East Cheshire NHS
NHS Trust

Draft 11.05.16

# Quality Account

## 2015/16


# Contents



**Contents page to be finalised**

# Forward

We are pleased to present our Quality Accounts for 2015-16.

Everything we have done throughout this year has been focused on providing the best care in the right place, to deliver our vision. However good the quality of care we provide in our own right, we recognise that patients' needs are increasingly best served when we work in collaboration with partner organisations. In the future, this will require a transformation to realign services so they remain safe, high quality, local and affordable.

Throughout 2015-16, we have also contributed to and delivered through Caring Together (East Cheshire) and Connecting Care (South Cheshire and Vale Royal); these are clinically-led partnership programmes aligned to the national plan and which are underpinned by the quality standards expected of care provision in the future.

As a health-economy we and our partners aspire to be a centre of excellence for care of the frail, vulnerable and those with chronic conditions and to be here for those in urgent need, when they need us. This type of patient need accounts for the majority of the care we currently provide at East Cheshire NHS Trust and is very much in line with the national transformation agenda outlined in the Five Year Forward View published by NHS England. We will work with our partners, patients, carers and workforce over the next year and beyond to innovate care models that continue to deliver great local care, safely, balanced with making the most of every NHS pound. Despite this being one of the most challenging years financially both for this trust and for the NHS as a whole, I am pleased that East Cheshire NHS Trust has been recognised in a number of ways that continue to reflect quality improvements, including:

- Out of Hours GP services in East Cheshire and South and Vale Royal rated as 'good' by the Care Quality Commission (CQC) - care you can have confidence in.
- The trust remains compliant with the CQC registration requirements - care you can have confidence in.
- Seen as 'best in class' for the effective and personalised care of patients requiring enhanced care, via the Haelo pilot award and which is being rolled out to benefit more patients - offering care you can have confidence in.
- The valuable contribution of our involvement through patient recruitment to, and engagement in, clinical research and trials placing us as the top recruiter for one of our clinical trials nationally. Evidence has shown that patients involved in such trials have better outcomes - demonstrating care you can have confidence in.
- Reaccreditation of our approach to Autism and a further national award in recognition of how we have progressed this agenda. This says a great deal about how we deliver care - care you can have confidence in.
- We continue to improve care and services whilst learning from experiences by listening to feedback through patient stories at Trust Board and through our Safety, Quality and Standards Committee, each of our services line quality forums and through recording, sharing and learning from incidents, complaints and staff feedback. We work hard to ensure care is right first time, although recognise we occasionally make mistakes and make sure we learn from these. We have also seen a further reduction in complaints about communication between clinicians and patients, whilst complying with the content and spirit of our Duty of Candour to be open and transparent.

There is more we must do and areas that we will be targeting for the forthcoming year include working with partners, carers and patients to provide support for earlier signs of deterioration for the frail, vulnerable and for those with long-term conditions. By organising care differently and where the use of technologies supports it, we will be able to offer earlier treatments that help avoid acute care in hospital.

These achievements are only possible with the support of an outstanding team of people. I would like to take this opportunity to thank our valued staff and volunteers who continue to demonstrate their commitment and dedication to the provision of safe, personal, high quality care and support for patients, be that in their own homes, in the community or in hospital. Every member of staff has worked tirelessly to provide care that is compassionate and right first time for our patients.

With your support, I look forward to another exciting, dynamic year of achievements,
Thank you.

Lynn McGill
Chairman

# Chief Executives Statement

Thank you for taking the time to read this quality account. I believe this document will give an understanding of the importance we place on quality improvement and give confidence that should you or your family need treatment at East Cheshire NHS Trust in the future, safe treatment will be provided by committed and caring staff.

Patient safety is at the centre of what we do each and every day. We see patients in their own homes, in outpatient settings across a wide geography as well as providing hospital care at the main site in Macclesfield. Our staff are trained and motivated to put the patient at the centre of what they do and it is pleasing to see the high levels of patient satisfaction acknowledged by those who we serve.

This quality account sets out our achievements during 2015/16 and our ambitions for the future and I hope that by reading the document you will have an understanding of the breadth of services our dedicated staff provide.

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.

### Statement of directors’ responsibilities in respect of the Quality Account.

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, 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 confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account. By order of the board.

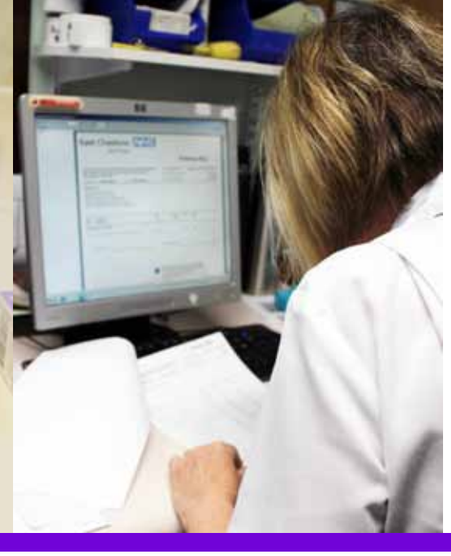
Lynn McGill
Chairman

John Wilbraham
Chief Executive



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

## To follow



*"I cannot speak highly enough of the treatment and care I have received. I feel extremely fortunate and am very grateful to everyone involved."*

**- Gynaecology Oncology**

**To follow**

**To follow**

## To follow

## To follow


## April 2015

Start the Year staff conference. Derek Mowbray a chartered psychologist, attended as key note speaker. His talk was entitled: 'Building Organisational Wide Positive Work Cultures'.

## May 2015

38 trust staff received a long service award (20 years at ECT or 25 continuous service).

This was in recognition of the valuable contribution and celebration of their hard work and commitment.

## June 2015

Dr Julie Walker – Advanced Specialist Nurse Practitioner in Cardiology, received the BHF – Heart Hero award.

This was a pioneering project which allowed patients who suffer from heart failure to be treated out of hospital.

## Year at a glance

## July 2015

Jacqui Williams commenced her role as the new Associate Director of Transformation.

This role leads on service development and improvement across all clinical services in the transformation agenda.

## August 2015

Anne Starkie and Jane Kelly awarded long service awards both having worked in the trust for 46 years each.

## September 2015

The trust celebrated World Sepsis Day on 14th September. A stand in the main reception gave staff, visitors and relatives an opportunity to learn more about sepsis.

SPOT IT-TREAT IT-BEAT IT

## October 2015

Dementia Together Event held on 14th October.

Donation by Macclesfield MS Society to the Neuro Physio Gym – mini active passive cycle pedals.

## Year at a glance

## November 2015

Staff Awards - Chairman's award to Sue Richmond Team Leader at Firdale Medical Centre for excellent leadership in practice. See top right photograph.

Antibiotic Guardianship day – led by Dr Raj Rajendran, Mel Stevens and Sally Stubbington - increasing awareness of antibiotic resistance. See middle right photograph.

Stop the Pressure Days – pressure ulcer prevention awareness. See top left photograph.

## December 2015

Emergency Department nurse Rachel Falconer honoured for working with Ebola patients in Sierra Leone with the Army Reserves. Rachel was presented with the Task Force Commanders Commendation by Prince William at Buckingham Palace.

## January 2016

Trust wins an award for being the most innovative and improved trust of the 12 who had taken part in the Haelo project. This work looked to improve the quality and effectiveness for patients who required enhanced care.


## February 2016

Winsford Health Visitors Wellbeing event in conjunction with the local mayor, Cheshire West and Chester Council, Brio Leisure, Cheshire Fire and Rescue and many more organisations.


## March 2016

The Open 2 Autism team won the 'Outstanding Health Services' category in the National Autistic Society's Autism Professional Awards held on 1st March 2016.

The awards recognise and reward services and professionals who are leading the way in innovative autism practice and making a real difference to the lives of autistic people in the UK. See middle left photograph.

## Harm-free care

Our trust cares for one of the most rapidly-ageing populations in England. Our patients are increasingly frail and elderly, often with multiple long-term conditions that require regular support and monitoring. Elderly patients are most vulnerable when they are unwell and careful risk assessment is needed to ensure care plans are put in place to reduce risk of avoidable harm.

The trust has committed to the national 'Sign Up to Safety' campaign. This initiative aims to support the NHS in reducing avoidable harm by 50% within five years.

# Our performance against 2015-16 quality priorities

ECT provides a wide range of hospital and community based health care services for the local population of east Cheshire, south Cheshire and Vale Royal.

The Trust Quality Strategy was refreshed in 2015 and sets out the quality priorities 2015-2019. This supports the Clinical Services Strategy which aims to ensure delivery of the best care in the right place for patients.

This will effectively move some patients care away from hospital and into more appropriate clinical care settings but recognises that care must be safe, clinically effective and provide a positive experience where ever the care is provided.

### In line with our strategic plan, our priorities for 2015-16 focused around:

- Harm-free care – 50% reduction in avoidable harms within 5 years
- Safe staffing – use evidence based tools to comply with NICE guidance on safe staffing
- Improving outcomes – use quality indicators to benchmark and monitor local performance to ensure we maintain quality outcomes
- Listening and responding – further improve patient and staff experience by listening to feedback and responding to concerns
- Staff engagement and training – recruitment of staff who share our values, who are caring and compassionate.
- Improve support to staff who work in disparate community services
- Strengthen the relationship between clinical staff and managers with a shared focus on improving patient and staff experience
- Integrated care – develop effective partnerships and new ways of working within an integrated care system.

Our achievements against all of these priorities can be seen in the following sections.



### Sign up to Safety Achievements

- Sign up to Safety - There has been a reduction in grade 3&4 pressure ulcers across both the community and hospital settings. Evidence of this can be seen on page 28.
- Bi-annual ommitted medication dose audits undertaken. Monthly incident reviews continue at Safe Medicines Group to highlight patterns, trends and lessons learnt. Learning applied to policy and practice. See page 51
- 'Safety Matters' newsletter produced quarterly to communicate key messages and increase staff awareness of medicines good practice
- Vitalpac rolled out to Emergency Department and Acute Assessment Unit. The VitalPAC system is used to electronically record patients' vital signs on handheld devices at the bedside. It increases both efficiency and patient safety by freeing up nurse time and monitoring patients in real time, warning immediately of any deterioration in their conditions. An acuity report produced daily from the system supports decision making around staffing pressures
- A new community nursing hand hygiene audit tool is being utilised across all teams
- Establishment of a training role in Infection Prevention and Control (IPC) team to support in clinical areas with aseptic non touch technique (ANTT) and hand hygiene
- Focus on cleanliness of the environment has been a priority and audits have shown improvements over time
- Introduction of pressure ulcer e-learning package for clinical staff
- Toolkit introduced across adult wards and piloted in community teams to support improved management of skin and continence
- Developed a revised environmental audit tool and all areas assessed by March 2016
- SSKIN bundle introduced across hospital ward areas and early implementor community teams at two community locations.

### What this means for patients

- Reduced risk of contracting healthcare - associated infections (HCAIs)
- Improved knowledge and skills of staff in relation to skin care and support for pressure ulcers
- Improved continuity in reviewing patients clinical needs
- Improved environment for patients attending clinics and hospital settings
- Staff are able to deliver the right care, at the right time, in the right place
- Improved knowledge and skills of staff in relation to care of patients skin integrity and reduce prevalence of pressure ulcer.

# Safe staffing

We will improve our understanding of safe staffing and patient dependency ratios across hospital and community services, strengthening service resilience over seven days, using recognised and evidence-based tools to comply with NICE guidance on safe staffing. More information about our performance can be found at:
www.eastcheshire.nhs.uk/About-The-Trust/Trust-Board/safe-staffing.htm

## Achievements

- Monthly papers are presented at Trust Board to inform staffing levels on hospital wards and community staffing as part of the national reporting process
- Bi-annual Safe Nursing Care Tool (SNCT) undertaken across hospital adult wards and findings reported to Trust Board
- Manchester Patient Safety Framework (MaPSaF) - a tool that has been developed to help healthcare teams and organisations reflect on their progress in developing a mature safety culture - is completed by staff.
- Benchmarking audit of community staffing levels undertaken as part of a national pilot.
- Participation in Haelo project and recognition at national conference of innovation and improvement work implemented. In September 2015, the trust was invited to take part in a 90-day improvement programme with a focus on supporting patients that have been identified as requiring an enhanced level of supervision on the ward to maintain their safety or the safety of others

  In January, the trust joined 12 other organisations in Manchester to showcase our achievements at the end of the 90-day cycle and were thrilled to win the award for the 'most innovative organisation' after delivering a video presentation showcasing our work
- Development of new initiatives in ward areas, for example the pilot of pharmacy technician medication rounds

## What this means for patients

- Assurance that staffing levels are regularly reviewed and are within national guidance
- Patients who require enhanced care have an individualised risk assessment undertaken to demonstrate the level of care they require
- Evidence that staff understand the importance and their role in ensuring patients safety.



# Improving outcomes

We are a learning organisation that is committed to continuous improvement and our aim is to provide the best possible evidence-based care. In some areas quality outcomes are well-developed and understood and national and local indicators are in place. We will continue to benchmark and monitor local performance to ensure we maintain quality outcomes.

Our aim is to use the community data sets we have developed through the roll-out of community nursing software system EMIS Web to agree and implement an effective range of key performance indicators across community services which will enable a consistent focus on quality outcomes across the organisation. These will be benchmarked to ensure continued learning from best practice.

## Achievements

- There are two community sites piloting mobile working, paper-light systems and the EMIS community IT system. This supports the clinical staff to have a greater focus on direct patient care and reduces levels of duplicated paperwork.
- Work commenced on quality markers in some community nursing teams, establishing a range of quality outcomes for future integrated service delivery
- Dementia Champions have been identified and trained across all community nursing teams.
- A MUST (malnutrition universal screening tool) assessment process has been developed for patients receiving care from community nurses to establish requirement of dietary supplements
- Advanced Quality (AQ) work continues to implement patient care bundles across a range of specialities
- Updates on governance and clinical information are delivered to staff via the bi-monthly Learning into Practice and Nursing Matters newsletters
- See Clinical and NCEPOD audit from page 42
- Work has been undertaken to raise awareness and support qualified nursing staff in preparation for revalidation for their nursing registration from April 2016
- The Care Certificate Programme for Health Care Support Workers and Allied Support Care Workers has been implemented. This sets out the minimum standards that new care workers need to be taught as part of their induction training to ensure the provision of compassionate, safe and high-quality care. This is being supported by an in-house, bespoke training package.
- An in-house nurse assessor training course has been developed to facilitate assessment of clinical and care certificate competencies
- Trust staff have undertaken NHS Academy Leadership courses.

## What this means for patients

- Assurance that patients will receive individualised patient care that is coordinated across professions and organisations
- The staff caring for our patients have the right skills and competencies to provide right care in the right place
- The project initiatives have supported clinical staff to have more time for direct patient care.

# Listening and Responding

We are committed to further improving patient and staff experience by listening to feedback and responding to concerns. We will shift the focus of our relationships with patients from 'what's the matter?' to 'what matters most to you?'

## Achievements

- Received National Autistic Society's 'Autism Access Award' for the second year and won the 'Outstanding Health Services' category in the Society's Autism Professionals Awards for the trust's Open2Autism project.
- The Haelo enhanced care project incorporated carer feedback, which is being used to review the visiting policy and carer facilities on hospital wards
- The trust has signed up to 'John's Campaign' to support carers who wish to participate in care whilst their loved one is an inpatient
- Appointment of a band 7 safeguarding nurse to support clinical teams in assessing and meeting needs of adults at risk
- Upgrades to some ward environments have been undertaken for example orthopaedic ward bathrooms
- Time to go Home campaign established to support appropriate and timely discharge of patients from in-patient areas
- Work has commenced to reduce the number of outpatient appointments that are cancelled. This will continue into next year.
- A focus on advanced care planning, general end of life support, rapid discharge and where appropriate the commencement of care plans for end of life. Work will continue on development of the Amber Care bundle for the deteriorating patient.

## What this means for patients

- Patient choice and carer involvement is being actively encouraged to improve patient experience
- Improved facilities in some ward areas
- Development of an open visiting policy.




# Staff engagement and training

## (part of the listening and responding domain)

We will recruit staff who share our values, who are caring and compassionate to ensure we deliver the right care, first time, every time.

The trust is committed to building positive levels of staff engagement and will continue to use 'Your Voice' as a vehicle. This takes a conversational approach, engaging staff at all levels for positive and effective change, supporting delivery of the Quality Strategy by involving staff in co-designing quality improvement schemes.

Our approach will bring staff together from across the organisation, working with individuals and teams to lead on quality initiatives. We will work with our clinicians to further strengthen the relationship between clinical staff and managers with a shared focus on improving patient and staff experience.

## Achievements

- A clinically led project was undertaken to redesign inpatient ward documentation and reduce duplication and the time staff spend on paperwork. This is currently being piloted.
- External funding was awarded to support the retention of nursing staff and is being used to create welcoming and dedicated staff rest areas on wards.
- Following the successful Haelo initiative, staff have become engaged with the importance of supporting relatives and carers and are undertaking fundraising activities to achieve their goals.
- Development of induction programs to support overseas nurses working at the trust
- Appointment of consultant psychiatrist to support development of training programmes in mental health.
- Development of e-learning training programme for mentors to encourage and support staff
- Development of bespoke clinical mandatory training for community nurses and matrons.

## What this means for staff

- We will have staff with the necessary knowledge and skills relevant to their role through the delivery of innovative development programmes and training
- Staff have the required skills to meet the holistic needs of patients
- We will have staff who will be able to deliver high quality clinical training. This will support our new starters and existing staff to acquire the competencies they need and developing new skills and capabilities as they progress
- We will develop fit-for-purpose induction and preceptorship programmes and support our assessors and mentors to fulfil their responsibilities.
- A motivated and engaged workforce
- Development of improved ways of working to support the most vulnerable patient groups.

# Integrated care

### What is integrated care?

Many people who have complex care needs receive health and social care services from multiple providers and in different care settings, without appropriate co-ordination or a holistic perspective. If services aren't well coordinated and based around an individual's needs, it can lead to confusion, repetition, delay, duplication, gaps in service delivery and people getting lost in the system.

Our aim is to develop effective partnerships and new ways of working within an integrated care system.


### Achievements

- Commenced work in the development of integrated teams working across the local health and social care economy

- Creation of a new 'complex care practitioner' role to support the integrated care teams

- Introduction of the pilot of Frailty Pathway – hospital and community teams working in a coordinated way with a streamlined assessment process for patients with complex care needs

  Links have been developed between secondary care Clinicians and GPs to improve communication in relation to patient care

- Introduction of the Friends and Family survey in the community

- There is work being undertaken to move from paper based nursing and patient records to electronic records. An electronic version of the nursing assessment and patient record has been developed and trialed across nursing teams in the east and south and vale royal localities. The benefits of this will be reduced duplication of writing and the sharing of patient records with other members of the health team ( in line with information sharing agreement) in order to ensure effective and timely communication about patient care

- Further work undertaken on the use of mobile devices in the community setting which supports:
  - contemporaneous recording of patient records
  - improved communication between teams
  - timely and responsive allocation of workload

- There has been a campaign approach to patient flow. Time to go Home focuses on ensuring safe and effective discharge from a hospital setting.

### What this means for patients

- Delivery of the best care in the right place
- Seamless care supporting a reduction in inappropriate admissions to hospital

- Clinical staff are supported in the provision of care they provide by senior medical staff ensuring development of an enhanced skill set

- Patients can feedback in real time about their care experience.

## Specified Indicators 2015-16

Auditors test two indicators annually according to the nature of the trust's activities. For 2015/16 these indicators are venous thromboembolism (VTE) and C. Difficile.

### VTE

The trust ensures 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. The results are collated through an electronic system directly linked with the patient administration system (PAS) for recording the completion of VTE assessments.
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.

During 2015/2016 the Trust has continued to adapt practice to echo national /local guidance and learn from RCAs incidents. These changes have consequently been reflected in our updated VTE Policy . These include:

- Pathway for management of endoscopy patients on anticoagulants
- Updated DVT pathway
- Update of tinzaparin shared care guidance to include revised dosing regime for high risk patients
- Update of guidance for Perioperative Management of Patients on Anticoagulant Therapy who Require Urgent Surgery
- Recommendation for use of the geko device and IPC in acute stroke as per NICE
- Guidance for stopping and starting New Oral Anticoagulants (NOAC's) in the peri-operative period

### Clostridium Difficile

The trust has exceeded its target for Clostridium difficile this year, however there were no lapses in care 16 cases. This is in line with the national picture. Work continues following learning from root cause analysis processes into each case. There is continued focus on antibiotic guardianship to ensure appropriate antibiotic prescribing. More information about C. Difficile can be found on page 26. Please see page 7 for the audit opinion.

## Data quality

### Relevance of data quality and action to improve data quality

The trust's Data Quality Policy states that all staff have responsibility 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 2015 to December 2015, the Secondary Uses Service Data Quality Dashboard was at 97.4%, against 96.2% 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 99.2%, outpatients was showing 99.9% against 99.4%, and accident and emergency was significantly above the national average of 95.1%, at 98.5%.

For a valid Healthcare Resource Group version 4 code, the scores are 99.8% for the trust against national scores of admitted patient care at 98.7%, outpatients at 100% and accident and emergency at 100%.

*"I was seen by the same consultant who had clearly read my notes beforehand. The consultant suggested several possible options to try and manage my long term condition and we made a plan for the next six months together. The whole team were happy and helpful."*

**- Outpatients**

## 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. Clinical Coding is carried out using the full patient case note supplemented by electronic systems, such as histopathology and radiology, which is considered best practice.

The Clinical Coding staff attend all mandatory Clinical Coding training as required, as well as Clinical Coding Speciality Workshops. Annually the trust undergoes an Information Governance Toolkit audit, which is nationally required. The trust has not been subject to a Capita PbR audit since 2014/15.

## Information Governance Toolkit

As part of the Department of Health's commitment to ensure the highest standards of information governance, it has developed an Information Governance Assurance Framework supported by the Information Governance (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 2016. The trust submitted evidence in March 2016, confirming Level 2 compliance against all the requirements. The trust's overall score was 67% or 'green' according to the IGT grading system.

There is a requirement for 95% of trust staff to be trained in information governance on an annual basis. The trust scored 96.36% during 2015-16.

## Review of services

During 2015/16 the trust provided and/or sub-contracted 13 NHS services. The trust has reviewed all the data available to it on the quality of care in 100% of these NHS services. The income generated by the NHS services reviewed in 2014/15 represents 100% per cent 55 of the total income generated from the provision of NHS services by East Cheshire NHS Trust for 2015/16.

The 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 Board, Governance Committee, Executive Management Board, Quality and Safety Board 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.

## Counter-fraud

The trust operates a counter-fraud policy available for all staff. Fraud information is also available on the trust website www.eastcheshire.nhs.uk/Our-Services/Counter-fraud.htm



## Duty of Candour

Candour is the quality of being open and honest. Patients, or someone lawfully acting on their behalf, should be properly informed about all of their treatment and care and this should involve any incidents that affect them and could result in harm. East Cheshire NHS Trust sustains a culture which supports staff to be candid.

The Francis Inquiry report in 2013 instigated many changes to health care. The drive to improve transparency and openness within the NHS and to provide assurance to our patients that we are doing everything we can to keep them safe has never been higher on the agenda. In November 2013 the department of health published the 'Hard Truths' report. In the report there was reference to making sure that people have confidence that they will be given the best and safest care. There is now a real commitment to greater openness and candour, to developing a culture dedicated to learning and improvement that continually strives to reduce avoidable harm.

The trust is committed to improving communication with patients, families and carers when a patient is involved in an incident, and where this includes moderate harm, (nonpermanent harm) severe harm (permanent harm) or death. We will also ensure that they are kept informed of the investigation and any outcomes.

If an incident is graded as no harm/near miss/ low harm then the patient/carer should be informed of the incident (Duty of Candour stage 1) and that the incident will be investigated by a senior member of staff. This must be documented in the patients' health record and on Datix – the trusts internal reporting system. Duty of Candour stage 2 is only applicable to incidents graded moderate harm, (non-permanent harm) severe harm (permanent harm) or death. The full policy on Duty of Candour can be seen on the trust website: www.eastcheshire.nhs.uk/About-The-Trust/policies/D/Duty%20of%20Candour%20Being%20Open%20Policy%20ECT2084.pdf

# Care Quality Commission

In May 2015, East Cheshire NHS Trust was given an overall 'Requires Improvement' rating by the Care Quality Commission (CQC) following its inspection of the trust in December 2014.

The CQC's report rated care across the organisation as 'good' and said that "across the board" East Cheshire staff worked hard to deliver compassionate care. Inspectors also found that patients were treated with dignity and respect and spoke positively about the care and treatment that they received.

Areas for improvement identified in the report include processes around reporting and communication, along with recruitment to community nursing roles. Since the report was published, the trust has been working with commissioners, the NHS Trust Development Authority and other partners to deliver an improvement programme and is aiming for a better evaluation when the CQC revisits the trust in the near future. See our CQC report at: www.eastcheshire.nhs.uk/news/East-Cheshire-NHS-Trust-responds-to-Care-Quality-Commission-report.htm

# Core Indicators

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 | Reason | Action to improve |
|---|---|---|---|---|
| **1: Preventing people from dying prematurely.** Summary Hospital-Level Mortality Indicator (SHMI): | | | | |
| A: SHMI value and branding July 2014 - June 2015 | 0.9873 (band 2 - as expected) | 14 trusts higher than expected<br>13 trusts lower than expected<br>Lowest = 0.6605<br>Highest = 1.2089<br>Average = 1.0044 | The trust performs within the expected range for this indicator. | The trust holds a monthly mortality subcommittee. All inpatient deaths are reported on datix and mortality figures scrutinised to enable the effective review of every inpatient death. |
| **2: Enhancing quality of life for people with long-term conditions** | | | | |
| B: Percentage of patient deaths with palliative care coded at either diagnosis or speciality level | 16.8% | National average = 26% | | |
| **3. Helping people to recover from episodes of ill-health or following injury.** Patient reported outcome for: | | | | |
| i) Groin hernia surgery | EQ5D Index: 57.5% | England EQ5D Index: 50.8% | | Health gain is marginally better than the England average. |
| ii) varicose vein surgery<br>iii) hip replacement surgery<br>iv) knee replacement surgery | 89.2%<br>88.6% | 89.6%<br>81.1% | Results are unable to show health gain as numbers are so small and therefore not included. | |

| Quality Indicator | East Cheshire NHS Trust (ECT) Data | Comparison | Reason | Action to improve |
|---|---|---|---|---|
| **96%3. Helping people to recover from episodes of ill-health or following injury.** Emergency readmissions to hospital within 28 days of discharge: | | | | |
| No further annual data available from provided source: | | | | |
| **4. Ensuring that people have a positive experience of care** | | | | |
| Responsiveness to inpatients' personal needs. | 75.3 (2014/15)<br>76 (2013/14)<br>75.8 (2012/13)<br>76.6 (2011/12)<br>75.5 (2010/11) | England:<br>76.6 (2014/15)<br>76.9 (2013/14)<br>76.5 (2012/13)<br>75.6 (2011/12)<br>75.7 (2010/11)<br>Worst – 67.4 (2014/15)<br>Best – 87.4 (2014/15) | The trust performs within the expected range for this indicator. | |
| Percentage of staff who would recommend the provider to friends or family needing care. | 79%<br>(Q2 2015/15) | England - 79%<br><br>Worst - 48%<br>Best - 100% | The trust performs within the expected range for this indicator. | |
| Percentage of patients who would recommend the provider to their friends and family | Oct 2014 - Sept 2015<br>A&E 88.9%<br>Inpatient 95.1% | England<br>87.6%<br>95.2% | The trust performs within the expected range for this indicator. | |
| **5. Treating and caring for people in a safe environment and protecting them from avoidable harm** | | | | |
| Percentage of admitted patients risk-assessed for venous thromboembolism | Q2 2015/16<br>96% | England - 95.9%<br>Best - 100%<br>Worst - 75% | The trust performs within the expected range for this indicator. | |

*"I was given lots of information on my chosen contraception. I was listened to about my issues and was helped in trying to get them sorted."*

**– Sexual Health**

| Quality Indicator | East Cheshire NHS Trust (ECT) Data | Comparison | Reason | Action to improve |
|---|---|---|---|---|
| **5. Treating and caring for people in a safe environment and protecting them from avoidable harm.** | | | | |
| Rate of C Difficile | April 2015 - March 2016<br><br>24 | England - 15.1<br>Worst - 62.2<br>Best - 0 | The trust performs below standard. | • We undertake post-infection reviews to identify any lapses in care relating to CDI toxin positive cases attributable to the hospital.<br>• Antimicrobial Stewardship - CQUINS for 16/17.<br>• Established operational IPC group to monitor and deliver improvements in clinical environments. |
| Rate of patient safety incidents and percentage resulting in severe harm or death. | Oct 2014- Sept 2015<br>5576 incidents<br>47.03 incidents per 1000 bed days<br>0.03 incidents per 1000 bed days resulting in severe harm or death<br>4 incidents resulting in severe harm<br>0 incidents resulting in death | England - 0.17 incidents per 1000 bed days resulting in severe harm or death<br><br>Worst - 1.18 (193 severe harm, 0 death)<br><br>Best - 0.02 (3 severe harm, 1 death) | A web-based, all staff incident reporting system is used in the trust. The patient harm field is mandatory. All clinical incidents are reviewed by the Risk Management Team. | Ongoing training and education of staff on incident reporting.<br>Improved process of check and challenge for serious incidents.<br>Duty of candour captured on the system to improve compliance. |
| Rate of patient safety incidents and percentage resulting in severe harm or death. | | | Team leaders and managers are assigned incidents as owners to investigate.<br>A high-level executive lead group considers all serious incidents. All those resulting in serious harm or death are verified by senior managers prior to upload. | Monthly data produced and sent to service lines on complaints, PALS, patient experience, incidents and claims.<br><br>Incident data used to inform improvement initiatives such as Sign up to Safety |



# Our Performance 2015/16

## Quality performance

The trust is measured on its performance against the Department of Health NHS Performance Framework, which provides a dynamic assessment of the performance of NHS providers that are not NHS foundation trusts. The assessments are across four key domains of organisational function - finance, quality of service, operational standards and targets, and quality and safety. Performance is assessed quarterly.

The trust's performance against national targets can be seen overleaf. Other areas of performance are illustrated throughout this section of the Quality Account and further performance statistics can be found on the trust website at: www.eastcheshire.nhs.uk

## National context

Despite extensive planning and cooperation between all types of NHS organisations, the health service faced considerable and widely-reported challenges on a national level over winter 2015-16. This was largely due to emergency admissions and the number of patients requiring admission to hospital – especially frail older people with complex health and social care needs. As a result, most NHS trusts struggled to meet national targets, particularly the four-hour emergency department standard.

| | Performance Standards | Target | 15/16 |
|---|---|---|---|
| Mortality | Risk Adjusted Morality Index 2014 | < latest peer | 95 |
| | Summary Hospital-Level Morality | 2 or 3 | 2 |
| Infection | Ecoli - includes hospital and community | N/A | 146 |
| | Hospital MRSA Confirmed Bacteraemia | 0 | 1 |
| | Hospital Acquired C Difficile (Year Target) - Avoidable and Unavoidable | <=14 | 26* |
| | Incidence of newly-acquired cat 3 and 4 pressure ulcers - hospital | <14 | 8 |
| | Incidence of newly-acquired cat 3 and 4 pressure ulcers - out of hospital | <14 | 30 |
| Incidents | Medication errors causing serious harm | N/A | 0 |
| | Never Events | 0 | 3 |
| | Hospital Serious Incidents | N/A | 51 |
| | Patient Safety: Falls resulting in patient harm per 1000 bed days | <2.5 | 2.5 |
| Complaints | Number of investigations where recommendations where made by Ombudsman | 0 | 1 |
| | Number of complaints | 200 | 177 |
| Experience | Ward Family and Friends Test % response | >20% | 39.3 |
| | ED Family and Friends Test % response | >15% | 26.0 |
| | Mixed Sex Accommodation breaches per 1000 FCE's | 0 | 0.30 |
| Access | 18 week - Incomplete Patients % | >=92% | 92.1 |
| | 18 week - Admitted Backlog | N/A | 429 |
| | ED: Maximum wait of 4 hours | 95% | 91.3 |
| | ED: The recording of a completed handover, (HAS) | 90% | 86.4 |
| Cancer | 2 Weeks maximum wait for urgent referral for suspected cancer | >=93% | 97.6 |
| | 2 Weeks maximum wait from referral for breast symptoms | >=93% | 95.2 |
| | 31 days maximum from decision to treat to subsequent treatment - Surgery | >=94% | 100 |
| | 31 day wait from cancer diagnosis to treatment | >=96% | 99.5 |
| | 62 day maximum wait from urgent referral to treatment of all cancer | >=85% | 87.4 |
| | 62 days maximum from screening referral to treatment | >=90% | 98.3 |

| | Performance Standards | Target | 15/16 |
|---|---|---|---|
| LoS | Average Length of Stay - non elective | 4.7 | 5.7 |
| | Average Length of Stay - elective | 2.8 | 3.6 |
| | Delayed transfer of care (Sitrep) | <2.5% | 9.3 |
| | Bed days lost through delays | N/A | 8811 |
| | % of bed days lost through delays | <2.5% | 9.7 |
| Staff | Core Staff in Post (FTE) | 2984.20 | 2744.85 |
| | Total Staff (FTE) | 3201.30 | 2959.97 |
| | % Sickness Absence - monthly | 4.83 | 5.14 |
| | % Sickness Absence - Rolling year | 4.73 | 4.55 |
| | % Compliance with Statutory and Mandatory Training - Rolling year | 90.0 | 92.63% |
| | % Corporate Induction attendance - Rolling 6 months | 90.0 | 94.31% |
| | % Appraisals and Personal Development Plans - Rolling year | 90.0 | 74.93% |
| | Safeguarding - Level 1 Compliance | 80% | 92.63% |
| | Safeguarding Children - Level 2 | 80% | 84.71% |
| | Safeguarding Adults - Level 2 | 80% | 76.54% |
| | Safeguarding Children - Level 3 | 80% | 77.41% |
| Finance | Total Pay Expenditure (£000) | 118,670 | 128,014 |
| | Bank Staff Expenditure (£000) | 4,133 | 3,746 |
| | Agency Staff Expenditure (£000) | 6,079 | 12,080 |
| | Cash (£000's) | N/A | 4,037 |
| | EBITDA (£000) | -1,625 | -19,407 |
| | (Surplus )/Deficit(£000) | -6,498 | -23,899 |

* There were 16 incidents were no lapses in care were identified.

# Commissioning for Quality and innovation (CQUIN)*

| Community | Achieved |
|---|---|
| Cultural transformation | |
| Nutrition and care plan | |
| Dementia awareness and champions | |
| Pressure Ulcer Prevention | |

| Acute | Achieved |
|---|---|
| SEPSIS screening | |
| SEPSIS Antibiotic administration | |
| Reduction in the number of falls with harm | |
| Acute Kidney Injury (AKI) | |
| Pressure Ulcer Prevention | |
| Advancing Quality acute myocardial infarction | |
| Advancing Quality heart failure | |
| Advancing Quality hip and knee replacement | |
| Advancing Quality pneumonia | |
| Advancing Quality stroke | |
| Advancing Quality COPD | |
| Cultural transformation | |
| Avoidable emergency admissions - diagnostic | |
| Avoidable emergency admissions - frailty pathway | |
| Avoidable emergency admissions integrated digital care record | |
| Avoidable emergency admissions MH coding | |

Waiting for final results

*The CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals.



# Examples of good practice and patient stories

## Surgical Specialties

### Dementia care

Following additional training in Dementia care, staff on the Orthopaedics ward have improved resources for patients and staff including:

- Improved information and study sessions on dementia, symptoms and tips on how best to manage behaviours
- Twiddle muffs made by staff and volunteers are used to distract patients pulling at indwelling devises or clothing and sheets
- Afternoon tea sessions have been introduced with the support of the dietician enabling staff to promote increased calorie intake in vulnerable patients and create social events.

### The Surgical Assessment Unit (SAU)

The SAU, opened in June 2015, is an integral part of the Surgical Floor. The unit receives referrals directly from GPs, provides accommodation and facilities for surgical acutely ill adult patients to undergo safe, accurate clinical assessment, initial investigations and treatment. On arrival patients are assessed by a doctor and senior nurse, receive high quality individualised care and are treated within 4 hours. The facility operates from 10am - 10pm, 7 days/ week and has improved patient experience in the following ways:

- Quick, safe, accurate nurse triage
- Early senior medical input
- Access to timely turnaround times in diagnostics (imaging, path lab)
- Methodical teamwork - optimum communication
- Improved discharge processes and daily return availability for routine tests
- Multi Disciplinary team on hand to prevent unnecessary admissions.

## Clinical Support and Diagnostics

### Living with & beyond Cancer

In order to meet the needs of the national Survivorship Agenda, this trust now hosts 3 separate Patient Support Programmes for Lung, Colorectal and Breast patients. This ensures that approx 70 patients per month, living with life limiting illness, or patients whose curative treatment is complete, have the opportunity to be supported by a programme of information sessions covering topics such as fatigue management, nutrition advice, physical exercise plans and anxiety management and managing a 'New Normal'.

### The Macmillan Support and Information Service (MQuISS)

The Macmillan Support and Information Service is currently working towards a new national Macmillan Quality Standard, due to be completed in April 2016. Twelve quality areas including governance, user centred service, development, equality and communication have to be graded and evidenced on a scale of 1-5. Every service and is expected to reach Level 4 by the end of April.

### New pilot project for Pharmacy team

An exciting new initiative has been put into place to support the MAU team, a Medicine Administration Technician commenced a training


programme in February 2016 to provide support to nurses to complete drug rounds at ward level. The aim is to provide:

- Increased patient safety
- Zero tolerance for missed doses
- Support to patients struggling with their medicines
- Release nursing time to provide more direct clinical care.

## Womens and Childrens

In 2015, the Women's and Children's Service Line secured a major contract to provide sexual health and contraception services across the Cheshire East Council footprint.

The contract, which is worth £11.31m over five years, commenced in October and comes shortly after the trust also began delivering a new sexual health service across the Cheshire West and Chester Council footprint.

As with the Cheshire West and Chester Council service, the new contract has a significant focus on convenience and accessibility – two areas identified as priorities by service users. The trust will be providing services from more community locations, as well as increasing accessibility at evenings and weekends and allowing appointments to be booked online.

The new service also aims to bring other benefits such as reduced rates of teenage pregnancy and greater access to sexual health and contraception advice for priority groups, including young people and men. As part of the new contract the trust commissioned a new purpose-built sexual health clinic in Crewe, complementing the sexual health centre in the west of the patch at the Fountains in Chester.

## Urgent Care

### AAU

The Acute Assessment Unit moved to the Emergency Department during 2015/16. This Unit accepts GP referrals, allowing patients to be seen directly by the most appropriate team and admitted only when necessary or discharged faster.

### Patient flow

In 2015/16 a number of support roles were developed to improve patient flow. The team enable patients to leave the ward areas with the assistance of trained staff to ensure that transport, contacting relatives, prescriptions and packages of community care are all in place for our patients. They also liaise directly with patients who have moved wards, away from their specialist consultant, to ensure continuity of care.

## Medical Specialties

### Community Diabetes Specialist Nursing service achievements

Diabetes is a complex condition, which is affected by, and can affect almost all daily living activities. Most decisions taken daily (e.g. the taking of insulin, food choices and activity levels) affect blood glucose levels. The Diabetes Specialist Nurses, based in the community form part of the Specialist Diabetes Team Network with the aim of providing as much care as possible within Primary Care to support patients with complex and poor blood glucose control. Good blood glucose control reduces the incidence of vascular complications (eg. eye disease, heart disease, renal disease, peripheral vascular disease). The team were part of a group who won the Eclipse Best Glycaemic Control in Diabetes Award for educating newly-diagnosed patients with type 1 diabetes.

### Integrated cardiology team

In 2015 Dr Julie Walker, Advanced Specialist Practitioner in Cardiology was awarded a heart hero award for innovation by the British Heart Foundation. Her work on the East Cheshire Project centred around the development of the integrated cardiology team and has changed the way in which cardiology patients are managed, reducing admissions, readmissions and length of stay for a number of cardiac conditions.

## Allied Health Services

### Self-referral

In conjunction with five practices in the south Cheshire and Vale Royal area a six month self-referral pilot was undertaken as part of the Local Quality Scheme. This pilot enabled patients to refer themselves directly to Musculoskeletal Outpatient services, without having to see a GP first. The aim was to improve patient access to local care. The pilot had no impact on waiting times, and patients choosing to self-refer reported better outcomes. There was a high level of patient satisfaction with the service, and willingness to access Physiotherapy in this way in future.

### Rapid Response

The community rehabilitation rapid access service was set up in East Cheshire with the aim of preventing hospital admission and re admission where possible by providing physio and/or Occupational Therapy at home within 24 hours of referral. (Monday - Friday.) Over a three month period 56% of patients reported that the rapid therapy intervention prevented them being admitted or readmitted to hospital.

## Integrated Care

### East Cheshire's NIMO team

The Neighbourhood Integrated Medicines Optimisation team (NIMO) is now in its third year. After a referral is made, NIMO will gain consent from the patient and utilise the patient's GP records, hospital discharge and outpatient notes, as well as any relevant blood results to formulate a plan to optimise their medication regime in their own home, or care home.

Dosage regimes are simplified, often resulting in a reduction in care calls and drug-costs. Compliance problems are tackled through patient education and compliance aids and general medication advice is offered to healthcare professionals and patients.

### Integrated Discharge Team

The Integrated Discharge Team consists of experienced hospital based health and social care professionals. The purpose of the Integrated Discharge Team is to provide multidisciplinary expertise and support to staff, all patients and their carers to enable safe and timely transfer

*"The complete package at home was brilliant and meant that I was able to go home earlier but still have the intensive therapy I would have had in hospital."*

**- Specialist Community Stroke Rehab**

from hospital to community. An Age UK Long Term placement officer is affiliated with the team to provide support to families looking for care homes. In addition the team provides a discharge lounge and transport service to take patients home from hospital.

In 2015/2016 the team undertook approximately 2200 full discharge assessments. This included:

- 73 assessments for Intermediate Care of which an average of 37 resulted in transfer to Intermediate care services (bed based or home)
- 81 assessments a month for social services of which an average of 38 resulted in implementation of new care packages, increase in existing care packages or short term interim placement in a care home
- 30 assessments were completed in relation to the Continuing Healthcare and Fast Track end of life processes.

Approximately 182 patients a month went to the discharge lounge prior to going home and approximately eight patients a day were accompanied home in the discharge vehicle.

## Patient Feedback

Patient feedback is vital to the trust enabling us to ensure that our services are meeting the needs and expectations of patients and their families and to identify areas for improvement. An annual programme of patient feedback work is carried out across all service lines.

The trust uses a range of methods to obtain patient feedback including paper questionnaires, online and telephone surveys, focus groups, patient stories and real time feedback using latest technologies.

Summaries of the trust's patient surveys can be found on the website at: www.eastcheshire.nhs.uk/Get-Involved/Patient-Surveys.htm

Some examples of areas covered by our feedback programme in 2015/16 include:

Surgical ward based focus groups, breast screening, sexual health, quarterly patient survey, smoking cessation, community stroke rehabilitation, community nursing.

**Examples of service improvements following patient feedback include:**

- **Colposcopy** - implementing direct referral from pathology means a reduction in waiting times between an abnormal smear result and a colposcopy appointment will be reduced. Updated appointment letters ensure all women are aware they can bring someone to support them during the procedure. These improvements support women and help reduce anxiety following an abnormal smear result.

- **Children's Ward** –a 'parents' group' is being established to review patient information leaflets and act as advisors to the ward. This will ensure that parents are involved in the ward and that decisions are made with 'the voice of the parent' in mind.

- **Community stroke rehabilitation** – to help patients feel more involved in decisions about their care and treatment information packs are now handed out as soon as patients are admitted to the service. Patients are involved in goal setting within five days of being screened for admission to the service and all patients hold a rehabilitation timetable so they are aware of their planned appointments.

- **Specialist weight management** – to support patients wishing to undergo surgery a specific bariatric surgery information session has been introduced to the programme for 2016.

- **Community nursing** – to improve satisfaction with appointments staff are reviewing the feasibility of timed appointment slots and team leaders are aiming to improve continuity of care when looking at shift patterns.

- **Podiatry** – following concerns about the booking procedure a review of the administration and appointment system is underway. A radio has been introduced in one clinic to improve privacy and minimise the risk of overhearing conversations in the treatment room.

- **Endoscopy** - work is underway to further drive down time from referral for investigation and contact by the department. Patient information is being reviewed along with the option of having this available electronically. Patient letters now clarify that the time stated on the appointment letter is the booking in time rather than their procedure time. A patient feedback box has been implemented and will be reviewed monthly and discussed at the team meeting to further improve patient experience.

## Health Matters

Each month we present a free public lecture – Health Matters - giving members of the public the opportunity to learn more about health issues that affect or interest them.

People attending the talks can also meet the local consultants and healthcare staff and put questions directly to them. The Health Matters series covers a range of popular clinical areas and has been an outstanding success in delivering key messages directly from senior trust staff to the community they serve. For a full programme, see the Health Matters page on the trust website: www.eastcheshire.nhs.uk/News-Events/Health-matters.htm

In 2015 we started video recording Health Matters lectures to help reach a wider audience. These videos can be viewed on the trust website: www.eastcheshire.nhs.uk/News-Events/health-matters-videos.htm

**Health Matters lectures over the year covered topics including:**

- Headaches
- Sexual health services
- Common conditions of the nose and sinuses
- Childhood allergies
- Patient safety

## PLACE (Patient-Led Assessments of the Care Environment) 2015

Each year acute hospitals within inpatient bed facilities are required to undertake a national PLACE report which seeks to provide information from patients on its delivery of the care environment.

The trust undertook the assessment of Congleton War Memorial Hospital in April 2015 and Macclesfield District General Hospital in June 2015. Representatives from Infection Prevention and Control, Facilities, ISS Healthcare and patient assessors took part in the assessments.

The aims and objectives of the PLACE Assessment is to provide a snapshot of our organisation and how it performs against a range of non-clinical activities which impact on the patient experience.

The assessment primarily looks at the following areas:

- Cleanliness
- External areas i.e. communal space, car parking, wheelchair accessibility, maintenance, signage
- Quality and availability of food and hydration
- Dementia Assessment (new addition this year)
- Communal areas i.e. signage, maintenance, fixtures & fittings
- Privacy, dignity and wellbeing

The criteria included in PLACE assessments represent both those aspects of care and good practice as identified by professional organisations whose members are responsible for the delivery of these services.

Overall the scores (see table below) have remained consistent with the assessments undertaken in 2014 and both sites scored higher than the regional averages. Privacy, Dignity and Wellbeing scores were slightly lower than last year due to TVs not being available to all patients.

| Site Name | Cleanliness | Food and Hydration | Privacy, Dignity and Wellbeing | Condition, Appearance and Maintenance | Dementia | Average Score |
|---|---|---|---|---|---|---|
| Macclesfield District General Hospital | 99.43% | 96.04% | 91.86% | 97.26% | 86.61% | 94.90% |
| Congleton War Memorial Hospital | 98.50% | 97.07% | 88.67% | 91.42% | 90.94% | 93.19% |
| North West Average Scores | 98.60% | 90.77% | 87.81% | 92.67% | 78.07% | 89.55% |



## Quarterly Audits

The trust is committed to regular patient feedback demonstrated by quarterly audits across inpatients, outpatients and community nursing looking at key areas of the patient journey.

### Inpatients

This audit looks 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 2015/16:

- 78% rated the cleanliness of the ward as 'very clean'
- 67% stated that they were 'definitely' involved in decisions about their care and treatment
- 76% said staff 'definitely' checked they were comfortable and had everything that they needed on a regular basis
- 79% of patients 'always' had enough privacy when discussing their condition / treatment
- 92% 'always' had enough privacy when being examined or treated
- 92% of patients said they were 'always' treated with dignity and respect
- 88% of patients said they were 'definitely' treated with care and compassion
- 67% of patients rated the overall level of care as 'excellent' and 31% rated it as 'good'

### Outpatients

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 2015/16:

- 80% of patients felt they were seen as soon as necessary for their appointment
- 78% rated the cleanliness of the department as 'very clean'
- 80% 'definitely' felt involved in decisions about care and treatment
- 98% 'always' had enough privacy when discussing treatment and when being examined
- 98% said they were 'always' treated with dignity and respect and 94% said they were 'definitely' treated with care and compassion.
- 76% rated the overall level of care as excellent, with 22% rating it as good.

### Community Nursing

2015 saw the introduction of a community based quarterly audit surveying patients that had received a visit from a community nurse:

During 2015/16:

- 93% stated that the nurse 'always' arrived as planned for their visits
- 93% said the nurse 'definitely' explained the reasons for any treatment or action in a way they could understand
- 86% said that they were 'definitely' involved as much as they wanted to be in decisions about their care and treatment
- 87% said they 'definitely' felt supported in managing their condition
- 99% were 'definitely' treated with dignity and respect
- 97% were 'definitely' treated with care and compassion.




## CQC National Adult Inpatient Survey 2015 – Data available 8th June 2016

The national adult inpatient survey results are due to be published on the 8th June 2016. The trust performance in this survey will be available to view online at www.eastcheshire.nhs.uk/Get-Involved/Patient%20engagement.htm

## CQC National Maternity Survey 2015

A total of 262 questionnaires were sent out to women who gave birth at the trust in January and February 2015. 122 completed surveys were returned giving a response rate of 47% compared to the national average of 41%.

The survey was split into three sections: antenatal care, labour and birth and postnatal care. However CQC only published the labour and birth section of the survey due to the fact that not all trusts were able to attribute whether the women in their sample had definitely received antenatal and postnatal care from their trust.

Overall the trust was classed as being in the top 20% of trusts (green) for five areas. Three of these areas were included in the labour and birth section of the survey and as such were published by CQC:

1. Midwives asking patients how they were feeling emotionally (antenatal)
2. Given appropriate advice when contacting the hospital at start of labour (labour / birth)
3. Skin to skin contact after birth (labour / birth)
4. Treated with dignity and respect (labour / birth)
5. Information about contraception (postnatal)

The trust was classed as being in the lowest performing 20% of trusts (red) for one area:

- Women told to arrange postnatal check up with GP (postnatal)

In the labour and birth section of the report the trust maintained or increased its scores across all criteria. The largest increase in scores for this section include being given appropriate advice when contacting hospital at start of labour and not being left alone at a time that worried them.

## 2015 National Cancer Patient Experience Survey

National level results will be published by NHS England on 7th June 2016 with trust level results being published on the 5th July 2016. These results will be available online at: www.eastcheshire.nhs.uk/Get-Involved/Patient%20engagement.htm

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*"Excellent continuity of treatment from pleasant, caring professionals with exceptional communication and 'people' skills. Wound care have gone beyond the requirement of duty to make my treatment a more pleasurable experience."*

**- Podiatry**

## Participation in clinical audits

Clinical audit is an important quality improvement process for the trust. By participating in relevant national audits, we can compare our practice with other similar organisations and identify whether we need to improve the services we provide. In addition, the participation in local audits allows services to measure the quality of patient care they provide.

Clinical audit evaluates the quality of care provided against evidence-based standards and is a key component of clinical governance and quality improvement. The trust produces an annual forward plan for clinical audit which incorporates national, regional and local projects. Progress against the forward plan is reviewed by the clinical audit and Research Effectiveness Group on a monthly basis.

The following sections summarises the clinical audit activity participated in by East Cheshire NHS Trust during 2015/16.

### National clinical audits

During 2015/16, the trust participated in 23 national clinical audits and four national confidential enquiries. This equated to 74% and 100% respectively of the audits in which it was eligible to participate.

The national clinical audits and national confidential enquiries that the trust participated in, and for which data collection was completed during 2015/16, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

| National clinical audit/programme | Participation Y/N | % Data submission | Actions taken |
|---|---|---|---|
| **Surgical Specialties** | | | |
| **General Surgery** | | | |
| NBOCAP National Bowel Cancer Audit Project | Y | 100% | Outcomes Audit – no actions |
| NELA Emergency Laparotomy | | | • Review abdomen pathway<br>• Review patient in under 24 hours from admission<br>• Discuss risks with patient/ relative<br>• Develop clear protocol for patients over 70 and all surgical patients. |
| **Trauma & Orthopaedics** | | | |
| NJR National Joint Registry | Y | 100% | • Ensure juniors are aware of importance<br>• Fill form immediately post-op<br>• Routine six monthly audit<br>• BMI to be documented at pre-op/ transferred from pre-op assessment documentation<br>• Look at uploading process |
| FFFAP Falls Fragility Fractures Audit Programme, NHFD National Hip Fracture Database | Y | 100% | • Improve theatre times<br>• Address 30 day follow up<br>• Develop six patients<br>• Use web run charts |
| **Anaesthetic Specialties** | | | |
| ICNARC Adult Critical Care Case Mix Programme | Y | 100% | Outcomes audit – no actions |
| NOAD Obstetrics & Gynaecology Database submission | Y | 100% | Not applicable - report not issued |
| **Clinical & Diagnostics** | | | |
| NBS National Comparative Audit of Blood Transfusion programme | Y | 100% | Not applicable – latest report issued relates to 2013 data collection |
| **Women and Children** | | | |
| **Acute Paediatrics** | | | |
| PNDA Paediatric National Diabetes Audit | Y | 100% | Not applicable – report not issued |
| British Society for Paediatric Endocrinology and Diabetes GH National Audit | Y | 100% - | Not applicable – report not issued |

| National clinical audit/programme | Participation Y/N | % Data submission | Actions taken |
|---|---|---|---|
| NNAP Neonatal Audit Programme (Neonatal Intensive and Special Care) Special Care/Neonatal | Y | 100% - Data taken automatically from Badgernet | Not applicable - national data collection ongoing over a number of years |
| Maternal, Infant and Newborn Clinical Outcome Review and Programme now called Mothers & Babies reducing risk by audit & Confidential Enquiries (MBRRACE) | Y | 100% of all relevant cases | Not applicable – report not issued |
| **Urgent Care** | | | |
| **Emergency Medicine** | | | |
| TARN Severe Trauma | Y | 25% | Not applicable - national data collection ongoing over a number of years |
| Vital Signs in Children | Y | 100% | Not applicable – report not issued |
| **Medical Specialties** | | | |
| **Cardiology** | | | |
| HF National Heart Failure | Y | 80% | Not applicable - national data collection ongoing over a number of years |
| MINAP (Myocardial Ischaemia National Audit Programme) | Y | 80% | Not applicable - national data collection ongoing over a number of years |
| **Respiratory** | | | |
| COPD Chronic Obstructive Pulmonary Disease | Y | 100% | Not applicable – report not issued |
| NLCA National Lung Cancer Audit | Y | 78% | Data collection still ongoing (3-5 year period – monthly returns) |
| Emergency Use of Oxygen | Y | 100% of eligible cases | Not applicable – report not yet published |



| National clinical audit/programme | Participation Y/N | % Data submission | Actions taken |
|---|---|---|---|
| **Stroke** | | | |
| SSNAP Sentinel Stroke National Audit Programme | Y | 100% | Reports published every three months. Stroke Coordinator reviews and reports back to internal Stroke Group – actions are then forward from there, e.g.<br>• Increasing number of therapy groups (Physio and OT)<br>• Changed over to an Acute pathway with Greater Manchester so all suspected strokes go to a hyper-acute centre; this has improved thrombolysis rates.<br>• Plans to increase consultant cover from April 2016 with consultants from Stepping Hill Hospital. |
| **Rheumatology** | | | |
| Rheumatoid and early inflammatory arthritis (new NCAPOP audit) | Y | 100% of consenting cases | Not applicable - national data collection ongoing over a number of years |
| **Diabetes** | | | |
| National (Adult) Diabetes Inpatient Audit | Y | 61 cases | Not applicable - report to be published in June 2016 |
| **Allied Healthcare** | | | |
| **Adult Community Therapies** | | | |
| Parkinson's disease (National Parkinson's Audit) | Y | 100% | Not applicable – report not issued |
| SSNAP Sentinel Stroke National Audit Programme | Y | 100% | See previous SSNAP entry |




| National clinical audit/programme | Participation Y/N | % Data submission | Actions taken |
|---|---|---|---|
| **Integrated Care** | | | |
| **Care of the Elderly** | | | |
| National audit of Inpatient Falls (Falls & Fragility Fracture Audit Programme) | Y | 100% | Report published in June but the trust currently has no lead on falls so actions yet to be finalised for ECT. |
| Care of the Dying in Hospital | Y | 48/50 = 96% | Not applicable – national report published 31 March 2016 |

The following national clinical audits were not participated in during 2015/16:

| National clinical audit/programme | Reason for non-participation |
|---|---|
| **Surgical Specialties** | |
| **General Surgery** | |
| Elective Surgery (National PROMS Programme) | N - Participation delayed - will be taking part next year |
| National Complicated Diverticulitis Audit | N - Participation delayed - will be taking part next year |
| **Ophthalmology** | |
| Ophthalmology Database | N - Delayed due to IT issues until 2016/17. |
| **Clinical & Diagnostics** | |
| **Renal Services SLA, Christie SLA, Marie Curie SLA** | |
| Renal Replacement Therapy (Renal Registry) | N - Unable to participate this year due to resourcing issues |
| **Women and Children** | |
| **Acute Paediatrics** | |
| Paediatric Asthma | N - Unable to participate this year due to resourcing issues |
| **Medical specialties** | |
| **Gastro** | |
| IBD Inflammatory Bowel Disease | N – Not participated in the audit in 2015/16 |



| National clinical audit/programme | Reason for non -participation |
|---|---|
| **Diabetes** | |
| National (Adult) Diabetes Adults | N – lack of capacity in the department |
| **Corporate** | |
| **Intermediate Care S&VR** | |
| NCAA National Cardiac Arrest Audit | N - Not participating as our local audit provides beneficial, extensive and quality data for us to use for the purpose of improving patient safety/quality. |
| **Studies not applicable to this trust** | |
| Prostate Cancer | Not applicable to trust – service provided at Stepping Hill |
| NAOGC National Audit of Oesophago-Gastric Cancer | Not applicable to the trust – service provided by tertiary centre |
| PICANet Paediatric Intensive Care Audit Network | Not applicable to the trust - we are not a designated PICA |
| Paediatric Pneumonia | Amended in April 2015 taken out of the National audit programme |
| UK Cystic Fibrosis Registry | Not applicable to trust - Paediatric service decommissioned in East Cheshire / insufficient patient numbers |
| VTE risk in lower limb immobilisation | Not applicable to the trust - not relevant to our practice in ED |
| Procedural Sedation in Adults | Not applicable - we do not have sufficient numbers to participate |
| Non-invasive ventilation | Amended in April 2015 taken out of the national audit programme |
| Adult Asthma | Amended in April 2015 taken out of the national audit programme |
| Adult Bronchiectasis | Not applicable - Amended in April 2015 added to the National Audit Programme – however, the trust had insufficient patient numbers to participate |
| Chronic Kidney Disease in Primary care | Not applicable to the trust – primary care |
| Congenital Heart Disease (Paediatric Cardiac Surgery) | Not applicable – provided by tertiary centre |

| National clinical audit/programme | Reason for non -participation |
|---|---|
| Coronary Angioplasty / National Audit of PCI | Not applicable – provided by tertiary centre |
| National Vascular Registry | Not applicable – provided by tertiary centre |
| Intra-thoracic transplantation (NHSBT UK Transplant Registry) | Not applicable – provided by tertiary centre |
| Liver transplantation (NHSBT UK Transplant Registry) | Not applicable – provided by tertiary centre |
| National audit of Intermediate Care | Not applicable - Auditing body have withdrawn audit |
| Cardiac Rhythm Management (CRM) | Not applicable – provided by tertiary centre |
| National Adult Cardiac Surgery Audit | Not applicable – provided by tertiary centre |
| Pulmonary Hypertension Audit | Not applicable – provided by tertiary centre |



# The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Audits

The following four NCEPOD audits were participated in during 2015/16, with progress reported to Clinical Audit and Research Effectiveness (CARE) Group at each meeting. One report issued in 2015/16 was presented to the CARE group as part of its delegated authority from the Board.

A summary of the NCEPOD studies participated in during 2015/16 is given below:

| NCEPOD Audit Reviewed | Actions and Progress |
|---|---|
| **Studies currently in progress** | |
| Mental health | Not applicable - national data collection ongoing over a number of years |
| Acute Pancreatitis | Data collection now closed. Report due 2016/17 |
| Chronic Neurodisability study | Data submitted |
| Non Invasive ventilation Study | Data submitted |
| **Previous Year Studies where reports have been presented to the CARE group** | |
| Sepsis | Report issued Autumn 2015 – actions identified and reported to CARE group -<br>• Formal teaching for Medical and Emergency Department teams with respect to diagnosis and severity stratification of sepsis, including sepsis terms and the management of sepsis.<br>• Production of portable pocket/badge cards for clinicians outlining the Criteria for severity stratification of sepsis Education of nursing and HCA staff with respect to appropriate investigations required for patients presenting with infection.<br>• Circulation of laminated posters in ED/AAU reminding staff of the required investigations.<br>• Re-audit following action plan |
| Gastrointestinal Haemorrhage | Report issued July 2015, feedback not yet received by CARE group |

*"The nursing care was second to none, care and compassion shown to all patients was outstanding, and teamwork showed that morale was high."*

**- Ward 1**

## Local clinical audits

65 local audits were approved on the forward planner for 2015/16. As at 31 March 2016 the trust had registered 63 local clinical audits across the seven clinical service lines and Corporate Services. This represents 96.9% of the agreed plan.

Progress against the forward plan is monitored at the monthly Clinical Audit and Research Effectiveness Group, which has representation from each of the service lines.

All completed audits are presented to the relevant service line audit meeting and a summary of the outcomes is included in the Clinical Effectiveness update report to the monthly Clinical Audit & Research Effectiveness Group.

### Audit examples of good practice

The following tables give examples of good practice detailing outcomes and actions taken, or planned, as a result of local clinical audits to improve the quality of healthcare provision at the trust.

<table>
<tr><th>Local Clinical Audit</th><th>Outcome</th></tr>
<tr><td colspan="2">Surgical Specialties</td></tr>
<tr><td>Compliance with Surgical Admissions Pro-forma</td><td>The purpose of this audit was to review trust documentation to determine:<br>-Are surgical pro-forma being used?<br>-Are the pro-forma being filled out completely?<br>-Are there any common reasons as to why some people are not using the pro-forma?<br>-Are Acute Kidney Injury (AKI) and Abbreviated Mental Test (AMT) assessments being completed?<br>Summary of results:
<table>
<tr><th>Standard</th><th>Met (%)</th><th>Not Met (%)</th></tr>
<tr><td>Use of surgical admission Pro-forma</td><td>31</td><td>69</td></tr>
<tr><td>AMT completion</td><td>9</td><td>91</td></tr>
<tr><td>AKI completion</td><td>0</td><td>100</td></tr>
</table>
The case notes of all surgical admissions during one working week (5 day) period (from 04/05/15-08/05/15) were also audited. Any elective admissions and referrals from other specialties were counted in total number of patients but notes were not audited. Only patients admitted as an emergency via A&E or GP referral had notes audited. A total of 13 doctors had clerked patients, with four of these doctors having used a pro-forma, the rest had used continuation sheets.</td></tr>
</table>



<table>
<tr><th>Local Clinical Audit</th><th>Outcome</th></tr>
<tr><td>Compliance with Surgical Admissions Pro-forma</td><td>12 patients should have had an Abbreviated Mental Test (AMT) performed on them according to the guidelines (all patients aged 75 years or over should be assessed for any cognitive impairment), but only 1 patient had any documentation of this taking place.<br><br>Conclusions:<br>• Compliance with completion of surgical pro-forma is poor<br>• AMTs are not being completed as they should be<br>• Acute Kidney Injury (AKI) pathways are not being completed<br>• Generally junior doctors do not like to use surgical pro-forma for a number of reasons;<br>- Illogical layout<br>- Not enough space to write or expand on “tick boxes”<br>- Cluttered<br>- Design makes it difficult to read documentation<br>• Positive comments about the pro-forma include;<br>- Good aid memoir, especially when starting surgical rotations<br>- Easy to locate within patient notes</td></tr>
<tr><td colspan="2">Actions Identified:<br>The surgical pro-forma should be re-designed in order to meet the needs of the junior doctors using the pro-forma. It should include any required CQUINs and required information set out by the trust. There should be communication to junior doctors to inform them that the need to use the pro-forma, so that compliance is improved and in line with compliance of use of medical pro-forma.</td></tr>
<tr><td>Audit of NICE Quality Standard Drug Allergy: Diagnosis and management</td><td>The purpose of this audit was to review trust prescribers’ documentation of medication allergy/ management of allergic reaction to those standards recommended by both NICE and trust policy. The results showed that we were not compliant with current documentation standards. Also with regards to clinical care of those patients who had suffered an anaphylactic reaction, none were referred to the Greater Manchester Rapid Access Anaphylaxis Clinic (GMRAAC) nor issued with an Epi-pen at discharge, as per trust guidelines and NICE guidance.</td></tr>
</table>

| Local Clinical Audit | Outcome |
|---|---|
| **Actions Identified:**<br>• A structured assessment guide to be produced on drug allergy available as a guideline on the clinical guidelines<br>• Include an article in the Safety Matters Newsletter to remind clinical staff or the importance of using the alert stickers, updating the alert page and recording allergy status on the discharge notification to GPs.<br>• Dissemination of the audit results and raise awareness of standards for allergy documentation and referral process to Greater Manchester Rapid Access Anaphylaxis Clinic (GMRAAC)<br>• Updating the medical and surgical admission pro-forma to include allergy/adverse medication reaction/sections and tick box to indicate that alert sticker and alert information page has been updated. | |
| Clinical & Diagnostics | |
| Self-Medication of Herbal Preparations in Out Patients | The aim of the audit was to establish the clinical significance of any interactions between prescribed & herbal medications and to compare the incidence of herbal medicine use in the local population with that in the literature. Also to ascertain whether patients disclosed information regarding HM use to their prescriber or did the prescriber enquire.<br>The results showed the incidence rates were largely similar (26% in the audit vs. 30% in the literature). There was also found to be a low level of prescriber enquiry into HM use. One serious interaction between HMs and conventional medicines was identified amongst the participants. |
| **Actions Identified:**<br>• Distribute the audit results via the usual trust channels to encourage prescribers to enquire about herbal medicines and patients to divulge their own herbal medicines use.<br>• Develop posters to display in outpatient areas to increase awareness of the risks associated with herbal medicines. | |
| Reducing harm from omitted and delayed medicines | The trust has declared compliance with NPSA/2010/RRR0009. This audit was to review if the trust remains compliant with National Patient Safety Agency (NPSA) recommendations. Objectives: To carry out a point prevalent audit to review drug charts in all ward areas and collect data regarding omitted doses. |



| Local Clinical Audit | Outcome |
|---|---|
| Reducing harm from omitted and delayed medicines | This audit shows that omitted doses occur frequently on wards. This is contrary to the data collected on the monthly nursing metrics. Omission of doses can cause serious harm to the patient resulting in longer inpatient stays and slower recovery. On the wards, the majority of omissions are accompanied by a valid reason code but approximately one in six omissions have either no reason code or use the code '6' unaccompanied by a reason. This shows that improvement needs to be made to demonstrate a good level of documentation of drug charts by nursing staff in line with the standards set out by the trust in the Safe and Secure Handling of Medicines policy. |
| **Actions Identified:**<br>• A 'Timeliness of Medicines Administration' poster is displayed in all ward areas<br>• Nurses should be made aware of the results of the audit and should be aware of the medicines management standards required by the trust<br>• Ensure communication is clear to pharmacy teams when medication is required urgently. Encourage wards where limited pharmacy cover available, to bleep their pharmacy team if medications are newly prescribed and unavailable.<br>• Print posters displaying the results of this audit so that they can be distributed to each ward and include results in trust Safety Matters Newsletter<br>• Re-audit missed and omitted doses at Macclesfield District General Hospital in 12 months<br>• Use highlighter pen to 'highlight' any missed doses when reviewing drug chart<br>• Ensure escalation of issue where a medicine has been omitted more than once i.e. inform the prescriber/ ward pharmacist. The reason why this has been happening should be investigated and appropriate action taken. | |
| Women and Children | |
| Feverish illness in children under five years | The aim of the audit was to establish if the NICE guideline on feverish illness in children (CG160) is being followed in the department. Out of the 17 standards, 15(88%) were met 100% of the time. Full set of observations was not recorded in one patient. Lumbar puncture was performed before the administration of antibiotics – 50% (1/2).This was a child in status epilepticus. Five of seven children (71%) who needed parenteral antibiotics received third generation cephalosporins. The other were treated appropriately according to our antibiotic policy(IV Amoxicillin for Pneumonia) |




| Local Clinical Audit | Outcome |
|---|---|
| Feverish illness in children under five years | The conclusions were:<br>• Only one child under six months in the audit<br>• Focus was clear after further history and examination<br>• From examination of data – children with TRUE unknown cause – had all tests<br>• All patients to have vital signs taken and recorded |
| **Actions Identified:**<br>• More training opportunities for junior members of clinical staff<br>• Consider development of A+E direct referral pathway <3 months<br>• Vital signs to be recorded by all nursing staff | |
| Vaginal Birth After Caesarean (VBAC) Re-audit | An audit was undertaken to ensure that the maternity service has an approved system for improving care and learning lessons relating to the care of all women who have a vaginal birth after a caesarean section that is implemented and monitored. The audit was a local audit. In order to monitor compliance for CNST Standard 2:10 Vaginal Birth after Caesarean Section, a monthly retrospective audit was undertaken in line with the NHS Litigation Authority CNST Maternity Standards 2013/14 Standard 2 Criterion 10.<br>Areas of good practice:<br>19/19 (100%) had a VBAC pro-forma in the notes<br>Areas for improvement:<br>5/19 (26%) did not have a documented plan for the place of labour<br>9/19 (47%) the woman was not advised re IV access in labour<br>6/19 (32%) did not have a plan if labour commenced early<br>7/19 (37%) did not have a plan if pregnancy prolonged<br>8/19 (42%) did not have a documented plan for the monitoring of the fetal heart in labour |
| **Actions Identified:**<br>• To ensure that middle grade/consultant obstetricians document an individual management plan for labour in compliance with unit guidelines ECNHST Vaginal Birth After Caesarean Section<br>• To ensure that middle grade/consultant obstetricians documented plan for the monitoring of the fetal heart in labour in compliance with unit guidelines ECNHST Vaginal Birth After Caesarean Section | |



| Local Clinical Audit | Outcome |
|---|---|
| **Urgent Care** | |
| Severe Sepsis | Awaiting further details |
| **Actions Identified:**<br>Awaiting Further details | |
| **Medical specialties** | |
| NICE CG109 – Transient Loss of Consciousness | The aim of this audit was to review the initial assessment process of patients presenting to A&E, AAU and MAU with transient loss of consciousness. The audit concluded that physicians had difficulty in differentiating between the different types of syncope, situational, reflex, vasovagal. Although most patients received appropriate investigations, the history taking needed to be improved as this is what will guide further management. Physicians did not use the ambulance sheet to assess patient's observations on presentation which is a valuable data source. |
| **Actions Identified:**<br>Clarification if A&E are currently using a syncope pathway as some doctors in the audit presentation believed there is one available. It will also need to be established if this follows NICE CG109 recommendations. | |
| Re-admissions Audit | The purpose of this audit was to identify any actions that could have prevented the readmission by any provider. As readmissions can be indicative of ineffective patient care, it is of high importance to ascertain those cases that were preventable and those deemed clinically unavoidable. Completion of the audit builds upon the Nanthealth pilot which took place on Ward 4 between June 2014 and October 2014. The aim of this initiative was to decrease readmission rates by identifying and targeting patients at high risk of readmission. For those patients identified, initial acute treatment was optimised and tailored care applied thereafter within the community. Completion of the audit revealed that 17 readmissions from an examined total of 47 were found to be preventable or possibly preventable. This equates to 31% of the sample. Community involvement or earlier community involvement could have prevented seven readmissions. A number of other reasons were noted for the remaining 10 readmissions, although no consistent theme was present throughout them. Poor quality eDNFs were identified in four cases. It is important to review these findings in the context of the small sample size i.e. 72 patients, which represents 3% of all readmissions for last year. |

| Local Clinical Audit | Outcome |
|---|---|
| **Actions identified:**<br>• Pathways of care must be established that utilise a case management approach to ensure that upon discharge from hospital, patients are followed up in the community in a timely way. This can link with the work being progressed for STAIRRS and integrated health and social care teams.<br>• Clinical eDNF training (including online and/or video) to be established to ensure that junior doctors are supported and trained in the writing of the eDNF.<br>• eDNF format to be re-designed. Initially this will focus on expanding the character limit applicable to free text boxes.<br>• Future annual readmission audits to consider sample size of 100 cases. | |
| **Allied Healthcare** | |
| Physiotherapy Patient Outcomes Audit 2015 | The aim of the audit was to establish the overall wellbeing of patients at initial assessment and then at discharge following a course of treatment. The audit covered a six month period and the patients were either GP or orthopaedic referrals.<br><br>The overall total outcome for the four sections audited for the 62 patients was a 26% increase in their quality of life, with improvement in their impairment, activity, participation and wellbeing. However, if the 66 patients' score who showed no movement and stayed the same because they had no issues in the four areas audited are discounted, then this equates to 40% improvement for patients in their quality of life. |
| **Actions Identified:**<br>• An action plan for this audit is still being developed | |
| **Integrated Care** | |
| Discharge Checklist Audit | The aim of the audit was to ascertain the level of acute adult ward compliance with East Cheshire NHS Trust Discharge Policy 2015 and NHSLA risk management standards in relation to the completion of the electronic discharge checklist. To compare all acute audit wards with the completion of the electronic discharge checklists and identify which wards may require support to achieve this. |



| Local Clinical Audit | Outcome |
|---|---|
| Discharge Checklist Audit | The findings of the audit were: -<br>• No wards apart from Ward 2 (small sample) consistently completed the discharge checklist<br>• Wards are not completing the discharge checklist for all patients who are discharged<br>• The frequency is inconsistent<br>• Patients and the trust insurance status is put at risk because there is no evidence of some ward discharges meeting the trust standards. |
| **Actions Identified:**<br>• A directive is required from senior management at the trust to matrons, ward managers and ward nurses advising them of the importance of completing the electronic discharge checklist in relation to patient safety and governance within the trust<br>• Wards should introduce cascade training and refresher training for all staff regarding the use of the bed management system and electronic discharge checklist<br>• Wards should ensure that all staff including bank and agency are aware of the need for a checklist to be completed<br>• A register should be kept by ward to evidence this training<br>• Ward should be responsible for performing their own audits to monitor compliance<br>• Any future audits should use random week samples from PAS for all wards rather than using Discharge and PAS<br>The potential outcome for improvement is:<br>• Improved patient experience<br>• Improved patient safety<br>• Compliance with NHSLA | |
| Diagnosis of Urinary Track Infections in the elderly patient | The aim of the audit was to ascertain if patients over the age of 65 are being diagnosed with UTI and also to ascertain whether there is an overreliance on urine dipstick use in making the diagnosis as SIGN advise that urine dipsticks should not be used to make a diagnosis of UTI in patients over the age of 65.<br>The audit concluded that:-<br>a) Patients over the age of 54 are being inappropriately diagnosed as having UTI.<br>b) Systemic inappropriate use of urine dipsticks to make the diagnosis by nurse and doctors across A&E and the medical wards. |

*"At my first appointment it would have helped the physio if they had more background info on me and my injury."*

**- Community physio**

| Local Clinical Audit | Outcome |
|---|---|
| Diagnosis of UTI in the elderly patient | c) Serious diagnosis were being missed as it was assumed the patient's symptoms were due to UTI.<br>d) Cases of C-diff and renal injury caused by inappropriate use of antibiotics in asymptomatic bacteria. |
| **Actions Identified:**<br>The recommendations included that urine dipsticks should only be used to exclude a UTI when diagnosis unclear and to stop the practice of dipping every patient's urine on admission to hospital or between ward transfers. In addition it was recommended that a UTI diagnostic pathway be designed. | |
| **Corporate** | |
| Re-admissions Audit | The purpose of the audit was to examine the reasons for the re-admission and whether it was related to the original reason for admission. The audit revealed that 31% of cases examined were thought to be preventable or possibly preventable. It is important to review these findings in the context of the small sample size i.e. 72 patients (3% of all re-admissions for 2014-15 year). The audit has shown that more effective communication and planning between hospital and community/primary care services could have a positive impact on readmission rates. This also incorporates processes and systems for discharge documentation which could be improved. |
| **Actions Identified:**<br>There were four recommendations from the audit:<br>• Pathways of care must be established that utilise a case management approach to ensure that upon discharge from hospital, patients are followed up in the community in a timely way. This can link with the work being progressed for STAIRRS and integrated health and social care teams.<br>• Clinical eDNF training to be established to ensure that junior doctors are supported and trained in writing of the eDNF.<br>• eDNF format to be re-designed. Initially this will focus on expanding the character limit applicable to free text boxes.<br>• Future annual readmission audits to consider sample sizes of 100 cases | |
| Annual Unified Do Not Attempt Cardio-pulmonary Resuscitation (uDNACPR) | The objective for the audit was to measure compliance against the uDNACPR Adult Policy following the recommendations made in the previous audit. |



| Local Clinical Audit | Outcome |
|---|---|
| Annual Unified Do Not Attempt Cardio-pulmonary Resuscitation (uDNACPR) | Conclusions:<br>• Overall this audit demonstrates relatively good compliance with the uDNACPR Adult Policy some aspects do however require significant improvement<br>• A summary of communication with the patient, or with the patients' relevant other, or details as to the reason communication cannot take place, needs to be significantly improved. An improvement regarding consultant review/ endorsement within the designated timescale (i.e. before the end of the next day) needs to be made<br>• Clinicians need to improve compliance with completion of the 'review' section.<br>• A significant improvement needs to be made in relation to ensuring the registered nurse responsible for the patient's care is informed of the decision and signs the uDNACPR Order in the relevant section, i.e. under the 'other' section<br>• An improvement needs to be made regarding filling in the uDNACPR Order completely and ensuring an entry detailing the uDNACPR decision is made in the medical notes. This entry must include details of discussion with the patient and/or relevant other or reason(s) as to why such discussions could not take place. |
| **Actions identified:**<br>• Audit report dissemination to all those identified as; 'Issued to for action' and/or 'Issued to for Information' due to lack of awareness.<br>• Escalation of poor compliance areas with the uDNACPR policy to the Medical Director<br>• Close liaison with Resuscitation Committee and clinical tutors if any issues related to uDNACPR arise<br>• Information regarding uDNACPR decisions included in training courses to raise awareness e.g. Basic Life Support, Immediate Life Support, Junior Doctors Induction<br>• New doctors to receive clarity on the uDNACPR policy through trust website. This will be reinforced at every opportunity during the Junior Doctor Resuscitation Update Sessions<br>• Nursing staff to be informed that signing and dating uDNACPR orders is mandatory at all uDNACPR training events<br>• uDNACPR Leaflets to be made available in all clinical areas | |

# 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. It provides patients with opportunities to participate in trials, and it also meets the obligations set out in the NHS Constitution that research is core business for the NHS.

Our clinical staff stay abreast of the latest treatment possibilities and active participation in interventional research can provide patients with access to treatments that are not yet widely available.

For the financial year 2015/16, 513 patients have been recruited to 39 studies. Currently there are 55 studies open to recruitment at trust. Of these, 21 studies are interventional. As well as this there are a large number of studies that are closed to recruitment but follow-up data is still being collected (e.g. survival status in oncology trials).

The trust is currently involved in clinical research studies of which the majority are National Institute for Health Research (NIHR) portfolio studies covering a variety of specialities including: stroke/cardiovascular, oncology, rheumatology and paediatrics.

The table below gives examples of the studies undertaken at the trust.

| Research Area | Aims and Achievements of the Study |
|---|---|
| **Surgical Specialties** | |
| **Surgery** | |
| ROCSS | ROCCS is a randomised controlled trial of the placement of a biological mesh at the site of stoma closure. The hypothesis is that reinforcing the stoma closure site with a collagen mesh (Strattice®) is superior to the standard technique in preventing herniation at two years.<br>Patient outcomes will be followed-up for the next two years. |
| National Complicated Diverticulitis Audit | N - Participation delayed - will be taking part next year |
| **Clinical Support & Diagnostics** | |
| **Oncology** | |
| FOAM | A phase III randomised study of folic acid supplementation in the management of menopausal symptoms in cancer survivors and healthy postmenopausal women. This study opened at the end of 2015 and so far several healthy volunteers and one cancer survivor have participated. A reduction in hot flushes has been reported already by participants despite the short treatment phase so far. |
| **Women's and Children's** | |
| **Paediatrics** | |
| PREDNOS-2 | Steroid sensitive nephrotic syndrome (SSNS) is the commonest kidney disease of childhood. Large amounts of protein are leaked into the urine resulting in generalised oedema (swelling). Treatment is with high dose oral prednisolone, a steroid drug which is effective, though associated with a number of serious side effects. Following successful initial treatment, 70-80% of children develop relapses where leakage of protein into the urine recurs. Three previous small studies have suggested that the use of a short course of daily prednisolone at the time of URTI reduces the rate of disease relapse.<br>The PREDNOS 2 study aims to determine whether the use of such therapy effectively and safely reduces the rate of relapse in a large population of UK children. We will randomise 300 children with relapsing SSNS to receive either 6 days of daily prednisolone or continue unchanged on their existing therapy (the current standard of care) each time they develop a URTI over a 12 month period. We will assess the incidence of URTI related relapse of nephrotic syndrome in both study arms and look carefully for side effects of treatment. |
| **Medical Specialties** | |
| **Stroke / cardiovascular** | |
| PATHWAYS | Improving the effectiveness of psychological interventions for depression and anxiety in the cardiac rehabilitation pathway. Pulmonary Arterial Hypertension (PAH) is a devastating condition with distressing symptoms. It can cause early death and treatment is very expensive. Quality of life is poor for these individuals and research has found high levels of depression, anxiety and panic. Symptoms of anxiety and panic (such as breathing difficulties) mimic symptoms of PAH. This means that patients are using more NHS services and medications for their psychological, rather than their physical symptoms. To investigate the effect of an 8-week Mindfulness-Based Stress Reduction (MBSR) programme compared to treatment as usual (TAU). We hope that MBSR will improve: 1) Psychological outcomes: anxiety, depression, quality of life; 2) Physical outcomes: disease progression and the stress hormone cortisol; 3) Reduce use of NHS resources, therefore saving money. Six patients so far have participated in this research at Macclesfield. |

| Research Area | Aims and Achievements of the Study |
|---|---|
| **Service Line 6 – Allied Health Services** | |
| **Physiotherapy** | |
| MSK-HQ | Validating the Arthritis Research UK Musculoskeletal Health Questionnaire (MSKHQ). The main aims of this study are to assess the validity, reliability and responsiveness of the MSKHQ when used in patients with musculoskeletal problems.<br><br>Consenting individuals recruited from physiotherapy clinics were asked to complete a questionnaire containing: clinical descriptive characteristics (e.g. age, gender, work status, and main presenting problem such as back, knee or shoulder pain), along with the MSKHQ and an existing validated quality of life measure (EQ5D5L). In order to examine test retest reliability when patients returned for their second consultation (typically a week or two later) they completed the MSKHQ again. |



## Our staff commitment to quality - 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"*

## Quality Strategy 2016-17

The Quality Strategy supports our pledge to provide safe, effective and personal care which will be the best care delivered in the right place for patients. This will effectively move some patients away from hospital care into more appropriate clinical settings demonstrating our commitment to integrated care and partnership working to achieve the trusts vision and objectives.

For East Cheshire NHS Trust, quality encompasses four elements:

- Harm-free care - care that is safe
- Integrated care - care that is co-ordinated and based around individual needs
- Improving outcomes - care that is clinically effective
- Listening and responding - care that provides a positive experience for patients, carers and families

The strategy is designed around these principles and our aspirations, building on existing work that the organisation and staff have undertaken and sets out the priorities for the period 2015 - 2019.

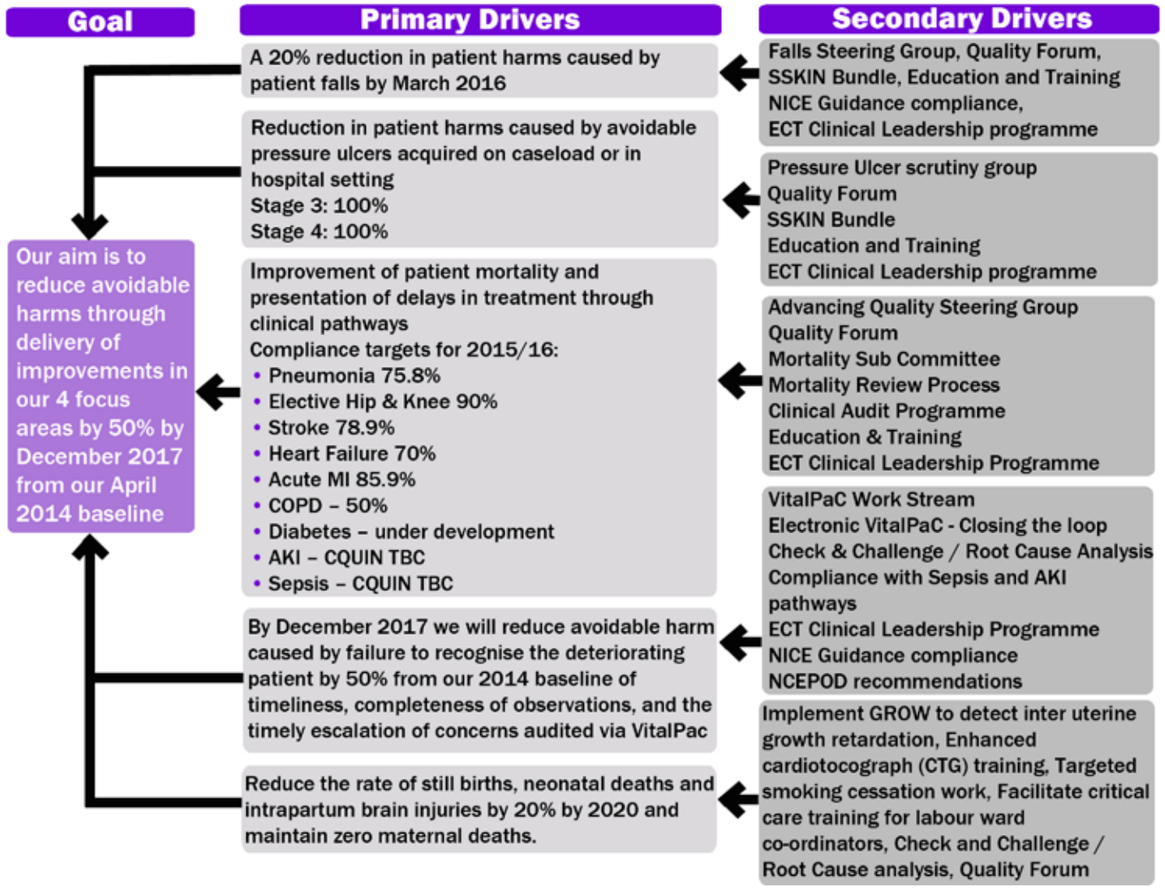
Our focus is on helping people to stay healthy and independent by providing support and services at the right time to prevent ill health and maintain quality of life. This approach of prevention and early intervention will help people maintain control of their lives, promote wellbeing and decrease their dependency on care services.

We aim to strengthen out of hospital care empowering more patients to receive the right care for them in their own homes or domiciliary setting. For patients who do require hospital care we will ensure an appropriate length of stay for their clinical care and support a safe discharge process. This care will be joined up by working alongside our commissioners, social care and other providers ensuring that we place the patient at the centre of all that we do.

For those people who need care services as they grow older these services will be provided to offer patient choice wherever possible, allowing them to maintain dignity and respect and enable people to return to independence in their daily lives. The aim is therefore to provide as much care out of hospital as possible designing and improving services that build on work already happening in community and practice settings. We will strengthen our professional leadership, motivating our staff to lead and deliver quality care.

We will continue to contribute to the public health agenda engaging families and carers in preventing ill health.


## Sign up to Safety




## Our Quality Priorities 2016-17

The Trust Quality Strategy was refreshed in 2015 and sets out the quality priorities 2015-2019, this supports the Clinical Services Strategy which aims to ensure delivery of the best care in the right place for patients. Quality priorities and achievements against objectives are reported through SQS Committee and quarterly Trust Board updates.

### Harm-free care

Continuing with the Sign up to Safety initiative focusing on further reduction in Pressure Ulcers and falls with harm, improved management of the deteriorating patient and mortality and the reduction in the rate of still-births, neonatal deaths and intrapartum brain injuries.

### What will we do?

- In line with our Sign up to Safety commitment to reduce patient harm caused by falls, we will continue to develop our local policy and strategy. The focus will be on improving practice and care in line with NICE guidance. This work will focus on how those patients most at risk are identified and assessed to reduce their risk of falls.

- Continue the roll out of care bundles – SSKIN to ensure patients receive an appropriate, consistent and personalised care plan, also be supported by the roll out of the revised nursing documentation on adult inpatient wards

- We will continue to review every hospital death to ensure the care provided was to the expected standard. We will use the findings to strengthen clinical practice and improve the care and treatment of our patients

- We will continue to work to a zero tolerance for MRSA bacteraemia and towards a reduction in avoidable CDiff. We are participating in a national IPC project. We will focus on improving the isolation of patients with infections and support the decision making process

- Continue to focus on ward cleanliness working with the contracted providers to ensure it meets infection control standards

- We will implement the Houdini initiative which is a standardised approach to support the early removal of urinary catheters which are no longer required , reducing the patients risk of infections

- Continue to improve our understanding of safe staffing levels required to match patient dependency and develop system to capture care contact hours as defined within the Carter report.

- We will review the outcome results of the community safer nursing care tool and use to influence and support future staffing levels and skill mix within this setting. We will also agree future monitoring schedule for community nursing teams

- Following the introduction of the Safety Matters newsletter, this will be further developed to be used as a training and communication tool in relation to medication incidences supporting a reduction in errors




## Integrated care

Many people who have complex care needs receive health and social care services from multiple providers and in different care settings, without appropriate co-ordination or holistic perspective. If services aren't well coordinated and based around an individual's needs, it can lead to:

- Confusion
- Repetition
- Delay
- Duplication and gaps in service delivery
- People getting lost in the system

Our aim is to develop effective partnerships and new ways of working within an integrated care system.

### What will we do?

- We will continue to work towards caring for people in their own home, where it is safe and appropriate to do so with teams which are working in a co-ordinated way to make this happen. We will ensure that patients who require an assessment of their care needs will undertake this as a single process with no need for repetition to different care providers.

- Building on the successful team working already in place we will equip our staff with the necessary knowledge and skills relevant to their role through the delivery of innovative development programmes and training.

- We will focus on delivering high quality clinical training supporting our new starters and existing staff to acquire the competencies they need and developing new skills and capabilities as they progress.

- We will develop fit for purpose induction and preceptorship programmes and support our assessors and mentors to fulfil their responsibilities.

## Improving outcomes

We are a learning organisation that is committed to continuous improvement. Our aim is to provide the best possible evidence based care.

### What will we do?

- We will continue to develop the clinical competencies for nursing and AHP staff. In addition we will review the skill mix within the adult ward areas responding to local and national recruitment/retention challenges, as part of this we will benchmark, review and consider the development of other roles to support staffing.

- We will develop and agree a data set and range of outcome indicators for community services as we move towards more integrated service provision.

- Continue to work with partners to develop quality outcomes for integrated community services developing a process to monitor clinical effectiveness of services.

- The trust has been selected to participate in an early implementor programme for the development of 7 day working. This work will be undertaken in conjunction with other agencies across the health economy.

- We will continue to work with partners on the development of the electronic Cheshire Care Record.

- We will continue with a planned Clinical Audit programme to support improvement of quality outcomes highlighting areas of best practice across the organisation.

- We will continue to evaluate and monitor ourselves against NICE standards to ensure we are using evidence based practice that meets the expected standards.

- As a signatory to the Dementia Friendly Hospital Charter, we will focus on dementia through initiatives including the dementia care bundle and further embedding of the Patient Passport. This will be further reinforced by an ongoing review of patient documentation across both community and hospital settings to support the move to mobile working in all clinical areas.

## Listening and responding

Further work will be undertaken improving carer involvement. This will continue to build on the success of the Haelo project and also a review of the visitors policy to develop a "Welcome "policy based on the principles of John's Campaign.

### What will we do?

- We will continue to build on the existing work undertaken with the National Autistic society supporting individuals with Autism who use our services.

- The Dementia Care bundle will be rolled and evaluated, work will continue to further develop and improve - reasonable adjustments/Patient Passports

- The trust will continue to raise awareness with partner agencies in relation to female genital mutilation and child sexual exploitation, supporting national initiatives, training and advising frontline staff.

- We will continue to seek solutions from patients and outside agencies in relation to making sure the discharge process meets the needs of patients/ carers. A number of engagement events will continue to take place, including linking in with care/nursing home colleagues.

- Feedback from patients from local surveys has highlighted themes relating to noise at night, access to televisions and Wi-Fi and food and cleanliness. The NHS Family and Friends Test has further highlighted length of waiting times, the wait for discharge medications and car parking.

- The existing visiting policy will be reviewed and a welcome policy will be developed.

- The trust recognises that access to internet is a priority for a number of our patients during their hospital stay and we will work towards the implementation of a Wi-Fi service.

- Time to Go Home campaign continues, this will focus on ensuring patients are supported through their care pathway in a timely and effective way, reducing any unnecessary time in hospital.



- We will continue to recruit staff who share our values, who are caring and compassionate to ensure we deliver the right care, first time, every time.
- Our approach will bring staff together from across the organisation, working with individuals and teams to lead on quality initiatives. We will work with our clinicians to further strengthen the relationship between clinical staff and managers with a shared focus on improving patient and staff experience.

## Staff Survey

The trust undertook a full survey of trust employees for the annual NHS Staff Survey, which was conducted between September and December 2015. This year, our response rate was 39%, an increase of 5% compared with the previous year . When compared with acute and community trusts, we compared favourably regarding:

- Staff believing their roles makes a difference to patients
- Equal opportunities for pay progression 87%
- Staff experiencing discrimination
- Staff able to contribute to improvements at work
- Staff feeling pressure to attend when feeling unwell

We compared less favourably in the following areas:

- Staff suffering work-related stress
- Staff reporting good communication between managers and staff
- Staff experiencing harmful errors, near misses or incidents in the last month
- Staff satisfaction with resourcing and support
- Effective team working

2% of staff who responded to the survey have experienced harassment, bullying or abuse from staff in the last 12 months.

The trust will work with our staff to ensure we address areas of improvement to staff working lives, health and wellbeing.

## Statements of assurance

A proportion of the income received at East Cheshire NHS Trust in 2015/16 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 2015/16 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 2015/16 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 NHS Eastern Cheshire, NHS South Cheshire and NHS Vale Royal clinical commissioning groups and Healthwatch can all be found on the following pages.



NHS
Eastern Cheshire
Clinical Commissioning Group

# East Cheshire Trust (ECT) Quality Account 2015/2016 commentary on behalf of Eastern Cheshire Clinical Commissioning Group (ECCCG)

NHS Eastern Cheshire Clinical Commissioning Group (ECCCG) welcomes the opportunity to comment upon the East Cheshire NHSTrust (ECT) Quality Account for 2015/2016. ECCCG have reviewed the content and believe this document to be an accurate account of ECT's position.

ECCCG is the commissioner for the majority of services that East Cheshire NHS Trust provides and this includes both community services and acute services. The trust is also still engaged as a key stakeholder within the transformation of care programme in Eastern Cheshire; The Caring Together Programme.

The trust's Quality Account demonstrates overall compliance with national prescribed statutory and mandatory obligations. We have made this assessment from both our review of the document, and from ongoing assessment of services through year. To ensure that the CCG is kept regularly updated the trust provides a performance report to inform the CCG as to the quality of services on a monthly basis.

The trust has again faced serious challenges with sustained pressure on services which include the achievement of the A&E 4 hour target and the 18 Week RTT I complete pathway Treatment Standard. The trust has faced challenges around staffing and retention over the previous year and this has had an effect upon some of the measures and their performance, coupled with winter pressures and a lack of bed capacity the trust has had issues with patient flow. Delayed Transfers of Care have seen an increase over the year from the previous position and the trust is working with stakeholders from across the health economy to address this issue.

The trust has made good progress with some of the elements of the 'Sign up to Safety' campaign through the successful launch of the SKKIN bundle the trust has reduced the number of grade 3&4 pressure sores across both the hospital and community setting. The programme has led to greater knowledge and skills for the staff and provided them with the skills to reduce the prevalence of pressure sores.

The trust continues to seek feedback from its patients to enable them to make positive changes to its services through improvement projects. The CCG commends this work but would like to see this as a high priority for the coming year. The CCG recognises the need to involve patients and carers with their care needs and this can only be done by engaging and listening to patients.

The CCG welcomes the priority areas identified by the trust to improve upon quality and quality outcomes through the development of the new quality strategy which we look forward to working with the trust on.

**Draft to be updated 11 May**

## South Cheshire and Vale Royal CCGs

**Comment requested not yet received.**



## ECT Response to Quality Account 2015/16

Healthwatch Cheshire East welcomes the opportunity to comment on the East Cheshire NHS Trust (ECT) Quality Account 2015/2016.

Healthwatch Cheshire East acts as the champion for the voice of the consumer and as such our comments and views on this report focus on how ECT have involved and listened to their consumers views (patients and their families).

We acknowledge the positive response from the trust to recommendations from our enter and view reports and how things have now changed for the benefit of patient experience. We would also like to acknowledge the importance the trust have with regard to PLACE visits and improving the patient experience; we are pleased to contribute to this aim as key partners. A note of contribution from Healthwatch in the report would highlight this relationship very well and demonstrate the positive working relationship we have.

Healthwatch Cheshire East has received many positive stories from the community praising the treatment and care received from the staff and volunteers at the trust. We recognise that the trust and the services it delivers are valued by the local community.

We welcome the recognition and importance the trust has placed on patient involvement and utilising patient stories to improve service delivery. Within the Quality Priority for 2015/2016 , 'Listening and Responding', we have seen a very positive response to patient requests for contact with regard to their negative experiences and the trust have been very effective in resolving them. The response to our Autism report from ECT was incredible in outlining how you will strive further in improving the experiences of people with autism and their carers.

Healthwatch Cheshire East has received comments from patient and carers experiencing complex care needs and how they receive health and social care services. We are keen to work together with ECT, the CCG and health and social care services to strive towards an holistic service and to support the navigation of integrated care in order to reduce delay, confusion and duplication for the patient and carer by working together to identify gaps in services.

We recognise that there have been significant challenges for the trust during 2015/2016 and value the relationship that Healthwatch Cheshire East and the trust have.  We look forward to continue working with the trust during 2016-2017 to enable our community to have a powerful voice helping to shape and improve these services for the future.

# Overview and Scrutiny Committee



## Glossary

**A+E** - Accident and Emergency
**AKI** - Acute Kidney Injury
**ACS** - Acute Coronary Syndrome
**AQ** - Advancing Quality
**AMi** - Acute Myocardial Infarction
**AMT**- Abbreviated Mental Test
**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
**Datix** - Internal incident reporting system
**DNACPR** - Do Not Attempt Cardiopulmonary Resuscitation
**DVT** - Deep Vein Thrombosis
**ECT** - East Cheshire NHS Trust
**ECNHST** - East Cheshire NHS Trust
**ED** - Emergency Department
**EDNF -**
**GP OOH** - GP Out of Hours Service
**FFT** - Friends and Family Test
**FT** - Foundation Trust
**GP** - General Practitioner
**HITS** - Home Intravenous Therapy Team
**IPC** - Integrated Personal Commissioning programme
**IV** - Intravenous
**LINkS** - Local Involvement Networks
**L+D** - Learning and Development
**MAU** - Medical Admission Unit
**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
**PAS** - Patient Administration System
**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
**SSKIN** - A five step model for pressure ulcer prevention
**STAIRRS** - Short Term Assessment, Integrated Response and Recovery Service
**TARN** - Trauma Audit and Research Networks
**TDA** - Trust Development Authority
**UTI** - Urinary Tract Infection
**VTE** - Venous Thromboembolism
**VV** - Varicose veins

**All images in this document are original photos are of trust staff and patients. Thanks to all who have given permission for us to use these images.**

**If you require this document in another language or format (including easy read and audio) please contact us using the details below:**


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

**By telephone**
01625 421000 - main trust switchboard
01625 661184 - Communications Department

**Via our website**
www.eastcheshire.nhs.uk

**By fax**
01625 661000

**@EastCheshireNHS** **@Echonhscharity**