Mid Cheshire Hospitals NHS
NHS Foundation Trust

Quality Account 2012/13

Quality and Safety at Heart

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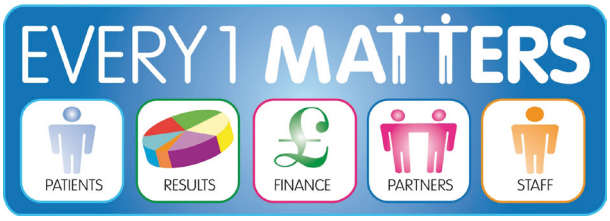
"Mid Cheshire Hospitals NHS Foundation Trust prides itself on the quality and safety of care it delivers to patients and carers"



Contents

Part 1
Statement on quality from the Chief Executive

I am pleased to present our fourth published Quality Account for the period of April 2012 to March 2013.

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

2012 has continued to be a successful period for the Trust, with many significant achievements in quality, safety and experience. We are extremely proud to have continued our success within Infection Control having only one MRSA infection this year and seeing a further reduction in the number of cases of Clostridium difficile, placing us amongst the highest performers in the North West.

Another achievement has been the continued reduction in our mortality rates. We were awarded the CHKS national awards for the **Most Improved Hospital in 2012**, against 23 quality indicators (including mortality) and the CHKS **top 40 Trusts in the country**.

In December 2012, the Care Quality Commission (CQC) conducted an unannounced visit to a number of wards at Leighton Hospital to assess against 5 essential standards of care. The Trust received a very positive report that reflected the direct experiences of patients on our wards on that day. Most notable were the patient comments in relation to being treated with care and compassion.

There have been many areas where we have introduced new services/ new pathways to improve quality. One example is the introduction of an acute oncology service, being one of the first hospitals in the region to put this service in place. We have seen great benefits to patients who have been diagnosed with cancer and the care they receive when they have unplanned admissions to hospital.

This report also demonstrates that the Trust has a number of assurance mechanisms in place which demonstrate how we scrutinise the quality of the care that we deliver. Examples of these are the extensive audit program and the nursing acuity tool used to ensure correct staffing is in place.

I would like to take this opportunity to give a huge ‘thank you’ to all our staff for your efforts in 2012. 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

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Throughout the document, there may be terminology that is not very familiar to readers. Where possible, the Trust has tried to write clearly in a user friendly way. However, some elements in the quality account are prescribed by the Department of Health or Monitor. To help readers, there is a glossary of terms at the back of the document in Appendix 1.

Part 2
Priorities for improvement and statements of assurance from the Board

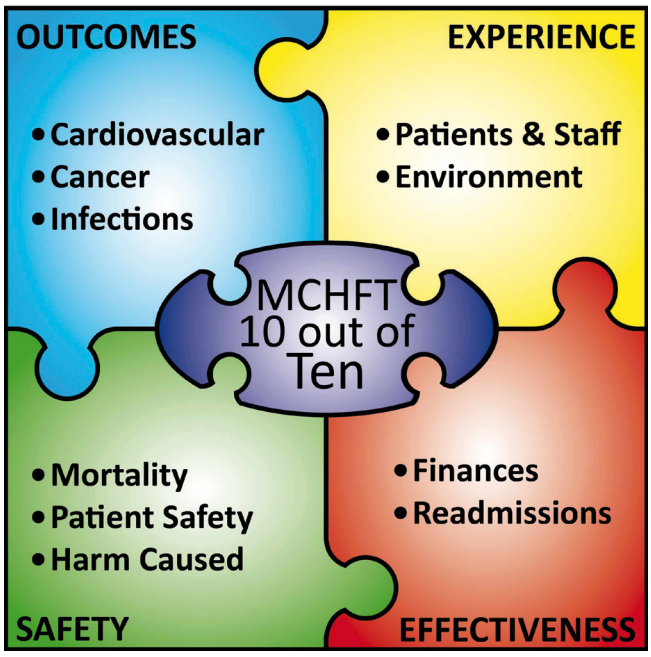
Quality, Effectiveness & Safety Committee (QuESt)

The Quality, Effectiveness and Safety Committee is responsible for providing information and assurances to the Board of Directors that the organisation is safely managing the quality of patient care, the effectiveness of quality interventions and patient safety.

During 2012/13, the Committee reviewed the 10 out of ten strategy indicators as stakeholder and public feedback had been that some of the indicators were causing confusion as they did not align to performance indicators and the outcomes framework. In considering this information, the Committee took this feedback on board and agreed to changes in two indicators: mortality and readmissions. The detail of the changes is explained in the relevant sections of the report.

Priorities for improvement in 2013/14

The Trust aims to be in the top 10% of all secondary care providers in England in ten agreed indicators of quality by 2014, selected through a public consultation process.



The quality consultation undertaken in January and February 2013 confirmed that these selected indicators remain a high priority to the local people.

These indicators are deliberately challenging as they are stretch targets designed to ensure the Trust drives improvement to the highest possible level, over and above nationally required targets.

Over the past year, it has been necessary to update the specific measures included within each indicator. This is explained within the summary of each indicator where this has taken place.

The following section provides an outline of each of the 10 out of ten indicators and how these are currently monitored and measured.

Progress against these targets during 2012/13 is described in part 3 of this report.

Safety

Mortality

To reduce the 12 month rolling Risk Adjusted Mortality Index (RAMI) by 10 points annually.

This indicator has been amended from 'to reduce mortality rates by 10 percentage points in patient groups where death is not expected.' The reason for this amendment is because this was of more significance to patients and the public.

Monitored:
A Trust 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) as the provider of comparative information and quality improvement services. This system provides information about mortality rates on a monthly basis.

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 information management 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 is 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 externally via the National Learning and Reporting System (NRLS). The NRLS send the Trust a report every six months on performance measured against other small acute Trusts.

Effectiveness

Readmissions

To reduce the number of patients who are readmitted to hospital within 30 days of discharge.

(This indicator has been amended from 'to reduce the number of patients who are readmitted to hospital within 7 days of discharge.' The reason for this amendment was to maintain consistency with national reporting requirements. It was identified that the use of the 7 day measure was causing confusion amongst members of the public and staff.)

Monitored:
The Trust monitors patients who have been readmitted as an emergency within 30 days.

Measured:
Readmissions to hospital within a 30 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 & 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.

Measured:
The nursing and midwifery acuity group reviews the results of the Safer Nursing Care (SNC) acuity / dependency monitoring tool which assesses 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 are also being reviewed, implemented and evaluated.

The ratio of doctors has, in the previous 3 years, been an element of the 10 out of ten strategy. The data previously used to report this indicator is no longer available to the Trust. There has been extensive work undertaken to look at other information available to the Trust such as the 2011 census and consultant episodes of care. Unfortunately, this has proven not to be able to provide the information the Trust needs in a robust way to support this indicator. Therefore it is no longer possible to report against this metric.

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 and comments to the customer care team). 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 Acute Myocardial Infarction (AMI).

Monitored:
The AMI mortality is monitored monthly by the emergency care division. The division's reducing mortality group reviews mortality and escalates issues when required to the Trust's hospital mortality reduction group. The division's performance report is also reviewed by 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's 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 data for acute admissions and length of stay is monitored by the Cancer Network. The Trust's acute oncology team reports this data to the surgery and cancer divisional board.

Measured:
The acute oncology unit measures the reasons for acute admissions to ensure the preferred place of care for patients diagnosed with cancer is achieved.

Infections

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

Monitored:
MRSA and *Clostridium difficile* rates 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 2012/13 the Trust provided and / or subcontracted 39 relevant health services.

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

The income generated by the relevant health services reviewed in 2012/13 represents 100% of the total income generated from the provision of NHS services by the Trust for 2012/13.

Feedback from patients

National Patient survey results

To improve the quality of services that the NHS delivers, it is important to understand what patients think about their care and treatment. The Care Quality Commission use national surveys to find out about the experience of patients when receiving care and treatment from healthcare organisations.

National inpatient survey 2011/2012

Between October 2011 and January 2012, a questionnaire was sent to 850 adult inpatients who had been admitted to Leighton Hospital.

Responses were received from 454 patients which equates to a response rate of 53%.

The collated results of this survey show that the Trust performed about the same as other Trusts in all categories:

- The emergency department
- Waiting to get a bed on the ward
- The hospital and the ward
- Doctors
- Nurses
- Care and treatment
- Leaving hospital
- Overall views and experiences

The Trust achieved particularly high scores in relation to providing information about the patients' condition, providing enough privacy when they were examined in the A&E department, waiting times to get a bed on a ward and explaining how to take medication in a way that patients could understand.

Areas identified for improvements

- **Explaining medication side effects** - Pharmacists now review medicines available at ward levels to reduce the drugs that are dispensed from Pharmacy and liaise closely with patients to discuss their drugs as they do this.

- **Reducing call bell delays** - The Trust has started to introduce care rounds by nursing staff to identify any help patients need on a regular basis, therefore reducing the need for patients to call for assistance.
- **Improving asking patients for their views about the quality of care they have received** - Over 200 patients discharged from hospital were telephoned at home to ask their views about the care they received.
- **Reducing discharge delays and improving patient information about delays** - Patients are encouraged to use the discharge lounge when waiting to go home. This area is staffed by a qualified nurse who can ensure patients are kept informed about delays and proactively makes sure they are kept comfortable. Feedback from patients about the discharge lounge and its services has been very positive.

National inpatient survey 2012/2013

Between October 2012 and January 2013, a questionnaire was sent to 850 adult inpatients who had been admitted to Leighton Hospital. Responses were received from 444 patients which equates to a response rate of 52%.

The CQC will publish a benchmark report including results later in 2013.

Examples of comments made by patients in the national inpatient survey 2012

Patients commented on what was particularly good about their care:

"I always have great confidence in the competence of doctors. The nursing staff were also absolutely excellent. Nothing was too much trouble for them. They were focused, well-informed, energetic and constantly helpful. I particularly appreciated the frequency with which my blood sugars were monitored, even in the early hours of the morning. I am glad to have the opportunity of expressing my appreciation of them."

"The nursing staff were excellent, they were very attentive and caring."

"I was on two wards whilst in hospital and on both of these wards the nursing staff were exceptional in their care of patients and skills."

"Staff at all times were helpful and courteous. The hospital was very clean."

"The doctors were meticulous in their explanations and how and why they were following certain procedures."

"Everyone – paramedics/ambulance staff/doctors/nurses and all hospital staff were appropriately pleasant. I was always a person, not a number."

Areas for action for 2012/2013

1. Ensuring standards of cleanliness in rooms and wards are maintained.
2. Continue to monitor response times to call bells for patients and ensure staffing levels are correct based on the dependency needs for each ward.
3. Reduce unnecessary noise on wards at night.

National accident and emergency survey

During 2012, a questionnaire was sent to 850 people who had attended the accident and emergency department (A&E) during March 2012. Responses were received from 392 patients which equates to a response rate of 46%.

The collated results of this survey show that the Trust performed about the same as other Trusts in all categories:

- Travel by ambulance
- Reception and waiting
- Doctors and nurses
- Tests
- Hospital environment and facilities
- Leaving the A&E department
- Overall views on experience

✓ Overall the Trust achieved an improved set of results since the previous survey in 2008.
✓ The overall average score has increased from 72% to 76%.
✓ The Trust has improved by more than 5% or more on 8 questions.
✓ There have been no reductions by 5% or more in any question.
✓ The Trust scores around average (middle 60%) on most questions.

Patients made the following comments about their care:

"I have angina and was told I had done the right thing in going to A&E. At no time did I feel I had wasted their time (from doctors and nurses). I was well care for until my blood results were available. I was treated extremely well and have nothing but praise for the A&E department I attended".

"It would have been helpful to have an idea about timespans i.e. how long it may be before being called through. After an hour I was called through. I thought it was to see a doctor, but it was to see a nurse. It would be helpful to know how it all worked".

Areas for action for 2012/2013

- Ensure the plasma information screen is up kept up to date with details of current waiting times in the department.
- Provide information about waiting times at triage and/or reception.
- Provide information leaflets to explain processes within the A&E department.

Patient and public involvement programme

The Trust has an annual Patient and Public Involvement programme which includes a range of methods of seeking feedback from patients, carers and service users including patient satisfaction surveys.

In 2012/13, 34 local patient surveys were undertaken, 11 of which were conducted using a touch screen survey kiosk. The kiosk is an electronic, mobile device which allows patients and visitors to complete the surveys online. Once the feedback has been collated action plans are implemented to address any issues which have been identified from the survey.

The following information provides some examples of results of local patient surveys and improvements made from the results of four randomly selected surveys:

Patrick Murphy Unit (Gynaecology Clinic)
49 responses received via the kiosk.

Examples of responses received:
97% of patients felt their privacy was respected
93% of patients said they would recommend Leighton hospital to friends and family
84% of patients felt they received information that was easy to understand prior to their appointment.

Areas to action:
70% of patients were not offered an alternative private area
20% of patients did not receive any information prior to their appointment which was easy to understand.

Changes implemented following the survey:

- ✓ A new private room has been identified for patients who wish to speak in confidence with staff.
- ✓ Waiting times are now displayed and updated on a regular basis in the waiting area.

Confidentiality survey
95 responses received via the kiosk.

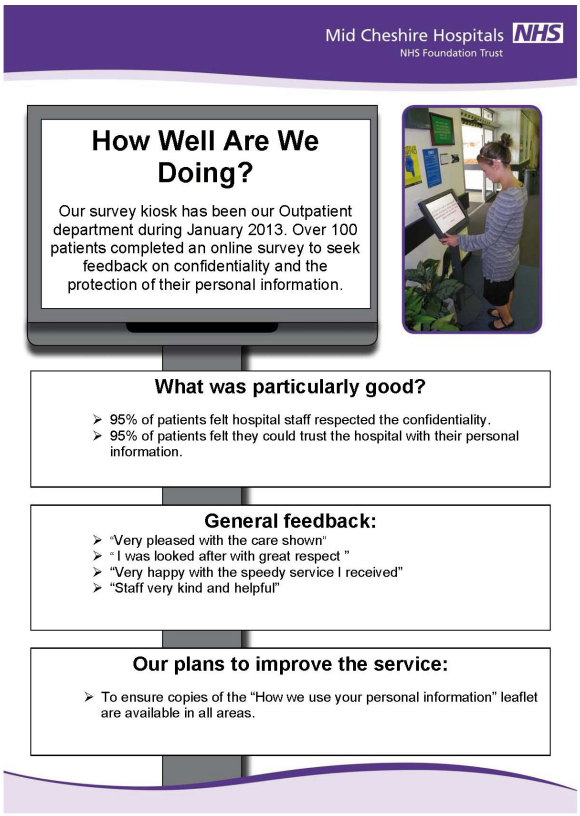
The following are the most recent examples of responses received:
95% of patients felt hospital staff respected the confidentiality.
95% of patients felt they could trust us as a hospital with their personal information.

Areas to action:
20% of patients did not feel adequately informed about how the hospital uses personal information.

Changes implemented following the survey:

- ✓ The introduction of the new "How we use your personal information" leaflet, copies now available in all areas.

A new style poster has been developed to ensure that feedback from surveys are displayed with clear actions highlighted as a result .



Macmillan Cancer Unit
92 responses received from a sample size of 100.

The following are the most recent examples of responses received:
100% of patients said staff treating them introduced themselves.
100% of patients felt staff listened carefully to what you had to say and their answers were informative and helpful'
100% of patients said the nurses gave them the opportunity to ask questions
98% of patients felt there was enough access to privacy if required
100% of patients felt the staff treated them treated them with respect

Areas to action:
Patients not always informed of clinic delays upon arrival to the unit.

Changes implemented following the survey:

- ✓ All patients/relatives are informed upon arrival of any clinic delays.

Nutrition survey
62 responses from a sample size of 75.

95% of patient said they were able to eat their meal without disturbance.
90% of patients felt their dignity was maintained during mealtimes.
90% of patients said they were offered regular drinks.

Areas to action:
87% of patients said they were not asked if they would like to eat their meal in the dayroom.
50% of patients were not offered the chance of washing their hands before their meal.
20% of patients said they were not offered condiments with their meal.

Changes implemented following the survey:
- ✓ Patients are now offered the use of the dayroom to eat their meals during their stay.
- ✓ All patients are now given hand wipes prior to their meals and offered condiments.

NHS Choices

Patients can comment about their experience on the NHS Choices website. There were a total of 76 new postings on the NHS Choices website in 2012/2013.

Leighton Hospital

Victoria Infirmary

As from December 2012, NHS Choices commenced using a star rating to assess NHS organisations. Leighton Hospital has achieved a star rating of 4.5 stars out of a maximum rating of 5 stars, whilst the Victoria Infirmary in Northwich has achieved 5 stars.

The Trust displays examples of positive postings on notice boards and actions any suggestions for improvement.

Examples of these include:

"The care I received in the Treatment Centre was considerate and efficient, staff were friendly and attentive"

"I have visited the Urology department on a number of occasions recently staff have always been friendly, courteous and efficient"

"From the moment I arrived until my departure staff treated me with courtesy, warmth and compassion in a very professional manner".

"Staff on ward 10 were fantastic, very attentive and made my stay a great deal easier".

"A service delivered by the Breast Care Unit with dignity, respect and compassion".

"I received efficient and effective treatment in the Accident and Emergency department".

"Staff in the Planned Investigations Unit were marvellous, they reassured and told me what they were doing and why".

Other patient and public involvement programme activities

Patient stories
Each month, the public board meeting is opened with a patient story. A patient story is where a patient, or carer, describes their experience of healthcare in their own words. The aim is to gain an understanding of what it is like to be a patient at the Trust, what was good and what could be improved. This is felt, by the organisation, to be an important way to set the tone of the meeting and ensure the Trust is grounded in the very essence of the patient experience.

Patient Register group meetings
The group consists of volunteers and members of the public who assist the Trust with various methods of involvement and is an opportunity for the Trust to share news of developments and to seek views form members. The meetings, held at local libraries, covered many topics which included presentations from the Eye Care Centre, the new Stroke Unit, Elmhurst Intermediate Care Centre, Pathology and the Infection, Prevention and Control Service.

Community talks
The Pathology Service Lead was invited to attend and talk to a community group. 2012 was National Pathology Year and an opportunity to increase public awareness and understanding. Pathology plays an important role in patient's diagnosis and treatment however, because much of the work is behind the scenes, many people are unaware of their vital contribution to medicine.

Readers' Panel
The panel has a total of 60 members and they have reviewed a total of 12 leaflets from April 2012 to March 2013. Leaflets included post operative information following surgery, Accident and Emergency information and parent information for babies who have MRSA and an easy read version of the Quality Accounts.

The panel submitted many suggestions including grammar changes and diagram or picture changes, overall the panel felt the leaflets were informative and the process supports staff in the development of patient information.

Patient Information
In 2012, the Trust introduced a patient information bedside folder. The folder includes information in relation to ward visiting times, car parking, and medication and discharge arrangements. The bedside folder was reviewed by the readers' panel, matrons, ward managers, executives and the infection control department, the folder is also available in other languages.

The Trust also has a number of leaflets now available in easy read version, all leaflets have been reviewed and approved by the Learning Disability Group. Leaflets include the following titles; Going for a blood test, Having a breast screening (x-ray), Having an ECG, Having an MRI Scan and Tell us what you think a patient feedback leaflet.

37 new patient information leaflets have been developed and an additional 36 have been reviewed either by the Patient Information Committee or Readers' Panel. 13 leaflets have been translated into other languages.

Review of complaints

The annual complaints report was produced and is available on the website via the Publication Scheme and the Customer Care pages - www.mcht.nhs.uk/customercare.

The Trust adheres to the Local Authority Social Services and National Health Service Complaints Regulations (England) 2009 and follows the Principles of Good Complaint Handling outlined by the Parliamentary and Health Service Ombudsman.

As part of the Trust's commitment to continuous improvement, a service review of the management of informal and formal complaints was undertaken in 2012. This has led to the development of a dedicated Customer Care Team who provide a single point of access for service users. This supports the single approach to dealing with complaints and provides flexibility to ensure complaints are dealt with effectively and that all feedback and lessons learned from complaints contribute to service improvement.

The Trust encourages feedback from service users on its complaint management processes and participates in the independent Patients Association Complaint Survey. The results of this survey help to identify any improvements that can be made to existing practice.

Some of the key themes of complaints received in 2012/13 involved communication, nursing care and delay in review/treatment and difficulties in parking, and are detailed opposite.

Communication – *issues raised in relation to lack of information for patients and relatives regarding treatment plans. Conflicting information given by different members of staff. Pathways/protocols not always explained properly.*

Actions taken:
- Communication skills workshops provided for staff.
- Communication & consultation skills training programme developed for medical staff.
- Dedicated "Nurse Co-ordinator" role introduced to wards to act as communication link for relatives.

Nursing Care – *issues raised regarding lack of nursing support with eating and drinking, making patients comfortable and assisting with toilet needs.*

Action taken:
- Care rounds are being introduced on a phased basis to check patients are comfortable and basic needs are met.

Delay in review/treatment – *some issues raised regarding wait times in the Emergency Department.*

Action taken:
- Patient assessment area (PAA) developed within the Emergency Department to aid patient flow and reduce wait times for patients for admission.

Car Parking – *issues raised regarding difficulty in finding a parking space during peak periods due to extensive building works across the hospital site.*

Actions taken:
- Reallocation of vacant employee parking areas to public / visitor parking. Intercom systems installed on entry and exit barriers linked directly to a Security Officer who can assist with locating a parking space. Reorganisation of security team working patterns to maximise the number of Security Officers on duty during peak periods.

The following table shows the number of complaints received, referrals to the Ombudsman and independent reviews over the past 3 years

Table 1: Overview of complaints received by the Trust

	2010/11	2011/12	2012/13
Number of complaints received	260	192	199
Number of independent reviews undertaken	1	0	0
Number of requests for review to the Ombudsman	3	10	5
Number accepted for review by the Ombudsman	0	3	4
Number upheld / partly upheld by the Ombudsman	0	1	2

Participation in clinical audits and research

The Trust is committed to embedding clinical audit throughout the organisation as a process for ensuring that healthcare provision is provided in line with best practice to optimise healthcare services. The process is facilitated through a clinical audit strategy (2010-13) that is managed through a central clinical audit function.

Both local and national clinical audit activity is instigated and led by clinicians with the support of the central clinical audit function.

National clinical audits

During 2012/13, there were 37 national clinical audits and no national confidential enquiries which covered the NHS services that the Trust provides. During the same period, the Trust participated in 70% of the national clinical audits in which it was eligible to participate.

The full list of national clinical audits can be seen in the following table which shows the clinical audits the Trust participated in and the percentage of cases submitted as required by the terms of reference for each clinical audit.

Table 2: National clinical audits participated in during 2012/13

National Clinical Audit	Participation	Data Submission
Adult community acquired pneumonia (British Thoracic Society)	Yes	100%
Adult critical care (Case Mix Programme – ICNARC CMP)	Yes	100%
National Joint Registry (NJR)	Yes	55%
Non-invasive ventilation - adults (British Thoracic Society)	Yes	In progress
Severe trauma (Trauma Audit & Research Network, TARN)	Yes	100%
National Comparative Audit of Blood Transfusion programme	Yes	100%
Potential donor audit (NHS Blood & Transplant)	Yes	Critical Care 100% Emergency Dept. 97.8%
Bowel cancer (National Bowel Cancer Audit Project)	Yes	100%
Head and neck oncology (Data for Head and Neck Oncology)	Yes	100%
Lung cancer (National Lung Cancer Audit)	Yes	100%
Oesophago-gastric cancer (National Audit for Oesphago-gastric Cancer)	Yes	100%
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Yes	100%
Heart failure	Yes	100%

National Clinical Audit	Participation	Data Submission
National Diabetes Inpatient Audit	Yes	100%
Diabetes (Paediatric)	Yes	100%
Pain database	Yes	44%
Carotid interventions audit	Yes	100%
Hip fracture database	Yes	95%
National audit of dementia	Yes	100%
Sentinel Stroke National Audit Programme (SSNAP)	Yes	100%
Elective surgery (National PROMs Programme)	Yes	80%
Epilepsy 12 audit (Childhood Epilepsy)	Yes	100%
Maternal, infant and newborn programme (MBRRACE-UK)	Yes	100%
Neonatal intensive and special care (NNAP)	Yes	100%
Paediatric asthma (British Thoracic Society)	Yes	100%
Paediatric pneumonia (British Thoracic Society)	Yes	Data collection in progress
Emergency use of oxygen (British Thoracic Society)	No	Consultant resource implications
Adult asthma (British Thoracic Society)	No	Consultant resource implications
Bronchiectasis (British Thoracic Society)	No	Consultant resource implications
Inflammatory bowel disease	No	Consultant resource implications
Renal colic (College of Emergency Medicine)	No	Availability of staff
Fractured neck of femur (College of Emergency Medicine)	No	Availability of staff
Paediatric fever (College of Emergency Medicine)	No	Availability of staff
Cardiac arrhythmia	No	Nurse specialist resource implications
National Cardiac Arrest Audit	No	Nurse specialist resource implications
Diabetes (Adult)	No	Data collection resource implications
Child health programme	No	New May 2012 – currently being reviewed

The reports of 17 national clinical audits were reviewed by the Trust in 2012/13. The table below highlights some of the actions taken to improve the quality of healthcare provided as a result of national clinical audits.

Table 3: Action taken following national clinical audit reports

National Audit	Actions Taken
Adult critical care (Case Mix Programme – ICNARC CMP)	A quarterly formal review of unexpected deaths has been instigated within the critical care unit.
National Joint Registry (NJR)	Compliant with standards to date but action is being progressed in relation to the patient's consent process to improve the Trust's submission rate.
Severe trauma (Trauma Audit & Research Network, TARN)	Good orthopaedic outcome measures were highlighted. Actions are now being undertaken to improve the numbers of patients seen by a Consultant in the emergency department and to reduce waiting times for CT scans and surgery.
National Comparative Audit of Blood Transfusion programme	Good compliance with labelling, adherence to policy and positive identification of patients. The Trust's transfusion policy is being updated to include revised processes for the handover of blood
Potential donor audit (NHS Blood & Transplant)	There has been a new appointment made to the chair of the organ donation committee. A new Trust policy for organ donation referral processes following completion of a risk assessment is being developed.
Lung cancer	A case of need has been prepared to support a second lung cancer specialist nurse and additional Consultant time. A respiratory service concept paper is being prepared and has been outlined in the emergency care division annual plan. Recording of patient information has improved in line with peer in the current dataset. The multi-disciplinary team structure is being reviewed to improve thoracic surgical presence.
Acute coronary syndrome or Acute myocardial infarction (MINAP)	There has been an improvement in compliance with prescribing patterns following the appointment of a permanent Consultant post.
Heart failure	There is a chronic heart failure protocol and specialist heart failure team in place to comply with the requirements for a multi disciplinary team clinical assessment of patients within 2 weeks of discharge.
Diabetes (Paediatric)	The percentage of patients with HbA1c (average plasma glucose concentration) <7.5% was the fourth highest in the country for compliance. Improvements in documentation have been implemented to address low compliance with key screening processes.
Pain database	There has been a change in the management of patients with epidural analgesia so that all patients with epidural analgesia are now cared for in the critical care unit. The acute pain team are developing updated pathways for the management of post-operative nausea and vomiting.
Hip fracture database	Multi-disciplinary team meetings have been implemented within the Unit in order to improve discharge arrangements for patients.
Sentinel Stroke National Audit Programme (SSNAP)	The thrombolysis service commenced in July 2012. The inpatient stroke services moved into a purpose built stroke unit in September 2012.

National Audit	Actions Taken
Elective surgery (National PROMs Programme)	Plans are being progressed to commence oral Apixiban for the prevention of deep vein thrombosis.
Epilepsy 12 audit (Childhood Epilepsy)	A paediatric epilepsy Nurse Specialist has been appointed and plans to appoint a paediatrician with an interest in epilepsy are currently under consideration.
Paediatric asthma (British Thoracic Society)	There has been a significant improvement in the documentation of assessments of inhaler technique and written discharge plans when compared to previous local audits.

Local clinical audits

The reports of 75 local clinical audits were reviewed by the Trust in 2012/13.

The table below highlights some examples of actions taken by the Trust as a result of local clinical audits to improve the quality of healthcare provided. All actions are agreed and followed up by the relevant clinical divisions to ensure they are implemented.

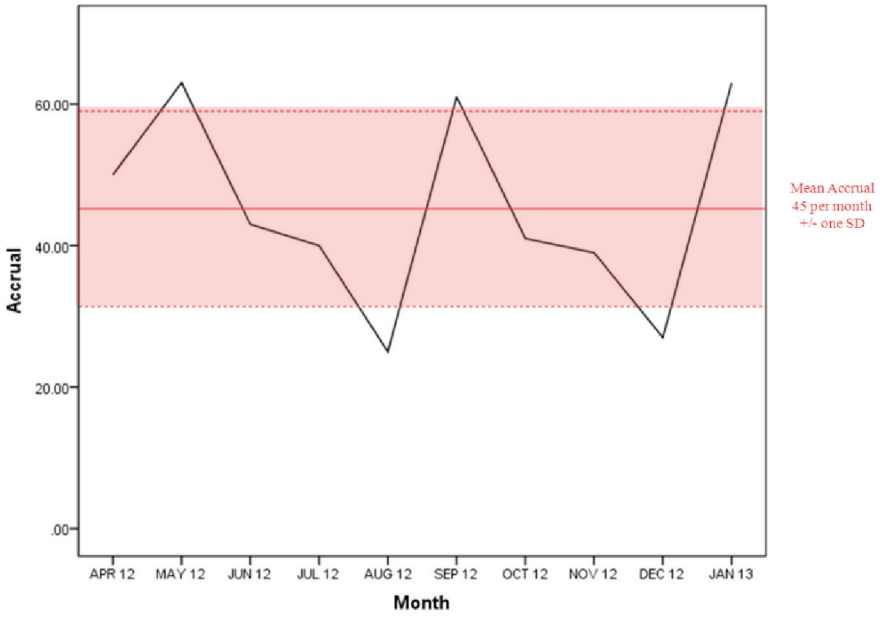
Table 4: Actions taken following local clinical audits

Local Audit	Actions Taken
Audit of Epidural Provisions within Labour Ward	A business case was presented to the Trust Board and subsequently anaesthetic cover has been increased on labour ward from 5 sessions per week to 10 sessions covering weekdays.
Re-audit of Latissimus Dorsi Flap (LDM) Reconstruction in MCHFT	The Trust VTE prophylaxis standards have been included in amended breast surgery protocols, including specific instructions around Enoxaparine, day-stay cases, in-patient cases and previous cases of VTE.
Audit of NICE CG124 Fractured Neck of Femur Patients on Orthopaedic Wards	A new pro-forma has been introduced for assessment and discharge to facilitate the mobilization and rehabilitation of patients who have undergone surgery for broken neck of femur. Plans are in place for a business case to be presented to the Clinical Commissioning Group for funding of a seven-day Physiotherapy service on the Orthopaedic wards.
Audit of Intra-Venous Urography (IVU)	Changes in practice have been agreed to stop using IVU series in favour of CT scanning where superior images are gained and improved diagnosis for treatment can be achieved.
Care of Babies with Prolonged Jaundice	A new Standard Operating Procedure and check list pathway detailing minimum tests required, in line with NICE guidelines, for prolonged jaundice cases has been introduced and now forms part of the clinical notes.

Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by the Trust between April 2012 and Jan 2013 that were recruited to participate in the National Institute of Health Research (NIHR) portfolio approved by a research ethics committee was 453.

The following chart shows the numbers of patients recruited to clinical trials over the past



10 months. There are, on average, 45 patients recruited each month.

Graph 1: Numbers of patients recruited to clinical trials

The Trust was involved in conducting 165 active clinical research studies during the reporting period including, but not limited to, the following areas:

- Cancer
- Cardiovascular
- Congenital Disorders
- Diabetes
- Eyes
- Generic Health Relevance and Cross Cutting Themes
- Infection
- Inflammatory and Immune System
- Injuries and Accidents
- Medicines for Children
- Musculoskeletal
- Oral and Gastrointestinal
- Primary Care
- Renal and Urogenital
- Reproductive Health and Childbirth
- Respiratory
- Skin
- 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 offered and contributing to wider health improvements. Clinical staff keep up to date with the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

The research and development team are constantly implementing change. The requirement for additional research opportunities for the local population was identified and, over the last year, partnerships have been developed with four local GP practices.

The Trust is now providing research at the primary /secondary care interface and, following feasibility assessments, NIHR studies have been implemented and successful recruitment has followed. This collaboration has sometimes proved challenging in a climate of constant change in the NHS but this has been overcome with good management support and exploring new ways of working.

Pictured above: Stephen O'Brien, MP for Eddisbury, meets with staff from the Trust's Clinical Research Department

Commissioning for Quality & Innovation framework (CQUIN)

A proportion (2.5%) of the Trust's income in 2012/13 was conditional upon achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Further details of the agreed goals for 2012/13 and for the following 12 month period are available online at:

www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275

The financial value of the 2012/13 CQUIN scheme for the Trust was £3,532,000.

For 2012/13, there were **national** CQUIN goals which focussed on the prevention of venous thrombo embolism (VTE), patient experience, dementia care and the NHS Safety Thermometer.

There were also **regional** goals which related to cancer staging, chemotherapy prescribing and advancing quality. The Trust and the local commissioners also agreed further **local** goals which are briefly described in the following table.

This table also shows the Trust's performance against each of the CQUIN goals. It can be seen that, of the 20 goals, the Trust achieved seventeen goals and has plans in place to address the three areas that were not achieved.

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

Key for Table 5 (opposite)

 = Achieved

 = Not Achieved

For goals 14 – 19, the Trust has anticipated the final results. The reporting period for the advancing quality programme does not close until August 2013.

Table 5: CQUIN results for 2012/13

Goal	Goal Name	Description of Goal	Achieved?
1	VTE prevention	Reduce avoidable death, disability and chronic ill health from VTE.	✓
2.	Patient Experience	Improve responsiveness to personal needs of patients.	✗
3.	Dementia Care	Improve awareness and diagnosis of dementia.	✗
4.	NHS Safety Thermometer	Improve collection of data in relation to pressure ulcers, falls, urinary tract infection and VTE	✓
5.	Cancer Staging Data	Increase number of patients' pre treatment data discussed and recorded at cancer MDT meetings	✓
6.	Chemotherapy Prescribing & Data Collection	Implementation of electronic prescribing of parenteral chemotherapy compatible with data collection using the systematic anti cancer therapy data set (SACT)	✓
7.	Prognostication & Advanced Care Planning	Implement prognostication of the last 12 months of life to ensure advanced care planning can take place.	✓
8.	Children and Young People Personal Diabetes Record	Develop and implement hand held records for children and young people with diabetes.	✓
9.	Children's Integrated Care Pathway	Develop and implement an integrated care pathway for children aged 0 - 2.5 years old who have complex physical or neurological conditions.	✓
10.	Co-ordinated Electronic Patient Records	Produce a strategy for a 5 year plan for hospital electronic patient records.	✓
11.	Implement Essence of Care Benchmarks	Implement the essence of care benchmarks as 'always events'	✓
12.	Medical Interventions and Medicines Management	Develop always events relating to medical interventions and medicine management.	✓
13.	Caring for Carers of Patients with Complex Needs	Document evidence of carers being actively involved where they wish to be involved, feel well informed and supported.	✓
14	AQ Acute Myocardial Infarction (AMI)	Implement the AQ care pathway for AMI	✓
15.	AQ Heart Failure	Implement the AQ care pathway for heart failure	✓
16.	AQ Hip and Knee Replacement	Implement the AQ care pathway for hip and knee replacement	✓
17.	AQ Stroke	Implement the AQ care pathway for stroke	✓
18.	AQ Patient Experience	All patients to complete an AQ PEMs survey	✓
19.	AQ Pneumonia	Implement the AQ care pathway for pneumonia	✗
20.	Integrated Neighbourhood Team	Participate in the development of an integrated neighbourhood team.	✓

Feedback from Care Quality Commission (CQC)

The Trust is required to register with the Care Quality Commission (CQC) and its current registration status is **unconditional** which means there are no conditions on its registration.

The Care Quality Commission has not taken enforcement action against the Trust during the period April 2012 to March 2013.

The Trust has participated in the following specials reviews and investigations by the Care Quality Commission during April 2012 to March 2013:

1. A targeted inspection programme for all acute NHS hospitals to assess services that provide the regulated activity of terminations of pregnancy. The focus of the visit was to assess the management of documentation that is used to certify the grounds under which a termination of pregnancy can lawfully take place. A random selection of medical records was checked by the CQC Inspectors who found that the Trust was compliant with the part of the regulation under review. No further action was required.

2. An annual unannounced inspection took place in December 2012 which reviewed the following outcomes for essential standards of quality and safety:
   - Outcome 1: Respecting and involving people who use services
   - Outcome 6: Cooperating with other providers
   - Outcome 7: Safeguarding people who use services from abuse
   - Outcome 9: Management of Medicines
   - Outcome 16: Assessing and measuring the quality of service provision

The Trust was found to be compliant in four of the five outcomes with minor concerns raised in relation to outcome 9: Management of Medicines.

In response to this, the Trust has developed an action plan to address the issues raised which will be monitored via the Trust governance processes.

The action plan included the dissemination of lessons learned posters and a list of critical medicines to all areas to raise staff awareness and remind them to report any incidents via the Trust's incident reporting system. Fortnightly audits to assess omissions and checking of controlled drugs has been commenced. A Trust-wide audit is proposed for the end of March 2013. Work is on-going on a new medication chart which will include standardised administration codes.

The report received from the CQC was very positive towards the services provided at the Trust. It included specific reference to the complimentary comments reported to the CQC Inspectors during their visit by patients regarding their care. Comments stated that staff were professional, caring and compassionate towards patients and respected their privacy and dignity.

Data quality assurance

NHS and General Practitioner registration code validity

The Trust submitted records during 2012/13 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:

99.9% for admitted patient care;
99.9% for outpatient care;
99.4% for accident and emergency care.

The percentage of records in the published data which included the patient's valid General Practitioner registration code was:

100% for admitted patient care;
100% for outpatient care;
100% for accident and emergency care.

Information Governance toolkit attainment

The attainment levels assessed provide an overall measure of the quality of data systems, standards and processes within an organisation. The Trust's Information Governance assessment report overall score for 2012/13 was 72% and the Trust was graded "not satisfactory".

The reduction in score when compared with the 2011 – 2012 assessment can be attributed to the shift in focus from some lower priority requirements to Information Governance training. The Information Governance team supported the training of over 3,000 staff, students and volunteers over the course of the year. Additionally, a large number of policies required review during 2012/13. Those which were not reviewed in time for this submission are expected to be in place by the baseline submission in October 2013.

The Trust has a progressive Information Governance committee which meets quarterly and has an agenda specifically focused around the six sections of the toolkit. The outstanding requirements are highlighted at each committee and toolkit leads provide feedback on the progress of requirements.

Clinical Coding error rate

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

- Primary diagnoses incorrect: 6.7%
- Secondary diagnosis incorrect: 4.4%
- Primary procedures incorrect: 3.6%
- Secondary procedures incorrect: 8.8%

The Trust's performance in relation to the clinical coding error rate is better than the national average and has also improved in all areas when compared with the results from last year. The results shown should not be extrapolated further than the actual sample audited. A cross section of services was reviewed within this sample.

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

- Deliver the recommendations of the payment by results audit
- Continue to deliver required training for all accredited coders
- Recruit to the internal coding auditor position
- Continually review coding resources and performance

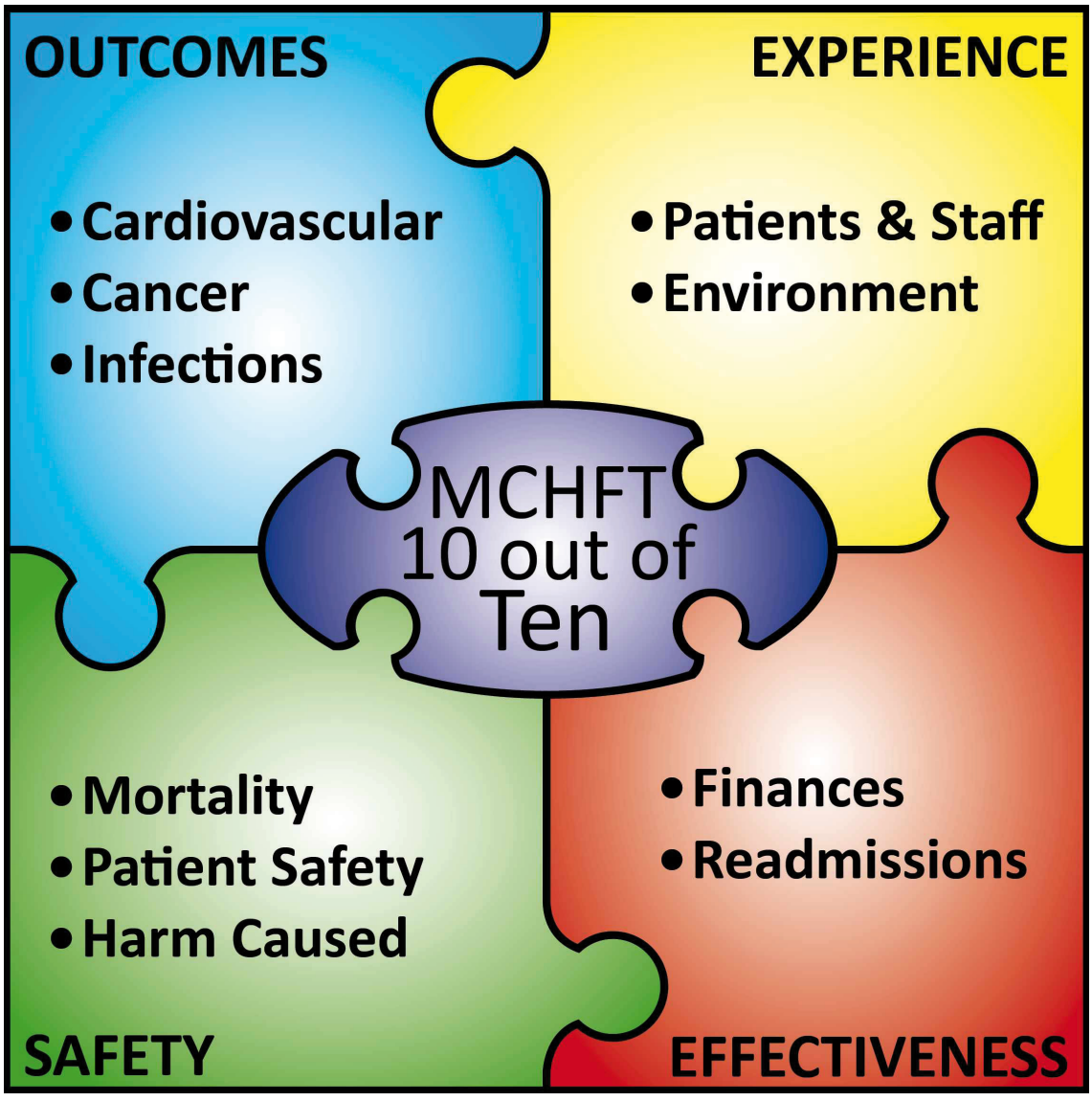
Part 3

Review of quality performance

This section of the Quality Account details progress against the Trust's 10 out of Ten strategy. It also describes the Trust's performance against areas of public interest or those recommended by other bodies such as Monitor and the Department of Health.

This review of quality performance has been detailed under the following domains of:

- Safety
- Effectiveness
- Experience
- Outcomes



Summary of overall progress

Achievement thresholds

As the Trust's 10 out of Ten quality indicators are stretch targets (over and above the national requirement), the achievement thresholds for the 2012/13 Quality Account have been set as Gold, Silver and Bronze.

Key

Achieved 10 out of Ten target (Top 10% of performing Trusts)

Performance in top 25% of performing Trusts or 10% away from 10 out of Ten threshold

Achieved better than peer or 25% away from 10 out of Ten threshold

Further work needed to achieve peer or better

Safety

Priority 1: Mortality – To reduce the 12 month rolling Risk Adjusted Mortality Index (RAMI) by 10 points annually

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 30 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)

- MRSA

- *Clostridium Difficile*

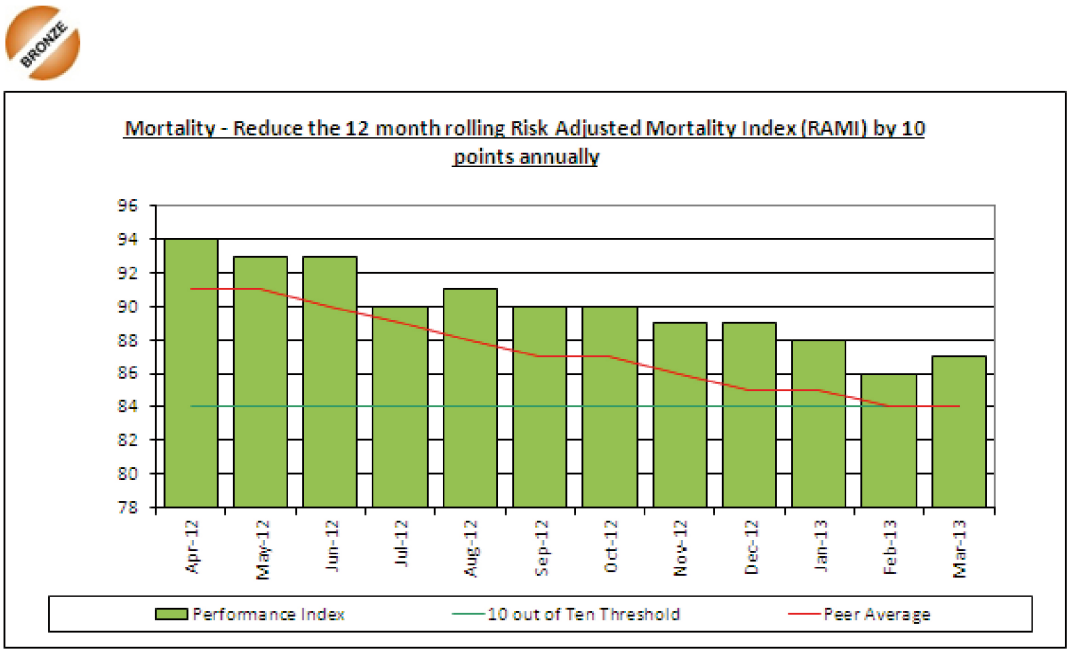
Safety

Priority 1: Mortality

To reduce the 12 month rolling Risk Adjusted Mortality Index (RAMI) by 10 points annually

In order to understand whether people are getting healthier or the 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 past medical history and existing conditions and displays this as an index. In general terms, the rationale for calculating death rates in hospital is so that they can be used as a measure of hospital quality.

Graph 2 shows the Trust's RAMI between April 2012 and March 2013 which demonstrates that the Trust's RAMI has reduced over the 12 month period.



Graph 2: RAMI between April 2012 and March 2013

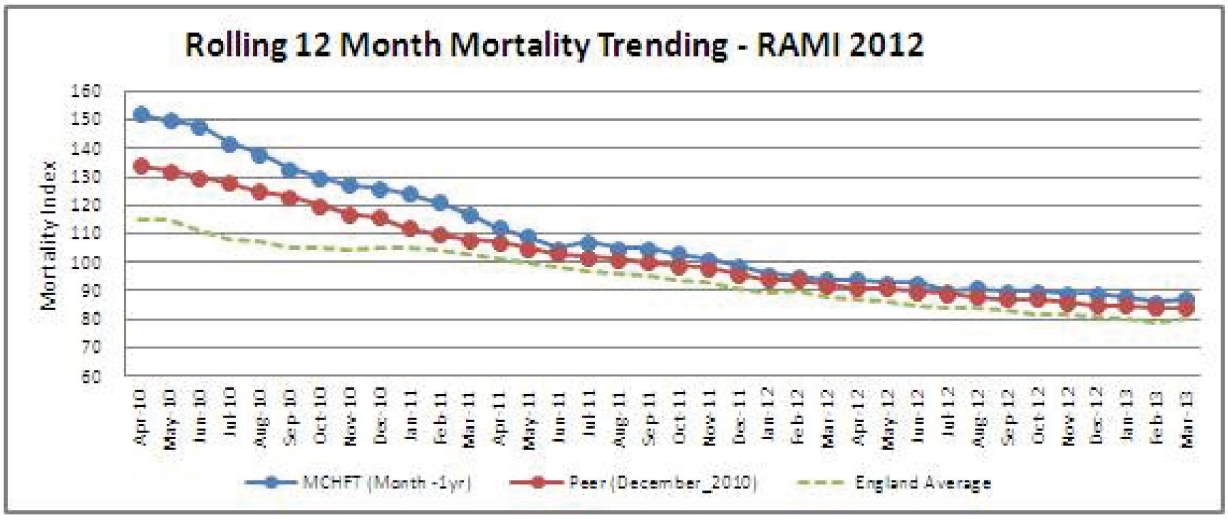
The Risk Adjusted Mortality Index (RAMI) developed by CHKS uses regression analysis to predict the expected probability of death for each patient based on the experience of the national norm for patients with similar characteristics:

- 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 CHKS as its provider for mortality data.

Work Programme to Improve Hospital Mortality Rates
Since 2009, the Trust has monitored its mortality rate through the Hospital Reducing Mortality 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 at 87 compared to the peer of 84. This is demonstrated in graph 3 below.

The Hospital Reducing Mortality Group undertakes case note reviews to identify areas of good practice. It also asks the question 'could the Trust have done things better?' An action plan for improvement is developed and monitored via the Hospital Reducing Mortality Group. The clinical divisions also undertake case note reviews.



Graph 3: Rolling Monthly Mortality Trending

Safety

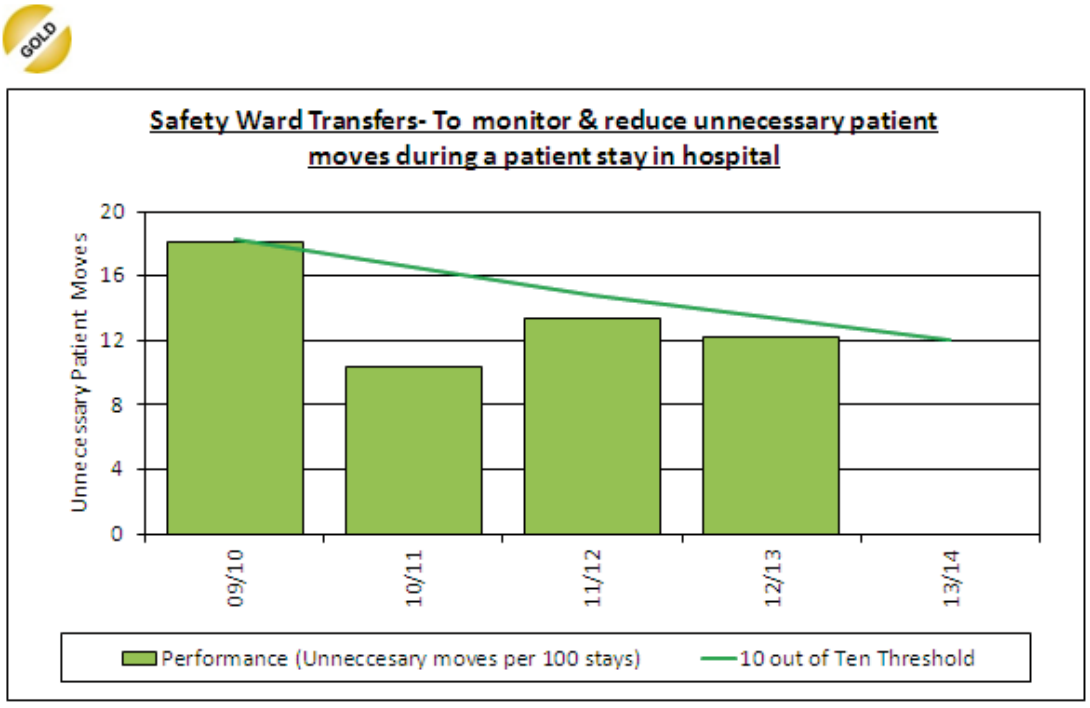
Priority 2: Patient safety

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

Patients appropriately 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 an increased length of stay in hospital. The documented goal for this priority is 'to reduce the number of times a patient is moved to another ward which is not connected with their care pathway'.

In 2010, following the launch of the Quality and Safety Improvement Strategy 2010-14, the Trust established a method of monitoring this quality indicator, which involved gathering performance data from 2009/10 in order to set a target for improvement. The target set is to achieve an annual 10% reduction from the starting point in 2009/10 for the remaining four years of the strategy.

Graph 4 shows the average number of unnecessary patient ward moves per 100 hospital stays since April 2009. The graph demonstrates that the Trust has consistently over-achieved against the target on an annual basis with an overall reduction of approximately 35% since the measure was introduced.



Graph 4: Unnecessary Patient Moves

The Trust intends to continue to reduce the number of unnecessary patient ward moves in 2013/14 by progressing the following actions:

- Ensuring that 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 that the bed configuration matches the demand for each specialty. This is being addressed through the Clinical Services Strategy and regular bed modelling reviews with the Divisional and Corporate teams
- Continuing to reduce the time patients spend in hospital and therefore reduce any circumstance of unnecessary ward moves
- 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.
- Ensuring that patients who have a diagnosis of dementia are not moved to another ward, unless for clinical reasons. This action is audited regularly and the last audit showed the Trust achieved 100% for not moving patients with dementia unnecessarily.

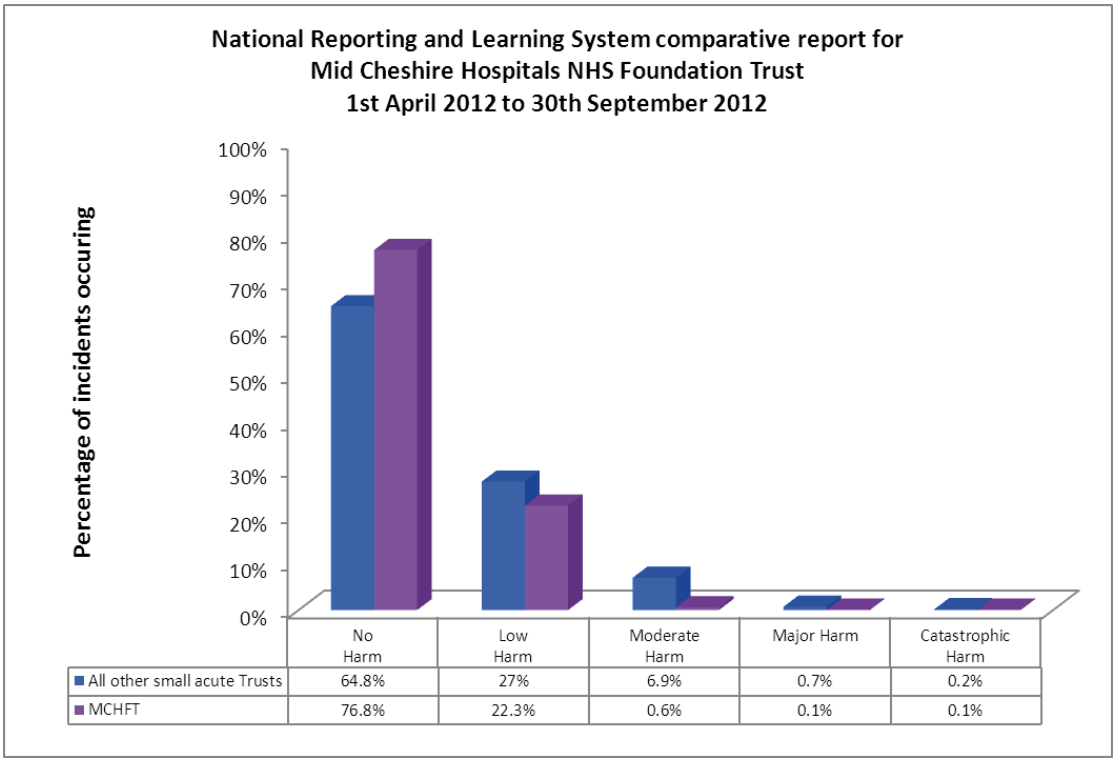
Safety

Priority 3: Harm caused

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

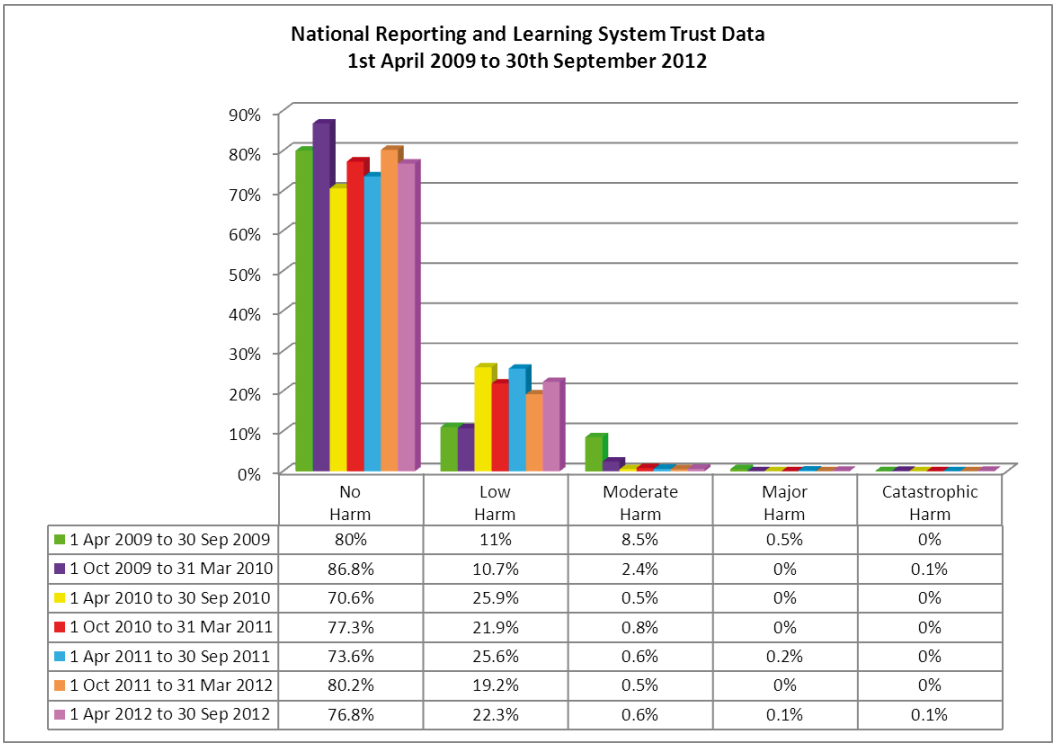
All patient safety incidents are reported to the National Reporting and Learning System (NRLS) on a weekly basis. The NRLS produce a comparative report on a 6 monthly basis which compares the Trust with 30 similar sized acute Trusts. From June 2012, this data has been published on the NHS Commissioning Board's Website as they have now taken over the functions of the National Patient Safety Agency (NPSA). This will ensure that patient safety is at the heart of the NHS and builds on the learning and expertise developed by the NPSA.

Graph 5 is the latest comparative reporting rate summary which provides an overview of incidents reported by the Trust to the NRLS between April 2012 and September 2012. This data is the latest available and was published in March 2013. The graph demonstrates that the Trust has a high number of reported no harm incidents and less harm incidents when compared to other acute Trusts of a similar size.



Graph 5: NRLS comparative data for April 2012 to September 2012

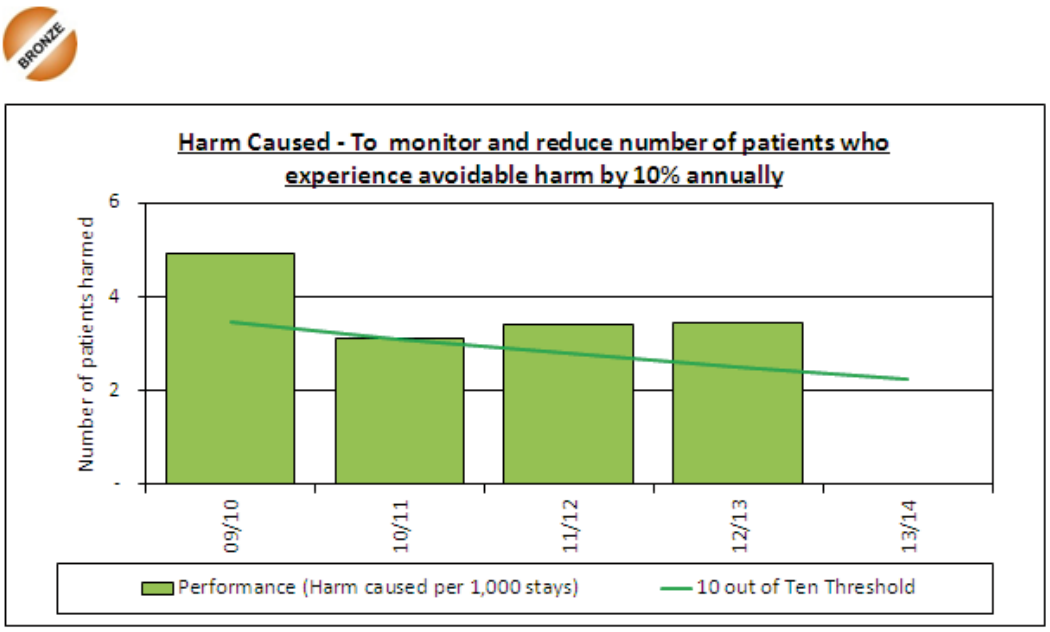
The reporting of no harm incidents is positive as it demonstrates that the Trust has a risk aware culture and that staff are open about reporting patient safety incidents.



	No Harm	Low Harm	Moderate Harm	Major Harm	Catastrophic Harm
1 Apr 2009 to 30 Sep 2009	80%	11%	8.5%	0.5%	0%
1 Oct 2009 to 31 Mar 2010	86.8%	10.7%	2.4%	0%	0.1%
1 Apr 2010 to 30 Sep 2010	70.6%	25.9%	0.5%	0%	0%
1 Oct 2010 to 31 Mar 2011	77.3%	21.9%	0.8%	0%	0%
1 Apr 2011 to 30 Sep 2011	73.6%	25.6%	0.6%	0.2%	0%
1 Oct 2011 to 31 Mar 2012	80.2%	19.2%	0.5%	0%	0%
1 Apr 2012 to 30 Sep 2012	76.8%	22.3%	0.6%	0.1%	0.1%

Graph 6: NRLS comparative data for the past 3 years

Graph 6 highlights the comparative data from the NRLS for the past 3 years. The graph demonstrates that the majority of incidents reported by the Trust resulted in no harm to patients and this has been consistent over the previous 3 years. The number of low, moderate and major harm incidents have all decreased in the period of October 2011 to March 2012 compared to the previous period of April 2011 to September 2011.



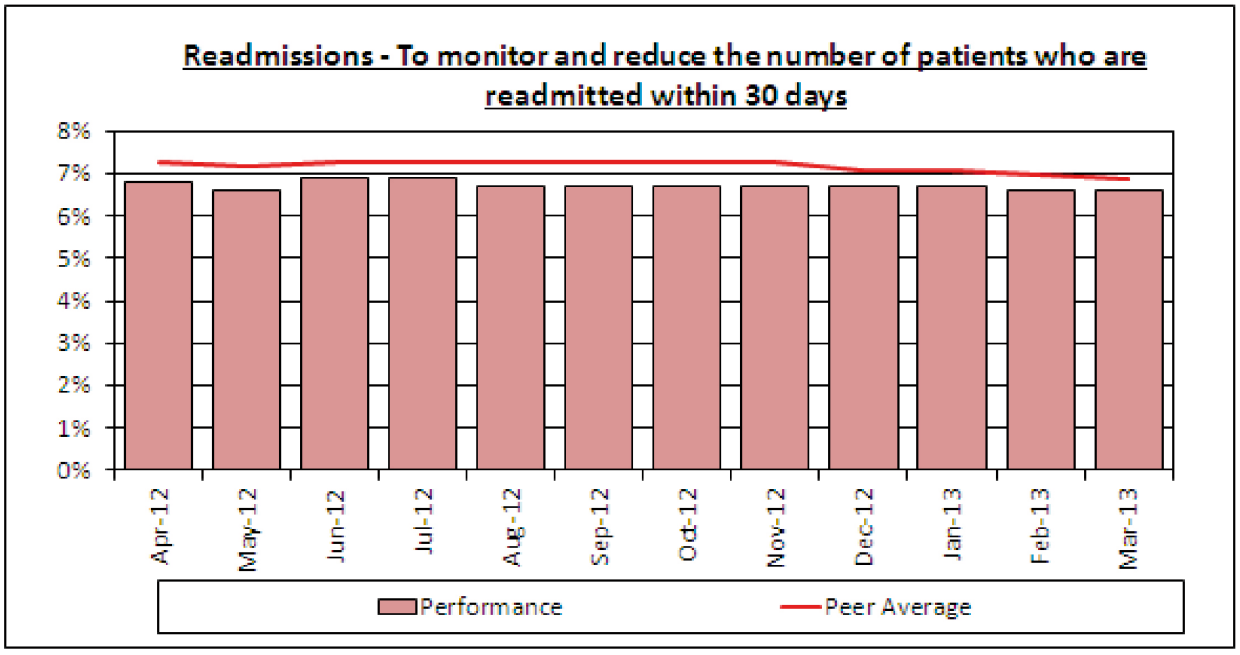
Graph 7: Avoidable harm caused

Graph 7 shows the Trust's performance against the 10 out of ten target to monitor and reduce the number of patients that experience avoidable harm by 10% annually. Although the Trust has not achieved this target, the number of patients that have experienced avoidable harm has remained the same during 2012/13 when compared to 2011/2012.

Effectiveness

Priority 4: Readmissions

To reduce the number of patients who are readmitted to hospital within 30 days of discharge



Graph 8: Reduction in number of patients readmitted within 30 days

To demonstrate effective discharge planning the Trust's priority is to reduce the number of patients readmitted to the hospital within 30 days of discharge. The graph above demonstrates that emergency readmissions within 30 days have reduced to 6.3% against a peer of average of 7.0%.

When the Trust's readmission rates are compared against the other acute Trusts in the North West of England, the Trust is in the top 10% of Trusts for the lowest readmission rates.

This success has been achieved through the daily monitoring of patients that are at high risk of readmission to ensure that a medical review is undertaken to assess each individual patient's wider health needs.

This review is followed up by a telephone call to the patient 72 hours following their discharge home by the integrated discharge team to ensure the continuing well being of the patient and to deal with any concerns that may have arisen.

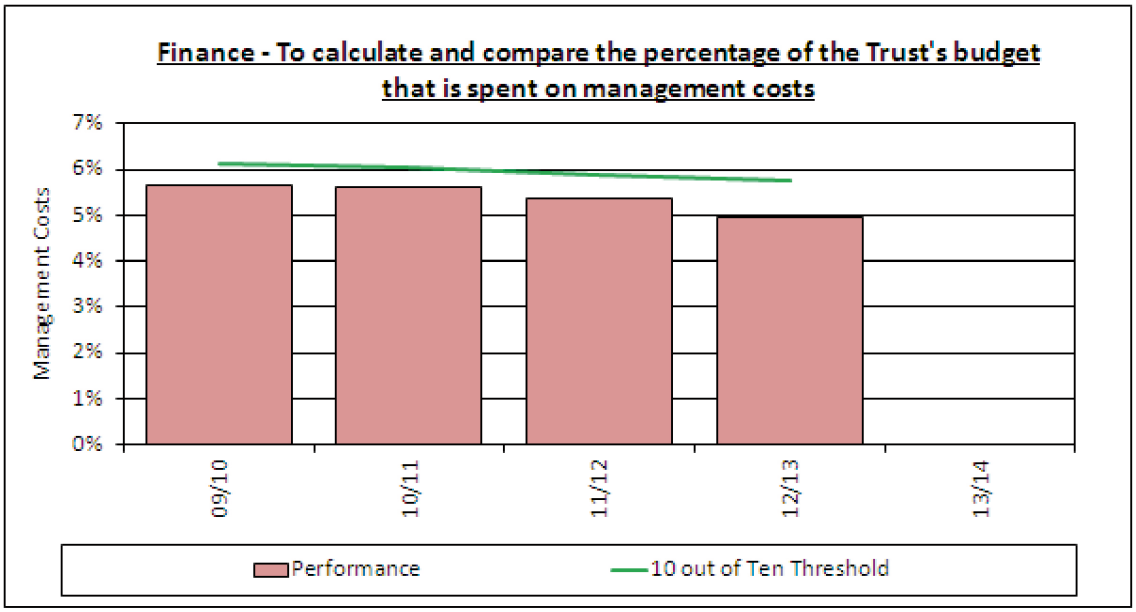
Effective links with the relevant community teams have also been progressed to ensure the continuity of care within the community.

Further work for 2013/14 will include the continued development of partnership working with Clinical Commissioning Groups (CCGs) and other community teams to develop the use of a single patient passport for patients with long term conditions and specific health needs.

Effectiveness

Priority 5: Finance

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



Graph 9: Trust's annual spend on management costs

On a quarterly basis, the Trust measures the percentage of income spent on management and this has continued to reduce through the year.

During 2012/13, the Trust has consistantly maintained a position lower than the target the Trust has set itself.

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

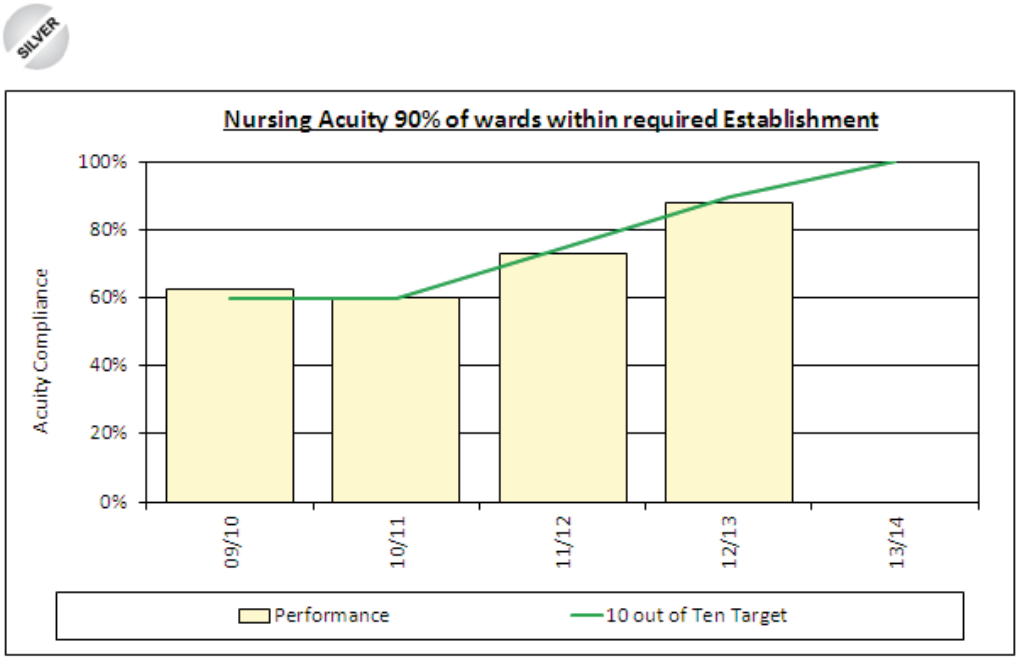
Nurses
Since 2008, the Trust has used the Safer Nursing Care Tool (SNCT), formerly known as the Association of UK University Hospitals Tool, to measure the acuity/dependency of adult inpatients to determine the required nurse staffing levels on its wards.

The acuity/dependency monitoring is undertaken at least every 6 months and the results are used to review staffing requirements and to adjust establishment budgets to meet the need of patients.

Information collated during 2012/13 has been reviewed by the Trust's Acuity group and escalated to the Executive Workforce Committee and the Executive Directors.

The aim for 2012/13 was that 90% of adult inpatient wards would be within range of their required establishment. The graph below shows that the Trust achieved 88% against the target of 90%.

Actions have been taken including the redeployment of staff from over established areas, the recruitment of qualified nurses from Ireland and Spain and the use of trained and unqualified bank staff employed by the Trust on a daily basis to ensure that the required staffing levels are met.



Graph 10: Nursing Acuity of Ward Areas

Doctors
The ratio of doctors has, in the previous 3 years, been an element of the 10 out of Ten strategy. The data previously used to report this indicator is no longer available to the Trust. There has been extensive work undertaken to look at other information available to the Trust such as the 2011 census and consultant episodes of care. Unfortunately, this has proven not to be able to provide the information the Trust needs in a robust way to support this indicator. Therefore it is no longer possible to report against this metric.

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 professionals, including doctors.

Consequently, during 2012/13, the Trust has appointed additional Consultants in Paediatrics, Emergency Care and 3 posts in Anaesthesia. The Trust has also received support from the Mersey Deanery to appoint an additional training grade post in Acute Medicine.

The Trust's investment in additional Consultant posts will continue in 2013/14.

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 2012, the Trust declared compliance in eliminating mixed-sex accommodation. The declaration of compliance has been published on the Trust's website 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 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 Board of Directors and also to the local Commissioners.

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 (DSSA) Group.

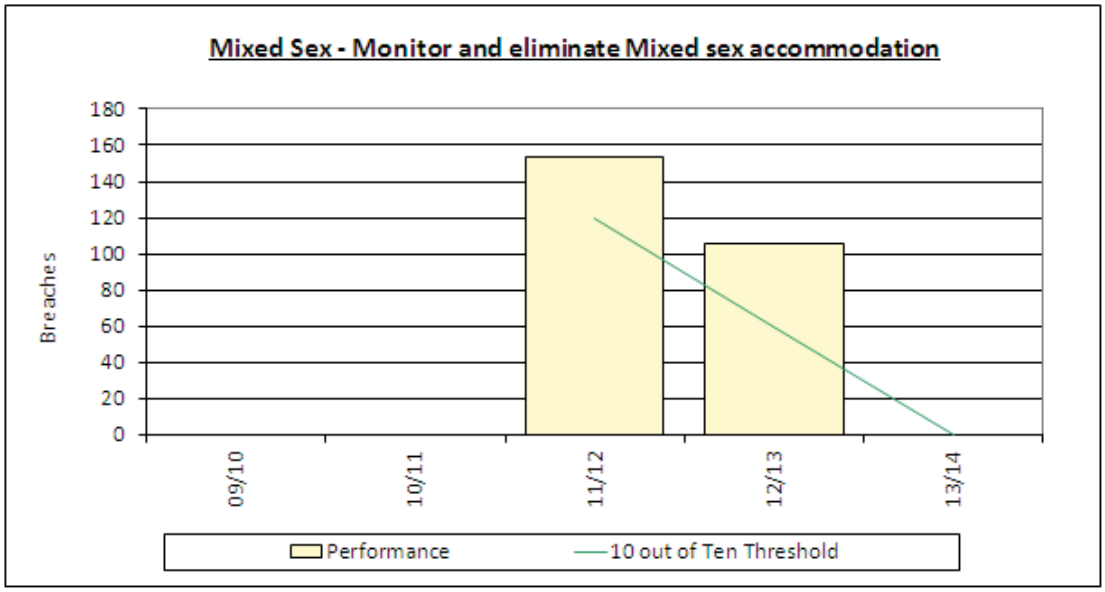
Patient feedback
Every month, volunteers assist the Trust asking patients about their experiences of same sex accommodation. The Trust is please to report that, over the past year, there have been no patient concerns raised as a result of mixed sex accommodation and all patients surveyed have never reported either sharing accommodation or washing/toilet facilities with patients of the opposite sex.

Changes made in practice
Previously, the Trust reported two areas where patients might receive care in an area that is not single sex. One of these was the Acute Stroke Bay and, earlier this year, the new stroke unit was opened with a purpose built acute stroke bay which has same sex accommodation. This means patients requiring acute care following a stroke are now cared for, during the whole of their stay, in high quality, safe, appropriate and same sex accommodation.

The other area where patients may receive care in a mixed sex environment is when they require clinical care in the intensive therapy unit/high dependency unit (ITU/HDU). There has been improved communication between staff working in these areas, bed managers and senior clinical staff to identify promptly when a patient is no longer likely to require ITU/HDU care. These patients are discussed at the twice daily bed meetings and plans made to move them to an appropriate ward when it is safe to do so. Unfortunately, there are occasions when this is not possible which leads to patients staying in ITU/HDU longer than they need and this is reported as a breach.

When these breaches occur, the staff always apologise to the patient and make every effort to address the situation as quickly and as safely as possible.

Graph 11 highlights the progress that has been made since last year. The numbers of breaches are reported monthly to the Trust Board, Commissioners and Health Authority.



Graph 11: Breaches within mixed sex accommodation

The development of the new theatre complex and critical care unit which is currently being built will negate mixed sex accommodation as the new unit has been designed with the resolution of this issue in mind. The new critical care facility is due to be opened in early 2014.

Outcomes

Priority 8: Cardiovascular

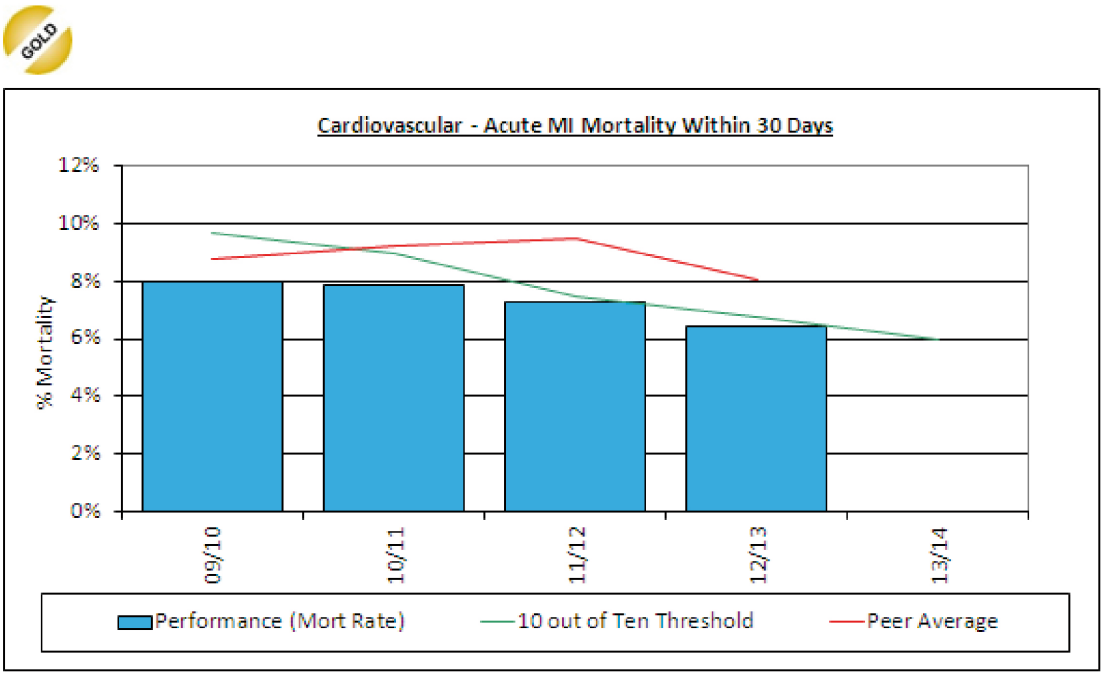
To reduce the 30 day mortality rate in patients following Acute Myocardial Infarction (AMI)

There were approximately 500 patients admitted in 2012/13 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 whilst the patient is still in hospital, phases 2 and 3 are offered following discharge and phase 4 is offered in partnership with Cheshire East Council and Age Concern Cheshire who fund exercise instructors for sessions held in Winsford and Sandbach.

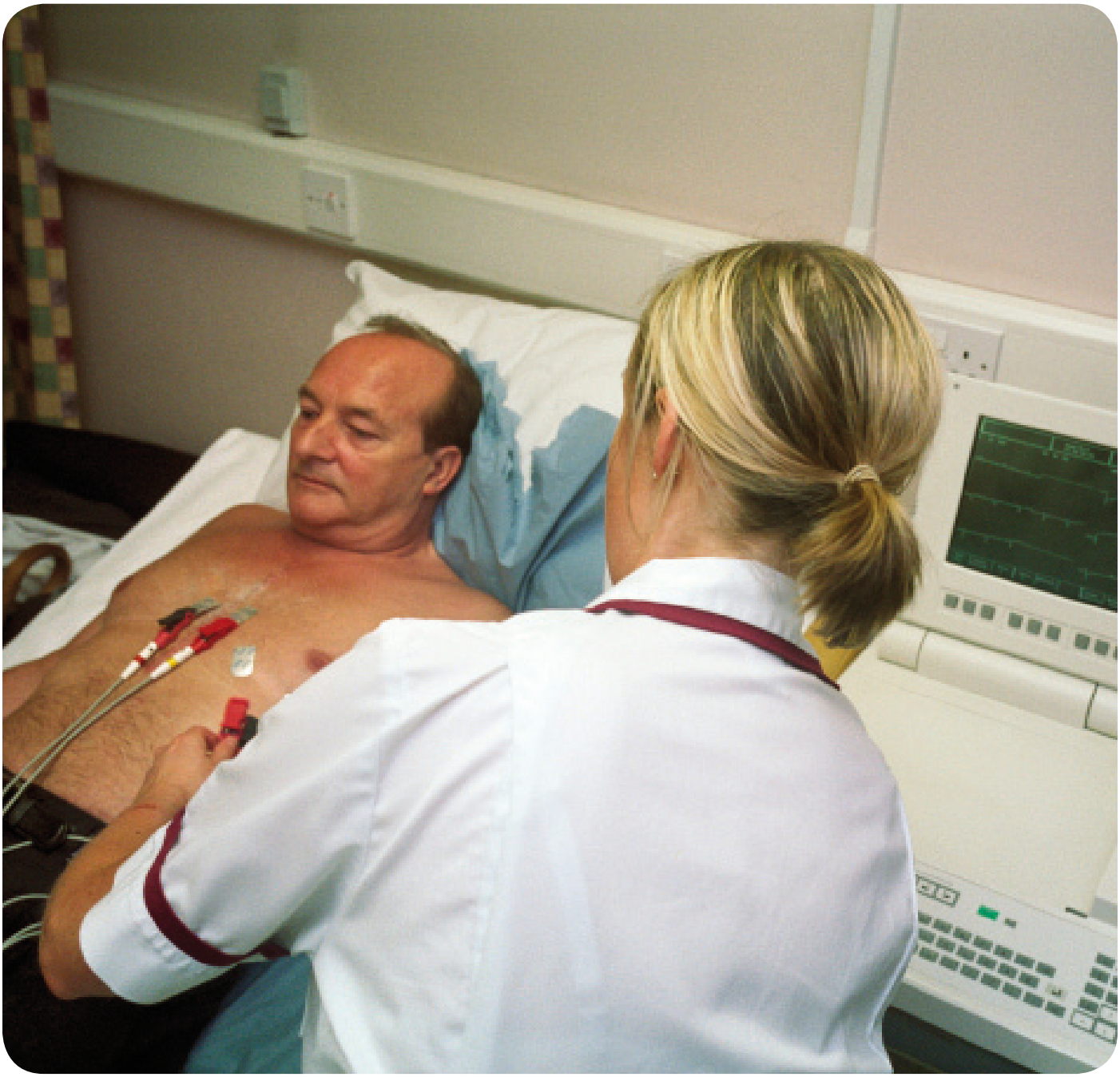
Cardiac rehabilitation aims to reduce patient mortality and morbidity and to provide support for both the patient and carer to enhance their quality of life. The chance of death following an AMI is significantly reduced when lifestyle modifications are made.

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 2012/13.



Graph 12: Trust's performance in reducing acute MI 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. The Trust compliance with the Advancing Quality Programme for AMI care and treatment is currently 98.8% (CQUIN target is 95%).



Outcomes

Priority 9: Cancer

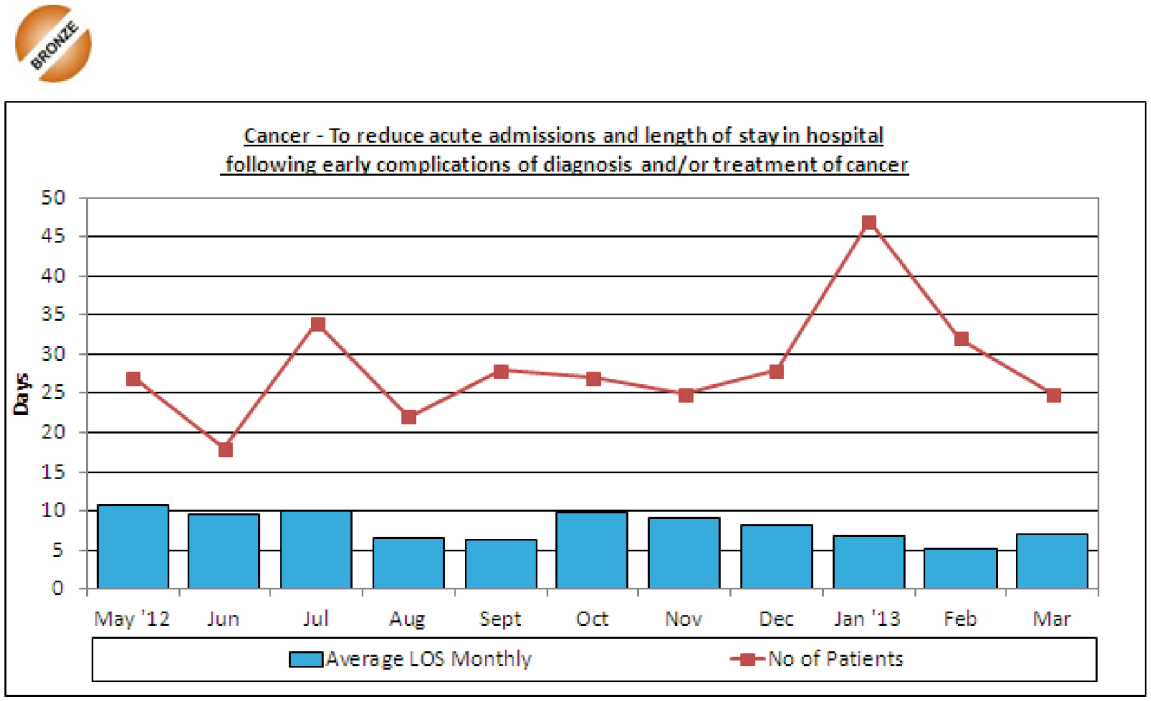
To reduce acute admissions and length of stay in hospital following early complications of diagnosis and / or treatment of cancer

The acute oncology team at the Trust was established in May 2012. The team consists of 2 Clinical Nurse Specialists and an multi disciplinary team co-ordinator.

MCHFT was one of the first Trusts in the Greater Manchester and Cheshire Cancer Network to establish an Acute Oncology Service and therefore there is very little peer data available to compare the Trust against. The intention of the implementation of the acute oncology team was to reduce the length of stay for patients admitted with complications of their cancer treatment or the cancer itself.

The introduction of a rapid alert system highlighting that a patient with a known cancer diagnosis has been admitted to A&E or into the hospital has meant that the acute oncology team can have a rapid intervention resulting in a reduction in length of stay. There is also improved patient experience as the acute oncology team know where that patient is up to on their cancer journey.

It can be seen in the data provided in graph 13 that the length of stay is decreasing steadily. The Cancer Network identified that there should be a reduction in length of stay of at least 1 day in the first 12 months, which has been achieved and exceeded by the team at MCHFT.



Graph 13: Average length of stay and numbers of acute admissions

Formal feedback from people who have used the service (patients, carers and staff) is due to take place in the summer of 2013, but initial informal feedback has shown that patients and their carers are benefitting from the service. The admitting medical teams report that they have benefitted in their decision making process with the specialist support of the acute oncology team ensuring that up to date clinical information and understanding is available from the tertiary cancer centre.

Outcomes

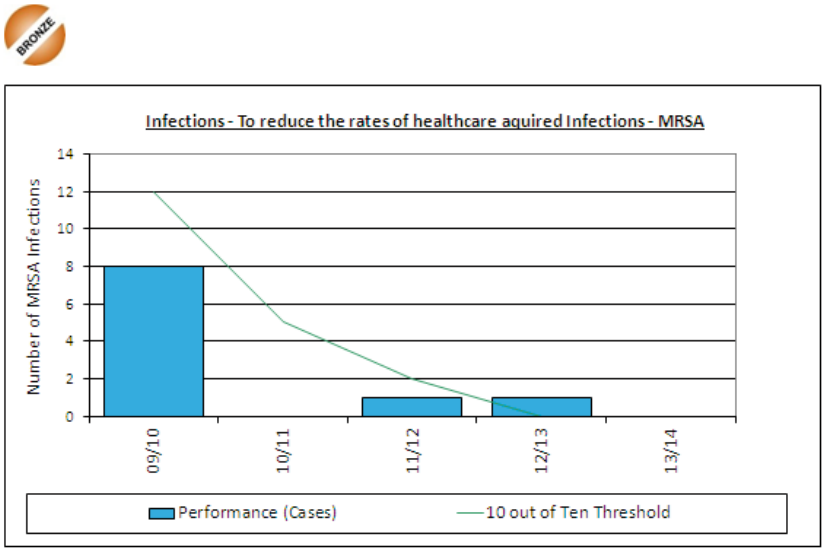
Priority 10: Infections

To reduce the rates of Healthcare Associated Infections (HCAI)

Planned Target Outcomes
To demonstrate an annual reduction in HCAI rates

MRSA bacteraemia	Target: 0	Actual 1	Not Achieved
Clostridium difficile	Target: < 54	Actual 23	Achieved

MRSA bacteraemia. The Trust has had one case of MRSA bacteraemia (blood stream infection) over the past twelve months, which means that the target of zero cases has not been achieved this year.

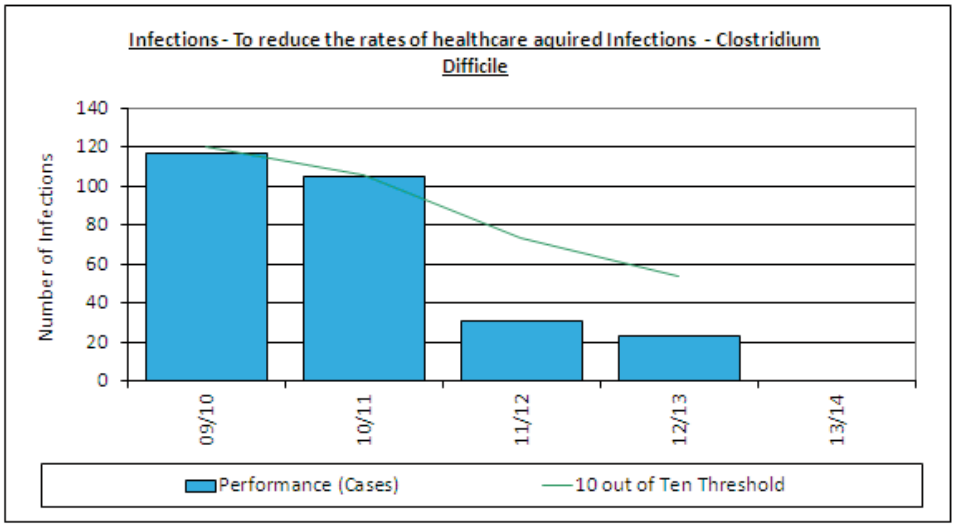


Graph 14: MRSA bacteraemia rates

Clostridium difficile - Rates of *Clostridium difficile* infection (CDI) Rates of *Clostridium difficile* infection (CDI) have continued to reduce over the last year and this is an on-going achievement for MCHFT.

The final CDI rate for the twelve month period stands at 23 cases, representing a 23% reduction from last year's reporting total for 2011/12 which was 30 cases.

This places the Trust amongst the top performing organisations in the North of England.



Graph 15: Clostridium difficile rates

Reduction Strategies
Effective infection prevention and control strategies target all types of HCAI and over the last year some of the infection prevention improvements have included:

- ✓ Cleaning standards have improved incrementally by 4% over the last 2 years as demonstrated through the use of a national audit tool
- ✓ The Trust now has a deep cleaning team that provides an additional 500 cleaning hours per month to perform a scheduled deep clean and ensure bed areas can be quickly prepared for the next patient
- ✓ Hand hygiene scores (compliance with hand hygiene practice) have improved over the last 2 years
- ✓ More staff have been trained in aseptic technique this year, which supports safe practice for patients with invasive devices or wounds
- ✓ Student Nurses on placement have received dedicated teaching time from the IPCS (Infection Prevention & Control Service)
- ✓ MCHFT has established a multi-disciplinary group looking at antibiotic stewardship; which supports the need to restrict certain antibiotics in specific patient groups and ensure careful and appropriate use of all antibiotics.

Next years' aim is to continue to drive up standards of clinical care by maintaining existing strategies and focus more on staff education within clinical areas.

Additionally, with recent changes in the delivery of healthcare, there is a need to consider how the Trust can further support patients on discharge if there is a risk of infection developing outside the hospital setting. Simple patient education and advisory leaflets may help to reduce any further treatment or readmissions that may be required due to infection.

Performance against quality indicators and targets

National quality targets

Table 9: National priority and performance standards

	2010-2011	2011-2012	2012-2013	Target	Achieved?
MRSA bacteraemias	8	1	1	0	✗
Clostridium Difficile infections	117	30	23	54	✓
Percentage of patient who wait 4 hours or less in A&E	98.1%	97.3%	95.04%	95%	✓
The percentage of Referral to Treatment (RTT) pathways within 18 weeks for completed admitted pathways	92.8%	91.1%	92.94%	90%	✓
The percentage of Referral to Treatment (RTT) pathways within 18 weeks for completed non-admitted pathways	97.6%	96.8%	96.96%	95%	✓
The percentage of Referral to Treatment (RTT) pathways within 18 weeks for incomplete pathways	N/A	N/A	95.6%	92%	✓
The percentage of patients waiting 6 weeks or more for a diagnostic test	N/A	N/A	0.87%	<1%	✓
Percentage of patients seen within two weeks of an urgent GP referral for suspected cancer	93.2%	95.4%	95.08%	93%	✓
Percentage of patients seen within two weeks of an urgent referral for breast symptoms where cancer was not initially suspected	N/A	94.6%	94.78%	93%	✓
Percentage of patients receiving first definite treatment for cancer within one month (31 days) of a cancer diagnosis	98.4%	99.6%	99.25%	96%	✓
Percentage of patients receiving subsequent treatment for cancer within 31 days where that treatment is surgery or anti-cancer drugs	100%	98.9%	100% 100%	98% surgery; 94% drugs	✓
Percentage of patients receiving first definite treatment for cancer within 62 days of an urgent GP referral for suspected cancer	85.6%	87.9%	89.71%	85%	✓
Percentage of patients receiving first definite treatment for cancer within 62 days of referral from an NHS Cancer Screening Service	N/A	92.9%	94.68%	90%	✓

✓ = Achieved ✗ = Not Achieved

National quality indicators

From 2012/13, all Trusts are required to report against a core set of indicators, for at least the last two reporting periods, using a standardised statement set out in the NHS (Quality Account) Amendment Regulations 2012. These regulations can be accessed through the following link - www.legislation.gov.uk/uksi/2012/3081/made

Where the data is made available by the Health and Social Care Information Centre, a comparison should be made of the numbers, percentages, values, scores or rates of the Trust's indicators with

a) the national average and
b) those Trusts with the highest and lowest figures.

The value and banding of the summary hospital-level mortality indicator (SHMI)

Date	Trust Performance	National Average	Highest Result	Lowest Result
July 2011 - June 2012	1.13 Higher than expected	1.00	1.25	0.71
October 2011 - September 2012	1.13 Higher than expected	1.00	1.13	0.89

The Trust is currently reviewing the data that feeds the SHMI reports and have enlisted the support of CHKS to do this. The Trust is also reviewing a selection of the SHMI categories to gain a greater understanding as to why some cases are being allocated to non-definitive categories such as:

- SHMI category 139 Malaise and fatigue;
- SHMI category 137 Nausea and vomiting;
- SHMI category 126 Open wounds of head, neck and trunk.

The Trust is also reviewing patients where their diagnosis is not recorded until after their second or third admission to hospital.

The Trust intends to take / has taken the following actions to improve this result, and therefore the quality of its service, by:

- Participating in the North West Mortality collaborative;
- Establishing a reducing mortality group which is chaired by the Medical Director;
- Establishing a reducing mortality group in the emergency care division;
- Reviewing case notes and developing action plans where appropriate.

The percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust

Date	Trust Performance	National Average	Highest Result	Lowest Result
July 2011 - June 2012	14.81%	18.6%	46.3%	0.3%
October 2011 - September 2012	15.27%	19.2%	43.3%	0.2%

This is an indicator designed to accompany the Summary Hospital-level Mortality Indicator (SHMI) and represents the percentage of deaths reported in the SHMI indicator where the patient received palliative care. The SHMI makes no adjustments for palliative care.

Using the same spell level data as the SHMI, this indicator presents the crude percentage rates of deaths that are coded with palliative care either in diagnosis or treatment specialty.

The Trust is below the national average for palliative care coded deaths which is a positive position to be in and reflects accurate coding practice.

The Trust's patient reported outcome measures scores (PROMS)

Date	Trust Performance	National Average	Highest Result	Lowest Result	Position Nationally
Groin Hernia Repair					
2011-2012	10.1	8.3	21.0	0	
2012-2013	9.2	9.1	31.03	0.14	Top 60%
Varicose Vein Surgery					
2011-2012	10.7	9.4	23.5	0	
2012-2013	8.2	9.3	27.2	0	Top 50%
Hip Replacement Surgery					
2011-2012	37.7	40.7	58.4	23.5	
2012-2013	49.9	43.7	69	0	Top 30%
Knee Replacement Surgery					
2011-2012	22.8	29.4	43.2	15.4	
2012-2013	52.7	31.2	52.7	0	Top performing Trust in country

The Trust intends to take / has taken the following actions to improve this result, and therefore the quality of its service, by:

- Working closely with patients undergoing surgery within the clinical focus groups to encourage their full participation in the completion of the PROMS questionnaires before surgery and six months following surgery;
- Using information leaflets which describe the process and value of the information collected through the use of the PROMS questionnaire.

The percentage of patients aged 0 to 14 readmitted to hospital within 28 days of being discharged

Date	Trust Performance	Peer Group Average
January 2011 - December 2011	9.3%	9.7%
January 2012 - December 2012	8.4%	10.3%

The Trust is pleased to report that it continues to be significantly below peer and considers that this is for the following reasons:

- More senior medical staff are available to review patients when they arrive and make prompt decisions with regard to treatment and follow up care;
- The development of more robust care pathways;
- Reclassification of some patients as assessments or ward attenders, rather than admissions, if not staying overnight.

The percentage of patients aged 15 or over readmitted to hospital within 28 days of being discharged

Date	Trust Performance	Peer Group Average
January 2011 - December 2011	7.0%	6.6%
January 2012 - December 2012	6.3%	6.3%

The data above shows a reduction in the percentage of readmissions for patients aged 15 or over, which has brought the Trust in line with its peer group. The Trust considers that this reduction is predominantly due to the following reasons:

- Introduction of a dedicated task and finish group to focus on readmissions;
- A daily review of patients who are readmitted or flagged as at high risk of readmission by the integrated discharge team;
- The integrated discharge team work closely with community teams, such as community matrons, alcohol liaison services and mental health, to support discharge;
- Introduction of ward-based pharmacy reviews of medications;
- Follow-up phone calls made by the integrated discharge team 48 hours post discharge.

The Trust intends to continue progressing the above actions to maintain improvement in this result and therefore the quality of its service.

The Trust's responsiveness to the personal needs of its patients

Date	Trust Performance	National Average	Highest Result	Lowest Result
2011	72.7	75.7	87.3	68.2
2012	73.5	75.6	87.8	67.4

This result is slightly lower than the national average. Comments from patients completing the national inpatient survey reflect the busy nature of the clinical environment, whilst highlighting that staff are very caring (more detail on the inpatient survey is included in part 2).

The Trust intends to take / has taken the following actions to improve this results, and therefore the quality of its service, by:

- Formally reviewing the staffing levels and skill mix on all inpatient wards every six months;
- Reviewing patient needs for staff requirements twice daily and making adjustments as required;
- Continuing the implementation of care rounds to respond proactively to patients' needs;
- Reviewing care pathways and implementing event-led discharge to avoid delays in patients waiting in hospital when they are medically fit to go home.

Staff employed by the Trust who would recommend the Trust as a provider of care to their family or friends (scores out of 5)

Date	Trust Performance	National Average	Highest Result	Lowest Result
2011 staff survey	3.52	3.50	4.05	2.84
2012 staff survey	3.59	3.57	4.08	2.90

This result is better than the national average. Staff frequently describe the Trust as a friendly place to work and, on the whole, they receive good support from their teams and line mangers.

The Trust intends to take / has taken the following actions to improve this result, and therefore the quality of its service, by:

- Presenting the results at key meetings and staff groups to agree which areas should be targeted for improvement. Currently, there is agreement that the Trust should focus on appraisals, involving staff in change, feedback on performance, health and well being and tacking violence;
- Meeting with senior divisional teams to discuss divisional reports;
- Undertaking further benchmarking of results with other Trusts and previous year's results.

The percentage of patients who were admitted to hospital who were risk assessed for Veneous thromboembolism (VTE)

Date	Trust Performance	National Average	Highest Result	Lowest Result
July 2012 - September 2012	96.3%	93.8%	100%	80.9%
October 2012 - December 2012	96.3%	94.1%	100%	84.6%

The Trust has consistently remained above the national average for the previous 2 reporting periods in relation to the percentage of admitted patients who were risk assessed for VTE.

The Trust has achieved the national CQUIN target of 90% in relation to VTE risk assessments for the past 2 years.

The Trust intends to take / has taken the following actions to improve this result, and therefore the quality of its service, by:

- Implementing the national guidance issued by the National Institute for Health and Clinical Excellence (NICE) relating to VTE risk assessment to ensure that all relevant patients are assessed on admission for their risk of developing a VTE. The VTE risk assessment has been included in the Trust's admission proformas to ensure this happens;
- Establishing a VTE Committee which reports into the integrated governance reporting structure. The group ensures that all national guidance is appropriately implemented and monitors the percentage of patients that are risk assessed on admission;
- Monitoring compliance monthly by the clinical divisions and quarterly by the Trust's VTE Committee.

The rate per utilised bed days of cases of Clostridium difficile infection reported within the Trust amongst patients aged 2 or over

Date	Trust Performance	National Average	Highest Result	Lowest Result
2010-2011	58.30	29.60	63.60	7.10
2011-2012	16.83	21.82	50.89	4.08
2012-2013	12.90	Not published	Not published	Not published

The above data shows a significant reduction in Clostridium difficile infections over the past three years and shows the Trust to be one of the best performing Trusts when compared to similar sized organisations. The Trust considers that this reduction is predominantly due to the following reasons:

- Limiting transfers within the Trust, particularly from viral diarrhoea and vomiting affected wards and close monitoring of symptomatic patients to ensure Clostridium difficile infection is not missed as a diagnosis;
- Providing additional cleaning resources to support the rapid response team to tackle infective areas (this has also increased cleaning scores and cleaning provision in other areas);
- Rolling out cholorine cleaning for all clinical areas and revised cleaning policy to ensure clinical equipment is effectively decontaminated;

- Greater reviews of antibiotic prescribing compliance and raised awareness within divisions following antibiotic audits performed by consultant microbiologists;
- Case management of Clostridium difficile infection patients by the Infection Prevention and Control Service and ongoing review of all side rooms used for isolation purposes to ensure effective isolation practice and appropriate clinical management;
- Undertaking detailed root case analysis on all Clostridium difficile infection cases, to highlight all relevant risk factors and potential risks for transmission to others;
- Weekly Clostridium difficile infection clinical review group ensuring all aspects of patient management are assessed / actioned;
- Two ring-fenced beds on the gastroenterology ward to ensure appropriate case management for Clostridium difficile infections;
- Reviewing the process for mattress decontamination and tagging of equipment to monitor decontamination schedules.

The number of patient safety incidents reported within the Trust

Date	Trust Performance	National Average	Highest Result	Lowest Result
October 2011 to March 2012	2511	1782	3871	809
April 2012 to September 2012	2695	1812	4545	815

It is viewed nationally and by the Trust that being a high reporter of incidents is a positive position as it demonstrates a risk aware culture within the Trust and that staff are open about reporting patient safety incidents. The Trust reports more patient safety incidents than the national average and this has been consistent for both reporting periods. The majority of the incidents reported resulted in no harm to the patient which again demonstrates a risk aware culture within the Trust.

The Trust intends to take / has taken the following actions to improve this result, and therefore the quality of its service, by:

- Committing to a *Just Safety* culture which encourages staff to admit when an error occurs without fear of punitive measure;
- Providing training on incident reporting throughout the Trust. This training ensures that all staff in the Trust know how to report a patient safety incident and they also understand the importance of incident reporting. This training is on-going and is included on induction for all new staff.

The number and percentage of patient safety incidents reported within the Trust that resulted in severe harm or death

Date	Trust Performance	National Average	Highest Result	Lowest Result
October 2011 to March 2012	2	17	64	0
April 2012 to September 2012	6	16	69	2

The Trust considers that this data is as described for the following reasons:

- The above data demonstrates that, although the Trust is a high reporter of patient safety incidents, when the Trust's data for patient safety incidents which result in severe harm or death is compared with other organisations, the Trust is consistently below the national average. This is a very positive position for the Trust.

The Trust intends to take / has taken the following actions to improve this results, and therefore the quality of its service, by:

- Undertaking a full root cause analysis for all incidents which result in severe harm or death. A review meeting is held following the incident investigation which is always chaired by an Executive lead to ensure that lessons are learned and actions are implemented to prevent a reoccurrence;
- Reporting all incidents which result in severe harm death to the Board to ensure openness within the Trust;
- Promoting the Trust's being open policy, which ensures that if an incident occurs which results in severe harm or death, the patient and / or their family are informed and the lessons learned and actions from the incident are shared with them.

Local quality indicators

Reducing patient falls - Governors' choice of indicator

A fall is not a diagnosis and often reflects a multiplicity of risk factors with normal physiological ageing, de-conditioning from inactivity and superimposed acute and chronic disease. However, a fall is of direct clinical relevance to an individual, with a clear impact and all too often a negative outcome in terms of health and quality of life (Close, 2005).

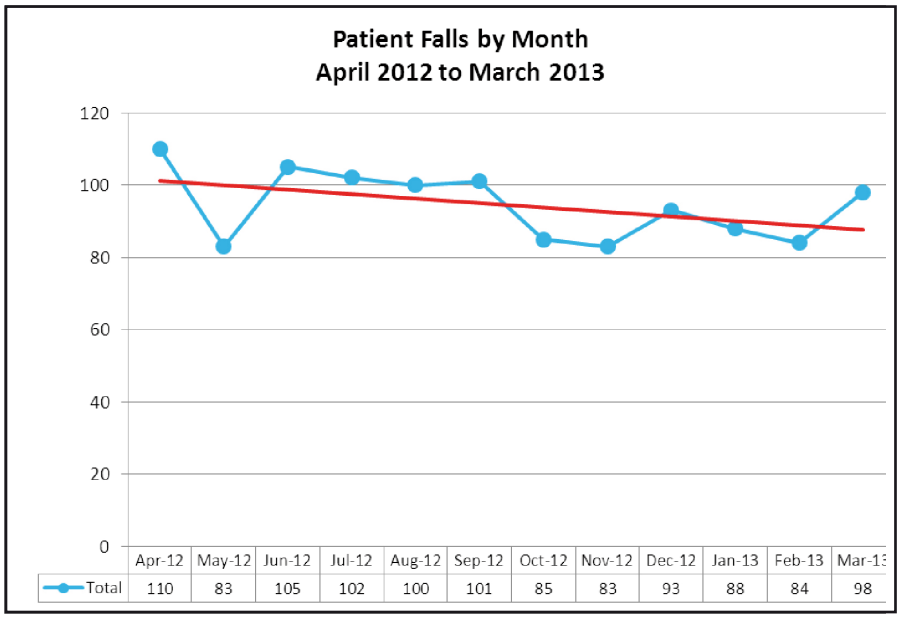
Falls are a considerable burden on patients, nurses and hospitals. Preventing falls from happening should be a priority in healthcare organisations. While the risk of falling cannot be eliminated, it can be significantly reduced through the implementation of an effective falls prevention programme (Oliver et al, 2009).

For people experiencing a fall, there may be many negative associations and perceptions, such as a sense of imminent loss of independence and risk of institutionalisation (Howland, Peterson & Levin, 1993).

There is a great deal of literature available in relation to patient falls that clearly demonstrates that patient falls in hospital are frequent occurrences. It is also known that patient falls in hospital can have a devastating effect on patients, their families and the nursing staff caring for the patient and that organisations as a whole also suffer in terms of reputation and financial loss.

Patient falls in hospital affect everyone involved in different ways. Despite patient falls prevention interventions being in place, patient falls remain the highest reported patient safety incident for the majority of Trusts, including MCHFT.

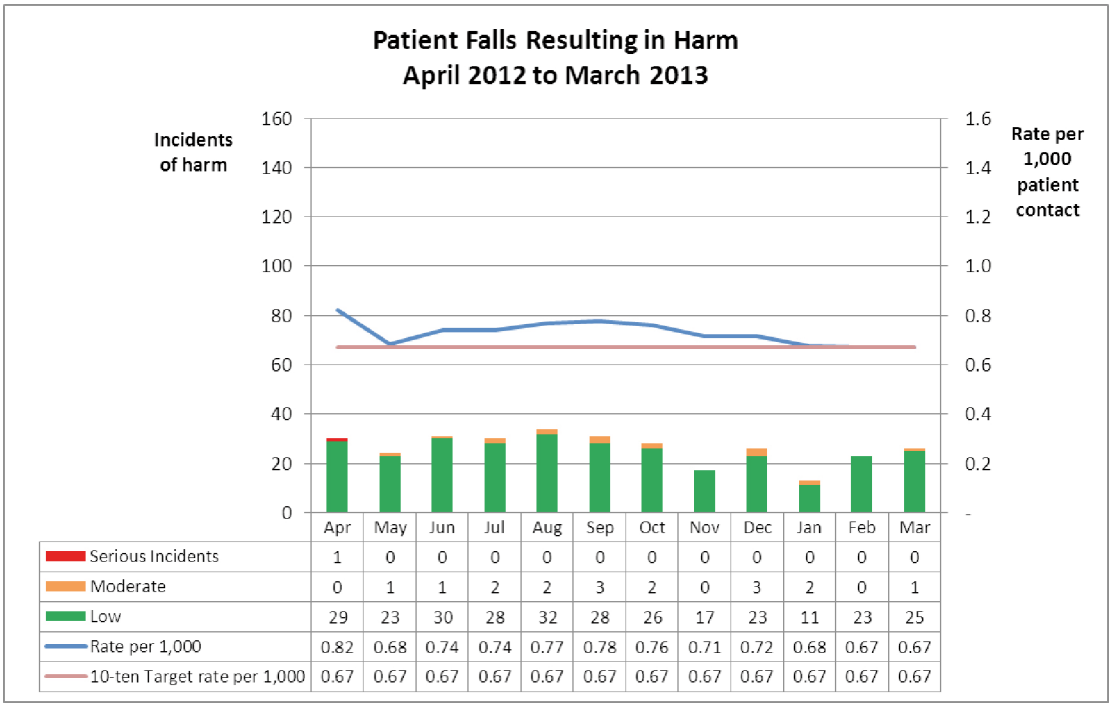
Graph 16 shows the number of patient falls at the Trust over a 12 month period between April 2012 and March 2013. The red line on the graph indicates that the overall number of falls has decreased over the last 12 months.



Graph 16: Patient Falls by Month

Work undertaken to reduce the number of patient falls and harm caused
The Trust has a patient falls prevention group which meets monthly. The group membership includes Clinicians, Nurses and Therapists and the group monitors all patients' falls on a monthly basis. A successful link nurse programme has been rolled out across the Trust to deliver education for staff on falls prevention and the Trust has been involved in number of national projects including Safety Express and FallSafe which have looked at reducing the harm from patient falls and fall prevention interventions.

Graph 17 highlights the patient falls that have resulted in harm between April 2012 and March 2013. The Trust set a target to reduce the harm from patient falls by 10% annually and this target is currently being achieved.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Serious Incidents	1	0	0	0	0	0	0	0	0	0	0	0
Moderate	0	1	1	2	2	3	2	0	3	2	0	1
Low	29	23	30	28	32	28	26	17	23	11	23	25
Rate per 1,000	0.82	0.68	0.74	0.74	0.77	0.78	0.76	0.71	0.72	0.68	0.67	0.67
10-ten Target rate per 1,000	0.67	0.67	0.67	0.67	0.67	0.67	0.67	0.67	0.67	0.67	0.67	0.67

Graph 17: Patient Falls Resulting in Harm

References

Close, J.(2005) "Prevention of falls - a time to translate evidence into practice", Age and Ageing, vol. 34, no. 2, pp. 98-100.

Oliver, D., Britton, M., Speed, P., Martin, F. C. & Hopper, A.H. 2009, "Development and evaluation of evidenced based assessment tool (STRATIFY) to predict which elderly inpatients will fall: case control and cohort studies", British Medical Journal, [Online], vol. 315, no. 7115, pp. 16.03.10. Available from: http://www.bmj.com/cgi/content/full/315/7115/1049. [16.03.10].

Howland, J., Peterson, E.W. & Levin, W.C. 1993, "Fear of falling among the community dwelling elderly", Aging health, vol. 5, no. ., pp. 229-243.

Incidents resulting in severe harm - mandated indicator

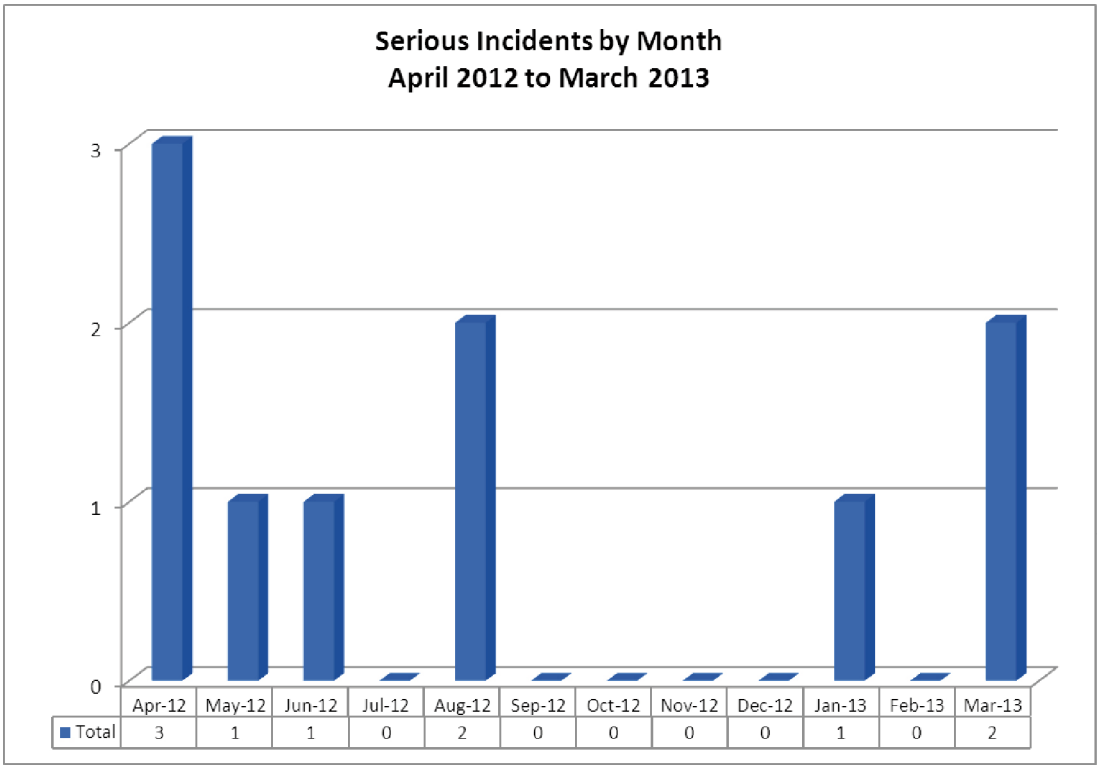
The Trust wants to deliver high quality, safe patient care. However, despite best efforts, human factors, systems and processes contribute to prevent this desire and patients are sometimes harmed unintentionally. The Trust is dedicated to reducing the avoidable harm caused to patients.

When harm is unintentionally caused, the Trust ensures that lessons are learned and that systems and processes are changed to prevent an incident from reoccurring. The Trust is committed to a Just Safety culture which encourages staff to acknowledge and report when an error occurs without fear of punitive measure.

When an incident which results in severe harm does occur, the incident is reported to the Trust Board, the local Clinical Commissioning Groups and the Strategic Executive Information System (StEIS) to ensure learning both locally within the Trust and across other healthcare providers.

A root cause analysis (RCA) is undertaken for all incidents resulting in severe harm to ensure that all contributory factors which led to the incident occurring are fully investigated and actions are implemented to prevent a reoccurrence. A review meeting is held following the investigation and this is led by an Executive Director. Following the review meeting, an action plan is developed, implemented and lessons learned are shared throughout the Trust.

Graph 18 shows the number of serious incidents reported within the Trust between April 2012 and March 2013 which resulted in severe harm. It can be seen that there has been a significant reduction in the past six months with only three serious incidents occurring between January and March 2013.



Graph 18: Serious incidents by month

Performance against local quality indicators

Indicator	2010-2011	2011-2012	2012-2013	Target	Achieved?
Cancelled operations (%)	1.19%	1.46%	1.32%	1.09%	✗
Cancelled operations – % breaching 28 day guarantee	6.8%	7.9%	15.83% *	5%	✗
Smoking during pregnancy	19.5%	18.3%	20.55%	< 15%	✗
Breastfeeding initiation rates	59.6%	62.8%	60.91%	65%	✗
Access to genito-urinary (GUM) clinics	99.9%	100%	100%	100%	✓
Falls risk assessments completed within 24 hours	96%	96%	96%	91%	✓
Pressure ulcer risk assessments completed within 24 hours	93%	95%	94%	91%	✓
Nutritional risk assessments completed within 24 hours	99%	97%	95%	91%	✓
% of patients who felt they were treated with dignity and respect	96%	100%	100%	100%	✓
% of patients who had not shared a sleeping area with the opposite sex	75%	100%	100%	100%	✓
% of patients who would recommend the hospital to family and friends	97%	87%	93%	No target	

✓ = Achieved ✗ = Not Achieved

* this equates to approximately 70 patients in 2012-2013.

Consultation on quality

Over the past 4 years, the Trust has consulted with the public, patients, staff and governors on its delivery of quality. Using the Trust's quality and safety strategy, the 10 out of Ten has been the focus for discussion and comment. These comments are then used to inform the annual Quality Account.

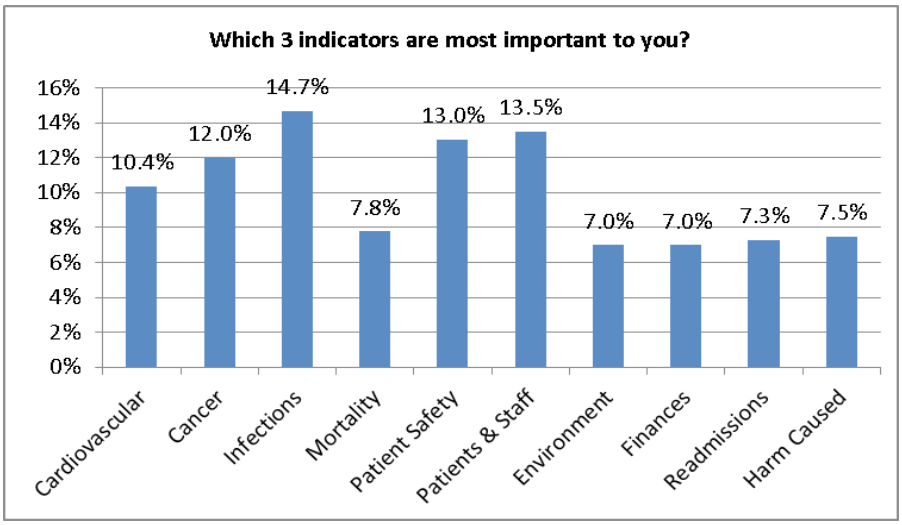
The 2012/13 Quality Account consultation was undertaken by staff and governors working together to meet with the public and patients at a variety of locations. Events at local supermarkets in Crewe, Sandbach, Winsford and Middlewich plus outpatient clinics in Crewe and Northwich generated 320 discussions and responses.

The aim of the consultation was to seek comments from the public regarding the Trust's 10 out of Ten priorities and to ensure the ten indicators are still considered essential markers of quality.

The results of the consultation showed that all the priorities are still considered important. Nobody suggested alternatives.

When asked to identify the most important priorities, reducing healthcare acquired infections was found to be the most important. The second most important priority was having the correct numbers of nurses and doctors closely followed by patient safety.

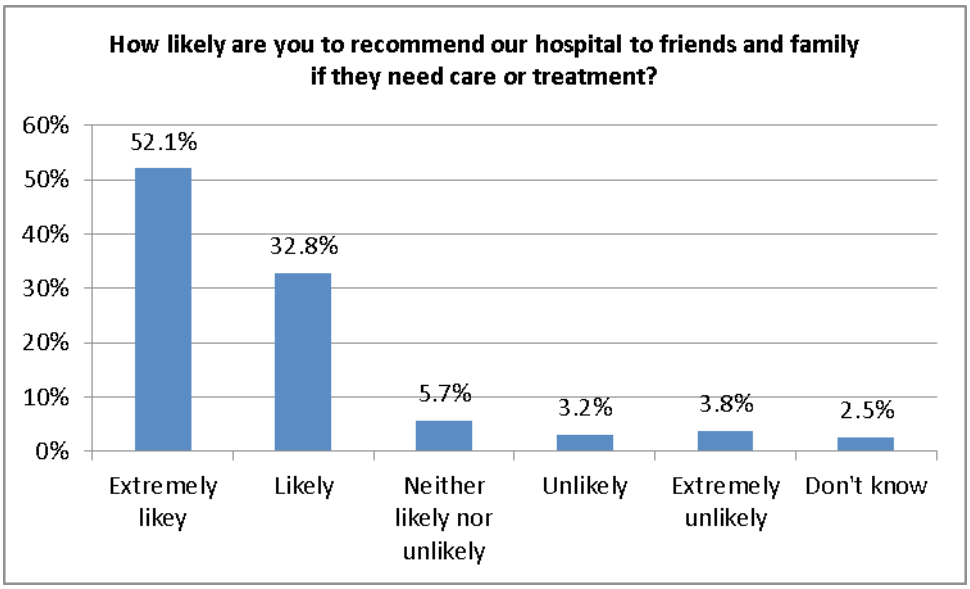
The following graph details the indicators that are considered most important by the 320 people included in the consultation.



Graph 19: Most important indicators identified during the consultation

The consultation process also asked the public and patients:
"How likely are you to recommend our hospital to friends and family if they need care or treatment?"

Responses to this were very positive with over half the people saying they would be extremely likely to recommend the hospital and its services.



Graph 20: Consultation response to question about how likely people were to recommend the hospital

Statements from external agencies

South Cheshire and Vale Royal Clinical Commissioning Groups

NHS Vale Royal Clinical Commissioning Group

NHS South Cheshire Clinical Commissioning Group

NHS South Cheshire Clinical Commissioning Group (NHS SCCCG) and NHS Vale Royal Clinical Commissioning Group (NHS VRCCG) welcome the opportunity to provide commentary on Mid Cheshire Hospitals NHS Foundation Trust (MCHfT) Quality Account for 2012/13.

We have discussed the development of this Quality Account with MCHfT over the course of the year and have been able to contribute our views on content and consultation. This Quality Account has been reviewed within both NHS SCCCG and NHS VRCCG by colleagues in commissioning, quality and performance.

After review, we believe that this Quality Account gives a fair, representative and balanced overview of performance against national and the local priorities as set by MCHfT in their 10 out of ten quality and safety improvement strategy 2010-2014 and other quality initiatives including Commissioning for Quality and Innovation (CQUIN).

We confirm that we have reviewed the information contained within the Quality Account and checked it against data sources where available to us as part of existing contractual performance monitoring discussions and found them to be accurate in relation to the services provided.

There is a very strong and clear focus on patient experience and this is welcomed.

There is evidence that engagement with patients and patient experience is used to inform the organisations understanding of how it is doing, where and what is working well and areas for improvement. However, we would have expected more information on outcomes and changes made, in particular those reported

by patients after discharge telephone calls. The CCGs recognise that it is an achievement for MCHfT to be a top performing Trust in the country 2012/13 for Patient Reported Outcome Measures (PROMS) for knee replacement and good results in hip replacement surgery.

This Quality Account demonstrates the commitment of the Trust Board to continue with the 10 out of ten strategy. There is evidence of triangulation of a range of data and feedback, for example patient surveys, both national and local, patient stories, complaints, internal audits. This demonstrates that patients remain at the centre of care and that patient safety and experience remains essential for delivering clinical services. The positive Care Quality Commission report also provides external evidence of quality of care, patient engagement and clinical effectiveness. However, we would have liked some initial information on the way MCHfT is responding to the Francis Report that was published in February 2013.

We acknowledge the initiatives MCHfT have implemented to reduce Clostridium Difficile infections, which is demonstrated in the continued reduction in numbers in 2012/13. This is to be congratulated.

We would like to praise MCHfT for their continuation of a Just Safety culture which encourages staff to report incidents without fear of reprisal. This has been evidenced by the number of incidents of no harm reported in year and demonstrates an open culture to reporting incidents. This is to be congratulated.

We acknowledge the continued progress in reducing the mortality rate. However, there needs to be a continued focus on this area. NHS SCCCG and NHS VRCCG welcome the open approach and the adoption and reporting of the national measure for mortality. Triangulation of relevant data and the outcome of work on specific priority areas such as general surgery will enhance understanding and support reduction in the mortality rate. NHS SCCCG and NHS VR CCG are committed to working with MCHfT in 2013/14 to continue the improvement.

We would like to see the continued progress that MCHfT are undertaking in relation to the ratio of nurses and doctors to each inpatient bed. We anticipate that, although the ratio of Doctors will not be reported nationally, MCHfT will develop a local measure to ensure that ratios are monitored throughout the year.

Overall, we welcome the vision described within the Quality Account. The CCGs agree with the priorities and will continue to work with MCHfT to seek the views of patients to ensure continuous improvement in the quality and clinical effectiveness of services provided by the organisation.

Yours sincerely

Simon Whitehouse
Chief Officer
NHS South Cheshire CCG
NHS Vale Royal CCG

Healthwatch Cheshire East

Thank you for a copy of your Quality Accounts 2012 – 2013 for Mid Cheshire Hospitals NHS Foundation Trust.

Healthwatch Cheshire East is a new organisation that came into existence on the `1st of April 2013. We will give children, young people and adults a powerful voice locally and

nationally. We will work to help people get the best out of their local health and social care services. Whether it's improving them today or helping to shape them for tomorrow.

Healthwatch Cheshire East is all about local voices being able to influence the delivery and design of local services. We therefore welcome the opportunity to work with Mid Cheshire Hospitals NHS Foundation Trust and to contribute to its annual Quality Account for 2013 -2014 but feel that we are unable to comment on the current document as we have only recently become operational and have yet to develop a evidence base from which we can make a valid and independent contribution.

We look forward to working with the Trust over the coming year.

Cheshire East Council Health and Wellbeing Scrutiny Committee

Comments on Mid Cheshire Hospital NHS Foundation Trust Quality Account 2012/13

(Note: these comments are based on the first consultation draft which was submitted to the Committee on 9 May 2013; it is understood that the comments below will be incorporated into the final version of the Quality Account)

The Committee welcomes the opportunity to comment on the Quality Account and would like to thank Julie Smith for attending the meeting on 9 May 2013.

The Committee:

- Is generally very pleased with the achievements made by the Trust during 2012/13 including the delivery of its 10 out of ten strategy.
- Is pleased to note that the Trust has taken on board the recommendations of the Francis Report in an effort to make improvements.
- Is concerned about the level of vacancies for nurses the Trust has experienced however is satisfied that a robust recruitment and retention scheme has now been put in place which it hopes will assist in maintaining high care quality.
- Approves of the recruitment of overseas nurses in the effort to ensure adequate levels of quality care are provided.
- Would like to see a comparison with the 2011/12 Quality Account to provide an illustration of whether the Trust has improved on previous performance.
- Is pleased that despite not hitting targets for reducing smoking during pregnancy and increasing breast feeding the Trust was working with CCGs and Public Health to improve the situation and expects the targets to be met in future.

The Committee suggests the following:

- That actual patient numbers should be included in statistics alongside percentages to provide greater context on the number of people affected.

- That statistics and information on Out Patients, particularly waiting times and care quality, should be included in the Quality Account alongside the excellent reporting on In Patients.
- That improvements to the way operations are scheduled need to be made to decrease the number of patients who do not receive an operation within 28 days of a previous appointment being cancelled.
- That statistics on incidents involving falls including why they happen need to be developed and publicised along with an action plan on how the Trust will tackle the issue.
- Although the Committee acknowledges that prescriptions cannot always be made available upon discharge more could be done to decrease delays between patients being discharged and receiving prescriptions.
- That statistics on incidents of bedsores (pressure ulcers) could be included in the Quality Accounts.

Governors

The Quality Account for 2012/13 was presented to the Council of Governors in April 2013. Governors' questions and comments have been directed to me, as Governor Representative for the Quality & Safety Improvement Strategy Committee, and I chaired a meeting on 13 May 2013 to address all matters raised. The Trust's Chairman, Director and Deputy Director of Nursing and Quality attended by invitation, and thorough questioning satisfied Governors as regards the substance and detail of the report.

The Quality Account is a fair and accurate representation of the Trust's patient-centred care, and gives a balanced view of successes and challenges. Every endeavour has been made to use clear and transparent language, graphics and data and to format the Account clearly, in the context of prescriptive rules determined by Monitor. 2012/13 was the penultimate year of the Trust's '10 out of Ten' targets; Governors are satisfied these have contributed to significant improvements in quality and outcomes for patients, staff, carers and members.

Jane Smart

Governor

Statement of Directors' responsibilities in respect of the Quality Report

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

Monitor has also issued guidance to NHS Foundation Trust Boards on the form and content of annual Quality Accounts (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 2012 - 2013*

- The content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2012 to March 2013
    - Papers relating to quality reported to the Board over the period April 2012 to March 2013
    - Feedback from the Commissioners dated 23 May 2013
    - Feedback from Local Healthwatch dated 9 May 2013
    - Feedback from the Health and Wellbeing Scrutiny Committee dated 16 May 2013
    - Feedback from Governors dated 21 May 2013
    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated August 2012.
    - The 2012 national patient survey
    - The 2012 national staff survey
    - The Head of Internal Audit's annual opinion over the Trust's control environment dated 21 May 2013
    - Care Quality Commission (CQC) quality and risk profiles dated February 2013

- 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 Accounts 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).

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, signed 28 May 2013,

John Moran
Chairman

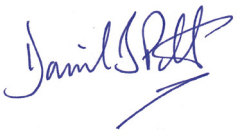
Tracy Bullock
Chief Executive

Dr Paul Dodds
Medical Director and
Deputy Chief Executive

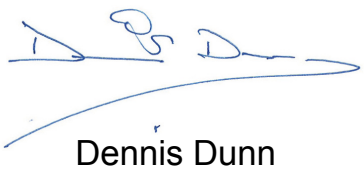
Denise Frodsham
Chief Operating Officer

Julie Smith
Director of Nursing
and Quality

Mark Oldham
Director of Finance



David Pitt
Director of Service Transformation
and Workforce



Dennis Dunn
Non-Executive Director

Dame Patricia Bacon
Non-Executive Director

John Barnes
Non-Executive Director

Mike Davis
Non-Executive Director

Ruth McNeil
Non-Executive Director

David Hopewell
Non-Executive Director

Appendices

Appendix 1 - Glossary and Abbreviations

Terms	Abbreviation	Description
Acute Myocardial Infarction	AMI	AMI is commonly known as a "heart attack" which results from the partial interruption of the blood supply to a part of the heart which can cause damage or death to the heart muscle.
Acute Trust		An acute Trust provides hospital services (not mental health hospital services, which are provided by a mental health trust).
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.
Board (of Trust)		The role of Trust's board is to take corporate responsibility for the organisation's strategies and actions. The chair and non-executive directors are lay people drawn from the local community and are accountable to the Secretary of State. The chief executive is responsible for ensuring that the board is empowered to govern the organisation and to deliver its objectives.
Care Quality Commission	CQC	The independent regulator of health and social care in England. Its aim is to make sure better care is provided for everyone, whether in hospital, in care homes, in people's own homes, or elsewhere. The CQC replaced 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.
Clinical Commissioning Group	CCG	This is the new GP led commissioning body who buy services from providers of care such as the hospital.
Clostridium Difficile	C-diff	A naturally occurring bacterium that does not cause any problems in healthy people. However, some antibiotics that are used to treat other health conditions can interfere with the balance of 'good' bacteria in the gut. When this happens, C-diff bacteria can multiply and cause symptoms such as diarrhoea and fever.
Commissioner		A person or body who buy services.
Commissioning for Quality and Innovations	CQUIN	CQUIN is a payment framework developed to ensure that a proportion of a providers' income is determined by their work towards quality and innovation.

Terms	Abbreviation	Description
Delivering Same Sex Accommodation	DSSA	DSSA was a national initiative launched in 2009 to eliminate mixed sex accommodation (EMSA) in hospital. There may be members of the opposite sex on a ward but they will not share the same sleeping area with members of the opposite sex unless this is required for clinical need, such as in the Intensive Care Unit.
Eliminating Mixed Sex Accommodation	EMSA	Please see description of Delivering Same Sex Accommodation.
Foundation Trust		A type of NHS Trust in England that has been created to devolve decision-making from central government control to local organisations and communities so they are more responsive to the needs and wishes of their local people. NHS Foundation Trusts have members drawn from patients, the public and staff and are governed by a board of governors comprising people elected from and by the membership base.
Healthcare Associated Infections	HCAI	A generic name to cover infections like MRSA and C-diff.
Health Protection Agency	HPA	The HPA was set up in 2003 to provide advice and information to protect the public in England from threats to health from infectious diseases and environmental hazards. In April 2013, the HPA will become part of Public Health England, a new executive agency of the Department of Health.
Health Service Ombudsman		The role of the Health Service Ombudsman is to provide a service to the public by undertaking independent investigations into complaints where the NHS in England have not acted properly or fairly or have provided a poor service.
Hospital Episode Statistics	HES	This is the national statistical data warehouse for England for the care provided by NHS hospitals and for NHS hospital patients treated elsewhere. HES is the data source for a wide range of healthcare analysis for the NHS, government and many other organisations and individuals.
Integrated Care System	ICS	The system used by the Trust to record patient activity.
Intensive Care National Audit and Research Centre: Case Mix Programme	ICNARC CMP	The ICNARC CMP is a high quality, clinical database holding over 18 years data relating to patient outcomes from adult, general critical care units in England, Wales and Northern Ireland.

Terms	Abbreviation	Description
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
Mothers and Babies: reducing Risk through Audits and Confidential Enquiries across the UK	MBRRACE-UK	A new organisation appointed by the Healthcare Quality Improvement Programme to investigate maternal deaths, still births and infant deaths to support the delivery of safe, equitable, high quality, patient centred maternal, newborn and infant health services.
Monitor		This is the regulator of NHS Foundation Trusts. It is an independent body detached from central government and directly accountable to Parliament.
Myocardial Ischaemia National Audit Project	MINAP	MINAP is a national audit established in 1999 to enable hospitals to measure their performance against targets and improve the care of patients following a heart attack.
National Neonatal Audit Programme	NNAP	An audit programme established with the aim of informing good clinical practice in aspects of neonatal care by auditing national standards.
National Patient Surveys		Co-ordinated by the CQC, they gather 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. All Trusts upload their incident reporting data to this database on a weekly basis
Patient Experience Measures	PEMS	PEMS are used to measure the patient's view of their experience during the clinical episode, looking at how patients feel at an emotional and physical level.
Patient Reported 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.

Terms	Abbreviation	Description
Patient Safety Metrics		A number of measures which together can be used to assess how well a hospital keeps patients safe from harm whilst under their care.
Quality Account		This is a statutory annual report of quality which provides assurance to external bodies that the Trust Board has assessed quality across the totality of services and is driving continuous improvement.
Re-admission Rates		A measure to compare hospitals which looks at the rate at which patients need to be readmitted to hospital after being discharged (leaving hospital).
Risk Adjusted Mortality Rates	RAMI	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.
Safer Nursing Care Tool	SNCT	The safer nursing care tool was launched in 2010 by the NHS Institute based on the work undertaken by the Association of UK University Hospitals (AUKUH). It is used to measure patient dependency/acuity to help determine nurse staffing levels on the wards.
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.
Secondary Users Service		This is the NHS data system for recording all NHS patient activity. It enables correct payments by commissioners for care provided by all provider services including acute trusts.
Sentinel Audit		A national audit that measures the care delivery provided for patients following the diagnosis of a stroke.
Sentinel Stroke National Audit Programme	SSNAP	SSNAP is a programme of work which aims to improve the quality of stroke care by auditing stroke services against evidence based standards.
Situation, Background, Assessment and Recommendation	SBAR	A national tool to standardise handover of care between clinicians
Stroke 90:10		An initiative, launched in North West England, which aims to significantly change frontline care practice for stroke patients in order to increase the number of stroke sufferers leaving hospital without serious disability.

Terms	Abbreviation	Description
Summary Hospital level Mortality Indicator	SHMI	SHMI is a hospital level indicator which measures whether mortality associated with hospitalisation was in line with expectations. The SHMI value is the ratio of observed deaths in a Trust over a period of time divided by the expected number given the characteristics of patients treated by that Trust Depending on the SHMI value, Trusts are banded between 1 and 3 to indicate whether their SHMI is low (3), average (2) or high (1) compared to other Trusts. SHMI is not an absolute measure of quality. However, it is a useful indicator for supporting organisations to ensure they properly understand their mortality rates across each and every service line they provide.
Systemic anti cancer therapy data set	SACT	The SACT collects clinical management information on patients undergoing chemotherapy in England.
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.
Venous Thrombo-Embolism	VTE	This is a blood clot which can develop when a person may not be as mobile as they are usually or following surgery. The blood clot itself is not usually life threatening, but if it comes loose it can be carried in the blood to another part of the body where it can cause problems – this is called a Venous Thromboembolism (VTE).

Appendix 2 - Feedback Form

We hope you have found this Quality Account useful.

To save costs, the report is available on our website and hard copies have been made available in waiting rooms or on request.

We would be grateful if you would take the time to complete this feedback form and return it to:

Clinical Quality and Outcomes Matron
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?

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

_____
_____
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