East Cheshire NHS Trust

Quality Account 2014/15

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Foreword

East Cheshire NHS Trust is totally committed to providing ***the best care in the right place*** and while we remain focused on improving quality, delivering safe, effective, personal care with dignity and compassion and can demonstrate this in many ways, there is more to our vision and aspiration.

To ensure we deliver what our patients tell us they want and to meet commissioner expectations, we need to offer greater accessibility to a wider mix of health professionals that go beyond support when people are ill. As a trust, we have invested more in integrated care, community care and out-of-hospital care, expanding services and laying the foundations for better ways of delivering care. It is also noted following our commissioners' comments that the trust recognises the work carried out in respect of adult safeguarding. We have continued to invest in new technologies which increasingly enable clinicians and care workers, affording more time to care.

While this is entirely in keeping with our plans, we must raise our ambitions further. We must work differently to best deploy our resources, our people and our passion for great services and care. By doing so, we will reach more of the people we serve as part of an NHS that does not recognise organisational boundaries, though does reward consistently good clinical outcomes and patient experiences. This is at the heart of our own clinical strategy and partnership work- Caring Together in the East of Cheshire, Connecting Care in South Cheshire and Vale Royal, together with the impact of Healthier Together and healthcare devolution in Manchester - a Greater Manchester commissioning initiative that we have embraced alongside our Southern Sector Partnership trusts.

We were the focus of a Care Quality Commission (CQC) inspection this year, which rated the quality of a range of our services across each of five domains. I was pleased and proud that the trust was recognised as 'good' for care consistently across all areas assessed. The CQC's report also pointed out many areas of best practice, which should provide assurance to those using our services. That said, overall, we have been rated as 'requires improvement', recognising there are areas of inconsistency in our service which we need to put right. Over the next few weeks and months, we will place focus here to ensure when reassessed, we move this rating to 'good' as a minimum, aiming for the best of the CQC's four rating grades, 'outstanding'.

Examples of recognised good practice include:

- our community dental service team and the oral hygiene education programme that is helping to improve children's oral health, in addition to responding positively to those with special needs;
- Good multidisciplinary team and agency working supported by good communication between teams, agencies and at handovers between staff which supports seamless care; discharge planning which is responsive to patients' wishes;
- Community Parkinson's nurses offering an 'in-reach' service for ward-based patients, sharing expertise;
- expansion of the home intravenous therapy service which supports early discharge; anticipatory pain relief prescribing for patients receiving palliative care to ensure a speedy response to their condition.

I was also pleased that during the year, those with cancer were assured they were receiving some of the best care and support in England when the trust was again placed in the top five service providers nationally, by patients, in a Macmillan Cancer Support league table measuring patient experience.

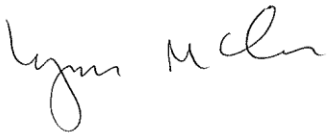
These examples evidence the trust's drive to deliver personalised care and services for patients and you can see more examples throughout this report.

Patient stories are key to this learning organisation and while we receive many accolades, we know there is always room for improvement. Our assurance framework underpins the recent introductions of new legislation, regulations and fundamental standards which makes clear individual and Board responsibility for a high standard of patient care. Central to these are the support for those to speak out, a Duty of Candour and assurances of fit and proper persons.

United by common values, the trust's Quality Account summarises our journey and what we have accomplished as we deliver our annual plan, moving us closer to our vision, ***delivering the best care in the right place***.

Whatever challenges we face during the year, it is evident that our people and teams contribute significantly to every patient experience. I would like to place on record my thanks and those of the trust for your tireless and unwavering commitment to our patients through the delivery of good personal care.

Thank you.



Chairman
East Cheshire NHS Trust

Chief Executive's statement

Every day our staff have the privilege and responsibility of providing care to hundreds of people across all ages and ethnicity, with acute or long term chronic illnesses, in high-tech areas or in people's own homes.

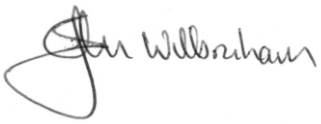
Wherever we provide care we are united in an ambition to ensure the highest levels of safety and quality are delivered to those who need us.

This ambition is only delivered through our continued scrutiny of the service we provide and ensuring we are continually looking at innovations within and outside of the NHS to ensure we are continually developing and improving.

We must also be open to learn from our own experiences when we sometimes do not meet the standards we set ourselves. Patient surveys, staff feedback, external reports and complaints are all a rich source of information to assist us in our vision of providing the best care in the right place.

I hope that by reading the document you can get an understanding of the breadth of services our dedicated staff provide and a flavour of their commitment to the patients we serve.

Best wishes,



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.

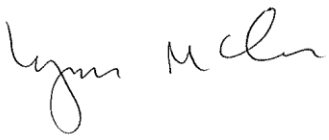
In this document, we will demonstrate how well we are performing, taking into account the views of our patients, staff and members of the public, and comparing our performance with other NHS trusts.

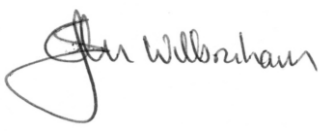
All NHS trusts are required to produce an annual Quality Account, which is also sometimes known as a quality report. We will use this information to help make decisions about our services and to identify areas for improvement.

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
East Cheshire NHS Trust

John Wilbraham
Chief Executive
East Cheshire NHS Trust

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

We are required to perform an independent assurance engagement in respect of East Cheshire NHS Trust's Quality Account for the year ended 31 March 2015 ("the Quality Account") and certain performance indicators contained therein as part of our work. NHS trusts are required by section 8 of the Health Act 2009 to publish a quality account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2015 subject to limited assurance consist of the following indicators:

- Percentage of patients risk-assessed for venous thromboembolism (VTE) (pages 59 and 62); and
- Rate of clostridium difficile infections (pages 60 and 62).

We refer to these two indicators collectively as "the indicators".

Respective responsibilities of directors and auditors

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations).

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

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

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

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

□□the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
□□the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2014-15 issued by DH in March 2015 ("the Guidance"); and
□□the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

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

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

- Board minutes for the period April 2014 to June 2015;
- papers relating to quality reported to the Board over the period April 2014 to June 2015;
- feedback from Eastern Cheshire Clinical Commissioning Group dated May 2015;
- feedback from South Cheshire Clinical Commissioning Group and Vale Royal Clinical Commissioning Group dated May 2015;
- feedback from Local Healthwatch dated May 2015;
- the Trust's complaints report published under regulation 18 of the Local Authority,
- Social Services and NHS Complaints (England) Regulations 2009, dated May 2015;
- the latest national patient survey dated 2015;
- the latest national staff survey dated 2014;
- the Head of Internal Audit's annual opinion over the trust's control environment dated March 2015;
- the annual governance statement dated 2 June 2015; and
- the Care Quality Commission's Intelligent Monitoring Reports dated July 2014 and December 2014;

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

This report, including the conclusion, is made solely to the Board of Directors of East Cheshire NHS Trust.

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

Assurance work performed

We conducted this limited assurance engagement under the terms of the guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- analytical procedures;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

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

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations. In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by East Cheshire NHS Trust.

Basis for qualified conclusion

The indicator reporting "Percentage of patients risk-assessed for venous thromboembolism (VTE)" did not meet the six dimensions of data quality in the following respect:

Validity – during our sample testing we identified two short stay admission patients who were recorded in the data set as not requiring a VTE assessment. This clinical assessment was not documented in the patient's notes. Whilst the Trust was able to retrospectively demonstrate that this was the appropriate decision for these two patients, we were unable to verify that this was the case for the wider population of short stay admission patients included in the data set.

Qualified conclusion

Based on the results of our procedures, with the exception of the matter reported in the basis for qualified conclusion paragraph above, nothing has come to our attention that causes us to believe that, for the year ending 31 March 2015:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

Grant Thornton UK LLP
4 Hardman Square
Spinningfields
Manchester
M3 3EB
4 June 2015

Our year at a glance 2014 -2015

April 2014 (Q4 / yr. end)

Trust starts work on major energy-saving scheme.

Macclesfield Hospital colleagues win major dentistry award

May 2014

Community dental clinics given Mouth Cancer Foundation accreditation.

Department of Health Nursing Director Viv Bennett visits trust health visitors in Crewe

June 2014

Open day recruits new nurses to the trust.

July 2014 (Q1 report)

Local patients, carers and family members vote for

August 2014

Health visitors awarded UNICEF's Baby Friendly Award

VitalPAC electronic patient monitoring system introduced

September 2014

Community health visitor becomes one of the first in the country to join a prestigious national fellowship programme

Oct 2014 (Q2 report)

Friends and family test rolled out to outpatients

Mouth cancer screening events across Cheshire

November 2014

Annual Staff Awards held - district nurse team leader Laura Reynolds receives Chairman's Choice Award.

Estates department wins prestigious Building Better Healthcare Journal award.

December 2014

Trust begins providing specialist community stroke rehabilitation services in South Cheshire and Vale Royal after a successful tender bid

Jan 2015 (Q3 report)

Local MP David Rutley praises the work of trust staff after visiting hospital and community teams

February 2015

The Royal Voluntary Service receives funding to place additional volunteers in Macclesfield Hospital's Emergency Department.

March 2015

Regional changes to stroke pathways introduced to improve outcomes for local patients.

Our performance against 2014-15 quality priorities

East Cheshire Trust provides a wide range of acute and community-based health care services for the local population of east Cheshire, south Cheshire and Vale Royal.

The priorities demonstrate our commitment to deliver safe, effective and personal care, working in partnership to develop innovative and integrated ways of working.

Our priorities for 2014-2015 focused around:

- Patient experience - specifically the NHS Family and Friends Test, 'always events' and outpatients.
- Clinical effectiveness - dementia and proactive care for patients with long-term conditions.
- Patient safety – reduction in pressure ulcers and the open and honest care project

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

Proactive care for patients with long-term conditions

Target

The trust worked with our colleagues in health and social care to develop and deliver care coordination in a consistent way for patients with complex needs. This included:

- Developing with colleagues in primary and social care an integrated proactive care plan for use across agencies
- Developing the role of the care coordinator with community staff
- Ensuring that patients identified as at `high risk' of being readmitted are provided with a pharmacy review and are supported on discharge
- Health colleagues having direct access to clinical advice

Achievements

- Partnership working across primary care, social services and ambulatory care to develop documentation used by primary and community care
- Development of processes to ensure that appropriate trust staff are notified that a patient who is at high risk of being readmitted has been admitted and discharge is supported
- All patients identified as at high risk by primary care colleagues and on a community caseload have a proactive care plan and named coordinator
- All admitted high-risk patients have a full review by the Pharmacy Team and are contacted by pharmacy after discharge to ensure that the patient fully understands their medication
- Development of a directory with contact details of clinicians who will support clinical colleagues with advice

What this means for patients

- Patients are supported to remain in their home
- All patients have the correct medication for their needs
- GPs will be informed about the admission and discharge of patients

Further improvements 2015/16

- Continue to roll out the project
- Review the trust's directory of services

Friends and Family Test

The NHS Friends and Family test is an important opportunity for patients to provide feedback on the care and treatment they receive with the aim to improve services. This year a staff survey based on this has been introduced in line with national requirements.

Target

- to implement the staff FFT survey
- to increase or maintain response rate in inpatient and emergency department surveys
- to reduce the number of negative response rates for the FFT survey
- to implement the FFT survey in day case and outpatient areas by October 2014

Achievements

Staff FFT
The trust implemented the NHS Staff Friends and Family Test in line with national requirements. We surveyed staff across the year and triangulated the results with other survey results. Combined, we will use them to inform plans to improve staff satisfaction and engagement.

Patient FFT - inpatient/emergency department/maternity
The Friends and Family Test was introduced as a way of gathering feedback from patients about their experience of the NHS.

It asked one question:

- How likely are you to recommend our ward/department to your friends and family if they needed similar care or treatment?
- A paper, text message or on line survey is completed, giving feedback.

Our results for 2014/15 can be seen within the national performance standards on page 31 of this report.

Maternity ranked first nationally
During the months of October, November and December 2014, our maternity services were ranked first out of 138 trusts nationally by the Family and Friends Test according to how likely mothers were to recommend us for care in labour.

Themes
The top three positive themes identified across the trust by the Family and Friends Test were:

- friendly and caring staff
- excellent care received
- good food

The top three themes for improvement were:

- lack of televisions that work in the wards
- poor choice of food for people with special dietary requirements
- staff are always busy

For the patients this means

- Patients can tell us about what works well and what needs improvement

- We can see if there are issues that are being identified on a regular basis so that these can be acted upon
- It is motivating for the staff to get the positive feedback
- Feedback is displayed on posters at the entrance to each ward on a monthly basis, so patients are able to see for themselves what has been said about their ward

Further improvements 2015/16

- Work continues to improve the response rates and increase the options patients can respond to the survey
- Work continues to improve the number of positive responses by making sure we listen and act on the feedback given
- FFT will be rolled out to all community services during the next year. FFT results can be seen on page 58 of the Annual Report

‘Always events’

Target:

- to ensure that specific actions in relation to discharge always happen when a patient is discharged from a ward

Achievements:

- to improve the patient experience, five actions or 'always events' agreed with a plan to assess how effective these were
- to improve compliance with post-discharge instructions, discharge lounge nurses now contact patients assessed as being at high risk of being readmitted by telephone to check that everything that was required on discharged had been undertaken and to reduce the risk of readmission into hospital.
- patients have been surveyed during March 2015 to evaluate if this has helped both the patient experience but also supported a reduction in patients being readmitted.

For the patient this means:

- they will have all the required information on discharge to ensure they understand their treatment plan.
- any medication they need at home will be given to them before they leave the hospital and that their GP has been informed.
- they will have a point of contact following discharge if they need to seek further advice.

Outpatients

Target:

- to improve the process for managing outpatient appointments
- to improve communication and the overall experience of patients attending outpatient clinics

Achievements:

- new process in place to review, monitor and escalate issues relating to outpatient appointments.
- the outpatient team have supported additional outpatient activity for specialties to reduce the waiting times for appointments
- there have been excellent results from the patient satisfaction questionnaire conducted quarterly in outpatients. See the trust website for further details
- there has been a reduction in PALS contacts relating to issues in outpatient services.

What this means for patients:

- patients are seen by their appointment time at clinic, if there are delays that these are clearly communicated.

Further improvements 2015/16:

- to increase the use of Friends and Family Test in improving the service based on feedback from our patients
- to develop more robust processes for the cancellation and reduction of clinics
- to improve the timeliness of the start times for outpatient clinics and reduce long waits in clinics for patients
- to further reduce the instances of PALS contacts and complaints.

Dementia care - innovative practice

Improving the hospital environment and quality of care for people living with dementia

Target:

- To ensure patients are appropriately assessed, investigated and referred on to the appropriate service
- To improve the diagnosis and referral of patients living with dementia and/or delirium by screening eligible patients in line with national requirements.
- Provide a sensitive care environment that enhances the patient journey from hospital admission to discharge. This was supported by capital investment awarded by the Department of Health and Kings Fund to upgrade a ward by using innovative environmental design principles for people living with dementia
- Improve patient and carer experience

Achievements:

- Review of assessment documentation used in the hospital
- Implementation of an electronic data collection tool to support timely assessments when first seen by the medical team
- Implementation of 'forget me knot' symbol to raise awareness and improve communication between staff groups supporting continuity of care.
- Proactive partnership working with local commissioners to agree and monitor progress
- Access to e-learning dementia care modules for all staff and development of an innovative bespoke dementia training programme for all healthcare disciplines
- Dignity Action Day (February 2015). The trust held an event to encourage engagement by means of a 'dignity tree' displayed on which suggestions for improvement relating to dignity were written on leaves.
- Monthly carer surveys used to support clinical teams to develop further ideas, themes or trends in order to further improve care for people with dementia
- Introduction and increased uptake of use of the 'This is Me' patient passport – a specific passport for dementia patients endorsed by the Alzheimer's Society
- Networks established with partner and voluntary organisations
- Implementation of a 'Breakfast Club' on Ward 9.

For patients this means:

- We have a ward where the environment meets the specific care requirements of patients living with dementia promoting the maintenance of social and enjoyable pastimes.
- We have staff who have undergone training to give them the skills and knowledge to care for patients living with dementia, allowing individualised, compassionate care.
- We support the family and carers of patients living with dementia.

Further improvements 2015/16:

- Develop options to replicate a dementia-friendly environment to any service redesign within the trust
- Implement a full range of co-ordinated activities on Ward 9
- Continue to build workforce capacity and competency through ongoing staff training
- Strengthen support mechanisms to share best practice and develop a 'buddy' ward with Cheshire and Wirral Partnership NHS Foundation Trust
- Identify dementia care champions and proactively work with voluntary organisations, local communities, schools and colleges to increase awareness and encourage dementia friends.
- Secure patient representatives to attend and contribute to the annual work plan via the dementia operational steering group

Reduction in pressure ulcers

Target:

The trust aimed to improve the assessment and management of patients in both community and hospital settings who are at risk of developing pressure ulcers in the following ways:

- To reduce the total number of newly-acquired pressure ulcers on caseload/during hospital stay by 25%
- To develop a training package to support staff in their management of pressure care
- Improve the recording of pressure area information and visual assessment by use of digital cameras
- To undertake a planned staff training programme across community and hospital teams.

- Explore and contribute towards the development of a dementia strategy.

Achievements

- E-learning package developed.
- Wound management and pressure ulcer prevention protocols updated
- Development of the skin care bundle for pressure ulcer prevention
- Development of staff information booklet on ‘top tips’ for prevention and grading of pressure ulcer.
- Roll-out of pressure ulcer training to hospital staff and targeted training for individual areas.
- Training delivered to assistant practitioners in the community for pressure ulcer prevention.
- Plans to update photographs of pressure ulcers on digital systems to allow them to be reviewed by the nurse specialist wherever they are located for prompt expert advice.

What this means for patients

- Staff will have the right skills to identify risk and prevent skin damage.
- Patients will have skin assessments undertaken within six hours of admission to hospital and appropriate care started.

Further improvements 2015/16

- Planned roll out of skin bundle to all areas by July 2015.
- For all wards and community teams to have access to digital imaging by April 2015.
- E-learning training to be rolled out and all staff to have access to it by April 2015.

Open and Honest Care project

This is focused on improving the quality of care provided to our patients when they are admitted to our hospital wards and units.

Target

- our overall aim is to further reduce harm and demonstrate this by publishing a specific set of patient outcomes and patient and staff experience information
- review current reporting systems and processes relating to clinical incident reporting
- establish robust data collection and measures
- develop and implement quality assurance frameworks to support ‘Open and Honest’ care reports

Achievements

- corporate nursing lead identified to drive and support implementation of 'Open and Honest' care project supported by a project group
- presentation to Trust Board and senior nursing colleagues to provide clarity and increased awareness
- established a 'buddy' organization to support implementation
- clinical templates have been developed to support clinical staff in collation of data with regards to pressure ulcers and injurious falls
- patient and staff experience questions aligned to the reporting template
- 'Did You Know' monthly ward information posters amended to include this information

For patients this means:

- receiving care and treatment that is safe and effective, at the point of need

Further improvements 2015/16

- establish monthly reports
- establish a website link to enable the public to view 'Open and Honest' care reports
- use the information in clinical areas to improve patient care
- implement skin bundle across all inpatient ward areas

Specified indicators

Auditors test two indicators annually according to the nature of the trust's activities. For 2014/15 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. The target has been consistently achieved since December 2014.

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.

In addition for 2015/16 the trust is developing a protocol for the management of high-risk patients. In addition specific work is being undertaken for patients attending Macclesfield Hospital's Endoscopy and Treatment Unit. We are also revisiting the VTE eLearning package to update in line with national and local requirements.

C. Difficile
More information about C. Difficile can be found on page 28

Please see page 5 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 2014 to December 2014, the Secondary Uses Service Data Quality Dashboard was at 97.2%, against 96.1% nationally. Meanwhile, for a valid NHS number being present in the data, the scores are above the national average. Admitted patient care was at 99.5% against 99.1%, outpatients was showing 99.9% against 99.3%, and accident and emergency was significantly above the national average of 95.1%, at 98.7%. For a valid Healthcare Resource Group version 4 code, the scores are 100% for the trust against national scores of admitted patient care at 98.5%, outpatients at 98.6% and accident and emergency at 96.1%.

Clinical coding

Clinical coding translates the medical terminology written by clinicians to describe the patients' diagnosis and treatment into standard, recognised codes.
The accuracy of this coding is a fundamental indicator of the accuracy of the patient records. There is a robust internal clinical coding audit and training programme which was developed in 2011/12. The trust has a Connecting for Health (CFH)-accredited auditor and trainer in post.

Coding is carried out using the full patient case note supplemented by electronic systems, such as histopathology and radiology, which is considered best practice.
The trust has not been subject to a Capita PbR audit in 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 2015. The trust submitted evidence in March 2015, 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 96.75% during 2014-15

Review of services

During 2014/15 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

of the total income generated from the provision of NHS services by East Cheshire NHS Trust for 2014/15.

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 within the corporate governance manual for the organisation which can be found on the staff intranet

Core indicators 2014/15

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

Quality Indicator	East Cheshire NHS Trust (ECT) Data	Comparison against worst/best performing trust and national average	ECT considers that this data is as described for the following reasons:	Actions to improve this score and so improve its quality of services by:
1: Preventing people from dying prematurely. Summary Hospital-Level Mortality Indicator (SHMI):				
A: SHMI value and banding July 2013 - June 2014	0.9644 (band 2 – as expected)	9 trusts higher than expected 15 trusts lower than expected 113 trusts as expected Lowest = 0.541 Highest = 1.198 Average = 0.995	The trust performs within the expected range for this indicator. This is in line with the trust TDA submission	The trust holds a monthly mortality sub-committee. All inpatient deaths are reported on datix and mortality figures scrutinised to enable the effective review of every inpatient death. The trust has a Mortality group to provide oversight of any required improvements
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	16.9%	National average = 24.6%		

Quality Indicator	East Cheshire NHS Trust (ECT) Data	Comparison against worst/best performing trust and national average	ECT considers that this data is as described for the following reasons:	Actions to improve this score and so improve its quality of services by:
3. Helping people to recover from episodes of ill-health or following injury. Patient reported outcome scores for:				
i) groin hernia surgery	EQ5D Index: 95.5%	England: EQ5D Index 91.4%	Health gain is marginally better than the England average	
ii,) ***varicose vein surgery Iii) hip replacement surgery iv, knee replacement surgery (primary)	90.6% 84.6	90.2% 90.2%	***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 against worst/best performing trust and national average	ECT considers that this data is as described for the following reasons:	Actions to improve this score and so improve its quality of services by:
3. Helping people to recover from episodes of ill-health or following injury. Emergency readmissions to hospital within 28 days of discharge:				
i) 0-15 years of age (% of discharge)	10.77 (2011/12) 11.70 (2010/11) 10.92 (2009/10) No further annual data available from provided source	England: 10.01 (2011/12) 10.01 (2010/11) 10.01 (2009/10) CECPCT (prior to CCG): 9.98 (2011/12) 11.92 (2010/11) 11.69 (2009/10)	The trust performs within the expected range for this indicator.	
ii) 16-74 Years (% of discharge)	10.01 (2011/12) 10.68 (2010/11) 9.94 (2009/10) No further annual data available from provided source	England: 10.14 (2011/12) 10.09 (2010/11) 9.92 (2009/10) CECPCT (prior to CCG): 9.40 (2011/12) 10.79 (2010/11) 10.06 (2009/10)		
iii) 75+ Years (% of discharge)	13.85(2011/12) 14.90 (2010/11) 14.29 (2009/10) No further annual data available from provided source	England: 15.29 (2011/12) 15.35 (2010/11) 14.86 (2009/10) CECPCT (prior to CCG): 14.40 (2011/12) 15.74 (2010/11) 15.03 (2009/10)		

Quality Indicator	East Cheshire NHS Trust (ECT) Data	Comparison against worst/best performing trust and national average	ECT considers that this data is as described for the following reasons:	Actions to improve this score and so improve its quality of services by:
4. Ensuring that people have a positive experience of care				
Responsiveness to inpatients' personal needs. (Standardised %)	65.6 (2013/14) 62.8 (2012/13) 66.2 (2011/12) 67.3 (2010/11) 66.5 (2009/10)	England: 68.7 (2013/14) 68.1 (2012/13) 67.4 (2011/12) 67.3 (2010/11) 66.7 (2009/10) Worst – 54.4 (2013/14) Best – 84.2 (2013/14)		We undertake regular feedback across all inpatient areas to ensure we remain responsive to patient needs. We theme responses from FFT comments to in order to improve our services.
4. Ensuring that people have a positive experience of care				
Percentage of staff who would recommend the provider to friends or family needing care.	60% (2014)	England: 66.0% (ALL ORGANISATIONS - 2014) 67.0% (ALL ACUTE TRUSTS - 2014) Worst = 38.0% Best = 93.0%		The family and friends test FFT .for all staff continues to be monitored and new ways of encouraging staff responses sourced for community services to enable greater engagement and participation.

Quality Indicator	East Cheshire NHS Trust (ECT) Data	Comparison against worst/best performing trust and national average	ECT considers that this data is as described for the following reasons:	Actions to improve this score and so improve its quality of services by:
4. Ensuring that people have a positive experience of care				
% of inpatients and patients discharged from Accident and Emergency who are likely or extremely likely to recommend the trust.	2014 -2015 A&E 86.1% Inpatient 93.2%	ENGLAND 64.4% 94.38%		Please see page 9 for more information on FFT.
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.	Q1-Q3 2014/15 97.74% (latest published information from Health & Social Care Information Centre) For information: the trust reports 97.47% for Q1-Q4 2014/15	Q1-Q3 2014/15 Best: Blackpool Teaching Hospitals (99.9%) Worst: North Cumbria University Hospitals (87.7%) England: 96.1%	The trust performs to required standard	Ongoing education of medical and nursing staff, including development of e-learning package RCA s for all hospital acquired VTE reviewed at monthly VTE group Daily monitoring within wards to ensure compliance

Quality Indicator	East Cheshire NHS Trust (ECT) Data	Comparison against worst/best performing trust and national average	ECT considers that this data is as described for the following reasons:	Actions to improve this score and so improve its quality of services by:
5. Treating and caring for people in a safe environment and protecting them from avoidable harm.				
Rate of C Difficile.	April 2013 March 2014 12.8 CDifficile infections per 100,000 bed days among patients aged two years and over. For up-to-date C Difficile data for 2014/15 please see the National Performance Standards at page 31.	England: April 2013 - March 2014 14.7 CDifficile infections per 100,000 bed days among patients aged two years and over. Best: Birmingham Women's Hospital (0.0) Worst: University College London Hospitals (37.1)	The trust performs to required standard	We undertake post-infection reviews to identify any lapses in care relating to CDI toxin positive cases attributable to the hospital. Antibiotic prescribing formed one of the trusts CQUINS for 2014/15. The measurements were fully achieved. A multi-disciplinary team review is undertaken on a monthly basis to ensure that patients with C Diff toxin and glutamate dehydrogenase (GDH) receive optimal care to enhance the recovery process.

Quality Indicator	East Cheshire NHS Trust (ECT) Data	Comparison against worst/best performing trust and national average	ECT considers that this data is as described for the following reasons:	Actions to improve this score and so improve its quality of services by:
5. Treating and caring for people in a safe environment and protecting them from avoidable harm.				
Rate of patient safety incidents and percentage resulting in severe harm or death.	Reported patient safety incidents The rate of patient safety incidents reported per 1,000 bed days The proportion of patient safety incidents reported that resulted in severe harm or death. Oct 13 - Sept 14 7705 incidents. 64 incidents per 1,000 bed days **0.06 %** resulting in severe harm of death **5** incidents resulting in severe harm **1** incident resulting in death.	**Overall for acute trusts non-specialist** **0.49%** resulting in severe harm or death Worst **83%** resulting in severe harm or death, **39** incidents resulting in severe harm, **0** resulting in death. Best **0%** resulting in severe harm or death. **5** incidents resulting in severe harm, **4** in death.	A web-based incident reporting system is used to capture incidents and is available to all staff via PCs. The patient harm field is mandatory on the incident reporting form. All clinical incidents are reviewed by the Risk Management Team. Training and communication takes place. There is ownership for all incidents as all team leaders and managers are assigned incidents to investigate. The trust has a high-level executive lead group which considers all serious incidents. All patient safety incidents which resulted in serious harm or death are verified by the head of safety risk and resilience prior to upload.	Ongoing training and education of trust staff on incident reporting. Improved process of check and challenge for serious incidents. Duty of candour captured on incident reporting system to improve compliance. Monthly data produced and sent to service lines on complaints, PALS, patient experience, incidents and claims. Incident data used to inform improvement initiatives such as Sign up to Safety.

Our performance in 2014/15

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 yet 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 below. 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 2014-15. 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, in the final two quarters of the year.

Trust access targets

C Difficile
The trust was set a maximum number of 14 cases in 2014/15, however the trust had 17 confirmed cases. Trust investigations indicated that in most cases, these instances were unavoidable, however increased training to support clinical staff in the management of C Difficile infections was carried out.

All individual C Difficile cases are reviewed to understand if there was anything that could have prevented the infection and any learning is shared with clinical teams.

Delayed transfers of care
These are patients who no longer need to be cared for within an acute hospital bed as they are medically fit for the next stage of their care. The trust has seen a significant increase in the number of patients who are classed as being delayed. This is due to a variety of reasons but the impact is a reduction in patient flow through the hospital, which impacts on our ability to achieve the standards for both the Emergency Department and elective patients being seen in 18 weeks.

Emergency access
The trust achieved the four-hour standard within the Emergency Department for the first two quarters of the year but, like most other trusts, not the final two quarters due to widely-reported winter pressures. Despite these challenges, staff across the trust both in community and hospital settings worked extremely hard to ensure the needs of patients were always met and high standards of care and safety were maintained.

18-week referral to treatment time
Many NHS organisations in England have been under increased pressure during 2014/15 due to the volume and complexity of emergency admissions. This impacted on planned activity, with an increased number of patients having surgical procedures postponed. Some patients have therefore waited longer than 18 weeks from GP referral to treatment. The trust has an agreed plan to reduce the backlog by June 2015.

National performance standards – East Cheshire NHS Trust Results

The trust is working with commissioners and partners to strengthen local reporting of quality outcomes, particularly in relation to community services.

	2014/15 Target	2014/15 Performance	2013/14 Performance
18 week Referral to Treatment - Admitted Patients	>=90%	**85.1%**	89.6%
18 week Referral to Treatment - Non-Admitted Patients	>=95%	**96.8%**	96.5%
18 week Referral to Treatment - Incomplete	>=92%	**92.9%**	93.6%
Diagnostic test waiting time within 6 weeks	>=99%	**99.5%**	99.2%
ED: Maximum waiting time of 4 hours	95%	**93.16%**	95.5%
2 Weeks maximum wait from urgent referral for suspected cancer	>=93%	**98.7%**	97.8%
2 Weeks maximum wait from referral for breast symptoms	>=93%	**95.3%**	95.7%
31 day wait from cancer diagnosis to treatment	>=96%	**99.00%**	99.5%
62 day maximum wait from urgent referral to treatment of all cancers	>=85%	**86.5%**	88.8%
62 days maximum from screening referral to treatment	>=90%	**98.4%**	95.2%
Delayed Transfers of Care	<3.5%	**9.2**	5.2%
Mixed Sex Accommodation	0	**0.58**	0.06
VTE Prevention	>=95%	**97.47**	95.0%
Hospital MRSA	0	**1**	1
Hospital CDiff (Avoidable and Unavoidable Combined)	14	**17**	15
Friends and Family Test (Positive Response Rate)			
Inpatient Wards		**93.2%**	92.0%
ED		**86.1%**	86.9%
Maternity (Overall)		**94.5%**	91.7%

Commissioning for Quality and Innovation (CQUIN)*

Community	Achieved
NHS Safety Thermometer	**No**
Long-term conditions / Proactive care	**Yes**
Pressure Ulcers	**No**
Family and Friends test (Staff)	**Yes**

Acute	Achieved
Family and Friends Test	**Partially**
NHS Safety Thermometer	**No**
Dementia	**Yes**
Reduction in emergency admissions – development of additional Ambulatory Care Pathways	**Yes**
Long-term conditions / Proactive care	**Yes**
Aseptic Non Touch Technique (ANTT) training	**Yes**
Antibiotic Prescribing	**Yes**
Management of the acutely ill patient	**Yes**
Pressure Ulcers	**No**
Advancing quality	**Partially**
Always Events	**Yes**
Homecare medication	**Yes**
Healthcare Inequalities – Breast Screening	**Yes**
Specialist commissioner – Always events, patient discharge	**Yes**
Public health – Health inequalities – Breast Screening	**Yes**
Dental Commissioners – Early implementation to day case and outpatients	**Yes**

*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

Quality Account Hip Fracture Pathway
Hip and Knee Rapid Enhanced Recovery Programme
The Rapid Recovery Joint Replacement Programme (RRP) was started on the 28th January 2013, with the primary aim to improve the quality of care for patients undergoing total hip and knee replacement. The project involves multidisciplinary team working in collaboration to support staff in the clinical area to follow the RRP. More than 400 patients have gone through this joint replacement programme, resulting in a reduced average length of stay by two days for both hips and knees. The primary aim is to improve the quality of patient care by cultivating a shared responsibility with patients for their pre and post-operative care through education and motivation. The gain for patients is that they will have less invasive techniques such as catheters and drains, be mobilised sooner and spend less time in hospital. The programme is rigorously audited.
Results (from 438 patients)

- More than half of all hip and knee replacement patients go home by post-operative
- There has been a slight reduction in pain score in both hip and knee patients despite 50% reduction in strong opioid analgesia
- There has been a reduction in nausea and vomiting and slight increase in post-op hypotension, which mostly appears to correct itself without any intervention.
- We have saved approximately £3,800 in analgesic drug costs since introducing the programme.
- There has been a significant reduction in catheterisation - 96% of patients did not require a urinary catheter and saved £6,699 in catheter consumable costs.
- Good patient satisfaction from telephone audit - the majority of patients discharged on or before three days reported their length of stay as ‘just right’.
- Post-discharge pain appears to have been controlled effectively. The majority reported that their pain was either ‘well controlled’ or ‘manageable’ while only a minority of patients reported moderate to severe pain at night.

Hip Fracture Enhanced Recovery
The trust’s Enhanced Recovery Hip Fracture Pathway is a patient-focused, multi-professional programme designed to reduce the morbidity and mortality in patients who have sustained a fractured neck or femur.

The primary focus is to ensure that the health status of this vulnerable group of patients is optimised and maintained from admission to discharge. The pathway ensures that patients’ abnormal health conditions are proactively managed and are given highly-calorific drinks to maximise their nutritional status to promote post-operative healing. Opioid free spinal anaesthetics are now standard to reduce the often high mortality risk of this group of patients.

A multi-modal analgesic regime has been designed to provide effective pain control to enable earlier mobilisation, while minimising the risk of analgesic side-effects.

The pathway involves two main documents; the Fracture Neck of Femur Clerking Proforma and the Multidisciplinary Care Pathway. Both documents are interlinked and correspond with the patient journey. The documents provide a framework to guide healthcare professionals to deliver evidence-based, consistently high-quality care to all patients at all times.

This involves cohesive multidisciplinary team working and a shared responsibility with the patient and carers to reduce the risks of hospital-acquired infections, postoperative

complications and cognitive impairment. The overall outcome is to improve the quality of patient care by reducing delays to surgery, facilitate a speedier return to patients' pre-fracture baseline and hopefully ensure an earlier discharge home.

Medical Specialties

Development of CPAP service
The Medical Specialities service line recently commenced a Continuous Positive Airways Pressure (CPAP) service. This is a process that supports patients with obstructive sleep apnoea syndrome (OSAS).

Undiagnosed and untreated OSAS can pose a serious health burden. It has been linked to poor quality of life, increased risk of road traffic accidents (up to five fold), and increased risk of uncontrolled diabetes and hypertension. There is emerging evidence linking it to adverse outcomes in patients at risk of ischaemic heart disease (IHD) and stroke.

CPAP treatment consists of a positive pressure machine, mask (nasal or full face) and tubing. Mild positive pressure is delivered to keep the upper airway open during sleep.

Across the country, the incidence of OSA and the associated syndrome (OSAS) has been exponentially increasing. GPs and hospital doctors are becomingly increasingly aware of the importance of diagnosis of OSA and are more alert to the symptoms and signs of the disease. As a result, referrals to sleep clinics (run primarily by respiratory physicians) have been steadily increasing. As an example, the trust received an increase of 20% in referrals to this service in 2014 from 2013.

A bi-weekly new patient nurse-led clinic commenced in December 2014 in conjunction with the consultant in respiratory medicine. The clinic is held in the main outpatient department at Macclesfield Hospital and patients are remotely monitored unless the team feel it necessary for patients to come into hospital for their follow-up. The new service has had very positive feedback from these sessions and work continues to develop it further.

Clinical Support Services patient story

Cancer services
Last year, a lady attended Macclesfield Hospital's Macmillan Cancer Resource Centre with her partner, who had just being diagnosed with advanced bowel cancer. The treatment plan was to offer palliative chemotherapy to the lady's partner but his overall prognosis was poor. The patient's partner was understandably distressed following such a dramatic and frightening outcome to what they believed would be a 'straightforward' oncology appointment.

The patient started his chemotherapy and he remained positive and physically well for some time but his partner was extremely anxious throughout, putting on a brave face to the outside world, while sharing her fears for the future with members of the team.

The financial advisor service within the trust (based with Age UK, who would normally only see those aged over 50 years) met with the couple, in the early stages of the patient's treatment as they had financial concerns. The advisor was able to clarify the application process of different benefits and signpost to agencies to help with future planning. This was found to be extremely helpful and reassuring.

As the patient's condition sadly deteriorated, the concept of dedicated person-centred counselling support for his partner was introduced (the patient himself declined this offer) which she engaged with at the Cancer Resource Centre with one of the volunteer counsellors. This continued until the patient's sad death, several months after the initial meeting with the couple, and a further ten weekly sessions of counselling were offered. Following this, a referral to the dedicated bereavement support team would be made if it was felt that on-going support was needed. This voluntary organisation is an important link to bereaved clients.

During this time the couple decided to get married. The team were made fully aware of the arrangements and enjoyed sharing their special day through photos and reminiscing. The volunteer complementary therapist who had been helping the patient's partner offered free additional relaxation therapies in the lead-up to the wedding to help the lady's heightened anxiety.

As a team working in the Macmillan Cancer Resource Centre, we felt privileged to have been able to offer a complete holistic approach to the care of both people in this story for almost a year. They became well known to our chemotherapy team and Macmillan pharmacists who worked to ensure the most positive experience possible for the patient and our non-clinical support team ensured his partner especially was kept 'safe' throughout this sad time.

NIMO pharmacy success story January 2015
The NIMO (Neighbourhood Integrated Medicines Optimisation) service is a new innovative pharmacy service to support patients with complex medication needs, in their own homes. The team comprises of two clinical pharmacists and one technician. An example of a patient story is as follows:

A house-bound patient was referred into the NIMO service by a Knutsford GP.

A comprehensive medication review was conducted by NIMO pharmacist in the patient's own home. The current medication was assessed against her medical conditions, relevant diagnostics results and any non-prescribed medication she was taking. A physical assessment of her falls and fracture risk and blood pressure was also carried out.

The review of the patient's own medications revealed some medication was out-of-date, including oral diabetic medication and insulin, which had been stored inappropriately.

Blood sugar checks were regularly taken and recorded by patient but on review these showed as abnormal. In discussion with the patient the pharmacist realised that the patient had no understanding of what medication she should be taking at what time.

There also appeared to be a stockpiling issue – for example 16 boxes of eye drops were found unopened in her cupboard.

Outcome
The patient's GP was informed of her non-compliance, poor management of diabetes and stockpiling of some medicines. The NIMO pharmacists discussed the issue with the patient's community pharmacist and an arrangement was made for them to provide blister packs for her medication and to deliver/ collect old blister packs each week in order to monitor compliance.

The NIMO pharmacist also referred the patient to a community matron to support on the management of her long-term conditions.

Without this NIMO visit the issues may have gone unnoticed, the patient's own medications would not have been reviewed and the patient's uncontrolled diabetes could easily have resulted in a lengthy hospital stay as well resulted in diabetic complications.

The NIMO service working closely with GPs and other health care professionals as well as access to hospital systems allowed for efficient and seamless healthcare.

"The staff in Macclesfield A&E are amazing. I was in just before Christmas with a fractured back and yes I had to wait for three hours, but so what? I was offered pain relief while I waited and I knew as soon as they could they would see me. If waiting means that the nurses and doctors can work on someone fighting for their life, or the more vulnerable, personally I'd wait all day!!"

Allied Health Services – patient story

Community Stroke Rehabilitation Team
The following patient story illustrates the patient pathway and the benefits of receiving interventions from the Specialist Community Stroke Rehabilitation Team (SCSRT). This service is provided by East Cheshire NHS Trust to Mid Cheshire Hospitals NHS Foundation Trust.

The patient was admitted to the Acute Stroke and Rehabilitation unit at Leighton Hospital, Crewe. She had a diagnosis of a stroke which resulted in left-sided weakness. She also had memory problems.

Prior to her stroke, the patient had been fully independent for indoor/outdoor mobility and all aspects of domestic and personal care and lived at home with her husband.

After the initial therapy assessments, the patient had a predicted length of stay of one to two weeks. She was given a predictive discharge date of February 3rd 2015.

The therapy team on the ward identified the patient suitable for SCSRT. The therapy teams liaised closely and it was agreed that the patient would be discharged into the team as soon as possible on Community Pathway 1. This meant that the patient would receive highly-specialised input at a high intensity in order to maximise her potential functional recovery and minimise any risk in her ability to achieve agreed goals.

Carer training took place on the ward and agreed times to visit at home.
The patient was discharged home on January 22nd 2015 (11 days prior to her predicted discharge date) and was first seen in her home on the 23rd of January.

The patient was assessed in her home environment. Advice and home exercise regimes were given. Goals were discussed and set with the patient and her husband.

A timetable of therapy visits were discussed and agreed with the patient and her husband and she immediately received a seven-day therapy service. The patient reported that she felt she was improving on a daily basis, becoming stronger and more co-ordinated. She also reported that her dependence on her husband for assistance with tasks was decreasing.

The patient was discharged from the SCSRT three days earlier than her initial predicted discharge on the 31st of January.

The patient was fully independent in her mobility both indoors and outdoors and she was safe ascending and descending the stairs independently. The patient was also independent in her self-care, being able to shower and dress independently, and she could also cook a meal safely, do the laundry and vacuum her home.

What this meant for the patient

- Discharge from an acute hospital environment 11 days prior to the predicted discharge date.
- Immediate access to specialist community service in stroke care. (Can also access speech and language therapy, psychology, specialist nursing and dietetics as required).
- Access to a seven-day therapy service.
- Opportunity to set shared meaningful goals.
- Opportunity to practice functional activities in her own home, making them more meaningful and available, incorporating them into daily routine rather than isolated in therapy treatment sessions.
- Consequently discharge from the stroke service as a whole was three days prior to the predicted discharge date initially set in the hospital environment.

Integrated Care - patient story

The patient was a 68-year-old lady who lived alone but had family living nearby. She was known to the district nursing team for many years, originally for treatment and care of ulcerated legs.

The patient was bariatric but her weight was not established as she was unable to be weighed. Her weight was estimated at approximately 40-50 stone.

She had been bedbound for the previous two years and was only able to lie on her left side and required carers to help her move. She initially had three carers to help but this was increased to four carers as moving the patient became more difficult. The district nurses visited each morning with carers to assess and dress ulcerated areas on her abdomen and legs and to check pressure areas.

As the patient's condition deteriorated, the visit would take up to an hour. The patient was nursed on a special mattress but due to her condition she was unable to sit up or get out of bed.

The multi-disciplinary team met to discuss the best way to manage the patient's care as her condition deteriorated and her preferred end-of-life care planned. This was agreed in conjunction with herself, her family and GP.

The patient wished to remain in her own home and practical issues such as meeting with the funeral director to discuss after-death arrangements were facilitated. The patient deteriorated quickly in last two days of her life but due to the preparation it meant that the difficult and complex arrangements following her death had already been agreed with the family and her end-of-life wishes were met.

*Patients have consented to the use of their stories although names have not been used in order to protect their identity

Our patient and staff feedback

The trust carries out surveys annually in order to ensure we are meeting our patients' expectations and where we are not, to formulate action plans for improvement. All local surveys are published on our trust website and can be found at: **http://www.eastcheshire.nhs.uk/Get-Involved/Patient-Surveys.htm**. All national surveys can be found on the CQC website **http://www.cqc.org.uk/content/surveys**.

The detail of the National Cancer Survey published by Quality Health can be found at https://www.quality-health.co.uk/resources/surveys/national-cancer-experience-survey/2014-national-cancer-patient-experience-survey

A summary of our annual surveys and the impact on patient care can be seen below.

Local feedback
East Cheshire NHS Trust is fully committed to improving the experience of all its patients. Listening, and more importantly, acting on patient feedback helps us to develop our services to ensure the best possible patient experience.

To this end a full programme of patient feedback work has been carried out across all areas of the trust covering a wide range of different subjects. The table below details the areas covered. Summaries of all our patient feedback exercises can be viewed on our website at http://www.eastcheshire.nhs.uk/Get-Involved/Patient-Surveys.htm

Example of local survey – mole mapping
Following the introduction of a new 'mole mapping' clinic at the trust, a feedback exercise was undertaken to evaluate the level of patient satisfaction with the new service. Mole mapping is a procedure where a special digital camera is used to record the positions and appearances of moles on a person's body so that regular checks will detect any changes that might lead to skin cancer.

A total of 118 self-completion questionnaires were posted out over summer 2014. 64 completed questionnaires were returned giving a response rate of 54%. Some of the feedback included:

- 92% of patients referred to the mole mapping service felt the length of time they had to wait for an appointment was acceptable.
- 89% of patients did not feel that they were lacking any information prior to attending their appointment.
- 95% of patients said that the mole mapping procedure was 'definitely' explained to them in a way that was clear and easy to understand and 98% of patients 'definitely' felt able to ask any question or raise any concerns.
- 97% of patients said that staff 'definitely' did all they could to make them feel at ease during the procedure and 97% also said that they 'definitely' had enough privacy during the procedure.

What this means for the patient
Following the survey, an action plan has been developed to ensure that no patient should wait longer than 18 weeks to be seen from initial referral to the service and improvements have been made to the appointment system to reduce the number of cancellations and moved appointments. Work is also underway to ensure that patients are clear what changes in their moles they should be looking for as this will provide further reassurance to patients.

Areas covered by our patient feedback programme 2014-2015 include:	
Surgical Specialities	Bowel function
	Colorectal cancer
	Stoma support
Clinical Support and Diagnostics	Breast screening
	Endoscopy and treatment unit
	Comfort audit
Women and Children	Children's community nursing
	Colposcopy
	Gynaecology oncology
	Sexual health
	Children's Ward
Urgent Care	National CQC survey carried out within this service line
Medical Specialities	Dermatology
	Chronic pain
	Mole mapping
	Specialist diabetes nursing
	Melanoma follow up
	Inpatient stroke services
Allied Health	Audiology
	Community stroke rehabilitation
	Diabetic retinopathy screening
	Therapies at MCHFT
	Community physiotherapy / occupational therapy
	Wheelchair service
	Paediatric therapies
Integrated Care	HITS
	Intermediate bed based care

Service users – what is important to them?

It is essential to the trust to gather the views of our service users in as many different ways as possible.

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 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.

Health Matters lectures over the year covered topics including:

- Rapid recovery from joint replacement
- Organ donation
- Dementia
- Behind the headlines of A&E care
- Stroke

For a full programme, see the trust website at www.eastcheshire.nhs.uk

"Lots of useful information on dental hygiene and I thought I knew it already"

"Very exciting and valuable possibilities for healthcare in the future - huge potential for the future"

Your views matter
During a number of Health Matters talks we also sought the views of our service users to assist us in the action plans for delivery of our Quality Account. A series of questions and their responses can be seen below.

What do you consider to be the five main contributors to improved quality care? (outside of the clinical requirements?)

Staff introducing themselves when they meet you	29
Patient information (written)	21
Patient information (digital)	8
Improved staff communication with patients (Priority 3 - Listening and responding - Care that provides a positive experience for patients, carers and families)	51
Bedside entertainment	2
A nice environment to wait in for your clinic appointment	8
Cleanliness - (Priority 1: Harm-free care)	55
Knowing which nurse and doctor is responsible for your care (Priority 2 - Improving outcomes - care that is clinically effective)	55
Food	16
Effective pharmacy	6
Timely discharge	11
Privacy	12
Assistance with feeding	6
On site shop	1
Car parking	11
Visiting hours	2
Appointment reminders	4
Discharge information and follow up care – knowing where to go (Priority 4 - Integrated care - Care that is co-ordinated and based around individual needs)	47
Exercise and diet advice	5
Other (please detail)	

Comments:

- Staff with time to treat you with courtesy and compassion.
- More help for people with disabilities – eg Alzheimer's, hearing, blind
- Cleanliness – quality care would demand it as a basic – to improve quality care other aspects must be considered
- Improve communications - explain care plans, pros and cons and alternative treatments
- Reassurance every half hour for patients waiting for results in the emergency department.

PLACE (Patient-Led Assessments of Care Environment) 2014

The trust undertakes the national PLACE report each year which seeks to provide information for the trust from patients on its delivery of the care environment.

The trust carried out the assessment of Macclesfield in March and Congleton in June. The assessment was undertaken by nine staff from Infection Prevention and Control, Nursing, Facilities and contractors and a large team of eight volunteer patient assessors.

The aim of PLACE assessments provides a snapshot of our organisation and how it is performing against a range of non-clinical activities which impact on the patient experience covering areas of:

- cleanliness;
- the condition; appearance; maintenance of the buildings and grounds of the healthcare premises;
- the extent to which the environment supports the delivery of care with privacy and dignity and;
- the quality and availability of food and hydration.

The criteria included in PLACE assessments are not standards, but they do represent both those aspects of care and good practice as identified by professional organisations whose members are responsible for the delivery of these services, including but not limited to the Healthcare Estates Facilities Managers Association, the Association of Healthcare Cleaning Professionals and the Hospital Caterers Association.

Cleanliness

Organisational Name	Site Name	Cleanliness	Food and Hydration	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Average Score	National Average 2013/14
East Cheshire NHS Trust	Macclesfield Hospital	99.91%	94.38%	94.24%	97.86	96.60%	N/A
East Cheshire NHS Trust	Congleton War memorial Hospital	98.64%	93.84%	97.62%	95.65%	96.44%	N/A
National Scores	North West	97.30%	89.10%	87.40%	91.90%	N/A	91.43%

The cleanliness scores on both sites have risen very slightly compared to last year which has been mainly due to working with the contractors more closely when monitoring the service.

Food and hydration

The food and hydration results increased at Macclesfield site this year as we have been working with our catering partner to improve the quality of the service, listening to the patients and within the contract parameters to improve the patient experience and monitoring the wards regularly. At Congleton Hospital the results were slightly down on last year. The choice of menu on the day was cooked and presented well but the choices offered were not liked by the panel and therefore marked down. This was rectified immediately after the audit with the contractor on site.

Privacy and dignity

Privacy and dignity results were lower than the previous year. The questions included: "When patients are given distressing news can the patient leave the department via another entrance? Or do they have to leave by walking back through the department?" Unfortunately, we have several areas that do not have this facility.

Condition, appearance and maintenance

Condition, appearance and maintenance provided the trust with a much-improved score due the continuing maintenance and decoration improvements at both hospitals. There has been an increase in signage across the trust and vast improvements to the car parking and road surfaces boosted the scoring.

- On the previous page is a table showing the PLACE results trust hospitals have received, together with average scores for other hospitals in the region. All three trust sites scored above regional averages by all measurements.

"I was quite scared when I came in and several of the nurses helped me through it. Everyone was kind and considerate - surgeon was excellent. Thank you."

"My wife, who has Alzheimer's, was admitted for observation after a fall - during her seven days before discharge she was cared for with understanding and attention by all the staff who made her stay as comfortable as possible."

Quarterly audits – inpatients

The trust is committed to regular patient feedback demonstrated by quarterly audits across all inpatient areas looking 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 2014/15:

- 81% of patients rated the cleanliness of the ward as 'very clean'
- 70% of patients stated that they were 'definitely' involved in decisions about their care and treatment
- 94% 'always' had enough privacy when being examined or treated
- 96% of patients said they were 'always' treated with dignity and respect
- 92% of patients said they were 'definitely' treated with care and compassion
- 71% of patients rated the overall level of care as 'excellent' and 27% rated it as 'good'

"I was very impressed with the attitude of the staff and the speed with which they dealt with me. I arrived at A&E at 8:50am and left to go home at 10:10. Amazing!"

"I was really impressed with my care from start to finish. Everyone was really sensitive and helpful."

For the patient this means that we are maintaining a high standard of care on our wards ensuring that patients are always involved in decisions about their care and are treated with dignity and respect, care and compassion at all times.

Quarterly audits – outpatients

In addition to the quarterly inpatient survey, we also conduct a quarterly audit across outpatient areas. This audit covers the patients' experience of the department, the care and treatment received, leaving the department and overall views on care and service received.

During 2014/15:

- 87% of patients rated the cleanliness of the department as 'very clean'
- 89% of patients 'definitely' felt involved in decisions about care and treatment.
- 98% of patients 'always' had enough privacy when discussing treatment and 99% 'always' had enough privacy when being examined.
- 98% of patients said they were 'always' treated with dignity and respect and 96% said they were 'definitely' treated with care and compassion.
- 82% of patients rated the overall level of care as excellent, with 18% rating it as good.

For the patient this means that they can be confident in a high level of cleanliness, care and compassion during their visit here.

Dementia CQUIN (Commissioning for Quality and Innovation)

One element of the dementia CQUIN standard is the requirement for the trust to undertake monthly feedback among carers and relatives of people with dementia. A short questionnaire has been developed to gauge how well relatives and carers feel staff understand dementia, how involved they feel in their relative's care and also to measure awareness of patient passports.

During 2014/15:

- 92% of respondents felt their relative 'definitely' had enough privacy when being examined or treated;
- 92% of respondents felt their relative had 'definitely' been treated with dignity and respect;
- 74% of respondents felt that the staff involved in their relative's care 'definitely' knew how to care for someone with dementia;
- 61% of respondents said that they 'definitely' felt involved in their relative's care with a further 33% saying they felt involved 'to some extent'.

"Hospital is a very distressing experience, but I felt in safe hands. Thank you."

"All the medical and non-medical NHS staff treated me professionally and with care and respect. All have been kind and knowledgeable in their fields."

"Thank you for the excellent care and attention I received during my stay in A&E. I was treated with respect and dignity at all times."

Further information on dementia can be found on page 49 of this report.

2014/15 National Cancer Patient Experience Survey

The 2014 National Cancer Patient Experience Survey, sent to a sample 118,081 patients at 153 NHS trusts that provide cancer treatments, asked patients how they rated the care they received. 229 patients from East Cheshire NHS Trust were sent a survey with 136 patients responding, a response rate of 66%. The national response rate was 64%.

The trust was rated as one of the top five trusts in England and in the top 20% of trusts for 42 areas out of a possible 62. 92% of patients rated their overall levels of care as excellent or very good.

For the patient this means the highest level of patient information, excellence in pain control and the patient receiving personal individualised care. Areas of action and improvement include patients being offered a written assessment and care plan

CQC National Emergency Department Survey 2014

East Cheshire NHS Trust was reviewed by 289 patients out of a random sample of 799 patients who attended the department in March 2014. Overall, the trust was classed as performing in line with other trusts for all criteria included within the survey.

For the patient this means improved waiting times in the department and a shorter time before speaking to a clinician and improved privacy and confidentiality at the reception area.

Actions for improvement include the availability of refreshments in the department and improved patient information on leaving the department on the patient's condition.

CQC National Adult Inpatient Survey 2014

East Cheshire NHS Trust was reviewed by 415 patients out of a sample of 810 patients who had been treated as an inpatient at the trust during summer 2014.

Overall, the trust was classed as performing in line with other trusts for the majority of areas. It was classed as performing better than other trusts in relation to hospital staff discussing whether additional equipment or adaptations would be needed at home following discharge.

The trust showed an improvement in its scores for 27 areas. The areas where the trust's performance was most improved include:

- Patients receiving enough help to eat meals
- Staff discussing whether adaptation or equipment was needed after discharge
- Clear written information given in relation to medication
- Patients being told who to contact if worried following discharge

The trust was classed as performing 'worse than other trusts' for patients being disturbed by noise at night from other patients and staff. A full action plan has been developed to address these and any other areas where the trust feels it could improve its performance.

NHS Staff Survey

A sample of trust employees took part in the annual NHS Staff Survey, between September and December 2014. Our response rate was 34%. When compared with acute trusts (a comparison with combined acute and community trusts is not yet possible), we compared favourably regarding:

- staff experiencing discrimination
- staff feeling pressure to attend when feeling unwell
- staff believing the trust provides equal opportunities for career progression
- staff appraisals – identified as one of the best 20% of acute trusts and staff experiencing harassment, bullying or abuse

We compared less favourably in the following areas:

- work pressure felt by staff and staff suffering work-related stress
- staff reporting good communication between managers and staff
- staff agreeing their role makes a difference to patients
- staff working extra hours

We will aim to improve in these areas using methods including the trust's staff engagement programme - Your Voice; Listening into Action, and the trust's wellbeing programme.

The staff survey has also highlighted a significant increase in staff reporting that the trust provides equal opportunities for career progression and promotion. The trust is in the best 20% in this area. The trust has invested in is a range of leadership development programmes accessible to staff across the whole organisation. These programmes have provided an opportunity for staff to increase their knowledge, skills and competence in order to prepare individuals for their next career move.

Audit participation

During 2014-15, 31 national clinical audits and four National Confidential Enquiries into Patient Outcomes and Death (NCEPODs) covered NHS services that East Cheshire NHS Trust provides.

During that period East Cheshire NHS Trust participated in 25 out of 31 (81%) of the national clinical audits and four out of four (100 %) of the NCEPODs which it was eligible to participate in.

The national clinical audits and national confidential enquiries that East Cheshire NHS Trust participated in, and for which data collection was completed during 2014-15 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Audit	Participation	Data collection 2014/15	Patient recruited 2014/15	% cases submitted in 2014/15
Neonatal intensive and special care (NNAP) (01/01/2014 to 31/12/2014**)**	Y	Y	133	100%
Epilepsy 12 (Childhood Epilepsy)	Y	Y	8	100%
Paediatric Intensive Care (PICAnet)	Y	Y	14	100%
Diabetes (Paediatric)	Y	Y	Data submission for the 2014-15 National Paediatrics Diabetes Audit (NPDA) opens 1st April 2015 - 29th June 2015.	All eligible patient data will be submitted.
Fitting child (care provided in emergency departments)	Y	Y	29	100%
Chronic Obstructive Pulmonary Disease	Y	Y	42	100% Audit Period 01/02/2014 to 31/03/2014
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Y	Y	On-going	Data completion date end May 2015
Heart failure	Y	Y	On-going	Data completion date end May 2015
Comparative audit of blood transfusion	Y	Data collection commences 01/02/15	Expected between 45-70	Depends on numbers submitted over data collection period

National Audit	Participation	Data collection 2014/15	Patient recruited 2014/15	% cases submitted in 2014/15
Adult critical care (ICNARC)	Y	Y	393	100%
Rheumatoid & early inflammatory arthritis	Y	Y	46	98%
Emergency laparotomy	Y	Y	From January 2014 to February 2015 – 117 cases entered	Two year data collection period
National Joint Registry	Y	Y	290	99%
Falls & Fragility Fractures Audit Programme, includes National Hip fracture database	Y	Y	223	100%
Inflammatory bowel disease (IBD)	Y	Y	40	100%
Stroke National Audit Programme SSNAP (combined Sentinel & SINAP)	Y	Y	245	100%
National Audit of Intermediate Care – South & Vale Royal Bed-based services Intermediate care at home Hospital at home. Transitional health beds	Y	Y	974	54.56%
Renal replacement therapy (renal registry)	Y	Y	45	100%
Lung cancer	Y	Y	127	117.5%
Bowel cancer	Y	Y	147	100%
Head & Neck Oncology	Y	Y	38	100%
Oesophago-gastric cancer	Y	Y	68	136%

National Audit	Participation	Data collection 2014/15	Patient recruited 2014/15	% cases submitted in 2014/15
Elective surgery (National PROMS programme) Includes Groin Hernia, Hip Replacement, Knee Replacement & Varicose Veins	Y	Y	Pre-operative questionnaires completed 605	Participation rate 77.4% (data published on 13/11/14 for the period April 13 to March 14)
	Y	Y	Post-operative questionnaires returned 326	Response rate 64.2% (data published on 13/11/14 for the period April 13 to March 14)
	The adjusted health gains demonstrate that we are not an outlier nationally in any of the specific conditions/procedures, therefore comparable to the national outcomes re: patient reported health gains and improved quality of life post procedure.			
TARN	Y	Y	49 cases submitted for the period April to December 2014 – data input on-going	Continuous data input
Prostate Cancer	Y	Y	108	100%
Older People (care provided in emergency departments)	N	N	This audit does not fall in line with our current ED practice	N/A
Mental Health (care provided in emergency departments)	N	N	This audit does not fall in line with our current ED practice	N/A
Pleural Procedures	N	N	Minimum numbers for participation not met	N/A
Adult community acquired pneumonia	N	N	Advancing Quality already collect data - therefore we do not take part in the National Audit	N/A
Cardiac arrest	N	N	N/A – Extensive, quality data provided through local audit	N/A

National Audit	Participation	Data collection 2014/15	Patient recruited 2014/15	% cases submitted in 2014/15
Chronic kidney disease in primary care	N/A	N/A	N/A	N/A
Congenital Heart Disease (Paediatric Cardiac surgery)	N/A	N/A	N/A	N/A
Adult Cardiac surgery	N/A	N/A	N/A	N/A
Pulmonary Hypertension	N/A	N/A	N/A	N/A
Cardiac arrhythmia	N/A	N/A	N/A	N/A
National Vascular Registry, including CIA and elements of NVD	N/A	N/A	Data for East Cheshire NHS Trust patients included in patient data submitted by UHSM	
Prescribing Observatory for Mental Health (POMH-UK)	N/A	N/A	N/A	N/A
Coronary Angioplasty	N/A	N/A	N/A	N/A
Adherence to British Society for Clinical Neurophysiology (BSCN) and Association of Neurophysiological Scientists (ANS) Standards for Ulnar Neuropathy at Elbow (UNE) testing	N/A	N/A	N/A	N/A
Ophthalmology	The prospective phase of the audit will commence data collection in September 2015			
Specialist rehabilitation for patients with complex needs	The Audit Management Organisation had not yet appointed @ 06/02/2015			
Diabetes (adults ANDA) includes National Diabetes Inpatient Audit (NADIA)	NADIA Steering Group advised there would be no data collection during 2014			
Parkinson's Disease	Healthcare Quality Improvement Partnership (HQIP) confirmed no eligible data collection in 2014/15			
Familial hypercholesterolaemia	HQIP advised not eligible for Quality Accounts 2014-15			
National Audit of Seizure Management (NASH)	Removed from Quality Accounts 2014-15			
Adult bronchiectasis	Removed from Quality Accounts 2014-15			
Paediatric Pneumonia (BTS)	BTS advised that the National Paediatric Pneumonia Audit had been postponed and that the audit would not run in 2014/2015.			
National Audit of Dementia (NAD)	HQIP stated no data collection in 2014-15			

Confidential Enquiries	Participation	Data Collection	% cases submitted
Child Health (CHR-UK)	N	N	No qualified cases submitted
Maternal Infant and Perinatal (previously Perinatal Mortality)	Y	Y	9/9 100%
National Confidential Enquiry into Patient outcome and Death (NCEPOD) Gastrointestinal Haemorrhage	Y	Y	5 qualified cases during data collection period
National Confidential Enquiry into Patient outcome and Death (NCEPOD) Sepsis	Y	Y	4 qualified cases during data collection period
National Confidential Enquiry into Patient outcome and Death (NCEPOD) Lower Limb Amputation	Y	Organisational questionnaire returned. This covered the rehabilitation of patients following lower limb amputation	No qualifying amputations for the data collection period
National Confidential Enquiry into Patient outcome and Death (NCEPOD) Tracheostomy Care	Y	Y	5 qualified cases during data collection period
National Confidential Enquiry into Suicide and homicide for people with mental illness (NCISH)	N/A	N/A	N/A

The reports of 16 national audits were reviewed by the provider and East Cheshire NHS Trust intends to take the following actions to improve the quality of healthcare provided:

National Audit	Actions and Progress
Surgical Specialties	National Emergency Laparotomy Audit The aim of the audit is to enable the improvement of the quality of care for patients undergoing emergency laparotomy through the provision of high quality comparative data from all providers of emergency laparotomy. The audit is currently running over three years. In Year 1 an organisational audit was performed, with individual patient data collection in Years 2 and 3. East Cheshire Trust has participated in the National Emergency Laparotomy Audit since it commenced in 2013. The Organisational Report of the National Emergency Laparotomy Audit has been reviewed by the Surgical Team and patient data continues to be input during the data collection period.
Women's and Children's	**Newborn Hearing Screening: Parent Satisfaction Audit 2014** This is the sixth Macclesfield NHSP Parent Satisfaction Audit, since the Macclesfield Newborn Hearing Screening Programme (NHSP) began in February 2004, as part of Phase 3 of a national five-phase rollout. The NHSP National Quality Standard concerning coverage and timeliness specifies that 95% of all babies should have completed the screen process by the 28th day of life and this Standard is regularly achieved at Macclesfield. Just under 80% of babies born at Macclesfield hospital have their screen completed as inpatients. Home births, babies born at other hospitals and babies requiring a further screen are seen as outpatients in a screening clinic which runs once a week in Children's Outpatients. Headline conclusions: • Quality Standards for coverage and timeliness are achieved. • Consistent and ongoing high standards of performance. • Responses received for "overall rating" were reported as 98% rating the process as Excellent and 2% as Good • Skills, knowledge, approachability and competence are perceived as "Excellent" by parents.

National Audit	Actions and Progress
Clinical Support & Diagnostics	**National Care of the Dying Acute Hospitals (NCDAH) Audit Round 4** The NCDAH is prepared by the Royal College of Physicians (RCP) in collaboration with the Marie Curie Palliative Care Institute Liverpool (MCPCIL). It reflects many of the issues identified in the Independent Review of the Liverpool Care Pathway (LCP) as well as what needs to be done to improve the quality of hospital care for dying people and their families. The audit aims to contribute to learning that can help to improve the care for dying patients and their relatives or carers in hospital settings. The standards of care evaluated in the audit were based on The End of Life Care Strategy and reflect recent national policy guidance, including: • Best care for the dying patient • NHS Constitution • NHS Outcomes Framework • The NHS Mandate • National Institute for Health and Care Excellence (NICE) Quality Standards • The Care Quality Commission (CQC) Essential Standards of Quality and Safety • End-of-Life Care Quality Markers • Guidance for doctors Where the organisational audit highlighted gaps, actions have been put in place to close the gaps. Key findings from the case note review highlighted that East Cheshire achieved higher than the national score in approximately 50% of the key performance indicators (KPIs). However, when compared with the other Cheshire and Merseyside Strategic Clinical Networks trusts' performance, East Cheshire was the only trust not to achieve the national benchmark of 55% for the summary KPI for the domain 'Discussion about senior doctor decision held with patients capable of participating'. A closer examination of the East Cheshire scores suggests that this was partly caused by the lack of evidence of discussions with patients and relatives/friends. Bereavement survey questionnaires were returned by 27 relatives (41% response rate). Confidence in the team scored highly along with nurses/doctors having time to listen/discuss the patient's condition with relative. National recommendations have been published and we plan to take the following actions:- 1. Introduction, education and roll out of Care Plan for End-of-Life Care- *emphasis on documentation of communication.* 2. Maintain end-of-life care sessions within mandatory training 3. Extend end of life training to trust induction and to non- qualified staff members. 4. Continue to explore seven day 9am – 5pm service for specialist palliative care. 5. Develop and launch written information to support visiting relatives to access facilities. 6. Ensure annual audit is completed including survey of bereaved relatives and reported at Board level. 7. Get end-of-life care represented as a standing agenda item at relevant committee.

National Audit	Actions and progress
Urgent Care	Paracetamol overdose – The data for this audit was collected in August and September 2013. Local findings were presented within and outside the Emergency Department. This has included presentations to the Emergency Department juniors, the medical meeting and Grand Round lectures as well as to various medical students and members of nursing staff. The department performs well at: • Recording size of ingestion. • Testing patients in whom paracetamol levels will direct management. The department showed an improvement on a background of national cohort worsening performance in treating patients with single acute overdose within eight hours of ingestion. The department, in common with most participating departments, performed poorly with patients in whom treatment is commenced on clinical grounds: • Single acute overdose presenting beyond eight hours from ingestion. • Staggered overdose Action taken: • Education of medical and nursing staff. • Update of the NAC prescribing tool to include time of prescription as well as time of administration Recommendation: Steps are needed to improve the timeframe within which patients presenting with an indication for immediate treatment, i.e. later presentation and staggered overdose, are identified, triaged, assessed and treated. The information to make this decision appears to be already gathered at triage – we sit in the top quartile of departments for recording time of ingestion. Delayed presentation of staggered ingestion need to be identified and these two groups of patients brought to the early attention of medical staff for immediate treatment. Possible future development: Patient Group Directive for treatment of two groups of patients by nurse prescriber on presentation and prior to medical assessment: • Staggered overdose taking more than 6g or 75mg/kg in total. • Single acute overdose taking more than 6g or 75mg/kg more than seven hours earlier.

National Audit	Actions and Progress
Medical Specialties	**Acute Kidney Injury (AKI)** following the NCEPOD "Adding Insult to Injury" report published in 2009, East Cheshire NHS Trust produced an AKI pro-forma. Following implementation of the pro-forma an audit was undertaken in 2010 with re-audit in 2011. Recommendations included:- • Updated and wider use of AKI pro-forma as per NICE guidelines. • Further education for junior doctors, pharmacists and nursing staff to raise awareness of the recommendation for cessation of nephrotoxic medication, renal USS and catheterisation of patients with AKI. • Continue to encourage timely identification and risk assessment of patients with AKI Selected trusts that utilised the AKI pro-forma were invited to participate in a national survey during 2012/13 to assess the current management of patients with AKI and East Cheshire NHS Trust took part. Conclusions from the audit reported: • East Cheshire NHS Trust is meeting the national average for the majority of components measured during AKI study • Increased use of AKI pro-forma on clerking patient • Failing on select few Next steps:- • Update the AKI pro-forma, according to the NICE guidance CG169 Acute Kidney Injury published in August 2013 • Re-audit planned for January 2015
Allied Health Services	An audit of performance against Commissioning for Quality and Innovation (CQUINS) linked to the Specialist Community Stroke Rehabilitation team has commenced in 2015. The aim is to audit compliance with the CQUIN on a quarterly basis, providing supporting evidence for the commissioners in order to achieve the linked financial allocation. The changes in practice that will be achieved are: 1. Provision of information and advice to stroke patients and their carers to support secondary prevention and self-management. 2. Provision of patient passports to stroke patients to support communication of the personal needs of patients

National Audit	Actions and Progress
Integrated Care	The South and Vale Royal Intermediate Care Service has participated in the National Intermediate Care Audit since 2010 and presented findings from the 2014 audit at the Integrated Care audit meeting. Two of the areas that patients were asked to feedback on were; • Quality of service provided for bed-based service and • Home-based services. Results show that South and Vale Royal achieved 100% for the five questions and statements below, which for each question, is above the national average. Q. Do you feel that there is something that could have made your experience of the service better? Q. I was aware of what we were aiming to achieve e.g. to be independent at home, able to go shopping Q. The length of time I had to wait for my care from the team to start was reasonable. Q. I had confidence and trust in the staff treating or supporting me. Q. Overall I felt I was treated with respect and dignity while I was receiving my care from this service.

The reports of two NCEPODs were reviewed by the Board, along with the protocols of three NCEPODs. East Cheshire NHS Trust intends to take the following action to meet the recommendations and requirements of each study. (We have taken into account the devolvement of responsibilities to other trust committees/groups and included actions informed by those bodies.)

Group or forum	National audit reviewed	Actions and progress
CARE Group (Clinical Audit Research and Effectiveness Group) monthly meetings	The following NCEPOD studies were reviewed by the CARE Group during 2014-15:- • GI Haemorrhage Study • Sepsis Study • Acute Pancreatitis Study The following NCEPOD reports were reviewed by the service lines during 2014-15:- • Tracheostomy Care: On the Right Trach? • Lower Limb Amputation: Working Together	**GI Haemorrhage study** discussed at the January and February CARE Group meetings. Trust NCEPOD reporter gave assurances that the dataset had been completed and returned to NCEPOD within timescales set. **Sepsis study** discussed at the May and August CARE Group meetings. Trust NCEPOD reporter had disseminated the paperwork to nominated lead for the prospective data collection to take place during 6th to 14th May 2014. Questionnaires disseminated to relevant consultants during August and all questionnaires returned by deadline, following national extension to timescales. **Acute Pancreatitis study** discussed at the December Care Group. Trust NCEPOD reporter liaised with the Information department to request the data for the patient identifier spreadsheet.

The reports of 120 local clinical audits were reviewed in 2014-15 and East Cheshire Trust intends to take the following actions to improve the quality of healthcare provided. (We have taken into account the devolvement of responsibilities to other trust committees/groups and included actions informed by those bodies)

Group or forum - CARE Group (Clinical Audit, Research and Effectiveness Group)

Monthly meetings.

Local audits reviewed - Clinical Records Management Audit and Re-audit

Actions and Outcomes

- CARE Group reviewed the results of the annual Clinical Records Management Audit conducted in spring 2014 and reported that all three business groups had achieved an increase in overall compliance compared with previous audit. The group agreed to carry out a re-audit in September 2014 for those specialties that had not achieved 75% compliance.
- The re-audit was carried out on 180 sets of case-notes across the service lines and compliance had increased in 70% of the criteria that have been re-audited across the service lines.
- One of the key issued identified related to the recording of alterations/deletions. Action taken included a review of the policy; which has made it clear as to what constitutes an alteration/deletion and the distinction between a minor alteration and a major change. This policy update has been disseminated as relevant and reviewed by the CARE Group members.
- The Clinical Records Management audit reports have been shared with the service line SQS Committees, to agree action plans with timescales for implementation.
- Any outstanding actions will be raised via the CARE Group quarterly reports to the trust's SQS Committee.

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Group or forum - Departmental Audit meetings Surgical Specialties

Local audits reviewed - All of the audits have actions plans for development or have achieved the standards of care. ***Audit of wound infection following elective upper limb surgery between January 2012 and June 2012.***

Actions and Outcomes

- To investigate the incidence of wound infection following elective upper limb surgery between January and June 2012 and the improvement of patient care by minimising risk of infection
- Standards of measurement: Incidence of infection in 3 previous departmental audits: 0.7%- 3.4%
- Incidence of infection reported in literature: 0.1%- 5%
- The incidence of wound infection following elective upper limb surgery between January and June 2012 was only 1.16%, which meets the local and international standards.

Group or forum - Clinical Support & Diagnostics. Audits have been undertaken by the pharmacy department and presented throughout the trust. We have included best practice examples.

Local audits reviewed All of the audits have actions plans for development or have achieved the standards of care. Audit to demonstrate the trust's compliance with National Patient Safety Agency (NPSA) Patient Safety Alert 20: Promoting Safer Use of Injectable Medicines.

Actions and Outcomes
An observational audit of intravenous medication administration was carried out across the trust to ensure compliance with NPSA 20 recommendations.

Observations were carried out over a four-month period by the Clinical and Professional Training Manager, of healthcare professionals administering intravenous medications.

Results:
The standards required to safely administer an IV medication were followed in the majority of observations.

Actions:

- Ensuring all syringes, including flushes, are labelled.
- Explaining to the patient, treatment and potential side effects.
- Checking of documented allergy status on front of drug chart prior to medication administration.

Actions from the audit have been assigned to the matrons and unit managers and the service line leads will oversee the completion of all actions identified

Group or forum - Women's & Children's

Local audits reviewed All of the audits have actions plans for development or have achieved the standards of care. (Snapshot VTE Audit on Maternity Ward and Audit of the NICE Clinical Guideline CG160 Feverish Illness in Children)

Actions and Outcomes

The aims of this audit were to measure how the Maternity Department performs, in comparison to that of different departments within the trust, regarding VTE assessments and prescribing.

The VTE process in Maternity is slightly different from that in the rest of the hospital due to alternative guidelines, risk factors and procedures. Trust-wide, the VTE is assessed by the doctors, whereas most of the time the VTE is assessed by the midwives who have an active role for the entire duration of these patients' pregnancies.

This audit was performed by a foundation year two doctor as a snapshot audit covering two days. Data was collected on 17 patients on the postnatal ward.

Results:
The department achieved 100% in several of the criteria measured including:

- Initial assessment at both antenatal and postnatal
- Provision of TED stockings to all risk patients
- All the patients were assessed for the right dosage of Tinzaparin according to weight

Actions:

- Re-assess the VTE 24 hours post-admission of any maternity patient
- Ensure the prescription for the Tinzaparin post re-assessment is done.

Audit of the NICE clinical guideline CG160 feverish illness in children
Aims of the audit:

- To determine whether we are following the NICE recommendations for the management of children aged under five, presenting with a fever of unknown cause.
- Aiming to improve the paediatric management of these children.

Results:
The department achieved 100% in several of the measured criteria including:

- Immediate life-threatening features identified
- Assessed in accordance with traffic light system
- Those who need parenteral antibiotics receive third-generation cephalosporin

NB: no children aged under three months were included, due to random sample and pro-forma automatically calculated results without taking into account other factors.

Actions:

- Re-audit be carried out on a prospective basis, on children with fever presenting to children's ward;
- Re-audit sample to include 50% patients aged under three months and 50% aged over three months.

Group or forum – Urgent Care

Local audits reviewed All of the audits have actions plans for development or have achieved the standards of care. Delirium in Critical Care

Actions and Outcomes

Aims of the audit:

To evaluate the recognition, prevention and management of patients at risk of delirium, following a drive to improve awareness among the nursing staff and changes to documentation that took place in 2013. The audit criteria and standards were based on the recommendations from NICE clinical guideline 103.

Results:

Delirium is a common condition associated with poor outcomes. All patients admitted to the Intensive Care Unit (ICU)/High Dependency Unit with a severe illness are at risk of delirium. Age, existing cognitive impairment and recent hip fracture compound that risk. This risk is not always documented.

All patients identified at risk of delirium should be screened and managed appropriately. Interventions to prevent and manage delirium are rarely documented.
The clinical guidelines on the pharmacological management of patients with delirium are not always referred to.

Actions:

Assessment

- Assess people at risk of delirium every eight hours using confusion assessment method (CAM)-ICU
- Embed delirium assessment into documentation by medical staff

Education

- CAM-ICU Diagnostic tool
- Non-pharmacological prevention and treatment

Medication

- Doctors to be aware of the prescribing criteria for delirium

Documentation

- Ensure pathway is completed
- Embed daily routine discussion of delirium assessment by consultant

Future

- Produce information for relatives/carers
- Review the use of physical restraints
- Provide a multi-component intervention package to prevent and treat delirium
- Re-audit in 2015 to ensure continued good practice and 100% compliance is achieved in all areas

Actions from the audit have been assigned and reviewed by the service line's Safety Quality Standards Committee.

Group or forum – Medical Specialties

Local audits reviewed All of the audits have actions plans for development or have achieved the standards of care. Audit to review the safe prescribing and administration of insulin.

Actions and Outcomes
Aims of the audit:
To review the safe prescribing and administration of insulin, by assessing the standards below. (The audit also reviewed ward nurses awareness of the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.

- Prescriber to sign and date
- Prescribers printed name, ID badge number and signature
- Type of insulin, brand and device
- Use 'units' in full, not 'u' or 'iu'
- Insulin administered by pen or insulin syringe
- Supply of insulin syringes in all areas
- Understanding of safe disposal of insulin needles

Standards met:

- Staff knew to use the insulin syringe to measure and prepare insulin
- All wards in Macclesfield Hospital keep stock of insulin syringes.
- All staff knew to use the sharps bin as written in the Policy for the Safe Administration of Insulin 2
- No prescription for insulin had abbreviated 'units'

Improvement needed:

- 16/18 prescriptions failed to meet all the criteria recommended by the NPSA and in the trust's Medicines Policy
- There was lack of awareness of how to safely remove insulin pen needles/ compliance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013

Actions:
Ensure prescribers are aware of the audit results and must include their signature, printed name and id number when prescribing medication (including insulin) on patients' drug charts. They must also include the type of insulin device.

All insulin prescribing errors are recorded on Datix and where they can be, reviewed by service line leads and the Safe Medicines Group.

The Task and Finish group is developing a policy for safe insulin pen needle disposal. This policy will be disseminated to all staff responsible for insulin administration and there will be training for staff on the use of safer sharps for insulin pen needles.

Group or forum – Allied Health Services

Local audits reviewed All of the audits have actions plans for development or have achieved the standards of care

DEN03 – Management and decontamination of surgical instruments (medical devices) used in acute care.

Actions and Outcomes

The 2014 annual dental audits were completed and submitted with scheduled follow-ups. Compliance issues included; expansion to create additional decontamination room at one site, along with facilities/equipment at two further sites.

Action plans where appropriate have been put in place.

All sites did fulfil the 'Essential' criteria but implementation of the actions would achieve 'Best Practice' at the identified sites.

Group or forum – Integrated Care

Local audits reviewed - All of the audits have actions plans for development or have achieved the standards of care. Audit on the Effectiveness of Prophylactic Proton Pump Inhibitors for Prevention of NSAIDs Associated Gastric and Duodenal Ulcers in Elderly

Actions and Outcomes

Aims of the audit: Chronic non-steroidal anti-inflammatory drugs (NSAIDs) are associated with gastric and duodenal ulcers, especially in vulnerable elderly patients.

The audit aimed to ensure that all elderly patients, who are taking NSAIDs on a regular basis are prescribed prophylactic proton pump inhibitors (PPIs) and are aware of the benefits and risks of these medications, to prevent development of upper gastrointestinal symptoms and ulcers.

Results:

- A total of 386 patients on NSAIDs were included in the audit on April 2014.
- 273 (71%) patients were prescribed concomitant prophylactic PPIs.
- 113 (29%) patients were not on PPIs, of them 90 (23%) patients were excluded.

Actions:

Postal letters were sent for the 23 (6%) patients who were prescribed NSAIDs without prophylactic PPIs. The 23 patients were seen in the practice, where the benefits and risks of concomitant use of PPIs were discussed and PPIs were prescribed.

A re-audit was done 12 weeks later.

Re-audit recommendations:

- A change in practice was made after the initial audit by Prescribing Prophylactic PPIs for patients who were prescribed regular NSAIDs without concomitant PPIs.
- After the re-audit it was recommended to: Continue the same practice, arrange an educational session for junior doctors to increase their awareness of factors contributing to NSAID-induced GI complications, particularly with respect to advanced age.
- Re-audit to be done 12 months later.

Audit examples of good practice

Surgical Specialties

Midazolam Usage for Sedation in Adults
Sedation is widely used in medical practice. Avoidable mortality and morbidity continues to happen despite multiple sets of recommendations and research.

The principal aims of the audit is to provide assurance that conscious sedation using midazolam is being performed safely and effectively at East Cheshire NHS Trust and that the recommendations of the National Patient Safety Agency (NPSA) Rapid Response Report entitled “Reducing Risk of Overdose with Midazolam Injections in Adults” (NPSA/2008/RRR011) [4] is being adhered to.

Our audit confirmed that the governance arrangements surrounding procedural sedation and in particular the administration of midazolam are good. In particular, we are fully compliant with all the recommendations of NPSA/2008/RRR011.

There are a number of different standards relating to midazolam administration. This likely reflects its usage by a number of different specialities for a variety of different indications.

We extracted the standards that we felt to be of most importance and based our audit on these. Overall the compliance was excellent, with only minor aberrations which are highlighted in the recommendations and action plan.

Recommendations:
- Action taken to ensure that all patients are given a leaflet explaining their sedation before they leave hospital
- Staff reminded to record any usage of flumazenil to reverse over-sedation on the trust’s incident reporting system, Datix.

Clinical Support and Diagnostics

Audit of Inclusion of Estimated Glomerular Filtration Rate (EGFR) on Outpatient Computerised Tomography (CT) Requests

The aim of the audit was to compare local provision of accurately-dated EGFR provision on CT request forms against Royal College recommendations and to examine the consequences of failure to meet these guidelines on Radiology workflow and manpower resources.

The use of intravascular contrast agents has increased dramatically in recent years. The potential risks of intravascular administration of contrast agents must be weighed against the potential benefits - acute renal failure is serious and costly. Nephropathy induced by contrast medium (CIN) remains one of the most clinically-important complications of the use of iodinated contrast medium.

Patients with EGFR < 45 ml/min are at progressively at increased risk of CIN which may invert the risk-benefit of proceeding with contrast-enhanced CT. Knowledge of recent EGFR is essential in risk stratification of patients and accurately-dated measurements are required on CT request forms as stated in current CT Standard Operating Procedure to clinical referrers.

Although all the patients in this audit had EGFR tests performed in a timely manner, only 16% of requests included these with relevant date on the form. 26% of patients have no EGFR result at time of request. Both of these issues combine to require CT staff to manually look up biochemistry results and accounts for eight full working days per year of lost superintendent radiographer time.

Findings from the audit as follows:

- 100% of patients had timely EGFR measurement at the time of CT contrast injection.
- 26% of patients did not have timely EGFR at time of making CT request requiring multiple checks until these results become available.
- 16% of 100% target achieved for these results to be included with accurate date on CT request form.
- Eight full working days of CT superintendent time lost per year spent looking up these omitted results.

Recommendations:

- Clinician refresh regarding existing standard operating procedure with respect to results being available at time of request, and including these along with date on the request.
- Present this audit data at Grand Round.
- Adhere more strictly to existing standard operating procedure for outpatient CT with respect to thorough form-filling to avoid significant loss of senior radiographer time.

Women's and Children's

Annual Maternity Safeguarding Audit

The objectives of the audit were to maintain, improve and monitor:

- frontline practice
- information sharing
- joint working

In line with Department of Health Working Together March 2014 methodology:

- 20 sets of hospital records were selected concerning babies delivered between April 2013 – April 2014, where safeguarding issues had been identified by midwifery staff.

The aims of the audit:

- To ensure that midwifery staff were working within the trust's Safeguarding Policy and guidelines
- To ensure information had been shared with health colleagues and partner agencies
- Ensure that the 'voice of the child' was being considered and documented

Recommendations:

- Improvements to be made in the documentation of postnatal care on the cause for concern form. This needs to be as contemporaneous as possible
- Multi-agency referral form to be filed in hospital records
- Safeguarding supervision to be undertaken every three months with the team leaders and ANC manager
- All child protection concerns to be notified to the named midwife
- All child protection concerns to be communicated with universal health services, eg GP and health visitor.

Actions from the audit have been assigned to the named midwife for safeguarding and antenatal team and will be monitored at maternity clinical governance meetings.

Urgent Care

Quality Improvement Project - Improving Medical Handover Project

Drivers:

- Patient safety
- Regional disparity
- Increasing out-of-hours activity
- Team communication
- National guidance
- Lack of documentation

RCP Handover Recommendations (Toolkit 1 2011) Structured Clinical Handover should:

- Be embedded in hospital culture and multidisciplinary teams
- Involve training in handover and communication
- Define who should be present
- Be tailored to individual hospitals/units

The project included four phases. Conclusions Phase I:

- We need a formal structured handover protocol
- We should introduce consultant-led morning handover
- We need to start keeping auditable documentation
- We need to ensure adequate training in handover for new doctors

Recommendations Phase II:

- Design a structured standardised handover protocol
- Implement changes from Wednesday April 2nd 2014
- Introduce daily morning handover with consultant presence
- Auditable documentation
- Handover education for new doctor induction
- Continue to build business case for electronic handover

Implementing change Phase III:

- Morning handover successfully introduced on rotation day
- Publicity via emails, medical staffing, daily presence, specialist registrar engagement
- Consultant presence, SpR-led
- Standardised handover protocol introduced twice daily
- Audit sheets

Resurvey/Audit Phase IV:

- June 2014 (two month post-implementation)
- Same themes resurveyed
- Similar number respondents
- Comparisons made with Phase I survey
- Audit sheets all collected: 98% compliance recorded

The next phase:

- Sustaining change – embedding culture (clinical champions),
- Encouraging timely handover, handover in medical induction
- ExtraMed (Hospipaedia) developing electronic admissions lists – functionality for documentation and task distribution during handover process
- Improved auditability
- Improved accountability and information governance.

Medical Specialties

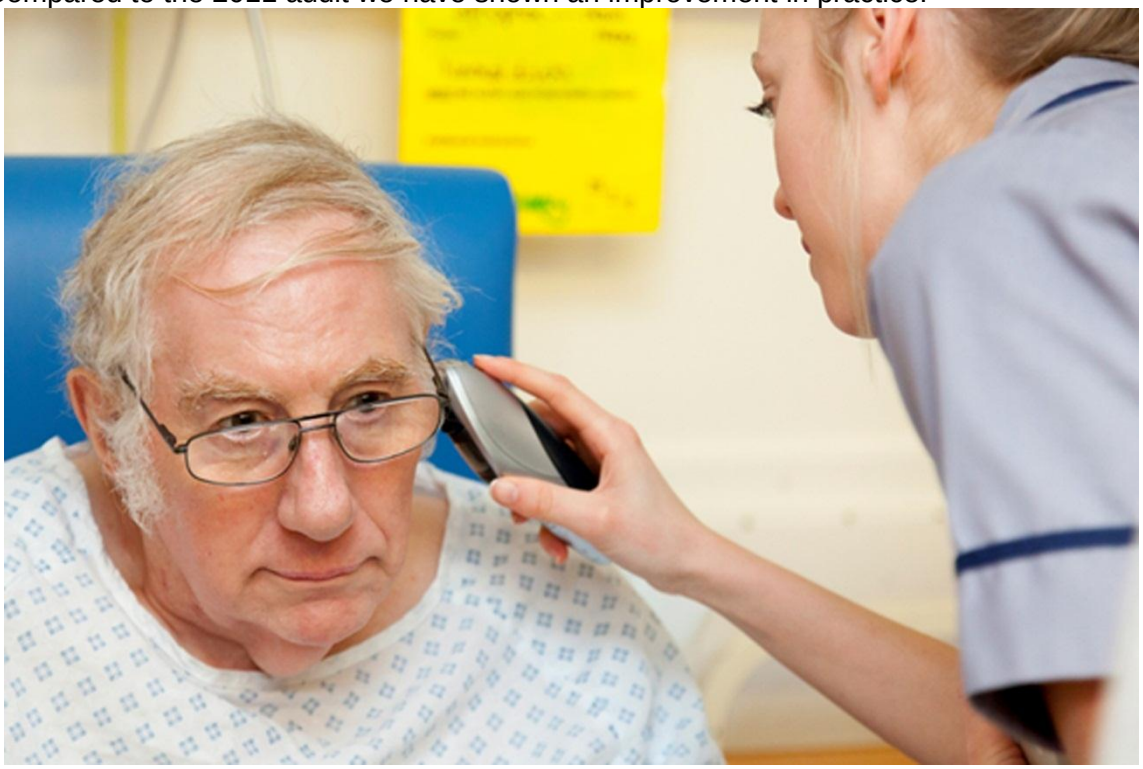
Warfarin prescribing for atrial fibrillation (AF) in stroke patients
All patients admitted with stroke and atrial fibrillation (AF) should have oral anticoagulants prescribed. Any contraindications should be documented and oral antiplatelet therapy commenced.

Methodology:
- Retrospective assessment of 261 patients admitted with stroke from 1/1/13 – 27/10/13
- Patients with a clinical coding of AF upon discharge were identified
- Review of all electronic discharge notification forms (eDNF) to see whether warfarin prescribed
- If no reason documented – patient notes were reviewed
- Results were tabulated

Results:
- 51 patients were identified between 1/1/13 – 27/10/13
- 31 (61%) of patients were prescribed warfarin on discharge
- Of the 20 patients not prescribed warfarin all had valid reasons documented
- 15 patients were placed on antiplatelet therapy
- The remaining five patients not on antiplatelet therapy had reasons documented

Recommendations:
- Extend audit to other wards in Macclesfield District General Hospital
- Medical staff education – audit presented to medical students, foundation year doctors and core trainees.
- Produce laminated sheets on the work stations to remind the discharge doctor to ensure patients with AF and stroke are risk stratified, oral anticoagulants offered and contraindications offered.
- Add a specific section on the eDNF to remind doctors to risk stratify patients in AF and offer anticoagulants

Compared to the 2011 audit we have shown an improvement in practice.



Integrated Care

Acute Trimethoprim Deficiency (in the elderly)
The aim of the audit was to evaluate whether we are following SIGN guidelines for the diagnosis of urinary tract infection (UTI) – specifically in the elderly. SIGN guidelines state "For inpatients over 65 years of age, diagnosis should be based on a full clinical assessment, including vital signs".

Methodology:

- Patients over the age of 65
- All patients had a diagnosis made of UTI either on admission or during hospital stay made by medical consultant.
- All patients were started on antibiotics to treat UTI
- Catheterised patients excluded once audit started

BMJ guidance states: "If a dipstick test has been done it should be considered useful only if the result is negative and no clinical features of urinary tract infection are present, thus excluding the latter. We do not recommend using urine dipstick tests to rule in the diagnosis of urinary tract infection in older people, on the basis of the evidence available from prospective studies and guideline recommendations".

Results:

- Of the 32 patients included in the audit, 15% met SIGN UTI diagnostic criteria, 85% did not meet the criteria.
- 90% of patients had diagnosis made/confirmed on urine dipstick, which is inappropriate according to SIGN and BMJ guidance

Recommendations:

- Urine dipsticks are not to be used to confirm diagnosis of UTI in the over 65s
- Do not treat as UTI unless they meet diagnostic criteria
- Caveat - If it is felt that a UTI is likely even when diagnostic criteria not met (history unobtainable) then check white cell count (WCC) and c-reactive protein (CRP)
- Observe the patient if unsure
- Chase up the results of the mid-stream specimen urine (MSU)

Corporate

New Unified DNACPR Policy

The objective for the interim audit was to measure compliance against the Unified Do Not Attempt Cardiopulmonary Resuscitation (uDNACPR) Adult Policy, published in August 2014. Comparisons with previous audits are not reflected, due to the fact the NHS North of England North West Unified DNACPR Adult Policy audit tool differs from versions previously used by ECNHST.

Methodology

- A standardised uDNACPR audit tool was used for the audit to assess whether East Cheshire NHS Trust policy was being followed in relation to uDNACPR decisions.
- A prospective study of 20 inpatients at Macclesfield District General Hospital (MDGH) with a uDNACPR order in place was undertaken.
- The audit was conducted by the resuscitation officer over a period of two days.
- As with previous audits, this audit assessed the adequacy of the documentation not the appropriateness of the uDNACPR decision.

Results:

Overall the audit demonstrated relatively good compliance with the uDNACPR Adult Policy, however the areas below require further improvement:-.

- A summary of communication with the patient, or details as to the reason communication cannot take place, needs to be significantly improved.
- A summary of communication with the patient's 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 needs to be made.
- Clinicians need to improve compliance with completion of the 'review' section.
- 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.
- 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 reasons as to why such discussions could not take place.

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The report including action plan has been issued trust-wide to the chief executive, interim medical director, Resuscitation Committee, heads of services, clinical directors, clinical tutors, Corporate Affairs and Governance Directorate and matrons. This will inform the audit results and required actions necessary to improve compliance. The re-audit is planned for May 2015.

Participation in clinical research

Participation in clinical research demonstrates the trust's ambition to improve the quality of care offered and make a contribution to wider health improvement.

Our clinical staff stay abreast of the latest treatment possibilities and active participation in research leads to successful patient outcomes. While maintaining the studies and following up participants recruited in previous years, a further 22 studies have been opened and 133 participants recruited to them in 2014/2015. These studies can either be approved by the National Institute of Health Research (NIHR) or other research studies including clinical trials conducted with external companies.

The trust is currently involved in clinical research studies of which the majority are portfolio studies covering a variety of medical specialities. Cancer services make up a large part of our portfolio which mirrors the situation nationally. The cancer unit runs a number of trials across a range of disease groups.

Oncology research

In 2014 the oncology research team at Macclesfield District General Hospital were the top recruiting site for an academic breast cancer study called POETIC, which recently closed to recruitment.

The POETIC (Perioperative Endocrine Therapy – Individualising Care) trial is a randomised phase III multi-centre trial in postmenopausal women with ER/PgR positive invasive breast cancer. The primary aim is to determine whether two weeks' perioperative aromatase inhibitor therapy before and after surgery improves outcomes compared with standard adjuvant therapy.

Out of the 130 sites recruiting, Macclesfield was the top recruiter, entering 147 patients into the trial, even beating the Royal Marsden Hospital, which sponsored the trial.

The success of the trial was as a result of:

- The time taken initially to set-up the trial by educating and informing staff in various departments.
- Getting the relevant departments on board to support the trial: e.g. radiology for identifying patients, pathology for sending off tumour blocks early to determine eligibility.
- Having the research team situated in the heart of the cancer resource centre where we work alongside the clinics.
- Having a research nurse attend every breast multidisciplinary team meeting to identify further patients.

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Quality Priorities 2015/16

Quality Strategy

The Quality Strategy demonstrates our commitment to deliver safe, effective and personal care, working in partnership to develop innovative and integrated ways of working that drive quality improvement. This will support the trust in achieving its vision and strategic objectives.

We aim to strengthen out of hospital care, enabling more patients to receive high-quality care in their own homes, in a community or domiciliary setting. Length of stay in hospital wards will continue to reduce, as a result of evidence-based enhanced recovery approaches for elective procedures, more timely discharge processes for complex elderly care and improved technology that safely supports remote monitoring.

We will ensure staff have the necessary knowledge, skills and competence to provide the best care in the best place for patients, listening and responding to individual needs and preferences. To fully achieve our ambition we need to work in a more integrated way.

We aim to 'join up' care more effectively by working in formal partnership with our commissioners, social care and other health providers through the Caring Together Programme in Eastern Cheshire and the Connecting Care Programme in South Cheshire and Vale Royal. We will build on our shared understanding of the needs of our population to strengthen services, co-designing quality standards for our community services, placing the patient at the centre.

Services will need to adapt and transform to meet the changing needs of our population. We will therefore continue to strengthen professional leadership, motivating and empowering doctors, nurses, midwives and allied health professionals to lead and deliver quality improvements.

Our explicit commitment to the national 'Sign up to Safety' campaign will further strengthen our focus and drive for harm-free care for all our patients within a culture of openness and transparency, learning and continuous service improvement.

The Quality Strategy is ambitious and achievable. It has been developed with service users, our staff and partners and embeds the values and behaviours we expect throughout every aspect of our work with a clear focus on safe, effective and personal care.

We look forward to seeing the positive and continuous improvement in patient outcomes, experience and performance metrics for the benefit of our patient population.

The Quality Strategy 2015-2019 supports the Clinical Service Strategy which aims to ensure that we deliver the best care in the right place for patients. This will effectively move some patients away from hospital care into more appropriate clinical care settings.

Quality care must be safe, clinically effective and provide a positive patient experience, wherever that care is provided.

For East Cheshire NHS Trust, quality encompasses four elements:

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

This 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 that prevent ill health and maintain quality of life. This approach of prevention and early intervention will help people maintain control of their lives and decrease their dependency on care services.

For young people we will continue to contribute to the public health agenda with a focus on improving the health of children and young people, through the early help programme, engaging families and carers in preventing ill health and maintaining wellbeing.

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.

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 for you."*

Quality improvement

What are we trying to accomplish?
We aim to reduce avoidable harm by 50%, to achieve the highest possible consistency of clinical care with better than expected mortality and to be in the top 20% of trusts for patent experience.

- No avoidable deaths
- Continuously seek out and reduce patient harm
- Achieve the highest compliance with evidence-based care bundles (Advancing Quality Programme)
- Deliver what matters most, working in partnership with patients, carers and families to meet their needs and improve lives
- Deliver integrated care close to home which supports and improves health, wellbeing and independent living

What have we achieved so far?

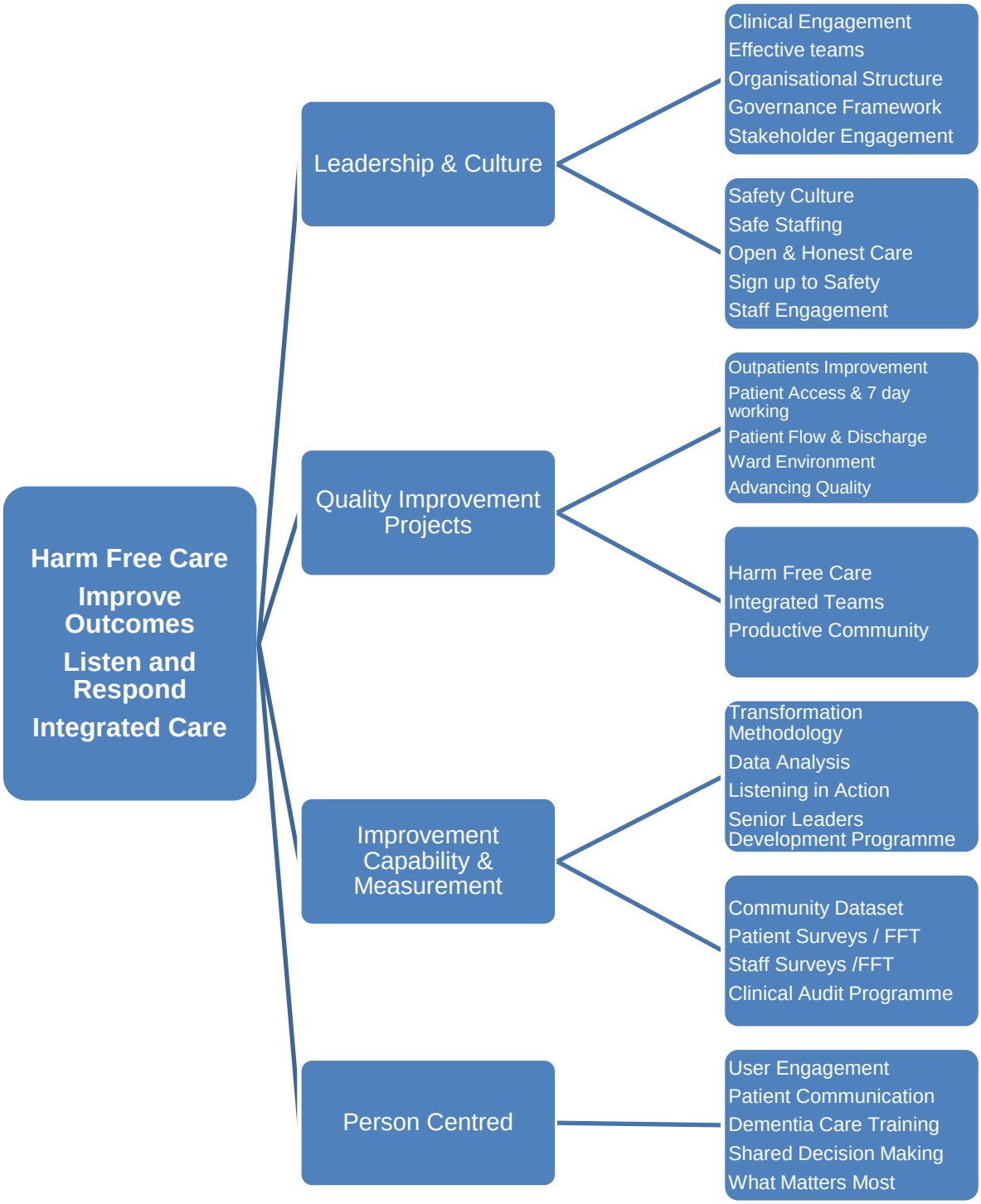
- Top five trust in the Patient Cancer Survey 2013/14
- First hospital in England to receive the National Autistic Society's Autism Access Award
- 87% of patients who expressed a preferred place of care achieved this in 2013/14
- 35% reduction in complaints
- 24% increase in compliments
- 20% increase in number of staff volunteers
- Improved awareness and community pilot of patient passports for long-term conditions
- 97.5% inpatient responses 'highly likely or likely' to recommend to friends and family
- 97.7% compliance with venous thromboembolism prophylaxis standard for all hospital admissions
- 79.1% breastfeeding initiation
- Rolled out electronic patient record system for community services (EMIS Web)
- Implemented enhanced recovery for major bowel surgery and hip and knee surgery, improving patient mobility and reducing length of stay by more than 50%
- Rolled out electronic recording of bedside observations on all acute ward areas
- Implemented a tool to measure the safety culture
- Adopted the NHS change model to plan, spread and sustain quality improvement

Measuring the safety culture
The Manchester Patient Safety Framework (MaPSaF) is a tool to help NHS organisations and healthcare teams assess their progress in developing a safety culture. MaPSaF uses critical dimensions of patient safety and for each of these describes five levels of increasingly mature organisational safety culture. The dimensions relate to areas where attitudes, values and behaviours about patient safety are likely to be reflected in the organisation's working practices. For example, how patient safety incidents are investigated, staff education, and training in risk management. The tool will be used to:

- Facilitate reflection on patient safety culture
- Stimulate discussion about the strengths and weaknesses of the patient safety culture
- Reveal any differences in perception between staff groups
- Help understand how a more mature safety culture might look
- Help evaluate any specific intervention needed to change the patient safety culture

Quality Improvement Model

To achieve our ambition we need an effective plan to engage with staff in all of our care settings. The following diagram summarises the areas of work we will prioritise over the next four years. Our intention is to identify variation in practice, apply service improvement methodology and improve efficiency and flow.



Our quality priorities for 2015 - 2016

Our priorities for 2015-2016 are consistent with our commitment to meet the requirements of the NHS Outcomes Framework, which contains indicators selected to provide a balanced coverage of NHS activity.

Harm-free care

Our trust has 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.

We will use the Summary Hospital-level Mortality Indicator (SHMIs), Risk Adjusted Mortality Indicators (RAMI) and crude mortality data to help us better understand any trends associated with patient deaths.

Medication errors
We will focus on 'near misses', omitted doses and low-harm incidents to further improve our approach to effective medicines management.

What will the outcome be?
Year-on-year improvement in relation to medicines management with a 50% reduction, over three years in omitted doses with no reason recorded.

Deteriorating patient
We will continue to roll out electronic systems (VitalPAC) to support the effective monitoring and management of the unwell patient and to ensure timely escalation of the deteriorating patient.

What will the outcome be?
All patients receive timely and responsive care in line with agreed care plan with appropriate escalation and intervention as required.

Infection prevention and control
We will continue to have a zero-tolerance approach to MRSA Bacteraemia. We will work towards an agreed improvement trajectory and year-on-year reduction in avoidable Clostridium Difficile.

What will the outcome be?
The achievement of agreed performance standards.

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.

What will the outcome be?

Clinical staffing levels in our community and hospital services will be benchmarked and aligned to agreed ratios. These will be reviewed six-monthly using recognised dependency assessment tools where these are available, supported by professional judgement.

Measured by?
Compliance with agreed levels for safe staffing will be monitored monthly with bi-annual reports to Trust Board.
We will assess the organisational 'safety culture' on an annual basis using a nationally-recognised tool, ensuring the trust demonstrates year-on-year improvement against the nine domains of safety culture including overall commitment to quality, with priority given to patient safety, organisational learning, education and team working in relation to safety issues.

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 datasets 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.

What will we do?

Quality data set community services - We will continue to work with our commissioners and local GPs to develop and agree a range of quality outcomes for community services and strengthen processes of data collection and clinical audit. We are already collecting activity data for community services but an improved focus is required to assess the clinical effectiveness, benefit to patients and any impact on other services. We will use information intelligently to support improved clinical outcomes, enabling staff to have real-time access to the care record in all settings.

Advancing quality - We will further develop the roll-out of advancing quality care bundles that ensure a consistent approach to patient care management.

Access to service and seven-day working - We will strengthen the supporting infrastructure for improved weekend working for example through enhanced ward clerk cover, PALS outreach, pharmacy access and therapies.

Intelligent Information - We will continue to encourage staff to report incidents and use data to understand how we can improve and share relevant learning across the organisation. This will be supported by improved technology and the development of effective performance reports that support the flow of key performance information from frontline services to the Trust Board.

Clinical Audit - We will agree a programme of clinical audit to support the continued improvement of quality outcomes, sharing learning and best practice across the organisation.

NICE Quality Standards - We will further develop evidence-based practice, ensuring we assess and appropriately implement NICE quality standards. This is important to ensure consistency and reliability of care delivery and benefit to patients. We will link with professional bodies regarding the development of safe staffing levels and monitoring of planned fill rates.

Leadership - We will ensure our clinical staff are effective through a programme of appraisal and revalidation, enabling them to feel empowered to deliver the highest quality care.

Ongoing development of core/specialist competency frameworks across all services for all grades of staff. We will lead the development of new models of care, benchmarking local service delivery against Royal College Standards and best practice.

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?’

What will we do?

Supporting vulnerable people
We will support the needs of individuals that require reasonable adjustments including patients with learning disability, dementia and autism, further developing self-care models.

Engaging patients, carers and service users
We will ask patients and their carers to tell us about what matters to them. We will engage service users in our services, building on our experience of involving patient representatives on recruitment panels and service development groups. We will focus on shared decision making with patients families and carers, involving staff in recognising the benefits of this.

Ward environment
We will improve the inpatient environment with a specific focus on reducing noise at night, enabling television, radio and internet access and increased single-room accommodation.

Timely discharge
We will improve our management processes to ensure there are no delays as a result of a wait for take-home medications or discharge information.

Cancelled outpatient appointments
We will strengthen our clinic booking processes to reduce the number of cancellations. Each specialty will have a trajectory of improvement.

End-of-life care
We will continue to encourage and support patients in identifying and achieving their preferred place of care at end-of-life.

Staff engagement and training

We will recruit staff who share our values, who are caring and compassionate.
We will continue to use 'Listening into Action' (LiA) methodology as a vehicle for improved staff engagement within the organisation. This takes a conversational approach to 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.

There will be a focus on the harder-to-reach groups, particularly those working in disparate community services.
We will also focus on engaging medical staff in leading quality initiatives and in further strengthening the relationship between clinical staff and managers with a shared focus on improving patient and staff experience

What will the outcome be?

- the trust aims to be in the top 20% of trusts for key indicators of patient and staff satisfaction.
- year-on-year improvement in patient survey responses relating to noise at night, discharge delays and hospital food.
- year-on-year improvement in outpatient survey responses in relation to waiting times for appointments and waiting times in the clinic.
- year-on-year improvement in staff survey responses in relation to staff recommendation of the trust as a place to work or receive treatment.
- implement measurement strategy in community and deliver year-on-year improvement.
- more 'better than expected' responses on the outpatient survey.
- positive responses to survey question: Do you feel your appointment today was worth the time? (biannual survey).

How will we measure this and know we are improving?
We will monitor a range of relevant indicators including:

- Friends and Family Test – patients and staff
- patient experience surveys
- complaints and PALS contacts
- commissioning for Quality and Improvement Targets (CQUIN)
- annual NHS Staff Survey and appraisal/professional revalidation process
- staff will understand and be able to articulate the four principles of person-centred care

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 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

What will we do?

Place of care - we will develop effective partnerships and new ways of working within an integrated care system to ensure patients receive care in the most appropriate setting for their needs.

This includes the development of effective multi-disciplinary team working focussed around the needs of patients, with the ability to respond to changes in care need in a flexible and timely way that prevents avoidable hospital admission.

Community-based teams such as district nurses, community allied health professionals and intermediate care teams provide high-quality and compassionate care within patients' homes or close by in community settings. We will ensure that out-of-hospital care and in-hospital care are of an equally high quality and the transfer of care between services must not appear disjointed for the patient.

Capability for integration

We will work with staff in both hospital and community settings to gain insight into their ambitions for improved co-ordination of care and personalised delivery.
We will support community staff in developing their knowledge and skills and provide practical support and resources from the service redesign team to enable transformation.

We aim to further strengthen and improve collective focus in the following areas:

- integrated community teams
- referral management processes
- documentation
- productive community improvement principles
- mobile working
- telemedicine
- delayed transfers of care
- paediatric community services
- information sharing

What outcomes are we working towards?

We know that we can improve the way we work between hospital and community services and with our partners.

We have considered what will be different if we get it right and are aligning to the ambitions of our commissioners. The following statements are examples of how we will evaluate our success, placing the patient at the centre of our efforts.

How will we measure this and know we are improving?

- patient satisfaction surveys in community settings
- staff survey responses to question relating to staff feeling involved in innovating and improving services for patients
- successful roll-out of integrated health and social care community teams
- involvement in national benchmarking and accreditation schemes e.g. IQIPS scheme
- (Improving Quality in Physiological Services) for Audiology
- development of EMIS to report clinical outcomes which are reported through the service line scorecard

Statements of assurance

A proportion of the income received at East Cheshire NHS Trust in 2014/15 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 2014/15 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 2014/15 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.

East Cheshire Trust (ECT) Quality Account 2014/2015 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 Trust (ECT) Quality Account for 2014/2015. ECCCG have reviewed the content and believe this is an accurate and comprehensive account and reflects the trust's position with the quality of services provided during 2014/15.

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

The trust's Quality Account complies with the prescribed statutory and mandatory obligations that it is required to adhere to. We have made this assessment from both our review of the document, and from our on-going assessment of services through the year. On a monthly basis we are provided with performance reports that inform us as to the quality of service provision.

The trust has faced particular challenges this year which include sustained pressure on services. Delivery of the A&E 4 hour treatment standard, as well as the 18 Week Referral to Treatment standard, have been a challenge. The trust took the opportunity to help treat those patients waiting longest for elective surgery through the national waiting list 'amnesty', which was approved by the CCG, NHSE and the Trust Development Agency. The continued success of this work has been challenged by the extraordinary winter pressures experienced this year. For a prolonged period in Quarter 4 the trust faced challenges with achieving these standards but has been pro-active in addressing the issues through improvement work centred on flow and capacity with a particular focus on reducing Delayed Transfers of Care which would release bed capacity.

The trust has continued to improve in other areas of quality through initiatives such as Sign up to Safety and through its Open and Honest Care Programmes, which have seen real developments in the provision of Harm Free Care. The trust has embraced the safety agenda and as an organisation they have set their objectives to delivering safety by reducing harm factors such as pressure sores and falls related harm.

We welcome and recognise the priority areas that the trust has set out in its work to develop quality outcomes through its Quality Strategy and we look forward to working collaboratively with them to further develop quality and safety for the services it delivers to the population of Eastern Cheshire.

East Cheshire Trust (ECT) Quality Account 2014/15 commentary on behalf of NHS South Cheshire CCG and NHS Vale Royal CCG

NHS South Cheshire Clinical Commissioning Group (CCG) and NHS Vale Royal Clinical Commissioning Group (CCG) welcome the opportunity to comment on East Cheshire NHS Trust (ECT) Quality Account 2014/15.

We have reviewed the content of the Quality Account and confirm that this complies with the mandatory elements required. However, it is important to point out that the services commissioned by NHS South Cheshire CCG and NHS Vale Royal CCG from ECT are predominantly community services, which will be the primary focus of our comments.
It was pleasing to see the introduction of the specialist community stroke rehabilitation services for South Cheshire and Vale Royal as one of the highlights in the 'Year at a Glance' section. This was further supported by a positive patient story that illustrated the pathway that was available and the benefits of having the intervention from the specialist community stroke rehabilitation team including earlier discharge from hospital and from the rehabilitation service. However, there was little in the document that related directly to other community services that we commission and it would have been appreciated to see these reflected along with any plans for improvements.

While the content of the patient stories reflects many of the 6C's from Compassion in Practice it would have been, in our opinion, useful to have a section dedicated to this subject. This could have included the basics of the 6C's, how it is being implemented in the community settings and what the plans are to ensure that Compassion in Practice is embedded within the teams and across the organisation.

The detail about the trust committing to the 'sign up to safety' campaign was minimal with the emphasis being on the priority areas where avoidable harm could be reduced. While those aims are to be commended it could have been useful to summarise what the pledges and action plans are for the campaign and how this is going to be communicated to frontline teams and other areas in the organisation.

We recognise and value the plan for the trust to continue working with NHS South Cheshire Clinical Commissioning Group and NHS Vale Royal Clinical Commissioning Group to develop and agree quality outcomes. We look forward to working together to identify quality outcomes for community services and strengthen the process for data collection and clinical audit particularly looking at the benefit to patients and impacts that occur.
No learning was highlighted from Adult Safeguarding or the large scale work that has been done with ECT regarding the commissioning standards. Instead safeguarding is only mentioned in relation to the annual maternity safeguarding audit. This feels like a missed opportunity and could have provided a scale of measurement and audit that could be threaded through all the service developments.

In 2015/16 we look forward to continuing working together in an open and collaborative manner in order to both develop and improve the quality of community services for our local population.

Healthwatch Cheshire East response to East Cheshire NHS Trust Quality Account 2014-2015

Healthwatch Cheshire East welcomes the opportunity to comment on the East Cheshire NHS Trust (ECT) Quality Account 2014/2015.

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).

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 welcomed the recognition and importance that 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 would have liked to have seen greater reference to ensuring that the trust specifically engages, listens and responds to patient groups that are seldom heard.

We have also received comments raising similar concerns to those the trust identified through the FFT with consumers reporting that there was a lack of staff on wards or very busy staff. We have been told that the impact of this on patients and their families makes them feel worried, concerned and distressed. We would therefore have liked to see how the trust was addressing this clearly reflected in the quality priorities for 2014/2015. We did welcome the target to increase the number of volunteers in the trust as these roles would add value to the care provided to patients.

We recognise that there have been significant challenges for the trust during 2014/2015 and value the relationship that Healthwatch Cheshire East and the trust have. We look forward to working with the trust during 2015-2016 to enable our community to have a powerful voice helping to shape and improve these services for the future.

If you would like more information regarding this document or if you require another language or format of this document (including easy read and audio) please contact us using our address details below:

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