East Cheshire NHS
NHS Trust

DRAFT IN CONFIDENCE

30/04/13

Quality Account 2012/13

Our Vision and Mission

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

Our mission

To provide high quality integrated and seamless services, as specified by Commissioners and delivered by highly motivated staff to our local population.

Our vision

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

Contents

Blank Page

Foreword - Chairman

Lynn McGill,
Chairman

Chief Executive Statement

John Wilbraham, Chief Executive
April 2013

Why are we producing a Quality Account?

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

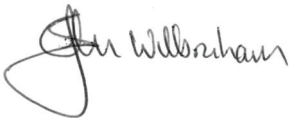
Respective responsibilities of Directors and auditors

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

In preparing the Quality Account, the Directors are required to take steps to satisfy themselves that:

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

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



John Wilbraham, Chief Executive

THIS YEARS LETTER TO BE UPDATED

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

I am required by the Audit Commission to perform an independent assurance engagement in respect of East Cheshire NHS Trust's Quality Account for the year ended xx March 20xx ("the Quality Account") as part of my work under section 5(1)(e) of the Audit Commission Act 1998 (the Act). NHS Trusts are required by section 8 of the Health Act 2009 to publish a quality account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010 and the National Health Service (Quality Account) Amendment Regulations 2011 ("the Regulations"). I am required to consider whether the Quality Account includes the matters to be reported on as set out in the regulations.

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

This report is made solely to the Board of Directors of East Cheshire NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 20xx.

Assurance work performed

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

Guidance 20xx/xx issued by the Audit Commission on xx April 20xx. My limited assurance procedures included:

- Making enquiries of management;
- Comparing the content of the Quality Account to the requirements of the regulations.

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

Limitations

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

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

Conclusion

Based on the results of my procedures, nothing has come to my attention that causes me to believe that the Quality Account for the year ended xx March 20xx is not consistent with the requirements set out in the regulations.

Signature
Julian Farmer
Audit

Our values and objectives

We will:

• Treat each other with respect and dignity

This applies to all our interactions at an individual and organisational level, with all partners, patients, the public and carers, colleagues and other agencies. This is demonstrated by our seeking the views of staff, patients, and partners in the delivery of our services.

• Commit to quality of care;

Our Board Objective is to improve quality, safety and the patient experience. This is confirmed at every Board meeting in public by listening to the experience of patients and by the prominence of quality issues on the Board agenda.

• Show compassion;

By listening to staff and patients we are reminded daily that we are in the business of healthcare and that for a large proportion of our patients when they are in contact with us it is a particularly stressful time. We expect our staff to show compassion as part of their daily work.

• Improve lives;

Achieving our Board Objectives will ensure we achieve our Mission, by doing so we will improve the lives of our patients by preventing ill health, treating illness and alleviating pain.

• Work together for patients;

We promote team work within the organisation both within departments, across departments and Business Groups. In addition, our approach to health and social economy challenge is to align financial incentives and service improvement.

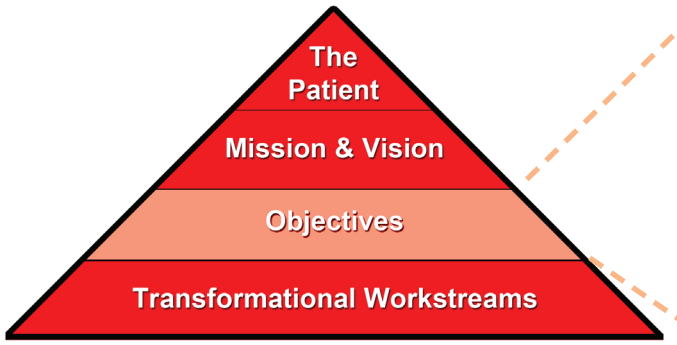
• Make everyone count.

We are aware of the variation in health experience and outcome. Our approach is to treat all our customers equally by ensuring that the staff have the training to do so. As an employer we are committed to equality of employment and the benefit the oragnisation will gain.

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

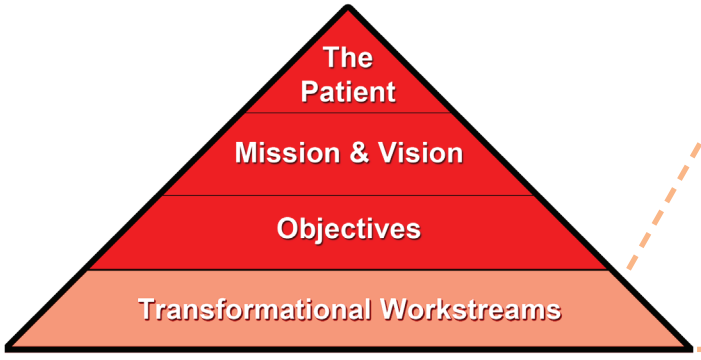
The Quality Strategy has been influenced by a range of drivers, the most significant of which are summarised below:

Our strategic objectives



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

Transformational workstreams

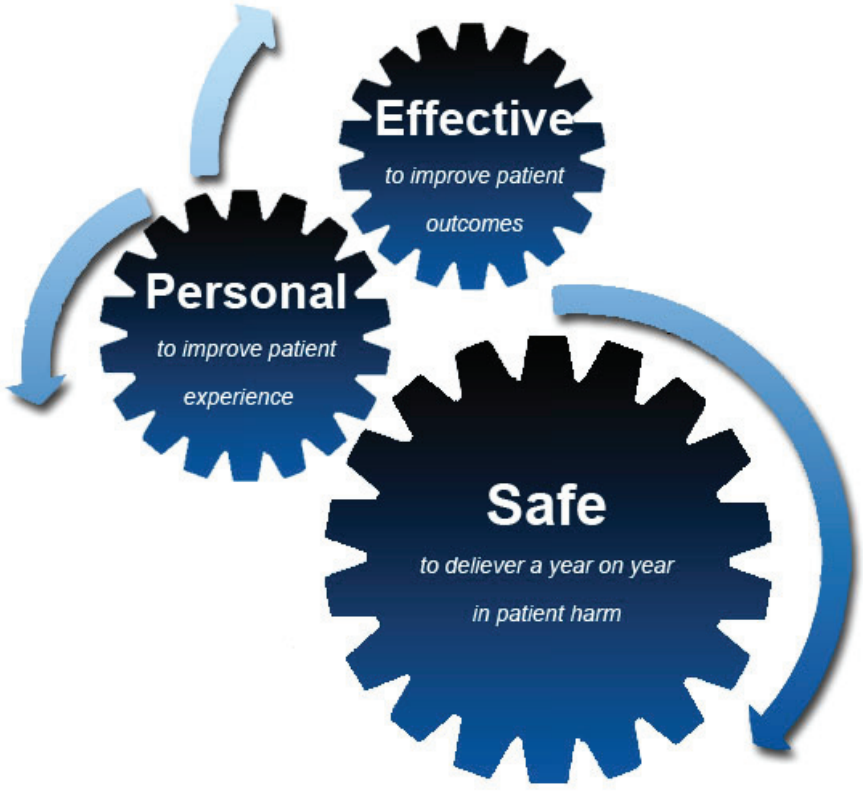


- Strengthening Operational Delivery
- Service Re-Design
- Organisational Development
- Cost Improvement Programme
- Governance and preparing for NHS Foundation Trust status
- Corporate and Social Responsibility

The Quality Strategy 2012/15

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

ADDITIONAL INFORMATION TO BE ADDED



Influences on our quality strategy

Since the introduction of the Quality Strategy the Chief Nursing Officer for England has shared her vision for nurses, midwives and care givers. This is a strategy to support the development and delivery of compassionate and high quality care that achieves excellent health and well being outcomes. It builds on the existing NHS Constitution and details six values: Care, Compassion, Communication, Courage, Competency and Commitment

We have introduced a staff pledge that is at the heart of everything we do.

We will care with compassion, ensuring we communicate effectively, have the necessary competence to understand your health and social care needs and the courage to speak up for you. We will demonstrate our commitment by working together, combining our knowledge, skills and expertise to maximise opportunities for innovation and excellence.

Quality priorities

Using feedback from stakeholders and our commissioners, the Trust has identified quality priorities covering 2013/14, that will further improve safety, patient experience and clinical effectiveness. These quality priorities were established by reviewing feedback from our patients, staff, stakeholders and members of the public, to identify what we need to improve and to provide consistently high quality care, and to be able to measure success over the next year.

We will explain in this section how each quality priority for 2013/14 will be achieved.

Performance against the 2013/14 quality priorities will be monitored internally using the Trust's performance dashboard tool and progress will be reported monthly to the Trust Board.

Last year the Trust introduced the Safety Thermometer which is a tool for measuring patient safety developed by the NHS Information Centre. This was a point prevalence survey to measure, monitor and analyse the frequency of four specific patient harm areas:

1. Falls
2. Pressure Ulcers
3. Catheter Associated Urinary Tract Infections
4. Venous-thromboembolism

Progress to date is reported in (on page x)

A national initiative this year is the Family and Friends Test.

The Friends and Family Test

The NHS has introduced a Family and Friends Test for all Trusts as a way of gathering feedback about patients experience, helping to drive improvements in hospital services. Any patient aged over aged 16 who has had an overnight stay or has attended and been discharged from the Accident and Emergency Department will have the opportunity to feedback on one simple question relating to their experience. "How likely are you to recommend our ward / department to friends and family if they needed similar care or treatment?"

The results are public ally produced for patients comparisons. This information is available in the Trusts ward areas and on our website at www.eastcheshire.nhs.uk

Comments from patients from the Friends and Family Test include the following.

"The Staff were Super. Nothing was too much trouble for them. Always Smiling. Your hospital should be very proud of them."

"Well all the staff very kind to me, took interest in me. In my eyes nothing could be improved at this present time."

"THIS IS MY SECOND STAY ON THIS WARD. I WOULD DEFINITELY RECOMMEND IT TO OTHERS, BECAUSE OF THE HIGH LEVEL OF SUPPORT FOR BOTH PHYSICAL & EMOTIONAL NEEDS. I FELT COMFORTABLE & SAFE AT ALL TIMES DURING MY STAY & WAS ABLE TO DISCUSS ANY WORRIES I HAD. I WAS INCLUDED IN ANY DECISIONS ABOUT MY CARE."

"The necessary treatment was given – not always as timely as required. A disruptive patient ruined rest + sleep over several days + nights. Empathy + compassion were not evident. There was an overriding need to tick boxes, meet targets + fill forms, information to me was however limited."

COMMENTS BOXES TO BE DESIGNED

Our top priorities for 2013/14 (including CQUIN)

SAFE To reduce patient harm in hospital		
Priority	**Quality indicator**	**How we will achieve**
Safety Thermometer	To reduce by 30% the number of patients recorded as having a category 2-4 pressure ulcer (old or new) as measured using the NHS Safety Thermometer	• Monthly assessments will be undertaken • A trajectory for the year has been agreed to achieve planned reduction • Monthly completion of point prevelance study • Monthly assessment of data • Triangulation of data from other sources eg Datix and Root Cause Analysis report.
Clostridium difficile	To ensure compliance with the acute Clostridium difficile standard	• Monitoring of Clostridium difficile action plan • Root Cause Analysis of all incidences • Continue with operational audit programme.
Improve the assessment and management of the acutely unwell patient	Improve the assessment and management of the acutely unwell patient	• Review current process - update standard operating procedure • Review documentation • Review training in relation to Track and Trigger • Development/implementation of IT supporting the Trigger system • Independent competency • Established Health Care Assistant development programme • Review of critical care outreach service provision.

Our top priorities for 2013/14 (including CQUIN)

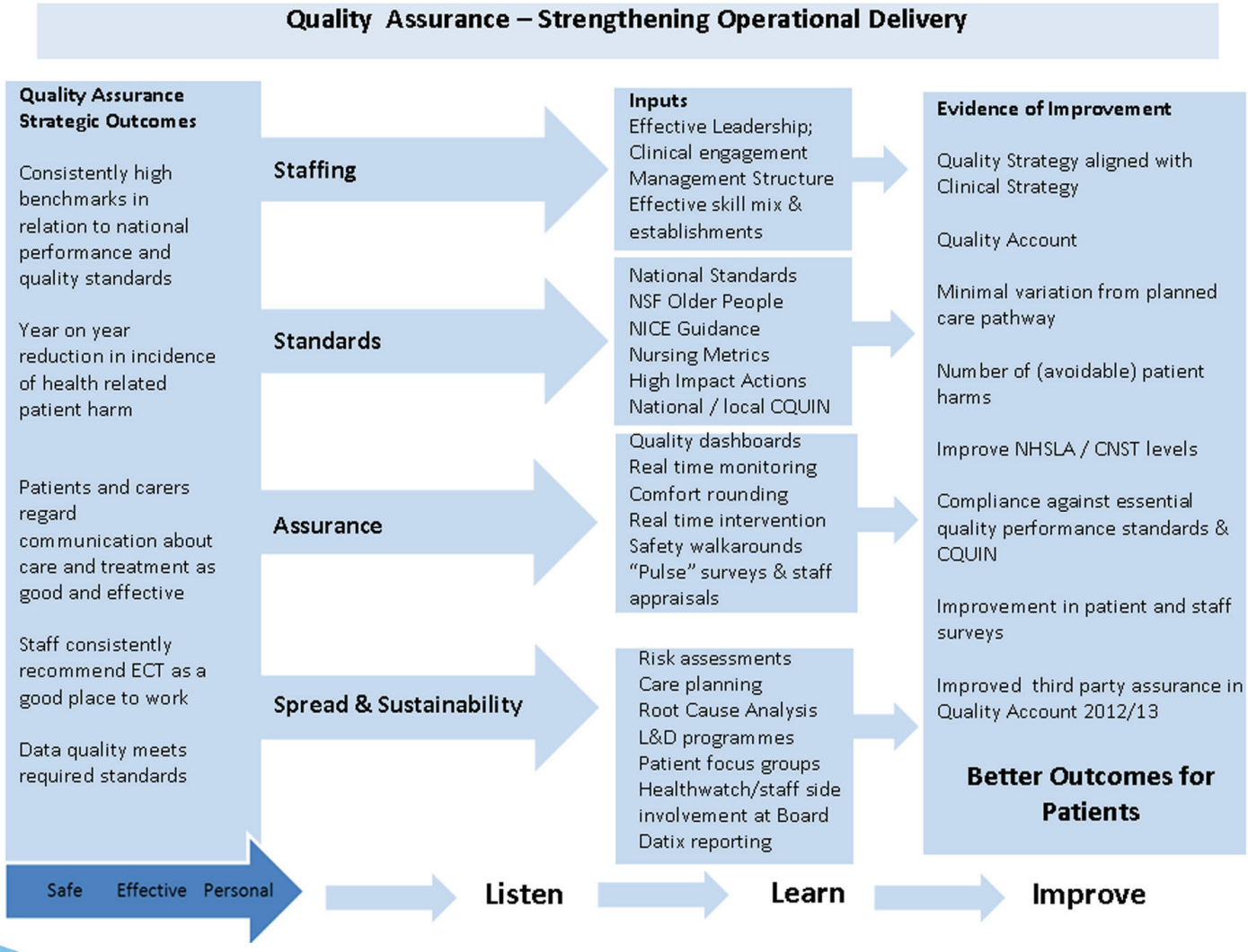
PERSONAL To provide a positive patient experience		
Priority	**Quality indicator**	**How we will achieve**
Friends and Family Test (FFT)	To improve the response rate on acute wards to 20%	• All patients will be given a survey form and information to explain what FFT is all about • Staff will encourage patients to complete the survey to support improvement in patient experience • Monthly information will be made available to patients and staff
Dementia Screening	To improve the diagnosis and referral of patients with dementia by screening eligible patients in line with national standards	• Effectively screen all non -elective patients over 75 years admitted to hospital • Patients with a positive screen will be referred back to their GP or an appropriate specialist for further support • Carers of patients with dementia will be surveyed to test if they feel supported.

Our top priorities for 2013/14 (including CQUIN)

EFFECTIVE To provide evidence based care		
Priority	**Quality indicator**	**How we will achieve**
The development and implementation of caring together neighbourhood teams	Development Caring together teams across all localities	• Establish health and social care teams in peer group locality areas • Implementing the pilot for risk profiling and aligning this to the neigbourhood teams in order to avoid admissions • Implementation of the self management programme for patients with identified long term conditions • Implementation of the care coordination role within the neigbourhood teams
Venous thromboembolism (VTE)	To ensure a minimum of 95% of patients have a risk assessment for VTE	• Ensure VTE risk assessments are carried out on all patients on admission • Effectively prescribe prophylaxis for all patients who are at high risk of developing VTE • Undertake a Root Cause Analysis on all patients with a hospital associated thrombosis.

How progress to achieve priorities will be monitored

The Trust has introduced a robust system of reporting to make sure that the Trust Board is given assurance about the quality of care it provides. There are many ways this will be carried out and the diagram below explains how the outcomes the Board requires are actioned by our staff. The actions below are measured to ensure that the standards are maintained and services are continually improved.



Statements of assurance

CONTENT TBC


Listening into Action
YOUR VOICE


PATIENT PHOTO!
Happy staff
Happy Patients
High Performing Trust!

Comissioning for Quality and Innovation (CQUIN)

The CQUIN framework was introduced in 2009 as a national framework that enables commissioners to reward quality achievements by linking income to improve improvement goals. During 2012/13 there were x national CQUIN's and x local CQUIN's.

CQUIN table to be re drawn.

2012/13 CQUINs	
Acute	
	Achieved Yes / No
VTE Prevention	YES
NHS Safety Thermometer	YES
Care of Dementia	NO
Prognostication and Advanced care planning for End of Life	YES
Admission Prevention - % reduction in five agreed ACS conditions	YES
Patient experience: Personal needs	NO
Cancer staging (Reported Quarterly, 1 month in arrears) - Quarter 3 data	Achieved Quarter 1 - 3, Quarter 4 data not yet available
AQ: Acute Myocardial Infarction (composite score) December 2012 data	YES
AQ: Heart Failure (composite score) December 2012 data	NO
AQ: Elective Hip & Knee Surgery (composite score) December 2012 data	YES
AQ: Elective Knee Surgery (composite score) December data	YES
AQ: Pneumonia (composite score) December 2012 data	YES
AQ: Stroke (composite score) December 2012 data	YES
AQ: Patient Experience % survey response rate - February data	YES
Cancelled Operations - All cancelled as % of all electives Payment is based on year end performance.	NO
Urgent Care Information	YES
Community	Achieved Yes / No
Community: Integration of patient services	YES
Community: NHS Safety Thermometer	YES
Community: Management of patients with low back pain	YES
Community: Falls prevention	YES

Care Quality Commission (CQC)

Registration under the Health and Social Care Act 2008 (Regulated Activity) Regulations 2009 and the Care Quality Commission (Registration) Regulations 2009

All NHS health care providers are required by law to register with the Care Quality Commission and declare compliance against 28 regulations. 16 regulations relate to quality and safety of care received by patients.

During 2012/13, East Cheshire NHS Trust has successfully maintained registration with the Care Quality Commission with no conditions.

However, following an inspection in February 2013, the Trust was found to be non-compliant in relation to three outcomes areas, including staffing levels, supporting workers and care and welfare of people who use services. An action plan to achieve full compliance has been put in place with the aim to achieve full compliance by May 2013.

All other outcomes inspected were fully compliant.

Relevance of data quality and action to improve data quality

The Trust's Data Quality Policy states that all staff have responsibilities for ensuring the quality of data meets required standards. Systems are in place to identify when data quality errors occur enabling the Trust to address the errors promptly. Overall data quality is reported monthly to the Trust Board. The Trust's overall data quality scores are better than the national average.

Secondary Uses Service

For 2012/13 (Apr-Jan), the average validity for the data items monitored in the Secondary Uses Service (SUS) Data Quality Dashboard is **96.6%** against a National score of 96.1%.

NHS number being present

Specifically, for a valid NHS number being present in the data the scores are above the National average: Admitted patient care at **99.3%** against 99.1%. Outpatients showing **99.8%** against 99.3% and A and E significantly above the national average of 94.9% at **98.0%**

Valid Healthcare Resource Group

For a valid Healthcare Resource Group version 4 code the scores are at **100%** for the following data sets for the Trust: Admitted Patient Care, Outpatients and Accident and Emergency. These are against National averages of 98.5%, 99.3% and 96.8% respectively.

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. There is a robust internal clinical coding audit and training programme which was developed in 2011/12. The Trust has a Connecting for Health (CFH) accredited auditor and trainer in post. Coding is carried out using the full patient case note supplemented by electronic systems such as histopathology and radiology which is considered best practice.

Information Governance Toolkit

As part of the Department of Health commitment to ensure the highest standards of information governance, it has developed an Information Governance Assurance Framework supported by the Information Governance Toolkit (IG Toolkit). The IG Toolkit is a self-assessment and reporting tool that organisations must use to assess local performance in line with Department of Health requirements. The Connecting for Health guidance states that all NHS organisations need to demonstrate compliance with all IG Toolkit requirements through achievement of at least Level 2 attainment and should be achieving Level 2 against all the requirements by 31st March 2013. The Trust submitted evidence in March 2013, confirming level 2 compliance against all the requirements.

Clinical Coding – Payment By Results (PBR)

Information not yet available

Will be available in final account

Patient and staff feedback

Patient feedback

We take the views of our patients, carers and staff very seriously. There are a number of different methods we use to collect data on patient and staff satisfaction, such as surveys, patient stories and patient experience groups, all of which provide us with vital information on how to improve the quality of our care. Below is a selection of feedback and results from our Patient Reference Group and the National Surveys that were conducted in 2012/13.

Patient Experience Reference Groups

As part of our ongoing commitment to quality improvements we hold Patient Reference Groups to increase our patients' involvement in the decisions we make. Two meetings of this group have been held in the past year, in May and November 2012.

At the first of these groups, progress with the projects implemented previously as a result of the Patient Reference Group's suggestions were reviewed. Positive comments were made by attendees on the speed of actions following the discussions and the suggestions made.

'The strength of the group lies in it not being restricted – people can say what they think without progress being held up by bureaucracy.'

In November 2012 discussion focused on the new Friends and Family Test and discharge arrangements. The groups reviewed and commented on the FFT proposal. Emerging themes were:

- Enhancing patient engagement and support of the Trust
- Staff mechanisms
- Timeliness of the question
- Management of cultural diversities.

National Adult Inpatient Survey 2012

East Cheshire NHS Trust was reviewed by 413 patients out of a sample of 805 patients who had been treated as an inpatient at the Trust during summer 2012.

Overall, the Trust was classed as performing in line with other Trusts for the majority of areas.

The areas where the Trust's performance was most improved include:

- Patients being asked to give their views on the quality of their care
- Doctors / nurses giving families all the information needed to help care for patient following discharge
- Following an operation or procedure patients receiving an explanation they could understand as to how things had gone
- Provision of same sex bathroom facilities
- Receiving copies of letters sent between hospital doctors and family GP
- Patients receiving enough help to eat their meals.

The Trust was classed as performing 'worse than other Trusts' in three areas:

- Enough information given to patients about their condition
- Side effects of medication being explained
- Patients knowing who to contact if worried about their condition after discharge.

A full action plan will be developed to help improve performance in these areas during 2012/13

National Emergency Department Survey 2012

The Trust was reviewed by 399 patients out of a random sample of 820 patients that were seen in the department between January and March 2012.

The Trust was in the top 20% of Trusts for 4 out of a possible 37 areas including:

- Staff telling patients about medication side effects to watch out for
- Staff telling patients when they could resume usual activities, such as when to go back to work or drive a car
- Staff telling patients about what danger signals regarding their illness or treatment to watch for after they went home
- Posters or leaflets displayed explaining how to complain about the care received

The Trust was not in the lowest 20% of Trusts for any area.

Areas where the Trust performance was most improved include:

- Being given enough privacy when discussing thier condition with the receptionist
- Initial wait to speak to a doctor / nurse
- Cleanliness of A&E department and Trust toilets
- Staff telling patients about medication side effects to watch out for, resume usual activities and danger signals regarding their illness on their return home

Following the survey an action plan has been developed to further improve patients' experience of the department and improvements have already been made in; ambulance to A&E turn around, reception privacy and alternative private discussion areas, dedicated triage service to reduce waiting times and a dedicated Emergency Nurse Practitioner for minor injuries. A dedicated nurse call bell system has been installed and deep clean programs are in place.

Local Feedback

A full programme of patient feedback work has been carried out across all areas of the Trust covering a range of different subjects including audiology, breast screening, breast surgery, breast feeding, cardio respiratory department, carers focus group, children's ward, coeliac disease, complaints service, dermatology, endoscopy and treatment unit, home intravenous therapy service (HITS), intensive care, maternity services, renal department, occupational therapy, paediatric diabetes, physiotherapy, special schools (inc. paediatric therapies) and supervision of midwives.

Specific examples of local feedback include:

Realtime feedback in the renal unit – patients in the renal unit were asked to complete a short survey on a touch-screen computer. This allowed the results to be collated and analysed on the same day and then fed back to the unit so that any action needed could be taken straight away.

Carers Focus Group – relatives / carers of patients on the Langley Unit were invited to a focus group to discuss the unit and how to improve the service offered.

- Overall carers were very happy with the care and attention that they and their relatives were receiving
- Overall carers rated the Langley Unit very highly and complimented the nurses extremely well
- Carers would like to see more physiotherapy for their relatives as currently the physiotherapists do not work at weekends (although rehab assistants are available).

Improvements made following the group include:

- Patients felt they received support if they were grouped with other patients that had similar conditions so now every effort is made to group patients this way
- Patients felt they would like more activities so the unit now has a weekly exercise group and a weekly bingo session.

Home Intravenous Therapy Service (HITS)

A paper based questionnaire was handed out to patients of the HITS service and returned to the Trust in a pre-paid envelope. The results highlighted that:

- All patients felt the staff treated them with kindness and compassion, dignity and respect and honesty and understanding
- 100% stated that they received an explanation as to the reason for their treatment
- 95% of patients said that staff definitely discussed their diagnosis, treatment and outcomes with them
- All patients said that the staff listened to their views and felt that the staff knew them as an individual
- All patients felt they had enough information in relation to their intravenous line and did not feel lacking in any information.

Comments in relation to the HITS team included:

"The nurses were very kind and understanding. They considered all my medical needs, and answered any questions. It is an excellent service."

"I really liked the care, respect and compassion shown by all of the staff."

"Being treated at home made me feel more relaxed and able to get on with life."

2011/12 Cancer Patient Experience Survey

The Trust was reviewed by 139 patients out of an eligible sample of 214 patients giving an overall response rate of 70%. All patients had a primary diagnosis of cancer and had been admitted to the Trust as either a day patient or an inpatient between 1st September 2011 and 30th November 2011.

The Trust was in the **top 20%** of Trusts for 21 areas including:

- Being given easy to understand written information about diagnostic tests
- Finding it easy to contact their Clinical Nurse Specialist
- The Clinical Nurse Specialist listening carefully to the patient
- Receiving answers they could understand from the Clinical Nurse Specialist
- Being told they were eligible for free prescriptions
- Admission dates not being changed by the hospital
- Being given written information about any operations

Following the survey there have been several improvements made including:

- A weekly financial support clinic has been set up to offer advice and information for patients. This is proving to be a very well utilised and helpful service.
- A new patient information leaflet has been developed to help support patients undergoing treatment for colorectal cancer.
- There is a project underway to look at the Trust practice around written assessments and care plans.

Cheshire East Local Involvement Network (LINK)

The Trust has received 13 'Enter and View' site visits from the Cheshire East Local Involvement Network over the past year to the following areas:

- Visits to wards 1, 5, 6, 7, Audiology and the Langley Unit (Ward 10) and two visits to ward 4
- Three visits to the paediatric unit and one to the Maternity Unit
- A visit to Knutsford District and Community Hospital during the consultation about the Tatton Ward closure.

There has been a significant amount of positive feedback following the visits, in particular around the following areas:

- Clean and bright environment and regular hand washing by staff
- Staff were helpful, courteous and polite and patients were appreciative of their care, feeling involved and informed
- On the Paediatric Unit, the therapy service was found to be impressive, along with the community play service enabling children to be treated at home
- All patients were appreciative of the facilities at Knutsford District and Community Hospital. There was little anxiety about the closure of Tatton Ward, and where there were queries, the issues around the building being 'fit for purpose' were discussed
- On the Maternity Unit, the team noted the availability of bariatric facilities, ergonomic chairs and signing provision, along with the private areas available.

The Director of Nursing Performance and Quality has responded to all 'Enter and View' reports providing further information where requested, acknowledging any improvements suggested and confirming any action to be taken. Service improvements as a result of these visits include improved home assessment visit timings, discharge arrangements, engagement between nurses and relatives/carers, nutritional improvement and meal time encouragement and support, Audiology reception facilities and improve patient information leaflets.

Cheshire West and Chester Local Involvement Network

The Trust has also had feedback from Cheshire West and Chester Local Involvement Network regarding the Out of Hours consultation concerning Northwich Royal Infirmary and Leighton Hospital, Crewe. As a result of the feedback received during the consultation and from the LINk, the plans to transfer some of the GP hours from Northwich to Leighton were put on hold.

Healthwatch

Local Involvement Networks (LINks) ceased to exist on 31st March 2013. The Trust would like to thank the LINks for their valuable contribution and the service improvements we have made as a result.

As from April 1st 2013, councils across England have been asked by the Government to set up a new organisation in their local area known as Healthwatch. This will act as the new local consumer champion for Health and Social Care. Its main role will be to:

- Provide information and advice to the public on Health and Social Care services
- To monitor and listen to the views of the public on Health and Social Care services
- To influence the way Health and Social Care services are provided in the future.

Healthwatch Cheshire East is currently recruiting members and will be fully functional around May/June 2013, for this reason, Healthwatch Cheshire East is not in a position to offer comment on this year's Quality Account.

YOUR VOICE : Listening into Action

The YOUR VOICE; Listening into Action Campaign was launched across the Trust on 8th October 2012. The purpose of the campaign is to increase staff engagement across the organisation by listening to staff, focussing on action (at a pace); developing sustainable solutions with staff; and building belief in the organisation and its ambition.

During October and November the campaign launched a pulse survey consisting of 10 questions to ascertain how engaged and valued staff were feeling right now. A total of 1411 staff (representing 40% of our workforce) completed the survey demonstrating a strong commitment to helping identify areas where staff engagement can be improved.

As part of the campaign five 'Staff Conversations' have been facilitated. These listening events have been very successful in bringing staff together to discuss what matters to them, what gets in their way, and how these issues can be overcome in order to make sustainable improvements for both staff and our patients.

We have captured over 2500 comments which have been used to identify some 'quick wins' to help make rapid improvements. Enabling our people schemes' are focussed corporate wide schemes that will benefit both patients and staff and we have launched '10 pioneering teams' which are dedicated projects within teams and departments to remove obstacles to support staff to do their jobs more easily.

YOUR VOICE
East Cheshire NHS Trust
Listening into Action

Staff survey information

The East Cheshire NHS Trust (ECNHST) staff survey was conducted between September 2012 and December 2012. 355 staff at ECNHST took part in the survey. The results are a snapshot of how staff felt at this time.

The results of the survey are presented into 28 key findings. Our results are compared to other acute Trusts in England, and to the Trust's performance in the 2011 survey. The findings are arranged under six headings, four pledges from the NHS Constitution, plus two additional themes. These are in the outlined in the table below.

Pledge 1	To provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities
Pledge 2	To provide all staff with personal development, access to appropriate training for their jobs and line management support to succeed
Pledge 3	To provide support and opportunities for staff to maintain their health well-being and safety
Pledge 4	To engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families
Additional 1	Staff satisfaction
Additional 2	Equality and diversity

Table to be re-designed

Changes since 2011 Survey:

The largest change in the survey since 2011 is evident in staff experience. Job satisfaction, and equality and diversity training, have shown most improvement. 16 factors have had no change since last year. Three measures are showing a reduced performance.

The Trust will be using the survey findings to shape our plans for the future. The Trust is pro-active in responding to our staff needs, and has already implemented a new a new staff engagement campaign- Your Voice...Listening Into Action (see Page 37) and a new health and wellbeing strategy.

A new Health and wellbeing strategy was launched November 2012. This strategy focuses on 3 main areas: mental health and well-being at work, physical wellbeing at work, and weight management and healthy lifestyle.

The strategy is designed to reduce stress in the workplace, reduce accidents, and assist our workforce in delivering healthier lives through our public authority deal pledges.

Both the Your Voice campaign, and the new health & wellbeing strategy were not fully implemented at the time of the 2012 staff survey; however it is expected that the benefits realisation of both these initiatives will be evidenced in the 2013 staff survey results.

Quality Performance in 2012/13

Our Achievements

Reduced the number of health acquired pressure ulcers at grades 3 and 4 by 10% from the 2011/12 baseline figure of 40.
Reduced the number of catheter associated urinary tract infections from the initial baseline assessment in Q1 by 10%, measured by the safety thermometer.
Rolled out the use of the Safety Thermometer as a safety monitoring tool Trust wide from April 2012.
Ensured a minimum of 90% of patients have a risk assessment for Venous thromboembolism. (except heart failure)
Successfully achieved the North West benchmarks for the Advancing Quality clinical care bundles.
Developed an infrastructure to support the clinical management of integrated care of patients with long term conditions.
MRSA in the acute setting had only one recorded case this year
Cancer targets achieved across all standards
18 weeks targets achieved across all three standards

Safe

To reduce the number of falls that cause harm from the baseline 2.8 per 1,000 bed days 2011/12 figure to 2.5 per 1,000 bed days.

How much: From 2011/12 baseline of 2.8 per 1,000 bed days to 2.5 per 1,000 bed days.

By when: March 2013

Progress: < Underachieved - Factors which have impacted on falls this year:

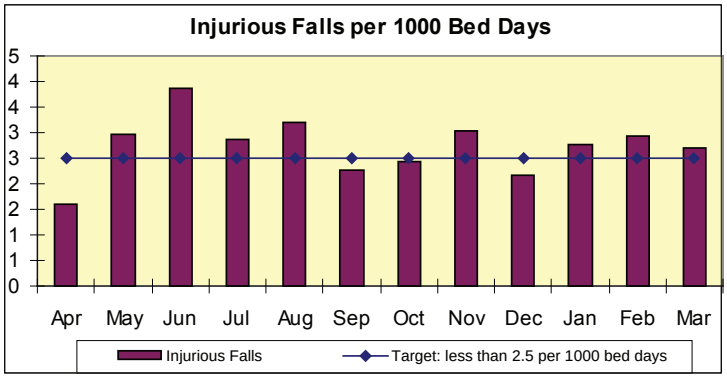
- Increased/Improved reporting on falls incidents
- Increase in the number of patients with multiple co-morbidities increasing the risk of falling.

Outcome:

- Injurious falls target achieved for four (out of nine) months of data
- Percentage of Injurious falls in comparison to 2011/12 are lower for six out of nine months of data

2012/13	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Injurious falls	1.6	3.0	3.9	2.9	3.2	2.3	2.4	3.0	2.2	2.8	2.9	2.7

2012/13



Improvements achieved

- Improved reporting
- Introduced falls awareness training onto Clinical Statutory and Mandatory Training
- Development and implementation of an integrated falls policy
- Developed an agreed model for undertaking falls risk assessment and supporting generic management plan for use in community settings, to reduce, to identify and target people at risk of falls in their own homes and prevent falls in the community through addressing contributing factors e.g. environmental
- Identified a network of 'Falls Champions' across hospital and community settings who will champion the cause of falls prevention, and to advocate, support and ensure the implementation and follow through of falls prevention initiatives
- Review of falls prevention programmes and education materials available within all health and social care organisations
- A revision and restructure of falls groups to provide an integrated approach to falls management/ prevention and clear monitoring and accountability for falls work across bed and home based services
- Pilot Project/scoping exercise undertaken in the South and Vale Royal area with the North West Ambulance Service, to look at pathways to reduce avoidable hospital admission for patients who have fallen, by providing direct referral route to Intermediate Care Services.

Future improvements

- Revision of falls risk identification for inpatients through the use of 'wristband identification' for inpatients
- Establishment of a training programme and implementation plan for the community based Falls Risk Assessment and management plan
- Ongoing work/analysis to provide relevant and timely staff training around falls prevention and management
- Alignment and development of falls prevention educational materials for patients/carers
- Review current audit tools to ensure that best information/intelligence is gathered and identify and communicate lessons learnt when patients have fallen in the hospital setting.

Safe

To reduce the number of health acquired pressure ulcers at grades 3 and 4 by 10% from the 2011/12 baseline figure of 40

How much: By 10% from the 2011/12 baseline figure of 40.

By when: March 2013

Progress: ✓ Target achieved

Outcome:

TABLE TO DEMONSTRATE ACHIEVEMENT TO BE INSERTED

Improvements achieved

- Robust system for reporting and checking accuracy of staging of pressure ulcer
- Link nurse system established to target ward performance
- New pressure ulcer prevention and management guidelines in operation
- Robust process of action learning from Root Cause Analysis for all stage three & four pressure ulcers that are health acquired
- Patient/carer friendly information leaflets to promote the importance of pressure ulcer prevention for clients at risk
- A training programme commenced with social services to target independent carer organisations out in the community on pressure ulcer prevention
- Consistent documentation for pressure ulcer prevention and management across the Trust
- Dressing formulary updated to ensure up to date products in use, in line with pressure ulcer prevention and management guidelines (NICE)
- Firm accurate baseline of pressure ulcers established within the Trust.

Future improvements

- To further embed governance and accountability into Link Nurse role
- To further analyse data to ensure prevention is targeted at key areas
- To revaluate the health acquired pressure ulcers, particularly in the community, to measure against set criteria of what is preventable and what is not
- To continue work with maternity and paediatrics to ensure risk assessment and prevention is targeted to working area.

Safe

To reduce the number of catheter associated urinary tract infections from the initial baseline assessment of 2.5 by 10%, measured by the safety thermometer.

By when: March 2013

Progress: ✓ Target achieved

Outcome:

TABLE TO DEMONSTRATE ACHIEVEMENT TO BE INSERTED

Improvements achieved

- Introduced safety thermometer points prevelance survey
- Reviewed catheter care plan
- National Houdini project pilot on control ward and actual ward re: compliance with saving lives
- Improved infection control data regarding catheter care

Future improvements

- Ongoing use of safety thermometer to continuously assess and improve catheter and UTI measurements. Re-visit, agree and clarify baseline and reduction percentage
- Undertake a review of the infection control team to incorporate a lead staff member to drive quality improvement and practice around catheter care
- Develop staff training program
- Produce an annual plan re: Houdini roll out
- Monitor and audit compliance against saving lives and implement changes to practice as required.

Safe

To roll out the use of the Safety Thermometer as a safety monitoring tool Trust wide from April 2012

By when: March 2013

Progress: ✓ Target achieved

Outcome:

TABLE TO DEMONSTRATE ACHIEVEMENT TO BE INSERTED

Improvements achieved

- Implementation of integrated and coordinated collection/point prevalence score on pre-identified dates
- Compliance with national reporting requirements with regards to the submission of NHS Safety Thermometer data
- Establishment of a data baseline against which we can track improvements or deterioration
- Preparation and development of local data collection through development of local database to be used in conjunction with national submission requirements, to enable trend data and drilling down to well performing and/or problem areas
- Showing overall compliance, type of harm by each category and percentage of harm free care
- Breakdown of community and acute data, acute by ward area and harm and community by locality and harm to enable analysis of specific data at local level e.g. pressure ulcers, falls etc.

Future improvements

- Ensure that data consistency is maintained and continue to embed the NHS Safety Thermometer in our patient safety culture
- Ensure that operational definitions are applied consistently, not only at a local level, but also a national level
- Work with commissioners to identify and set improvement goals – likely to be focused on improvement in pressure
- To work with the national Safety Thermometer leads and Tissue Viability Network to further develop, standardise and understand the data generated with regards to tissue viability and pressure ulcer prevalence - e.g. with particular clarification/consideration given to capturing un-gradable pressure ulcer incidences
- Develop mechanisms for sharing and cascading database/Safety Thermometer performance information with teams to enable understanding of individual team performance/contribution.

Effective

To ensure a minimum of 90% of patients have a risk assessment for Venous thromboembolism

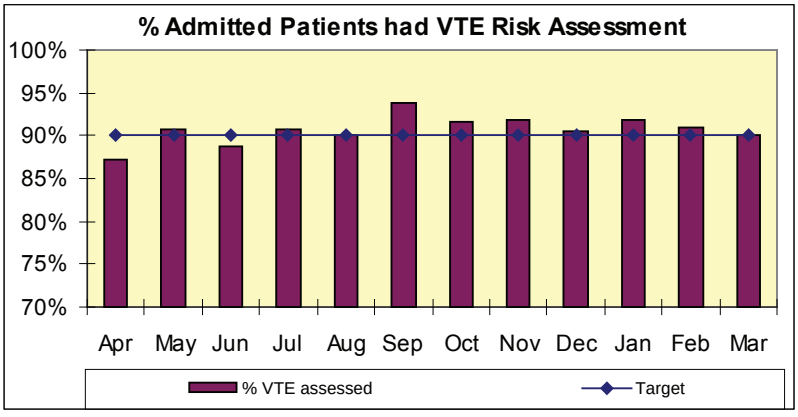
By when: March 2013

Progress: ✓ Target achieved

Outcome:

VTE prevention, reduce avoidable death, disability and chronic ill health from Venous thromboembolism

%	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
12/13 Plan	90	90	90	90	90	90	90	90	90	90	90	90
12/13 Actual	87.3	90.8	88.8	90.8	90.1	93.9	91.6	91.8	90.4	91.8	91.0	90.1



Improvements achieved

- Audit process embedded on wards and departments
- Improved competence monitoring

Future improvements

- Ongoing education of medical and nursing staff
- Training for all staff on electronic recording system
- Venous thromboembolism policy to be reviewed to include Deep Vein Thrombosis and Pulmonary Embolism guidelines on one document
- Daily auditing within wards to ensure non compliance is manage at the earliest opportunity
- Systems and processes for data collection and input and neccessary improvements are being taken and reviewed via the Venous thromboembolism steering group
- Work has commenced to ensure CQUIN target for 2013/14.

Effective

To successfully achieve the North West benchmarks for the Advancing Quality clinical care bundles.

We participate in:

Acute Myocardial Infarction AMI, Heart Failure, Hip & Knee, Pneumonia and Stroke. We currently do not participate in Dementia and First Episode Psychoses that were introduced more recently.

By when: March 2013

Progress:

✓ Target achieved - in AMI, Hip & Knee, Pneumonia and Stroke.

Outcome:

Below is a breakdown of each clinical focus areas and the Trust's results for the individual measures. The red lines on the green bar show the minimum and maximum score achieved in the region.

NEW TABLE TO BE ADDED

Improvements achieved

- To date, the clinical focus groups, Hip & Knee and Stroke demonstrate improvement in overall composite quality scores from the previous year (April 2011-March 2012)

- Hip and Knee currently resides in 5th place in terms of the performance ranking AQ table whereas Stroke is currently ranked in 3rd place.

- An improved stroke database and lean events have secured

Future improvements

- Review membership of sub-groups in particular Heart Failure and enlist more champions re: Advancing Quality (AQ)
- Strengthen clinical engagement in order to improve and sustain Heart Failure standards
- AQ lead to attend programme lead meetings in order to receive regular appraisal of AQ programme and share best practise
- Undertake regular audit of clinical documentation. Review and amend as required.
- Secure workforce resource for AQ data collection recurrently
- Monitor AQ performance via the Acute Business Group's balanced scorecard and via Quality Account Dashboard
- Monitor action plan to ensure target achievement.

Effective

To develop an infrastructure to support the clinical management of integrated care of patients with long term conditions.

By when: March 2013

Progress: ✓ Target achieved

Outcome:

The neighbourhood teams are made up of groups of health and social care professionals. Health services work alongside social services and generalists work alongside specialists to deliver proactive, personalised coordinated care for patient's over 65 with a Long Term Condition.

Patient and carers will have an input to the decisions about their own care and support in enabling them to self-care–'no decision about me without me'

Who are the Neighbourhood Teams?

Using the learning from the Knutsford early implementer site the professionals identified to work in the neighbourhood team are GPs, Community Matrons, District Nurses, Physio's, OT's, Social Workers and Community Psychiatric Nurses. In the future, health trainers provided by Age UK and Psychological Wellbeing Workers will be introduced to the team.

How do these Neighbourhood Teams work?

National Evidence (Department of Health) shows one of the most effective models to improve quality of care to patients, is by the professionals working in a Neighbourhood Team case managing patients together, such as the model used in North East Outer London. Fortnightly clinical team meetings are held in clusters of practices to discuss and agree case management plans for identified patients.

Improvements achieved

- Closer collaboration across organisations and professions aligned to integrated teams e.g Knutsford, Winsford, Rope Green teams in preparation for care coordination
- Information sharing agreement and privacy impact assessments completed
- Further roll out of patient passports and use of assistive technology.

Future improvements

- Continued roll-out of neighbourhood/ extended practice teams across all Clinical Commissioning Groups
- Development of care coordination within integrated teams
- Establishment of health coaches role and dementia champions
- Further expansion of telehealth
- Development of Risk Profiling and Multi Disciplinary team meetings.

Effective

To improve the diagnosis and referral of patients with dementia by screening eligible patients in line with national standards.

By when: March 2013

Progress: < Underachieved

Outcomes:

- The electronic recording system was delayed due to technical reasons
- Quarter four has seen a 6% increase in medical admissions

Improvements achieved

- Nursing documentation reviewed and amended to include dementia screening assessment
- Acute confusion pathway developed and piloted
- IT software updated to capture data collection
- Chief Executive signed up to commit to becoming a dementia friendly hospital
- The Kings Fund Environmental Assessment Tool has been adopted and an assessment undertaken in clinical areas.
- Submission to Department of Health re: Dementia funding advanced to second stage
- Dignity workbook for staff developed and implemented.

Future improvements

Second stage bid submitted to secure national monies re creating dementia friendly environment

- Review and re-launch acute Confusional Pathway
- Utilise Admiral nurse to facilitate training prior to re-launch of pathway
- Audit compliance of pathway
- Undertake a training needs analysis for staff working within acute care of the elderly
- Consider Registered Mental Nurse modules
- Review membership of dementia steering group
- Establish operational dementia steering group and Terms of Reference
- In conjunction with comissioners and social care, explore the development of local dementia strategy
- Explore the development of dementia nurse specialist role
- Monitor patient experience reports and improve in categories relating to dignity and care from previous year's baseline
- Develop stronger partnership and recruitment with the volunteers sector
- Develop elearning opportunities in dementia care for staff.

Effective

To reduce the number of cancelled operations.

How much: By 2% from 2011/12 baseline figure of 7.54% to 5.5%

By when: March 2013

Progress: < Underachieved

Outcome:

Pressure of emergency activity on surgical bed stock.

Despite not achieving the required standard, the level of cancellations in 2012/13 has improved on the previous year.

2012/13

Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	Overall year end
13.3%	**6.5%**	**7.6%**	**8.0%**	**6.1%**	**8.2%**	**5.5%**	**6.5%**	**5.9%**	**13.1%**	**15.8%**	10.3%	8.7%

NEW BAR CHART TO BE ADDED

Improvements achieved

- Introduction of the Surgical Admissions Lounge
- Development of a short stay area for orthopaedic and surgical electives
- Increase in day case rates for surgery
- Centralised booking team established for all elective specialties
- Development of National Confidential Enquiry into Patient Outcome and Death list to ensure emergency cases do not result in cancellation of non urgent elective work
- Spaces reserved for Cancer patients on specific consultants lists.

Future improvements

- Flexible job plans for newly appointed surgeons in some specialties to facilitate utilisation of dropped lists
- Establishment of Key Performance Indicators for monthly reporting at Theatre utilisation group
- Development of an orthopaedic waiting lounge
- Further increase in daycase rates for orthopaedics, breast surgery and general surgery
- Explore options for development of electronic bed booking system.

Effective

To improve the timeliness of initial clinical assessment of patients attending A&E by ambulance from 84.6% to 95% in less than 15 minutes.

By when: March 2013

Progress: < Underachieved

Outcome:

- High levels of pressure within the A&E departments due to medical assement areas being used as in patient capasity.
- increased departmnental pressures due to multiple ambulance arrivals at one time.

	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
12/13 Plan	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
12/13 Actual	**86.8%**	**90.6%**	**87.9%**	**87.7%**	**87.5%**	**91.2%**	**92.0%**	**92.9%**	**90.0%**	**89.9%**	**85.8%**	91.0%

New bar chart

Improvements achieved

- Improved compliance with Ambulance Capacity Management System
- Agreed participation in the Ambulance Service “Rapid Handover” procedures
- Ambulance Triage system in Emergency Department (ED) managed by Band 7 Shift Leader to ensure timely and effective handover from Ambulance to ED.

Future improvements

- Implementation of North West Ambulance rapid hand over system to develop purpose built Ambulance “Drop off” Bays to expedite ambulance handover and turnaround
- Nursing workforce review underway to consider the nursing requirements across the department, including the provision of Triage.

Performance against national targets 2012/13

2012/13 Target	Monitor Standards	In Month Target	In Month Performance	Quarter 4 Performance	YTD Performance	Level of Risk
95%	A&E: Maximum waiting time of 4 hours in A&E	>=95%	90.26%	88.23%	93.88%	High
No more than 1	Hospital MRSA bacteraemia year on year reduction versus trajectory for the year	0	0	0	1	High
No more than 10	Community MRSA bacteraemia year on year reduction versus trajectory for the year	1 or less	0	1	5	Moderate
No more than 24	Hospital Acquired CDifficile (Year Target)*	2 or less	0	2	29	Significant
No more than 90	Community Acquired CDifficile (Year Target)	7 or less	6	15	68	Moderate
>=93%	2 Weeks maximum wait from urgent referral for suspected cancer	>=93%	99.3%	98.4%	98.2%	Low
>=93%	2 Weeks maximum wait from referral for breast symptoms	>=93%	96.8%	97.1%	97.5%	Low
>=94%	31 days maximum from decision to treat to subsequent treatment - Surgery	>=94%	100.0%	100.0%	100.0%	Low
>=98%	31 days maximum from decision to treat to subsequent treatment - Drugs	>=98%	100.0%	100.0%	100.0%	Low
>=96%	31 day wait from cancer diagnosis to treatment	>=96%	100.0%	100.0%	100.0%	Low
>=85%	62 day maximum wait from urgent referral to treatment of all cancers (including patients treated at a tertiary centre)	>=85%	83.8%	89.1%	90.7%	Low
>=90%	62 days maximum from screening referral to treatment (including patients treated at a tertiary centre)	>=90%	100.0%	100.0%	99.0%	Low
>=90%	18 week Referral to Treatment - Admitted Patients - 90% within 18 weeks	>=90%	90.0%	90.8%	91.2%	Moderate
>=95%	18 week maximum wait - Non-Admitted Patients - 95% within 18 weeks (including community)	>=95%	97.8%	98.0%	98.2%	Low
>=92%	18 week maximum wait - Incomplete - 92% within 18 weeks	>=92%	92.1%	92.7%	93.1%	Low
>50%	Data completeness (Community)	>50%	Community system being implemented. Compliance by April 2014			Low

2012/13 Target	Other National Standards	In Month Target	In Month Performance	Quarter 4 Performance	YTD Performance	Level of Risk
0	18 week maximum wait - Delivery in all specialties - number of specialties failing as total in Admitted, Non-Admitted and Incomplete results	0	15			Moderate
>=99%	Diagnostic test waiting time	>=99%	99.2%	99.2%	97.6%	Significant
<3.5%	Delayed Transfers of Care	<3.5%	4.6%	5.3%	5.0%	High
0	Mixed Sex Accommodation breaches	0	0	0	0	Low
>=90%	VTE risk assessment	>=90%	90.09%	90.97%	90.70%	Low

* Hospital Acquired CDiff (Year Target) A revised annual target of 42 was agreed with Commissioners (Contract Variation)

TABLE TO BE RE-DRAWN

Data Requirement	Data Average	National Average	East Cheshire NHS Trust considers that this data is as described for the following reasons	East Cheshire NHS Trust has taken the following actions to improve this score and so improve its quality of services by:
SHMI 1. The SHMI value and SHMI banding for the trust;	Oct 2011 - Sep 2012 0.9862 Band 2 - As Expected July 2011 - June 2012 1.0079 Band 2 April 2011 - March 2012 1.0029 Band 2 Jan 2011 - Dec 2011 1.0176 Band 2 Oct 2010 - Sep 2011 1.0111 Band 2	Oct 2011 - Sept 2012 = 1.0 10 Trusts Higher than Expected 18 Lower than Expected	The Trust now performs within the expected range for this indicator. Improvements have been made due to focus work by the Trust Mortality Group. This is in line with our Trust TDA submission	The Trust holds a monthly Mortality Meeting where low risk deaths are reviewed and Mortality figures scruitinised. The meeting has recently developed a process to enable the effective review of every avoidable death.
2. The percentage of patients admitted to a hospital within the trust whose treatment induded palliative care; and	Oct 2011 - Sep 2012 1.0% July 2011 - June 2012 0.9% April 2011 - March 2012 0.8% Jan 2011 - Dec 2011 0.6% Oct 2010 - Sep 2011 0.4%	Oct 2011 - Sep 2012 1.0% July 2011 - June 2012 1.0% April 2011 - March 2012 1.0% Jan 2011 - Dec 2011 1.0% Oct 2010 - Sep 2011 0.9%	The Trust now performs within the expected range for this indicator. Improvements have been made due to focus work by the Trust Mortality Group. This is in line with our Trust TDA submission	The Trust holds a monthly Mortality Meeting where low risk deaths are reviewed and Mortality figures scruitinised. The meeting has recently developed a process to enable the effective review of every avoidable death.
3. The percentage of patients admitted to a hospital within the trust whose deaths were induded in the SHMI and whose treatment included palliative care.	Oct 2011 - Sep 2012 15.0% July 2011 - June 2012 14.0% April 2011 - March 2012 13.4% Jan 2011 - Dec 2011 10.2% Oct 2010 - Sep 2011 7.1%	Oct 2011 - Sep 2012 18.9% July 2011 - June 2012 18.4% April 2011 - March 2012 17.9% Jan 2011 - Dec 2011 17.2% Oct 2010 - Sep 2011 16.4%	The Trust now performs within the expected range for this indicator. Improvements have been made due to focus work by the Trust Mortality Group. This is in line with our Trust TDA submission	The Trust holds a monthly Mortality Meeting where low risk deaths are reviewed and Mortality figures scruitinised. The meeting has recently developed a process to enable the effective review of every avoidable death.
PROMS score Groin Hernia VV Hip Replacement Knee Replacement	No modelled scores have been provided for these records due to the unreliability of the statistical models when presented with a small number of results. East Cheshire has low volumes of activity in this area and so no scores are available.		Results are unable to show health gain as numbers are so small and are therefore not induded.	Improve patient participation by active encouragement by clinical staff. Development of reminder system for responses. Improve circulation and review of outcomes by clinical teams
Readmissions The percentage of patients of all ages and genders who were readmitted to hospital within the trust within 28 days of being discharged	11.63%	11.42%	Age and co-morbidity of patients above national average	All readmissions are reviewed by clinical teams to identify learning. Development of an electronic alert system for high intensity service users. Development of a pathway to support patients with alcohol related conditions to prevent the need for an acute admission.Patient Journey coordinators to continue to develop role and support ward staff in effective discharge planning. Expansion of nurse specialist cardiology team using an integrated approach with community teams to manage patients with long term cardiac conditions. Development of ACS pathway assessment area.

				pathway assessment area.
Responsiveness to inpatients' needs The score, based on the CQC national inpatient survey, for responsiveness to patients' needs	Overall score: 62.8 Q1. Involvement in decisions about treatment/care: 72 2. Hospital staff being available to talk about worries/concerns: 53.6 3. Privacy when discussing condition/treatment: 83.9 4. Being informed about side effects of medication: 36.6 5. Being informed about who to contact if worried about condition after leaving hospital: 68.2	National Score ??	Operational pressures including increased patient dependency and throughput has challenged the workforce.	Develop an action plan involving all relevant areas. Regular monitoring of performance which will be scrutinised at Business Unit Safety, Quality and Standards committees, trends identified and corrective actions agreed. This will be documented in the minutes of these meetings and forwarded to the Patient Experience Group who will oversee progress.
The percentage of staff who responded to the NHS staff survey that they agree or strongly agree that if a friend or relative needed treatment, they would be happy with the standard of care provided by the trust	60%	Average for acute trusts = 60%	The Trust has undergone a number of organisational restructures, which have impacted on staff morale across all areas. The Trust is working towards Foundation Trust status. Operational pressures induding patient dependency and throughput has challenged the workforce.	Your Voice:Listening into Action has been implemented in the Trust to further engage with staff, listening and responding to ideas for improvement. There has been an increase in acute ward nursing establishment to improve the baseline staffing levels. The application for FT status continues. The achievement of quality standards continues.
VTE The percentage of admitted patients who were risk-assessed for VTE	Apr 2012 87.3% May 2012 90. 8% June 2012 88.8% Q1 2012 89.1% July 2012 90.8% Aug 2012 90.1% Sep 2012 93.9% Q2 91.6%	Apr 2012 93.4% May 2012 93. 6% June 2012 93.3% Q1 2012 93.4% July 2012 93.9% Aug 2012 93. 9% Sep 2012 94.0% Q2 93.9%	The Trust performs to the required standard.	On-going education of medical and nursing staff. On-going training on electronic system. VTE policy to be reviewed to indude DVT and PE guidelines in one document. Daily auditing within wards to ensure non compliance is managed at earliest opportunity.
CDiff rate The rate of C. difficile infections per 100,000 bed days amongst patients aged two years and over apportioned to the trust	April 2011 - March 2012 24.4 C. difficile infections per 100,000 bed days amongst patients aged two years and over	April 2011 - March 2012 21.8 C. difficile infections per 100,000 bed days amongst patients aged two years and over	Issues in Q1 and Q2 . New consultant Microbiologist commenced in post following gap in service after requirement of previous post holder. Action plan implemented. Evidence that the situation was brought back in control.	Continue with established MDT antibiotic ward rounds. Infection prevention and control team (nursing and medical) to work with CCG and GP's in reviewing antibiotic prescribing and overall management of patients with Long Term Condition that have potential to develop CDiff. Continue to develop CDiff management training. Continue with Root Cause Analysis review of all identified cases. Development of actions plans where required to be monitored within the clinical business group.
Reported patient safety incidents The rate of patient safety incidents they have reported per 100 admissions The proportion of patient safety incidents they have reported that resulted in severe harm or death.	10.51 incidents per 100 admissions Apr 2012-Sep 2012 0.3% resulting in severe harm or death (4 incidents resulting in severe harm, 2 resulting in death)	National average / total not given For all small acute trusts Apr-Sep 2012: Rate per 1000 admissions not given 0.9% resulting in severe harm or death	The web based incident reporting system is used to capture incidents and is available to all staff via PCs The patient harm field is mandatory on the incident reporting form All clinical incidents are reviewed by the Risk Management Team Training and communication takes place There is ownership for all incidents The Trust has a high level Executive lead group which considers all serious incidents	On-going training and education of Trust staff on incident reporting. The Trust is moving to Business Group specific reporting within the quarterly report to monitor reporting levels and trends The Trust is promoting the Duty of Candour across the organisation and have a "being open" policy Manchester Patient Safety Framework tool rolled out to Clinical Business Groups sub committees

Initiative	
Trust wide standardisation of intravenous practices, through competency based training and assessment programme. Ongoing assessment of competencies and knowledge to maintain standards across health economy.	
Aims	**Benefits**
All staff complete an evidence based workbook. The workbook starts at a basic level and build in complexity to appeal to staff with different levels of knowledge. Staff attend an intravenous study day with the workbook. Day consists of theoretical and practical participation Staff undergo competency assessment in clinical practice at least 3 times per skill. Competencies signed off and at level 1-4 using KSF outcomes to use at appraisal. Certificate issued and a date is set for an annual assessment. To maintain competencies. A key element of this is that staff learn best practice standards - maintain those standards and involve their patients in the process	• Educated workforce • Staff developed and feel values • Standardisation • Best practice cascaded • Safe and efficient services • Identifies and rectifies poor practice • Improved quality • Infection risk decreases • Enhanced patient experience • Reduced length of stay • Raises the profile of intravenous services within the trust • Encourages integration • Empowered and educated patients.

Initiative	
In September 2012, the Trust implemented a pilot Advanced Level 3 Apprenticeship in Health and Social Care.	
Aims	**Benefits**
The overall aim of the programme is to nurture home grown talent and facilitate local young people to work and have a career in the NHS. Working in partnership with Macclesfield College the scheme provides local young people with the opportunity to work as Health Care Assistants on the nurse bank whilst developing their skills and knowledge in health care. The apprentices work 30 hours a week in the Trust and attend college for 1 day a week. The Professional Practice Team supports the skills development of the apprentices in practice and designed a clinical placement programme to ensure that the apprentices experience care delivery in a range of clinical areas including medicine, surgery, orthopaedics, intermediate care and the community. Assessment of competency in practice is provided as part of the partnership agreement with Macclesfield College.	• The scheme provides a real opportunity for local students from our community to gain work experience and contribute to care that we deliver at the Trust. • The apprentices are supported by the Professional Practice Team and the Trust's ward staff to gain skills and competencies to deliver high quality care. The students also have access the Trust's state of the art simulation facilities where they can learn to deliver quality care in a safe realistic environment. • On completion of the Diploma the apprentices may have the option to either move on to a Foundation degree Trainee Assistant Practitioner programme, or enter Professional training.

Initiative
The home intravenous therapy service (HITS) was launched in 2012 driven by ECT strategic objectives and national agenda such as QIPP. Organisations are now required to manage patient throughout more effectively. HITS has a rare opportunity to promote cost effectiveness and improve quality of care. This is achieved by expediting discharge of patients no longer requiring hospital admission and where appropriate avoid admission all together.

Aim	Benefits
The HITS has been designed specifically to benefit a wide range of patients. Service pathways have been designed so that future patients will be considered, regardless of the condition. If the patient can safely undergo their intravenous therapy at home or in the community we will develop pathways to facilitate this. The service is split into two elements. Outpatient antibiotic therapy (OPAT) and speciality pathways, such as cardiology, alcohol detox, respiratory etc. The OPAT service is supported by district nursing teams who have worked hard through 2012 to achieve competence in IV antibiotic reconstitution and administration. The team has undergone competency assessment and has access to continually expanding educational resources. As a result we no longer have drugs supplied by a private provider. The Trust is working on admission avoidance pathways with GP's. This will benefit our over crowded A&E department and will allow for resources to be diverted to more appropriate areas.	• Educated Workforce • Enables best care at the right place • High Quality Service • Reduction hospital acquired infection • Promotes cost efficiency • Collaborative working • Integrated approach • Promotes efficiency in bed stock • Reduces waiting times for orthopaedics procedures • Reduces A&E activity

Initiative	
The introduction of Staff Training on 1 April 2013. In line with the National Core Skills Framework staff will complete their core statutory and mandatory training electronically.	
Aim	**Benefits**
From 2 April, 2013 staff will complete their Core Statutory and Mandatory training electronically through an e-learning programme, rather than via face-to-face delivery. The refresher period will also change to every three years rather than annually. There will still be a very limited number of places on the face-to-face programme reserved for staff who are unable to complete the modules online. Electronic Statutory and Mandatory Training (estat and Mand) is based on the modules developed for the National Core Skills Framework. The modules meet all the legislative and best practice guidelines required for statutory and mandatory training.	• Reduced time scales • The whole programme can be completed in approximately two hours saving time for staff • Cost effectiveness • The need for travel, a network of trainers and the general overheads of training can be reduced significantly. All national NHS e-learning is provided to the NHS free of charge • Accessibility • All materials can be made available online. This means there are no waiting lists, learning can be undertaken close to the time of need and the programme completed flexibly to fit in with the needs of staff.

Initiative	
The Resuscitation Council (UK) state that all clinical services must ensure tht their staff have immediate access to appropiate resuscitation euipment and drugs to facilitate rapid resuscitation of the patient in cardiopulmonary arrest. Standardisation of such equipment throughout an organisation is recommended.	
Aim	**Benefits**
Standardisation of the Crash Trolleys, and the layout of the equipment stored within - has the potential to improve the outcome following in-hospital cardiopulmonary arrest and reduce anxiety levels when staff respond to medical emergencies.	• Standardised equipment improves quality, safety and the patient experience by ensuring resuscitation equipment is readily available and fit for purpose • Consequently this benefits both patients and staff alike.

Initiative	
The Trust has invested in the reconfiguration of the discharge team and the establishment of the Patient Journey project which supports the overall Patient Flow programme for East Cheshire NHS Trust.	
Aim	**Benefits**
The aim of the reconfiguration and project is to strengthen the management of the discharge process by supporting ward based staff and moving from a 5 day service to a 7 day service in order to reduce the % of delayed transfers of care from the Trust to < 3.5% of inpatient bed stock. This will be achieved by:	• Provision of a 7 day service which will support increased discharges at the weekend • Early identification of patients requiring assisted discharge planning (providing assurances that the Trust is meeting it's legal obligations regarding pre-discharge assessments and entitlements to all patients) • Robust management of delays associated with 'Patient Choice' issues by improved and timely communication between Trust staff and it's patients and their carers (reduced patient/carer complaints re: discharge management) • Improved compliance with Trust policy through on-going education and training of Trust staff • Provision of a consistent monthly reporting process.

Initiative	
District Nursing-Pressure Sore Prevention.	
Aim	**Benefits**
To raise the profile of good pressure area care with effective and nursing assessments. All staff to be aware of their personal roles and responsibilities. Focus upon evaluation and treatment of nutritionally compromised patients.	• "At risk" patients were identified and a series of audits were undertaken to ensure the correct measures, care plans and risk assessments were carried out and were reviewed. • Morale has been improved as the team feel they are taking a proactive part in effective management of pressure ulcers. • Improvements in overall health and nutrition of patients on case load is beginning to be apparent.

Initiative	
A review of the nurses establishment across the acute wards	
Aim	**Benefits**
Work was undertaken to access the level of patient dependency in relation to the nurse establishment on the acute wards Benchmarking using a selection of nursing models was undertaken and was triangulated to agree the revised model A business case was developed and taken to Trust Board. Trust Board agreed aditional resources - £880k to support the improve staffing levels	• Nurse to patient ratio improved to six/seven patients to a qualified health care assistant • Improve nursing capcity to support patients and give quality care • Reduced levels of temporary staffing • Better continuity of care • Staff are aware of and are better able to work to the Trusts policies and procedures • improved staff moral.

Initiative	
Implement a community matron alert system.	
Aim	**Benefits**
To inform community matrons when a patient on their case load has attended A&E or has been admitted	• Matrons informed in real time regarding patients on their case load. • Improved communication • More effective management of patients supporting discharge at earliest opportunity

Initiative	
Implementation of tele health by community matrons	
Aim	**Benefits**
To allow community matrons to monitor patients with long term conditions remotely	• Patients can have vital reading such as blood pressure temperature pulse and oxygen saturation recorded within their own home. • Allows early intervention • Allows matrons to prioritise their work load • Reduces the requirement of home visits and patients attend GP practise.

East Cheshire NHS Trust teams shortlisted for national awards

The respiratory and cardiac teams at East Cheshire NHS Trust have been shortlisted for the Care Integration Awards, thanks to the excellent integrated services they provide.

The scheme's success has also been recognised by other healthcare professionals including the School of Nursing and by other Trusts, which are looking to adopt this model of care.

Kath Senior, Director of Nursing, said:

"It's great that the excellent work these teams are doing on behalf of the Trust has been recognised.

"By providing integrated services of this nature we can make a really positive difference to the patient experience, effectively supporting them and enabling them to adjust more easily to living back at home and managing their own conditions.

East Cheshire NHS Trust named NHS patient feedback challenge winner

East Cheshire NHS Trust was one of nine ambitious organisations leading patient experience projects to spread their innovative practices to other areas of the NHS, after being selected as winners of the NHS Patient Feedback Challenge. The project, entitled Patient & Family Echo, was a joint application by the Trust and Clever Together, a leading change and transformation agency.

They have been awarded £150,000 to spread the Patient & Family Echo process to health and social care organisations across the nation. Patient & Family Echo is a patient experience improvement tool that engages and empowers staff to 'echo' the voice, experience and needs of patients and families into their organisation. It aims to create organisations that value, listen and respond to feedback in order to continuously improve patient experience.

Audit participation

Participation in clinical audits 2012/2013

During 2012-13, 34 national clinical audits and four (NCEPODs) national confidential enquiries covered NHS services that East Cheshire NHS Trust provides.

During that period East Cheshire NHS Trust participated in 27/34 (79%) of the national clinical audits and 4/4 (100%) (NCEPODS) of the national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that East Cheshire NHS Trust participated in, and for which data collection was completed during 2012-13, are listed below, alongside the number of cases submitted to each audit or enquiry, as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Clinical Audit	Participation	Data collection 2012/13	% cases submitted in 2012/13	Patient recruited 2012/13
Neonatal intensive and special care (NNAP)	✓	✓	100%	166 admissions
Paediatric Pneumonia (BTS)	✓	✓	100%	40
Paediatric Asthma (BTS)	✓	✓	100%	23 cases submitted
Pain database	X	X	N/A	N/A
Epilepsy 12 (Childhood Epilepsy)	✓	✓	Data input commenced 01/03/13	N/A
Paediatric Intensive Care (PICAnet)	✓	✓	100%	12
Paediatric Cardiac surgery	N/A	N/A	N/A	N/A
Adult Cardiac surgery	N/A	N/A	N/A	N/A
Emergency use of oxygen (BTS)	✓	✓	100%	11 cases submitted
Adult community acquired pneumonia (BTS)	X	X	N/A	N/A

Audit participation

National Clinical Audit	Participation	Data collection 2012/13	% cases submitted in 2012/13	Patient recruited 2012/13
Non invasive ventilation – adults (BTS)	X	X	N/A	Not enough cases submitted
Cardiothoracic transplant	N/A	N/A	N/A	N/A
Cardiac arrest	X	X	N/A	N/A
Comparative audit of medical blood transfusion	✓	✓	100%	40
Adult critical care (ICNARC)	✓	✓	100%	410
Potential donor audit	✓	✓	TBC	TBC
Fever in children	✓	✓	100%	50
Diabetes (adults ANDA)	X	X	N/A	N/A
Diabetes (paediatric PNDA)	✓	✓	100%	95
Fractured neck of femur	✓	✓	100%	50
Parkinson's disease	X	X	N/A	N/A
Adult asthma (BTS)	✓	✓	100%	13
Bronchiectasis (BTS)	X	X	N/A	Not enough cases submitted
NJR hip knee and ankle replacements	✓	✓	TBC	TBC
Health promotion in Hospitals (NHPHA)	N/A	N/A	N/A	N/A
Inflammatory bowel disease (IBD)	✓		N/A	N/A
Suicide and homicide in mental health (NCISH)	N/A	N/A	N/A	N/A
Vascular surgery (VSGBI Vascular Surgery Database)	N/A	N/A	Data for East Cheshire NHS Trust patients included in patient data submitted by UHSM	Data for East Cheshire NHS Trust patients included in patient data submitted by UHSM
Carotid interventions	N/A	N/A	Data for East Cheshire NHS Trust patients included in patient data submitted by UHSM	Data for East Cheshire NHS Trust patients included in patient data submitted by UHSM
MINAP	✓	✓	Ongoing	Data completion date end of May 2013

Audit participation

National Clinical Audit	Participation	Data collection 2012/13	% cases submitted in 2012/13	Patient recruited 2012/13
Heart failure	✓	✓	Ongoing	Data inputting until end of May 2013
SINAP	✓	✓	100%	320
Cardiac arrhythmia	N/A	N/A	N/A	N/A
Renal replacement therapy (renal registry)	✓	✓		
Renal transplantation	N/A	N/A	N/A	N/A
Lung cancer	✓	✓	TBC	TBC
Bowel cancer	✓	✓	TBC	TBC
Head and Neck Oncology	✓	✓	TBC	TBC
Oesophago-gastric cancer	✓	✓	TBC	TBC
National Hip fracture database	✓	✓	100%	227
TARN	✓	✓	TBC	TBC
Renal Colic	✓	✓	100%	10
Prescribing Observatory for Mental Health (POMH-UK)	N/A	N/A	N/A	N/A
Psychological therapies	N/A	N/A	N/A	N/A
Pulmonary Hypertension	N/A	N/A	N/A	N/A
National Audit of Dementia (NAD)	✓	✓	100%	40
Coronary Angioplasty	N/A	N/A	N/A	N/A

Audit participation

Confidential Enquiries	Participation	Data collection 2012/13	% cases submitted in 2012/13
Asthma Deaths (NRAD)	✓	✓	100%
Child Health (CHR-UK)	✓	2	100%
Maternal Infant and Perinatal	✓	✓	100%
National Confidential Enquiry into Patient outcome and Death (NCEPOD) Subarachnoid Haemorrhage	N/A	N/A	N/A
National Confidential Enquiry into Patient outcome and Death (NCEPOD) Alcohol Related Liver Disease	✓	Organisational questionnaire returned Jan 2013	No patient data submitted
National Confidential Enquiry into Patient outcome and Death (NCEPOD) Bariatric Surgery	N/A	N/A	No patient data submitted as ECT does not undertake Bariatric Surgery
National Confidential Enquiry into Patient outcome and Death (NCEPOD) Cardiac Arrest Procedures	✓	✓	100%
Suicide and homicide in mental health (NCISH)	N/A	N/A	N/A
Elective Surgery (National PROMs Programme)	✓	✓	Average participation rate provisional data for Oct 2012 to Jan 2013 = 63%

The reports of 5 National Audits were reviewed by the provider and East Cheshire NHS Trust intends to take the following actions to improve the quality of healthcare provided:

National audit	Actions and progress
British Thoracic Society Adult Asthma Audit 2011	The British Thoracic Society Adult Asthma audit was carried out between 1st September 2011 to 31st October 2011 and data on 16 patients was submitted by East Cheshire NHS Trust. Recommendations from the audit: 1. Recording inhaler technique reviews 2. Advice regarding visit with GP within a week of discharge 3. Hospital follow-up appointments within 4 weeks 4. Written management plans.
Newborn Hearing Screening: Parent Satisfaction Audit 2012	The NHSP National Quality Standard to do with coverage and timeliness specifies that 95% of all babies should have completed the screen process by the 28th day of life and this Standard is regularly achieved at Macclesfield. Around 80% of babies born at Macclesfield District Hospital are screened as inpatients. Home births, babies born at other hospitals and babies requiring a further screen are seen as outpatients in a screening clinic which runs once a week in Children's Outpatients. This is the fifth Macclesfield NHSP Parent Satisfaction Audit since the Macclesfield Newborn Hearing Screening Programme (NHSP) began in February 2004 as part of Phase 3 of a national five phase rollout. The overall aim is to provide evidence to the NHSP Quality Assurance team of parental satisfaction in the Newborn Hearing Service as delivered at Macclesfield, also to highlight any areas for improvement and to track changes in these areas over a period of time. In the main, the results replicate those given in previous audits, underlining the consistent and ongoing high standards of performance demonstrated by the Screening Team and also their excellent skills, knowledge, approachability and competence as perceived by the parents surveyed. Ongoing problems with the ordering and supply of the PCHR (Red Book) which were substantial in 2009 and 2010 now seem to have been resolved with adequate stocks and no restrictions to ordering. Although the number of respondents noting that the checklist had been pointed out to them has risen to 68% in 2012, from 59% in 2010, this will be highlighted to the Screeners for further emphasis and their Screener Dialogue will be monitored during practical observations.

National audit	Actions and progress
National Diabetes In-Patient Audit Results	This is a rolling National annual audit looking at data from 2009 to 2011, with audit week in September each year. This audit was carried out as a one day snapshot audit during audit week. Data on 49 patients was submitted by East Cheshire NHS Trust. Benchmarking data is available from 2010. Recommendations from the audit: 1. "Think glucose" implementation to raise awareness of in-patient diabetes a. Referral guidelines to diabetes team. 2. Insulin prescription chart to tie in with a. Diabetic Ketoacidosis Pathway b. Hypoglycaemia pathway c. Peri-operative pathway d. Intra-partum care pathway e. Self-administration policy for insulin (in line with NPSA insulin alert) and decision tree for assessment f. Insulin passports. 3. More importantly - to reduce insulin prescription errors & management errors. 4. To comply with NPSA insulin alert by the end of August. 5. To reconsider the support of in-patient diabetes specialist nurses 6. Rolling training programme for a. Junior doctors b. Ward based staff. Further discussion during the audit presentation highlighted a general consensus, that Macclesfield District Hospital should have an in-patient diabetes nurse support and this is to be liaised within the restructure of the community business group.

The reports of two Confidential Enquiries were reviewed by the Board and East Cheshire NHS Trust intends to take the following actions to improve the quality of healthcare provided. (We have taken into account the development of responsibilities to other Trust committees/groups and included actions informed by those bodies.)

Group or forum	National audit reviewed	Actions and progress
CARE Group (Clinical Audit Research and Effectiveness Group) monthly meetings. *National Audit scorecard reviewed by this group on a monthly basis and Business Unit audit scorecards reviewed by this group on a quarterly basis.*	Review of Cardiac Arrests 2011 (referring to NCEPOD – Cardiac Arrest Procedures Study 2010, "A Time to Intervene Report") reviewed 09.07.12	Audit report published March 2012 based on a Review of Cardiac Arrests 2011. Key recommendation from this audit was Clinicians at East Cheshire NHS Trust must comply with the CPR & DNACPR Policies to avoid undignified CPR attempts during the dying process. CARE added support to East Cheshire NHS Trust, via Resuscitation Committee, to comply with the 5 principal recommendations from NCEPOD 'Time to Intervene?' Report (June 2012).
	NCEPOD "A Mixed Bag", an enquiry into the care of hospital patients receiving parenteral nutrition (2010) reviewed 09.07.12	An audit was conducted in line with NCEPOD - A Mixed Bag. The Nutrition Support Team has improved the management of Parenteral Nutrition in the hospital in respect of issues such as line care and monitoring. Implementation of the Parenteral Policy and the Request for Parenteral Nutrition pro-forma has been key to assessing suitability of patients for Parenteral Nutrition and its safe and effective use.

The reports of 58 @ 19/03/13 local clinical audits were reviewed by the provider in 2012-13 and East Cheshire NHS Trust intends to take the following actions to improve the quality of healthcare provided. (We have taken into account the development of responsibilities to other Trust committees/groups and included actions informed by those bodies)

Group or forum	Local audits reviewed	Actions and Outcomes
CARE Group (Clinical Audit, Research and Effectiveness Group). Monthly meetings. *Business Unit Audit scorecards are reviewed by this group on a quarterly basis*	Looked after children (NICE)	CARE Group acknowledged the extent this public health guidance highlighted the importance of collaborative working and good practice.
	Glaucoma (NICE)	CARE acknowledged this presentation as an example of good audit practice for improving patient care in an outpatient setting. Actions from audit – tailored management plan to be agreed between doctor and patient. Patient survey to be conducted to monitor quality of service.
	Medicines Adherence (NICE)	CARE Group acknowledged the ongoing improvements shown from the results of this audit and processes in place to progress further. Audit results were disseminated at Business Unit Safety Quality Standard (SQS) and Audit meetings.

Group or forum	Local audits reviewed	Actions and Outcomes
CARE Group (Clinical Audit, Research and Effectiveness Group). Monthly meetings.	Specialist Neonatal Care (NICE Quality Standard)	Original audit of the self assessment checklist highlighted the provision of Specialist Neonatal Speech & Language Therapy was not met. Deputy Speech & Language Manager progressed this status to partial compliance as trained Speech & Language Neonatal care is now available. CARE acknowledged this as an example of good practice, added support to a business case for additional resources and requested this be added to risk register.
	Lung Cancer (NICE Quality Standard)	CARE acknowledged this as an excellent example of good practice and collaborative approach with relevant agencies, to improve lung cancer service to East Cheshire NHS Trust patients. Radiology service was highlighted as integral to the efficient service provided. CARE supports all opportunities to continue to 'fly the flag' with GP's and Primary Care.
	Infection Control (NICE)	CARE Group were informed that Statutory & Mandatory training covered the core elements of Infection Control. Since the formation of the integrated Trust this training has been rolled out to include those working in the community arm of the Trust.
	Bacterial Meningitis & Meningococcal Septicaemia in Children & Young People (NICE)	Quality standard self assessment checklist audited and presented at CARE Group. Three statements identified as being non-compliant with a timescale of one month given to meet compliance. Actions completed against all three statements within one month and compliance status updated to full compliance.

Group or forum	Local audits reviewed	Actions and Outcomes
CARE Group (Clinical Audit, Research and Effectiveness Group). Monthly meetings.	Patient Experience in Adult NHS Services (NICE Quality Standard)	Quality standard was presented at CARE Group, illustrating evidence of the individual compliance status against the 14 statements. The group noted that 'Statement 8 - Patients are made aware they can ask for a second opinion' provides a challenge as it is difficult to obtain evidence and to find suitable ways on implementing this. CARE Group agreed that further discussion to take place with Clinical Commissioning Group (CCG), as to whether this should be a high level approach instigated by CCG across all their organisations.
Acute Care Business Group monthly audit meetings.	**Medical Specialties:** Clinical Assessment in Stroke	The aim of the audit was to assess the completeness of neurological examination & use of the stroke pro-forma in patients admitted with a possible stroke diagnosis. The quality of the initial assessment has the potential to have significant impact on patient care and diagnosis particularly in stroke patients with the advent of thrombolysis. The conclusion was that we are falling short in our initial assessment of stroke patients and / or our documentation in relation to this. Recommendations with an implementation date of March 2013: 1. Full neurological assessment for patients admitted with a neurological problem 2. Clear documentation of reasons why parts of assessment not done if unable to do so 3. Neurological teaching sessions for Junior Doctors.

Group or forum	Local audits reviewed	Actions and Outcomes
Acute Care Business Unit monthly audit meetings.	**Orthopaedic Surgery –** Venous thromboembolism Prophylaxis in Orthopaedic In-Patients (NICE)	In line with NICE guidelines to reduce the number of VTEs, all hospitalised patients must have a risk assessment to prevent potentially fatal venous thrombo-ebolisms. The aims of the audit: 1. Ensure all patients have Venous thrombo-embolism Prophylaxis (VTEP) 2. Ensure all patients have mechanical VTEP unless contraindicated 3. Ensure all patients who have pharmacological intervention receive the correct drug, with the correct dose, at the correct time and for the correct duration The recommendations and actions from the audit: 1. Education of all doctors regarding the importance of filling out VTE risk assessments at admission, 24 hourly and weekly. 2. To ensure all forms are filled in correctly, and duration of treatment is included in the drug chart. 3. To re-audit with a larger sample size. 4. Review the benefits of carrying out a weekly risk assessment on orthopaedic inpatients (as per NICE guidelines).

Group or forum	Local audits reviewed	Actions and Outcomes
Acute Care Business Unit monthly audit meetings.	**Urgent Care** Management of Deliberate Self-Harm in A & E	The audit was conducted to compare our practise to national standards set by Royal College of Psychiatry with the objective to educate or to formulate a pro-forma to improve management of deliberate self harm (DSH) at MDGH. We retrospectively audited 15 patients from January to March 2012 who attended Emergency Department with DSH. Recommendations from the audit included; production of an assessment pro-forma, teaching all Health Professionals & Junior Doctors on Induction day and to re-audit in 6 months.
	General Surgery Cholecystectomy – Readmissions & Complications	The audit was conducted against the British Association of Day Case Surgery with the objective being, to increase the proportion of laparoscopic cholecystectomies done as day cases within the Trust, as this would have beneficial cost implications. The audit aimed to find and address the factors that led to an overnight or prolonged stay. The recommendations from the audit included; to default laparoscopic cholecystectomies to day case, unless social or surgical reasons, to conduct Post-op review at the end of list/day and to carry out telephone assessments on discharge as this would reduce readmission rates.

Group or forum	Local audits reviewed	Actions and Outcomes
Acute Care Business Unit monthly audit meetings.	**Clinical Services** Hand Hygiene in Clinical Environments in Radiology (NICE)	Hand hygiene is one of the most important procedures for preventing the spread of infection. Local Trust policies & NICE Guidance mandate good hand hygiene measures. 1 in 9 patients acquire HAI (Hand Hygiene Infection) which results in increased length of stay and further care and treatment is an adverse outcome for the patient. At 97% compliance all Radiology areas fell well within the targets set by the Trust, with no single month falling below the target. Recommendations from the audit included; - Clean jewellery well - Minimum of 30 seconds is recommended hand washing time - Ongoing re-audit to ensure compliance at all times (particularly summer time when rise in Methicillin-resistant Staphylococcus aureus and Clostridium difficile).
	Breast Surgery Lipomodelling Audit, (Dec 12)	Awaiting report/presentation to enable info to be extracted and added in.

Group or forum	Local audits reviewed	Actions and Outcomes
Families & Wellbeing Unit monthly audit meetings including Maternity & Women's audit meetings. All of the audits have actions plans for development or have achieved the standards of care.	**Midwifery** Decision to delivery time interval for grade 1 & 11 caesarean section	It is of utmost importance for the mother and fetus wellbeing, that the emergency caesarian sections grade 1 and 2 are performed within specific time limits. The aim was to audit the time from decision to delivery for grade 1 and 2 emergency caesarean sections in order to optimise clinical outcomes. In addition, to audit the adequacy of documentation in the patient notes according to the hospital policy. Greater than 95% concordance was set as the standard. Recommendations and actions from the audit: 1. To focus on documentation of decision and consultant involvement, by clinician involved in making the decision. 2. Maintain the high standards of practice of grade 1 and 2 caesarean sections. 3. Education of Senior clinician involved in the decision process regarding the need for better documentation in cases of emergency caesarian sections.

Group or forum	Local audits reviewed	Actions and Outcomes
Families & Wellbeing Unit monthly audit meetings including Maternity & Women's audit meetings.	**Childrens Services** Insertion & Management of Nasogastric Tubes in Paediatric Unit	The nasogastric tube care plan used on the Children's Ward at Macclesfield District General Hospital, was updated in June 2011 to reflect the recommendations of both NPSA & NICE. The aim of this audit was to assess whether patients on the Paediatric unit who require nutritional input, or other carers requiring the use of a Nasogastric tube are receiving quality, safe & effective care based on local & national guidelines. Several recommendations were made to improve patient care including: 1. Medical staff to document a full assessment and rationale for using a nasograstric tube. 2. All staff to be assessed for competency in use of nasogastric tube and to be introduced as a standard for all new starters to the ward. The findings of the audit have been shared with the Special Care Baby Unit Advanced Neonatal Nurse Practitioner and the actions to date are in line with the implementation dates set.
	Dietetics Weight Management Audit – NICE	Recommendations from the audit included ways in which to improve data collection of outcome measures and further assist patients in weight reduction within constraints of current weight management team. The team have actioned the recommendations, which included additional training for staff, trialling a drop in weigh session and working closely with IT analyst to ensure accurate coding of patient data. The implementation of these recommendations has led to improvements in service and patient care.

Group or forum	Local audits reviewed	Actions and Outcomes
Community Service Business Unit bi-monthly audit meetings. All of the audits have actions plans for development or have achieved the standards of care.	**Community East Locality** Audit of Giant Cell Arteritis (GCA) against BSR guidelines	Two actions that have been implemented following the audit: 1. Education for FY1 and FY2s on GCA as part of their annual teaching programme – implemented October 2012. 2. GCA investigation and management protocol on the East Cheshire NHS Trust intranet site – Clinical Guideline Intranet micro-site implemented February 2013.
	Community South & Vale Royal Locality Occupational Therapy Service Audit against National Occupational Therapy Standards	This audit assessed nine areas; - Accountability - Service users Best Interests - Consent - Practise and Progress - Competence - Record Keeping - Collaborative Working - Effective Communication - Management. An action plan was compiled to address any low compliance areas and this will be re-audited annually.

Families & Wellbeing Business Group

The National Confidential Enquiry into Maternal and Child Health (CEMACH) produced a report into why Children Die (2007). This report concluded that up to two thirds of childhood deaths may be preventable. A key finding was that prompt recognition of deterioration of a child's illness was paramount in preventing a child's death.

The recommendation from this report is that all areas that care for paediatrics in hospital should have a 'standardised and rational monitoring system for children developing critical illness - an early warning score'.

In 2009 the children's ward at Macclesfield District Hospital introduced a paediatric early warning scoring tool (PEWS). Despite extensive staff training and encouragement several clinical audits showed very poor results, mainly focused on poor compliance in recording by the nursing staff and a negative view of its use by both medical and nursing staff.

A working group was formulated and a peer review was undertaken of the current tool and, following very negative feedback from Partners in Paediatrics forum (PIP), combined with the poor audit results prompted a radical redesign of the tool to age specific charts, which other hospitals found more user friendly. The new tool introduced had been adapted from tools available on the NHS Institute for Innovation and Improvement. This new tool was launched in February 2012 and all medical and nursing staff had extensive training and teaching and competency booklets were distributed.

Following an audit in May 2012, and a comparison with previous audits, there had been improvements in the recording of the early warning score, thereby improving the quality of care provided to children. However, the audit report did still highlight that further improvement could be achieved once the new tool is embedded.

Community Services Business Group - GP Out of Hours Service

Trial additional shifts in GP Out of Hours services to cope with potential extra demand.

The aim of bringing in additional GP time was to enable A&E to refer more primary care patients to the GP Out Of Hours Service, and release A&E pressures. This was due to an increase in A&E clinical incidents reported, which could be seen by the GPOOH/New Service. Examples of these incidents arose from:

- Incorrect use of the A&E Department by patients
- Staffing pressures – 1 GP on A&E Saturday/Sunday nights
- Bed and ward pressures - sending to A&E when ward full
- Increased demand due to population rise and language barriers / patient education.

Additional commissioned shifts were piloted between 1st June 2012 and 31st July, 2012, every Saturday and Sunday from 6pm until 12pm.

A&E felt that the additional commissioning shifts were beneficial and well received – increasing their capacity. The impact was measured by the number of appointments required, shorter waiting times to be seen at base and shorter waiting times for home visits. Demand has not decreased; however, it has remained constant.

Service GPs on Saturday and Sunday afternoons and evenings, stated that the additional shifts were significantly beneficial, as it reduced pressure on them and it meant they could accept more patients and support A&E in a more flexible way. The service Triage Team noticed improvement in relationships between the A&E Triage and the service, due to the additional GP cover. It did mean that post 10pm there were two Doctors on duty giving more flexibility in the event of home visits and any sudden increase in demand.

These additional shifts meant the service could offer a better, more robust service to our patients, and additional support to A&E, and thus a safer transfer and handover of patients.

Adult Physiotherapy Service

There has been a rolling program of training staff in the use of the STarT BACK Tool since its introduction as part of the IMPaCT Research Study with Keele University in 2008. The Back Pain Specialists, who have been responsible for the training, undertook a service wide audit in June 2012 which identified that 91.37% of staff had received training in the use of the tool.

The Back Pain Specialists have manually audited the use of the tool (April – July 2012) and patient outcomes.

Results showed 942 patients with low back pain were assessed, of these 824 patients were assessed with the STarT BACK tool. Overall 75% of patients had a positive outcome (problems resolved/resolving/ goals near achievement – Modified Goal Achievement Score (MGAS).

Care Home Learning and Development Team

Background

One of the roles of the team is to deliver training and support to Registered Nurses within the 32 Nursing Homes in the East Cheshire area, to enable them to administer subcutaneous fluids. This means residents can be treated for dehydration within the home thus providing quality care for the resident and avoiding hospital admission. The aim was to quantify the potential number of bed days saved by the use of subcutaneous fluids within nursing homes.

Progress

Data collected from April 2012-February 2013 shows that subcutaneous fluids were administered to 94 patients over 730 days (although not all homes responded to the data requests). At an estimated cost of £260** per bed day, this equates to a potential saving of £189800 during the 11 month period. The service thus supports the Trust objectives of improving the patient experience, achieving financial sustainability and working with partners to provide integrated and innovative services.

Actions

-To examine the data by individual home to identify nursing homes that have not returned data. This will enable us to raise awareness of the procedure within those homes.

-To use the data to evaluate whether the service will be rolled out to the Central Cheshire nursing homes.

** Bed cost sourced from the In Patient Services Manager at MDGH.

Acute Care Business Group

The Department of Elderly Care Medicine participated in the North West Regional Falls Audit (which was the final cycle of four over an eight year period) by conducting a retrospective case note review. Participation in this audit provided an opportunity to benchmark and collaborate services to fit in with National standards.

The aims and objectives of the audit:

- To evaluate if patients with falls are managed appropriately
- To assess if the Trust are using the falls risk assessment tool properly
- To determine if falls interventions are undertaken robustly
- To ascertain if the Trust are compliant with the national guidance
- To ascertain if the Trust are showing continued improvement with the best available research.

One of the aims from this audit was to improve assessment processes and care planning and this was achieved in the majority of cases, with marked improvement from the 2009 audit. The results highlighted other areas of good practice with improvements made on the 2009 audit:

- As a reflection of more frequent assessments, up to two thirds were identified at risk for falls
- Medications reviewed and changed more by clinicians
- More falls and ward transfers identified
- More additional assessments (moving and handling, continence, bedrail, alternative bed).

Areas for improvement were also highlighted in the audit including staff training for falls awareness and a re-audit is planned to monitor these areas.

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

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

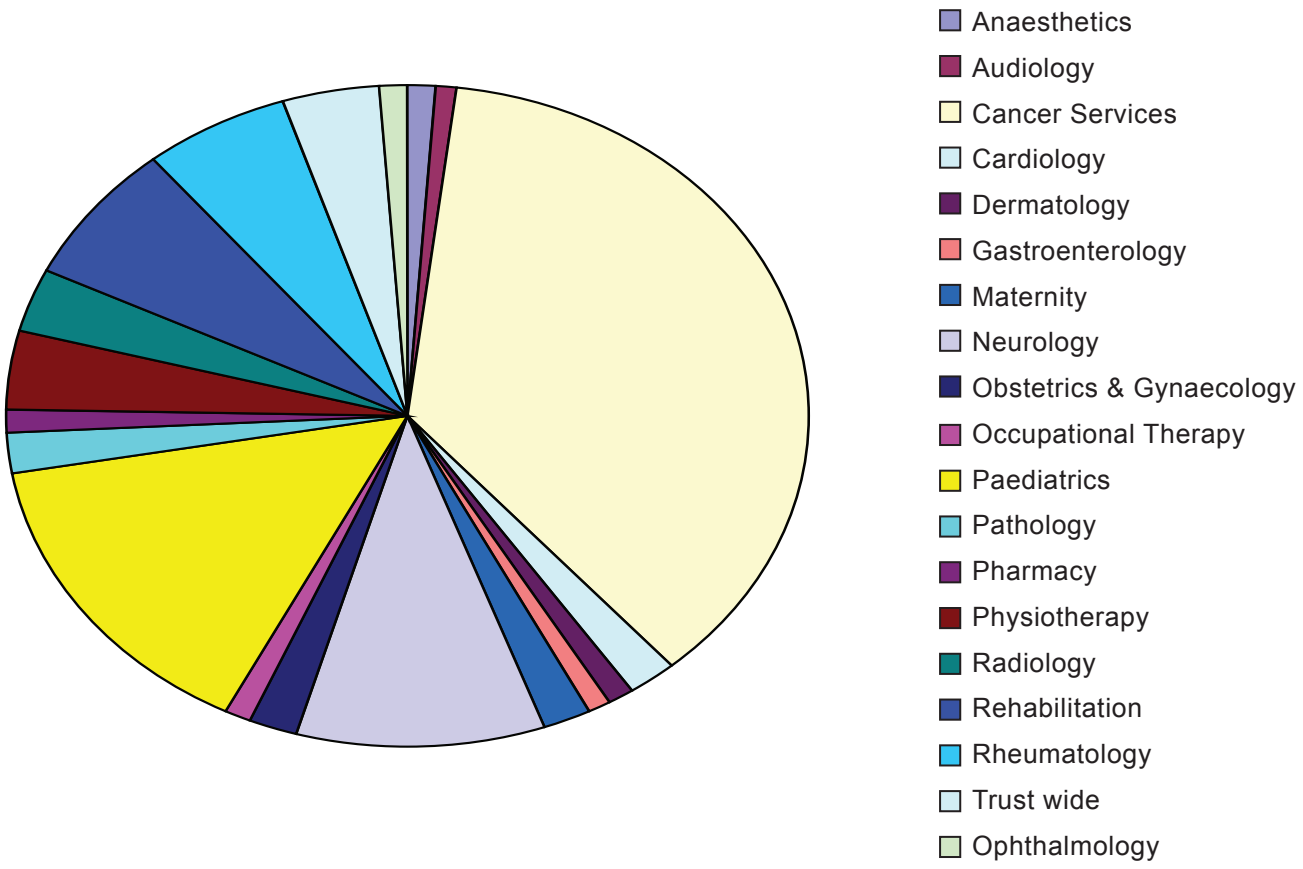
Whilst maintaining the studies and following up participants recruited in previous years, a further 27 studies have been opened and 379 participants were recruited in 2012-13. A further nine studies are awaiting approval by East Cheshire NHS Trust research staff for research that has been approved by the ethics committee.

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

The Trust is currently involved in 101 active clinical research studies covering 19 medical specialities, which are:

Areas of Clinical Research	
Anaesthetics	Paediatrics
Audiology	Pathology
Cancer Services	Pharmacy
Cardiology	Physiotherapy
Dermatology	Radiology
Gastroenterology	Rehabilitation
Maternity	Rheumatology
Neurology	Trust wide
Obstetrics & Gynaecology	Ophthalmology
Occupational Therapy	

Distribution of action studies across The Trust



As can be seen in the chart above Cancer services make up a large part of our portfolio which mirrors the situation nationally. The Cancer Unit runs a number of trials across a range of disease groups.

Written statements from other bodies

Glossary

Term	Explanation
ANTT	Aseptic Non - Touch Technique
BTS	British Thoracic Society
CARE	Clinical Audit Research and Effective
CEMACH	Confidential Enquiries into Maternal and Child Health
CEM	College of Emergency Medicine
CDiff	Clostridium Difficile
CQC	Care Quality Commission
CNST	Clinical Negligence Scheme for Trusts
COPD	Chronic obstructive pulmonary disease
CQUIN	Comissioning for Quality And Innovation
CSBU	Community Services Business Unit
CSLN	Cumbria and Lancashire Stroke Network
CXR	Chest XRay
DNAR	Do Not Attempt Resuscitation
HSMR	Hospital Standardised Mortality Ratio
ICNARC	Intensive Care National Audit And Research Centre
MBU	Medical Business Unit
MDGH	Macclesfield District General Hospital
MRSA	Methicillin-resistant Staphylococcus aureus

TO BE UPDATED

MINAP	Myocardial Ischaemia National Audit Project
NRAS	National Rheumatoid Arthritis Society
NHSLA	NHS Litigation Authority
NICE	National Institute of Clinical Excellence
NIHR	National Institue of Health Research
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NNAP	National Neonatal Audit Programme
NPSA	National Patient Safety Agency
PAS	Patient Administration System
PROMS	Patient Reported Outcome Measures
RCP	Royal College of Physicians
RA	Rheumatoid arthritis
RAMI	Risk Adjusted Mortality Index
SBAR	Situation Background Assessment Recommendation
SINAP	Stroke Improvement National Audit Progr\mme
SQS	Safety, Quality Standards
TARN	Trauma Audit and Research Networks
VTE	Venous Thromboembolism
VSGBI	Vascular Society of Great Britain and Ireland

Feedback Form

We hope that you have found this Quality Account interesting and helpful.

This report is available n our website. Hard copies can be made available on request.

We would be grateful if you would take the time to complete this feedback forma and return in to:

The Engagement Office
East Cheshire NHS Trust
Victoria Road, Macclesfield, Cheshire, SK10 3BL

Email: ecn-tr.Yourvoice@nhs.net

How useful did you find this report?

Very useful ☐
Quite useful ☐
Not very useful at all ☐

Did you find the contents?

Too simplistic ☐
About right ☐
Too complicated ☐

Is the presentation of data clearly labelled?

Yes, completely ☐
Yes, to some extent ☐
No ☐

If no, what would have helped?

.....

Is there anything in this Account that you found particularly interesting and helpful?

.....

Thank you for your time.

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

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

East Cheshire NHS Trust
Macclesfield District General Hospital
Victoria Road
Macclesfield
SK10 3BL

Follow us @eastcheshirenhs