East Cheshire NHS
NHS Trust

Quality Account 2010/11

Statement from Chief Executive

"East Cheshire NHS Trust has become 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.

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 emergency care floor. We have invested in our clinical technology with the installation of a new CT scanner and digital breast mammography.

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.

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 quality sustainable 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.

Finally, I am pleased to confirm that the Board of Directors has reviewed this report and confirmed that it is an accurate reflection of our performance. Each month the Board reviews progress against quality standards and this report is based on these performance indicators.

John Wilbraham
Chief Executive
April 2011

Statement of Directors Responsibilities in Respect of Quality Accounts

The Directors are required under the health act 2009 and the National Health Service (Quality Accounts) Regulations 20110 to prepare Quality Accounts for each financial year.

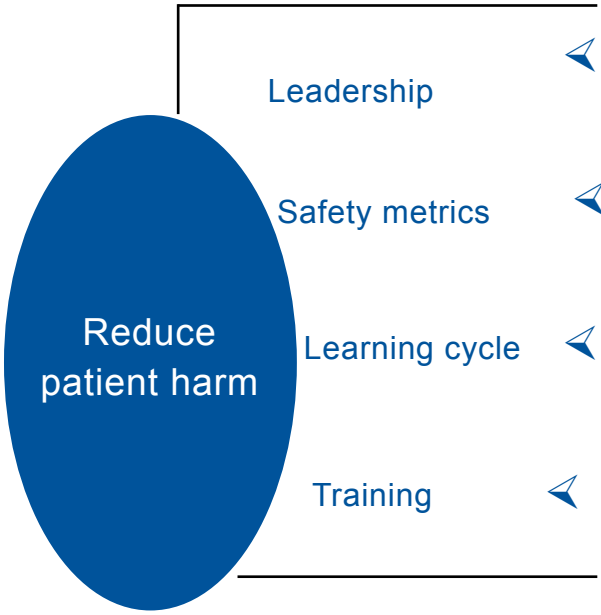
A quality account is an annual report to the public from providers of NHS healthcare about the quality of services delivered.

The main purpose of a quality account is to encourage trust boards and leaders of health care organisations to assess quality of their services and to demonstrate a commitment to deliver continuous, evidence based quality improvement. This ensures that progress is explained to the public and allows for scrutiny, debate and reflection on quality improvements thereby reinforcing local accountability.

Quality Improvement Strategy

Can we save lives?

Period	Deaths	Expected	Time
Sept 09 - Aug 10	640	689.2	92.9
Oct 09 - Sept 10	645	695.2	92.8
Nov 09 - Oct 10	649	701.4	92.5
Dec 09 - Nov 10	668	704.6	94.8
Sept 09 - Aug 10	647	696.4	92.9



Quality Improvement Programme

Safe	Personal	Effective
• Falls • Infections • Mortality	• VTE • Stroke • Pressure care	• VTE • Care pathway • Privacy and dignity • Communications

Building system capability

⇨ Listen ⇨ Learn ⇨ Improve

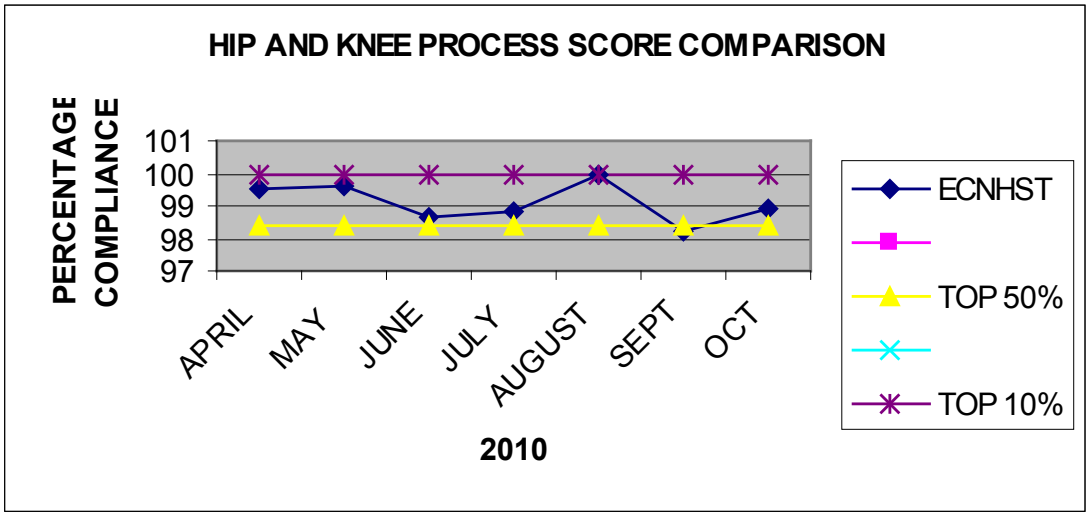
How good is our care?

- Effective ward teams
- Clinical engagement

- Ward to board
- Quality dashboard

- Benchmark improvements
- Root cause analysis

- Culture and continuous improvement.
- Organisational and delopment plan.



What does success look like?

Priorities for improvements - looking forward to 2011/12

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

Following another successful year for the trust in 2009/10 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. We have identified three key priorities that we believe will ensure that the quality of care we provide is enhanced. In the forthcoming year the following areas are our priorities for improvement and will be included in our quality reports in 2011/12.

These priorities have been selected by engaging with our staff, patients and user groups, and other stakeholders informed; by feedback from patient surveys, complaints and incidents, 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

How progress to achieve priorities identified will be monitored and reported by the provider.

Following our assessment our top priorities will be:

Priority	Quality indicator	Quality domain
Reduce patient harm in hospital	• To reduce the number of falls per thousand bed days from 20010/11 baseline. • To reduce the incidence of health care acquired MRSA, Clostridium Difficile and infections. • To maintain or reduce Hospital standardised mortality ratio (HSMR) from 2010/11 baseline.	Safety
Provide evidence based care	• To ensure 90% of eligible patients receive Venous Thromboembolism (VTE) assessment on admission to hospital. • To increase percentage of patients with stroke for whom all 9 stroke indicators are met from 2010/11 baseline. • To reduce the prevalence of pressure ulcers per 1000 bed days from 2009/10 baseline.	Effectiveness
To provide positive patient experience	• To reduce the number of cancelled operations as a percentage of the total number of planned admissions. • To reduce length of stay for patients who are medically fit for discharge or transfer of care. • To ensure we are compliant with same sex accommodation regulations. • To reduce the number of complaints relating to poor communication.	Experience

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 within reach.

Arrange bedside table.

Ensure water is available.

3. Patient needs

"Do you need to use the bathroom?"

4. Position

"Are you comfortable?"

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. All NHS organisations are encouraged to improve the reporting of patient safety incidents. Embedding a culture where 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.

Hospital Standardised Mortality Ratios (HSMR) are used to calculate the numbers of deaths that would be expected in a particuliar hospital. The calculated "expected" number of deaths is based on the national deaht 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 HSMR is the ratio of actual deaths to expected deaths. East Cheshire NHS Trust's HSMR is 92.9%

- Our aim is to maintain or reduce HSMR from 20010/11 baseline.
- To increase percentage of patients with stroke for whom all 10 stroke indicators are met from 2010/11 baseline.

Patient experience

We recognise that short notice cancellations impact on patient experience and we aim to improve performance in this area. We aim to:

- To reduce the number of cancelled operations as a percentage of the total number of elective admissions
- We are committes 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. In addition we will develop community services to support a reduction in emergency readmissions.

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

- To reduce the number of complaints relating to poor communication

Developing capacity and capability

The trust is committed to developing a culture of continuous improvement in patient safety. Introducing a development programme 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, 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.

- 80% of all staff having had an annual appraisal
- 90% of all new staff having had an induction
- 90% of all staff to have undertaken statutory and mandatory training
- Sickness absence rates 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.

These include:

- Falls assessment
- Pressure area care
- Privacy and dignity
- Infection prevention and control
- Pain management
- Nutritional needs assessment
- Medicine prescribing and administration
- Cleanliness

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 such as recruitment to clinical trials.

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

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 94.48% 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

Review of 2010/11 priorities

Safe

VTE Prevention Programme

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

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

By when: March 2011

Outcome: 76% at February 2011-03-29

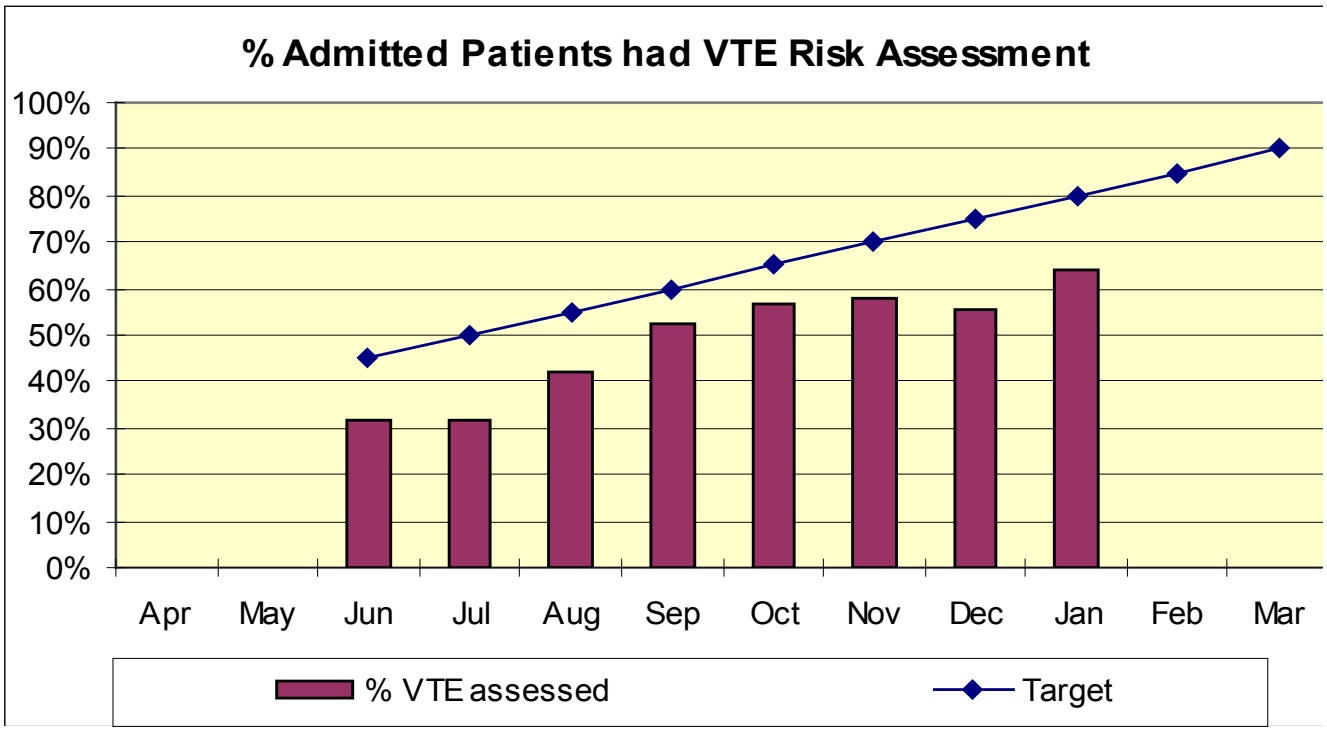
? Norman Ambage to provide percentage to go in at end of March. We are improving, but further required - this will continue to be a priority for 2011/2012

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 1000 bed days
Reduce the number of serious medication errors to less than 0.68 per 1000 bed days.

By when: March 2011

Outcome: Achieved reduction in serious medication errors to 2.7 per 1000 bed days.

Progress: = On track to achieve

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 medical errors now complete additional training.

Safe

Reduce impact of medication errors

Future improvements

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

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 per year.

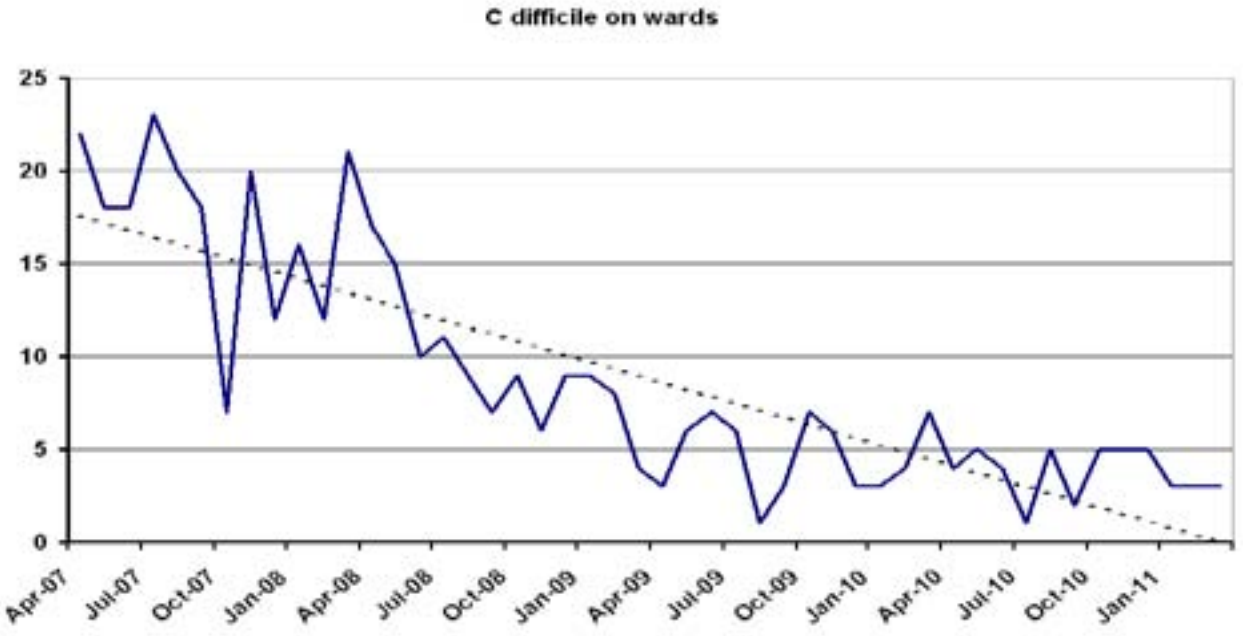
By when: March 2011

Outcome: 45 cases of Clostridium Difficile
3 MRSA Bacteraemias

Progress: ✓ target achieved

Current status:

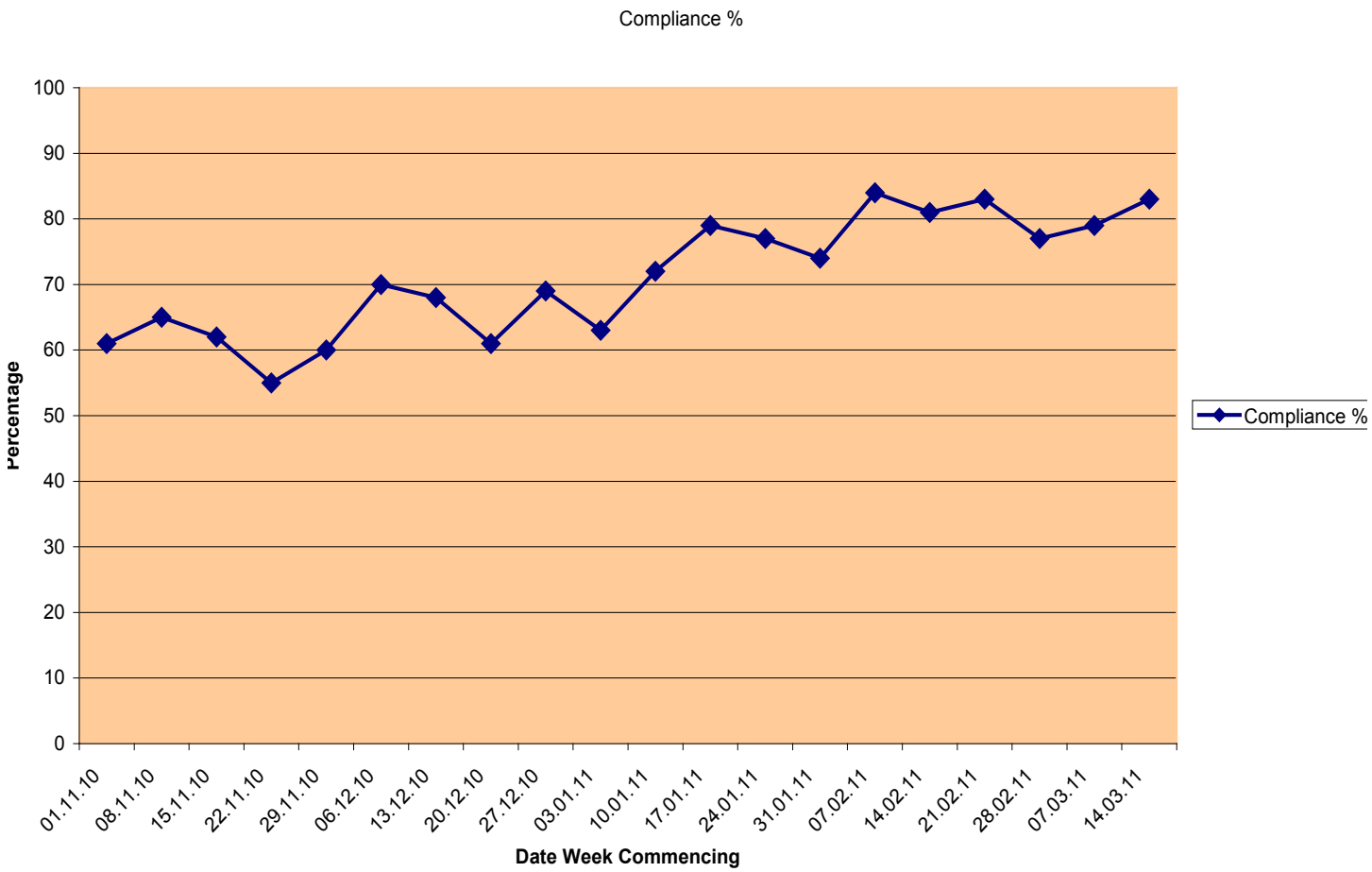
Incidence of Clostridium difficile infections on wards (2007-2011)



Safe

To protect patients within our care from hospital acquired infection

Compliance with MRSA screening for emergency admissions



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: 100%

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.

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.

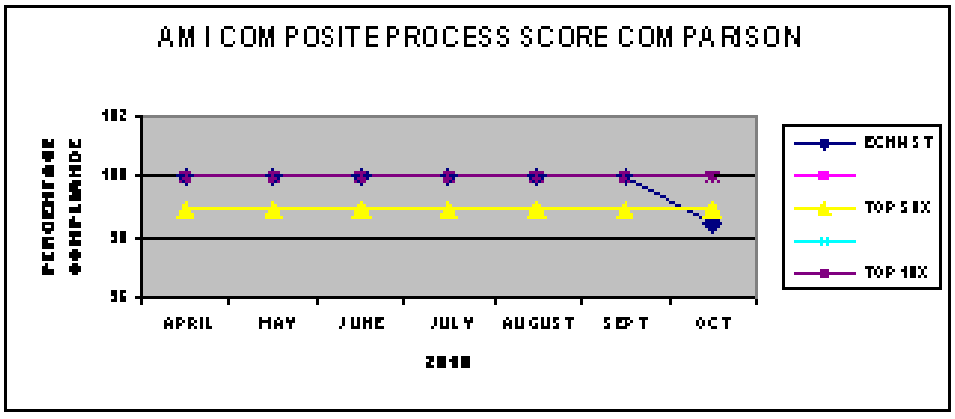
By when: March 2011

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 composite Process Score (CPS)**



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 education and training.
- 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 trauma theatre sessions.

Graph to be inserted

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.

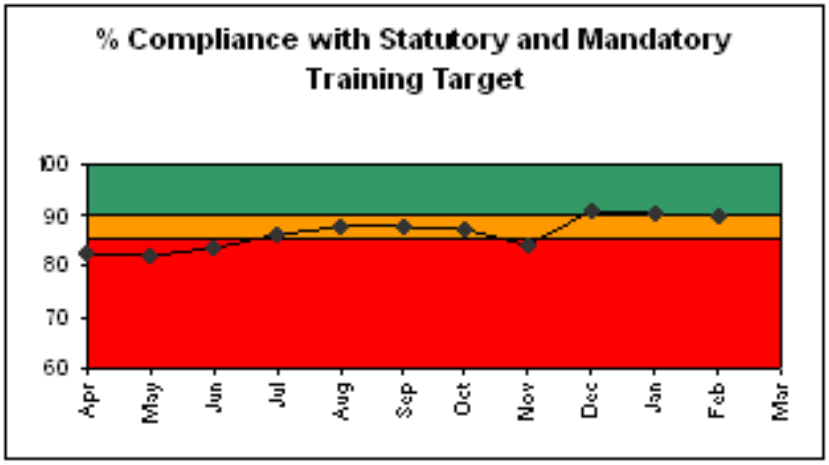
To engage staff in supporting the continuous improvement of patient care and quality standards.

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

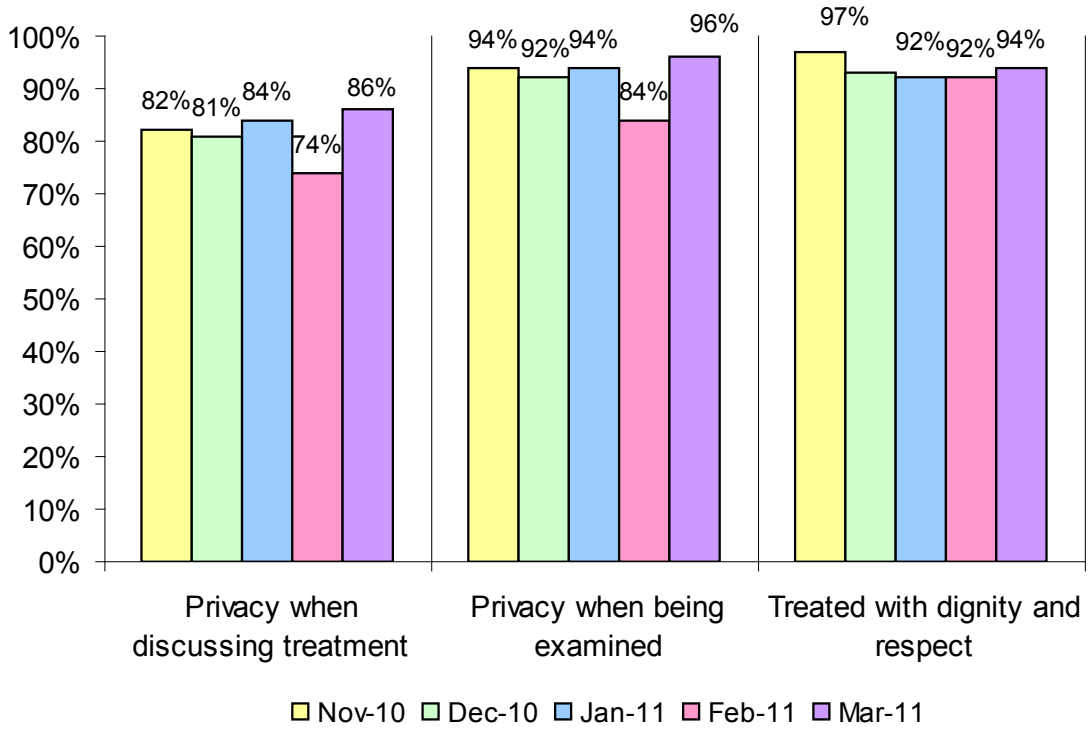
HOW MUCH: The trust aim was to achieve the upper quartile performance in all four clinical areas.

BY WHEN: End of March 2011

OUTCOME: All accommodation will be compliant from 1 April 2011.

PROGRESS: = On track to achieve

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



Personal

Privacy, dignity and respect

Improvements achieved

- 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 to be added

Personal

Learning through Incident reporting

What: To improve incident reporting and be in the highest 25% of reporters.

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 national reporting and learning system and continue to raise staff awareness.

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 35/40 (87%) of the national clinical audits and 100% 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 completed in 2010/11	% cases submitted
Perinatal mortality (CEMACH)	✓	✓	100%
Neonatal intensive and special care (NNAP)	✓	✓	100%
Paediatric pneumonia (British Thoracic Society)	✓	✓	100%
Paediatric asthma (British Thoracic Society)	✓	✓	100%
Paediatric fever (College of Emergency Medicine)	✓	✓	62%
Childhood epilepsy (RCPH National Childhood Epilepsy Audit)	✓		Registered, data not submitted
Diabetes (RCPH National Paediatric Diabetes Audit)			Data submission to start in June 2011.
Emergency use of oxygen (British Thoracic Society)	✓	✓	100%
Adult community acquired pneumonia (British Thoracic Society)	✓		Data collection ongoing 31.05.11

Audit

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)	No		
Heavy menstrual bleeding			
Heavy menstrual bleeding (RCOG National Audit of HMB)	✓		Data collection ongoing
Ulcerative colitis and Crohn's disease (National IBD Audit)	✓	✓	Awaiting %
Parkinson's disease (National Parkinson's Audit)	No		
COPD (British Thoracic Society European Audit)	No		
Adult asthma (British Thoracic Society)	✓	✓	100%
Bronchiectasis (British Thoracic Society)	✓	✓	Awaiting %
Hip, knee and ankle replacements (National Joint Registry)	✓	✓	100%
Elective surgery (National PROMs Programme)	✓	✓	100%
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	✓	✓	Subsidiary hospital
Carotid interventions (Carotid Intervention Audit)	✓	✓	100%
Acute Myocardial Infarction & other ACS (MINAP)	✓	✓	96%
Heart failure (Heart Failure Audit)	✓	✓	Data collection ongoing
Acute stroke (SINAP)	✓		100%

Audit

Renal replacement therapy (Renal Registry)	✓	✓	100%
Renal transplantation (NHSBT UK Transplant Registry)	✓	✓	Awaiting %
Renal colic (College of Emergency Medicine)	✓	✓	Awaiting %
Lung cancer (National Lung Cancer Audit)	✓	✓	Data to be submitted June 2011
Bowel cancer (National Bowel CancerAudit Programme)	✓	✓	Awaiting %
Head and neck cancer (DAHNO)	✓	✓	100%
Hip fracture (National Hip Fracture Database)	✓		219 patients included to date
Severe trauma (Trauma Audit and Research Network)	✓	✓	Awaiting %
Falls and non-hip fractures (National Falls and Bone Health Audit)	✓	✓	80%
O neg blood use (National Comparative Audit of Blood Transfusion)	No		Previously undertaken in 2007, due to be re-audited in 2013.
Platelet use (National Comparative Audit of Blood Transfusion)	✓	✓	100%
NCEPOD Cardiac Arrest Procedures Study .	✓	✓	100%
CMACE Maternal Obesity in the UK	✓	✓	100%
CMACE Saving Mother's Lives Report 2006-8	✓	✓	Awaiting %

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 Business Unit

National Neonatal Audit Programme (NNAP)

Report and action plan produced 16/12/2011.

Recommendations

- R1-Conduct audit on why 12 mothers (out of 33=36%), not given or received steroids
- 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 re: 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 – 3 times / year
- Regular junior doctors training to coincide with every 4 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 UDS data collected:

- Whether patients get 45 minutes therapy 5 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

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 audit highlighted that they were 55% compliant to the CNST standard. 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
- Discussed at Women's Governance meeting.
- CNST Hotspots created and presented on notice boards in relevant areas

Another example of this is the perinatal trauma audit undertaken in September 2010, the audit highlighted that the unit was 20% compliant to the management of third and fourth degree tears (CNST standard) .The following actions were implemented, the re-audit evidenced that they are now 100% compliant to the above 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.

Paediatric Business Unit

The Paediatric Business 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:

Audit

NICE CG99- constipation

- Presented at the paediatric meeting, to consultants and Junior Drs outlining key findings and areas for improvement.
- A good practice document created outlining the requirement to detail history- including diet, lifestyle stool pattern & 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) , CNTT service.
- 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.
- 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:

Audit

Radiology- Serum Creatinine and contrast agent in high risk inpatients undergoing 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 eGFR <60 to be required to have hydration optimisation.
- Minimal hydration (oral and 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.

NICE CG74- Surgical Site Infection audit

- In process of devising antibiotic prophylaxis policy specific to E.N.T. 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 asParkinson'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.

Audit

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.

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%.

Medical Business Unit

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 I.V 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)

Audit

NICE guidance CG94 Unstable angina and 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 CCU.

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 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. Further examples are provided in the following section 4.55
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 • Bacterial Meningitis and Septicaemia reviewed 14.02.11 • Venous Thromboembolism (VTE) reviewed 14.02.11 • Diarrhoea and Vomiting in Children reviewed 14.03.11	To be re-audited against NICE guidelines. To discuss the antibiotics policy with Pathology Services and to develop an Early warning Score for paediatrics. This subject will be reaudited in October Development of Standard Operating Procedure to ensure VTE risk assessment is confirmed as a mandatory procedure/ development of training package. Reaudit 12 months. PGD to be amended to include ID 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 • Antibiotic Point Prevalence Audit report reviewed 07.10 • Slips, trips and Falls audit report reviewed 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 (NHSLA and RCP standards) report reviewed 20.01.11	Actions, where appropriate, are detailed in individual meeting minutes and available if required
Women and Children Business Unit	A monthly CNST progress report is submitted to the Clinical Governance meeting, along with the action plans and monthly monitoring report. On 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 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 Ill 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	
	• Serum Creatinine and contrast agent in high risk inpatients undergoing CT. • Medicine Adherence Board	

Examples of good practice

Group or forum	Local audits reviewed	Action
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 3 presentations per meeting. For example: 1. Acute alcohol withdrawal audit (NICE CG100) 2. Reducing re-admissions audit 3. Infection control 6 monthly audit report	Actions, where appropriate, are detailed in individual meeting minutes and 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. The following is an example of the audits presented and discussed at the two audit meeting (paediatric, Midwifery): 1: Auscilation 2: NICE Intrapartum 3: Outcome of babies born to rheus negative mothers. 3: NICE feverish Child.	Actions, where appropriate, are detailed in individual meeting minutes and available if required

Examples of good practice

Group or forum	Local audit reviewed	Action
Surgical Business Unit monthly audit meetings.	Rolling programme with the intention to present and discuss all audit projects. Up to 2 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 and 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 3 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 and 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 8 new studies, 3 of which were randomised controlled trials (RCT) which are the gold standard for research. There are a further 3 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, 4 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.

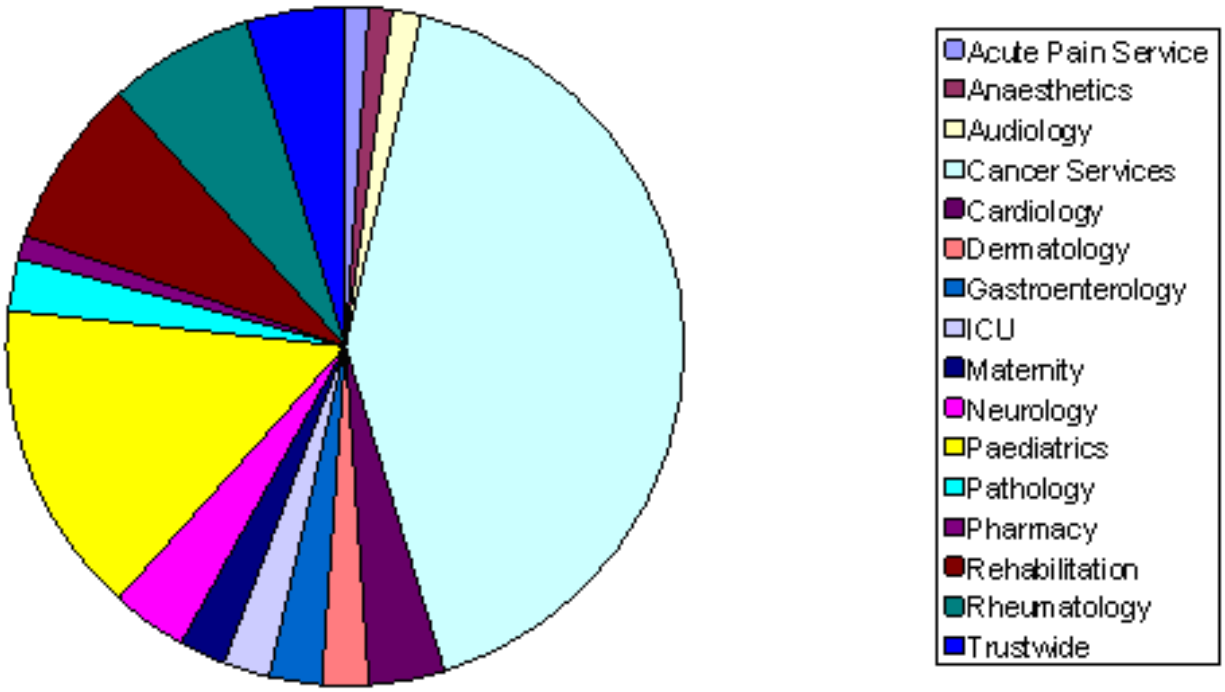
Participation in clinical research

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.

Distribution of active studies across the trust



Written Statements from other bodies

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

Commentary from Local Involvement Networks (LINKS)

Commentary from Overview and Scrutiny Panel (OSC)

Patient choices any positives from Lyn Bailey

Email request 29/3

Written Statements from other bodies

Appendices

Appendix one

Glossary and Abbreviations

Acknowledgements

- Kath Senior
- Julie Green
- Salford Royal NHS Foundation Trust

Appendices

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

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

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