

# Quality report 2009/10

## Part 1: Statement on quality from the Chief Executive

Everything we do at The Christie is directed at achieving the best quality care that we possibly can. I am therefore delighted to introduce this quality report building on the quality report that we produced last year.

We have a strong track record of publishing data on quality through our monthly quality accounts which contain information on each of the three components of quality: patient experience, safety and effectiveness of services. This annual report shows the progress we have made over the past 12 months and our aspirations for the future.

It is because of the hard work of all our staff that we achieved all the national targets in 2009/10 other than the 62 day target for which we have declared partial compliance. We are working with the Care Quality Commission (CQC) and our cancer network to try and have this assessment resolved. During the year we again received ratings from the CQC of excellent for both quality of care and use of resources and were the top scoring Trust for overall quality of care in the national inpatient survey. The cancer research programme in Manchester, to which we are a leading contributor, was the highest placed in the most recent National Research Assessment Exercise.

In addition to the national targets we set ourselves some extremely challenging local objectives including changing our outpatient service so that nine out of 10 patients wait less than 20 minutes from their appointment time to being seen by a consultant. We have achieved this local target and have also improved on the day waiting times for pharmacy and for chemotherapy although over the coming year we want to reduce these waiting times further.

We have been reporting information on the effectiveness and clinical outcomes of our care in our monthly performance reports for over a year. This is a developing area in which we believe that we are leading in the cancer field by making data public. We intend to continue these developments, demonstrating the role of The Christie in providing effective therapy against the background of poor general health and a higher incidence of cancer across the network of communities that we serve.

In March 2010 we opened, in Oldham, the first of our network of Christie radiotherapy centres. This is enabling people in the north east of Greater Manchester to get the best possible radiotherapy care closer to where they live. Over 1800 treatments a year will be provided there, for people who previously would have had to travel to our main site in South Manchester. This was a fantastic first for The Christie and will be followed next year by the opening of a similar centre in Salford.



Our statistics show that we provide high quality care and we want to maintain this position. However, it is the voices of patients that really make the difference both in assuring us that we get it right most of the time but more importantly letting us know when we get it wrong and allowing us to make changes. We are extremely grateful to the many people who as governors, members, patient representatives or as patients take the time to support and advise us.

The board of directors is strongly committed to building on our already high standards of quality and to maintaining our reputation for excellence throughout the coming years when the additional resources available to the NHS each year will be very limited. The board's quality assurance committee will scrutinise and monitor our quality programmes. Our council of governors will also support and advise us on current quality and priorities for the future through our governors' quality committee.

I hope that you find this quality report of value. We are continually striving to improve our care and welcome feedback. The support and commitment of all of our stakeholders is vital to us in maintaining and building on our current achievements.

I have great pleasure in presenting this report to you and in certifying the accuracy of the data it contains.

*Cshaw*

Caroline Shaw  
Chief Executive  
4th June 2010

## Part 2: Priorities for improvement and statements of assurance from the board



### 1. Our Quality Priorities for 2009/10 and 2010/11

In 2009/10 we set ourselves three priorities for quality improvement:

1. To achieve 85% of patients waiting no longer than 20 minutes between the time of appointment and the time they are seen, by March 2010 – we have achieved this objective and have set ourselves a target of improvements in pharmacy and chemotherapy for 2010/11
2. To maintain very low levels of MRSA and Clostridium difficile infection and reduce these levels in line with trajectories agreed with our commissioners – we have achieved this target and continue to apply rigorous measures to maintain low levels of hospital acquired infection
3. To increase the percentage of our patients with electronically recorded (reported) stage data – we continue to work towards this target through the improvement in data capture systems for example by implementing the Somerset Cancer Data system and by reporting data to the regional cancer intelligence service

Our priorities for improving quality in 2010/11 have been agreed by the board of directors as part of our corporate objectives for the year, within the overarching context of our quality framework. These objectives are shown in the table on pages 28/29. They will be monitored by the board of directors through the coming year.



These corporate objectives are based on the milestones set out in our five year strategy and bring together national policy with internal clinical priorities and the feedback from stakeholders (clinicians, commissioners, local authorities, universities, cancer network) obtained in our regular external stakeholder audit. They also reflect discussions held with our governors at council, committee and sub-group meetings and at a seminar during preparation of the five year strategy. In addition they draw on two strategic events for clinicians held during 2009/10.

### 2. Statements of Assurance from the Board

#### 1. Review of services

During 2009/10 The Christie provided the following NHS clinical services:

1. Critical Care
2. Haematology and Transplantation
3. Surgery
4. Endocrinology
5. Clinical Oncology
6. Medical Oncology
7. Chemotherapy
8. Radiotherapy
9. Oncology for young people
10. Radiology
11. Pathology
12. North West Medical Physics

The Christie has reviewed all the data available on the quality of care in all of these NHS services.

The income generated by the NHS services reviewed in 2009/10 represents 100 per cent of the total income generated from the provision of NHS services by The Christie for 2009/10.

### 2. Participation in Clinical Audits and Confidential Enquiries

During 2009/10, there were eight national clinical audits and three national confidential enquiries that applied to NHS services provided by The Christie and we participated in all of them.

The number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry is shown in the table below.

The reports of seven national clinical audits were reviewed in 2009/10 and The Christie is taking the following actions to improve the quality of healthcare provided:

1. Establishing action plans where recommendations are relevant to The Christie
2. Working with the Greater Manchester and Cheshire Cancer Network (GMCCN) to address matters relating to wider planning of cancer services (e.g. The results of the national lung cancer audit referring to multi-disciplinary team functioning)

The reports of 58 local clinical audits were reviewed in 2009/10 and The Christie is taking the following actions to improve the quality of healthcare provided:

1. Establishing action plans and re-audits for each local audit
2. Reporting and monitoring of action plans through the Clinical and Research Governance Committee, the Risk Committee where appropriate, and the Quality Assurance Committee

### National clinical audit and national confidential enquiry eligible and participated in:

	Numbers submitted (eligible)	Percentage of Eligible Submitted
NBOCAP – The national bowel cancer audit programme	36 (36)	100
NLCA – National lung cancer audit	137 (137)*	100
DAHNO – Data for head and neck oncology audit	149 (149)*	100
ICNARC – Intensive Care National Audit & Research Centre Case Mix Programme	255 (491)*	100
ABCP – National comparative Audit of Blood Collection Process	32 (40)	80
NMBRA – National Mastectomy & Breast Reconstruction Audit	48 (63)	76
AUGIS – National oesophageal – gastric cancer audit	480 (480)*	100
NCDHAH – National Care of the Dying Audit of Hospitals	30 (30)	100
NCEPOD – Parenteral Nutrition	11 (19)	58
NCEPOD – Acute kidney injury	32 (32)	100
NCEPOD – Perioperative care	0 (1)	0

\*successful submission dependent on referring trusts entering tumour record. Data shows numbers accepted by national audits. NCEPOD – National Confidential Enquiry into Patient Outcome and Death

## Quality objectives

Quality domain	Quality domain	Completion Date	Clinical Lead	Director Responsible	Reason for Inclusion
Improve Clinical Effectiveness (Corporate Objective 1)	Demonstrate and publish improvements in survival rates for specific cancers including comparative data where available and with appropriate commentary	June 2010	Associate Medical Director	Medical Director	Discussion at Board of Directors and Governance
	Commission a programme of disease based clinical audits of clinical effectiveness with at least two audits completed for each disease group	July 2010 – Programme Commissioned March 2010 – Programme Completed	Chair of Clinical Audit Committee with Associate Medical Director	Medical Director	Discussion at Executive Team and Governance Committee
Improve Patient Experience (Corporate Objective 5)	Continue to reduce waiting times and improve patient satisfaction with outpatients, chemotherapy and pharmacy	March 2011	Divisional Director Clinical Support Services	Chief Operating Officer	Stakeholder review feedback
Improve Patient Safety (Quality Framework item)	Improve the management of neutropenic sepsis as measured by "door to needle" times for antibiotics	March 2011	Clinical Director Medical Oncology	Chief Operating Officer	Commissioners and cancer network – NCAG/NCEPOD reports
	Improve the assessment of venous thrombo-embolism risk in line with national guidance	March 2011	Clinical Directors	Medical Director	Commissioners – CQUINS measure
Address Inequalities in healthcare access (Operating Framework)	Improve access to radiotherapy treatment for disadvantaged communities by opening the Oldham and Salford radiotherapy units	Oldham – March 2010 Salford – 2011	Consultant in Clinical Oncology	Opening – Director of Finance and Business Development Operation – Chief Operating Officer	Operating Framework
	Improve access to chemotherapy treatment for disadvantaged communities by making optimum use of local chemotherapy facilities	March 2011	Clinical Director Clinical Oncology	Chief Operating Officer	Operating Framework

**Key:**

NCAG – National Cancer Advisory Group  
NCEPOD – National Confidential Enquiry into Patient Outcome and Death  
CQUINS – Commissioning for Quality and Innovation

**Quality goals agreed with commissioners**

Objective	Target	Outcome
Number of patient safety incidents resulting in patient harm	To report number	Achieved
Discharge summary to be sent to patients GP within 48 hours of discharge from The Christie	100% by 31 March 2010	Achieved
Maximum of 20 minutes waiting time in Outpatient department from appointment time to be seen by clinician	80% by 31 March 2010	Achieved
Annual collection & publication of clinical audit data for new developments & presentation of clinical evidence and outcomes	To report to commissioners	Achieved
Progression towards OECL accreditation	To have undertaken initial visits and data submission	Achieved
Implementation of Somerset Cancer Registry	System implementation	Achieved

**3. Participation in Clinical Research**

In 2009/10 1,926 patients receiving NHS services provided or sub-contracted by The Christie were recruited to participate in research approved by a research ethics committee.

**4. Quality Goals Agreed with Commissioners**

A proportion of The Christie's income in 2009/10 was conditional on achieving quality improvement and innovation goals agreed between The Christie and our commissioners for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework (CQUINS).

The table above shows the goals for improved quality included within the CQUINS framework for 2009/10.

In 2010/11 £1.7 million of our income is dependent on the achievement of quality improvement and innovation goals.

**5. The Care Quality Commission's View of The Christie**

The Christie is required to register with the Care Quality Commission and is currently registered to provide diagnostic and screening procedures, surgical procedures, and treatment of disease, disorder or injury with no conditions on registration.

The Care Quality Commission has not taken any enforcement action against The Christie or undertaken any special reviews or investigations during 2009/10.

The Christie is subject to periodic reviews by the Care Quality Commission and the last review was on 18th December 2009. The CQC's assessment of The Christie following that review was that on inspection the CQC found no evidence that The Christie has breached the regulation to protect patients, workers and others from

**Data quality**

	% of records in published data with patients valid NHS number	% of records in published data with patients valid General Medical Practice Code
Admitted patient care	99.7	100.00
Out patient care	99.6	100.00
Accident and emergency care	Not applicable	Not applicable

the risks of acquiring a healthcare associated infection. Fifteen measures were assessed and no concerns were found.

**6. Data Quality**

The Christie submitted records during 2009/10 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

**7. Information Governance**

The Christie's score for Information Quality and Records Management, assessed using the Information Governance Toolkit for 2009/10 was 82%.

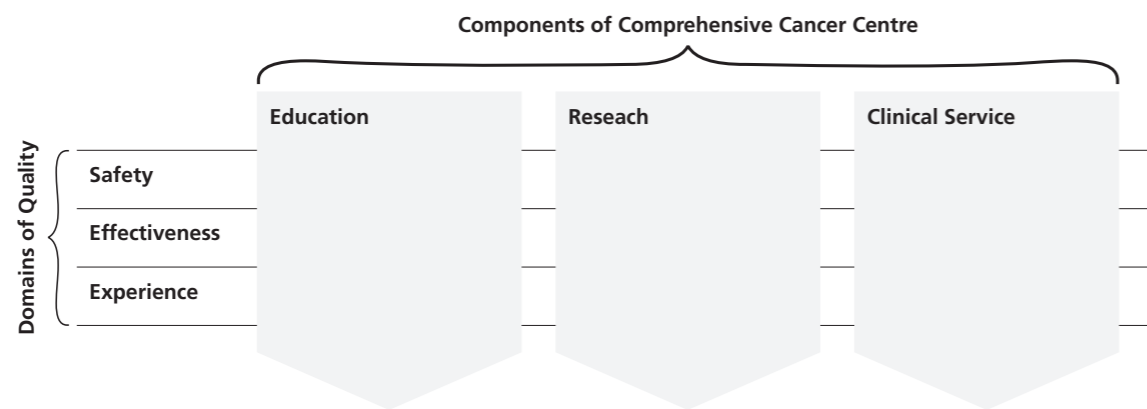
In 2009/10 The Christie was subject to the Payment by Results clinical coding audit by the Audit Commission for admitted patients and outpatients.

The error rate reported in the latest published admitted patients audit for diagnosis and treatment coding (clinical coding) was 7.4% (compared to the national average error rate of 12.8% for 2008/09).

The services reviewed in these audits were clinical haematology in the admitted patients audit and medical oncology, clinical oncology and haematology oncology in the outpatients audit. The results should not be extrapolated beyond the actual sample audited.

### Part 3: Review of quality performance in 2009/10

#### Framework for quality reporting



#### Introduction

In February 2009 The Christie adopted a framework for quality reporting (see diagram) with monthly quality accounts included in our regular integrated performance reports as well as this annual quality report. The board of directors believes that quality of care should where possible be reported and scrutinised frequently so that any adverse trends can be identified early and acted upon.

The monthly quality accounts for The Christie are reviewed at our management board by key senior clinical leaders and the directors of research and education. Quality accounts for individual divisions are reviewed as part of the regular performance review meetings with the executive team. Any matters of concern are followed up either through the divisional meetings or through the risk committee chaired by the chief executive.

The board's Governance Committee updated its terms of reference and changed its name to the Quality Assurance Committee from 1 April

2010 to emphasise the focus and importance given to quality assurance. It receives the minutes from the Clinical and Research Governance Committee and the Risk Committee along with a number of reports relating to quality.

Our governors receive reports on quality of care every quarter at the governors' quality committee. The executive team regularly reviews the quality of care within the hospital through visits to clinical areas. Non-executive directors and governors also undertake regular visits to clinical areas to see at first hand the quality of care and environment and to hear directly from patients about their experience of the hospital.

This section of our quality report draws on the quality information in the monthly integrated performance reports and includes additional annual indicators for which annual reporting is appropriate. The data is drawn from regular surveys, audits or routine data systems that have been established to provide a focus on and assurance about quality of care.



#### 1. Patient Experience

Satisfaction levels with care provided at The Christie are extremely high and all our efforts are directed towards ensuring the best possible experience for patients at a time of enormous stress and worry for them and their families. In 2009/10 we were the top rated trust nationally for overall quality of care in the national inpatient survey.

We take enormous pride in our environment and receive top ratings in the annual Patient Environment Action Team (PEAT) audits. We are highly rated in surveys for respecting our patients' privacy and dignity. We provide single sex accommodation unless there is a clinical need for mixed accommodation (for example, where patients need specialist care and intervention such as in the critical care unit and surgical step down unit) or when patients choose mixed accommodation, (for instance, in the young oncology unit).

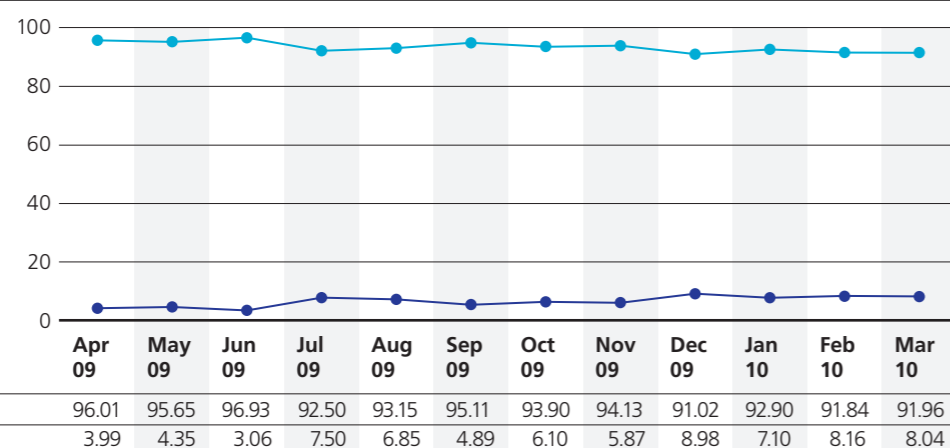
We place particular emphasis on the feedback received directly from patients and their families whether that be through our own patient surveys, complaints, the results of national surveys or meeting our governors. During 2009/10 some of our governors and our designated non-executive director patient champion have visited different areas of the hospital to meet some of our patients. These visits have been very valuable and almost all the feedback has been very positive.

Against the general background of demonstrable high standards of patient experience we have included three indicators of patient experience that we wish to monitor and improve upon:

- satisfaction as assessed through monthly patient surveys,
- complaints and
- on the day waiting times

Improvements in these indicators will support our objective of providing the best possible care. They also reflect the key concerns of the staff, the board of directors, our governors and members.

**Indicator 1 – Patient Satisfaction Survey (2009/10)**

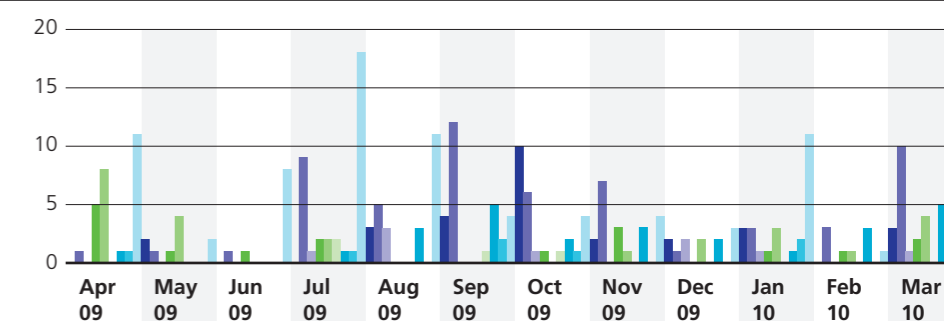


**Indicator 1 – Patient Satisfaction**

Every month we interview 100 patients to assess their satisfaction with their care. On average throughout the year more than 93% of patients have assessed their experience as either 'excellent' or 'good'.

We look for patterns of concerns amongst patients rating their care as fair or poor and take action to address these concerns. The most frequent reason for fair or poor ratings is on the day waiting particularly for chemotherapy and in our pharmacy. This is described in more detail in indicator three.

**Indicator 2 – Complaints by type 2009/10**



**Indicator 2 – Complaints**

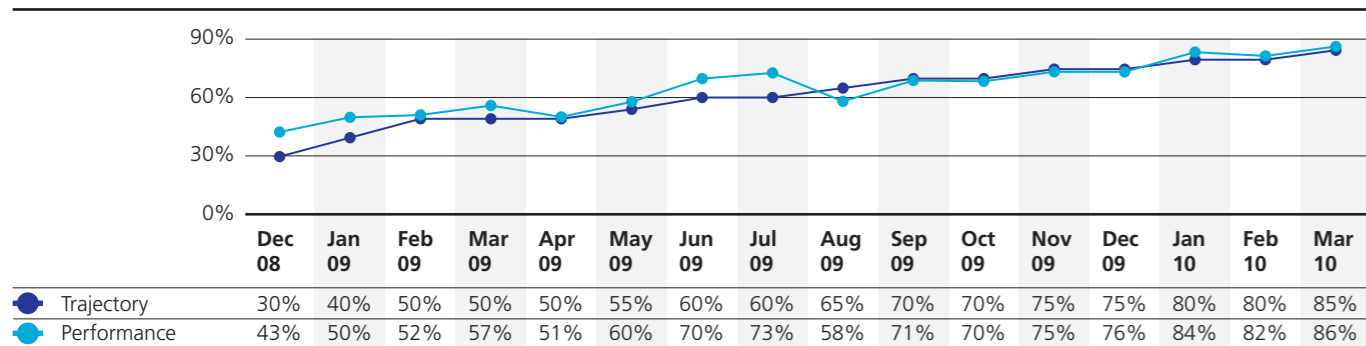
In 2009/10 we received 165 individual complaints, of which 123 were level two and 42 were level three. We classify complaints as level two or three with level three being the most serious. Contacts received through our Patient Advisory Liaison Service are categorised as level one.

For all of the categories listed in the chart overleaf, responsiveness, including on the day waiting times, was the most common issue raised. Whilst complaints about waiting in the outpatient department have reduced in line with the reductions in waiting times, as in our patient surveys, there is continued concern about on the day waiting times for chemotherapy and pharmacy.

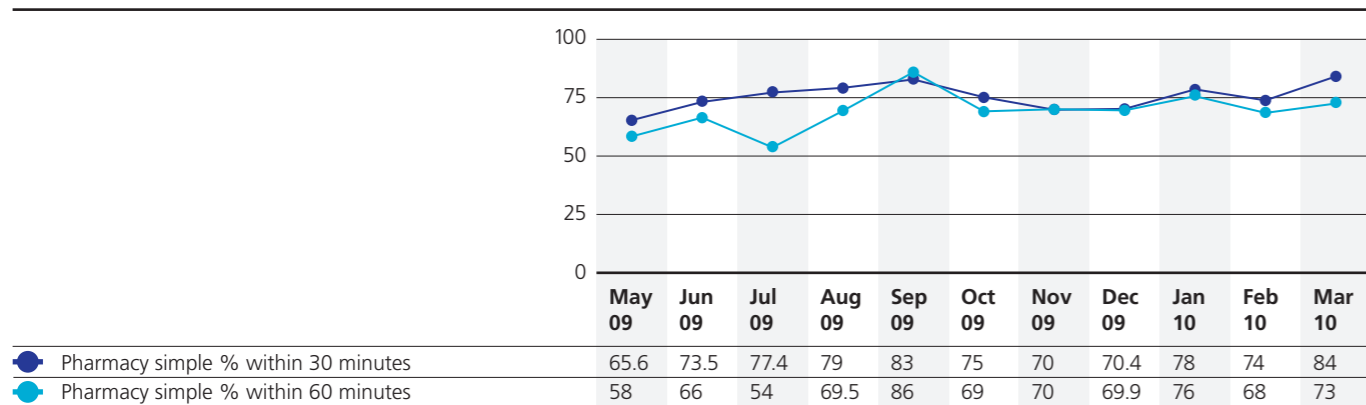
In 2009/10 we responded to 40 level three complaints within the timescales agreed with the complainant.

In 2009/10 four complaints were referred to the Parliamentary and Health Service Ombudsman (PHSO). Two were closed by the PHSO requiring no action from The Christie. One has been closed pending local resolution with another NHS body and will be reopened when all the other relevant organisations have concluded their investigations. The other case has been closed until the conclusion of an independent review by The Royal Marsden. The PHSO will re-open the case if the complainant does not accept the outcome of the review.

**Indicator 3 – Progress against 20 minutes wait – outpatients**



**Indicator 3 – Pharmacy waits**



**Indicator 3 – On the day waiting times**

In 2009/10 we set ourselves a challenging target of ensuring that 85% of outpatients were seen within 20 minutes of their appointment time when attending The Christie. This would ensure a significantly better patient experience.

The graphs above show that we have achieved this target for waiting in the outpatient department and have improved waiting in pharmacy. However, our aim is to improve waiting times for both pharmacy and chemotherapy further and we have set this as one of our quality objectives for 2010/11.

**2. Clinical effectiveness and outcomes**

**Introduction**

National and local clinical audits show that the care provided by The Christie is effective in prolonging life and reducing the pain and distress associated with cancer and its treatment.

Outcomes such as mortality and complication rates after complex urological surgery, complex gynaecological surgery and complex colorectal surgery at The Christie have been reported to the board of directors. Such published outcomes have set international benchmarks for standards of care. Similarly outcomes of radiotherapy and chemotherapy for specific cancer types have shown care at The Christie to be of international standard. These results are published in professional journals and are now discussed at The Christie's regular mortality and morbidity meetings.

The board of directors receives a presentation before each board meeting, from a clinician describing the outcomes and effectiveness of the care that they provide. The board of directors also receives summary reports on the outcome measures and reports discussed at the quarterly morbidity and mortality meetings. More detailed technical reports are made available to board members.

We have a process in place to review the circumstances of all deaths that occur within 30 days of the last chemotherapy treatment and this is undertaken through our disease groups. Of the deaths that do occur, most are in relation to progression of the underlying illness. The proportion of deaths due to a complication of chemotherapy treatment occurs in less than 1% of all patients treated, but these are analysed so that we can, if possible, try to reduce the risks further for specific types of treatment or patient groups.

**Indicator 1 – One and five year survival rates**

Nationally published data shows that in Greater Manchester five year survival rates are not statistically different from the national average. However, one year survival rates are lower than the national average.

We work in a part of the country where many people have poor general health including, for example, a higher rate of smoking related diseases such as cancer. In some parts of the Greater Manchester and Cheshire Cancer Network general practitioner and diagnostic services have been weak and it is only in the last five years that the type of specialist diagnostic and initial treatment teams that are needed for effective, early treatment have been formed. We, therefore tend to see patients for treatment whose cancer is at a more advanced stage or who have other illnesses such as heart disease which prevents them from receiving the most effective, but potentially dangerous treatment.

These factors affect the one year survival rates published nationally and locally. This indicator is recognised proxy for timeliness of presentation and diagnosis.

**One Year Relative Survival Rates for All Malignant Neoplasms (excluding skin cancers)**

Year of diagnosis	Men (%)	Women (%)	All (%)
1985-1989	49.3	61.4	55.5
1990-1994	53.6	64.2	59
1995-1999	58.9	67	63
2000-2004	64.1	69.4	66.7

	Men (%)	Women (%)	All (%)
Greater Manchester	61.2	67.3	64.2
Merseyside and Cheshire	63.4	67.8	65.7
South Cumbria and Lancashire	62.5	66.5	64.5

Source: National Cancer Intelligence Network – latest years' available data

This table shows that whilst one year survival rates have improved in the past 25 years the rates in the North West of England remain consistently below the national average indicating that patients in our area are more likely to delay seeking treatment until their cancer is more advanced.

Our aim here is to provide leadership within the Greater Manchester and Cheshire Cancer Network to improve awareness of cancer symptoms and to support earlier local diagnosis, through for example screening programmes.

A different picture is shown by looking at five year survival rates which are a proxy indicator for the effectiveness of treatment and an indicator of long term outcome. The table shows that for all cancer types the five year survival figures in Greater Manchester are similar to those for England as a whole. Differences between the figures do not reach statistical significance.

**Five Year Relative Survival – Common Cancers**

	England		Greater Manchester	
	Men	Women	Men	Women
Prostate	75.7		77.3	
Bladder	64.9	53.5	60.4	51.3
Female Breast		82.2		82.3
Ovary		39.2		45.3
Cervix		67.8		66.1
Oesophagus	9.2	9.2	9.0	8.1
Stomach	13.4	14.4	13.8	13.5
Colorectal	49.5*	50.4*	48.5	49.4
Pancreas	3.0	2.3	3.6	3.1
Lung	6.2	7.2	5.8	7.7
Melanoma	80.2	90.2	82.7	89.9

Source: National Cancer Intelligence Network – latest years' available data.

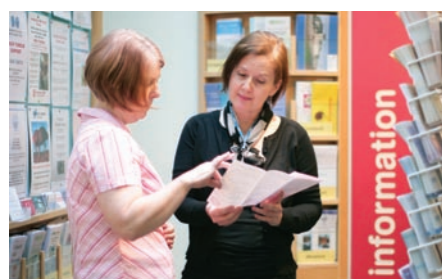
\*national estimates

Our aim here is to work with the Greater Manchester and Cheshire Cancer Network to ensure effective diagnostic, treatment and referral pathways to The Christie and to ensure, through our clinical audit and other mechanisms that the treatment we provide meets best evidence based practice guidelines.

As the lead cancer centre in the region we have a responsibility to lead improvements in cancer services across the Greater Manchester and Cheshire Cancer Network. Whilst both one year and five year survival rates are determined by many factors other than the services provided by The Christie they are influenced by our services.

Our aim is to support schemes directed to cancer prevention and earlier detection as well as ensure rapid diagnosis and referral when needed.

Demonstrating that our treatments are effective is as important as demonstrating our contribution to improvements in cancer care across the Greater Manchester and Cheshire Cancer Network.



**Indicator 2 – Clinical Audit Programme**

Clinical audits of our services provide data on the effectiveness and outcomes of care directly provided by The Christie. The clinical audit programme is approved by the clinical and research governance and the quality assurance committees and the outcomes of individual audits are monitored by the clinical audit committee.

In 2009/10, 82 audits were completed across the range of our services and reported in the annual clinical audit report. Some audits are reported to the quality assurance committee and the board of directors.

**Indicator 3 – Outcomes of Treatment (Includes indicators of surgical and radiotherapy treatment)**

Our aim is to increase the range of published treatment outcomes. The following examples show audit data that was considered by the board of directors in 2009/10 either in the monthly integrated performance reports or the regular clinical presentations.

*Example a – Surgical outcomes following radical cystectomy*

An analysis of 846 patients undergoing radical cystectomy showed mortality at 30 and 60 days to be 0.6% and 2.6% respectively. This data has been accepted for publication in the Journal of the European Association of Oncology. The results are statistically significantly better than any other case series for this procedure despite the case mix containing more difficult and advanced cases than published results from other centres. The results from The Christie are now accepted as the UK national benchmark.

*Example b – Mortality following colorectal surgery*

Of 739 cases undertaken over a 12 month period (from April 2008) 207 were in the intermediate, major or major complex categories. Overall there were three deaths and 34 post operative complications. Of the three deaths two were in-patients undergoing minor procedures but were due to disease progression. One death resulted from a major complication.

These mortality and complication rates are lower than expected for the case mix of patients being operated on although directly comparable data from other centres is not available.

**Example c – Cervical cancer outcomes following radiotherapy**

**For the 249 patients from The Christie five year survival rates were:**

	<b>N</b>	<b>%</b>
Stage one	85	72
Stage two	65	53
Stage three	64	30
Stage four	18	22

The overall five year survival rate is 52%.

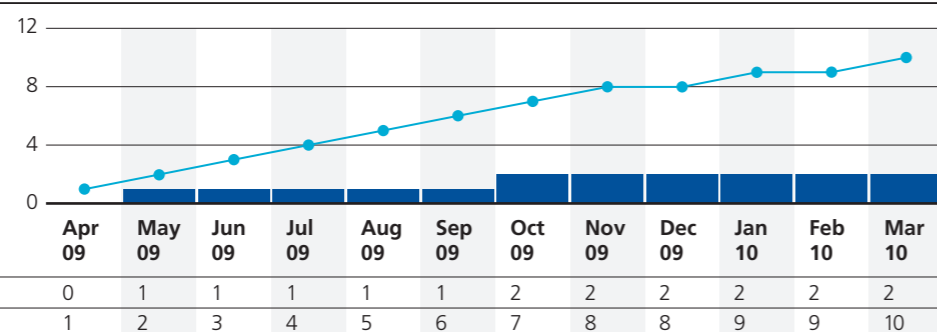
*Example c – Cervical cancer outcomes following radiotherapy*

Audit data on the outcomes of 1,412 patients with cervical cancer from 42 centres and produced by the Royal College of Radiologists shows that 249 (20%) of patients in the audit were from The Christie.

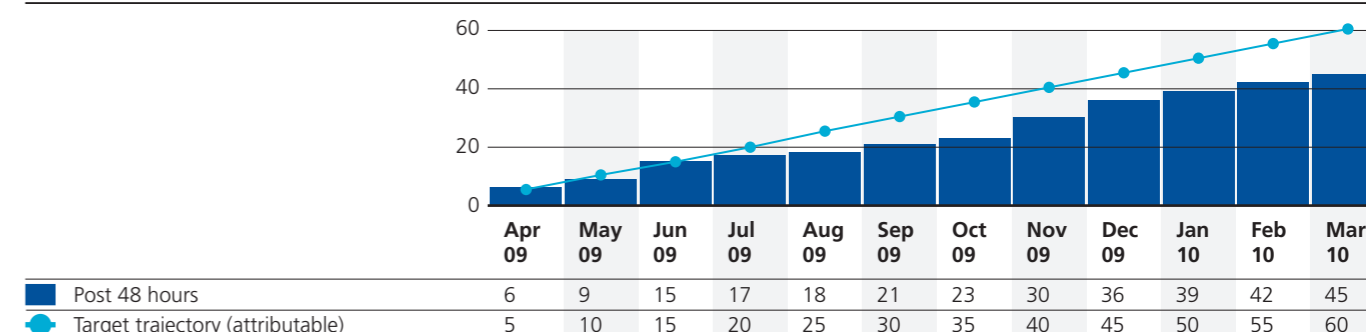
The data demonstrates that The Christie deals with a higher proportion of patients with advanced disease (35% with stage three or four) than any other UK centre.

A general conclusion of the audit is that bigger centres (i.e. The Christie) have less toxicity due to treatment and have higher survival rates.

**Indicator 1 – MRSA bacteraemia**



**Indicator 2 – Cumulative Clostridium difficile attributable – actual against target**



**3. Safety**

**Introduction**

To demonstrate the safety of our services we have selected two indicators of patient safety: healthcare acquired infections and untoward incident reporting and learning.

Many organisations now use the hospital standardised mortality rates (HSMRs) published nationally as an indicator of safety. We are not able to do this as the published rates exclude patients with cancer. Instead we monitor the number of patient deaths at The Christie each week and investigate if this number rises above eight in any particular week. During 2010/11 we are introducing an audit of in-hospital mortality.

**Indicator 1 – Healthcare Acquired Infections – MRSA**

We have low levels of healthcare acquired infections despite the particular vulnerability of many of our patients to infections as a result of their disease and treatment. Low rates of healthcare acquired infections indicate high standards of cleanliness, hygiene, antibiotic use and other measures to prevent cross-infection.

In 2009/10 we had two cases of MRSA bacteraemia and we screened 100% of appropriate elective patients on admission for MRSA.

**Indicator 2 – Healthcare Acquired Infections – Clostridium difficile**

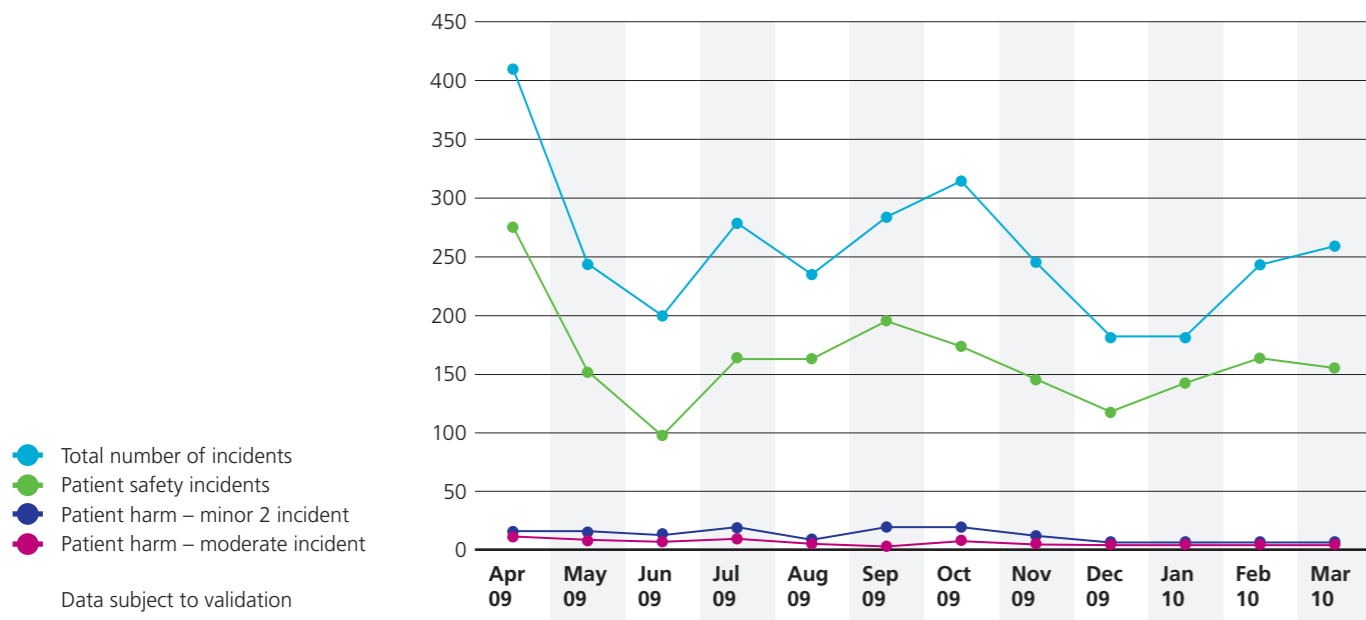
In 2009/10 we had 45 attributable cases of Clostridium difficile infection compared with a maximum permitted number for the year of 60 attributable cases (i.e. cases considered to have developed whilst an in-patient).

There were a further 41 cases where symptoms developed within 48 hours of admission and are therefore considered as having been acquired before admission. There were no outbreaks of Clostridium difficile and no cases of cross-infection, indicating high standards of infection control in the hospital.

During the year we received an unannounced visit from the Care Quality Commission to review infection control. We were rated green on all parameters assessed.

section layout TBC dependent on feedback re: performance/annex amends

**Indicator 3 – Trend analysis**



**Indicator 3 – Untoward Incidents**

We have a strong internal system of untoward incident reporting and review which enables us to identify underlying problems and to learn from events, thereby preventing recurrence.

In addition to our internal system we report patient safety events to the National Patient Safety Agency. Comparison of our reporting practices with those of other trusts in the same cluster shows that we have high levels of reporting but low levels of patient harm, indicating that there is an appropriate culture of reporting and learning at The Christie.

Our reporting rate is approximately one per 10 hospital admissions which indicates appropriate levels when compared with similar trusts. 94.5%

of our patient safety incidents resulted in no harm (benchmark of 67.8%). 5.3% resulted in low harm (benchmark 25.8%) and 1% resulted in moderate harm (benchmark 5.7%). This indicates particularly good reporting and learning from near misses, such as the pharmacist interventions to identify and prevent prescribing errors.

All reported incidents are investigated. Moderate incidents are reported on a weekly basis to the executive team and are reviewed by a panel of Christie executives. A report on the outcome is presented to the risk committee. Serious incidents and those requiring external reporting along with a sample of moderate incidents are reviewed by a panel chaired by a non-executive director and reported to the board of directors.



**Performance against key national priorities**

In 2009/10 The Christie achieved all applicable national targets set out in the Monitor compliance framework except the 62 day cancer waiting times target for which we reported partial compliance. Our performance against key national priorities is shown on pages [44 and 45].



Patients in the 62 day cancer pathway are all referred from other hospitals and we also treat a large number of patients with complex needs and provide some highly specialized treatments. As a result of this, some patients arrive at The Christie very late in this pathway.

An independent clinically-led audit has demonstrated that the level of service and the quality of patient experience for patients on the 62 day cancer pathway are at least as good as in the previous two years when we were achieving the previous target. However, we were unable to achieve compliance for the revised 62 day cancer target because of changes to the method of counting and relevant adjustments made by the Care Quality Commission in 2009/10. These changes have resulted in an apparent fall in our performance.

We are working with the Care Quality Commission and our cancer network to try and get this assessment resolved.

The Christie has declared to the Care Quality Commission that it was compliant with standards for better health and the essential standards of quality and safety.

## Performance against key national priorities

	Monitor Target	Threshold	Q1	Q2	Q3	Q4	Annual total
Weighting 1.0	Clostridium difficile year on year reduction	<60 attributable cases p.a.	6	6	15	9	45
	MRSA year on year reduction	<10 cases p.a.	1	0	1	0	2
	18 week referral to treatment – NAP	95%	Achieved	Achieved	Achieved	Achieved	Achieved
	18 week referral to treatment – AP	90%	Achieved	Achieved	Achieved	Achieved	Achieved
	31 day cancer extended target	98%	99.8%*	99.8%*	99.9%*	99.9%*	Achieved
	62 day cancer extended target	79%	66.4%*	70.3%*	61%*	61.4%*	64.7%*
	Monitor Target	Threshold	Q1	Q2	Q3	Q4	Annual total
Weighting 0.5	31 day cancer	96%	99%*	98.1%*	98.2%*	97.3%*	98.1%*
	2 week urgent cancer referral	93%	100%	100%	100%	100%	100%
	MRSA screening	100%	100%	100%	100%	100%	100%
	28 day readmission – cancelled ops	95%	100%	100%	100%	100%	100%
	Minimise delayed transfers of care	Under 3.5%	0%	0%	0%	0%	0%

\* subject to validation and breach reallocations