East Cheshire NHS
NHS Trust

QUALITY ACCOUNT
2009/2010

CONTENTS

PART 1

SUMMARY STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

2009/10 has been a very successful year for the Trust in many ways and I would wish to start by giving our thanks to the staff at the Trust for the service they have given over the last 12 months. Their dedication is appreciated by the Board, especially during the period of extreme bad weather during the winter months.

The Trust is ever mindful of patient quality and safety and our focus on infection control has seen a significant reduction in Clostridium difficile and the lowest levels of MRSA bacteraemia since the introduction of the target several years ago. The Care Quality Commission reinforced this success with the outcome of their unannounced visit confirming that the Trust was meeting its obligations under the hygiene code.

The Trust Board recognises its role in placing quality and safety at the centre of what it does. The Board adopted its quality strategy in July 2008 and this is being refreshed for the 2010/11 financial year.

As part of this commitment £292,000 has been spent in 2009/10 to ensure that single sex accommodation can be achieved within the Trust so that patients can retain their privacy and dignity whilst being cared for.

The Trust has been recognised for its progress in a number of areas. Our stroke service was highly recommended in the national patient safety awards. The Trust was also identified as one of five hospitals in the North West to become Tier 2b paediatric allergy centres as part of the Department of Health best practice pilot across the region. This involves hospital consultants working closely with GPs and community health colleagues for example school nurses. We have also been named as one of the top 5 hospitals for quality of care by CHKS, a commercial company working within the NHS.

The standardised mortality rate at the Trust compares favourably and has been reducing further during the year

These achievements have been made against a challenging financial backdrop and the Trust has completed its financial recovery plan in 2009/10 which allows the Trust to enter 2010/11 with confidence having registered with the Care Quality Commission without conditions and focusing now on working with partners to deliver services in a more integrated way allowing a move to Foundation Trust status as required by the Department of Health.

We very much hope you enjoy reading this document and that it gives a feel for the real achievements made during the year for the benefit of our patients.

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 2010 to prepare Quality Accounts for each financial year.

In preparing these accounts, Directors are required to take steps to satisfy themselves that:

- The Quality Account present a balanced picture of the NHS Trust's performance over the period covered;
- The performance information reported in the Quality Account is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data, quality standards and prescribed definitions, and is subject to appropriate scrutiny and review;
- The Quality Account has been prepared in accordance with relevant requirements and guidance.

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

By order of the Board

Kathy Cowell
Chairman

John Wilbraham
Chief Executive

PART 2

PRIORITIES FOR IMPROVEMENT IN 2010/2011

INTRODUCTION

The Trust has a significant number of quality and safety improvement initiatives underway.

These include requirements from the Primary Care Trust who commission our services, standards from the Care Quality Commission as well as the Trust's own internal Quality Strategy.

The Primary Care Trust set out their requirements in the contract in a Quality Schedule. These standards are monitored monthly by the Primary Care Trust. The commissioners also provide funding for achievement of specific initiatives called Commissioning Quality Initiatives (CQuin). There are 9 CQuin initiatives.

The Trust registered with the Care Quality Commission (CQC) from the 1st April 2010. The Care Quality Commission registers NHS Trusts with or without conditions. The Trust was registered without conditions.

The CQC have 16 quality standards. These standards describe the outcomes that patients should expect. Through 2010/11 we have a programme of audits in place to provide assurance that we continue to achieve these outcomes.

Since 2008 the Trust has had its own Quality Strategy that focused on 10 areas, 5 in improving patient safety and 5 on the patient experience.

Our achievements in all of these areas are described in Part 3.

The Quality Strategy agreed in 2008 has been updated and now has 31 aims. This will support continuous improvement through the coming years.

The Trust Board has agreed the following statements as underpinning principles for continuing to improve the care we give to patients:

- Do me no harm (safety)
- Make me better (clinical effectiveness)
- Be nice to me (patient experience).

THE PRIORITIES

In order to focus our efforts on continuous improvement the following 10 areas are identified as priorities. The Individual Performance Indicators are listed in Appendix 2.

DO ME NO HARM (safety)

Aim:- To reduce the number of falls sustained by patients within our care and to improve the care of patients who attend or are admitted to hospital following a fall.

Measured by:- Nine performance indicators.

Monitored by:- Monthly reports internally and annually by Royal College of Physicians organisational audit for falls and bone health.

Reports to:- Trust Board monthly via Chief Executive's Report.

Aim:- To protect patients within our care from hospital acquired infection.

Measured by:- Four performance indicators including a continued reduction in Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile (Cdiff).

Monitored by:- The Director of Infection Prevention and Control weekly and monthly by the Board.

Reports to:- Infection Control Committee and Trust Board through the Chief Executive's Report monthly.

Aim:- To reduce the impact of medication errors on patients within our care.

Measured by:- Eight performance indicators.

Monitored by:- Quality Strategy Steering Group.

Reports to:- Medicines Management Group and Trust Board monthly via Chief Executive's Report.

MAKE ME BETTER (clinical effectiveness)

Aim:- To reduce avoidable death, disability and chronic ill health from venous thromboembolism (VTE) for patients within our care.

Measured by:- Two performance indicators.

Monitored by:- Monthly returns to the Department of Health.

Reports to:- Trust Board monthly through the Chief Executive's Report and quarterly to the Primary Care Trust.

Aim:- To deliver evidence based interventions to patients within our care with a diagnosis of acute myocardial infarction, heart failure, pneumonia, stroke or undergoing hip or knee surgery.

Measured by:- Two performance indicators.

Monitored by:- North West SHA Advancing Quality Team.

Reports to:- Trust Board monthly through the Chief Executive's Report.

Aim:- To support the timely and effective discharge of patients within our care to the most appropriate setting of an expected discharge date and providing timely information to GPs.

Measured by:- Seven performance indicators

Monitored by:- Monthly by the Primary Care Trust.

Reports to:- Trust Board monthly through the Chief Executive's Report.

BE NICE TO ME (patient experience)

Aim:- To ensure that patients within our care are treated in privacy with dignity and respect.

Measured by:- Four performance indicators including the provision of same sex accommodation unless it is clinically justified.

Monitored by:- Executive review of daily information. Local and national patient surveys and complaints and monthly by the Primary Care Trust.

Reports to:- Trust Board via the Chief Executive's Report on breaches of same sex accommodation and Privacy and Dignity quarterly to the Board by the Patient Experience Report.

Aim:- To ensure that our patients' concerns and complaints are listened to, are investigated appropriately and acted upon and lessons are learnt.

Measured by:- Five performance indicators including a process to ensure lessons have been learnt.

Monitored by: Patient Experience Group.

Reports to:- Trust Board monthly via the Chief Executive's Report and quarterly by Patient Experience Report.

Aim:- To develop all of our staff to ensure that they act as a role model; take personal responsibility; have the courage to speak up and make their voices heard and to deliver care in the best interests of the patient and their families.

Measured by:- Performance indicators as identified in the project plan.

Monitored by:- Project Steering Group monthly.

Reports to:- Executive Management Team monthly and 3 times a year to the Trust Board.

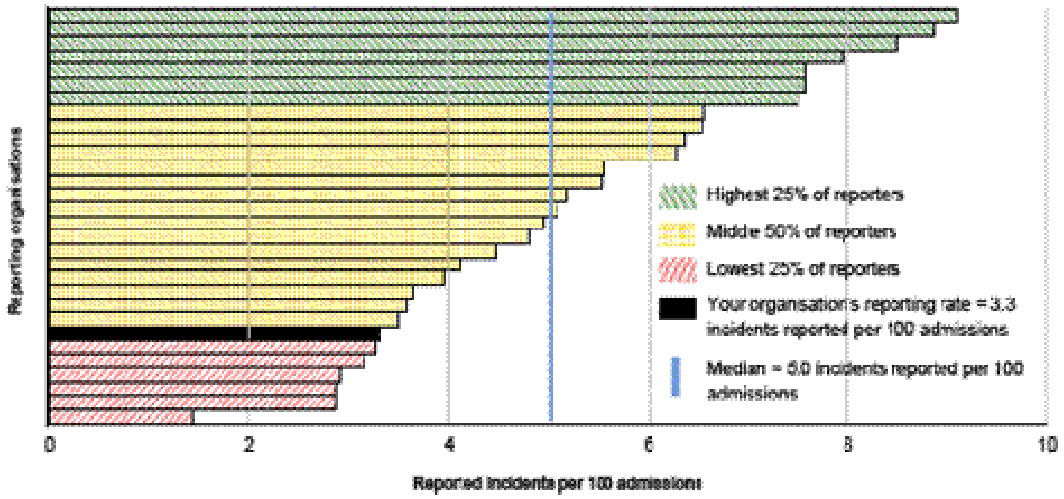
INCIDENT REPORTING

Most incidents that occur are minor. Organisations that report more incidents usually have a more effective safety culture. The following table is the Trust's performance between April and September 2009 and is lifted directly from the National Patient Safety Agency website.

Are you actively encouraging reporting of incidents?

The comparative reporting rate summary shown below provides an overview of incidents reported by your organisation to the National Reporting and Learning System (NRLS) between 1 April 2009 and 30 September 2009. 605 incidents were reported during this period.

Figure 1: Comparative reporting rate, per 100 admissions, for 30 small acute organisations.



Organisations that report more incidents usually have a better and more effective safety culture. You can't learn and improve if you don't know what the problems are. So:

- Encourage staff to report things that go wrong. Don't shoot the messenger!
- Make it easy to report and provide feedback. Make reporting useful!
- Use national comparative data from the NRLS to better understand the reporting and learning culture in your organisation.
- Review steps your organisation can take to make reporting matter.

Tips to help you: *Act on reporting: five actions to improve reporting; Questions are the answer! Seven questions every board member should ask about patient safety at:* www.nrls.npsa.nhs.uk

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

Measured by:- Two performance indicators.

Monitored by:- Clinical Risk Management Group monthly.

Reports to:- Trust Board monthly through the Chief Executive's report.

PART 3

REVIEW OF QUALITY PERFORMANCE

INTRODUCTION

In order for NHS bodies to be compared the content of this first section of Part 3 is prescribed in the Statutory Instrument – The National Health Service (Quality Accounts) Regulations 2010 No: 279.

REVIEW OF SERVICES

East Cheshire NHS Trust was established in 2002 providing a wide range of acute health services to the population of Eastern Cheshire, with a catchment area of approximately 200,000, and the borders of the neighbouring areas of Stockport, High Peak and North Staffordshire.

The Trust consists of three hospitals at Macclesfield, Knutsford and Congleton in Cheshire.

East Cheshire NHS Trust provides a full range of general acute secondary care hospital services through a Clinical Business Unit (CBU) structure. These are Surgical Services, Outpatient Services, Medical Services and Women's and Children's Services.

The Clinical Business Units are led by Clinical Directors who are senior consultants supported by Associate Directors who manage the service.

There are also a number of support services that contribute to the efficient running of the organisation such as Governance, the Estate and Facilities function, Human Resources and Financial Support.

There is a performance management process in place for internal and sub-contracted services. This process provides assurance on the quality of service that is delivered. Trust Board reports throughout the year demonstrate this process.

The income for East Cheshire Trust was 82.9 million for 2009/10 million from our main commissioners (Central and Eastern Cheshire PCT) and 15.5 million from other local Primary Care Trusts.

PARTICIPATION IN CLINICAL AUDITS

NATIONAL AUDITS

During 2009/10 the Trust took part in 17 national audits out of 26 (65%) and 1 national confidential enquiry out of 4. Information about national clinical audits is forwarded directly to lead consultants by the organising body eg Royal Colleges. The lead clinician decides if it is appropriate for their service to be involved.

The following audits were those that the Trust did participate in with the number of cases submitted to each audit as a percentage of the number required by the terms of the audit or enquiry.

- NNAP: neonatal care (1478/3414) 43%
- ICNARC CMPD: adult critical care units
- NLCA: lung cancer
- NBOCAP: bowel cancer
- DAHNO: head and neck cancer
- MINAP (inc ambulance care): AMI & other ACS 100%
- Heart Failure Audit (N=44)
- NHFD: hip fracture
- TARN: severe trauma

- Adult cardiac interventions
- National Sentinel Stroke Audit (n=40-60) 100%
- National Audit of Dementia: dementia care (n=40) 100%
- National Falls and Bone Health Audit (n=60) 100%
- National Comparative Audit of Blood Transfusion: changing topics (n=50) 100%
- National Mastectomy and breast reconstruction Audit.
- National Oesophago-gastric Cancer Audit
- RCP Continence Care Audit (n=34/40) 85%

National Confidential Enquiries

Emergency and elective surgery in the elderly.

The following audits were those that the Trust could have participated in.

- NNAP: neonatal care
- NDA: National Diabetes Audit
- ICNARC CMPD: adult critical care units
- National Elective Surgery PROMs: four operations*
- CEMACH: perinatal mortality
- NJR: hip and knee replacements
- NLCA: lung cancer
- NBOCAP: bowel cancer
- DAHNO: head and neck cancer
- MINAP (inc ambulance care): AMI & other ACS
- Heart Failure Audit
- Pulmonary Hypertension Audit
- NHFD: hip fracture
- NAPTAD: anxiety and depression
- TARN: severe trauma
- NHS Blood & Transplant: potential donor audit
- Adult cardiac interventions
- National Kidney Care Audit (2 days)
- National Sentinel Stroke Audit (n=40-60)
- National Audit of Dementia: dementia care (n=40)
- National Falls and Bone Health Audit (n=60)
- National Comparative Audit of Blood Transfusion: changing topics
- British Thoracic Society: respiratory diseases
- College of Emergency Medicine: pain in children; asthma; fractured
- National Mastectomy and Breast Reconstruction Audit
- National Oesophago-gastric Cancer Audit

National Confidential Enquiries:

- Parenteral nutrition,
- Emergency and Elective Surgery in the Elderly,
- Surgery in Children,
- Peri-Operative Care Study

EAST CHESHIRE NHS TRUST AUDITS

Audits are carried out in a number of ways. To test whether patients receive the care they expect we carry out local audits eg patient's view of cleanliness on wards and the hand washing of staff.

Clinical audits are also carried out by clinical staff with the support of the Audit Department. These audits focus on compliance with clinical standards such as National Institute for Clinical Excellence

(NICE) guidance. During 2009/10 144 audits of this type commenced. The audits support our compliance with standards and identify areas for improvement. The priorities of which are set out in Part 2 of the Quality Account.

In addition to both local and clinical audits the Trust commissions time from a NHS consortium (termed internal audit) who carry out audits for the Trust Board to provide assurance that the Trust is working to the standards expected. Two examples of this type of audit would be the prevention of infection and assessing the process and the evidence for registration with the Care Quality Commission.

RESEARCH

The Trust works as part of a research network helping to improve the current and future health of the population it serves.

In 2009/10 496 patients have been recruited to participate in research approved by a Research Ethics Committee. This exceeded all requirements. As a comparison 275 patients were recruited in 2008/09.

There is a rigorous ethics process applied both to the study itself and the recruitment process. Patients have all the information they need and actively have to consent to take part in any study.

COMMISSIONING FOR QUALITY AND INNOVATION (CQuin)

Central and Eastern Cheshire Primary Care Trust provide specific funding for certain initiatives. For 2009/10 this related to the management of patients with alcohol problems and the provision of electronic discharge information for GPs.

The development of the alcohol pathway aims to ensure that patients treated within the Trust with alcohol related conditions are appropriately assessed and referred to alcohol support services. In this way the local health services can support individuals who want to address their alcohol issues as well as treating them for the consequence of these issues. The alcohol CQuin monitors the Trust in agreeing the pathway between professionals, training staff in the use of the pathway and then delivering the screening, advice and initial interventions detailed within the pathway.

The improvement of discharge arrangements specifically relating to estimating a discharge date within 24 hours of admission and ensuring share care and continuing health care assessments were completed in a timely way.

The financial amount for achievement of these outcomes was £600,000.

CARE QUALITY COMMISSION

In February 2010 the Trust received an unannounced visit from the Care Quality Commission in relation to the Hygiene Code.

Three inspectors visited wards of their choosing and were very rigorous in checking standards of hygiene and infection control.

The Trust was pleased to be found compliant with the Hygiene Code.

In April 2010 the Trust was required to register with the Care Quality Commission. The Trust is now registered with no conditions attached to that registration.

The ratings for 2009/10 are not yet available. In 2008/09 the Trust was given a rating of ‘fair’ for quality and ‘good’ for resources.

DATA QUALITY

All Trusts are required to send to the Department of Health (via the Secondary User Service) a complete and valid data set for each individual episode of patient care when patients are admitted, attend an outpatient clinic or attend the Emergency Department. The data quality of these records is assessed and benchmarked. The data is assessed for "completeness" (ie, all required fields filled) and "validity" (ie, all the data items are valid). All scores for each type of patient activity are then combined to present an overall percentage score

The Trust submitted records during 2009/10 (April 2009 – February 2010) to the Secondary User Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

98.9% for admitted patient care (national score 97.2%).
99.8% for Out Patient Department care (national score 96.5%).
97.2% for Accident and Emergency care (national score 90.9%).

The percentage of records in the published data which include the patients valid General Medical Practice Code was

100% for admitted patient care.
100% for Out Patient Department care.
100% for Accident and Emergency care.

INFORMATION GOVERNANCE TOOLKIT ATTAINMENT LEVELS

Ensuring information about patients and staff is kept confidentially and only shared on a need to know basis is critical to good governance.

The Information Governance Toolkit is an assessment document that supports the checking of systems and processes.

The assessment has also been the subject of a separate audit to ensure that the findings are robust. The scores are rated using red, amber and green. For 2009/10 East Cheshire Trust scored 72% (green).

CLINICAL CODING ERROR RATE

The Trust was subject to the payment by results clinical coding audit during the reporting period and the error rates were as follows:

- Primary diagnosis incorrect 12.67% * (2008/09 9%, 2007/08 13.6%).
- Secondary diagnosis incorrect 4.88% (2008/09 7.5%, 2007/08 11.5%).
- Primary procedures incorrect 2.47% (2008/09 14%, 2007/08 16.8%).
- Secondary procedures incorrect 7.95% (2008/09 4%, 2007/08 24.7%).

***** High number of Healthcare Resource Group changes related to paediatrics and availability of discharge summaries - this is now resolved.

HOSPITAL STANDARDISED MORTALITY RATE (HSMR)

The Hospital Standard Mortality Rate is a calculation that provides hospitals with a benchmark in relation to death in hospitals. A rate below 100 in the 'relative risk' column shows performance better than the benchmark

Dr Foster Intelligence Hospital Standardised Mortality Rates

Rolling 12 month HSMR

The Hospital Standardised Mortality Rate (HSMR) for the 12 months from Jan 08 to Sep 2009. This data was produced from the national system as at 9th March 2010

Time Period	Deaths	Expected	Difference > More <Less	Relative Risk	Confidence Limit Low	Confidence Limit High
Jan 08 - Dec 08	732	710.1	>21.9	**103.1**	95.7	110.8
Feb 08 - Jan 09	733	716.1	>17.2	**102.4**	95.1	110.1
Mar 08 - Feb 09	727	724.1	>3.1	**100.4**	93.2	108.0
Apr 08 - Mar 09	747	732.3	>14.9	**102.0**	94.8	109.6
May 08 - Apr 09	735	730.1	>5	**100.7**	93.5	108.2
Jun 08 - May 09	718	736.4	<18.4	**97.5**	90.5	104.9
Jul 08 - Jun 09	697	735.6	<38.6	**94.8**	87.8	102.1
Aug 08 - Jul 09	692	736.5	<44.4	**94.0**	87.1	101.2
Sept 08 - Aug 09	684	724.0	<39.9	**94.5**	87.5	101.8
Oct 08 - Sept 09	680	730.3	<49.5	**93.1**	86.3	100.4
Nov 08 - Oct 09	667	731.8	<64.8	**91.1**	84.4	98.3
Dec 08 - Nov 09	649	728.3	<79.3	**89.1**	82.4	96.2
Jan 09 - Dec 09	645	732.8	<87.8	**88.0**	81.4	95.1

The benchmark figure is always 100 with values greater than 100 representing performance worse than the benchmark and values less than 100 representing performance better than the benchmark. The Trust has shown a continuous reduction in HSMR.

QUALITY STRATEGY

The Trust's Quality Strategy focused on 10 areas on patient safety and 5 on improving the patient experience.

The following were the areas of focus:

- Advancing Quality by introducing a more systematic approach to the following conditions acute myocardial infarction, community acquired pneumonia, hip and knee replacements.
- Reducing health care acquired infections.
- Reducing hospital acquired pressure sores.
- Reducing inpatient falls.
- Reducing serious medication errors.
- Improving Customer Care.
- Improving the monitoring of patients to check for early deterioration.
- Improving privacy and dignity.
- Improving record keeping.
- Improving patient nutrition.

There has been improvement in 8 of the 10 areas over the year as demonstrated below. Two of the areas that require quantifiable changes are the reduction of falls and medication errors and these are priority areas for 2010/11 as described in Part 2 of this Quality Account.

REDUCING HEALTH CARE ACQUIRED INFECTIONS

Over the period the Trust has continued to make good progress in reducing Health Care acquired infections.

The number of MRSA bacteraemias has fallen progressively over the last 5 years.

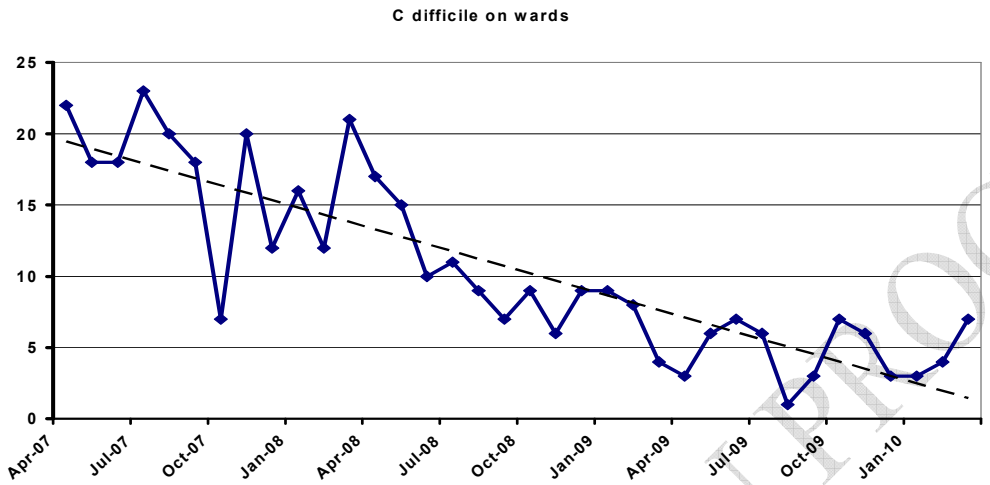
Year	Cases of MRSA bacteraemia
2005 – 2006	21
2006 – 2007	15
2007 – 2008	14
2008 – 2009	14
2009 – 2010	9

A maximum of 10 MRSA bacteraemias was set for the East Cheshire area. A total of 9 cases has been recorded, 7 cases were recorded in the hospital and 2 developed in the community. All cases were followed up by a root cause analysis and discussion with the relevant clinicians. In 4 of the cases intravenous cannulation was the probable cause. This was the most common theme and therefore is a priority area for 2010/11.

A maximum trajectory of 127 Clostridium difficile cases was set by the Strategic Health Authority for 2009-10. However, as we had had only 114 cases in 2008-9, the Trust set its own internal maximum of 67 cases to match that of the Strategic Health Authority for 2010-11. In the year 2009-10 there were 55

cases of Clostridium difficile in the hospital, against the trajectory of 67, representing a reduction in cases of more than 50% over the previous year. The improvement may be ascribed largely to improved cleanliness, particularly in relation to commodes and toilet areas, as well as to better antibiotic prescribing.

The number of Clostridium difficile infections on the wards has been falling for several years. Three years ago there were new cases seen almost on a daily basis, whereas now there may be only 1or 2 a week.



REDUCING HOSPITAL ACQUIRED PRESSURE SORES

Pressure sores are graded from numbers 1 – 4; 1 being reddening of intact skin to 4 being a serious wound. In agreement with the Primary Care Trust a planned reduction of all grades was targeted for the Medical and Surgical Clinical Business Units. Across the whole Trust there were 22% less pressure sores and none of the most serious kind. A further 5% reduction has been targeted against the actual numbers for 2010/11.

REDUCING INPATIENT FALLS

The reduction of patient falls has proved challenging. Despite devising a strategy and action plan; raising awareness with staff, patients and relatives via a leaflet and training; monitoring risk assessments on patients and purchasing movement alarms a reduction in patient falls has not occurred.

In addition functional electrical stimulation (FES) was introduced in neuro-physiotherapy. FES is recommended by the National Institute for Clinical Excellence (NICE). It speeds up the patient's recovery and reduces the risk of falling. This service has been officially recognised by the North West Strategic Health Authority as an example of innovative practice.

Reduction in falls has been identified as a priority area for 2010/11. Key performance indicators have been agreed and these will be monitored by the Quality Strategy Implementation Group monthly and by the Royal College of Physicians audit on falls and bone health. A more focused approach has been actioned working directly with 2 wards to implement falls prevention and management. The Project Office has also been engaged to support progress in this area.

REDUCING MEDICATION ERRORS

The vast majority of medication errors are minor. Medication errors can be classified as prescribing, dispensing or administrative errors. Progress in reducing errors has not been as expected. A detailed

study was undertaken in this complex area to improve our understanding of the issues. The conclusions and action plans of this study have outlined a number of areas of work that is now being taken forward by the new Chief Pharmacist. The Project Office has also been engaged to support progress in this area.

An internal audit identified concerns about the storing and dispensing of controlled drugs. Significant improvement has now been made in this area and practice is monitored to ensure high standards are maintained.

IMPROVING CUSTOMER CARE

During this period the sixth National Inpatient Survey was received.

The Trust was in the top 20% for the following areas:

- Choice of hospital – being offered a choice of hospital for your first appointment when referred to see a specialist.
- Length of wait – feeling you waited right amount of time on waiting list to be admitted.
- Changes to admission dates – not having admission date changed by the hospital.
- Not feeling threatened – not feeling threatened by other patients or visitors during your stay.
- Quality of food – rating hospital food as good.

The Trust was in the lowest performing 20% for the following two areas:

- Hand washing by doctors.
- Hand washing by nurses.

Considerable work has been undertaken to address these issues. This has been demonstrated in the reduction in health care acquired infections and improvements in the "committed to being clean audits" which ask for patients views on hand washing.

FORMAL COMPLAINTS

The following table shows the number of formal complaints received by the Trust, the severity of those complaints and the response times.

	KPIs	Qtr 1	Qtr 2	Qtr 3	Quarter 4			Total Year to Date	Total 2008/9
Formal Complaints					**Jan**	**Feb**	**Mar**		
Medicine		10	11	12	2	9	12	56	72
Surgery		10	10	14	3	3	7	47	43
Women & Children's		4	4	8	2	1	3	22	13
Outpatients		2	3	3	0	1	3	12	4
Corporate Division		0	0	0	0	0	0	0	1
Pathology		1	1	0	0	0	0	2	0
Nursing & Patient Care Standards		0	0	1	0	0	0	1	1
No. Of Complaints Received by PCT re ECNHST		0	2	0	0	1	0	3	
No. Of Complaints Referred to the Ombudsman		1	0	1	2	4	0	8	
No. Of Complaints Upheld									
Level of Severity of Complaints									
High - Risk score of 15+				0	0	0	0	0	

Medium - Risk score of 9-15				0	0	0	0	0	
Low - Risk score of 1-8		28	29	38	7	14	25	141	
Performance against Targets									
Contact with complainant within 48 working hrs of receipt of complaint	100%	100%	100%	100%	100%	100%	100%	100%	
Response to complainant within agreed timescale	100%	100%	100%	97%	100%	100%	100%	99%	98%

Learning lessons from complaints is a priority for the organisation. The following are examples where improvements have been made:-

Patient passports for patients with learning difficulties have been developed and introduced to ensure that individual's needs are clear and information is available to Doctors, Nurses and Administrative Staff in an easy to read format to optimise levels of support for the patient during the patient's journey. This has been developed with patients with learning disabilities and their carers and has been really well received.

A review of systems took place within the Emergency Department and improvements were made so that the time taken from the initial patient x-ray to the result was reduced.

A change was made to telephone lines within Customer Care to allow easier access to the service.

Laminated notices have been placed in the entrance to Congleton Hospital stating the start and finish times of the phlebotomy service. Queue numbers are available for patients arriving early to ensure they are seen in chronological order.

A family was invited to the documentation 'lean' event in order to share their experience and contribute to the improvement.

A rapid improvement event in Stroke Services was held in March 2009. The purpose of the event was to look at how processes could be improved to provide best practice for stroke patients.

The 40+ members of staff were inspired to make several service improvements. The Acute Stroke Unit and the Stroke Rehabilitation Unit were combined so that stroke care is provided in the same unit by the same staff. One of the most significant pieces of work to come out of the event was the creation of the stroke oracle data base. Thus database records and reports on all vital care information so that patient safety issues can be identified and addressed immediately. The Trust received recognition for the database which was "highly commended" in the National Patient Safety Awards 2010.

The following table shows the improved performance against key indicators.

Sentinel Audit 06,08 and Oracle

9 Key indicators	2006	2008	Jan-Mar 2010 (of discharges to early April)
Swallow screening <24 hours	89	90	90
Brain scan <24 hrs admission	31	38	89
Physio < 72 of admission	59	77	98
OT < 4 days of admission	34	80	100
Weighed during admission	53	79	96
Mood assessed during admission	56	32	93

Rehab goals set by MDT	76	95	93
Antiplatelet < 48 hrs	38	81	75 (<24)
90% stay on stroke unit	59	62	85
Average LOS			23
Admitted straight to Stroke unit (of discharges to date)			64

IMPROVING THE MONITORING OF PATIENTS TO CHECK FOR EARLY DETERIORATION

Prior to April 2009 a tool that enhanced the assessment of patients and checked for early signs of a deteriorating clinical condition was only used in certain areas. Further training and support has been given to staff and the tool is now fully implemented across all wards. The Healthcare Community reaped the benefit of a new way of working with the development of the Emergency Floor which co-located the Emergency Unit and the Medical Admissions Unit adjacent to the Emergency Department (ED). This has resulted in faster assessments for patients and a reduction in the number of medical emergency admissions.

IMPROVING PRIVACY AND DIGNITY

Extensive building alterations have been undertaken throughout the year. £292,000 has been spent on enhancing the layout in clinical areas and increasing the number of bathroom and toilet facilities. Unless clinically necessary patient care is now delivered in same sex accommodation.

Staff training has been a real focus over the year and privacy, dignity and respect is included in induction and mandatory training programmes. To improve access for staff the Royal College of Nursing Dignity DVD is also available on the Trust intranet with a privacy and dignity workbook to test your knowledge.

Following an impact assessment in the Physiotherapy Department the following service improvements have been made.

- More space for wheelchair users in the waiting area.
- Leaflets including information on chaperoning.
- Communication box for patients and visitors to offer feedback.
- New, better fitting curtains purchased and privacy screens in rooms.

A number of visits were also undertaken by LINk (formerly Patient and Public Involvement Forum) following the development of its Enter and View Strategy.

2009/10 saw a further development of Christie at East Cheshire to provide oncology services in a pleasant and accessible environment and to avoid the need for patients to travel to Manchester for chemotherapy treatment.

IMPROVING RECORD KEEPING

A rapid improvement event was held in September 2009 focusing on improving care documentation used by nurses. The aim of the event was to agree with nursing staff an approach to standardising documentation.

Ensuring timely and accurate recording of information maximises the quality of care for patients ensuring that patients receive the right care in the right place at the right time. The revised admission document and care plans have been launched in May 2010. The paperwork is easier for nurses to complete and

reduces duplication thereby ensuring that documentation can be completed quickly and patients get the care they need sooner.

Internal audit undertook an audit of records, the recommendations made have been actioned ensuring the Trust is meeting the required standards for the Care Quality Commission registration.

IMPROVING PATIENT NUTRITION

A multidisciplinary event took place during 2009/10 to focus on patient nutrition and a number of improvements have subsequently been implemented. The assessment of patients being screened using the Malnutrition Universal Screening Tool (MUST) increased from 30% to 70%. A greater emphasis on non-clinical activities not taking place at mealtimes and increased volunteer support to give additional assistance in the timely distribution of meals and help for individual patients. In addition a 'top tips' nutrition newsletter was issued to staff.

NATIONAL PATIENT SAFETY AGENCY PATIENT ENVIRONMENTAL ACTION TEAM ASSESSMENTS (PEAT)

Assessments for the environment, food provision and privacy are undertaken and scores awarded by hospital for each element. The results range from poor to excellent. The following assessment took place in February and March 2010.

SITE NAME	ENVIRONMENT SCORE	FOOD SCORE	PRIVACY AND DIGNITY SCORE
Congleton War Memorial Hospital	Good	Excellent	Good
Knutsford and District Community Hospital	Good	Excellent	Good
Macclesfield District General Hospital	Good	Good	Good

STATEMENTS FROM LOCAL INVOLVEMENT NETWORKS (LINK), OVERVIEW AND SCRUTINY COMMITTEE (OSC) AND PRIMARY CARE TRUST (PCT)

In *High Quality Care for All,* published in June 2008 Ministers set out the Governments vision for putting quality at the heart of everything the NHS does. The key component of the new Quality Framework would be a requirement for all providers of NHS services to publish Quality Accounts. The aim of the Quality Account is to improve public accountability and to engage Boards in understanding and improving quality in their organisations.

The Primary Care Trust, Local Involvement Networks (LINk) and the Overview & Scrutiny Committee (OSC) have important roles in the development of these accounts and maximising their success.

This Quality Account has been reviewed by the Central & Eastern Primary Care Trust and Western Cheshire Primary Care Trust, LINk and the OSC.

Their comments are documented below:-

LINk Local Involvement Networks

OSC Overview and Scrutiny Committee

PCT Primary Care Trust

APPENDIX 1
GLOSSARY

TERM	ABBREVIATION
Clostridium difficile	Cdiff
Methicillin Resistant Staphylococcus Aureus	MRSA
Care Quality Commission	CQC
Commissioning Quality Initiatives	CQuin
Venous Thromboembolism	VTE
Clinical Business Unit	CBU
Primary Care Trust	PCT
National Neonatal Audit Programme	NNAP
National Diabetes Audit	NDA
Intensive Care National Audit and Research Centre	ICNARC
Case Mix Programme Dataset	CMPD
Patient Reported Outcome Measures	PROMS
Confidential Enquiry into Maternal and Child Health	CEMACH
National Joint Registry	NJR
National Lung Cancer Audit	NLCA
National Bowel Cancer Audit Programme	NBOCAP
DAta for Head and Neck Oncology	DAHNO
Myocardial Ischaemia National Audit Programme	MINAP
Acute Myocardial Infarction	AMI
Acute Coronary Symdrome	ACS
National Hip Fracture Database	NHFD
National Audit of Psychological Therapies for Anxiety and Depression	NAPTAD
Trauma Audit and Research Network	TARN
National Institute for Clinical Excellence	NICE
Hospital Standardised Mortality Rate	HSMR
Advancing Quality	AQ
Acute Myocardial Infarction	AMI
Patient Environmental Action Team	PEAT
Functional Electrical Stimulation	FES
Emergency Department	ED
Local Involvement Networks	LINk
Overview and Scrutiny Committee	OSC
Accident and Emergency	A and E
Minor Injuries Unit	MIU
International Normalised Ratio	INR
General Practitioner	GP
CHKS - Name of Company	CHKS
Heart Failure	HF
Malnutrition Universal Screening Tool	MUST

APPENDIX 2
KEY PERFORMANCE INDICATORS

To reduce the number of falls sustained by patients within our care and to improve the care of patients who attend or are admitted to hospital following a fall.

- To have in place a Falls and Bone Health Policy that includes falls prevention and reduction
- 95% of older patients who attend A and E or MIU following a fall receive a falls and bone health screening and appropriate referral or signposting for appropriate management
- 95% of older patients admitted with a fragility fracture receive a falls and bone health assessment and have a falls management plan for inpatient and post discharge care
- To have personnel are in post with job descriptions that give a commitment to the management of falls and bone health for the roles of Falls Lead/Coordinator, Consultant in Geriatric Medicine and Fracture Liaison Nurse
- To achieve the six standards for hip fracture care as recommended in "The care of patients with a fragility fracture" (blue book) which summarises best practice in the care and secondary prevention of fragility fractures.
- Reduction in overall inpatient falls rate per 1000 bed days against 2008/09 baseline of
- Reduction in overall injurious inpatient falls rate per 1000 bed days against 2008/09 baseline of
- Increase prescribing of antiresorptive therapy against 2008/09 baseline of
- Reduction in number of deaths in hospital for patients with a hip fracture against 2008/09 baseline of

To protect patients within our care from hospital acquired infection.

- To implement best practice in accordance with Saving lives
- No more than 4 MRSA Bacteraemia
- No more than 50 Clostridium Difficile (internal target, 63 for PCT)
- No more than 72 MRSA isolates (internal target)

To reduce the impact of medication errors on patients within our care.

- Year on year reduction of medication errors
- A reduction in percentage of patients on warfarin with an INR greater than 6
- A reduction of patients receiving low molecular weight heparin outside protocol limits.
- A reduction in percentage of patients needing antidote to overdose of midazolam
- A reduction in percentage of patients needing antidote to overdose of opiates
- 100% accuracy of insulin prescriptions.
- % antibiotics administered on time for elective patients
- % antibiotics discontinued on time for elective patients

To reduce avoidable death, disability and chronic ill health from venous thromboembolism (VTE) for patients within our care.

- 100 % of patients receiving a VTE risk assessment on admission to hospital
- 100% of patients, who are at risk, are treated using NICE guidance

To deliver evidence based interventions to patients within our care with a diagnosis of acute myocardial infarction, heart failure, pneumonia, stroke or undergoing hip or knee surgery.

- Improve all scores on an ongoing basis
- To be in the top 25% hospitals in the North West for all care bundles

To support the timely and effective discharge of patients within our care to the most appropriate setting of an expected discharge date and providing timely information to GPs.

- 85% patients to have an expected date of discharge set within 24 hours admission / definitive diagnosis
- 100% of patients discharged from wards 10 and 11 have a share care assessment
- 100% of patients are advised how to take their medicines and any possible side effects
- 100% of patients are provided with clear written or printed information about their medication
- 75% of the Continuing Healthcare Assessments are completed by the Trust within 5 working days of being triggered by the screening checklist
- 100% of patients referred for Continuing Health Care Assessments to receive an information leaflet and complete consultation checklist
- 100% of discharge summaries to be issued within 24 hours of discharge

To ensure that patients within our care are treated in privacy with dignity and respect.

- To eliminate mixed sex accommodation unless clinically justifiable
- 80% front line staff receive Privacy and Dignity training
- Decrease of 5% in the number of patients sharing bathroom and toilet facilities as measured by the National Patient Survey
- The Trust will be in the top 20% of Trusts for 'Treated with Dignity and Respect' as measured by the National Patient Survey

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

- 100% of complaints are acknowledged with 2 working days
- 100% of internal complaints are answered within 25 working days
- 100% of complaints that cross organisational boundaries are answered within agreed timeframes
- 60% staff are trained in customer care training
- Evidence of learning and improvement

To develop all of our staff to ensure that they act as a role model; take personal responsibility; have the courage to speak up and make their voices heard and to deliver care in the best interests of the patient and their families.

- KPIs to be agreed by the project steering group.

To be in the highest 25% for incident reporting

- Top 50% by end of 2nd Quarter.
- Top 25% by end of 4th Quarter.