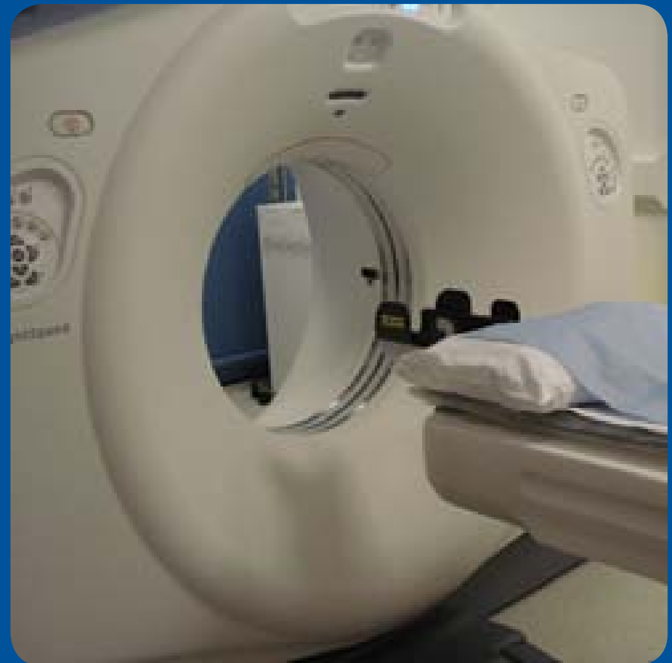
East Cheshire NHS
NHS Trust



Quality Account 2010/11

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Foreword

One of the most important roles of the board is to ensure that we harness all the energy, passion, commitment and creative ideas from our workforce, staff and volunteers alike, to provide really effective patient care in an environment that contributes to the patients wellbeing.

That means engendering an open culture where we are clear about the challenges we face and remain determined to face them together. We celebrate success and remain confident that people feel able to discuss events so we can learn and improve from them. To make this a reality, everyone has to take responsibility for their part in delivering our plans.

By aiming to place the trust in the top quartile for quality of care, we have seen significant improvements as evidenced in the report that follows and I am especially delighted that the trust was recently recognised as one of the top 40 hospitals in the country by CHKS and our maternity services were judged to be amongst the best in the country on a number of occasions

The trust delivers its services as part of a much wider health care system and we recognise the genuine support provided by our partners.

Thank you to everyone who has contributed to these achievements and for their on going commitment to quality of care.

> "Thank you to everyone who has contributed to these achievements and for their ongoing commitment to quality of care."

Lynn McGill
Chairman

Trust awards 2010/11

The trust is proud to have won a number of awards during 2010/11, including the following:

Cheshire East Local Safeguarding Children's Board Award for outstanding contribution in the community

CHKS 40 Top Hospitals for 2011 Award

British Journal of Midwifery 2011 - 'Excellence in Supervision Award'

North West Respiratory Best Practice Awards 2011 - Best practice in integrated care

International Journal of Palliative Nursing Awards 2011 - 'Best Multidisciplinary Care Team of the year'

International Journal of Palliative Nursing

British Journal of Midwifery Practice Awards 2010 - Midwife of the Year Award

Statement from Chief Executive

"East Cheshire NHS Trust became an integrated trust from April 2011 and this provides enormous potential for us to work with partners to reduce duplication and reduce waste that has no added value for patients. We intend to start delivering the benefits immediately, redesigning care pathways and improving the patient experience alongside improving the productivity of the services we deliver. Clinical redesign will be a major strand of the transformation of our current services. We will seek to use information technology and review our estate infrastructure to ensure we derive maximum benefit for our users and our staff. This year we have included the Quality Account for Cheshire East Community Health, see page 45.

Last year we set out a deliberate plan to proactively engage staff in improving services for patients. We engaged staff and partners in working together to overcome barriers to improvement, and the benefits of this are reflected in our achievements throughout the report. Our aim is to align our culture with patient safety and quality.

We have achieved and exceeded many of our key priorities last year and will continue to build on these successes. We have continued to improve our environment with a new renal unit and structural refurbishment of the Endoscopy Unit. We have invested in our clinical technology with the installation of a new CT scanner and digital breast mammography unit. We believe it is important to be open and transparent with our patients and public.

Last year we recognised that we needed to improve our level of incident reporting and we took positive steps to raise awareness and ensure that incidents and 'near miss' events are appropriately reported. As a result our level of reporting has improved from being one of the lowest in the cluster of comparable trusts to very close to upper quartile. This supports improved investigation and learning.

The first year of the integrated trust will build on the previous success of both Cheshire East Community Health and East Cheshire NHS Trust. We wish to involve and enable staff to define the mission, vision and values of the new organisation which have been proposed by both boards:

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

During this year we will be preparing for Foundation Trust status and aim to achieve this by working with clinical leaders to clarify our service strategy. This will involve further development of our partnerships with General Practitioners and other acute hospitals. We intend to deliver clinically viable high quality services from a sustainable financial base.

> "We have achieved and exceeded many of our key priorities last year and will continue to build on these successes to further improve standards of care"

Our organisation is committed to improving quality and delivering safe, effective and personal care. We will further strengthen professional leadership, empowering senior nurses, midwives and allied health professionals to lead and deliver quality improvements. The lead nurses in wards, departments and within the community, will lead quality improvements with support from specialty clinicians and a dedicated team of clinical matrons. Delivery of evidence based interventions will continue to be a priority and we expect patients to receive treatment in the most appropriate place for their care needs. Monitoring of 'real time' patient experience will be fundamental in assessing the quality of our services. We hope our quality account reflects the high level of achievement we have already had in relation to quality and safety, and a clear commitment to further develop and improve care standards for our patients.

The trust has a positive approach towards quality and has this year been endorsed as one of the top 40 best performing hospitals in England by CHKS, the UK's leading provider of healthcare intelligence and quality improvement services. "

> "Care and Compassion are what matter most..." NHS Constitution

Statement of Directors Responsibilities in Respect of Quality Accounts

The directors are required under the Health Act 2009, National Health Service (Quality Accounts) Regulations 2010 and National Health Service (Quality Account) Amendment Regulation 2011 to prepare Quality Accounts for each financial year.

The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporate the above legal requirements).

In preparing the Quality Account, 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, is subject to appropriate scrutiny and review; and the Quality Account has been prepared in accordance with Department of Health guidance;

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

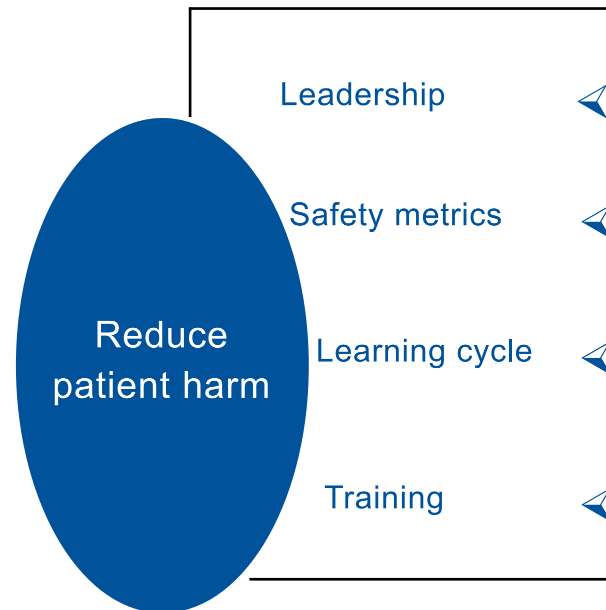
John Wilbraham
Chief Executive
April 2011

Quality Improvement

Our aim is to ensure safe, effective and personal care for all our patients.

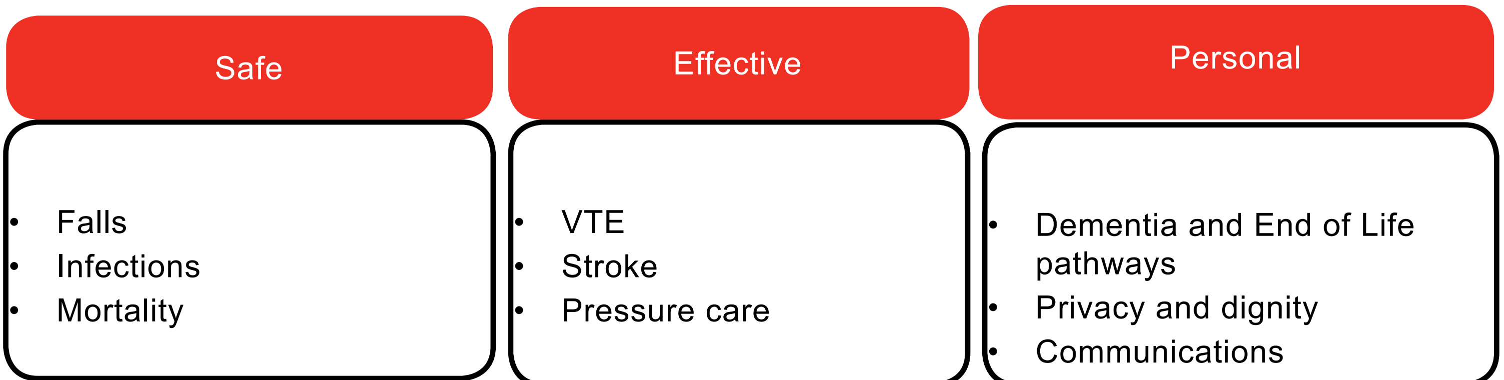
Safety

Time period	Deaths	Expected	Relative risk*
Oct 09 - Sept 10	645	695.3	92.8
Nov 09 - Oct 10	649	701.5	92.5
Dec 09 - Nov 10	668	704.6	94.8

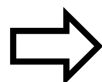


*The average rate for people dying is expressed as 100. The trust scored 92.7, which is below the 'expected' death rate. The rate is termed 'relative risk'.

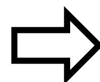
Quality Improvement Priorities



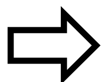
Patient Experience



Listen



Learn



Strategy

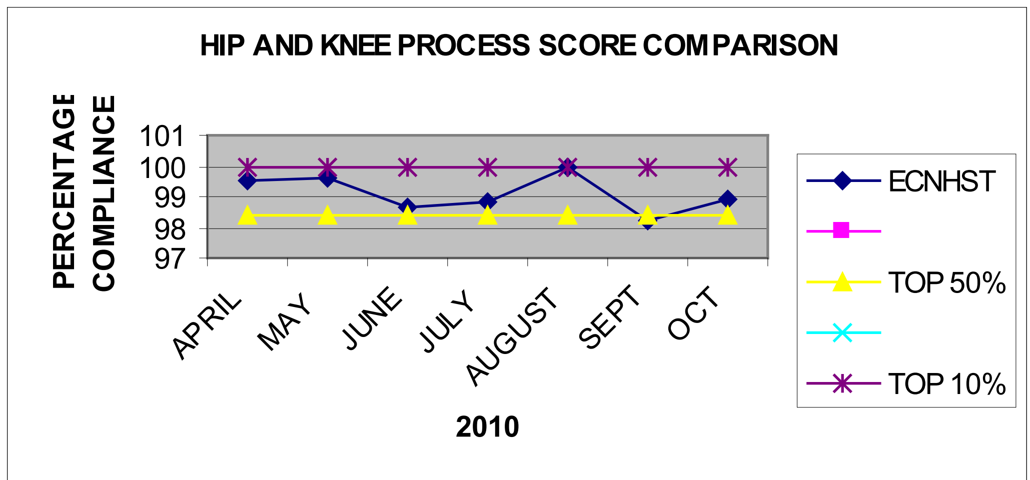
- Effective ward teams
- Clinical engagement

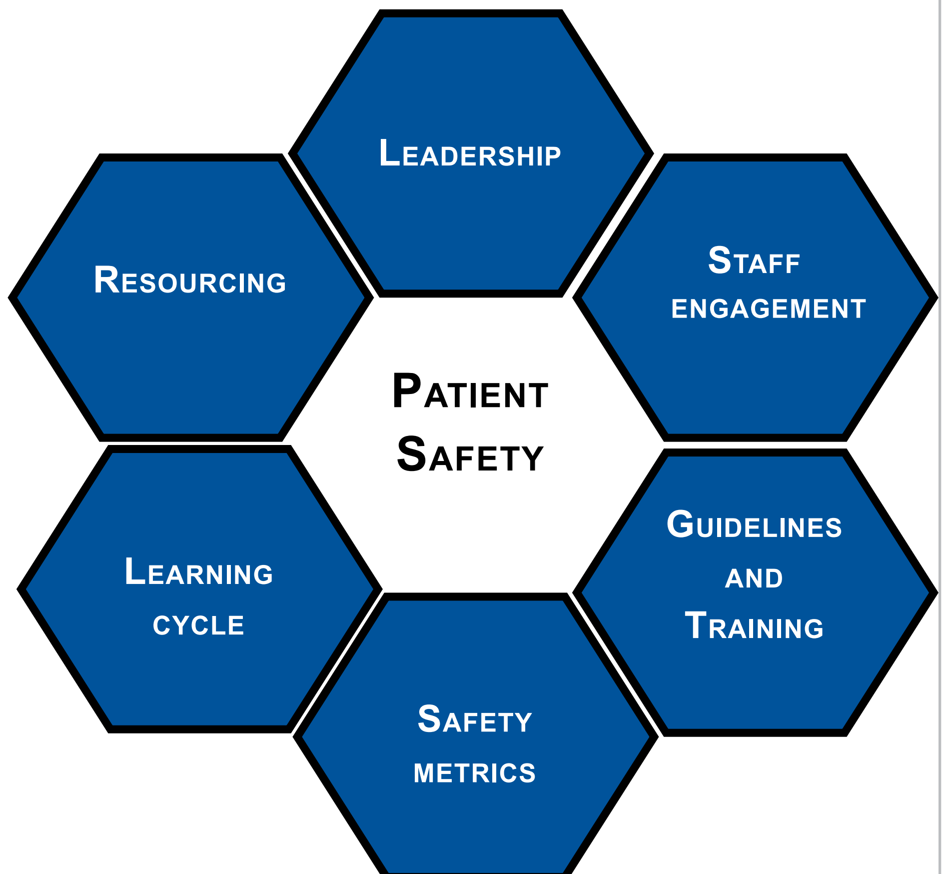
- Ward to board
- Quality dashboard

- Benchmark improvements
- Root cause analysis

- Culture and continuous improvement
- Organisational and delopment plan

Effectiveness





Improve

Priorities for improvements - looking forward to 2011/12

Description of areas for improvement in the next 12 months and why these have been chosen

Following another successful year for the trust in 2010/11 we want to further improve the quality of the services we provide across the three key areas of safety, clinical effectiveness and the personal experience of our patients, carers and visitors.

Priorities have been selected by engaging with our staff, patients, user groups, and other stakeholders. Feedback from patient surveys, complaints and incidents have also been considered to ensure that we are focussing on the right areas for improvement.

We have also considered the views of commissioners. The Commissioning for Quality and Innovation (CQUIN) payment framework enables commissioners to reward excellence, by linking a proportion of healthcare providers' income to the achievement of local quality improvement goals. The trust has agreed seven indicators with commissioners for 2011/12 for acute and community services. These carry a financial incentive of 1.5% (£2.25m) of the value of acute and community contracts to improve standards in the following areas:

- Prevention of Venous Thromboembolism (VTE).
- Responsiveness to personal needs of patients.
- Care of dementia patients in hospital and the community.
- Improving choice for patients on end of life pathways.
- Enabling provision of services out of hospital by more effective collaboration between clinicians in acute and primary care.
- Improved and timely discharge information for GPs.
- Further development of patient passports for long term conditions.

Through our engagement with patients, the public and other partners we know the areas **highlighted** are also their priorities for future improvement.

Our top prorities (including CQUINN)

Priority	Quality indicator	How we will achieve	Quality domain
Reduce patient harm in hospital **SAFE**	1. To reduce the number of falls per 1000 bed days from 2010/11 baseline of 2.45.	See future improvements page 11	Safety
	2. To reduce the incidents of health care acquired MRSA, *Clostridium Difficile* and infections: MRSA bactaremia to less than 2 for hospital setting and less than 10 for community; *Clostridium Difficile* to less than 33 for the hospital and 104 for the community.	See future Improvements page 11	Safety
	3. To maintain or reduce Hospital Standardised Mortality Ratio (HSMR) from 2010/11 baseline of 92.7	See effectiveness section page 10	Safety
Provide evidence based care **EFFECTIVE**	4.To ensure 90% of eligible patients receive Venous Thromboembolism (VTE) assessment on admission to hospital.	See future Improvements page 11	Effectiveness
	5. To increase the percentage of patients with stroke for whom all ten stroke indicators are met from the 2010/11 baseline of 93%.	See effectiveness section page 10	Effectiveness

	6. To reduce the prevalence of all pressure ulcers by 10% from 2010/11 baseline of 291 in hospital and 330 in the community.	See effectiveness section page 10	Effectiveness
To provide positive patient experience **PERSONAL**	7. To reduce the number of all cancelled operations as a percentage of the total number of planned admissions which was 10.7% in 2010/11.	See experience section page 11	Experience
	8. To reduce the length of stay for patients who are medically fit for discharge or transfer of care, which during 2010/11 was 4.4%.	See experience section page 11	Experience
	9. To ensure we are compliant with same sex accommodation regulations.	See experience section page 11 and future improvements on page 11	Experience
	10. To reduce the number of complaints relating to poor communication.	See experience section page 11	Experience
	11. To increase the number of patients at end of life who are on a care of the dying pathway.	See experience section page 11	Experience
	12. To increase the number of staff trained in dementia care to 70%	See experience section page 11	Experience

How progress to achieve priorities identified will be monitored

Patient safety

In terms of patient safety, the trust is committed this year to reducing the number of falls, hospital and community acquired infections and pressure ulcers. Patient falls are the highest reported incidents in the trust and we have set a challenging target reduction for falls that result in patient harm. In 2011/12 'Hourly rounding' will be used for all patients to improve their care. This is currently being introduced on two acute wards. All patients identified as medium or high risk via the 'Falls Risk Assessment' must be checked against the 'Four P's' and have the results of this interaction recorded.

The Four Ps:

1. Pain

"How is your pain?"

2. Possessions

Move call bell, tissues, glasses etc within reach.

Arrange bedside table.

Ensure water is available.

3. Patient needs

"Do you need to use the bathroom?"

4. Position

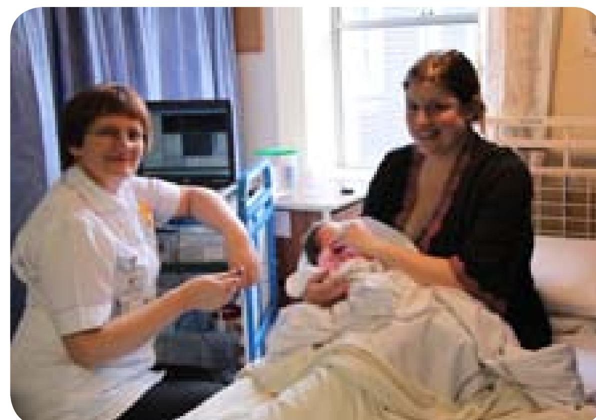
"Are you comfortable?"

Role of the matron

The role of the matron will become more clinically focussed, with all hospital matrons working three days a week within clinical areas.

All NHS organisations are encouraged to improve the reporting of patient safety incidents. Incident reporting is seen as a positive indicator of a mature and learning organisation. We have had an emphasis on improving incident reporting in the last year. In 2011/12, the trust will introduce web-based incident reporting across the organisation. This will ensure that every opportunity is given to learn from things which go wrong with the aim of reducing the risk of a similar incident in the future.

The trust will measure its success in 2011/12 by tracking its incident reporting performance to the National Patient Safety Agency (NPSA) and reporting progress at the Trust Board's Safety Quality and Standards Committee.



Effectiveness

In relation to clinical effectiveness, we are committed to ensuring evidence based care. We will ensure a robust and sustainable system is in place for the assessment and management of Venous thrombo-embolism (VTE).

Assessment tools for all specialties have been developed. The level of compliance with completing the tools is less than 90% and therefore remains a quality improvement for 2011/12.

The Hospital Standardised Mortality Ratios (HSMR) are used to calculate the numbers of deaths that would be expected in a particular hospital. The calculated "expected" number of deaths is based on the national death rates for each age group, sex, admission source admission type, length of stay and diagnostic group. The sum of the expected deaths gives the total expected deaths for that hospital. The Hospital Standardised Mortality Ratio is the ratio of "actual deaths" to "expected deaths". The national average is 100. We are at 92.7, which is good. Our aim is to maintain or reduce HSMR from 20010/11 baseline. This will be achieved by continuing to work with business units to review clinical effectiveness practice, through an agreed framework.

An increase in the percentage of patients with stroke for whom all 10 stroke indicators are met from 2010/11 baseline will be achieved by increasing the number of patients admitted directly to the Stroke Unit and by ensuring that 90% of the patient stay is on the Stroke Unit.

A reduction in the prevalence of pressure ulcers from the 2010/11 baseline, which was 291 by 10%, this will be achieved through focussing on prevention using the 4 Ps Model. We are introducing a 'zero tolerance' for pressure ulcers. Any pressure ulcer is investigated by undertaking a root cause analysis which enables learning to take place and to be shared across the trust.

Patient experience

We recognise that short notice cancellations impact on patient experience and we aim to improve performance in this area. We aim to reduce the number of cancelled operations as a percentage of the total number of elective admissions.

This will be achieved by applying good practice across theatre management to ensure best use of capacity and management of emergency care demand. We will monitor delays in the transfer of care of cancelled operations and the number of staff trained in dementia care. In addition we will audit end of life care to support patients dying in their preferred place of care. We are committed to ensuring the pathway of care is as efficient and patient focussed as possible. We will therefore also reduce length of stay for patients who are medically fit for discharge or transfer of care from 2010/11 baseline. To achieve this we will develop community services to support a reduction in emergency re - admissions and facilitate appropriate and timely discharges to the community.

We have undertaken significant estates work to support our commitment to eliminate mixed sex bathroom and sleeping accommodation by the end of March 2011. All ward areas have separate male and female bays with allocated bathroom facilities. The Day Case and Endoscopy Units will become same sex accommodation from April 2011. The majority of breaches occur in these two treatment areas and the trust will therefore be compliant. Increased staff awareness on the importance of maintaining privacy and dignity continues to be important to us and we have included this in our annual statutory and mandatory training programme.

Improving communications will be achieved by:

- Working with clinical teams, to implement a consistent system for safe handover.
- Providing further customer care training with the aim of resolving concerns at service level.

Developing capacity and capability

The trust is committed to developing a culture of continuous improvement in patient safety.

Introducing a development programme for management and clinical leadership will build leadership capacity to confidently and competently drive innovation and change. We will ensure staff have access to senior managers through initiatives such as Safety Rounds, regular Chief Executive and Executive Director visits to clinical areas. In addition, we are strengthening arrangements for education, learning and development so that staff can access the support they need when they need it to maintain their skills and continually develop. We will build on the success of the 'Your Voice' initiative of last year to continue to develop improvement capability in all our staff and ensuring that:

- 80% of all staff have an annual appraisal.
- 90% of all new staff have an induction.
- 90% of all staff to have undertake statutory and mandatory training annually.
- Sickness absence rates of less than 4.25% overall. We are currently reviewing our quality dashboard which will enhance our ability to improve quality. This will support the development of 'ward to board reporting'* which will include key quality improvement metrics for:
- Falls assessment
- Pressure area care
- Privacy and dignity
- Infection prevention, control and cleanliness
- Pain management and nutritional needs assessment
- Medicine prescribing and administration

* Ward to board reporting ensures that quality issues at ward level are reported to Trust Board.

We can confirm that our organisation is:

- Performing to essential standards, such as securing Care Quality Commission registration.
- Measuring our clinical processes and performance, for example through participation in national audits.
- Involved in national projects and initiatives aimed at improving quality eg recruitment to clinical trials

A proportion of East Cheshire NHS Trust's income in 2010/11 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 20010/11 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 2010/11 of NHS services. The income generated by the NHS services reviewed in 2010/11 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 trust is benchmarked by the Audit Commission as part of Advancing Quality Audit and has not been highlighted as an outlier.

East Cheshire NHS Trust has not participated in any special reviews or investigations by the Care Quality Commission (CQC) during the reporting period.

Data Quality

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 and we are able 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 consistently better than the national average.

For 2010/11, the average completeness for all data fields is:

- Admitted Patient Care (APC) data set is 99.9% (compared to the national 98.0%).
- Outpatient data set the trust score is 99.5% (compared to 93.2% nationally).
- A&E data set the score is 89.0% (compared to 87.8%).

East Cheshire NHS Trust submitted records during 2010/11 to the Secondary User Service (SUS) for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data. The percentage of records in the published data which included the patients' valid NHS number was:

- 99.1% for admitted care (nationally 98.4%).
- 99.7% for outpatient care (nationally 98.8%).
- 97.6% for accident and emergency care (nationally 91.6%).

The percentage of records in the published data which included the patients' General Medical Practice was:

- 100% of admitted care (99.8% nationally)
- 100% for outpatient care (99.8% nationally)
- 100% for accident and emergency care (99.7% nationally)

Clinical coding translates the medical terminology written by clinicians to describe the patients' diagnosis and treatment into standard, recognised codes. The accuracy of this coding is a fundamental indicator of the accuracy of the patient records. With regard to the clinical coding error rate, East Cheshire NHS Trust was identified by the Audit Commission as not requiring a Payment by Results Clinical Coding Audit during 2010/2011. This was based on reported information from the 2009/2010 audit which stated:

"The trust is performing well compared to the overall performance of trusts in 2008/09. The Trust HRG error rate has reduced compared to the previous audits and it is implementing the recommendations from our 2008/09 review, indicating a commitment to improving performance. This year the Trust's HRG error rate is 5.7 percent. The national average in 2008/09 was 8.1 per cent and The Strategic Health Authority (SHA) average error rate in 2008/09 was 8.0 per cent". "The coding arrangements are generally good, which is leading to improvements in coding accuracy. The trust has well structured and legible case notes, supplemented with electronic systems, such as histopathology, microbiology, radiology. Coding is carried out using the full patient case note, which supports accurate coding by allowing access to all relevant information. Internal audits have been implemented, and there is clinical engagement in the coding process". The most recent audit (February 2011) highlighted that the general standard of clinical coding at the trust was good. 92.5% of primary diagnoses audited and 94.5% of the primary procedures were correctly recorded. The results met the Information Governance toolkit requirement 505 at level 2. As of 31 March 2011 we are level 2 for 20 of the 22 key requirements relating to information governance. We have an action plan in place and will be level 2 against all key requirements by June 2011.

Review of 2010/11 priorities

< Behind schedule = On track to achieve ✓ target achieved

Safe

VTE Prevention Programme

What: To prevent venous thromboembolism (VTE) in adult patients in hospital.

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

By when: March 2011

Outcome: 80% at March 2011

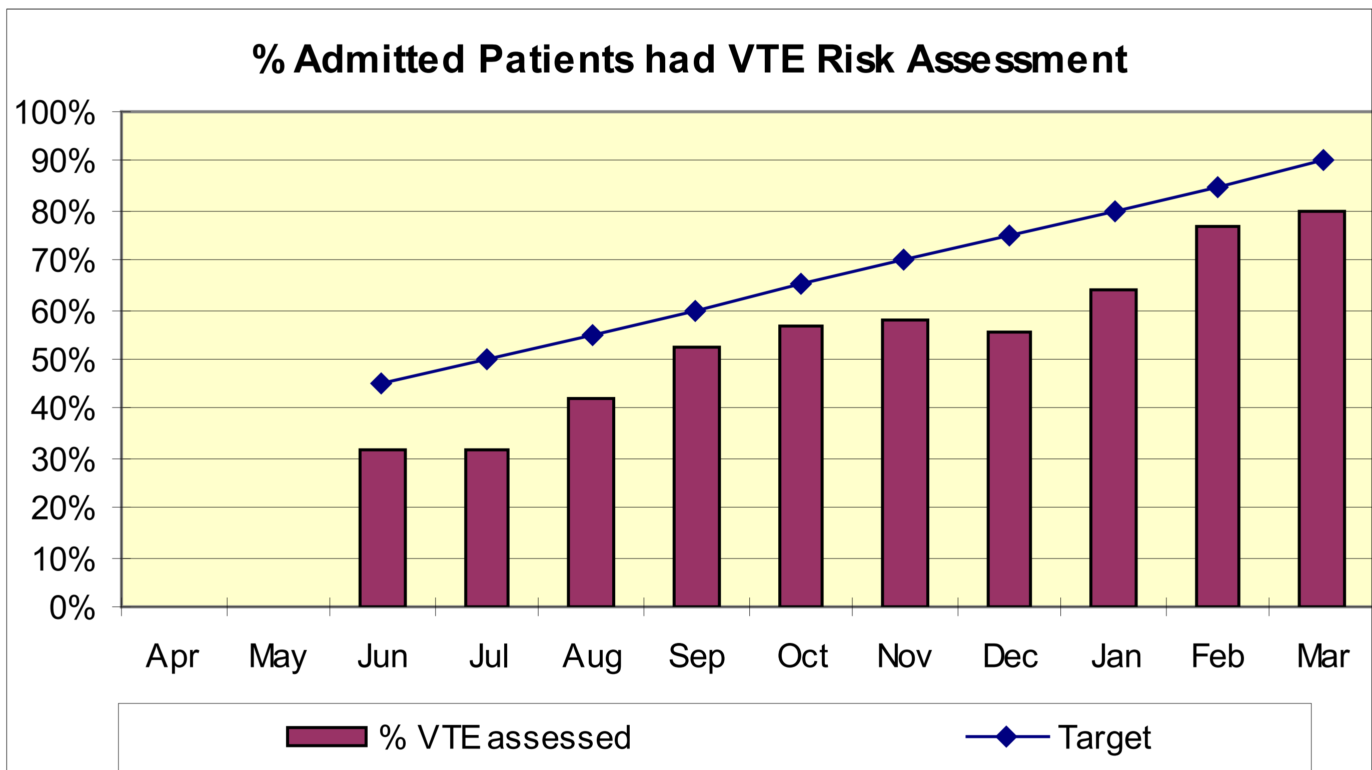
We are improving, but further action is required - this will continue to be a priority for 2011/2012

Progress: < Behind schedule

Safe

VTE Prevention Programme

Current status:



Improvements achieved

- Demonstrable month on month improvement.
- Supporting documentation in place (paper based).
- Risk assessment and prescribing training has been established and implemented.

Future improvements

- Establish a system to collect information electronically and simplifying data collection to link to prescription charts.
- Standardise prescribing prophylaxis.
- Continue to audit risk assessment and prescribing documentation.

Safe

Reduce impact of medication errors

What: Reduce harm from high risk medications.

How much: Reduce the number of medication errors to less than 2.92 per 1,000 bed days and reduce the number of serious medication errors to less than 0.68 per 1,000 bed days.

By when: March 2011

Outcome: Achieved reduction in serious medication errors to 0.6 per 1000 bed days at the end of March 2011.

Progress: ✓ target achieved

Improvements achieved

- Allocated ward based pharmacists to review prescription charts and attending consultant ward round
- Controlled drugs audits undertaken.
- Improved reporting standards.
- NSPA alerts reviewed and increased staff awareness of penicillin and insulin medications.
- Safe medicines newsletter developed and implemented.
- Implemented a Multidisciplinary Safe Medicines Management Group.
- Training DVD developed with core modules.
- All staff involved in medication errors now complete additional training.

Future improvements

- Develop module for controlled drugs.
- Engage matrons and clinical leads in further staff awareness of common medication errors.

Safe Medicines newsletter

January 2011 www.eastcheshire.nhs.uk

SAFE

TO PROTECT PATIENTS WITHIN OUR CARE FROM HOSPITAL ACQUIRED INFECTION

WHAT: To reduce the incidence of hospital acquired infection.

HOW MUCH: No more than 4 MRSA bacteraemia per year.
No more than 50 ***Clostridium Difficile*** infections per year.

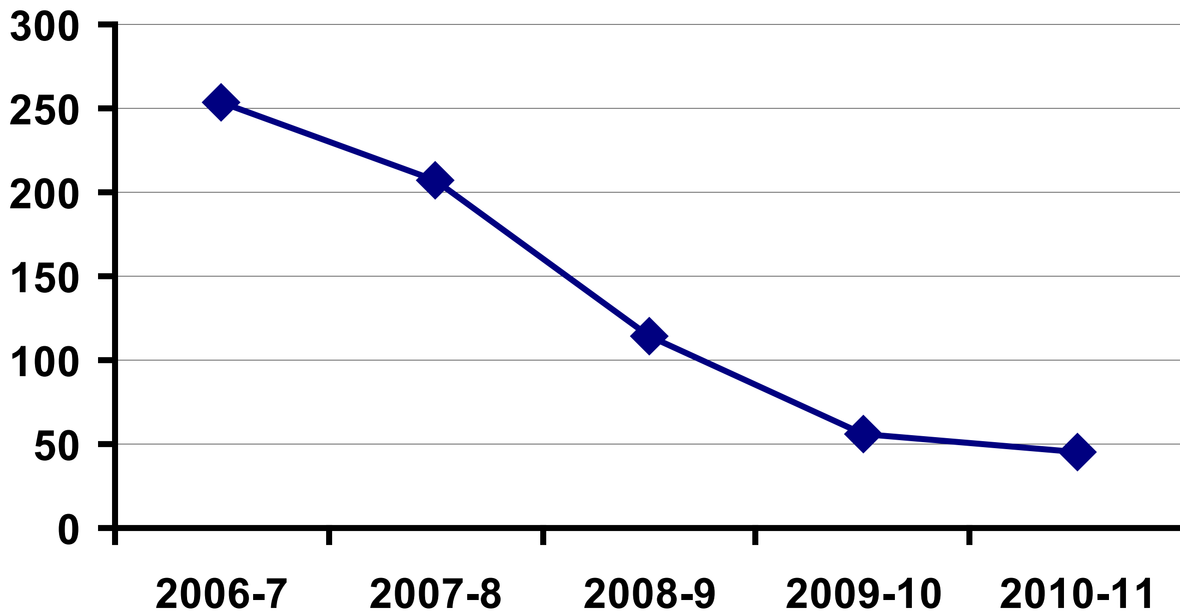
BY WHEN: March 2011

OUTCOME: 45 cases of ***Clostridium Difficile infections***
3 MRSA Bacteraemias

PROGRESS: ✓ target achieved

CURRENT STATUS:

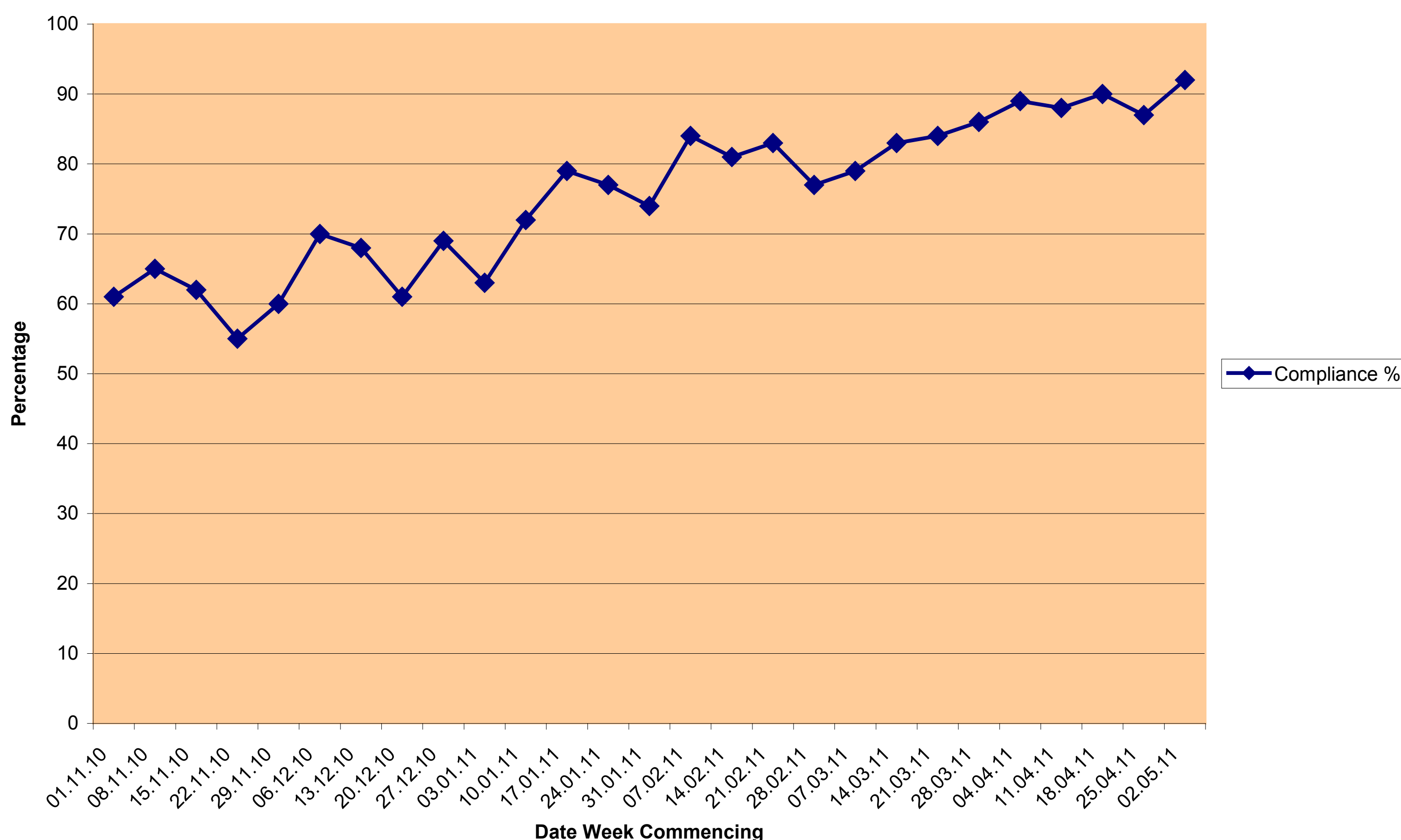
Incidence of *Clostridium Difficile* **infections on wards (2007-2011)**



SAFE

TO PROTECT PATIENTS WITHIN OUR CARE FROM HOSPITAL ACQUIRED INFECTION

Introduction of screening for emergency admissions



FUTURE IMPROVEMENTS

- Continued focus on Aseptic Non Touch Technique (ANTT), ensuring this is embedded as custom and practice.
- Clinical practice of invasive device management, establish task and finish groups to support the business units in driving forward action plans to improve practice.
- Continuation of the MRSA emergency and planned admission screening project, as part of this the trust will be participating in the National MRSA prevalence study in May.
- Review and implementation of the Antibiotic policy.
- Learning from lessons identified from root cause analysis for each *Clostridium Difficile* and MRSA Bacteraemia.

Safe

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: 100% achievement in the agreed timescale.

By when: March 2011

Outcome: ✓ target achieved

Progress: 'To make an impact next year from what we have learnt from complaints this year' Complaints provide valuable feedback to the organisation about the quality of services we deliver and provide evidence to patients and the public of what action we are taking to learn from complaints and put in place quality measures. East Cheshire NHS Trust collects information on complaints as part of Regulation 18 of the 'Local Authority Social Services and NHS Complaints (England) Regulations 2009.' During this year the trust has not been required to take action to implement recommendations following the referral of complaints to the Health Service Ombudsman.

In 2010/11 we have identified the following areas of improvement made as a result of complaints received:

Improvements achieved

- Improved record keeping by reducing duplication and developing an integrated nursing document.
- A new pathway for the management of patients with breast cancer has been introduced, in order to set the standard that all newly diagnosed patients are referred to and seen by the specialist Breast Care Nurse.
- Improved practice in administration of drugs through the implementation of peer - led teaching as part of junior doctors teaching programme.
- We have improved our ability to indentify trends and themes from complaints and incidents.

Future improvements

- Developing plans to document care plans and engage patients.

Safe

Reduce the number of injurous falls per thousand bed days

What: To improve the management of those who attend or are admitted to hospital following a fall or fracture and those who are at risk of falling whilst in hospital or following discharge.

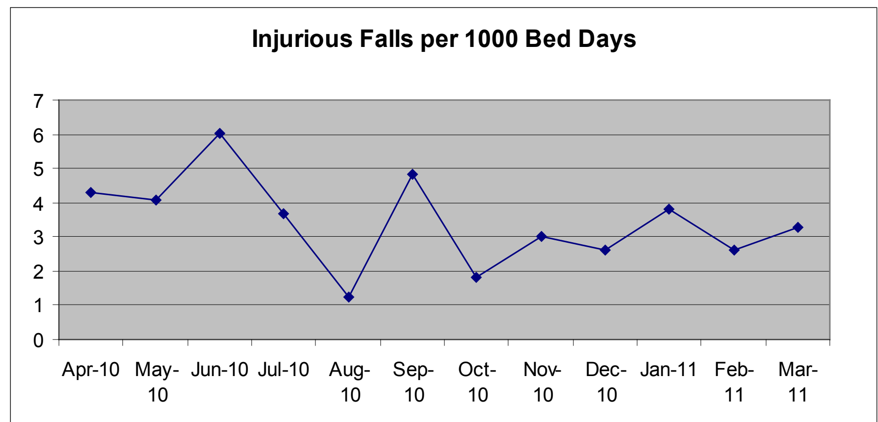
How much: To show month on month reduction in overall injurious inpatient falls rate per 1,000 bed days against 2009/10 baseline of 2.45.

By when: March 2011

Outcome: There has been improvement in reporting incidents and although the target has not been achieved good progress has been made.

Progress: < Behind schedule

Current status: See graph: Injurious falls per 1,000 bed days.



Improvements achieved

- Daily review and root cause analysis undertaken of inpatient falls and data from root cause analysis shared with business units to show trends and recommendations made.
- Raised awareness of all staff in falls prevention and post falls patient review.
- New information leaflets completed and distributed.
- Post falls head injury protocol completed and distributed.

Future improvements

- Falls risk assessment and care pathway documentation drafted and being reviewed against the Fours Ps - Pain, Posessions, Patient needs and Position.

EFFECTIVE

ADVANCING QUALITY

WHAT: Improving the delivery of evidence based care to patients with acute myocardial infarction (heart attack), heart failure, hip and knee replacement and community acquired pneumonia.

HOW MUCH: The trust aim was to achieve the upper quartile performance in all four clinical areas.

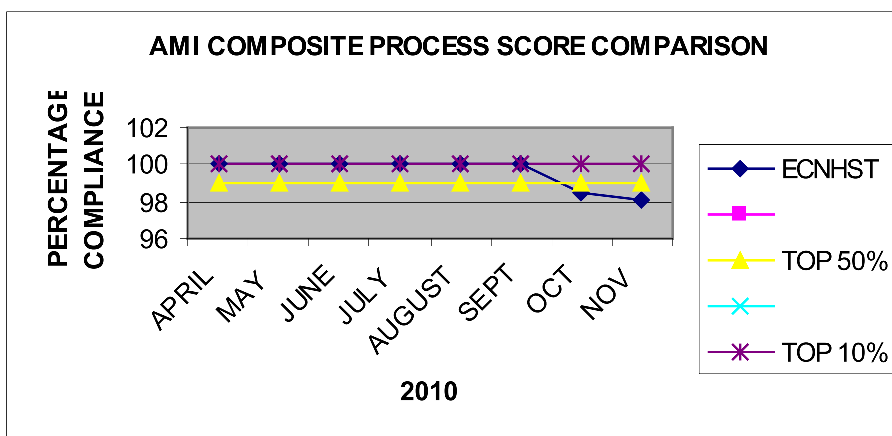
BY WHEN: March 2011

OUTCOME:

- Acute Myocardial Infarction (AMI) - 100% (target 91.2%).
- Heart failure - 80.87% (target 65.34%).
- Community acquired pneumonia – 83.13% (target 78.41%).
- Elective hip and knee replacement surgery – 98.3% (target 93.8%)
- (reporting period quarter 2 July 2010 to September 2010)

PROGRESS: ✓ target achieved

CURRENT STATUS: **Graph: Advancing quality performance hospital comparative report**



Effective

Advancing Quality

Future improvements

- Further improve patient referrals for smoking cessation advice and information and practical support.
- Monitor timeliness of antibiotic prescription and administration.
- Continue staff education and training programme.
- Implement new cardiology and pneumonia parameters from 1 April 2011.
- Continue collection of stroke baseline data.
- Appoint to new post for data collection/ input.
- Review capacity and demand of trauma theatre sessions.

Service Performance

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

2010/11 Target	Care Quality Commission Standards	2010/11 Performance
>95%	1. Maximum waiting time of 4 hours in A&E	97.25%
<5%	2. Cancelled Operations not re-admitted within 28 days	6.1%
No more than 4	3. MRSA bacteraemia year on year reduction versus trajectory for the year	3
No more than 63	4. Hospital Acquired CDifficile (Year target)	45
Less than or equal to 11.1 Weeks	5. 18 week Referral to Treatment - Admitted Patients - **Median**	12.3
Less than or equal to 27.7 Weeks	6. 18 week Referral to Treatment - Admitted Patients - **95th percentile**	22.2
Less than or equal to 6.6 Weeks	7. 18 week maximum wait - Non-Admitted Patients - **Median**	4.3
Less than or equal to 18.3 Weeks	8. 18 week maximum wait - Non-Admitted Patients - **95th percentile**	17.3
Less than or equal to 7.2 Weeks	9. 18 week maximum wait - Incomplete Patients - **Median**	6.3
Less than or equal to 36 Weeks	10. 18 week maximum wait - Incomplete - **95th percentile**	21.8
93%	11. 2 Weeks maximum wait from urgent referral for suspected cancer	98.0%
93%	12. 2 Weeks maximum wait from referral for breast symptoms	97.3%
94%	13. 31 days maximum from decision to treat to subsequent treatment - Surgery	100%
98%	14. 31 days maximum from decision to treat to subsequent treatment - Drugs	100%
96%	15. 31 day wait from cancer diagnosis to treatment	99.6%
90%	16. 62 days maximum from screening referral to treatment (including patients treated at a tertiary centre)	96.6%
85%	17. 62 days maximum from consultant upgrade to treatment (including patients treated at a tertiary centre)	95.4%
85%	18. 62 day maximum wait from urgent referral to treatment of all cancers (including patients treated at a tertiary centre)	88.7%
68%	19. Reperfusion - Thrombolysis within 60 minutes of call (February data)	78.6%
>98%	20. Waiting Times for Rapid Access Chest Pain Clinics	99.5%
< 3.5%	21. Delayed Transfers of Care	4.4%
80%	22. Stroke - Patients who have spent more than 90% of their time on a stroke unit	82.8%

Effective

Organisational Development

What: To develop all of staff to ensure that they act as a role model and take personal responsibility to deliver care in the best interests of patients.

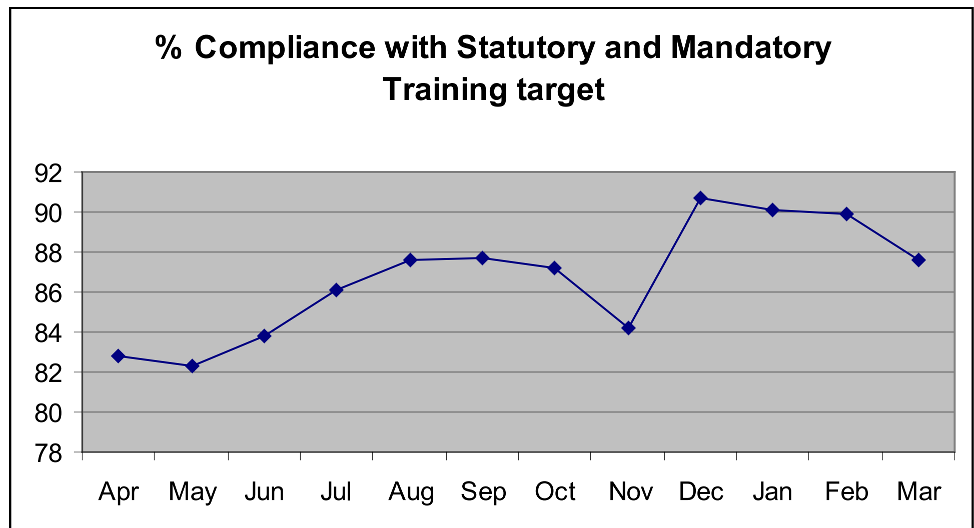
To engage staff in supporting the continuous improvement of patient care and quality standards.

How much: Improve overall performance in staff survey.

By when: March 2011

Outcome: See graph

Progress: ✓ target achieved



Improvements achieved

- We engaged staff through listening in our "Your Voice" initiative.
- From the feedback received we were able to identify a need to further develop clinical leadership and management capability to empower decision making at the front line.
- Commenced work with teams to clarify roles and responsibilities using a recognised development tool.
- We have introduced a Leaders Bulletin which reinforces the important role leaders and line managers have in promoting open communications with staff and creating a climate for staff ideas and feedback to be heard

Future improvements

- We are developing an integrated leadership and management development programme – which includes specific development for ward managers to reinforce role modelling and encouraging staff engagement.
- In light of integration with Cheshire East Community Health, the trust requires a new Organisational Development Plan. Initial work is being undertaken to develop an overarching 'Transformation Plan' to which the Organisational Development Plan will contribute to delivery.
- Develop an integrated quality dashboard for acute and community services relating to infection prevention control performance indicators.

PERSONAL

PRIVACY, DIGNITY AND RESPECT

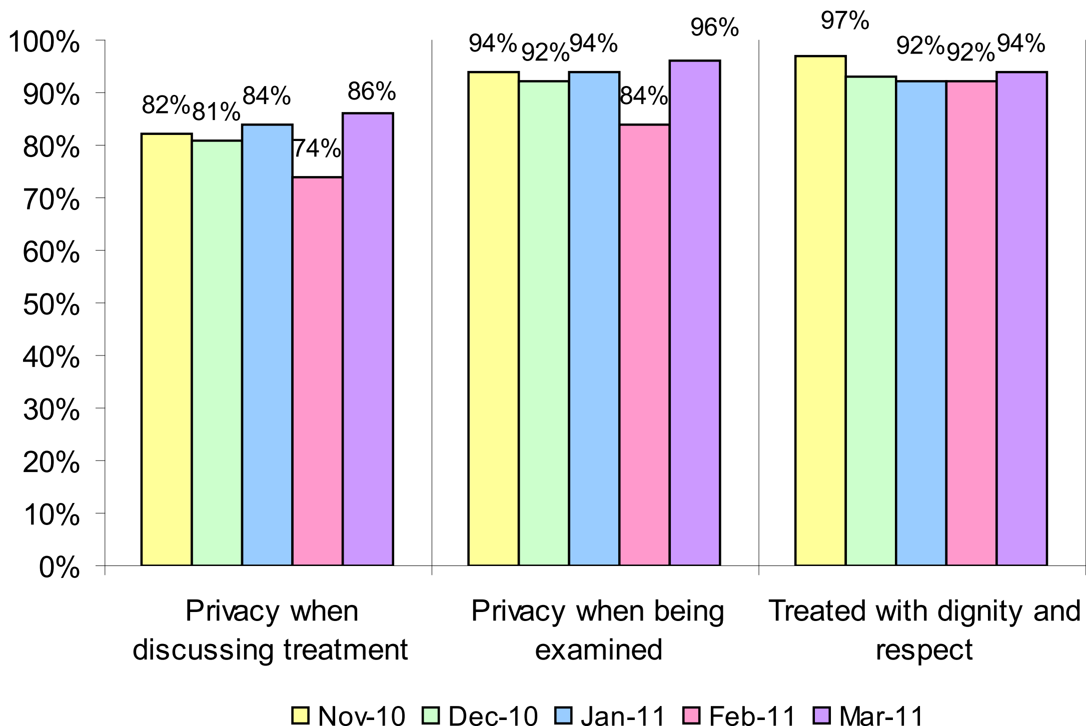
WHAT: Ensure patients within our care are treated with privacy, dignity and respect

HOW MUCH: The trust aim was to achieve the upper quartile performance in all four clinical areas.

BY WHEN: End of March 2011

OUTCOME: All accommodation is compliant with same sex requirements from 1 April 2011.

CURRENT STATUS: **Graph: Patient Satisfaction with privacy and dignity at the hospital**



Personal

PRIVACY, DIGNITY AND RESPECT

Improvements achieved

- We have published our declaration of compliance with same sex accommodation on our trust website www.eastcheshire.nhs.uk.
- Changes made to patient facilities to ensure same sex bathroom and sleeping accommodation.
- Implemented real time patient experience reporting.
- Incorporated privacy and dignity awareness in statutory and mandatory training.

Future improvements

- Continue to extend real time patient experience monitoring.
- Continue to monitor clinical practice in relation to privacy and dignity.

Patient quotes

My daughter was treated as an individual and spoken to like a young adult - the conversation and situation was tailored to my child. '

'The whole staff can be congratulated on the care of the patient. It is with dignity, respect and cheerfulness. The food is excellent.'

Professional care, thoughtful, helpful, pleasant staff always smiling and willing to listen to any doubts you have, put your mind at ease. Peace and privacy when needed!

Personal

Learning through Incident reporting

What: To improve incident reporting and be in the highest 25% of reporters to support improved learning from reported incidents.

How much: To be in the top 25% of reporters in the cluster group.

By when: End of March 2011

Outcome: The trust is 0.2 incidents/100 admissions away from being in the top 25% of reporters in our cluster group. This data is published every six months and we will not know if we have achieved improvement until July 2011.

Progress: = On track to achieve

Current status: Graph: Incident reporting position

Period for reports	Position on graph (in cluster group)	% Area of reporting
April – September 2008	16	Mid 50%
October 2008 – March 2009	3	Lower 25%
April – September 2009	7	Lower 25% - higher end
October 2009 – March 2010	12	Mid 50%
April – September 2010	21	Mid 50% - higher end

Improvements achieved

- This year we have focused on the importance of reporting incidents and the links to improving patient safety.
- Awareness raising has been part of induction and mandatory training sessions.
- We have presented changes in practice to our Safety, Quality and Standards Committee of the Board.

Future improvements

- Implement a web based reporting system which will also support improvement in uploading data to the

AUDIT

PARTICIPATION IN CLINICAL AUDITS 2010/2011

During 2010-2011, 40 national clinical audits and three national confidential enquiries covered NHS services that East Cheshire NHS Trust provides.

During that period East Cheshire NHS Trust participated in 34/40 (82.5%) of the national clinical audits and 2/3 (66%) national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that East Cheshire NHS Trust was eligible to participate in during 2010-2011 are as follows 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.

	Participation	Data collection 2010/11	% cases submitted
Perinatal mortality Confidential Enquiry into Maternal and Child Health (CEMACH)	✓	✓	100%
Neonatal intensive and special care National Neonatal Audit Programme (NNAP)	✓	✓	100%
Paediatric pneumonia (British Thoracic Society)	✓	✓	100%
Paediatric asthma (British Thoracic Society)	✓	✓	100%
Paediatric fever (College of Emergency Medicine)	✓	✓	62%
Childhood epilepsy Royal College of Paediatric and Child Health (RCPH National Childhood Epilepsy Audit)	✓	Data due June 2011	
Diabetes Royal College of Paediatric and Child Health (RCPH National Paediatricb Diabetes Audit)	✓	Data collection ongoing	
Emergency use of oxygen (British Thoracic Society)	✓	✓	100%
Adult community acquired pneumonia (British Thoracic Society)	✓		Data collection ongoing 31.05.11

AUDIT

	Participation	Data collection 2010/11	% cases submitted
Non invasive ventilation (NIV) – adults (British Thoracic Society)	✓		Ongoing
Pleural procedures (British Thoracic Society)	✓	✓	100%
Vital signs in majors (College of Emergency Medicine)	✓	✓	100%
Adult critical care (Case Mix Programme)	✓	✓	100%
Potential donor audit (NHS Blood and Transplant)	✓	✓	100%
Diabetes (National Adult Diabetes Audit)	✓	Ongoing	
Heavy menstrual bleeding (HMB Royal College of Obstetricians and Gynaecologists (RCOG National Audit of HMB)	✓		Data collection ongoing
Ulcerative colitis and Crohn's disease (National Inflammatory Bowel Disease Audit)	✓		Data collection ongoing
Parkinson's disease (National Parkinson's Audit)	Audit deferred		
Chronic Obstructive Pulmonary Disease (COPD) (British Thoracic Society European Audit)	Local data collection this year		
Adult asthma (British Thoracic Society)	✓	✓	100%
Bronchiectasis (British Thoracic Society)	✓	✓	100%
Hip, knee and ankle replacements (National Joint Registry)	✓	✓	100%
Elective surgery (National Patient Reported Outcome Measures Programme (PROMs)	✓	✓	100%
Peripheral vascular surgery Vascular Society of Great Britain and Ireland (VSGB1) Vascular Surgery Database	✓	✓	Subsidiary hospital

Audit

	Participation	Data collection	% cases submitted
Carotid interventions (Carotid Intervention Audit)	✓	✓	100%
Acute Myocardial Infarction & other (Acute Coronary Syndrome (ACS0) Myocardial Ischaemia Audit Project (MINAP)	✓	✓	96%
Heart failure (Heart Failure Audit)	✓	✓	Data collection ongoing
Acute stroke Stroke Improvement National Audit Programme (SINAP)	✓		100%
Renal replacement therapy (Renal Registry)	✓	✓	100%
Renal transplantation (NHS Blood and Transport UK (NHSBT) Transplant Registry	✓	✓	100%
Renal colic (College of Emergency Medicine)	✓	✓	Awaiting %
Lung cancer (National Lung Cancer Audit)	✓	✓	100%
Bowel cancer (National Bowel CancerAudit Programme)	✓	✓	Awaiting %
Head and neck cancer Data for Head and Neck Oncology (DAHNO)	✓	✓	100%
Hip fracture (National Hip Fracture Database)	✓		100%
Severe trauma (Trauma Audit and Research Network)	✓		
Falls and non-hip fractures (National Falls and Bone Health Audit)	✓	✓	80%
O neg blood use (National Comparative Audit of Blood Transfusion)			Previously undertaken in 2007, due to be re-audited in 2013.
Platelet use (National Comparative Audit of Blood Transfusion)	✓	✓	100%

Audit

	Participation	Data collection	% cases submitted
National Confidential Enquiry into Patient outcome and Death (NCEPOD) Cardiac Arrest Procedures Study	✓	1st stage ✓	1st stage100%
(NCEPOD) Elective and Emergency Surgery in the Elderly (EESE) Study (NCEPOD) Peri operative care	✓	✓	87%
Centre for Maternal and Child Enquiries (CMACE) Maternal Obesity in the UK	✓	✓	
Centre for Maternal and Child Enquiries (CMACE) Saving Mother's Lives Report 2006-8	✓	✓	100%

Audit

The reports of 12 national clinical audits were reviewed by the provider in 2010-2011 and East Cheshire NHS Trust intends to take the following actions to improve the quality of healthcare provided:

Paediatric Unit

National Neonatal Audit Programme (NNAP)
Report and action plan produced 16/12/2011.

Recommendations (R)
- R1-Conduct audit on why 12 mothers
- R2-To improve the documentation confirming that parents are seen by a senior member of the
- neonatal team within 24 hours of admission of the baby
- R3-2 years follow up

Medical Business Unit

Pleural procedures (British Thoracic Society audit) presented December audit meeting. **Action point:** Increased Education - fixation of drains (in process)

National Diabetes in-patient audit 2009 action plan
- To implement “ think glucose “ “ putting feet first “ for in-patient diabetes care.
- Regular half day diabetes training for nursing staff – three times a year.
- Regular junior doctors training to coincide with every four months change around time on basic diabetes management.
- To strengthen ‘ Link nurses group’ to implement safe insulin prescribing.
- Future audits for NPSA insulin prescribing.

SINAP (Acute Stroke) actions from October 2010 and February 2010 report
Additions to the data collected:
- Whether patients get 45 minutes therapy five days a week.
- Whether state of continence has been checked by day 14.
- Assessment of urinary continence on day 14-18 and management plan must be in place.
- Does the carer have a named contact for information?
- Does the carer have written information on diagnosis and management plan?
- Does the carer have enough training to do the caring?
- Do patient and carer have copies of the care plan by the time of discharge?

AUDIT

NATIONAL PATIENT SAFETY AGENCY (NPSA) 20 SAFER USE OF INJECTABLES AUDIT

Resulting actions:
- Drug fridge temperatures are now monitored daily by ward managers.
- Staffing levels on paediatrics were reviewed to ensure double checks by two trained staff for all intravenous (IV) drug administration.
- Written procedure for eye contamination is now available on Ward 5
- Members of staff involved in IV injectable incidents will now complete IV administration training section on intranet medicines management DVD and certificate of completion kept in personal file (ward managers, clinical leads, clinical tutors).

NICE GUIDANCE CG94 UNSTABLE ANGINA AND NON ST ELEVATION MYOCARDIAL INFARCTION (NSTEMI) AUDIT
Resulting actions:
- The new chest pain pathway has been introduced which will help capture clinical data required to comply with the NICE guidelines.
- The eDNF option for prompting entry of duration of Clopidogrel Rx is being explore.
- We are working on adopting GRACE scoring on the Coronary Care Unit.

Insulin Prescribing Errors Audit in response to NPSA Alert on safe insulin prescribing
Resulting actions:
- A separate insulin prescription chart is in progress to comply with recommendations from NPSA Alert.

The reports of 97 local clinical audits were reviewed by the provider in 2010-2011 and East Cheshire NHS Trust intends to take the following actions to improve the quality of healthcare provided (a sample of best practice has been selected for inclusion).

Maternity
The Maternity Service has a robust, approved system in place for improving patient care and learning lessons following an audit, they ensure any actions required are implemented and monitored. An example of the improvement the system delivers is the Vaginal Birth after Caesarean Section (VBAC) audit undertaken in 2010. The unit introduced the following actions and improved compliance to 100% by January 2011. • Altered Care Pathway for Vaginal Birth after Caesarean Section. • VBAC proforma amended. • Presented at Midwifery Audit Meeting, highlighted key areas for improvement

Audit

- Discussed at Women's Governance meeting.
- CNST Hotspots created and presented on notice boards in relevant areas.

Another example of this is demonstrated through the perinatal trauma audit undertaken in September 2010, whereby a re-audit evidenced that actions undertaken as a result of the initial audit, achieved 100% compliance of the required standard.

- Introduced Physiotherapist Sticker.
- Presented findings to Obstetricians, midwives highlighting key areas for improvement.
- Introduced record keeping tool, to be used for all types perinatal trauma.
- CNST Hot spots created to identify areas of underperformance.

Paediatrics

The Paediatric Unit focuses their audits mainly around NICE and National audits as a standard of best practice. They have undertaken 20 audits, between April 2010 and March 2011 of which nine of these are NICE audits. The action plans are monitored using an audit scorecard and an audit register as a process of ensuring that the actions are implemented. The following is an example of the actions that they have implemented to improve patient care both in the trust and in the community:

NICE CG99- constipation

- Presented at the paediatric meeting, to consultants and Junior Doctors outlining key findings and areas for improvement.
- A good practice document created outlining the requirement to detail history- including diet, lifestyle stool pattern and passage of meconium.
- Training sessions have been conducted outlining the processes and correct management of constipation.
- Link added to streamline as a prompt, to ensure correct processes adhered to.
- Involved APNP (Advanced Nurse Paediatric Practitioner), Children's Community Nursing Team (CCNT) Services.
- Now following referral pathways for managing constipation so that bulk get treated in the Community.
- Information leaflets designed and provided to children and parents.

Early warning score

- Discussed key findings and action plan progress at each Clinical Governance Meeting.

Audit

- Introduction of processes to ensure safeguarding policy and practice are consistent across the trust, through creating a process where each clinical area has an identified safeguarding children champion and notice board where up to date information can be displayed.
- Included on Paediatric Induction Programme.
- Training programme commenced for safeguarding children, surgical business unit staff have had the session. In progress to train Medical Business Unit.
- Guidance notes created.
- Poster created and displayed in clinical areas reminding staff to complete referral form to social care as per the referral pathway
- Electronic follow up to training poster created to re-enforce the importance of recording face to face discussions, telephone conversations and documenting agreed.

Surgical Business Unit

The Surgical Business Unit have implemented a number of actions to improve patient care at both local and trust level. All audits are presented at the individual audit meetings on a monthly basis and action plans are created. The action plans are then monitored using an audit scorecard and an audit register as a process of ensuring that the actions are implemented.

Any actions that are felt to be significant i.e. high risk or applicable to the whole of the surgical business unit are discussed at the monthly Safety Quality and Standards meeting, if felt to be of high risk it is added to the risk register. The following is an example of the actions they have implemented to improve patient care:

Radiology- Serum Creatinine and contrast agent in high risk inpatients undergoing Computerised Tomography (CT) audit.

- Discussed recommendations at the Safety Quality standards meeting.
- Presented findings and discussed recommendations at the radiology audit meeting.
- Communication forwarded to all clinical staff in the trust, stating the following actions to be implemented:
- CT Inpatients with Glomerular Filtration Rate (eGFR) <60 to be required to have hydration optimisation.
- Minimal hydration (oral and intravenous - (IV) to be cited on yellow ward form for CT; clinical contraindications to this will be identified by ward doctors who will liase as necessary with Radiology.
- Use of separate contrast agent in patients with sub-optimal renal function (eGFR<60) is to be abandoned; all patients having IV contrast in CT will have Optiray 300.
- eGFR <30 will be discussed with supervising Radiologist.

Audit

NICE CG74- Surgical Site Infection audit

- In process of devising antibiotic prophylaxis policy specific to Ear, Nose and Throat surgery.
- Improved quality of documentation through presenting findings at the following meetings:
- Safety Quality Standards meeting
- Surgical Audit meeting
- Anaesthetic Audit Meeting
- Removed confusion over first choice of solution for skin preparation and communicated to the surgical business unit. Clinician produced paper appraising the evidence supporting use of 2% chlorexidine.

Outpatients and Clinical Support Business Unit

Neuro-physiotherapy out-patients exercise class

There has been detailed guidance over recent years, highlighting the importance of offering a comprehensive care pathway to those living with Long term Conditions (LTC's) such as Parkinson's Disease (PD), Stroke and Multiple Sclerosis (MS).

There is good evidence to suggest that exercise post stroke is beneficial and that increased duration of exercise affects functional recovery depending upon the level of impairment to begin with It has been shown to improve speed, tolerance and independence during walking. It has been stated that aerobic exercise should be a component of stroke rehabilitation due to the positive evidence towards improved aerobic capacity post stroke. On this basis the Neuro-Physiotherapy Team set up a pilot exercise class which formed the basis of an audit complete with action plan.

An action from this audit was to continue offering the exercise class. This action has been completed in that the audit has used validated outcome measures and the results show improvements in function for patients. The class has therefore now been integrated into our service and we hold a waiting list for those people wishing to participate.

Dysphagia Screen Training for nurses

An initial audit in 2008 highlighted the need for a high quality, competency based training programme for nursing staff to enable them to carry out a basic swallow screen on patients with suspected dysphagia.

The 2008 audit recommended: A programme should be devised and implemented by the Speech and Language Therapy Team to train nurses to carry out and document the swallow screen.

AUDIT

A further audit was conducted in 2010, which documented: A much larger percentage are now screened within 24 hours (16% in 2008 and 66% in 2010) and far more screens are documented in the medical or nursing notes (40% in 2008 and 68% in 2010).

The most significant improvements have been seen on the stroke units where the percentage of stroke patients receiving a swallow screen within 24 hours is monitored on a monthly basis by the stroke coordinator and is regularly above 80%.

The number of National Audit Reports reviewed by your board and provide details of actions taken to improve the quality of Local Audit Reports reviewed. (We have taken into account the devolvement of responsibilities to other trust committees/groups and included actions informed by those bodies).

Group or forum	National audit reviewed	Actions
CARE Group (Clinical Audit, Research and Effectiveness Group). Monthly meetings Business Unit Audit scorecards are reviewed by this group on a quarterly basis	Diabetes Inpatient National Audit data reviewed 11.10.10 Familial Hypercholesterolemia National Audit reviewed 08.02.11	Not applicable to East Cheshire NHS Trust

Examples of good practice

East Cheshire NHS Trust

1. Recommendations made in the NCEPOD report 'A mixed bag' 2010, a multiprofessional nutrition support team has been formed to provide cross speciality cover and assist where enteral and parenteral nutrition is problematic.

2. The number of local clinical audit reports reviewed by your board and provide details of actions taken to Improve the quality of Local Audit Reports reviewed.

(We have taken into account the devolvement of responsibilities to other trust committees/groups and included actions informed by those bodies).

Group or forum	Local audits reviewed	Actions
CARE Group (Clinical Audit, Research and Effectiveness Group). Monthly meetings.	• Medicines Adherence (CG76) reviewed 13.12.10	Audit findings to go to surgery Audit meeting for discussion. Re - audit agreed for 12months
Business unit audit scorecards are reviewed by this group on a quarterly basis	• Shoulder Resurfacing Arthroplasty reviewed 14.02.11	To be re-audited against NICE guidelines.
	• Bacterial Meningitis and Septicaemia reviewed 14.02.11	To discuss the antibiotics policy with Pathology Services and to develop an Early warning Score for paediatrics. This subject will be reaudited in October 2011.
	• Venous Thromboembolism (VTE) reviewed 14.02.11	Development of Standard Operating Procedure to ensure VTE risk assessment is confirmed as a mandatory procedure and development of training package. Re - audit 12 months.
	• Diarrhoea and Vomiting (D&V) in Children reviewed 14.03.11	Patient Group Directive to be amended to include number. D&V Policy to be reviewed by Medicines Management Group.

Examples of good practice

Group or forum	Local audits reviewed	Actions
Business Unit Safety, Quality Standards (SQS) groups Medicine Business Unit Audit SQS	• Warfarin Audit recommendations reviewed 15.04.10 • College Emergency Medicine audits report reviewed 05.10.10 • Antibiotic Point Prevalence Audit report reviewed 07.10.10 • Slips, trips and Falls audit report reviewed 10.10.10 • Atrial Fibrillation audit recommendations reviewed 16.12.10 • Trustwide VTE report reviewed 16.12.10 • NPSA Medicines Adherence audit report reviewed 16.12.10 • NPSA Insulin prescribing audit report reviewed 16.12.10 • NPSA 20 Safer Use of Injectables report reviewed 20.01.11 • Record keeping audit NHS Litigation Agency (NHSLA) and Royal College of Physicians standards) report reviewed 20.01.11	Actions, where appropriate, are detailed in individual meeting minutes, which are available if required.
Women and Children Business Unit	A monthly CNST progress report is submitted to the Clinical Governance meeting, along completion of action plans they are signed off by the Clinical Director or Associate Director.	
	The following is an example of the audit reports that have been discussed and approved:	

Examples of good practice

	• Safeguarding Children report 04.2011 • Ectopic Pregnancy and its management (May 2010) • Caesarean Section Audit (July 2010/ Jan 2011) • Admissions to Neo Natal Unit (NNU) (November 2010) • Administration of Oxygen • Bacterial Meningitis (Dec 2010) • Training Needs Analysis • Record Keeping Report • Antibiotic Point prevalence (2011) Example of action plans reviewed: • Diarrhoea and Vomiting (Dec 2010) • Oxytocin (May 2010) • Breast Feeding (July 2010) • Diabetic Keto Acidosis • Severely unwell pregnant women • Fetal blood sampling	
Surgical Business Unit	• Acute Renal Failure Audit • (NCEPOD Acute Kidney Injury) • Record Keeping Audit (NHSLA and RCP standards) report reviewed 2011. • Gall Stone Pancreatitis Audit (July 2010- Added to risk register).	

	• NICE Clinical Guideline CG74 - Surgical Site infection. (Removed confusion over first choice solution • Serum Creatinine and contrast agent in high risk inpatients undergoing Computerised Tomography CT. • Medicine Adherence Board	
Outpatient and Clinical Support Business Unit	• Outpatient Services Script audit reviewed 05.10.10 • Neuro Physiotherapy – Exercise Group for long term conditions audit reviewed 16.11.10 • Regional Audit of the Management of Hypercalcaemia of Malignancy reviewed 16.11.10	
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. For example: 1. Acute alcohol withdrawal audit (NICE CG100) 2. Reducing re-admissions audit 3. Infection control six monthly audit report	Actions, where appropriate, are detailed in individual meeting minutes, which are available if required.
Women and Children monthly audit meetings	Rolling programme, with a process in place to ensure that all audits have been presented and reviewed by end of fiscal year.	Actions, where appropriate, are detailed in individual meeting minutes and available if required

EXAMPLES OF GOOD PRACTICE

Group or forum	Local audit reviewed	Action
	The following is an example of the audits presented and discussed at the two audit meeting (paediatric, Midwifery): 1: Auscultation 2: NICE Intrapartum 3: Outcome of babies born to rhesus negative mothers. 3: NICE feverish Child.	
Surgical Business Unit monthly audit meetings.	Up to two presentations per meeting. The following is an example of the audits presented and discussed: 1: Blood Sampling Audit 2: Handover Audit 3: Colorectal Imaging Audit	Actions, where appropriate, are detailed in individual meeting minutes, which are available if required.
Outpatient and Clinical Support Business Unit audit meetings	Rolling programme with the intention to present and discuss all audit projects. Up to three presentations per meeting. For example:- 1. Surgical management of Otitis Media with Effusion in children (NICE) reviewed 23.02.11 2. Exercise group for long term conditions – Neuro Physiotherapy reviewed 23.02.11 3. Evaluation of melanoma reviewed 23.02.11	Actions, where appropriate, are detailed in individual meeting minutes, which are available if required.

Participation in clinical research

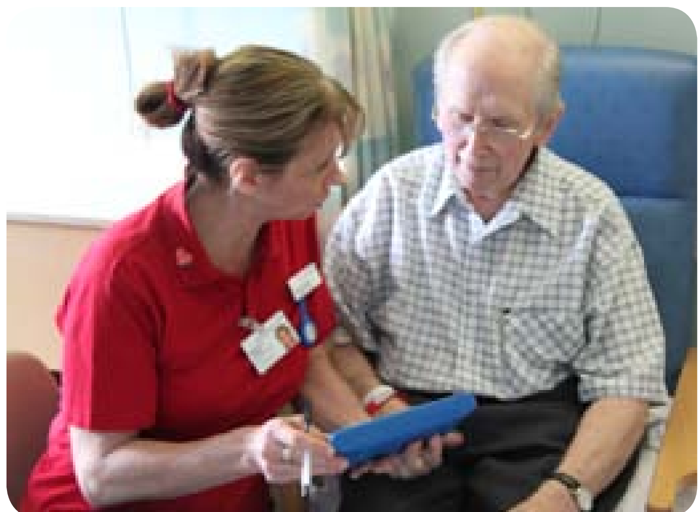
Research in the trust has continued to increase over the past year. Eighty approvals were granted for new and amended studies throughout 2010/11 compared to 64 in the previous year. This demonstrates the trust's commitment to research as a driver for improving the quality of care and our contribution to wider health improvement.

As can be seen in the above diagram, cancer studies make up the largest part of our portfolio which mirrors the situation nationally. During this year the cancer team opened eight new studies, three of which were randomised controlled trials (RCT) which are the gold standard for research. There are a further three studies currently awaiting approval. The range of disease groups covered within the unit has been increased by opening lung and skin cancer trials. Over the forthcoming year there are plans to investigate opening gynaecological trials, further widening the choice offered. East Cheshire NHS Trust recruited 20% of their cancer patients to RCT's which was the highest percentage recruitment out of the 14 trusts in Greater Manchester and Cheshire.

In Paediatrics, four new studies have been opened including the first paediatric diabetes study. Recruitment has increased from 27 patients in 2009/10 to 32 in 2010/11. Our site is a high recruiting site for the MAGNETIC trial with our initial target recruitment of 10 patients being exceeded by a further 16 recruits to date.

The Stroke Team have opened two new rehabilitation studies this year, and have continued to recruit approximately 10% of the stroke patient population to trials. The SOS and ENOS trials in particular are recruiting well for the size of trust.

In rheumatology two new studies have been opened, with a further study currently awaiting approval. Recruitment has increased from 30 patients in 2009/10 to 32 patients in 2010/11.

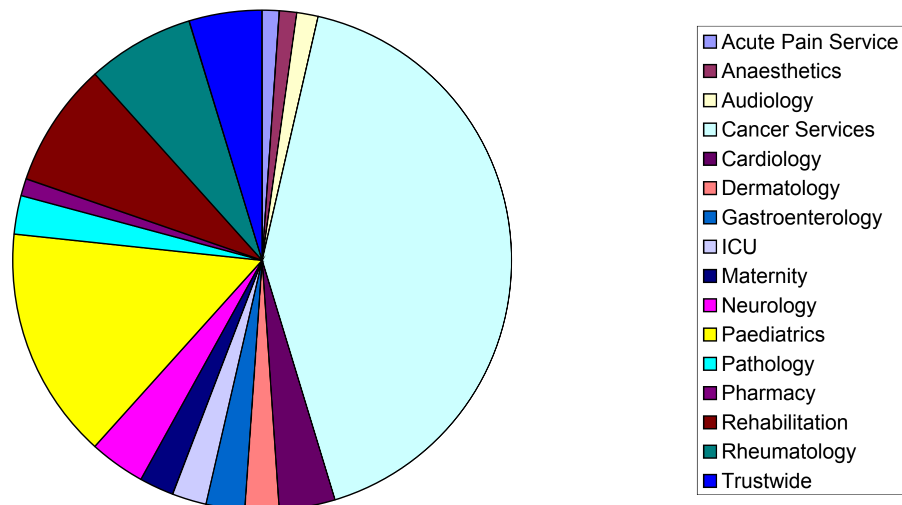


PARTICIPATION IN CLINICAL RESEARCH

Commitment to research as a driver for improving the quality of care and patient experience
The number of patients receiving NHS services provided or sub-contracted by East Cheshire NHS Trust in 2010/11 that were recruited during that period to participate in research approved by a research ethics committee was 583 (until end of February).

Participation in clinical research demonstrates East Cheshire NHS Trust commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

There were 44 clinical staff participating in research approved by a research ethics committee at East Cheshire NHS Trust during 2010/11. These staff participated in research covering 16 medical specialties.



Cheshire East
Community
Health

Quality Account 2010/11

FOREWORD

In 2010/11 Cheshire East Community Health (CECH) continued to be a direct provider organisation, which means that although it was part of Central and Eastern Cheshire PCT. it operated as an autonomous arms length organisation. CECH provided a comprehensive range of community based healthcare services in patients own homes, GP surgeries, health centres, and clinics, some working in partnership with other providers in the NHS, public and independent sectors. We are committed to delivering the highest quality of accessible clinical care that is convenient for patients and is based on the needs of the local communities that we serve.

Review of 2010/11 priorities

In 2010/11 CECH's priorities included the following:

Safety

- Infection control

Effectiveness

- Obesity measurement in children
- Access to sexual health services
- Delivering the 18 week waiting time target

Patient experience

- Treating patients with dignity and respect
- Surveying patients to seek their views
- Engaging patients and carers

Review of 2010/11 priorities

< Behind schedule   = On track to achieve   ✓ target achieved

Safety

To protect patients within our care from hospital acquired infection

What: Reducing the incidence of Clostridium difficule*

How much: Less than 176 cases

By when: March 2011

Outcome: ✓ target achieved

Progress: Cheshire East Community Health 105 cases.

*C.diff - a case is classed as community if it is a GP sample or the specimen was taken on the day of admission or the following 2 days.

Review of 2010/11 priorities

Safety

To protect patients within our care from hospital acquired infection

What: Reducing MRSA bacteraemia

How much: Less than 11 cases

By when: March 2011

Outcome: ✓ target achieved

Progress: 6 cases

For MRSA bacteraemia a community case is a case where the blood cultures were taken within 48 hrs of admission to hospital.

Review of 2010/11 priorities

Safety

To promote healthy lifestyles amongst children

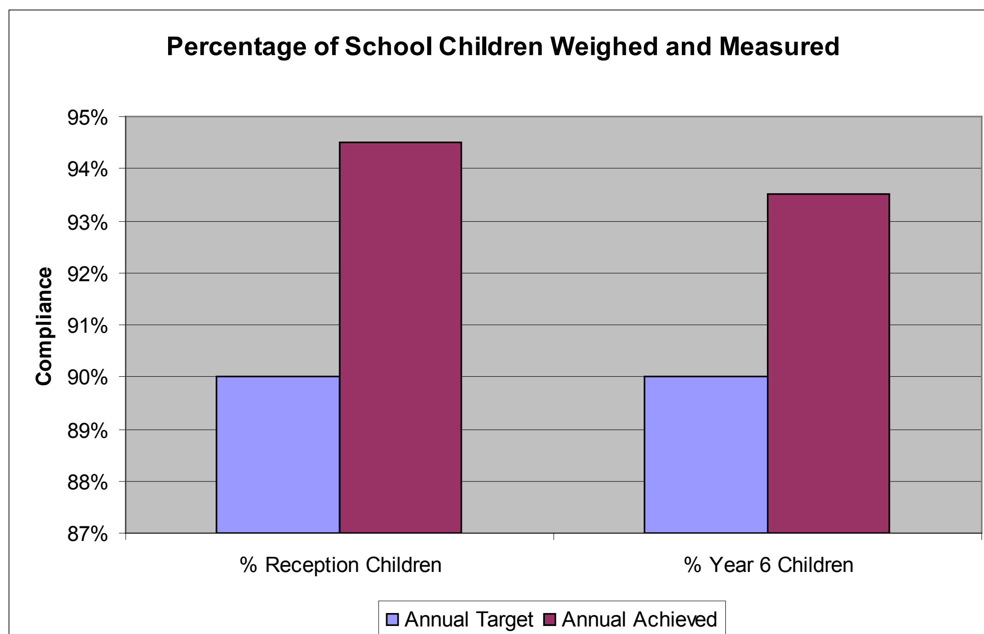
What: Obesity Measurement of Children in reception and Year 6. The School Nursing Service plays a crucial role in promoting healthy lifestyles amongst school aged children. One of the key elements of this support is to measure children's height and weight and provide education advice on healthy eating.

How much: 90% of both reception and year 6 pupils

By when: March 2011

Outcome: ✓ target achieved

Progress: Graph: Percentage of school children weighed and measured



Review of 2010/11 priorities

Safety

Access to sexual health services

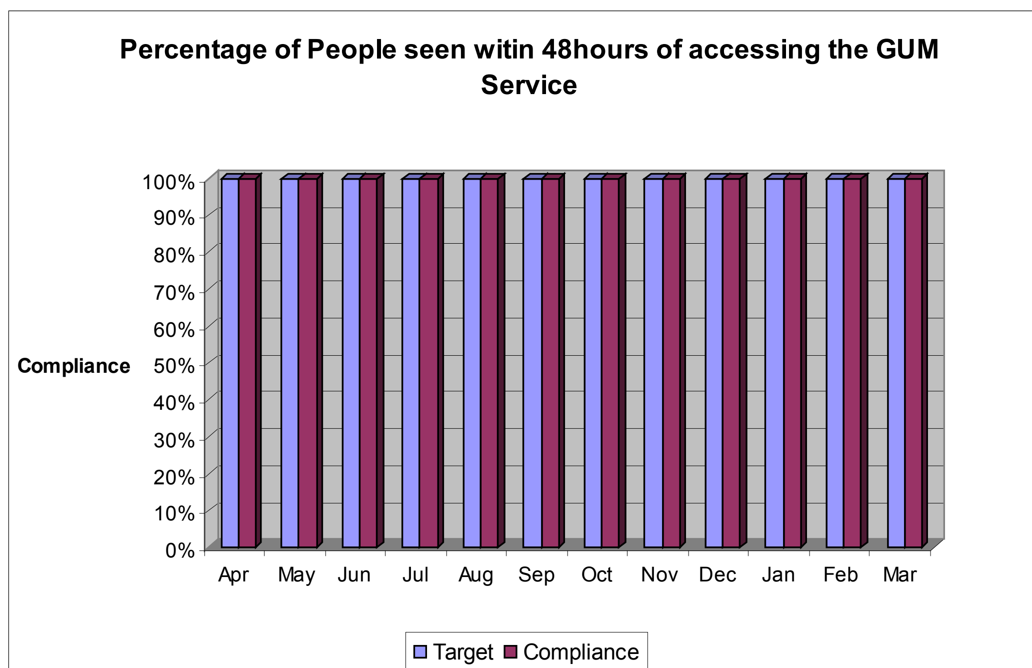
What: Access to Genito Urinary Medicine (GUM) Services within 48 hours

How much: 95%

By when: March 2011

Outcome: ✓ 100% target achieved

Progress: The Genito Urinary Medicine (GUM) service has redesigned it clinic access arrangement to ensure that the service consistently meets this target. Speedy access for patients is clearly key to delivering effective sexual health care.



Review of 2010/11 priorities

Safety

To meet the 18 weeks target for our services

What: Ensuring patients are seen within 18 weeks in the following services:

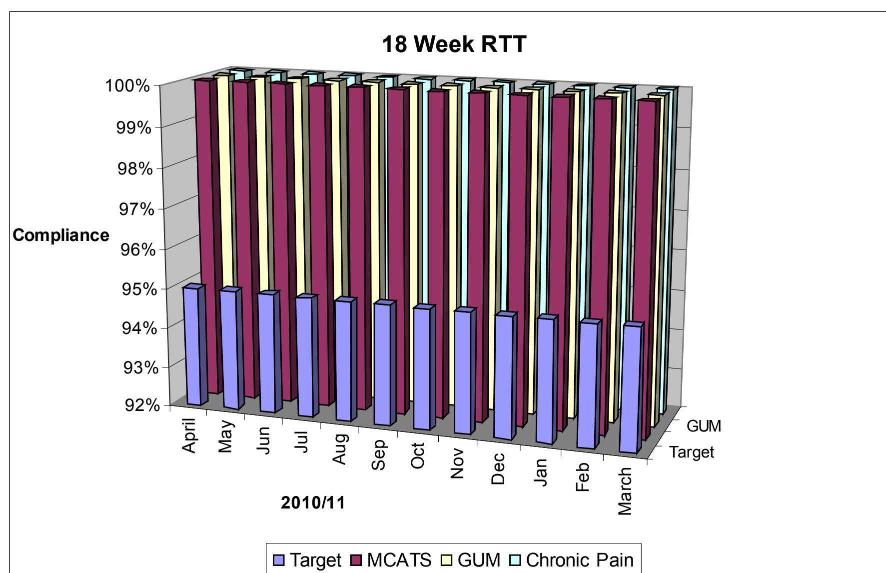
- Genito Urinary Medicine
- Chronic Pain
- Musculoskeletal Assessment and Treatment

How much: Equal to or more than 95%

By when: March 2011

Outcome: ✓ target achieved

Progress: The 18 week target has been delivered over and above the national requirement in all 3 of the above services thereby ensuring that patients are treated in a timely manner.



Review of 2010/11 priorities

Safety

Privacy, Dignity and Respect

What: Ensuring patients are treated with dignity and respect

By when: March 2011

Outcome: 98% of the 302 patients surveyed as part of the patient satisfaction survey said they were treated with dignity.
99% of the 237 patients surveyed said they had privacy.
96% of the 296 patients surveyed said they felt involved in their care and treatment plans.

Progress: There are now 24 dignity champions working across Cheshire East Community Health. Patient surveys are undertaken on a routine basis providing the results highlighted in the table below.

Audit

Participation in clinical audits 2010/2011

During 2010-2011, 84 audits were registered with the Clinical Audit Department of which 59 (70%) were fully completed and 25 were carried over to 2011-12.

5 national clinical audits covered NHS services delivered by Cheshire East Community Health relating to the National Falls and Bone Health Audit, Primary Care Foundation Benchmarking on Out of Hours Services, NHS Benchmarking Network: Intermediate Care Services, National Benchmarking Audit for District Nursing Services, The national clinical audits that Cheshire East Community Health was eligible to participate in during 2010-2011 are as follows 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.

	Participation	Data collection 2010/11	% cases submitted
Lower back pain NICE guidelines	✓	✓	100%
Effectiveness of pressure garments for post surgical pathway	Deferred for 2011/12		
Comparative audit of treatment options and cost for obese patients	✓	✓	100%
Primary Care Dental Services - Audit of compliance against HTA 01-05 decontamination standards	✓	✓	100%
Weight management programme audit	✓	✓	100%
Physiotherapy input into critical care versus NICE guidelines for rehabilitation after critical illness	✓	✓	40 patients
Physiotherapy treatment of amputee patients benchmarked against BACPAR guidelines	✓	✓	20 patients
Annual audit of palliative care management	✓	✓	100%
Audit of adherence to NICE guidance on management of fever in under 5s	✓	✓	100%
National audit falls and bones health in older people	✓	✓	

Acknowledgements

Acknowledgements

- Director of Nursing, Quality and Performance
- Director of Corporate Affairs and Governance
- Marketing and Communications Officer
- Head of Professional Practice.

Note: All abbreviations have been explained in full throughout the document.

Written Statements from other bodies

Commentary from Central and Eastern Cheshire Primary Care Trust (CECPCT)

Central and East Cheshire Primary Care Trust fully supports the Quality Account for 2010-11 from East Cheshire Trust as an accurate and representative reflection of the trust's position concerning quality of services provided.

The account is presented in an easy to read format which helps to make it more understandable and accessible to the public/patients/families whilst still meeting the requirements of the Department of Health.

The improvements that are demonstrated across a range of factors are to be celebrated, particularly in the areas of safety and patient experience. There is very good evidence of audits in business units that are also bringing about improvements to patient care being led out by clinicians; the section highlighting good practice demonstrated the trust is keen to learn from itself and others. Some areas have not demonstrated as much progress as had been anticipated over 2010-11 but there are plans in place to improve further during 2011-12. Benchmarking against others has been applied in order to learn lessons and progress more quickly.

The trust has had a challenging year, particularly through the winter period, as well as preparing to take over the responsibility for the community services from the 1 April 2011. This is now in place and the trust is planning for the transformation and integration of services alongside the commissioners (GP Consortia , Local Authorities and PCT).This will continue to deliver improved patient experience as part of the quality agenda.

Commentary from Cheshire East LINk

Thank you for the opportunity to comment upon the trust's Quality Accounts. This is an easily readable document and we understand that there has been consultation with Public Patients, Staff and Commissioners in the development of priorities. This we commend. We congratulate the trust upon becoming an integrated trust from April 2011 and understand that this has been a difficult period both for the trust and Cheshire East Community Health. We welcome the mission, vision and values as agreed by both boards as a way forward to implement and improve care.

Quality Improvement Strategy

Cheshire East LINk welcomes the identified elements of the strategy. On page 4 the statement "Ward to board" does need some explanation and will not be readily understood by the public. We note that the trust is currently reviewing its "quality dashboard" and approve the inclusion of the eight quality improvements proposed.

Written Statements from other bodies

Cheshire East LINk welcomes the identified top priorities:

- Reduce Patient harm in hospital
- Provide evidence based care
- To provide positive patient experience.

We also welcome the assurance given to the Overview and Scrutiny Committee that the trust is now compliant with same sex accommodation and of the intent to try reduce further the already below national average hospital standardised mortality rates.

Patient safety

Cheshire East LINk welcomes:

- The improvement in reporting of incidents.
  We note the improvement in incident reporting and that the trust is now 0.2 incidents per 100 admissions away from being in the top 25% of reporting trusts in its cluster. This is commendable although as a LINk we do find it difficult to differentiate between having a high reporting level and a high proportion of incidents!

- The introduction of “zero tolerance” for pressure ulcers and the intent to undertake root cause analysis in each case should any occur.

- The initiative of “hourly rounding” for patients identified as being at medium or high risk of falls via the “Falls risk assessment”. The LINk’s Authorised Representatives have had experience of this initiative when undertaking an enter and view visit to one of the two wards currently piloting this initiative.

Care Quality Commission (CQC)

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 during the reported period the trust has not been required to participate in any special reviews or investigations by the CQC.

Hospital acquired infections

Cheshire East LINk is pleased to note the reduction of hospital acquired infections and congratulates the trust upon achieving the national targets in both MRSA Bacteraemias and Clostridium Difficile. We also note the improving compliance in MRSA screening of all emergency admissions.

Audits and clinical research

We note the audits and clinical research in which the trust has participated during the reported period.

Written Statements from other bodies

Further comment

The document as available to us (and as presented at Overview and Scrutiny) still has data to be added. However we note that Appendix one will be Glossary and Abbreviations. This is vital.

Again Cheshire East LINk appreciates the opportunity to comment.

Commentary from Cheshire West and Chester LINk

Due to staff leave we are unable to provide a response.

Commentary from Overview and Scrutiny Panel (OSC)

To follow

Copies of this report, including different formats, are available from the Communications and Engagement Department.
Telephone: 0161 661184

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

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