East Cheshire NHS
NHS Trust








Quality Account 2011/12

Safe ➲ Effective ➲ Personal

Contents

1. Foreword

East Cheshire NHS Trust is committed to improving quality and delivering safe, effective and personal care, within a culture of learning and continuous service improvement. The Quality Account represents one aspect of the continued drive to improve the quality and safety of the services which we provide.

At a time of considerable change across the health care system and locally we have achieved much we can be proud of this year:

- Dr Susan Knight, a member of our team of consultants was nominated by her patient and nationally recognised as a Healthcare Champion by the National Rheumatoid Arthritis Society;
- the trust was presented with the Macmillan Quality Environmental Award for the improvements made to our Cancer Resource Centre. The award identifies and recognises cancer environments that provide high levels of support and care to people affected by cancer, and links quality environments with enhanced health outcomes; and
- the trust have also been granted the Inspire mark by the London 2012 Inspire programme, in recognition for their efforts towards the NHS 2012 Sport and Physical Activity Challenge, that has helped staff improve their health and wellbeing through simple changes in their work and personal lives. And there are many more achievements to detail on the pages that follow.

Never complacent, we continue to stretch ourselves and learn where we know we could do better. We are ready for the challenges ahead and determined to face these together through positive engagement with our staff, patients, stakeholders and members of the public. We want our patients, staff and stakeholders to trust that we will be able to provide the highest standards of care to them; therefore we take note of all of their feedback and use this as a basis for planning further improvements at the trust.

A major focus for 2012/13 will be the ongoing implementation of the trust's Quality Strategy which details a number of quality improvement initiatives that will enhance patient safety to improve the experience and clinical outcomes for our patients.

Thank you to all who have contributed to this year's achievements and for your unwavering commitment to safe, personal care delivered in the right place.

"Quality is at the forefront of everything we do"

Lynn McGill,
Chairman

2. Our Quality Achievements

Above: Integrated Respiratory Team receiving the North West Respiratory Best Practice 'Team of the Year Award'

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Trust awards 2011/12

East Cheshire NHS Trust is proud to have celebrated a number of key achievements throughout 2011/12.Each achievement illustrates our strong commitment to provide patients with the best standards of care possible.

Olympic 2012 Inspire Mark

NHS 2012 Olympic challenge Silver Award

Guardian Public Service Awards shortlisted 2011

National Rheumatoid Arthritis Society Healthcare Champions award

Macmillan Quality Environment Mark for Cancer Resource Centre

The Information Standard

Statement from Chief Executive

The trust is committed to ensuring that quality drives our Clinical Strategy and is at the core of everything we do.

The trust's Clinical Strategy aims to ensure that we deliver the best care in the right place for the health care needs of patients. This will divert patients away from hospital into more appropriate clinical care settings. It is important that this shift and change in service delivery supports quality improvements in patient care and experience.

For East Cheshire Trust, Quality is therefore about three clear priorities:

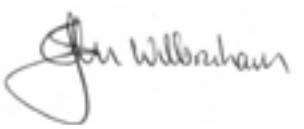
- Delivering care services that are as clinically safe and effective as possible with a year on year reduction on health care related patient harm.
- Delivering care in a manner whereby patients are treated with compassion, dignity and respect, with patients and carers consistently rating the trust as good or excellent in relation to communication about care and treatment
- Delivering evidence based pathways of care, supported by an attitude and culture within our entire organisation whereby everyone is constantly striving for excellence and continuous quality improvement in all that they do

The trust intends to be the provider of excellence for specialist services for older people in community or hospital care settings.

The trust will continue to actively pursue full integration and transformation of clinical pathways within and across the organisation, working proactively and collaboratively to expand our opportunities of working with others.

We will provide as much care out of hospital as possible designing and improving services that build on work already happening in community and practice settings. Our aim is to provide a quality of healthcare we would want for ourselves,our families and our friends.

We will ensure that all clinical care provided is appropriately measured for its safety, effectiveness and patient experience, where we can increasingly measure the ultimate outcomes of care, and where information on quality is acted upon rapidly and effectively to ensure continual improvement.



John Wilbraham, Chief Executive
April 2012

> **"Our aim is to provide a quality of healthcare we would want for ourselves,our families and our friends."**

Why are we producing a Quality Account?

East Cheshire NHS Trust welcome the opportunity to provide information on the quality of our services to patients, staff and members of the public. In this document we will demonstrate how well we are performing, taking into account the views of our patients, staff and members of the public, and comparing our performance with other NHS trusts. All NHS Trusts are required to produce an annual Quality Account, which is also sometimes known as a Quality Report. We will use this information to help make decisions about our services and to identify areas for improvement.

Independent Auditor's Limited Assurance Report to the Directors of East Cheshire NHS Trust on the annual Quality Account

I am required by the Audit Commission to perform an independent assurance engagement in respect of East Cheshire NHS Trust's Quality Account for the year ended 31 March 2012 ("the Quality Account") as part of my work under section 5(1)(e) of the Audit Commission Act 1998 (the Act). NHS trusts are required by section 8 of the Health Act 2009 to publish a quality account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010 and the National Health Service (Quality Account) Amendment Regulations 2011 ("the Regulations"). I am required to consider whether the Quality Account includes the matters to be reported on as set out in the regulations.

Respective responsibilities of Directors and auditors

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011).

In preparing the Quality Account, the Directors are required to take steps to satisfy themselves that:
• the Quality Accounts presents a balanced picture of the trust's performance over the period covered;
• the performance information reported in the Quality Account is reliable and accurate;
• there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
• the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and

• the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account.

My responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to my attention that causes me to believe that the Quality Account is not consistent with the requirements set out in the regulations. I read the Quality Account and conclude whether it is consistent with the requirements of the regulation and to consider the implications for my report if I become aware of any inconsistencies.

This report is made solely to the Board of Directors of East Cheshire NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010.

Assurance work performed

I conducted this limited assurance engagement under the terms of the Audit Commission Act 1998 and in accordance with the NHS Quality Accounts Auditor.

Guidance 2011/12 issued by the Audit Commission on 16 April 2012. My limited assurance procedures included:
- Making enquiries of management;
- Comparing the content of the Quality Account to the requirements of the regulations.

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

The scope of my assurance work did not include consideration of the accuracy of the reported indicators, the content of the quality account or the underlying data from which it is derived.

Non financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information. It is important to read the Quality Account in the context of the criteria set out in the regulations.

Conclusion

Based on the results of my procedures, nothing has come to my attention that causes me to believe that the Quality Account for the year ended 31 March 2012 is not consistent with the requirements set out in the regulations.

Julian Farmer
Officer of the Audit Commission
Aspinall House
Aspinall Close
Middlebrook

"East Cheshire NHS Trust welcome the opportunity to provide information on the quality of our services"

3. Our plans for the future

Safe ➲ Effective ➲ Personal

Our vision and objectives

Quality is at the core of our mission and vision statements, and underpins our organisational values, strategic objectives and transformation plan. The Trust Board has agreed a Clinical Strategy that will build on existing strengths as the preferred provider of local, high quality and patient focussed healthcare.

Our mission

To provide high quality integrated services, as specified locally by Commissioners and delivered by highly motivated staff.

Our vision

East Cheshire NHS Trust will deliver the best care in the right place. This applies not only to the population of Cheshire but also to our neighbouring areas including Stockport, High Peak and North Staffordshire.

Our values

We will ensure we:

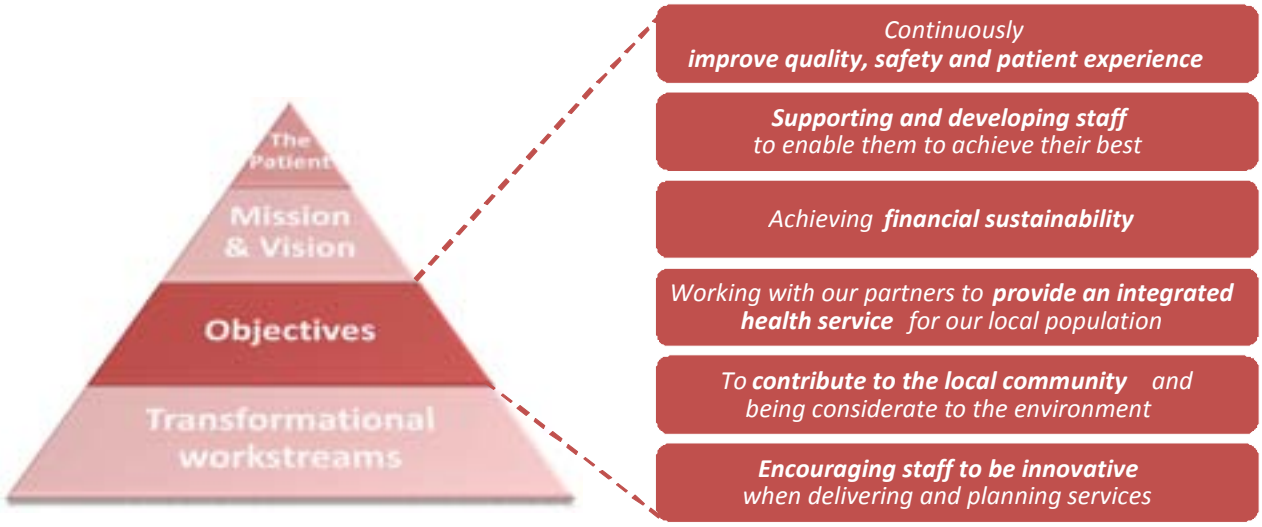
- treat each other with respect and dignity;
- commit to quality of care;
- show compassion;
- improve lives;
- work together for patients;
- make everyone count.

"Our organisation is committed to improving quality and delivering safe, effective and personal care, within a culture of learning and continuous service improvement."

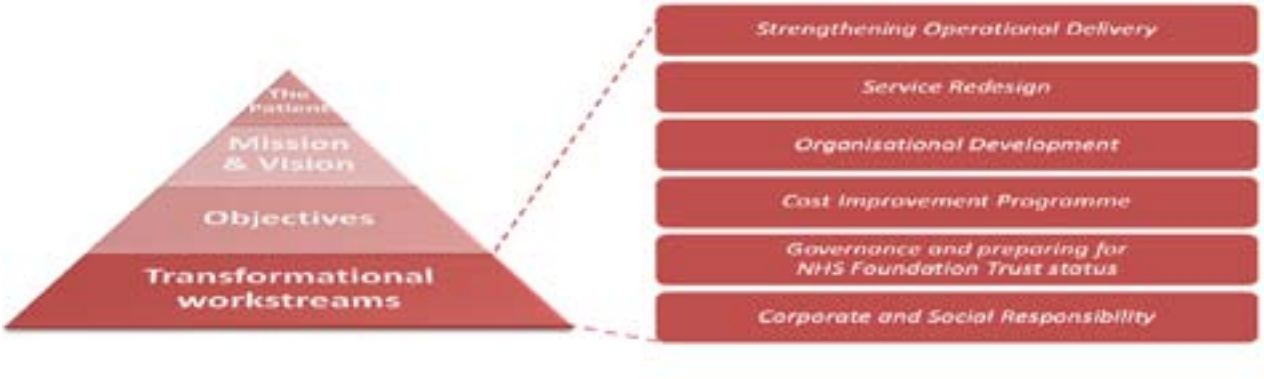
Our vision and objectives

East Cheshire NHS Trust (the trust) is committed to ensuring that quality drives our clinical strategy and is at the core of everything we do.

Our strategic objectives

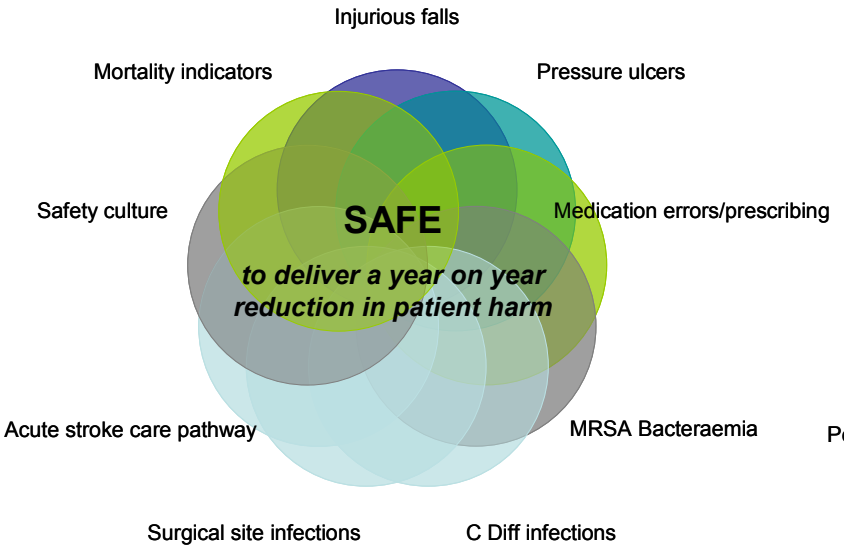


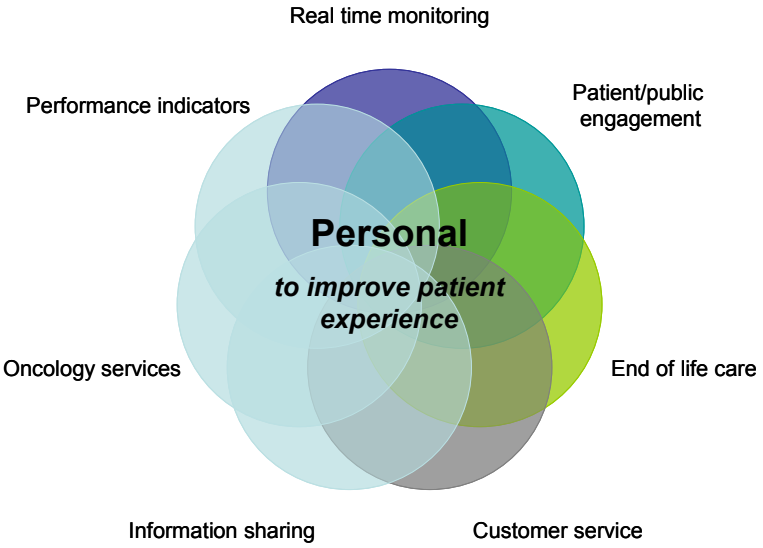
Transformational workstreams

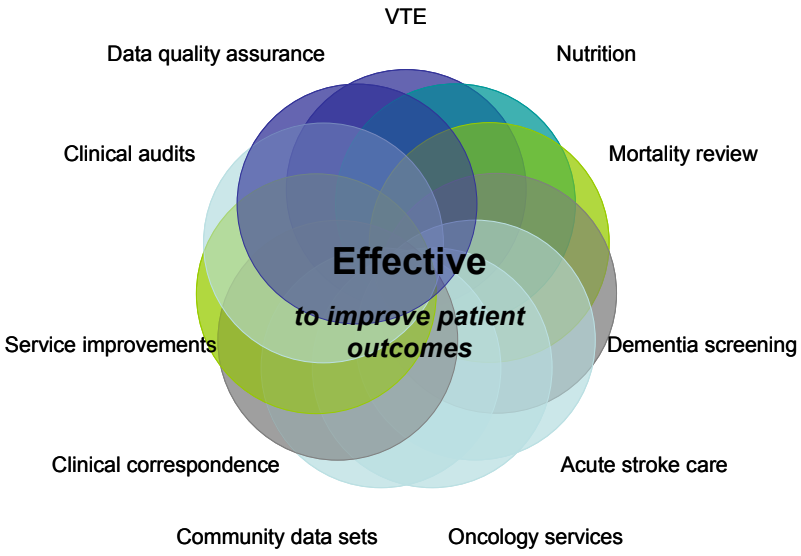


The New Quality Strategy 2012/15

The new Quality Strategy ensures that quality is at the forefront of everything we do. The trust is committed to improving quality and delivering safe, effective and personal care with a culture of learning and continuous service improvement. The quality strategy indentifies the overarching priorities for improvement in community and acute settings for the next 4 years, as depicted below:







Influences on our New Quality Strategy

The new Quality Strategy has been influenced by a range of drivers, the most significant of which are summarised below:

Influences on our New Quality Strategy: *Staff and patient Feedback*

Patient and staff feedback

We take the views of our patients and staff very seriously. There are a number of different methods we use to collect data on patient and staff satisfaction, such as surveys, patient stories, patient experience groups, all of which provide us with vital information on how to improve the quality of our care. This page details a selection of feedback and results from our Patient Reference Group and the national surveys that were conducted in 2011/12.

Patient Experience Reference Groups

As part of our ongoing commitment to quality improvements we hold regular Patient Reference Groups to increase our patient's involvement in the decisions we make. In order to help us set our quality priorities for this year we held a Patient Experience Reference Group on 12 March 2012, where we asked our patients 'What does quality of care mean to you?' Below are a selection of responses and feedback we received from the group:

The group agreed that quality of care falls into 5 key areas:

- Information
- Being treated as an individual
- Communication
- Feeling relaxed
- Bring treated with dignity and respect

'It is important we know who is who, what uniforms people wear and who we should speak to when under care, as seeing someone different each time, made me feel like I had to start again.'

'When the flow of patient, relative and staff communications is right way and explained in a way we understand, that is quality of care.'

'When quality of care is good, you feel like you are the only person in the room.'

'Communications is vital on every level. It is important to know what is happening to you.'

The group were presented with the new research document published by the King's Fund entitled 'What matters to patients'. In the analysis of research interviews with 2,661 people across England and Scotland, voluntary sector insight and literature review, the most commonly reported things that matter to patients were:

- feeling informed and being given options
- staff who listen and spend time with patient
- being treated as a person, not a number
- patient involvement in care and being able to ask questions
- the value of support services (for example, patient and carer support groups)
- efficient processes

People in the Patient Reference Group spoke about the 'reluctance to ask the staff' and feeling they shouldn't be asking. Patients feel the staff are busy and don't want to interrupt and take their time up. It would be better if the nurse went round to the relatives and asked if everything was alright, were they worried about anything.

The trust recognises that the quality of relationships and communications between NHS staff and patients is of great importance to patients and is a key indicator for patient experience. The trust have taken the following actions to improve communications and the quality of our relationship with our patients.

- Communications is included in the trust's statutory and mandatory training.
- Clinical handover practices now include a safety briefing for staff at the beginning of their shift and the actual patient handover now takes place closer to the patient's bedside.
- Comfort rounding has been introduced trust wide which involves ward managers undertaking general checks of their patients to ensure the patient is as comfortable as possible.

'Communication is Key. Feeling prepared and knowing what will happen or if there is a delay during your stay in hospital helps you to feel less anxious. If you have the knowledge you can cope with it more.'

Patient reference group March 2012

Influences on our New Quality Strategy: *Staff and patient Feedback*

A number of other patient surveys are also circulated throughout the year, below are some examples from the Picker Institute National Adult Outpatient Survey and the Quality Health National Adult Inpatient Survey, both of which were conducted in 2011.

National adult outpatient survey 2011

The trust was reviewed by 513 patients out of a sample of 850 patients who had had an outpatient appointment during May 2011.

The trust was in the top **20%** of NHS trusts for 8 out of a possible 39 areas including:

- Patients seen at their stated appointment time.
- Patients given accurate advice about how long the waiting time would be.
- Patients informed how they would find out the results of their tests.
- Patients given clear explanation of their test results.
- Patients given the right amount of information about their condition or treatment.
- Doctors or nurses not talking in front of patients as if they weren't there.
- Patients given consistent information by staff.
- Patients treated with dignity and respect.

'The care that I received both as in patient and outpatient has been excellent. Ward 6 and physio must be some or the best care in the country.'

'I was given a nasal spray which numbed my throat but this wasn't explained to me, so as I was waiting outside finding it hard to breath and swallow I had to ask a nurse'.

'Yes I was very satisfied that I was seen on time and treated like a person and not a number.'

'Everyone was accommodating and polite! Felt someone has finally listened after a long time of not being well!'

The trust was in the lowest 20% of trusts for 7 areas. The main themes concerned information about medication, which is reflected across trusts nationally, and also help to self manage conditions.
An action plan has been drawn up and improvements are already being made in the Outpatients Department. The trust's SQS Committee oversee these plans.

For example

- Monthly audits are carried out on the number of clinics cancelled with less than 6 weeks notice;
- a staff nurse is responsible on a daily basis for ensuring that patients consistently have up to date information about delays in clinics; and
- cleanliness in the waiting area and toilets is being more closely monitored and charts are now up in the toilets to advise patients when cleaning has taken place.

National adult inpatient survey 2011

East Cheshire NHS Trust was reviewed by 455 patients out of a sample of 828 patients who had been treated as an inpatient at the trust during summer 2011.

The trust was in the top **20%** of NHS trusts for two areas:

- letters sent from hospital doctors to GPs were written in a way that patients could understand; and
- the visibility of information on the wards about patient and visitor hand washing requirements.

The trust was in the middle 60% of NHS trusts for all other areas, however, there were a number of areas where the trust results were at the top end of this range:

- Staff not making contradictory statements.
- Further improvements in same sex accommodation.
- Patients given the right amount of information about their condition or treatment in A&E.
- Hand wash gels available for patients and visitors.
- Patients not feeling threatened by other patients or visitors.
- Admission date not changed by the hospital .
- Doctors and nurses not talking in front of patients as if they weren't there .
- Enough privacy when being examined or treated.
- Patients given a full explanation of what would be done during their operation.

Influences on our New Quality Strategy: *Staff and patient Feedback*

'Communication between medical staff and patient was excellent. I have nothing but praise for the skill and care of all staff.'

'The overall quality of care was very high, and special mention should be made of the nurses and auxiliaries who were competently efficient and immensely courteous.'

'The manner of both doctor and nurses were lovely, calming and caring. I came home feeling a future of hope as at the time my illness was getting me down.'

'Communication between staff, patients and relatives could be improved.'

A number of areas have been highlighted for improvement during 2012/13 including:

1. Patients' perception of the time from referral to admission.
2. Information around discharge remains an ongoing area of focus for the trust to address in the coming year.
3. Patients' perception of hand washing will be improved by staff making sure patients are aware that they are washing their hands.
4. Improved communications between staff members, patients and thier family/relatives.

The following service improvements have already been made in these areas:

- Implementation of a Patient Reference Group which enables patients and carers family to become more involved in helping us to improve our services.
- Improvements in how staff members talk to patients about their worries.
- Opportunity for families to talk to a doctor about the care received.

5. Questions around food, including: rating of food; and being given a choice and being given enough help with eating.

The following service improvements have already been made to the trust's food:

- improvements to the pureed and soft mashable meals for patients;
- option of baked potato at evening meal alongside soup and sandwiches; and
- implementation of evening snacks.

Following a recent visit from The Care Quality Commission and Cheshire East LINk the trust were commended for the improvements made in this area.

4. Our Quality Priorities

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Priorities for improvement - looking forward to 2012/13

Quality priorities

In this section we will report our progress against our quality priorities in 2011/12 and our ongoing commitment to future progress

Using feedback from stakeholders and our commissioners, the trust has identified quality priorities covering 2012/13, that will further improve safety, patient experience and clinical effectiveness.

These quality priorities were established by reviewing feedback from our patients, staff, stakeholders and members of the public to identify what we need to improve to provide consistently high quality care, and to be able to measure success over the next year.

We will explain in this section how each quality priority for 2012/13 will be achieved.

During 2011/12 the trust has developed a robust governance structure to enable the effective monitoring and reporting of the quality of care we deliver to our Trust Board.

In 2012/13 the trust will implement the ward and departmental performance dashboard tool to enable clinical teams, ward sisters and departmental managers to measure their service areas performance Performance against the 2012/13 quality priorities will be monitored internally using the trust's performance dashboard tool and progress will be reported monthly to the Trust Board.

The NHS Safety thermometer

During 2012/13 the trust will implement the NHS Safety Thermometer across acute and community settings. The NHS Safety Thermometer is a tool for measuring patient safety, developed by the NHS Information Centre. The tool is being used nationally to conduct a point prevalence survey to measure, monitor and analyse the frequency of four specific patient harms.

The identified harms which will be measured are falls, pressure ulcers, catheter associated urinary tract infection (hospital and community) and venous thromboembolism, VTE - blood clots (hospital setting only). The NHS Safety Thermometer provides a quick and simple point of care survey which allows teams to measure harm and the proportion of patients that are 'harm free' during their working day, for example at shift handover or during ward rounds. This is calculated by dividing the number of patients receiving harm free care (the numerator) by the total number of patients surveyed

Priorities for improvements - looking forward to 2012/13

(the denominator). Data will be collected on the third Wednesday of every month for all inpatients and for those patients on a community nurses caseload on that day.

The thermometer provides a 'temperature check' on harm to help trusts build up a picture of patient safety issues and to help trusts see the impact of actions implemented. It can be used alongside other measures of harm to measure local and system progress.

Were patients protected from harm?	Pressure ulcer	Fall (with harm)	Urine infection (in patients with catheters)	VTE (newly acquired)
Patient 1	✗	✓	✓	✓
Patient 2	✗	✗	✓	✓
Patient 3	✓	✓	✓	✓
Patient 4	✓	✓	✓	✓
Patient 5	✓	✓	✗	✓
NO	2/5 (40%)	1/5 (20%)	1/5 (20%)	0/5 (0%)
YES	3/5 (60%)	4/5 (80%)	4/5 (80%)	5/5 (100%)

Above: Sample of the Safety Thermometer from the NHS Information Centre.

Note: Deep Vein VTE (Venous Thromboembolism) is a blood clot in one of the deep veins in the body.

"I would like to add that as an ex nurse, Macclesfield Hospital is an example of how nursing care should be. The chemo staff were fantastic and a three night admission with an embolism showed how good A&E staff are. The Ward 4 staff, watching their care of the frail and elderly patients was inspiring." (Breast Cancer Service)

Anonymous Breast Cancer Service patient survey Dec 2011

Our top prorities for 2012/13 (including CQUIN)

Priority	Quality indicator	How we will achieve
Reduce patient harm in hospital **SAFE**	To reduce the number of falls that cause harm from the baseline 2.8 per 1,000 bed days 2011/12 figure to 2.5 per 1,000 bed days.	• Continue to monitor the completion of assessments, care planning and implementation of appropriate care, for patients who are at risk of falling. • Embed the Falls Pathway into practice and ensure compliance. • Work within multi professional teams to ensure medication is reviewed in a timely manner.
	To reduce the number of health acquired pressure ulcers at grades 3 and 4 by 10% from the quarter 4 2011/12 baseline figure of 40.	• Continue to monitor the completion of assessments, care planning and implementation of appropriate care, for patients who are at risk of developing a pressure ulcer. • Ensure staff have access to appropriate equipment. • Implement dressing packs with tape and measures to monitor the size of the pressure ulcer. • Educate patients about the importance of pressure relief when cared for in their own home.
	To reduce the number of catheter associated urinary tract infections from the initial baseline (TBC) assessment in Q1 by 10%. This will be monitored by using the safety thermometer.	• Monitor compliance with the care pathway. • Educate relevant staff about the high risk factors of infection and how to reduce them. • Encourage the practice of early removal of catheters and promote nurse led practice. • Provide evidence based care using the latest equipment and techniques. • Ensuring compliance against the Saving Lives High Impact Interventions. • We will also maintain our quality standards for MRSA and CDiff. .

Our top prorities for 2012/13 (including CQUIN)

Priority	Quality indicator	How we will achieve
Reduce patient harm in hospital **SAFE**	To roll out the use of the Safety Thermometer as a safety monitoring tool trust wide from April 2012.	• Senior sisters in the hospital and Team leaders in the community will ensure that assessments are completed and that that data is collected from all relevant areas on the third Wednesday of every month.
Provide evidence based care **EFFECTIVE**	To ensure a minimum of 90% of patients have a risk assessment for Venous thromboembolism (VTE, blood clots).	• Ensure VTE risk assessments are carried out on all patients on admission. • Effectively prescribe prophylaxis for all patients who are at high risk of developing a VTE.
	To sucessfully achieve the North West benchmarks for the Advancing Quality clinical care bundles. **What are care bundles?** A bundle is a collection of "carefully packaged evidence based standards directed at a particular condition or clinical scenario" (British Medical Journal).	• Provide evidence based care in accordance with the Advancing Quality measures for patients with heart failure, pneumonia, stroke and hip and knee replacements. • Ensure care is documented in a timely manner. • Conduct a regular audit of compliance with the Advancing Quality measures, to ensure all patients receive the right care at the right time.

Our top prorities for 2012/13 (including CQUIN)

Priority	Quality indicator	How we will achieve
Provide evidence based care **EFFECTIVE**	To develop an infrastructure to support the clinical management of integrated care of patients with long term conditions.	• Multi agency educational events. • Establish baseline profiles of patients with a long term condition by GP Practice. • Establish a baseline staffing profile of skill mix and competence by staff group. • Work with partners to develop service specifications.
To provide positive patient experience **PERSONAL**	To improve the diagnosis and referral of patients with dementia by screening eligible patients in line with national standards.	• Effectively screen every patient over the age of 75 years admitted into hospital. Patients with a positive screening will be referred back to their GP or an appropriate specialist for further support. • Improve the patient experience based on the 5 National Inpatient Survey questions covering decisions on your care and treatment, privacy and dignity, quality of the medical information provided and patient concerns.

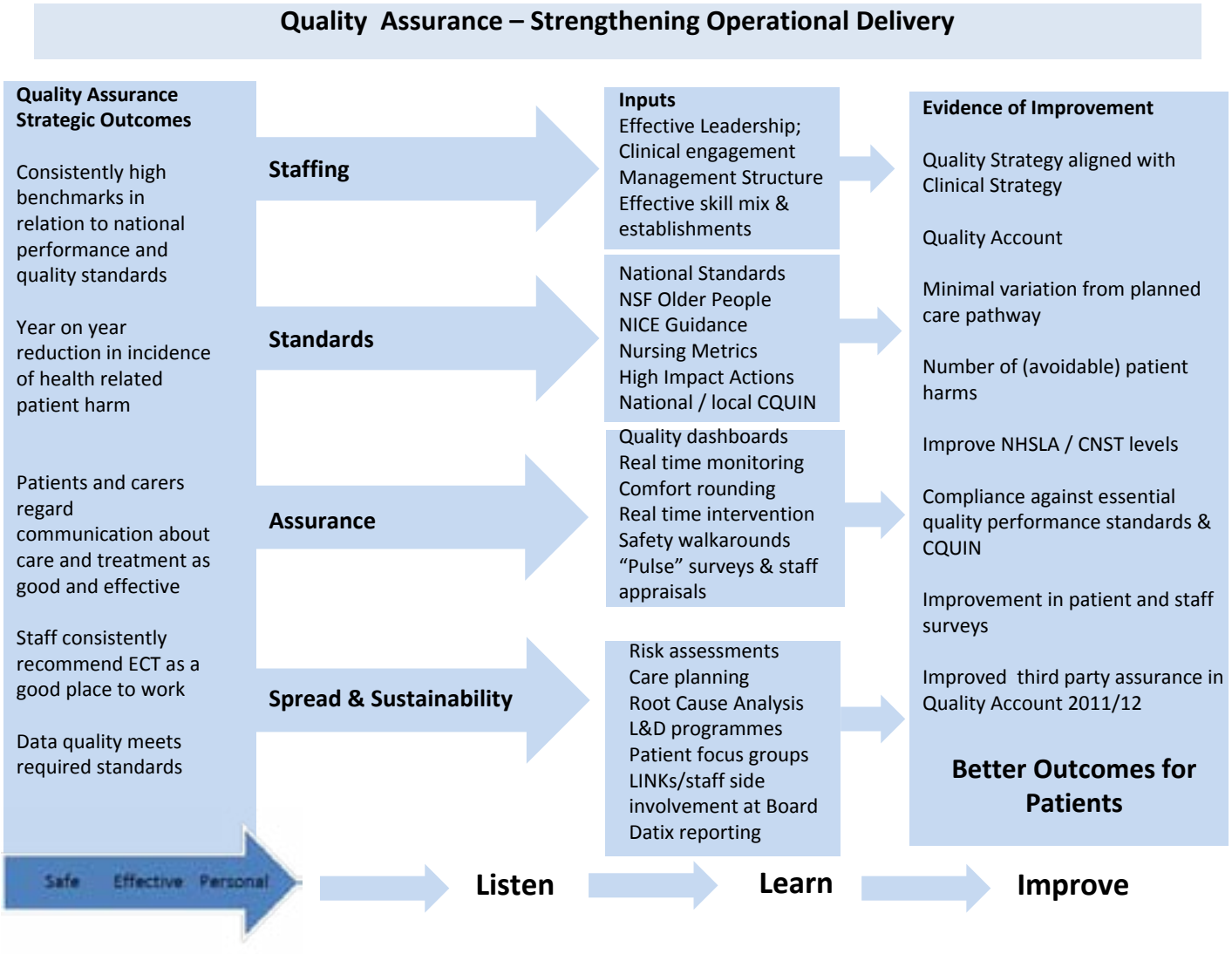
Our top prorities for 2012/13 (including CQUIN)

Priority	Quality indicator	How we will achieve
To provide positive patient experience **PERSONAL**	To reduce the number of cancelled operations from 7.54%, (baseline figure in 2011/112) to 2%.	• The Surgical Admissions Lounge will be commissioned in July 2012. • Review of the theatre scheduling policy will improve alignment with availability/ consultant teams.
	To improve the timeliness of initial clinical assessment of patients attending A&E by ambulance from 84.6% to 95% in less than 15 minutes.	• Further develop effective triage and co ordination role in A&E. • Maintain clinical assessment facility.

How progress to achieve priorities identified will be monitored

The trust has introduced a robust sytem of reporting to make sure that the Trust Board is given assurance about the quality of care the trust provides.

There are many ways this will be carried out and the diagram below explains how the outcomes the board requires is actioned by our staff. The actions below are measured to ensure that the standards are maintained and services are continually improved.



Statement of Assurance

A proportion of East Cheshire NHS Trust's income in 2011/12 was conditional on achieving quality improvement and innovation goals agreed between East Cheshire NHS Trust and commissioners through the Commissioning for Quality and Innovation Payment Framework.

Further details of the agreed goals for 2012/13 are available electronically at www.institute.nhs.uk or www.eastcheshire nhs.uk.

East Cheshire NHS Trust has reviewed all the data on the quality of care in 2011/12 of NHS services.

The income generated by the NHS services reviewed in 2011/12 represents 100% of the total income generated from the provision of NHS services by the trust. East Cheshire NHS Trust is required to register with the Care Quality Commission and the current registration status has no conditions.

The Care Quality Commission (CQC) regularly check the services provided by NHS trusts to ensure that all required standards of patient care are being met.

The trust was inspected by the CQC following an unannounced visit in Septemeber 2011, the CQC identified moderate concerns for outcomes 4 and 5.

The trust has been announced as fully compliant with all standards of care.

Third parties have also had the opportunity to comment on the Quality Account and their comments have been included within the account.

The Audit Commission have reviewed data quality relating to three areas:

- 62 day cancer waiting times
- End of Life Care
- Clostridium difficile

Data Quality

Relevance of data quality and action to improve data quality

High quality data is the foundation for credible information to support good clinical decision making, service planning, evaluation and clinical audit.

The trust's Data Quality Policy states that all staff have responsibilities for ensuring the quality of data meets required standards. However, we have specific staff whose responsibility for data quality is greater and we have systems in place to identify when data quality errors occur, which enables the trust to address the errors promptly.

Overall data quality is monitored monthly and the results are reported monthly to the Trust Board. The trust's overall data quality scores are better than the national averages.

For 2011/12 (April-November), the average validity for the data items monitored in the Secondary Uses Service (SUS) Data Quality Dashboard is:

Data set	Trust score	National score
Admitted Patient Care (APC)	99.8%	95.5%
Outpatients	97.0%	92.9%
A&E	91.0&	93.8%

Specifically, for a valid NHS number being present in the data the scores are:

Data set	Trust score	National score
APC	99.4%	98.7%
Outpatients	99.8%	99.0%
A&E	97.8%	92.7%

For a valid HRG **(Healthcare Resource Group)** version 4 code the scores are:

Data set	Trust score	National score
Admitted Patient Care (APC)	100%	98.3%
Outpatients	100%	99.2%
A&E	100%	96.7%

East Cheshire NHS Trust will be taking the following action to improve data quality in 2012/13:

- To improve our A&E data quality sets in 2012/13 by ensuring our clinical Patient Administration System (PAS) is upgraded to collect and send out ethnicity data.
- We will continue to increase awareness of the importance of data quality.

"Everything seemed well run and organised. I felt confident about the doctors and nurses, their skills and treatment"

Anonymous National Outpatient Survey 2011

5. Review of Quality Performance in 2011/12

2011/12 OUTCOMES

QUALITY INDICATOR	TARGET ACHIEVED	PRIORITY FOR 2012/13
Falls reduction	✓	✓
Reduction in infections	✓	
Pressure ulcers reduction	X	✓
Reduction in HSMR	✓	
VTE prevention	✓	✓
Improve stroke care	✓	
Reduction in cancelled operations	X	✓
Delivery of same sex accommodation	✓	
Reduction in length of stay for medically fit patients	✓	
Number of patients involved in end of life care plan	✓	
Staff undertaking basic training in dementia care	✓	
Response to complaints	X	✓

Review of 2011/12 priorities

< Behind schedule = On track to achieve ✓ target achieved

Safe

Reduce the number of injurious falls per thousand bed days

What: To reduce the number of injurious falls per 1,000 bed days.

How much: From 2010/11 baseline of 2.45 per 1,000 bed days.

By when: March 2012

Progress: < Behind schedule

Outcome: **Table- Falls and Injurious Falls per 1000 bed days March 2012**

	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Injurious falls	2.8	3.8	4.0	1.9	3.3	3.0	1.2	1.7	3.8	1.0	3	3.6
Target: less than 2.5 per 1,000 bed days	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5

Year to date: 2.8

Safe

Reduce the number of injurous falls per thousand bed days

Improvements achieved

- Improvements in the completion of assessment and reassessment of patients who are at risk of falls.
- The implementation of a new care plan for patients who are at risk of falls.
- The implementation of a new Falls Pathway for patients who have fallen.
- We have introduced patient comfort rounding, which involves ward managers undertaking general checks of their patients to ensure the patient is as happy and as comfortable as possible.

Future improvements

- To continue to monitor the completion and recording of patient falls assessments.
- To embed the Falls Pathway into practice and ensure compliance.

"Comfort rounding is getting back to basics and enabling nurses to interact with patients on a more regular basis"

Matron Orthopaedic and surgical wards

"Comfort rounding has proved to be an effective tool to aid delivery of high quality care and enhance the patient experience."

Sisters Ward 4 and Ward 7

Safe

To protect patients within our care from hospital acquired infection

What: To reduce the incidence of hospital acquired infection caused by MRSA.

How much: No more than 2 MRSA bacteraemia per year in the acute hospital setting and less than 10 in the community setting.

No more than 33 Clostridium Difficile infections (CDI) per year in the hospital setting and 104 for the community setting.

By when: March 2012

Progress: ✓ target achieved

Outcome:

MRSA bacteraemia

- 2 patients developed MRSA bacteraemia in the acute hospital setting.
- 8 patients developed MRSA bacteraemia in the community setting. (Community MRSA bacteraemia cases are recorded for all community acquired infections, including those in nursing homes, community hospitals and patient residencies.

Clostridium Difficile infections

- 27 patients developed Clostridium Difficile in the acute hospital setting.
- 78 patients developed Clostridium Difficile in the community setting.

Safe

To protect patients within our care from hospital acquired infection

Improvements achieved

- Reduction in MRSA bacteraemia and ***Clostridium Difficile*** in both acute and community cases from 2010/11.
- Health economy approach following the trust integration in April 2011.

Future improvements

- To develop specific Aseptic Non Touch Technique (ANTT) guidelines for Podiatry Services.
- Health economy approach to CDI by carrying out follow up assessments of all patients in their homes.
- Working with relevant areas both in acute and community settings to avoid hospital admissions.
- We will maintain our high standards in infection control, ensuring we continue to meet national and local standards.

Acute

- MRSA acute hospital setting - no more than 2 MRSA bacteraemia cases (internal stretch target 0).
- CDiff acute hospital setting - no more than 33 CDiff cases ((internal stretch target 25).

Community

- MRSA Community setting - no more than 10 MRSA bacteraemia cases (internal stretch target 0).
- CDiff community setting - no more than 104 CDiff cases ((internal stretch target 90).

"Everything about the hospital was excellent. Very clean, easy to find the wards etc. All the doctors and nurses were great. The nurses were always on the ward ready to help."

National Inpatient Survey 2011

Safe

Saving lives

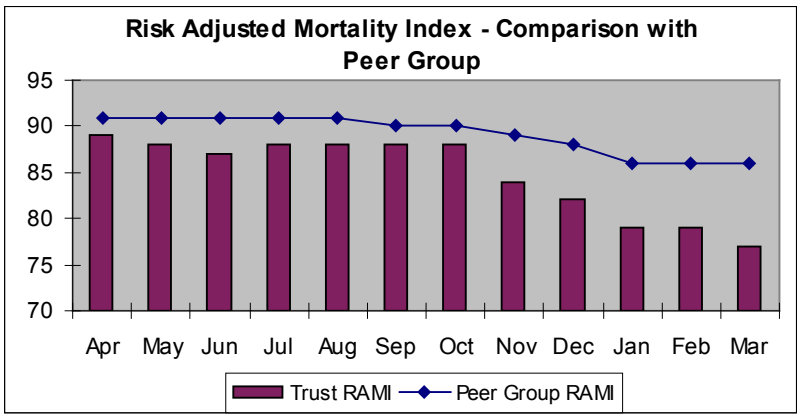
What: To maintain or reduce the Risk Adjusted Mortality Index (RAMI). A mortality ratio is described as the number of observed deaths divided by the number of predicted deaths. The technical definitions for observed deaths and predicted deaths vary from model to model. The trust uses the RAMI - this is a risk adjusted mortality index and is produced by the CHKS, which is routinely used by the trust for benchmarking quality data.

How much: Reduce from 2010/11 baseline of 92.7.

By when: March 2012

Progress: ✓ target achieved

Outcome: Graph - Risk adjusted mortality index



Improvements achieved

- The introduction of a monthly Mortality Group led by the Deputy Medical Director with representatives trust wide. The purpose of the group is to monitor, review and receive assurance on the effective implementation of national and local strategies targeted at reducing preventable mortality in accordance with patient choice, reducing adverse events, improving outcomes and quality of care for patients.

Future improvements

- Work is underway to further improve the accuracy of coding the data used to calculate the trust's RAMI score and to evaluate areas of clinical practice within the trust. representatives trust wide. Any anomalies' are picked up and scrutinised by appropriate staff.
- Work is underway to further improve the accuracy of coding the data used to calculate the trust's RAMI score and to evaluate areas of clinical practice within the trust.

Effective

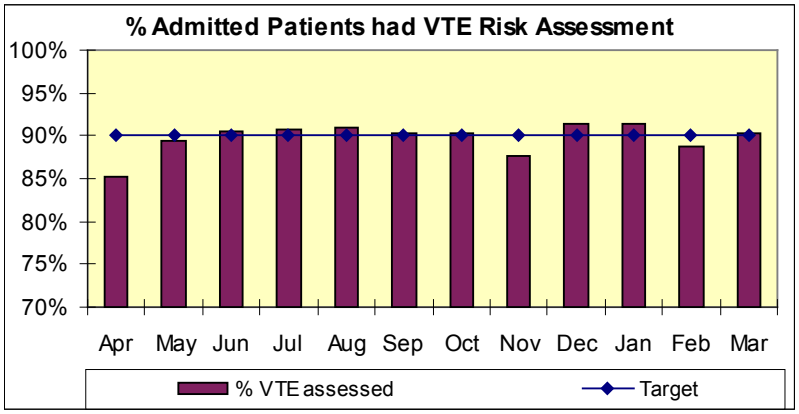
VTE Prevention Programme

What: To reduce hospital acquired venous thromboembolism (VTE)

How much: 90% of all eligible adult patients to have had a VTE risk assessment on admission to hospital.

By when: March 2012

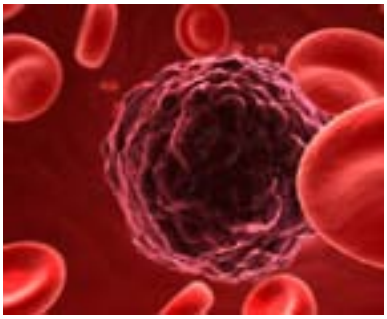
Progress: ✓ target achieved.
The trust achieved the set standard as required in the agreed CQUIN.



Outcome: Graph - % of admitted patients who have had a VTE Assessment

Improvements achieved

- Appropriate patients who are at very low risk of VTE have been identified. This includes patients having a hospital admission in the Endoscopy and Treatment Unit, Intermediate Care admissions to the Aston Unit and day case patients in clinical hematology, rheumatology, oral surgery and ophthalmology.
- An electronic track and trigger system has implemented to identify patients who require assessment and a trigger is made if this is not completed.



Future improvements

- Ensure the VTE Process is continually embedded into the trust's clinical practices.
- Achieve 90% compliance of patients risk assessed for VTE in quarter 3 and 4 for 2012/13.

Note: Deep Vein VTE (Venous Thromboembolism) is a blood clot in one of the deep veins in the body.

Effective

Improving the quality of care for stroke patients

What: To increase the percentage of patients with stroke for whom all ten stroke indicators are met.

How much: From the 2010/11 baseline of 93% to be above this figure by the end of the financial year of 2011/12.

By when: March 2012

Progress: ✓ target achieved. Between April 2011 and the end of March 2012 the average score for the ten monitored stroke performance indicators has averaged 97%.

Outcome: **Data taken from the Stroke Oracle database 2011/12**

Performance indicators	Year to date
Admitted directly to a Stroke Ward	87.73%
Scan within 24 hours of admission	99.61%
90% of LoS on dedicated ward	91.70%
Rehab goals agreed by MDT	99.12%
Aspirin prescribed within 24 hours	96.10%
Swallow screening within 24 hours of admission	96.05%
Physio assessment within 4 working days	98.86%
OT assessment within 4 working days	100%
Weighed prior to discharge	99.25%
Mood assessed prior to discharge	97.71%
Audit score	**97**

The ability of achieving greater than the baseline of 93% has come from maintaining the high percentage of assessments carried out within time and by working with other departments and services over the last year to improve the number of patients admitted directly to the Stroke Ward.

Effective

Improving the quality of care for stroke patients

This has led to an improvement in the percentage of patients who spend more than 90% of their stay on a Stroke Unit.

Improvements achieved

- Improvements in the percentages achieved has been made in six of the ten performance indicators. The other four have remained unaltered, but are at the required standard. The largest improvement has been in the percentage of patients admitted directly to the Stroke Unit, this has gone up from 76 to 87%.

Future improvements

- The aim for the ten stroke performance indicators is to maintain the average level above 95%. At present the Stroke Service is in discussion with Cumbria and Lancashire Stroke Network (CSLN) to become part of their telemedicine thrombolysis Out of Hour's Service. This would entail the purchase of a telemedicine cart and laptops. Doctor Sein, the Stroke Consultant at Macclesfield District General Hospital would join the on-call rota system with the CSLN allowing Macclesfield District General Hospital to provide a 24 hour Thrombolysis Service.

Experience

Pressure Ulcer Prevention Programme

What: To prevent Pressure Ulcers developing whilst in our care – both hospital and community setting.

How much: To reduce the incidence of all hospital acquired pressure ulcers by 10% from 2010/11 baseline of 291 incidents in hospital and 330 prevalence in the community.

To review the incidence of pressure ulcers in the community setting and establish a baseline of incidence.

By when: March 2012

Progress: < Behind schedule

Outcome: The baseline detailed above was reviewed during 2011 as a result of a data quality assessment. It was agreed that targets should be set on health acquired pressure ulcers rather than all, as had previously been set. The data collection tool was adapted to enable pressure ulcers to be differentiated into “health acquired” and those that are “admitted with”.

A baseline was agreed for 2011/12 to show a reduction of health acquired pressure ulcers of 10% for all grade 3 and 4 pressure ulcers.

- Community setting – no more than 15 grade 3 and 4 pressure ulcers developed in the community setting.
- Acute hospital setting – no more than x grade 3 and 4 pressure ulcers developed in the acute hospital setting.

Experience

Pressure Ulcer Prevention Programme

Performance by grade 3 and 4 pressure ulcers

Setting	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	March	Total
Community	0	1	0	0	0	1	0	1	5	4	2	0	14
Acute	5	1	9	2	1	5	0	0	2	0	0	1	26

This performance and the collection of incidence data for health acquired pressure ulcers sets the baseline for 2012/13 for both acute and community. The NHS Safety Thermometer will support the identification of the prevalence of pressure ulcers across East Cheshire NHS Trust.

Improvements achieved

- New baseline established.
- Action plan developed and implemented to achieve compliance with NICE guidance.
- Supporting documentation now in place for risk assessment prevention care plans.
- Pressure prevention guidelines updated.
- Consistent monitoring of pressure ulcers developed through incident reporting.
- Risk Assessment and prescribing training has been established and implemented.

Future improvements

- Establish link nurse system to cascade best practice.
- To audit the number of pressure ulcers developing whilst in our care to establish a firm. accurate baseline and aim to reduce these numbers.
- To improve learning from root cause analysis of stage 3 and 4 pressure ulcers.

Experience

Reducing cancelled operations

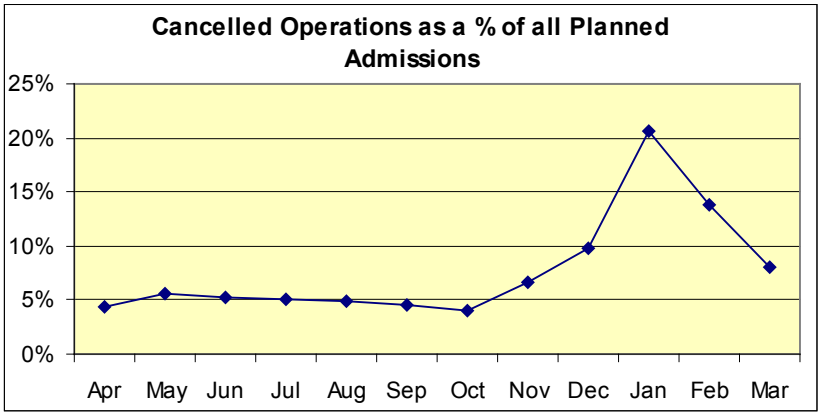
What: To reduce the number of all cancelled operations as a percentage of the total number of planned admissions.

How much: **Patient cancellations have reduced over the past year by a total of 44%,** the target is to further reduce these in line with national benchmarks to 2% or under. This will be achieved over the next 6 months, through the commissioning of a surgical admissions lounge which will allow elective admissions to be accommodated pre operatively without the need for a vacant in-patient hospital bed.

By when: March 2012

Progress: < Behind schedule

Outcome: **Graph - Cancelled operations**



Improvements achieved

- The implemention of a robust monitoring mechanism for all planned admissions.
- Proactive planning on a daily basis by the senior management team.

Future improvements

- The introduction of the Surgical Admissions Lounge will allow us to ensure operations take place on the day they are planned, reducing patient stress and anxiety caused due to unexpected cancellations.
- Further improvements in compliance with estimated data discharge and increased usage of criteria nurse led discharge to enable patients to go home earlier in the day rather than waiting for a medical review.
- Introduction of an NCEPOD theatre to provide sufficient emergency operating time when required.
- Scheduling of consultants and medical staff holidays to ensure full utilisation of resources.

Experience

Reducing the average length of stay for patients who are medically fit for discharge

What: To reduce the length of stay for patients who are medically fit for discharge or transfer of care.

How much: From 4.4% in 2010/11.

By when: March 2012

Progress: ✓ target achieved. Improved integrated working between primary and secondary care, third sector services and social services.

Outcome: 3.8% of occupied bed days were delayed discharges from April to March 2012.

Improvements achieved

- Improved monitoring system of Delayed Discharges as a % of both acute and non-acute bed stock.
- Robust escalation procedures in place.
- Established links with out of area colleagues.
- Improved and more timely approach to the Continuing Health Care process.
- Introduction of Patient Journey co-coordinator to facilitate assessment and discharge planning on admission.
- Reduced length of stay on Short Stay Unit through consistent multidisciplinary approach to discharge planning, led by a dedicated discharge facilitator.
- Development of the patient passport.
- The trust have also reduced readmissions from 4.4% in 2010/11 to 3.7% in 2011/12.

Future improvements

- Build on current integrated working relationships including out of area colleagues.
- Establish link nurse system to improve discharge planning.

Experience

Delivery of Same Sex Accommodation

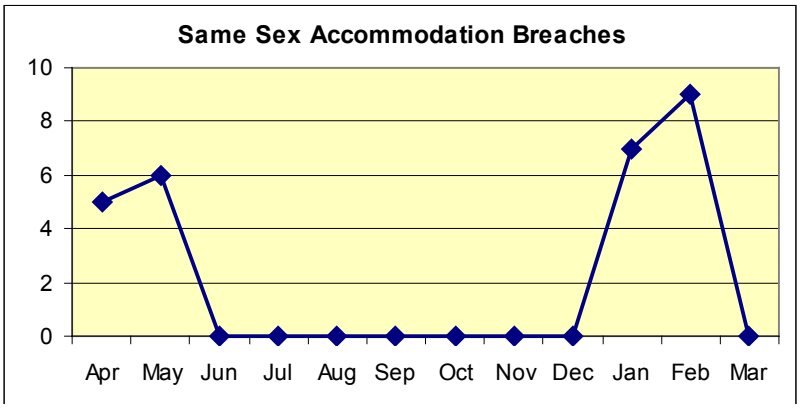
What: To ensure we are compliant with same sex accommodation regulations.

How much: The trust is committed to having a zero tolerance approach to non clinically justified breaches of same sex accommodation.

By when: March 2012

Progress: ✓ target achieved. All inpatient areas now have same sex designated bays and bathing facilities.

Outcome: Graph - Same Sex Accommodation Breaches at March 2012



N.B In the reporting months Jan - Feb 2012 the trust were faced with increasing winter pressures. The reported figure of 8 breaches on the graph occured through one mixed sex instance.

Improvements achieved

- All inpatient areas now have same sex designated bays and bathing facilities.
- Signs highlighting the designated same sex areas are now available in all same sex areas, trust wide.

Future improvements

- Following the trust's current bed reconfiguration project further work will be carried out to enhance the delivery of same sex accommodation if necessary.

Experience

To ensure that our patients concerns and complaints are listened to, investigated appropriately and acted upon

What: Complaints acknowledged and responded to in agreed timescales.

How much: To acknowledge and respond to complaints, within agreed timescales, in 100% of instances.

By when: March 2012

Progress: < Behind schedule

As at the end of quarter 4 we can report:
- 100% of complaints were acknowledged within agreed timescales; and
- 90 % were responded to within agreed timescales.
- 39 complaints were related to communication during 2011/12.

Outcome:

- Target for acknowledgement of complaints achieved.
- Achievement of the target for response to complaints will continue to be a priority for 2012/2013.

Improvements achieved

A revised complaints process was introduced in January 2012. This process aims to enhance;

- ownership and coordination of investigations within respective business units;
- accountability for associate director, and where appropriate clinical lead sign off; and
- quality control measures within the Customer Care Team.

Experience

To ensure that our patients concerns and complaints are listened to, investigated appropriately and acted upon

- In order to support the implementation of the new process, monthly training on responding to complaints has been introduced from February 2012.
- Further Root Cause Analysis training took place in March, which provided managers and clinical leads with the underpinning knowledge and skills to undertake robust investigations, identify root causes and lessons learned.

Future improvements

- Investigations - understanding the root cause and implementing agreed action plans
- More involvement of carers and relatives.
- More involvement of volunteers.
- Advanced communications training to help concerns before a complaint is made.
- Introduction of dashboard for complaints to alert of any delays in the process.
- Use of Datix software for the administration of the complaints process.
- Reduction of the percentage of complaints where communication relating to patient care was the primary source of the complaint.

"Thank you for your help with finding out why my mother was discharged from A&E last November 2011. The reply I had was informative and helpful."

Anonymous complainant feedback to Customer Services March 2012

Experience

To increase the number of patients who are involved in their end of life care plan

What: To implement the care of the dying pathway for all patients identified as at end of life. To support those patients who choose to identify a preferred place of care to achieve their wish.

How much: 80%

By when: March 2012

Progress: ✓ target achieved.

Outcome: Patients with an established preferred place of care at end of life:
- 80% for month 11 (Feb 2012) - acute patients died at their preferred place of care.
- 81% of community patients died at their preferred place of care as at March 2012

Improvements achieved

- The trust has achieved a 31% increase between August 2011 and February 2012 in the number of end of life patients who are cared for on a care of the dying pathway.
- We have reduced the number of deaths in hospital by 1%.
- 100% of specialist palliative care staff have attended advanced communication skills training.
- Other staff who care for patients at the end of life have now commenced basic level training in communication skills.

Future improvements

- The trust will continue to monitor and sustain the number of patients at end of life who are on a care of the dying pathway at 80% by annual spot audit carried out by the End of Life Team.

"Nurses and staff could not have been more caring and considerate. Mum could not have received better care. Thank you so much for the care you offered her" (End of Life Care Team)

Anonymous trust website contact form Feb 2012

Experience

Staff training and development

What: To increase the number of clinical staff trained in basic dementia care awareness.

How much: From 10% in 2010/11 to 70% in 2011/12

By when: March 2012

Progress: ✓ target achieved

Outcome: 85% of acute staff trained in basic dementia care awareness at the end of March 2012.

Improvements achieved

- Improved knowledge and confidence of staff when caring for people with dementia.
- The "This is Me" Patient Passport was implemented in October 2011 and a register is now kept of patients using the passport. Patient passports aim to give health professionals vital information about a patient, their health conditions, medication, communication needs and best ways of engaging with the individual patient. This means that a patient's particular need can be met effectively and therefore a consultation or examination is likely to be more successful.
- A new Dementia Care Pathway has also been developed, which supports clinical decision making for patients with dementia, supporting best evidence based care.
- A dementia awareness workbook has been developed to help staff gain knowledge about dementia and help to support those that work with people who have dementia. Completion of the workbook enables staff to demonstrate their knowledge and skills in providing care and support for those people who have dementia. This provides evidence of continuous learning.

Future improvements

- Planned bespoke dementia care training sessions to specialist staff groups in 2012/13. Topics to include understanding behaviour in dementia and decision making in dementia.
- Using the Simulation Clinical Skills area to assess staff working as a multi-professional team when caring for patients with dementia in both acute and community settings.

Performance against national targets 2011/12

East Cheshire NHS Trust aims to meet all national targets and priorities.

Performance against national targets 201112

Current Level of Risk: Green (Low) Yellow (Moderate) Amber (Significant) Red (High)

2011/12 Target	Care Quality Commission Standards	In Month Target	In Month Performance	YTD Performance	Level of Risk
>95%	1. A&E: Maximum waiting time of 4 hours in A&E	>95%	98.98%	95.16%	Significant
< 5%	2. A&E: Unplanned Reattendance Rate from Quarter 2	<5%	1.73%	2.34%	Moderate
< 5%	3. A&E: Left Department Without being Seen Rate from Quarter 2	<5%	0.33%	0.57%	Low
> 95%	4. A&E: Time to Initial Assessment within 15 mins - Ambulance patients from Quarter 2	95%	89.1%	91.5%	Significant
< 60 mins	5. A&E: Time to Treatment - Median - Mins from Quarter 2	< 60 mins	63	61	Moderate
No more than 2	6 (a). **Hospital** MRSA bacteraemia year on year reduction versus trajectory for the year	0	1	2	Significant
No more than 10	6 (b). **Community** MRSA bacteraemia year on year reduction versus trajectory for the year	1	0	8	Moderate
No more than 33	7. **Hospital** Acquired CDifficile (Year target)	3	3	27	Moderate
No more than 104	7. **Community** Acquired CDifficile (Year target)	9 or less	5	67	Moderate
Less than or equal to 23 Weeks	8. 18 week Referral to Treatment - Admitted Patients - **95th Percentile**	<23 weeks	21.9	27.5	Significant
Greater than or equal to 90%	9. 18 week Referral to Treatment - Admitted Patients - **90% within 18 weeks**	90.0%	91.5%	77.3%	Significant
Less than or equal to 18.3 Weeks	10. 18 week maximum wait - Non-Admitted Patients - **95th percentile**	<18.3 weeks	16.0	18.6	Moderate
Greater than or equal to 95%	11. 18 week maximum wait - Non-Admitted Patients - **95% within 18 weeks**	>95%	97.8%	95.7%	Low
Less than or equal to 28 Weeks	12. 18 week maximum wait - Incomplete - **95th percentile**	<28 weeks	23.6	23.5	Low
93%	13. 2 Weeks maximum wait from urgent referral for suspected cancer	93%	98.6%	97.8%	Low
93%	14. 2 Weeks maximum wait from referral for breast symptoms	93%	96.4%	97.5%	Low
94%	15. 31 days maximum from decision to treat to subsequent treatment - Surgery	94%	100.0%	100.0%	Low
98%	16. 31 days maximum from decision to treat to subsequent treatment - Drugs	98%	100.0%	100.0%	Low
96%	17. 31 day wait from cancer diagnosis to treatment	96%	100.0%	99.5%	Low
90%	18. 62 days maximum from screening referral to treatment (including patients treated at a tertiary centre) *	90%	100.0%	98.6%	Low
85%	19. 62 days maximum from consultant upgrade to treatment (including patients treated at a tertiary centre)	85%	100.0%	93.7%	Low
85%	20. 62 day maximum wait from urgent referral to treatment of all cancers (including patients treated at a tertiary centre)	85%	90.8%	86.3%	Moderate
80%	21. Stroke - Patients who have spent more than 90% of their time on a stroke unit	80%	100.0%	91.7%	Low
< 3.5%	22. Delayed Transfers of Care	< 3.5%	6.4%	3.8%	Moderate
<5%	23. Cancelled Operations not re-admitted within 28 days	< 5%	0.0%	0.0%	Low

* **See page 47**

Performance against national targets 2011/12

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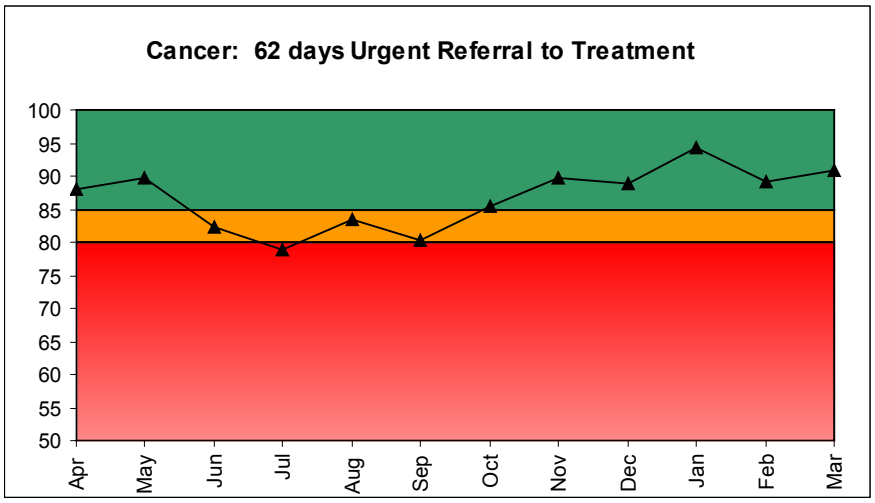


Now including those patients treated at tertiary centres.The year end performance is Green. The Greater Manchester and Cheshire Cancer Network has recently issued its own performance details for providers based on the Somerset National System and on recent changes to breach allocation rules. This data differs slightly to our own data, due to the delay in record completion. The GM&CN data show: October 76.4% compliance, November 84.5%, December as 88.9%, January at 93.0% and February at 85.2%. Calculations to mirror these results in-house will be implemented in 2012/13.

Never events

The trust had 3 Never events in 2011/12. Never events are serious, largely preventable patient safety incidents that occur when relevant preventative measures are not followed.

No/low harm occurred as a result of these events.

The 3 events were:

1. Methotrexate administration
2. Retained swab
3. Retained swab

Root cause analyses was undertaken to identify contributory factors and ensure immediate action was taken to prevent further events.

6. Examples of best practice 2011/12

Safe ➲ Effective ➲ Personal

Best practice examples

Initiative	Aims and how it works	Benefits
1. STARTBACK Asessment Tool Following participation in an implementation research study during 2011/12, by Keele University regarding the use of the STARTBACK Assessment Tool, the trust's Community Adult Physiotherapy Service adopted the use of this treatment approach for thier practices.	The STARTBACK Assessment Tool is a validated tool which enables the identification of a patients level of risk of developing persistent disabling symptoms from thier back pain. The tool is applied as a patient questionnaire at initial assessment. The questionnaire consists of 8 questions, to which the patient is required to respond positively or negatively. Their responses then generates a score, which determines thier level of risk.	• This identification enables a patients to receive a personal and targeted treatment approach according to their level fo risk. • Clinical efficiency • Improvements in health related quality of life. • Average savings of £34.39 per patient compared to usual care. • Improved patient experience.
2. Electronic Prognostic and Asessments Information Guide for End of Life (EPAIGE) Prognostication in chronic, debilitating and life threatening illness presents a major challenge particularly in the acute care setting.	In order to improve the quality of prognosis and provide an improved quality of care at end of life approach for our patients the trust's End of Life Care Team introduced the EPAIGE system in 2011/12. The EPAIGE offers a dynamic, easy to use electronic tool that can be used across care settings to support the management of patient pathways at end of life and into bereavement. The tool uses evidence based guidelines and national indicators to facilitate early indentification of people with a life limiting illness.	• More proactive approach to planning and implementing care designed to meet patient needs and choice. • Improvements in care delivery aligned to patient preferences. • Fewer crises interventions leading to improved patient and family experience. • A reduction in complaints. • Improved decision making. • Improved team working and releasing time to care.

Best practice examples

Initiative	Aims and how it works	Benefits
3. Productive Community Services Programme In order to facilitate information sharing and deliver evidence based practice, during September 2011 the trust's District Nursing Team implemented the Productive Community Services Programme. The Productive Community Services is an organisational wide programme that provides an evidence-based approach to improve the way the trust work across the range of services and pathways of community care.	The programme is a practical application of lean based techniques to help engage frontline teams improve quality and productivity in their service area. Examples of the changes implemented since the start of the programme: • Zones introduced in store rooms to enable cost savings and reduce time for staff locating items. • Development of a system of signage, which identifies if staff members are able to help with a patient query or if they need time to complete tasks without being disturbed. This system has shown greater productivity in the team.	• Reduction in ineffective work practices. • Improved workflow processes and efficiency. • Enables more patient time. • Improved patient experience. • Improved quality of care delivered. • Improved team working and partnerships. • Cost savings and improved productivity. • Improved communication and engagement between patients and staff.
4. Simulation training sessions The NHS Institute for Innovation and Improvement has recognised and attributed poor communication as a factor in over 50% of patient harm incidents. Communication using the SBAR tool, alongside team working, situational awareness and prioritisation are an integral part of simulation sessions at the trust.	During 2011/12 we strengthened the number of simulation training opportunities for frontline staff to learn together. Simulation uses sophisticated lifelike human manikins and simulated ward or operating theatre settings, to provide doctors and nurses with an opportunity to rehearse the management of rare or serious clinical events in a way that does not put patients at risk.	• Multi disciplinary learningand learning can be applied immediately in the workplace. • Unique opportunities to develop individual and team-based skills. • Supports the provision of higher quality and safer patient care.

Best practice examples

Initiative	Aims and how it works	Benefits
5. The introduction of Supervisory Senior Sister Band 7 Roles Following national guidelines and a consultation with senior ward staff on their roles and responsibilities, the the trust introduced new supervisory roles.	The initiative aims to strengthen operational delivery and the role of the ward sister in the interests of patient care, whilst also making the responsibility of the ward sister clear: to oversee patient care in a clinical area.	• The Senior Sisters are now more visible and acessible to patients, staff and visitors. • Allows dedicated time for improving the quality of care experienced by service users and patients. • Helping to create a culture of learning and development.
6. SBAR - Situation Background Assessment Recommendation In order to improve communication between staff members and foster a culture of patient safety, the trust introduced SBAR to clinical areas in 2011/12. SBAR is a structured method for communicating critical information that requires immediate attention and action.	SBAR aims to improve communication between teams, through the delivery of clear and effective communications. The tool consists of standardised prompt questions within four sections, to ensure that staff are sharing concise and focused information. The tool is used at the start and end of every shift.	• Effective communications and engagement between staff and service areas. • Used during handover SBAR reduces the time spent on this activity thereby releasing time for clinical care. • Contributes to effective escalation and increased patient safety.
7. Patient Comfort rounding In order to improve communications between staff and patients the trust introduced comfort rounding in 2011/12.	Comfort rounds" are where staff proactively ask patients on a regular basis whether they have any needs. Comfort rounds aim to improve the patient experience and involve them in their care plan.	• Increased patient contact and satisfaction. • Reassurance of patient centred care delivery. • Improved communication between staff and patients. • Improved patient safety and comfort.

7. Review of clinical research in 2011/12

Safe ➲ Effective ➲ Personal

Audit participation

Participation in clinical audits 2011/2012

During 2011-12, 34 national clinical audits and two national confidential enquiries covered NHS services that East Cheshire NHS Trust provides.

During that period East Cheshire NHS Trust participated in 31 (94%) of the national clinical audits and 2/2 (100%) national confidential enquiries which it was eligible to participate in. Two national audits were discontinued and 9 were not applicable.

The national clinical audits and national confidential enquiries that East Cheshire NHS Trust participated in, and for which data collection was completed during 2011-12 are listed below alongside 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.

National Clinical Audit	Participation	Data collection 2011/12	% cases submitted in 2011/12
Perinatal mortality (IMBRACE UK)	Audit discontinued	X	X
Neonatal intensive and special care (NNAP)	✓	✓	100%
Paediatric pneumonia (BTS)	✓	✓	100%
Paediatric Asthma (BTS)	✓	✓	18/25 (72%)
Pain management in children (CEM)	Audit discontinued	X	X
Childhood epilepsy	✓	✓	100%
Paediatric Intensive Care (PICAnet)	✓	✓	100%
Paediatric Cardiac surgery	N/A	N/A	N/A
Paediatric diabetes	✓	✓	100%
Emergency use of oxygen (BTS)	✓	✓	100%
Adult community acquired pneumonia (BTS)	✓	✓	100%

Audit participation

National clinical audit	Participation	Data collection 2011/12	% cases submitted in 2011/12
Non invasive ventilation – adults (BTS)	N/A	N/A	N/A
Pleural procedures (BTS)	✓	✓	100%
Cardiac arrest	X	X	Deferred until 2013
Severe sepsis and septic shock (CEM)	N/A	N/A	N/A
Adult critical care (ICNARC)	✓	✓	100%
Potential donor audit	✓	✓	100%
Seizure management (CEM)	X	X	Audit discontinued
Diabetes (adults)	X	X	N/A
Heavy menstrual bleeding	✓	✓	80%
Chronic pain	X	X	N/A
Ulcerative colitis and Crohn's disease (IBD audit)	✓	✓	13/33 patients (39%)
Parkinson's disease	✓	✓	100%
Adult asthma (BTS)	✓	✓	100%
Bronchiectasis (BTS)	X	N/A	N/A
NJR hip knee and ankle replacements	✓	✓	100%
PROMs elective surgery	✓	✓	23.5% (2/2/12) 100% patients asked
Intra thoracic transplantation	N/A	N/A	N/A
Liver transplantation	N/A	N/A	N/A
Coronary angioplasty	N/A	N/A	N/A
Peripheral vascular surgery (VSGBI)	✓	✓	100%
Carotid interventions	✓	✓	100%

Audit participation

National clinical audit	Participation	Data collection 2011/12	% cases submitted in 2011/12
MINAP	✓	✓	100%
Heart failure	✓	✓	98%
SINAP	✓	✓	100%
Cardiac arrhythmia	N/A	N/A	N/A
Renal replacement therapy (renal registry)	✓	✓	100%
Renal transplantation	N/A	N/A	N/A
Lung cancer	✓	✓	100%
Bowel cancer	✓	✓	97.3%
Head and neck cancer	✓	✓	100%
Oesophago-gastric cancer	✓	✓	50%
National Hip fracture database	✓	✓	100%
TARN	✓	✓	23%
Prescribing in mental health services	N/A	N/A	N/A
Schizophrenia	N/A	N/A	N/A
Bedside transfusion	✓	✓	100%
Medical use of blood (red cells)	✓	✓	100%
Risk factors (health promotion in hospitals)	X	X	N/A
National Confidential Enquiry into Patient outcome and Death (NCEPOD) Bariatric Surgery Study	✓	✓	N/A
National Confidential Enquiry into Patient outcome and Death (NCEPOD) Cardiac Arrest Study	✓	✓ Stage 2	Stage 2 100%

Review of National Audits in 2011/12

The reports of 10 national clinical audits were reviewed by the provider 2011/12. The table below shows the actions we intend to take to improve the quality of healthcare provided. A sample of best practice has been selected for inclusion in this year's Quality Account.

National Clinical Audits: Actions to improve quality

National audit	Actions and progress
Community Services Business Unit - BTS Pneumonia Guideline Audit This National audit was undertaken to assess the compliance of Community acquired pneumonia management with 2002 British Thoracic Society (BTS) guidelines.	**Actions** • Mild cases of Pneumonia do not require CXR for diagnosis. It is better if we grade the pneumonia as mild or severe. • All children presents with sats <92 should receive Oxygen. • Re-audit **Progress** Actions complete, monitoring to be completed by end of May 2012.
Medical Business Unit - BTS Audit Adult Asthma The object of the audit was to evaluate if we are following appropriate treatment, as per British Thoracic Society guidelines, in the management of adult asthma patients admitted to hospital.	**Actions** • Steroids within 4 - 6 hours. • Recording of inhaler technique checks by • Respiratory Team. • Advice regarding visit with GP within a week of discharge. • Written management plans. **Progress** Actions complete, monitoring in progress.
Outpatient and Clinical Support Business Unit – Diagnosis and Management of early rheumatoid arthritis against 2009 NICE guidelines This audit was carried out against several guidelines including National Audit Office Report 2009 and the 2009 NICE guidelines.	**Actions** • Importance of documentation, i.e. providing leaflets, Disease Activity Score. • Highlights the need for referral guideline and treatment pathway. • The provision of more capacity for patients with suspected early RA (seen within 2 weeks of referral).

Review of National Audits in 2011/12

National Clinical Audits: Actions to improve quality

National audit	Actions and progress
Outpatient and Clinical Support Business Unit – Diagnosis and Management of early rheumatoid arthritis against 2009 NICE guidelines	• Designated clinic time for follow up of patients with early RA, with previously obtained inflammatory markers for calculation of disease activity score. • Podiatry services • Public awareness • Re-audit with more number of patients
	Progress Actions complete, currently being monitored.
National Patient Safety Agency (NPSA) Safer use of intravenous gentamicin for neonate Patient safety incidents was reported involving administration of gentamicin at the incorrect time, prescribing errors and issues relating to blood level monitoring. A review of neonatal medication incidents reported to the National Reporting and Learning System between April 2008 and April 2009 identified 507 patient safety incidents relating to the use of intravenous gentamicin. **Aims of the audit** • To develop a local protocol. • The initial dose and frequency of administration. • Blood level monitoring • Arrangements for subsequent dosing adjustments based on blood levels taken.	**Actions** • Local protocol developed • Highlight it in the Paediatrics Audit meeting • Provide feedback / update to the nurses • Re-emphasize importance of this process The outcome of this audit will ensure a robust protocol is in place to improve patient safety.
	Progress Actions complete, monitoring nearing completion.

Review of Local Audits in 2011/12

The reports of 126 local clinical audits were reviewed by the provider in 2011-12 and East Cheshire Trust intends to take the following actions to improve the quality of healthcare provided. A sample of best practice has been selected for inclusion in this year's Quality Account.

Local Clinical Audits: Actions to improve quality

Speciality	Audit title	Actions and progress
Acute Community Service	**Nutrition Now – Dietetic** This was a preliminary audit to assess what was happening on the ward with regards to nutrition prior to commencing nutrition training in the form of 'Nutrition Now'.	**Actions** • Implement training package 'Nutrition Now' to ward staff. • Commence snack trolley to make sure patients receive appropriate snacks. Reassess in six months time. **Progress** All actions complete.
Children and families	**Sedation in Children and Young People - Paediatric** The aim of the audit was to find out how we are doing with children and younger people undergoing sedation against NICE Guidance CG112.	**Actions** • Sedation care plan to be reviewed and provision of patient leaflet along with the care plan. • Ensure using the care plan even for neonates and inpatients. • Proper filing of the care plan • Yearly Paediatric BLS training and sedation medication training. • A re-audit is planned a year after the above have been implemented.

Review of Local Audits in 2011/12

Local Clinical Audits: Actions to improve quality

Speciality	Audit title	Actions and progress
Children and families	**Sedation in Children and Young People - Paediatric**	The outcome of the action plan will ensure improvements are made with the standard of documentation which will lead to better patient safety. **Progress** Actions complete, monitoring nearing completion.
Acute medicine	**Blood Culture Technique** The aims of this audit were to improve aseptic technique of all staff taking cultures, and to lower the rate of contamination of blood cultures taken. The audit was conducted to ascertain whether we were following National Guidelines for taking blood cultures.	**Actions** 1. Poster presentation 2. Education for all F1/F2 doctors 3. Education of nursing all staff, as most blood cultures are taken by them 4. Re audit planned to check that practise is being adhered to. If the above actions are completed and the correct procedures are followed the contamination rate will decrease thus ensuring greater patient care and safety. **Progress** Actions complete. Re-audit to take place.

Review of Local Audits in 2011/12

Local Clinical Audits: Actions to improve quality

Speciality	Audit title	Actions and progress
Care for Elderly	**Delirium Audit** The aim of the audit was to establish if patients who are admitted to Macclesfield District General Hospital to the orthogeriatric service, are being adequately risk assessed and appropriately cognitively assessed, in line with current NICE guidance. With our aim to improve an evolving service. Delirium is characterised by a disturbance of consciousness and a change in cognition that develop over a short period of time.	**Actions** • Pro-forma for use in elderly patients developed • Orthogeriatrician booklet for juniors developed • Education events for juniors • Look at Care pathway for patients with delirium • Feedback to ward staff on MUST score, analgesics, laxatives, fluid balance charts, catheterize. The outcome of this audit will lead to improved care. **Progress** All actions complete.
Oncology	**Oncology Emergency Admissions** The National Confidential Enquiry into Patient Outcome and Death (NCEPOD 2008) has recently analysed the care given to patients nationally who received systemic anticancer therapy in June and July 2006 and who died within 30 days of treatment.	**Actions** • Development of an acute oncology steering local group. • Additional non-surgical oncology resources needed. • Additional consultant appointments needed in the Greater Manchester and Cheshire cancer Network. • Implement an acute oncology patient alert system, to allow for known patients to be identified by their treating teams and managed quickly and effectively.

Review of Local Audits in 2011/12

Local Clinical Audits: Actions to improve quality

Speciality	Audit title	Actions and progress
Oncology	**Oncology Emergency Admissions** In only 35% of cases was care judged to have been good by the advisors, with 49% having room for improvement and 8% receiving less than satisfactory care. This audit aimed to bring about a step change in the quality and safety of chemotherapy services for adult patients with either solid cancers or haematological malignancies.	• Triage to be supported by an acute oncology nurse who will work along side existing staff. This will provide expert knowledge and skills without deskilling the existing workforce. • Access to specialist oncology advice off site will be provided by The Christie NHSFT. • Clear pathways and protocols for treatment and where required transfer to a designated hospital will be created and implemented to provide clear guidance. • Re-audit to be conducted within one year.
		Progress Actions complete. Re-audit to take place.
Surgery	**Surgical Business Unit including Women's Services Audit** The Surgical Business Unit have implemented a number ofactions to improve both systems and patient care at both local and trust level.	

Review of Local Audits in 2011/12

Local Clinical Audits: Actions to improve quality

Speciality	Audit title	Actions and progress
Surgery	**Surgical Business Unit (including Women's Services Audit)** **Maternity and Women's Services CNST Standard 1:7 – Maternity Records** The audit outlines the standards for effective record keeping and the process for storage arrangements of maternity hand held records and medical records. The aim and objective is to demonstrate that current practice regarding documentation is in line with unit guidelines and to identify changes to improve practice and disseminate good practice.	**Actions** **No actions were necessary.** The areas of good practice from the audit were that 100% of records had:- • Cardiotocographs filed in the health records. • Anaesthetic and epidural records were filed in the health records. • Fetal blood sampling reports were filed in the health records. • Antenatal screening and ultrasound results were filed in the health records • The health records were all secure. **Progress** No actions were necessary.
Orthopaedic Department	**Orthopaedic Department** The aim was to quantify the readmissions that occurred over the past seven years in a single orthopaedic firm, and to look at each case and define the circumstances surrounding their readmission.	**Actions** • Consultants need to be made aware of readmission on day one. • Discharge summaries to GP to be improved. • More support information for patients, helpful telephone numbers and self help websites.

Review of Local Audits in 2011/12

Local Clinical Audits: Actions to improve quality

Speciality	Audit title	Actions and progress
Orthopaedic Department	**Orthopaedic Department** The objective was to work out ways to reduce overall readmissions, for which we receive no payment, and to ensure safe discharge for all patients.	• Develop management protocol for A&E and Orthopaedic on call. • Set up orthopaedic department/clinic to allow for extra capacity. • Memo to all orthopaedic doctors • regarding changes. There is a potential to reduce readmissions by around 75%, this can be achieved through simple changes to our practice. **Progress** Actions in complete, monitoring nearing completion.

"My brother has just returned home from a short stay at Macclesfield District General Hospital. My family and I can not thank you enough for the care we received. Macclesfield District General Hospital is a credit to the NHS. Thank you to all the wonderful staff in the Egerton Unit."

David Pattison and family Feb 2012

Examples of good practice

Following a review of the trust's local clinical audits a number of audits have been highlighted below as examples of good practice in improving the quality of care and the delivery of trust's services.

Group or forum	Local audits reviewed	Outcomes
CARE Group (Clinical Audit, Research and Effectiveness Group). Monthly meetings.	• Rheumatoid arthritis – drugs for treatment after failure of a TNF inhibitor (NICE) • Psoriatic arthritis – etanercept, infliximib and adalimumab (NICE)	CARE Group acknowledged this audit as an excellent example of good practice, demonstrating compliance with NICE guidelines and High Cost Drugs. A re-audit in 6-12 months was agreed.
Business unit Audit scorecards are reviewed by the CARE Group on a quarterly basis	• Unstable Angina & NSTEACS (NICE) • Rapid Access Chest Pain (NICE)	No actions from CARE Group. The trust is unable to comply with CG95 Rapid Access Chest Pain as no funding is currently available. The CARE Group has requested this to be added to the risk register and the trust to inform its Commissioners.
	• Diabetic Foot Problems (NICE)	CG119 is documented as non compliant, on the Medical Business Unit (MBU) NICE scorecard and is already on the MBU risk register. The level of risk to the trust needs to be evaluated by completion of a risk assessment, as an outcome of the results of the National Diabetes audit.
	Constipation in Children and Young Adults	Compliance status partial, re audit to be carried out October 2011.

Examples of good practice

Group or forum	Local audits reviewed	Outcomes
	• Diarrhoea and Vomiting in Children	Paediatrics to be updated regarding ID number on prescription sheets and to check MMG approval on policy. Re audit to be carried out October 2011.
Business Unit Safety, Quality Standards (SQS) groups	**Medicine Business Unit Audit SQS**	1. RCP Annual case note audit 2. Audit of Adult Crash Trolleys 3. VTE Audit Feedback 4. MINAP Data 5. National Audit of Continence Care
	Community Service Business Unit SQS (CSBU The CSBU have now established their SQS meetings, a section of the agenda has been dedicated to Clinical Audit and a monthly report is produced to inform the group of all audit activity for theirbusiness unit.	Currently no audits have been presented to this group.
	Surgical Business Unit SQS	1. Audit on pharmacy interventions on O/P prescriptions forms • Consent to Treatment Audit Report • Record Keeping Audit (NHSLA and RCP Standards)
	Maternity and Women's Services	A monthly CNST progress report is submitted to the Clinical Governance meeting, as action plans are completed they are signed off by the Clinical Director or Associate Director.

Examples of good practice

Group or forum	Local audits reviewed	Outcomes
Business Unit Safety, Quality Standards (SQS) groups	**Maternity and Women's Services**	The following is an example of the audit reports that have been discussed and approved: • Care of women in labour • Intermittent Auscultation • Skills Drills • CMACE Obesity • NPSA audit of injectable medicine administration 10.05.11 • Audit of adult crash trolleys 06.09.11 • DNAR audit report 06.09.11
	Outpatient and Clinical Support Business Unit	• NPSA audit of injectable medicine administration 10.05.11 • Audit of adult crash trolleys 06.09.11 • DNAR audit report 06.09.11
Departmental Audit meetings	**Medicine Business Unit monthly audit meetings** • Rolling programme with the intention to present and discuss all audit projects. Up to three presentations per meeting. • Dementia • CT guided biopsy for Lung Cancer • Secondary Osteoporosis Management according to NICE guidance	Actions, where appropriate, are detailed in individual meeting minutes, which are available if required.

Examples of good practice

Group or forum	Local audits reviewed	Outcomes
Business Unit Safety, Quality Standards (SQS) groups	**Outpatient and Clinical Support Business Unit**	• NPSA audit of injectable medicine administration 10.05.11 • Audit of adult crash trolleys 06.09.11 • DNAR audit report 06.09.11
Departmental Audit meetings	**Medicine Business Unit monthly audit meetings**	Actions, where appropriate, are detailed in individual meeting minutes, which are available if required.
	Maternity and Women's Services monthly audit meetings Rolling programme, with a process in place to ensure that all audits have been presented and reviewed by endof fiscal year. 1. Care of women in labour 2. Continuous electronic fetal monitoring 3. Neonatal Jaundice (NICE)	Actions, where appropriate, are detailed in individual meeting minutes, which are available if required.
	Surgical Business Unit monthly audit meetings Audit examples being discussed Up to two presentations per meeting. 1. Morbidity and Mortality 2. Emergency surgical procedures 3. Surgical site infection	Actions where appropriate, are detailed in individual meeting minutes, which are available if required.

Examples of good practice

Group or forum	Local audits reviewed	Outcomes
Departmental Audit meetings	**Outpatient and Clinical Support Business Unit audit meetings** • Rolling programme with the intention to present and discuss all audit projects. Up to 3 presentations per meeting. • The following is an example of the audits presented and discussed: • Scalp Cooling Audit • Nurse Dysphagia Screen Audit • Audit of Pharmacy Interventions on O/P Prescription forms.	Actions, where appropriate, are detailed in individual meeting minutes, which are available if required.
	Community Service Business Unit Following integration, work has been carried out to develop clinical audit leads, the leads have now been established and work is in progress to develop a rolling programme for Planned Care, Acute Community Service and Children and Families. The following is an example of the audits presented and discussed: • COPD Pathway • Food Allergy in Children and Young People • Down Syndrome Care Pathway Re-audit	Actions, where appropriate, are detailed in individual meeting minutes, which are available if required.

Examples of good practice

Group or forum	National audits reviewed	Outcomes
CARE Group (Clinical Audit Research and EffectivenessGroup) monthly meetings.	**National Lung Cancer Audit 2010 reviewed 14.11.11**	The 2010 national report on 2009 data was presented at CARE Group and showed how East Cheshire favourably stand compared to other trusts and the processes that are in place to improve our performance for the forthcoming year.
National Audit scorecard reviewed by this group on a monthly basis and business unit audit scorecards reviewed by this group on a quarterly basis.	**National Diabetes Inpatient Audit 2010 reviewed 08.08.11**	The 2010 report was presented at CARE Group. The group agreed that as an outcome of the results of the National Diabetes Audit, the level of risk to the trust needs to be evaluated by completion of a risk assessment and, if appropriate, elevated as a corporate risk.
	Dementia – National Audit on Dementia National Dementia Strategy reviewed 11.04.11	Primary Care Trust confirmed CQUIN monies attached to dementia governance facilitator to support consultant in elderly care to complete an action plan to include training and care pathway to secure this funding. A re-audit in 12 months was agreed. Governance facilitator to work with consultant in elderly care.

Participation in clinical research

Participation in clinical research demonstrates the trust's commitment to improving the quality of care offered and making a contribution to wider health improvement.

Our clinical staff stay abreast of the latest treatment possibilities and active participation in research leads to successful patient outcomes.

The number of patients receiving NHS services provided or sub-contracted by East Cheshire NHS Trust in 2011 that were recruited during that period to participate in research approved by a research ethics committee was 623.

This figure refers to patients recruited into National Institute of Health Research (NIHR) approved studies. We also recruited staff and patients into other research studies, including clinical trials conducted with external companies.

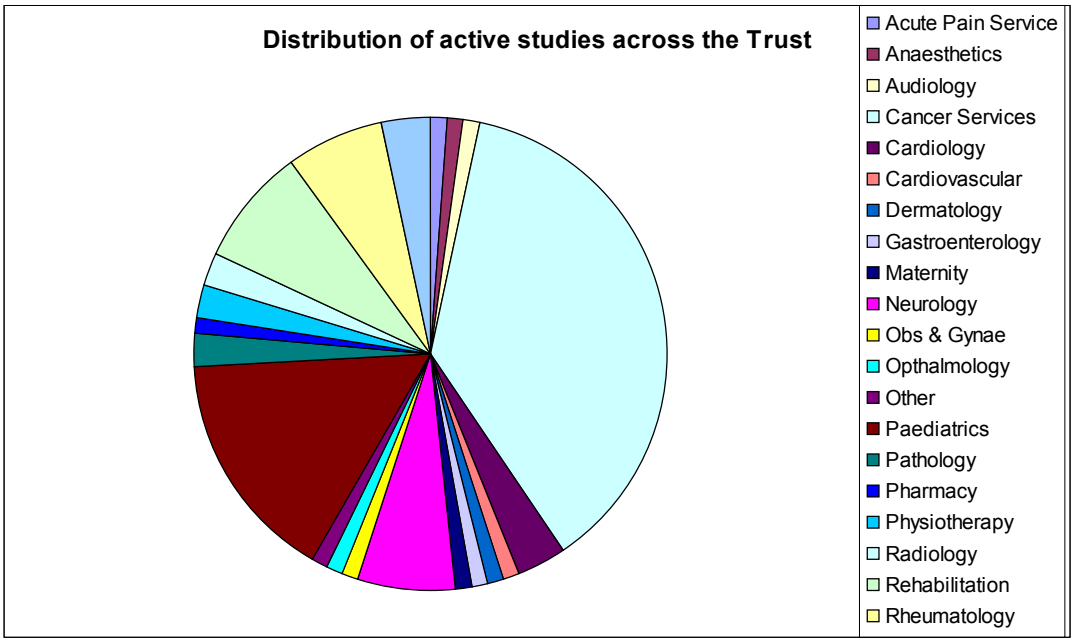
The trust is currently involved in 89 active clinical research studies covering 20 medical specialties which are as follows:

Areas of clinical research	
Acute Pain Service	Anaesthetics
Audiology	Cancer Services
Cardiology	Cardiovascular
Dermatology	Gastroenterology
Maternity	Neurology
Obstetrics and Gynecology	Ophthalmology
Paediatrics	Pathology
Pharmacy	Physiotherapy
Radiology	Rehabilitation
Rheumatology	Trust wide

"An excellent service from the diabetic nurse. This is the first time I have felt that I have understood my illness and the forms of treatment and my lifestyle changes that are required." (Diabetes Specialist Nursing Service)

Anonymous Patient Satisfaction Survey March 2011

Participation in clinical research



As can be seen in the chart above Cancer Services make up the largest part of our portfolio which mirrors the situation nationally. The Cancer Unit runs a number of trials across a range of disease groups including lung and skin cancer trials.

In Paediatrics a number of studies have opened including the first paediatric diabetes study. Recruitment in paediatrics in 2011 was 60 compared to 47 in 2010.

The Stroke Team have a number of studies open which are recruiting well. Two of the larger recruiting studies SOS and MAESTRO will be closing soon so the team are working with the Stroke Research Network Team to find new studies.

"I have nothing but praise for the cancer treatment and care I received at Macclesfield Hospital. I was always treated with kindness, patience, understanding by everyone. Everyone was always cheerful and professional, sensitive and good humoured too." (Cancer Research Team)

Cancer Research Patient Survey Jan 2012

Written Statements from other bodies

Commentary from NHS Eastern Cheshire Clinical Commissioning Group (ECCCG)

NHS Eastern Cheshire Clinical Commissioning Group (ECCCG), as part of NHS Cheshire, Warrington and Wirral, has reviewed this Quality Account and believe it is an accurate and comprehensive reflection of the trust position concerning the quality of services provided during 2011-12.

ECCCG is the commissioner primarily responsible for commissioning services from East Cheshire Trust and uses monthly performance reports in order to assess levels of quality compliance or areas of concern. It is through these arrangements that the accuracy of this Quality Account has been validated.

The trust has had a challenging first year of as a joint provider of both community and acute services. During 2011/12 the trust has worked closely with ECCCG and the trusts data quality has improved. They continued to improve their performance in areas of safety and patient experience and we look forward to seeing further improvements from the influence of the trusts new Quality Strategy. ECCCG was pleased to see the trust prompt response to their Care Quality Commission visit in September 2011 when they had two outcomes 'not fully met'. The trust responded effectively and both of these outcome measures were reassessed as compliant by the CQC follow up visit in February 2012.

Unfortunately the trust has had three Never Events during 2011/12 and we are hoping next year this remains at zero. The trust has developed an effective governance structure for the monitoring and reporting of care, we would have liked to have seen evidence in this Quality Account of the reporting to Trust Board about this review of the quality of services delivered. We are pleased to see the continuing achievement by the trust against the MRSA target and C Diff target for both the acute and community services.

The trust has performed well against the goals set in the Commissioning for Quality and Innovation Schemes (CQUIN) for both acute and community services. The trust achieved the Venous Thromboembolism risk assessment target of 90% in quarter 4 and for 2012/13 have a target to achieve 90% for both quarter 3 and 4. We would encourage the trust to stretch their internal target for this in the coming 12 months.

The trust is to be congratulated in their improvement in the delivery of the quality of care for patients who have had a stroke. The delivery of same sex accommodation was a challenge for the trust, at the beginning of the year, but excellent progress has been made in improving compliance through the year.

The trust had a challenge to achieve and maintain delivery of the 18 week referral to treatment target and they should be congratulated in the achievement of this target for the last 5 months of 2011/12.

Written Statements from other bodies

Similarly the trust has found achievement of 6 week diagnostics targets as challenging and this will require focus in the coming year.

The 4 hour Accident and Emergency Target for the year was achieved by the trust but they failed quarter four. They have been working with the CCG and the local GP practices to manage the pressures on Accident and Emergency.

ECCCG will continue to seek further assurance from the trust regarding areas which need work to enable compliance to NICE guidelines as stated in this document.

Clinical Audit/Research, participation in national audit and their own audit programme is commendable and is reassuring to see the trusts willingness to undertake Clinical Audit and re audit as it is very time consuming and we appreciate the high level of involvement.

ECCCG is pleased to see the trusts new Quality Strategy is focusing on areas that the ECCCG have prioritised in particular in reducing falls and pressure ulcers, and reducing the number of patients who have their dates of admission for surgery cancelled. We support the priorities that the trust has identified for the forthcoming year and look forward to continuing to work in partnership with the Trust to assure the quality of services commissioned in 2012-2013.

Commentary from Health and Wellbeing Scrutiny Overview and Scrutiny Committee (OSC)

Note: these comments are based on the first consultation draft which was submitted to the committee on 3 April 2012; it is understood that the comments below have been incorporated into the final version of the Quality Account

Cheshire East Council

The committee welcomes the opportunity to comment on the Quality Account and has the following comments:

The trust is commended in achieving or being on track to achieve its targets in relation to:

- reducing the number of injurious falls per thousand bed days;
- protecting patients within the trust's care from hospital acquired infection;

Written Statements from other bodies

- maintaining or reducing the Hospital Standardised Mortality Ratio (HSMR);
- reducing hospital acquired venous thromboembolism (VTE);
- improving the quality of care for stroke patients;
- reducing the average length of stay for patients who are medically fit for discharge;
- delivery of same sex accommodation through the provision of same
- sex designated bays and bathing facilities in all inpatient areas;
- complaints are acknowledged and responded to in agreed timescales;
- an increase in the number of clinical staff trained in basic dementia care awareness.

In particular, the committee notes and commends:

- the work done to deliver same sex accommodation in the day surgery and endoscopy unit through the
- introduction of all female and all male lists;
- the work carried out around falls reduction including the introduction of “comfort rounding” ie regular
- checks on in-patient’s needs;
- the reduction in cases of hospital acquired infection including there being no cases of MRSA occurring in April – November 2011, and only one case in each of December, January and February – the committee suggests that this success is highlighted and publicised to address any misconceptions around infection rates;

The committee suggests the following:

- in relation to the improvements in stroke care quality, the committee suggests that more evidence is included in the Quality Account to demonstrate these improvements;

- in relation to the Safety Thermometer, which the committee understands is a monthly assessment on each patient (either an in-patient or a patient in the community) – whereby the patient is assessed in relation to risk of harm or incident from falls, catheter use, pressure ulcer or deep vein clot (in patient only) – the Committee suggests that a fuller explanation is included in the Quality Account;

- in relation to page 42 onwards that covers the trust’s involvement in audits in 2011/12, the committee suggests that the final column listing “conclusions and actions to be taken” is amended to ensure information is listed consistently;

- in relation to page 49 that refers to the Oncology Audit, the committee is concerned that the National Confidential Enquiry judged care to be “good” in only 35% of cases. The committee hopes the recent appointment of an Acute Oncology Nurse and other actions outlined at the meeting will address this low rate and suggests that further information on the action taken to address this low rate is included in the account. In addition, it is noted that a re-audit is to be conducted within one year which is hoped will demonstrate a greater number of judgements of care as “good”;

Written Statements from other bodies

- the committee notes that the target to reduce the number of cancelled operations has not been met and numbers of cancelled operations has risen over recent months – the committee notes action taken to address this and hopes the target to reduce this in line with national benchmarks of 2% or under is achieved during the forthcoming year;

- the committee supports the introduction of a Patient Experience Group which is hoped will improved communication with both patients and carers;

- the committee commends the trust for achieving the target of reducing the average length of stay for patients who are medically fit for discharge, but suggests that readmission rates should be included to give a fuller picture.

Commentary from Cheshire East LINk

Thank you for the opportunity to comment upon the trust's Quality Account for 2011/12.

This is an easily readable document. We note the consultation process undertaken with the Patient Reference Group to ensure that the priorities of patients and relatives are addressed and included in the new Clinical Strategy. This we commend.

Cheshire East LINk welcomes the statement that, as an integrated trust, the trust aims to provide as much care within the community setting as possible.

The NHS Safety Thermometer

We note and approve the introduction and explanation of the National Safety Thermometer which will be used to monitor four specific patient harms:

- Falls
- Pressure ulcers
- Catheter associated urinary tract infections (in community and hospital)
- Venous thromboembolism (in hospital)

We welcome the clearly laid out and easily understood Review of 2011-12 priorities. In particular we note the continued improvement in the reduction of hospital acquired infections, both within hospital and in the community, and congratulate the Trust upon achieving the national targets in both MRSA Bacteraemias and Clostridium Difficile.

Written Statements from other bodies

We note also the compliance with same sex accommodation and the reduction of, the already below average, Risk Adjusted Mortality Rates. We congratulate the trust on these achievements.

Cheshire East LINk is pleased to note that the trust has secured registration from the CQC to provide integrated primary and secondary care without conditions. We are also pleased to note that, following an unannounced visit from the CQC in February 2012, the trust was found to be fully compliant in all standards of patient care.

Audits and clinical research

We note the audits and clinical research in which the Trust has participated during the reported period. In particular we note the local audits undertaken which ensure and improve patient care.

Commentary from Cheshire West and Chester LINk

CWaC LINk value the opportunity to comment and are pleased to note the improvements made by the trust during the last twelve months. They found the report thorough and easy to read.

Acknowledgements

- **Director of Nursing, Performance and Quality**
- **Associate Director of Nursing, Performance and Quality**
- **Director of Corporate Affairs and Governance**
- **Associate Director of Corporate Affairs and Governance**
- **Head of Integrated Governance**
- **Clinical Audit Department**
- **Head of Professional Practice**
- **Marketing and Communications Officer**

Glossary

Term	Explanation
ANTT	Aseptic Non - Touch Technique
BTS	British Thoracic Society
CARE	Clinical Audit Research and Effective
CEMACH	Confidential Enquiries into Maternal and Child Health
CEM	College of Emergency Medicine
CDiff	Clostridium Difficile
CQC	Care Quality Commission
CNST	Clinical Negligence Scheme for Trusts
COPD	Chronic obstructive pulmonary disease
CQUIN	Comissioning for Quality And Innovation
CSBU	Community Services Business Unit
CSLN	Cumbria and Lancashire Stroke Network
CXR	Chest XRay
DNAR	Do Not Attempt Resuscitation
HSMR	Hospital Standardised Mortality Ratio
ICNARC	Intensive Care National Audit And Research Centre
MBU	Medical Business Unit
MDGH	Macclesfield District General Hospital
MRSA	Methicillin-resistant Staphylococcus aureus
MINAP	Myocardial Ischaemia National Audit Project
NRAS	National Rheumatoid Arthritis Society
NHSLA	NHS Litigation Authority
NICE	National Institute of Clinical Excellence
NIHR	National Institue of Health Research
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NNAP	National Neonatal Audit Programme
NPSA	National Patient Safety Agency
PAS	Patient Administration System
PROMS	Patient Reported Outcome Measures
RCP	Royal College of Physicians
RA	Rheumatoid arthritis
RAMI	Risk Adjusted Mortality Index
SBAR	Situation Background Assessment Recommendation
SINAP	Stroke Improvement National Audit Progr\mme
SQS	Safety, Quality Standards
TARN	Trauma Audit and Research Networks
VTE	Venous Thromboembolism
VSGBI	Vascular Society of Great Britain and Ireland

Copies of this report, including different formats, are available from the Communications and Engagement Department.
Telephone: 01625 661184

It is also available online at www.eastcheshire.nhs.uk

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