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Health and Adult Social Care Scrutiny Committee

Agenda

Date:	**Thursday, 14th April, 2011**
Time:	**10.00 am**
Venue:	**Committee Suite 1,2 & 3, Westfields, Middlewich Road, Sandbach CW11 1HZ**

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

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

1. **Apologies for Absence**

2. **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**

   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.

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

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

To approve the minutes of the meeting held on 10 March 2011 as a correct record.

5. **Northwest Ambulance Service - Response Times**

To receive an update regarding the action taken on response times

6. **Cheshire and Merseyside Review of Vascular Services**

To receive a presentation on the Cheshire and Merseyside review of vascular services and its implications.

7. **Quality Account - Mid Cheshire Hospital NHS Foundation Trust** (Pages 7 - 78)

To give consideration to the Mid Cheshire Hospital NHS Foundation Trust Quality Account.

8. **Quality Account - East Cheshire Hospital Trust**

To give consideration to the East Cheshire Hospital Quality Account - report to follow

9. **Health Inequalities in Cheshire - Centre for Public Scrutiny Pilot Project** (Pages 79 - 86)

To note the pilot project in which Cheshire East and Cheshire West and Chester Council participated to contribute to a Scrutiny Toolkit on Health Inequalities.

10. **Review of Children's Heart Surgery** (Pages 87 - 94)

A national consultation is underway into the future of children's heart surgical services. There are 4 options for surgical centres in the future (outside of London). As each option proposes a centre at Alder Hey Children's Hospital, Liverpool, the Committee is asked whether it wishes to look at the matter any further as this will not result in any changes to services for patients in Cheshire East

11. **Task/Finish Group - Future Healthcare Project Knutsford and Congleton** (Pages 95 - 100)

To give consideration to the draft final report of the Task and Finish Group

Agenda Item 4

CHESHIRE EAST COUNCIL

Minutes of a meeting of the **Health and Adult Social Care Scrutiny Committee**
held on Thursday, 10th March, 2011 at Committee Suite 1,2 & 3, Westfields, Middlewich Road, Sandbach CW11 1HZ

PRESENT

Councillor B Silvester (Chairman)
Councillor C Beard (Vice-Chairman)

Councillors C Andrew, S Bentley, D Flude, S Furlong, S Jones, W Livesley, M Lloyd and C Tomlinson

Apologies

Councillors D Bebbington, A Moran and A Thwaite

94 DECLARATION OF INTERESTS/PARTY WHIP

RESOLVED: That the following declarations of interest be noted:

- Councillor D Flude – personal interest as a member of Dial A Ride;
- Councillor S Jones – personal interest as a member of the Alzheimers' Society.

95 ALSO PRESENT

Councillor R Domleo, Portfolio Holder for Adult Services
Councillor A Knowles, Portfolio Holder for Health and Wellbeing

96 PUBLIC SPEAKING TIME/OPEN SESSION

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

97 MINUTES OF PREVIOUS MEETING

RESOLVED: That the minutes of the meeting of the Committee held on 6 January be approved as a correct record.

98 NORTH WEST AMBULANCE SERVICE

The Committee welcomed Sarah Byrom, Dave Kitchin and Ian Moses from the North West Ambulance Trust (NWAS) who were attending to discuss:

- Response times in Cheshire East;
- The Foundation Trust application;
- Serious and untoward incidents.

In relation to response times, the Committee had received figures showing response times by postcode area from April 2010 – February 2011. The figures showed that response time targets were not being met in many areas. Current targets categorised calls as follows:

- **Category A**: Serious and life-threatening
- **Category B**: Serious but not life-threatening
- **Category C**: Not immediately life-threatening or serious

With the Response times standards as follows:

- 75 percent of Category A calls within 8 minutes
- 95 percent of Category A calls in 19 minutes
- 95 percent of Category B calls in 19 minutes
- 95 percent of category C calls in 60 minutes (locally agreed target)

The Committee expressed concern over these figures and sought explanations as to why the response times were so low and what action NWAS was taking to address the issues.

In response, officers of NWAS explained that the low response times correlated to rural areas and to meet the targets would require far more vehicles and paramedics than current resources would allow. There had been an increase in demand of 8% compared to the previous year but this had not been matched by an 8% increase in resources.

However, there were a number of measures that could be taken to ensure patients were treated as quickly as possible. NWAS officers explained that specific winter pressures had been addressed through the use of additional resources from St Johns Ambulance, Red Cross and Mountain Rescue teams. In relation to general performance and responding to calls, there was increasing use of Community First Responders, investigations into devising Co-Responder schemes (with the Fire Service), advice given over the phone and redirecting callers to existing community resources. The increase in Community First Responder schemes had had a positive impact.

In the future a new national call system would be introduced where callers would ring 111 for non emergency calls; this had been piloted in the North East and had reduced inappropriate emergency calls. It was important that strategies to reduce demand could be introduced as calls classed as Category A when received, were often not found to be life threatening when the ambulance crew arrived.

NWAS officers explained that cross border response agreements were in place and ambulances from out of the area would be used if it was more appropriate and timely than using one from NWAS. A crew would take a patient to the most appropriate hospital for treatment (such as a specialised centre) which could be an out of area location, which would impact on the time taken to get the ambulance back into service. There were also sometimes issues around turnaround times at hospitals. It was also relevant to note that even though an ambulance was stationed in an area it may not remain there as it would be out responding to calls and may not return to the station for a long time.

It was noted that Cheshire East was an area with an increasing elderly population, with healthcare needs, along with increases in chronic illness. There were also areas of deprivation which had their own health and social care needs.

All paramedics were currently undergoing diploma training which would mean they could treat patients in the more appropriate manner using the most up to date techniques.

A directory was being developed regarding services available in the community which would ensure that each patient was handed over to the most suitable service, if they did not require hospital. If an ambulance crew was called out they would always ensure a safe handover for the patient.

In response to a question regarding SatNavs the Committee was advised that such systems were updated as soon as uploads became available but all systems were there to assist local knowledge.

99 **ADULT SERVICES CHARGING POLICY REVIEW**

The Committee considered a report on a review of the Adult Services Charging policy. A formal consultation had taken place between 2 November 2010 and 31 January 2011.

The report outlined how all Councils were under severe financial pressures due to reductions in grant funding from central government along with growing financial pressures resulting from the rising elderly population and increased demand for care.

Cheshire East Council was projecting an over-spend of £9.2m in Adult Services and was seeking ways to address this. One such method was to look at changing what people pay for care services including closing the gap between the charges service users pay for commissioned care services and the real cost of that commissioned care service. Consideration was also given to new charges that could be introduced to offset the administrative costs the Council pays for certain tasks (eg Deferred Charge Agreements and Appointeeships).

The impact of the changes would primarily be in the community provision offered to around 4000 customers. The report outlined that many people would be unaffected by the changes as they were entitled to a free service (66%), some would see a small change due to the percentage of disposable income as a charge rising from the current level of 90% (19%). Those who paid a flat rate fee may see their charges increase – this was currently 8% of customers. People paying full cost or standard charge (7%) would see the greatest increase but would be able to consider purchasing care services from the open market at competitive prices.

The proposals relating to charging for community provision were aimed at removing as much subsidy as possible – the current policy was 90% of disposal income. During the consultation process, respondents felt that increasing this charge to 100% of disposal income was too high an increase, in too short a timescale. Officers explained that if a customer's circumstances changed they could be reassessed. The report summarised the findings following the consultation process which had provoked a wide range of reactions. Many people had sympathised with the Council's financial position whereas others felt that social care users were already in an economically and emotionally vulnerable position and should not be penalised further –suggesting other options such be explored instead such as increases in Council tax or staffing/bureaucracy cuts.

There was also debate over whether the assessment of what is essential and what is disposable was flawed.

The report outlined the range of consultation undertaken including public meetings, facilitated meetings at Day Centres, discussion and engagement with Third Sector groups, website information, letters in invoices to service users and a poster campaign.

During discussion of the item the following points were raised:

- Whether a review following a customer's change in circumstances would be done quickly and robustly?
- How many customers were currently awaiting a review following a change in their circumstances – either financial or care needs?
- Whether any work was taking place to ensure people were claiming all benefits to which they were entitled?
- The importance of giving clear explanations to people about any costs for their care or increases in costs and the importance of sensitively managing difficult messages to vulnerable people;
- What information do people get to help them make a decision as to the most appropriate package of care to meet their own individual needs?

In response, L Scally explained that a number of these points were being addressed in current work including looking at performance information, consideration of whether it would be helpful to place finance officers within Local Implementation Teams, investigations as to how people could be helped to best prepare financially for the future (through bonds and annuities) and she would report to a future meeting covering all the points raised.

RESOLVED: that the outcome of the consultation process on the review of the Adult Services Charging policy be noted and a report be submitted to a future meeting of the Committee on the points raised at the meeting.

100 ADULT SERVICES TRANSPORT

The Committee considered a report on a consultation undertaken regarding Adult Services transport. The original timescale for the consultation had been extended so that the consultation ran from 2 November 2010 to 31 January 2011.

The consultation proposed a phased programme from April 2011 to move away from Strategically Commissioned Adult Transport provision over the next two financial years. The Council was committed to ensuring that no individual would have commissioned transport withdrawn without an appropriate alternative solution being available to them to meet their eligible unmet transport needs. The proposal for a two year phased programme would enable interest from the market to be measured and enable a safe transition for customers. It was recognised that there may be a need to retain a small element of strategically commissioned transport for individuals in exceptional circumstances who could not be supported to travel through alternative transport options.

The report explained that strategically commissioned transport did not meet the requirements of personalisation as it gave limited choice and flexibility.

During the first twelve months of the programme, the focus would be on market development to scope and develop a range of services such as appropriate alternative transport options in the private market, developing volunteer services with the Third Sector, concessionary travel for carers, accreditation of accessible taxis, accessible buses, scoping rural transport issues and examining options.

The consultation also outlined how currently the transport budget was used to deliver transport to 420 adults to and from their day care provision using fleet transport vehicles (43 minibuses) or hired transport. The current cost per one way trip was £9 to the Council but £2 to the service user and it was proposed that this cost to the user be increased to £4 per one way trip from 9 April 2011.

During discussion of the report the following issues were raised:

- The phased approach was welcomed;
- Appropriate alternatives must be available and service users and carers must receive full information on all options;
- What would happen to the Dial A Ride service and was it likely to be able to take on new customers or was it running at full capacity already? In response, the Committee was advised that community transport operators were a very important option for service users and this type of transport would need developing in the future;
- The importance of providing transport options in rural areas.

RESOLVED: That the consultation process and proposals be noted.

101 **RATIONALISATION AND TEMPORARY CLOSURE OF BUILDINGS IN ADULT SERVICES**

The Committee considered a report on the future of the facility at 291 Nantwich Road, Crewe. The matter had been considered at Cabinet on 18 October 2010 when it had been agreed not to close the facility at that stage but to re-examine the future of the building in March 2011.

Since then, officers had held regular meetings with users of the service at 291 Nantwich Road who felt affection for the building and felt secure there. However, it was considered good practice to move mental health day services, wherever possible, away from day centres into more socially inclusive settings such as libraries and community centres. A room had subsequently been identified at the Oakley (Leisure) Centre, West Street, Crewe which would become available daily to mental health service users by early summer. This would provide a dedicated space for them but would also provide the opportunity to branch out and share some facilities with other community groups and the general public. Other groups who currently used 291 Nantwich Road had also been offered relocation to the Oakley Centre or Hilary Centre. Services users were happy with this outcome.

RESOLVED: that the proposals relating to the closure of 291 Nantwich Road, Crewe and alternative arrangements made for service users, be supported.

102 **GOVERNMENT PROPOSALS FOR "LOCAL ACCOUNTS"**

103 **PUBLIC HEALTH WHITE PAPERS: COUNCIL'S RESPONSE TO CONSULTATION**

104 **THE CHESHIRE AND WIRRAL COUNCILS JOINT SCRUTINY COMMITTEE**

The meeting commenced at 9.30 am and concluded at 11.55 am

Councillor B Silvester (Chairman)

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Leighton Hospital
Middlewich Road
Crewe
Cheshire
CW1 4QJ

Tel : 01270 255141
Fax : 01270 587696

Email : julie.smith2@mcht.nhs.uk
PA: chris.ralphs@mcht.nhs.uk
PA: Direct Dial: (01270) 612453

Our Ref: JS/ek/01

5 April 2011

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 second draft Quality Account for 2010/11 and, as last year when you provided comments regarding its content to us, we welcome and value your contribution.
Your comments will be directly inserted into the Quality Account which is to be published in June 2011.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 be pleased to receive your comments by the end of April 2011 if this is at all possible.

With sincere thanks

Best wishes

Julie Smith
Director of Nursing & Quality
Mid Cheshire Hospitals NHS Foundation Trust

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Mid Cheshire Hospitals NHS
NHS Foundation Trust

Quality Account 2010/11

Quality and Safety at Heart
Mid Cheshire Hospitals NHS Foundation Trust
Quality Account 2010/11

"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 2010/11

Part 1

Statement on Quality from the Chief Executive

I was appointed to the position of Chief Executive in October 2010, having been the Deputy Chief Executive and Director of Nursing at the Trust for the previous 5 years, and I am delighted to present our second published Quality Account for the period of April 2010 to March 2011.

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

As an organisation, we strive to deliver the best possible service and quality of care to our patients and carers, whilst consistently looking for areas of further improvement.

During 2010/2011, we have continued to make significant progress against our five year "10 out of Ten" Quality and Safety Improvement Strategy which was launched in 2009. The priorities in the Strategy are focussed around the four domains of quality and are intended to improve outcomes, experience, safety and effectiveness. In particular, we have agreed baseline data for our top ten criteria and embedded these principles in the appraisal process so that all staff are actively involved in processes to reinforce the importance of quality for our patients.

This message is reinforced to our staff through the promotion of our values and behaviours which are made available at training sessions and during appraisals. The values and behaviours that we ask our staff to embrace are:

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

I am particularly proud of the Trust's performance in a number of key quality areas such as having zero MRSA bacteraemias over the past 12 months. This is a commendable achievement for all clinical areas within the Trust. The Trust's mortality rates have previously been higher than the national average. However, over the last 12 months we have seen a rate of improvement that has been faster than the national average and for the past two consecutive months, we have performed better than the peer average. We have continued our implementation of initiatives as part of the Patient Safety First Campaign and the Leading in Patient Safety Programme which includes the introduction of patient safety walkrounds with Trust Board Members and Governors.

As part of our Quality Matters programme we have redesigned the way our operating theatres work to improve productivity and patient experience. This has been a huge undertaking and I am grateful to all the staff who have been part of making this happen, whether through providing leadership and direction or through cooperation and embracing the significant change process.

In January 2011 we launched our coaching framework and currently have thirteen qualified coaches available to support our staff. Coaching is fundamental to the development of our staff especially during times of significant transition and will ensure that, as an organisation, we have invested in our staff to enable them to give their best.

The work we have undertaken over the past year to improve the care offered to adults and children with a learning disability was recognised recently when the Trust won a Northwest Positive Action Award for Excellence in Clinical Care. This is something that we are particularly proud of and the learning from this will be rolled out to improve services for other vulnerable groups of patients such as those with Alzhiemers and other forms of Dementia.

We were also highly commended by the Northwest Stroke Collaborative (Stroke 90:10) for improvements in care we delivered for patients following a stroke. This included undertaking specific treatment and investigations within 24 hours of admission. As a result of this work our overall national performance in relation to stroke care has improved significantly from the lower quartile to the middle quartile. Within some key indicators recorded, we are performing within the upper quartile. We recognise there is still work to do and believe we have the right calibre of dedicated staff to ensure this important service for our patients continues to progress.

I would like to take this opportunity to thank and congratulate all our staff in their achievements over the past year. I would also like to extend my appreciation to our Governor's, Members, Patient Representatives and other Stakeholders who have helped shape our quality programme by taking time out to support and advise us.

I confirm that, to the best of my knowledge, the information presented in this document is accurate. I hope you enjoy reading this Quality Account and find it of value. We are continually striving to improve our care and would therefore welcome any feedback you may have.

Tracy Bullock
Chief Executive
Mid Cheshire Hospitals NHS Foundation Trust
tracy.bullock@mcht.nhs.uk

Statement of Directors' Responsibilities in Respect of the Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year.
Monitor has also issued guidance to NHS Foundation Trust Boards on the form and content of annual Quality 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.
In preparing the Quality Report, Directors are required to take steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the *NHS Foundation Trust Annual Reporting Manual*;
- The content of the Quality Report is consistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2010 to March 2011
  - Papers relating to Quality reported to the Board over the period April 2010 to March 2011
  - Feedback from the commissioners (Central & Eastern Cheshire Primary Care Trust) dated XX/XX/2011
  - Feedback from governors dated XX/XX/2011
  - Feedback from LINks dated XX/XX/2011
  - Feedback from Overview and Scrutiny Committee dated XX/XX?2011
  - The 2010 national patient survey
  - The 2010 national staff survey
  - Care Quality Commission (CQC) quality and risk profiles
- The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions and is subject to appropriate scrutiny and review. The Quality Report has been prepared in accordance with Monitor's annual reporting guidance.

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

By order of the Board
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.....Date.....Chairman

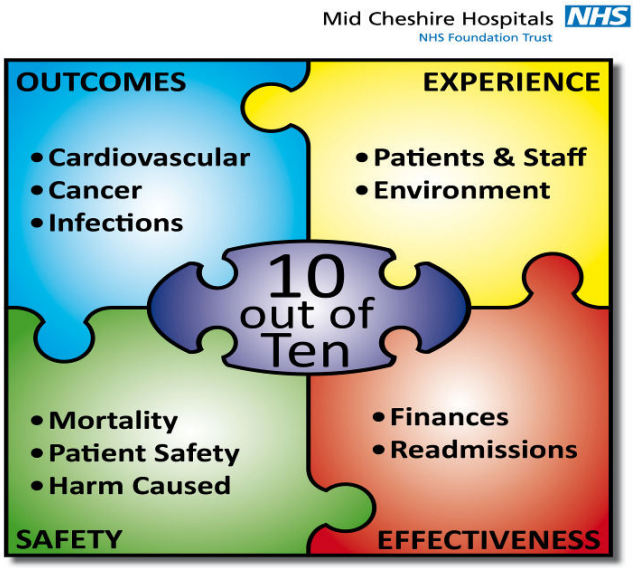
Mr John Moran

.....Date.....Chief Executive

Mrs Tracy Bullock

Part 2
Priorities for improvement in 2011/12 and Statements of Assurance from the Board

The Trust has continued to be involved in many quality and safety improvement initiatives, which will all help achieve the key priorities for 2011/12. The Quality & Safety Improvement Strategy has mapped out the priorities of improvement for 2010/14 and is largely focused around the 10 out of Ten programme. These priorities are based on the four domains of quality and are intended to improve outcomes, experience, safety and effectiveness.



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 two of the 10 out of Ten programme has successfully achieved the following objectives:

- Identify the Trust top ten metrics with baseline data
- Set stretch targets where baseline data was available
- Embed individual objective setting as part of the appraisal process
- Publish the Quality & Safety Improvement Strategy

Year three of the programme intends to progress plans to improve outcomes against the ten criteria identified which were previously agreed following a public and staff consultation.

Safety

Mortality

Aim: To reduce mortality rates by 10 points 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 to identify areas for improvement in the quality of care provided by the Trust. Action plans are developed to address the lessons learnt to ensure changes in practice are made. As the Trust monitors all mortality rates the overall intention is to reduce mortality for patient groups where death is not expected.

Measured: The Trust uses CASPE Healthcare Knowledge Systems (CHKS) to identify the low mortality healthcare resource groups (HRG's). Any HRG with less than 0.05 probability of death is used for calculation purposes. This system provides monthly information so that the Trust can closely monitor mortality rates with the aim of seeing a 10 point reduction by 31 March 2011.

Patient Safety

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

Monitored: The episodes are monitored through the Integrated Care System (ICS) which is a patient management system used by the Trust.

Measured: The number of patient moves during each emergency or unplanned admission will be measured using the Trusts Management Information System. The clinical divisions monitor this information on a monthly basis.

Harm Caused

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

Monitored: The Patient Safety Team review all patient safety incidents in order to identify lessons to learn and implement changes in practice. This is reported in the Integrated Governance monthly assurance report.

Measured: The Trust's incident reporting system is used to determine the number of patients who suffer avoidable harm. In addition to learning from the National Leading Improvement in Patient Safety (LIPS) programme the Trust is considering reviewing healthcare records using the Global Trigger Tool to determine if avoidable harm was caused.

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Effectiveness

Readmissions

Aim: To reduce the number of patients who are readmitted to hospital within 7 days of discharge.

Monitored: Readmissions to hospital within a 7 day period following discharge as an emergency admission are being monitored by the clinical divisions on a monthly basis.

Measured: Readmission rates have previously been monitored on a monthly basis for patients who were readmitted as an emergency. The Trust now monitors readmissions within a 7 day period and 30 day period.

Finance

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

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

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

Experience

Patients & Staff

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

Nursing
2010/11 – 60% of wards to be within required establishment.
2011/12 – 75% of wards to be within required establishment.
2012/13 – 90% of wards to be within required establishment.
2013/14 – 100% of wards to be within required establishment.

Doctors
By 2014 the ratio of doctors to each patient bed will be in line with the Royal College recommendations for each clinical speciality.

Monitored: A Nursing and Midwifery Acuity* Group has been established which is chaired by the Deputy Director of Nursing & Quality This Group meets bi-monthly and reports to the Executive Workforce Committee.

The European Working Time Directive (EWTD) and data from Doctor Foster has been used in the monitoring of medical staff. This is being used as the safety assessment in calculating the ratio of medical staff to inpatient beds.

Measured: The Nursing and Midwifery Acuity Group reviews the results of the Association of UK 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, implemented and evaluated.

*acuity - a description of how unwell a patient is.

Environment

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

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

Measured: The DSSA group reviews incident reports and patient feedback (via surveys, complaints and the Patient Advice and Liaison Service). 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.

Outcomes

Cardiovascular

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

Monitored: The data relating to the mortality in AMI within 30 days is collated by the Trust using CASPE Healthcare Knowledge Systems (CHKS) on a monthly basis

Measured: CHKS currently measures these mortality levels and benchmarks the Trust against its peer organisations.

Cancer

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

Monitored: The baseline data for acute admissions and length of stay has been established.

Measured: The Acute Oncology Unit measures reasons for acute admissions and ensures achievement of preferred place of care for patients diagnosed with cancer.

Infections

Aim: To reduce the rates of healthcare acquired infections:

- Methicillin-Resistant Staphylococcus aureus (MRSA) – zero blood stream bacteraemias
- *Clostridium difficile* – to perform better than the nationally agreed target.

Targets
2010/11 MRSA - 5
2010/11 *Clostridium difficile* - 106
(National targets are agreed annually).

- Urinary tract infection – Following receipt of National guidance it has been agreed that the Trust will monitor the incidence of urinary catheter insertion.

Monitored: MRSA and *Clostridium difficile* are monitored on a monthly basis and reported to the Strategic Infection Control Committee and Central and Eastern Cheshire Primary Care Trust. The Trust is currently developing a methodology for collecting appropriate information in relation to urinary tract infections.

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.

Monitoring & Reporting of 10 out of Ten via the Quality, Effectiveness & Safety Committee

In recognition of the priority given to quality and safety, the Board of Directors 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 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.

QuESt oversees the quality of patient care across the organisation. It provides the strategic direction and vision for the provision of quality and safety improvement across the Trust. It lends support and guidance to all staff to improve quality and safety.

Patient safety incidents and actions taken / planned are also reported to the Board of Directors 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. The report is discussed at the Operational Integrated Governance Committee which has representation from all of the divisions.

The priorities for 2011/12 were arrived at through a number of mechanisms:-

- Those outlined in the quality and safety improvement strategy
- Those mandated or suggested by Monitor and the Department of Health
- Those identified in the Quality Account published in 2010/11.

The views of relevant stakeholders, public and staff were taken into account when deciding the areas for inclusion.

The extent of this consultation is included within the section on the Consultation on Quality.

Statements of Assurance from the Board

The following statements relate to; the review of services, participation in clinical audits and research, commissioning for quality and innovation framework, the Care Quality Commission and data quality. The aim is to offer assurance to the public that the Trust is performing to essential standards as well as providing high quality care to patients.

Review of Services

During 2010/11, the Trust provided and / or sub-contracted 39 NHS services.

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

The income generated by the NHS services reviewed in 2010/11 represents 100% of the total income generated from the provision of NHS services by the Trust for 2010/11.

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

- Service dimensions: such as population demographics, trading account position and whether or not the service is essential
- Service delivery: which looks at aspects relating to meeting performance standards and targets / quality standards
- Service design: which reviews where the service is located, for example: centrally or in the 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

Participation in Clinical Audits

Clinical audit

The Trust is committed to embedding clinical audit throughout the organisation, as a process for improving the quality of healthcare provided. In order to achieve this, during 2010/11, the Trust developed a Clinical Audit Strategy (2010/13) and adopted the Good Governance Institute Self Assessment Maturity Matrix. This was developed in conjunction with the Healthcare Quality Improvement Partnership (HQIP) to address clinical audit at Board level.

The Trust has a comprehensive programme of national and local clinical audit projects that is supported through a central clinical audit department. The Effective Clinical Practice Group reports quarterly to the Operational Integrated Governance Committee, with escalation to Strategic Information Governance Committee as necessary. The majority of national comparative audit projects in which the Trust

participates are part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP) which is funded through HQIP. Local clinical audit projects are supported by the central clinical audit function and form an essential part of the Trust's governance structure.

During 2010/11, 41 national clinical audits and 1 national confidential enquiry covered NHS services that the Trust provides. This equates to 70% of the national clinical audits and 100% national confidential enquiries of the total number in which the Trust was eligible to participate.

The full list of national clinical audits and national confidential enquiries is shown in Table 1

Table 1 also shows the audits and confidential enquiries the Trust participated in and the percentage of cases submitted as required by the terms of reference for each audit or enquiry.

Table 1: National clinical audits and confidential enquiries undertaken 2010/11

AUDIT TITLE	PARTI-CIPATION	DATA SUBMISSION (%) / NON-PARTICIPATION REASON
PERI- & NATIONAL		
Perinatal Mortality (CMACE)	Yes	100
Neonatal Intensive and Special Care (NNAP)	Yes	100
CHILDREN		
Paediatric Pneumonia	No	Participation planned 2011-12
Paediatric Asthma	No	Participation planned 2011-12
Paediatric Fever	Yes	100
Childhood Epilepsy (Epilepsy12)	Yes	Recently registered
Diabetes	Yes	100
ACUTE CARE		
Emergency Use of Oxygen	No	Resource implications
Adult Community Acquired Pneumonia	No	Resource implications
Non Invasive Ventilation	Yes	Recently registered
Pleural Procedures	No	Resource implications
Cardiac Arrest	Yes	Recently registered
Vital Signs in Majors	Yes	100
Adult Critical Care	Yes	100
LONG TERM CONDITIONS		
Diabetes	No	Currently under review
Heavy Menstrual Bleeding	Yes	Recently registered
Chronic Pain	Yes	Recently registered
Ulcerative Colitis & Crohn's Disease	No	Resource implications
COPD	No	Resource implications
Adult Asthma	No	Resource implications
ELECTIVE PROCEDURES		
Hip, Knee & Ankle Replacements (NJR)	Yes	Data available April 2011
Elective Surgery (PROMs)	Yes	93
Peripheral Vascular Surgery (VSGBI)	No	Resource
Carotid Interventions	Yes	Data available April 2011
CARDIOVASCULAR DISEASE		
Familial Hypercholesterolaemia	Yes	100
Acute Myocaridal Infarction & Other ACS (MINAP)	Yes	98.5
Heart Failure	Yes	Data available April 2011
Acute Stroke (SINAP)	Yes	98
Stroke Care (Sentinel Stroke)	Yes	Data available April 2011
RENAL DISEASE		
Renal Colic	Yes	100
CANCER		
Lung Cancer	Yes	Data available April 2011
Bowel Cancer	Yes	Data available April 2011
Head & Neck Cancer	Yes	100
TRAUMA		
Hip Fracture (NHFD)	Yes	* Data available April 2011
Severe Trauma (TARN)	Yes	>65
Falls & Non-Hip Fractures	Yes	65
BLOOD TRANSFUSION		
O Neg Blood Use	Yes	100
Platelet Use	Yes	100
NCEPOD		
Cardiac Arrest Procedures	Yes	100

The reports of 18 national clinical audits were reviewed by or on behalf of the Trust in 2010/11. Table 2 highlights some of the actions taken to improve the quality of healthcare provided as a result of national clinical audits.

Table 2: Action taken following national clinical audit reports

National Diabetes Audit: Paediatric (NDA)	Investment in skills and resources to improve the quality of care and outcomes for diabetic children highlighted in the audit include: • The purchase and use of continuous home subcutaneous glucose monitoring, to help families understand how and why blood glucose varies and to self-manage better. • New multimedia educational tools used in practice at diagnosis and follow-up, to improve understanding and awareness of pathophysiology and management. • Increased numbers of children on basal bolus insulin regime and insulin pumps • More children attending Diabetes UK holidays, introducing a greater acceptance of diagnosis and necessary management.
Adult Critical Care (Case Mix Programme)	Improvements have been made through comparative data on infection rates which has informed tightening of infection control measures including a revised antibiotic policy. Cooling of cardiac arrest patients has been instigated, which has been shown to improve outcome in out of hospital cardiac arrest and enable more patients to survive to go home.
Elective Surgery (PROMS)	First publication of PROMS data in September 2010. The questionnaire completion and return rate are above the national average. The majority of respondents reporting an improvement in their health following surgery. The PROMS reports are reviewed quarterly by the Lead Physicians in each of the specialist areas.
National Sentinel Stroke Audit	The National Sentinel Audit organisational and clinical was published in February 2011.The report demonstrates significant improvement from the 2008 audit results. For further information on stroke care please refer to the outcomes section of this report.
College of Emergency Medicine: Pain in Children	Along with training on patient group directives for triage nurses, the following measures are being implemented to improve the promptness of analgesia administration and re-evaluation of pain scores: • Implementation of dosing tables for analgesia • Alteration to Emergency Department notes format to include pain re-evaluation • A prompt for carers to ask for re-evaluation following analgesia included on triage leaflet and plasma screens

College of Emergency Medicine: Fractured Neck of Femur	To improve standards for x-ray times and pain scoring, re-education/training sessions for triage staff are being implemented together with a process for prioritisation of x-ray for patients with a suspected fractured neck of femur.

The reports of 71 local clinical audits were reviewed by or on behalf of the Trust Board in 2010/11. Table 3 highlights some of the actions taken by the Trust as a result of local clinical audits to improve the quality of healthcare provided. The Trust have taken the following actions to improve the quality of healthcare provided

Table 3: Actions taken following local clinical audits

Re-Audit of the Use of the Liverpool Care of the Dying Pathway (LCP)	The audit identified variation in the uptake of the LCP across Clinical Divisions, although there was evidence of best practice in use even where LCP documentation was not used. A training programme is being introduced and implemented by the MacMillan Nurses to rollout the use of the LCP throughout the Trust, in line with the continued roll out of Prognostic Indicator Guidance.
Audit of Intravenous Urogram (IVU) Radiograph Series in Medical Imaging	The audit recommended CT Scan and X-ray of Kidneys, Ureters and Bladder for patients with renal colic to reduce unnecessary radiography in Intravenous Urogram. Patients are now referred for this alternative non-invasive investigation within the capacity of the CT scanner.
Audit of Length of Hospital Stay after Mastectomy	The audit highlighted a length of stay after mastectomy of between four and nine days (the national average is five days). As drainage of mastectomy wounds is an important determinant of length of stay, ward protocols are being amended to shorten the length of drainage time associated with longer hospital stay post mastectomy and further training has been provided for ward nurses in removing drains and discharging patients following mastectomy.
Re-audit of Coding and Payment by Results in Fractured Neck of Femur	Improvements have been made in coding diagnosis (91%) and procedure (96%). Further changes are being made to the Fracture Neck of Femur Pathway, in conjunction with the Orthopaedic Unit and Clinical Coding for codes to be included in the pathway and coding information to be completed by the relevant surgeon.
Audit of Obstetric Early Warning Score	The re-audit showed improved rates for recording Obstetric Early Warning Scores, particularly in areas where there is a higher staff/patient ratio. Recording of pulse and blood pressure were very good but respiratory rate and oxygen levels require improvement.. Phase Two of the electronic record system for maternity patients (SIGMA) has been adapted to incorporate all indicators for Obstetric Early Warning Scores.

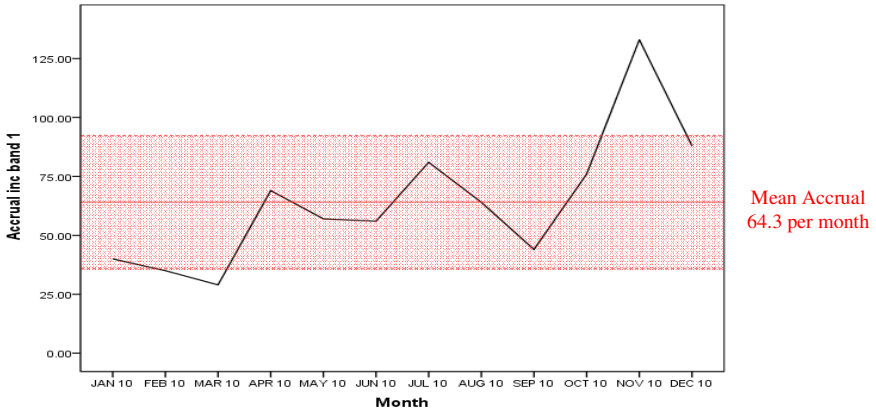
Research

Participation in clinical research

Participation in clinical research demonstrates the Trust's commitment to improving the quality of care offered and making a contribution to wider health improvement.
The number of patients receiving NHS services provided or sub-contracted by the Trust between April and December 2010 that were recruited during that period to participate in the National Institute of Health Research (NIHR) portfolio research which was approved by a research ethics committee was 668.

This is a 108% increase since the previous reporting period (March 2009 to February 2010). However, it should be noted that one study: Fungal Infection Risk Evaluation (F.I.R.E) accounts for nearly all of this increase.

Graph 1 Number of Patients Recruited to NIHR Portfolio Clinical Trials Jan 2010 to Dec 2010



The Trust was involved in conducting 139 active clinical research studies during 2010/11 including, but not limited to, the following areas:

Areas of Clinical Research 2010/11	
Cancer	Medicines for Children
Cardiovascular	Mental Health
Congenital Disorders	Musculoskeletal
Diabetes	Oral and Gastrointestinal
Generic Health Relevance and Cross Cutting Themes	Reproductive Health and Childbirth
Infection	Primary Care
Inflammatory and Immune System	Skin
Injuries and Accidents	Stroke

There were 9 (7.45 Whole Time Equivalent) clinical research staff participating in research approved by a research ethics committee at the Trust during the 2010/11.
The Trust was involved in conducting 2 clinical research studies in cardiovascular medicine during 2010/11. The treatment of high cholesterol levels to reduce the incidence of vascular events has been recruiting and treating patients since 2007. Over the same period, mortality amenable to mortality rates from causes considered preventable in cardiovascular medicine changed from the previous year and Cardiology improved its risk adjusted mortality index by 28.5%.

Two particular examples of how research can benefit patients are described below and demonstrate the link between the Trust's participation in research and drive to continuously improve the quality of services provided.

Reducing Blood Tests for Children
A research study on Early Morning Salivary Cortisol (EMSC) from the Medicine for Children Research Network (MCRN) took place on the Paediatric Unit. When patients have been on one type of asthma medication for some time, one of the side effects can be a reduction in the production of a hormone called cortisol. Cortisol is important in helping the body fight infection and heal itself after injury. The aim of the study was to identify patients who are at risk of low levels of cortisol and to treat prior to it becoming a problem. Normally this is done through blood sampling but the study is trying to determine whether this can be done by a saliva test instead. Clearly the saliva test would be much more acceptable to parents and children.

One patient, who had been treated with inhaled steroids (ICS) for asthma for many years, was enrolled in the study. At the time of the saliva test he was an apparently a well child without any symptoms. The test revealed a very low level of available cortisol. As he and his family were about to leave for a holiday it was imperative that he was seen by his asthma physician and oral corticosteroid therapy commenced. This was carried out and he and his family went on their planned holiday with a supply of the necessary medication. Without such treatment the consequence may have been a severe adrenal crisis that could be life threatening. This specific example is highlighted to show that our local research can benefit our local patients.

Portable Ultrasound Scanner
A clinical audit of inpatient echocardiograms was undertaken in August 2009 by the Emergency Care Division. It was identified from the results that there was delay for patients who were too unwell to be transported to the Ultrasound Department.

The Research Department purchased a portable ultrasound scanner which is being used to treat patients in clinical areas as well as to conduct further research studies. The portable ultrasound scanner is also currently being utilised in a stroke trial. This trial is a study of patients diagnosed with stroke, of which 10% will develop blood clots in the veins in their legs. The clots can be dangerous if they travel up the vein to the heart or lungs. Normal care can involve treatment with aspirin or other blood thinning drugs or stockings to reduce the risk of clots forming but the study is trying to find out if a new treatment, Intermittent Pneumatic Compression (IPC) helps to reduce the risk further. In this treatment, inflatable sleeves are wrapped around the legs and are inflated intermittently. This gently squeezes the legs and increases the blood flow in the veins. As part of this trial the dedicated mobile ultrasound scanner, necessary for the trial work, is also shared with clinical routine service to reduce delays.

Commissioning for Quality & Innovation framework (CQUIN)

A proportion of the Trust's contracted income in 2010/11 was conditional upon achieving quality improvement and innovation goals agreed between the Trust and its Commissioners through the CQUIN payment framework. This equates to a total of £1.9 million over the year. Further details of the 2010/11 agreed goals and those agreed for 2011/12 are available on request from the Deputy Director of Performance & Quality.
These are also available electronically via the Trust Internet site: www.mcht.nhs.uk

Two of the agreed CQUINs related to improving the discharge arrangements for patients leaving hospital and improving the use of emergency theatres.

Development of an Integrated Discharge Team. The Integrated Discharge Team is a combined health and social care team which aims to support wards to commence the discharge planning process at the earliest opportunity after the patient is admitted to hospital. The team focuses on patients with the most complex discharge needs which require by their nature, more integrated working between care agencies. The Integrated Discharge Team provide:-

- Early referral to social services
- Named health and social care links per ward
- A case link allocated to each patient
- A case manager to actively manage particular cases due either to delays or complexity
- Support to the wards to allow them to do achieve the days planned tasks

It is anticipated that these improvements should reduce the unnecessary time patients stay in hospital and better plan for their care after they leave hospital.

New Emergency Process in the Operating Theatre.
The purpose of this revised process is to ensure optimum utilisation of the emergency theatre facility and staffing, performing appropriate patient procedures within an agreed timeframe. Effective information transfer ensures the protection of patients and minimises clinical risk. Continuity of information underpins all aspects of a seamless service providing continuity of care and patient safety.

Benefits of the new process include:-

- A core group of theatre staff led by the Emergency Theatre Co-ordinator to ensure a smooth seamless service and continuity of patient care
- Use of a central area in the main theatre suite with IT access
- Clinical discussion and input from all members of the multi-disciplinary team to agree on the patients prepared and the order of priority for that session, based on National Confidential Enquiry into Patient Outcome and Death (NCEPOD) coding.
- Priority sessions/timeslots identified for all specialities
- Timeslots allocated to each patient booked onto the Emergency List which will allow medical teams plan the work for that day

What others say about the Trust

Care Quality Commission (CQC)

The Trust is required to register with the Care Quality Commission (CQC) and its current registration status is **unconditional**.

The Care Quality Commission has not taken enforcement action against the Trust during the period April 2010 to March 2011

The Trust has participated in special reviews and investigations by the Care Quality Commission relating to the following areas during April 2010 to March 2011.

- CQC Review of support for families with disabled children
- Responsive review of the Trust following a number of breached safety alerts and a complaint relating to Maternity Care. A responsive review is a review of services that is undertaken when the CQC has received a complaint or has concerns in relation to compliance with the essential standards of quality and safety. The review at the Trust looked into:
  - Outcome 4 - Care and welfare of people who use services (in relation to maternity services)
  - Outcome 9 - Management of Medicines
  - Outcome 17 - Complaints

The Trust has taken the following action to address the conclusions or requirements reported by the CQC provide monthly updates as required by providing:

- The Maternity Action Plan includes the development of care pathways for women who were in high risk groups. These are updated monthly with all outstanding actions within the allocated timescales.
- The Pharmacy Staffing action plan was completed in February 2011 with all vacancies being filled.
- All breached safety alerts are closed and future alerts monitored monthly to ensure timescales are not breached

The CQC were satisfied with the Trust's arrangements regarding complaints management and agreed no further actions were required.

Quality and Risk Profiles

The CQC plans to keep a constant check on all information that is available to them for each organisation. This intelligence is collated into a Quality and Risk Profile (QRP) which will be published for each organisation on a monthly basis. The QRP aims to gather all the information known about a provider in one place. This will enable the CQC to assess where risks lie and prompt front line regulatory activity such as inspection.

Following a meeting with the Regional Manager in February 2011 it has been agreed that the Director of Nursing and Quality and the Governance Lead will meet with the CQC to review the information held in the QRP on a quarterly basis. This will give the Trust an opportunity to provide information for any areas of concern and provide assurance to the CQC. Following this meeting a report will be submitted to Strategic Information Governance Committee (SIG) outlining the discussion and any progress made. This report is to provide assurance internally that the Trust is progressing against areas of concern as some of the data is collected from annual audits such as the patient and staff survey.

Data Quality

The overall responsibility for the accuracy and completeness of data quality is held by the Chief Executive of the Trust. The Data Quality has been updated in the past year and is available on the Trust Intranet.

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

- The Trust's Quality Committee meets bi-monthly and reports to the Information Governance Committee
- Completeness, validity and accuracy audits of non-clinical patient data
- Annual clinical coding audit
- Training and annual updates for all staff responsible for entering patient data on to operational systems. All junior coders are trained by the Cheshire and Merseyside Clinical Coding Academy and are required to achieve the Foundation qualification. All qualified coders receive mandatory refresher and specialty workshops annually

The Trust is currently specifically targeting the following areas to improve data quality:

- Completeness and validity of the recording of patient's ethnic groups
- Completeness and validity of patient's NHS number
- Improving the timeliness of the recording of patient events, particularly in Accident & Emergency and for admissions, transfers and discharges.

NHS and General Medical Practice Code Validity:

The Trust submitted records during 2010/11 to the Secondary Uses Service for inclusion in the Hospital Episodes Statistics .

The percentage of records in the published data which included the patient's valid NHS number was:

****% for admitted patient care;

****% for out patient care;

****% for accident and emergency care

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

****% for admitted patient care;

****% for out patient care;

****% for accident and emergency care

Figures available@ April 11th 2011

Information Governance Toolkit Attainment Levels:

The attainment levels assessed provide an overall measure of the quality of data systems, standards and processes within an organisation.

The Trust's Information Governance Assessment Report overall score for Version 8, 2010/11 was 41% and the Trust was graded Unsatisfactory (Red).

The reduction in score when compared with the 2009 – 2010 assessment can be attributed to the changes made to both the requirements of Version 8 of the Information Governance Toolkit and the way in which evidence is now evaluated and submitted to Connecting for Health.

To ensure compliance is achieved in future assessments, the Trust has implemented comprehensive action plans for all unsatisfactory rated requirements which are to be monitored by the relevant Trust committees. The Information Governance Toolkit Action and Annual Plan was passed by the Operational Integrated Governance Committee in March 2011.

Clinical Coding Error Rate

Accurate data quality and clinical coding are imperative to support patient care and to ensure the information is used for improving health care and ensuring more effective management.

The Trust was not subject to the Payment by Results clinical coding audit during 2010/11 by the Audit Commission.

Part 3

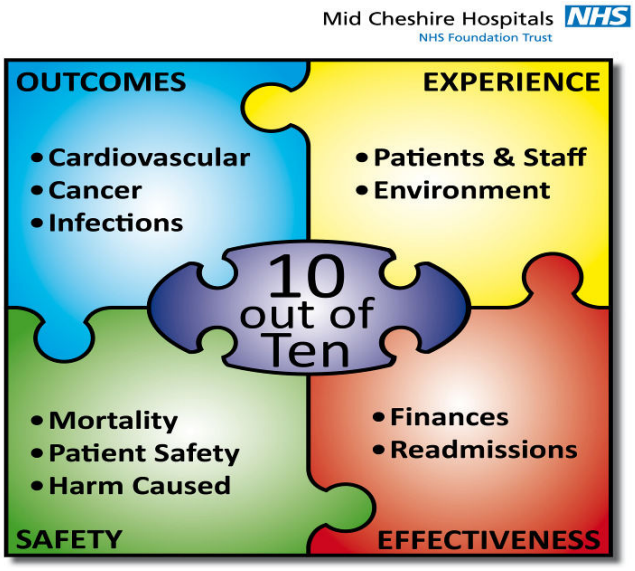
Review of Quality Performance

The 2010/11 Quality Account specifically details the progress against the Trust's 10 out of Ten strategy together with 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 following domains of:

- Safety
- Effectiveness
- Experience
- Outcomes

10 out of Ten Strategy

The Trust aims to be in the top 10% of all secondary providers in England in ten agreed indicators of quality by 2014.
The key indicators for this strategy are shown below:



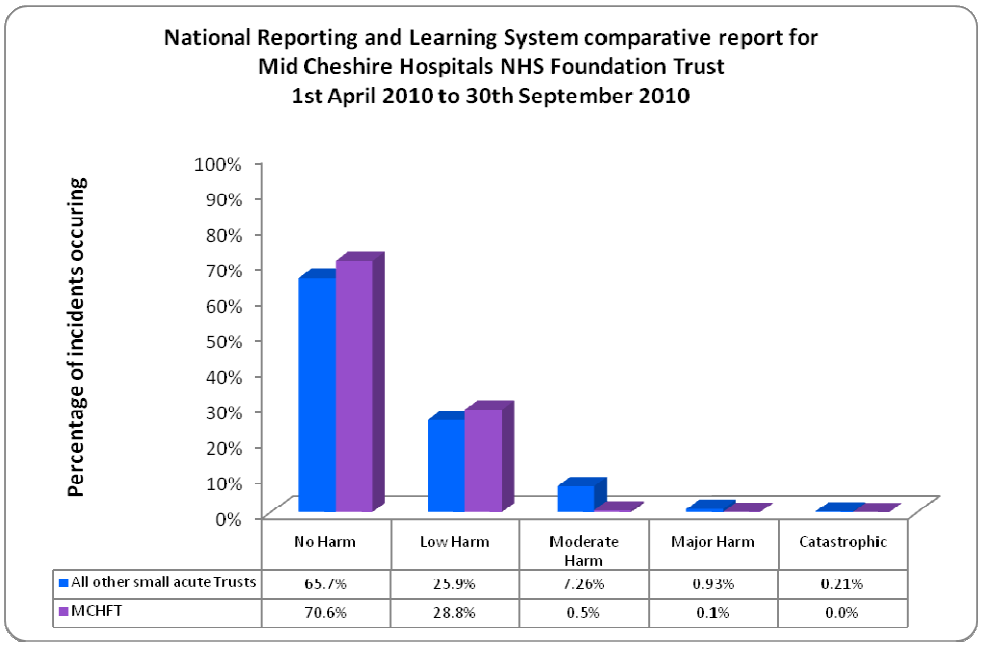
Review of Performance in relation to:

Safety

Reduce Avoidable Harm

All patient safety incidents are downloaded to the National Patient Safety Agency (NPSA) via the National Reporting and Learning System (NRLS) on a weekly basis. Every 6 months the NRLS produce a comparative report comparing the Trust with 30 similar sized, acute Trusts. This data is published on the NPSA's website. Graph 2 is the latest comparative reporting rate summary which provides an overview of incidents reported by the Trust to the NRLS between April 2010 and September 2010. This data is the most recent available, published in March 2011. In comparison to previous data received April to September 2009 the Trust has made significant improvements in reducing harm in the severe harm categories i.e. moderate and above.

Graph 2: Incident Reporting April 2010 to September 2010



Period	No Harm	Low Harm	Moderate Harm	Major Harm	Catastrophic
1 April 2010 to 30 September 2010	70.6%	25.9%	0.5%	0.%	0.0%
1 October 2009 to 31 March 2010	86.8%	10.7%	2.4%	0.0%	0.1%
1 April 2009 to 30 September 2009	80%	11%	8.5%	0.5%	0.0%

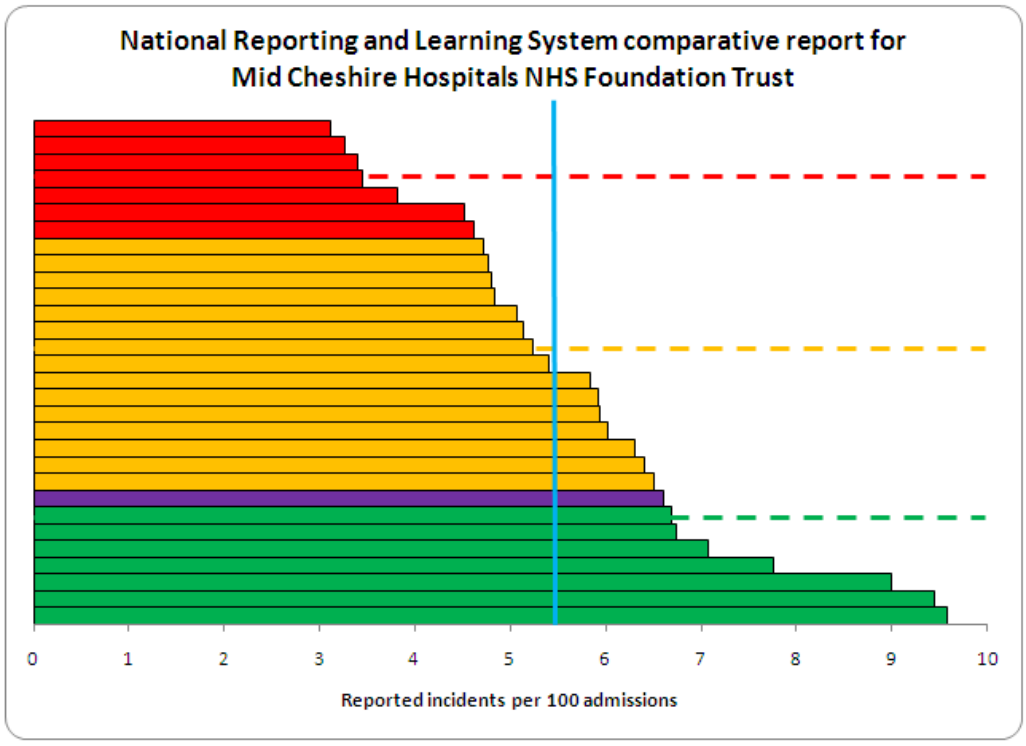
Please refer to Chapter 3 of the Annual Report to see changes in practice following the serious incidents.

Maintain the Trust's Safety Culture

The data on harm caused to patients is collated from the Trust's incident reporting system. Staff report patient safety incidents in order for the Trust to learn from experience and share lessons learned to prevent a reoccurrence. To encourage staff to report patient safety incidents the Trust has adopted a 'Just Safety Culture'. A just safety culture is both attitudinal as well as structural, relating to both individuals and organisations. Adverse personal attitudes and corporate style can enable or facilitate the unsafe acts and conditions that are the precursors for accidents and incidents. It requires not only actively identifying safety issues but responding with appropriate action

In October 2009 to March 2010 the Trust was in the middle 50% of the reporting Trusts. The Trust is now in the upper 50% illustrating an improvement in incident reporting. Graph 3 demonstrates this.

Graph 3: Reported Incidents per 100 Admissions



75th Percentile 50th Percentile 25th Percentile

	Lowest 25% Reporters
	Middle 50% Reporters
	Highest 25% Reporters
	MCHFT
	Median = 5.5 incidents reported per 100 admissions

Period	No of incidents reported per 100 admissions
1 April 2010 to 30 September 2010	6.61
1 October 2009 to 31 March 2010	6.00

Implement National Patient Safety Initiatives

The Trust has taken part in two national patient safety initiatives with the aim to ensure that the Trust has the capacity and capability to eliminate avoidable harm to patients.

Patient Safety First Campaign
The campaign has now finished but work continues with the implementation of interventions. The Patient Safety First website continues to deliver up to date information and interventions to reduce harm caused to patients.

Deterioration
- The Early Warning Score (EWS) and Escalation Guidelines have been revised and re-implemented, this has resulting in an increase to the calls made to the Critical Care Outreach Team. This team provides expert advice and support in the management of the critically ill patient
- The Situation, Background, Assessment and Recommendation (SBAR) Communication Tool is in the progress of being rolled out across the Trust. This enables staff to provide clear and concise information to escalate the deteriorating patient
- The Trust has an established Mortality Reduction Group which undertakes case reviews. Lessons are learned and shared and actions taken to reduce mortality

Leadership
- *Becoming a Manager* and *Managers Moving On* development programmes continue to be well subscribed to. These courses ensure staff have the skills to become effective and efficient managers
- Patient Safety Walkrounds have been reviewed and are recommenced in January 2011. The Patient Safety Walkround ensures that the Trust leaders are seen to be committed in both word and visibility to the primary aim of 'first, do no harm'.

Pre Operative Care
- The World Health Organisation (WHO) checklist is now being used in every theatre. This ensures that theatre staff are prepared for the expected procedure and also prepared for any un-expected events.

NHS Institute of Innovation and Improvement
The Leading in Patient Safety Programme has now been completed with twice yearly updates from the Institute of Innovation and Improvement. Following the programme the Medical Director was invited by the NHS Institute of Innovation and Improvement to attend the Patient Safety Executive Development programme in the United States of America.
- Plan Do Study Act (PDSA) cycles of change are now frequently used when implementing a change in process or introducing new documentation. This ensures that small steps of change can be implemented before moving to the next area of implementation
- Statistical Process Charts (SPC) are now used to plot improvements. These charts identify visible areas of improvement and are supported by narrative.

Safety

Priority 1:Mortality

To reduce mortality rates by 10 points in patient groups where death is not expected.

In order to understand whether people are getting healthier or our Trust is getting safer, it is necessary to calculate death rate. The death rate is the number of people who die in relation to the size of the population in which these people live. In general terms, the rationale for calculating death rates in hospital is that they can be used to measure hospital quality in some way.

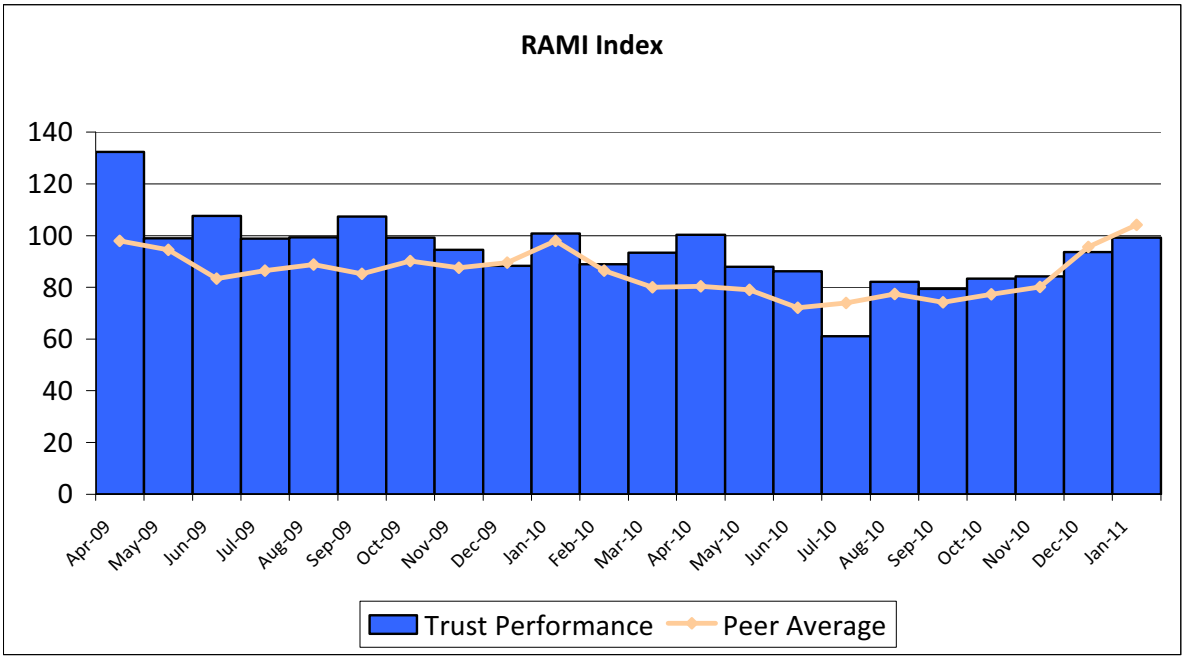
Mortality was chosen as a local priority by:

- The Council of Governors
- Consultation for the Trust 10 out of Ten objectives, in particular focusing on patient groups where death is not expected.

To date there have been no unexpected patient deaths from these groups.

Graph 4 demonstrates the Trust Risk Adjusted Mortality Index (RAMI) which shows a recent reduction in the Trusts RAMI.

Graph 4: RAMI Index April 2009 – January 2011



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

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

CHKS is the provider of comparative information and quality improvement services for healthcare professionals. The Trust uses the CHKS signpost to calculate the Risk Adjusted Mortality Index (RAMI).
The mortality index is the ratio of the observed number of deaths to the expected number of deaths in a particular population.

In 2010/2011 the Trust participated in the North West Reducing Mortality Collaborative facilitated by the North West Advancing Quality Alliance (AQuA). The collaborative is a 12 month improvement programme for a group of nine regional Trusts who have found they have a higher than expected Hospital Standardised Mortality Ratio (HSMR), to come together to reduce their HSMR score by 10 points. A frontline team in the Trust have been delivering improvement work in clinical areas to improve safety and reduce mortality

Safety

Priority 2: Patient Safety

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

Patients are rightly moved as part of their care pathway or if the patient's diagnosis has changed and care is being transferred to another specialist. However, too many ward moves (for example, to allow for the admission of acutely ill patients) can impact adversely on patient care and result in a longer length of stay.

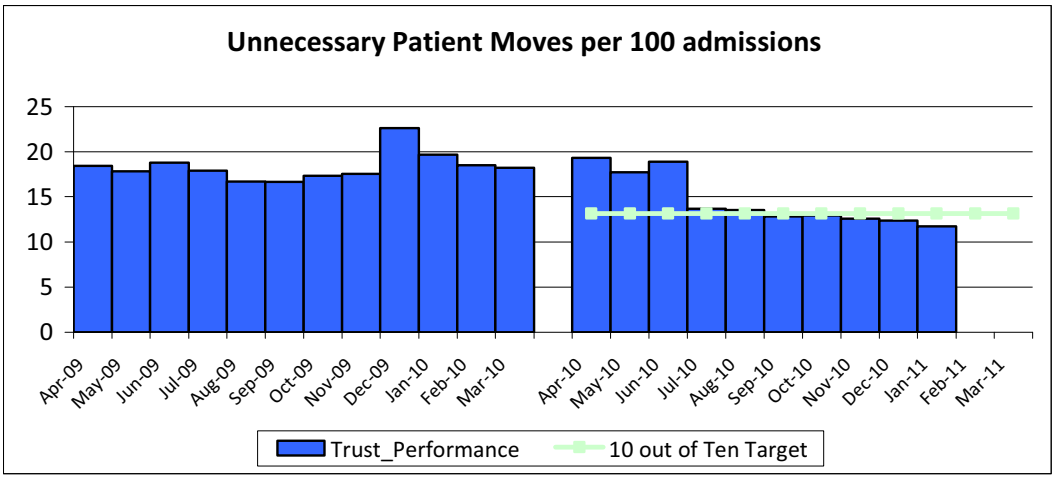
In the Quality and Safety Improvement Strategy the Trust stated it would establish a method of monitoring this quality indicator, gather the historical data and set a target for improvement, this is presented in graph 5.
It can be seen that progress has been made and the Trust has started to reduce the numbers of unnecessary patient moves over the past year

Having established a methodology and target for improvement the Trust intends to reduce the number of unnecessary patient ward moves by: -

- Ensuring patients are admitted first time to the right specialty / ward to care for their needs
- Monitoring / investigating the care of patients who have moved frequently in their hospital stay
- Ensuring the bed configuration matches the demand for each specialty
- Reducing the time a patient spends in hospital and therefore the opportunity for them to be moved unnecessarily.

Graph 5 below shows the average number of unnecessary patient ward moves per patient since April 2009. The green line shows the target the Trust would like to achieve to improve this quality indicator by 2014.

Graph 5: Unnecessary Patient Moves per 100 admissions



Safety

Priority 3: Harm Caused

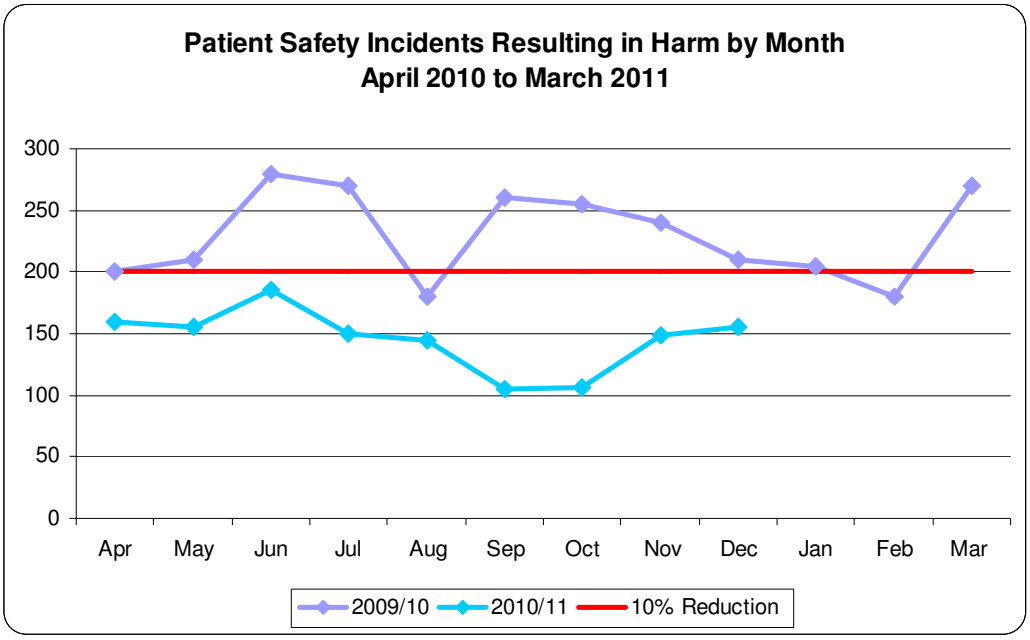
To monitor and reduce the number of patients who experience avoidable harm by 10% annually

The National Patient Safety Agency (NPSA) 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. You can't learn and improve if you don't know what the problems are' (NPSA 2011).

The Trust's incident reporting system is used to determine the number of patients who experience avoidable harm. All patient safety incidents are reported in the Integrated Governance Quarterly Assurance Report which includes lessons to learn and changes in practice. The report discussed at the Operational Integrated Governance Committee which has representation from all of the divisions. All serious patient safety incidents and actions taken/planned are reported to the Board of Directors by the Medical Director on a monthly basis. Serious patient safety incidents are also monitored and reported to the QuESt Committee. Central and Eastern Cheshire Primary Care Trust receive a monthly serious incident report which provides assurance on the management of these incidents.
Graph 6 demonstrates the reduction in harm caused to patients over the past 12 months.

Graph 6:Patient Safety Incidents Resulting in Harm



Review of Performance in relation to:
Effectiveness

Quality Matters

The Quality Matters programme is now into it's third year using "Lean" methodology to review Trust wide services and is aimed at:

- Improving patient care
- Improving staff morale
- Improving efficiency

After a successful one year pilot phase the programme progressed with a two year plan where the emergency care pathway, theatre efficiency and gynaecology outpatients were reviewed.

Improving theatre productivity, patient experience and staff morale
A revised theatre template was introduced in October 2010 with progression to four hour theatre sessions and forward planning for elective sessions to be undertaken 50 weeks of the year. The workforce redesign permitted creativity when job planning within clinical teams, creating speciality teams which allowed improved co-ordination and planning of emergency theatres. This revised template also allowed for a dedicated children's theatre.

Improve the patient flow through the Emergency Department, Emergency Admissions Unit & Core Wards
The Quality Matters team undertook a review of the emergency patient pathway from front door to discharge: The implementation of information systems enabled the staff to examine the overview of a patient's journey, which led to the patient flow policy with additional targets for discharges.

Overall, the average length of patient stay was reduced by one day. Patients with complex discharge needs are managed by the Integrated Discharge Team which includes partnership working with external agencies. As part of the improved patient flow it is hoped that patient experience will improve along with a reduction in unnecessary hospital stays.

Improving Outpatient efficiency, process flow and patient experience
The review of Gynaecology Outpatients in 2010 was aimed at improving the flow of patients through the Trust and improving patient experience for service users. As part of this review the referral process was redesigned as was the service provision for hysteroscopy. Nurse led clinics were introduced, along with a review of all follow up appointments.

Coaching for Quality & Organisational Development

The Trust officially launched its Coaching Framework on 19 January 2011. Thirteen coaches have now received certification from the European Mentoring and Coaching Council (EMCC) following the training programme with i- Coach Academy.

The Trust has developed a two-pronged approach to developing a coaching culture in the organisation.

Part One

Access to an accredited internal coach has been made available to all senior managers and to staff currently on development programmes. The initial offer is of four sessions with a coach with the option of a further two sessions if required. There may also be occasions where use of an external coach will be more appropriate. Staff usually access a coach after discussions with their line manager.

Part Two

The second element in developing a coaching culture across the organisation will be the delivery of an in-house one-and-a-half day "Essential Coaching Skills for Managers" programme, to which all line managers will be invited to attend. This programme is intended to develop a line manager's capacity to use coaching skills in their conversations with their teams and across all levels of the organisation in their everyday interaction with each other and service users. It is not intended to develop them as internal coaches.

Effectiveness

Priority 4: Readmissions

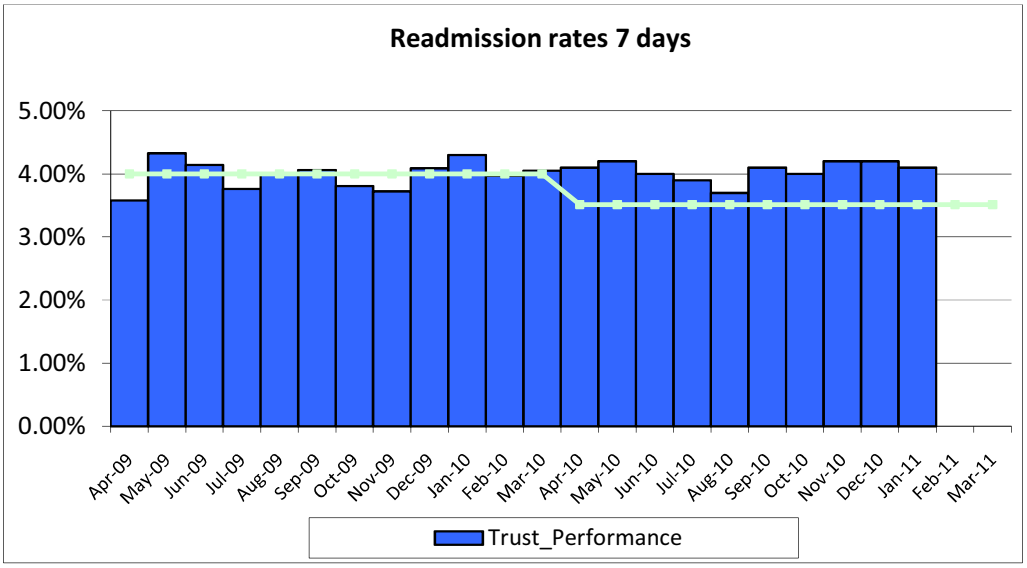
To reduce the number of patients who are readmitted to hospital within 7 days of discharge

The Trust's Quality and Safety Improvement Strategy stated that the Trust would reduce the number of patients who are readmitted to hospital within 7 days to match the peer average. Overall, the Trust is planning to reduce readmissions by 22.5% by 2014.

The Trust has been working to do this by: -

- Monitoring readmissions on a monthly basis and developing plans to remedy underlying problems, within clinical divisions
- Improving the advice / instructions given to patients on discharge
- Improving the planning of patient discharge by ensuring patients have a planned date of discharge, soon after admission, so all professionals, patients and relatives know the estimated date for leaving hospital
- Developing an Integrated Discharge Team with social care colleagues to ensure closer working and collaboration in planning patient discharges
- Introducing an electronic system for creating and delivering clinical discharge information for the patients, to improve the timeliness of information reaching the General Practitioner
- Working with primary care colleagues to ensure urgent referrals to hospital are managed in an appropriate setting, for example, urgent care centre to help avoid potentially unnecessary admissions to hospital

Graph 7:Percentage of patients readmitted within 7 days since April 2009



Effectiveness

Priority 5: Finance

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

Under the NHS Operating Framework there is a requirement to reduce management costs allowing more income to be reinvested into NHS care for patients.

The Trust's priorities for improvements have echoed in reducing the percentage of the Trust's income spent on management costs.

Over the financial year, the Trust has been monitoring it's management costs on a quarterly basis against it's own pre-defined targets. The cumulative quarterly performance for 2010/11 is as follows:

Table 4 Cumulative Quarterly Performance 2010/2011

	Plan % of Income	Actual % of Income
Quarter 1	6.08	5.79
Quarter 2	5.86	5.62
Quarter 3	5.82	5.61
Quarter 4	6.04	

The Trust's future target is presented below.

Table 5 Planned Percentage of Income 2011/2013

Year	Plan % of Income
2011/12	5.89
2012/13	5.74

In addition the Trust on an annual basis has monitored it's annual management costs in accordance with the Department of Health's definition. The Trust's performance was *x%* of total income for 2010/11, compared with 5.2% of total income in 2009/10.

For 2010/2011 Quarter 1 to Quarter 3 the actual management costs as a percentage of income are lower than the 2010/11 Quarter 1 to Quarter 3 targets and also the future years targets. This is due to the Trusts income (up to December 2010) being significantly higher than initially forecast. Also there has been a recruitment freeze on a number of non clinical posts which has contributed to the lower percentage. However, the Trust anticipates that in 2011/12 and 2012/13 it will not generate these levels of surplus income above plan.

Review of Performance in relation to:

Patient Experience

Improve on the results of National Patient Surveys

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 the Trust about their experiences.

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

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National Inpatient Survey

The National Inpatient Survey is the main source for reporting the perception of our patients and is used in comparative performance tables and quality indicators. Unfortunately the most recent survey (2010) shows a general fall in patient satisfaction levels and, when compared to other Trusts,' responses were lower.

The seventh survey of adult inpatient involved 162 acute and specialist NHS Trusts. The Trust received questionnaires from 480 patients, a response rate of 52%. Patients were eligible for the survey if they were aged 16 years and older, had at least one overnight stay and were not admitted to maternity or psychiatric units.

Table 6: National Inpatient Survey 2010/11

Questions	2009	2010	↑↓→	Northwest
Were you involved as much as you wanted to be in decisions about your care and treatment?	67	64	↓	69
Did you find someone on the hospital staff to talk to about your worries and fears?	62	56	↓	60
Were you given enough privacy when discussion your condition and treatment?	77	77	→	79
Did a member of hospital staff tell you about medication side effects to watch for when you went home?	37	35	↓	41
Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	40	41	↑	72

Based on a report by IPSOS Mori, key drivers are identified to focus on to improve overall patient satisfaction. The Trust monitors progress against key aspects of patient experience relating to care and services.

Table 7: Comparisons of results from National Inpatient Surveys

National Inpatient Survey – Mean Rating Scores	2009	2010	Change →↑↓
Cleanliness of hospital room or ward	96	94	↓
Cleanliness of toilets and bathrooms	88	87	↓
Getting answers to questions from doctors	82	81	↓
Involvement in decisions about care and treatment	88	84	↓
Amount of privacy when discussing treatment	89	90	↑
Amount of privacy when being examined or treated	98	98	→
Overall were you treated with respect and dignity	96	95	↓
Overall rating of care (Excellent, Very good and good)	93	89	↓

Actions following the National Inpatient Survey
The Trust aims to improve the following areas:

- Reducing unnecessary noise at night
- Provision of information for patients
- Reduce delays on discharge
- Provide more information about medications

National Maternity Survey

Over 25,000 women who had given birth in January and February 2010 responded to the survey nationally. All women aged 16 or over who received care from a Trust, and who had either given birth in hospital, or at home were eligible to take part. The Trust had a 60% response rate with 244 women responding.

Participants were asked about all aspects of maternity care, including the first clinician appointment and the quality of care provided in the community in the weeks following discharge from hospital.

The results of the survey have been used to identify areas of improvement

Table 8: National Maternity Survey 2010/11

National Maternity Survey Mean Rating Scores	MCHT 2007	MCHT 2010	↑↓→	National 2010
At the start of pregnancy choice of where women could have their baby	90	84	↓	83
Choice of where antenatal checkups would take place	18	59	↑	25
Women having an episiotomy having stitches within 20 minutes	67	70	↑	60
Overall rating of care during labour and birth rated as excellent, very good and good	89	96	↑	93
Women given a copy of the Red pregnancy book	81	67	↓	78
Treated with kindness and understanding after the birth of their baby	86	89	↑	93
Women breast feeding in first few days	61	48	↓	59

Women were also asked what was particularly good about their care with free text and comments included:

"The midwives and doctors that helped deliver my baby were brilliant. I felt completely safe and in control at all times. I cannot praise them enough, I was well looked after. The care I received in hospital was outstanding."

National Cancer Services Survey

The survey included all adult patients with a primary diagnosis of cancer who had been admitted to an NHS Trust as an inpatient or as a day case and had been discharged between 1 January 2010 and 31 March 2010. 362 eligible patients from the Trust were sent a survey with 219 completed surveys returned.

The responses were from patients with a range of tumour groups seen here with the largest number of respondents being patients with breast, colorectal, urological and prostate cancer.

Areas of Concern

The survey identified 3 questions where the Trust scored in the lowest 20% of trusts.

- Ward Nurses – 'always / nearly enough nurses on duty'. The average % for the Trust was 56% with the national threshold for the lowest 20% being 57%
- Hospital Care and Treatment – 'always given enough privacy when discussing condition and treatment'. The average % for the Trust was 79% with the national threshold for the lowest 20% being 80%
- Hospital Care and Treatment – always given enough privacy when being examined or treated. The average % for the Trust was 89% with the national threshold for the lowest 20% being 91%.

"Cancer care at the Macmillan Unit at Leighton Hospital is excellent. Doctors, nurses, all staff are professional, efficient, kind, caring and helpful in every way to make chemotherapy treatments as comfortable as possible"

Patient Recommendation

In 2010, nearly 4,000 patients were asked in local patient surveys if they would recommend the Trust to family and friends based on their experience as a patient: 91% of patients declared that they would recommend the Trust to others compared to 86% in 2009.

Improvements Achieved: Local Patient Surveys:

Supporting patient needs
A pager system was introduced to help patients with a hearing impairment to be made aware of their appointment in clinic when waiting in the out patient department.

Support group established
A survey identified 94% of respondents expressed an interest in attending an Inflammatory Bowel Disease Support Group. A focus group has been held to establish what patients would like from a group and meeting dates have been set with the first topics on diet and a consultant led question and answer session.

Support for patients and visitors
Signage has been improved from Out Patients to the Breast Screening Unit.

Waiting times
Reception staff in the Treatment Centre advise patients regards waiting times on arrival and posters have been introduced to ask patients to report to reception if they have been waiting longer than 20 minutes.

National Staff Survey
The national staff survey was undertaken from September – December 2010 and 57% of the 844 staff returned a completed survey. The results from Quality health were available to the Trust in early March 2011. The Care Quality Commission (CQC) benchmark results were made available shortly after.

The results are currently being analysed by each Clinical Division, and action plans will be produced and monitored to address specific areas of staff feedback.

The results and progress against patient surveys are available on the Trusts website.

Privacy & Dignity

The Trust continues to make patients' privacy and dignity a priority, understanding that being treated courteously and with compassion are what all patients expect and deserve. The Trust has particularly made progress during 2010/11 in the care it provides for patients with dementia and learning disabilities.

Dementia Care

Improving care for patients with dementia in the acute setting is a key focus of the Trust. The priority for 2009/10 was to improve training and education for staff, and enormous strides have been made in this area.

An active Dementia Care Link Nurse Group is now well established. The *"Double D's"* – Dedicated to Dementia, now have representation across all wards and departments and have received specialist training from an Advanced Practitioner in Dementia.

There has been excellent attendance and evaluation of the Mental Health Awareness training provided by Cheshire East Council, and the Trust are working collaboratively with Cheshire Hospices' Education to improve the end of life care offered to patients with dementia.

The Trust has recently commissioned the Campaigns Officer / Dementia Care Trainer from The Alzheimer Society to provide specific training for health care assistants. This training will give advice on how to care for people with dementia from a very practical point of view. It is the health care assistants that provide much of the basic nursing care to many patients, so these training days help the provision of excellent care by providing an increased understanding as to what it is like to have dementia.

The Trust was recently invited to a supper event at the Royal College of Nursing in London to support of their Dementia project which is focusing on improving the experience of care for people with dementia and their carers in general hospitals.
The supper provided an important opportunity to bring people together in developing a shared approach and a lively discussion took place highlighting a number of key points:

- Making dementia a priority for ***everyone*** delivering care in these settings
- Sharing and disseminating innovative practice
- Delivering outcomes from the project that will enable staff to deliver good quality care; including considering staffing levels
- Linking dementia in with other quality improvement initiatives

The Trust will be working with the Royal College of Nursing (RCN) to help deliver this important agenda.

Learning Disabilities

The work undertaken by the Trust over the past year to improve the care offered to adults and children with a learning disability was recognised recently when the Trust won a Northwest Positive Action Award for Excellence in Clinical Care.

The development of Learning Disability Guidelines (available on the hospital intranet), a hospital passport aimed at gathering key information to help staff understand patients with learning disabilities better and the development of picture pathways to make certain investigations less daunting for patients are all examples of the work that has been recently undertaken. The Trust continues to work collaboratively with Cheshire and Wirral Partnership NHS Foundation Trust and Learning Disability Awareness training is being provided to all appropriate staff.

Improve the handling of complaints

Following implementation of the Local Authority Social Services and National Health Service Complaints (England) Regulations in April 2009, the Trust has continued to work towards ensuring that its complaints handling is more individualised and responsive to complainants' needs. Complainants are contacted within three working days, in line with the Regulations, and are offered the choice of a meeting or a written response. As a consequence, the number of meetings held with complainants this year has increased from x to x.

The Trust has clear procedures in place for complaints handling which comply with Outcome 17 of the Essential Standards of Quality and Safety by the Care Quality Commission.

The Trust complies with the National Patient Safety Agency (NPSA) guidance on Being Open and, where deficiencies in care have been identified, an apology and explanation is always offered.

Where action plans have been developed, these are shared with the complainant and updates are provided at a later stage for assurance that the Trust has learnt from the complaint. This improvement came about as a direct result of the Trust's annual complaints survey where it was identified that only 39% of complaints felt confident that action would be taken to improve the areas about which they had raised concerns. Action plans are reviewed and monitored on completion.

A Complaints Review Panel meets bi-monthly and consists of a Non-Executive Director (Chair), the Director of Nursing and Quality, the Medical Director, the Deputy Director of Nursing and Quality, a Governor representative, the Complaints and Legal Services Manager and a patient representative. The Panel is responsible for providing information and assurances to the Board of Directors through the Patient Experience Committee that the Trust is safely managing all issues relating to the management of complaints. The Panel reviews complaints data to identify trends and monitors the implementation of action plans resulting from complaints. The Panel also reviews outcomes of independent reviews by the Ombudsman.

A system has been introduced to ensure that complaints are linked in more closely to risk governance if serious untoward incidents are identified. Serious concerns raised in complaints are discussed at the Trust's monthly Risk Governance meeting. Since July 2010 a member of Integrated Governance now attends the Patient Experience Team's monthly operational meeting to enable issues and trends to be identified as soon as possible.

The following table 9 shows the Number of Complaints, Referrals to the Ombudsman and Response Times over the past 4 years

Table 9: Number of Complaints, Referrals to the Ombudsman and Response Times over the last 4 years

	2007/08	2008/09	2009/10	2010/11
Number of Complaints received	261	268	245	
Number of Independent Reviews undertaken	1	1	3	
Number of Requests for Review to Ombudsman	0	0	9	
Number accepted for Review by Ombudsman	0	0	0	
Response Times within 25 Days (or agreed timescale with complainant)	84%	98%	96%	

Examples of changes made as a result of complaints

- The Trust holds an annual Complaints Best Practice event where experience of handling complaints is shared across divisions to promote best practice. This year a complainant was invited to attend to share the experience of making a complaint
- All patients with dementia now have a capacity assessment and a dietician referral on admission
- Photographs of the matrons, service managers, ward managers and lead nurse are now available on the medical wards so that patients and relatives know who to contact if they have any concerns
- Off duty rotas have been changed to ensure that there is a co-ordinator on duty on the late shift which is when the majority of visitors arrive and want information about their relatives
- A web cam service has been introduced on the Neonatal Intensive Care Unit so that all mothers who are separated from their babies are able to see them at any time

To assess if patients making a complaint feel they have been treated fairly and not discriminated against, an annual survey of complainants is undertaken.

The results are as follows:

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

Experience

Priority 6: Patients & Staff

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

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Nurses

The Trust has introduced the AUKUH (Association of UK University Hospitals) adult acuity / dependency tool to help determine the optimum nurse staffing levels on the wards. The AUKUH tool has been developed to help NHS hospitals measure (patient dependency and / or acuity) and provide evidence based decision making about nurse staffing levels and workforce requirements. Acuity and dependency measurements traditionally take place twice yearly in January and July.

In 2009, assisted by the acuity / dependency results, it was agreed to provide an additional budget for 26 healthcare assistants and three qualified nurses.

In 2010/11, the results were collected in July, October and January. Due to ward reconfigurations within the Trust, it was agreed that the Emergency Care Division would undertake their audits in July and October whilst the Surgery and Cancer Division would undertake audits in October and January.

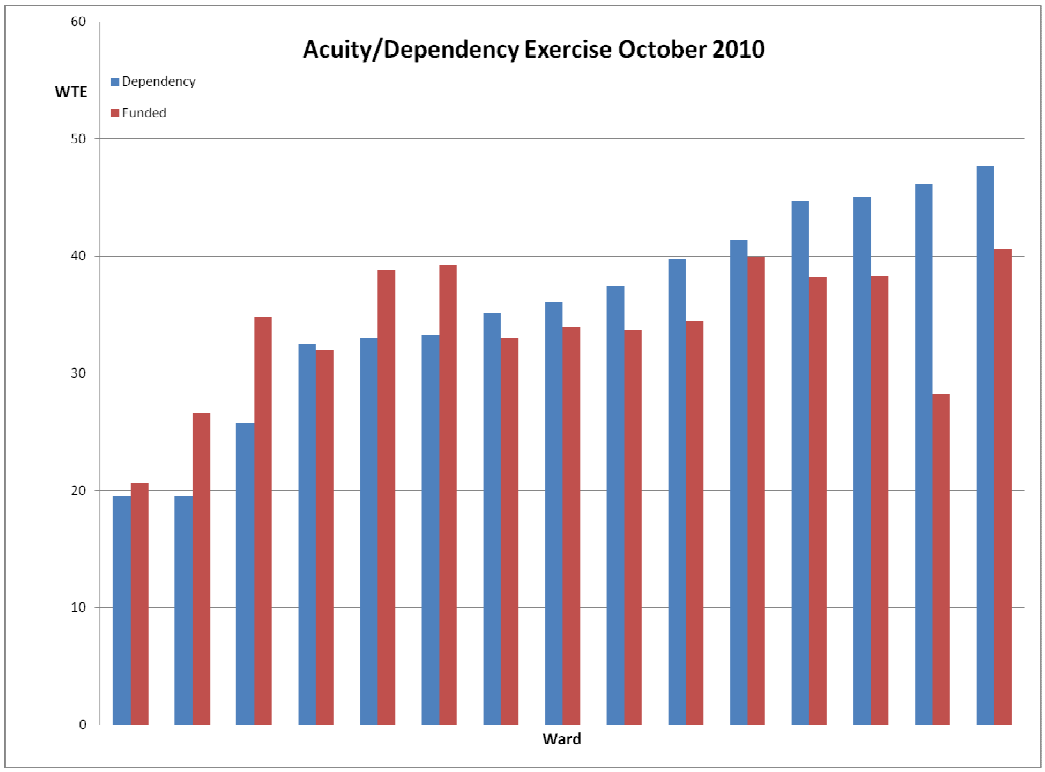
The aim for 2010/11 was that 60% of wards would be within range of their required establishment. In October 2010, 9 of the 15 wards reviewed were within range which means that this target has been achieved.

Work is currently ongoing within the Trust to review and trial alternative workforce tools for paediatrics, maternity, intermediate care and the assessment units.

Graph 8 below, represents the results from the acuity /dependency in October which shows that twelve wards are within range of their funded establishments.

The graph demonstrates an increase in patient acuity/ dependency against the funded staffing establishment for that ward.

Graph 8: Demonstrates the Acuity / Dependency results from October 2010



Doctors

The Trust's Quality and Safety Improvement Strategy stated that the Trust would ensure the correct ratio of doctors to each inpatient bed to ensure the provision of safe, effective and compassionate care to all its patients. The Trust has reviewed the available benchmarking tools to measure the skill mix of medical staff and has utilised Dr Foster Research to assist calculating a baseline. Dr Foster Research is a hospital marketing and measurement tool, used to provide comparative information on health and social care. Dr Foster Research has examined the ratio of doctors to 100 beds at each NHS Trust or Board in England. This data is to be utilsed by the Trust to calculate the appropriate numbers and skill mix of medical staff required for the 10 out of Ten. This Dr Foster ratio has been shown to have a strong link to mortality figures, in hospitals with high doctors per bed tend to have better than expected mortality ratios, and vice versa. Trust performance against locally defined peers shows the Trust to be twelfth out of fifteen for numbers of doctors per 100 inpatient beds. The actual ratio of doctors per beds has to take into account the social and demographic profile of the community it serves. As such further investigation into the case mix is currently underway.

Experience

Priority 7 Environment

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

All wards within the Trust operate a “no-mixing” policy. There have been considerable changes to the environment and ways of working to ensure the Trust complies with the need to eliminate mixed sex accommodation.

The Trust has received positive comments with regards it’s coloured doors, signage and patient information leaflets.

The following improvements have been identified to help promote single sex accommodation:

- Mobile telemetry units
- Collaborative working with the patient placement team
- A process mapping exercise within the surgical assessment unit

The Trust will be publishing a declaration of compliance of single sex accommodation in April 2011 following the approval of the Board of Directors.

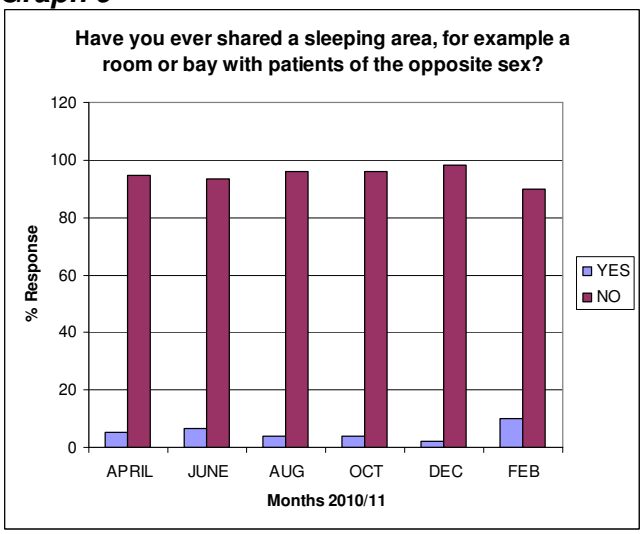
Delivering same sex accommodation was highlighted at the National Dignity Day in March 2011 which was well evaluated by Trust staff.

Delivering same sex accommodation was highlighted at the National Dignity Day in March 2011 which was well evaluated by staff.

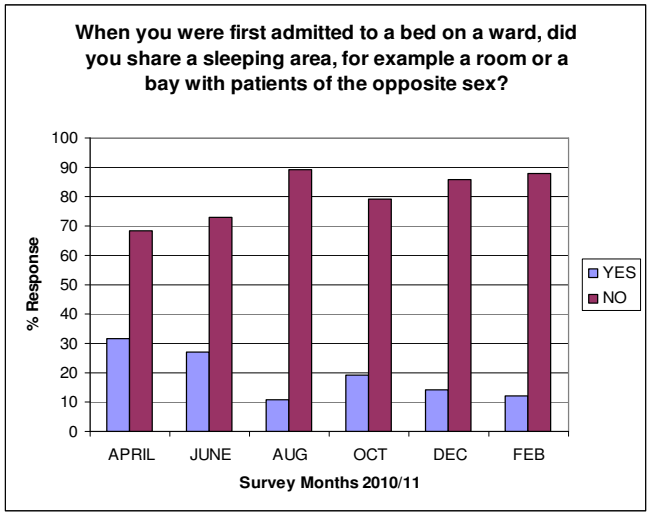
Every month a survey of 100 patients takes place which highlights patient experience in relation to same sex accommodation. As well as answering the specific questions it gives patients an excellent opportunity to discuss any issues or comments they may in respect of privacy and dignity at the Trust.

The results for these are shown in graphs 9, 10 & 11.

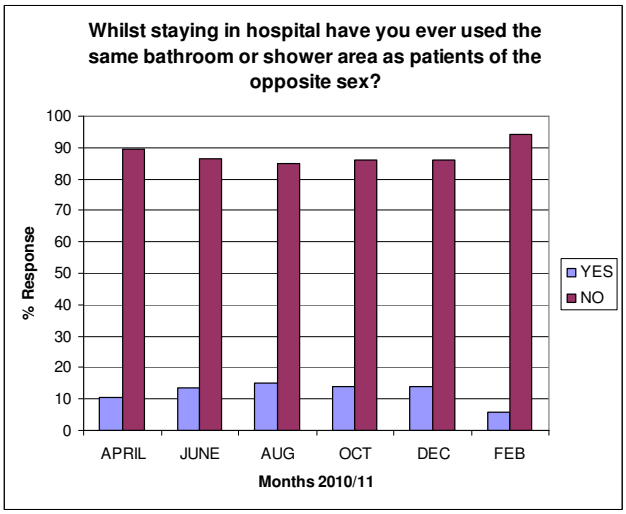
Graph 9



Graph 10



Graph 11



Review of Performance in relation to:

Outcomes

Advancing Quality (AQ)

Advancing Quality is a regional programme which was commenced in 2007, going live in 2008. The aim of the project is for Trusts to collect and report on a set of clinical measures for four patient groups.

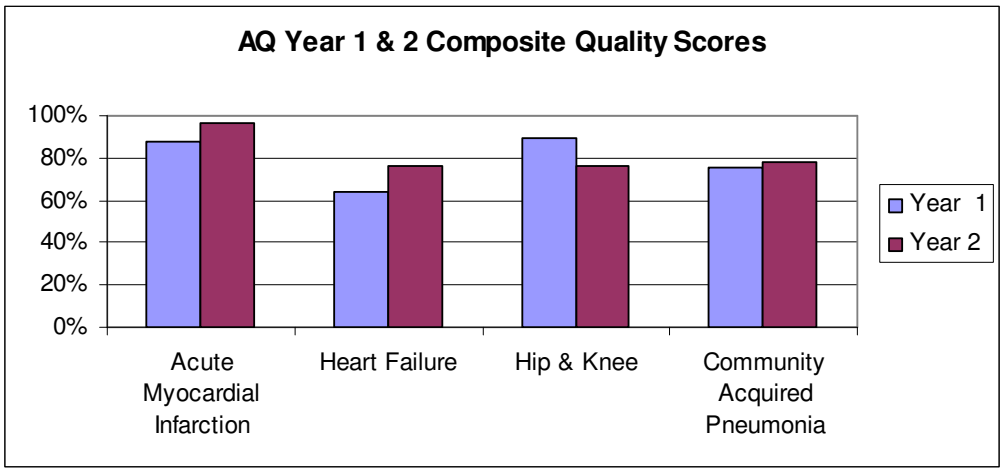
- Acute Myocardial Infarction (AMI)
- Heart failure
- Hip and Knee Replacement Surgery
- Community Acquired Pneumonia

With continuous service improvement, the Trust aims to optimise patient care, improve clinical outcomes and reduce inpatient length of stay. The data is collected retrospectively and based on the final discharge diagnosis.

The Advancing Quality project entered its third year in April 2010, and for Year 3 has joined the CQUIN (Commissioning for Quality and Innovation) programme.

Year one saw the Trust in the top 50% of North West Trusts for Heart Failure and Community Acquired Pneumonia. In Year 2, the Trust improved in all but one of the focus groups, but only managed to achieve the Top 50% in Heart Failure. These results are shown in graph 12

Graph 12: Composite Quality Scores for Advancing Quality Year 1 and 2



The composite scores measures the overall summary of care received. As can be seen, the Hip and Knee replacement surgery group failed to improve in year 2 and this was predominantly due to local practice within orthopaedics not meeting the north west guidance. Practice has now been altered and the results for hip and knee replacement surgery are improving.

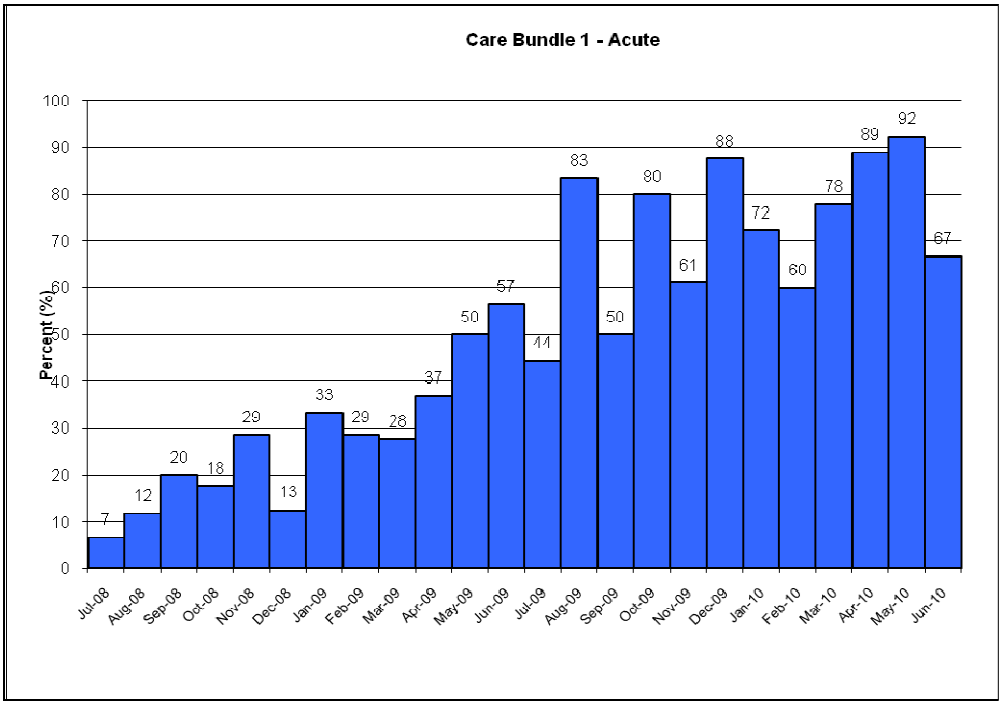
Stroke

The Northwest Stroke Collaborative (Stroke 90:10) commenced in January 2009,with the aim of improving the care and management of patients who have suffered a stroke. The project was separated into 2 bundles of care, one focusing on acute care and the other on rehabilitation. A care bundle is a collection of interventions that may be applied to a particular condition. The bundle aims to tie practice together into a cohesive unit that must be adhered to for each and every patient.

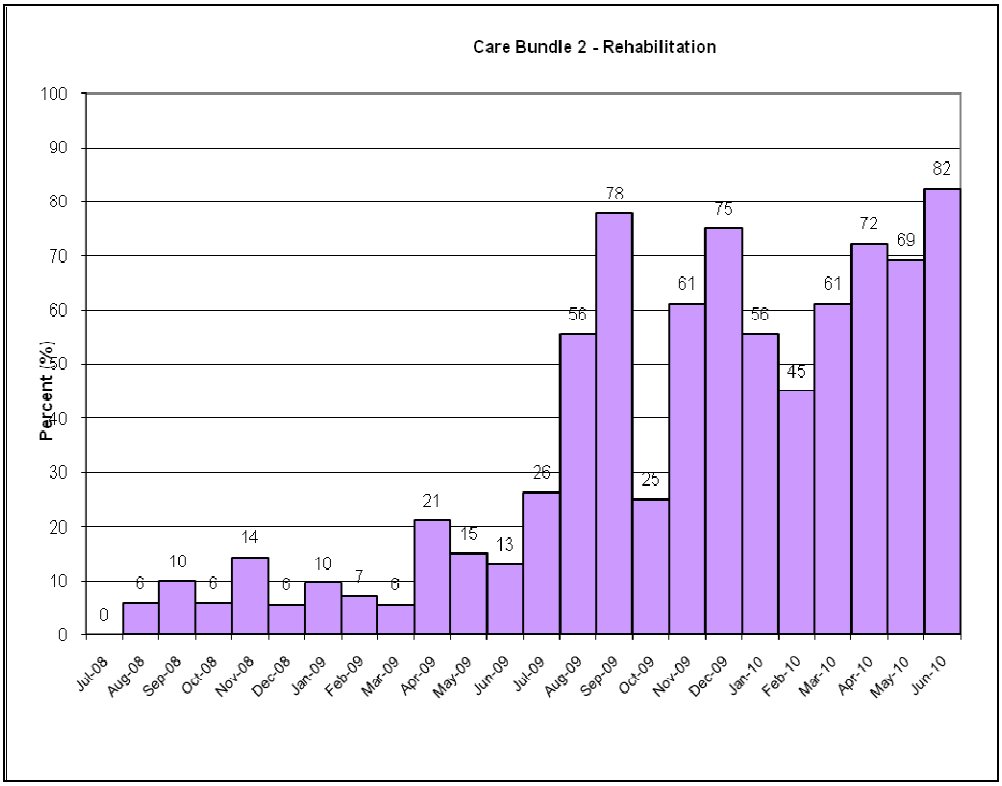
Stroke 90:10 held its summit meeting in November 2010, and the final data submission having taken place in July 2010. The final results from July 2010 for each care bundle are shown in graphs 13 &14

Final Results

Graph 13: Care Bundle 1 Compliance July 2008 to July 2010



Graph 14: Bundle 2 Compliance July 2008 to July 2010



National Sentinel Audit for Stroke.

The National Sentinel Stroke Audit is a bi-annual audit that is carried out by the Royal College of Physicians to measure the organisation of stroke care facilities at the Trust and the clinical care the patient who has had a stroke receives. This data is collected for an agreed number set of patients admitted from 1 April to 30 June 2010.

The organisational score for 2010 was 61.62 moving up to the middle half from the lower quartile in 2008, showing great improvement in the Trusts processes and facilities to care for these patients.

The clinical audit results also show great improvements in the care of the stroke patient at the Trust. The nine key indicators of care showed the Trust to be performing in the upper quartile, above the national average. The overall Trust total domain scores moved from the lower quartile in 2008 into the middle half in 2010

The Trust has implemented many service improvements as part of this project and was rewarded with a “Highly Commended Award” for improvement to Stroke Care by the Faculty of Stroke 90:10.

Outcomes

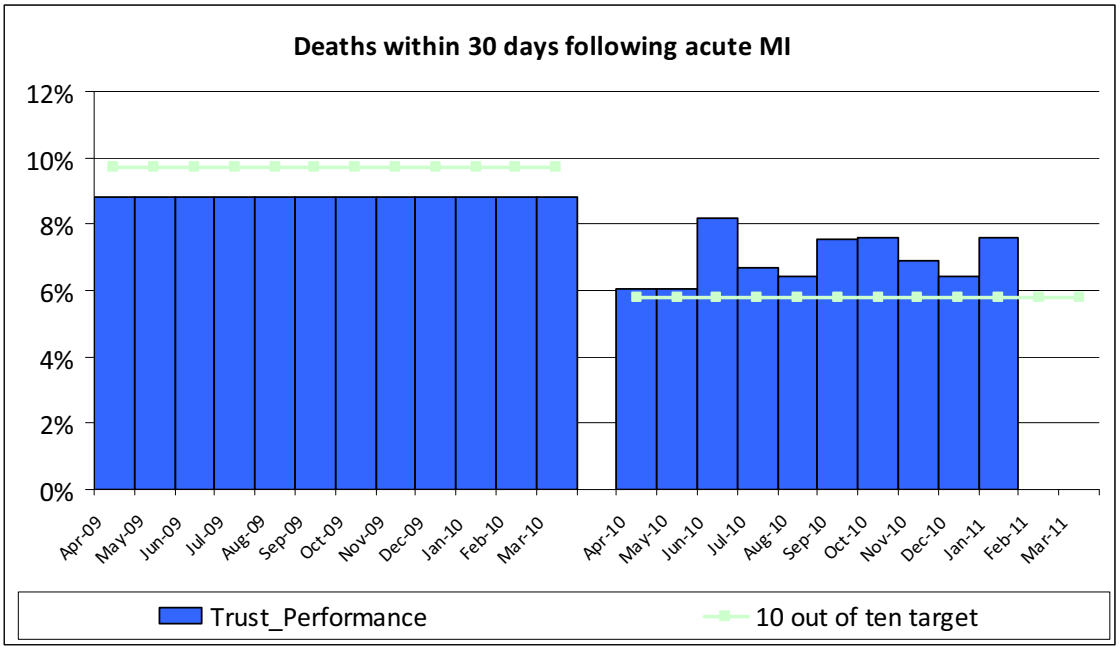
Priority 8 Cardiovascular

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

The aim for patients who have suffered an AMI is to return to a full and healthy life style as soon as possible. Following initial medical intervention patients are strongly encouraged to enter a cardiac rehabilitation programme which can help with lifestyle change, including diet and exercise. Instances of death following an AMI can be reduced following these interventions and processes. Benchmarking this information against comparable peer information allows the Trust to direct its resources accordingly.

The Trust uses data from CHKS to monitor the mortality with 30 days following AMI.

Graph 15: Death within 30days following AMI



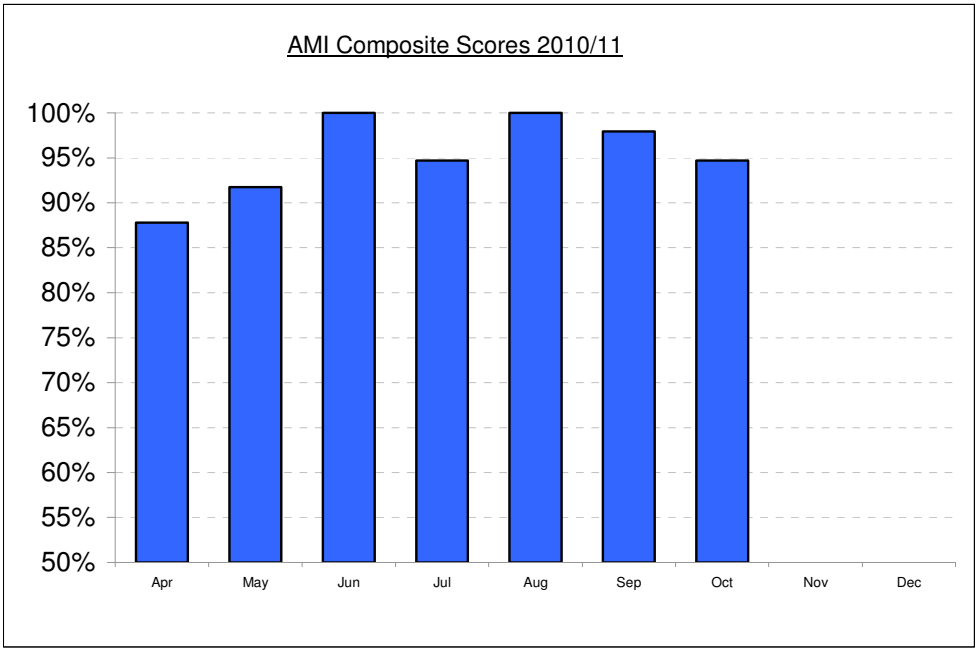
The Trust must also be aware of the outcomes of those patients who return to a normal healthy lifestyle as this is a true measure of success or failure of the AMI programme.

AMI is one of four conditions monitored by the Advancing Quality Programme. It was chosen due to its high prevalence in the North West of England. The aim of the programme is to record and report on a set of clinically agreed measures to improve outcomes for patients. The identification of the AMI population is based on discharge diagnosis hence the lapse in available results.

Advancing Quality AMI Metrics

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

Graph 16: shows the Trust's results for delivery of the appropriate care to the AMI patient group on 2010/11



The Trust has participated in Advancing Quality since 2008 and is continuously striving to improve the care patients receive whilst in hospital. Identification of patient who have been diagnosed with AMI is taken from the discharge diagnosis, hence there is a delay in the monthly reported scores

Following discharge from the Trust all AMI patients are entered into the Cardiac Rehabilitation Programme. This rehabilitation consists of a team of specialists who support the patient during their inpatient stay (phase 1) and throughout their journey back into the community. Cardiac Rehabilitation aims to reduce patient mortality and morbidity, to provide support for both patient and carer and enhance quality of life.

Outcomes

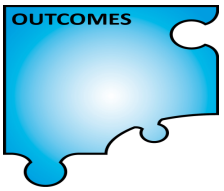
Cancer – To improve survival rates for patients diagnosed with cancer.

At present there is no available measurement tool to monitor or measure the survival rates for patients diagnosed with cancer. There are many data collection systems for patients diagnosed with cancer, but they are primarily measured on a national level. The Trust is part of the Central & Eastern Cheshire Primary Care Trust (CECPCT) all available data is presented as part of the return for the CECPCT and cannot be broken down to individual Trusts.

The data is further complicated as, following diagnosis, treatment for individual patients is often at other hospitals depending on the type of cancer. The stage at which the cancer is diagnosed contributes to the complexity of this outcome measure.

The Trust has met with the Greater Manchester & Cheshire Cancer Network and Merseyside & Cheshire Cancer Network with the aim of being able to collate data to enable measurement of this metric. Unfortunately the collation of data is not straight forward and due to the unavailability of local data the indicator has had to be altered.

The amended metric chosen will continue to encompass the patient diagnosed with cancer but will focus on reducing readmissions and length of stay in hospital following any complications of diagnosis / treatment.



Outcomes

Priority 9 Cancer

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

In Year 2 of the 10 out of Ten strategy the original indicator for the cancer outcomes was changed due to the lack of available data. The baseline data for the revised indicator was established with stretch targets agreed until 2014. Overall the Trust is aiming to reduce admissions by 0.5-2.0 days per admission. The Acute Oncology Team has commenced the monitoring of acute admissions and length of stay in hospital following early diagnosis and /or treatment of cancer. along with the reasons for admission.

It is hoped that the Greater Manchester and Cheshire Cardiac Network will have purchased and installed the Recurring Admission Patient Alert (R.A.P.A) system throughout the Network in early 2011. This will allow the Acute Oncology Team to identify patients, intervene and manage patients at the 'front door', ensuring optimum healthcare treatment and advice are available.

Table 10:

Actual No. of Cancer Patients admitted as an Emergency and Length of Stay 2008-09 by Acute Trust

Acute Trust	Actual 2008 - 2009		Actual 2008-09
	Patients per week	Patients per Day	Average Length of Stay (days)
Pennine Acute Hospitals NHS Trust	141	20	7.2
Wrightington, Wigan and Leigh NHS Foundation Trust	67	10	5.4
Christie Hospital NHS Foundation Trust	65	9	6.4
Central Manchester University Hospitals NHS Foundation Trust	64	9	8.2
Salford Royal NHS Foundation Trust	62	9	6.8
Mid Cheshire Hospitals NHS Foundation Trust	58	8	5.9
University Hospital Of South Manchester NHS Foundation Trust	57	8	6.9
Stockport NHS Foundation Trust	51	7	10.7
Tameside Hospital NHS Foundation Trust	43	6	6.2
Bolton Hospitals NHS Trust	39	6	8.6
East Cheshire NHS Trust	36	5	6.8
Trafford Healthcare NHS Trust	21	3	7.2
Grand Total	**703**	**100**	**7.1**

NB These figures are based on patients admitted as an emergency who already had a cancer diagnosis or who were subsequently diagnosed with cancer during their admission. It is assumed that some (not all) of these patients would be seen by/benefit from the acute oncology service.

Data courtesy of Greater Manchester & Cheshire Cancer Network.

An audit of 30 sets of patient case notes was undertaken in November 2010 to measure the Trusts current position in respect of length of stay. It was found to be 5.2 days, which demonstrates improvement on the 5.9 days reported in 2008/09. It is recognised that this is a small sample of case notes that were reviewed by the Trust, but work will continue in this area over the coming year.

Outcomes

Priority 10 Infections

To reduce the rates of Healthcare Associated Infections (HCAI)

Goal

To comply with national guidelines and annual targets for Methicillin Resistant Staphylococcus Aureus (MRSA) and *Clostridium difficile* infection rates. To establish a baseline for monitoring urinary tract infections (UTIs) and implement surveillance processes in 2010 and set a year on year improvement target.

Planned Target Outcomes

Demonstrate an annual reduction in HCAI rates
2010/11 *Clostridium difficile* < 106
2010/11 MRSA bacteraemia < 5
Establish baseline for UTI surveillance 2010
MRSA screening for emergency admissions by December 2010

Progress Made by March 2011

1) ***Clostridium difficile.*** Rates of *Clostridium difficile* infection (CDI) have fluctuated over the year and this has predominantly been linked to episodes of Norovirus (winter vomiting) within the Trust and seasonal activity. Rates of CDI were significantly lower from May to October 2010, with the highest number per month seen in November & December 2010; during which outbreaks and admission activity peaked. Whilst the Trust has not seen the reduction it would have like to, it has met its annual trajectory of less than 106 cases for the year. The final CDI rate for the twelve month periods stands at ***. The target for next year (2011/12) is 73 cases in a twelve month period, which will provide a significant challenge. To achieve this objective, CDI will remain a key area of focus with target actions, along with a whole health economy approach to improvement.

2) **MRSA bacteraemia**. The Trust has not reported any cases of MRSA bacteraemia over the past 12 months and this is a commendable achievement. The Trust currently represents the best in class within England for small acute hospitals in relation to MRSA bacteraemia rates. A number of measures have been implemented as part of overall infection prevention strategies and this includes focussing on Aseptic Non Touch technique (ANTT),a standardised process for attempting to clear (or reduce the amount of) MRSA from patients carrying it (to reduce the risk of systemic infection) and revising cleaning methods within the Trust. The target for 2011/12 is 2 MRSA bacteramias and work will continue to ensure that avoidable infections are prevented within the organisation.

3) **Urinary Tract Infections (UTIs).** Due to nationally changing requirements for the monitoring of UTIs, this goal has not been fully achieved. National guidance has reviewed the UTI surveillance criterion and recommends that the incidence of catheter insertion provides a more meaningful metric. The Trust has reviewed catheter insertion incidence three times over the last 18 months in the form of

prevalence surveys and the following insertion rates (percentage of patients with a catheter) have been 12%, 11% and 14%. Establishing an improvement target is difficult, due to the lack of national data available for benchmarking. However, a recently published national document indicated that two Trusts who had implemented change management strategies had initial catheter insertion rates of 21% and 24 % respectively. A Trust in the Northwest (of similar in size to this Trust) reported a catheter insertion rate of 32%, reducing to 16% after proactive measures. This indicates that the Trust's insertion rate appears to be well below the national average. Further data will be collated next year in relation to catheter insertion, as this metric is also included in the Northwest's patient safety initiative; Patient Safety Express Host.

4) **MRSA Screening**. In December 2010, the Trust implemented MRSA screening for all emergency admissions, as required by the Department of Health. Compliance with screening requirements and positivity rates are detailed below;

Table 11: Compliance with MRSA Screening

Month	Numbers of patients screened			Numbers of patients MRSA positive (from screened patients)		
	Surgery and Cancer	Emergency Care	Overall	Surgery and Cancer	Emergency Care	Overall
January 2011	447	553	1000	2	10	12
February 2011	390	632	1022	5	11	16
March 2011	329	398	727	4	6	10

MRSA screening will continue as a proactive measure, as early detection allows timely suppression therapy (attempt to clear MRSA carriage) and this reduces the risk of the patient developing a bloodstream infection.

External Assurance and Performance Indicators

The external assurance and performance indicators have been fixed by Monitor. The Trust will report on the following performance indicators:

- MRSA – this is reported in priority 10, as it is part of the 10 out of Ten Programme
- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers

Also included is the Trust's Governors' locally selected indicator which has been chosen as Mortality for 2010/11.

Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers

There has been considerable work within the Trust over the last 12 months to improve the timeliness of the 62 day pathway in all tumour groups:

- Reorganisation of the cancer tracking team to enhance efficiency and allocate responsibility effectively.
- Appointment of a Cancer Data Manager to manage, monitor and report on current and predicted target performance.
- Weekly meetings with Divisional Manager to highlight and enable action on pathway delays.
- Meetings with clinical and service leads to analyse suspected cancer pathways and identify required improvements.

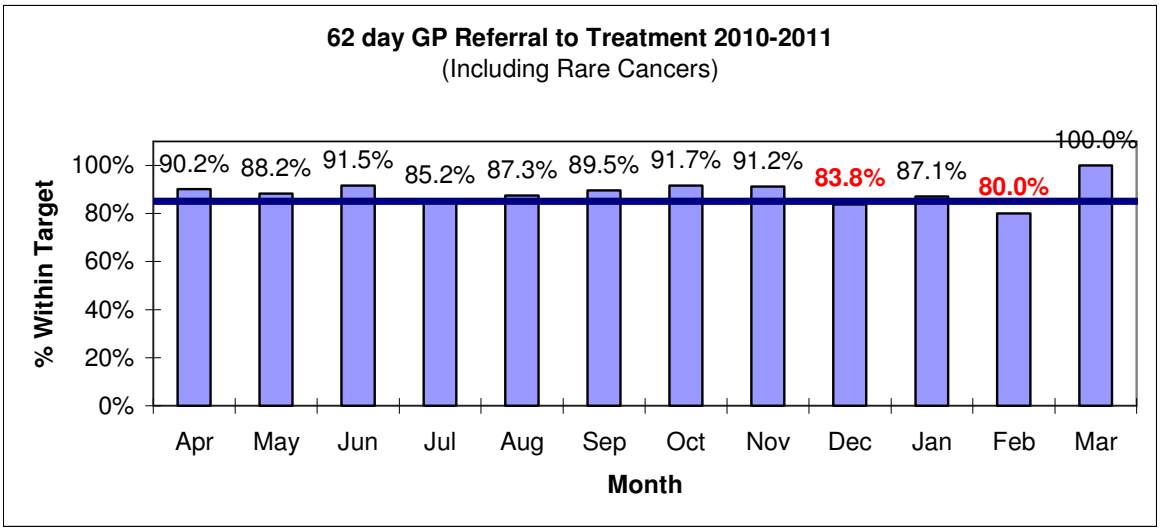
This work is ongoing and further work is planned both at Trust and Greater Manchester & Chester Network level to ensure that pathways are efficient and also to ensure communication between Trusts is effective and within agreed protocols:

- Development of GP referral proformas to reduce inappropriate referrals and to enhance efficiency at the start of the 62 day pathway.
- Regular reporting of performance and breach reasons of individual tumour groups to clinical and service leads.
- Network led work to improve communication between Trusts and standardise transfer of care procedures.
- Reduction of average days to/from referral to first seen to 5 days as part of the Surgery & Cancer Division 10 out of Ten.

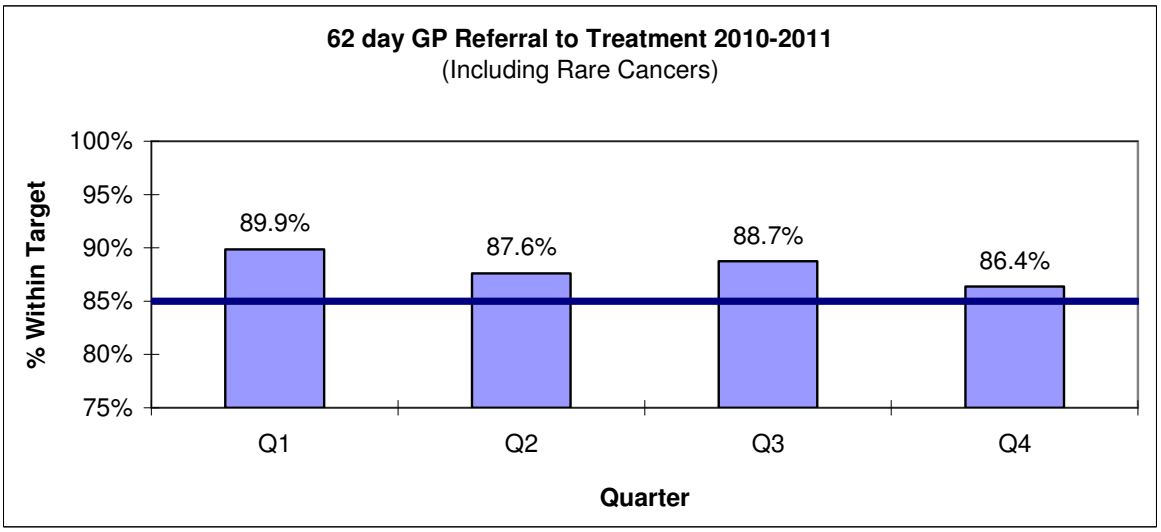
A high number of respondents (41%) highlighted that all 10 indicators were important, with 155 of the 200 surveyed naming Infections as the most important.

When looking at those who only chose 3 or fewer indicators (57) the results were slightly different. This may be a better indicator statistically as it focuses the results into respondent who felt strongly about a small number of areas.

Graph 17: 62 day GP Referral to Treatment 2010/11 - monthly



Graph 18: 62 day GP Referral to Treatment 2010/11



Consultation on Quality

The consultation process for the Quality Account commenced on 21 September 2010 until 1 March 2011.

The objective of the Consultation was to:

- Ask local people and Members of the Foundation Trust for feedback on the 10 key priorities for the Trust
- Recruit new Members as Foundation Trust Members
- Ask local people how they would like to see the Trust grow and where interest lay for access Trust information

Through partnership working, the Trust once again joined with the Cheshire Police Authority to participate in a joint consultation exercise. The Police Authority aimed to directly consult with the community to gather views about public priorities. Members from the Trust also visited local supermarkets in Winsford and Crewe to gain public opinion on the importance of the Trust's 10 out of Ten.

Surveys were sent to members who receive regular news from the Trust to put forward their views on the Trust's 10 priorities as well as assisting in the mapping of the future.

The public were once again asked to prioritise the list of 10 key areas as well as give comments indicating which areas they felt were important. The overall number of responses received was 200 and the results below demonstrate the public's opinion of the importance of the Trust's 10 out of Ten.

Table 12

Indicator	Rank	Count	%
Infections	1	155	77.5%
Patient Safety	2	154	77.0%
Cancer	3	152	76.0%
Cardiovascular	4	145	72.5%
Patient & Staff	5	137	68.5%
Environment	6	127	63.5%
Readmissions	7	126	63.0%
Finance	8	124	62.0%
Harm Caused	9	123	61.5%
Mortality	10	116	58.0%

Graph 19

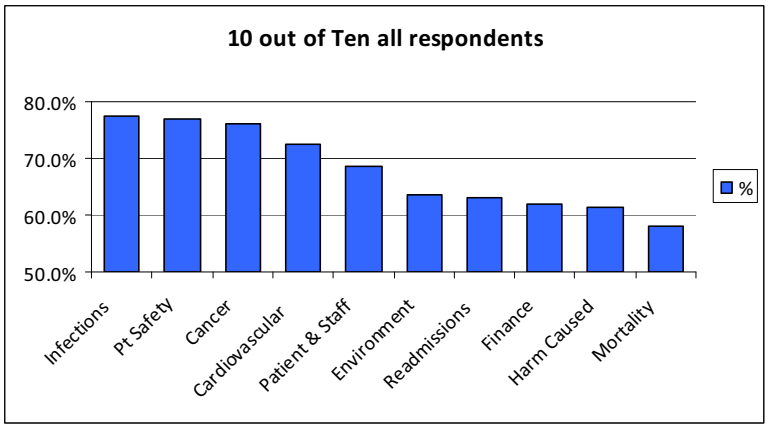
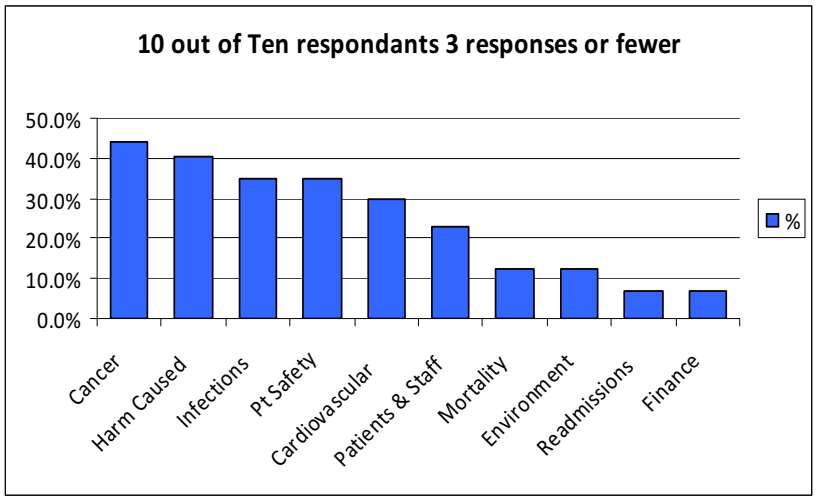


Table 13: Indicators where 3 or fewer chosen 2010/11

Indicator	Rank	Count	%
Cancer	1	25	43.9%
Harm Caused	2	23	40.4%
Infections	3	20	35.1%
Patient Safety	4	20	35.1%
Cardiovascular	5	17	29.8%
Patients & Staff	6	13	22.8%
Mortality	7	7	12.3%
Environment	8	7	12.3%
Readmissions	9	4	7.0%
Finance	10	4	7.0%

Graph 20



In 2009, Infections, Cancer and Mortality were the most important in people's minds equating to 53.95% of all the respondents. Infections were ranked the most important with 44 out of 215 responses (108 people) highlighting that area.

To clarify a person could choose one, two or three different groups and still be included in this sub-analysis, hence why 108 people generated 215 different responses.

Overall it has been demonstrated that the 10 indicators chosen by the patients, public and staff in 2009 are still regarded as important when measuring quality.

Statements from Local Involvement Network (LINk), Overview and Scrutiny Committee (OSC) and Central and Eastern Cheshire Primary Care Trust (CECPCT) and Governors

Local Involvement Network (LINk)

Overview and Scrutiny Committee (OSC)

Central and Eastern Cheshire Primary Care Trust

Governors

Readers' Panel

Key National Priorities

Table 14: - Quality Overview

Safety Measures Reported		2008-2009	2009-2010	2010-2011	Result
Hospital Falls/ injuries (falls/1000 bed days) (*)		6.41	6.09%		
Falls assessment risks completed within 24hrs (*)		83%	96%	95%	↓
Waterlow tests completed within 24 hours of admission (*)		98%	93%	94%	↑
Nutritional assessment completed within 24 hours of admission		82%	99%	97%	↓
Performance Indicators					
A & E Waiting Times		98.1%	97.3%		
Access to Genito-urinary medicine (GUM) clinics		99.9%	100%		
Cancelled Operations	% of cancelled operations	1.19%	1.46%		
	% of breaches of the 28 day guarantee	9.5%	14.4%		
Ethnic coding data quality		84.1%	85.3%		
Inpatients waiting longer than 26 week standard		0%	0%		
Outpatients waiting longer than 13 week standard		0.14%	0%		
Rapid access chest pain clinic waiting times		100%	100%		
Patient Experience Measures Reported					
% of patients that would recommend hospital to family /friends		N/A	97%	N/A	
Overall how would you rate the care you received **		93%	93%	89%	↓
% patients who felt they were treated with dignity & respect		97%	96%	95%	↓
% patients who had not shared sleeping area with opposite sex		74%	75%	76%	↑

* *monitored monthly.* ***Patients rating their care as excellent, very good & good*

Table 15: National Priority and National Core Standards

National Targets and Regulatory Requirements	2008-2009	2009-2010	2010-2011	Target	Result
MRSA Bacteraemias	15	8			
Clostridium Difficile Infections	142	117			
Smoking During Pregnancy	22.5%	19.5%			
Breastfeeding Initiation Rates	59.5%	59.6%			
18 week maximum wait from point of referral to treatment (admitted patients)	89.1%	92.8%			
18 week maximum wait from point of referral to treatment (non- admitted patients)	97.2%	97.6%			
Maximum wait of 31 days from diagnosis to treatment of all cancers	96.2%	98.4%			
Maximum waiting time of 2 weeks from urgent GP referral to first outpatient appointment for all urgent suspected cancer referrals (note change of definitions and targets between 2008/09 and 2009/10)	98.7%	93.2%			
Maximum waiting time of 31 days for subsequent treatments for all cancers	Target from 09/10	100%			
Maximum two month wait from RTT for all cancers (note change of definitions and targets between 2008/09 and 2009/10)	95.9%	85.6%			
Thrombolysis	74.5%	66.7%			
Core Standards Submission	Full Compliance				

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

Appendices

Appendix 1 - Glossary & Abbreviations:

Term	Abbreviation	Description
Advancing Quality	AQ	A programme which rewards hospitals which improve care in a number of key areas – heart attacks, pneumonia, hip and knee replacements, heart failure and heart bypass surgery – when compared to research which identifies what best care constitutes.
Aseptic Non Touch Technique	ANTT	Aseptic Non-Touch Technique aims to prevent micro-organisms on hands, surfaces or equipment from being introduced to a susceptible site.
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.
C.A.S.P.E Healthcare Knowledge Systems	CHKS	An independent company which provides clinical data/intelligence to allow NHS, and independent sector organisations, to benchmark their performance against each other.
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.
Global Trigger Tool	GTT	Uses internationally agreed triggers to identify adverse events during case note review to measure the overall level of harm in a health care organisation.

Healthcare Associated Infections	HCAI	A generic name to cover infections like MRSA and C-diff.
Healthcare Resource Group	HRG	Is a grouping consisting of patient events that have been judged to consume a similar level of resource
Healthcare Quality Improvement Partnership	HQIP	The Healthcare Quality Improvement Partnership, **HQIP**, promotes clinical audit and healthcare quality improvement, managing the National Clinical Audit and Patient Outcomes
IPOS MORI		A leading market research company in the UK.
Liverpool Care Pathway	LCP	The LCP is a document which should be used to facilitate best practice and improve care of the dying patient. Adapted from the hospice model of care the LCP is a holistic, multidisciplinary and evidence based tool which focuses on the physical, psychological and spiritual needs of the dying patient (and their families) in the last few days of life
Leading Improvement in Patient Safety	LIPS	The Leading Improvement in Patient Safety (LIPS) programme is about building the capacity and capability within hospital teams to improve patient safety
Methicillin-Resistant Staphylococcus Aureus	MRSA	Staphylococcus aureus is a bacterium which is often found on the skin and in the nose of about 3 in 10 healthy people. An infection occurs when the bacterium enters the body through a break in the skin. A strain of this bacterium has become resistant to antibiotic treatment and this is often referred to as MRSA.
Mid Cheshire Hospitals NHS Foundation Trust	MCHFT	The organisation which runs Leighton Hospital, Crewe, Victoria Infirmary, Northwich and Elmhurst Intermediate Care Facility, Winsford
Monitor		Monitor authorises and regulates NHS foundation trusts and supports their development, ensuring they are well-governed and financially robust.

National Patient Survey		Co-ordinated by the CQC, 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 and Learning System	RLS	National database that allows learning from reported incidents

Safety First		A report commissioned by Sir Liam Donaldson, Chief Medical Officer, to reconsider the organisational arrangements currently in place to ensure that patient safety is at the heart of the healthcare agenda. The report explicitly aimed to address issues raised by the National Audit Office in its report, A Safer Place for Patients, as well as to look at the NHS approach to patient safety more widely.
Sentinel Audit		A national audit that measures the care delivery provided for patients following the diagnosis of a stroke.
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: quality.accounts@mcht.nhs.uk

How useful did you find this report?

Very useful ☐

Quite useful ☐

Not very useful ☐

Not useful at all ☐

Did you find the contents?

Too simplistic ☐

About right ☐

Too complicated ☐

Is the presentation of data clearly labelled?

Yes, completely ☐

Yes, to some extent ☐

No☐

If no, what would have helped?

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

CHESHIRE EAST COUNCIL

Health and Adult Social Care Scrutiny Committee

Date of Meeting:	14 April 2011
Report of:	Borough Solicitor
Subject/Title:	Centre for Public Scrutiny pilot project – Health Inequalities

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1.0 Report Summary

1.1 This report outlines the Centre for Public Scrutiny (CfPS) pilot project in which Cheshire East and Cheshire West and Chester Council participated to contribute to a Scrutiny Toolkit on Health Inequalities.

2.0 Recommendation

2.1 That the work undertaken to date be noted and used to inform future scrutiny work, where relevant.

3.0 Reasons for Recommendations

3.1

4.0 Wards Affected

4.1 All

5.0 Local Ward Members

5.1 Bucklow and Knutsford Wards

6.0 Policy Implications including - Climate change - Health

6.1 Not known at this stage

7.0 Financial Implications

7.1 Not known at this stage

8.0 Legal Implications (Authorised by the Borough Solicitor)

8.1

9.0 Risk Management

9.1

10.0 Background and Options

10.1 In January 2010 Cheshire East Council and Cheshire West and Chester Council successfully bid to take part in the Centre for Public Scrutiny (CfPS) Health Inequality Scrutiny programme aimed at raising the profile of overview and scrutiny as a tool to promote community well-being and help councils and their partners in addressing health inequalities within their local community. This was to be achieved by various methods including:

- Developing a resource kit designed to provide Councils with help, support and advice to encourage them to undertake scrutiny reviews of Health Inequalities;
- Identifying and working with "Scrutiny Development Areas" who will have a key role in making the kit a comprehensive resource for local councils and partners, testing existing models of scrutiny and developing and defining new ones.

10.2 A small sum of money to support the project was allocated, along with an Expert Advisor to assist Members and Officers.

10.3 The Cheshire project focused on identifying health inequalities in rural areas which may exist in small hidden "pockets" and therefore be more difficult to find. In order to test out methodologies, two rural areas were identified, one in Cheshire East and one in Cheshire West and Chester. The Indices of Multiple Deprivation (IMD) were used to identify rural areas in Cheshire with high levels of deprivation as this is a known measure - deprivation is usually nationally defined using Lower Super Output Areas as the geographical measure, and the Index of Multiple Deprivation (IMD) 2007 as the measure of deprivation. The IMD combines a range of deprivation indicators into a single score - the indicators used are: Income; Employment; Health deprivation and disability; Education, skills and training; Barriers to housing and services; Crime; and Living environment.

10.4 The area chosen in Cheshire East to test methodologies was identified as Knutsford Rural, part of the Bucklow Ward comprising an area south of Knutsford including Plumley, Marthall, Ollerton and Peover; this was a rural area that was close to an urban area. The area chosen in Cheshire West and Chester was part of the Broxton Ward including Malpas, Tilston and Farndon, which differed from the Cheshire East area in that it was further away from any urban conurbation.

10.5 A Joint Scrutiny Panel was established comprising:

- Cheshire East Councillors C Andrew, D Flude, S Jones, B Livesley and A Moran (appointed as Chairman of the Panel);
- Cheshire West and Chester Councillors E Johnson, P Merrick, G Smith and A Wright.

10.6 The Panel met on 5 occasions, including undertaking a tour of the two pilot areas; information was sought from a variety of stakeholders; and Councillors and

officers went out into the two areas on a number of occasions to undertake face to face interviews.

10.7 In addition, the Panel held a mini scrutiny review which focused on a specific topic in a two hour session; the Panel carried out its mini review on "Access to mental health services in rural areas" and heard evidence from NHS professionals, a representative of the Local Involvement Network and the Head of Rural Affairs from Cheshire Community Action.

10.8 The findings from the project were presented at a Centre for Public Scrutiny event in London on 17 November which the Chairman of the Panel, together with the Scrutiny Officer from CWAC, attended. Subsequently, the findings were written up by the Panel's Expert Advisor into a Case Study (attached) and will form part of the Toolkit chapter on Local Understanding. The Toolkit is to be launched shortly.

10.9 A major purpose of this project was to help develop a Scrutiny toolkit though investigating and piloting various methodologies. It is hoped that the findings from the project as well as the experience gained will be useful in any future work to investigate health inequalities or indeed Scrutiny work looking at other areas which may want to utilise the use of the mini scrutiny review, Information Grid etc.

11.0 Access to Information

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

Name: Denise French
Designation: Scrutiny Officer
Tel No: 01270 686464
Email: denise.french@cheshireeast.gov.uk

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HEALTH INEQUALITIES cfps RESOURCE KIT

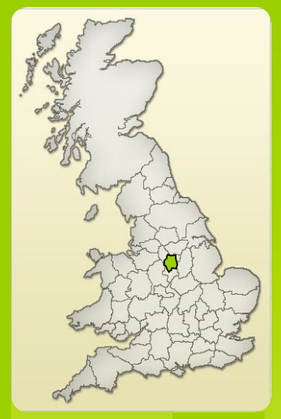
Health inequalities in rural areas

Cheshire East Council, Chester West and Chester Council

draft 17.3

cfps the centre for public scrutiny
better scrutiny for better government

A Joint Scrutiny of "What is Health inequality in rural areas" was undertaken February – November 2010 by two "new" unitary Councils in Cheshire – Cheshire East and Cheshire West & Chester. A Joint Health Overview and Scrutiny Committee was set up for this purpose. The review focussed on identifying and addressing persistent "pockets" of health inequalities believed to exist in rural areas but which are masked by overall and average levels of greater affluence and wellbeing in those areas. The review also set out to ask about what we mean by rural health inequalities as this may not be the same as for urban areas.



Reason for choosing topic

Initially the Councils were interested in improving a very wide range of aspects of Health Inequalities in rural areas including how health promotion/improvement schemes could best focus on areas of greatest need, and using mapping activities to tackle health inequalities, and a series of mini-reviews of areas such as Pregnancy and early years, Education, Accessing Services and Advice, and Older People. At an initial scoping meeting, the review lead Officers recognised that this would not be deliverable in the timescales, and the aspects were reviewed in terms of what would both be of local interest and create new knowledge.

Early impact

This review demonstrated just how complex health inequalities are and how rural areas are viewed differently by different people. For example, where country life can be peaceful and idyllic to one person, it can be isolated and lonely for another.

The review highlighted to members this difference of opinion and challenged them to look beyond this and really understand the communities the review was focussing on.

Whilst it is still early days, the review highlighted a "Data" gap. The review wanted to look at data at a very small population level – and this was not readily available. They developed ways of deciding what information they needed, and a model for filling this gap.

Data sharing or lack of it was another issue that the review encountered. Therefore work is now underway to produce data sharing protocols to achieve better outcomes for local people.

However perhaps one of the most exciting emerging areas of work is with the new GP Consortia for West Cheshire and its relationship to scrutiny. The consortia has expressed an interest in the review and its findings and wants to work with members to produce better ways of working together to tackle rural health inequalities. It is hoped that similar progress can be made with the GP consortia in Cheshire East as well as the findings being a useful reference document for the emerging Health and Wellbeing Boards in their role in tackling health inequalities.

Innovation

The review set out to do something very innovative – to see what information could be found out about hidden "pockets" of health inequalities. The particular challenge was finding the "pockets" within areas generally assumed to be "wealthier".

The review found it very difficult to obtain data that could help members to understand rural inequalities at a sufficiently low level. Therefore the review created a methodology for addressing low level data. This included the definition of 3 types of information sources, and an information grid which lists possible sources of information, both "traditional" and "creative", and their degree of usefulness. As an example of the creative use of information, animal neglect can be indicative of poor health of the owner, or a fire services risk assessment can indicate someone in need of support for smoking cessation.

The USP

The review set out to do something very innovative - to see what information we could find out about "pockets" of health inequalities that are masked by not occurring in areas of consistent and ubiquitous health inequalities. Whilst it was recognised that the latter is a characteristic of urban areas of with large areas of uniform deprivation, it was also noted that "pockets" of deprivation and health inequalities occur everywhere, so are an issue of wider interest. The challenge here had been finding the "pockets" within areas generally assumed to be "wealthier".

The review found it very difficult to obtain Type 1 information. However, it created a methodology - the Type 1 information grid). It also demonstrated that the Type 2/3 information is a rich source and should be valued equally with statistical data even though it may not be "statistically robust".

Key Learning Points

Do a stakeholder analysis right at the start - getting the right partners involved in the review at an early stage is key.

Research your topic thoroughly and choose something that will be interesting/innovative and add to knowledge rather than the topics that have all been looked at before.

Use simple one-page project planning techniques to help to define and break down the review's stages, and sequence and schedule the work of the review.

Consider at the beginning all the types of information that may be useful and try to gather this information in parallel. Think carefully about how you are going to communicate (eg questionnaire, flyer); the actual questions to be asked; who you are going to ask; and where you are going to ask them - we found some people less forthcoming on their own doorsteps than when "out and about."

Highlighting Innovation

The review created a methodology for addressing data on "pockets" of deprivation and health inequalities. This included the definition of 3 types of information sources, and an information grid which lists possible sources of information, both "traditional" and "creative", and their degree of usefulness. As an example of the creative use of information, animal neglect can be indicative of poor health of the owner, or a fire services risk assessment can indicate someone in need of support for smoking cessation.

However, the type 2 and 3 information has enabled the review to challenge assumptions, and revealed that there are different types of "rural". The review highlighted the need for agencies to work together to join up their use of information on vulnerable people in innovative ways.

Models of Scrutiny developed

This review developed a methodology for using data in different ways. This included:

Type 1 information grid - setting out the stakeholders that could hold useful information for the review. The grid also comments on the usefulness and accessibility of the data as it relates to health inequalities. The grid also categorised the information - traditional vs innovative/ creative sources.

Type 2 information questionnaires - two questionnaires were developed to get the views of members and rural dwellers.

Type 3 information A mini-scrutiny review to look at mental health services in rural areas, and the health inequalities experienced.

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The Project Journey

Health Inequalities in Rural Areas

Cheshire East Council, Chester West and

In 2009, Cheshire West and Chester partnered with Cheshire East Council in their bid to become a Scrutiny Development Area. The two Councils were new Unitary Councils formed earlier that year, with a large rural population, and the scrutiny committee wanted to understand health inequalities in rural their rural communities.

Whilst Officers were keen to look at around 10 rural areas, it was agreed that, to manage the workload, the process would be piloted in two rural areas – one in each Council – and rolled out around the autumn to a further tranche of rural areas. Some time was spent on the methodology of how to select the pilot areas, with a review of data in the component parts of the Index of Multiple Deprivation. Ultimately it was agreed that this was not crucial and that two areas from a list of the 10% of areas scoring highest in the Index of Multiple Deprivation would be chosen. One community had the characteristics of "urban edge" rural and the other "deep rural".

An initial literature search suggested that there were few academic sources on the review topic.

The review identified and examined three types of information sequentially:

- **Type 1** – information held by other organisations such as the Council and Primary Care Trust (PCT), or that ought to be available from them.
- **Type 2** – "anecdotal" information – information which is not currently available but which the review created by (a) asking Councillors their views and (b) local Councillors and Officers going out and talking with local residents in the two pilot rural areas about their experience of health inequalities.
- **Type 3** – information derived from a "mini-review" of one aspect of the experience of health inequalities in rural areas.

Four meetings of the Joint Health Overview and Scrutiny Committee were held, along with an intermediate and an end-point Action Learning Review.

Members also made a visit to each of the two pilot rural areas chosen, and toured the areas, visiting facilities to get a "feel" for the areas. Members commented at the final Action Learning Review meeting on how helpful this had been:

"I didn't think there were any Health Inequalities in the rural areas – my views have changed, " Panel Member.

What was the experience of seeking the 3 types of information?

Type One information was sought from an enormous range of stakeholder organisations, and a "flyer" was created to let external organisations know about the review and seek their input/co-operation. However, they were either unable to share/ process this information or unwilling to do so; for example, because small patient numbers might make individuals identifiable. This raised the question; do agencies really know who are the people who are experiencing or most at risk of health inequalities? (For example agencies may target a group of people known to live in sheltered housing, but be failing to meet the needs of the scattered elderly or young mothers living individually in small hamlets).

Our key conclusion, in relation to type one information (eg people on benefits) is that it can identify a RISK of experiencing health inequalities.

Although frustrated with the lack of progress with collecting type one information, the review moved on to an alternative source – going directly to the experience of local people themselves. Councillors and Officers felt that, looking back, they had spent too long on trying to get the type one information, and could have moved on sooner.

The Project Journey

Type two information was gathered via a questionnaire to Members to elicit their views; and a questionnaire for Members/Officers to use 1:1 with rural dwellers, to seek their view on the health inequalities experienced. This produced useful "anecdotal" information and gave us a much clearer view of the key role that access to facilities – and to transport to facilities – plays in rural dwellers' access to healthcare, quality food, leisure activities and other aspects that contribute to health and well-being. The opportunity to make greater use of Parish Councils – who to talk to - was highlighted.

Type Three information was gained by a focus on one aspect of rural health inequalities – mental health. This used a model of "mini-scrutiny" to hold a two-hour mini-review on this topic, with witness presentations, and proved a rich source of information.

At the time of writing, the final scrutiny report and its recommendations are being taken through the committee system for endorsement. The Councils recognise that they chose a difficult topic, but are proud of their willingness to take a risk and be innovative, and of creating a methodology that can be used by other Councils.

Safe and Sustainable

Children's congenital heart services in England

NHS

Specialised Services

Review of Children's Congenital Heart Services in England: Briefing 3

Spring 2011

1.0 Background information

This briefing provides an update on the public consultation which forms part of the NHS review of children's congenital cardiac services. This is the third briefing we have sent to all Health Overview and Scrutiny Committees in England to update them about the ongoing review of children's heart surgery services. Previous briefings were issued in August and November 2010.

It is possible that some HOSCs may consider the recommendations for change - that have now been published - to be a 'substantial variation', requiring us to formally consult with those HOSCs. The 2003 Direction from the Secretary of State requires scrutiny committees to convene a joint HOSC when two or more HOSCs consider that proposals affecting a population larger than a single HOSC to be substantial.

2.0 Aims of the review

What does the review aim to achieve?

- Better results in the surgical centres with fewer deaths and complications following surgery
- Better, more accessible diagnostic services and follow up treatment delivered within regional and local networks
- Reduced waiting times and cancelled operations
- Improved communication between parents and all of the services in the network that see their child
- Better training for surgeons and their teams to ensure the sustainability of the service
- A trained workforce expert in the care and treatment of children and young people with congenital heart disease
- Centres at the forefront of modern working practices and innovative technologies that are leaders in research and development
- A network of specialist centres collaborating in research and clinical development, encouraging the sharing of knowledge across the network

3.0 The review process: Where are we now?

The options for change

The Joint Committee of Primary Care Trusts (JCPCT), the decision-making body for *Safe and Sustainable* held a meeting in public on 16th February. At this meeting the recommendations for changes to the way children's congenital heart services were discussed and the options for reconfiguring the service were agreed.

What will we be consulting on?

We will be consulting on the following key areas:

- Standards of care: proposed national quality standards of care to be applied consistently across the country
- Congenital heart networks: development of networks to coordinate care and ensure more local provision (e.g. assessment, ongoing care)
- The options: the number and location of hospitals that provide children's heart surgical services in the future
- Better Monitoring: improvements for analysis and reporting of mortality and morbidity data

There are currently 11 surgical centres across England:

- Alder Hey Children's Hospital, Liverpool
- Birmingham Children's Hospital
- Bristol Royal Hospital for Children
- Evelina Children's Hospital, London
- Freeman Hospital, Newcastle
- Glenfield Hospital, Leicester
- Great Ormond Street Hospital for Children, London
- John Radcliffe Hospital, Oxford (surgery services are currently suspended)
- Leeds Teaching Hospital
- Southampton General Hospital
- Royal Brompton Hospital, London

The four options that the public will be consulted on are:

Option A
Seven surgical centres at:
- Freeman Hospital, Newcastle
- Alder Hey Children's Hospital, Liverpool
- Glenfield Hospital, Leicester
- Birmingham Children's Hospital
- Bristol Royal Hospital for Children
- 2 centres in London

Option B
Seven surgical centres at:
- Freeman Hospital, Newcastle
- Alder Hey Children's Hospital, Liverpool
- Birmingham Children's Hospital
- Bristol Royal Hospital for Children
- Southampton General Hospital
- 2 centres in London

Option C
Six surgical centres at:
- Freeman Hospital, Newcastle
- Alder Hey Children's Hospital, Liverpool
- Birmingham Children's Hospital
- Bristol Royal Hospital for Children
- 2 centres in London

Option D
Six surgical centres at:

- Leeds General Infirmary
- Alder Hey Children's Hospital, Liverpool
- Birmingham Children's Hospital
- Bristol Royal Hospital for Children
- 2 centres in London

London
The preferred two London centres in the four options are:

- Evelina Children's Hospital
- Great Ormond Street Hospital for Children

New national quality standards to improve care
New national quality national standards have been developed as part of this review to help ensure that services produce better outcomes for children and are safe and sustainable. These are the quality criteria that experts believe must be met by any hospital that performs heart surgery on children. The proposed standards were developed in partnership with healthcare professionals, parents and patient groups and they are part of this consultation.

The development of congenital heart networks
Safe and Sustainable is proposing that surgical centres are not just responsible for the care they provide but that they lead a congenital heart network. These networks would ensure services are better coordinated and strengthen existing local assessment and ongoing care services where they exist and develop more outreach support in areas that have been neglected in the past. The standards set out the proposed roles for Specialist Surgical Centres, Children's Cardiology Centres and district level services and how the different parts of the network will work together.

4.0 The public consultation

Consultation timings:

The NHS has launched a four month public consultation. It will end on 1st July 2011.

Who will consult?

The Joint Committee of Primary Care Trusts

The NHS has established a national Joint Committee of Primary Care Trusts (JCPCT) which has legal powers for consultation and decision making. The committee includes the Chair of each of the 10 Specialised Commissioning Groups in England (each SCG Chair is a PCT Chief Executive).

The Welsh Assembly Government and the Welsh Health Specialised Services Committee were invited to join the JCPCT as Welsh children are usually referred to a heart surgical centre in England. They have chosen to attend meetings as observers to enable them to continue to ensure the interests of children in Wales are represented.

How will the NHS consult with the public?

The NHS wants as many people with an interest in children's congenital cardiac services to take part in the consultation. Everyone's view will be considered. The public will be able to take part in the consultation in the following ways.

Printed communications: We will be publishing a consultation document. This will be available to view online and printed copies will also be available upon request. We will also be producing a range of posters and leaflets to help promote the consultation events taking place around the country.

Online: Our website www.specialisedservices.nhs.uk/safeandsustainable will carry an online version of the consultation document, a link to the response form, materials (leaflets and poster) on the consultation process, and a video about the consultation.

Face to face events in England and Wales: We will hold over 15 face to face events in England and Wales, including three events specifically for young people. These events will help give people the information they need and answer any questions they may have, with the aim of encouraging people to take part in the consultation. The events will give people the opportunity to put their views to local clinicians and commissioners. More information and a link to the registration page can be found on our website.

We will be holding consultation events at:

Location	**Date**	**Time of primary event**	**Proposed Venue**
London (Event for young people)	Sat 19 March	11am-1pm	Charing Cross Hotel
Birmingham	Mon 4 April	6-8pm	Maple House
Cardiff	Tues 5 April	6-8pm	Cardiff City FC Stadium
Newcastle	Thurs 7 April	6:30-8:30pm	Discovery Museum
Birmingham (Event for young people)	Sat 9 April	11am-1pm	Maple House
Oxford	Wed 4 May	6-8pm	Kassam Stadium
London	Sat 7 May	11am- 1pm	Emirates Stadium
Warrington	Mon 9 May	6-8pm	Halliwell Jones Stadium
Leeds	Tues 10 May	6-8pm	Royal Armouries Museum
York (Event for young people)	Sat 14 May	11am-1pm	The Royal Hotel York
Cambridge	Wed 18 May	6-8pm	De Vere University Arms Hotel
Gatwick	Thurs 19 May	3-5pm	Copthorne Effingham Park
Southampton	Tues 24 May	6-8pm	The Guildhall (part of the Civic Centre)

Taunton	Tues 7 June	3-5pm	Taunton Racecourse
Leicester	Thurs 16 June	6-8pm	Walkers Stadium

Media relations: We are also working with the media to ensure information about the review process and the consultation appears nationally and locally.

What happens to the consultation responses?

Ipsos MORI, an independent company will collect and analyse all the responses and a comprehensive analysis of the responses will be published in a final report. The Joint Committee of Primary Care Trusts will consider the report carefully to help them evaluate the four options and make a final decision. We expect a final decision to be made in Autumn 2011. Implementation of any changes to children's congenital heart services are expected to start in 2013.

5.0 Is there support for the review?

There is strong support. The review was instigated at the request of national parent groups, NHS clinicians and their professional associations.

The review is supported by the following organisations:

What engagement has taken place?

The review process has benefitted from the input that clinicians and parents have provided to help shape the national standards and the design of the future service. A range of engagement activity has taken place, including national and regional engagement events for parents and staff. Summaries of the meetings are on our website. The Safe and Sustainable review team has provided updates to keep parents and staff informed about the progress of the review.

The Gateway report

The Safe and Sustainable review process has itself been subject to external scrutiny. The Office of Government Commerce 'Gateway' report (September 2010) into the process concluded that "the Steering Group is seen as having exercised real leadership in the work to articulate the clinical case and to develop quality standards". It also noted that "stakeholder engagement to date has been robust and impressive, and there is widespread support for the new standards and the case for reconfiguration."

The NCAT report

The NHS National Clinical Advisory Team has also delivered a very positive independent assessment of the review. NCAT has concluded that there is a strong case for reconfiguring paediatric cardiac surgery by reducing the number of cardiac surgery centres across England, and has endorsed the proposed network model of care. Both reports have made some helpful recommendations which we are now acting on.

Have any decisions been made by the NHS?

The NHS has not yet made any decisions on the future configuration of services. No decisions will be made until the outcome of consultation has been considered.

In October we issued a statement about one of the current centres, the John Radcliffe Hospital in Oxford. The NHS review team has recommended to the Joint Committee of PCTs that this centre should not be included in any potential configuration option. This is because the service at the John Radcliffe Hospital received the lowest ranking as part of the assessment process by a significant margin and that it would be the least likely of all the centres to be able to meet the new quality standards in the future. The JCPCT has accepted this recommendation.

The NHS has not yet made any decisions on the future configuration of services. No decisions, including on the future of the service at the John Radcliffe Hospital, will be made until the outcome of consultation has been considered.

5.0 Key dates

April – June 2011: Regional public consultation events

1st July 2011: Formal public consultation ends

July – Sept 2011: Analysis of consultation by independent third party

Autumn 2011: JCPCT considers outcome of consultation

Winter 2011: Decisions expected

2013: Implementation

6.0 Would you like further information?

HOSCs have already told us how they would like to scrutinise the consultation and representatives of the regional Specialised Commissioning Groups have been in contact with local HOSCs to arrange meetings to discuss the review and the consultation with them.

Do let us know if you would like any further information and please do register to participate in forthcoming consultation events.

Contact details
The NHS review is led by NHS Specialised Services on behalf of the 10 Specialised Commissioning Groups in England.

Please contact: Zuzana Bates, Project Liaison Manager, Zuzana.Bates@nsscg.nhs.uk

NHS Specialised Services, 2nd floor, Southside, 105 Victoria Street, London SW1E 6QT

Direct Line: 020 7932 3771

For further information please contact us, or see our website:
www.specialisedservices.nhs.uk/safeandsustainable

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REPORT OF THE TASK/FINISH PANEL ON FUTURE HEALTHCARE PROPOSALS FOR KNUTSFORD AND CONGLETON

Introduction

At its meeting on 29 July 2009, the Health and Adult Social Care Scrutiny Committee established a Task/Finish Panel to consider and make recommendations on the proposals by Central and Eastern Cheshire Primary Care Trust (PCT) for future healthcare provision in Knutsford and Congleton.

The Committee established a Task/Finish Panel comprising:

Councillor Dorothy Flude (Chairman)
Councillor Gordon Baxendale
Councillor Shirley Jones
Councillor Tony Ranfield
Councillor Andrew Thwaite
Councillor George Walton

The Panel had the following Terms of Reference:

"To exercise the Health Scrutiny function in relation to the Central and Eastern Cheshire Primary Care Trust's proposals regarding future healthcare in Knutsford and Congleton.

(the role of health scrutiny is to comment upon:

- *Whether as a statutory body, it has been properly consulted;*
- *Whether, in developing the proposals for service changes, the consulting body has taken into account the public interest through appropriate patient and public involvement and consultation;*
- *Whether the proposals are in the interests of the local health service)."*

Background and history

The Primary Care Trust, working with GPs, had introduced a programme to develop new and comprehensive healthcare provision throughout its patch. This reflected the need for Health Services to adapt to meet changing needs (such as the expected doubling of the over 85s age group by 2020); took on board opportunities offered by new technologies; and recognised that most people wished to remain independent and in their own homes for as long as possible.

The PCT, together with local GPs, wanted to provide more services locally and recognised that this meant bringing services together into shared premises. It is not affordable to duplicate advanced diagnostic and treatment facilities across different GP practice locations nor is it desirable to continue to provide services in relative isolation from other service providers. Existing

surgeries cannot be expanded or modified to accommodate the additional services and meet health and safety legislation.

Knutsford

The PCT's specific proposals for Knutsford therefore meant the provision of modern purpose built premises:

- Bringing together three GP practices – Toft Road Surgery, Manchester Road Medical Centre and Annandale Medical Centre;
- Providing a comprehensive range of clinics and out-patient services to provide local care for people with long-term conditions and disabilities or those requiring follow up to hospital treatment;
- An extended range of diagnostic services and test facilities to provide prompt and convenient diagnosis, treatment and monitoring of health concerns;
- Integrated services with Cheshire East Council;
- Intermediate services aimed at:
    - supporting people in their own homes;
    - providing community hospital beds to avoid unnecessary acute hospital admissions;
    - supporting earlier discharge from acute hospitals.

Process during 2008 - 2010

The PCT had followed a procurement process that saw GPI appointed as the developer for the Knutsford healthcare project.

The Panel heard from Andrew Caldwell of GPI who explained that GPI was a local third party developer of primary care premises. Primary care centres were funded through public finance and GPI would take on all risks until financial close. They would build the premises then lease the building to the GPs and Primary Care Trust on a lease agreed with the District Valuer, meaning that GPI would retain ownership of the building.

It was envisaged that a site of 2 – 2.5 acres was needed for the Knutsford project. A long list of potential sites was produced by GPI and discussed with local GPs and the PCT. This long list was then reduced to 5 sites that were notified to the Community Panel and local press. (A Community Panel had been established by the PCT in August 2008 to act as a point of contact between the PCT and local people). None of the sites was currently for sale. The site owned by Aldi was favoured but the company was not interested in selling. The remaining 4 sites were scored and rated and Shaw Heath identified as the best site. The three sites of Shaw Heath, the Town Centre site (comprising the Community Hospital, Bexton Court and the Stanley Centre) and the Golf Club were all then appraised in more detail.

Meetings had been held with planning and highways officers from Macclesfield Borough Council, regarding site issues, up to 1 April 2009

when Cheshire East Council came into being. The conclusion was that Shaw Heath would be the simplest site to develop as a healthcare centre. There could also be mutual benefit derived from relocating the services currently provided on the Town Centre site to Shaw Heath. A formal Consultation Process was begun by the Central and Eastern Cheshire Primary Care Trust on 1 September 2009. The consultation was suspended at the end of October 2009 when the PCT was advised by Cheshire East Council that the site at Shaw Heath was no longer available.

The Task/Finish Panel has undertaken visits to the 3 shortlisted sites:

- The site at the Golf Club was not considered to be a viable proposition and the Panel did not support any further consideration of this site as a location for the new premises;
- The Town Centre site – this site is in a central location close to a number of other existing facilities, it is accessible for people attending on foot, it is a location that local people are familiar with visiting for health and social care needs; however, parking appears limited and excessive traffic may cause highway difficulties in an area of narrow streets and residential properties;
- Shaw Heath – this is a 7 acre site which the Panel feels could easily accommodate all the services which the PCT/local GPs/the Local Authority wanted to provide as well as having potential for future expansion to meet future needs; the Panel would support the retention of the Household Waste Recycling Centre on the site; a Transport Plan would be required.

From visiting the sites, the Panel's preferred site is Shaw Heath. The Panel invited Councillor P H Mason, the Portfolio Holder for Procurement, Assets and Shared Services, L Quinn, Borough Treasurer and Head of Assets and A Pritchard, Assets Manager to a meeting in February 2010 to seek information as to whether site issues could be resolved and the project could resume. The Panel was advised that there was a commitment among officers of relevant council departments to work with officers from the Primary Care Trust to try to make progress with the Knutsford project and a meeting would be set up with relevant officers to discuss a way forward.

<u>Congleton</u>

This project aimed to bring together 3 existing GP practices onto a new site with enhanced facilities. The War Memorial Hospital, Congleton would have an increased number of intermediate care beds but diagnostic and out patient services could move to the new provision.

An exercise had been undertaken to assess and then weight a shortlist of theoretically available sites. This had resulted in the Fairground site (in the town centre adjacent to the library and police station) being identified as the preferred site and this development would be part of a whole new

town centre development. The Panel visited the Fairground site. No formal consultation was undertaken.

Position from May 2010

In May 2010, the Primary Care Trust issued a Premises Statement that stated that projects in a number of areas, including Knutsford and Congleton, would be put on hold until at least autumn 2010, unless the developments could be made cost neutral in real terms. In the light of this statement, the Panel suspended its work for a temporary period.

In September 2010, the Health and Adult Social Care Scrutiny Committee was consulted on the temporary closure of the Tatton Ward, Knutsford Hospital, due to difficulties in providing appropriate medical cover at the site. Cheshire East Cabinet on 18 October then approved the related temporary closure of Bexton Court, which provided Social Care services from the same site, and shared some support facilities with East Cheshire Trust (ECT). Outpatient services by Cheshire and Wirral NHS Partnership Trust and Cheshire East Community Health were also delivered from the hospital site.

A report was then submitted to the PCT Board on 30 November 2010 with a number of recommendations on current “on hold” primary care premises projects. It was recommended that the original project for a new build integrated health facility in Knutsford be stopped on the basis that the PCT should continue to work with the GP Practices and the Council to understand what could be done to develop patient services. In relation to Congleton, the new build project was also to be stopped but there could be a possible alternative “supersurgery” scheme.

This Panel then resumed its work and has held a number of meetings. The Panel has visited the Knutsford Hospital site and been advised about current services available at the site from both health and social care providers. Members have received progress updates from officers of the East Cheshire Hospital Trust, Primary Care Trust and Adult Social care. The Panel has also considered information and views from the Knutsford Town Plan Implementation Committee on the temporary closures. The Panel understands local GPs are now interested in revisiting the future healthcare proposals in Knutsford and, in view of their future role as commissioners of services, will have an important role in influencing decisions about future local service provision.

The Panel is also aware of changes in social care including a move away from building based services, increasing use of personalised budgets and the potential for a new specialised dementia facility in the north of the Borough. Members have been advised about a number of property related reviews underway by the Council, covering the future location of Independent Living Teams/Centres; Lifestyle Facilities and library buildings. It is important that the potential release of buildings is taken

account of when assessing the need for new facilities for health and social care.

The Panel was advised that specialist consultants had been commissioned by the PCT to gather the views of the major stakeholders in Knutsford and propose a way forward and a possibly modified scheme. Their work was completed by the end of February and a stakeholder meeting was held on 1 March to outline findings. The Panel understands that the outcome of the meeting was positive and it was felt that there was great potential for future provision of services in Knutsford. However, more time is needed before any firm proposals can be developed. In the meantime, a doctor has been appointed who will start with the Hospital Trust in April.

The Panel is aware that the Knutsford Community Hospital is a highly valued facility by the local community and is pleased to hear that there is real potential for future service provision in Knutsford. The Panel welcomes the joined up approach by all parties and hopes that partners can work together to contribute to a vision for future health and social care service delivery in Knutsford which can then be translated into some real service improvements.

In relation to Congleton, the Panel is pleased to hear that an alternative "supersurgery" scheme involving the former Borough Council offices may be possible as it is under active consideration by developers as part of the Town Centre development scheme. However, at this stage no further details are known.

Conclusion

The Panel is disappointed with the outcome for Knutsford given the resources that had previously been committed to developing the project. It has been difficult to finalise its report and come to conclusions due to delays arising during the General election period, financial difficulties of the PCT and then the coalition Government's proposals for substantial change in the NHS.

However, it now appears that there are new opportunities to develop both health and social care provision in Knutsford in the light of renewed interest from local GPs and possible opportunities arising from changes in health and social care and referred to earlier in the report. It appears that a new vision for health and social care can be developed in the Knutsford area and the Panel strongly supports this.

The Panel hopes that health and social care provision in Congleton can similarly reach a successful conclusion.

The Panel is grateful to all who have contributed to its work in particular Geoff Wood (PCT), Sandra Shorter (Adult Social Care, Cheshire East

Council), Val Ahearne (East Cheshire Hospital Trust) and Denise French (Scrutiny Team, Cheshire East Council).