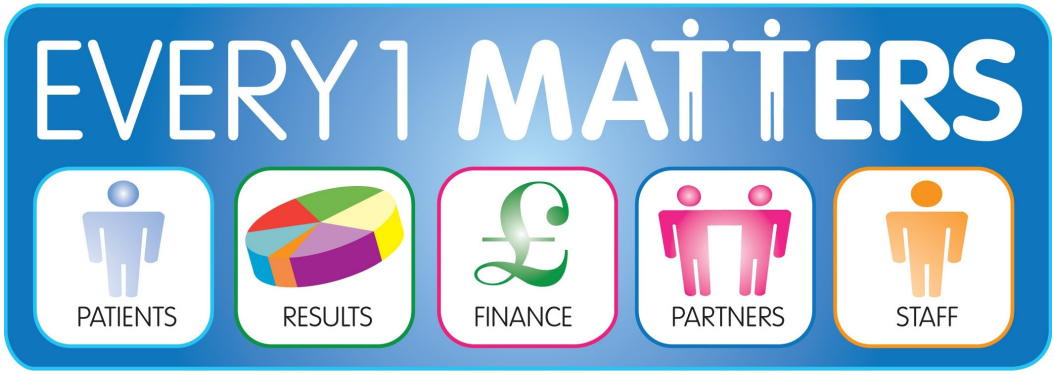
Mid Cheshire Hospitals NHS
NHS Foundation Trust

Quality Account 2011/12

Quality and Safety at Heart

Mid Cheshire Hospitals NHS Foundation Trust
Quality Account 2011/12

"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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Part 1 - Statements on Quality

Summary Statement on Quality from the Chief Executive

I am pleased to present our third published Quality Account, which covers the period of April 2011 to March 2012.

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

2011/12 has been a successful year for the Trust, with a number of great achievements. Firstly, in February we celebrated two years with no MRSA bacteraemia cases. As a result the Trust was considered to be 'Best in Class' of all similar sized Trusts and is ranked within the top 25 Trusts across the country by the Department of Health

Another achievement has been the significant reduction in our mortality rate. Over the past few years our rate has been above average. Following a sustained programme of work over a number of years and a concerted effort by staff across the Trust we have made great progress and are now only one point above our CHKS peer group. Against a planned 10-point reduction we achieved a 12-point reduction against our CHKS Risk Adjusted Mortality Index (RAMI).

The Trust has also received national recognition this year in the form of coveted awards and television coverage. Earlier in the year we were featured on Channel 4's Dispatches programme, which focused on the positive steps we have taken to improve patient nutrition across the Trust. More recently we won the 'Enhancing Patient Dignity' category in the November 2011 Nursing Times Awards for our 'Look at My Ability, Not My Disability' programme, which has improved the hospital experience of patients with learning disabilities.

Either side of winning the Nursing Times award the Trust played a part in two projects which triumphed at the Health Service Journal award ceremonies – one for Central and East Cheshire Community Health's Integrated Respiratory Team, and the other for collaborative working with local Clinical Commissioning Groups which saw a reduction in unnecessary hospital attendances from care homes. Both of these collaborative projects have demonstrated that the Trust is committed to working with the local community to improve the quality of care for patients.

In May the Care Quality Commission (CQC) conducted an unannounced visit to two wards at Leighton Hospital to assess whether older patients were treated with dignity and respect and whether their nutritional needs were met. We are pleased to confirm that the Trust met the standards on both aspects and that we have implemented the minor recommendations needed to ensure that we continue to meet these essential standards.

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I would like to take this opportunity to give a huge 'thank you' to all our staff for their efforts in 2011/12. I would also like to extend my appreciation to our Governors, Members, Patient Representatives and other Stakeholders who have helped shape our quality programme by taking time out to support and advise us.

I 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

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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 Account) Regulations 2010 to prepare the Quality Account 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 2011/12;
- The content of the Quality Report is consistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2011 to March 2012
    - Papers relating to Quality reported to the Board over the period April 2011 to March 2012
    - Feedback from the Commissioners dated ********
    - Feedback from Governors dated ********
    - Feedback from LINks dated ********
    - Feedback from the Overview and Scrutiny Committee dated ********
    - The Trust's complaint report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 19/05/2011
    - The 2011 national patient survey
    - The 2011 national staff survey
    - The Head of Internal Audit's annual opinion over the Trust's control environment, dated 01/06/2011
    - Care Quality Commission (CQC) quality and risk profiles, dated September 2011

- The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over this period;
- The performance information reported in the Quality Report is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions and is subject to appropriate scrutiny and review. The Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Account regulations published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual).

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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

John Moran	Tracy Bullock
Chairman	Chief Executive
Date	Date

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Part 2 - Priorities for Improvement and Statements of Assurance

Quality, Effectiveness & Safety Committee (QuESt)

In recognition of the priority given to quality and safety the Board of Directors has established an Executive Committee known as QuESt. This Committee meets bi-monthly, reports to the Board of Directors and is chaired by the Chief Executive.

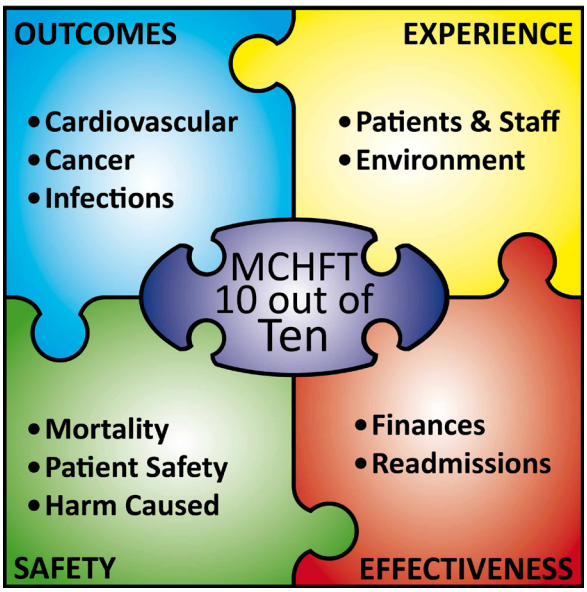
The terms of reference and membership were ratified at the January 2010 meeting of the Board of Directors. The Committee is responsible for providing information and assurances to the Board of Directors that it is safely managing the quality of patient care, the effectiveness of quality interventions 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 also lends support and guidance to all staff to improve quality and safety.

Priorities for Improvement in 2011/12

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

A. Continuous monitoring of the 10 out of Ten
B. Formal reporting of the 10 out of Ten to the Quality, Effectiveness and Safety Committee (QuESt)
C. Individual objective setting embedded as part of the staff appraisal process
D. Review of the Quality & Safety Improvement Strategy 2010/14.



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Safety

Mortality

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

Monitored:
A Hospital Mortality Reduction Group is well established and 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 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 measure mortality rates with the aim of seeing an annual 10 percentage point reduction.

Patient Safety

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

Monitored:
The number of patient moves during each emergency admission is monitored using the Trust's Management Information System. The clinical divisions monitor this information on a monthly basis.

Measured:
All patient moves are measured through the Integrated Care System (ICS) which is the patient management system used by the Trust.

Harm Caused

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

Monitored:
The Patient Safety Team reviews 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 and presented to various committees in the Trust's Governance Structure.

Measured:
The Trust's incident reporting system is used to determine the number of patients who suffer avoidable harm. All patient safety incidents are reported to the National Patient Safety Agency via National Learning and Reporting System (NRLS). The NRLS send the Trust a report every six months on performance measured against other small acute Trusts.

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Effectiveness

Readmissions

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

Monitored:
The Trust monitors patients who have been readmitted as an emergency within 7 days.

Measured:
Readmissions to hospital within a 7 day period following discharge as an emergency admission are measured using ICS.

Finance

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 and compared with available benchmarking data to 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 the total actual expenditure.

Experience

Patients & Staff

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

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. This process is undertaken at least every 6 months. Similar tools for nurses and midwives working in other areas of the Trust and for medical staff are being reviewed, implemented and evaluated.

*Acuity - a description of how unwell a patient is

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Environment

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 quarterly 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.

Outcomes

Cardiovascular

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

Monitored:
The AMI mortality is monitored monthly by the Emergency Care Division (ECD). The ECD reducing mortality group reviews issues and escalates to the Trust's Hospital Mortality Reduction group. The ECD performance report is reviewed and any issues are escalated to the Performance and Finance Committee.

Measured:
The data relating to mortality in AMI within 30 days is collated by the Trust using CHKS on a monthly basis. This rate is benchmarked against the Trust peer organisations.

Cancer

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 is monitored by the Cancer Network. The Acute Oncology Team will report these within the Surgery and Cancer Division.

Measured:
The Acute Oncology Unit will measure the reasons for acute admissions and ensure achievement of preferred place of care for patients diagnosed with cancer.

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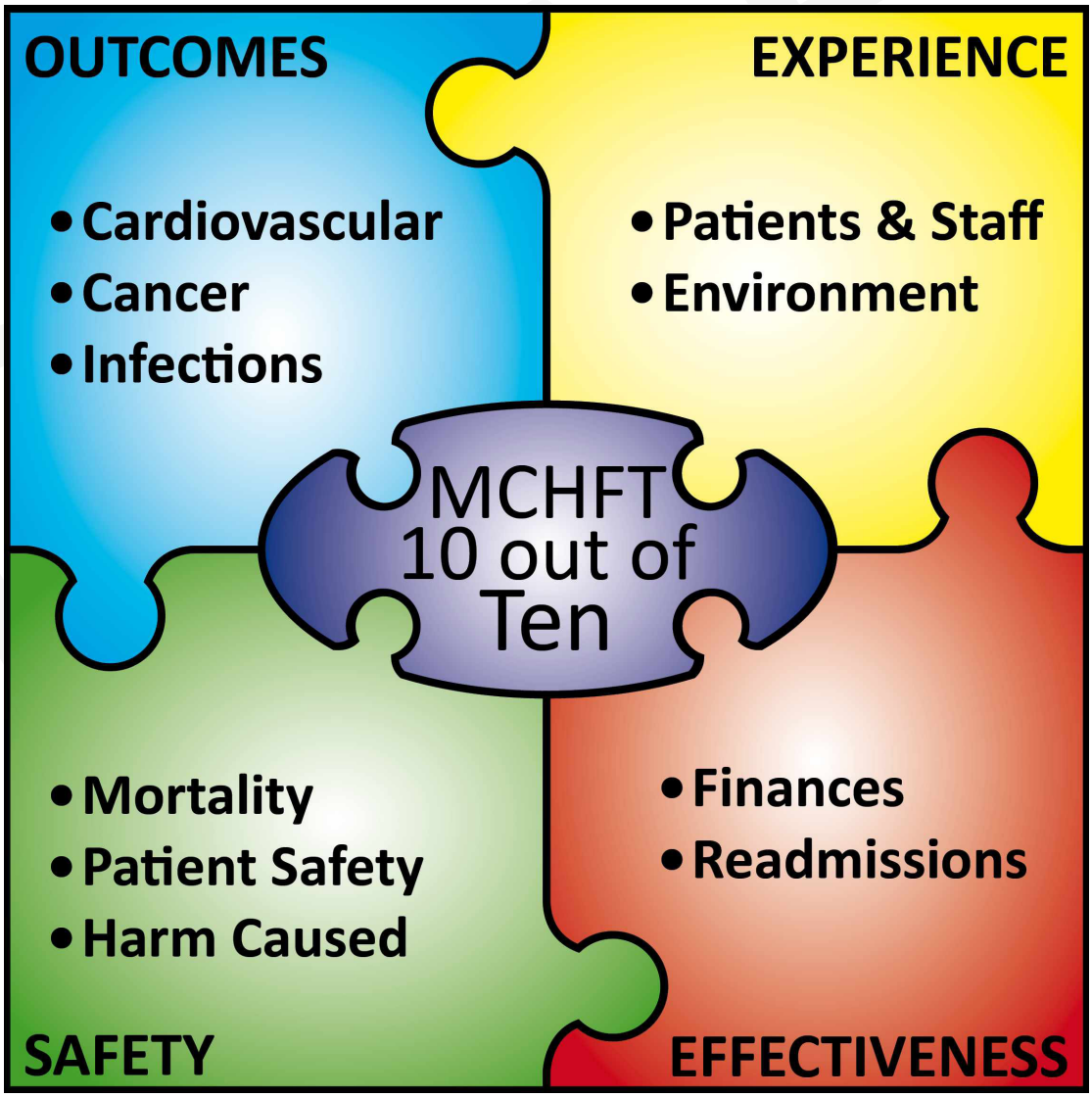
Infections

To reduce the rates of Healthcare Associated Infections (HCAI).

Monitored:
MRSA and Clostridium difficile are monitored on a monthly basis and reported to the Strategic Infection Control Committee which is chaired by the Director of Nursing & Quality.

Measured:
The rates of MRSA and Clostridium difficile are measured and benchmarked nationally by the Health Protection Agency (HPA).



Statements of Assurance from the Board

Review of Services

During 2011/12 the Trust provided and/or subcontracted 39 NHS Services.

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

The income generated by the NHS services reviewed in 2011/12 represents 100% of the total income generated from the provision of NHS services by the Trust for 2011/12.

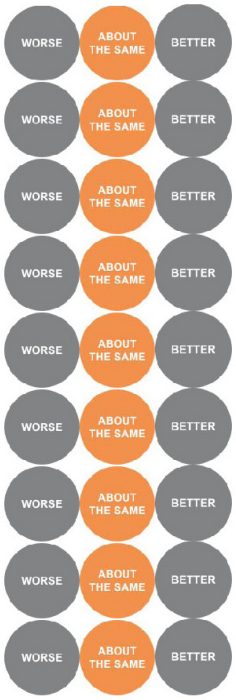
NHS Patient Survey Programme

National Outpatient Survey

The CQC uses national surveys to find out about the experience of patients when receiving care and treatment from healthcare organisations. Between June and October 2011 a questionnaire was sent to patients who had recently attended an outpatient appointment at Leighton Hospital and Victoria Infirmary. Responses were received from 459 patients. The collated results of this survey are displayed below and show that the Trust performed about the same as other Trusts in all categories:

Table 1: Responses to Outpatient Survey 2011/12

How the score compares with other Trusts	
7.3/10	Before the appointment
5.1/10	Waiting in the hospital
8.6/10	Hospital environment and facilities
8.4/10	Tests and treatments
8.8/10	Seeing a doctor
8.8/10	Seeing another professional
8.4/10	Overall about the appointment
6.8/10	Leaving the outpatients department
8.8/10	Overall impression



The full report is available at http://www.cqc.org.uk/survey/outpatient/RBT

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Examples of patient comments from the survey and actions taken:

Although I was there to see a Rheumatologist I was shown to the waiting area for blood tests. I was worried it was the wrong place as it was not explained to me properly.

Action taken:
Signposting has been improved to confirm to patients the correct waiting area

To be kept better informed about the length of time kept I was waiting for my outpatient appointment.

Action taken:
The local standard for patients to be seen within 30 minutes of their appointment time includes ensuring updates are given and times clearly displayed

Patients commented on what was particularly good about their care:

Friendly staff, porters work hard to give patients a good service and reception staff.

Always completely satisfied. Always have complete faith in the treatment. Staff always pleasant and helpful.

Reception staffs were very polite. Very clean waiting area and comfortable seats. My appointment letter always came in the post very quickly and I was always reminded by automated phone calls a few days before to confirm time and date.

National Inpatient Survey

Each year the Trust takes part in the National Inpatient Survey. The questionnaire was sent to 850 patients in October 2011. The results will be made available to the Trust in April 2012 and disseminated to staff. The inpatient survey action group will then meet to review the results and take forward plans for improvement.

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Patient and Public Involvement Programme

The Trust has an annual Patient and Public Involvement Programme which includes methods of patient involvement such as patient surveys. In 2011/12, the Trust participated in 44 local surveys, 12 of which were conducted via the kiosk. Once the feedback has been collated action plans are implemented to address any issues which have been identified from the patient survey. The action plan is then monitored by the Action Group for Patient Experience.

Victoria Infirmary Outpatient Department
49 responses received from a sample size of 80.

The following are the most recent examples of responses received:
- 93% of patients said the outpatient department was clean
- 78% of patients were seen within 30 minutes of their appointment time
- 100% of patients felt they were given enough privacy when discussing treatment
- 92% of patients said staff explained why they needed tests in a way they could understand
- 100% of patients said staff made them feel at ease
- 100% of patients felt they had been treated with privacy & dignity when they attended the outpatient department.

Key issues
- 50% of patients were not informed of clinic delays
- 73% of patients were not told the reason for the delay.

Paediatric Audiology
185 responses received from a sample size of 200.

The following are the most recent examples of responses received:
- 96% of parents said the Audiology department was easy to find
- 83% of parents said that the staff in the Audiology department were very helpful
- 99% of parents and their children were treated with privacy and dignity
- 100% of parents said they would recommend Leighton Hospital to friends and family.

Key issues
- Insufficient information from referrer regarding testing process
- Lack of toys in Victoria Infirmary waiting room

Sexual Health Clinic
81 responses received from a sample size of 100.

The following are the most recent examples of responses received:
- 79% of patients said reception staff in the clinic were welcoming, courteous and helpful
- 90% of patients felt they had confidence and trust in the health care professional treating them
- 83% of patients felt they were treated with privacy and dignity.

Key issues
- Improve patients' perception of confidentiality
- Improve waiting times
- Patients highlighted a need for a hot drinks machine.

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Infection Control
36 responses received from a sample size of 50.

The following are the most recent examples of responses received:
- 97% of patients said the ward environment smelt clean, fresh and pleasant
- 94% of patients said the ward was tidy and uncluttered
- 100% of patients said the toilets were clean

Key issues
- Staff to encourage patients to wash their hands before mealtimes
- Staff to ensure patients and relatives have access to infection control leaflets and information
- Staff to increase the use of appropriate decontamination of hands using hand gel between patient contact.

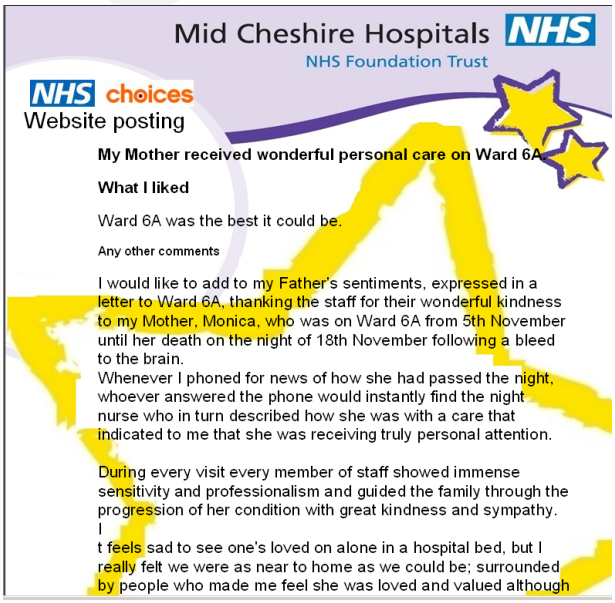
All local patient surveys include a question to ask if they would recommend the Trust to family and friends.

To date, 85% of patients said they would recommend the Trust to family and friends.

NHS choices

Patients can post comments about their experience on the NHS Choices website. There were 37 new postings on the NHS Choices website in 2011/2012.

89% (33 out of 37) of postings said they would recommend the hospital to their friends and family. The Trust displays examples of positive postings on notice boards and actions any suggestions for improvement.


Mid Cheshire Hospitals NHS
NHS Foundation Trust
NHS choices
Website posting
My Mother received wonderful personal care on Ward 6A
What I liked
Ward 6A was the best it could be.
Any other comments
I would like to add to my Father's sentiments, expressed in a letter to Ward 6A, thanking the staff for their wonderful kindness to my Mother, Monica, who was on Ward 6A from 5th November until her death on the night of 18th November following a bleed to the brain.
Whenever I phoned for news of how she had passed the night, whoever answered the phone would instantly find the night nurse who in turn described how she was with a care that indicated to me that she was receiving truly personal attention.
During every visit every member of staff showed immense sensitivity and professionalism and guided the family through the progression of her condition with great kindness and sympathy.
I
t feels sad to see one's loved on alone in a hospital bed, but I really felt we were as near to home as we could be; surrounded by people who made me feel she was loved and valued although

Examples of these include:

Womens, Childrens and Sexual Health Division
Maternity – "Staff were excellent and I was treated with dignity throughout my whole stay."

Maternity - "The midwives were very supportive and reassuring throughout my labour, my after care on ward 23 was excellent."

Maternity - "My experience was awful."

Gynaecology Services - "The atmosphere and environment was exceptionally calming and relaxing. All areas were clean and tidy. The staff were polite, calm and welcoming."

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Emergency Care Division
Emergency department – "I was treated efficiently and well during my visit to A&E. At each stage staff explained to me what was happening."

Surgery & Cancer Division
Urology Services – "Fantastic first time experience! The staff were amazing, friendly and chatty and made me feel at home."
Urology Services – "I was very happy with staff professionalism and attitude, very good indeed."

Urology Services - "I felt belittled and patronised."

Audiology Department - "I was very impressed with the enthusiasm, care and attention given to both me and an elderly aunt."

Ear, Nose & Throat Services - "All staff were friendly, professional and helpful. Both Doctors gave clear explanations and answered all questions thoroughly. I was extremely pleased with the service I received."

Ophthalmology- "Medical staff not communicating clearly."

When the Trust receives negative comments on the NHS Choices, the contact details for the Patient Advice and Liaison Service / relevant Matron are issued to the person posting the comments so they can make contact if they choose to.

Review of Complaints

The Trust adheres to the Local Authority Social Services and National Health Service Complaints (England) Regulations which came into effect in April 2009. This sets out a single approach to dealing with complaints and gives organisations the flexibility they need to deal with complaints effectively. It also encourages a culture that uses people's experiences to make services more effective, personal and safe.

The following table shows the number of complaints received, referred to the Ombudsman, re-opened complaints and Independent Reviews over the past 3 years:

Table 2: Overview of Complaints Received

	2009/10	2010/11	2011/12
Number of complaints received	245	260	173
Number of Independent Reviews undertaken	3	1	0
Number of Requests for Review to the Ombudsman	9	3	9
Number accepted for Review by the Ombudsman	0	0	3

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Participation in Clinical Audits

The Trust is committed to embedding clinical audit throughout the organisation as a process for ensuring that healthcare provision is provided in line with evidence of best practice and improving practice to optimise healthcare services. The process is facilitated through the Clinical Audit Strategy (2010-13) that is sustained through a central Clinical Audit function which reports through the Integrated Governance structure to the Medical Director. Both local and national clinical audit activity is instigated and led by clinicians with the support of the central Clinical Audit function.

During 2011/12, 39 national clinical audits and 1 national confidential enquiry covered NHS services that the Trust provides. This equates to 77% of the national clinical audits and 100% of the national confidential enquiries of the total number in which the Trust was eligible to participate.

Table 3 shows the clinical audits and national confidential enquiries the Trust participated in and the percentage of cases submitted as required by the terms of reference for each clinical audit or enquiry.

Table 3: National clinical audits and confidential enquiries undertaken 2011/12

Audit Title	Participation	Data Submission (%) / Non-Participations Reason
Peri & Neo-Natal		
Perinatal Mortality (MBRRACE-UK)	Yes	
Neonatal Intensive and Special Care (NNAP)	Yes	
Children		
Paediatric Pneumonia (British Thoracic Society)	Yes	80
Paediatric Asthma (British Thoracic Society)	No	Resource implications
Pain Management (College of Emergency Medicine)	Yes	
Childhood Epilepsy (RCPH National Childhood Epilepsy Audit)	Yes	100
Diabetes (RCPH National Paediatric Diabetes Audit)	Yes	100
Acute Care		
Emergency Use of Oxygen (British Thoracic Society)	Yes	
Adult Community Acquired Pneumonia (British Thoracic Society)	No	Resource implications
Non Invasive Ventilation - Adults (British Thoracic Society)	Yes	
Pleural Procedures (British Thoracic Society)	No	Resource implications

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Audit Title	Participation	Data Submission (%) / Non-Participations Reason
Cardiac Arrest (National Cardiac Arrest Audit)	No	Organisational issues delayed registration for 2011/12
Severe Sepsis & Septic Shock (College of Emergency Medicine)	Yes	100
Adult Critical Care (ICNARC CMPD)	Yes	100
Potential Donor Audit (NHS Blood & Transplant)	Yes	
Seizure Management (National Audit of Seizure Management)	Yes	100
Long Term Conditions		
Diabetes (National Adult Diabetes Audit)	No	Currently under review
Heavy Menstrual Bleeding (RCOG National Audit of HMB)	Yes	
Chronic Pain (National Pain Audit)	Yes	
Ulcerative Colitis & Crohn's Disease (UK IBD Audit)	No	Resource implications
Adult Asthma (British Thoracic Society)	No	Resource implications
Elective Procedures		
Hip, Knee & Ankle Replacements (National Joint Registry)	Yes	96.36%
Elective Surgery (National PROMs Programme)	Yes	92%
Peripheral Vascular Surgery (VSGBI Vascular Surgery Database)		Resource implications
Carotid Interventions (Carotid Interventions Audit)	Yes	100
Cardiovascular Disease		
Acute Myocardial Infarction & Other ACS (MINAP)	Yes	99.9
Heart Failure (Heart Failure Audit)	Yes	54
Acute Stroke (SINAP)	Yes	98
Cardiac Arrythmia (Cardiac Rhythm Management Audit)		Resource implications
Cancer		
Lung Cancer (National Lung Cancer Audit)	Yes	100
Bowel Cancer (National Bowel Cancer Audit Programme)	Yes	
Head & Neck Cancer (DAHNO)	Yes	
Oesophago-gastric cancer (National O-G Cancer Audit)	Yes	
Trauma		
Hip Fracture (National Hip Fracture Database)	Yes	n=248

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Audit Title	Participation	Data Submission (%) / Non-Participations Reason
Severe Trauma (TARN)	Yes	
Blood Transfusion		
Bedside Transfusion (National Comparative Audit of Blood Transfusion)	Yes	100
Medical Use of Blood (National Comparative Audit of Blood Transfusion)	Yes	100
Health Promotion		
Risk Factors (National Health Promotion in Hospitals Audit)	Yes	100
End of Life		
Care of the Dying in Hospital (NCDAH)	Yes	
NCEPOD		
Alcohol Related Liver Disease	Yes	In submission

* refers to submission numbers not rates as data submission was commenced part way through the audit.

The reports of 16 national clinical audits were reviewed by the Trust in 2011/12. Table 4 highlights some of the actions taken to improve the quality of healthcare provided as a result of national clinical audits.

Table 4: Action taken following national clinical audit reports

Audit	Actions Taken
Neonatal Intensive and Special Care (NNAP)	In order to meet the requirements of the National Neonatal Audit Programme two year health follow-ups have been initiated for babies leaving the Neo-natal Unit.
Renal Colic (College of Emergency Medicine)	Development of a local Renal Colic pathway with appropriate paperwork/ checklist in conjunction with the Urgent Care Centre, Urology and Radiology departments. Further and on-going departmental triage training is taking place relating to analgesia provision.
Vital Signs (College of Emergency Medicine)	Changes to casualty cards to prompt repeat observations within appropriate timescales. Early Warning Score trigger included in notes to meet clinical indicator targets.
Elective Surgery (PROMS)	PROMS now include varicose vein surgery and hernia repair as well as elective hip & knee surgery. The questionnaire return rates are >90%. The PROMS results are reported at QuESt.
Acute Myocardial Infarction & Other ACS (MINAP)	Acute Myocardial Infarction is no longer thrombolysed within the Trust – minimal revascularisation occurs. Angioplasty services are provided through emergency transfer to University Hospital of North Staffordshire.

Audit	Actions Taken
Bowel Cancer (National Bowel Cancer Audit Programme)	100% discussion at Multi Disciplinary Team (MDT) meetings. The data is now included in the Somerset Database and transferred by the Cancer Services Data Manager to the national database.
Head & Neck Cancer (DAHNO)	The data is now included in the Somerset Database and transferred by the Cancer Services Data Manager to the national database.
Severe Trauma (TARN)	Bi-annual multi-specialty meetings have been incorporated into the Trust's Rolling Clinical Audit schedule in line with essential requirements for Trauma Units.
Bedside Transfusion (National Comparative Audit of Blood Transfusion)	Implementation of a chart for transfusion observations following the previous re-audit has resulted in the Trust meeting the targets for all aspects of the study. Trust Policy incorporates the 'no wristband, no transfusion' practice in line with patient safety and best practice.
Risk Factors (National Health Promotion in Hospitals Audit)	The 2011 health promotion audit showed overall improvements in the assessments of patients' risk factors and improvements in the delivery of health promotion. Examples include: • smoking (81% assessed 2009, 84% assessed 2011) and • alcohol misuse (63% assessed 2009, 78% assessed 2011)

The reports of 62 local clinical audits were reviewed by the Trust in 2011/12. Table 5 highlights some of the actions taken by the Trust as a result of local clinical audits to improve the quality of healthcare provided.

Table 5: Actions taken following local clinical audits

Audit	Actions Taken
Audit of Improving Oral Care for Stroke Patients	Stroke patients developing aspiration pneumonia related to dysphagia require oral care as an integral part of hygiene. The project recommendations resulted in the use of suction toothbrushes and oral care guidelines for nil by mouth and dysphagic patients, being rolled out through the Emergency Care Division.
Quality of Medical Examination Reports in Child Protection Cases	Introduction of standardised medical reports incorporating identification of report writers, improved details of peer discussion, consultant countersignatures and timelines for report dictation or writing.
Management of Post-Partum Haemorrhage (PPH)	Introduction of PPH pro-forma to incorporate initiation of basic resuscitation measures and cross matching of blood where active bleeding occurs and weighing of blood loss in all PPH patients. Emphasis on manual compression during local skill drills.
NICE TA210: Clopidogrel and MR Dipyridamole for Prevention of Occlusive Vascular Events	Trust wise awareness programme implemented to highlight guidelines in line with updated pharmacy policy to meet current therapy recommendations. Stroke nurse involvement in commencing appropriate therapy and inclusion in stroke pro-forma.

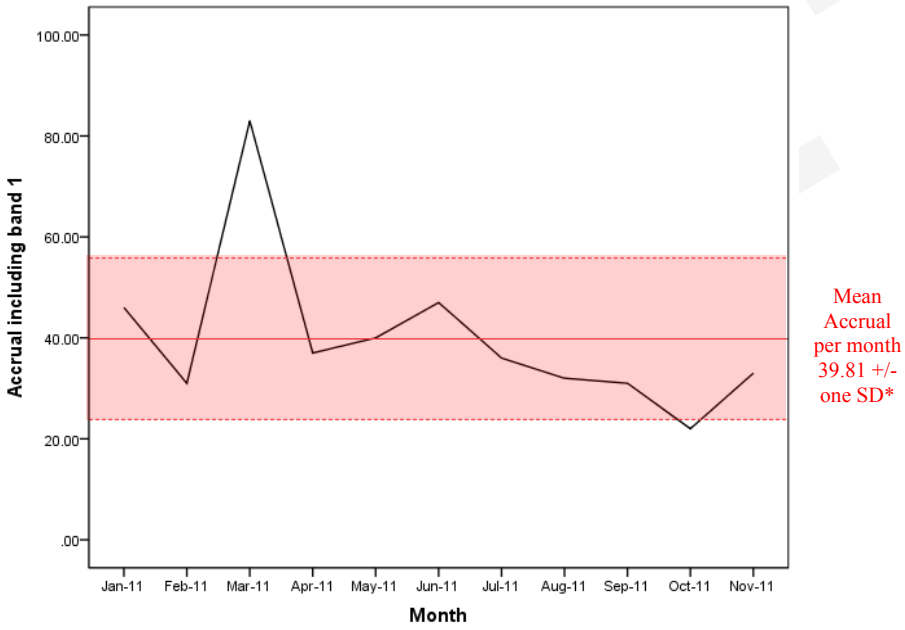
Audit	Actions Taken
Pharmacy Audit of Clopidogrel	Pharmacist counselling on indications and duration of medication on commencement. Issue of twenty-eight day supply of treatment only for Acute Myocardial Infarction patients (STEMI) with date incorporated on discharge medications. One year review date for NSTEMI patients incorporated on discharge medications.
Medicines Reconciliation Re-audit	Instigated review of pharmacy service ward cover. New ward rotas introduced providing extension of cover and a more integrated ward based service. Standardised re-training of the medicines reconciliation process for all existing staff and standardised training implementated for new staff.

Participation in Clinical Research

The number of patients receiving NHS services provided or sub-contracted by the Trust between April 2011 and November 2011 that were recruited to participate in National Institute of Health Research (NIHR) portfolio approved by a research ethics committee was 286.

Graph 1: Number of Patients Recruited to NIHR Portfolio Clinical Trials

*Mean Accrual per month: recruitment on average, just under 40 participants to trials per month between Jan and Nov 2011.



The Trust was involved in conducting 154 active clinical research studies during the reporting period including, but not limited to, the following areas:

- Cardiovascular Disease
- Congenital Disorders
- Diabetes
- Opthalmics
- Generic Health Relevance and Cross Cutting Themes
- Infection
- Inflammatory and Immune System
- Injuries and Accidents
- Medicines for Children
- Musculoskeletal Disease
- Oral and Gastrointestinal Disease
- Primary Care
- Renal and Urogenital Disease
- Reproductive Health and Childbirth
- Respiratory Disease
- Skin Disease
- Stroke

There are nine clinical research staff participating in research approved by a research ethics committee during the reporting period. Participation in clinical research demonstrates the Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

Below is one patient's personal experience of participating in the HELP[1] trial.

Ella's Story

"I felt apprehensive when I was first approached about taking part in the HELP study. I thought "another diet!" But what did I have to lose? The research midwife came to my home and she explained the programme then asked a million and one questions! Then it was time for me to be weighed. As usual I made excuses, I'm pregnant, it doesn't matter. But deep down I knew it did matter. The day of the first meeting arrived. I didn't much feel like going and I thought it would be another diet to learn that I probably won't stick to! I was also feeling very tired as I was still working and also Mum to three energetic children! Anyway, I went to the group.

"The Midwives, the Slimming Club ladies, and also the other Mums-to-be were really welcoming and soon I started to relax and enjoy the group!

"At first, the diet/healthy eating plan seemed confusing and complicated but I took my welcome pack with a smile. The midwives explained the maternity side of the programme and slimming club representatives explained the eating plan and answered all our questions. If there was something they were unsure of, they would find out for us. I went home feeling positive that I had made a good choice for me and my baby bump. Especially as I was starting to have early symptoms of Symphysis Pubis Dysfunction (SPD), so the healthier I was the better it would be for managing the condition.

"Once at home I read through all the booklets and the next day I started the plan. I was surprised at how easy it actually was. If I was unsure about syns (extra foodstuff you are permitted per day) I just sent a text and the reply was sent to my phone! I soon settled into the plan and even started to cook for the family! NO more double shopping, we were all eating the same - healthy!

"As my pregnancy progressed, so did the SPD. My mobility was worsening every day and soon needed crutches and at the end even a wheelchair. I started to think I couldn't continue with the HELP programme,, I couldn't exercise so what was the point in trying to follow the 'diet'. But I tried to go to as many meetings as possible and came home sore but glad that I had been. At the group I had support from everyone and had a laugh, it was now also my support group! On the weeks I wasn't able to make it, I had a friendly phone call from the midwives to check all was OK. At first my Husband didn't like the idea of me doing the plan. He thought it would be bad for me and the baby. I kept telling him all about the plan and that it wasn't so much a diet but a plan to teach healthy eating and that he was also on the plan but hadn't realised! Before I knew it, I gave birth to my beautiful son who weighed an impressive 9lb 9oz!

"I was excited about my first weigh in without the baby bump! I closed my eyes as I stood on the scales and couldn't believe it when I opened them and saw that I weighed less than when I started! I really feel that without the group I would've put on an enormous amount of weight, especially because the SPD meant I wasn't able to exercise at all and spent pretty much all day lay on the sofa.

"Every day I feel stronger and in less pain and am slowly getting my mobility back. I am still going to

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[1] Healthy Eating and Lifestyle in Pregnancy (HELP): A cluster randomised trial to evaluate the effectiveness of a weight management intervention in pregnancy on weight at 12 months following birth, gestational weight gain and pregnancy and birth outcomes.

the group each week because I can until my baby is 6 weeks old. I have managed to continue with my healthy eating and am enjoying a weight loss each week. I have found a slimming group near to where I live and when it's time I shall enroll and continue until I reach my goal of getting a healthy BMI before the end of my maternity leave!"

CQUIN: Commissioning for Quality & Innovation framework

The CQUIN framework was introduced in April 2009 as a national framework for locally agreed quality improvement schemes. These schemes require the development of clear plans and goals through agreement between providers and commissioners. The goals have a proportion of the provider's contract income linked to them which is earned by the provider upon achievement of the goals. The overall financial value of CQUIN schemes is currently 1.5% of the provider's contract value. The expected financial value of the 2011/12 CQUIN scheme is approximately £2,050,000. The NHS Institute for Innovation and Improvement designed a standard template for CQUIN schemes to ensure each goal is clearly defined and able to be measured with a financial weighting attributed as a percentage.

For 2011/12, there were two national CQUIN goals which focussed on the prevention of Venous Thromboembolism (VTE) (goal 1) and Patient Experience (goal 2). The Strategic Health Authority (SHA) negotiated seven regional goals with commissioners which were included within MCHFT's CQUIN scheme. These related to Advancing Quality (AQ) (goals 10-15) and the Trauma Audit and Research Network (TARN) (goal 16). The Trust and the local commissioners also agreed a further seven local goals (goals 3-9).

The following table shows the Trust's performance against each of the CQUIN goals. It can be seen that of the 16 goals agreed that the Trust achieved fourteen goals and has plans in place to address the two areas that were not achieved.

Full details of the CQUIN schedule are available on the Trust's website under 'Quality' which can be accessed via the homepage at www.mcht.nhs.uk.

Table 6: CQUIN Results

Goal No.	Goal Name	Description of Goal	Achieved / Not Achieved
1	Venous Thrombo-embolism (VTE) prevention	Reduce avoidable death, disability and chronic ill health from VTE.	✓
2.	Patient experience – personal needs	Improve responsiveness to personal needs of patients	✗
3.	Admission avoidance	Development of an emergency referral system for GPs that avoids admission to hospital	✓
4.	Patient passports for people who are frequent attendees at A&E	Reduction in the number of people identified as frequent attendees to A&E being admitted to hospital	✓
5.	Learning Disabilities	Improve the care of people with Learning Disabilities	✓
6.	End of Life Care	Reduce the numbers of patients who die in hospital where their preferred place of care is not in hospital	✓
7.	Paediatric Passport	Development and implementation of patient passport for children with complex health care needs	✓
8.	Dementia Care	Improvement in the care of patients diagnosed with Dementia	✓
9.	Management of High Cost Drugs	To ensure high cost medicines and technologies are used in a safe, effective and appropriate way within available funding	✓
10.	AQ Acute Myocardial Infarction	Implementation of AQ Care Pathway Acute Myocardial Infarction	✓
11.	AQ Heart Failure	Implementation of AQ Care Pathway Heart Failure	✓
12.	AQ Hip and Knee Replacement	Implementation of AQ Care Pathway Hip and Knee Replacement	✓
13.	AQ Pneumonia	Implementation of AQ Care Pathway Pneumonia	✗
14	AQ Stroke	Implementation of AQ Care Pathway Stroke	✓
15.	AQ Patient Experience	All patients complete an AQ Patient Experience Measures Survey	✓
16.	TARN	Submission of TARN data to SHA	✓

For goals 10 -15 the Trust anticipates the recorded results. The reporting period for the Advancing Quality Programme does not close until August 2012.

✓ = Achieved ✗ = Not Achieved

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Care Quality Commission (CQC)

The Trust is required to register with the CQC and its current registration status is unconditional. The CQC has not taken enforcement action against the Trust during the period April 2011 to March 2012. The Trust has participated in special reviews and investigations by the CQC relating to the following areas between April 2011 to March 2012.

- CQC/Ofsted Integrated Inspection of Safeguarding and Looked After Children's Services in East Cheshire.

  The report highlighted the Youth Council, which is a voice for young people on the services provided within the Trust, as very good and also mentioned the high quality knowledge and well embedded awareness regarding childrens' safeguarding within the Maternity Department.

- A targeted inspection programme in acute NHS hospitals to assess how well older people are treated during their hospital stay.

  The unannounced review of the Trust looked into:

  Outcome 1:
  People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run:

  The report stated that all patients were happy with the way staff treated them and that they were treated with dignity and respect. The inspectors declared the Trust compliant with Outcome 1.

  Outcome 5:
  Food and drink should meet people's individual dietary needs:

  The report highlighted a number of good practices within the Trust and most patients seemed satisfied with the quality of the food and commented that it arrived hot. The CQC did comment on confusion around the Red Plate system. To address these minor concerns an action plan was developed. This included clarity about the Red Plate programme and how it is used and actions to ensure the correct completion of fluid balance charts and food charts. This action plan was completed within the allocated timescale.

Quality and Risk Profiles (QRP)

The CQC plans to keep a constant check on all information that is available for each organisation. This intelligence is collated into a QRP which is published for each organisation on a monthly basis. The QRP aims to gather all the quality and safety information known about a provider in one document. This enables the CQC to assess where risks lie and guides front line regulatory activity such as inspection.

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The Director of Nursing and Quality, Deputy Director of Nursing and Quality and the Governance Lead meet with the CQC to review the information held in the QRP on a quarterly basis. This gives the Trust an opportunity to provide information for any areas of concern and provide assurance to the CQC.

Data Quality

NHS and General Practitioner Registration Code Validity

The Trust submitted records during 2011/12 to the Secondary Uses Service for inclusion in the Hospital Episodes Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was:

**** 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 Practitioner Registration Code was:

**** for admitted patient care;
**** for out patient care;
**** for accident and emergency care

Information Governance Toolkit Attainment

The Trust's Information Governance Assessment Report score overall for 2011/12 was 68% and was graded unsatisfactory. Although the Trust achieved an unsatisfactory rating, the Trust has improved its submission by 24% since 2010/11 submission.

Progress on the Toolkit is monitored through the Integrated Governance Monthly Report which is reported at the Operational Integrated Governance Committee. Each Toolkit lead also provides an update on their section of the IG Toolkit action plan to the Information Governance Committee which meets on a quarterly basis.

Clinical Coding Error Rate

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

- Primary Diagnoses incorrect: 10.0%
- Secondary Diagnosis incorrect: 9.6%
- Primary Procedures incorrect: 3.8%
- Secondary Procedures incorrect: 8.3%

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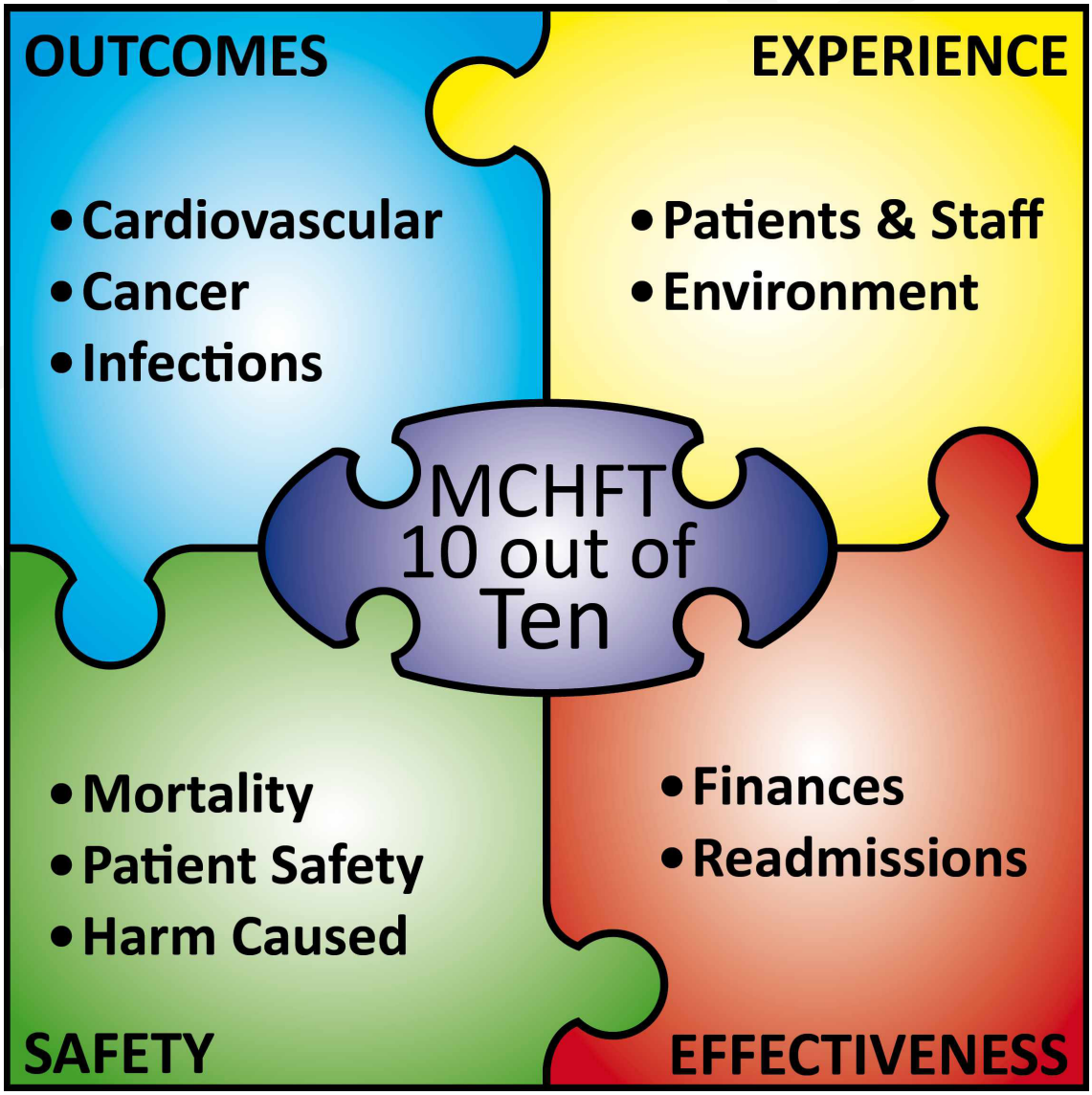
Part 3 - Review of Quality Performance

The 2011/12 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 Summary of Overall Progress

Safety

Priority 1: Mortality – to reduce mortality rates by 10 percentage points in patient groups where death is not expected 

Priority 2: Patient Safety - to monitor and reduce the number of unnecessary patient moves during a patient's stay in hospital 

Priority 3: Harm Caused- to monitor and reduce the number of patients who experience avoidable harm by 10% annually 

Effectiveness

Priority 4: Readmissions – to reduce the number of patients who are readmitted to hospital within 7 days of discharge 

Priority 5: Finance – to reduce the percentage of the Trust's budget that is spent on management costs 

Experience

Priority 6: Patients & Staff – to ensure that the ratio of doctors & nurses to each inpatient bed is appropriate for delivering safe high quality patient care 

Priority 7: Environment - to monitor and eliminate mixed sex accommodation for all patients admitted to the Trust (unless based on clinical need) 

Outcomes

Priority 8: Cardiovascular – to reduce the 30 day mortality rate in patients following Acute Myocardial Infarction (AMI) 

Priority 9: Cancer – to reduce acute admissions and length of stay in hospital following early complications of diagnosis and / or treatment of cancer 

Priority 10 Infections – to reduce the rates of Healthcare Associated Infections (HCAI) 

 = Achieved

 = Not Achieved

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Safety

Priority 1: Mortality

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

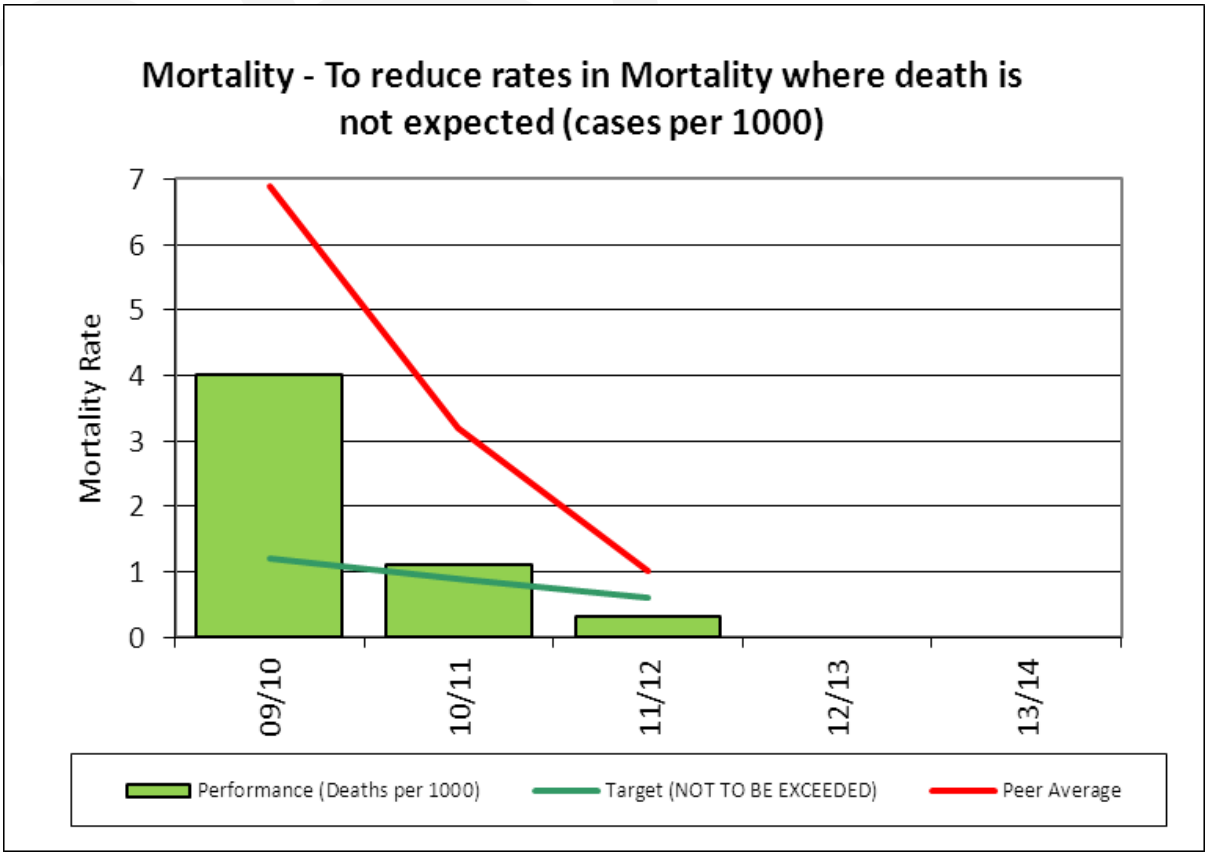
In order to understand whether people are getting healthier or our Trust is getting safer, it is necessary to calculate the death rate. The crude death rate is the number of people who die in relation to the number of hospital admissions The Risk Adjusted Mortality Index (RAMI) takes into account several factors including the relative risk of each patient's conditions and displays this as an index (100 being the expected rate). In general terms, the rationale for calculating death rates in hospital is so they can be used as a measure of hospital quality.

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 2: Mortality rates where death is not expected



A mortality ratio is described as the number of observed deaths divided by the number of predicted deaths. The technical definitions for observed deaths and predicted deaths vary from model to model. The two largest commercial companies that supply mortality data to the NHS are Dr Foster and CHKS.

Dr Foster
Dr Foster's Hospital Standardised Mortality Rate (HSMR) is based upon hospital episode statistics for the 56 clinical classification system diagnostic groupings that lead to 80% of all in-hospital deaths. The risk of death is calculated for each individual admission using binary logistic regression and adjustments are made for the factors that have been found by statistical analysis to be significantly associated with hospital death rates. These include:

- Age
- Sex
- Emergency status
- Number of prior emergency admissions
- Socio-economic deprivation
- Co-morbidity
- Palliative care
- Month of admission (for some respiratory diseases)

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

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

CHKS is the provider of comparative information and quality improvement services for healthcare professionals. The Trust uses the CHKS Signpost benchmarker to calculate the Risk Adjusted Mortality Index (RAMI).

The Summary Hospital Level Mortality Indicator
In view of the controversy arising from the different statistical models used to measure hospital mortality rates, in 2010 the Department of Health set up a steering group to look into mortality measurement and devise a new measure that could be used throughout the NHS. As a result the NHS Information Centre launched the Summary Hospital-Level Mortality Indicator (SHMI) in October 2011, with the data being published on NHS Choices.

Work Programme to Improve Hospital Mortality Rates
Since 2009 reducing the Trust's mortality rate has been led by the Hospital Mortality Reduction Group. Data from CHKS submitted to the Board of Directors each month has shown that the Trust's RAMI has fallen year on year, and is now similar to that of our peer group, albeit still higher than the England average.

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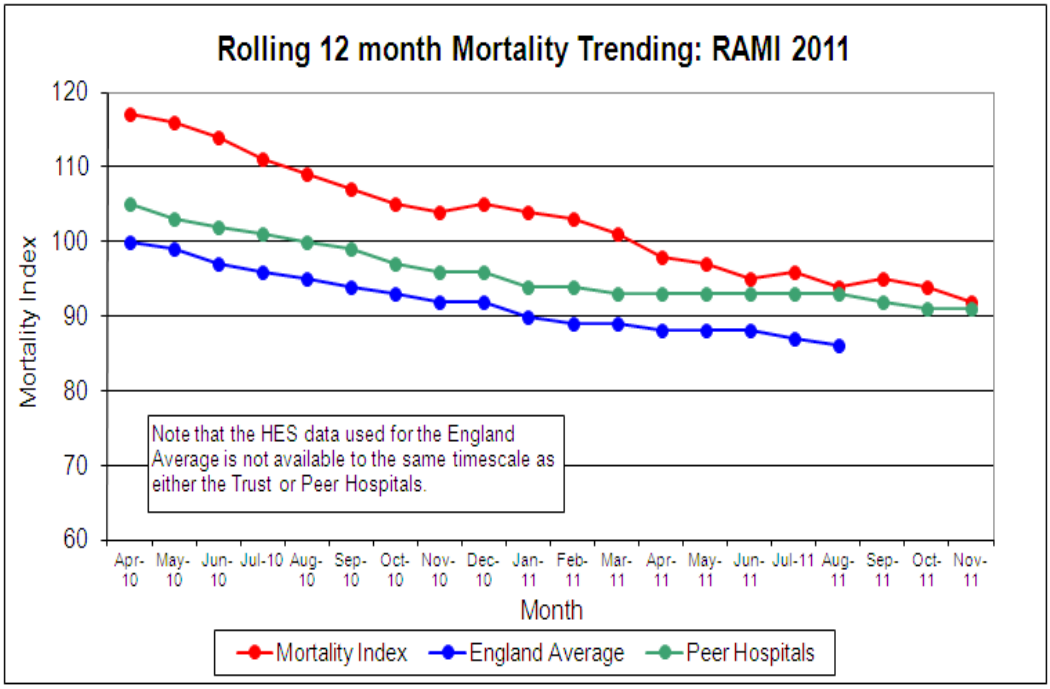
Graph 3: Rolling 12 Month Mortality Trending : RAMI 2011/12



(Source:CHKS Signpost 2011)

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Safety

Priority 2: Patient Safety

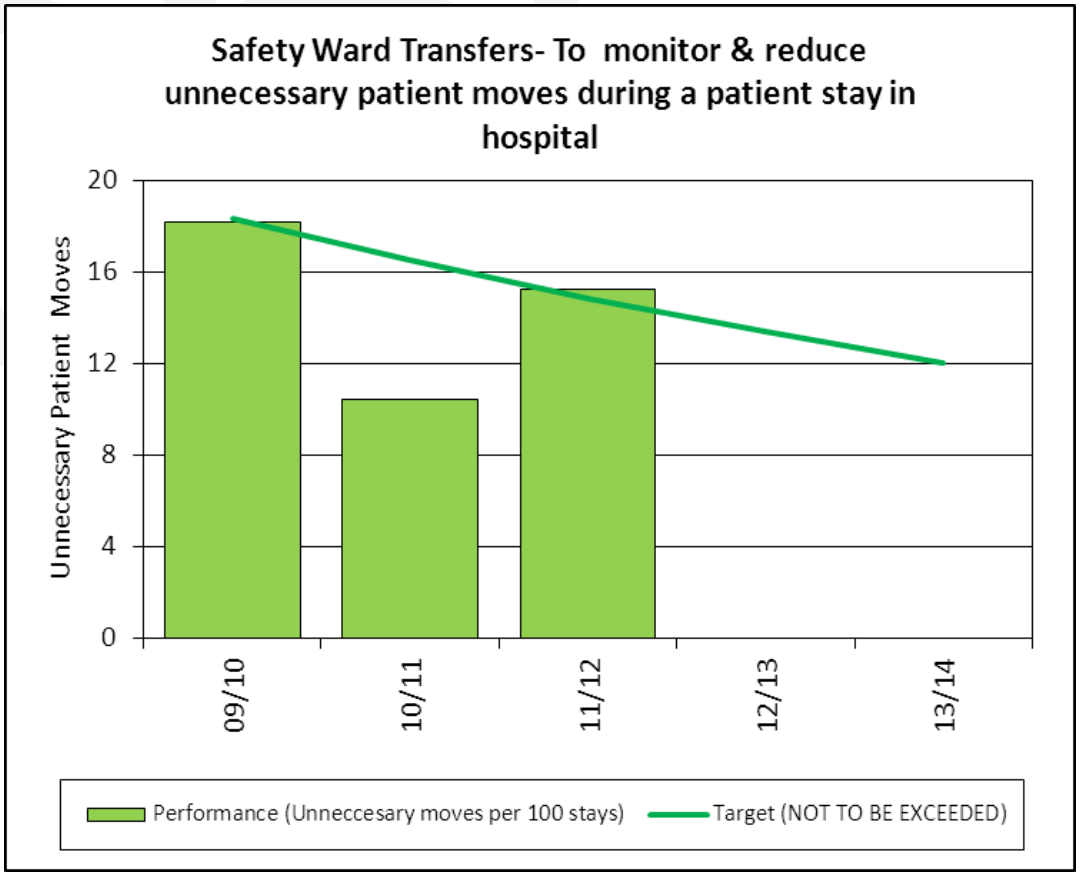
To monitor and reduce the number of unnecessary patient moves during a patient's stay in hospital

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

Last year, following the Quality and Safety Improvement Strategy 2010-14, the Trust established a method of monitoring this quality indicator, gathered the actual performance data from 2009/10 and set a target for improvement. This target was to achieve a 10% reduction, from the 2009/10 performance, in unnecessary ward moves each year for the remaining 4 years of the strategy.

Graph 4 shows the average number of unnecessary patient ward moves per 100 hospital stays since April 2009. This graph shows that the Trust achieved a 37% reduction up to 2011/12 from the 2009/10 levels, which is ahead of the target level set for that year.

Graph 4: Unnecessary Patient Moves per 100 hospitals stay



The Trust intends to reduce further the number of unnecessary patient ward moves by continuing the actions it has taken in 2011/12:

- Ensuring patients are admitted to the appropriate specialty and ward to care for their needs
- Monitoring and investigating the care of patients who have moved frequently during their hospital stay
- Ensuring the bed configuration matches the demand for each specialty. This will be done through the Clinical Service Strategy which includes proposals around an acute short stay ward and a frail elderly service
- Continuing to reduce the time a patient spends in hospital and therefore reduce the opportunity for them to be moved unnecessarily
- Ensuring that reducing unnecessary ward moves is a personal objective of each member of the Patient Placement Team (who oversee ward moves within the hospital).

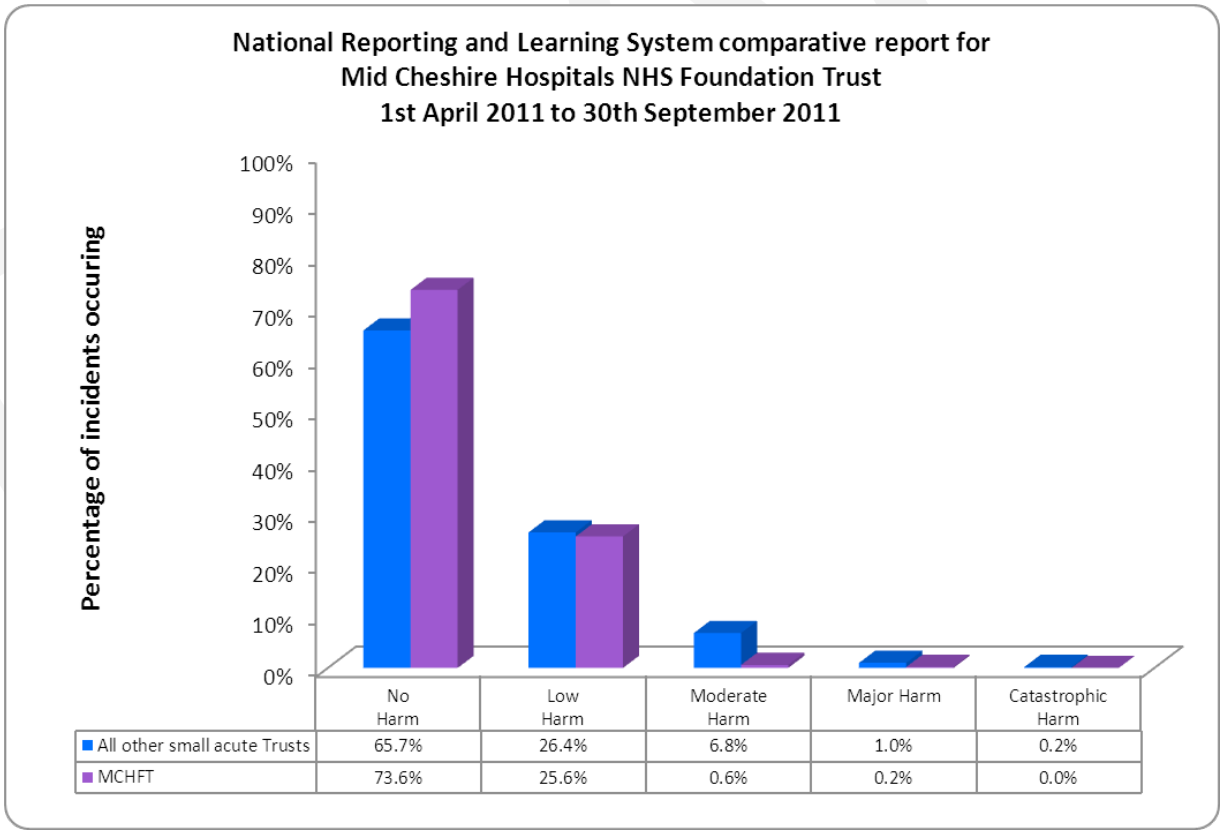
Safety

Priority 3: Harm Caused

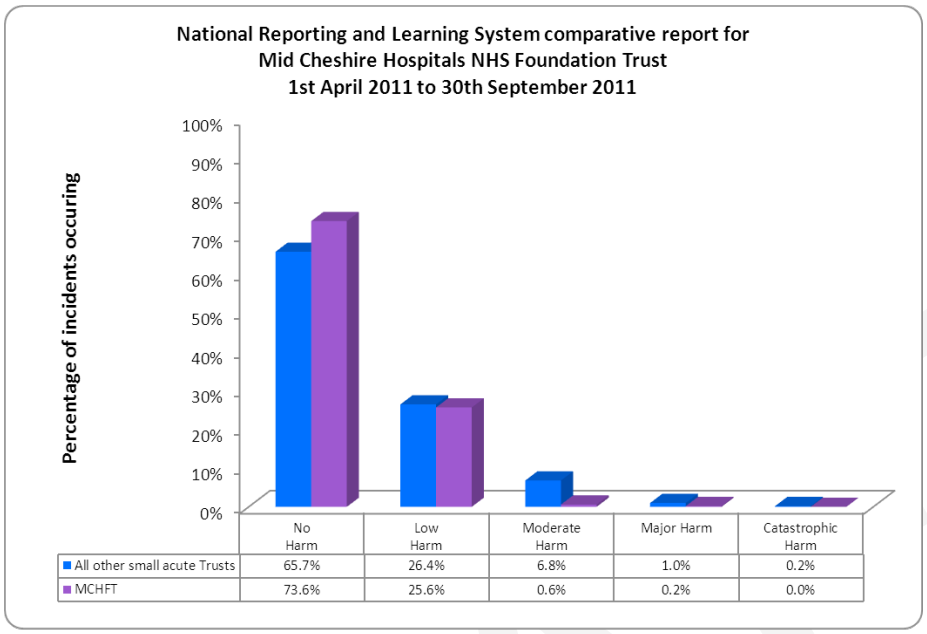
To monitor and reduce the number of patients who experience avoidable harm by 10% annually

All patient safety incidents are monitored by 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 5 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 for April to September 2009 the Trust has made significant improvements in reducing harm in the severe harm categories i.e. moderate and above.

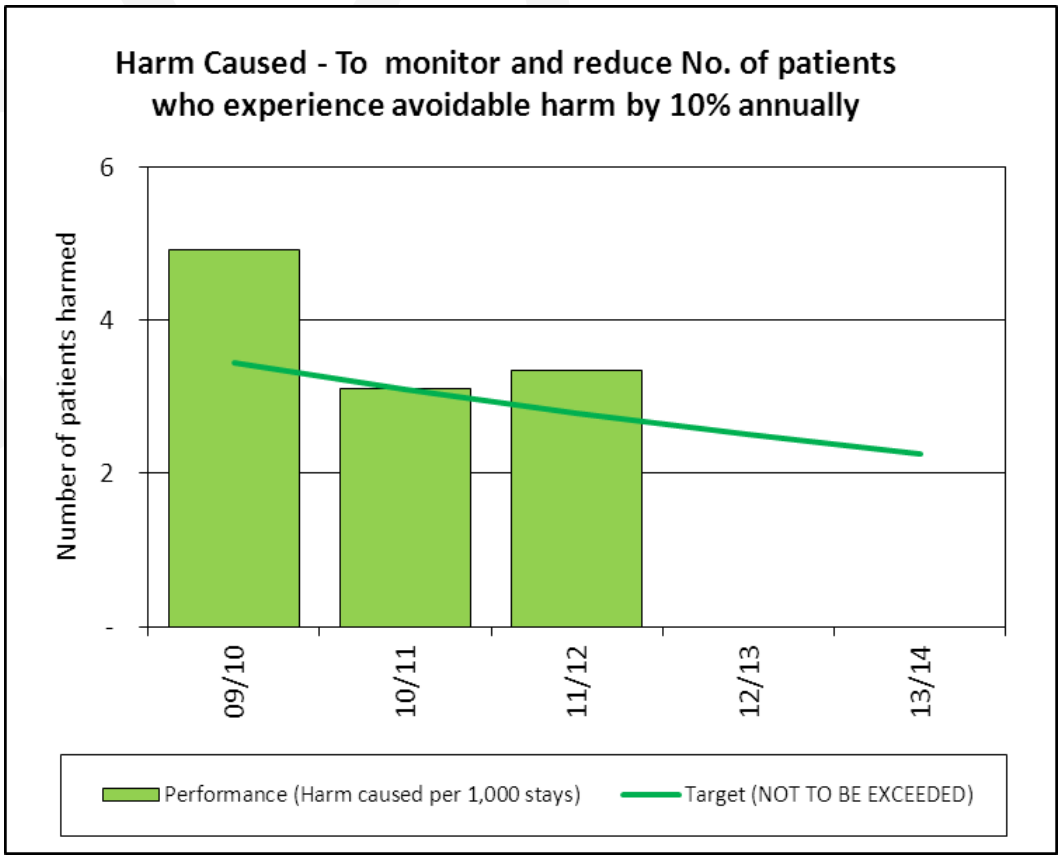
Graph 5: NRLS comparative data for April to September 2011



Graph 6: NRLS comparative data for the past 3 years



Graph 7: Avoidable Harm Caused



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 states that the Trust will 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 to 2% by 2014.

The Trust has been working to do this by:

- Introducing daily monitoring of readmissions and working with clinical divisions to develop plans to reduce issues commonly associated with readmissions to hospital
- Introducing patient passports for patients who are admitted frequently to hospital providing the medical teams with detailed information about individual patient's care plans
- Improving the advice and instructions given to patients on discharge
- Improving the planning of patient discharge by agreeing with patients an intended date of discharge as soon as possible after admission, so all professionals, patients and relatives are aware of the expected date for leaving hospital
- Launching the Integrated Discharge Team who work collaboratively with social care colleagues, planning discharges for patients with complex care needs to ensure a smooth transition to a community setting when leaving hospital
- Extending the hours of operation of the Integrated Discharge Team to include weekend working and a follow-up phone call 72 hours after a patient has left hospital to ensure continuity of care
- Reviewing the standard template used when creating electronic discharge information for patients to enable a multi-disciplinary approach to entering information, thus improving the timeliness and quality of information reaching the patient's General Practitioner
- Working with the urgent care centre and acute physicians to introduce revised care pathways, to ensure that certain patient conditions can be treated in other ways instead of being admitted to hospital
- Working with social care and mental health colleagues to introduce a rapid review service within the Emergency Department to avoid unnecessary admissions to hospital

As a result of these actions, the Trust achieved a reduction in readmission rates during 2011/12. Unfortunately, the target of 3% was not achieved. However, as the graph shows, the Trust is currently performing better than peer Trusts which is a significant achievement.

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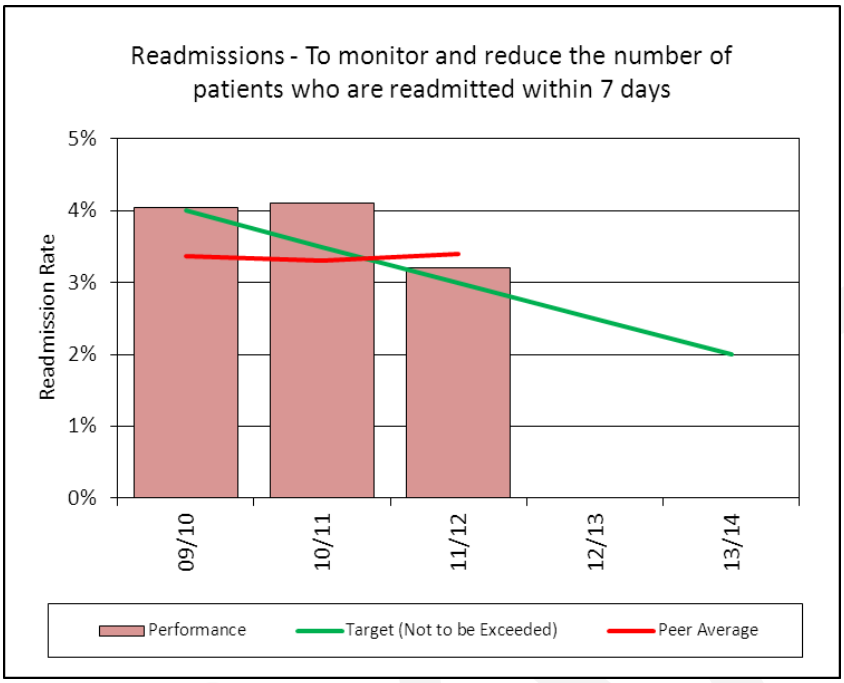
Graph 8: Annual Readmission Rates



Effectiveness

Priority 5: Finance

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

The NHS Operating Framework requires a reduction in management costs to allow more income to be reinvested into NHS care for patients.

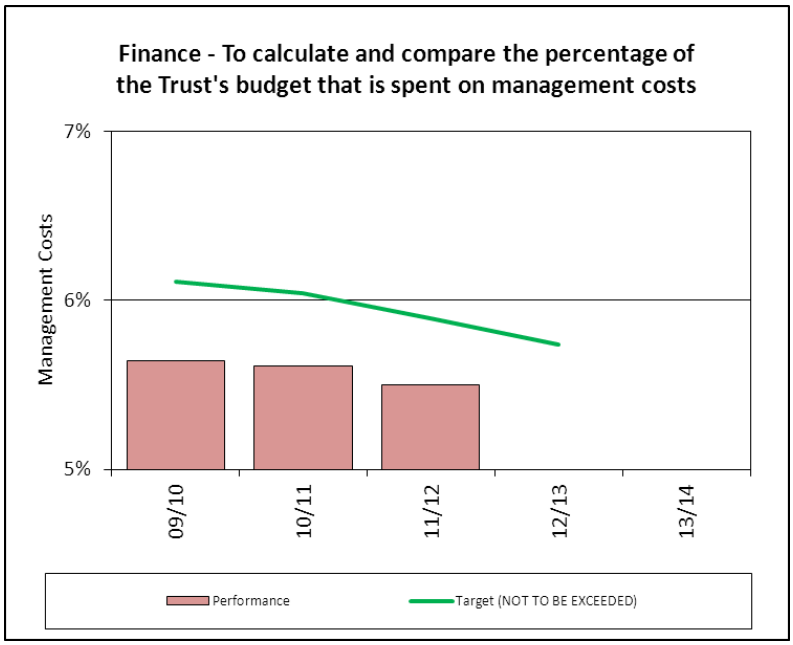
The Trust's priorities for improvements have echoed this requirement by reducing the percentage of the Trust's income spent on management costs.

Over the financial year, the Trust has been monitoring its management costs on a quarterly basis against its own pre-defined targets. The cumulative quarterly performance for 2011/12 is shown in the following table. It can be seen that the target set by the Trust has been achieved.

Table 7: Management Costs as a Percentage of Income

	Target % of Income	Actual % of Income	Achieved (Y) Not Achieved (N)
Quarter 1	6.0	5.5	Y
Quarter 2	6.0	5.5	Y
Quarter 3	6.0	5.5	Y
Quarter 4	5.9		

Graph 9: Trust Annual Spend on Management Costs



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Experience

Priority 6: Patients & Staff

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

Nurses
Since 2008, the Trust has used the AUKUH* adult acuity / dependency tool for adult inpatient wards to provide evidence based decision making for nurse staffing levels. The AUKUH developed the acuity / dependency tool as national workload model for use in NHS hospitals. It matches patients against the level of care required ranging from 0–3 and each level of acuity/dependency is allocated an amount of nursing time based on Whole Time Equivalents (WTE):

*AUKUH – Association of UK University Hospitals

Level 0:	0.79 WTE nurse per bed	Level 1a:	1.70 WTE nurse per bed
Level 1b:	1.86 WTE nurse per bed	Level 2:	2.44 WTE nurse per bed
Level 3:	6.51 WTE nurse per bed		

Following the results in June 2009 the Trust Board approved the additional funding for 28.79 additional WTE staff for the Emergency Care Division wards (25.89 WTE Band 2 and 2.90 WTE Band 5 staff). Since June 2009 the adult inpatient wards have continued to collect data every 6 months and adjust staffing levels based on the information acquired. Some areas decided to collect data more frequently if their results fluctuated significantly based on patient flow and activity.

In July 2010 the maternity unit commenced using the Birth Rate Acuity. This system provides "real time" information on the numbers of midwives needed to match the needs of the women in the labour ward. It measures the intensity of need arising from the number and clinical status of women and infants during labour, delivery and other women being cared for in the delivery suite against the number of midwives available to provide care.

The STEAM method (System To Escalate And Monitor) for recording paediatric acuity was developed and introduced in 2004 in Wales. The STEAM tool was piloted across the Children's and Adolescent Unit (CAU) between March and August 2011. Information collated during 2011/2012 relating to adult nurse staffing levels has been discussed at the Trust's acuity group and escalated to the Executive Workforce Committee.

The aim for 2011/2012 was that 75% of adult inpatient wards would be within range of their required establishment. In October and November 2011, the wards collected their data to demonstrate their required establishments. These results are shown in the following graph against the funded establishment levels for each ward.

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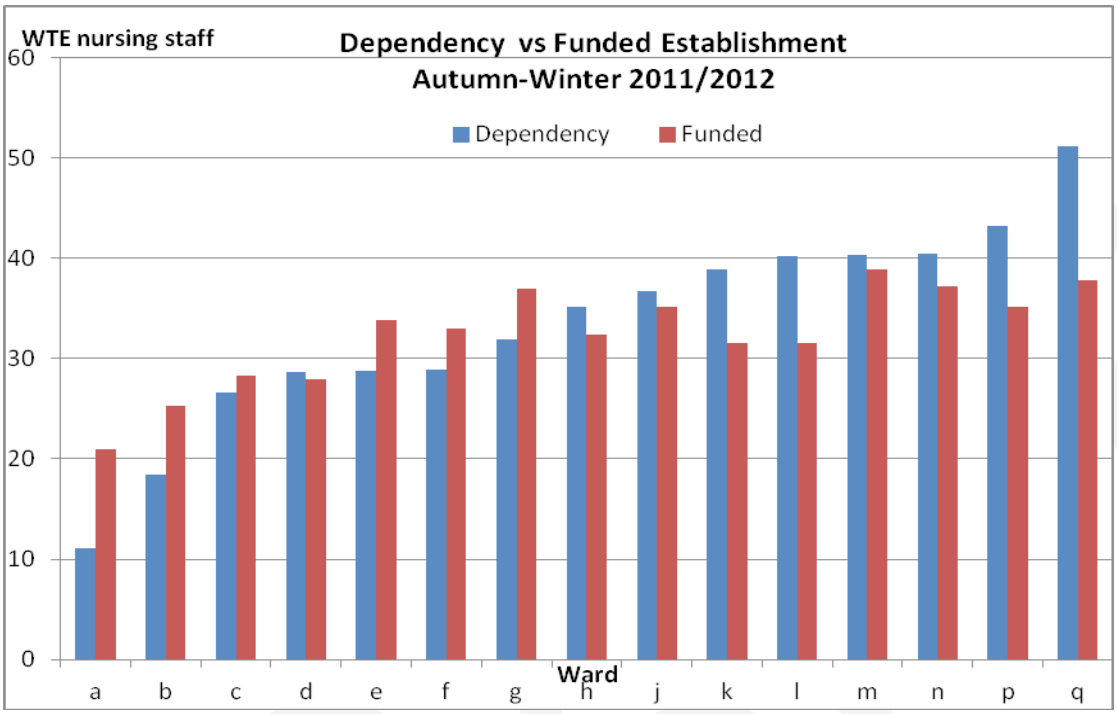
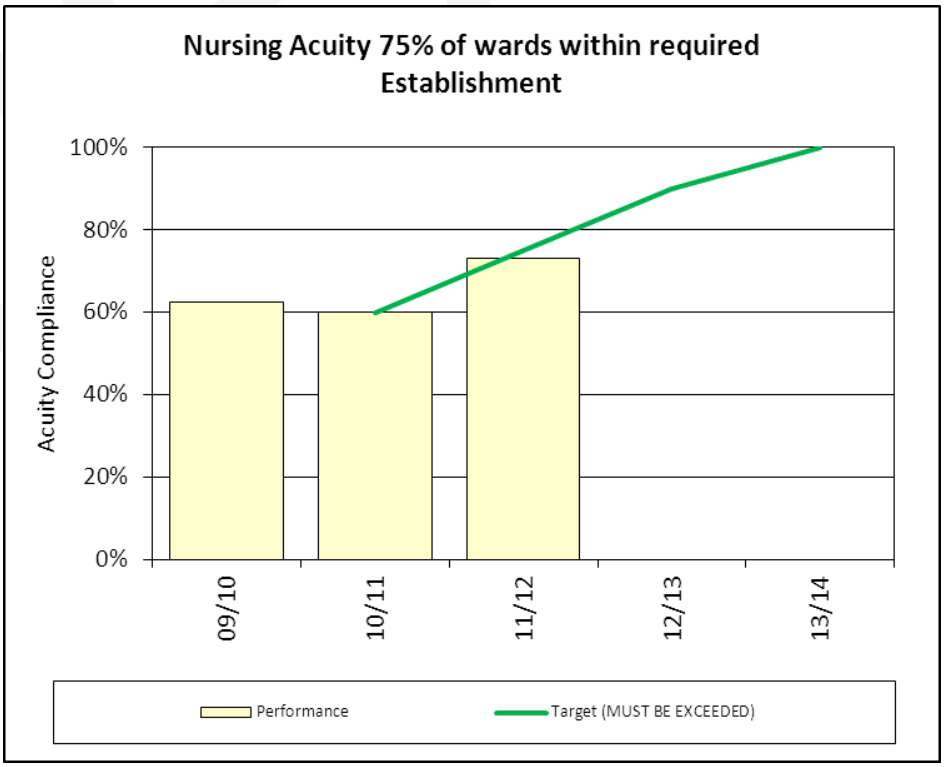
Graph 10: Dependency vs funded establishment for Autumn / Winter 2011/2012



Graph 11: Nursing Acuity of Ward Areas



It can be seen that eleven of the fifteen wards reviewed were within range of their required establishment which equates to 73%. This means this target was not achieved.

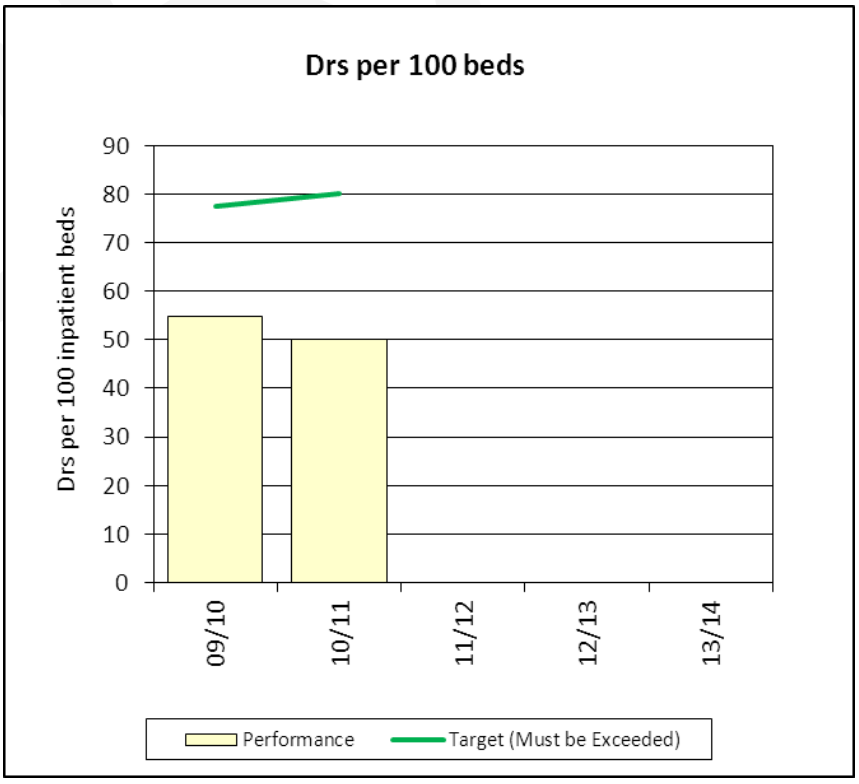
The four wards outside this range were under established (have too few staff). Actions have been taken to address this balance in the short term including the redeployment of staff from over to under established areas.

Doctors

The Trust strives to provide safe, effective and compassionate care to all its patients and is committed to ensuring appropriate staffing levels for all healthcare groups including Doctors. Dr Foster benchmarking data is used as a guide to staffing levels and the data for the year 2010/11 indicated that the Trust was in the bottom quartile nationally for medical staffing numbers. As a result during 2011/12 the Trust has appointed additional Consultants in Orthopaedic Surgery, Colorectal Surgery and Anaesthesia. The Trust has also received support from the Mersey Deanery to increase Training Grade posts in Breast Surgery and Care of the Elderly.

The Trust's target is to be in the top quartile of performing Trusts and investment in additional Consultant posts continues to be a priority.

Graph 12: Dr Foster – Number of Doctors per 100 inpatient beds



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Experience

Priority 7: Environment

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

On 1 April 2011, the Trust declared compliance in eliminating mixed-sex accommodation. The Declaration of Compliance has been published on the Trust's web site and reads as follows:

Mid Cheshire Hospitals NHS Foundation Trust is pleased to confirm that the Trust is compliant with the Government's requirement to eliminate mixed-sex accommodation, except when it is in the patient's overall best interest, or reflects their personal choice.

The Trust has the necessary facilities, resources and culture to ensure that patients who are admitted to its hospitals will only share the room where they sleep with members of the same sex, and same-sex toilets and bathrooms will be close to their bed area.

Sharing with members of the opposite sex will only happen when clinically necessary (for example where patients need specialist equipment such as in Intensive Care, Coronary Care or the High Dependency Unit) or when patients actively choose to share (for instance the renal dialysis unit or chemotherapy unit).

If care should fall short of the required standard, the Trust will resolve it as quickly as possible and report it via the Trust Committee Structures to the Trust Board and also to the local Primary Care Trust.

The Trust has also set up an audit mechanism to make sure any reports are not misclassified and discusses the results of these audits at the Delivering Same Sex Accommodation group.

Changes made in practice
There have been many changes in practice to ensure the Trust's compliance with providing same sex accommodation:

- The Emergency Assessment Unit moved to a ward area with bays and side rooms to increase privacy and ensure same sex accommodation

- The Clinical Decisions Unit within the Emergency Department was redesigned and a partition installed to promote a quieter environment and enhance the provision of privacy. This development is shown opposite:

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- The signs for toilets, bathrooms and bays have been redesigned and are monitored closely to ensure they are used appropriately. These signs are also helpful for patients with memory and/or cognitive impairment

- Coloured privacy doors have been fitted at the entrance to each bay to improve privacy for patients, reducing the risk of infection and enabling patients to find their way to and from the toilet independently thus improving dignity for patients. Feedback from patients about the availability of these doors has been positive, for example:

  "When I used to try and find my way back to my bed from the toilet all the bays looked the same. Now when I am looking for my bed all I need to do is look for the right coloured door and I know I am in the right place."

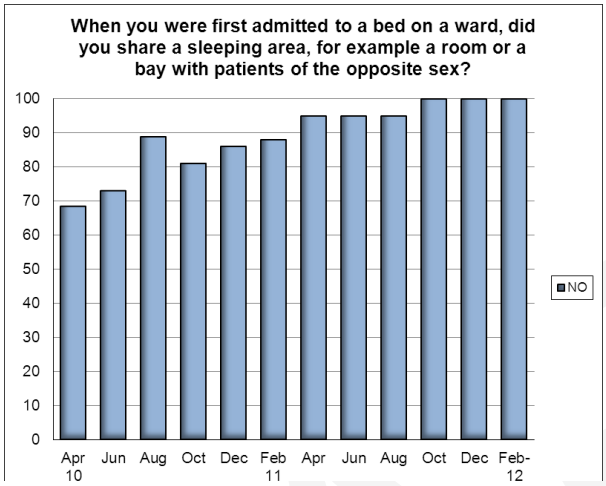
- Privacy screens have also been installed in areas where sexes may be mixed for specialist clinical reasons for example, the Acute Stroke Bay (ASB)

Patient feedback

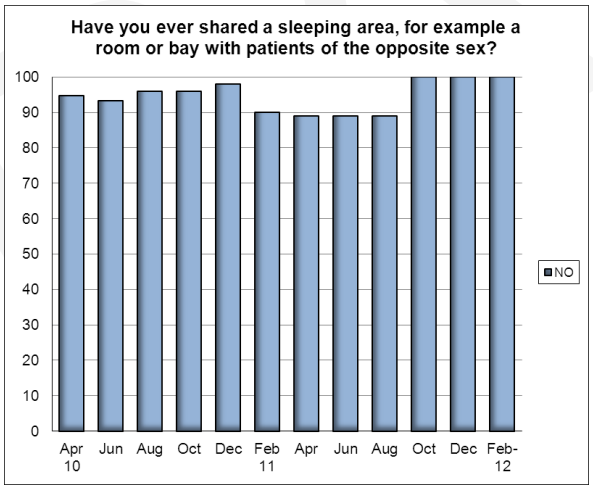
Every month, volunteers assist the Trust asking 100 patients about their experiences of same sex accommodation.

These results are shown below and demonstrate significant improvements when compared with last year's result.

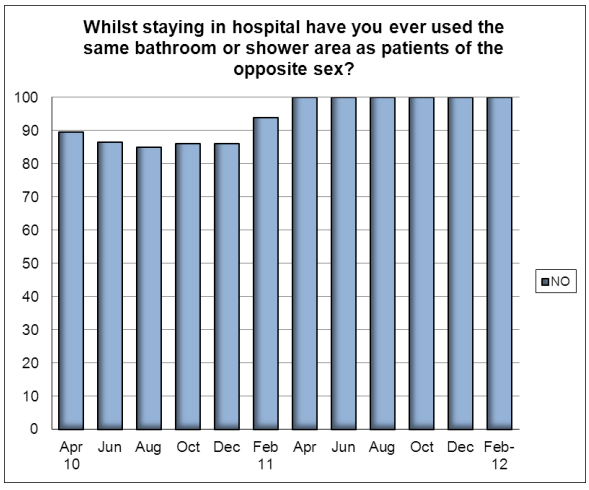
Graph 13: Experiences when first admitted



Graph 14: Experiences during stay



Graph 15: Experiences regarding washing facilities



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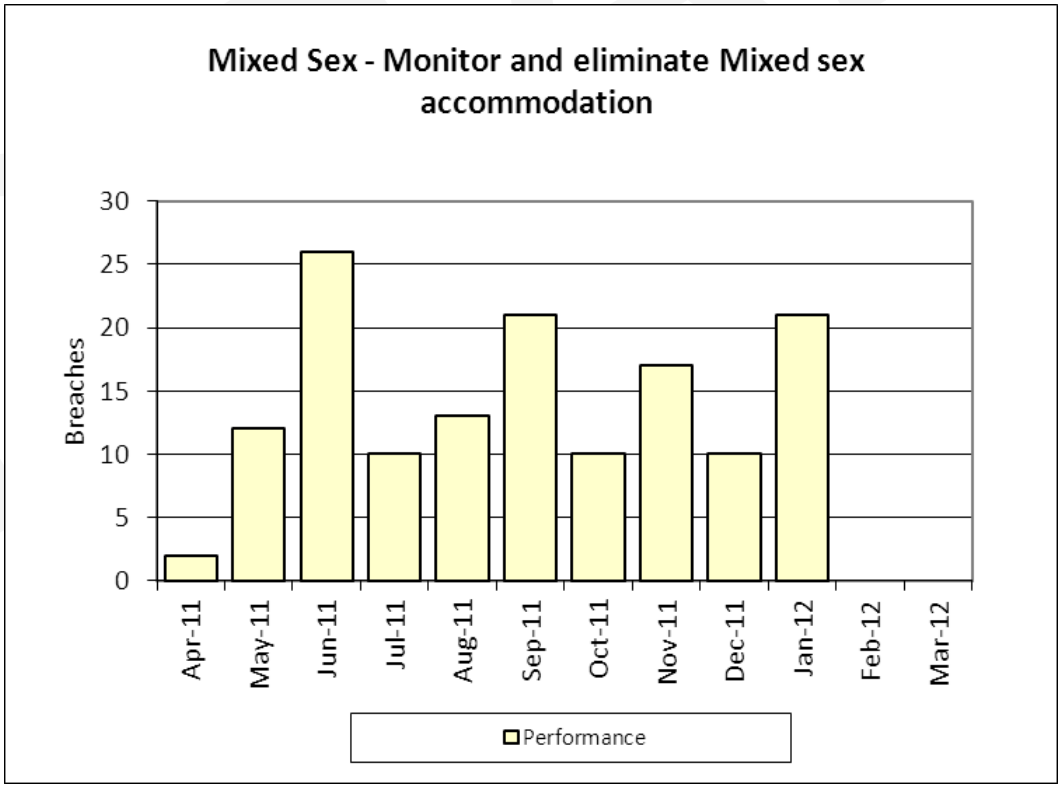
The Trust is pleased to report that over the past years there have been no patient concerns raised as a results of mixed sex accommodation and all patients surveyed have never reported either sharing accommodation or washing / toilet facilities with patients of the opposite sex.

Reporting breaches

Every month the Trust reports the number of non-clinical breaches that occur to the Commissioners, Strategic Health Authority, internally to the DSSA Group and the Patient Experience Committee. These figures relate to patients who are cared for with patients of the opposite sex once their clinical condition no longer requires them to stay in that area. All breaches that occur in the Trust happen in the Acute Stroke Bay and the Intensive Care / High dependency Units.

When these breaches occur the staff always apologise to the patient and make every effort to address the situation as quickly as possible. This requires co-ordination with the patient placement team and other ward staff. The numbers of breaches that have occurred over the past year are shown in the graph below:

Graph 16: Monthly Breaches within Mixed Sex Accommodation



Outcomes

Priority 8: Cardiovascular

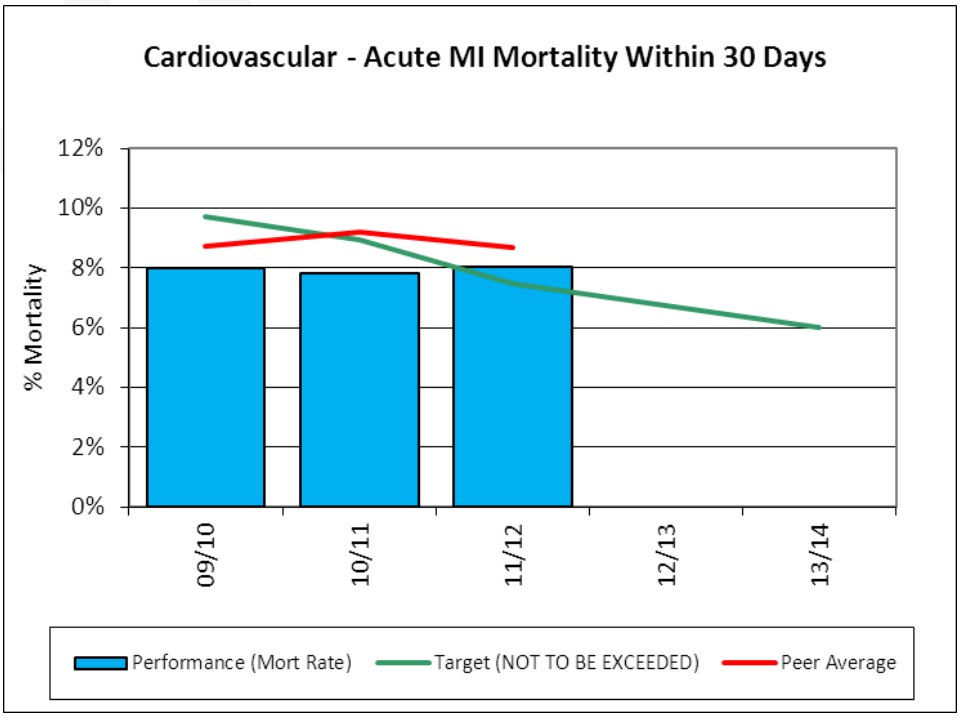
To reduce the 30 day mortality rate in patients following Acute Myocardial Infarction (AMI)

There were approximately 600 patients admitted in 2011/12 with a diagnosis of Acute Myocardial Infarction (AMI). Many of these patients were transferred to tertiary hospitals for further treatment and intervention. Patients were then either discharged home or transferred back to the Trust to continue their care.

For all patients who suffer an AMI a return to an active and healthy lifestyle is positively encouraged with everyone being invited to join the Cardiac Rehabilitation Programme. This programme is set out in 4 phases. Phase 1 is offered while an inpatient, phases 2 & 3 following discharge and phase 4 is offered in partnership with other organisations. Cardiac Rehabilitation aims to reduce patient mortality and morbidity and to provide support for both the patient and carer to enhance their quality of life. Death following an AMI is significantly reduced when lifestyle changes are made and strictly followed.

The Trust uses data from CHKS to monitor mortality within 30 days following AMI and it can be seen from the following graph that the Trust has achieved the target to reduce deaths following AMI during 2011/12.

Graph 17: Acute AMI Mortality within 30 days



AMI is one of five clinical conditions that are monitored through the Advancing Quality (AQ) Programme. It has been chosen due to its high prevalence in North West England. The aim of this programme is to report on a set of clinically agreed measures to improve outcomes for patients.

Advancing Quality Measures:

- Aspirin/antiplatelet administered within 24 hours of hospital arrival
- Thrombolytic treatment within 30 minutes of hospital arrival – if clinically indicated
- Smoking Cessation advice given
- Discharge medications provided

The Trust compliance with the Advancing Quality Programme for AMI care and treatment is currently 100%.

Outcomes

Priority 9: Cancer

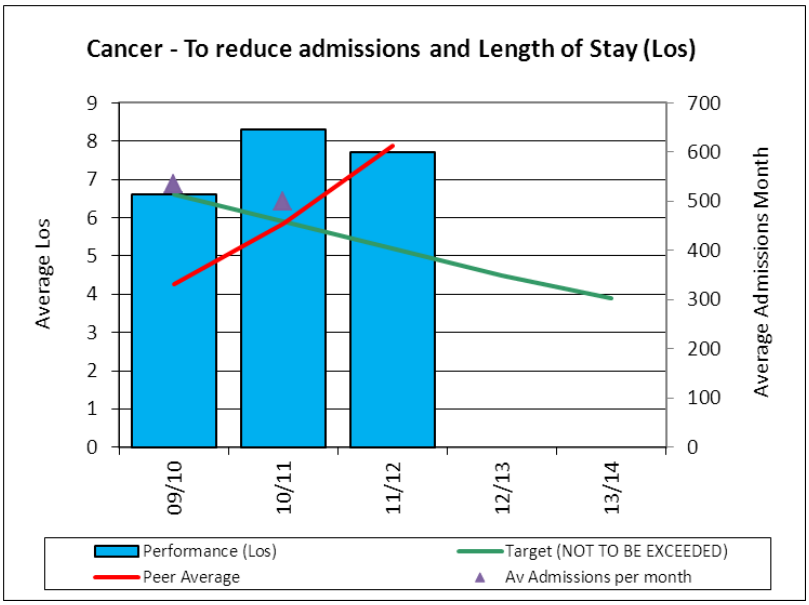
To reduce acute admissions and length of stay in hospital following early complications of diagnosis and / or treatment of cancer.

The outcome for the Trust's cancer target for 2011/12 has not been successfully achieved. The graph shows that there has been some improvement in reducing the length of stay for patients admitted as an emergency who have a diagnosis of cancer, but this is still higher than the target set by the Trust.

Investment has been secured from the Greater Manchester and Cheshire Cancer Network to implement the Acute Oncology Service in 2012/13. This investment is for two Acute Oncology Clinical Nurse Specialists and administrative support for the team. Funding has also been received for a rapid alert system so that the specialist nursing team will receive an alert as soon as a patient with known or suspected cancer attends the Emergency Department. This nursing team will aim to see, review and support all acute admissions. They will ensure that, if admission is avoidable, the patient is provided with the support required to return home from the Emergency Department with appropriate early follow up by an Oncologist. The team will also ensure that admitted patients remain in hospital for the shortest length of stay possible which will improve the individual's quality outcomes ensuring that their care is provided in their chosen location.

The Trust team will be supported by the Cancer Network who are implementing an education programme as well as supporting all Trusts by ensuring that appropriate patient pathways are established for a number of common cancer related complications. The implementation of this service will further support the ongoing work throughout the Cancer Network to support the provision of cancer treatment closer to patients' homes.

Graph 18: Cancer Length of Stay and Acute Admissions



Outcomes

Priority 10: Infections

To reduce the rates of Healthcare Associated Infections (HCAI)

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		
2011/12 Clostridium difficile < 73	Actual 29	**Achieved**
2011/12 MRSA bacteraemia < 2	Actual 1	**Achieved**
Establish baseline for UTI surveillance 2011/12		**Achieved**
MRSA screening for emergency admissions by December 2011		**Achieved**

Clostridium difficile

Rates of Clostridium difficile infection (CDI) have dramatically reduced over the year and this is a significant achievement for the Trust. The final CDI rate for the twelve month period stands at 29, which represents a 74% reduction compared to last year's reporting total for 2010/11 of 105. The objective for the forthcoming year (2012/13) is 54 cases in a twelve month period; which is a 28% reduction from last year's target of 73 cases.

MCHFT has, however, achieved (and exceeded) next year's target already this year by reporting a total of *** CDI cases at the end of March 2012. Irrespective of this achievement, work will continue to focus on CDI prevention strategies over the forthcoming year.

MRSA bacteraemia

The Trust has had one case of MRSA bacteraemia (blood stream infection) over the past two years and this is an exceptional achievement for the Trust. A Department of Health press release issued in August 2011 reported that the Trust was among 25 acute organisations in England that had no MRSA bacteraemia cases for the 2010/11 reporting period. During 2011/12 we had one case only, which was in late February 2012. The target for 2012/13 is zero cases of MRSA bacteraemia.

Urinary Tract Infections (UTIs)

There are currently different national criteria for measuring UTIs, with no single method or way of comparing organisational rates nationally. For this reason the Trust has continued to measure catheter insertion rates; as advised by a sub-group of the Health Protection Agency in 2010. Over the last three years, the Trust catheter incidence has remained fairly static; ranging from 11-15% of patients with a catheter at any one time. This includes long term catheters already in place before admission and also short term catheters that may only be in place following a surgical procedure.

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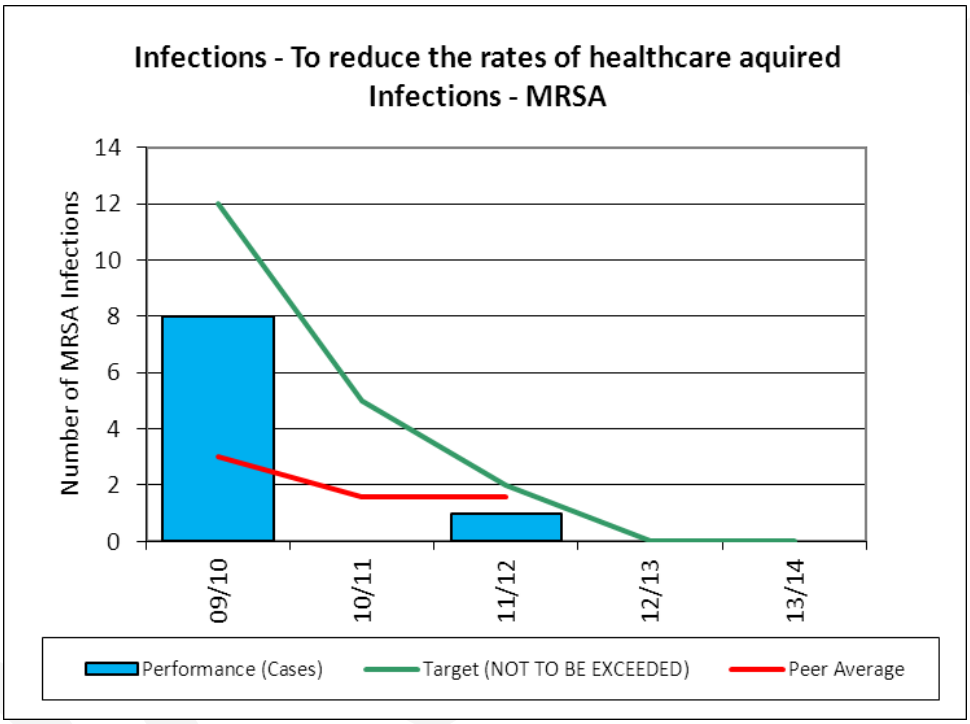
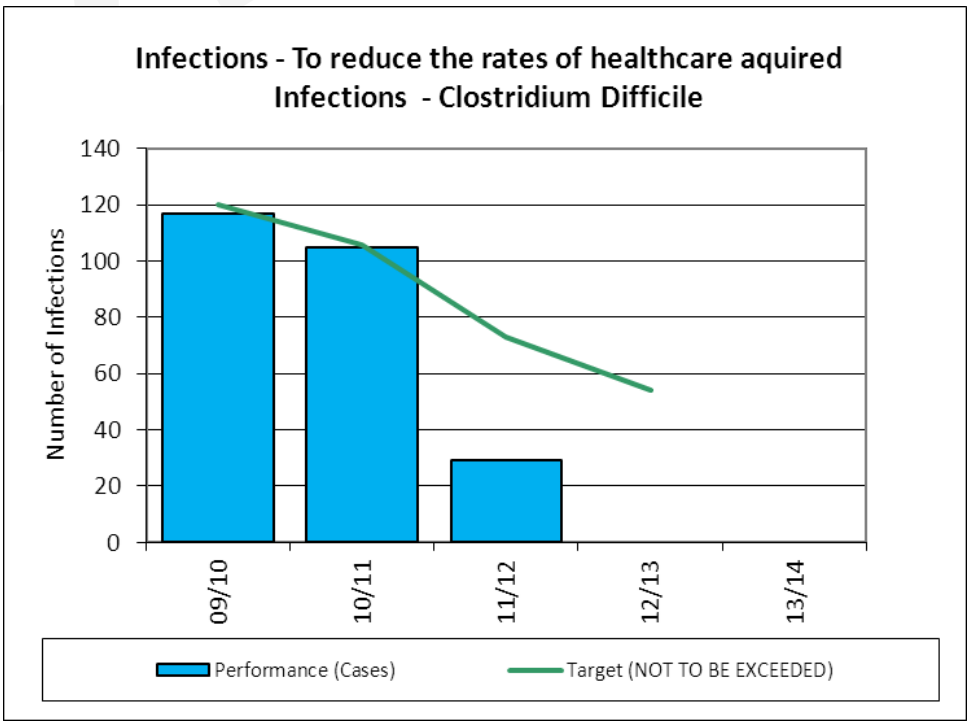
From April 2012 UTIs will be reviewed in more detail when patient information is collected as part of the National Safety Thermometer initiative. This programme will review key aspects of patient safety and measure progress each month to evaluate how effectively we prevent harm.

Graph 19: MRSA rates



Graph 20: *Clostridium Difficile* rates



External Assurance and Performance Indicators

Venous Thromboembolism

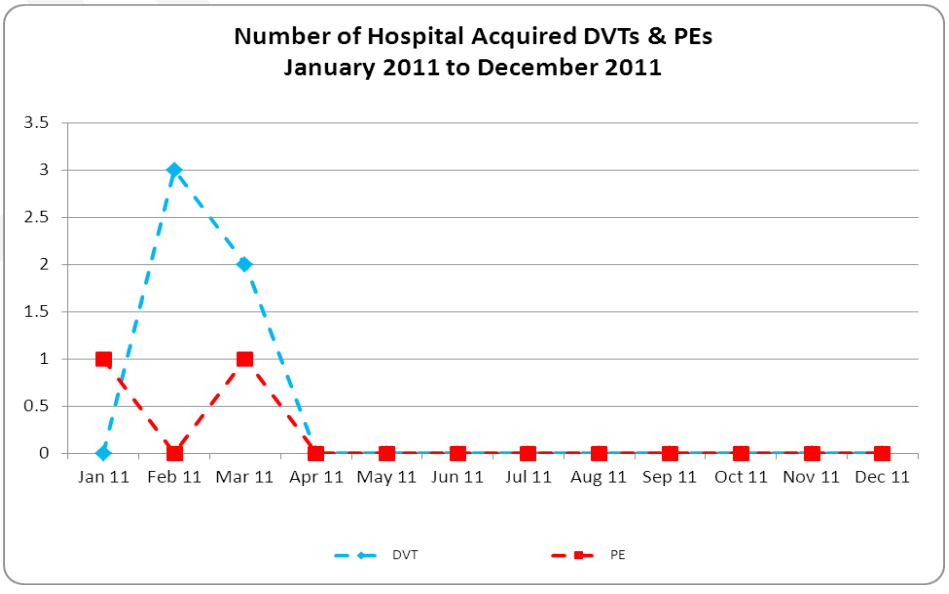
Venous Thromboembolism (VTE) is a common, serious and frequently underestimated medical condition caused by the formation of blood clots.

The most common form is deep-vein thrombosis (DVT), which occurs when blood clots develop in the deep veins of the body, usually in the legs. DVT partially or completely blocks veins and disrupts the normal flow of blood back to the heart.

Part of a clot may break off and lodge in the arteries that supply the lungs, resulting in a condition known as pulmonary embolism (PE). A PE is a medical emergency that can cause irreversible damage to the lungs and can result in death.

To improve patient safety and reduce mortality from VTE the National Institute for Health and Clinical Excellence (NICE) issued national guidance: 'Venous thromboembolism: reducing the risk' CG92 in January 2010. This document sets out a framework for Trusts to follow to ensure that all adults admitted to hospital are assessed for the risk of developing VTE and actions taken if appropriate. The Trust has implemented the VTE risk assessment form and, since its full inception in June 2010, has seen a significant reduction in the number of patients developing a VTE. For the past 9 Months no patient has developed a VTE whilst in our care.

Graph 21: Hospital Acquired DVTs and PEs



(Source: Trust data February 2012)

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Consultation on Quality 2011/12

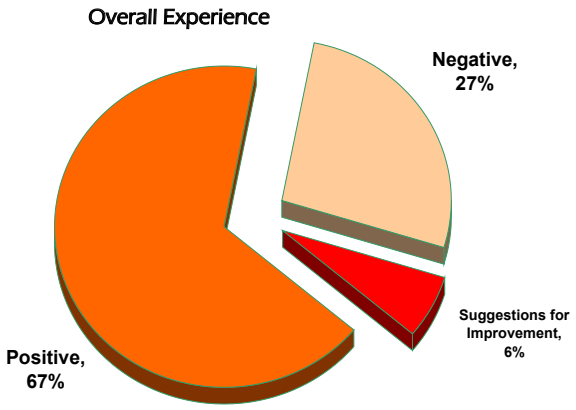
Over the past 3 years the Trust has consulted with public, patients, staff and Governors on the delivery of quality. Using the Trust's Quality and Safety metrics the 10 out of Ten, has been the focus for discussion and comment. These comments are then used to inform the annual Quality Account.

The Quality Account Consultation 2011/12 commenced in September 2011 and was completed in November 2011. The Trust had set a target of 500 responses for this consultation which it had exceeded by the end of the organised events. The Trust visited many local events and local places of interest including Crewe library, Asda supermarket in Crewe and Sandbach Market. Events attended included the 'Vocational Achievement Celebration' which was held at Crewe Alexandra Football Club and the 'Black History Month' event organised by the Organisation Caring for Ethnic and All Nations (OCEAN). A consultation event at Manchester Metropolitan University (MMU) ensured the Trust surveyed a broad cross section of the local population. Patients and members of the public were also included in the consultation events through discussions in the out patients departments at Leighton hospital and the Victoria Infirmary.

The aim of the consultation is to seek comments from the public regarding the Trust's 10 out of Ten annual achievements and to ensure that the ten indicators of quality are still essential markers within the quality domain. Comments were also collated on the quality of service delivery by the Trust and suggestions on areas for improvement were encouraged.

To date the Trust has received many positive comments with regards to service delivery, patient experience and quality.

Graph 22: Overall Trust Experience



There was a small percentage of people consulted that lived out of area had not used the services at the Trust or, had no comment to make.

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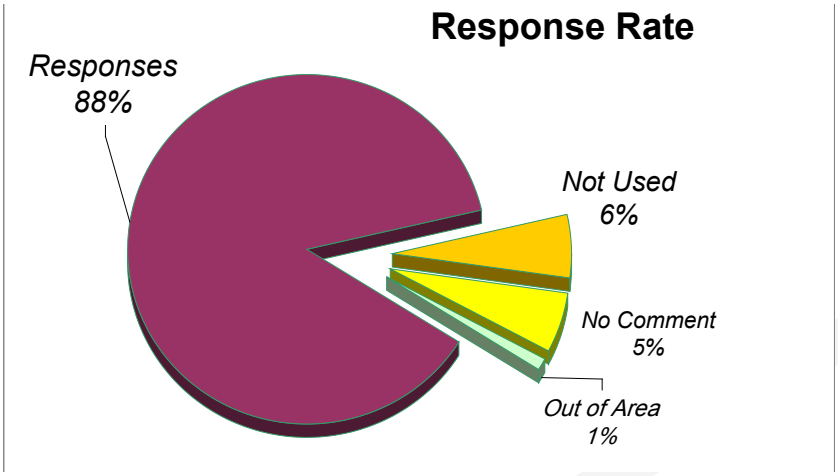
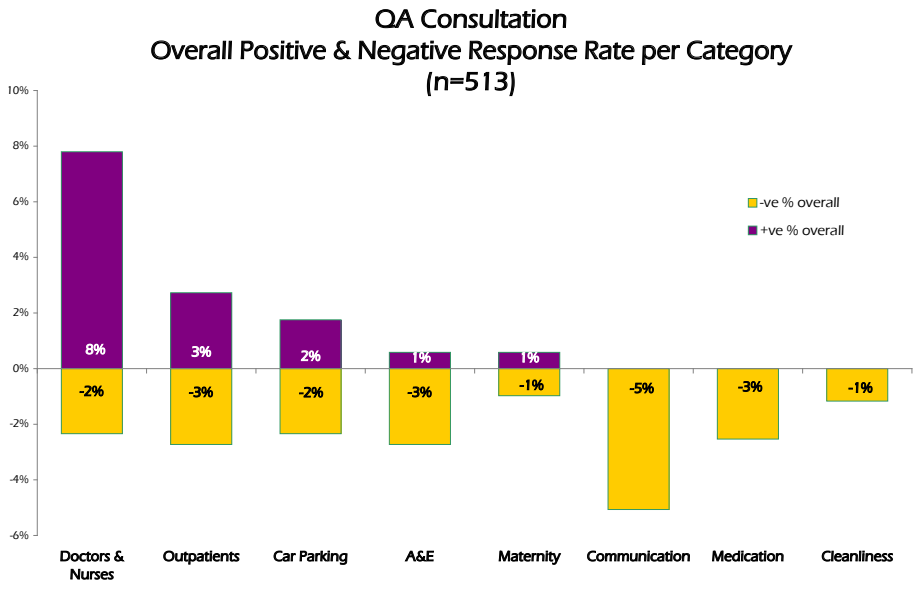
Graph 23: Response Rate



The comments recorded during the consultation were collated and categorised. Graph 22 below demonstrates the positive and negative comments recorded.

Graph 24: Positive and Negative Responses



The majority of comments that were received regarding Doctors and Nurses were positive. Views of nurses as friendly and caring were described throughout the consultation, although comments about the lack of nurses or lack of time to care were evident.

There were many comments received about the Outpatient departments although this could be partly due to the consultation events being held in these areas. Flexible appointments were highlighted as a positive for the Trust, with delays in starting times for consultations being a criticism of the service provision. There were fewer comments about carparking in this years consultation.

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

LINK

Overview and Scrutiny Committee

Central & Eastern Cheshire Primary Care Trust

Governors

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Key National Priorities

Table 10: Quality Overview

Safety Measures Reported	2009-2010	2010-2011	2011-2012	Improved (Y) Not improved (X)
Hospital Falls/ injuries (falls/1000 bed days) (*)	6.09	6.98	8.39	X
Falls assessment risks completed within 24hrs (*)	83%	96%	96%	-
Waterlow tests completed within 24 hours of admission (*)	98%	93%	95%	Y
Nutritional assessment completed within 24 hours of admission	82%	99%	97%	X
Patient Experience Measures Reported				
% of patients that would recommend hospital to family /friends	N/A	97%	85%	X
Overall how would you rate the care you received **	93%	93%		
% patients who felt they were treated with dignity & respect	97%	96%	100%	Y
% patients who had not shared sleeping area with opposite sex	74%	75%	100%	Y

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

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Table 11: National Priority and Performance Standards

National Targets and Regulatory Requirements		2009-2010	2010-2011	2011-2012	Target	Achieved (Y) Not Achieved (N)
MRSA Bacteraemias		15	8	0	2	Y
Clostridium Difficile Infections		142	117	23	73	Y
Smoking During Pregnancy		22.5%	19.5%	18.3%	< 15%	N
Breastfeeding Initiation Rates		59.5%	59.6%	62.8%	> 65%	N
18 week maximum wait from point of referral to treatment (admitted patients)		89.1%	92.8%	91.1%	> 90%	Y
18 week maximum wait from point of referral to treatment (non- admitted patients)		97.2%	97.6%	96.8%	> 95%	Y
Percentage of patients seen within two weeks of an urgent GP referral for suspected cancer **		98.7%	93.2%	95.4%	> 93%	Y
Percentage of patients seen within two weeks of an urgent referral for breast symptoms where cancer is not initially suspected **				94.6%	> 93%	Y
Percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer**		95.9%	85.6%	83.7%	> 85%	N
Percentage of patients receiving first definitive treatment for cancer within 62 days of referral from an NHS Cancer Screening Service **				92.9%	> 85%	Y
Percentage of patients receiving first definitive treatment within one month of a cancer diagnosis		96.2%	98.4%	99.6%	> 96%	Y
Percentage of patients receiving subsequent treatment for cancer within 31 days **			100%	98.9%	> 95%	Y
Performance Indicators						
A & E Waiting Times			98.1%	97.3%	96.7%	N
Access to Genito-urinary medicine (GUM) clinics			99.9%	100%	100%	Y
Cancelled Operations	% of cancelled operations		1.19%	1.46%	1.09%	Y
	% of breaches of the 28 day guarantee		9.5%	14.4%	5.36%	Y
Ethnic Coding Data quality			84.1%	85.3%		

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

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Appendices

Appendix 1 - Glossary and Abbreviations

Terms	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.
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.
Delivering Same Sex Accommodation	DSSA	An initiative led by the Department of Health to ensure patients do not share sleeping accommodation with members of the opposite sex, unless required for clinical need.
Healthcare Associated Infections	HCAI	A generic name to cover infections like MRSA and C-diff.
Healthcare Resource Group	HRG	Healthcare Resource Groups (HRGs) are standard groupings of clinically similar treatments which use common levels of healthcare resource.
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

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Terms	Abbreviation	Description
National Patient Safety Agency	NPSA	They lead and contribute to improved, safe patient care by informing, supporting and influencing organisations and people working in the health sector.
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.
National Reporting and Learning System	NRLS	National database that allows learning from reported incidents
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.
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.
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.
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.

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Appendix 2 - Feedback Form

We hope you have found this Quality Account interesting and helpful.

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 interesting and helpful / not interesting/helpful?

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