



CLINICAL GOVERNANCE ANNUAL REPORT 2010/2011

CONTENTS

	Page No:	
1	Introduction	3
2	Trust framework for clinical governance	3
2.1	Clinical & research governance committee	3
3	External assessments	4
3.1	Care Quality Commission	4
3.2	NHS Litigation Authority risk management standards	4
3.3	PEAT	4
4	Clinical audit	5
5	Complaints	6
6	Consent	8
7	Education	9
8	Equality and Diversity	10
9	Facilities	11
10	Infection Control	11
11	Medical devices	12
12	Medicines management	12
13	NICE Guidance	14
14	Nutrition	14
15	Patient Advice and Liaison Service (PALS)	16
16	Patient information	17
17	Patient & public involvement	18
18	Patient safety incidents	19
19	Project work	20
20	Research Governance	21
21	Resuscitation	23
22	Safeguarding adults	23
23	Safeguarding children	24
24	Safety alerts	24
25	Thrombosis committee	25
26	Transfusion	25
	Appendix 1 Contributors to the annual report	27

1. Introduction

The Christie NHS Foundation Trust is committed to delivering top quality cancer care, equally accessible to all, alongside world class research and excellent education.

As part of the national approach to developing clinical governance, all trusts are required to produce a clinical governance annual report which looks back at achievements over the previous year.

Clinical governance can be described as a national framework for achieving quality improvement. It encompasses all the procedures and processes that ensure patients receive a high quality service. It is not complicated – it ‘happens’ every time a patient’s comments change how we work, every time an incident is reported that prevents it happening again, every time a complaint is investigated, every time a member of staff suggests an idea for improving services and every time a recommendation arising from an investigation is completed.

The clinical governance annual report for The Christie NHS Foundation Trust has been developed by members of the governance team and various trust leads. It has been approved by the clinical and research governance committee. The report shows that there continues to be a sound system of clinical governance across the trust.

The report is based on a selection of clinical governance areas. It includes examples of good practice and quality improvements from a random selection. There is not room to include them all, but we are able to show that we have made significant progress and that we continue to learn from patient feedback, research, audit and incidents that occur. The report reflects the excellent work undertaken by hard working, professional and caring clinical and non-clinical staff.

2. Trust framework for clinical governance

The trust’s corporate plan for 2010/11 included 9 strategic goals. There are links to clinical governance in all of our objectives. Assurance for clinical and corporate governance is sought and obtained from the Audit and Quality Assurance committees, of which the non-executive directors are members.

Our committee structure has been scrutinised and refined over recent years. There is a robust framework and reporting structure. All clinical divisions are represented at the clinical and research governance and risk committee, which meets monthly.

The divisions manage their risks – clinical and non-clinical – through their risk registers. The board of directors receives a monthly report which highlights the key risks faced by the organisation. These are included in the performance reports so that actions to reduce risk scores can be monitored. It is the responsibility of the divisions to review all high level risks and action plans and to ensure the action plans are being progressed so that the risk scores for the high level risks are reduced. The high level risks are also reviewed by the risk committee. In addition, all risks are reviewed by these committees every quarter to monitor any changes which reflect current activity and any threats to services.

2.1 Clinical & research governance committee

The committee met 12 times over the year. Regular items on the agenda included significant clinical incidents, complaints, inquests, management of safety alerts and updates on project work. In addition, the committee received the minutes and exception reports from the sub-committees that feed into the clinical and research governance committee as part of the trust’s committee reporting structure. Several policies were submitted for approval. The majority of these were revised documents but the committee did also approve new or re-worked policies for implementation within the trust. These included:

- Arterial blood gas sampling policy
- Privacy and dignity policy
- Massive transfusion policy
- Oral care policy
- The McKinley T34 syringe driver in palliative care
- Epilepsy guidelines
- Protocol for seconding trust employees on to pre-registration nurse training programmes

The adoption of a trust-wide approach to such issues helps to improve patient safety as it ensures consistency.

As part of the trust procedures for the introduction of new techniques and technologies, the committee was pleased to support the work of the radiology team in the off-label use of biodegradable oesophageal stents in patients with oesophageal tumours. The benefits to the patient were significant and risks reduced, with an improved quality of life.

3. External assessments

3.1 Care Quality Commission

From April 2010 the trust has been registered with the Care Quality Commission for 3 regulated activities under the Health and Social Care Act: treatment of disease, disorder or injury; surgical procedures; diagnostic and screening procedures. We must comply with essential standards of quality and safety which are outcome based rather than being focussed on systems and processes. Progress against each standard is essential to maintain high quality, safe and effective care and treatment for patients. The Christie is committed to continuously improving patient care and the patient experience.

3.2 NHS Litigation Authority risk management standards

The promotion of good risk management, governance and assurance is integral to the NHSLA schemes. The risk management standards for acute trusts are designed to address organisational, clinical and non-clinical/health and safety risks. The standards identify 5 key areas for risk management which are then divided into 10 criteria, are as follows:

- Standard 1 – governance
- Standard 2 – competent and capable workforce
- Standard 3 – safe environment
- Standard 4 – clinical care
- Standard 5 – learning from experience

Following our assessment at level 2 in 2010, the leads for each criterion continue to work to achieve a higher compliance with the standards to ensure we can demonstrate that our policies, procedures and monitoring systems are well embedded within the organisation and in line with our framework for risk management.

3.3 PEAT

The Patient Environmental Action Team (PEAT) inspection took place in February 2011. The details provided below are based on the findings reported on the day. The formal report and result is not expected until the summer but is expected to reflect the same excellent result.

PEAT inspections are an annual assessment of the environment as viewed from a patient perspective, so only areas of the site that are accessed by patients are inspected. The team who carry out the assessment are made up of the director of nursing and governance, head of facilities, senior facilities managers, modern matrons, infection control, patient representatives and governors. This year we also invited an external assessor who is a senior manager at another trust.

The assessment is a standard pro forma carried out at all hospitals and the criteria have remained as per 2010. The results are used as a benchmarking exercise once the results are confirmed. Each area has a number of categories to be evaluated against a marking system of 0-5 where 5 is excellent. In addition with respect to cleaning this is measured against the national specification for cleanliness in percentage terms.

The patient areas assessed included wards, bereavement suite, OPD, public toilets, lifts, staircases, patient information centre, Oak road car park Oak road entrance and, for the first time, Oak road patient treatment centre.

The assessment results for cleaning reflect an achievement of 96% average over 12 months recorded on the C4C software system.

All other areas received a score of 5, with the exception of car parking. It was agreed that whilst the car parks are well maintained and satisfy all DDA requirements it is acknowledged that on occasion the car park spaces are often full and do not satisfy the capacity demands.

It should also be pointed out that although extremely clean, the Oak Road entrance and carpet in this area appears to be tired looking and worn. A full refurbishment of Oak Road entrance is to take place during the summer of 2011.

4. Clinical Audit

This year 184 projects have been registered, up from 124 in 2009/10. Although more projects were registered in advance for this year's programme than in the past, this still reflects both an increase in required audits and the numbers of projects being advised to the clinical audit department. Projects with standards to audit against are registered as clinical audit; others are registered as effectiveness projects.

Type of project	n	%
Clinical audit (CA)	139	76%
Clinical effectiveness (CE)	45	24%
Total	184	100%

Clinical audit priorities

Examples of completed audits are given in the clinical audit annual report but include national audits, audits of NICE guidance, audits required for NHSLA & CQUIN targets, eg:

- National cancer audits, eg lung, head & neck, bowel
- Audit of 30 day mortality following systemic anti-cancer therapy (SACT)
- Re-audit of MEWS (modified early warning score)
- Audit of inpatient prescribing
- Annual re-audit of the completion of the nutritional screening tool
- Screening for risk of VTE (venous thrombo-embolism)

All 139 clinical audits and 84% of clinical effectiveness projects met agreed trust priorities.

Trust priority	CA	CE	Overall
A. High risk / governance	23	1	24 (13%)
B. External 'must do'	71	7	78 (42%)
C. Quality improvement	45	30	75 (41%)
D. Does not meet trust priorities		7	7 (4%)
Grand Total	139	45	184 (100%)

Participation by clinical divisions

Participation in audit is widespread across divisions, departments and disease groups.

Lead Division	CA	CE	Overall
Networked Services	45	21	66 (36%)
Support Services	47	15	62 (34%)
Cancer Centre	32	9	41 (22%)
Nursing & Governance	15		15 (8%)
Grand Total	139	45	184 (100%)

Completion of projects

Projects are recorded as complete once recommendations have been agreed. Of the projects incomplete at this time, 41% clinical audits (32% overall) are awaiting final recommendations and action plans. The remainder have either not been carried out (including changes to national guidance and projects being merged) or are awaiting information about their status. The projects carried forward have completion dates in 2011 or later.

Project status	CA	CA	CE	CE	Overall	Overall
Complete	47	34%	14	31%	61	33%
Incomplete	45	32%	24	53%	69	38%
Carried forward to 2011	47	34%	7	16%	54	29%
Total	139	100%	45	100%	184	100%

An internal audit review of the clinical audit function was undertaken during 2010. The following recommendations were made in January 2011 which supported a business case for the continued funding of the department. An action plan has been approved and is being implemented.

Ref	Recommendation	Risk rating
1.1	Development of Annual Audit Programme and Oversight at Executive Level.	High
2.1	Clinical Audit Reports & Action Plans completed and disseminated to appropriate staff groups and committees and monitored	High
3.1	Reporting of Clinical Audit Projects / outcomes to key governance committees/clinical groups at local and organisational level	High
4.1	Monitoring of the 5 Year Plan	Medium
5.1	Alignment of Clinical Audit Staff to divisions and disease groups - consistency in reporting and engagement	Medium
6.1	2009/10 Clinical Audit Annual Report is presented to key committees of the Trust	Medium
7.1	Abandoning of Clinical Audit Projects - document and that all priority audits are completed according to plan.	Medium
8.1	Clinical Audit Programme undergoes approval and ratification	Low

5. Complaints

On 1 April 2009, the local authority, social services and National Health Service Complaints (England) Regulations 2009 replaced the previous NHS complaints regulations. These regulations merged health and social care complaints to make the process more straightforward for complainants.

The complaints process has two stages; local resolution (carried out by the NHS body) and, if the complainant remains dissatisfied, referral to the parliamentary and health service ombudsman.

The complaints process is more patient focussed and driven, with a greater emphasis on personal contact with the complainant to aid resolution. Formal timescales for responses have been withdrawn, however, internal timescales have remained in place as detailed below to ensure responses are issued promptly.

The Christie process for managing complaints splits them into two categories and they are dealt with as outlined below:

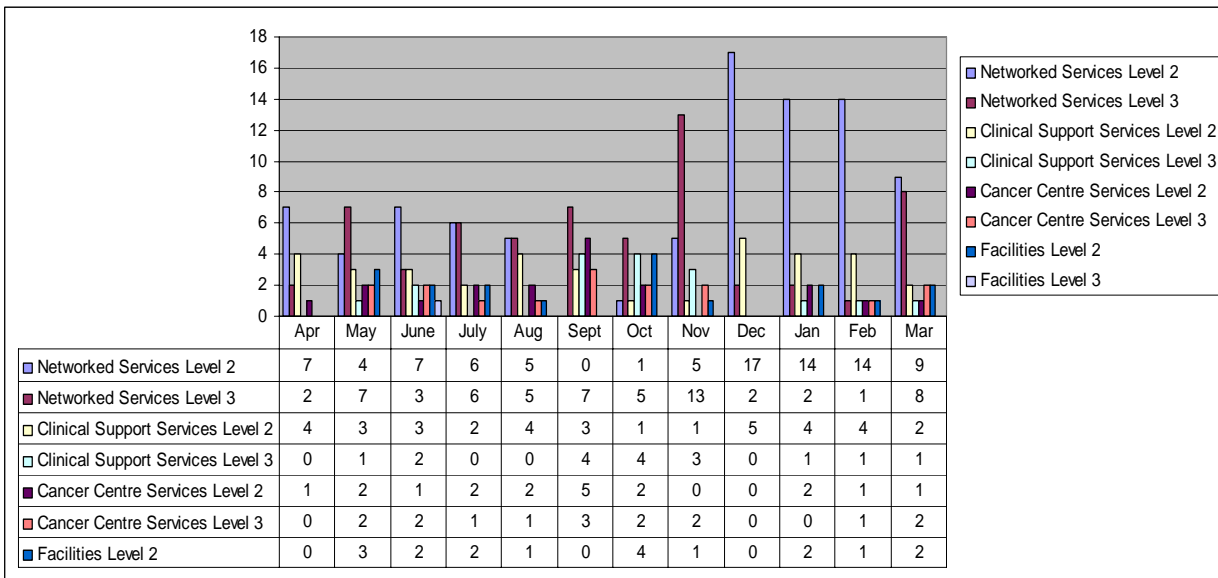
Level 2 – These are concerns which should be responded to directly by the division. This can include negative comments forms requiring a response from the divisions. These concerns can come via complaints/PALS. The majority of cases will fall within this category and will be mainly service related. A response can be provided by telephone, a meeting or in writing, depending on the complainant's requirements and the nature of the case. (If a complaint is resolved by telephone or at a meeting, the complaints department should be provided with confirmation of the details provided to the complainant). Depending on the nature of the concerns raised and the means of communication the division use, the internal timescale for this type of case is 10 – 15 working days.

Level 3 – These are complaints which take some time to investigate and relate primarily to concerns regarding treatment. Other serious matters will also be looked at under this level e.g. allegations of abuse or theft. These complaints are referred to the chief executive who will issue a response. If a meeting is held, the meeting notes will be issued from the chief executive. The internal timescale for a written response is 25 working days. We will ensure meetings are held promptly, where possible within 25 working days, and certainly within three months.

Receipt of complaints by division

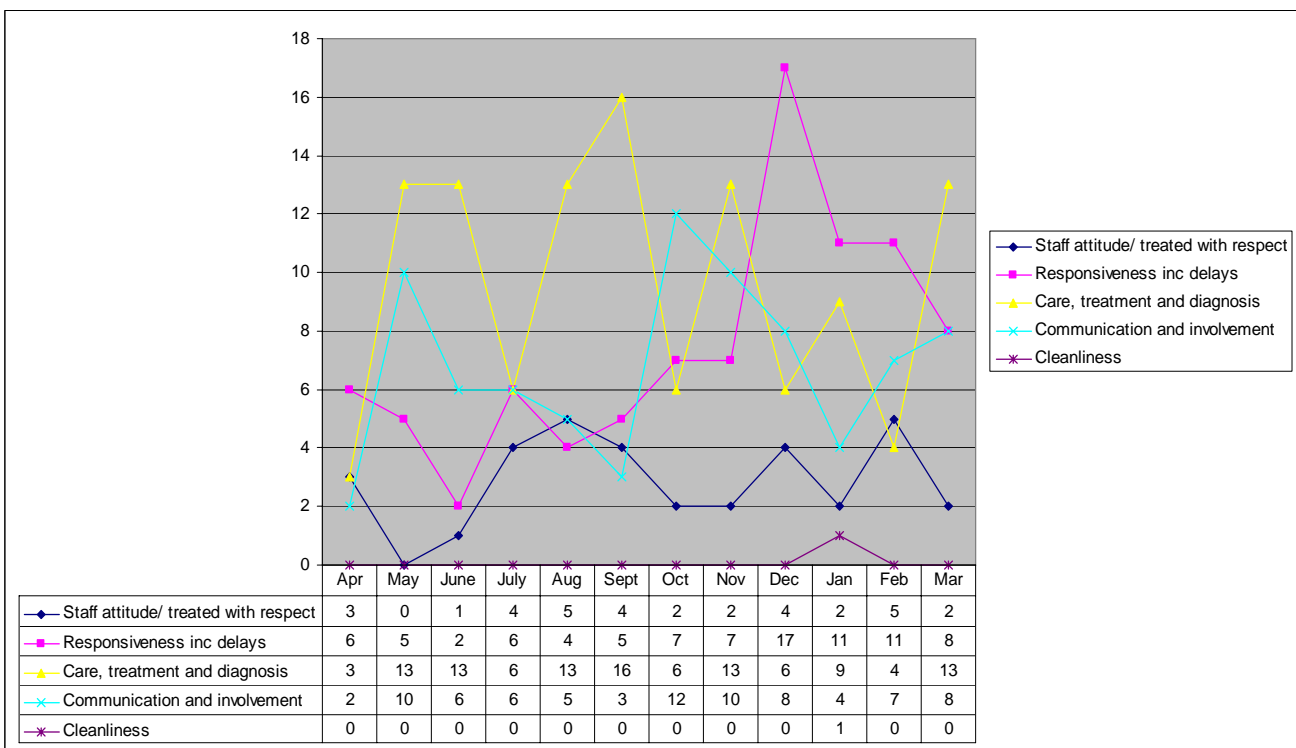
We received 236 individual complaints last year, a number of which related to two or more divisions. These break down as 155 level 2 complaints and 81 level 3 complaints.

Complaints are also recorded by division to allow us to maintain an accurate record of the number of complaints received by each division. If a complaint is received relating to two divisions it is, therefore, logged under both. The graph below shows the number of complaints received by each division on a monthly basis. This shows the receipt of 89 level 2 and 61 level 3 complaints received by Networked Services, 36 level 2 and 17 level 3 by Clinical Support Services, 19 level 2 and 16 level 3 by Cancer Centre Services and 18 level 2 and one level 3 by Facilities.



Complaints by subject

This graph highlights the range of issues that were complained about. 263 issues were raised within the complaints received during this year.



As the figures show, in some months a number of complex complaints were received, raising a number of issues relating to several divisions.

Care, treatment and diagnosis issues were the most common ones raised this year (105). This is due to some complaints raising a large number of issues relating to these areas. All issues within a complaint are logged separately so if a complaint raises 15 issues all relating to care and treatment, all 15 issues are logged separately. The receipt of 105 issues relating to care, treatment and diagnosis is not indicative of a widespread problem in these areas.

We received a large number of issues relating to responsiveness, including delays. As with previous years, a number of concerns were raised regarding chemotherapy. It was expected that the opening of the new patient treatment centre would reduce the number of delays experienced by patients attending for chemotherapy. There were initially some issues within the new unit leading to delays but the division is making significant progress in reducing these delays.

We also received 81 issues relating to communication. These included communication with the patient/family, internal communication and external communication (ie with other NHS organisations). As outlined in the actions taken section of this report, we have taken steps to improve communication further.

Timescales

Between April 2010–March 2011, the deadline was due for written responses to be sent in 174 cases and this was met in 168 cases (96.55%). This is within our target of 95%. We held complaint resolution meetings in 23 level 3 cases during this period. The other complaints were responded to directly by the relevant managers either by telephone or in person when patients attended their next appointments.

Actions taken

We have taken a number of actions in response to complaints, which have included:

- Improvement to our induction packages for new secretaries implemented
- Dignity issues were reiterated to ward staff during a ward meeting
- Signs have been placed on the entrance door into the relaxation room, on the wall near the organ/pc and on the wall by the television re noise levels
- SpR has reflected on concerns re the way bad new was broken and discussed with their lead consultant
- We have installed electronic warning messages that inform people when they use a lighter or match that the entrance is a no smoking area
- The importance of verifying patient addresses has now been highlighted with the relevant ward team
- Doctor has agreed to update communication skills by attending a communication course
- A number of actions have been taken to improve the experience of our chemotherapy patients. These include enabling patients to make two shorter visits, one to have bloods taken and see the doctor and the second to return the next morning for treatment

Referrals to the Parliamentary and Health Service Ombudsman (PHSO)

Two complaints were referred to the PHSO this year. The PHSO declined to investigate both cases. One was closed by the PHSO requiring no action from The Christie. In the other case, the clinical advice obtained by the PHSO confirmed that the patient was afforded the correct care. However, we were asked to send an apology to the complainant regarding information in our responses which the PHSO felt were contradictory. This apology was sent to the complainant.

6. Consent

The trust policy for consent to examination & treatment has been reviewed and updated in line with NHSLA standards. Compliance with the policy will continue to be monitored through annual audit.

There is increased focus on processes for providing assurance that health care professionals taking consent are competent to do so. This not only includes the tightening up of the existing process but the introduction of formal re-affirmation of competence as minimum every three years.

New consent forms have been developed and some existing consent forms updated, reflecting treatment changes and innovations.

Mandatory consent training is reaching all relevant staff groups via the monthly combined mandatory training day, the junior doctor teaching programme and consultant mandatory training days.

7. Education

Education and Training

The Christie School of Oncology was launched in September 2010, three years ahead of plan. This is an exciting new initiative for The Christie, bringing together all education and training across the healthcare professions and involves strengthening our partnerships and joint ventures with key external stakeholders and educational partners; the Universities of Manchester, Salford and Liverpool and the Manchester Academic Health Sciences Centre.

Our clinical experts and internal stakeholders, as part of the School of Oncology, continue to provide an important contribution to the training of internal clinical staff and undergraduate and post graduate courses run by our academic education institutions locally, nationally and internationally. This ensures that The Christie is ever present in delivering the highest quality education in oncology and palliative care; including specifically North Western medical physics, medical, nursing and complementary therapies departments.

Key educational successes during 2010/11

The School of Oncology is committed to providing an expanding and diverse portfolio of educational events and visits.

We have delivered twelve successful national education events this year, attracting several hundred delegates from across the country. Each event has been highly rated by delegates and our prospectus next year looks set to expand further. It is important that we respond to the changing and diverse nature of future service and workforce needs and in keeping with this, we are taking the lead in the provision of acute oncology education and training across the North West Region. In addition, we have developed a rolling programme of educational visits for senior oncology nurses from the Hong Kong health authority; the overseas scholarship programme for senior oncology nurses.

These successes have realised significant income generation by The School of Oncology this year which we will be able to re-invest back into developing the knowledge and skills of Christie staff; notably with a new post of clinical skills educator to enable the development of a broad range of work based generic and advanced clinical skills and vocational courses for registered and non registered staff across professions. This will further enhance patient care and increase our contribution to the education of the future healthcare workforce across the region and beyond.

The internationally renowned Maguire Communication Skills Training Unit has joined the School of Oncology this year. Two additional trainers have been recruited to accommodate the increasing demand for its courses across the country. A new communication skills course has been developed aimed at ward based staff and its success has led to it being commissioned by local trusts and regional cancer networks.

Other key education achievements and outputs 2010/11

The central education functions have made considerable progress in developing both internal and external education partnerships by

- Developing in partnership, the Masters in cancer research (MRes) with the University of Manchester commencing September 2010 together with the new Masters in psycho oncology with the University of Salford, demonstrating our ability to collaborate effectively
- Planned joint international cancer nursing research conference with University of Manchester/Christie April 2011. The Christie new events function is undertaking the facilitation and management of the conference
- Implementing a service level agreement to manage all training events for the north area of the UK, National Cancer Research Network (NCRN)
- Continued engagement, collaboration and education support provided for internal stakeholders across the professions via the Clinical Professional Education Forum, Pre-registration Education Group and clinical skills training steering group. These forums have been invaluable in pulling together all the disparate strands of education activity and identifying future education opportunities, joint working initiatives and skills gaps.
- Supporting clinical staff applying for awards and writing for publications – notable award successes include Nursing Times Awards (2009) Steve Hill - Highly Commended for The patient pathway: making quality count Award and Young Oncology Unit - Highly Commended for Child Health Award. Shortlisted for 2010, Helen Ferns - Finalist in Cancer Nurse Leader of the Year Award and Infection Control Team - Infection Control Award
- Developing and producing the first ever Christie education prospectus – this recognises and demonstrates the breadth of educational activity across the organisation across professions
- Delivering high quality education and training – ensuring a competent and capable workforce
- Achieved top scores in the NW region for the quality of clinical and medical oncology handover scores for medical trainees (GMC 2010 medical trainee survey)
- Developed in-house clinical and educational supervisors training for consultants supervising medical trainees
- Continue to receive positive clinical placement evaluations for pre-registration students across all professions
- Introduction of dietetic, radiography and paramedic students for the first time
- Development of an internal CPD programme for advanced nurse practitioners including observed structured clinical exams (OSCE). This has resulted in collaborative work with the University of Salford in developing a programme of regional events for advanced nurse practitioners
- Training needs analysis projects undertaken, identifying clinical skills training requirements and skills gaps for healthcare assistants, assistant practitioners and research nurses – training programmes and competencies in development
- Development of a communication skills training position paper for all staff groups and recommended actions
- Implementation of Oracle Learning Management System (OLM) improving the accuracy and efficiency of reporting for risk management training compliance
- Proposals and plans in place for modernised, flexible and fit for purpose mandatory training
- Processes for managing the funding and provision of academic courses for all staff groups has been updated and streamlined
- Developing educational facilities
- Completion of the refurbishment and development of new library and learning zone – incorporating an IT suite and additional education seminar room (May 2010)
- Extended opening hours of the education centre
- Identification of a new clinical skills training space on ward 3. Work underway to develop detailed business case for further expanding the education centre

8. Equality and diversity

The Christie NHS Foundation Trust must be compliant with the requirements of the Human Rights Act 1998 and the Equality Act 2010, which prohibits discrimination of people with 'protected characteristics' (age, disability, gender reassignment, race, sex, sexual orientation, religion and belief). The statutory duties are applicable to the provision of services to patients and in the employment of staff.

A Single Equality Scheme was developed to replace the existing three equality schemes for race, gender and disability. This sets out our corporate equality and diversity aims, current position and progress made, and detailed action plans for ongoing improvement.

The trust's equality & diversity policy was revised in line with the requirements of the Equality Act. Key elements of the new legislation were also integrated into the mandatory equality and diversity development programmes for all staff groups, including clinical staff, to ensure all are aware of best practice in supporting individual patient needs, and to work effectively with staff colleagues. To date, approximately one half of the total workforce has attended these programmes.

Equality impact assessment is a legal duty on all public authorities to assist in our aim for equal outcomes in health services to patients and in employment. It involves a systematic analysis of effects of the trust's activities on patients and employees in relation to their gender, race and disability etc., with the outcomes of the assessment shaping improvement plans to the policy under development. The trust has adopted a robust methodology for carrying out the assessments, including the training and guidance for relevant managers in how to conduct assessments and use of an online assessment toolkit for the completion and storage of the assessments. The equality impact assessment quality assurance group has been established to assess the quality of the content and outcomes of equality impact assessments completed using the online toolkit.

For the fourth year, we brought together a team of colleagues to take part in the Manchester Pride celebrations to support our patients and colleagues in the lesbian, gay, bisexual and transgender community. We worked in partnership with other North West NHS trusts to provide healthcare information to thousands of visitors from all around the region during the event. The trust's involvement was extremely well-received by the public.

This year has seen considerable development in the management and promotion of equality and diversity issues at the trust, and further significant developments are planned for the next 12 months.

9. Facilities

The following improvements have been made to patient facilities over the year:

- Replacement of carpeting in various areas with vinyl hard flooring
- Improved patient facilities within the mould room treatment areas
- OPD updated in clinical rooms to include new sanitary ware
- New waste segregation rooms on wards 9-12
- Patient lift refurbishment
- New Patient Information Centre
- Internal redecoration of main thoroughfares
- Improved DDA toilet facilities in Radiotherapy
- Oak Road Patient Treatment Centre opened
- Improved signage

10. Infection Prevention and Control

MRSA

MRSA identification and control remains a large part of the infection control team commitments. The trust remained below the trajectory annual total set by the commissioning PCT for bacteraemias. The trust has not had an MRSA bacteraemia since October 2009. The majority of new colonised patients identified were found on admission or from other health care facilities.

There was a cluster of MRSA patients on ward 12 in January and February. The root cause analysis identified that the screening of patients was not being carried out correctly. Nose, throat and groin were screened but wounds, nephrostomies etc. were not. This resulted in positive patients being nursed on the main ward. Emergency admission patients were not being prescribed MRSA suppression treatment. Ward 12 had been extremely busy at this time and had a large number of very dependant patients. The ward was understaffed and was relying heavily on agency staff who were witnessed by the IPCT not following infection control precautions when caring for infected patients.

MSSA

The trust has been reporting MSSA bacteraemia since January 2011. The trust has had 10 cases since March 2010.

CDI

There were no outbreaks of *C. difficile* infections (CDI) in 2010/11. There has been no evidence of any cross infection in any of the cases identified as they are all sent for ribotyping. There is a comprehensive CDI action plan that is reviewed as part of the IPC programme at the IPCC. The trust remained below the trajectory annual total set by the commissioners.

Swine Flu

The first swine flu patients presented to the trust. The number of positive swine flu patients peaked in December when 40 new patients were identified.

11. Medical devices

The Medical Devices and Procurement Committee met 6 times over the year. Regular agenda items include incidents involving medical equipment, and faulty equipment reports. 12 reports of faulty medical equipment were made to the Medicines and Healthcare products Regulatory Agency (MHRA).

The committee approved a number of proposals which were submitted. These included:

- Trial of new PICC
- Trial of Hospira Plum A+ infusion pumps
- Replacing Graseby MS26 syringe drivers with McKinley T34 syringe drivers for symptom control in palliative care
- Trial of a new oesophageal stent
- Trial of intraductal bile duct ablation for complex strictures and stent re-occlusion

The trust invested significantly in the replacement of patient weighing scales across the whole organisation. This was to ensure compliance with a safety alert from the Department of Health. The trust has standardised scales to minimise the risk to patient safety e.g. when used for diagnosis, treatment or medication of patients. A robust service and maintenance programme was also initiated for calibration and other safety checks to be undertaken.

12. Medicines management

Drugs Committees

The drugs & therapeutics committee met monthly. Regular agenda items included:

- new drug applications (14 approvals including 3 NICE drugs)
- NICE guidance
- financial drug statements
- drug audits
- drug budget planning

A focal point is the approval and revision of drugs policies, shared care protocols (in collaboration with GPs) and patient group directions.

Policies approved included:

- oral care
- management of sepsis including neutropenic sepsis
- management of chemotherapy-induced diarrhoea

These three were also adopted by the Greater Manchester & Cheshire cancer network (GMCCN).

Local trust policies approved included:

- antimicrobial guidelines for infections

- a switch in low molecular weight heparins from enoxaparin to dalteparin
- the management of epilepsy in neuro-oncology patients – the latter was drafted in response to a clinical incident noted by the safe medicines practice committee.

Shared care protocols were approved for:

- fulvestrant, ibandronate and goserelin
- dalteparin
- degarelix and LHRH analogues
- Interferon and octreotide in carcinoid syndrome

New patient group directions were approved:

- covering contrast media for CT scanning
- Meronem, gentamicin, tazocin to facilitate the national target of 1-hour door to needle time in treating suspected neutropenic sepsis

Other pieces of work included:

- drafting chapter 8 (malignant disease) of the Greater Manchester joint drug formulary involving trust-wide consultation as well as consultation across Greater Manchester.
- facilitation of the use of the Interim Cancer Drugs Fund introduced October 2010
- drafting the trust response to the following Department of Health consultations: (i) Cancer Drug Fund and (ii) Value-based approach to the pricing of branded medicines

The drugs management committee met monthly receiving papers and clinical recommendations on new drug applications approved by drugs & therapeutics committee. There was significant financial scrutiny of the drugs budget particularly overspends and subsequent audits eg metastatic herceptin, abraxane, immediate release fentanyl preparations. The drugs CIP was achieved through ongoing work to reduce chemotherapy wastage, the batching of drugs from Baxter, therapeutic and generic substitution. Clinical teams eg ovarian, colorectal disease groups presented audits of the effectiveness of 2nd and 3rd line chemotherapy treatments to inform clinical and cost effective practice.

Strategic items discussed included approval to look at 3rd party provision of outpatient dispensary medicines.

Work co-ordinated by the safe medicines practice committee has included:

- Ongoing review of all drug incidents related to prescribing, dispensing and administration
- Inpatient audits of prescribing practice
- Potential for use of pre-filled syringes for CCU
- Implementing actions from NPSA rapid response reports eg producing a poster for wards in response to RRR09: Reducing harm from omitted or delayed medicines

Other medicines governance issues:

- Monthly audits of the trust intrathecal policy have continued to be undertaken and are compliant
- Quarterly reports have been submitted to the Controlled Drugs Local Intelligence Network reporting no significant issues.

Pharmacy service improvements

In the last 12 months, outpatient waiting time has been monitored monthly as a CQUINs target with performance figures reported for simple and complex prescriptions. By the end of the financial year target times had been achieved. Initiatives such as increasing the use of pre-packs, supply via homecare and pre-ordering treatments all contributed towards reducing patient waiting time and an improved patient experience.

The automated ward drug cupboards on wards 4 and HTU demonstrated savings in staff time and drugs. A business case was submitted and the cupboards have been funded. The project work has been published in Hospital Pharmacy Europe (add reference).

Pharmacist prescribing commenced in the ovarian cancer clinic, supporting the medical team and facilitating patient throughput improving the patient experience by reducing waiting time.

Within the new Oak Road treatment centre is a new dispensary and aseptic unit designed to support the expanding clinical trials portfolio of the trust. Commissioning of the new unit has just completed.

Working with other trusts

Collaboration continues with Clatterbridge Oncology Centre and the Royal Marsden by regular dialogue and meetings to share experience and learning on areas such as:

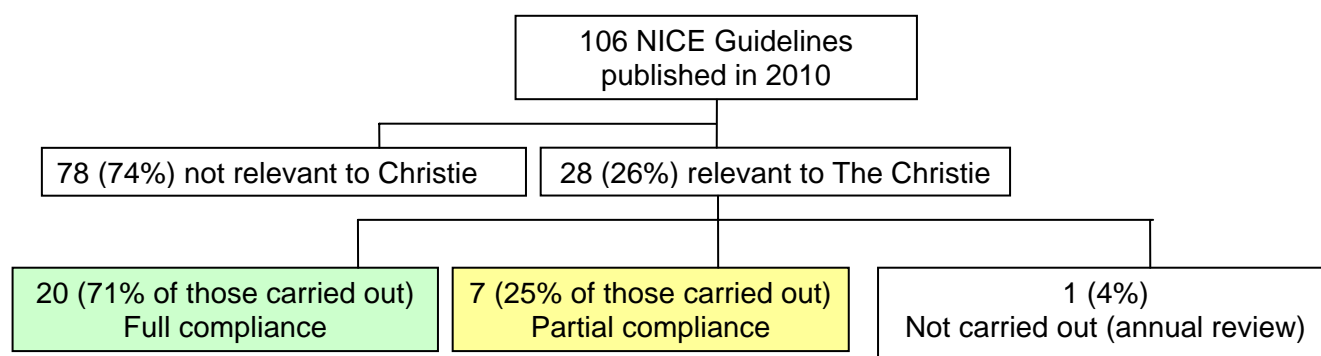
- Electronic prescribing
- Dose-banding of chemotherapy
- Clinical policies eg extravasation

The pharmacy team continue to lead and support the GM&CCN chemotherapy crosscutting group and the pharmacy group in the production of policies in particular the network adoption of the management of neutropenic sepsis.

13. NICE guidance

The reporting period for NICE guidance is three months in arrears to allow for implementation of guidance.

Update on The Christie implementation of NICE guidance – 1 January – 31 December 2010



The partially compliant guidance are clinical guidelines (5) which require a longer period for full implementation, a NICE Quality standard (1) and a public health interventional procedure (1). 5 have been audited, resulting in action plans which are being monitored. Two have resource issues for implementation.

NICE guidance is being reviewed for its priority for inclusion in the 2011-12 audit programme. The introduction of the cancer drug fund is changing audit requirements for medicines guidance as there is an approval process for these. 15 NICE audits have been completed this year and 21 are ongoing. Overall 67 of 110 (61%) guidelines carried out at the Christie have audit or monitoring data. The drugs & therapeutics committee have reviewed all 58 guidance related to medicines and prioritised 1 for audit in 2011-2.

14. Nutrition

During 2010 work has continued by the nutrition steering committee to meet NICE guidance, Care Quality Commission standard outcome 5 (nutrition), CQUINs for nutrition and other national standards. This report highlights a number of areas that have been achieved and where the trust needs to continue to make progress to continue to meet national and local standards and targets for nutrition.

Achievements in 2010/11

Outpatient nutritional screening

- A screening tool and care plan has been developed for outpatients and is now implemented for all new patients. This is being carried out by temporary dietetic assistant staff of which business cases have been developed for permanent funding to enable this to continue. Currently the trust is achieving 100%.

Oral nutrition support

- An audit carried out in February 2011 for inpatient screening has shown an improvement in screening of inpatients to 100%
- All wards are monitored three times a week to ensure patients have been nutritionally screened on admission by the dietetic team
- The oral nutrition support part of the nutrition policy is ready to be incorporated into the trust nutrition policy
- The inpatient screening tool has been revised and adapted to the changing needs of the patients
- The nutrition care plan has been revised to meet CQC outcomes
- A guideline was written for completing the inpatient screening tool and is now available on the dietetic web page
- Funding for a catering dietitian was secured for 12 months to revise and develop the patient menus using patient feedback. The post holder is now carrying out this work
- The patient food charge has been updated

Enteral nutrition support

- The enteral feeding group has now merged with the gastrostomy group
- Production of a home enteral feeding pack for patients going home with enteral feeding tubes
- Development of an electronic nasogastric training package which is shortly due to go live on the clinical skills site
- Conversion of the nasogastric tube care standards on placement and care of NG tubes into an SOP skills website
- Competency-based training guidelines as part of the NG training package

Parenteral nutrition

- Development of a parenteral nutrition monitoring form
- The contract for parenteral nutrition review took place in January 2011; this has been extended for a further 12 months with Baxter
- A new TPN prescription bag was approved

Re-feeding syndrome

- This will be incorporated into the nutrition policy and is being finalised with pharmacy, pathology and medical input

Training/education

- Nutrition screening training – there was a nutrition week in September 2010 for two weeks where the dietetic department carried out intensive screening training to all wards. This has continued on a weekly basis until all qualified staff have had training. This training programme will continue for all new starters and for refresher training in the future
- Nutrition education to critical care doctors/nursing staff continues
- Nutrition is now part of the regular training programme to the FY2 doctors. This includes nasogastric tubes, re-feeding syndrome and enteral feeding patients
- Regular HCA and housekeeper study days on nutrition include assistance at meal times, protected meal times, special diets, dysphagia and nutrition on the wards
- Parenteral nutrition teaching session for nurses on the IV study day

Action plan of nutrition steering committee for 2011

Action	Sub-group	Lead	Time line
1. To develop a trust nutrition policy which incorporates all areas of nutrition (oral, protected meal times, enteral and parenteral and re-feeding syndrome)		Lorraine Gillespie	December 2011
2. To promote and audit compliance of protected meal times on wards	Oral nutrition support	Lorraine Gillespie	August 2011
3. To review and develop patient menus to ensure all special dietary, ethnic and cultural requirements are met	Oral nutrition support	Lorraine Gillespie Rosie Gill	February 2012
4. To develop a protocol for placement of gastrostomy tubes by the development of a risk factor checklist to identify patients requiring early gastrostomy tube placement	Enteral feeding	Lorna Leeder	June 2011
5. To deliver a national enteral feeding tubes study day in September 2011	Enteral feeding	Lorna Leeder Lynne Wilbraham	September 2011
6. To develop a training pack for naso jejunal tubes	Enteral feeding	Deborah Peet Lynne Wilbraham	September 2011
7. To continue to maintain nutritional screening on the wards by: <ul style="list-style-type: none"> • carrying out regular training on nutritional screening on the wards • ensuring all patients can be weighed by availability of scales for those with reduced mobility and non weight-bearing patients 	Oral nutrition support	Lorraine Gillespie	December 2011

15. Patient Advice and Liaison Service (PALS) and informal comments

PALS aims to:

- Advise and support patients and carers
- Provide information on NHS services
- Listen to concerns, suggestions or queries
- Help sort out problems quickly

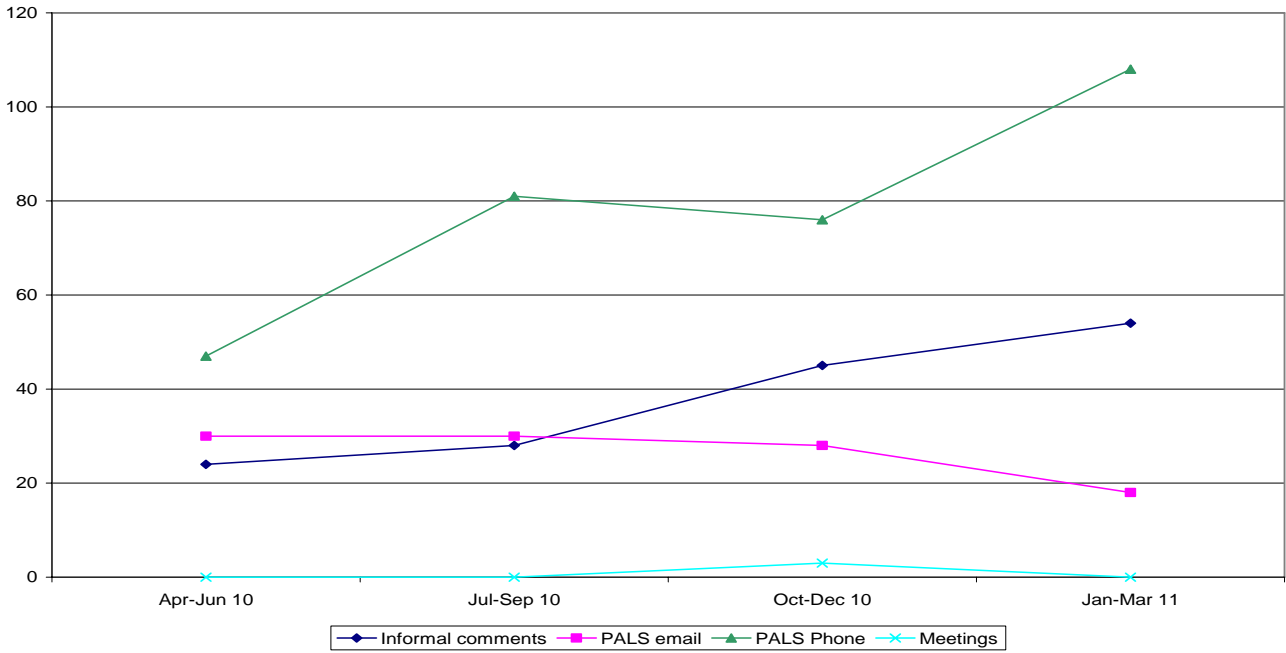
PALS can be contacted by phone or email. Arrangements can also be made for a person to discuss concerns face to face. Concerns and suggestions are also raised using a comment form available in a number of locations in the hospital or via the internet. PALS support meetings between patients/families with clinicians/clinical staff.

PALS activity includes facilitating further conversation with the doctor or other clinical staff and the patient or relative to enable better understanding of treatment and outcomes.

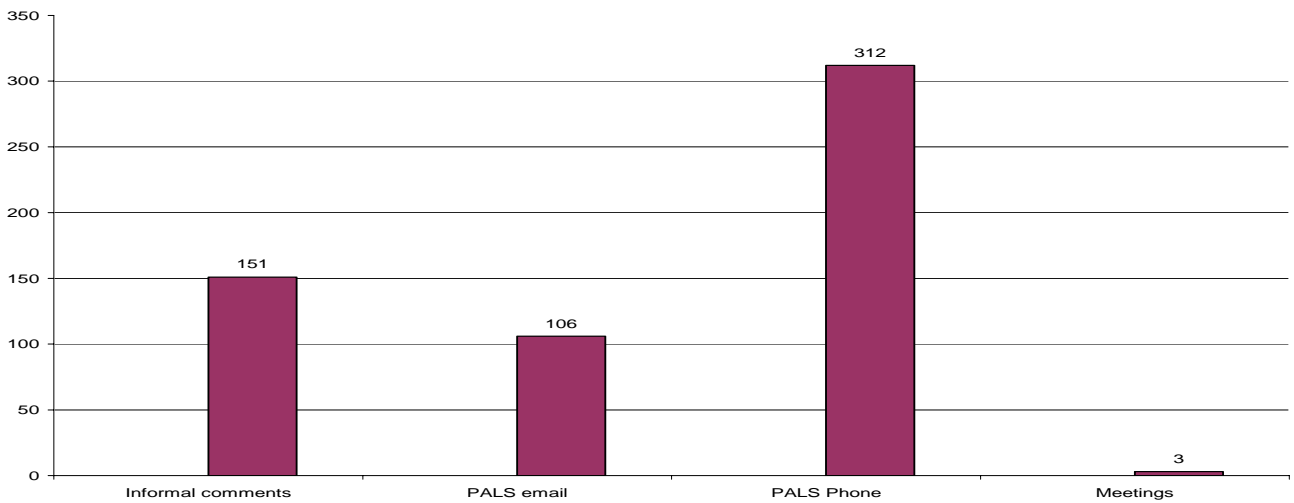
Issues raised and positive comments are sent to the manager of the department involved requesting information or for action if appropriate.

The first graph shows the quarterly activity for April 2010 to March 2011, the second graph indicates how people have contacted PALS. Both graphs exclude activity relating to level 2 complaints.

PALS activity by quarter



PALS activity 2010/11



16. Patient information

At the end of March 2011, the patient information service had a library of 554 items of information. This includes information for patients, carers and health professionals in a variety of formats: printed materials, audio and DVDs.

New patient information:

Over 50 new leaflets and information sheets as well as two new booklets were produced during the year. Each publication is considered by the information committee and undergoes wide consultation with staff. It is also piloted with patients and their feedback shapes the final copy before the final design and printing. New information was produced on 'Bereavement Services' and 'Radiotherapy to surgical scar sites for patients with mesothelioma' as well as a range of information on penile cancer and nuclear medicine tests.

Updated patient information:

48 booklets and leaflets were updated this year and reviewed by the information committee.

Our links:

- We have been preparing for **information prescriptions** – a national programme led by the National Cancer Action Team. The aim is to be able to offer all patients with cancer an information prescription outlining the range of information available and signposting patients/carers to helpful services.
- The patient information department is also applying for certification with the **Information Standard** which accredits the processes used to produce information.
- Peripheral clinics: There is a good working relationship and regular contact with staff at the 18 peripheral clinics. Regular orders are dispatched for treatment and supporting information. The aim is to ensure that patients are given treatment information at their first consultation with The Christie doctor which often takes place at the peripheral hospitals.
- Cancer information centres: There are close working relationships with the staff and volunteers at the cancer information centre which keeps a full range of Christie information as well as Macmillan booklets and a wide range of information on local services.
- Information link workers: Each department and ward has a link worker. They play a key role in the information service: keeping the display in the leaflet racks up-to-date; ensuring that patients have the right information and liaising with ward colleagues to make sure they are aware of all new developments in patient information and to feed back any problems.

Trust website:

With the web development manager and web content manager, the patient information manager is responsible for overseeing the quality of The Christie website and for the content of the patient information website.

In 2010/11 the patient information site had over 1 million page views. There is interest from all over the world particularly the USA, Canada, Australia, India, Germany, Ireland, Netherlands, Korea and Malaysia.

The top five for chemotherapy regimens were BEP 5 days, Docetaxel & Cisplatin, DHAP, ABVD and ICE.

Information about plastic surgery, gynaecology and radiotherapy continues to be very popular with over 50,000 page views as well as pain relief and urology. The 'top' three booklets were:

1. Having a colonoscopy (39,668)
2. Care of your central venous catheter (22,717)
3. Having a flexible gastroscopy (29,516)

17. Patient and public involvement Involvement and getting feedback

As a foundation trust we are developing links with our 20000 members and the governors who are elected by the members.

Governor involvement

Governors have been involved in the plans for the Oak Road treatment centre, which opened in November 2010 and the Salford radiotherapy centre, currently being built.

They commented on feedback from patients and carers, which they received in the form of the quarterly Patient Experience reports. They have had presentations from departments who have introduced initiatives to improve the patient experience.

They have reviewed plans to grow membership and ensure it is representative.

Governors have also taken part in the Patient Environment Action Team (PEAT) inspection. This involved walking around The Christie, giving a view on the environment and where it can be improved.

They have continued with the sessions where they talk to patients and relatives in waiting areas or on wards to get their feedback on the service they have received at The Christie. Their findings are reviewed by the departments and wards involved.

Member involvement

Members are informed of future developments at The Christie and have the opportunity to give their views. There are a number of ways in which they get to hear about our plans, for example they are sent a newsletter with all the latest news, they can attend the Annual General meeting, they are also invited to The Christie open days and the public engagement events held in their local authority area. They contact the membership office with their comments and suggestions.

Getting feedback

We ask patients for their opinion on the service they have received. These can be as part of a national survey, for example the National Inpatient survey and the National Cancer survey, where we can compare our results to other hospitals in England and establish where we need to target our efforts to improve.

We ask approximately 100 patients every month across all departments and wards to rate issues like cleanliness, attitude of staff, communication and standard of food and drink

Departments within The Christie also carry out surveys and use the information to develop a local action plan.

LINKs involvement

The Christie has developed links with the Local Involvement Networks (LINKs). They were invited to an event at The Christie in May 2010, where they were given a tour of the hospital, presentations on the Oak road treatment centre and our quality accounts and shown a video of key achievements over the year.

18. Patient safety incidents

A total of 2193 patient safety incidents, including accidents, were reported between April 2010 and March 2011. This compares with 1916 incidents reported in 2009/10, representing an increase of 14.4%. The trust is classed as a high reporting, low harm trust by the NPSA.

During 2010/11, six SUI panels were held and 30 clinical incidents went to executive review, three of which did or will go on to full SUI panel. These related to a delays in treatment, failures of videoconferencing facility with a potential to delay patient treatment, communication between teams and transfusion-related issues. No Never Events were reported during the year.

The top 20 categories for patient safety incidents are as follows:

Description	Number of incidents	Description	Number of incidents
Medication	908	Extravasation	35
Slips, trips and falls	275	Pressure ulcer	33
Communication failure/misunderstanding	246	Resources	23
Problem with records	140	Discharge/transfer	16
Exposure to harmful agent	81	Admissions	16
Blood transfusion	66	Appointment	16
Nutrition	58	Collision with object	15
Problem with patient care/monitoring	54	IT issues	14
Medical equipment	49	Problems with high risk	11

		patients/specimens	
Lab investigations	47	Images for diagnosis	11

Falls are broken down further into the following sub-categories:

Type of fall	Number of incidents
Fall on same level	143
Fall from bed, chair or height	96
Trip	20
Slippery floor	11
Near miss	5

Patient safety incidents by severity

Near miss	946
Minor 1	808
Minor 2	250
Moderate incident	126
Death	3

43% of the patient safety incidents were near misses where harm did not occur owing to an intervention or observant staff. 5.8% of the patient safety incidents were classified as significant (moderate, major or resulted in a patient death).

Patient safety incidents by location

The top 8 locations of patient safety incidents are as follows:

Ward/adjacent areas	1010
Outpatient areas	711
Radiotherapy	134
Office	116
Pharmacy	58
Radiology	38
Laboratory	29
Theatres	29

All patient safety incidents are uploaded to the National Reporting and Learning System. This enables national trends to be identified. In addition, external reports were made to the Strategic Health Authority, Medicines and Healthcare products Regulatory Agency, Health and Safety Executive and Care Quality Commission when indicated.

Examples of improvements made during 2010/11 in response to patient safety incidents include:

- care plans for managing confused patients
- revision of entonox protocol and laminated checklist attached to entonox units
- reiteration of need to complete cross-match sample forms and tubes at the bedside to reduce risk of patient identification error
- clinicians reminded to complete referral form for procedure team referrals
- allergy information added to front of new nursing documentation
- regular checks of CPR controls on electric profiling beds
- implementation of a BT managed service for videoconferencing for MDTs
- software upgrade to linear accelerators
- improved information on chemotherapy administration and complex dispensing processes displayed on screens in ORTC
- review of results acknowledgement process

19. Project work

Productive Ward

Releasing time to care – ‘the productive ward’ is a national programme developed and supported by the NHS Institute of Innovation and Improvement (NHSI). The initiative focuses on improving ward processes & environments to enable nurses and therapists to spend more time on patient care thereby improving safety and efficiency.

In July 2008 The Christie commenced implementation of Productive Ward led strategically by a project lead (0.5 WTE) and operationally by ward based improvement facilitators absorbed into daily activity.

Key achievements to date

- A new stationery cupboard opposite the nurse’s station on ward 12 has allowed for the centralisation of admin supplies. Over £1000 of excess supplies identified and redistributed – potential saving year on year due to better stock management
- Undertaking the meals modules has enabled the team on ward 4 to identify areas for improvement. The meals process is now more logical, calmer and organised. Initial observations demonstrated that an average meal time took 1 hour 15 minutes and it now takes 20-30 minutes, resulting in meals being served hot and on time and time released for other duties
- By undertaking the well organised ward module on haematology and transplant unit (HTU) £7000 of excess/expired stock was identified and redistributed around the trust – potential saving year on year due to better stock management
- An activity follow on the medical assessment unit (MAU) identified that staff were spending 20 days a year locating the controlled drug cupboard keys. By introducing a second set of keys (one for each arm of the ward) time wasted has been reduced by at least 50%
- Working collaboratively with critical care outreach ward 12 undertook the observations module to implement a more streamlined, accurate and purposeful observations process. The result has been the implementation of observation prescriptions, raised awareness and education, more appropriate referral to critical care outreach, swifter critical care intervention and an appropriate length of stay.
- Excess stock has been redistributed from the MAU in collaboration with the procurement project. This has allowed space to be created to re-organise the ward environment and support the essential improvement required.
- The refurbishment of the dirty utility on the MAU has incorporated a large storage cupboard, streamlining stock management, reducing the time looking for items and providing a cleaner, tidier environment.
- As part of the well organised ward module staff on the HTU worked collaboratively with medical illustration to produce a picture directory of all stock, making it easier to locate items, thus saving time. This system has been rolled out across the organisation.
- Custom made magnetic white boards have been developed on every inpatient ward to support the patient status at glance module. The introduction of a traffic light system to communicate patient activity has reduced the number of staff interruptions.
- During the ward round module the staff on ward 4 realised that there was confusion around ward round days and which medical staff worked for each team. As a result a schedule was developed which includes staff pictures, making it easier to plan ward activity, identify appropriate staff members and reduce wasted time.
- By undertaking the admissions and discharges module on ward 4 and HTU both processes have been standardised by developing separate admissions and discharges checklist. This ensures that every patient receives the same standard of care and staff have a prompt to ensure a smooth turnover of patients.
- The team on ward 11 in collaboration with the ward based pharmacist have introduced the medicines module. By timing the medicines process they have identified areas for ongoing improvement.

The future of productive ward

The guided implementation by the project lead ended in August 2010. However, it must be understood that Productive Ward is a strategic imperative not a short term change initiative. The challenge now for

the inpatient areas is to sustain the changes already made and continue to utilise lean methodology learnt over the preceding 24 months to drive efficiency and quality care.

- The steering group meetings continued to run monthly, in the first instance, until March 2011, chaired by an experienced Productive Ward facilitator from Cancer Centre Services with the support of a modern matron from Networked Services
- Ongoing progress is monitored via the modern matrons

Conclusion

The power of the productive ward programme is that it puts frontline clinical staff back in control of the care that they give to their patients, encouraging them to question how they work and giving them simple tools and skills development to support them, on the job.

20. Research Governance

Research governance is managed within the trust through the Research and Development Division. The R&D administration team undertake all regulatory and governance checks prior to project approval. More than 120 new projects and in excess of 390 amendments have been approved over the last 12 months. In light of continued changes within research management the team have adapted and strengthened systems and processes to facilitate a streamlined and compliant approach to project approval. An example is the development of a dedicated Clinical Trials Resource Group (CTRG) database for the collection of information relating to all proposed trials where responses and queries raised by the different departments are kept. This ensures that there is a record of any conditions or limitations agreed for the conduct of projects during this set up phase and ensures the timely review and ease of access by the CTRG members.

The R&D division board meets bi-monthly and divisional performance, achievements and any governance issues are discussed. The risk register is reviewed and any incidents occurring within the division are discussed. In order to identify any emerging trends in incidents the R&D governance team has initiated a quarterly analysis for all incidents within the division and going forward this will feature in future reports.

The development of research facilities has continued with the opening of the new expanded Clinical Trials Unit in the Oak Road Treatment Centre, strengthening of the Manchester Cancer Research Centre (MCRC) Tissue Bank, continued growth of the Clinical Trials Coordination Unit (CTCU) and currently plans are being drawn up for the MCRC building. Capacity and capability development are key to enable The Christie to develop innovative programmes of multidisciplinary translational research, which aims to improve outcomes for cancer patients.

Key Highlights

Clinical Trials Unit – Oak Road Treatment Centre

This expanded unit opened for business 22 November 2010 and doubles the capacity to undertake early phase research; the clinical trials inpatient unit is currently being developed and will open in the autumn 2011.

The Christie Trials Coordination Unit

Within the remit of its NIHR registration, the CTCU continues to expand its portfolio of Investigator-led studies. Following a successful infrastructure funding bid in 2009/10 there have been appointments of additional key staff to support the management of the Christie-sponsored studies; to support grant funding bids (through the appointment of a research support manager) and to develop and manage key quality processes, (including an update to the research pharmacovigilance process), through the appointment of a dedicated Quality Manager.

The continuing development of the CTCU has also necessitated a review of its organisational structure and currently plans are being drafted to ensure that the team is provided with a more robust operational structure to undertake its management and governance activities within the umbrella of the Research Division.

Manchester Cancer Research Centre Biobank

The MCRC Biobank has been actively recruiting patients now for 3 years and has collected sample 'six-packs' consisting of tissue, blood and urine from well over 1600 cancer patients across the Greater Manchester area. It collects samples from five collaborating trusts across the region which are: The Christie NHS Foundation Trust (CFT), Salford Royal NHS Foundation Trust (SRFT), University Hospital of South Manchester Foundation Trust (SMUHT), Central Manchester and Manchester Children's Hospital NHS Foundation Trust (CMMC) and Pennine Acute Hospitals Trust (PAT). Tapping into the expertise at each of these trusts ensures the MCRC Biobank captures as many samples from all different cancer disease groups as possible.

In the last quarter of 2009, the MCRC Biobank opened for business, allowing researchers within the MCRC to apply to use collected samples. A generic ethics approval held by the Biobank allows researchers easy access to banked samples for cancer research projects and targeted collection can also be carried out where the Biobank does not already hold desired samples within the bank. Approved projects include collection of tissue for a European clinical trial into gastrointestinal stromal tumours and several tissue microarray projects. The MCRC Biobank has access to a recently purchased automated tissue microarrayer within the Paterson Institute for Cancer Research and this, coupled with the Biobank's ability to collect large numbers of tissue samples, will allow tissue microarrays from all cancer types to be constructed and utilised for high quality cancer research projects

Research Quality

The R&D Governance Team has continued to develop with the addition of key appointments e.g. Research Strategy Manager. Work is ongoing to develop and strengthen the systems and process that underpin the clinical trial activities conducted on site. The R&D Governance Team has undertaken seven internal audits, study, process and facilities during the last 12 months. Audit findings have been disseminated through a series of divisional and trust wide seminars to raise awareness and facilitate sharing of best practice.

There have been a number of external study specific audit and inspections conducted in the last year in the main these have been positive. Where areas of non compliance have been highlighted robust corrective and preventive actions have been developed which are tracked through divisional board to satisfactory completion.

Research Training

The division has delivered Good Clinical Practice training to 296 personnel across 12 hosted sessions during the past 12 months. In response to feedback received training for 2011 will be delivered in house and in addition to required regulatory components being delivered there will be a focus on relevant trust policy, systems and processes to ensure consistency and promote continual improvements in research quality.

Research projects and research funding

Commercial performance has continued to develop well and incomes have increased. The key commercial performance measures are set up time, patient recruitment and quality (i.e. regulatory compliance / staff training). This is independently evaluated by a pharmaceutical company. The trust performed well on each of these measures and achieved targets set. There have been significant improvements within the R&D division for approval of study amendments due to changes in processes and a strengthening the infrastructure support.

21. Resuscitation

During 2010/2011 403 members of staff were trained in Basic Life Support (BLS) with an additional 94 trained in BLS and defibrillation as a practical session. 129 staff members were trained in Hospital - Intermediate Life Support with 51 members of nursing staff trained in Acute Illness Management (AIM) and 26 support workers (HCAs/APs) trained in Support Workers Acute Illness Management SWAIM. We are an accredited centre for AIM/SWAIM with the Greater Manchester Critical Care Network

The lead for critical care Outreach/Resuscitation course directs the Resuscitation Council UK accredited 2 day course for Advanced Life Support which is open to all grades of medical staff and senior nurses. It

is advertised on the national UK Resuscitation Council website and generates interest nationally and internationally. It is open to external and internal candidates.

Looking forward to 2011/12, we plan to run 3 courses this year where a multi-disciplinary faculty will be invited to instruct, with the outreach/resuscitation lead acting as course director. This is an opportunity for good networking regionally from the critical care and resuscitation perspective and also gives outside professionals the opportunity to view our facilities.

22. Safeguarding adults

In 2010, a multidisciplinary group was established at The Christie, with support from colleagues with expert knowledge, to explore the range of issues relating to optimal provision of care for the most vulnerable patients, including the elderly frail patient, the patient with learning disabilities and the patient with mental health issues. This group has proposed that a pathway approach should be developed. This starts with identification of need at referral into the cancer service; sensitive documentation to raise awareness amongst all staff who deal with the patient; specific measures, including enhanced information and support, that are developed in relation to the specific needs; and education and support for the professionals. The pathways include the various processes involved in staging cancer, planning treatments, undergoing treatment, management of side-effects and aftercare. This includes access to help out of hours when problems arise, as well as elective care, and clear links with the staff or carers who support the patient at home or in residential care settings. In October 2010, the group facilitated a workshop for The Christie clinical colleagues with input from colleagues with expert knowledge of vulnerability, to identify the key stages of patient treatment and where additional information or support is required for vulnerable adults.

Health Innovation and Education Clusters (HIEC) are new partnerships between the NHS, higher education, industry and other public and private sector bodies. The purpose is to enable high quality care and services through the application of research and innovative practice to patient care by strengthening the co-ordination of education and training so that it has the breadth and depth to support excellence. Commencing in autumn 2010 as a Greater Manchester HIEC, The Christie multi-disciplinary team is working in partnership with Manchester Metropolitan University to consider the treatment trajectory of chemotherapy patients, including vulnerable patients undergoing chemotherapy. The aims and objectives of this project are to establish baseline information on current care communication systems/ methods across stakeholders, sectors and settings using surveys and patient focus groups, and to use appropriate innovations, educational and knowledge transfer approaches to introduce and embed effective communication practise and systems changes, as appropriate.

A grand round presentation took place in June 2010, entitled 'Cancer management and the patient with learning disability: what do we have to learn?' Chaired by Dr Wendy Makin, the event linked in to national Learning Disability Week, raising the awareness of senior clinical colleagues on learning disability and reviewing the learning from recent patient cases.

23. Safeguarding children

The mandatory level 1 training for all staff has been moved to the combined mandatory study day. This is for all trust staff and is repeated every 3 years, to ensure that all trust staff receive the appropriate training in safeguarding.

Inclusive to this, for staff who may have contact on some occasions with children under 19 years of age, e.g. in clinics or the radiotherapy department, e-learning training will be mandatory at level 2. The e-learning programmes are being rolled out and compliance to this is being monitored by the learning and development department.

For staff that have regular contact with children and young people, e.g. working on the Young Oncology Unit, will continue to receive training from the Manchester Safeguarding Children Board at level 2. Nursing staff, physiotherapists, and occupational therapists will complete a full day of training. Medical staff will complete the e-learning training. This will be repeated every 3 years.

Safeguarding policies have been updated, as required by national guidance. All policies are available to staff via the intranet.

The trust will be continuing with CRB checks for all staff, and staff will be required to enrol with the new Vetting and Barring scheme if this rolls out.

Named and designated safeguarding staff will continue to attend professional meetings on a regular basis and feedback via internal safeguarding meetings.

24. Safety alerts

Safety alerts issued by the Medicines and Healthcare products Regulatory Agency (medical device alerts), DH Estates & Facilities and guidance from the National Patient Safety Agency and Department of Health are distributed via the Central Alerting System (CAS).

The risk management team is responsible for ensuring that the alerts are promptly acknowledged, forwarded to appropriate and relevant members of staff and departments and that appropriate action is taken in response to each alert. The policy for the management of safety alerts is followed at all times to ensure patient safety.

Type of alert	Number of alerts received April 2010 – March 2011
Medical device alert	101
NPSA guidance	13
DH Estates & Facilities alert	9
Department of health	4

The risk management team achieved 98% (126/127 alerts) compliance in 2010/11 with the relevant deadlines for acknowledging receipt of alerts within 48 hours. The trust missed one deadline for actions to be completed by one day – whilst appropriate action had been taken, the website had not been updated. Performance is monitored by the both the governance and risk and divisional balanced scorecards and compliance with meeting the set deadlines is monitored by the strategic health authority.

Individual alerts are reviewed and monitored by the most relevant trust committee, for example, safe medicines practice committee, chemotherapy delivery group and/or the clinical and research governance committee. Quarterly reports detailing all alerts received via CAS are reviewed by the clinical and research governance and health and safety committees to ensure the management of safety alerts is monitored.

25. Thrombosis Committee

Work is progressing around VTE compliance. Internal targets are being met.

26. Transfusion

The hospital transfusion committee (HTC) is committed to delivering top quality care in transfusion medicine throughout The Christie NHS Foundation Trust. This is achieved through ongoing audit, education, policy development and clinical practice. The committee met quarterly during 2010/2011.

The hospital transfusion team (HTT) met every 4-6 weeks in 2010/2011 to manage the operational aspects of the transfusion service. Two members of the HTT are new to their role, Dr Kulkarni, consultant haematologist taking over from Adrian Bloor, and Sharon Swift, transfusion practitioner replacing Jayne Addison.

Product Usage: A total of 13,437 blood products were transfused across inpatient and outpatient services.

Transfusion budget: The first quarter of the financial year was under budget. Although the latter part of the year did see an increase in platelet usage from the demand of high users. Efforts have been made

to remain vigilant with the continued use of blood products throughout the year to ensure that there continues to be a consistent reduction in blood use and savings against the transfusion budget without compromising patient care.

Traceability Data: In order to comply with the 2005 Blood Safety & Quality Regulations the transfusion laboratory must be able to trace all blood products from donor to recipient. Compliance with traceability documentation remains good, but 100% compliance is sometimes difficult to achieve with a paper based system. The average traceability figure over the last year is 98.9%.

Wastage data: The wastage was 154 products at a cost of £20,558.

Training and education: Approximately 200 staff received training on transfusion safety via the IV study day and approximately another 200 received training relevant to their role within the organisation.

Audit activity: The transfusion practitioner co-ordinated a national comparative re-audit of platelet transfusion and three local audits with recommendations from the HTT.

Developments: The automaton is currently in the progress of being introduced into the laboratory with the aim for completion of May 2011.

The Transfusion Practitioner has developed a procedure and policy which will enable Nurse Clinicians to prescribe blood products. The Christie NHS Foundation Trust is only one of two trusts in the north west that have extended the scope of prescribing blood products to non-medics. This will improve the patient's experience whilst attending clinics with their nurse clinician. There are now 11 Nurse Clinicians in The Christie who have completed their non-medical prescribing of blood products.

Appendix 1

Contributors to the annual report

The following have contributed to this report. Their support is gratefully acknowledged as this report could not have been written without them.

Eileen McGuigan	Complaints and claims manager
Gill Goodwin	Lead nurse, quality and professional practice
Jane Hadfield	Risk and health and safety manager
Jo Ann Hughes	Equality and diversity manager
Joanne Woolley	Clinical audit manager
Jude McLellan	Critical care outreach/resuscitation lead
Julie Gray	Lead nurse, clinical governance
June So	Director of pharmacy
Karen Hellewell	Clinical education manager
Lindsay Ratapana	Matron, clinical haematology
Lorraine Gillespie	Dietetic manager
Lynn Hope	R&D project manager – governance & compliance
Margaret Watson	Patient information manager
Oonagh McGugan	Lead nurse Infection prevention and control
Rosie Gill	Technical manager for soft facility services
Sharon Swift	Specialist transfusion practitioner
Sue Mahjoob	Patient and public involvement/PALS manager