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DATE: 30 March 2012

Dear Councillor

HEALTH AND WELLBEING SCRUTINY COMMITTEE - TUESDAY, 3RD APRIL, 2012

I am now able to enclose, for consideration at next Tuesday, 3rd April, 2012 meeting of the Health and Wellbeing Scrutiny Committee, the following reports that were unavailable when the agenda was printed.

Agenda No Item

Draft Quality Account - East Cheshire NHS Trust (Pages 1 - 64)

Report of
To consider the draft Quality Account of East Cheshire NHS Trust (to follow).

Yours sincerely

Denise French

Scrutiny Officer

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East Cheshire NHS
NHS Trust

DRAFT VERSION 1

QUALITY ACCOUNT 2011/12

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 2011/12 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"

2. Our Quality Achievements

Add picture - to be completed

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

The Information Standard
Certified member
This organisation has been certified as a producer of reliable health and social care information.
www.theinformationstandard.org

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 thereforeabout three things:

- designing and delivering care services that are as clinically safe and effective as possible
- delivering care in a manner whereby patients are treated with compassion, dignity and respect in a clean and pleasant environment personal to each individual. Equally important to patients, is the whole experience of their visit to outpatient clinic or hospital from whether they could park easily to whether they found staff helpful and respectful.
- developing an attitude and culture within our entire organisation whereby everyone is constantly striving for excellence and continuous quality improvement in all that they do

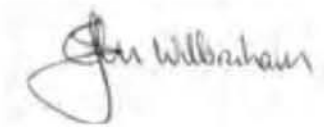
The trust intends to be the provider of excellence for specialist services for older people in community or hospital care settings.

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.

The aim is to 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.

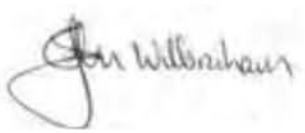
Statement of Directors Responsibilities in Respect of Quality Accounts

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 Account 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 2012

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

3. Our plans for the future

Add a picture - to be completed

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

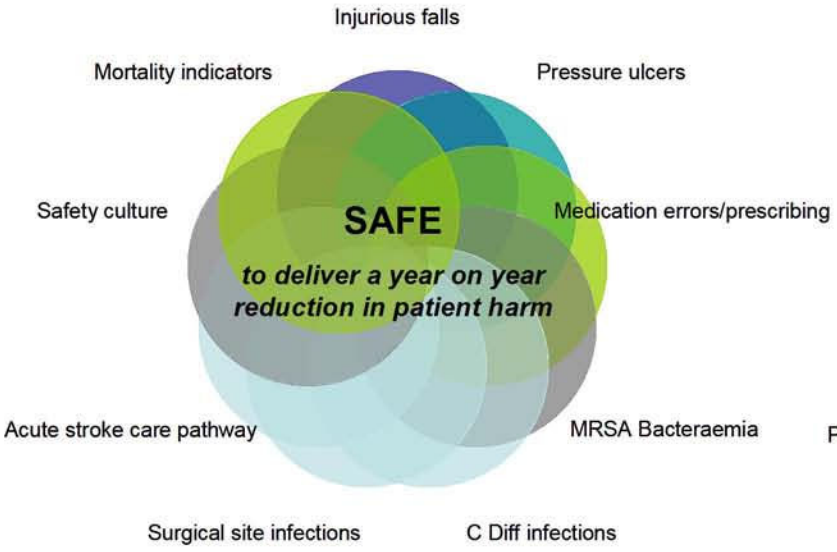
- *Continuously* ***improve quality, safety and patient experience***
- ***Supporting and developing staff*** *to enable them to achieve their best*
- *Achieving* ***financial sustainability***
- *Working with our partner to* ***provide an integrated health service*** *for our local population*
- *To* ***contribute to the local community*** *and being considerate to the environment*
- ***Encouraging staff to be innovative*** *when delivering and planning services*

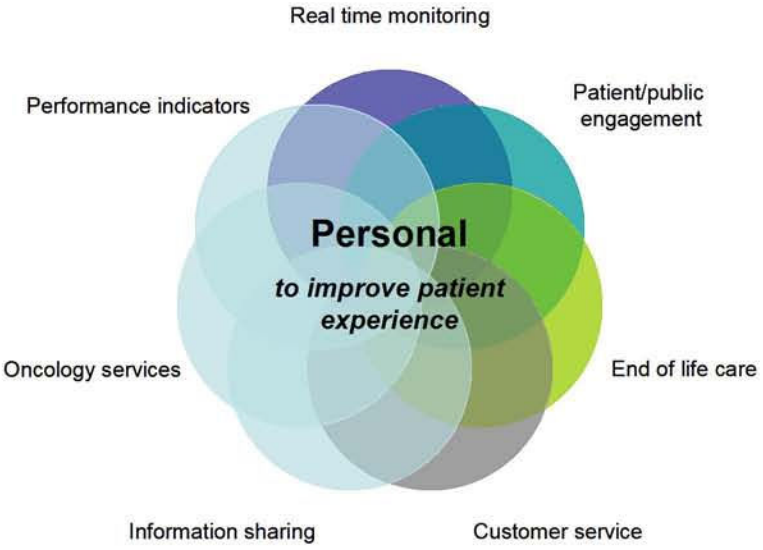
Transformational workstreams

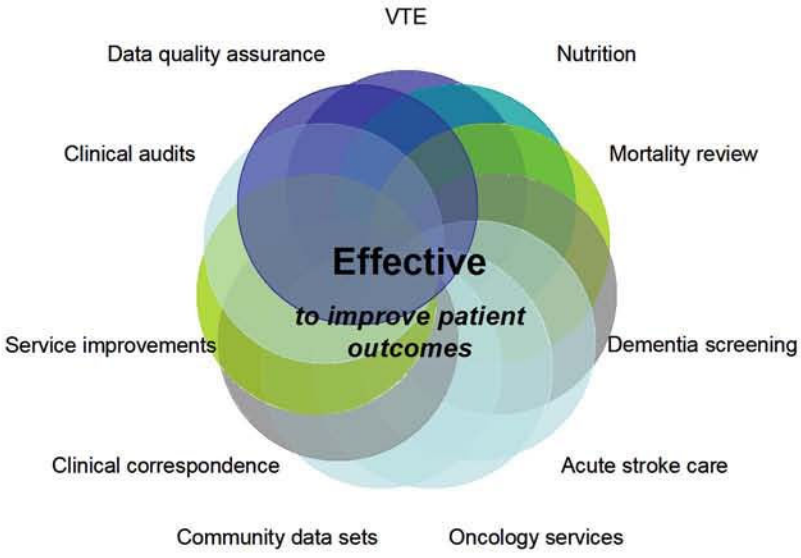
- *Strengthening Operational Delivery*
- *Service Redesign*
- *Organisational Development*
- *Cost Improvement Programme*
- *Governance and preparing for NHS Foundation Trust status*
- *Corporate and Social Responsibility*

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:

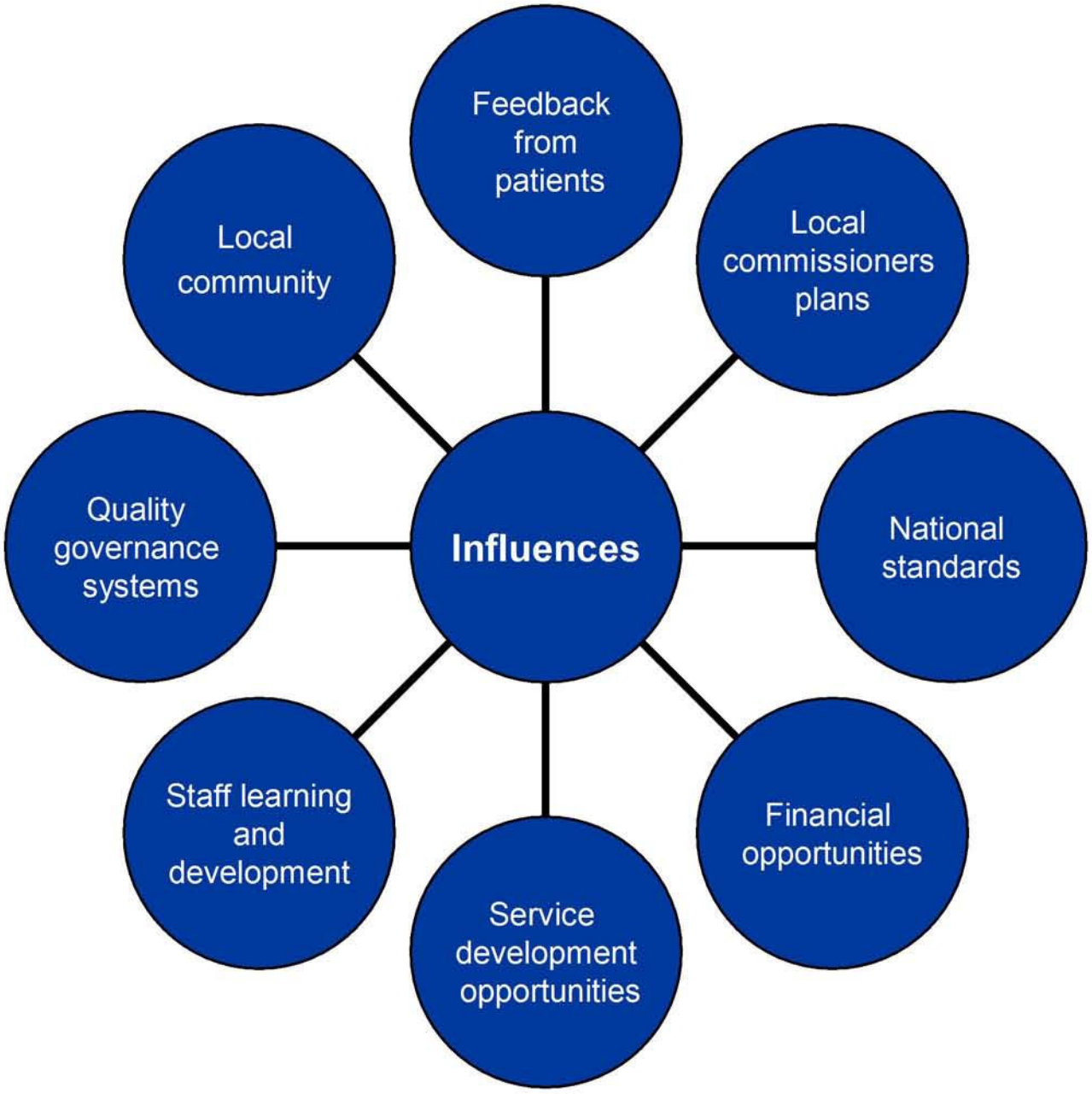






Influences on our New Quality Strategy

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



4. Our Quality Priorities

Add picture - to be completed

Priorities for improvement - looking forward to 2012/13

Quality priorities

In this section we will report our progress against our quality priorities in 2010/11 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 2012/2013 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 2012/2013 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 also implement the NHS Safety Thermometer across the acute and community settings. The thermometer is a national improvement tool for measuring, monitoring and analysing the frequency of 4 specific patient harms (these are falls, pressure ulcers, catheter associated urinary tract infection and venous thromboembolism, VTE - blood clots) and harm free care.

The NHS Safety Thermometer provides a quick and simple point of care survey instrument 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 (the denominator).

Priorities for improvements - looking forward to 2012/13

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

Example

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%)

N.B 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 CQUINN)

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 figure of **X**	• 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. • To 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 2, 3 and 4 by 10% from the quarter 4 baseline figure of **X**	• 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.	• 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.

Our top prorities for 2012/13 (including CQUINN)

Priority	Quality indicator	How we will achieve
Reduce patient harm in hospital **SAFE**	To roll out the use of the Safety Thermometer as a monitoring tool trust wide.	**See page 16**
Provide evidence based care **EFFECTIVE**	To reduce hospital acquired venous thromboembolism (VTE, blood clots)	• Ensure VTE risk assessments are carried out on all patients on admission. • Effectively prescribe Propholaxis for all patients who are at high risk of developing a VTE.
	To sucessfully achieve 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, community accrued pulmonary conditions, hip conditions, hip and knee and stroke. • 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.

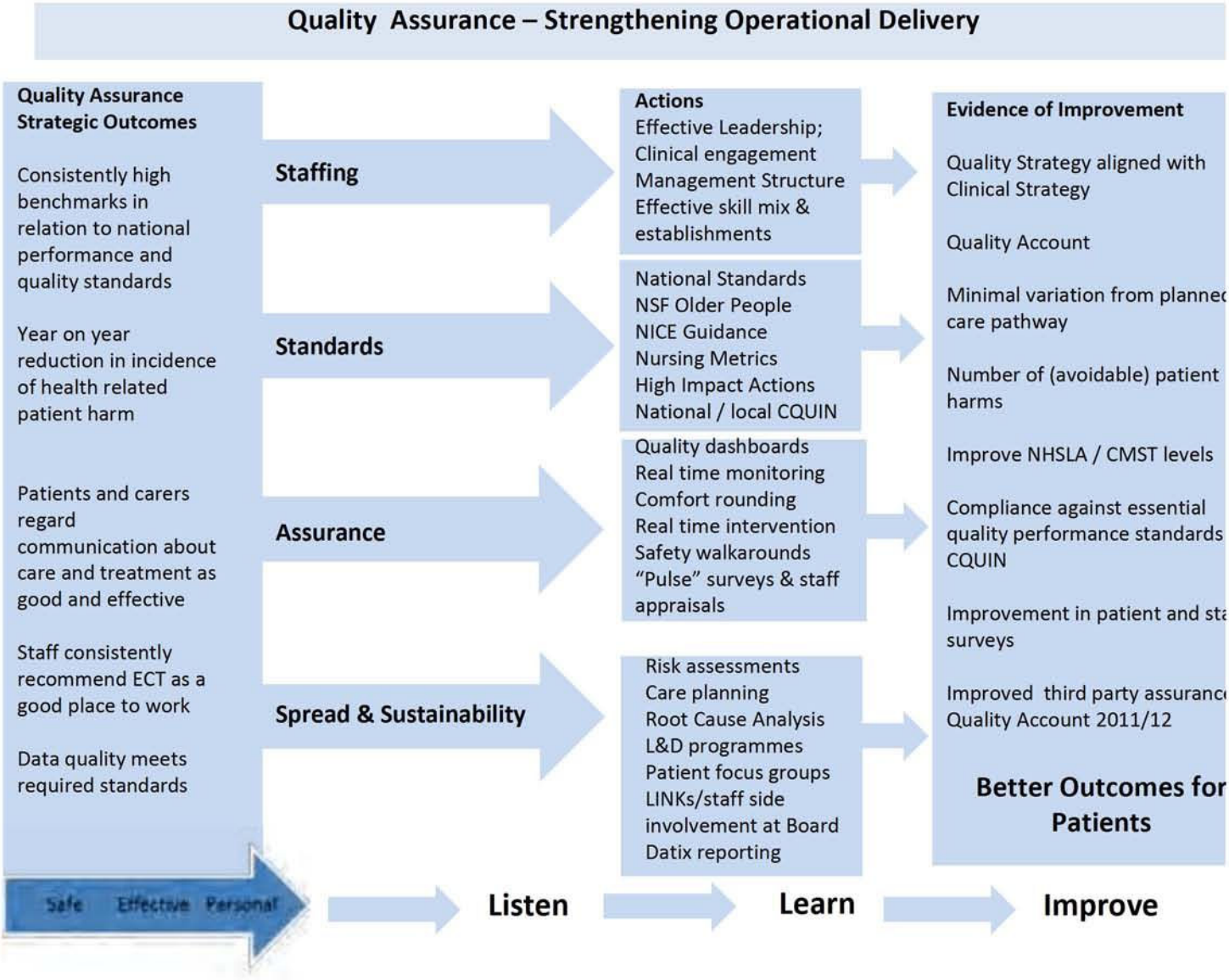
Our top prorities for 2012/13 (including CQUINN)

Priority	Quality indicator	How we will achieve
To provide positive patient experience **PERSONAL**	To improve the diagnosis and referral of patients with dementia.	• 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.
	To reduce the number of cancelled operations to 2% or under of all patient admissions.	• The Surgical Admissions Lounge will be commissioned in July 2012, although an interim lounge will be available from May 2012, whilst work is undertaken on the new designated area.
	To improve the assessment times of patients coming to A&E in an ambulance.	X

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 trust is benchmarked by the Audit Commission as part of Advancing Quality Audit and has not been highlighted as an outlier.

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.

A recent follow up review of care, carried out on 28 February 2012 observed how people were being cared for, looked at records of people who use services, talked to staff and to people who use our services. The review was carried out in specific relation to two areas of required improvement identified by the trust and by the CQC in September 2011.

1. The care and welfare of people who use services
2. Meeting nutritional needs.

Following the further unannounced inspection in Feb 2012 the trust is assessed as Compliant with all standards of patient care.

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

Add picture - to be completed

Review of 2011/12 priorities

< Behind schedule = On track to achieve ✓ target achieved

Safe

Reduce the number of injurous falls per thousand bed days

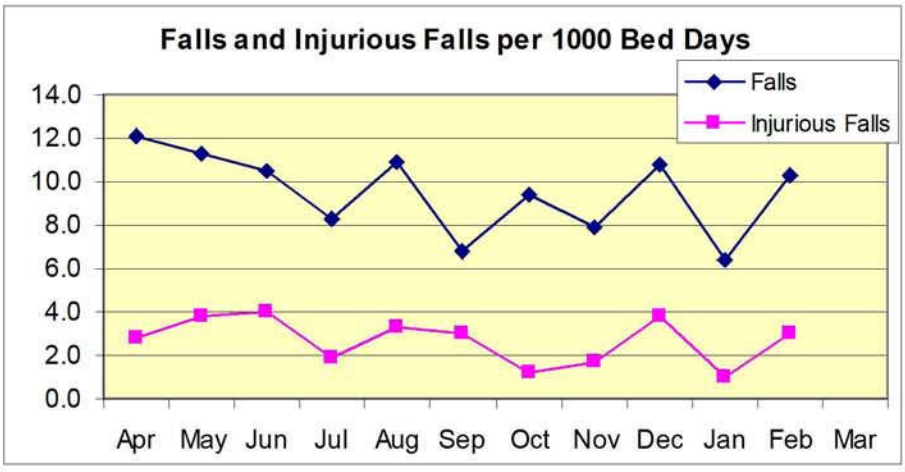
What: To reduce the number of injurous falls per 1,000 bed days.

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

By when: March 2012

Outcome: = On track to achieve at Feb 2012.

Progress: Graph - Falls and Injurious Falls per 1000 bed days Jan 2012



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.

"I think that a minority of patients underestimate the work that many NHS staff do. I witnessed a couple of difficult patients during my stay and their care was excellent."

Anonymous National Inpatient Survey 2011/12

SAFE

TO PROTECT PATIENTS WITHIN OUR CARE FROM HOSPITAL ACQUIRED INFECTION

WHAT: To reduce the incidence of hospital acquired infection.

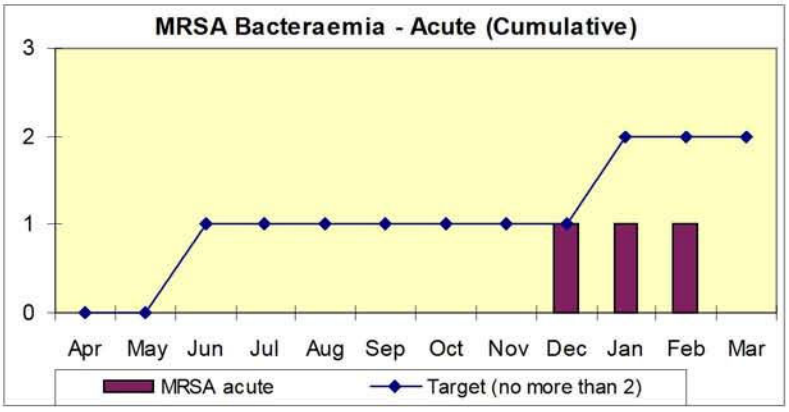
HOW MUCH: No more than 2 MRSA bacteraemia per year in the hospital setting and less than 10 in the community setting.
No more than 33 ***Clostridium Difficile*** infections (CDI) per year in the hospital setting and 104 for the community setting.

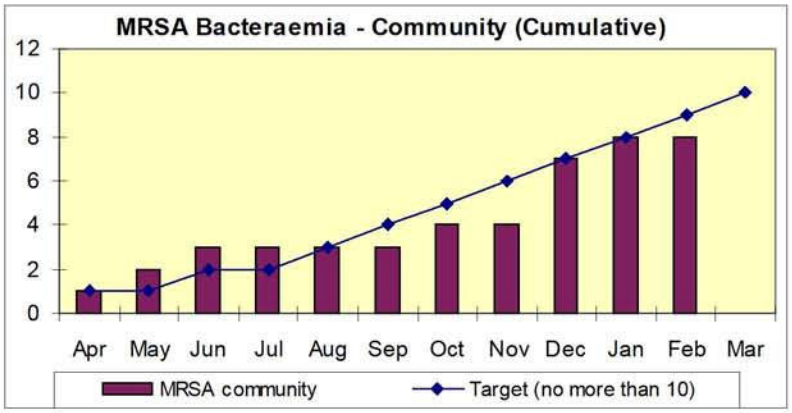
BY WHEN: March 2012

OUTCOME: ✓ target achieved.

PROGRESS:

GRAPHS - HOSPITAL ACQUIRED MRSA INFECTION RATES AT FEB 2012



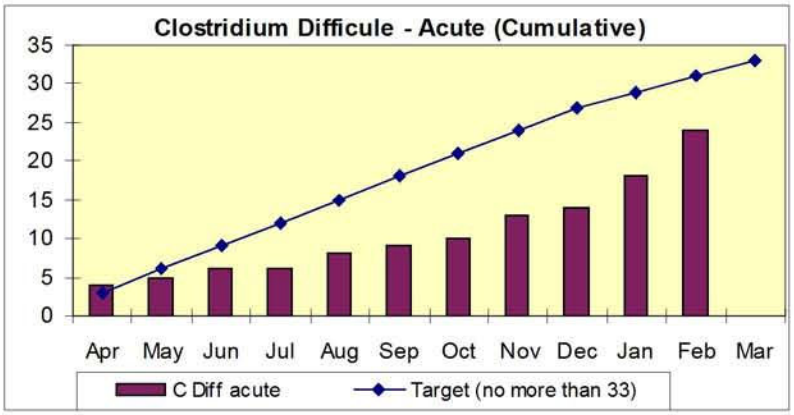


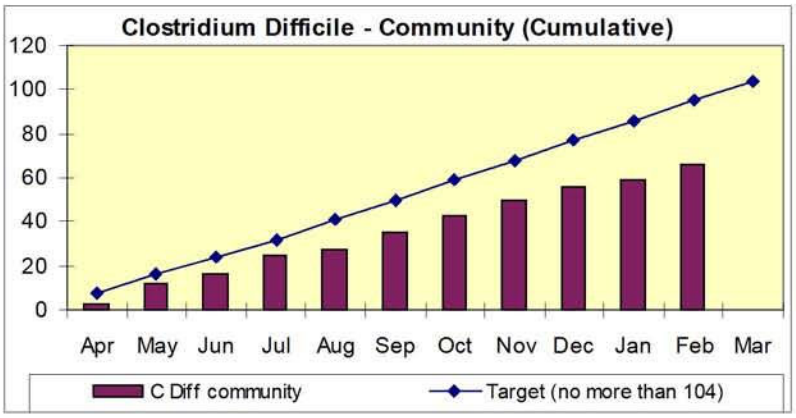
Safe

To protect patients within our care from hospital acquired infection

Progress:

Graphs - hospital acquired Cdiff infection rates at Feb 2012





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 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.

"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 Hospital Standardised Mortality Ratio (HSMR). Hospital mortality rates refer to the percentage of patients who die while in the hospital. Mortality rates are calculated by dividing the number of deaths among hospital patients with a specific medical condition or procedure by the total number of patients admitted for that same medical condition or procedure.

How much: From 2010/11 baseline of 92.7.

By when: March 2012

Outcome: In line with the national directive East Cheshire NHS Trust moved to using the Risk Adjusted Mortality Index (RAMI) in 2011 to measure hospital mortality. The RAMI for the trust in 2010/11 was 90. The RAMI score, using this same benchmark, for the latest period available (April 2011 - Feb 2012) has fallen to 78. The RAMI benchmark gets refreshed every year and using the new benchmark for period X our new RAMI score is 88.

Progress: ✓ target achieved

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 abnomalies are picked up and scrutised by appropriate staff.

Effective

VTE Prevention Programme

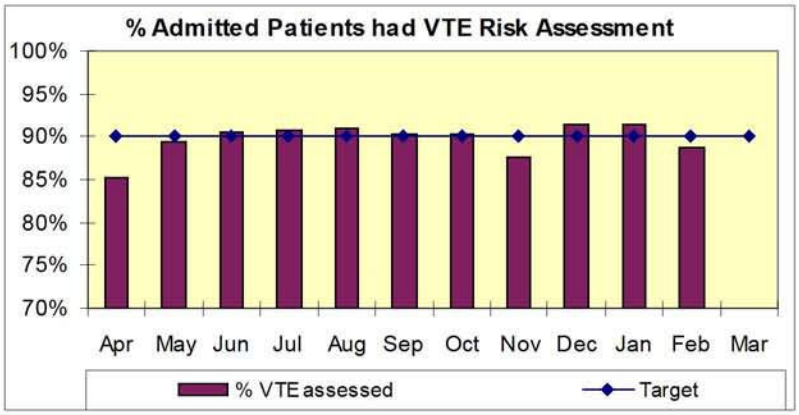
What: To reduce hospital acquired venous thromboembolism (VTE)

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

By when: March 2012

Outcome: = On track to achieve at Feb 2012.

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.

N.B 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

Outcome: ✓ target achieved. Between April 2011 and the end of February 2012 the average score for the ten monitored stroke performance indicators has averaged 96%.

Progress: 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 Unit. 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. 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 prevalence of all pressure ulcers by 10% from 2010/11 baseline of 291 in hospital and 330 in the community.

By when: March 2012

Outcome: Due to the integration of the trust and Cheshire East Community Health in April 2011 a change of monitoring systems occured which left inconsistencies in data caputure systems for pressure ulcers. Since Oct 2011 the trust have moved to a more consistent approach indentifying pressure ulcers by grade and when and where they were developed.

Progress: < Behind schedule

Improvements achieved

- 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

Outcome: < Behind schedule

Graph - Cancelled operations as a % of planned admissions

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.

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

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

Progress: 3.5% of occupied bed days were delayed discharges from April to February 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.

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

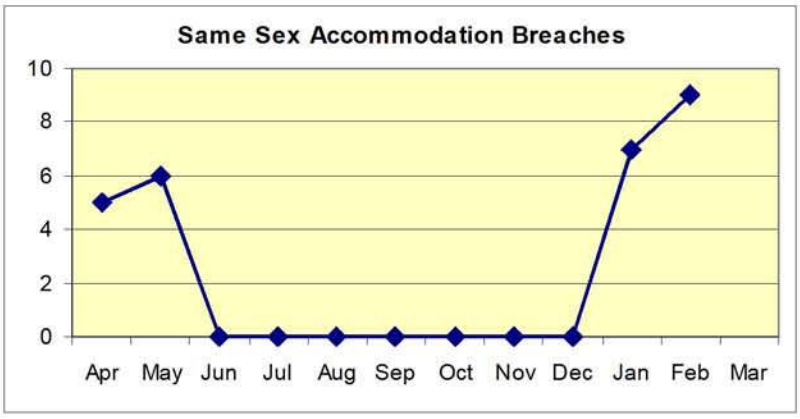
What: To ensure we are compliant with same sex accommodation regulations.

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

Outcome: All inpatient areas now have same sex designated bays and bathing facilities.

Progress: Graph - Same Sex Accommodation Breaches at Feb 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

Outcome: = On track to achieve

As at the end of quarter 3 we can report:
- 100% of complaints were acknowledged within agreed timescales; and
- 94.08% were responded to within agreed timescales.

Progress:

- 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.

- 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

Experience

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

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 other 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 increase the number of patients at end of life who are on a care of the dying pathway.

How much: Above 50%.

By when: March 2012

Outcome: ✓ target achieved.

Improvements achieved

- The trust have achieved a 30% increase of patients who are at end of life on the care of the dying pathway.
- We have reduced the number of palliative care 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

Outcome: To increase the knowledge base of acute clinical staff who may care for people who have dementia.

Progress: ✓ target achieved

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.

Future improvements

- Planned bespoke dementia care training sessions to specialist staff groupsin 2012/13. Topics to include understanding behaviour in dementia, decision making in dementia, communicating with people with dementia and nutrition and 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.

To be completed

6. Review of clinical research in 2011/12

Add picture - to be completed

AUDIT PARTICIPATION

PARTICIPATION IN CLINICAL AUDITS 2011/2012

During 2011-12, **X** 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 **X and %** of the national clinical audits and 2/2 (100%) national confidential enquiries which it was eligible to participate in.

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 (CEMACH)	✓	x	x
Neonatal intensive and special care (NNAP)	✓	✓	
Paediatric pneumonia (BTS	✓	✓	Closing 31 March
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)	x	x	x

AUDIT PARTICIPATION

National clinical audit	Participation	Data collection 2011/12	% cases submitted in 2011/12
Non invasive ventilation – adults (BTS)	✓	x	x
Pleural procedures (BTS)	✓	x	x
Cardiac arrest	X	X	Deferred until 2013
Severe sepsis and septic shock (CEM)	X	X	Trust not eligible to participate
Adult critical care (ICNARC)	✓	✓	100%
Potential donor audit	✓	✓	100%
Seizure management (CEM)	X	X	Audit discontinued
Diabetes (adults)	x	x	x
Heavy menstrual bleeding	✓	Ongoing	x
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)	✓	x	x
Bronchiectasis (BTS)	✓	x	x
NJR hip knee and ankle replacements	✓	✓	100%
PROMs elective surgery	✓	✓	23.5% (2/2/12) 100% patients asked
Intra thoracic transplantation	N/A	x	x
Liver transplantation	N/A	x	x
Coronary angioplasty	N/A	x	x
Peripheral vascular surgery (VSGBI)	✓	✓	100%
Carotid interventions	✓	✓	100%

AUDIT PARTICIPATION

National clinical audit	Participation	Data collection 2011/12	% cases submitted in 2011/12
MINAP	✓	Ongoing	100%
Heart failure	✓	✓	x
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	x	x	x
Oesophago-gastric cancer	x	x	x
National Hip fracture database	✓	✓	109.5%
TARN	✓	✓	x
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	Deferred until 2013
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 Natiional 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	Conclusions/Actions to be taken
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.	**Conclusion** • Overall our compliance to BTS pneumonia guideline was good. • If pre-school child presents with wheeze, chances of having chest infection is quite low • CXR is not required in mild cases of Pneumonia. • Amoxicillin is first choice of antibiotics in under 5 years of age. • A new BTS guideline for pneumonia is going to publish in mid 2011. **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
Medicine 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 hrs • Recording of inhaler technique checks by respiratory team. • Advice regarding visit with GP within a week of discharge. • Written management plans.

Review of Audits in 2011/12

National Clinical Audits: Actions to improve quality

National audit	Conclusions/Actions to be taken
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). • 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
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 adjustmentsbased 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.

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	Conclusions/actions
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'.	**Conclusions** • The results show that the majority of patients who scored on the nutritional screening tool were appropriately referred to the dietitian but the documentation of actions taken was poor. • The delivery of dietetic recommendations in the form of snacks and full fat milk was also poor. • The monitoring of patients in the form of food record charts was low and it was more likely that they would be completed if they were under the care of the dietitian. **Actions** • Implement training package 'Nutrition Now' to ward staff. • Commence snack trolley to make sure patients receive appropriate snacks. Reassess in six months time.

Review of Local Audits in 2011/12

Local Clinical Audits: Actions to improve quality

Speciality	Audit title	Conclusions/actions
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. The outcome of the action plan will ensure improvements are made with the standard of documentation which will lead to better patient safety.
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.	**Conclusion** A survey, by way of a 9 point questionnaire, was carried out over a three week period, in the Emergency Department, Medical Assessment Unit, Emergency Assessment Unit and Short Stay Unit. Staff involved in taking blood cultures were requested to fill in the questionnaire, and to prevent bias, direct observation of the procedure was planned for 10% of the sample size.

Review of Local Audits in 2011/12

Local Clinical Audits: Actions to improve quality

Speciality	Audit title	Conclusions/actions
Acute medicine	**Blood Culture Technique**	**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 The audit was presented at the Medical Business Unit Audit meeting in January 2012, with# the resulting action that if the correct procedure is followed, the contamination rate will decrease, thus ensuring greater patient care and safety.
Care for Elderly	**Delirium Audit** The aim of the audit was to establish if patients who are admitted to MDGH 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.

Review of Local Audits in 2011/12

Local Clinical Audits: Actions to improve quality

Speciality	Audit title	Conclusions/actions
Oncology	**Oncology Emergency Admissions** The National Confidential Enquiry into Patient Outcome and Death (NCEPOD 2008) has recently analysed the care given to patients who received systemic anticancer therapy in June and July 2006 and who died within 30 days of treatment. 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 care9 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.	**Actions** • Development of an acute oncology steering group. • Additional non-surgical oncology resources needed. • Additional consultant appointments needed in the Greater Manchesterand 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. • 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.
Surgery	**Surgical Business Unit including Women's Services Audit**	The Surgical Business Unit have implemented a number of actions 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	Conclusions/actions
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.	**Conclusions** The audit findings and recommendations were discussed at Clinical Governance Committee 14th September 2011. The areas of good practice 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 The final report was presented and disseminated at the monthly clinical audit meeting on 14 September 2011.
Orthopaedics	**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. 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.	**Conclusions** • Discharge, information sent to GP insufficient • No support for patients during first few weeks post discharge. • The audit also found that inconsistent patient information was provided. **Actions** • Consultants need to be made aware of readmission on day one.

Review of Local Audits in 2011/12

Local Clinical Audits: Actions to improve quality

Speciality	Audit title	Conclusions/actions
Orthopaedics	**Orthopaedic Department**	• Discharge summaries to GP to be improved. • More support information for patients, helpful telephone numbers and self help websites. • 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. The results were submitted, assessed and presented at the Orthopaedic Audit Meeting where the conclusions and recommendations were discussed and an action plan formulated which is currently being acted upon.

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	Conclusions/actions
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	Conclusions/actions
	• 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	Conclusions/actions
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	Conclusions/actions
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	Conclusions/actions
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	Conclusions/actions
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.

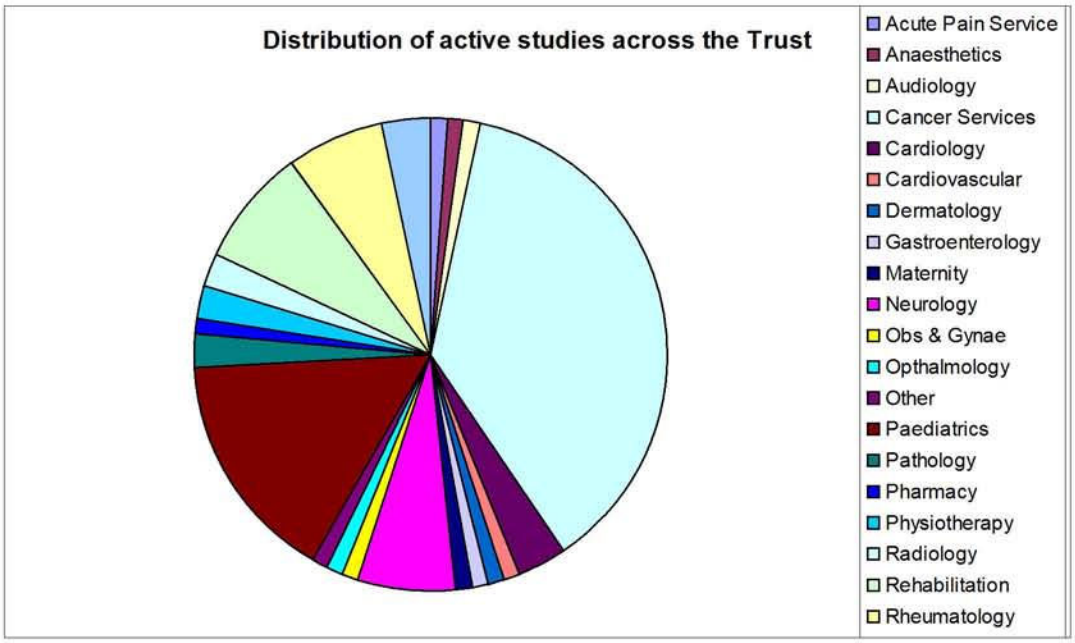
The trust is currently involved in 89 active clinical research studies covering 20 medical specialties which are as follows:

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 Central and Eastern Cheshire Primary Care Trust (CECPCT)

Commentary from Overview and Scrutiny Panel (OSC)

Written Statements from other bodies

Commentary from Cheshire East LINk

Commentary from Cheshire West and Chester LINk

ACKNOWLEDGEMENTS

GLOSSARY

TERM	EXPLANATION
BTS	
CEMACH	
CEM	
CNST	
HSMR	
ICNARC	
MINAP	
NICE	
NCEPOD	
NNAP	
PROMS	
RAMI	
SHMI	
SINAP	
TARN	
VTE	
VSGBI	

TERM	EXPLANATION

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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