Mid Cheshire Hospitals NHS
NHS Foundation Trust

Quality Account 2010/11

Quality and Safety at Heart
Mid Cheshire Hospitals NHS Foundation Trust
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"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

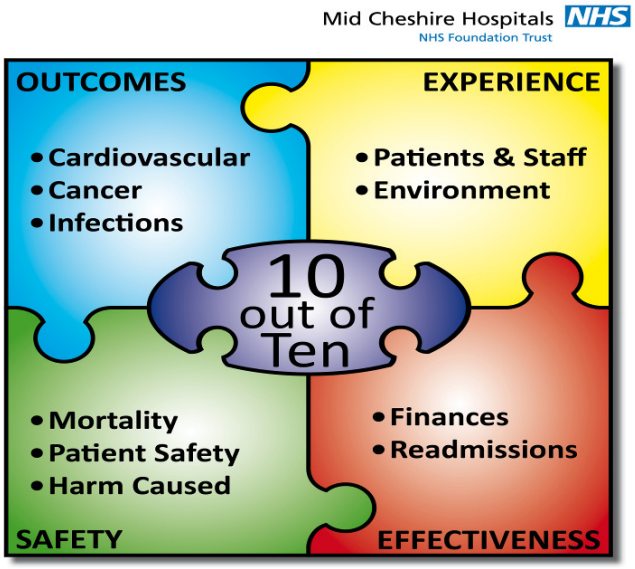
Mr John Moran

.....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.

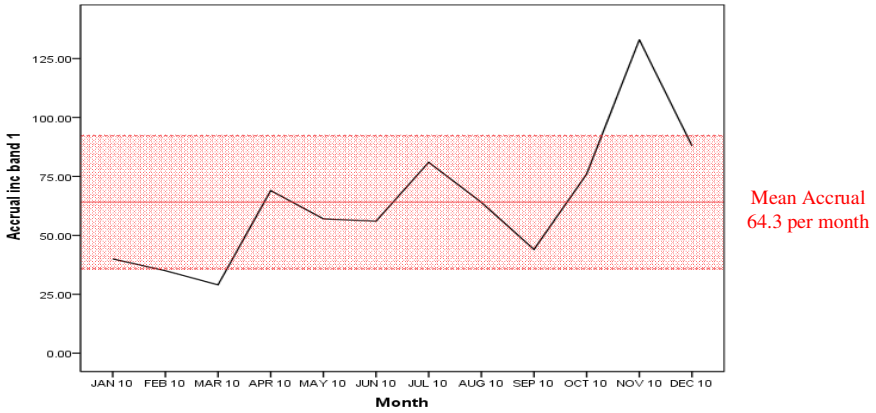
Research

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

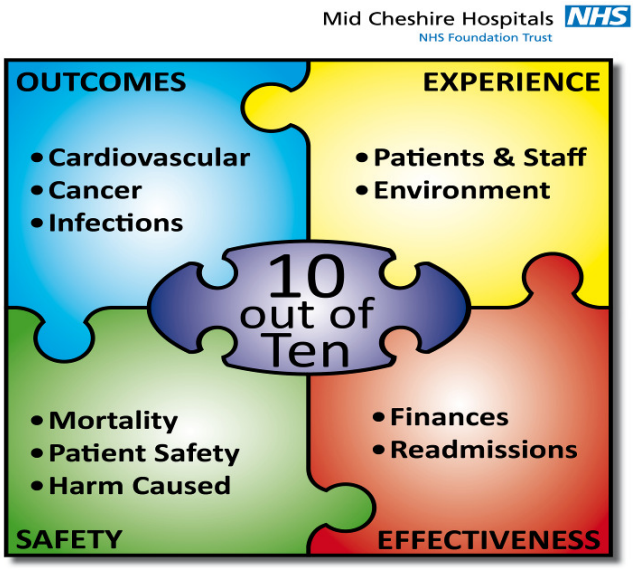
Review of Quality Performance

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:



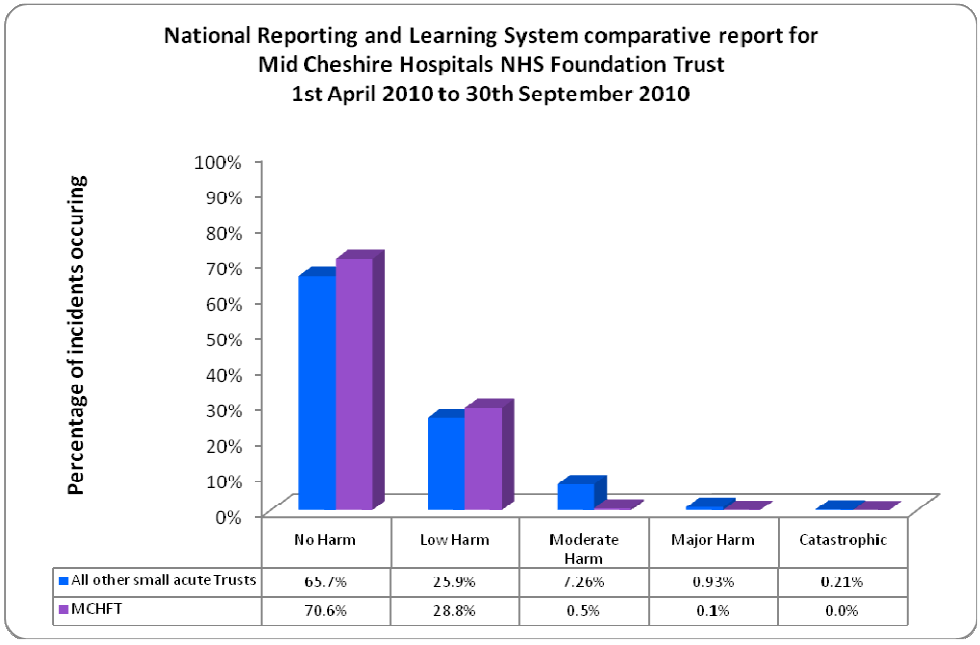
Review of Performance in relation to:

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%

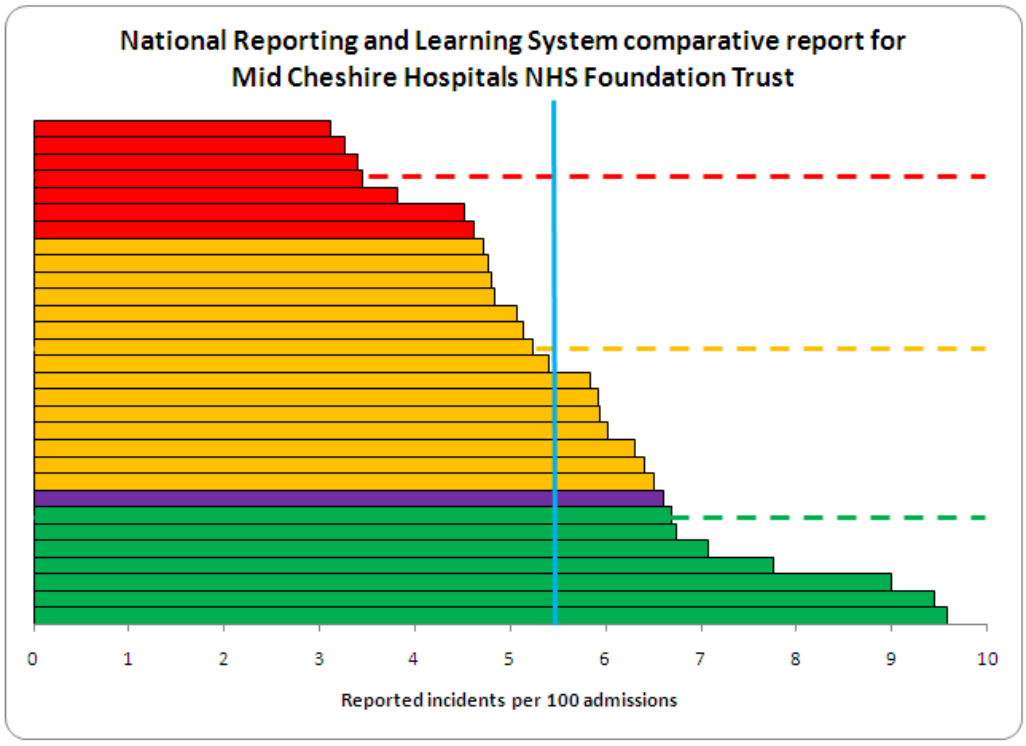
Please refer to Chapter 3 of the Annual Report to see changes in practice following the serious incidents.

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.

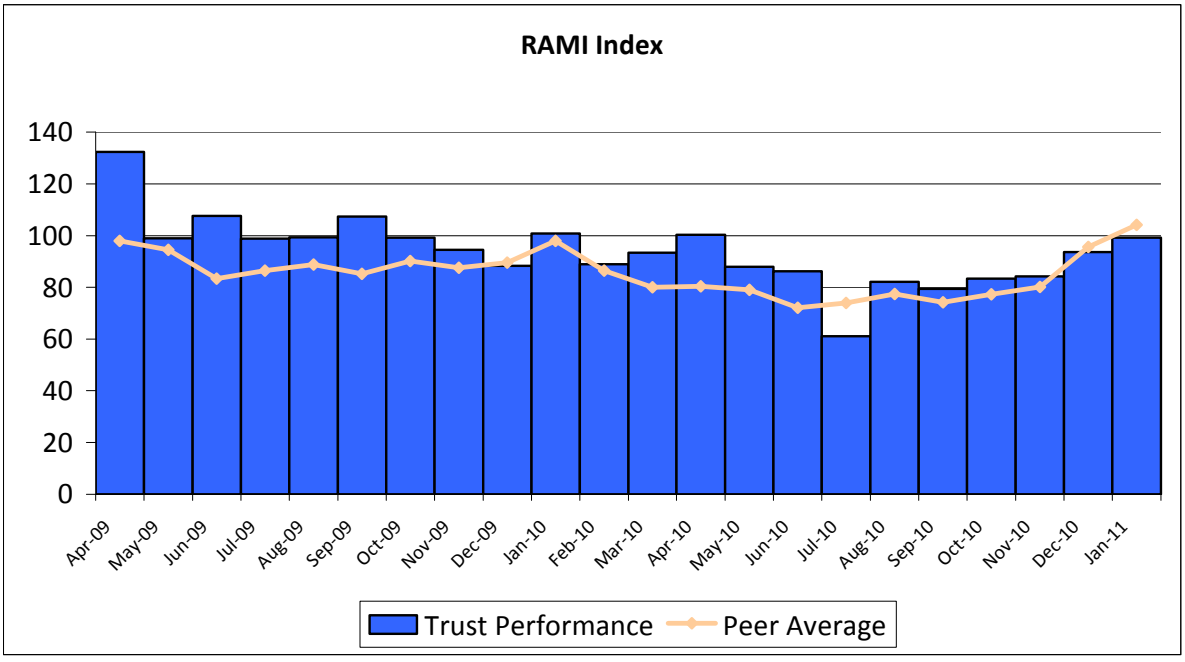
Mortality was chosen as a local priority by:

- 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.

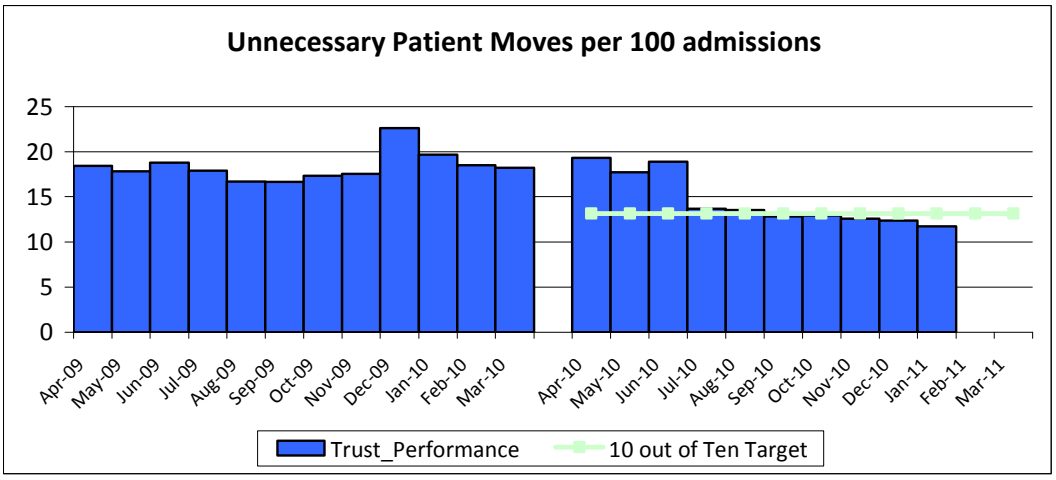
In the Quality and Safety Improvement Strategy the Trust stated it would establish a method of monitoring this quality indicator, gather the historical data and set a target for improvement, this is presented in graph 5.
It can be seen that progress has been made and the Trust has started to reduce the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

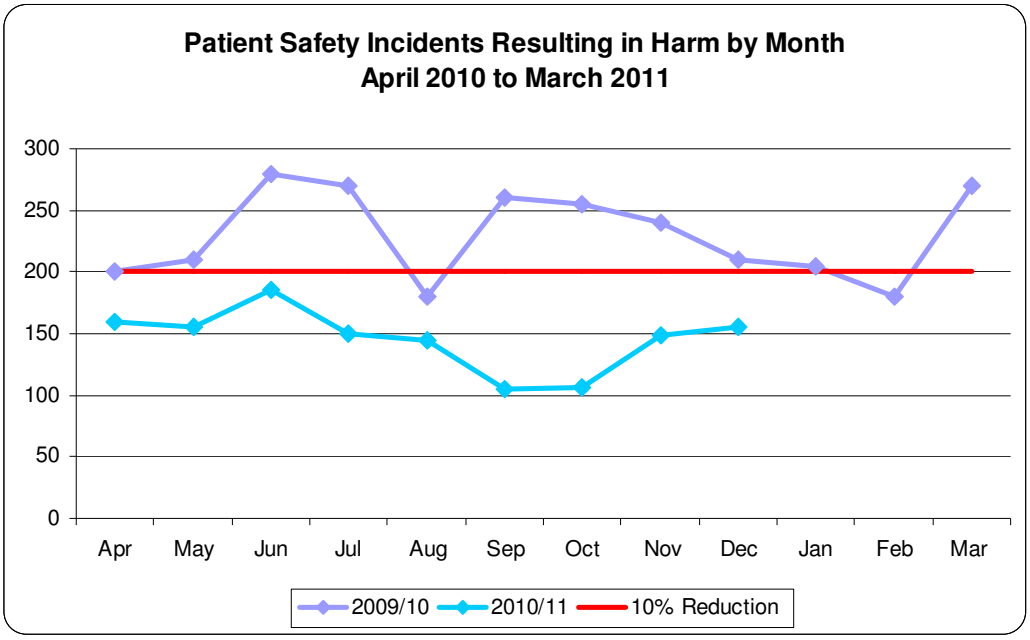
To monitor and reduce the number of patients who experience avoidable harm by 10% annually

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

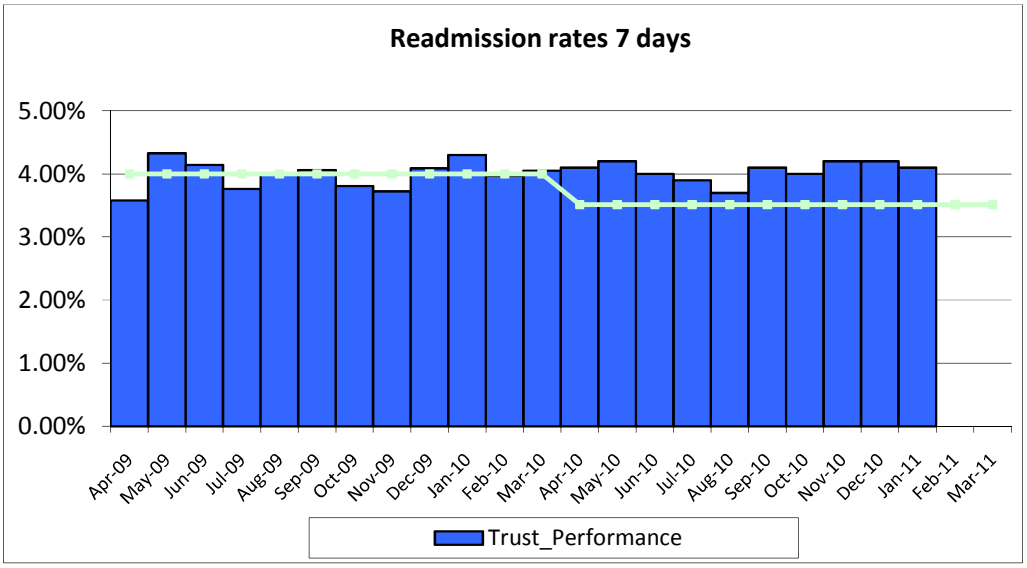
To reduce the number of patients who are readmitted to hospital within 7 days of discharge

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.

:

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.

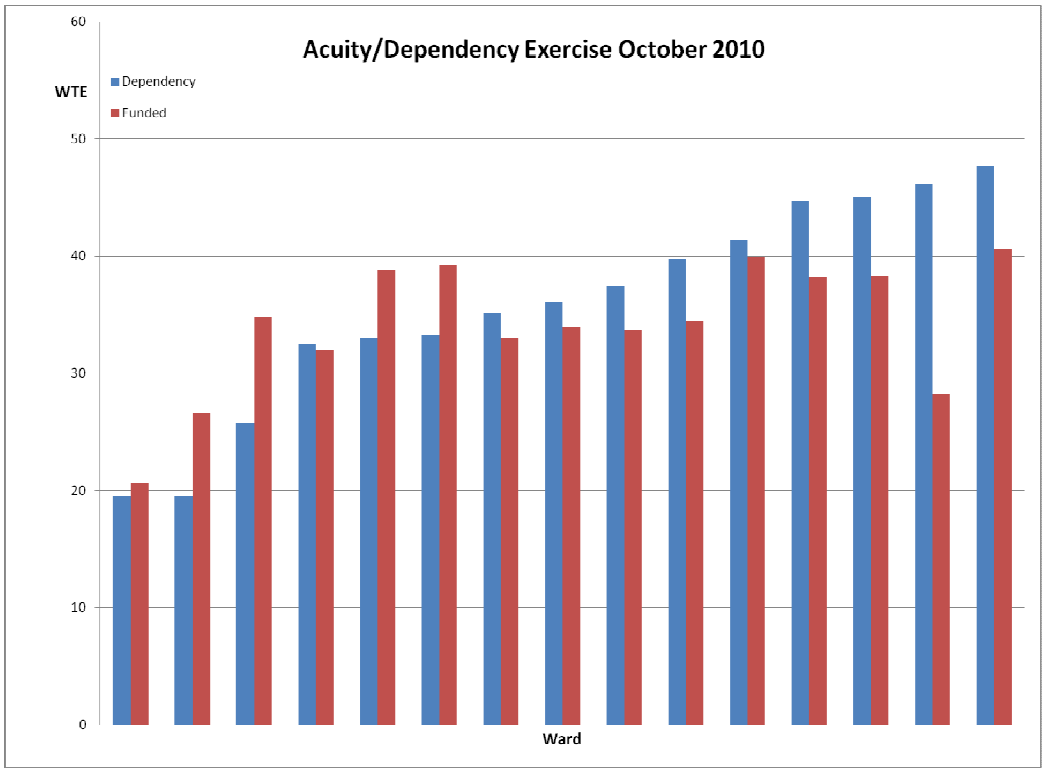
The aim for 2010/11 was that 60% of wards would be within range of their required establishment. In October 2010, 9 of the 15 wards reviewed were within range which means that this target has been achieved.

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.

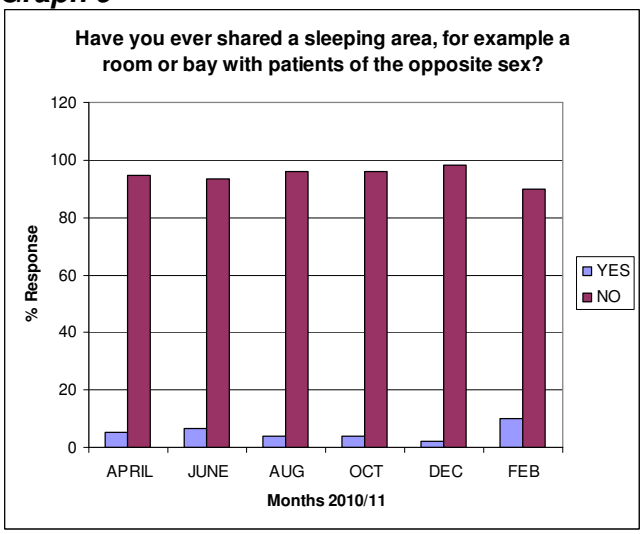
Delivering same sex accommodation was highlighted at the National Dignity Day in March 2011 which was well evaluated by Trust staff.

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

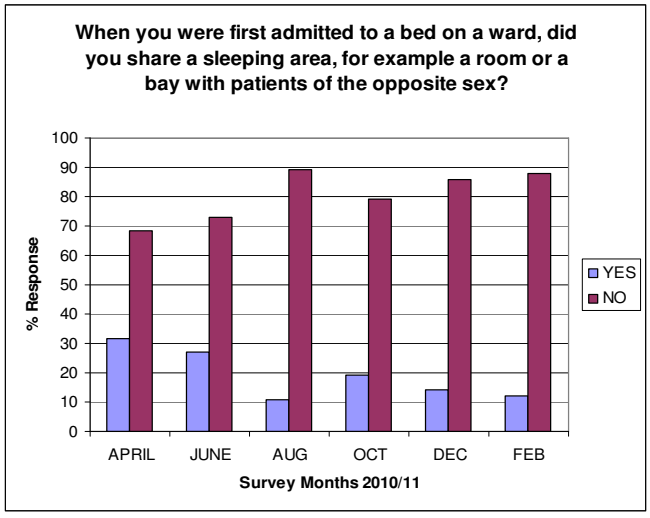
Every month a survey of 100 patients takes place which highlights patient experience in relation to same sex accommodation. As well as answering the specific questions it gives patients an excellent opportunity to discuss any issues or comments they may in respect of privacy and dignity at the Trust.

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

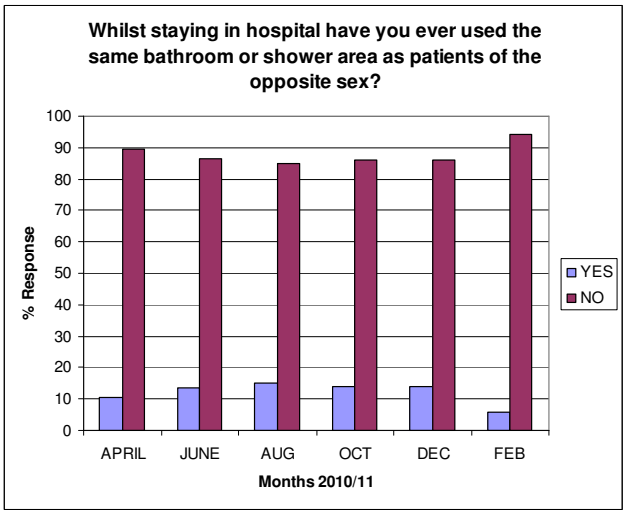
Graph 9



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.

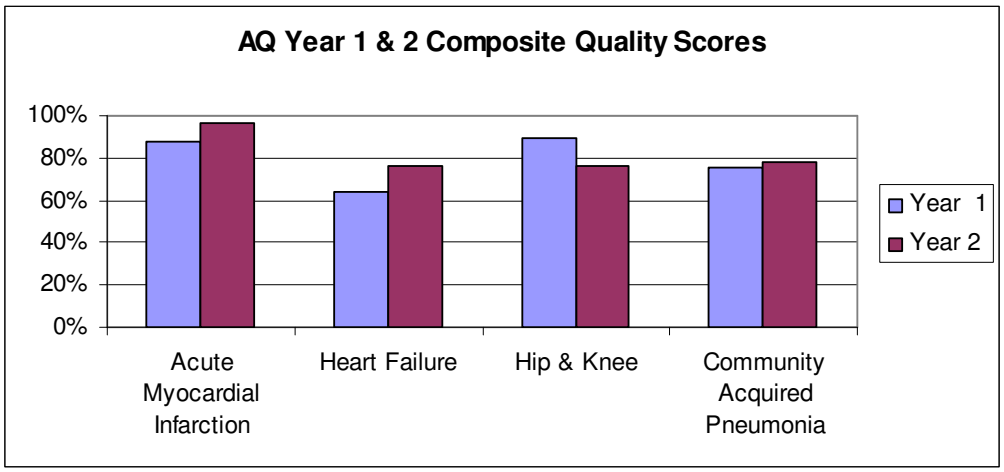
- Acute Myocardial Infarction (AMI)
- Heart failure
- Hip and Knee Replacement Surgery
- Community Acquired Pneumonia

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.

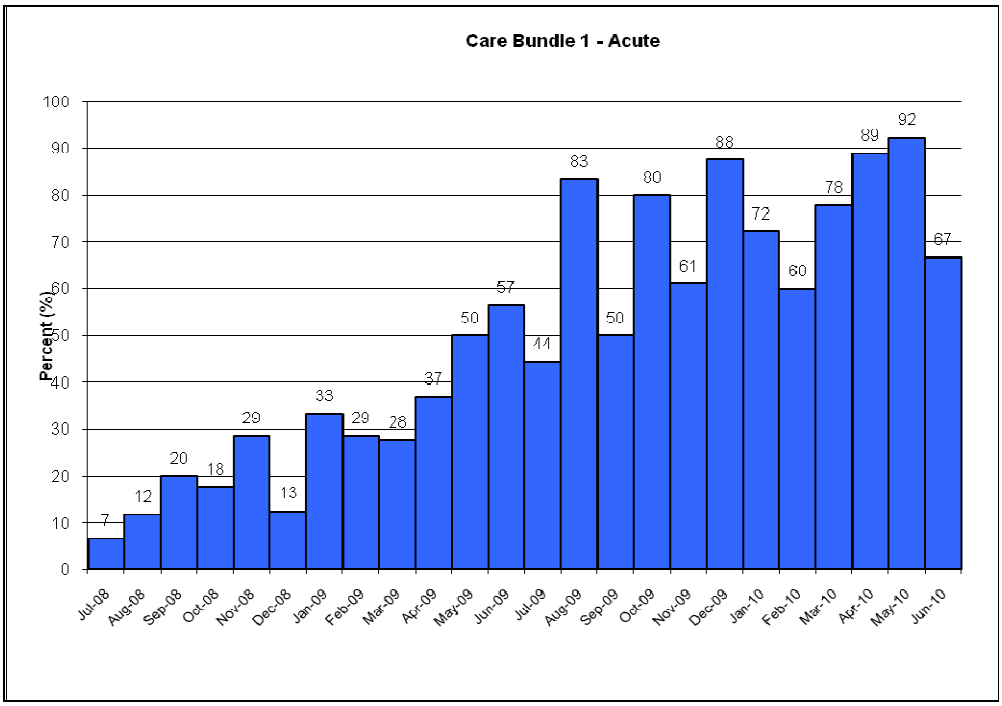
Stroke

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.

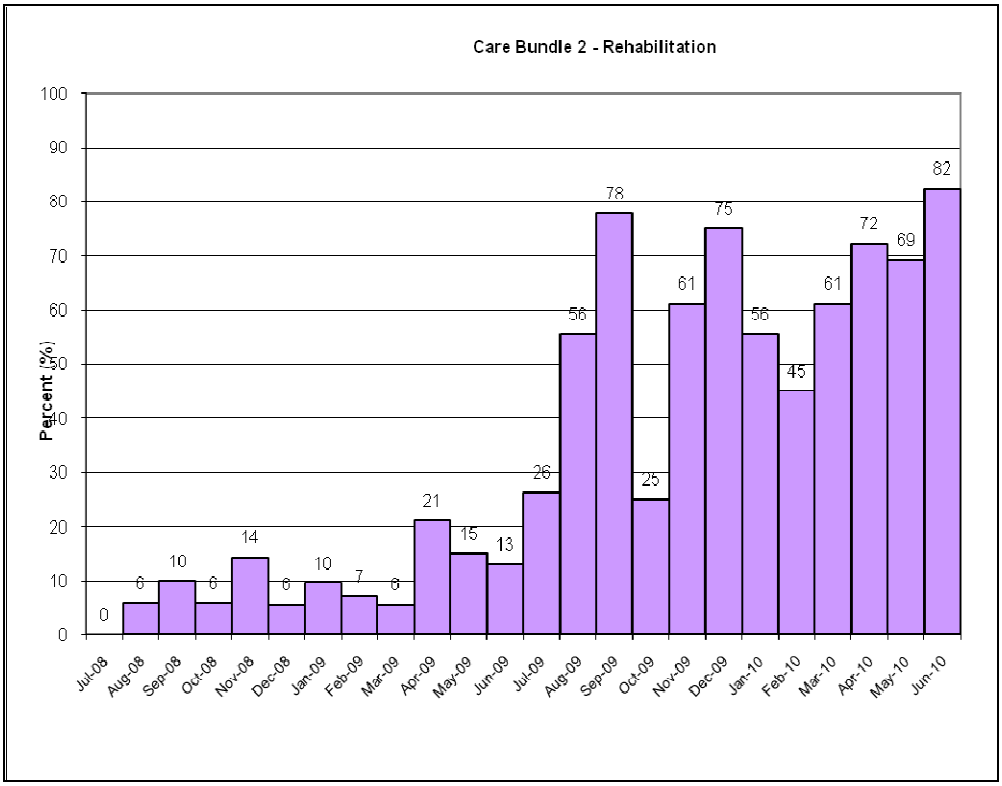
Stroke 90:10 held its summit meeting in November 2010, and the final data submission having taken place in July 2010. The final results from July 2010 for each care bundle are shown in graphs 13 &14

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

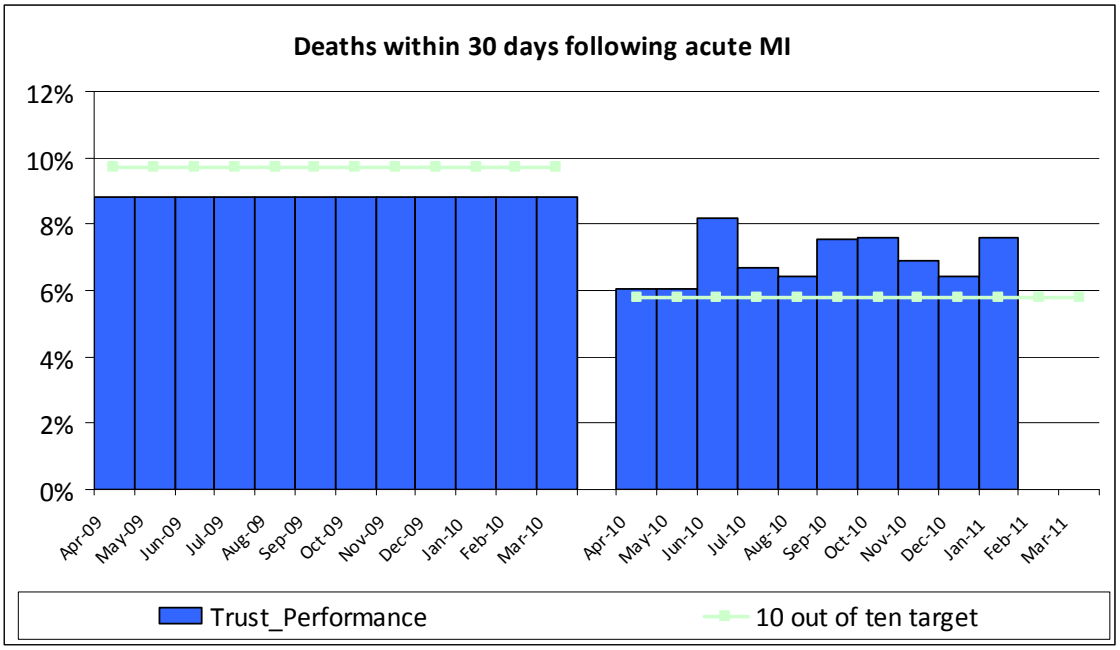
Priority 8 Cardiovascular

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



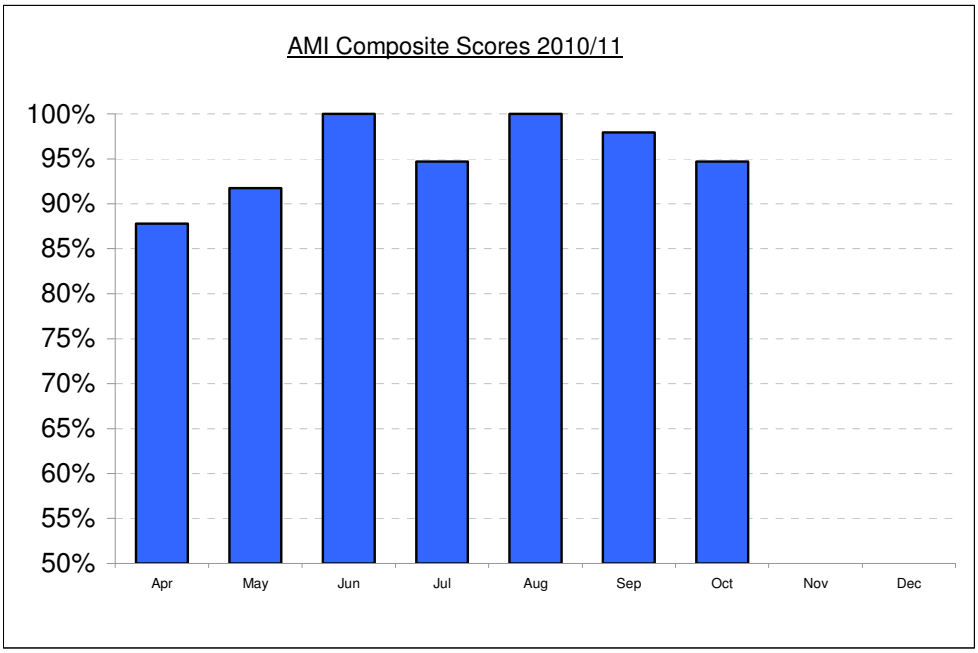
The Trust must also be aware of the outcomes of those patients who return to a normal healthy lifestyle as this is a true measure of success or failure of the AMI programme.

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

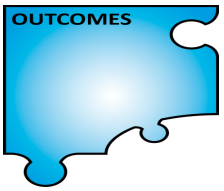
Cancer – To improve survival rates for patients diagnosed with cancer.

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.

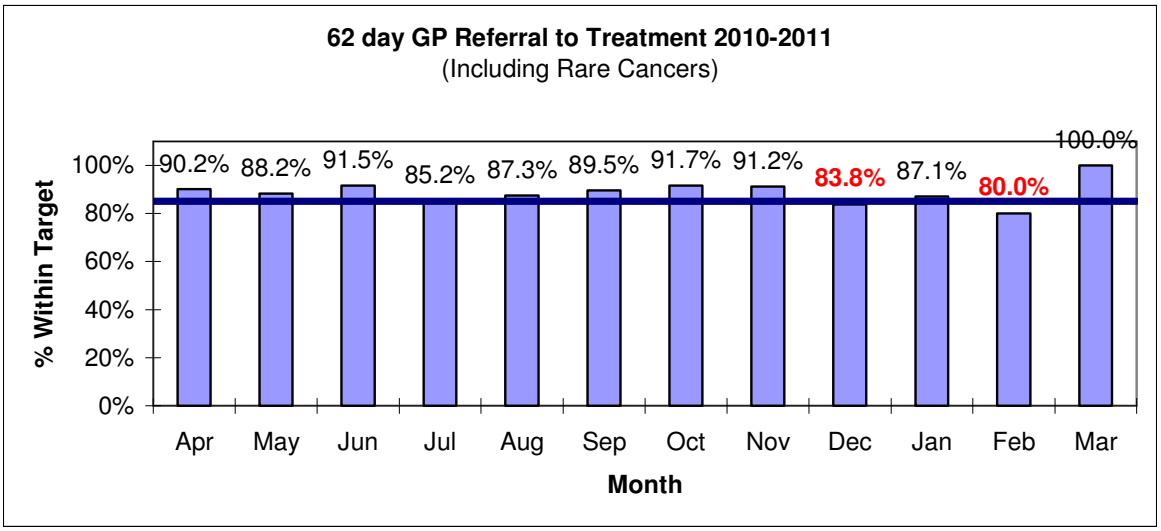
This work is ongoing and further work is planned both at Trust and Greater Manchester & Chester Network level to ensure that pathways are efficient and also to ensure communication between Trusts is effective and within agreed protocols:

- 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.

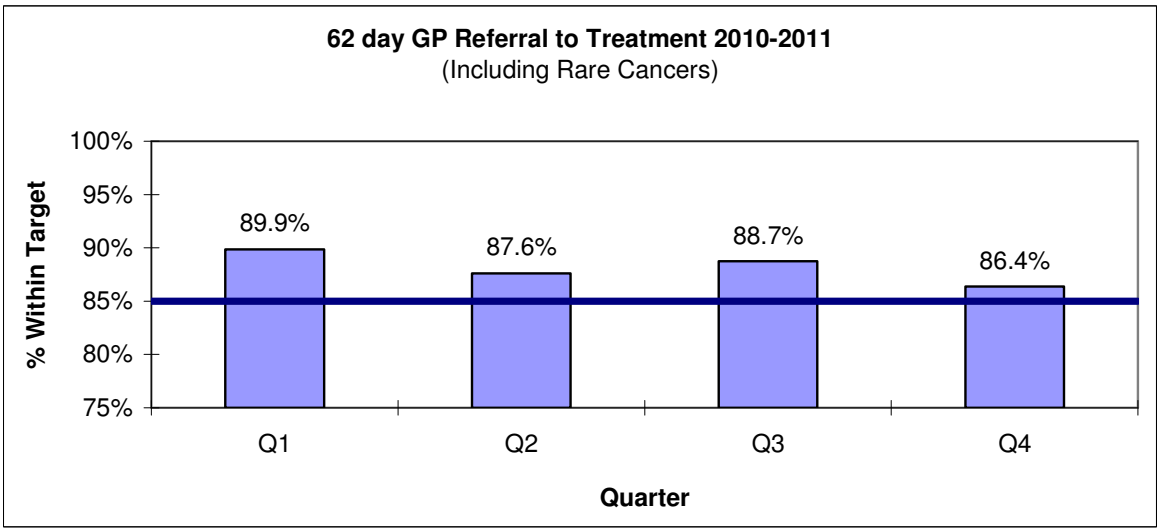
A high number of respondents (41%) highlighted that all 10 indicators were important, with 155 of the 200 surveyed naming Infections as the most important.

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

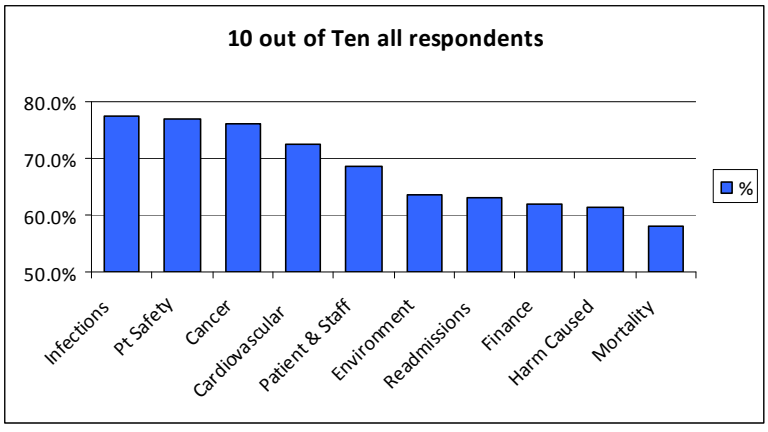
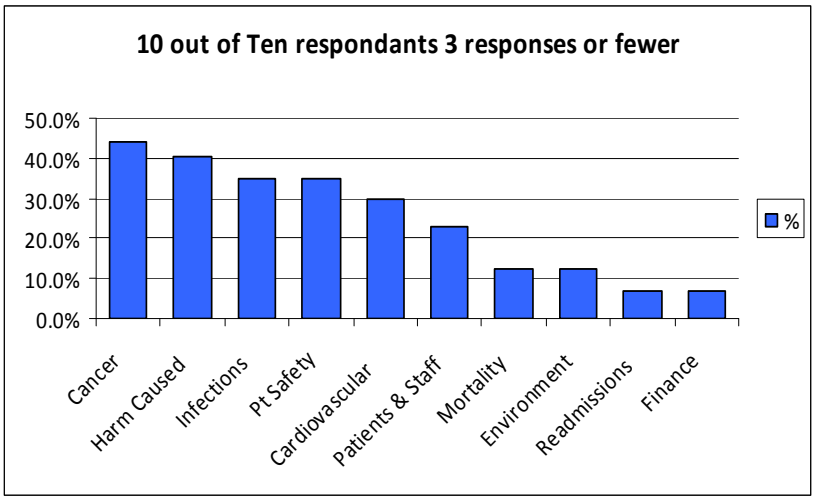


Table 13: Indicators where 3 or fewer chosen 2010/11

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?