is consistently high for patients diagnosed with Acute Myocardial Infarction.

Interventions for all patients being admitted with Heart Failure:

- Investigation – Echocardiogram (ultrasound of the heart)
- Medication on discharge provided
- Smoking cessation advice given
- Written discharge instructions provided for activity, diet, symptom worsening follow-up, medications and weight monitoring.

Graph 5: - Heart Failure - Composite Scores

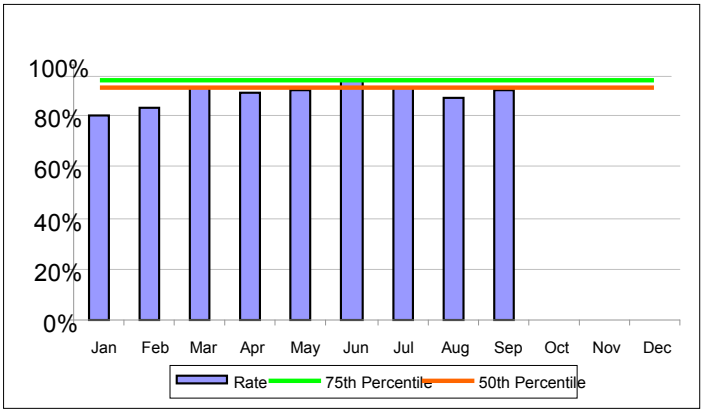


The overall results for heart failure have taken time to improve due to the difficulty in identifying these patients prior to discharge as they can be admitted to a variety of emergency care wards with differing symptoms. The Trust has a designated heart failure nurse assigned to help identify these patients and deliver discharge instructions.

Interventions for all patients undergoing Hip and Knee Replacement Surgery:

- Recognition of medications taken prior to admission
- Anti-coagulant medication administered during admission
- Antibiotic therapy administered during surgery

Graph 6: – Hip & Knee Replacement Surgery - Composite Scores

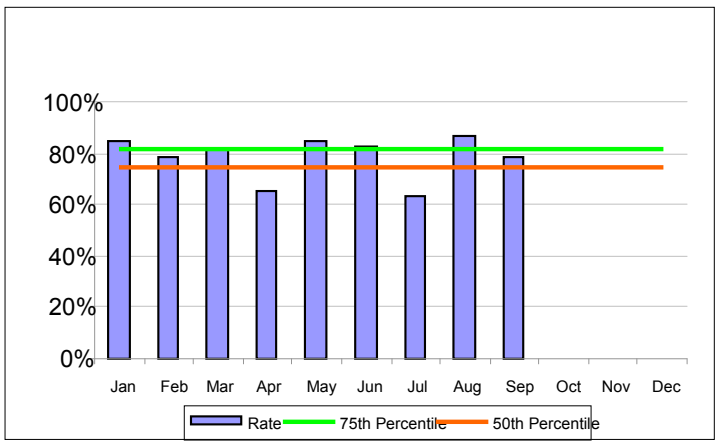


The graph above demonstrates the Trust is delivering consistently high levels of care to patients undergoing hip and knee replacement surgery.

Interventions for all patients being admitted with Community Acquired Pneumonia (CAP):

- Oxygen assessment on arrival
- Recommended antibiotics prescribed to treat CAP
- Antibiotics administered within 6 hours of admission
- Blood cultures (if indicated)
- Smoking cessation advice given

Graph 7:- Community Acquired Pneumonia - Composite Scores



The graph demonstrates overall high compliance with patients receiving a high standard of care when admitted with Community Acquired Pneumonia. Reduced scores can be seen in April and July. This was due to several patients not being offered smoking cessation during their stay.

Summary:

Overall, it can be seen that the Trust provides a high standard of care to patients admitted with any one of the four clinical conditions. The first year of Advancing Quality has focussed on the process of collecting information from patient records. The second year will focus on improving care delivery. Early diagnosis is imperative to compliance with these interventions. This allows communication alerts to appropriate healthcare professionals to ensure patients receive the right care at the right time.

Clinical Effectiveness

Priority 3: Implement the most Clinically Effective Care – Stroke 90:10

Why? *To enhance standards of patient care and management, to improve clinical outcomes and overall patient experience for patients diagnosed with a stroke.*

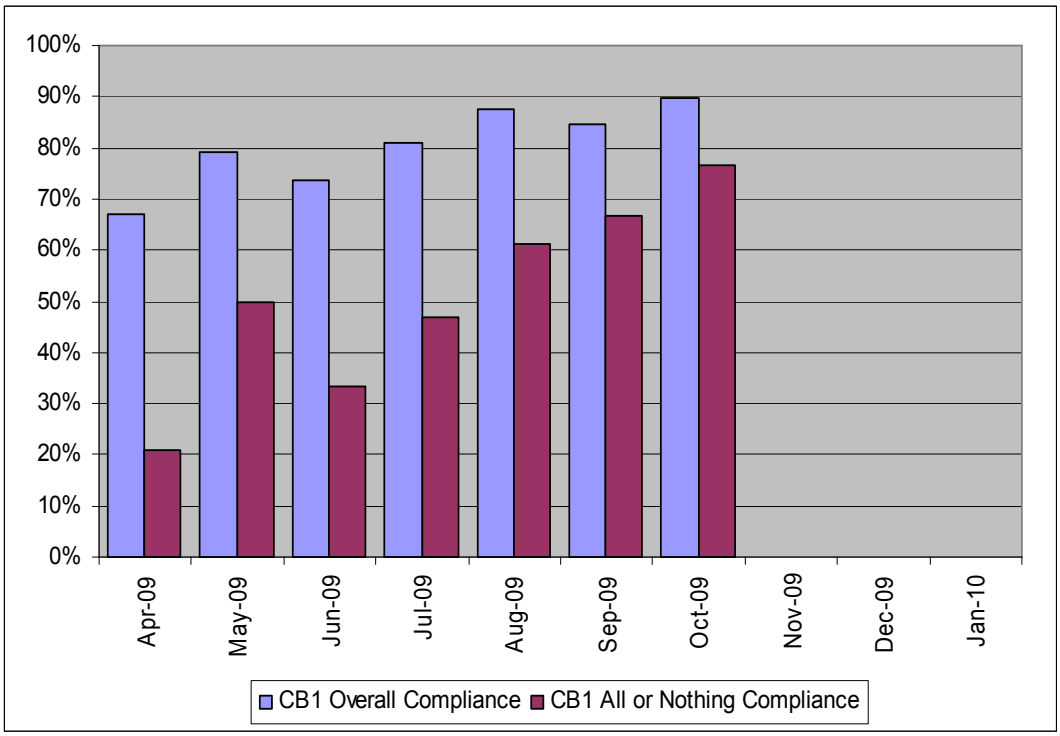
Stroke 90:10 is a Northwest Collaborative that commenced in January 2009. Its aim is to improve the care and management of patients who have suffered a stroke. The implementation of Stroke 90:10 does this by ensuring patients receive a plan of care that has been clinically proven. This plan of care consists of a care bundle approach. The Trust's aim is that all patients admitted with a diagnosis of a stroke will receive all of care bundles 1 and 2. Stroke 90:10 is a pilot project therefore there is no historic data

Care bundle 1 was implemented in January 2009 and concentrated on the acute care of stroke patients. Care bundle 2 was implemented in May 2009 focussing on the rehabilitative aspect of stroke care.

Care bundle 1

- CT scan to be undertaken within 24 hours
- Aspirin therapy to be administered within 24 hours
- Weight to be recorded
- Swallow to be assessed within 24 hours

Graph 8: - Results of care bundle 1



The blue area within the graph shows that patients received at least one of the elements with care bundle 1.

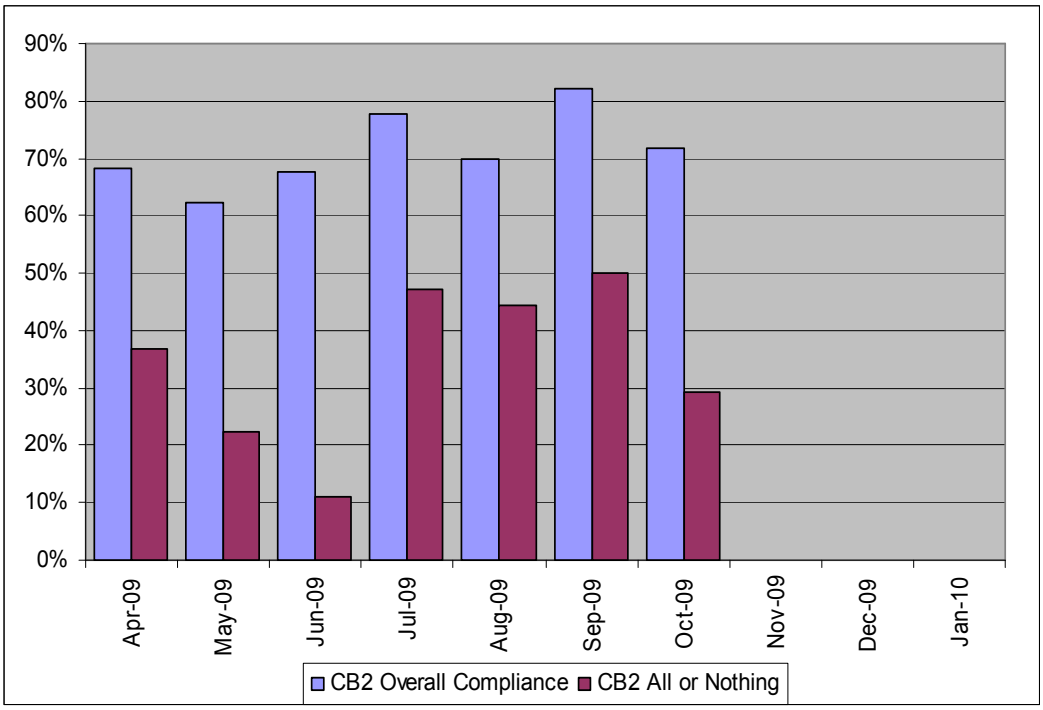
The red area shows whether or not patients received all of care bundle 1 during their stay.

In relation to care bundle 1, the graph shows overall month on month improvement since the introduction of the Stroke 90:10 project. The stroke team will continue to monitor performance and make the necessary changes until it is demonstrated that the improvements are sustained.

Care bundle 2

- Physiotherapy to be commenced within 72 hours
- Occupational Therapy to be commenced within 4 days
- Multidisciplinary goal setting to take place
- Mood Assessment to be undertaken
- 50% of the patients' stay to be in the stroke unit

Graph 9: - Results of care bundle 2



The blue area within the graph shows that patients received at least one of the elements within care bundle 2.

The red area shows whether or not patients received all of care bundle 2 during their stay.

In relation to care bundle 2, the graph shows fluctuating results since the introduction of the Stroke 90:10 project. This is predominantly related to patients not always being admitted to the stroke unit. The stroke team will continue to monitor performance and make the necessary changes until it is demonstrated that the improvements are sustained.

The Sentinel Audit is the national audit which measures the care patients receive following the diagnosis of stroke. The audit is in two parts, the organisational structure and the clinical pathway. The improvement initiatives are ongoing in stroke management and care and the trust is optimistic that it will attain a score of 90 in the Sentinel audit which commences in April 2010.

Patient Experience

Priority 1: Improve on the results of National Patient Surveys

Why? *To further our commitment to ensuring every patient receives the best possible experience within the trust*

To improve the quality of services, it is important to understand what patients think about their care and treatment. One way of doing this is by asking patients who have recently used their local health services to tell us about their experiences.

The Trust participates in the NHS Survey programme co-ordinated by the CQC which enables us to build up a picture of patient's experiences over time.

An action group for patient experience monitors progress on action plans developed following patient surveys.

Summary of results from the National Outpatient Survey

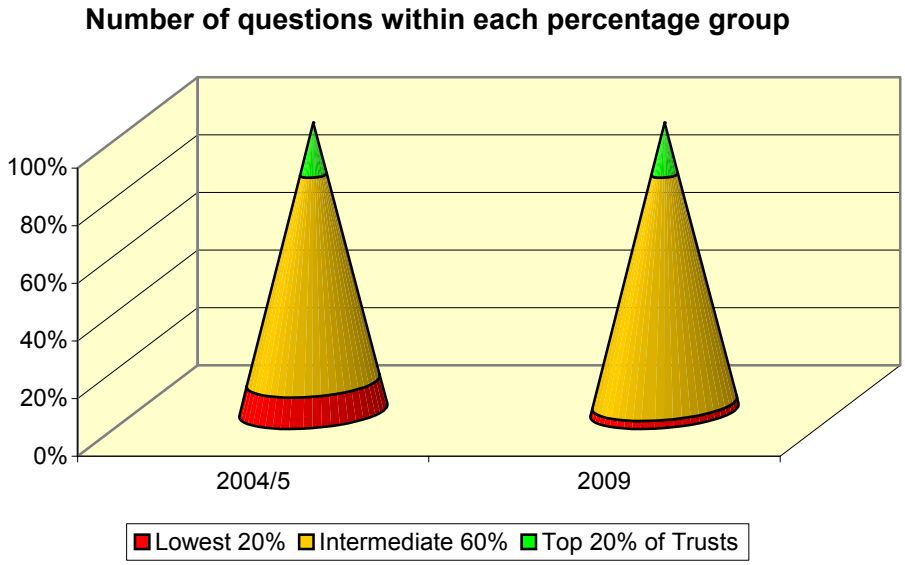
The Trust focuses on key areas to ensure continued improvement in patient satisfaction. Trust scores from the National Outpatient Survey conducted in 2009 demonstrated progress made since the previous survey in 2004.

Figure 5: - Comparisons of results from National Outpatient Surveys

National Outpatient Survey – Mean Rating Scores	**2004**	**2009**	**Change⇧⇩**
Cleanliness of department	80	85	⇧**5**
Cleanliness of toilets	77	83	⇧**6**
Getting answers to questions from doctors	80	83	⇧**3**
Involvement in decisions about care and treatment	82	83	⇧**1**
Amount of privacy when discussing treatment	93	94	⇧**1**
Amount of privacy when being examined or treated	95	97	⇧**2**
Overall were you treated with respect and dignity	93	93	–
Overall rating of care	81	82	⇧**1**

These scores are calculated by converting responses to particular questions into scores. For each question in the survey, the individual responses are scored on a scale of 0 to 100. A score of 100 represents the best possible response. Therefore, the higher the score for each question, the better the trust is performing.

Graph 10: - National Outpatient Survey – Benchmarked number of questions



This shows, there has been progress in improving the Trust's benchmarked scores so that there are less questions in the lowest 20% and more in the top 20% of Trusts. This reflects the considerable efforts that have been made in the outpatients department to improve the care and treatment of on offer to patients.

The following table provides results from the National Patient Survey programme to assess progress against the Public Services Agreement (PSA) targets agreed. The dimensions are grouped questions with a common theme and show that the trust has performed higher than the national score on four out of five dimensions. The Trust has improved on two of the five dimensions since 2004 and is static on two dimensions.

Outpatient survey

Figure 6: – Dimension scores for the Outpatient Survey compared to National benchmark data

Dimensions Mean Rating Scores	2004*	2009	2009 National Benchmark data
Access and Waiting	69	71 +	69
Safe High Quality, Coordinated Care	86	85 -	82
Better Information More Choice	79	79 =	77
Building closer relationships	79	79 =	86
Clean, comfortable place to be	71	74 +	68

*Survey not conducted nationally since 2004

Improvements achieved:

The Trust has a comprehensive range of information available for patients at pre operative assessment appointments, in clinics, wards and departments.

An information leaflet has been produced to promote the leaflet package to patients in GP practices.

Patient Recommendation

Finding a measure that helps the Trust know if it is achieving its aim of being the 'hospital of choice for local people' is quite a challenge. In 2009, the Net Promoter Score (NPS) was included in all of the Trust's local patient surveys. The NPS (Reichheld 2006) offers a way to capture what people will say in terms of 'word of mouth' locally. The net promoter score is a measure to capture whether or not the Trust is the hospital of choice for local people. In 2009, 1000 patients were asked in local patient surveys if they would recommend the trust to family and friends based on their experience as a patient: 86% of patients declared that they would recommend the Trust to others.

This question also appears in the Care Quality Commission National Outpatient Survey and 98% of patients said they would recommend the Outpatient Departments to family and friends.
(N= 737 patients)

Patient Reported Outcome Measures (PROMS)

Patient Reported Outcome Measures are health questionnaires completed by patients admitted to hospitals for elective hip or knee replacement, hernia repair or varicose vein surgery. The questionnaire is completed before surgery and then six months after operation to measure individual health outcomes.

The National PROMS is run by Northgate Information Solutions in partnership with Quality Health for the Department of Health. The National PROMS commenced in April 2009 with Advancing Quality PROMS transferring over in October 2009.

The Trust started to collect Patient Reported Outcome Measures (PROMS) in Orthopaedics in January 2009 as part of the Advancing Quality project.
Results from these questionnaires suggest that we are operating on patients with more pre-existing healthcare conditions than other trusts in the Northwest of England.

Table for Compliance for National PROMS

Figure 7: – PROMS completion rates

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Hip & Knee Replacement - number of eligible patients	25	32	33	34	36	34	33	37	30	32	32	
Percentage return rate	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	
Hernia - number of eligible patients		12	14	19	16	13	19	37	27	30	23	
Percentage return rate	**n/a**	**100%**	**100%**	**100%**	**100%**	**100%**	**90%**	**89%**	**74%**	**77%**	**78%**	
Varicose Veins - number of eligible patients		7	8	15	3	5	10	29	12	15	20	
Percentage return rate	**n/a**	**100%**	**100%**	**100%**	**100%**	**100%**	**80%**	**100%**	**75%**	**87%**	**90%**	
MCHFT TOTAL - number of eligible patients	25	51	55	68	55	52	62	103	69	77	75	
Percentage return rate	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**94%**	**96%**	**86%**	**88%**	**91%**	

* n/a – Not applicable

Completion of the PROMS questionnaire is voluntary; hence the return rate is often less than 100%.
Results from Northgate Information Solutions available 8th April 2010.

Patient Experience

Priority 2: Improve Privacy & Dignity for Patients

Why?: *The Trust believes that all its patients, their families, friends and carers have the right to be treated with dignity and respect, maintaining their privacy at all times.*

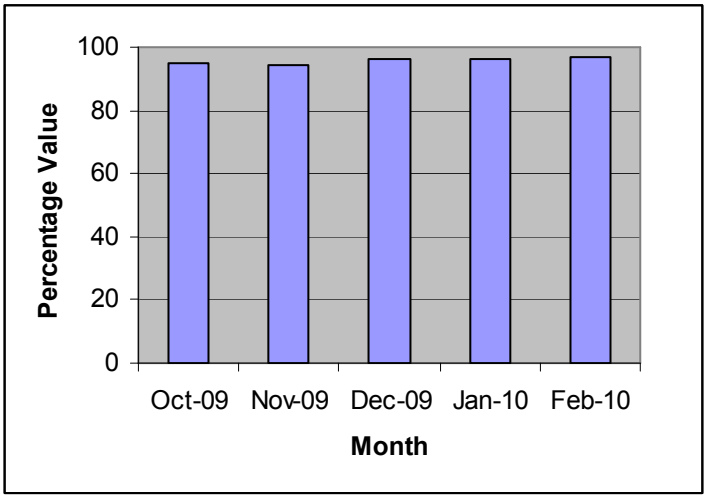
"Never take persons dignity; it is worth everything to them and nothing to you"
Frank Barron

The Trust has recently published the Mid Cheshire Mission which highlights to staff points to remember when dealing with patients, relatives and the public:

- Always greet people first and with a smile
- Do not leave patients, relatives, staff or the public waiting for assistance
- Always introduce yourself
- Always ask people how they would like to be addressed
- Do not judge others
- Be kind and compassionate
- Find out about people, their lives and stories
- Be sensitive to the needs of others
- Always treat people with dignity and respect
- Remember the privileged position you are in

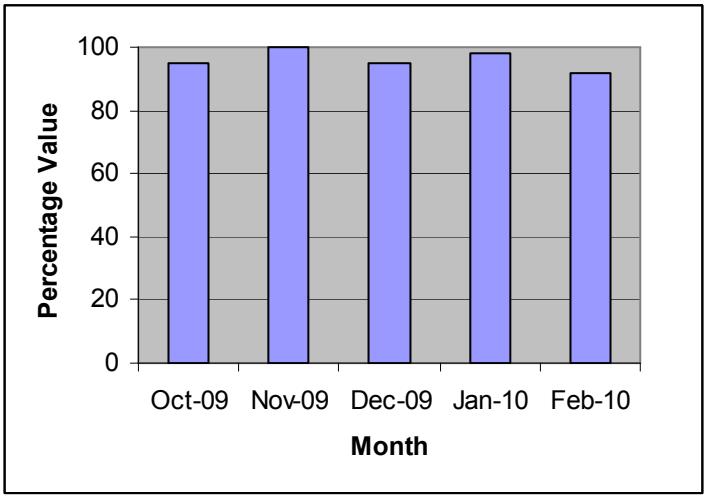
Every month a sample of patients across the Trust are asked the following questions:-

Graph 11: - Are you given enough Privacy & Dignity when being treated or examined?



This graph shows that a high volume of patients feel they are treated with Privacy & Dignity.

Graph 12: - During your stay, have you been treated with Dignity and Respect?



This illustrates that the vast majority of patients felt they were treated with Privacy & Dignity during their hospital stay.

The Trust is committed to delivering same sex accommodation and none of our wards have mixed sex bays. Certain assessment areas such as the Emergency Assessment Unit, the Surgical Assessment Unit, Acute Stroke Unit and Ward 1 (Cardiology) do at times contain mixed sex areas due to clinical need. The Trust has invested in privacy screens and privacy doors to help maximise the dignity of our patients whilst also reducing the risk of spreading infection.

There has also been a great deal of work done at the Trust to improve the quality of care, dignity and respect offered to patients with dementia. These improvements have been recognised as best practice by the Alzheimer's Society, which has published an article in their 'Living with Dementia' magazine highlighting the changes that have been made.
(Follow this link to 'Living with Dementia' magazine www.alzheimers.org.uk)

Examples of changes made include:

- The installation of coloured privacy doors to promote independence and reduce possible barriers to dignity

- The development of communication friendly signs which are suitable for patients with cognitive impairment

- Training for staff in dementia care

- Provision of an activity lounge – where patients with dementia can socialise, engage with staff and other patients and enjoy interactive games

Patient Experience

Priority 3: Improve the handling of complaints

Why? *To ensure patients are satisfied with the handling of any complaint they may have and to be treated fairly.*

The NHS Constitution sets out the right for patients to:

- Have their complaint dealt with efficiently, and properly investigated,
- Know the outcome of any investigation into their complaint,
- Take their complaint to the independent Parliamentary and Health Service Ombudsman if they are not satisfied with the way the NHS has dealt with your complaint.

The new complaints procedure came into effect from April 2009. This focuses on a more responsive handling of complaints with early contact with complainants to identify the issues they want resolving and the outcomes they are looking for.

The new legislation has replaced the previous 25 working day limit with flexible timescales which are agreed with the complainant. This has meant that, wherever possible, the complainant is contacted by telephone to agree the issues within the complaint. Where this is not possible, a letter is sent to the complainant stating the issues identified within the complaint, giving the opportunity for the complainant to respond if any issues have been missed or not included or even just to discuss how the complaint will be progressed.

Figure 8: - Number of Complaints, Referrals to the Ombudsman and Response Times

	2007/08	2008/09	2009/10
Number of Complaints received	261	268	
Number of Independent Reviews undertaken	1	1	
Number of Requests for Review to Ombudsman	0	0	
Number accepted for Review by Ombudsman	0	0	
Response Times within 25 Days (or agreed timescale with complainant)	84%	98%	

Examples of changes made as a result of complaints

- Visiting times on the orthopaedic unit were changed to provide relatives with the opportunity to speak to a senior member of staff between 14.30 and 16.00 each day.
- All patients who have a suspected melanoma are now offered a hospital appointment two to three weeks after their surgery to discuss the results in clinic with their Dermatologist.
- Ward folders have been introduced on the maternity wards in response to questions raised by new mums for information on ward facilities. The folders have been developed following consultation with parents at Monks Copperhill Baby Café, Winsford Children Centre, Underwood West Children Centre and Community Polish groups

In a survey conducted in 2009, patients rated their satisfaction in how complaints were handled as follows:

	Target for 2010/11
• 48% of respondents felt their complaint was resolved satisfactory.	65%.
• 47% said they were offered a meeting.	75%.
• 10% felt reassured that action would be taken to improve the areas of concern to them.	50%
• 76% said they received a copy of the trust's Complaints leaflet	90%

Consultation on Quality

The consultation process for the Quality Accounts commenced on 24th October 2009, running through until 11th December, 2009.

The objectives of the consultations were to:

- ⇨ Ask local people for feedback on the 10 key priorities for the Trust.
- ⇨ Recruit members of the public as Foundation Trust Members.
- ⇨ Provide an opportunity for Foundation Trust Governors and staff to talk to members of the public about the quality of services provided.

Through partnership working, the offer was made by the Public Engagement Manager of the Cheshire Police Authority to participate in a joint consultation exercise. The Police Authority aimed to directly consult with communities in key towns across the policing area in order to gather people's views about public priorities. In this new initiative, both organisations aimed to out to find out what mattered to the public. The Constabulary Exhibition Vehicle was located in prominent places in Crewe, Northwich, and Sandbach enabling staff and volunteers to engage with members of the public. Displays were also organised in several local supermarkets including Morrisons in Winsford and Sainsbury's in Crewe and displays at local GP surgeries in Nantwich and displays within the Trust.

Foundation Trust members involved in monitoring Quality, Patient information and Research & Development were selected to support the consultation events. Question cards were widely distributed to gain public opinion.

The public were asked to prioritise from a list of 10 areas, and there was also a section for comments. Each event was well attended with approximately 45 applications for Foundation Trust Membership. The total number of responses received by the Trust was 370. The responses received were varied; the priorities that were chosen are documented on the table overleaf.

Analysis of Responses

Figure 9: – Priorities of the Public

Group	%	Rank
Infections	77%	1
Cancer	70%	2
Mortality	67%	3
Staff Dev	64%	4
Patients Safety	63%	5
Heart Disease	59%	6
Readmissions	58%	7
Fit for Purpose	49%	8
Finances	49%	9
Prevent Harm	48%	10

As this was the first quality consultation there is no historic data available.

This shows that the publics' main priority for the Trust was prevention of Infections.

The majority of respondents regarded all 10 priorities as important for the Trust to monitor and measure.

Readers Panel

The Trust's Readers Panel consists of 50 members of the public and volunteers. On a monthly basis, the trust produces information for patients in draft format, which is forwarded to the members of the reader's panel for evaluation and comment. Members were recently asked if they would be interested in reviewing the Quality Account. 25 members responded and their feedback has been incorporated into the final version of this Quality Account.

Statements from Local Involvement Networks (LINk), Overview and Scrutiny Committee (OSC) and Primary Care Trust (PCT)

In *High Quality Care for All,* published in June 2008, Ministers set out the Governments vision for putting quality at the heart of everything the NHS does. The key component of the new Quality Framework was a requirement for all providers of NHS services to publish Quality Accounts. The aim of the Quality Account is to improve public accountability and to engage Boards in understanding and improving quality in their organisations.
The Primary Care Trust, Local Involvement Networks (LINk) and the Overview & Scrutiny Committee (OSC) have important roles in the development of these Accounts and maximising their success.
This Quality Account has been reviewed by the Central & Eastern Primary Care Trust, Western Cheshire Primary Care Trust, LINk and the OSCs for Cheshire East and Cheshire West & Chester.
Their comments are documented below:-

LINk Local Involvement Networks

OSC Overview and Scrutiny Committee

PCT Primary Care Trust

Key National Priorities

Figure 10: - Quality Overview

Safety Measures Reported	2008-2009	2009-2010	Improved ⇧⇩⇨
1. Number of patients with MRSA Infections	15		
2. Number of patients with Clostridium Difficile	142		
3. Hospital Falls/ injuries (falls/1000 bed days) (*)	6.41		
4. Falls assessment risks completed within 24hrs (*)	83%	96%	↑
5. Waterlow tests completed within 24 hours of admission (*)	98%	93%	↓
6. Nutritional assessment completed within 24 hours of admission	82%	99%	↑
Clinical Outcome Measures Reported			
1. Risk Adjusted Mortality Index	104		
2. Stroke Sentinel Score	42		
3. Stroke mortality rates (acute Cerebral Vascular Disease)	23%		
Patient Experience Measures Reported			
1. % of patients that would recommend hospital to family /friends	80%		
2 Overall how would you rate the care you received **	93%		
3. % patients who felt they were treated with dignity & respect	88%		
4. % patients who had not shared sleeping area with opposite sex	89%		

* *monitored monthly*.

***Patients rating their care as excellent, very good & good*

Figure 11: - National Targets & Regulatory Requirements

National Targets and Regulatory Requirements	2008-2009	2009-2010	Achieved National Target
The trust has met the HCC Core Standards and National Targets			
Clostridium Difficile year on year reduction	0.76%		
MRSA – Maintaining the annual number of MRSA bloodstream infections at less than 2003/04 level (23)	15		
18 week maximum wait from point of referral to treatment (admitted patients)	89.1%		
18 week maximum wait from point of referral to treatment (non- admitted patients)	97.2%		
Maximum waiting time of 4 hours in A& E from arrival to admission, transfer, discharge	98.1%		
Maximum wait of 31 days from diagnosis to treatment of all cancers	96.2%		
Maximum waiting time of 62 days from urgent referral to treatment for all cancers	95.9%		
Maximum waiting time of 2 weeks from urgent GP referral to first outpatient appointment for all urgent suspected cancer referrals	98.7%		

Nb. There were definitional changes to the cancer targets from 1st January 2009.

- 2009/10 Stroke Mortality Rate for England 21.6%

Appendices

Appendix 1 - Glossary & Abbreviations:

Term	Abbreviation	Description
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.
The Association of UK University Hospitals	AUKUH	A national tool used to measure patient dependency/acuity to help determine nurse staffing levels.
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.
Comparative Health Knowledge Systems (Ltd)	CHKS	An independent company which provides clinical data/intelligence to allow NHS, and independent sector organisations, to benchmark their performance against each other.
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.
Healthcare Associated Infections	HCAI	A generic name to cover infections like MRSA and C-diff.
Methicillin-Resistant Staphylococcus Aureus	MRSA	Staphylococcus aureus is a bacterium which is often found on the skin and in the nose of about 3 in 10 healthy people. An infection occurs when the bacterium enters the body through a break in the skin. A strain of this bacterium has become resistant to antibiotic treatment and this is often referred to as MRSA.
Mid Cheshire Hospitals NHS Foundation Trust	MCHFT	The organisation which runs Leighton Hospital, Crewe, and Victoria Infirmary, Northwich.
National Patient Survey		Co-ordinated by the Healthcare Commission, it gathers feedback from patients on different aspects of their experience of care they have recently received, across a variety of services/settings: Inpatients, Outpatients, Emergency care, Maternity care, Mental health services, primary care services and Ambulance services.

Patient Recorded Outcome Measures	PROMs	A programme in which patients complete a questionnaire on their health before and after their operation. The results of the two questionnaires can be compared to see if the operation has improved the health of the patient. Any improvement is measured from the patient's perspective as opposed to the clinicians.
Patient 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 Matters		The trust's programme to look in detail at the clinical pathways and processes to progress quality, reduce waste and improve efficiency.
Re-admission Rate		A measure to compare hospitals which looks at the rate at which patients need to be readmitted to hospital after being discharged (leaving hospital). Readmission measures can use different time periods between leaving and being readmitted to hospital e.g. 14 and 28 days.
Risk Adjusted Mortality Rates		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.
Reporting & Learning System	RLS	National database that allows learning from reported incidents
Safety First		E 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.
Sentinel Audit		National audit that measures the organisational provision and the care delivery.
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.
Ten out of 10		The name of the trust's strategic objective to improve quality by aiming for the trust to be in the top 10 percent of hospitals nationally for the top ten indicators of Quality by 2014.

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:

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

Email: Elizabeth.Kanwar@mcht.nhs.uk

How useful did you find this report?

Very useful ☐

Quite useful ☐

Not very useful ☐

Not useful at all ☐

Did you find the contents?

Too simplistic ☐

About right ☐

Too complicated ☐

Is the presentation of data clearly labelled?

Yes, completely ☐

Yes, to some extent ☐

No☐

If no, what would have helped?

Is there anything in this guide you found useful/ not useful?