East Cheshire NHS
NHS Trust

Quality Account

2013/14

The best care, in the right place

Year at a glance

This year has delivered some excellent achievements. The rewards, accolades and achievements we receive are a result of the hard work and dedication our staff put in throughout the year, to be the best at delivering patient care in the region.

April 2013

Integrated community and acute teams shortlisted for national awards

May 2013

Trust named CHKS Top 40 for third time in a row

June 2013

Innovative text service for young people launched by school nurses

October 2013

CNST Level 3 - top safety accreditation for maternity services

November 2013

Ward 9, winners of the patient choice award for quality of care

December 2013

Dr Foster online - trust performing "as expected" for mortality rates

Cancer patients receiving some of the best care and support in England

Cancer patients were assured they were receiving some of the best care and support in England when the trust came second in a league table measuring patient experience.

July 2013

Trust secures funding to improve quality of care for dementia patients

August 2013

Family and Friends Test launched for patients

September 2013

Trust placed in second-safest banding (band 5) by Care Quality Commission (CQC)

January 2014

Recognised as regional leaders to improve end of life quality of care

February 2014

New service to improve lung cancer diagnosis and treatment launched

March 2014

Macclesfield Hospital stroke co-ordinator nominated for top award

Our quality account describes our key achievements for 2013/14 and sets our priorities for the year ahead. We have made excellent progress in the past year in strengthening the quality of our acute and community services, and there is still more we can do. Our aim is to provide the best care in the right place for all of our patients, all of the time.

Kath Senior, Director of Nursing, Performance & Quality

Quality assurance monitoring 2012/15

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 generated by our staff.

Board Objectives

1. PATIENTS - Provide the best services to our population through improvements to safety, productivity and patient experience

2. PEOPLE - Empower, develop and value staff in providing innovative patient-focused care

3. PARTNERSHIPS - Actively develop sustainable services through effective partnerships

4. RESOURCES - Effectively provide services that are sustainable both now and in the future

Strategic Outcomes

1. Delivery of care services that are as clinically safe and effective as possible with a year on year reduction in health related harm

2. Delivery of care in a manner whereby patients are treated with compassion, dignity and respect with patients and carers consistently; rating the trust as good or excellent in relation to communication about care and treatment

3. Delivery of evidence based pathways of care, supported by an attitude and culture within the organisation whereby everyone is striving for excellence and continuous quality improvement in all that they do

Evidence of Improvement

1. Quality Account

2. Minimal variation from planned care pathway

3. Number of (avoidable) patient harms

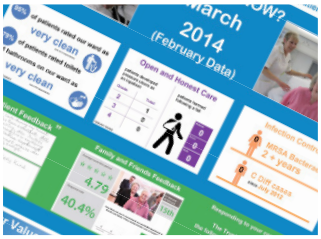
4. Compliance against essential quality performance standards and CQUIN

5. Improvement in patient and staff surveys

6. Improved third party assurance in Quality Account 2012/13

7. Improved Quality Governance

Leadership	Quality Governance	Patient & Family Involvement	Training & Development	Measure for Improvement
Restructure of clinical and management leadership Further embed nursing & Allied Health Professional (AHP) strategy and 6 Cs	Risk management Datix reporting Root cause analysis SQS committees Risk registers Rapid Assessment of Disease Activity in Rheumatology (RADAR)	Real-time monitoring Patient stories Patient/carer focus groups Learning from complaints and incidents Family and Friends Test (FFT) and other patient surveys	Revalidation Staff appraisal Role-specific training Statutory & mandatory training Competency framework AWARE	Data quality Annual quality accounts Quality dashboards CQC quality rating



Our quality promise

A focus on safety and quality has always been central to everything we do at East Cheshire NHS Trust. However, the publication of the Robert Francis QC report, the Don Berwick report and the report of Professor Sir Bruce Keogh further heightened our pledge to provide quality care in a compassionate and dignified way.

Even before the publication of the last year's high-profile reports into patient safety the trust took action to improve quality measures before taking into account the report's full recommendations. A single trust-wide action plan which embraces our community and acute services is now in place to embed improvement through one single mechanism.

The trust is dedicated to the delivery of:

• Care services which are as clinically safe and as effective as possible with a year-on-year reduction in health-related harm

• Care in a manner whereby patients are treated with compassion, dignity and respect

• Evidence-based pathways of care, supported by values-based attitudes and a culture within the organisation where everyone is striving for excellence and continuous quality improvement in all that they do.

We have a significant opportunity as a provider of both community and hospital services to provide seamless care benefiting the patients we serve. This gives us opportunities to shape services innovatively across care pathways that are not always available to other providers. We work with and support our clinical leaders to forge closer relationships with GPs and clinicians from other partner organisations for the benefit of all our patients. We want to embrace opportunities to extend our reach into the community and primary care so that only those who really need to, go to hospital.

The trust is a formal member of the Caring Together programme, a framework for integrated health and social care in eastern Cheshire, led by Eastern Cheshire Clinical Commissioning Group (ECCCG). Caring Together seeks to address the local health and social care challenges that we face in providing the future needs of our population across self care, primary care, community care and acute and specialist services.

The South Cheshire and Vale Royal CCGs are working together on a similar, Connecting Care programme for whole-system transformation with partners, including the trust. This programme is also seeking to create integrated care systems that improve care outcomes and make best use of care resources.

Contents

Throughout this document you will see quotation boxes like this:
These feature genuine comments about our services made by patients and their families.

Foreword

East Cheshire NHS Trust is totally committed to improving quality and delivering safe, effective, personal care with dignity and compassion. This has never been more important at a time when we are seeing a greater number of older patients cross our threshold, often with complex health needs.

Our vision is to deliver the best care in the right place, be this at home, in the community or in hospital - an approach wholly aligned with our commissioners. We have moved markedly in developing 'wrap around' patient services and on the following pages, you will see examples of how we continue to shift care safely, supporting services that aim to keep patients out of hospital when it is clinically safe to do so.

Over the last twelve months, the trust has focused on ensuring that quality improvements are in place, informed through patient stories at public trust board meetings. Recent years have seen the publication of a series of key reports, including Francis, Berwick, Keogh, Cavendish and Clwyd-Hart, so we have consolidated their recommendations and delivered them coherently through one of the trust's six overarching programmes of work - Strengthening Operational Delivery, demonstrating that we are applying NHS lessons learned elsewhere, so ensuring consistently safe, high-quality care.

Delivering improvements when resources are under pressure, we must spend wisely to benefit patients. To that end, we have invested in innovative technologies that support our workforce at the front line, enabling our staff to spend more time with patients.

Strong team work is a key factor of all achievements. By working in different ways, united by common values, we are making sure we deliver the right care first time, every time. We are actively listening to patient feedback, which has been overwhelmingly positive. However, we can always improve and we take learning from complaints and incidents, which have high levels of openness and reporting, to inform improved practice, which is reflective of how we act on and deliver our Duty of Candour. I am delighted that we have been accredited with CNST level 3, the highest level of regulatory assurance for maternity services and recognised as a provider of high-quality, low-risk service provision as measured by the Care Quality Commission, positioned at risk level 5, where 1 is poor/high risk and 6 is excellent/low risk. In addition, this year cancer patients were assured they were receiving some of the best care and support in England when the trust came second in a Macmillan Cancer Support league table measuring patient experience.

We are also actively listening to what our staff tell us about how we provide care. By empowering staff to share and act on the big and little ideas through the Your Voice – Listening into Action programme, we are all taking steps to transform services locally, as shown when we were recognised as the first autism-friendly hospital in England by the National Autistic Society.

Working more frequently with partners is an increasing theme in how we deliver high-quality care. In the coming year, this will become more evident through Caring Together in the East of Cheshire, Connecting Care in South Cheshire and Vale Royal and the impact of Healthier Together, a Greater Manchester commissioning initiative that we are embracing, alongside our South Sector Partnership trusts. As we deliver services, we will ensure we do things once across our health economy, avoiding duplication. Examples include the locality teams where primary, secondary and social care partners identify patients more likely to be at risk to better manage their care; the discharge teams, where health and social care partners coordinate care for a seamless transition between services.

The trust's Quality Account summarises our continued drive to improve quality and safety, demonstrating much to celebrate, although we remain focused on the challenges ahead. Delivering accessible care across

patient pathways, organisations and with partners to achieve great patient outcomes and experiences through sustainable services is a high priority for the trust over the next three years.

This year's Quality Account is written at the end of the first year of consolidation following significant healthcare system changes. This trust is clear that quality is the overriding hallmark of successful patient care and experience. I would like to take this opportunity to thank every member of staff, each of whom have worked tirelessly, contributing to this year's achievements and for your unwavering commitment to safe, compassionate and personal care delivered in the right place.

Thank you.

Lynn McGill
Chairman

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Chief executive's statement

Any questions I had were answered fully. All the people involved in the procedure inspired confidence

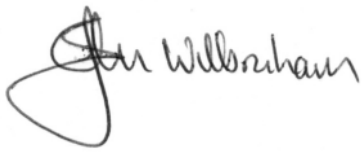
Chief executive's statement

Consistent delivery of quality in the care we provide is high on the agenda both of the patients we serve and the staff who provide services. Patients' expectations are rising, as they should, and it is important that we seek to exceed their expectations each time we touch their lives.

The board hear first-hand at our meetings the impact our staff have on the lives of patients to ensure we remain grounded in the purpose of our organisation to deliver the best care in the right place, providing sustainable, safe, effective and personalised care of which we can all be proud.

This quality account documents the achievements of our staff in providing high-quality care, as well as showing where we have innovated to improve the services we deliver. This account is the product of input from our staff and other partners and is not only a review of the 2013/14 year but also a commitment to the continued focus on quality improvement at the trust.

I hope the document demonstrates to you talent of our staff and their true dedication to the provision of high-quality services when you need them.



John Wilbraham
Chief executive

Director's statement

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;

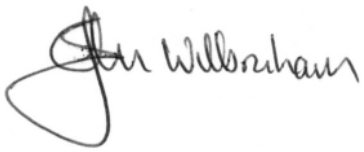
• the performance information reported in the Quality Account is reliable and accurate;

• 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

Auditor's letter

***Insert text - auditor's letter – to be updated on receipt ***

INDEPENDENT AUDITORS' LIMITED ASSURANCE REPORT TO THE DIRECTORS OF EAST CHESHIRE NHS TRUST ON THE ANNUAL QUALITY ACCOUNT

We are required by the Audit Commission to perform an independent limited assurance engagement in respect of East Cheshire NHS Trust's Quality Account for the year ended 31 March 2013 ('the Quality Account') and certain performance indicators contained therein as part of our 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, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ('the Regulations').
Scope and subject matter

The indicators for the year ended 31 March 2013 subject to limited assurance consist of the following indicators:

We have agreed VTE and F&F

• percentage of patient safety incidents that resulted in severe harm or death; and

• the number and rate of clostridium difficile infections for patients aged two or more on the date the specimen was taken. We refer to these two indicators collectively as 'the indicators'.

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 Regulations). 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; and

• 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.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

• the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;

• the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2012/13 issued by the Audit Commission on 25 March 2013 ('the Guidance'); and

• the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and to consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

• Board minutes for the period April 2012 to June 2013;

• papers relating to the Quality Account reported to the Board over the period April 2012 to June 2013;

• feedback from the Commissioners dated May 2013;

• feedback from Local Healthwatch dated May 2013;

• the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated 7 May 2013;

• feedback from Cheshire East Council Health and Wellbeing Scrutiny Committee dated May 2013;

• the latest national patient surveys;

• the 2012 national staff survey;

• the Head of Internal Audit's annual opinion over the trust's control environment dated April 2013;

• the annual governance statement dated 6 June 2013;

• Nine Care Quality Commission quality and risk profiles published monthly between May 2012 and March 2013; and

• the results of the Payment by Results coding review dated 22 May 2013.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively 'the documents'). Our responsibilities do not extend to any other information.

This report, including the conclusion, 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 2010.

We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and East Cheshire NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement under the terms of the Audit Commission Act 1998 and in accordance with the Guidance. Our limited assurance procedures included:

• evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;

• making enquiries of management;

• testing key management controls;

• analytical procedures;

• limited testing, on a selective basis, of the data used to calculate the indicators back to supporting documentation;

• comparing the content of the Quality Account to the requirements of the Regulations; and

• reading the documents.

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

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.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability.

The precision of different measurement techniques may also vary. Furthermore. The nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by East Cheshire NHS Trust. Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2013:

• the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;

• the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and

• the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

Julian Farmer
Senior Statutory Auditor, for and on behalf of Grant Thornton UK LLP

The quality strategy

I appreciate the speed of which I was seen from the doctors to the clinic at a time to suit my job

The quality strategy 2014/15

The trust is committed to ensuring that quality drives our clinical strategy and is at the core of everything we do.

The trust's clinical strategy aims to ensure that we deliver the best care in the right place for the healthcare needs of patients. This will support patient care away from hospital into more appropriate clinical care settings. It is important that this shift and change in service delivery supports quality improvements in patient care and experience.

For East Cheshire NHS Trust, quality is therefore about three things:

1. Designing and delivering care services that are as clinically safe and effective as possible

2. Delivering care in a manner whereby patients are treated equally, with compassion, dignity and respect in a clean and pleasant environment personal to each individual

3. Developing an attitude and culture within our entire organisation whereby everyone is constantly striving for excellence and continuous quality improvement in all that they do

Equally important to patients is their whole experience of services provided by the trust: from their care during a hospital appointment or inpatient stay or at home from a district nurse; whether they could park easily at a hospital site to our communication with them and whether staff were helpful and respectful. Developing an attitude and culture within our entire organisation whereby everyone is constantly striving for excellence and continuous quality improvement in all that they do is crucial.

Our quality will be supported by:

- ensuring required standards are achieved

- investigating and taking action on substandard performance

- planning and driving continuous improvement

- identifying sharing and ensuring delivery of best practice, and

- identifying and managing risk to quality of care.

Our focus is on helping people to stay healthy and independent by providing support and services that prevent ill health and maintain quality of life. This approach of prevention and early intervention of low-level support will help people to maintain control of their lives and decrease their dependency on care services.

However, there will continue to be increasing numbers of people who need care services as they grow older and these services need to offer patient choice wherever possible, and maintain dignity and respect. Many services, including re-enablement and intermediate care, provide short-term intensive support at times of crisis to enable people to return to independence in their daily lives. The trust intends to be the provider of excellence for specialist services for older people in community or hospital care settings.

The trust will continue to actively pursue full integration and transformation of clinical pathways, working proactively and collaboratively to expand our opportunities of working with others. The aim is to provide out-of-hospital care where appropriate, designing and improving services that build on work already happening in the community, working closely with GPs to achieve this.

The trust's board is made aware of potential risks to quality through the Board Assurance Framework. Trust boards are accountable for ensuring that patients continue to receive high-quality healthcare. Placing quality at the heart of an organisation is widely believed to improve patient outcomes while being a more cost-effective way to deliver modern healthcare. For example, by putting systems in place to prevent the occurrence of methicillin resistant staphylococcus aureus (MRSA) infections or pressure ulcers, you minimise the cost of treating them. The trust has placed quality as a key corporate objective and has ensured, through the application of the NHS knowledge and skills framework, that all staff have this as a key personal objective.

Our aim is to provide a quality of healthcare we would want for ourselves, our families and our friends.

The quality strategy describes how we will improve the safety and effectiveness of care while continuing to develop our patient focus. Our aim is to ensure that all clinical care provided is appropriately measured for its safety, effectiveness and patient experience, where we can increasingly measure the ultimate outcomes of care, and where information on quality is acted upon rapidly and effectively to ensure continual improvement.

The full quality strategy can be found on our website at: www.eastcheshire.nhs.uk

Our staff commitment to quality

East Cheshire NHS Staff pledge

"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."

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 compassionate and high quality care that achieves excellent health and wellbeing outcomes. It builds on the existing NHS Constitution and details six values: Care, Compassion, Communication, Courage, Competency and Commitment.

Our patients' opinions

Our patients' opinions are not just important to us as an organisation - patient opinion is a vital tool to help us understand the impact of our actions both to reward and praise staff in the delivery of quality care and to assist us in improving the quality of our service.

The Friends and Family Test - patients

In 2013, the NHS introduced a Family and Friends test for all trusts as a way of gathering feedback about patient's experience, helping to drive improvements in hospital services. Any patient aged over aged 16 who has had an overnight stay, received maternity care or has attended and been discharged from the accident and emergency department has 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?"

For patients under 16, we have a young person's online survey, developed in conjunction with children, that can be completed on any digital device including iPads and a paper-based survey that is always available on the ward and in outpatient clinics. A further age-appropriate way of capturing feedback is done using a 'washing line'. This involves patients writing on pictures of clothing: good comments go on t-shirts and bad comments go on a pair of pants. These are then pegged out on a mocked-up washing line for all to see.

We have also carried out a feedback exercise at Knutsford High School in relation to the young person's sexual health clinic. This was run in conjunction with the school nursing team. A questionnaire and a link to an online survey were distributed through the pupil's book bags. The aim of this was to promote the clinic location and times of the service.

The results of the Family and Friends test are publicly produced for patients' comparisons. This information is available in the trust's ward areas and on our website at www.eastcheshire.nhs.uk. Full details of how the trust has used this test as a 2013/14 priority and its outcomes can be found on page 40.

During 2014 the Family and Friends test for patients will also be extended to cover day cases and outpatients.

The Friends and Family Test - staff

During 2014 we will start to collect feedback from staff as the Family and Friends test is launched for staff to take part in. The results of this feedback will be published the trust website at www.eastcheshire.nhs.uk

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Our quality action plan

Efficient, friendly manner, pleasant, comfortable and clean surroundings

Our quality action plan 2013/14

The aims of the Quality action plan for 2013/14 were centred around three quality areas:

• To deliver a year-on-year reduction in avoidable patient harm within a health care setting

• To continuously improve patient outcomes through early identification and appropriate management

• To continuously improve the experience of patients using our services.

Over the past 12 months, the trust monitored its quality standards through various methods, such as:

• Positioning against peer/national benchmarks

• Clinical audits

• External assurance – Care Quality Commission, Clinical Negligence Scheme for trusts, Healthwatch, deanery visits, NW audit

• Patient feedback

Specific details on each of our priorities can be seen below. In summary:

Year-on-year reduction in patient harm

The trust has achieved in the following areas:

• Reduction in injurious falls

• Reduction in grade 3 & 4 pressure ulcers

• Reduced medication errors

• Fewer cancelled operations

• Reduction in confirmed cases of C Difficile

• Acute stroke indicators against Advancing Quality standards. Placed in top five hospitals for stroke care in the North West.

• Reduced mortality – Risk Adjusted Mortality Index (RAMI) and the Summary Hospital-level Mortality Indicator (SHMI)

• Safety thermometer

Unfortunately, the trust had one case of MRSA bacteraemia confirmed during the year, against a target of zero. As part of the post-infection review process it was identified that the MRSA blood stream infection was unavoidable. However there has been learning from this which has included a review of the MRSA screening process.

The trust also reported three blood steam contaminants during the year. MRSA blood stream (BSI) contaminants relate to blood cultures which are MRSA positive but the patient does not have MRSA bacteraemia. This can be due to contamination when the sample was taken. No patient harm occurred as a result of these contaminants. However it is important to reduce the risk of further contaminants and a review of blood culture sampling has taken place. Training for practitioners has been strengthened and the creation of blood culture packs will further improve documentation of the procedure in patients' notes. The trust has an ongoing focus to ensure appropriate clinical management of invasive lines. This is being driven by the Home Intravenous Therapy Service (HITS) team, infection control and practice educators.

Improve clinical outcomes

The trust has achieved in the following areas:

• 95% venous thromboembolism (VTE) assessment on admission

• Alcohol intervention and advice

• Improving inhaler technique

• Mortality reviews - for every patient the trust reviews the entire episode of care prior to death

• Management of the acutely unwell patient

• Improvements in dementia screening

• Caring Together – development of neighbourhood teams

• Roll out of EMIS web – secure, patient record data systems which save time and money for primary and secondary healthcare providers and help improve the patient experience

• Falls prevention.

The trust was less successful in achieving targets of completing outpatient clinical correspondence with GPs within 14 days and Advancing Quality standards (as set by the Advancing Quality Alliance) in the treatment of heart failure and myocardial infarction.

Improve patient experience

The trust has achieved in the following areas:

• Annual audit programme

• End-of-life care and associated staff training

• Friends and Family test – inpatients and emergency department

• Roll out of Friends and Family test to maternity

• Reduced number of complaints relating to communication

• Key performance standards include:

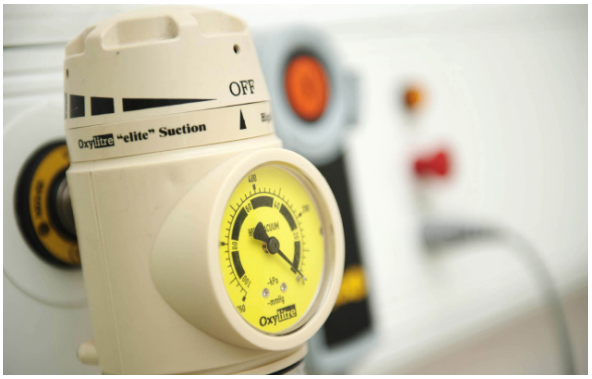
– Emergency department four-hour target, 18 weeks referral to treatment (RTT), 62-day cancer wait, same sex accommodation (SSA) breaches, diagnostic waiting times.

Safeguarding

The trust has over-achieved against the agreed trajectory for level one safeguarding training. This is not the case for levels two and three which are role specific. An action plan has been agreed with commissioners to deliver a significantly improved position by the end of quarter one.

The trust is pleased to report that following an unannounced CQC inspection earlier in the year, staff were able to demonstrate compliance with the expected safeguarding standards. Ongoing monitoring takes place via audits including internal peer reviews, led by the governance team and involving multidisciplinary staff.

The trust is currently implementing recommendations from the recently published intercollegiate document - Safeguarding children and young people: roles and competences for health care staff (third edition).



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Our achievements

The compassion, diligence and total perseverance of staff to provide long-term care is clear

Quality performance 2013/14

Each year all trusts are performance monitored on a range of high level, national performance standards.

East Cheshire NHS Trust's performance against the 2013/14 standards is tabled below. The equivalent performance in 2012/13 is also included, and where the 2013/14 standards did not apply, this has been noted.

2013/14 Target	Monitor Standards	In Month Target	2013/14 Performance	2012/13 Performance
95%	A&E: Maximum waiting time of 4 hours in A&E (calendar month)	>=95%	**95.49%**	93.88%
0 (2012/13 Target = 1)	Hospital MRSA bacteraemia year on year reduction versus trajectory for the year	0	1	1
No more than 24	Hospital Acquired CDifficile (Year Target)	2 or less	**14**	29
>=93%	2 Weeks maximum wait from urgent referral for suspected cancer	>=93%	**97.7%**	98.2%
>=93%	2 Weeks maximum wait from referral for breast symptoms	>=93%	**95.7%**	97.5%
>=94%	31 days maximum from decision to treat to subsequent treatment - Surgery	>=94%	**100.0%**	100.0%
>=98%	31 days maximum from decision to treat to subsequent treatment - Drugs	>=98%	**100.0%**	100.0%
>=96%	31 day wait from cancer diagnosis to treatment	>=96%	**99.5%**	100.0%
>=85%	62 day maximum wait from urgent refferal to treatment of all cancers (including patients treated at a tertiary centre)	>=85%	**87.7%**	90.7%
>=90%	62 days maximum from screening referral to treatment (including patients treated at a tertiary centre)	>=90%	**95.2%**	99.0%
>=90%	18 week Referral to Treatment - Admitted Patients - 90% within 18 weeks	>=90%	89.6%	91.2%
>=95%	18 week maximum wait - Non-Admitted Patients - 95% within 18 weeks (including community)	>=95%	**96.5%**	98.2%
>=92%	18 week maximum wait - Incomplete - 92% within 18 weeks (UNADJUSTED)	>=92%	**93.6%**	93.1%
>=99%	Diagnostic test waiting time	0%	**99.2%**	97.6%
<3.5%	Delayed transfers of care	<3.5%	5.2%	5.0%
0	Mixed Sex Accommodation breaches (Per 1000 FCE's)	0	0.06	0
>=95%	VTE Prevention - risk assessment	>=95%	**95.00%**	90.70%

Commissioning 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 2013/14 ten acute and two community goals were achieved.

Over the next 12 months, the continued achievement of the agreed goals will be undertaken through the Commissioners Quality Service Review Group. Where achievement is labelled as 'NO' in the table below, an explanation of why and plans to improve these areas are detailed in our review of quality performance starting on page 30.

Community	Achieved
NHS Safety Thermometer	tbc
Long-term conditions	✓
Falls	tbc
Self-care	✓

Acute	Achieved
Family and Friends Test	✓
NHS Safety Thermometer	tbc
Dementia	✓
Venous thombolysis	✓
Long-term conditions	✓
Alcohol	✓
Falls	tbc
Improving inhaler tech	✓
Advanced care planning EOL	✓
Advancing quality - Pneumonia	✓
NIC - Improved access to breast milk in pre-term infants	✓
NIC - Retinopathy of pre-maturity screening	✓

Safety thermometer

The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care.

Target

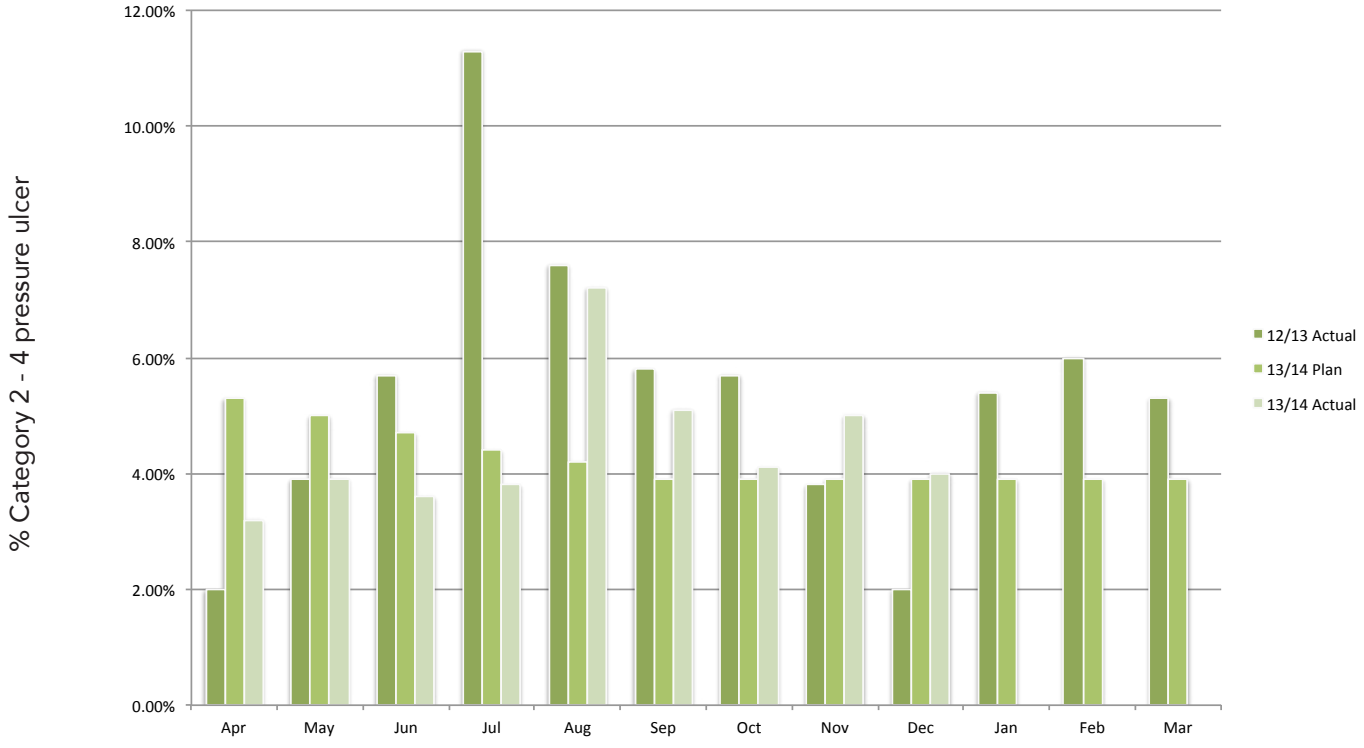
The trust committed to reducing by 30% the number of patients recorded as having a category 2-4 pressure ulcer (old or new) as measured using the NHS Safety Thermometer. The baseline is the median of August 2013 to January 2014 - 5.55%.

Payment to the trust in achieving this quality measure is triggered on achieving more than 95% of the agreed improvement goal between April and September 2013 followed by maintenance of that goal between October 2013 and March 2014.

An improvement goal of 30% was agreed.

After an initial positive start with the target achieved from April to July, there were fluctuations in achievements and the overall required percentage was not met.

Important note: Safety thermometer measures all pressure ulcers grades 1-4, which may have developed prior to care at the trust. In addition, it does not consider avoidable or unavoidable incidences which would more accurately reflect the true performance.



Achievements:

• Development of competency assessment in pressure area care for registered and unregistered staff (as part of the competency framework development work).

• Initial identification and training of link nurses.

• Development of staff e-learning package for pressure ulcer prevention, assessment and management – implementation planned for early April 2014.

Improvements:

• Work underway to undertake mini root cause analysis (RCA) on all stage 2 pressure ulcers reported as part of the transparency project development.

• Tissue viability involvement in all root cause analysis of stage 3 and 4 pressure ulcers - this enabled the trust to collate and consider trend analysis and root cause across the organisation. This in turn allows the accurate identification of the incidence in terms of pressure ulcers that are classed as avoidable and unavoidable.

• Development and implementation of bespoke templates within the incident reporting system to improve data quality, trend analysis and learning.

• Targeted training to areas of highest incidence delivered to highest reporting acute ward and community nursing team areas.

Clostridium Difficile

A clostridium difficile infection (CDI) is a type of bacterial infection that can affect the digestive system. It most commonly affects people who are staying in hospital.

Target

The trust committed to ensure compliance with the acute CDI maximum of 24. The trust had 15 cases.

Antibiotic stewardship continues to be a primary focus in reducing rates of CDI. Antibiotics are very important for the management of infections. Non-prudent use of antibiotics will lead to antibiotic resistance, thereby making them ineffective and increasing the chances of CDI infection. It is essential that we restrict the use of antibiotics for genuine infections for a dedicated length of time and at the right dose.

This control has contributed to a month-on-month reduction of cases.

As always, the best place to get care, fantastic high morale staff Very clean, very friendly

Achievements:

Following each individual case review, robust action plans are implemented to ensure lessons learnt can be used to focus changes in clinical practice. During 2013/14 the infection control team has implemented a process of home visits for patients who are identified as having CDI following discharge from hospital or after a GP sample - this is in addition to the infection prevention visits undertaken for inpatients.

These visits are intended to support the patient in understanding what CDI is and any actions they need to take on a day-to-day basis to manage their symptoms. In addition, the infection control nurses work with clinical areas to promote hand hygiene across multi-disciplinary teams. This is evaluated by routine audits and will be further strengthened by teaching sessions in clinical areas.

Improvements:

Continual monitoring of cleanliness standards is ongoing, in line with the trust's commitment to improving the quality of the patient's journey.

Management of acutely unwell patients

Improving the management of patients on our wards who require high levels of care.

Target

The trust aimed to improve the assessment and management of the acutely unwell patient in the following ways:

- Review current processes and update the standard operating procedure
- Review documentation
- Review training in relation to Track and Trigger and implement relevant IT to support the Trigger system
- Establish a health care assistant (HCA) development programme
- Review the critical care outreach service provision.

Achievements:

• 100% statutory and mandatory training delivered, including maternity

• Uploaded Minimum Standards policy onto the trust intranet

• All documentation reviewed

• Delivered fluid balance training trust-wide to all disciplines and promoted new fluid balance charts

• Developed sepsis care bundle and sepsis training trust-wide

• The critical care outreach service has been supported with increased staff hours.

• A trust-wide consultation forum has been developed with the executive team which included key stakeholders and service users. This has since set the standards to improve the care delivered to acutely unwell patients.

• An audit is now carried out twice yearly to monitor performance.

• Healthcare assistant training - the 'Aware' programme began in October 2013. So far, 66 healthcare assistants have completed the training.

Improvements:

• Planned improvement in the next 12 months will allow electronic vital sign recording to be implemented in acute ward areas to improve the recognition and response to acutely ill adult patients.

• Planned development of further HCA training in 2013/14

Caring Together – neighbourhood teams

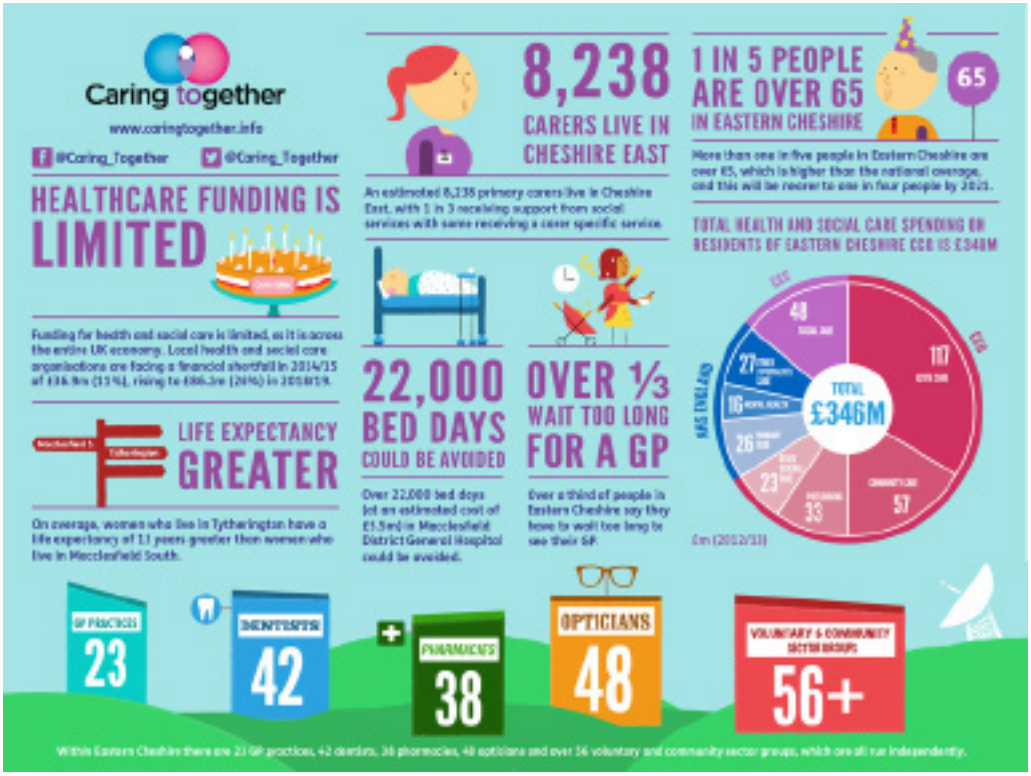
We believe that our patient's should sit at the heart of a pro-active care system. Caring Together is an alliance of all area's of health and social care working together to create a joined up service across eastern Cheshire.

Target

National policy and best-practice documents promote integrated care models as effective approaches to providing the best care for vulnerable people with complex long-term conditions. The aim for the trust in 2013/14 was to extend integrated working as demonstrated in neighbourhood teams.

Patients identified for care coordination are often frail, older people with multiple teams involved in their care. Currently, this can be fragmented with duplication and sometimes gaps in provision. The neighbourhood teams will involve patients and their carers in the planning of care and making of key decisions, ensuring care is centred on the patients' needs.

The local response has been to establish neighbourhood teams and extended practice teams, which are made up of health and social care professionals who work alongside each other to deliver proactive and coordinated care for patients with long-term conditions. Priorities include admission avoidance, early help and self-management.



Achievements:

During 2013/14, teams were established across five areas in East Cheshire and 11 in South and Vale Royal. The teams are developing effective processes which mean that patient care can be tailored to individual needs and is joined-up across all the professionals involved, including GPs, community nurses, therapists, mental health workers and social workers.

A new role introduced to the team in the last year is that of the wellbeing coordinator, whose role is to help people understand and manage their care and guide people to services and interventions which can improve their health and wellbeing. Wellbeing coordinators are currently working in Macclesfield, Knutsford, Congleton, Winsford and Crewe.

Improvements:

The established teams meet on a regular basis with a clinical focus to discuss and review patient needs. Separate implementation meetings are also held for all organisations and professional groups to attend and contribute to the shaping of the teams as they develop and evolve.

This includes building links with other services that can contribute to effective processes, such as the hospital discharge team, which can help to identify patients at high risk of admission who would benefit from proactive, coordinated community care.

In future, the teams will further develop the use of technology (remote blood pressure monitoring, for example) and discuss self-management strategies with patients.

Continuing to build links with teams across acute, primary, community and social care, and embedding robust processes, will be the focus of 2014/15, along with setting up teams in the remaining localities.

Venous thromboembolism (VTE)

When a blood clot breaks loose and travels in the blood, this is called a Venous thromboembolism (VTE)

Target

The trust aimed to ensure that a minimum of 95% of patients have a VTE risk assessment completed on admission, and that 95% of incidences of hospital-acquired VTE have a root-cause analysis completed by March 2014.

VTE risk assessment completed on admission (%)

April	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
91.9%	93.3	94.6	92.0	91.5	92.8	94.4	94.8	98.2	99.1	98.8	98.3

VTE hospital-acquired root - cause analysis

	April	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
No. VTE cases	0	1	3	1	1	2	1	1	1	0	2	
No. RCA under-taken	0	1	3	1	1	2	1	1	1	0	2	
% RCA under-taken	100	100	100	100	100	100	100	100	100	-	100	

Achievements:

• During 2013/14, the trust moved to an electronic system directly linked with the patient admission system (PAS) for recording the completion of VTE assessments.

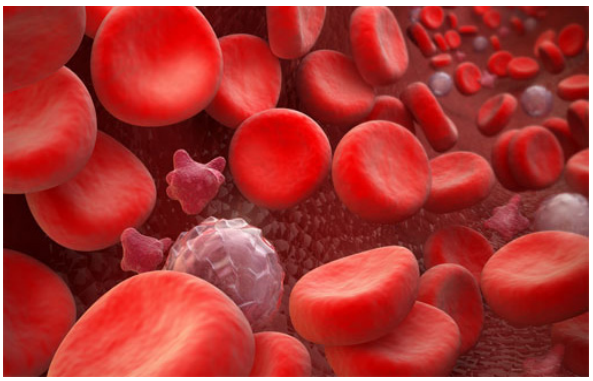
• The target has been consistently achieved since December 2014

• A process for root-cause analysis with hospital-acquired VTE was developed. Incidences of VTE are investigated by the patient's named consultant, reports are fed back to the VTE group for approval, comment and recommendation and then presented at the appropriate speciality Safety and Quality Standards Committee (SQS) and clinical audits meetings for shared learning

• An e-learning package for trained staff has been agreed.

Improvements:

• Work continues to ensure that all patients are assessed within the agreed timescales.



Friends and Family Test

The NHS Friends and Family Test is an important opportunity for you to provide feedback on the care and treatment you receive and to improve services.

Target

The trust target was to increase the response rate from acute wards patients to 20%, and emergency department patients to 15%, by March 2014. This has been achieved.

The Friends and Family Test (FFT) was introduced as a way of gathering feedback from patients about their experience of the NHS. Any patient over the age of 16 who has had an overnight stay or attended the Emergency Department is asked one question:

How likely are you to recommend our ward/department to your friends and family if they needed similar care or treatment?

A paper, text message or online survey is completed, giving feedback. These are our results for 2013/14

	April	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
% Response (Inpatients)	17.4	20.4	28.5	22.0	18.8	48.8	39.2	30.8	34.1	33.4	33.3	26.1
% Response (Emergency Dept)	8.0	25.0	28.5	21.6	24.9	24.7	20.4	24.1	21.3	23.0	20.7	21.1
% Response (Maternity / Overall)*	-	-	-	-	-	-	5.5	16.4	28.4	61.9	52.1	28.1

*Monitoring only introduced in Oct 2013.

Achievements:

• Full roll out to all inpatient areas undertaken from April 2013.

• Significant improvement in response rates through the year.

• The FFT results are displayed at the entrance to each ward. Themes are identified from the free text feedback by each ward manager and actions take on any identified areas of concern.

The top three positive themes identified across the trust are:

1. Friendly professional, polite and helpful staff
2. Excellent first-class care and
3. Staff were reassuring and answered questions.

The top themes for improvement are:

1. Lack and cost of TVs
2. Food - in particular the evening meal /supper menu, and
3. Noise – especially at night.

Action plans are in place to address areas for improvement and due to the success of the roll-out, the trust has shared its experiences with other organisations.

Improvements:

• Ongoing work to improve the response rate and use the information to improve the patient experience.

• Roll-out to the emergency department has also been successful and this has moved to a text message system, which has been well received.

• Roll-out to maternity commenced in October 2013.

• Roll-out to staff will commence in April 2014.

• Work continues to improve the overall 'net promoter' score.

• Roll-out to day cases and outpatients by October 2014

Dementia

Dementia is a syndrome (a group of related symptoms) associated with an ongoing decline of the brain and its abilities.

Target

The trust aim for 2013/14 was to improve the diagnosis and referral of patients with dementia by screening eligible patients in line with national standards. This has been achieved by effectively screening all non-elective patients aged 75 years and over who are admitted to hospital, and referring patients with a positive screen back to their GP or an appropriate specialist for further support. Carers with dementia will be surveyed to see if they feel supported. In addition, the views of carers caring for people with dementia were also sought.

Ward 9 is the best and made our experience of the hospital system rosy - lovely ward and great staff

Achievements:

• Following the successful submission of a two-stage application process in August 2013, the trust was awarded £326,000 to improve the environment of care for people with dementia. The funding enabled the construction of a new conservatory and garden, a new communal seating area, improved décor, lighting, flooring and signage and interactive digital artwork

• Ward 9 received the 'Team of the Month' award October 2013.

• Ward 9 received 'Team of the Year' at the trust's annual award ceremony in November 2013.

• The trust achieved the dementia Commissioning for Quality and Innovation (CQUIN) key quality indicators.

• The trust commissioned three two-day courses in partnership with the University of Chester. The course content was tailor-made to ensure that our learning outcomes were met, which underpinned increasing inter-disciplinary knowledge and skill sets.

Improvements:

• An assessment of the Ward 9 environment was undertaken in April 2013 using The King's Fund Enhancing the Healing Environment (EHE) assessment tools. This supported and informed the proposed project plans for refurbishment.

• A '15 steps challenge' assessment was undertaken as part of the 'productive ward' series. The toolkit enables teams to collate first impressions of a ward area from a patients perspective and tests the 'confidence in care' concept.

• A detailed project plan has been developed to ensure that proposals outlined in the original bid for the funding are delivered within the specified timescale and within budget.

• A key stakeholders event held in December 2013 provided an opportunity for potential providers, professional, voluntary groups and members of the general public to obtain public engagement on the dementia initiatives.

• A dementia operational group was established and now meets monthly to drive service improvements, increase dementia awareness and training among staff and promote wider engagement with a view to implementing the Department of Health's national dementia strategy, 'Living well with dementia'.

A patient story

Neighbourhood team meeting: Mrs F was on the list of patients at high risk of re-admission in the next year.

Her GP would not have referred the patient to the community matron service as this patient was not identified as being in need of advanced nursing and case management, although she did have long-term conditions.

The case was discussed at the neighbourhood team meeting. A group of professionals developing the care co-ordination model decided to assess this lady and learn from the case, to see if the risk monitoring systems in use were identifying appropriate patients.

Initially, the community matron was identified as the most appropriate care coordinator as her main condition was chronic obstructive pulmonary disease (COPD), with previous admissions for type 2 respiratory failure.

Initial assessment involved the community matron and the outreach pharmacist. The patient was, at that point, under the care of the integrated respiratory team for her COPD. The community matrons took over her care. A number of issues were identified, including her inability to use her inhalers correctly. These were changed to nebulisers immediately. Nebulisers are only prescribed after careful assessment and are used to deliver medication in the most appropriate way for patients when inhalers are not felt appropriate.

It was also apparent that the patient had been inappropriately adjusting her oxygen supply, which exacerbated her condition. A control mechanism which prevents over-use of oxygen was then fitted to the patient's oxygen supply.

Within the next three weeks of assessments, the community matrons identified that Mrs F was in the palliative phase (final stages of life) of the disease, which had not until this point been identified. The family were becoming very anxious. Had the community matron team not been involved, this lady may have been admitted to hospital as often families feel unable to cope with a loved one's deterioration. In this case, they had not been prepared for the terminal stage.

Mrs F expressed that her preferred place of care was her home and her family supported this. The community matrons facilitated this choice and Mrs F passed away very peacefully at home, five weeks after the first discussions at the neighbourhood team meeting.

87% of patients who express a preferred place of care in which to die achieved this wish.

Data quality

Confidentiality when checking in.....could be improved

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Data quality 2013/14

Care Quality Commission

East Cheshire NHS Trust is required to register with the Care Quality Commission (CQC) and its current registration status is that all standards are being met. The CQC has not taken enforcement action against East Cheshire NHS Trust during 2013/14.

The CQC, which regulates the care offered by the NHS and inspects trusts on an annual basis, conducted an in-depth inspection of the hospital in August 2013 – rating it against five standards. The report noted the hospital met all the required standards it was inspected against and also highlighted many positive comments from patients and their families.

During 2013/14 the trust has provided the following regulated activities, as defined by the Care Quality Commission.

- Dementia
- Diagnostic and/or screening services
- Family planning services
- Maternity and midwifery services
- Nursing care
- Personal care
- Services for everyone
- Surgical procedures
- Termination of pregnancy
- Treatment of disease, disorder or injury
- Caring for children (0 - 18yrs)
- Caring for adults under 65 yrs
- Caring for adults over 65 yrs

East Cheshire NHS Trust systematically and continuously reviews data related to the quality of its services. The trust uses its integrated quality, safety and performance scorecard to demonstrate this.

Reports to the trust's board and sub-committees, Clinical Management Board, Safety Quality and Standards Committee and the performance management framework all include data and information relating to our quality of services. The trust has reviewed all the data available on the quality of care in all of these NHS services.

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. The Secondary Uses Service dashboard is continually monitored.

Areas for improvement are identified and quality errors, such as invalid NHS numbers, are rectified. Overall, data quality is reported monthly to the trust board. The trust's overall data quality scores are better than the national average.

Data quality

Under figures for April 2013 to October 2014, the Secondary Uses Service Data Quality Dashboard was at 93.9%, against 95.9% nationally.

Meanwhile, for a valid NHS number being present in the data, the scores are above the national average. Admitted patient care was at 99.6% against 99.1%, outpatients was showing 99.8% against 99.3%, and accident and emergency was significantly above the national average of 95.7%, at 98.3%.

For a valid Healthcare Resource Group version 4 code, the scores are 100% for the trust against national scores of admitted patient care at 98.6%, outpatients at 99.2% and accident and emergency at 96.8%.

Clinical coding

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 2014. The trust submitted evidence in March 2014, confirming Level 2 compliance against all the requirements. The trust's overall score was 67% or 'green' according to the IGT grading system.

Clinical coding – Payment By Results (PBR)

No PBR audit was carried out in the year 2013/14.

Review of Services

During 2013/14 East Cheshire NHS Trust provided and/or sub-contracted 13 NHS services.

The Trust has reviewed all the data available to them on the quality of care in 100% of these NHS services.

The income generated by the NHS services reviewed in 2012/13 represents 100% per cent of the total income generated from the provision of NHS services by East Cheshire NHS Trust for 2013/14

Patient and staff feedback

Friendliness and competence makes the whole experience almost enjoyable

Patient and staff feedback

CQC – National Maternity Survey 2013

The trust was reviewed by 151 women out of a sample of 266 who had given birth at the trust during January and February 2013.

The survey looked at experiences under categories of 'antenatal care', 'labour and birth', 'postnatal care' and 'infant feeding support'. As mothers could have received 'antenatal care', 'postnatal care' and 'infant feeding support' at a trust or location different to where they gave birth, the CQC would only publish benchmarked data for the 'labour and birth' sections of the questionnaire.

Overall, the trust was classed as performing in line with other trusts for all criteria included within the 'labour and birth' section of the survey.

An action plan has been developed to further improve mothers' experience of labour and birth at the trust. Improvements have already been made in relation to the explanations and information given following the birth via dedicated support workers on the ward and an opportunity to discuss the birth prior to discharge.

There is also ongoing work to develop an advanced recovery programme for women undergoing an elective caesarean section. This will enable the length of stay in hospital to be reduced, so that women are able to return home with their baby sooner following the birth.

East Cheshire NHS Trust was able to identify where respondents had received 'antenatal care', 'postnatal care' and 'infant feeding support' from its services. Due to this it was also possible to benchmark against other trusts that were also able to make these identifications for the remainder of the survey.

When looking at the survey overall the trust was classed as performing in line with other trusts for the majority of criteria. The trust was classed as performing better than other trust in three areas:

- Having a choice of where antenatal appointments took place

- Having a contact number for a midwife/midwifery team once at home following the birth.

- Mothers being asked how they felt emotionally once at home following the birth

Areas of focus for improvement in 2014/15 are:

- Mothers being told they would need to arrange a postnatal health check with their GP

- Consistent advice given by health professionals in relation to baby feeding

- Mothers being offered advice/information in relation to contraception.

The maternity care I received was second to none. The staff are very conscientious and professional, and I had great faith in them. So much so I recommended other expectant mothers to go there.

The 2012/13 National Cancer Patient Experience Survey

The trust was in the top 20% of trusts for 47 areas out of a possible 62 in the survey, which was commissioned by NHS England.

212 patients who received cancer treatment at the trust during a set time period were asked to rate the care they received. A total of 131 patients completed the survey giving a response rate of 68%.

East Cheshire NHS Trust was ranked second out of 155 trusts nationally on patient experience.

There were three areas where the trust scored as the highest or joint-highest in the country:

- Patients overall rating of care as excellent/very good (96%)

- Patient received understandable answers to important questions all/most of the time from hospital doctors (95%)

- Patients thought they were seen as soon as necessary (prior to diagnosis) (95%).

In addition, the areas where the trust saw the largest improvements in its scores were:

- Hospital staff giving information on financial help

- Patients definitely involved in decisions about care and treatment

- Patients being told they could bring a friend when they are first told they have cancer

- Patient received understandable answers to important questions all/most of the time from hospital doctors

- Staff completely explained what would be done during any tests

The trust was in the lowest scoring 20% of trusts for two areas:

- Possible side effects of treatment explained in an understandable way

- Patient taking part in cancer research.

An action plan has been developed to ensure that possible side-effects of treatment are fully explained and a review of the patient information provided has been undertaken. Work is already underway to further promote clinical trials within the trust (for example, through our 'Health Matters' public lectures and posters in the Cancer Resource Centre) and recruitment is now well ahead of plan.

There were some occasions when I felt that the Doctor treating me did not explain enough...though I didn't doubt his intention to care for me (there) seemed to be a lack of communication skills.

The CQC National Adult Inpatient Survey 2013

East Cheshire NHS Trust was reviewed by 425 patients (out of a sample of 809 patients) who had been treated as an inpatient at the trust during summer 2013.

Overall, the trust was classed as performing in line with other trusts for the majority of areas. It was classed as performing better than other trusts in relation to hospital staff discussing whether patients would need any further health or social care services after leaving hospital.

The trust showed an improvement in its scores for 33 areas. The areas where the trust's performance was most improved include:

- Length of time waiting to get to bed on a ward
- Enough information given about condition while on the ward
- Side-effects of medication being fully explained
- Being told who to contact if worried following discharge
- Having enough nurses on duty.

The trust was classed as performing 'worse than other trusts' for patients being offered a choice of food and changes to the patient menu have already been implemented. Other areas highlighted for improvement include:

- Patient receiving enough help to eat meals
- Patients experiencing a delay when waiting to be discharged.

Quarterly audits – inpatients

The trust is committed to regular patient feedback, demonstrated by quarterly audits across all inpatient areas.

These audits look at key areas including the patient's experience of the ward environment, views on care and treatment, preparations for discharge and overall views on the level of service and care received.

During 2013/14:

- 98% of patients said they were made to feel welcome on arrival at the ward
- 87% of patients rated the cleanliness of the ward as 'very clean'
- 85% of patients 'always' had enough privacy when discussing their condition/treatment
- 93% 'always' had enough privacy when being examined or treated
- 96% of patients said they were 'always' treated with dignity and respect
- 91% of patients said they were 'definitely' treated with care and compassion
- 73% of patients rated the overall level of care as 'excellent' and 24% rated it as 'good'.

I couldn't have been more impressed with the compassion and care shown by the staff - watching them deal with an elderly lady brought me to tears - the compassion shown to her was amazing.

Quarterly audits – outpatients

Along with the trust's participation in the quarterly inpatient survey, the trust also conducts a quarterly audit across outpatient areas. This audit covers the patient's experience of the department, the care and treatment received, leaving the department and overall views on care and service received.

During 2013/14:

• 95% of patients felt welcome on arrival at the department

• 80% of patients rated the cleanliness of the department as 'very clean'

• 86% of patients 'definitely' felt involved in decisions about care and treatment

• 96% of patients 'always' had enough privacy when discussing treatment and 99% 'always' had enough privacy when being examined

• 99% of patients said they were 'always' treated with dignity and respect and 97% said they were 'definitely' treated with care and compassion

• 81% of patients rated the overall level of care as 'excellent', with all remaining respondents rating it as 'good'.

Dementia Commissioning for Quality and Innovation (CQUIN) system

One element of the dementia Commissioning for Quality and Innovation (CQUIN) system is the requirement for the trust to undertake monthly feedback among carers of people with dementia.

A short questionnaire has been developed to gauge how well relatives and carers feel staff understand dementia, how involved they feel in their relatives care and to measure awareness of patient passports.

Overall:

• 91% of respondents felt their relative 'definitely' had enough privacy when being examined or treated

• 91% of respondents felt their relative had 'definitely' being treated with dignity and respect

• 71% of respondents felt that the staff involved in their relatives care 'definitely' knew how to care for someone with dementia

• 58% of respondents said that they 'definitely' felt involved in their relatives care with a further 34% saying they felt involved 'to some extent'

• 54% of patients who did not have a patient passport on arrival at hospital were subsequently given one following admission.

Discharge arrangement could be made clearer, in plenty time, before it is due to happen.

Intermediate care services

Intermediate care services took part in a national benchmarking survey, which also included an audit in relation to patient experience.

The feedback was very positive - the key themes were that the staff were very caring and involved them in the decisions around their care.

Eastern Cheshire intermediate care services

As part of ongoing service improvement, Langley and Aston intermediate care units (at Macclesfield and Congleton hospitals respectively) are involved in a project to attain the National Quality Mark for Elder-Friendly Hospital Wards.

Among other things, this consisted of data collection over a three-month period from February 2013 to May 2013. The aim of the process is to help individual services understand their performance, identify areas of achievement and improvement and provide a basis for action planning. This is an ongoing, year-long project.

The data from the Langley Unit showed that patients had a positive experience, both with the attitude and care from the staff. The staff worked hard and the environment was clean. Patient comments stated that they found the staff friendly and courteous at all times.

Community patient feedback results show that of responses received, 100% regarded their care as 'good' or 'excellent'.

South Cheshire and Vale Royal patient feedback programme

There is a planned annual programme of patient feedback across acute and community areas of the trust. Below are the results of two large scale surveys across community areas, both of which were rated highly by our patients.

Podiatry

- 95% of respondents 'always' treated with kindness and compassion
- 96% 'always' treated with dignity and respect
- 96% 'always' had enough privacy when being treated
- 95% said that staff 'definitely' discussed their diagnosis and treatment plan
- 100% said they felt treated as an individual.

Outpatient physiotherapy

- 96% of respondents 'always' treated with kindness and compassion
- 97% 'always' treated with dignity and respect
- 95% 'always' had enough privacy when being treated
- 92% said that staff 'definitely' discussed their diagnosis and treatment plan
- 98% said they felt treated as an individual.

All the team were caring, helpful and pleasant and made me feel valued - and more to the point, made my feet more comfortable than I have been for years.

Podiatry and physiotherapy surveys

The podiatry and physiotherapy patient surveys were carried out across all localities and as such the action plans for these areas cross boundaries and are not specific to South Cheshire and Vale Royal but will impact on this area.

The actions are summarised below:

Podiatry

• Patients can now book appointments through the therapy booking centre

• All staff are reminded to introduce themselves and explain their role

• Patient centred action planning is now in place to further involve patients in their treatment

• Customer care skills training for staff is in place.

Physiotherapy

• Consent for students to be present during treatment is formally requested and documented

• Patients are made aware they have the right to ask for a second opinion in relation to their treatment

• Further development of a pilot study to allow patients to self-refer into the service without the need to see their GP as the first point of contact.

Your Voice; Listening into Action

During 2013 our Your Voice; Listening into Action (LiA) programme has continued to gather momentum and energy across the organisation. The programme is currently supporting 26 improvement projects covering a range of teams, services and departments including community matrons, pharmacy, patient discharge, pre-operative assessment unit, community dental services,

During the year, our engagement work has facilitated over 50 staff conversations on a range of topics and challenges that matter the most to staff including communications, the Francis Report, information technology, reward and recognition, patient discharge, recruitment and selection and our values and behaviours.

A new online conversation tool called 'Your Voice Online' was launched, enabling whole workforce participation in staff conversations.

Over the last 12 months we have seen some fantastic results and wider recognition of the benefits of our staff engagement programme.

One example is our 'Safety in Numbers' project led by nurse consultant Heather Cooper. The project has focussed on exploring IT interventions and solutions to support the recording and tracking of patient observations, improving quality and safety standards.

Through this work, Heather has engaged with a wide range of staff and key stakeholders to identify the trust's requirements for the future. This work has been instrumental in informing and strengthening a bid to the Department of Health's Nursing Technology Fund.

Building on the work and successes during Listening into Action's first year, the focus in future will be to support clinical change. In particular:

• The quality and safety of patient care (what we do for our patients)

• Enhancing the patient experience (how we do what we do for our patients)

• Enabling our front-line teams (supporting who delivers the service with what they need).

Staff health and wellbeing

East Cheshire NHS Trust is fully committed to the health and wellbeing of its employees. We want to do as much as we can to enable our employees to be at their best, be energised, motivated and committed to their work.

Employee wellbeing relates to all aspects of your working life, from the quality and safety of your physical environment, to how you feel about your work. The aim of any employee wellbeing strategy is to make sure employees are safe, healthy, happy, and engaged at work and should encompass the following key areas:

• Better physical and mental health - an environment that promotes healthy behaviours

• Better work – a happy and engaging work environment

• Better relationships – good communications and social connections

• Better specialist support – interventions to manage health and wellbeing.

Wellbeing initiatives for 2013/14 included, weight loss, pilates, membership of the trust choir and complimentary therapies.

Staff survey information

The staff survey was conducted between September 2013 and December 2013. 339 staff took part.

The survey results are presented into 28 key findings and results are compared to other acute trusts in England.

The survey asks staff a how they felt at the time under six categories:

1. Personal Development
2. Job role
3. Managers
4. Organisation
5. Health, wellbeing and safety at work
6. Background information

Results compared with other acute trusts

Out of 28 key factors, comparing East Cheshire NHS Trust to other trusts, 10 factors scored better than average, with seven of these placing us in the top 20% of all acute trusts.

Seven factors were scored as average, and 11 factors were scored below average. Work has commenced to improve these areas using the Your Voice - Listening Into Action approach.

Changes since 2012 survey

Since 2012, we have seen an increase in the number of staff reporting good communication between senior management and staff.

Over the last 12 months the trust has worked hard to improve communication, for example by introducing the chief executive's monthly podcast, holding senior leaders' forums at a variety of locations and introducing a chief executive email alert to communicate key messages across the organisation.

However, it has been recognised that further work still needs to take place and this has been identified as a Listening into Action priority area for 2014/2015.

One of the factors which has seen a significant improvement is the number of staff who have received health and safety training within the last 12 months. This score places us in the top 20% of acute trusts. There are 26 factors that have had no change since last year.

The trust will be proactively responding to the staff survey feedback and will be using the Your Voice - Listening into Action approach to engage with staff, discuss the findings and harness ideas and suggestions as to how the trust can make sustainable improvements.

Core indicators

Very efficient, professional and friendly team at all times - answered my silly questions with patience and reassurance

Core Indicators 2013/14

All trusts are required to include their performance against nationally-selected quality indicators. In addition, the national performance average is required to be included. East Cheshire NHS Trust's performance against the selected national quality indicators is presented below.

Quality Indicator	East Cheshire NHS Trust (ECT) Data	Comparison against worst/best performing trust and 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:
Preventing people from dying prematurely. Summary Hospital-Level Mortality Indicator (SHMI):				
A: SHMI value and banding July 2012 - June 2013	1.0305 (band 2 – as expected)	9 trusts higher than expected 17 trusts lower than expected 115 trusts as expected Lowest = 0.959 Highest = 1.1563 Average = 0.996	The trust performs within the expected range for this indicator. This is in line with the trust TDA submission	The trust holds a monthly Mortality Meeting where low risk deaths are reviewed and mortality figures scrutinised to enable the effective review of every avoidable death.
B: Percentage of admitted patients whose treatment included palliative care July 2012 - June 2013	0.9%	National average = 1.14%		
C: Percentage of admitted patients whose deaths were included in the SHMI and whose treatment included palliative care (context indicator). July 2012 - June 2013	14%	National average = 20.3%		

Quality Indicator	East Cheshire NHS Trust (ECT) Data	Comparison against worst/best performing trust and 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:
Helping people to recover from episodes of ill-health or following injury. Patient reported outcome scores for:				
i) groin hernia surgery	EQ5D Index: 0.087	England: EQ5D Index: 0.86	Health gain is marginally better than the England average	
ii,iii,iv) varicose vein surgery, hip replacement surgery, knee replacement surgery (primary)			Results are unable to show health gain as numbers are so small and therefore not included	
Helping people to recover from episodes of ill-health or following injury. Emergency re-admissions to hospital within 28 days of discharge:				
i) 0-15 years of age (% of discharge)	ECT: 10.77 (2011/12) 11.70 (2010/11) 10.92 (2009/10) No further annual data available	England: 10.01 (2011/12) 10.01 (2010/11) 10.01 (2009/10) CECPCT (prior to CCG): 9.98 (2011/12) 11.92 (2010/11) 11.69 (2009/10)	Age and co-morbidity of patients above national average	All readmissions are reviewed by clinical teams to identify learning. Implemented an electronic alert system for high-intensity service users. Implemented a pathway to support patients with alcohol related conditions to prevent the need for an acute admission. Implemented a number of ambulatory care pathways to prevent the need for acute admissions. Work continues to expand this initiative which includes a pilot scheme, working as an integrated health economy to manage patient discharge. Expansion of Home Intravenous Therapy Service
i) 16-74 Years (% of discharge)	ECT: 10.01 (2011/12) 10.68 (2010/11) 9.94 (2009/10) No further annual data available	England: 10.14 (2011/12) 10.09 (2010/11) 9.92 (2009/10) CECPCT (prior to CCG): 9.40 (2011/12) 10.79 (2010/11) 10.06 (2009/10)		
i) 75+ Years (% of discharge)	ECT: 13.85(2011/12) 14.90 (2010/11) 14.29 (2009/10) No further annual data available	England: 15.29 (2011/12) 15.35 (2010/11) 14.86 (2009/10) CECPCT (prior to CCG): 14.40 (2011/12) 15.74 (2010/11) 15.03 (2009/10)		

Quality Indicator	East Cheshire NHS Trust (ECT) Data	Comparison against worst/best performing trust and 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:
Helping people to recover from episodes of ill-health or following injury. Emergency readmissions to hospital within 28 days of discharge:				
Ensuring that people have a positive experience of care Responsiveness to inpatients' personal needs. Average weighted score of 5 questions.	ECT: No data available for 2014 62.8 (2012/13) 66.2 (2011/12) 67.3 (2010/11) 66.5 (2009/10)	England: 68.1 (2012/13) 67.4 (2011/12) 67.3 (2010/11) 66.7 (2009/10) Worst - 57.4 (2012/13) Best - 84.4 (2012/13)	Missing	Missing
Ensuring that people have a positive experience of care Percentage of staff who would recommend the provider to friends or family needing care.	ECT: Januray 2014 66% February 2014 64% 61% (2013)	England: 65.0% (ALL ORGANI-SATIONS - 2013) 67.0% (ALL ACUTE TRUSTS - 2013) Worst = 40.0% Best = 89.0% January 2014 65% Worst = 4% Best = 100% February 2014 64% Worst = 4% Best = 100%	The trust in response to the changing NHS environment has reviewed its strategic direction for sustainability and has become involved in new ways of working with health and social care organisations in the locality. Organisational change has impacted on staff across all areas of the trust.	Your Voice:Listening into Action continues to engage staff and further encourage feedback and ideas. The achievement of quality standards continues.
Treating and caring for people in a safe environment and protecting them from avoidable harm. Percentage of admitted patients risk-assessed for venous thromboembolism.	ECT: Oct-12 91.5% Nov-12 91.8% Dec-12 90.4% Q3 (2012-13) 91.3% Jan-13 91.8% Feb-13 91.0% Mar-13 90.1% Q4 (2012-13) 91.0% Apr-13 92.0% May-13 93.3% Jun-13 94.6% Q1 (2013-14) 93.3% Jul-13 93.5% Aug-13 95.3% Sep-13 92.9% Q2 (2013-14) 93.8% Oct-13 94.4% Nov-13 94.4% Dec-13 98.5% Q3 (2013-14) 95.7%	England: Oct-12 94.3% Nov-12 94.4% Dec-12 93.8% Q3 (2012-13) 94.2% Jan-13 94.4% Feb-13 94.2% Mar-13 94.3% Q4 (2012-13) 94.3% Apr-13 95.1% May-13 95.5% Jun-13 95.7% Q1 (2013-14) 95.5% Jul-13 96.0% Aug-13 95.7% Sep-13 95.6% Q2 (2013-14) 95.7% Oct-13 95.9% Nov-13 96.0% Dec-13 95.6% Q3 (2013-14) 95.8%	The trust performs to required standard	On going education of medical and nursing staff, including development of e learning package Implementation of RCA for all hospital acquired VTE Daily monitoring within wards to ensure compliance Implementation of revised electronic reporting system.

Quality Indicator	East Cheshire NHS Trust (ECT) Data	Comparison against worst/best performing trust and 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:
Helping people to recover from episodes of ill-health or following injury. Emergency readmissions to hospital within 28 days of discharge:				
Treating and caring for people in a safe environment and protecting them from avoidable harm. Rate of C Difficile.	ECT: April 2012 March 2013 23.1 C.Difficile infections per 100,000 bed days amongst patients aged two years and over.	England: April 2012 - March 2013 17.3 C.Difficile infections per 100,000 bed days for specimens taken from patients aged 2 years and over. Worst 30.8 Best 0.0	The trust performs to required standard	Implementation of individual case reviews for all positive patients both on the wards and in the community. Implementation of home visits for patients following discharge from hospital. On going audit. On going education of medical and nursing staff. Appointment of additional antibiotic. Pharmacist hours.
Treating and caring for people in a safe environment and protecting them from avoidable harm. Rate of patient safety incidents and percentage resulting in severe harm or death.	• Reported patient safety incidents • The rate of patient safety incidents reported per 100 admissions • The proportion of patient safety incidents reported that resulted in severe harm or death. Oct 12 - Mar 13 10.9 incidents per 100 admissions 0.2 % resulting in severe harm of death 4 incidents resulting in severe harm 1 incident resulting in death. Apr 13- Sept 13 13.8 incidents per 100 admissions 0.12% resulting in severe harm or death (3 incidents resulting in severe harm, 0 resulting in death)	Overall for small acute trusts 7.7 Incidents per 100 admissions 0.8% resulting in severe harm or death Worst 17.5 incidents per 100 admissions (small acute trusts) 0.9% resulting in severe harm or death, 39 incidents resulting in severe harm, 0 resulting in death. Best 4.1 Incidents per 100 admissions (small acute trusts), 1.0% resulting in severe harm or death. 5 incidents resulting in severe harm, 4 in death.	A 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 as all team leaders and managers are assigned incidents to investigate. The trust has a high level executive lead group which considers all serious incidents. All patient safety incidents which resulted in serious harm or death are verified by the clinical risk manager prior to upload.	On-going training and education of trust staff on incident reporting. Monthly and quarterly reporting has been amended to be business group specific, allowing reporting levels and trends to be monitored. Incident data available for each service area throughout the trust which can be used to provide feedback to individual teams.

Examples of best practice 2013/14

End-of-life care

Aim:

To co-ordinate and manage palliative and end-of-life care for patients at home.

Benefits:

• Patients enabled to die in their Preferred Place of Care (PPC)

• End-of-life care is provided in a coordinated way

• 87% of patients who expressed a PPC achieved this

• 24/7 support from qualified staff

• Maintains respect and dignity in home environment

• Carer and family support

• Respects person's wishes and personal needs at last stages of their life.

National Quality Mark project for Elder-Friendly Hospital Wards in Aston and Langley units.

Aim:

To help individual services understand their performance, identify areas of achievement and improvement and provide a basis for action planning.

Benefits:

• Langley Unit showed that patients had a positive experience both with the attitude and care from the staff. The staff worked hard and the environment was clean.

• Patient comments stated that they found the staff friendly and courteous at all times

• Community patient feedback results show that of responses received 100% regarded their care as good or excellent.

AQUA project in intermediate care to improve frail elderly pathway

Aim:

To improve the safety of patients on discharge and ensuring patients are actively involved in the decision making in relation to their rehabilitation.

Benefits:

• Strengthening care coordination with patients

• Improved staff morale by focusing directly on patient pathway

• Reduction in length of stay

• Closer monitoring and support to patients.

Open 2 autism

Aim:

To increase the awareness of autism for all healthcare staff to improve the patient experience

Benefits:

• East Cheshire NHS Trusts project, 'Open 2 autism' was the winner of the NHS North West Leadership Award for Patient Inclusivity

• The trust is the first in the UK to be recognised by the National Autistic Society thanks to its pioneering work with autistic patients

• 'Open 2 Autism' is a groundbreaking project which aims to improve autism awareness and help healthcare staff develop their understanding of the condition so they can support and make reasonable adjustments for people with autism coming into their clinical area

• The trust is working with the National Autistic Society to gain their access accreditation award (to be confirmed in May 2014)

• The project will allow us to break down barriers and enable staff to make positive changes to improve the healthcare we offer to our patients.

Reducing healthcare-associated infections

Aim:

As part of its ongoing commitment to reducing healthcare-associated infection, NHS England implemented a zero-tolerance approach for MRSA blood stream infections (MRSA BSI).

Benefits:

• Changed the way MRSA BSI is reported. Dependent on the outcome of the review process, they are attributed to either the acute trust or the appropriate Clinical Commissioning Group. This joint approach enables a health economy approach to improve patient outcomes.

• For the period 2013-14, the trust had one identified case of MRSA BSI. This was subject to an internal review identifying lessons learnt. This information was then shared across the organisation and used to improve the quality of patient care.

Home intravenous therapy service

Aim:

To allow patients to be treated at home with home intravenous therapy so that a hospital admission can be avoided or a stay in hospital shortened.

Benefits:

• HITS specialist cardiology pathway developed in 2013 to enable patients to receive all appropriate intravenous therapy treatment at home. This reduces the risk of hospital-acquired infections.

• Palliative cardiac patients required frequent hospital admissions (average 11 days)

• End-of-life patients' wishes to die at home. An annual audit of 250 patient deaths showed 78% achieved their preferred place of care at the end of life.

• Generates cost efficiency with 50% saving when compared with acute admission

• 500 bed days saved April to Sept 2013.

Acute Assessment Pilot

Aim:

The Acute Assessment Pilot is a large-scale transformational programme designed to change the management of patients who require emergency health care via the introduction of ambulatory care. For patients this means not being admitted to hospital where this is not clinically indicated.

Benefits:

• Dedicated assessment and treatment area to provide an alternative to hospital admission

• Rapid access to diagnostics equivalent to the response times for patients in the emergency department

• Facilitating admission only as a clinical choice for patients with an underlying life- threatening illness or need for surgery is essential and requires a change in cultural behaviours, particularly on the part of medical staff, i.e. admission is not the default position

• Responsive multi-disciplinary community support to manage onward care

• Where applicable - access to a comprehensive geriatric assessment via a pilot to support interface between the acute admission areas, ambulatory care clinic, emergency department, medical admission unit and community services.

• Clear pathways to enable patients with an identified ambulatory care condition or frail elderly patients with multiple needs, to be assessed and discharged with support within a community setting in a timely manner.

Audit participation

Excellent, pleasant staff and very good results

Audit Participation

Participations in clinical audits 2013/14

During 2013-14, 31 national clinical audits and three National Confidential Enquiries into Patient Outcome and Death (NCEPOD) requests covered NHS services that East Cheshire NHS Trust provides.

During that period, the trust participated in 31 of the national clinical audits and three out of the three (or 100% of the) NCEPODs which it was eligible to participate in.

The national clinical audits and NCEPODs that East Cheshire NHS Trust participated in, and for which data collection was completed during 2013/14, 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 Audit	Participation	Data collection 2013/14	Patient recruited 2013/14	% cases submitted in 2013/14
Neonatal intensive and special care (NNAP)	Y	Y	135 admissions	100%
Paediatric Asthma (BTS)	Y	Y	7	100%
Epilepsy 12 (Childhood Epilepsy)	Y	Y	6	100%
Paediatric Intensive Care (PICAnet)	Y	Y	16	100%
Paediatric Bronchiectasis	N	N	Minimum number of cases not met	N/A
Diabetes (Paediatric)	Y	Y	96	100%
Moderate or severe asthma in children (care provided in emergency departments)	Y	Y	31	97%
Paracetamol overdose (care provided in emergency departments)	Y	Y	50	100%
Severe sepsis & septic shock	Y	Y	33	100%
Emergency use of oxygen (BTS)	Y	Y	33	100%
Chronic Obstructive Pulmonary Disease	Y	Y	Data collection February to May 2014	Data collection February to May 2014

National Audit	Participation	Data collection 2013/14	Patient recruited 2013/14	% cases submitted in 2013/14
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Y	Y	Ongoing	Data completion date end May 2014
Heart failure	Y	Y	Ongoing	Data completion date end May 2014
Comparative audit of blood transfusion	Y	Y	15	100%
Adult critical care (ICNARC)	Y	Y	444	100%
Rheumatoid & early inflammatory arthritis	Y	Y	Data collection commenced 1st February 2014	Data collection commenced 1st February 2014
Emergency laparotomy	Y	On-line data entry commenced 07/01/2014	Organisational audit submitted August 2013	Two year data collection period commenced December 2013
National Joint Registry	Y	Y	360	100%
Falls & Fragility Fractures Audit Programme, includes National Hip Fracture Database	Y	Y	242	100%
Inflammatory bowel disease (IBD)	Y	Y	14	100%
National audit of seizure management (NASH)	Y	Y	50 patients	100%
Stroke National Audit Programme SSNAP (combined Sentinel & SINAP)	Y	Y	267	100%
Renal replacement therapy (renal registry)	Y	Y	56	100%
Lung cancer	Y	Y	120	111%
Bowel cancer	Y	Y	152	Upload deadline October 2014, so improvements expected in amount and quality of data
Head & neck oncology	Y	Y	5	End date 31st October 2014

National Audit	Participation	Data collection 2013/14	Patient recruited 2013/14	% cases submitted in 2013/14
Oesophago-gastric cancer	Y	Y	42	Upload deadline October 2014, so improvements expected in amount and quality of data
Elective surgery (national PROMS programme) Includes groin hernia, hip replacement & knee replacement	Y Y	Y Y	Pre-operative questionnaires completed 547 Post-operative questionnaires returned 374	Response rate 76.3% Response rate 72.5%
Cardiac arrest	N	N	N/A - Extensive quality data provided through local audit	N/A
Diabetes (adults ANDA) includes National Diabetes Inpatient Audit (NaDIA)	Y - Participated in NaDIA September 2013	Y	43 Bedside Audit Questionnaires 30 Patient Experience Questionnaires	100%
TARN	Y	Y	77 cases submitted @ 31/03/14 - data input ongoing	Continuous data input
Congenital heart disease (paediatric cardiac surgery)	N/A	N/A	N/A	N/A
Adult cardiac surgery	N/A	N/A	N/A	N/A
Pulmonary hypertension	N/A	N/A	N/A	N/A
Cardiac arrhythmia	N/A	N/A	N/A	N/A
National Vascular Registry, including CIA and elements of NVD	N/A	N/A	Data for East Cheshire NHS Trust patients included in patient data submitted by UHSM	
Prescribing Observatory for Mental Health (POMH-UK)	N/A	N/A	N/A	N/A
National audit of schizophrenia	N/A	N/A	N/A	N/A
Coronary angioplasty	N/A	N/A	N/A	N/A
Prostrate cancer	HQIP stated no data collection 13/14			
National Audit of Dementia (NAD)	HQIP stated no data collection 13/14			

Participations in confidential enquiries 2013/14

Confidential Enquiries	Participation	Data Collection	% cases submitted
Child Health (CHR-UK)	N	N	No relevant cases / patient in status reported
Maternal Infant and Perinatal (previously Perinatal Mortality)	Y	Y	100% (7/7)
National Confidential Enquiry into Patient outcome and Death (NCEPOD) Subarachnoid Haemorrhage	Y	Y	1 qualified case during data collection period
National Confidential Enquiry into Patient outcome and Death (NCEPOD) Tracheostomy Study	Y	Y	5 qualified cases during data collection period
National Confidential Enquiry into Patient outcome and Death (NCEPOD) Lower Limb Amputation Study	Y	Organisational questionnaire completed and returned October 2013. This covered the rehabilitation of patients following lower limb amputation	No qualifying amputations for the data collection period
National Confidential Enquiry into Patient outcome and Death (NCEPOD) Gastrointestinal Bleeding Study	Y	Organisational questionnaire completed and returned January 2013	No patient data submitted
National Confidential Enquiry into Suicide and Homicide for people with mental illness (NCISH)	N/A	N/A	N/A

National clinical audits 2013/14

The reports of six 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
Acute Care The National Stroke Audit 2012 results were presented and discussed at the medicine audit meeting in May 2013. The audit has two sections: 1. Organisational component (bi-yearly) 2. Clinical section, (previously bi annually for 60 patients) now reported for ALL stroke patients via SSNAP.	The audit measured stroke services as at 2nd July 2012 covering eight domains. The audit enables stroke services to be compared with national standards outlined in: • The fourth edition of the National Clinical Guideline for Stroke (ICWP 2012) • The NICE Quality Standards for Stroke (2010) • The National Institute for Health and Clinical Excellence Stroke Clinical Guideline (2008) • The National Stroke Strategy 2007 East Cheshire NHS Trust strengths were reported as: • Strong inpatient multi-disciplinary team working • Thrombolysis-trained staff • 6/7 acute unit criteria filled • Involvement in research and patient/carer views are sought.
Families & Wellbeing BTS National Paediatric Asthma 2013 results were presented and discussed at the paediatric audit meeting in February 2014. Audit criteria • Children (aged over 12 months) who had been admitted to the paediatric unit during the month of November 2013 with wheezing/asthma Audit standard • BTS/SIGN: British Guideline on the Management of Asthma	Of the criteria set - seven patients were eligible for participation in the audit on which the data is based. Conclusions from the audit reported that admission clerking is good. However there are lessons to be learnt in respect of the use of the discharge summary. As at 31st January 2014 none of the seven patients audited had been re-admitted. Actions from the audit: • Increased use of asthma pro-forma • Review BTS guidelines when discharging asthma patients • Review whether GP follow-up is required.

National Audit	Actions and progress
Community National Patient Safety Alert (NPSA) treatment dose - Low Molecular Weight Heparins (LMWH)audit. An audit was carried out across all wards at Macclesfield District General Hospital over a two-week period in February 2014 by the pharmacy team. This audit reviewed the current trust prescribing practice for treatment dose LMWH to ascertain if the trust is complaint with NPSA recommendations.	The results of this audit highlight that, in the duration of the data collection, for the majority of patients treated with LMWH, the trust is compliant with NPSA RRR014 recommendations. Actions from the audit : • Ensure accurate patient weight are recorded on the front of all inpatients charts for a patient's prescribed treatment doses of LMWH • Ensure that the urea and electrolyte levels are reviewed within 24 hours of admission and documented in the patient's notes. This provides evidence that the prescriber has considered the patient's renal function when prescribing appropriate treatment doses of LMWH • Ensure that prescribers are familiar with the trust venous thromboembolism (VTE) policy (this policy covers both prophylactic and treatment doses of low molecular weight heparins) • Ensure any prescriber involved in a prescribing error for LMWH completes the venous thromboembolism (VTE) e-learning module • Following this audit, an F1 training session on the NPSA LMWH alert has been included in the F1 annual training plan as this was recorded as a high priority.

The report of one Confidential Enquiry Into Patient Outcome and Death was reviewed by East Cheshire NHS Trust's board and as a result, the trust is taking the following action to improve the quality of healthcare provided: (We have taken into account the devolvement of responsibilities to other trust committees and 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 group audit scorecards reviewed by this group on a quarterly basis.	NCEPOD "Knowing the Risk" (A review of the peri-operative care of surgical patients) Reviewed 08.04.13	The audit reviewed the peri-operative care of 'high-risk' surgical inpatients. The group discussed the definition of 'high-risk'. High-risk is determined following assessment of an individual patient's requirement. CARE Group suggested a future audit may include the peri-operative care of fracture neck of femur patients.

The reports of 94 local clinical audits were reviewed by the provider in 2013-14 and the trust intends to take the following actions to improve the quality of healthcare provided. (We have taken into account the devolvement of responsibilities to other trust committees/groups and included actions informed by those bodies)

Group or forum	Local audits reviewed	Actions and Outcomes
CARE Group (Clinical Audit, Research and Effectiveness Group) monthly meetings. Business group audit scorecards are reviewed by this group on a quarterly basis	Clinical Records Management audit and re-audit	Aim of the audit: • CARE Group reviewed the results of the 2012 round of the Clinical Records Management audit and agreed to carry out a re-audit in June 2013 for those specialties that had not achieved 75% compliance. Results: • Following the re-audit, CARE Group agreed to set up a working group to review the audit tools and align the processes in readiness for the next full round of the audit. • Revised audit tools were piloted and are now in use. Results will be reported back via the business group audit leads to SQS. Actions: • An action plan, with timescales for implementation, will be agreed. Any outstanding actions will be raised via the CARE Group quarterly reports to trust SQS Committee.
Departmental audit meetings All of the audits have actions plans for development or have achieved the standards of care. Acute Care Business Group monthly audit meetings	Antibiotic ward round data July 2012 - June 2013	Aims of the audit: • To assure compliance of antibiotic prescribing with the trust policy • Are key performance indicators (KPIs) met? Results: • Appropriate choice of antibiotic. Target >90% - achieved 96% (achieved) • Antibiotic courses have no avoidable missed dose. Target >90% - achieved 92% (achieved) • Prescriber indication on drug chart. Target 100% - achieved 68% • Prescriber on stop or review. Target 100% - achieved 66% Actions: • Prescribe all initial doses of antibiotics as a STAT (single dose) dose, with time for administration • Inform nursing staff so antibiotics can be given promptly • A re-audit of ward rounds will be carried out to ensure continual improvements are made.

Group or forum	Local audits reviewed	Actions and Outcomes
Departmental audit meetings (cont)	Neurological assessment in stroke (re-audit)	Aims of the audit: • To appraise the actions from the initial audit (September 2012) • To establish the improvement to the quality of service for stroke patients • To review the completeness of neurological examination in patients. 38 case notes were randomly selected to include in the audit. Results: • Compared to the initial audit data, the re-audit showed a vast improvement in the completeness of the neurological assessment in patients admitted to the Acute Stroke Unit (ASU) with an increase from 33% to 87%. Actions: • The teaching session on neurological examination and documentation becomes part of the regular foundation teaching programme. This will ensure continual improvement in the service we provide to patients, while supporting and developing staff to enable them to achieve their best.
	Central and Eastern Cheshire locality integrated care pathway for the dying (adult) audit	Aims of the audit: • To determine if the Integrated Care Pathway (ICP) for the dying (adult) was being appropriately and effectively applied across different care settings within central & eastern Cheshire. (The audit proved to be a timely review of compliance with the Version 12 Liverpool Care Pathway (LCP) that, at the time of the audit, had been in place for almost two years). Results: • The results of the audit demonstrated that the local ICP/LCP was being largely applied for the length of time for which it was intended (up to 72 hours before death) and that 70% (n-65) of all deaths audited died within 72 hours of pathway commencement. • For the remaining 30% (n-28) of patients there was evidence within 46% (n-13) of pathways that the appropriateness of continuing the pathway for more than 72 hours had been reviewed by the team caring for the patient. • In 65% of cases the pathway was used with patients who had a non-cancer diagnosis and the challenges of diagnosing dying within different disease groups has been highlighted within the LCP review.

Group or forum	Local audits reviewed	Actions and Outcomes
		Actions: • This cross-locality audit listed twelve recommendations, from which an action plan has been devised identifying clinical leads and implementation dates for each action. • Examples of recommendations included communication, training and documentation.
	Review of Cardiac Arrests 2012 Healthcare institutions have an obligation to provide an effective resuscitation service, failure to provide an effective service is a failure of a duty of care.	Aims of the audit: • The aim of the review of cardiac arrests audit undertaken between January 1st and December 31st 2012 was to ensure that a high quality resuscitation service is provided for patients within the trust and improve adherence with the trust Cardiopulmonary Resuscitation Policy. Results: • The 2012 results indicated a 96.2% compliance rate with the Cardiac Arrest Team Activity (CATA) pro-forma return during 2012. • The compliance percentage for 2011 was 75.1%, for 2010 the figure was 65.2% and for 2009 35.4%. • The steady increase in compliance, year on year, indicates effective communication/education regarding the requirement for CATA pro-forma completion.
Trauma & orthopaedics	Early results of Xiapex injections & patient satisfaction audit Dupuytren's disease is a common condition affecting a significant proportion of the population within the UK. It can result in severe functional limitations of hand function. Injectable collagenase Clostridium histolyticum (CHC) is a new non-surgical treatment option which has been shown to have significant effects on joint contractures.	Aims of the audit: • To assess the use of injectable CHC within a district general hospital setting and evaluate patient satisfaction. • Prospective data was collected on all patients with Dupuytrens disease, over a six month period, where surgical options were being considered. • Patients were seen in outpatient clinic by a consultant upper limb orthopaedic surgeon and, if inclusion criteria were met, they were offered injectable collagenase as part of their treatment options. Results: • The current results of the use of CHC are encouraging and it is a very useful option in the treatment of Dupuytren's contractures. • East Cheshire NHS Trust usage and results for Xiapex as the first-line treatment of symptomatic Dupuytren's contractures are in keeping with results from large centres.

Group or forum	Local audits reviewed	Actions and Outcomes
		Actions: • As CHC is a non-surgical procedure, patients who are high-risk surgical candidates due to medical co-morbidities, are offered CHC as an alternative treatment. • The increased risk of significant peri-operative complications with revision surgery makes the concept of a minimally-invasive procedure appealing.
Breast surgery	Patients with breast cancer under 35 audit. Breast cancer in patients under 35 is rare but is serious and might be aggressive.	Aims of the audit: • To ensure practice is in line with NICE guideline CG80 (early and locally advanced breast cancer) and to evaluate how the early detection of breast cancer may improve survival rate. • The audit was conducted retrospectively on 648 patients aged under 35 years old presenting to the low-risk group clinic, during the period April 2010 to July 2013. Results: • Incidence of breast cancer under 35 remains very low • Majority of patients have benign breast changes / benign lumps like fibroadenoma • All patients diagnosed with breast cancer were over 28 year old • Management for breast cancer under 35 was carried as per standard protocol. Actions: • Continue the same screening and treatment plane • Advise females to contact GP for any breast lump or axillary lump • Repeat retrospective audit to follow up the patients with cancer to discover the outcome and survival rate.
Families & Wellbeing Business Group monthly audit meetings including Maternity & Women's audit meetings	Midwifery CNST Standard 3.1 Severe Pre-eclampsia The incidence of eclampsia and its complications have decreased significantly in the United Kingdom since 1992, following the introduction of management guidelines for eclampsia and pre-eclampsia. However, eclampsia remains the second most common cause of direct deaths.	Aims of the audit: • To ensure the maternity service has approved documentation for the management of severe pre-eclampsia that is implemented and monitored. • To demonstrate that current practice regarding documentation is in line with the unit guidelines (severe pre-eclampsia and eclampsia). • To identify where changes are needed to improve practice. • To identify and disseminate good practice. Results: • The results of this audit measured 100% compliance and all three objectives were met.

Group or forum	Local audits reviewed	Actions and Outcomes
	Paediatrics Urinary tract infection in children under 16 audit	Aims of the audit: • To evaluate the management of urinary tract infections (UTIs) measured against the NICE quality standards for UTI in infants, children and young people under 16 (associated NICE guidance – CG54 UTI in children) Four standards were audited: 1. Evidence of a urine sample collected within 24 hours in children presenting with fever of 38 degrees 2. Evidence of risk factors for UTI and serious underlying pathology recorded as part of their history and examination 3. Evidence of positive urine results differentiated between E.Coli and non-E. Coli organisms 4. Evidence of information being given about how to recognise infection and to seek medical advice straight away Results: • The audit results showed 100% adherence to quality standards 1, 2 and 3 and partial compliance with standard 4. Actions: • Use a clerking checklist/pathway to ensure all necessary questions are covered. • Ensure the current information leaflets are utilised to give information to parents on discharge, with clear documentation in the notes. As a result of implementing the actions, the quality of patient care will be improved.
	Eastern Cheshire Sexual Health Service Ensuring that the safeguarding documentation standards for our patients are met	Aim of the audit: • To measure compliance with the safeguarding and Fraser Guideline documentation standards for all clients under the age of 16. • The audit was conducted on a sample of 108 patients covering the three month period 1st October to 31st December 2012. Results: • The results show that documentation standards need to be improved with 31% not meeting the standard.

Group or forum	Local audits reviewed	Actions and Outcomes
		Actions: • Clear instructions need to be incorporated in the Lilie user's manual and clinical guidelines to ensure that all members of staff are following the same process. • All staff should receive update training on the completion of appropriate templates and documentation. • Reception staff need to be trained to ensure that all male patients, when given out condoms, must be booked in to see a health care professional at each consultation. • The combined contraception template on the patient management system needs to include the same drop-down menu as the other templates. Implementation of these recommendations will ensure staff will be supported and developed, to enable them to achieve their best, ensuring continual improvement in the service they provide.
	Dental Dental Audit outcome and subsequent upgrade of non-compliant facilities	Aim of the audit: • This was a re-audit due to concerns of non-compliance highlighted in previous audits. Result: • The result of the dental audit at Victoria Infirmary, Northwich highlighted the compliance failure in the premises and facilities at the centre. • The facility required a large scale program of modernisation and installation of modern up-to-date decontamination equipment. • This required a full risk assessment and board approval from both East Cheshire NHS Trust and Mid Cheshire Hospitals NHS Foundation Trust (MCHFT) to finance the project. Action: • A refurbishment has taken place in collaboration with MCHFT, this includes a newly-created dedicated decontamination facility, now separate from the clinical environment.

Group or forum	Local audits reviewed	Actions and Outcomes
		• New modern equipment has been installed, with the ability to log and closely monitor all activity and maintain an assurance of effective instrument processing. • Patients can now be assured that effective processing of reusable instruments and a reliable infection control and logging system is in place for patient safety.
Community Service Business Group bi-monthly audit meetings Eastern Cheshire	Dermatology Cancer Services Peer Review Audit - Timeliness of Notification of Diagnosis to GP - Skin Cancer. Annual audit undertaken by dermatology specialist nurse - July 2013.	Aims of the audit: • To determine compliance against the following criteria: • GPs should be notified of a patient's diagnosis within 24 working hours or 48 hours if over a weekend. Action: • All dermatology consultants are required to indicate on ALL GP correspondence where a patient has been informed of a cancer diagnosis. Secretaries are then required to prioritise this correspondence. Results: • The results showed that 81% of GPs received notification of a patient's diagnosis either before or within 24 hrs (compared to 56% in 2012).

Participation in clinical research

Participation in clinical research

Participation in clinical research demonstrates the trust's ambition to improve the quality of care offered and make 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.

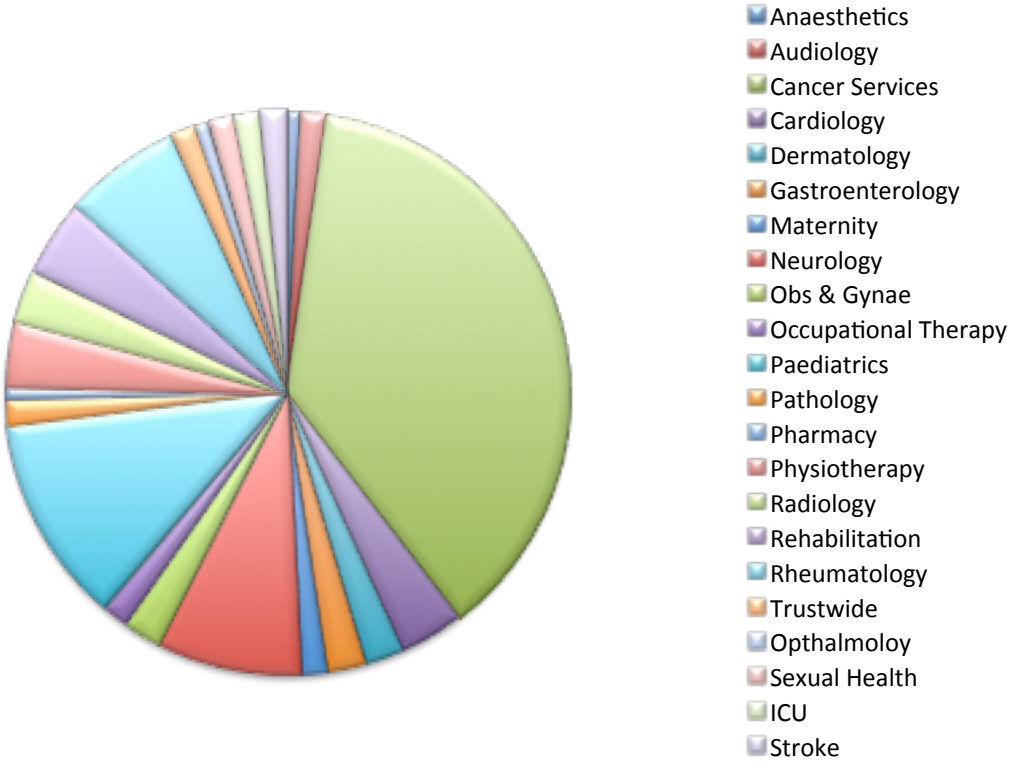
While maintaining the studies and following up participants recruited in previous years, a further 33 studies have been opened and 1331 participants were recruited in 2013-14. A further seven studies are awaiting approval by East Cheshire NHS Trust research staff for research that has been approved by the ethics committee.

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

The trust is currently involved in 134 active clinical research studies, of which 112 are portfolio studies covering 21 medical specialities.

As can be seen in the chart below, 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.

Distribution of active studies across the trust and areas of clinical research



Audit examples of good practice

Community Services Business Group

Re-audit of NICE Clinical Guidance CG88 - The early management of persistent non-specific low back pain within the Adult Physiotherapy Service.

The aim of the re-audit was to demonstrate the compliance of current physiotherapy practice within East Cheshire NHS Trust (Community Business Unit), to the guideline CG88 issued by the National Institute for Health and Care Excellence (NICE) in May 2009.

The objectives set were to establish whether patients receive treatments as specified by the NICE guideline as follows:

- Advice on self-management
- Structured exercise
- Manual therapy
- Acupuncture
- Psychosocial management, if not responding to above treatments or identified as "at risk" of poor outcome.

One hundred patients were audited during September 2012 to January 2013 from across all of the adult community physiotherapy bases (Community Business unit) within East Cheshire NHS Trust. Of the 100 patients audited, 70% were female and 30% male. Their age ranged from 19 to 75 years old, with the highest proportion of patients being in the 30 – 50 year age range (40%).

The audit concluded all patients audited during the period were managed appropriately in line with NICE Guideline CG88.

A planned re-audit in two years will ensure continuation of high quality care for patients and sustainability of compliance with NICE guideline CG88.

Families & Wellbeing Business Group

1. East Cheshire NHS Trust Maternity Services achieved CNST level 3 in September 2013, with the completion of 50/50 standards at the highest level. To achieve the level 3 accreditation, the maternity services conducted a series of 50 clinical audits (throughout 2012-13), which were measured against the 5 CNST standards (each standard contained 10 criteria). The clinical effectiveness department worked in cohesion with maternity services to provide consistency and support the assurance process. The achievement of CNST level 3 demonstrates excellence in quality of care and reduces the financial premium paid to the NHSLA.

2. Joint working between paediatric speech and language therapy and local councils/schools.

Partnership agreements have been put in place with Cheshire West and Chester and Cheshire East councils covering the commissioning of paediatric speech and language therapy in early years settings, in mainstream and special schools in areas of high depravation.

We are continuing to commission with individual schools or clusters of schools and engaging with new schools to look at future commissioning.

Acute Care Business Group

NICE guidelines recommend the use of antibiotic prophylaxis for large bowel surgery. Surgical site infection is a type of healthcare- associated infection in which a wound infection occurs after an invasive surgical procedure.

The aim of this audit was to look at surgical site infections (SSI) and the appropriate use of antibiotic prophylaxis in large bowel surgery. A UK study in 2000 showed the consequence of a healthcare associated infection resulted in an average additional stay of 6.5 days and a cost of £3,246.

The audit was carried out on a retrospective basis and data was collected on 42 patients with surgical site infections between October 2011 and June 2013.

Results of the audit show that 33% of patients had a delay in their discharge and 21% of patients were re-admitted due to infection. The results show we are partially compliant with the requirement of giving antibiotic prophylaxis for all large bowel surgery.

As a result of this audit actions identified included:-

• Education of surgical staff on the importance of antimicrobial prophylaxis with development of a training session

• Update the current antimicrobial prophylaxis guidelines based on local antibiotic sensitivity patterns and latest evidence base

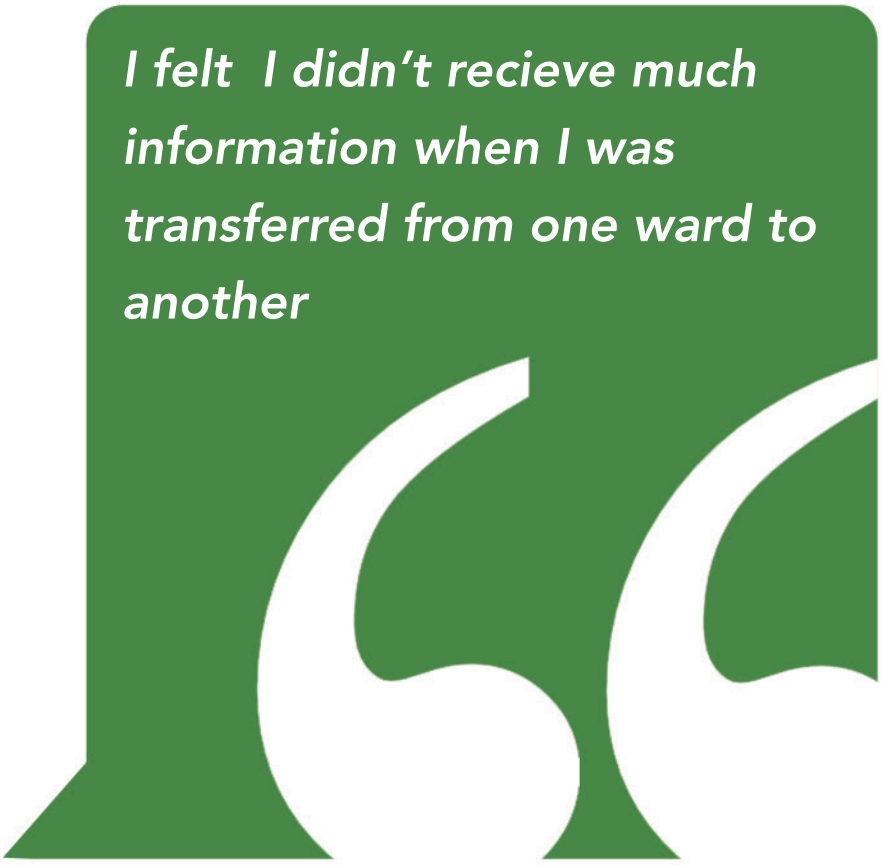
• Undertake root cause analysis (RCA) on delayed discharges and readmissions with SSI

• Develop a workshop which focuses on improving documentation skills and awareness on the importance of SSI

Outcomes from the implementation of these actions include improvements in quality of patient care along with a reduction in delays in discharge and re-admission rate.

Our quality priorities for 2014/15

I felt I didn't recieve much information when I was transferred from one ward to another



Our quality priorities for 2014/15

Priority	Indicator	How will we achieve
Patient experience		
Friends and Family Test (FFT) Continue to develop the FFT survey process for both patients and staff.	• To implement the staff FFT survey • To increase or maintain response rate in inpatient and emergency department surveys • To reduce the number of negative response rates for the FFT survey • To implement the FFT survey in day case and outpatient areas by October 2014	• Work with an agreed supplier in order to deliver the survey every quarter, engaging staff through communications and staff-side support. • Work to continue to increase response rates across all areas, developing a range of options to collect survey responses • Ward/department managers will continue to review feedback and identify themes and actions for improvement in each ward area. • Surveys will be implemented within the required timeframe
'Always event' To ensure that specific actions in relation to safe discharge always happen.	• To improve the patient experience • To improve compliance with post-discharge instructions • Reduce the need for readmission into hospital.	• The minimum 'always events' to take place at discharge will be implemented. • This will be supported by the patient journey coordinators. • A post-discharge phone call to patients will be made to monitor progress and compliance, increase patient engagement and improve their experience of the trust.
Outpatients • To improve the process for managing outpatient appointments • To improve communication and the overall experience of patients attending outpatient clinics	• To reduce the volume of clinics cancelled resulting in patients appointments having to be re scheduled • Establish alternative process for managing the follow up process for outpatients • To reduce the number of PALS contacts/complaints relating to the cancellation of clinics and delays in clinic	• Monitor and improve the timeliness of communication in relation to requests to reduce/cancel clinics by clinicians • Investigate and implement alternative process to manage follow-up appointments • Establish customer care/ communication programme for staff.

Priority	Indicator	How will we achieve
Clinical effectiveness - improving clinical outcomes		
Dementia To ensure patients are appropriately assessed, investigated and referred on to appropriate services.	• To improve the diagnosis and referral of patients with dementia and/or delirium by screening eligible patients in line with national requirements.	• All non-elective patients aged over 75 years admitted to hospital will be asked the screening questions. • Patients with a positive screen to be referred back to their GP or specialist for further support and or treatment. • Carers of patients with dementia to be surveyed to establish if they feel supported. • A newly-refurbished 'dementia environment' elderly care ward will be completed in April 2014
Proactive care for patients with long-term conditions	• To support improved management of patients with long-term conditions to be managed within a community care setting	• To implement a tool that assesses patient's and their future probability of readmission with follow-up care coordination in the community. • To continue to develop the health and social care teams in locality areas. • To undertake further work with patients with a long-term condition to help them better self-manage their condition. • To continue to support the care coordination of patients within the neighbourhood teams.
Patient safety - reduction in patient harm		
Reduction in pressure ulcers	• To reduce the total number of newly-acquired pressure ulcers on caseload/during hospital stay by 25%.	• Use evidence-based practice to support the prevention, identification and treatment of pressure ulcers.

Priority	Indicator	How will we achieve
Reduction in pressure ulcers	• To develop a training package to support staff in their management of pressure care.	• Improve the recording of pressure area information and visual assessment by the use of digital cameras. • Undertake a planned staff training programme across acute and community areas. • Work with patients and carers to ensure a better understanding of prevention and treatment.
Transparency project	• To implement the transparency project – 'Open and Honest Care' Report on the following metrics for publication on a monthly basis:- • Safety Thermometer • Friends and Family Test (FFT) • Healthcare-acquired infections (MRSA/CDIFF) • Pressure ulcers Grade 2-4 acquired while in hospital • Falls sustained while in hospital where moderate/severe/fatal harm occurred • Patient experience survey • Staff experience survey • A patient story (quarterly) • An improvement story (quarterly) Overall aims are to: • Reduce the incidence of pressure ulcers acquired in hospital. • Reduce the incidence of moderate/severe falls sustained in hospital. • Triangulate data from patient and staff surveys where harm has occurred to elicit themes and trends.	• Establish a steering group to monitor and progress implementation of transparency 'Open and Honest' care project. • Work with key stakeholders to facilitate data collection, analysis and communication strategies. • Engage frontline clinical staff with the project in order to seek improvements and actions required inclusive of resource implications and identifying preventative measures. • The communication team will provide monthly 'Did you know?' boards following quality assurance checks. • The engagement department will support with the analysis of patient and staff experience surveys. • Attend NHS England meetings to keep abreast of new metrics for consideration e.g. publishing of staffing levels.

Statement's of assurance

I cannot speak highly enough regarding the staff and the speed at which I was attended to

Statements of assurance

A proportion of the income received at East Cheshire NHS Trust in 2013/14 was conditional on achieving quality improvements and innovation goals agreed between the trust and its commissioners.

The goals agreed can be found at www.institute.nhs.uk or through the trust website at www.eastcheshire.nhs.uk.

East Cheshire NHS Trust has reviewed all of the data on the quality of care in 2013/14 and the reports, achievements and improvements planned can be seen throughout this report.

East Cheshire NHS Trust is required to register with the Care Quality Commission (CQC). This report can be found at www.cqc.org and during 2013/14 successfully maintained registration with no conditions.

A number of third party organisations have also had the opportunity to comment on the trust's Quality Account this year. The reports of Eastern Cheshire Clinical Commissioning Group, the local council's overview and scrutiny committee and Healthwatch can all be found on the following pages.

The Audit Commission have also reviewed the data quality reported in all areas of the Quality Account.

Eastern Cheshire Clinical Commissioning Group

South Cheshire Clinical Commissioning Group

Vale Royal Clinical Commissioning Group

Healthwatch Cheshire East

Cheshire East Council
Health and Wellbeing Scrutiny Committee

Glossary

Term	Explanation
A+E	Accident and Emergency
ACS	Acute Coronary Syndrome
AQ	Advancing Quality
AMi	Acute Myocardial Infarction
CARE	Clinical Audit Research and Effective
CCG	Clinical Commissioning Group
CFH	Connecting for Health
CHKS	Caspe Healthcare Knowledge Systems
CDiff	Clostridium Difficile
CQC	Care Quality Commission
CNST	Clinical Negligence Scheme for Trusts
CPR	Cardiopulmonary resuscitation
CQUIN	Commissioning for Quality And Innovation
DNACPR	Do Not Attempt Cardiopulmonary Resuscitation
DVT	Deep Vein Thrombosis
ECT	East Cheshire NHS Trust
ECNHST	East Cheshire NHS Trust
ED	Emergency Department
GP OOH	GP Out of Hours Service
FFT	Friends and Family Test
FT	Foundation Trust
GP	General Practitioner
HITS	Home Intravenous Therapy Team

IV	Intravenous
LINkS	Local Involvement Networks
L+D	Learning and Development
MDGH	Macclesfield District General Hospital
MDT	Multi-Disciplinary Team
MRSA	Methicillin-Resistant Staphylococcus Aureus
MINAP	Myocardial Ischaemia National Audit Project
NHS	National Health Service
NHSLA	NHS Litigation Authority
NSF	National Service Framework
NHSP	Newborn Hearing Screening Programme
NICE	National Institute of Clinical Excellence
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
OT	Occupational Therapist
PE	Pulmonary Embolism
PBR	Payment by Results
PROMS	Patient-Reported Outcome Measures
QIPP	Quality, Innovation, Productivity and Prevention
RCA	Root Cause Analysis
SHMI	Summary Hospital-level Mortality Indicator
SUS	Secondary Uses Service
SQS	Safety, Quality Standards
TARN	Trauma Audit and Research Networks
TDA	Trust Development Authority
UTI	Urinary Tract Infection
VTE	Venous Thromboembolism
VV	Varicose veins

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